



Consumer Assistance in Health Reform

The Affordable Care Act (ACA) establishes new requirements and resources for consumer assistance in order to help people navigate the changing health coverage system, find affordable coverage, determine eligibility for assistance, appeal denied claims and program eligibility determinations, resolve problems, and answer questions related to their health coverage.

Experience underscores need for consumer assistance. For years, millions of Americans have been estimated to be eligible for but not enrolled in public programs such as Medicaid and CHIP.¹ Studies of health insurance literacy document that consumers do not understand their health insurance coverage – including benefit limits and exclusions, network designs, and cost sharing features – or, when they have coverage choices, how to evaluate options.² And, when claims are denied or other coverage problems arise, many consumers find it difficult to resolve problems on their own and don't know where to turn for help.

The ACA seeks to expand coverage and to promote competition among health insurers in order to control costs. Achieving these goals depends on consumers' ability to actively and effectively participate in health coverage in ways they do not today. This brief outlines the needs for consumer assistance that people will have and the resources available under the ACA to address them, and identifies implementation issues that may impact the effectiveness of consumer assistance.

The need for consumer assistance

The job of consumer assistance will not be limited to a single task. Rather, as consumers seek to get and keep health coverage, they may face a series of challenges that assisters will need to address.

Increasing public education and awareness – Surveys continue to find that many Americans lack a basic understanding of the new plan options and financial assistance that will become available in 2014. A recent Kaiser Family Foundation poll showed that two-thirds of the uninsured and a majority of Americans overall say they have too little information to know how the Affordable Care Act will affect them.³ A necessary first task for consumer assistance will be to inform the public about individuals' responsibility to enroll in qualified coverage, new coverage options and subsidies, and where to go for more help.

¹ See for example "The State of Children's Health, Care and Coverage," April 4, 2011, at <http://www.kff.org/ahr040411video.cfm>

² Quincy, L and Child, W, "Health Insurance Literacy: A Call to Action," February 2012. Available at http://www.consumersunion.org/pub/Health_Insurance_Literacy_Roundtable_rpt.pdf

³ Kaiser Family Foundation, March 2013 Tracking Poll. Available at <http://www.kff.org/kaiserpolls/8425.cfm>

Determining eligibility for assistance – Two main types of insurance affordability programs (IAP) will be available beginning in 2014 – expanded Medicaid coverage and subsidized private non-group health insurance coverage through Exchanges.

The ACA expands and simplifies eligibility for Medicaid so that all adults with income up to 138% of the federal poverty level (FPL) can gain coverage under the program.⁴ States have the option of electing this expansion and some have indicated they will not do so, at least initially.

In addition, new private health insurance coverage options will be offered along with financial help to make coverage affordable. Advance-payment premium tax credit (APTC) subsidies – available on a sliding scale to those with income between 100% and 400% of FPL– will reduce the monthly premium people pay for non-group coverage.⁵ To be eligible for APTC, people also must be ineligible for other sources of health coverage – Medicaid, Medicare and other specified public programs, or employer-sponsored group health plan coverage that meets minimum standards. Cost sharing reduction (CSR) subsidies will also be available on a sliding scale for people with income between 100% and 250% FPL.

Consumers can apply for IAP through state Exchanges, and Exchanges are required to make it as simple as possible for consumers to determine eligibility and enroll in the correct assistance program. Exchanges must use a single streamlined application for all IAPs and provide for online application and enrollment. Even so, many consumers are likely to need additional help. One state, for example, estimates that between 20 and 25 percent of people who enroll in new coverage in 2014 will need consumer assistance.⁶ Consumers might seek assistance when they aren't familiar with new coverage programs or if they find health insurance confusing. Language assistance will be important to an estimated 9 percent of nonelderly adults who have limited English proficiency. Other people might need help sorting out more complex personal circumstances, such as when family members have mixed eligibility status for Medicaid, or when job-based coverage is available to some, but not all, family members. When disputes arise over eligibility for assistance – either at initial enrollment or at renewal – consumers may also need help appealing eligibility decisions.⁷

Enrolling in coverage – For newly insured individuals who enroll in non-group coverage, a choice of plans and coverage levels will be available. Multiple insurers are expected to offer policies in every Exchange and new plan options – health insurance co-ops and multi-state health plans – will also be offered. Consumers will need to compare plan options in order to make an informed enrollment decision. Traditionally, consumers have had difficulty understanding and evaluating options due to the complexity of products and programs, health insurance literacy barriers, and other factors. Starting in 2014, plan

⁴ Medicaid eligibility restrictions for non-citizens will remain unchanged.

⁵ This means individuals with incomes between approximately \$11,500 and \$46,000 would be eligible for premium subsidies; for a family of 4, subsidies would apply for income of \$23,550 to \$94,200.

⁶ Washington Health Benefit Exchange: Proposed Navigator Program, January 2013. Available at http://wahbexchange.org/wp-content/uploads/HBE_130111_Navigator_Program_Plan_Draft.pdf

⁷ The appeals systems will also vary depending on the nature of the dispute. Different processes will apply for disputes over Medicaid eligibility, eligibility to participate in the Exchange, and disputes over year-end reconciliation of taxes owed. See Salganic S, et al, "Making the Affordable Care Act Work for New York's Consumers," October 2012. Available at http://b3cdn.net/nycss/dc35662a7590c21108_9um6befdp.pdf

comparison will be quite a bit easier. Private health insurance policies will become more standardized and new, easier-to-read plan summaries also must be available.⁸ However, significant plan differences will persist:

- All non-group policies will cover essential health benefits, though insurers will have some flexibility to vary covered benefits within limits.⁹
- All policies will also be offered with different cost sharing options – labeled as bronze, silver, gold, and platinum. But, insurers will have flexibility to vary the specifics of cost sharing within these “metal tiers” as well, within limits.¹⁰
- Other plan features, such as provider networks and drug formularies, can also vary.

Before enrolling, consumers also might seek help evaluating plan choices, taking into account the subsidies for which they are eligible. Most people who buy non-group coverage through the Exchange are expected to be eligible for subsidies.¹¹ Premium tax credit subsidies will be based on the cost of the second lowest cost silver plan offered in an Exchange, but people can use the APTC subsidy to purchase any policy offered in the Exchange. Cost sharing subsidies, however, can only be applied to silver plans.

Assisting with questions and coverage problems – All consumers – not just those who will be covered in the Exchange – may experience difficulty using insurance once they’ve enrolled. Consumers tend to find health insurance confusing, and often have difficulty resolving problems and questions on their own. For example, a 2009 Kaiser Family Foundation national survey of consumer experiences with health plans found that 26% of privately insured adults reported their plan wouldn’t pay for care they thought was covered. Of these individuals only 9 percent eventually got insurance to pay for the treatment, while 40 percent went without treatment or paid out of pocket for care.¹² Especially when people are sick, managing insurance problems can be a challenge and many give up. Another survey found that even when problems generated out-of-pocket costs to the patient of more than \$1,000 or led to a serious decline in health, fewer than 40 percent of individuals complained to their health plan, and only rarely (3%) did they file complaints with state regulators.¹³ Unresolved insurance problems can result in medical debt and/or difficulty accessing care. Consumers report they want and need help, but many don’t know where to turn. In another KFF survey, 89% of consumers didn’t know the agency that

⁸ Kaiser Family Foundation, “Uniform Coverage Summaries for Consumers,” October 2011. Available at <http://www.kff.org/healthreform/upload/8244.pdf>

⁹ States are permitted to limit variation in covered plan benefits. See Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule. February 25, 2013. Available at <http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf>

¹⁰ States are permitted to limit variation in plan cost sharing design. See Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule. February 25, 2013. Available at <http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf>

¹¹ Congressional Budget Office, “Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision, July 24, 2012. Available at <http://cbo.gov/publication/43472>

¹² NPR/Kaiser Family Foundation/Harvard School of Public Health, “The Public and the Health Care Delivery System,” April 2009, available at <http://www.kff.org/kaiserpolls/posr042209pkg.cfm>

¹³ Brian Elbel and Mark Schlesinger, “Responsive Consumerism: Empowerment in Markets for Health Plans,” *The Millbank Quarterly*, Vol. 87, No. 3, 2009.

regulates health insurance in their state; 84% wanted an independent entity where they could seek help.¹⁴

Navigating mid-year changes – Income fluctuation, employment changes, or changes in family or immigration status may also change eligibility for IAPs for many individuals. One study estimates that as many as 50 percent of low income adults might experience income or other changes that would shift their eligibility from Medicaid to Exchange coverage (or the reverse) at least once within a year.¹⁵ People will be required to report mid-year eligibility changes, and may be offered opportunities to enroll in new coverage or assistance for which they become eligible. However, consumers will first need to recognize changes – for example, when a baby is born a family’s eligibility for assistance can change, even if income remains steady, because poverty thresholds change with household size – and know to act on them promptly. Otherwise they might lose the opportunity to enroll in new coverage. In addition, in the case of some mid-year changes that would reduce the amount of APTC subsidy to which a person is entitled in a year, failure to report changes could result in people having to repay through their income tax returns some or all of APTCs that were appropriate when they first enrolled but that no longer apply. This could cause financial burdens for some individuals or discourage them from applying for assistance.

Mid-year changes in enrollment might also result from failure to pay premiums on time. Under the ACA, APTC assistance constitutes a partial subsidy. Individuals remain responsible for paying a portion of the premium; even the poorest individuals would be required to pay approximately \$20 per month for self-only coverage.¹⁶ Consumers may need help resolving disputes over missed or late payments. People dis-enrolled for non-payment might require help finding new coverage options.

Sources of consumer assistance

The ACA and its implementing regulations provide for multiple sources of consumer assistance. Programs vary to some extent by the populations served; the nature of assistance provided; qualifications and other requirements pertaining to the providers of consumer assistance; and in the sources, timing, and amount of funding available for each program.

Statewide Consumer Assistance Programs (CAPs)

Section 1002 of the Affordable Care Act established a program of State Consumer Assistance Programs or ombudsman programs (CAPs) funded by federal grants to states.¹⁷ Federally-funded state CAPs were first established in 2010. Most are still in place today, although some operate at reduced levels due to funding uncertainty.

¹⁴ Kaiser Family Foundation, “National Survey of Consumer Experiences with Health Plans,” June 2000.

¹⁵ Sommers B and Rosenbaum S, “Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges,” *Health Affairs*, February 2011.

¹⁶ See <http://healthreform.kff.org/Home/KHS/SubsidyCalculator.aspx?source=FS>

¹⁷ CAP provisions of the ACA are written into Section 2793 of the Public Health Service Act.

Consumer assistance duties - To be eligible to receive a grant, States must establish and carry out programs that provide a full range of consumer assistance services and activities. Five main duties required of CAPs are to:

- assist consumers with filing complaints and appeals, including appeals of denied claims and other adverse determinations by health insurers and group health plans;
- collect, track, and quantify problems and inquiries encountered by consumers;
- educate consumers on their rights and responsibilities with respect to group health plan and health insurance coverage;
- help consumers with enrollment in private health insurance or group health plan coverage;
- resolve problems obtaining health insurance subsidies (APTCs).

CAPs are also required to “advocate freely and vigorously” on behalf of consumers.¹⁸ Typically, CAP assistance involves casework that tends to be more hands-on and resource-intensive compared to, for example, call centers that provide brief informational responses to consumer questions. Consumers who seek help from CAPs may have multiple contacts with the program over a period of time as CAP staff work with a health plan or regulator to diagnose a problem and resolve it.

Qualifications and training – A CAP grant recipients must be a state agency or entity. Most CAP programs are housed in state Insurance Departments or Health Departments or offices of the state Attorney General. In two states, the CAP is located in a freestanding Consumer Ombudsman agency. States are permitted to partner with non-profit organizations to provide assistance services in local communities and half of CAPs do so. The federal government provides a dedicated staff team within the Center for Consumer Information and Insurance Oversight (CCIO) to support the CAPs, providing software, information resources, and ongoing training and technical assistance. Regular conference calls with CAP grantees also offer programs an opportunity to share information and learn from each other. It is common for CAP workers to “pick up the phone at any time and call any of the other programs.”¹⁹

Population served - CAPs are required to serve all residents of a state, although specified duties generally relate to assistance enrolling in or resolving problems with private health insurance and group health plans. People covered in self-insured employer sponsored group health plans can and do call on CAPs for assistance; though federal law still preempts states from regulating such plans, the CAP program effectively empowers states to help enrollees of such plans by advocating on their behalf to help resolve problems such as denied claims. CAPs also are allowed – but not required – to use grant funds to assist individuals with enrollment and problem resolution in public programs, such as Medicaid or the Pre-existing Condition Insurance Program (PCIP). If CAPs decide not to provide assistance to public program enrollees, they must at least make appropriate referrals to Medicaid or other applicable agencies. Beyond merely giving a consumer the name and phone number of another agency, CAP

¹⁸ Affordable Care Act – Consumer Assistance Program Grants. Funding Opportunity Number: CA-CAP-12-002, CFDA: 93.519, June 7, 2012.

¹⁹ Grob R, et al., “The Affordable Care Act’s Plan For Consumer Assistance with Insurance Moves States Forward But Remains A Work in Progress,” *Health Affairs*, February 2013.

personnel in many states will call the agency on the consumer's behalf, and even remain involved in the case, collaborating with the other agency, until the problem is resolved.²⁰ This referral is sometimes described as a "warm handoff." Finally, CAPs must meet standards for accessibility, and provide assistance that is culturally and linguistically appropriate.

Sentinel Function - The ACA mandates that CAPs track consumer problems and inquiries and report data to the Secretary of Health and Human Services (HHS.) In turn, HHS is required to analyze data to identify areas where more enforcement is needed and share this information with state insurance regulators and the Departments of Labor and Treasury. HHS has released one report summarizing the first year of CAP data.²¹ In the first year, as many programs were getting started, CAPs provided assistance to more than 200,000 consumers, including helping to appeal almost 26,000 denied claims and recover more than \$18 million in covered benefits. CAPs also received more than 3,000 inquiries about new ACA protections, such as the requirement to continue dependent coverage to age 26 and the prohibition on health insurance rescissions. Through data and their familiarity with the details of consumer problems, CAPs are in a position to identify opportunities to strengthen consumer protection such as through improved notice requirements and better coordination of regulatory agencies. To date, however, data collection and reporting by CAPs has been somewhat inconsistent and this sentinel function remains a work in progress.²²

Funding – The ACA permanently authorized "such sums as may be necessary" to support CAPs and made an initial appropriation of \$30 million for the program. The first federal CAP grants were issued in September 2010, establishing 38 programs in 33 States and the District of Columbia. A second round of \$30 million in CAP grants was awarded in August 2012 to 21 states and DC. To date, 36 States and DC have established CAP programs using federal grant funds.²³ States also can use and have used funds from Exchange establishment grants, authorized under Section 1311 of the ACA, to support some CAP activities that are directly related to the planning and implementation of an Exchange.²⁴

Funding limitations and uncertainty have resulted in uneven implementation of CAP assistance across states.²⁵ Under the ACA there is no fallback authority for the federal government to establish CAPs in states that do not.

²⁰ Grob R, et al.

²¹ "Summary of Consumer Assistance Program Grant Data from October 15, 2010 through October 14, 2011, June 7, 2012, available at <http://cciio.cms.gov/resources/files/csg-cap-summary-white-paper.pdf.pdf>

²² Grob R, et al.

²³ Two other states, Ohio and Wisconsin, also received CAP grants in 2010 but returned funds shortly after the November elections. US Territories are also eligible to receive CAP grants; 4 Territories received grants in 2010 and 2 received grants in 2012. For more detail on CAP grant recipients and awards see <http://statehealthfacts.kff.org/comparereport.jsp?rep=88&cat=17>

²⁴ States may not use 1311 grant funds to support the entire functionality of their CAP programs, but can use funds for activities that also relate to Exchange functions, such as conducting outreach and developing training programs. See "State Consumer Assistance Program Participation in Exchange Core Area 10", November 21, 2011. Available at http://cciio.cms.gov/resources/files/Files2/11172011/cap_exchange_funding_memo.pdf.pdf

²⁵ Grob R, et al.

Exchange Programs of Consumer Assistance

Consumer assistance is also a core function of health insurance Exchanges. Assistance required in Exchanges focuses primarily on outreach, eligibility and enrollment. All Exchanges are required to provide a website that displays consumer information about available plans and financial assistance, including a subsidy calculator, and that enables people to submit an electronic application for assistance and to enroll online in a QHP. Exchanges must also operate a toll-free call center to provide information and respond to requests for assistance. In addition, under the ACA and its implementing regulations and other guidance, several programs of direct consumer assistance are authorized to be offered through Exchanges: Navigators, In-Person Assistance Programs, and Certified Application Counselors. Navigators and Certified Application Counselors are required for all Exchanges. In-Person Assistance Programs may or may not be offered depending on whether an Exchange is state based, federally facilitated, or a partnership Exchange. The duties, qualifications, populations served and funding sources for these programs vary by program, as well as by who (States or the federal government) runs the Exchange.

Navigator programs are required by statute, while regulations and other federal guidance outline requirements and standards regarding In-Person Assistance programs and Certified Application Counselors. These other types of “non-Navigator” assisters can be used to fill gaps in or supplement the work of Navigators programs. In addition, the source and timing of funding for non-Navigators are different than for Navigators; as a result states may establish multiple programs in order to maximize resources available for consumer assistance.

Navigators

The ACA requires all Exchanges to establish a Navigator program to help consumers learn about qualified health plan coverage and subsidies offered through Exchanges and enroll in such coverage. As a required component of Exchanges, Navigator programs must be established starting in 2014, although recent federal guidance acknowledges that Navigator programs might not be fully functional in every state in 2014 and expressly permits States to use non-Navigator consumer assistance programs to fill in any gaps during the initial year.²⁶

The structure of and responsibility for Navigator programs will vary somewhat depending on the decision states make regarding the operation of health insurance Exchanges. States will establish, operate, train, oversee and fund Navigator programs in state-based Exchanges (SBEs). The federal government will do so in federally-facilitated Exchanges (FEEs). In state partnership Exchanges (SPEs) where the state elects to take on a consumer assistance role, the federal government will establish and

²⁶ Patient Protection and Affordable Care Act: Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel. Proposed rule. April 5, 2013. Available at <http://www.gpo.gov/fdsys/pkg/FR-2013-04-05/pdf/2013-07951.pdf>

fund the Navigator program and provide training, while States will be responsible for the day-to-day operation of Navigator programs and can supplement training.

Consumer assistance duties – In all states, entities that serve as Navigators will be required to:

- conduct public education activities to raise awareness about the Exchange and maintain expertise in eligibility, enrollment, and program standards under the Exchange;
- provide accurate and impartial information concerning private health insurance plans offered through the Exchange – called qualified health plans or QHPs – and about premium and cost sharing subsidies available for such plans; this information must also acknowledge other health programs;
- provide fair and impartial help to people in selecting a QHP;
- provide referrals to state CAPs or other appropriate state agencies that can help people with other grievances, complaints or questions regarding their health coverage; and
- provide information and assistance in a manner that is culturally and linguistically appropriate and accessible by persons with disabilities.

Qualifications and training – In all states, the Exchange must designate at least one community and consumer-focused nonprofit group as a Navigator. In addition, the Exchange must designate at least one other type of Navigator from a list of specified categories.²⁷ Health insurance issuers, including their subsidiaries and associations, are prohibited from being Navigators. So is any person or entity that receives any direct or indirect consideration from a health insurance issuer in connection with the enrollment of people in a private health insurance plan, whether offered in or outside of an Exchange (e.g., insurance agents paid commissions by insurers). Navigators must meet applicable licensing, certification or other standards prescribed by the state or Exchange. Conflict-of-interest standards also apply and Navigators will be required to submit to the Exchange a written plan for remaining conflict-free while serving in this capacity. Navigators also must comply with privacy and security standards adopted by the Exchange.

Navigators must have or develop relationships with individuals or employers likely to be eligible to enroll in QHP coverage through the Exchange. Finally, Navigators must undergo training to ensure expertise in the needs of underserved and vulnerable populations, eligibility and enrollment rules and procedures, the range of QHP options and IAPs offered through an Exchange, and privacy and security standards for personal information. Federal Navigator training will take up to 30 hours and certification will require a passing score on HHS-approved examinations. States may use the federal training program or develop their own Navigator training programs.

Population served – In general Navigators must target information and assistance to individuals and employers who seek private health plan coverage offered in the Exchange. However, states can require

²⁷ 45 CFR §155.210. These categories are (1) trade, industry, and professional associations; (2) commercial fishing industry organizations, ranching and farming organizations; (3) chambers of commerce; (4) unions; (5) resource partners of the Small Business Administration; (6) licensed agents and brokers, and (7) other public or private entities or individuals that meet the requirements for Navigators including, but not limited to, Indian tribes and tribal organizations and State or local human service agencies.

Navigators to also help individuals apply for and enroll in Medicaid, and some have elected to do so.²⁸ The range of types of eligible entities enumerated in the ACA indicates that states can establish Navigator programs that are locally focused and specialize in providing assistance to targeted groups or communities. In state partnership Exchanges, for example, HHS has said Navigators may target their outreach and assistance to specific ethnic, geographic, or other communities.²⁹

Sentinel function – The ACA does not specify data collection or reporting responsibilities for Navigators. States may choose to require Navigators to track data on consumer inquiries, concerns and problems. To date no federal guidance has specified this role for Navigators in FFEs or SPEs.

Funding – Navigators are funded by grants financed by an Exchange’s operating revenue, which will first be generated in 2014 through assessments on health insurers offering coverage within a State. To finance the planning and establishment of Exchanges, states can also receive federal grants through the end of 2014 under Section 1311 of the ACA.³⁰ States are prohibited from using Section 1311 grants to fund their Navigator grants, but can use them for planning activities related to Navigators, such as the development of training materials or to build and test Navigator programs.³¹ In the initial year of operation, states can also use Section 1311 grants to establish (In-Person Assistance programs if their Navigator programs are not yet fully developed. States that elect to use Navigators to provide Medicaid assistance can also fund programs using Medicaid administrative funds.

For the 34 federal and partnership Exchanges combined, HHS will provide \$54 million in funding to support Navigator programs in the first year. That amount will be apportioned based on the number of uninsured in a state.³²

After 2014, states and the federal government will determine the budget for Navigators within overall Exchange operating revenues. There are no requirements to devote a specified portion of Exchange operating revenues for Navigators or other forms of consumer assistance. Specific details of Navigator

²⁸ See for example, “Options for the Design and Implementation of Maryland’s Navigator Program” November 15, 2012, available at <http://marylandhbe.com/wp-content/uploads/2013/01/MHBE-Navigator-Report-Final.pdf>. See also “Request for Applications, Consumer Assistance for the New York State Health Benefit Exchange: In Person Assistors and Navigators,” available at <http://www.health.ny.gov/funding/rfa/1301300317/1301300317.pdf>.

²⁹ See “Guidance on the State Partnership Exchange” issued by CCIIO on January 3, 2013. Available at <http://cciio.cms.gov/resources/files/partnership-guidance-01-03-2013.pdf>

³⁰ Section 1311 grants are funded by an open-ended federal appropriation through the end of 2014, allowing states to make considerable investments in outreach, planning, IT, systems development and other activities necessary to establish new Exchanges.

³¹ Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges. Funding Opportunity Number: IE-HBE-11-004, CFDA: 93.525, January 20, 2011. See also Center for Consumer Information and Insurance Oversight, Guidance on the State Partnership Exchange, January 3, 2013. Available at <http://cciio.cms.gov/resources/files/partnership-guidance-01-03-2013.pdf>

³² Apportioned amounts range from \$600,000 for Alaska to almost \$8.2 million for Texas. See Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges, CFDA 93.750, April 9, 2013.

compensation will also be determined by the Exchange. Options under consideration include a flat fee payment per successful application and performance-based block grants tied to enrollment targets.³³

In-Person Assistance Programs

In-Person Assistance (IPA) programs, distinct from Navigators, may also be established within an Exchange, depending on the state. IPA programs are required in state partnership Exchanges where the state elects to take on a consumer assistance role; they are optional in state-based Exchanges, and they will not be offered in federally facilitated Exchanges.³⁴

In states operating a partnership Exchange, HHS requires such programs because “some communities may not have entities that apply to be Navigators, while other entities intending to serve specific communities may not be selected to receive a Navigator grant.” In states running their own Exchanges, IPA programs are optional and states have flexibility to use IPA programs to expand or strengthen consumer assistance in their Exchanges. State-based Exchanges may also rely more heavily on In-Person Assistance Programs in 2014 if their Navigator programs are not fully functional in that year.

In general, IPA programs are required to ensure that in-person assistance is available to consumers who need it. They are supposed to supplement Navigator programs, not replace them nor duplicate effort. States have broad authority to design IPA programs. For example, IPA programs might operate only during initial and annual open enrollment periods when demand for eligibility and enrollment assistance is highest.³⁵

Consumer assistance duties – Specific duties for IPA programs will be determined by the Exchange. For example, the IPA program might help consumers apply for subsidies and enroll in plans, but not engage in general outreach activities.

Qualifications and training – The Exchange will also determine who can serve as an In-Person Assister. States have the option of contracting with CAPs to provide IPA services.³⁶ Like Navigators, IPA programs must provide information and assistance in a manner that is culturally and linguistically appropriate and accessible by persons with disabilities. Conflict-of-interest standards for Navigators also will apply to

³³ See for example, California Health Benefit Exchange, “Assisters Program: In-Person Assistance and Navigator Stakeholder Webinar,” March 14, 2013, available at

http://www.healthexchange.ca.gov/Stakeholders/Documents/Assisters2ndWebinar%20March14-2013_FINAL.pdf

³⁴ Cite January 3 2013 guidance on state partnership Exchange; Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges, November 16, 2012, available at

<http://cciio.cms.gov/resources/files/hie-blueprint-11162012.pdf>; and May 12, 2012 general guidance on FFE.

³⁵ Center for Consumer Information and Insurance Oversight, Guidance on the State Partnership Exchange, January 3, 2013. Available at <http://cciio.cms.gov/resources/files/partnership-guidance-01-03-2013.pdf>

³⁶ Center for Consumer Information and Insurance Oversight, Guidance on the State Partnership Exchange, January 3, 2013. Available at <http://cciio.cms.gov/resources/files/partnership-guidance-01-03-2013.pdf>

IPAs. Federal training standards and programs for Navigators will also apply to In-Person Assistants, and states will have the option of supplementing training programs.³⁷

Sentinel function – States may choose to require IPA programs to track data on consumer inquiries, concerns and problems. To date no federal guidance has specified this role for IPA programs in SPEs.

Funding – States can use Section 1311 grants to set up and fund first year costs for IPA programs. Thereafter programs would need to be funded by Exchange operating funds or other sources.

Certified Application Counselors

Recently CMS proposed that a third program of consumer assistance be available in all Exchanges – Certified Application Counselors (CACs).³⁸ The proposed rule cites a long tradition of state Medicaid and CHIP agencies working with health care providers and other organizations to serve as application assistants. It proposes that states have the option of designating certain organizations, such as community health centers, and formally certifying their staff and volunteers to act as application assistants. In addition, the proposed rule requires Exchanges to have a program of Certified Application Counselors.

Consumer assistance duties – Medicaid CACs would provide information about Medicaid and CHIP, help individuals complete applications and renewals, gather required documentation, respond to requests from the Medicaid agency, and provide case management between eligibility determinations and renewals. Exchange CACs would provide information on all insurance affordability programs and QHP coverage options and help individuals apply for and enroll in coverage.

Qualifications and training – State Medicaid programs would designate who can act as a Medicaid CAC. The Exchange can also designate organizations to be CACs. In addition, federal regulations would require Exchanges to certify any individual who asks to be a CAC and who registers with the Exchange and completes training. Exchanges would also be required to certify Medicaid-designated CACs. States have the option of creating a single certification process for both types of CACs. Both Medicaid and Exchange CACs must undergo training in eligibility and benefit rules governing enrollment in QHPs and all insurance affordability programs. Both must also be trained in and subject to rules relating to the confidentiality and security of information. The proposed rule estimates training for Medicaid CACs will take an average of 50 hours. Under the proposed rule, Exchange CACs can have – but must disclose to the Exchange and to potential applicants whom they assist – conflicts of interest, including relationships with QHPs. Both types of CACs must provide assistance that is accessible to persons with disabilities.

³⁷ Patient Protection and Affordable Care Act: Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel. Proposed rule. April 5, 2013. Available at <http://www.gpo.gov/fdsys/pkg/FR-2013-04-05/pdf/2013-07951.pdf>

³⁸ Medicaid, CHIP, and Exchanges: ...Other Provisions Related to Eligibility and Enrollment for Exchanges..., Proposed rule, January 22, 2013. Available at <http://www.gpo.gov/fdsys/pkg/FR-2013-01-22/pdf/2013-00659.pdf>

Medicaid CACs – but not Exchange CACs under the proposed rule – must also provide assistance appropriate to the needs of LEP individuals.

Sentinel function – States may choose to require CACs to track data on consumer inquiries, concerns and problems. To date no federal guidance has specified this role for CACs.

Funding – Under the proposed rule, CACs are volunteers or work for organizations willing to pay them for their assistance services. CACs are not funded by the Exchange through grants or directly. CACs (both Medicaid and Exchange) are also prohibited from charging individuals a fee for assistance.

Comparison of Programs of Consumer Assistance under the ACA

	CAPs		Navigators			IPAs			Medicaid		Exchange
	SBE	SPE**	FFE**	SBE	SPE*	FFE**	CACs	CACs	Exchange	CACS	
Required?	Yes	Yes	Yes	State option	Yes	Yes	State option	State option	State option	Yes	Yes
Population Served											
• People seeking QHP	Yes	Yes	Yes	State option	Yes	Yes	State option	State option	State option	n/a	Yes
• People seeking Medicaid	State option	State option	No	State option	State option	No	State option	State option	Yes	n/a	Yes
• Enrollees of private plans, including ESI	State option or refer to CAPs	State option or refer to CAPs	No Refer to CAPs	State option	State option	No Refer to CAPs	State option	State option	No	n/a	No
Duties											
• Education/outreach	Yes	Yes	Yes	State option	Yes	Yes	State option	State option	No	n/a	No
• Help with QHP and subsidy application through Exchange	Yes	Yes	Yes	State option	Yes	Yes	State option	State option	State option	n/a	Yes
• Help with Medicaid enrollment	State option or refer to Medicaid	State option or refer to Medicaid	No Refer to Medicaid	State option	State option or refer to Medicaid	State option or refer to Medicaid	State option	State option or refer to Medicaid	Yes	n/a	State option
• Help with mid-year changes	Yes	Yes	Yes	State option	Yes	Yes	State option	State option	Yes	n/a	Yes
• Resolve plan problems, appeal denials	State option or refer to CAPs	State option or refer to CAPs	No Refer to CAPs	State option	State option or refer to CAPs	No Refer to CAPs	No	No	No	n/a	No
• Data collection and reporting	State option	State option	To be determined	State option	State option	To be determined	State option	State option	State option	n/a	To be determined
• LEP standards	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	n/a	No
• Accessibility standards	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	n/a	Yes
• Privacy and information safeguards apply	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	n/a	Yes
Training	HHS	HHS ***	HHS	State	HHS	HHS	State	HHS	Medicaid	n/a	HHS ****
Funding	Fed grants to states; \$60 million so far	Grants from Exchanges; amount determined by Exchange	Fed grants (\$54 million) in year 1, then grants from Exchanges; amount determined by Exchange	\$1311 grants in year 1 (States request amount); then funded by Exchange						n/a	n/a

* State-based Consumer Assistance Partnership Exchanges

** Federally Facilitated Exchanges and SBEs that do not elect a consumer assistance role

***State option to supplement federal training

The Role of Insurance Brokers and Agents

Private health insurance traditionally has been sold through brokers and agents (described herein as brokers) who receive a commission for each new policy or renewal. Brokers are expected to continue to sell private health insurance outside of Exchanges. In addition, ACA regulations specify that Exchanges may permit agents and brokers to enroll individuals and employers in QHPs sold through the Exchange and brokers may continue to receive commissions as compensation for such sales if they meet other requirements. In particular, they must register with the Exchange, complete training on insurance affordability programs and QHPs, and comply with privacy and security standards. In addition, they must ensure that consumers complete an eligibility verification and enrollment application through the Exchange web site. Brokers can use their own web site to display plan choices, but their site must display all QHP data that the Exchange site displays and their site cannot provide financial incentives to select any plan. In addition, brokers can help individuals apply for subsidies and other insurance affordability programs.³⁹

Alternatively, brokers can apply to serve as Navigators. However to qualify as Navigators they must not earn commissions for the sale of health insurance in any market in or outside of the Exchange.

In a number of states, legislation would restrict the role of Navigators and other assisters in relation to brokers. In Maryland for example, Navigators, upon contact with an individual who acknowledges having existing health insurance coverage obtained through a broker, must refer the individual back to the broker for information and service.⁴⁰ In several other states, legislation would prohibit Navigators from engaging in any activities that require a broker license. Other state legislation would require Navigators to obtain surety bonds for protection against wrongful acts, errors and omissions, or to meet other requirements that apply to licensed brokers.⁴¹ Recent proposed federal regulations emphasize that any state licensing, certification or other standards for Navigators that prevent the application of ACA Navigator provisions are preempted. The proposed rule offers as one example state requirements that Navigators obtain errors and omissions coverage, but does not otherwise elaborate on the types of state standards that might prevent the application of ACA's Navigator program requirements.⁴²

³⁹ 45 CFR § 155.220

⁴⁰ See MD INS 31-113(f)(8). Exceptions to this rule include when the individual prefers not to be referred back to the broker, when the broker is not authorized to sell QHPs in the Exchange, and when the individual is eligible for subsidies but has not obtained them. Legislation in other states (e.g., HB 564 in New Mexico, HB 2608 in Illinois) would impose the same requirement for Navigators to refer consumers to brokers, but without these exceptions.

⁴¹ Georgetown University Center on Health Insurance Reforms, "Pending Legislation on Navigators in the 50 States and DC," available at http://chirblog.org/wp-content/uploads/2013/03/Gtown_CHIR_NavigatorLegislation1.pdf

⁴² Patient Protection and Affordable Care Act: Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel. Proposed rule. April 5, 2013. Available at <http://www.gpo.gov/fdsys/pkg/FR-2013-04-05/pdf/2013-07951.pdf>

How Will It All Work?

Key implementation details, which will need to be worked out in each state, will determine how effective consumer assistance programs will be. A number of factors will be important to consider as implementation moves forward.

Funding

Resources available for consumer assistance are likely to be uneven across states, at least during the first year. In general, state-based Exchanges have had the opportunity to draw down considerable federal grant resources to plan and build new consumer assistance capacity. Partnership Exchanges that elect a consumer assistance partnership will also have access to substantial federal grant funds to build their new programs. By contrast, states where a federally-facilitated Exchange is operating will have more limited resources, at least until the Exchanges are established and new operating revenues become available.

Many states are still working out their budgets for consumer assistance for 2013-2014. New York, for example, intends to make \$27 million per year available for Navigator and In-Person Assistance funding over each of the next five years.⁴³ New York's CAP estimates the cost of consumer assistance at \$90 per case, on average, reflecting a wide range of problem types (such as complex health claims denial cases addressed under the CAP program and more straightforward eligibility and enrollment assistance cases.)⁴⁴ California will make up to \$43 million in grants available to nonprofit organizations and other entities to serve as Navigators, budgeting for a payment of \$58 per successful enrollment in the first year.⁴⁵ In Texas, by contrast, federal Navigator funding is anticipated to be just over \$8 million for the first year.⁴⁶

Early experience with CAPs shows that limited and uncertain funding can hamper the continuity and effectiveness of assistance programs. Once Exchanges and their operating budgets are established, states and the federal government will need to decide on a level of resources to devote toward consumer assistance over time.

⁴³ NY State Department of Health, Request for Applications, Consumer Assistance for the NY State Health Benefit Exchange: In Person Assistors and Navigators. Available at

<http://www.health.ny.gov/funding/rfa/1301300317/1301300317.pdf>

⁴⁴ Community Health Advocates 2012 Annual Report. Available at

http://communityhealthadvocates.org/sites/communityhealthadvocates.org/files/publications/%5Bsite-date-yyyy%5D/CHA%202012%20Annual%20Report_0.pdf

⁴⁵ California Health Benefit Exchange, Outreach and Education Grant Application. Available at

<http://www.healthexchange.ca.gov/Pages/OutrchandEdProg.aspx>

⁴⁶ Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges, CFDA 93.750, April 9, 2013.

Organization and coordination of assisters

Beyond the dollar resources, effectiveness of consumer assistance will also depend on how states organize and coordinate their programs. Ideally, consumers would be able to find all the assistance they need in one place or through one phone call. In New York, for example, Community Health Advocates (CHA) runs a central toll free hotline and contracts with a network of 30 nonprofit organizations that receive grants and contracts to provide a full range of consumer assistance to individuals with all types of health coverage and the uninsured. CHA staff can help consumers apply for Medicaid or Exchange subsidies, appeal eligibility determinations, enroll in coverage, and resolve disputes with health plans when they arise. The network also provides assistance and outreach for small employers seeking information about ACA and their coverage options. The CHA network is organized on a “hub and spokes” model. A central organization coordinates other network organizations, provides training, technical assistance, individual case reviews, and data collection and holds regular meetings where unique cases and emerging issues can be jointly discussed. The community based organizations of CHA specialize in serving target populations – such as neighborhood, ethnic, or income groups – and develop close contacts and trust with their constituents. With support from the central CHA system, these organizations can provide a full range of help to clients.⁴⁷

Massachusetts is another state that has tried to link its assistance programs and entities within an overall structure. In Massachusetts, ACA-like health reforms have been in place since 2006 and 98 percent of state residents are now insured. The state created a centralized Health Reform Outreach and Education Unit to coordinate all consumer outreach and assistance functions. The Outreach Unit coordinates activities of the state’s Medicaid program and its health insurance Exchange (the Commonwealth Connector.) It also manages state grant funding for community-based organizations and institutions to conduct outreach and enrollment and trains and provides technical assistance to these grantees. The state’s primary nonprofit assistance organization, Health Care For All (HCFAMA), staffs a HelpLine for consumers to help them find and enroll in coverage and resolve coverage problems. HCFAMA also contracts with the state to provide CAP services. For both the HelpLine and the CAP, HCFAMA tracks data on consumer inquiries and complaints and provides feedback to government officials on trouble spots, such as call backlogs and carrier compliance concerns.⁴⁸

Within FFE states, coordination of assistance programs may pose special challenges. The federal government will need to recruit a network of Navigators in each state and, by definition, will not have a state-based Exchange official to help coordinate this network. Navigators may benefit from ongoing contact with federal agency staff, and with each other, in order share best practices and learn from their mutual experiences. However, the amount of federal resources and staffing that will be available for

⁴⁷ Community Service Society, “Making Health Reform Work: Consumer Assistance Programs,” September 2010.

⁴⁸ Community Service Society, “Making Health Reform Work: Consumer Assistance Programs,” September 2010. Also Blue Cross Blue Shield of Massachusetts Foundation, “Effective Education, Outreach, and Enrollment Approaches for Populations Newly Eligible for Health Coverage,” March 2012, available at <http://bluecrossmafoundation.org/tag/publication-collection/health-reform-toolkit-series>

coordination is not yet known. In addition, FFE state Navigators will need to coordinate with state Medicaid agencies – though Medicaid eligibility likely will not be expanded in all FFE states – and with state CAPs – though not all FFE states have CAPs. As a result it may be more difficult for Navigators to coordinate with other assisters; in turn, it may be more difficult for consumers to enroll in coverage or resolve problems. In addition to coordination by the federal government, navigators in FFE states may turn to outside sources of support and networking. For example, following enactment of the State Children’s Health Insurance Program (SCHIP), a privately funded effort – the Covering Kids and Families Initiative – organized non-profit organizations and corporate partners in states to promote public education, outreach, and enrollment assistance to expand coverage for children. In addition to recruiting partners, the initiative provided financing and other resources such as outreach tool kits to support these efforts.⁵⁰

Training, Technical Assistance and Oversight

Training of consumer assisters will also be key. Assisters will need to become familiar with new coverage options and financial assistance programs and their eligibility rules and procedures. Various new market rules and consumer protections will also take effect in 2014. Proposed federal rules indicate that assistance training programs will involve 15 modules – including eligibility rules for subsidies, tax implications of enrollment decisions, basic concepts about health insurance, privacy and security standards, and others – to be completed in up to 30 hours.⁵¹

States can rely on federal training, supplement it, or develop their own training programs. For example, modules might also be developed to anticipate and address specific needs of certain populations. Such modules might target young adults, who may be eligible for different coverage options compared to other individuals, such as “catastrophic” health plans, student health plans, and the option to remain covered as a dependent under their parents’ policy. Working individuals may need specialized help understanding health benefits offered by employers, or recognizing how another family member’s access to group health benefits affects their own eligibility for subsidies, or navigating job-based and Exchange open enrollment periods if they occur at different times. Immigrants and permanent non-citizen residents of the US may also face unique questions and problems. So might older individuals who are nearing or working past the age of Medicare eligibility.

At least at the outset, training in many states may be somewhat limited. Officials will need to balance the need for very detailed and specific training against costs, the limited time for training before open season begins, and the possibility that training requirements might overwhelm potential assisters.

Whatever their initial training, assisters inevitably will encounter unfamiliar problems and situations and will need to call on a supervisor or other expert for help in order to provide the consumer with accurate and appropriate assistance. In New York’s “hub and spoke” model, spoke program staff are trained to

⁵⁰ See Robert Wood Johnson Foundation Covering Kids and Families Initiative, <http://www.coveringkidsandfamilies.org/about/>

⁵¹ Patient Protection and Affordable Care Act: Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel. Proposed rule. April 5, 2013. Available at <http://www.gpo.gov/fdsys/pkg/FR-2013-04-05/pdf/2013-07951.pdf>

help consumers sign up for coverage and subsidies and navigate insurance changes, while hub program staff provide technical assistance on more difficult cases. Continuing education is also required of assisters. Hub program staff conduct ongoing learning opportunities for spoke organizations, such as webinars and monthly case review meetings to spot trends and help assisters identify issues correctly.⁵²

Quality assurance will also be a factor determining the strength of consumer assistance. States and the federal government may adopt different approaches to monitoring the work of consumer assisters in order to identify concerns and the need for remedial training. In some states, assisters who help with eligibility and enrollment may be required to log in to a dedicated web portal that can also track certain case information and outcomes. Periodic audits or case reviews might be instituted. Ensuring that consumers get consistent information, no matter where they seek help, will matter to the success of assistance programs.

Looking to the future

Finally, early experiences providing consumer assistance can yield lessons for the future and can inform efforts by states and the federal government to strengthen programs over time. Feedback from assisters to government agencies may point out what works and what can be improved. Evaluation of different approaches to funding, training, coordinating, and monitoring of assistance programs could measure how these factors impact enrollment rates, persistence of enrollment, and other consumer experiences. To the extent states and the federal government conduct such assessments and share their findings, consumer assistance in the second year of health reform may develop in ways that contribute even further to effective implementation.

⁵² Connecting Consumers to Coverage: the Role of Navigators and Consumer Assistance Programs in Implementing Health Reform in New York, September 2011. Available at <http://nyshealthfoundation.org/uploads/resources/navigators-consumer-assistance-programs-september-2011.pdf>

This publication (#8434) is available on the Kaiser Family Foundation's website at www.kff.org.