COVERED CALIFORNIA POLICY AND ACTION ITEMS

November 21, 2013

IDENTITY PROOFING POLICY

David Maxwell-Jolly, Chief Deputy, Executive Director

COVERED CALIFORNIA

IDENTITY PROOFING PROCESS KEY ISSUES

Federal Guidance Requires Identity Proofing

- Federal guidance released in June 2013 requires identity verification for all consumers applying for health insurance through the individual and SHOP Marketplaces.
- Identity proofing ensures applicants are who they say they are.
- The Remote Identity Proofing Program is a federally-sponsored service that verifies applicants' identities based on correct answers to security questions, which may pertain to applicants' credit history, residential history, or other identifying attributes.

Implementation of the Single Streamlined Application and related identity proofing processes is a joint effort between Covered California and the Department of Health Care Services. The current identity proofing process includes the following:

1. Paper: The consumer provides a signature attesting to his/her identity, under the penalty of perjury.
2. Online: The consumer provides an electronic signature attesting to his/her identity, under the penalty of perjury.
3. In-Person: In-person enrollment assistance personnel must provide verification of identity to become certified and must verify applicants' identities.
4. Phone: The consumer provides a recorded verbal attestation that the consumer is who he/she says he/she is, under the penalty of perjury.

PROPOSED REVISION IDENTITY PROOFING PROCESS

Covered California and DHCS have revised the identity proofing process to include use of the federal identity proofing service:

- Individuals applying online and or over the phone will respond to Remote Identity Proofing ("RIDP")-supplied questions to verify their identities.
- CalHEERS will be equipped to interface with the Federal Data Services Hub for the RIDP.
- Applicants in the individual marketplace will be able to verify their identity via one of the following channels:
  - Paper application: Signature under the penalty of perjury
  - In-person: Verification of identity through review of photo documentation or other acceptable proof.
  - Non-paper application: Federal Data Services Hub Remote Identity Proofing Process **OR** in-person proof of identity **OR** mail or electronic transmission of proof of identity
- SHOP Marketplace identity verification process will remain unchanged

Required actions

- Recommend approval by the Covered California Board of proposed identity proofing regulations
- DHCS will also codify identity proofing requirements consistent with Covered California's proposed regulations.

SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP) PROPOSED APPEALS REGULATIONS

Anne Gezi, SHOP Manager

SHOP APPEALS REGULATION TIMELINE

Activity	Proposed Timeline
Stakeholder Review of Draft Proposed Dispute & Appeals Regulations	October 15 – November 11
Board Meeting – Approval of Proposed Regulations	November 21
Submit to Office of Administrative Law for Approval	November 22

SHOP PROPOSED APPEALS REGULATIONS

Article 6. Application, Eligibility, and Enrollment Process for the SHOP	
Sections:	**Table of Contents:**
§ 6540	Definitions
§ 6542	General Eligibility Appeals Requirements for SHOP
§ 6544	Informal Resolution
§ 6546	Dismissal of Appeals
§ 6548	Hearing Requirements
§ 6550	Expedited Appeals
§ 6552	Appeals Decisions

SHOP APPEALS REGULATION HIGHLIGHTS

HIGHLIGHTS:

- An employer/employee may appeal:
  - An eligibility determination or failure to make such a determination; or
  - A failure of the SHOP to provide written notice of an employer's eligibility determination within 15 calendar days of receiving an application.
- An employer/employee has 90 days to request an appeal.
- An employer/employee shall have an informal resolution period.
- Appeals not resolved during the informal resolution will go to a formal hearing with the Department of Social Services (DSS).
- Appeals decisions will be issued to the appellant within 90 days of the appeal submittal date.

PROPOSED SHOP APPEALS REGULATIONS

Summary of § 6540: Definitions

- Define an appeals request and the process for requesting an appeal.
- An appellant is an employer or employee.
- The California Department of Social Services (CDSS) is the designated appeals entity for the SHOP.
- Defines an appeals representative.

PROPOSED SHOP APPEALS REGULATIONS

Summary of § 6542: General Eligibility Appeals Requirements for SHOP

- An employer/employee shall have the right to appeal:
  - An eligibility determination made by the SHOP; or
  - A failure of the SHOP to provide written notice of an employer's eligibility determination within 15 calendar days of receiving an application.
- An employer/employee shall have 90 days to request an appeal from the date of notice of the eligibility determination.
- Notices of the right to appeal a denial of eligibility must include the reason and the procedure to file an appeal.

PROPOSED SHOP APPEALS REGULATIONS

Summary of § 6544: Informal Resolution

- An employer and employee shall have an opportunity for informal resolution prior to a hearing with the appeals entity.
- If the appellant is not satisfied with the outcome of the informal resolution process, the designated appeals entity will schedule a hearing with an Administrative Law Judge.
- If the appellant is satisfied with the informal resolution, a hearing is not scheduled with the appeals entity and the appeal is closed.
- The SHOP will electronically transfer all documents to the appeals entity before an appeal goes to hearing.

PROPOSED SHOP APPEALS REGULATIONS

Summary of § 6546: Dismissal of Appeals

- The appeals entity has the right to dismiss an appeal if the appellant withdraws the request in writing or fails to comply with appeal request standards.

- If an appeal is dismissed, the appeals entity shall within 15 business days from the date of the dismissal, provide written notice to the appellant including the reason for the dismissal.

- The appeals entity will vacate a dismissal and proceed with the appeal if the appellant shows, in writing, good cause why the appeal should be reinstated.

PROPOSED SHOP APPEALS REGULATIONS

Summary of § 6548: Hearing Requirements

- Establishes the appellant's rights to a hearing.
- When a hearing is scheduled, the appeals entity shall send written notice to the appellant of the date, time, and location or format of the hearing no later than 15 days prior to the hearing date.
- The hearing shall be conducted by an Administrative Law Judge.
- The hearing shall be conducted by telephone, video conference, or in person.

PROPOSED SHOP APPEALS REGULATIONS

Summary of § 6550: Expedited Appeals

- Establishes a process for an appellant to request an expedited appeal where there is an immediate need for health services.
- Ensures a hearing is set on an expedited basis with the appeals entity.

PROPOSED SHOP APPEALS REGULATIONS

Summary of § 6552: Appeals Decisions

- States that appeals decisions must be based solely on the evidence and the eligibility requirements for the SHOP.
- Appeals decisions must be issued to the appellant within 90 days of the date on which an appeal request is received, unless the 90-day timeline is extended due to good cause.
- Upon notice from the appeals entity, SHOP will implement the appeal decision.

READOPTION OF FINGERPRINTING AND CRIMINAL BACKGROUND CHECK EMERGENCY REGULATIONS

Katie Ravel, Director of Program Policy

FINGERPRINTING & CRIMINAL RECORDS CHECKS – READOPTION OF EMERGENCY REGULATIONS

- Emergency regulation approved at the June 20, 2013 Board meeting.
- 180-day emergency regulation period expires on December 25, 2013 – asking for readoption today.

Key Provision

- Require fingerprint-based criminal background checks for any employees, prospective employees, contractors, subcontractors, volunteers or vendors who will have access to personal information of Covered California applicants and enrollees.

INCOMPATIBLE ACTIVITIES STATEMENT

Gabriel Ravel, Assistant General Counsel

INCOMPATIBLE ACTIVITIES STATEMENT

- Required under Government Code Section 19990.

- Modeled on and drawing from:
  - Requirements in the Government Code;
  - Other state entities' statements; and
  - Conflict rules specific to Covered California in Government Code 100500.

EXAMPLES OF INCOMPATIBLE ACTIVITIES FOR COVERED CALIFORNIA EMPLOYEES AND OFFICERS

- Accepting a gift with the knowledge that it was given for purposes of influencing official action.
- Directly or indirectly selling goods or services to Covered California.
- Maintaining a professional health care practice.
- Performing any act as a private citizen while knowing or having reason to know that act later will be subject to the employee's review as a state official.

COVERED CALIFORNIA BOARD OF DIRECTORS RECOMMENDATION REGARDING THE QUALITY RATING SYSTEM (QRS)

Jeff Rideout, Senior Medical Advisor

COVERED CALIFORNIA

CHARTING A PATH TO USE HISTORICAL CAHPS INFORMATION FOR QUALITY REPORTING IN JAN 2014

- CAHPS information available for 9 of 11 issuers and 11 of 13 plans:
  - No scores available for Chinese Community or Valley Health Plan.
  - No score to be posted for Alameda Alliance.

- Information available for all plans offered in 17 of 19 regions.

- 10 measures available across commercial HMO, PPO & Medi-Cal plans:
  - Access to Care(4): getting needed care (2), getting care quickly (2)
  - Doctors and Care (3): all health care (1), personal doctor (1), specialist (1)
  - Plan Service (3): rating of health plan (1), customer service (2)

- 4 measures excluded since not used in Medi-Cal: plan information on costs (2); claims processing (2)

- Underway: comparison of HEDIS/CAHPS scores and distribution vs. CAHPS only.

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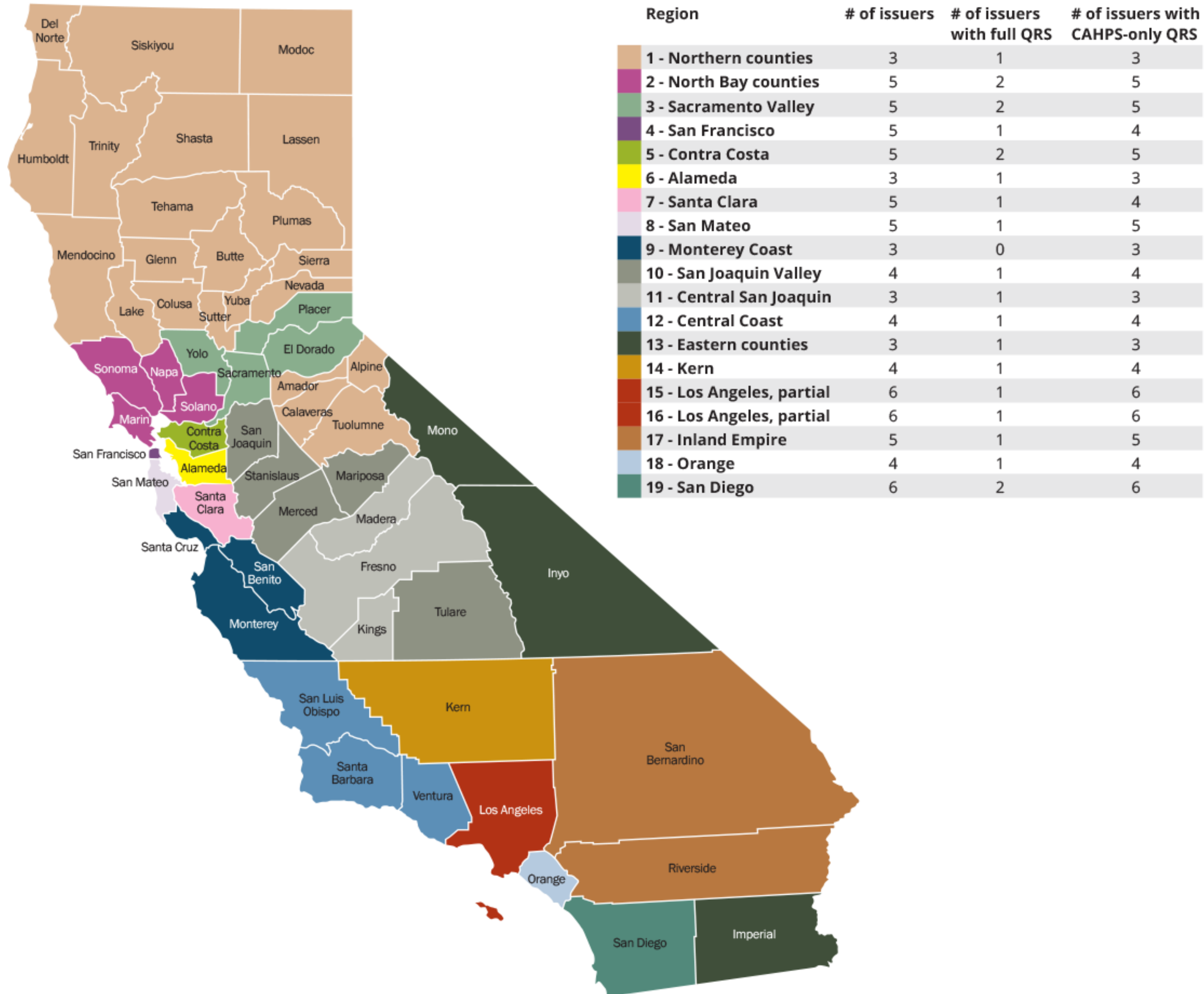
WHAT WOULD CALIFORNIA LOOK LIKE FOR CONSUMERS USING HISTORICAL DATA FOR SOME PLANS?



Region	# of issuers	# of issuers with full QRS	# of issuers with CAHPS-only QRS
1 - Northern counties	3	1	3
2 - North Bay counties	5	2	5
3 - Sacramento Valley	5	2	5
4 - San Francisco	5	1	4
5 - Contra Costa	5	2	5
6 - Alameda	3	1	3
7 - Santa Clara	5	1	4
8 - San Mateo	5	1	5
9 - Monterey Coast	3	0	3
10 - San Joaquin Valley	4	1	4
11 - Central San Joaquin	3	1	3
12 - Central Coast	4	1	4
13 - Eastern counties	3	1	3
14 - Kern	4	1	4
15 - Los Angeles, partial	6	1	6
16 - Los Angeles, partial	6	1	6
17 - Inland Empire	5	1	5
18 - Orange	4	1	4
19 - San Diego	6	2	6

RESULTS OF CAHPS SCENARIO TESTING- NEAR FINAL

	1 Star	2 Star	3 Star	4 Star
Using Regional PPO Benchmark	0	4	5	2
Using National PPO Benchmark	2	5	3	1
Using California PPO Benchmark	No meaningful performance distribution benchmarks is possible given only 6 plans			

COVERED CALIFORNIA

RECOMMENDATION ON QUALITY RATING SYSTEM (QRS)

- Staff recommends that Covered California implement a Quality Rating System using (1)10 CAHPS measures common to both commercial and Medi-Cal plans, (2) a single summary score for each plan compared to the regional PPO benchmark, and (3) a 1-4 star rating system.

- The earliest anticipated presentation of QRS information is January 2014 and will include all plans that have scores available. Plans for which no CAHPS information is available will be noted as "first information available in 2015." (note: Covered California has not yet conducted focus group testing on this terminology. As the language is tested, revisions may be made).

- The implications of this decision on the "Group 3" plan performance assessment of attachment 14 of the model contract have not been determined and will need further review.

ISSUES CONSIDERED BUT NOT RECOMMENDED

- Single measure of overall rating of plan (used by CO Exchange):
  - No reasonable distribution of plan scores-all very high or low.
  - Measure is very sensitive to product type (HMO, PPO, Medi-Cal).
  - Results of this single measure diverged from the 10 measure set results.
- National or state benchmarks:
  - Insufficient number of plans at state level to create meaningful distinctions.
  - National benchmark masked known western region differences related to population served and plan design features.
- Subset that excluded 3 care/physician related questions
  - No meaningful difference in distribution; implied policy decision.

IMPORTANT CMS UPDATE: NATIONAL QRS PROGRAM ISSUED ON 11/18/13 FOR 60 DAY PUBLIC COMMENT

- Exchange specific
- 42 proposed measures:
  - 29 “clinical” (primarily HEDIS) and 13 consumer survey (CAHPS)
  - 76% NQF endorsed
  - 83% included in at least one “Federally-established” program
- Stresses consumer use for plan choice and proposes a global rating to for ease of use by consumers.
- Highly similar to Covered CA’s original design, including the current CAHPS-only version.
- Experience drawn specifically from NQF Measure Criteria (Measure Application Partnership-“MAP”) and Medicare Advantage 5 Star program.
- Comment period ends January 14, 2014.
- No date given for when such QRS information would be available for enrollees to use.

OPTIONS FOR COVERED CALIFORNIA TO OFFER PEDIATRIC DENTAL COVERAGE IN 2015

Jon Kingsdale, Ph.D., Steve Wessling, ASA, MAAA
& Julia Lerche, FSA, MAAA, MSPH

INPUT REQUESTED

Send public comments to qhp@hbex.ca.gov

Comments requested by December 7, 2013

Current plan to propose final recommendation for action in January, 2014.

BOARD OF DIRECTORS' CHARGE FROM AUGUST MEETING

"The Board fully recognizes the value of preventive oral health for California's children, and embraces a policy that includes pediatric dental services embedded into contracted health plans. It is the Board's intention to make pediatric dental health available to families as an embedded benefit through the Exchange no later than the 2015 plan year, recognizing the technical and rating complexities involved with doing so…therefore….the Board hereby directs the staff to …draft a recommendation for embedded pediatric dental benefits in consultation with stakeholders for Board approval before the end of this year."

Q4 2013 PEDIATRIC DENTAL RE-START

Pediatric Dental Policy Development Proposed Timeline	
Date	**Milestone**
✓ August 22	Scope of work developed and shared at scheduled Board meeting
✓ October 15	Draft analysis completed
✓ October – November	Draft analysis shared with stakeholders for comment
➔ November 21	Recommendations presented to the Board for discussion and public comment
December 19	Recommendations presented to the Board for action

COVERED CALIFORNIA PEDIATRIC DENTAL 2015

Policy

- Back to basics and architecting POLICY
  - *What is the "best" public policy for California's children?*
  - *What should Californians be mandated to purchase?*
  - *Who should pay?*
- Policy decisions guide building the solution

Product

- Based on Policy decisions build the PRODUCT
  - *Is it best to embed the benefit or bundle?*
  - *Should there be a single shared medical and dental OOPM? How will cost sharing work?*
  - *How will products be billed?*

Portfolio

- Based on Policy decisions build the PORTFOLIO
  - *How many options are in the portfolio?*
  - *Which should be offered? Embedded, bundled or stand-alone?*
  - *What happens when you place a 10 EHB next to a 9.5 EHB?*

PROPOSED POLICY OBJECTIVES

Primary:

1. **Maximize the availability of the advanced premium tax credit for the pediatric dental benefit**
2. **Ensure the enrollment of all eligible children (≤18) in the pediatric dental benefit**

Additional:

3. Ensure the application of all consumer protections to the dental benefit
4. Fairly spread the cost of the dental benefit across populations with and without children
5. Equalize benefit design (coverage) on and off the Exchange
6. Structure cost sharing to ensure a meaningful dental benefit (OOPM, deductibles)

REVIEW OF HEALTH PLAN DEFINITIONS

The Affordable Care Act requires Covered CA to offer consumers health plans covering 10 Essential Health Benefits (EHBs). "Pediatric Services" (dental and vision) comprise one of the ten benefits, and pediatric dental can be referred to as a "0.5" benefit. The following health plan definitions reference the 10 Essential Health Benefits:

- **0.5 plan** – a stand-alone dental plan that includes pediatric dental coverage
- **9.5 plan** – a health insurance plan that does NOT include pediatric dental coverage, but includes the remaining 9.5 Essential Health Benefits
- **10.0 plan** – a health insurance plan that includes coverage for all 10 Essential Health Benefits (including pediatric dental)
    - **Embedded** - a single policy and premium covering all 10 Essential Health Benefits. Pedi-dental coverage is "embedded" in the health plan
    - **Bundled** - two distinct 9.5 and 0.5 insurance policies sold together as a package

AFTER CONSIDERING A RANGE OF OPTIONS* TO ACHIEVE OUR POLICY OBJECTIVES, ONE RECOMMENDATION WAS SELECTED FROM THREE FINALISTS.

A. Change/waiver in CMS regulations to add 2nd lowest 70% stand alone dental premium for calculating advanced premium tax credits, and screen for pedi-dental at “check-out,” or

B. Work with issuers to offer 10.0 embedded essential health benefits and 0.5 dental plans, or

C. Solicit both embedded 10.0 and 9.5 plans, except for the Silver level (10.0 only), and screen for pedi-dental at “check-out.”

** All considered options can be viewed in the full Wakely Report*

RECOMMENDED OPTION:

B. Work with issuers to offer 10.0 embedded essential health benefit and 0.5 dental plans for 2015

- Require dental-only deductible
- Require "protected" dental out-of-pocket-maximums, wherever possible
- Require single out-of-pocket maximum for high deductible plans, including catastrophic
- Consider changing age curve to eliminate cross subsidization of embedded pediatric dental

STAKEHOLDER FEEDBACK 1

Meetings: October 29 & November 13

- Is there a meaningful market for a ".5" if offered alongside embedded?
- Is lack of a "9.5" option on Exchange contrary to Federal guidance?
- Requests to honor business process needs of dental and health plans - help meet deadlines but also not proceed too quickly and do it right.

STAKEHOLDER FEEDBACK 2

- Support for an "integrated," protected dental out-of-pocket maximum
- No final consensus point of view on cost-sharing strategies; various combinations proposed
- No consensus on policy importance of maximizing APTC availability: some yes (consumer, health, children's groups) some no (dental plans)

STAKEHOLDER FEEDBACK 3

- Transition issues need more attention; disruption a concern if move to embedded from current standalone environment

- How will individual market pediatric dental solutions be applied to SHOP? Considerations? Timeline?

FINALIST RECOMMENDATIONS-QUICK VIEW

	MEETS POLICY GOALS		ADDRESSES KEY ISSUES		
	MAXIMIZE APTC	ASSURE ENROLLMENT OF CHILDREN	FAIR COST ALLOCA-TION	CONSUMER CHOICE	TECHNICAL FEASIBILITY
A. Change/waiver in CMS regulations + check-out screen	✓	✓	✓	✓	✓
B. 10.0 embedded essential health benefits and 0.5 dental plans	✓	✓	✓*	✓	✓
C. Embedded 10.0 plus 9.5 plans at all levels-- except Silver: embedded only + check-out screen	✓	✗**	✓*	✓	✗

*If age curve revised

**Complexity = consumer confusion + lower enrollment

SUMMARY COMPARISON OF THE RECOMMENDED OPTION WITH DEFAULT OPTION - SEPARATE HEALTH AND DENTAL PLANS

- Recommended Option: 10.0 – Protected Out-Of-Pocket Maximum
  - 10.0 embedded pedi-dental, with a dedicated $1,000 dental out-of-pocket maximum and $6,350 total out-of-pocket maximum (2X for family).
  - Modeled with a separate dental deductible (as in current .5 plans)

- Default Option: Separate 9.5 +.5 Policies – Under SB 639
  - Medical out-of-pocket maximum reduced by $1,000 ($2,000 for Family) and premiums increase ~ 1.5%

Assumptions:

- *Impact assumes family of four is purchasing a .5 stand alone dental plan under the 9.5 +.5 option*
- *Plan designs, estimated claim costs, and premium are reflective of 2014*

FAMILY OF FOUR - IMPACT OF RECOMMENDATION RELATIVE TO DEFAULT

- **Helped** Families generally benefit as premiums will be lower than under default due to –

  1. A higher out-of-pocket maximum on medical ($6,350 vs. $5,350) and;
  2. The cost of pediatric dental is spread across entire population, including adults without dependent children.

- **Hurt** Those who are hurt generally have out-of-pocket costs higher than $5,350/$10,700 that are not offset by the premium decrease.

- **FPL*** Similar for those between 250-400% of federal poverty level; Eligibility for tax credits increases % and magnitude of those helped by recommended option.

** FPL - Those eligible to receive the advanced premium tax credits*

SINGLE ADULT – IMPACT OF RECOMMENDATION RELATIVE TO DEFAULT

- **Helped** None are helped.
- **Hurt** Single adults are hurt from the premium increase. In addition, those with out-of-pocket costs higher than $5,350/$10,700 are affected on the cost side.
- **FPL*** Most single adults who qualify for a federal subsidy would be indifferent to either option; Those who would be hurt by recommended option relative to default would be those with out-of-pocket costs higher than $5,350/$10,700

** FPL - Those eligible to receive the advanced premium tax credits*

ILLUSTRATIVE IMPACT OF RECOMMENDED OPTION* VS. DEFAULT**

DPPO ***	Impact of recommended option vs. default					
	Unsubsidized			APTC Subsidized		
	Helped	Hurt	Total	Helped	Hurt	Total
Family of Four (per year)						
% of Families	85.7%	14.3%	100.0%	85.9%	14.1%	100.0%
Average (Savings)/Cost	($665)	$383	($516)	($753)	$297	($604)
Range of (Savings)/Cost	($666) - $0	$0 - $1,334	($666) - $1,334	($755) - $0	$0 - $1,245	($755) - $1,245
Single Adult (per year)						
% of Single Adults	None Helped	100.0%	100.0%	Unaffected	6.2%	100.0%
Average (Savings)/Cost		$64	$64		$1,000	$62
Range of (Savings)/Cost		$2 - $1,002	$2 - $1,002		$0 - $1,000	$0 - $1,000

Note: Amounts and ranges, while best estimates, are illustrative. Actual experience will vary.

** Refers to Option 2 in the Wakely Report*

*** Refers to Options 5/6 in the Wakely Report*

****Assuming 2nd lowest DPPO premium in Region 4 (San Francisco)*

ADDITIONAL PREMIUM ON SINGLE ADULTS

- While most will benefit from the recommended option, additional premium will be charged to the unsubsidized; including single adults
- The current age rating methodology causes older adults to be disproportionately affected
- The estimated 15% of enrollees who would benefit from pediatric dental would pay 6% of the costs; the other 94% would be paid for by adults who don’t benefit from embedding

Age	Age Factor	↑ in Annual Premium*	
		DHMO	DPPO
0-20	0.635	$8	$25
21-24	1.000	$13	$39
40	1.278	$17	$50
50	1.786	$24	$70
60	2.714	$36	$106
64	3.000	$40	$117
Average	1.455	$19	$57

- *Change in annual premium is an estimate with many dependencies; amounts depicted are based on an estimate for illustrative purposes. 2nd lowest 2014 DHMO and DPPO premiums in Region 4 (San Francisco) utilized for this comparison. This do not represent maximums or minimums; rather it seeks to convey the effect that differences in product can have on premium.*

RECOMMENDATION RECAP

Work with issuers to offer 10.0 embedded essential health benefit and 0.5 dental plans for 2015

- Require dental-only deductible
- Require "protected" dental out-of-pocket-maximums, wherever possible
- Require single out-of-pocket maximum for high deductible plans, including catastrophic
- Consider changing age curve to eliminate cross subsidization of embedded pediatric dental

IF EMBEDDED, COVERED CA STILL HAS TO DECIDE *HOW TO* EMBED THE PEDIATRIC DENTAL BENEFIT

Require Embedded DPPO in 10.0 QHPs	Require Embedded DHMO in 10.0 QHPs
Offer Both 10.0 Plans, w/ Embedded DPPO & DHMO	Allow Issuers to Embed either DPPO or DHMO

2nd-lowest priced DPPO (Anthem)	Typical Premium = $25	12,861 dentists
2nd-lowest priced DHMO (Delta)	Typical Premium = $11.49	5,347 facilities

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METHODOLOGY FOR ANALYSIS

- **Plan Designs**
  - In analysis of costs, medical plan used is Silver with $900 deductible, 30% coinsurance, and $6,350 OOPM; stacked deductible and out-of-pocket maximum
  - Stand alone dental plan proxies the Standard California PPO Low Option

- **Methodology**
  1. Medical and dental annual claim amounts trended to 2014 and simulated 10,000 times for a each member of a family of four and a single adult
  2. For each of option, the resulting claim costs and out-of-pocket expenses were determined
  3. The net total annual impact (including out-of-pocket costs, premiums, and advanced premium tax credits) of selecting the recommended option was determined
  4. The comparison is displayed separately for a family of four and a single adult (≥21) and for those eligible for advanced premium tax credits
  5. The resulting net impacts on a household's premium and out-of-pocket costs are separated into those who were "helped" or "hurt" by the recommended option - including by how much (average and range of "help" or "hurt").

ILLUSTRATIVE IMPACT OF RECOMMENDED OPTION* VS. DEFAULT**

DHMO ***	Impact of recommended option vs. default					
	Unsubsidized			APTC Subsidized		
	Helped	Hurt	Total	Helped	Hurt	Total
Family of Four (per year)						
% of Families	85.5%	14.5%	100.0%	85.5%	14.5%	100.0%
Average (Savings)/Cost	($320)	$721	($169)	($247)	$792	($96)
Range of (Savings)/Cost	($320) - $0	$0 - $1,680	($320) - $1,680	($247) - $0	$0 - $1,753	($247) - $1,753
Single Adult (per year)						
% of Single Adults	93.8%	6.2%	100.0%	Unaffected	6.2%	100.0%
Average (Savings)/Cost	($40)	$960	$22		$1,000	$62
Range of (Savings)/Cost	($40) - $0	$0 - $960	($40) - $960		$0 - $1,000	$0 - $1,000

Note: Amounts and ranges, while best estimates, are illustrative. Actual experience will vary.

** Refers to Option 2 in the Wakely Report*

*** Refers to Options 5/6 in the Wakely Report*

****Assuming 2nd lowest DHMO premium in Region 4 (San Francisco)*

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NAVIGATOR PROGRAM REGULATIONS

Sarah Soto-Taylor, Deputy Director Community Relations

NAVIGATOR PROGRAM BACKGROUND

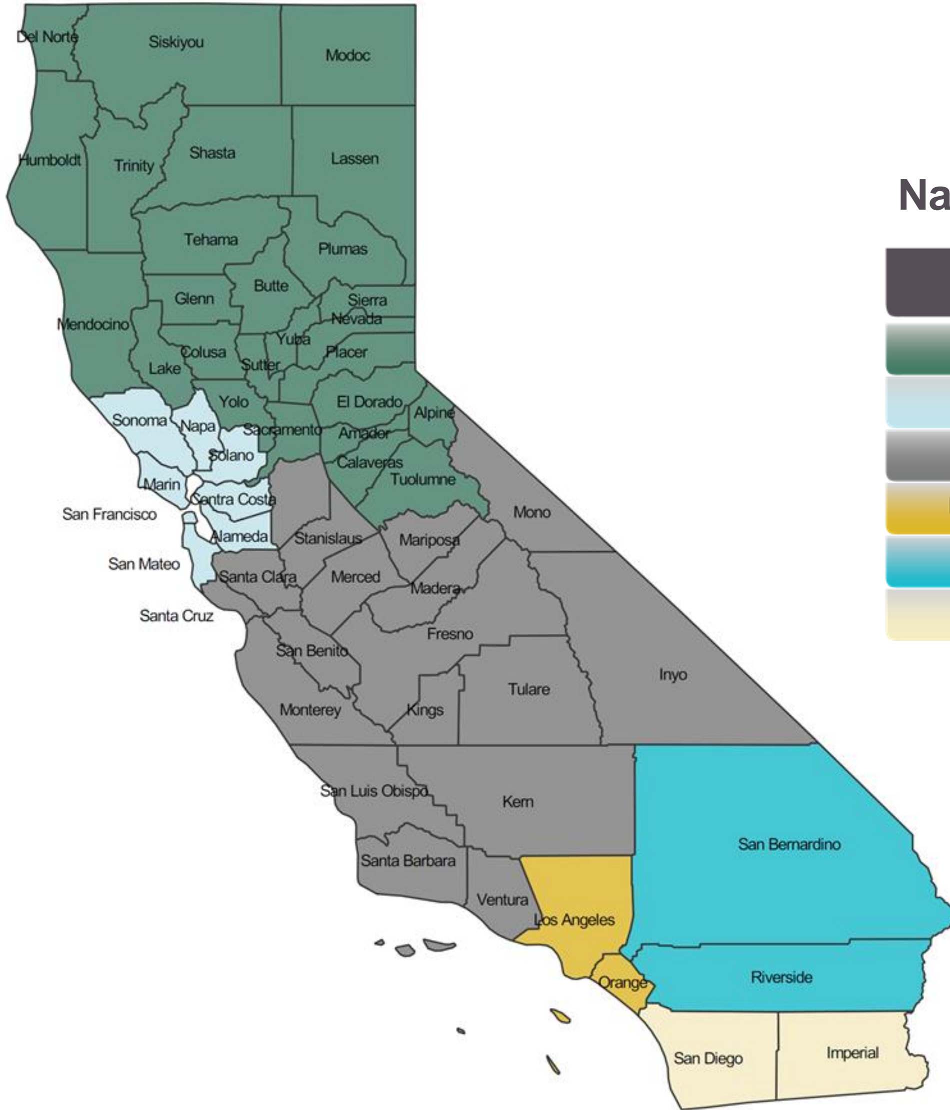
- Navigator Grant Program Webinar October 28, 2013
  - $5 million competitive grant program
  - Outreach, Education and Enrollment Activities
  - Presentation can be viewed here

- The Navigator Grant Program will test alternatives to reach eligible consumers with two key funding strategies:
  - Targeted funding pool – Award smaller grants to organizations that are reaching hard-to-reach populations within one or more regions.

    Potential Funding: $1,000,000 to $2,000,000
  - Regional funding pool – Encourage regional collaborations, established and emerging partnerships to submit a joint proposal under a lead entity to ensure broad reach into Covered California's target markets in a single region.

    Potential Funding: $3,000,000 - $4,000,000

NAVIGATOR PROGRAM BACKGROUND



Navigator Grant Program Regions

Region	% of State	Pricing Regions
North	7%	1,3
Bay Area	10%	2,4,5,6,8
Central CA	17%	7,9,10,11,12,13,14
Los Angeles	49%	15,16,18
Inland	10%	17
San Diego	7%	13,19

NAVIGATOR PROGRAM BACKGROUND

Navigator Program Timeline	Date
Navigator Grant Application Release	February 3, 2014
Navigator Applications Due	March 3, 2014
Review effective O&E strategies based on Open Enrollment Data	March-April 2014
Announcement of Intent to Award	April 23, 2014
Contract Negotiations	April 24 – May 14, 2014
Navigator Affiliation & Background Check	May 16 – June 5, 2014
Navigator Grantee Training & Certification	June 2 – July 3, 2014
Navigators Begin Enrollment Assistance	**July 1, 2014**
Special Enrollment Period	July 1 – Sept 30, 2014
Open Enrollment Period	Oct. 15 – Dec. 07, 2014
End of Grant Award Period	December 31, 2014
Evaluation and Comparison of Outreach, Education and Enrollment programs	Jan. – Feb. 2015

- Outreach and Education strategies will be analyzed using enrollment data at the end of the first open enrollment period.

- A comparative analysis of the Outreach and Education Grant, In Person Assistance, and Navigator Programs will be conducted in January and February of 2015.

NAVIGATOR PROGRAM BACKGROUND

Feedback from Stakeholder on Navigator Program Key Policies:

- There was general support of program policies presented, with minimal feedback received in the following areas:
  - Total funding of $5 million may be insufficient
  - Geographic regions too large (Original recommendation 3 now 6 regions)
  - General support of Regional and Targeted Population funding pool
  - Concerns over aggressive goals relative to proposed award size within regions
  - More emphasis needed on retention activities
  - Existing relationships with Targeted Population is of greater program value than cost effectiveness and robust infrastructure
  - Provide ongoing support beyond enrollment for those covered for the first time
  - Request for enrollment and demographic data prior to release of Application
  - Allow organizations to apply as a regional lead and a sub for targeted population

NAVIGATOR PROGRAM BACKGROUND

The following organizations responded:

1. California Coverage & Health Initiatives; California Primary Care Association; Community Health Councils, Inc.
   - Additional signers: California Pan-Ethnic Health Network; Children's Defense Fund-California; Children Now; The Children's Partnership; The Greenlining Institute; United Way of California
2. California Health Collaborative
3. California Pan-Ethnic Health Network
4. Del Norte Senior Center
5. Everett Hunter Foundation
6. Gonzalez, Allan (Individual)
7. NAMI California
8. Young Invincibles

NAVIGATOR REGULATIONS

- Article 8. Enrollment Assistance.
  - Section 6650 Definitions
    - Adding Navigator and Navigator Program meaning
    - Definition of Navigator Eligible and Ineligible Entities
      - Staff recommend adopting the same categories of compensated entities as the In-Person Assistance Program
  - Adding Section 6656 Application and Selection Criteria
    - Incorporation of the Navigator Program Request for Application by reference
      - Application will be available in draft form in early December for stakeholder input
    - Defining that at lease one grant shall be awarded to a non-profit Community Based Organizations and any one of the other categories of eligible entities
  - Section 6664 Roles and Responsibilities
    - Adding the requirement that Entities and Counselors registered in the Navigator Program must also conduct public education to raise awareness about Covered California