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Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges

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E. Project Narrative

The California Health Benefit Exchange (California Exchange) has been working since it was established through state legislation in 2010 to lay the groundwork for the unprecedented expansion of coverage that will benefit millions of Californians starting in 2014. The California Exchange has made, and continues to make, dramatic progress through accelerated planning and development activities undertaken during the state's first Level I Exchange Establishment grant now in progress, August 15, 2011 to August 14, 2012. The work of the California 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 the California Exchange.

In partnership with the federal government, the California Exchange is seeking to continue and expand its planning, development and implementation activities for a state-administered Exchange through a second federal Level I grant (1.2) as outlined in this application. This project narrative describes progress in core planning areas during the current Level I grant and outlines the proposed program activities for the second Level I grant period, August 15, 2012 to June 30, 2013. The California Exchange expects to develop and submit additional funding Establishment grant applications, including the Level II establishment grant application, prior to the end of this proposed Level I grant (1.2) period.

a. Demonstration of Past Progress in Exchange Planning Areas

The California Exchange is making significant progress in the development and implementation of the programs, systems and support services that will be needed for a state-administered California Exchange anticipated to provide health coverage for nearly 3 million Californians at full implementation in 2016. The California Exchange demonstrated progress in the core areas and work plan items of the first Level I grant (1.1), meeting, and in many cases exceeding, the objectives and tasks identified in that first work plan.

Progress to date includes the following significant accomplishments:

- Refining with public input and stakeholder participation the mission, vision and values driving the creation of the California Exchange and specific policy principles to inform activities in major core areas;
- Holding regular, well-attended public Board meetings with extensive public participation and adopting systematic strategies and processes for stakeholder input and participation;
- Defining 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 securing 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, engaging 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 applications in Medi-Cal (California's Medicaid program) and Healthy Families (California's Children's Health Insurance Program (CHIP)), and securing through competitive solicitations consulting and expert resources to build, refine, and launch CalHEERS functionality by mid-year 2013;

- Developing and cultivating 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 the California Exchange and the Affordable Care Act (ACA);
- Recruiting and hiring key senior managers and knowledgeable staff to manage and conduct Exchange activities and core functions; and
- Developing internal business, operational and financial management systems and processes to support the work of the Exchange.

Below is a status report on the progress and activities of the California Exchange in the Level I grant (1.1) as originally outlined in the grant work plan submitted and approved in 2011.

Strategic Visioning

During the grant period, the California Exchange engaged Board members, stakeholders and staff in a public and inclusive process of strategic visioning to inform the development and implementation of the Exchange going forward. The resulting vision, mission and values shown below in Figure 1 are integrated into all planning and operational activities of the Exchange and will continue to be the foundation for ongoing implementation and operations.

Figure 1 California Exchange
Vision, Mission and Values
*The **VISION** of the California Health Benefit Exchange is to improve the health of all Californians by assuring their access to affordable, high quality care.* *The **MISSION** of the California Health Benefit Exchange 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.* *The California Exchange holds six core **VALUES**: 1) consumer-focused, 2) catalyst, 3) affordability, 4) integrity, 5) partnership, and 6) results.*

Business and Operational Planning

During the early months of the grant period, the California Exchange engaged in business and operational planning to identify major work areas and timelines consistent with federal requirements and practical operational considerations for establishing a fully functional Exchange by 2014. The California Exchange contracted with Public Consulting Group (PCG) to support business and operational planning and to provide staff support resources to plan and track day-to-day operations while the Exchange actively recruited and hired permanent state staff. In many instances, the California Exchange was able to rely on experienced part-time state retirees with critical expertise to help provide temporary staff support and management assistance.

The initial business and operational planning process identified four functional areas for active planning and development during the Level I grant (1.1) period: (1) Eligibility and enrollment program elements, including design and development of CalHEERS; (2) Consumer outreach, marketing and assistance; (3) Qualified health plan selection, certification and management; and (4) the Small Business Health Options Program (SHOP). Work begun in 2010 to conduct information technology (IT) system analysis and design continued. During the 1.1

grant period, the California Exchange released detailed solicitations for vendors and consultants in each of the four functional areas, managed proposal review and vendor selection processes and executed contracts with selected consultants and vendors. Throughout the process, draft solicitations were subject to public review, comment and revision while all vendor contracts incorporated concrete deliverables, timelines and contract performance measurement provisions.

During May and June 2012, the California Exchange engaged the Board, staff and senior managers in a more detailed planning and budgeting process guided by its vision, mission and values and the following principles:

- ***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 resulting Business and Budget plan for the period August 15, 2012 through June 30, 2013 identified organizational units and business functions, proposed staffing and outside vendor services and budget levels by core area. The planning process was a key element in the development of this proposed grant application and budget and will serve as an organizational benchmark going forward.

Background Research

Background research continues to be essential to decision-making and policy development for the California Exchange. During this first Level I grant (1.1) period, the California Exchange adopted and consistently uses an evidence-based policymaking framework to guide decision-making (see Figure 2).

Figure 2 **California Health Benefit Exchange** **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 also fortunate to have significant in-state research and policy resources including world-renowned research universities, private foundations dedicated to health research and health policy, and other independent organizations engaged in health and health policy research. As a result, the California Exchange Board and staff regularly access and constantly seek existing information sources to inform development and planning activities. When necessary, the Exchange also commissions issue-specific or market-specific research and data gathering when a data gap or need for specialized research or information is identified. Below is an illustrative list of some of the existing relevant research used by the California Exchange to inform its planning to date:

- The California HealthCare Foundation and The California Endowment sponsored research and published multiple reports on California's insurance market, state Exchange models and options and potential impacts of the Affordable Care Act. In addition, research on enrollment and the potential impacts of the coverage provisions of the Affordable Care Act conducted by external organizations such as the Blue Shield Foundation of California with Jonathan Gruber of the Massachusetts Institute of Technology, the Urban Institute, Families USA, the Kaiser Family Foundation and RAND were early resources for initial planning and strategic planning.
- The Blue Shield of California Foundation supported technical analysis in the early stages of planning for the CalHEERS procurement which provided valuable information regarding the "as-is" environment and alternative approaches for the Board to consider.
- Pacific Community Ventures, a California-based nonprofit organization which works to create jobs and economic opportunity in lower-income communities, conducted a study and released a report entitled, *"Health Care and Small Business: Understanding Health Care Decision Making in California"* (October 2011). The report details the demographics of small business owners in California, how and why they make decisions to offer health insurance (or not), who they trust as sources of information about health care, and how likely they are to respond to the new online California Exchange and tax credit provisions as the Affordable Care Act is rolled out. Report authors presented their findings to the Board in December 2011.
- Several California-based consumer stakeholder and advocacy groups, such as the California Pan-Ethnic Health Network, Western Center on Law and Poverty, The Children's Partnership, Consumers Union and Health Access developed papers on Exchange-related topics, such as creative approaches to eligibility and enrollment, health literacy, and consumer preferences and needs related to choosing among health care coverage options.

The California Exchange also commissioned new focused research, which included:

- The California Exchange contributed funding, along with The California Endowment, for the California Simulation of Insurance Markets (CalSIM) jointly developed by the University of California (UC) Berkeley Center for Labor, Research and Education and the University of California at Los Angeles (UCLA) Center for Health Policy and Research. CalSIM, developed with extensive input from stakeholders and potential data users, including California-based consumer organizations, is a California-centric, micro-simulation model that estimates the effects of the Affordable Care Act 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. Building on California-specific research by the California Pan-Ethnic Health Network, immigration status and English proficiency are integrated in order to generate "take-up" predictions. The CalSIM model then simulates the coverage decisions of employers to offer insurance and decisions of individuals to take up in private markets and public insurance programs. To inform development of CalSIM, the California Exchange convened a panel of national experts to recommend elements and revisions for the model. The California Exchange has and will continue to use demographic profile data on potential eligible

populations developed by UC and CalSIM to help shape marketing and outreach strategies. This research is ongoing and iterative and capable of including additional variables and factors as the need arises and data are available.

- The California Exchange engaged Milliman, an independent actuarial and consulting firm, to conduct a preliminary analysis of the available benchmark options for essential health benefits in California as described in the Department of Health and Human Services (DHHS) December 16, 2011 Bulletin. Milliman provided a point-in-time comparative analysis of the relative costs, services and benefits of the benchmark options which is posted on the California Exchange website and is helping to inform California's decision-making in this area.

To contribute to the knowledge and research base for the Board, staff and stakeholders, the California Exchange also organized expert panel presentations during Board meetings, so far involving nearly 35 national, state and local subject matter experts highlighting lessons learned, evidence-based practices, and model programs across a range of topics and issues. The panels covered qualified health plan contracting and delivery system reform; communication, outreach and enrollment, including branding, marketing, consumer awareness and the role of navigators and assisters in supporting enrollment; public and private customer service center programs and call centers; and the Small Business Health Options Program (SHOP), including historical experience and lessons learned from previous California small employer purchasing programs.

Stakeholder Consultation

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.

Serving as a Resource

The California Exchange serves as a resource, information clearinghouse and discussion forum for stakeholders across the state; posting on the Exchange website information regarding federal rules and guidance and state responses, policy and program issue proposals and background, and written stakeholder comments and feedback. In addition, the Exchange regularly communicates electronically with more than 2,000 individuals who have signed on to its listserv. Exchange staff and Board members are invited to participate in meetings, events and conferences throughout the state, where attendees receive information and updates on activities and planning by the California Exchange and have opportunities to provide input and ask questions in real-time.

The California Exchange has also participated in the stakeholder work group focused on Assembly Bill 1296 (Chapter 641, Statutes of 2011), the Health Care Reform Eligibility, Enrollment, and Retention Planning Act, which requires the California Health and Human Services Agency (CHHS), in consultation with Department of Health Care Services (DHCS), Managed Risk Medical Insurance Board (MRMIB), the California Exchange, the California Office of Systems Integration, counties, health care service plans, consumer advocates, and other stakeholders, to plan and develop standardized single, accessible application forms and related renewal procedures for state health subsidy programs and to identify the policy and statutory changes needed to develop and implement the proposed system for health coverage.

Public Board Meetings

The California Exchange holds public Board meetings at least once a month and is governed by the state Bagley-Keene Open Meeting Act of 2004 requiring that all meetings of state boards and commissions be publicly noticed with an agenda at least ten days before the meeting and that the public have opportunity to provide comment at the meeting. On average, Board meetings draw 150 attendees with public comment provided by one-fourth of all participants. In addition, all Board meetings are webcast with opportunities for phone participants to ask questions or make comments. Board meeting minutes, agendas, meeting materials and stakeholder comments received are publicly posted on the website. In addition, Board meetings are held throughout this very large and diverse state to engage local communities in the discussions.

Small Group Stakeholder Meetings

During the grant period, California Exchange staff, together with state program partners (DHCS, Medi-Cal) and (MRMIB, Healthy Families), jointly convened 17 small group stakeholder meetings throughout the state. In these sessions, consumer advocates, providers, county representatives and health insurance agents discussed marketing, eligibility, enrollment, and retention issues affecting public coverage programs and the Exchange. Participants represented 25 of California's 58 urban and rural counties. The California Exchange posted online and distributed at Board meetings a detailed summary of the meetings and findings: *"Achieving Health Care Coverage Success in 2014 and Beyond: Stakeholder Input on Strategies for Marketing, Eligibility, Enrollment and Retention."*

Seeking feedback on qualified health plan issues, the California Exchange held five stakeholder sessions with more than 100 health care providers, consumer advocates, brokers and business representatives in rural communities and urban centers and posted online and distributed at Board meetings a summary of the feedback received: *"The California Path to Achieving Effective Health Plan Design and Selection and Catalyzing Delivery System Reform: Stakeholder Input on Key Strategies."*

Soliciting Feedback on Draft Work Products and Policies

The California Exchange has a consistent practice of seeking and relying on in-person and written stakeholder feedback on vendor solicitations and contract scopes of work, Board option and recommendation issue briefs, contractor reports and recommendations, defining principles in core areas and financial and budget planning documents. Just a few examples of this active process of seeking stakeholder input during the period of the grant include:

- Comment requests on draft vendor solicitations including multiple CalHEERS related vendor solicitations, solicitations for consultants on outreach, marketing and consumer assistance, qualified health plan management and delivery system reform and SHOP implementation. By way of illustration, the Exchange received comments from dozens of entities, with more than 1,300 specific comments and recommendations submitted from stakeholder groups on the draft CalHEERS vendor solicitation. Feedback received resulted in revisions to the final solicitations and vendor contracts in all cases.
- Requests for written responses to subject matter questions related to core area activities such as marketing, eligibility, enrollment, and retention questions and options for qualified health plan selection and management. The California Exchange compiles the comments received and posts online detailed summaries by topic area.
- Prior to final submission, public and stakeholder input regarding draft state comments on proposed federal rules developed jointly with state partner agencies.

Scheduled Meetings and Webinars
The California Exchange held regular meetings of two stakeholder working groups on individual Exchange eligibility and enrollment and on SHOP eligibility and enrollment. The Exchange also offered four information and feedback sessions via webinar to solicit input on marketing, outreach, eligibility and enrollment.

Legislative and Regulatory Action

Prior to the Level I grant (1.1) period, in the Fall of 2010, California enacted the necessary enabling state legislation for the California Exchange, the California Patient Protection and Affordable Care Act (CA-ACA). In addition, 2010 and 2011 legislation provided state authority and direction for the implementation of many of the early federal reforms.

The California Exchange works in partnership with other state agencies and programs on state legislation, regulation and federal reform implementing activities. The Exchange collaborated with Department of Health Care Services (DHCS) and the Managed Risk Medical Insurance Board (MRMIB), and state health insurance regulators, California Department of Insurance (CDI) and Department of Managed Health Care (DMHC), to develop and submit joint comments on federal proposed regulations that will impact the California Exchange and other programs. The California Exchange engaged stakeholders during the development of comments to understand the impact of the proposed regulations on California consumers, providers and plans, as well as the business community.

During the period of the grant, the new Director of Government Relations assumed lead responsibility for working with federal and state policy makers on state and federal legislation, regulations and implementation activities. The Exchange Board authorized staff to provide technical assistance and input on legislation now pending in the 2011-12 California legislative session, including bills relating to changes in the individual and small employer markets, essential health benefits and other federal reform provisions. The California Exchange often serves as the catalyst for bringing state agencies together to discuss and consider policy issues and joint opportunities for action and collaboration on cross-cutting issues affecting multiple state programs and agencies.

Health Insurance Market Reforms

During the grant period, the California Exchange continued to conduct research and analysis on the federal market provisions in law and emerging federal rules, comparing federal reforms to existing state law and identifying the implications for Exchange selection, certification and monitoring of participating health plan issuers and qualified health plans. Additional state legislative action will be needed to conform state law to Affordable Care Act market reform provisions effective 2014 and the California Exchange is tracking pending state legislation, participating in and often convening collaborative issue analysis and discussions, and providing technical assistance on state legislation affecting the Exchange.

It is clear that the health insurance market reforms in the Affordable Care Act will result in sweeping changes to California's private insurance market. For illustration purposes, the California HealthCare Foundation(CHCF) *Snapshot: California's Individual and Small Group Markets on the Eve of Reform,* highlights point-in-time characteristics of California's existing markets. In 2011, California's individual and small group health insurance markets served just under 15% of the state's population — about 5 million people altogether. Additional findings in the *CHCF Snapshot* include:

- In 2011, approximately 2.1 million Californians purchased individual health insurance and an estimated 3.4 million received coverage through group plans purchased by small employers.

- About 40% of those purchasing individual coverage would have qualified for subsidies through the Exchange, and another 18% would be eligible for Medi-Cal, if 2014 rules had been in effect in 2011.
- Age-rated premiums for individual coverage varied by age as much as five-fold, in contrast to the Affordable Care Act requirement limiting these differences to three-to-one.
- Anthem Blue Cross PPO had 40% of the individual market, followed by Kaiser Health Maintenance Organization (HMO) (17%) and Blue Shield Preferred Provider Organization (16%).
- Individual insurance provided less comprehensive coverage than group coverage, paying an average of 55% of medical expenses, compared to 80% to 90% of expenses for group coverage. Of the 2 million Californians who purchased private individual coverage, 70% of individuals were in high deductible plans as compared to 1% of large group enrollees.
- 2 million of the more than 5 million uninsured Californians live in a household headed by someone who works in a small business with fewer than 50 employees.
- The small group market in California is dominated by Kaiser (22%), Anthem (22%) and Blue Shield (20%).
- More than half of all California workers are enrolled in an HMO product.

The California Exchange actively works with state partner agencies, including California's two health insurance regulatory agencies, CDI and DMHC, to monitor and ensure state compliance with and enforcement of federal health insurance market reforms. DMHC regulates HMO products and some PPO products, while CDI oversees the remaining PPOs and traditional indemnity coverage. Health insurance market reforms are made more complex in California because of the two state regulatory agencies, requiring ongoing legal and regulatory analysis of the relationship between federal reforms and state law.

Governance

Under CA-ACA, the California Exchange is an independent state entity governed by a five-member Board whose members are appointed by the Governor and Legislature. As noted in the stakeholder consultation section, the Board is fully constituted, all meetings are public and subject to California's Bagley-Keene Open Meeting Act and Board and Exchange documents are regularly posted on the public Exchange website. Key accomplishments of the Board during the grant period include:

- Recruiting and hiring Peter V. Lee as Executive Director, and with his leadership bringing on other senior staff including the Chief Operating Officer, Chief Technology Officer, Chief Financial Officer, General Counsel, Deputy Chief Operations Officer, Deputy Director of Eligibility and Enrollment, Director of Program Policy, Director of Government Relations, CalHEERS Project Director and SHOP Director;
- Adopting conflict of interest standards and policies for Board members, external consultants and Exchange staff;
- Establishing a deliberative process to adopt the organizational Vision, Mission and Values; and
- Developing internal policies and processes to support Board meetings and decision-making.

The Board, staff and contractors of the California Exchange are subject to appropriate provisions of the California Political Reform Act and implementing Conflict of Interest Code provisions adopted by the California Fair Political Practices Commission. During the period of the Level I grant (1.1), the Exchange Board also adopted a separate Exchange conflict of interest code consistent with the CA-ACA and specific to the duties and activities of the California Exchange (see Appendix I). The Board also adopted organizational bylaws for the Exchange consistent with state and federal laws applicable to Exchange operations, outlining Board membership, powers and duties, committees, meeting procedures and other operational aspects of the Exchange.

The Board follows a decision making process which is built on public discussion and airing of potential options and policies under consideration at one publicly noticed Board meeting with decisions typically made at a subsequent publicly noticed Board meeting. In addition to the underlying evidence-based policymaking framework adopted by the Board, staff implemented a consistent and progressive process for providing issue background and options briefings to the Board as follows: (1) Board Background Briefing -- includes issue background information without options; (2) Board Options Briefing -- includes options for consideration; and (3) Board Recommendation Briefing -- includes options and recommendations for board action. Under state law, the Board has authority to discuss issues relating to personnel and contracts in closed session, subject to provisions of the state open meeting law. In instances where time is of the essence, the Board can and does, by public vote and resolution, from time-to-time 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. During this period, the Board also developed and adopted bylaws for Board governance and action.

Program Integration

As outlined in numerous sections of this progress report, the California Exchange works closely with state health programs, health insurance regulators and other state agencies and programs in development of the California Exchange and to lay a foundation for implementing the Affordable Care Act. Key areas of collaboration include development of joint vendor solicitations where appropriate, joint responses to proposed federal regulations, shared stakeholder consultation strategies and forums, and collaborative analysis of federal statute and implementing regulations compared to state law.

The California Exchange, DHCS and MRMIB released joint solicitations for design and development of CalHEERS, a project that is jointly governed by representatives of these three entities, and for a joint Marketing, Outreach, Education and Assisters Program discussed in more detail in the related core areas. The California Exchange collaborated with DHCS, MRMIB, DMHC, and CDI to develop 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.

Finally, the California Exchange worked with DHCS, MRMIB, DMHC, CDI and the Legislature to analyze potential benchmark plan options for California based on the essential health benefit federal bulletin. The Exchange led the analysis by securing the services of Milliman consulting to provide an initial analysis of the options. California's benchmark for essential health benefits will be the subject of state legislation since under federal law will apply to health insurance products both inside and outside of the Exchange.

California Exchange IT Systems

The California Exchange is making significant progress toward designing and building the IT systems needed to support Exchange business and operational processes, including the design and development elements of CalHEERS. CalHEERS will serve as consolidated support for eligibility and enrollment in Exchange programs, Medi-Cal and Healthy Families.

During the period of the grant, the California Exchange, DHCS and MRMIB established an Executive Steering Committee composed of the executive leads of each agency 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 the requirements of the Affordable Care Act, to maintain and operate the software functionality, and to provide related services. 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.

DHCS and MRMIB also administer and oversee a number of individual health care service delivery programs that will be served by the new system. Each of these agencies will retain authority over the system design related to their programs. The primary business objective of CalHEERS is to provide a "one-stop shop," "no wrong door" system for determining eligibility for non-subsidized coverage for individuals in the California Exchange and subsidized coverage for individuals eligible for the following Applicable State Health Subsidy programs:

- Modified Adjusted Gross Income (MAGI) Medi-Cal;
- Children's Health Insurance Program (Healthy Families);
- Access for Infants and Mothers (AIM);
- Advanced premium tax credits in the California Exchange; and
- Cost sharing reductions in the California Exchange.

CalHEERS business functionality will include eligibility and enrollment, financial management, health plan management, reporting, outreach and education, consumer assistance and SHOP support.

The California Exchange, in partnership with DHCS and MRMIB, shared draft concepts for the enrollment IT systems at board meetings and held additional public meetings throughout the state (see Stakeholder Consultation), collecting and reviewing written feedback and comments on program and design elements. 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 Affordable Care Act resources and make the solutions developed under this solicitation widely available to support federal or other states' efforts to implement the Affordable Care Act.
- ***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.

The selected CalHEERS contractor will serve as a system integrator charged with design, development and deployment of functionality to meet the requirements of the Affordable Care Act relating to the California Exchange, Medicaid and CHIP. Notification of intent to award the contract to Accenture was issued on May 31, 2012.

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 Affordable Care Act 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" is having the appropriate mix of staff and consultants retained to launch, operate and sustain the California Exchange.

During the grant, the California Exchange developed and maintained 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). CDSS assists 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. The California Exchange initiated internal policies and procedures to comply with state and federal requirements related to California Exchange operations.

Oversight and Program Integrity

The California Exchange is committed to implementing an effective program to prevent waste, fraud and abuse with funds used to start up and operate the California Exchange. The California Exchange Board adopted integrity as one of its core values, defined as earning the public's trust through its commitment to accountability, responsiveness, transparency, speed, agility, reliability, and cooperation. Strategies include getting outside expertise to review planning processes and decisions and building checks and oversight into major contracts. Further, the Board adopted conflict of interest standards and policies for designated personnel, consultants and new hires.

The California Exchange regularly uses outside expertise in its contracting processes to build an additional level of oversight and monitoring. The California Exchange hired retired annuitants with extensive procurement expertise to set up contracting processes. Major solicitations are reviewed prior to release by partner organizations including the DHCS, MRMIB and the California Health and Human Services Agency.

Consumer Assistance -- Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints

In order to deliver on the Affordable Care Act goal of a "no wrong door" service system that provides for a consistent and quality consumer experience at all entry points, the California Exchange is investing resources to 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.

In addition to CalHEERS functionality, during the Level I grant (1.1) period, California has been exploring the most effective strategies to assist Exchange enrollees and potential enrollees, including: (1) Development of a robust Assisters Program, including Navigators, who will provide individualized services to persons who require help navigating the eligibility and enrollment process, and (2) Establishment of a consumer assistance function that supports consumers from the point of enrollment inquiry to post-enrollment problem resolution.
During the grant period, the California Exchange released a communications solicitation for development of a marketing, outreach and education campaign and plan, including a proposed design of the Assisters Program. The contract was awarded to Ogilvy Public Relations Worldwide who in partnership with Richard Heath and Associates (RHA) developed a comprehensive plan of outreach, marketing, education and consumer assistance.

<u>Assisters (including Navigators)</u>
Enrollment "assisters" offered through trusted and known channels will be critical to building a culture of coverage so that as many consumers as possible enroll in affordable health insurance. The California Exchange Assister Program must help individuals overcome complex and diverse barriers to enroll into coverage, and must

also provide information and services in a fair, accurate, impartial and culturally linguistic manner. In the early years of implementation, RHA estimates 50% to 75% of consumers may need some type of assistance in order to successfully enroll. During the Level I grant (1.1), RHA developed and presented a draft Assisters Program plan to the Exchange Board, outlining options and recommendations for the role, eligibility and standards, training, recruitment and compensation of "Assisters," including Navigators as required in federal law.

Stakeholders submitted a large volume of comments, which resulted in modifications to the proposed program. After further review and comments from stakeholders, the Exchange Board adopted the following framework for its Assisters Program:

- Certified Enrollment Assisters will be trained, certified and registered with the Exchange and must complete education, eligibility and enrollment activities for individuals. They will assist in completing eligibility requirements for all Exchange products and programs, including subsidies, and assist with the selection of and enrollment in a Qualified Health Plan, Medi-Cal or Healthy Families. Assisters may target specific markets or populations (e.g., low income; cultural and linguistic groups).
- Assisters 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.
- Assisters must be certified annually after completing any required training. Enrollment entities and organizations and their affiliated Assisters must sign a Code of Conduct and other agreements designed to avoid conflicts of interest and steering.
- Assisters must complete training offered by the Exchange 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.
- Only those Assisters that are designated as Navigators will be compensated by the Exchange (from its operational funds). Navigators will receive $58 for each successful application resulting in enrollment in an Exchange Qualified Health Plan and may also be compensated for enrollment in Medi-Cal and Healthy Families, depending on securing revenues to support those activities. All other Assisters, including health insurance agents, hospitals and providers, will not be compensated by the Exchange (but may receive compensation from other sources).
- The Outreach and Education Grant Program (to be developed during the proposed grant period as part of Consumer Assistance and Outreach) will be integrated and aligned with the Assisters Program, since the two programs are complementary.
- The Exchange, DHCS, MRMIB or their designated entity will: (1) provide training, technical assistance and professional development for all Assisters; and (2) recruit and monitor the Assisters network in order to ensure geographic, cultural and linguistic access to target markets, as well as program quality and compliance.

<u>Consumer Assistance</u>
Multiple state agencies provide consumer assistance in California. During the Level I grant (1.1) period, the California Exchange initiated collaborative discussions with existing state consumer assistance programs to identify opportunities for collaboration. California's two health insurance regulatory agencies, DMHC and CDI, administer programs to provide consumer assistance and complaint services for enrollees in products subject to their jurisdiction. In 2011, the DMHC Help Center responded to calls from 49,000 individuals and CDI handled more than 25,000 calls. Both departments assisted consumers with grievances and appeals (25,922), referrals to other programs or assistance services (19,567) and independent medical reviews of coverage denials (3,367). Both DMHC and CDI track and provide services to consumers who are limited English proficient and DMHC

provided assistance to 8,000 individuals enrolled in Medi-Cal managed care programs. Since the Exchange will offer QHPs that are overseen by DMHC and CDI, coordination and collaboration with these two agencies will be essential for the Exchange consumer assistance function.

During the Level I grant (1.1), the Exchange met individually with existing state program representatives and also organized a meeting of state agencies currently providing or involved in consumer assistance, including DMHC, CDI, Office of Patient Advocate, DHCS, MRMIB, and CHHS. Participating agencies provided program overviews and information to inform Exchange consumer assistance planning activities and to lay the groundwork for collaborative planning and coordination in the implementation of health care reform.

In 2010, DMHC was awarded $4.1 million to operate California's Consumer Assistance Program (CAP). California's CAP experience and the data collected will be a tremendous resource for the state in many ways, and will help the Exchange in developing coordinated and effective consumer assistance once Exchange programs are operating. California's currently funded CAP program has four 4 major elements: (1) Website enhancement; (2) Consumer education campaign; (3) Communication systems upgrade; and (4) Enhancement of consumer assistance and education programs.

As part of the CAP, DMHC made partner grants totaling $1.6 million to five regional Community Based Organizations (CBOs) which are part of the Health Consumer Alliance. Regional CAP grantees are funded to do all of the following:

- Serving individuals with health care problems, including eligibility problems related to enrollment, retention, application processing, and termination in health insurance programs, or service problems related to billing and payments, quality or appropriateness of care, patient rights, and customer service;
- Accepting certain referrals from the DMHC Help Center, providing referrals for consumers to external review organizations, and referring potential enforcement issues to DMHC, CDI and the U.S. Department of Labor;
- Providing outreach and education to reach people in their communities to make sure consumers actually enroll and know where to go for help with problems;
- Training in-service staff on all facets of CAP service delivery to consumers;
- Utilizing appropriate consumer education and training materials;
- Collecting and reporting data on the number and type of contacts as well as the resolution of consumer issues. HCA submits monthly and quarterly reports to DMHC. This data includes the number and type of consumer issues, summaries of outreach and education activities, and consumer success stories; and
- Statewide management of all program and fiscal components of the project.

Figure 3
California Consumer Assistance Program (CAP) Data
October 15, 2010-April 15, 2012

Case/ Caller type	Number reported
Uninsured	2,229
Insured in Transition	5,174
Insured Other Problems	28,940
Other Assistance Referred	25,695
Information only	15,193
Total	**77,231**

Outreach and Education

With a short timeframe to contact, educate and begin enrolling its culturally and linguistically diverse population, with potential enrollees living in both large urban and remote rural areas spread over a large geographic area, California faces multiple challenges to ensure that it reaches eligible individuals with information about the new health coverage options and with support to help them enroll in the Exchange or other public coverage programs. 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.

The California Exchange and its state partners, DHCS and MRMIB, established the following principles to inform development of the marketing, outreach and education plan:

- ***Promote maximum enrollment of currently uninsured individuals in coverage*** – including subsidized coverage in the Individual Exchange and SHOP, Medi-Cal and Healthy Families programs, 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***. 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.

To develop the outreach and marketing plan, Ogilvy considered California's complex linguistic and cultural diversity, especially among potential enrollees, partners, and stakeholders. Further, the sheer size of California, its expensive and broad media markets (11 distinct media markets and 13 threshold languages) and California's complex urban and rural communities, necessitated collaboration with a wide range of stakeholders, foundations and community leaders. Stakeholders and experts provided ideas on strategies and best practices for marketing, eligibility, assisters/navigators, enrollment and retention programs for communities with distinct cultural preferences and differences, as well as approaches to reach individuals with special literacy, health care literacy or language needs as well as those with multiple language and literacy challenges.

Ogilvy solicited input from a wide variety of sources, including an initial round of four focus groups, as well as Exchange-sponsored meetings held throughout the state, stakeholders, and other state exchanges. Ogilvy conducted focus groups in Los Angeles and Fresno, in English and Spanish, with uninsured participants between the ages of 18-44 years with incomes at or above 138% of the federal poverty level. Many participants had previously been insured but lacked current coverage due to unemployment, lack of affordable options, or aging out of parental plans. Participants were receptive to the idea of purchasing health coverage from a one-stop Exchange that allowed for comparison among plans, but were skeptical that high quality, affordable plans would actually be available. Many were concerned about cost, online security and the ability to talk to someone if they had questions.

The Exchange, DHCS and 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, Ogilvy presented the Exchange Board with a comprehensive seven-phase outreach, education and marketing proposal spanning three years through the end of 2015. (See Figure 4.) The proposed objectives, based on the principles for the project, informing the introduction, launch and implementation of the

campaign as articulated by Ogilvy 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 the 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. Tie the public offerings (Medi-Cal and Healthy Families) and private insurance offerings together under the positive and new umbrella.
- **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 targeted levels, including enrolling 2.8 million Californians newly eligible for Medi-Cal, Healthy Families, subsidized coverage in the Exchange or enrolling in the Exchange without subsidies by the end of 2014.

Exchange staff, working with project sponsor staff, made revisions to the outreach and education recommendations for further Board consideration and action, and in June 2012, the Board tentatively adopted the revised plan for marketing, outreach and education and the framework for the Assisters Program described in the previous section. However, the Board also called for conducting additional research and analysis via focus groups, surveys, and other means to determine the optimal time to launch paid media, in order to finalize the outreach and education plan. The additional analysis will include review and evaluation of the results of existing outreach and public education campaigns, such as the Medicare Part D rollout, to understand the return on investment of various strategies and the most effective use and timing of various outreach and education activities, including paid media.

In response to stakeholder input, the Board increased funding for the Outreach and Education Grant Program to $40 million for the first two years (2013 and 2014). The majority of the grants would be distributed during the timeframe that aligns with the open enrollment period and airing of paid media. In addition, the Exchange and its project sponsors will work with state foundation and private sector organizations to support additional funding for outreach and education grants and other outreach activities. After evaluating the success and impact of the grant program in helping individuals learn about and enroll in insurance affordability programs, including Exchange programs, project sponsors will determine the need for and the optimal structure of outreach and enrollment grants going forward.

Figure 4 California Marketing, Outreach and Education Plan Proposed 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
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 ▪ Continued 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 III 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 III including heavy paid, earned and social media ▪ Evaluation and measurement ▪ All Navigator and Assister activities and update curriculum

Health Plan Management

The primary focus of the California Exchange Health Plan Management function is to offer qualified health plans (QHPs) through the Exchange that meet state and federal certification requirements, avoid adverse selection in Exchange coverage programs, and evaluate state options for risk adjustment and reinsurance programs. As the first state to pass legislation establishing a health benefit exchange after the passage of the Affordable Care Act, the California Exchange is directed to pursue an "active" purchaser strategy. In addition, the California Exchange Board has noted that one of its key values is to be a catalyst for change in California's health care system by using its market role to stimulate innovation and adoption of new strategies to provide high quality, affordable health care, promote prevention and wellness, and reduce health disparities.

During the first Level I grant (1.1), the California Exchange has been meeting regularly with stakeholders and potential health plan partners, including the largest carriers 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 based , solicited stakeholder input and refined the principles based on that input. The Exchange principles to guide QHP selection and oversight are:

- ***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 grant period, the California Exchange conducted a competitive solicitation to support planning in the QHP core area and selected PricewaterhouseCoopers (PwC) to assist the Exchange in accomplishing the following: 1) develop necessary timelines, cost estimates and background for development of this federal grant application and proposed budget; 2) establish standards and processes for the certification and competitive selection of qualified health plans to provide coverage in the Exchange; 3) develop an ongoing program of certification, recertification and decertification, performance measurement, quality monitoring and compliance for participating health plans; 4) recommend strategies for Exchange programs or activities that might improve the broader health care delivery system in the state; and 5) develop an implementation timeline and process for health plan selection and ongoing monitoring.

With PwC's support and guidance, the California Exchange 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, the Exchange is developing recommendations for Board consideration during the Level I grant (1.2) in the following areas, among others:

- Minimum certification standards for QHPs including further defining the requirement of being "in good standing" with state regulatory requirements, as well as provider network adequacy, accreditation, and quality reporting standards;
- Benefit plan design options related to the optimal number and type of QHPs by coverage tier level, region and premium levels, including 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.

Small Business Health Options Program (SHOP)

The California Exchange must develop a viable SHOP design and approach to provide coverage for small businesses and their employees consistent with state and federal requirements. As required in CA-ACA, the California Health Benefit Exchange will establish a small business exchange that is separate from the individual market exchange.

During the grant period, the California Exchange conducted a competitive solicitation and selected PwC, contracted to assist in the development of the QHP selection and certification process, to also assist the Exchange in developing options related to the formation of the SHOP. The staff of the California Exchange, with support from PwC, identified issues and policy choices related to the establishment of the SHOP exchange and developed a series of Board briefing documents to offer options and preliminary recommendations on those issues for Board consideration. The options and recommendations were informed by stakeholder input, review of national lessons, including previous California experiences with small employer purchasing programs, expert advice and invited public comments. In addition, the Exchange held a stakeholder input forum on SHOP issues and worked closely with a working group focused on SHOP enrollment and eligibility issues. The issues under evaluation to date include:

- Alignment of the QHPs in the individual and SHOP Exchanges, including whether health plans must participate in both exchanges, and differences in benefit plan offerings between the two;
- Extent of employer versus employee choice of health plan and benefit designs in SHOP;
- SHOP agent strategy, involving the options for engagement with agents and the structure of agent payments for sales and distribution of SHOP Exchange products;
- Small employer benefits administration and ancillary benefit options and the extent to which the SHOP Exchange will provide additional services that add value such as administration for employers of continuation coverage for employees, flexible spending accounts or health spending accounts;
- Employer contribution and participation options; and
- Promoting the employer tax credit for health coverage to overcome the low utilization of the credit to date.

b. Proposal to Meet Program Requirements

The California Exchange is seeking funding for a second Level I Exchange Establishment grant (1.2) to implement the next level of planning and development activities. As described in detail below and in the work plan attached as Attachment A, during this proposed period of the second Level I grant (August 15, 2012-June 30, 2013) the California Exchange will:

- Engage in ongoing planning, research and stakeholder consultation;
- 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;
- Design and refine program and operational elements, including advancing the development of CalHEERS and internal operational policies to support a seamless and coordinated enrollment and eligibility function and effective consumer assistance and support;
- Refine and implement an aggressive marketing, outreach, and public education program to set the stage for 2014 in the public arena and among targeted, potentially eligible constituencies;
- Finalize and execute a procurement and certification process for qualified health plans to be offered in the individual and SHOP Exchange starting in 2014;
- Submit the Exchange Blueprint, secure federal approval for the operation of a state-based Exchange and submit a Level II multi-year establishment grant proposal, budget and timeline;
- Develop and execute a multi-year plan for evaluation and monitoring of California Exchange programs and implementation of federal health reforms in the state; and,
- Maintain and enhance operational coordination, financial management support and business operations in service of the mission and functions of the Exchange.

The California Exchange will continue to make progress in most of the federal core areas during the Level I grant (1.2) period. Figure 5 identifies and compares the federal core areas with the work plan core areas used by the California Exchange in developing this grant proposal.

Background Research and Evaluation

The California Exchange 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. During the time period for the proposed Level I grant (1.2), the Exchange expects to engage in the following research and evaluation activities:

- Continue to work with UC Berkeley and UCLA to refine CalSIM estimates of potential enrollment in the Exchange and other public coverage programs, as well as distill demographic and profile information that will be critical to the development of effective, California-specific programs and services. Having a robust data set with so much detail, including information on health-seeking behaviors, chronic diseases, and regional variation, will help the Exchange in its effort to plan for and provide services and programs that can really work for the sheer size and ethnic and cultural diversity of California communities anticipated to be the customers of the Exchange. The Exchange will also engage UC Berkeley and UCLA in helping to define data elements in CalSIM and the California Health Interview Survey, and support related data collection, that can provide the information needed for state evaluation of the impacts of the Affordable Care Act and the implementation of Exchange programs.

- The Exchange will engage actuarial services and supports to help in modeling benefit design options, including consideration of standardized benefit plan designs with heavy emphasis on changes to cost-sharing structures. The goal of the analysis will be to identify the benefit plan design options consistent with the coverage tiers established in the Affordable Care Act, Exchange principles and the overall goal of offering consumers choice and the opportunity to compare options that provide the best value for their dollar. Further, well designed cost-sharing structures should draw consumers to the Exchange as well as encourage appropriate utilization of covered health care services, especially preventive services. Having actuarial expertise will be essential for the Exchange to evaluate QHP benefit proposals and to estimate the potential costs and utilization for Exchange coverage offerings under multiple scenarios;

- During the period of the proposed Level I grant (1.2) , the Exchange will engage in extensive 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. To develop the plan, the Exchange will need to catalogue and reconcile the multiple existing data and research sources in the state, conduct a gap analysis and develop rigorous quality and success indicators and measures to meet federal requirements and ensure a continuous quality improvement process for all activities of the Exchange. The evaluation plan will be driven by the Board-adopted vision, mission, and values, including the value of "results" which holds that the impact of the Exchange will be measured by its contributions to expanding coverage and access, improving health care quality, promoting better health and health equity, and lowering costs for all Californians. The Exchange hopes to build on the 2011 CHCF-funded report by the State Health Access Data Assistance Center entitled, "*A Framework for Tracking the Impacts of the Affordable Care Act in California,*" which identified potential metrics, available state data sources and data gaps to measure the effects of health reform in the state.

Stakeholder Consultation

The California Exchange 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 core areas. During the period of the Level I grant (1.2), the California Exchange will employ all of the strategies implemented in Level I (1.1) including:

- Hosting public Board meetings subject to state open meeting laws and public comment opportunities;
- Posting all materials and background on issues before the Exchange on the public Exchange website, including public and stakeholder reports and comments received;
- Providing updates on Exchange activities and opportunities for stakeholder feedback and input via an email distribution list;
- Engaging in Tribal consultation;
- Hosting one-on-one and small group meetings with stakeholders, experts and state partner agencies; and
- Convening topic-specific statewide ad hoc meetings, webinars and local listening sessions.

In addition, for the period of the Level I grant (1.2) the California Exchange will finalize and implement a comprehensive stakeholder consultation plan that includes several standing advisory committees to focus on discrete issue areas such as: health plan management, communications and outreach and the SHOP Exchange. During this grant period, the California Exchange will also initiate discussions with tribal organizations to develop and adopt a formal tribal consultation policy.

FIGURE 5
COMPARISON OF FEDERAL CORE AREAS AND CALIFORNIA WORKING CORE AREAS

FEDERAL GRANT CORE AREAS	CALIFORNIA CORE AREAS[*]
1. Background Research 2. Stakeholder Consultation 3. State/Legislative Regulatory Actions 4. Governance 5. Program Integration 6. Exchange IT Systems 7. Financial Management 8. Program Integrity 9. Health Insurance Market Reforms 10. Providing Assistance to Individuals and Small Businesses, Appeals 11. Business Operations / Exchange Functions a. Certification, recertification and decertification of Qualified Health Plans b. Call center c. Exchange website d. Premium tax credit and cost sharing calculator e. Quality rating system f. Navigator program g. Eligibility determinations for Exchange, Medicaid, advance payments, etc. h. Seamless eligibility and enrollment process with Medicaid and state health programs i. Enrollment process j. Application and notices k. Individual responsibility determinations l. Administration of tax credits and cost-sharing reductions m. Adjudication of appeals and eligibility n. Notification and appeals of employer liability o. Information reporting to IRS and enrollees p. Outreach and education q. Risk adjustment and transitional reinsurance r. SHOP Exchange-specific functions	**1. Background Research and Evaluation** **2. Stakeholder Consultation** **3. Governance, Legislative and Regulatory** a. Governance b. State/Legislative Regulatory Actions c. Health Insurance Market Reforms **4. Program Integration** a. Program Integration b. Seamless eligibility and enrollment process with Medicaid and state health programs **5. Qualified Health Plan Management** a. Certification, recertification and decertification of Qualified Health Plans b. Quality rating system/business components c. Enrollment process / QHP components d. Risk adjustment and transitional reinsurance **6. SHOP** a. Providing assistance to individuals and small businesses, appeals b. SHOP Exchange-specific functions c. Financial management **7. Eligibility and Enrollment** a. Providing assistance to individuals and small businesses, appeals / individuals b. Call center / business components c. Exchange website / business components d. Navigator program / permanent support e. Eligibility determinations for Exchange, Medicaid, advance payments, etc. / business components f. Enrollment process g. Application and notices / business components h. Individual responsibility determinations / business components i. Administration of tax credits and cost-sharing reductions j. Adjudication of appeals and eligibility / oversight k. Notification and appeals of employer liability l. Information reporting to IRS and enrollees **8. Consumer Assistance and Outreach** a. Navigator program / development period b. Outreach and education **9. Information Technology** a. Call center/ IT components b. Exchange website / IT components c. Premium tax credit and cost sharing calculator d. Quality rating system / IT components e. Eligibility determinations for Exchange, Medicaid, advance payments, etc. / IT components f. Enrollment process / IT components g. Application and notices / IT components h. Individual responsibility determinations / IT components i. Administration of tax credits and cost-sharing reductions / IT components **10. Operations and Financial Management** a. Financial management b. Program integrity c. Administration of tax credits and cost-sharing reductions / oversight

[*] The California Exchange planning process for Level I grant (1.2) was developed using the California core areas listed above in the right-hand column. As the Figure illustrates, some federal core areas are in more than one California core area, but all federal core areas are addressed in the California plan.

Governance, Legislative and Regulatory

The California Exchange 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.

The California Exchange 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 I grant (1.2), 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 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 core area, staff will 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 governance core 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. Legal staff are responsible for drafting and reviewing regulations and contracts of the Exchange before they are considered by the Board, analyzing proposed regulations and statutes that impact Exchange activities and working with other state agencies to ensure compliance with state and federal laws and regulations implementing the Affordable Care Act.

This grant period will also be a critical time period for the California Exchange to develop and submit to the federal government its draft Blueprint and to engage in the process of securing federal approval for Exchange operations by January 1, 2013. The process will engage the Board, Exchange staff, state partners and stakeholders to ensure and document that the California Exchange meets or will meet all legal and operational requirements associated with its intention to develop a state-based Exchange by 2014.

Program Integration

The California Exchange works closely in partnership and coordination with state agencies and programs, including state health programs and health insurance regulators in development of the California Exchange and to lay a foundation for implementing the Affordable Care Act. This commitment to program integration is most effectively demonstrated in the development of joint vendor solicitations and contract monitoring for major

program areas such as CalHEERS and development of a statewide marketing, outreach and enrollment program. These ongoing partnerships and relationships will continue and expand during the period of the Level I grant (1.2). The Exchange will continue to be a catalyst to bring state agencies together across programs through developing, leading and participating in cross-agency project teams, and developing and sharing analyses and options related to cross-cutting issues.

During the period of the Level I grant (1.2), the Exchange will, in collaboration with CHHS, execute the mandatory agreements with DHCS and MRMIB related to enrollment, and roles and responsibilities between Exchange programs and other state health 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 will also reach out to potential new state program partners to implement additional Exchange program efforts, data collection and comprehensive outreach strategies. These state agency partners could include: the California Department of Social Services, California Department of Public Health, Employment Development Department, Department of Motor Vehicles, California Department of Aging, California Department of Consumer Affairs, California State Lottery, Franchise Tax Board, 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 will also 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 programs for children 5 and under, local Mental Health Services Act programs and agencies, and local community-based organizations, including consumer assistance programs.

The Exchange also recognizes the importance of two-way coordination and referral of consumers accessing health care programs and human service programs, such as the state’s Temporary Assistance to Needy Families program (CalWORKS) and food assistance program (CalFresh). During the Level I (1.2) grant period, the Exchange, DHCS and MRMIB, will be focusing primarily on developing a robust and seamless eligibility and enrollment system for health insurance affordability programs. At the same time, the Exchange will engage stakeholders in the coordination and determination of the approach to horizontal integration over the longer term.

Given the size and complexity of the California health insurance market, the Exchange will also need to work closely with DMHC and CDI to analyze the potential impacts from Affordable Care Act 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 and market reform legislation pending in the current legislative session comes to conclusion.

During the Level I grant (1.2) period, the California Exchange will engage in discussions with affected state agencies to identify specific tasks and coordination efforts that may be necessary for other state agencies to perform in support of effective implementation of the Exchange and related Affordable Care Act provisions. The Exchange may submit future Exchange establishment grant requests to support partner state agencies in these tasks as a result of the planning and coordination activities proposed in this application.

Qualified Health Plan Management

During the time period for the Level I (1.2) Establishment Grant, the California Exchange will actively implement a comprehensive plan to select, certify and ensure the readiness of qualified health plans that will be offered through the Exchange starting in 2014. QHP selection and management operations will be developed and implemented within the framework created by federal and state rules and laws and by Exchange certification and selection standards. The scope of this work will be influenced by the degree of QHP issuer participation, the complexity of issuer proposals, issuer requests and requirements, unanticipated market conditions, and consumer demand and response to the Exchange -- all of which will require that the Exchange is organized and staffed to be responsive to planned as well as unanticipated market and policy changes.

In executing the job of plan selection and issuer oversight during 2013-2015, the Exchange will rely on its partnership with regulators, CDI and DMHC, to assist in ensuring baseline compliance with the federal requirement that issuers must be in "in good standing" with state licensing agencies to participate in the Exchange and entry-level threshold QHP certification standards. Interagency agreements with California's two health plan regulators will be critical to the efficiency of the Exchange as it executes its QHP selection process. These agreements will be focused on reducing redundancy for issuers, regulators and the Exchange. Moreover, many Exchange decisions regarding benefit plan design, QHP oversight and monitoring will impact the routine work of regulators' reviewing and approving issuer product offerings both inside and outside of the Exchange.

During the period of the Level I grant (1.2) , the Exchange must establish a process to certify and select the QHPs and this process is planned to be completed prior to the initial availability of the Exchange enrollment website scheduled for July 1, 2013. This will enable potential enrollees to review plan offerings in anticipation of the October beginning of the open enrollment period. Thereafter, the Exchange must 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 Board staff working in coordination with CDI and DMHC, as well as in collaboration with DHCS and MRMIB in their program management and oversight of coverage programs, and health plans participating in those programs.

<u>QHP Selection and Certification</u>

The California Exchange anticipates the following activities during this grant period related to QHP selection and certification and contracting:

- **September 2012 - December 2012: Finalize and release QHP solicitation.** Exchange staff and consultants will draft QHP solicitation documents for Board and public review and consideration. These documents and the certification process may need to be revised and updated as a result of additional federal guidance and state law changes, development of important components of the solicitation, such as the Quality Rating System and the Risk Adjustment methodology, and input from stakeholders. The first year solicitation is expected to be released in October 2012 with health plan responses due by the end of the year.
- **January 2013 to June 2013: Certify, Select, and Negotiate with QHPs to be offered on the Exchange.** Health plan responses to the QHP solicitation will be evaluated to determine if they meet the rate

review and certification standards established by the Exchange. The California Exchange will work closely with CDI and DMHC on issues such as premium rate review, including justification of any rate increases, Medical Loss Ratio and rebate determinations, certification of actuarial values of the federally mandated coverage tiers, sometimes referred to as "precious metals, " and review of issuer rate development methodologies to ensure compliance with federal and state-established criteria. Bidder review will also evaluate the extent to which the bidders meet other standards that have been established, such as for service area and provider network adequacy, accreditation, quality rating system reporting and operational readiness. The Exchange will evaluate proposals as an "active purchaser" in which bidders who meet the certification standards and can demonstrate added value will enter into discussions with the Exchange to finalize pricing and potential contract terms and conditions. Selected QHPs are expected to be announced by June 2013. A modified certification and selection process is envisioned for multi-state health plans and to the extent they are offered, supplemental plans, such as stand-alone dental and vision.

- **April 2013 to October 2014: Work with selected QHPs to assure operational readiness for initial open enrollment effective starting January 1, 2014.** For the remainder of 2013, Exchange staff will work with issuers to coordinate preparations for the first annual enrollment. Key activities will include training, operational readiness assessment and testing for data exchange, funds transfer and other functions, data collection for compliance and consumer decision support tools, marketing and sales, and development of processes for member enrollment and ongoing customer service and support.

QHP Quality Ratings

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 Affordable Care Act 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 QHPs to participate in the Exchange.

The Affordable Care Act requires the Exchange to rate each QHP on value as measured by quality and price. Until the Federal guidance is issued it is unclear how much flexibility states may have to require additional criteria. If flexibility is permitted, the Exchange may consider including additional information, such as provider quality ratings or customer service support. The California Exchange anticipates the following activities during this grant period related to QHP quality ratings:

- **September 2012 - December 2012: Incorporate Quality Rating System Requirements into QHP solicitation document and contracts.** The California Exchange will develop a Quality Rating System that meets or exceeds federal guidelines and determine how to incorporate the Quality Rating System into QHP certification criteria and reporting. The QHP solicitation documents and model contract will incorporate a description of the required metrics and the value calculation methodology.
- **September 2012 - June 2013: Develop a plan and implement the process for collection, reporting and monitoring of Quality Rating System metrics.** The California Exchange will develop a process for the collection and monitoring of the quality metrics. The plan and process will take into consideration the frequency of data collection and updates, Exchange data storage capacity and analytic capability.

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. Initial federal rules have been issued and the Center for Center for Consumer Information and Insurance Oversight released an initial bulletin on the model and methodology that is under consideration. States will 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 by November 16, 2012 and state models will be subject to federal approval. If a state implements its own model, it must be updated or adjusted at least as frequently as the federal model.

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. State legislation is pending in the 2011-12 legislative session as of this writing, which could determine California's approach to risk adjustment and reinsurance and the Exchange will continue to participate in providing technical assistance on legislation affecting the Exchange. The California Exchange anticipates participating in the following activities during this grant period related to risk adjustment and reinsurance:

- **September 2012 - December 2012: Evaluate federal reinsurance and risk adjustment models.** Activities to complete this planning task include development of policies to mitigate adverse selection inside and outside of the Exchange, evaluation of alternative models and assessment, and estimation of resources necessary to administer a state risk adjustment program. The state will need to develop a proposed alternative model if a decision is made to not adopt the federal model and determine which state agency or agencies might be most appropriate to lead the reinsurance and risk adjustment programs. As part of the process, the Exchange will facilitate public discussion and feedback from stakeholders on the risk adjustment and reinsurance options. A state model should address technical issues and specifications, operational processes such as timing of data refreshes, reporting, fees and payment schedules, as well as data collection and verification standards. A key consideration for the state will be whether to take advantage of the opportunity to have federal administration of the risk adjustment program, or to administer the program within the state, potentially tailoring the model to best fit California's circumstances.
- **January 2013 - December 2013: Communication with issuers and development and testing of reinsurance and risk adjustment models.** Transitional reinsurance will be in effect from 2014 -2016 and risk adjustment will be permanent beginning January 2014. Further guidance on the federal methodologies is expected in the Fall of 2012. This timeline permits states and health plans to simulate and test the reinsurance and risk adjustment models prior to member enrollment in the Exchange, although the true effects of either of these programs cannot be known in advance. Simulation modeling must be completed and communicated to health plans so that they have some understanding of the programs to incorporate the anticipated effects into their pricing assumptions.

Small Business Health Options Program (SHOP)
The state Affordable Care Act requires the Exchange Board to establish the SHOP program separate from the Exchange activities related to the individual market, 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.

The California Exchange has engaged consultants, experts and stakeholders to consider the design and implementation options for SHOP to maximize the viability and effectiveness of the program. As outlined in the progress report section of this application in more detail, among the considerations are the array of products and services that might be provided to attract and support small employers and their employees to the program and potential design and operational considerations to militate against adverse selection initially and over time. California has significant experience and history related to small employer purchasing programs which has yielded important information and lessons learned for the SHOP design. As the Board develops the SHOP, it will incorporate into the business and operations plan and the IT development work the related functionalities to support SHOP services for employers and employees.

During the period of the Level I grant (1.2) , the California Exchange will continue to refine, develop and begin implementation of its operational plan for the SHOP and coordinate QHP selection and certification with the efforts outlined above for the individual Exchange. The Exchange must establish processes to facilitate employer applications, determine eligibility, enroll eligible employers, allow employees to select from qualified health plan options according to policies adopted by the Board, process premium payments, and resolve account and billing issues. The SHOP will include a small employer relations function that provides assistance to employers and their employees with support and problem resolution related to SHOP coverage. SHOP administration will include processes for notification and appeals of employer eligibility, data transmittal to ensure employers, employees, and QHPs receive necessary information, data storage to maintain records of QHP enrollment, monthly data reconciliation of enrollment and employer participation information and development of employer enrollment reporting processes. These processes and systems must be designed, developed and integrated into CalHEERS in time for open enrollment in October 2013.

The Exchange will also develop a process to certify and select agents to support SHOP product offerings, provide sales tools and support, and produce management reports. This process must be completed prior to the initial open enrollment period starting October 1, 2013. Exchange responsibilities in this area will necessarily include: development of agent selection criteria and licensing management; development of agent solicitation, applications, training and communication materials; development of agent data management and reporting processes; development of agent commission payment processes, including premium and commission reports, reconciliation, and discrepancy resolution.

Eligibility and Enrollment

The California Exchange and the supporting CalHEERS system will provide the state's eligible population with statewide portal access to affordable health care coverage and facilitate their enrollment in health plans operated by the Exchange, DHCS and MRMIB. The population targeted for outreach will include both the currently uninsured and those likely to be uninsured in the near term. CalSIM enhanced enrollment projections for the first five years of implementation show steady growth, reaching 2.2 million individuals enrolled in the Exchange with subsidies by 2019, with another 2.2 million in the individual insurance market or enrolled in the Exchange without subsidies. These enrollment estimates reflect an enhanced enrollment scenario based on robust efforts for outreach and education, simplification of eligibility determination, culturally and linguistically appropriate outreach and enrollment assistance, and maximum use of pre-enrollment strategies. During the period of the Level I grant (1.2), California will continue to refine enrollment targets, and target populations, to inform the eligibility and enrollment system processes as well as other Exchange programs, including the outreach, education and consumer assistance functions.

A well-designed and smoothly operating eligibility and enrollment process is critical to attaining these enrollment levels. Adding to the complexity is the cultural, linguistic and geographic diversity of California's

population, a factor that will affect the design of virtually all aspects of the eligibility and enrollment process. For example, threshold languages for both written and verbal communications will be initially identified during the grant period (and may change as California's demographics change). Communications with applicants and enrollees will require translation into appropriate languages in order to maximize consumer understanding and access.

During the Level I grant (1.2)period, the Exchange will continue working with DHCS, MRMIB and other agencies to develop and document a "no wrong door" process for application, eligibility determination, and enrollment into Exchange, Medi-Cal and Healthy Families programs. The close partnership established to date with DHCS and MRMIB on eligibility and enrollment activities (as well as marketing and outreach) will continue and develop during this grant period. The Exchange and its partners will develop processes for coordinating applications, notices and appeals between programs as required in state and federal law and coordinating enrollments into health plans in the Exchange. 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 data sources as well as newly developing sources being made available through federal data sets and portals as part of the federal Affordable Care Act implementation activities.

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, perform eligibility determinations (described in the Information Technology section). Eligibility and enrollment program expertise and support will help inform the design and testing of CalHEERS eligibility and enrollment systems 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, at a minimum, in the following areas:

- CalHEERS website, including calculators;
- Premium tax credit and cost sharing reduction;
- Assisters Program (includes Navigators)
- Eligibility determinations for Exchange, Medi-Cal and Healthy Families programs;
- Enrollment process;
- Application and notices;
- Individual responsibility determinations;
- Adjudication of appeals of coverage;
- Consumer assistance;
- Notification and appeals of employer liability; and
- Information reporting to Internal Revenue Service and enrollees.

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, including:

- In partnership with DHCS and MRMIB, 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 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.

Consumer Assistance and Outreach

California faces outreach and education challenges that make it unique among states that are establishing their own exchanges. With an estimated 3.1 million adults eligible for subsidies and millions more eligible to purchase unsubsidized coverage through the Exchange, CalSIM estimates dwarf those of many other states. California's outreach and education task is daunting in sheer size, scope and complexity. For example, in order to reach potential Exchange consumers, the state's outreach and media efforts must not only be in the 13 threshold languages currently used in the state Medi-Cal program, but must reach out to diverse consumers using media markets that are among the largest in the nation. California is one of only two states that have two of the top 10 Nielsen-ranked Designated Market Areas (DMAs) and is the only state with three of the top 20 DMAs. It also has more DMAs than any other state.

Moreover, the California Exchange has identified a large target population for its outreach and education efforts, but also identified smaller subpopulations for potential focused outreach, including 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% of coverage-eligible uninsured; new Medi-Cal eligibles; "hard-to-move" individuals, who either resist purchasing insurance even if they can afford it, or resist enrolling in Medi-Cal and Healthy Families even though eligible; and small business owners and entrepreneurs that employ persons who are under- or uninsured. Once refined through further research during the Level I grant (1.2) period, each of these subpopulations could require development of different messages and micro-targeting to both encourage and maintain their enrollment in coverage programs.

Further complicating planning for California's outreach and education efforts, and potential program costs, are the thousands of potential partners (e.g., community-based organizations (CBOs), faith-based organizations (FBOs), non-governmental organizations (NGOs), health plans, and county welfare and health department offices) who are logical partners and supporters in the effort to maximize enrollment of eligible Californians. The California Exchange hopes to work with key "influencers," such as health care providers, faith-based organizations, and community leaders that are trusted messengers for uninsured Californians. Significant materials costs and labor will be required to support outreach efforts that successfully reach the state's culturally, linguistically and geographically diverse population.

The magnitude of the task has prompted the California Exchange to determine that what is needed is an aggressive outreach, public awareness and assisters program 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, business and other organizations; and a simple, web-based enrollment portal. During the grant period, the Exchange expects to implement Phases I and II of the multi-year campaign illustrated earlier in Figure 4 as described below.

Phase I: September 1, 2012 to December 31, 2012. This "build out" phase will begin with further research, including a cultural and linguistic needs assessment, to inform branding, message and creative development. The additional research findings, supplemented by the previous research and research conducted by others, will form the basis for development of a comprehensive media plan. Activities in this phase will include:

- Conduct qualitative and quantitative research consisting of:
  - ✓ One-on-one message strategy interviews, conducted in threshold languages with uninsured adults who are receptive, as well as those less receptive, to purchasing health coverage through an Exchange, in order to identify factors that distinguish the two groups. The findings will be important for message development;
  - ✓ Focus group interviews with small employers from a variety of cultural/linguistic groups, half of whom are receptive and half not, to using Exchange-based enrollment; and
  - ✓ Advertising copy testing with individuals and small employers to assess message comprehension, perceived relevance, believability and persuasiveness.
- Finalize a brand name for the Exchange. One of the earliest deliverables from Ogilvy will be recommendations for a brand name, which is needed to implement outreach and marketing efforts;
- Develop a paid media plan that responds to the time-limited challenges of promoting the Exchange to a diverse population of eligible persons and small employers who have little or no knowledge of the Affordable Care Act and its benefits and who are culturally, linguistically, and geographically diverse;
- Conduct additional research and analysis to determine appropriate date to launch paid media (i.e., whether to launch before the scheduled July 2013 start date);
- Develop creative materials and messages to support the paid media plan;
- Develop educational materials, such as brochures, event displays, speaker training materials, and promotional items, to help raise awareness, increase understanding and motivate action;
- Develop strategies to coordinate and share advertising, public relations and outreach activities with other governmental agencies and partners, as well as elected officials;
- To augment paid media efforts, identify potential partnerships with CBOs, FBOs, non-governmental NGOs and other organizations that already have established relationships with target populations, particularly those that are hard to reach through paid media and general marketing efforts. These partners would serve as trusted messengers to convey information about the Exchange and encourage enrollment and retention of coverage. Likely partners include health care providers (e.g., community clinics); labor unions; trade and small business associations; organizations serving multi-ethnic and specialized language populations; retailers (e.g., ethnic markets); and educational organizations (e.g., schools);
- Develop an Outreach and Education Grant Program to enable community and nonprofit organizations that lack the resources to become full partners. Define grantee eligibility and selection criteria, amount of grants, numbers of grantees, solicitation and selection process, grantee accountability and reporting requirements, evaluation measures, etc.;
- Develop plans to participate in and host events and festivals for outreach to targeted populations, including multicultural and ethnic events, health fairs, sporting events, etc.; and
- Develop a social media plan to provide readily-accessible information and assistance to target populations via mobile devices.

At the conclusion of Phase I, initial planning for all aspects of the Consumer Outreach, Marketing and Assisters Program will be completed and ready for implementation starting in Phase II.

Phase II: January 1, 2013 to June 30, 2013. Phase II marks the preparation and initial launch of aggressive public relations and outreach activities to educate target populations about the new health coverage options and the benefits of health coverage, as well as how to access that coverage through a one-stop Exchange. Outreach will be conducted through a variety of methods, including targeted media relations and partnerships with organizations that have established relationships with the target audiences. A paid media campaign will begin implementation toward the end of the phase. Activities in Phase II include:

- Begin work with partners identified in Phase I to help them start informing their constituencies about the Exchange, available coverage options, and how to enroll. When possible, leverage partnerships that lend themselves to media promotions and events;
- Conduct market segmentation study of both uninsured and individually insured persons to understand differences based on culture/language and plan eligibility status (i.e., eligibility for public programs, subsidized private plans, and no subsidy);
- Implement the Outreach and Education Grant Program developed in Phase I;
- Identify and begin executing interagency agreements with state departments that already provide services to the target populations, in order to provide potential enrollees with information about the Exchange, available coverage options, and how to enroll. Likely departments are: Employment Development Department, Department of Motor Vehicles, Franchise Tax Board, Board of Equalization, and MRMIB;
- Conduct targeted outreach to ethnic communities, including media relations campaigns tailored to print and broadcast outlets that reach Latino, African American, and Asian Pacific Islander communities;
- Start participating in events and festivals identified in Phase I to disseminate information on new coverage options and promote the benefits of health care. Events will be selected for their potential to reach large segments of targeted populations;
- Begin implementing the paid media campaign by preparing for the initial round of media buys and placements preliminarily scheduled to take place in summer 2013 (date may be changed based on analyses conducted in Phase I). The campaign will include a mix of traditional and new media, including television, online and mobile video, radio, commercial print media, ethnic and community newspapers, and/or direct mail; and
- As open enrollment nears, embark on an aggressive media relations effort for both the general market and ethnic press to publicize the impending launch of open enrollment and the availability of new health coverage options.

During the period of the Level I grant (1.2) , the California Exchange expects to continue in partnership with DHCS and MRMIB to refine, adjust and begin implementation of the multi-phase approach to consumer outreach, marketing and assisters as recommended by Ogilvy Public Relations Worldwide. Throughout the seven phases, plans and strategies will be evaluated and improved as appropriate.

Assisters Program

Federal law and the CA-Affordable Care Act require the California Exchange to establish a navigator program and to set standards and compensation for navigators to aid in education, enrollment and ongoing use of public and qualified private health plans. As outlined in the Progress to Date section, during the Level I grant (1.1) period, 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, which will provide individualized services to persons who require help navigating the eligibility and enrollment process. California’s

assisters program will include paid Navigators as required in federal law, but will also include other individuals and entities who are certified to provide assistance but are not paid directly by the Exchange.

The California model of a broad base of "Certified Enrollment Assisters" mirrors the integration model proposed by Maryland and considered by other states, where health insurance agents, hospitals, physician offices, providers and others compensated by other sources, or who have a business interest in enrolling individuals, are not considered navigators but are essential partners in the enrollment assistance process. Under this model, all Assisters would need to be trained, certified and registered with the Exchange, or its designated entity, in order to enroll people. This approach to assistance also includes the deployment of education and awareness specialists to conduct personalized education to engage hard to reach and target populations and support them in getting to assistance resources. Delivered by a trusted messenger, this knowledge is particularly important to eliminating barriers to enrollment for limited English proficient, low-literacy, hard-to-reach and newly eligible populations.

The Exchange anticipates the following activities related to development of the Assisters Program during the Level I grant (1.2) period:

- Refine the design of the Assisters Program, including education, eligibility and enrollment activities performed by Assisters; eligibility criteria to be an Assister and enrollment entity; certification and training requirements for Assisters; training curriculum, including length and topics, and frequency of re-training; recruitment of Assisters; conflict of interest standards and program monitoring for quality assurance and compliance;
- Determine entities eligible for payment as Navigators;
- In partnership with DHCS and MRMIB, determine source of funds for payments to Assisters who enroll persons in Medi-Cal or Healthy Families;
- Develop administrative procedures and systems to register, certify and monitor enrollment entities and Assisters;
- Begin recruitment activities to encourage eligible entities to apply for certification as Assisters;
- Conduct broad and targeted outreach in order to create a diverse network of Assisters with cultural, linguistic and geographic competence to reach diverse target populations;
- Launch the training program for Assisters. Review and revise curriculum as appropriate; and
- Begin certifying and registering Assisters who have successfully completed training and meet other Exchange requirements.

<u>Consumer Assistance</u>
In addition, to the core requirement to provide seamless, "no wrong door," multi-portal consumer assistance and support related to Exchange eligibility and enrollment activities, federal law and regulations require that exchanges have an accessible consumer assistance service function and tools that provide for a toll-free consumer assistance call center, Internet web site with specified information and functionality, including information about and access to navigators, and referrals to appropriate and available consumer assistance programs in the state. The basic program goals of the Exchange consumer assistance function will be to help consumers navigate health coverage and delivery systems, secure access to needed services, guarantee consumer protections and consumer rights, and resolve problems that arise post-enrollment.

As a foundation, the Exchange will build outreach, consumer engagement, and accountability processes with its contracted health plans to ensure that consumers get timely assistance with eligibility questions and plan enrollment issues, and, once enrolled, access to needed services and assistance with problem resolution. The

work to ensure effective and timely consumer assistance from issuers participating in the Exchange will build on and need to be coordinated with existing state law on health plan appeals and grievance and oversight by state insurance regulators, CDI and DMHC.

In addition, the Exchange will establish processes to ensure that individuals enrolled in Exchange programs who have problems at any point in the process get timely resolution to their concerns, and have appropriate support. Complaint and problem monitoring systems will also be important sources of information for the Exchange to identify systemic problems and build a culture of continuous quality improvement.

During the period of the Level I grant (1.2) , the California Exchange will work with state partners and stakeholders to accomplish these goals. Coordination will be essential to the design and implementation of a consumer assistance function which builds on and coordinates with existing state, regional and local consumer assistance programs but is not duplicative. The California Exchange will work with CHHS, CDI and DMHC, and with other state agencies involved with consumer assistance, including DHCS, MRMIB, the Office of the Patient Advocate, and stakeholders, to analyze data from existing programs, including data from the federally-funded Consumer Assistance Program, to help define the elements of an Exchange consumer assistance function. This will include working with CDI and DMHC to properly refer to them consumers needing assistance in areas subject to regulatory oversight, such as network adequacy, out-of-network charges and independent medical review of coverage denials.

During the Level I grant (1.2) , the California Exchange will collaborate with existing state consumer assistance programs to develop standardized referral protocols and shared training modules, as well as common data collection and measurement of outcomes and program effectiveness. The California Exchange consumer assistance/ombudsman function may through state partners or nonprofit organizations also rely on community and local consumer assistance programs. The Exchange may submit future Exchange establishment grant requests to support consumer assistance services as a result of the planning and coordination activities proposed during this grant period.

Information Technology

The California Exchange is and has been engaged from its inception in rigorous analysis and system design to develop the information technology (IT) capacity to support Exchange functionality and operations. The Exchange has from the start been engaged in those activities through active partnership with the state agencies administering California's other state health care programs, DHCS and MRMIB. The CalHEERS project is governed by an Executive Steering Committee that represents each of the participating agencies and has guided the project through the procurement process.

Having executed its CalHEERS contract with Accenture, the Exchange has also secured a project management and technical support contractor to support management of the project, including the completion of project management artifacts for CMS review and approval. The internal Exchange team will be led by the Chief Technology Officer and the CalHEERS Project Director. Together, they will finalize plan management functions, including a contingency plan.

During the period of the Level I grant (1.2) , the Exchange will continue to design and implement CalHEERS functionality as outlined in the attached IT work plan and to develop internal capacity to provide technical support and maintenance services for the internal Exchange IT and computer systems. The IT systems plan for the Level I (1.2) period includes making significant progress in the design, building, and testing of the CalHEERS

system to support eligibility and enrollment functions as well as other operational needs of the Exchange. The core activity will be the work of the Systems Integrator in leading the development effort.

The contracted Systems Integrator (SI) services encompass confirming requirements; designing, coding, and integrating system components; conducting unit, integration and system testing; assisting with user acceptance testing; developing system documentation; designing and conducting organizational change management; providing training; implementing the system statewide; and operating the system. The CalHEERS SI will be responsible for developing the work products and deliverables for and supporting the Exchange throughout the Preliminary Design Review (PDR), Detailed Design Review (DDR), Final Detailed Design Review (FDDR), Pre-Operational Readiness Review (PORR), and Operational Readiness Review (ORR). The CalHEERS SI will also be responsible for launching system elements according to the following schedule:

- Internet 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.
- Enrollment functionality by September 28, 2013 to enable applicants eligible for Exchange coverage to enroll with qualified health plans.
- Financial Management 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 June 30, 2013, the SI activities include:

- Development of the CalHEERS system support for eligibility and enrollment, plan management, financial management, assister management, and SHOP and provider directory functionality;
- Planning and initiating organizational change management services; and
- Coordination in the development of interfaces required to be established with other existing program systems, to help provide the seamless, “no wrong door” approach to accessing health coverage or where online verification eligibility data can be achieved.

Additional work will be required to establish data exchange capability through interfaces between the CalHEERS system and other health programs eligibility systems, including those supporting Medicaid and CHIP eligibility as well as other systems that provide information to verify data received from applicants and current enrollees. These interfaces will be constructed wherever possible to provide real time information exchange in order to support online eligibility determinations.

The Exchange has also engaged contract services to provide project management, technical, and business support services to assist the Exchange IT staff in leading the CalHEERS development effort. Additionally, IV&V services will provide an early warning of technical risks and deviations from requirements, which will allow the project team to take the necessary corrective actions.

IT activities during the Level I (1.2) period will also include planning and procurement of the service center infrastructure to provide telephone access, and to support other program administrative functions such as mail processing. Planning will be done in conjunction with DHCS and MRMIB and county welfare departments and other service providers as service center functions need to be designed and operated in conjunction with related functions supporting applicants and enrollees in other health subsidy programs such as Medi-Cal and Healthy Families, as well as other public programs.

Operations and 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 Affordable Care Act 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" is having the appropriate mix of staff and consultants retained to launch, operate and sustain the California Exchange.

During the Level I grant (1.2) , the California Exchange will continue to develop and maintain 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). CDSS assists 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.

The California Exchange is committed to implementing an effective program to prevent waste, fraud and abuse with funds used to start up and operate the California Exchange. During the Level I grant (1.2) , the California Exchange 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 develop, review and finalize the Exchange sustainability plan consistent with state and federal requirements, and the California Exchange vision, mission and values, inviting and incorporating stakeholder input, for submission with the Level II Exchange Establishment grant.

c. Evaluation Plan

During the period of the Level I grant (1.2), the Exchange will engage in a program-wide evaluation planning effort. The Exchange will engage an expert consultant to assist in the research and gap analysis to identify existing data sources and measures, as well as new data collection methods to support ongoing evaluation of Exchange programs and activities. The process will rely on both primary data collection and secondary data sources focused on supporting ongoing evidence-based policymaking by the Exchange.

The evaluation planning process will incorporate evaluation activities intended to measure: 1) core area grant supported activities, and 2) IT related tasks and supporting activities. An evaluation work group comprised of Exchange staff, state partners and expert consultants will underpin this process. In collaboration, the work group will identify intended outcomes in specified areas (e.g. outreach/marketing, health care system utilization changes, health outcomes, etc.).

Throughout the evaluation planning process, the Exchange will engage the Board, policymakers and stakeholders to gather their input and comments. Upon adoption by the Board, Exchange staff and consultants will perform evaluation oversight and data review/synthesis against established metrics and other outcome measures.