USE

**ELG-002**

**Determine Individual Eligibility**

**Use Case**

**Colorado Health Benefit Exchange (COHBE)**

**Version 1.1**

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# Use Case: Determine Individual Eligibility

## Goal

The goal of this Use Case is that an individual visits the Exchange to determine an individual’s eligibility for insurance affordability programs (i.e. subsidies, Medicaid, CHP+).

This Use Case completes succesfully when the system has determined eligiblity for the insurance affordability programs. If the customer is elgibile for financial assistance through the Exchange or meets the affordability exemption (APTC, CSR, Catastrophic), this information will be displayed to the individual. If an individual or any person in the family is determined eligible for state programs, the Exchange will provide links to PEAK to complete enrollment. If a Customer is found ineligible for both subsidies and state programs, they will still be allowed to shop for and enroll in QHPs offered through the Exchange.

## Brief Description

A Customer will access the Individual Exchange to provide self-attested essential information as part of completing the Single Streamlined Application (which include First Name, Date of Birth, State Residency, Native American status, household composition, and income) needed to determine eligibility for APTC, CSR, or state medical programs.

The Customer will receive a notification of the eligibility determination. The user can be either eligibile for state medical programs such as Medicaid or CHP+ or eligible for subsidies such as APTC or CSR, but not both. Depending on the eligiblity determination, the user can then choose to either stay in the Exchange and shop for QHPs or proceed to PEAK to view and enroll in Medicaid or CHP+ plans.

If the user decides to stay in the Exchange, the user is presented with plans based on their eligibility offered on the Exchange, including any special plans 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, less APTC amount, to the user. Additionally, if the user is shopping for a family that has mixed eligibility, the Exchange will present Qualified Health Plans (QHPs) and a link to PEAK to view and enroll in a relevant state medical plan.

The individual can appeal the eligibility for APTC, CSR or Catashtrophic plans or the amount of APTC or level of CSR and the appeal will be reviewed by COHBE.

## 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.
* EL017: The System shall allow the Customer to review the information provided by EES or submitted verification documents and if needed, provide additional documentation to support verification or self-attestation, through a verification process.
* EL020: The Exchange shall be able to utilize External Eligibility Service to determine potential eligibility for the State medical programs.
* EL030: The System shall have the capability, with appropriate permissions; to override Exchange provided Eligibility Determinations.
* 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.
* EL053: The System shall have the ability to transmit income and household composition information as required by the External Eligibility Service to determine which members of the household may be eligible for state medical programs and APTC/CSR.
* EL054: The System shall have the ability to receive information from EES such as income (both at the individual and household level), citizenship status, incarceration status and residency for data verification process. The information will provide source of data and results.
* EL071: The System shall use Verified income to enable the Exchange to calculate Advance Premium Tax Credits or other federal cost sharing assistance or subsidies.
* 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.
* EL180: The System shall restrict eligibility business processes by role, e.g. Navigator, Broker would have access. Plan approver would not.
* EL191: The System shall capture and store all Eligibility Determinations and archive this information for future reference.
* EL192: The System shall assign or display the Eligibility Determination for each member of the household, including information about benefits (if applicable) and provide recommended next steps, e.g.
  + Potential eligibility for public program(s), show program(s) and benefit(s).
  + Eligibility for subsidized private insurance, show subsidy amount.
  + Eligibility for Exchange (private insurance).
  + All information provided will adhere to COHBE defined usability standards.
* EL198: The Exchange shall NOT provide final eligibility determinations or support any appeals processes for any State supported programs including but not limited to Medicaid, CHIP, SNAP, and TANFF.
* EL201: The System shall record actions related to the PII (Personally Identifiable Information) provided for determining eligibility, i.e. the date, time, client identification, and user identification must be recorded when electronic eligibility information is created, modified, deleted, or printed and an indication of which action(s) occurred must also be recorded.
* EL205: The System shall have the ability to generate a formal written notice to the customer that documents the final eligibility determination and the data used to make this determination.
* EL211: The information (data and supporting documentation provided) used in the eligibility determination shall be securely stored, retained and shall be made available to authorized user through the System.
* EL220: The System shall retain data sent to the EES and its responses.
* EL240: After completion of the application process and submission, the System shall indicate to the consumer that the consumer is likely eligible for other human services assistance programs (e.g. TANF and SNAP) as determined by the EES and direct the consumer to the application process in the State System.
* 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).
* EL260: The System shall be configured to comply with the eligibility business processes identified in CMS Eligibility and Enrollment Blueprint; Exchange Business Architecture Supplement.
* EL288: The System will have the ability to transmit to CMS the final eligibility determinations and the data used to make this determination.
* GF040: SHOP employees and individual households will use a unified process to determine benefits and eligible plans.
* 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.
* SH074: When an employee ceases employment, the employee will be able to visit the Individual Exchange to receive an eligibility determination and enroll in an individual or family health plan by using the employee’s existing profile.
* IF020: The System shall provide the Customer with the ability to upload supporting documentation such as birth certificates.
* EL022: In the event that the additional information gathered from EES does not satisfy the determination requirements, the System will prompt the Customer with the option to supply additional content.

## Primary Actor

### Individual

An Individual will enter the Exchange to provide required personal data for eligibility determination to qualify for QHP plans or state medical programs available to them. Or an individual could be applying on someone else’s behalf.

### Employee

An Employee logged in will proceed as an Individual to determine their eligibility for QHP plans within the Exchange or state medical programs available to their family members. Employees can be evaluated for APTC, CSR or Catastrophic if employer plan was not affordable. If employer plan was affordable, employee can still be evaluated for Catastrophic plans.

### Broker

A Broker will enter the Exchange to act on behalf of an Individual to provide personal information for their client’s and family members in determining eligibility for QHP plans or state medical programs.

## Secondary Actor

### The Exchange

The Exchange will provide the eligibility results that the EES has determined for the Customer and their family members based on the Customer’s personal information entered as part of the streamlined application once logged in to an account.

### The External Eligibility Service (EES)

EES will provide the Exchange and state program eligibility determinations for each family member based on the self-attested data entered by the Customer. Additionally, EES will calculate and return Federal Poverty Level (FPL) percentages for Customers using the Exchange. Based on information returned from EES, the Customer may be asked to provide additional documentation.

### Back Office

The Back Office will provide the ability for the Customer to appeal an eligibility determination by manually processing the appeal, determine whether the appeal should be granted or not and then override the previous eligibility decision within the Exchange if needed. They will also verify supporting documentation.

### CMS

### CMS will provide the ability to receive notification of final eligibility determination for the Customer and each family member once all eligibility factors that require verifications have passed.

### OIT Gateway

The OIT Gateway will provide information from the Golden Record and receive updated Golden Record data information from the Exchange.

## Pre-Conditions

* The Customer has an account on the Exchange and has logged in.
* At least one execution of the Provide Household Composition must have taken place. **Note:** It is up to the Customer to determine how much of their family information to provide during the execution of the Provide Household Composition Use Case. To get an accurate eligibility determination, the user will need to accurately and completely perform the Provide Household Information Use Case prior to performing this use case.
* Data elements to be populated and user verified prior to this Use Case include:
  + Baseline Applicant Information
  + Income and Additional Information
  + Program Specific Questions

## Successful Post-Conditions

This use case is complete when the Customer has reviewed his eligibility determination and chooses to proceed with next steps within the Exchange such as Shop for Individual Plan.

## Triggers

The following events would trigger this Use Case:

* An individual would like to know his or her eligibility for insurance affordability programs (i.e. subsidies, CHP+ and Medicaid).

## Assumptions

* This use case will be updated for Dental and Vision requirements or a separate use case will be created.
* 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.
* The EES will make appropriate calls to external sources to perform data verification as needed.
* The EES will perform the determination of employer minimum essential coverage as part of the EES determination of APTC and CSR eligibility.
* The response from EES indicating eligibility will be near real-time. However completion of the subsequent data verification process will not be real-time.
* The Carrier will provide the CSR plan with four variations; the Silver Plan only version and the three CSR plans for level 1 through 3. The plans will be linked, so systematically, the Exchange can determine which plan to move the Customer to.
* Once Navigator’s role has been defined, this Use Case may be updated or a separate use case will be created.

# Flow of Events

The Business Process Activity diagram below shows the COHBE processes for the Determine Individual Eligibility Use Case. The steps numbered on the diagram below have detailed explanations in the sections that follow.

Figure 1: Determine Individual Eligibility BPM



Figure 2: Determine Individual Eligibility (Continued) BPM



## Basic (Main) Flow – Determine Individual Eligibility

The Basic Flow through this use case is the user having entered all required self-attested data to be verified by external sources in order to determine each member’s eligibility for any of the insurance affordability programs. They will know if they are available for APTC, CSR, or state medical programs consideration and directed appropriately with next steps.

### Process Eligibility Determination Request with Self Attested Information

The Exchange will use the Customer’s self-attested information that they have provided in order to make an eligibility determination on a real-time basis. This information will be sent from the Exchange through the EES, proceed to Step 2.1.2.

### Determine Exchange Eligibility, Exchange Subsidy & State Program Eligibility for Each Family Member

The Exchange will send to EES information on the Customer’s tax family, including information for each family member. EES will determine and send back to the Exchange each family member’s insurance affordability program eligibility (see Interface, Section 5.6.2). Additionally, the EES will verify the Customer’s self-attested information against external sources. The EES will communicate back to the exchange any discrepancies between the self-attested information and the external source, including the identification of the external source and value and if the discrepancy is outside the reasonable compatibility bounds of 10 percent.

**Note**:

* It is the responsibility of the EES to determine if an Individual is eligible for APTC or CSR. Itis the responsibility of the Exchange to calculate specific APTC or CSR amounts.
* It is the responsibility of the EES to determine the FPL% for Customers using the Exchange.
* Customers found ineligible for both subsidies and state programs will still be allowed to shop for and enroll in QHPs through the Exchange.

### Data Verification

EES will receive the Customer’s data that they provided within the Exchange to determine their eligibility based on a call to external sources to verify their incarceration status, lawful presence and Modified Adjusted Gross Income (MAGI).

### Did External Source Verification Pass?

If the determination of eligibility was verified through all external sources (interface responses Y for Lawful Presence, CO Eligibility and Reasonable Compatibility), then proceed to Alternate Flow, Step 3.2.1. If for some reason the verification process did not pass, proceed to Step 2.1.5.

### Is Exchange Responsible for Completing Document Verification?

The Exchange will have to determine who is responsible for collecting and processing supporting documentation in the event that Customer has not passed data verification. If all members are potentially eligible for Medicaid they will be sent to PEAK (Step 3.3.1), who will request and process all relevant documentation. Members eligible for APTC/CSR will move to step 2.1.6.

### Create Request for Additional Documentation

If eligibility could not be determined for reasons such as not within the 10% comfort level from the external sources versus the Customer’s self-attested income amount, then a request will be sent to the Customer to request additional documentation, proceed to Alternate Flow, Step 3.1.1.

### Is Customer Potentially Eligible for State Medical Programs?

Based on data from EES, the Exchange will determine if the Customer is potentially eligible for state medical programs. If the Customer or members of their family are not eligible for state medical programs, then they will proceed to Step 2.1.8. If they are eligible for state medical programs, then they will move on to Step 2.1.9.

**Notes:**

* Even if the Customer or any member of their household is eligible for state medical programs, if they are under the age of 30 they may also be considered for Catastrophic plans.
* Even if Customers are eligible for state medical programs (and ineligible for APTC or CSR), they can still shop for QHPs on the exchange.

### Determine APTC and CSR

The Exchange will calculate APTC (see Business Rule, Section 5.1.1), CSR (see Business Rule, Section 5.1.2), Affordability Exemption (see Business Rule, Section 5.1.8), and Catastrophic Eligibility (see Business Rule, Section 5.1.3). The user will proceed on to Step 2.1.9.

**Notes**:

* It is the responsibility of EES to determine:
  + if an Individual is eligible for APTC or CSR.
  + the FPL% for Customers using the Exchange.
* Itis the responsibility of the Exchange to calculate specific APTC or CSR amounts.

### Determine Catastrophic Eligibility

The Exchange will determine Catastrophic Eligibility (see Business Rule, Section 5.1.3).

### Archive/Store Eligibility Determination

All eligibility determinations will be stored and archived for each Customer that uses the Exchange. This data will be used for notifications, identifying if additional documentation is needed, and satisfying requests for information from various state agencies, proceed on to Step 2.1.11.

### View Eligibility Decision

The Customer will be able to view their eligibility decision and proceed on to Step 2.1.12.

### Is Entire Family Potentially Eligible for State Program and Wish to Enroll?

If the entire Customer Family is potentially eligible for state medical programs and wishes to enroll, they may choose to exit the Exchange and go to PEAK by clicking on a link that will be provided (Alternate Flow, Step 3.3.1).

If the Customer is not potentially eligible for state medical programs, but does not want to enroll, or if they are enrolling in Medicaid through PEAK, but decide that they want to sign up for a QHP plan in case they are denied from PEAK, they may proceed to Step 2.1.13.

Note on Customers with disabilities:

If an individual begins the application in COHBE and the applicant is determined ineligible for MAGI Medicaid but is eligible for subsides, AND answered yes to any non-MAGI Medicaid question on the SSA, COHBE will inform the Consumer that they may be potentially eligible for Medicaid. The Customer will also be informed that s/he can shop for QHPs with subsidies while the non-MAGI determination is being processed. If the consumer chooses to pursue QHP enrollment with subsidies, they will be allowed to do so on COHBE. After the Customer has selected a plan and submitted the application for enrollment, they will be provided a link to PEAK to complete the full Medicaid determination from HCPF based on non-MAGI qualifications. In the meantime, COHBE will track the individual’s enrollment in a QHP with subsidies and wait to receive a notification about HCPF’s final eligibility determination based on the individual’s non-MAGI Medicaid status.

### Is Customer Not Eligible for State Program and Wish to Appeal?

If the Customer is determined not eligible for state medical programs, but thinks they should be, they may proceed to PEAK (Alternate Flow, Step 3.3.1) to appeal the eligibility decisions made about state programs. If the Customer does not wish to appeal the state medical program eligibility decision, the user will proceed to Step 2.1.14.

### Does Customer Want to Appeal Exchange Subsidy Determination?

If the Customer does not agree with the eligibility determination for subsidies or the subsidy amount (such as CSR level), the user may apply for an appeal (Alternate Flow, Step 3.4.1). If the user does not want to appeal the Exchange subsidy determination, they will proceed to Step 2.1.15.

**Note:** This includes appeal of eligibility of Catastrophic plans. If the individual is over 30, but believes other plans are not affordable, they will need to request an appeal and provide proof that other plans are not affordable.

### Determine Relevant Plans

Based on information the Customer has provided, the Exchange will determine what plans are relevant for the Customer (Business Rule, Section 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, Section 5.1.7), less APTC amount, to the user. Additionally, if the user is shopping for a family that has mixed eligibility, the Exchange will provide a link to PEAK to view and enroll in state medical plans, such as Medicaid or CHP+, for which family members are eligible in addition to QHP plans displayed on the Exchange.

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

### Next Steps

If the Customer wants to continue in the Exchange, they will proceed to next steps, such as:

* Shop for Individual Plan – the user wants to shop for a plan available to them.
* Manage Individual Information – the user wants to update their account.

# Alternate Flows

## Additional Documentation Needed

### Receive Request for Additional Documentation

The Customer will receive a request for additional documentation if the external source check was unable to verify their self-attested data, such as their income amount.

### Is Documentation Provided?

The Customer will have the choice to provide the requested documentation in order to continue within the Exchange. If providing the needed documentation, then proceed to Alternate Flow, Step 3.1.3. If not, then proceeded to Exception Flow, Step 4.1.1.

### Provide Additional Documentation to the Exchange

The User may provide additional documentation to support self-attestation or may choose to provide this documentation at a later point in time. The user has 90-Days from time application (enrollment) is submitted to provide the documentation, see Submit Individual Application Use Case or the Exchange will automatically re-perform the eligibility determination, using the external source values in replacement of unverified self-attested information.

### Manual Data Verification

The Back Office will receive the additional documentation requested and manually verifying the information provided by the external sources against the most recent information provided by the Customer. The Back Office will process a “failed” response manually from the EES, which would occur if the Exchange does not receive an eligibility data verification response back from EES within 7 days.

### Is Documentation Accepted?

If the Back Office has validated the documentation that was provided by the Customer, proceed to Alternate Flow, Step 3.1.6. If not, proceed to Alternate Flow, Step 3.1.7. The user has 90 days to provide the documentation requested in order to continue with their eligibility determination. If documentation supporting a Customer’s self-attested income is not provided after 90 days, the APTC amount will be adjusted to be in line with the MAGI received through the IRS.

### Record Verified Data

The Exchange will record the manually verified data that is received from the Back Office which will be tied back to the Customer’s account while proceeding on to Step 2.1.4.

### Process Eligibility Determination Request with External Source Information

If the documentation that was provided was not accepted by the Back Office, it will be sent back to the Exchange to again process the eligibility determination using the external source information gathered previously by calling the EES (Step 2.1.2).

## Eligibility Determination Notifications

### Send Eligibility Determination Notification

The Exchange will send eligibility determination notification per user preference, to the Customer identifying sources used for eligibility determination and outcome of determination. The Exchange will send eligibility determination information to CMS as well. Based on verified Customer data, the Exchange will also send the individual’s data to MDM for update.

### Receive Notification of Final Eligibility Determination

The Customer will receive from the Exchange a final notification of their eligibility determination approval. This notification will delivered via the Customer’s indicated communication preference and this use case will end (Exception Flow, Step 4.1.1).

### Receive Notification of Final Eligibility Determination

The Exchange will send information to CMS about the Customer’s final Eligibility Determination.

## Customer Available for PEAK

### Make Available to PEAK

If the Customer is potentially eligible for state programs and has opted to proceed to PEAK, the user information entered will be passed to PEAK using the interface identified in Section 5.6.1.

## Eligibility Appeal Process

### Appeal Exchange Subsidy Use Case

The Customer may appeal Exchange determined eligibility, such as the amount of APTC received, CSR level and eligibility for Catastrophic plans.

### Is Appeal Granted?

If the appeal is granted, the back office will override an eligibility input or the eligibility determination itself (as part of the Appeal Exchange Subsidy use case). If the appeal is not granted, proceed to Step 2.1.13.

## Data Verification

### Has Application Been Submitted to Carrier?

### If the Carrier has already received the application proceed with Step 3.5.2. If not, then proceed to Step 2.1.15

### Is APTC/CSR subsidy Invalid?

If the Customers determination of eligibility was verified through all external sources after the application has been submitted, proceed to Step 2.1.15. If for some reason the verification process did not pass after the Customer’s application to the Carrier has been submitted then proceed to Step 3.5.3 and Step 3.5.5.

### Is CSR Subsidy Invalid?

If the Customer’s CSR subsidy is unchanged then proceed to Step 2.1.15. If the Customer’s CSR subsidy has changed then proceed to Step 3.5.4.

### Modify Enrollment from CSR to Equivalent Silver Plan

The exchange will modify the Customer’s enrollment to the equivalent CSR Silver Plan of the appropriate CSR Level. If the Customer is no longer eligible for CSR, after their application has already been submitted to the Carrier, they will automatically be enrolled in an equivalent Silver Plan (Business Rule, 5.1.9).

### Is APTC Subsidy Invalid?

If the Customer’s APTC subsidy is unchanged then proceed to Step 2.1.15. If the Customer’s APTC subsidy has changed then proceed to Step 3.5.6.

### Modify APTC Credit

If it determined that the Customer’s originally indicated maximum APTC has changed,and the customer’s current APTC amount is greater than the new maximum APTC amount the exchange will set the customer’s APTC to be equal to the new maximum APTC amount.

### Update Subsidy Information on Enrollment

If the subsidy changed due to the user’s income amount changing, the Exchange will need to update the user’s subsidy information (CSR Level or non-CSR eligibility, APTC and maximum APTC) accordingly and proceed on to Alternate Flow, Step 3.5.3.

### Notify Carrier

The Exchange will need to notify the carrier of any premium changes that may have occurred due to an updated subsidy for any given Customer.

### Carrier Receives Notification

The Carrier will receive a notification from the Exchange indicating that a change has occurred with the subsidy amount for a given Customer affecting their portion of the premium cost to be paid.

### Notify CMS

The Exchange will notify CMS of any subsidy changes that may have occurred with a given Customer due to a change in income.

### CMS Receives Notification

CMS will receive the notification from the Exchange indicating that a Customer has had a change occur with their subsidy affecting their total premium amount.

### Notify Customer

The Exchange will notify the Customer of any subsidy changes that may have occurred due to a change in income.

### Customer Receives Notification

The Customer will receive a notification from the Exchange indicating a change has occurred with their subsidy affecting their portion of the premium amount to be paid.

# Exception Flows

## End Determine Individual Eligibility Session

### End

The Exception Flow entails the user choosing not to proceed with the next steps after eligibility has been determined and leaving or not going back into the system. If the Customer decides to log back in to their account at a later date, they will be able to continue with eligibility, shopping, or updating their account.

# Specifications

## Business Rules

### 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 is covered through a family member’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 (SLESP)

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. This amount is prepopulated for all remaining months of the calendar year beyond the effective date of coverage. SLESP for months before the effective date should not be changed.

#### Determining the Contribution Amount

The Customer’s required contribution is calculated as the Customer’s annual income multiplied by the Customer’s contribution percentage (2%-9.5% of total income depending on their FPL threshold).

#### 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

#### Determining the Annual APTC Amount

The annual APTC amount is the difference between the sum of the monthly SLESP amounts and the annual contribution amount.

#### Determining the Monthly Max APTC Amount

The potential APTC amount is the annual APTC amount minus the amount of APTC awarded to the effective date of new policy. If the potential APTC is greater than 0, the monthly max APTC amount is the potential APTC divided by the number of months remaining in the calendar year. Otherwise, the max APTC amount is 0.

### 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 Federal Exchange for affordability or hardship.  The affordability and hardship screening will not apply to pre-screening.

### Determine External Source Discrepancy

The system will determine documentation needed to support each of the following conditions.

#### Income Variance

If the external verification sources determine income variance does not pass reasonable capability, the Exchange will be notified that income verification has failed and user will need to provide supporting documentation. They will still be allowed to proceed with enrollment and will have to provide the documentation within 90 days of enrollment.

#### Incarceration Status

The external verification sources determine incarceration status verification and will notify the Exchange. If verification has failed, user will be asked to provide supporting documentation. They will still be allowed to proceed with enrollment and will have to provide the documentation within 90 days of enrollment.

#### Lawful Presence

The external verification sources determine lawful presence verification and will notify the Exchange. If verification has failed, user will be asked to provide supporting documentation. They will still be allowed to proceed with enrollment and will have to provide the documentation within 90 days of enrollment.

### Determine Relevant Plans

Based on the customer provided zip code, information entered in step potential eligibility from the Exchange, 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 the CSR plan with the highest AV that all family members qualify for.
* **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 customer will be allowed to search for providers that participate in CHP+ and are in the plan network of the same carrier. Medicaid plans will not be displayed on the Exchange and will instead be available on PEAK.

For information entered, plan rates will vary depending on age, tobacco usage and county.

### User Fees

See Business Rule 5.1.6 in Anonymous Eligibility Assessment Use Case.

### Determining Plan Premium

See Business Rule 5.1.8 in Anonymous Eligibility Assessment Use Case.

### Affordability Exemption

The customer will be considered granted an affordability exemption if the customer provided an affordabilitiy certificate number on their SSA issued by the federally funded exchange (note that the validity of the code will not be checked).

### CSR Plan Equivalent

The Carrier will provide the CSR plan with four variations; the Silver Plan only version and the three CSR plans for level 1 through 3. If the Customer is no longer qualified for CSR plans, the user will be moved to the silver plan. If the Customer’s CSR level has changed, the Customer will be moved to the CSR plan with the highest AV value that all members of a family qualify for.

## Process Rules

### Did External Source Verification Pass?

The EES will make a call to external sources to verify eligibility information including FPL%, Incarceration status and Lawful presence. This validation process will be based on reasonable compatibility between the self-attested data provided by the Customer and the data received from the external sources.

### Is Customer Potentially Eligible for State Medical Programs?

The system will determine based on responses from the EES if the Customer is eligible for PEAK. If eligible, the system will not calculate APTC or CSR for the Customer, otherwise, the system will. The system will always evaluate the Customer for Catastrophic eligibility.

### Is Documentation Accepted?

The Back Office will determine if the documentation that the user uploaded is what was requested is complete and correctly received in order to process and verify manually.

### Is Appeal Granted?

The Back Office will determine if the Customer’s appeal is valid or not. They may need to ask for more documentation from the Customer in order to make this determination. If the appeal is valid, the Back Office may need to override the previous eligibility determination within the Exchange.

### Has Subsidy Changed?

The system will determine if the subsidy amount will change due to the data verification process indicating that the income self-attested was either much higher or much lower than the data provided by external sources. The system will need to adjust affectively the APTC amount or CSR level depending on which subsidy the Customer has chosen.

## Workflow

### Worklist Definitions

Worklists for the appeal exchange subsidy and data verification processes will be defined in the corresponding use cases.

## UI Screen Details

### UI Flow Considerations

There are no UI considerations for the Determine Individual Eligibility Use Case.

## Communications

### Imaging Requirements

#### Uploading of Documentation

The Customer may be asked to upload documentation to verify their self-attested data, such as:

* Birth Certificate
* Driver’s License
* Tax Form
* Green Card
* Pay Stub

### Form Requirements

There are no Form Requirements for the Determine Individual Eligibility Use Case.

### Notices Requirements

#### Eligibility Notification to Customer

The notification will need to provide:

* Sources used for eligibility determination
* Eligibility determination

#### Request for Customer to Provide Additional Documentation

The notification will need to provide:

* This notification requests supporting documentation from the customer to assist in verifying their self-attested information.

### Other Communication Requirements

There are no Other Communication Requirements for the Determine Individual Eligibility Use Case.

## Interfaces

### Transfer Customer to PEAK

A customer enters data into the Exchange, and then finds out through the Eligibility determination process that they are eligible for Medicaid, or CHP+. They will be given the option to go to the PEAK system, taking the data already entered with them.

Data Elements Sent:

|  |
| --- |
| Data Elements |
| Name – Last, First, Middle |
| Date of Birth |
| Last 4 digits of SSN |
| Permanent Address (street, city, state, zip) |
| Email address |
| Phone number ( home and mobile) |
| Gender |
| CO Driver’s License Number |
| \* Any ADDITIONAL data gathered |

Data Elements Received:

|  |
| --- |
| Data Elements |
| Transfer Acknowledgment |

### Eligibility Verification from EES

Once the user is ready to have their data validated and verified, the Exchange will make a call to the EES with the self-attested data to be verified. TheEES system will call other state and federal systems to determine the accuracy and validity of the self-attested data. If errors are found, the field name and error system will be noted in the response. If data is verified successfully, the EES will return the additional data for a streamlined Enrollment application including FPL(%), MAGI($), Incarceration Status, Lawful Presences status, CO Residency status, and the relating source systems for which they were found.

Data Elements Sent:

|  |
| --- |
| Data Elements |
| Zip code / County |
| # in Household |
| Per Member of Household |
| Smoker |
| SSN |
| Name (Last, First, Middle) |
| Pregnant |
| US Citizenship |
| Gender (M or F) |
| Blind / Disabled |
| MAGI |
| Incarceration Status |
| Native American Status |

Data Elements Received:

|  |
| --- |
| Data Elements |
| Eligible State Programs |
| Streamlined Enrollment Application Data including:  FPL (%)  MAGI ($), Source System  Incarceration Status (Y/N), Source System  Lawful Presence (Y/N), Source System  CO Residency (Y/N, Source System (TBD) |

## Reporting

### Exchange Subsidy & State Program Eligibility

The system must be able to track and report on the number of Customers determined eligible for:

* APTC
* CSR
* Medicaid
* CHP+
* Catastrophic Plans

## User Security

The User Security details listed in this Use Case are not intended to be a full reference of User Security requirements for the project. This section houses User Security requirements that are specific to this Use Case.

### Security Controls

All information sharing practices, website hosting practices, administrative controls, technical controls, and physical access controls will be enacted as detailed in the COHBE Privacy Impact Assessment.

All security controls used to protect the confidentiality, integrity, and availability of the system will be enacted as detailed in the COHBE System Security Plan.

Security controls specific to the protection of federal tax information (FTI) or requirements above the common control baseline will be enacted as detailed in the COHBE Safeguard Procedures Report.

## Activity Log and Audit Trail

The Activity Log and Audit Trail details listed in this Use Case are not intended to be a full reference of Activity Log and Audit Trail requirements for the project. This section houses Activity Log and Audit Trail requirements that are specific to this Use Case.

### Personal Identifiable Information (PII)

The System shall record actions related to the PII provided for determining eligibility, i.e. the date, time, client identification, and user identification must be recorded when electronic eligibility information is created, modified, deleted, or printed and an indication of which action(s) occurred must also be recorded.

## Data Elements

| Process Step Reference  **\*Required Field** | Field Name  **\*Required Field** | Required Field? | Action Taken | Actor Performing Action | Format, if known |
| --- | --- | --- | --- | --- | --- |
| 2.1.2 | FPL |  | * Create | * EES | * Percentage |
| 2.1.2 | MAGI |  | * Create | * EES | * Dollar Amount |
| 2.1.2 | Medicaid |  | * Create | * EES | * Plan |
| 2.1.2 | CHIP |  | * Create | * EES | * Plan |
| 2.1.2 | Source |  | * Create | * EES |  |

# Future Release Notes

CRs are being created that affect this use case, which will be reflected within this document at a later date:

* The Exchange will no longer allow for the selection of Medicaid or CHIP plans.
* The Exchange will no longer provide TANF or SNAF information to the Customer.
* The data verification call will be made to the ESV and not the EES.
* The Exchange will need to display CHIP providers instead of CHIP plans.
* The Exchange will forward disability and blindness users automatically over to PEAK.
* The Exchange will utilize a list of “reasonable explanations” that Customers can use to indicate why their self attested information was outside the reasonable compatibility bounds. If they chose one of the reasonable explanations, they would be allowed to move forward with application processing and additional documentation would not be requested.

# Appendix A - Glossary

Table 1: Glossary

|  |  |
| --- | --- |
| Term | Definition |
| **Alert** | An **“Alert”** is a message that the System dispatches internally that requires action or indicates an exception condition. |
| **Alternative (process path)** | An **“alternative”** is one subset of many steps within a process that achieve the same result or process end state. |
| **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. |
| **Appeal** | An “**Appeal”** is a formal request made by or on behalf of a Customer or Employer for reconsideration of a prior ruling, determination or disposition made by the Exchange. An Appeal typically causes the creation of a Case and requires some external adjudicator to make a determination. |
| **Apply / Application** | A customer submits a completed Uniform Enrollment **Application** for healthcare benefits prior to being enrolled in a plan. A customer goes through the following steps during their shopping experience   * Anonymous shopping * Preliminary eligibility screening optional * Plan shopping * Apply for coverage * Enroll in plan |
| **Capture** | An image is “**captured**” once the document type has been identified and all applicable data fields have been identified, verified and entered into the system. |
| **COHBE** | Colorado Health Benefit Exchange**, “COHBE”** is used interchangeably with “Exchange” throughout the documents. |
| **Cost Sharing Reductions (CSR)** | “**Cost Sharing Reductions**” are payments of specific medical claims paid directly to carriers/providers by the federal government for individuals who fall between 133% and 400% of the federal poverty level (FPL). |
| **Customer or Consumers** | “**Customers**” or “**Consumers**” 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. |
| **EES – External Eligibility System** | The **EES, or External Eligibility System** is an external service that is called by the Exchange and other state systems (e.g., Peak and CBMS) to determine whether an individual is eligible for various state and federal health care programs including Medicaid and APTC/CSR. |
| **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. |
| **Enrollment** | **“Enrollment”** occurs when a Carrier accepts an Application and commits to providing healthcare benefits to the applicant(s) within the provisions of a healthcare coverage plan. |
| **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 Consumers 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. |
| **Insurance Affordability Program** | Advanced Premium Tax Credits (APTC), Cost Sharing Reductions (CSR) and state programs such as Medicaid or Child Health Plan Plus (CHP+).. |
| **Master Data Management (MDM)** | The **MDM** system will contain a “golden record” of a person’s associated record throughout the State database systems. It is to contain data for a Colorado resident that would point other systems to additional State systems and the residents corresponding data in that system. |
| **Modified Adjusted Gross Income (MAGI)** | An Individual’s **Modified Adjusted Gross Income (MAGI)** is a measure used by the IRS to determine if the Individual is eligible for Advance Premium Tax Credits (APTC) or Cost Sharing Reductions (CSR). |
| **Navigators** | “**Navigators”** are persons authorized to assist Customers in their activities to shop for insurance through the Exchanges. |
| **Override** | An authorized COHBE representative may “**Override”** a determination made by the System in specific circumstances. |
| **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. |
| **Riders** | A “**Rider”** is a provision in an insurance policy allowing for amendments to its terms and/or coverage. Addition of a Rider to a plan will have an impact on pricing. Riders are not eligible for APTC or CSR. |
| **Self-Attested Data** | **“Self-Attested Data**” is information provided by a consumer 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). |
| **Service Representative** | Service Representative (ServRep or SR): A COHBE representative who assists Participants, Customers, and/or Users in using the Exchange and/or the System. **NOTE**: **CSR** is used to mean Cost Sharing Reductions and shall **not** be used to mean ‘customer service representative’. |
| **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. |