EASY, EFFICIENT, AND REAL-TIME (EER):

A Framework for a First-Class Health Insurance Enrollment Experience in California

The Children's Partnership

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Introduction

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.

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."[1] In order to meet that standard, all decisions about California's eligibility, enrollment, and retention (EER) system must be measured by their impact on the state's ability to consistently help Californians find and maintain coverage without needless hassle or delay.

Time is of the essence in designing and building a system that meets this high standard. California must be ready to open doors to nearly 2.13 million nonelderly, new Medi-Cal and 1.71 million nonelderly, new Exchange consumers by January 1, 2014.[2] As a practical matter, this leaves approximately two years to put the new system in place.

In addition, the EER system must support approximately 8 million Californians who are already covered by Medi-Cal[3] and Healthy Families,[4] as they renew or transition among coverage options in 2014 and beyond. The combined total of nearly12 million consumers will come from all walks of life, and will expect shopping for coverage and actual enrollment to be as easy and reliable as other consumer experiences, such as online banking, tax filing, and retail.

This Framework describes expectations for Californians' health insurance enrollment and retention experience. ***At its essence, the envisioned system will be easy to access, easy to use, informative, dependable, secure, and empowering.***

The Children's Partnership intends for this document to help set expectations for California's emerging policy and technical debate on enrollment reform. Working with other stakeholders, our next effort will focus on plotting out a Roadmap for achieving a system that fulfills these expectations for California consumers. We will begin distributing that Roadmap at the end of the year.

Background

California has a long history of efforts to improve access to available health coverage, both private and public, through mechanisms such as streamlining eligibility rules, cross-program data-sharing to facilitate eligibility determinations, and regulation of managed care entities to ensure consumer protection.[5] In 2009, the California Health and Human Services Agency embarked on the planning of a modernized eligibility and enrollment system with the intent of creating an "Enterprise Enrollment Portal."[6]

Despite its history of working to address this issue, California still relies on a patchwork of enrollment procedures and systems, of varied sophistication, across its public programs.[7] Challenges to moving forward have included funding concerns, governance disputes, antiquated technology, and vested interests on the part of vendors and agencies.[8]

The ACA requires California and every state to overcome those obstacles and establish a seamless, simple health insurance enrollment system that encompasses Medi-Cal, Healthy Families, the new Exchange, and other available state and local programs.[9] Importantly, the mandates of ACA and related funding opportunities provide strong incentives and resources to overcome these historic obstacles.

Building from California's Challenging Starting Point

- California currently fails to enroll all eligible consumers – for example, nearly 40% of California's 1.1 million uninsured children are estimated to be eligible for Medi-Cal or Healthy Families programs.[a]
- "The continuing patchwork of program enrollment systems is inefficient and unfriendly to consumers."[b]
- "Siloed enrollment processes supported by stand-alone systems act as barriers to the uninsured seeking benefits."[c]
- "[N]o processes now exist to tap into the information available in existing state and other databases for asset, income, and other information that could minimize the burden on applicants."[d]
- As recently as 2008, there did "not appear to be significant collaboration nor coordination among various major Medi-Cal system enhancement and replacement initiatives."[e]

Specifically, ACA requires states to build EER systems with the following features:

> Consumer-friendly: ACA requires states to create enrollment systems that ensure individuals are screened for all available health subsidy programs and enrolled and/or retained in the appropriate program, with minimal information and documentation required from applicants.
>
> Coordinated: ACA requires states to allow submission of a single application through multiple channels and to coordinate efforts across available health subsidy programs in order to enable seamless transitions between programs when needed.
>
> Simplified: ACA requires states to simplify and coordinate eligibility rules across programs to achieve a streamlined enrollment process that uses electronic systems to securely retrieve and verify data to facilitate the eligibility determination.[10]

The availability of enhanced federal funding for the development of supporting information technology, through both Medicaid administrative funding and Exchange planning and establishment grants, is critical to California's success.

To obtain enhanced Medicaid funding, states are required to develop systems that ensure seamless coordination between Medicaid and the Exchange, to provide a "21st Century customer experience for all individuals, and [to] provide for person-centric outreach, eligibility, and enrollment."[11] Similarly, in order to receive enhanced funding for Exchange and Medicaid IT systems, states must coordinate across health programs to develop IT systems that "support a first-class customer experience," which it defines as "similar to that experienced by customers of leading service and retail companies and organizations."[12]

With California's new Health Benefit Exchange Board in place, the foundational work begins now to expand health care coverage and to maximize the performance and integration of eligibility and enrollment processes for available programs. Using this Framework, stakeholders can ground that process in a consumer's experience. California faces many choices as it designs an enrollment experience that complies with ACA.

This paper presents a consumer perspective to guide those choices in a direction that meets the clear federal requirements and effectuates ACA's expectation for a "first-class consumer experience." This Framework will become the grounding chapter in an upcoming Roadmap for how California can move forward to achieve this ideal.

The Framework for California's Consumer-Mediated[13] Enrollment Experience

The following section describes the features that are necessary for California to deliver the first-class enrollment experience expected by ACA.

Californians will enter this enrollment experience with highly varied situations, needs, and goals. The EER system must serve them all well, accommodate their individual circumstances, and provide them with the optimal results, in clear terms. Therefore, this Framework speaks to the common features of the ideal consumer experience, but calls out some unique aspects of it for different types of users through relevant examples.

See Appendix A for a one-page graphic illustrating how a California family would experience the enrollment process once ACA is up and running. A more detailed guide is available online at www.childrenspartnership.org/Roadmap.

Many Doorways for Entering the Online System

Consumers should be able to apply for all available health coverage programs from multiple points of entry, such as hospitals, schools, program offices, community organizations, or at home, using their choice of online, telephone, in person, or mail-in application methods. At some entry points, consumers will be able to apply on their own, while at others they will be helped by a navigator or receive other application assistance.

Consumers should be able to choose the location/ method that best suits their needs and be able to:

- ☑ Apply through all existing gateway entry points (such as the Child Health and Disability Prevention Program (CHDP) gateway), all of which should be modified to function with the simplicity and usability of the standard EER application process;
- ☑ Decide, at any point, to request follow-up assistance to complete the process and/or to switch application formats; and
- ☑ Use the same online portal for all electronic applications, whether the consumer is applying with or without assistance. For example, if a consumer applies with the help of a Certified Application Assistant (CAA), the CAA would fill out the online application for the consumer and help them proceed through the steps in much the same way the consumer would experience at home.

Regardless of the method by which a consumer applies (online, by mail, by phone, or in person), each application should be integrated into the new high-performance enrollment system for efficient, consistent, and accurate processing into the appropriate health coverage program. For example, an application submitted by mail should be electronically entered and processed using the same automated rules and systems used for online applications.

Convenient Assistance Available

Consumers should be able to get assistance at any point as they proceed through the application/ renewal process—either live, automated, via e-chat or phone, depending on the time of day or day of the week. Live human assistance should be available, in real time, beyond normal business hours.

Simple Means for Starting the Process

It is anticipated that many consumers will apply online, with or without the aid of a navigator, and will start the process by establishing a user account on the basis of a few basic, minimally required pieces of demographic information to establish and authenticate the person's identity.

A consumer should also be able to submit an application without creating an account, but the system will then not be able to support many of the efficiencies for that consumer following enrollment and at renewal.

- ☑ The online application must be clear, logical, user-friendly, and able to accommodate needs of persons with disabilities, low literacy levels, and limited English proficiency throughout the whole process.

For example, in accordance with California law, help should be provided by bilingual staff speaking at least threshold languages and interpreters used for other languages.

- ☑ Within a particular family, the account should be able to refer to an individual, to the whole family, or any components of the family that make sense. Information requested to complete the process will pertain only to the applicant, not to any non-applicant(s) in the family.

  For example, in a family with employer coverage for only the parents, the account will be set up for just the child/children. In that case, the parents would be prompted to complete an application for themselves (and include themselves in the account or set up their own account), but would also be given a chance to "opt out" of such application.

- ☑ The consumer should only be presented with relevant questions. For example, a male applicant will not be asked about pregnancy status.

  Furthermore, having answered the minimal essential set of questions, the consumer should have the option of skipping questions that they do not consider relevant to their circumstances.

  However, where the system identifies that an applicant has skipped some essential questions, it should prompt the applicant later to return to answer relevant questions that could improve their benefits or lower their costs.

- ☑ At any point, a consumer should be able to create an account to save and store his or her information and complete the process later.

  The account should give the consumer a simple means to inquire about the status of his or her application and enrollment, relevant dates (such as renewal dates), premium payment history, and to file complaints and/or pursue any grievances/claims that he or she may have regarding the eligibility process. Such actions would be possible online, by phone, by mail, or in person.

Existing Information Reused

Where the consumer already has an account, prior account information should be made visible to the consumer as he or she proceeds through the process, allowing for the reuse of information and/or selections that are still relevant.

Consumers should be able to return to an established account at any time to update information and make changes to reflect new circumstances or to manage insurance coverage as appropriate (e.g., including renewing coverage or changing plans at open enrollment).

Data Made Available in Real Time to Complete the Application or Renewal

The EER system must be able to securely locate, retrieve, reconcile, and organize relevant information about an authenticated consumer from multiple available federal and state databases to fill in pieces of his or her eligibility picture.

- ☑ The consumer should be given an opportunity to authorize the system to query available databases and import or verify relevant information about them and/or their family members to either create or update an account.

- ☑ The consumer should have an opportunity to see the information that was deemed most pertinent/current (i.e., that which is being used to make the determination) and learn from where that information came.

Opportunity Provided to Review and Correct Information

All consumers should be given the opportunity to review the eligibility information imported into their application and either validate it as correct or submit corrections and updates, as relevant, prior to the submission of an application or renewal form.

Real-Time Results Provided

Having submitted an application and/or renewal form, including the electronic signature, the consumer should receive real-time notice regarding program eligibility for every member of the account who is seeking coverage with respect to all available programs, including Medi-Cal, Healthy Families, the Exchange with and without subsidies, and other available options.[14]

This could include notification of being eligible, notification of temporary eligibility pending further review, notification that some or all account members are already enrolled, and/or notification of ineligibility based on the information provided. Importantly, the process would not end here for anybody.

- ☑ Those found eligible should be prompted to proceed through the rest of the enrollment process, including choosing a plan, and given an opportunity to add details to provide a more precise eligibility picture (i.e., to provide information about factors that might improve their benefits or lower their costs, such as disability status).
- ☑ Those individuals receiving a notice of temporary coverage pending further review should also be notified as to the reason a final determination was not possible (such as the need to reconcile data, etc.). These consumers should receive clear and understandable instructions to access care during the temporary period, where applicable; learn of any steps they must take to facilitate the final determination; and check on the status of their case.

  In some, but not all, of these cases, documentation could be required to finalize the determination and consumers would be informed how and when to provide it. Temporary coverage should become effective immediately for those in Medi-Cal and Healthy Families, whereas those getting coverage through the Exchange could have their effective date delayed a short time to accommodate administrative issues.
- ☑ Those individuals found to already have insurance should be given a chance to renew coverage during the same transaction (where they're already enrolled in Medi-Cal, Healthy Families, or subsidized Exchange coverage) and also given a chance to submit current information to determine whether they are eligible for better/lower cost coverage.

  For example, an employee that receives coverage through an employer would have the opportunity to submit information to determine whether he or she and dependents qualify for subsidized coverage as well as to assess options for unsubsidized coverage through the Exchange.
- ☑ Those who appear ineligible for all available programs, based on the information provided, should be informed and given an opportunity to provide further information and possibly documentation to address relevant eligibility concerns.

  In addition, before an outright denial is issued, the consumer should be given an opportunity to speak with an eligibility worker or with a community-based application assistor – ideally, in real time.

Opportunity to Compare and Choose a Carrier or Plan

With program eligibility in hand, the consumer should then be given the opportunity to select an insurance carrier/plan.

All options that are available to that consumer and their family at the appropriate subsidy level should be provided, in real time, and the consumer should be able to accurately identify and compare benefits, costs, and available providers/hospitals/clinics, etc.

Consumers should be given clear, understandable information to help weigh their options–including cost calculators and quality information, to the extent available–either online or by follow-up mailing, if they prefer.

- ☑ Those found eligible for the Exchange should be informed as to the amount of subsidy available at each plan level (i.e., bronze, silver, gold, and platinum). Those who prefer to complete carrier/plan selection at a later time would be able to do so.
- ☑ Some consumers will be faced with eligibility for multiple programs within a single family. These families should be able to evaluate and complete the health plan selection process for all family members and relevant programs, and identify options that help the family coordinate care and coverage across programs, as relevant.

For example, a family with an income above 133% of the federal poverty level might include a mother who receives coverage through her employer, a father who qualifies for subsidized coverage through the Exchange, and children that qualify for Medi-Cal or Healthy Families. Using the EER system, this family should be aware of the array of choices among carriers and plans, for all members, and be able to select among relevant options, including options that are available to multiple family members across programs.

- ☑ Consumers should be provided similar information allowing them to compare their options at each open enrollment period (as well as at transitions due to changed circumstances) and be informed about how to change their carrier or plan if they so choose.

Opportunity to Submit Additional Information

When consumers qualify for any program that involves paying premiums or limited benefits (i.e., anything but full scope Medi-Cal) and after they learn the premium required for their carrier/plan choice, they should be given the opportunity to answer any questions that they may have skipped in the application and/or review details such as income, again, to check against their own records and ensure greatest accuracy.

Coverage Effective Promptly

Consumers who are enrolled in Medi-Cal and Healthy Families would get coverage immediately, whereas those placed in the Exchange and other programs might experience a delay in effective coverage (up to the first day of the following month). Exchange-enrolled consumers should have the ability to select a date of effective coverage to fit their needs (e.g., they may have existing coverage that will terminate on a particular date, or they may be moving to a new state on a specific date, etc.).

After selecting a carrier/plan, consumers should immediately be e-mailed a printable "proof of eligibility, enrollment, and benefits" for use in receiving care on that effective date as well as clear information about how to access care and information about how to address problems they may experience with their carrier/plan. Such information would be mailed as well, along with their benefits card or equivalent.

Electronic Reminders and Payment of Premiums

Where the consumer will be required to pay a premium to participate in the plan, he or she should have the option to make that payment electronically. Consumers should be able to use their accounts to establish automatic premium payments, to specify whether and how they would like to receive payment reminders (e.g., by e-mail, phone, or text), and to learn how to submit premium payment by text message.

Clear Information About Rights and Responsibilities

At important points in the process, the consumer should be informed about any expectations that accompany a specific step in the process and any financial or legal obligations that result.

For instance, the consumer should be notified as to what types of changed circumstances (such as increases in income) will result in different subsidy levels/program enrollment and what steps to take under such circumstances to ensure that they do not get hit with unexpected cost reconciliation.

Consumers should be given clear and understandable information as to rights and opportunities for appeal and grievance processes as well as any relevant deadlines and contact information. And, they should be informed about privacy and confidentiality protections as well as the protocols that are in place in case of a breach.

Option to Apply for Other Public Benefits

Before completing the enrollment process, consumers should be asked whether they want to use this eligibility information to apply to other public programs that provide important benefits such as cash, food, shelter, and other assistance.

Any consumer who answers in the affirmative should be able to select from a list of specific programs and initiate that process, or should be

able to select "see what I'm eligible for" and proceed that way. The information from their account should be electronically poured into the other program(s)' eligibility process, and the consumer could then continue through that enrollment process online, to the greatest degree possible.

Periodic, Timely Notifications

The consumer should receive periodic notifications by mail as well as by e-mail, text, phone message, and/or other format, according to their preference, as minimally necessary. Such notification would be made regarding payment due, payment received, renewal reminders, open enrollment periods, and any other relevant notices.

Simple Means for Updating Coverage as Circumstances Change

The system should contact the consumer when it identifies any changes in circumstances that could change his or her coverage options, both where the change might benefit the consumer as well as where it might reduce their premium subsidy.

In such instances, the system should send an alert, with a statement clearly saying what changes are indicated by available data, including an estimate of new cost burdens as relevant, and encourage the consumer to update the account information to update their eligibility.

Creating a First-Class Consumer Experience in California: Key Considerations for Moving Forward

The first step in building a suitable EER system is to describe its critical features as seen through the eyes of the consumer. This Framework has done just that. With it as the starting point, the next steps to get California's improved system up and running include the following.

Culture Change

Operating a consumer-centered eligibility and enrollment system will require a significant shift from current practices among eligibility workers, governing agencies, and IT systems to create a more welcoming environment. In order to accomplish such a shift, we urge leadership to start now to ready the ground and foster a culture of coverage among officials and eligibility workers at all levels of the system. A critical feature of this shift involves collaboration and improved data exchange across agencies—practices that are not adequately carried out today.

Streamlining

Importantly, achieving this culture shift will require policy and practice changes that streamline Medi-Cal, Healthy Families, and other available programs made in conjunction with the new rules that are being established for the Exchange. Unless the underlying program rules are simplified and seamlessly coordinated, eligibility workers and systems will not be able to change current practices significantly.

Consumer Involvement

Planners should involve consumers in the development of the EER system as well as test the system among a range of consumers, at all phases. Without real consumer input, the system will not be optimally usable and could impede efforts to reach, enroll, and retain eligible Californians.

Modern Technology

The first-class consumer experience is premised on a back-end technology (i.e., not visible to that consumer) that can quickly, accurately, and securely locate, retrieve, filter, organize, and analyze data for them. Getting such results by 2014 will require robust interoperability—that is, means for bidirectional communication—between any new systems developed for this purpose and existing, reusable systems (which will have to be adapted and improved for this purpose). It does not require the state to start from scratch.

From the consumer perspective, it doesn't matter which entity or technology performs which part of the process. It only matters that the process flows without a hitch, provides the exact same

result regardless of where consumers originate their application, and places them in the appropriate program.

Leverage Available Federal Resources

California has already missed several opportunities to leverage substantial federal funding to support the design, development, and deployment of the modernized system of systems. Given California's continuing fiscal constraints, all available federal funding streams ought to be tapped at an enhanced match wherever possible. In addition, other supports like the Enrollment UX 2014 project,[15] verification interfaces being developed pursuant to §1561 of ACA, and the reusable assets developed by innovator states should be leveraged to the greatest degree possible in the development and design of California's EER system.

Build in Transparency and Accountability

To ensure that the system performs optimally, it must be tested before and after deployment. Rigorous performance measures need to be developed and employed to assess whether the system applies rules consistently and appropriately. And, data must be gathered regularly to allow the state and interested parties to evaluate system performance as well as flag unanticipated issues. To establish workable performance measures, California can work with other states and related federal efforts. Furthermore, California should designate a single agency that will be held accountable for the performance of the system.

Conclusion

This Framework is the first step of a two-step project, the second of which will lay out a detailed Roadmap for putting this Framework into place in California by January 1, 2014.

The final Roadmap will reflect input from stakeholders and be grounded in the real, on-the-ground processes and systems that exist today. It will address the practical realities that pose a challenge to implementing this Framework, presenting realistic timelines and phasing.

California should use the consumer perspective as the organizing principle for its EER system in order to create a first-class user experience, as is called for by ACA. This Framework provides that new, essential vantage point.

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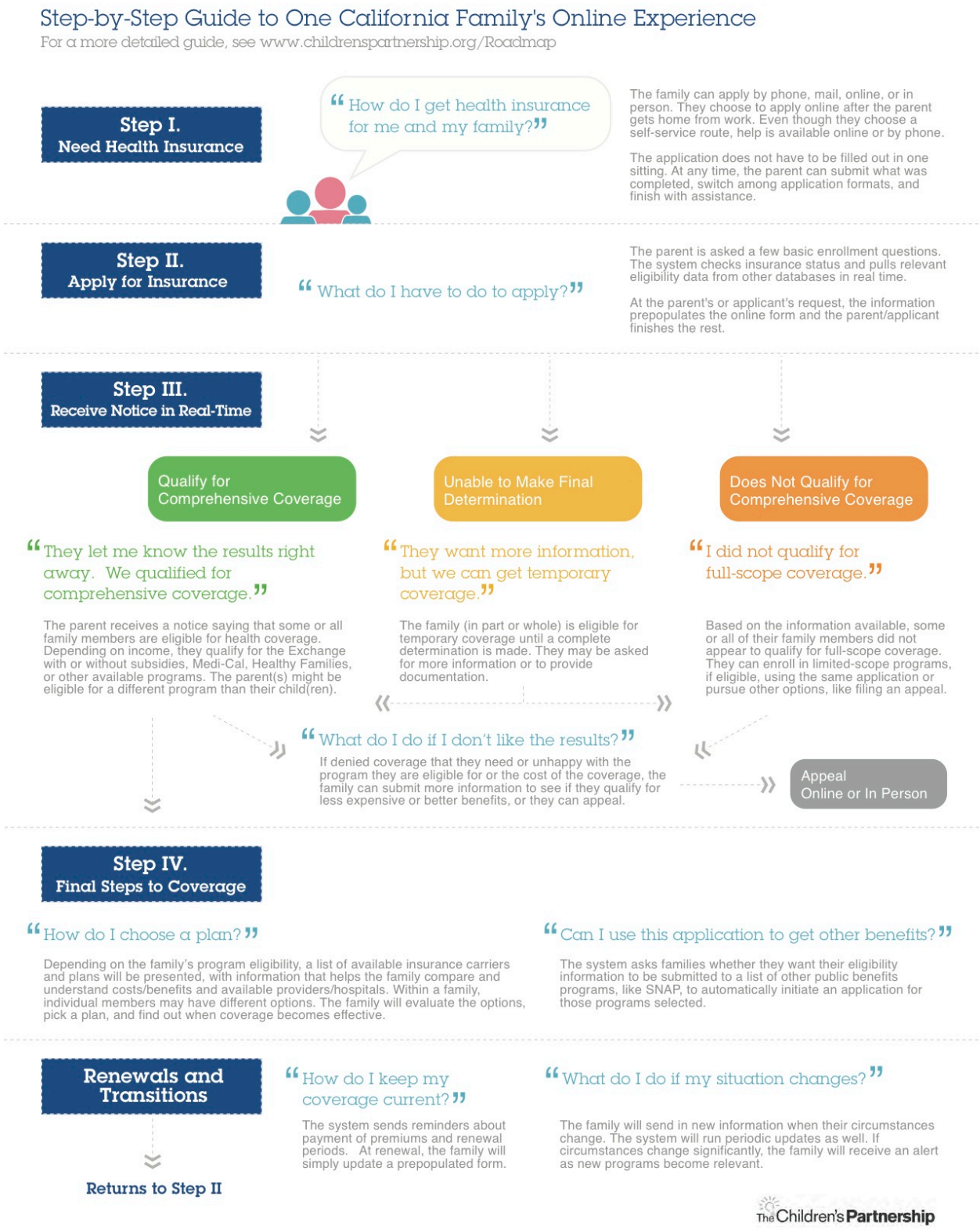
APPENDIX A


Step-by-Step Guide to One California Family's Online Experience
For a more detailed guide, see www.childrenspartnership.org/Roadmap
Step I.
Need Health Insurance
"How do I get health insurance for me and my family?"
The family can apply by phone, mail, online, or in person. They choose to apply online after the parent gets home from work. Even though they choose a self-service route, help is available online or by phone.
The application does not have to be filled out in one sitting. At any time, the parent can submit what was completed, switch among application formats, and finish with assistance.
Step II.
Apply for Insurance
"What do I have to do to apply?"
The parent is asked a few basic enrollment questions. The system checks insurance status and pulls relevant eligibility data from other databases in real time.
At the parent's or applicant's request, the information prepopulates the online form and the parent/applicant finishes the rest.
Step III.
Receive Notice in Real-Time
Qualify for Comprehensive Coverage
Unable to Make Final Determination
Does Not Qualify for Comprehensive Coverage
"They let me know the results right away. We qualified for comprehensive coverage."
The parent receives a notice saying that some or all family members are eligible for health coverage. Depending on income, they qualify for the Exchange with or without subsidies, Medi-Cal, Healthy Families, or other available programs. The parent(s) might be eligible for a different program than their child(ren).
"They want more information, but we can get temporary coverage."
The family (in part or whole) is eligible for temporary coverage until a complete determination is made. They may be asked for more information or to provide documentation.
"I did not qualify for full-scope coverage."
Based on the information available, some or all of their family members did not appear to qualify for full-scope coverage. They can enroll in limited-scope programs, if eligible, using the same application or pursue other options, like filing an appeal.
"What do I do if I don't like the results?"
If denied coverage that they need or unhappy with the program they are eligible for or the cost of the coverage, the family can submit more information to see if they qualify for less expensive or better benefits, or they can appeal.
Appeal
Online or In Person
Step IV.
Final Steps to Coverage
"How do I choose a plan?"
Depending on the family's program eligibility, a list of available insurance carriers and plans will be presented, with information that helps the family compare and understand costs/benefits and available providers/hospitals. Within a family, individual members may have different options. The family will evaluate the options, pick a plan, and find out when coverage becomes effective.
"Can I use this application to get other benefits?"
The system asks families whether they want their eligibility information to be submitted to a list of other public benefits programs, like SNAP, to automatically initiate an application for those programs selected.
Renewals and Transitions
Returns to Step II
"How do I keep my coverage current?"
The system sends reminders about payment of premiums and renewal periods. At renewal, the family will simply update a prepopulated form.
"What do I do if my situation changes?"
The family will send in new information when their circumstances change. The system will run periodic updates as well. If circumstances change significantly, the family will receive an alert as new programs become relevant.
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End Notes

[1] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Guidance for Exchange and Medicaid Information Technology (IT) Systems, Version 2.0* (Baltimore, MD: May 2011) 4.
[2] Nadereh Pourat, et al., *Californians Newly Eligible for Medi-Cal Under Health Reform* (Los Angeles, CA: UCLA Center for Health Policy Research, May 2011) 1; Nadereh Pourat, et al., *Who Can Participate in the California Health Benefit Exchange?* (Los Angeles, CA: UCLA Center for Health Policy Research, May 2011) 1.
[3] Hanh Kim Quach, *New Federal Health Law Will Significantly Expand Medi-Cal Eligibility and Enrollment* (Sacramento, CA: California Budget Project, Oct. 2010).
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[5] For example: Western Center on Law & Poverty, *SB87 Guide: Changes in the Medi-Cal Eligibility Determination Process* (Los Angeles, CA: Western Center on Law & Poverty, Nov. 2001); The Children's Partnership, *California's Express Enrollment Program* (Santa Monica, CA: The Children's Partnership, Jul. 2006); Catherine Teare, et al., *Connecting Kids to Health Coverage: Evaluating the Child Health and Disability Prevention Gateway Program* (Oakland, CA: California HealthCare Foundation, Aug. 2007); Debra Roth and Deborah Kelch, *Making Sense of Managed Care Regulation in California* (Oakland, CA: California HealthCare Foundation, Nov. 2001).
[6] California Health and Human Services Agency, Office of Systems Integration, *Enterprise Enrollment Portal: Implementation Advance Planning Document* (Sacramento: California Health and Human Services Agency, Jun. 2009).
[7] California Legislative Analyst's Office, *Moving Forward with Eligibility and Enrollment Process Improvement* (Sacramento: LAO, 3 May 2010) 9-10.
[8] Ibid.; Eclipse Solutions, *Modernizing Enrollment in California's Health Programs for Pregnant Women and Children: A Blueprint for the Future* (Sacramento, CA: Eclipse Solutions, 10 Aug. 2007).
[9] Beth Morrow and Julia Paradise, *Explaining Health Reform: Building Enrollment Systems that Meet the Expectations of the Affordable Care Act* (Washington, DC: The Children's Partnership and Kaiser Commission on Medicaid and the Uninsured, Oct. 2010).
[10] Beth Morrow and Julia Paradise, *Explaining Health Reform: Eligibility and Enrollment Processes for Medicaid, CHIP, and Subsidies in the Exchanges* (Washington, DC: The Children's Partnership and Kaiser Commission on Medicaid and the Uninsured, Aug. 2010).
[11] U.S. National Archives and Records Administration, Office of the Federal Register, *Federal Register*, Vol. 76, No. 75 (19 Apr. 2011): 21959.
[12] Op. cit. (1).
[13] §1561 Adopted Standards Recommendations, Appendix A defines consumer-mediated as: "Adopting approaches where the consumer has the authority to make choices and direct use and reuse (i.e., for themselves, by programs or by other authorized third parties) of their enrollment information to the extent practicable."
[14] It is important to note that the program landscape in California is in transition. Changes being considered include the operation of a Basic Health Plan and the option of moving some or all Healthy Families enrollees into Medi-Cal. In addition, it is still unclear what other options will be available, such as county programs and Family PACT.
[15] The Enrollment UX 2014 project is a public-private partnership working to deliver design specifications to support a best-in-class user experience to help ensure that large numbers of eligible consumers successfully enroll in and retain coverage. For further information, see http://www.healthexchange.ca.gov/Documents/Meeting-Materials/24MAY2011/Eligibility%20and%20Enrollment%20-%20First%20Class%20User%20Experience%20Design%20for%20ACA%20Enrollment.pdf.

Box, Page 3

[a] 100% Campaign, "California Children's Health Coverage" (17 Mar. 2011, analyzing 2009 California Health Interview Survey data) (available at www.100percentcampaign.org).
[b] Op. cit. (Catherine Teare, et al., 5) 25.
[c] California Health and Human Services Agency, Office of Systems Integration, *Enterprise Enrollment Portal Project: Implementation Advance Planning Document* (Sacramento: California Health and Human Services Agency, Jun. 2009) 14.
[d] California Legislative Analyst's Office, *Moving Forward with Eligibility and Enrollment Process Improvements* (Sacramento: LAO, 3 May 2010) 9.
[e] Hubbert Systems Consulting, *Medicaid Information Technology Architecture State Self-Assessment* (Washington, DC: U.S. Department of Health Care Services, Office of HIPPA Compliance, 30 May 2008) 9.

Other E-Enrollment and Health IT Resources from The Children's Partnership

Available at www.childrenspartnership.org

From Silos to Linkages: Improving Outcomes for Vulnerable Youth Through the Wise Use of Information Technology (2011)

Mobile Technology: Smart Tools to Increase Participation in Health Coverage (2011)

Explaining Health Reform: Building Enrollment Systems that Meet the Expectations of the Affordable Care Act (2010)

Explaining Health Reform: Eligibility and Enrollment Processes for Medicaid, CHIP, and Subsidies in the Exchanges (2010)

Building an Express Lane Eligibility Initiative: A Roadmap of Key Decisions for States (2010)

Electronic Information Exchange for Children in Foster Care: A Roadmap to Improved Outcomes (2010)

School-Based Telehealth: An Innovative Approach to Meet the Health Care Needs of California Children (2009)

Technology-Enabled Innovations for Improving Children's Health (2009)

Building Efficient and Effective Medicaid and CHIP Enrollment Systems: Core Requirements to Ensure the Greatest Value for Children and Families (2009)

E-Health Snapshot: Federal Support for Health Information Technology in Medicaid - Key Provisions in the American Recovery and Reinvestment Act (2009)

Improving Health Outcomes for Children in Foster Care: The Role of Electronic Record Systems (Full Report, 2008; Executive Summary, 2009)

E-Health Snapshot: A Look at Emerging Health Information Technology for Children in Medicaid and SCHIP Programs (2008)

Information Technology Making a Difference in Children's Lives: An Issue Brief for Leaders for Children (2008)

Meeting the Health Care Needs of California's Children: The Role of Telemedicine, 2nd Edition (2008)

E-Health Snapshot: Harnessing Technology to Improve Medicaid and SCHIP Enrollment and Retention Practices (2007)

About The Children's Partnership

The Children's Partnership (TCP) is a national, nonprofit organization working to ensure that all children—especially those at risk of being left behind—have the resources and opportunities they need to grow up healthy and lead productive lives. The Children's Partnership focuses particular attention on the goals of securing health coverage for every child and their families and on ensuring that the opportunities and benefits of digital technology reach all children. Consistent with that mission, we have educated the public and policy-makers about how technology can measurably improve children's health, education, safety, and opportunities for success. We work at the state and national levels to provide research, build programs, and enact policies that extend opportunity to all children and their families.

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