

FOCUS *on* Health Reform



AUGUST 2010

EXPLAINING HEALTH REFORM:

Eligibility and Enrollment Processes For Medicaid, CHIP, and Subsidies in the Exchanges

On March 23, 2010, the Patient Protection and Affordable Care Act (ACA) became law, requiring most U.S. citizens and legal residents to have health insurance and establishing a state-based system of health benefit Exchanges through which individuals can purchase coverage, with financial support for those between 133–400% of the federal poverty level, and expanding Medicaid eligibility to those with income below that level. A number of provisions in the ACA require states to design and operate coordinated, technology-supported enrollment processes to assist Americans who lack access to affordable employer-based coverage in obtaining health coverage through Medicaid, the Children's Health Insurance Program (CHIP), or the Exchange. The law requires states to develop consumer-friendly application processes for these health subsidy programs, coordinate across them to enable seamless transitions, and reduce the burdens of application and renewal by minimizing the up-front information and documentation required to establish eligibility and instead developing procedures that tap available data from other sources.

The accompanying chart summarizes and provides highlights of the legislative language from ACA regarding the main enrollment provisions, particularly those of relevance to low- and moderate-income families. These provisions require enrollment systems that are:

Consumer-friendly: ACA requires states to create enrollment systems that ensure that applicants are screened for all available health subsidy programs and enrolled in the appropriate program, with minimal collection of information and documentation from applicants.

Coordinated: ACA requires states to coordinate efforts across available health subsidy programs to enable seamless transitions between those programs.

Simplified: ACA requires states to operate a streamlined enrollment process and foster administrative simplification, using uniform income rules and forms as well as paperless verification procedures.

Technology-enabled: ACA requires states to operate enrollment Web portals and securely exchange and utilize data to support the eligibility determination. In addition, ACA directs the Secretary of Health and Human Services to establish standards and protocols for electronic enrollment and eligibility systems, to allow for significantly improved streamlining and cross-agency capabilities.

With the passage of health reform, the United States has begun to build a culture of coverage, laying the foundation for this culture shift through new health coverage options, protections, and subsidies, as well as through provisions that promote individual responsibility. The first stone in this foundation has been laid with the July 1, 2010 launch of a federal informational Internet portal (<http://www.healthcare.gov>) that will ultimately have significant operational capabilities. Further, ACA tasks states with constructing an enrollment system that assists people in understanding their choices and helps them obtain and keep appropriate health coverage. In order to achieve the optimal enrollment process, with the technology that can support it, states need to begin planning and developing their policies, procedures, and systems right away, to ensure deployment by 2014.

CONSUMER-FRIENDLY

| Summary | Section | Specifics |
|---|---|---|
| Helps consumers understand their options | § 1103 | The Secretary of Health and Human Services (Secretary) will create, operate, and update an Internet portal to help consumers identify and compare available affordable coverage options, including Medicaid and CHIP. The portal was launched July 1, 2010: http://www.healthcare.gov/ . It will be fully functional as of October 1, 2010. |
| | § 1311(c)(5) | The Secretary will also design, for use by the Exchanges, a model template for an Internet portal that will assist individuals in "determining whether they are eligible to participate in an Exchange or eligible for a premium tax credit or cost-sharing reduction," among other functions. |
| Helps families apply online | § 2201 [New §1943(b)(1) of the Social Security Act (SSA)] | States are required to operate an Internet website that links the Exchange, Medicaid, and CHIP (as relevant). These websites shall allow individuals to compare available health subsidy programs and apply for or renew such coverage. State websites shall be in operation by January 1, 2014. |
| Provides for a single, streamlined application form | § 1413 | <p>The Secretary is required to develop a single, streamlined form that States can use for all those applying on the basis of income to applicable State health subsidy programs and that can be filed by an applicant online, in person, by mail or phone. Applicable state health subsidy programs include: premium tax credits and cost-sharing reductions in the Exchange, Medicaid, CHIP, and § 1331 state qualified basic health plans.</p> <p>States can develop their own single, streamlined form as an alternative to the Secretary's form as long as it meets the same standards.</p> <p>For applicants not applying on the basis of income, such as foster children and SSI beneficiaries, states may use a supplemental or alternative form.</p> |
| Reduces administrative burdens on applicants | § 1413(b)(2) | Individuals filing the single form "shall receive notice of eligibility for an applicable State health subsidy program without any need to provide additional information or paperwork unless... information provided on the form is inconsistent with data used for the electronic verification... or is otherwise insufficient to determine eligibility." |
| | § 2002(a) | No asset test will be applied in Medicaid for individuals whose income is calculated using modified adjusted gross income (MAGI), including parents and other non-elderly adults as well as children. |
| Expands presumptive eligibility for Medicaid applicants | § 2202 | At state option, all hospitals participating in a state Medicaid program can grant presumptive eligibility to all Medicaid eligible populations (not only pregnant women and children). This option is effective January 1, 2014. |
| Provides assistance to help consumers obtain coverage | § 1311(i) | Exchanges will set up a Navigator grant program to provide fair and impartial, culturally and linguistically appropriate information concerning enrollment in qualified health plans and available subsidies through the Exchange, facilitate enrollment in qualified health plans, and provide referrals for complaints. |
| | § 2201 [New SSA §1943(b)(1)(F)] | In addition, states will establish procedures for conducting outreach and providing enrollment assistance to vulnerable and underserved populations eligible for Medicaid and CHIP. |

SIMPLIFIED

| Summary | Section | Specifics |
|--|---------------------|---|
| Increases uniformity in income rules for all health subsidy programs | § 2002 § 2101(d) | <p>Modified adjusted gross income (MAGI) will be used to determine eligibility for all subsidized health programs. MAGI is defined in § 1401 (newly added § 36B(d)(2) of the Internal Revenue Code of 1986).</p> <ul style="list-style-type: none"> • A standard 5% income disregard will be used to determine Medicaid eligibility. • Provides exceptions to the use of MAGI, including when eligibility is determined for elderly individuals, dual eligibles, medically needy individuals, and those for whom eligibility is based on receipt of other aid (such as SSI and foster care assistance) and when an income finding has been made by an Express Lane agency. |
| Standardizes information required to establish eligibility for individual coverage, financial assistance, or exemption from individual mandate | § 1411(b) | <p>All applicants to the Exchange in the individual market will provide:</p> <ul style="list-style-type: none"> • Name, address, date of birth (DOB). • Citizenship (attestation and social security number (SSN)) or immigration status (attestation, SSN, identifying information as determined by Secretary and Homeland Security). <p>Individuals applying for a premium tax credit and/or cost-sharing reduction, or for exemption from the individual mandate, must also supply the following information:</p> <ul style="list-style-type: none"> • Information about income and family size. This can be supplied by the tax return, pursuant to § 1414. • As applicable, information related to changes in circumstances. • As applicable, information about available employer coverage. |
| Requires paperless verification and determination processes for the Exchange | § 1411(c) | <p>The Secretary shall provide that verifications and determinations of eligibility for participation in the Exchange, premium tax credits, and cost-sharing reductions, and eligibility for exemptions from the individual mandate are done electronically or by checking information submitted against federal records.</p> <p>The Secretary can modify the required verification methods if doing so will “reduce the administrative costs and burdens on the applicant.” One possible modification specifically mentioned in ACA is the possibility of allowing an applicant to request the Secretary of the Treasury to provide information directly to the Exchange or Secretary.</p> |
| Maximizes role of data-matching to support eligibility determination processes | § 1413(c) | <p>“Each applicable State health subsidy program shall participate in a data matching arrangement for determining eligibility for participation...” Using the data matching arrangement, each health subsidy program shall, to the maximum extent practicable:</p> <p>“(i) establish, verify, and update eligibility for participation in the program using the data matching arrangement...; and</p> <p>(ii) determine such eligibility on the basis of reliable, third party data... obtained through such arrangement.”</p> <p>An exception applies if the Secretary determines that “the administrative and other costs of use in the data matching arrangement... outweigh its expected gains in accuracy, efficiency, and program participation.”</p> <p>The data matching program will apply only to individuals who receive assistance from a health subsidy program or who apply for such assistance by filing the single, streamlined application form or by requesting an eligibility determination and authorizing disclosure of information required for that purpose.</p> |

TECHNOLOGY-ENABLED

| Summary | Section | Specifics |
|--|---------------------|--|
| Maximizes role of the Internet for purposes of application and enrollment | § 1413 § 2201 | Individuals will have access to an Internet website through which they can apply for and renew coverage online using the single, streamlined application for all health subsidy programs. Through the website, applicants who are eligible for Medicaid, CHIP, and premium tax credits or other subsidies through the Exchange will be able to compare their options. |
| Provides for secure electronic exchange of data | § 1413(c) § 2201 | Requires states to securely exchange data to determine eligibility. "Each state shall develop for all applicable health subsidy programs a secure, electronic interface allowing an exchange of data (including information contained in the application forms...) that allows a determination of eligibility for all such programs based on a single application." |
| Creates information technology standards and protocols to facilitate electronic enrollment | § 1561 | <p>The Secretary shall establish standards and protocols for electronic enrollment that allow for the following:</p> <ol style="list-style-type: none"> (1) "Electronic matching against existing Federal and State data, including vital records, employment history, enrollment systems, tax records, and other data determined appropriate by the Secretary to serve as evidence of eligibility and in lieu of paper-based documentation." (2) "Simplification and submission of electronic documentation, digitization of documents, and systems verification of eligibility." (3) "Reuse of stored eligibility information... to assist with retention..." (4) "Capability for individuals to apply, recertify and manage their eligibility information online..." (5) "Ability to expand the enrollment system to integrate new programs, rules, and functionalities, to operate at increased volume, and to apply streamlined verification and eligibility processes to other Federal and State programs, as appropriate." (6) "Other functionalities" necessary to streamline the process for applicants. <p>Provides for grants to states and localities to develop or adapt existing systems to meet the new standards and protocols. More broadly, the Secretary "shall notify" states about these standards and procedures and "may require, as a condition of receiving Federal funds for the health information technology investments, that States or other entities incorporate such standards and protocols into such investments."</p> |

This brief was prepared by Beth Morrow of The Children's Partnership and Julia Paradise of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured.

For further information about ACA, beyond its enrollment provisions, please go to the Kaiser Family Foundation's Health Reform site, at: <http://healthreform.kff.org/>.

This publication (#8090) is available on the Kaiser Family Foundation's website at www.kff.org.

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Health Benefit Exchanges: An Implementation Timeline for State Policymakers

By Patrick Holland and Jon Kingsdale

July 2010

Overview

This timeline is a resource for states to use in planning for the development of Health Benefit Exchanges under the Patient Protection and Affordable Care Act (PPACA). The overall timeline encompasses a core set of the major developmental tasks that states will need to address in order to launch their exchanges in compliance with PPACA by 2014. Appended to the overall timeline are four “threads” or sub-timelines that provide more detail on each of four major sets of tasks referenced in the overall timeline.

This resource reflects the authors’ experience in Massachusetts, as the founding executive director and chief financial officer of that state’s Health Connector, in developing the Commonwealth’s exchange. It also incorporates guidance from PPACA, plus what the authors have subsequently learned from preliminary efforts in three other states that have begun to plan for their exchanges. However, it does not reflect any official guidance, nor is it meant to be definitive. Clearly, as the United States Department of Health and Human Services (HHS) and other federal agencies develop regulations, programs and authoritative guidance for the states, much that is assumed herein may change or develop in far greater detail than is now known. Moreover, each state will want to customize a timeline to its particular circumstances and objectives.

These timelines are offered as a starting point—high-level summaries, grounded in the experience of the authors. The purpose here is to identify the optimal lead time a state needs to fully explore policy options and for an exchange to become operational. In doing so, the brief emphasizes: (a) the importance of strategic planning; (b) the need to sequence and coordinate inter-related tasks; and (c) the effort required to procure the services of and manage relationships with large vendors, including issuers of qualified health plans. Under PPACA, states enjoy a long lead-time and federal grant support

for planning exchanges and related market reforms. However, the complexity of these tasks requires advanced planning and close coordination with HHS, and the timelines suggest the need to start planning soon.

Far from being definitive, these timelines are meant to spark conversation in the states. A framework for identifying major decisions is offered, not detailed project management charts. These major decisions should be informed, to the extent feasible, by each state’s strategic objectives. For example, is the state simply looking to build an easy-to-use shopping tool for consumers? Or is it looking at the exchange more broadly as a market mechanism for transforming the way carriers do business and contract with providers? This strategic choice will inform the exchange’s contracting strategies with health plans, the decision-support tools that it offers consumers, and its marketing and outreach efforts. To take another example: is the state concerned that its exchange help ease the transition for safety-net providers from reliance on disproportionate share payments and other uncompensated care funding to commercial insurance reimbursement? Or is the state’s priority simply to moderate premium increases? Again, this strategic choice will affect health plan contracting strategies, whether the state should develop a Basic Health Program, and the nature of the state’s insurance market reforms.

As states begin to grapple with the specific issues of exchanges in the context of broader health insurance reform, these policy choices will be made—either implicitly without full understanding or explicitly and consciously. Starting the planning process early gives states the opportunity to understand the strategic options before making choices; starting late may mean states realize their implications only after they have rushed to implement decisions. PPACA clearly identifies some key choices: it gives states an option to merge their non-group and small-group markets; to contract out the exchange’s eligibility determination to the state’s Medicaid program; to join a multi-

state exchange or to leave the exchange to the federal government; to develop its own Basic Health Program in place of the exchange for the uninsured with incomes up to 200 percent of the federal poverty level (FPL); and to define small employers as those firms with up to 50 employees (for two years), rather than 100 employees. The timelines here raise other key decisions and indicate the substantial time required just to perform the major operational tasks of launching an exchange.

PPACA provides states with time and resources for strategic and operational planning; in the absence of such planning, each state will confront strategic choices without clearly understanding their implications, and will rush to implement programs that require long lead times. A hastily implemented exchange could disrupt the market and require significant state resources to repair.

The timelines suggest a daunting set of tasks, but the “take-away” can be as simple as recognizing the need to find an organizational home or work group in each state to begin this effort soon. That home might be a newly authorized exchange, a governor’s task force, or an existing department of state government. The entity’s ultimate productivity is likely to be directly related to the extent to which it is expected to execute and be accountable for these decisions. Eventually, such an entity will need very detailed implementation plans and timelines. For now, we hope that this document will spur states to begin to discuss and plan, while they still have plenty of time to do so.

We have outlined five timelines in the pages that follow. The Overall Timeline – Major Functions addresses the overall plan to develop a state-based Health Benefits Exchange under PPACA, working toward the legislatively mandated “go live” date of January 1, 2014. As the Timeline suggests, many activities necessary for the exchange to be fully operational by 2014 will need to be completed well before the go-live date. We have also included four additional sub-

timelines that are more detailed “threads” of activity embedded in the overall timeline. These four threads are for: (1) Eligibility and Subsidy Determination; (2) IT/Website Infrastructure; (3) Outreach, Marketing, and Advertising; and (4) Qualified Health Plan Procurement. Others, such as call center development, or enrollment and premium billing are important, but the four included here are especially significant in strategic terms.

Finally, this timeline builds toward an effective date for insurance coverage through the exchange of January 1, 2014. In 2010 and 2011, we have suggested fairly long intervals within which to start and complete the early planning tasks, as some states will have already begun this effort and others may prefer to wait. **This is the time for strategic planning.** The timeframes become tighter in 2012 and 2013, as key dependencies build toward going live with the exchange. Moreover, some states may have an interest in going live sooner than January 1, 2014, in which case the tasks in 2012 and 2013 would need to be shifted forward. This timeline also makes certain assumptions about the timing of initial grant funding, developing standards and protocols to facilitate the enrollment of individuals in subsidized programs, federal guidance regarding a system for eligibility and subsidy determination, and final approval of state-based exchanges from HHS. Except where specified by PPACA, these assumptions are the authors’ and do not represent any particular insight into federal policy.

Please note that these timelines are not completely chronological as many of these activities will occur simultaneously; in addition, different states may undertake various activities at different times. Finally, the reader should understand that a number of dates used in these timelines are dependent on the federal government issuing regulations, guidelines, and other programmatic information and have been determined by the authors based on reasonable assumptions.

About the Authors

Jon M. Kingsdale, Ph.D., was the founding executive director of the Commonwealth Health Insurance Connector Authority, an independent authority established in 2006 under Massachusetts’ landmark health reform legislation. As the executive director for the first four years of reform, he led key initiatives to make health insurance universally available and to reform health care financing in Massachusetts. The Massachusetts experience was fundamental to national reform and the model for insurance reform and exchanges under the federal Patient Protection and Affordable Care Act of 2010.

As a senior executive at the Tufts Health Plans for 20 years, Mr. Kingsdale was responsible for strategic planning, product development, public affairs and government relations. Prior to Tufts Health Plan, he worked in strategic planning and reimbursement at Blue Cross of Massachusetts, researched hospital

finances at the Harvard School of Public Health, consulted on health policy issues in Washington, D.C., and worked as a reporter for *Forbes*.

Patrick Holland is currently the managing director of Wakely Consulting Group. As one of the leading figures in the implementation of health care reform in Massachusetts, Mr. Holland previously served as the first chief financial officer of the Commonwealth Health Insurance Connector Authority. He led the financial operations and health plan procurements there from its inception in 2006 through February 2010.

Most recently recognized for creating an innovative competitive bidding model for the purchase of health care services, including the use of predictive modeling to encourage private health insurers participating in the insurance exchange to expand access and competitively price premiums, Mr. Holland leveraged the existing health insurance market to organize high quality, cost effective health care for Commonwealth Care, a publicly subsidized health insurance program for low income adults.

Mr. Holland brings a broad and unique perspective to healthcare finance and analytics, honed by nearly 20 years in the health care industry, including leadership positions at health insurers, integrated provider systems, a national cost management organization and most recently the start-up health insurance exchange called the Health Connector.

TABLE 1: Deadlines relevant to the development of a Health Benefit Exchange established by PPACA

| | | |
|-----------|---|---|
| 9/23/2010 | HHS to establish interoperable standards and protocols for enrollment in federal and state HHS programs | Section 1561 |
| 3/22/2011 | HHS to make available grants for planning and development of exchanges | Section 1311(a) |
| 3/23/2011 | HHS to develop standards for compiling and providing enrollees with a summary of benefits and coverage explanations | Section 1001, amending Public Health Services Act, Section 2715 |
| 1/1/2013 | HHS approves that the state will be willing and able to implement the exchange by 1/1/2014 | Section 1321(c) |
| 7/1/2013 | HHS to provide loans to assist with start-up costs for Co-Ops | Section 1322(b) |
| 1/1/2014 | Exchange must be operational | Section 1311(b) |

Overall Timeline through January 1, 2014 – Major Functions

Major Milestone: State workgroup begins to develop the informational database and understanding of issues that will inform discussions with state leaders and the drafting of grant applications

Timing: 4/1/2010 to 12/31/2010

- Staff health reform implementation workgroup (inter-agency/legislative)
- Develop project plan to apply for HHS exchange implementation grant when available
- Estimate range of enrollment take-up for individual/small-group markets
- Estimate the number of covered lives for “grandfathered” plans
- Scope out Medicaid expansions and changes
- Estimate cost and revenue impacts of PPACA on state budget
- Assess impact of new insurance rating rules on premiums
- Understand the potential of adverse selection to be experienced by exchange and develop mitigating policies
- Consider impact on the exchange of PPACA’s risk adjustment requirement
- Assess eligibility determination issues under PPACA for exchange, CHIP, Medicaid, etc.
- Identify state agencies/ legislative leaders to be involved in implementation

Major Milestone: States apply for Federal grants for: (1) HIT Enrollment Standards & Protocols (Section 1561 of PPACA); and (2) Development of its Health Benefit Exchange (Section 1311 of PPACA)

Timing: October 2010 to June 2011

- See Timeline #1 – Eligibility and Subsidy Determination Thread

Major Milestone: State begins to develop a strategic plan for its Health Benefit Exchange in context of implementing PPACA’s other key elements and passing state health care reform enabling legislation

Timing: 8/1/2010 to 10/31/2011

- Develop goals of an exchange
- Decide whether to organize state-based exchange, join multi-state exchange, or cede function to HHS
- Decide whether a new or modified office of consumer protection (ombudsman) is needed to meet the requirements of PPACA and, if so, whether to place it in the exchange
- Decide on a basic strategy for exchange, e.g. more or less aggressive in selective contracting for Qualified Health Plans (QHPs)
- Implement state review of health plan premium rates consistent with federal guidance (informing issue as it relates to the role of the Health Benefit Exchange)
- Develop governance and organizational structure for exchange
- Develop model legislation for exchange and insurance market reform
- Develop short term (3 months) administrative budget and identify personnel key for “Day 1”
- Enact insurance market reforms, including definition of small group market (50 vs. 100 employees)
- Authorize creation of Health Benefit Exchange
- Assess incremental costs (if any) to the state of its mandated benefits, in light of federal definition of Essential Health Benefits
- Decide whether to develop a Basic Health Program (for uninsured up to 200 percent FPL)

Major Milestone: State establishes Health Benefit Exchange and begins the planning to go operational

Timing: 1/1/2011 to 3/31/2012

- Appoint governing board (if any) and executive director (ED)
- Make key decisions identified during the strategic planning stage (see above)
- ED begins hiring key personnel
- Locate physical space for exchange
- Purchase computers and equipment
- Develop schedule of meetings with governing board (if any)
- Develop formal Plan of Operations
- Develop financial systems (general ledger, accounts payable, payroll, etc.)
- Develop funds flow model to identify future funding needs
- Develop budget for procurements of key IT systems

Major Milestone: State develops, issues, and reviews RFP for IT/Website Infrastructure and related decision-support tools

Timing: 7/1/2011 to 4/30/2012

- See Timeline #2 – IT/Website Infrastructure Thread for overview of detailed tasks
- If exchange is not established before 7/1/11, a significant component of IT/Website procurement may need to be undertaken before exchange is staffed

Major Milestone: State seeks and receives final approval from HHS for implementation of its Health Benefit Exchange

Timing: 1/1/2012 to 12/31/2012

- Submit application documents
- Respond to HHS inquiries
- Negotiate adjustments to meet HHS requirements for approval

Major Milestone: Exchange begins to develop and implement “Plan of Operations”

Timing: 1/1/2012 to 4/30/2012

- Begin regular meetings with key stakeholders
- Solicit market input from interested stakeholders for upcoming RFPs
- Begin policy development and document key processes (certification of exemptions from the mandate; rating of health plans; information to disseminate with decision support tools; Navigator; etc.)
- Create analyses to inform upcoming key decisions

Major Milestone: Select audit firm to assess system of internal controls and key processes and systems

Timing: 3/1/2012 to 6/30/2012

- Objective third-party review of all systems of internal control
- Assess adequacy of accounting and financial reporting system
- Determine adequacy of data security and back-up systems
- Test compliance with laws, regulations, contracts, and grant agreements

Major Milestone: Select vendor(s) for outreach, marketing, and advertising and develop strategy and materials

Timing: 4/1/2012 to 7/31/2012

- See Timeline #3 – Outreach, Marketing, and Advertising Thread for details

Major Milestone: Develop RFPs for:

- Navigators
- Call Center
- Financial Systems/Subsidy Reconciliation

Timing: 4/1/2012 to 7/31/2012

- Develop business/legal document to begin the formal procurement process
- Process with exchange governing body (if any), Commissioner of Insurance and Medicaid director
- Legal review
- Create "Data book" to provide detailed information to bidders for each RFP

Major Milestone: State implements federal eligibility and subsidy determination guidelines

Timing: 7/1/2012 to 12/31/2012

- See Timeline #1 – Eligibility and Subsidy Determination Thread for details

Major Milestone: IT/Website infrastructure developed and implementation well underway

Timing: 7/1/2012 to 4/30/2013

- See Timeline #2 – IT/Website Infrastructure Thread for details

Major Milestone: Issue RFPs and select vendors for:

- Navigators
- Call Center
- Financial Systems/Subsidy Reconciliation

Timing: 8/1/2012 to 12/31/2012

- Create procurement selection committees
- Develop scoring criteria
- Hold bidder's conference
- Release Q&A
- Process with exchange governing body (if any)
- Select vendors and notify all relevant parties
- Begin project management meetings
- Develop internal vendor management process
- Finalize technical specifications and reporting protocols
- Integrate all projects to ensure necessary overlap

Major Milestone: Begin development of Qualified Health Plan (QHP) RFP Specifications

Timing: 1/1/2013

- Create procurement selection committees

Major Milestone: Select QHPs and begin implementation

Timing: 7/1/2013

- See Timeline #4 – QHP Procurement Thread for details
- Begin consultation with QHPs over marketing & outreach activities

Major Milestone: Launch marketing & outreach campaign

Timing: 9/1/2013

- See Timeline #3 – Outreach, Marketing, and Advertising Thread for details

Major Milestone: Full Enrollment Systems Testing (all IT processes)

Timing: 9/1/2013

- Develop detailed testing plan
- Test functionality of systems between exchange, health plans, decision-support tools, Navigators, provider search function, etc.

Major Milestone: Begin selling health insurance

Timing: 11/1/2013

- Web portal fully functional
- Call center fully functional
- QHPs begin selling approved plans on exchange

Major Milestone: Health Benefit Exchange fully operational

Timing: 1/1/2014

Timeline #1 - Eligibility and Subsidy Determination Thread

Note: Due to unique timing issues, states will need to consider an entity accountable for the early planning, development and the awarding of grant funding for eligibility and subsidy determination as the Health Benefit Exchange may not be functioning prior to the effective date of certain key milestones.

Major Milestone: HHS, in consultation with the HIT Policy and HIT Standards Committees, shall develop interoperable and secure standards and protocols that facilitate enrollment of individuals in federal and state HHS programs (PPACA Sec. 1561)

Timing: 9/23/2010 (This date is 6 months after enactment of PPACA within which HHS is expected to issue standards)

- Electronic matching against existing federal and state data
- Simplification and submission of electronic documentation
- Capability for individuals to apply, recertify, and manage their eligibility information online including at home, at points of service and other community-based locations

Major Milestone: Federal grant money for HIT Enrollment Standards & Protocols available to states and other entities, to develop new and adapt existing technology systems to implement recommended standards and protocols

Timing: After 9/23/2010 (assumes grants available after HHS meets the 180-day requirement to develop standards)

- Those eligible for a grant must be a state, political subdivision of a state or local government entity
- Focus to be on changes to eligibility criteria and implementation of common application

Major Milestone: States apply for federal grant money for HIT Enrollment Standards & Protocols

Timing: 9/24/2010 to 3/31/2011

- State to decide recipient for grant funding such as Office of Medicaid, exchange or other state entity
- Complete application in compliance with HHS guidance
- Application must include proposed reduction in maintenance costs of technology systems
- Assurance that state (or entity) will share appropriate enrollment technology adopted under grant with other qualified entities at no cost, as required by PPACA

Major Milestone: States begin evaluative process of streamlining procedures for enrollment through a Health Benefit Exchange and state Medicaid, CHIP, and other health subsidy programs

Timing: 9/24/2010 to 6/30/2011

- Analyses of streamlining of process should be done in coordination with development of new or upgrade of existing enrollment systems
- Until further guidance from HHS is available, state can use PPACA Section 1413 to inform discussion and consideration of common enrollment elements of existing subsidized programs and elements of enrolling newly eligible individuals through the Health Benefit Exchange
- Consider need for IT vendor, and, if necessary, begin RFP process and vendor selection

Major Milestone: HHS to establish a system under which residents of each state applying to an exchange will be screened for eligibility under the state Medicaid, CHIP, and other health subsidy programs and enroll residents in such programs, if appropriate

Timing: 1/1/2011 to 6/30/2011 **start date is assumed based on reasonability standard*

- HHS to develop a single, streamlined form-form to be applicable to all state health subsidy programs and Health Benefit Exchange
- May be filed online, in person, by mail, or by telephone
- State may develop and use its own simple, streamlined form, if consistent with standards promulgated by HHS

Major Milestone: HHS to develop guidelines and a system for determining eligibility for exchange participation, premium tax credits, cost-sharing subsidies, and individual responsibility (mandate) exemptions

Timing: 1/1/2011 to 6/30/2011 **start date is assumed based on reasonability standard*

- Those eligible for a grant must be a state, political subdivision of a state or local government entity
- Focus to be on changes to eligibility criteria and implementation of common application

Major Milestone: State begins development of detailed technical specifications and implementation of simplified, streamlined eligibility determination and subsidy system, including electronic data interfaces with HHS

Timing: 7/1/2011 to 6/30/2012

- Assess federal guidelines against current eligibility system
- Ensure coordination with state Medicaid program and Health Benefit Exchange
- Develop secure electronic interface between all state-subsidized programs
- State-subsidized programs shall participate in a data matching arrangement for determining eligibility for participation in the program
- Develop electronic interfaces between state and HHS
- Ensure that enrollment systems meet federal specifications
- State may contract out function to the state Medicaid agency, but only if such agency complies with HHS requirements

Major Milestone: States begin evaluative process of streamlining procedures for enrollment through a Health Benefit Exchange and state Medicaid, CHIP, and other health subsidy programs

Timing: 7/1/2012 to 12/31/2012

- System will ideally be functional prior to beginning of QHP procurement
- Health plans, as part of RFP bid specifications, will need to understand technical details of interfacing with modified or new enrollment system

Timeline #2 - IT/Website Infrastructure Timeline Thread

Major Milestone: HHS to develop standards for compiling and providing enrollees with a summary of benefits and coverage explanations

Timing: No later than 3/23/2011

- Accurate description of the benefits and coverage
- Unified format, not to exceed four pages in length and in font size no smaller than 12-point
- Standards to be developed in consultation with the National Association of Insurance Commissioners (NAIC)

Major Milestone: State develops IT/Website Infrastructure approach

Timing: 5/1/2011 to 6/30/2011

- Creation of state inter-agency work team
- Solicit input from interested constituents such as consumer advocacy groups, health plans, business community, and brokers/intermediaries
- Begin process of determining elective content to be included on web portal including provider search function, consumer support tools, and health reform information

Major Milestone: State develops RFP for IT/Website Infrastructure vendor

Timing: 7/1/2011 to 9/30/2011

- Gap analysis of existing state tools, if any, that can be leveraged as part of the implementation
- Use existing web sites (state agencies, health plans, consumer groups) to assess level of information currently available to consumers
- Incorporate work identified by state inter-agency work team
- Development of a budget for web portal
- Identify selection committee to review RFP submissions
- Develop scoring criteria for vendor selection
- Development of vendor contract
- Process RFP with governing body of Health Benefit Exchange (*key assumption is that exchange is functioning at this time*)

Major Milestone: RFP issued and vendors respond

Timing: 10/1/2011 to 12/31/2011

- State publishes RFP
- Hold bidder's conference
- Release Question & Answer (Q&A) document to interested vendors

Major Milestone: State review of vendor submissions

Timing: 1/1/2012 to 4/30/2012

- Selection committee reviews all submitted bids
- Vendor bids are evaluated and scored
- Follow up questions and vendor responses completed
- Best and Final process, if applicable
- Vendor recommendation communicated to governing entities (state Medicaid office, Health Benefit Exchange governing body)

Major Milestone: State selects IT/Website Infrastructure vendor

Timing: 5/1/2012 to 6/30/2012

- Vendor selected
- Vendor contract finalized
- Project teams identified
- Kick-off meetings, goals of project, timelines established and communicated to all stakeholders

Major Milestone: State completes development of Eligibility and Subsidy Determination System

Timing: 7/1/2012 to 12/31/2012

- Critical electronic interface with web portal
See Timeline #1 – Eligibility and Subsidy Determination Thread for details

Major Milestone: State and vendor develop detailed business specifications and begin implementation

Timing: 7/1/2012 to 3/31/2013

- Software platform and electronic interfaces developed
- Application controls indentified
- Development of elective content to be included on web portal
- Electronic interfaces with other partners such as state Medicaid Office, Qualified Health Plans, etc

Major Milestone: Web Portal business specifications refined based on research and planning gained from marketing vendor

Timing: 1/1/2013 to 4/30/2013

- See Timeline #3 – Outreach, Marketing, and Advertising Thread for details
- Finalize “look and feel” of website based on consumer research
- Determine differences for non-group and small group market segments

Major Milestone: State selects QHPs

Timing: 7/1/2013

- Key participant in completing/testing web portal electronic interfaces (See Timeline #4 – Qualified Health Plan Procurement Thread for details)

Major Milestone: Systems integration completed and tested with all major stakeholders

Timing: 4/1/2013 to 10/31/2013

- Development completed
- Electronic interfaces tested
- Web portal functionality tested
- Process and protocols with other parties such as QHPs completed

Major Milestone: Website goes live

Timing: 11/1/2013

Timeline #3 - Outreach, Marketing, and Advertising Campaign Thread

Major Milestone: Create marketing and outreach strategy and develop Outreach, Marketing, and Advertising RFP

Timing: 4/1/2012 to 7/31/2012

- Marketing and outreach strategy informs RFP development
- Determine goals of state for procurement
- Provide data on size of target population segments
- Develop budget parameters
- Process with exchange governing body (if any)
- Develop business and legal documents

Major Milestone: State releases RFP and vendors respond

Timing: 8/1/2012 to 9/30/2012

- Hold bidders' conference
- Release Q&A document to interested vendors
- Create procurement selection committee
- Develop scoring criteria

Major Milestone: State evaluates vendors' responses

Timing: 10/1/2012 to 11/30/2012

- Score submissions
- In-depth interviews and references for finalists
- Request "Best and Final," if applicable

Major Milestone: Select Outreach, Marketing, and Advertising vendor

Timing: 12/1/2012 to 12/31/2012

- Inform all vendors
- Approval by exchange governing body (if any)
- Negotiate final contract terms with selected vendor

Major Milestone: Begin market research and planning activities

Timing: 1/1/2013 to 3/31/2013

- Define research objectives and specify methodology (e.g., interviews, focus groups, surveys)
- Conduct market research
- Meet with key stakeholders
- Conduct website usability "audit"
- Determine messaging, media channels and best approaches for reaching market segments
- Develop Return-on-Investment (ROI) metrics

Major Milestone: Finalize outreach & marketing campaign

Timing: 4/1/2013 to 8/31/2013

- Determine media mix
- Develop branding strategy and communication style guide
- Finalize implementation timelines and designate accountable individuals
- Begin discussion with potential partners, alliances
- Meet with advocacy community, agents and QHPs to educate/inform messaging
- Determine specific budgetary needs
- Communicate marketing plan to governing body (if any)

Major Milestone: Execute marketing campaign

Timing: 9/1/2013

- Finalize creative materials
- Put digital campaign tactics into operation
- Place media buy
- Develop work plan to monitor results, including survey research and feedback
- Create financial variance reports for actual expenditures

Timeline #4 - Qualified Health Plan Procurement Thread

Major Milestone: Develop RFP specifications for Qualified Health Plans (QHPs)

Timing: 1/1/2013 to 3/31/2013

- Identify goals of procurement
- Develop strategy for procurement
- Create incentives for health plans to participate, if applicable
- Develop business/legal document to begin formal procurement process
- Schedule ongoing communications/updates with exchange governing body
- Coordination/Communications with other state agencies such as the Division of Insurance & Office of Medicaid
- Legal review of procurement documents
- Creation of "Data book" to provide detailed information to bidders for RFP
- Regular communications with prospective QHP issuers
- Regular communications with other interested parties (e.g., advocacy community, providers, brokers)
- Finalize benefit designs for QHPs
- Model funds flow for exchange administrative fee, broker commissions, and intermediary fees such as a sub-connector, if applicable

Major Milestone: Begin formal procurement

Timing: 4/1/2013

- Publish RFP
- Hold a bidders' conference
- Release Q&A document to interested vendors
- Develop scoring criteria for RFP submissions
- Create selection committee

Major Milestone: Responses due from health plans

Timing: 6/1/2013

- Evaluate and score responses
- Develop follow up questions with health plans
- Modify procurement strategy based on health plan responses
- Process with exchange governing body (if any)
- Negotiate contracts upon selection

Major Milestone: Select QHPs and begin implementation

Timing: 7/1/2013

- Selection of QHPs by exchange governing body (if any)
- Notification to health plans
- Begin cross functional implementation meetings (e.g., with sales/marketing; actuarial/underwriting; operations; enrollment/billing; member services)

Major Milestone: Finalize all IT and operational protocols

Timing: 8/1/2013

- Finalize business requirements with QHPs
- Develop Policies & Procedures manual
- System design and functional workflow
- Begin development of broker & navigator training modules

Major Milestone: Development of member collateral materials

Timing: 9/1/2013

- Work with QHPs to review all member collateral materials
- Content for web portal, brokers, and Navigators complete
- Begin broker and navigator training

Major Milestone: Development of IT interfaces with health plans

Timing: 9/1/2013

- Enrollment files or secured interfaces with QHPs' enrollment and fulfillment system and with HHS ready for testing
- Test interfaces with QHPs' rating system for premium quotes
- Test funds flow reconciliations

Major Milestone: "Go Live": Qualified Health Plan products offered to Individual/Small Group markets

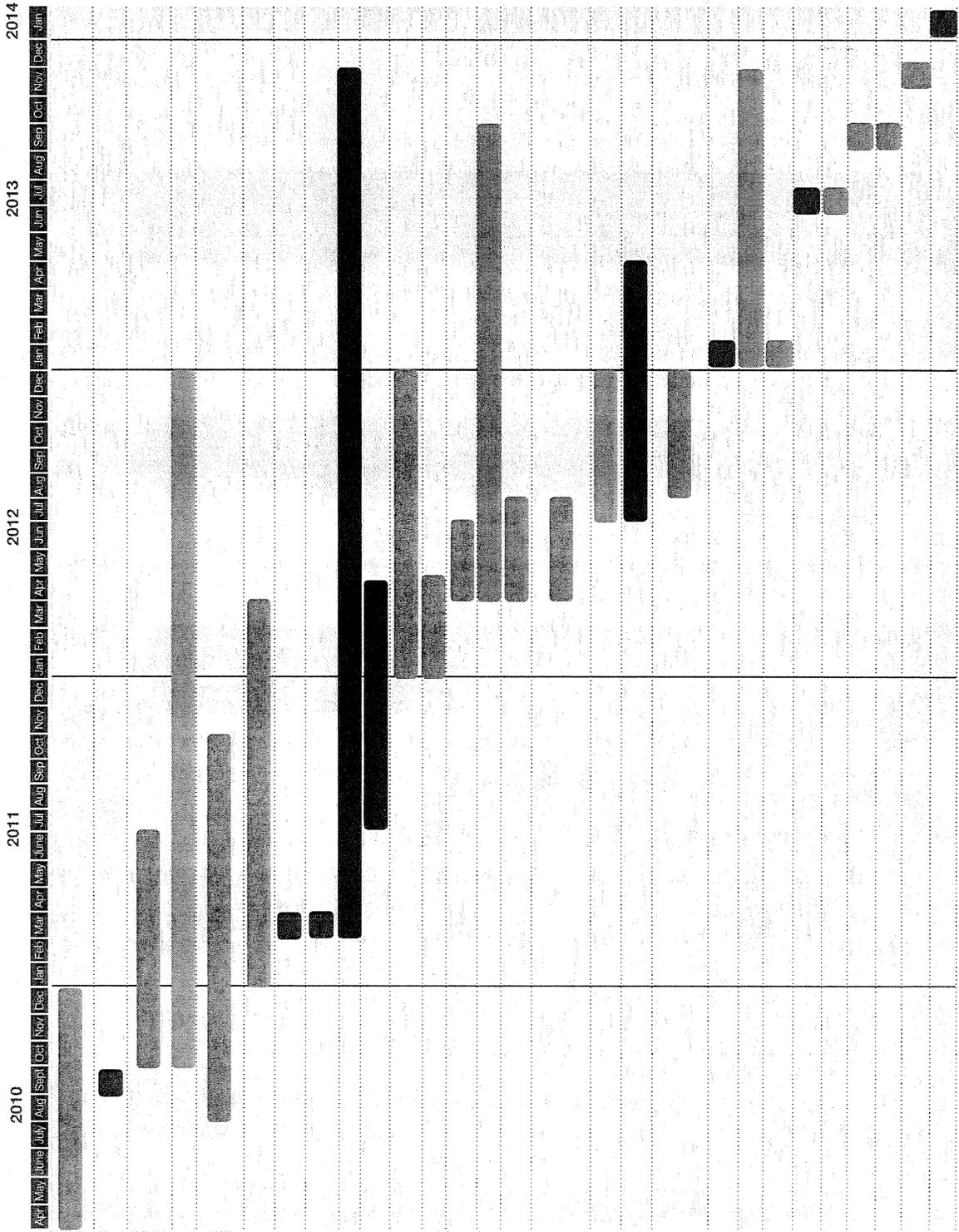
Timing: 11/1/2013

- Member collateral materials available
- Member enrollment and tracking capabilities operational
- Call center operational
- Web portal functionality for comparison shopping
- Collection of member premiums (if applicable)

¹ Section 1321 of PPACA indicates January 1, 2013, as the deadline for the states to have their proposed exchanges approved by the Secretary; failing this, the Secretary is authorized to operate an exchange for a state. It is not yet known what the Secretary will require by the end of 2012 as evidence that a state-based exchange can be operational by January 1, 2014. The authors have made their own assumption that something short of signed, long-term contracts between an exchange and its vendors will suffice for the Secretary's purpose and that states will want the Secretary's approval before making such contractual commitments to vendors.

Under PPACA, Navigators are to be funded from operations of the Health Benefit Exchange. Therefore, although we have noted within the overall timeline for go-live by 2014, the implementation of Navigators will most likely be post 1/2014 for states.

Major Exchange Timeline Tasks from "Health Benefit Exchanges: An Implementation Timeline for State Policymakers"



State workgroup begins to develop the informational database and understanding of issues that will inform discussions with state leaders and the drafting of grant applications

HHS to establish interoperable standards and protocols for enrollment in federal and state HHS programs

States apply for Federal grants for: (1) HIT Enrollment Standards & Protocols (Section 1561 of PPACA); and (2) Development of its Health Benefit Exchange (Section 1311 of PPACA)

Timeline #1 – Eligibility and Subsidy Determination Thread

State begins to develop a strategic plan for its Health Benefit Exchange in the context of implementing PPACA's other key elements and passing state health care reform enabling legislation

State establishes Health Benefit Exchange and begins the planning to become operational

HHS to make available grants for planning and development of exchanges

HHS to develop standards for compiling and providing enrollees with a summary of benefits and coverage explanations

Timeline #2 – IT/Website Infrastructure Thread

State develops, issues, and reviews RFP for IT/Website Infrastructure and related decision-support tools

State seeks and receives final approval from HHS for implementation of its Health Benefit Exchange

Exchange begins to develop and implement "Plan of Operations"

Select audit firm to assess system of internal controls and key processes and systems

Timeline #3 – Outreach, Marketing, and Advertising Thread

Select vendor(s) for Outreach, Marketing, and Advertising and develop strategy and materials

Develop RFPs for:

- Navigators
- Call Center
- Financial Systems/Subsidy Reconciliation

State implements federal eligibility and subsidy determination guidelines

IT/Website infrastructure developed and implementation well underway

Issue RFPs and select vendors for:

- Navigators
- Call Center
- Financial Systems/Subsidy Reconciliation

HHS approves that the state will be willing and able to implement the exchange by 1/1/2014

Timeline #4 – Qualified Health Plan (QHP) Procurement Thread

Begin development of QHP RFP specifications

HHS to provide loans to assist with start-up costs for Consumer Operated and Oriented Plans (CO-OPs)

Select OHPs and begin implementation

Launch Marketing & Outreach Campaign

Full Enrollment Systems Testing (all IT processes)

Begin selling health insurance

Health Benefit Exchange fully operational