ACHIEVING HEALTH CARE COVERAGE SUCCESS IN 2014 AND BEYOND:

STAKEHOLDER INPUT ON STRATEGIES FOR MARKETING, ELIGIBILITY, ENROLLMENT AND RETENTION

MARCH 22, 2012

CALIFORNIA HEALTH BENEFIT EXCHANGE
DEPARTMENT OF HEALTH CARE SERVICES
MANAGED RISK MEDICAL INSURANCE BOARD

I. INTRODUCTION

Marketing, Outreach, Enrollment and Retention Input Process

The Patient Protection and Affordable Care Act of 2010 not only provides new coverage options and substantial subsidies, it requires states to create a simple way for individuals and small businesses to obtain affordable health care coverage. The California Health Benefit Exchange, California Department of Health Care Services (DHCS), and the Managed Risk Medical Insurance Board (MRMIB) are working in close partnership to develop marketing and outreach strategies to maximize enrollment of eligible Californians into the right health coverage for them and help them understand their rights. Additionally, Assembly Bill 922 (Monning, Statutes of 2011) expanded the duties and responsibilities of the Office of Patient Advocate with regard to providing outreach, education and consumer assistance to all Californians.

The Exchange, DHCS, and MRMIB (collectively referred to here as program partners) solicited stakeholder input to inform strategies for marketing, outreach, enrollment, and retention to assure maximum coverage in insurance affordability programs including Medi-Cal (California's Medicaid program), Healthy Families (California's Children's Health Insurance Program), Exchange premium tax credits and cost sharing subsidies as well as unsubsidized Exchange coverage. Input into helping plan for and develop education, outreach and assistance programs has been received through multiple channels including:

- *Written comments*. Stakeholders were invited to submit written comments on over 50 questions developed in collaboration with the Exchange's Individual and Small Business Advisory Groups (see Appendix A).
- *Small group sessions*. Program partners convened a series of small group sessions around the state to solicit feedback from a diverse group of stakeholders.
- *Stakeholder comment letters and reports*. Program partners received helpful comment letters and reports that will inform development of outreach and assistance strategies.
- *Exchange Board meetings*. Stakeholders have and will continue to provide public comment on outreach and assistance at monthly Exchange Board meetings.
- *Assembly Bill 1296*. This input is being used to inform the stakeholder engagement called for under the Health Care Reform Eligibility, Enrollment, and Retention Planning Act (AB 1296, Bonilla, Statutes of 2011).

This report is a compilation of input from the first three channels.

Small group sessions were convened by the Exchange, DHCS, MRMIB, and OPA. Seventeen sessions were convened between November and December 2011 in Fresno, Los Angeles, Oakland, Rocklin (Placer County), Sacramento, San Bernardino, San Diego, San Francisco, and San Mateo. Separate sessions were convened for consumer advocates, providers, county representatives, and brokers to encourage open dialogue. This diverse group of participants collectively serve or represent over 25 California urban and rural counties (see Appendices B).

- Consumer advocates represented community- and faith-based organizations, legal aid organizations, and immigrants' rights groups.
- Brokers represented large and small firms serving individuals and small and large businesses.
- Providers represented public and private hospitals, clinics, physicians in solo and group practice, retail pharmacies and clinics, and Planned Parenthood facilities.
- County meetings included senior leadership and union line staff from over twenty counties and each of California's three county-based eligibility systems.

What follows is a summary of stakeholder input received in the small group sessions on marketing, outreach, enrollment, and retention questions. Program partners and contractors will incorporate suggestions from the small group sessions and written comments to inform the communications plan and the design of the assisters program.

Over 30 organizations and individuals submitted comments and letters (see Appendix C). Written comments are summarized below (see Appendix D), and full comments are available online: http://www.healthexchange.ca.gov/StakeHolders/Pages/Default.aspx. Related reports on outreach, enrollment, and assistance are also posted online and listed for reference in this report (see Appendix E).

Next Steps

Program partners are collaborating to develop a marketing and outreach plan to inform Californians about the full range of affordable health coverage that will be available to millions as of January 2014 and support their enrollment into health care programs. Program partners are contracting with Ogilvy Public Relations Worldwide to design a plan for a comprehensive statewide communications, marketing, outreach and education campaign to promote insurance affordability. The campaign will identify short- and long-term outreach, education and marketing strategies, including an assessment of promotional activities and methods used to communicate with various diverse target audiences. This engagement also includes the development of an implementation plan for an enrollment "assisters" program including training and performance requirements for enrollment entities.

II. PERSPECTIVES ON SUCCESS

Overall Success

Participants were asked to share their views on what successful coverage expansion would mean in 2014, 2016, and 2019. Participants shared aspirations that ranged from launching successful information technology systems to driving delivery system reform. Participants generally felt that program partners should focus on core competencies for a successful launch in 2014 and turn to health status and delivery system improvements in later years. Many participants emphasized that affordability would be a key marker of success in each year.

The selection of quotes below represents the breadth of participants' visions of success.

- A consumer advocate in Fresno said that success means people will "understand, trust and believe" in our programs.
- A broker in Los Angeles emphasized that success is "sustained affordability in 2016 and beyond."
- A county representative in San Bernardino noted that coverage is not the end point. Success means we have "a system of care in place to handle the newly eligible."
- A provider in San Diego said that in a successful delivery system "you monitor and address disparities between the young and old, women and men, and between racial and ethnic groups."
- For a provider in San Francisco "prevention won't be an afterthought" by 2016.

Enrollment Success

Participants were asked how they would define success based on enrollment of individuals eligible for insurance affordability programs. Participants offered a wide range of estimates though many felt that enrollment would grow over a period of years and did not expect enrollment to be high in the first year. Estimates ranged from a low of 20 percent enrollment by the end of 2014 to a high of 100 percent enrollment by 2019. While a few participants did aspire to enrollment of 100 percent of those eligible, others cautioned that enrollment in 2019 could be as low as 50 percent of those eligible given the challenges of communicating the benefits of health insurance. Many noted that enrollment would depend on the simplicity of enrollment systems and the affordability of health plans offered through the Exchange.

Participants also offered specific thoughts on successful enrollment of target populations. For example, a Fresno provider stated that success would mean enrolling 100 percent of eligible individuals who had contact with the health care system in the first year of coverage expansion.

III. MARKETING, PROMOTION AND OUTREACH

Strategies for Reaching Target Populations

Participants were asked to share recommendations for effectively marketing coverage options to target populations. Their feedback emphasized the need to understand target populations and tailor marketing and outreach to address their priorities using clear and simple messages. Some themes included:

- *Understand the priorities of target populations*. Participants encouraged program partners to learn what matters most to target populations. For example, participants noted that young and healthy individuals have different priorities from those with chronic conditions who seek regular care. Similarly, some target populations may

be motivated by the availability of affordable coverage while others may be more concerned about their liability for a tax penalty if they do not purchase coverage.

- *Tailor marketing and outreach to target populations*. Participants consistently emphasized the need to tailor marketing and outreach strategies to reflect the unique priorities and values of diverse target population. In addition to the target populations listed in question 1 (see Appendix A), participants frequently mentioned the need to design effective outreach for young and healthy individuals, families with mixed immigration status, and individuals above 400 percent of the federal poverty level who will be able to purchase coverage through the Exchange but will not be eligible for subsidies.
- *Use clear and simple messages*. Participants in many sessions talked about the complexity of health care coverage today and encouraged program partners to develop clear and simple messages that can be effectively translated in culturally and linguistically appropriate ways. A provider in the Sacramento session urged program partners to focus on the basics: coverage, eligibility, and access to care.

Several key considerations emerged in discussions on reaching target populations.

- *Prioritizing marketing and outreach efforts.* Participants noted that the cost of marketing and outreach will vary across target populations with some populations being easy to reach through low-touch strategies and others requiring resource-intensive targeted outreach. A consumer advocate in San Francisco noted that program partners will face this trade off in designing and budgeting for outreach and that the partners should be sure to have some focus on "hard-to-reach" populations.
- *Timing for marketing and outreach.* Some participants suggested that aggressive outreach and marketing should begin early to educate consumers about future coverage options and build brand awareness for the Exchange. Other participants felt that consumers would be more receptive to "just in time" information coinciding with the availability of expanded coverage.
- *Perception of government programs*. Some participants representing consumer advocates, brokers, and providers noted that many potential enrollees do not trust government programs and cautioned against branding that emphasizes government agencies. Participants also talked about the need to eliminate the stigma associated with publicly-subsidized health care programs today. Some participants recommended developing a statewide brand for insurance affordability programs that would emphasis health care coverage over program distinctions.
- *Need for balanced risk pool*. Several participants spoke to the importance of having a balanced risk pool for the Exchange and the need for effective marketing and outreach strategies to reach healthy individuals who may be less likely to purchase coverage.
- *Connection with human services*. Some participants noted that many individuals are served by multiple health and human services programs and recommended giving consideration to integrating the outreach and enrollment process for these programs including the CalWORKS financial assistance program and CalFRESH supplemental nutrition program (also known as food stamps). However, several participants

raised concerns about adding complexity and time to the enrollment process and noted that these activities could significantly increase the cost of assistance.

Top Marketing and Outreach Activities

Participants were asked about what top marketing and outreach strategies program partners should pursue. They provided valuable practical suggestions informed by on-the-ground experience enrolling individuals and small businesses in coverage.

- *Tell the stories of real people.* Participants across all stakeholder groups urged program partners to tell the stories of individuals, families and businesses who benefit from new coverage opportunities. Participants recommended highlighting different stories geared to each target population.
- *Leverage existing, trusted community networks.* Participants emphasized the need to leverage California's existing local marketing and outreach networks that are serving newly eligible populations today. These networks include county eligibility workers, agents and brokers, community-based health and social services programs, certified application assistants, California Coverage & Health Initiatives, legal aid organizations, Tribal administrative offices and health programs, promatoras, 2-1-1, and faith-based organizations.
- *Use social media to reach young adults*. Participants across stakeholder groups highlighted the need to use social media to reach young adults.
- *Work with schools to encourage coverage*. Participants across stakeholder groups encouraged marketing and outreach through schools to disseminate information about coverage and educate children and parents about the value of health coverage. Specific suggestions included using school events such as a back-to-school night and open house to highlight coverage options.
- *Work with colleges and universities to reach young adults*. Many participants recommend working with colleges and universities to educate young adults leaving school about their coverage responsibilities and options. Specific strategies included working with student health clinics, school media, parent/student orientation, and alumni associations.
- *Use ethnic media*. Participants emphasized the importance of using ethnic print, radio and television channels to inform individuals with limited English proficiency about the value and availability of coverage.
- *Give providers outreach tools.* Participants emphasized that providers play a key role in informing patients about coverage options at the point of service. Participants recommended that program partners do "in reach" to providers at hospitals, clinics, individual and small group physician offices, and pharmacies to educate them about coverage options and provide them with resources including written materials that meet health literacy standards to share with patients. Other suggestions included partnering with provider associations and professional schools to educate providers about coverage options.
- *Tailor outreach strategies for rural communities*. Participants talked about the needs of rural communities that may have limited Internet access and fewer community

resources for learning about and enrolling in coverage. A consumer advocate in Fresno recommended conducting outreach at community centers, libraries and other public Internet access points where individuals may apply for coverage online. Fresno participants also recommended working with post offices and farm bureaus which can be important gathering places in rural communities.

- *Tailor outreach strategies for small businesses.* Participants gave several suggestions for reaching small businesses including outreach with agent and broker networks; local, state, and ethnic chambers of commerce; agencies that issue business licenses; trade associations; and publications where small businesses advertise.
- *Other marketing and outreach strategies to explore.* A consumer advocate in San Diego noted that many people will not think of themselves as health care coverage consumers. Participants recommended marketing to individuals in non-health contexts including partnering with large retailers, local sports teams, and television and radio personalities to promote coverage.
- *Special marketing and outreach for SHOP.* When asked whether the Exchange should actively market the Small Business Health Options Program (SHOP) or rely on agents and brokers as the key marketing strategy, participants generally agreed that it would be in the Exchange's best financial interest to actually use brokers to market the SHOP. A broker in Los Angeles stated that the Exchange will need a robust program with agents and brokers to educate small businesses about the unique aspects of the SHOP including the benefit of plan choice.
- *Marketing oversight*. Participants were asked to share ideas for coordinating public and private marketing activities, and potential conflicts regarding provider marketing. Participants favored allowing private entities such as pharmacies and retail clinics to customize their marketing campaigns for insurance affordability programs as long as program sponsors approve key messages. Additionally they suggested that program partners implement clear and efficient review processes for marketing materials and maintain ongoing partnerships with private entities engaged in marketing.

Strategies to Maximize Early Enrollment

Participants were asked to provide input on strategies to facilitate maximum enrollment of eligible individuals with minimal assistance for coverage effective on January 1, 2014. Participants shared a variety of strategies and partnership opportunities.

- *Auto-enroll the LIHP Population.* Many participants emphasized the importance of successfully auto-enrolling Low Income Health Program (LIHP) enrollees in Medi-Cal. This county-based program serves low-income adults who are not eligible for Medi-Cal today but will become eligible in 2014. A county representative in San Bernardino suggested exploring the possibility of auto-enrolling individuals on LIHP waiting lists.
- *Maximize enrollment in insurance affordability programs.* Participants recommended working with entities that serve potentially-eligible populations including:
  - Individuals receiving CalFRESH benefits
  - Parents of children enrolled in the Healthy Families Program
  - Families that participate in the National School Lunch and First 5 programs

- Individuals receiving unemployment or disability insurance
- Individuals receiving housing subsidies
- Young adults aging out of foster care
- Individuals receiving Social Security benefits who are not eligible for Medicare
- Individuals previously eligible for COBRA coverage
- Recently-separated veterans
- Individuals receiving services from public health programs including the Family Planning, Access, Care and Treatment Program (Family PACT); Women, Infants and Children Program (WIC); and the Breast and Cervical Cancer Treatment Program (BCCTP).

- *Maximize enrollment among individuals who may not be eligible for subsidies.* Participants suggested working with agencies that serve broad segments of the population including those who may be eligible to purchase unsubsidized coverage in the Exchange. Specific suggestions included working with local utility companies and tax agencies to provide information about coverage options on standard forms.
- *Maximize enrollment among individuals who use health services.* Many participants recommended working with providers to maximize enrollment among individuals who are currently accessing health services. Some participants recommended co-locating assisters at health care facilities such as hospital emergency departments and provider offices to facilitate enrollment. Another suggestion was that program partners set up mechanisms to receive information from clinics and other providers that could be used for targeted outreach or pre-enrollment. Participants noted the need for safeguarding the privacy of personal health information if these strategies are used.

Strategies to Maximize Retention

Participants were asked about ways to maximize retention among those enrolled in coverage. Responses indicated the importance of simple renewal processes and use of health care services to show enrollees the value of coverage.

- *Simplify program rules.* County representatives and other participants encouraged program partners to use electronic verifications wherever possible and minimize the use of paper renewal processes to maximize retention.
- *Ensure access to care.* Many participants emphasized the importance of ensuring access to care to boost retention. A county representative in San Bernardino said that use of health care services is critical to making the value connection for the consumers, especially those who have not had insurance previously. Specific strategies included educating individuals about the value of preventive care and providing incentives for seeing a primary care provider.

Effective Messengers and Messages

Participants were asked to share their recommendations for effective messengers and messages. They encouraged program partners to highlight the stories of people who benefitted from coverage and enlist trusted sources to deliver messages.

- *Stories from people who benefitted.* Participants across stakeholder groups noted the effectiveness of sharing real stories from people who benefitted from coverage.
- *Trusted community leaders providing clear and consistent messages.* Participants across sessions stressed the importance of using trusted community spokespeople to deliver clear and consistent messages. Examples of trusted messengers included providers, brokers, CAAs, teachers, religious leaders, and ethnic media outlets. A provider in San Diego recommended identifying local "health heroes" to deliver messages.

IV. ENROLLMENT ASSISTANCE, NAVIGATORS AND HEALTH INSURANCE AGENTS

Perspectives on Entities' Roles in Providing Enrollment Assistance

Participants were asked about the role various entities including community groups, counties, agents and brokers, and providers should play in enrolling individuals and families in insurance affordability programs. Participants generally agreed that all entities have a role to play although their core competencies vary.

- *Levels of support.* Several participants raised concerns about the cost of assistance and its impact on the sustainability of the Exchange. A participant in the Sacramento session questioned whether the Exchange could afford to pay for any enrollment assistance. Many participants noted that while a simple and user-friendly enrollment portal could reduce the need for in-person assistance for a significant portion of the eligible population, some individuals would always need in-person assistance.
- *Need all hands on deck*. Many participants stated that the huge task of enrolling millions of newly eligible individuals beginning in 2013 would require an "all hands on deck" approach. A broker in Los Angeles encouraged program partners to create an environment where everyone is engaged to have a role to play.
- *Different groups start with different core competencies.* Participants noted differences in core competencies across enrollment entities, and stakeholder groups were generally open about their gaps in knowledge. For example, brokers pointed out their lack of experience with public programs as did consumer advocates with private insurance products. However, both groups expressed a willingness to learn in order to assist consumers through the full eligibility and enrollment process.
- *Existing trusted sources.* Participants pointed out that most target populations have trusted sources for coverage information today. Small employers and purchasers in the individual market are familiar with the broker model, while public program beneficiaries are more likely to use counties, consumer groups, and safety net providers for enrollment assistance. Many participants emphasized the importance of ensuring that existing trusted sources have a role to play in enrollment.
- *Diversity of views.* Participants in consumer advocate and broker sessions expressed widely divergent views on the roles of these two groups with respect to

enrollment in the individual Exchange. Some consumer advocates expressed a strong perspective that brokers should not play a role in the individual Exchange because of their lack of familiarity with public insurance affordability programs. Conversely some brokers felt that consumer groups would not be well suited to provide assistance in the individual Exchange because of the complexity of private insurance which brokers must be licensed to sell today. Many county representatives felt they were uniquely qualified to provide enrollment assistance for insurance affordability programs because of their current role and infrastructure for determining eligibility for health and human services programs. At the same time, many consumer and broker representatives expressed great concern about counties providing effective enrollment assistance for many individuals – especially those who are eligible for the Exchange.

The discussion highlighted key considerations for program partners in designing and monitoring enrollment assistance programs.

- *Levels of assistance.* Several participants suggested that groups may want to offer different levels of assistance ranging from basic assistance geared toward individuals with relatively simple situations to advanced assistance for hard-to-reach populations and complicated cases. However, others noted that levels of expertise could necessitate referrals which would be inconsistent with a "no-wrong-door" application process and real-time enrollment.
- *Need for oversight.* Participants recognized the need for oversight of entities providing enrollment assistance. Concerns were raised about providers and health plans steering individuals to particular products, brokers encouraging enrollees to sign up with carriers that pay higher commission, and community groups focusing solely on simple cases to maximize funding.

Supporting Applicants across the Continuum of Assistance

Participants were asked to give their opinions about a continuum of assistance ranging from "no-touch" to "high-touch". Participants generally agreed that use of assistance will fall into three categories: (1) self-service through mailing in material or the online enrollment portal, (2) mailed or online enrollment with phone assistance to resolve questions, and (3) in-person assistance. In this context, comments included:

- *Need for assistance will change over time.* Participants generally agreed that both phone and in-person assistance needs will be high initially and that the need for in-person assistance will decline over time as people become more familiar with private insurance products and online enrollment.
- *Be ready for high need in early years.* Many participants felt that a majority of applicants would need in-person assistance in the early years of coverage expansion as individuals learn about insurance affordability programs and struggle with the complexities of health insurance, possibly for the first time. Estimates ranged from 50 percent to a high of 95 percent. However, some noted that the need for in-person assistance could be reduced by offering a user-friendly enrollment portal and consumer support tools including phone and online assistance.

- *Understand the assistance needs of young people.* Some participants stated that young technology-savvy adults will be able to enroll online without assistance. Others felt that young people will need significant assistance because they tend to be unfamiliar with health insurance. A participant in Fresno suggested conducting focus groups with young people to better and more specifically understand their assistance needs.
- *Scope of assistance.* Some participants advocated for a broad scope of paid assistance that would include ongoing case management in addition to eligibility and enrollment services though others cautioned about the cost of ongoing assistance.

Methods of Payment for Enrollment Assistance

Participants were asked to share their opinions about appropriate payment methods for work performed by various enrollment entities. Participants were asked to respond to four specific payment options including no payment, flat application payment, grants, and commissions. Participants generally agreed that enrollment entities should be paid for their work and that multiple payment models or hybrid models would be needed.

- *No payment*. Under this payment model, enrollment entities would not receive compensation from program partners for enrolling individuals in insurance affordability programs or the unsubsidized Exchange. Participants generally stated that enrollment entities should be paid for enrollment activities. Many participants stated that payment is needed to provide the training required to ensure accuracy and quality.
- *Flat application payments*. Under this payment method, enrollment entities would receive a flat payment for each application. For example, in the early years of the Healthy Families Program, certified application assistants were paid $50 for assisting with an initial application and $25 for application renewals. Many participants supported this model. A provider in San Francisco stated that flat payments should be adequate to reimburse for the time and effort of enrollment. Participants also suggested that this approach could be modified to allow for "intensity-based" payments to provide higher reimbursement for more complex cases or could be linked to grants to support enrollment on hard-to-reach populations.
- *Grants*. Under this model, enrollment entities would be awarded a set amount of funding to provide enrollment services. Participants noted that grants are effective to fund up-front costs for outreach and education. Grants could also be used to support the intensive efforts required to enroll hard-to-reach populations. Some participants expressed a preference for grants over flat fees because the certainty of the funding makes it easier to budget for staffing and other operational costs.
- *Premium-based commissions*. Under this payment method, enrollment entities – typically brokers – receive a specific percentage of the premium cost of an individual enrolled in a health plan. Participants had mixed responses on whether a commission model will be necessary in the context of easier enrollment and a reformed market in which underwriting is no longer allowed with many noting that with market reform this payment method was inappropriate. Brokers emphasized

the commission payment mechanism should be maintained to cover the costs of their intensive enrollment and retention efforts particularly in the small group market. Several participants stated that broker commissions should be the same inside and outside the Exchange to prevent adverse selection.

- *Hybrid model*. Several participants suggested using a hybrid of both flat application payments for regular caseload combined with grants to fund start up or targeted enrollment of hard-to-reach populations.

The discussion highlighted key considerations in developing payment models.

- *Direct versus indirect benefits.* Many participants agreed that providers have an important role to play in providing enrollment assistance; however, some participants felt that providers should not be paid for enrollment activities because they will derive significant benefit from the increase in coverage. Some participants suggested stationing community-based or county assistants in providers' offices to take advantage of this critical entry point into the health care system.
- *Unintended consequences and the need for monitoring.* Some participants noted that flat application fees could encourage "cherry picking" easy cases while intensity-based payments could encourage "upcoding" to increase payment. Other participants noted that grant payments could be difficult to link directly to outcomes. Participants consistently pointed to the need for effective oversight and performance monitoring to ensure that payments are tied to successful enrollment.

Requirements and Standards for Assisters, Navigators and Brokers

Participants were asked: (1) what training requirements and performance standards should be implemented for navigators, and (2) what additional standards brokers should have to meet to the extent the Exchange uses brokers in the individual and/or small group markets. Participants emphasized the need for a thorough understanding of public programs and private insurance coverage for all entities that provide enrollment assistance and agreed that performance standards are critical to ensuring quality and accountability.

- *Training and certification requirements for navigators.* Participants noted the importance of rigorous initial and ongoing training covering both eligibility for insurance affordability programs and health insurance products. Participants noted the importance of being able to assist families that may qualify for multiple programs. Several brokers recommended that navigators be trained and licensed.
- *Performance standards for navigators*. Participants supported strong performance standards to ensure successful enrollment leading to high retention.
- *Participation standards for brokers*. Brokers generally agreed that they would need additional training in public programs to provide comprehensive enrollment assistance to applicants in the individual Exchange including those with family members who are eligible for Medi-Cal and other insurance affordability programs.

Acknowledgements

The California Health Benefit Exchange, Department of Health Care Services, and the Managed Risk Medical Insurance Board would like to thank each participant and commenter for their rich and valuable contribution to this input process. We also thank the groups that helped identify participants and host sessions: California Academy of Family Physicians, California Association of Health Underwriters, California Hospital Association, California Medical Association, California Pan-Ethnic Health Network, California Primary Care Association, California Welfare Directors Association, Health Access, San Diegans for Healthcare Coverage, United Ways of California and the respective United Ways of Fresno and San Diego, and Western Center on Law and Poverty.

APPENDIX A: STAKEHOLDER QUESTIONS

OVERARCHING INPUT

1. Regarding your overall vision, hopes and aspirations for the expansion of coverage through the Exchange, Medi-Cal, Healthy Families and through private coverage in California, what are your perspectives on:
    a. What would "success" look like in January 2014?
    b. What would "success" look like in January 2016?
    c. What would "success" look like in January 2019?

MARKETING, PROMOTION AND OUTREACH

For each of the questions that follow, if you have information and/or perspectives that are different for different target populations please describe -- including, but not limited to:

a. Non-English/monolingual speakers
b. Eligible individuals of different ages and different family compositions (e.g., children and members of families eligible for coverage from different programs)
c. Different racial, ethnic and cultural groups
d. Individuals whose first point of contact as being eligible is when they are receiving services (e.g., at an ER)
e. Different education levels
f. Individuals across spectrum of prior interaction with state/county social service support (e.g., from those with lots of experience to no experience)
g. Individuals without insurance (who have or have not had previously)
h. Small businesses with and without insurance
i. Individuals and businesses in rural areas

2. In addition to the potential market segments noted above, what are potentially important ways marketing and promotion should be segmented?

3. What are the top activities you think of in terms of marketing and outreach for the Exchange, Medi-Cal and Healthy Families?

4. What would you define as a successful marketing and outreach campaign? How can the Exchange build the kind of consumer attitude of loyalty, support and even affection that the public has for Medicare and Social Security?

5. What sales, outreach and assistance channels are most effective and efficient for populations in the individual market?

6. What sales, outreach and assistance channels are most effective and efficient for small employers?

7. How can the Exchange most effectively promote the availability of tax credits for eligible small businesses?

8. Which populations will be least likely to enroll without assistance in understanding their eligibility or the enrollment process?

9. Which populations should the Exchange focus on specifically and what outreach and assistance channels will be most effective and efficient for those populations?

10. How can enrollment be designed to facilitate maximum enrollment of eligible individuals with minimal assistance and as early as possible (e.g., enroll in 2013 to have maximum enrollment effective 1/1/2014)?

a. What populations might be automatically enrolled or have eligibility determinations made automatically?
b. How could the Exchange, Medi-Cal and/or Healthy Families enroll people previously eligible for COBRA with minimal effort on the part of the individual?
c. How could the Exchange, Medi-Cal and/or Healthy Families enroll people currently enrolled in or attached to public health coverage such as Family PACT enrollees or family members of Healthy Families kids?
d. How could the Exchange, Medi-Cal and/or Healthy Families maximize enrollment of subsidy or coverage eligible individuals who are currently covered by individual private insurance?

11. What steps can the Exchange take to assure the maximum possible retention of eligible individual enrollees who do not have affordable employment-based coverage?

12. What steps should the Exchange take to assure retention of small employers?

13. How should the Exchange consider the potential enrollment for employees of larger employers?

14. What steps should the Exchange, DHCS and/or MRMIB take to assure that any individual who disenrolls from or loses eligibility for coverage with one program is automatically or seamlessly enrolled in (or informed about) their rights for other coverage when the individual meets Affordable Care Act requirements?

15. Who would be the most effective messenger for marketing to different high priority populations?

16. How can the Exchange marketing efforts be best coordinated with national and state government partners and private sector partners (e.g., providers, plans, health insurance agents, and foundations)?

17. What type of marketing oversight standards should the Exchange use to prevent inappropriate steering?

18. What messages, branding, and outreach efforts should the Exchange use to get individuals ready to enroll in coverage in 2013? For example, what messages would be effective in generating interest/demand among the currently uninsured?

19. Should the Exchange do its own marketing related to the small employer program or should it rely on existing distribution channels (e.g., health insurance agents)?

ENROLLMENT ASSISTANCE, NAVIGATORS AND HEALTH INSURANCE AGENTS

20. What roles should the following entities play in Exchange, Medi-Cal and Healthy Families enrollment for individuals and families?
    a. Community/consumer groups
    b. Counties
    c. Health insurance agents/general agents
    d. Providers/community clinics
    e. Health plans

21. What roles should the following entities play in supporting enrollment of small businesses in the Exchange?
    a. Community/consumer groups
    b. Counties
    c. Health insurance agents/general agents
    d. Providers/community clinics
    e. Health plans

22. What would define a successful navigator program? What would define a successful relationship between health insurance agents and the Exchange?

23. How do enrollment assistance needs vary for individuals, small businesses and self-employed individuals? How should the Exchange take these differences into account in developing requirements for navigators, health insurance agents, counties or others (and what differences might that mean for any of the questions that follow)?

24. How would you define a continuum of assistance to support applicants based their needs and the complexity of their issue? Are there the natural "cut points" in the continuum of assistance (e.g., issues that do not need human intervention; issues readily addressed on the phone or those that would be best served by in-person assistance)?

25. Given the current licensing requirements for health insurance agents, what additional participation standards should the Exchange employ to the extent it uses health insurance agents in the individual market of the Exchange? What additional standards for health insurance agents might be appropriate for enrollment of small businesses in the Exchange?

26. What minimum criteria should navigators meet? What training/certification requirements should navigators meet?

27. What requirements should navigators have for providing culturally and linguistically appropriate services?

28. What should be the scope of work of navigators? What, if any, role should navigators play in ongoing case management/outreach to individuals after they enroll?

29. To what extent, if at all, should financial support be provided for community-level activities in advance of open enrollment?

30. What performance standards should navigators have (e.g., requirements for case volume or service time)?

31. How will the work of navigators be coordinated with other consumer assistance groups to provide effective, non-redundant services? How do we leverage the current certified application assistant (CAA) network?

32. What types of services beyond initial enrollment do health insurance agents provide today for individuals? What services beyond initial enrollment to health insurance agents provide for small businesses?

33. What are payment options and appropriate outcome measures for enrollment work performed by the entities listed below (e.g. fixed price per enrollment, percentage of premium, grants)?
    a. Community/consumer groups
    b. Counties
    c. Health insurance agents/general agents
    d. Providers/community clinics
    e. Health plans

34. How, if at all, should potential payments vary based on:
    a. The type of entity providing the services;
    b. The complexity of the service/client being served; or
    c. Other factors?

35. What are the implications of payment policies for enrolling individuals in health insurance coverage being the same or different inside and outside the Exchange?

36. Should payment to health insurance agents be made by the Exchange or plans in the individual market portion of the Exchange? Should payment to health insurance agents be made by the Exchange or plans in small business Exchange?

37. What responsibilities/linkages should navigators have to non-health social services programs?

38. What responsibilities/linkages should health insurance agents have to public health care programs and/or non-health social service programs?

39. For each of the questions identified below, note differences, if any, that may relate to how the responses should relate to individuals, small employers, and self-employed solo individuals.

40. What works today in terms of assisting individuals and small businesses in enrolling in public and private coverage? What doesn't work?

41. What infrastructure currently exists to enroll individuals and small businesses in coverage?

42. What community-based organizations and providers should be prioritized given their relationships with the uninsured and newly-eligible (e.g., hospitals and clinics that have high-volume uninsured traffic)?

43. What are models for county-community enrollment partnerships?

44. How should the performance of California's eligibility and enrollment system be measured and reported?

45. How can California assure that the enrollment IT system provides culturally and linguistically appropriate enrollment services?

46. What process can be used to minimize gaps in coverage and facilitate transitions between programs? What considerations should be made for payment grace periods?

47. What role should the Exchange play in the enrollment of any non-health service programs?

48. How can the Exchange facilitate enrollment using existing state data?

49. In what circumstances/programs should we do pre/auto-enrollment?

50. How should the enrollment system accommodate employer/employee choice? Full-time versus part-time employees? Residency (group/employee/out-of-state)?

51. How should the system handle overlap with other existing public programs such as Healthy San Francisco?

52. To what extent should we maintain existing eligibility doors (e.g., presumptive eligibility for pregnant women)?

53. What are the key functions a service/call center must provide?

54. How should the performance of the service/call center be measured and reported?

APPENDIX B: SMALL GROUP SESSION PARTICIPANTS

The following is a list of individuals who attended the small group sessions.

Aidun, Soroosch SEIU 721		Cota, Irma North County Health Services San Marcos
Alejandre, Beatriz 2-1-1 Fresno		Crosby, Neil Warner Pacific Insurance Services Westlake Village
Alexander, Michael United Way Fresno		Curley, Tim Children's Hospital Central California Madera
Ambegaokar, Sonal National Immigration Law Center Los Angeles		Davis, Cheryl Placer County
Ansell, Phil Los Angeles County		Deloney, Gladys Sacramento County
Applegate, Christine Stanislaus County		Diamond, Melissa CalWIN
Bailey, Kitty North County Health Services San Marcos		Doi, Shari Los Angeles County
Berry, Stephanie California Primary Care Association Sacramento		Douglas, Eric CVS Illinois
Boatman, Ron Arrowhead Regional Medical Center San Bernardino		Edwards, Ann Sacramento County
Britton, James SEIU Local 39		Ellis, Meaghan San Bernardino County
Brooks, Sarah CA Association of Public Hospitals and Health Systems Oakland		Flores, Marta E. Family Health Centers of San Diego San Diego
Broyles, Julianne California Advocates, Inc. Sacramento		Forbes, Norma Fresno Healthy Communities Access Partners Fresno
Burton, Richard J. Placer County		Forer, Elizabeth Venice Family Clinic Venice
Capell, Beth Health Access Sacramento		Franklin, MD, Sherry California Medical Association
Cassinelli, Cindy Monterey County		Galloway-Gilliam, Lark Community Health Councils Los Angeles
Chan, Eddie North East Medical Services San Francisco		Garcia, Jane La Clinica de la Raza Oakland
Chavez, Laura Los Angeles County		Gatton, Larry Los Angeles County Department of Health Services Los Angeles
Chenault, Jeanine San Bernardino County		Gee, Hayward Los Angeles County
Chin, Wil Los Angeles County		Gravette, Hannah San Diego Organizing Project San Diego
Christianson, Alan Community Medical Centers Fresno		Gross, Byron J. National Health Law Program Los Angeles
Cid, Amparo California Rural Legal Assistance Foundation Fresno		Hamilton, Kevin Clinica Sierra Vista Fresno
Colburn, Gordon Colburn Insurance Services, Inc. San Dimas		Harwell, Kathy Stanislaus County
Cooper, Jacey Kern Medical Center Bakersfield		Hausan, Linda San Bernardino County

Heatley, Lester Sacramento County		Lundy, Erik Lundy Insurance Services El Cajon
Henderson, Sandy Plan/Financial Fresno		Lunski, Esq. Jennifer Woodruff-Sawyer & Co San Francisco
Hobson, William Watts Healthcare Corporation Los Angeles		Lutosky, Mike Discovery Benefit Solutions San Diego
Hogeland, Susan California Association of Family Physicians San Francisco		Maggio, Isabelle Los Angeles County
Hood, MD, Rodney Multicultural IPA San Diego		Manzo, Pete United Ways of California South Pasadena
Hsu, Lambert Benefit Pro Insurance Services San Diego		Marin, Maribel 2-1-1 Los Angeles
Hutchison, June San Bernardino County		Maxwell, Judy Maxwell Insurance Redding
Johnson, Beverly Beasley San Mateo County		McCaffrey, Mike New York Life Insurance Company Simi Valley
Kahf, Yaman Integrated Healthcare Holdings Incorporated Santa Ana		McKennett, Marianne Scripps Family Medicine Residency Chula Vista
Kersey, Lynn Maternal and Child Health Access Los Angeles		Meseke, Carolyn DiBuduo & DeFendis Insurance Brokers Fresno
Kimbley, Susan Placer County		Milevoj, Ratan Children's Hospital Central California Madera
Kiryczun, Eduardo San Mateo County		Millan, Mark Family HealthCare Network Visalia
Knoll, Gregory E. Consumer Center for Health Education and Advocacy San Diego		Morrison, Jim Morrison Insurance Services Carlsbad
Koehler, Linda Rose Herzog Insurance Agency Pleasanton		Nelson, John J. Warner Pacific Insurance Westlake Village
Kumar, Navinda Los Angeles County		Noller, Rhonda Sacramento County
Lake, Paul Sacramento County		Ohanian, John 2-1-1 San Diego
Landsberg, Elizabeth Western Center on Law & Poverty Sacramento		Olson, Rae Lee The Vita Companies Mountain View
Lewis, Kim National Health Law Program Los Angeles		Pearson, Kim San Mateo County
Light, Jessica San Mateo County		Pfeifer, MD, Kelly San Francisco Health Plan San Francisco
Loew, Susan Riverside County		Phillips, Mike Jewish Family Services Patient Advocacy Program San Diego
Lopez, Laura Street Level Health Project Oakland		Pittman, Brianna Planned Parenthood of California Sacramento
Lumsden-Dvorak, Catherine DiBuduo & DeFendis Insurance Brokers Fresno		Piva, Laini Placer County
Rapponotti, Karen C-IV		Smith, Jenine San Francisco General Hospital San Francisco
Reid, Charlene Tehama County		Spencley, Jan San Diegans for Healthcare Coverage San Diego

Reyes, Hali CalWIN		Stewart, Cindy Clinica Sierra Vista Fresno
Rocha, Margarita Centro La Familia Fresno		Stokes, Kelly Walmart Arizona
Rogers, Louise San Mateo County		Swanson, Nancy San Bernardino County
Roselle, Larry United Way Fresno, Stanislaus		Sylvester, Michael Los Angeles County
Rosen, Chuck CPR Insurance and Financial Services Simi Valley		Taylor, Bill Los Angeles County
Roy, Nancy Health Care Insurance Solutions Ramona		Thai, Queyn Integrated Healthcare Holdings Incorporated Santa Ana
Russo, Michael CALPIRG Los Angeles		Thomas, CaSonya San Bernardino County
Sablan, MD, Oscar Sablan Medical Clinic Firebaugh		Timberlake, Ellen Santa Cruz County
Sanders, Mary 2-1-1 Los Angeles		Toledo, Pedro Redwood Community Health Coalition Petaluma
Sandhu, Satinder Walgreens California		Tovar, Ambar United Farm Worker Foundation Bakersfield
Saporta, Carla Greelining Institute Berkeley		Voigt, Scott Walmart California
Serota, Martin AltaMed Health Services Los Angeles		Wade, Lindsey Hospital Association of San Diego and Imperial County San Diego
Sevenikar, Gerilynn Sharp Healthcare San Diego		Wagstaff, Bruce Sacramento County
Sheldon, Meg California Welfare Directors Association		Waldman, MD, Jeffrey Planned Parenthood Concord
Shupe, Suzie California Coverage Health Initiatives Sacramento		Walter, Stephen Community Medical Centers Fresno
Siegel, Barbara Neighborhood Legal Services, Health Consumer Center Pacoima		Wang, Betty San Mateo County
Simmons, Noelle San Francisco County		Weikel, David Mental Health America of the Central Valley Fresno
Simon, Clarisa E. San Mateo County		Wong, Doreena Asian Pacific American Legal Center Los Angeles
Singh, Navject San Mateo County		Woodruff, Heather Barney and Barney San Diego
Skidmore, Beth SEIU 721		Wu, Ellen California Pan-Ethnic Health Network Oakland
Smith, Sam Genesis Financial/Creative Employee Benefits, Inc. Sherman Oaks		Wulsin, Lucien Insure the Uninsured Project (ITUP) Los Angeles
Srinivasan, Srija San Mateo County		York, Bill 2-1-1 San Diego
Starr, Mark Placer County		Zimmerman, Barry Ventura County

APPENDIX C: INDEX OF WRITTEN COMMENTS

The following organizations and individuals submitted written comments or letters to the Exchange on the questions listed in Appendix A. Comments are summarized below in Appendix D. Full length comments are available online at: http://www.healthexchange.ca.gov/StakeHolders/Pages/Default.aspx

100% Campaign

AARP California

Alliance to Transform CalFRESH

Anthem Blue Cross

California Healthcare Institute, Inc.

California Pan-Ethnic Health Network

California School Health Centers Association

Catholic Charities of California

Community Health Councils, Inc.

Consumers Union

CVS Caremark

Delta Dental

Greenlining Institute

Having Our Say Coalition

Health Access Project and the Asian American Legal Center

Health Care Planning and Policy

Health Consumer Alliance

Health Plan of San Joaquin

Inland Empire Health Plan

Kaiser Permanente

Maximus

Paradigm Healthcare Services

Planned Parenthood Affiliates of California

San Bernardino County

San Francisco Department of Public Health

San Mateo County Health System

SEIU

Small Business Majority

UC Berkeley Center for Labor Research & Health Access California

UnitedHealthcare

Warner Pacific Insurance Services

APPENDIX D: HIGHLIGHTS OF WRITTEN COMMENTS

Below is a summary of written comments received on the questions listed in Appendix A. Comments were submitted by organizations and individuals listed in Appendix C. Full-length comments are available online at: http://www.healthexchange.ca.gov/StakeHolders/Pages/Default.aspx

OVERARCHING INPUT

1. **Regarding your overall vision, hopes and aspirations for the expansion of coverage through the Exchange, Medi-Cal, Healthy Families and through private coverage in California, what are your perspectives on:**
   a. **What would "success" look like in January 2014?**
   b. **What would "success" look like in January 2016?**
   c. **What would "success" look like in January 2019?**

Success in 2014:

- Respondents' vision of 2014 generally included some version of an enrollment and eligibility system that was "One Stop, No Wrong Door" and was simple, logical, seamless, understandable, and culturally and linguistically appropriate.
- Many respondents envisioned a robust network of navigators (culturally and linguistically appropriate, trusted by the community).
- Several groups mentioned additional hopes for the Exchange, which included robust consumer protections and adequate provider networks in place.
- Many groups urged the Exchange to start now with pre-enrollment and education.

Success in 2016:

- The visions for 2016 were similar, with some additional details such as:
  - Website and all documents in all threshold languages.
  - Technological and human systems in place to facilitate enrollment between programs and in non-health coverage programs, such as CalFresh and CalWORKS.
  - Competitive plans, affordable premiums and lower overall costs.
  - Innovative health plan choices to improve health outcomes.
  - One respondent noted that "success means the Exchange has seized its opportunity to be a catalyst for change in the broader health care delivery marketplace".

Success in 2019:

- Several groups wanted to see a certain percentage of eligible Californian's enrolled ranging as high as 100 percent.

- Several groups mentioned the need for maintaining enrollment.
- Affordability was also mentioned, as was increasing the "culture of coverage" Several groups mentioned the vision for the most vulnerable and hard-to-reach populations being enrolled. Responses ranged from focusing on getting people covered, to establishing a data collection system that would measure the effectiveness of programs and plans in increasing health outcomes.

MARKETING, PROMOTION AND OUTREACH

2. In addition to the potential market segments noted above *(see Appendix A)*, what are potentially important ways marketing and promotion should be segmented?

Respondents provided the following additions to the provided list of target populations:

- Individuals with chronic diseases.
- Caretakers of elderly parents.
- The under-employed and self-employed including laborers.
- Mentally ill, alcoholic and drug addicted people.
- Persons with disabilities.
- Persons living in mixed-immigration status families.
- Homeless and unstably housed.
- Native Americans.
- Individuals who don't see the value in interest in receiving health care services.

3. What are the top activities you think of in terms of marketing and outreach for the Exchange, Medi-Cal and Healthy Families?

- Respondents mentioned using "trusted community based partners" as being critically important, and several specifically recommended using "promotoras". Several respondents also suggested a broad advertising plan (billboards, radio, etc.) but several other respondents did not think a broad messaging campaign was cost effective.
- Several respondents mentioned the need for the outreach messages to include not just the importance of getting insurance, but how to find out the steps needed to get it.
- Places and activities ranged from churches and schools, to discount office stores (for small business) and barber shops.
- There were many specific suggestions for messages, and several respondents called attention to the fact that we should not assume that consumers or small businesses know what the "ACA" or "The Exchange" means.

4. **What would you define as a successful marketing and outreach campaign? How can the Exchange build the kind of consumer attitude of loyalty, support and even affection that the public has for Medicare and Social Security?**

   Several respondents noted loyalty comes not from marketing and outreach, but from having a quality stable program, with good customer service. Information must be accurate and consistent no matter the source in order to build credibility and loyalty. There must be no sense of a "second class" program.

5. **What sales, outreach and assistance channels are most effective and efficient for populations in the individual market?**

   Many respondents suggested building on California's existing sales and outreach infrastructure, including agents and brokers, CAAs, health plans, schools, counties, and faith-based organizations. For young adults in the individual market, social media was cited frequently.

6. **What sales, outreach and assistance channels are most effective and efficient for small employers? *AND* 7. How can the Exchange most effectively promote the availability of tax credits for eligible small businesses?**

   Many respondents noted that small employers rely on brokers, agents, and peer-to-peer discussions and groups, such as chambers of commerce and industry associations. However, several respondents mentioned that small businesses had low awareness of the Exchange and its potential products, including tax credits.

8. **Which populations will be least likely to enroll without assistance in understanding their eligibility or the enrollment process?**

   Respondents noted that populations with low English skills, families with mixed immigration status, and those who have never had insurance would be least likely to enroll without assistance.

9. **Which populations should the Exchange focus on specifically and what outreach and assistance channels will be most effective and efficient for those populations?**

   This question elicited a diversity of views among respondents. Some respondents gravitated towards the most cost effective to serve – "young invincibles" – while others thought that the focus should be on the hardest to reach – those with the weakest history of health insurance coverage and language and/or immigration barriers.

10. How can enrollment be designed to facilitate maximum enrollment of eligible individuals with minimal assistance and as early as possible (e.g., enroll in 2013 to have maximum enrollment effective 1/1/2014)?

Many respondents discussed those already enrolled in some type of coverage as the "low hanging fruit." There was significant discussion of "auto enrollment" from existing programs such as Family PACT, but consumer organizations cautioned that a consumer's agreement should always be sought prior to enrollment.

11. What steps can the Exchange take to assure the maximum possible retention of eligible individual enrollees who do not have affordable employment-based coverage? *AND* 12. What steps should the Exchange take to assure retention of small employers?

There were several suggestions that making sure that the program worked well and was affordable and easy to use was the most important aspect of retention. There were also suggestions to make premium payments more automatic, such as through payroll deductions and allowing for a grace period for payment of premiums.

Some focused on the mechanics of retention (such as "passive renewal") and others on the overall value of the program to consumers: "Retention happens when people see a benefit to health benefits and are given the opportunity to reenroll."

13. How should the Exchange consider the potential enrollment for employees of larger employers?

Among those who commented, the answers were similar to questions about retention and loyalty previously discussed: showing that the programs are cost effective and consumer friendly, and cost effective for businesses. "Both small and large employers are all about cost."

14. What steps should the Exchange, DHCS and/or MRMIB take to assure that any individual who dis-enrolls from or loses eligibility for coverage with one program is automatically or seamlessly enrolled in (or informed about) their rights for other coverage when the individual meets Affordable Care Act requirements?

Respondents stressed the importance of "seamless transitions" without specific instructions as to how to accomplish this. Some referred to building on the current bridging programs between Healthy Families and Medi-Cal. Many felt that if consumers became ineligible for one program, the Exchange should automatically enroll them in or notify them about other programs, without them having to resubmit documentation. One group stressed that it must be made clear to consumers when and how to report income changes.

One respondent mentioning developing an equitable process for "default" enrollment in participating qualified health plans to minimize breaks in coverage. Specifically,

"All systems should connect to each other seamlessly. It should not require additional manual or paper processes to keep continuity of coverage."

15. Who would be the most effective messenger for marketing to different high priority populations?

Several groups mentioned the need to be very careful about the fears of undocumented and mixed immigration status families. Some respondents suggested celebrity messengers, but many others discounted this in favor of "word of mouth" Several respondents suggested marketing "success stories" once people were enrolled.

16. How can the Exchange marketing efforts be best coordinated with national and state government partners and private sector partners (e.g., providers, plans, health insurance agents, and foundations?

Two main types of coordination were mentioned: (1) establishing a network of communicators who are coordinated and aligned in their outreach efforts and messaging, and (2) a coordinated information technology system.

17. What type of marketing oversight standards should the Exchange use to prevent inappropriate steering?

There were two distinct points of view: one was to use the same guidelines used by the Department of Managed Health Care and the California Department of Insurance for commercial plans, so that plans in the Exchange is not disadvantaged; and the other Healthy Families Participating Plan Marketing Guidelines, perhaps with more stringent oversight and penalties.

18. What messages, branding, and outreach efforts should the Exchange use to get individuals ready to enroll in coverage in 2013? For example, what messages would be effective in generating interest/demand among the currently uninsured?

Respondents mentioned two approaches, one based on marketing a new product (branding, etc.) and one based on specific marketing messages for specific populations. There were many suggestions for specific "catchy" marketing messages. Some respondents mentioned focus groups to test key concepts, such as whether or not "coverage" means anything to consumers in the individual market.

19. Should the Exchange do its own marketing related to the small employer program or should it rely on existing distribution channels (e.g., health insurance agents)?

Responses reflected a diversity of views. Some respondents recommended the Exchange doing its own marketing, some recommended using existing distribution channels, and some recommended both. The dependence of small employers on

brokers and agents was mentioned, and the importance of a financial incentive to brokers and agents was also emphasized.

ENROLLMENT ASSISTANCE, NAVIGATORS AND HEALTH INSURANCE AGENTS

20. What roles should the following entities *(see Appendix A)* play in Exchange, Medi-Cal and Healthy Families' enrollment for individuals and families? What roles should the following entities play in exchange enrollment in the individual exchange and/or SHOP? What are the payment options and appropriate outcome measures?

Several counties noted that they played key roles in assisting consumers. Again, "trusted community groups," including past CAAs and schools were frequent responses. A few respondents felt that community groups should be limited to outreach and education, not enrollment. Many mentioned providers as potential enrollers, but some felt that providers should only do outreach, and be separated from the enrollment aspect.

Respondents expressed differing views, with those currently involved in enrollment highlighting their strengths.

- Unions and counties expressed concerns about using community-based organizations to actually enroll although there were several suggestions that organizations, brokers, clinics and other providers were all needed to achieve "no wrong door."
- Some thought clinical settings were not appropriate for enrollment; others noted the success of providers in enrolling in programs such as Family PACT.

Regarding payment, some thought there should be a "flat fee" with perhaps adjustment for regional differences or for serving multiple languages. Some felt that in order for brokers and agents to participate, they must be paid "competitive commissions" so that they wouldn't have an incentive not to enroll in public programs or the Exchange.

21. What roles should the following entities play in supporting enrollment of small businesses in the Exchange?

Respondents noted the importance of agents and brokers and ease of enrollment for small business.

22. What would define a successful navigator program? What would define a successful relationship between health insurance agents and the Exchange?

- This question elicited a diversity of responses. One group mentioned that brokers are meant to "sell" not "educate" while others thought that good connections could be established between agents and the Exchange.
- Consumer groups suggested that the most important thing was independence and duty to the consumer, and that all navigators must embrace the concept that

beneficiaries should be enrolled in the most generous, most affordable plan for which they qualify.

- Some thought that success had to be measured not just in numbers enrolled, but in terms of success in reaching marginalized populations. One respondent suggested dedicating a senior position at the Exchange to work on agent/broker relationships.

23. How do enrollment assistance needs vary for individuals, small businesses and self-employed individuals? How should the Exchange take these differences into account in developing requirements for navigators, health insurance agents? Counties or others?

In terms of small business, it was noted that the SHOP product is complex and new and it will take time and effort to educate agents and their clients about its value.

24. How would you define a continuum of assistance to support applicants based their needs and the complexity of their issue? Are there the natural "cut points" in the continuum of assistance (e.g., issues that do not need human intervention; issues readily addressed on the phone or those that would be best served by in-person assistance)?

- Many respondents stated that there would be a high need for human assistance. For example, even though it was suggested that comparing benefits online could be initially helpful, several respondents felt that in the end, individuals and small business would need in persons support.
- Many respondents expressed concern about automation. Most felt that a key component of the call center should be an easy way for consumers to move from automated to non-automated assistance.
- Some suggested a “case manager model” was needed to enroll and help applicants make the best use of their coverage, as well as maintain that coverage or move to a new product if needed.

25. Given the current licensing requirements for health insurance agents, what additional participation standards should the Exchange employ to the extent it uses health insurance agents in the individual market of the Exchange? What additional standards for health insurance agents might be appropriate for enrollment of small businesses in the Exchange?

Suggestions included that certification standards should be similar to the current standards for agents and brokers supplemented with specific training on Affordable Care Act requirements, Medicaid and CHIP. Others wanted to make sure that agents and brokers were trained more like CAAs.

26. What minimum criteria should navigators meet? What training/certification requirements should navigators meet?

Responses to this question varied. Some supported the CAA model, including the online training offered in recent years. Others felt that navigators should have to prove their familiarity with the groups with which they were promising to work.

27. What requirements should navigators have for providing culturally and linguistically appropriate services?

Many respondents felt that navigators should have experience working in the community they will be serving and should be able to communicate effectively with their client base. Many respondents referred to the Medi-Cal threshold language requirements, acknowledging that not every navigator would be able to assist in all languages but that they should be able to connect applicants easily to a group with the needed language expertise. Several groups noted that the online component must also be in multiple languages.

28. What should be the scope of work of navigators? What, if any, role should navigators play in ongoing case management/outreach to individuals after they enroll?

Responses varied on the question of the navigator's scope of work. Some felt that it was necessary for navigators to do outreach, enrollment, retention and help with utilization, especially for those consumers that were not familiar with having insurance. However, some felt navigators should not actually enroll individuals in health plans. Some felt that questions about benefits and claims after enrollment should be handled by issuers.

Some were concerned that to do a broader scope of work, additional training would be needed; others thought that because of their cultural linguistic competence and trusted status, community based navigators were as in the best position to help consumers learn to use the health system once enrolled.

29. To what extent, if at all, should financial support be provided for community-level activities in advance of open enrollment?

Many respondents thought these activities should be funded, with a particular emphasis on education in underserved, rural, immigrant, and monolingual communities.

30. What performance standards should navigators have (e.g., requirements for case volume or service time)?

Responses to this question varied based on the respondent's opinion about how extensive navigators' work should be. Some respondents mentioned that performance standards focused just on quantity create disincentives for navigators

to help consumers with more complicated situations and hard-to-reach populations such as LEP, homeless persons and persons with mental health disabilities.

31. How will the work of navigators be coordinated with other consumer assistance groups to provide effective, non-redundant services? How do we leverage the current certified application assistant (CAA) network?

Respondents noted that close coordination of the navigation program with consumer assistance groups will be important. Some respondents suggested that a survey be done to look at gaps in the CAA network, and provide additional training and incentives to complete the network. One respondent mentioned that the newly-expanded Office of the Patient Advocate could provide a clearinghouse and coordinate consumer assistance duties that link between agencies, offices, programs, consumer assistance, and navigators.

Some felt that CAAs should provide an introductory level of assistance geared towards straightforward enrollments and could then refer more complicated cases to more developed consumer assistance programs.

32. What types of services beyond initial enrollment do health insurance agents provide today for individuals and /or small businesses?

Agents provide plan selection, understanding policy terms such as premium costs, cost-sharing, application of deductibles, obtaining health plan treatment approvals, payment options, etc. brokers help select and manage plans. The brokers/agents often help resolve service problems and act as an advocate for the group on issues such as claims, eligibility or billing issues. They also help the group to renew or make annual changes to plans and at times assist the business in annual open enrollment meetings.

33. What are payment options and appropriate outcome measures for enrollment work performed by the entities listed below (e.g. fixed price per enrollment, percentage of premium, grants)?

Many respondents recommended a combination of both enrollment reimbursements fees and grants. Some noted that broker payments should be competitive to outside the exchange. Some noted that grants require significant administration and that fees that incorporated upfront costs would be more cost effective. Other respondents felt that, at least initially, California must employ all methods available.

34. How, if at all, should potential payments vary based on?

Some suggested flat payments adjusted for regional variation and others suggested adjusting for the difficulty of the population served.

35. What are the implications of payment policies for enrolling individuals in health insurance coverage being the same or different inside and outside the Exchange?

Respondents noted that it was important to have reimbursement equal in and out of the Exchange to avoid adverse incentives.

36. Should payment to health insurance agents be made by the Exchange or plans in the individual market portion of the Exchange? Should payment to health insurance agents be made by the Exchange or plans in small business Exchange?

One respondent reported that the ACA does not allow health plans to directly or indirectly reimburse navigators for an Exchange enrollment. To avoid adverse selection and to have a consistent implementation of the application assistance reimbursement system, the Exchanges should reimburse the navigators, agents and brokers.

37. What responsibilities/linkages should navigators have to non-health social services programs?

Some respondents felt that it was too big of a job to focus beyond health insurance in the near term, but many thought that the inclusion of non-health programs was a key part of a "roadmap" to the future, hoping to implement it in the years after 2014.

38. What responsibilities/linkages should health insurance agents have to public health care programs and/or non-health social service programs?

Many respondents indicated a desire to eventually have non-health program incorporated. Some thought health insurance agents should have basic training in CalFresh and other social services and that the agents and brokers should be highly encouraged to refer the applicants to other non-health social service programs.

Some respondents felt that community-based navigators would connect with other programs once the infrastructure is developed as part of their mission, but that brokers and agents would need to expand their mission and be paid for it.

39. For each of the questions identified below, note differences, if any that may relate to how the responses should relate to individuals, small employers, and self-employed solo individuals.

40. What works today in terms of assisting individuals and small businesses in enrolling in public and private coverage? What doesn't work? *AND* 41. What infrastructure currently exists to enroll individuals and small businesses in coverage?

Some respondents noted that this varied greatly from county to county, particularly depending on provider infrastructure. Respondents mentioned CAAs, clinics,

hospitals, schools, insurance agents, and tax professionals and financial advisors and brokers. These networks could be a natural building block for the navigator network needed across California. Respondents expressed divergent views about how centralized enrollment functions should be.

42. What community-based organizations and providers should be prioritized given their relationships with the uninsured and newly-eligible (e.g., hospitals and clinics that have high-volume uninsured traffic?

Many respondents noted this answer would vary depending on the locality and who is currently providing services.

43. What are models for county-community enrollment partnerships?

Respondents mentioned regional models like Cover the Kids in Sacramento, health consumer assistance agencies in Los Angeles, and county based programs in Santa Clara and San Francisco.

44. How should the performance of California's eligibility and enrollment system be measured and reported?

Suggested performance metrics included:

- Percent of applications submitted online
- Percent of eligibles enrolled
- Enrollee satisfaction
- Customer service
- Volume of automated ability to enroll across programs
- Lack of churn

Some thought existing Healthy Family reports were a good base, others that they did not contain enough specific information. Several noted that success in switching between programs should be assessed.

45. How can California assure that the enrollment IT system provides culturally and linguistically appropriate enrollment services?

Several respondents mentioned that this was important, some noting that language access was important on line as well as through navigators.

46. What process can be used to minimize gaps in coverage and facilitate transitions between programs? What considerations should be made for payment grace periods?

Several consumer groups suggested that coverage shouldn't end until the consumer is actually transferred to another program, some referred to the bridging program between Medi-Cal and Healthy Families. Respondents generally preferred a grace

period of between 30-90 days. The issue of transitions between programs was of great concern to several respondents.

47. What role should the Exchange play in the enrollment of any non-health service programs?

Though some felt that the Exchange should focus solely on health coverage, many respondents felt that enrolling in non-health service programs was a strong future goal. The most robust version of this was "The Exchange should capitalize on its world-class, modern connection to millions of Californians and the eligibility information they provide to on-line applications and eligibility determinations for Cal Fresh, other social services and working-family tax credits, and seamless benefits management for consumers."

48. How can the Exchange facilitate enrollment using existing state data?

Respondents recommended that CalHEERS tap into state sources of income data to ensure more current and accurate income data is used (e.g., EDD data). Government data sources could be used to trigger reminders to report significant income changes that could affect subsidy amounts. The Exchange should utilize data already on file with public programs to facilitate enrollment. Express Lane Eligibility (ELE) provisions in the Children's Health Insurance Program Act allow California to base Medi-Cal and Healthy Families eligibility for children on the findings of other need-based programs, even if the program use different methodology. The Exchange can facilitate enrollment by using existing State data to help validate the identity of applicants. State data can be used to pre populate enrollment and renewal online forms.

49. In what circumstances/programs should we do pre/auto-enrollment?

Some focused on the rights of consumers to actively consent to being enrolled, and the need to fully understand the programs to use them, and some seemed to respond based on what was possible. The most frequently mentioned populations were individuals and families using existing public coverage programs, especially partial coverage programs such as Family PACT and BCCTP. Non-health programs such as CalFresh, WIC, and School Lunch were also mentioned. CalFresh has similar income, asset and citizenship-status rules of Cal Fresh and Medi-Cal.

Some stated that newborns should be enrolled before leaving the hospital and the Exchange should consider pre-enrollment for any party currently enrolled in a county indigent program.

50. How should the enrollment system accommodate employer/employee choice? Full- time versus part-time employees? Residency (group/employee/out-of-state)?

Respondents suggested that the SHOP enrollment platform should make choice of plans simple, with quality and service ratings alongside price and the employer contribution level in a straightforward manner. Several groups mentioned that

without a variety of choices SHOP would not have much new to offer small businesses and would not succeed.

51. How should the system handle overlap with other existing public programs such as Healthy San Francisco?

Few answers were received, all citing that they should overlap. Concern was expressed about different income and eligibility rules for different programs.

52. To what extent should we maintain existing eligibility doors (e.g., presumptive eligibility for pregnant women)?

Respondents expressed concern about maintaining successful doors for pregnant women and children, including presumptive eligibility for pregnant women. California Children's Services (CCS) and CHDP were also mentioned as programs important to maintain because of their unique qualities and as eligibility doors. It was also mentioned as unique programs. In general, respondents felt that "no wrong door" meant maintaining existing eligibility doors while adding new ones.

53. What are the key functions a service/call center must provide? Key Functions for a Service/Call Center:

Many respondents noted the need for cultural and linguistic competence, easy referrals, and an easy way to refer clients to a physical person. Some suggested that call center personnel be trained like CAAs, and that they must be able to answer questions instead of just reading a defined script. They should be able to help with plan changes and renewals as well as enrollment. For questions they cannot answer or that need detailed follow up, some suggested they should be trained to refer to expert outside organizations, such as Health Consumer Alliance offices.

54. How should the performance of the service/call center be measured and reported?

Respondents noted that there should be established performance measures and benchmarks. Specific suggestions included call volume, hold times, abandonment rates, speed to answer with a live person, whether callers have access to multiple languages, and satisfaction through post call surveys.

"Secret shoppers" and outside evaluators were suggested. It was also noted that all performance standards should be weighed on a cost/benefit basis.

APPENDIX E: RELATED REFERENCE MATERIALS

In addition to the written comments and letters submitted in response to the questions in Appendix A, the following reports were provided to Exchange Board members as background for discussions on outreach and assistance strategies.

Outreach

Massachusetts Health Reform Toolkit Series: Effective Education, Outreach, and Enrollment Approaches for Populations Newly Eligible for Health Coverage (1/12)

Massachusetts Health Reform Toolkit Series: Implementing a Successful Public Education & Marketing Campaign to Promote State Health Insurance Exchanges (5/11)

Maryland – Education and Outreach Workgroup: Draft White Paper (10/10)

Maryland – Weber Shandwick Marketing Report (11/11)

Enrollment Practices

UC Berkeley Labor Center – The Promise of the Affordable Care Act, the Practical Realities of Implementation: Maintaining Health Coverage during Life Transitions (10/11)

UC Berkeley Labor Center – Maximizing Health Care Enrollment through Seamless Coverage for Families in Transition: Current Trends and Policy Implications (3/11)

Consumers Union – Addressing Barriers to Online Applications: Can Public Enrollment Stations Increase Access to Health Coverage? (11/11)

State Health Access Reform Evaluation – The Secrets of Massachusetts' Success (11/09)

Kaiser Family Foundation – Explaining Health Reform: Building Enrollment Systems that Meet the Expectations of the Affordable Care Act (10/10)

Kaiser Family Foundation – Explaining Health Reform: Eligibility and Enrollment Processes for Medicaid, CHIP, and Subsidies in the Exchanges (8/10)
Brookings – The Choice Architecture of Automatic Enrollment (6/09)

Vanguard – Measuring the Effectiveness of Automatic Enrollment (12/07)

User Experience 2014 Project – Designing a First-Class User Experience for Affordable Care Act Enrollment: Project Overview (2/12)

Navigators

Manatt Health Solutions – Maryland Study of Navigator Program and Consumer Assistance (11/11)

Community Health Councils – Bridging the Divide: Designing the Navigator System for California's Exchange (1/12)

Western Center on Law & Poverty – Streamlining California's Fragmented Consumer Assistance Systems (11/11)