California Health Benefit Exchange: Stakeholder Questions

Assuring Maximum Enrollment – California Marketing, Eligibility, Enrollment, and Retention

OVERARCHING INPUT

Question #1:

Regarding your overall vision, hopes and aspirations for the expansion of coverage through the Exchange, Medi-Cal, Healthy Families and through private coverage in California, what are your perspectives on:

a. What would "success" look like in January 2014?
b. What would "success" look like in January 2016?
c. What would "success" look like in January 2019?

Comments	Organization
We are advocates for CalFresh, California's largest social service program, providing a debit card for grocery purchases to 3.7 million low-income Californians of all ages. Success would look like: a. <u>January 2014: On-Line Health Coverage & CalFresh Enrollment, Along with Targeted Referrals for Other Human Services</u>. • The Health Exchange is successfully launched for health coverage. • Consumers, after completing their health care application, will also have the option to: 1) use CalHEERS to apply for nutrition assistance through CalFresh, receive an eligibility determination for CalFresh, be mailed their electronic benefit card (if eligible), and receive seamless support for both health and nutrition; 2) be provided with targeted referrals to other social services, including their county welfare offices for CalWORKs and other aid, local WIC agencies, local child care resource & referral agencies, local help-lines and charities, volunteer income tax assistance clinics, and other appropriate connections necessary to health and wellness. • Planning and implementation for human services integration *beyond* referrals is underway on a two-year timeline, to maximize the federal funds available through December 31, 2015. b. <u>January 2016: On-Line Health Coverage, Nutrition Assistance, and Applications to More Social Services to Support Health</u>. • Consumers, after they have completed their health coverage applications, are not only able to apply and receive eligibility determinations for CalFresh; consumers also may have the option to complete and submit applications through CalHEERS for other major wellness supports -- including social services such as CalWORKS, child care subsidies, other cash aid, WIC and other nutrition programs, and working family tax credits like the EITC and child credit, among others – and be connected to the appropriate local services and offices for follow-up. c. <u>January 2019: One-Stop Shop</u>. • Consumers use the Health Exchange as a "one-stop shop" to access all health and wellness supports to which they choose to apply, allowing consumers to 1) "tell their story" once and 2) to communicate about their benefits in a seamless way through a range of channels, including on-line, telephone, mail, and local offices.	Alliance to Transform CalFRESH

All individuals and employers who want to purchase coverage through the CA HBEx are aware of the exchange and able to purchase ACA-compliant health plans offered by their carrier-of-choice in a "world class shopping experience." Those individuals and employers who still desire to purchase coverage off the exchange are not disadvantaged in doing so, beyond a potential loss of subsidy, and both marketplaces remain fair and competitive for the carriers serving them.	Anthem Blue Cross
b. Success in 2016: All of the above in (a) and in addition: 1) the website, application and vital documents would be translated into the top 20 languages, including the all of the Medi=Cal threshold languages. 2) There would be a very robust program of culturally and linguistically competent navigators, brokers, and certified application assisters. 3) There would be an expanded network of primary and specialty care providers who provide timely access to culturally and linguistically competent health care services. 4) There would be a comprehensive consumer protection program that would be broadly publicized and easily accessible so all patients would understand how to file complaints and/or any appeals process. 5) There would be an accurate and comprehensive data collection system with useful demographic information, including race, ethnicity, age, gender, oral and spoken language, disability, and other relevant data elements, with an explanation to those providing the information that the information is voluntary and would be used to address the needs of populations experiencing health disparities. 6) The population-based data would be available to the public in order for any interested stakeholder to monitor and evaluate the effectiveness of outreach efforts of the Exchange and others responsible for outreach and education to eligible populations, as well as to measure access to health programs and quality health care services and utilization of the programs and services. 7) The CalHEERS system would include horizontal integration of other social services programs, such as CalWORKS, AIM, etc. to link automatic enrollment into the appropriate health program and vice versa. c. Success in 2019: All of the above in (a) & (b) and in addition: 1) A truly universal, single payer health care system where all those in the state, including undocumented and all legal immigrants have access to quality health care services. 2) If we have not yet achieved a single-payer, universal health care system in California, the current health care system would be very easily accessible and navigable for every population, including vulnerable and health disparities populations, provide health insurance coverage for as many eligible residents as possible, and provide culturally and linguistically appropriate, quality health care services to those enrolled in any health plan or insurance product. 3) The network of providers would be robust and proved timely access to primary and specialty care providers. Health providers will share best practices and follow established standards of care. 4) The data collection system would measure the effectiveness of the health programs and plans, including increased access to services, increased prevention of chronic diseases, reductions in health disparities, and improved quality of care for all Californians.	Asian Pacific American Legal Center (APALC)
a. What would "success" look like in January 2014? • The Health Exchange is successfully launched, allowing consumers to enroll in health coverage online, by phone, and in person.	California Family Resource Association

- Consumers have local access to culturally and linguistically competent support from Certified Application Assisters (CAAs) and Navigators.
- The roles of CAAs and Navigators are well-defined and well-supported, including the training, technical assistance, and compensation necessary to make support accessible to all consumers.
- The foundation is laid for Family Resource Centers (FRCs) throughout California to successfully participate in education, outreach, enrollment, and navigation assistance for individuals and small businesses in their communities.
- Consumers have access to, and are successfully using, an established Medical Home and specialty medical care. Consumers are using the coverage to which they have gained access, and are receiving the high-quality care they need.
- Consumers are taking full advantage of the health care subsidies for which they qualify.
- FRCs and other Assisters are working with consumers in a strengths-based manner, which utilizes and builds upon the strengths of individuals and families in order to improve health and wellness outcomes.

b. What would "success" look like in January 2016?
- "Horizontal Integration" is fully implemented. When consumers access the Exchange, they are prompted to enroll seamlessly in the other health and human services that are essential to thrive. For example, CalFresh, CalWORKs, working-family tax credits, and other supports.
- FRCs and other Assisters are kept consistently up to date with current information and resources for serving consumers.
- FRCs are successfully assisting consumers with enrollment and navigation of the Exchange.
- FRCs are contributing to the retention of consumers in CALHEERS by providing ongoing, culturally and linguistically competent support and assistance to consumers in their local communities.

c. What would "success" look like in January 2019?
- FRCs in Navigator roles are providing education, outreach, enrollment, and navigation assistance to consumers, contributing to the retention of consumers in the Exchange.
- Horizontal Integration is fully implemented, and consumers are able to complete and submit an application for a wide range of non-health support services through the Exchange.
- All Californians who qualify for health coverage are enrolled, are actively managing their health, and are utilizing all appropriate subsidies available to them through the exchange and other health and human services programs.
- Health outcomes for Californians are measurably improved with a transformed health delivery system that focuses on wellness and prevention.

These comments apply to both the individual and SHOP Exchanges: a. The Exchange invests in and conducts outreach and education in multiple languages to maximize enrollment in 2014. Written documents are translated into Medi-Cal Managed Care Threshold languages and available on the Exchange website with links in at least 15 different languages to oral interpretation as needed. Information is provided at a 6th grade level in language that the community can understand. The Exchange contracts with and provides training for Navigators and Assisters capable of providing culturally and linguistically appropriate outreach and enrollment in the Exchange, Medi-Cal and CHIP. The state conducts a large and well-funded launch of the program in coordination with community-based organizations well ahead of the enrollment period in 2013. The Exchange, DHCS and MRMIB issue notices to the newly eligible in the LIHP, Family PACT, AIM and other public programs about the availability of coverage. The notices include referrals to safety-net services for those ineligible for coverage in the Exchange due to immigration or other status. There is an easy, clear, multilingual process set-up for those who will be requesting exemptions from… (comments cut off on PDF). b. The majority of those newly eligible for coverage in Medicaid and subsidies in the Exchange are enrolled. Immigrants from mixed status families and Limited-English-Proficient (LEP) consumers are able to navigate easily through the Exchange to get coverage for themselves and their family members. The state is able to effectively track which populations are being enrolled in health coverage by race, ethnicity, primary language and geographic region and has in place a robust plan to target outreach to hard-to-reach, under-enrolled populations. Consumers have timely access to care and consumer assistance through Assisters and the Exchange Navigator program. The state has put into place an effective appeals process that is culturally and linguistically appropriate so when people have problems enrolling they know where to go. The state has developed a fully functioning IT system that includes horizontal integration of human services programs with health coverage enrollment. c. The majority of those eligible for subsidies and Medicaid including hard-to-reach populations are enrolled in health coverage. Immigrants from mixed status families and Limited-English-Proficient (LEP) consumers are able to navigate easily through the Exchange to get coverage for themselves and their family members. There is a clear reduction in health disparities in our state. Enrollment numbers are large enough that the Exchange has the leverage to be an active change agent to improve quality, promote prevention and wellness and eliminate health disparities in our state.	California Pan-Ethnic Health Network (CPEHN) and Having Our Say Coalition
In 2014 and beyond, success would look like 90% of all eligibles are enrolled with satisfactory utilization. Utilization being defined as appropriate to maintain preventive health and manage chronic issues.	Children's Health Initiative of San Joaquin County
2014: • A strong brand name that establishes a positive image and vision and mission of the Exchange and CalHEERS; foundational structures in place, including IT system, which allows pre-population/smooth	Consumers Union

shared information among CALHEERs agencies (and other agencies such as EDD, etc.); a robust public education campaign in place, executed with community-based assisters; at least 1 million enrollees have been enrolled and will have had a positive consumer experience around both eligibility and enrollment (e.g. re. phone lines, friendly, timely service) etc.; establish measurements and begin documenting at plan level and aggregate a wide variety of metrics to evaluate success; wide public knowledge of Exchange's role in the marketplace and a positive impression of the Exchange.. Hard to reach populations successfully engaged. 2016: • Five million enrollees in the Exchange, including in SHOP, and smooth system functions for eligibility and enrollment determinations and consumer assistance; some horizontal integration between public programs (CalFresh, etc.) and the Exchange; high trust with the public as evidenced by surveys/polls; information on cost containment in the system gathered by Exchange about plans; risk adjustment/single state pool successfully implemented; California able to assess and evaluate metrics and respond with policy positions to enhance or improve the system; California metrics evidence that health reform is reducing the rise of health care costs; no evidence of adverse selection; Exchange is self-sustaining. 2019: • Low rate of uninsured Californians, lowest rate in the nation; full enrollment of all people eligible in Exchange, Medi-Cal and Healthy Families populations; high retention rates, health of Californians improved by specified measures; cost controls in place, metrics improving; no adverse selection.	
CVS Caremark supports access to quality, affordable coverage for all Americans. As such, we believe that success will be achieved by enrolling the maximum number of individuals / households eligible to receive coverage through the Exchange, Medi-Cal and Healthy Families. To achieve this in January 2014 will require a number of critical success factors, including but not limited to the following: • Multi-channel and multi-lingual public awareness campaign • A robust network of navigators and consumer resources • Individual understanding of penalties, subsidies, and benefit options and terms • Sustained employer coverage in the state to the extent possible • Expansive set of on-exchange choices balancing richness and restrictions to allow individuals to select the most appropriate plan to meet their individual needs • Innovative plan designs, such as restricted networks • Affordable coverage options for consumers • Balanced risk pool to ensure a stable marketplace for health insurer • Robust monitoring and measurement system to assess performance and progress of Exchange against key criteria and to promptly identify necessary changes for subsequent years	CVS Caremark

b. What would "success" look like in January 2016? As time passes, CVS Caremark believes that success will involve the Exchange providing greater access to healthcare, as measured by the enrollment of eligible individuals. In particular, this is likely to entail some of the following: • Retention of newly covered lives • Continued promotion of Exchange benefits to support addition of incremental lives • Competitive marketplace among health insurers • Minimized / optimized health insurance premiums and overall system costs, which would be valuable for both consumers and assist California in achieving long-term financial viability c. What would "success" look like in January 2019? As the Exchange evolves, we expect that the offerings of qualified health plans will become more innovative, further expanding choice and driving down costs for consumers. In addition, we believe that a successful Exchange will begin to provide ancillary products and services that will improve health outcomes for consumers. For example, dental and vision insurance, wellness programs, and gym memberships could be attractive to consumers and would help to fulfill the goals of the Exchange. The Exchange itself should also evolve. For example, creating a protocol or interface to seamlessly transition Employer lives that enter onto the Exchange beginning 2017 will maximize success for this new Exchange population. Furthermore, we know that the prescription drug benefit can be an important component of an insurance plan design, and the Exchange should contemplate how to offer it within the initial design. In the later years, we can envision even more information being provided at the point of enrollment, as consumers gain comfort around the Exchange mechanism and its offerings.	
a. Specifically in 2014, success would look like a California Health Benefit Exchange that offers access to both mandated children's benefits and optional adult coverage through a healthy mix of both stand-alone dental policies offered by dedicated dental-only specialists, and full service health plans, with both types of issuers engaged in healthy competition to offer those benefits through the exchange. A web portal where both medical-only and dental-only policies are easily compared and selected based on price and available dentist network, with premiums, tax credits and federal subsidies for those who are eligible seamlessly allocated and facilitated through backend processes that are invisible to the subscriber, yet easily accommodated using basic programming logic. The exchange should both offer the essential pediatric dental benefit as well as accept an individual's existing family dental coverage outside the exchange as satisfying the essential benefit requirement in order to allow families to keep their current family dentist. b. Moving towards 2016 through 2018, we see success as an outgrowth of an evolving consultative process whereby dental policy issuers work closely with exchange staff to refine and improve exchange dental products and streamline administrative processes so as to increase affordability and reduce administrative expense. Success would also include increasing access to children's dental care through Healthy Families, increasing access to adult dental coverage through Medi-Cal, and	Delta Dental

reducing the impacts of "churn" on beneficiaries that move in and out of these programs, and into and out of the commercial dental programs available through the exchange. c. Ultimately, as the Exchange gains experience, success would reflect increasing volumes of individuals and small businesses gaining access to pediatric and adult dental care both inside and outside the Exchange marketplace. As individuals obtain and keep coverage, they will learn more about dental care techniques and about the connection between oral health and overall health.	
a. Success in 2014 would mean that there is 50% enrollment for those eligible into the Exchange and Medi-Cal, individuals are able to learn of their eligibility status and enroll in real time, and the Exchange is linked among other HHS systems/programs (i.e. social security agency, edd, etc.). Also, a robust and coordinated system of well-informed Navigators is in place. b. Success in 2016 would mean that there is 85% enrollment for those eligible into the Exchange and Medi-Cal, individuals are easily able to transition between health insurance programs, and programs are linked so that individuals no longer have to submit paper forms when unnecessary. A "culture of coverage" exists, meaning that those responsible for enrolling individuals assume that individuals are eligible for some form of coverage, rather than focusing on the services that people are not eligible for (See: Enroll America, Ten Ways to Make Health Coverage Enrollment and Renewal Easy). Also, a coordinated navigator program that employs navigators who are representative of communities of color, accessible to communities of color, and knowledgeable of the needs of communities of color should be in place. c. Success in 2019 means that there is 100% enrollment of those eligible into the Exchange and Medi Cal, the Exchange is fully utilizing all technology needs for enrollment, a strong "culture of coverage" exists amongst Californians. Marketing, Promotion and Outreach: 1. Partner with existing organizations already working with non-English/monolingual speakers. 2. Ensure you are employing a robust system of navigators that are familiar with the language and culture of the community. 3. Utilize ethnic media, but first determine which ethnic media outlets are most often utilized within the community. 4. Need to meet Medi-Cal standards for threshold languages for everything being developed. (See: Kaiser Family Foundation http://www.kff.org/medicaid/upload/Connecting-Eligible-Immigrant-Familiesto-Health-Coverage-and-Care-Key-Lessons-from-Outreach-and-Enrollment-Workers-full-report-pdf.pdf.) 5. The literacy level of all educational and application materials should be low (5th grade level). Also, the application should be easy and simple to complete. (See: Kaiser Family Foundation: http://www.kff.org/medicaid/upload/Connecting-Eligible-Immigrant-Families-to-Health-Coverage-and-Care-Key-Lessons-from-Outreach-and-Enrollment-Workers-full-reportpdf.pdf.)	The Greenlining Institute

a. In January 2014, "success" would include the following milestones: (a) Enrollment, Eligibility and Retention system is fully set up with seamless connection with other public health coverage programs; (b) the Exchange products are affordable (less expensive than private markets); (c) Distribution channels (for outreach and enrollment) are fully identified and approved; (d) all other operational support systems are set up; (e) populations who are pre-identified as eligible for the Health Exchange or Medicaid expansion (e.g., parents of the children enrolled in the Healthy Families program, parents of children who are on the Medi-Cal Percent of Poverty category, parents who have children only enrolled in Medi-Cal, etc.) are notified and most of them have already enrolled; (f) existing public program enrollees (e.g., LIHP, AIM, PCIP, etc.) would be auto-enrolled in their new programs and be notified; (g) other uninsured populations are aware of the program and know the benefits of the program; and a significant number of them start to sign up. b. In January 2016, "success" would include the following milestones: (a) All operations systems are stable and refined with lessons learned from the previous two years; (b) Health quality, health outcome, and other performance measures are fully defined and implemented; (c) more than 50% of the eligible population are enrolled; (d) products offered are more affordable; (e) significantly influenced the market's general insurance premium rate; (f) conduct a preliminary assessment of the Exchanges' values according to the work and results of the previous 2 years; (g) gain public trust; (h) establish a strong partnership with health plans, providers, communities, etc. c. In January 2019, "success" would include the following milestones: (a) All operations systems continue to be refined with lessons learned from previous five years; (b) Health quality, health outcome, and other performance measures are fully implemented and evaluated; (c) more than 75% of the eligible population enrolled; (d) The Exchanges' values are fully delivered.	Inland Empire Health Plan
Given California's diverse populations across the state, counties know the best way to meet needs which vary from person to person. Offering multiple pathways to assistance for children, families and individuals has cut the red tape, removed roadblocks, and reduced the need to visit an office. Whether it is online, over the phone, by mail, or in person for more complicated cases, counties are promoting ways to achieve better service delivery and greater efficiency in meeting people's needs. These services include customized assistance to specific populations such as: a. Translation services for non-English speakers, b. Cultural competency to provide modified delivery of service to an array of: o Age groups, o Racial/ethnic groups, o Educational/literacy levels, and o Individuals requiring special accommodation. c. One-on-one education through the application process for customers who are new to the human services system. d. Established access in rural areas to provide services to high need populations. e. Online Click-to-Chat option available for hearing impaired in addition to traditional TTD services.	San Bernardino County

a. The Santa Cruz County LIHP program will have successfully transitioned LIHP clients to the Medi-Cal program. The existing Santa Cruz County Healthcare Outreach Coalition will have been trained on and operationalized the outreach and enrollment process determined for the Exchange. Santa Cruz County Human Services Department will have an outreach plan in place to ensure that CalFresh and General Assistance clients who are potentially eligible are aware of healthcare expansion and are assisted with enrollment. b. Increase in Santa Cruz County residents having health care coverage. % COULD BE ADDED.	Santa Cruz County
To minimize barriers to enrollment and to ensure a "one-stop" approach for families with individuals eligible for different health insurance programs, create one centralized electronic system for determining potential or final eligibility for a range of available programs. Success at any point in time should be rooted in: (1) public and eligibility population awareness of HBEX, (2) number of uninsured enrolled in available programs (unemployed and employed), (3) public feedback and applicant and enrollee satisfaction, (4) the application completion rate, (5) the average duration between when an application is initiated on-line and an applicant is enrolled, and (6) re-enrollment and retention statistics.	San Francisco Department of Public Health
a. A successful SHOP Exchange in 2014 will have a smooth launch that provides a good user experience to its initial customers - and will be offering something distinguished from the outside market. These initial customers will begin to tell their peers about the SHOP and participation will grow. Brokers, navigators and other trusted small business channels will be board to assist the exchange in an aggressive outreach campaign targeted at both businesses that currently offer, and those that do not offer insurance. b. By 2016, the SHOP enrollment should be growing as small business owners are hearing positive feedback from their peers and are enrolling. A successful SHOP would have looked at lessons learned over the first two years of operation and made the necessary adjustments to meet the needs of small business owners. c. In 2019, a successful SHOP will continue to see increases in enrollment and should by now be offering additional administrative services that its customers have expressed an interest in having. The Exchange "brand" should be understood by small business owners as an avenue to purchase affordable coverage in a hassle-free manner.	Small Business Majority
Under the Affordable Care Act (ACA), California has the unprecedented opportunity to construct a smart, efficient, consumer-centered system for connecting people with appropriate health care coverage. Ultimately, California's success (whether in year one, or after two to six years of operation) in achieving this goal must be measured in terms of the number of people who are able to purchase and maintain coverage, thereby decreasing the state's uninsured rate and increasing positive health outcomes for its residents. However, success must also be demonstrated in how well the "system" works for consumers. In that regard, the ACA sets a high bar, calling on states to build a first-class consumer experience with a "high level of service, support, and ease of use, similar to that experienced by customers of leading service and retail companies and organizations." While consumer confidence can be built over time (and different outcomes may be expected in later years), getting it right out of gate will be critical to setting expectations for an efficient	The 100% Campaign

and workable system. As such, when the doors open in 2013, success will mean that consumers can: • Access the enrollment system through many doorways, being able to choose the location and method that best suits their needs (whether online, by mail or phone, in person, or through gateways) in addition to obtaining consumer assistance at any juncture. • Apply for coverage using a clear, logical, and user-friendly application requesting the minimal amount of information required, being screened for all available health coverage programs, and being referred to other health and human services programs, if applicable. • Receive real-time enrollment and automatic renewal using data available from electronic databases, in a way that is transparent and eliminates the need for unnecessary paper documentation. • Manage health care enrollment for all family members across programs in a single online location that allows for comparing and choosing a plan, paying premiums, and reporting a change of circumstances, with seamless transfer between programs, if applicable. More specifically: 1a.) Success in 2014 will feature: eligibility and enrollment system that has pre-enrolled people since Oct 2013; successful outreach and education methods ensuring that consumers know about ACA opportunities, have a positive view of it, are anxious to enroll AND know how to access enrollment whether by web, phone or in person; planning in place for further integration of eligibility and enrollment systems among human services and income support programs. 1b.) The state has until December 2015 to get federal 90/10 funds to integrate CalHEERS with other systems. By 2016, we expect consumers applying and seeking other help are easily given options to enroll in health coverage. For example, people come to CBOs, 211s, etc. seeking help with other problems. If the state invests time and resources so people only have to go through eligibility process once, it will speed up the enrollment process. By 2016, we also expect technological and human systems will have been changed to facilitate enrollment, starting with CalFresh and CalWorks and eventually expanding to childcare, EITC, WIC, etc. By 2016, we hope state laws on eligibility requirements have been changed where needed. 1c.) By 2019, we envision 90% of the 5 million uninsured are covered. All systems are appropriately up and running, integrated enrollment with public benefits is working successfully and retention issues have been resolved.	
One of the most important factors for Exchange success is meeting the decision-making and implementation milestones in a timely manner to be prepared for the January 1, 2014 start date. It is expected that California must submit its certification plans to HHS by Fall 2012 to be eligible for HHS certification by January 1, 2013. Implementation is expected to begin in January 2013 to support an October 1, 2013 start date for open enrollment and a January 1, 2014 deployment. Additionally, in the first quarter of 2013, health plans must also be able to start applying for Qualified Health Plan (QHP) certification. Final federal and state rules for Exchange QHP requirements, products, enrollment, operational structure, etc. are required for plan decision making on Exchange participation and readiness. The January 1, 2014 timeline was aggressive as passed, and the need for federal rules on a variety of Exchange subjects is creating additional pressure. Any efforts the Exchange can make to expedite the decision-making and implementation process will be very useful. Another significant success factor is a positive consumer experience. The Exchange should work	UnitedHealthcare

collaboratively with issuers to reach out to individuals, families and small businesses and provide consumer friendly tools and information. Additionally, a smooth data transfer process will help facilitate an eligibility and enrollment activities in a timely manner. Exchanges should be designed to maximize choice and competition both inside and outside the Exchange marketplace. To achieve this, Exchanges should be set up in a manner that: • Develops fair and efficient markets; • Promotes competition, choice and innovation in product offerings; and • Encourages participation while preventing adverse selection. The California Health Benefit Exchange and issuers share an interest in encouraging eligible individuals, families and small businesses to obtain and maintain continuous coverage. A broad choice of issuers and health plans will help encourage initial and continued participation by consumers in the Exchange; in a competitive Exchange environment, issuers will be competing on price and quality, and they will strive for innovation and improvement to differentiate their products. The California Exchange should promote innovation and provide the flexibility for issuers to develop plan benefits that consumers both want and can afford. This approach will help preserve affordability while still giving consumers choice, control, and an ability to purchase different levels of coverage. Concerns regarding the simplicity of the consumer experience are best addressed through advanced filtering and search technology to help consumers narrow the number of insurance products to those that best meet their particular needs. Participating issuers should be encouraged to differentiate their QHP offerings to appeal to a wide variety of consumers and employers with different needs and preferences, while remaining consistent with federal standards regarding Essential Health Benefits and specified actuarial values. For example, at a particular actuarial plan value (e.g., Silver), some consumers and employers might wish to purchase a high deductible health plan that would be compatible with a Health Savings Account, while others may prefer a plan that offers more first-dollar coverage of pharmacy benefits and lower deductibles. As long as both types of plans are certified as being actuarially equivalent, Exchanges should promote this flexibility to advance consumer choice. Factors for actuarial equivalence should focus on certification by a qualified actuary prepared in compliance with the standards of actuarial practice, state law and regulations, and an appropriate tolerance level for the size of the book of business and fluctuations in trend and utilization. To the extent allowed by federal and state law, issuers should have the flexibility to determine which metallic actuarial levels they will offer and the number of plans per metallic level within the Exchange. Exchange contracting requirements beyond those specified under existing law may limit innovation and discourage a broad range of issuers from participating. Additional Exchange contracting criteria will add to issuers' administrative costs and increase premiums both inside and outside the Exchange, since the Affordable Care Act requires that issuers charge the same premium rate for plans offered inside and outside the Exchange.	

MARKETING, PROMOTION AND OUTREACH

Question #2: In addition to the potential market segments noted above, what are potentially important ways marketing and promotion should be segmented?	
Immigrants comprise more than one quarter (27%) of California residents. For children, the proportion (41%) is even higher. Most non-citizens (70%) live in households that also have citizens. About 75% of non-citizen Latinos live in households with citizens and about 60% of Asian non-citizens live in mixed-status households. Citizens, legal permanent residents including refugees and asylum seekers are eligible for coverage in the Exchange, Medi-Cal and Healthy Families making them and their noncitizen households an extremely important market segment. This population may be less likely to enroll due to lack of information as well as concerns about the impact of enrollment on immigration status. The state should consider specific strategies and best practices in terms of marketing to this population. The state should also target education and outreach efforts to low-income, foster youth, homeless, and the formerly incarcerated to ensure they are aware that they may be eligible for health coverage in the Exchange or Medi-Cal.	CPEHN and Having Our Say Coalition
Some important factors that marketing materials should encompass are that materials need to be written in plain language in all languages; visual icons should be added when doing so will enhance message clarity; messaging should be developed to account for those who may enthusiastically embrace the Exchange as well as for those who may feel forced.	Children's Health Initiatives of San Joaquin County
• Young adults. This population is not likely to purchase health insurance on their own but may be unemployed or underemployed, making them eligible for either Medi-Cal or subsidies in the Exchange. Additionally, those who are under the age of 26 may not be aware of the ACA provision allowing them to stay on their parent's plan. An explanation of this provision should be included in all marketing aimed at young adults under 26. • Caretakers of elderly parents. This population spans all demographics and due to caretaker obligations, this population is usually unable to obtain any type of consistent full-time employment. Additionally, members of this segment are often too young to qualify for Medicare. • The unemployed (especially those not already linked to a public program). With an unemployment rate in California of 11.1%,1 this population is either using or is soon to run out of COBRA benefits, paying on a fee-for-service basis for healthcare or delaying care because of the cost. Because of their lack of employment, this population would be eligible for Medi-Cal or subsidies in the Exchange. • The under-employed and self-employed (e.g., laborers/handymen, domestic workers, clerks, restaurant workers and owners of small retail stores). Many of these individuals are not likely to afford health coverage and where some may receive healthcare for their children via public programs, their income could put them over the current income level for eligibility in Medi-Cal. • Homeless population. Los Angeles County alone is home to an estimated 51,000 homeless individuals, with more than 62% of the population between 25-54 years of age.2 Partnerships with agencies particularly serving this population, including local shelters, health centers, social services agencies and advocacy organizations will be crucial to ensuring that this Medi-Cal eligible population enrolls in and continues coverage. • Populations with specific health conditions (e.g., sickle cell, HIV/AIDS, diabetes, childhood asthma). Because	Community Health Councils

of their need for specific medical treatment, this population can take comfort in having access to health coverage and in no longer being denied coverage. The State could work with providers that address these illnesses to ensure their clients are linked to enrollment in either Medi-Cal or the Exchange.	
With so many newly covered lives falling into Medi-Cal, and with branding questions open, the Exchange needs to better understand the public's view of Medi-Cal vs. private insurance. Public programs may hold a stigma for middle-income populations, as well as small business owners. It makes sense to test middle-income, and not just low-income, perceptions including the currently insured. We cannot assume all uninsured are low-income (consider the self-employed). There is a need to engage trusted messengers as "foot soldiers" to help with education and outreach, test messages with a diverse group of community leaders. Women, as family health managers, hear messages differently, so breaking out by gender may make sense. In addition, testing partner audiences (insurers, brokers, HMOs, a wide array of providers, hospitals and health systems, clinics and other delivery sites, pharmacies, business and trade organizations, labor groups, and religious leaders) would be beneficial. Previous study segmentations done for similar roll-outs of new public programs or by private parties (e.g. nonprofits' messaging work on ACA) if available to the state, may be useful to review. Look forward to obtaining data similar to work developed by Weber Shandwick for the Maryland Exchange. Build on work developed in Massachusetts. Evaluations of prior outreach and marketing efforts done by or for various foundations may have helpful findings. See, e.g., the evaluations attached to CU's cover letter.	Consumers Union
The Exchange might also consider segmenting individuals with chronic disease as an additional cohort. These individuals have the greatest need for health care, but may have inconsistent or limited experience with health insurance to date. Another relevant segment could include individuals who are high utilizers of healthcare. Similar to those with chronic disease, these individuals may be in great need of health insurance, but may have unique relationships with the health care system that should be considered when marketing to these individuals.	CVS Caremark
Segmentation of Marketing: 1. Work with regional ethnic chambers to reach ethnic small businesses. 2. Utilize similar tactics like the "Text for Baby" campaign at bus stops is a great way to reach underserved and LEP populations. (See: http://www.text4baby.org/index.php/partnerresources/2-uncategorised/105) 3. Provide taglines in Medi-Cal Managed Care threshold languages for people to find ways to access more information 4. Use social networking sites such as Facebook and twitter. (See: The Greenlining Institute: iHealth: How to Ensure the Health Benefit Exchange Reaches all Californians). 5. Provide the outreach materials to various sources, for example, partner with schools (during enrollment), community clinics, emergency rooms, churches, any information going out to students at community colleges and seniors at 4 year institutions (See: Kaiser Family Foundation http://www.kff.org/medicaid/upload/Connecting-Eligible-Immigrant-Families-to-Health-Coverage-and-Care-Key-Lessons-from-Outreach-and-Enrollment-Workers-full-report-pdf.pdf.)	The Greenlining Institute

In terms of the populations outlined in "A – G" above, community-based organizations and existing local programs have been successful in building trust in less historically-targeted communities. This includes organizations that have bilingual and bicultural staff, those that have expertise in enrolling families and children in different public programs and can discuss those options with families, and those that understand the requirements necessary for different programs. Most importantly, these locally-based groups can present these individuals and families with information they can understand, through either oral or written communications. Persons with disabilities and/or mobility limitations, persons living in mixed-immigration status families, and homeless people should be specifically targeted.	Health Consumer Alliance
Market segmentation is an effective way to reach out to different populations with different characteristics. However, keeping the number of different market segments to an optimum level will be more effective and will avoid messaging confusion. We recommend having two different marketing and outreach plans - one for individual and one for SHOP. For the Individual market, the cultural & linguistic sensitivity factor and regional difference factor should be included in all marketing activities. Across this marketing spectrum, communications and support materials must be simple to understand. In addition, the Individual market could be segmented in the following categories - (a) individuals who currently have an established interaction with state/county public programs such as parents of the children enrolled in the Healthy Families program, county MIA/LIHP/CMSP participants with income above 133% FPL, AIM, PCIP, etc., (b) uninsured individuals who will likely have contact with state/county in the near future. For example, when they file their income tax during the first quarter of the year; (c) individuals, who do not have affordable employment-based coverage, and (d) individuals who are difficult to reach or we do not have a point of contact.	Inland Empire Health Plan
M&O via libraries and school nurses could take special campaigns, respectively. Another small but crucial channel: bankruptcy attorneys and court personnel: people applying due to medical expenses are ripe customers, I would think. M&O to the non-computerized population will be hard as you know so this is a "market" to be segmented all by itself. M&O via libraries and school nurses could take special campaigns, respectively. Another small but crucial channel: bankruptcy attorneys and court personnel: people applying due to medical expenses are ripe customers, I would think.	Lucy Johns, MPH
Promote the no-wrong-door approach currently set by counties. The system works. One application to different programs. Let counties and the State determine eligibility without having the customers figure out which program(s) they need to apply. • One application allows screening to multiple programs. • Simplify access with self-service/online applications. • Customized/targeted situational marketing based on specific population groups. • Open Local Access to Exchange: All counties should have a link to the HBEx.	San Bernardino County
• Families • Individuals • Young adults who think they are invincible and may not see the value in health insurance • Earlier messaging in the schools. Make health care coverage an expectation for kids, a rite of passage, and a major benefit.	Santa Cruz County

Marketing should be targeted to minority-owned businesses, many of which may have never offered coverage for their workers and may prefer to communicate in a language other than English. Marketing should also be aimed at "hard to reach" businesses that do not spend the workday in an office such as farmers and construction firms.	Small Business Majority
Question #3: What are the top activities you think of in terms of marketing and outreach for the Exchange, Medi-Cal, and Health Families?	
To reach members, use marketing channels that are already in place including: providers, brokers/agents, employers, and direct from health plans to members. In addition, HBEx should use direct marketing via mail and email. To facilitate this, email addresses should be captured at all entry points and health plans should be able to acquire, within normal business or FCC guidelines, lists from which to direct market.	Anthem Blue Cross
Family Resource Centers (FRCs) and Family Strengthening Organizations (FSOs) should be key partners in outreach and education activities around the Exchange, especially to ensure that low-income and minority populations are effectively reached. FRCs/FSOs have a wealth of experience educating and enrolling low-income and minority populations in a variety of health and human services programs. Their expertise and existing relationships with key populations enable them to effectively market the Exchange to key audiences, and will serve as an asset to the Exchange throughout the implementation process. In addition to building ongoing relationships with individuals and families, FRCs/FSOs also engage in community-building, education, and outreach activities that reach members of the community that are not adequately reached through traditional or mainstream channels. For example, FRCs/FSOs often work with television, radio, and newspaper outlets that target members of a specific community, such as minority, immigrant, or ESL/monolingual communities. FRCs/FSOs also establish relationships with schools, health centers, religious centers, and other community institutions that allow them to engage in effective outreach that finds and engages people where they are. Many newly-eligible individuals will also prefer or require a local, face-to-face point of entry into the Exchange. FRCs/FSOs are proven effective resources for those whose access to services is constrained by factors such as limited health literacy, rural location, frequent churn, lack of computer/phone access, cultural/linguistic barriers, reticence to work directly with government entities, etc. In a state as diverse and complex as California, it is crucial that education and outreach activities around the Exchange are tailored for each unique audience. Leveraging the existing local relationships and expertise of community-based organizations will enable the Exchange to reach this goal, and ensure maximum enrollment by January 1, 2014. FRCs/FSOs are uniquely positioned to support this strategy and enable the Exchange to avoid the pitfalls of a 'one-size-fits-all' approach to marketing.	California Family Resource Association
The Exchange should engage trusted community partners in marketing to consumers about the Exchange. This could include testimonials from people who have benefited by coverage. Marketing should begin as soon as possible to deter deceptive marketing scams aimed at taking advantage of vulnerable seniors, disabled, Limited English-Proficient (LEP), immigrants and communities of color who may not know about the law and their rights as consumers. Exchange materials should be branded with an official seal or look to deter false advertising. Outreach	CPEHN and Having Our Say Coalition

and marketing should be done through cultural brokers in the communities, who are trusted resources, either as health promoters, promotoras, faith based organizations, schools or other community organizations. The state should work with Navigators and promotoras to conduct focus groups with diverse communities in multiple languages in order to design effective marketing campaigns. As part of the roll-out of new health coverage options leading up to 2014, the Exchange should develop an "enrollment corps" that could travel around the state, with laptops and phones to enroll people at events and fairs similar to U.S. Census volunteers. Other suggestions include using e… (comments cut off on PDF).	
Leverage existing channels that are mandatory by nature especially official processes that attract large populations such as DMV Vehicle Registration; School Registration; Voter Registration; Unemployment benefits; CalWorks, CalFresh and General Relief. Notices/"stuffers" sent to recipients should be in different colors to stand out. Community Based Organizations and congregations are also a valuable resource and oftentimes provide established and high trust community events with large attendance that can serve to promote the Exchange marketing messages.	Children's Health Initiative of San Joaquin County
The success of California's new coordinated healthcare system will in part depend on the investment in and design of the public information and social marketing campaign to educate individuals on new coverage options and changes to existing coverage options. As the State develops its social marketing plan, its first two activities must include the development of multiple partnerships and the implementation of a far-reaching media campaign. First, the State should identify and develop partnerships with entities that are trusted sources of information for families and communities. These partnerships will be helpful in getting the message out and distributing vital information to their networks. The State will need to work in coordination with these partners to create a unified message and set of materials that can be easily modified depending on the target audience. Second, the State will need to develop and implement a media plan that utilizes a wide range of traditional mass media and new marketing strategies. Public service announcements, static advertisements (e.g., billboards, posters), the use of ethnic mass media and social networking tools and connecting with recognized and trusted spokespersons should be included in that plan. Understanding the power of specific media strategies for different populations will be key to getting the word out and making sure that Californians are fully knowledgeable about how, why and where to access coverage.	Community Health Councils
Identify and use trusted messengers. If the audience doesn't trust the messenger, they won't listen to the message. Will likely need a variety of messengers to reach various populations, including the "hard-to-reach." Augment the messengers' duties with strategic "big blasts": public service announcements; billboards, social media hits. Often, based on prior public program outreach campaigns, media is a first way consumers hear about a new program, but it is less likely to be a direct source of enrollment. Another type of high-profile activity we suggest is a short series of "town halls" starting in 2012 around the state attended by Exchange leadership to put a human face on the Exchange and convey a sense of dialogue with the broader public. Drumbeats: inclusion of written information on all government websites and notices (e.g. tax forms), on retailer materials (e.g. grocery bags), and through social media. Community-based activities such as health fairs (e.g. California Endowment's "We Connect" events), booths at	Consumers Union

county fairs, school health assister one-on-one work, promotores and canvassers, town halls where there is an opportunity for interaction. Over time, based on Healthy Families and Children's Health Initiatives (CHI) experience, one-on-one community activities—especially at schools and clinics—should be prominent and the most credible way consumers learn about program coverage. "In-reach"—connecting with eligible people where they seek other services (e.g. clinics)—has been successful, as well. Families that learned about CHIs and Healthy Families through schools tended to be highly likely to also apply there. See evaluations by D. Hughes, UCSF, et al. (provided as an attachment) and "Designing Subsidized Health Coverage Programs to Attract Enrollment: A Review of the literature and a Synthesis of Stakeholder Views" (2008) available at http://aspe.hhs.gov/health/reports/08/subenroll/index.shtml. Tax preparers and preparation centers would be useful in 2013, specifically to explain potential tax credits in 2014. Study the Massachusetts experience in detail; though the number of uninsured, health system, and demographics there are quite different than in California, there may be lessons from which we can learn. They used a wide variety of strategies to explain reform to their residents and have valuable information on what worked and what didn't. For example, healthy young men are very hard to reach – they went after them through their mothers ("Get Insured for Mothers' Day"). Taken together, outreach should be organized and run like a campaign with clear branding and messages and action steps to be taken by those receiving the messages. Research on social marketing shows that people need to hear messages (about new programs or about healthy habits) at least three times before the messages start to "sink in." Overlapping with similar audiences should be a goal rather than a concern.	
There are several activities that CVS Caremark would suggest undertaking as a means of marketing the Exchange, Medi-Cal and Healthy Families. We have seen that public awareness campaigns are often an effective way to reach the greatest number of individuals. Community events and town hall forums are also useful as a tactic to improve understanding among the population. Similarly, consumer consultations, like those offered by CVS/pharmacy during the launch of Medicare Part D and each year since during open enrollment period can provide a personalized experience that often enhances an individual's perception of the program and result in a more informed decision for the consumer. Earned media also can accomplish this goal by demonstrating the benefits that the Exchange, Medi-Cal and Healthy Families bring to its enrollees.	CVS Caremark
Our experience with the Medicaid population is that underrepresented populations look to their community for most of their information about health services. Therefore outreach through social services agencies, clinics, community programs and public schools is advisable.	Delta Dental

For many underserved populations, direct assistance is one of the most powerful outreach and marketing tools available, particularly within communities that are Limited English Proficient (LEP). Word of mouth follows after direct assistance is given to one member of the community and brings in more people seeking assistance. Part of this is the concept of the "promotora", or a community health worker/educator, who is a trusted and known member of the community who can reach individuals who would otherwise be less likely to seek health coverage for themselves or their families. In order to facilitate this process, vendors should be prepared to engage in "retail campaigning", e.g., developing in-person education and training with schools, churches, and other locally-based organizations. They should also consider radio and television advertising and advertorials to reach these groups.	Health Consumer Alliance
The priority for marketing and outreach is to get the word out through a simple, portable message. All written materials should use simple terminology and there should be simple identifiable steps that lead a person through the process to get insurance. Outreach should occur where target audiences visit such as at banks, schools, faith based locations, grocery stores, large retailers, etc. Billboards and Radio spots are effective in getting messages out into the community.	Health Plan of San Joaquin
Top activities in terms of marketing and outreach for the Exchange, Medi-Cal and Healthy Families in the next couple of years are the following: (a) have clear & realistic goals each year and develop a marketing plan with strategies and support activities; (b) establish a Health Navigator program, (c) create many enrollment and outreach channels in addition to the Health Navigators, such as allowing many other entities and community-based organizations to help individuals apply for their eligible program, (d) determine a "brand" for the new program (e.g., should we brand "Exchange" as a "government" or "commercial" product? Should the campaign be product-specific or general affordable health coverage options? etc.) and then build and launch public awareness and direct response programs. California has many existing "sales" channels, such as brokers, agents, CAAs, health plans, schools, counties, faith-based organizations, etc.; and it is important to build upon these existing channels. In order to uphold the Board's principle of "no wrong door", the future enrollment and outreach system should include all existing qualified entities that have been working with and understand their communities and the people they serve.	Inland Empire Health Plan

• A simplified application process.
• An automated system that supports multiple pathways to ensuring residents receive assistance/self-service options.
• Remove branding of government/welfare programs and promote terms like "health coverage" or "health insurance."
• Maximize reach by conducting "situational marketing" based on targeted groups (i.e. College students, part-time employees, ethnic groups, etc.).
• Market on existing well used Websites:
  o Public computers home page, state/county departments
  o Social Media: Facebook, Smartphone Applications
• Utilize community partners who have established relationships with the public for message delivery:
  o Community Based Organizations (CBOs), Faith Based Organizations (FBOs), Advocacy groups, Workforce Investment Board, etc. can deliver the HBEx message to difficult to reach populations.
  o 211 is highly utilized by CBOs, FBOs, advocacy groups, and private/public organizations.
	San Bernardino County

• Online applications – modifying existing online Benefits CalWIN for Healthy Families and other Exchange products. • Social media usage. • Advertising in non –traditional places where potential enrollees frequent – laundry mats, schools, day care/after school programs	Santa Cruz County
Important to ensure that marketing, promotion and outreach activities are not limited to clinical sites where services are received. To the fullest extent possible, outreach activities should take advantage of and partner with non-clinical locations frequented by potentially eligible clients such as community groups, advocacy organizations, etc.	San Francisco Department of Public Health
Small employers make decisions related to healthcare based on input for trusted channels of information such as brokers, accountants, business groups and their peers. The top outreach/marketing activities for the Exchange should be working with these types of trusted advisors for outreach, education and enrollment.	Small Business Majority
In order to perform successful marketing and outreach for the Exchange, Medi-Cal and Healthy Families, the Exchange should rely on trusted messengers in all the diverse communities across the state to carry the message and educate. We need to reach consumers who have never accessed services before so messages need to be distributed quite widely. We do not recommend spending money on glossy marketing campaigns but rather keeping marketing/outreach local and regional. Social media should be relied on heavily, as should the use of technology such as smart phones, robocalling, and text messaging.	The 100% Campaign
Question #4: What would you define as a successful marketing and outreach campaign? How can the Exchange build the kind of consumer attitude of loyalty, support, and even affection that the public has for Medicare and Social Security?	
A successful campaign will encourage active choice of health plan by the member, lead to engagement and conversation with the member, and create or support a brand identity that is meaningful to the member and leads to retention. Initially, this will be facilitated by an easy and streamlined enrollment process that allows the member easy access to a choice of enrollment methods.	Anthem Blue Cross
A successful marketing and outreach campaign is one that is capable of reaching out to California's diverse communities. The campaign should be simple but able to highlight how health coverage benefits individuals and small business through scenarios that connect people to what the coverage and cost is as well as what benefits are being offered. The Exchange could base the launch of its marketing and outreach campaign on the U.S. Census outreach model including public service announcements with trusted spokespeople as part of the launch of its marketing campaign. The Exchange can build the kind of consumer attitude of loyalty the public has for Medicare and Social Security by ensuring the enrollment process is as easy and uncomplicated as possible. To reach diverse populations, staff, Assisters and Navigators should look and speak like the communities they are serving. The Exchange should contract with promotoras and community health workers; have representatives go to community events so that people can get to know them; and go through nontraditional outreach partners such as restaurants, salons and farmer's markets. There sho… (Comments cut off on PDF).	CPEHN and Having Our Say Coalition
For the State's social marketing and outreach campaign to be a success, consumers should: a. be fairly knowledgeable about what coverage options are available to them; b. be aware of the basic benefits, requirements and protections they will receive;	Community Health Councils

c. understand the importance of coverage;
d. know how to enroll and where to go for assistance; and
e. feel assured of the program's reliability.

To ensure this happens and help build consumer confidence in the Exchange, four important elements must be included in the campaign design:

1. A unifying brand and consistent messaging. The brand should covey that the program is reliable and is focused on the consumer. Messages should be clear and consistent as well as diminish any stigmas consumers have about publicly sponsored programs. Therefore messages should:
    - Not assume that the consumer knows what the ACA is or about its implementation in California. They should provide simple and easy information on how the consumer can enroll themselves and their families.
    - Avoid alienating certain populations such as undocumented populations. Families may be dissuaded from seeking coverage if not all family members are eligible so messages should be inclusive and promote a culture of coverage.
    - Promote key benefits that may attract a specific audience (e.g., for younger adults focusing on value for the money and access to preventative services).
    - Articulate business practices or policies that allow for simplified enrollment and seamless transitions between programs (i.e., automatic renewals, bridging between programs and multiple avenues of assistance). Knowing they can easily obtain and retain coverage provides consumers with a sense of security.
    - Establish a "culture of coverage" in which maintaining health insurance coverage becomes a norm for all children and families. There can be no stigma or perception of a "second tier" system. The public must see subsidized coverage through the Exchange as being equal in quality to coverage that is not subsidized and to employer-based coverage.
2. Cultural and linguistically relevant messages and imaging. Visual and verbal messaging must by culturally and linguistically relevant. This goes beyond translation and must include: sensitivity and use of culturally appropriate terminology, symbols, gestures and even color; the use and representation of a broad cross-section of the ethnic, racial, age, cultural, and socio-economic diversity of the population, business community and family structure.
3. Easy to understand materials and recognizable logo. Campaign materials and logos should be created that are culturally and linguistically appropriate. There should be a standardized "user-friendly" format for presenting coverage options that can be used by any agency, provider or community-based organization willing to assist with outreach activities. All consumer-related promotional and informational materials must meet the State's highest cultural, linguistic and language access (literacy level) standards. This should apply, but not be limited to, the dissemination and exchange of information via websites, toll-free telephone lines, media, required forms, and correspondence to the consumer. Materials should also be thoroughly vetted by consumers and other stakeholders prior to implementation. The State should also develop an easily recognizable 800 number that links to the call center.
4. Linkages with trustworthy entities. The State must develop partnerships with entities and utilize information

channels that consumers are already familiar with and trust (e.g., local Elected Officials local safety-net providers, well known neighborhood advocates/activists, local media personalities, etc.). Partnerships with trusted people and agencies add legitimacy in the eyes of the consumer. Additionally, it will be important that the social marketing and outreach campaign begins early in 2013. Consumers will need to be as familiar with the program as possible well in advance to make enrollment a smooth process. Furthermore, the campaign should be strong from 2014 through 2019 as consumers gain an understanding of the program and to convey any changes that occur during that time. A plan should be in place from the outset and data collected throughout the campaign to conduct real-time evaluation of its effectiveness, changes that need to be made and at what level the campaign should continue after 2019.	
The ultimate measure of success is a high number of inquiries to the Exchange and high enrollment and retention of eligible individuals in the Exchange, Medi-Cal, Healthy Families and other public health coverage programs, with creative and efficient use of resources. Research indicates targeted, decentralized, community-based, in-person outreach is most effective in creating awareness that leads to enrollment. See, "Designing Subsidized Health Coverage Programs to Attract Enrollment: A Review of the literature and a Synthesis of Stakeholder Views" (2008) available at http://aspe.hhs.gov/health/reports/08/subenroll/index.shtml. The same research finds that a broad spectrum of partnerships favoring programs and promoting them is key to achieving enrollment. Ubiquitous and frequent exposure to well-crafted messages cements new programs in the public's mind and can dispel myths about the Exchange and other health coverage programs. It will be important to be present in individuals' minds even before they need to use the new Exchange. Marketing and outreach will need to be culturally and linguistically sophisticated to effectively meet California's diverse population. Building loyalty, success and affection for the Exchange will be won over time and rest on managing consumer expectations, providing smooth, consumer-friendly service without major glitches (e.g. security breaches, subsidy reconciliation problems that create problems for people with the IRS). One of the best ways to manage expectations and have a smooth roll out is to pilot test the outreach materials and the enrollment processes ahead of open enrollment. The Healthy San Francisco coverage initiative is a good example of this (see ASPE report in answer to Question #3). The Exchange can build support by gathering and promoting individual success stories—highlighting the benefits and value provided to families or individuals. Also, making insurance understandable with a high level of in-person consumer assistance is critical. Managing expectations and avoiding negative perceptions will be key. Note: Achieving awareness through mass media is different from effective enrollment, which requires additional steps and partners, primarily community-based assisters. Also, effective sources of outreach may change over time, with some investment in state and local media effective in certain stages of outreach, but those strategies may shift to word-of-mouth and community messengers who may take on the main role. See Santa Clara and San Mateo CHI experiences described in evaluations by Dana Hughes, UCSF et al., (Attached to CU's cover letter). Likely the Exchange will have to continue to run a strong public education campaign to ensure a balance against the media efforts of the insurance industry.	Consumers Union

The state of Massachusetts conducted a successful outreach campaign when it initiated universal coverage by deploying TV advertisements, billboards and direct mail, and leveraging civic and community leaders to generate support. In addition, the Massachusetts Connector created partnerships with visible entities within the community, including CVS/pharmacy stores, the Boston Red Sox, etc. These partnerships helped to improve community sentiment around the Exchange by depoliticizing the benefits. The launch of Medicare Part D also was successful in its marketing and outreach. In addition to raising awareness, efforts focused on helping seniors to understand the offerings available to them. And, since 2005/2006, retail pharmacies have served as an important point of contact where seniors have been able to obtain appropriate advice and use plan finder tools to aid in plan selection, often leveraging their own prescription drug history. Ultimately, motivating individuals to act will require a multi-channel communication effort that builds maximum awareness and understanding of the Exchange offerings.	CVS Caremark
The loyalty to the Exchange will be built over time as the public learns that this program is stable and long-term. Medicare and Social Security have the public's affection because they are well-established programs that individuals feel they can count on. A successful marketing and outreach campaign will include basic and easily understandable information about the medical and dental benefits available through the Exchange. The campaign should include information about where individuals can seek additional and more detailed information. The outreach effort should be customized and targeted to hard to reach populations such as non-English speakers and low-income workers. It is crucial that information be accurate and consistent no matter the source in order to build credibility with the individuals accessing the Exchange.	Delta Dental
Successful Marketing: Building consumer loyalty and support will require effective and efficient functionality, and strong customer service from start up. Work with a small group of the population to begin using the system in a trial phase and have them tell their story to advertise the positive benefits of the Exchange. As we move in to 2014, continue to use people's stories regarding ease of access to advertise the benefits of the Exchange. Advertisements should be in various languages and should appear in mainstream and ethnic media outlets.	The Greenlining Institute
The affection towards Medicare and Social Security exists because these years have existed for many years and have consistently provided benefits. The same affection can be achieved by creating a product that is clear and easy to use and navigate and provides quality services. Developing an eligibility and enrollment system that really offers "no wrong door" and permits trusted community sources to access the system will build credibility in hard-to-reach populations. Additionally, attempts to de-stigmatize publically-subsidized programs such as Medi-Cal should be taken into account. Success in marketing and outreach must also be measured when target populations are enrolled and retained, and the public's needs are met in a timely manner.	Health Consumer Alliance
An effective campaign uses images and photos that appeal to the target audience. A campaign that targets community members should use "real" photos and images to depict an everyday people. Effective campaigns include grassroots outreach efforts through established and credible sources of information within communities.	Health Plan of San Joaquin
A successful marketing and outreach campaign should achieve the following results - public awareness, minimum level of public confusion about products offered and point of purchase/entry, robust enrollment with consumer protection, and retention (consumer loyalty). It should also demonstrate collaboration and partnership with all entities across the servicing spectrum. In order to build a consumer attitude of loyalty, one of the first steps that the Exchange may want to consider is to define the brand of the "Exchange product" to assess where it is on the brand spectrum of public vs. commercial products. The stigmatism of Medi-Cal is still strong in the community; but the	Inland Empire Health Plan

Healthy Families Program has done very well in branding its product.	
The word/concept "Exchange" means nothing to consumers. Exchange is a mechanism, not something done to help anyone. So name change might be in your future, name change to imply "there for you forever." CaliforniaCares. CaliforniaHFY (Health for You).	Lucy Johns, MPH
4A. The success of the program will ultimately be based on maximized enrollment, educating the public - understanding of the program, and a seamless program enrollment/transition process. 4B. Communication with the public is critical when establishing consumer loyalty. • Change the cultural mindset and target situational marketing. • Use branding to market a person's right to health coverage and to receive services. • Change the attitude/perception of the HBEx in house. Educating and making sure HBEx partners are on board to ensure effective interaction with the public so the message can reach them accurately. • Setting up an attractive offer which can encourage the public to participate such as affordability of programs, scope of services provided, and freedom of physician choice. o Simplified access to the application/case o Showing the link between coverage vs. cost of uninsured o Understanding freedom of choice • Personalize the Exchange – Market success stories similar to the Affordable Care Act (ACA) marketing. • Track the sources of traffic to know which promotional technique is working better whether its email campaign, online ads or referrals.	San Bernardino County
• Message is standardized and seamless across all healthcare programs available • Enrollment increases across a variety of demographics	Santa Cruz County
The best proxy for predicting which subgroups are least likely to enroll without assistance would be local data on enrollment and retention rates in previous Health Care Coverage Initiative programs and in the new Low Income Health Program. The populations include, but are not limited to the following: homeless persons/unstably housed, Native Americans and young adults.	San Francisco Department of Public Health
A successful campaign will result in small business owners viewing the SHOP as a "small business advocate" that offers low prices and saves employers time/money by handling administrative issues. This can be achieved by using trusted channels of information, demonstrating the Exchange understands the needs of small businesses and deemphasizing the role of government.	Small Business Majority
Question #5: What sales, outreach and assistance channels are most effective and efficient for populations in the individual market?	
The internet will be a central, and ACA required, component in any state's marketing effort. AARP recently commissioned research that looked at existing consumer information websites and provided recommendations on attributes of public reporting that enhance the consumer experience in obtaining information. Cronin, Carol. "State Health Insurance Exchange Websites" A review, discussion and recommendations for providing Consumers Information about Quality and Performance," AARP, July 2011. The report is based on a review of existing websites and provides recommendations on a range of topics that may be helpful in developing templates for providing	AARP California

comparative plan information to consumers. The recommendations address information presentation and navigation, education and decision support, limiting the number of health plan choices, health plan performance -- including complaints/grievances and appeals -- as well as other types of performance information (quality, cost), and integrating information about individual providers with information about the plans. http://www.aarp.org/content/dam/aarp/health/medicare_insurance/2011-07/2011-cronin-report-final.pdf	
Currently, Anthem's agent distribution channel is responsible for the largest share of enrollment in individual products. Online submission is the most efficient means to enroll in individual products.	Anthem Blue Cross
Generally speaking, using various media outlets and working with local organizations and other trusted agencies will reach most individuals who will benefit from the Exchange and/or Medi-Cal Expansion. However, different populations will respond to different media outlets. • The use of mass media outlets, including ethnic and language specific electronic and print advertisement and community programming, is the crucial element in reaching most market segments. According to a report by New American Media, in 2009 ethnic media reached 57 million or 87% of all African Americans, Hispanics and Asian Americans on a regular basis. This was a 16% increase over 4 years prior. It will be critical for the state to identify those ethnic media channels and newspapers that resonate with different populations. • Outreach channels should also include print advertisements in high traffic public places (e.g., malls, sports venues, personal care facilities, entertainment outlets). In thinking through the messages and appropriate spokespeople to be placed on advertisements, the state should identify public personalities who will appeal to multiple audiences or a few that can deliver the message to specific audiences. • Social Media is a basic communication and information tool for a younger/tech savvy population. The development of smartphone and other online enrollment channels (including chat opportunities, access to online service reps, etc.) will be vital. Additionally, whereas ethnic and racial technology gaps still exist, more minorities are utilizing technology than ever before. Many (46% of African Americans and 51% of Hispanics) are accessing the internet on their cell phones. The State will need to take this into consideration as it develops its social media strategies and messaging. Promoting the spectrum of available coverage programs through the state and local public and private agencies and organizations (e.g., schools, WIC, DPSS ~ CalWorks/Food Stamps) that routinely interface with families and newly eligible adults increases the likelihood they will learn about the options available to them, utilize services and know where to go for assistance when needed. Partnerships with local agencies should include intact Certified Application Assistant, Promotora and Community Health Educator networks that have an established record in the segmented communities. Local faith-based agencies provide another channel to reach eligible individuals and families. Print material should be readily available and disseminated through the communication vehicles of all state agencies such as the State Franchise Tax Board, Employment Development Department and through partnerships with the private sector. Partnerships with cities are of value in providing access to thousands of families and individuals through their mass transit systems (bus and rail), after-school programs, family resource centers, child care centers, parks and recreation programs, and public libraries, which are also well positioned as a resource for information	Community Health Councils

dissemination. The marketing team should be responsible for developing relationships with major pharmacy chains, public utility companies (mobile phone, cable television, gas, electric, etc.) and other businesses within the private sector that have on-going communication tools and billing processes with the public.	
The following may be effective and efficient channels for populations in the individual market: HMOs, a wide array of providers, hospitals and health systems, clinics and other delivery sites, pharmacies, schools, business and trade associations, labor groups, religious organizations, non-profit community groups, state agencies, navigators, brokers/agents. Primary care doctors and health care clinic staff are trusted entities so engaging them as partners in outreach may be particularly effective. (though plan choice may not be appropriate by them). See also report on CU's prior project on school-based outreach and enrollment for Medi-Cal and Healthy Families (Attached to CU's cover letter). The main approach on that project was a "Request for Information" form attached to the Free and Reduced-Price School lunch application. This allowed parents likely eligible for these programs to express interest in applying and have their requests funneled to the state. CU and others learned many practical lessons from that effort, including identifying the need for data tracking, with RFIs at one point being the main source of Healthy Families applications. The report also describes potential funding sources—especially the MAA and LEA programs under Medicaid—as means for drawing down federal funds to support these activities.	Consumers Union
Through our initial exploratory consumer research, we know that the uninsured and subsidy-eligible individuals might be considered "free agents" today and therefore would find value in receiving information about their health insurance options in 2014 across a range of sources (e.g. internet / user-friendly website, TV, radio and print advertisements, as well as direct mail). In addition, individuals expressed strong interest in receiving information at sites of care (including retail pharmacies and retail clinics), as this coincides with their consideration of health care options. Beyond just receiving educational materials, individuals also mentioned that the option to speak to someone at these locations would be very valuable. While not tested in our research, individuals may also be receptive to receiving information at sites of wellness, such as gyms, YMCAs, etc. These venues may be an effective means of enrolling those that are uninsured due to lack of perceived need. It is also conceivable that unions could play a valuable role in disseminating information and gaining support among individuals and their extended network of contacts.	CVS Caremark
The cost to reach individual prospects through traditional advertising and direct marketing can be high – the cost per acquisition from direct mail can average about $300 per person in the medical/dental insurance industry, so efforts should be focused on the more cost-effective online channel. The Exchange should explore joint marketing efforts with community partners to promote the Exchange utilizing advertising, direct marketing, online marketing, social media, and community event participation.	Delta Dental

Sales, Outreach and Assistance Channels: 1. Work with regional ethnic chambers to reach ethnic small businesses. 2. Utilize similar tactics like the "Text for Baby" campaign at bus stops is a great way to reach underserved and LEP populations. (See: http://www.text4baby.org/index.php/partner-resources/2-uncategorised/105) 3. Provide taglines in Medi-Cal Managed Care threshold languages for people to find ways to access more information 4. Use social networking sites such as Facebook and twitter. (See: The Greenlining Institute: iHealth: How to Ensure the Health Benefit Exchange Reaches all Californians). 5. Provide the outreach materials to various sources, for example, partner with schools (during enrollment), community clinics, emergency rooms, churches, any information going out to students at community colleges and seniors at 4 year institutions (See: Kaiser Family Foundation http://www.kff.org/medicaid/upload/Connecting-Eligible-Immigrant-Families-to-Health-Coverage-and-Care-Key-Lessons-from-Outreach-and-Enrollment-Workers-full-report-pdf.pdf.)	The Greenlining Institute
Television, radio, print	Health Consumer Alliance
The most effective and efficient sales, outreach and assistance channel strategy is to build upon existing California's sales and outreach infrastructure. California has many existing "sales" channels, such as brokers, agents, CAAs, health plans, schools, counties, faith-based organizations, etc. In order to uphold the Board's principle of "no wrong door", the future enrollment and outreach system should include all existing qualified entities that have been working with and understand their communities and the people they serve. With an estimate of several million people eligible for Health Exchanges and Medicaid Expansion, we need all qualified sales and outreach channels.	Inland Empire Health Plan
We believe that community-based health centers and clinics, including Planned Parenthood health centers, offer an excellent venue to engage prospective and eligible people to enroll in the Exchange. Planned Parenthood affiliates in California operate more than 100 community health centers that serve nearly one million low-income, ethnically diverse individuals every year. As such, Planned Parenthood is uniquely qualified to serve as a gateway to the Exchange, including many of patients who are served by the state's Family PACT program, the majority whom will be eligible under the ACA for expanded Medi-Cal coverage. **Sales, outreach and channels to reach target population** Reaching targeted specific populations (ethnic, age, public program participants, etc.) to enroll in the Exchange will require outreach to these individuals in ways that they can trust, with information that is culturally and linguistically appropriate, and that is relevant to their own situation in life. Nonprofit organizations, cultural groups, religious institutions, and existing health care providers that currently serve these populations can serve as trusted conduit of information. Planned Parenthood has been proven to be a highly trusted source of information and place for women and men to obtain reliable reproductive health information and to receive confidential health care services. In addition, the Exchange will need to employ unique and creative strategies to successfully reach, engage and enroll the "young invincibles," those women and men who are young and healthy and perceive that they do not need comprehensive health coverage or that cost of doing so is prohibitive. Because more than 50 percent of our clients are between 18 and 29 years of age, Planned Parenthood health centers provide an excellent place to reach this target population. Tactically, we believe that the Exchange will need to utilize a comprehensive, multi-faceted	Planned Parenthood Affiliates of California

outreach strategy that includes paid and earned media, outreach at targeted community events, the use of navigators and assisters in targeted communities and the recruitment of opinion leaders within targeted communities to serve as a trusted voice to promote enrollment in the Exchange. Many models of community intervention exist in public health to reach targeted groups with social norm and/or behavioral change and take-action messages. One very successful model in California is the state's tobacco use prevention campaign and the smoking cessation program directed by the California Department of Public Health Tobacco Control Program.	

• Mass media
  o Radio Blasts
• Target cultural diversity
• Modern Technology
  o Online - Websites and Social Media
  o Text messaging
  o Advertising and promotion on Websites frequented by large numbers of the population.
• Engage Community Partners to disseminate/educate
  o CBOs, FBOs, advocacy groups, schools
• Generate a personalized Annual Status report – Like the SSA Statement annual benefits report.
• Include notification for small businesses/employers during tax quarterly/annual filing, or when applying for a business license.
	San Bernardino County

• Social marketing – YouTube, Twitter, Facebook, LinkedIn, Craig's List • Radio and TV for those with low literacy levels • Buses, subways	Santa Cruz County
Important to ensure that marketing, promotion and outreach activities are not limited to clinical sites where services are received. To the fullest extent possible, outreach activities should take advantage of and partner with non-clinical locations frequented by potentially eligible clients such as community groups, advocacy organizations, etc.	San Francisco Department of Public Health
Question #6: What sales, outreach and assistance channels are most effective and efficient for small employers?	
Agents are the most effective and efficient channels for small employers to enroll in small group products. Agents play a key role in conveying the value proposition of coverage, providing expertise and recommendations, and facilitating widespread outreach to small employers.	Anthem Blue Cross
See answers to # 5 above. Brokers will play an increased role in the SHOP due to pre-existing relationships with employers for other insurance products. It will be important for the SHOP exchanges to partner early with brokers and provide them with something that is "sell-able." The overriding message for employers must be affordability and administrative simplicity.	Consumers Union
In our experience most small employers utilize the services of a broker or agent to purchase health and dental insurance. Often small businesses do not have any one person responsible for health insurance decisions, and the business owner doesn't have the time or knowledge to decide on a benefits package without an advisor. Employers may be more open to a self-service model in the future, but our experience would suggest that the Exchange should utilize the agent or broker community in order to efficiently reach small employers initially.	Delta Dental

Sales, Outreach and Assistance Channels for Small Employers: 1. Work with regional ethnic chambers to reach ethnic small businesses. 2. Utilize similar tactics like the "Text for Baby" campaign at bus stops is a great way to reach underserved and LEP populations. (See: http://www.text4baby.org/index.php/partner-resources/2-uncategorised/105) 3. Provide taglines in Medi-Cal Managed Care threshold languages for people to find ways to access more information 4. Use social networking sites such as Facebook and twitter. (See: The Greenlining Institute: iHealth: How to Ensure the Health Benefit Exchange Reaches all Californians) 5. Provide the outreach materials to various sources, for example, partner with schools (during enrollment), community clinics, emergency rooms, churches, any information going out to students at community colleges and seniors at 4 year institutions (See: Kaiser Family Foundation http://www.kff.org/medicaid/upload/Connecting-Eligible-Immigrant-Families-to-Health-Coverage-and-Care-Key-Lessons-from-Outreach-and-Enrollment-Workers-full-report-pdf.pdf.)	The Greenlining Institute
Small business associations, ethnic chambers of commerce, television, radio, print	Health Consumer Alliance
The exchange should take a multi-channel approach to outreach and assistance. The exchange must partner with the various business chambers and human resources groups in order to effectively outreach to small and large group employers. In addition, businesses appreciate a "face" to the product or message, so it is important to not only rely on various media channels to inform the public on the benefits of the exchange, but also to utilize outreach representatives who can best convey messaging to diverse groups. There needs to be agreement on the definition of small employer. The insurance industry defines a small employer as "50 employees and under". Outreach tactics to a group with 45 employees greatly differs from outreach tactics to groups with 5 employees.	Health Plan of San Joaquin
Utilize community partners to distribute program material and educate on program benefits: • Workforce Investment Board, Employment centers • Chambers of Commerce • Association groups • Community groups • College student unions • Office supply stores/warehouses	San Bernardino County
Brokers will be very efficient here. Not only are they trusted sources, they have longstanding ties to small businesses. Peer-to-peer recommendations will also be effective.	Small Business Majority
Question #7: How can the Exchange most effectively promote the availability of tax credits for eligible small businesses?	
Promoting tax credits to small businesses will be a challenge. We believe that the use of agents to educate and raise awareness will be the most effective approach and least costly. From our experience, we believe that direct messaging to employers will have limited effect.	Anthem Blue Cross

Incorporate knowledge of tax credits (along with Exchange offerings) into broker continuing education and training requirements. Certain state agencies interact with small businesses on a regular basis—e.g. EDD and Board of Equalization—and have their attention. These agencies could routinely mention the Exchange small business tax credits. Another way would be through small business groups/associations that are supportive of the Exchange. Tax preparers who work with small business owners can help educate. Across all entities, pair information about tax credits with information about the benefits of Section 125 plans. Most small firms don't have these plans, but would benefit from implementing them. The Exchange could facilitate the use of Section 125 plans.	Consumers Union
Again, the current small employer outreach models are largely built on utilizing the broker and agent communities, therefore disseminating information about tax credits through the broker and agent community would be effective. Also, general educational sessions, newsletters/articles, and on-line sites that explain the tax credits simply and clearly are recommended. The Exchange should partner with organizations with which the small business community interacts such as local Chambers of Commerce and professional organizations.	Delta Dental
Promotion of Tax Credits for Small Employers: Reach out to ethnic chambers, ethnic media, business licensing boards (state, county, local/city, etc.), and accountants to promote the availability of tax credits to ethnic small businesses. (See: Insight at Pacific Community Ventures and The California Endowment. http://www.pacificcommunityventures.org/insight/reports/Heatlh_Care_and_Small_Business_2011.pdf.)	The Greenlining Institute
Partner with small business associations, chambers, ethnic chambers, additional marketing in television, radio, print.	Health Consumer Alliance
The use of outreach representatives to present basic details of the exchange, including tax credits, to chambers and other business associations would be the most effective strategy. In addition, making these outreach representatives available to answer questions and meet with individual business owners is a key component to these presentations based on the assumption that tax credit eligibility and determination is defined by very specific criteria that cannot be covered through a presentation alone.	Health Plan of San Joaquin
Utilize community partners to distribute program material and educate on program benefits: • Workforce Investment Board, Employment centers • Chambers of Commerce • Association groups • Community groups • College student unions • Office supply stores/warehouses	San Bernardino County
Utilizing the Workforce Investment Boards (WIB) Chambers of commerce, Business Associations and the Small Business Development Centers in local communities as champions for healthcare.	Santa Cruz County
The Exchange should partner with brokers and accountants to assist with outreach. The tax credits should also be a key component of a marketing strategy since employers using the tax credit will be able to save significant money by purchasing plans through the Exchange. Calculation of the tax credit should automatically be part of the SHOP enrollment process so we can catch even those employers who don't know about the credit.	Small Business Majority
Question #8: Which populations will be least likely to enroll without assistance in understanding their eligibility or the enrollment process?	

We believe that those least likely to enroll without assistance will include individuals who were previously uninsured, who have limited or no English proficiency, or who are over age 50 and/or have pre-existing or current medical conditions.	Anthem Blue Cross
California's low-income, seniors, disabled, Limited-English-Proficient (LEP), immigrants and communities of color may be least likely to enroll without additional assistance. Because of complex eligibility rules, lack of translated materials and/or knowledge of the right to oral interpretation, these groups will need even more one-on-one assistance than other market segments.	CPEHN and Having Our Say Coalition
"Non-English speakers, migrant families, young adults (w/ and w/o high school education, working), unemployed"; "Undocumented parents, for their un/documented kids. Immigrants, particularly Latinos (for themselves and their kids). Non-English speakers (for themselves and their kids)."; "Non English speakers, homeless families (high mobility), uninsured families, adults with a criminal history."; "The majority of the population that we see in our SBHC, which includes Spanish speaking, those without insurance and those who have difficulty being able to complete the paperwork without assistance." ; "Undocumented parents of eligible (born here) children, currently uninsured, those without health care home"; "The majority of people will need assistance. This is a new concept to many."	California School Health Centers Association
Based on our prior experience with our "Healthy Kids, Healthy Schools Project" (which worked to enroll in Healthy Families/Medi-Cal/CHIs in the public schools, especially through linkages with the school lunch program), we believe the following populations will be least likely to enroll without focused outreach and assistance: immigrants, those new to or averse to public programs, those whose first language is not English, those new to insurance altogether; people with disabilities; those working more than one job and with little time, esp. during usual "business hours" are most likely to need help. While not the same as the Exchange-eligible people, those families overlap as the Exchange should seek the parents of HFP children. But even outside those populations, many people will need help to ensure they enroll and choose the RIGHT plan for them—key to long-term satisfaction and retention. We presume the contractor assisting the state agencies will obtain demographics (similar to those obtained for Maryland) to capture a snapshot of California's uninsured population, to better understand who needs to be reached and the kind of help (including marketing/shopping preferences) they will be most receptive to.	Consumers Union
Our experience with the Denti-Cal program indicates when adults are not knowledgeable about the dental services available or if they are not receiving dental services themselves, they are less likely to seek services for their children. In the interest of assuring dental coverage for kids, it would appear that uninsured individuals who have very little experience with the insurance market will need to be specifically targeted in the outreach effort in order to assist during enrollment to pick the best plan for their child's needs.	Delta Dental
Populations Least Likely to Enroll: 1. Formerly incarcerated 2. Those with strong language barriers, monolingual 3. Mixed Status Families (See: Kaiser Family Foundation http://www.kff.org/medicaid/upload/Connecting-Eligible-Immigrant-Families-to-Health-Coverage-and-Care-Key-Lessons-from-Outreach-and-Enrollment-Workers-full-reportpdf.pdf.) 4. People without internet access (See: The Greenlining Institute: iHealth: How to Ensure the Health Benefit Exchange Reaches all Californians).	The Greenlining Institute

5. Ethnic small businesses still have very little knowledge about the Exchange and the small business tax credit (See: Treasury Inspector General, Affordable Care Act: Efforts to Implement the Small Business Health Care Tax Credit, http://www.treasury.gov/tigta/auditreports/2011reports/201140103fr.pdf)	
Many health consumers will need an in-person encounter in order to adequately serve their needs or will need to talk to a bilingual advocate who works in the community and can help them navigate local resources. A need will remain for access to in-person and locally-based consumer assistance. The Exchange should provide in-person assistance or arrange for that assistance to be provided by existing consumer assistance programs or community-based organizations. Those with functional limitations or disabilities, Limited English Proficiency and those in mixed-status families will be least likely to enroll on their own and should receive additional consideration. Utilizing a model like the Health Consumer Alliance (HCA) organizations as well as the Medi-Cal/Healthy Families Enrollment Entity that employs Certified Application Assistors (CAAs) should be considered.	Health Consumer Alliance
Populations least likely to enroll without assistance are non-English speaking, Limited English Proficient speakers, those with no and low literacy levels, pregnant teens, seniors and persons with disabilities, emancipated minors and caregivers	Health Plan of San Joaquin
Populations that will be least likely to enroll without assistance in understanding their eligibility or the enrollment process include immigrants, non-English speaking, low-income families, and people living in the rural areas. Currently, there are almost a million people who are eligible for Medi-Cal but have not enrolled.	Inland Empire Health Plan
Those least likely to enroll will be individuals without citizenship documentation, people worried about income and qualifying, people with English language challenges and others who are marginalized in society – people who are homeless and those with mental illness, alcohol/drug addictions, etc.	Planned Parenthood Affiliates of California
• Small businesses - There has not been sufficient outreach to disseminate Exchange information to small businesses. • Immigrants – Even though the Exchange will not service the undocumented population, there is a high concentration of documented immigrants throughout California. • Young adults - They are also under informed. Utilize venues frequented by this population such as student unions, colleges, financial aid offices, social media… • Homeless Population - This population is high risk and in need of health services.	San Bernardino County
We note that populations unlikely to successfully enroll include those with behavioral health issues, such as serious mental illness and addiction. Behavioral health providers and family members are critical partners in reaching and enrolling these consumers.	San Mateo County Health System
Those with low literacy levels in their preferred language. It is often assumed that individuals are literate in their preferred language and that is not always the case.	Santa Cruz County
The best proxy for predicting which subgroups are least likely to enroll without assistance would be local data on enrollment and retention rates in previous Health Care Coverage Initiative programs and in the new Low Income Health Program. The populations include, but are not limited to the following: homeless persons/unstably housed, Native Americans and young adults.	San Francisco Department of Public Health

Given the complexities of purchasing coverage for a small group, few employers will want to attempt this solo. In particular, firms that have not provided coverage in the past and minority-owned business will be very likely to want assistance.	Small Business Majority
Question #9: Which populations should the Exchange focus on specifically and what outreach and assistance channels will be most effective and efficient for those populations?	
We'd suggest that the HBEx focus specifically on subsidy eligible individuals for targeting outreach. Assistance provided face-to-face or via phone, or through a robust online tool, is likely to be most effective.	Anthem Blue Cross
The Exchange should reach the newly eligible in the community, through local ethnic media (television, radio, newspapers), trusted community organizations (CBOs) and service providers, clinics, promotoras and community health workers, schools, churches, senior centers, mobile clinics and other community services (hair salons, flea markets, shelters, libraries). Another avenue is the use of mobile phones (texting, social media for those with smart phones). Mobile clinics were also mentioned. In order to reach all communities the state needs to meet people where they are by providing enrollment in schools, clinics, community based organizations, churches, medical/clinic settings – offering sites at malls, shelters, farmers markets. By addressing accessibility issues (transportation, internet, service locations) and offering information in both various languages and simple to read formats the Exchange, DHCS and MRMIB can help to maximize enrollment in these programs.	CPEHN and Having Our Say Coalition
"The exchange should focus on non-English speaking families and young adults. For non-English speaking families, the exchange can consider training flagship CBO's in various ethnic communities to lead seminars on the exchange and process of enrollment. For young adults, informational pamphlets at CBO's, commercials, radio spots, and some online forums could be useful. City Colleges can also serve as hubs to reach working young adults"; "Immigrants, non-English speakers, parents of adolescents, the underinsured. Through schools and SBHCs!"; "Coming from a school district I would like to see schools included as the vehicle in which families can get assistance. The schools are in the neighborhood and tend to be trusted places where families always go. We have had tremendous success this last year with health insurance outreach and enrollment in the schools. We have a dedicated person (and have recently hired another .5 person) focusing specifically on this; we work directly with our county CHI to create a seamless system to get families enrolled."; "Low income community. Outreach and enrollment would be most effective at school clinics, school parent groups, non-profit agencies, and day care centers."; "Populations in low-income neighborhoods and the schools districts serving in these localities. Churches, synagogues and mosques."; "Poorly educated people living in poverty. People to whom English is a second or absent language. Community Health Center and School Based direct out- and in-reach activities." "The schools themselves hold great potential for reaching these populations, but in addition, local community groups (Concerned Citizens of South Central Los Angeles, for instance) could be effective outlets."	California School Health Centers Association
Although the State should create a social marketing plan that reaches as many California groups as possible, there are a few populations that should be prioritized to eliminate disparities in coverage. This includes the following populations and potential points of access: • Uninsured but eligible children. To reach this population, use California's existing network of Certified	Community Health Councils

Application Assistors (CAAs) and Outreach, Enrollment, Retention and Utilization (OERU) agencies because they are local, on-the-ground and able to reach families where they are (e.g., schools, clinics, WICs, Head-Starts, community and faith-based organizations). CAAs are seen as trusted entities and understand community norms, challenges and how to appropriately convey complex messages. Local CHIs (Children Health Initiatives) also work closely with CAAs and OERU agencies to coordinate local outreach and this expertise and connection should be utilized. • Parents/caregivers of children in Medi-Cal and Healthy Families who are currently uninsured. Outreach to this population can be done via the child's health and/or mental health provider (e.g., nurses, counselors, and front-office staff). All health providers should be supplied and trained with information regarding enrollment in new and existing healthcare coverage options that they can share with parents and other family members. Schools will also be a main channel; statewide the California Department of Education should be involved in the creation of a mass media campaign across all county school districts. Understanding that children and their families have many needs and that the State comes in contact with a variety of organizations and agencies, the State should particularly work with local childcare providers and children-serving organizations (licensed day care, pre-school, Head Start, Boys and Girls Clubs, YMCA, AYSO, Little Leagues), public assistance agencies (WIC, Cal Fresh), and agencies that operate group homes or assist teens aging out of the foster care system. • Low-income working childless adults. This population will need to be reached through a variety of methods. For those who access social or health services, local community/faith based organizations, community clinics (Federally Qualified Health Centers and private clinics) and government agencies (housing and employment departments) will be good avenues. For those who don't access local services, outreach will need to include mass media (TV, radio particularly for the low-literacy Populations) and local community events and fairs. Messaging should be displayed and disseminated through partnerships with local supermarkets, pharmacies, public transit, and point of contact facilities that aren't traditionally part of the health information community (malls, beauty and nail salons, etc.).	
In addition to the vulnerable population segments listed in the questions and in our comment to #8, we suggest the Exchange and its partners dedicate some focus on job fields with fewer insured people and more part-time workers: e.g., retail staff, fast food staff; domestic and home health care workers; garden landscapers; part-time school employees; farm workers; other self-employed professions; adjunct faculty at colleges. Part of the work delegated to the vendor assisting the Exchange and partners should be to identify the specific segments of the population that are uninsured, where they live, where they shop, how they access information, their demographics (gender, marital status, race, income, employment, etc.) — (See Weber Shandwick report for Maryland.) "In-reach" efforts (see comment to #3) by the state using information in its possession would help target those likely in need of subsidized programs: the parents of Health Families and Medi-Cal children; families of kids on Free or Reduced-Price Lunch/Breakfast Programs etc.	Consumers Union
The Exchange should focus on individuals who are currently uninsured, as well as those who are insured but eligible for Medicaid or premium subsidies. These individuals would realize the greatest benefit from enrolling through the Exchange, but may not be as familiar with the coverage landscape today. Preliminary findings of CVS Caremark research (currently in progress) have shown that these individuals are likely	CVS Caremark

to use the internet to locate information, but also would value consultations and forums. In addition, the Exchange should consider tactics to communicate through existing channels in today's Individual insurance marketplace, including insurance agents and healthcare providers, as they will be able to communicate effectively with their existing customer base (i.e. to express the importance of retaining coverage) as well as the new customers that they interface with.	
Populations to Focus On: 1. Target harder to reach populations (see #8). You will need to create a more robust marketing and outreach strategy to reach the populations from #8. You will need to reach and gain the trust of an initial few. Identifying and working with leaders in the community and utilizing ethnic media can help you reach these groups. Because many of these communities are close-knit, reaching a few key figures will help you enroll the rest of the population. 2. Also focus on the largest populations that will be eligible to take advantage of ACA expansions: Latinos, Asians, Blacks and Young Adults. Conduct outreach through churches (Black/ Latinos), promotores (Latinos), schools churches- media (Asians); cultural centers such as barber shops (Black), social media (Black, Latina, Young Adults). (See: Kaiser Family Foundation http://www.kff.org/medicaid/upload/Connecting-Eligible-Immigrant-Families-to-Health-Coverage-and-Care-Key-Lessons-from-Outreach-and-Enrollment-Workers-full-report-pdf.pdf and The Greenlining Institute: iHealth: How to Ensure the Health Benefit Exchange Reaches all Californians.)	The Greenlining Institute
The Exchange should focus primarily on those who are 1: uninsured and 2: those who will be able to easily move from one category or program to Exchange products. That includes the populations that are most likely to be uninsured (LEP persons, communities of color, low-income populations). Those who will likely be eligible are those enrolled in county Section 17000 programs, the Low Income Health Program, Family PACT, Breast and Cervical Cancer Treatment/Prostate Cancer Treatment Programs, Every Woman Counts, among others. The Exchange should look to the groups that have gotten these populations enrolled in the other coverage programs, and should look into options like auto-enrolling via counties, DHCS and MRMIB lists, and contracting with community-based organizations to maintain local trust.	Health Consumer Alliance
The Exchange should focus on those who are previously uninsured and those who have low literacy rates. Effective and efficient outreach channels would be local community based organizations and knowledgeable Certified Application Assistants.	Health Plan of San Joaquin
We encourage the Exchanges to focus on all market segments, instead of a specific population, with targeted strategies and support activities for each market segment.	Inland Empire Health Plan
Populations not functioning daily on computers will need concerted attention. How? I don't know but somebody will I hope.	Lucy Johns, MPH
Conduct outreach in the places and venues where these populations frequent most. • Small businesses - Utilize community partners to distribute program material and educate on program benefits. For assistance channels, see #5 response. • Young adults - Utilize venues frequented by this population such as student unions, colleges, financial aid offices. Also, this population is high tech. They work better with online methods. Web applications, social media outreach, and mobile phone applications are some of the methods to attract this target population.	San Bernardino County

• Homeless – Utilize community centers, food banks, shelters, and law enforcement. This population may need assistance with the application process.	
Young people are a critical target market that requires a tailored marketing strategy. Social media must be a part of this approach.	San Mateo County Health System
• Creating a message on the value of health insurance for those who are uninsured will be important. • Incentivize the sign up process	Santa Cruz County
A significant number of the likely eligibles are already accessing health care services through county and community clinic sites. Collaborating with community clinics, local health departments, and patient financial services at various non-profit hospitals would allow the exchange to focus on the most vulnerable clients in need of insurance to access services. These locations employ eligibility workers or other staff who can act as navigators to either route a client directly to the exchange on-line (either at home or at a designated terminal) or provide application assistance if required. These locations would also be effective sites for any marketing collateral and ideal for an in-service from the State for their employees.	San Francisco Department of Public Health
Brokers will the most efficient way to reach businesses that currently use brokers. Peer-to-peer communication and navigators may be better suited for firms that do not currently use brokers.	Small Business Majority
Under health reform, there will be a mix of consumers newly eligible for coverage. Some will have lower incomes and be new to health insurance, while others will have more moderate incomes with or without experience purchasing employer coverage. While broad-based media campaigns, social media, and online enrollment will be important channels for a number of these consumers (especially those more savvy to the health insurance marketplace), most challenging will be connecting with harder-to-reach populations who have no or limited knowledge of health insurance and who may rely more heavily on word-of-mouth, in-person assistance, and a paper application. Outreach and assistance strategies should take the following into consideration. • The Navigator program should provide education about the different programs, help with completing an application, and information on navigating care once enrolled. A variety of entities will be eligible to receive navigator grants, but California should ensure broad representation from those with established relationships and trust in under-served communities, experience conducting successful outreach strategies, and demonstrated expertise in providing cultural and linguistically appropriate assistance. To be relevant, the Navigator program should be operational prior to open enrollment in 2013.	The 100% Campaign
Given limited time, resources, and capital, we suggest that the Exchange focus on the marketing activities that provide the most value to consumers. We suggest focusing on currently uninsured individuals and promoting the significant financial incentive for obtaining coverage through the Exchange. Additionally, it will be important for the Exchange to encourage a diverse population with a range of health care needs to participate; this will help meet the goals of increasing the total number of individuals with health insurance coverage and having a stable risk pool. Broad participation will be important to the overall long-term success of the Exchange.	UnitedHealthcare

Question #10: How can enrollment be designed to facilitate maximum enrollment of eligible individuals with minimal assistance and as early as possible (e.g., enroll in 2013 to have maximum enrollment effective 1/1/2014)? a. What populations might be automatically enrolled or have eligibility determinations made automatically? b. How could the Exchange, Medi-Cal and/or Healthy Families enroll people previously eligible for COBRA with minimal effort on the part of the individual? c. How could the Exchange, Medi-Cal and/or Healthy Families enroll people currently enrolled in or attached to public health coverage such as Family PACT enrollees or family members of Healthy Families kids? d. How could the Exchange, Medi-Cal and/or Healthy Families maximize enrollment of subsidy or coverage eligible individuals who are currently covered by individual private insurance?	
a. Since eligibility is largely based on family size and income, there are many existing systems and programs that should be used to identify those who are potentially eligible. Income and family size data gleaned from state income tax returns, public assistance programs, unemployment insurance rosters, and low-income energy assistance rolls could be used to identify eligible households. Those who are clearly eligible should be notified of their eligibility and potential benefits and invited to apply or obtain more information from the Exchange, a Navigator or similar source of unbiased information. For those who appear to be eligible based on available data, but who are not clearly, currently eligible (for example, someone who appears to be eligible based tax filing for the previous tax year) should be notified and invited to apply or obtain more information. Such notification should indicate eligibility and benefits based on the available data while noting that these would change if income or household size has changed. Automatic enrollment would be inappropriate when it would result in financial liability for the individual, for example, where enrollment for an Exchange plan would result in personal liability for premiums. Exchange enrollment should remain voluntary since the ACA's individual mandate has exceptions based on affordability or religion. Even if not exempt from the mandate, individuals would still have the option to pay the ACA-related tax penalties in lieu of carrying qualifying insurance coverage. Automatic enrollment would be appropriate when it would not result in financial liability for premiums or other enrollment costs, provided that policies and plans can be readily changed. For example, when an uninsured person seeks hospital care, it would be appropriate for the hospital to determine eligibility for Medi-Cal and to effectuate enrollment. Ideally, the hospital staff would assist the consumer in the selection of a plan that has a network that best matches the consumer's current health care providers and medical needs. Those enrolled in such a manner should be able to switch plans at will and should be provided with information on plan selection and enrollment assistance services available to them.	AARP California
Applicants must be able to access culturally and linguistically appropriate assistance electronically, by mail, by phone and in person. There should be a 24 hour multilingual hotline. The enrollment system should be designed with an appropriate rules engine which can successfully serve families with complex cases (e.g. mixed status families, employee versus individual etc.). Individuals should be allowed to self-attest with regards to citizenship and other required eligibility documentation, with follow-up assistance to occur later. The Exchange should contract with Navigators from community-based organizations and partner with them to	CPEHN and Having Our Say Network

provide classes and/or community forums on how to fill out applications for health coverage (similar to a citizenship class). Individuals should have one enrollment ID number (similar to Healthy Families) so that wherever you go you can always access your application. This could help to cut down on false rejections. The enrollment number should be transferable to applications for other health and human services programs. If applicable there should be one family application where everyone in a family can apply to… (comment cut off on PDF). a. AB 714 (Atkins) attempts to identify the universe of people the state should target for pre-enrollment. Specifically, the state should look to current health and welfare programs like LIHP, AIM, Family PACT, SNAP, ADAP, Every Woman Counts, CalWORKs etc. for potential enrollees. b. Individuals should be notified of their eligibility for the Exchange and any changes to their current coverage as soon as possible but no later than the beginning of 2013. After signing a waiver, individual enrollee data should be pre-populated into the Exchange. Enrollment forms for current health coverage programs should be changed ahead of 2014 to ensure that those forms are collecting the appropriate data for determining eligibility in the Exchange and Medicaid in 2014. d. We support AB 792 (Bonilla), which attempts to identify people undergoing life transitions that the state should target for pre-enrollment. Specifically, the state should look to emancipated foster youth, individuals changing jobs, undergoing divorce or dealing with the death of a spouse as well as other categories identified in AB 792.	
High-level coordination between the Exchange, Medi-Cal and Healthy Families and multiple public assistance agencies is necessary for automatic and seamless enrollment of eligible individuals and families into a healthcare coverage program. Public programs such as WIC, AIM and Family PACT are natural links because participants or other individuals in the family may become eligible for Medi-Cal or the Exchange due to their income. Other obvious links should be made with: the California Department of Education through local school lunch programs and child care programs, Utility Assistance Programs (e.g., CA Lifeline, Low Income Home Energy Assistance Program) and Housing Assistance Programs; state unemployment as individuals move in and out of employment; the Department of Motor Vehicles. These state and local departments must work together to establish automatic healthcare coverage enrollment links via their existing electronic systems. Joint materials (brochures, introductory letters) between the State coverage programs and other public agencies would demonstrate the collaboration between agencies to the consumer and support for seamless enrollment. An effort should also be made to establish cooperative agreements with federally funded programs operating at the local level such as job and workforce development programs. Hospitals also provide a great linkage to uninsured individuals who may be eligible for Medi-Cal or the Exchange. The State should coordinate with hospitals to link potential enrollees who seek emergency room services and either pay out-of-pocket or access the hospitals' charity services. Coordinating with the Department of Managed Health Care and Health Plans to obtain a list of COBRA enrollees is another avenue to identify potential beneficiaries. For example, the State could create a joint notice with health plans notifying their COBRA enrollees of their potential eligibility, provided that their information is still valid, and automatic enrollment into a coverage program. Through the Healthy Families program, the State could generate a list of families who applied for but were rejected given their income level (over 250% FPL but less than 400%). The State could follow-up and notify these individuals of their potential eligibility in the Exchange and provide them with the opportunity to	Community Health Councils

update their information and automatically enroll in the program or reject enrollment. Additionally, in order to participate in the Exchange, Qualified Health Plans should be required to share their list of individuals with existing insurance policies who have incomes below 400% FPL or the smallest amount of coverage (i.e., catastrophic). These individuals would have the opportunity to enroll in Medi-Cal or the Exchange with the option of remaining with their current health plan. Additionally, to maximize enrollment prior to 2014, it is necessary for the State to provide funding opportunities and resources to various experienced OERU organizations to support specifically enrollment efforts (i.e., school and community-based outreach and enrollment "Navigator" contracts and grants). These "Navigator" contracts/grants can promote mandated out stationing of Navigator/CAA enrollers in nontraditional locations frequented by populations typically referred to as "hard-to-reach" (e.g., homeless shelters, mental health centers, churches). These locations can also be used to provide outreach materials targeting those individuals who will become newly eligible starting January 2014.	
There are some populations that can be auto-enrolled or at least pre-screened (with an opt-out provision), such as parents of children enrolled in the Healthy Families Program, individuals enrolled in CalFresh, parents of kids in the Free and Reduced-Price School Lunch/Breakfast Programs, FamilyPACT and others. Private stakeholders—such as hospitals subject to "charity care" requirements and reduced price provisions of law in California, tax preparers, and colleges that do loan counseling for graduating students—would also have information about who may be eligible. Privacy considerations may impede their turning over such information for pre-enrollment, but they could be asked to perform an outreach function by alerting the likely eligible individuals to contact the Exchange. We suggest that the state Exchange review how Massachusetts converted its uncompensated care pool recipients into their Exchange, via a federal waiver, as there may be a number of population segments here that may be able to convert or move to the Exchange through auto-enrollment. (CU background on Massachusetts is attached.). We also recommend that the Exchange formally ask the low-income health plans (LIHPs) to keep an inventory of those who applied but are ineligible for LIHP or unable to enroll because enrollment is capped; come 2014, these individuals may be likely Exchange eligible individuals. But note that even for those likely to be eligible for pre-enrollment will require some assistance to enroll.	Consumers Union
b. The Exchange could also disseminate information to the DMHC's Health Care Help Center, which received grant funds to assist consumers with insurance matters (including reaching the uninsured). d. If an individual is covered by private insurance, they may like their coverage and want to keep it. However, marketing and outreach efforts, through social media, community programs, or through brokers and agents, should highlight the availability of tax subsidies through the Exchange to assist these individuals in paying for their coverage. Those with existing family dental coverage outside the Exchange will want to either keep this coverage or purchase similar family coverage through the Exchange. Therefore a range of coverage options should be available to mirror the private market.	Delta Dental

Facilitate Maximum Enrollment: a. Those who are already in the system should be automatically rolled over - including the formerly incarcerated (see: Enroll America, 10 Ways to Make Health Coverage Enrollment and Renewal Easy) c. During renewal period, partner with schools around the beginning of the year to inform parents. Also partner with health centers, clinics, and doctors. (See: Kaiser Family Foundation http://www.kff.org/medicaid/upload/Connecting-Eligible-Immigrant-Families-to-Health-Coverage-and-Care-Key-Lessons-from-Outreach-and-Enrollment-Workers-full-reportpdf.pdf) d. Work with employers to post and disseminate information	The Greenlining Institute
This will be a multi-pronged approach, using multiple pools for enrollment and strategies to enroll the newly eligible. Generally, inter-agency relationships will be important in communicating information and ensuring that consumers get to the program for which they qualify with the least onus possible placed on the enrollee. Coordination between the Exchange, DHCS, and MRMIB will be critical, with the newly-expanded Office of the Patient Advocate, DMHC and CDI as the regulators. Also, locally-based organizations, employers, and other possible assisters will be key to ensure success. The Exchange should consider a separate strategy to concentrate on auto-enrollment on the public programs side. Though mail, telephone and/or electronic communications will be necessary for families and individuals in this category, the importance of locally-based organizations that have trusted relationships with people in their areas cannot be overstated. Providing those groups the tools they need to expand outreach and education will go a long way to assist those who have never lived in a culture of coverage. a. The state should identify people that will most certainly be eligible for Medi-Cal or the Exchange, e.g. those receiving General Relief/General Assistance, parents of HF children, people with FamilyPACT, etc. An application should be started for these individuals with their consent. b. COBRA notices should include information about the availability of subsidized coverage and how to apply. c. Seek the applicant's consent to use the information already known by the state about family size, income etc. to start an application for the person. They will have to complete the application, e.g. pick a plan but should not be required to give information already contained in a state system. d. Those currently enrolled in limited scope or state-only health programs will represent a good number of those who can easily auto-enroll. This includes the Low Income Health Program, Family PACT, Breast and Cervical Cancer Treatment/Prostate Cancer Treatment Programs, Every Woman Counts, parents of children in Healthy Families, women who are on or have been on the Access for Infants and Mothers program, and parents of children in the Medi-Cal child-only benefit. Close partnerships must be developed between the Exchange and other solicitors, the Employment Development Department, and the federal Social Security Administration, and organizations employed to help families and individuals enroll should be subject to oversight from the solicitors as data sharing is key.	Health Consumer Alliance
Populations that will benefit from automatic enrollment are infants, pregnant moms, those who are receiving citizenship, uninsured persons seeking help in medical offices and emergency rooms and pharmacies. This can be done by extending temporary coverage until eligibility is processed and determined.	Health Plan of San Joaquin

Enrollment Design: (a) The Initial Open Enrollment Period should last at least to the end of the personal income tax filing period (October - April), or for the first entire year of the Exchange, if possible. The Healthy Families Program (HFP) took two years to enroll about 30% of the eligible population. (b) Populations who might be automatically enrolled or have eligibility determinations made automatically includes, LIHP, county MIA/CMSP, parents of the children enrolled in the HFP, parents of the child-only Medi-Cal groups, AIM, PCIP, MRMIP, and other groups who receive any type of public assistance.	Inland Empire Health Plan
• Pre-enrollment is critical for access. There needs to be a place for individuals to pre-enroll. The Exchange can use this database to: o Target marketing to these individuals o Pre-screen eligibility o Streamline enrollment • Align the rules and regulations to streamline transition between programs and remove burden from customer. • Utilize existing venues: o Add required language to COBRA notices • Eliminate the “Big Brother” stigma of access to personal information – Address the sensitivity of personal information and reduce concerns. Educate on privacy requirements and practices.	San Bernardino County
In addition to the MCE and HCCI populations that will be "pre-enrolled" through County Low Income Health Programs, other key populations to enroll include uninsured clients served by public entities such as county specialty mental health plans, CCS, and AOD providers. Health plans, particularly the COHS and other public plans can be effective partners in reaching Medi-Cal and Healthy Families participants who become newly eligible for subsidies.	San Mateo County Health System
e. Eliminate wait period for individuals voluntarily leaving private insurance to enroll in Healthy Families.	Santa Cruz County
Allowing applicants to “pre-enroll” before launch could be an excellent way to achieve maximum enrollment. This would reduce the website traffic on and immediately after January 1, 2014. The information systems for the HBEx should be able to exchange information with Medi-Cal, Healthy Families and county programs, like Healthy San Francisco, to minimize how many times an individual must enter the same information. At the time of initial or renewal eligibility determination for any program, an individual should be able to enroll in the HBEx if they are found ineligible for other programs. The State should collaborate with county LIHP programs and indigent programs to create a simple transition path to the exchange for clients currently using health care services. This will require releasing all program requirements and HBEx screening questions to the counties as early as possible. There would be a web-based software neutral interface between HBEx and a county’s current eligibility system to allow submission exchange applications when the client comes in for their annual redetermination for the county program.	San Francisco Department of Public Health
Once the Exchange is accepting applications in 2013, California will have almost 4 million people to enroll into the insurance affordability programs (in addition to the applicants who will be seeking unsubsidized Exchange coverage). Fortunately, Medi-Cal already has a presence in millions of lives and can be utilized to target large groups of newly eligible individuals prior to launch. California should implement the following “maximum enrollment” strategies. • Parents of Medi-Cal and Healthy Families children. Some of the adults who will gain eligibility for Medi-Cal or	The 100% Campaign

subsidized Exchange coverage are parents of children who are enrolled in Medi-Cal or Healthy Families. For most of them, eligibility information already held by the programs will be adequate to determine eligibility. A simple pre-populated application should be forwarded to each consumer requesting consent to make an eligibility determination if they are uninsured and confirmation of data on file, along with any changes or additions (including whether other family members need coverage). The materials should also provide information on how to finalize the process (either online, phone, fax, or by mail) and how to obtain assistance if needed. While multiple contacts may be required to reach these families, the number of consumers that could potentially be reached will make it an efficient use of resources. The determination for parents should also reset the enrollment period for the child so that the family has the same renewal dates. If new information would detrimentally change the child's eligibility, he or she would stay enrolled in their current program through the established renewal date (consistent with California's continuous eligibility for children policy). • Healthy Families children, ages 6-18, between 100% and 138% of the Federal Poverty Level (FPL). Under the ACA, Medi-Cal will provide coverage to children and non-elderly adults up to at least 138% FPL. Since Healthy Families currently covers some children within this income range, those children in Healthy Families must be shifted into Medi-Cal. California should rely on Healthy Families income and other eligibility findings to automatically transfer these kids. Given the state's joint Medi-Cal/Healthy Families application, it is likely that most parents or caretakers have already provided affirmative consent to enroll their children in Medi-Cal. This allows for a one-time automatic rollover of affected Healthy Families children into Medi-Cal. To limit disruptions, California should help ensure that children, if their parents so choose, remain with the same health insurer when possible (or at the very least maintain their provider network), educate families on how to obtain care, and monitor any shifts in access to care. Other strategies to consider include auto-enrollment of PCIP and MRMIP enrollees; family members of AIM enrollees, and/or other human services programs like CalFresh and CalWorks that may also serve families with eligible income levels. Additionally, forming partnerships with other entities that serve large numbers of children and their families – such as Children's Health Initiatives (CHIs) and the state Department of Education – can help to help educate consumers about coverage options, inform families about requirements and availability of health coverage and actually enroll eligible family members into care.	
As a threshold question, it appears clear that automatic enrollment will have to be limited to individuals that do not have to pay member premiums, since the necessary consent and information required for payment will not be available to the State. This would seem to limit the appropriate population to Medi-Cal and certain Healthy Families program participants.	UnitedHealthcare
Question #11: What steps can the Exchange take to assure the maximum possible retention of eligible individual enrollees who do not have affordable employment-based coverage?	
To promote retention of individual enrollees, we'd recommend that the HBEx: appropriately staff and train the service center, create a robust online enrollment and assistance tool, engage agents to conduct outreach and enrollment, and permit health plan issuers to adequately compensate these agents.	Anthem Blue Cross
Retention of healthcare coverage is a cost-effective way to improve the continuity and quality of healthcare for children and families. Children and families often lose coverage at the time of annual renewal or when they fail to	Community Health Councils

pay the monthly premiums required by some health insurance programs. In an effort to retain children and families currently enrolled in a health insurance program, the following retention strategies are recommended: • Provide easy methods for paying premiums. Paying premiums should be made easy through the adoption of auto-pay programs with local banks and credit unions; payment by a wide range of credit and debit cards; online bill pay and payroll deduction; and payment via phone through the Exchange call center. In addition, for those who do not have access or choose not to use conventional banking, enrollees should have the option of paying at key locations within communities following the Healthy Families model of using pharmacies and bill payment centers. • Provide affordable premiums and flexible payment plans. Implement a 3-month grace period for non-payment of premiums before coverage is dropped. Multiple attempts should be made to contact the individual for payment via several methods of communication (e.g., phone, mail, email). • Assign retention specialists or navigators. Provide renewal assistance in the community at outstations with cultural and linguistic competency to walk individuals through new health benefits, navigate services, troubleshoot issues, retain coverage and educate consumers of his/her rights. Additionally, ensure that these Retention Specialists or Navigators do not have excessive caseloads that would preclude their meeting the needs of individual clients and their families. • Create support systems for a "Passive Retention" approach. A "Passive Retention" approach works for the consumer by providing pre-populated renewal forms (i.e., only a signature is required if there are no changes to personal information affecting eligibility such as income) and electronic fund transfers from bank accounts to pay premiums so that action is not required on the part of the consumer to reenroll. Basically, if there are no changes, the consumer remains covered and does not need to take any action. • Develop and utilize IT systems. Develop IT systems that will generate automatic alerts to consumers' emails and smart phones to trigger payment or renewal action to ensure continuity of care. The Navigator Program should be required to utilize social media as a way to assist families who have missed their renewal period when a successful phone or mail contact has not been made. • Implement a Quality Improvement Plan. A Quality Improvement Plan (QIP) within the Exchange, Medi Cal and Healthy Families will ensure attentive and appropriate customer service. By assessing the enrollment/retention system through feedback from consumers, Navigators and Agents/Brokers will assist with ongoing improvements and program integrity. Evaluation of progress on QIP should be reported at least twice a year or quarterly for the Exchange so that problems and gaps in services are acknowledged and remedied expediently.	
Achieving affordability and smooth operation of subsidies will be key to enrollees keeping coverage, as will minimizing the paperwork and other requirements on individuals to re-enroll every year. In addition, from our prior work in the schools, we know that getting enrollees to utilize health care services shows them the value of having coverage. Supporting public education efforts and encouraging appropriate use of preventive services, will help with long-term retention. Also, the state agencies can take action to vigorously use the federal data services hub, and also develop secure and efficient information sharing at the state level between programs in order to pre-populate data for re-enrollment.	Consumers Union

Additionally, the state needs to have a monitoring and tracking system in place that collects data and reports on patterns and practices and that can identify particular segments that are at risk of losing coverage and to then respond with changes in policy to help resolve those problems and help people retain coverage. Early warnings about how changes in income, if not reported, can trigger pay-back/reconciliation would help avoid surprises that could sour consumers on the Exchange. In addition, a robust consumer assistance program that provides assistance with re-enrollment and retention must be in place, for those who cannot otherwise stay enrolled without assistance; thus structuring additional payment to assisters for retention/re-enrollment activities makes sense. From the CHI experience we know that one of the main problems in retaining enrollees was when people relocated, CHIs lost contact with enrollees and were unable to communicate with them. The San Mateo CHI took specific steps to combat that, with great success, including by sending quarterly address change reminders, calling families at least three times to remind them to renew (including 1 weekend/night call), offering $30 Target gift cards for re-enrollment 30 days before the termination date, and offering phone assistance with re-enrollment. See "Evaluation of San Mateo CHI" (Aug. 2005), by Embry Howell of Urban Institute and Dana Hughes, UCSF (Attached to CU's cover letter). Work with tax preparers to remind filers about their health insurance obligation annually, and remind them that subsidy assistance is available.	
Employers can play a critical role in educating employees of the options and resources available to them and in supporting employees as they look to make their plan selections.	CVS Caremark
If an individual cannot afford the coverage being offered through their employer, the Exchange's best way of keeping the individual is to keep plan prices affordable inside the Exchange by focusing on a competitive marketplace, transparent pricing, and choosing essential benefit benchmarks that properly balance coverage with cost	Delta Dental
Maximum Retention: Customer service is key: 1. Making it easy for individuals to renew their insurance (smart phone application, provider office can help renew/offer info on other plans). (See: The Greenlining Institute: iHealth: How to Ensure the Health Benefit Exchange Reaches all Californians) 2. Also aim for 12-month coverage periods with annual enrollment, and make it easy to switch options as a result of changing life circumstances. (see: Enroll America, 10 Ways to Make Health Coverage Enrollment and Renewal Easy) 3. Utilize an annual renewal form that individuals only return if they need to change their plans. (see: Enroll America, 10 Ways to Make Health Coverage Enrollment and Renewal Easy) (4) Employers should inform employees of their options. 4. All individuals should be able to access materials in their preferred language (utilize Medi-Cal threshold languages as a standard).	The Greenlining Institute

Outreach should target the uninsured—or those in need of coverage or care—instead of promoting a single coverage option. Outreach should target all those in need of coverage or care to reach a wide range of individuals whose eligibility for all insurance affordability programs can be determined by the exchange. Retention happens when people see a benefit to health benefits and are given the opportunity to reenroll. Marketing and Outreach to small businesses will need to take into consideration that those who are employed, but uninsured, may not have the skills needed to deal with enrollment and reenrollment issues.	Health Consumer Alliance
The lower income population without access to employer-sponsored coverage has high mobility. Pre-populated forms that assure confirmation of key demographic and contact information can increase success in retention.	San Mateo County Health System
• Simplify the renewal process as much as possible • Online renewal process	Santa Cruz County
Question #12: What steps should the Exchange take to assure retention of small employers?	
Given that the small employer tax credit is only available for two years, the SHOP exchange must define a value proposition that will retain groups that migrated for the tax savings. To do so, we recommend the HBEx should focus on offering: administrative ease, unique bundling options, account management resources, and competitive rates and products.	Anthem Blue Cross
Ensure that use of the exchange is administratively simple.	Consumers Union
Regardless of size, most (if not nearly all) employers will want to support their employees and can serve as a useful channel of communication and proactively guide individuals to the right information sources.	CVS Caremark
Our experience is that small employers value customer service tools that can respond to questions about plans, rates, or any other issues that may come up during the enrollment process or during the plan year. Specific plan benefit questions that occur after enrollment should be handled by the issuers to be efficient.	Delta Dental
Retention of Small Employers: 1. Make information and help easy to access for both the employer and their employees 2. Provide materials in multiple languages and at an appropriate health literacy level so that individuals can easily understand all information provided 3. Create a system in which insurance is automatically renewed unless things have changed (see: Enroll America, 10 Ways to Make Health Coverage Enrollment and Renewal Easy)	The Greenlining Institute
Keeping cost lower than purchasing insurance outside of the exchange.	Health Plan of San Joaquin
See San Francisco experience with small employers via Healthy SF; lots of lessons here about small employer behavior, positive and negative. Tangerine Brigham at: Tangerine.Brigham@sfdph.org is place to start.	Lucy Johns, MPH
• Conduct periodic evaluations - Annual or bi-annual redeterminations/evaluations. • Maintain open communication with small business groups through newsletters/flyers and seasonal conferences. • Simplified coverage renewal. (Self-declaration or check box for no change.)	San Bernardino County
Small businesses can be retained by the SHOP Exchange if they feel they are saving time and money by using the Exchange. Employee choice and additional HR-type services are very attractive. Once an employer gets used to having these features, the outside market will become less attractive, and owners will be more likely to stick with the SHOP.	Small Business Majority

SHOP Exchange Requirement 58 of the CalHEERS RFP requires functionality to determine if an employee is eligible for any subsidized health coverage. This requirement is unnecessary and potentially harmful because eligibility for subsidized health coverage has no bearing on eligibility for the SHOP Exchange and determining eligibility for these other programs has the potential to raise privacy concerns for individuals in the SHOP Exchange.	UC Berkeley Labor Center and Health Access California
Question #13: How should the Exchange consider the potential enrollment for employees of larger employers?	
The SHOP exchange should initially focus on successfully serving the small group market that includes employers most likely looking for a turn-key solution that doesn't require HR expertise. Once established and running smoothly, the SHOP could then target certain segments of larger employers, such as those with high percentages of transitory, part-time or low-wage employees. For instance, this might include the restaurant, retail, and other service sector occupations. However, there is a real risk of adverse selection against the SHOP if large employers are permitted to obtain coverage on the SHOP. Given community rating requirements that apply in SHOP, large employers with lower medical costs would have an incentive to self-insure leaving large employers with higher medical expenses to obtain coverage through the SHOP.	Anthem Blue Cross
As an employer of 200,000 individuals nationwide, CVS Caremark recognizes the role that these firms can play in educating employees of their options and providing decision support tools to help them transition to alternative forms of coverage. And, as a leading pharmacy benefit manager who works with large employers, we have some relevant insights from our experience in managing prescription drug benefits for retirees. When employers decide to terminate coverage for these individuals, they will proactively establish the right mechanisms to ensure a “soft landing” for these individuals, whether through subsidy support, providing group auto enrollment into a plan, or directing them to an exchange coordinator who can work with them directly to review the coverage alternatives.	CVS Caremark
Cost is the main driver. Larger employers use brokers to purchase insurance. If you can demonstrate that an employer can reduce costs without losing service levels by going through the exchange rather than through a broker, more employers will consider the exchange	Health Plan of San Joaquin
• Manage the Exchange through ‘Open Enrollment’ • Choice and value purchasing of an insurance plan and doctor • Virtual access - online self-service enrollment	San Bernardino County
Groups over 50 employees typically have the option to self-insure their benefits, and it is reasonable to expect that the lowest cost groups would opt to self-insure and the highest cost groups would find the community rates within the Exchange to be most attractive, making products within the Exchange increasingly more expensive for those small groups electing coverage. Limiting the small group market to groups with fewer than 50 employees will also minimize market disruption and avoid overtaxing Exchanges’ administrative systems in the initial years. Given these concerns, we would appreciate more information regarding what the Exchange is considering regarding large employers, and we welcome further discussion of the issues.	UnitedHealthcare

Question #14: What steps should the Exchange, DHCS and/or MRMIB take to assure that any individual who disenrolls from or loses eligibility for coverage with one program is automatically or seamlessly enrolled in (or informed about) their rights for other coverage when the individual meets Affordable Care Act requirements?	
A significant portion of the California's population will experience changes in income or other circumstances that will change their eligibility for state programs and the Exchange and its subsidies. In the current economic climate, it is likely that many households will experiences multiple increases and decreases in income over the course of a year. To ensure seamless transitions, AARP suggests that California and its Exchange give preference in the selection of plans to those that participate in all forums and that offer identical or similar health care provider networks in each. The goal should be a structure where consumers do not experience disruptions or gaps in coverage or ongoing care and are not required to change health care providers. Ideally, a change in circumstances should only trigger adjustments in premiums and out-of-pocket costs for the consumer. Alternatively, a system would need to be developed to minimize the disruption of care and coverage. This would require careful coordination between programs and their respective plans and provider networks to prevent gaps in care and coverage and to effective communication and transfers of medical records between providers in the various networks. Particular attention would need to be devoted to those who are receiving on-going care and treatment where any gap or change in providers could have dire medical consequences.	AARP California
All application forms should include a check-box authorizing that program to share enrollee information with DHCS, MRMIB and the Exchange should a person lose eligibility or coverage in one or another program. The Exchange, DHCS and MRMIB should put a system into place where people receive notification of their eligibility for coverage and a follow-up call to encourage enrollment.	CPEHN and Having Our Say Coalition
Within Medi-Cal and Healthy Families, a bridging process is currently in place to move individuals and families from one program to the other when their eligibility changes during annual renewal. This bridging process should be extended to the Exchange and from the Exchange to Medi-Cal and Healthy Families. Medi-Cal and Healthy Families beneficiaries should be informed that their provider is in the QHP. If the provider is not in the QHP, they should be allowed to stay with them for a period of time to ensure continuity of care. For individuals in the Exchange, the QHP should do its best to identify any changes in income or life situations that would make them eligible for Medi-Cal or Healthy Families before they are dropped for non-payment.	Community Health Councils
The Exchange should be driven by the ACA's policy to require only "minimally necessary" information. The IT and policy decisions should dictate that transitions between programs allow for real-time transfer of information so that as much as possible, a person can be transferred from one program to another without requiring more information than minimally necessary. Questions once asked that do not change (i.e. citizenship) should not be re-asked once the status has been confirmed. The rules between agencies and programs should be designed to be consistent in order to ensure accurate and timely coordination and coverage decisions. The system designed to implement transitions should be coordinated amongst all programs, transparent, and accountable (including a delineated responsibility on one agency to monitor transitions and disenrollments).	Consumers Union

Disenrollments/terminations of coverage should be reviewed—all, if possible— to ensure that the individual is screened appropriately for alternative coverage. For specific situations that are predictable and can be anticipated within the system (e.g., aging out of dependent status or foster care or loss of employment or a decrease in hours), the Exchange and its partners should, to the extent possible, require relevant private parties (e.g. employers) to communicate information to the appropriate state agency. For example, the Exchange should require that employers provide notice about health coverage options from the Exchange, Medi-Cal and Healthy Families, in addition to COBRA, when an employee's hours and/or income is reduced or they suffer a job loss altogether. As well, applications for unemployment insurance benefits should also include information about health coverage options.	
Optimization of the planned „No Wrong Door" Policy could not only help to ensure that access points enroll individuals in all programs, but also could help to solve disenroll or re-enroll issues.	CVS Caremark
In the case of dental, children or adults who are accessing dental coverage through Healthy Families or Medi-Cal should have access to Exchange products that are similar and offer the same network providers so that they may easily transition between plans if necessary.	Delta Dental
Automatic and/or Seamless Enrollment: Create a culture of eligibility. If denied or kicked out from one program, the system should automatically tell you about other programs an individual may be eligible for and/or automatically enrolls individuals into other programs for which they are eligible. (see: Enroll America, 10 Ways to Make Health Coverage Enrollment and Renewal Easy)	The Greenlining Institute
Constant communication and a system for feedback within programs, departments, agencies, and offices is key. A feedback loop should be in place well ahead of Exchange product enrollment. No one should have a lapse in coverage. If someone is on Medi-Cal and their income increases at annual renewal, they should be transferred to the Exchange without a break in coverage. Someone who has already submitted information once should not have to do so again if it is not subject to change. For example, if someone has proven their citizenship status for Medi-Cal they should not have to do so again when they transfer to Exchange coverage.	Health Consumer Alliance
To ensure that individuals do not lose health coverage because of "eligibility churning", the enrollment and eligibility system has to build in the program's specific eligibility requirements in the back end either through a single streamlined system or if with multiple systems, all systems should connect to each other seamlessly. It should not require additional manual or paper processes to keep continuity of coverage.	Inland Empire Health Plan

Pre-enrollment through current public programs such as a Family PACT is the most efficient and expeditious way to capture the population Medi-Cal and the Exchange will serve. Because of PPAC's familiarity with the Family PACT program we wish to emphasize the benefits of capturing this patient population for enrollment in the Exchange. Our qualified patients are enrolled on site in the Family PACT program, and are immediately eligibility for family planning services under the program. These patients are essentially healthy individuals who are the dream enrollees of any health plan – primarily low cost, low usage patients. Family PACT eligible enrollees are uninsured individuals whose income is 200% FPL or less. However, PPAC urges the Exchange Board NOT to auto-enroll individuals if this means enrolling individuals without specific consent by the individual. Family PACT provides highly sensitive services to its enrollees. Eligibility for Family PACT includes insured individuals who, for confidentiality purposes, must seek out-of-plan providers for these sensitive services. Due to this recognition of the sensitivity of the services provided, we believe it would be a violation of patient confidentiality to automatically enroll Family PACT beneficiaries in the Exchange.	Planned Parenthood Affiliates of California
Establish an efficient system that will support transition between programs and interface with federal, state, and county government data bases.	San Bernardino County
While assuring choice of plans and providers is important, we urge the Exchange to consider an equitable process for "default" enrollment in participating qualified health plans to minimize breaks in coverage. Logic that aims to keep consumers with existing providers would be ideal.	San Mateo County Health System
The State should make sure that the different eligibility and enrollment systems of record can exchange information to facilitate an individual changing between programs. This will require the exchange to release detailed program requirements and, if possible, exchange screening questions as early as possible, so they can be incorporated in the county's electronic eligibility systems.	San Francisco Department of Public Health
There are an endless number of scenarios by which individuals will find themselves with life changes that could affect their eligibility for any of the insurance affordability programs and require transfer to a new program (whether during the year or at renewal). To ensure seamless transitions, the state should eliminate any requirement that these enrollees complete another application or submit documentation. Additionally, to ensure that there are no gaps in coverage between the time coverage under the prior program is terminated and coverage under the new program becomes effective, Medi-Cal and Healthy Families should maintain coverage through the end of the month after an affirmation that the receiving program enrollment has occurred, consistent with the Exchange's first of the month coverage effective date. The state should also be proactive in identifying instances in which an individual may need to transfer between programs, due to a change in circumstances. The federal proposed rules generally place the responsibility for reporting changes on the consumer but the state can: • Establish clear and easy-to-understand descriptions on when a change should be reported. For example, the enrollment system rules engine could calculate and notify the subsidized Exchange enrollee as to the specific income change that would alter their subsidy level, and thus necessitate reporting. Enrollees should be able to report these changes through the same avenues available to them at enrollment (online, phone, mail, or in-person) and when making a premium payment. • Assist consumers who will experience negative financial consequences if new data were not considered (i.e., they	The 100% Campaign

have experienced loss of income and should be placed in Medi-Cal or they have experienced a material increase in income and need to adjust their premium tax subsidy). Strategies should include mid-year data checks such as with unemployment insurance (in addition to those minimally required of the Exchange by proposed federal rules for such things as death) and following up with families who stop making Exchange premium payments. However, the state should be strategic in the application of these data checks to target only instances of significant changes in order to eliminate unnecessary and burdensome administrative processes for the consumer and state. • Create pathways for individuals in Exchange coverage who need to self-report other mid-year changes. This particularly pertains to newly pregnant women between 133% FPL and 201% of FPL who would become eligible for Medi-Cal pregnancy-related care. Medi-Cal offers several important benefits that might be missing from commercial Exchange coverage, including health education, psychosocial services, nutrition counseling, and breast pumps. As such, women at these income levels enrolled in Exchange coverage should be educated on the need to report a pregnancy and the benefits of receiving Medi-Cal benefits if pregnant, and, at their option, provided Medi-Cal pregnancy services as a wraparound to their Exchange coverage. Pregnant women newly enrolling in insurance affordability programs should also be provided with information on this option.	
Question #15: Who would be the most effective messenger for marketing to different high priority populations?	
"Young adult-- some pop icon or big-name athlete"; "Peers from the same target populations - using a promotora model, or youth peer outreach model. Peers need training/partnership with enrollment experts."; "Schools are an excellent way to reach parents across populations. Written materials are not as effective with marginal populations as is direct contact."; "You need to use various messengers - schools, DHA, DHHS, mental health, PSAs, churches, buses, etc."; "County has been effective in the past. All community health clinics have also been effective as well as sites already serving low income community."; "Community outreach workers, certified application assisters, school staff, clinic receptionists, Emergency room staff, discharge planners, public health nurses, parenting educators, and childbirth educators."; "Peers, promotoras, trusted clinical providers in community clinics, school personnel, pastors"	California School Health Centers Association
Generally speaking, using various media outlets and working with local organizations and other trusted agencies will reach most individuals who will benefit from the Exchange and/or Medi-Cal Expansion. However, different populations will respond to different media outlets. • The use of mass media outlets, including ethnic and language specific electronic and print advertisement and community programming, is the crucial element in reaching most market segments. According to a report by New American Media, in 2009 ethnic media reached 57 million or 87% of all African Americans, Hispanics and Asian Americans on a regular basis. This was a 16% increase over 4 years prior. It will be critical for the state to identify those ethnic media channels and newspapers that resonate with different populations. • Outreach channels should also include print advertisements in high traffic public places (e.g., malls, sports venues, personal care facilities, entertainment outlets). In thinking through the messages and appropriate spokespeople to be placed on advertisements, the state should identify public personalities who will appeal to multiple audiences or a few that can deliver the message to specific audiences. • Social Media is a basic communication and information tool for a younger/tech savvy population. The	Community Health Councils

development of smartphone and other online enrollment channels (including chat opportunities, access to online service reps, etc.) will be vital. Additionally, whereas ethnic and racial technology gaps still exist, more minorities are utilizing technology than ever before. Many (46% of African Americans and 51% of Hispanics) are accessing the internet on their cell phones. The State will need to take this into consideration as it develops its social media strategies and messaging. Promoting the spectrum of available coverage programs through the state and local public and private agencies and organizations (e.g., schools, WIC, DPSS ~ CalWorks/Food Stamps) that routinely interface with families and newly eligible adults increases the likelihood they will learn about the options available to them, utilize services and know where to go for assistance when needed. Partnerships with local agencies should include intact Certified Application Assistant, Promotora and Community Health Educator networks that have an established record in the segmented communities. Local faith-based agencies provide another channel to reach eligible individuals and families. Print material should be readily available and disseminated through the communication vehicles of all state agencies such as the State Franchise Tax Board, Employment Development Department and through partnerships with the private sector. Partnerships with cities are of value in providing access to thousands of families and individuals through their mass transit systems (bus and rail), after-school programs, family resource centers, child care centers, parks and recreation programs, and public libraries, which are also well positioned as a resource for information dissemination. The marketing team should be responsible for developing relationships with major pharmacy chains, public utility companies (mobile phone, cable television, gas, electric, etc.) and other businesses within the private sector that have on-going communication tools and billing processes with the public.	
Identifying effective messengers will require some original and ongoing research, which presumably the vendor will undertake, to identify high priority populations and determine their receptivity to various messengers just as private companies do. Research does show that in the non-group market, trusted community representatives and word-of-mouth are highly influential. Additionally, research also indicates that providing messages from a mixture of sources helps. The Exchange should begin work now to identify these trusted local leaders, for example identifying respected small business owners in an immigrant community. See "Designing Subsidized Health Coverage Programs to Attract Enrollment: A Review of the literature and a Synthesis of Stakeholder Views" (2008) available at http://aspe.hhs.gov/health/reports/08/subenroll/index.shtml For example, we know from other health promotion efforts in CA that promotores, schools, nurses and pharmacists are trusted within communities. Further research could evaluate whether particular populations trust health plan/program information from groups such as religious organizations and providers, sports figures, clinics, etc. It will be important to identify early success stories (or early champions) with which target populations identify and in order to promote their stories or messages to the given audience. We know that for younger audiences, social media will be an important messenger/medium. Additional research should be conducted, however, to see if younger audiences will act on information received through social media.	Consumers Union

We have seen market research and real-world examples (e.g., in Massachusetts) that demonstrate that real people with real stories (e.g. whose lives have been changed by having health insurance) provide the most meaningful testimonials. Working with a professional media firm to create these marketing collateral will be important for the Exchange to ensure optimal results.	CVS Caremark
Effective Messengers: 1. Promotoras 2. People and organizations already trusted in these communities 3. Health clinics 4. Celebrities in the community 5. Conducting social media campaigns (See: Kaiser Family Foundation http://www.kff.org/medicaid/upload/Connecting-Eligible-Immigrant-Families-to-Health-Coverage-and-Care-Key-Lessons-from-Outreach-and-Enrollment-Workers-full-reportpdf.pdf, and The Greenlining Institute: iHealth: How to Ensure the Health Benefit Exchange Reaches all Californians, and Reducing Racial and Ethnic Disparities: The Action Plan From the Department of Health and Human Services. Health Affairs. 30(10): 1822-1829)	The Greenlining Institute
Trusted community-based organizations like the Health Consumer Alliance fill a critical role as messengers to high priority populations. Additionally, targeted media spots, particularly in LEP communities.	Health Consumer Alliance
Churches; social clubs; in rural areas, maybe stores like hardware, feed, auto body, local cafes (signs in the restroom!)	Lucy Johns, MPH
Define the high priority populations and use target/customized outreach by utilizing channels the community trusts such as CBOs/FBOs, advocacy groups. Again, situational marketing comes in play. Also, making this program personal by providing success stories, the community will view the program as a benefit.	San Bernardino County
Spanish language radio/TV	Santa Cruz County
In addition to the message from federal, state and local governments, it is important to have a variety of trusted community messengers outside of government, including, community based organizations, faith-based entities, community leaders, and potential celebrities in sports and arts/entertainment.	San Francisco Department of Public Health
Effective messengers for marketing to different high priority populations include community based organizations, faith communities, promotoras, providers, and school nurses.	The 100% Campaign
Question #16: How can the Exchange marketing efforts be best coordinated with national and state government partners and private sector partners (e.g., providers, plans, health insurance agents, and foundations)?	
To coordinate the HBEx marketing efforts with national and state government partners, ideally states would integrate their systems. California could research migration patterns across states lines for individuals likely to be eligible for the exchange, and work specifically with those states. For example, CA could work with Arizona to reach migrant farm workers who move between the states for harvests.	Anthem Blue Cross
The Exchange, based on the vendor's findings and stakeholder input, should develop its naming/logo/messaging, and—as done in the joint comments by the relevant state agencies to HHS—collaboratively develop a cohesive plan	Consumers Union

for marketing and outreach with partner state and local agencies/officials. Federal resources and other support will be welcome, as well. Perhaps an Exchange intergovernmental coordinator or task force would be helpful. Standardized materials, templates and speaker trainings (as well as customized ones for specific audiences/languages/cultures) will need to be developed, distributed and made available online at the Exchange website as well as other websites, both public and private. A discrete, private website area may be helpful as a place where partner organizations, navigators etc. can create a community to share stories and support each other's efforts with strong privacy and security provisions protecting consumers. Since the marketing need will be massive and ongoing, a good deal of delegation to partners in the private sector (e.g. at sporting events, health walks, canvasses, community meetings, at local newspapers, via doctors etc.) will likely be needed and appropriate. Cross-state learning can yield efficiencies as well. Thus, California should have a sharing relationship with other states that are also trying to develop effective campaigns and tools, and share the cost of this market research and tool development. Example: a viral video or a game format to attract younger audiences that might be costly to develop by one state, alone.	
Ultimately, the campaign must rely upon multiple sources and channels of communication that reinforce each other. To accomplish this will require a network of communicators who are coordinated and aligned in their outreach efforts and messaging, as well as a coordinated IT system that also enables diligent follow-up with consumers.	CVS Caremark
Brokers should be recruited to be an army to bring enrollees to the SHOP. Brokers and other private sector partners will be more effective than governmental partners.	Small Business Majority
Question #17: What type of marketing oversight standards should the Exchange use to prevent inappropriate steering?	
Without a level playing field between insurance sold inside and outside the Exchange, the Exchange and those they serve will be at risk. Any compensation system for Navigators, agents and brokers should prohibit steering of consumers outside the Exchange and should be free of any incentives for or against Exchange sales. This could be accomplished by allowing agents and brokers to sell QHPs only if there is a uniform compensation system for sales they make on products inside or outside the Exchange.	AARP California
There should be limited regular oversight with annual marketing audits that allow the state to check that marketing messages are not misleading. Collateral and communication reviews should not be required unless they are related to a benefit change, issue mitigation, or significant plan change. All other marketing, collateral and communications should only be reviewed during the annual audit. This would improve the "speed-to-market" of messages and permit health plans to be more responsive to market and member needs. This would also reduce the workload required by the state for reviews.	Anthem Blue Cross
Since the role of the Navigator is to assist the consumer impartially, a consumer-focused non-profit organization would seem the most apt to fill this role. These organizations are the least likely to be at risk of posing a conflict of interest and the most attuned to consumer needs. Additionally, we encourage the Exchange to work with CDI and DMHC to bar health plans and/or brokers who engage in deceptive marketing practices from becoming Qualified Health Plans and selling insurance in the Exchange.	CPEHN and Having Our Say Coalition

In an effort to avoid steering, marketing guidelines should be created for Qualified Health Plans that can be modeled from the Healthy Families Program. In addition to what is outlined in the "Healthy Families Participating Plan Marketing Guidelines," QHPs should not be allowed to hire or utilize volunteer enrollers. The Exchange Board should adopt the Healthy Families Monitoring, Oversight & Disciplinary Action Process with the change that coordination will be made with the Department of Insurance to report any violations and that consequences could include loss of the plan's qualifying status. Additionally all Navigators and Agents/Brokers should adhere to similar outreach guidelines and be subject to monitoring to ensure that clients are not inappropriately steered to specific health plans.	Community Health Councils
All marketing materials by plans, as well as materials used to provide outreach, educational assistance, or promotion of the Exchange, Medi-Cal, Healthy Families, and the Basic Health Plan (if adopted) should be reviewed in advance of use and approved by the appropriate entity (Exchange, DHCS, MRMIB, DMHC, or CDI). In addition, mechanisms should be set up for sharing amongst relevant agencies (e.g. AG's office, CDI, DMHC, DHCS) of information about any deceptive representations made by any party about the Exchange, individual mandate, or creditable coverage therefore. An MOU amongst the relevant agencies may be appropriate to ensure clear lines of enforcement authority. General "unfair and deceptive practices" prohibitions (similar to that found in existing consumer statutes, and as interpreted by case law) could be embodied in Exchange guidance/regulations since it is impossible to anticipate every specific tactic that might be geared toward steering. Identical producer commission structures inside and outside the Exchange would be an important standard so that producers are not incentivized to steer consumers to the market that best compensates them. In Texas, a working group of plans in Medicaid managed care helped the state surface steering and other deceptive practices as plans reported on their competitors.	Consumers Union
The Exchange should install guidelines to ensure that navigators do not act inappropriately, such as by steering individuals to certain health plans based on financial interest. However, the Exchange should take care not to impose unnecessary restrictions or limitations on navigators" interactions that make it more difficult for navigators to assist patients. The Exchange should consider taking steps to encourage providers, including retail pharmacies and retail clinics, to reach out to their patients to assist with enrollment, particularly to populations that might otherwise face greater challenges or be harder to reach, such as those with disabilities, individuals with low literacy or limited English proficiency, and populations that experience health disparities due to race, color, national origin, or mental illnesses and substance use disorders.	CVS Caremark
Oversight Standards: The following steps will help minimize fraud and build trust within communities: 1. Any and all marketing materials need to go through the HBEX staff before being distributed to public. 2. The Exchange should create standards to ensure that any and all marketing materials cover certain items, and have branding standards (e.g. all material should look the same and/or have a distinct logo). 3. Sanctions should be in place to discipline individuals and organizations who use materials inappropriately. (See: http://www.healthycal.org/archives/5595)	The Greenlining Institute
Navigators should have no financial incentives to steer.	Health Consumer Alliance

Marketing oversight standards are important to prevent inappropriate steering. Currently, DMHC and DOI regulate the marketing practices of health plans and enrollment agents to ensure consumer protection. The Exchange Board can use these existing oversight standards. By creating additional requirements for the promotion of the Exchange products, the unintended consequence could be an unfair marketing practice between the individual products in the private market and those in the Exchange. The marketing standards for the individual products in the Exchanges should be the same as for those in the private market.	Inland Empire Health Plan
Set a standard site and have consistent marketing materials for distribution.	San Bernardino County
To prevent inappropriate steering, the Exchange should consider reviewing all marketing materials to be used by messengers and require some sort of approval process in order for the materials to be endorsed by the Board.	The 100% Campaign
In 2014 and beyond, the health care marketplace will have many mechanisms in place to prevent inappropriate health plan steerage, such as adjusted community rating, guaranteed issue, pooling of risk inside and outside the Exchange, and risk sharing programs. General commercial health plan marketing standards that have been historically used in states should also be adequate for Exchange oversight of QHP marketing activities. The Exchange can play an important role by ensuring the Exchange participants are required to follow the existing standards and support the available anti-steering mechanisms.	UnitedHealthcare
Question #18: What messages, branding, and outreach efforts should the Exchange use to get individuals ready to enroll in coverage in 2013? For example, what messages would be effective in generating interest/demand among the currently uninsured?	
We suggest that outreach efforts focus on education about subsidy eligibility and the open enrollment period. In addition, HBEx might consider partnering with providers to reach consumers, as individuals will often take the advice of providers with respect to health plan enrollment or public program eligibility.	Anthem Blue Cross
The Exchange should reach the newly eligible in the community, through local ethnic media (television, radio, newspapers), trusted community organizations (CBOs) and service providers, clinics, promotoras and community health workers, schools, churches, senior centers, and other community services (hair salons, flea markets, shelters, libraries). Because of vulnerability to deceptive marketing practices, the state should engage in a public relations campaign with official information, branding a look for Exchange materials so consumers know how to identify Exchange products. The state could also engage in U.S. Census type outreach including public service announcements with trusted spokespeople from the community. We asked participants to provide suggestions for naming the website for the Health Benefit Exchange. Participants felt that the site should not have a ".gov" domain name. The name should include some combination of "health for you," be short and descriptive. Suggestions included: • HealthCareForAll.ca.us • Ebhi.com – exchange for a better health insurance • Health4all.gov	CPEHN and Having Our Say Coalition

We suggest starting with the branding efforts as soon as possible. Extensively test with consumers the brand alternatives that people from all walks of life can identify with, that will dispel social stigma and earnestly convey that the Exchange is a pro-consumer destination. For the currently uninsured, it will be important to say that it will be simple to get and keep coverage, and it will be within their financial means. The Massachusetts experience and Maryland marketing presentation by Weber Shandwick have some good ideas for messaging, branding, etc. — messages with emotional meaning, including use of personal anecdotes that are motivating and strike a balance between individual medical care and public health.	Consumers Union
CVS Caremark has experience encouraging consumers to enroll in programs, like our ReadyFill program (i.e., automatic refills for maintenance prescriptions). We also have fielded extensive behavior change research (in collaboration with faculty from Dartmouth College, the University of Pennsylvania, and Carnegie Mellon University) that helps inform the language and framing used in marketing communications to consumers. In these examples, results have shown that “active choice” messaging in which consumers must make an affirmative decision (vs. opting out or in) produces better results in driving individuals to take action and making people responsible for their choices. For instance, the Exchange would include language that denotes that not enrolling is an active choice to pay for one’s own healthcare. In addition, the Exchange must also contemplate how to tailor health communications to market public health more efficiently to different market segments. For example, there may be opportunities to frame choices in the context of what would be seen as a positive outcome (i.e., a benefit or incentive) versus highlighting a potential negative (i.e., a risk or penalty). There also may be advantages to framing options in terms of what is best for the individual or, in the broader context, what is best for their family or the community at large.	CVS Caremark
Our experience shows us that the low-income populations and non-English speaking population will respond best to marketing and outreach through trusted community partners. It is crucial to spread the word about available tax subsidies and that these are private health plans with full provider networks to service their needs.	Delta Dental
The marketing efforts for a new product should address three stages that the consumers go through before they make their purchase decision, which are: learn, feel, and do. Therefore, we may need to build public awareness about the program, build a brand of the products offered, and then conduct a direct response campaign. The marketing campaign should include at least two approaches - direct to consumer and business to business - to optimize the results. One of the key decisions is where the Exchange product fits on the brand spectrum of the public and commercial products. The "mandate" message has to be well balanced with the "program benefits".	Inland Empire Health Plan
"Think you can't afford health insurance? Think again!" Affordability is major barrier and therefore needs to be knocked down right away. Another barrier: I don't need it. "Think you don't need health insurance? Picture of car wreck or falling off a balcony beer can in hand. Think again!" Test whether "coverage" means anything to consumers; I would think not nearly as much as "health insurance." Everybody in the US for more than a year knows what that is. "Coverage" is code for "This isn't insurance," as in Healthy SF.	Lucy Johns, MPH
• Register today for healthcare tomorrow • Uncovered? Get covered! • Get on the road to better health! • Follow the path to healthcare! • Your path to health coverage!	San Bernardino County

• You deserve better health • Protect your family and yourself • Health care coverage is around the corner! • Got pain? Get healthcare coverage! • Prepare for the unexpected, get health insurance • No health care benefits? We can help. • Healthcare Coverage Leads to Healthy Life • Seek Security in Healthcare Coverage	
Creating a message on the value of health insurance for those who are uninsured will be important.	Santa Cruz County
Question #19: Should the Exchange do its own marketing related to the small employer program or should it rely on existing distribution channels (e.g., health insurance agents)?	
For the SHOP exchange, HBEx should do very little other than brand marketing for the exchange. Radio, TV, and print advertising are expensive and only minimally effective in reaching employers. Agents will be the best vehicle to market to employers, as long as they are appropriately incented.	Anthem Blue Cross
The Exchange should expand beyond existing channels, utilizing all relevant public and private partners to promote the Exchange to small employers, while continuing to utilize effective channels that are in place.	Consumers Union
HBEX Marketing to Small Businesses: Yes, the Exchange should do its own marketing, particularly for the ethnic small employers who are less likely to use brokers or agents. (See Insight at Pacific Community Ventures and The California Endowment. http://www.pacificcommunityventures.org/insight/reports/Heatlh_Care_and_Small_Business_2011.pdf.) The Exchange needs to conduct direct outreach to these entities (i.e. use ethnic media), but should also contract with those who are already trusted resources in the community.	The Greenlining Institute
The exchange should both do its own marketing and rely on existing distribution channels. The agents have the ability to promote both the exchange and commission based products. If we don't offer the agents a commission comparable to existing insurance products, then they have no incentive to promote exchange products over commission based products.	Health Plan of San Joaquin
Do own. Agents won't promote unless they're paid. See MRMIB experience to decide this. Maybe there's money to pay, esp. first 1-2 yrs? State needs its own brand: this is the government, here to help. Uh-huh. Show me. But in the long run, this is needed.	Lucy Johns, MPH
• Both, the exchange should present the message to the public and rely on the distribution channels to disseminate the information. • Develop one website to compare plans.	San Bernardino County
Since many small businesses do not offer health insurance they may not be accustom to working with health insurance agents. Simple, easy to access online information about the Exchange and health care programs would be helpful.	Santa Cruz County

Both. The Exchange should build upon models already in place for the bulk of the outreach (brokers, business groups, etc.). However, the Exchange should do marketing on its own, albeit with a very different strategy than it uses for the individual pool.	Small Business Majority

ENROLLMENT ASSISTANCE, NAVIGATORS AND HEALTH INSURANCE AGENTS

Question #20: What roles should the following entities play in Exchange, Medi-Cal and Healthy Families enrollment for individuals and families? a. Community/consumer groups b. Counties c. Health insurance agents / general agents d. Providers / community clinics e. Health plans	
We believe that all of the entities listed should be sources of education and information and facilitators of enrollment in the HBEx. For rural and frontier counties specifically, county and community-based organizations will be particularly important for successful enrollment. We encourage HBEx to ensure that all entities tasked with facilitating enrollment are licensed and trained to educate the public about their health insurance and enrollment options.	Anthem Blue Cross
With respect to individual coverage, those surveyed shared that they would be most comfortable enrolling through the following entities in the order listed below: • CAAs, Eligibility workers, patient navigators, promotoras • CBOs, non-profits • Medical staff • Faith based organizations • Schools • Family & friends Counties, health insurance agents and/or health plans were not mentioned.	CPEHN and Having Our Say Coalition
"A) community groups: assistance with enrollment; translation of exchange policy. B) counties: training on enrollment for community workers/health providers. D) community clinics: outreach, provision of pamphlets, community forums, also, schools: education/outreach."; "A.) as peer outreach workers B) as promoters within related county/contracted agencies C) to train folks in how to enroll, answer questions, and be a general/specific resource re benefits D) conduct outreach and enrollment. possibly	California School Health Centers Association

employ/coordinate community outreach efforts. expand the payors they can bill to include private insurance (that's available through the exchange E) not sure yet. Also, conduct outreach and enrollment with school registration. SBHCs can act like D) above."; "Schools - Our Healthy Start staff already do outreach for health insurance and sign up over 40-50 families per year (small, rural county)."; "Since I am coming from the district I will reiterate the importance of using schools and creating partnerships with various groups, including CHI, community clinics, hospitals, etc. Again, we have had success with outreach to our families for enrollment. We not only have a centralized location where families are enrolled but we also schedule meetings at specific schools during family nights, back to school nights, health fairs, open house, etc. It helps to have a district person involved in this endeavor because it allows for easy access to principals, schools, and central office."; "I'd have to say all of the above will need to play a part in enrollment. I'd add to this Community Clinic coalitions such as Community Health Partnership in Santa Clara County."; "Consumer groups should help to direct the process and provide feedback to accessing the underserved communities; Counties should help to manage population data on enrollment; insurance agents should be more flexible about extending grace periods for coverage since we know the population is mobile and maybe even consider a one year enrollment with capitation paid at point of service, i.e., school based health centers; providers should be linked to the insurance plans and be capable and willing to bill for services; billing should be streamlined and focused on one year membership with POS capitation; schools should use their healthy start funding to have at least one enroller per school and if possible have SBHC on site." "There are really several roles: Helping employers understand their options, and helping employees understand their options and generally helping people who are not employed by a firm offering insurance, all need to have access to assistance. Historically, employers and employee have used insurance agents - however the role of independent agents is clouded by both the new Exchange process, the subsidy process and where they fall in the distribution of health care dollars if "administrative costs" are capped (HHS has been silent on this issue). Individuals not offered insurance have sought help from Counties- understaffed now for enrollment assistance. Counties are unlikely to take on coverage beyond the mandated Medi-Cal and related public programs. Some more thinking needs to go into this area."; "a. community education about how to use your health insurance benefits. b. very little c. the same role they play now, especially in the exchanges. d. providing enrollment services, facilitating enrollment and providing locations for electronic enrollment services. e. information sharing. Schools could also be a location for electronic enrollment services and enrollment service assistance."	
The Healthy Families training can be used as a model to illustrate how stakeholders can meaningfully participate in the enrollment assistance and navigation pieces of the Exchange.	Children's Health Initiative of San Joaquin County
We can envision a two-step process whereby the Exchange first starts to filter the word out to these entities—like a "save the date" notice that a new service is coming to help Californians get/stay healthier and meet the mandate, with specific info on dates when and places where materials/training/assisters will be available. The second step would be getting these entities to reach their constituents. For that part, it is important that all types of groups and organizations be given access to materials and training to enroll their constituent individuals and families. Materials must be relevant to the type of group posed in the question. This includes	Consumers Union

consumer-tested educational information on the Exchange, tax credits, etc. and training on how to enroll people using the web portal, phones, mail and in-person. Apple, for example, has a very clear video to train consumers on how to use Apple software - inexpensive and available 24/7. There should be reference materials about Exchange processes that these groups can access on an ongoing basis in order to keep current.	
We believe that health care providers have an important role to play in educating consumers and supporting enrollment. In particular, our research and experience have demonstrated that retail pharmacies and retail clinics are effective locations to provide health care information to individuals in a clear understandable manner and at a time when they are more receptive to receiving information than in other settings. We have realized great success in providing clinical / health care support through one-on-one counseling initiatives like our adherence programs as well as the aforementioned Medicare Part D enrollment support.	CVS Caremark
Role of Different Orgs in Enrollment: (a & b) Community and consumer groups and county entities who are already trusted resources within communities should continue to play active roles in the enrollment process. (See: Kaiser Family Foundation http://www.kff.org/medicaid/upload/Connecting-Eligible-Immigrant-Families-to-Health-Coverage-and-Care-Key-Lessons-from-Outreach-and-Enrollment-Workers-fullreport-pdf.pdf) (d) Providers and community clinics should have educational materials about plans and should have information on assisters. They should be able to inform patients on the different programs available. Some providers and clinics already act as assisters in the enrollment process, where this is the case, they should be able to continue to provide this service e) Health plans should not do enrollment. Individuals/families should go through the Exchange. Health plans can inform participants of other options they may be eligible for when they drop individuals from their coverage	The Greenlining Institute
The cooperation of existing government agencies and non-profits should be expanded to incorporate the strengths each brings to the enrollment process. a. **We recommend that wherever possible, the Exchange be required to provide some consumer assistance through referrals to independent non-profit agencies and make it a priority to refer certain vulnerable populations for this assistance, such as low-income populations that require assistance with public and newly available private health insurance options.** Independent consumer assistance should be provided by organizations that have a history of successfully working on health care access issues for these populations, have capacity for providing legal assistance, and can work on system-wide barriers. Where possible, local in-person assistance should be available. In particular, consumer groups such as the Health Consumer Alliance have relevant experience in an array of consumer assistance duties. They are premised on three pillars, including their independent affiliation that allows them to serve consumers with no self-interest, their ability to act as legal champions and provide high-level support to consumers, and their focus on changing systems to better serve consumers. It would be a natural fit to utilize an HCA-type organization as assisters and/or navigators.	Health Consumer Alliance
Community and consumer groups can play a large roll with small businesses. It is important have exchange	Health Plan of San Joaquin

representatives available to promote the product in person to small businesses. Agents can play a role, but we must incentivize them accordingly. Health plans and providers can play a role in promoting the exchange and assisting members with enrolling	
Community & consumer groups, counties, agents/brokers, providers, and health plans can play outreach, education, and enrollment (application assistance) roles in Exchange, Medi-Cal and Healthy Families enrollment for individuals and families. With an estimate of several million people eligible for Health Exchanges, Medicaid Expansion, and Healthy Families and to uphold the Board's principle of "No wrong door", we need all qualified outreach, education and enrollment channels and allow them to perform these functions. Currently, many health plans that are trained and certified by MRMIB are helping families to apply for Medi-Cal and the Healthy Families Program. To get this certification from MRMIB, these public health plans have gone through a rigorous training program conducted by MRMIB, and have submitted a formal MC/HFP Application Assistance plan for MRMIB to review and approve. One of the key elements is that at the point of application assistance health plans must fully inform applicants of their choice about all health plans that participate in the HFP. Health plans cannot steer enrollment to their plan only. All application assistance phone calls and documentation must be retained. In addition, health plans do not receive any application assistance reimbursement from the state. Since 2001 (when the state began to allow health plans to provide MC/HFP application assistance), health plans have effectively assisted over a couple hundreds of thousands of children to apply for MC/HFP. Most of the HFP parents will be eligible for the Health Exchanges program. Under the Board's enrollment principle of "no wrong door", we urge the Board to permit health plans (with good standing MC/HFP application assistance plan with MRMIB) to assist individuals and families to apply for HE, MC, and HFP for all members of their families at a one-stop shop. This will be another outreach and enrollment arm besides the Health Navigator Program. As indicated in the ACA, health plans will not be able to participate in the Health Navigator program and will not be able to receive the HN reimbursement.	Inland Empire Health Plan
Have to decide who introduces vs. who knows the rules. Maybe policy should be all are introducers ("You can get health insurance! Here's the website, phone number!") but only certain are expected to know the rules. Hellish to expect all these entities to know the rules.	Lucy Johns, MPH
Fully implementing the ACA will require multiple avenues of consumer outreach/education and to enroll eligible consumers. Providers should not be prohibited from participating in enrollment and consumer assistance activities. Planned Parenthood serves over one million Californians each year, the vast majority of whom will become eligible for expanded coverage in 2014. Employing navigators in community clinics like Planned Parenthood presents an essential opportunity to bring people into coverage as they are entering the health care system. Planned Parenthood provides care for many patients who are young and essentially healthy, but in need of reproductive health services like birth control. Getting these healthy young lives into coverage will be essential to building up a positive risk pool for expanded Medi-Cal and the Exchange. Planned Parenthood health centers are located throughout the state in underserved areas, providing care for vulnerable and marginalized populations. In our communities, we are a trusted source of information and quality health care. Utilizing the trust capital of safety net health care providers like Planned Parenthood will reinforce the legitimacy of health care reform and new coverage options. Creating a mechanism for provider based enrollment facilitates	Planned Parenthood Affiliates of California

the "No Wrong Door" approach that has been one of the foundations of the ACA. A patient walks into the doors of a health care provider, whether at a community clinic or an emergency room, should be able to apply for coverage and receive care that day.	
All of the entities listed should play some role in helping families enroll in health coverage, and should be considered in light of the niches they serve. For example, community groups and county social services offices have long-standing and trusted relationships with low- and moderate-income families. Insurance agents likely have existing relationships with middle-income families and self-employed individuals, which could be leveraged to cover health insurance. In addition, providers and clinics interact with all patients and can help facilitate enrollment at the point of service. Finally, because health plans will have a financial interest in enrollment, they should be expected to support public education and outreach activities and can further facilitate enrollment by linking to and closely coordinating with the streamlined eligibility and enrollment system. Furthermore, health plans can help fund the navigator program in a way that protects against steering or other ethical concerns.	The 100% Campaign
Health care coverage is a complex decision, and individuals and small employers have traditionally relied on advisors to help guide them through the process. We believe that the evolving health care system should retain the highest level of quality regarding health care purchasing assistance, and the agent/broker relationship with clients should continue. We believe that Navigators should be individuals or entities that are not affiliated with, employed by, or in any way acting on behalf of any person or entity with a financial stake in a consumer's selection of a plan, including providers. Navigators should be independent and avoid any appearance of a conflict of interest. Such protections ensure consumers receive the most appropriate assistance in selecting and enrolling in a health benefit plan. Current Medi-Cal assistance resources should also continue to provide assistance to the Medicaid-eligible population.	UnitedHealthcare

a. Community/consumer groups: I think they should be fully engaged and encouraged to go enroll as many people as they can. My sense of things is that the populations of folks these groups serve are generally low income people who, for the most part, are either uninsured or underinsured. Their constituencies are unique and one that the traditional insurance distribution system, for one reason or another, has been unable to reach out to with any meaningful results. Keep in mind that this group of people will likely have pent-up care needs and may be very costly in terms of claims. As for the payment program for these groups, different compensation programs motivate different groups and entities. How you support/compensate them in their efforts may be different in the way you pay clinics, counties or agents (assuming you choose to do so). Your payments system may need to be designed with the idea in mind that one form of compensation may not effectively and equally motivate all groups of distributors. b. Counties: I'm not sure what their role might be and, therefore, don't have a strong opinion about this. One way to ascertain counties role in the distribution of health insurance is to determine what communities or groups they are uniquely in touch with and then design a compensation program that is appropriately motivating. c. Health insurance agents: I think their primary role would be to bring non-subsidized people who already have traditional coverage into the exchange. To recruit agent activity, the exchange would need to pay a reasonable commission within market standards. In order to guard against paying commissions on subsidized business, perhaps the exchange could pay agents competitive commissions on non-subsidized business only. Agent driven business would benefit the exchange financially in the form of greater retention, lower claims and greater customer satisfaction. d. Provider community clinics: They should be empowered and motivated to enroll as many individuals as they can, too. But I think it is important to understand that the enrollment they bring will be folks who need immediate care and are, by definition, higher utilizers. e. Health Plans: I will defer to the help plans to answer address their role here.	Warner Pacific Insurance
Question #21: What roles should the following entities play in supporting enrollment of small businesses in the Exchange? a. Community/consumer groups b. Counties c. Health insurance agents / general agents d. Providers / community clinics e. Health plans	
For the SHOP exchange, we believe that enrollment should happen at the carrier level, not at the exchange itself. The entities listed as possible facilitators can support the process, but should meet current regulatory standards and requirements.	Anthem Blue Cross
Navigators should at a minimum pass the Healthy Families Program test, receive Medi-Cal training, have an association with an enrollment entity, and all navigators agree to assist all eligibles, not just ones that fall within desirable exchange categories.	Children's Health Initiative of San Joaquin County
There likely will be a heightened role for brokers when it comes to enrolling small employers in the Exchange.	Consumers Union

Enrollment for Small Businesses: a. Community and consumer groups who are already trusted resources within communities should continue to play active roles in the enrollment process. (See: Kaiser Family Foundation http://www.kff.org/medicaid/upload/Connecting-Eligible-Immigrant-Families-to-Health-Coverage-and-Care-Key-Lessons-from-Outreach-and-Enrollment-Workers-full-reportpdf.pdf) b. Counties should provide information to businesses on health insurance programs upon licensing or renewal. c. Incentives for a health insurance agent to enroll people in any one program should not be allowed when selling plans in the Exchange. d. Providers and community clinics should have educational materials about plans and should have information on assisters. They should be able to inform patients on the different programs available. Some providers and clinics already act as assisters in the enrollment process, where this is the case, they should be able to continue to provide this service e) Health plans should not do enrollment. Individuals/families should go through the Exchange. Health plans can inform participants of other options they may be eligible for when they drop individuals from their coverage	The Greenlining Institute
County eligibility workers should be able to access eligibility for public programs and exchange programs which will facilitate enrollment into the exchange.	San Bernardino County
c. Of the groups listed in Question #21, brokers/agents hold, by far, the most trust amongst employers. The other groups do not have much of a history of working with small businesses. Employers will want to know if these groups understand the many unique needs/challenges that small employers face. If business owners do not think they "get" them, they are not likely to want to interact with them.	Small Business Majority
With respect to enrollment of small business owners and their employees, evaluating the role of insurance agents and health plans will be important. Because of the existing relationships many small businesses have with insurance agents, it is likely that some small businesses will continue to rely on agents. Similarly, some small businesses purchase coverage directly through a health plan. Health plans should be expected to support education and outreach activities to small businesses in order to ensure small business linkages to the broader streamlined eligibility and enrollment system and programs.	The 100% Campaign
Question #22: What would define a successful navigator program? What would define a successful relationship between health insurance agents and the Exchange?	
Exchanges should award grants to Navigators based on the best interests of consumers. Factors the Exchange should consider in selecting Navigators include costs and the impact on premiums, experience and ability, and relationships with target groups within the population the Exchange is serving. Navigators should be able to: • Conduct public education activities, including outreach to diverse, lower-income, culturally or linguistically isolated and difficult to reach populations; • Distribute accurate and impartial information concerning enrollment in qualified health plans, Medicaid, CHIP and other state health programs and their respective networks of health care providers, all available subsidies, and transitions between plans, subsidies and assistance programs based on	AARP California

variations in income and other changes in circumstances; and
- Provide information in a manner that is culturally and linguistically appropriate to the needs of consumers.

AARP supports the use of multiple categories of Navigators in each state with some Navigators being community and consumer-focused non-profit organizations. For consumers with existing relationships with community-based organizations, a high level of trust in the relationship may already exist. Among members of communities that may be less familiar with health insurance, trust in relationships with existing community-based organizations may be central to effective outreach. Given the Exchanges' target audiences, we believe that a range of types of entities will be needed to effectively reach the various audiences including those with experience with underserved, difficult to reach and low-income populations, the uninsured, and those for whom cultural and language barriers exist.

Significant portions of those currently uninsured will be eligible for Medicaid in 2014 and many consumers will experience changes in income or other circumstances which will warrant transitions between Exchange and Medicaid and other state programs. Navigators should be required to advise and assist consumers eligible for Medicaid, CHIP and other state health programs and to have the requisite knowledge and experience in each program's eligibility standards, coverage and benefits and with the administering state agencies.
To prevent conflicts of interest, the prohibition on Navigator compensation from insurers for products purchased through the Exchange should extend to insurance products sold outside the Exchange. Without such a prohibition, there could be financial incentives for Navigators to steer individuals to non-Exchange products and their responsibility to provide fair, accurate and impartial information about Exchange and non-Exchange products would be compromised. Moreover, the public perception of Navigators' integrity will be damaged if some Navigators are able to profit from non-Exchange sales. We are particularly concerned about unintended consequences if those not eligible for tax subsidies are steered to non-Exchange products. This might result in adverse selection to the detriment of the Exchange and its Qualified Health Plans.
To ensure that information provided by Navigators is fair, accurate, and impartial, all written and other information and education materials should be submitted for review and approval by the Exchange before they are used by Navigators. Another approach would be for the Exchange to provide materials for use by Navigators.

The Medicare Advantage program offers an appropriate model, where HHS reviews each insurer's materials and provides standardized templates that plans can draw on.

Navigator program should be fully operational well in advance of the initial open enrollment period in 2013. The need for Navigator assistance will never be greater than before and during the initial enrollment period. Timely startup will require that Exchanges establish grant and certification standards and award grants soon.
AARP believes consumers will be best served by having a variety of options available to them for enrolling in QHPs. They should be able to enroll directly online, with the assistance of the Exchange's call center or a Navigator, or through agents or brokers. Outreach and marketing should specify that use of agents and

brokers is optional.	
Navigators should be appropriately trained and licensed, and HBEx should perform regular oversight to ensure that Navigators are avoiding steerage. Health insurance agents should be able to receive compensation for facilitating enrollment.	Anthem Blue Cross
A successful Navigator program would readily meet the needs of all eligible consumers and businesses, regardless of income group, linguistic group, geographical area, segment of the small business community, and other key demographics. Additionally, in order to ensure that individuals with limited-English proficiency can obtain adequate assistance, overall Navigator capacity would include sufficient linguistic capacity to meet the needs of threshold languages by service area, including bilingual staff. Navigators would be available outside "regular" business hours.	Consumers Union
A successful navigator program would provide high-quality, unbiased assistance to consumers making it the tool of choice for consumers when evaluating their coverage options. A successful navigator would not only help to raise awareness of the Exchange, but would also facilitate enrollment, resulting in high yield among those that used navigator services. A successful partnership between health insurance agents and the Exchange would involve agents working with the Exchange to provide coverage, rather than agents looking to alternative channels (e.g., off-Exchange individual market) to secure coverage for their clients. While the Exchange will create an organized marketplace that does not exist today, agents will still have a role to play in supporting consumer selection.	CVS Caremark
In the individual market, the navigators must be given access to training materials through online portals, exchange/plan contacts, in-person training sessions, and webinars. The licensing process should include a requirement for continuing education and training similar to the agent/broker license processes that states have today A successful navigator program would make contact with and enroll a high number of eligible and uninsured individuals into a wide variety of plans.	Delta Dental
Successful Navigator Program: 1. The Navigator Program should be up and running early. A successful program would be one in which navigators become trusted resources for community members. Navigators would be capable of informing people in a culturally and linguistically competent manner, and the community would immediately think of the navigator as the go to resource. 2. Health insurance agents should not be considered navigators because they are motivated to sell plans, not to educate. (See: Effective Health Outreach to Cultural Communities, http://www.medtronic.com/downloadablefiles/outreach_brochure.pdf and California Coverage & Health Initiative, Leveraging the Local Experience of Community Based Organizations in Implementing the Affordable Care Act, http://cchi4families.org/pdf/uploads/Executive%20Summary_new050411.pdf)	The Greenlining Institute
A successful navigator program is defined by the principles of independence and duty to the consumer. The concept that beneficiaries should be enrolled in the most generous, most affordable plan for which they qualify should drive the functions of a Navigator program. Additionally, California must plan around a diverse uninsured population that will need different types of assistance. Locally-based organizations have played this role for many years and should be sought to continue to do so through the Navigator program.	Health Consumer Alliance

• A Successful navigator should know the links to various programs. • Assist customers with the application but not enroll. • Check and measures must be in place to deter any conflict of interest situations.	San Bernardino County
There is a need for multiple avenues for enrollment into these programs. Community/consumer groups can provide information and assist with enrollment. Counties can include information on exchange along with all county health programs, facilitate information sharing with HBEx and should provide application assistance for special populations. Healthy insurance agents/general agents can be appropriately incentivized and monitored to program information and assist in enrollment, particularly for the self-employed or for small employers. Providers/community clinics should be used as a significant resource. The State should explore opportunities that allow providers and community clinics to enroll uninsured individuals into these programs with appropriate safeguards to prevent possible conflicts of interests that may arise from both enrolling and providing services. In addition, eligibility workers or other staff in these settings can act as navigators to either route a client directly to the exchange on-line (either at home or at a designated terminal) or provide application assistance if required.	San Francisco Department of Public Health
A successful navigator program needs to first determine what populations we need to reach, and then hire the appropriate navigators to reach those populations (not the other way around). Navigators will have to demonstrate they understand the needs of small employers. The relationship between brokers and the Exchange needs to be strong, vibrant and long-term. The SHOP cannot survive without a partnership with the broker/agent community. The brokers/agents should act as de-facto salespeople for the Exchange.	Small Business Majority
In our opinion, a successful navigator program would be one that efficiently and economically maximizes enrollment of eligible individuals into health coverage in a consumer-friendly manner. To that end, our children's health coalition has developed "Statewide Guiding Principles for Consumer-Focused Navigators in California" (available at http://cchi4families.org/pdf/uploads/Navigator%20Guiding%20Principles%20Oct%2011.pdf). We believe these guiding principles offer a direction for the conversation about navigators that seeks to manage legitimate concerns raised about training, steering, and accountability.	The 100% Campaign
Question #23: How do enrollment assistance needs vary for individuals, small businesses and self- employed individuals? How should the Exchange take these differences into account in developing requirements for navigators, health insurance agents, counties or others (and what differences might that mean for any of the questions that follow)?	
Individuals, who will be faced with the full range of options available on the HBEx as compared to employees who may have choices restricted by an employer, will have greater need for education about the coverage options available. In addition, after enrollment, members will not have an HR department for support, but will look to agents and carriers for assistance with questions and issues. For small businesses, the agent is critical for assisting employers with identification of options and plan selection, enrollment, and ongoing service support. Carriers may also offer assistance for employers and their enrolled employees. This approach has already proven effective; new SHOP exchange infrastructure to supplement this support is not necessary.	Anthem Blue Cross

Market research would be required to form a complete picture, but as a guiding principle, it is essential to establish a thorough understanding of the consumer "buying process" at the segment level. That is, in order to establish the most appropriate activation efforts targeted at a specific audience, the action steps, considerations, and interactions starting at the origination / awareness stage all the way through purchase and renewal must be well-understood. Furthermore, understanding a segment's behaviors and attitudes can be as important – if not more so – as being able to portray their demographic characteristics.	CVS Caremark
Enrollment Assistance Needs: It is necessary to have a robust network of navigators and assisters identified for small businesses, individuals, and self-employed individuals. Navigators and assisters should be available during nontraditional business hours, should be able to provide linguistically and literacy-level appropriate services. Each type of Navigator/Assister should have separate certification to ensure that all groups are receiving accurate information. (See: Effective Health Outreach to Cultural Communities, http://www.medtronic.com/downloadablefiles/outreach_brochure.pdf, and California Coverage & Health Initiative, Leveraging the Local Experience of Community Based Organizations in Implementing the Affordable Care Act, http://cchi4families.org/pdf/uploads/Executive%20Summary_new050411.pdf and Impacting Health Disparities Through Community Outreach: Utilizing the CLEAN Look (Culture, Literacy, Education, Assessment, and Networking), http://www.moffitt.org/CCJRoot/v14n1/pdf/70.pdf)	The Greenlining Institute
For groups of 10 or more employees, brokers are commonly used. For smaller groups, health insurance isn't commonly offered. For individuals and self-employed, the majority go directly to the health plans and some work with an insurance broker.	Health Plan of San Joaquin
It is important to acknowledge the fundamental distinction between how coverage information will be sought in the Individual Exchange, and how coverage will be offered or obtained in SHOP. Applicants in the Individual Exchange will be curious and motivated as they search for plan, benefit, and cost information. The SHOP employee will, almost by definition, be less self-directed and will likely be inclined to do as directed. The Individual Exchange and its central portal will presumably be used by individuals seeking coverage and information about coverage options. The current construct envisions providing those inquiring individuals with a network of "assisters," including ready access to navigators, a Web site, and a call center to respond to inquiries. SHOP enrollees, on the other hand, will not be seeking coverage; rather, they will be responding to an offer to select a plan from a limited number of choices. This distinction should guide the development of SHOP policies and processes, in order to ensure that employees have the same access to information and assistance as individual consumers. Because the individual entering the Exchange will automatically be presented with various forms of information, including "assisters," and multiple options to consider while the SHOP-qualified employee will not, we recommend that SHOP adopt policies and processes that provide access for employees to the full range of assisters, including navigators, call centers, etc.	The 100% Campaign

Question #24: How would you define a continuum of assistance to support applicants based their needs and the complexity of their issue? Are there the natural "cut points" in the continuum of assistance (e.g., issues that do not need human intervention; issues readily addressed on the phone or those that would be best served by in-person assistance)?	
In the individual market, assistance should be available to consumers in their choice of forum (e.g., online, email, phone). For the SHOP exchange, it will be important to have multiple portals for the submission of group data. Agents, Navigators, and groups should be able to email, fax, or mail data. Systems and processes should be developed to image and attach a unique group ID to this data, so that it can be shared across departments responsible for enrollment.	Anthem Blue Cross
While there is a continuum of assistance anticipated, we really won't know how people interface with the Exchange and its product offerings until the program is up and running. We can look at the experience under the SHIP program and the CAA program here in California, but the Exchange was specifically created to fill a gap in our health care system: to reach populations that historically have not interfaced with health coverage programs in the past. For the Exchange to be able to identify the natural "cut points" will require some experience with enrollees, and focus group and consumer testing to better understand the specific target populations— the state should identify whether there are issues that may not require human intervention, can best be served over the telephone, or require in-person assistance. Research shows there is pervasive confusion among applicants for subsidized programs about: 1. insurance concepts; 2. income eligibility criteria; 3. required documentation. "Designing Subsidized Health Coverage Programs to Attract Enrollment: A Review of the literature and a Synthesis of Stakeholder Views" (2008) available at http://aspe.hhs.gov/health/reports/08/subenroll/index.shtml. Consumers Union's recent research indicates that in the private market, there is significant confusion with health coverage terms. See "What's Behind the Door: Consumers' Difficulties Selecting Health Plans" available at http://www.consumersunion.org/pub/pdf/Consumer%20Difficulties%20Selecting%20Health%20Plans%20Jan%202012.pdf The Exchange may have even further layers from the typical public program, with tax credit and reconciliation issues. Based on prior experience, we can assume the following steps related to enrollment: 1. start the application 2. get all documents and information assembled to complete the application and submit 3. obtain eligibility determination 4. choose plan 5. pay premiums timely and use health care services 6. maintain eligibility/notify of income changes 7. re-determination. It MAY be that the front-end steps require the most help, while plan choice (if we have simple standardized information and defaults), use of medical services, and re-determination will require less hands-on help, although this will naturally vary depending on the users' health insurance or general literacy, their culture and language needs, and health status.	Consumers Union

Operationally, the Exchange must consider all possible process flows for consumers, given how preferences and learning methods vary. For some, that could be as simple as making information accessible for self-education. For others, it will require multiple modes of communication and live real-time support in order to ensure maximum understanding of benefits and instill confidence in decision-making.	CVS Caremark
Information that can be provided with a degree of accuracy and which the individuals will not have questions about could be automated. These include plan search and comparisons, but enrollees will likely have lots of questions about specific coverage they are interested in. The Exchange might consider instant messaging support as well as in-person assistance to help individuals compare benefits online. Subsidy eligibility will likely generate a lot of questions that will need to be handled by in-person support.	Delta Dental
Within the world of public health benefits, having in-person assistance available has helped beneficiaries secure and keep their coverage. As many of the newly-eligible will qualify for Medi-Cal, similar models should be maintained.	Health Consumer Alliance
Circumstances such as income fluctuations, family growth, and employment changes will undoubtedly occur frequently during a consumer's lifespan, which will impact their eligibility for different health coverage and subsidies. It is critical that HBEX design systems and employ strategies to address their changing needs and individual complexities. We echo the suggestions offered by The Children's Partnership in their report, Building a Consumer-Driven Eligibility, Enrollment, and Renewal System: Essential Design Features for Effective Health Reform in California, such as: • Establishing easy and clear reporting mechanisms to inform the state when changes should be reported • Assisting consumers in identifying significant changes that will impact their eligibility status • Ensuring no disruptions in coverage if circumstances do change • Utilizing multiple outreach strategies, from websites to community based organizations It is important that HBEX recognize that different communities prefer different methods of accessing information. For example, according to research by Lake Research Partners for the Centers for Medicare & Medicaid Services, 64 percent of English-speaking parents say they would be more likely to enroll in Medicaid or CHIP if it meant applying online while only 26 percent say they would be more likely to enroll if it meant going to a government office. In contrast, 62 percent of Spanish-speaking parents say they would be more likely to enroll if it meant applying at a government office, and 58 percent say they would be more likely to enroll if it meant doing so online. From this research, we can infer that different communities respond to different methods of outreach and seek assistance in different ways. It is important that the navigator program reflect this as well. Consumers will want to use different options and the assistance provided should reflect the varying level of literacy, access to technology, diversity in language and access to government services that occur in California.	The 100% Campaign
Question #25: Given the current licensing requirements for health insurance agents, what additional participation standards should the Exchange employ to the extent it uses health insurance agents in the individual market of the Exchange? What additional standards for health insurance agents might be appropriate for enrollment of small businesses in the Exchange?	
Agents and brokers who sell Exchange products should be required to meet all the Navigator standards in	AARP California

terms of knowledge and experience and required to provide the same unbiased information and data on Exchange products, Medicaid and other state programs. Allowable compensation systems for agents and brokers should be uniform for products sold inside and outside the Exchange to discourage steering. Agent and broker compensation should be based on an objective evaluation to fairly determine the value added by their services in the context of the Exchange and the ACA's fundamental alteration of the individual and small group insurance market. The changes made by the ACA and the plan selection standards adopted by the Exchange and state agencies should result in a greatly simplified system of plan comparison and selection by consumers and small business. With uniform coverage and benefit standards, plan ratings, and centralized enrollment and oversight through the Exchange, it should be much easier to compare competing plans. New free counseling and enrollment assistance will be available through the Exchange and Navigators. In addition, the Exchange, Navigators and ombudsman program should provide assistance and intervention services for consumers experiencing problems with coverage and claims. These changes may diminish the need for and value of services currently provided by agents and brokers.	
Current licensure requirements are sufficient, but HBEx should consider developing an exchange-specific "certification," similar to the certification required of agents who sell Medicare or senior products. This certification would be required for agents who want to sell products on the individual or SHOP exchanges. The certification should be maintained via continuing education credits/classes.	Anthem Blue Cross
If agents and brokers are permitted to provide assistance to individuals, small businesses and/or self-employed individuals, the licensing requirements should be more robust to ensure that they are trained to provide information about Exchange products, including cost-sharing and advanced premium tax credits, as well as other public health programs that individuals, employers and employees may be eligible for, including Medi-Cal and Healthy Families. It may be useful to have a separate licensing for health care agents and brokers. The licensing should require fluency in the ACA and state rules on cost-sharing and advanced premium tax credits, particularly on the implications of the reconciliation process, and a deep understanding of public health programs, including Medi-Cal, Healthy Families, and the Basic Health Option (if implemented). The licensing requirements should also require some sub-licensing to identify, train and license health agents to be able to provide culturally and linguistically appropriate services. In addition to licensing requirements, those health agents and brokers wishing to sell policies for QHPs would also be required to register with the Exchange to obtain permission to sell QHP products.	Consumers Union
CE course requirements on marketing to diverse populations and educating on exchange rules would be valuable. It is also crucial that navigators understand the benefits of the myriad of plan options available.	Delta Dental

If the Exchange uses health insurance agents in the individual market, the Exchange should consider requiring agents undertake a training program offered by the Exchange to "certify" them to sell Qualified Health Plans (QHPs). Any such training and certification program should include, at a minimum, training in: basic knowledge of QHPs and public health coverage programs, including how to conduct basic screening for public program eligibility and make appropriate referrals; how to use the Exchange Portal; eligibility and application process for advance premium tax credits and reconciliation; how to provide fair and impartial information about QHPs and other coverage options; cultural and linguistic competency; enrollment troubleshooting; addressing changing life circumstances that require coverage transitions; addressing the needs of families with multiple coverage needs including dependent coverage; and how to make referrals to a consumer assistance program or navigator. For such certification, the Exchange should consider requiring agents to sign code of conduct similar to that signed by Certified Application Assistants agreeing to remain impartial in the provision of information. Failure to uphold the code would lead to decertification. The Exchange should consider a similar training for agents doing enrollments in the SHOP with an emphasis on the particular skills that will be necessary to serve that market. In both cases, agents must be sensitive to and trained to address the needs of individual Californians and families who will straddle the two Exchanges due to eligibility, income fluctuations, and changing life circumstances.	The 100% Campaign
Question #26: What minimum criteria should navigators meet? What training/certification requirements should navigators meet?	
Navigators must at a minimum: conduct public education activities to raise awareness of the availability of qualified health plans, subsidies, and mandate exemptions; distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits and cost sharing; facilitate enrollment in qualified health plans; provide referrals to any applicable office of health insurance consumer assistance; maintain expertise in eligibility, enrollment, and program specifications for the Exchange, Medicaid and other state health programs; and provide information in a manner that is culturally and linguistically appropriate to the diverse needs of the California population being served, including individuals with limited English proficiency, and ensure accessibility and usability of Navigator tools and functions for individuals with disabilities. As required by the ACA, Navigators must be able to demonstrate existing relationships, or readily established relationships, with employers and employees, consumers (including the uninsured and underinsured), and the self-employed. It would be appropriate to establish minimum training standards for Navigators. These should include training on the products offered through the Exchange, Medicaid and other state programs; eligibility standards and enrollment procedures for tax subsidies, Medicaid and other state programs; cultural competency training relating to individuals with limited English proficiency, minority cultures and persons with disabilities; and referrals to applicable consumer assistance programs. Navigators should also be required to demonstrate, initially and on an ongoing basis that they have achieved and are maintaining a requisite level of expertise in all these areas.	AARP California
Navigators should meet the same requirements that apply to health insurance agents.	Anthem Blue Cross

• Navigators must be trained and competent in the language(s) for which they claim to be fluent, able to provide telephonic and in-person assistance, and direct consumers to written translations of applications, forms, and notices. Navigators must also provide consumer education regarding eligibility and enrollment, the rights of consumers, dispute resolution and referrals, as well as translations of vital documents in prevalent languages. • The Exchange should select Navigators that demonstrate an ability to reach and assist the types of individuals and small businesses that will use the Exchange services taking into account the racial, ethnic, and geographic diversity of the state. • Navigators should understand the state health benefit programs for which consumers may qualify and be able to refer individuals to safety-net and other human services. • The Exchange should establish quality standards and develop mechanisms to assess Navigator • performance and accountability, including ongoing evaluation and improvement. The standards for… (comments cut off on PDF).	CPEHN and Having Our Say Coalition
A majority of the individuals performing the Navigator role should be from consumer or community-based organizations and should adhere to the following principles, along with completing a formal training track (see below): • A sole duty to consumers and/or small businesses; • Accountability to the Exchange; • Knowledge of the full range of health programs available in both the public and private arena, including the Exchange offered plans, Medicaid, CHIP, the Basic Health Plan (if applicable), Medicare, job-based coverage (including ERISA plans), COBRA, etc.; this understanding would include eligibility and enrollment policies as well as consumers rights under each type of coverage and the basics of individual and employer responsibility; • Knowledge of premium tax credits and cost-sharing reductions, and the importance of updating income information if there have been significant changes since the previous tax year; • Demonstrated ability to assist consumers in choosing plans that best meet their needs, including how to compare plans and use standard plan documents • Understand and comply with privacy laws and fair information practices governing the Exchanges, including practices to safeguard consumer and employee information, • Demonstrated ability to address cultural and language competency issues. • Duty to provide fair and unbiased information; • Knowledge of where to refer consumers for further information and help. • There should be an evaluation process in place to ascertain Navigator knowledge and capabilities. Training should be standardized and robust, requiring an initial (at least) 2 day training, as well as ongoing continuing education (e.g. 2 hours per month) in order to provide a vehicle for Navigators to ask questions, as well as learn about changes in the law and policy that affect their work and the coverage of potential enrollees. Additionally, the monthly continuing education should provide an avenue for Navigators and other assisters to share and identify any patterns or practices that are barriers to coverage.	Consumers Union
As previously mentioned, CVS Caremark recently conducted market research on uninsured and subsidy-eligible individuals. These individuals overwhelmingly believed that a “certified” advisor would provide them with the most comfort and confidence. While the exact form of certification was not explored, consumers felt	CVS Caremark

that this created a higher level of trust, particularly given this audience's relatively low exposure to health care and health insurance today. At a minimum, the knowledge level of navigators should be validated as well as their fit for individuals of different health status and risk tolerance.	
There should be a navigator certification program and the renewal should occur on a recurring basis with continuing education requirements. Navigators should have some minimal performance metrics that they are held to and they should be given thorough training that involves the functions of the exchange and the carriers who participate in the exchanges, including dental plans.	Delta Dental
Minimum Requirements for Navigators: 1. Navigators should be required to provide culturally and linguistically competent service, similar to the Knox-Keene Act (See: http://healthconsumer.org/cs016knoxkeene.pdf) 2. Navigators should be representative of (or VERY familiar) with the demographic/community they are serving (See: Effective Health Outreach to Cultural Communities http://www.medtronic.com/downloadablefiles/outreach_brochure.pdf and Impacting Health Disparities Through Community Outreach: Utilizing the CLEAN Look (Culture, Literacy, Education, Assessment, and Networking), 2007, http://www.moffitt.org/CCJRoot/v14n1/pdf/70.pdf) 3. The current model for assisters is a good model to follow (See: http://www.healthcare.gov/news/factsheets/2010/10/capgrants-states.html#ca and http://www.opa.ca.gov/partner/resources.aspx for more information.)	The Greenlining Institute
As to training and certification, high-quality training similar to that offered through the Department of Managed Health Care's Consumer Assistance Program is recommended. This training incorporates introductions to public programs and changes to the health insurance market that are prompted by the Affordable Care Act. Navigators should be required to report data, and the Navigator administrator should be able to assess quality assurances, including audits.	Health Consumer Alliance
At a minimum, navigators should be equipped with the following for training/certification: knowledge of programs, benefits, features, and eligibility requirements; pass a test to achieve certification; know about public products available inside and commercial products outside of the exchange; and agree to abide by a code of conduct.	Health Plan of San Joaquin

The Health Navigators should meet the following minimum criteria: • Attend a training program conducted by the Exchanges, and pass a test in order to be "certified" by the Exchanges. The Healthy Families Program's Certified Application Assistance (CAA) program could be a good reference for the Exchanges. • Demonstrate knowledge of qualified health plans and products sold in the Exchange. • Demonstrate knowledge of other public healthcare coverage programs including Medi-Cal and Healthy Families. • Be familiar with the individual commercial products sold outside of the Exchanges. • Agree to and comply with the Codes of Conduct of a Health Navigator (which should be developed in collaboration with stakeholders and ultimately, approved by the Exchanges). • Demonstrate knowledge of cultural sensitivity. The training/certification program should include at least the following components: • Offer two separate training programs for the Individual and SHOP markets (in key threshold languages). • Offer in-person and web-based training options. • Include an initial training program and an ongoing annual training program. • Require all Navigators to pass a test after their initial training in order to be "certified". • The Navigators will likely assist individuals to apply for MC/HFP during a Health Exchanges' application assistance point of contact. Therefore, it is important that the HN training program includes the MC/HFP Certified Application Assistance training components for those who have not been certified by the HFP. Existing CAAs will be exempt from this training component.	Inland Empire Health Plan
Training and certification Navigators who are responsible for helping consumers determine eligibility and enroll in coverage should be knowledgeable about eligibility and enrollment policies for public programs (Exchange, Basic Health Plan, Medi-Cal, Healthy Families), the ACA's premium tax credits and cost-sharing subsidies, safeguarding consumer information, and how to assist consumers in choosing plans that best meet their needs. To accomplish this level of education and certification, we encourage the use of Internet based opportunities like online training courses and webinars to the greatest degree possible. These are ways to ensure adequate and thorough training while making the certification process easily accessible. Setting up onerous training or certification standards that require navigators to travel, or spend extensive amounts of time in a classroom setting will limit the ability of many potential navigators to participate.	Planned Parenthood Affiliates of California
Navigators should be certified in a similar process as the State's CAA for Healthy Families. The process should be on-line and navigators should be affiliated with a formal enrollment entity (e.g. non-profit, a health care location, etc.) for compliance and tracking purposes.	San Francisco Department of Public Health
We support the federal Proposed Rule's requirement that Navigators must meet licensing, certification or other standards prescribed by states or Exchanges. We believe certification standards should be similar to the current standards for agents and brokers supplemented with specific training for Navigators on Affordable Care Act requirements, Medicaid and CHIP, in addition to individual and small group products.	UnitedHealthcare

Question #27: What requirements should navigators have for providing culturally and linguistically appropriate services?	
The provision of cultural and linguistically appropriate services by Navigators should be driven by market needs. Navigators should work within those markets where they can support the linguistic needs of the population, including the provision of written materials in appropriate languages. We also note that carriers are already required to make enrollment and key marketing material available in the languages of California's principal populations, which could be leveraged by Navigators.	Anthem Blue Cross
Navigators should be subject to the same requirements as Exchanges with regard to translating materials and providing oral assistance to LEP individuals. If Navigators provide information through a website, we also suggest Navigators include links to translated materials, taglines, and information on how consumers can obtain oral language services. Navigators must be trained and competent in the language(s) for which they claim to be fluent, able to provide telephonic and in-person assistance, and direct consumers to written translations of applications, forms, and notices. Navigators must also provide consumer education regarding eligibility and enrollment, the rights of consumers, dispute resolution and referrals, as well as translations of vital documents in prevalent languages.	CPEHN and Having Our Say Coalition
Navigators who work with minority groups should be familiar with and trained to address common questions and concerns from people of different ethnic backgrounds and cultural beliefs. In order to fulfill these language assistance needs, navigators must have available sufficient resources to meet the interpretive requirements of California's Language Assistance Program regulations (CCR 1300.67.04), which will likely require a vendor who can supply interpretive services in any language need presented.	Delta Dental
Requirements for a Culturally/Linguistically Competent Navigator Program: Navigators should have experience working in the community they will be serving and should be knowledgeable of the community and their needs. Navigators should be able to communicate effectively with the community they will be serving. (See: Effective Health Outreach to Cultural Communities http://www.medtronic.com/downloadablefiles/outreach_brochure.pdf and Impacting Health Disparities Through Community Outreach: Utilizing the CLEAN Look (Culture, Literacy, Education, Assessment, and Networking), 2007, http://www.moffitt.org/CCJRoot/v14n1/pdf/70.pdf)	The Greenlining Institute
Navigators should be able to prove they meet health literacy standards in their outreach materials (generally a sixth-grade reading level) and the Navigator administrator should be able to meet Medi-Cal managed care threshold languages depending on the language density of the region.	Health Consumer Alliance
To provide culturally and linguistically appropriate services, navigators should: be bilingual and have access to interpretive services; a list of providers listed by ethnicity and language capabilities; a list of community based organizations that families can seek out for additional assistance; cultural sensitivity and awareness training.	Health Plan of San Joaquin

A system needs to be set up that will encourage the broadest range of navigators possible, to encourage the participation of navigators who can provide culturally and linguistically appropriate services for the diverse citizens of California. Every entity that employees navigators will not be able to provide services in all Medi-Cal threshold languages, and a referral system and available phone number should be available to connect those who need specialized language services, or other assistance, to a navigator able to help them. The Exchange should specifically seek to incentivize the engagement of a wide range of navigators by ensuring the training and certification process is not especially cumbersome or too expensive. In addition, ensuring culturally and linguistically appropriate IT services for the enrollment system will allow both individuals and navigators to access and understand this system. The IT system should use terminology that is accessible to readers at a grade school reading level as recommended by the National Institutes of Health. In addition, materials provided, whether by internet, mail, phone, and in-person, should be translated into all Medi-Cal threshold languages. The IT system should be designed to allow users to easily access the enrollment system from traditional computer, tablets and other mobile devices.	Planned Parenthood Affiliates of California
There should be a process to recruit and attract a wide-array of navigators who can provide culturally and linguistically appropriate service and who may be affiliated with various cultures/language communities within an area. Monolingual navigators may be ideal in certain areas, provided that they align with the language needs of their local community. However, part of the training could include redirecting an applicant to an appropriate location (web or in person) if the navigator cannot serve the client's needs.	San Francisco Department of Public Health
Navigators should be subject to the same requirements as Exchanges, per proposed federal rules, with regard to translating materials and providing oral assistance to limited English proficient (LEP) individuals. For example, if Navigators provide information through a website, we suggest Navigators include translated materials, taglines, and information on how consumers can obtain oral language services. California state agencies have experience contracting with community-based organizations to provide culturally and linguistically competent consumer assistance to limited English proficient Californians. This experience could serve as a model for the Navigator program and help provide further clarification on what types of standards and qualifications Navigators must have in order to be successful in maximizing enrollment in the Exchange. At a minimum we would urge HBEX to consider the following requirements that Navigators must be trained and competent in the language(s) for which they claim to be fluent, able to provide telephonic and in-person assistance, and direct consumers to written translations of applications, forms, and notices and able to provide consumer education regarding eligibility and enrollment, the rights of consumers, dispute resolution and referrals, as well as translations of vital documents in prevalent languages. In addition, HBEX should select Navigators that demonstrate an ability to reach and assist the types of individuals and small businesses that will use the Exchange services taking into account the racial, ethnic, and geographic diversity of the state and the population particular Navigators intend to serve.	The 100% Campaign

Cultural and linguistically appropriate standards are critical for successful efforts to gain broad participation in the Exchange. In order to reduce confusion, increase consistency, capitalize on successful outreach programs, and reduce infrastructure costs, it is recommended that the Exchange import and adopt established rules and standards from existing law. Although there are many places to look for these standards, we believe the language included in the appeals and grievances regulations in 45 CFR Part 147 is a good example of successful standards, and that the Exchange should consider similar language for adoption.	UnitedHealthcare
Question #28: What should be the scope of work of navigators? What, if any, role should navigators play in ongoing case management/outreach to individuals after they enroll?	
Navigators should offer support to consumers with respect to seeking eligibility determination and completing an application for enrollment. Once an individual is enrolled in a plan, the carrier should provide ongoing support to the individual.	Anthem Blue Cross
The primary function of Navigators should be to do outreach and enrollment. The state might want to consider instituting a two-tier system if necessary between those conducting outreach, education and enrollment and those making eligibility determinations. Based on the level of expertise, it may be possible to train some Navigators to do follow-up and case management as long as they are supervised by a non-profit legal service provider or some other entity. Participants liked the Healthy Families model where health promoters do enrollment in the field.	CPEHN and Having Our Say Coalition
With the newly enhanced Office of Patient Advocate (OPA), the state is well poised to provide services for Californians across the spectrum, from eligibility and enrollment, through to appeals and grievance support. The Exchange could contract with OPA to provide the Navigator function for individual Exchange products, which is a more limited role than the services that OPA is mandated to provide across health coverage programs. While not all OPA staff or community-based organizations contracted with OPA would have to be versed in Exchange products, there should be capacity to support all levels of assistance an individual might need for Exchange coverage. Navigators need not be responsible for case management, but could help with outreach to potential enrollees, subject to rules around marketing and any or all training and certification requirements. An optional Navigator role in retention/re-enrollment would make sense. This was our experience with CAAs: the relationship with the enrollee makes them ideal for helping ensure re-enrollment (with appropriate compensation).	Consumers Union
Navigators should be responsible for educating individuals about the Exchange, supporting individuals as they look to select an insurance plan, and perhaps most importantly, ensuring that individuals make a purchase. Ongoing case management should be balanced with the goal of maximizing enrollment of eligible individuals. CVS Caremark would recommend that the impact of ongoing case management / outreach on consumer loyalty and support be explored before it is offered.	CVS Caremark
Navigators should have a focused role of objectively assisting in the eligibility and enrollment process by providing information and answers to questions about the benefits available through the exchange. Questions about benefits and claims after enrollment should be handled by issuers.	Delta Dental

Scope of Work for Navigators: 1. Utilize case management to help with renewal. 2. Some populations may need education on how to use their health insurance after they are enrolled. (See: Kaiser Family Foundation http://www.kff.org/medicaid/upload/Connecting-Eligible-Immigrant-Families-to-Health-Coverage-and-Care-Key-Lessons-from-Outreach-and-Enrollment-Workers-full-report-pdf.pdf) 3. Navigators should also help individuals change their health plan if a change occurred in their status that negatively impacts their coverage or causes them to be underinsured.	The Greenlining Institute
Navigators should be able to assist consumers in getting through the health care system, including help with enrollment, where to go for health care, assessing what plan or option might be best for them (free of steering), helping underrepresented groups, collecting and reporting data, and connecting consumers to additional high-level assistance or independent legal assistance if necessary.	Health Consumer Alliance
The Health Navigators' scope of work includes: outreach, education, enrollment and retention. The reimbursement module should include initial application assistance and renewal application assistance.	Inland Empire Health Plan
A Navigator should: • Know the rules of the program • Guide the customer to the right program • Assist the customers with the application, but does not make an eligibility determination	San Bernardino County
Navigators should be limited to application assistance, application submission, and program referral and should redirect applicants with more detailed questions to a centralized call center to ensure standardized responses. Navigators should be given standardized “next steps” materials to provide to help clients their responsibilities for enrollment and retention. (e.g. updating their address, who to call with questions, completing annual renewal, etc.).	San Francisco Department of Public Health
Navigators should serve California consumers eligible for either the Exchange’s qualified health plans or public coverage options equally. This will allow for continuity of coverage and enhance access to and enrollment in the most suitable coverage. While training requirements may differ somewhat between navigators and agents, both professional categories must be skilled at assisting consumers in Exchange and public program enrollments. Additionally, care coordination should be included as a value-added service provided by navigators and agents and would include assisting consumers with finding medical and dental homes, as well as scheduling first appointments.	The 100% Campaign
The Navigator role, as defined by the Affordable Care Act, is to help consumers through the eligibility and enrollment process, and we believe they should be certified and trained to perform these functions. A role that would involve outreach/case management beyond eligibility and enrollment, including one that potentially addresses the health and wellness of the consumer, requires specific training and is a different role. It is likely that the individuals and entities that seek to become Navigators will have varying qualifications, backgrounds, and skills, and only a subset will likely have the dual training as a case worker. Thus, we recommend that Navigators focus on the role of eligibility and enrollment.	UnitedHealthcare

Question #29: To what extent, if at all, should financial support be provided for community-level activities in advance of open enrollment?	
We recommend that the Navigator program be established and fully funded well in advance of the October 2013 enrollment date. This will ensure that Navigators are trained to begin educating communities about their options in advance of the enrollment period. This will also ensure that Navigators have the necessary resources to successfully, seamlessly and quickly enroll all those who are eligible as well as to dispel any myths or confusion as a result of deceptive marketing practices.	CPEHN and Having Our Say Coalition
Consumers Union believes that financial support for community-level activity in advance of open enrollment is important so that communities can gear up and prepare themselves for that intensive period. Much education of CBO staff as well as potential enrollees about insurance concepts, the Exchange process, and subsidies will be needed. In the Level II grant, it would be ideal to leverage significant federal resources for this sort of funding to prepare adequately on the local level and establish trust and credibility in order for the Exchange to be effective and cover the greatest number of people possible.	Consumers Union
Grassroots efforts targeted to locations in the community where consumers visit or congregate with some regularity appear to be reasonable means to create local appreciation of the Exchange requirements and benefit options as well as to foster peer-to-peer support.	CVS Caremark
Community activities are the best way to reach otherwise hard to access areas of the population. As finances permit, community activities should be used to inform the public of the benefits and services available through the exchange.	Delta Dental
Financial Support for Community Outreach: Make grant funding available for education, particularly in underserved, rural, and monolingual communities. (See: California Coverage and Health Initiatives, http://cchi4families.org/pdf/uploads/Executive%20Summary_new050411.pdf)	The Greenlining Institute
Funding activities to activate enrollment is important. Widespread community and popular education campaigns, particularly those designed and provided in non-English languages can create a pathway that will eventually help vulnerable persons feel comfortable applying for and getting coverage.	Health Consumer Alliance
Broad community-level public education and outreach at least 3-6 months in advance of open enrollment will be very important to make consumers aware of their health care options and their obligations under the Affordable Care Act, with special emphasis on specific populations. To be most effective, outreach and education should be conducted at the community level, and as "close" to the consumer as possible. As California learned with the advent of CHIP, local, community-based outreach by trusted messengers was more effective than costly marketing campaigns conducted by the state. The education and outreach must be carried out where the consumers live, work, and attend school. As such, we believe that significant financial support should be provided for community-level activities to community-based organizations, in addition to any financial support for broad statewide or regional advertising/public relations campaigns (e.g., TV commercials, billboards, newspaper advertisements, etc.) the state Exchange may choose to undertake.	The 100% Campaign
Question #30: What performance standards should navigators have (e.g., requirements for case volume or service time)?	
Navigator calls should be monitored for accuracy of information provided. In addition, call centers should have performance standards with respect to measures such as wait times and call abandonment rates.	Anthem Blue Cross

The Exchange should establish quality assurance measures that evaluate the services provided by Navigators. At a minimum, Navigators must be capable of responding to consumers in a timely manner and of providing culturally and linguistically appropriate services as required. Navigators should track both the volume of clients served as well as the number successfully enrolled in order to measure quality in addition to efficiency. Additionally, the Exchange should be notified of any consumer questions or complaints. Navigators should report on demographic data to the Exchange so the Exchange can evaluate the effectiveness of the Navigator program in reaching hard-to-reach populations. Participants would like to see a secure system of checks and balances between Navigators and the Exchange to ensure quality services including privacy of information. Consumers want timely follow-up from Navigators with a clear timeline for when a consumer can expect to hear back regarding approval or rejection of an application and when coverage will start.	CPEHN and Having Our Say Coalition
Performance standards should be based on a balance of quality of service and productivity. Standards should include objectivity, professionalism and accuracy.	Delta Dental
Performance standards should not focus on quantity alone because this creates disincentives for navigators to help consumers with more complicated situations such as mixed status families; self-employed persons, seasonal workers, or other consumers with complicate income calculations; and difficult-to-reach populations such as LEP, homeless persons and persons with mental health disabilities.	Health Consumer Alliance
The Health Navigators should meet at least the following performance standards: • Requirement to meet an acceptable level of "approved" new application rate. • Requirement to meet an acceptable level of "approved" renewal application rate. • Requirement to meet an acceptable level of complaint rate (e.g., steering, product knowledge, adverse selection, cultural sensitivity, etc.). • Requirement to help families apply for Medi-Cal and/or Healthy Families if they are not qualified for any Exchange products.	Inland Empire Health Plan
Question #31: How will the work of navigators be coordinated with other consumer assistance groups to provide effective, non-redundant services? How do we leverage the current certified application assistant (CAA) network?	
Health insurance company representatives, agents, and Navigators if appropriately licensed, are best positioned to facilitate plan selection and enrollment. Relying on these groups will avoid redundancy and best promote a positive member experience. Consumer assistance groups may generate leads and referrals. CAAs could also be available as resources to support agents and Navigators, such as through translation services for non-principal languages.	Anthem Blue Cross

The state should examine the current CAA structure to see if and/or how it could be applied to this new program. For example, Navigators could be trained by legal services providers with the background and expertise to help resolve complex eligibility cases similar to the CAA model. Navigators should be responsible for outreaching to large numbers of individuals. Legal service providers, state and/or county workers may need to be involved in more complex cases regarding eligibility and enrollment issues including appeals and grievances.	CPEHN and Having Our Say Coalition
There should be coordination to limit the potential overlap of services. We suggest that an assessment be conducted to identify where there are current gaps in the CAA network to determine where coordination is needed. It is critical to have well defined requirements at the eligibility level to ensure consistent and non-redundant services.	Delta Dental
Coordinating with Navigators and other orgs: 1. Employ regional network patching to fill in navigators where there is a lack of consumer assistance groups. 2. The existing CAA network should be utilized as assisters.	The Greenlining Institute
The newly-expanded Office of the Patient Advocate is able to perform as a clearinghouse and coordinator for consumer assistance duties that link between agencies, offices, programs, consumer assistance, and navigators. For existing assistance structures, such as CAAs and the Health Consumer Alliance, it is possible that either group could be designated a navigator, though many CAAs will need considerable additional training on coordination between programs, employer coverage, appeals, and subsidies and cost sharing. It is also possible that they can provide an introductory level of assistance geared towards straightforward enrollments and could then refer more complicated cases to more developed consumer assistance programs.	Health Consumer Alliance
The Health Navigator program should build upon existing consumer assistance systems. There are many existing statewide, regional and local organizations that currently provide outreach and enrollment activities for Medi-Cal, Healthy Families and commercial products. It is important to build a bridge between the Health Navigator program and these organizations for product knowledge sharing and referrals. At best, the Health Exchanges should proactively reach out to these organizations and encourage them to participate in the Health Navigator program. These organizations have a depth of knowledge in effective and efficient outreach activities to their communities. They could be one of the best outreach channels to the lower income or subsidized population.	Inland Empire Health Plan
Close coordination of the navigation program with consumer assistance groups will be essential to ensure that consumers have access to the full range of necessary services and to reduce redundancies between the programs. Because the skills required to reach members of a community to educate them on health options and enroll them (navigation) are not the same set of skills required to assist enrolled individuals with complex problems that arise in utilizing one's coverage and lodging grievances or appeals (consumer assistance), the two programs should be separately administered though coordinated and complementary in their operations. Experience shows that individuals assisted with an application for coverage will return to the assistor for help when questions or problems arise regarding utilizing their coverage or accessing care. Navigators will need to be trained to refer individuals when the circumstances require the particularized skills of a consumer assistance program. In some cases, consumer assistance programs will qualify to be navigators rendering	The 100% Campaign

such referrals unnecessary. California has been very successful in leveraging the skills of local, trusted community resources (CAAs) to conduct education in health coverage options and to assist in enrollments. The cadre of thousands of active CAAs in the state can form, with additional training, a ready workforce for the navigator program in the individual, and in some circumstances, the SHOP Exchanges. Elements of the training conducted for CAAs by the Managed Risk Medical Insurance Board and agencies in local communities that conduct CAA training can serve as the basis for a curriculum for the training of Navigators. This curriculum will need to be significantly augmented with elements of the Department of Insurance's agent licensure training (elements of health insurance, pertinent sections of the CA Insurance Code, ethics), and additional components (public health programs, QHPs, Essential Benefits, SHOP, tax credits and reconciliation, linkage to other public benefits, etc.). With appropriate training and credentialing programs, the Exchange will be able to leverage the skills and expertise of CAAs as navigators.	
Question #32: What types of services beyond initial enrollment do health insurance agents provide today for individuals? What services beyond initial enrollment to health insurance agents provide for small businesses?	
For individuals, agents offer other types of coverage (e.g., life, dental), help resolve consumer issues, review plan options during open enrollment, facilitate policy changes such as addition/deletion of dependents, and educate members on their coverage. For small businesses, agents provide a range of services beyond initial enrollment, including evaluation of plan options; financial and tax consulting; ongoing claims service support; ongoing enrollment, underwriting, and billing support; and renewal evaluation. Agents continue to receive compensation in years after the initial sale of the policy, which is due to their provision of these services.	Anthem Blue Cross
The brokers/agents often help resolve service problems and act as an advocate for the group on issues such as claims, eligibility or billing issues. They also help the group to renew or make annual changes to plans and at times assist the business in annual open enrollment meetings.	Delta Dental
Brokers/agents provide consulting to their clients to assist them in selecting the correct plan for their business (taking in to consideration number of employees, location, culture of business, cost, etc.). After the enrollment process, brokers also assist with the management of those plans (adding/dropping employees and dependents, tweaking benefits as needed, administering HSA/HRA, etc.)	Small Business Majority
With regard to small businesses, comments presented by insurance agent representatives on the SHOP enrollment and eligibility stakeholder work group emphasized that insurance agents often provide assistance to employers and employees beyond initial enrollment. They report that agents often assist with plan selection, understanding policy terms such as premium costs, cost-sharing, application of deductibles, obtaining health plan treatment approvals, payment options, etc. Insurance agents often view their role as an on-going resource that is not limited to initial enrollment. In order to attract small businesses to the SHOP, it will be important that such services continue to be provided to small businesses, whether by agents and/or the SHOP itself.	The 100% Campaign

Question #33: What are payment options and appropriate outcome measures for enrollment work performed by the entities listed below (e.g. fixed price per enrollment, percentage of premium, grants)? a. Community / consumer groups b. Counties c. Health insurance agents / general agents d. Providers / community clinics e. Health plans	
Compensation to agents for the sale of exchange products should be at parity with compensation in the off exchange market. Without such parity, agents would be at a financial disadvantage in directing clients to on-exchange plans relative to off-exchange options. The actual amount of compensation should be market-specific (e.g., individual vs. small group). In addition, there should be compensation for both new and renewing accounts, as there is today, to encourage ongoing service and retention support.	Anthem Blue Cross
Other than health plans/issuers themselves, any entity that provides assistance for enrollment work should be compensated at the same rate, based on a flat fee, with an additional fee for re-enrollment. Using a percentage of premium by plan, which are ever escalating, would mean ever escalating enrollment fees. If a percentage approach is preferred, however, it could be calculated based on an average of premiums of all plans. Under federal law, health plans/issuers may not be compensated for enrolling people in public coverage or QHPs.	Consumers Union
Outcome measures should focus on the number of individuals consulted and the number of individuals enrolled. Successful enrollment support would not only reach a large number of individuals, but would also have a high rate of converting the consultation into enrollment. In addition, customer satisfaction with the Exchange should be tested. These ratings of consumer satisfaction likely would measure elements of trustworthiness, accessibility, relationship qualities, ability to tailor conversation to meet individual needs, etc. As for payment options, all those mentioned above are worthy of consideration, in addition to the use of continuing education credits for professionals in fields that require ongoing learning / training.	CVS Caremark
Reimbursement for successful application assistance should be a fixed price per enrollment to avoid risk adverse selection and inappropriate steering.	Inland Empire Health Plan
To encourage the participation of organizations, individuals, and providers who can be leveraged as navigators, we recommend payment of a flat fee for each new or recertified enrollee, one which reflects the representative average cost of hiring and training navigators as well as the staff time required to assist an individual through the eligibility and enrollment process. Providing an extra incentive for the enrollment of non-English speakers would assist organizations and providers in hiring navigators able to provide culturally and linguistically appropriate services. A higher fee, or additional incentive payment, should be provided for enrolling individuals in all of the Medi-Cal threshold languages.	Planned Parenthood Affiliates of California

c. Payment for brokers must be competitive with what they are getting on the outside market. Otherwise, brokers will be incentivized to sell against the Exchange.	Small Business Majority
There are a number of ways that the compensation structure could be set up. Historically, California outreach and enrollment programs have been funded either via grants to community based organizations or by reimbursements for successful enrollments to Enrollment Entities (who engage Certified Application Assistants), including CBOs and insurance agents and brokers. The ACA references grants as opposed to reimbursements for enrollments. Other states, such as Oregon, have seen great success in enrollment through a combination of both enrollment reimbursements fees and grants. There are benefits and consequences associated with each – while grants might be better for community and consumer groups that might be employing a variety of outreach methods to enroll consumers, grants require significant administration from HBEX (or whatever entity the state would designate to administer the grant). The administering body would need to create standards related to grant eligibility, measurements, reporting, etc. Basing compensation on reimbursements for successful applications has the benefit of simplicity and incentivizes successful enrollments. California already has the infrastructure developed through MRMIB to implement this sort of reimbursement program. However, the flat rate enrollment reimbursement fee provides an incentive to enroll the "low hanging fruit". Additional incentives will be needed (such as grants) to support the more difficult work of outreaching and enrolling the hard-to-reach populations who will make up a large part of those eligible for coverage through the Individual Exchange. Finally, the Exchange could consider developing a compensation program that mirrors how insurance agents and brokers are currently compensated – through commissions. In our view, the best approach is to develop a compensation system for assistors similar to that used in Oregon where grants are provided to motivate community organizations and consumer groups coupled with enrollment reimbursement fees. Considering how new the Exchange will be to consumers it is important to, at least initially, employ all methods available to encourage enrollment.	The 100% Campaign
Question #34: How, if at all, should potential payments vary based on: a. The type of entity providing the services; b. The complexity of the service/client being served; or c. Other factors?	
Payments could vary based on the enrolling entity, but we are concerned about the potential for negative unintended consequences of varying payment based on the complexity of the service or client. Agents and Navigators should be incented to take on all comers, regardless of their complexity or potential for eligibility. We also suggest that payments reflect the entirety of the role, including post-sale services that the agents or	Anthem Blue Cross

Navigators should play during the full course of their relationship with the individual or group. Consumers and groups will want an unbiased entity that will continue to work with them as coverage issues arise or needs evolve, and so payment should be structured accordingly. .	
Those we surveyed noted that there should be a fee paid per enrollee, or that funding be structured based on the percentage of uninsured and/or underinsured within each ethnic group. Another recommendation was that the funding be funneled through county departments of public health, who could re-grant the money to these community entities. There are many different models the state could consider in deciding on a payment plan. One model we would highlight is the now defunct Naturalization Services Program (NSP). Under the program, community based organizations received a stipend for each citizenship application filed with UCCIS. Organizations received an additional stipend for every successful application filed. CBOs were encouraged to partner with other CBOs in their geographic region to reach as many people as possible.	CPEHN and Having Our Say Coalition
As stated above, assistance with enrolling and re-enrolling should be compensated as a flat fee, regardless of the entity providing the assistance. For assistance with other services, such as filing appeals and grievances, there may be a different compensation structure - either a monthly flat rate provided to the entity providing the services, or funding for dedicated assister positions in an already established agency (e.g. Office of Patient Advocate)	Consumers Union
The fixed price per enrollment could be varied according to regional difference to reflect different cost associated with outreach and enrollment.	Inland Empire Health Plan
Payments should vary based on the entity providing the service, because the entities that will be enrolling consumers will need to be as diverse as the population that will be utilizing their services. As aforementioned, community and consumer groups, even public agencies, have established relationships with their communities and will be more likely to benefit from grants that will support their already established approaches. On the other hand, small businesses may prefer to interact with insurance agents who may not like the granting process.	The 100% Campaign
Question #35: What are the implications of payment policies for enrolling individuals in health insurance coverage being the same or different inside and outside the Exchange?	
Processes should be designed to ensure that there is minimal adverse selection inside the Exchange. Therefore, payment should be structured so as to avoid adverse selection effects or steering.	Delta Dental
It is important that enrollment entities be paid the same for coverage inside and outside the Exchange or there may be adverse selection problems.	Health Consumer Alliance
To avoid adverse selection, the potential payment amounts/levels for agents and brokers in the SHOP and Individual Exchanges should be competitive with the payment amounts/levels for the non-Exchange commercial products. In 2008, the Center for Medicare and Medicaid Service (CMS) re-engineered the payment structure that health plans can have for their agents and brokers. One of the goals of this new payment structure is to protect consumers from being “steered” into a health plan or product that they do not prefer. It also fosters a fair competitive enrollment environment. This could be a good reference for the Exchange in building a payment structure for the agents and brokers.	Inland Empire Health Plan

Whether the Exchange and the State of California are able to develop payment policies and appropriate regulation and parity of payments for enrollment inside and outside of the Exchange will have an enormous impact on the short term success and long term sustainability of the Exchange. If payments for enrollment inside of the Exchange are substantially inferior to agents' payments outside of the Exchange, inappropriate steering could be a threat to the viability of the Exchange.	The 100% Campaign
Question #36: Should payment to health insurance agents be made by the Exchange or plans in the individual market portion of the Exchange? Should payment to health insurance agents be made by the Exchange or plans in small business Exchange?	
Payments to agents should be made by the plans.	Anthem Blue Cross
The ACA does not allow health plans to directly or indirectly reimburse Health Navigators for an Exchange enrollment. To avoid adverse selection and to have a consistent implementation of the application assistance reimbursement system, the Exchanges should reimburse the Navigators, agents and brokers.	Inland Empire Health Plan
Question #37: What responsibilities/linkages should navigators have to non-health social services programs?	
As the Exchange is integrated with social services, Navigators should: 1) have a CalHEERS Navigator functionality that includes social services; 2) receive initial and ongoing training in the social services included in CalHEERS; 3) have their social services applications through CalHEERS tracked; 4) maintain consumer confidentiality protections for social services (as for health); and 5) receive compensation for their social services applications through CalHEERS (potentially through USDA SNAP Education & Outreach funds and/or other analogous funds).	Alliance to Transform CalFRESH
California's new and simplified enrollment form and IT system for health coverage should flag individuals who may be eligible for non-health related social services and refer those individuals to the appropriate assisters.	CPEHN and Having Our Say Coalition
Consumers Union would like to see the initial primary focus of Navigators' be on assisting individuals with health coverage. If further down the road the Navigator program is successful and robust, the agencies and stakeholders should consider whether the program should be expanded to cover non-health social services.	Consumers Union
To the extent that an increased understanding of these programs allows navigators to have a more fulsome conversation with consumers and allows for participation in these available services to be maximized, it would seem reasonable to have navigators also be able to articulate the specifics and process associated with enrolling in these other programs. And, if it appears to be overwhelming for navigators to take this on as part of their consultations during the 2013 open enrollment period (i.e., for 2014), it certainly could be incorporated as part of the roadmap for subsequent years.	CVS Caremark
Responsibilities/Linkages to Non-health Services: 1. Create a seamless system enabling people to determine eligibility for other programs 2. Navigators should be able to assist with use of this system.	The Greenlining Institute

Ideally, Navigators will be employed by organizations and service centers that have a history providing assistance across a spectrum of public benefits programs. They can identify clients who might be eligible for multiple programs during the intake or enrollment process and help them apply for additional benefits. Additional legislation addressing horizontal integration of programs is in the works. Upon entering the CalHEERS system, applicants who appear to be eligible should, with their consent, have their information used to start an application for CalFresh, CalWORKs, and possibly other programs. Ideally, Navigators can identify these clients during the intake or enrollment process and help them apply for additional benefits. CalHEERS should also have this functionality built in as soon as possible.	Health Consumer Alliance
The ACA requires states to develop a single streamlined application system where individuals can apply for Health Exchanges, Medicaid and CHIP. In addition, one of the CA Health Exchanges Board's enrollment principles is "no wrong door". Therefore, it is critical to require Health Navigators to help individuals apply for Medi-Cal and the Healthy Families Program at the Health Exchanges application assistance point of contact, if these individuals are not eligible for any Exchange products. To enforce this provision, states can use the Health Navigator grant for the Health Exchanges, Medi-Cal and Healthy Families application assistance. It is also highly recommended that Health Navigators refer individuals to other eligible social service programs (WIC, CalFresh, etc.).	Inland Empire Health Plan
Question #38: What responsibilities/linkages should health insurance agents have to public health care programs and/or non-health social service programs?	
Health insurance agents should have basic training in CalFresh and other social services included in CalHEERS, in order to provide consumers with general guidance and to be able to connect them with more expert help.	Alliance to Transform CalFRESH
Navigators should provide for linkages with housing assistance, utility payment assistance, and other critical family assistance services and resources.	Anthem Blue Cross
Health insurance agents should be able to refer potentially eligible clients to those who can assist with enrollment into public health care programs as well as to safety-net providers.	CPEHN and Having Our Say Coalition
Health insurance agents and brokers should have training and licensing standards that require them to understand public health programs sufficiently to make appropriate referrals in order to ensure that they are not enrolling people in private pay coverage when they are eligible for insurance affordability programs (e.g., cost-sharing reductions, advanced premium tax credits, Medi-Cal, Healthy Families, and/or Basic Health Plan). Those agents and brokers that are participating in the assister program should be able to conduct assistance consistent with the Navigator program. See answer to #33 and 34.	Consumers Union
To the extent that an increased understanding of these programs allows insurance agents to have a more fulsome conversation with consumers and allows for participation in these available services to be maximized, it would seem reasonable to have agents also be able to articulate the specifics and process associated with enrolling in these other programs. And, if it appears to be overwhelming for navigators to take this on as part of their consultations during the 2013 open enrollment period (i.e., for 2014), it certainly could be incorporated as part of the roadmap for subsequent years.	CVS Caremark

If brokers are "certified" to be a Health Navigator, it is essential to require that a Health Navigator help individuals apply for Health Exchanges, Medi-Cal and/or Healthy Families program. The Exchanges should consider using the Health Navigator grants to enroll all uninsured individuals in their eligible program. Payment structure could be the same or different for these three programs. The brokers should be highly encouraged to refer the applicants to other non-health social service programs.	Inland Empire Health Plan
Question #39: For each of the questions identified below, note differences, if any that may relate to how the responses should relate to individuals, small employers, and self-employed solo individuals.	
Question #40: What works today in terms of assisting individuals and small businesses in enrolling in public and private coverage? What doesn't work?	
Submission of applications online is most efficient.	Anthem Blue Cross
The following research has helpful findings, as of 2008, including on Healthy San Francisco: "Designing Subsidized Health Coverage Programs to Attract Enrollment: A Review of the literature and a Synthesis of Stakeholder Views" (2008) • http://aspe.hhs.gov/health/reports/08/subenroll/index.shtml	Consumers Union
Increasingly, companies are developing robust web-based decision support tools that match an individual's purchasing criteria and past history against the range of insurance options to produce a recommended plan for consideration. These tools, often in conjunction with live one-on-one support, provide a starting point for consumers as they evaluate the numerous and often complicated set of choices available to them. Additionally, as noted previously, CVS Caremark assists Medicare members each year to enroll in Medicare Part D, consistent with Medicare Part D requirements. The plan finder tool, together with a thorough analysis of an individual's prescription history, helps to ensure an individual selects a plan that is best suited to his/her needs. Pharmacist training in consultations and insurance products is critical to ensuring that this enrollment support is useful in the end.	CVS Caremark
In the individual market, our experience shows that websites, call centers and agents are more effective than paper communications. Also, in person community health fairs are very effective. For small group, agents and brokers tend to provide information for use by the group, as well as materials from issuers for use in open enrollment. Online tools can be effective for small groups.	Delta Dental
Assisting in Enrollment: Notifications are often written at a level that is at too high of a literacy level or not in the appropriate language for the consumer. This is ineffective. Notifications should instead be written at a low literacy level and be linguistically appropriate. (See: The California Medicare Part D Language Access California Coalition, "Please Hold": Medicare Part D Leaves Limited-English Proficient Beneficiaries Waiting for Access, http://www.greenlining.org/resources/pdfs/PleaseHold.pdf; and Cancer Control Journal, Impacting Health Disparities Through Community Outreach: Utilizing the CLEAN Look (Culture, Literacy, Education, Assessment, and Networking), http://www.moffitt.org/CCJRoot/v14n1/pdf/70.pdf)	The Greenlining Institute
Local, community-based organizations and CAAs play critical roles in helping enroll consumers into coverage. Trained, bilingual staff on the ground is needed to reach sometimes hard to reach populations including LEP consumers, immigrants and mixed-status families, homeless individuals, individuals with disabilities.	Health Consumer Alliance

In terms of assisting individuals and small businesses in enrolling, the personal approach works. Having un-biased representatives that can inform small businesses and sell the exchange is important	Health Plan of San Joaquin
California's Family PACT Program provides an excellent model for provider-based enrollment and demonstrates the success of on-site provider enrollment in facilitating the enrollment process and allowing individuals to receive immediate access to services. Health care providers like Planned Parenthood that providers services to populations most likely to become newly eligible for coverage under the Exchange are essential partners in the enrollment process. These providers are known and trusted within the communities they serve. They are likely to serve the population that may be most difficult to enroll into coverage: young, health individuals who are essential to the risk pool, yet less likely to seek coverage unless they understand the benefits. Reaching these individuals at the time they are seeking services and allowing them to enroll in coverage and gain access to services without waiting could provide the incentive needed to reach this population. PPAC therefore recommends that the Exchange look to Family PACT as a model for enrolling individuals in coverage.	Planned Parenthood Affiliates of California
There is great variability across the State with regards to community-based infrastructure to support enrollment into available coverage programs. For communities that have such capacity, through a network of CAAs who have established trust with hard-to-reach populations and brokered partnerships with safety net providers, in particular, community-County models could be a cost-effective channel to funnel enrollment through the Exchange/ portal. These networks could be a natural building block for the navigator network needed across California. It would be ideal, in building a single and unified portal for California, for local communities to not have to duplicate infrastructure/ rules that will be administered by the Exchange/MRMIB/DHCS. For example, for Californians ineligible to purchase in the Exchange, a mechanism to relay such ineligibility to the applicant could make the process of applying for locally supported coverage much more efficient for the client and entities like Counties. We would like to simplify our local enrollment process to ask a few questions related to County residency, income and assets (and not screen for all available programs) if a client is ineligible to purchase in the Exchange.	San Mateo County Health System
Today, 75% of small businesses utilize a broker for assistance in enrollment in private coverage. And of those that use brokers, 88% say they give their brokers' opinions a lot of weight. Also, peer-to-peer communication between small business owners is very effective today.	Small Business Majority
In terms of experience with enrolling low-income children into Medi-Cal and Healthy Families, we know that some of the things that work are: the established network of Certified Application Assistors (CAA) in California; a fair compensation model for assistors that provides incentive to participating in assisting consumers with enrollment; accessible and trusted messengers and assistors from within the community; a simple and easy application and enrollment experience (process, ease for the majority of consumers, required documentation, plan selection, etc.); and easy-to-access, and linguistically appropriate assistance online or by phone. We know that what doesn't work are cumbersome or burdensome documentation requirements and/or enrollment processes for consumers; and perverse, unbalanced, and non-existent financial compensation arrangements with assistors (including brokers/agents).	The 100% Campaign

Question #41: What infrastructure currently exists to enroll individuals and small businesses in coverage?	
To enroll individuals and small businesses in coverage, infrastructure exists to: provide a quote, conduct intake, confirm documentation and eligibility, create an electronic archive of the documentation, conduct underwriting, enroll members, mail enrollment materials, set-up electronic account access, and pay agent/broker commissions.	Anthem Blue Cross
For individual coverage, carrier websites/online enrollment, carrier call centers, brokers (online and in-person), all aided by education and outreach programs. For small business coverage, current infrastructure involves a carrier sales person/department working with a broker (or general agents) to educate the broker and assist in providing rates and benefits to assist small businesses in evaluating options. Once the small business decides what option to purchase, brokers/agents work with the carrier to enroll the voluntary small business employees. When the employees are enrolled they are set-up in the carriers' systems and can begin using benefits based on the date of enrollment and receipt of payment.	Delta Dental
Health insurance brokers, Certified Application Assistors, health plan websites, and health plan phone numbers	Health Plan of San Joaquin
Brokers/agents are currently enrolling most small businesses that provide coverage. They have a business model already in place, have long-standing relationships with small business owners, and are amongst the most respected voices on healthcare issues.	Small Business Majority
There is certainly an established network of Certified Application Assistors (CAA) throughout California that have a great experience with and knowledge about enrollment of uninsured children into Medi-Cal and Healthy Families. Many of these same individuals and organizations also facilitate enrollment into other health and/or social service programs for other or all family members, and these linkages will be important in facilitating enrollment into HBEX. The extensive knowledge of the needs of their local communities make the CAA network a rich one to build from in developing outreach, education, and navigation for HBEX. As the state conducts an audit of existing enrollment assistance infrastructure, a number of important entities should not be overlooked, including providers, clinics, hospitals, schools, insurance agents, and tax professionals that provide important financial advice and referrals.	The 100% Campaign
Question #42: What community-based organizations and providers should be prioritized given their relationships with the uninsured and newly-eligible (e.g., hospitals and clinics that have high-volume uninsured traffic)?	
We recommend that prioritization should initially be based on volume and type of population served prior to 2014. However, post-2014, these may change and so prioritization should be reviewed annually. Organizations that should be considered include FQHCs and RHCs; Health Care Access Program organizations; and clinics, hospitals, and providers receiving MSP, MIA, and/or Bridge to Reform funding.	Anthem Blue Cross
Family Resource Centers (FRCs) and Family Strengthening Organizations (FSOs) should play a key role in education, outreach, enrollment, navigation, and retention activities related to the Health Benefit Exchange. FRCs/FSOs are effective points of contact for individuals who are key targets of the Exchange's outreach	California Family Resource Association

efforts, particularly members of low-income communities and minority populations who are less accessible through traditional channels.

CFRA represents over 200 FRCs/FSOs. Our members serve thousands of California families annually, predominantly in low-income and in ethnically, linguistically and culturally diverse communities. Approximately 85% of CFRA members provide enrollment assistance for programs like Medi-Cal, Healthy Families, CalFresh, SSI and other health and human services assistance. At least 60% of the individuals served by CFRA members are racial/ethnic minorities, and approximately 90% of CFRA members provide services in languages other than English.

In addition to providing services to individuals and families, the vast majority of CFRA members also maintain working relationships with key partners in their communities, such as School Districts, Government Social Service Agencies, Community Health Centers, County Child Welfare/Social Services, etc.
FRCs/FSOs have a unique role in connecting individuals and families to the services they need, and do so in a manner that is effective, efficient, and culturally competent. Their experience educating and enrolling key populations in health and human services programs makes FRCs/FSOs uniquely qualified and well-positioned to assist with outreach and enrollment in the Exchange.

a. FRC/FSO services and service-delivery are tailored to match the needs of each community. FRCs/FSOs understand that different populations encounter different barriers to receiving services and information. The FRC/FSO model accounts for this and designs its services and service delivery style accordingly. By partnering with FRCs/FSOs, CALHEERS can take advantage of existing in-roads to a variety of diverse communities and populations.
b. FRCs/FSOs are designed to be accessible to the communities they serve. They create an environment that is welcoming, respectful, culturally competent, and not intimidating. Many communities feel uncomfortable working directly with government representatives at the federal, state, or local level. CALHEERS can overcome this significant obstacle by taking advantage of the local connections that exist between FRCs/FSOs and newly-eligible consumers.
c. FRCs/FSOs establish ongoing relationships with the families they serve, enabling them to provide ongoing support and navigation assistance. Enrollment is only part of the challenge. CALHEERS will have to accommodate the needs of “high-churn” populations whose information and eligibility status will change frequently. The majority of CFRA members surveyed report having contact with the families they serve several times per month, with more than 30% of respondents having contact with families one or more times per week. This type of consistent relationship with professional service providers is a rare quality, and facilitates the education, enrollment, navigation, and especially retention of consumers in CALHEERS.

d. As trusted hubs of information and resources, FRCs/FSOs are deeply rooted, well-established members of their communities. They build strong connections with individuals, families, schools, businesses, and other community institutions. This allows FRCs/FSOs to reach a wider variety of

consumers than other organizations, and to work with them on a deeper level than other organizations. e. FRCs/FSOs are culturally competent service providers. They reflect and integrate the cultural, linguistic, and socioeconomic needs of their communities into their service-delivery models.	
With respect to individual coverage, those surveyed shared that they would be most comfortable enrolling through the following entities in the order listed below: • Community-based organizations, promotoras, CAA's, senior centers • Community-based clinics with case managers and nurses • Churches • Schools (Counselors, teachers) • Family members	CPEHN and Having Our Say Coalition
Priority CBOs: CBOs with proven track records of successfully serving vulnerable populations through outreach, education, enrollment in social services and supports, and assistance maintaining services. CBOs can partner with hospitals and clinics for enrollment purposes, so providers can focus on service capacity not enrollment activities.	Catholic Charities of California
CVS Caremark is well positioned to provide support to the uninsured and newly-eligible through its large store footprint. With nearly 900 stores and 55 MinuteClinics in California, we have the direct touchpoints to assist the uninsured and newly-eligible. Our health care professional staff comprised of 3,000 pharmacists and 100 nurse practitioners in the state are dedicated to supporting individuals on their path to better health.	CVS Caremark
All of the Federally Qualified and low income dental clinics would definitely be a target for relationship development. We are currently working with many of these dental clinics today and relationship building is an ongoing effort. Efforts should also include Pediatrician and Obstetrician outreach to reach the parents and parents-to-be with a message about oral health and dental programs.	Delta Dental
Prioritized CBOs and Providers: 1. Hospitals, community clinics, and family resource centers should be prioritized to inform patients of public programs. 2. Entities already providing consumer assistance and education should also receive priority.	The Greenlining Institute
CBOs with proven track record and mission of serving consumers should be prioritized. Other priorities are CBOs that have a history of working with hard to reach populations and those that have an independent affiliation that allows them to serve consumers with no self-interest, the ability to act as legal champions and provide high-level support to consumers, and a focus on changing systems to better serve consumers	Health Consumer Alliance
Considering the great disparateness of community resources amongst California counties, there cannot be a blanket answer to this question. For example, it might make sense for most counties if hospitals are prioritized, but some counties with underserved populations do not have a hospital. Rather, our recommendation is to survey the counties to determine which institutions make the most sense to prioritize in their individual context. The list of priority organizations and providers for them to consider should include hospitals and clinics with high-volume uninsured traffic, FQHCs, Family Resource Centers, 2-1-1s and other	The 100% Campaign

referral organizations, free tax assistance organizations, local health initiatives, Public Health Departments and Vital Statistics Registries, school-based health centers and others.	
Question #43: What are models for county-community enrollment partnerships?	
Currently, CBOs throughout California contract with the California Department of Public Health's Network for a Health California to conduct USDA-funded CalFresh (formerly Food Stamps) Outreach, including CalFresh eligibility screening and application assistance. These CBOs work with county CalFresh offices to increase participation in CalFresh. One CBO holds bi-monthly clinics for pre-screened clients to enroll in the program. Clients are pre-screened by CBO staff for likely eligibility for CalFresh; they are then invited to the next clinic. These clinics are staffed by CBO outreach workers (who assist clients to complete CalFresh applications) and county CalFresh staff who immediately review the completed applications, conduct required interviews, and make determinations. Clients who are waiting to meet with a county representative also receive a nutrition education presentation by a partner CBO. Many of the newly-enrolled clients receive their benefits within a week. This model shows extremely effective collaboration between county and CBO staff to increase CalFresh enrollment and improve client nutrition.	Catholic Charities of California
See CU report: "Addressing Barriers to Online Enrollment: Can Public Enrollment Stations Increase Access to Health Coverage" on some effective partnerships between LA Unified School District and Medi-Cal/CHIP and Healthy Howard Maryland between Howard County and Healthy Maryland. http://www.consumersunion.org/pdf/Addressing_Barriers.pdf. In addition, Maine, Massachusetts, New York, and Texas have interesting models. The strongest programs are those that provide the opportunity for face-to-face assistance from trusted staff located in the communities where potential applicants have access to public transportation and can speak directly with an assister without the use of a translator or interpreter.	Consumers Union
Potential model programs include Alameda, Santa Clara and San Francisco County Programs in addition to First Five Programs.	Delta Dental
Models for Enrollment: Regionally based programs that are linked directly with the county such as Cover the Kids in Sacramento are good models. See: http://www.coverthekids.com/	The Greenlining Institute
Los Angeles County operates a model for assistance and training that employs two policy and service organizations, Neighborhood Legal Services and Maternal Child Health Access, which train community-based organizations in different health programs and are overseen by the County Department of Public Health. This has been a successful model that utilizes the talents and knowledge of local organizations, alleviates the administrative burdens on the county, and gives clients a safe space to receive assistance.	Health Consumer Alliance
Children's Health Initiatives or local/Community Health Initiatives are models for county-community enrollment partnerships. These organizations are public-private partnerships that began as county-wide initiatives more than a decade ago. They perform outreach, enrollment, retention, and utilization services to underserved and hard-to-reach populations. Additionally, they provide excellent linkages for the uninsured to coverage programs, providers, and non-health public assistance programs.	The 100% Campaign

Question #44: How should the performance of California's eligibility and enrollment system be measured and reported?	
We recommend including the most common measure of performance: turnaround time from initial intake to issuance of member ID cards. Other metrics that may be useful are online completion rates and phone hold times for individual members, and the time it takes to receive complete group documentation for small businesses.	Anthem Blue Cross
The enrollment system should be designed and able to demonstrate that it can serve families with complex cases (e.g. mixed status families, employee versus individual etc.) where different family members may be eligible for different programs based on eligibility criteria.	CPEHN and Having Our Say Coalition
The most important aspect of the evaluation is to design metrics that assess not only the functionality of the IT system, but also how that technology interacts with the policies and procedures of the eligibility and enrollment system. The IT RFP proposal laid out a number of system functions that would allow the eligibility and enrollment system to collect and report data. Periodic spot checks across programs (Medi-Cal, Healthy Families, and private products) through customer experience surveys, for example, could accomplish this. The evaluation plan should include not only data collection and checks, but engage stakeholders from the diverse populations availing themselves of the eligibility and enrollment system, including assisters, those enrolled in the health coverage programs, and those who were unable to enroll, were denied coverage or started the enrollment process but did not complete it. We also commented in our IT RFP on the importance of testing systems and in this context, policies vis-a-vis systems, should be consumer tested (we referred to it as "User Acceptance Testing") to ensure that the system is meeting the needs of those whom it was created to help.	Consumers Union
Performance metrics could include the percent of applications submitted online, percent of eligibles enrolled, enrollment in QHP/QDP by percent, enrollee satisfaction (before, during, and after enrollment), customer service (first time resolution), volume of automated data (percent of enrollment forms that are pre-populated with data, tax data, unemployment data, employer, etc. and across public programs), ability to enroll across programs (number of new applications, just for switching between programs)	Delta Dental
Performance Measurements: In order to monitor performance of eligibility and enrollment system, collect data on race that can be disaggregated by ethnic group, (See: Closing Data Gaps: Unpacking Asian American Diversity. The Greenlining Institute.) Data on preferred language; data on the number of people applying to program and the number of people accepted into the program, as well as the number of people who were missing documents and the number of people who were missing documents but were followed up with. Exchange should also survey its users on their experience during the enrollment process (pop up on website or on phone). This survey should be delivered in a linguistically and culturally appropriate manner.	The Greenlining Institute
Performance should be measured and reported by collecting data on: Transfers between programs without breaks in coverage. Success of no-wrong-door: applying at Exchange but eligible for Medi-Cal successfully enrolled in Medi-Cal and visa-versa. Look at each of these measures specifically for LEP communities.	Health Consumer Alliance

Timeliness and real-time determinations as much as possible, such as measuring what percentage of applications are processed timely. Additionally, statistics on exactly how many days it took to process applications would be useful. Appeals: # of denials appealed; processing times for appeals; ##s of appeals granted and denied. Notices: review of notices for timeliness, proper content. Kaiser Family Foundation just published an Issue Paper on Performance Measurement Under Health Reform: Proposed Measures for Eligibility and Enrollment Systems and Key Issues and Trade-offs to Consider. December, 2011. You could bring this to the Board's attention in the response to this question. Here is a link to the report: http://www.kff.org/medicaid/upload/8269.pdf Stakeholder input on and review of performance review measures before they are adopted. In addition to the collection of statistics, the Board should consider periodic surveys of stakeholders to determine how the eligibility/enrollment process is functioning.	
From MAXIMUS perspective, California's eligibility and enrollment system incorporates not only the IT infrastructure, but also the program's day-to-day business operations that compliment it. There are two aspects of measuring the eligibility and enrollment system performance: 1) the technical performance of the infrastructure and 2) outcome measures of the program that the system enables. California's eligibility and enrollment system should be measured using metrics for quality, system performance, data integrity and reportable information that is easily accessible. There are industry standard metrics on system availability, unscheduled downtime, processing speed, accuracy of transaction, and the like, which can be required through the RFP. Contracting entities typically require that technical performance measures be reported through weekly, monthly, or quarterly status reports. A more critical aspect of measuring and reporting the eligibility and enrollment system performance, however, is involved with the outcomes achieved by the program operations. This program-based outcomes measurement and reporting relies on a strong foundation of performance management, use of Service Level Agreements, implementation of Quality Assurance programs, and customer satisfaction surveys, as described below. **Performance Management** Our recommended approach begins with the vendor having a corporate policy that underscores the company's commitment to rigorously fulfilling their contractual performance responsibilities. It is complemented by procedures at the individual project level that stipulate how key indicators are documented, monitored, and mitigated when performance is not at the levels to which they aspire. The policy is based on the application of a common accountability framework built around the external performance reports that are shared with state clients, as well as internal reports that are used by project management staff. While the reporting formats may differ from project to project depending on the indicators and the periodicity of the reports, the policy assumes a common way of monitoring compliance and generating "early warning" signals when performance is out of alignment with expectations. The management approach we recommend provides necessary information to managers and staff to assess goal accomplishments and improve operational performance. To measure goal attainment, we use quantitative performance indicators for each aspect of program operations. We break overall project goals	MAXIMUS

into individual goals and performance measures for the different business units that contribute to accomplishing the overall objective. Our employees are expected to comply with these standards and we hold them accountable if they do not comply.

We apply our people, tools, and technology to ensure that performance indicators are being met. If our monitoring indicates a slippage in performance or a degrading trend, managers are expected to make immediate adjustments in staffing patterns. Our ability to quickly adjust to changing project conditions is one of the notable strengths of our project operations, and it is a reflection of the commitment of our employees to being adaptable in the service of the people who depend on us for access to the benefits of public programs.

Setting the Right Service Levels

The creation of performance standards is an essential part of project management. By defining specific performance measures for the program, the Exchange communicates some of its major concerns for the success of its contracted operations. The measures generally fall into one of three categories: timeliness, quality, and customer satisfaction. Having worked closely and successfully with our state clients in other health and human services projects, we have a deep understanding of the value of performance indicators as well as the means to continually monitor our progress toward meeting these indicators.

Contracting for eligibility services provides the Exchange with an opportunity to hold its service provider accountable for achieving certain performance standards. Contracted Service Level Agreements (SLAs), sometimes referred to as Performance Standards can be used to ensure that the desired performance is achieved. Contracted standards are often coupled with financial penalties for not achieving the SLA, or performance bonuses if the SLA is met or exceeded. Developing SLAs requires the Exchange to:

- Consider its desired and required outcomes in light of the cost of achieving them. For example, a state may want customer calls to be answered within two seconds but the cost to so do so would far outweigh the benefit when industry standards indicate that customers are satisfied to have their call answered in 30 to 60 seconds.
- Ensure that SLAs define the desired outcome of the work to be performed without dictating how to do the work, thereby stifling vendor innovation.
- Consider the interplay between SLAs and customer satisfaction. An SLA requiring an average speed to answer a customer call of three minutes may be acceptable to the Exchange but would likely result in high levels of complaints or high call abandonment rates.
- Clearly define the expected outcome and what must be measured to demonstrate compliance to eliminate conflicting and subjective interpretations.
- Require that vendors describe their detailed approach to monitoring its performance and meeting the SLAs. Sample requirements include:
    - Describe how performance will be measured against the Service Levels defined in the RFP
    - Describe your performance management plan and how it will be integrated into the vendor's overall project management approach
    - Describe the performance metrics that will be established for this project, including those for the systems operations and the document management functions
    - Describe the performance management dashboard that will be developed based on the

vendor's previous experience
  - Describe any tools or products that will be used to track and monitor performance
  - Describe the vendor's organizational structure for ensuring that Service Levels are met
- Require that the selected vendor submit a formal quality management or performance management plan to be delivered and approved by the Department during project start-up. This plan should define the specific methods, tools, and reporting to be deployed by the vendor to ensure that quality and performance standards are achieved (as outlined in the previous bullet).
- Require that the vendor demonstrate that they have met similar SLAs for similar work to provide the Department with assurance that the vendor has a record of delivering to expectations, rather than letting the cost of the penalty drive whether or not it is "worth the effort and cost" to meet the SLA.

The chart below, Sample SLAs, lists SLAs that we consider to represent best practices in call center and eligibility processing for the Exchange's consideration.

Function	SLA Type	SLA
Eligibility Assessment	Quality	▪ 97% of all eligibility assessments are accurately completed on a monthly basis (with accuracy defined to address critical errors)
Missing Information	Quality	▪ 95% of all missing information notices mailed to eligible beneficiaries are accurate and complete on a monthly basis.
Customer Service Center Operations	Quality	▪ 95% of client call handling is accurately completed on a monthly basis
Customer Service Center Operations	Quality	▪ No more than 1% of calls may be blocked on a monthly basis
Customer Service Center Operations	Customer Satisfaction	▪ Ensure on a quarterly basis that at least 80% of all survey respondents express satisfaction with program
Customer Service Center Operations	Timeliness	▪ Average speed to answer (ASA) of 60 seconds on a monthly basis
Customer Service Center Operations	Timeliness	▪ No more than 5% of calls abandoned after 30 seconds on a monthly basis
Eligibility Assessment	Timeliness	▪ On a monthly basis, complete 100% of eligibility assessments within ten business days from receipt of a valid and complete application
Eligibility Assessment	Timeliness	▪ On a monthly basis, process all renewals on a timely basis, before the expiration of the current authorization period.
Missing Information	Timeliness	▪ On a monthly basis, send 100% of missing information letters within two business days

Sample SLAs. *Best Practice SLAs measure outcomes to ensure excellent customer service and compliance with state and federal regulations.*

Service Monitoring and Evaluation

The entity responsible for the administration of the Exchange should be required to establish a quality management program to sample eligibility and enrollment operations and report results to the Exchange

oversight entity. The Exchange should require the entity to register its quality management system to the ISO standards. The oversight entity should also provide independent reviews of the Exchange administrator's operation, which would be facilitated by operational reporting requirements imposed by the Exchange oversight entity. To achieve the Exchange's overall program performance goals, measuring customer service will be an essential component. First, to ensure that there is a sufficient staffing level to uphold the customer service standards, and the practical means to monitor the performance of Customer Service Representatives (CSRs), MAXIMUS recommends use of workforce management systems to aid the forecasting of required staffing levels and skill sets, including threshold languages, and documenting all calls for subsequent review. Second, to verify that all calls are accurate, thorough, and conducted with professionalism and courtesy in the languages needed to serve the customer community, we recommend two methods for call monitoring, which should be conducted by Supervisors and QA Specialists: **Live Call Monitoring:** MAXIMUS supervisors see real-time call center statistics (hold time, for example) and participate in silent, live monitoring of employees as they interact with individual callers. They provide coaching to staff or take over a call from a staff member, if necessary. An informative message is played to all callers to ensure their awareness of potential call monitoring for quality assurance purposes. Each CSR is subject to live call monitoring at least once a month with more frequent monitoring for employees who are new or have performance issues. **Call Recording**: MAXIMUS uses software solutions to digitally record every personal interaction through our Call Centers. This software enables us to retrieve and listen to conversations according to a broad range of parameters besides date or CSR. The call recording tool includes an administrative interface that allows supervisors and QA staff to classify and sort calls based on call criteria for efficient retrieval and playback. Review of recorded phone messages enables supervisors to provide direction and guidance to staff on an ongoing basis. It also allows QA staff to note trends and make recommendations for additional training in targeted areas. As an example, MAXIMUS typically structures the ongoing evaluation of our Call Center performance around the following goals: **HIPAA Verification:** Verifying caller's identity is one of the key components of HIPAA security. We work with our clients to identify appropriate components for the initial HIPAA verification during the call. Once the protocol is established, the QA staff along with the Supervisors use it as a checklist to make sure that each CSR fully follows the enrollee authentication process. **Courtesy and Demeanor:** Our CSRs are extensively trained in dealing with challenging callers while maintaining a calm and courteous manner. QA Specialists monitor the CSRs' voice, inflection, tone, and words to ensure that each caller is treated with respect and dignity.	

Communication Clarity: CSRs are expected to take the necessary steps to ensure they fully understand each caller's questions. In turn, they are also evaluated on the extent to which the callers understand their responses. QA Specialists and Supervisors are trained in how to assess the effectiveness of this two-way communication and intervene when necessary. **Providing Accurate Information and Taking Correct Actions:** QA Specialists monitor the accuracy of information provided to callers as well as the actions CSRs take in response to particular situations, such as explaining why additional documentation must be sent to address a discrepancy with data received from a third party data match. Because they are experts on program policies and guidelines, our QA Specialists are able to immediately provide corrective feedback to a CSR whose grasp of the program's details is sub-optimal or who fails to take every step that is necessary to fully respond to a caller's needs. When necessary, retraining or mentoring is provided. **Documenting Details of the Call:** To ensure program integrity and our accountability to the Exchange, it is crucial for CSRs to accurately document all details of each call. This may include a consumer's concerns, general inquiries about the program, initiation of the renewal self-attestation, or updating eligibility information. The Exchange software solution should provide the means to monitor the extent to which calls are being properly documented. **Average Wait/Hold Time Thresholds:** Using automated reports and call monitoring, our QA Specialists determine the average time that callers wait or hold for a live voice. Our telephony systems support rapid response time to calls by our CSRs. Refresher training and on-the-job coaching are used if the behavior of a CSR is seen as delaying customers having their calls answered by a live voice. Besides monitoring the performance of individual CSRs, the QA Department also assesses the accuracy of mail processing and eligibility determinations, identifying and documenting trends related to certain types of situations or questions. This information can be used to improve processes and explore different ways these processes can be handled more efficiently. Based on these monitoring results, MAXIMUS periodically conducts refresher training sessions, which include a review of frequent errors and exams to ensure proficiency. In addition to monitoring individual conversations and aggregate service center processing statistics, the QA Department also evaluates the effectiveness of the IVR in shortening wait times, directing calls to CSRs who are qualified and trained to assist with specific questions, and the provision of personalized information that is immediately available from the system. The key to successful automation in a call center is ensuring that the customer experience is improved by the automation. We recommend monitoring detailed customer activity within the IVR self-service application to gauge customer satisfaction, provide necessary reporting and tracking information, and determine potential areas for improvement. We also suggest tracking and reporting on statistics that indicate the quantity of customer visits to each self-service menu option within	

the IVR. In addition to this basic activity tracking, we advise monitoring such things as the last prompt played for all calls that transferred to a live CSR. This data offers valuable information about why callers leave the IVR and require the assistance of a CSR. We also recommend that the Exchange monitor and measure the number of times each IVR prompt is played prior to a caller ending his self-service session. By closely monitoring caller behavior within the IVR, the Exchange will be able to determine the effectiveness of the self-service options being provided and make improvements to ensure that they offer a superior caller experience. **Consumer Satisfaction** In addition to reporting metrics, feedback on the performance of the system should be solicited from users and stakeholders of the Exchange through customer service surveys, participation at advocacy and community-based organization meetings/events, and attendance at all stakeholder meetings. Evaluating consumer satisfaction is an important part of our QA strategy Using information obtained from a customer service questionnaire that callers can opt to take (or that can be sent through the mail or made available through a website), the Exchange can assess how delivery of services is perceived and identify any changes or improvements that may help them to better serve enrollees, applicants, and interested consumers. Phone surveys offer the benefit of being brief, and callers can complete them using their touch tone phone to select a response to each question. The chart below, Sample Survey Questions, shows the questions that are included in our Massachusetts IVR survey as an example of what we recommend be developed for the Exchange. **Massachusetts IVR Consumer Satisfaction Survey** **Please rate your overall satisfaction with the service you received:** ▪ Press 1 for very satisfied; 2 for satisfied; 3 for dissatisfied; 4 for very dissatisfied **Was your Issue resolved?** ▪ Press 1 for yes or 2 for no **Please rate your satisfaction with the timeliness of the service you received:** ▪ Press 1 for very satisfied; 2 for satisfied; 3 for dissatisfied; 4 for very dissatisfied **Please rate your satisfaction with the information you received:** ▪ Press 1 for very satisfied; 2 for satisfied; 3 for dissatisfied; 4 for very dissatisfied **Please rate your satisfaction with the clarity of the information you received:** ▪ Press 1 for very satisfied; 2 for satisfied; 3 for dissatisfied; 4 for very dissatisfied **What was the reason for your call?** ▪ Press 1 for request application; 2 for information about a notice; 3 for eligibility information; 4 for other inquiry **Did the Customer Service Representative assisting you promise a call back?** ▪ Press 1 for yes or 2 for no **Sample Survey Questions.** Consumer Satisfaction Surveys delivered through the IVR are easy for Consumers to complete and require a minimum amount of their time.	
The evaluation of the eligibility and enrollment system should involve a transparent process and solicitation of feedback from various stakeholders, including beneficiaries and others involved in the	Planned Parenthood Affiliates of California

health care system. Safety net providers like Planned Parenthood health centers who currently service a large portion of the population that will be newly eligible for care will likely have valuable information to share the experience of our clients in navigating the new eligibility system and enrolling in coverage. Other important stakeholder feedback will likely come from navigators, community health workers, and other trusted service providers within communities throughout the state. Over time, success should be measured by the system's ability to reach diverse and marginalized populations. Evaluations should also focus on coverage outcomes for individuals with incomes between 138% - 250% FPL who are likely to transition between Medi-Cal and the Exchange to ensure that this system functions appropriately to avoid gaps in coverage.	
Key performance metrics should include processing turnaround time from completion of all processes by the client to final eligibility determination; renewal rate; accuracy rate; and lack of "churn" among the applicants for health coverage. CA should closely monitor the number successfully enrolled and retention rate, by key demographic groups (age, ethnicity, language) to assure equitable access to and retention in coverage.	San Mateo County Health System
Application volume reports by county, city, ethnicity, age, employment status, completion rate, assisted vs. non assisted, etc. The State could start with the publicly available enrollment reports generated for Healthy Families as a basis and expand from there.	San Francisco Department of Public Health
Question #45: How can California assure that the enrollment IT system provides culturally and linguistically appropriate enrollment services?	
The enrollment IT system can provide culturally and linguistically appropriate services by supporting language selection online and for interactive voice response. For small businesses, leads will generally be directed to agents who will need to be able to offer culturally and linguistically appropriate services.	Anthem Blue Cross
We applaud translation of the Exchange web portal into Spanish which will greatly improve access to health coverage in the Exchange. The web portal should also be translated into Chinese, the third most common language spoken in California and the state should require translation of vital sections of the web portal, as well as the IVR into Medi-Cal Managed Care threshold languages with a clearly delineated timeline for when the translations will be completed so consumers can access this information right away, rather than allowing for a state option to purchase translation of the web portal to support threshold languages at some future date. The cost of providing web portal translation in threshold languages should be weighed against the cost of NOT having the full translations/functionality available - i.e., the ongoing/recurring costs of telephonic interpretation vs. the one-time costs of programming. Regardless of the state's decision, the web portal should be designed now to allow for the capability to support other translations at a future date.	CPEHN and Having Our Say Coalition
Section 1300.67.04 of the California Code of Regulations requires that health care service plans have available a language-assistance program to assist enrollees with limited English proficiency with both oral and written communications. The system should be translated into languages that meet a minimum threshold using census data, and interpretive services should be available to supplement any language that fails to meet the threshold and is not offered in translation.	Delta Dental
Culturally/Linguistically Appropriate IT System: 1. At minimum, the website needs to have taglines in the Medi-Cal threshold languages that direct non-English speakers as to where and how they can receive help in their preferred language.	The Greenlining Institute

2. Online chat for assistance with enrolling should also be available in the managed care threshold languages. 3. On each web page of the website there needs to be a box indicating how consumers can access consumer assistance via the call center, chat, or link to assisters. The information in this box should be written in all of the top threshold languages. (See: Effective Health Outreach to Cultural Communities, 2000 http://www.medtronic.com/downloadablefiles/outreach_brochure.pdf and California Coverage & Health Initiative, Leveraging the Local Experience of Community Based Organizations in Implementing the Affordable Care Act, http://cchi4families.org/pdf/uploads/Executive%20Summary_new050411.pdf)	
Application and other key eligibility documents translated into Medi-Cal threshold languages. Assistance in the applicant/recipient's primary language. Use of CBOs with bilingual/bicultural staff. It is critical that the website be user-friendly and accessible to everyone, including those unfamiliar with computers and the Internet, those with low health care literacy, those who are LEP, those who require large print, and those who use assistive technologies. Specifically, the website should be available in languages in addition to English. While the Board seems to have committed through the CalHEERS RFP to have the website also in Spanish, other prominent languages should be considered also (depending on the number of LEP individuals in a particular language group). Possibly, rather than translate the entire web portal into a third or fourth language, certain vital sections could be translated based on the importance of the information provided in those sections. Further, the website should include taglines on the home page in multiple languages, based on the Medi-Cal managed care requirements (at least the top 15 language groups). These taglines should explain to LEP individuals how to access information that is not translated. This tagline should direct consumers where to call to access oral communication of the information contained on the website or to access documents the agency has translated. Ideally the entire tagline would be on the homepage of the website. If that is not possible due to space or format limitations, then the homepage, at a minimum, should include a direct link to the taglines and could use the name of the language as the link. For example, SSA's "Multilingual Gateway" (http://ssa.gov/multilanguage/) includes the names of 15 languages in English and the non-English language and when a consumer clicks on the language, the consumer is taken to a webpage with information in that language. It is also important that the information be written at a low literacy level so that individuals, and particularly LEP individuals, can understand the information. Having materials written at a low "register" (literacy level) is essential to ensure comprehension so that the provision of information is not merely pro forma but offers a real opportunity for enrollees to understand the information. This will be real challenge, as many of the concepts involved are quite complex, e.g., the various actuarial values and cost-sharing features of the QHP options. Because of the complex nature of the material involved, it is critical that serious attention be made to make the concepts as understandable as possible.	Health Consumer Alliance

The enrollment IT system can provide culturally and linguistically appropriate enrollment services by capturing enrollee oral and written language preferences and ensuring that it is on the eligibility file; ensure that all materials in written format (handouts and website) have an appropriate literacy level; and that the application is available in various languages and formats. For example, a video on the website could explain the application and enrollment process in American Sign Language.	Health Plan of San Joaquin
At the highest level, the Exchange is targeting the uninsured and those who purchase individual insurance—consumers who are most likely to need assistance in understanding complex insurance concepts and have the least experience in selecting among multiple, and oftentimes confusing alternatives. Among the uninsured, there are many low income, low literate, and/or Limited English Proficient (LEP) consumers. The National Assessment of Adult Literacy found that more than half of the uninsured have either basic or below-basic health literacy. The study also found health literacy rates are much lower for Spanish-speaking individuals. Health literacy and income are highly correlated, with the demographic groups eligible for the highest subsidies also least likely to be able to understand complicated concepts or read material written at the tenth-grade level or above. Access to employer-sponsored coverage is also highly correlated to income, which means that those with the highest literacy levels will also be the least in need of Exchange coverage. Further, a recent study of parents' perceptions of CHIP and Medicaid found that a top barrier to enrollment is the perception of a difficult enrollment process. For English-speaking parents, another barrier is confusion about income eligibility. However, Spanish-speaking parents were concerned about affordability and costs. The two groups had very different preferences for enrollment methods, with English-speaking parents favoring self-service options and Spanish-speaking parents favoring in-person options. These findings point to the need for clear differentiation in both access points and system messaging to these two groups. For example, it will be important for California to include income ranges and emphasize online or other self-service options for English-speaking audiences. For Spanish-speaking audiences, the messages should emphasize affordability and talk about in-person assistance. The populations who need the most assistance using the Exchange are those who are the hardest to reach and will require a focused effort in order to get the information they need to make appropriate decisions about their health care choices. Much research on health literacy points to the conclusion that the design of the enrollment system, as well as the messaging of the website, can significantly affect the ability of many of the target audiences to enroll in health plans that best meet their own needs and the needs of their family. In order to provide culturally and linguistically appropriate enrollment services, the actual IT platform should provide a robust enrollment solution that supports multiple languages from a technical and functional standpoint. The enrollment system as a whole should be capable of providing culturally and linguistically appropriate services to consumers in accordance with the State threshold language needs (concentration levels). Enrollment literature and other communications should be provided to individuals in accordance with the State threshold language requirements, with English being the default language for those languages that fall outside of the State threshold language requirements. The system design process should place an emphasis on usability, as well as providing culturally appropriate enrollment material and questions for various demographics and different regions of the state. Moreover, using plain language strategies makes it possible to reach many low-literate adults without sacrificing the key	MAXIMUS

elements of high quality online delivery channels: good organization, streamlined and concise writing, a friendly, conversational tone and a clean uncluttered design. Plain language means using familiar, everyday words to explain program components; words that most adults know and understand. Plain language strategies include organizing the content carefully while using the readers' logic, so they find answers to their questions easily; using clear, concise sentences and short paragraphs to create easy-to-absorb chunks of information; using navigation aids, such as headings and sections, to guide readers through the material and enable them to find what they need, and formatting to enhance readability, with plenty of white space, a standard font, print that is big enough to read easily, and other design features that promote readability. Regardless of the delivery channel, when consumers can read new information easily and understand it right away they can also absorb it, learn from it, and act on it. They depend less on others to interpret information for them, their confidence gets a boost as the fear of struggling with on-line material recedes, and they have access to accurate information whenever they want it. With these principles in mind, MAXIMUS applauds the State for participating in the UX 2014 effort to design a consumer-oriented interface for the eligibility and enrollment system, and we recommend that your RFP incorporate references to the UX 2014 guidelines to ensure that the system is designed in a way that supports consumers with different levels of abilities. The incorporation of requirements for compliance with Section 508 and other accessibility guidelines for consumers with disabilities in the RFP will help assure that the system is available to all consumers. Finally, to ensure a culturally and linguistically appropriate system, MAXIMUS urges the Exchange to require its vendor to conduct usability testing and focus groups with a diverse group of stakeholders early in the design process. MAXIMUS emphasizes the importance of getting input early from a variety of community groups and advocates, especially those working with LEP consumers. To this end, MAXIMUS offers the expertise of our Center for Health Literacy, a nationally recognized resource that specializes in the design and implementation of culturally and linguistically appropriate websites and enrollment materials. MAXIMUS established the Center for Health Literacy (the Center) to contribute to reducing health disparities among the diverse populations our clients serve. In 2000 MAXIMUS found that its clients had a critical need for plain language writing and design services. At that time MAXIMUS had begun acting as a broker for states' Medicaid managed care enrollment services, and the MAXIMUS project managers quickly saw that they needed effective ways to explain the new managed care environment to Medicaid clients who could then use what they learned to make informed decisions about their health care. In order to reach this diverse audience—many of whom have limited literacy skills— the company needed people with specialized writing and design skills. The Center is a group of writers, graphic designers, researchers and translators who understand the language and literacy needs of diverse populations and can develop effective communication materials. The Center is comprised of creative experts who produce high quality, easy-to-read and easy-to-understand print and web materials that reinforce key messages, demonstrate simple and intuitive design, and utilize cost-efficient, accurate production processes. Our work is grounded in qualitative research: one-on-one usability testing and focus groups that help us tailor materials to the literacy level of the target audience. Should you be interested, we are happy to make these services available to the	

Exchange or selected vendor.	
The enrollment IT system should be reviewed to ensure that applicants with limited formal education can complete the process with minimal assistance. This may include creating an enrollment portal in languages other than English, as appropriate.	San Francisco Department of Public Health
Similar to our comments for Navigators, it is recommended that the Exchange import and adopt established rules and standards from existing law. Although there are many places to look for these standards, we believe the language included in the appeals and grievances regulations in 45 CFR Part 147 is a good example of successful standards and that the Exchange should consider similar language for adoption.	UnitedHealthcare
Question #46: What process can be used to minimize gaps in coverage and facilitate transitions between programs? What considerations should be made for payment grace periods?	
The proposed 90 day grace period encourages gaming of the system. In effect, it permits individuals to stop paying premiums 90 days prior to the next open enrollment period, without any penalty, and then re-enroll in a new plan during the open enrollment period. Yet carriers are at risk and must pay any claims incurred during those 90 days, despite not collecting any premiums for that coverage period. We recommend that the grace period be reduced, that claims be pended during the grace period, and that coverage termination be retroactive to the date on which the member stopped paying premiums. In addition, we recommend steps to discourage individuals from taking advantage of this loophole, such as restrictions on or requirements for re-enrollment in coverage after termination for non-payment of premiums.	Anthem Blue Cross
The payment grace period is a critical issue, and could make the enrollment system self-defeating if not addressed. There is no point in enrollment if participants are dropped for failure to pay due to unrealistic grace periods. Plan premiums exchange-wide should be due on the same day of the month / quarter. This would allow navigators to support enrollees to remember their payments without needing access to the enrollee's actual plan bills or documents.	Catholic Charities of California
An IT system that has the capacity to allow interaction among agencies (e.g. CALHEERS agencies and EDD) would help minimize gaps and facilitate transitions.	Consumers Union
Minimize Gaps in Coverage: Strive to minimize gaps in coverage: As individuals transition from system to system or experience changes in status, they should receive immediate notification of their eligibility for certain programs. For example, individuals should receive information about health programs they are eligible for when they receive information about unemployment benefits. When individuals go to the DMV to update their license or change their address, they should receive health insurance eligibility information. Also, upon release from prison, former inmates should be notified of their health insurance options and connected to the appropriate enrollment resources.	The Greenlining Institute

When someone's circumstances change and they are transferring from one program to another their coverage in their existing program should not end until they are actually enrolled into the new program. Annual renewal form showing someone is not eligible for one program should be transferred to the other program to use to enroll them. Consumer cannot be required to give the same information multiple times. We support the 90-day premium payment grace period proposed by the Exchange Eligibility NPRM.	Health Consumer Alliance
The overarching vision of the Affordable Care Act (ACA) is a dramatic reduction in the number of people lacking health insurance through a comprehensive system that scales the cost of coverage according to a family's ability to pay. A key challenge for states in responding to this opportunity is creating a program design that seamlessly and transparently accommodates the movement of people across the three main subsidized programs: Medicaid, CHIP, and the exchange(s). Health insurance affordability under ACA is achieved through a combination of Medicaid coverage, low-cost CHIP coverage and sliding scale subsidies for policies purchased through an exchange. This continuum of financial assistance is related to a combination of family income, the age of individual family members, pregnancy status, and a state's pre-existing Medicaid and CHIP eligibility parameters. When people move from one program to another because of these factors, it is common for their coverage to be temporarily interrupted. This "on and off" coverage phenomenon is often referred to as "churn" and it is highly undesirable because it: • Disrupts continuity of care and adherence to a medical home model • Degrades reliable access to cost-effective preventive care • Generates higher administrative costs associated with multiple eligibility processing tasks for the same individual or family • Promotes adverse selection because the people least likely to churn are those that have chronic or ongoing high-cost health care needs. While churn is most commonly discussed in connection with movement between eligibility-based programs, it may also occur as a person moves from employer sponsored coverage to subsidized coverage through an event like the loss of a job or an employer's decision to cancel coverage. Preventing or minimizing churn is one of the most basic strategic challenges faced by leaders who are charged with designing and implementing the exchange concept. Perhaps the simplest way to demonstrate the risk of churn is through several hypothetical examples of consumer families that illustrate the sorts of challenges that will arise once ACA is fully implemented. These examples show how people may move between the three principal coverage options and the extent to which confusion, gaps in coverage and operational inefficiencies could develop without a fully integrated solution. • Family of four with income at 160% of the federal poverty level (FPL): father works for a commercial construction business that used to offer bare-bones coverage but dropped it, pregnant non-working mother, and two children ages 10 months and 17 years. o At initial application, the father is eligible for a subsidy in the exchange, the mother and youngest child qualify for Medicaid, and the oldest child is eligible for CHIP o Following the birth of the third child, the mother's eligibility will switch to the exchange, the	MAXIMUS

middle child to CHIP, and the new baby will be added to Medicaid
    - Two years later, the oldest child turns 19, loses CHIP eligibility and will transfer to the exchange
- Family of two with income at 125% FPL: monolingual first generation Hispanic mother with proper immigration credentials works as a cook in a restaurant without health insurance, 15- year old American-born son. Son is currently on CHIP and the only experience the mother has had with government-sponsored coverage is when she was pregnant and on Medicaid 16 years ago.
    - At initial application, the mother qualifies for Medicaid and the son is transferred from CHIP into Medicaid at the same time
    - When the son gets a part-time job in high school, their family income will rise above 138% FPL which means the mother will transfer to the exchange and the son back to CHIP
    - When the son turns 19, he will move off CHIP and onto the exchange
- Family of two with current income of 220% FPL (down from 450% when the husband was working): self-employed accountant with a husband, who had a job as a web designer but lost it at the start of the recession and has been unable to find work, trying to conceive a child.
    - At initial application, both qualify for subsidy through the exchange
    - If they have a baby, the child will be eligible for CHIP
    - If their income rises slightly, the child will lose CHIP eligibility and join the parents on the exchange
    - If the husband finds work comparable to his old position, the family's income will dramatically rise and they will no longer qualify for subsidy or CHIP

The first critical strategy to minimize these gaps in coverage is to provide a modernized and multi-channel eligibility process that helps consumers to accurately and efficiently complete the initial application and subsequent renewal processes, and adapt to transfers between the three programs as their situations change. Key features of a program design that maximizes access include:

- A short, unified application that works across multiple public health insurance programs and that hides the complexity of the relationship between the three primary coverage options
- A reduction in the documentation required by applicants to determine their eligibility
- Multiple means to submit an application, including online, over the phone, and through the mail
- Online and phone-based self-service tools that are available 24/7
- Single point of access for personalized customer service and assistance

A centralized model is a significant departure from the traditional eligibility approach in which locally based caseworkers handle all tasks associated with an application and become de facto custodians of a family's account. While this model may have been attractive in the past, when most people conducted their personal business face-to-face, it is becoming rapidly obsolete and unaffordable in a world where many people expect and want to conduct transactions online or over the phone. This centralized model makes these transitions easier for the consumer, and provides more checks and balances to ensure that families do not "fall through the cracks" and experience gaps in coverage.

A second strategy is to encourage individuals who disenroll from or lose eligibility for coverage with one

program to be automatically or seamlessly enrolled in (or informed about) their rights for other coverage. All communication provided to the consumer related to disenrollment or denial of eligibility should provide clear directions and guidance to the recipient on other coverage options for which they would be potentially eligible. For example, if a child ages out of the Healthy Family Program, the disenrollment correspondence should include information about programs for which the individual may be eligible. The communication should include a request for the individual's permission to refer their eligibility data to another program for eligibility determination. Once permission is received, the eligibility date can be shared with the appropriate programs and speed up the subsequent eligibility/enrollment process. Pre-notification to the individual of pending or potential disenrollment should be completed well-in-advance of the disenrollment date, giving consumers' time to consider the options available. Aside from mailed correspondence, this notification can be delivered through a billing statement note, reminder call, text message or e-mail. In addition, families who have been disenrolled or denied coverage in public programs could be contacted through an outreach campaign to alert them to the benefits of the Exchange and the potential opportunity for them to seek coverage once again. Additional measures can also be taken to prevent disenrollment, including sending consumers a reminder for renewals, missing information, payments due, past due payments, and required documentation. This could include telephone calls, text messaging, e-mail, mailed correspondence, billing statement special notes, and electronic notification through their secured online account. In all of these scenarios, potential applicants, disenrolled individuals, or individuals with the potential for disenrollment can be directed to a website or to a call center line for more detailed information regarding the options available to them. A third strategy is to ensure that the consequences for gaps in coverage to individuals and families should be communicated early and often by the Exchange to consumers. Exchange materials (media, publications, correspondence, etc.) should include a "grab your attention" focus on the value of coverage and the risks of breaks in coverage. A fourth strategy involves encouraging health plans to provide products in all four categories: Medicaid, CHIP, subsidized, and unsubsidized coverage. Today, most states have different plans for Medicaid or CHIP than those available through commercial coverage. Functioning as an active purchaser, the Exchange could require that plans providing commercial coverage in the Exchange also provide a plan for Medicaid and CHIP clients. The Exchange should also work with the plans to ensure that provider networks are as similar as possible across these Medicaid, CHIP, and subsidized/non-subsidized product offerings. In this way, the consumer will not experience gaps in care, even if his or her status does change. A final strategy surrounds the use of grace periods. Allowing for a payment grace period has a positive effect on retention, as it eliminates the issues associated with clients going in and out of the program due to late payments. With a grace period, payments received are applied to the case and the client/family is reinstated without a gap in coverage, providing continuity of care.	
Pre-enrollment through current public programs such as a Family PACT is the most efficient and expeditious way to capture the population Medi-Cal and the Exchange will serve. Because of PPAC's familiarity with the Family PACT program we wish to emphasize the benefits of capturing this patient population for enrollment in	Planned Parenthood Affiliates of California

the Exchange. Our qualified patients are enrolled on site in the Family PACT program, and are immediately eligibility for family planning services under the program. These patients are essentially healthy individuals who are the dream enrollees of any health plan – primarily low cost, low usage patients. Family PACT eligible enrollees are uninsured individuals whose income is 200% FPL or less. However, PPAC urges the Exchange Board NOT to auto-enroll individuals if this means enrolling individuals without specific consent by the individual. Family PACT provides highly sensitive services to its enrollees. Eligibility for Family PACT includes insured individuals who, for confidentiality purposes, must seek out-of-plan providers for these sensitive services. Due to this recognition of the sensitivity of the services provided, we believe it would be a violation of patient confidentiality to automatically enroll Family PACT beneficiaries in the Exchange. A key foundation of the ACA is that it provides a seamless coverage structure for Medi-Cal, other public healthcare programs and the Exchange to ensure coverage for the uninsured, most of who are poor. Still, there are some situations where gaps in coverage are anticipated, e.g., individuals who no longer qualify for the Exchange due to loss of income, individuals who fail to pay premiums, young adults who reach age 26 and must seek their own coverage, etc. The bulk of transitions between the Exchange and Medi-Cal/Healthy Families are likely to be for individuals who have incomes between 138% - 250% FPL. These are the people for whom an unanticipated car repair is necessary in order to get to work or a non-covered emergency medical expense undermines the ability to make a premium payment. In addition, fluctuating income due to layoff or losing a job, or due to pregnancy, may mean the individual qualifies for Medi-Cal rather than the Exchange. In order to minimize gaps in coverage and facilitate transitions between the programs we strongly recommend that transitions in coverage are streamlined so a single agency conducts eligibility determinations for Medi-Cal and the Exchange. The eligibility determinations are made by the program based on information provided either by the enrollee or a government data source. The agency would already have all of the information necessary for enrollment in either program for an individual so the application/enrollment process would quickly take place. An essential element of this model is that the plans serving this transitional population would all be Medi-Cal plans in order to guarantee continuity of care for the enrollee. Within this single agency model there is also a need to harmonize the timing of coverage as between Medi-Cal and private plans since Medi-Cal's coverage is retroactive to three months prior to enrollment and private coverage begins the first month after enrollment. Because the intent of the ACA is to establish a means for low income uninsured people to access and retain health care coverage, it is important to develop a process that allows individuals to remain covered during economically challenging times. Dis-enrolling individuals because of a temporary inability to pay for premiums undermines the entire purpose of the ACA. It would be important to seek information from enrollees regarding the reason for non-payment of premiums. Where there is a reasonable explanation, such as an unanticipated emergency expense, a grace period and opportunity to negotiate a payment plan that addresses the financial needs of the enrollee would be in order.	
The ACA and proposed federal rules go a long way in coordinating the eligibility rules between the programs. Nonetheless, the programs retain certain differences, which could create gaps in coverage, especially for those moving between programs. Some of the ways California should address this are:	The 100% Campaign

• To mitigate possible problems with differences in how income is defined (Medi-Cal and Healthy Families use current monthly income and subsidized Exchange coverage uses annual income), California should require that applicants are asked about "reasonably predictable decreases in future income" during the application process. The state should also implement a federal option to maintain Medi-Cal or Healthy Families eligibility for enrollees with fluctuating monthly incomes so long as their annual income for the current calendar year remains at or below the program income standard. Without these changes, a person (such as a seasonal worker) could find themselves ineligible for both Medi-Cal or Healthy Families and subsidized Exchange coverage. • To eliminate gaps in coverage for Healthy Families-eligible children when employer coverage becomes unaffordable and the family can no longer maintain it, California should eliminate the three-month waiting period in Healthy Families, which is not required under federal law. This policy would be consistent with Exchange coverage rules, which allow consumers without affordable employer coverage (as long as they are not enrolled in that coverage) to obtain Exchange coverage. • The state should also conform its premium grace period in Healthy Families (currently 60 days) to that required under the Exchange (three months). It will also be important to use non-payment of premiums as a trigger for following up with families to determine whether their circumstances have changed. This will enable smoother transitions in cases where the consumer is not making payment because of a decrease in income, and are possibly newly eligible for Medi-Cal.	
The CalHEERS RFP states that it will interface with EDD to confirm income and employers of applicants and will receive consumer information from the DMV. HBEX should also work with existing institutions that reach individuals at the time of life transitions, such as EDD, courts, the DMV, and educational institutions, to ensure that these individuals are notified of the opportunities for affordable coverage made possible through the ACA and are connected to enrollment.	UC Berkeley Labor Center and Health Access California
Question #47: What role should the Exchange play in the enrollment of any non-health service programs?	
The Exchange should capitalize on its world-class, modern connection to millions of Californians and the eligibility information they provide to deliver 1) streamlined on-line applications and eligibility determinations for CalFresh, other social services and working-family tax credits, based on the information provided for health coverage and 2) seamless benefits management for consumers, with appropriate consumer controls, confidentiality protections, and the preservation of in-person, telephone, mail and all other "doors" for support. In this way, the Exchange will dramatically improve both health outcomes and government services for all.	Alliance to Transform CalFRESH
The Exchange could serve as a vital link for enrollment in multiple non-health service programs. This is an existing function of casework staff in CBOs.	Catholic Charities of California
The enrollment IT system should be capable of making an automatic referral to other public assistance programs and vice versa. This should include technology that allows data used to determine eligibility in one program to prepopulate the application for services in other programs. This would expedite enrollment and reduce paperwork redundancy for the consumer. Although Navigators/CAAs/Enrollers will be well-trained in	Community Health Councils

health coverage programs, it is not feasible to expect full knowledge in all public programs. Therefore, the Exchange must set up a comprehensive referral system to local resources by zip code so that consumers can locate assistance and services near their home, work, and school.	
As we stated in our comments to the IT RFP, we believe the infrastructure needs to be in place that would enable "horizontal integration" and a broader function beyond health care, but we urge the Exchange to have a laser-sharp focus on health insurance at the outset. Establishing its credibility on core functions should be the top priority. And it would be wise to see how well the CalHEERS system functions for health care before determining a role for the Exchange in non-health service programs.	Consumers Union
To the extent that the Exchange is "wired" appropriately to access information and enrollment forms for these other programs, it would be a logical extension to pursue given that there will be a captive audience in place.	CVS Caremark
It is logical and beneficial for the exchange to link people to non-insurance health-service programs that can help people gain access to fitness, nutrition, preventive practices and other health and oral health improvement resources because improving health is an equally important outcome of health reform as is access to coverage. Increased awareness about health issues may also occur simply due to the exchange expanding individual's access to coverage	Delta Dental
Enrollment in Non-health Programs: Where able, the Exchange should provide legibility determination for non-health service programs and link to enrollment information.	The Greenlining Institute
Once a consumer has completed the single health application, she or he should be given the option to have that same information used to start an application for cash aid programs, nutrition support, and other public programs; not just a referral but the beginning of an application with the consumers' consent. The reality is that the health IT system must be operational by October 2013 and the federal funding for the public program integration is available through 2015 so could be phased in. However, the IT system must be built with this functionality in mind at the front end.	Health Consumer Alliance
Something important at issue here but not sure what it is. Health status reflects multiple determinants. If that's the point here, plans and providers need to connect to "non-health service programs" so members can access variety of services that could influence their health. The Exchange per se ensures access to health insurance. Your mission includes: "…using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities." Maybe before taking on the multiple determinants of health, have a conference, do an RFP, get advice from experts somehow, to conceptualize an Exchange's *direct role* in contrast with what it could reward plans and/or providers to offer. One model: UK, where all have access and then decades later a whole different structure was developed to address multiple determinants because disparities haven't disappeared. (This under attack now by Conservative government.) In sum: Get everyone insured with a long-term vision to get everyone healthy as possible. Latter is intervention for the long term - yours? Should be extensively discussed. Wait a minute!! You're talking about CalFresh! Sorry. Not obvious from context for this newcomer. Sorry!! CalFresh=point of contact for info about Exchange, clearly. No opinion how this should happen.	Lucy Johns, MPH
The Exchange should seek to act as the HR Department of a small business. This could involve enrollment of: COBRA, HSAs, HRAs, wellness plans, cafeteria plans, etc.	Small Business Majority

California should build this new enrollment process in a manner that connects consumers with other human service programs (specifically, CalFresh and CalWORKS) that they are likely eligible for. Most immediately this can occur by sending, with the enrollee's consent, relevant information from the health coverage application to other programs for processing or follow up. Eventually, other health and human service programs should be a part of the health coverage eligibility functions, particularly the web enrollment portal. Federal guidance paved the way for this integration by allowing states, through 2015, to include human service programs in the new eligibility systems for the affordability insurance programs, without apportioning out development costs to the other public programs. To make the most of this funding opportunity, California should integrate other human service programs into Cal-HEERS before the end of 2015.	The 100% Campaign
Question #48: How can the Exchange facilitate enrollment using existing state data?	
Enrollment with Current State Data: The Exchange should utilize existing state data to automatically switch people over or enroll people from public programs in to the Exchange or Medi-Cal, or other areas, where feasible. (See: Ten Ways to Make Health Coverage Enrollment and Renewal Easy. Enroll America, and Coalition for Access and Opportunity: http://www.singlestopusa.org/ACA%20and%20Human%20Services%20Integration%20-%20Toolkit%20-%20Short%20List%20of%20Opportunities%20-%2010%2027%200612.pdf)	The Greenlining Institute
In addition to the federal verification hub the CalHEERS should tap into state sources of income data to ensure more current and accurate income data is used, e.g. EDD data.	Health Consumer Alliance
The Exchange can facilitate enrollment by using existing State data to help validate the identity of applicants. Even if the Federal Data Hub is fully operational in the near future, in many instances State data may be more up-to-date and accurate. The Exchange should work with the California Technology Agency to define data contracts with the DMV, EDD, and Department of Public Health (Birth and Death indexes) and to define web services which can be utilized in near-real-time. The Exchange can also facilitate enrollment by using State data to help validate the income of applicants. To validate income, the Exchange should work with the California Technology Agency to define data contracts with FTB and EDD (unemployment and disability payments) and define web services which can be utilized in near-real-time. Finally, the Exchange can facilitate enrollment by using existing State and program data to help pre-populate an applicant's information. If an applicant is participating, or has previously participated, in another State program, the information could be used to help pre-populate an application. Potential programs and departments include: Medi-Cal, SACWIS, WIC, Dept. of Justice, licensing, etc. Even in the case where individuals are continuing enrollment in the same program, providing a pre-populated form improves the likelihood that an individual will successfully maintain enrollment and prevent any gaps in coverage. For example, in the Healthy Families Program, prior to annual eligibility review, individuals receive a pre-populated form to return, requiring only minimal information to be provided on the part of the applicant.	MAXIMUS

While assuring appropriate protection of privacy and security, the State needs to revise its approach to access to key databases such as MEDS to facilitate rather than hinder improved effectiveness and efficiency in the eligibility and retention of public benefits such as health insurance. Assuring appropriate matching of key demographic information among DHCS/State eligibility, health plans and providers could streamline administration of eligibility and promote more continuous coverage.	San Mateo County Health System
The Exchange may be able to use data on small business from EDD. Also, the Secretary of State may have useful data given her role in issuing business licenses.	Small Business Majority
In addition to strategies for using Medi-Cal and Healthy Families data (discussed in question 10), California has a unique opportunity to utilize data already on file with public programs to facilitate enrollment. Express Lane Eligibility (ELE) provisions in the Children's Health Insurance Program Act allow California to base Medi-Cal and Healthy Families eligibility for children on the findings of other need-based programs, even if the program uses different methodologies from those used by Medi-Cal and Healthy Families. This can greatly simplify the eligibility process for large numbers of uninsured consumers enrolled in other public programs. Additionally, the modernized and integrated electronic eligibility system and data sharing envisioned by the ACA should provide the infrastructure for connecting the other public programs with Medi-Cal and Healthy Families for simpler processing. The ACA and proposed rules contemplate the use of ELE by exempting ELE applicants from the new Modified Adjusted Gross Income standard. Even so, to be truly beneficial, California should seek, through a waiver, the ability to apply ELE to adults as well as children. Since applying ELE to a wider population is consistent with the intent of the ACA, federal officials should want to encourage its greater application. California should begin by using the data already gathered for other public programs to implement large-scale, one-time enrollment when ACA first takes effect. CalFresh is a good place to start, where 370,000 enrolled individuals have no insurance coverage. (2009 California Health Interview Survey) These individuals have already provided demographic information, a social security number, and proof of legal immigration status or citizenship, in addition to having an eligibility finding that places them under 130% FPL. The state should access the information in the CalFresh case files to automatically complete a Medi-Cal eligibility determination. Individuals would be contacted to provide affirmative consent to enroll, along with selecting a plan, to complete the enrollment process. Between now and 2014, the CalFresh application should also be modified to allow families to opt out of such information sharing. This same process should be applied at renewal.	The 100% Campaign
Government data sources could be used to trigger reminders to report significant income changes which could affect subsidy amounts. Research should be done to investigate the prevalence of the problem and the cost-effectiveness of data matching to identify individuals who could face potential overpayments.	UC Berkeley Labor Center and Health Access California
Question #49: In what circumstances/programs should we do pre/auto-enrollment?	
The Exchange should seek to pre-enroll participants in CalFresh – especially single adults – who are not insured, given the similar income, asset and citizenship-status rules of CalFresh and Medi-Cal (as of 2014).	Alliance to Transform CalFRESH

Pre/Auto-enrollment: Pre-enroll eligible individuals and families who are currently public program participants (WIC, Medi Cal, Reduced Lunch, etc.,) (See: Ten Ways to Make Health Coverage Enrollment and Renewal Easy. Enroll America, and Coalition for Access and Opportunity: http://www.singlestopusa.org/ACA%20and%20Human%20Services%20Integration%20-%20Toolkit%20-%20Short%20List%20of%20Opportunities%20-%2010%2027%200612.pdf)	The Greenlining Institute
Consumers should give their consent to be enrolled for several reasons. They may well not use coverage that they don't know about /didn't agree to enroll in. Further, as a practical matter, someone can't have or at least can't use HF or Exchange coverage unless they are enrolled in a plan and they must eventually pay premiums. It is critical for consumers to understand the process and their coverage.	Health Consumer Alliance
Disenrollment in one program for loss of eligibility should automatically prompt the system to determine and inform the individual of their other options. Ideally, the HBEx will be programmed with logic to refer clients to the appropriate program, based on their income level and can transmit an electronic referral in some manner. The HBEx should consider pre-enrollment for any party currently enrolled in a county indigent program where the county has sufficient information in an electronic system to determine if the client meets current eligibility requirements. This process should begin in mid-2013 to ensure that the HBEx is not overwhelmed by volume on January 2014.	San Francisco Department of Public Health
In addition to the enrollment strategies discussed in questions 10 and 48, California should explore the auto enrollment strategy of ensuring that all infants born in the state receive health insurance prior to leaving the hospital. In fact, babies whose mothers have Medi-Cal at the time of delivery are already deemed eligible for Medi-Cal for the first year of life. There is no application or eligibility determination required. Instead, a mother completes a one-page Newborn Referral Form or contacts her eligibility worker. Unfortunately, efforts to make the process more systemic, e.g. allowing hospitals to electronically enroll the eligible infants, have not come to fruition. California should implement the newborn hospital gateway by requiring hospitals to automatically enroll infants born to Medi-Cal moms into Medi-Cal through the Exchange web portal. No application would be required (although an application could be submitted on behalf of other family members requiring coverage.) This same process should be applied to someone who has subsidized Exchange coverage. Prior to leaving the hospital, the family should be able to log into their account (or the hospital could be required to submit information on the child's birth to the Exchange through the enrollment web portal) to add the child to subsidized Exchange coverage or Healthy Families, as applicable. Guaranteeing that families leave the hospital with insurance for their newborns ensures that there will be no delay in bringing them in for well-baby care, which begins in the first weeks of life.	The 100% Campaign
HBEX should have the capacity to accept pre/auto-enrollment data from EDD for individuals who enroll in Unemployment Insurance or State Disability Insurance if/when EDD has the capability to transmit such data.	UC Berkeley Labor Center and Health Access California

Question #50: How should the enrollment system accommodate employer/employee choice? Full- time versus part-time employees? Residency (group/employee/out-of-state)?	
The decision of employer vs. employee choice should come early in the plan selection process, as this decision will affect available products and pricing (to account for increased adverse selection risk in employee choice model). Groups should be permitted to change their designated approach only at renewal, and not mid-year. Group and employee applications should capture full/part-time status and average number of hours worked. Group enrollment screens will also need to capture the total number of employees; the number who are full-time, part-time (eligible), and part-time (not-eligible); and valid waivers.	Anthem Blue Cross
Employees of small businesses should be provided choice of health plans. In addition, the SHOP should require that QHPs offer plans in the SHOP that provide dependent coverage. While some small businesses may not provide financial coverage for dependents, the QHPs should be available to be offered to dependents at the employee's expense.	Consumers Union
The enrollment system needs to be flexible enough to allow both employer and employee choice. To accommodate employer choice it must allow the employer to choose from a variety of plan options and then apply to the carrier. For the employee choice there needs to be a way for the employees to be tied back to the employer for tracking and billing purposes. There should be specific definitions for what is a full-time versus part-time person (# hours worked per week.) It is then up to the employer or the employee to verify those numbers. There should also be set definition of residency (i.e., # of employees (or %) of a group that can reside outside of the state. Often this is stated as no more than 10%, but it can vary and needs to be standardized across carriers	Delta Dental
To accommodate employer/employee choice, the system should be configurable to support the employer and employee choice at various levels defined by the State and/or employer. The SHOP system needs to make it easy for employers and employees by offering unique capabilities that may not be available outside the exchange and providing them maximum flexibility prior to and after enrollment. Examples of this include: • The ability to estimate costs and preview the plans before asking the employer to register and commit to the program. • The option to enroll and set up payroll deduction services without a minimum contribution requirement for employers. Since employer sponsored healthcare is not taxed, even when the employee pays 100% of the costs, their premium would be paid pre-tax and thus saving the employee money over purchasing individual insurance with post tax dollars. • Aggregated contribution for the employee and aggregated premiums for the employer. • Self-service access to manage employee roster, pay invoices and reconcile bills. • Multiple ways to reach support channels for both employees and employers The system should support sub-groups where employees can be segregated based on criteria of class and location. We recommend that employers be allowed to create sub-groups, however the State may choose the	MAXIMUS

limit the types of classes (Hourly, Salary, Part-time, Full-time, Management). The system should also support a well - designed plan advisor tool for employees to choose the best plan that meets their needs regarding benefits, price and providers. The State can also configure additional questions to help filter the available plans even further, and match the employee preferences. Employees can then compare the remaining plans in regards to benefits, price, ratings, providers, and total out of pocket cost.	
Regardless of level of employment (full-time or part-time), employees should have as much choice as possible in terms of plan selection, and should be provided with tools and assistance for making those selections. Additionally, all workers should have access to, and be informed about, coverage options in the Individual Exchange and in other public programs. The SHOP has a vital function to perform by being a key coverage gateway for employees and their dependents and family members.	The 100% Campaign
Question #51: How should the system handle overlap with other existing public programs such as Healthy San Francisco?	
For small businesses, employees enrolled in certain municipal and county health plans that provide comprehensive coverage should be considered to be "valid waivers" for purposes of groups meeting minimum participation requirements.	Anthem Blue Cross
We suggest the Exchange include information on all programs and let the consumers decide.	Delta Dental
For other existing public programs that are not health insurance programs, such as Healthy San Francisco, an individual should first be screened for participation in the HBEx. If the participant is ineligible for or has been approved for a waiver from HBEx enrollment, the online application or application assistor should refer the person to the applicable county indigent program for potential eligible screening. Local indigent care programs should ensure that their eligibility provisions promote eligibility into Medi-Cal or HBEx for eligible, but not enrolled individuals.	San Francisco Department of Public Health
Question #52: To what extent should we maintain existing eligibility doors (e.g., presumptive eligibility for pregnant women)?	
The state should continue to automatically enroll income eligible pregnant women and newborns into health coverage through presumptive eligibility. The state should continue to use “Express Lane Eligibility” to maximize enrollment into new coverage programs.	CPEHN and Having Our Say Coalition
Consumers Union believes that the impact of ACA should be to broaden coverage that already exists, rather than narrow coverage for those who are already eligible for coverage. To that end, all efforts should be made to preserve existing eligibility doors.	Consumers Union
PE for pregnant women and the CHDP Gateway are vital avenues to allow pregnant women to access prenatal services and kids to get preventive and other needed care. They work well and should be continued. The state should explore streamlining them into the HEERS.	Health Consumer Alliance
From having worked with the Medicaid and CHIP populations across the country, MAXIMUS understands that it is important to “meet consumers where they are.” Many low income and Limited English Proficiency (LEP) clients feel more comfortable going through community-based, faith-based, or ethnic/cultural organizations	MAXIMUS

with which they are familiar and with whom they have established a trusting relationship. This reliance on trusted sources is especially important in Latino and other immigrant communities, where there is a reluctance to provide confidential information to government programs for fear of incurring problems with immigration laws. Some of the target population also may prefer in-person assistance that is available in their immediate neighborhoods as many of the target population do not have access to affordable transportation to travel to a centralized location. Other LEP consumers wish to remain in their neighborhoods to have access to application assisters that speak their native language. The Enrollment Entity-Certified Application Assistor approach in HFP and PCIP has provided a trusted eligibility "door" that should continue to exist, even if it is migrated to a navigator function. Keeping the needs of these diverse populations in mind, MAXIMUS believes that existing eligibility doors should be strengthened to include the Exchange in their screening process. In this way, California could successfully deliver on the ACA concept of "No Wrong Door." Maintaining existing eligibility doors would include expanding the current online portals to screen for the Exchange, building an interface process to transmit the screening data collected through these eligibility portals to the Exchange, and promoting the Exchange through school outreach. The existing contact correspondence used in schools could also be enhanced to include other coverage options for the members of the student's family. With pregnant women in particular, accessing benefits through their trusted provider and obtaining presumptive eligibility so that they can receive services when they are initially receiving provider services enhances access to critical pre-natal care. Presumptive eligibility is a good mechanism for more immediate coverage in warranted situations. The important aspects of establishing presumptive eligibility are associated with consistency of application for the determined business rules/criteria, designated oversight for end-to-end evaluation of the use of presumptive eligibility, value based on metrics, and so forth. The Services Oriented Architecture being advanced for the eligibility and enrollment system makes integration with these existing eligibility doors achievable in a cost effective and efficient manner. While it is possible to integrate multiple existing access points into the system, it may not be wise to maintain all existing eligibility doors, as it depends upon their uptake rates as to whether they are providing a valuable consumer service and should be maintained. Additional research should be conducted to evaluate what eligibility doors work well today, as well as to identify those channels that remain less effective. Utilizing the data to determine the success rate of enrolling applicants based on the existing eligibility doors, a decision can be made as to which channels should remain open and be enhanced to promote a diverse range of options to the population.	
PPAC recommends maintaining all existing eligibility doors in an effort to realize the goal of "no wrong door" to coverage. The purpose of eligibility doors is to remove barriers to access for individuals in need of immediate non-emergency medical care. Presumptive eligibility for pregnant women is the perfect example of an eligibility door that eliminates barriers for uninsured pregnant women to access prenatal	Planned Parenthood Affiliates of California

care for this high risk population. Another example is the on-site enrollment for Family PACT, a critical component in the success of that family planning program. Based on the most current data, the Family PACT program averted 286,700 unintended pregnancies in 2007, saving the state $1.88 billion in public sector costs from contraception to age 2. In both of these examples, access to immediate enrollment and services are critical to positive health outcomes for women and their families.	
California provides a number of health services to its residents beyond Medi-Cal and Healthy Families (though they are oftentimes interconnected). These services and/or programs include pregnancy-related care (through AIM), presumptive eligibility for pregnant women, health assessments for children (CHDP), family planning (Family PACT), and breast and cervical cancer treatment (BCCTP). Elimination of these critical services could leave many without essential services, even if eligible for subsidized Exchange coverage. Before any changes are made to the programs, the state should conduct an analysis to determine what populations they serve and services they provide that cannot be obtained elsewhere or which have strong connections to the community to understand how best to integrate the programs into the new health reform landscape. In addition, undocumented immigrants (who are not eligible for full scope Medi-Cal, Healthy Families, and subsidized Exchange coverage and cannot purchase coverage through the Exchange) are eligible for pregnancy-related and restricted Medi-Cal for emergency situations and some county level programs. California should create coverage pathways so that undocumented individuals applying for an insurance affordability program for him or herself or on behalf of a family member (such as an eligible child) can be directed to the applicable services. California officials should also pay special attention to the California Children's Services (CCS) program, which ensures, currently through separate reimbursement, that children with special health care needs get seen and cared for by providers with expertise with their condition. This program has worked relatively well as a complement to Medi-Cal and Healthy Families for children enrolled in those programs, and can work in the same manner for those enrolled in subsidized coverage. To effectively identify these children, the single application for the insurance affordability programs should ask whether an applicant child has any specific medical condition requiring special treatment, services, medical equipment, etc. Finally, presumptive eligibility for pregnant women and for children screened at the Single Point of Entry as eligible for Medi-Cal should be maintained but fully integrated into the ACA and proposed federal requirement that applicants receive eligibility determinations in real-time. Consistent with this policy, whenever there is a need to conduct follow-up that does not allow for a real-time determination, California should temporarily enroll any applicant who appears Medi-Cal or Healthy Families-eligible, pending resolution of the data issue. This procedure will be in place for subsidized Exchange coverage (otherwise eligible applicants have 90 days to resolve discrepancy during which time they will receive coverage) and is compatible with current California law.	The 100% Campaign

Question #53: What are the key functions a service/call center must provide?	
The Exchange call center must be capable of providing interpretation in any language as required by California Government Code section 100503(y), Title VI of the Civil Rights Act of 1964, and Section 1557 of the ACA. Additionally, call centers should operate outside of normal business hours; provide assistance to consumers and businesses on a broad range of issues; track and record questions and complaints from callers and make that data publicly available; track and tabulate call resolution and consumer wait times and hang ups. The centers should use recorded data to help inform problems and achieve or improve customer service goals.	CPEHN and Having Our Say Coalition
Timely and effective enrollment into coverage hinges on the tools consumers have available to them to make informed decision about the benefits, health plans and providers that fit their personal needs and/or the needs of their families. Additionally, consumer assistance must go beyond outreach and enrollment and support retention of coverage and utilization of services to truly drive down costs, ensure access, and promote better health outcomes. An effectively designed and managed call center can provide access for those unable to use other communication vehicles. Therefore, the following functions are necessary for its overall success: • 24 hour services or at a minimum extended service hours (e.g., 5am-11pm) for individuals who work traditional and non-traditional hours • Ability to answer questions regarding the application process as well as status of an application • Multi-language access or at the very least accommodate/respond to California's 11 threshold languages • Respond to questions about the Exchange, Medi-Cal, and Healthy Families including policies and procedures, benefits, eligibility and QHPs • Provide referrals to local resources and services (e.g., OERU agencies for additional follow-up, troubleshooting, public assistance agencies/services) based on the consumer's zip code • Connect consumers to the Patient Advocate/Ombudsman to respond to consumer complaints, issues with QHPs, etc. • Coordinate with all other major call centers or helplines statewide to provide local referrals for in-person assistance (e.g., health insurance/services and public assistance) • Take payments or connect consumers to the payment center/department.	Community Health Councils
The Exchange call center should serve as a full-function customer service center providing all consumers with direct access to Exchange services, as well as providing contact information for assisters on the local level as needed. Additionally, to ensure that individuals with limited English proficiency can obtain adequate assistance, the Exchange should have bilingual staff for certain threshold languages. Exchange call centers also must be able to assist callers in other languages through a language line. The call center should operate inside and outside "regular" business hours. It should provide multi-lingual and culturally competent assistance, reflecting the Limited English Proficiency (LEP) population that will comprise a large proportion of those eligible for Exchange products and subsidies. It should also track and record questions and complaints from callers and make aggregate data publicly available. The Exchange should use	Consumers Union

this record to identify and address prominent problems identified by callers, as well as track and tabulate call resolution and customer wait times and hang ups and be able to use this record to identify and achieve customer service goals.	
Key Functions for a Service/Call Center: A service/call center should provide culturally competent and linguistically competent service in the Medi-Cal Managed Care threshold language standards. They should be able to answer customer's questions and do automatic enrollment. (See: The California Medicare Part D Language Access California Coalition, "Please Hold": Medicare Part D Leaves Limited-English Proficient Beneficiaries Waiting for Access, http://www.greenlining.org/resources/pdfs/PleaseHold.pdf) They should have the ability to refer clients to a physical person or organization who can help the individual enroll. They should also be able to help individuals with plan renewals and changes in plan. Service/Call center workers should provide personalized answers to customer's questions as opposed to providing individuals with stock answers. Service/Call center agents must be certified, and should have same certification requirements as navigators and assisters. (See: California Coverage & Health Initiative, Leveraging the Local Experience of Community Based Organizations in Implementing the Affordable Care Act, http://cchi4families.org/pdf/uploads/Executive%20Summary_new050411.pdf and Kaiser Family Foundation http://www.kff.org/medicaid/upload/Connecting-Eligible-Immigrant-Familiesto-Health-Coverage-and-Care-Key-Lessons-from-Outreachand-Enrollment-Workers-full-report-pdf.pdf).	The Greenlining Institute
A call center must be able to answer basic questions on eligibility, programs and health plans available, and most importantly, refer callers to experienced consumer advocates who are capable of helping individuals as well as identify trends and patterns in problems and barriers, and who have capacity to address those issues systemically. The Health Consumer Alliance is such a model and would be well-suited to partner with any call center.	Health Consumer Alliance
The key functions that a service/call center should have are: to be available more than 8am to 5pm. Accessibility should include evenings and weekends. It is important to have bilingual staff who have knowledge about programs and benefits. Staff who are able to link callers to the application process and provide eligibility confirmation over the phone. A post call survey for customer satisfaction on how the staff member handled the call will provide valuable feedback.	Health Plan of San Joaquin
A Service Center should be able to: • Provide general information, • Assist customer in Navigating an On-line system, • Complete a verbal information gathering session, and • Assist the customer with the selection of health care provider. • Make real-time changes to a customer's data, address, phone number, household, income, etc. • Make provider changes as desired by the customer. Also, a **full-service** Service Center should have a self-service system so the customer could get basic information prior to speaking to an agent and the ability to web-chat with the user of the On-line system. Hours of availability should be sufficient to cater to a wide range of customer schedule needs, including some evening hours, Saturday hours a few times a month. (Like DMV?)	San Bernardino County

The call center should have both technical assistance and enrollment/ application assistance functions. The technical team should ideally be able to: (1) remote into the client's computer, where possible, to aid with navigation issues, (2) direct clients to a navigator if they prefer application assistance, and (3) to route to the appropriate staff if the client has more detailed questions. The service/call center should be well acquainted with both eligibility rules and the products listed on the exchange. There should be little to low wait times for callers and language capacity in all of the key threshold languages.	San Francisco Department of Public Health
The Call Center should assist with enrollment as well as deal with questions that come up after the health plan is already in place. A separate Call Center should be set up for employers and employees. The Exchange should be prepared to educate and enroll new employees as they are hired, elect coverage, etc.	Small Business Majority
The service/call center housed within the Exchange should translate into providing all consumers with real time assistance with all aspects of health care enrollment that is available in person, by phone or mail, and online. This includes in-person support offered at convenient locations where applicants can get questions answered or obtain assistance in completing the application in addition to phone or online support that is available beyond normal business hours. To ensure the effectiveness of this assistance, the state should establish timeliness standards for how promptly a person can get through on a phone line, schedule an appointment with a helper, and other relevant measures. A key function of a call center will be to answer consumer questions about health coverage in the language the consumer is comfortable in and, when appropriate, direct that person to local in-person or online resources (e.g., to find more info or get further help, or complete an application, etc.) Any service center operated by the Exchange should be closely coordinated with and have strong referral linkages with other programs/centers in the state that do similar work, including but not limited to the DMHC Help Line, the Office of the Patient Advocate, the Department of Insurance hotline, and the Health Consumer Alliance.	The 100% Campaign
When establishing call centers, clear parameters and responsibilities must be established. HHS should define an industry standard "rules of the road" guide that is made available via the Exchange to outline when a member would contact the Exchange versus when they would contact the issuer directly. It could also include when they should contact their employer. The Exchange call center should seek to avoid unnecessary transfers that result in sending enrollees back and forth between call centers. Training issues must be considered; it will be important for the Exchange to consider whether call center employees should be specialized in some topics (e.g., Medicaid) instead of having all employees trained on all aspects. In order to appropriately protect consumers, if Exchange call center employees make product recommendations, they should be subject to agent/broker licensing requirements.	UnitedHealthcare
Question #54: How should the performance of the service/call center be measured and reported?	
We recommend measuring: call hold time, call abandonment rates, average talk time, call transfer rates, customer satisfaction, and percentage of callers that complete applications following receipt of guidance from the call center.	Anthem Blue Cross

As a condition of the Exchange contracting process, all telephonic and in-person consumer assistance functions must be provided in a culturally and linguistically appropriate manner including the provision of oral assistance in any language to limited English proficient consumers. The Exchange must collect data on the service/call center to identify and address prominent problems identified by callers in order to identify and achieve outreach and consumer service goals. Data collected should include but not be limited to: caller demographics including race, ethnicity, language, sex and disability; problems and questions consumers experience with health coverage; type of coverage involved; referrals and services provided to individuals; and provider and industry behavior. Callers should be informed that the collection of this data will help to improve health care quality.	CPEHN and Having Our Say Coalition
Several measurements are used to determine the efficiency and effectiveness of a call center. The following are critical components necessary for the call center to meet its goals and objectives and should be measured via a Quality Improvement Plan: • Clear and transparent purpose, objectives and measurements • Established standard, performance measures and benchmarks (call volume; hold times, call times; time before call is answered, etc.) • Adequate call center workforce to field incoming calls (i.e., provide proper number of staff to handle calls during operating hours and more staff at specific hours of the day when the call volume is highest) • Comprehensive, standardized, and ongoing staff training • Infrastructure to manage and maintain call center technology system (phone lines, automatic transfers, etc.) • Client satisfaction. To measure these components, the following assessments should be made by an outside evaluation firm to ensure there is no conflict of interest: • Staff and client surveys on challenges and successes immediately following the call • Report the number of complaints received about the call center • Navigator and referral agency feedback/input (via stakeholder process) • Use of “secret shoppers” and evaluation of a sampling of calls across topics and languages to ensure consistent service and messages and appropriate referrals made • Evaluation progress report on call center at 3 months, 6 months, and 12 months to make for ongoing adjustments/maintenance and management • Evaluation report on operating hours and the percentage of incoming calls to determine the appropriate hours and staff required to meet demand and ensure resources are being used effectively and efficiently • Transparency on all levels is shared with the public (progress report/performance measure results; consumer/advocate solicited feedback; next steps/recommendations for improvements, work plans and timelines).	Community Health Councils

The enrollment function of an exchange must have different metrics that track how well call center representatives get people to the right programs and enroll people. Standard management call center reports track global items like average speed of answer, call abandonment rate, call subject matter, call resolution, call volume by type.	Delta Dental
Performance Measurement for a Service/Call Center: The following data should be collected and available (quarterly) with an annual report/analysis produced annually: The number of calls received, the preferred language of customers, the number of cases/questions that were resolved by call center agents, the average wait time before a customer is able to speak directly with an agent, and the number of cases/questions that needed to be passed to another agent. Each customer who calls a service/call center should have the option of filling out a brief, culturally and linguistically appropriate customer satisfaction survey at the end of call. Also set up measures ensuring that customers are easily able to reach an individual that speaks their preferred language. (See: The California Medicare Part D Language Access California Coalition, "Please Hold": Medicare Part D Leaves Limited-English Proficient Beneficiaries Waiting for Access, http://www.greenlining.org/resources/pdfs/PleaseHold.pdf)	The Greenlining Institute
The number of persons assisted, as well as number or volume of resolutions to systemic or individual issues.	Health Consumer Alliance
Performance of the service/call center can be measured and reported by: hold time defined as by the time the call is placed until a live person is reached; abandonment rate; speed to answer with a live person; whether callers have access to languages; and satisfaction through post call surveys.	Health Plan of San Joaquin
Performance should be measured by creating Key Performance Indicators such as: • Average Handle Time • Average Speed of Answer • Agent Adherence to schedules • Service Levels Call Center Manager should provide a report on these Key Performance Indicators at regular intervals.	San Bernardino County
Key metrics include time to answer, the volume of calls, the nature of the call, and the caller type. These metrics should be reported publically on a recurring basis.	San Francisco Department of Public Health
Small business owners have limited time and limited patience for things like call centers. Hold times must be minimal, Call Center employees must be respectful of small business owners' time, and the process should be efficient.	Small Business Majority

GENERAL COMMENTS

General Comments	
Schools enjoy a unique position within communities and their ability to meet the needs of under- and uninsured children and families where they are and with staff who have established trusting relationships is paramount to schools' success with health outreach and enrollment. Schools are often the first, and sometimes only, place where students and their families are introduced to the concept of health and health	Paradigm Healthcare Services

insurance. They are able to guide students and families through the maze of support services available in a given area with specific attention paid to individual social, economic, and cultural factors. Schools are often better placed to help parents and guardians get proper information related to Medicaid services. Medicaid administrative reimbursement to schools is one example of an investment that pays substantial social and economic dividends to this end. School-Based Medi-Cal Administrative Activity (SMAA) claiming allows schools to sustain and reinvest in outreach efforts, while encouraging greater interaction and collaboration with community resources. Providing additional financial or other resources to schools to help them continue being a cost-effective and efficient outreach and enrollment channel, be it continuing to support the school-based MAA programs or removing barriers to reimbursement and enrollment (such as initiating an ELE state plan amendment for Express Lane Eligibility which allows States to use eligibility findings from other public benefit programs to facilitate enrollment in Medicaid or CHIP), would benefit the goals of HBEX, the Triple Aim, and the greater ACA. Because schools in California vary dramatically in size and available resources, it is questionable whether or not certain schools will be able to handle any additional service burdens. The Exchange should be aware that while some schools have the capacity for providing additional outreach services, many will not. At the same time, it is imperative to recognize that one of the primary entry channels for under- or uninsured students to health services is the school which they attend regularly. Thank you for taking the time to review my comments on the importance of supporting schools in the significant role they currently and will continue to play under the ACA.	
In order to maximize enrollment in the Exchange, Medi-Cal, and other health coverage programs in 2014, the Exchange must start to educate people now about their eligibility for coverage. We recommend that the Navigator program be established and fully funded well in advance of the October 2013 enrollment date in order to ensure that Navigators have the necessary resources to successfully, seamlessly, and quickly enroll all those who are eligible and to dispel any myths or confusion as a result of deceptive marketing practices aimed at those who may not know about the law and their rights as consumers, including seniors, disabled, Limited-English-Proficient (LEP), immigrants, and communities of color. Since the role of the Navigator is to assist the consumer impartially, the Exchange should contract with consumer-focused non-profit organizations with the demonstrated capacity to serve California's diverse communities. Below are some additional points we would like to highlight. • A successful marketing and outreach campaign is one that is capable of reaching out to California's diverse communities. The state should conduct focus groups in multiple languages ahead of 2013 in order to target marketing efforts to racial and ethnic communities. • In order to reach all communities the state needs to meet people where they are by providing enrollment in schools, clinics, community based organizations, churches, and medical/clinic settings, and offering sites at malls, shelters, and farmers markets. By addressing accessibility issues (e.g., transportation, internet, service locations) and offering information in various languages and easy to read formats, the Exchange, DHCS, and MRMIB can help maximize enrollment in these programs. • The enrollment system should be designed with an appropriate rules engine which can successfully serve families with complex cases (e.g., mixed status families, employee versus individual, etc.).	Having Our Say Coalition

Individuals should be allowed to self-attest with regards to citizenship and other required eligibility documentation, with follow-up assistance to occur later. There should be an easy, clear, multilingual process set-up for those who will be requesting exemptions from Exchange coverage, including undocumented immigrants. • The Exchange, DHCS and MRMIB should issue notices to the newly eligible in the LIHP, Family PACT, AIM and other public programs about the availability of coverage. Notices should also be sent to consumers experiencing life changing events that might make them eligible for coverage. The notices should include referrals to safety-net services for those ineligible for coverage in the Exchange due to immigration or other status. • Applicants must be able to access culturally and linguistically appropriate consumer assistance electronically, by mail, by phone, and in person. The Exchange call center must be capable of providing interpretation in any language as required by California Government Code section 100503(y), Title VI of the Civil Rights Act of 1964, and Section 1557 of the ACA.	
Every health plan that sells through the exchange should be required to publish their entire medical necessity definition and provide a URL to their plan's medical/clinical policies so that consumers can see how plans make coverage decisions about distinct treatments or conditions.	Linda Bergthold, Ph.D.
Overall, we appreciate the opportunity to provide comments in-person during the stakeholder input session conducted at the San Mateo County Human Services Agency on Tuesday, November 29th. We appreciate your incorporating the feedback relayed during that session. It will be critical for the Exchange/ DHCS/ MRMIB to overcome the administrative complexity of the existing Medi-Cal program to promote a user experience for the lowest income consumers that can be completed more quickly with fewer burdens on the consumer. This will require much greater reliance on and open-ness to use of third party (rather than client provided) information, as well as a more distributed network of eligibility determination that better harnesses the roles and information residing in other points in the continuum of the healthcare purchasing and utilization continuum.	San Mateo County Health System
The individual market has undergone a substantial change during the last year-and-a-half. The new environment appears to be quite challenging to all carriers including the biggest ones. Some carriers have either withdrawn from the California marketplace or are on the “sidelines” and not actively marketing product. The larger carriers are challenged with pressure from the regulatory environment and ever increasing health care costs. The changes in 2014 may exacerbate some of these challenges, especially considering the population of newly insured people and their immediate care needs (see Massachusetts Connector experience). So as you contemplate the design of the exchange, I think it behooves you all to keep all this in mind and the importance of balancing the type of enrollment you get as much as you can. Given the current realities of the individual market (it’s tough for carriers) and the potential challenges with the 2014 reforms, it wouldn’t take much of a hit to make the exchange unworkable for California because you may find yourselves without important suppliers. On another note, you touched on the question of the role of general agents but there wasn’t much discussion	Warner Pacific Insurance

about this. So allow me to address this a bit here. I strongly believe that general agents could be very helpful in your efforts to encourage agents to look your way and bring decent enrollment into the SHOP. Embracing the GA model would immediately give you access to over 15,000 employer quote requests per month and 30,000 agents. Money that you would otherwise spend on promoting the SHOP could in fact be devoted to the individual exchange because the GA system could be doing the recruiting, educating and motivating agents on your behalf via a variable cost structure. One of the biggest challenges that the SHOP faces is its relative complexity and a general lack of demand for this kind of product. The SHOP product will almost be "boutique" in nature and thus it will take time and effort to educate agents and their clients about its value. GA's could be a very big help to you here.	

SEIU COMMENTS

We have been attempting to collect responses from many different members of our unions. These responses on this sheet represent the responses of a cross-section of eligibility workers from various programs represented by SEIU Local 721. We had members with experiences in all programs from 18 to 40 years of experience. We essentially made our own questionnaire for our members here. You will see the questions below and then the reference to a specific HBEX question where applicable and then the answer below it. 1. In your opinion what are the main obstacles in managing an increase in client enrollment? (Check all that apply) a. Insufficient staffing b. I.T. case management systems c. State regulations and requirements d. A, B, C- all of the above Comments: • Not everyone has a computer, internet access, or a smart phone (cost associated with ownership). Time limit on computer at library is 30 min. • Smart phone doesn't take the client through the application. Need adobe acrobat on smart phone. Difficult to fill out the entire application on the phone. • On-line applications may cause duplicate applications- some clients re-apply multiple times because they don't know if the application went through, they are confused by the on-line process and re-attempt, or they forget to include a document so re-apply. Staff is required to review all the applications and determine it's the same people. • Some clients do not know how to read and write. Also, language barriers. • Clients need assistance on paperwork; need someone to check information on application. • If clients come into office; staff is able to direct them to additional programs. Or if they do not qualify, direct to other programs that community organizations offer. • State has designed the program to keep people out; need to simplify progress; lots of questions on	SEIU

application.

2. What type of outreach and community education is needed to manage an increase in enrollment? (Check all that applies)
    a. Outreach at community events
    b. Advertising
    c. Social media
    d. A, B, C- all of the above

Comments:

- Need educational campaign
- Also outreach to faith-based and non-profit organizations

1. What groups of clients are MOST likely to apply for benefits in person (not through Internet or phone)? (Check all that applies) *Related to Q. 8, 9, & 10 from HBX survey :* elderly, youth, disabled, homeless, immigrant, non-english speaking
2. What groups of clients are LEAST likely to apply for benefits in person, but will prefer to enroll through Internet or phone? (Check all that applies) Related to Q. 8, 9, & 10 from HBX survey. G. Other- People with part time jobs, students, people that can't come in during office hours.
3. What steps can we take to overcome obstacles and ensure a maximum enrollment and retention of clients? (Check all that applies) *Related to Q. 11 on the HBX survey*
    - Simplifying the enrollment process
    - Reducing regulations and requirements
    - increasing staff.

Comments:

- "Plain language is the best"- e.g., people don't understand what household composition is.

4. Should community groups play a role in enrolling eligible clients in 2014? *Related to Q. 20 on the HBX survey*
    - Yes
    - No
    - If yes, how should they be involved?
        - Directly enrolling clients
        - Referring clients to registration offices

Comments:

- If community groups are going to be involved, they can help clients fill out the paper. However, they should NOT be allowed to touch the system (hard to change once it is in the system).
- Clear instructions to clients that once he/she fills out the application, it doesn't guarantee you will get it; eligibility worker will be in touch with you.

- Community groups should not determine of eligibility- can cause confusion when regulations or requirements change. Can say MAY qualify but do not guarantee qualification. At the end of the day, public employees/county/state is accountable.
- Current problems is that people who are at community centers/non-profit centers who help enroll are issuing people card without checking if they have it; issuing double applications (multiple state index number/SIN to one individual.)

5. Should counties play a role in enrolling eligible clients in 2014? *Related to Q. 20 on the HBX survey*
    - Yes
    - No
    - If yes, how should they be involved?
        - Directly enrolling clients
        - Referring eligible clients to registration offices
        - Other

Comments:

- County employees are able to enroll clients in multiple programs they qualify for.
- Provide counselor-like role by giving clients information of other programs, county employees, are knowledgeable of community resources if they are not eligible: Food bank, shelter, etc.

6. Should labor unions play a role in enrolling newly eligible clients in 2014?
    - Yes
    - No
    - If yes, how should they be involved? (Check all that applies)
        - Advocating for a county based eligibility system
        - Advocating for client rights and access
        - Other [fill in field]
        - Comments: [Fill in Field]

Comments:

- Advocating for a county based eligibility system
- Advocating for client rights and access

7. How can the county work with community groups and clinics to increase enrollment? *Related to Q. 43 on the HBX survey*
    - Some DPSS sites have a meeting with community groups once a month to discuss ideas, comments, suggestions, and to address concerns. Share resources between parties.
8. How should the success of the eligibility system be measured and reported? *Related to Q. 44 on the HBX survey*
    - First-time applicants

9. What support do eligibility workers in your county need to succeed in enrolling and retaining clients? • Additional staffing • Trainings 10. Other comments or ideas on how to improve our eligibility system to be more efficient: [text box] • Take away barriers, simplify the application process • If use technology need to improve computer systems. We have a number of other responses coming in from Local 521, UHW and other Locals. We are planning to submit them soon and trust that the Exchange will read them with interest.	