September 13, 2012

Katie Marcellus
Director of Program Policy
California Health Benefit Exchange

Exchange Stakeholder Engagement Plan

Dear Ms. Marcellus:

In response to your email on 9/11/12 requesting suggestions on the engagement plan, I am providing you feedback that a large group of key stakeholders in San Diego County have approved to share with the Exchange. I hope you will incorporate these suggestions in your plan and most importantly, present to the key decision makers in the Exchange so they can make decisions that meet the needs of the communities throughout California. I would be happy to facilitate a conference call to discuss these comments in detail. I look forward to working with you.

HBEX Decisions and Pending Decisions	Issues	Suggestions
Marketing and Communications - Outreach and Education – Large media, public relations and communications budget – with approximately 1% (without paid media) proposed for local partnerships. Now $20 million/year for 2 years for community outreach and education grants with specifics under discussion in September and October	Funding now linked to Assistors Program. Most funding is for open enrollment to develop relationships and infrastructure in advance. HBEX considering grants; coordinated outreach and education across a county or region not yet raised.	Recognize regional, coordinated outreach and education programs in both scope and scale of funding Recognize need to allocate outreach and education funds to build infrastructure and relationships in advance of open enrollment
Service Centers (3) will be State-operated with potential that one will be County-run. Close collaboration and funding to Counties for Medi-Cal.	Concerned with one 1-800-call-in number as primary response and assistance; adequacy of local information for selection of plans/providers or referral for assistance. 211 San Diego will receive calls anyway; want 211 integrated with local programs or they must refer to State line No commitment to use CalHEERS data for Medi-Cal determination by counties	Recognize and integrate local call centers such as 211 into State plans. Use of the single application process initiated through CalHEERS must be seamlessly interfaced with County and State systems (one touch and done)

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Navigators redefined to be individuals not tied to a funder or provider (reconsidering clinics). Must be tied to an enrollment entity, trained by the State and certified. Reimbursement of $58/enrollment in Exchange Program only. No payment for retention or Medi-Cal	Does not address support/delegation for regional coordination. No payment for Medi-Cal not known at time of assistance or and for retention. Most uninsured are workers and/or in working families; no business outreach	Navigator Program as a regional entity through which outreach, education and enrollment assistance is coordinated. Payment for Medi-Cal enrollment Navigators should be able to work with business and SHOP
Direct Benefit Assistors are brokers, clinics and hospitals to be trained and certified by the State to assist with enrollment and tied to enrollment entity. No compensation to DBA.	While no board change made, HBEX has indicated to clinics they can be Navigators; an issue relative to bias concerns. Needs clarification (will result in backlash). May be empty promise since no funds for Medi-Cal (75% or more are <100% FPL)	Providers are significant enrollment assistance resources and should be encouraged to continue to provide assistance to their patients (with limited requirements)
Brokers enrolling in the Individual Exchange will be paid by health plans. Brokers enrolling businesses in the SHOP will be paid by the Exchange at market rates. Same payment structure for brokers for same products in and out of the Exchange. Brokers will also be required to assist with Medi-Cal eligibility.	Navigator payment of $58 per enrollment is limited to Individual Exchange, initial enrollment and no retention incentives or Medi-Cal enrollment funding. Exchange paid broker fees could be used to help fund outreach and assistance for both Exchange and Medi-Cal programs. Federal law allows brokers to be Navigators as long as no funding directly from health plans.(Exchange only)	Increase Navigator payment to recognize efforts for outreach, application assistance and a retention incentive.
SHOP issues are just beginning to be heard by the Exchange Board and comments are being solicited; it has been decided that operation of the SHOP will be contracted out to another entity. Benefit options were key issues. Allow QHPs to only partially align benefits between individual and SHOP exchanges	Most uninsured are workers or in the families of workers. The silos between business and individual enrollment not wise; experience demonstrates reliance on brokers without incentives will not maximize coverage. If a business can enroll directly but chooses to use assistance of a Navigator, that Navigator should be compensated by Exchange (actually save money)	Allow Navigators to educate and assist with SHOP enrollment when they are conducting outreach and assistance to employees (see Brokers). Establish assistance fees for Navigators assisting employers with their SHOP enrollment

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SHOP Employer vs Employee Choice was discussed and comments being solicited regarding whether employer may choose both plans and Tiers (benefits) or set contribution level at specific tier allow tier choice by employee.	Many health plans argued against employee choice due to concerns that "sick" employees will buy up, others like options. If employee plan not adequate to meet needs, they will end up sicker or will elect to go direct to Exchange; ACA promised options and choice	Allow employees choice to buy up from employer choice of plans (most similar to existing market where employer sets contribution level and employee chooses benefits)
Qualified Health Plans (QHP) rules and requirements set by Board) – one vote, 35 decisions. Network Adequacy defined as existing DMHC/DOI regulations (recognition that inadequate)	Existing regulatory requirements do not ensure access nor are they well monitored; adding millions to the insured roles requires that access be better defined and monitored due to capacity concerns and inaccuracy of some plan provider lists	Exchange should establish standards for Exchange product network adequacy which are tied to consumer access (e.g, NCQA) and monitored; ACA is about access and health improvement, not the status quo
Essential Community Providers (ECP) defined and QHP requirements set at 15% ECPs per *geographic region*.	No clear geographic regions definition. Threshold for Inclusion of Essential Community Providers too low (15% balanced - one hospital). Concerns regarding continuity of care/enrollee provider preferences.	Use consumer geographic access/choice ECP standards not rate regions, etc. to ensure continuity, choice and access to care. Maintain low Medi-Cal threshold for MDs. Eliminate or increase percentages separated by type of provider (hospital, clinic, PCP, Specialist)

Sincerely,

NICK MACCHIONE, MS, MPH, FACHE
Director