



Connecting Consumers to Coverage: The Role of Navigators and Consumer Assistance Programs in Implementing Health Reform in New York

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PREPARED BY:

Trilby de Jung
Empire Justice Center

Carrie Tracy
Elisabeth R. Benjamin
Community Service Society



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The Empire Justice Center is a statewide organization devoted to improving the systems under which low-income New Yorkers live. Empire Justice engages in policy advocacy and analysis, provides back-up support to legal services and community-based organizations, and engages in impact litigation in health access and other issue areas critical to low-income families.

The Community Service Society of New York (CSS) is an informed, independent, and unwavering voice for positive action that serves the needs of low-income New Yorkers.

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Executive Summary

New York has the historic opportunity to successfully link its consumers and small businesses with health coverage as it implements the new Federal health reform law, the Affordable Care Act (ACA). The ACA promises to provide coverage to 32 million Americans and help bring down the cost of coverage for millions of others.¹ Individuals will be mandated to have coverage and employers will either have additional coverage incentives or responsibilities, depending on the number of people they employ. Enrollment systems in each state will have to be brought to scale in relatively little time to prepare for the surge of new consumers.

Recognizing this enrollment challenge, the ACA requires that each state either establish its own state-based health insurance exchange or default to a Federal exchange by 2014. The exchanges will facilitate individual enrollment in public coverage and affordable commercial coverage. Low- and middle-income consumers who do not qualify for public coverage will receive subsidies to purchase private insurance. Additionally, small businesses will be able to purchase coverage for their employees through the exchange. While the details have yet to be settled upon, a broad consensus has emerged that New York will opt to establish its own exchange, which is expected to enroll as many as 1.2 million—out of a total 2.6 million uninsured—New Yorkers.

The success of New York's exchange will depend largely on the ability of individuals and small businesses to enroll in and maintain health insurance coverage. No doubt, successful coverage rates will require a broad publicly-funded social marketing campaign—much like the one Massachusetts used when it implemented its State-based health reform effort.² But despite the best laid marketing plans, purchasing and enrolling in coverage will remain a daunting task for many individuals and small businesses alike.

To help consumers with the enrollment challenge, the ACA directs state exchanges to establish a Navigators program (Navigators) to coordinate with Consumer Assistance Programs (CAPs). Together, these programs are charged with helping individuals and small businesses make good coverage choices, streamline enrollment, and troubleshoot coverage problems when and if they arise. The ACA assigns functions to Navigators and CAPs and provides some examples of the type of entities that could serve as Navigators and CAPs, but the exact parameters and interplay between the two programs remain unsettled.

Both programs are charged with providing enrollment assistance and education for consumers. Navigators are specifically charged with providing culturally and linguistically appropriate education information and enrollment assistance. CAPs likewise are charged with providing education and enrollment information, but also are directed to provide consumers and small businesses with information on consumer rights and responsibilities, assist them with appeals, and conduct trends analysis. Federal guidance is unclear about how the two programs will coordinate with each other beyond requiring Navigators to make referrals to CAPs for more

Executive Summary *(continued)*

intensive consumer assistance.³ Likewise, Federal guidance is opaque about the continuing role of existing systems of insurance enrollment—health plans, brokers, local government offices, health care providers, and so forth.

Despite the ACA's recognition that effective enrollment and consumer assistance is an essential component of health reform, important design questions about the Navigators and CAPs remain unanswered and must be resolved for New York to move forward: What should be the core functions of Navigators and CAPs in New York? How should New York structure and administer its Navigators and CAPs to maximize integration and avoid duplication of efforts? How should New York leverage existing enrollment and consumer assistance resources into the Navigators and CAPs? How much will the Navigators and CAPs cost and how should they be funded?

This paper seeks to address these questions and the unresolved ambiguities presented by the ACA. To do so, we conducted an analysis of New York's existing enrollment and assistance landscape; held a series of facilitated conversations and interviews around New York State with key stakeholders—nearly 250 in all; and augmented unanswered questions with legal analysis and a review of the existing literature. Although this report takes into consideration the viewpoints of a variety of stakeholders around New York representing different interests, the final recommendations are the authors' own.

Accordingly, this report addresses the ambiguities concerning the duties of the two programs, distills key points from stakeholder discussions and research, and presents recommendations on how New York should design its Navigators and CAPs in order to avoid duplication and best meet the ACA's enrollment and assistance challenges. Key recommendations about how New York should implement its Navigators and CAPs are as follows:

RECOMMENDATION #1: THE ESSENTIAL FUNCTIONS OF NAVIGATORS AND CAPS SHOULD BE INTEGRATED INTO A SINGLE PROGRAM

Stakeholders were routinely confused by the perceived functional overlap between Navigators and CAPs under the ACA and believed consumers would likewise confuse the two programs given their apparent redundancy of services. To avoid duplication and confusion, we recommend that:

- ▶ New York should create one integrated program that meshes the full range of functions of both the Navigators and CAPs.
- ▶ All New Yorkers in need of health care help, including small businesses, should be eligible for assistance from the new, integrated program, regardless of the form of coverage they qualify for or purchase. However, the program should prioritize those groups who need the most assistance navigating the health care system.
- ▶ The integrated program should not be responsible for the exchange's broad-based social marketing/media promotion campaign, but should be consulted to ensure appropriate targeting and consistency in message and materials.

RECOMMENDATION #2: THE NAVIGATOR/CAP SHOULD USE A “HUB-AND-SPOKES” ADMINISTRATIVE INFRASTRUCTURE

Stakeholders pointed out that not every consumer or small business needs every service offered by the Navigators and CAPs, and that services could be performed by different groups with different areas of expertise. However, all New Yorkers should receive high-quality, internally consistent services. To best allocate limited public resources, we recommend that:

- ▶ The integrated Navigator/ CAP should feature a single entity or exchange staff serving as a central hub to ensure consistency of the services throughout the State. This hub should contract with the other entities (“spoke groups”) around the State best suited to provide the required services to targeted populations.
- ▶ To ensure that New Yorkers can access high-quality, consistent services, we recommend that the central hub:
 - implement a training and quality assurance program and develop common outreach and educational materials;
 - maintain a central web-based database to enroll consumers and small businesses, monitor spoke groups’ performance, and analyze trend data;
 - ensure that an appropriate level of liability insurance is adopted; and
 - establish uniform privacy protection standards for all Navigator/CAP entities.

RECOMMENDATION #3: THE NAVIGATOR/CAP SHOULD LEVERAGE EXISTING RESOURCES BY SOLICITING GRANT APPLICATIONS, FORMALIZING RELATIONSHIPS, AND OFFERING TECHNICAL ASSISTANCE

Stakeholders noted that many of New York’s existing resources, including community-based facilitated enrollers, chambers of commerce, affinity groups, and nonprofits, are ideally positioned to provide Navigator and CAP services. To leverage these existing resources, we recommend that:

- ▶ Existing community-based and business-oriented groups should be solicited to become spoke groups. Care should be taken in this transition to ensure that current enrollment and assistance capacity is maintained and exceeded in 2014.
- ▶ Navigator/CAP spoke groups should have a formalized relationship with State and local officials, who will remain an important resource.
- ▶ The central hub should offer resources to and accept consumer assistance referrals from groups who offer significant enrollment assistance but may be barred from becoming Navigators. Resources should include training and other materials.

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- ▶ To further ensure consistency of services throughout the State, New York should continue support for plan-based facilitated enrollers in the public insurance market to maintain critical enrollment capacity for low-income people not legally mandated to carry coverage.

RECOMMENDATION #4: FINANCING FOR THE NAVIGATOR/CAP SHOULD BE SECURED FROM AVAILABLE FEDERAL FUNDS AND FEES ON INSURERS OPERATING INSIDE AND OUTSIDE THE EXCHANGE

Stakeholders identified a variety of financing possibilities. We recommend that:

- ▶ Funding currently designated for enrollment assistance and consumer support should be rolled over into New York's new Navigator/CAP, including:
 - Exchange and Establishment Grant funds (in the near term, 2011-2014); and
 - Funds currently set aside for community-based facilitated enrollment, once those enrollers are transitioned into the new Navigator/CAP.
- ▶ A portion of the Medicaid administrative funding that will be used to support the exchange should be directed to the new Navigator/CAP.
- ▶ Ongoing funding from exchange activities should be generated through broad-based fees on insurers both inside and outside the exchange.

Introduction

The Core Functions of Navigators and Consumer Assistance Programs

Under the ACA, most residents of the United States—with some notable exceptions—will be mandated to have health insurance coverage.⁴ States must design and implement a health insurance exchange, or opt into a Federal one, to facilitate enrollment in coverage. Exchanges essentially will be web-friendly marketplaces where individuals and small businesses can view their health insurance options, enroll in public coverage or private plans, and apply for subsidies. As a result, in 2014, an estimated 32 million uninsured people are expected to enroll in coverage.⁵

For New Yorkers, the ACA means that many of the existing 2.6 million uninsured will soon be required to either have coverage, seek an exemption from doing so, or pay a penalty. Because the individual mandate will not apply to everyone, and largely because it will not apply to New York's lowest-income residents, experts believe that approximately 1.2 million New Yorkers will gain coverage,⁶ as follows:

- ▶ Roughly half of enrollment will be in Medicaid, as eligibility is expanded to include people with incomes up to 138% of the Federal Poverty Level (FPL) (or \$25,600 for a family of three in 2011).⁷
- ▶ Potentially, another 467,000 New Yorkers would enroll in a Basic Health Plan, if New York adopts one.⁸
- ▶ If New York does not adopt a Basic Health Plan, roughly 600,000 people with incomes up to 400% of FPL (or \$67,000 for a family of three) will enroll in subsidized commercial health plans in the new exchange.⁹
- ▶ Some individuals who do not qualify for subsidies will purchase coverage through the exchange,¹⁰ and others will accept job-based offers of coverage rather than pay a penalty.¹¹

As described immediately below, the ACA provides for two programs designed to educate and assist these varied consumers with enrollment and use of their health coverage: Navigators Programs (Navigators) and Consumer Assistance Programs (CAPs). Their core functions are as follows.

NAVIGATOR PROGRAMS

Starting in 2014, state exchanges must establish Navigators which will “at least”¹² : act as insurance information experts, facilitate enrollment into Qualified Health Plans (QHPs),¹³ and make appropriate referrals to CAPs.¹⁴ Navigators must offer culturally and linguistically appropriate outreach and education in order to facilitate enrollment.¹⁵ Federal law and guidance does not require Navigators to enroll consumers into public health insurance programs as

Introduction *(continued)*

well as QHPs. However, Federal guidance does offer Federal funding to states that elect to use Navigators to enroll consumers into federally-funded Medicaid and the State Children's Health Insurance Program.¹⁶

The ACA specifies the types of organizations that might qualify as Navigators (including trade groups, professional associations, and community nonprofits), and explicitly bars any entity serving as a Navigator from receiving compensation from a health insurance plan in connection with enrollment.¹⁷ As described later, this is potentially problematic for brokers, who customarily are compensated directly by insurers. In July 2011, the U.S. Secretary of Health and Human Services issued proposed exchange guidance indicating exchanges must provide Navigator grants to groups from at least two of the following categories: (1) community and consumer-focused nonprofit groups; (2) trade, industry, and professional associations; (3) commercial fishing, ranching, and farming groups; (4) Chambers of Commerce; (5) unions; (6) resource partners for the small business administration; (7) licensed agents and brokers; and (8) other public or private entities (e.g., Indian tribes, State or local human service agencies).¹⁸

CONSUMER ASSISTANCE PROGRAMS (CAPS)

The ACA also creates state-based CAPs to help consumers understand and use the complex new health coverage options. The CAPs' duties are to: (1) assist consumers with grievance and appeals; (2) collect and track consumer problems with health plans; (3) provide education and information to consumers about their rights and responsibilities; (4) assist consumers with enrollment; and (5) resolve consumer problems with securing tax credits. Initial Federal funding for CAPs was authorized in October 2010. Consumer assistance related to exchange activities will be available to states through 2014 under Exchange Establishment Grants. Unlike Navigators, CAPs must help individuals whether they acquired coverage through the exchange or through other means.

Under the ACA, states can designate an independent agency or an ombudsman to serve as their CAP. In October 2010, New York designated Community Health Advocates (CHA), a project of the Community Services Society, to act as New York State's CAP. CHA currently performs the first four of the required CAP functions and is exploring mechanisms to conduct outreach and provide tailored services to the small business community.¹⁹

Table 1 presents key components of the two programs in a side-by-side comparison, describing the functions with language from the most recent Federal guidance (statutory terms are used for CAPs because no Federal guidance has been issued to date).

Introduction (continued)

TABLE 1: Key Components of Consumer Assistance and Navigator Programs Under the ACA		
	NAVIGATORS	CAPS
ACA Section	§1311(i)	§1002
Timing	Start date: 2014	Start date: October 2010
Funding & Administration	<ul style="list-style-type: none"> Exchange generates funding for Navigators & awards grants. Qualifying states may also claim a share of Medicaid/SCHIP administrative match. 	<ul style="list-style-type: none"> States receive HHS funding for state-based programs. ACA authorization \$30 million (\$2.2 million in New York State) in FY 2011. HHS funding for consumer assistance related to exchange activities under Exchange Establishment grants through FY 2014.
Functions	<p>NAVIGATORS MUST “AT LEAST” PERFORM THE FOLLOWING DUTIES:</p> <ul style="list-style-type: none"> Maintain expertise in eligibility, enrollment, and program specifications and conduct public education; Provide information and services in a fair, accurate, and impartial manner; Facilitate enrollment in QHPs; Refer enrollees with questions, grievances, or complaints about health plans or coverage to CAPs or other appropriate State agency; and Provide information in a culturally and linguistically appropriate way, ensuring access for consumers with disabilities. 	<p>CAPS MUST PERFORM THE FOLLOWING DUTIES:</p> <ul style="list-style-type: none"> Assist consumers with appeals and grievances; Collect, track, and quantify problems and inquiries from consumers with group health plans and other health insurance coverage; Educate consumers on their rights and responsibilities with respect to health insurance coverage; Help consumers with enrollment in health insurance coverage by providing information, referrals and assistance; and Resolve consumer problems with obtaining tax credits.
Entities	<p>BROAD LIST OF BUSINESS AND COMMUNITY GROUPS ELIGIBLE. GRANT RECIPIENTS MUST INCLUDE ENTITIES FROM AT LEAST TWO CATEGORIES:</p> <ul style="list-style-type: none"> Community and consumer-focused nonprofit groups; Trade, industry, and professional associations; Commercial fishing, ranching, and farming groups; Chambers of Commerce; Unions; Resource partners for the small business administration; Licensed agents and brokers; and Other public or private entities (e.g., Indian tribes, State or local human service agencies). 	<p>STATE HAS CHOICE OF:</p> <ul style="list-style-type: none"> Independent office of health insurance consumer assistance; or State ombuds program.

SOURCES: ACA, PL 111-148, §§1002, 1311(i); Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866 (proposed July 15, 2011) (to be codified at 45 CFR pt. 155); Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges. Special Programmatic Terms and Conditions, ¶1.

Introduction *(continued)*

The ACA’s description of the functions of Navigators and CAPs creates an ambiguity and overlap between the two programs—especially in the area of education and enrollment in coverage—and raises important questions about how the two programs should relate to one another, as well as to existing consumer enrollment and assistance resources. This report seeks to address these questions in New York.

We begin with a review of existing enrollment and consumer assistance infrastructure, and then provide input gained through a broad series of meetings held with stakeholders around the State. The result is a series of recommendations on how New York should design its Navigator and CAP in order to avoid duplication of programs and services and deliver critically needed consumer assistance in the most efficient and effective manner possible.

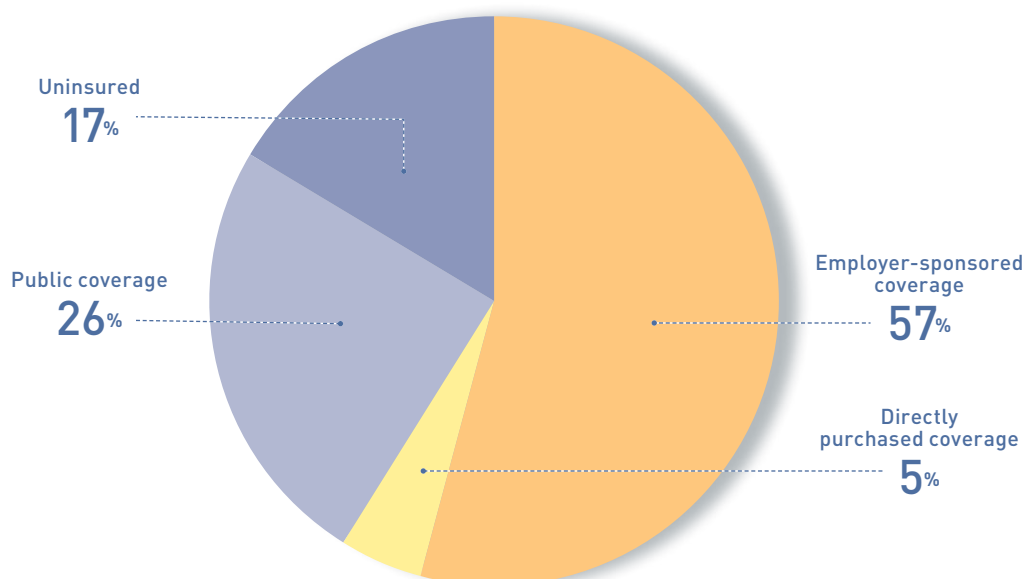
THE CURRENT LANDSCAPE IN NEW YORK:

Where New Yorkers Go to Get Help with Enrolling in and Using Their Health Care Coverage

New York has led the nation in providing both enrollment and consumer assistance services. The ACA provides an important opportunity for New York to review and build on this foundation. This section briefly reviews the existing enrollment and assistance landscape formed in response to the current distribution of insurance coverage in New York. Appendix A lists entities that offer enrollment assistance to small businesses and individuals seeking or using health coverage. Appendix B lists groups that are active in assisting consumers with problems that arise after coverage is in place.

Providers of consumer enrollment and assistance in New York reflect the sources of coverage currently available to consumers. As described in [Table 2](#), more than half of the 16.7 million New York residents under the age of 65 have insurance through their employers, which traditionally offer enrollment and basic troubleshooting assistance by human resources departments in large and mid-sized employers and by brokers and agents or Chambers of Commerce and other professional associations for small-sized employers.

TABLE 2: 2009 SOURCES OF HEALTH COVERAGE FOR NEW YORKERS UNDER AGE 65



SOURCE: CSS Analysis of U.S. Census Bureau, Current Population Survey, 2010 Annual Social and Economic Supplement (numbers do not total to 100% because individuals report multiple forms of coverage during the reporting year).

The Current Landscape in New York: Where New Yorkers Go to Get Help with Enrolling in and Using Their Health Care Coverage (*continued*)

One quarter of New Yorkers (approximately 4.2 million) are enrolled in public health programs. There are many programs to assist them with enrollment and navigation, including State and local government offices, Maximus, CHA, and other community-based organizations (CBOs). As described in detail in Appendix A, local governments and Facilitated Enrollers (FEs) are responsible for handling hundreds of thousands of public insurance applications and renewals each year.

Approximately 17% (2.6 million) of New Yorkers are uninsured. Most of these people have incomes below 300% percent of the FPL (\$67,000 for a family of three in 2011). Many uninsured people use free or low-cost health care clinics for their health care, and seek insurance information through the Internet and the groups listed in the preceding paragraph.

The individual market in New York is tiny (fewer than 25,000 enrollees)²⁰ because of extremely expensive premiums—running to more than \$1,000 per month for an individual.²¹ Only 5% of consumers purchase coverage for themselves directly from an insurance carrier. These consumers seek enrollment assistance most often from the insurance carriers themselves, the Internet, or affinity groups. Consumers in the individual market who encounter problems also resort to informational websites, and seek assistance from state and local agencies, CHA, professional associations, and other affinity groups.

When a consumer enrolled in job-based coverage encounters a problem accessing services, generally the first step is to contact the employer, insurer, or health care provider. That first call often resolves the problem. Small business employees often turn to brokers, agents, and Chambers of Commerce who helped set up their coverage when a call to the carrier does not resolve the issue.²²

As described in Appendix B, State regulatory agencies and CBOs also play an important role in assisting consumers with problems that are not easily resolved, such as: enrollment and eligibility issues, denials of eligibility, claims and billing disputes, health plan and charity care denials, grievances, and appeals. New York's regulatory agencies help consumers with thousands of requests for help with public and private coverage every year. The Department of Health, Department of Insurance, Attorney General, and Division of Consumer Protection are principal government venues for health consumer assistance.²³ Each of these State units screens calls to determine whether the unit can use its enforcement powers to resolve the problem, or refer it to another State agency.

Consumer-oriented advocacy groups and community nonprofits offer services through trusted, mission-driven employees who often live and work in the communities they serve. These community-based resources have proved vital whenever consumers have experienced major health coverage transformation: for example, the transition to managed care for Medicaid beneficiaries, and the roll-out of private drug plans in Medicare.²⁴

BUILDING TOWARD THE FUTURE:

Implementing the ACA's Navigator and Consumer Assistance Program Framework in New York

As described earlier, the ACA requires states to establish Navigator programs to help individuals and small businesses enroll in coverage and CAPs to address more complex issues as they arise. The ACA and Federal guidance provide little direction on how best to coordinate or integrate the two programs. New York stakeholders have important input to offer as New York moves forward with developing its Navigator and CAP and we asked them to help address these questions:

- ▶ How can New York best achieve the core functions of the Navigators and CAPs?
- ▶ How should New York structure and administer its Navigators and CAPs to assure integration and coordination?
- ▶ How can New York leverage existing resources into the Navigators and CAPs?
- ▶ How much will the Navigators and CAPs cost and how should they be financed?

The answers to these questions, addressed through in-depth discussions with a significant number of stakeholders and supplemented with additional legal and policy research, are summarized below.

STAKEHOLDER MEETINGS

The findings of this report are based on original policy research conducted by the Community Service Society (CSS) and the Empire Justice Center (Empire Justice). CSS conducted a literature review of relevant laws, regulations, and guidance and policy papers. CSS and Empire Justice created materials including a conversation guide and presentation to be used in stakeholder convenings. To ensure geographic diversity, nine convenings were held around the State, in New York City, Rochester, Buffalo, Troy, Binghamton, Watertown, and Long Island. Participants in these meetings included consumer advocates, facilitated enrollers, brokers, immigrant organizations, providers, government agencies, consumers, and more. The convenings were facilitated by the Children's Defense Fund – New York (CDF-NY), the New York Immigration Coalition (NYIC), the Public Policy and Education Fund of New York, the Medicare Rights Center (MRC), The Legal Aid Society (LAS), Medicaid Matters New York (MMNY), and the New York Association on Independent Living (NYAIL). CSS and Empire Justice conducted interviews with an additional 46 individual stakeholders, including staff at existing consumer assistance programs in New York State, brokers, general agents, New York City and State officials, public health insurance plans, and affinity groups. In all, we met or spoke with more than 240 Stakeholders.²⁵ A complete list of interviews can be found in Appendix C. Input from these Stakeholders has been integrated into the recommendations discussed in this paper.

Building Toward the Future: Implementing the ACA's Navigator and Consumer Assistance Program Framework in New York *(continued)*

HOW CAN NEW YORK BEST ACHIEVE THE CORE FUNCTIONS OF THE NAVIGATORS AND CAPS?

This section addresses how New York can best deliver the core Navigator and CAP functions, while simultaneously avoiding duplication of services. As described in the introduction above, the ACA requires Navigators to focus on: (1) public education and (2) enrollment into QHPs offered through the exchange. While CAP services overlap with Navigator services in the areas of (1) public education and (2) enrollment, they also provide (3) assistance to consumers with appeals and grievances; (4) collection and reporting of data and identification of trends in consumer problems; and (5) resolution of consumer problems with tax credits. As described below, this report recommends that New York integrate all five functions into a single Navigator/CAP capable of helping all New Yorkers access health care coverage and services.

One-Stop Shopping

The stakeholders with whom we met were consistently challenged by the apparent functional overlap of services offered by Navigators and CAPs, as described in the ACA. Concern about potential duplication of services in the area of education and enrollment led some to suggest that Navigators conduct all education and enrollment, and CAPs should focus on helping consumers use their health plans, appeal adverse decisions, collect data and monitor trends.²⁶ Others felt that both types of entities should perform education and enrollment.²⁷ Virtually all stakeholders expressed concern that consumers would confuse the two programs and get lost in a maze of referrals. They stressed the need for “one-stop shopping” for consumers.

Ultimately, most stakeholders recommended that consumers should be able to get information and enrollment help whether they arrive at the door of a Navigator or a CAP.²⁸

Another wrinkle to this apparent overlap about the programs' functions stems from a confusion about which types of consumers are supposed to be served by each program. The ACA indicates that Navigator services should target enrolling people into QHPs offered by the exchange, while CAP services target consumers with any type of health insurance, regardless of whether it's acquired inside or outside the exchange (e.g., people who have employer-sponsored coverage, self-insured plans, union sponsored plans, or Medicare and other public programs).

Stakeholders urged that New York adopt an integrated Navigator/CAP proficient in serving all consumers, regardless of the source of their coverage. In support of this position, stakeholders cited a broadly-circulated report which estimated that as many as

“
CHA is a one-stop shopping experience for New York health care consumers. We help consumers with everything from finding coverage to appealing a coverage denial, helping consumers with individual or employment-based commercial insurance, public coverage, or no coverage at all.
”

PRIYA MENDON
Director, Community Health Advocates

Building Toward the Future: Implementing the ACA's Navigator and Consumer Assistance Program Framework in New York *(continued)*

50% of those newly eligible for coverage are likely to have eligibility shifts between Medicaid and the exchange during the course of a single year.²⁹ Bolstering the argument for serving all consumers is the fact that recently issued Federal guidance does offer Federal funding to states that elect to use Navigators to enroll consumers into federally-funded Medicaid and the State Children's Health Insurance Program.³⁰

In further support of the idea of an integrated "one-stop shopping" experience, stakeholders identified three potentially overlooked groups of consumers who might need extra assistance: (1) consumers transitioning between, into, or out of job-based coverage; (2) consumers transitioning onto Medicare and/or other forms of public coverage;³¹ and (3) mixed immigrant status families (where different individual members would be eligible for different coverage, such as job-based coverage, QHPs, public insurance, or low-cost care at clinics or hospital-based financial assistance).³² All of these groups are likely to have a high need for the services of a Navigator/CAP.

The ACA requires Navigators to help small businesses/employers access tax credits and purchase coverage through the exchange, but it is difficult to predict how many small businesses will use a Navigator/CAP. Small businesses that do not offer coverage face no penalties, and many of their employees may seek coverage directly through the exchange as individuals. While not dispositive, the experience in Massachusetts indicates that only 4,500 of the 220,000 consumers enrolled through the Massachusetts Connector are from small businesses.³³ One survey of employers claimed that as many as 30% would "definitely or probably" drop coverage after 2014.³⁴ Another study quickly refuted that prediction.³⁵

Stakeholders stressed that the Navigator/CAP should reach employers and employees including the self-employed, as well as individual consumers.³⁶ At the same time, many of the broker and business stakeholders we interviewed felt that small businesses would continue their existing purchasing practices, despite the launch of a New York exchange.³⁷ We believe that small business should be actively engaged by the Navigator/CAP. However, we recommend that the initial focus of the integrated Navigator/CAP be primarily on individuals, who will need the most support and, secondarily, on small businesses that currently appear to rely on already established forms of assistance (e.g., brokers or Chambers of Commerce, as described in more detail below).

Broad-Based Outreach Campaign

Many stakeholders suggested that integration of the two programs would be the best way to leverage the available resources for education and enrollment so that staff would be knowledgeable about the broad array of coverage options.³⁸ They stressed the need for standardized outreach and education materials, so that consumers receive consistent messages about their options in familiar formats.³⁹

Stakeholders emphasized the need to adopt a regionally-responsive outreach model. They felt strongly that consumers should be able to get information about health coverage in many different ways, according to their customs and needs, including: radio or TV, ethnic media, billboards, and doctors. Several emphasized that Navigators and CAPs will not only have to

Building Toward the Future: Implementing the ACA's Navigator and Consumer Assistance Program Framework in New York *(continued)*

provide information, but also counter a great deal of misinformation, and that these efforts will not be successful without a broad-based campaign.⁴⁰ We recommend that such a campaign be launched with resources independent of the Navigator/CAP, but campaign design staff should involve the Navigator/CAP staff to ensure consistency of messaging.

Finally, any public education campaign should link the public with the Navigator/CAP as part of its message content. While it is relatively easy to have outreach efforts direct consumers to stationary Navigator/CAP sites in urban areas with good public transportation systems, the campaign also must be tailored to connecting consumers to the Navigator/CAP in geographically underserved or rural areas where staff may have to travel significant distances to reach consumers and small businesses⁴¹ and where Internet access may be limited.⁴²

Some constituencies might be hard to reach through general outreach and advertisements, or may need a different kind of assistance than most. For example, new immigrants and people with limited English proficiency or low literacy will require specialized outreach and assistance.⁴³ Hotline and Internet resources, as well as Navigator/CAP office sites, must also be carefully designed to ensure that they are accessible to people with disabilities.⁴⁴

RECOMMENDATION #1: To avoid duplication of services and to reduce confusion among consumers, we recommend that the essential functions of the Navigator and CAP be integrated into a single program. The integrated Navigator/CAP should mesh the full range of functions of both the Navigator and CAP. All New Yorkers, including small businesses, in need of health care help should be eligible for assistance from the new, integrated program, regardless of the form of coverage they qualify for or purchase. However, the program should prioritize those groups who need the most assistance navigating the health care system. The integrated Navigator/CAP program should not be responsible for the exchange's broad-based social marketing/media promotion campaign, but should be consulted to ensure appropriate targeting and consistency in messages and materials.

HOW SHOULD THE NAVIGATOR AND CONSUMER ASSISTANCE PROGRAMS BE STRUCTURED AND ADMINISTERED TO ASSURE INTEGRATION AND COORDINATION?

The ACA does not dictate the administrative structure of Navigators or CAPs, but recently proposed Federal regulations indicate that the CAP and Navigator structure should be well integrated within the exchange, stating "[t]he exchange must have a consumer assistance function, including the Navigator program ... and must refer consumers to consumer assistance programs in the State when available and appropriate."⁴⁵ A number of potential administrative models for the Navigators and CAPs were identified by the stakeholders. Given the diversity of the stakeholders' views, no uniform consensus emerged about the program's administrative structure. This section describes the administrative issues identified, and ultimately recommends that New York adopt a "hub-and-spokes" model, described below.

Some stakeholders argued that the Navigator/CAP should be administered by various regions or even counties. For example, New York City's Human Resources Administration believes there

Building Toward the Future: Implementing the ACA's Navigator and Consumer Assistance Program Framework in New York *(continued)*

should be a New York City-specific, data-driven Navigator program that leverages existing government resources. This program would make grants to entities able to successfully engage hard-to-reach individuals, such as those in culturally isolated communities, and small businesses.⁴⁶ Other stakeholders felt that different regions of the State might need geographic-specific models. For example, grants might be made to CBOs in regions where they are strong, and grants might be made to government or private entities in other areas where there is less capacity to serve as Navigator or CAP entities.⁴⁷

In the end, it appeared that the majority of stakeholders preferred to have one central statewide entity coordinate and support the grantees. These stakeholders cited ongoing difficulties that exist now with the State and 58 local governments administering enrollment for public coverage programs.⁴⁸ Some participants in the Binghamton and Watertown meetings were familiar with the CHA hub-and-spokes model and recommended its adoption as the integrated Navigator/CAP.⁴⁹ Stakeholders who participated in CHA, or who knew about CHA's work, approved of the hub-and-spokes system.⁵⁰ One stakeholder, whose program was funded as a CHA agency, said that being part of a network helped her agency remain up to date on program developments and gave it the resources needed to help consumers more effectively.⁵¹

The CBO Facilitated Enroller (FE) stakeholder participants also recommended that one central "hub" provide uniform training, a single database, and technical support for community-based "spokes," to ensure programmatic uniformity and consistency of service.⁵² Centralized data and quality control measures could ensure uniform and high-quality assistance in all parts of the State, as well as public access to performance and sentinel data.⁵³

Some suggested that a State agency should perform the hub functions because it would be accountable and have regulatory enforcement powers.⁵⁴ Others preferred that a nonprofit act as the hub, arguing that it would be more responsive to community needs.⁵⁵ Ultimately, no consensus emerged on whether the hub should be a government agency or a nonprofit.⁵⁶

Accordingly, we recommend that New York adopt an integrated hub-and-spokes model Navigator/CAP. The central hub would contract with local entities best suited to provide Navigator/CAP services across the State and should have the flexibility to contract with different agencies for different functions when appropriate. Some agencies will have the capacity to perform all of the CAP functions, while others will have the capacity only to perform the outreach, education, and referral functions assigned to Navigators. The central hub should ensure that all Navigator/CAP functions are available in all regions of the State and strive to create a network that maximizes one-stop shopping for all New Yorkers in need of assistance with accessing health care services.

We next address four related administrative issues: (1) ensuring consistent training and quality assurance; (2) collecting data; (3) adopting liability insurance; and (4) protecting consumer privacy.

Ensuring Consistent Training and Quality Assurance

The ACA directs HHS to establish standards for Navigator grantee training and licensing, if appropriate. The proposed Federal regulations essentially delegate this question to the

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states, merely stating that in order to receive a grant, a Navigator must “[m]eet any licensing, certification or other standards prescribed by the State or the exchange, if applicable.”⁵⁷

Training needs will be significant for an integrated Navigator/CAP, given the complexities involved in assessing eligibility for multiple programs. “Spokes” program staff will need to be trained to help consumers sign up for public coverage, private coverage, and subsidies, as well as to facilitate movement between coverage owing to changes in family income or circumstances.⁵⁸ Program staff will also need to ensure that small businesses are aware of all enrollment and coverage options, integrating FE-like and broker-like functions.⁵⁹

Nationally, there is a lively debate about the training and qualifications of Navigators. Consumer representatives to the National Association of Insurance Commissioners (NAIC) proposed that HHS or NAIC develop a model training program and certification exam for Navigators.⁶⁰ NAIC, upon intensive lobbying by the brokers, issued draft recommendations suggesting that Navigators be subject to the same state licensing requirements as brokers.⁶¹

In New York, there are two parallel training and certification programs. Agents and brokers who sell health insurance must take a training course approved by the State Department of Insurance and pass an exam.⁶² Facilitated Enrollers have State Department of Health training requirements, but are not licensed or certified.⁶³ Some brokers would support a proposal that the exchange develop an independent Navigator training and certification program, as long as it includes essential information about New York insurance law to protect consumers.⁶⁴

We recommend that the central hub require all spoke groups to participate in a comprehensive basic training on eligibility and enrollment in public and private options.⁶⁵ Assigned staff should pass an exam based on the curriculum in order to be certified as Navigators/CAP service providers. Program staff should also be required to take continuing education courses approved by the exchange and to pass recertification exams on a regular basis. Serious consideration should be given to continuing education requirements.⁶⁶

Given the myriad laws that apply to the services consumers will use, program staff will also need extensive training to help consumers with problems that arise once coverage is in place.⁶⁷ Some suggested that the most sensible use of resources would be to maintain separate CAP-trained advocates rather than trying to train every advocate to perform the full range of Navigator and CAP functions.⁶⁸ The central hub should have the flexibility to consider this option, among others, to erect the most effective and efficient statewide network possible.

The central hub should implement a vigorous quality assurance program to ensure that spoke groups are well trained and offering consistent services. Stakeholders urged that every consumer in the State should have a consistent experience, regardless of which Navigator/CAP group the consumer uses.⁶⁹ Accordingly, to ensure statewide consistency of services, the quality assurance program should consist of reviewing a randomized number of enrollments and other CAP services provided by spoke groups. In addition, regular meetings of spoke groups should be convened to ensure that issues are correctly identified, experiences and strategies

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are shared, and trends are spotted. This information should be shared with exchange staff and other government regulators, as appropriate. The next section addresses how data collection can further support the Navigator/CAP quality assurance mechanisms.

Collecting Data and Optimizing Web-based Tools

The ACA directs CAPs to collect and report data to HHS about problems and inquiries encountered by consumers, thus performing a “sentinel function” by analyzing the data for trends.⁷⁰ Stakeholders stressed the importance of this function and further urged that the public be able to access the analysis as well as any evaluations by the government of the performance of the program.⁷¹

We recommend requiring each spoke group in the new Navigator/CAP to collect basic data about the services provided to consumers and report these data to the central hub. The hub should use these data and other quality assurance measures to ensure that consumers receive consistent and high-quality assistance in every location, and to identify systemic enrollment issues and track the success of outreach efforts. The central hub should report data on quality assurance and trends in consumer access issues to relevant government agencies on a quarterly basis, and to the public at least annually.

A centralized hub will also be able to support the web-based tools Navigator/CAP staff will need to assist with enrollment and advocate for consumers. Stakeholders supported giving Navigator/CAP staff the ability to access the exchange’s centralized web-based enrollment program to help consumers apply for coverage and resolve problems with their coverage.⁷² Meeting participants came up with several ideas for useful web-based tools, many of which coincide with State officials’ priorities for its Early Innovator grant.⁷³

- ▶ Stakeholders agreed that the enrollment website should include an option for people to enter their income and be screened and directed, if eligible, to the public coverage application.⁷⁴
- ▶ Many felt the system should have the capacity to screen and pre-approve people for Emergency Medicaid or hospital financial assistance when they apply for coverage through the exchange and are ineligible for other options.⁷⁵
- ▶ Several meeting participants suggested that the system should have the ability to track application status and an online tool to sort and compare plans by using standardized benefits packages on an “apples-to-apples” basis.⁷⁶
- ▶ Many stressed the need for translating enrollment tools, applications, and the web portal into multiple languages and ensuring accessibility to low literacy or disabled consumers.⁷⁷
- ▶ Stakeholders also felt Navigators should have access to mobile devices to allow them to conduct enrollment in the field.⁷⁸

**What gets measured gets done,
so data collection is important.**

AILEEN MARTIN

Executive Director of the North Country Children’s Clinic

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Adopting Liability Insurance

Stakeholder conversations in New York and related conversations nationally have raised the issue of whether and to what extent Navigators and CAPs should carry liability coverage. Federal law and guidance is essentially silent on this issue.

Most brokers maintain “errors and omissions” coverage, a sort of malpractice insurance for brokers who advise consumers about health insurance.⁷⁹ Stakeholders representing national broker groups urge that all Navigators be required to carry errors and omissions insurance coverage.⁸⁰ The existing consumer enrollment and assistance programs, including CHA and the State’s Facilitated Enrollment program do not require grantees to obtain errors and omissions coverage.⁸¹ Rather than carrying this type of insurance, consumer advocates suggest that Navigator entities could carry professional liability coverage.⁸² The exchange itself could also choose to provide liability coverage or otherwise indemnify all its Navigator/CAP entities.

We recommend that the integrated Navigator/CAP hub require a minimum level of either “errors and omissions” or professional liability coverage, as appropriate.

Protecting Consumer Privacy

This section addresses the issue of how a Navigator/CAP should integrate consumer privacy protection rules. Experts have questioned whether Navigators are subject to Federal health and finance privacy laws, specifically the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Gramm-Leach-Bliley Act (GLBA). Stakeholders also identified possible privacy concerns for consumers.⁸³

Federal exchange guidance allows “responsible parties,” presumably including a Navigator/CAP, to file electronic applications on behalf of consumers and sets out a framework for privacy and security standards.⁸⁴ Based on this guidance, it appears that New York’s exchange will be governed by the HIPAA privacy rule since it will determine a consumer’s eligibility for insurance subsidies and public coverage. The HIPAA privacy rule poses a challenge for the Navigator/CAP program because it requires covered entities to obtain a written release before accessing protected health information—potentially a significant barrier to enrollment.⁸⁵

Two solutions present themselves. First, the exchange could consider the Navigator/CAP a “business entity” under HIPAA, enabling it to access exchange records without a separate release.⁸⁶ Second, the exchange could include a “check off” box on applications so that Navigator/CAP staff can be deemed “responsible parties” with consent to handle protected health information. We suggest adopting both of these solutions. The large civil penalty of \$25,000 against any person who knowingly or willfully discloses or inappropriately uses confidential information by the exchange offers further privacy safeguards.⁸⁷

Finally, we do not believe that the Navigator/CAP program falls under the GLBA because their staff will not be selling insurance.⁸⁸ Federal guidance does not refer to GLBA as a relevant standard for state exchanges.⁸⁹

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RECOMMENDATION #2: We recommend that the Navigator/CAP use a “Hub-and-Spokes” administrative infrastructure. A single entity or exchange staff should act as the central hub to ensure consistency of the services throughout the State. This hub should contract with the other entities (“spoke groups”) around the State best suited to provide the required services to targeted populations. This administrative structure will ensure that consumers and small businesses are able to access the appropriate level of service to meet their unique needs. To ensure that New Yorkers can access high-quality, consistent services, we recommend that the central hub: (1) implement a training and quality assurance program and develop common outreach and educational materials; (2) maintain a central web-based database to enroll consumers and small businesses, monitor spoke performance, and analyze trend data; (3) ensure that an appropriate level of liability insurance is adopted; and (4) establish uniform privacy protection standards for all Navigator/CAP entities.

HOW CAN NEW YORK LEVERAGE EXISTING RESOURCES INTO A NEW NAVIGATOR/CAP?

This section addresses the potential concern that New York might not build on its existing resources when establishing a Navigator/CAP. Among the stakeholders, there was strong consensus that New York’s Navigator/CAP should build on the solid foundation of existing enrollment and consumer assistance agencies active in the State.⁹⁰ These entities are described in Appendices A and B.

While some felt that governmental agencies should be given preference for inclusion in New York’s new Navigator/CAP,⁹¹ many preferred nonprofit CBOs in the role of Navigator/CAP grantees.⁹² A number of stakeholders pointed to the success of the community-based FEs, which reach isolated and vulnerable populations, including rural residents, seniors, consumers in transition or crisis, low-income and unemployed people, homeless, migrant and seasonal workers, persons with physical and mental disabilities, young adults, and immigrants.⁹³

New York’s FE program has been a national leader in increasing enrollment of eligible children and adults in public coverage. Through this program, New York funds services provided by trained advocates at both CBOs and public health plans (PHPs).⁹⁴ Community-based FEs are uniquely able to perform effective community outreach to hard-to-reach populations. We recommend transitioning the CBO-based FEs into the integrated Navigator/CAP. Their functions should be broadened accordingly to enable them to work effectively with elderly and disabled consumers, small businesses, and middle-income consumers who will be purchasing insurance or otherwise getting information through the exchange. PHP-based FEs should be maintained outside of the new Navigator/CAP, as described in greater detail below.

Nonprofits and those Chambers of Commerce and affinity groups which are not barred from participation as Navigators also should be transitioned into the new Navigator/CAP. Those with existing relationships with small businesses and other key constituencies will be critical spokes in the wheel of the Navigator/CAP. Some of these entities are described in Appendices A and B.

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Resources Outside the New Navigator/CAP

Some existing enrollment and consumer assistance resources will not or cannot be incorporated in the Navigator/CAP. These resources will remain an important source of assistance and should be supported:

► **Affinity Groups:** Often New Yorkers receive assistance through affinity groups such as unions, professional organizations, and Chambers of Commerce. Some, such as the Freelancers Union, directly sell insurance to their members.⁹⁷ Others, like some Chambers of Commerce, act as brokers to sell coverage to members.⁹⁶ The Dairylea Cooperative both sells insurance to the dairy farmer members of the cooperative and acts as a broker for non-farmers that support the dairy industry.⁹⁷ These entities appear to be barred from accepting Navigator grants under the ACA when they directly sell insurance or receive commissions from a carrier. Those affinity groups that merely provide information, but do not sell or broker coverage, can participate in the Navigator/CAP.⁹⁸

“
Many Chambers already fulfill the role of Navigator. We want to be part of the exchange, we want to help promote the exchange and distribute the products within it as long as we have some input into those products. As long as the financial structures that are currently in place for compensation to Associations remain in place, there's really no reason why the State or Federal government should be paying us to be play the role of Navigator.
”

TODD TRANUM
President/CEO, Chautauqua County
Chamber of Commerce

► **Brokers:** Stakeholders felt that employers would want to continue to use brokers in 2014.⁹⁹ The ACA clearly states that brokers are one category of entity that can become Navigators, but the conflict of interest provision, discussed above, prohibits a Navigator from getting direct compensation from a carrier to enroll a consumer into a QHP.¹⁰⁰ Brokers may have to choose between accepting commissions for sales of coverage and accepting Navigator grants. If brokers cannot help small businesses and consumers to enroll in exchange-based coverage, it could have an impact on the exchange's distribution of risk, individual and small business purchasing behavior, and the exchange's purchasing power. This apparent paradox cannot be resolved without further Federal and State guidance. The exchange should conduct a study, soliciting input from consumer advocates, small businesses and their representatives, and brokers to resolve this paradox. The study should also determine whether brokers should receive commissions for sales of individual policies, which is currently prohibited by law.

► **State Regulatory Agencies:** Currently, consumers can go to SDOI for help with commercial insurance products regulated by the State and to the SDOH for help with public insurance products and the Division of Consumer Protection or the Attorney General's Health Bureau for general insurance problems.

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Stakeholders noted that advocates often work closely with these agencies.¹⁰³ Government agencies are uniquely empowered with regulatory enforcement authority—a valuable resource for the Navigator/CAP. We recommend that this relationship be formalized with regular meetings.

- **Providers:** Many providers (e.g., hospitals and health centers) enroll consumers in coverage.¹⁰⁴ Providers are a critical outreach and enrollment resource for some hard to reach consumers.¹⁰⁵ In Massachusetts, State-trained safety net providers, along with CBOs, drove much of the State's enrollment in Medicaid and subsidized coverage through its exchange.¹⁰⁶ While few providers are likely to participate in a Navigator/CAP, they will continue to perform enrollment services both to ensure revenue and to help patients.
- **Plan-Based FEs:** The ACA's clear prohibition of Navigator grant funding to insurance carriers appears to bar the exchange from grants to plan-based FEs.¹⁰⁷ New York permits health plans to include FE services in the administrative portion of premiums.¹⁰⁸ Given the large number of applications (330,000 in 2010) that are submitted by plan-based FEs, we recommend that this program be continued after 2014. Plan-based FEs should be trained to identify and refer subsidy-eligible and other consumers to the Navigator/CAP.

RECOMMENDATION #3: We recommend that the Navigator/CAP leverage existing resources by soliciting grant applications, formalizing relationships, and offering technical assistance to grantees and non-grantees alike. Stakeholders identified that many of New York's existing resources, including community-based FEs, Chambers of Commerce, affinity groups and nonprofits, are ideally positioned to provide Navigator and CAP services. To leverage these existing resources, we recommend: **(1)** existing community-based and business-oriented groups should be solicited to become spoke groups, making special efforts to transition current enrollment and assistance capacity; **(2)** Navigator/CAP spoke groups should have a formalized relationship with State and local officials, who will remain an important resource; **(3)** the central hub should offer resources (including training and educational materials) to and accept consumer

BROKER COMMISSION CONTROVERSY RELATES TO NEW ADMINISTRATIVE COST RULES UNDER THE ACA

There is pressure on insurers to cut back on the administrative portions of insurance premiums, including broker commissions. Insurance companies want to reduce their administrative costs (called medical loss ratios) by replacing percentage-based broker commissions with a flat per member per month fee. Brokers have worked hard to influence the national debate, with mixed results.¹⁰¹ Now, the brokers are taking their cause to the states, lobbying legislators and local regulators. They are pressuring some states to enact legislation ensuring that only they can serve as Navigators—with accompanying strong compensation requirements.¹⁰²

Flat-fee structures are already used in some exchanges. Utah charges a flat \$37 per employee per month; Massachusetts employers pay a flat fee of \$10 per employee per month. Both exchanges charge the flat fee to every small business purchaser; if no broker is involved, the fee goes to the exchange to cover administrative costs.

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assistance referrals from groups who offer significant enrollment assistance but may be barred from becoming Navigators. To further ensure consistency of services throughout the State, New York should continue support for plan-based FEs in the public insurance market to maintain critical enrollment capacity for low-income people not legally mandated to carry coverage.

HOW MUCH WILL A NAVIGATOR/CAP COST? AND HOW SHOULD IT BE FINANCED?

This report addresses two financing questions: (1) how much will it cost New York to run an integrated Navigator/CAP; and (2) what sources of financing are available to support the Navigator/CAP? We address these points in turn below.

The Cost of a Navigator/CAP in New York

Determining how much it costs to assist each consumer varies greatly depending on the type of service being provided—enrollment assistance versus consumer assistance.

New York's community-based FE program spends about \$150 for each application submitted, spending approximately \$17 million annually on 112,000 public insurance enrollments.¹⁰⁹ However, the New York public insurance application is an extremely detailed eight-page questionnaire that requires extensive documentation of personal information. While the Federal government has yet to issue guidance about new application rules, it is reasonable to assume that in 2014 the public insurance and exchange application process will be significantly easier to complete.

When Massachusetts implemented its health reform, it provided \$3.5 million annually to fund Navigator-like CBOs to provide outreach and enrollment assistance.¹¹⁰ From 2006 through 2009, the Massachusetts CBOs helped 92,000 individuals with application assistance,¹¹¹ at an approximate cost of \$114 per person.

Because CAPs provide such a variety of services, it is difficult to estimate how much each consumer interaction costs—estimates range from \$45 to \$781 per case. CAPs are not able to quantify all of the assistance provided, and different tasks take different amounts of time and effort. Cost-per-case estimates for CAPs around the country vary significantly: California's Health Consumer Alliance (\$781); Connecticut's Office of the Healthcare Advocate (\$375); Nevada's Office of the Governor, Consumer Health Assistance Office (\$87); and Massachusetts's Health Care for All (HCFA) (\$45).¹¹² In New York, CHA spends an average of approximately \$143 on each case, including one-on-one assistance and presentations.¹¹³

Table 3 provides an estimated cost to New York in 2014 for providing enrollment assistance and consumer assistance, based on extrapolations from the enrollment experience of Massachusetts and the current assistance rates in New York. Between 2006 and 2009, when Massachusetts implemented its health reform, 430,000 (two-thirds) of its 650,000 uninsured residents enrolled in coverage.¹¹⁴ Assuming that the CBOs' application assistance resulted in successful enrollments, they probably assisted more than one in every four consumers who enrolled during that time (or approximately 30,000 people a year). One study predicts that up to

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1.2 million New Yorkers will enroll in coverage through the exchange between 2014 and 2019.¹¹⁵ If New York's Navigator/CAP similarly helps one in four of these uninsured consumers, it will assist approximately 100,000 consumers annually between 2014 and 2019. Adding in the 112,000 annual enrollments currently conducted by the community-based FE program, we estimate that the Navigator/CAP will enroll 212,000 consumers annually¹¹⁶ in the first two years of the exchange's operations, at a cost of \$31.8 million each year, and 145,000 consumers¹¹⁷ in each of the next three years, at a cost of \$21.8 million a year. [\(See Table 3.\)](#)

We can estimate the need and overall cost for consumer assistance services in New York based on similar extrapolations. Although CHA estimates it spends approximately \$143 per consumer served, with the augmentation of its central hotline, the program is now able to serve more New Yorkers at a lower cost. For example, this year CHA will serve approximately 25,000 consumers for a cost of \$2.2 million, or roughly \$88 per consumer.¹¹⁸ During 2007, the first full year of health reform implementation in Massachusetts, the number of cases served by its CAP, Health Care for All, quadrupled.¹¹⁹ It continued to grow slightly each year through 2009, as the individual mandate and other reforms took effect. If CHA's case load quadruples in 2014 to approximately 110,000 consumers, the program will need a budget of \$15.7 million (using the \$143 per consumer rate).

TABLE 3: ESTIMATED NEED AND COSTS FOR ENROLLMENT AND CONSUMER ASSISTANCE

	MASSACHUSETTS	NEW YORK (2014 ESTIMATES)
ENROLLMENT ASSISTANCE		
Uninsured before exchange	650,000	2.6 million
Enrolled during first three–five years of exchange	430,000	1.2 million
Number of assisted enrollments per year	30,000	212,000
Cost per consumer	\$114	\$150
Annual Cost for Enrollment	\$3.5 million annually	\$21.8–\$31.8 million annually
CONSUMER ASSISTANCE		
Consumer Assistance Numbers	37,000 (calls in 2009)	110,000 (consumers in 2014)
Cost per consumer	\$15 (per call)	\$88–\$143 (per consumer)
Annual Budget	\$554,275	\$9.7–\$15.7 million
Grand Total New York Navigator/CAP Estimated Annual Budget		\$31.5–\$47.5 million

These estimates drive an overall budget for a combined Navigator/CAP that could range from approximately \$31.5 million to \$47.5 million per year. Importantly, these estimated costs do not include any cost-of-living or trend adjustments.

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Potential Sources of Financing

The ACA and HHS guidance state that Navigators must be financed by the exchange.¹²⁰ But recent Federal guidance indicates that Medicaid financing can be used to support Navigators when they engage in activities related to Medicaid or SCHIP beneficiaries—an important option for New York.¹²¹ Nationally, CAPs, on the other hand, received \$30 million dollars in initial funding under the ACA, of which New York's portion was \$2.2 million. New York can continue to receive Federal funding for consumer assistance related to exchange activities under the Exchange Establishment grants through 2014—but these grants cannot support Navigators.¹²² Accordingly, come 2014, New York will need to finance a significant portion of both programs with State funds.

Policy experts have identified a number of financing options for the exchange. For example, a New York-based foundation, the United Hospital Fund, has identified four New York-specific financing options for the exchange: (1) State general funds; (2) assessments on insurers operating in New York; (3) administrative fees on exchange carriers; and (4) existing mechanisms created under the Health Care Reform Act (HCRA).¹²³ National consumer advocates support broad-based fees on insurers, both inside and outside the exchange,¹²⁴ arguing that the exchange will benefit insurers that do not offer plans on the exchange by educating consumers about coverage options and improving the functioning of the overall market.¹²⁵ Some New York stakeholders also suggested that funding should be raised through assessments on all products.¹²⁶ Imposing fees only on plans sold on the exchange could result in higher premiums for those plans, reducing consumer incentives to participate in the exchange.¹²⁷

We first recommend maximizing Federal matching funds for Navigator/CAP activities related to Medicaid and SCHIP enrollment and assistance. Currently, New York draws approximately \$8.5 million in Federal funding for its community-based FE program, but this is only a small piece of the Federal matching funds that are potentially available. Federal guidance indicates that states that choose to use Navigators to assist with Medicaid and SCHIP enrollment can access Federal administrative matching funds as long as the work is performed under a contract that specifies a method for identifying expenditures attributable to Medicaid and SCHIP activities.¹²⁸ This allows all Navigator/CAP staff that assist with public program enrollment to be supported with the Federal administrative matching funds. Accordingly, the total Federal match available to support the Navigator/CAP program in New York should be well in excess of the \$8.5 million currently channeled into the community-based FE program.

To augment this base of Federal and State matched funding, we recommend imposing broad-based fees on insurers, both inside and outside the exchange, as means for generating the additional funding that will be needed to run an integrated Navigator/CAP in New York.

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RECOMMENDATION #4: We recommend that financing for the Navigator/CAP be secured from available Federal funds and fees on insurers operating inside and outside the exchange. Funding that is currently designated for enrollment assistance and consumer support should be rolled over into New York's new Navigator/CAP, including: (1) Federal Exchange and Establishment Grant funds (in the near term, 2011-2014) and (2) funds currently set aside for the community-based FE program, once they are transitioned into the new Navigator/CAP. In addition, the program should maximize Federal financing (Medicaid and SCHIP administrative funding) to support the exchange and its Navigator/CAP. Finally, supplemental funding should be generated by the exchange through broad-based fees on insurers both inside and outside the exchange.

Conclusion

Implementation of the ACA will bring new opportunities for millions of New Yorkers to enroll in health coverage. New York is already a leader in providing consumer assistance for education, enrollment, navigation, and more. But our State's existing services are driven by limited forms of coverage. Come 2014, the wave of newly eligible consumers will require some heavy lifting by enrollment and consumer assistance providers to ensure smooth transitions to new forms of coverage.

The bulk of enrollment effort in the exchange is likely to be directed toward individuals without job-based coverage who are uninsured; most experts and current data do not indicate a huge jump in rates of small businesses taking advantage of tax credits and new plans offered on the exchange. The diversity of the population and the complexity of the screening and enrollment task beg for a dynamic and robust but integrated Navigator/CAP to catch those who would fall through the cracks, guide those who need help, and to speak out when problems arise. New York will need the help of every trained consumer assistance provider in the State, including brokers, providers, and carriers.

While discussion and suggestions set forth in this report have taken into consideration the viewpoints of a variety of stakeholders representing different interests around New York, the final recommendations are the authors' own. As such, they are not meant to be taken as points of consensus among every stakeholder with whom we spoke. However, the recommendations do represent a common goal shared by every stakeholder we spoke with, which is to bring the promise of the ACA to fruition.

A strong, integrated, Navigator/CAP will be fundamental to this cause.

Appendix A

Entities That Offer Enrollment Assistance

- ▶ **Brokers and Agents for Small Businesses:** There are 1.6 million New Yorkers enrolled in coverage through the small group market,¹²⁹ where New York small businesses typically obtain coverage through insurance brokers or agents.¹³⁰ An insurance agent generally represents one or more carriers, while a broker represents the consumer and may sell coverage from any insurance company licensed in the State. General agents, who serve as wholesalers and provide technical support to brokers, are involved in enrollment of many small groups.¹³¹ In 2009, there were 19,850 brokers and agents in New York.¹³²
- ▶ **Chambers of Commerce and Affinity Groups for Small Businesses:** In some regions of the State, small businesses also use local Chambers of Commerce, Granges, and other local organizations, such as the Dairy Lea Cooperative, for help enrolling in commercial coverage.¹³³ In New York City and nine other downstate counties, brokers can help small businesses and sole proprietors purchase coverage from a health insurance exchange called HealthPass, which covers 33,000 consumers.¹³⁴ HealthPass customers receive consumer assistance through contracts with private companies called Health Advocate and Medical Cost Advocate.¹³⁵
- ▶ **Affinity Groups and Internet Resources for Moderate-Income Individuals:** Moderate-income consumers are typically on their own when it comes to seeking enrollment assistance in New York. Agents and brokers do not receive commissions on individual products, but they are compensated for enrolling people into HealthyNY, a State-sponsored commercial product for moderate-income consumers.¹³⁶ Other coverage alternatives include affinity groups such as the Freelancers Union.¹³⁷ There are a variety of websites that aggregate and display coverage options.¹³⁸ However, it is usually up to the consumer to follow up with a program or carrier. For those unable to find affordable private plans, the only means of accessing care is often through community-based clinics or financial assistance programs at local hospitals.
- ▶ **Local Governments:** Fifty-eight local departments of social services (LDSS) also provide assistance with enrollment. In New York City, the largest LDSS, the Human Resources Administration's (HRA) Medicaid Helpline, assists 7,000 consumers a day through an interactive voice response system, and counselors assist an additional 2,000 consumers a day.¹³⁹ Other City hotline numbers assist more than 4,000 consumers a day with questions about Medicaid.¹⁴⁰ HRA's Medical Insurance and Community Services Administration (MICA) Managed Care Client Service unit and the NYC Department of Health and Mental Hygiene assist providers and consumers with managed care plan issues.¹⁴¹ Social service districts upstate are faced with diminishing resources and struggle to process applications and provide essential consumer assistance within the timelines required by Federal law.

Appendix A (continued)

- ▶ **Maximus:** Maximus is a private vendor which performs two functions for New York. First, it runs New York's Statewide Enrollment Center, launched in June 2011. Its staff will assist eligible New Yorkers with public program enrollment Medicaid phone and mail renewal using an information technology program that automates determinations and allows workers to confirm and verify certain information in real time. Second, it conducts Medicaid managed care and Family Health Plus enrollment and consumer assistance for approximately 4,000 callers daily from 23 counties.¹⁴²
- ▶ **Facilitated Enrollers for Low-Income Individuals:** Facilitated Enrollers (FEs) can only enroll low-income individuals into public coverage: Child Health Plus, Medicaid Managed Care, and Family Health Plus. Currently, FEs are not funded to help consumers apply for disability-related Medicaid.¹⁴³ There are two types of FEs: those who work for community-based organizations (CBOs) (including health and human service providers, immigrant organizations, and local government agencies) and those who work for public health insurance plans. Both employ FE workers who are local community members able to provide assistance during the day, evenings, and on weekends and can reach isolated consumers with home visits.¹⁴⁴ Both provide outreach to those potentially eligible for public insurance, educate them about their coverage options, and help them enroll in or renew their coverage.¹⁴⁵ There are currently 1,386 FEs working for the public health plans in New York¹⁴⁶ In addition, 41 CBO-based FEs are spread throughout the State. Combined, New York's FE program provides services in more than 60 languages.¹⁴⁷ In 2010, FEs submitted more than 430,000 public coverage applications for consumers.¹⁴⁸

Appendix B

Entities That Offer Assistance with Health Coverage Problems

State Regulatory Agencies

- ▶ **New York State Department of Health (SDOH):** Consumers with public coverage (Medicaid, Family Health Plus, Child Health Plus, and other Medicaid-related programs) can call the toll-free private call center listed on the back of their card. Difficult questions are forwarded to the SDOH Division of Coverage and Enrollment Local District Support Office, where 20 staff members receive hundreds of calls each week, with as many e-mails and written requests for help.¹⁴⁹ Another SDOH office, the Complaint and Utilization Review Unit of the Bureau of Managed Care Certification and Surveillance, helps providers and consumers with managed care plan issues. The unit's 5.5 staff members, along with 5.5 staff members in regional offices, take 1,000 calls a month; they processed more than 900 contacts that were formally identified as complaints in 2010.¹⁵⁰
- ▶ **New York State Department of Insurance (SDOI):** The SDOI's Consumer Services Bureau Health Unit helps consumers address problems with commercial insurance, including enrollment, termination of coverage, plan navigation, and billing issues. In 2009, the Bureau received 31,500 complaints about accident and health plans, and processed 4,200 external appeals.¹⁵¹ Six employees work on external appeals, while 18 staff members address other kinds of complaints.¹⁵² In addition to helping consumers resolve individual cases, the Bureau is able to assess administrative penalties on carriers that do not follow the law.
- ▶ **The State Attorney General:** The Office of the Attorney General helps consumers with individual advocacy and impact litigation through its Health Care Bureau (HCB), which staffs a Health Care Helpline. Calls from consumers involve benefit and coverage denials, billing and payment problems, medical discount scams, predatory lending issues, and other health coverage navigation problems.¹⁵³ The office can offer more help with plans governed by New York State law, including individual policies and fully-insured employer-sponsored plans, than with self-insured employer-sponsored coverage.¹⁵⁴ In 2010, the HCB received 3,700 complaints and made 3,800 referrals to other agencies.¹⁵⁵

Nonprofit Sources of Consumer Assistance

- ▶ **Community Health Advocates (CHA):** The Community Service Society of New York (CSS) operates New York's ACA-funded statewide independent Consumer Assistance Program, which serves consumers with all forms of insurance coverage and access to care issues. CSS, in partnership with three specialist nonprofits, the Empire Justice Center (Empire Justice), the Legal Aid Society (LAS) and the Medicare Rights Center (MRC), serves as the hub for 21 CBOs located in geographically diverse areas of the State and provides training, support, quality assurance, and

Appendix B (continued)

a central live-answer consumer helpline with a toll-free number. The CBOs, trusted resources in their communities, provide education workshops and one-on-one counseling for consumers. CHA staff members provide linguistically and culturally competent services on the ground where consumers live and work. Between November 2010 and June 2011, CHA helped consumers with one-on-one assistance in more than 7,600 cases in 58 counties throughout New York, and more than 8,750 consumers through outreach and education.

- ▶ **Health Insurance Information Counseling and Assistance Program (HIICAP) for Medicare Beneficiaries:** Based out of the State Office for the Aging, HIICAP is New York's State Health Insurance Program (SHIP), a Federally-funded initiative to provide education and one-on-one assistance to 3 million Medicare beneficiaries in New York.¹⁵⁶ HIICAP serves every county in New York with roughly 500 paid and volunteer counselors.¹⁵⁷ In 2010, HIICAP helped more than 134,000 Medicare beneficiaries one-on-one, and conducted 4,000 presentations.¹⁵⁸ The State Office for the Aging also funds a consortium of seven community-based agencies to provide technical assistance to HIICAP programs, and legal representation to HIICAP consumers with appeals.¹⁵⁹
- ▶ **Other Nonprofits:** The Legal Aid Society (LAS) and Medicare Rights Center provide direct consumer assistance services to consumers, technical assistance, and policy analysis. Empire Justice is a back-up center for legal services programs and other groups. Selfhelp Community Services provides both technical assistance to advocates and assistance to low-income consumers with chronic health needs. LAS, Empire Justice, and Selfhelp operate a web resource for health advocates across New York, NYHealthAccess.org. Other organizations that provide assistance to consumers and advocates include: the New York Immigration Coalition (NYIC), the Center for Independence of the Disabled and other Independent Living Centers in New York City, the Urban Justice Center, the New York Legal Assistance Group, New York Lawyers for the Public Interest, Independent Living Centers, member organizations of New York State Community Action, Inc., and a network of legal services offices.

Appendix C

Discussion Participants

REGIONAL STAKEHOLDER MEETINGS

BINGHAMTON AREA STAKEHOLDER CONVERSATION • March 10, 2011
Convened by Public Policy and Education Fund

Mary Clark, Citizen Action of New York/PPEF

Bob Cohen, Citizen Action of New York/PPEF

Debra Sanderson, Chenango County Agency on Aging

Bette Osborne, Chenango County DSS

Chris McAvoy, Chenango Health Network

Nancy Adams-Smith, Bayridge Group

Carol Lindhorst, American Cancer Society

Alecia Furney, Mothers and Babies Perinatal Network

Andrea Minor, Mothers and Babies Perinatal Network

Stacey Kalechitz, Broome County CASA

Jessie Kowalczyk, Maternal Infant Services Network

Stephanie Hill, Rural Health Network

Donna DiVirgilio, Mothers and Babies Perinatal Network

Connie Palmer, Mothers and Babies Perinatal Network

Lenore Boris, Free Clinic (operated by SUNY Upstate)

Mary Petco, UHS

Debra Marcus, Planned Parenthood of South Central New York

Ingrid Husisisan, Planned Parenthood of South Central New York

Chris Baron, Lourdes Hospital

Wanda Mead Campbell, Citizen Action of New York/PPEF

Sharon Chesna, Mothers and Babies Perinatal Network

Theresa Kaschak, Mothers and Babies Perinatal Network

John Barry, Southern Tier AIDS

Peg Blackman, American Cancer Society

Fred Brooks, Citizen Action of New York

Jack Salo, Rural Health Network

Shelli Cordisco, Action for Older Persons

Kathy Pfaffenbach, Catholic Charities Emergency Assistance Program

Gary Doupe, United Methodist Church (retired pastor/Planned Parenthood of South Central New York)

Jean Gregor, Citizen Action of New York/PPEF

Appendix C (continued)

BUFFALO AREA STAKEHOLDER CONVERSATION • March 14, 2011

Convened by Public Policy and Education Fund

Bob Cohen, Citizen Action of New York/PPEF, PPEF/CANY Staff, Program Moderator
Trilby De Jung, Empire Justice Center

Annette Morris, Sheehan Health Network
Angela Leavy, Sheehan Health Network
Tracy Pettigrew, Kaleida Health, Facilitated Enroller
Janice Marrow, Blue Cross/Blue Shield
Don Gibson, Independent Health
Edwin Martinez, Citizen Action of New York/PPEF/Panorama Hispano
Ellen Kennedy, Consumer
Brhan Gebremariam, Citizen Action of New York/PPEF,
Frank Steffen Jr., Directions in Independent Living
Adriana Gonzalez-O'Dell, Hispanics United of Buffalo
Ina Ferguson, Consumer
Hillary Clarke, American Cancer Society
Michael Rivera, Hispanics United of Buffalo
Fred Bristol, Buffalo Niagara Partnership, Chamber of Commerce
Debbie Licata, University of Buffalo School of Dental Medicine
Nicole Bell, Head Start
Broderick Cason, Univera Health Care
Jane Piazza, Coalition for Economic Justice, consumer
Mary Rose Gaughan, New York State Department of Health
Thomas E. Haydeck, Legal Services for the Elderly, Disabled or Disadvantaged in W.N.Y.

LONG ISLAND STAKEHOLDER CONVERSATION • March 15, 2011

Convened by Public Policy and Education Fund

Bob Cohen, Citizen Action of New York/PPEF

Erika Walker, Upper Hudson Primary Care Consortium, CHA Program
Julius Schultz, Consumer
Mary Dewar, Health care advocate/Consumer
Frank Olear, Health care advocate/Consumer
John Muir, Health care consultant
Cesar Malaga, Hispanic American Association
Juanita Torres, Northfork Spanish Apostolate

Appendix C (continued)

Barbara Buehring, Consumer
Jack Wick, CPR Insurance
Kathryn McCaffrey, Consumer
Grace Welch, Mid-Suffolk National Organization for Women (NOW)
Leah Jefferson, American Cancer Society
Linda Hassberg, Empire Justice Center (Long Island office)
Carol Gordon, Long Island Progressive Coalition
Gwen O'Shea, Health and Welfare Council of Long Island
Margaret Gillard
Lisa Tyson, Long Island Progressive Coalition
Garrett Armwood, Long Island Progressive Coalition

ROCHESTER AREA STAKEHOLDER CONVERSATION • February 28, 2011
Convened by Medicaid Matters New York, Finger Lakes Health Systems Agency (FLHSA),
and Partnership on the Uninsured

Trilby de Jung, Empire Justice Center
Unauay Miller, NYAIL
Lara Kassel, MMNY
Wade Norwood, FLHSA

Sheila Betters, Excellus Blue Cross Blue Shield
Marilyn Hally, Livingston County DSS
Bill Bach, Bene-Care Agency
Mary Rose Gaughan, NYDOH
Laura Gustin, RPCN
Gail Newton, URM CCH
Susan Aiello, Mercy Outreach
Ellen Lewis, Mercy Outreach
Bill Anderson, RBA
Melanie Funchess, MHA/MCCMH
Deb Peartree, Monroe Plan
Christine Wagner, St. Joseph's Neighborhood Center
Deborah Cisco, Livingston County Chamber
Kris Monzel, Westside Health Center
Diane Coleman, Center for Disability Rights
Keith Chambery, Genesee Health Facilities
Courtney Walker, CCSI

Appendix C (continued)

Jeanette Weiss, MVP
Matt Pulver, MVP
Kimm Benedetto, RGHS
Reid Perkins, Monroe Plan
Elisa De Jesus, Ibero American Action League, Inc.
Rosa M. Lloyd, National Kidney Foundation
Kim Foster, Highland Hospital
Candice Lucas, CSP-MC
Kingdom Mufhandu, URM
Jay Rudman, AIDS Care
Anita Marrero, Perinatal Network of Monroe County
Kaaren Smith, Livingston County Office for the Aging
Sherry Coronas, MCLAC
Julie Hutchinson, Community Health Nurse-FINCH Consulting
A. Bush, PNMC
John L. Zehr, The Shore Winds
Dannis Matteson, St. Joseph's Neighborhood Center
Cynthia Oswald, Livingston County Chamber
Bonnie Bohme, PPRSR
Phyllis Jackson, TAMF/His Hands Nurturing Outreach Center
Andy Doniger, MD, Monroe County DOH
Alfredo M. Gonzalez, Lifetime Care
Cathy Kausch, Excellus
Pat Campbell, RACF
Paula Hollinger, consumer
Melisa Fowler, CCSI
Kim Wynn, CCSI
Jean Angililli, Cornell CE
Tom Sullivan, consumer
Patrick Dovan, MVP Healthcare
Jim Sonnantino
Amy Sherman, Rochester General
Marilyn Dollinger, RN, St. John Fisher
Joanne Insull, Arthritis Foundation
Constantino Fernandez, MD, Strong Memorial Hospital
Pat Schiebler, DHS
Kristinne Seibel, Child Care Council INC.
Hilda Rosario-Escher, Ibero American Action League, Inc.

Appendix C (continued)

Stephanie Urena, Fidelis Care
Lisa Pfeifer, Monroe Plan
Mike Nazar, MD, Unity
Bob Thompson, Excellus

TROY STAKEHOLDER CONVERSATION (ALBANY REGION) • February 23, 2011 Convened by Medicaid Matters New York (MMNY) and New York Association on Independent Living (NYAIL)

Melanie Shaw, NYAIL
William Reyes, Healthy Capital District Initiative
Christopher Walsh, Independent Living Center of the Hudson Valley
Clifton Perez, Independent Living Center of the Hudson Valley
Carrie Snyder, Independent Living Center of the Hudson Valley
Karen Garofallo, Independent Living Center of the Hudson Valley
Nyisha Brown, Independent Living Center of the Hudson Valley

WATERTOWN AREA STAKEHOLDER CONVERSATION • March 8, 2011

Convened by Medicaid Matters New York and New York Association on Independent Living
Lindsay Miller, New York Association on Independent Living
Lara Kassel, Medicaid Matters New York
Penny Ingham, North Country Prenatal/Perinatal Council
Stephanie Robinson, North Country Prenatal/Perinatal Council
Aileen Martin, North Country Children's Clinic
Joey Horton, NYS Coalition for School-Based Health Centers
Dennis Baeslack, Greater W'town-North Country Chamber of Commerce
Brenda Campany, Northern Regional Center for Independent Living
Leesa Dowdle, Cerebral Palsy Assn of the North Country
Mark Curtis, Northern Regional Center for Independent Living
Kathy Barkley, Northern Regional Center for Independent Living
Richelle David, Northern Regional Center for Independent Living
Charlie Merrick, Northern Regional Center for Independent Living
Tina Robbins, Jefferson Country DSS
Kathy Connor, Northern Regional Center for Independent Living
Kim Smith, Northern Regional Center for Independent Living
Charmaine Gaines, Northern Regional Center for Independent Living
Dolores Surowiec, consumer

Appendix C (continued)

MEDICARE RIGHTS CENTER STAKEHOLDER CONVERSATION • New York City, February 24, 2011

Convened by Medicare Rights Center (MRC)

Doug Goggin-Callahan, MRC

Heather Bates, MRC

Ilana Raskind, MRC

Rebecca Masutani, MRC

Fay Mattana, MRC volunteer

Nicki Morelli, MRC volunteer

Shelly Levine, MRC volunteer

Rob Mencher, MRC volunteer

Andy Olesker, MRC volunteer

Laura Corwin, MRC volunteer

Joan Gloss, MRC volunteer

Sid Bjandari, MRC staff

Maria Miranda, MRC volunteer

Myrial Delban, MRC volunteer

New York Immigration Coalition Stakeholder Conversation

New York City, February 15, 2011

Convened by New York Immigration Coalition

Jenny Rejeske, Marija Sajkas, Andrew Jones, New York Immigration Coalition

Nora Chaves, Community Service Society

Joy Paone, Lutheran Social Services of New York

Aileen Kim, Project Hospitality

Ayaz Ahmed, South Asian Council for Social Services

Anna Shubashvili, Tvistomi – Georgian Community Organization

Eunjee Shin, Korean Community Services

Shena Elrington, New York Lawyers for Public Interest

Karina Moran, Northern Manhattan Improvement Corporation

Lana Khrapunskaya Shorefront YM-YWHA of Brighton-Manhattan Beach

Tara Lannen-Stanton, New Americans Program, Queens Library

Suki Terada Ports, Family Health Project

Dio Gica, YMCA of Greater NY

Monica Merlis, Jewish Community Relations Council of NY

Ki Hyun Kathy Chae, Esq., MinKwon Center for Community Action

Police Officer Mona Suazo, NYPD, Immigrant Women Liaison and
Community Affairs representative

Detective Nasser, NYPD, Immigrant Women Liaison and Community Affairs representative

Andrew Detty, United Hospital Fund

Appendix C (continued)

Ami Kadar, Centro Independiente de Trabajadores Agrícolas
Natalie Birch, The Legal Project
NYC Office of Citywide Health Insurance Access
Juanita Torres, North Fork Spanish Apostolate
Mirna Cortés, Central American Refugee Center
Adriana Bernal, Hudson River HealthCare Inc.
Esther Garcia, Hudson River HealthCare Inc.
José Perez, Esq., Smith, Sovik, Kendrick and Sugnet.
Berlotte Israel, DwaFanm

FACILITATED ENROLLER STAKEHOLDER CONVERSATION • New York City, February 24, 2011

Convened by Children's Defense Fund-NY (CDF-NY)
Abigail Claflin, CDF-NY
Jennifer Marino Rojas, CDF-NY
Gabriela Silverio, CDF-NY

Lorraine Gonzalez, Children's Aid Society
Kate Hansen, Structured Employment Economic Development Corp (DBA Seedco)
Lori Andrade, Health and Welfare Council of Long Island
Leoni Parker, Westchester County Department of Health
Alexander Rodriguez, Metropolitan Council on Jewish Poverty
Maria Viera, Ridgewood Bushwick Senior Citizens Council, Inc.
Monserate "Cathy" Villegas, NYCDOH
Sandra Jean-Louis, Public Health Solutions
Stacy Villigran, Nassau-Suffolk Hospital Countil
Liliana Melgar, Hispanic Federation
Jenny Fernandez, Alianza Dominicana
Josephina Davila, Make the Road NY
Rinda Reyes, The Joseph P. Addabbo Family Health Center
Michelle Goldkrantz, Yeled V' Yalda Early Education Center
Gloria Baca, Health and Welfare Council of Long Island

Appendix C (continued)

ADDITIONAL STAKEHOLDER INTERVIEWS

AFFINITY GROUPS • MARCH 1, 2011

CSS: Elisabeth Benjamin, Carrie Tracy, Nora Chaves, Priya Mendon
Shawn Nowicki, Director of Health Policy, HealthPass
Mark Kessler, Director of Strategic Initiatives HealthPass
Vince Ashton, Executive Director, HealthPass
Adam Huttler, Executive Director, Fractured Atlas
James Brown, Director of Health Services, The Actors Fund

FREELANCERS UNION AND FREELANCER INSURANCE COMPANY • March 9, 2011

CSS: Elisabeth Benjamin
Sara Horowitz, Executive Director, Freelancers Union

GENERAL AGENTS • March 4, 2011 and March 31, 2011

CSS: Elisabeth Benjamin, Priya Mendon, Carrie Tracy, Nora Chaves

Phil Fina, Vice President and CFO, FILCO
Ilana Arbeit, Benefits Consultant, FILCO

J.P. Galaris, Savoy Associates
Brian Bulger, First National Administrators

HEALTH INSURANCE INFORMATION COUNSELING AND ASSISTANCE PROGRAM • April 5, 2011

CSS: Carrie Tracy, Priya Mendon

Linda Petrosino, HIICAP Coordinator, New York State Office for the Aging

INSURANCE BROKERS • April 1, 2011

CSS: Elisabeth Benjamin, Priya Mendon, Carrie Tracy

Jim Cosares, Jimco Associates
Richard Schoetz, Schoetz & Cohen Insurance Broker
Alex Miller, Millennium Medical Solutions
Stephen DeMaria, Associated Consulting Group

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LOCAL CHAMBERS OF COMMERCE • March 17

CSS: Elisabeth Benjamin, Carrie Tracy

Carl Hum, President and CEO, Brooklyn Chamber of Commerce

Dean Mohs, Vice President, Insurance Services, Brooklyn Chamber of Commerce and Executive Director, Brooklyn HealthWorks

Todd Trantum, President/CEO, Chautauqua County Chamber of Commerce

NEW YORK CITY HUMAN RESOURCES ADMINISTRATION • February 25, 2011

CSS: Elisabeth Benjamin, Priya Mendon, Carrie Tracy

Marjorie Cadogan, Executive Deputy Commissioner of the Human Resources Administration's Office of Citywide Health Insurance Access (OCHIA)

JoAnne Bailey, Director of Policy and Research, OCHIA

Linda Hacker, Medical Insurance and Community Services Administration

Stana Nakhle, Director of Private Health Insurance Initiatives, OCHIA

NEW YORK STATE ASSOCIATION OF HEALTH UNDERWRITERS • May 11, 2011

CSS: Elisabeth Benjamin, Carrie Tracy

Dan Colacino, Chair of Legislative Committee, NYSAHU

NEW YORK STATE ATTORNEY GENERAL HEALTH CARE BUREAU • May 12, 2011

CSS: Carrie Tracy

Brant Campbell, Assistant Attorney General, Health Care Bureau

NEW YORK STATE DEPARTMENT OF HEALTH AND DEPARTMENT OF INSURANCE • May 4, 2011

CSS: Elisabeth Benjamin, Priya Mendon, Carrie Tracy

Laura Dillon, Principal Examiner, Consumer Services Bureau, Health Unit, State Department of Insurance

Mary Lou Festa, Office of Health Insurance Programs, Bureau of Medicaid and FHP enrollment, Division of Coverage and Enrollment, Local District Support Office

Appendix C (continued)

Carol Anne McKay, Research Analyst, Health Reform, Bureau of Policy Analysis and Initiatives,
Division of Coverage and Enrollment, Office of Health Insurance Programs

Hope Goldhaber, Bureau of Managed Care Certification and Surveillance,
Division of Managed Care, Complaint/Utilization Review Unit

NEW YORK DEPARTMENT OF STATE, DIVISION OF CONSUMER PROTECTION • April 29, 2011

CSS: Carrie Tracy

Lisa Harris, Acting Director, Division of Consumer Protection

Jorge Montalvo, Director of Strategic Initiatives, Division of Consumer Protection

PUBLIC HEALTH PLANS • March 17, 2011

CSS: Elisabeth Benjamin, Carrie Tracy

Empire Justice Center: Trilby de Jung

Patricia Boozang, Managing Director, Manatt Health Solutions

Alice Lam, Manager, Manatt Health Solutions

Sandra Oliver, VP Compliance, Health Plus

David Willhoft, VP Marketing, Health Plus

Mark Santiago, Senior VP Marketing, Hudson Health Plan

Cathy Clancy, Senior VP for Corporate Development Strategy & Network, Hudson Health Plan

Ishmael Carter, Director of Marketing, Neighborhood Health Providers

Hannah Erickson, Marketing Analyst, Neighborhood Health Providers

David Thomas, Senior VP and CEO, Fidelis Care New York

Pamela Hassen, Chief Marketing Officer, Fidelis Care New York

Roger Milliner, Deputy Executive Director of Marketing, MetroPlus Health Plan

Stanley Glassman, COO, MetroPlus Health Plan

Daniel P. McCarthy, EVP and COO, Healthfirst

George Hulse, VP External Affairs, Healthfirst

RURAL/FARMING ASSOCIATIONS • April 4, 2011

Empire Justice Center: Trilby de Jung

Kevin O'Keefe, Vice President, Sales & Marketing, Dairyalea Cooperative

Andrea Haradon, SAY2 Rural Health Network

Endnotes

- ¹ Letter from Congressional Budget Office to John Boehner, Speaker of the U.S. House of Representatives, January 6, 2011.
- ² Massachusetts spent \$7.2 million between 2006 and 2011 on its three-phase social marketing campaign promoting its health reform law. “Implementing a Successful Public Education & Marketing Campaign to Promote State Health Insurance Exchanges,” Health Reform Toolkit Series: Resources from the Massachusetts Experience, Blue Cross Blue Shield of Massachusetts Foundation, May 2011.
- ³ See Patient Protection and Affordable Care Act of 2010 (ACA), Pub. L. No. 111-148, § 1311(i)(3)(D); see also Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866 (proposed July 15, 2011) (to be codified at 45 CFR pt. 155).
- ⁴ See Patient Protection and Affordable Care Act of 2010 (ACA), Pub. L. No. 111-148, §5000A. Exemptions include: religious conscience; health care sharing ministry members; undocumented immigrants; incarcerated individuals; individuals for whom the required contribution would exceed 8% of their household income; taxpayers with income below the filing threshold; members of Indian tribes; and a hardship exemption to be determined by HHS.
- ⁵ Congressional Budget Office letter, *supra* n. 1.
- ⁶ P. Boozang, M. Dutton, A. Lam, and D. Bachrach, “Implementing Federal Health Care Reform: A Roadmap for New York State,” New York State Health Foundation, August 2010.
- ⁷ *Id.* Much of the Medicaid enrollment is expected to be from consumers who are currently eligible, but unenrolled, in public coverage.
- ⁸ E. Benjamin and A. Slagle, “Bridging the Gap: Exploring the Basic Health Insurance Option for New York,” Community Service Society of New York, June 2011.
- ⁹ *Id.*
- ¹⁰ *Id.*
- ¹¹ C. Eibner, F. Girosi, C. Price, A. Cordova, P. Hussey, A. Beckman, and A. McGlynn, “Establishing State Health Insurance Exchanges: Implications for Health Insurance Enrollment, Spending, and Small Businesses,” Rand Corporation, 2010.
- ¹² Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866 (proposed July 15, 2011) (to be codified at 45 CFR pt. 155).
- ¹³ Under the ACA, state exchanges are to offer Qualified Health Plans (QHPs). QHPs must be certified according to Federal and state laws and guidelines and must offer an essential health benefits package. See ACA §1301; see also Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866 (proposed July 15, 2011) (to be codified at 45 CFR pt. 155).
- ¹⁴ See Patient Protection and Affordable Care Act of 2010 (ACA), Pub. L. No. 111-148, § 1002; see also, Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866 (proposed July 15, 2011) (to be codified at 45 CFR pt. 155).
- ¹⁵ ACA, *supra*, n. 3 at §1311(i).
- ¹⁶ See Patient Protection and Affordable Care Act of 2010 (ACA), Pub. L. No. 111-148, § 1002; see also, HHS Discussion of Proposed Regulation, 76 Fed. Reg. 136, 41878 (July 15, 2011), stating: “If the State chooses to permit or require navigator activities to address Medicaid and CHIP administrative functions, and such functions are performed under a contract or agreement that specifies a method for identifying costs or expenditures attributable to Medicaid and CHIP activities, the Medicaid or CHIP agencies may claim Federal funding for a share of expenditure incurred for such activities at the administrative Federal financing participation rate described in 42 C.F.R. § 433.15 for Medicaid and 42 C.F.R. § 457.618 for CHIP.”
- ¹⁷ The full list of examples of Navigator entities in the law are: “trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, resource partners of the Small Business Administration, other licensed insurance agents and brokers, and other entities...” ACA, *supra*, n. 3. at §1311(i)(2). §1311(i)(4) states that “a navigator shall not...receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan.”
- ¹⁸ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866 (proposed July 15, 2011) (to be codified at 45 CFR pt. 155).

Endnotes (continued)

- ¹⁹ CHA cannot currently assist individual consumers with tax subsidy issues because the subsidies are not yet available.
- ²⁰ P. Newell, "The Big Picture III: Private and Public Health Insurance Markets in New York, 2009," United Hospital Fund, April 2011.
- ²¹ New York State Insurance Department, *Premium Rates for HMO Standard Individual Health Plans by County*, available at <http://www.ins.state.ny.us/ihmoindx.htm>.
- ²² Personal communication with Ilana Arbeit and Phil Fina, FILCO, March 4, 2011; personal communication with Jim Cosares, Jimco Associates, Richard Schoetz, Schoetz & Cohen Insurance Broker, Alex Miller, Millennium Medical Solutions, Stephen DeMaria, Associated Consulting Group, April 1, 2011; personal communication with J.P. Galaris, Savoy Associates and Brian Bulger, First National Administrators, March 31, 2011.
- ²³ The Complaint and Utilization Review Unit also collects complaint data from each managed care plan certified by the Department of Health on a quarterly basis and analyzes the data to identify trends. The Unit works with the plans to identify the cause of a trend and address it. The Unit has the authority to take disciplinary action, ranging from a letter of concern requiring a corrective plan to fines. Personal communication with Hope Goldhaber, Department of Health, Bureau of Managed Care Certification and Surveillance, Complaint and Utilization Review Unit, May 4, 2011. The State Division of Consumer Protection also helps consumers mediate health care billing issues. Personal communication with Lisa Harris, Acting Director for Division of Consumer Protection, April 29, 2011.
- ²⁴ C. Tracy, E. Benjamin, and C. Barber, "Making Health Reform Work: State Consumer Assistance Programs," Community Service Society of New York, September 2010.
- ²⁵ For a full list of all stakeholders who participated, see Appendix C.
- ²⁶ Report on Binghamton Stakeholder Conversation, March 10, 2011; Report on Buffalo Stakeholder Conversation, March 14, 2011.
- ²⁷ Report on Binghamton Stakeholder Conversation, March 10, 2011; Report on Buffalo Stakeholder Conversation, March 14, 2011.
- ²⁸ Report on NYC Stakeholder Conversation, February 15, 2011.
- ²⁹ B.D. Sommers and S. Rosenbaum, "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges," 30 *Health Affairs*. 228-36 (2011).
- ³⁰ See HHS Discussion of Proposed Regulation, 76 Fed. Reg. 136, 41878 (July 15, 2011) (stating: "If the State chooses to permit or require navigator activities to address Medicaid and CHIP administrative functions, and such functions are performed under a contract or agreement that specifies a method for identifying costs or expenditures attributable to Medicaid and CHIP activities, the Medicaid or CHIP agencies may claim Federal funding for a share of expenditure incurred for such activities at the administrative Federal financing participation rate described in 42 C.F.R. § 433.15 for Medicaid and 42 C.F.R. § 457.618 for CHIP." See also, Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866 (proposed July 15, 2011) (to be codified at 45 CFR pt. 155). ("An entity that serves as a Navigator must carry out at least the following duties...").
- ³¹ Report on the Medicare Rights Center Stakeholder Conversation, February 24, 2011.
- ³² Report on Rochester Stakeholder Conversation, February 28, 2011; Report on Buffalo Stakeholder Conversation, March 14, 2011.
- ³³ S. Corlette, J. Alker, J. Touchshner and J. Volk, "The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned," Georgetown University Health Policy Institute, March 2011.
- ³⁴ S. Singhal, J. Stueland, and D. Ungerman, "How US health care reform will affect employee benefits," McKinsey Quarterly, June 2011.
- ³⁵ S. McMorro, L.J. Blumber, and M Buettgens, "The Effects of Health Reform on Small Businesses and Their Workers," Urban Institute, June 2011.
- ³⁶ Personal communication with New York City HRA, February 25, 2011; Report on New York Immigration Coalition (NYIC) Stakeholder Conversation, February 15, 2011; Report on Binghamton Stakeholder Conversation, March 10, 2011; Report on Rochester Stakeholder Conversation, February 28, 2011.
- ³⁷ Personal communication with Shawn Nowicki, Mark Kessler, Vincent Ashton, HealthPass, March 1, 2011.
- ³⁸ Report on Community-based Facilitated Enroller Stakeholder Conversation, February 24, 2011; Report on Binghamton Stakeholder Conversation, March 10, 2011; Report on Buffalo Stakeholder Conversation, March 14, 2011.
- ³⁹ Report on Medicare Rights Center Stakeholder Conversation, February 24, 2011.

Endnotes (continued)

- ⁴⁰ Report on Medicare Rights Center Stakeholder Conversation, February 24, 2011.
- ⁴¹ Report on Community-based Facilitated Enroller Stakeholder Conversation, February 24, 2011; Report on Long Island Stakeholder Conversation, March 15, 2011.
- ⁴² Report on Binghamton Stakeholder Conversation, March 10, 2011.
- ⁴³ Report on NYIC Stakeholder Conversation, February 15, 2011; Report on Buffalo Stakeholder Conversation, March 14, 2011.
- ⁴⁴ Report on Troy Stakeholder Conversation, February 23, 2011.
- ⁴⁵ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866 [proposed July 15, 2011] (to be codified at 45 CFR pt. 155).
- ⁴⁶ M.A. Cadogan, J.R. Bailey, A.M. Diop, S. Nakhle, *Healthcare Reform at the Local Level: Framework for a Navigator Program in New York City*, New York City Human Resources Administration Office of Citywide Health Insurance Access (2011) http://www.nyc.gov/html/hra/downloads/pdf/HRA_NYC_Navigator_Program.pdf
- ⁴⁷ Report on Binghamton Stakeholder Conversation, March 10, 2011; Report on Rochester Stakeholder Conversation, February 28, 2011.
- ⁴⁸ M. Dutton, W. Bernstein, K. Bhandarkar, and S. Ingargiola, "The Role of Local Government in Administering Medicaid in New York," United Hospital Fund, 2009. Participants in one conversation vehemently opposed a suggestion that Department of Social Services offices serve as the local Navigator/CAP, perceiving them to be ineffective. Report on Buffalo Stakeholder Conversation, March 14, 2011.
- ⁴⁹ Report on Binghamton Stakeholder Conversation, March 10, 2011; Report on Community-based Facilitated Enroller Stakeholder Conversation, February 24, 2011; Report on Watertown Stakeholder conversation, March 8, 2011.
- ⁵⁰ Report on Community-based Facilitated Enroller Stakeholder Conversation, February 24, 2011.
- ⁵¹ Report on NYIC Stakeholder Conversation, February 15, 2011.
- ⁵² Report on Community-based Facilitated Enroller Stakeholder Conversation, February 24, 2011. Others voiced that every consumer in the state should have the same experience. Report on Buffalo Stakeholder Conversation, March 14, 2011.
- ⁵³ Report on Medicare Rights Center Stakeholder Conversation, February 24, 2011.
- ⁵⁴ Report on Binghamton Stakeholder Conversation, March 10, 2011.
- ⁵⁵ Report on NYIC Stakeholder Conversation, February 15, 2011.
- ⁵⁶ Report on Community-based Facilitated Enroller Stakeholder Conversation, February 24, 2011.
- ⁵⁷ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866 [proposed July 15, 2011] (to be codified at 45 CFR pt. 155).
- ⁵⁸ B.D. Sommers and S. Rosenbaum, "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges," 30 Health Affairs 228-36 (2011).
- ⁵⁹ Personal communication with Kevin O'Keefe, Dairyalea Cooperative, and Andrea Haradon, SAY2, April 4, 2011.
- ⁶⁰ NAIC Consumer Representatives comments on the draft NAIC white paper, "The Comparative Roles of Navigators and Producers in an Exchange: What are the Issues?," submitted March 18, 2011.
- ⁶¹ National Association of Insurance Commissioners (NAIC), "The Comparative Roles of Navigators and Producers in an Exchange What are the Issues?" (*draft white paper* April 28, 2011); "Core Principles Relating to Health Care Reform Initiatives in New York To Protect the Interests of Consumers and Producers," Independent Insurance Agents and Brokers of New York, Inc., March 11, 2011; Independent Insurance Agents and Brokers of America, comments on the draft NAIC white paper "The Comparative Roles of Navigators and Producers in an Exchange: What are the Issues?," submitted March 18, 2011; BenefitMall comments on the draft NAIC white paper "The Comparative Roles of Navigators and Producers in an Exchange: What are the Issues?," submitted March 18, 2011; The Council of Insurance Agents and Brokers comments on the draft NAIC white paper "The Comparative Roles of Navigators and Producers in an Exchange: What are the Issues?," submitted March 18, 2011; National Association of Health Underwriters comments on the draft NAIC white paper "The Comparative Roles of Navigators and Producers in an Exchange: What are the Issues?," submitted March 18, 2011.

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- ⁶² New York State Department of Insurance website, <http://www.ins.state.ny.us/licinfo.htm>. Brokers and agents can choose between taking a 20-hour course and related exam to sell health and accident insurance products, or taking a 40-hour course and related exam to sell health, accident, and life insurance products. See generally PSI licensure, New York State Insurance Department Candidate Information Bulletin, effective January 13, 2011. To renew a license every two years, a broker or agent must submit proof of having attended 15 hours of continuing education courses. See New York State Department of Insurance website. In addition to information about commercial coverage, the training and exam include information about public health coverage programs, including worker's compensation, Social Security and state disability insurance, Medicaid and Medicare; approximately 10% of the health and accident exam covers these issues. See PSI licensure, New York State Insurance Department Candidate Information Bulletin, effective January 13, 2011.
- ⁶³ HIICAP has a three-day training module that local programs use to train new staff and volunteers. Counselors participate in a monthly update call and program coordinators attend an annual two-day training to prepare for open enrollment season. Personal communication with Linda Petrosino, HIICAP Coordinator, New York State Office for the Aging, April 5, 2011. The New York State Department of Health (NYSDOH) offers basic and advanced training to FEs through a training contractor, with additional trainings for updates on changes to public programs or more intensive training on complex issues. All FEs are required to complete the basic two and a half day training, which covers the basics about public health programs, documentation and the application process, how to help a client choose a managed care plan, and more. Personal communication with New York State Department of Health personnel, April 28, 2011. CHA also has a two-day training and monthly update calls. Personal communication with Priya Mendon, Director, Community Health Advocates, April 22, 2011.
- ⁶⁴ Personal communication with Daniel Colacino, Chair of Legislative Committee, New York State Association of Underwriters, May 10, 2011.
- ⁶⁵ Report from Community-based Facilitated Enroller Stakeholder Conversation, February 24, 2011; Report on NYIC Stakeholder Conversation, February 15, 2011; Report on Rochester Stakeholder Conversation, February 28, 2011; Personal communication with Andrea Haradon of SAY2, April 4, 2011; Report on Medicare Rights Center Stakeholder Conversation, February 24, 2011.
- ⁶⁶ Report on Medicare Rights Center Stakeholder Conversation, February 24, 2011.
- ⁶⁷ Report on NYIC Stakeholder Conversation, February 15, 2011; Report on Binghamton Stakeholder Conversation, March 10, 2011.
- ⁶⁸ Report on Binghamton Stakeholder Conversation, March 10, 2011; Report on Buffalo Stakeholder Conversation, March 14, 2011; Report on Long Island Stakeholder Conversation, March 15, 2011.
- ⁶⁹ Report on Buffalo Stakeholder Conversation, March 14, 2011.
- ⁷⁰ ACA, *supra*, n. 3 at §1002(d).
- ⁷¹ Report on Troy Stakeholder Conversation, February 23, 2011; Report on Watertown Stakeholder Conversation, March 8, 2011.
- ⁷² This would allow a consumer to begin the enrollment process at one location, then follow up with a Navigator or CAP staff at a different location to complete enrollment or seek other assistance. Report on Community-based Facilitated Enroller Stakeholder Conversation, February 24, 2011.
- ⁷³ J. Arnold, "Early Innovator," presentation at United Hospital Fund Coordinating Medicaid and the Exchange meeting, May 12, 2011.
- ⁷⁴ Report on Troy Stakeholder Conversation, February 23, 2011.
- ⁷⁵ Report on Rochester Stakeholder Conversation, February 28, 2011; Report on NYIC Stakeholder Conversation, February 15, 2011.
- ⁷⁶ Personal communication with Shawn Nowicki, Mark Kessler, Vincent Ashton, HealthPass, Adam Huttler, Fractured Atlas, and Jim Brown, Actors Fund, March 1, 2011; Personal communication with NYC HRA, February 25, 2011; Report on Rochester Stakeholder Conversation, February 28, 2011.
- ⁷⁷ Report on Troy Stakeholder Conversation, February 23, 2011; Report on NYIC Stakeholder Conversation, February 15, 2011; Report on Buffalo Stakeholder Conversation, March 14, 2011.
- ⁷⁸ Report on Community-based Facilitated Enroller Stakeholder Conversation, February 24, 2011.
- ⁷⁹ Personal communication with Richard Schoetz, May 23, 2011.
- ⁸⁰ Independent Insurance Agents and Brokers of America, comments on the draft NAIC white paper "The Comparative Roles of Navigators and Producers in an Exchange What are the Issues?", submitted March 18, 2011; BenefitMall comments on the draft NAIC white paper "The Comparative Roles of Navigators and Producers in an Exchange What are the Issues?", submitted March 18, 2011; National Association of Health Underwriters comments on the draft NAIC white paper "The Comparative Roles of Navigators and Producers in an Exchange What are the Issues?", submitted March 18, 2011.

Endnotes (continued)

- ⁸¹ Personal communication with New York State Department of Health personnel, April 29, 2011.
- ⁸² NAIC Consumer Representatives comments on the draft NAIC white paper “The Comparative Roles of Navigators and Producers in an Exchange What are the Issues?”, submitted March 18, 2011; Families USA, National Women’s Law Center, Center on Budget and Policy Priorities, AFSCME, SEIU comments on the draft NAIC white paper “The Comparative Roles of Navigators and Producers in an Exchange: What are the Issues?”, submitted March 18, 2011.
- ⁸³ Report on Community-based Facilitated Enroller Stakeholder Conversation, February 24, 2011.
- ⁸⁴ See HHS Discussion of Proposed Exchange Regulation, 76 Fed. Reg. 136, 41882, 4196 (July 15, 2011). Security standards will be dictated by HIPAA, which require covered entities to maintain reasonable and appropriate administrative, technical, and physical safeguards for protecting electronic information. Privacy standards, on the other hand, will be dictated by HIPAA only if a state’s exchange functions satisfy the definition for covered entities handling protected health information as defined in HIPAA regulation.
- ⁸⁵ Office for Civil Rights, U.S. Department of Health and Human Services, Summary of the HIPAA Privacy Rule, OCR Privacy Brief, available at: <http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf>.
- ⁸⁶ However, in Massachusetts, the state CAP is not considered a business entity, and must obtain a written release before accessing a consumer’s records in the state database. Personal communication with Brian Rosman, Health Care For All Massachusetts, April 21, 2011.
- ⁸⁷ ACA, *supra*, n. 3 at § 1411(g); see also Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866 (proposed July 15, 2011) (to be codified at 45 CFR pt. 155).
- ⁸⁸ The GLBA statute requires financial institutions, including health insurance issuers, to follow specified standards to protect consumers’ personal information. NAIC Consumer Representatives comments on the draft NAIC white paper “The Comparative Roles of Navigators and Producers in an Exchange: What are the Issues?”, submitted March 18, 2011.
- ⁸⁹ HHS indicates that it will require compliance with both HIPAA (as discussed above) and the confidentiality and safeguarding requirements of Section 6103 of the Tax Code. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866 (proposed July 15, 2011) (to be codified at 45 CFR pt. 155).
- ⁹⁰ Report on Binghamton Stakeholder Conversation, March 10, 2011; Report on Community-based Facilitated Enroller Stakeholder Conversation, February 24, 2011; Report on NYIC Stakeholder Conversation, February 15, 2011; Report on Rochester Stakeholder Conversation, February 28, 2011; Report on Watertown Stakeholder conversation, March 8, 2011.
- ⁹¹ Report on Binghamton Stakeholder Conversation, March 10, 2011.
- ⁹² Report on Long Island Stakeholder Conversation, March 15, 2011. Immigrant advocates said that many immigrants would be more likely to trust a CBO than a government agency. Report on NYIC Stakeholder Conversation, February 15, 2011.
- ⁹³ See, e.g., Report on Binghamton Area Conversation, March 10, 2011.
- ⁹⁴ Personal Communication with Public Health Plan representatives, March 17, 2011.
- ⁹⁵ Personal communication with Sara Horowitz, Freelancers Union and Freelancers Insurance Company, March 9, 2011. The Freelancers Union has a subsidiary company—Freelancers Insurance Company—that sells insurance to their members. See <https://www.freelancersinsuranceco.com/fic/about-us/index.html>.
- ⁹⁶ Personal communication with Carl Hum and Dean Mohs of Brooklyn Chamber of Commerce, and Todd Trantum, Chautauqua County Chamber of Commerce, March 17, 2011.
- ⁹⁷ Personal communication with Kevin O’Keefe, Dairylea Cooperative, April 4, 2011.
- ⁹⁸ For example, the Actors Fund has a program that helps artists learn about coverage and affordable care options and provides telephone and in-person counseling. Personal communication with Jim Brown, Actors Fund, March 1, 2011.
- ⁹⁹ Personal communication with Carl Hum and Dean Mohs, Brooklyn Chamber of Commerce, March 17, 2011; Personal communication with Shawn Nowicki, Mark Kessler, and Vincent Ashton, HealthPass, March 1, 2011.

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¹⁰⁰ ACA, *supra*, n. 3 at § 1311(i)(4). This has already created conflict in other states as some producer organizations argue that brokers can, or should be allowed to, receive commissions from insurers and receive Navigator grants. Producers in some states appear to be interested in becoming Navigators, and possibly preventing others from serving as Navigators, for two reasons: to replace lost income as commissions are reduced and to retain market share by preventing other entities from entering the business of selling coverage. Producers can play a positive or negative role in the implementation of the exchange. If producers are not allowed to be compensated for selling coverage, they may steer sales out of the exchange. Exchanges created in the past found that most small businesses continued to seek the help of producers, and the employers who enrolled without the help of a producer required more time and attention from exchange staff. *See, e.g.*, J. Yegian, T. Buchmueller, J. Robinson, and A. Monroe, "Health Insurance Purchasing Alliances for Small Firms: Lessons from the California Experience," California HealthCare Foundation, May 1998. On the other hand, some non-producer stakeholders do not believe it would be appropriate for brokers to serve as Navigators, because of real or perceived conflicts of interest. Report on Long Island Stakeholder Conversation, March 15, 2011; Personal communication with Jim Brown, Actors Fund, March 1, 2011.

¹⁰¹ NAIC, the trade group for state insurance regulators, adopted a resolution that declared support for the brokers and urged Federal officials to ensure that producers would be "adequately compensated" by exchanges. (Resolution to Protect the Ability of Licensed Insurance Professionals to Continue to Serve the Public, Adopted August 17, 2010, NAIC.) But NAIC and the U.S. Department of Health and Human Services, the Federal agency charged with implementing the ACA, ruled that broker commissions must count in the non-medical costs portion of the MLR calculation.

¹⁰² Iowa Legislature, Senate File 391 Section 7(1)(c).

¹⁰³ Report on Troy Stakeholder Conversation, February 23, 2011.

¹⁰⁴ The amount of provider-based enrollment is potentially very significant. For example, the New York City Human Resources Administration estimates that as many as 12% of its annual enrollment is generated by hospital-originated applications for Medicaid. Personal communication with Human Resources Administration officials, May 25, 2011.

¹⁰⁵ Report on NYC Stakeholder Conversation, February 15, 2011; Report on Binghamton Stakeholder Conversation, March 10, 2011; Report on Long Island Stakeholder Conversation, March 15, 2011; Report on Rochester Stakeholder Conversation, February 28, 2011.

¹⁰⁶ S. Dorn, I. Hill and S. Hogan, "The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage," The Urban Institute, November 2009.

¹⁰⁷ ACA, *supra*, n. 3 at § 1311(i)(4); *see also* Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866 (proposed July 15, 2011) (to be codified at 45 CFR pt. 155).

¹⁰⁸ *Id.*

¹⁰⁹ Community-based facilitated enrollers submitted 112,000 applications in 2010, with a program budget of \$17 million. Personal communication with New York State Department of Health staff, June 24, 2011. Because the plan-based facilitated enrollment is funded through the administrative portion of a plan's premium cost, it is not possible to estimate the cost of this program or the cost per application submitted.

¹¹⁰ The program received \$500,000 in funding during 2006. In 2010, the funding level was reduced to \$2.5 million. The sources of funding for the grants also changed. From 2006-2009, the Legislature appropriated money from the general fund for these grants. In 2009 and 2010, some or all of the funding came from transfers to Medicaid from quasi-public agencies, Health and Educational Facilities Authority (HEFA) and the Health Connector Authority. Beginning in 2010, the grants are funded entirely by the Health Connector Authority. Personal communication with Kate Bicego, Health Care for All Massachusetts, June 28, 2011.

¹¹¹ *Id.*

¹¹² C. Tracy, E. Benjamin, and C. Barber, "Making Health Reform Work: State Consumer Assistance Programs," Community Service Society of New York, September 2010. These figures are not directly comparable. Each program has a different method of counting the number of consumers served. The case mix, from outreach to appeals, is different for each program as well. HCFA reports the number of contacts with consumers, rather than the number of cases. For the purposes of this calculation, we estimated that each case requires an average of three calls to resolve.

¹¹³ Community Health Advocates 2010 Annual Report.

¹¹⁴ Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, "Massachusetts Health Care Reform: Three Years Later," September 2009.

Endnotes (continued)

- ¹¹⁵ P. Boozang, M. Dutton, A. Lam, and D. Bachrach, "Implementing Federal Health Care Reform: A Roadmap for New York State," New York State Health Foundation, August 2010.
- ¹¹⁶ This figure includes 100,000 new enrollees engaged through the exchange, added to the existing annual demand for community-based FE services of 112,000.
- ¹¹⁷ This figure includes 33,000 new enrollees engaged through the exchange, added to the existing annual demand for community-based FE services of 112,000.
- ¹¹⁸ CHA's statewide program is in its first year; this number is extrapolated from the current rate of consumer assistance.
- ¹¹⁹ Health Care for All did not receive a grant from the Commonwealth to support this consumer assistance work.
- ¹²⁰ ACA, *supra*, n. 3 at §1311; see also Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866 (proposed July 15, 2011) (to be codified at 45 CFR pt. 155).
- ¹²¹ See HHS Discussion of Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866 (proposed July 15, 2011) (to be codified at 45 CFR pt. 155). stating: "If the State chooses to permit or require navigator activities to address Medicaid and CHIP administrative functions, and such functions are performed under a contract or agreement that specifies a method for identifying costs or expenditures attributable to Medicaid and CHIP activities, the Medicaid or CHIP agencies may claim Federal funding for a share of expenditure incurred for such activities at the administrative Federal financing participation rate described in 42 C.F.R. §433.15 for Medicaid and 42 C.F.R. §457.618 for CHIP."
- ¹²² U.S. Department of Health and Human Services, Office of Consumer Information and Insurance Oversight, Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges, January 20, 2011; see also, Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges, Special Programmatic Terms and Conditions, ¶1.
- ¹²³ P. Newell and R. L. Carey, "Building the Infrastructure for a New York Health Exchange: Key Decisions for State Policymakers," United Hospital Fund, 2011. For more information on New York's existing funding mechanisms for health coverage programs, see E. Benjamin and A. Garza, "Three Steps to Affordable Health Coverage for New York's Employers," Community Service Society of New York and New York State Health Foundation, June 2010.
- ¹²⁴ Comments by Center on Budget and Policy Priorities on NAIC draft white paper "Financing the Exchange," submitted March 18, 2011.
- ¹²⁵ *Id.*
- ¹²⁶ Personal communication with New York City Human Resources Administration, February 25, 2011.
- ¹²⁷ Comments by Illinois Chamber of Commerce and Association of Washington Business on NAIC draft white papers "Financing the Exchange" and "The Comparative Roles of Navigators and Producers in an Exchange: What Are the Issues?," submitted March 18, 2011.
- ¹²⁸ See HHS Discussion of Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866 (proposed July 15, 2011) (to be codified at 45 CFR pt. 155).
- ¹²⁹ P. Newell, "The Big Picture III: Private and Public Health Insurance Markets in New York, 2009," United Hospital Fund, April 2011.
- ¹³⁰ Personal communication with Ilana Arbeit and Phil Fina, FILCO, March 4, 2011; Personal communication with Jim Cosares, Jimco Associates, Richard Schoetz, Schoetz & Cohen Insurance Broker, Alex Miller, Millennium Medical Solutions, Stephen DeMaria, Associated Consulting Group, April 1, 2011; Personal communication with Shawn Nowicki, Mark Kessler, and Vincent Ashton, HealthPass, March 1, 2011; Personal communication with J.P. Galaris, Savoy Associates and Brian Bulger, First National Administrators, March 31, 2011.
- ¹³¹ Personal communication with Dean Mohs, Brooklyn Chamber of Commerce, June 5, 2011.
- ¹³² Bureau of Labor Statistics, U.S. Department of Labor, Occupational Employment Statistics, New York State Insurance Sales Agents, May 2009.
- ¹³³ Personal communication with Carl Hum and Dean Mohs, Brooklyn Chamber of Commerce, March 17, 2011; Todd Trantum, Chautauqua County Chamber of Commerce, March 17, 2011; Personal communication with Kevin O'Keefe, Dairylea, and Andrea Haradon, SAY2, April 4, 2011.

Endnotes (continued)

- ¹³⁴ Personal communication with Shawn Nowicki, Mark Kessler, and Vincent Ashton, HealthPass, March 1, 2011.
- ¹³⁵ Personal communication with Shawn Nowicki, HealthPass, May 16, 2011; See HealthPass Website FAQs <http://www.healthpass.com/faqs1.html>.
- ¹³⁶ In addition to serving small businesses and sole proprietors, at least two Chambers of Commerce (Brooklyn and Syracuse) help individual consumers find appropriate health insurance options as part of their contracted Healthy NY responsibilities with the Department of Insurance.
- ¹³⁷ Personal communication with Sara Horowitz, Freelancers Union and Freelancers Insurance Company, March 9, 2011; Personal communication with Adam Huttler, Fractured Atlas, March 1, 2011.
- ¹³⁸ The U.S. Department of Health and Human Services recently set up www.healthcare.gov, which provides a consolidated list of coverage options to individuals and small businesses who enter basic information. At the State level, the State Department of Health's website lists public coverage options, and the State Department of Insurance also lists all individual plans and HealthyNY plans available in the State, by county, with premium rates and insurer contact information. See New York State Department of Health: http://www.health.state.ny.us/health_care/index.htm, New York State Department of Insurance: <http://www.ins.state.ny.us/chealth.htm>. New York City's Human Resources Administration's Office of Citywide Health Insurance Access also has a website, NYC Health Insurance Link, which allows consumers to perform a tailored search for individual or small business coverage, available at www.nyc.gov/hilink.
- ¹³⁹ Personal communication with Marjorie Cadogan, NYC HRA, June 8, 2011.
- ¹⁴⁰ *Id.* HRA's Infoline handles 1,763 daily calls related to Medicaid on average and 2,109 each day on average through its IVRS. On average, 418 calls a day to 311 are related to Medicaid.
- ¹⁴¹ *Id.*
- ¹⁴² Personal communication with New York State Department of Health and Maximus, May 8, 2011. In March 2011, Maximus took an average of 3,921 calls every day from consumers in the 23 counties.
- ¹⁴³ Personal communication with Heidi Siegfried, Director of Health Policy, Center for Independence of the Disabled of New York, May 18, 2011.
- ¹⁴⁴ Children's Aid Society and Children's Defense Fund-New York, "Community-based Facilitated Enrollment: Meeting Uninsured New Yorkers Where They Are," February 2005.
- ¹⁴⁵ *Id.*
- ¹⁴⁶ Personal communication with New York State Department of Health personnel, April 28, 2011.
- ¹⁴⁷ Personal communication with New York State Department of Health personnel, April 13, 2011.
- ¹⁴⁸ Personal communication with New York State Department of Health personnel, April 13, 2011.
- ¹⁴⁹ Local District offices also call this office for help with complicated issues. Personal communication with Mary Lou Festa, State Department of Health's Division of Coverage and Enrollment Local District Support Office, May 4, 2011.
- ¹⁵⁰ Personal communication with Hope Goldhaber, Department of Health, Bureau of Managed Care Certification and Surveillance, Complaint and Utilization Review Unit, May 4, 2011.. The Unit processed 936 complaints in 2010.
- ¹⁵¹ Personal communication with Laura Dillon, Principal Examiner, Consumer Services Bureau, Health Unit, State Department of Insurance, May 4, 2011.
- ¹⁵² *Id.*
- ¹⁵³ New York Attorney General's Health Care Bureau, "Real Problems with Health Care Real Solutions for New Yorkers," available at http://www.ag.ny.gov/bureaus/health_care/pdfs/real_problems_with_health_care.pdf.

Endnotes (continued)

¹⁵⁴ Personal communication with Brant Campbell, Assistant Attorney General, May 12, 2011.

¹⁵⁵ Personal communication with Brant Campbell, Assistant Attorney General, May 17, 2011.

¹⁵⁶ The program has focused primarily on seniors, who make up the bulk of New York's nearly 3 million Medicare beneficiaries, but strives to serve younger, disabled Medicare beneficiaries as well.

¹⁵⁷ Personal communication with Linda Petrosino, Health Insurance Information Counseling Assistance Program (HIICAP) Coordinator, New York State Office for the Aging, April 5, 2011.

¹⁵⁸ HIICAP saw a 31% increase in calls to its Helpline last year, from 36,022 to 47,214 calls. Personal communication with Linda Petrosino, HIICAP Coordinator, New York State Office for the Aging, April 27, 2011.

¹⁵⁹ The seven organizations funded to provide back up to HIICAP are Selfhelp Community Services, Legal Services for the Elderly in Western New York, Empire Justice Center, New York Statewide Senior Action Counsel, Medicare Rights Center, the Legal Aid Society and the Community Service Society.



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