\ USE

**Colorado Health Benefit Exchange (COHBE)**

**ELG-001 Anonymous Eligibility Assessment**

**Use Case**

**Version 1.1**

**November 13th, 2012**

REVISION HISTORY

|  |  |  |  |
| --- | --- | --- | --- |
| Version | Date | Modified By | Description |
| 0.1 | 2012-09-05 | Raghavan Raghuraman/ Jenny Wu | First Draft |
| 0.2 | 2012-09-12 | Raghavan Raghuraman | Post JAD Discovery Updates |
| 0.3 | 2012-10-04 | Raghavan Raghuraman | Post JAD Elaboration Updates |
| 1.0 | 2012-10-12 | Raghavan Raghuraman | Post JAD Verification Updates. |
| 1.1 | 2012-11-13 | Raghavan Raghuraman | Corrections to Business rule 5.1.1 |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

TABLE OF CONTENTS

[1 Use Case: Anonymous Eligibility Assessment 6](#_Toc338439157)

[1.1 Goal 6](#_Toc338439158)

[1.2 Brief Description 6](#_Toc338439159)

[1.3 Requirements Traceability 7](#_Toc338439160)

[1.4 Primary Actor 8](#_Toc338439161)

[1.4.1 Individual 8](#_Toc338439162)

[1.5 Secondary Actor 8](#_Toc338439163)

[1.5.1 Exchange 8](#_Toc338439164)

[1.5.2 PEAK/CBMS 8](#_Toc338439165)

[1.6 Pre-Conditions 8](#_Toc338439166)

[1.7 Post-Conditions 8](#_Toc338439167)

[1.8 Triggers 9](#_Toc338439168)

[1.9 Assumptions 9](#_Toc338439169)

[2 Flow of Events 9](#_Toc338439170)

[2.1 Basic (Main) Flow – Anonymous Eligibility Assessment 10](#_Toc338439171)

[2.1.1 Enter Zip Code and County 10](#_Toc338439172)

[2.1.2 Enter Anonymous Eligibility Assessment Information w/Income 10](#_Toc338439173)

[2.1.3 Without SSN Determine estimated MAGI, FPL and Potential Eligibility for Medicaid and Other State Programs. 11](#_Toc338439174)

[2.1.4 Determine APTC, CSR, and Catastrophic Eligibility 11](#_Toc338439175)

[2.1.5 View Results of Anonymous Eligibility Assessment Determination 11](#_Toc338439176)

[2.1.6 If potentially eligible does user wish to go to PEAK? 11](#_Toc338439177)

[2.1.7 If definitely eligible for PEAK? 11](#_Toc338439178)

[2.1.8 Determine Relevant Plans 12](#_Toc338439179)

[2.1.9 View Plans Relevant for Customer 12](#_Toc338439180)

[2.1.10 Modify APTC 12](#_Toc338439181)

[2.1.11 Sort Plans 12](#_Toc338439182)

[2.1.12 Filter Plans 13](#_Toc338439183)

[2.1.13 Compare Plans 13](#_Toc338439184)

[2.1.14 Does User Want to Select a Plan? 14](#_Toc338439185)

[2.1.15 Add Plans to Shopping Cart 14](#_Toc338439186)

[2.1.16 Does Plan Have Riders? 15](#_Toc338439187)

[2.1.17 Does User Want to Add Rider? 15](#_Toc338439188)

[2.1.18 Add Rider to Shopping Cart 15](#_Toc338439189)

[2.1.19 Proceed with Registration? 15](#_Toc338439190)

[2.1.20 Next Steps 15](#_Toc338439191)

[3 Alternate Flows 16](#_Toc338439192)

[3.1 Redirected to PEAK 16](#_Toc338439193)

[3.1.1 Redirected to PEAK 16](#_Toc338439194)

[3.2 Does user want to start over? 16](#_Toc338439195)

[3.2.1 Does user want to start over? 16](#_Toc338439196)

[4 Exception Flows 16](#_Toc338439197)

[4.1.1 End Anonymous Eligibility Assessment Session 16](#_Toc338439198)

[5 Specifications 17](#_Toc338439199)

[5.1 Business Rules 17](#_Toc338439200)

[5.1.1 Determine Potential Eligibility. 17](#_Toc338439201)

[5.1.2 Determination of APTC 18](#_Toc338439202)

[5.1.3 Calculation of CSR 20](#_Toc338439203)

[5.1.4 Calculate Catastrophic Eligibility 20](#_Toc338439204)

[5.1.5 Determining Relevant Plans 20](#_Toc338439205)

[5.1.6 User Fees 21](#_Toc338439206)

[5.1.7 Determining Age for Premium Rating 21](#_Toc338439207)

[5.1.8 Determining Plan Premium 21](#_Toc338439208)

[5.1.9 Determining Rider Cost 21](#_Toc338439209)

[5.2 Process Rules 21](#_Toc338439210)

[5.2.1 Available Riders 21](#_Toc338439211)

[5.3 Workflow 21](#_Toc338439212)

[5.4 UI Screen Details 21](#_Toc338439213)

[5.4.1 Homepage 21](#_Toc338439214)

[5.4.2 Family Details 22](#_Toc338439215)

[5.4.3 Income Details 22](#_Toc338439216)

[5.4.4 Eligibility Results 22](#_Toc338439217)

[5.4.5 Relevant Plans (Anonymous Eligibility Assessment), Sort and Filter 22](#_Toc338439218)

[5.4.6 Compare Plans 22](#_Toc338439219)

[5.4.7 View Riders 22](#_Toc338439220)

[5.5 Communications 23](#_Toc338439221)

[5.5.1 Imaging Requirements 23](#_Toc338439222)

[5.5.2 Form Requirements 23](#_Toc338439223)

[5.5.3 Notices Requirements 23](#_Toc338439224)

[5.5.4 Other Communication Requirements 23](#_Toc338439225)

[5.6 Interfaces 23](#_Toc338439226)

[5.7 Reporting 23](#_Toc338439227)

[5.8 User Security 23](#_Toc338439228)

[5.9 Activity Log and Audit Trail 24](#_Toc338439229)

[6 Future Release Notes 24](#_Toc338439230)

[7 Appendix A - Glossary 25](#_Toc338439231)

[8 Appendix B – Data Elements 27](#_Toc338439232)

# Use Case: Anonymous Eligibility Assessment

## Goal

The goal of this Use Case is to provide Customers anoymously visiting the Individual Exchange to determine affordability of Exchange QHPs with the potential Exchange benefits such as APTC and CSR for themselves and dependents.

The Use Case ends successfully when the Customers proceed to create an account or log in to an existing account to enroll in plans added to their shopping cart.

## Brief Description

A Customer accesses the Individual Exchange where without logging in they are prompted to enter a zip code and decide whether they would like to perform an Anonymous Eligibility Assessment. The Customer then proceeds to input minimal information including their Income information. Once this information is submitted, the Exchange determines a general estimated MAGI, an FPL score based on the estimated MAGI and potential eligibility for State programs, which once calculated will allow the Exchange if necessary to calculate potential exchange subsidies (APTC, CSR, Catastrophic). The combined subsidies and eligibility results are then displayed to the user. If the Customer and all dependents are potentially eligible for State programs, then they will be prompted to create an account to subsequently proceed with a full eligibility determination.

If the Customer and dependents have potential mixed family eligibility then they are presented with plans offered on the Exchange, including any special plans such as Catastrophic or Cost Sharing Reduction (CSR) plans that the Customer is potentially eligible for. If the Customer is eligible for the Advance Premium Tax Credit (APTC), the plan will be displayed with premium cost, less APTC amount, to the user. Also in case of mixed family eligibility the user will be able to only see CHP+ plans on the Exchange.

Based on information provided by the Customer, the system will display available relevant plans.  The user can sort, filter, compare, review and select plans. If the Customer finds a plan they like, the Customer may add the plan to a shopping cart and proceed to logging in or creating an account. Once logged in, they can use the plan added to the shopping cart for enrollment.

## Requirements Traceability

The following requirements are covered within this Use Case:

~~AM070: The Individual Exchange shall have single sign-on capability with the State’s security application enabling the user to access the State medical assistance portal (PEAK) without being prompted for his login credentials.~~

AM245: The System shall be configured to support the eligibility business processes identified in CMS Harmonized Security and Privacy Framework - Exchange TRA Supplement.

EL010: Anonymous shopping and preliminary eligibility screening allows the customer to discover health plans in the specified coverage area.

EL011: Anonymous shopping and preliminary eligibility screening allows the customer to find primary care physicians and their health plan participation.

EL012: Anonymous shopping and preliminary eligibility screening allows the customer to review and compare plans, including plan services, health plan benefits, maximum out-of-pocket and estimated annual out-of-pocket or total estimated cost of plan, as applicable.

EL014: Anonymous shopping and preliminary eligibility screening allows the customer to save, within a single browsing session, a plan of each type (medical, dental, vision) using a shopping cart concept and present that chosen plan upon registration and subsequent eligibility determination, to facilitate the shopping process.

EL131: When the Customer answers key questions on the System, such as First Name, Last Name, DOB, Residency, and Gender, real-time edit checks may prompt the Customer for contextually relevant additional information, if required.

EL110: The Customer will provide the Exchange with enough information (generic browsing profile) to determine the Customer’s approximate eligibility level based on integration with the External Eligibility Service and the health plans that are available within the coverage area (using zip codes).

EL111: The System shall provide the capability to conduct a preliminary screen of a Customer’s eligibility for financial assistance and healthcare benefits for which s/he potentially qualifies, based on self-attested data.

EL120: The System shall display the results of the anonymous shopping and preliminary eligibility screening and provide recommended next steps.

EL132: The System will require the Customer to enter only minimally required individual/family profile information to support their current task.

~~EL162: The System shall enable the customer to remain securely logged on while their eligibility determination is processed by the External Eligibility Service, consistent with security protocols.~~

EL250: The System shall make available to the State Gateway service any relevant information needed to pre-populate subsequent state electronic applications with data previously entered during the data capture process (EL052).

EL289: The System shall allow customers to seek QHP coverage even if they are potentially eligible for a state medical program. For example, if a customer is disabled, the customer will have the option to enroll in QHP plan until determination is made, in order to ease access to care.

GF061: The Exchange shall provide user assistance and corresponding links so that there is "no wrong door" across the spectrum of Exchange entry and exit points.

GF076: Service Representatives will be able to perform all of the activities of the System on behalf of Customers, should Customers need assistance or not have access to the System. Activities of Service Representatives will be limited to the functions required by their roles.

PS035: The System shall have the ability to accept, display and assign customers to catastrophic plan types. Catastrophic plans are a lower level metal tier than Bronze plans. There may be specific eligibility criteria for these plans.

## Primary Actor

### Individual

An Individual will enter the Exchange to shop for possible QHP plans available to them by providing basic information, without logging into an account.  Employees not logged in and acting as an individual may perform an Anonymous Eligibility Assessment, but Employees logged in will not be able to perform an Anonymous Eligibility Assessment.

## Secondary Actor

### Exchange

The Exchange enables the Customer to check for potential eligibility for state medical programs and exchange subsidies. The Exchange also facilitates re-directing of the Customer to PEAK when appropriate.

### PEAK/CBMS

PEAK/CBMS is the state’s Medicaid system and a Customer who is deemed potentially eligible can choose to go to PEAK to view eligible plans.

## Pre-Conditions

* A Customer is accessing the Exchange and is not logged into the Exchange.

## Post-Conditions

The use case ends when:

* The Customer decides to proceed with registration on the Exchange in order to enroll in plans they are eligible for.
* The Customer decides to get redirected to PEAK to check for additional benefits that may be available to them.
* The customer may have a health plan added to his or her shopping cart.

## Triggers

The following events would trigger this Use Case:

* A Customer decides to access the Individual Exchange to check for potential Eligibility for Exchange subsidies (APTC, CSR, Catastrophic) for themselves and dependents by entering basic information.

## Assumptions

* The Exchange will determine potential eligibility for Anonymous Eligibility Assessment.
* Use case will be updated for Dental and Vision requirements or new use case created.
* Once Navigator’s role has been defined, use case may need to be updated or new use case created.
* Service Representatives will perform all actions on behalf of an individual when supporting a customer.
* Individuals and Service Representatives will have the same capabilities in all functional flows (Service Reps will actually have more than Individuals) – therefore any reference to an Individual will apply to Service Representatives.
* User Fees will be in premium price for shopping cart and assumed one fee per policy.
* Users that are logged-in to the Individual exchange will shop for plans either using complete and correct information or ‘anonymous’/generalized information using the Shop for Individual Plan use case. They will not use this use case.

# Flow of Events

The Business Process Activity diagram below shows the COHBE processes for the Anonymous Eligibility Assessment Use Case.

Figure 1: Anonymous Eligibility Assessment BPM



## Basic (Main) Flow – Anonymous Eligibility Assessment

### Enter Zip Code and County

The Customer enters the Primary Applicant’s Zip Code, then proceeds to step 2.1.2, to enter other information needed for Anonymous Eligibility Assessment. If the zip code entered by the user crosses county lines then a dropdown list will pop up prompting the user to enter the County that they belong to.

### Enter Anonymous Eligibility Assessment Information w/Income

The Customer will be asked to provide number of household members and generic basic information for each member of their household, including:

* First Name
* Birth Month and Birth Year, indicated as MM/YYYY (Business Rule 5.1.7)
* Gender
* Pregnancy Status ( Only if gender selected is Female)
* Tobacco Use
* Disability/Blindness status
* Citizenship or legal resident status

If Legal resident then Customer will be asked to provide number of years that he/she resided in the US.

Once required information is entered, the user is prompted to submit household income “Please provide your average projected weekly/monthly take home pay (please consider any additional income i.e. social security benefits, child support, student loan income, rental income, veterans benefits and unemployment benefits)”.

### Without SSN Determine estimated MAGI, FPL and Potential Eligibility for Medicaid and Other State Programs.

Once the information entered in step 2.1.2 is submitted the Exchange processes this information and returns potential eligibility information for each member of the family and the family’s FPL. See Business rule 5.1.1.

### Determine APTC, CSR, and Catastrophic Eligibility

The FPL score calculated in step 2.1.3 is used by Exchange to calculate potential APTC (see Business Rule 5.1.2), CSR (see Business Rule 5.1.3) and Catastrophic Eligibility (see Business Rule 5.1.4).

### View Results of Anonymous Eligibility Assessment Determination

Once the potential APTC, CSR and Catastrophic eligibility from step 2.1.4 are complete, the results of Anonymous Eligibility Assessment are then displayed to the user. The results will contain:

* FPL percentage for the Customer’s household
* Display of potential eligibility for each member of the household describing what state benefits they are potentially eligible for (Medicaid, CHP+ or QHP)
* Display of potential Exchange benefit eligibility for each member of the household for APTC (premium assistance), Catastrophic and CSR plans.

### If potentially eligible does user wish to go to PEAK?

If the Customer or their dependents are potentially eligible for additional benefits from PEAK due to a disability or blindness condition (see Business rule 5.1.1) then they will be shown a message in step 2.1.5 that they may be potentially eligible for added benefits on PEAK and will be provided with a link to get redirected to it. If the Customer wishes to go to PEAK then they can do so by clicking on the link else they can choose to stay in the Exchange.

### If definitely eligible for PEAK?

In step 2.1.5 if it is determined by the Exchange that the Customer does not have mixed family eligibility (QHP and (Medicaid or CHP+)) and the Customer is a legal resident having resided greater than or equal to 5 years in the US with less than 100% FPL or the Customer is pregnant with an FPL score less than 250% (see Business rule 5.1.1) then they will be informed that they cannot receive both Medicaid and discounts and will need to proceed to perform a full eligibility determination or shop for full priced plans anonymously. If the Customer does not come under either of the 2 conditions then they can proceed to step 2.1.8 and continue to shop for plans on the Exchange.

### Determine Relevant Plans

Based on information the Customer has provided, the Exchange will determine what plans are relevant for the Customer (Business Rule 5.1.5). All available plans will be returned and displayed within the system; including plans the Customer is determined eligible for based on the eligibility assessment, such as Catastrophic or Cost Sharing Reduction (CSR) plans. If the Customer is eligible for the Advance Premium Tax Credit (APTC), the plan will be displayed with premium cost (Business Rule 5.1.8), less APTC amount, to the user. Additionally, if the user is shopping for a family that has mixed eligibility, the Exchange will present only CHP+ plans for which family members are eligible for in addition to QHP plans. Medicaid plans will only be displayed on PEAK.

Plans will have User Fees (Business Rule 5.1.6) built into the plan cost, if applicable.

### View Plans Relevant for Customer

The user will be able to view a list of plans available to them. The list of plans will include attributes such as Monthly Premium (minus APTC, if applicable), Insurance Carrier, Plan Name, Insurance Carrier Logo, Quality Rating, Prescription Tier Structure (Generic/Preferred Brand/Non-Preferred Brand/Specialty) Cost, , Office visit Co-Pay , Specialist Co-Pay, Emergency Room Co-Pay, Maximum Out-of-Pocket Cost, CHP+ product available, Estimated Total Out-of-Pocket Cost (will be determined as part of upload to plan and will be characteristic of plan)), Plan type, Metal level (includes Catastrophic) and Riders. From the list of plans, a user will be able to Sort, Filter and Compare Plans. Users may also modify amount of APTC from view plans to see how this will impact their monthly premium. Each plan will have multiple rows with an expanded list of fields for attributes similar to those indicated above.

### Modify APTC

Users may modify amount of APTC from view plans to see how this will impact their monthly premium. The user may return to Modify APTC multiple times to view how it affects their premium amount or they may opt out of APTC altogether.

### Sort Plans

If the user chooses to sort plans, they can sort based on Annual Deductible, Monthly Premium, Carrier, Quality Rating and Maximum Out-of-Pocket Cost. To sort, the user selects the sort option from the dropdown box. Only one sort can be applied at a time during any shopping experience. The default sort is by Plan Premium amounts from lowest to highest.

### Filter Plans

If the user chooses to filter, they can filter by Annual Deductible (linked to premium) , Carriers, Provider (Primary Care Physician and Hospital), Formulary, Quality Rating, Metal (Catastrophic, Silver, Bronze, Gold, Platinum), Monthly Premium Range, APTC, CSR, Riders, Maximum Out-of-Pocket Cost, and Public Plan Participation. The filters should list the number of plans that pass the filters and the total number of available plans.

### Compare Plans

If the user chooses to compare plans, they can compare up to 3 plans at a time, in a side by side view, based on:

1. A link on to the Summary of Benefits and Coverage
2. A link to a plan brochure provided by the carrier
3. A link to the more detailed COHBE page
4. The benefits comparison chart

The headlines for the comparison chart will be indicated as:

* 1. Important Questions
     1. Annual Deductible
     2. Out-of-Pocket Maximums
     3. Plan Type
     4. HSA account compatible
     5. Referrals – If needed or not
  2. Provider Office Visits –In-Network
     1. Primary Care
     2. Specialist
     3. Periodic Health Exam – Preventive Care
     4. Periodic OB/GYN Exam – Preventive OB/GYN
     5. Well Baby Care
  3. Testing
     1. Lab Fee
     2. X-Ray
     3. Advanced Imaging (MRI/PET/CT scans)
  4. Prescription Drugs
     1. Generic
     2. Preferred Brand
     3. Non-Preferred Brand
     4. Specialty
  5. Immediate Care
     1. Emergency Room Services
     2. Emergency Transportation (Ambulance)
     3. Air Ambulance
     4. Urgent Care
  6. Facilities
     1. Outpatient Surgery (Facility Fee from SBC)
     2. Inpatient Hospital (Facility Fee from SBC)
  7. Maternity
     1. Prenatal and Post Natal Care
     2. Delivery and Inpatient Care
  8. Mental Health Benefits
     1. Mental/Behavioral Outpatient
     2. Mental/Behavioral Inpatient
     3. Substance Abuse Outpatient
     4. Substance Abuse Inpatient
  9. Pediatric Dental and Vision (If applicable)
     1. Eye Exam
     2. Glasses/Contacts (Materials)
     3. Dental Exam
     4. Cavities (if in EHB)
     5. Additional Dental (if in EHB)
  10. Out-of-Network Coverage
      1. Available
      2. Out-of-Network Deductible
      3. Out-of-Network Coinsurance
  11. Riders
      1. Standardized riders available for coverage

The Customer can do side by side comparisons for an unlimited number of times until they find a plan that meets their needs.

### Does User Want to Select a Plan?

The Customer selects the plan that they feel fit their needs best, by clicking the “Add to Cart” button from either within the plan listings or on the comparison screen. If a user chooses to add a plan to the shopping cart, they will proceed to step 2.1.14 if the user chooses not to add a plan to the shopping cart, they will proceed to step 3.1.1

### Add Plans to Shopping Cart

Plans added by the Customer to the shopping cart will be stored within the Exchange during the same session for the Customer to proceed with registration. If the Customer leaves the Exchange and returns, their plan selection will not remain in the shopping cart, since no account was logged into. In order for the plan selection to remain in the shopping cart, the user must first log in by proceeding to step 2.1.18

### Does Plan Have Riders?

For the plans added to the shopping cart, the Exchange will allow the user to select riders applicable to the plan (see Process Rule 5.2.1). If riders are available, users will proceed to step 2.1.17. If riders are not available, the user will proceed to step 2.1.18

### Does User Want to Add Rider?

From step 2.1.15, if riders are available for the plan, users may choose to add riders to the plan they selected. Riders will include description, details and cost (Business Rule 5.1.9) for each. If users choose to add riders, they will proceed to step 2.1.17, where the user can add available riders. If the user chooses to not add a rider, even though riders are available for the plan, they will proceed to step 2.1.18.

### Add Rider to Shopping Cart

Riders added by the Customer to the shopping cart will be stored within the Exchange during the same session for the Customer to proceed with registration. If the Customer leaves the Exchange and returns, their rider(s) selected will not remain in the shopping cart, since no account was logged into. In order for the rider(s) selection to remain in the shopping cart, the user must first log in by proceeding to step 2.1.18. Once the selected rider is added to the shopping cart, its cost is added to the premium amount of the plan.

### Proceed with Registration?

The user decides at this time to either continue with registration or to leave the Exchange. If user chooses to proceed with registration, they will proceed to step 2.1.19. If Customer chooses to not proceed with registration and leaves the system, then their plan selection(s) will not be retained and the Anonymous Eligibility Assessment use case will end.

See Exception flow 4.1.1.

### Next Steps

In this step the user must login if they have a username or password or they must register to create an account. Being logged in, the user may then proceed to:

* Create Individual Account – the user creates an account on the Exchange.
* Determine Individual Eligibility – the user wants to obtain final eligibility determination.
* Participate in Enrollment Period – the Individual is notified of the open enrollment period by the Exchange and then participates in it.
* Disenroll from Plans- The Customer may choose to disenroll from plans.
* Manage Individual Information – The Customer may want to change or update his personal information on the Exchange.

# Alternate Flows

## Redirected to PEAK

In this step the user has chosen to go to PEAK to view plans that he/she may be eligible for.

### Redirected to PEAK

In step 2.1.6 if the Customer wishes to go to PEAK to view additional benefits that he/she may be potentially eligible for then they can click on a link that is provided as part of the results page in step 2.1.5 and will be redirected to PEAK in this step. If the Customer does not wish to go to PEAK they can stay in the Exchange in step 2.1.7.

## Does user want to start over?

In this step the user decides whether he/she wants to abandon shopping for plans and start all over again.

### Does user want to start over?

If the Customer wishes to abandon shopping for plans and return to the start of the Anonymous Eligibility Assessment, they will be able to start over by clicking on the COHBE logo which will enable them to return to the homepage to Enter Zip Code (step 2.1.1) in order to make any changes to the Household composition, Tobacco User, Date of Birth statuses and/or Effective Date in order to view relevant plans while shopping. Effective Date, initially, will be defaulted to 01/01/2014 and the field will not be changeable until agreed upon Change Request (CR) implementation. Information entered as a part of the Anonymous Eligibility Assessment process before the user wanted to start over will be retained for the next attempt as long as the user stays in the same session. If the Customer decides that they do not want to start over with their shopping experience, they will proceed to step2.1.19.

# Exception Flows

### End Anonymous Eligibility Assessment Session

At step 2.1.18 the Customers have the option of Proceeding with Registration and enrolling in the plans that they have added to their shopping cart in that session. If they choose not to proceed with registration then they can simply end their session on the Exchange or navigate away from it.

# Specifications

## Business Rules

### Determine Potential Eligibility.

Once the Customer has entered his basic self-attested information and Income details as identified in step 2.1.2, the Exchange determines the following:

* General estimated MAGI based on household Income provided in step 2.1.2
* FPL based on the calculated estimated MAGI

FPL is calculated as follows:

FPL percentage = (general estimated MAGI / FPL income)\*100

|  |  |
| --- | --- |
| **Household size** | **FPL income** |
| 1 | 11,170$ |
| 2 | 15,130$ |
| 3 | 19,090$ |
| 4 | 25,050$ |
| 5 | 27,010$ |
| 6 | 30,970$ |
| 7 | 34,930$ |
| 8 | 38,890$ |
| Each additional member add | 3960$ |

*The above table lists data based on US Department of Health and Human Services 2012 guidelines for Federal poverty level.*

Note: All FPL in the system will be configurable to accommodate changes from time to time.

* Potential Eligibility for State programs such as Medicaid and CHP+

Pending CR: Calculations for general estimated MAGI, FPL and potential eligibility for State programs will be performed within the Exchange instead of an external service.

Based on the below user entered information:

* **Citizenship:**  If a Customer is a US citizen or legal resident who has resided in the US for greater than or equal to 5 years and if their FPL is less than 100% then they will be asked to create an account and proceed to perform a full eligibility determination or go back and shop anonymously for full priced plans. If the Customer is identified as a legal resident who has resided in the US for less than 5 years then they will be eligible for APTC corresponding to an FPL score of 100%.
* **Pregnancy Status:** If a Customer identifies themselves as a female in step 2.1.2 and then indicates that she is pregnant then she may become potentially eligible for the following based on the income entered:

If FPL>400% then the Customer will not be eligible for any APTC and can only shop for full priced plans.

If FPL > or equal to 250% but less than or equal to 400% then the Customer will be eligible for APTC corresponding to the FPL in that range.

If FPL<250% then the Customer will not be eligible for APTC and will be asked to proceed to create an account and perform a full eligibility determination.

* **Disability/Blindness:** If a Customer indicates that they are disabled or blind then they may be potentially eligible for Medicaid based on the household income entered in the same step. The Customer will be provided with a link to PEAK with a message that they may be eligible for additional benefits. The following rules will apply in this case if the Customer decides to shop on the Exchange.

If FPL> 400% then the Customer will not be eligible for any APTC and can only apply for full priced plans.

If FPL> or equal to 100% but less than or equal to 400% then the Customer will be eligible for APTC corresponding to the FPL in that range.

If FPL<100% then the Customer will be asked to submit an application for full eligibility determination if they are a citizen or legal resident for more than 5 years in the US else they will be defaulted to an APTC corresponding to 100% FPL if they are a legal resident who has resided less than 5 years in the US.

* **Household Income:** The Customer’s household income information will be used by the Exchange to calculate a general estimated MAGI and an FPL score based on the MAGI and also in the determination of eligibility for State programs.

### Determination of APTC

A Customer that has an FPL score that is not more than 400% FPL is eligible for Advance Premium Tax Credit (APTC), as long as the Customer is not already covered by minimum essential health benefits (Medicare, CHP+, employer plan or on a spouse’s health plan). Customers eligible for APTC with FPL scores less than 100% will have their APTC amount calculated at 100% FPL.

#### Determining Maximum APTC

The exchange will calculate the maximum APTC that an eligible Customer is allowed to get, which can be reduced depending on the plan the Customer ultimately enrolls (cannot exceed EHB premium) in as well as any reduction the Customer initiates on his or her own. The maximum APTC that a Customer can possibly get is calculated based on the second least expensive Silver plan offered in the Customer’s coverage area minus the Customer’s contribution amount.

#### Determining the Second Least Expensive Silver Plan

This plan is determined by rating the EHB portion of all Silver plans offered in the Customer’s coverage area based on the Customer’s coverage family and age. Tobacco use will not be factored into this calculation.

#### Determining the Contribution Amount

The Customer’s required contribution is calculated as the Customer’s monthly income multiplied by the Customer’s contribution percentage.

#### Determining the Contribution Percentage

The Customer’s contribution percentage is calculated based on the Applicable Percentage table, which is defined as follows:

|  |  |  |  |
| --- | --- | --- | --- |
| FPL Score at Least | FPL Score Less Than | Initial Percentage | Final Percentage |
| 100% | 133% | 2.0 | 2.0 |
| 133% | 150% | 3.0 | 4.0 |
| 150% | 200% | 4.0 | 6.3 |
| 200% | 250% | 6.3 | 8.05 |
| 250% | 300% | 8.05 | 9.5 |
| 300% | 400% | 9.5 | 9.5 |

The rules for determining the applicable percentage using the applicable percentage table are as follows:

* FPL scores less than 100% will be treated as 100%.
* Determine which row the Customer’s FPL score qualifies for.
  + If less than 133% the applicable percentage is 2%
  + If equal to or greater than 300% (while not equal to or greater than 400%) the applicable percentage is 9.5%
* If the row has the a differing initial and final percentage the applicable percentage is calculated (using two decimals of precision) as follows:
  1. Subtract the FPL score from the FPL Score at Least column value
  2. Subtract the FPL Score at Least column value from the FPL Score Less Than column
  3. Divide the result of step a by the result of step b.
  4. Subtract the Initial Percentage column value from the Final Percentage column value
  5. Multiple the result of step c by the result of step d
  6. Add the result of step e to the Initial Percentage column value

### Calculation of CSR

Calculation of CSR is based on the enrollee’s family FPL score. There are 3 levels of CSR:

* Level 3 – If the FPL score is equal to or greater than 0 percent FPL but not more than 150 percent FPL.
* Level 2 – If the FPL score is equal to or greater than 150 percent FPL but not more than 200 percent FPL.
* Level 1 – If the FPL score is equal to or greater than 200 percent FPL but not more than 250 percent FPL.

For example, if a customer has an FPL score of 172% (as returned by the Exchange) the customer will be at CSR level 2.

### Calculate Catastrophic Eligibility

Catastrophic plans are available to a Customer if they are under the age of 30 on the first day of the plan coverage period or they have been granted an exemption by the Exchange for affordability or hardship.  The affordability and hardship screening will not apply to pre-screening.

Catastrophic eligibility calculation will be performed even if the user is eligible for State medical programs such as Medicaid or CHP+.

### Determining Relevant Plans

Based on the customer provided zip code, information entered in step 2.1.2, potential eligibility from the Exchange, and effective date (defaulted initially to 01/01/2014 and post Go Live will need user input), the system will determine appropriate plans to be displayed to the user. Plan rates are based on county, if however the zip code entered by the user crosses county lines then the dropdown list of counties will pop out and the user will need to select the county they belong to.

If the Exchange determined that the Individual is potentially eligible for:

* **APTC:** APTC will be reflected in the premium cost displayed as part of the plan information to the user.
* **Catastrophic Plans:** Based on catastrophic plan eligibility, the system will display relevant plans.
* **CSR Plans:** Based on the CSR level the customer falls in, the system will display relevant plans. A customer that is eligible for a CSR level may select CSR plans for a lower level if available. For example if a customer has an FPL score of 172% (as determined by the Exchange) the customer is able to select from Level 2 and Level 1 CSR plans.
* **State medical programs:** The Exchange determines a Customer’s potential eligibility for state medical programs and will display the corresponding plans. If any of the household members of the Customer is deemed eligible for Medicaid or CHP+ plans and the rest of the members are QHP eligible then the relevant CHP+ plans will be displayed in the Exchange. Medicaid plans will not be displayed on the Exchange and will instead be available on PEAK.

For information entered in step 2.1.2, plan rates will vary depending on age, tobacco usage and zip code.

### User Fees

See Business Rule 5.1.6 in Anonymous Shopping use case.

### Determining Age for Premium Rating

See Business Rule 5.1.1 in Anonymous Shopping use case.

### Determining Plan Premium

See Business Rule 5.1.3 in Anonymous Shopping use case.

### Determining Rider Cost

See Business Rule 5.1.4 in Anonymous Shopping use case.

## Process Rules

### Available Riders

The Exchange will display riders while shopping for plans, if plan selected has riders associated with the plan. If riders are not available for the plan then the Customer may proceed to step 2.1.18. Refer to section 5.4.10 for screen details.

## Workflow

There are no Workflow requirements for the Anonymous Eligibility Assessment Use Case.

## UI Screen Details

### Homepage

* A dropdown list of counties will popup when the user enters a Zip Code that crosses county lines. The user can then select their county from this list.

### Family Details

* For Date of Birth only month and year of birth will be asked
* State residency question will not be asked.
* Citizenship status will have options Citizen or legal resident. If the legal resident option is chosen then the user will be asked to enter how many years they have resided in the US.

### Income Details

* The user is prompted to submit household income “Please provide your average projected weekly/monthly take home pay (please consider any additional income i.e. social security benefits, child support, student loan income, rental income, veterans benefits and unemployment benefits)”.

### Eligibility Results

* If applicable a link to PEAK will be provided.

### Relevant Plans (Anonymous Eligibility Assessment), Sort and Filter

* New column for Rider needs to be added to this screen.
* Need to change verbiage to include potentially eligible for.
* Plan premium needs to be added as the default sort option.
* For data elements on this screen please refer to Appendix B

### Compare Plans

Please refer to Appendix B for the data elements on this page.

### View Riders

* Up to four riders will be displayed.
* Cost will be shown for the rider.
* User will have option to select the riders they want to include.
* User sees premium cost plus cost of each rider.
* Running total cost of all riders will be added.
* Riders can be unselected.
* Default is no riders will be selected on plans, until users select riders to be added.

## Communications

### Imaging Requirements

There are no Imaging Requirements for the Anonymous Eligibility Assessment Use Case.

### Form Requirements

There are no Form Requirements for the Anonymous Eligibility Assessment Use Case.

### Notices Requirements

There are no Notices Requirements for the Anonymous Eligibility Assessment Use Case.

### Other Communication Requirements

There are no Other Communication Requirements for the Anonymous Eligibility Assessment Use Case.

## Interfaces

There are no Interface Requirements for the Anonymous Eligibility Assessment Use Case.

## Reporting

The following reports were identified.

* How many Customers ran an assessment and created an account?
* How many Customers were transferred over to PEAK?
* Where in the Anonymous Eligibility Assessment process did they leave the process?

## User Security

User entered Information in step 2.1.2 includes the following identified Protected Health Information that will need to protected.

* Pregnancy Status
* Disability/Blindness
* Smoker

## Activity Log and Audit Trail

* Logging is needed and the ability to turn logging on and off depending on performance impacts.
* Name will not be logged.

# Future Release Notes

There are no Future Release Notes for the Anonymous Eligibility Assessment Use Case.

# Appendix A - Glossary

| Term | Definition |
| --- | --- |
| **Anonymous Shopping** | **“Anonymous Shopping”** means the ability for a Customer to review health plans that are available to him or her without revealing personally identifiable information. Information needed to Anonymously Shop is very limited. |
| **Advanced Premium Tax Credit (APTC)** | **“Advanced Premium Tax Credits (APTC)**” are premium payments made by the federal government directly to carriers on behalf of individuals who fall between 133% and 400% of the federal poverty level (FPL). |
| **Benefits** | “**Benefits**” are to be interpreted as Health Plan Benefits unless otherwise specified in the document. |
| **COHBE** | Colorado Health Benefit Exchange**, “COHBE”** is used interchangeably with “Exchange” throughout the documents. |
| **Customer or Customers** | “**Customers**” or “**Customers**” may be used interchangeably and are terms meant to define individuals or small employers or employees of small employers learning about opportunities to purchase, shopping to purchase, purchasing insurance through the Exchange, or modifying insurance purchased through the Exchange. References to Customers include, as appropriate, dependents of Customers, employees and dependents of employees and others covered by insurance purchased by Customers through the Exchange. |
| **Eligibility** | “**Eligibility**” is a broad term that can mean, as an example, one or more of the following:   * An Individual’s ability to purchase on the Exchange * An Individual’s ability to opt out of the Individual Mandate * An Individuals entitlement to advanced premium tax credits or cost sharing reductions (“**MAGI Eligibility**”) * An Employer’s ability to use the SHOP Exchange to provide employees with health insurance options * An Employer’s entitlement to premium tax credits * A Carrier’s ability to offer QHP’s through the exchange   Unless specifically stated as “**MAGI Eligibility**”, the term Eligibility should be interpreted as broadly as possible within the context of the requirement. |
| **Eligibility Determination** | **“Eligibility Determination”** is the process of determining a Customer’s eligibility for various programs (including Medicaid, CHP, APTC and CSR) using the External Eligibility Service (EES). The determination may be either preliminary or final depending on when the EES is called (either at preliminary screening stage or after application has been completed). |
| **Employee** | An **“Employee”** is a person who is employed by a company or small business who obtains insurance through the Exchange. |
| **Exchange** | During the implementation phase, the terms “**Exchange**” or “**Exchanges**” are meant to include technology, services, business processes, people, and other resources required to implement, operate and/or maintain the requirements or functions needed to support the ability for Customers to shop for and purchase health insurance. Specifically related to interpretation of a requirement, the term “Exchange” implies that the implementation of a requirement is not strictly limited to a technology solution.   * Individually, the term “Exchange” refers to each Exchange or both Exchanges as appropriate in the context. * The Exchange is NOT a state agency but a standalone non-profit entity. It will serve as an aggregator of individual policies sold by private insurers and underwritten using the new federal and state underwriting and rating rules. * The Small Business Health Options Program (SHOP) Exchange will support the specific needs of small employers. * For context, the Exchanges will act much like an “Expedia or Orbitz for Health Insurance” system. They will allow individuals and small firms to obtain information, compare and purchase private health insurance plans. The Exchanges will also be the entities that will evaluate whether or not a particular insurance policy meets the criteria set out by the new federal rules for policies offered to individuals and small employers. |
| **Individual** | **“Individual”** is generally meant to identify a person who obtains insurance for themselves and/or their dependents through the Individual Exchange. |
| **Navigators** | “**Navigators”** are persons authorized to assist Customers in their activities to shop for insurance through the Exchanges. |
| **PHI** | Protected Health Information as defined in HIPAA/HITECH is any information in the medical record or designated record set that can be used to identify an individual and that was created, used or disclosed in the course of providing a health care service such as diagnosis or treatment. |
| **Preliminary Eligibility Screening** | “**Preliminary Eligibility Screening** “ or “**Pre-Screening**” is the ability for a Customer to get a preliminary indication of his or her potential qualification for financial assistance and/or cost sharing reduction using a limited amount of Customer data including self-attested income and citizenship status. Preliminary screening is subject to subsequent final eligibility determination during enrollment. |
| **Qualified Health Plan (QHP)** | **“Qualified Health Plan (QHP)”** generally refers to health plans that meet all the criteria set forth by CMS, the DOI and the Exchange and are offered on the Exchange. In some instances, QHP means both the carrier offering the plan and the plan itself. |
| **Self-Attested Data** | **“Self-Attested Data**” is information provided by a Customer that has not been validated by COHBE or other government system. The Exchange will develop a process to validate Self-Attested data. Once validated, Self-Attested data will override any system-provided data (e.g., income, citizenship status). |
| **System** | The “**System**” means all of the software, configurations, data, processes, and equipment used to provide the Exchanges and the System is also referred to as the “**solution**.” During the implementation phase, “System” is taken to mean the technology component of the Exchange. |
| **Users** | “**Users**” are users of the Exchange authorized by COHBE and may include operators, administrators, Customers, brokers, navigators, etc., who interact with the System. Users may be internal or external to COHBE. |

# Appendix B – Data Elements

| Data Items | Sort | Filter | Plan Rows | Plan Detail or Comparison | Drilldown on Carrier Logo, Detail Links |
| --- | --- | --- | --- | --- | --- |
| Monthly Premium | X | X | X |  |  |
| Quality Rating | X |  | X |  |  |
| Carrier Name | X | X | X |  |  |
| Carrier Logo |  |  | X |  |  |
| Plan Name |  |  | X |  |  |
| Metal Tier |  | X | X |  |  |
| Estimated Out-of-Pocket | X |  | X |  |  |
| Emergency Room Copay |  |  | X |  |  |
| Provider |  | X |  |  |  |
| Formulary (Drug Name) |  | X |  |  |  |
| Prescription Drug Tier Structure: |  |  | X | X |  |
| Generic |  |  | X | X |  |
| Preferred Brand |  |  | X | X |  |
| Non-Preferred Brand |  |  | X | X |  |
| Specialty |  |  | X | X |  |
| Riders included in Plan (Code) |  |  | X |  |  |
| APTC Filter (if applicable) |  | X |  |  |  |
| CSR Filter (if applicable) |  | X |  |  |  |
| Important Questions: |  |  |  | X |  |
| Plan Type |  |  | X | X |  |
| Annual Deductible | X | X | X | X |  |
| Maximum Out-of-Pocket |  | X |  | X |  |
| HSA Account Compatible |  |  |  | X |  |
| Referrals Needed |  |  |  | X |  |
| Provider Office Visits In-Network: |  |  |  | X |  |
| Office Visit Copay |  |  | X | X |  |
| Specialist Copay |  |  | X | X |  |
| Periodic Health Exam |  |  |  | X |  |
| Periodic OB/GYN Exam |  |  |  | X |  |
| Well Baby Care |  |  |  | X |  |
| Testing: |  |  |  | X |  |
| Lab Fee |  |  |  | X |  |
| X-Ray |  |  |  | X |  |
| Advanced Imaging (MRI, CT, PET scans) |  |  |  | X |  |
| Immediate Care: |  |  |  | X |  |
| Emergency Room Services |  |  |  | X |  |
| Emergency Transportation (Ambulance) |  |  |  | X |  |
| Air Ambulance |  |  |  | X |  |
| Urgent Care |  |  |  | X |  |
| Facilities: |  |  |  | X |  |
| Outpatient Surgery |  |  |  | X |  |
| Inpatient Hospital |  |  |  | X |  |
| Maternity: |  |  |  | X |  |
| Prenatal and Post Natal Care |  |  |  | X |  |
| Delivery and Inpatient Care |  |  |  | X |  |
| Mental Health Benefits: |  |  |  | X |  |
| Mental/Behavioral Outpatient |  |  |  | X |  |
| Mental/Behavioral Inpatient |  |  |  | X |  |
| Substance Abuse Outpatient |  |  |  | X |  |
| Substance Abuse Inpatient |  |  |  | X |  |
| Eye Exams |  |  |  | X |  |
| Glasses/Contacts |  |  |  | X |  |
| Dental Exam |  |  |  | X |  |
| Cavities |  |  |  | X |  |
| Additional Dental |  |  |  | X |  |
| Out-of-Network Coverage: |  |  |  | X |  |
| Available |  |  |  | X |  |
| Out-of-Network Deductible |  |  |  | X |  |
| Out-of-Network Coinsurance |  |  |  | X |  |
| Rider: |  |  |  | X |  |
| Standarized Riders available for coverage |  |  |  | X |  |
| Links: |  |  |  |  |  |
| Summary of Benefits and Coverage |  |  |  | X |  |
| Plan Brochure |  |  |  | X |  |
| Detailed COHBE page |  |  |  | X |  |
| Detailed Policy Form |  |  |  |  | X |
| Public Program Plans offered by Carrier |  | X |  |  | X |
| MLR Information |  |  |  |  | X |
| Transparency Measures: |  |  |  |  | X |
| Claims Payment Policy |  |  |  |  | X |
| Periodic Financial Disclosures |  |  |  |  | X |
| Data of Enrollment |  |  |  |  | X |
| Data on Disenrollment |  |  |  |  | X |
| Data on Number of Claims Denied |  |  |  |  | X |
| Data on Rating Practices |  |  |  |  | X |
| Information on Cost Sharing and Payments |  |  |  |  | X |
| Information on Enrollee Rights |  |  |  |  | X |
| Quality Information collected on Exchange |  |  |  |  | X |
| DOI Complaint Data |  |  |  |  | X |