What is the Blueprint?

The Blueprint is the application describing readiness to perform Exchange activities and functions to the U.S. Department of Health and Human Services (HHS) for states seeking approval to operate a State-based Exchange.
Blueprint Components

Declaration Letter + Exchange Application
MN Declaration Letter

- Confirm intention to operate state-based Exchange
- Minnesota does not intend to operate a state-based Risk Adjustment program in 2014 but may consider in later years. Will defer to federal program in 2014.
- State will not operate a state-based reinsurance program. Will defer to federal program in 2014.
MN Declaration Letter cont.

- Streamlined eligibility process and infrastructure will facilitate eligibility for Medicaid and premium tax credits/cost sharing reductions. Do not intend to use federal service.
- Designation of state authorized agent(s) forthcoming.
Section 2: Application

- Files and documentation submitted by the State that demonstrates its Exchange’s ability to perform a particular Exchange activity.
- A compilation of:
  - Attestations
  - Descriptions of processes
  - Supporting documentation
  - Reference files
1.0 Legal Authority and Governance

- Enabling authority for Exchange and SHOP
- Board and governance structure

Open policy area, will not be attested to as complete
2.0 Consumer and Stakeholder Engagement and Support

- Stakeholder consultation plan
- Tribal consultation plan
- Outreach and education
- Call center
- Internet website
- Navigators
- In-person assistance program (if applicable)
- Agents/brokers (if applicable)
- Web brokers (if applicable)
MN Evidence: 2.1 Stakeholder Consultation Plan

- Stakeholder engagement plan, Task Force, Work Groups
- Signed Tribal consultation policy
Minnesota Health Insurance Exchange Technical Work Groups

- **General Charge**: Develop, discuss, and provide technical assistance on options directly to the Commerce Commissioner and indirectly to the Health Insurance Exchange Advisory Task Force.
- **Expectations**: One Exchange staff member and one stakeholder will co-lead each technical work group. Timelines and deliverables are expected to match the schedule determined by the Department of Commerce and the Health Insurance Exchange Advisory Task Force. All minutes and deliverables will be published online.

**Adverse Selection and Encouraging Market Competition and Value**

- **Scope**: Provide technical assistance on options to avoid adverse selection between the Exchange and the outside market for individuals and small employers and employees, and provide options for incentives for encouraging market competition and value.
- **Members**: 10-20 stakeholders will be asked to participate including consumer, large and small employer, health insurer, navigator, agent/broker, provider, and provider representatives as well as agency and legislative staff and market experts (actuarial, risk adjustment, etc.)
- **Meetings**: Weekly for 2 hours starting November 2011, less frequent meetings in 2012.
- **Subgroups**: Starting in 2012, (1) Risk Sharing and Risk Adjustment, and (2) Plan Certification.

**Navigators and Agent/Brokers**

- **Scope**: Provide technical assistance and develop information on options for navigators and agents/brokers to assist individuals and small employers and employees seeking coverage through a Minnesota Health Insurance Exchange.
- **Members**: 10-20 stakeholders will be asked to participate including consumer, large and small employer, health insurer, navigator, agent/broker, provider, and provider representatives as well as state agency and legislative staff.
- **Meetings**: Weekly for 2 hours starting November 2011, less frequent meetings in 2012.

**Governance**

- **Scope**: Identify and summarize information on potential options for the long-term governance of a Minnesota Health Insurance Exchange.
- **Members**: 10-20 stakeholders will be asked to participate, including health care law experts and state agency and legislative staff.
- **Meetings**: Weekly for 2 hours starting November 2011. Will merge with Financing work group and meet less frequently in 2012.

**Financing**

- **Scope**: Provide technical assistance and information on options related to the ongoing financing of a Minnesota Health Insurance Exchange.
- **Members**: 10-20 stakeholders will be asked to participate including consumer, large and small employer, health insurer, navigator, agent/broker, provider, and provider representatives as well as state agency and legislative staff.
- **Meetings**: Weekly for 2 hours starting November 2011. Will merge with Governance work group and meet less frequently in 2012.

**Tribal Consultation**

- **Scope**: Consult with tribal governments regarding the design and development of a Minnesota Health Insurance Exchange to address issues for American Indians.
- **Members**: Roughly 10 participants including Tribal and state agency representatives.
- **Meetings**: Existing group to continue to meet monthly.

**IT and Operations**

- **Scope**: Provide technical assistance related to information technology and operational issues for the development of a Minnesota Health Insurance Exchange.
- **Members**: 10-20 stakeholders will be asked to participate including consumer, small and large employer, health insurer, navigator, agent/broker, provider, county, and tribal representatives as well as state agency staff.
- **Meetings**: Will begin meeting in spring 2012 and may develop into multiple subgroups later in 2012.

**Individual Eligibility**

- **Scope**: Provide technical assistance and information on options for criteria, functions, processes, and assistance to support streamlined individual eligibility determinations for public and private coverage through a Minnesota health insurance Exchange.
- **Members**: 10-20 stakeholders will be asked to participate including consumer, health insurer, navigator, agent/broker, provider, county, and tribal representatives as well as state agency staff.
- **Meetings**: Will begin meeting in early 2012.

**Small Employers and Employees**

- **Scope**: Provide technical assistance and information on options available to small employers and employees through a Minnesota Health Insurance Exchange.
- **Members**: 10-20 stakeholders will be asked to participate including small employer and employee, health insurer, navigator, agent/broker, provider, county, and tribal representatives as well as state agency staff, health care market experts, legal experts, and human resources experts.
- **Meetings**: Started meeting in early 2012.

**Measurement and Reporting**

- **Scope**: Provide technical assistance and information on options for the reporting of cost, quality, and satisfaction for health insurers, benefit plans, and providers through a Minnesota Health Insurance Exchange.
- **Members**: 10-20 stakeholders will be asked to participate including consumer, small and large employer, health insurer, navigator, agent/broker, provider, and provider representatives as well as agency staff and other experts.
- **Meetings**: Started meeting in early 2012.

**Outreach, Communications and Marketing**

- **Scope**: Provide technical assistance and explore options related to outreach, marketing, and communication for a Minnesota Health Insurance Exchange.
- **Members**: 10-20 stakeholders will be asked to participate including consumer, small and large employer, health insurer, navigator, agent/broker, provider, and provider representatives as well as agency staff and other experts.
- **Meetings**: Started meeting in early 2012.

Contact: Carley Barber, Exchange Project Manager. Phone: 651.296.8578, email: carley.barber@state.mn.us
MN Evidence: 2.2 Tribal Consultation Policy

- Signed Tribal consultation policy
- Tribal work group meeting agendas and summaries
Minnesota Health Insurance Exchange Tribal Consultation Policy

1. INTRODUCTION

Consultation is an enhanced form of communication that emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues and better outcomes.

To establish and maintain a positive government-to-government relationship between the state and Indian tribes, consultation must occur on an ongoing basis so that tribes have an opportunity to provide meaningful and timely input on issues that may have a substantial direct effect on Indian Tribes. Consultation with Tribal Governments is especially important in the context of CMS programs because Indian Tribes serve many roles in their tribal communities:

- Tribal members are beneficiaries of services provided by the Indian Health Services (IHS), by tribal health programs operating under the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended, and by urban Indian health programs operating under Title V of the Indian Health Care Improvement Act.
- Tribal members are also eligible to enroll in Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), and Exchanges.
- Tribal governments operate businesses, are employers, and are health care providers, through administration of hospitals, clinics, and other health programs.

Many IHS and Tribal facilities are located in remote and isolated locations, experience difficulty in recruitment and retention of health professionals, and endure challenging socio-economic conditions. The involvement of Indian Tribes in the development of federal and state policies related to health care is crucial for mutual understanding and development of culturally appropriate approaches to improve American Indians’ access to federal and state health care programs, to enhance health care payment and resources to IHS and Tribal health providers, and to contribute to overall improved health outcomes for Indian people.

2. BACKGROUND

Since the formation of the Union, the United States has recognized Indian Tribes as sovereign nations. A unique government-to-government relationship exists between Indian Tribes and the Federal Government; this relationship is grounded in the U.S. Constitution, numerous treaties, statutes, Federal case law, regulations and executive orders that establish and define a trust relationship with Indian Tribes. This relationship is derived from the political and legal relationship that Indian Tribes have with the Federal Government and is not based upon race.

On November 5, 2009, President Obama signed an Executive Memorandum reaffirming the government to government relationship between the Indian Tribes and the Federal Government,
MN Evidence: 2.3 Outreach and Education

- Market research, PR and branding RFP
- Market research contract (Salter Mitchell)
- Marketing and communications plan
MN Evidence: 2.4 Call Center

- Call center assessment in process
- Work plan

Open area, will not be attesting to as complete
MN Evidence: 2.5 Internet Web Site

- MN technical infrastructure contract
- Business process models
MN Evidence: 2.6-2.9 Navigators, In-person Assisters, Agents/Brokers, Web brokers

- MN technical infrastructure contract
- Business process models
- Description of options

Open policy area, will not be attesting to as complete
3.0 Eligibility and Enrollment

- Single streamlined application for Exchange and SHOP
- Coordination strategy with Insurance Affordability Programs and SHOP
- Application, updates, acceptance and processing and responses to redeterminations
- Notices, data matching, annual redeterminations and response processing
- Verifications
- Document acceptance and processing
- Eligibility determinations
3.0 Eligibility and Enrollment

- Eligibility determinations for APTC and CSR
- Applicant and employer notification
- Individual responsibility requirement and payment exemption determinations
- Eligibility appeals
- QHP selections and terminations, and APTC/advance CSR information processing
- Electronically report results of eligibility assessments and determinations
MN Evidence: 3.1 Single Streamlined Application(s) for Exchange and SHOP

- MN technical infrastructure contract
- Business process models
- Interagency agreements
- List of data elements

Awaiting federal single streamlined application from HHS
Single Streamlined Application Data Elements for Insurance Affordability Programs

Account Creation/Sign-in (for online application)
1. Account Creation Data elements TBD (May just be name, email address)
2. Sign in options: Individual, Assistant, Navigator, Agent/Broker
3. User ID and password

Applicant Rights and Responsibilities Information
1. Privacy, Confidentiality, and Data Sharing Information
2. Accept terms?

Contact Information
Household Contact
1. Name of Contact (First, middle name, last, suffix)
2. Home Address (Street, apartment, City, State, Zip Code)
   a. Need option for no fixed address
3. Mailing Address – if different from home address
4. Phone Numbers
   a. Primary (where you can be reached) (type – cell phone)
   b. Secondary (type – cell phone)
5. Language
   a. Spoken
   b. Read
6. Preferred forms of communication
   a. Email – provide email address
   b. Text message
   c. Option to receive notices electronically
7. Applying for coverage for himself/herself?

Authorized Representative
1. Yes/No
2. If yes, Name of Authorized Representative (First, middle name, last, suffix)
3. Organization, if associated with an organization
4. If yes, Mailing Address (Street, apartment, City, State, Zip Code)
5. If yes, Phone number
6. If yes, Permissions to:
   a. Sign application
   b. Receive notices
   c. Act on applicant’s behalf for all matters related to the application or account
7. Signature of applicant designated the representative

Financial Assistance
1. Seeking financial assistance? (Y/N)
2. If yes to (1), and application is being completed through an assistant/navigator/agent/broker
   account via sign-in or an authorized representative was designated then,
   a. Authorization of third party to view Federal Tax Information
   i. Contact information (detail to be determined with IRS)
MN Evidence: 3.2 Coordination Strategy with Insurance Affordability Programs and SHOP

- Interagency agreements
- Roles and responsibilities
- MN technical infrastructure contract
- Business process models
STATE OF MINNESOTA
INTERAGENCY AGREEMENT

WHEREAS, the Minnesota Department of Human Services (hereinafter "DHS") and the Minnesota Department of Commerce (hereinafter "DOC") are empowered to enter into interagency agreements pursuant to Minnesota Statutes, 471.59 subdivision 10; and

WHEREAS, DHS is the designated state Medicaid agency and is responsible for administering the Medical Assistance (hereinafter referred to as the "MA") program; and

WHEREAS, DHS is modernizing the current Eligibility Determination and Enrollment Systems for the MA program; and

WHEREAS, DOC has been awarded a Health Insurance Exchange Level I Establishment Grant by the federal Department of Health and Human Services through a Health Insurance Exchange Level I Establishment Grant Agreement to design and develop a Minnesota Health Insurance Exchange ("Exchange") that includes enrollment, eligibility and account management functions that benefit the MA program; and

WHEREAS, the Health Insurance Exchange Level I Establishment Grant Agreement requires, among other items, cost allocation to the MA program, and

WHEREAS, DOC and DHS have a mutual interest in the design and development of the Exchange as it pertains to public program enrollment, eligibility and account management within the Exchange.

NOW, THEREFORE, it is agreed:

I. DOC Duties: DOC shall:
   a. Allocate eligible Health Insurance Exchange development costs to the MA program in accordance with OMB-A-87 requirements and standards. Eligible costs and the cost allocation methods are outlined in Exhibit A, which is attached hereto and incorporated herein.
   b. Invoice DHS for MA eligible costs in accordance with the terms of Exhibit A.
   c. Obtain any and all necessary approvals/Grant Reviews required by the Center for Consumer Information and Insurance Oversight (CCIIO).
   d. Invoice the Minnesota Department of Health ("MDH") for the Minnesota state share of the Provider Display Module as defined in Exhibit A. The Minnesota state share for the provider Display Module shall be paid to DHS to the extent necessary for obtaining Federal Financial Participation ("FFP") and invoiced in accordance with the terms of Exhibit A.

II. DHS Duties: DHS Shall:
   a. Reimburse DOC for the MA share of any and all development costs of the Exchange in
<table>
<thead>
<tr>
<th>Activity / Function</th>
<th>Exchange Business</th>
<th>DHS Business</th>
<th>Exchange Legal</th>
<th>DHS Legal</th>
<th>MN.IT (Exchange, DHS, Comm)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analysis and requiremments documentation of Eligibility Policy for Insurance Affordability Programs (IAP) for initial launch of Exchange: Medicaid - CHIP - Advanced Payment Tax Credit (APTC)</td>
<td>Accountable for final approval of documented eligibility policy requirements for: APTC - CSR</td>
<td>Responsible for all IAP programs</td>
<td>Accountable for final approval of documented eligibility policy requirements for: Medicaid - CHIP - BHP</td>
<td>Informed</td>
<td>Consulted</td>
</tr>
<tr>
<td>Analysis and requiremments documentation of Mandate Exemption</td>
<td>Accountable for final approval of requirements</td>
<td>Responsible</td>
<td>Consulted</td>
<td>Informed</td>
<td>Informed</td>
</tr>
<tr>
<td>Analysis and requiremments documentation of policy for eligibility to enroll in OHP through the Exchange for initial launch of</td>
<td>Accountable for final approval of requirements</td>
<td>Responsible</td>
<td>Consulted</td>
<td>Informed</td>
<td>Informed</td>
</tr>
<tr>
<td>Analysis and requiremments documentation of Exchange Notices policy requirements: template (dynamic/static) content, etc.</td>
<td>Responsible and Accountable for overall notice design and content for all IAP, SHOP notices and general communication</td>
<td>Responsible</td>
<td>Informed</td>
<td>Informed</td>
<td>Informed</td>
</tr>
<tr>
<td>Analysis and requiremments documentation of Medicaid and CHIP Appeals business requirements for initial launch of</td>
<td>Consulted</td>
<td>Responsible and Accountable for non-legal business policy requirements</td>
<td>Consulted</td>
<td>Responsible and Accountable for legal adjudication requirements</td>
<td>Informed</td>
</tr>
</tbody>
</table>
MN Evidence: 3.3 Application, Updates, Processing and Responses to Redeterminations

- MN technical infrastructure contract
- Business process models

Evaluating options related to in-person, phone and mail in conjunction with customer service assessment and navigator/broker provisions. Will not be attested to as complete
II.  **Entire MNHIX Functionality**

1. The Contractor will be required to work with and facilitate integration with specified external systems (e.g., Federal Data Services Hub, SERFF).
2. The Contractor’s Solution will allow all notices generated through any module to be viewed via a User account.
3. The Contractor’s Solution will provide an option for an individual, once an individual has created an account, to save data and exit the application process at a later time and continue the application process at generally the same place in the application workflow as when they exited.  
4. The Contractor’s Solution will determine if an individual has an account within the system before they are able to save a session point of progress.
5. The Contractor’s Solution shall provide the ability for an individual to search and select an Assister for assistance.
6. The Contractor’s Solution shall allow Assistors to act on behalf of individuals, families, households, employers, and employees.  
7. The Contractor’s Solution shall display to individuals, at the beginning of a process, of the number of steps required to complete the process, which steps they have completed, (if practical to display that information at the start of a process) which step they are currently completing, (if practical to display that information at the start of a process) how many steps remain, and general information they may need to complete the process. The State will provide to the Contractor for inclusion in the display: the general information needed to complete a process.
8. The Contractor’s Solution shall receive electronic reports from various sources (for example, premium payment history from issuers).
9. The Contractor will make a recommendation for the effective definition of both a “Case” and a “household” based on the State provided requirements and Contractor’s interpretation of Federal policies and regulations. These definitions will be utilized by the MNHIX system to accurately determine eligibility for Insurance Affordability Programs. The State will have the final approval for all definitions.
10. Assistors can be further defined by type by an agreed upon role base security functionality or rights. The state will provide the type, the role-based security requirements and rights in a format provided by the contractor and the solution will use standard Curam configurable capabilities.
11. The Contractor’s Solution will support acceptance of reports of suspected fraud and referral to designated entities, by allowing certain Assistors to manually set a special caution flag and manually contact a referring entity per State provided requirements. Assistors will use the standard Curam functionality to meet this requirement.

III.  **Module 1 – Individual Eligibility and Exemption**

a. Provide information on health programs and screen eligibility of programs without log-in or account creation.

1. The Contractor’s Solution will provide the ability to perform Pre-Screening through the use of the Contractor’s standard calculator functionality for individuals to determine MNHIX participation, potential eligibility for Insurance Affordability Programs: advance
MN Evidence: 3.4 Notices, Data Matching and Annual Redeterminations

- MN technical infrastructure contract
- Business process models
- List of data sources
- Redeterminations policy documentation
- Use cases and state transition documents from vendors

Awaiting additional federal guidance
MN Evidence: 3.5 Verifications

- MN technical infrastructure contract
- Business process models
- Data sources
- Data elements
MN Evidence: 3.6 Document Accepting and Processing

- MN technical infrastructure contract
- Business process models
- Updated State privacy and security standards to incorporate Exchange
MN Evidence: 3.7-3.10 Eligibility Determinations, Notifications, Appeals, Individual Responsibility Exemption Determination and QHP Selection & Termination

- MN technical infrastructure contract
- Business process models
3.11 Eligibility Appeals

- Process models
- Policies and procedures
- Interagency agreements

Awaiting federal guidance

Open area, will not be attesting to as complete
MN Evidence: 3.12 QHP Selections & Terminations and APTC/advance CSR Information Processing

- MN technical infrastructure contract
- Business process models

Awaiting federal guidance
MN Evidence: 3.13 Electronically Report Results of Eligibility Assessment and Determinations

- MN technical infrastructure contract
- Business process models

Awaiting federal guidance
Because Minnesota does not have a State-based program, no specific documentation is required for this activity area.
4.0 Plan Management

- Appropriate authority to perform and oversee certification of QHPs
- QHP certification process
- Plan management system(s) or processes that support the collection of QHP compliance
- Support issuers and provide technical assistance
- Issuer recertification, decertification, and appeals
- Timeline for QHP accreditation
- QHP quality reporting
MN Evidence: 4.1 Appropriate Authority to Perform and Oversee Certification of QHPs

- Voluntary extension and application of existing provisions of state law for health plans seeking to offer products on Exchange in 2014
- Existing regulatory authority under Minnesota Departments of Commerce and Health
MN Evidence: 4.2 QHP Certification Process

- Interagency agreement with the Minnesota Departments of Commerce and Health
- MN technical infrastructure contract
- Business process models
- Plan certification guidance
- Minnesota Departments of Commerce and Health Regulatory Bulletin
- SERFF business process flows
Administrative Bulletin #2012 – 2

To: All Minnesota Health Plan Companies
From: Minnesota Departments of Health and Commerce
Subject: Patient Protection and Affordable Care Act Reforms
Date: October 8, 2012

I. Background and Purpose.

The purpose of this bulletin is to provide a compliance guide relating to the State of Minnesota’s (“State”) implementation of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152 (the “Affordable Care Act” or “ACA”), mandates in accordance with Minnesota statutes.

Bulletins are the State’s interpretations of existing law and general statements of State policy. The State’s Department of Health (“Health”) and Department of Commerce (“Commerce”), (collectively “the State”) jointly issue this bulletin to facilitate a streamlined, consistent interpretation and application of Minnesota law for health plan companies and other interested members of the public on this important topic. This bulletin applies to all companies authorized to write health insurance in the State, including health carriers and health maintenance organizations.

II. State Position.

Due to the dynamic nature of pending health care market reforms and in contemplation of a Minnesota Health Insurance Exchange, (the “Exchange”), the State issues this bulletin to provide health plan companies guidance as to certain aspects of reform implementation. The State contemplates issuing further guidance prior to full implementation of the Affordable Care Act and as further regulations are promulgated. The State has and will continue to require compliance with the provisions of the ACA as they become effective.

1. Existing Products and Guaranteed Renewability.

The Affordable Care Act has and will require benefits beyond those which were previously mandated in Minnesota. The most significant benefits mandates will take effect on January 1, 2014. The Affordable Care Act preserves Health Insurance Portability and Accountability Act’s (“HIPAA”) guaranteed renewable requirements and exceptions, as well as requires that all health plans other than grandfathered plans be guaranteed renewable as of January 1, 2014. 42 U.S.C. § 300gg-42 (for individual plans) and 42 U.S.C. § 300gg-12 (for group plans).
Minnesota Health Insurance Exchange Plan Certification Guidance

October 9, 2012

The purpose of this guidance is to describe the certification requirements intended to apply to Qualified Health Plans (QHPs) offered for sale on the Minnesota Health Insurance Exchange ("the Exchange") in 2014 and to issuers offering QHPs for sale on the Exchange in 2014. Additionally, this guidance refers to the certification process and relevant timelines for issuers intending to offer QHPs for sale on the Exchange in 2014 outlined in an October 2012 bulletin from the Department of Health and Commerce.

Certification Requirements Issuers Offering QHPs on the Exchange

Federal law requires that a health insurance issuer offering health plans for sale on the Exchange must have a certification issued by or recognized by the Exchange demonstrating that each health plan it offers on the Exchange is a QHP according to the applicable federal regulations. 45 C.F.R. §§ 156.200-156.291. Additionally, federal law requires that the Exchange have in place a process to ensure that QHP issuers meet various other requirements. 45 C.F.R. §§ 155.410(b), 155.1003(b), 400.1312(b).

In order to meet these federal requirements, the Exchange intends to rely upon voluntary extension and application of existing provisions of state law to QHPs offered for sale on the Exchange in 2014. By utilizing this approach, the Exchange will leverage the capacities of existing state regulatory agencies to carry out most components of the certification process, while directly carrying out only some components.

1. QHP issuer participation standards

A. An issuer must be recognized by the Exchange to demonstrate that each health plan it offers in the Exchange is a QHP. 45 C.F.R. § 156.200 (a). The Exchange will provide such notice to issuers.

B. QHP issuers must ensure that each QHP complies with benefit design standards, as defined in Sections 2707 and 1302 of the Patient Protection and Affordable Care Act. 45 C.F.R. §§ 156.20 & 156.200 (b)(3). The Department of Commerce will assess compliance with benefit design standards for issuers through its form review process, while the Department of Health will assess compliance with benefit design standards for HMOs.

C. QHP issuers must be licensed and in good standing to offer health insurance in each state in which it provides coverage. 45 C.F.R. § 156.200 (b)(4). Minnesota Statutes, Chapter 62D will provide the applicable licensing certification standard for HMOs, while Minnesota Statutes, Chapters 60A and 62C will provide the applicable licensing certification standards respectively for issuers and service plan corporations.

D. QHP issuers are required to implement and report on a quality improvement strategy or strategies consistent with the standards of the ACA, disclose and report information on health
MN Evidence: 4.3 Plan Management Systems or Processes to Support Collection of QHP Issuer and Plan Data

- MN technical infrastructure contract
- Business process models
- SERFF business process flows
F. The Contractor’s Solution will receive notification from insurers regarding disenrollment, termination, and other changes in enrollment provided to the insurer.

G. Communicate enrollment, disenrollment and termination information with employees, employers and Assistors as appropriate reflecting different scenarios including employees resignation and termination, and COBRA eligibility. *(7)*

11. The Contractor’s Solution will generate information to facilitate premium payment and tracking. *(8)*
   A. The Contractor’s Solution will display net costs to employees (after employer contribution) for different plans and different Family compositions. *(5)*
   B. The Contractor’s Solution will display the QHP costs for the employee pool for employer. *(4)*
   C. The Contractor’s Solution will provide small businesses with an aggregated monthly bill for the costs of employees’ coverage and options to view, premium payment options and track premium payments. *(6)* *(7)*

12. The Contractor’s Solution will communicate with other entities as necessary. *(7)*
   A. The Contractor’s Solution will notify the Federal government of confirmed enrollment, disenrollment and termination to facilitate appropriate payment of any tax credits.
   B. The Contractor’s Solution will send and receive HIPAA compliant 834 and/or other standard transactions and acknowledgements related to enrollment and disenrollment information.
   C. The Contractor’s Solution will reconcile enrollment information and employer participation information with QHPs at least monthly.

VI. Module 4 – Health Plan Benefits and Navigator/Broker Certification and Display

a. The MNHIX will collect data from issuers seeking certification for proposed QHPs.

1. The Contractor’s Solution will interact with the System for Electronic Rate and Form Filing (SERFF) to receive a defined set of benefits, rates and other data elements related to plan information from issuers after certification for proposed QHPs in SERFF. Certification is handled by SERFF. *(6)*
   A. The Contractor will participate in and assist with activities as needed with SERFF to enhance SERFF capacities to fulfill MNHIX needs. SERFF will handle certification and recertification of plans, Contractor will not assist with certification or recertification of QHP data.
   B. The Contractor will establish a calculator for connected QHP benefit and design to facilitate enhanced User understanding of potential out-of-pocket costs related to the use of certain services. SERFF will send a rate table look-up for all plans.

2. The Contractor’s Solution will take plan base rates and calculate exact premium based on allowed underwriting criteria. This is a functionality related to rate tables and a rating engine.
MN Evidence: 4.4 Ensure Ongoing QHP Compliance

- Utilize regulatory compliance processes at the Minnesota Departments of Commerce and Health for 2014
MN Evidence: 4.5 Support Issuers and Provide Technical Assistance

- Exchange Organizational Chart
- Existing processes at the Departments of Commerce and Health
- SERFF training and technical assistance
MN Evidence: 4.6 Issuer Recertification, Decertification and Appeals

- MN technical infrastructure contract
- Business process models
- SERFF business process flows
- Interagency agreement with the Minnesota Departments of Commerce and Health
MN Evidence: 4.7 Timeline for QHP Accreditation and 4.8 QHP Quality Reporting

- Plan certification guidance
5.0 Risk Adjustment and Reinsurance

- Risk adjustment program
- Reinsurance program

- Minnesota intends to use Federal service
- Minnesota may decide to conduct state-based risk adjustment in the future
6.0 Small Business Health Options Program (SHOP)

- Compliance with federal regulatory requirements
- SHOP premium aggregation
- Electronically report results of eligibility assessments and determinations for SHOP
MN Evidence: 6.1 SHOP

- MN technical infrastructure contract
- Business process models
- Minnesota Departments of Commerce and Health Regulatory Bulletin
MN Evidence: 6.2 SHOP Premium Aggregation

- MN technical infrastructure contract
- Business process models
MN Evidence: 6.3 Electronically Report Results of Eligibility Assessment and Determinations for SHOP

- MN technical infrastructure contract
- Business process models

Awaiting federal guidance
7.0 Organization and Human Resources

- Organizational structure and staffing resources to perform Exchange activities

- Evidence:
  - Organizational chart
  - Hiring strategy
  - Position descriptions
8.0 Finance and Accounting

- Long-term operational cost, budget and management plan

- Evidence:
  - Financial modeling to date – Wakely Consulting
  - Description of financing options

Open policy area, will not be attesting to as complete
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility Determinations and Enrollment</td>
<td>0.19</td>
<td>4,934,841</td>
<td>5,509,311</td>
<td>6,083,780</td>
<td>7,208,897</td>
<td>8,693,523</td>
<td>10,130,683</td>
<td>7,878,740</td>
<td>9,866,519</td>
</tr>
<tr>
<td>Website</td>
<td>0.05</td>
<td>1,205,457</td>
<td>1,345,786</td>
<td>1,486,114</td>
<td>1,760,952</td>
<td>2,123,609</td>
<td>2,474,671</td>
<td>1,924,578</td>
<td>2,410,142</td>
</tr>
<tr>
<td>Customer Service</td>
<td>0.25</td>
<td>6,403,992</td>
<td>7,149,487</td>
<td>7,894,982</td>
<td>9,355,058</td>
<td>11,281,672</td>
<td>13,146,689</td>
<td>10,224,320</td>
<td>12,803,879</td>
</tr>
<tr>
<td>Premium Billing</td>
<td>0.11</td>
<td>2,768,785</td>
<td>3,091,102</td>
<td>3,413,419</td>
<td>4,044,687</td>
<td>4,877,664</td>
<td>5,684,009</td>
<td>4,420,515</td>
<td>5,535,795</td>
</tr>
<tr>
<td>Subtotal: Systems Dvlpmnt and Support</td>
<td>0.60</td>
<td>15,313,075</td>
<td>17,095,686</td>
<td>18,878,296</td>
<td>22,369,594</td>
<td>26,976,468</td>
<td>31,436,052</td>
<td>24,448,152</td>
<td>30,616,335</td>
</tr>
<tr>
<td>IT Infrastructure (internal)</td>
<td>0.02</td>
<td>546,223</td>
<td>609,809</td>
<td>673,396</td>
<td>797,931</td>
<td>962,260</td>
<td>1,121,335</td>
<td>872,074</td>
<td>1,092,096</td>
</tr>
<tr>
<td>Marketing/Advertising/Outreach</td>
<td>0.13</td>
<td>3,371,513</td>
<td>3,763,995</td>
<td>4,156,476</td>
<td>4,849,029</td>
<td>5,847,656</td>
<td>6,814,354</td>
<td>5,299,596</td>
<td>6,636,665</td>
</tr>
<tr>
<td>Consulting/Profession Contracts</td>
<td>0.06</td>
<td>1,469,151</td>
<td>1,640,176</td>
<td>1,811,202</td>
<td>2,146,160</td>
<td>2,588,148</td>
<td>3,016,005</td>
<td>2,345,579</td>
<td>2,937,361</td>
</tr>
<tr>
<td>Administrative (Personnel, Facility, General Admin)</td>
<td>0.15</td>
<td>4,059,399</td>
<td>5,052,075</td>
<td>6,121,938</td>
<td>6,222,504</td>
<td>7,620,401</td>
<td>8,003,234</td>
<td>7,493,068</td>
<td>8,045,796</td>
</tr>
<tr>
<td>Appeals</td>
<td>0.04</td>
<td>922,928</td>
<td>1,030,367</td>
<td>1,137,806</td>
<td>1,348,229</td>
<td>1,625,888</td>
<td>1,894,670</td>
<td>1,473,505</td>
<td>1,845,265</td>
</tr>
<tr>
<td>Subtotal – Program Operations</td>
<td>0.40</td>
<td>10,369,215</td>
<td>12,096,422</td>
<td>13,900,818</td>
<td>15,363,854</td>
<td>18,644,353</td>
<td>20,849,599</td>
<td>17,483,823</td>
<td>20,557,182</td>
</tr>
<tr>
<td>Total Operating</td>
<td>1.00</td>
<td>25,682,290</td>
<td>29,192,108</td>
<td>32,779,114</td>
<td>37,733,448</td>
<td>45,620,821</td>
<td>52,285,651</td>
<td>41,931,975</td>
<td>51,173,517</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## 8.0 Finance and Accounting Revenue Options Model

<table>
<thead>
<tr>
<th>Revenue Options</th>
<th>Revenue Base</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Low</td>
<td>Med</td>
<td>High</td>
</tr>
<tr>
<td>Total costs as percent of Estimated Revenue</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QHP/Premium with hold/Premium Add-on</td>
<td></td>
<td>4.84%</td>
<td>3.96%</td>
<td>3.47%</td>
</tr>
<tr>
<td>Portion of Premium – Fully Insured</td>
<td>6,000,000,000</td>
<td>0.36%</td>
<td>0.41%</td>
<td>0.46%</td>
</tr>
<tr>
<td>Broad Health Care Tax</td>
<td>23,350,000,000</td>
<td>0.09%</td>
<td>0.11%</td>
<td>0.12%</td>
</tr>
<tr>
<td>HMO Premium Revenue</td>
<td>4,000,000,000</td>
<td>0.64%</td>
<td>0.73%</td>
<td>0.82%</td>
</tr>
<tr>
<td>HMO, NFP Health Service Plan, Community Integrated Network Revenue</td>
<td>6,900,000,000</td>
<td>0.37%</td>
<td>0.42%</td>
<td>0.48%</td>
</tr>
<tr>
<td>Hospital Net Patient Revenue</td>
<td>7,788,500,000</td>
<td>0.33%</td>
<td>0.37%</td>
<td>0.42%</td>
</tr>
<tr>
<td>MCHA Assessment Base</td>
<td>6,049,000,000</td>
<td>0.42%</td>
<td>0.48%</td>
<td>0.54%</td>
</tr>
<tr>
<td>Broad base – other tax (sin tax)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Fund/HCAF Appropriation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (grants, advertisement)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
9.0 Technology

- Compliance with HHS IT guidance
- Adequate technology infrastructure and bandwidth
- IV&V, quality management and test procedures
MN Evidence: 9.1-9.3 Compliance with HHS IT Guidance, Adequate Technology and Bandwidth, IV&V, Quality Management and Test Procedures

- MN technical infrastructure contract
- Infrastructure and architecture design
- Exchange Life Cycle artifacts and reviews
- IV&V RFP
EXHIBIT B

Technical Infrastructure/Architecture Requirements

I. Summary Statement

The Contractor will perform services necessary for the development and maintenance of the information technology system components (hereinafter "Modules") and services necessary to make operational the Minnesota Health Insurance Exchange (hereinafter "MNHIX") Information Technology (hereinafter "IT") Modules. Within these components, Contractor has duties, further identified below, and specifically related to the IT technical infrastructure and Architecture components of Contractor’s Solution, functionally described in Exhibit A to the parties’ contract.

Superscript references signify the Module numbers that the specific activity needs to coordinate, assist or interact with to fully perform the activity or to utilize shared functionality.

In order to meet the requirements of Section 2 of the Contract, Contractor’s Solution must include the following technical infrastructure and architectural components as well as the functional requirements identified in Exhibit A to the parties’ contract. Additionally, the State must meet all of its duties identified below.

II. Entire Exchange Functionality
   a. Contractor Duties

1. The Contractor will provide recommendations on the software and hardware architecture for the MNHIX. The State will have the final approval for all architecture decisions.

2. The Contractor will provide recommendations on the connection requirements to the State’s electronic document management system for the MNHIX. The State will have the final approval for all architecture decisions.

3. The Contractor will provide recommendations on the Service Oriented Architecture (SOA) standards and guidelines for the MNHIX. The State will have the final approval for all SOA standards decisions.

4. The Contractor will provide recommendations on MNHIX interoperability design standards. The State will have the final approval for all interoperability design standards.

5. The Contractor will provide recommendations on a patch and vulnerability management policy for the MNHIX. The State will have the final approval for all architecture decisions.

6. The Contractor will provide recommendations on a disaster recovery plan for the MNHIX. The State will have the final approval for all disaster recovery plans.
<table>
<thead>
<tr>
<th>ID</th>
<th>Task Name</th>
<th>Duration</th>
<th>Start</th>
</tr>
</thead>
<tbody>
<tr>
<td>401</td>
<td>Sprint HIX4 - Solution Planning</td>
<td>90 days?</td>
<td>Wed 1/16/13</td>
</tr>
<tr>
<td>402</td>
<td>HIX4 - Conduct Solution Planning Meeting With State</td>
<td>5 days?</td>
<td>Wed 1/16/13</td>
</tr>
<tr>
<td>403</td>
<td>HIX4 - Update Solution Planning Document</td>
<td>2 days</td>
<td>Wed 1/16/13</td>
</tr>
<tr>
<td>404</td>
<td>HIX4 - Deliver Updated Solution Planning Document To State</td>
<td>5 days</td>
<td>Wed 1/16/13</td>
</tr>
<tr>
<td>405</td>
<td>HIX4 - Update Project Sessions Schedule</td>
<td>5 days</td>
<td>Wed 1/16/13</td>
</tr>
<tr>
<td>406</td>
<td>HIX4 - Deliver Updated Project Sessions Schedule To State</td>
<td>1 day</td>
<td>Tue 1/22/13</td>
</tr>
<tr>
<td>407</td>
<td>HIX4 - Solution Planning Complete</td>
<td>6 days?</td>
<td>Tue 1/22/13</td>
</tr>
<tr>
<td>408</td>
<td>Analysis and Definition</td>
<td>30 days?</td>
<td>Wed 1/23/13</td>
</tr>
<tr>
<td>409</td>
<td>HIX4 - Conduct Process Model Review Sessions</td>
<td>10 days</td>
<td>Wed 1/23/13</td>
</tr>
<tr>
<td>410</td>
<td>HIX4 - Conduct Detailed Business Architecture Sessions</td>
<td>10 days</td>
<td>Wed 1/23/13</td>
</tr>
<tr>
<td>411</td>
<td>HIX4 - Conduct Functional and Technical Requirement Elaboration</td>
<td>10 days</td>
<td>Wed 1/23/13</td>
</tr>
<tr>
<td>412</td>
<td>HIX4 - Requirements Validation Documentation Update</td>
<td>23 days?</td>
<td>Fri 1/25/13</td>
</tr>
<tr>
<td>413</td>
<td>HIX4 - Update Requirements Traceability Matrix</td>
<td>13 days</td>
<td>Fri 1/25/13</td>
</tr>
<tr>
<td>414</td>
<td>HIX4 - Develop Business Rules Documentation</td>
<td>13 days</td>
<td>Fri 1/25/13</td>
</tr>
<tr>
<td>415</td>
<td>HIX4 - Develop Integrated Use Cases</td>
<td>13 days</td>
<td>Fri 1/25/13</td>
</tr>
<tr>
<td>416</td>
<td>HIX4 - Refine Detailed Process Models</td>
<td>13 days</td>
<td>Fri 1/25/13</td>
</tr>
<tr>
<td>417</td>
<td>HIX4 - Update Requirements Validation Documentation Update</td>
<td>13 days</td>
<td>Fri 1/25/13</td>
</tr>
<tr>
<td>418</td>
<td>HIX4 - Submit Updated Requirements Validation Documentation For Review</td>
<td>6 days</td>
<td>Thu 2/1/13</td>
</tr>
<tr>
<td>419</td>
<td>HIX4 - State Reviews Updated Requirements Validation Documentation</td>
<td>5 days</td>
<td>Wed 2/1/13</td>
</tr>
<tr>
<td>420</td>
<td>HIX4 - Conduct Updated Requirements Validation Documentation Review With State</td>
<td>5 days</td>
<td>Wed 2/1/13</td>
</tr>
<tr>
<td>421</td>
<td>HIX4 - Prepare Updated Requirements Validation Documentation For State Approval</td>
<td>2 days</td>
<td>Mon 2/18/13</td>
</tr>
<tr>
<td>422</td>
<td>HIX4 - Submit Updated Requirements Validation Documentation For State Approval</td>
<td>6 days</td>
<td>Thu 2/14/13</td>
</tr>
<tr>
<td>423</td>
<td>HIX4 - State Approves Updated Requirements Validation Documentation</td>
<td>6 days</td>
<td>Thu 2/14/13</td>
</tr>
<tr>
<td>424</td>
<td>HIX4 - Requirements Validation Documentation Update Complete</td>
<td>6 days</td>
<td>Thu 2/14/13</td>
</tr>
<tr>
<td>425</td>
<td>HIX4 - Gap Analysis Update</td>
<td>23 days?</td>
<td>Fri 2/15/13</td>
</tr>
<tr>
<td>426</td>
<td>HIX4 - Submit Updated Gap Analysis For Review</td>
<td>6 days</td>
<td>Thu 2/14/13</td>
</tr>
<tr>
<td>427</td>
<td>HIX4 - State Reviews Updated Gap Analysis</td>
<td>5 days</td>
<td>Wed 2/14/13</td>
</tr>
<tr>
<td>428</td>
<td>HIX4 - Conduct Updated Gap Analysis Review With State</td>
<td>2 days</td>
<td>Wed 2/14/13</td>
</tr>
<tr>
<td>429</td>
<td>HIX4 - Prepare Updated Gap Analysis For State Approval</td>
<td>7 days</td>
<td>Mon 2/18/13</td>
</tr>
<tr>
<td>430</td>
<td>HIX4 - Submit Updated Gap Analysis For State Approval</td>
<td>6 days</td>
<td>Thu 2/14/13</td>
</tr>
<tr>
<td>431</td>
<td>HIX4 - State Approves Updated Gap Analysis</td>
<td>6 days</td>
<td>Thu 2/14/13</td>
</tr>
<tr>
<td>432</td>
<td>HIX4 - Gap Analysis Update Complete</td>
<td>6 days</td>
<td>Thu 2/14/13</td>
</tr>
<tr>
<td>433</td>
<td>HIX4 - Analysis and Definition Complete</td>
<td>6 days</td>
<td>Thu 2/14/13</td>
</tr>
<tr>
<td>434</td>
<td>HIX4 - Development</td>
<td>25 days?</td>
<td>Wed 2/14/13</td>
</tr>
<tr>
<td>435</td>
<td>HIX4 - Design Sprint Software</td>
<td>15 days</td>
<td>Wed 2/14/13</td>
</tr>
<tr>
<td>436</td>
<td>HIX4 - Develop Functional Specifications</td>
<td>28 days</td>
<td>Wed 2/14/13</td>
</tr>
</tbody>
</table>

Project: MNHIX - 20120723-ProjectSc
Date: Mon 1/16/12

Page 11
<table>
<thead>
<tr>
<th>#</th>
<th>ARTIFACT</th>
<th>DEFINITION</th>
<th>Provided to States / Required / Recommended Industry Best Practice; As Needed to Supplement PMP</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.7</td>
<td>Change Management Plan (Supplement to PMP)</td>
<td>Defines the approach, administrative procedures, roles and responsibilities for submitting, evaluating, coordinating, approving or disapproving business and technical changes to baseline items.</td>
<td>As Needed to Supplement the PMP</td>
</tr>
<tr>
<td>2.8</td>
<td>Configuration Management Plan (Supplement to PMP)</td>
<td>Establishes the technical and administrative direction and surveillance for the management of configuration items (i.e., software, hardware, and documentation) associated with the project that are to be placed under configuration control.</td>
<td>As Needed to Supplement the PMP</td>
</tr>
<tr>
<td>2.11</td>
<td>Financial Status Report (Supplement to PMP)</td>
<td>Report to depict investment consumption on a periodically basis.</td>
<td>Required</td>
</tr>
<tr>
<td>2.12</td>
<td>Performance Measurement Plan (Supplement to PMP)</td>
<td>Identify and prioritize the performance measurement goals and objectives and standards for project processes (e.g., product functionality, regulatory compliance, project deliverables, project management performance, documentation, testing, etc.), and describe how they will be satisfied.</td>
<td>As Needed to Supplement the PMP</td>
</tr>
<tr>
<td>2.13</td>
<td>Performance Measures (Supplement to PMP)</td>
<td>Key performance indicators of significant accomplishments or events</td>
<td>Required</td>
</tr>
<tr>
<td>2.14</td>
<td>Training Plan (Supplement to PMP)</td>
<td>Description of training effort to use and support the system, including initial and subsequent remedial training for business users and system support personnel</td>
<td>As Needed to Supplement the PMP</td>
</tr>
<tr>
<td>2.15</td>
<td>Release Plan (Supplement to PMP)</td>
<td>Descriptions of the system functionality that will be developed and implemented in each release, and the rationale for each release.</td>
<td>Required</td>
</tr>
<tr>
<td>3</td>
<td>Alternatives Analysis</td>
<td>Potential alternatives for project solution design and implementation, and associated conditions when an alternative may be more viable.</td>
<td>Required</td>
</tr>
<tr>
<td>4</td>
<td>Cost Allocation Plan / Methodology</td>
<td>Plan to allocate system costs appropriately between Exchanges, Medicaid, CHIP, and other programs.</td>
<td>Required</td>
</tr>
<tr>
<td>5</td>
<td>MITA State Self Assessment / MITA Roadmap</td>
<td>Self assessment against MITA framework. Conducted at AR and 12 months after MITA 3.0 is released.</td>
<td>Required (Medicaid only)</td>
</tr>
<tr>
<td>6.1</td>
<td>Privacy Impact Assessment</td>
<td>Determines if Personally Identifiable Information (PII) is contained within a system, what kind of PII, what is done with that information, and how that information is protected.</td>
<td>Required</td>
</tr>
<tr>
<td>6.2</td>
<td>Business Requirements</td>
<td>Initial, traceable requirements for business and technical functionality to be delivered upon project completion</td>
<td>Required</td>
</tr>
<tr>
<td>7.1</td>
<td>Use Cases</td>
<td>A use case is a description of steps or actions between a user or &quot;actor&quot; and a software system which leads the user towards something useful. Can either complement or be derived in place of User Stories.</td>
<td>Recommended Industry Best Practice</td>
</tr>
</tbody>
</table>
MINNESOTA
DEPARTMENTS OF HUMAN SERVICES
And
COMMERCE

REQUEST FOR PROPOSALS

FOR
A QUALIFIED CONTRACTOR(S) TO
Perform Independent Verification and Validation of systems for the Health Insurance Exchange and Department of Human Services Eligibility and Enrollment Systems Modernization (EEX)

For communication assistance, contact Minnesota Relay Service at 7-1-1 or 1-800-637-3529. If you ask, we will give you this information in another form, such as Braille, large print, or audiotape.

September 17, 2012
10.0 Privacy and Security

- Privacy and security standards policies and procedures
- Safeguards based on HHS IT guidance
- Safeguard protections for Federal information
MN Evidence: 10.1-10.3 Privacy and Security Standards, Policies and Procedures, Safeguards

- MN technical infrastructure contract
- Business process models
- Federal compliance documentation
- Description of existing state privacy and security standards
  - Includes gap analysis of existing state agency policies and procedures and apply or leverage as applicable to the HIX
2. The Security and Privacy Requirements Landscape

As indicated above, there are a myriad of federal laws, regulations, guidance, and standards that may be difficult to navigate. Appendix A provides a brief overview of the key federal security and privacy laws that are essential to understanding the basic requirements levied upon federal agencies, state partners, contractors, and supporting commercial companies. These include:

- Federal Information Security Management Act (FISMA) of 2002
- Health Insurance Portability and Accountability Act (HIPAA) of 1996
- Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009
- Privacy Act of 1974
- e-Government Act of 2002
- Patient Protection and Affordable Care Act of 2010

All parties must confront the following issues when defining a risk-based security and privacy framework. This section presents a high-level guide to help address these issues:

- What key federal and state security and privacy laws, regulations, standards, and guidance apply to my system?
- How are entities defined in the context of security and privacy?
- What key technical considerations must be addressed to develop harmonized security and privacy requirements?

This document and future Exchange Reference Architecture supplements should help answer these questions.

2.1 Determining the Applicability of Federal Mandates

2.1.1 Crosswalk of Laws, Required Standards, and Guidance

All federal agencies, and in some cases their contractors, must comply with FISMA, the Privacy Act of 1974, and the e-Government Act of 2002. Certain federal and state agencies, and health care entities must comply with HIPAA and HITECH requirements. Federal and state agencies, as well as contractors, must comply with Tax Information Security Guidelines as a condition of receipt of FTI. Finally, states and other non-federal entities must comply with state laws and regulations.

Table 1 provides a crosswalk of some of the key standards and guidance that may apply to specific entity types. The table shows two major sectors for entities, "Federal" and "non-Federal". Within each sector, there are designations for HIPAA covered entities (CE), business associates (BA), or "other."
Table 1. Crosswalk of Certain Key Laws, Standards, Guidance, and Agreements that May Apply

<table>
<thead>
<tr>
<th>Security and Privacy Laws, Requirements, and Standards</th>
<th>Entity Type</th>
<th>Federal CE</th>
<th>Federal, Non-CE</th>
<th>Non-Federal CE</th>
<th>Non-Federal, Non-CE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.1 ITSM</td>
<td>Appendix Reference</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>A.2, A.3 HIPAA &amp; HITECH (1-2)</td>
<td>Yes</td>
<td>Yes(3)</td>
<td>No</td>
<td>Yes(3)</td>
<td>No</td>
</tr>
<tr>
<td>A.4 Privacy Act of 1974</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>A.5 42 CFR Act of 2007</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>A.7 IRC 6503</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>State Laws</td>
<td>Federal CE</td>
<td>Business Associate</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>A.1 FIPS 199 and 200</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>A.1 NIST Guidance</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>A.4 OMG Privacy &amp; Security Guidance</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>A.6 Patient Protection and Affordable Care Act/PPACA Final Rule</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>A.7 IRS Publication 1075</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Guidance and Controls</th>
<th>Entity Type</th>
<th>Federal CE</th>
<th>Federal, Non-CE</th>
<th>Non-Federal CE</th>
<th>Non-Federal, Non-CE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.2 Business Associate MOU</td>
<td>Yes(4)</td>
<td>Yes(4)</td>
<td>No</td>
<td>Yes(4)</td>
<td>Yes(4)</td>
</tr>
<tr>
<td>A.5 Inforamation Security Agreement</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>A.6 Data Sharing Agreement/Data Use Agreement</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>A.7 IRS Data Exchange Agreement</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>


(2) The Health Information Technology for Economic and Clinical Health (HITECH) Act was enacted as part of the American Recovery and Reinvestment Act of 2009. HITECH amended HIPAA to strengthen the privacy and security protections for health information and to improve the workability and effectiveness of the HIPAA Rules. HHS has not finalized all of the regulations that will implement the changes to date; however, final rules are expected sometime in the second quarter of 2012.

(3) The HITECH Act extends the applicability of certain HIPAA Privacy and Security Rule requirements to business associates of covered entities.

(4) There are certain exceptions. See 164.504(e)(3)(iv).
**Affordable Care Act (ACA) Internal Revenue Service (IRS) Safeguard Procedures Report (SPR)**

<table>
<thead>
<tr>
<th>#</th>
<th>Publication 1075 Requirement Reference pages 38-49, Section 7.3 Safeguard Procedures Report</th>
<th>Agency SPR Content</th>
<th>Additional Information Needed to be Submitted by Agency Additional information requested in <strong>red</strong> must be submitted within 30 days. Information in <strong>blue</strong> must be submitted with next SAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Provide the name, title, address, email address and telephone number of the agency official, including but limited to agency director or commissioner authorized to request FTI from the IRS, the SSA, or other authorized agency.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2</td>
<td>Provide the name, title, address, email address and telephone number of the agency official responsible for implementing the safeguard procedures, including but not limited to the agency information technology security office or equivalent and the primary IRS contact.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 2.1 | Provide an organizational chart or narrative description of the receiving agency, which includes all functions within the agency where FTI will be received, processed, stored and/or maintained. If the information is to be used or processed by more than one function, then the pertinent information must be included for each function.  
**Note:** The description must account for off-site storage, consolidated data centers, disaster recovery organizations, and contractor functions.  
**Attachments:** Organization chart (recommended) |
| 3.1 | Provide a flow chart or narrative describing:  
- the flow of FTI through the agency from its receipt through its return to the IRS or its destruction  
- how it is used or processed |
<table>
<thead>
<tr>
<th>CFR</th>
<th>Policy</th>
<th>DHS Policy</th>
<th>Technology Controls (documented standards)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a)</td>
<td>Creation, collection, use and disclosure.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1)</td>
<td>Where the Exchange creates or collects personally identifiable information for the purposes of determining eligibility for enrollment in a qualified health plan; determining eligibility for other insurance affordability programs, as defined in 155.20; or determining eligibility for exemptions from the individual responsibility provisions in section 5000A of the Code, the Exchange may only use or disclose such personally identifiable information to the extent such information is necessary to carry out the functions described in §155.200 of this subpart.</td>
<td>2.16 Requesting, Accessing, Using, or Disclosing Minimum Necessary Information</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Exchange may not create, collect, use, or disclose personally identifiable information while the Exchange is fulfilling its responsibilities in accordance with §155.200 of this subpart unless the creation, collection, use, or disclosure is consistent with this section.</td>
<td>DHS employees must request, access, use, or disclose only the minimum amount of protected information necessary to provide services and benefits to clients, and to comply with applicable laws and DHS policies permitting disclosures. DHS retains discretion to make its own minimum necessary determination when disclosing protected information.</td>
<td></td>
</tr>
<tr>
<td>(3)</td>
<td>The Exchange must establish and implement privacy and security standards that are consistent with the following principles:</td>
<td>2.1 Rights of Individuals From Whom DHS Obtains Information</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Individuals from whom DHS collects confidential data, private data, and protected health information (referred to collectively as &quot;protected information&quot;) have the right to have that information safeguarded, to comment on what it contains, to have reasonable access to it, and to know the circumstances under which it is being shared.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>DHS will maintain policies and procedures concerning the rights of individuals from whom DHS collects protected information. DHS will provide ongoing training to its staff regarding the safeguarding of protected information and the rights of individuals regarding their protected information.</td>
<td></td>
</tr>
</tbody>
</table>
11.0 Oversight, Monitoring and Reporting

- Routine oversight and monitoring of Exchange activities
- Track/report performance and outcome metrics related to Exchange activities
- Uphold financial integrity provisions including accounting, reporting and auditing procedures
MN Evidence: 11.1 - 11.3 Routine Oversight and Monitoring, Track Performance and Metrics, Financial Integrity

- Internal controls document
- State policies and procedures

*Performance metrics is an open area, will not be attesting to as complete*
Exchange Program Integrity (Internal Control Blueprint)

State of Minnesota
Statewide Finance Policies and Reporting

http://www.beta.mmb.state.mn.us/financial-policies

http://www.beta.mmb.state.mn.us/financial-report

Matrix of oversight needs, existing resources and processes to be leveraged, new resources and processes to be developed
12.0 Contracting, Outsourcing and Agreements

- Contracting and outsourcing agreements
- Evidence:
  - Copies of all contracts and agreements
Process and Next Steps

- All Blueprint application submission materials will be posted on the Exchange website on a rolling basis
  http://mn.gov/commerce/insurance/topics/medical/exchange/index.jsp
- Some documents will be posted in the next few days, while others are planned for late October and early November
- All documents will be available for public comment
- Comments can be submitted to PublicComments.HIX@state.mn.us.
Open Areas/Policy Options
Governance Options

1. State Agency
   - Existing State Agency
   - Creation of a New Agency

2. Public/Private Organization

3. Private Non-Profit
## Governance Models

<table>
<thead>
<tr>
<th>State Agency</th>
<th>Efficacy</th>
<th>Sustainability</th>
<th>Strategic Response</th>
<th>Accountability</th>
<th>Operational Flexibility</th>
</tr>
</thead>
</table>
| **Benefits** | • Experience; systems in place  
• Access to necessary data  
• Familiarity among the public  
• Existing structure  
• Maximum public participation  
• Ease of interagency cooperation  
• Govt. already performs key functions, Medicaid (DHS), insurance policy certification (Commerce)  | • Ultimate singular accountability  
• Large infrastructure available for support  
• Deep bench of expertise  
• Ability to access ongoing public resources  | • Established relationship with federal government  
• Familiarity with market  
• Availability of national networks  
• Established mechanisms for dealing with consumer concerns  
• Most responsive to needs of state  | • Greatest transparency and direct accountability to governor, legislative auditor and policy makers  
• Strong record of information protection  
• Familiarity and established mechanisms for dealing with consumer concerns by and with public  
• Purely public and direct oversight  | • Statutory procurement and rulemaking provide an existing, open process  
• OET resources an asset  
• Established Employee/Benefit Programs  |
| **Difficulties** | • Inflexibility  
• Timeliness, cumbersome  
• Private stakeholder trust  
• Commercial insurance experience  
• Politics, administration change  
• General fund budgeting  
• Start up cost/time, if a new agency  
• May be challenge to hire talent  
• Potential conflicts between private/public sector roles  | • Subject to changing political priorities; greatest volatility  
• Inherent conflict between govt. as regulator and govt. as exchange operator  | • Cumbersome  
• Historical scope as limiting factor  
• Potential conflict if also regulator  | • Less private sector trust  
• Potential for less stakeholder involvement  
• Subject to political influence  
• Does not easily allow input from outside  
• May be perceived as big government  
• Possible confirmation requirements  | • Public procurement, rulemaking and information technology statutes can be cumbersome, technical, rigid, and time-consuming  
• State hiring and retention is inflexible  
• Difficulty customizing within state structure  |
# Governance Models

<table>
<thead>
<tr>
<th>Public/Private</th>
<th>Efficacy</th>
<th>Sustainability</th>
<th>Strategic Response</th>
<th>Accountability</th>
<th>Operational Flexibility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefits</strong></td>
<td>• More flexible; Market&lt;br&gt;• Public/private partnership&lt;br&gt;• Access to needed data&lt;br&gt;• More public trust than private&lt;br&gt;• Balance accountability and efficiency&lt;br&gt;• Established governance models&lt;br&gt;• Agency management agreements possible&lt;br&gt;• Better ability to work with agencies&lt;br&gt;• Ease of access to external resources</td>
<td>• Greatest ability to design exchange-specific governance structure&lt;br&gt;• Able to fully integrate Medicaid&lt;br&gt;• Can be somewhat insulated from political influence and changing priorities</td>
<td>• Potential to respond quickly&lt;br&gt;• Could build in state agency support&lt;br&gt;• Ability to build focus on public role&lt;br&gt;• Consumers and vendors could be represented on board&lt;br&gt;• More customer service focused&lt;br&gt;• Can build a link to address state needs</td>
<td>• Trust and confidence from private sector&lt;br&gt;• Accountability structure may be tailored to fit goals of Exchange&lt;br&gt;• Less subject to political influence&lt;br&gt;• More trusted by public than private company&lt;br&gt;• Tested and established structure</td>
<td>• Ability to customize processes for policies and procedures&lt;br&gt;• Speed and flexibility in procurement&lt;br&gt;• Likely access to OET and IT resources&lt;br&gt;• Additional flexibility in hiring&lt;br&gt;• Existing similar state entities which work well to model from</td>
</tr>
<tr>
<td><strong>Difficulties</strong></td>
<td>• Startup&lt;br&gt;• Process required to collaborate with state&lt;br&gt;• Staffing depth&lt;br&gt;• Need to create a framework&lt;br&gt;• Less public input&lt;br&gt;• Must install public data protection&lt;br&gt;• May be more costly to set up&lt;br&gt;• Accountability must be built</td>
<td>• Modified transparency and accountability&lt;br&gt;• Difficulty attracting and maintaining qualified governance with time to dedicate</td>
<td>• Less public input&lt;br&gt;• Less credibility with federal gov’t&lt;br&gt;• Need to develop mechanisms for responding to consumer concerns&lt;br&gt;• No experience dealing with served populations&lt;br&gt;• Conflicts of interest if vendors on board&lt;br&gt;• Balance competing public and private interests</td>
<td>• Less accountable than government without legislative incorporation&lt;br&gt;• No automatic established information security structure</td>
<td>• Possibly required to build policymaking framework&lt;br&gt;• Required to establish and interface with IT infrastructure&lt;br&gt;• Employment subject to market pressures, possibly increasing costs</td>
</tr>
<tr>
<td>Governance Models</td>
<td>Private Non-Profit</td>
<td>Efficacy</td>
<td>Sustainability</td>
<td>Strategic Response</td>
<td>Accountability</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------</td>
<td>----------</td>
<td>----------------</td>
<td>---------------------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Benefits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Customer-focused mission</td>
<td>• Greatest flexibility to generate revenue</td>
<td>• Potential to respond quickly</td>
<td>• Confidence of private sector</td>
<td>• Ability to customize processes for policies and procedures</td>
</tr>
<tr>
<td></td>
<td>• Market responsiveness</td>
<td>• Greatest reward</td>
<td>• Consumers and vendors could be represented on board</td>
<td>• Established accountability models</td>
<td>• Speed and flexibility in procurement</td>
</tr>
<tr>
<td></td>
<td>• Private sector trust</td>
<td>• Potentially greatest long term credibility with business stakeholders</td>
<td>• More customer service orientation</td>
<td>• Flexibility to tap expertise</td>
<td>• Additional flexibility in hiring</td>
</tr>
<tr>
<td></td>
<td>• &quot;Newness&quot; could energize staff</td>
<td>• Most removed from political influence</td>
<td>• Vendors would have more trust in leadership</td>
<td>• Most removed from political influence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Highly developed governance</td>
<td>• Fast reaction to marketplace needs</td>
<td>• More customer service orientation</td>
<td>• Ability to take risk carries the potential for failure</td>
<td>• Requires to build policymaking framework and IT infrastructure</td>
</tr>
<tr>
<td></td>
<td>• Ability to tailor to meet needs of private sector</td>
<td>• Ability to take risk carries the potential for failure</td>
<td>• Lenient public input</td>
<td>• Assumes public responsibility without built-in accountability</td>
<td>• Information privacy concerns</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ability to take risk carries the potential for failure</td>
<td>• Least credibility with federal gov't</td>
<td>• Could drift from required exchange functions</td>
<td>• Less accountable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Potentially attenuated transparency and accountability</td>
<td>• Less focus on government role</td>
<td>• Not subject to statutory framework assuring accountability</td>
<td>• Employment subject to market pressures, possibly increasing costs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Need to develop mechanism for responding to consumer concerns</td>
<td>• Difficulty self-regulating</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Conflicts of interest if vendors on board</td>
<td>• Potential bias in board representation as compared to populations served</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Concern that won't attend to state needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Difficulties</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Necessary authority for tasks</td>
<td>• Less public input</td>
<td>• Assumes public responsibility without built-in accountability</td>
<td>• Required to build policymaking framework and IT infrastructure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Not the same public interest as government</td>
<td>• Least credibility with federal gov't</td>
<td>• Could drift from required exchange functions</td>
<td>• Information privacy concerns</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Requires standards for collaboration with state agencies</td>
<td>• Less focus on government role</td>
<td>• Not subject to statutory framework assuring accountability</td>
<td>• Less accountable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Less influence with Legislature (than Agencies);</td>
<td>• Need to develop mechanism for responding to consumer concerns</td>
<td>• Difficulty self-regulating</td>
<td>• Employment subject to market pressures, possibly increasing costs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Less public oversight</td>
<td>• Concern that won't attend to state needs</td>
<td>• Potential bias in board representation as compared to populations served</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Governance Considerations

- **Board Structure**
  - Board size
  - Compensation
  - Reserved/delegated powers
  - Terms, staggering and term limits
  - Appointing Authority-sole or shared
  - Confirmation/Removal of Members
Governance Considerations cont.

- **Application of State Statutes**
  - Chapter 10A Ethics in Government Act
  - Chapter 13D Open Meeting Law
  - Chapter 13 Data Practices Act
    - Chapter 14 Rulemaking Procedures
    - Chapter 16C Procurement Policy
    - Chapter 16E Office of Enterprise Technology
    - Section 43A, State Employee Compensation and Code of Ethics
Finance Options

- To be discussed at October 24, 2012 Exchange Advisory Task Force Meeting
- Exchange must be self sustaining in 2015
- Financing Options
  - User Fee
  - Portion of Premium (Exchange only)
  - Portion of Premium (Fully Insured Market)
  - Broad based health care tax
  - Broad based other tax (Sin tax)
  - General fund appropriation
  - Health Care Access fund appropriation
  - Other (naming rights, advertising, web brokers, grants)
  - Combination
Financing Options – User Fee

Pros

- Works in all Governance structures
- Aligns costs to direct purchasers of insurance through the Exchange
- Transparent
- Scalable to enrollment
- Collection could occur at the Exchange via premium collection process

Cons

- Does not reflect all of the benefits an Exchange may provide to other consumers, insurers, providers and navigators/brokers
- May discourage participation in Exchange (dependant on cost level and transparency)
- Potentially invisible to consumer if rolled into premium and looks like added costs of product (Individual premiums inside the Exchange would be larger than outside)
- May impact adverse selection
- Tied to enrollment - Hard to predict first few years
- Per person costs vary with number of participants and the relation of fixed and variable costs
- Add-on fee may not be allowed to be part of APTC calculation (answer from HHS pending)
Financing Options – Portion of Premium (Exchange)

Pros

• Works in all Governance Structures
• Would most closely relate exchange business operations and market relationships.
• Premiums same inside and outside Exchange, would not discourage individual participation
• Scalable to enrollment
• Collection could occur at the Exchange via premiums

Cons

• Acknowledges some but not all of the benefits an Exchange may provide to other consumers, insurers, providers and navigators/brokers
• May discourage carriers from participating in Exchange
• Tied to enrollment - Hard to predict first few years
• Per person costs vary with number of participants and the relation of fixed and variable costs
Financing Options – Broad Based Health Care Tax

Pros

- Fully acknowledges Exchange may benefit a broad base of consumers and stakeholders.
- Reflects shift in marker as coverage expands (potential for increased revenue from current surcharges and taxes)
- Premiums the same inside and outside the Exchange
- Broad base – lower cost per person
- Predictable (known base - similar to current state surcharges and taxes)
- Tied directly to estimated budget (not directly to enrollment)

Cons

- Non-profit lack authority to assess non-participants
- Require appropriation of current resources
- Further reduces link between exchange business relationship and funding source
- To extent a service is not covered within the Essential benefit set, service may still be included in assessment.
- Not transparent, cost shift
- Potential interaction with other processes (reinsurance, rate regulation, etc.) enhances uncertainties.
- Possibly creates competition between Exchange and other product distribution channels (brokers, plans, etc)
- Not tied to enrollment – fixed revenue may lead to under or over collections, not adjust for unexpected participation changes.
Financing Options – Broad Based Other Tax (Sin Tax)

Pros

- Broad base – reduced costs per person
- Recognizes Exchange as a public good
- Spreads costs beyond health industry
- May have public health benefit
- Premiums not impacted
- Predictable – known base
- Tied directly to estimated budget (not directly to enrollment)

Cons

- Non-profit lack authority to tax
- Further reduces link between exchange business relationship and funding source
- Amount increased for Exchange may not be large enough to impact behavior
- Require appropriation
- Raises taxes
- Not transparent, cost shift
- Not tied to enrollment – fixed revenue may lead to under or over collections, not adjust for unexpected participation changes.
Financing Options – General Fund

Pros

- Broad base – reduced costs per person
- Recognizes Exchange as a public good
- Spreads costs beyond health industry
- Premiums not impacted
- Appropriation is predictable
- Tied directly to estimated budget (not directly to enrollment)

Cons

- Non-profit lack authority to tax
- Require appropriation
- Further reduces link between exchange business relationship and funding source
- Not transparent, cost shift
- Not tied to enrollment – fixed revenue may lead to under or over collections, not adjust for unexpected participation changes.
- If tie to savings, savings may be difficult to isolate and recapture
Financing Options – Health Care Access Fund

Pros
- Broad base – reduced costs per person
- Recognizes Exchange as a tool to increase health care coverage
- Premiums not impacted
- Appropriation is predictable
- Tied directly to estimated budget (not directly to enrollment)

Cons
- Non-profit lack authority to tax
- Require appropriation
- Further reduces link between exchange business relationship and funding source
- Not transparent, cost shift
- Compete with other health care access needs
- Primary funding source of health care access fund expires in 2019
- Not tied to enrollment – fixed revenue may lead to under or over collections, not adjust for unexpected participation changes.
- If tie to savings, savings may be difficult to isolate and recapture
Financing Options – Other (Naming Rights, Advertising, Web Brokers, Grants, etc)

Pros

- Would be able to raise revenue
- Reduce or eliminate the need for fees and assessments on consumers and stakeholders.
- Exchange could directly collect revenues
- Supreme court decision on mandate not impact revenue source.

Cons

- Funding may not be predictable or stable.
- Questions on who could advertise, conflict of interest concerns.
- Exchange would need to compete and show value to attract funding.
- Could potentially harm the independent nature of an Exchange.
- Not tied to enrollment – not adjust for unexpected participation changes.
Navigators and Agents/Brokers

- To be discussed at multiple future meetings of the Exchange Advisory Task Force starting on October 24, 2012
- Multiple options for Navigators, In-Person Assisters, and Brokers/Agents for:
  - Participation requirements
  - Training
  - Compensation
  - Interaction with Customer Service
Navigators and Agents/Brokers

- Exchanges must have a Navigator program that:
  - Performs certain requirements
  - Includes at least two types of eligible entities from a proscribed list, one must be community non-profit
  - Can not require licensure or E&O insurance

- Exchanges may also have separate programs for Brokers, In-Person Assisters, and Web Brokers:
  - Must comply with federal standards for training, conflict of interest, and privacy/security
  - Multiple compensation options: through Exchange, through insurers, through feds for 2014 for in-person assister program
Customer Service

- Currently in process of conducting customer service assessment:
  - Evaluate existing functionality against federal requirements
  - Determine options for call center
  - Determine options for required processing of eligibility applications by phone, in-person, and mail
  - Consider options for interactions with Navigators, In-Person Assisters, and Brokers