

State Health Reform Assistance Network

Charting the Road to Coverage

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Building on a Solid Foundation: Leveraging Current Programs and Infrastructure in Navigator Program Development

Prepared by **Rachel Dolan, Christina Miller, Kimm Mooney, and Anne Gauthier,**
National Academy for State Health Policy

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For more information, please contact Rachel Dolan at rdolan@nashp.org or (202) 238-3334, or Christina Miller at cmiller@nashp.org or (202) 338-3340.

TABLE OF CONTENTS

Building on a Solid Foundation: Leveraging Current Programs and Infrastructure in Navigator Program Development..... 1

Executive Summary..... 3
Executive Summary Table: Current Consumer Assistance Entities and Key Areas of Leverage for the Navigator Program..... 4

Introduction And Purpose 4

The Navigator Program: Key Design Considerations 5
*Table 1. Early State Plans for Navigators** 8

Current State Programs and Opportunities for Incorporation with the Navigator Program..... 8
Table 2. Activities and Functions of Consumer Assistance Entities..... 9
 APPLICATION ASSISTERS 9
Box 1. Summary Profile: Application Assisters 10
 OUTSTATIONED ELIGIBILITY WORKERS 10
Box 2. Summary Profile: Outstationed Eligibility Workers 11
 ENROLLMENT BROKERS 11
Box 3. Summary Profile: Enrollment Brokers..... 12
 INSURANCE AGENTS AND BROKERS 12
Box 4. Summary Profile: Agents and Brokers..... 13

Conclusion: Key Next Steps for Navigator Development..... 13

Appendices 15

Appendix A. Navigator Program Requirements and Training 15
 FINANCING 15
 ENTITIES ELIGIBLE TO SERVE AS NAVIGATORS..... 15
 CONFLICT OF INTEREST PROVISIONS 15
 TRAINING 15

Appendix B. State Profiles 16
 CALIFORNIA 16
 LOUISIANA 18
 MARYLAND 19
 MASSACHUSETTS 20
 MINNESOTA 21
 NEW YORK 22
 OREGON 23
 RHODE ISLAND 24
 TENNESSEE 25

Appendix C. Resource List 26

Appendix D. Interviewee List..... 28

EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (ACA) establishes health benefits exchanges and requires them to create a navigator program to assist consumers and small businesses as they apply for and enroll in coverage. The navigator program is just one piece of a larger consumer assistance infrastructure created by the ACA, and many states may already have entities performing functions similar to those required of navigators. While still early in their planning stages, this report highlights six states that have given thought to their navigator program as well as potential lessons from their planning efforts so far.

Given statutory and regulatory requirements as well as practical considerations, there are a number of issues states will need to take into account as they work to build an effective navigator program to serve the consumers in their state, including:

- seamless coordination with Medicaid and CHIP;
- target populations;
- data sharing;
- specialization of roles;
- need for trust;
- oversight and accountability;
- training;
- integration with Small Business Health Options Program (SHOP);
- procurement issues; and
- financing and compensation.

Interviewed states, like many others, have programs or consumer support entities in place that they plan to learn from and build upon as they create their navigator programs including application assisters, outstationed eligibility workers, enrollment brokers and insurance agents and brokers. Each program or entity has a number of skills and areas of expertise that states can leverage to meet the legislative requirements associated with navigators, but each also presents challenges associated with expanding its scope to serve a new population or to accomplish a more robust set of tasks. **Application assisters** have established relationships in the community and can fulfill a regulatory requirement to have at least one community group as a navigator, but their programs may be small and lack infrastructure needed to serve as navigators. **Outstationed eligibility workers** are familiar with state programs and public coverage, but know little about commercial insurance. **Enrollment brokers** are knowledgeable about managed care organizations, but are very specialized in their skillset and usually do not perform robust outreach functions. **Insurance agents and brokers** are experienced with commercial insurance and have relationships in place with small employers, but know little about public programs and may be challenging to engage and incentivize in the navigator role.

As states move forward in their navigator planning and development efforts we outline next steps states can take to ensure that their program is coordinated, efficient and targeted:

- **Perform an inventory of current programs and potential resources.** This includes programs and resources used to engage consumers through sister programs and agencies, public assistance programs, community groups and local, state and national programs.
- **Clearly define the vision for the navigator program based upon identified considerations.** States have great discretion in their navigator program design, and their decisions related to the considerations outlined in this brief will impact the types of entities, practices or resources that might be leveraged for the program.
- **Communicate clearly and frequently with stakeholders and partners.** States should identify key stakeholders related to the navigator program and communicate with them about the goals of the program to build relationships and create clarity around potential roles for the groups.

In order to implement a robust and effective navigator program that will meet both the needs of the exchange and of eligible consumers, states will need to establish clear goals for navigators and specify target populations, employ clear communication strategies and complete an assessment of the issues and available resources.

Executive Summary Table Current Consumer Assistance Entities and Key Areas of Leverage for the Navigator Program						
			Experience Performing Relevant Navigator Duties			
	Typical target population	Potential to supplement funding through Medicaid match ¹	Outreach and education	Application assistance	Enrollment assistance	Referrals to other customer assistance
Application Assistors	“Hard-to-reach” populations eligible for public coverage	Yes	Often strong experience/ capacity to do outreach; established relationships with community partners	Yes	Varies, not typically required	Heightened familiarity of applicable state and community resources
Outstationed Eligibility Workers	Those that might be eligible for public coverage	Yes	Varies by state; established relationships with community partners	Yes	Varies, not required	Familiarity with state resources available to assist consumers
Enrollment Brokers	Medicaid eligible	Yes	Varies by state and contract; typically minimal engagement of “new” consumers	No	Yes, specifically into managed care insurance plans	Referrals to state resources available to assist consumers
Ins. Agents/ Brokers	Small businesses/ small group markets; Some individual market	No, unless take on service to Medicaid eligibles	Some, for their own target groups; though established community partnerships	Yes	Yes	No

¹ In situations where navigators perform duties related to Medicaid or CHIP, states may use Medicaid/CHIP match funding to support those activities. U.S. Department of Health and Human Services. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers. Federal Register 77 (27 March 2012): 18310. Print.

INTRODUCTION AND PURPOSE

The Patient Protection and Affordable Care Act (ACA) requires health benefit exchanges to establish a navigator program to perform outreach and enrollment assistance to individuals and families enrolling in qualified health plans (QHPs), or plans certified to be sold through state or regional exchanges. The navigator program is just one, though critical, piece of the new consumer assistance landscape created by the ACA that envisions a “no wrong door” entry into health insurance coverage through the exchange, Medicaid and the basic health program, if adopted. States have great discretion on a number of issues related to the navigator program, including the entities that can serve as navigators and the additional duties states may require them to perform. Decisions made in regards to navigator development may vary widely across states depending on characteristics of the consumers they intend to target, how they choose to optimize available resources and whether or not they will require all navigators to perform all required program functions.ⁱ The Supreme Court decision in *National Federation of Independent Business v. Sebelius* may also raise additional considerations for states as they make policy decisions related to their Medicaid program.ⁱⁱ States will need to consider the impact of any potential changes to Medicaid and how those changes may impact their uninsured population moving forward.

By requiring states to include at least one community and consumer-focused non-profit group as a navigator entity,ⁱⁱⁱ federal officials have signaled that navigators are an important means to ensure that exchanges deliver culturally and linguistically appropriate outreach and education. As states choose to establish state-based exchanges, select a federal-state partnership model for their exchange, or default to a federally facilitated exchange, management of the navigator program may vary, but the need to connect to community-based groups remains.¹ Although this new program has specific requirements, many states

¹ States may elect to establish and run their own exchange, partner with the federal government or default to a federal exchange. States that partner with the federal government have the option to perform plan management or consumer assistance functions, which includes navigators.

may have entities already performing functions similar to those required of navigators, and there is an important opportunity to build on these existing programs.

The purpose of this brief is to help states, as they build their navigator programs, understand where they might leverage current resources and programs to help people navigate through health coverage programs. It offers an analytic framework for states to design programs that both meet navigator requirements, and draw upon current best practices and resources in order to best serve all persons eligible for insurance affordability programs and other publicly financed health care beginning in 2014. The analysis and information derive from a review of state reports (see Appendix C) and structured interviews with Medicaid/CHIP and exchange officials from California, Louisiana, Maryland, Massachusetts, Minnesota, New York, Oregon, Rhode Island and Tennessee.²

While there are a variety of examples and programs states may draw upon for their navigator design, this paper focuses on the specific experiences of common sources of eligibility or enrollment assistance for consumers across states: enrollment brokers, outstationed eligibility workers, application assisters and insurance agents and brokers.³

- **Application assisters** help individuals and families complete and submit their Medicaid (or other social service) application, and are commonly based in community groups or with providers or community health centers. Some assisters also help individuals and families at the time of renewal, or when eligibility issues need to be resolved.
- **Outstationed eligibility workers** are a requirement of the Medicaid program: states must have staff at Federally Qualified Health Centers (FQHCs) and disproportionate share hospitals (DSH) that are capable of handling initial receipt and processing of applications from pregnant women, children and youth.^{iv}
- **Enrollment brokers'** fundamental role is to facilitate unbiased and informed enrollment into a Medicaid and/or CHIP managed care organization and to help states meet federal requirements to ensure the enrollment and disenrollment process for Medicaid managed care is fair.
- **Insurance agents and brokers** are certified or licensed private entities that assist individual consumers and small businesses with selection of and enrollment into private insurance plans.

This report first provides an overview of the functions and requirements of the navigator program and key areas of considerations for states. It then addresses how states can leverage existing programs to meet the legislative requirements associated with navigators, including advantages and disadvantages. Finally, it provides next steps for states as they move forward in their navigator planning and development efforts to ensure that their program is coordinated, efficient and targeted. Appendix A includes a detailed outline of navigator requirements. Appendix B includes profiles of selected states' outreach, application assistance and enrollment broker best practices. A list of resources is included in Appendix C.

THE NAVIGATOR PROGRAM: KEY DESIGN CONSIDERATIONS

Many states have existing outreach, application or enrollment assistance programs (see Appendix B for detailed profiles of these programs in selected states), yet navigators, as envisioned by the ACA, are to perform similar functions but with different goals. Navigators are a function of an exchange, designed to help the millions of new individuals, families and small businesses who will gain coverage in 2014.

The ACA specifies a series of required functions navigators must meet, including:

- provision of culturally and linguistically appropriate outreach, education, and information;
- distribution of fair and impartial information concerning enrollment in QHPs;
- distribution of information regarding premium tax credits and cost sharing assistance;
- facilitating enrollment in QHPs; and
- referral to consumer assistance agencies or entities.^v

When developing their navigator program, states must decide whether their navigators will also facilitate enrollment into Medicaid in addition to QHPs. The final rule addresses a number of potential issue areas with relevance for states

² This paper also draws on previous research on enrollment broker and application assistance programs in Massachusetts, Louisiana, New York, Maryland and Oregon.

³ While many states also have in place Consumer Assistance Programs that deal with insurance grievances and complaints, the states we interviewed did not mention leveraging their CAP programs specifically for the navigator program and as such it is beyond the scope of this paper.

contemplating how to coordinate between programs, including entities eligible to participate in the program, and the requirement that at least one navigator entity be a community-based organization (CBO) or a consumer-focused nonprofit. The rule also addresses the eligibility requirements to be used for selection, funding issues and a required training program.^{vi} For more details about navigator requirements, please see Appendix A.

States have the capability to shape the navigator program to fit their vision with the flexibility granted by the federal rules. Although states are still in the initial stages of planning their navigator programs, early ideas are beginning to take shape; they are approaching the program in ways that make sense for their state. Questions they are addressing include:

- Should all navigators be able to serve any consumer seeking coverage through the exchange, or should specific navigators target specific populations?
- Will navigators be required to perform all program tasks including appropriate outreach, application assistance, and plan selection?
- Will the program be open to any type of entity or will the state identify specific entities eligible to apply?
- What resources might the state require entities to have in place before applying or what might the state wish them to deliver or develop as a condition of participation in the program?
- Will the state require separate navigators for the SHOP and the individual exchanges?

Across interviewed states, a number of themes emerged as potential areas for attention as they plan their navigator programs and other changes to prepare for the influx of enrollment in 2014. The following are specific issues for states to consider as they make decisions about implementing a navigator program.

Seamlessness and the Role of Medicaid and CHIP: States will need to decide the role of navigators with respect to Medicaid/CHIP. While navigators are primarily a function of the exchange, they have the flexibility to also work with those eligible for public programs. States will need to decide how navigators will fit into the Medicaid/CHIP enrollment process, including how integrated they will be. With an influx of new individuals coming to seek public coverage or coverage through an exchange, states will need to be prepared to guide them to the appropriate place, no matter where they enter. The ACA creates “no wrong door” entry for Medicaid, CHIP and QHP enrollment, meaning individuals and families who may be eligible for tax credits in the exchange may enter through Medicaid and vice versa. Navigator programs need to be prepared for these scenarios and have a protocol for either coordinating with public programs or for helping individuals apply for and enroll directly into those programs. With each decision related to the role of Medicaid and CHIP, states will need to think through the implications for the consumer experience. Additionally, including Medicaid and CHIP assistance in the activities of the navigator may help fund the program, since these activities are eligible for at least 50 percent federal matching funds, offsetting and supplementing the funds that the exchange must provide from its own operational budget.^{vii}

Target Populations: States can use the demographics of their target population, and proven methods to overcome barriers to reaching them, in their selection of navigators. After assessing potential exchange consumers—including the currently uninsured—states will need to decide if there are any specific populations they wish to target and then use that information to select navigators in order to maximize the program’s intended impact. Some may have navigators focused toward targeting traditionally hard-to-reach populations like those with limited English proficiency or rural populations; others may target “new” populations who will, for the first time, be exploring and selecting insurance plans; and still others may use navigators as part of broad state-wide engagement of all populations. The choice of target populations will influence the need for specific skills sets in selected navigators, including the ability to engage with and conduct comprehensive outreach and education to designated audiences.

Data Sharing: Regardless of the level of integration between exchange and Medicaid application, eligibility and enrollment processes, the programs will need to share data on individuals and families. The ACA allows individuals to apply for coverage at multiple entry points, and navigators and agencies will need to either integrate their data or be able to share it as they refer people to the appropriate source of coverage. This is crucial to seamlessness and coordination. States will need to develop explicit policies for what data navigators are required and allowed to handle. Furthermore, inasmuch as data is stored and processed through the exchange itself, explicit safety training and certification processes may be required to ensure the secure transfer and use of data by all or by selected navigators.

Specialization of Role: States are considering specialized or tiered roles for navigators based on populations different navigators would serve, and would vary their levels of qualification accordingly. Specialization would allow navigators to

serve populations with different needs and to take advantage of existing competencies in groups that may serve as navigators. Federal regulations allow for this approach, as not all navigators are required to perform every duty and they cannot be required to be licensed brokers.^{viii} If opting for this specialized approach, clear processes will need to be established to “hand off” other functions either to other navigator or consumer assistance entities or to the exchange itself to help ensure seamlessness.

Need for Trust: Navigators have the potential to be valuable partners because of the relationships selected entities have already cultivated and continue to cultivate in their communities. To be successful, navigators will need the trust of individuals, families and businesses seeking assistance with enrollment into various types of coverage. Trust in navigator entities is critical for success in reaching out to newly eligible or enrolled populations, and the vulnerable or underserved populations that the state has traditionally not been able to reach. Lake Research Partners recently conducted a survey on behalf of Washington on issues related to navigators. Their results indicate that trustworthiness is a crucial characteristic for navigators, as individuals will need to be comfortable providing them with sensitive personal information.^{ix} States will also have to trust navigators to be good stewards of public funds.

Oversight and Accountability: Given that navigators will be dealing with sensitive personal information and assisting individuals with the important process of enrolling in health coverage, oversight and accountability are critical. Final regulations codify conflict of interest requirements for navigators,^x but oversight will still be needed to ensure that navigators are fulfilling legal requirements, that they are not improperly using personal information and that they are effective at assisting individuals, families and small businesses. There are also special considerations given to individual tax information. Some states are considering various forms of certification to ensure accountability of navigators.

Training: Navigators will need both knowledge about public programs as well as about QHPs and private insurance plans. Currently, most groups that provide enrollment or application assistance are knowledgeable about either Medicaid or private insurance; very few work with populations across programs or different types of coverage. Training will be critical to ensure that navigators are informed about all coverage options and are able to provide fair, as well as culturally and linguistically appropriate, information. Navigators may also need to be trained to refer individuals to and coordinate with other state assistance programs, consumer appeals and grievance programs or insurance brokers, depending on the program’s structure.

Small Business Health Options Program (SHOP) Integration: States are still grappling with the distinct role and rules regarding the SHOP exchange. Given that the SHOP and individual exchanges will serve very different constituencies, a “one-size-fits all” navigator program may not be appropriate for every state. The SHOP exchange will serve small businesses and will need to make the process simple and attractive across a range of types of small businesses. The individual exchange will serve a wide range of individuals across socioeconomic levels and will need to consider that when selecting appropriate navigators. The SHOP exchange may provide another opportunity for states to develop tiered roles for navigators, if states develop only one program for both individual and SHOP navigators.

Procurement Issues: Many states have existing contracts with CBOs or other entities that may perform some of the duties required of navigators. States may want to consider if they are able to leverage these contracts and build off them for the navigator program. If states are not able to use existing contracts, they should look for opportunities for coordination at renewal. Even if procurements remain separate for navigators and other groups, states should examine the experiences and lessons learned from prior contracts and previous experience working with CBOs and other potential navigators within the state.

Financing/Resources: States are concerned about how to finance their navigator programs and other consumer outreach, as well as sufficient human resources for their exchanges. States cannot use federal money to fund the operational costs of the navigator program, so they will likely need to build navigator costs into the overall operating budget of the exchange. While the program funding could simply come from the overall exchange financing mechanism, such as a broad-based assessment or user fees, some states are thinking outside traditional funding sources, including advertising revenue, funding from providers or even philanthropic support specifically for the work of navigators. Human resources are also an important consideration for the program as the exchange and the state will need to have enough personnel to serve as navigators, manage navigator certification and training and to continue other public program outreach, if desired.

Compensation: Grants and contracts are among the methods states can employ to compensate navigators. The specific terms of a grant or contract the state employs will depend on the entities selected to be navigators as well as the goals of the program, such as an increase in take-up rates overall or within a specific target population group. A state could employ a combination of methods and tailor the payment structure for each to the specific duties the navigator performs, including providing incentives for the outcomes the state wishes to promote. Incentives could be structured in a number of ways, such as compensating entities that can offer a wider range of services to consumers or that complete more levels of training than is required, or compensating differently for different outcomes.

California	California is planning to develop an Assister Program, which will include a variety of organizations that will help individuals and families apply for and learn about both the exchange and public programs. A subset of these assisters, known as Certified Enrollment Assistants, will serve as the state's formal navigators. These Certified Enrollment Assistants will be trained, certified, registered and compensated by the exchange specifically for the purpose of enrolling consumer in exchange programs.
Maryland	Maryland has decided to have separate navigator programs for the individual and SHOP exchanges because of the diversity of needs and populations between the two markets. The SHOP navigator program will focus on outreach to small employers who do not currently offer insurance. The state will require SHOP navigators to have a "SHOP navigator license" which will be issued by the insurance commissioner. The individual exchange navigator program will place more emphasis on outreach and enrollment efforts for vulnerable populations. The exchange will issue certification for individual navigators. Neither the SHOP nor the individual navigators will be required to be licensed producers. The state also issued a Request for Proposals on May 30, 2012, for support and analysis in the development of the program.
Minnesota	Minnesota is considering tiered certification for navigators to build off existing expertise organizations may already have. The state recognizes that each navigator would have different skill sets, each of which would be applicable to certain types of enrollees over others. Compensation would be aligned with the varying levels of certification. Organizations would be able to gain expertise through additional training.
Oregon	Oregon's exchange board recently discussed a potential "Agent Management Program." Through this program the exchange would become a business entity, which in Oregon would allow the exchange to affiliate with a number of producers and pass the carrier commission on to them. The exchange would develop a network of affiliated agents across the state that would help both small businesses and individuals with insurance advice and services. Given that the exchange would be the distributor of commissions, agents would have no incentive to recommend one plan over the other and would instead work with all plans available through the exchange.
Rhode Island	Rhode Island has had success with their Family Resource Counselor (FRC) program and sees potential opportunities to model their navigator program similarly, especially with regards to a centralized training and payment agency. Key considerations for the navigators are that they are located in the community, are accessible to all potential eligible individuals, are unbiased in terms of health plan choice, and do not have any financial incentive tied to an eligibility determination. The state hopes to create a navigator system that assists the clients, in whatever manner is necessary to help them successfully "navigate" the health care system.
Tennessee	Tennessee has a strong broker presence and has worked intensively with agents and brokers to bring them into the conversation. The state convened an Agent/Broker Technical Advisory Group (TAG) throughout 2011 to provide expertise on a number of issues. The state recently released a Request for Information related to the SHOP exchange and indicates the state may require small businesses to purchase coverage through brokers in the exchange. Tennessee has also pinpointed specific hard-to-reach populations that navigators will target, including: limited English proficiency speakers, the limited literacy population, and the homeless/transient population. The state hopes to engage community organizations that have existing relationships with these groups to work as navigators.

* Many states' navigator programs are still a "work in progress." These summaries do not represent final decisions. For more detail about state plans for navigator design information see Appendix B

CURRENT STATE PROGRAMS AND OPPORTUNITIES FOR INCORPORATION WITH THE NAVIGATOR PROGRAM

Although the navigator program is a new consumer support structure to be developed in conjunction with the exchange, the concept behind navigators and their activities is not novel. Across states, several types of consumer support entities currently perform many of the functions required of navigators. Often such programs have evolved to meet the unique landscapes and needs of both states and consumers, and the formality of these programs, as well as their structures, support mechanisms and target audiences, vary greatly across and within states. For example, a state may have existing relationships with CBOs, formally through an outreach or application assistance program or informally through stakeholder meetings and workgroups. Many states also have established programs that perform outreach or application or enrollment assistance for individuals seeking assistance with acquiring public coverage through their Medicaid, CHIP or other human services agencies. Still, other entities in states may have developed communication structures, data collection and sharing strategies or stakeholder relationships that states can use as models for the navigator program.

Common examples of these current entities include enrollment brokers, outstationed eligibility workers, application assisters and insurance agents and brokers (See Table 2 for a breakdown of the common functions of these entities). These entities serve niche markets of consumers and are key points of opportunity for states to examine how they might build upon established infrastructure to leverage existing resources, experience and relationships for their navigator programs. States

should take care to closely identify and examine such programs not only within but across states, and identify the opportunities and challenges to incorporating the work of each into their navigator design.

Table 2
Activities and Functions of Consumer Assistance Entities

	Navigators	Enrollment Brokers	Application Assisters	Eligibility Workers	Agents/Brokers
Typical target population	All exchange consumers (individuals or sm. businesses applying for QHPs; potentially those eligible for public coverage)	Medicaid eligible	"Hard-to-reach" populations eligible for public coverage	Those that might be eligible for public coverage	Small businesses/ small group markets; some individual market
Conduct outreach & education	Yes	Varies by state and contract	Yes	Varies by state	Some, for their own target groups
Provide application assistance	Yes ⁵	No	Yes	Yes	Yes
Provide enrollment assistance	Yes	Yes	Varies, not required	Varies, not required	Yes
Referrals to other customer assistance	Yes	Yes	Varies, not required	Varies depending on available state resources	No

⁵ Regulations specify that navigators must facilitate enrollment in QHPs and assist individuals in applying for premium tax credits and cost-sharing reductions.

Application Assisters

Some states have a formal or informal application assistance program to provide individuals and families with assistance in completing and submitting their Medicaid, CHIP or other social service application(s). In some states, these assisters also help individuals or families at the time of renewal, when a change in circumstance occurs or with eligibility issues that need to be resolved. Some states compensate for these services—for example, per completed application or per successful application—although some provide the services without compensation (See Appendix B for more details about state compensation models).

Application assisters may be hosted by a variety of entities and target diverse populations, but most commonly they are housed in CBOs, tribal or faith-based groups and with providers and community health centers, making them prime candidates to fulfill the federal requirement that at least one navigator entity be a community or consumer-focused non-profit. Many application assisters already serve as de facto navigators for the state’s uninsured, with established lines of communication with community leaders, partners and the population-at-large through which they can conduct outreach. Often, these assisters have a heightened awareness of local populations, including cultural sensitivities, particular health needs, provider networks and other available resources. Oregon’s outreach and application assistance network, for example, has strong ties to the community, which has helped Oregon successfully implement and maintain high enrollment in its Healthy Kids program. Likewise, a key piece of Massachusetts’ 2006 health reform efforts included the deployment of outreach contractors, financial counselors and hospital staff as application assisters at CBOs and community health centers across the state.

Application assisters may vary greatly within a state, some focused more on providing targeted outreach, while others may have optimized application and case management strategies to better ensure continuous coverage for their intended audiences, including consumer education tools related to eligibility requirements and renewal processes. Some come from organizations with strong infrastructure and resources to draw from, and others from organizations of limited, yet strongly mission driven, means. Some are housed within organizations of key status for desired target populations within a community, such as church groups or community associations, and some may only have been established to provide a small subset of services to designated constituencies. Whatever the experiences of application assisters, they offer states lessons in outreach and assistance strategies for their navigators as well as the potential to be leveraged as navigators themselves. Minnesota, for instance, foresees a role for its application assistance program, through which the state provides resources to 120 organizations to conduct outreach and application assistance. However, the state will not make decisions about whether to leverage pieces of the program, or the program in its entirety, in its navigator design until a clearer vision is set for its navigator program and the population(s) it will serve.

Some more robust application assistance programs may easily transition into the role of navigators, able to provide assistance to any consumer seeking assistance with acquiring health coverage, through expansion of services and additional training. States may also consider how they might leverage Medicaid administrative matching funds to support these assisters who will also function as navigators. However, application assisters more limited in their experience, resources and even target populations, may be better suited as entities that partner with navigators through coordinated outreach strategies and plans to transition information about individuals and families that may churn between eligibility for public programs and subsidies for QHPs.

Box 1 Summary Profile: Application Assisters
Potential points of leverage for navigator program
<ul style="list-style-type: none"> • Fulfills requirement to have one navigator entity be a community or consumer-focused nonprofit • Experience working with populations in need of public coverage • Often strong experience/ capacity to do outreach • Often community-based and mission driven with high levels of cultural competency for their target populations • Heightened familiarity of applicable state and community resources • Costs may partially be covered by Medicaid resources
Potential challenges to their incorporation as navigators
<ul style="list-style-type: none"> • Minimal experience working with populations currently not eligible for public coverage, or actively seeking coverage • Lack experience in plan selection and enrollment assistance • May need more robust infrastructure to handle technology and data sharing requirements of navigators

Outstationed Eligibility Workers

A requirement of the Medicaid program is that states must have workers at FQHCs and DSH hospitals to receive and handle initial processing of Medicaid applications from pregnant women, children and youth.^{x1} Known as outstationed eligibility workers (OEWs), these workers are often state or county employees whose salaries are eligible for a 50 percent Medicaid administrative match. These workers help individuals to apply for public assistance benefits at locations other than typical Medicaid or social services offices; optimally, they are in locations that are more geographically accessible to potential consumers than state or county offices. They also assist in providing comprehensive education to consumers regarding eligibility requirements and processes, as well as reporting requirements and renewal processes. Some states have expanded the role of OEWs beyond the legal requirement to also assist with outreach for and enrollment in other public programs. Other states, however, have struggled with maintaining robust OEW programs, experiencing high turnover rates for these workers.

As a part of a state's current consumer assistance landscape, many OEWs offer critical experience with reaching consumers through their location at key providers of services to the uninsured (e.g. safety net facilities). Because they are locally based, they are often aware of the specific needs, priorities, and cultural sensitivities of the populations they work with, and have cultivated valuable personal relationships with providers, consumers and other stakeholders in order to improve their reach.

The extent to which a state might leverage the work of its OEWs into its navigator program varies greatly based upon the infrastructure that has been established through the OEW program, including readiness to take on additional functionality related to plan enrollment, data sharing and work with exchange populations, as well as whether and how the state might wish to leverage the funding available for OEWs through the Medicaid match. For instance, Rhode Island has developed a robust system of outreach, application assistance and case management through its OEWs—known as Family Resource Counselors (FRCs)—and is considering integration of these entities into its navigator program. Anticipating this move, the state has included available navigator requirements as part of a revised application for entities wishing to apply as FRCs.

Even if sufficient infrastructure is not in place to efficiently incorporate OEWs into the navigator program, states should strongly consider ways to leverage the resources and relationships OEWs have developed to optimize resources and coordinate the programs as appropriate. States opting to specialize or “tier” the roles of their selected navigators may consider how to incorporate OEWs as part of this tiered structure. This may include establishing protocols for enhanced data sharing, as well as coordination of outreach methods and messages between OEWs and navigators.

Box 2

Summary Profile: Outstationed Eligibility Workers**Potential points of leverage for navigator program**

- Experience working with populations in need of public coverage
- May be plugged in to data sharing system with state and/ or insurers through previous work
- Are likely familiar about other state resources available to assist consumers
- Costs can partially be covered by Medicaid resources

Potential challenges to their incorporation as navigators

- Minimal experience with populations not eligible for public coverage or actively seeking coverage
- Current experiences/ capacity varies by state investment (esp. for outreach)
- Lack experience in plan selection and enrollment assistance
- High turnover rates in personnel/ lack of stable structure to sustainably build upon

Enrollment Brokers

Many states with Medicaid managed care have an enrollment broker whose fundamental role is to facilitate unbiased and informed enrollment into a Medicaid and/or CHIP plan and to help states meet federal requirements to ensure the enrollment and disenrollment process under Medicaid managed care is fair. This process is separate from the eligibility determination process, which necessarily precedes enrollment into Medicaid and/or CHIP and is usually conducted by state or local agencies, rather than a contracted enrollment broker.

As enrollment facilitators for individuals found eligible for Medicaid or CHIP, enrollment brokers offer a host of experience relevant to the navigator program, including the provision of unbiased coverage information to health care consumers such as information about copayments, coinsurance, covered services and provider networks. Their experience equips them with a familiarity about managed care insurance plans in general (and about those specifically in the state) and knowledge of factors important to guiding consumers through plan selection and enrollment as well as necessary follow-up and renewal. They also have an increased awareness of other state resources available, including federally required, easily understandable information related to providers, enrollee rights, grievances and appeals, covered items and services and comparative information on plans.^{xii} Moreover, enrollment brokers have established relationships and systems for information sharing with the state and insurers.

The precise role and activities of enrollment brokers varies from state to state. Some states have built requirements into their enrollment broker contracts beyond the performance of enrollment functions. For example, Louisiana has contracted with its enrollment broker to conduct activities to help ensure network adequacy and create and supply informational charts to beneficiaries about available plans. To take advantage of the experience, resources and functionality already developed through their enrollment broker contracts, some states may opt to fully integrate enrollment brokers into their navigator program by expanding the current work of enrollment brokers to include application assistance, selection of a QHP and more robust outreach. As navigators, enrollment brokers would serve as a single stop assistance service for all Medicaid and exchange consumers, ensuring a seamless experience for any individual seeking assistance from this entity. This integration model may also prove advantageous as Medicaid or CHIP may partially fund the work of enrollment brokers for the work they do with those respective populations.

However, despite the advantages enrollment brokers may offer, they lack experience working with non-Medicaid or CHIP populations and insurance plans. Furthermore, as they connect with consumers after they submit applications, they have limited experience conducting application assistance and often minimal experience with outreach and engagement targeting new populations, except where explicitly contracted by a state to do so.

The extent to which a state plans to coordinate eligibility and enrollment processes for exchange and Medicaid populations will determine the success of the enrollment broker as navigator. For example, California envisions developing a unified system for eligibility and enrollment determination through its exchange and plans to merge or adapt its robust enrollment broker program into this new system accordingly. Because of their niche activities and knowledge from working exclusively

with enrollment into Medicaid/CHIP (as opposed to application assistance), some enrollment brokers may be too specialized to effectively and efficiently morph into a state’s navigator design. In this case, a state might opt instead to preserve enrollment brokers as a specialized entity to work specifically with its Medicaid-eligible population. This could alleviate some burden on both navigators and enrollment brokers, as each can focus its resources and knowledge on a distinct subset of the population, with opportunity to refer consumers to one or the other as necessary for guidance through either Medicaid enrollment or the exchange. However, to ensure a “no-wrong-door” approach for consumers, states will need to consider ways in which they might coordinate the work of enrollment brokers and navigators, including data sharing and clear consumer messaging and referral systems identifying the purpose and role of each.

Box 3

Summary Profile: Enrollment Brokers

Potential points of leverage for navigator program

- Familiarity with managed care insurance plans
- Experience guiding populations through plan selection/ enrollment
- Established information sharing mechanism with state and/ or insurers
- Familiarity with other state resources available to assist consumers
- Experience providing culturally competent, unbiased assistance
- Experience with case management (enrollment, follow-up, renewal)
- Costs can partially be covered by Medicaid resources

Potential challenges to their incorporation as navigators

- Experience solely with Medicaid recipients and Medicaid managed care insurance plans
- Lack experience in application assistance
- Minimal experience conducting outreach and public education to engage new populations
- Might currently be too specialized, may be difficult and/or costly to fully integrate them as navigators so that they can serve exchange populations

Insurance Agents and Brokers

Many states have a long history with insurance agents and brokers, who are certified or licensed private entities that connect consumers with insurers and insurance products. Insurance brokers represent insured individuals and are not necessarily affiliated with insurance carriers, while insurance agents act as representatives of an insurance company. Typically targeting businesses as their client base, both agents and brokers have a keen knowledge of laws regulating private insurance (e.g. HIPAA and COBRA⁴) and may serve as a human resource (HR) provider for those businesses that may not have HR personnel to handle insurance processing and inquiries.

A state has flexibility to determine the role of insurance agents and brokers in their exchange. While the ACA includes licensed insurance agents and brokers as examples of entities that may serve as navigators, the law also stipulates that navigators cannot receive compensation from a health insurance issuer for enrolling individuals or employers in a plan—a common source of income for insurance brokers.

Their understanding of private market insurance, their ability to educate consumers about complicated and unfamiliar health insurance concepts—including coinsurance, deductibles, service limitations, etc.—as well as their experience providing guidance from application through enrollment into an insurance plan, positions insurance agents and brokers as field experts in guiding individuals through the acquisition of private coverage. This knowledge base can easily be transitioned into an exchange world where these entities will have access to enhanced tools to assist them in sorting through coverage options. Furthermore, agents and brokers often work with businesses and other consumers in the small group market, uniquely positioning them as prime partners in navigating consumers who will be eligible to participate in coverage through the SHOP exchange. However, establishment of an exchange does alter the environment under which agents and brokers currently operate. It may be difficult to establish an adequate payment structure and clear conflict of interest standards for these entities

⁴ The Health Insurance Portability and Accountability Act and the Consolidated Omnibus Budget Reconciliation Act provide protections to individuals who lose group insurance coverage.

whose past income has relied heavily on payment directly from carriers for enrolling individuals or groups into specific plans. As a group, agents and brokers have pushed back in many states where they view the exchange, and even other navigators, as competitors to their current work with private market insurance plan selection and enrollment.

Working intensively with agents from the beginning of the state’s planning process, Tennessee was able to understand and address agents’ concerns about a potential exchange in the state. By reaching out and communicating clearly to the agent community about its vision for an exchange (if it is to build one) the state has now drawn this community in and will continue to work with them on developing their new role, particularly related to SHOP coverage. To draw upon the system agents have established, Tennessee is considering a requirement that any small group wishing to purchase SHOP coverage must do so through an agent for the first two years the exchange operates. Additionally, whereas agents initially showed interest in serving as navigators for all potential exchange consumers, including those that may qualify for Medicaid, clarified messaging about the responsibilities involved in navigating these populations have since led agents to focus their efforts on their role within the SHOP exchange.

<p>Box 4 Summary Profile: Agents and Brokers</p>
<p>Potential points of leverage for navigator program</p> <ul style="list-style-type: none"> • Experience working with small group market populations (small employers) • Some outreach experience/ established community relationships • Familiarity with how to sort through available insurance options including benefits, costs and provider networks • Established relationship with current consumers for follow-up, renewal, etc.
<p>Potential challenges to their incorporation as navigators</p> <ul style="list-style-type: none"> • Minimal experience with populations outside of current small group market, especially those eligible for public coverage • May see other navigators or the exchange itself as competition, versus as partners or a tool they can work with depending on funding structure and perceived incentives • Establishing fees or reimbursement may be tricky; typically receive funding direct from carriers; potential conflict of interest issues

CONCLUSION: KEY NEXT STEPS FOR NAVIGATOR DEVELOPMENT

The preceding section highlights just some examples of the wealth of programs and experience states have to draw from for their navigator programs, each offering its own strengths and challenges if incorporated into a state’s overall navigator design. States will ultimately be accountable for creating a program that can meet state and federal regulations and effectively engage exchange consumers, while balancing limited resources and a need to develop infrastructure and fair compensation policies for navigators.

Below are several steps for states to consider as they continue to develop their navigator programs and judge how best to leverage any existing programs, entities, or resources:

Perform an inventory of current programs and potential resources. This includes programs and resources used to engage consumers through sister programs and agencies—Medicaid, CHIP and other public assistance programs—as well as community groups, county and local programs and national programs. Many such programs have long established ties to consumers or have resources that states can easily leverage or adapt as part of the navigator program or to ease the burden on navigators. Some states, for example, use free and reduced lunch applications as a means of identifying or performing outreach to individuals that may be eligible for other forms of assistance.

Community groups such as chambers of commerce or social clubs often have established means and even personnel to reach various constituencies about new coverage options, while providers of all types are important points of contact for health care consumers. By identifying these opportunities, states can better steer the resources of their navigators toward areas of deficiency to create as robust an engagement strategy as possible.

Clearly define the vision for the navigator program based upon identified considerations. States have great discretion in their navigator program design, and their decisions related to identified considerations (seamlessness, data sharing, specialization of roles, need for trust, SHOP integration, procurement, financing/ compensation, oversight/ accountability, training, target populations) will impact the types of entities, practices or resources that might be leveraged for the program. States envisioning a more specialized navigator design, for example, may confer specific responsibilities, like outreach and education or QHP selection, to those entities already conducting similar activities for exchange target populations. On the other hand, states opting to create a more uniform design—where all navigators are able to assist any consumer seeking coverage (public or private)—may choose to build navigator programs by adding duties and infrastructure upon a program already in place to serve populations in need of coverage. The sooner a state establishes this vision, the sooner it can identify and engage appropriate partners and develop clear strategies to effectively and efficiently build its navigator program.

Communicate clearly and frequently with stakeholders and partners. This paper identifies various entities that can bring a diversity of strengths and ideas to contribute to a state’s navigator program design. However, each also operates under its own agenda or mission that may influence its willingness to engage with the state or selected navigator entities and how effectively it may perform within the structure of the navigator program. States should recognize the distinct identities and priorities of each while also striving to communicate their own goals and intentions clearly to stakeholders. This will bolster cohesiveness of the navigator program as well as the performance of required navigator tasks as designated to various entities.

Through an assessment of these issues and available resources, clear establishment of navigator goals and target populations and clear communication strategies, states will be well on their way toward implementing a robust and effective program to meet the needs of their exchange and eligible citizens.

APPENDICES

Appendix A. Navigator Program Requirements and Training

The ACA specifies a series of required functions navigators must perform related to outreach and consumer assistance, including facilitation of qualified health plan (QHP) selection and providing information in a culturally and linguistically appropriate manner. Navigators will also need to assist individuals in applying for tax credits and cost-sharing reductions through the exchange.

Financing

The law is clear that, unless navigators provide services to Medicaid and/or CHIP beneficiaries, states may not use federal funds to finance navigator programs; exchanges must instead use other sources of funding.^{xiii} Payment to navigators may potentially involve a series of grants or contracts with different entities or a single contract with one entity to manage the program.

Entities Eligible to Serve as Navigators

While the navigator program requires at least two types of eligible entities to participate as navigators in a state, it does not place an upper limit on the number of groups that may act as navigators. The final rule requires one of the two entities be a community or consumer-focused nonprofit. A broker license is not required to perform navigator duties.^{xiv}

Conflict of Interest Provisions

Exchanges must develop a set of conflict-of-interest standards for navigators. The final rule allows exchanges to set the standards and recommends they include financial considerations, employment and activities, and disclosures, among other issues. The ACA prohibits health insurance issuers from compensating navigators for enrolling individuals in health insurance plans, including both QHPs and plans sold outside the exchange.^{xv}

Training

Exchanges must develop a training program for all individuals that perform navigator functions, including staff members of organizations designated as navigators. The training must ensure navigators are competent in the needs of underserved and vulnerable populations, eligibility and enrollment procedures, and the range of public programs and QHP options available through the exchange. Additionally, navigators must be trained in the proper handling of tax data and other personal information.^{xvi}

The final rule indicates that CCIIO/CMS will release additional guidance on navigator training, including standards on linguistic and cultural competency.^{xvii}

Appendix B. State Profiles

CALIFORNIA

California has two major health coverage programs: Medi-Cal, the state Medicaid program, and the Healthy Families Program (HFP), California’s CHIP program for children under 19 who are below 250 percent FPL and who do not qualify for Medi-Cal.^{xviii} Roughly 60 percent of the total Medi-Cal population, or 4.4 million people, is served by Medi-Cal managed care.^{xix} Whether an individual is required to enroll in a Medi-Cal managed care plan depends on the county in which he or she lives. There are three models of managed care operating in 30 counties in California: the Two-Plan model, the County Organized Health Systems (COHS) model, and the Geographic Managed Care (GMC) model. In Two-Plan model counties, Medi-Cal managed care enrollees can choose from one of two health plans contracted by the Department of Health Care Services.^{xx} Counties operating the GMC model offer several commercial plans in which Medi-Cal managed care beneficiaries can enroll. In COHS model counties, all beneficiaries receive care from the same managed care plan. This plan is created by the County Board of Supervisors and is run by the county.^{xxi}

California’s Enrollment Brokers

The state has contracted with Maximus to serve as the enrollment broker for Medi-Cal managed care. In the counties with GMC or the Two-Plan model, the enrollment broker performs outreach, enrollment and health plan management for eligible individuals. If an individual has not selected a plan after 60 days from his or her date of eligibility determination, the individual is auto-assigned a plan. In COHS counties, individuals are enrolled in the county health plan after eligibility is determined. It is the duty of the enrollment broker to conduct follow-up outreach about the services available in the county plan.

To achieve the state’s vision of a seamless and simplified experience for Medi-Cal enrollees and those eligible for subsidized programs, CHIP and the exchange, California is considering creating a process for Medi-Cal recipients in which an individual can apply for coverage and do plan selection similar to that being created for exchange applicants. The state is currently thinking through how this simplification will be implemented and what this would mean for the Medi-Cal enrollment broker.

Enrollment Entities and Certified Application Assistants

Uninsured individuals applying for HFP can receive assistance from community organizations known as Enrollment Entities (EEs) and the Certified Application Assistants (CAA) that work for those entities. Community-based organizations that are interested in becoming an Enrollment Entity must submit an application along with applicable state licenses or tax status verification to the HFP office.^{xxii} Prospective applicants must sign a Code of Conduct, participate in a 5-hour web-based training course, and take and pass a certification exam to be granted the authority to provide assistance to families.^{xxiii} CAAs assist individuals completing applications for initial enrollment and renewal, answer questions about programs, refer applicants to county Department of Social Services or the HFP office when necessary, and assist in HFP plan selection. In addition, CAAs inform families about program changes and work to prevent loss of coverage. Enrollment Entities and CAAs have access to Health-e-App, California’s online application system which is used to submit an application for HFP and to screen certain low-income children and pregnant women for no-cost Medi-Cal. CAAs can use Health-e-App to submit applications and help HFP applicants select health plans.

Originally, EE’s received \$60 per successful initial application submitted through the Health-e-App and \$50 per HFP Annual Eligibility Review (AER) assisted application for renewals.^{xxiv} Funding for the program was suspended in 2009, however, due to fiscal challenges in the state. While Healthy Families maintains a certification and training process for assisters, there is no longer any formal reimbursement. Regardless, there are currently 23,000 CAAs still active in California.

Preliminary Thinking on California Navigator Program

California is currently developing a new Assisters Program encompassing a variety of entities that will provide grassroots and culturally linguistic application and enrollment assistance to potentially eligible families looking to enroll in Medi-Cal, Healthy Families or subsidized and non-subsidized coverage in

Key Elements California
Enrollment Broker
<ul style="list-style-type: none"> • Outreach, member enrollment, and health plan selection depending on county model
Outreach
<ul style="list-style-type: none"> • Enrollment Entity (EE) and Certified Application Assistants (CAA) – not compensated • Broad range of community-based organizations

the exchange. A subset of these assisters, known as Certified Enrollment Assistors, will be certified to assist individuals and families apply for and learn about coverage through the exchange. Certified Enrollment Assistors will be broken into two categories: those compensated by the exchange (navigators), including non-profits, community clinics, county social services offices, and labor unions, and those not compensated by the exchange, including health insurance agents, hospitals, and providers. A recent report about the Assister Program recommends that all Certified Enrollment Assistors be required to conduct education, eligibility and enrollment services as mandated by the ACA, but gives discretion as to the subset of other services assistors might be required to perform, including outreach, retention and utilization services. The report also recommends that Certified Enrollment Assistors complete annual training and recertification programs.^{xxv}

LOUISIANA⁵

Outreach and Enrollment Assistance for Bayou Health

Louisiana is currently in the process of implementing Medicaid managed care, termed Bayou Health. Consumers largely receive enrollment assistance in navigating options available in Bayou Health through an enrollment broker who is required to:

- supply existing and new beneficiaries with a welcome letter and comparison chart of all available plans;
- maintain a call center and website where families will be able to enroll in their preferred network;
- conduct “secret shopper” activities to ensure that network adequacy and customer service requirements are being met by the plans and their contracted providers; and
- create a complaint tracking system, which has a variety of sources.

Because the program is new and will require the transition of nearly 900,000 Medicaid and CHIP recipients in the state to select an MCO for the first time, the state has also contracted with a separate communications firm to conduct outreach and education about the program.^{xxvi}

Application Assistance for Bayou Health

Potentially eligible families in Louisiana can get help completing their application at one of over 500 application centers in the state. These centers are community-based organizations with existing relationships with the communities they serve. The state compensates the centers \$14 for each completed application they submit to the Department of Health and Hospitals, regardless of the outcome of that application. The state also relies on the outreach infrastructure built by the Louisiana Covering Kids and Families network, which provides a contract to one organization in each of nine administrative regions in the state to build coalitions to promote coverage and access. This network of engaged organizations has helped the state implement Bayou Health by educating the public about the program. These contracts will not be renewed after July 1, 2012.

Louisiana has chosen not to pursue the establishment of a state-based exchange.

Key Elements Louisiana
Enrollment Broker
<ul style="list-style-type: none"> • Member enrollment into MCO – with comparison chart of all plans • Call center • Secret shopper • Complaint tracking system
Education Contractor
<ul style="list-style-type: none"> • Public education about Medicaid managed care
Outreach
<ul style="list-style-type: none"> • 9 contracted entities building coalitions in each region • 500+ application assisters, compensated at \$14 per complete application

⁵ While Louisiana has decided not to pursue a state-based exchange, their experience with assisting consumers in the enrollment process has been successful and may serve as a model for other states.

MARYLAND

Maryland has three health insurance assistance programs: Medical Assistance, the state’s Medicaid program; Maryland Children’s Health Insurance Program (MCHIP), the CHIP program; and Primary Adult Care (PAC) for adults ages 19 and older with incomes under 116 percent FPL. MCHIP provides coverage to pregnant women of any age whose incomes are at or below 250 percent FPL, and children under age 19, who are not eligible for Medicaid, and whose family incomes are at or below 200 percent FPL. Medical Assistance covers low-income families and children with incomes at or below 116 percent FPL and medically needy individuals with incomes up to 200 percent FPL. About 80 percent of eligible populations are in the managed care program, called HealthChoice.

Eligibility and Enrollment Processes for Public Coverage Programs

The Department of Human Resources, in coordination with local Health Departments and Department of Social Services, conducts the eligibility determinations for the Medical Assistance programs. Applications for Medical Assistance and MCHIP can be mailed to or completed in person at local Department of Social Services. The Department of Health and Mental Hygiene (DHMH) staff determines eligibility for the PAC program. PAC applications can be submitted to the state PAC office. Once eligibility determinations are made, enrollees who are eligible for managed care receive a mailing with information about the 7 MCOs participating in HealthChoice. If an enrollee, who does not already have a primary care provider (PCP), fails to choose a plan within 21 days from the date after the information is received, he or she will be auto-assigned a plan. If an enrollee fails to choose a plan within that time frame but already has a PCP, the enrollee will be assigned to the MCO in which his or her doctor belongs.

Maryland’s Enrollment Brokers

Maryland has contracted with Policy Studies, Inc. to serve as the enrollment broker for Medicaid and CHIP. The primary functions of the enrollment broker include:

- outreach and education to Medicaid and CHIP enrollees about enrollment into an MCO and selection of a PCP;
- assistance with MCO plan change if requested during annual renewal; and
- work to maintain at least 80 percent voluntary enrollment as opposed to auto-assignment.

Key Elements Maryland
Enrollment Broker
<ul style="list-style-type: none"> • Outreach and education about enrollment into MCO and PCP selection • Maintains 80% voluntary enrollment into MCO versus auto-assignment • Attends outreach events • Active procurement for enrollment broker services released in September 2011

The vendor is also required to attend a certain number of outreach events each month to provide information, answer questions, and potentially enroll individuals who know their eligibility status. The vendor also operates a call center for MCO enrollment.

Maryland released an active procurement for enrollment broker services in September of 2011. When developing the RFP, the state made some significant changes to the enrollment broker program, in part to meet new and anticipated needs of the ACA and future coverage expansions. These changes included adding the PAC program, increasing the number of accountability measures and requiring the vendor to have a web-based enrollment system. The state has not yet awarded a new enrollment broker contract.

Preliminary Thinking on Maryland’s Navigator Program

Within the Maryland exchange, there will be two navigator programs: one operating in the individual market, and the other in the SHOP exchange. Both programs will be compensated by grants from the exchange and will require some form of certification. SHOP navigators will receive a license from the Insurance Commissioner and individual navigators will be certified by the exchange. Navigators in the individual market will target outreach and enrollment activities toward the state’s most vulnerable populations as well as help individuals transitioning between programs. Key areas of focus for these navigators will be the ability to explain changes in eligibility and the differences between plans to consumers. Navigators in the SHOP exchange will focus their outreach and enrollment activities on small business owners who do not currently offer insurance to their employees.

MASSACHUSETTS

In Massachusetts, there are two major public health programs: MassHealth, the state’s Medicaid program, and Commonwealth Care, a health insurance program in which individuals receive subsidies to help pay for premiums. Each has its own entity, called a customer service vendor, which provides enrollment assistance services. The customer service vendor for MassHealth is responsible for:

- call center operations;
- member enrollment into Medicaid managed care organizations;
- premium billing; and
- dissemination of enrollment packets and other communication.

Community Outreach Grants

There is an insurance mandate in Massachusetts and the Commonwealth has, until recently, had a robust outreach program that includes grants to community-based organizations for community education. Funding for the program in the past was from either a direct budget allocation to MassHealth, contributions from the Connector or both. The Commonwealth will eliminate these contracts in 2012, as the state no longer has funding for them.

Application Assisters

In addition to the 51 contracted entities, the Commonwealth maintains a cadre of over 6,000 application assisters which serve as the only means to access the Virtual Gateway (VG), or online application. Among those represented, the application assisters are outreach contractors, community-based organizations, community health centers, financial counselors and hospital staff. These assisters enter into a trading partner agreement with the Commonwealth of Massachusetts and are trained on the online VG system. While the Commonwealth does not compensate the application assisters per application for their assistance, it is in their financial interest to help individuals get coverage so they can be reimbursed for health services provided if applicable. Once an application is approved, the assisters may act as case managers following up with families to facilitate their annual renewal.

Key Elements Massachusetts
Enrollment Broker
<ul style="list-style-type: none"> • Call center • MCO enrollment and premium billing • Send out materials
Education Contractor
<ul style="list-style-type: none"> • Public education about Medicaid managed care
Outreach
<ul style="list-style-type: none"> • 51 Contracted Entities – contracts ending this year • 6,000 application Assisters, not compensated • Partners: CBOs, health centers, financial counselors and hospital staff

Preliminary Thinking on Massachusetts’s Navigator Program

Massachusetts launched its version of an exchange, known as the Massachusetts Connector, in 2006. Accompanying this launch the state also engaged in a comprehensive outreach strategy targeting businesses, various consumer groups, and even leveraging the messaging power of the popular baseball team, the Boston Red Sox, to spread the word about the Connector. Previously mentioned outreach grants and applications assisters were also a key part of this successful strategy to engage new consumers and provide them with coverage. Although the state has downsized these efforts, it is considering how it might incorporate some of the infrastructure that had been established, as well as leverage its established connection with consumer groups into its navigator planning and overall exchange outreach strategy.

MINNESOTA

Minnesota has two major public health programs: Medical Assistance (MA), the state’s Medicaid program, and MinnesotaCare, a publicly subsidized program for Minnesota residents who do not have access to affordable health care coverage, including children and parents with gross household incomes at or below 275 percent FPL and childless adults with gross household incomes up to 250 percent FPL.^{xxvii} Roughly 60 percent of MA beneficiaries are enrolled in managed care plans, with the remaining enrollees receiving care through fee-for-service plans.^{xxviii} All MinnesotaCare beneficiaries receive services through managed care plans.

Application Processing for MA and MinnesotaCare

Potentially eligible individuals can apply for MA through county-level Department of Human Services offices. County workers can answer questions, review applications, and determine eligibility. Not every county processes MinnesotaCare applications and cases, however. Individuals must apply through the state MinnesotaCare office or through a select number of county Department of Human Services offices. MA managed care and MinnesotaCare enrollees can select a plan during the application process. If the enrollee fails to select a plan after a specified period of time, a plan is auto-assigned.

Community Application Agents

Legislation in 2007 established the Minnesota Community Application Agent (MNCAA) Program to assist people applying for MA and MinnesotaCare. Currently, there are 120 organizations participating in MNCAA across the state that provide a variety of outreach and application services. These organizations range from providers to community based organizations, tribal organizations, schools, and an insurance agent. An organization can enter into one of two different contracts with the state to serve as an application agent. In the first type of contract, application agents receive a \$25 bonus from the state for each individual an application agent assists who is then successfully enrolled in MA or MinnesotaCare. The second type of contract is a data sharing agreement in which no bonus is paid. Organizations with this type of contract do not assist individuals with applications. Instead, they provide information on public programs and can refer potentially eligible uninsured individuals to other application agents. Outreach activities conducted by application agents with either type of contract include developing public service announcements, attending local events, distributing flyers and interacting with the community in different ways. The state operates an MNCAA resource center that is staffed by Department of Human Services employees to support application agents through trainings and by providing resource materials and answers to policy questions.

Key Elements Minnesota

Outreach

- 120 organizations participating in Minnesota Community Application Agent (MNCAA) Program
- Two contract types: 1. data sharing agreement- not compensated 2. \$25 bonus for each successful application
- State-operated MNCAA resource center

Preliminary Thinking on Minnesota’s Navigator Program

In early 2012, a workgroup convened by the state submitted recommendations to the governor on what the navigator program should look like, including creating a seamless experience for consumers as they transition between markets within the exchange and between difference state programs. The workgroup was composed of consumers, employers, legislators, Medicaid representatives, agents/brokers, health care providers and health insurers, among other stakeholders. The workgroup proposed creating different navigator roles to address the needs of Minnesota’s diverse populations, including rural populations, Native Americans and minority groups, as well as to utilize skill sets among navigators that would be more applicable to certain enrollee populations. Tiered training and certification were also proposed as ways of leveraging existing skills among potential navigators. Finally, the state wishes to engage as many different groups as possible to serve as navigators for the exchange.

NEW YORK

New York has three major public health plans: Medicaid, Child Health Plus (CHP) for children under 19 who are below 400 percent FPL and who do not qualify for Medicaid, and Family Health Plus (FHP), which is a Medicaid expansion for low-income individuals between the ages of 19 and 64 up to 100 percent FPL for adults without dependents and 150 percent FPL for parents with children.^{xxix} County-based staff makes eligibility determinations for Medicaid and FHP while eligibility in CHP is done by health plan staff. Communication and coordination among the responsible agencies is key to reducing delays in processing times.

Families are only mandated to enroll in Medicaid managed care if the county in which they live has been approved to implement the mandatory Medicaid managed care program under the terms of the 1115 waiver (full implementation by all counties is expected by late 2012 or early 2013). An enrollment broker provides services in the counties to assist individuals with enrollment into managed care plans. Specifically, the enrollment broker is required to:

- educate applicants and recipients of Medicaid about Medicaid managed care and help enrollees choose a plan or auto-assign if they do not;
- assist people in applying for exclusions and exemptions; and
- operate a call center.

Facilitated Enrollment in New York

New York conducts outreach through two fronts: dedicated staff that engages in grassroots outreach by building partnerships with community agencies, and through the Facilitated Enrollment Program, which gives grants to one organization in each county (41 in total) to provide application assistance. Health plans also serve as Facilitated Enrollers (FEs) but are not grantees. In addition to assisting families with applying for public health coverage, New York’s FEs help with plan selection and are obligated to educate about all plans available. Both the enrollment broker and the FEs have built strong relationships with their communities. In urban areas particularly, the enrollment broker is often the first point of contact for families with questions about their coverage. The FEs are based in the community and meet with families wherever it is convenient for them; they speak over 60 languages and are trusted by the families they serve.

Key Elements New York
Enrollment Broker
<ul style="list-style-type: none"> • Educate about managed care and enroll in MCO • Assist with exclusions and exceptions • Operate call center
Outreach
<ul style="list-style-type: none"> • Dedicated staff • Facilitated Enrollment program: grants to 41 community-based organizations as well as a health plan function

Preliminary Thinking on New York’s Navigator Program

A report by the New York State Health Foundation laid out several recommendations for the state as it delves into its navigator design specifically addressing the ambiguities that exist between consumer assistance programs (CAPs) and navigators. The report suggests a "hub-and-spokes" administrative infrastructure for its navigator program with services performed by different groups with different areas of expertise yet all operating under 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 including community-based facilitated enrollers, chambers of commerce, affinity groups, and nonprofits. According to suggestions from the report, the navigator program should be funded through a combination of methods including fees on insurers in and outside of exchanges, existing state funds for community-based facilitated enrollment entities, and Medicaid administrative funds.^{xxx}

OREGON

Oregon has two major public coverage programs: the Oregon Health Plan (Medicaid) and Healthy Kids—a coverage option fully subsidized for children under 19 below 200 percent FPL, partially subsidized for families with annual incomes between \$46-69K, and available at full cost for all other uninsured families. Enrollment into a managed care plan for these two programs is mandatory, barring a few very limited and specific exceptions.^{xxx1} However, because Oregon does not have a contracted enrollment broker to help families select an MCO, families are left to make the decision on their own at the time of application. The application includes language encouraging the family to choose an MCO. If the family does not choose a plan, they are automatically enrolled into an MCO that operates in their county. Families can change their MCO within the first 30 days of coverage.

Oregon’s Application Assisters

Oregon has built a network of outreach and application assistance providers with strong ties to the community to aid in the application process. The program partners with entities in a variety of ways. Funding from a 1 percent tax on insurance carriers was used to support the expansion of Healthy Kids; part of that support is through grants to 23 community organizations to promote Healthy Kids and to reimburse more than 700 application assisters at more than 300 organizations for successful applications (\$75 if at least one child on an application is successfully enrolled). The state also provides free marketing materials to health plans, employers, medical providers, school districts and other stakeholders with access to potentially eligible families. This community penetration has helped Oregon successfully implement Healthy Kids and maintain high enrollment.

Key Elements Oregon
Outreach <ul style="list-style-type: none"> • 23 grantee entities, more than 700 Application assisters at more than 300 organizations. Grantees receive various grant award amounts while other types of assisters receive \$75 per application that leads to at least one enrollment • Broad community participation: employers, medical providers, school districts, etc.

Preliminary Thinking on Oregon’s Navigator Program

Oregon’s early efforts have focused on the role of agents and brokers in the exchange. The state’s exchange board recently discussed a potential “Agent Management Program.” Through the program, the exchange would become a business entity, which in Oregon would allow the exchange to affiliate with a number of producers and pass the carrier commission on to them. The exchange would develop a network of affiliated agents across the state that would help both small businesses and individuals with insurance advice and services. Given that the exchange would be the distributor of commissions, agents would have no incentive to recommend one plan over the other and would instead work with all plans available through the exchange.^{xxxii}

RHODE ISLAND

Rhode Island’s Medicaid program is known as Medical Assistance. There are three Medical Assistance programs for children and families: RItE Care, a Medicaid managed care program; RItE Share, a premium assistance program that helps enrollees pay for employer sponsored health insurance plans; and Medical Assistance for Children with Special Health Care Needs. Most enrollees in RItE Care and Medical Assistance for Children with Special Health Care Needs receive health care services through managed care plans. Exceptions are children who live in institutional facilities and enrollees who have other coverage.

Application Submission and Eligibility Determinations for Medical Assistance

Individuals can mail Medical Assistance applications to the Department of Human Services (DHS) office in their town or city or they can seek assistance from a Family Resource Counselor in an FQHC or disproportionate share hospital. Once an applicant is determined eligible for coverage, enrollees whose employer provides insurance may be put into RItE Share if it is found that doing so would be cost effective for the state. The DHS office sends a letter to the enrollee stating whether he or she was enrolled into RItE Care or RItE Share. Individuals can select one of two managed care plans on the Medical Assistance application: UnitedHealthCare of New England or Neighborhood Health Plan of Rhode Island. If an enrollee does not choose a health plan when applying, he or she is auto-assigned.

Family Resource Counselors

Nearly 100 Family Resource Counselors (FRCs), stationed in health centers and hospitals across Rhode Island, conduct outreach and provide unbiased application assistance to uninsured/underinsured individuals applying for Medical Assistance. FRCs can also screen families for WIC, the RI Works Program (cash assistance), SNAP and Child Care Subsidies and refer them to appropriate state offices. The program helps reduce the administrative burden placed on the Department by assisting families who wish to enroll in health coverage and providing education on coverage renewal and service utilization. FRCs can also provide unbiased information on managed care plan selection. The services carried out by FRCs meet a federal Medicaid requirement to provide application assistance in the community.

Key Elements Rhode Island
Outreach <ul style="list-style-type: none"> • Nearly 100 Family Resource Counselors (FRCs) stationed in hospitals and health centers • Provide outreach and unbiased application assistance • Program contracted out to the Rhode Island Health Center Association

The state has contracted with the Rhode Island Health Center Association (RIHCA) to develop and manage the program. Rhode Island pays the RIHCA directly rather than paying FRCs individually. The RIHCA is responsible for hiring FRCs, developing and implementing training curriculums, record keeping, payments to FRCs, and distributing fees to health centers and hospitals that train FRCs.

Preliminary Thinking on Rhode Island’s Navigator Program

Fitting within Rhode Island’s vision for health reform to have an integrated approach that builds upon existing resources and structures, discussions are currently underway as to how best to do this. Rhode Island is considering using the FRC model of centralized training and payment for navigators, particularly due to limited state human resources. While the FRC program is the basis of the navigator program, the state recognizes the need to expand the population served and the scope of knowledge necessary to become a navigator.

TENNESSEE

Tennessee has several statewide public health care programs. In addition to TennCare, the state’s Medicaid program, Tennessee operates Cover Tennessee to address the health insurance needs of working uninsured Tennesseans who are not eligible for TennCare. Four programs operate within Cover Tennessee: CoverTN, which provides affordable health insurance options to small businesses, the self-employed, and individuals who cannot afford other coverage; CoverKids, the state’s CHIP program for uninsured children under 18 and pregnant women whose family incomes are below 250 percent FPL;^{xxiii} CoverRX, a prescription assistance program for low-income individuals without pharmacy benefits; and AccessTN, which covers Tennessee residents who are otherwise uninsurable due to preexisting medical conditions.

Application and Enrollment in TennCare and Cover Tennessee

Individuals can submit completed applications for TennCare by mail or in person at their local Department of Human Services (DHS) office or by completing an online application. Cover Tennessee program applications can be mailed to their respective state offices. Individuals can also apply for CoverKids through an online application. DHS county employees determine eligibility for TennCare applicants. All enrollees in TennCare receive services through a managed care plan, which an enrollee can select during the application process. The state is divided into three regions and each region has two available managed care plans. TennCare Select is the only MCO operating across the state and is for foster children, children receiving SSI and children under 21 who reside in nursing facilities or in an Intermediate Care Facility for persons with mental retardation. If an applicant expresses a plan preference, the DHS worker will indicate that plan on the application. Applications for individuals who are found eligible for coverage by DHS staff are sent to the Division of Member Services where enrollment is completed. If an enrollee does not select a plan, he or she is auto-assigned.

Outstationed Eligibility Workers

Outstationed hospital-based workers are a source of outreach and education on the state’s Medicaid program. When uninsured individuals go to a hospital to receive care, state hospital-based workers can provide information on state programs, distribute applications, and if available, provide a tablet for individuals to use to fill out the online application. Social workers can also carry out these activities in hospitals where there are no state hospital-based workers. The state offers training on public programs but does not reimburse outstationed workers or social workers for these outreach activities.

Community mental health centers and Federally Qualified Health Centers (FQHCs) in Tennessee have also helped facilitate applications for TennCare, but the state does not track how many applicants are assisted in these locations.

Key Elements Tennessee
Outstationed Eligibility Workers
<ul style="list-style-type: none"> • State hospital-based workers • Outreach and education • Distribute applications • Provide tablets to fill out online applications • Not reimbursed for outreach activities

Preliminary Thinking on Tennessee’s Navigator Program

Although the state has not made a final decision regarding whether or not it will establish its own exchange, Tennessee has engaged multiple stakeholders to help guide the design of the navigator program. Preliminary discussions suggest that navigators will come from a robust selection of community and faith-based groups. Tennessee has pinpointed three specific hard to reach populations that navigators will target, in addition to other uninsured individuals. These groups are: limited English proficiency speakers, particularly Spanish speaking communities and the Somali refugee population, the limited literacy population and the homeless/transient population. The state hopes to engage community organizations that have existing relationships with these groups to work as navigators. The challenges associated with communicating with these three groups will influence the outreach and education activities carried out by the navigators. Due to the circumstances of these groups, the state recognizes that promotional materials may not be as effective as with other uninsured populations and expects that navigators will need to have more face-to-face interactions with these identified populations to successfully enroll individuals in coverage. Other preliminary thoughts include having navigators only provide assistance in the individual exchange. Agents and brokers will assist employers in the small employer market. The state is also looking to develop a training curriculum for navigators with the help of provider-sponsored philanthropy.

Appendix C. Resource List

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- Minnesota Department of Human Services, *Minnesota Community Application Agent (MNCAA) Program*. 2009. http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=MNCAA_01
- Minnesota Health Insurance Exchange Advisory Task Force *Minnesota Health Insurance Exchange Advisory Task Force Recommendations* January 2012. <http://mn.gov/commerce/insurance/topics/medical/exchange/Exchange-Advisory-Task-Force/index.jsp>
- Oregon Health Insurance Exchange Corporation *Board of Directors Meeting Agenda*, April 2012. <http://orhix.org/meetings.html>
- Rhode Island Department of Human Services *Rite Care/Rite Share fact sheet* 2012. <http://www.dhs.ri.gov/FamilieswithChildren/HealthMedicalServices/RiteShare/tabid/212/Default.aspx>
- Tennessee Insurance Exchange Planning Initiative *Frequently Asked Questions from Insurance Exchange Listening Sessions* January 2012. www.tn.gov/nationalhealthreform/forms/faqwhitepaper.pdf

Wakely Consulting Group. “New York Health Benefit Exchange: Role of Third Party Assisters” Presentation, Health Benefit Exchange Stakeholder Meeting, March 14, 2012. <http://www.healthcarereform.ny.gov/timeline/>

Washington State Health Care Authority *Washington State Health Benefit Exchange: Potential Role and Responsibilities of Navigators* 2012 www.hca.wa.gov/hbe/documents/NavigatorRecommendations.pdf

Appendix D. Interviewee List

California

Len Finocchio, Associate Director, California Department of Health Care Services

Rene Mollow, Acting Deputy Director for Health Benefits and Eligibility, California Department of Health Care Services

Thien Lam, Deputy Director of Eligibility and Enrollment, California Health Benefit Exchange

Maryland

Patricia Nowakowski, Director, Office of Eligibility Services, Maryland Department of Health and Mental Hygiene

Massachusetts

Stephanie Chrobak, Director of Commonwealth Care Program, Massachusetts Commonwealth Health Insurance Authority

Carolyn Pitzzi, Director of Outreach and Education, Massachusetts Office of Medicaid

Minnesota

Jennifer Ditlevson, Outreach Specialist, Minnesota Department of Human Services

Susan Hammersten, Health Reform Implementation Manager, Minnesota Department of Human Services

Louisiana

Ruth Kennedy, Medicaid Deputy Director, Bayou Health Project Director, Louisiana Department of Health and Hospitals

New York

Gabrielle Armenia, Director, Bureau of Child Health Plus Enrollment, New York City Department of Health and Mental Hygiene

Norma Shook, Medical Assistance Specialist II (Field Assistance, Local District Liaison), New York State Office of Managed Care

Oregon

Jessica Kendall, Outreach Manager, Oregon Office of Healthy Kids, Oregon Health Authority

Jon Gail, Outreach Manager, Oregon Office of Healthy Kids, Oregon Health Authority

Rhode Island

Lissa DiMauro, Chief of Family Health System, Executive Office of Health and Human Services

Meg Ivatts, Independent Consultant, Faulkner Consulting Group, supporting the State of Rhode Island Exchange Initiative in the area of Consumer Support

Tricia Leddy, Senior Policy Advisor, Executive Office of Health and Human Services

Angela Sherwin, Principal Policy Associate, Office of the Health Insurance Commissioner

Tennessee

Brian Haile, Director, Insurance Exchange Planning Initiative

Tracy Purcell, Director of Member Services, Bureau of TennCare

Notes

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