VERMONT HEALTH INSURANCE EXCHANGE PLANNING

TASK 6.0: ANALYSIS OF EXCHANGE FINANCIAL FUNCTIONS
DELIVERABLE 2: DRAFT MATRIX OF FINANCIAL AND BUSINESS OPERATIONS

INTRODUCTION

Bailit Health Purchasing is assisting the State of Vermont with the design of its health insurance Exchange to meet the requirements of the federal affordable Care Act (ACA). Burns & Associates, Inc. (B&A), under contract with Bailit, is responsible for Task 6.0 of the Exchange work plan: An Analysis of Exchange Financial Functions.

In its first deliverable, B&A provided an overview of the financial infrastructure and practices in place in other state insurance programs, with a particular focus on the Catamount Health program and, to a lesser extent, the State Employees Health Insurance Plan.

This second deliverable builds upon the work of the first deliverable. Specifically, the following matrix outlines the finance and business functions to be performed by the Exchange and includes preliminary options and responsible parties for each. To delineate Exchange financial and business functions, B&A worked from the federal Office of Consumer Information and Insurance Oversight's Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges, which describes the requirements for applications for Establishment Grants. The State will have to outline its strategies for performing each of these functions in order to receive an Establishment Grant, so the organization of this matrix is intended to allow the State to begin to develop its responses using this framework.

After consulting with Bailit, B&A has included the following Core Areas from the grant instructions:

- Core Area 7: Financial Management
- Core Area 10: Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints
- Core Area 11: Business Operations of the Exchange

Within Core Area 11, the grant instructions include 19 discrete functions, which are listed separately in the matrix, although several have significant overlap. The grant instructions do not provide sub-functions for Core Area 7, but due to the varied components and importance of financial management, B&A created its own sub-functions. The State needs to consider each Core Area, but has discretion in which strategy to employ (e.g., the State must consider how premiums for coverage through the SHOP Exchange will be handled, but acting as an 'aggregator' is optional).

The matrix includes the following sections:

- Core Area Title
- Description – For Core Areas 10 and 11, the descriptions are adapted from the grant instructions. Since the grant instructions did not provide significant detail related to Core Area 7, B&A included its own descriptions, drawing on its previous deliverable.
- Milestones – The grant instructions list a number of milestones over the next few years. Those that are identified as mandatory in the grant application are noted with a ** in the matrix. For Core Area 7, B&A has included suggested milestones.
- Options and Responsible Parties – B&A has provided preliminary options, with responsible entities, for the State to consider.

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A listing of the functions and the potential responsible parties are summarized in the table below.

Function	Potential Responsible Party
Core Area 7: Financial Management	
7a. Develop Infrastructure and Internal Controls	Exchange Staff
7b. Exchange Funding	Depends on funding sources
7c. Premium Payments	(a) Exchange Staff, (b) Contractor, or (c) no role
7d. Premiums for Coverage Purchase through the SHOP Exchange	(a) Exchange Staff, (b) Contractor, or (c) no role
7e. Transparency and Reporting Mechanisms for the Public	Exchange Staff
Core Area 10: Providing Assistance to Individuals and Small Businesses, Coverage Appeals, & Complaints	
10. Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints	Included in 11a-11r
Core Area 11: Business Operations of the Exchange	
11a. Certification, Recertification, Decertification	BISHCA or Exchange Staff
11b. Call Center	Exchange Staff or Contractor
11c. Exchange Website; Premium Tax Credit & Cost-Sharing Reduction Calculator	DCF or UMass solution
11d. Quality Rating System	BISHCA or Exchange Staff
11e. Navigator Program	Exchange Contractors
11f. Eligibility Determinations for Exchange Participation, Advance Payment of Premium Tax Credits, Cost-Sharing Reductions, and Medicaid	(a) DCF Staff, (b) Exchange Staff, or (c) contracted Enrollment Broker
11g. Seamless eligibility and enrollment process with Medicaid and applicable State health subsidy programs	
11h. Enrollment Process	
11i. Applications and Notices	
11j. Individual Responsibility Determinations	
11k. Administration of advance premium tax credits and cost-sharing reductions	
11l. Adjudication of Appeals and Eligibility Determinations	AHS Human Service Board or Exchange Staff
11m. Notification and Appeals of Employer Liability for the Employer Responsibility Payment	VDOL process using ALJs or Exchange Staff
11n. Information Reporting to IRS and Enrollee	Part of 11f above
11o. Outreach and Education	Exchange Contractors
11p. Free Choice Voucher	Exchange Staff or Contractor
11q. Risk Adjustment, Transitional Reinsurance, and Encounter Reporting	Depends on federal guidance
11r. SHOP-Specific Functions	Combined with consumer Exchange functions

B&A's third deliverable under this task will be a revision to this matrix based upon feedback from the State and other stakeholders. The revised matrix will include preliminary cost estimates for each functional area. To the extent possible, B&A will develop cost estimates by the Core Areas listed above using the budget format required by the Establishment Grant instructions. Assuming timely feedback from the State, B&A's third deliverable will be completed by April 18, 2011.

Core Area		Description	Suggested Milestones (Core Area 7 did not have Required Milestones in Establishment Grant application)	Options and Responsible Parties
Core Area 7: Financial Management				
7a	**Develop Infrastructure and Internal Controls**	Complying with state and federal regulations requires that the Exchange have in place internal controls, accounting and auditing standards, reporting capabilities, etc.	First quarter 2013: in preparation for Exchange readiness review conducted by CMS	<u>Accounting System</u> - Utilize the state's VISION accounting system if it can accommodate the Exchange's needs - Build or import an accounting system and build interfaces with VISION <u>Policies and Procedures</u> - Adapt from and build on existing Catamount Health, Medicaid, State Employee Health Plan etc. policies and procedures

Core Area		Description	Suggested Milestones (Core Area 7 did not have Required Milestones in Establishment Grant application)	Options and Responsible Parties
7b	**Exchange Funding**	Exchanges must be financially self-sustaining by January 1, 2015. States have considerable latitude in determining how the Exchanges will be funded. As such, the State will have to determine how to fund the Exchange and how to collect the revenues. Additionally, procedures will have to be established to manage premiums and decisions made regarding the extent of Exchange involvement in this process.	Self sustaining by January 1, 2015	- Add a surcharge to all premiums for insurance coverage obtained through the Exchange; managing collection of this surcharge will depend upon the process for premium payments discussed in 7c - Establish an employer assessment; this may or may not be modeled on the existing Catamount Health assessment, which is collected by the Department of Labor - Increase or redirect tobacco taxes; these taxes are currently collected by the Department of Taxes and distributed to specified beneficiaries - Charge fees for services provided (e.g., providing 'aggregator' services for small businesses as discussed in 7d) - Establish new taxes or assessments (e.g., a sugared drink tax) - General Fund appropriations - Inasmuch as the Exchange performs administrative functions that benefit Medicaid, federal funds may be claimed by AHS for some functions

Core Area		Description	Suggested Milestones (Core Area 7 did not have Required Milestones in Establishment Grant application)	Options and Responsible Parties
7c	**Premium Payments**	Premiums for health insurance obtained by individuals through the Exchange will (presumably) be paid by the individuals themselves, who may receive federal premium assistance tax credits. The Exchange will need to determine how premiums will flow from individuals to insurers.	First quarter 2013: in preparation for Exchange readiness review conducted by CMS	- The Exchange could contract with a financial services company to manage receipts and collections and disbursements to insurers; AHS currently contracts with TD Banknorth to handle billing and deposits for Catamount Health - The Exchange could hire staff to manage receipts and collections and disbursements to insurers - The Exchange could opt to play little or no role, with individuals making payments directly to insurers as is done currently by residents who receive coverage through Catamount Health without premium assistance
7d	**Premiums for Coverage Purchased through the SHOP Exchange**	Small businesses may purchase coverage for its employees through the SHOP Exchange. It is possible that employees with a choice of multiple qualified health plans will choose different plans, requiring a process for small businesses to make payments to multiple insurers.	First quarter 2013: in preparation for Exchange readiness review conducted by CMS	- The Exchange could serve as an 'aggregator', wherein small businesses make a single payment to the Exchange, which then disburses the funds to the various appropriate insurers - The Exchange may contract for this function using a process similar to that for Catamount Health discussed in 7c, or hire staff perform this function - The Exchange could opt to play little or no role, with small businesses responsible for making payments directly to insurers

Core Area		Description	Suggested Milestones (Core Area 7 did not have Required Milestones in Establishment Grant application)	Options and Responsible Parties
7e	**Transparency and Reporting Mechanisms for the Public**	The Exchange must publish on an Internet website the following: - average costs of licensing, regulatory fees, and any other payments required by the Exchange - administrative costs of such Exchange - monies lost to waste, fraud, and abuse Similarly, health plans seeking certification as qualified health plans must submit to the Exchange the following information: - Claims payment policies and practices - Periodic financial disclosures - Data on enrollment - Data on disenrollment - Data on the number of claims that are denied - Data on rating practices - Information on cost-sharing and payments with respect to any out-of-network coverage - Information on enrollee and participant rights under this title	First quarter 2013: Outline of plan for publishing data in preparation for Exchange readiness review conducted by CMS. Fourth quarter 2013: Capacity to publish information on the website as required First quarter 2013: Outline of policies and procedures related to data that will be collected as part of health plan certification Third quarter 2013: Processes in place and data reporting flows fully outlined	- The website requirements must be considered as part of the development of the Exchange website discussed in 11c The information collected from health plans that are ultimately certified as a qualified health plan can be: -reviewed by existing BISHCA staff, -reviewed by staff hired specifically for Exchange functions, or -reviewed by an Exchange monitoring contractor

Core Area		Description (adapted from Establishment Grant application)	Required Milestones (from Establishment Grant application)	Options and Responsible Parties
Core Area 10: Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints				
10	**Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints**	Exchanges must 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 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.	** 2011: Analyze data collected by consumer assistance programs and report on plans for use of information to strengthen qualified health plan accountability and functioning of Exchanges. ** 2012: If the State chooses to operate these functions within the Exchange, establish protocols for appeals of coverage determinations including review standards and timelines and provision of help to consumers during the appeals process. ** 2012: Draft scope of work for building capacity to handle coverage appeals functions. ** 2012: Analyze data collected by consumer assistance programs and report on plans for use of information to strengthen qualified health plan accountability and functioning of Exchanges.	- These functions are separately delineated in the Business Operations section of the grant application (11a – 11r)

Core Area		Description (adapted from Establishment Grant application)	Required Milestones (from Establishment Grant application)	Options and Responsible Parties
Core Area 11: Business Operations of the Exchange				
11a	**Certification, Recertification, Decertification**	The Exchange must establish a process to certify, recertify, and decertify qualified health plans. In order to facilitate open enrollment in mid to late 2013, Exchanges must begin the process of selection and certification of qualified health plans in 2012.	** first quarter 2013: Launch plan management and bid evaluation system to allow upload of qualified health plan bids and other required information.	- BISHCA could be assigned this task on behalf of the Exchange as BISHCA currently oversees and regulates the insurance industry in Vermont, and licenses insurers to do business in the State - The Exchange could develop in-house capacity to fulfill this task

11b	**Call Center**	The Exchange must operate a toll-free hotline to respond to requests for assistance from consumers. 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 ACA may affect individual access to health insurance.	** third quarter 2013: Launch call center functionality and publicize 1-800 number. Prominently post information on the Exchange website related to contacting the call center for assistance.	- The Establishment Grant application states that "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."
				  - The Consumer Assistance Program is currently operated as a partnership between the Attorney General and the University of Vermont
				  - Vermont Legal Aid operates the Office of Health Care Ombudsman and operates a statewide hotline to help individuals navigate the complexities of the current health care system
				- Contract for the service. DHVA currently contracts with MAXIMUS to operate a toll-free line to (primarily) provide assistance to Green Mountain Care recipients and applicants.
				- The Exchange could develop in-house capacity to fulfill this task

Core Area		Description (adapted from Establishment Grant application)	Required Milestones (from Establishment Grant application)	Options and Responsible Parties

11c	**Exchange Website and Premium Tax Credit and Cost-Sharing Reduction Calculator**	The Exchange must maintain a website that, at a minimum:
		- provides applicants and enrollees standardized comparative information on qualified health plans, and allows them to apply for coverage and enroll online
		- includes transparency information
		- provides access to an electronic calculator that allows individuals to view an estimated cost of their coverage
			** first quarter 2011: Begin developing requirements for systems and program operations, including requirements related to online comparison of qualified health plans, requirements related to online application and selection of qualified health plans, premium tax credit and costsharing reduction calculator functionality; requests for assistance, linkages to other State health subsidy programs and other health and human services programs as appropriate.
			
			** first quarter 2012: Begin systems development.
			** third quarter 2012: Submit content for informational website to HHS for comment.
			** fourth quarter 2012: Complete systems development and final user testing of informational website.
			
			** first quarter 2013: Launch information website.
			** first quarter 2013: Collect and verify plan data for comparison tool.
			** third quarter 2013: Test comparison tool with consumers and stakeholders.
			** before open enrollment 2013: Launch comparison tool with pricing information but without online enrollment function.
			** as early as mid-2013: Launch fully functioning comparison tool with pricing information and online enrollment functionality on the first day of open enrollment.
				- Website functionality will have to be built or imported
				  - Build on the existing online application available through DCF
				  - Utilize the Exchange information technology framework being developed by the University of Massachusetts Medical School

Core Area		Description (adapted from Establishment Grant application)	Required Milestones (from Establishment Grant application)	Options and Responsible Parties

11d	**Quality Rating System**	Each Exchange must 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.		- This function may or may not be coupled with the certification of health plans discussed in 11a above
				  - BISHCA could be assigned this task on behalf of the Exchange as BISHCA currently oversees and regulates the insurance industry in Vermont, and licenses insurers to do business in the State.
				  - The Exchange could develop in-house capacity to fulfill this task

11e	**Navigator Program**	Each Exchange must establish a Navigator program, as required by Section 1311(i) of the ACA, 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.	** second quarter 2013: Determine Navigator grantee organizations and award contracts or grants	- According to the ACA, Navigators must have existing relationships, or the ability to readily establish relationships, with employers and employees, consumers, or self-employed individuals likely to be qualified to enroll in a qualified health plan. These entities may include trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, resource partners of the Small Business Administration, or licensed insurance agents and brokers. - May include the Consumer Assistance Program and/or the Office of Health Care Ombudsman noted in 11b

Core Area		Description (adapted from Establishment Grant application)	Required Milestones (from Establishment Grant application)	Options and Responsible Parties
11f	**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. 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 The Exchange must also have a process to handle appeals of eligibility determinations for enrollment in a qualified health plan and premium tax credits and cost-sharing reductions.	** first quarter 2011: Begin developing requirements, including requirements on the Exchange side and in other applicable state health subsidy program (OASHSP), (and other program agencies as appropriate), including integrating or interfacing with OASHSPs to support enrollment transactions and eligibility referrals, coordinating appeals, coordinating applications and notices, managing transitions, and communicating the enrollment status of individuals ** first quarter 2012: Begin system development, including any systems development needed by OASHSPs (and other programs as appropriate). ** fourth quarter 2012: Complete system development and prepare for final user testing, including testing of any systems within OASHSPs (and other programs as appropriate). ** first quarter 2013: Begin final user testing, including testing of all interfaces. ** third quarter or before open enrollment 2013: Complete user testing, including full end-to-end integration testing with all other components. ** as early as mid-2013: Begin conducting eligibility determinations for OASHSPs, coordinating all relevant business functions, and receiving referrals from OASHSPs for eligibility determination.	- Add Exchange eligibility to existing DCF eligibility workers' responsibilities - Establish a new unit to manage Exchange eligibility determinations - Utilize existing DVHA staff that compute Catamount premium assistance amounts - An eligibility requirements document for the Exchange should be developed to determine what functionality can be integrated into the VIEWS system once it is in place

Core Area		Description (adapted from Establishment Grant application)	Required Milestones (from Establishment Grant application)	Options and Responsible Parties
11g	**Seamless eligibility and enrollment process with Medicaid and applicable State health subsidy programs**	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. Longer term, 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. 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.		- Consideration as part of 11f

Core Area		Description (adapted from Establishment Grant application)	Required Milestones (from Establishment Grant application)	Options and Responsible Parties
11h	**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.	** first quarter 2011: Begin developing requirements for systems and program operations, including: providing customized plan information to individuals based on eligibility and QHP data, submitting enrollment transactions to QHP issuers, receiving acknowledgements of enrollment transactions from QHP issuers, and submitting relevant data to HHS. ** first quarter 2012: Begin systems development. ** fourth quarter 2012: Complete systems development and prepare for final user testing. ** first quarter 2013: Begin final user testing, including testing of all interfaces. ** third quarter of 2013 or before open enrollment: complete user testing, including full end-to-end integration testing with all other components. ** as early as mid-2013: Begin enrollment into qualified health plans.	- Consideration as part of 11b, 11c, 11e, and 11f

Core Area		Description (adapted from Establishment Grant application)	Required Milestones (from Establishment Grant application)	Options and Responsible Parties
11i	**Applications and Notices**	The Exchange must implement requirements for applications and notices, 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.	** as early as mid-2013: Begin utilizing applications and notices to support eligibility and enrollment process.	- Consideration as part of 11c and 11f

Core Area		Description (adapted from Establishment Grant application)	Required Milestones (from Establishment Grant application)	Options and Responsible Parties
11j	**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 ACA, and to communicate information on such requests to HHS for transmission to IRS.	** first quarter 2011: Begin developing requirements for systems and program operations, including: accepting requests for exemptions, reviewing and adjudicating requests, exchanging relevant information with HHS. ** first quarter 2012: Begin systems development. ** fourth quarter 2012: Complete systems development and prepare for final user testing. ** first quarter 2013: Begin final user testing, including testing all interfaces. ** third quarter 2013 or before open enrollment: Complete user testing, including full end-to-end integration testing with other components. **as early as mid-2013: Begin processing exemptions from individual responsibility requirements and payment and reporting to HHS on outcome of determinations.	- Consideration as part of 11f

Core Area		Description (adapted from Establishment Grant application)	Required Milestones (from Establishment Grant application)	Options and Responsible Parties
11k	**Administration of advance premium tax credits and cost-sharing reductions**	The Exchange must perform administrative activities related to premium tax credits and costsharing 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.	** first quarter 2011: Begin developing requirements for systems and program operations, including providing relevant information to QHP issuers and HHS to start, stop, or change the level of premium tax credits and cost-sharing reductions. ** second quarter 2012: Begin systems development. ** fourth quarter 2012: Complete systems development and prepare for final user testing. ** first quarter 2013: Begin final user testing, including testing all interfaces. ** third quarter 2013 or before open enrollment: Complete user testing, including full end-to-end integration testing with other components. **as early as mid-2013: Begin submitting tax credit and cost-sharing reduction information to QHP issuers and HHS.	- Consideration as part of 7a, 11b, 11c, and 11f
11l	**Adjudication of Appeals and Eligibility Determinations**	The Exchange must implement a process for processing appeals of eligibility determinations made by the Exchange for premium subsidies and Exchange participation, and this process will coordinate with Medicaid and CHIP.	**as early as mid-2013: Begin receiving and adjudicating requests.	- Assign appeals to the Human Services Board in AHS that hears appeals regarding Medicaid eligibility - Establish a new appeals process for Exchange eligibility determinations

Core Area		Description (adapted from Establishment Grant application)	Required Milestones (from Establishment Grant application)	Options and Responsible Parties
11m	**Notification and Appeals of Employer Liability for the Employer Responsibility Payment**	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.	** first quarter 2011: Begin developing requirements for systems and program operations including: coordination of employer appeals with appeals of individual eligibility and submission of relevant data to HHS. ** first quarter 2012: Begin systems development. ** third quarter 2012: Complete systems development and prepare for final user testing. ** first quarter 2013: Begin final user testing including testing all interfaces. ** third quarter 2013: Complete user testing, including full end-to-end integration testing with all other components. **As early as mid-2013: Begin notifying employers in coordination with eligibility determinations.	<u>Notifications</u> - Consideration as part of 11k <u>Appeals</u> - Utilize the same processes and resources as used for the Unemployment Insurance program, which includes three levels: an administrative law judge, the employment security board, and the Vermont Supreme Court - Establish a new appeals process for Exchange eligibility determinations

Core Area		Description (adapted from Establishment Grant application)	Required Milestones (from Establishment Grant application)	Options and Responsible Parties
11n	**Information Reporting to IRS and Enrollee**	The Exchange must report to the IRS and enrollees each year certain information regarding the enrollee's coverage provided through the Exchange.	** first quarter 2011: Begin developing requirements for systems and program operations, including: capturing data used in enrollment process, submitting relevant data to HHS for later use in information reporting, and capacity to generate information reports to enrollees. ** first quarter 2012: begin systems development. ** third quarter 2012: Complete systems development and prepare for final user testing. ** first quarter 2013: Begin final user testing including testing all interfaces. ** third quarter 2013: Complete user testing, including full end-to-end integration testing with all other components.	- Consideration as part of 7e and 11f
11o	**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.		- Utilize the entities serving as Navigators - Procure contractor(s)

Core Area		Description (adapted from Establishment Grant application)	Required Milestones (from Establishment Grant application)	Options and Responsible Parties
11p	**Free Choice Voucher**	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.	** first quarter 2011: Begin developing requirements for systems and program operations, including reporting to employers and managing financial components of Free Choice Vouchers. ** first quarter 2012: Begin systems development. ** fourth quarter 2012: Complete systems development and prepare for final user testing. ** first quarter 2013: Begin final user testing, including testing all interfaces. ** third quarter 2013 or before open enrollment: Complete user testing, including full end-to-end integration testing with other components. ** as early as mid-2013: Have in place 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.	- Similar to 7c, the Exchange could contract with a financial services company to manage receipts, collections, and disbursements - The Exchange could hire staff to manage receipts, collections, and disbursements

Core Area		Description (adapted from Establishment Grant application)	Required Milestones (from Establishment Grant application)	Options and Responsible Parties

11q	**Risk Adjustment and Transitional Reinsurance**	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 will release more guidance in the future.		- Dependent on final federal requirements
				- If encounter data must be collected:
				  - Use DVHA's MMIS vendor
				  - Use the VCURES database vendor

11r	**SHOP-Specific Functions**	The Small Business Health Options Program (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.	** first quarter 2011: Begin developing requirements for systems and program operations. ** first quarter 2012: Begin systems development. ** fourth quarter 2012: Complete systems development and prepare for final user testing. ** first quarter 2013: Begin final user testing, including testing all interfaces. ** third quarter 2013 or before open enrollment: Complete user testing, including full end-to-end integration testing with other components. ** as early as mid-2013: Begin enrolling employees of small employers into qualified health plans.	- Assuming that the Exchanges are combined, the functions of the consumer and SHOP Exchanges will presumably be combined