California Health Benefit Exchange: Stakeholder Input Form
Marketing, Outreach & Education, and Assisters Program

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The California Health Benefit Exchange welcomes your input on the marketing, outreach and education and assister issues under consideration. These issues are laid out in a draft recommendations report submitted by Ogilvy Public Relations and available on the Exchange website. In particular, we are seeking comments regarding Phases 1 and 2, but we welcome comments and specific suggestions on all phases and other aspects of the report. Please submit your comments to the Exchange at info@hbex.ca.gov by close of business Thursday, May 31, 2012.

Issue	Comments
1. Overarching strategies	See below
2. Marketing strategies	See below
3. Communication strategies	See below
4. Phase descriptions	See below
5. Budget narrative	
6. Other comments	Guiding principles

Health Access California offers comments on numerous aspects of the draft marketing and outreach plan as well as separate comments on the proposal on assisters.

Health Access California notes that there is much that is commendable in the marketing and outreach plan. We appreciate the depth and detail of the plan, the seriousness and scale that is contemplated, and the concerted focus on addressing the size and diversity of California's communities.

The policy changes in the Affordable Care Act are as significant as the creation of Medicare or Social Security—and the marketing and outreach plan must be commensurate with both the challenge and opportunity of enrolling literally millions of Californians in coverage. Consequently, we urge the board to adopt the most comprehensive marketing and outreach plan, to scale with the state's size, complexity, and challenges. The draft calls this the "gold" option—we would rename it the "California"-size option. To ensure clarity in describing the level of effort and associated costs for the three levels of the plans, we recommend you assign names to them that do not correspond to the "precious metal tiers" to avoid any potential confusion in future discussions.

1. A target for January, 2014.

Health Access appreciates the specific, numerical goals outlined in the proposal—both to set a common understanding of the shared objective of the marketing plan, and as a metric to ensure the plan is ambitious enough. However, the first goal is not until the end of 2014, much too late to make course corrections or adjustments. Health Access believes that the Exchange should aim for mass enrollment on day one, January 2014. We understand we can't reach full enrollment in the months leading up to January 2014, and appreciate the real logistical and resource challenges. But every month that goes by leaving Californians uncovered means families facing economic insecurity and unresolved health issues; federal dollars left in Washington, D.C. and not coming in to California's health system and economy; and a smaller and likely sicker risk pool in the Exchange, raising concerns about adverse selection. Health Access would advocate that in addition to the goals in the plan, another goal is set for reaching a certain number by Feburary or March of 2014. The marketing plans of Hollywood movies are judged by opening weekend box office; political campaigns crescendo to election day turnout. While we want the Exchange marketing effort to have a far longer-lasting shelf life than a movie premiere, it is appropriate to set an expectation for an aggressive pre-enrollment strategy and strong first month and/or quarter.

2. The challenge of misinformation: An aggressive response; starting in 2012

Health Access believes the plan underestimates the scale of the problem it needs to solve. The issue is not just lack of awareness of the Affordable Care Act, as posited by the Ogilvy PowerPoint and in charts like on Page 32—it is the significant confusion and misinformation on a massive scale by the opponents of reform. In fact, some organizations that actively opposed enactment of health reform have an official role in enrollment and eligibility. As such, the public agencies responsible for implementing reform face a very substantial public information challenge, to provide truthful information in a trustworthy way . Surveys by the Kaiser Family Foundation, The California Endowment, and the Robert Wood Johnson Foundation all suggest (subject to more opinion research and testing) that the misinformation campaign by the opposition to health reform has created negative attitudes based on misinformation. We would also note that both Social Security and Medicare have overcome similar negative campaigns to become respected and admired as fundamental to American society.

To counter this, we would argue that this plan needs to include an aggressive plan to counter misinformation, to provide truthful information about the new benefits offered by the Exchange, Medi-Cal, and related programs under the Act, and in a depoliticized way. Some parts of the plan, around "media relations" obliquely suggest this capacity, but it needs to be explicit. This problem of misinformation needs to be an explicit challenge, with specific remedies, including a "rapid response" type capacity. We are reminded that in the past few years, the paid advertising referencing health reform associated with political campaigns has dwarfed all other communications regarding the Affordable Care Act, and we expect this year to be no different.

We also suggest that the need to counter misinformation should impact the timing of any public information effort. We expect significant misinformation to come out of the 2012 election campaigns—both by opponents of reform, and perhaps even by overzealous supporters. As such, a politically neutral public education effort to simply correct misinformation and supply key facts would be valuable

in 2012. If it is not possible to commence such an effort in the summer of 2012, Health Access would at the very least urge the Exchange to begin its public education effort in November 2012 to respond to and refute misinformation. We are concerned about leaving months of misinformation out in the public unchallenged, without a credible, authoritative voice until the beginning of 2013. Whether marketing movies, selling consumer products, or building enrollment campaigns, it is not too early to start with an "It's Coming" message in late 2012, just a year out from when people can start enrolling and pre-enrolling for coverage,

3. "Guiding principles": Better understanding the target audience

The guiding principles help to frame the communications objectives as well as the marketing strategies.

a. Who is the target audience for the Exchange?

The "guiding principles" assume (without any evidence) that the target audience is the "uninsured". While the currently uninsured is currently a target population, and one we place a high priority on, this is an incomplete and fundamentally flawed assumption, particularly for the Exchange. One-half to two-thirds of those who are uninsured in any given year move into or out of coverage in that year. (Short and Graefe, 2003). Uninsurance is a condition, not a population. Treating the "uninsured" as a single or static population to be targeted is an erroneous assumption not borne out by the evidence. Over the span of few years, the number of Californians who find themselves uninsured at some point rises to over 11 million (Families USA).

This doesn't mean the problem isn't urgent: The short-term uninsured end up with substantial out of pocket costs as well as worse health outcomes because of gaps in coverage. Even short gaps in coverage of less than six months are problematic for consumers both financially and in terms of health outcomes. In fact, the long term uninsured spend less out of pocket on health care but have much worse health outcomes than the short-term uninsured while those with continuous coverage spend the least and have better health outcomes.

Another major population for the Exchange is those currently in the individual market—who right now get coverage in the least efficient, most expensive way possible. Many are income-eligible for subsidies, and desperately need the financial help, and others will welcome the ease of enrollment, organized choices, and "seal of approval" and bargaining power that the Exchange will likely provide.

Again, this is not a static population: Under current conditions, about half the individual market turns over in two years: that is, about half of those with individual coverage exit individual coverage, mostly to take up employment-based coverage.

The target audience for the Exchange is primarily a transitional population that is moving between periods of job-based coverage. The movement between Medi-Cal and the Exchange is much less significant in terms of volume for the Exchange than the movement between the Exchange and private sources of coverage (job-based and individual market).

If half the uninsured are uninsured for less than a year and half the individual market turns over in two years, who are the target audiences for the Exchange?
* First, people who have employment-based coverage but are about to lose it;
* Second, in Phases 1 and 2, people who currently have individual coverage but are eligible either for subsidies through the Exchange (an estimated 600,000 Californians) or through Medi-Cal (about 261,000 Californians) (CalSIM 3/2012)
* And third, those uninsured for more than a year or 24 months (an estimated 1.6 million of the 4.58 uninsured who will be eligible for coverage in 2014).

Finally, different communications objectives and marketing strategies are in order if the target audiences are the currently insured as well as the uninsured. The marketing plan spends significant time of specific demographic populations (which is very important), but far less attention on the actual conditions that lead people to become uninsured. As much as for specific ethnic groups, a detailed plan should be considered for the sub-populations that currently find themselves with a major gap in coverage or having to buy coverage as an individual. This includes:

- Early retirees
- Divorced
- High school and college graduates in their 20s
- Self-employed (contractors, independent professionals, freelance writers/programmers, etc)
- Part-time workers
- Low-wage working families

Whether we are talking about narrow market segments (aspiring actors now waiting tables in Los Angeles; just-starting coders in Silicon Valley) or broad categories (early retiree, recent community college grad), there are likely corporations and advertisers already targeting them. These are the categories that can suggest useful targeting for both paid and earned media approaches.

b. Why does it matter who the target audiences are? Because their benefits are different, particularly today.

Recent research indicates that essential health benefits will provide significantly more comprehensive coverage than current individual coverage but less comprehensive than group coverage.(Gabel et al 2012) Why does this matter in terms of marketing and outreach?

Someone who has individual coverage today and who is subsidy eligible will be pleasantly surprised to have more comprehensive benefits at lower cost. Someone who has individual coverage today but is not subsidy eligible may face higher premiums in return for more comprehensive benefits: since most of this population is above the median income, there will be a need to educate them about the benefits of the changes.

Conversely, someone who is losing employment-based coverage may find that Exchange coverage is like unemployment insurance: much better than no coverage but not as good as what they had on the job. (Gabel et al 2010, 2011, and 2012 on comprehensiveness of ESI). While the cost of the premium and cost-sharing is scaled to income, for some individuals, Exchange coverage will not be as comprehensive or affordable as coverage on the job particularly for higher income individuals.

The communications objectives for each of these target audiences is quite different and so are the marketing strategies. And the communications objectives are quite different than a focus on the "benefits of coverage" if the target audience was previously insured rather than a static uninsured population.

c. Who is the target audience for Medi-Cal? Who are the childless adults?

The FamilyPACT program currently serves 1.5-2 million adults, 95% of them income-eligible for Medi-Cal in 2014. This is roughly the number of adults newly eligible for Medi-Cal (CalSIM, 3/2012). There are a number of other, much smaller programs serving limited populations or providing limited benefits, generally for higher risk individuals.

Educating these adults with limited benefit programs about the availability of no-cost, comprehensive Medi-Cal requires a different marketing and outreach strategy, involving cooperation with service providers as well as targeted education. Not only should these populations receive information regarding full scope Medi-Cal, but they should be able to avail themselves of easy, coordinated, virtually automatic enrollment strategies. They should be able to enroll without encountering cumbersome, bureaucratic application processes that delay their entitlement (and enable California to take advantage of augmented federal reimbursement and grants to defray state costs.

d. "Promote retention of existing coverage in public programs and the individual market"—and employment-based coverage

The majority of Californians under age 65 get their coverage through employment, not public programs or the individual market. Maintaining employment-based coverage is central to the viability of health reform. Californians who get affordable coverage on the job should be encouraged to keep it, or to take it up if they have not. For many Californians such employment-based coverage will be more affordable and often more comprehensive than even subsidized coverage through the Exchange.

The communication objectives should include take-up and retention of affordable employment-based coverage. This is a fundamental premise of health reform—just over half of Californians currently have coverage through an employer, and the Affordable Care Act seeks to bolster what has been an eroding percentage. A marketing plan won't work if we ignore how half of Californians get coverage today; the reform won't work if such a major pillar of the health system falls.

4. Retention: too narrow a concept

So long as a multi-payer system exists, some churning in the source of coverage will occur. Because of the populations served, retention in a particular program is too narrow a concept for the overarching strategy. It is not retention in a particular program that is the objective: it is remaining covered without gaps in coverage.

For some Californians who lack access to affordable, employment-based coverage, the Exchange may provide a long-term source of coverage. Populations in this category would include the long-term self-employed, part-time workers, early retirees (under age 65) without employer retiree health, and other populations that lack access to affordable job-based coverage.

For others, the Exchange is a residual market, like the individual market today. For most Californians who get coverage through the Exchange, Exchange coverage will be a transitional stage between one source of job-based coverage and another. Retention is a wrong concept for this population. For this population, the goal should be to transition seamlessly from private, employment-based coverage to the Exchange and then back to affordable, employment-based coverage when it becomes available.

Health Access supports reducing barriers to maintaining coverage. The requirement to re-enroll in coverage itself is a considerable barrier that is not faced by those on Medicare or with job-based coverage. For those on Medicare, enrollment is a once in a lifetime task. For those with job-based coverage, enrollment generally occurs at the time of employment with no need to re-enroll so long as employment with the same employer continues.

Health Access recognizes that many of those who are eligible for public programs fail to enroll or to remain enrolled because of barriers to coverage. We support efforts to retain public program coverage for those who are eligible for it, but encourage the marketing and outreach team to visualize retention more broadly. It should be seen as retention of coverage from the appropriate source, recognizing that in a multi-payer system individuals will transition from one source of coverage to another, not just over the course of a lifetime but sometimes in the course of a single year.

This is also why we want the Exchange to maintain long-term communication and relationships with Californian consumers. It is likely those who use the Exchange to fill a gap in coverage at one point in their career will come back to the Exchange later.

5. Communication objectives

“Help target consumers understand the benefits of health insurance coverage”: If we are correct that most consumers have previously had coverage, the question is whether they understand the benefit of it. Our observation based on years of opinion research is that they do, but this is a testable proposition. Our work with focus groups and polling is that people value health coverage greatly and in a deeply personal way, and virtually no one argues against health coverage as a modern necessity.

The National Association of Insurance Commissioners (NAIC) and Consumers Union have conducted focus groups that indicate average consumers encounter great confusion regarding commonplace insurance terminology, such as “deductibles,” and “co-payments,” and have almost no idea about the full costs of common medical procedures. It would be useful to gauge if people understand the full level of benefit—both the health impacts and financial consequences of being uninsured. We would be interested if people understood the potential enormity of the bill that an uninsured person faces. An untested question may be whether this is true especially in first and second generation immigrant communities that come from different health systems and comparative cost expectations.

“Help target consumer..understand insurance language”: Why? Most of us who drive automobiles cannot explain how the internal combustion engine operates. Those of us who use computers usually take their internal workings on faith. Consumers should be provided information in a manner that is comprehensible to them. If the information is unduly complex, the rules should be simplified so that consumers do not live in fear of fine print “gotcha’s”. Health Access would hope that between meeting standards for essential benefits, actuarial value, and other criteria for qualified health plans, that politicies offered in the Exchange have a de facto “Good Housekeeping” seal of approval, so consumer don’t have to be fearful of the fine print.

“Tie the public and private insurance offerings together under the umbrella of the marketplace”: Health Access would encourage testing about whether this should be a broad message or a targeted one, and whether this supports the viability of the Exchange or undermines it with specific constituencies. Whether the Exchange and Medi-Cal should be bundled together for marketing purposes should be rigorously tested. Health care providers seem to distinguish sharply between Medi-Cal and Healthy Families as well as between Medi-Cal and Medicare: if the Exchange is perceived as being an extension of Medi-Cal, will providers steer consumers away from it? Again, this is a testable proposition by surveying physicians. Most of the subsidy-eligible Exchange population will NOT have come from public programs but will instead have previously had private coverage, primarily employment-based coverage. This will even more true once the Exchange is past the initial enrollment period of the first year or two.

It saddens us that Medi-Cal is seen as second-rate coverage because of lack of adequate provider reimbursement and the failure of oversight of Medi-Cal managed care plans: Health Access has vigorously opposed efforts to decrease Medi-Cal provider reimbursement and is currently seeking more effective DMHC oversight of Medi-Cal managed care. If the Exchange is equated with Medi-Cal rather than being perceived as a program for the middle class such as Social Security or Medicare, middle class consumers may be deterred from seeking even transitional coverage from the Exchange. The difference in cost-sharing in Medi-Cal and the Exchange will also make it difficult and/or counterproductive to have a seamless marketing message for both. Again, these are questions that are worthy of testing rather than assumptions to be accepted without challenge.

6. "Coordinating with State Agencies"

This discussion focuses on a coordinated marketing campaign by a number of state agencies.

First, many of the childless adults newly eligible for Medi-Cal are already covered by state programs or provided care by the safety net of county hospitals, county clinics and community clinics. Providing messaging that works for these program providers will be critical.

Second, the discussion of possible partnerships with state and federal agencies will be critical to educating employers as well as the broader public about the availability of coverage. Loss of coverage frequently coincides with life transitions like losing a job, changing jobs, moving, or divorce. The triggering events that cause people to lose employer-based coverage often put them into contact with institutions that can serve as gateways for enrollment into the health insurance exchanges (as we have detailed in our research brief with the UC Berkeley Labor Center). We believe it is important that the coordination among state and federal agencies (and the private sector) is not limited just to education. Predicated on appropriate privacy concerns, it should also include active referrals, (semi) automatic enrollment, and other contacts by a 'receiving agency' that facilitate "a culture of coverage." We are particularly pleased to see both the DMV and the Postal Service included because moving is highly correlated with lack of coverage: similarly the unemployed are likely to be uninsured so the inclusion of the Employment Development Department is critical. We are also very pleased to see the inclusion of a broad spectrum of the education community which has proven itself an important ally in expanding coverage to kids.

To the maximum extent possible, these partnerships should focus not only on marketing and outreach but also providing streams of information that facilitate automatic enrollment. Today when someone moves, the Postal Service provides this information to magazines and direct-mail marketers: tomorrow when someone moves, the Postal Service should also provide this information to CalHEERS in order to facilitate automatic enrollment in coverage. If my subscription to my favorite magazine can follow me to a different house, so should the opportunity to stay enrolled in coverage with the opportunity to opt out if I have other coverage.