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Office of Consumer Information and Insurance Oversight

Cooperative Agreement to Support Establishment of the Affordable Care Act's Health Insurance Exchanges

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Level 2.0 Establishment Grant

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COVERED CALIFORNIA

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E. Project Narrative

In the fall of 2010, California enacted the first state law in the nation, the California Patient Protection and Affordable Care Act (CA-ACA),[*] establishing a health benefit exchange under the federal Affordable Care Act (ACA). The CA-ACA expressed legislative intent for the California Health Benefit Exchange (California Exchange) as follows:

- Reduce the number of uninsured Californians by creating an organized, transparent marketplace for Californians to purchase affordable, quality health care coverage, to claim available federal tax credits and cost-sharing subsidies, and to meet the personal responsibility requirements imposed under the federal act [ACA];
- Strengthen the health care delivery system;
- Guarantee the availability and renewability of health care coverage through the private health insurance market to qualified individuals and qualified small employers;
- Serve as an active purchaser, including creating competitive processes to select participating issuers and other contractors;
- Require that health care service plans and health insurers [collectively carriers in California law, issuers as in federal law hereafter in this narrative] issuing coverage in the individual and small employer markets compete on the basis of price, quality, and service, and not on risk selection; and
- Meet the requirements of the federal act and all applicable federal guidance and regulations.

The California Exchange (effective October 2012 branded as ***COVERED CALIFORNIA***) has been working since it was established in 2010 to lay the groundwork for the dramatic expansion of coverage that will benefit millions of Californians starting in 2014. The Exchange has made, and continues to make substantial progress through accelerated planning and development activities. California expects that coverage in the Exchange will begin on time by January 2014. The work of the Exchange has involved not only the Board and staff of the Exchange, but a wide array of committed partners across the state who have joined together to achieve the vision and mission of California's Exchange.

The California Exchange received two Level 1 Exchange Establishment grants to support planning and development activities and as of this writing has reached a level of readiness that meets the federal expectations and application requirements for Level 2.0 Establishment funding. In partnership with the federal government, Covered California is seeking Level 2.0 grant funding to continue and expand its planning, development and implementation activities for a state-administered Exchange and to bring the California Exchange into full operation by January 2014. This project narrative highlights the progress California has made and continues to make during the Level 1 grant periods and outlines the proposed program activities for the Level 2.0 grant.

[*] AB 1602, Chapter 661 and SB 900, Chapter 659, Statutes of 2010, collectively referred to here as CA-ACA.

a. Discussion of Existing Exchange Planning and Exchange Establishment Progress

Covered California is making significant progress in the development and implementation of the programs, systems and support services that will be needed for a state-administered exchange anticipated to provide health coverage for more than 2 million Californians at full implementation in 2017. Covered California has consistently demonstrated progress in the core areas and work plan items identified in previous planning and establishment grants, in many cases exceeding the objectives and tasks identified in the first two work plans.

Planning and establishment progress to date includes the following significant accomplishments:

- Appointed the five-member Board of Directors governed by California public open meeting laws, state and Federal conflict of interest laws and Board approved policies and bylaws;
- Embraced through public deliberations a shared vision, mission and values to guide the work of the Board, state government, stakeholders and public as outlined in Figure I below;
- Convened regular (26 to date) open and transparent public board meetings in multiple venues with agendas, minutes and materials publicly noticed via website with opportunities for public participation in all Board meetings in person, by telephone and webcast;
- Engaged more than 300 individual and organizational stakeholders in exchange decision making and program design, including consumers, small business, health plans, labor unions, agents and brokers, through a variety of methods (written requests for input, webinars, workgroups, board meetings, public comment, etc.) and also developed a Board-approved, comprehensive Stakeholder Engagement Plan and Tribal Consultation Policy;
- Recruited and hired executive director, key senior managers and staff with specialized knowledge and expertise to lead the planning, establishment and operation of Covered California;
- Developed and cultivated active partnerships and collaborations with state programs and agencies, the Legislature and key decision makers on shared research, analysis and action related to implementation of Covered California and the ACA;
- Adopted evidence-based decision making and policy development practices informed by background research in the form of expert panels, state and national policy briefs, commissioned reports, best practice dissemination, data collection and actuarial analysis;
- Developed public and transparent processes for introducing, exploring, refining and adopting Board decisions through resolution;
- Adopted the best practice of establishing and publicly disseminating guiding principles for each major program area and activity to ensure thoughtful and goal-oriented program development, implementation and evaluation;
- Defined the program elements, essential tasks and required system supports in major core areas including eligibility and enrollment, outreach and marketing, consumer assistance and qualified health plan management, and secured through competitive solicitations valuable expert resources and consultants to help advance decision-making, system design and implementation approaches in each area;
- In partnership with sponsoring state Titles XIX and XXI agencies, engaged in extensive system review and analysis to design the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS), an information technology system that will serve as consolidated support for eligibility and enrollment in Exchange programs, as well as coordinated referrals to Medi-Cal (California's Medicaid program), and

securing through competitive joint solicitations consulting and expert resources to build, refine, and launch CalHEERS functionality by mid-year 2013;

- Collaborated with California Department of Health Care Services (DHCS) and the Major Risk Medical Insurance Board (MRMIB) to solicit competitive bids and award a contract to Ogilvy Public Relations Worldwide for branding and communications support for the Covered California outreach, marketing, and education campaign, including design of the assisters and navigators programs, and to spearhead implementation of a multi-faceted, multi-cultural, multi-media plan to promote the availability of new health insurance options for individuals and small businesses under the banner of the new Exchange brand name: ***COVERED CALIFORNIA***;
- Through a competitive solicitation process, secured the consulting services of PricewaterhouseCoopers, (PwC) and engaged the Board, staff and stakeholders in research, options development and analysis to inform the selection and certification of Qualified Health Plans (QHPs) to provide coverage in the Exchange. Developed a draft QHP solicitation document and a solicitation for consultants to help manage the QHP selection and certification process;
- Through a competitive solicitation process, secured the expert consulting services of PwC to also assist in planning for the Small Business Health Options Program (SHOP) design and development. Prepared a solicitation for SHOP administration that was issued in October 2012;
- Partnered with multiple state government entities with shared responsibility for public coverage, consumer assistance and health insurance oversight to file joint comments on proposed federal rules;
- Enacted internal financial controls and accounting procedures to ensure program integrity and guard against waste, fraud and abuse; and
- Secured three consecutive federal grants to plan and establish California's state-based Exchange with successful reviews by the Center for Consumer Information and Insurance Oversight (CCIIO) at key intervals based on achievement of work plan deliverables and early benchmarks.

Figure 1
Covered California

Vision, Mission and Values

*The **VISION** of Covered California is to improve the health of all Californians by assuring their access to affordable, high quality care.*

*The **MISSION** of Covered California is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.*

*Covered California holds six core **VALUES**: 1) consumer-focused, 2) catalyst, 3) affordability, 4) integrity, 5) partnership, and 6) results.*

Below is a status report on the progress made by Covered California in the Level 1.1 and 1.2 establishment grants (Level 1 grants).

Key Findings of Background Research: Sharing Expertise

Background research is at the foundation of decision-making and policy development for the California Exchange. In 2011, the California Exchange adopted and consistently uses an evidence-based policymaking framework to guide decision-making as illustrated in Figure 2.

Figure 2 Covered California Process for Evidence-based Policy Making
1. Legal Scope ▪ Regulatory requirements ▪ Prohibited approaches ▪ Allowable alternatives 2. "Just the Facts" ▪ Current California activities ▪ California and National relevant data 3. Stakeholder Perspectives 4. Options and Recommendations 5. Detailed budget and timeline for implementation

California is fortunate to have significant in-state research and policy resources including world-renowned public universities, private foundations dedicated to health research and health policy, organized and active small business forums, and other independent organizations engaged in consumer advocacy, health policy and research. As a result, the Covered California Board and staff regularly access and continuously seek existing information sources to inform development, planning and implementation activities. In addition to collecting, assimilating and distributing external background research, Covered California produces and shares information and resources within California, with other state-based Exchanges under development, and with CCIIO. Below is an illustrative list of some of the relevant research which has helped to inform the planning and establishment of Covered California to date:

- **Private Health Foundations** – Covered California has relied heavily on sponsored research and multiple published reports on California insurance market trends, profiles of the uninsured, state Exchange models and options and potential impacts of the ACA as provided by the Blue Shield of California Foundation, California HealthCare Foundation, The California Endowment, and Kaiser Family Foundation.
- **CalSIM** – The California Endowment has supported the development of the California Simulation of Insurance Markets (CalSIM), an enrollment modeling program jointly developed by the University of California, Berkeley (UCB) Center for Labor, Research and Education and the University of California at Los Angeles (UCLA) Center for Health Policy and Research. CalSIM is a California-centric, micro-simulation model that estimates the effects of the ACA on the enrollment of individuals in insurance coverage from all sources, including employment-based coverage as well as Exchange, Medicaid and other coverage. This research is ongoing and iterative and capable of incorporating additional variables and factors as the need arises and data are available, as evidenced by recent work presented to the Board on health premium price elasticity. The California Exchange has supported the refinement and use of the model in informing its planning for Exchange program implementation.
- **Stakeholders and Strategic Partners** – National consumer advocacy organizations such as Families USA and the Urban Institute were early contributors to the Covered California planning process through data on enrollment and the potential impacts of coverage provisions contained in the ACA. On an ongoing basis, valued state-based partners, including California Pan-Ethnic Health Network, The Children's Partnership, Congress of California Seniors, Consumers Union, Health Access, Western Center on Law and Poverty, and others serve as resources on Exchange-related topics such as eligibility and enrollment, health literacy, consumer preferences, and the unique needs of diverse populations.

- **Expert Panels** – It is the practice of Covered California to invite subject matter experts to present to the Board, meeting attendees and the public participating in Board meetings through webinar. As issues arise, the Exchange organizes experts from varied backgrounds and expertise to provide important context and market research, lessons learned, best practices, and delivery system innovations to help educate the Board, staff, and stakeholders to inform evidence-based decision making. To date, more than 40 local, state and national experts have joined in 10 panel discussions or Board presentations including such topics as: small business perspectives on health care decision making in California; QHP contracting and delivery system reform planning; communication, outreach and enrollment; the SHOP and small employer coverage landscape; exchange service center options; and user experience and consumer choice.
- **Independent experts –** As needed, Covered California engages experts to conduct targeted research where data gaps exist or external subject matter expertise is warranted. A few examples include:
  - → *Actuarial analysis*. Covered California helped support the state's consideration of the essential health benefits benchmark options as outlined in the federal Department of Health and Human Services (DHHS) December 16, 2011 Essential Health Benefits Bulletin. Under contract to Covered California, Milliman provided a point-in-time comparative analysis of the relative costs, services and benefits of the ten benchmark options. Based in part on data provided by that Milliman analysis, California enacted state legislation (Senate Bill 951, Chapter 854 and AB 1453, Chapter 866, Statutes of 2012) designating the Kaiser small group health plan as California's minimum essential health benefits benchmark for the individual and small employer markets. Milliman analysts continue to work with Covered California to analyze market risk and selection options for SHOP scenarios, including providing an independent opinion about the potential selection impact of employer choice, paired choice and employee choice of coverage outlined in the ACA.
  - → *Evaluation*. The Exchange engaged NORC at the University of Chicago to develop a robust evaluation plan for measuring and monitoring progress toward achieving the Covered California vision using currently available and new data sources. This follows on an earlier policy brief on employee- based coverage jointly produced by NORC, UC Berkeley and Towers Watson.

Legal Authority and Governance: A Solid and Sustainable Foundation

CA-ACA specifies the make-up and appointing authority for the five-member Exchange Board and establishes the Exchange as an independent state agency. CA-ACA called for California's Exchange to be governed by a newly created state Board with members appointed by the Governor and the Legislature. In 2011, the Covered California Board was constituted, with all five members appointed, and the Board has been meeting since April 2011. The Board twice elected the Secretary of the California Health and Human Services Agency (CHHS) as Chair, recognizing the importance of actively coordinating and collaborating with existing state agencies involved in providing health coverage to California residents.

CA-ACA also includes specific authority and requirements for Exchange operations and administration, including hiring and recruitment of Exchange staff and leadership, and specifies the powers and duties of the Exchange Board relative to administration of the Exchange, determining eligibility and enrollment in the Exchange and arranging for coverage through selective contracting with QHP issuers. CA-ACA requires the Exchange to operate a separate SHOP program and to assist qualified small employers in enrolling their employees in coverage through SHOP. CA-ACA also requires the Exchange to conduct an annual independent audit and to report to the Legislature annually regarding implementation and performance of the Exchange. CA-ACA sets forth basic conditions of participation for QHP issuers and requires, for example, issuers in the Exchange to offer and sell at least one product in each of the five ACA coverage tiers, prohibits issuers not providing coverage in the Exchange from offering catastrophic coverage outside of the Exchange and imposes other specific coverage

requirements on issuers who are not participating in the Exchange. Finally, CA-ACA requires the Exchange to ensure that Exchange operations and functions do not exceed the combination of federal funds, private donations and other non-state General Funds available for the Exchange.

Under state law, the Board is subject to California's open meeting law but has authority to discuss issues related to personnel and contracts in closed session. The Board may, by public vote and resolution, authorize the Executive Director to finalize contracting documents, reports, grant submissions and other time sensitive documents or activities, consistent with Board-adopted policy and guidance. California's public open meeting laws prevent the entire Board from meeting or communicating with each other on other Board matters outside of public session except as described above. In order to ensure ongoing Board engagement and appropriate Board oversight, Covered California often works with a Board subcommittee of two-members to directly engage in the Board's behalf, including attending small group stakeholder meetings, focus groups, public webinars, strategy sessions and policy development with Exchange staff, and reviewing proposed draft policies, recommendations and grant-related submissions etc., with the results of those discussions communicated at the public Board sessions. This approach has enabled the five-member Board to expand its statewide presence and to be nimble and responsive to stakeholder and other requests for consultation and involvement.

Stakeholder Consultation: A Core Value and Critical Component

The California Exchange is committed to stakeholder consultation with diverse interests and communities in all aspects of program planning, design and implementation and employs multiple strategies, approaches and venues to actively engage individuals, organizations and the public. Leading strategies include: serving as a resource and conduit for information; conducting public Board meetings; soliciting stakeholder input in writing and in-person; convening one-on-one and small group meetings; and posting draft material for review and comment on the California Exchange website (www.healthexchange.ca.gov) in advance of Board discussion and action. In addition, during the grant period, California Exchange staff participated in meetings with Indian tribal leaders leading to the Tribal Consultation Policy described below.

Throughout the early planning and Level 1 grant periods, Covered California actively solicited input and integrated feedback from diverse stakeholder groups to inform and improve all aspects of program planning, design and implementation. In addition, embedded in key contracts (marketing, outreach and enrollment and health information technology) are detailed provisions, high-level expectations and critical contractor deliverables related to stakeholder consultation. To capture the diverse perspectives and keen insights of numerous stakeholder audiences (e.g. consumers, tribal leaders, health plans, small business owners, labor unions, agents and brokers, and state partners), during the Level 1 grant periods, Covered California has employed multiple strategies, approaches and venues to actively engage individuals, organizations and the public including:

Board meetings and ongoing communication activities

- Public board meetings;
- Panel presentations;
- Sharing reports and comment letters;
- Exchange email distribution list includes more than 2,500 individual subscribers;
- Tribal consultation;
- One-on-one stakeholder meetings and presentations;
- Workgroups and topic-specific input; and
- Publishing draft proposals for public comment.

Individual and Small Business Workgroups

- Ad hoc statewide meetings;
- Topic-specific written stakeholder input; and
- Topic-specific webinars.

Following two years of extensive stakeholder consultation and public discussion, in September 2012 the Covered California Board approved a comprehensive Stakeholder Engagement Plan. The plan was initially presented to the Board in April 2012 and was substantively revised based on Board and stakeholder feedback. The Exchange Board recognizes that stakeholder engagement accomplishes multiple goals, including: 1) gathering general and topic specific input on policy issues, 2) building and sustaining partnerships, 3) fostering better understanding of the Exchange, and 4) understanding how Exchange policies impact stakeholders and partners.

Under the revised Stakeholder Engagement Plan, effective January 1, 2013, stakeholder engagement with Covered California will include continuing all of the activities above on an ongoing basis, modifying and enhancing as needed. In addition, the new Plan calls for the Exchange to revise its current advisory group structure (disbanding the two standing advisory committees) and to establish three new advisory groups as follows: 1) Plan management and delivery system reform; 2) Marketing, outreach and enrollment assistance; and 3) SHOP. The Exchange is currently accepting nominations and applications for the new advisory groups.

Tribal Consultation

Open and continuous Tribal consultation creates opportunities for the Exchange to build culturally appropriate, meaningful relationships with Tribes and to develop and adjust its services and programs in ways that make them user-friendly and culturally appropriate for Indian members. During the Level 1 grant periods, the Exchange developed and adopted a formal Tribal Consultation Policy, based on feedback received at the Exchange's first Tribal consultation meeting in July 2012 and discussions with tribal leaders and members. The Tribal Consultation Policy outlines the Exchange's commitment to annual consultation with Tribes, includes specially-requested meetings with Tribal leaders, and describes the formation and structure of a new Tribal Advisory Workgroup.

The Tribal Consultation Policy calls for a Tribal Advisory Workgroup to provide Covered California with advice and guidance on the development of policies impacting Tribes on a regular, ongoing basis. Members of the Workgroup were nominated by Tribal leadership, Tribal health programs and urban Indian health programs, and represent the following geographic regions: Northern California, Southern California, Central-East California, and Central-West California. The Tribal Advisory Workgroup will meet at least quarterly with the Exchange, and the Chair of the Workgroup will coordinate with the Exchange to schedule meetings and create agendas. Finally, to ensure that American Indian/Alaska Natives are informed of ongoing Exchange Tribal activities, Covered California has created a page on its website documenting Tribal consultation activities, including the Exchange's Tribal Consultation Policy, Workgroup meeting schedules, meeting agendas, and materials, and a dedicated e-mail address for Tribes to contact the Exchange or submit comments on Exchange proposed activities and policies.

Long Term Operational Costs: Taking Covered California to Scale

During Level 1 grant periods, Covered California engaged the Board, staff and senior managers in a detailed planning and budgeting process guided by its vision, mission and values. Long-term planning is embedded in the internal planning, budgeting and financial management processes of the Exchange. The process yielded the following guiding principles for Exchange financial management and planning:

- ***Seek the highest value for the lowest cost.*** Because affordability is of paramount importance, all expenses should have maximum impact and the lowest possible ongoing expense to deliver the service or function needed.
- ***Distinguish one-time development efforts and costs from ongoing costs.*** As a "start-up," the Exchange must plan for and execute a transition from one-time development efforts (and costs) to a fully operational ongoing enterprise. Clarity about this distinction should guide our planning efforts.
- ***Plan fluidly.*** There will be uncertainty on many fronts that will become clearer over time – from the number and types of health plans offered to the size of enrollment. The Exchange must engage in planning that allows for course correction while building the capacity to deliver the effective and high quality services essential for success.
- ***Embrace interdependence and partnerships.*** The Exchange must work closely with and engage resources from private and public sector entities at the national, state and local levels to be successful. The Exchange's success depends as much or more on its partnerships than on its direct resources.
- ***Evidence-based planning: Test and verify.*** The Exchange should continuously validate and test its assumptions against comparable organizations and efforts.

The Covered California management team embarked on a series of internal exercises to accurately assess the current, future and long-term operational costs of the Exchange. At present, there are multiple budget planning processes in play: 1) California's annual state budget development cycle, 2) Exchange budget planning and forecasting for continued start-up costs, implementation phase and sustained operations, 3) CCIIO Blueprint budget process and filings, and 4) ongoing grant monitoring and application for necessary Exchange Establishment funds.

During the Level 1 grants, the California Exchange also did extensive modeling and analysis to develop a long term sustainability plan for support of Exchange operations starting in January 2015 when federal funds will no longer be available. CalSIM is a California-centric, micro-simulation model that estimates the effects of the ACA on the enrollment of individuals in insurance coverage. CalSIM relies on four data sets to model employer and individual behavior, including both national and state survey data. This research is ongoing and iterative and capable of including additional variables and factors as the need arises and data are available. For example, the CalSIM model was recently used to model and evaluate potential effects of different premium price levels (price elasticity) on Exchange enrollment and take-up rates.

Based on development of the CalSIM model and enrollment projections, the Exchange was able to evaluate and model multiple financial scenarios with the goal of developing its long term financial sustainability plan. Covered California has adopted the program and policy goals of enrolling the maximum number of eligible individuals possible, including developing robust outreach and consumer assistance programs to support and promote maximum enrollment. Covered California's annual enrollment goals for the first three years of operation are as follows:

- **By 2015:** Enrollment of 1.4 million Californians newly eligible for subsidized or unsubsidized coverage;
- **By 2016:** Enrollment of 1.9 million Californians newly eligible for subsidized or unsubsidized coverage; and
- **By 2017:** Enrollment of 2.3 million Californians newly eligible for subsidized or unsubsidized coverage.

At the same time, the Exchange developed budget projections and financial strategies using more conservative enrollment estimates than those above, as well as building in design and staffing contingencies in program areas

such as eligibility and enrollment, outreach, consumer assistance and administration that can be adjusted based on actual enrollment levels.

The detailed Exchange financial sustainability plan is discussed as an Early Benchmark achieved in Section (b) and the full Financial Sustainability plan is attached as Appendix II.

Program Integration: Coordinating Functions and Leveraging Resources

Covered California works closely with state health programs, health insurance regulators and other state agencies and programs in development of the Exchange to lay a foundation for implementing the ACA in California. As a result of more than two years of informal discussions, joint planning sessions, formal agreements, common vision, collective responsibility and shared government mandates, Covered California is considered an active and viable partner with multiple state agencies, including:

- California Department of Health Care Services (DHCS), which administers the state's Medicaid program;
- Major Risk Medical Insurance Board (MRMIB), which has administered the state's Children's Health Insurance Program (CHIP) referred to as Healthy Families in California, the Access for Infants and Mothers (AIM) and the state's two high risk pools, the state-funded Major Risk Medical Insurance Program and the federally funded Pre-existing Condition Insurance Plan *(Note: Healthy Families children will transition to Medi-Cal beginning January 1, 2013 and the program will cease to enroll new applicants the date the transition begins)*;
- California Department of Managed Health Care (DMHC), the state regulator for managed care health plans, health maintenance organizations (HMOs) and some preferred provider organizations (PPOs), and
- California Department of Insurance (CDI), which regulates the remaining PPOs and traditional indemnity products such as long term care insurance and disease-specific supplemental policies.

During the Level 1 grant periods, key areas of program integration include development of joint vendor solicitations where appropriate, joint responses to proposed federal regulations, shared stakeholder consultation strategies and forums, and collaborative analysis and interpretation of federal statute and implementing regulations as compared to state law. Covered California joined with DHCS, MRMIB, DMHC and CDI in developing collective responses to federal requests for comments, including joint comments on the establishment of exchanges, reinsurance, risk corridors and risk adjustment, the basic health program, the premium tax credit, and the summary of benefits and coverage.

Two examples of large-scale collaboration across departments included the advance planning, research and release by Covered California, DHCS and MRMIB of joint solicitations for major collaborative work: 1) design and development of CalHEERS, the statewide information technology project jointly governed by representatives of the three entities (awarded to Accenture LLC in June 2012) and 2) solicitation for the outreach, marketing, education and assisters program (awarded to Ogilvy Public Relations Worldwide in February 2012).

Business Operations: Supporting a First-Class Experience for all Users

During the Level 1 grant periods, the California Exchange invested significant time, energy and resources to planning for and beginning to build the business operations of the Exchange which will support and ensure the first-class user experience. As a core value, the Exchange relies on evidence-based policy making that begins with establishing operating principles for major areas of activity and involves data collection and research, options development and refinement, stakeholder input and consultation, leading to staff and Board deliberation and decision and policy implementation. By design, Covered California will have many "clients" -- consumers, employers, health plans, brokers and agents, regulators and other state partners with whom its clients interface. To achieve its mission of "increasing the number of insured Californians," the Exchange

recognizes the vital importance of a first-class user experience for all customers. The goal is to streamline the process at each point of contact to ensure the end user an efficient, effective and satisfactory experience.

Covered California meets regularly and actively communicates with the appropriate federal agencies, including CCIIO, to describe and share information about the developing business processes. On March 26 and 27 of this year, senior managers of Covered California met in-person with CCIIO for the Level I Establishment Planning Review to evaluate progress in the activities critical to the establishment of a state health insurance exchange. As background to the meeting, Covered California compiled documentation and background materials related to the planning and research activities of the Exchange during the initial Level 1 grant period and identified key questions for CCIIO related to state exchange implementation. The March meeting culminated in a favorable letter from Centers for Medicare and Medicaid Services (CMS) dated April 23, 2012, offering key insights and identifying next steps for Covered California. Covered California and CMS met in September of this year for an extensive design review of CalHEERS and assessment of progress in the development of California's emerging Exchange information technology system.

Much of the business functionality of the Exchange will be resident in the CalHEERS program which will include capabilities to support eligibility and enrollment, navigator and assister certification and funding, financial management, health plan enrollment processing, QHP certification and data collection, federal and state reporting, service center/consumer assistance and SHOP support in collaboration with the selected SHOP vendor. In addition to organization-wide participation in the development and design of CalHEERS, the Exchange has been actively reviewing and analyzing applicable state and federal laws and guidance and working collaboratively with stakeholders and state agency partners to define and refine the operational policies, procedures and service functions that will be needed for a functioning and operational Exchange.

More detail about the complex elements of CalHEERS and Exchange functionality follows in the Program Proposal in section (b). The section below highlights activities during the Level 1 grants in four core areas: Financial Management, Customer Service Center, Outreach, Marketing and Education and QHP Management.

Financial Management

The goal of the financial management function for the Exchange is to implement, direct, and maintain high-quality operational coordination, execution, and financial support services that fully meet the organization's current and future operational, financial, accounting, auditing, personnel and business service needs. The California Exchange financial management strategy is three-fold: 1) use existing state financial management and accountability tools, 2) comply with all provisions of the ACA and federal grant terms, and 3) build financial systems as needed and appropriate to support and monitor Exchange consumer services, including premium payments, subsidies and health plan payments. In addition, a core element of financial management for Covered California is having the appropriate mix of staff and consultants retained to launch, operate and sustain Exchange operations.

During the Level 1 grant periods, the California Exchange continued to develop and improve routine internal financial and accounting systems, protocols, and policies to monitor and track California Exchange grants, revenues and expenditures with accounting and administrative support from the California Department of Social Services (CDSS). The California Exchange also developed internal financial systems and accountability to actively monitor the use of federal Exchange grant funds consistent with federal grant requirements and relevant federal rules and to ensure that internal controls work to prevent waste, fraud and abuse. CDSS assisted the California Exchange in adhering to DHHS financial monitoring activities and establishing a financial and management structure with experienced staff and ability to respond to federal audits. CDSS is currently providing training and

transitional support because the Exchange has acquired skilled staff and is assuming responsibility for financial management as a fully functional independent state agency.

Customer Service Center

During the Level 1 grant periods, Covered California engaged in extensive analysis of options and operational requirements for conducting the eligibility and enrollment function and providing customer service from initial consumer inquiry about Covered California programs, through the eligibility and enrollment process to ongoing consumer assistance and post-enrollment support. The study, analysis and planning process led to adoption of the following principles for Covered California's Service Center:

- **Provide a first-class consumer experience.**
- **Offer comprehensive, integrated and streamlined services.**
- **Be responsive to consumers and stakeholders.**
- **Assure cost-effectiveness in the achieving of customer service excellence.**
- **Optimize best-in-class staffing to support efficient eligibility and enrollment functions.**

The Customer Service Center will be the first point of consumer contact with Covered California. During the Level 1 grant periods, in planning for a first class consumer experience consistent with the principles above, the California Exchange explored many Service Center options including public/private partnerships, stand-alone delivery model, delegation of authority to other state entities or shared jurisdiction with county welfare offices where Medi-Cal eligibility is determined. After extensive stakeholder input and Board deliberations, the Board voted to approve a hybrid model: centralized administration in partnership with one county-based site to be awarded through a competitive process. The California Exchange will organize the centralized, multi-site service center model through carefully developed processes and protocols to refer individuals potentially eligible for Medi-Cal to counties for the eligibility determination. The Service Center will receive and respond to consumers seeking to purchase Exchange coverage and provide multi-channel access including phone, fax, e-mail, web, and live chat. Customer service will be provided in multiple languages (using culturally and linguistically appropriate staff and resources) to ensure that consumers with limited English proficiency are properly served and provided assistance.

The California Exchange will staff the Service Center function at three locations in the state with a centralized Command Center to provide scheduling and workload management for all three locations. The main facility will be in Sacramento, a second facility in southern/central California and the third county-based site at a location to be determined through the competitive process. The centralized Command Center will provide scheduling and workload management and reporting of key performance indicators across all 3 locations. This Center will forecast day-to-day staffing distribution across the Service Center functional areas: fielding calls from the public, processing paper applications, handling incoming and outgoing mail, and managing targeted marketing campaigns. The Exchange anticipates the need for an annual surge of staff resources to handle the health plan open enrollment period with a significant number of staff hired as permanent intermittent staff so that staffing can be adjusted to accommodate fluctuations in demand between open enrollment periods and other times of the year.

During the Level 1 grant periods, the Exchange conducted extensive modeling of application flows, phone calls related to general inquiry, active applications, and support for enrolled individuals. Providing responsive customer service will be critical to the success of the Exchange. The Exchange planning for the potential capacity of the Service Center required extensive analysis of the expected workloads and the projected volumes that the Service Center will be called on to handle. The Service Center will need to staff at a level that answers calls

quickly, handles on-line, e-mail, or other inquiries on a timely basis, and provides quick and accurate feedback regarding application for health coverage. The Exchange must also handle support for enrolled assisters, agents, and health plans who need assistance in serving their clients and subscribers. In addition to responding to incoming inquiries, the Exchange needs to provide support for handling incoming and outgoing mail operations. The accumulated workload volume of all of these features, as well as referrals to counties for individuals who may be eligible for other programs, will determine the capacity and staffing needed for the Service Center.

Outreach, Marketing and Education

With a short timeframe to contact, educate and begin enrolling its culturally and linguistically diverse population, California faces multiple challenges to ensure that it reaches eligible individuals with information about the new health coverage options and provides them with support to help them enroll in the Exchange. Like other states, California faces the challenge of educating consumers, small business owners and other stakeholders about the opportunities for coverage created by the ACA.

California faces outreach and education challenges that make it unique among states establishing their own exchanges. First, California's outreach and marketing efforts must factor in the many languages spoken by California's target populations. As a reference point, the state's Medicaid program uses 13 spoken and 12 written threshold languages to serve program beneficiaries. Second, California is the largest state in terms of population and one of the biggest in terms of geographic reach. Potential Exchange enrollees live in both large urban and remote rural areas spread over a large geographic area. Lastly, California is home to the largest and most expensive media markets in the nation. It is one of only two states with two of the top 10 Nielsen-ranked Designated Market Areas (DMAs) and is the only state with three of the top 20 DMAs.

The Exchange's outreach, marketing and education effort will reach nearly every Californian – approaching 38 million residents – with a positive message on the new coverage options. The estimated target audience of potential Exchange consumers totals approximately 5.3 million California residents as of 2014, including 2.6 million uninsured who qualify for subsidies in the Exchange and 2.7 million uninsured who do not qualify for subsidies but can obtain individual coverage regardless of health status inside or outside of the Exchange. Every Californian who is at risk of being uninsured should have knowledge of the Exchange, just as every American who expects to turn 65 knows about Medicare and Social Security. Ultimately, the goal is to have every Californian eligible for coverage take action to enroll in coverage.

Covered California informs the development of its marketing, outreach and education plan by considering the following principles:

- ***Promote maximum enrollment of currently uninsured individuals in coverage*** including subsidized coverage in the Individual Exchange and SHOP, as well as for individuals who can purchase coverage without subsidies.
- ***Build on and leverage existing resources, networks and channels*** to maximize enrollment into health care coverage, including close collaboration with partners and state agencies with common missions and visions.
- ***Consider where eligible populations live, work and play and*** select tactics and channels that are based on research and evidence of how different populations can best be reached and encouraged to enroll and, once enrolled, retain coverage.

The magnitude and complexity of the task of reaching out and successfully enrolling millions of eligible Californians led the Exchange to determine that what is needed is an aggressive outreach, marketing, public

awareness and enrollment assistance program. The comprehensive approach is based on the utilization of a wide variety of tools: careful research; targeted mass, social and paid media; public relations; partnerships with a wide array of community, faith, labor, health care, government, business and other organizations; and a simple, web-based enrollment portal. While outreach and education efforts by other entities are not directly comparable, they are helpful in providing a sense of the scale of effort necessary to reach Californians. For example, Kaiser Permanente, a well-established HMO which has existed in California since 1948, spends by their estimate $50 million a year on brand marketing and additional millions on more targeted marketing.

During the Level 1 grant periods, the California Exchange released a communications solicitation for development of the outreach, marketing and education campaign and plan to include a proposed design of an in-person assisters program. The contract was awarded to Ogilvy Public Relations Worldwide who in partnership with Richard Heath and Associates (RHA) developed a comprehensive proposal and plan of outreach, marketing, education and consumer assistance. The goal statement for California's program is:

> ***The success of Covered California will depend on connecting with California's diverse communities in a wide variety of ways to make them aware of new options for health coverage, help them sort out their options and give them the support they need to enroll.***

The California Exchange, DHCS and MRMIB worked with Ogilvy to conduct extensive research, including focus group meetings around the state and additional research to more clearly identify and understand smaller subpopulations for potential focused outreach. Identified subpopulations include women between the ages of 18-49 years, and subgroups of women such as those age 18-34 years who are single mothers, etc; young adults age 18-34; older adults age 35-64; Latinos, who comprise an estimated 57 percent of coverage-eligible uninsured Californians; "hard-to-move" individuals, who may resist purchasing insurance even if they can afford it; and small business owners and entrepreneurs that employ persons who are under- or uninsured.

Given the culturally and linguistically diverse, Limited English Proficient, low-literacy, rural and urban newly eligible populations, Covered California will need to offer intensive and multi-faceted assistance to overcome barriers to enrollment. In addition, the research and analysis activities reinforced the notion that a state as large, complex and diverse as California needs an aggressive infusion of grassroots community-based outreach and education beginning in 2013. Anything less would result in slow take-up rates and a more lengthy and costly enrollment campaign to meet goals impacting the affordability of health care coverage provided by Covered California. If slow take-up rates occur, it would have a significant impact on the financial sustainability of Covered California starting in 2015.

The Exchange, DHCS MRMIB, with support from the Ogilvy team, developed options and recommendations informed by stakeholder input, review of national lessons and expert advice that were shared with stakeholders and the public. In May 2012, the Board adopted a comprehensive seven-phase outreach, education and marketing proposal spanning three years through the end of 2015 (See Figure 3).

Figure 3
California Marketing, Outreach and Education Plan
Strategies by Coverage Phases

 **PHASE I** Build Out September - December 2012	▪ Research, creative, message development, refine media plan, education and outreach grant program ▪ Aggressive earned and social media program ▪ Specific Latino, African American, Asian Pacific Islander and other outreach, including small business ▪ Begin to develop Assisters Program management plan, administrative and IT system design and training curriculum
 **PHASE II** Consumer Outreach & Education The Benefits of Coverage & "It's Coming" January - June 2013	▪ Begin educating consumers ▪ Begin paid media to promote the benefits of coverage and "it's coming" ▪ Segmentation / baseline study ▪ Finalize training materials and tools, begin recruitment of organizations, training of Navigators and Assisters and provide technical support ▪ Award outreach and education grants to regional and/or local partners as "trusted messengers" to conduct awareness building and educational activities
 **PHASE III** Get Ready, Get Set... Enroll! July 2013 - March 2014	▪ Extensive earned, paid and social media to announce the opportunity to enroll ▪ Open enrollment #1: Sustain open enrollment for six months ▪ Marketplace launch conference and bus tour ▪ Continue outreach to community-based organizations, faith-based organizations, non-governmental organizations, small business, etc. ▪ Continue recruitment of organizations, training of Navigators and Assisters and technical supports assistance
 **PHASE IV** Retention, Reinforcement & Special Enrollment April - July 2014	▪ To help address churn and promote special enrollment: paid, earned media, social media, storytelling ▪ Lower (or no) levels of paid media ▪ 1st tracking survey ▪ Conduct analysis of Navigator and Assister pool and continue to recruit organizations to reach all targeted segments. Ongoing training of Navigators and Assisters and technical support assistance
 **PHASE V** Get Ready, Get Set... Enroll! August - December 2014	▪ Open enrollment #2 ▪ Use all outreach tools in Phase 2.0I including heavy paid, earned and social media ▪ All Navigator and Assister activities
 **PHASE VI** Retention, Reinforcement & Special Enrollment January - July 2015	▪ To help address churn and promote special enrollment: paid, earned media, social media, storytelling ▪ Lower (or no) levels of paid media ▪ 2nd tracking survey ▪ All Navigator and Assister activities and update curriculum
 **PHASE VII** Get Ready, Get Set... Enroll! August - December 2015	▪ Open enrollment #3 ▪ Use all outreach tools in Phase 2.0I including heavy paid, earned and social media ▪ Evaluation and measurement ▪ All Navigator and Assister activities and update curriculum

The proposed objectives, based on the principles for the project informing the introduction, launch and implementation of the campaign are:

- **Become a trusted health insurance resource for Californians seeking health insurance and information**. Establish a strong brand identity to help drive emotional connection with consumers that the new "marketplace" is a new way to shop for and compare insurance coverage options. Be recognized as a catalyst for change in California's health care system and committed to making the lives of Californians better.

- **Motivate target consumers to consider buying health insurance coverage, explore options for coverage and ultimately enroll in a plan.** Develop and disseminate effective messages that resonate with Californians who do not have health insurance in a culturally and linguistically appropriate manner.
- **Increase the number of insured Californians** to 2017 targeted levels, including subsidized coverage and unsubsidized coverage in the Exchange.

Health Plan Management

The California Exchange has broad state and federal authority to implement procedures for the certification, recertification, and decertification of QHPs, consistent with the guidelines established by the ACA, DHHS rules and guidance and the CA-ACA. State and federal law require the Exchange to impose specific standards for QHP coverage including, but not limited to, reporting and justifying premium increases, reporting and publishing various data elements regarding claims, finances, and enrollment, and informing enrolled individuals regarding the amount of cost sharing they can expect in the form of deductibles, copayments, and coinsurance. Beyond these specific requirements, the Exchange also has the authority and the requirement to determine the standards and criteria for the selection of QHPs based on what is in the best interests of qualified individuals and qualified small employers. CA-ACA requires the Exchange to be an active purchaser and to contract with issuers that provide health care coverage choices that offer the optimal combination of choice, value, quality, and service.

During the Level 1 grant periods, Covered California met regularly with stakeholders and potential health plan partners, including the largest issuers in the state as well as small regional health plans, to begin to lay the groundwork for the coverage options that will be offered in the Exchange. The Board considered and adopted principles to guide the selection and oversight of QHPs in the Exchange as follows:

- ***Promote affordability*** for the consumer and small employer – both in terms of premium and at point of care.
- ***Assure access to quality care*** for consumers presenting with a range of health statuses and conditions.
- ***Facilitate informed choice of health plans and providers*** by consumers and small employers.
- ***Promote wellness*** and prevention.
- ***Reduce health disparities*** and foster health equity.
- ***Be a catalyst for delivery system reform*** while being mindful of the Exchange's impact on and role in the broader health care delivery system.
- ***Operate with speed and agility*** and use resources efficiently in the most focused possible way.

During the Level 1 grant periods, the California Exchange engaged in extensive planning, analysis and stakeholder consultation to design the process and the standards for selecting and contracting with issuers to provide QHP coverage in the Exchange. The Exchange engaged PwC to help in the development and evaluation of options and approaches for selection, contracting and monitoring of QHP issuers. The Exchange analyzed ACA and CA-ACA requirements, as well as existing state standards applicable to health plans in California. This was a complex undertaking since in California there are two state agencies, and two underlying statutory frameworks, that define and regulate oversight of health insurance issuers. DMHC is the state regulator for managed care health plans, HMOs and some PPOs, and CDI regulates the remaining PPOs as well as traditional indemnity products, such as long term care insurance and disease-specific supplemental policies, and other non-health insurance products. According to California HealthCare Foundation (CHCF), in 2011, DMHC regulated HMO and PPO products covering 21.6 million lives, including managed care plans providing coverage in Medi-Cal and private individual and small group products. CDI regulated health insurance products covering an estimated 2.6 million Californians, primarily in PPO model coverage, including 2 million in individual coverage.

With PwC's support and guidance, Covered California engaged in a data collection and research process to identify and compare products in the California market including benefits, premiums and enrollment in the top selling products through review of plan descriptions, evidence of coverage documents and cost sharing summaries. Through comparison of federal requirements applicable to QHPs and existing state licensing and regulatory standards, and consistent with the QHP selection and oversight principles, during the Level 1 grant periods the Exchange made significant progress in the following areas:

- Minimum certification standards for QHPs including further defining the ACA requirement that issuers be "in good standing" with state regulatory requirements, as well as provider network adequacy, accreditation, and quality reporting standards;
- Potential benefit plan design options for offering the optimal number and type of QHPs by coverage tier, region and premium levels, benefit cost sharing approaches, actuarial review of alternative benefit designs and analysis regarding inclusion of supplemental benefits, such as vision and dental services;
- Definition and strategies to ensure sufficient participation of Essential Community Providers to serve the Exchange population as required in federal law;
- Process elements and design for the QHP selection process, a draft solicitation template and supporting documentation;
- Strategies to ensure ongoing monitoring of QHP contract standards and performance measurement;
- Recertification and decertification of QHPs; and
- Potential strategies to foster better value in the broader health delivery system through Exchange contracting and QHP management policies.

Based on extensive internal analysis, public discussion and stakeholder input, Covered California adopted the following criteria for QHP selection:

- Develop an overall value selection process that considers quality, service and price for the consumer.
- Offer a healthy mix of HMO and PPO products in each region.
- Assure statewide coverage and recognize different local/regional markets.
- Give preference to bidders who include more Essential Community Providers in their provider networks, giving greater weight to responders who demonstrate commitment to serving the cultural, linguistic and health care needs of the low-income, uninsured population, including by contracting with Federally Qualified Health Centers.
- Encourage innovations in health care delivery that emphasize quality initiatives, increase patient safety and promote care improvement through payment reforms.
- Encourage multi-year contract proposals.

Incorporating these principles, the Exchange developed a draft QHP solicitation that was subject to significant internal review and stakeholder review and input. The Exchange also sought non-binding notices of intent to bid by QHP issuers. Through this process, 33 distinct health issuers submitted Notice of Intent to provide coverage for both SHOP and the individual exchange. There was substantial interest in high population areas which will increase competition. Five bidders proposed to offer statewide coverage and there were no fewer than six bidders in each region of California.

Exchange IT Systems: Investing in a Consumer-Focused System

From the earliest days of the California Exchange, the Board, staff and stakeholders, in partnership with other state partner agencies have maintained intense focus on the design and development of CalHEERS. The

California Exchange is making significant progress toward designing and building the IT systems needed to support Exchange business and operational processes through design and development of core elements and functionality in CalHEERS.

During the Level 1 grant periods, Covered California conducted multiple solicitations and selected vendors related to IT development and CalHEERS, including a solicitation for a system integrator to design, develop and deploy CalHEERS functionality to meet federal requirements; a solicitation and contract for a vendor to provide project management and technical consulting services to support State project staff during the design, development and implementation of CalHEERS; and a vendor to provide project Independent Verification and Validation Services.

The California Exchange established an Executive Steering Committee composed of the executive leads of the Exchange and DHCS to oversee extensive collaborative planning and research initiated during the early Exchange planning period. The planning and research in this time period led to joint solicitation and selection of vendors to design, develop and deploy software functionality to meet ACA requirements, to maintain and operate the software functionality, and to provide related services. In May of 2012, Accenture was selected to serve as the System Integrator for the Project. The goals of the CalHEERS solicitation and vendor selection process were:

- ***Provide an open, fair, and accurate process that maximizes competition*** while allowing the California Exchange the flexibility to acquire the highest quality goods and services.
- ***Conduct a solicitation*** and project to meet California and federal deadlines, and deliver a high quality solution while minimizing risk.
- ***Award a price-competitive contract*** for a solution that is compliant with federal requirements, including funding requirements.
- ***Demonstrate effective leveraging of open source IT solutions*** developed in other states with ACA resources and make the solutions developed under this solicitation widely available to support federal or other states' efforts to implement the ACA.
- ***Deliver a first-class consumer experience*** that accommodates the needs of each type of consumer and facilitates an end-to-end process that attains and maintains health coverage, from eligibility and enrollment through plan comparison and selection to premium payment and long-term retention.

While system planning and development is jointly governed, the Exchange has authority over Exchange development and operations in CalHEERS, including the IT services required to support its programs. The primary business objective of CalHEERS is to provide a "one-stop shop," "no wrong door" system for determining eligibility for Exchange coverage and subsidies. CalHEERS also needs to support prompt and timely transfer of individuals who may be eligible for other state health insurance affordability programs such as Medi-Cal to the counties for screening and eligibility processing.

California prepared an initial IT gap analysis as background to the submission of the first Level 1 grant application in June of 2011 and continued to revise and update the analytical results ongoing. Exchange staff presented a more in-depth IT gap analysis and detailed information relating to the emerging CalHEERS system to CCIIO as background for the March 2012 Establishment Review discussed above, including the CalHEERS concept of operations, the master project management plan, the risk management plan, the CalHEERS risk register, the Medicaid Information Technology Architecture (MITA) self-assessment and the CalHEERS privacy impact assessment.

In October 2012, the Exchange received approval from CMS for funding activities related to the design, development and implementation (DDI) and the maintenance and operations (M&O) of CalHEERS as submitted in the Advanced Planning Document (APD). CMS approval included both the budget and cost allocation plan for the project. The Exchange will submit APD updates as needed if there are changes in the project scope, cost, cost allocation or timeline.

Through the combination of Exchange staff and leadership, staff in state and local partner agencies and qualified vendors and contractors, Covered California is implementing an aggressive design and build schedule with the aim of having the system supports in place to ensure timely and full operation of Exchange systems for initial open enrollment in 2013 and coverage for Exchange enrollees effective January 2014.

Reuse, Sharing and Collaboration: Maximizing State and Federal Funds

Through a preliminary planning grant and two consecutive establishment grants, Covered California has been a learning organization sharing and learning from state partners, stakeholders, other states and CCIIO as together the federal government and participating states build the consumer-focused marketplaces for health coverage envisioned in the ACA. Through a variety of methods, Covered California exchanges information with other states and CCIIO and, in turn, benefits from shared best practices, model programs and process challenges.

California participates in the CCIIO-developed Cooperative with other states who have a technology System Integrator in place to learn and share best practices and strategies. Given its substantial work and progress to date, California plays a central role in the Cooperative to facilitate information sharing, problem solving and technical assistance. Another resource for information sharing is the Collaborative Application Lifecycle Tool (CALT) established by CCIIO; Covered California is an active user of this web-based portal posting artifacts as developed and utilizing materials uploaded by other states and CCIIO. Webinars with states and CCIIO provide additional opportunities for cross-collaboration. Covered California serves as both a resource in presenting information to others as well as listening to state and national leaders share information on their experiences and progress in exchange core areas. The California Exchange hosted an all-state webinar on August 8, 2012 to provide an overview of its report "*Qualified Health Plan Policies and Strategies to Improve Care, Prevention and Affordability*" and further solicit input from other state exchanges on QHP policies. Representatives from more than 25 states attended the webinar.

Early on, Covered California aspired to be a catalyst for delivery system reform and an active partner consistent with its organizational values. It is through reuse, sharing and collaboration that these ideals are achieved. First and foremost, Covered California recognizes its interdependence with California's and DHCS as evidenced by joint planning and collaboration related to eligibility and enrollment coordination, outreach and marketing, and IT system development (CalHEERS).

At the Federal level, California looks to DHHS and CCIIO to help with the initial build out of the Exchange in critical areas such as risk adjustment and reinsurance and hopes to work collaboratively with CCIIO to develop a tailored risk adjustment methodology that reflects California's unique needs. In conjunction with and pending DHHS approval, California also intends to develop a single, streamlined application. During the March 2012 Establishment Review, the California Exchange requested information from CCIIO on the development of the federal call center and best practices under consideration, including anticipated call mix and volume estimates, scripts, support costs and information from focus groups on questions asked and information sought. Finally, California intends to work closely with CCIIO and other federal agencies to successfully integrate the federal data hub as a tool to process applications and determine eligibility.

Organizational Structure: Expertise to Lead and Learn

Covered California began in September 2010 as a "start-up" organization with an interim Executive Director and initial staff on loan from other state government departments. From this early, skeletal beginning the Exchange relied on a few subject matter experts to join the Exchange staff as temporary consultants and augment the small number of loaned and limited term staff and retired government annuitants. Within months, several key positions had been filled and in August 2011, the Board hired Peter V. Lee as Covered California's first Executive Director.

Despite external issues that impacted recruitment efforts, including uncertainty regarding the Supreme Court decision on the ACA and California's persistent state budget crisis, the Exchange has successfully recruited, hired and trained 60 employees as of October 2012. With a core level of staff support now in place, Covered California is well positioned to develop systems, implement policies and manage the ongoing operations of the Exchange heading into 2014.

Covered California's organizational development strategy places a high value on readiness to offer health care coverage to millions of Californians in 2014 with the long-term objective of financial sustainability after 2015. As a principle, the leadership of Covered California looks to leverage uniquely qualified resources through competitive vendor solicitations and time-limited contracts to access specialized knowledge, experience and skills as needed. On a parallel path, Covered California continues to recruit qualified employees to support the ongoing operation of the Exchange and plans to grow to over 200 employees by June 2013.

Through careful internal planning, and with input from expert advisors, Covered California has adopted the following organizational structure to support the development, implementation and operation of the Exchange:

- **Office of the Director:**
  The Executive Director provides cross-organizational strategy and leadership direction in concert with the Exchange Board.

- **Operations Division:**
  The Operations Division consists of Administration, Eligibility and Enrollment, Grant Management and Information Technology. This division is responsible for the formulation, implementation and evaluation of the administrative policies and procedures and operational processes for the Exchange. These tasks include implementation of strategic, tactical and operational plans; design and management of internal control systems; and organizational structure. Operations is also responsible for the development of eligibility and enrollment coordination with DHCS.

- **Financial Division:**
  The Financial Division is responsible for planning, implementing, managing and controlling all financial-related activities of the Exchange, including accounting, finance, forecasting, budgeting and related government compliance. Finance is also responsible for the development and administration of the Covered California financial sustainability plan.

- **Information Technology and System Development**
  CalHEERS is jointly sponsored by the California Exchange and DHCS. Oversight is provided through the CalHEERS Executive Steering Committee comprised of a single representative from each of the project sponsors who, together, have overall authority for the project and project milestones. The steering committee provides project vision, leadership and direction and it holds responsibility for ensuring that

the deliverables and functionality of the CalHEERS Project are achieved. Changes to the project scope, budget, and schedule must be approved by the steering committee.

- **Product Development, Sales, and Marketing Division:**
  The Product Development, Sales and Marketing Division is responsible for the design, development and execution of health plan contracting for both individual and small employer products. This division develops contracting strategy utilizing regional, state and national models for benefit design. This division also includes oversight of the SHOP Exchange and is responsible for small employer group coverage, including those eligible for the federal small business tax credit.

- **Legal Division:**
  The Legal Division is responsible for providing the Executive Director and senior staff with legal advice on matters pertaining to the Exchange, its programs and operations, and as needed, providing guidance on federal rules and requirements.

- **Government Relations Division:**
  The Government Relations Division is the primary point of contact for the Exchange on health insurance market reforms and legislation affecting Exchange programs. This division represents Exchange positions on legislative proposals with members of the California Legislature, staff and committee consultants, key advocacy representatives and stakeholder organizations. Staff members serve as key liaisons to other state departments, including regulators and CalHEERS program sponsors.

- **Program Policy Division:**
  The Program Policy Division is responsible for the development and implementation of Exchange program policy and regulatory development. These tasks include stakeholder engagement, tribal consultation, application and form development, grant management, program integration, strategic planning, and State plan management.

- **Communications, Public Relations and Marketing Division:** The Communications, Public Relations and Marketing Division is responsible for the ongoing public information and public affairs functions of the Exchange including statewide outreach efforts to stakeholders. This division serves as the official Exchange spokesperson, initiating and responding to inquiries from public organizations, news media, or individuals.

- **Actuary and Research Division:**
  The Actuary and Research Division is responsible for the collection and analysis of data, trend reporting and market analysis to inform Exchange policy development helping staff and leadership to assess risk to the Exchange based on statistical modeling. This division will manage and design data collection and survey tools, review historical cost data and prepare comparative data analyses and recommendations on health plan proposals.

Program Integrity: Managing Resources to Reduce the Number of Uninsured in CA

The vision and mission of Covered California incorporates the dual goals of health coverage expansion and decreased cost/improved affordability. To achieve both goals, the Board and staff have determined that strong financial management practices are essential to establishing and sustaining Covered California. As such, Covered California's financial audit requirements ensure compliance with Generally Accepted Auditing Standards (GAAS). The Exchange will follow standards applicable to financial audits contained in the Government Auditing

Standards issued by the Comptroller General of the United States and Federal guidelines established under the Cooperative Agreement awarded by DHHS.

The basic financial statements are prepared in accordance with GAAP and then presented according to Government Auditing Standards Board (GASB) requirements. A Federal Single Audit (Required in OMB Circular A-133) to monitor and ensure financial integrity of Covered California will be conducted as required, and will engage an independent CPA firm to provide audit oversight and monitoring of all financial policies and procedures. By California statute, the Exchange is responsible for accurate accounting and an annual report to DHHS; required to conduct an annual audit beginning January 1, 2016; and required to provide an annual report to the California Legislature and Governor made available to the public via the Exchange website.

Under the ACA, Covered California must meet additional provisions related to accounting, receipts and expenditures; cooperate with any investigation initiated by Office of the Inspector General; and be subject to annual audits by the DHHS Secretary. The General Accounting Office (GAO) holds oversight for long-term study and evaluation of all state Exchanges.

Affordable Care Act Requirements: Implementing the ACA in California

In 2010, California moved aggressively to enact state legislation implementing key provisions of the ACA affecting health insurance markets, including:

- California Health Benefit Exchange – AB 1602 (Chapter 655 Statutes of 2010) SB 900 (C. 659/2010)
  Creates Covered California; establishes the five-member governing board and describes the basic responsibilities and authorities of the Exchange;
- Premium rate review – SB 1163 (C. 661/2010)
  Requires all health insurance premium filings with CDI and DMHC to be reviewed and certified by an independent actuary to ensure premium costs are accurately calculated and all proposed rate increases to be posted on the carrier and regulatory websites. California's consumer protections in this area exceed what federal law requires under the ACA;
- Dependent coverage – SB 1088 (C. 660/2010)
  Prohibits issuers from setting the limiting age for dependent children covered by their parents' health insurance policy at less than 26 years of age;
- Coverage for children – AB 2244 (C. 656/2010)
  Implements the federal ACA prohibition on pre-existing condition limitations for children under age 19 and provides additional protections beyond federal law. Establishes a mandatory open enrollment period in the individual market, during which issuers can adjust rates for children based on health status, up to a maximum of two times the standard rate for a healthy child. Prohibits issuers from offering new individual policies to anyone in the state for five years if they fail to write new contracts for children on or after January 1, 2011;
- Coverage for preventive services – AB 2345 (C. 657/2010)
  Requires health coverage contracts and policies to cover preventive services as specified in the ACA with no cost-sharing; and
- Cancellation and rescission of coverage – AB 2470 (C. 658/2010)
  Prohibits California issuers from canceling insurance unless there is a demonstration of fraud or intentional misrepresentation of material fact. Exceeds federal law and requires issuers to continue coverage during the period of a consumer's appeal to CDI or DMHC for review of the decision to cancel or rescind coverage.

Both CDI and DMHC responded with additional regulatory or policy guidance as necessary to further refine the requirements and clarify how specific provisions will be enforced. Early insurance reforms are in effect, including premium rate review, coverage for children, preventive services without cost sharing and limits on rescission. California also passed emergency legislation in 2010 to establish the California Pre-existing Condition Insurance Plan (PCIP) for individuals who cannot obtain private coverage because of their health status or claims history (SB 227 (Ch. 31/2010) and AB 1887 (Ch. 32/2010). PCIP is administered by MRMIB which also operates the state's existing high risk pool. PCIP opened for enrollment in October 2010 and, as of September 2012 was providing health care coverage to nearly 14,000 eligible Californians.

In the 2011-12 legislative session, California enacted additional ACA implementation legislation, including:

- Health and Human Services Automation Fund – AB 174 (Ch. 815/2012)
  Establishes the California Health and Human Services Automation Fund within the State Treasurer's Office to facilitate the flow of funds for health and human services IT projects, including Exchange projects, and authorizes information sharing between the state Employment Development Department, Franchise Tax Board and the California Exchange related to Exchange eligibility determinations.
- Consumer Disclosure – AB 792 (Ch. 851/2012)
  Starting in 2014, requires health plans to notify individuals who lose individual or group coverage about the new coverage options available, including coverage in the Exchange and Medi-Cal.
- Small group coverage market reforms – AB 1083 (Ch. 1083/2012)
  Enacts ACA-related reforms affecting coverage sold to employees with small businesses.
- Essential Health Benefits – AB 1453 (Ch. 854/2012) and SB 951 (Ch. 866/2012)
  Establishes California's essential health benefits benchmark plan for individual and small group coverage in accordance with the ACA.
- Eligibility and Enrollment – AB 1580 (Ch. 856/2012)
  Makes technical changes to conform California law with the ACA as it relates to program interface with Medi-Cal and the proposed CalHEERS information technology project.
- Exchange Unfair Business Practices – AB 1761 (Ch. 876/2012)
  Prohibits an individual or entity from falsely representing him or herself as an official representative of the California Exchange.
- Multiple Employer Welfare Arrangements (MEWA) - SB 615 (Ch. 266 Statutes of 2012)
  Prohibits MEWAs from offering, marketing, representing, or selling any product, contract, or discount arrangement as minimum essential coverage or as compliant with the ACA essential health benefits requirement unless it meets the applicable requirements under the ACA.

Covered California, through its Board and staff leadership, assumes a lead role in state and national policy discussions related to health insurance coverage and the market reforms needed to support individuals and employers eligible for expanded coverage. In this capacity, staff works closely with California's Health and Human Services Agency, DHCS, MRMIB, DMHC, CDI, the California State Senate and Assembly and the Office of Governor Edmund G. (Jerry) Brown. The Exchange Director of Government Relations and Director of Program Policy convene, lead or participate in informal, ad-hoc meetings, regular intergovernmental workgroups, stakeholder forums, and technical assistance advisory groups with regulators and state programs.

The Covered California Board receives regular legislative updates at public meetings and has authorized Exchange staff through resolution, to engage in discussions that advance the vision, mission and values of the Exchange and support implementation of the ACA in California. In the legislative session that ended September 30, 2012, the Exchange was instrumental in supporting numerous bills that move California closer to expanding

coverage for millions of uninsured individuals. At the federal level, California has responded to all requests for comment on ACA and market-related regulations, often in collaboration with other state departments on behalf of shared programs.

SHOP: Putting Covered California to Work

In compliance with the CA-ACA, California is creating a separate exchange to serve small businesses and their employees, the Small Business Health Options Program (SHOP). In consultation with stakeholders, Covered California issued a solicitation for small business health option design and development, awarding the competitively bid contract to PricewaterhouseCoopers, (PwC) LLC in March 2012. In April 2012, the Board and public benefited from a panel presentation on the SHOP landscape, hearing from state and national experts on consumer choice, plan design and employer preferences.

After extensive analysis, internal evaluation and public discussion, Covered California determined that during the initial, critical start-up and implementation phase of SHOP (October 1, 2013 – December 31, 2015), it will be most efficient and effective for a qualified vendor to administer the California SHOP and support its business functions. The vendor (yet to be selected) will be responsible for: 1) sales support and fulfillment, 2) agent and general agent management, 3) eligibility and enrollment, 4) financial management, 5) customer service, and 6) either using information technology services provided under CalHEERS or provide a separate solution. An internal, Exchange SHOP Operations Implementation Project Team will oversee and support the vendor, including enforcing the global marketing efforts which include branding, standards, and general oversight of marketing and collateral development. In later years, the Exchange will evaluate whether it is advisable for the Exchange to bring these functions in-house or continue to partner with a qualified vendor.

In June 2012, the SHOP Director joined the Exchange team and, together with PwC developed and issued the draft SHOP vendor solicitation. Following extensive Board and stakeholder review and comment, the solicitation was revised and a final version approved for issuance on November 9, 2012 with the goal of selecting the SHOP contractor before January 1, 2013. More information on the California SHOP Exchange is included below.

b. Proposal to Meet Program Requirements: Level 2.0

As demonstrated above, since passage of early exchange-enabling state legislation in 2010, California has been actively developing, designing and establishing a state-based and fully state-administered Exchange with the goal of offering coverage to eligible Californians by January 2014. California has made substantial progress. Through the federal Exchange Blueprint process, California has been steadily and aggressively conducting an internal self-assessment of readiness to complete the applicable Exchange activities. California expects that coverage in the Exchange will begin on time by January 2014.

The California Health Benefit Exchange is working aggressively to comply with all federal ACA requirements relating to exchanges, including: design and development of CalHEERS; execution and completion of a selection and certification process for qualified health plans; design and implementation of a statewide outreach, marketing and education campaign; and implementation of a comprehensive consumer assistance strategy including a multi-site service center and in-person assistance programs. The Exchange is partnering in these efforts with DHCS and with California's two state health plan regulators, DMHC and CDI.

Through this application, Covered California is seeking Level 2.0 funding to continue Exchange planning and development activities, to bring the Exchange to full operation by 2014, to provide ongoing access to quality, affordable health care through December 31, 2014, and to move to sustainability thereafter. As described in

detail below and in the work plan attached as Attachment A, during this proposed period of the Level 2.0 grant Covered California will:

- Build out the administrative and operational infrastructure, including a multi-site customer service center, to support a robust and successful Exchange serving eligible individual purchasers;
- Refine, test and bring online CalHEERS to support a seamless and coordinated enrollment and eligibility and operational function for Exchange programs, including timely referrals to other health insurance affordability programs in the state;
- Establish through an external vendor(s) the California SHOP Exchange to serve small employers and their employees;
- Evaluate, select, certify and contract with QHP issuers to provide coverage through the individual and SHOP exchanges;
- Refine and fully implement comprehensive outreach, marketing, public education and consumer assistance programs to maximize enrollment and support consumers in enrolling and post-enrollment;
- Continue to actively collaborate with state partner agencies administering public coverage programs and regulating health insurance markets to maximize coordination and integration of existing and newly developing health coverage programs, consumer services and oversight functions;
- Implement a multi-year strategy for evaluation and monitoring of Covered California programs and implementation of federal health reforms in the state;
- Offer and provide subsidized and unsubsidized coverage to eligible Californians in the individual and SHOP exchanges, including conducting initial open enrollment for coverage effective in 2014 and annual open enrollment for coverage effective in 2015, and
- Maintain and enhance operational coordination, financial management support and business operations in service of the mission and functions of the Exchange, including implementing the long-term financial sustainability plan.

Early Benchmarks

Simultaneous to the completion of this grant application, Covered California has been working with CCIIO to submit and demonstrate on a modular basis through the federal Blueprint process the state's readiness for operation of a state-based Exchange and demonstration of early deliverables and satisfaction of early benchmarks. This section briefly shows that Covered California has met or will meet all of the early benchmarks outlined in the Cooperative Agreement.

Gap analyses

As outlined in the Progress to Date section above, since its inception, Covered California has been actively engaged in detailed analysis of existing state programs, services and capacity that can support and will need to be enhanced in order to operate Covered California in fulfillment of its state and federal mission and vision. Every decision and program element reflects extensive and ongoing gap analyses of existing state programs and services and reconciliation with the potential system demands of Exchange activities and operations.

IT Gap Analysis

California prepared an initial IT gap analysis as background to the submission of the first Level 1 grant application in June of 2011 and continued to revise and update the analytical results ongoing. The gap analyses and collaboration among state partners led to and informed the design of CalHEERS and ongoing analysis is an integral part of the CalHEERS implementation process. Exchange staff presented a more in-depth IT gap analysis and detailed information relating to the emerging CalHEERS system to CCIIO as background for the March 2012 Establishment Review.

Actuarial and market analyses

Covered California will continue to emphasize evidence-based decision making through collection of existing research and supporting or engaging in original research necessary to inform its planning and implementation activities, including ongoing actuarial and market analysis.

The Exchange engaged external actuarial services and supports to help in modeling benefit design options, including consideration of standardized benefit plan designs and cost-sharing options. The analysis helped to identify the benefit plan design options consistent with the coverage tiers established in the ACA, other requirements of state and federal law, Exchange principles and the overall goal of offering consumers choice and the opportunity to compare coverage options. Ongoing actuarial expertise will also be essential for the Exchange to evaluate QHP coverage proposals and to estimate the potential costs and utilization for Exchange coverage offerings under multiple scenarios.

Given the size and complexity of the California health insurance market, the Exchange will also need to work closely with DMHC, CDI and state policymakers to analyze the potential impacts of ACA implementation on coverage both inside and outside of the Exchange. The Exchange will be a convener and a contributor to state level discussions on strategies and policies to limit adverse selection between the Exchange and the outside insurance market. While there have been useful and productive state-level discussions to date involving the Exchange, policymakers, regulators and stakeholders, during this next period those discussions will accelerate as the Exchange moves to select its qualified health plans.

Stakeholder and Tribal Consultation

As outlined above, California implemented from the early days of Exchange planning and development a comprehensive stakeholder consultation process. It has relied on multiple strategies and forums to engage stakeholders and capture their input. California developed and adopted a stakeholder engagement plan and tribal consultation policy as outlined above. California expects to continue to actively engage stakeholders and to implement the new stakeholder consultation plan effective January 2013.

Long Term Operational Cost Analysis and Sustainability Plan

Covered California conducted an in-depth, five-year analysis (2013-2017) of its activities, estimated costs, projected membership, and revenue estimates to prudently plan for the appropriate scale of the Exchange in order to support and sustain the operation when federal funds are no longer available starting in 2015. The Exchange conducted extensive financial analysis to provide a base understanding of how variations in membership, associated costs and revenues may affect the long-term operational cost of the Exchange over time and how to anticipate, identify and manage the uncertainty that accompanies these estimates. The Exchange organized and developed its financial management and sustainability plan around three core areas, each of which is subject to independent variables: 1) enrollment estimates for individuals and small employers through the SHOP; 2) potential revenue sources; and 3) Exchange cost structure.

The California Health Benefits Exchange developed a comprehensive financial plan to guide the development, implementation and operation of the Exchange (Appendix III). The plan identifies the resources needed to build and operate the Exchange. The Exchange's financial plan provided the information needed to shape this Level 2.0 grant request. The plan provides for separate financial analysis for the two lines of business to be undertaken by the Exchange: individual exchange and SHOP, which will offer employer-based coverage to employees of small businesses. The plan assumes that these two operations will each be supported by the revenues that each separately collects through plan assessments.

The Exchange relied on CalSIM enrollment projections to provide a richly detailed picture of potential enrollment in subsidized and unsubsidized Exchange coverage. Covered California selected the CalSIM enhanced levels of enrollment as its target for outreach, marketing, education and enrollment support strategies, but planned the scale of the Exchange staffing and operations budget based on lower enrollment estimates with contingency plans in the event expectations are not met. The CalSIM model includes an enrollment scenario or "Base" level of overall enrollment. For financial modeling purposes, the Exchange constructed a second, lower enrollment scenario 20% below the "Base" scenario with a slower pace of enrollment.

The enabling legislation authorizes the Exchange to assess a fee to be paid by participating health plan issuers. These issuers will contract with the Exchange to offer QHPs, either through the Exchange or separately in the individual market. At this time, the Exchange anticipates charging a participation fee on QHPs sold by issuers both inside and outside of the Exchange. The Exchange is considering several revenue generating options:

- A fixed percentage of the total premium for QHPs offered in the Exchange;
- A fixed percentage of the total premium for products with the same QHP designs that are sold outside of the Exchange;
- A fixed participation fee charged to issuer;
- A fixed participation fee charged to enrollees, including in the individual market and/or the SHOP;
- A participation fee for supplemental services such as vision and dental coverage sold within the Exchange; and
- A participation fee for other insurance products such as life and/or disability insurance that may be offered for employers in the SHOP.

Covered California is currently operating under Level 1 grant funding . The financial sustainability plan assumes Level 2.0 grant support for 2013 and 2104 and collection of revenues from assessments on QHP issuers starting during the initial start-up year in 2014. The in-depth analysis of Covered California's financial sustainability demonstrated that its operations can be self-supporting under a wide range of enrollment conditions. The financial sustainability plan provides reasonable and realistic estimates for the expected costs and revenues for the Exchange under a varied set of demand assumptions, a necessity in a state as large, complex and diverse as California.

LEVEL 2.0 EXCHANGE ACTIVITIES

This section outlines the basic strategies Covered California is and will be implementing in each of the Exchange activities categories identified in Section 4A of the June 29, 2012 Cooperative Agreement.

Legal Authority and Governance

Covered California will continue to be governed by an independent five-member Board that is appointed by the Governor and Legislative leaders. This structure is an accountable and transparent structure to conduct Exchange business in the light of public scrutiny and active public participation.

Covered California maintains policy development, government relations and legal functions to support its ongoing planning and implementation activities. Duties of staff in these areas include ensuring the Exchange complies with all relevant state and federal laws, regulations and reporting requirements. Staff conduct and disseminate for Board and public review and consideration policy and legislative analyses and provide technical assistance to the Legislature and state partner agencies on issues and policies affecting the Exchange.

During the period of the Level 2.0 grant, Exchange staff will be continuing to provide policy and analytical support to the Board and will conduct ongoing legal analysis to identify additional or revised state law changes

or regulations necessary to ensure that the Exchange can effectively develop and implement its programs. The Exchange staff will continue to track and monitor state legislation affecting the Exchange, including working with other state agencies and the Legislature to ensure that California successfully implements and monitors federal health insurance market reforms. In this activity area, staff also monitor and facilitate progress reporting on federal establishment grants and work plans; develop quarterly federal grant reports; develop and maintain federally-required agreements with state health programs regarding respective roles and responsibilities; develop state mandated annual and specific reports including annual legislative reports and other reports required by state law or the Board; and monitor federal activities including regulations, guidance, informational bulletins and webinars, and prepare summaries and analyses for the Board, staff and the public.

The legal and governance activity area also includes the provision of legal advice and consultation necessary to the development and implementation of programs, policies, and contracts established by the Exchange, including, for example, ensuring that the Exchange appropriately draws down federal funds, its enrollees qualify for federal subsidies to purchase insurance, Exchange programs and contractors comply with state and federal privacy laws, Board members, staff and contractors comply with state and Board conflict of interest policies and state and federal procurement rules. In addition, the Exchange enabling statute authorizes the Exchange to adopt regulations through the use of emergency regulations, with a shortened timeline and review process. Legal staff are responsible for drafting, reviewing and finalizing regulations governing the operations of the Exchange. Legal staff also review contracts before they are considered by the Board.

Consumer and Stakeholder Engagement and Support

From the beginning, Covered California built in and prioritized regular and meaningful consumer and stakeholder input and engagement and oriented its program development activities to actively and effectively support consumers to learn about, seek out and enroll in Exchange programs.

Stakeholder Engagement

Covered California retains a firm and unwavering commitment to robust stakeholder consultation and active engagement in all aspects of Exchange programs. Stakeholder consultation is built in to the Exchange planning and program processes in all activity areas. As a public agency subject to the Bagley-Keene open meeting laws, the Exchange Board deliberates and makes decision in public meetings with detailed background materials and agendas made publicly available in advance of each meeting.

Going forward, Covered California is committed to continuing to serve in its role as a statewide resource, information clearinghouse and discussion forum for stakeholders. The Exchange has emerged as the “go to” source for up-to-date information on federal rules and guidance as well as state responses to new federal policy directions. Holding the core values of partnership and serving as a catalyst for reform, Covered California takes seriously its role and responsibility to bring and share resources with the public, be a convener of experts and policy discussions, a conduit of information and crafter of new ideas and innovations.

Tribal Consultation Plan

During the Level 2.0 grant period, California will fully implement the Tribal Consultation Policy adopted by the Board in November 2012 and described in section (a) above.

Outreach, Marketing and Education

During the Level 2.0 grant period, the Exchange expects to move from the build out and planning phases to full implementation of its comprehensive multi-year outreach, marketing and education campaign illustrated in Figure 3, phases 2.0I-V, through the period ending December 2014. Activities during this period include:

- Extensive earned, paid and social media to increase public awareness of the Exchange as a coverage option and to connect potential Exchange enrollees to coverage during the initial and annual open enrollment periods;
- Outreach and coordination with potential local partners, including community-based organizations, faith-based organizations, non-governmental organizations, health care providers, labor organizations, trade associations, and small businesses;
- Solicitation and selection of organizations to receive and administer regional and local outreach and education grants to supplement the statewide campaign;
- Selection, certification, training and launch of external enrollment assisters -- in-person assisters and navigators;
- Training and certification of health insurance agents as unpaid assisters to help individuals evaluate options and sign-up for coverage through the Exchange; and
- Evaluation design, baseline data collection and measurement of the effectiveness of key elements of the outreach, marketing and education campaign.

Outreach and Education Grant Program

Covered California has determined that a state as large, complex and diverse as California needs an aggressive infusion of grassroots community-based outreach and education beginning in 2013 to ensure maximum enrollment success. During the Level 2.0 grant period, California will finalize and conduct a solicitation for outreach and education grants to regional and/or local partners who will serve as trusted messengers, removing barriers and helping eligible Californians to take action to get enrolled in coverage. The grant program is based in part on the communications literature suggesting that a person needs to be exposed on average five times before a desired behavior is explored or acted upon. The outreach and education grants will supplement and reinforce the statewide media and outreach campaign and expand its reach. The Exchange will award outreach and education grants separately focused on the individual and SHOP Exchanges.

Grantees will focus on awareness building and education activities. Examples of information and activities grantees will perform both face-to-face and in other communication formats include the following:

- Explain the individual mandate and the potential for penalties;
- Explain the value of having health coverage;
- Inform the person about Covered California and the coverage available, including answering questions about subsidized and non-subsidized coverage options;
- Provide basic information and direct the person to tools and resources that assist in comparing costs, benefits and coverage options;
- Direct individuals to Exchange eligibility resources, including the Exchange service center and in-person enrollment assistance;
- Provide education about open enrollment in subsequent years;
- Initiate reminders about the importance of maintaining coverage in subsequent years; and
- Educate individuals about the requirement under federal law for most individuals to have affordable coverage.

Grants to organizations focused on SHOP will support informing employers about the new SHOP offering in the market. SHOP outreach grantees will provide critical information to businesses that currently do not provide health insurance to their employees. These activities could include:

- Educating employers about the importance and benefits of offering health insurance to their employees;
- Explaining to employers the ACA requirements to offer health insurance and the potential penalties; and
- Helping employers to understand coverage options and premium pricing of QHPs offered in the SHOP and the benefits of obtaining coverage through the SHOP.

The Exchange will set performance goals and measurement strategies for outreach grants to ensure their effectiveness and facilitate ongoing monitoring.

Consumer Assistance Programs

During the Level 1 grant periods, California explored the most effective strategies to assist Exchange enrollees and potential enrollees and developed several approaches to offering consumer assistance prior to, during and after Exchange enrollment. The California Exchange worked to develop a broad range of outreach and support for consumers to help them enroll in coverage and access their benefits, including web-based support, Service Center staff and in-person support through navigators and assisters, and partnerships with state and local organizations and trusted institutions such as churches and schools. The California Exchange recognizes the need to provide robust enrollment assistance delivered through channels that are trusted and known to potential Exchange enrollees.

The consumer assistance strategies of the Exchange will include: (1) A dynamic and first-class Exchange-operated customer service center; (2) Development of a robust Assisters Program, including in-person assisters and navigators, who will provide individualized enrollment assistance, (3) Training and certification as assisters of health insurance agents who will be able to help individuals access and successfully enroll in Exchange coverage; and (4) Problem resolution and post-enrollment assistance through relationship with QHP issuers, state regulators and existing independent consumer assistance programs.

Customer Service Center

As outlined in section (a), the California Exchange engaged in extensive analysis of options and operational requirements for providing customer service at the California Exchange from initial consumer inquiry about Exchange programs, eligibility and enrollment to ongoing consumer assistance and support.

During the Level 2.0 grant period, the process of bringing up the Covered California Service Center will be a primary focus to ensure that the Service Center is fully developed, tested, modified and operational by mid-2013. The California Exchange will administer a centralized, multi-site service center model with specific processes and protocols to refer individuals potentially eligible for Medi-Cal to counties for the eligibility determination. The Service Center will receive and respond to consumers seeking to purchase Exchange coverage and provide multi-channel access including phone, fax, e-mail, web, and live chat. Customer service will be provided in multiple languages (in culturally and linguistically appropriate manners) to ensure that consumers with limited English proficiency are properly served and provided assistance.

In order to deliver on the ACA goal of a “no wrong door” service system that provides for a consistent and quality consumer experience at all entry points, the California Exchange will develop culturally and linguistically appropriate oral and written communications and targeted strategies for populations with limited access such as persons with disabilities. The CalHEERS design will facilitate eligibility determinations and enrollment through multiple access points including the web, mail, phone and in-person applications.

External Eligibility and Enrollment Support and Assistance

Federal law and the CA-ACA require the California Exchange to establish a Navigator grant program to aid in public awareness and education, enrollment and ongoing use of qualified health plans offered through the Exchange. As outlined above, during the Level 1 grant periods, the California Exchange engaged in the process of analysis, discussion and stakeholder input resulting in Board adoption of a broad program of assistance, referred to as the "assisters" program, for face-to-face, individualized services to persons who require help navigating the eligibility and enrollment process. The California Exchange will implement and administer both an in-person assisters (IPA) program and a Navigator program.

The Guiding Principles of the in-person assistance and navigator programs (collectively referred to as the Assisters Program) are:

- Promote maximum enrollment of individuals into health coverage by providing a one-stop shop marketplace for affordable, quality health care options and health insurance information.
- Encourage individuals offered affordable, employment-based coverage to take that coverage.
- Build on and leverage existing resources, networks and channels to maximize enrollment, including close collaboration with state and local agencies, community organizations, businesses and other stakeholders with common missions.
- Consider where the eligible populations live, work, play and shop; and, select tactics and channels that are based on research and evidence of how different populations can best be reached and encouraged to enroll (and once enrolled, retain coverage).
- Marketing and outreach strategies will reflect and target the mix and diversity of those eligible for coverage.
- Establish a trusted statewide Assisters Program that reflects the cultural and linguistic diversity of the eligible populations.
- Ensure that Assisters are knowledgeable of both subsidized and non-subsidized health care options.

The following program framework, adopted by the Board, will apply to Navigators and IPAs:

- Navigators and IPAs will be trained, certified and registered with the Exchange and complete education, eligibility and enrollment activities for individuals. They will assist in completing eligibility processing for Exchange products and programs, including subsidies, and assist enrollees with the selection of and enrollment in a QHP.
- Navigators and IPAs must be affiliated with an enrollment entity or organization that is registered with the Exchange and that meets established eligibility criteria. Individual assisters will not be eligible to enroll individuals in Exchange products and programs.
- Navigators and IPAs must be certified annually after completing any required training. Enrollment entities and organizations and their affiliated Navigators or IPAs must sign a Code of Conduct and other agreements designed to avoid conflicts of interest and steering.
- Navigators and IPAs must complete training offered by the Exchange which will be made available at no cost to the enrollment entity. Although a two/three-day session is envisioned, abbreviated training may be offered for individuals already trained to enroll consumers in health coverage.
- The Outreach and Education Grant Program (as above) will be integrated and aligned with the Navigator and IPA program, since the two programs are complementary.
- The Exchange or its designated entity will: (1) provide training, technical assistance and professional development for all Navigators and IPAs; and (2) recruit and monitor the Navigator and IPA network in

order to ensure geographic, cultural and linguistic access to target markets, as well as program quality and compliance.

During the Level 2.0 grant period, the California Exchange will develop a joint application for entities that wish to provide enrollment assistance through the Navigator or IPA programs. The Exchange expects to release the assisters application in the first quarter of 2013 and begin training Navigators and IPAs in May 2013.

Navigator Program

The California Exchange will operate a Navigator program in compliance with federal regulations and guidance that will award grants to eligible entities including community and consumer-focused nonprofit groups. During the Level 2.0 grant period, the California Exchange will finalize the Navigator program design and will recruit, train and certify Navigator grantees. The Navigator grant program will be funded using Exchange operational funds through grants to eligible organizations that perform the five required duties of a Navigator. Through the Navigator grant program, the Exchange will be able to target grant awards to ensure the participation of organizations with access to hard to reach populations. Organizations will be able to apply for different grant amounts based on their demonstrated capacity to enroll consumers and grant awards will specify enrollment goals for the Navigator entity.

In-Person Assistance Program

The IPA program will provide additional enrollment assistance through entities that are certified and trained by the Exchange. Participating entities will receive $58 for an application that results in successful enrollment into the Exchange's programs and $25 for successfully assisting consumers to retain Exchange coverage during the annual eligibility redetermination process. Entities applying for the IPA program will have to demonstrate experience in working with Exchange target populations and could include, for example, community and consumer focused non-profit organizations, faith-based organizations, Indian tribes, tribal organizations, and county social service agencies.

The California Exchange will use the start-up year of 2013 to test and evaluate the impact of the distinct funding and program designs of the Navigator and IPA programs in facilitating successful enrollment in the Exchange. Necessary improvements will be made to the Navigator and IPAs programs in subsequent years to ensure that enrollment goals are met in the most consumer-friendly and cost-effective manner.

Health Insurance Agents

To maximize the ability of the Exchange to reach all geographic areas of California, the Exchange will partner with state licensed health insurance agents who will be certified by the Exchange as unpaid assisters. A robust agent network will expand the sales force capabilities of the Exchange, giving people in all areas of the state access to expertise and personal attention in evaluating and applying for Exchange coverage and programs. To meet the diverse needs of potential Exchange enrollees, the Exchange will seek agents who offer culturally and linguistically diverse services.

In California, health insurance agents are regulated by CDI. California law requires agents to have an active life and health agent "business entity" license which allows them to sell health insurance to both the individual and employer-sponsored health insurance market segments. To be authorized to represent and enroll in the Exchange, all licensed agents will also be required to complete an Exchange-sponsored training program. The agent training program will address Exchange policies and values, technical training, product training and an overview of agent support tools and resources. Agents who complete training will be designated as unpaid assisters and will be expected to present to all enrollees a full picture of the alternative plans offered by the

Exchange. Agents selling Exchange individual coverage will be compensated by the issuer if the agent is appointed by the issuer that the enrollee selects.

In the small business market in California, employers, issuers, chambers of commerce, and other business associations often have well-developed relationships with agents and brokers. Small businesses will be able to use agents to provide assistance in navigating the range of options that will become available through SHOP. Agents selling SHOP coverage will be appointed and compensated directly by the Exchange. The Exchange will also contract with a set of General Agents to offer their services within the SHOP.

Problem Resolution and Post-Enrollment Consumer Assistance

During the period of the Level 2.0 grant, Covered California will finalize and implement a multi-faceted consumer assistance program for Exchange enrollees who experience problems during enrollment or post-enrollment. Covered California will establish and administer consumer assistance programs consistent with the following principles:

- Build systems that foster "one-touch and done" capabilities to quickly resolve consumer concerns and minimize the number of "hand offs" between different entities.
- Resolve problems at the "lowest level" as often as possible. If a problem is between the consumer and the health plan, the health plan should take responsibility for resolving the issue. Elevation of problems should be the exception, not the norm.
- Collect information on problems and complaints to be used for system improvement (regardless of who handles the problem).
- Consider cost-effectiveness for consumers and purchasers when developing systems. Build on existing consumer assistance programs to lower support costs.
- Ensure that individuals have access to independent assistance when needed. Health plans must be held accountable for problem resolution, but consumers should also have the ability to access help outside of their health plan, including through the Exchange, from regulatory bodies and from independent consumer assistance programs.
- Establish formal appeals processes as appropriate and required in state and federal law.

Enrollees who contact the Exchange for assistance in resolving problems will be served by the Exchange Service Center staff. The Service Center will be the first point of contact for Exchange enrollees and will develop specific protocols and procedures to identify the nature of a consumer's problem or complaint and an internal process to track and respond promptly to problems raised. Service Center staff will have access to a robust database through CalHEERS reflecting a consumer's eligibility, health plan choice and related information to help in quickly assessing the best approach and/or entity who can most quickly resolve the issue.

Exchange enrollees contacting the Service Center may also be transferred to their health plan's complaint unit or to the appropriate State regulatory entity -- enrollees of DMHC-regulated health plans to the DMHC Help Center and those in CDI health plans to the CDI Consumer Hotline. Complaints and inquiries will be handled consistent with existing state regulatory standards and the Exchange will work with the regulators in the coming months to define roles and responsibilities. The Exchange will coordinate with DMHC and CDI to help in training their staff on Exchange programs, benefits and services and to support capacity development to enable them to provide services to those newly enrolling in coverage under the ACA. The Exchange will continue its partnership with DHCS so that problems with the Medi-Cal program are appropriately resolved by either DHCS or county welfare offices that administer Medi-Cal eligibility and enrollment on behalf of DHCS.

As part of this process, the Exchange will partner with DMHC, CDI, Office of the Patient Advocate and independent consumer assistance programs to develop common metrics related to assessing the types of consumer problems that emerge, best practices in problem resolution and standards to measure the effectiveness of the assistance services provided. The Exchange will also work with these organizations to develop appropriate screening questions to determine whether the consumer is receiving coverage through the Exchange and how best to ensure they are connected with the most appropriate entity to handle their request or complaint. The Exchange will coordinate with existing state agencies and local consumer assistance programs in the development of common referral protocols, training materials and consistent messaging related to the ACA, the Exchange and participating Exchange qualified health plans.

By collaborating with existing consumer assistance programs, Covered California will build on the current federally-funded Consumer Assistance Program (CAP) administered by the DMHC. California's CAP program funds are being used to assist in the development of a coordinated seamless point of entry for Californians needing consumer assistance with their health care. In addition, CAP in California has focused on maximizing assistance to low income and non-English speaking communities which is consistent with Exchange priorities and goals. Under the first found of CAP funding, DMHC awarded funds to the five regional consumer centers of the Health Consumer Alliance to do all of the following:

- Assist consumers in obtaining health care;
- Assist consumers with internal and external grievance and appeal processes;
- Accept referrals from the DMHC Help Center;
- Conduct outreach to local groups regarding the expansion of health care coverage and programs under the ACA;
- Develop training materials for community-based organizations and staff of consumer assistance programs;
- Collect and report data on consumer issues and outreach events; and
- Provide policy recommendations to resolve systemic problems.

DMHC is currently in the process of selecting CAP grantees for the second round of federal funding. As part of the Level 2.0 grant, the Exchange will work with DMHC to provide supplemental support to the CAP grantees for assistance, data collection and reporting related to Exchange eligible and enrolled individuals. In the hope that federal CAP funding will be available beyond 2013, the additional Level 2.0 Exchange grant funds will ensure that CAP grantees can assist, collect data and report on problems affecting Exchange enrollees -- with special emphasis on updates during the early launch and start-up phase in 2013 -- to provide critical information in support of real-time quality improvement. The Exchange is requesting Level 2.0 funds to support this Exchange-specific regional consumer assistance capacity related to 2013 open enrollment and through the end of 2014.

Eligibility and Enrollment

A well-designed and smoothly operating eligibility and enrollment process is critical to achieve the robust enrollment goals established by Covered California. During the Level 2.0 grant period, the Exchange will continue working with DHCS and other agencies to develop and document a "no wrong door" process for application, eligibility determination, and enrollment into Exchange programs. The Exchange and its partners will develop common processes for coordinating applications, notices and appeals between programs as required in state and federal law, coordinating enrollments into the Exchange and Medi-Cal. The partners will also continue to identify best approaches to reach out to and simplify the application process for eligible enrollees for all programs, including using existing known state data sources, as well as newly developing sources being made available through federal data sets and portals.

Eligibility and enrollment activities in the grant period will support development and testing of CalHEERS, the IT system for the Exchange that will, among other functions, support eligibility determinations. Eligibility and enrollment program expertise and support will help inform the design and testing of CalHEERS in preparation for the initial launch of the statewide portal in July 2013, and the start of open enrollment on October 1, 2013. Specific functionality and capacity will be designed and implemented in CalHEERS, at a minimum, in the following areas:

- Eligibility processing and determinations;
- Eligibility and processing of premium tax credits and cost sharing reductions;
- Enrollment processing, including QHP selection;
- Assisters program certification, payments and management;
- Applications, updates, verifications and required notices for individuals and small employers;
- Periodic examination of data sources;
- Annual eligibility redeterminations;
- Individual responsibility determinations and payment exemptions;
- Adjudication of appeals of coverage;
- Website elements, including premium and cost-sharing calculators;
- Consumer assistance and case management processes to provide ongoing support to enrollees;
- Determination of eligibility based on availability of affordable employer-sponsored coverage;
- Notification and appeals of employer liability; and
- Information reporting to Internal Revenue Service and enrollees as required.

Additional eligibility and enrollment activities during the grant period will include development of policies, procedures and materials that are necessary to build the foundation of eligibility and enrollment operations, and fully implementing the Exchange eligibility and enrollment functionality including:

- In partnership with DHCS, develop and translate program materials, forms, notices and letters to applicants and subscribers;
- Provide operational support for CalHEERS eligibility and enrollment operations, the Service Center, and the Assisters Program, including development and documentation of business rules and work flow, training materials, work instructions and/or scripts, and regulations. The Exchange will provide customer telephone assistance to support eligibility and enrollment and provide ongoing assistance to current enrollees through the Exchange service center;
- Identify data and design reports to track and monitor performance and quality standards, eligibility and enrollment, and state/federal reporting and audit requirements;
- Begin developing methods of measuring and evaluating the effectiveness of the Exchange in meeting the needs of consumers for incorporation in the Exchange evaluation plan. A process for identifying eligibility and enrollment policy issues and corrective action as needed will be developed; and
- Build capacity for and establish protocols related to appeals of coverage determinations, including review standards, timelines and consumer assistance. The Exchange will identify and execute an interagency agreement with another state agency to operate the coverage appeals function.

California plans to develop and use a DHHS-approved single, streamlined application to determine eligibility and collect information that is necessary for enrollment in a QHP for the individual Exchange and for other state-administered coverage programs. The Exchange and DHCS are in the process of identifying all required data elements to be included on the application. The Exchange has developed process flows for the application

process and is working with Accenture, the CalHEERS vendor, to confirm these flows and ensure that they reflect all anticipated required data elements. Once the DHHS-developed application is released, the Exchange will review and evaluate its contents. It is California's intention to use the federal application as its baseline for ensuring that the Exchange captures the minimum required data elements in its state-developed application. The Exchange will also review the application for consistency with state law. The Exchange will submit California's single, streamlined application for the individual market to DHHS for review and approval soon after the DHHS-developed application is released. Upon approval by DHHS, the California Exchange will make available the single, streamlined application to consumers in late-September 2013. California will develop and use a DHHS-approved application for SHOP employers and employees as specified in federal rules and follow a similar process as for the individual Exchange.

Coordination strategy

During the period of the Level 2.0 grant, the Exchange will, in collaboration with CHHS, execute the mandatory agreements with DHCS and MRMIB related to eligibility and enrollment, and roles and responsibilities between Exchange programs and other state health insurance affordability programs, as well as agreements with state health insurance regulators, CDI and DMHC, to define roles and responsibilities related to qualified health plans and monitoring of health insurance market reforms.

The Exchange also recognizes the importance of referral of consumers accessing health care programs to human services programs, such as the state's Temporary Assistance to Needy Families program (CalWORKS) and food assistance program (CalFresh). During the Level II grant period, the Exchange and DHCS will primarily focus on developing a system by which to enroll individuals into Covered California products. The Exchange will continue to engage with the CDSS, counties, and stakeholders in the coordination and determination of a long-term approach to horizontal integration with human service programs. The streamlined application will include questions gauging an individual's interest in seeking available human services through existing programs and will be referred to the individual's county of residence as appropriate.

Coordination among the Exchange and DHCS is critical to successful implementation of the ACA in California. These agencies hold weekly status meetings to ensure that all parties are fully informed about implementation progress and issues, as well as Joint Application Design (JAD) sessions between these agencies and the CalHEERS contractor on system specifications multiple times each week. Policy Committee meetings are held on a regular basis, attended by management staff representing the Exchange and DHCS, with county participation. These meetings focus on problem identification and resolution, including status updates on progress in resolving previously identified problems. In addition, Executive Steering Committee (ESC) Meetings review overall progress and important policy issues. The Directors or their designees of the Exchange and DHCS serve as the members of the ESC. The Exchange will also develop interagency agreements with several state departments to facilitate eligibility and enrollment, such as data matching to determine an individual's eligibility for insurance affordability programs. DHCS already has many of these relationships in place. However, the Exchange must establish separate agreements to ensure appropriate data sharing for its programs. Agreements will be developed between the Exchange and the following state agencies:

- California Department of Public Health (CDPH) Vital Records, for death information and other vital statistics;
- Employment Development Department (EDD), for earned income data and the eligibility of small businesses to participate in SHOP; and
- Franchise Tax Board (FTB), for tax data.

The Exchange will also reach out to potential new state program partners to implement additional Exchange program efforts, data collection and comprehensive outreach such as Department of Motor Vehicles, California Department of Aging, California Department of Consumer Affairs, California State Lottery, University of California, California State University and other state agencies that have contact with those likely to be uninsured or losing coverage. The Exchange will also work with state agencies with access to relevant and helpful data, including the Office of Statewide Health Planning and Development, which collects and maintains data on health facilities and health care service utilization which may be useful as the Exchange considers its delivery system improvement activities, and the Office of the Patient Advocate which is charged with tracking and analyzing state data on problems and complaints by, and questions from, consumers about health care coverage. The Exchange has begun initial discussions with MRMIB related to coordination and transition planning for enrollees in the Pre-existing Condition Insurance Plan and the Major Risk Medical Insurance Program.

The Exchange will look to federal agencies for data collection, retrieval and potential outreach connections such as the Indian Health Service, the Social Security Administration, the Internal Revenue Service and the US Postal Service. The Exchange will identify opportunities to also reach out to and partner with local agencies that provide services to and work with consumers who may be accessing and eligible for Exchange services including: local county social services agencies, local First 5 Commissions, which administer Proposition 10 tobacco tax revenues dedicated to health and social service programs for children ages 5 and under, local Mental Health Services Act programs and agencies, and local community-based organizations, including educational institutions and consumer assistance programs.

Notices and Data Matching

The Exchange is in the process of developing CalHEERS, which will have the capacity to send notices, including notices in alternative formats and multiple languages; conduct periodic data matching; and conduct annual redeterminations and process responses in-person, online, via mail, and over the phone as required in federal regulations. The Exchange will conduct additional periodic data matching consistent with federal rules. In close collaboration with DHCS, the Exchange is in the process of developing a verification plan which identifies the primary, secondary and tertiary data sources that will be used during the initial eligibility, periodic verification, consumer-reported and annual eligibility redetermination processes, including any information in which self-attestation will be accepted. Once the comprehensive verification plan is developed, the plan will be submitted to DHHS for approval. The following includes a list of potential data sources that California is considering to use to verify eligibility factors:

- Social Security Number – Federal Hub (Social Security Administration);
- Residency – Self attestation unless other data sources indicate the person is not a California resident;
- Citizenship and immigration status – Federal Hub (Social Security Administration and Department of Homeland Security);
- Incarceration – Self attestation; with matching against Federal Hub (Prisoner Update Processing System (PUPS); if available);
- Household income – Federal HUB and IRS followed by EDD/FTB;
- Family/household size – Self attestation;
- Whether an individual is an Indian – California hopes to verify this information through the Federal Hub. If this information will not be available through the Hub; paper documentation may be required;
- Enrollment in an eligible employer-sponsored plan (if applicable) – Self attestation through responses to an application question and verification through the California Exchange's SHOP system. At this time,

California has not identified other trusted state data sources to verify this eligibility criteria; however, research and analysis continues;

- Eligibility for qualifying coverage in an eligible employer-sponsored plan - Self attestation through responses to an application question and verification through the California Exchange's SHOP system. At this time; California has not identified other trusted state sources for verifying this data. California anticipates working with the data sources to be collected by the federal government on employer-sponsored plans;
- Eligibility for non-employer-sponsored minimum essential coverage – Federal Hub and Medi-Cal Eligibility Determination Data System (MEDS); California suggests that eligibility for programs such as Medicare, TRICARE, Peace Corps minimum essential coverage, and Veterans health minimum essential coverage be included in the Federal Hub; Verification of other public subsidized health care programs that provide minimum essential coverage will occur through California's state MEDS system.

Qualified Health Plan Management

During the period of the Level 2.0 grant, the Exchange will finalize and implement the process to certify and select Exchange QHPs. QHP certification, selection, contracting and monitoring will be a major focus of Level 2.0 activity. The Exchange goal is to have QHP selection final by the summer of 2013 so that potential enrollees will be able to review plan offerings in advance of the October 1 open enrollment period. Thereafter, the Exchange will establish a process to certify or recertify QHPs by September 15 of each year in anticipation of the annual open enrollment period. This ongoing process will be the responsibility of the Exchange working in coordination with DMHC and CDI, as well as in collaboration with DHCS and MRMIB in their program management and oversight of state coverage programs, and the contracting health plans participating in those programs.

After an extensive internal process and stakeholder and Board input, Covered California is in the process of finalizing its QHP solicitation. The solicitation is comprehensive and reflects policy choices based on detailed analysis, review of state and federal requirements, and options development by the Exchange over many months. The solicitation, among other things, defines what it means for an issuer to be in good standing with its regulating agency, establishes the options for issuer bids in geographic regions and portions of geographic regions, and sets expectations regarding federal requirements relating to issuer inclusion of essential community providers, network adequacy, accreditation, and quality reporting. Solicitation responses to these questions will be used as the basis for determining whether a proposed QHP has met the minimum requirements. In addition, the Exchange is asking for information it will use to exercise its "active purchaser" statutory authority to select among QHP bidders who have met the licensed and in good standing requirements. Issuers will submit the bids electronically through Proposal Tech, under contract with the Exchange, which will take the final QHP solicitation and convert it into an electronic RFP, "eRFP."

The Exchange has been meeting and consulting regularly for the last several months with CDI and DMHC to work out the necessary division of labor related to QHP selection and monitoring of ACA and CA-ACA market-wide requirements. The Exchange will continue to work with regulators to establish communication flows and support an efficient and robust QHP certification process. The obligations of the regulators to the Exchange and the communication responsibilities of each will be spelled out in interagency agreements. These agreements will include turnaround time of reviews, QHP certification criteria that are within the jurisdictional authority of each regulator and confidentiality terms that apply to different types of communications between the Exchange and each of the regulators. The Exchange will also finalize detailed processes for recertification, decertification and appeals of decertification. In general, the Exchange's strategy for recertification will be comparable to the process in place for certification.

The Exchange Health Plan Management division anticipates receipt of an estimated 305 QHP offerings from issuers based on the responses received to the Notice of Intent to Bid. In addition to bids for issuers to serve different areas of the state, the Exchange anticipates receiving both dental and vision plans from which it will select participating plans.

Ongoing Health Plan Management

Health plan management functionality will reside in CalHEERS. The CalHEERS staff assigned to Plan Management are building in capability to upload plan-specific data and information, including benefits and cost sharing, geographic regions served, premiums and performance measurement metrics. QHP issuers will also be required to submit regular provider network updates to the Exchange so CalHEERS can maintain a centralized provider network directory developed for enrollment, re-enrollment and changes in enrollment when a member experiences a life event that qualifies for changing plans. Exchange contracts with QHP issuers will contain specific ongoing reporting requirements which will enable the Exchange to monitor compliance with Exchange-specific provisions, including but not limited to accreditation status and Essential Community Provider (ECP) network requirements. Covered California will collaborate with CDI and DMHC going forward regarding ongoing QHP issuer compliance with state and federal requirements and Exchange certification standards.

QHP Quality Measurement and Quality Ratings

Starting at the end of 2014, the Exchange will require its QHP issuers to report on Exchange enrollees using eValue8™ metrics. eValue8™ collects quality data that is inclusive of Healthcare Effectiveness Data and Information Set (HEDIS), National Committee for Quality Assurance (NCQA) and Quality Compass data.
One of the major advantages to the Exchange from using the eValue8™ tool as part of the QHP certification process is that it can be used every year as a performance measurement and quality monitoring tool. This will allow the Exchange to benchmark QHP performance year over year. In addition, the Exchange must publish information that is helpful to consumers to compare and select among the QHP offerings. The quality rating system envisioned in the ACA has the potential to be a competitive differentiator to the extent it clearly communicates differences in health plan value and allows consumers to make informed choices. In future QHP solicitations, the quality rating system could also be a tool for comparison and selection of the QHP issuers to participate in the Exchange. The ACA requires the Exchange to rate each QHP on value as measured by quality and price. Once the federal guidance on quality rating is issued, the Exchange will evaluate how best to incorporate the federal expectations into its certification and QHP monitoring process.

Web-Based Entities

The Exchange is considering a unique and separate policy for web brokers (“Web-based Entities”) which allows the Exchange to determine if web-based entities will be allowed to facilitate consumer enrollment in QHPs and the Advance Premium Tax Credit. The policy will be set to ensure that the offering of plan choice by web-based agents provides an unbiased and easily-understood presentation of the consumer coverage choices.

Risk Adjustment and Reinsurance

The risk adjustment program is a permanent program that will begin in 2014 and is intended to protect health plans operating in the individual and small group markets, inside and outside of the Exchange, from the potential of attracting a higher than average health risk. States have the option of deferring to federal administration or state administration of risk adjustment and must notify CCIIO of its intention in this area as part of the Exchange Blueprint process and state models will be subject to federal approval.

The transitional reinsurance program is a temporary two-year program that will be financed by assessments on the entire health insurance market. Because the risk adjustment and transitional reinsurance programs apply to

insurance products both inside and outside the Exchange, development and operation of these programs are not solely an Exchange function and implementation requires a collaborative state decision regarding designation of agency administrative responsibility and authority.

As part of the Exchange Blueprint declaration, the state will submit its notification that, as of this writing, California intends to rely on the federal risk adjustment and reinsurance programs. The primary reason for this is that the state is working diligently on so many other critical state implementation activities related to Covered California and state oversight of health insurance market and regulatory reforms. Federal support in this area will complement those efforts.

However, California also intends to actively work with CCIIO to ensure that any risk adjustment program methodology implemented in California is developed in consideration of California's health delivery system and health insurance models. Specifically, California is unique in the extent to which health plans in the state historically contracted with large multispecialty medical groups and independent practice associations on a capitated, fixed per member, per month basis, in health maintenance organization (HMO) coverage products. Under this approach, California health plans also often delegate to the medical groups by contract shared responsibility for a variety of care management and administrative functions, including utilization review, specialty referrals, disease management and some claims payment functions. California's "delegated model" is aimed at creating financial incentives at the medical group level for improved management of health care delivery and health care costs, and many observers, including participating medical groups and health plans, believe that the delegated model has contributed to California's relative success in containing health care costs over time. Another California-specific factor is the role of an integrated delivery system HMO as a major player in the individual and small group markets. State officials hope to work closely with DHHS to ensure, at least on a transitional basis, a risk adjustment methodology in California that is workable and appropriate given unique characteristics of California's health delivery system.

SHOP

CA-ACA requires the Exchange Board to establish the SHOP program separate from the individual market Exchange, to hire a Director of the SHOP, collect premiums and administer all other necessary and related tasks, including, but not limited to, enrollment and plan payment, in order to make the offering of employee plan choice as simple as possible for qualified small employers. Covered California engaged consultants, experts and stakeholders to consider the design and implementation options for SHOP to maximize the viability and effectiveness of the program.

California's Existing Small Employer Market

According to a California HealthCare Foundation (CHCF) report presented to the Exchange Board in May 2011, *California's Individual and Small Group Markets on the Eve of Reform, 2011,* California's individual and small group health insurance markets combined currently serve just under 15 percent of the state's population — about 5 million people altogether. CHCF estimated that California's small group market, serving firms with 2-50 employees, provides coverage to an estimated 2.5 million people, about 8 percent of non-elderly Californians.

California's small employer coverage market (2-50 employees), controlled by state law since 1992, includes the requirement that issuers offer and sell all products to all small employers regardless of the age, health status or claims experience of the group. California's small employer law, among other elements, also limits pre-existing condition exclusions to six months, requires guaranteed annual renewal, limits health status rate adjustments to no more than plus or minus 10 percent from standard rates and restricts geographic rating differentials to nine carrier defined regions. Issuers may also impose participation (e.g., 70 percent of eligible employees must enroll)

and contribution requirements (e.g., the employer must pay at least 50 percent of the premium). As a result, enrollees in small group coverage typically pay a fraction of their premium.

In 2012, California passed legislation (AB 1083, Chapter 852, Statues of 2012) revising state rules for small employer coverage to reflect ACA requirements and additional changes applicable to small employer coverage both inside and outside of the Exchange. AB 1083 prohibits any pre-existing condition coverage exclusions, limits premium rating factors as outlined in the ACA to age, family size and geography, and establishes 19 standard geographic rating regions that will apply to all small employer coverage. The Exchange will develop the California SHOP consistent with the ACA, its implementing regulations and applicable state law.

Design of the California SHOP

Given California's already competitive guaranteed issue small employer coverage market, the Exchange has adopted relatively conservative estimates on how many small employers will join California's SHOP. Covered California will contract with an outside vendor to administer the SHOP based on a competitive bid process. The SHOP administrator contract will exclude several SHOP business functions that are considered "core" operational and policy functions. Core functions that will be internal to the Exchange include:

- Governance, Policy Development, and Quality Assurance: the Exchange will retain governance and policy-making authority and ensure that Vendors are meeting contractual quality standards;
- Health Plan Management: the Exchange will retain control over health plan selection, certification and ongoing management of qualified health plan relationships for the SHOP Exchange;
- Legal: the Exchange will manage legal issues internally but does not assume responsibility for legal issues unrelated to SHOP;
- Marketing Strategy: the Exchange will retain responsibility for developing and maintaining a Marketing Strategy. The Marketing Strategy will include building overall consumer awareness of the Exchange's brand and services statewide, both for individual consumers and small business employers; planning and conducting consumer-oriented statewide media campaigns that generate general awareness for the Exchange, its mission, and how to access services and Customer Service; establishing and maintaining brand guidelines and standards for the Exchange, including look-and-feel for print and electronic collateral, letter and notice templates, and application and change form templates.

The Exchange plans to contract with the SHOP Vendor for the following services:

- Sales Support and Fulfillment. The SHOP Administrator will have responsibility for sales which may include, but are not limited to, managing all small business sales channels; supporting direct enrollment of small employers without the assistance of a licensed Agent; defining and executing targeted regional, and/or product-specific, and/or population-targeted advertising campaigns in the small business market (e.g. placing advertisements in Business Journals); recruiting, training, and managing a sales force that is accountable for delivering the Agent participation goals; maximizing multiple channels to service the small employer market, including direct mail, phone, web, and mobile; establishing and maintaining an electronic and direct-mail fulfillment capability for the printing and distribution of SHOP Agent sales support materials; creating, printing and distribution of sales and marketing collateral including Welcome Kits, Applications Forms, Product Brochures, Agent Sales Materials, etc.; reporting on Agent sales performance; maintaining a Customer Relationship Management (CRM) software tool for managing a statewide small employer sales pipeline and book of business; and supporting online web-based and paper-based enrollment.

- Agent and General Agent Management. The SHOP Administrator will be accountable for delivering agent participation and membership goals developed by the Exchange. The Administrator will lead sales and sales support for the SHOP through lead generation, lead qualification and distribution, campaign and channel reporting, and development of small employer and member focused retention programs for the SHOP. In addition, the Vendor will manage the full lifecycle of Agent engagement, which will include recruiting agents, training and certifying agents on SHOP products, services and values, supporting and tracking agent sales pipeline and enrollment growth opportunities (including product training and the development / distribution of Agent Field Manuals). The Administrator will also support and track agent-driven renewal activity. The SHOP Administrator will manage all reporting required to manage the network of agents, to development and implementation of agent recognition programs. This also includes providing agents with tools and reports to manage their books of business (Quotes, Renewals, Enrollment Activities, etc.). The Vendor will develop a comprehensive set of managerial reports to track sufficient statewide agent representation, participation, and sales forecast attainment.

- Eligibility and Enrollment. Eligibility and enrollment in the SHOP occurs uniquely for employers. Employers (or agents on their behalf) must register in the Exchange, select QHPs and contributions for their employees, load their employee rosters, and subsequently employees select from products offered for themselves and their dependents.

- Financial Management. The SHOP Administrator will support the requirements for the SHOP to process financial transactions for employers (premium billing and reconciliation), issuers (employer and aggregate billing and exchange fees), and agents (commissions) while providing the ability for the Exchange to monitor, report on and take corrective action as required. The SHOP Administrator will manage and provide data required for reinsurance and risk adjustment reporting, general accounting, premium aggregation and processing and related support.

- Customer Service. The SHOP Administrator will be expected to deliver a turn-key, best-in-class customer service capability including all systems, policies, procedures, and personnel capable of handling the projected volumes of agents, general agents, employers, and employees, and having sufficient redundancies and fail-over capability to remain in operations during a natural disaster. The SHOP Administrator will plan, establish, operate, and maintain the SHOP service center functionality and provide information to support the following service center functions: call center, fulfillment, and imaging and document management system.

- Information Technology Services. The SHOP Administrator may either propose to use CalHEERS functionality to support its operation or propose any alternative existing system to provide this support. The Exchange may elect to utilize SHOP administrator technical capabilities to initiate SHOP operations.

Other SHOP design and policy options considered and determined by the Exchange to date include:

- SHOP and Individual Exchange QHP Alignment. The Exchange will partially align its health plan and benefit design structures between the exchanges. The partial alignment model provides the Exchange with the flexibility to select QHPs that provide an optimal level of choice for participants, while limiting additional administrative expenses and maintaining negotiating leverage with health plan issuers. Issuers bidding to offer coverage in the individual Exchange will be required to also submit bids to participate in SHOP, but issuers may choose to only offer coverage in SHOP without offering coverage in

the individual Exchange.

- SHOP benefit designs. Generally speaking, the Exchange will offer similar benefit designs in the individual and SHOP exchanges but the Exchange will also consider issuer proposals for alternative benefit designs if it will provide more choice and opportunities for innovation in design that would benefit consumers.

- Extent of employer vs. employee choice. SHOP employers will choose the tier (metal level) of coverage available to their employees, and employees will be able to choose any QHPs offered by an issuer in that coverage tier.

- SHOP agent strategy. In the SHOP, the Exchange will set and pay SHOP commissions to Agents based on market competitive small business commissions. General Agents serve as intermediaries between the SHOP and agents and provide sales support and enrollment assistance for agents in the SHOP market segment. General agents will be compensated by the Exchange according to a separate contractual agreement. Agents will not be required to utilize the services of a General Agent. They will have the choice to work directly with the Exchange or through an Exchange-approved General Agent. To ensure that agents are prepared to support SHOP enrollment by January 2014 the Exchange has defined agent enrollment goals by year. The Exchange anticipates in its early months of operation a sizeable number of agents will seek certification and appointment with the SHOP, and the number of participating agents will grow consistently thereafter.

- Small employer benefits administration and ancillary benefit options. Both the individual Exchange and the SHOP will offer supplemental dental and vision benefits. The Exchange will evaluate in the coming months to the extent to which it is desirable and feasible for the California SHOP to offer other benefit administration services for small employers such as, COBRA, Cal-COBRA and health savings account administration.

- Employer contribution and participation options. The California SHOP will use the same contribution and participation requirements allowed generally in the small group market under California law.

Organization and Human Resources

During the Level 2.0 grant period, Covered California will be actively recruiting to fill staff vacancies consistent with the Level 2.0 budget and staffing plan included as part of the budget in this application. A primary area of hiring focus will be recruitment of the Service Center staff which will account for over 70 percent of the overall staff. In addition, the Exchange will be recruiting for key personnel on the Executive team including, Chief Financial Officer, General Counsel, Director of Product Development and Sales, and a Director of Research.

The Exchange will also be focused during this grant period on assessing and supporting staff development. This includes training, coaching and team building activities to ensure the growth and evolution of the Exchange through launch, implementation, sustainability and beyond.

Finance and Accounting

The goal of the financial management function for the Exchange is to implement, direct, and maintain high-quality operational coordination, execution, and financial support services that fully meet the organization's current and future operational, financial, accounting, auditing, personnel and business service needs.
During the Level 2.0 grant period, the Exchange will continue to build its internal financial management capacity and systems including the following activities:

- Development of internal tracking and reporting mechanisms to effectively manage and allocate funds from multiple federal grants and distinct budgeted elements;

- Development and refinement of internal policies and procedures to ensure financial activities are handled responsibility, including oversight of spending, payments and contract management;

- Development of process flows to illustrate the management and reporting of premium payments for both the individual and SHOP exchanges, including developing interagency agreements with the State Controller and State Treasurer;

- Convening and supporting a health plan technical workgroup composed of issuer representatives to assist the Exchange with the development of financial processes and required interfaces for the management of premium payment processing in both the Individual and SHOP exchanges.

Covered California is committed to improving internal systems to prevent waste, fraud and abuse of Exchange revenues. During the Level 2.0 grant, Covered California will revise and expand its fraud prevention activities to include development of a multi-year plan for the prevention of waste, fraud and abuse related to federal Exchange grant funds. In addition, the Exchange will continue to refine and adjust the Exchange financial sustainability plan consistent with state and federal requirements, and the Covered California vision, mission and values, inviting and incorporating stakeholder input, for submission with the Level 2.0 Exchange Establishment grant.

Technology

The mission of the Exchange information technology program is to deliver quality services, support and technical solutions to achieve the business objectives of Covered California. The Exchange IT division aims to provide agile, cost-effective, innovative, reliable and secure technology that meets current and future information management and operational services. The services provided by the Exchange information technology division will include IT support for exchange operations, financial management, health plan management, SHOP, program integration, eligibility and enrollment, consumer assistance and outreach.

Covered California is and has been engaged from its inception in rigorous analysis and system design to develop the information technology capacity to support Exchange functionality and operations. CalHEERS is now in the design phase and during the period of the Level 2.0 grant will continue through design, testing and operational phases. The Exchange IT solution will be developed in conformance to DHHS guidance and requirements.

During the Level 2.0 grant period, the Exchange will continue development, testing, implementation, and initial operations of CalHEERS, which will serve as consolidated support for eligibility and enrollment in Exchange programs, and the launching of the single application that will provide access to programs offered by the Exchange as well as Medi-Cal. The Exchange will continue to work with its contractors, including the Systems Integrator to develop and operate CalHEERS, Project Management and Technical Support Services Contractor to support the Exchange throughout the CalHEERS development, and the Independent Validation and Verification Contractor to provide ongoing assessments and reporting on the project.

Prior Level 1 grants included funding for the first twelve months of the above-listed contracts, staffing, and other operational contracts/agreements supporting the CalHEERS project. The Level 2.0 IT budget request is based on the contracts listed above and the work done to date to identify the IT systems and supports that will be needed

to comply with provisions of the ACA. IT systems analysis, design, and development has been an early and sustained activity of the California Exchange, and the proposed budget is based on extensive research, expert consultation, refinement of development strategies and collaboration with DHCS. The budgeted amounts for IT are based on actual expected costs and contract development with the vendors who will perform the work.

During the course of the Level 2.0 Grant period, the CalHEERS project will accomplish the development and implementation of the following major features:

- Interfaces with the current MEDS (the central Medi-Cal eligibility data index), SAWS (the Statewide Automated Welfare Systems) that support public assistance eligibility processes at the county level, and the infrastructure and architectures of MRMIB, Franchise Tax Board, Employment Development Department, State Controller's Office, and State Treasurer's Office;
- Work products and deliverables for and supporting the Exchange throughout the Detailed Design Consult (DDC), Final Detailed Design Review (FDDR), Pre-Operational Readiness Consult (PORC), and Operational Readiness Review (ORR);
- Enrollment web portal by July 1, 2013 to enable consumers to use anonymous screening, shop and compare tools, SHOP employers to register and setup accounts, and assisters to register to prepare to support Open Enrollment on October 1, 2013;
- By September 28, 2013, the functionality to enable citizens to determine if they are eligible for health benefits and to enroll with health plans;
- Functionality to complete the Baseline CalHEERS by January 1, 2014 to enable Exchange staff to fully utilize the back office components of CalHEERS and the remaining reporting functionality and consumers to gain access to more robust plan management tools.

Through December 31, 2014, the System integrator will continue to operate CalHEERS including:

- Application Support Services, which include Service Management, Release and Configuration Management, and Technical Support.
- Hosting Support Services, which include Managed Hosting, Systems Management, Storage Management, Network Management, Data Center Services, and Disaster Recovery.

Privacy and Security

Covered California recognizes the responsibility it has to adequately safeguard the privacy and security of personal and business information it will obtain in operating the individual and SHOP exchanges, including personal information, small business identifiers, social security number, home addresses and contact information, protected health information, and financial data such as credit card numbers and security codes. To this end, Covered California has been diligent in its efforts to build and support stringent privacy and security protections for its many clients – consumers, health plans, small business, etc.
The CalHEERS design incorporates security measures within the program's overall governance framework. Specifically for security, governance is a specialized and focused component of the larger program's governance structure. This security governance structure maintains accountability, ownership, decision-making capabilities, and policy.

CalHEERS design and functionality incorporates protections to ensure compliance with federal and state privacy laws and standards including:

- **Federal mandates:** Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health (HITECH) Act, ACA, Internal Revenue Service (IRS) regulations, Social Security Administration privacy and security requirements, privacy laws, requirements imposed by CMS, IRS Standards – Publication 1075, and the IRS Safeguard Procedure Report;
- **State-level Considerations:** DHCS requirements, notifications and state privacy laws; and
- **Standards:** Federal Information and Security Act (FISMA), National Institute of Standards and Technology (NIST), Federal Information Processing Standards (FIPS), and Medicaid Information Technology Architecture (MITA), and the CMS Minimum Acceptable Risk Standards for Exchanges (MARS-E).

CalHEERS Enterprise Security Framework is used to fulfill the applicable security requirements contained in the CMS MARS-E Suite. This establishes a standard approach to developing the appropriate security protections, to plan for security risks, and to ensure that data is exchanged with Interface partners safely and securely.

Oversight, Monitoring and Reporting

Even in the first months of planning, the California Exchange Board identified "results" as a core value. Throughout the planning and establishment process, Covered California relied on background research and external benchmarks to measure progress and quantify success with the ultimate triple aim goal of: 1) better care, 2) lower cost and 3) improved population health. The specific goals of evaluation for Covered California are: (1) Determine Exchange success and effectiveness in achieving its mission and vision; (2) Assess the performance of the Exchange as an enterprise; and (3) Ensure that state and federal reporting requirements are met. The Exchange evaluation process is anchored in its values and the following implementation principles:

- Regularly evaluate effectiveness of programs and policies.
- Identify trends to enable continuous improvement.
- Inform evidence-based decision making.
- Identify disparities in access, utilization and quality.
- Align evaluation measurement with state and federal efforts.
- Partner broadly to assess impact on the health care system.
- Share findings broadly.

During the Level 1 grant periods, the Exchange initiated internal evaluation planning engaging health care and health insurance experts and researchers, diverse stakeholders and state partner agencies to develop and begin to collect essential baseline data for implementation of a long-term evaluation plan. The Exchange contracted with NORC at the University of Chicago to help in organizing the evaluation planning process and established an evaluation advisory panel of independent experts in research, program evaluation and performance measurement.

In collaboration with the advisory group, state partners, and Covered California senior leadership, NORC developed a logic model, based on the Exchange mission statement, to inform the evaluation planning process. Building on the model, NORC developed a draft evaluation plan with proposed evaluation questions, data sources and indicators, including relative levels of direct Exchange accountability and control. The Plan calls for Covered California to hold itself most accountable for the strategies and actions over which it has the greatest influence, such as increasing the number of Californians with health insurance or improving the affordability of

coverage, but the Plan also calls for the Exchange to track and measure long term system impacts from health reform where the Exchange is only one actor in affecting the outcomes.

During this Level 2.0 grant period, Covered California will finalize and implement the preliminary evaluation work of NORC through design of consumer and plan satisfaction surveys, development of data sets to measure and monitor operations, and establishment of baseline comparisons for evaluation of Exchange functionality based on internal targets, external indicators and peer groupings with other state-based Exchanges.

Contracting, Outsourcing and Agreements

From the outset, Covered California has strategically partnered with outside experts to leverage limited state and federal resources during the critical start-up phase of the Exchange. One of the first actions taken by the Board was to approve competitive awards of vendor contracts to assist in developing a business operations plan, defining IT parameters, and charting a strategic and sustainable course of direction for Covered California.

As the Exchange has evolved, so, too, has the contracting and outsourcing process. For the past year, Covered California has followed an interactive, systematic approach that involves a five-part public vetting of major vendor contracts: 1) enlisting internal and external experts in development of draft solicitations; 2) releasing draft solicitations publicly to solicit input and stakeholder comment; 3) integrating feedback into the final solicitation; 4) reissuing final solicitation, and 5) assembling subject matter experts to critically evaluate the strengths and weaknesses of vendor proposals before awarding a final contract.

As needed, the Exchange involves California's Department of General Services in the acquisition of consulting services. All approved contracts are in compliance with state and federal rules and are further subject to Covered California's Board-adopted conflict of interest code. The contracting process has allowed the Exchange to extend the goals of the ACA to vendors by embedding contract language requiring strict privacy and security standards among other key deliverables.

Covered California is interdependent with multiple state government departments and has actively partnered with other programs by establishing interagency agreements with DHCS and MRMIB. During the Level 2.0 grant period, the Exchange will develop additional agreements with other state agencies as outlined throughout this grant narrative.

Vendors, contractors and consultants have played a crucial role in the "stand-up" of the Exchange, providing a bridge from the first year of start-up operations to a fully operational, self-supporting and financially self-sustaining Exchange.

Challenges to Completion of the Level 2.0 Work Plan

As this application underscores, Covered California has been forcefully pressing ahead since its inception to analyze state conditions and capacities, and to assess the resources, activities and timing needed, leading to full and successful operation of the Exchange by January 1, 2014. While the timelines are aggressive, and the work plan activities substantial, the Exchange views those aspects of the work as not only challenges but also as public expectations and hopes that it can deliver quality coverage options to eligible Californians on time and as envisioned by the ACA and the CA-ACA. As the Level 2.0 grant period unfolds, the California Exchange expects to continue its approach of collaboration, consultation and flexibility in order to achieve the goals and milestones of the Level 2.0 work plan and to overcome any challenges that arise.

The Exchange has a dedicated team of Board members, leadership and staff, state partners and engaged stakeholders committed to success of Covered California at all levels. The staff works tirelessly to accomplish the tasks and deliverables set out by the Board and its planning process and actively engages consultants and external resources to support its core operations and meet goals and timelines. California works very closely with CMS and CCIIO to provide regular updates on progress and challenges. Covered California looks forward to continued federal support and guidance, including additional guidance on key ACA requirements that will help to inform its development and implementation efforts. The California Exchange will continue to keep CCIIO apprised of progress during the Level 2.0 grant and notify it of any potential delays that would impede progress on the work plan.