Comments to the Board – External

Table of Contents

October 5, 2017 Board Meeting

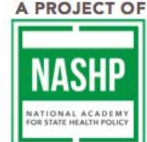
FOR PUBLIC DISTRIBUTION

Correspondence with Elected/Government Officials

- Joint letter from NASHP State Health Exchange Leadership Network to U.S. Senate Finance Committee — September 25, 2017
- Letter from Covered California to CMS Administrator Seema Verma — September 12, 2017
    - Report: Marketing Matters: Lessons From California to Promote Stability and Lower Costs in the National and State Individual Insurance Markets

Correspondence with Stakeholders

- California Association of Health Underwriters — September 29, 2017
- California Medical Association — October 4, 2017

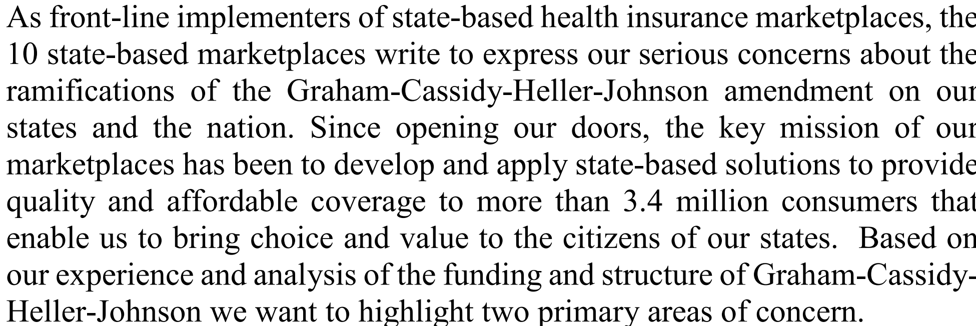


Trish Riley, Project Director | Executive Director, National Academy for State Health Policy
10 Free Street, 2nd Floor | Portland, Maine 04101 | 207.874.6524

September 25, 2017

The Honorable Mitch McConnell, Majority Leader
The Honorable Charles Schumer, Minority Leader
The Honorable Orrin Hatch, Chairman, Senate Finance Committee
The Honorable Ron Wyden, Ranking Member, Senate Finance Committee
The Senate of the United States of America
Washington, D.C., 20510

Dear Leaders McConnell and Schumer and Senators Hatch and Wyden,



As front-line implementers of state-based health insurance marketplaces, the 10 state-based marketplaces write to express our serious concerns about the ramifications of the Graham-Cassidy-Heller-Johnson amendment on our states and the nation. Since opening our doors, the key mission of our marketplaces has been to develop and apply state-based solutions to provide quality and affordable coverage to more than 3.4 million consumers that enable us to bring choice and value to the citizens of our states. Based on our experience and analysis of the funding and structure of Graham-Cassidy-Heller-Johnson we want to highlight two primary areas of concern.

Potential Collapse of Individual Health Care Markets

Over four years of operation, we have learned many valuable lessons about our health insurance markets and the needs of our consumers. We know that two policies provide the predictability that is a necessary component of stable and affordable insurance markets: (1) moving the health insurance markets to ones that no longer screen for pre-existing conditions and promote a common risk pool with a broad mix of enrollees; and (2) providing financial support to consumers to make health care affordable and support a stable risk pool. While we encourage opportunities to innovate within our markets, this proposal dramatically changes current policy and the likelihood that consumers will get financial assistance, which risk wide-scale market disruption, including issuer exits, dramatically escalating prices, loss of coverage, and/or elimination of consumer protections**.** Graham-Cassidy-Heller-Johnson's time–limited and greatly reduced funding for both the current Advanced Premium Tax Credit and states' Medicaid programs will challenge the ability of our states to effectively provide our consumers with sustained, affordable, and value-based coverage options without risking deep cuts in coverage or significant tax increases. With greatly reduced funding, states will confront difficult choices. If they protect low-income residents

through their Medicaid program, the likely reduction of tax credits for the individual market could trigger the collapse of individual markets – health plans will not participate in markets in which they must take all comers without financial protections. This collapse would mean not only that those who currently benefit from subsidies would no longer have coverage, but that the millions in the individual market who pay for their own coverage would face the prospect of losing the possibility of getting any coverage. For states that opt to protect their individual markets, they would do so at the direct expense of those who are enrolled in Medicaid programs. In addition, the broad discretion given to the Secretary of Health and Human Services to adjust the financing formula increases the unpredictability and instability of the market.

Implementation of Effective State-Based Solutions Would Be Impossible in the Two-Year Window Provided

To the extent a state has the resources and wants to support an individual market, Graham-Cassidy-Heller-Johnson requires each state, most of which now operate under the federal marketplace, to convert current programs and policies in just two years. During implementation of our marketplaces, we witnessed firsthand the practical realities and challenges of implementing statewide insurance programs. Drawing from this experience, we know it is critical that any reforms have sufficient time and resources built in for states to develop efficient programs that are informed by evidence and best practices and are transparent to consumers. For us, we had a broad road-map, substantial federal financial support and a four-year lead time to launch our individual marketplaces. Given the great complexities related to information technology systems, eligibility and enrollment processes, developing marketing and outreach and health plan contracting – the struggles in meeting a four-year launch timeframe were huge (as evidenced by the well documented challenges facing healthcare.gov in 2014). The two-year timeline – calling for full state-based responsibility of programs to be created out of whole-cloth by 2020 – does not take into consideration the policy, administrative, legislative, financial, operational and regulatory hurdles that each state would need to navigate. While Graham-Cassidy-Heller-Johnson provides the appearance of state-based autonomy, even those states that have established state-based marketplaces would be greatly challenged to convert to a purely state-operated system absent core federal administrative and technology infrastructure supports, such as the administration of risk adjustment processes and the operation of the "federal hub" for managing eligibility and enrollment processes.

Representing diverse states, consumers, and political leadership, we encourage a return to the development of bipartisan solutions to stabilize our markets. In the short-term, financing of cost-sharing reduction payments and establishment of a federal reinsurance program will accelerate stability and help drive down costs in our markets. We encourage additional flexibility for states under ACA section 1332 waivers, while also ensuring all consumers continue to receive comprehensive and affordable coverage and protection for pre-existing conditions as in the ACA. Additional flexibility could clarify: 1) the ability to meet deficit neutrality requirements over the lifetime of the waiver, not year by year, thus allowing states

; and 2) flexibility to establish open enrollment periods that are more suitable to meet local needs.

Beyond additional flexibility, we believe that the creation of planning grants and establishment of expedited federal processes for review and approval of waivers (without diminishing public

comment opportunities) could provide states with heightened opportunity to appropriately innovate in consideration of timely and local factors.

Long-term, we are committed to working with you to better understand key cost-drivers of our health insurance markets and develop solutions that will lead to lasting cuts in health care spending across the country.

We would be pleased to provide any additional information to assist in your important deliberations

Sincerely,

Louis Gutierrez Executive Director Massachusetts Health Connector	**Chiqui Flowers** Interim Administrator Oregon Health Insurance Marketplace	**Mila Kofman** Executive Director DC Health Benefit Exchange Authority
Heather Korbulic Executive Director Nevada Health Link	**Peter V. Lee** Executive Director Covered California	**Pam MacEwan** Chief Executive Officer Washington Health Benefit Exchange

Allison O'Toole
Chief Executive Officer
MNsure

Kevin Patterson
Executive Director
Connect for Health Colorado

Zachary Sherman
Acting Director
HealthSource RI

Jim Wadleigh
Chief Executive Officer
Access Health CT

September 12, 2017

Ms. Seema Verma
Administrator, Centers for Medicare and Medicaid Services
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Promoting Stability and Lower Costs in the Individual Health Insurance Market through Investments in Marketing

Administrator Verma:

For five years, Covered California has sought to both make the individual market work for consumers in California and use our experience to inform national policy strategies. Tomorrow, we will continue in that track with the release of *Marketing Matters: Lessons from California to Promote Stability and Lower Costs in National and State Individual Markets*. We are providing you with this report in the hopes that it can inform the work of the Centers for Medicare and Medicaid Services (CMS) and of state-based marketplaces regarding the role and impact of marketing and outreach in promoting enrollment and stability in individual insurance markets.

The *Marketing Matters* report provides a comprehensive overview of California's experiences, strategy and tactics with marketing and outreach efforts, as well as a review of the best available evidence about the role of marketing in promoting enrollment and retention in the individual market. The report also includes findings on how these efforts have been crucial to promoting stability in the market through strong enrollment, a healthy risk mix and a strong return on investment. With the high-churn nature of the individual market, health insurance must be "sold" in order to maintain enrollment and ensure a healthy risk mix. As such, marketing and outreach are critical elements to preserving stability in the individual marketplace.

I have appreciated the opportunity to previously share with you the critical role the marketing has played in making the individual insurance market in California among the healthiest in the nation. The impact of California's investments in marketing and outreach are clear. The lessons from California, informed by leading national experts on marketing, sales and the individual health insurance market, are important to other states and the federal government.

In July we sent you a draft of this report, in response to Secretary Price's call for comments on efforts that could help stabilize the individual insurance market. Since that time we have updated the report, in particular to model the potential impacts on the 39 states supported by the federally-facilitated marketplace of either increased spending or if federal spending were reduced, as was recently announced. The evidence is that marketing does matter and insufficient investments for marketing and outreach are likely to have immediate and dramatic effects on retention and new enrollment which, in turn, could worsen the risk pool and destabilize the market. According to the analysis:

BOARD MEMBERS Diana S. Dooley, Chair Paul Fearer Genoveva Islas Marty Morgenstern Art Torres EXEC. DIRECTOR Peter V. Lee

- If CMS reduces the marketing and outreach spending by the proposed 72 percent, to $47 million, the results are likely to be stark:
    - One million fewer Americans enrolled in health insurance. This would include 660,000 subsidy-eligible consumers, which would reduce take-up of subsidy eligible consumers by 10 percent, from 58 percent in 2017 to 52 percent in 2018.
    - Premiums for 2019 would be, on average, 2.6 percent more than they would otherwise be due to the smaller consumer pool and less healthy risk profile of the remaining group.
    - $1.3 billion in higher premiums in 2019 for the remaining 9.4 million insured consumers in the individual market. Of this group, unsubsidized consumers would pay $465 million more in premiums.

- In contrast, the report models the impact of what would likely happen if the federal government invested in marketing at a comparable level to Covered California over the next three years. This would entail investing about $480 million in 2018 with modest increases in spending in 2019 and 2020 and would likely result in:
    - 2.1 million more Americans would either enroll in or retain their health insurance.
    - Premiums over the three years would be on average 3.2 percent lower due to the improved risk profile that results from more enrollment.
    - The savings would be large; consumers would save $6 billion over a three-year period translating to a five to one return on investment.

The California case, as detailed in *Marketing Matters*, demonstrates that extensive marketing and outreach helped the state's individual market have one of the highest take-up rates and lowest risk scores in the nation. As a result, premiums were between $850 million and $1.3 billion lower than they would have been if the state had the national average risk mix in 2015 and 2016.

Additionally, marketing and outreach have a uniquely large return on investment as robust investments in marketing and outreach bring more healthy people into the risk pool thus lowering premiums. We estimate that, in California, every marketing dollar yields more than a 3-to-1 return on investment; efforts to promote the value of coverage and the options available to consumers boosted the enrollment of healthy consumers and likely lowered premiums by 6 to 8 percent in 2015 and 2016.

As detailed in *Marketing Matters*, the evidence for the positive effects of marketing and outreach to the market are clear, and our report detail the potential impacts of investment choices that are before you as you are a steward for the millions served by the Federally-facilitated Marketplace. For the individual market to maintain enrollment and a sustainable and healthy risk mix, sufficient resources for marketing and outreach activities are necessary.

We believe that the *Marketing Matters* report provides timely and relevant evidence that we hope is useful to you and the Secretary as CMS continues to assess market stabilization and planning strategies for the coming years. As always, please do not hesitate to contact us if you have questions, or would like to further discuss the report findings or any other matter for which we may serve as a resource.

Sincerely,

Peter V. Lee
Executive Director

cc: The Honorable Tom Price, Secretary, U.S. Department of Health & Human Services

Randy Pate, Deputy Administrator and Director, Center for Consumer Information and Insurance Oversight
Diana S. Dooley, Secretary, California Health and Human Service Agency; Chair, Covered California Board of Directors

Attachments:

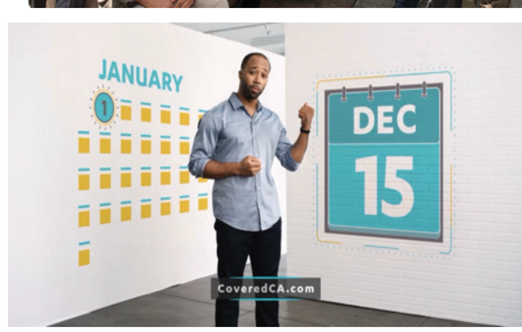
Full Report
Marketing Matters: Lessons From California to Promote Stability and Lower Costs in National and State Individual Insurance Markets
http://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_9-17

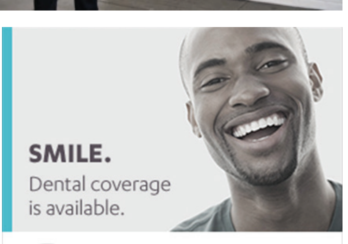
Issue Brief
Marketing Matters: How Marketing and Outreach Builds Stable Marketplaces and Pays Off for the Federal Government
http://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_Issue_Brief.pdf

MARKETING MATTERS:

Lessons From California to Promote Stability and Lower Costs in National and State Individual Insurance Markets

Peter V. Lee, Vishaal Pegany, James Scullary and Colleen Stevens





September 2017

À#),-3*%$'%+%,0/Ā

8C@MĀ@KJMĀ[illegible] 7/3 Ā$(7756 Ā#66436Ā-52 Ā!(1/-4 3/(Ā7Ā&54 2 47,Ā'7() /1/7Ā(3+Ā#4:,5Ā !467 6Ā3Ā%(7/43(1Ā3+Ā7 (7,Ā"3+/9/+8(1Ā3685(3*,Ā$ (50,76Ā[illegible]C@KĀMJ?P>ODĀ>JG=JM<DDĀ =JOCĀDDON?@Q@[illegible]@IĀ<I?ĀDDĀOC@Ā>M@[illegible]DHK@H@IODIĀJĀ(<GDAJMIDĀ[illegible]MJ<?Ā HPGOD!>C<II@G[illegible]<I?ĀJPOM@<>CĀKMJBMĀH[illegible]@MĀOC@ĀK[illegible]

+DMNOĀ<I?ĀAJM@HJNO[illegible]ĀIĀOC<Q@Ā=@@IĀK[illegible]OC<M?<I?ĀNH<MRJMF[illegible] ?@?D>@?Ā@JK[illegible]ĀOC@ĀN[illegible](<GDAJMIDĀ[illegible]@?P><OD[illegible]@IM[illegible] ?D@M[illegible]OC@ĀODI"Ā8C<IFNĀJ(JQ@M@?Ā(<GDAJMIDĀ2 <MF@D Ā4POM@<>CĀ<I?Ā 7<G@NĀ<I?ĀOC@ĀH HPID><ODJINĀ<I?Ā5P=GD>Ā6@GDJIN[illegible] OJĀ[illegible]@NĀOJĀB@OĀ[illegible]NPM@?"Ā+JM[illegible]OCD M@KJMO ĀOC<IFNĀ<GNJĀBJĀOJĀJPM[illegible]<I?Ā5D>Ā6@GDJINĀ)DQDNDIN ĀRCJĀRJMF@?[illegible]@IO[illegible]M@N@<M>CĀ<I?[illegible]

; @Ā<GNJĀRĀOJĀOC<IFĀOC[illegible]<I?Ā[illegible] JPMĀ<MF@[illegible]<I?ĀJPM[illegible]KMJBM<HN[illegible]Ā=P[illegible]Ā$(<HK=@GGĀR<G?Ā (<N<IJQ<#2 >(<II Ā.HKM@IO<Ā(JHHPID<ODJINĀ,MJPK Ā1<BM[illegible]H HPID><ODJINĀ 346(Ā <ĀOC@[illegible]D@M[illegible](CD<BJ Ā4BG[illegible]Ā5DD<>G@Ā([illegible]Ā2<I< B@H@IO D>C<M?Ā - @<OC[illegible]NNJ>D<O@N"Ā<I?Ā;@=@MĀ7C<ID?FF"Ā

+JMĀOC[illegible]@KJMO[illegible]@IO[illegible]ĀOC@[illegible]$ĀNO<O@!=<N@?Ā[illegible] @<?@MN%[illegible]

7K@>D<GĀOC<IFNĀBJĀOJĀ[illegible]AJPI?@MĀ[illegible] ,MQ@N ĀOC@Ā5M@ND?@IOĀ[illegible]"Ā 'J=Ā0J>C@M[illegible] +<HDGT[illegible]<I?Ā5P=GD>Ā[illegible] 2 @?D>[illegible]Ā6T<I Ā@I@M<GĀ<I<B@M[illegible] *S@>PO[illegible]Ā4AAD>@M Ā[illegible] *R<G?%Ā'@ONTĀ7O<M[illegible]JMĀ<O[illegible]OC@[illegible]<H-Ā:&1Ā-@GG"Ā

À"-10Ā -2%.%$Ā !*(&-.,(!Ā

(JQ@M@?Ā(<GDAJMIDĀ[illegible]NPM<I>@Ā[illegible](<GDAJMIDĀ<I?Ā [illegible]NPM<I>@[illegible]JQ@M@?Ā (<GDAJMID[illegible]<I?ĀB@OĀADI<I>D<GĀ<NNDNO<I>@ĀJIĀ <[illegible]JINPH@M[illegible] DINPM<I>@ĀKG<INĀ<I?Ā>CJJ[illegible]<I?Ā=P?B@O"Ā)@K@I?DIBĀJIĀOC@[illegible]JINPH@M[illegible]@!>JNOĀJMĀIJ!>JNOĀ 2 @?D<GĀKMJBM<H"Ā

(JQ@M@?Ā[illegible]K<MOĀJA[illegible]CJN@Ā[illegible]Ā OC@Ā[illegible]NPM<I>@Ā[illegible](<GDAJMIDĀ[illegible]JINPH@MN"Ā.OĀDNĀJQ@MN@@IĀ=TĀ<Ā [illegible] <=JPOĀ(JQ@M@?Ā(<GDAJMID Ā[illegible]RRR"(JQ@M@?(&">JH"Ā

Ā

Ā

Ā

Ā

!'%")$&#Ā !))"'(Ā Ā-9EEBAEĀ*DB@Ā(5?=:BDA=5ĀĀ FBĀ0DB@BF9Ā2F56=?=FJĀ5A8Ā-BI9DĀ(BEFEĀ=AĀ/5F=BA 5A8Ā2F5F9Ā+A8=H=8G5?Ā+AEGD5A79Ā.5D>9FEĀ

Ā

Ā

09F9DĀ4"Ā-99!Ā4=E<55?Ā09;5AJ!Ā,5@9EĀ27G??5DJĀ5A8Ā(B??99AĀ2F9H9A

Ā

29CF9@69DĀ%#$&Ā

Ā

3<=EĀ8B7G@9AFĀ=EĀ=AĀF<9@5A5A7Ā@5JĀ69Ā7BC=98ĀBD7BF<BGFĀC9D@=EE=BA"

2G;;9EF98Ā7=F5F=BA'Ā09F9DĀ4"Ā-99!Ā4=E<55?Ā09;5AJ!Ā,5@9EĀ27G??5DJĀ5A8Ā(B??99AĀ2F9H9AE"ĀĀ

*'0.,342.'Ā63Ā%43136+Ā&6'(.Ā'2*Ā"39+4Ā 3565Ā.2Ā$'6.32'0Ā'2*&6'6+Ā!2*.8.*7'0Ā!2574'2)+Ā#'4/+65*

Ā

)9E=;AĀ5A8Ā?5JBGF'Ā1B69DFĀ295EFDB@

'-;61=593Ā'-==1;< Ā4CPPLKPĀ1OLJĀ.?IGDLOKG?ĀQLĀ8OLJLQCĀ:Q?@GIGQVĀ?K
4LTCOĀ.LPQPĀGKĀ6?QGLK?IĀ?KBĀ:Q?QCĀ3KBGSGBR?IĀ3KPRO?KACĀ5?OHC

+-.71Ā:2Ā":9=19=<Ā

$@1/>=5?1Ā*>8 - ;AĀ!! #Ā

8=;:0>/= 59 Ā!!! &Ā

&ĀĀ4AĀ*17759Ā%1-7=4Ā&9>;-9 /1Ā59Ā=4Ā805:50>-7Ā'-;61=Ā&<Ā"4-77193593Ā!!!!!!!!!!!!!!!!!!!!!!! (Ā

Ā 3KK?QCĀ-G?POCPĀ5?KVĀ8CLMIĀ,SLGBĀ3KPRO?KACĀ!!! (Ā

Ā ; FCĀ3KBGSGBR?IĀ3KPRO?KACĀ5?OHCQĀ7GCOCKQĀ?KBĀ:CMPĀ5?OHCQGKEĀ!!!!!!!!!!!!!!!! Ā

&ĀĀ61=593Ā-90Ā>=;1-/4ĀB AĀ41Ā(>8 .1;<C Ā#-=-Ā+4-=Ā&92:;8Ā
' - ;61=593Ā&9?1<+8=<Ā!!! #$Ā

Ā 5 ?HGKEĀQFCĀ9GEFQĀ.KSCPQJCKQĀ LSCOCBĀ GLOKGĀ?MMOL?AFĀ!! #$Ā

Ā 5 ?OHCQGKEĀ?KBĀ?AFQPRIQPĀGKĀ.GDLOKG?Ā!! #&Ā

Ā 9 CROKĀLKĀ3KSCPQJCKQĀGKĀ.GDLOKG?Ā!!! #(Ā

Ā < KQ?MMCBĀ8CKQG?IĀCLDĀ1?IIVĀGIGQ?QCBĀ6CQMI?ACĀ5GOCĀ0UM?KPGLKĀ!!!!!!!!!!!!!!!!!!! $"Ā

Ā 8LQCKQG?IĀAOC?PCBĀ,OLJ CKQĀ2GEFCOĀ8OCJGRJ PĀCPRIQGKEĀ1OLJ Ā4LTCOĀ1CBCO?I
5 ?OHCQGKEĀ:MCKBGKEĀ!!! $&Ā

Ā . LSCOCBĀ.GDLOKG?KPĀ?OHPĀDLOĀBGKĀ!!! $'Ā

Ā 8OLJLQGKEĀ9CKQĀ1LKĀ!! $)Ā

Ā : Q?QC -?PCBĀ5?OHCQĀ:MCPĀ,QQCĀ?KBĀ9CQ?GKĀ?ĀCQCĀ9GFQ ĀGĀ!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!! %"Ā

Ā 8COPLK ;L 8COPLKĀ,PPGPQ?KACĀ?IIVĀ;FOLREFĀ,ECKQPĀ?KBĀ=GQ
8OLJLQGKEĀ.OLIIJCKQĀ!!! %%Ā

Ā , AQGSCIVĀ@LO?QGKEĀ2?IQFĀ8I?KPĀ?KBĀ,ECKQPĀ!!! %&Ā

Ā 3KSCPQJCKQĀ5?OHCQĀ?KBĀ/?KGKEĀ8COACKQĀLDĀ8OCJ!!! %'Ā

Ā 5 C?PROGKEĀQGJĀ=?IRCĀ!!! %(Ā

Ā 5 ?OHCQGKEĀ-CNR?QCIVĀ?KBCĀ!! %*Ā

Ā **Ā**

&&&%ÃĀ<Ā:9Ā=41Ā;71Ā:2Ā(;61=593Ā.90Ā*>=;1./4 Ā=:Ā+;:8:=1Ā$9;: 7781 9=Ā59=41ĀĀ 8905?50>.7Ā8<>;.9/1Ā (.;61= Ā Ā%"Ā

Ā 1=?OĀ"+Ā5MFAOEI4CĀAMNĀ8MAIEPHNĀ Ā%"Ā

Ā 1=?OĀ#+RĀMAIANNĀJBĀODAĀ,BEJMA@A?OĀJANĀ6OĀM=INGAĀO0 MGGAHOĀ Ā%$Ā

Ā 1=?OĀ$HĀĀ2ECDĀDPMIĀ ĀDA@EQ@P=G=MFAO0ALPEMANĀCIEEP=IOĀ7 ICJEICĀĀ 5 =MFAOEICĀ0IOAIONĀ Ā%'Ā

Ā 1=?OĀ%A@AMĀ4=RĀ9ALPEMAN5=MFAEOCĀ Ā%(Ā

Ā 1=?OĀ&+PĀ<EPĀ5=MFAO=KGNĀ,MĀ-ANOĀ8OIEA@ĀOJĀ8MJIHAĀ-M@Ā0MJGGAHOĀ Ā%*Ā

Ā 1=?OĀ'0HĀNPMEIEĀ=ĀO=>GĀ@EQ@P=G=MFAO0ALPEMANĀC=CEICĀCAIONĀ=I@ĀĀĀ 5 PGOEĀ=IIAGĀ0IMJGAHOĀ:OMACSĀ Ā&"Ā

Ā 1=?OĀ(+Ā5MFAOEICĀ0IOAHI ONĀ=I Ā AĀ;EAM@ĀOĀ5AAOĀA<E@Ā9 =I CAĀB5 =MFAOEIANĀ Ā&(Ā

Ā 1=?OĀ)5+ĀMFAOĀ6AA@NĀ4A=@ĀAJKGAOĀ8 MJ@PIOĀD=O6 AAO;DAEMĀ6@N Ā&)Ā

Ā 1=?OĀ*5+ĀMFAOĀ3 8 JGEP=G6 APQ9=I@ĀN=IĀ0?JIJH E?6 A?ANNEOSĀ Ā&*Ā

&- Ā$Ā71819=<Ā:2Ā$221/=5?1Ā(1=593ĀĀ*>=;1./4 Ā.90Ā$9;: 7781 9=Ā;2Ā=41Ā8905?50>.7ĀĀ 8<>;.9/1Ā (.;61= Ā Ā!Ā

Ā 8=E@Ā5@E=Ā Ā%Ā

Ā 0=MIA@Ā5@E=Ā Ā"Ā

Ā 3 Ā8AMNJIĀ0MJGAHOĀ Ā$Ā

Ā : PKKJMOEICĀEIĀ8AMNJIĀ0IMJGG=H@Ā0IMJGGĀ8=MOIAMNĀ Ā'Ā

Ā ; =MCAOA@ĀMA=?D Ā!Ā

Ā 7 IGEIAĀ0MJGAHOĀ Ā'Ā

Ā ; AGGEICĀODMASĀJBĀQAM@Ā=GEBJMIEĀJGGAAN Ā(Ā

Ā 2 AGKEICĀ=I@Ā0I?JPEICĀ;DJNAĀ>JĀO=MOĀ:DJKKCĀ Ā)Ā

Ā 9 AOAIOEIĀ:PKKJMOĀ Ā!Ā

Ā 7 ICJEICĀ9ANA=M?DĀOJĀ3ABJMHAOEĀ=I@Ā7POMA=?DĀOAOAE Ā"Ā

Executive Summary

Marketing and outreach are crucial investments to promote enrollment in the individual health insurance market. They are investments that pay off by fostering a healthier pool of consumers, which in turn lowers premiums for everyone. California has demonstrated that you need to invest money to save money.

Selling health insurance is uniquely difficult. While sick people are motivated to buy health insurance, healthier people need to be reminded, nudged and encouraged; they need to be convinced of the value of having health care coverage. Marketing is necessary to overcome the innate biases that discourage consumers from purchasing something that does not provide an immediate return.

California's experience shows that a stable individual insurance market does not just happen on its own — investments in marketing and outreach attract a healthier risk pool, lower premiums and encourage health insurance companies to participate in the market with more certainty and potential returns.

Effective marketing and outreach require a multifaceted approach grounded in solid research and a critical review of the return on investment. This report provides an overview of California's marketing and outreach experience, strategy and tactics. It also provides evidence of the impact of marketing and the potential application of this evidence to decisions by the Federally-facilitated and state-based marketplaces.

Major findings of this report include:

- Because of Covered California's extensive marketing and outreach, California's individual market — both on- and off-exchange — has one of the best take-up rates and lowest risk scores in the nation. This bigger and healthier enrollment translates to 20 percent lower costs than Covered California would have otherwise had if its risk score were the same as the national average — specifically, on-exchange premiums were $2.6 billion lower for 2015 and 2016. Covered California's marketing and outreach expenses in 2015 and 2016 likely lowered premiums by 6 to 8 percent. The lower premiums resulted in healthier consumers being more likely to enroll because of the reduced price of insurance, which further drives down the premium. (See Table 1: Potential Return on Covered California's Marketing Investment, 2015 and 2016.) Covered California estimates that every marketing dollar likely yields a more than three-to-one return on investment (ROI).
- The federal government is on a path to dramatically underspend on marketing and outreach — with the investment plans for 2018 being one-tenth of Covered California's spend. Lower investments mean less stable markets and higher premiums. The federal government collects a health plan assessment on premiums paid on the Federally-facilitated Marketplace (FFM) that is 3.5 percent of premium. The purpose of this assessment is specifically to pay for marketing and outreach to promote viable marketplaces for consumers, as well as ongoing

operations.[1] The Centers for Medicare and Medicaid Services (CMS) estimates that the federal government will collect $1.2 billion in plan assessments for calendar year 2018.[2] The federal government's planned 2018 spending of $47 million to promote marketing and outreach for 39 states is one-tenth of the $480 million it would be spending if it spent the same percentage of premium on marketing as does Covered California: If the FFM made this investment over three years, it would likely pay off with more than two million more Americans getting insurance, premiums that are 3 percent lower and higher participation of health plans, all with over a 400 percent return on investment. (See "Untapped Potential of Federally-facilitated Marketplace Marketing Expansion" section beginning on page 20.) If the federal government goes ahead with its planned 72 percent reduction in marketing and outreach spending, for a national spend of $47 million, there will likely be one million fewer Americans getting insurance, a less healthy risk pool in premiums that will be over 2.5 percent higher in 2019 (representing a premium increase for those remaining insured of $1.3 billion).

- California's experience and research provide evidence to support nine facts on the importance of making marketing and outreach a priority for federal and state public marketplaces. (See Section III: Facts on the Role of Marketing and Outreach to Promote Enrollment in the Individual Insurance Market.)
- California's experience in promoting enrollment in a large and diverse state can provide a framework to assess the level and nature of federal or other states' investments. (See Section II: Marketing and Outreach "By the Numbers": Data That Inform Marketing Investments; and Section IV: Elements of Effective Marketing, Outreach and Enrollment for the Individual Insurance Market.)

Covered California provides this report in an effort to inform the planning and investments of other marketplaces with the belief that the best path to improvement is transparency and the sharing of best practices. California is not an island. We have much to learn from other parts of the nation and Covered California has a stake in the success of efforts to assure stability in individual markets nationally. Understanding that the combination of strategies and tactics that worked for California may not fully apply to other states or the federal marketplace, nonetheless, the evidence is clear that a combination of marketing and outreach efforts is critical to promoting markets that work for consumers.

---

[1] Under 45 CFR §156.50 (https://www.ecfr.gov/cgi-bin/text-idx?SID=92e241490966e0b1b87f14d3683ca144&mc=true&node=se45.1.156_150&rgn=div8), a plan assessment fee is charged to participating issuers to recoup the costs for the following federal activities in connection with the operation of the Federally-facilitated Marketplace: provision of consumer assistance tools, consumer outreach and education, management of a Navigator program, regulation of agents and brokers, eligibility determinations, enrollment processes, and certification processes for health plans.

[2] 2018 plan assessment revenue for the FFM is found on page 10 of the Centers for Medicare and Medicaid Services' FY 2018 budget justification document, available at https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2018-CJ-Final.pdf.

The federal government, other state-based marketplaces and California have a responsibility to make investments that pay off for Americans and to continually seek to improve operations. California looks forward to continuing to learn from the lessons of others as it seeks to promote enrollment and a stable individual marketplace, and is happy to share links to a range of actual marketing material that are available for use or adaptation by other public exchanges.

An issue brief summary of this report can be found at http://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_Issue_Brief.pdf.

Introduction

California and other state-based marketplaces on average have attracted and retained a healthier risk mix than have the 36 states supported by the Federally-facilitated Marketplace (FFM). The Centers for Medicare and Medicaid Services has found that California had the lowest "average plan liability risk score" in the individual market for both 2014[3] and 2015,[4] and continued to have one of the lowest risk scores in the nation for 2016.[5]

While a range of factors contribute to a good risk mix and resulting lower premiums, Covered California understands that "good risk is earned." With that in mind, Covered California makes marketing investments and policy decisions to promote broader enrollment to ensure the best possible risk mix. The lynchpin to a good risk mix is significant, ongoing and effectively targeted investments in marketing and outreach.

Marketing is a critical element to creating a successful business. By building brand value in consumers' eyes, a business is making an investment in its future. Doing marketing and outreach correctly requires:

- Hiring the best subject-matter experts (both staff and contractors).
- Learning from research about consumers' perspectives and their experience.
- Coordinating with partners to execute comprehensive and strategic outreach efforts annually.
- Adapting to changing circumstances and new insights.

Health insurance offered to individuals is no different. In fact, in many ways selling health insurance is harder. Behavioral science shows that health insurance is a product that needs to be explained, promoted and sold because there are innate biases that make individuals skeptical about the need for coverage. (See page 7, Why Selling Health Insurance in the Individual Market is Challenging.)

In 2016, Covered California spent $99 million on marketing and outreach, and in 2017, that number was $122 million. For the upcoming 2018 enrollment year, Covered California has budgeted $111 million — one-third of its 4 percent user fee assessed on health plans or 1.4 percent of on-exchange premiums. The effective cost of Covered California's marketing and outreach investments is approximately 0.9 percent of total individual market premium — in many ways, a more appropriate point of reference to

---

[3] Centers for Medicare and Medicaid Services: Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year (Sept. 17, 2015) https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf

[4] Centers for Medicare and Medicaid Services: Appendix A to June 30, 2016 Risk Adjustment and Reinsurance: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Appendix-A-to-June-30-2016-RA-and-RI-Report-5CR-063016.xlsx

[5] Centers for Medicare and Medicaid Services: Appendix A to March 31, 2017 Risk Adjustment and Reinsurance: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Appendix-A-to-March-31-2017-Interim-RA-Report_5CR_033116.xlsx

compare since the entire individual market benefits from the broad marketing efforts that result in a better risk pool and lower premiums.[6]

California's significant marketing investments are proportionate to the size of the state and the size of its individual insurance market. California has implemented its marketplace in the context of having one of the most culturally, linguistically and geographically diverse markets in the nation. Consumer needs vary among different demographic groups, geographic areas and population centers. To better communicate and encourage enrollment, Covered California's marketing and outreach strategy is informed by data-driven research on potential enrollment populations and their demographic characteristics.

California's size and diversity does not mean its experience is exceptional; rather, it makes California's lessons relevant to other states and the federal marketplace because California is a microcosm of the United States. Its experience can provide relevant lessons for other marketplaces to consider, whether those markets are larger, as is the FFM, or smaller in the case of individual states.

With four years of experience in promoting enrollment, Covered California has learned the following lessons about fostering a stable and competitive individual market that works for consumers:

- Health insurance needs to be sold. Consumers need to be convinced to spend their discretionary income on coverage.
- Marketing and outreach have a dramatically positive return on investment (ROI). Covered California estimates that every dollar likely yields a more than three-to-one ROI — with both consumers and the federal government being the beneficiary of those investments.
- Marketing will always be needed because the individual insurance market churns significantly. Consumers enter and leave as their coverage needs change.[7]
- Underinvesting in marketing likely contributes to instability in the marketplace, higher premiums for consumers and less participation by health plans.
- Marketplaces need to hire skilled marketing and outreach staff; ensure sufficient spending; conduct appropriate marketing, communications and outreach functions; and adequately staff vendor management and coordination of agents and navigators.

---

[6] Since plans in California must offer "mirrored" versions of on-exchange products outside the exchange at the same price, the assessment in California is effectively spread across the entire individual market. Since the FFM and most state-based marketplaces assess fees only based on on-exchange enrollment and may not have comprehensive off-exchange enrollment or plan-selection data, to compare consistently, most of the data in the "By the Numbers" section compares spending only as a percentage of on-exchange premium for 2018. As described in the By the Numbers section, this high churn has continued.

[7] In the period from 2008 to 2011, prior to major Patient Protection and Affordable Care Act provisions taking effect, only 42 percent of individual market enrollees kept their coverage after 12 months, and 80 percent of them experienced coverage changes to other types of health insurance (the majority obtaining employer-based coverage).

Covered California provides this report to share its approach, rationale and detailed marketing and outreach plans because it believes the best path to improvement is transparency, setting benchmarks and learning from the best in private and public spheres. This report aims to help inform federal and state policy-makers about the size and nature of marketing and outreach investments that are needed to help foster stable insurance markets and to promote a good risk mix. At the same time, Covered California provides this report to foster discussion and feedback as it seeks to continually improve its own marketing and outreach efforts.

This report includes the following four sections:

I. **Why Selling Health Insurance in the Individual Market Is Challenging**
Behavioral economics, social psychology and cognitive neuroscience explain that the individual health insurance market is different from selling other products and services because of innate biases that make selling health insurance a challenge. It also contrasts individual health insurance to employer-based coverage, Medicare and other public programs.

II. **Marketing and Outreach "By the Numbers": Data That Inform Marketing Investments**
Provides a review of Covered California's multifaceted approach and financial considerations to making marketing and outreach investments. Further describes why marketing and outreach are investments likely to pay off for federal and state-based marketplaces.

III. **Facts on the Role of Marketing and Outreach to Promote Enrollment in the Individual Insurance Market**
Identifies nine key facts based on early evidence or proven data that can help inform investments in marketing and outreach by policy-makers.

IV. **Elements of Effective Marketing, Outreach and Enrollment for the Individual Insurance Market**
Concrete examples of California's marketing and outreach tactics, with a summary of their costs in dollars and as a percentage of on-exchange premium, as well as links to more examples of materials and research used in California.

Marketing is essential to continually maintain the healthiest possible risk pool. There may be room for debate on what the right mix of marketing investments should be. Only through getting and continually refreshing a large and balanced risk pool can stable premiums in the individual market be assured.

I. Why Selling Health Insurance in the Individual Market Is Challenging

Innate Biases Mean Many People Avoid Buying Insurance: Human bias leads consumers to perceive health insurance as something they do not need and overcoming those barriers requires deep insight and sophisticated marketing.

Selling health insurance in the individual market is not like selling other products and services, such as cars and cellphones. It is far more difficult because it requires overcoming several innate biases that affect most people.

There is significant evidence from behavioral economics, social psychology and cognitive neuroscience that finds humans behave irrationally. This explains why some individuals do not take the rational action of protecting themselves with health insurance. Getting people to change these behaviors requires deep insight and sophisticated marketing — especially to enroll the young and healthy to ensure a large, stable pool of participants.

Individual health insurance is a particularly challenging product to sell, even with substantial subsidies. While individuals with health conditions have high motivation to get insurance, healthy people have biases that discourage them from getting care. In large-group health insurance and programs such as Medicare, these biases are addressed by including certain mechanisms to counter them.

What follows are biases most people harbor that make selling health insurance a challenge:

- **Loss Aversion Bias: Consumers see the initial cost of buying a health insurance policy as a loss. Every day that they do not get "a payoff" from the insurance is considered a loss.** Under the prospect theory, people value avoiding a loss at twice the power of receiving a gain.[8] Healthier people would rather accept the risk of being uninsured than face the absolute certainty of paying premiums compared to the uncertainty of a gain in the form of having care paid for by their insurance.[9]
- **Temporal Discounting: Younger and healthier consumers are more tolerant of risk and are willing to make decisions that may adversely affect them in the future.** Individuals discount the future and put all emphasis on the present.[10]

---

[8] Kahneman, Daniel, and Amos Tversky. "Prospect theory: An analysis of decision under risk." *Econometrica: Journal of the*

[9] Schneider, Pia. "Why should the poor insure? Theories of decision-making in the context of health insurance." *Health Policy and Planning* 19, no. 6 (2004): 349-355.

[10] Thaler, Richard. "Some empirical evidence on dynamic inconsistency." *Economics Letters* 8, No. 3 (1981): 201-207.

Similar to saving for retirement[11] or dieting,[12] people tend to put off buying health insurance. The combination of a cost today and an uncertain future payoff presents a classic temporal discounting barrier.

- **Optimism Bias: When it comes to buying health insurance, people assume they will not get seriously ill nor fall victim to catastrophic health events.** Eighty percent of the population, across gender, race, nationality and age, consistently and routinely underestimate the risk of negative things happening and overestimate the chances of winning or achieving positive things.[13]
- **Availability Bias: Individuals who have never suffered a serious health issue, or are young and healthy and cannot imagine a time when they will need insurance, suffer from the availability bias.** Humans tend to believe what is "available" to their common experience.[14] The more an idea is abstract, invisible or distant in time or space, the less available it is in imagining. Most people are relatively healthy and do not foresee themselves as being sick or needing care.
- **Status Quo Bias: If individuals currently do not have health insurance, enrolling them is even harder.** The research on the status quo bias reveals that it is difficult to make people take action to change their current status.[15, 16]
- **Self-Efficacy: When signing up, consumers worry about understanding health insurance and making the wrong choice when deciding on their own.** A significant barrier to people doing something new is called self-efficacy. In a study examining insurance decision-making with Medicare patients, it was found that the consumers with greater self-efficacy wanted to make decisions on their own but preferred having advice.[17] Those with less self-efficacy were less knowledgeable about Medicare, in poorer health, and preferred delegating insurance decisions to someone they trust, such as spouse. These findings suggest that education and outreach activities could help build trust with less informed consumers, and support the role of agents, Navigators and others to help consumers with complex decision-making.

---

[11] Ersner-Hershfield, Hal, G. Elliott Wimmer and Brian Knutson. "Saving for the future self: Neural measures of future self-continuity predict temporal discounting." *Social Cognitive and Affective Neuroscience* 4, No. 1 (2008): 85-92.

[12] Barlow, Pepita, Aaron Reeves, Martin McKee, Gauden Galea and David Stuckler. "Unhealthy diets, obesity and time discounting: a systematic literature review and network analysis." *Obesity Reviews* 17, No. 9 (2016): 810-819.

[13] Sharot, Tali. "The optimism bias." *Current Biology* 21, No. 23 (2011): R941-R945.

[14] Tversky, Amos, and Daniel Kahneman. "Availability: A heuristic for judging frequency and probability." *Cognitive Psychology* 5, No. 2 (1973): 207-232.

[15] Samuelson, William, and Richard Zeckhauser. "Status quo bias in decision making." *Journal of Risk and Uncertainty* 1, No. 1 (1988): 7-59.

[16] Anderson, Christopher J. "The psychology of doing nothing: forms of decision avoidance result from reason and emotion." *Psychological Bulletin* 129, No. 1 (2003): 139.

[17] Kan, Kathleen, Andrew J. Barnes, Yaniv Hanoch, and Alex D. Federman. "Self-efficacy in insurance decision making among older adults." *The American Journal of Managed Care* 21, No. 4 (2015): e247-54.

The Individual Insurance Market is Different and Requires More Marketing: The individual health insurance market Is different from employer-based or public sources of coverage, such as Medicare — and must be heavily marketed and sold.

The Affordable Care Act includes multiple policy levers to encourage broad-based enrollment in the individual market, including:

- The availability of premium tax credits and cost-sharing reduction subsidies through marketplaces.
- The individual shared-responsibility provision (individual mandate).
- Mechanisms to support marketing for the federal or state-based marketplaces.

The first two policy levers have been critical in achieving coverage gains. However, they are not enough to encourage consumers to purchase and keep insurance.

Some suggest that the relative absence of marketing for health insurance in the employer, Medicare or Medicaid markets should inform efforts of public exchanges in the individual market. However, the individual market is fundamentally different from these sources of coverage, which both serve different populations and have structural features that efficiently maximize enrollment and attract both low- and high-risk consumers.

These major coverage sources do not rely heavily on marketing for the following reasons:

- **Employer-Sponsored Insurance:** Employer-sponsored insurance is the main source of coverage for 150 million nonelderly Americans.[18] Employers offering coverage generally pay for a significant percentage of that coverage so that nearly all employees participate in coverage at the beginning of employment — the take-up rate of 79 percent reflects the fact that the vast majority of those employees eligible for job-based coverage sign up.[19] Marketing to those with employer-based coverage is a critical function of the employer-employee communication, and does not require additional marketing for purposes of "selling." Further, a substantial portion of employers have "auto-enrollment" processes that facilitate higher enrollment.[20]

[18] Kaiser Commission on Medicaid and the Uninsured (2015). "The uninsured: A primer — key facts about health insurance and the uninsured in America. Washington, D.C.: http://kff.org/uninsured/report/the-uninsured-a-primer/. See supplemental tables — Table 1: 270.2 million non-elderly people, 55.5 percent of whom are covered by ESI.

[19] Some of the reasons workers are not covered by their employer include: 1) They are not eligible for benefits, 2) they already have coverage through a spouse or 3) they refuse employer coverage. See Exhibit 3.2 in Kaiser/HRET 2016 "Survey of Employer-Sponsored Health Benefits", available here: http://www.kff.org/health-costs/report/2016-employer-health-benefits-survey/

[20] According to recent national surveys, more than 40 percent of employers automatically enroll workers in health benefits. Kaiser/HRET "Survey of Employer-Sponsored Health Benefits" (2015).

- **Medicare:** Most consumers qualify for Medicare upon turning 65 or when they are under 65 but disabled. Because Medicare Part A (hospital) effectively has no premiums for eligible consumers, they are automatically enrolled if they have contributed their payroll tax. Medicare Parts B (outpatient) and D (prescription drugs) are voluntary and require eligible consumers to pay a monthly premium, with subsidies available on a sliding scale. Unlike younger people, those eligible for Medicare are far less likely to experience innate biases that may impede enrollment — instead those who are eligible for Medicare know they need health care coverage. For those over the age of 65, 90 percent use at least one prescription drug and 39 percent use more than five.[21] Additionally, two-thirds of Medicare beneficiaries live with multiple chronic conditions.[22] Not only are older individuals more aware of their potential need for health care than are younger people, but there are now penalties in the form of increased premiums for consumers who do not sign up.

  The marketing and outreach efforts to promote enrollment in Medicare Advantage and Medicare Part D are also totally different from the individual market. The Center for Medicare and Medicaid Services reports spending only $9.7 million to promote Medicare Part D and Medicare Advantage, but health plans themselves spend what is sure to be billions to promote their plans. The best data available is for 2017, the advertising spend alone of private health plans to promote enrollment was likely more than $350 million.[23] This figure does not include other forms of marketing expenses, such as digital marketing and direct mail. It also does not include health plans' agent commissions to promote enrollment. Medicare Advantage uses extensive marketing to enroll consumers and relies heavily on agents and brand-marketing investments similar to those of Covered California. Agents in California are paid approximately $500 a year for the first year a consumer enrolls in a Medicare Advantage plan. If the ratio of marketing spend to agent commission payments in Medicare is anywhere close to that of the individual market — Medicare Advantage plans and Medicare Part D plans are paying close to $2 billion in commissions to agents. This spending is similar to spending by health plans in public marketplaces which does not promote enrollment itself, but promotes the selection of their plan among all potential plans in a choice environment (see Fact 5: Public Marketplaces Are Best Positioned to Promote Broad Enrollment, starting on page 49).

---

[21] Kantor, Elizabeth D., Colin D. Rehm, Jennifer S. Haas, Andrew T. Chan, and Edward L. Giovannucci. "Trends in prescription drug use among adults in the United States from 1999-2012." *Jama* 314, no. 17 (2015): 1818-1830

[22] Centers for Medicare and Medicaid Services. Chronic Conditions among Medicare Beneficiaries, Chartbook, 2012 Edition. Baltimore, MD. 2012.

[23] See, Duggan, et al., "Who benefits when the government pays more? Pass-through in the Medicare Advantage program." *Journal of Public Economics* 141 (2016), which found average spend on advertising per Medicare enrollee in Medicare Advantage Plans and Medicare Part D plans of $5.90 a year. This average spend was multiplied by 19.1 enrollees in Medicare Advantage and 41.3 enrollees in Medicare Part D.

- **Medicaid:** Because Medicaid is a public insurance program available at little-to-no cost to the consumer, it is easier to convince eligible consumers to enroll into Medicaid since the financial barrier has been removed. Additionally, because eligible consumers can enroll year-round and in some states[24], at the point of care (when Medicaid-eligible individuals show up needing care at a hospital they can be immediately enrolled), there is less need to market during an open-enrollment period. Even with these enrollment advantages, research has highlighted the importance of marketing and outreach to promote higher take-up rates for those eligible for Medicaid.[25]

[24] Presumptive Medicaid eligibility is a state option under Sec. 2001 of the Patient Protection and Affordable Care Act.

[25] Wright, et al. "Low-Cost Behavioral Nudges Increase Medicaid Take-up Among Eligible Residents of Oregon." *Health Affairs* (May 2017).

II. Marketing and Outreach "By the Numbers": Data That Inform Marketing Investments

Marketing and outreach need to be executed well and be focused on the right target populations. Marketing and outreach investments should generate sufficient offsetting returns in the form of enrollment, better risk mix and lower premiums to justify their "load" on premiums.

The payoff of marketing investments takes multiple forms, including:

- Increased enrollment that leads to a better risk mix and resulting lower premiums.
- Certainty for health plans that they will enroll a healthier mix of consumers, which allows them to price accordingly and decide if participating in the individual market makes financial sense.
- Lower premiums for individuals who do not receive federal tax credits.
- Lower premiums translating into lower federal-subsidy payments.

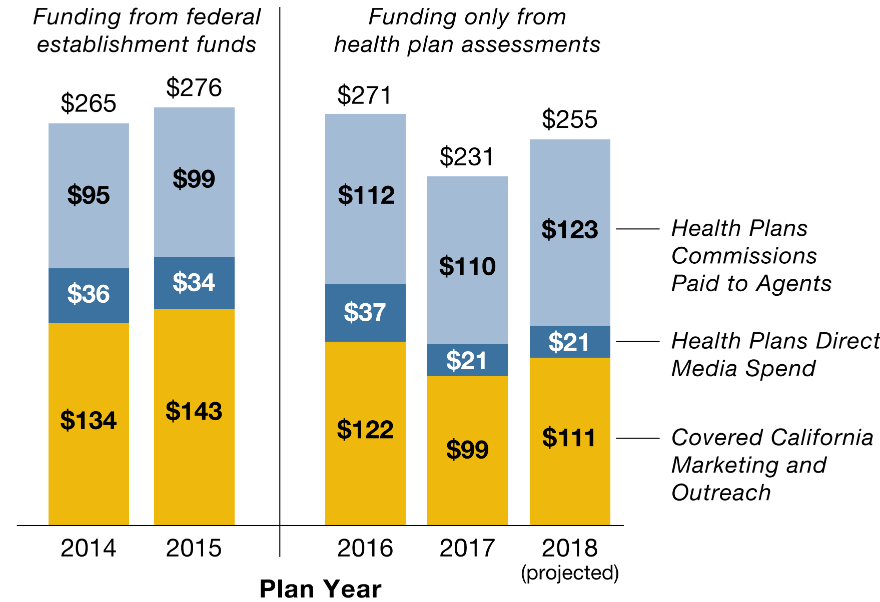
This section of the *Marketing Matters* report provides some of the data that frames California's investment approach.

Making the Right Investment: Covered California's Approach

A good risk mix does not just happen. Since its inception, Covered California has consistently invested in substantial marketing and outreach. These investments are grounded in the perspective that such investments lower premiums and attract a healthier risk pool. While there is no magic formula to determine how much marketing is sufficient, Covered California provides a pathway to help each marketplace determine its appropriate level of investment.

Covered California's multi-channel approach has resulted in marketing and outreach budgets that will average more than $120 million annually over its first five years. While the first two years of operations were supported by federal establishment funds, Covered California has continued to make investments in marketing and outreach a priority. These investments complement what health plans pay directly on marketing and commissions to agents. All together, the investments by Covered California and its 11 contracted health plans totaled nearly $1.0 billion over the past four years. Adding planned spending for 2018, the total increases to $1.3 billion and averages to approximately $260 million per year (see Figure 1: California On-Exchange Individual Market Marketing and Outreach Investments, 2014–18).

FIGURE 1
California On-Exchange Individual Market Marketing and Outreach Investments (millions), 2014–18[26]

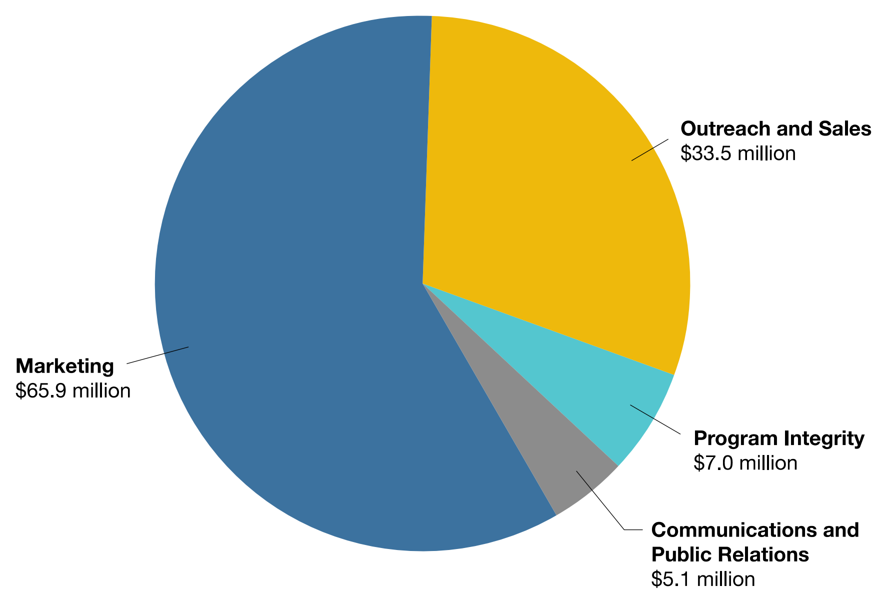


Looking ahead, Covered California has budgeted $111 million for FY 2017–18 which is broken down as follows (see Figure 2: Covered California's 2018 Marketing and Outreach Investments — $111 million):

- **Marketing** ($65.9 million): Includes paid media buys on television, radio, print, digital and out-of-home advertising to promote enrollment and the importance of coverage. Covered California has earmarked more than $43 million of the marketing budget specifically for paid media.
- **Outreach and Sales** ($33.5 million): Support for Covered California's extensive system to support in-person enrollment and enrollment partners such as Certified Insurance Agents, certified enrollers and Navigator grantees.
- **Communications and Public Relations** ($5.1 million): Covered California invests heavily in earned media to encourage enrollment during open and special enrollment. The $5.1 million supports a staff of 15 Covered California media professionals and a contract with the global public relations firm, Ogilvy. During the fourth open-enrollment period Covered California conducted more than 200 interviews with various media outlets, generating 90 million impressions.
- **Other program administrative expenses** ($7 million): Support for consumer protection.

[26] Covered California's health plan agent paid commissions are estimated based on enrollment data and best available information on commission rates, but may not reflect actual health plan spend. 2018 figures are projected using Covered California's proposed 2017–18 budget and direct-media spend is assumed to be the same as 2017. To enable common benchmarks based on a share of on-exchange premium (Figures 1 and 11), Covered California attributed plans' direct-media spending proportionally based on 68 percent of individual market enrollment being on exchange and 32 percent off exchange.

FIGURE 2
Covered California's 2018 Marketing and Outreach Investments — $111 million



Marketing and Outreach Results in California

Covered California's decision to continue to make substantial marketing and outreach investments is rooted in research that shows enhanced marketing improves take-up in the individual market. While it is difficult to establish empirically the precise effects of marketing investment and the specific benefits of each incremental dollar invested in marketing, there is substantial evidence that Covered California's aggressive marketing and outreach have been important contributing factors to California's higher take-up and the healthier risk profile as compared to the experience of the Federally-facilitated Marketplace (FFM).

Two critical pieces of evidence reinforce the hypothesis that Covered California's approach, including marketing as a critical component, results in higher enrollment and a healthier risk mix:

- Covered California has achieved a take-up rate among those who are subsidy eligible that is nearly 25 percent higher than the average for FFM states (see Figure 3: Comparing California and the Federally-facilitated Marketplace Take-Up Rates — 2014-2016). This data indicates that as of 2016, Covered California enrolled about 79 percent of subsidy-eligible individuals compared to the average for FFM states (64 percent).[27]

[27] See Kaiser Family Foundation Analysis of 2016 effectuated enrollment data: http://www.kff.org/health-reform/state-indicator/marketplace-enrollees-eligible-for-financial-assistance-as-a-share-of-subsidy-eligible-population/.

- As documented and reported by CMS, Covered California's enrollment reflects a substantially healthier mix of enrollees.[28] The CMS-calculated risk score of California's individual market is approximately 20 percent lower than the national average (see Figure 4: Comparison of FFM, SBM and Covered California Risk Scores). This 20 percent lower risk score means that California's $6.5 billion on-exchange premium for 2016 is roughly $1.3 billion lower than it would have been if the average risk of individual market enrollees in California were the same as the FFM average.[29]

While factors other than marketing and outreach contribute to some of the differences in take-up and risk mix in California, marketing and outreach play a significant role in the higher enrollment and healthier risk mix outlined above.

Further study is needed to better understand the specific return on investment for different levels of incremental spend. Available data provides parameters for modeling the potential return on investment and national benefits if the federal government were to make incremental increases in its marketing and outreach to be on a scale comparable to California. The two central hypotheses that support these investments are:

- Marketing and outreach result in more people signing up; and

FIGURE 3

Comparing California and the Federally-facilitated Marketplace Take-up Rates — 2014–2016

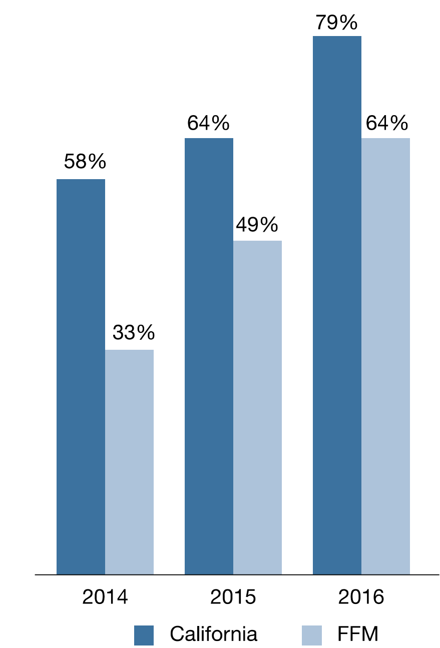
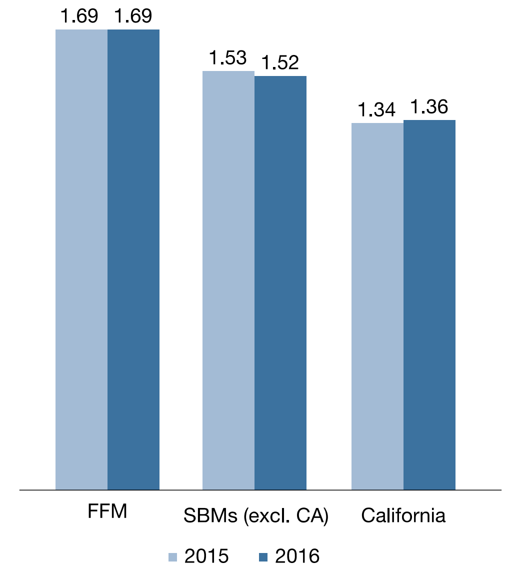


FIGURE 4

Comparison of FFM, SBM and Covered California Risk Scores



[28] Centers for Medicare and Medicaid Services. (2017) "Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2016 Benefit Year." https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf

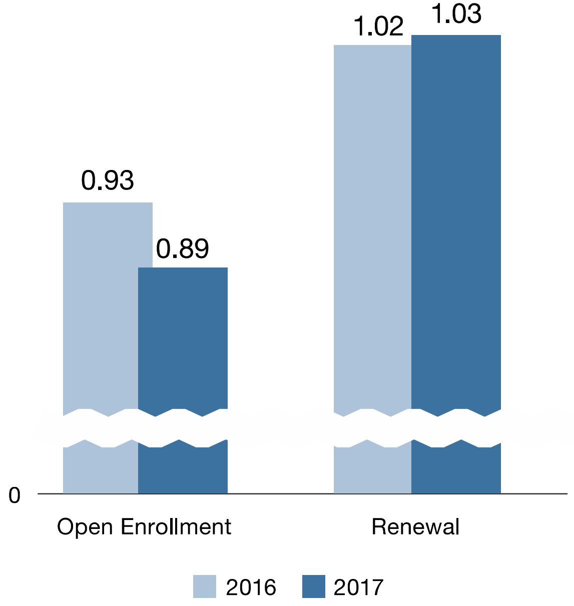
[29] See Table 1: Potential Impacts of Enhanced Marketing and Outreach — 2018–2002, in the "Return on Investment in California: Marketing has likely delivered California a better than three-to-one return on investment" section, starting on page 17.

- The incremental enrollment from those who sign up due to marketing contribute to a healthier risk mix.

In 2017, new Covered California enrollment translated to a better risk mix. Using a concurrent risk-score model[30] based on data from the State Office of Statewide Health Planning and Development (OSHPD), Covered California analyzed open-enrollment cohorts to measure its effectiveness in attracting a balanced risk mix.[31] During open enrollment, new consumers obtain coverage for the coming year and existing enrollees renew their coverage.[32] New enrollees in 2017 have a 15.7 percent lower mean risk score than renewing enrollees — an improvement of 4.3 percent between 2016 and 2017. (See Figure 5: Covered California Risk Scores by Enrollee, 2016 and 2017.) At the same time, renewing members have consistently had a mean risk score of ~1.03 from year to year, and the 2017 cohort has fewer chronic conditions than the 2016 cohort. This suggests that Covered California is successfully attracting new healthy enrollees to stabilize the risk pool.

FIGURE 5

Covered California Risk Scores by Enrollee, 2016 and 2017



Additionally, Covered California attracted a good risk mix in the context of an average 13.2 percent rate increase in 2017, which suggests that the availability of tax credits to defray the cost of health insurance is a significant driver of enrollment.[33]

---

[30] The Chronic Illness and Disability Payment System (CDPS) model is used by many states to evaluate their Medicaid program enrollment. CDPS calculates risk scores using an individual's age, gender and chronic-condition diagnoses (e.g., diabetes) listed in the following clinical encounters: hospitalizations, emergency department (ED) visits and ambulatory care. Since ambulatory data is not currently available by OSHPD, Covered California uses hospitalization and ED visits because these two categories have a 70 percent correlation with patient morbidity among Medicaid beneficiaries.

[31] Bertko, John, Andrew Feher and Jim Watkins. "Amid ACA Uncertainty, Covered California's Risk Profile Remains Stable." (2017). http://healthaffairs.org/blog/2017/05/15/amid-aca-uncertainty-covered-californias-risk-profile-remains-stable/, and "Covered California Continues to Attract Sufficient Enrollment and a Good Risk Mix Necessary for Marketplace Sustainability" (2017). http://hbex.coveredca.com/data-research/library/CoveredCA_Sufficient_Enrollment_Good_Risk_Mix.pdf

[32] To simplify year-to-year enrollment, Covered California automatically renews existing consumers into the same coverage, if available, at the end of the renewal period if they do not actively change their health plan. Consumers are notified of their option to change plans during the open-enrollment period should their preferences change.

[33] The premium change for 2017 followed two years of markedly lower premium increases (4.2 percent and 4 percent in 2015 and 2016, respectively). In 2016, 87 percent of Covered California enrollees were eligible for subsidies. Because premium tax credits are benchmarked to the second-lowest-cost Silver plan in an individual's rating region, consumers can purchase a typical plan adjusted to the costs in their local market. Effectively, this regional benchmark insulates subsidy-eligible consumers from rate increases.

Return on Investment in California: Marketing has likely delivered California a better than three-to-one return on investment.

Determining whether marketing investments "pay off" requires analysis of the extent to which incremental spending on marketing and outreach result in a higher take-up rate. Using this simple and limited definition of return on investment, it appears that marketing and outreach have delivered to California a better than three-to-one return, meaning Covered California saved Californians and the federal government anywhere from a low of $853 million to a high of $1.3 billion by having lower premiums in 2015 and 2016 alone.

Return on Investment — More than "just" lower premiums

Measuring return on investment based on lower premiums for those insured is an appropriate metric to assess the value of marketing and outreach spending, but it understates the broader positive impacts. First, more people getting and staying insured. Second, to the extent that marketing provides a better and more stable risk pool, health plans are more likely to see the individual market as a safe place to compete. Fostering greater participation and competition between health plans promotes consumer choice and helps keep premiums low through the market forces of competition.

One way to calculate California's return on investment can be done by looking at: The risk mix relative to the national average and the associated impact on premiums; Covered California's marketing spending; and an attribution of the portion of the premium difference to the marketing efforts.

Covered California has generated a strong take-up rate among healthier enrollees in the individual market, as documented by CMS.[34] The CMS-calculated risk scores of California's individual market enrollees is approximately 20 percent lower than the national average. By and large, this 20 percent lower risk score means that the $6.5 billion in premiums collected in 2016 is roughly $1.3 billion lower than it would have been if the average risk of individual market enrollees in California was actually the same as the FFM average (See Table 1: Potential Return on Covered California's Marketing Investment, 2015 and 2016).

The better risk mix needs to be viewed in the context of an unsurprising companion fact — better enrollment. First, Covered California has achieved a take-up rate among those who are subsidy eligible that is nearly 25 percent higher than the average for FFM states (see Figure 3: Comparing California and the Federally-facilitated Marketplace Take-Up Rates — 2014–2016). The data indicates that as of 2016, Covered California enrolled approximately 79 percent of subsidy-eligible individuals compared to the average for FFM states (64 percent).

Other research has indicated that enhanced marketing improves take-up in the individual market or in public programs, but independent and comprehensive research

[34] Centers for Medicare and Medicaid Services. (2017) "Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2016 Benefit Year" https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf

on this topic is sparse.[35] Part of the reason is the difficulty in establishing with precision which enrollees and what elements of a better risk mix result from marketing. For instance, while it is clear that Covered California's aggressive marketing and outreach led to differences in enrollment and the risk mix, other factors surely explain some of the difference in the risk mix resulting in lower premiums.[36]

To account for the potential impact of other factors on enrollment and risk mix, Covered California made several analytic assumptions in calculating the potential return on investment of marketing and outreach spending. First, Covered California's analysis excluded the 2014 plan year — the initial year of the implementation of the Affordable Care Act — because in this first year, there were challenges with the rollout of the FFM and healthcare.gov that may have affected enrollment. Second, rather than base the return on investment on a comparison of enhanced marketing (the relatively higher marketing spending in California compared to the FFM), the analysis used Covered California's entire marketing and outreach spending as the basis to assess possible ROI.[37] Covered California then looked at 2015 and 2016 to model two assumptions relative to what portion of the better risk mix to attribute to marketing and outreach: Applying only one-third of the difference to marketing and outreach and applying half of the difference to marketing and outreach.

If one-third of the difference in gross premiums between California and the FFM is attributed to Covered California's marketing and outreach, then it likely resulted in premium savings of $853 million for 2015 and 2016 (from what premiums might have been without that spending on marketing). When compared to the marketing and outreach investments of $265 million in 2015 and 2016, the return on investment would likely be three-to-one.[38]

---

[35] Wright, Bill, Ginny Garcia-Alexander, Margarette Weller and Katherine Baicker. (2017). "Low-Cost Behavioral Nudges Increase Medicaid Take-Up Among Eligible Residents of Oregon." *Health Affairs*. 36(5): 838-845: Karaca-Mandic, Pinar, Andrew Wilcock, Laura Baum, Colleen L. Barry, Erika Franklin Fowler, Jeff Niederdeppe, and Sarah E. Gollust. "The Volume Of TV Advertisements During The ACA's First Enrollment Period Was Associated With Increased Insurance Coverage." *Health Affairs* 36, no. 4 (2017): 747-754, and "Advertising cutbacks reduce Marketplace information-seeking behavior: Lessons from Kentucky for 2018." http://theincidentaleconomist.com/wordpress/advertising-cutbacks-reduce-marketplace-information-seeking-behavior-lessons-from-kentucky-for-2018/.

[36] In addition to the role of marketing and outreach, better risk mix can be potentially attributed to other variables, including: 1) the size and efficacy of marketing efforts by health plans or others 2) whether a state converted all plans to Affordable Care Act-compliant plans in 2014 to create a common risk pool and 3) whether a state expands Medicaid. In California's marketplace, there is the additional factor of the work Covered California does in creating competitive markets. Covered California fosters broad competition while selecting health plans based on their networks, rates, capabilities and consumer-focus. Covered California also negotiates rates and works with health plans, consumer advocates and others to establish patient-centered benefit designs that promote access, retain a healthy risk pool and help consumers shop. To learn more about the key ingredients to California's success in expanding coverage and creating a competitive marketplace, see: http://hbex.coveredca.com/data-research/library/CoveredCA_Key_Ingredients-05-18-17.pdf.

[37] To assess the potential return on investment of enhanced federal spending — detailed in the next section — Covered California considered only potential new federal spending. By applying the entire Covered California marketing and outreach budget to the "return" of the lower costs, this analysis reduces the ROI.

[38] This analysis focused on return on investment for on-exchange enrollees only: however, CMS-calculated risk scores apply to the entire California individual market. In examining the total California individual market, if one-third of the difference in gross premiums between California and the FFM is attributed to Covered California's marketing and outreach, then its marketing efforts resulted in premium savings of $1.3 billion in 2015 and 2016. When compared to the marketing and outreach investments of $265 million in 2015 and 2016, the return on investment would be nearly five-to-one.

TABLE 1 Potential Return on Covered California's Marketing Investment — 2015 and 2016			
	2015	**2016**	**Two-Year Impact**
Gross Premiums			
Covered California	$6.0 billion	$6.5 billion	$12.5 billion
Average Risk Scores			
FFM States	1.69	1.69	—
California	1.34	1.36	—
Difference	*21% lower*	*20% lower*	—
Estimated Covered California Gross Premiums if California had FFM Risk Scores			
Covered California gross premiums	$7.26 billion	$7.8 billion	$15.1 billion
Difference	*$1.26 billion*	*$1.3 billion*	*$2.56 billion*
***Assumption:* Premium Savings Due to Marketing and Outreach**			
If marketing explains 1/3 of gross premium difference ($1.3 billion)	$420 million	$433 million	$853 million
If marketing explains half of gross premium difference ($1.3 billion)	$630 million	$650 million	$1.3 billion
Covered California Marketing and Outreach Investments			
Covered California	$143 million	$122 million	$265 million
Return on Marketing Investment[39]			
If marketing explains 1/3 of gross premium difference ($1.3 billion)	194%	255%	222%
If marketing explains half of gross premium difference ($1.3 billion)	341%	433%	383%

If marketing explains half of the difference in gross premiums, then potential premium savings of $1.3 billion would be attributed to marketing and outreach, with a likely return on investment of nearly five-to-one.

The benefits of marketing in California, however, go beyond the lower premiums directly attributable to better risk mix. Consumers who gained insurance benefited, and the participation of health plans that saw a stable environment resulted in more competition.

[39] These percentages were calculated as follows: (Premium Savings – Marketing Investment) divided by Marketing Investment. E.g., for 2015: ($420 million - $143 million) divided by $143 million. The percentages displayed reflect the net return after paying back the marketing investment. In the narrative accompanying this table, we describe the return on marketing investment as the total return generated for every dollar invested, such that 194% would translate to nearly three-to-one, i.e., one dollar to pay back the initial marketing investment and two dollars of premium savings.

Untapped Potential of Federally-facilitated Marketplace Marketing Expansion: Resources available from existing federal plan assessments would support enrollment growth, improve stability in the individual markets and lower premiums.

In the years leading up to 2018, the federal government had been on a path of incrementally increasing its investments in marketing and outreach. The Centers for Medicare and Medicaid Services (CMS) spent approximately $118 million to promote enrollment and retention for 2016 (with $51 million for advertising and $67 million for the Navigator program.) (See Table 2: Federal Spending on Marketing and Outreach — 2016 to 2018.) For 2017, this investment was increased to about $165 million ($100 million for advertising and $63 million for the Navigator program).[40] While these investments were far lower than Covered California's as a percentage of premium, in those two years they increased by 22 percent — from 0.36 percent to 0.44 percent of total gross premium collected in the FFM.[41] In addition, the 2017 spending reflected about 13 percent of the reported $1.3 billion in marketplace premium assessments collected for marketing and outreach and other operational supports for the FFM.

TABLE 2
Federal Spending on Marketing and Outreach — 2016 to 2018

	2016 Actual			2017 Actual			2018 Proposed		
Marketing Spend	$ Millions	2015-16 Change	% of Premium	$ Millions	2016-17 Change	% of Premium	$ Millions	2017-18 Change	% of Premium
Advertising	$51.2	—	0.16%	$100	95%	0.27%	$10	-90%	0.03%
Navigators	$67	—	0.20%	$63	-6%	0.17%	$36.8	-42%	0.11%
Total	**$118.2**	**—**	**0.36%**	**$163**	**38%**	**0.44%**	**$46.8**	**-71%**	**0.14%**
FFM Gross Premiums	$33 billion			$37.1 billion			$34.3 billion		
Plan Assessments	$1.15 billion			$1.3 billion			$1.2 billion		
Spend as Share of 3.5 %	10%			13%			4%		

In August, CMS announced its planned investment of $47 million for marketing and outreach for 2018, with planned advertising spending of $10 million and Navigator program spending of $37 million. This spending is less than one-third of 2017 spending, and is one-tenth of what CMS would be spending if it were to invest in marketing at the same rate as does Covered California. The spending also represents only 4 percent of the estimated $1.2 billion in the federal marketplaces' premium assessments for 2018.

---

[40] Centers for Medicare and Medicaid Services (2017) "CMS Announcement on ACA Navigator Program and Promotion for Upcoming Open Enrollment."https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-08-31-3.html. See also the CMS fact sheet, http://big.assets.huffingtonpost.com/cms-fact-sheet.pdf.

[41] These figures were calculated by dividing the total marketing and outreach spend by total gross premiums for 2016 and 2017. Total gross premiums were derived by dividing publicly reported marketplace premium assessment revenues of $1.15 billion for 2016 and $1.3 billion for 2017 by 3.5 percent. See page 10 of the Centers for Medicare and Medicaid Services' FY 2018 budget justification document, available at: https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2018-CJ-Final.pdf.

For *Marketing Matters*, Covered California modeled the incremental benefits and impacts of increasing the marketing and outreach spending based on the 2017 baseline amount of $165 million. The proposed reduction in marketing and outreach spending announced in August will likely lead to lower enrollment, reduced retention of existing consumers and a worse risk mix — resulting in higher premiums. Covered California's modeling did not contemplate such a significant reduction.

Based on California's experience, if the FFM were to expand its investments in marketing from 2018 to 2020 to be commensurate with Covered California's investments as a percentage of premium — which we estimate to be $480 million, an increase of approximately $315 million over the 2017 spending of $165 million — the benefits from this increased investment would be immediate and profound.[42]

Exact impacts are difficult to project, but based on reasonable assumptions about how much the market would grow, and the health status of new enrollees, a plausible outcome would be that:

- 1.3 million more Americans would gain subsidized insurance.
- Premiums would be reduced an average of 3.2 percent from 2018 to 2020 for all insureds in the individual market. (See Table 3: Potential Impacts of Enhanced Marketing and Outreach for FFM States — 2018-2020.)

To model the potential benefits of enhanced marketing spending, this analysis starts with the best available information on a few fronts:

- The president's budget estimates that the plan assessments for FY 2018 will be $1.2 billion. This information is used as the basis for calculating the starting enhanced funding of marketing and outreach for 2018.[43]
- The FFM total marketing and outreach spending for 2017 was $165 million. Although CMS recently announced it will spend $47 million on marketing and outreach for 2018, this analysis assumed spending would continue at the same rate as 2017.

---

[42] To develop this model, Covered California used the CMS-reported budget (https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2018-CJ-Final.pdf) for health plan assessments of $1.2 billion as the basis for calculating what a 1.4 percent of premium spend would equate to for the FFM. This calculation is used to determine potential 2018 spending with subsequent years' marketing reflecting only an increase of 4 percent spending. Covered California considered a range of increases in the take-up rate based on enhanced marketing spending. The range of potential increases in enrollment was from 5 percent to 25 percent. Similarly, we modeled a range of differences in the health status of the incremental enrollment — ranging from 10 percent healthier and less costly to 40 percent healthier and less costly. Based on California's enrollment and risk mix experience, as well as its return on investment, we model the most likely impact of the enhanced investments to result in a 20 percent enrollment increase from 2017 to 2020 (with net enrollment reflecting a year-over-year increase of 10 percent in 2018 and 4.5 percent in 2019 and 2020), and that those incrementally enrolled individuals would be 25 percent healthier and less costly. Under these two assumptions, Covered California's marketing and outreach investments would have been responsible for the enrollment of more than 350,000 Californians, and lowered premiums by more than 4 percent compared to what they would have been without the enhanced marketing. This is consistent with our return on investment analysis that found a potential return on investment of more than three-to-one if only one-third of Covered California's healthier risk mix were attributed to marketing. For additional details on the modeling and assumptions, see http://hbex.coveredca.com/data-research/MarketingMatters-ModelingMethods-09-13-17.pdf.

[43] 2018 plan assessment revenue for the FFM is found on page 10 of the Centers for Medicare and Medicaid Services' FY 2018 budget justification document, available at https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2018-CJ-Final.pdf.

TABLE 3
Potential Impacts of Enhanced Marketing and Outreach for FFM States — 2018–2020[44]

	2018			3 Year Total (2018-2020)	
	Baseline (Projected at 2017 level)	**Enhanced** (Hypothetical)	**Difference** (Impact)	**Potential 3 Year Impact Due to Enhanced Marketing**	
Marketing Spend					
Baseline	$165 million	$165 million	—	—	$531 million
Enhanced	—	$315 million	—	—	$968 million
Total	$165 million	$480 million	$315 million	—	$1.5 billion
Enrollment					
				End of Period Enrollment	Difference from Baseline
On-Exchange Subsidized	6,622,133	7,284,347	662,213	7,946,560	1,324,427
On- and Off-Exchange Unsubsidized	3,773,076	4,150,384	377,308	4,527,691	754,615
Total	10,395,209	11,434,730	1,039,521	12,474,251	2,079,042
Premiums (Individual)					
Per Member Per Year	$5,374	$5,252	– $122	Average Premium Decrease (2018–2020)	
Percent Change	– 2.3%			– 3.2%	
Total Premiums (Aggregate)					
Core Group				Total Cumulative Premiums (3 Years)	Difference from Baseline
On-Exchange Subsidized	$35.6 billion	$34.8 billion	-$809 million	$110.7 billion	– $3.8 billion
On- and Off-Exchange Unsubsidized	$20.3 billion	$19.8 billion	– $461 million	$63 billion	– $2.1 billion
Subtotal	$55.9 billion	$54.6 billion	– $1.3 billion	$173.7 billion	– $5.9 billion
Marketing-Induced Group					
On-Exchange Subsidized	—	$3.5 billion	$3.5 billion	$16.8 billion	$16.8 billion
On- and Off-Exchange Unsubsidized	—	$2 billion	$2 billion	$9.6 billion	$9.6 billion
Subtotal	—	$5.5 billion	$5.5 billion	$26.4 billion	$26.4 billion
TOTAL					
On-Exchange Subsidized	$35.6 billion	$38.3 billion	$2.7 billion	$127.5 billion	$13.1 billion
On- and Off-Exchange Unsubsidized	$20.3 billion	$21.8 billion	$1.5 billion	$72.6 billion	$7.4 billion
Subtotal	$55.9 billion	$60.1 billion	$4.2 billion	$200.1 billion	$20.5 billion
Potential Return on Investment of Enhanced Marketing (return is lowered premiums for original group)					
Potential ROI	303%			508%	

Assumption: Enhanced marketing leads to 20 percent increase in enrollment of consumers who are 25 percent loss costly to insure.

[44] The baseline spending for 2018 is FFM total marketing and outreach spending of $165 million for 2017. Although CMS recently announced it will spend $47 million on marketing and outreach for 2018, this analysis assumed spending would continue at the same rate as 2017. Baseline enrollment for 2018 uses 2017 effectuated enrollment for the FFM. The $480 million marketing and outreach spend for 2018 under enhanced was calculated by applying California's benchmark of 1.4 percent of premium to the FFM's projected $34.3 billion in total gross premiums. FFM total gross premiums is derived by dividing CMS' reported $1.2 billion in plan assessment revenue for 2018 by the 3.5 percent user fee on plans. The $480 million then grew by 4 percent (instead of medical inflation) for each year thereafter.

If the FFM were to increase its marketing and outreach spending to be 1.4 percent of on-exchange premium for 2018, and then increase that spending by 4 percent per year (rather than increasing it to keep pace with the growth of premium), total marketing and outreach investments over three years would be approximately $1.5 billion — an increase of nearly $1 billion over the 2017 spending rate. Over three years, this investment would represent only 1 percent of total FFM on-exchange gross premiums from 2018 to 2020.

As previously mentioned, the results from these federal investments include the following potential benefits under Covered California's assumptions of 20 percent enrollment growth of enrollees that are 25 percent less costly to insure:

- 2.1 million *more* Americans would enroll in or keep their health insurance over this three-year period. This would include covering 1.3 million more subsidy-eligible Americans, increasing take-up of subsidy-eligible consumers by 20 percent, from 58 percent in 2017 to 70 percent in 2020.
- Premiums over the three years would be on average 3.2 percent *less* than they would be absent the enhanced marketing investments because of the better health of the additional enrollees.
- After a three-year phased enrollment growth of 20 percent, the enhanced federal marketing spending would have a better than 400 percent return on investment, based *only* on looking at lower premiums for those who would have had insurance under a baseline (not the enhanced marketing scenario).

The biggest beneficiaries of these investments would be:

- Individuals who get insurance because of the effective marketing; and,
- Unsubsidized individuals who were already insured and are now paying lower premiums — saving them more than $2.1 billion in premiums over the three years.

The proposed federal spending on marketing and outreach for 2018 is neither supported by the evidence nor a rational application of good business principles. The evidence so far is clear — marketing is a potentially effective and efficient mechanism for both improving take-up *and* lowering premiums. The benefits, however, go beyond these impacts by fostering marketplaces that insurance carriers see as stable and competitive. In addition, all insured consumers in the FFM would benefit from expanded and more certain participation of health plans, which fosters greater competition.

Potential Decreased Enrollment and Higher Premiums Resulting From Lower Federal Marketing Spending

In light of the recent announcement by CMS to reduce planned marketing and outreach to $47 million, Covered California also analyzed the potential impact of reduced marketing and outreach spending. This analysis examines possible impacts on enrollment and the financial impacts to those remaining insured in the individual market when fewer consumers enroll or maintain their coverage because of reduced marketing spending. Based on a scenario in which enrollment declines by ten percent in 2018, which is likely a conservative estimate, the impact on reduced enrollment, worse risk mix and higher premiums would impact some consumers immediately and likely lead to higher costs and less market stability in 2019 (see Table 4. Potential Impacts of Reduced Marketing and Outreach for Federally-facilitated Marketplace States [2018]).

Based on the assumption of 10 percent loss in enrollment of consumers who are 25 percent less costly to insure, the potential impacts of the proposed reduced marketing investment include:

- One million fewer Americans enrolled in health insurance. This would include 660,000 subsidy-eligible consumers, which would reduce take-up of subsidy-eligible consumers by 10 percent, from 58 percent in 2017 to 52 percent in 2018.
- Premiums for 2019 would be, on average, 2.6 percent more than they would be because of the smaller consumer pool and less healthy risk profile of the remaining group. This would translate to $1.3 billion higher premiums in 2019 for the remaining 9.4 million insured consumers in the individual market. Of this group, unsubsidized consumers would pay $465 million more in premiums.

If the same reduced spending were to lead to a decline in enrollment by 20 percent, which is easily in the range of the possible, this would lead to 2.1 million fewer insured Americans, of whom 1.3 million would have been subsidy-eligible. Under this scenario, the number of insured consumers in the individual would shrink from 10.4 million to 8.3 million and would be less healthy overall. Premiums would likely increase by 5.3 percent, meaning insured consumers remaining in the individual market would pay $2.4 billion in higher premiums — of which $850 million is borne by unsubsidized consumers.

TABLE 4
Potential Impacts of Reduced Marketing and Outreach for FFM States — 2018[45]

	2018		
	Baseline (Projected with 2017 Marketing Spend)	**Reduced** (Projected Based on Announced Spending)	**Difference** (Impact)
Marketing Spend			
Baseline	$165 million	$47 million	—
Enhanced	—	—	—
Total	$165 million	$47 million	– $118 million
Enrollment			
On-Exchange Subsidized	6,622,133	5,959,920	– 662,213
On- and Off-Exchange Unsubsidized	3,773,076	3,395,768	– 377,308
Total	10,395,209	9,355,688	– 1,039,521
Premiums (Individual): Impact on Premium for 2019 Based on Health Status Change Only			
Per Member Per Year	$5,374	$5,512	$138
Percent Change	—	2.6%	2.6%
Total Premiums (Aggregate)			
Remaining Insured After Reduced Enrollment (Premium Difference is Estimated Impact on 2019 Premiums Based on Health Status Change Only)			
On-Exchange Subsidized	$32 billion	$32.8 billion	$821 million
On- and Off-Exchange Unsubsidized	$18.2 billion	$18.7 billion	$468 million
Total	$50.3 billion	$51.6 billion	$1.3 billion
Reduced Enrollment Group (Premium Difference is Gross Reduction in Premium for 2018 Based on Non-Coverage)			
On-Exchange Subsidized	$3.6 billion	—	– $3.6 billion
On- and Off-Exchange Unsubsidized	$2 billion	—	– $2 billion
Total	$5.6 billion	—	– $5.6 billion

Assumption: Enhanced marketing leads to 20 percent increase in enrollment of consumers who are 25 percent loss costly to insure.

[45] The baseline spending for 2018 is FFM total marketing and outreach spending of $165 million for 2017. The reduced marketing spend for 2018 is based on the recent CMS announcement that proposed $47 million in marketing and outreach spending. Baseline enrollment for 2018 uses 2017 effectuated enrollment for the FFM. Reduced enrollment is modeled based on a 10 percent reduction.

Covered California's Benchmarks for Spending: Marketing and outreach spend provides a benchmark to inform federal and other SBM spending.

Based on public reports, the federal investment in marketing and outreach for 2017 was $165 million and the planned spending for 2018 is $47 million.[46] If the FFM spent the same percentage of on-exchange premium on marketing and outreach as does Covered California (1.4 percent), the FFM would invest approximately 10 times its planned 2018 spending amount ($480 million) on marketing and outreach. Given the FFM's current level of health plan assessments of $1.2 billion, the $480 million would represent 40 percent of the assessment collected (compared to California's rate of about 35 percent).[47]

To provide a benchmark for potential federal marketing investments, Covered California conducted a "what if" scenario for potential FFM spending across major elements of a multi-channel marketing and outreach effort if it spent the same proportion of premium to promote enrollment as does Covered California (see Table 5: California 2018 Marketing Spend as a Benchmark for the Federal Marketplace).

Regarding potential allocation among marketing and outreach areas, it is likely that in most instances the FFM spends far less proportionately than does Covered California. There may be two areas where the FFM is spending as much or more proportionally as Covered California:

- The FFM has operated a significant and sophisticated outreach program to individuals who have initiated their application. Similarly, Covered California conducts email outreach and follows up with these individuals in other ways. The direct costs of these efforts are relatively low, however, and are reflected in Covered California's information technology budget.
- The FFM has historically made significant investments in its support for the Navigator program. This was the only area of spending where it appeared that CMS was spending at a higher rate as a percentage of premium than was Covered California. Covered California's Navigator program, with grants totaling $6.5 million, reflects an investment of 0.08 percent of premium. CMS recently announced a reduction of federal support for the Navigator program from $62.5 million in 2017 to $37 million for 2018. With the reduction in spending, CMS is on track to spend about one-tenth of one percent of on-exchange premium in support of the Navigator program. What is striking is not the fact that CMS might adjust particular tactics, but that it cut Navigator funding in half in one-year and at the same time reduced all other marketing expenditures by 90 percent, from $100 million in advertising for 2017 to $10 million for 2018.

---

[46] Centers for Medicare and Medicaid Services. (2017) "CMS Announcement on ACA Navigator Program and Promotion for Upcoming Open Enrollment." https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-08-31-3.html. See also CMS fact sheet, http://big.assets.huffingtonpost.com/cms-fact-sheet.pdf.

[47] The other major spending areas funded by health plan assessments is the maintenance and updating the healthcare.gov enrollment site and the support for the call center. Covered California does not have data on the amount of federal spending on these two functions, nor is it within the scope of this report to assess the efficiency of the website and call center functions and the amount spent on them.

TABLE 5
California 2018 Marketing Spend as a Benchmark for the Federal Marketplace[48]

	Covered California Marketing and Outreach as 1.4% of Premium (35% of Plan Assessment)		"WHAT IF" SCENARIO FFM Spends 1.4% of Premium on Marketing and Outreach (40% of Plan Assessment)	
Projected Gross Premium (billions)	$7.8 billion		$34.3 billion	
Projected Enrollment	1.4 million		7.7 million	
Total Plan Assessment Dollars	$314.4 million		$1.2 billion	
Marketing and Outreach	$111.5 million		$480 million	
MARKETING — Select Breakdown for Benchmarking Purposes			Federal Allocation by Channel *if* Same as Covered California	
	$ Millions	**% of Premium**	**$ Millions**	**% of Premium**
PAID MEDIA				
Television	$18.1	0.23%	$79.6	0.23%
Digital Display	$9.7	0.12%	$42.8	0.12%
Radio	$8.3	0.11%	$36.4	0.11%
Paid Search	$2.3	0.03%	$10.2	0.03%
Paid Social	$1.9	0.02%	$8.5	0.02%
Print	$3.1	0.04%	$13.6	0.04%
Out-of-Home	$1.5	0.02%	$6.7	0.02%
TOTAL	**$45.0**	**0.58%**	**$197.8**	**0.58%**
NON-PAID MEDIA				
Collateral, Printing, Fulfillment, Postage	$11.0	0.14%	$48.4	0.14%
Marketing Operations	$4.9	0.06%	$21.4	0.06%
Personnel Services	$2.9	0.04%	$13.0	0.04%
Research	$2.1	0.03%	$9.2	0.03%
TOTAL	**$20.9**	**0.27%**	**$92.0**	**0.27%**
OUTREACH & SALES				
Covered California for Small Business	$18.9	0.24%	$83.1	0.24%
Navigators	$6.5	0.08%	$34.3	0.10%
Personnel Services	$6.3	0.08%	$27.7	0.08%
Other Enrollers Program Administration	$1.8	0.02%	$2.2	0.01%
TOTAL	**$33.5**	**0.43%**	**$147.2**	**0.43%**
EARNED MEDIA				
TOTAL	**$5.1**	**0.07%**	**$22.4**	**0.07%**

[48] Notes related to considering Covered California's marketing and outreach expenditures to set benchmarks:

- The projected gross premium and enrollment would likely be substantially higher for the FFM with increased marketing and outreach expenditures.
- Support for agents to enroll in Covered California programs, such as: a statewide storefront program, agent referral program, management of Covered California for Small Business and an agent-focused program.
- Earned media includes staff and contractual public relations and the consumer-facing website (before the application).

For additional details on Covered California's budget, see its 2017–18 budget (http://hbex.coveredca.com/financial-reports/PDFs/CoveredCA_2017-18_Budget_final.pdf).

Promoting Retention: Marketing and outreach investments are linked to better retention, which helps mitigate the high turnover in the individual market.

Covered California's experience is that 40 percent of its enrollees leave the marketplace each year, which is a "natural" part of the individual market (see Figure 6: Covered California Health Coverage Transitions in 2016). Not only is churn natural,[49] but Covered California's survey data finds that, in California, the vast majority of those leaving do so for other coverage.

This churn means that continual outreach is needed to maintain enrollment and to newly enroll people who lose employer-based insurance, parental coverage, or coverage from public programs.

For California, the turnover means that while Covered California was providing coverage to about 1.4 million people (as of April 2017), since the first open-enrollment period in January 2014, more than 2.9 million unique Californians have had both subsidized and unsubsidized coverage through Covered California. Some of these people had coverage for as short as a month while others for as long as the entire three years. Looking at subsidy-eligible consumers only, Covered California has enrolled 2.35 million unique individuals since 2014. (See Figure 7: Covered California: Continuous and New Subsidized Insureds, 2014–2016.)

FIGURE 6

Covered California Health Coverage Transitions in 2016

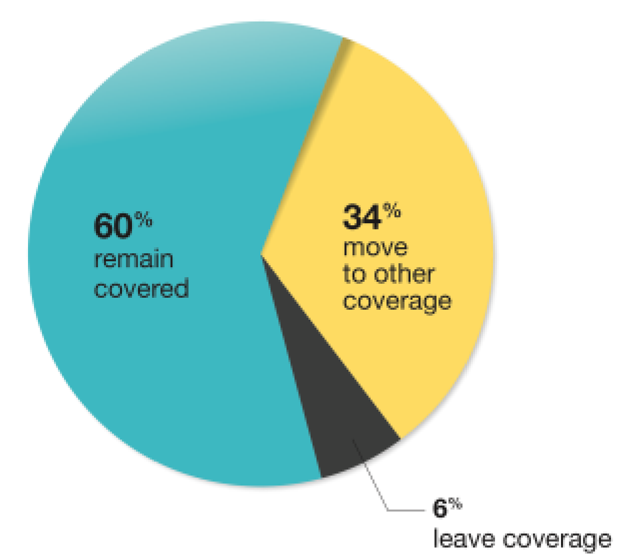
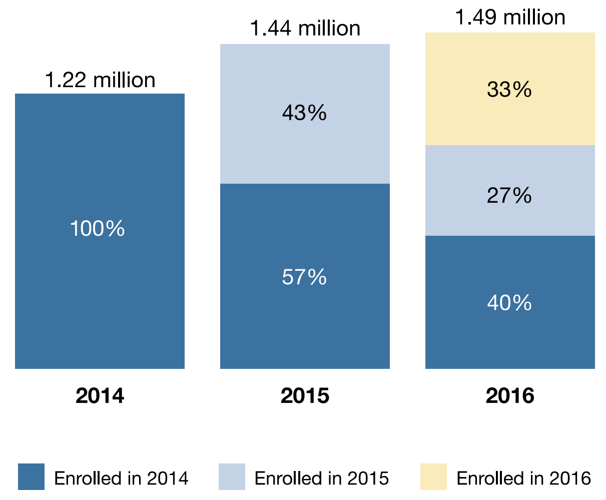


FIGURE 7

Covered California: Continuous and New Subsidized Insureds, 2014–2016



---

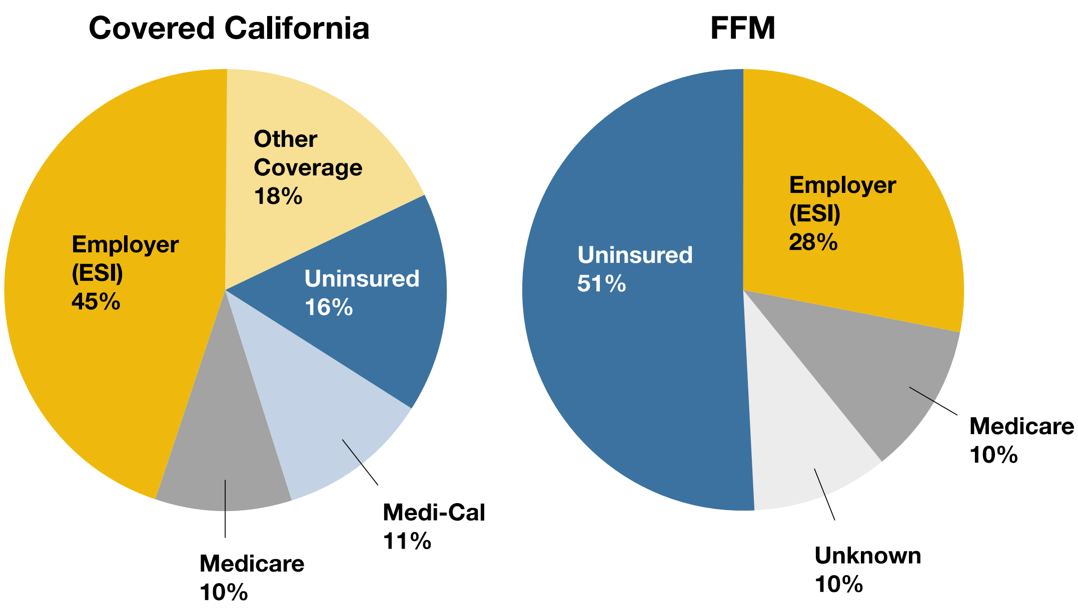
[49] In the period from 2008 to 2011, prior to major Patient Protection and Affordable Care Act provisions taking effect, only 42 percent of individual market enrollees kept their coverage after 12 months, with 80 percent of those experiencing coverage changes to other types of health insurance (the majority obtaining employer-based coverage).

When comparing Covered California and the federal marketplace's experience on where consumers go once they leave the exchange, there is evidence that marketing helps those enrollees who might churn stay insured. The vast majority of Covered California's enrollees who leave coverage (84 percent) move on to another form of insurance coverage (e.g., employer-based coverage from new employment or aging into Medicare), and only 16 percent become uninsured. By contrast, the latest data from CMS indicates that consumers who leave the FFM are more than three times as likely to become uninsured as are those leaving Covered California (see Figure 8: Coverage Transitions in 2016: Comparing Covered California to FFM Survey Data).[50]

While some of the higher rate of people leaving FFM coverage to be uninsured may be attributable to the fact that many states in the federal marketplace did not expand Medicaid, it is important to note that only 11 percent of Covered California consumers left the marketplace and enrolled in Medi-Cal (California's Medicaid program). If that same proportion held true on the federal marketplace, at least 40 percent of consumers

FIGURE 8

Coverage Transitions in 2016: Comparing Covered California to FFM Survey Data[51]



[50] For Covered California, the 6 percent uninsured number in Figure 6: Covered California Health Coverage Transitions in 2016 is based on the entire 2016 enrollment while the 16 percent uninsured number for Covered California in Figure 8: Coverage Transitions in 2016: Comparing California to FFM Survey Data is based on the subset of Covered California enrollees that leave the marketplace.

[51] Survey data reflect respondents who paid at least one month's premium but ultimately left coverage. Covered California's value of "other coverage" includes consumers who reported Medicaid, individual market off-exchange health insurance and other sources (e.g., TRICARE). FFM survey results (https://downloads.cms.gov/files/cost-disruptions-trends-report-06-12-17.pdf) do not explicitly report on Medicaid or uninsured statuses following marketplace enrollment, the "unknown" category represents individuals who CMS does not report have either employer-sponsored insurance or Medicare, CMS did not release any details about this group, but it could include similar categories of individuals who transitioned to Medicaid or other sources of coverage.

leaving the FFM would still be dropping coverage to be uninsured. This means that the FFM would still have nearly three times as many consumers leaving to become uninsured than does Covered California (hypothetical 40 percent versus 16 percent).

Marketing and outreach are part of what makes coverage "sticky." These efforts encourage those with coverage who do not use medical services to stay covered by reinforcing that decision through marketing and outreach. Given the natural churn in the individual market, keeping existing consumers insured is a key function of marketing. Just as Chevrolet invests billions in marketing even though the "Chevy brand" is very well known and millions drive their cars, marketing of insurance promotes retention of individuals who have already enrolled. Since relatively few who get insurance actually use their insurance for expensive services, there is the risk that they may either drop coverage — as appears to be happening at high rates in the FFM — or not renew. Marketing and outreach efforts are important to reinforce the ongoing value of having insurance, especially for those who only use the health care system occasionally. These enrollees are precisely the people an individual insurance market needs to enroll and retain to maintain a good risk mix.

State-Based Marketplaces Attract and Retain a Better Risk Mix

While it is not possible to say with certainty how much marketing and outreach contribute to improved retention, there is a clear pattern that Covered California and other state-based marketplaces that spend on marketing and outreach and focus on retention have a better risk mix and lower premiums than the FFM. Covered California believes this is an issue that warrants more research, but the early indication is that marketing does make a difference and matters not only for promoting initial enrollment, but also to foster retention.

The Centers for Medicare and Medicaid Services (CMS) has previously found that California had the lowest "state liability risk score" in the individual market for both 2014[52] and 2015[53], and continued to have one of the lowest risk scores in the nation in 2016.[54] The CMS report shows the "average risk score" across federal marketplace states, state-based marketplaces and California was nearly the same from 2015 to 2016. Because California's individual market had a risk profile that was 20 percent better than the national average (21 percent better in 2015 and 20 percent better in 2016), this means health care costs would be about 20 percent lower based on health status. (See Figure 4: Comparison of FFM, SBM and Covered California Risk Scores.)

Further, the report found that other state-based marketplaces collectively had a healthier risk mix than the national average (10 percent better in 2015 and 11 percent

[52] Centers for Medicare and Medicaid Services: Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year (Revised: Sept. 17, 2015) https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf

[53] Centers for Medicare and Medicaid Services: Appendix A to June 30, 2016 Risk Adjustment and Reinsurance: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Appendix-A-to-June-30-2016-RA-and-RI-Report-5CR-063016.xlsx

[54] Centers for Medicare and Medicaid Services: Appendix A to March 31, 2017 Risk Adjustment and Reinsurance: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Appendix-A-to-March-31-2017-Interim-RA-Report_5CR_033116.xlsx

better in 2016), which meant that health care costs in those 10 states would be 10 percent lower than the national average.[55]

Covered California, in an analysis of those rates, cites three reasons that it, and other state-based marketplaces, was relatively successful in attracting and retaining a healthier mix of consumers than the national average:[56]

- Covered California and state-based marketplaces appear to be investing proportionately more in marketing and outreach than is the federal government.
- State-based marketplaces, like California, were more likely to convert all health coverage in the individual market into Affordable Care Act-compliant plans and created one common risk pool as of 2014.
- California and other states with state-based marketplaces were more likely to expand their Medicaid program, which has a positive impact on the health status of the individual market.[57] Of the 12 state-based marketplaces, 11 expanded their Medicaid programs.[58]

The positive impact on the risk mix is continuing into 2017. Generally, the risk profile of a group gets less healthy over time, and the fact that California's risk mix is holding steady is clear evidence that relatively healthier individuals are continuing to sign up for insurance.

While *Marketing Matters* does not include a full review and analysis of all state-based marketplace marketing efforts, as a group, they clearly do a better job of attracting and retaining consumers than does the Federally-facilitated Marketplace (FFM).[59]

The number of effectuated consumers for both the federal and state-based marketplaces peaks in March every year. An analysis of the latest data from CMS shows that state-based marketplaces retained a higher percentage of those consumers, whether through more enrollment during the special-enrollment period or by retaining a higher rate of existing consumers than the federal marketplace, or both (see Figure 9: Comparing FFM and State-Based Marketplaces' Retention and Special Enrollment Performance). By November, state-based marketplaces — including California — had an effectuated enrollment that was approximately 94 percent of their peak figure, while the federal marketplace had about 85 percent of its peak enrollment total at that time.

---

[55] The analysis excludes Massachusetts and Vermont because risk-score data was not available for these states.

[56] Covered California press release "New Federal Report Shows the Individual Markets Across the Nation Are Stable (July 6, 2017): http://news.coveredca.com/2017/07/new-federal-report-shows-individual.html

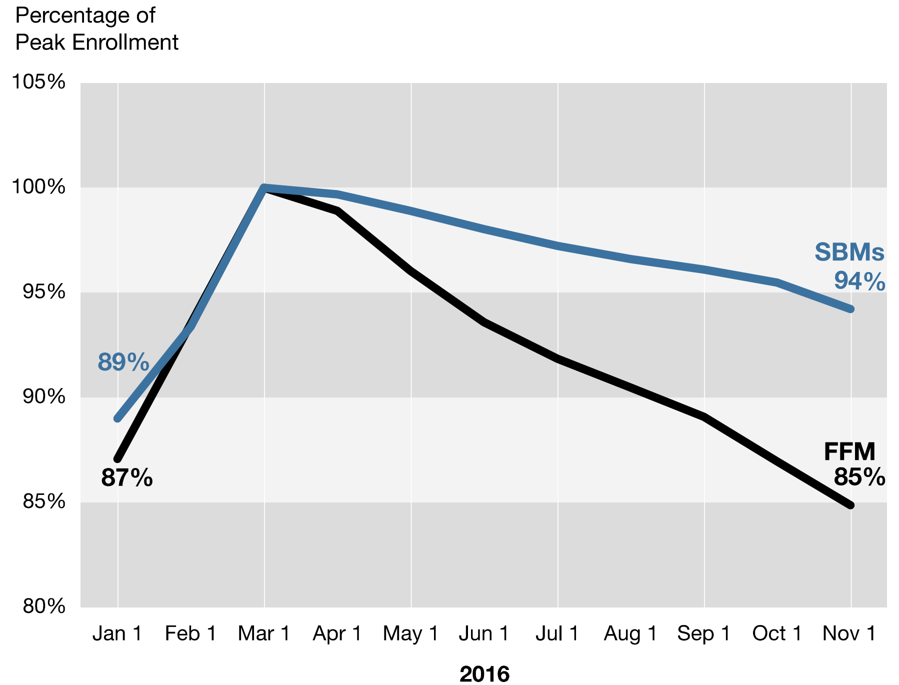
[57] Sen, Aditi P. and Thomas DeLeire. The Effect of Medicaid Expansion on Marketplace Premiums. 2016. https://aspe.hhs.gov/system/files/pdf/206761/McaidExpMktplPrem.pdf

[58] Kaiser Family Foundation "Current Status of State Medicaid Expansion Decisions (Jan. 1, 2017): http://www.kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/

[59] Centers for Medicare and Medicaid Services: 2017 Effectuated Enrollment Snapshot (June 12, 2017): https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf

FIGURE 9

Comparing FFM and State-Based Marketplaces' Retention and Special-Enrollment Performance



Marketing is about getting people covered, but it is also about keeping them covered. State-based marketplaces appear to do more marketing that is targeted to their communities than the federal marketplace does, which helps them maintain a healthier risk mix (see Figure 4: Comparison of FFM, SBM and Covered California Risk Scores).

As discussed earlier, in California, exit surveys have found that 84 percent of consumers who leave Covered California move onto other sources of coverage, and only 16 percent become uninsured. While data on where consumers go when they leave other state-based marketplaces is not available, the latest data from CMS[60] shows that consumers who leave the federal marketplace are three times more likely to become uninsured. This provides additional evidence of the potential positive impact of marketing investments. (See Figure 8: Coverage Transitions in 2016: Comparing California to FFM Survey Data.)

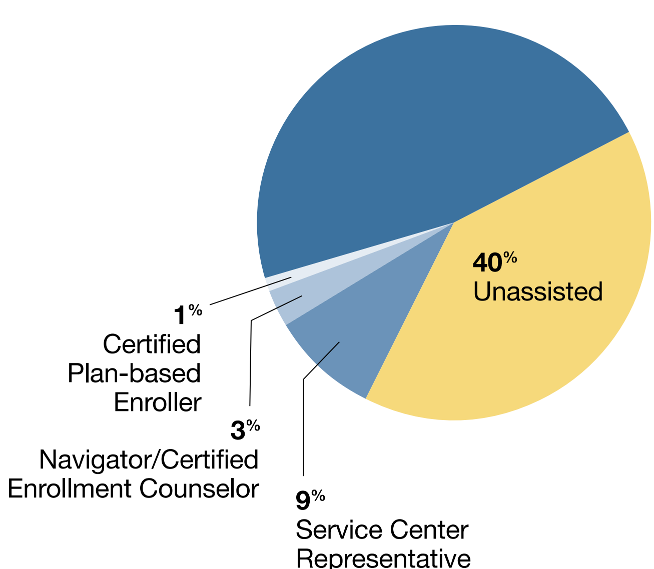
[60] FFM survey results (https://downloads.cms.gov/files/cost-disruptions-trends-report-06-12-17.pdf) do not explicitly report on Medicaid or uninsured statuses following marketplace enrollment; the "unknown" category represents individuals who CMS does not report have either employer-sponsored insurance or Medicare: CMS did not release any details about this group, but it could include similar categories of individuals who transitioned to Medicaid or other sources of coverage.

Person-to-Person Assistance, Especially Through Agents, Is Vital to Promoting Enrollment.

Most of Covered California's enrollment comes from a range of channels that provide person-to-person assistance to help people enroll. At Covered California, about 40 percent of all enrollment is from consumers who enroll directly through the website (CoveredCA.com) (see Figure 10: Covered California 2017 Enrollment by Service Channel), but most consumers want and need personal assistance with enrolling.

FIGURE 10

Covered California 2017 Enrollment by Service Channel



The biggest single channel for enrollment is through Certified Insurance Agents who are paid directly by health plans through commissions. Agents enroll 47 percent of Covered California's consumers. These are trained and licensed professionals who operate storefronts and do in-person retail sales. It also includes web-based entities. All agents must be certified by Covered California.

Some health plans have decades of experience funding agent channels to attract and enroll consumers. Covered California has successfully established a variety of programs to promote and partner with agents.

After agents, the next most common way that consumers enroll is through Covered California's Service Center, which in 2017 enrolled about 9 percent of all those who got insurance through Covered California. The Service Center also helps many more consumers by answering questions about their coverage. The FFM and all state-based marketplaces operate service or call centers, which represent a substantial functional area and cost center for marketplaces.

Covered California's Navigators — funded directly by Covered California through a performance-based competitive grant — generate about 3 percent of enrollment. Navigators in California reflect a diverse mix of community-based organizations that provide particularly important support for enrolling potentially hard-to-reach populations. As is described in more detail in the description of Covered California's Navigator program in the next two sections, Covered California's investment over the past four years has been substantially reduced while on a relative basis funding for other channels has increased.

Actively Collaborating With Health Plans and Agents Works: Marketing and outreach are about the combined efforts of health plans and marketplaces (health plan marketing and agent commissions, plus marketplace spending on marketing and outreach).

Marketing and outreach to promote enrollment in the individual market is a combination of what is done directly by health plans — in both marketing and commission payments to agents — and what is funded and done by public marketplaces. Covered California recognizes the critical need to complement the marketing activities of the health plans it contracts with by actively collaborating with them to promote enrollment. Each Covered California health plan shares its detailed marketing plan and budget with Covered California as a required element of the health plan's contract.[61]

Prior to the passage of the Patient Protection and Affordable Care Act, marketing, enrollment and acquisition costs in the individual market were high. The high acquisition costs were a central rationale for the medical loss ratio for the individual market being set at 80 percent — compared to 85 percent for the group insurance markets. Not only were direct marketing costs high, but agent commissions were substantial and medical underwriting (the cost of screening applicants to either exclude or charge higher premiums to those with pre-existing health conditions) was a significant cost.

PricewaterhouseCoopers (PwC), in an analysis conducted for Covered California, found that the average acquisition cost for health plans in the pre-Affordable Care Act individual market was 7.6 percent of premium.[62] The plans that generally participated in the individual market were those with deep experience in medical underwriting and extensive agent sales strategies, since the bulk of the individual market sales were through agents. Before the Affordable Care Act agents were paid an average 6.3 percent of premium for their efforts to enroll and retain individuals and families.

Since the launch of the Affordable Care Act, there have been big changes in the individual market, resulting in far lower acquisition costs and hence smaller increases on premiums. Among the changes:

- Health plans no longer have any medical underwriting expenses.
- While overall enrollment, including enrollment done through agents, has increased dramatically, agent commissions on a per-case basis have dropped significantly and a larger percentage of enrollment is not subject to commissions. Commissions in California have dropped from 6.3 percent of total individual market premium pre-Affordable Care Act to about 1.5 percent in 2017 (inclusive of on- and off-exchange commissions).
- The portion of consumers enrolling without an agent, which used to be very low, is now substantial. Health plans are not paying agent commissions for these

---

[61] See Covered California's contractual terms related to marketing, see pp. 18–22 of the Qualified Health Plan Issuer Contract: http://hbex.coveredca.com/insurance-companies/PDFs/2017-2019-Individual-Model-Contract.pdf.

[62] See PricewaterhouseCoopers analysis: Covered California 2016-2022 Market Analysis and Planning: http://board.coveredca.com/meetings/2016/5-12/Covered CA and PwC Market Planning and Analysis_Board Draft.pdf (page 4).

individuals, which in California represent about 47 percent of on-exchange enrollment and an estimated 10 percent of the off-exchange enrollment.

- Enrollment through public marketplaces like Covered California, state-based marketplaces or the Federally-facilitated Marketplace generates large new and healthier enrollment because the subsidies make coverage affordable to millions of Americans.
- Public marketplaces charge health plan assessments to cover their costs.[63]
- There have also been additional costs to health plans, such as: interfacing with marketplaces and the federal government, billing and reconciling membership and financial information.
- In many other states, the entry of many new plans that did not have experience in selling in the individual market (many of which did not know how to price or market effectively) resulted in their leaving after a few years.

In California, as in the rest of the nation, health plan investments in marketing primarily promote the individual health plan, rather than broadly inform the public about the marketplace or open enrollment. Because of the potential that consumers coming to the marketplace may pick any plan, individual plans do not have the same incentive as the marketplace itself to promote enrollment generally. Health plan marketing that targets their off-exchange products encourages consumers to enroll directly through them rather than through a marketplace. Shopping through a marketplace allows consumers to review all coverage options in the market.

Based on discussions with leaders of other state-based marketplaces and with national health plans, California's experience appears to be similar to that occurring nationally in three areas:

- Commissions to insurance agents have dropped significantly as a percentage of premiums, but total payments have continued to be high with the growth in enrollment.
- Health plan direct-marketing expenses vary dramatically by health plan. Some health plans spend very little and rely entirely on marketing conducted by public marketplaces, and a few plans make relatively large investments that come close to matching their pre-Affordable Care Act marketing investments.
- Health plan marketing spending is often focused on "selling the plan" and promoting the brand. Few plans promote open enrollment and provide information about the marketplace to consumers who may be subsidy eligible.

State-based marketplaces generally report that their own investments in marketing and outreach have been reduced significantly since federal establishment funds were exhausted. Boards or legislative bodies have not been sympathetic to raising the premium assessment to support expanded or continued marketing.

[63] California's assessment for 2018 is 4 percent of premium; the FFM is 3.5 percent of premium.

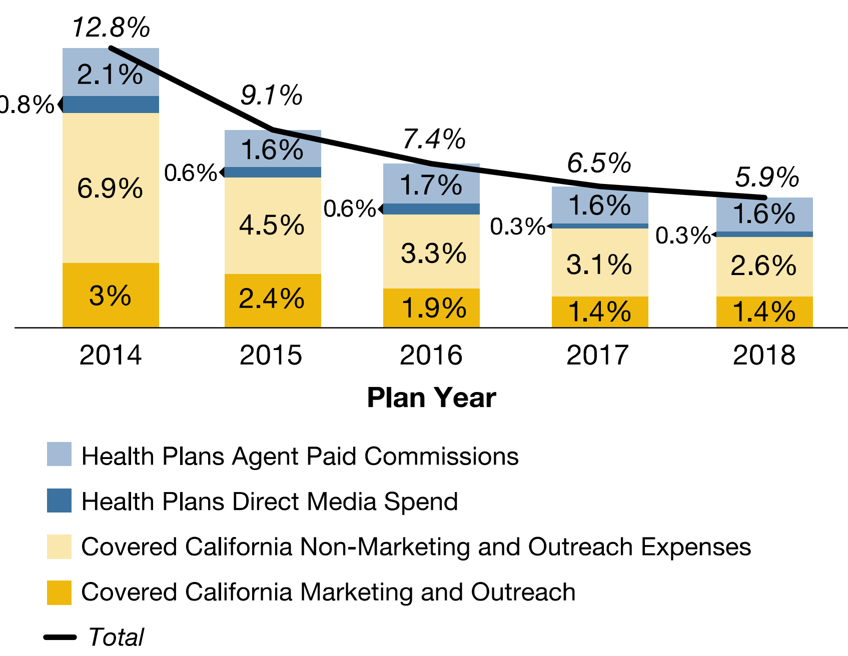
The picture of health plan marketing in states using the federal marketplace is even more opaque. The federal government has no requirements to spend on marketing and outreach and does not request data related to the type, scope and nature of health plans' marketing and outreach efforts. The one exception is that plans in the FFM are prohibited from discriminating and employing marketing practices or benefit designs that discourage the enrollment of consumers with significant health needs.[64]

Investments in Marketing Are a Declining Percent of Premium.

In California the aggregate spending of health plans and Covered California to promote enrollment has remained relatively constant over the past four years, with on-exchange spending ranging from $231 million to $265 million (see Figure 1: California On-Exchange Individual Market Marketing and Outreach Investments [millions], 2014–18), but while California's total marketing and outreach spending has remained consistent, it has fallen dramatically as a percentage of premium (see Figure 11: California On-Exchange Total Acquisition Costs as a Share of Premium, 2014–18).

FIGURE 11

California On-Exchange Total Acquisition Costs as a Share of Premium, 2014–18[65]



[64] See 45 CFR §147.104(e): https://www.ecfr.gov/cgi-bin/text-idx?SID=92e241490966e0b1b87f14d3683ca144&mc=true&node=se45.1.147_1104&rgn=div8, §156.200(e): https://www.ecfr.gov/cgi-bin/text-idx?SID=92e241490966e0b1b87f14d3683ca144&mc=true&node=se45.1.156_1200&rgn=div8, and §156.225(b): https://www.ecfr.gov/cgi-bin/text-idx?SID=92e241490966e0b1b87f14d3683ca144&mc=true&node=se45.1.156_1225&rgn=div8.

[65] Covered California's health plan agent paid commissions are estimated based on enrollment data and best available information on commission rates, but may not reflect actual health plan spend. 2018 figures are projected using Covered California's proposed 2017–18 budget and direct-media spend is assumed to be the same as 2017. To enable common benchmarks based on a share of on-exchange premium (Figures 1 and 11), Covered California attributed plans' direct-media spending proportionally based on 68 percent of individual market enrollment being on exchange and 32 percent off exchange.

While health plans have decreased their average commission to agents,[66] they have increased their year-over-year total dollar investment in agent commissions because of higher enrollment. In the period of four years, from 2014 to 2017, health plans' on-exchange commission payments to agents in California have risen by 16 percent (from $95 million to $110 million) (see Figure 1: California On-Exchange Individual Market Marketing and Outreach Investments [millions], 2014–18). These payments reflect 1.6 percent of total on-exchange premium and 1.5 percent of total individual market premium (inclusive of off-exchange commissions) as of 2017. (This compares to the national pre-Affordable Care Act figure of 6.3 percent of total individual market premium.)

For 2017, Covered California represents about 40 percent of aggregate marketing and outreach investment for the individual market and is 0.9 percent of total individual market premium for 2017. Covered California's investments in marketing and outreach also benefited those consumers who enrolled off-exchange — roughly 650,000 Californians. Premiums paid by off-exchange consumers in California represent about $3.6 billion in 2017.

The initial years of any product or service require investing to promote brand recognition. Covered California's initial two years of marketing expenses (FY 2013–14 and FY 2014–15) were paid for with federal establishment funds. The average Covered California marketing and outreach annual investment in its first two years was about $138 million. While aggregate on-exchange marketing spend as a share of premium has declined since 2014, Covered California's marketing and outreach investments represent between 40 and 50 percent of the total marketing and outreach investment in California's individual market from 2014 to 2018.

Measuring Lifetime Value: Measuring the lifetime value of a member helps assess appropriate returns on marketing and outreach investments.

As a longitudinal measure, the lifetime value of a member is the amount of revenue earned by Covered California on each enrollee. Since Covered California is totally reliant on its plan assessments for revenue — receiving no direct state or federal funding — understanding how much revenue is generated by each enrollee is a vital business question. The lifetime value is the total revenue earned for each enrollee that must support all of Covered California's operations. The average member tenure for subsidy-eligible enrollees is 25.4 months and 23 months for non-subsidy-eligible enrollees, which translates to an average of $492 lifetime value ($500 lifetime value for each subsidized member and $433 for non-subsidy member) enrolled in 2018.[67]

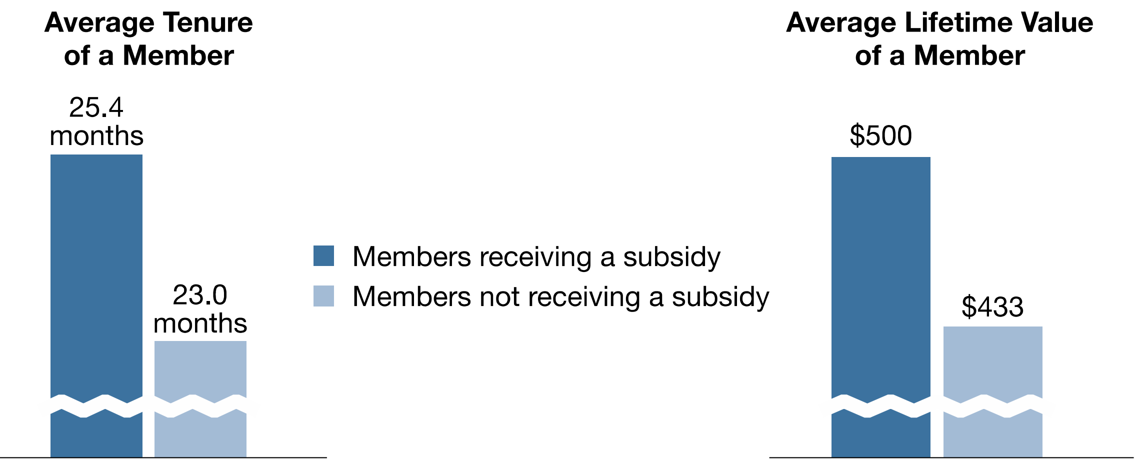
---

[66] The average commission paid to agents in California has been cut four-fold from the pre-Affordable Care Act rate of more than 6 percent to about 1.5 percent of premiums for their business.

[67] For the FFM, based on an average monthly premium of $433 for the 2017 and 2018 enrollment years and assuming an average tenure of 24 months, the lifetime value to the FFM of Americans enrolled is $364 — which is collected in the form of a 3.5 percent plan user fee to support marketing, enrollment and retention efforts and other marketplace functions. If the FFM allocated the same 35 percent of the lifetime value to marketing and outreach as does Covered California, it would spend about $127 per person enrolled directly on marketing and outreach that supports new enrollment and retention.

FIGURE 12

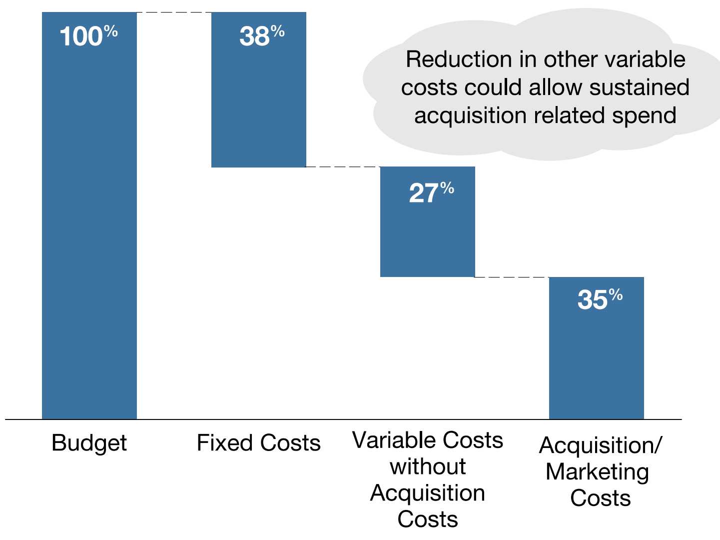
Average Member Tenure and Lifetime Value for Covered California Enrollees



For 2018, Covered California will allocate about 35 percent of its 4 percent user fee — 1.4 percent of premium — for marketing and outreach; the other 65 percent will be used for information technology, the service/call center, plan management, and administration (see Figure 13: Covered California's Revenue and Cost Breakdown). For planning purposes, Covered California allocates one-third of an average enrollee's lifetime value to marketing and outreach, which equates to roughly $164 per person. When taking this long-range perspective of the lifetime value of a member, it helps provide the basis of assessing what investments in marketing and outreach generate sufficient returns to warrant their investment.

FIGURE 13

Covered California's Revenue and Cost Breakdown[68]



[68] Plan Management, the information technology to support CoveredCA.com, and Covered California Administration are considered fixed costs. Covered California's Service Center and Marketing and Outreach are considered a mix of fixed and variable costs.

Marketing Must Be Adequately Funded: Health plan assessments (user fees) are part of California's path to adequately fund marketing to ensure a good risk mix and long-term sustainability.

Since marketing is integral to having a good risk mix and lower premiums, if policy-makers do not ensure it is adequately resourced, underfunded marketing will result in smaller and less-healthy enrollment and higher premiums. States that operate state-based marketplaces are free to establish their own assessment or funding structure, but since exchanges are required to be self-sustaining, the most common source of funding for marketing is derived from a "user fee," an assessment levied on participating plans for each covered enrollee.

Covered California has collected an assessment on health plan premiums since January 2014. Initially, the fee was set at a fixed per-member, per-month (PMPM) assessment of $13.95. In 2017, the assessment was converted to a percent of premium, with the initial assessment set at 4 percent. Covered California will keep the same assessment level for 2018 and has shared projections that detail decreases in the assessment level in future years.[69] Since the assessment was initiated during the early years when Covered California was supported by federal establishment funds, these assessments have built a substantial reserve that Covered California can use, along with new revenue, to fund future activities.

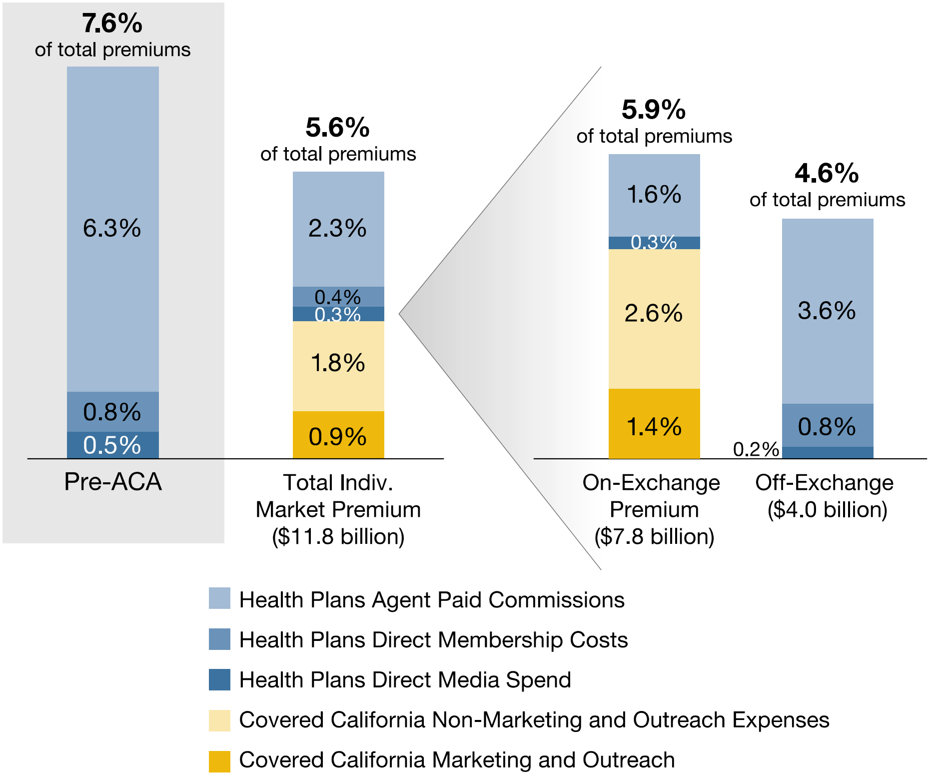
Covered California has structured its 2018 budget such that 1.4 percent of premium is dedicated for marketing and outreach while the remaining 2.6 percent is for non-marketing exchange expenditures. For "on-exchange" enrollment, when loading the entire Covered California plan assessment as an "acquisition cost," and taking into account health plans' agent-paid commissions (1.6 percent of premium) and direct-media spend (0.3 percent of premium) total member acquisition costs are 5.9 percent of premium for 2018 (see Figure 14: Comparing California's Individual Market Total Marketing, Acquisition and Retention Costs as a Share of Premium, Pre- and Post-Affordable Care Act (2018)). These acquisition costs are also represented as a share of the total individual market premium, which would be 5.6 percent of premium. This illustrates that direct expenses for marketing and acquisition are far lower than before the Affordable Care Act.[70]

[69] See page 17 of Covered California's 2017-18 budget (http://hbex.coveredca.com/financial-reports/PDFs/CoveredCA_2017-18_Budget_final.pdf)

[70] See PricewaterhouseCoopers analysis: Covered California 2016-2022 Market Analysis and Planning http://board.coveredca.com/meetings/2016/5-12/Covered CA and PwC Market Planning and Analysis_Board Draft.pdf (page 4).

FIGURE 14

Comparing California's Individual Market Total Marketing, Acquisition and Retention Costs as a Share of Premium, Pre- and Post-Affordable Care Act (2018) [71]



Collectively, the 2018 acquisition costs for health plans in the individual market has dropped from the pre-ACA rate of 7.6 percent of premium to 5.6 percent in California. This 2 percent reduction equals to an annual cost saving of $236 million for consumers and the federal government.[72]

Federal regulations currently define two fee structures for states that use the federal infrastructure: 3.5 percent of premium for the FFM, and 3 percent of premium for marketplaces on the federal platform.[73] Neither the Affordable Care Act nor federal regulations clearly define the portion of the federal marketplace user fee that should be dedicated to fund marketing and outreach. However, as discussed in the next sections, the federal government has an obligation to fund and support marketing and outreach.

---

[71] The expense category of "direct membership costs" reflects management and data-related expenses for enrollment of members and costs for medical underwriting (in pre-ACA period). For pre-ACA and off-exchange, all values shown are based on a PricewaterhouseCoopers analysis. The category for direct membership costs also came from the PwC analysis and are based on post-ACA health plan cost benchmarks of 0.8 percent of premium for off-exchange and 0.4 percent of premium for the total individual market. Other values were calculated using available data on agent commission rates and the 2017-18 Covered California budget.

[72] This was calculated by multiplying 2 percent by $11.8 billion (total individual market gross premium).

[73] See 45 CFR §156.50 (https://www.ecfr.gov/cgi-bin/text-idx?SID=92e241490966e0b1b87f14d3683ca144&mc=true&node=se45.1.156_150&rgn=div8) and the annual HHS Notice of Benefit and Payment Parameters for 2018 (https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-30433.pdf).

III. Facts on the Role of Marketing and Outreach to Promote Enrollment in the Individual Insurance Market

Just as health care should be "evidence-based," so too should the assessment, planning and investments in ensuring enrollment in the individual market promotes stability and a good risk mix. Informed by Covered California's experience, this section contains evidence related to the role of marketing and outreach and public exchanges.

Fact 1: Marketing Lowers Premiums.

Marketing lowers premiums by attracting a better risk mix, a larger and more stable risk pool and more participation by health plans that see a more profitable market. While some believe that reducing marketing and outreach efforts will lower premiums, well-targeted marketing fosters a better risk mix and lowers premiums far more than the direct expense of marketing.

Getting consumers insured in the individual health insurance market has historically been a costly proposition,[74] but evidence from California shows that the Affordable Care Act has helped lower acquisition costs as a portion of premiums and marketing may have driven enrollment. A recent analysis by PricewaterhouseCoopers (PwC) examined the implementation of Covered California and its impact on member-acquisition costs in the individual market, both on and off exchange.[75] The PwC analysis found that in California the Affordable Care Act contributed to a 26 percent reduction in the costs of signing up new insureds in the individual market ("member acquisition costs"), from 7.6 percent to 5.6 percent of total premium, pre- and post-Affordable Care Act (See Figure 14: Comparing California's Individual Market Total Marketing, Acquisition and Retention Costs as a Share of Premium, Pre- and Post-Affordable Care Act [2018]). This reduced acquisition cost reflects attributing the entire Covered California plan assessment as an acquisition cost. PwC found that even after incorporating the entire user fee levied on participating Covered California plans, and including additional costs for health plans, the overall California individual market benefited from a lower share of total premium paid to agent and broker commissions. These lower acquisition costs mean that consumers are saving over $236 million[76] annually compared to pre-Affordable Care Act acquisition costs spent on the individual market in California.

Since marketing is integral to the business case of generating a good risk mix and lower premiums, if policy-makers do not ensure it is financed with a dedicated funding source, it runs the risk of being chronically underfunded. Total marketing and outreach investment by the Federally-facilitated Marketplace (FFM) was $165 million, which represents about 0.44 percent of the 2017 FFM premium and a spending on marketing

[74] The high cost of member acquisition was the central factor in the Medical Loss Ratio being set at 80 percent for the individual market compared to 85 percent for employer groups. See "Actively Collaborating With Health Plans and Agents Works" beginning on page 34.

[75] See PricewaterhouseCoopers analysis: Covered California 2016-2022 Market Analysis and Planning http://board.coveredca.com/meetings/2016/5-12/Covered CA and PwC Market Planning and Analysis_Board Draft.pdf (page 4).

[76] This was calculated by multiplying 2 percent by $11.8 billion (total individual market gross premium).

at about one-third of California's rate of investment for 2017 (see Table 2: Federal Spending on Marketing and Outreach — 2016 to 2018). The planned spending for 2018 of only $47 million represents a very risky underfunding of marketing and outreach. For 2018, Covered California plans to spend the equivalent of approximately 1.4 percent of on-exchange premium for marketing and outreach, which would translate to $480 million spend for the FFM, using its planned assessment as the basis for calculating its total assessment of $1.2 billion. [77]

California's experience shows that marketing investments are associated with a more balanced risk mix, lower rate increases and higher enrollment. Federal data shows the healthier risk mix of those enrolled in California, with a risk mix that means health care costs are about 20 percent lower than in FFM states. (See "By the Numbers" for more discussion of California's risk mix.) Based on Covered California's enrollment and the good risk mix that has been generated as a result, the weighted average rate change for Covered California plans in 2015 was 4.2 percent and in 2016, it was 4.0 percent. While the 2017 rate change averaged 13.2 percent, the majority of that increase was a reflection of the expiration of the federal transitional reinsurance program. In addition to promoting a more balanced risk mix, lower rate changes and increased enrollment, marketing investments benefit those in the individual market who do not get any subsidy by lowering their premium and improving the value of the Advance Premium Tax Credits.

[77] 2016 and 2017 plan-assessment ("user fee") revenue for the FFM is found on page 10 of the Centers for Medicare and Medicaid Services' fiscal year 2018 budget-justification document, available at: https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2018-CJ-Final.pdf.

Fact 2: Awareness of the Affordable Care Act Does Not Translate to Enrollment: Consumers still need to know about the availability of financial help.

Research shows education and tailored marketing on the availability of financial help is still important, relevant and needed. While there have been substantial increases in the overall awareness of Covered California and support of the Affordable Care Act over the last five years, one of the key drivers of consumers seeking insurance is their understanding that they can get financial help. As late as 2017, 73 percent of uninsured and subsidy-eligible consumers surveyed were not sure if they were eligible for financial help or incorrectly assumed they were not. Increasing awareness of subsidy eligibility leads to stronger enrollment, higher retention rates, healthier consumer pools and lower premiums.

The Affordable Care Act was the most significant piece of health reform in the past 50 years and has garnered significant news coverage and paid media about it over the past five years. While there have been dramatic increases in the general knowledge and support for the Affordable Care Act, knowledge is *not* the primary catalyst for enrollment. The key to enrollment in the individual market is affordability. Consumers need to know that there are subsidies available to them. Research shows that significant resources are still required to encourage consumers who are subsidy-eligible to research the options available to them.

In California, awareness and support for both the Affordable Care Act and Covered California has increased dramatically over the past five years and marketing has been a key contributor to that awareness. Research shows that a consumer's overall awareness of marketing by Covered California is a key factor in them actively talking to friends and family about Covered who had seen marketing by Covered California were 50 percent more likely to have purchased a Covered California plan when they were aware of marketing messaging than those who were not aware of marketing messaging. These same respondents reported very high rates of seeking additional information, talking about Covered California and considering buying insurance. (See Figure 15: Exposure to Marketing Leads Consumers to Shop and Talk).

FIGURE 15

Exposure to Marketing Leads Consumers to Shop and Talk

Discuss Covered California with friends and family

Think about purchasing insurance through Covered California

Look for more information on the Covered California website

A 2015 study by NORC at the University of Chicago found that unaided awareness of Covered California stood at 12 percent in 2013, the year before the exchange began

offering coverage. Over the next two years, awareness improved to 79 percent in 2014 and 85 percent in 2015.[78] (See Figure 16: Awareness of Covered California.)

A recent survey,[79] shows awareness remains strong with 89 percent of survey respondents saying they were aware of the Affordable Care Act and/or Covered California. A majority of survey respondents (57 percent) said they knew “a fair amount” or “a lot” about Covered California.

FIGURE 16

Awareness of Covered California

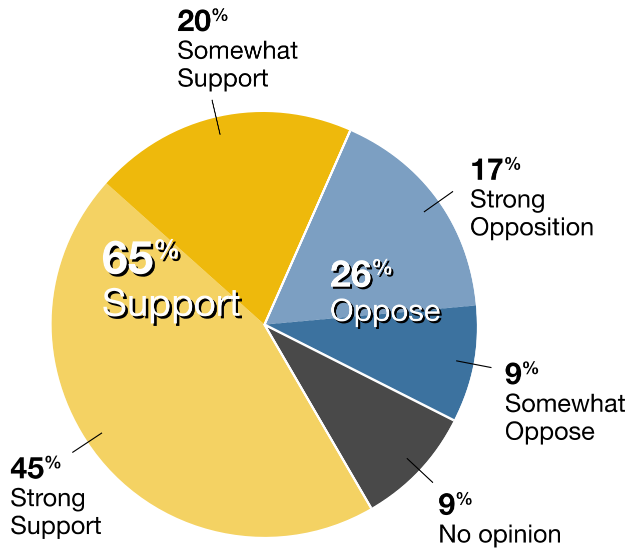
2013	2014	2015
12%	79%	85%

In addition, a 2017 study found supporters of the Affordable Care Act outnumbered opponents by more than two to one in California.[80] When Californians were asked whether they support or oppose the Affordable Care Act, two out of three (65 percent) said they support the law, with 45 percent strongly supporting the law. By comparison, just 26 percent opposed the law, while another 9 percent were undecided.

This represents a record level of public support for the Affordable Care Act, exceeding measures found in prior annual statewide surveys. (See Figure 17, Support for the Affordable Care Act in California.).

FIGURE 17

Support for the Affordable Care Act in California



Despite this widespread awareness and support of Covered California and the Affordable Care Act, research shows that general knowledge does not translate into people knowing about whether they personally qualify for financial help. In 2017, nearly three-quarters of uninsured Californians who were specifically screened as uninsured and eligible for subsidies, did not realize they could receive financial help in the form of subsidies or assumed they were not eligible, even though they were. (See, Figure 18: Understanding of Subsidy Eligibility Among Subsidy-Eligible Californians (2017).

[78] NORC at the University of Chicago. (2015). “Covered California Overview of Findings from the Third California Affordable Care Act Consumer Tracking Survey.”

[79] A Quantitative Study on Current Attitudes of Uninsured and Select Insured Californians Toward Health Insurance Coverage (September 2017).

[80] Berkeley IGS Poll. 2017. “Over Half of Californians Worry that They or a Family Member Will Lose Health Coverage if the Affordable Care Act is Repealed.”

Knowledge of subsidy eligibility is critical. Studies show that awareness of financial help is what motivates consumers to seek out information and enroll in coverage. The research has been confirmed in California, where 88 percent of those who signed up for subsidized coverage say that financial help is an important motivator (see, Figure 19: Importance of Subsidy as a Motivator for Covered California Enrollment). A consumer's personal knowledge of subsidy eligibility makes the marketing messages personal and relevant, increasing their likelihood of enrollment and renewal of their coverage.

Among the uninsured, expectations of future subsidy eligibility is strongly associated with future enrollment or renewal intent. Those who expect to be eligible for subsidies next year are twice as likely to plan to enroll in Covered California (71 percent) as those who do not know if they will be eligible (34 percent).[81] Renewal intent of members is also higher among those who expect to be eligible for subsidies next year (94 percent) than among those who do not expect to be eligible for subsidies (70 percent).

This data from consumer surveys is reinforced by the many focus groups that Covered California has conducted over the past five years. Marketing is never "one and done." The data also supports the current theme in Covered California's messaging, which encourages people to check their eligibility (e.g., "check with our experts to find out if you qualify for help paying for health coverage" and "financial help is available, so check for yourself to see what savings you qualify for").

FIGURE 18

Understanding of Subsidy Eligibility Among Subsidy-Eligible Californians (2017)

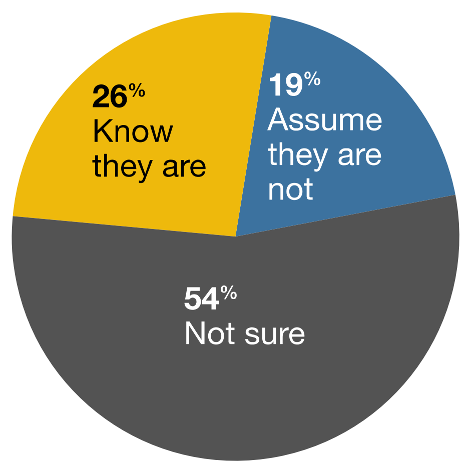
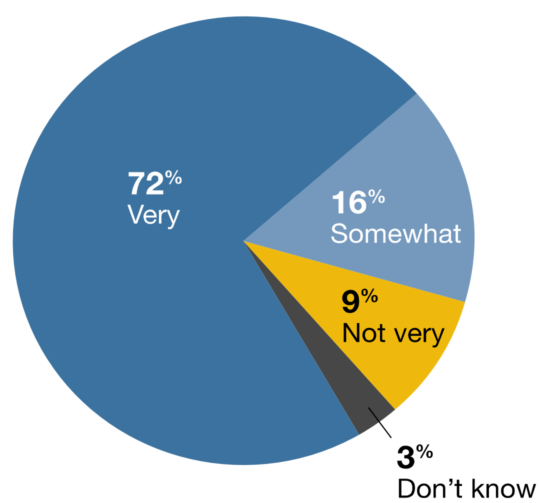


FIGURE 19

Understanding of Subsidy Eligibility Among Subsidy-Eligible Californians (2017)



[81] Greenberg Research. (2017). "A Quantitative Study on Current Attitudes of Uninsured and Select Insured Californians Toward Health Insurance Coverage."

Fact 3: The High Churn in the Individual Market Requires Significant Ongoing Marketing Investments.

There is high churn in the individual market because consumers frequently leave when they obtain coverage from other sources (e.g., employers, Medicare). This means significant and ongoing marketing investments are required to convince newly eligible consumers to purchase insurance and promote retention of healthy consumers.

The launch of a new path to insurance entailed substantial marketing and outreach investments in the early years of the Affordable Care Act. Covered California invested $134 million in 2013–14 and $143 million in 2015 in marketing and outreach. The significant investment garnered high brand awareness and was a key ingredient to California having the best risk mix in the nation in 2014, when an enrollment of 1.4 million consumers during open enrollment.

The need to convince consumers to purchase or keep existing insurance, however, is not a "one-and-done" proposition. The individual market is notable for its high turnover. For some people, the individual market is an important coverage pathway as consumers transition between different coverage types. Covered California's experience is that 40 percent of its enrollees leave its marketplace each year (see Figure 6: Covered California Health Coverage Transitions in 2016.)

"Churning" of enrollees is a natural part of the individual market.[82] This churn means that continual outreach is required to maintain enrollment. Covered California's survey data finds that the vast majority (85 percent) of its churn reflects consumers leaving for other coverage such as employer-based coverage from new employment or aging into Medicare. This means that while Covered California was providing coverage to about 1.4 million Californians (as of April 2017), more than 3 million Californians have enjoyed coverage through Covered California since it opened its doors in 2014.[83] In striking distinction, it appears that in FFM states, more than half of those leaving coverage become uninsured.

The high rate at which FFM enrollees leave coverage to go without insurance appears to mean that not only do states served by the FFM experience the "natural" churn resulting from consumers transitioning to other coverage, but there is substantial loss of enrollment from those deciding to go without insurance. At least some of this loss can be attributed at least in part to the failure to invest in marketing that promotes retention. The direct impact is a worse risk mix and higher premiums, since those leaving to go without insurance will virtually always be "healthier" than those who maintain coverage.

[82] From 2008 to 2011, prior to major Patient Protection and Affordable Care Act provisions taking effect, only 42 percent of individual market enrollees kept their coverage after 12 months, with 80 percent of those experiencing coverage changes to other types of health insurance (the majority obtaining employer-based coverage). Sommers, Benjamin D. "Insurance cancellations in context: stability of coverage in the non-group market prior to health reform." *Health Affairs* 33, no. 5 (2014): 887-894.

[83] Coverage could be as short as a month or as long as three years.

Fact 4: Federal Law Requires Marketing.

Public marketplaces are mandated by federal law and regulations to perform various marketing and outreach activities to encourage participation and target broad and diverse communities. As part of long-term self-sustainability, federal law and regulation permit marketplaces to levy an assessment on participating plans to recoup the costs for exchange functions, including marketing and outreach. California's projected plan assessment revenue for 2018 is estimated to be $314.4 million while the federal marketplace is estimated to collect $1.2 billion.

Public marketplaces are mandated by federal law and regulation to perform various marketing and outreach activities to encourage participation and target broad and diverse communities.[84] Marketplaces' broad-based enrollment strategies further two key goals in improving coverage and affordability: (1) increasing the number of Americans with insurance, and (2) improving the risk mix and lower premiums for everyone.

State-based marketplaces and state partnership exchanges are expressly required to conduct marketing and outreach to comply with implementing the Affordable Care Act's requirements. In the required exchange "Blueprint" application for federal establishment funds, state-based marketplaces and state partnership exchanges were required to describe how they perform various consumer and stakeholder engagement and support activities.[85] For states on the Federally-facilitated Marketplace, the Department of Health and Human Services carries out the exchange functions on their behalf. The consumer and stakeholder engagement and support activities include developing a stakeholder consultation plan, conducting outreach and education, implementing Navigator and in-person assistance programs and supporting agents and brokers.

During the first two years, all marketplace functions for California, including those for marketing and outreach, were paid for with federal establishment funds. California marketing and outreach investments of $134 million and $143 million in 2014 and 2015 represent 26 percent of its federal establishment funds. During the initial launch years, other state-based marketplaces also heavily invested in marketing and outreach and likely spent a similar share of establishment funds as California. Nationally, if the same proportion of establishment funds nationally were spent on marketing and outreach as in California, this would equate to $1.05 billion invested in marketing and outreach out of $4.04 billion in aggregate federal establishment funds (excluding California).[86]

As part of long-term self-sustainability, federal law and regulation permit marketplaces to levy an assessment on participating health plans to recoup the costs for exchange functions, including marketing and outreach.[87] California's projected plan assessment revenue for 2018 is based on 4 percent of premium and is estimated to be $314.4

[84] Sections 1311(d)(6), 1311(i), 1312(e) of the Affordable Care Act and 45 CFR 155.205(e), 155.210 and 155.220.

[85] Other parts of the application required a description of how the state-based marketplace or state partnership marketplace would implement various functions, including: legal authority and governance, eligibility and enrollment, and privacy and security.

[86] The dollar amount presented here was calculated using publicly reported data on federal establishment funds (https://www.cms.gov/cciio/resources/marketplace-grants/index.html).

[87] Section 1311(d)(5)(A) of the Affordable Care Act and 45 CFR 155.160.

million. For the federal marketplace, the Centers for Medicare and Medicaid Services (CMS) collects an assessment based on 3.5 percent of premium and estimates that it will collect $1.2 billion in plan assessments for fiscal year 2018.[88]

CMS understood that it would need to spend a significant amount on marketing to ensure that the shorter open enrollment period would be well-understood and not result in lower enrollment.[89] For 2018, CMS had previously noted in the proposed rule that it intended "to conduct extensive outreach to ensure that all consumers are aware of this change and have opportunity to enroll in coverage within this shorter time frame."[90] In the final rule, CMS noted that it agreed with commentators that "because of the compressed timeframe, consumers may require additional assistance with submitting requested documents in choosing the plan that works best for them."[91] The final rule also states that "many Navigators already focus on the populations who may require this additional help, such as consumers with limited English proficiency and low-income and rural communities."

As policy-makers consider future investments in marketing and outreach, there are two potential funding sources: through a user fee assessed on participating plans, or budget appropriations. Due to the challenging political environment, it seems a special appropriation is unlikely.

If funded through the state or the federal budget process, or both, there is concern that other budget priorities will crowd out funding for marketing and outreach, resulting in disruption to long-term strategic planning and volatility in the risk mix. A clear advantage of dedicating a specific percentage of the user fee for marketing and outreach is that it would not depend on the politically volatile budget processes and would allow marketplaces to have greater year-to-year certainty.

---

[88] 2018 plan assessment revenue for the FFM is found on page 10 of the Centers for Medicare and Medicaid Services' FY 2018 budget justification document available at https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2018-CJ-Final.pdf.

[89] The federal government adopted a shorter open enrollment period for 2018 — from Nov. 1 through Dec. 15, 2017. Covered California has opted to keep the full three-month enrollment period — from Nov. 1, 2017 through Jan. 31, 2017.

[90] See proposed market stabilization rule issued February 10, 2017: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-03027.pdf.

[91] See final market stabilization rule issued April, 13, 2017: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-07712.pdf.

Fact 5: Public Marketplaces Are Best Positioned to Promote Broad Enrollment.

Public marketplaces are well positioned to support and coordinate an "umbrella" strategy that promotes enrollment and competition. Many health plans have relatively little expertise in direct-to-consumer marketing, and others have scaled back on marketing because investments could lead consumers to pick other plans.

Health plans in the individual market have incentives to foster enrollment for their own plans, but public marketplaces — whether state-based or the federal marketplace — have incentives to promote broad enrollment regardless of the health plan selected. Broader enrollment, irrespective of which carrier gains from it, promotes the mission of public marketplaces of expanding coverage and promotes a better risk mix that saves consumers money in lower premium.

Prior to the Affordable Care Act, selling insurance in the individual market was a niche business. Those insurers that were successful were good at risk selection through benefit design and medical underwriting which allowed them to select consumers based on risk, charge higher premiums depending on applicants' health status and deny coverage due to a pre-existing condition. Before the Affordable Care Act, the primary marketing expense for carriers in the individual market was in the form of payments to insurance agents. PricewaterhouseCoopers (PwC), using national data reports that payments to agents represented approximately 6.3 percent of premium prior to the implementation of the Affordable Care Act.[92] With the advent of the Affordable Care Act and the elimination of medical underwriting, health plans dramatically reduced their payments to agents. At the same time they generally have not increased their direct non-agent marketing spending. The reason appears to be that in a "choice" environment, health plans do not want to encourage consumers to come to the marketplace where they are one of multiple offerings. Because of the potential that consumers coming to the marketplace may pick any plan, individual plans do not have the same incentive as the marketplace itself to promote enrollment generally. Rather, they seek to promote marketing and outreach efforts that are more narrowly focused on enrolling consumers into their plans. This often means health plans either invest in "search engine" marketing, which seeks to grab shoppers already looking for coverage, or promoting their off-exchange plans so that consumers enroll directly rather than through the marketplace that presents all coverage options to consumers.

Beyond having an incentive to invest in marketing, public marketplaces are uniquely positioned to create umbrella strategies that complement and reinforce health plans' marketing and agent commission spending. Over the past three years, marketing spending by health plans in California collectively has declined both in total dollars and as a percentage of premium. While the spending in California by particular plans varies

[92] See PricewaterhouseCoopers analysis: Covered California 2016-2022 Market Analysis and Planning http://board.coveredca.com/meetings/2016/5-12/Covered CA and PwC Market Planning and Analysis_Board Draft.pdf (page 4).

dramatically, with some spending virtually nothing while others spend as much as 2 percent of premium, the aggregate marketing spend as a share of premium has declined since the 2014 launch (see Figure 11: California On-Exchange Total Acquisition Costs as a Share of Premium, 2014–18). Covered California's marketing and outreach have consistently represented half of the total spend for 2014–17. Given Covered California's substantial contribution to aggregate marketing spend, one way in which Covered California executes an umbrella strategy is by actively coordinating with its contracted plans to complement their media advertising and agent commission payments. All contracted plans are required to provide full and detailed marketing plans, which Covered California uses to identify gaps and opportunities.[93]

One example of using information shared with Covered California to foster better enrollment is in the area of targeting subsidy-eligible Asian Americans. California's diversity is reflected in those eligible for subsidies — 22 percent of whom are Asian Americans, with the biggest populations being Chinese, Korean and Vietnamese. Many of these individuals prefer to receive information in their native language. For open enrollment in 2016, Covered California found that collectively the health plans spent 87 percent of their marketing and advertising on material that was in English, 12 percent on material in Spanish and roughly 1 percent on in-language marketing for major communities speaking Chinese, Korean, Vietnamese and other Asian languages. Based on this information, Covered California prioritized Asian-language advertising targeting Asian-language-dominant populations and English-language advertising targeted at bilingual Asians. Covered California better targeted these channels and achieved very positive results — the enrollment in Covered California closely matches the demographic profile of those eligible for subsidies — with about 23 percent of enrollment consisting of Asian Americans.

[93] To see Covered California's contractual terms related to marketing, see pp. 18-22 of the Qualified Health Plan Issuer Contract: http://hbex.coveredca.com/insurance-companies/PDFs/2017-2019-Individual-Model-Contract.pdf.

Fact 6: Ensuring a Stable Individual Market Requires Engaging Agents and a Multi-Channel Enrollment Strategy.

Agents and web-based entities are funded by health plan commissions and do not have an incentive or the resources to promote the overall marketplace. The marketing and outreach "umbrella" strategy can and should support in-person enrollment through agents (such as through developing a brand, collateral material and "storefronts") but agents cannot fill the gap left from underinvestment by the public exchange or health plans.

Enrollment comes from a wide range of channels and requires a wide range of efforts to educate consumers and sign them up for the plan that best fits their needs. While approximately 40 percent of Covered California consumers enroll directly through the website at www.CoveredCA.com (see Figure 10: Covered California 2017 Enrollment by Service Channel), the majority of consumers want and need personal assistance with enrolling. In addition, consumers enrolling online without any help may do so after receiving in-person assistance.

Since opening its doors in 2014, Covered California has enrolled more than 3 million individuals cumulatively, an accomplishment that builds on significant investments in marketing and strong relationships with Certified Insurance Agents, Navigators and other enrollment assisters; its contracted health plans; as well as robust choice-architecture tools that help enrollees make informed health plan selections.

As important as a good website is to promoting self-service, many people want and need person-to-person assistance. What follows are the elements of a broad multi-channel enrollment support structure.

Certified Insurance Agents

Covered California partners with approximately 15,000 Certified Insurance Agents across the state. Many of them are small-business owners who are trusted voices in their communities. These agents have invested significantly to promote Covered California's brand and enthusiastically work to enroll consumers. Agents make investments in web-based marketing, television advertising, call centers, enrollment centers and events, direct mail and canvassing, all of which complement Covered California's efforts.

Since agents pay for marketing through the commissions they receive from health plans, Covered California believes a marketplace should support agents and brokers by complementing and supplementing their marketing efforts. The results of these efforts are evidenced by the fact that Certified Insurance Agents represent Covered California's largest sales channel, accounting for 47 percent of all enrollees.

Covered California has cultivated relationships with the agent community by actively working with them on branding, promotion and coordination. Building these relationships has led to the development of approximately 800 "storefronts" (i.e., enrollment centers)

— the vast majority of which are owned, operated and entirely supported by agents — that all use common branding and promotion rules developed by Covered California. These storefronts allow Covered California to be on hundreds of "Main Streets" across the state and promote enrollment in both on-exchange and off-exchange plans, which benefits the overall risk mix.

Beyond promoting storefronts and an array of promotional tools that support agents, as a matter of contract with its health plans, Covered California has established a "floor" of engagement by all of them. Since agents are required to fairly and equally present all health plan options to consumers — regardless of their commission arrangement — Covered California has been concerned that some plans may seek to "ride on the coat tails" of other plans commissions. In addition, some plans proposed to alter their commission structures to only pay commissions for enrollments during the open enrollment period and not during special enrollment. Covered California exercised its role in promoting fair competition and a level playing field for consumers by requiring all health plans to pay the same amount of commissions throughout the year.[94] While Covered California has not established a specific floor on commission rate, it actively monitors each plan's agent commissions as part of the annual rate negotiation process between Covered California and its plans.

Agents That Are Web-Based Entities

While some consider web-based entities as possible substitutes for public marketplaces, it is important to note that web-based entities are agents paid on commission. The main distinction between web-based entities and other agents is web-based entities are online and often more narrowly focus on the "point of sale." Like retail agents, they do not have an affirmative duty or financial incentive to develop and direct an umbrella marketing and outreach strategy for the individual market. A marketplace should consider web-based entity services in the context of the value they add by increasing enrollment and reducing costs to the service center — value that is paid for out of the commission payment made by contracted plans and incorporated in plans' overall premium. Covered California has many web-based entities among its Certified Insurance Agents and some of these are significant sources of enrollment. What follows are strategic considerations for assessing web-based entities in the context of the broader marketing and member retention effort:

- When a marketplace is examining partnerships with agents that are web-based entities, it should consider them through the lens of the marketplace's overall marketing and sales-channel distribution strategy. This requires closely examining the way web-based entities harmonize or conflict with existing relationships with health plans and other agents, as well as the downstream impacts to consumers. Not all web-based entities' business models are the same. As marketplaces assess opportunities to increase enrollment, a key value proposition for collaborating with web-based entities is based on the extent to which certain models can reach consumer segments at the point of decision-

[94] See Section 2.2.6 (http://hbex.coveredca.com/insurance-companies/PDFs/2017-2019-Individual-Model-Contract.pdf.)

making that complements an exchange's own marketing efforts, such as individuals experiencing job transitions. In this capacity, a web-based entity might complement the efforts of a marketplace by providing additional membership, maximizing enrollment and ensuring a diverse risk mix.

- There is the potential for conflict with a marketplace if a web-based entity cannibalizes sales that would have otherwise occurred directly through the marketplace. Such a scenario could result in higher acquisition costs for the marketplace and potential sales channel conflicts with health plans and other agents. Web-based entities may compete with the marketplace for members who would have enrolled through the marketplace under any circumstances, with the web-based entities paying for the same search engine marketing on Google and other search engines. This could drive up marketing costs for the marketplace that is attempting to reach the same customer. The net effect is that the marketplace could potentially end up paying more in online marketing and competing for members it would have enrolled anyway. In addition, if these same individuals would have enrolled directly with the exchange, the health plans may be incurring unwarranted agent commission expenses.
- Finally, to the extent web-based entities undertake any role in determining eligibility for tax credits there needs to be clear processes to ensure program integrity and detect fraud. Covered California has a robust consumer protection and fraud review process that receives substantial dedicated resources as part of its marketing and outreach investments.

Service/Call Center and Website

Covered California's website and service/call center are the second and third most popular enrollment channels, accounting for 40 percent and 9 percent of all sign ups respectively.

An effective website is essential to delivering a positive consumer experience, which brings in new enrollment and retains existing consumers. Websites can be accessed at any time and as of 2018 Covered California's website (CoveredCA.com) is optimized to allow for enrollment on mobile devices. For consumers preferring customer service by phone, the quality of a call center is also critical to delivering superior customer service in enrolling and retaining members. This involves staffing and service-level thresholds and standards so consumers can receive trained and competent telephone support in enrolling or managing their account.

While a marketplace's website and service/call center are important enrollment channels, their success depends on inducing consumers to shop for health insurance. Consumers with greater health care needs will seek out the marketplace on their own, but marketing and outreach are needed to balance the risk pool with healthier individuals and continuously refresh it with new enrollees. This requires marketing and outreach to raise awareness of the marketplace and encourage the value of health insurance.

Navigators

The Navigator program is federally mandated for all state health exchanges and has been an important component of the overall strategy to promote enrollment in the FFM and state-based marketplaces.

At the federal level, Navigator funding has been a consistently major recipient of the FFM's marketing and outreach investments. Since the launch of the Affordable Care Act, federal support for Navigators in FFM states amounted to $67 million for 2014[95] $60 million for 2015,[96] $67 million for 2016[97] and $63 million for 2017.[98] The $63 million for 2017 supported 103 grant recipients in 34 states. For each year, these costs do not include the management and oversight of the Navigator program.

The Navigator grant funding for 2017 reflected about 0.17 percent of the FFM premium, which appears to be nearly 40 percent of all federal investments in promoting enrollment. In this area, the federal government was investing substantially more than was Covered California, which spent about half the federal amount as a percentage of premium, about 0.08 percent of premium on its Navigator program (for additional details, see the "By the Numbers" section on benchmarking investing on page 26). CMS has announced plans to reduce Navigator funding significantly for 2018, to $37 million. Informal reports are that many state-based marketplaces continue to invest a high proportion of their marketing and outreach budgets on Navigator programs.

Covered California made a significant investment in community-based outreach education and enrollment during its first two years, developing important relationships with community organizations across the state that had experience in both reaching and assisting California's diverse populations, and proven success with enrolling consumers in health care programs. In 2013–2014, the first year of enrollment efforts, Covered California funded outreach and enrollment grantees and paid community organizations on a per-enrollment basis, with total payments of $47.8 million. For 2014, this level of support reflected 1.1 percent of premium, or about six times higher than the 2017 FFM premium percentage.

Covered California has looked closely at the return on that investment and examined enrollment totals, demographic breakdowns and retention levels generated by these efforts. The data showed that while navigators were a key contributor to Covered

---

[95] Centers for Medicare and Medicaid Services: Navigator Grant Recipients (Oct. 18, 2013) https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/navigator-list-10-18-2013_2.pdf

[96] Centers for Medicare and Medicaid Services: Navigator Grant Recipients for States with a Federally-facilitated or State Partnership Marketplace (Oct. 18, 2013) https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/navigator-list-09-08-2014.pdf

[97] Centers for Medicare and Medicaid Services press release: CMS awards $67 million in Affordable Care Act funding to help consumers sign-up for affordable Health Insurance Marketplace coverage for 2016 (Sept. 2, 2015) https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-09-02.html

[98] Centers for Medicare and Medicaid Services press release: CMS awards consumer assistance funding to support 2017 Health Insurance Marketplace enrollment (Sept. 9, 2016) https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-09-06.html

California's outreach, over the first three years (2014–2016) they represented only 3 percent of the overall enrollment.

Based on Covered California's review of the efficacy of the Navigator program, the funding for the program has been decreased significantly since the first two years. Covered California has committed to supporting Navigators with $6.5 million in grant funding for fiscal year 2017–2018. This represents 6 percent of the marketing budget and is about 40 percent less than the $10.9 million in grant funds distributed in 2014–2015.

While Covered California has decreased its support for Navigators and they do not enroll as many consumers as other channels do, Covered California does not evaluate their impact based solely on volume of enrollment. Navigators enroll a higher proportion of key demographic populations, which are often more difficult and expensive to reach, including Latino and African-American communities and those speaking languages other than English.

As an example, during the most recent open-enrollment period, Navigators signed up 7,405 consumers who identified as Latino, which was 52 percent of the total enrollment by Navigators. By comparison, Latinos only represented 16 percent of the consumers whom agents signed up, even though the overall total was much larger, at 29,428.

TABLE 6
Covered California's 2017 Ethnicity by Enrollment Channel

Race / Ethnicity	Agents Enrolled		Navigators Enrolled	
	Percent	Total	Percent	Total
(non-respondent)	47%	86,077	19%	2,756
American Indian/Alaska Native	0%	169	0%	32
Asian	17%	31,168	12%	1,703
Black or African American	1%	2,289	3%	408
Latino	16%	29,428	52%	7,405
Multiple Races	1%	1,360	1%	105
Native Hawaiian or Pacific Islander	0%	215	0%	30
Other	3%	5,941	2%	344
White	15%	27,216	10%	1,366
Total	100%	183,863	100%	14,149

Covered California has developed a data-driven methodology for selecting grantees that is consistent with its goal of both ensuring hard-to-reach consumers have access to in-person enrollment assistance while ensuring it builds an organization that is self-sustaining. Based on Covered California's use of lifetime value as a framework for assessing marketing and outreach investments, it has sought to ensure that the cost per acquisition of consumers through the Navigator grant program does not exceed $200 per enrollee. In 2016–17 the cost per acquisition averaged $175 per person. Not only is this well below the cost per acquisition during Covered California's initial years, when

some Navigators spent several times that amount, but it closely mirrors both the marketing attribution for lifetime value and the average agent commission.

TABLE 7
Covered California's 2017 Navigator Enrollment Cost per Acquisition

Sample of Organizations	Enrollment and Retention for FY 2016–2017	Funding for FY 2016–2017	Cost per Acquisition
Alameda Health Consortium	3,254	$500,000	$153.66
AltaMed Health Services Corporation	3,829	$500,000	$130.58
Council of Community Clinics	3,157	$500,000	$158.38
Redwood Community Health Coalition	2,710	$500,000	$184.50
Asian Americans Advancing Justice	1,805	$300,000	$166.20
All Other Grantees	25,808	$4,800,000	$185.99

As Covered California considers its Navigator program for future years, it is evaluating how to continue to reward performance and assure all communities have effective vehicles to support their enrollment. Covered California continues to look at how funding is tied directly to assessment of the effectiveness of the effort to promote enrollment and retention. Investments in community-based organizations to support enrollment need to be held to the same level of accountability and validation as are all marketing and outreach investments.

As the federal government and other state-based marketplaces examine their own Navigator grants and enrollment results, Covered California looks forward to better understanding their assessment of the ROI that these channels garner and how that return relates to other marketing investments.

While there has been a clear commitment at the federal and state level to funding the Navigator programs, more research needs to be done to examine how effective those programs have been in each market. Moving forward, a crucial element to building stable marketplaces will be for each market to determine the efficacy of their efforts and whether navigator funding is at an appropriate level.

Fact 7: Marketing Investments Can Be Tiered to Meet a Wide Range of Market Sizes.

Marketing is crucial and is a central function of any marketplace. While some marketing functions benefit from a big scale (e.g., developing creative TV content), in most areas the scope and nature of investments can be tiered to meet a wide range of market sizes.

Right-sizing marketing and outreach investments is critical for promoting enrollment and retention. California has found a successful formula for marketing and outreach for the individual market — combining the efforts of the marketplace, health plans and agent commissions for member acquisition — which would reflect 5.9 percent of on-exchange premiums for 2018. Out of this amount, Covered California has structured its user fee such that it invests 1.4 percent of exchange premiums directly in marketing and outreach. This formula has proven successful given California's multi-year ability to create a stable market by attracting sufficient enrollment and a balanced risk mix.

Covered California makes significant investments in dedicated staffing in the areas of paid media, support for agents and ongoing earned media efforts. With paid media including $18.1 million in television advertising, the development and creative costs are easier to spread. California is a large state and these are examples of some of the economies of scale in conducting marketing.

Smaller states, however, can still make investments with fewer dedicated staff, focusing on those marketing investments that require less overhead, such as radio and search engine marketing. Digital marketing, on the Web and through social media, can be efficiently pursued by health exchanges of any size. Because these channels are lower cost than traditional media outlets, they can be scaled and measured far more easily. They can also be rapidly turned on and off and are particularly effective at reaching defined population segments.

Covered California believes that when the Federally-facilitated Marketplace (FFM) or state-based marketplaces spend less proportionally on marketing and outreach, they jeopardize their respective risk pools and negatively affect the premium trend in future years.

Fact 8: Marketing Needs to Lead People to Products That Meet Their Needs.

The success of marketing and outreach is critically reliant on the quality and price of the insurance products being offered. Consumers in California benefit from having patient-centered plan designs that are readily understandable and provide access to needed care.

Covered California has 11 health plans competing for enrollment, but Covered California's patient-centered plan designs[99] mean insurers compete with one another based on premium, network, quality, consumer tools and service. The benefits of the common patient-centered benefit designs are significant, including:

- Californians seeking coverage through the marketplace can easily compare health plans knowing that every health plan has the same cost-sharing levels and benefits. The more-important factors for differentiation used by consumers in making plan selections (price being the most important) are readily understandable and include the total price of both premium and out-of-pocket potential costs and other factors (e.g., provider networks and plan quality).
- The patient-centered plan designs are constructed to minimize financial barriers to access for consumers, reduce confusion and reinforce efforts to promote higher-value care delivery, such as better use of primary care.
- Standardization simplifies both the "sales" and the enrollment process to boost enrollment and the delivery of services in clinician offices. The simplification is especially important to previously uninsured individuals or those who are otherwise new to the purchase of individual coverage. In addition, it appears that simplified and standard designs mean that consumers are more likely to select "higher-value" products. In particular, lower-income consumers who are eligible for the cost-sharing subsidy are more apt to understand the relative value of their Silver cost-share reduction plan in contrast to the Bronze alternative.
- Promoting better value at the point consumers select a health plan should promote retention and have positive effects on the risk pool.

Covered California believes its efforts to promote true consumer competition, in which shelf space is devoted to a limited number of products in each tier, is a substantial benefit to consumers. The continuing improvement of benefit designs should be based on evidence of the implications of respective designs with regard to consumer understanding, access to services, cost and other factors. Covered California has begun additional work to evaluate the impact of different benefit designs and design features and how those impacts may differ by the characteristics of the consumers using them (e.g., income level, subsidy level, education, language, and race and ethnicity).

---

[99] Covered California's patient-centered plan designs for 2017 are available for reference (http://www.coveredca.com/PDFs/2017-Health-Benefits-table.pdf)

Fact 9: Marketing Is Politically Neutral and Is an Economic Necessity.

Marketing is politically neutral and is an economic necessity to creating and maintaining stable insurance markets.

While there are widely varied opinions about the Affordable Care Act, the economic reality is that ensuring that the individual market remains as stable as possible, with affordable premiums for those who do and do not receive subsidies, is a basic business proposition.

Marketing is one of the key ways to promote the enrollment that is essential to having stable markets. Covered California, as well as other state-based marketplaces, has engaged in vigorous and robust marketing since day one to create and maintain stable insurance markets. The marketing campaigns, as well as the outreach and education programs, promote the value of coverage, not a particular political approach or perspective. As part of its community outreach, Covered California has worked with both Democratic and Republican elected officials to make sure their constituents understand the benefits available to them.

With Covered California's efforts, California's market is more stable than are those in the Federally-facilitated Marketplace. In addition, Californians have more knowledge and a better understanding of Covered California than they do of the Affordable Care Act — evidence that effective marketing can transcend the political rhetoric.[100]

Marketing should not be about the politics. The singular goal of marketing should be about creating a stable individual market. The formula is simple: Marketing and promoting enrollment improve the risk mix, which helps protect consumers and meets their needs.

[100] Greenberg Research. (2017) "Covered California Sentiment Research. Wave 2: A Quantitative Study on Current Attitudes of Uninsured and Select Insured Californians Toward Health Insurance Coverage."

IV. Elements of Effective Marketing, Outreach and Enrollment for the Individual Insurance Market

Building a stable individual insurance market requires that public exchanges undertake a multi-faceted approach grounded in a thorough understanding of the needs of consumers shopping for health insurance, the individual market itself and the needs of key players operating in that market. Covered California's strategy, since opening its doors in 2014, has been to create robust multi-channel, multi-lingual and ethnically diverse outreach efforts to promote the value of the product that is being offered and to help educate consumers about their options and benefits. In addition, Covered California has worked in partnership with health plans, agents and community groups to reach consumers on multiple fronts with the support and services they need.

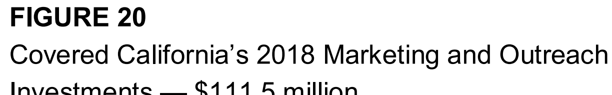
Covered California never takes for granted a key principle: *health insurance needs to be sold*. This principle is as true today as it was when the marketplace first launched since 40 percent of Covered California consumers "churn" out of the exchange each year for other forms of coverage.

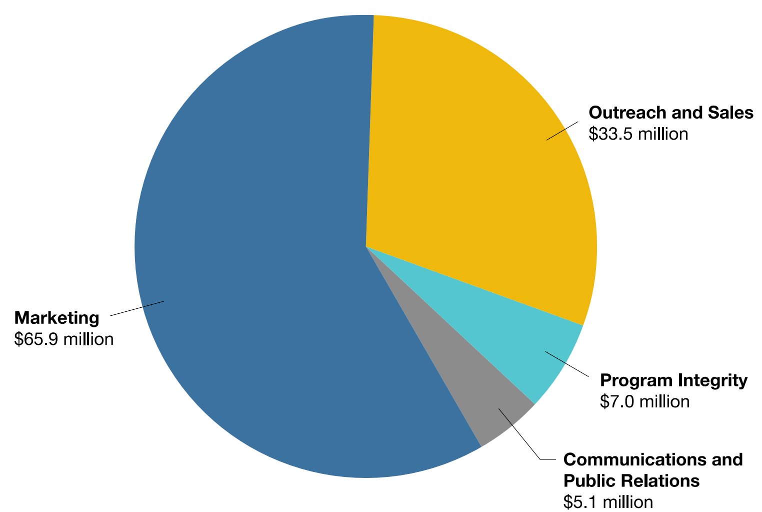
Marketing and outreach are an investment. Marketing is about more than slick television ads or a well-functioning website; it entails a commitment to hire the best experts, learn from their research and hear their outreach advice; it requires coordinating with community partners, agents and health plans; and investing in skilled teams to execute comprehensive and strategic outreach efforts, year after year. Marketing and outreach must adjust along the way to adapt to the changing needs and understanding of consumers, and recognizing new opportunities and ways to improve each year.

While the bulk of *Marketing Matters* provides an analysis of the rationale behind making marketing investments, the section that follows offers a look at the wide-ranging efforts that Covered California has undertaken to promote enrollment in health insurance.

Each of the investments described contributes to an overall marketing, outreach and enrollment assistance spend of more than $111 million (see Figure 20: Covered California's 2018 Marketing and Outreach Investments — $111.5 million).

FIGURE 20


Covered California's 2018 Marketing and Outreach Investments — $111.5 million



Covered California Marketing Assets are Available for Use

Covered California will make available shareable assets to be used by others, including other state-based marketplaces. These will include key messaging, TV and radio scripts and completed creative assets such as digital and social ads. The variety of creative assets will highlight key motivational and informational message points, such as the value of health insurance, availability of financial help, preventive care, the choice of plans and health insurance companies, how to get help and the enrollment deadlines.

The marketing assets are available at: http://www.coveredca.com/marketing-toolkit/

Each section includes in-depth information and examples of marketing, outreach and enrollment assistance efforts used by Covered California to promote and maintain broad enrollment and a healthy risk mix. The sections include:

- **Paid Media**: Covered California invests significantly in marketing on television, radio, in print and on digital platforms to promote enrollment by conveying the value of coverage. Covered California spent $39 million on television, radio, print, digital advertisements and billboards during the fiscal year 2016–17. The average Californian was exposed to one of its ads an average 50 times during the 2016–17 open-enrollment period, generating nearly 2 billion impressions statewide. Covered California plans to increase its paid media in fiscal year 2017–18 to $45 million.
- **Earned Media**: During the fourth open-enrollment period, Covered California conducted 200 interviews with newspapers, radio, television and online news sources. These interviews generated nearly 90 million impressions and were worth an ad value of nearly $2.4 million.
- **Supporting in-Person Enrollment and Enrollment Partners**: Covered California works with partners in the public as well as private sector in every community, including approximately 15,000 independent insurance agents, 5,000 certified enrollers and 46 Navigator grantees. More than 50 percent of all consumers enroll with the support of person-to-person assistance from agents and other enrollers. Covered California supports these enrollers with a field-based outreach support staff, training and communications programs and a certified agent and enroller service center. Opportunities are also provided through special programs, including storefront and events programs; “Help on Demand,” the mobile-enhanced agent consumer-referral tool; and by providing access to branded collateral. Covered California’s brand is represented in approximately 800 storefronts operated by insurance agents and Navigator grantees, which support enrollment in cities and towns across the state. For fiscal year 2016–17, Covered California has 57 full-time employees in outreach and sales, with a total budget of $34 million, including $7.1 million to fund 46 Navigator enrollment entities. In addition, Covered California service centers

handled more than 2.7 million phone calls in the last year, with a staff of 843 and a budget of $92 million.[101]

- **Targeted Outreach**: Covered California's marketing includes extensive "in-language" marketing — targeting consumers who speak Spanish, Mandarin, Cantonese, Korean, Vietnamese and other Asian languages. This has resulted in a demographic enrollment that matches the eligible population. Marketing also targets African-Americans through a range of media and outreach strategies and the LGBTQ community in newspapers and magazines that provide a platform for long-form messaging while targeting specific lifestyles, location and culture through radio, out-of-home and digital ads.
- **Online Enrollment**: Covered California invests significantly in an online enrollment portal that makes it easy for consumers to enroll and compare plans in order to find the best value. Approximately 40 percent of consumers self-enroll through the online enrollment application, rather than enrolling through an agent or other form of person-to-person assistance. Separate from the marketing budget, Covered California plans to spend $36 million to increase the ease and effectiveness of its online enrollment system during the upcoming fiscal year, plus $8.3 million on IT infrastructure to drive efficiencies throughout the organization to provide better customer service.
- **Telling the Story of Covered California Enrollees**: All over California, people are getting access to the care they deserve through Covered California. In their own words, they are sharing why health insurance is so important to them in videos that appear on CoveredCA.com and social media channels.
- **Helping and Encouraging Those Who Start Shopping**: Covered California's sales funnel consists of prospects who are in all stages of the consumer journey. The funnel consists of "Awareness," "Consideration," and "Purchase Intent."
- **Retention Support**: Covered California conducts robust ongoing communications with those who enroll, and uses its call centers, direct mail, email and other customer service efforts to keep its members informed, while boosting retention efforts. These efforts seek to build relationships with customers, resulting in brand loyalty and increased customer satisfaction.
- **Research**: Research helps Covered California better understand what resonates with consumers, and allows Covered California to remain nimble and quickly change as situations warrant. Research, such as user testing, consumer experience surveying and focus groups, allow Covered California to better understand its customers and identify effective messaging.
- **Organization and Staffing**: Covered California has invested in having a skilled and experienced staff who know how marketing works. The staff knows how to effectively manage the competitive bidding process in order to find, secure and engage top-class vendors. They also conduct in-depth evaluations, both

[101] As discussed previously, for the purposes of this report, Covered California Service Center costs are not included in the marketing and outreach budget.

internally and externally, to better understand consumers' needs and remain nimble in determining what works. Covered California plans to increase the staffing of Marketing, Outreach and Sales from 157 positions to 168 in fiscal year 2017–18, with more than $16 million allocated to support their salaries and benefits.

The efforts of Covered California, however, are not all that has contributed to the creation of a stable individual market in California. The exchange operates in a state where private insurers have also invested in marketing and invested significant resources to support agent commissions. Covered California's planned outreach spend of approximately $111 million is complemented by another $299 million[102] in spending by private insurance plans to promote enrollment in health insurance in the individual market — bringing the total annual spend to more than $400 million.

California's circumstances are unique, but also directly relevant to other states and the Federally-facilitated Marketplace. As one of the most populous and diverse states in the country, California is truly a microcosm of our nation, with numerous large media markets surrounded by hundreds of miles of rural landscape. California's success through targeted investments in marketing and outreach provides a benchmark that may be helpful to inform strategic planning by the federal government and other states that are also working to foster stable and competitive individual markets.

[102] This figure comprises $123 million in on-exchange agent commissions, $145 million in off-exchange agent commissions, and $31 million in direct media advertising.

Paid Media

Using a multi-channel strategy to reach California's diverse communities, nearly every Californian will be exposed to one of Covered California's TV, radio, print, billboard or digital advertisements on average 90 times during the 2017 plan year. Consumers are encouraged to sign up during open enrollment through strategic media placements that drive traffic to CoveredCA.com and keep Covered California top of mind as Californians are making health insurance decisions during open enrollment and throughout the year.

The goal is to acquire 700,000 new members and retain current members for the 2017 plan year, using the "It's Life Care" theme. Covered California wants its consumers to understand the value of health insurance for everyday life, improve understanding of what Covered California offers consumers, and increase consumer understanding of health insurance.

Covered California is targeting insured and uninsured Californians of multiple ethnicities who are subsidy eligible (federal poverty level 138 percent to 400 percent), as well as non-subsidy-eligible Californians, ages 26-54 with a household income between $50,000 and $130,000.

Many consumers face barriers to purchasing insurance, such as:

- The consequences of not having health insurance are not immediate or impactful enough.
- It is not clear to them why Covered California is the right place to purchase health insurance.
- People do not have the knowledge they need to make decisions with confidence.

In Table 8 and Figure 21: Covered California Media Spend by Channel for 2017 and following sections, Covered California provides benchmark information by showing: (1) the total spend by Covered California by media channel; (2) the percent that spend represents as a percentage of on-exchange premium[103]; (3) the percent the segment represents for Covered California's marketing and outreach budget[104]; (4) total impressions, if applicable[105]; and (5) where available, aggregate spending of the 11 health plans in Covered California.[106] After presenting these figures for 2017, each section includes the projected spend for the upcoming 2018 plan year.

[103] The percent of spend to premium is calculated by dividing the total spend by $6.9 billion (the total premium collected by Covered California in 2017).

[104] The percent of spend to marketing and outreach is calculated by dividing the total spend by $99 million (the total marketing and outreach budget for Covered California in 2017).

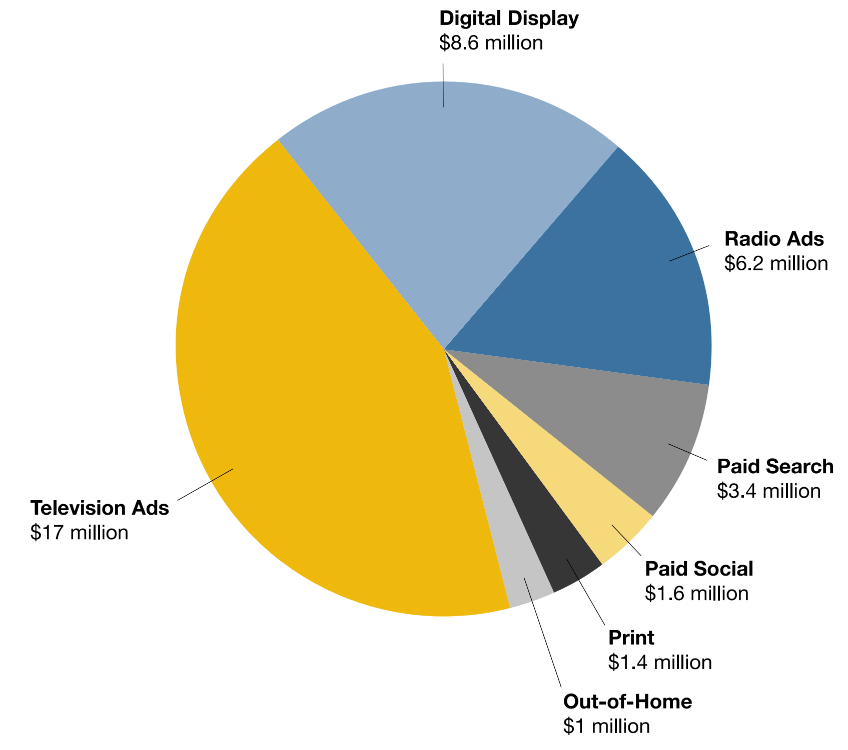
[105] Impressions are a measure of the number of times a consumer in California viewed a Covered California ad.

[106] Compared to Covered California spending.

TABLE 8
Covered California Media Spend by Channel for 2017

Channel	Covered California Spend	Percent of Spend to On-Exchange Premium	Percent of Spend to Covered California Marketing and Outreach Budget	Total Impressions	Health Plan Spend by Channel
Television	$17,050,000	0.25%	17.3%	413,887,303	$2.8 million
Radio	$6,234,090	0.09%	6.3%	256,407,270	$4.4 million
Digital Display	$8,586,910	0.12%	8.7%	1,255,842,869	$6.4 million
Social	$1,573,000	0.02%	1.6%	195,204,781	$106,000
Search	$3,367,000	0.05%	3.4%	279,950,394	$8.6 million
Print	$1,364,000	0.02%	1.4%	49,540,228	$480,000
Out-of-Home	$1,023,000	0.01%	1.0%	343,887,136	$5.2 million
Total	**$39 million**	**0.57%**	**39.8%**	**2.8 billion**	**$28 million**

FIGURE 21
Covered California Media Spend by Channel for 2017



Covered California is committed to continuing robust paid-media marketing efforts in the future with a total marketing and outreach budget for 2018 of $111.5 million, of which $45 million is allocated for paid media.

TABLE 9
Covered California's Planned Paid Media Spend by Channel for 2018

Media Channel	Budget	Percent of Spend to Covered California Marketing and Outreach Budget
Television	$18,102,773	0.23%
Radio	$8,273,348	0.11%
Digital Display	$9,736,168	0.12%
Social	$1,942,893	0.02%
Search	$2,329,000	0.03%
Print	$3,100,493	0.04%
Out-of-Home	$1,515,325	0.02%
Total	**$45,000,000**	**0.58%**

As mentioned previously, by using a multi-channel strategy to reach California's diverse communities, nearly every Californian will be exposed to one of Covered California's TV, radio, print, billboard or digital advertisements on average 90 times in 2017. In the following pages we describe the efforts in each of the following paid-media channels.

Television

Covered California uses television advertising to drive overall brand awareness and keep Covered California top of mind. Certain advertisements carry a specific call to action to drive engagement.

"Welcome to Answers"
English/Spanish

"Happy"
English, Mandarin, Cantonese, Korean, Vietnamese

Other TV Advertising Examples
Scene (English) https://youtu.be/5tIy2cbwO0A
Scene (Spanish) https://youtu.be/2Mty13Gloao

Radio

Covered California incorporates traditional radio ads, traffic sponsorships, streaming and DJ endorsements to drive incremental reach by complementing the TV schedule and providing continuity in a cost-efficient way. It also keeps Covered California top of mind and creates a local connection with its target audience by aligning with local DJs and stations.

Digital Display

Digital ads drive users to CoveredCA.com to encourage engagement and to generate more qualified leads.

Social Media

These efforts are designed to increase awareness and enthusiasm for open enrollment and renewal through informed, targeted social engagement. The social media efforts include:

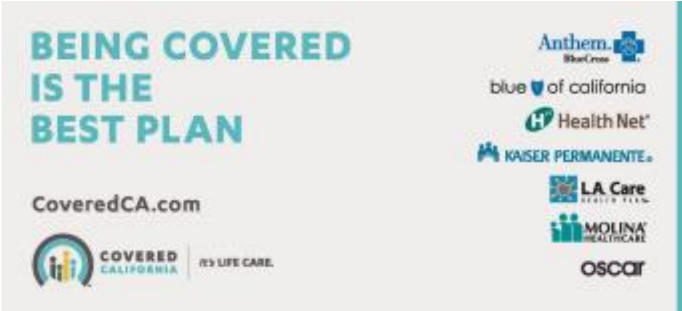
- Providing reliable, actionable information to support current members and prospective customers.
- Promoting content with brand-controlled messages that inspire consumers to engage with and share that content.
- Cross-promoting media campaign content including imagery, video and messaging.
- Actively monitoring all social channels and providing social customer support, primarily on Facebook and Twitter.
- Encouraging members to shop due to rate changes.

Search Engine Marketing

Paid search funnels traffic from all other paid media to CoveredCA.com, encouraging engagement and intercepting consumers seeking information about open enrollment and Covered California through search engines.

Print
Covered California purchases advertisements in newspapers and magazines to extend reach and increases the frequency of message against niche target segments. Covered California provides a platform for long-form messaging and creates a local connection with our target by partnering with local community publications.

Out-of-Home
Covered California purchases billboards, posters and transit shelter ads to extend overall campaign reach, drive awareness and keep the Covered California brand top of mind.



Collateral Materials
Collateral materials are a tool to support the Covered California sales teams to help educate consumers about health insurance and Covered California.

Covered California invests millions of dollars to promote the benefit of insurance on printed materials that are distributed to consumers and enrollment partners. In 2017, Covered California spent $5.7 million on these materials, which accounted for 0.09 percent of the premium collected by Covered California and 5.8 percent of Covered California's marketing and outreach budget.

TABLE 10
Covered California's Collateral Spend in 2017

Total Collateral Spend in 2017	**$5.7 million**
Percent of Spend to Premium	0.09%
Percent of Spend to Marketing and Outreach Budget	5.8%

Earned Media

Covered California invests heavily in earned media to encourage enrollment during open and special enrollment. Earned media is publicity gained through promotional efforts other than paid media advertising, usually "earned" through the establishment and development of ongoing positive working relationships with members of the media. At Covered California, this is done in the form of interviews with media outlets, print-ready articles for newspapers, tweets, phone banks, community outreach efforts and press briefings.

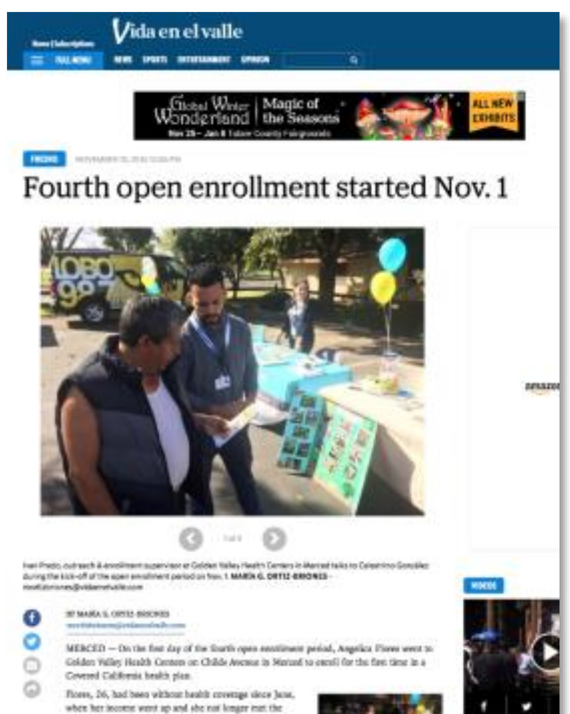
In 2017, earned media efforts amounted to $4.5 million. This spend was to support a staff of 15 Covered California media professionals and a contract with the global public relations firm, Ogilvy. These efforts have won numerous awards including the prestigious PR Week "Best in Public Sector" in 2017.

In the fourth open-enrollment period alone, Covered California conducted more than 200 interviews with newspapers, radio, television and online news sources, generating nearly 90 million impressions with an ad value of nearly $2.4 million.

In previous open-enrollment periods, Covered California has highlighted the “basics” of health insurance and literally shined spotlights on places where consumers can enroll. Covered California’s bus visited hospitals throughout California at media events to highlight the cases and types of care provided to those who gained health insurance through Covered California. Examples of Earned Media Coverage:

The Mercury News

Obamacare: Key moves by Covered California helped keep premiums down


Vida en el valle

Fourth open enrollment started Nov. 1

Covered California’s investment of $4.5 million in earned media results in significant coverage across the country and the state and helps support overall outreach efforts.

TABLE 11
Covered California’s Earned Media Spend in 2017

Total Earned Media Spend in 2017	**$4.5 million**
Percent of Spend to Premium	0.07%
Percent of Spend to Marketing and Outreach Budget	4.6%
Total Impressions	90 million

In-Person Enrollment

Covered California supports a variety of sales channels to provide free, confidential in-person enrollment assistance. These channels include Certified Insurance Agents, community enrollers and Covered California's Service Center.

Certified Insurance Agents

Certified Insurance Agents work one on one with consumers to help them complete the Covered California application and select and enroll in a health insurance plan. Certified Insurance Agents provide impartial information about a consumer's plan choices, and they can offer advice about which plan may best meet a consumer's needs.

Certified Insurance Agents support two markets:

- Individual market: Offers on-exchange individual plans to individual consumers.
- Covered California for Small Business: Offers on-exchange small business plans to small business consumers.

There are currently 15,174 Certified Insurance Agents across the state, who are experienced in selling health insurance. Because of their experience, agents currently have a higher consumer enrollment effectuation rate when compared to the other sales service channels (this also includes self-enrollers and the Service Center representatives). Agents account for 47 percent of current Covered California enrollment.

Agents are not compensated by Covered California; they are compensated by health plans directly. Since Covered California's inception, agents across the state have received hundreds of millions of dollars in compensation. In 2016, agents are estimated to have received $229 million in compensation in the individual market ($117 million from plans in Covered California and $112 million outside of Covered California).

Covered California's investment of $9 million reflects only Covered California's direct expense to support agents and agent-based sales. It does not include agent commissions paid by the health plans. In 2017, Covered California estimates that health plans paid $110 million in agent commissions and $129 million off-exchange.

TABLE 12
Health Care Market Spend for Agents in 2017

Total Agent Support Spend in 2017	**$9 million**
Percent of Spend to Premium	0.13%
Percent of Spend to Marketing and Outreach Budget	9.1%

Community Enrollers
Covered California works closely with a variety of community enrollers to assist consumers to sign up for coverage. Except for the Navigator grant program, community enrollers are not compensated. Below are the types of community enrollers:

- **Navigator Grant Program:** Grant-based partners providing outreach, education and pre- and post-enrollment services to individual consumers.
- **Certified Application Counselor Program:** A network of certified counselors providing enrollment service to individual consumers. There are currently 2,145 Certified Application Counselors.
- **Plan-Based Enrollment Program:** Carrier-specific certified enrollers. There are currently 1,033 Plan-Based Enrollers.
- **Community Outreach Network:** A network of organizations distributing Covered California marketing materials. There are currently more than 300 Community Outreach Network partners.
- **Medi-Cal Managed Care Program:** Enrollers specifically assigned to help with Medi-Cal qualified enrollees. There are currently 26 Medi-Cal Managed Care Plan-Based Enrollers.

Community enrollers have an established and trusted presence in the communities they serve and speak 17 different languages. Three percent of current Covered California consumers were enrolled by community enrollers.

The most important set of community enrollers is composed of groups funded in part by the Navigator grant program, which awarded grants to organizations with a goal of enrolling new entrants into the marketplace efficiently; not to exceed $200 per acquisition.

Navigators are compensated through competitive grants. In FY 2016–2017, Navigator grants totaled $7.1 million, and were distributed to 46 Navigator enrollment entities. Currently, there are 1,354 Navigator Certified Enrollment Counselors who have assisted 124,570 consumers from Sept. 1, 2016, to April 30, 2017.

TABLE 13
Community Enroller Spend in 2017

Total Community Enroller Spend in 2017	**$8.2 million**
Percent of Spend to Premium	0.12%
Percent of Spend to Marketing and Outreach Budget	8.3%

Covered California Service Center

The Service Center provides comprehensive pre- and post-enrollment education and support to Covered California consumers by responding to consumer inquiries, enrolling them in coverage and promptly resolving challenges.

The Service Center FY 2017–2018 budget is $86,843,965, and is not a part of the marketing and outreach budget. However, Service Center representatives serve a critical function in assisting consumers to enroll. In 2017, the Service Center enrolled 9 percent of all enrollment.

The Service Center offers a critical function in handling 2,778,616 calls.

Covered California's Service Center budget of $89.9 million is 1.3 percent of spend to premium, which is not reflected in the marketing and outreach total spend.

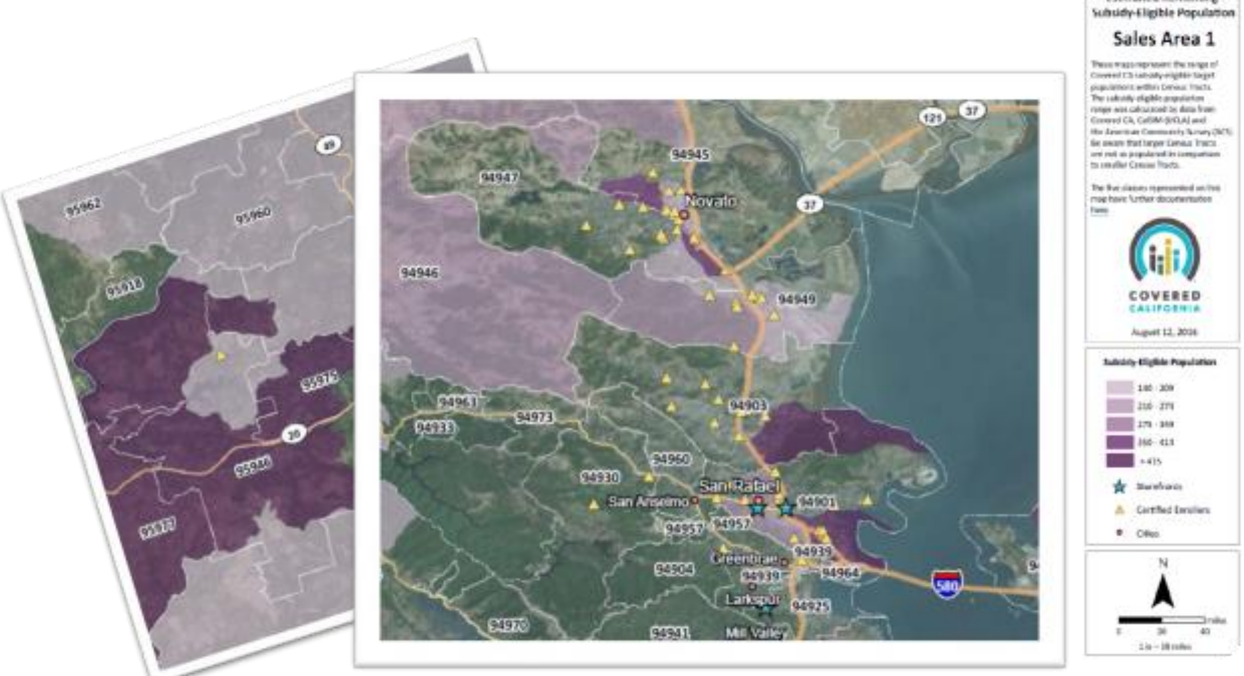
TABLE 14
Service Center Spend in 2017

Total Service Center Spend in 2017	**$89.9 million**
Percent of Spend to Premium	1.3%

Supporting in-Person Enrollment and Enrollment Partners

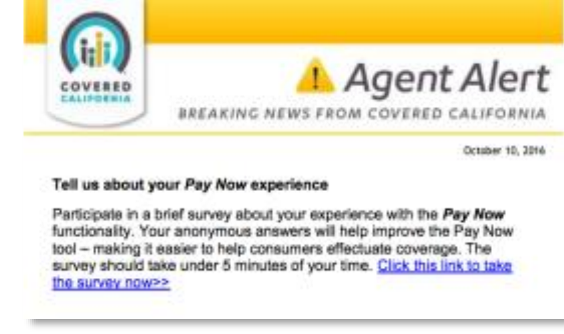
Covered California endeavors to support all of our enrollment partners with tools they can use to enroll consumers.

- **Business Analytics:** Sales partners can use regional heat maps to identify the locations of subsidy-eligible consumers.

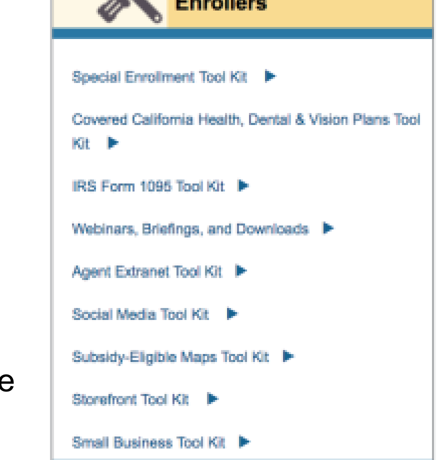


- **In-Person Administrative System (IPAS):** The system of record for community enrollers in the Navigator grant program and Certified Application Counselors, Plan-Based Enrollers and Medi-Cal Managed Care. Developed to help community enrollers manage the administration and monitoring of their reports, productivity reports, and counselor roster management.
- **Agent and Community Enroller CalHEERS Portals:** The system of record for our certified agents and certified community enrollment partners. Developed to offer direct access and administration of their consumer enrollment portal.
- **Agent Extranet:** Additional resource created to offer certified agents a secured portal with tailored book of business databases, intended to support retention and enrollment activities.
- **Training Webinars:** Additional web-based training resource intended to be used on a regular basis with a quick turnaround time for our enrollment channels to disseminate urgent information and program and system updates.

- **E-News and Alerts:** E-based resource intended to be used on a regular basis with a quick turnaround time for our enrollment channels to disseminate urgent information and program and system updates.



- **Tool Kits:** Issue-specific bundle of centralized documents, forms, FAQs and additional resources for quick access. Intended to help enrollment channels access one entry point into comprehensive information for specific issue or campaign. This is a web-based resource.



- **Sales Channel Meetings:** Hosted kickoff meetings statewide to incorporate sales partner trainings and regional meetings in high density areas where certified enrollers reside and work for enrollment strategy planning. In total, facilitated 98 agent and community partner meetings.

- **Field Operations Support:** The field operations team and the account services team are liaisons between Covered California headquarters and certified agents and community leaders, as well as liaisons between Covered California headquarters and the community enrollers program.

- **Find Local Help:** Covered California's website includes a page that allows consumers to find a certified enroller or other entities that can assist them to complete their enrollment. The page includes storefronts (explained in the next bullet), offices for certified enrollment agents and other enrollers and enrollment events.

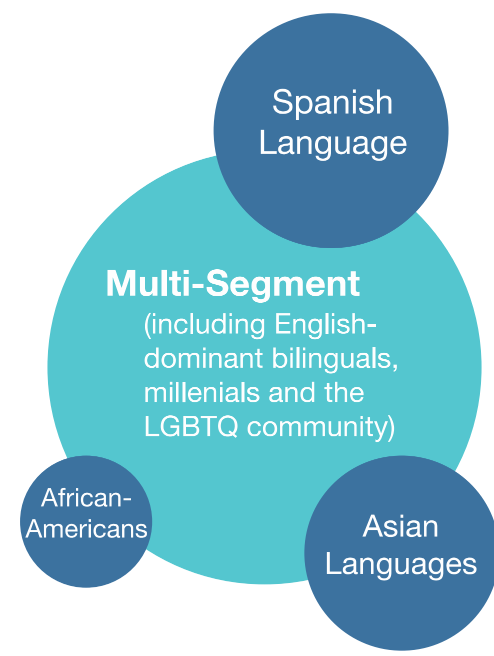
- **Storefronts:** Storefronts are brick and mortar offices operated by Covered California certified enrollment partners to assist consumers in applying for coverage. Currently there are 776 storefronts throughout California (75 percent of storefronts are owned by agents, 18 percent offer assistance in Spanish and another 18 percent offer assistance in other languages — Chinese, Vietnamese, Korean, etc.)

- **Enrollment Events Portal:** Covered California offers consumers a web-based locator tool to find events in their community. In 2016, there were 4,998 enrollment events throughout California.
- **Help on Demand:** An Uber-like experience to connect consumers to expert local enrollment assistance available at CoveredCA.com. This tool provides direct support from a certified enrollment agent/counselor. More than 750 Certified Insurance Agents with a proven track record are selected to be part of the Help on Demand network. Help on Demand supports 17 different languages.

Targeted Outreach

Covered California's media and marketing campaign is organized around cultural segments that specifically complement the extensive community outreach campaigns happening in all parts of the state. The campaign segments are: general market (multi-segment), Latino, Asian-Pacific Islander, African American and LGBTQ (see Figure 22: Covered California Multi-Segment Target Audiences).

FIGURE 22
Covered California Multi-Segment Target Audiences.



Multi-Segment Outreach

Reaching diverse communities is a key to Covered California. Its multi-segment marketing plan assumes:

- TV still king, but digital and mobile consumption on the rise.
- Adults ages 25 to 54 spend between three to four hours a day watching TV. Time-shifted viewing is up by nearly 15 percent while average time spent on Live TV has decreased by only three minutes.
- Adults spend more than 13 hours per week listening to radio. Ninety percent of people stated they listen to traditional radio while 53 percent said they listen to digital radio. Digital music consumption is on the rise.
- In 2010, the General Market spent just 24 minutes a day consuming non-voice media on their phones. In 2013, the rate catapulted to two hours and 22 minutes of mobile consumption (more than five times higher).
- Subsidy eligible and non-subsidy eligible ages 25-54 spend between 17-20 hours per week on the internet.

Multi-segment placements were made in television, radio, digital, social and search. Examples of Covered California placements include:

Latino Outreach

Latinos make up 40 percent of California's population and represent 38 percent of the subsidy-eligible population. In the 2017 open-enrollment period, Latinos represented 35 percent of subsidy-eligible enrollments. There are two distinctive groups in the Latino community: those who prefer to consume media in Spanish, and those who prefer to consume media in English. Covered California has been working with culturally competent staff and contractors who understand how to reach this community, including the advertising agency Casanova/McCann.

To better understand how to appropriately reach the Latino community, Covered California applies research findings to ensure its messages are appropriate for this community. Our research shows that:

- Latinos are less familiar with Covered California than other groups are.
- They are more likely to have looked into coverage but have not attempted to enroll.
- Though insurance was not a priority for them, it is a priority for their children to have health insurance.

Less acculturated Spanish-dominant Latinos have similar characteristics but show some important differences:

- Less likely to have had health insurance in the past.
- More likely to have tried to enroll in Covered California but did not complete enrollment.
- Issues with terminology and overwhelming confusion were a more significant hurdle.
- They are less concerned about having issues with their health and more confident in their ability to obtain health care elsewhere, such as in Mexico and at corner clinics.

Applying these findings, Covered California developed a paid media rationale to reach this group.

- There is dual consumption with higher engagement in-language.
- California Latino adults ages 25-54 spend 20+ hours per week watching TV.
- Over 90 percent of Latino adults 25-54 are reached weekly by radio. It is an efficient high frequency medium to help generate top-of-mind awareness among the Latino target.
- Latinos spend more time online — 3.5 hours per day on a home computer compared to 3.3 hours per day for non-Latinos.
- Sixty-nine percent pay more attention to ads created specifically for Latinos or ads created for the general population that include Latinos.

Spanish-language placements were made in television, radio, print, digital, out-of-home, social and search. Examples of Covered California placement in Latino-specific outlets include:

Spanish-Language Media Outreach
The Latino market is California's largest subsidy-eligible population, making it one of the most important. There is a three-pronged approach to reaching this community:

- Promote Covered California's mission through well-crafted messages for TV, print, online and radio.
- Partner with Spanish media to conduct phone banks and regional media tours.
- Sponsor health care roundtables with experts and clients who can share their experiences.

Asian-Pacific Islander Outreach
The Asian-Pacific Islander community (API) makes up 15 percent of the California population and represents 21 percent of the subsidy-eligible population and also the percentage enrolled in Covered California.

The API community is incredibly diverse, requiring specific outreach methods. Reaching the API community requires efforts in multiple languages.

Covered California has been working with culturally competent staff and contractors who understand how to reach this community, including Imprenta Communications and interTrend Communications.

To better understand how to appropriately reach the API community, Covered California applies research findings to ensure messages that are appropriate to this community. Research shows the following:

- Covered California as a government-funded program was seen as positive in these communities, whereas other segments do not see this as a selling point.
- "Name-brand insurance companies" resonated well.
- The API segment's strategy to avoid medical attention was to maintain a healthy lifestyle.
- Most insured API community respondents obtained their health insurance coverage through insurance agents who also provide them with home, auto or life insurance. They rely heavily on agents to do the legwork and make suggestions for them.

Applying these findings, Covered California developed a paid media rationale to reach this group.

- There is an affinity to in-language content, in both traditional and digital.
- Nearly 50 percent of the API community are dual-language TV viewers.
- While the API community are tech savvy, many still use traditional media such as TV, radio, and print to get culturally relevant entertainment and information.
- The API community is leading the digital revolution and 40 percent spend more time viewing streamed content than live video content (compared to 33 percent of the total population).
- Newspapers and magazines are widely read by the API community. Sixty-eight percent of Chinese and 66 percent of Koreans read their news through hard copy print.

Asian-language placements were made in television, radio, print and digital. Examples of Covered California placement in API-specific outlets include:

African-American Outreach

The African-American community makes up 6 percent of the California population and represents 5 percent of the subsidy-eligible population. In the 2017 open-enrollment period, African-Americans represented 4 percent of subsidy-eligible enrollments.

African-American outreach must take the following into consideration:

- When asked why they have not signed up with Covered California, many reported thinking they were not eligible.
- African Americans are also the most likely to rationalize that it is cheaper to pay the tax penalty than the cost of coverage.
- In the African-American community, building trust in government and Covered California is essential.

To better understand how to appropriately reach the African-American community, Covered California applies research findings to ensure messages that are appropriate to this community. Their research shows the following:

- Lean into culture — there is heavy consumption across channels.
- Ninety percent of African-Americans believe that Black media is more relevant to them.
- African-Americans watch TV more than any other group at more than 200 hours per month or 37 percent more than any other group.
- Radio is the leading medium reaching African-Americans ages 25 to 54 at 94 percent.
- Eighty percent of African-Americans are internet users.

African-American placements were made in television, radio, print, digital and out-of-home. Examples of Covered California placement in African-American-specific outlets include:

LGBTQ Outreach

The LGBTQ community is an important segment to reach. Covered California’s research shows:

- The message with the strongest resonance is that Covered California has knowledgeable experts who are part of the LGBTQ community who can help you choose and enroll in a health plan that best fits your needs.
- The Affordable Care Act coverage of many transition services (e.g. hormone treatments and transition surgeries) was respected by this group.
- It is important to use imagery and messages that are clear and unambiguously directed at the community in LGBTQ media. The use of LGBTQ imagery in mainstream media “thrills” them.
- The LGBTQ respondents felt that if they maintained a healthy lifestyle, they could avoid the need for medical attention.

Applying these findings, Covered California developed a paid media rationale to reach this group.

- Digital remains the core source of targeted content.
- The highest consumption among the LGBTQ community remains targeted content sites and blogs; 67 percent of gay men and 58 percent of lesbians.
- More than one-third of LGBTQ Web users said they have increased their visits to these sites in the past year.
- Forty-one percent of gay men had read LGBTQ email newsletters during the past week, and 50 percent had read regional LGBTQ publications.

LGBTQ placements were made in print and digital. Examples of Covered California placement in LGBTQ-specific outlets include:

Online Enrollment

Covered California has invested significantly into developing an online application that serves consumers' needs. Forty percent of consumers self-enroll through the online application.

In the last year, Covered California spent more than $65.2 million on information technology. The information technology budget is not a part of the marketing and outreach budget, but signing up is a critical function in enrolling consumers.

TABLE 15
Information Technology Spend in 2017

Total Information Technology Spend in 2017	**$65.2 million**
Percent of Spend to Premium	0.94%

Covered California's website, CoveredCA.com, was developed to serve as the first point of entry for Californians searching for information about Covered California and on how to enroll. The website includes a wealth of information to educate consumers on how to choose the best plan. The website is updated often to refine the consumer experience based on user testing.

As part of online enrollment, Covered California created a shopping tool that makes it easy for consumers to shop for and compare the best plan that fits their needs. The shopping tool allows consumers to review their plan options side by side.

Telling the Story of Covered California Enrollees

Covered California also works to tell the story of Californians who have benefited from a Covered California plan. All over California, people are getting access to the care they deserve through Covered California. In their own words, our members are sharing why health insurance is so important to them. Find them at: www.CoveredCA.com/real-stories.

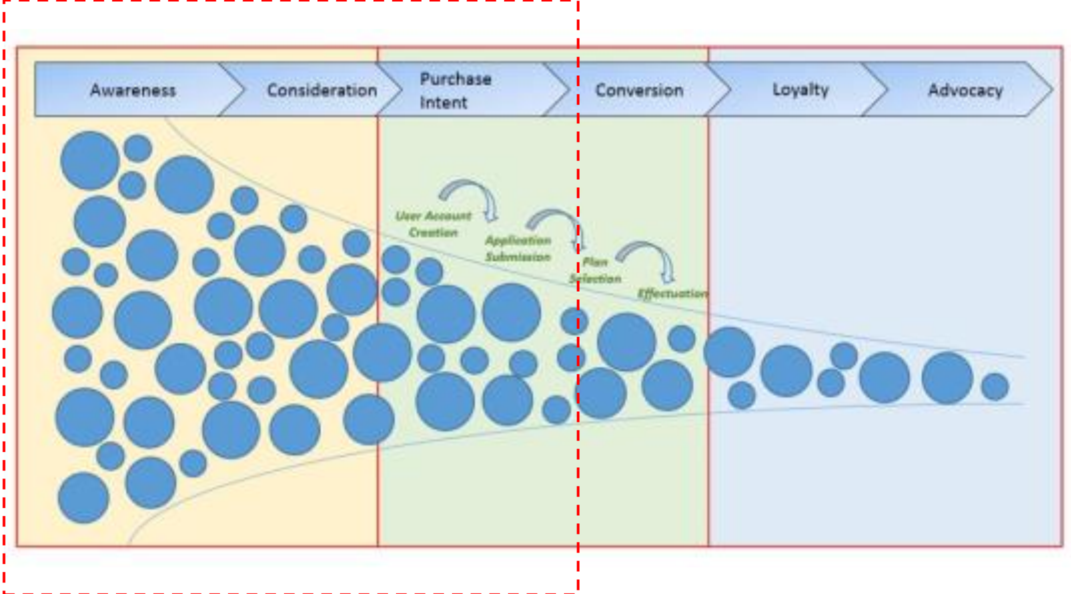
Helping and Encouraging Those Who Start Shopping

Covered California attempts to reach consumers in different stages of the shopping experience, or funnel, to make sure they are getting the information they need. Covered California's sales funnel consists of "prospects" who are in all stages of the consumer journey (see Figure 23: The Interested Consumer Sales Funnel Overview). The high funnel in particular consist of:

- **Awareness:** The prospect is aware that Covered California exists and has a general understanding of its services and products.
- **Consideration:** The prospect has a pretty clear understanding of what Covered California offers, and are considering themselves as potential consumers.
- **Purchase Intent:** The prospect has started the application process online and is on track to eventually select a plan. It is here where prospects straddle the line between the high funnel and low funnel.

FIGURE 23

The Interested Consumer Sales Funnel Overview



Funnel Communication examples:

COVERED CALIFORNIA | It's LIFE CARE.

ONE WEEK LEFT!

Dear **Shawna**

We know there is a lot of discussion in the media about the recent federal election, but rest assured, Covered California is still here for you. We encourage you to enroll in a plan that best fits your health care needs and to avoid the tax penalty, which will still be in effect for 2017. **Once enrolled, financial assistance and rates will not be affected for 2017 coverage.** Having health insurance in place to help cover the cost of 'life's unexpected moments' provides financial protection for you and your family and will give you peace of mind knowing you'll have it when you need it! We will keep you informed of any changes in the future.

You have until December 15, 2016 to enroll in a health plan for coverage beginning January 1, 2017. Log in to your Covered California account or Shop and Compare plan options in your area.

ENROLL

Need Help?

- **NEW:** Help on Demand - Have a Certified Enroller **CALL YOU** within minutes!
- If you need help, you can contact a Certified Insurance Agent or Enrollment Counselor for free assistance.
- You can also call the Covered California Service Center at 1-800-300-

COVERED CALIFORNIA | It's LIFE CARE.

Real Stories of Covered California

Life is unpredictable, it can throw something your way when you least expect it. Have you ever thought "it won't happen to me" or "I am healthy, so I don't need health insurance?"

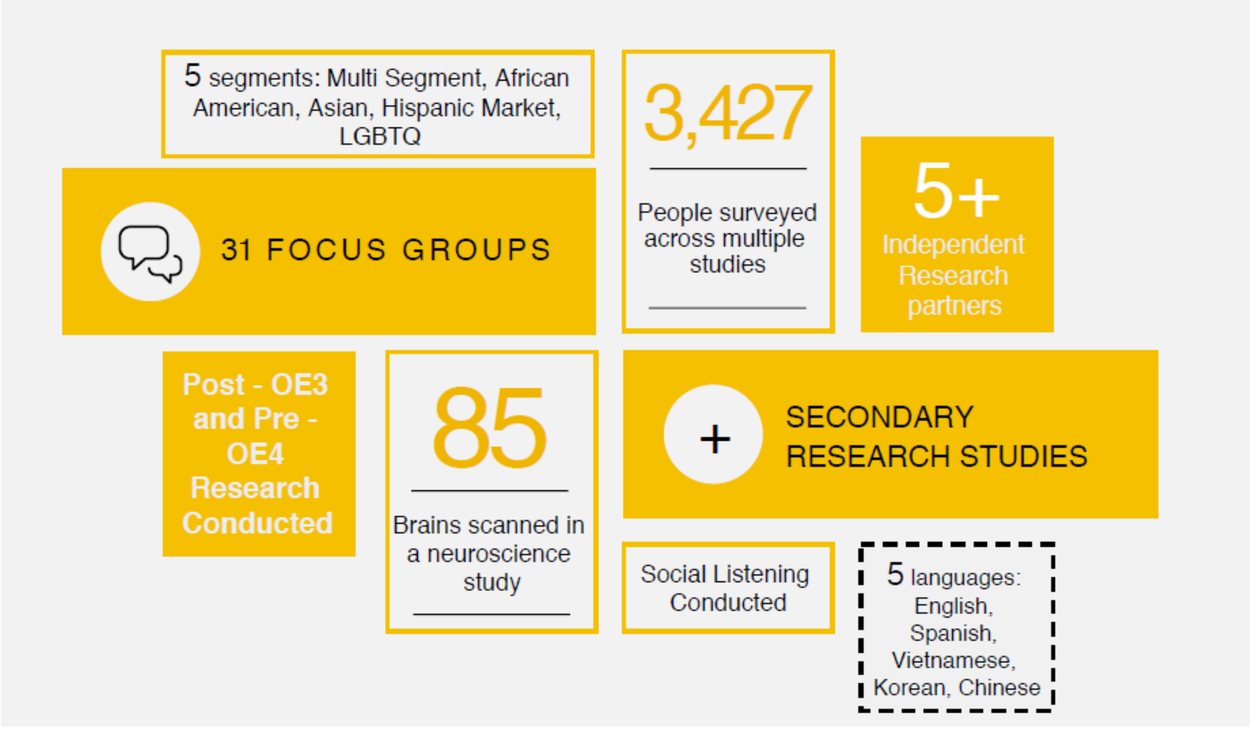
We never know what's going to happen day to day, and having a health plan in place to help cover the cost of the unexpected is a big reason people choose to have health insurance. This financial protection for you and your family will give you peace of mind knowing you'll have it when you need it!

These Covered California members' lives were changed when they received coverage and were brave enough to share their experiences with us. Watch the videos below and see what the unexpected could be like!

Retention Support

Covered California endeavors to maximize the retention and renewal of 1.3 million Covered California members, keep members insured and promote informed access and utilization of benefits. It aims to nurture leads with messages targeted to where they are in the enrollment process to help conversion through multiple touches.

Ongoing Research to Inform Marketing and Outreach Strategies



To help inform the fourth open-enrollment periods' creative efforts and planning, Covered California conducted qualitative and quantitative research with uninsured Californians in the multi-segment, African-American, Latino, API and LGBTQ communities.

Across all segments, the research found:

- **The new brand campaign, "It's life care,"** which emotionally conveys the value of coverage, tested very well.
- **The remaining uninsured are harder to convince** and they have found ways to cope.
- **Awareness of Covered California** is good, but there is still confusion about what Covered California is and what it offers. Audiences want specifics.
- **Affordability** is, by far, offered as the No.1 barrier.
- Consumers feel overwhelmed. **Health insurance is complicated,** and they face difficulties with the shopping and enrollment process.

The following are the top-performing message topics across segments and channels:

- Preventive care with specific examples.
- Availability of dental coverage.
- Health insurance at a lower cost.
- Choice of plans, including names of health insurance companies.
- Free expert help.

Research also identified key barriers and motivators for consumers. These barriers and motivators allow Covered California to best message to its consumers.

TABLE 16
Barriers and Motivators for Covered California Consumers[107]

Key Barriers	Motivators
Cost and Competing Priorities	Lower Cost
Lack of Basic and Specific Information	Preventive Care and Dental Coverage
Lack of Urgency/Need	More/Better/Consistent Coverage
Complicated Process	Peace of Mind
	Simplicity and Convenience When Enrolling

Covered California conducts and commissions a wide range of research and analysis to inform its marketing, outreach and enrollment efforts, including focus group testing, quantitative surveys, user testing and expert academic research. The following is a sample of some of the research conducted both to inform marketing, outreach and enrollment efforts as well as bring the best products to the marketplace:

- “An Integrated Quantitative and Qualitative Study on Post-Election Attitudes Toward Enrolling in and Renewing Health Insurance Coverage” (January 2017). Conducted by Covered California, this research analyzed sentiment among Covered California enrollees. (http://www.coveredca.com/news/pdfs/CC_Current_Sentiment_Topline_012417_FINAL.pdf).
- “Consumer Survey,” conducted by Covered California in October 2015. This survey found that 85 percent of consumers who move on from Covered California coverage remain insured, with 44 percent acquiring employer-based coverage, 16 percent going to Medi-Cal, 13 percent getting private health coverage, 11 percent getting another form of coverage and 15 percent becoming uninsured (http://hbex.coveredca.com/data-research/library/2015CA-Affordable-Care-Act%20Consumer-Tracking-Survey.pdf).

107 These key barriers and motivators were gleaned from focus groups conducted by Covered California in May 2016.

- “Consumer Tracking Survey,” conducted by the independent research organization NORC at the University of Chicago in October 2015. This survey showed that a third of eligible consumers still did not understand they could get help to buy health insurance (http://hbex.CoveredCA.com/data-research/library/2015CA-Affordable-Care-Act%20Consumer-Tracking-Survey.pdf).
- “Sorting out the Health Risk in California’s State-Based Marketplace” (Jan. 2015). The study was conducted by a team of researchers from the University of California, San Francisco; the Department of Health Care Services and actuaries from Covered California. The study appeared in the journal *Health Services Research.* An analysis of state data on health care usage by Covered California enrollees found that many were healthier and presented less risk to insurance companies than expected, helping drive down the cost of health premiums offered through the exchange in 2015 (http://escholarship.org/uc/item/3b490590).
- 2014’s “Lessons Learned” is a comprehensive overview of practices that worked and course corrections following Covered California’s first open-enrollment period (http://www.coveredca.com/PDFs/10-14-2014-Lessons-Learned-final.pdf).

September 29, 2017

Mr. Peter Lee, Executive Director
California Health Benefit Exchange Board
1601 Exposition Blvd.
Sacramento, California 95815

SUBJECT: **PROPOSED RULEMAKING: CALIFORNIA CODE OF REGULATIONS, TITLE 10, CHAPTER 12, ARTICLE 9: PLAN BASED ENROLLERS – MODIFICATIONS REQUESTED**

Dear Executive Director Lee:

The California Association of Health Underwriters (CAHU) is pleased to have the opportunity to provide comments regarding the proposed rulemaking changes in the California Code of Regulations, Title 10, Chapter 12, Article 9, noticed on August 25, 2017. These proposed regulations are to ensure that there is not a conflict of interest between Plan Based Enrollers (PBEs) and the services of other Certified Enrollers, including Licensed Certified Agents. CAHU believe that there are major clarifications needed before these regulations are adopted.

CAHU is the state's largest association of health insurance agents. Our licensed members provide reliable insurance advice, act as the consumer's advocate when dealing with carriers and provide a number of essential services relating to individual and group insurance coverage, post enrollment. Our members also act as a trusted and effective marketing channel for health information for all consumers and potential consumers of health care insurance coverage. Altogether, CAHU provides a unified voice for more than 32,000 California health insurance and benefit professionals throughout the state representing more than 15 million California health insurance consumers.

Nearly 15,000 Certified Insurance Agents (CIA's) are on the front-line for Covered California in every community in the state. Close to half of those enrolled in Covered California products were enrolled by CIA's during the 2015-16 Open Enrollment Periods. Licensed, certified health insurance agents' direct experience with consumers, small employers, their employees and families gives agents a unique understanding of what they want, need and find affordable. Agents are also there to provide on-going, personal support to their clients after they purchase their coverage and are not left to impersonal call center representatives when they have a problem or issue to resolve. Licensed, certified agent provide their services at no cost to the consumer.

CAHU believes there is a significant problem in the regulations and modifications needs to be made in both the Summary and the proposed regulation itself. The issue is the word "sell" and how it is used throughout the summary and regulation to describe the services of the plans based enroller and agents. Enrolling is all that PBEs are allowed to do for their plan employer. Agents are authorized under state law to sell insurance, and must pass knowledge tests, take ethics training, ensure continuing educations requirements are met, and if they wish to place consumers into Exchange Plans, must also become Certified Insurance Agents, which requires more education and training.

California law is very clear that only licensed life and health agents are authorized to sell health insurance. The summary and the proposed regulation need to change to comport with the California Insurance Code to ensure Agents are the only Certified Enrollers legally authorized to "sell" insurance. PBEs and other Certified Enrollers may not "sell" insurance to consumers--they enroll consumers. The entire summary of the proposed regulation mistakenly states PBEs "sell". That is factually incorrect. This inaccurate summary needs to be corrected before this rulemaking moves further toward adoption in order to avoid misunderstanding by both certified enrollers and consumers.

By statute, Insurance Code Section §1631, only licensed agents may sell insurance. Section 1631 reads, "*1631. Unless exempt by the provisions of this article, a person shall not solicit, negotiate, or effect contracts of insurance, or act in any of the capacities defined in Article 1 (commencing with Section 1621) unless the person holds a valid license from the commissioner authorizing the person to act in that capacity. The issuance of a certificate of authority to an insurer does not exempt an insurer from complying with this article.*"

This is why CAHU believes the wording in the proposed summary and rulemaking are inaccurate and the term "sell" is used inappropriately. Agents believe that the clarification on the differences between PBEs and other Certified Enrollers is an important clarification. The clarification ensures consumers understand that when using a PBE, they are offered enrollment in only the products offered by their PBE employer. For a PBE to do more would be actually soliciting to sell insurance and would require licensure by the Department of Insurance. Agents are concerned that consumers using a PBE will not have the option of enrolling in another QHP plan that may better suit their respective needs and budget.

Again, CAHU appreciates the opportunity to provide comments. We are available to discuss these concerns with you or your staff at your convenience. Please contact either Faith Lane or Juli Broyles at (916) 441-5050.

Sincerely,

Stephanie Berger
President
California Association of Health Underwriters

cc:
The Honorable Diana Dooley, Secretary, California Health and Human Services
Members, California Health Benefit Exchange Board
Jennifer Kent, Executive Director, Department of Health Care Services
Dave Jones, Insurance Commissioner
Robert Manzer, Covered California
Drew Kyler, Covered California
Kelly Green, Covered California

California Medical Association
Physicians dedicated to the health of Californians
1201 J Street, Suite 200, Sacramento, CA 95814-2906 • 916.444.5532 • Fax 916.444.5689

October 4, 2017

James DeBenedetti, Director of Plan Management Division
Covered California
1601 Exposition Blvd
Sacramento, CA 95815

Sent via email to james.debenedetti@covered.ca.gov

RE: Comments on Covered California's Passive Health Plan Replacement Policy and Proposed Regulatory Changes

Dear Mr. DeBenedetti:

On behalf of our more than 43,000 physician and medical student members, the California Medical Association (CMA) would like to provide our input on Covered California's passive health plan replacement policy and proposed regulatory changes. Anthem Blue Cross of California's (Anthem) withdrawal from 16 of California's 19 rating regions will cause health care and coverage disruption for thousands of patients. CMA supports Covered California's efforts to ensure coverage is maintained for patients who lose access to their health plan. CMA, however, has concerns with the disruption of patient care caused by Anthem's withdrawal as well as the passive health plan replacement policy and proposed regulatory changes.

Covered California's proposed regulation provides that, if the enrollee's current QHP or the issuer of the QHP in which the enrollee is currently enrolled is no longer available, the enrollee shall be enrolled in the lowest cost QHP offered by the same QHP issuer or offered by a different QHP issuer, respectively, that is available to the enrollee through the Exchange at the same metal tier, as determined by the Exchange on a case-by-case basis. CMA is concerned that not using additional criteria in the determination of replacement plans, such as product type and the availability of the patient's physician in the replacement plan, will cause confusion and disruption of care. Accordingly, to the extent possible, we urge Covered California to also take into account product type and the availability of the patient's physician in the replacement plan when passively renewing patients. Moreover, CMA urges Covered California to give patients time to actively select their own replacement plan and only automatically enroll them in a plan at the latest possible date that will allow for coverage to be effective January 1st. By allowing patients some time to select their own replacement plan will hopefully mitigate some of the confusion and disruption caused by the plan changes.

Covered California's proposed regulation also provides that when an enrollee dependent attains the age of 26 before the beginning of the following benefit year, the enrollee shall be enrolled in the lowest cost QHP that is available to the enrollee through the Exchange at the same metal tier. Again, in order to avoid plan confusion and disruption of care, we suggest that Covered California

give patients time to actively select their own replacement plan prior to automatically enrolling them in a replacement plan.

CMA submitted comments to Covered California on July 26, 2017 related to Covered California's provider directory. In those comments, we strongly urged Covered California to ensure the accuracy of its provider directory given that the purpose of the provider directory is to assist consumers with plan selection. CMA is reiterating the importance of an accurate provider directory especially when patients will be relying on the provider directory to determine which plan contracts with their physician when selecting a replacement plan.

Once a patient selects a replacement plan, to the extent possible, we strongly urge Covered California to require health plans to match patients with their existing primary care physician. We are aware that 84 percent of physicians contracted with Anthem are also available through another health plan in Covered California. Given that less than 100 percent of physicians contracted with Anthem are available through another health plan in Covered California, a number of patients will need to switch physicians causing disruption of care. We urge Covered California to clearly communicate well in advance to these patients that their physician is not available through another health plan in Covered California.

We also urge Covered California to communicate well in advance to physicians of Anthem's withdrawal from 16 of California's 19 rating regions and that this may result in patients switching physicians. Finally, we encourage Covered California to require the health plans to report to Covered California the number of patients that had the option to keep their primary care physician and that Covered California make these reports available to stakeholders.

*****

We appreciate your consideration of our input and look forward to working with Covered California and other stakeholders to minimize the disruption of care and coverage for thousands of patients. I can be reached by phone at (916) 551-2543 or by email at creyes@cmanet.org should you require any clarification or additional information regarding CMA's comments.

Respectfully submitted,

Catrina Reyes, Esq.
Associate Director
Center for Health Policy
California Medical Association