Study of Navigator Program and Consumer Assistance

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Commissioned by the Maryland Health Benefit Exchange, in conjunction with the Navigator and Enrollment Advisory Committee

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EXECUTIVE SUMMARY

Background

In April 2011, Maryland became one of a handful of states to pass legislation authorizing the development of a statewide Exchange.[1] The Maryland Health Benefit Exchange (MD HBE) Act commissioned a number of studies to inform the legislature as it makes key policy and operational decisions for the MD HBE. One of the commissioned studies requires the Exchange to consider options for the design and operation of the Navigator Program. This report is the result of that mandate.

Approximately 720,000 uninsured individuals reside in Maryland.[2] These individuals represent the Navigator's target population for enrollment into the individual Exchange.[3] In 2014, new affordable coverage options for low and middle income individuals, combined with the insurance mandate, will draw enrollment into the Exchange. Ultimately, 624,000 Marylanders are expected to become newly insured or switch coverage as a result of these changes. Approximately 405,000 individuals will enroll into the Exchange, including 244,000 eligible for subsidized coverage. An additional 219,000 individuals will be newly enrolled in Medicaid.[4] Maryland's uninsured rate is predicted to drop from 15% to 7%.[5]

Navigator Program Requirements

The ACA establishes the Navigator Program as a core functional requirement for state HBEs to assist these target populations.[6] ACA and proposed federal regulations outline: 1) the basic eligibility requirements of Navigators, 2) the types of entities eligible for Navigator grants, 3) the minimum duties Navigators must perform, 4) restrictions on compensation and 5) program financing requirements.

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[1] State of Maryland, Chapters 1 & 2, Acts of 2011.
http://mlis.state.md.us/2011rs/chapters_noln/Ch_1_sb0182T.pdf
http://mlis.state.md.us/2011rs/chapters_noln/Ch_2_hb0166T.pdf

[2] "Health Insurance Coverage in Maryland Through 2009." Maryland Health Care Commission, January 2011.

[3] Other studies previously conducted or in progress provide detailed demographic and social profiles of these individuals A separate study is underway by Weber Shandwick providing more in-depth research on the demographics of the uninsured population in Maryland. Copies of their report can be found at: http://dhmh.maryland.gov/healthreform/exchange/AdvComm/mtg-nav-enroll.html. Additionally, the Maryland Health Care Cost Commission conducted a detailed study on Health Insurance Coverage in Maryland, published in January 2011. That study can be found at: http://mhcc.maryland.gov/health_insurance/insurance_coverage/insurance_report_2009_20110120.pdf

[4] "M. Buettgens, J. Holahan, C. Carroll, "Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid," prepared for the Robert Wood Johnson Foundation State Coverage Initiatives by the Urban Institute, March 2011, available at http://www.rwjf.org/files/research/71952.pdf

[5] "M. Buettgens, J. Holahan, C. Carroll, "Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid," prepared for the Robert Wood Johnson Foundation State Coverage Initiatives by the Urban Institute, March 2011, available at http://www.rwjf.org/files/research/71952.pdf

[6] The Patient Protection and Affordable Care Act of 2010, Navigators, §1311(i), 42 USC § 18031(i).

Navigators must at a minimum: 1) conduct public education activities to raise awareness of the availability of qualified health plans; 2) distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits and cost-sharing reductions under the ACA; 3) facilitate enrollment in qualified health plans; 4) provide referrals to any applicable office of health insurance consumer assistance; 5) maintain expertise in eligibility, enrollment, and program specifications; and 6) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange, including individuals with limited English proficiency, and ensure accessibility and usability of Navigator tools and functions for individuals with disabilities.

During scheduled discussions on the Navigator Program, Maryland stakeholders unanimously agreed that Navigators should serve both Medicaid and QHP populations. While serving the Medicaid population is not a federal requirement, the Exchange can choose to operate its Navigator Program across both populations. Serving all consumers regardless of the type of coverage for which they are eligible (QHP or Medicaid) will allow for continuity of coverage and, as previously noted, unprecedented and important collaboration between the public and private markets. The program features described in this report and in the models section are designed through this lens.

Navigator Program Features

The framework for the Navigator Program is defined in federal law, but the MD HBE is responsible for determining how best to structure the program for Maryland. As part of this study, stakeholders considered and commented on the potential features of the Navigator Program, including: functions, training, compensation, licensure/certification, and oversight.

Navigator Functions

Navigator functions should focus on ACA requirements, with a post-enrollment support functionality for Navigators targeting small business. Navigators must refer individuals to existing consumer assistance programs for post-enrollment support, though some Advisory Committee members expressed concern that such resources are inadequate to meet the growing need and may need to be supplemented by Navigators. Care coordination services should be evaluated in the longer-term as a possible value-added service that might help attract and retain consumers as customers of the Exchange, and support Maryland's overall health goals.

Training

Training for Navigators is important should be built off a core base which offers additional modules for specialization based on job functions. Additional training should be required by some Navigators to develop the expertise to manage more complex issues or target specific populations.

Licensure/Certification and Oversight

Mechanisms to ensure quality assurance and accountability are critical. Oversight of Navigator functions is the responsibility of the Exchange, but may also include the Maryland Insurance Administration and Department of Health and Mental Hygiene, depending on how Navigators operate. Current vehicles for enforcing standards and oversight may need to be adjusted to meet the new demands of the Navigator program.

Compensation

Navigators must be paid for their services in a way that ensures the success of the Exchange. Navigator compensation must be structured to: 1) encourage small businesses and individuals to purchase health insurance through the Exchange; 2) avoid conflicts of interest and steering (promoting one plan over another because a particular plan may result in higher compensation to the Navigator); and 3) motivate and enable high level of performance by Navigator Programs. Three options were explored by the Advisory Committee, including: salaried Navigators employed by the Exchange, commission-based compensation and performance-based grants.

Navigator Program Models for Small Group and Individual Exchanges

Separate Navigator Program models are presented for the Small Business and Individual markets in recognition of the difference in the current distribution infrastructure and in the future functions and market dynamics for Navigators serving individuals and small businesses. Ultimately, the individual and small group Navigator functions could be integrated or administered separately, depending on the operational structure and need of the MD HBE.

The formulation of the models took into account several overarching considerations outlined by the Maryland Legislature in the MD HBE Act, including the degree to which the model supports the effective delivery of services to be performed by the Navigators and the degree to which existing market resources are leveraged to fulfill the Navigator role. Other considerations include ensuring that services are provided in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange. This includes ensuring sufficient accessibility and usability of Navigator tools and functions for individuals with disabilities and individuals with limited English proficiency. Navigator compensation was also a consideration, as the MD HBE Act requires that the study address how to minimize a or avoid disparities between Navigator compensation and the compensation of brokers outside the Exchange.

Small Group Models

Small Group Model #1: Navigator-Broker Model

The first small group model is the Navigator-Broker Model. The Navigator-Broker model seeks to integrate the existing small group delivery system by utilizing licensed brokers contracted by the MD HBE as Navigators. In this model:

- Navigators provide all ACA functions and all post-enrollment services currently provided by brokers;
- Navigators must be fully licensed as insurance brokers;
- Navigators also must be trained and certified to sell into the Exchange
- Compensation is aligned to broker compensation in the private market.

Small Group Navigator Model #2: Broker Interface/Employed Navigator Model

The second small group model is the Broker Interface and Limited Employed Navigator model ("Broker Interface Model"). In this model:

- MD HBE employs a limited number of Navigators (employed navigators) to serve small business seeking coverage directly from the Exchange.
- Navigators provide all ACA functions and all post-enrollment services currently provided by brokers.
- Brokers are not Navigators, but may sell QHP products offered by the Exchange if trained and certified by the Exchange.
- Brokers are compensated for QHP enrollment not as Navigators, but through traditional method (by the carriers)

Analysis

The two models do not differ significantly in their ability to meet the criteria used to evaluate each model. Rather, they offer different approaches to similar ends. The most notable difference between the models is the addition of employed Navigators in the Broker Integration Model (Model 2). This feature may offer greater ability for the MD HBE to target services to underserved market segments, thus increasing accessibility to small businesses and enhancing cultural and linguistic capacity. On the other hand, it may be perceived by some as competing with brokers and therefore impacting existing private sector employment.

Individual Market Models

Individual Model #1: Market Integration

The first individual model is the Market Integration model. In this model:

- Entities contracted as Navigators would provide the ACA and state mandated Navigator functions
- Navigators provide application assistance services to all consumers for all coverage options in the Exchange including Medicaid, CHIP, advance premium tax credits and QHP enrollment without subsidies

- Brokers are not Navigators, but may be trained and certified by the Exchange to sell QHPs to individuals.
- Brokers are paid for QHP enrollments by insurers, not by the MD HBE.
- Brokers do not provide Medicaid eligibility and enrollment assistance, but refer consumers who appear Medicaid eligible to Navigators or the Exchange

Individual Navigator Model #1 Alternative A: Market Integration Variation

This model variation is identical to the Market Integration Model (Model #1), except entities contracted as Navigators could provide the full range of Navigator functions OR specialize in a limited set of Navigator services and/or target their services to a specific population.

Individual Market Consolidation Model #2

The second individual model is called the Market Consolidation model. In this model:

- All functions – including all enrollments into QHPs and Medicaid/MCHIP – would be performed by Navigators contracted by the MD HBE.
- Navigators may include CBOs, providers and other organizations.
- Navigators are compensated by the MD HBE through performance-based contracts.
- Brokers wishing to sell QHP products to individuals would need to be contracted and compensated as Navigators. Brokers would not be permitted to sell QHP products unless they contracted as Navigators.

Individual Market Consolidation Model #2 Alternative A

This model variation is identical to the Market Consolidation Model (Model 2), except entities contracted as Navigators could provide the full range of Navigator functions OR specialize in a limited set of Navigator services and/or target their services to a specific population.

Analysis

One of the main differences between the Market Integration and Market Consolidation models relate to Medicaid enrollment. In the Market Integration Model (Model #1), brokers perform QHP but not Medicaid/MCHIP enrollment. The inability to ensure all entities engaged in Exchange enrollment can serve all programs (Medicaid, CHIP, APTC and QHPs) is likely to reduce access to individual coverage and impede continuity between public and private coverage.

On the other hand, the Market Integration Model (Model #1) is more likely to minimize the discrepancy between compensation inside and outside the HBE, as brokers are compensated directly by commercial insurance carriers in this model. This model is also more likely to minimize disruptions in private sector employment.

Variation alternatives for both models may provide for better delivery of services in a culturally, linguistically appropriate manner or in meeting other needs (e.g., accessible to individuals with physical, cognitive, and mental disabilities and/or limited literacy skills) since it allows a more diverse array of organizations and capabilities to compete for these limited functions. However, these models may create challenges for program oversight.

Next Steps

The Navigator Program is critical to the success of the Exchange. Designing and implementing such a program will take time and the consideration of the needs of consumers, the interests of the MD HBE, stakeholder preferences and the impact on the existing market. The MD HBE Act lays out a short term path to support important but high level design decisions. However, much of the work will begin once a model is chosen, including establishing the necessary contracting mechanisms, developing training programs and obtaining any necessary changes in state law.

INTRODUCTION

Beginning in 2014, many Americans will have access to affordable, comprehensive health insurance for the first time. The Patient Protection and Affordable Care Act (ACA) expands Medicaid eligibility and authorizes new state-based health benefit exchanges (HBEs or Exchanges) to offer affordable coverage options for individuals and small businesses. The Exchanges will connect consumers and employers to Qualified Health Plans (QHPs) operating in the Exchange and serve as an access point for Medicaid/Children's Health Insurance Program (CHIP) eligibility and enrollment. To meet the needs of the large number of consumers who will become eligible for insurance in 2014, the ACA charges Exchanges with establishing a network of Navigators to assist consumers with making informed decisions about appropriate coverage and getting enrolled.

Maryland has moved quickly to implement the federal legislation. In April 2011, Maryland became one of a handful of states to pass legislation authorizing the development of a statewide Exchange.[7] The Maryland Health Benefit Exchange Act (MD HBE Act) put Maryland on the path to Exchange implementation in three key ways. The MD HBE Act:

1) Created the Maryland Health Benefit Exchange (MD HBE or Exchange) with a governance structure and legal framework to serve an estimated 720,000 uninsured nonelderly Maryland residents;[8]
2) Codified in state law the functions and duties required of the MD HBE; and,
3) Commissioned a number of studies to inform the legislature as it makes key policy and operational decisions for the MD HBE.

One of the commissioned studies requires the Exchange to consider options for the design and operation of the Navigator Program. This report is the result of that mandate.

Study Overview

The MD HBE established a Navigator and Enrollment Advisory Committee (Advisory Committee) to assist in considering the options for design of Maryland's Navigator program and consumer assistance activities. Advisory Committee membership and co-chairs are listed in Attachment A. Manatt Health Solutions (Manatt) was retained by the MD HBE after a competitive procurement process to study and provide program design options taking into account the

[7] State of Maryland, Chapters 1 & 2, Acts of 2011.
http://mlis.state.md.us/2011rs/chapters_noln/Ch_1_sb0182T.pdf
http://mlis.state.md.us/2011rs/chapters_noln/Ch_2_hb0166T.pdf
[8] *Health Insurance Coverage in Maryland through 2009*, Maryland Health Care Commission, January 2011.

questions listed below. Questions 1-7 are mandated by the MD HBE Act.[9] Questions 8-10 were added by the Navigator and Consumer Assistance Request for Proposal (RFP).[10]

1) What is the infrastructure of the existing private sector health insurance distribution system in the state and to what extent are private sector resources available and suitable for use by the Exchange?
2) What effect will the Exchange have on private sector employment in the health insurance distribution system in the State?
3) What functions, in addition to those required by the Affordable Care Act, should be performed by Navigators?
4) What training and expertise should be required of Navigators, and do different markets and populations require Navigators with different qualifications?
5) How should Navigators be retained and compensated, and how can disparities between Navigator compensation and the compensation of insurance producers outside the Exchange be minimized or avoided?
6) How will the Exchange ensure that Navigators provide information in a manner culturally, linguistically, and otherwise appropriate to the needs of the diverse populations served by the Exchange, and that Navigators have the capacity to meet these needs?
7) What other means of consumer assistance may be appropriate and feasible, and how should it be designed and implemented?
8) What type of solicitation, if any, should be conducted of individuals or employers?
9) What methods should the Exchange use to determine the number of Navigators needed and how should the Exchange identify organizations that could serve as Navigators?
10) What standards should be required of Navigators and what oversight mechanisms should be used by the Exchange?

The purpose of this study is to provide a neutral, informative report that sets forth Navigator program design options for the consideration of the Advisory Committee. The Advisory Committee will utilize this information to develop a vetted Navigator options paper to be presented to the MD HBE Board for review and consideration. Finally, the MD HBE Board will develop formal recommendations to the Legislature regarding the design of a Navigator program for the MD HBE.

[9] State of Maryland, Chapters 1 & 2, Acts of 2011.
http://mlis.state.md.us/2011rs/chapters_noln/Ch_1_sb0182T.pdf
http://mlis.state.md.us/2011rs/chapters_noln/Ch_2_hb0166T.pdf
[10] *Study of Navigator Program and Consumer Assistance Request for Proposal*, July 11,2011,
http://dhmh.maryland.gov/healthreform/exchange/pdf/RFPs/Navigator_RFP_07112011.pdf

Methodology and Organization

In consultation with Advisory Committee members and co-chairs, Manatt implemented a three-part strategy to develop Navigator Program options:

1) Survey of State and National Navigator policy development
2) Landscape scan of Maryland's existing private sector and community-based health insurance distribution system
3) Key stakeholder input

A brief overview of the approach follows.

Survey of State and National Navigator Policy Development

Manatt conducted a survey of evolving state and national policy developments with regard for Navigator Programs. This survey included:

- A compilation of federal Navigator Program requirements and guidance;
- A state-by-state analysis of Navigator-related provisions in enacted state legislation, state Navigator Program Work Plans, published reports, and minutes from public proceedings; and
- A literature review of issue briefs, white papers and comments on proposed rulemaking from key national stakeholders such as the National Association of Insurance Commissioners, National Academy of Social Insurance, and consumer advocacy organizations.

This information enabled Manatt to identify program requirements and develop the parameters for program options. The compilation of federal Navigator Program requirements and guidance are included in the *Navigator Requirements Section* below and results of the state survey and literature review are included in Attachments D and E.

Landscape Scan of Maryland's Existing Private Sector and Community-Based Health Insurance Distribution System

To inform how the Navigator Program design could leverage existing private sector resources, Manatt assessed the existing health insurance and consumer assistance infrastructure in Maryland. This assessment included analyzing the populations served and services offered by brokers, state and local Medicaid agencies, the Medicaid enrollment vendor, community-based organizations (CBOs) and safety net providers. The size and scope of the private sector health insurance distribution system in Maryland was also assessed to determine the extent to which private sector resources could be leveraged to support Navigator functions. Manatt relied on existing sources of data and key informant interviews to identify the overall capacity and distribution of the existing health insurance distribution system in Maryland.

Stakeholder Input

Stakeholder input was a critical source of information in the development of the proposed options. Over 70 individuals were either interviewed, participated in facilitated discussion groups or submitted written comments as a part of this process. Manatt solicited stakeholder input through four mechanisms:

1) Facilitated small group discussions with targeted stakeholders;
2) Individual or entity-level interviews to collect targeted information or data;
3) Written public comment; and,
4) Advisory Committee meetings.

Manatt, with oversight from the MD HBE staff and the Advisory Committee, developed questions and discussion guides to facilitate the collection of comprehensive information and actionable guidance. Manatt conducted 90-minute facilitated discussions with the following stakeholder groups (a listing of individual attendees can be found in Attachment B):

- Consumers Representatives/Consumer Advocacy Groups
- Commercial Health Plans
- Medicaid Managed Care Organizations
- Small Business (two sessions)
- Brokers
- Providers

Manatt also conducted interviews with representatives from the following state agencies:

- Maryland Insurance Administration (MIA)
- Department of Health and Mental Hygiene (DHMH)
- Department of Human Resources (DHR)
- Maryland Attorney General- Health Education and Advocacy Unit (HEAU)

Stakeholder input was documented and presented to the Advisory Committee for feedback. Written comments were posted on the Exchange website for public review at [http://dhmh.maryland.gov/healthreform/exchange/pdf/Compiled-Public-Comments-FINAL.pdf]

Report Organization

This report begins with a description of the Navigator requirements under current state and federal law and findings regarding the existing health insurance distribution system in Maryland (*Navigator Requirements* and *Maryland's Insurance Market, Insurance Distribution System and Consumer Assistance Programs,* respectively). The report then assesses the potential design features for implementing the Navigator program to support enrollment into the MD HBE

(*Navigator Program Features*). The following section, *Navigator Program Operating Models* integrates the program features into high-level operating model options for the Advisory Committee's consideration. The last section, *Navigator Implementation Considerations*, addresses potential next steps and a high-level Navigator Program implementation timeline.

NAVIGATOR REQUIREMENTS

Federal Requirements

The ACA mandates the creation of "Exchanges" that offer consumers a coordinated eligibility and enrollment system for health insurance coverage by January 1, 2014. Exchanges are designed to be marketplaces where individuals and small businesses can shop or apply for affordable health coverage through QHPs,[11] Medicaid or CHIP. Exchanges also must determine consumer eligibility for and implementation of advance premium tax credits and cost-sharing reductions.[12,13] The law permits and encourages state-based Exchanges, although a federal exchange may be established for consumers in states that choose not to operate one or fail to have one in place by 2014.

Exchanges must be consumer-oriented, with minimal administrative hurdles,[14] and offer consumers the opportunity to enroll in coverage online, in person, by mail and by phone.[15] The exchanges must also offer robust consumer assistance, including a website featuring a coverage calculator to determine plan costs, a toll-free hotline, and navigators to assist consumers with understanding, applying for and enrolling in a health insurance plan.[16] As the primary focus of this report, a more detailed description of the statutory and regulatory requirements for the Navigator Program follow.

The ACA and Proposed Federal Regulations

Establishment of a Navigator program is a core functional requirement for state health benefit Exchanges under the ACA.[17] The ACA outlines: 1) basic eligibility requirements of Navigators; 2) types of entities eligible for Navigator grants,; 3) minimum duties Navigators must perform; 4) restrictions on compensation; and 5) program financing requirements. The law also addresses the information technology (IT) systems and other tools, such as a call center, required to ensure an efficient and seamless eligibility and enrollment experience for users of the Exchange. Navigators will need to interact with these systems as they assist consumers.

[11] Proposed regulations at 42 CFR § 155.20 define ''Qualified health plan'' as health plans that are certified by and offered through an Exchange.
[12] The Patient Protection and Affordable Care Act of 2010 §1311(d)(4)(F), §1413, §2201, 42 USC § 18031(i).
[13] "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Proposed Rule." *Federal Register* 76 (15 July 2011): 41875. Print.
[14] Ibid.
[15] "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Proposed Rule." § 155.405 Single streamlined application. *Federal Register* 76 (15 July 2011) 41917. Print.
[16] "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Proposed Rule." § 155.205 Required consumer assistance tools and programs of an Exchange *Federal Register* 76 (15 July 2011): 41915-6. Print.
[17] The Patient Protection and Affordable Care Act of 2010, Navigators, §1311(i), 42 USC § 18031(i).

On July 11, 2011,[18] the U.S. Department of Health and Human Services (HHS) released proposed regulations on the establishment of state Exchanges. The regulations, once finalized, codify the statutory requirements of the Navigator Program, as well as add new requirements related to the types of entities eligible to be Navigators, the basic eligibility requirements to be a Navigator and the duties required of Navigators. The regulations also clarify that the Navigator Program must serve both the individual and small group Exchanges and that states may elect to have Navigators serve Medicaid recipients as well. The statutory and proposed regulatory requirements follow. The proposed regulatory requirements are marked by an asterisk (*).

Basic Requirements:

Navigator entities must meet the following eligibility criteria:

1) Able to reach the target population. The law requires Navigator entities to be able to demonstrate that they have existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a QHP;
2) Capable of carrying out the minimum duties;
3) Meet licensure and conflicts of interest standards to be established by the Secretary via regulation;
4) Provide information that is fair, accurate and impartial;
5) Meet any licensing, certification, or other standards prescribed by the state or Exchange, if applicable;* and
6) Not have any conflict of interest during the term as Navigator.*

Types of Entities:

States must select at least two of the following types of entities as Navigators:

1) Trade, industry, and professional associations;
2) Commercial fishing industry organizations;
3) Ranching and farming organizations;
4) Community and consumer-focused nonprofit groups;
5) Chambers of commerce;
6) Unions;

[18] "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Proposed Rule." § 155.205 - 10 *Federal Register* 76 (15 July 2011): 41915-6. Print.

7) Small business development centers;
8) Other licensed insurance agents and brokers;
9) Indian tribes;*
10) Tribal organizations;*
11) Urban Indian organizations;*
12) State or local human service agencies;* and
13) Other entities that meet the basic eligibility requirements.

Minimum Duties: Navigators must, at a minimum, perform the following duties:

1) Conduct public education activities to raise awareness of the availability of QHPs;
2) Distribute fair and impartial information concerning enrollment in QHPs, and the availability of premium tax credits and cost-sharing reductions under the ACA;
3) Facilitate enrollment in QHPs;
4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under the ACA,[19] or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage;
5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges;
6) Maintain expertise in eligibility, enrollment, and program specifications and conduct public education activities to raise awareness about the Exchange;*
7) Provide information and service in a fair, accurate, and impartial manner. Such information must acknowledge other health programs;* and
8) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange, including individuals with limited English proficiency, and ensure accessibility and usability of Navigator tools and functions for individuals with disabilities.*

[19] Section 2793 of the Public Health Service Act creates Consumer Assistance Programs to assist consumers with filing complaints and appeals, assist consumers with enrollment into health coverage, and educate consumers on their rights and responsibilities. In addition, by law Consumer Assistance Programs must collect data on consumer inquires and complaints to help the Secretary of HHS identify problems in the marketplace and strengthen enforcement. Starting in 2014, programs must also help resolve problems with premium credits for Exchange coverage. See https://www.cfda.gov/?s=program&mode=form&tab=step1&id=ca090412b09e1b0d0d95a2823d1fe12a.

Compensation: The law places restrictions on how Navigators may be compensated. Navigators may not receive any payment–direct or otherwise–from commercial health insurers for an enrollment into a QHP.[20]

Program Financing: The law prohibits states from using federal Exchange funding for the Navigator Program, requiring that the Program be sustained out of Exchange operating funds.[21] The regulations clarified that to the extent Navigators serve Medicaid recipients, the program can apply for federal Medicaid matching funds.[22]

Information Technology: The ACA requires the development of IT systems to support the eligibility and enrollment functions of state Exchanges.[23] The technology backbone is intended to provide a high quality customer experience, that enables seamless coordination between "Exchanges, Medicaid and CHIP and between the Exchanges and plans, employers, Navigators and brokers, and CBOs and providers providing enrollment assistance."[24] The IT systems must also be capable of supporting program evaluation efforts.

Exchange Call Center: The ACA requires the Exchange to have a call center with a toll-free number to respond to requests for assistance by consumers.[25] States have significant flexibility in designing the call center. While not required by law, the call centers will serve as a conduit to Navigators and Consumer Assistance Programs.[26]

[20] "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Proposed Rule." § 155.210(c) Prohibition on Navigator conduct. *Federal Register* 76 (15 July 2011) 41915. Print.
[21] The Patient Protection and Affordable Care Act of 2010, Navigators: Funding, §1311(i)(6), 42 USC § 18031(i).
[22] The preamble to proposed regulations on the Navigator Program clarifies that if a state chooses to permit or require Navigator activities to address Medicaid and CHIP administrative functions, the Medicaid or CHIP agencies may claim Federal funding for a share of expenditures incurred for such activities at the administrative Federal financial participation rate. "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Proposed Rule." *Federal Register* 76 (15 July 2011): 41878. Print.
[23] The Patient Protection and Affordable Care Act of 2010, Health Information Technology Enrollment Standards and Protocols, §1561, 42 USC § 18031(i).
[24] CMS, "Guidance for Exchange and Medicaid Information Technology (IT) Systems, Version 2.0," May 2011. http://cciio.cms.gov/resources/files/exchange_medicaid_it_guidance_05312011.pdf
[25] The Patient Protection and Affordable Care Act of 2010, Navigators: Standards, §1311(d)(4)(B), 42 USC § 18031(i).
[26] " Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Proposed Rule." § 155.205(a) Call center. *Federal Register* 76 (15 July 2011) 41915. Print.

MARYLAND INSURANCE MARKET, INSURANCE DISTRIBUTION SYSTEM & CONSUMER ASSISTANCE PROGRAMS

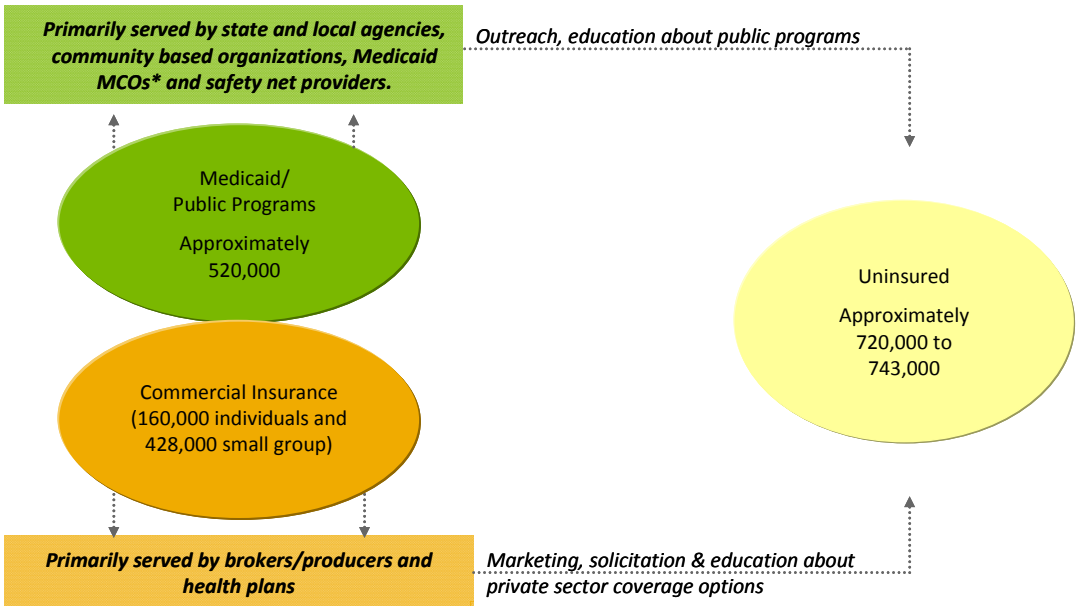
To inform the Navigator Program's design and function, it is important to understand the current marketplace, including how individuals and small business currently obtain both private and public insurance coverage, and the profile of Maryland's uninsured population. Maryland's uninsured population ultimately reflects the "target market" for the Navigator Program.

Current Maryland Insurance Market

Eight-five percent (85%) of nonelderly Marylanders have some form of health insurance coverage and 15% are uninsured.[27] Seventy-five percent (75%) of Marylanders have private insurance coverage. Included in that 75% are approximately 428,000 people who obtain coverage through small employers and 160,000 people who have coverage through the individual market.[28] Approximately 18%, or 520,000 individuals, are enrolled in some form of public insurance coverage.[29] Since 8% of the nonelderly insured in Maryland report more than one type of coverage, the sum of coverage percentages combined with the uninsured percentage exceeds 100%.

[27] "Health Insurance Coverage in Maryland Through 2009," Maryland Health Care Commission, January 2011.
[28] Carey, R.L. & Gruber, J.M. "A Health Insurance Exchange for Maryland? Comparing Massachusetts and Maryland", Maryland Association of Health Underwriters and National Association of Insurance and Financial Advisors of Maryland. 2010. Report commissioned by the Health Insurance Buyers and Brokers Coalition of Maryland.
[29] "Health Insurance Coverage in Maryland Through 2009," Maryland Health Care Commission, January 2011. Note that Medicaid enrollment is lower than anticipated due to the Medicaid undercount. Additionally, the report shows the total percentage of nonelderly residents who reported having had each type of coverage. Consequently, the sum of percentages in the private and public markets exceed 85%. Please refer to the Maryland Health Care Commission report for more details.

Figure 1: Current Maryland Small Group, Individuals & Public Insurance Marketplace Impacted by Exchange Implementation[30]



** Note Medicaid MCOs are not permitted to perform outreach to individuals.*

Both the existing individual and small groups commercial insurance market will be impacted by the MD HBE. Small group market premiums in Maryland currently are amongst the highest in the nation.[31] Maryland implemented small group health reform in 1993 that required employers to offer a Comprehensive Standard Benefit Plan, established a community rate that varies only by age and geography between specified percentages and prohibited insurers from imposing preexisting condition exclusions or rating on health status. These protections ensured access but made the small group products more expensive. In 2009, the General Assembly passed legislation that provided more flexibility in rating in the small group by permitting preexisting condition limitations to the extent that they are allowed in the large group, permitting the use of health status in rating over a specified manner and timeframe upon entry of a small employer into the small group market, and authorized health insurance carriers to vary a rate charged for a health benefit plans in the small group up to 50% above or below the community rate based on age or geography.[32]

Individual market premiums are lower than the national average for individual market.[33] Maryland does not require that insurers that receive an individual application for insurance

[30] The description of the Maryland health insurance market only applies to the under age 65, non-large group populations.
[31] AHIP Center for Research and Policy, "Small Group Health Insurance in 2008," March 2009 available at: http://www.ahipresearch.org/pdfs/smallgroupsurvey.pdf
[32] http://mlis.state.md.us/2006rs/misc/2006_IssuePapers.pdf (p. 131) and http://mlis.state.md.us/2010rs/misc/MajorIssuesReview2007-2010.pdf (p. J-31 and J-32)
[33] AHIP Center for Research and Policy, "Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits," December 2007.

offer coverage. Maryland allows medical underwriting, which permits carriers to offer or deny coverage only to those individuals who pass their screening criteria.[34] Applicants can be denied coverage based on their health status.[35]

Eligibility for public health insurance in Maryland (Medicaid and the Maryland CHIP program, or MCHIP) is determined based on income, age, citizenship or immigration status, state residency, and disability or health status. Maryland currently provides public coverage to children with incomes below 300% of the federal poverty level (FPL), to adults with incomes below 128% FPL, (however, some adults receive a limited package of benefits). Certain subpopulations, such as pregnant woman and people with disabilities, are offered coverage at higher incomes. Maryland, like many other states, mandatorily enrolls select individuals into managed care organizations (MCOs). MCOs are health insurers that contract with the state to manage care and assume the risk associated with administration of benefits. As of October 2010, approximately 74% of the total Medicaid recipients in the state were enrolled in MCOs. The remaining individuals, primarily the disabled and individuals also eligible for Medicare, receive benefits paid for an a fee-for-service basis directly by the state.[36]

Currently, the commercial and public insurance distribution systems are served by organizations operating in silos. Brokers serve employers, including small businesses, and to a lesser extent individuals, purchasing commercial health insurance. State and local government agencies, CBOs and safety net health care providers assist individuals with enrollment in Medicaid and MCHIP. Although a significant number of individuals experience income fluctuations that cause them to cycle in and out of the Medicaid program, current commercial market coverage options are by and large unaffordable to lower income individuals. This gap reinforces the siloed nature of the distribution systems for private and public coverage options.

Uninsured Demographics in Maryland

Approximately 720,000 uninsured individuals reside in Maryland.[37] These individuals represent the Navigator's target population for enrollment into the individual Exchange.[38] The design of

[34] Carey, R.L. & Gruber, J.M. "A Health Insurance Exchange for Maryland? Comparing Massachusetts and Maryland," Maryland Association of Health Underwriters and National Association of Insurance and Financial Advisors of Maryland, 2010. This study was commissioned by the Maryland Association of Health Underwriters and the National Association of Insurance and Financial Advisors of Maryland.

[35] The Maryland Health Insurance Plan (MHIP) is a state-sponsored insurance plan for individuals who are unable to obtain individual insurance coverage.

[36] Kaiser Family Foundation "State Health Facts: Maryland, " Accessed November 2011. http://www.statehealthfacts.org.

[37] "Health Insurance Coverage in Maryland Through 2009," Maryland Health Care Commission, January 2011.

[38] Other studies previously conducted or in progress provide detailed demographic and social profiles of these individuals A separate study is underway by Weber Shandwick providing more in-depth research on the demographics of the uninsured population in Maryland. Copies of their report can be found at: http://dhmh.maryland.gov/healthreform/exchange/AdvComm/mtg-nav-enroll.html. Additionally, the Maryland Health Care Commission conducted a detailed study on Health Insurance Coverage in Maryland, published in January 2011. That study can be found at: http://mhcc.maryland.gov/health_insurance/insurance_coverage/insurance_report_2009_20110120.pdf

the Navigator program must take into account the demographics of the uninsured and consider how best to target specific populations for enrollment. Key demographic information includes:

1) 81% of the uninsured have incomes less than 400% of the FPL, making them potentially eligible for Medicaid or tax subsidies for QHPs in 2014;
2) 65% of the uninsured are minority populations, with the majority of those individuals being either Black/African American or Hispanic and lower-income;
3) 45% of the uninsured are between the ages of 19 and 34, the single largest age bracket of uninsured individuals;
4) 46% have no more than a high school education, making health literacy an important consideration for the design of the Navigator program;
5) 79% of the uninsured reside in families where a worker is employed in the private sector, with 42% of those individuals employed in a small business, indicating the need for the Exchange to target both small businesses and their workers.

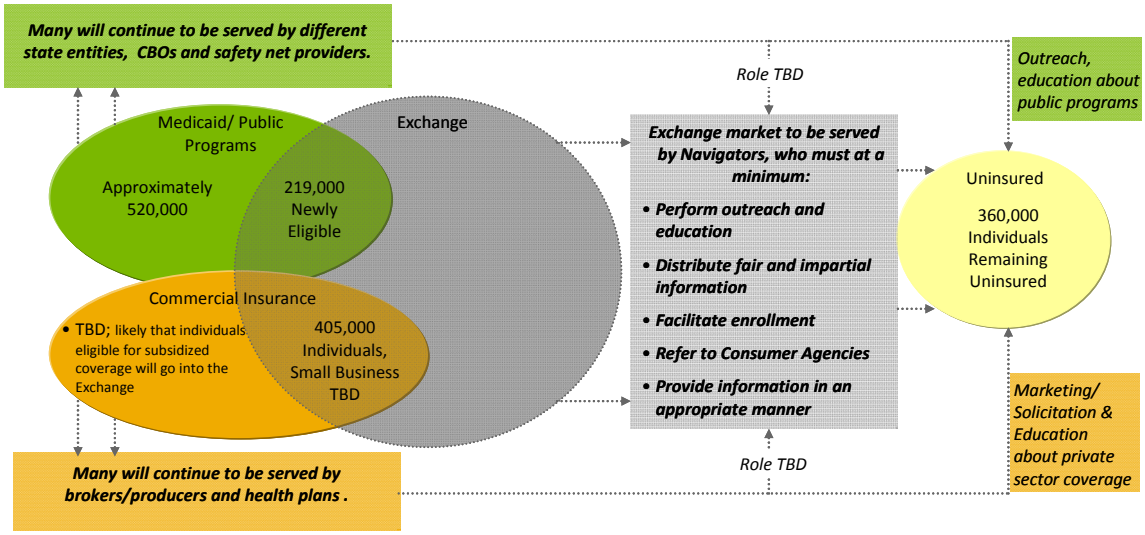
Post-ACA Marketplace

In 2014, new affordable coverage options for low- and middle-income individuals, combined with the insurance mandate, will draw enrollment into the Exchange. Ultimately, 624,000 Marylanders are expected to become newly insured or to switch coverage as a result of these changes. Approximately 405,000 individuals are anticipated to enroll into the Exchange, including 244,000 eligible for subsidized coverage. An additional 219,000 individuals will be newly enrolled in Medicaid.[39] Maryland's uninsured rate is predicted to drop from 15% to 7%, with an estimated 360,000 individuals remaining without coverage.[40]

[39] "Buettgens, M., Holahan, J., & Carroll, C. "Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid," prepared for the Robert Wood Johnson Foundation State Coverage Initiatives by the Urban Institute, March 2011, available at *http://www.rwjf.org/files/research/71952.pdf*

[40] Ibid.

Figure 2: Post January 1, 2014 Marketplace Impacted by Exchange Implementation[41]



The convergence of lower income individuals, who have primarily been served through the public insurance distribution system, with commercial insurance coverage, primarily served through the private insurance distribution system, is unprecedented. Decisions made about the design and function of the Navigator Program serving the individual market, in particular, need to be made with a solid understanding of the distribution systems serving both the public and private health insurance markets in Maryland.

Private Insurance Distribution System

Brokers, online brokerage firms, intermediaries, consultants, benefit professionals and health insurers are all involved in the sale of private health insurance in Maryland.[42] Health insurance sales into the individual and small group markets are almost exclusively generated by brokers, intermediaries and health insurers. Brokers provide individuals and small groups with information on their health insurance options, assist with or facilitate the completion of the

[41] The description of the Maryland health insurance market only applies to the under age 65, non-large group populations.

[42] Advisors play a minor role in the sale of health insurance. Advisors are individuals who, for compensation, examine or offer to examine a policy, or give or offer to give, advice or information about: the terms, conditions, benefits, coverage, or premium of a policy or the advisability of changing, exchanging, converting, replacing, surrendering, continuing, or rejecting a policy, or of accepting or procuring a policy from an insurer. An advisor also represents to the public that the person gives or is engaged in the business of giving advice or information to holders of policies. Like brokers, advisors typically cover more than health care insurance. For more information on insurance advisors including the complete definition please see: Maryland Insurance Code Ann. § 10-201 (2011). Definitions.

insurer's application and the underwriting process, and submit the application materials to the health insurer on behalf of an applicant.[43]

Intermediaries support brokers by providing a central point of access for most health plans offered by most insurers operating in the state's individual and small group markets. There are three primary intermediaries in Maryland: BenefitMall, GroupBenefit Services, and Kelly and Associates Insurance Group. These intermediaries provide brokers standardized information to compare health plans, generate premium quotes across multiple carriers, process enrollment and provide ongoing account management during the year.[44] Intermediaries also do premium billing and collections across multiple insurers (e.g., health, life, disability, etc). This enables the employer to receive a single bill from the intermediary even when contracting with multiple insurers.[45]

Broker Licensure

The activities associated with the sale of private health insurance are regulated by the Maryland Insurance Administration (MIA). The MIA requires licensure for "*Any person that, for compensation, sells, solicits, or negotiates insurance contracts, including contracts for nonprofit health service plans, dental plan organizations, and health maintenance organizations.*" [46,47]

Maryland law refers to individuals requiring licensure as "insurance producers." However, licensed individuals or entities engaged in the sale of health insurance contracts are commonly referred to in Maryland as "brokers." For the purposes of this study the term "broker" is not used to refer to intermediaries or the online brokerage firms. Because the functions of a Navigator mirror most closely those of a broker, as defined here, they are the primary focus of the discussion on the current private insurance distribution system within this report.

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[43] Carey, R.L. & Gruber, J.M. "A Health Insurance Exchange for Maryland? Comparing Massachusetts and Maryland", Maryland Association of Health Underwriters and National Association of Insurance and Financial Advisors of Maryland, 2010.

[44] Ibid.

[45] The documents developed for the SHOP Committee provide in-depth descriptions on the role of intermediaries in the Maryland market that can be used supplement the information on intermediaries contained in this report. http://dhmh.maryland.gov/healthreform/exchange/AdvComm/mtg-shop.html

[46] Maryland Insurance Code Ann. § 1-101 (2011) Definitions. "(cc) Negotiate means to confer directly with or offer advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers. (kk) Sell means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurer. (ll) Solicit means to attempt to sell insurance or to ask or urge a person to apply for a particular kind of insurance from a particular insurer."

[47] This study refers exclusively to ***health*** insurance producers unless otherwise noted. Producers in Maryland must be licensed in one of six major lines of insurance: Life, Health, Property, Casualty, Variable, and Personal Lines or have a limited license issued in the following limited lines: Automobile, Credit Products, Travel (Individuals Only), Title, and Motor Vehicle Rental Company/Franchisee (Firms Only). For more on limited licensure, please refer to the section Navigator Program Features. More information on the types of producer licensure requirements can be found at the MIA website: http://www.mdinsurance.state.md.us/sa/producer/index.html

In order to obtain an initial license, brokers who are Maryland residents must at least:[48]

1) Be 18 years or older;
2) Enroll in pre-licensing education, by choosing a course provider through an MIA-approved pre-licensing education vendor for 60 hours online/in-person classes for a fee;
3) Pass a licensure exam that determines competence in health insurance and familiarity with applicable state laws through an MIA-approved pre-licensing education vendor;
4) Pay a $70 licensure exam fee and a $54 license application fee; and
5) Submit a licensure application.

The license is valid for two years and then must be renewed.[49] Exam scores are valid for one year.[50] Once licensed, brokers are required to take 24 credits of continuing education courses every two years. Further information on licensure and licensing requirements, including information about non-resident licensing and renewals can be found on the MIA's website.[51]

Health insurers in the Maryland market typically have requirements for brokers engaged in the sale of their products that extend beyond licensure. These requirements include obtaining and submitting proof of errors and omissions in insurance coverage. Insurers generally require a coverage minimum amount, which is currently between $1 million and $2 million.

Broker Market Penetration

The Sage Policy Group, Inc. in a report commissioned by the Health Insurance Buyers and Brokers Coalition of Maryland, reports that 24,963 licensed brokers are engaged in selling one or more insurance products (e.g., life, health, property and casualty, etc.) in Maryland.[52] The MIA tracks the number of brokers currently licensed to sell all insurance products, but does not track the number of brokers that only sell health insurance or the number actively engaged in the business of selling health insurance. This same study reports that approximately 20,000

[48] Insurers also have a requirement that brokers have errors and omissions insurance coverage. Insurers generally require a coverage minimum amount, which is currently between $1 million and $2 million.
[49] Individuals requesting health as their major line of insurance who actively hold one of the following designations may be granted a waiver from pre-licensing education: Registered Health Underwriter (RHU); Certified Employee Benefit Specialist (CEBS); Registered Employee Benefit Consultant (REBC); Health Insurance Associate (HIA)
[50] Bienemann, J., "Maryland Insurance Administration Producer Licensing Q&A," http://www.mdinsurance.state.md.us/sa/docs/documents/producer/licensing-docs/licensing-faqs-contacts04-11rev.pdf.
[51] "Initial Producer Licensing", Maryland Insurance Administration, http://www.mdinsurance.state.md.us/sa/docs/documents/producer/licensing-docs/initialproducerlicensinginstruction10-09rev.pdf.
[52] "20,000 Direct Jobs in Maryland: The Economic Impact of Maryland's Health Insurance Brokerage/Underwriting Industry," Sage Policy Group, Inc. February 2011, http://www.bizjournals.com/baltimore/pdf/Health-brokers-report.pdf.

individuals, including intermediaries, consultants, benefit professionals and advisors, are engaged in the health care distribution system. [53]

Anecdotally, both intermediaries and insurers observe that approximately 1,900 to 2,000 brokers actively sell health insurance in Maryland's individual and small group markets.[54] Over 90% of small businesses that purchase insurance do so with the assistance of a broker.[55] The remaining coverage is purchased online or placed directly with the insurers. In the small group market, commercial insurers interviewed for this study observed that the vast majority—approximately 85% of the individual and small businesses coverage purchased from each carrier—comes through the "same 300 to 400 brokers." Small businesses and carriers interviewed for this study observed high rates of market penetration in the small group market and did not view broker capacity or distribution as a concern.

In the individual market, approximately 40% to 50% of individuals use an in-person broker to purchase insurance while the remaining individuals coordinate directly with the health plan or through an online brokerage firm (such as ehealthinsurance.com).[56,57] For most brokers, individual sales are a small percentage of their overall business. This means that brokers tend to not specialize in the individual market but that most, if not all, of the "active" brokers in the market sell some small number of individual policies.

Approximately 405,000 individuals in Maryland are expected to enroll into the individual Exchange. With 1,900 to 2,000 "active" brokers in total, broker capacity and distribution is a cause for concern in the individual exchange market, irrespective of how brokers conduct business with the MD HBE. The broader private health insurance distribution community, inclusive of both "non-active" brokers, and the 20,000 who work in the health insurance industry, represent a potential source for distribution that could supplement existing broker efforts. However this community currently is not organized around selling to the individual market.

Brokers and health insurers also report that brokers often target different market segments, such as particular industries, languages or cultures, in addition to geographic areas. Existing studies available to test these assertions are either not available or not reliable.[58] Given the

[53] "20,000 Direct Jobs in Maryland: The Economic Impact of Maryland's Health Insurance Brokerage/Underwriting Industry," Sage Policy Group, Inc. February 2011, http://www.bizjournals.com/baltimore/pdf/Health-brokers-report.pdf.

[54] Carey, R.L. & Gruber, J.M. "A Health Insurance Exchange for Maryland? Comparing Massachusetts and Maryland," Maryland Association of Health Underwriters and National Association of Insurance and Financial Advisors of Maryland, 2010. Note: Carey and Gruber do not cite their source for the 2,000 figure. Additional confirmation on the range came from discussions with both health insurers and an intermediary.

[55] Ibid.

[56] Ibid.

[57] Discussions with Maryland health insurers account for the range of the percentage of business placed directly with health insurers.

[58] The MIA commissions an annual repot to summarize the statistical information that relates to life and health insurance producer examinations. The report assesses the race/ethnicity, gender, educational level and native

diversity of the populations anticipated to enroll in the Exchange, having a better understanding of the "reach" and experience of brokers in targeted communities would be helpful.

Broker Compensation

Brokers compensation levels vary by insurer, however, brokers generally are compensated either on a per contract (subscriber) per month fee or as a percentage of the premium. Broker payments are embedded in insurance product premiums. Premiums are paid by the employer or individual directly to the health insurer, who in turn compensates the broker. Employers and individuals are charged the same premium amount regardless if they use a broker or not. Brokers interviewed for this study estimate compensation to be between 1.5% – 5% of the total premium value.[59] Many insurers within the market pay on a per contract per month (PCPM) fee, which equates to $20 to $25 PCPM.[60] Most brokers earn approximately $68,000 to $73,000 annually.[61]

Although brokers serve both the individual and small group markets, the two markets have notable distinctions, therefore the functions that brokers provide are discussed separately in this report.

Role of Brokers in the Small Group Market

Both brokers and health insurers operate marketing programs that target small groups. Health insurer marketing campaigns are broader and tend to rely on traditional advertising channels to raise awareness of insurance products and the brand of the insurer. Broker marketing and solicitation occurs through community events, referrals and re-sale, and is based heavily on relationships.

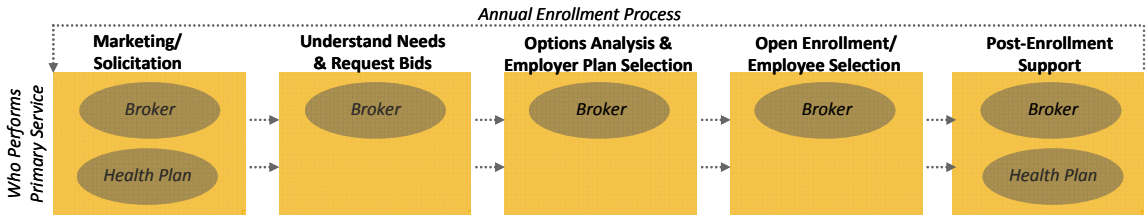
language for examinees. However, since it is voluntary for examinees to report on these fields, the data is not reliable enough to draw conclusions.

[59] As previously mentioned, MHIP is a state-sponsored insurance plan for individuals who are unable to obtain insurance coverage due to a pre-existing condition. An MHIP policy can be purchased directly from CareFirst (the administrator of the plan) or individuals can use a broker. For this plan, brokers are compensated on a per application basis. This per application fee is $100. The brokers interviewed for this study did not feel compensation was adequate to cover the costs. Brokers also stated that they generally perform this service when requested by individuals but do not proactively seek to enroll individuals into this product.

[60] Carey, R.L. & Gruber, J.M. "A Health Insurance Exchange for Maryland? Comparing Massachusetts and Maryland," Maryland Association of Health Underwriters and National Association of Insurance and Financial Advisors of Maryland, 2010

[61] "20,000 Direct Jobs in Maryland: The Economic Impact of Maryland's Health Insurance Brokerage/Underwriting Industry," Sage Policy Group, Inc. February 2011, http://www.bizjournals.com/baltimore/pdf/Health-brokers-report.pdf

Figure 3: Small Group Enrollment Process



Although some brokers focus solely on health insurance, most brokers market and sell more than just health insurance products, such as dental, life, short-term and long-term disability, and accidental death.

Brokers work closely with individual businesses to understand their unique needs, including understanding industry dynamics, the number and demographics of employees, cash flow and financing requirements, and the overall philosophy that the small business has with regard to providing insurance coverage to employees. Brokers weigh this knowledge against various plan designs, including deductible and co-payment levels, flexible spending account or health savings account options, out-of-pocket maximums and limits on particular services. Once brokers have a complete understanding of the needs of employers, they submit multiple bids to different insurers.

Once the bids are returned, the broker helps the employer understand different benefit options and to identify levers for adjusting the bids to meet the desired premium rate. For example, the broker may work with the employer to adjust the level of in-network versus out-of-network benefits or the level of cost-sharing. Once the plan(s) is selected by the employer, the broker works to assess cost-sharing levels, develop a payment plan, and address any tax implications.

Brokers then work with the employer during the annual open enrollment/employee selection time period to sign up individual employees for health insurance plans. Brokers develop customized materials for employers to explain the plan options. They sometimes host on-site sessions at employer locations to answer questions and work one-on-one with employees to identify the plan that works best for them. Enrollment into a plan is processed quickly by the health insurer.

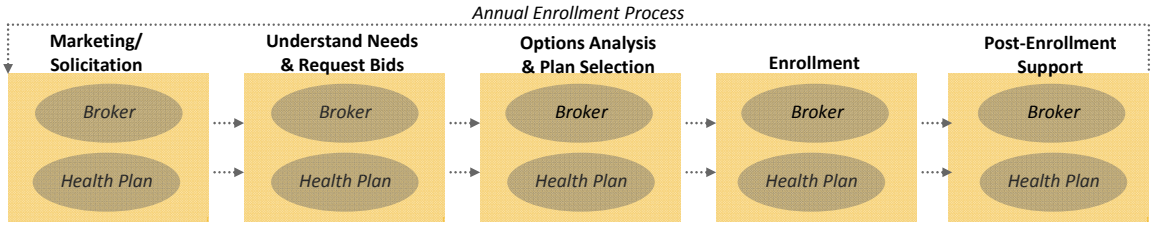
Once plan selection is finalized and employees are enrolled, brokers support employers and their employees in resolving a range of problems that may occur, such as issues and/or questions related to COBRA, Section 125 administration, benefits, coverage and premium payment. These services supplement the support offered by commercial health insurers for benefit administration.

Role of Brokers in the Individual Market

While the small group market is dominated by brokers, the individual market is an equal mix of broker support and individuals going directly to the health plans or through on-line

intermediaries. A brief overview of the functions performed by brokers to enroll individuals in health plans is provided below.

Figure 4: Individual Enrollment Process



Similar to the small group market, brokers plan marketing and solicitation activities in community settings and at local events, and leverage word-of-mouth referrals to identify individuals seeking to purchase insurance. Brokers interviewed for this study stated that some of their individual customers are the employees of small business who are ineligible to purchase health insurance (such as a part time worker) or who opt out of small group coverage for a variety of reasons, including where the small group premium is higher than what an individual could obtain in the direct market.[62]

Also similar to the small group market, brokers must understand the unique needs of the individual, including price sensitivity, and explain varying types of coverage options and products. Brokers then request bids from insurers for products likely to meet the individual's needs.

Once the bids return, the broker explains the different benefit options and potential levers that could be used to change the premium amount or anticipated out-of-pocket costs. This discussion includes strategies like raising the deductible or eliminating particular services from the policy. Once the broker identifies an appropriate plan for that individual's needs, the broker processes their enrollment into the selected plan. In the individual market there is no open enrollment period as there is in the small group market.

Post-enrollment support for individuals generally is not as robust as that offered to small groups. Most post-enrollment support is provided by health insurers that administer the benefits. However, some brokers do provide support when needed to resolve individual issues or concerns.

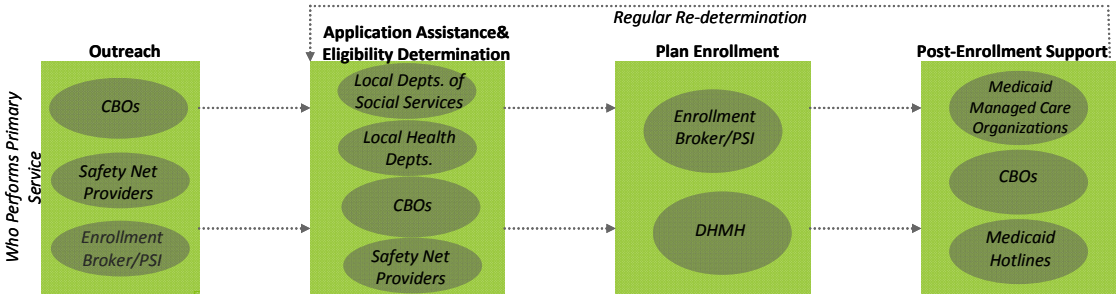
[62] Chapter 301 of House Bill 1178 (passed in May of 2011) authorizes brokers to provide to small employers certain information about certain state health programs for their employees. Brokers can provide information about Maryland's Medicaid and CHIP programs. This information is limited to income eligibility thresholds and application instructions. The brokers we interviewed for this study were mixed in their response as to whether they have directed individuals to public programs. Most brokers supported targeting the "working poor" and other uninsured individuals who do not/cannot enroll in a small employer's health plan for enrollment either into public programs or subsidized/non-subsidized QHPs in the exchange.

Public Enrollment Resources

Several notable differences exist between the health insurance distribution system for commercial insurance and the public insurance enrollment system for low-income individuals. Public coverage enrollment is supported by government and charitable funds. The state performs many functions directly with salaried or hourly employees. Services contracted on behalf of the state generally are procured through a competitive process in which performance-based grants or contracts are awarded. These awards typically dictate the roles, responsibilities and expectations of the awardees, and do not compensate either individuals or entities on a "per enrollee basis" or "PCPM" basis. CBOs and safety net providers supplement the outreach and enrollment efforts by the state. These organizations typically rely on private foundation grants and donations and, again, compensation is either salaried or hourly. Volunteers often are deployed to supplement the efforts of paid employees.

Unlike the private sector distribution process, which generally has a broker or a health insurer work with the individual or small business from marketing through post-enrollment support, enrollment of an individual into a public program requires many different organizations coming together to support the process. A brief overview of the functions performed by the different organizations is provided below.

Figure 5: Public Programs Enrollment Process



While brokers perform "marketing and solicitation," entities that support public programs conduct "outreach." Outreach sometimes is targeted at vulnerable subpopulations, such as the homeless, the mentally or cognitively impaired, individuals newly released from prison, individuals with substance abuse issues, low-income minority populations, low-income pregnant women and other underserved populations. Outreach tends to be clustered in urban environments and other high priority geographic areas.

Outreach for public programs is conducted at community events, such as health fairs, by CBOs and local departments of health. Safety net health care providers also perform outreach, educating individuals about insurance options and assisting with enrollment at the point of care, including in hospitals and clinics. MCOs are prohibited from conducting direct marketing to eligible individuals and therefore they are not direct participants in the outreach process.

Outreach activities typically focus on educating individuals on eligibility criteria, application processes and health services available through public coverage programs. Unlike private coverage, which has many benefit designs (e.g., deductibles, co-insurance, service configurations) public health coverage offers standardized benefits for most populations across all MCOs. Therefore, education about public health insurance programs focus on how to enroll in coverage and how to utilize services once enrolled. Often, outreach workers offer educational support and assistance on issues beyond public health insurance coverage, including earned income tax credits, food stamps, temporary cash assistance, child care subsidies, and housing assistance.

Various organizations work with individuals to complete the application for public programs and collect the necessary documentation to verify eligibility. This process can be burdensome, requiring an understanding of complex eligibility criteria and collection of documents to establish identity, residency, household composition, citizenship, and income. The targeted populations often do not have this information readily available nor understand (or trust) why the state needs this information to process enrollment. Outreach workers help applicants gather the documents to comply with eligibility requirements.

Local Departments of Social Services and the Local Health Departments are primarily responsible for enrolling individuals and families in public health insurance programs, with additional assistance provided by CBOs and safety net providers. Funding for state and contracted entities has been reduced in recent years due to state budget cuts, creating capacity constraints. Stakeholders interviewed for this effort reported capacity concerns with getting applications completed and submitted for eligibility determination in a timely manner, and observed that an increase in community-based enrollment assistance support services was necessary to meet the expanding needs.

Eligibility ultimately is determined by the Local Departments of Social Services and the Local Health Departments.[63] Most completed applications are processed within 30 days; applications requiring a disability determination must be processed within 90 days.

A distinguishing characteristic in the public programs is that the eligibility determination and plan enrollment are two distinct processes. Once eligibility is processed, individuals are then enrolled into an MCO by the enrollment broker, currently Policy Studies Inc. Enrollment is based on the preference of the individual, with their plan choice often driven by the plan affiliation of their current providers. Proactive outreach is conducted by the enrollment broker to ensure that eligible individuals have the information that they need to make a decision about plan enrollment.[64] Individuals who do not select an MCO are auto-assigned into a plan. All

[63] Local Health Departments can only determine eligibility for public health care insurance programs.
[64] The Hilltop Institute published a paper entitled "Navigators: A Background Paper" on August 11, 2011 that provides an in-depth overview of the activities of the enrollment broker. The report can be access at: http://www.hilltopinstitute.org/publications/Navigators-BackgroundPaper-August2011.pdf.

enrollments are processed into an MCO within 30 days. No stakeholder interviewed for this study reported a capacity concern with enrollment into MCOs.[65]

Post-enrollment support for public programs is similar to that of the individual market for private insurance. Medicaid MCOs administer benefits and are the primary point of contact for questions or issues related to accessing care. CBOs also often assist with trouble-shooting and issue resolution. Additionally, Medicaid operates hotlines that provide advice and information.

Consumer Assistance Resources

Navigators are required to make appropriate referrals to "consumer assistance programs" to assist individuals and small group employers in resolving problems related to using health insurance coverage. In October 2010, the federal government provided $30 million in grants to 35 states and the District of Columbia to establish and support state consumer assistance programs. These one-year grants were designed to help consumers enroll in health coverage, file complaints and appeals against health plans, and understand their rights. Consumer assistance entities must track consumer complaints to help identify common problems and strengthen enforcement.

Once Exchanges are operational in January 2014, consumer assistance programs must resolve problems with obtaining premium tax credits for coverage through the Exchange and accept referrals from the Navigator Program for enrollees with a grievance, complaint or question regarding their health plan, coverage or a determination under such plan or coverage. If a consumer raises an issue to a Navigator that is under the purview of a consumer assistance program, the Navigator must transfer the consumer to the appropriate program. In order to support seamless and secure handoffs, appropriate IT systems must be in place. Thus, the Exchange must ensure that Navigators are properly trained on both the issues that require transfer to the consumer assistance program and how to effectuate the transfer.

While the ACA contemplates the ongoing operation of consumer assistance programs, federal funds to operate the programs have been authorized but not appropriated for consumer assistance programs beyond the first year, making the likelihood of additional federal funds to support the existing grant unlikely.

Several consumer assistance resources are run by the state, or on behalf of the state, which will need to intersect with the Navigator Program. Programs currently offering consumer assistance services in Maryland include the following:

Maryland Attorney General's Health Education and Advocacy Unit: The Maryland Attorney General's HEAU received a $599,220 grant from the federal government to expand its consumer assistance functions. The HEAU provides mediation services to consumers to help

resolve complaints against health insurance carriers. The Unit offers a variety of services/resources including:

1) Medication and ombudsman services to assist with appeals processes and billing disputes;
2) Information on Maryland-specific insurance rules, such as guarantee issue;
3) Connection to coverage options, such as the Maryland Health Insurance Plan (MHIP), Medicaid or commercial insurance resources; and,
4) Consumer hotline and complaints filing.

Maryland Insurance Administration: Provides assistance to consumers, businesses, health care providers (including doctors and hospitals), and producers (agents or brokers) in all areas of insurance. The MIA offers a variety of services/resources including those that: [66]

1) Provide information about different types of insurance coverage;
2) Provide advice and support to take action or procedures that residents may take to help resolve their insurance problems;
3) Support residents by obtaining information or explanations from insurance companies or their representatives (this may involve written and verbal contact with such companies or persons);
4) Investigate a company's action(s) to determine compliance with state law, regulations and policy contracts; and
5) Take corrective action against a company if it violated a state law, regulation or policy which the MIA enforces.

Department of Health and Mental Hygiene: Runs the Health Choice Enrollee Action Line which assists Medicaid managed care enrollees in resolving complaints against MCOs.

Baltimore Health Care Access' Consumer Ombudsman and Assistance Program (via a contract with the state): Assists Baltimore City residents with Medicaid managed care concerns.

Administrative Care Coordination Unit/Local Health Departments (except in Baltimore City): Assist residents by providing ombudsman services in resolving Medicaid managed care concerns.

The Navigator Program will need to interact with each of these programs to ensure consumers are seamlessly transitioned to these post-enrollment support services as the needs arise.

[66] "Insurance Assistance for Maryland Consumers," Maryland Insurance Administration, http://www.mdinsurance.state.md.us/sa/docs/documents/consumer/insuranceassistance02-10.pdf.

Navigators will also need to interact with the MD HBE call center, which the ACA requires Exchanges to implement.[67] Consumer advocates have raised concerns about the adequacy of consumer assistance resources in light of the increasing participation in health insurance coverage under the ACA, and the likely transitional issues as new products and services are launched and hundreds of thousands of uninsured individuals obtain coverage, some for the first time. An alternative or supplemental approach is to include consumer assistance with the range of functions performed by Navigators. This is addressed in detail in the next section. At the very least, it appears that Maryland's consumer assistance capacity should be monitored over time to ensure consumer needs are being met.

[67] Maryland recently issued an RFP to support the MD HBE to: develop an inventory of current public sector call centers and consumer assistance resources and their capabilities, provide an analysis of consumer assistance data received through these call centers, and develop a road map for how an exchange call center can best coordinate with existing resources. The reports generated by this study will be important to inform the design of the Navigator Program.

NAVIGATOR PROGRAM FEATURES

The framework for the Navigator Program is defined in federal law, but the state is responsible for determining how best to structure the program for its population. As part of this study, stakeholders considered and commented on the potential features of the Navigator Program, including: functions, training, compensation, licensure/certification, and oversight. Stakeholder input demonstrated not only different values (often based on whether the stakeholder was involved in the private or public market) but of ways of defining particular features. For each program feature, a set of options was developed. Understanding the "range of possibilities" is critical in order to identify broader operating models for consideration.

During scheduled discussions on the Navigator Program, Maryland stakeholders unanimously agreed that Navigators should serve both Medicaid and QHP populations. While serving the Medicaid population is not a federal requirement, the Exchange can choose to operate its Navigator Program across both populations. Serving all consumers regardless of the type of coverage for which they are eligible (QHP or Medicaid) will allow for continuity of coverage and, as previously noted, unprecedented and important collaboration between the public and private markets. The program features described in this report and in the models section are designed through this lens.

The analysis of each program feature below draws on information obtained through research and includes stakeholder and Advisory Committee input. Unless explicitly stated, the analysis and considerations apply regardless of whether the Navigator is serving the individual or small group (SHOP) market. In some instances, the analysis may be unique to one market or the other. When that occurs, it is noted in the text.

Navigator Functions

The establishment of a Navigator Program creates an opportunity to broadly rethink how to best enroll individuals into coverage that best meets their needs and, ultimately, connects them to health care. However, the Navigator Program will have limited resources and will inevitably be required to prioritize the deployment of program funds. The purpose of this section is to present options for prioritizing Navigator Program functions.

Areas of Consensus on Navigator Functions

- ✓ *Navigator functions should focus on ACA requirements, with a post-enrollment support functionality for Navigators targeting small business.*
- ✓ *Navigators must refer consumers to existing consumer assistance programs and resources for post-enrollment support, though some Advisory Committee members remain concerned that such referrals are inadequate to meet the need and may need to be supplemented by Navigators.*
- ✓ *Care coordination services should be evaluated in the longer-term as a possible value-added service that might help attract and retain consumers as customers of the Exchange, and support Maryland's overall health goals.*

ACA-Required Functions

Navigators must provide functions mandated under the ACA including:

1) Outreach and education
2) Distribution of fair and impartial information concerning enrollment in QHPs and the availability of premium tax credits and cost sharing assistance
3) Facilitating enrollment in QHPs
4) Referring to consumer assistance agencies or entities
5) Providing information in a manner that is culturally and linguistically appropriate to the needs of the population

While the ACA is directive in the types of functions required, the level at which those functions are deployed is up to the state. For example, the ACA requires that Navigators perform outreach. However, the number of Navigators engaged in outreach, the strategies they deploy, and the extent to which they target specific subpopulations and geographic areas are up to the MD HBE. Generally, stakeholders viewed ACA-mandated functions as a substantial undertaking, requiring deployment of a vast and diverse network of individuals and entities. Consumer advocates, provider groups, and MCOs also articulated strong support for intensive efforts to target vulnerable subpopulations. While recognizing likely resource constraints, there appeared to be a strong consensus for an intensive approach to implementing ACA requirements while leveraging the capabilities and resources of Maryland's current distribution system.

Post-Enrollment Support

Some Advisory Committee members and stakeholders expressed strong support for the inclusion of post-enrollment support among Navigator functions. Post-enrollment services include responding to questions and inquires about existing coverage and stepping in when needed to resolve issues around claims payment or coverage. Many of these services are required of consumer assistance programs authorized, but not fully funded, under the ACA and described earlier in this report. In essence, Navigators would serve as a resource to individuals and small business to help them manage through not just the enrollment processes, but also other administrative issues associated with health insurance coverage.

There was broad consensus that post-enrollment support is critical to successful utilization of health insurance coverage in both public and commercial markets. However, there was not consensus on the relative importance of having Navigators perform these functions, particularly for individuals. Some Advisory Committee members felt post-enrollment support for individuals receiving coverage through QHPs or public programs were the responsibility of other entities, including MCOs and health plans, and therefore should not compete for limited Navigator resources.

Post-enrollment support for small businesses as a Navigator function, on the other hand, had stronger support among the Advisory Committee. Because small businesses currently receive this level of service from brokers and this type of support will still be available outside of the

Exchange, the Advisory Committee was concerned that excluding such services would make small business coverage offered through the MD HBE less attractive. Thus, it was felt that those Navigators serving or targeting the small group market needed to provide post-enrollment support functions or risk disadvantaging the MD HBE in the small business market.

Care Coordination and Access

Care coordination, often provided by licensed social workers, registered nurses or other qualified individuals, involves assisting individuals in translating their insurance coverage into access to and appropriate utilization of health care services. This function was viewed to be of particular importance given the influx of newly covered individuals as a result of the ACA, some of whom may have never had health insurance. The care coordinator would serve to help these individuals learn how to use their benefits and obtain health care services.

There was consensus that targeted care coordination is a valuable service. When prioritizing the importance of care coordination in light of limited resources, there was general consensus that care coordination, while desirable, is a lower priority than either ACA-mandated functions or post-enrollment support. However, it may be possible for the Exchange to consider a targeted care management program once funding and resources are better understood.

Navigator Training

The ACA does not explicitly require Navigator training; however, the draft regulations discuss training and request comments on whether the federal government should implement specific training requirements for Navigator grantees.[68]

Areas of Consensus on Navigator Training

- ✓ *Training for Navigators is important should be built off a core base which offers additional modules for specialization based on job functions.*
- ✓ *Additional training should be required by some Navigators to develop the expertise to manage more complex issues or target specific populations.*

Given the complexities associated with ACA implementation and the merging of the individual and public programs markets, training Navigators – and anyone performing Navigator-like functions – must be a priority for the MD HBE. Training must at a minimum address: 1) the products offered through the Exchange, including Medicaid and QHPs, 2) eligibility for QHP subsidies or Medicaid, 3) cultural competency training to individuals with limited English proficiency, minority cultures and people with disabilities, 4) how to use the Exchange and process enrollment and 5) how to provide referrals to applicable consumer assistance programs.

Stakeholders generally agreed that it was unlikely that one person could be sufficiently trained across all areas and target populations, and that additional training should be required by some

[68] "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Proposed Rule." Federal Register 76 (15 July 2011): 41877. Print.

Navigators to develop the expertise to manage more complex issues. Additional training content should be determined based on the functions Navigators perform and the targeted populations they serve. This suggests that the Exchange will need to establish a system to: 1) identify the areas requiring additional expertise, 2) allocate Navigators amongst the areas of expertise, 3) catalogue individual Navigator expertise for reference by other Navigators, and 4) develop processes and tools to pass consumers from one Navigator to another based on need.

While some materials can be leveraged from existing distribution channels, such as Medicaid eligibility training, broker training by MIA and CBO cultural competency models, additional training on the Exchange will need to be developed for this purpose. In addition, the Exchange will need to consider how training relates to Navigator eligibility criteria and whether training should be enforced through a licensure/certification process and/or contractual requirements. Finally, the Exchange will need to explore the method of training best suited for the MD HBE (e.g., online, CD ROM, in person).

Navigator Licensing/Certification and Oversight

Areas of Consensus on Oversight

- ✓ *Mechanisms to ensure quality assurance and accountability are critical.*
- ✓ *Oversight of Navigator functions may involve multiple agencies, depending on how Navigators operate.*
- ✓ *Current vehicles for enforcing standards and oversight may need to be adjusted to meet the new demands of the Navigator program.*

Federal rules do not establish specific requirements for oversight and enforcement and leave such decisions up to the state for consideration. The Exchange ultimately will be responsible for determining which individuals and entities are permitted to perform Navigator related functions, how they are compensated, how enrollment and other services are implemented through the Exchange, as well as overall performance monitoring of Navigators and tracking and resolving consumer complaints regarding Navigators. Given the populations served by the Exchange and the Navigators role in facilitating enrollment into plans, several state agencies may need to participate in the oversight and enforcement functions of the program. To the extent Navigators are licensed, the Exchange will need to coordinate closely with MIA. To the extent Navigators serve Medicaid recipients, coordination with DHMH will be critical. The agencies should engage early in the program's development to establish clear lines of responsibility and to ensure selected Navigator entities meet each of their needs.

The issue of oversight is closely linked to licensure. Licensure/certification was one of the most contested issues among stakeholders and will have a significant impact on the type of entities able and willing to serve as Navigators. While federal requirements do not currently require Navigators to be licensed, the proposed rules explicitly permit states to require Navigators to meet licensure/certification requirements. A key challenge for the Exchange will be ensuring sufficient consumer protection while creating a process that is flexible and responsive to the market. In other words, if licensure rules are overly burdensome, the program may not attract the number of Navigators necessary – or with the right expertise – to serve the market.

Maryland state law currently requires licensure of any "person that, for compensation, sells, solicits, or negotiates insurance contracts."[69] Some Navigator functions would appear to fall outside licensure requirements under current law. Outreach activities, post-enrollment support, and enrollment in public health insurance coverage likely would not qualify as "selling, soliciting or negotiating" insurance contracts. Volunteers, who are not being compensated for their efforts, similarly do not appear to be contemplated under current licensure rules. Other functions are less clear. MIA has not issued an official opinion on whether assisting small business or individuals with enrollment into QHPs offered by the Exchange qualifies as "selling, soliciting or negotiating" insurance contracts under current law, and Advisory Committee members offered varying opinions on whether such activities should or must be licensed. Thus, for the purposes of developing policy recommendations, this report focuses on the range of potential policy options, including those that may require change in current state law or regulatory guidance. Three potential mechanisms for enforcing Navigator programs standards were identified for consideration:

- Contracting
- Licensure or Limited Licensure
- Certification

Contractual Requirements

The state currently uses contracting mechanisms to procure most outreach and enrollment services for public health insurance programs and is therefore familiar with using contracting tools to establish eligibility criteria and performance benchmarks. The state has previously used performance based grants/contracts to engage with CBOs in outreach and education campaigns and with the Medicaid enrollment broker to perform the complete set of enrollment services. Accordingly, CBOs generally support the use of performance based contracts to establish the appropriate foundation for Navigator oversight and enforcement mechanisms.

However, until the MIA, working with the Exchange, resolves whether individual licensure is required to advise and enroll a consumer into a commercial health plan, it is unclear whether contractual requirements alone will be sufficient to comply with Maryland state laws.

Licensure or Limited Licensure

Under current Maryland Insurance law, there are two forms of licensure for producers. The first is referred to in this report as "full licensure," Full licensure currently is required for all brokers selling individual and small group health insurance products.[70] The second form is "limited licensure." Limited licensure is allowed for limited entities performing certain types

[69] Maryland Insurance Code Ann. § 1-101 (2011) Definitions.

[70] Refer to Maryland Insurance Code Ann. § 1-101 (2011) for the definition of an insurance producer; refer to Maryland Insurance Code Ann. § 10-101 (2011) for licensure definitions and for more information on the licensing process.

insurance sales, such as rental car insurance and cell phone insurance. In essence, limited licensure enables certain entities to be exempt from full licensure requirements.[71] Under the rental car law, for example, rental companies may sell insurance in connection with, and incidental to, the rental of a motor vehicle. The policies must be approved by MIA, and the rental company must hold an appointment with each authorized insurers. The rental company also must provide a training program, approved by MIA, for any employee who sells, solicits, or negotiates insurance coverage under this licensure. However, the rental car employees directly involved in the sale of the policy do not need to be separately licensed.

One potential approach contemplated by the Advisory Committee was the creation of a new category of "limited licensure" specifically for Navigators engaged in health insurance enrollment activities for QHP and public health insurance programs. This could be structured in one of two ways. First, the entity employing the Navigators could be licensed and responsible for ensuring that individual employees are appropriately trained. This is similar to what currently happens today for rental car insurance. The second approach would be to require the licensure of individuals, but narrow the scope of the requirements to focus specifically on Navigator functions. Under this second option, the limited license would enable an individual to perform Exchange-related enrollment responsibilities, but not in the commercial market outside the Exchange.

As noted above, stakeholders had mixed views on licensure. CBOs expressed particular concern about the resources necessary for individual Navigators to become fully licensed, noting it would be challenging for existing staff and resource-intensive to implement. CBOs also note that the expertise and services required to assist individuals in coverage through the MD HBE are different than what is contemplated by current broker licensure requirements, making the current training and test a poor proxy for determining Navigator preparedness. Brokers suggested that full licensure would best protect consumers from Navigators who may not fully understand the complexities associated with private coverage. They also suggested that licensure is not overly burdensome as over 20,000 Marylanders are licensed brokers.

Ultimately the Advisory Committee was in consensus that if Navigators are required to be licensed, licensure requirements would need to be updated based on the new market and products created as part of the Exchange. For example, current training is solely focused on the existing commercial market and does not address new coverage options under the ACA. The licensing process is an opportunity to coordinate with the training program and provide valuable content on the Exchange offerings, in addition to the MIA requirements. The MD HBE will need to work with MIA to review and revise the current licensing process.

[71] Maryland Insurance Code Ann. § 10-604 (2011) refers to a limited licensure for rental vehicle insurance, and defines the insurance as: "A limited lines license to sell insurance in connection with, and incidental to, the rental of a motor vehicle"

Certification

Finally, a "certification program" could be implemented to ensure individuals are qualified to perform as Navigators or interact with the Exchange. Certification either could replace licensure or limited licensure (MIA would need to determine whether this is permitted under current law), or could be required by the MD HBE in addition to licensure or limited licensure requirements. The primary benefit of certification is greater flexibility to craft Navigator requirements to the needs of the MD HBE.

Navigator Compensation, Retention, and Sustainability

The following section describes the options for Navigator compensation and retention, and two potential funding sources for program operations. While ACA expressly prohibits Navigators from receiving compensation directly from insurers for enrollment into a QHP, the state can design compensation in multiple ways to solicit high performance.

Compensation/Retention

The compensation model for Navigators has far reaching implications for the success of the Navigator program, and ultimately of the MD HBE. Stakeholders articulated a general consensus that Navigator compensation must be structured to:

Areas of Consensus on Compensation and Sustainability

- ✓ *Navigators must be paid for their services in a way that ensures the success of the exchange.*
- ✓ *The Exchange should seek Federal Medicaid match for a fair share of costs associated with Medicaid recipients.*

- Encourage small businesses and individuals to purchase health insurance through the Exchange;
- Avoid conflicts of interest and steering (promoting one plan over another because a particular plan may result in higher compensation to the Navigator); and;
- Motivate and enable high quality Navigator Programs.

It was also acknowledged that Navigator functions performed for individuals and small businesses may require different compensation structures.

The following compensation options were considered for the Exchange Navigator Program:

Salaried Employees: State staff currently provide a number of functions for public health insurance programs that are being contemplated for the Navigator Program. State employees are responsible for Medicaid and MCHIP eligibility and enrollment determinations and assist with outreach and education and post-enrollment support.

Commission-Based Compensation: Depending on how they are structured, commission-based fees could either increase or reduce the risk of steering – into a particular plan or to plans

outside the Exchange. Commission-based payments would incentivize brokers to serve as Navigators; however, the payment rate would need to be commensurate to payments outside the Exchange to avoid incentives to sell external products. To avoid the risk of steering within the Exchange, the payment rates should be equal no matter which QHP the individual enrolls in. Commission fees that continue for the duration of the contract reward brokers the longer the consumers stay enrolled, thus incentivizing brokers to help consumers stay insured.

Performance-Based Grants: The state has extensive experience procuring services through performance based grants. In particular, the state and CBOs have worked together previously under such financial arrangements, thus giving CBOs and the state familiarity with this structure.

The Exchange may implement multiple payment strategies. This would not be unique to Maryland. In Massachusetts (see *Attachment C*), consumer assistance entities that support the subsidized individual market are paid through grants. Consumer assistors on the non-subsidized individual and small group market are paid a commission. The Exchange will need to determine how to structure payments such that compensation fairly reflect the work effort and market demands of Navigator entities.

Navigator Program Sustainability

Federal law requires that Exchanges finance Navigator Programs through operational funds; Federal Exchange establishment grant dollars may not be used.[72] Therefore, the Exchange must develop a sustainability model that recognizes the program as a "cost center" that has to be funded via corresponding revenue.

Ultimately, two sources were identified for the Navigator program.

1) **Medicaid.** While expressly permitted in proposed federal regulations, federal funding is only available for 50% of the costs.[73] Thus, the State would be required to designate matching funds. The funds would flow from the federal government to DHMH and then from DHMH to the Exchange. This may require state legislative authorization and appropriation.
2) **Commissions.** To the extent the Exchange has employees to perform the services of a Navigator, or that individuals or small businesses purchase directly from the Exchange, the Exchange could receive a commission from the health insurer that would otherwise

[72] The Patient Protection and Affordable Care Act of 2010, Navigators: Funding, §1311(i)(6), 42 USC § 18031(i).
[73] The preamble to proposed regulations on the Navigator Program clarifies that if a state chooses to permit or require Navigator activities to address Medicaid and CHIP administrative functions, the Medicaid or CHIP agencies may claim Federal funding for a share of expenditures incurred for such activities at the administrative Federal financial participation rate. "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Proposed Rule." *Federal Register* 76 (15 July 2011): 41878. Print.

have gone to a broker. This business model mirrors what is in place in Massachusetts and Utah for their direct business..[74]

It is unlikely that these two revenue sources will bring the Navigator program of the Exchange to "break even" which means that the program will need to be funded through the broader operating model of the Exchange.

[74] Commissions paid by insurers are built into the premiums and are paid by the insurers to the brokers.

NAVIGATOR PROGRAM OPERATING MODELS

The design of a Navigator program requires the integration of the various programmatic features – functions, training, certification/licensure, compensation, retention, sustainability and oversight. The purpose of this section is to outline high level Navigator operational models for consideration. As previously discussed, it is not the charge of this study to recommend a single operating model but rather to identify the range of models, and options within those models, for consideration by the Advisory Committee, Exchange Board, and ultimately, the Legislature.

The formulation of the models took into account several overarching considerations outlined by the Maryland Legislature in the MD HBE Act, including the degree to which the model supports the effective delivery of services to be performed by the Navigators and the degree to which existing market resources are leveraged to fulfill the Navigator role. Other considerations include ensuring that services are provided in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange. This includes ensuring sufficient accessibility and usability of Navigator tools and functions for individuals with disabilities and individuals with limited English proficiency. Navigator compensation was also a consideration, as the MD HBE Act requests that disparities between Navigator compensation and the compensation of brokers outside the Exchange be minimized or avoided.

As previously mentioned, ACA requires IT systems to support the eligibility and enrollment functions of state Exchanges.[75] This IT system is a prerequisite for all of the models discussed in this paper. All models require an ability to track enrollment from initial outreach and education all the- way through enrollment in coverage and any necessary hand-offs with consumer assistance programs. Information t systems also should track Navigator performance and assist with program evaluation.

Separate Navigator Program models are presented for the Small Business and Individual markets for the purposes of this analysis. The models were constructed separately in recognition of the difference in the current infrastructure for providing Navigator-like functions as well as differences in the future functions and market dynamics for Navigators serving individuals and small businesses. Ultimately, the individual and small group Navigator functions could be integrated or administered separately, depending on the operational structure and need of the MD HBE.

Two small business models are discussed in detail below, followed by a discussion of individual models. These models are not mutually exclusive.

[75] The Patient Protection and Affordable Care Act of 2010, Health Information Technology Enrollment Standards and Protocols, §1561, 42 USC § 18031(i).

Small Group Navigator Options

As previously discussed, over 90% of the small group market purchases health insurance through a broker. The services brokers perform for that market include customizing purchasing decisions to meet the small businesses' needs, offering post-enrollment support and HR-related functions that may be difficult for other organizations or the Exchange to replicate. Brokers have a strong market incentive to form lasting relationships with their small business clients, and interviews with small business confirmed that customized services and an understanding of the individual business needs are highly valued and drive small business decision-making in retaining and maintaining broker services.

There was consensus among Advisory Committee members that, given the high rate of market penetration of brokers in the small group market and the general sense of satisfaction expressed by carriers and small businesses in the facilitated discussion groups, Navigator services should build upon, and not disrupt, the existing services performed by brokers for the small business marketplace. Therefore, both Small Group models leverage brokers as either the primary or exclusive distribution arm of the Exchange and assume that brokers will continue to perform the same functions that they currently do for small groups.

Small Group Navigator Model #1: Navigator-Broker Model

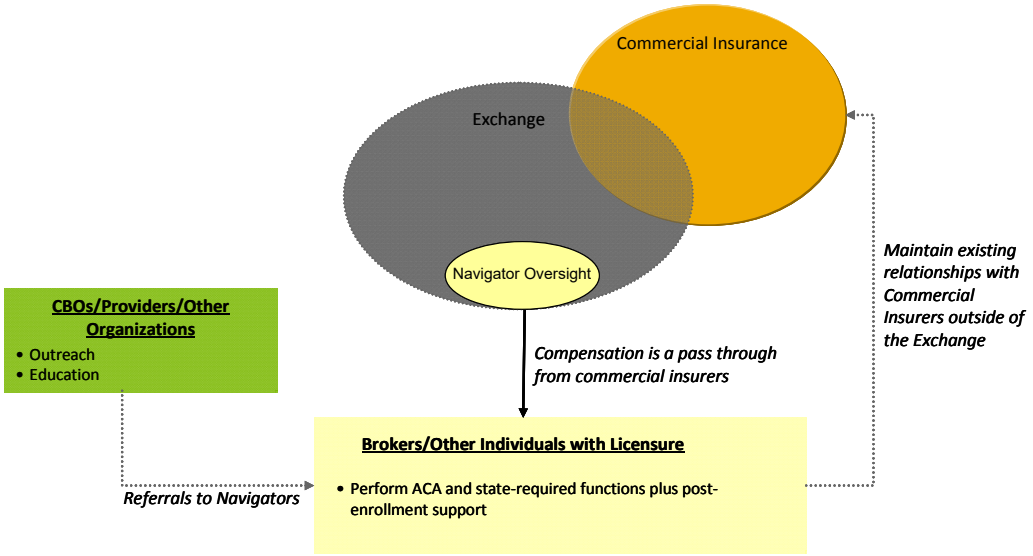
The first small group model is the Navigator-Broker Model. In this model:

- Navigators provide all ACA functions and all post-enrollment services currently provided by brokers;
- Navigators must be fully licensed as insurance brokers;
- Navigators also must be trained and certified to sell into the Exchange; and
- Compensation is aligned to broker compensation in the private market.

The Navigator-Broker model seeks to integrate the existing small group delivery system by utilizing fully licensed individuals in the State of Maryland and who attend/pass a training program to contract with the MD HBE and become Navigators, designated "Navigator-Broker" for the purposes of this discussion.

An overview of the model is in Figure 6, below.

Figure 6: Small Group Model #1 Navigator-Broker



This model assumes that the full range of functions currently offered by brokers would be provided to small businesses, including post-enrollment support, which is beyond the minimum functions required under the ACA. This would be necessary to meet the expectations held by small businesses and ensure the competitiveness of the SHOP.

Not every licensed producer would automatically be a Navigator-Broker. Navigator-Brokers would need to comply with training requirements dictated by the MD HBE which would cover, at a minimum, training on the Exchange IT systems and enrollment processes, QHP offerings (networks, quality measures, cost sharing, product tiers, benefit packages), consumer assistance programs and training to ensure cultural and linguistic competence and access to services for persons with disabilities. These requirements would be set forth in contracts between Navigator-Brokers and the MD HBE.

While brokers serving the small group market today are most likely to seek Navigator-Broker status, it is possible under this model that new entities would seek to enter the market. For example, CBOs and chambers of commerce could employ or form relationships with licensed brokers to serve their communities or constituencies as Navigator-Brokers. In addition, other types of entities could be engaged, with or without compensation, to provide outreach, education and referrals to Navigator-Brokers.

Compensation for Navigator-Broker services would be administered by the MD HBE at rates designed to mirror those available in the market outside the Exchange.[76] Unlike the current market, payment rates would be standardized across carriers to avoid incentives to steer enrollment to higher paying carriers.

[76] Since broker commissions are already built into the premium rates filed by health insurers, consideration would need to be given for how this could occur.

Oversight would be conducted by the MD HBE in coordination with the MIA. The ACA requires that "Navigator[s] must not receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or qualified employees in a Qualified Health Plan." This has been interpreted to permit brokers and other licensed individuals to serve as Navigators while also maintaining a business outside of the Exchange with commercial insurers. For the Exchange to ensure that brokers or other licensed individuals meet the ACA requirement, oversight would need to extend beyond the Exchange and into the non-Exchange market. Such oversight also would be important to ensure continued alignment in payments to prevent incentives to steer small businesses away from coverage options within the MD HBE.

The financing of these payments would depend on the overall financial sustainability model of the MD HBE, but the Exchange could seek to capture enrollment-based payments currently made by commercial carriers to brokers through a carrier assessment, that would essentially be passed-through the MD HBE to Navigator-Brokers for the policies sold through the Exchange. In addition, oversight and contracting mechanisms housed within the Exchange would need to be funded through the operating model of the Exchange, as would any outreach or education services provided by entities other than Navigator-Brokers. Thus, carrier enrollment payments alone likely would not be adequate to cover the full costs of this model.

Small Group Navigator Model #2: Broker Interface/Employed Navigator Model

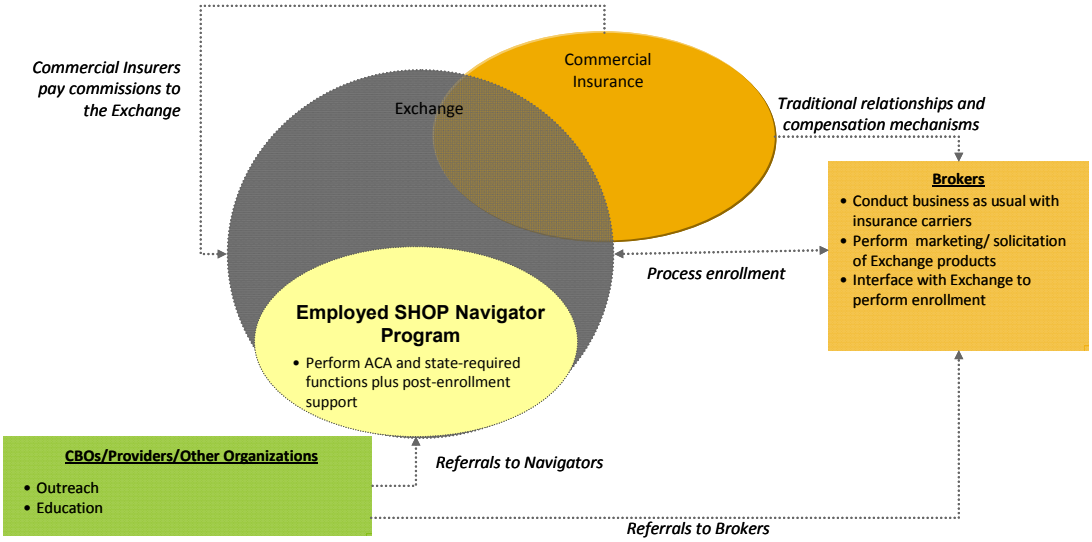
The second small group model is the Broker Interface and Limited Employed Navigator model ("Broker Interface Model"). In this model:

- Navigators provide all ACA functions and all services currently provided by brokers;
- MD HBE employs a limited number of Navigators to serve small business seeking coverage directly from the Exchange.
- Brokers are not Navigators, but required to be trained and certified by the Exchange to sell QHPs;
- Brokers are compensated for QHP enrollment not as Navigators, but through traditional method (by the carriers); and

In this model, brokers are not Navigators, but instead are leveraged to sell QHP products in their current role as the primary distribution channel through which small businesses purchase health insurance coverage. Brokers must be certified to sell QHPs; certification would require training on the Exchange and may encompass other criteria, such as the ability to offer all QHPs. Certified brokers are permitted to enroll small businesses in QHP coverage within the Exchange and are compensated by insurers for this enrollment the same way they are compensated currently. Brokers are not compensated by or through the Exchange,

In addition, the MD HBE would directly employ a limited number of "Employed Navigators" to serve businesses who opt to not use a broker. Employed Navigators would fill gaps due to market failure in broker distribution channels. Examples of market failures include a lack of brokers who are certified with the Exchange in specific geographic areas (for example, lower-income communities, or underserved rural regions) or who serve hard-to-reach segments of the small business community (for example, linguistic minority and immigrant business owners). An overview of the model is in Figure 7, below.

Figure 7: Small Group Model #2 Limited Employed Exchange with Broker Interface



Similar to Small Group Model #1, this model assumes that the full range of functions currently offered by brokers would be provided to small businesses to ensure the competitiveness of the Exchange.

It is unclear whether Employed Navigators would need to be licensed under current state law. Regardless of licensure, quality assurance and oversight would be conducted by the MD HBE, in part through employee performance requirements. If licensure is required, oversight would need to be coordinated with the MIA. Employed Navigators would need intensive training to support employer needs and purchasing decisions, in addition to training specific to the MD HBE. They would be compensated as salaried employees of the Exchange.

It is anticipated that most small businesses will continue to use brokers to access both Exchange and non-Exchange markets. However, for those that want to go directly to the Exchange or for small businesses not currently reached by brokers, the Exchange would receive the commission from the commercial insurer. This is consistent with how both Massachusetts and Utah operate their Exchanges. Any deficit between the commissions earned and the operating costs of the Navigator Program would need to be supported by Exchange operating funds.

Impact of Different Small Group Options

The following section evaluates the small group models against several criteria. These criteria reflect values articulated in the MD HBE Act as well as priorities identified by the Advisory Committee.

Small Group Operating Model Criteria	
Operating Criteria	Offers appropriate functionality and consumer assistance support
	Provides information in culturally, linguistically, and otherwise appropriate manner
	Minimizes risk of steering away from Exchange
	Ensures sufficient and appropriate training of Navigators
	Provides sufficient oversight, quality and consumer protections
Market Assessment Criteria	Appropriately leverages existing State resources
	Minimizes negative impact on employment in private market distribution system
	Easily accessible to small groups
	Supports service continuity between existing/new insurance purchasing options

The two models do not differ significantly in their ability to meet the criteria listed above. Rather, they offer different approaches to similar ends. The most notable difference between the models is the addition of employed Navigators in the Broker Integration Model (Model #2). This feature may offer greater ability for the MD HBE to target services to underserved market segments, thus increasing accessibility to small businesses and enhancing cultural and linguistic capacity. On the other hand, it may be perceived by some as competing with brokers and therefore impacting existing private sector employment.

Operating Criteria Considerations

Functionality. Both models offered the full range of functionality and post-enrollment assistance support for the small group market.

Culturally, Linguistically and Otherwise Appropriate Manner. Both models have the potential to offer culturally competent, linguistically diverse services that are also accessible to persons with disabilities. The Broker Interface Model (Model #2) provides an explicit mechanism for ensuring that small group outreach is targeted to hard to reach and underserved small businesses through the deployment of Employed Navigators. However, Model #1 also could address this need by providing financial incentives through differential payment rates for Navigator-Brokers serving underserved small businesses.

Compensation Structure. Compensation in both models minimizes the risk of steering away from the Exchange by making payments to brokers equal both inside and outside the Exchange.Health plan stakeholders noted that it would be difficult to charge the same price for plans both in and outside of the Exchange (a requirement under ACA) if broker commissions were not also the same.

Training. Training is required in both models to address the complexities associated with the small group market – although the training curriculum would need to be altered based on the model ultimately deployed. In the Broker Interface Model (Model #2)training regarding the small group market would need to be more intensive for Employed Navigators who lack that experience.

Oversight, quality assurance and consumer protections. Both models provide for oversight by the MD HBE. Because both models leverage licensed brokers, the MD HBE would need to coordinate oversight with MIA, including sanctions and penalties. Both models also may benefit from enhanced oversight to ensure that brokers are not steering into particular QHPs, or steering business to products or carriers outside of the Exchange.

Market Assessment Criteria Considerations

Leverages Existing State Resources. Both models leverage the existing broker distribution infrastructure within Maryland. The Broker-Navigator Model (Model #1) relies solely on the existing distribution system while the Broker Integration Model (Model #2) offers direct access to the Exchange. There is some duplication of existing resources in the Broker Integration Model (Model #2), although if Employed Navigators are targeted to fill in gaps on the current distribution system, overlap will likely be minimal.

Minimizes Negative Impact of Private Sector Employment. Since both models leverage the existing private (broker-based) distribution system and structure compensation evenly inside and outside the market, neither Navigator Program model should impact private sector employment.[77] For the Broker Integration Model (Model #2), there may be some concern that Employed Navigators could not compete and/or unnecessarily overlap with the services and capabilities within the broker market.

Accessible to Small Businesses. Both models are accessible to small businesses since they allow these businesses to use any broker who is trained and certified with the MD HBE. The Broker Interface Model (Model #2) offers greater flexibility to small businesses as they will have access to both the certified broker market and employed Navigators.

[77] It is worth noting that there are other factors that could impact private sector employment. For example, if the Exchange is ultimately successful in attracting small businesses through some combination of products, services and pricing, the exchange could have a positive impact on private sector broker employment. Conversely, if many small businesses opt to drop coverage in 2014, private sector/broker employment could shift from primarily serving small business to primarily serving the individual market, or, depending on the role of brokers in the evolving individual market, could decline overall.

Supports Continuity of Services. Both models allow small businesses to maintain their existing, trusted relationship with their broker. However, this continuity depends on brokers wanting to become certified with the Exchange in order to offer Exchange-related products and services to small businesses. If a broker does not become certified with the Exchange, the small business would need to go to the Exchange directly (if available) or switch brokers.

Individual Navigator Options

The Individual Exchange intersects with both the private and public insurance markets and, as such, is much more complex. Unlike with small businesses, there is no existing dominant mechanism connecting uninsured individuals with coverage. Brokers currently serve approximately half of those with individual coverage in the private market, but have little or no interaction with public programs. The Maryland DHMH in conjunction with the Maryland DHR (who have oversight for the Local Departments of Social Services) is primarily responsible for enrolling individuals in Medicaid and CHIP, with support from a contracted enrollment broker, providers and CBOs. However, these entities have little or no knowledge of commercial individual coverage options. The state lacks consensus on how the existing market should be leveraged to meet the needs of individuals likely to obtain coverage through the MD HBE, and how the delivery of services should be structured.

There does appear to be consensus among the Advisory Committee and stakeholders that Navigators should perform outreach, education, eligibility and enrollment services for the newly-eligible Medicaid population. An estimated 360,000 uninsured Marylanders are expected to become eligible for coverage under expanded Medicaid eligibility criteria mandated under the ACA. The ACA mandates a coordinated eligibility and enrollment process across the full range of insurance affordability programs – including Medicaid, CHIP and tax subsidies for QHPs administered by the Exchange – and researchers predict high rates of transitions across these programs.[78,79] Thus, Navigators working on behalf of the MD HBE will likely encounter Medicaid eligible individuals as they carry out their responsibilities and can play an important role in helping individuals obtain coverage and ensure continuous coverage as they transitions between programs.

While the policy imperative for integrating Navigator functions across Medicaid and QHPs is compelling, implementing an integrated Navigator program poses significant operational challenges. The ACA requires a seamless eligibility experience for individuals across Medicaid and QHPs, yet recent guidance makes clear that differences in program eligibility rules,

[78] This study assumes that existing Medicaid eligibility and enrollment activities would continue "as is" and focused on the expectation that Navigators would have to conduct outreach to Medicaid-eligible populations and populations eligible for subsidized and non-subsidized QHPs.

[79] Bachrach, Deborah. Boozang, Patti. Dutton, Melinda. "Medicaid's Role in Health Benefits Exchange: A Road Map for States", Manatt Health Solutions, April 2011 available at: www.manatt.com/news-areas.aspx?id=13626 and Ingram, Carolyn. Gore, Suzanne. McMahon, Shannon, "Ten Considerations for States in Linking Medicaid and the Health Benefit Exchanges", Center for Health Care Strategies, Inc. page 2-4 http://www.rwjf.org/files/research/20110812chcsbrief.pdf

enrollment processes, health plans and benefits will continue to exist.[80] Navigators will need to understand the rules and offerings for both QHPs within the Exchange as well as those related to Medicaid and CHIP. Combining such a wide-range of knowledge into one program – much less one individual "Navigator" – is unprecedented.

Two primary models have emerged for a Navigator program targeted to individuals.[81] Each model has two alternatives, which offer flexibility in contracting for the wide range of services

Individual Navigator Model #1: Market Integration

The first individual model is the Market Integration model. In this model:

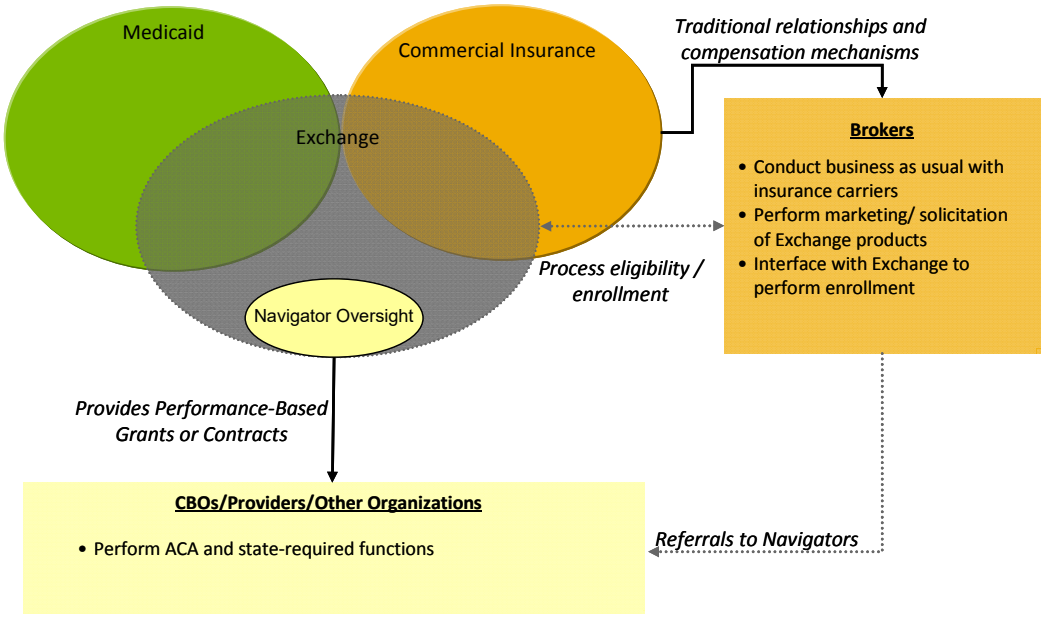
- Entities contracted as Navigators would provide ACA and state-mandated Navigator functions.
- Navigators provide application assistance to all consumers for all coverage options in the Exchange including Medicaid, CHIP, advance premium tax credits and QHP enrollment.
- Brokers are not Navigators, but may be trained and certified by the Exchange to sell QHPs to individuals.
- Brokers do not provide Medicaid eligibility and enrollment assistance, but refer consumers who appear Medicaid eligible to Navigators or the Exchange.
- Brokers are paid for QHP enrollments by insurers, not by the MD HBE.

This model seeks to leverage and preserve the existing public and private coverage infrastructure. In this model, Navigators would be contracted by the MD HBE to perform the range of Navigator functions, including enrollment into Medicaid and QHPs. At the same time, brokers would be able to become certified with the Exchange to sell QHP products to individuals, but not as Navigators. An overview of the model is in Figure 8.

[80] *CMS-9974-P*, "Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers," 76 FR 51202

[81] Two individual models were considered and discarded. One model had the Exchange fully employing all Navigators. The Advisory Committee believed this model did not appropriately leverage existing market resources already performing outreach to individuals for Medicaid and other public programs. The Advisory Committee also believed that brokers could be better leveraged to facilitated enrollment into QHPs. Another model discarded limited Navigators to fully licensed brokers. This model was believed to not appropriately leverage existing resources and capabilities of community based organizations, providers and/or other entities currently serving the public insurance market. Additionally, Committee members felt like licensed individuals/brokers might not represent the best choice for outreach to newly-eligible Medicaid population and the QHP-eligible population-particularly in a cultural, linguistic or otherwise appropriate manner.

Figure 8: Individual Model #1 Market Integration



In this model, Navigators would receive performance-based grants or contracts from the MD HBE to perform ACA-required functions in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange, including individuals with limited English proficiency and ensure accessibility and usability of Navigator tools and functions for individuals with disabilities. Navigators would need to offer the full spectrum of services, although different individuals within the contracted entity or different sub-contractors of the entity could perform specific functions or services.

Brokers certified by the Exchange would be permitted to enroll individuals into QHPs, work with the Exchange or Navigators to determine eligibility for advance premium tax credits/cost sharing reductions, and refer Medicaid-eligible populations to Navigators for enrollment. Given that brokers are not Navigators under this model, they would be compensated directly by commercial insurance carriers. Under current law, brokers are not permitted to conduct Medicaid enrollment activities Furthermore, no mechanism exists for compensating brokers that are not Navigators for Medicaid enrollment activities. It will be crucial to this model's success that seamless transition mechanisms are established that enable Medicaid/MCHIP eligible individuals served by brokers to avoid disruption or delay in enrollment.

Within this model, the Exchange would provide oversight and program management functions, but would not directly employ any Navigators or Brokers.

Navigators would be required to have training covering the Exchange IT systems and enrollment processes, QHP offerings (networks, quality measures, cost sharing, product tiers and benefit packages), public insurance eligibility criteria and referral options, cultural competency training and knowledge of consumer assistance programs and when/how to make

appropriate hand-offs to consumer assistance organizations. Brokers would participate in a subset of this training resulting in certification, a pre-requisite to conducting business within the Exchange.

While it is unclear if licensure is required for enrollment in QHPs within the Exchange, this model is likely to work best if contracted Navigator entities are granted some form of limited licensure and/or certification in order to enroll individuals in QHPs. This could take the form of certification, entity-licensure or a requirement that specific individuals be within an entity obtain limited licensure. This model does not assume that every individual employed by Navigator agencies and engaged in Navigator functions would need to be a licensed broker, as that would be difficult to bring to scale.

Oversight of the Navigator Program would be conducted by the MD HBE. The MD HBE and the MIA would need to coordinate to address licensing/certification and oversight roles and responsibilities. Additionally, given the interface with Maryland Medicaid, oversight would also need to be coordinated for Medicaid populations with the DHMH.

The Navigator Program would be funded through the operating costs of the Exchange and Medicaid, which provides 50% federal matching funds for activities performed by Navigators related to the newly eligible Medicaid population.

Individual Navigator Model #1 Alternative A: Market Integration Variation

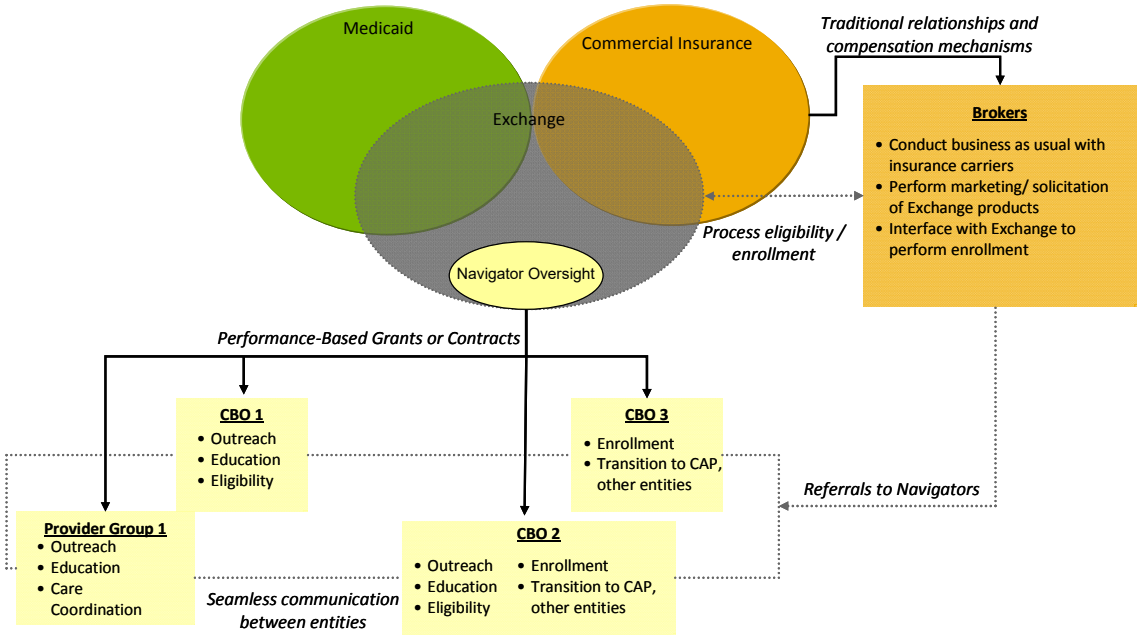
This model variation is identical to the Market Integration Model (Model #1), except:

- Entities contracted as Navigators could provide the full range of Navigator functions OR specialize in a limited set of Navigator services and/or target their services to a specific population.

Shown in Figure 12, this model allows multiple organizations, including community based organizations, provider groups or other qualified entities, to submit contracts to perform all or some subset of the Navigator services and/or target their services to specific populations. This would enable the MD HBE to target its contracts to organizations with specific expertise or community relationships. For example, if the MD HBE wanted to offer more intensive outreach and education services for a particularly hard to serve population, this model would permit that flexibility, which is expressly allowed for in the proposed regulations.[82]

[82]"Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Proposed Rule." *Federal Register* 76 (15 July 2011) 41877. Print.

Figure 9: Individual Model #1 Market Integration Model, Alt. A



Because this variation allows entities to perform different functions, licensure, oversight and training also would vary. For example, entities that perform only outreach and education may not be required to meet licensure requirements. And more in-depth training could be targeted to organization responsibilities.

Managing multiple hand-offs would be a critical to this model's success, making robust IT system crucial. Oversight of multiple entities and contracts also would need to occur in this alternative model.

All other components of this model are identical to Market Integration Model #1.

Individual Market Consolidation Model #2

The second individual model, outlined in Figure 13, is called the Market Consolidation model. In this model:

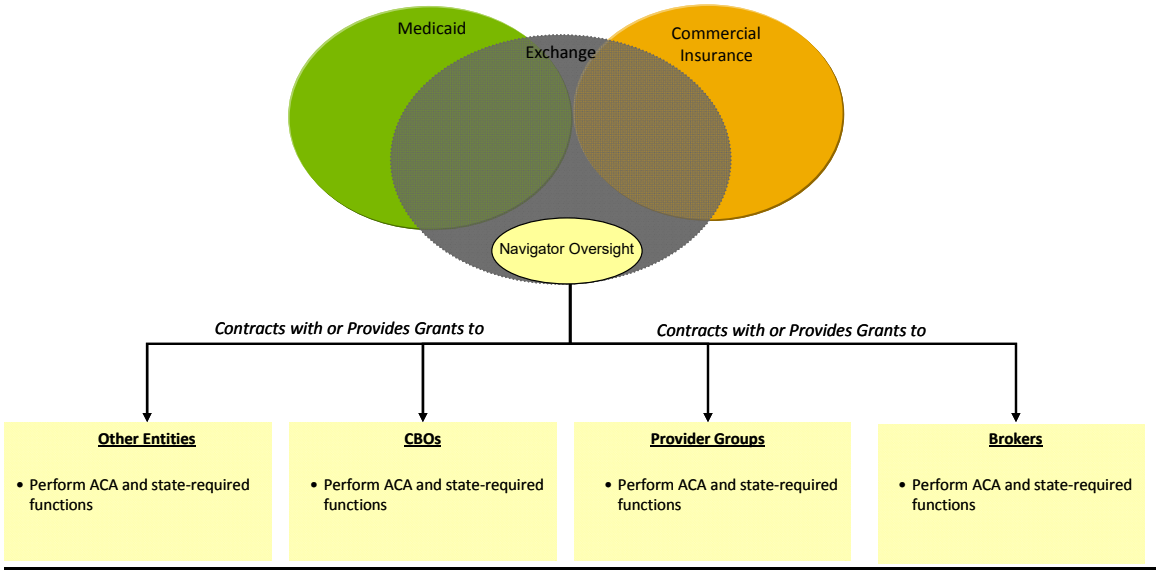
- Entities contracted as Navigators would provide ACA and State-mandated Navigator functions.
- Navigators provide application assistance to all consumers.
- Navigators are compensated by the MD HBE through performance-based contracts.

- Brokers wishing to sell QHP products to individuals would need to be contracted and compensated as Navigators. Brokers would not be permitted to sell QHP products unless they contracted as Navigators.

- All other aspects of the model (training, licensure, oversight) align with the Market Integration Model (Model #1).

Similar to the Market Integration Model (Model #1), in this model, entities seeking to become Navigators would compete for performance-based grants or contracts from the MD HBE. Brokers wishing to sell individual products on the Exchange would need to compete to become Navigators. Like the Market Integration Model (Model #1) Navigators would not be required to be licensed but may be required to have limited licensure or certification. The Navigator Program would be funded through the operating costs of the Exchange and Medicaid dollars, for which the federal government provides a 50% federal matching rate for activities performed by Navigators related to the newly eligible Medicaid population.

Figure 10: Individual Model #2 Market Consolidation Model



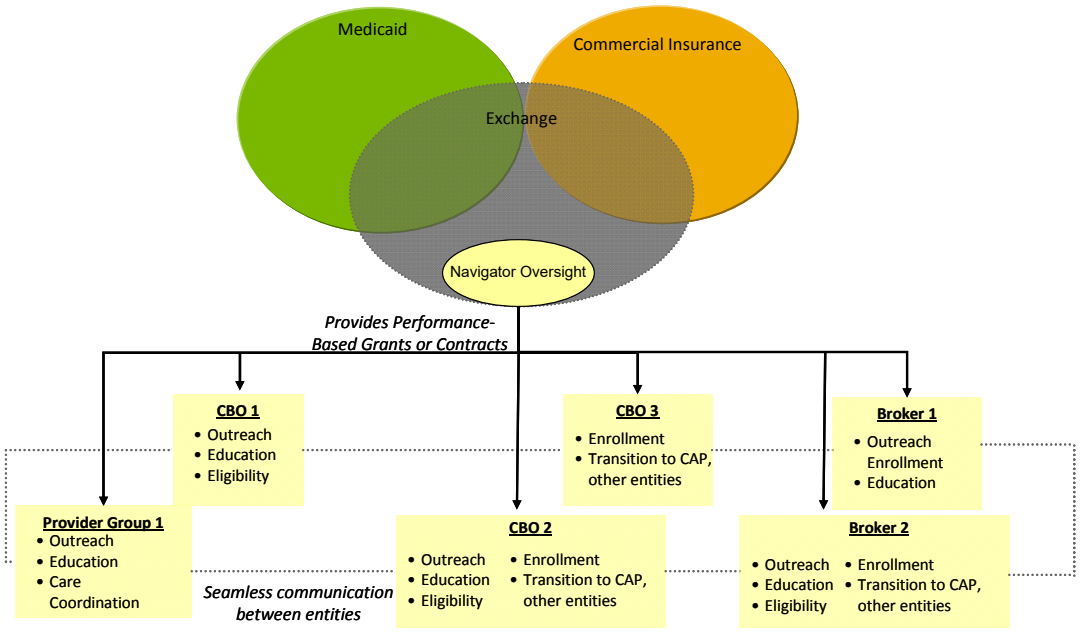
The other features of this model, including cultural competency and linguistic access requirements, Navigator functions, training, and oversight, mirror the Individual Market Integration Model (Model #1).

Individual Market Consolidation Model #2 Alternative A

As with the Variation on the Market Integration Model (Model #1A), the Market Consolidation Model Variation (Model #2A) permits entities contracted as Navigators to specialize in a limited set of Navigator services and/or target their services to a specific population. This model offers

the same trade off as the previous Variation – allowing more flexibility in functions, training and licensure requirements, but requiring more coordination. All other components of this alternative are identical to Model #2

Figure 11: Individual Model #2 All Contracting Organizations, Alt. A



Potential Impact of Different Individual Exchange Options

The main difference between the Market Integration and Market Consolidation models relate to Medicaid enrollment. In the Market Integration Model (Model #1), brokers perform enrollment for QHPs, but not for Medicaid/MCHIP. The inability to ensure all entities engaged in Exchange enrollment can serve all programs (Medicaid, CHIP, APTC and QHPs) is likely to reduce access to individual coverage and impede continuity between public and private coverage.

Individual Operating Model Criteria	
Operating Criteria	Offers appropriate functionality and consumer assistance support
	Provides information in culturally, linguistically, and otherwise appropriate manner
	Minimizes risk of steering away from Exchange
	Ensures sufficient and appropriate training of Navigators
	Provides sufficient oversight, quality and consumer protections
Market Assessment Criteria	Appropriately leverages existing State resources
	Minimizes negative impact on employment in private market distribution system
	Accessible to eligible populations and encourages enrollment
	Supports service continuity between public/private markets

Variation alternatives for both models may provide for better delivery of services in a culturally, linguistically appropriate manner or in

meeting other needs (e.g., accessible to individuals with physical, cognitive, and mental disabilities and/or limited literacy skills) since it allows a more diverse array of organizations and capabilities to compete for these limited functions. However, these models may create challenges for program oversight.

Finally, the Market Integration Model (Model #1) is more likely to minimize the discrepancy between compensation inside and outside the HBE, as brokers are compensated directly by commercial insurance carriers in this model. This model is also more likely to minimize disruptions in private sector employment.

The following section reviews the models through the lens of the criteria for successful Navigator program (above). The differences between the models are noted. Unless the alternatives are specifically mentioned, they do not impact the considerations against the criteria.

Operating Criteria Considerations

Functionality. While both individual models require the same ACA- and state-required functions by the Navigators, they differ in how these services are provided. In the Market Consolidation Model (Model #2), Navigators are the only entities engaged in individual enrollment activities within the Exchange, and all Navigators enroll in all coverage options (Medicaid, MCHIP, APTC and QHPs). In the Market Integration Model, Navigators also perform enrollment across all programs. However, brokers under this model are performing only QHP enrollment.

Another difference relates to the Variation Models. Models #1 and #2 offer "One Stop Shopping" which minimizes transitions across multiple entities. However, the Variation alternatives facilitate the addition of targeted functionality beyond the ACA requirements if desired by the MD HBE.

Culturally, Linguistically and Otherwise Appropriate Manner. Through training and contracting requirements, both models have a framework for ensuring that Navigators provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange, including individuals with limited English proficiency and ensure accessibility and usability of Navigator tools and functions for individuals with disabilities. The variation alternatives for both models allows a more diverse array of organizations and capabilities to compete for these functions.

Compensation Structure. The Market Integration Model (Model #1) minimizes the discrepancy between compensation inside and outside the HBE, as brokers would be compensated directly by commercial insurance carriers in a non-Navigator role. In Model #2, brokers would be compensated by performance-based grants of contracts given by the HBE. The level of compensation and how that compensation relates to the external market would need to be determined by the Exchange. If compensation is not adequate or comparable to the external

market, it is likely that brokers will opt to not become Navigators. Since subsidies for QHPs are only available in the Exchange, this may or may not ultimately limit the number of individuals who sign up for subsidized QHP coverage. However, this may limit enrollment among consumers above 400% of FPL who are not eligible for federal tax subsidies to purchase QHPs within the Exchange.

Training. Training requirements do not vary across the two main models. However, the Variation alternatives to Model #1 and #2 would need to be targeted based on the functions provided by the contracted entity. It is anticipated that organizations or individual who have no prior experience with the Medicaid market would need extensive training in this area. Conversely, organizations or individuals who have no prior experience with the commercial market would also require extensive training in the commercial market.

Oversight, quality assurance and consumer protections. Similarly, oversight requirements do not vary across the two main models. However, oversight is likely to be more easily conducted in Models #1 and #2 rather than in the variation alternatives. The variation alternatives to both models would require the MD HBE to perform oversight for a larger number of entities responsible for a varying array of services. However, contracting with multiple entities would allow each contracted organization to offer a more targeted set of skills and services which may lead to fewer issues that require oversight and attention.

Market Assessment Criteria Considerations

Leverages Existing State Resources. Both models were developed to maximize the ability of the Exchange to leverage existing private sector resources in the state. Maryland has a robust infrastructure of CBOs, safety net providers and brokers. Neither Model #1 nor Model #2 relies on employed Navigators by the Exchange (beyond program oversight). There may be some duplication of services between the role of the Navigator and the functions and services performed through Maryland's Medicaid program. How to coordinate the programs and manage hand-offs between the MD HBE and the Medicaid program will need to be addressed as the specific model for the Navigator program emerges.

Minimizes Negative Impact of Private Sector Employment. Both models leverage the existing private distribution system, thereby mitigating the likelihood of any negative impact on private sector employment as a result of the Navigator program. In the Market Integration Model (Model #1), the compensation for brokers is targeted to match the external market, which further helps to minimize a negative impact on private sector employment as a result of Exchange implementation. The Market Consolidation Model (Model #2) would require brokers to compete for Navigator grants, which could adversely impact employment in the broker market if only a limited number are permitted to participate in the Exchange.

It is worth noting that other factors could impact private sector employment in the health insurance distribution system. For example, it is anticipated that the Exchange will be successful in attracting 405,000 individuals, many of whom will have been uninsured. Such an

influx of new entrants into the market should have a positive impact on the private distribution system, which includes brokers as well as CBOs and other organizations that help administer both public and commercial insurance programs.

Accessible to Eligible Populations. Both models are accessible to the eligible populations because they rely on organizations that have established relationships and mechanisms to target the uninsured as well as extensive experience fulfilling the needs of individuals enrolled in commercial plans. However, the inability of brokers to enroll individuals in public programs in the Market Integration Model (Model #1), makes that model a weaker option for consumer access.

Support Continuity of Coverage between Public/Private Insurance. Both models support continuity of coverage between public and private insurance. In both models, the Navigators span across Medicaid and QHPs, creating an exceptional opportunity to maintain health insurance coverage as individuals move in and out of public programs. However, the Market Integration Model (Model #1) presents additional challenges for promoting continuity of coverage between public and private programs because brokers – not serving as Navigators – would only enroll individuals into QHPs and not public programs.

Intersection of the Small Group and the Individual Exchange Navigator Programs

While the Navigator Program options are presented separately for the individual and small group Exchanges, consideration needs to be given to how the Navigator Program will operate across both Exchange populations. For example, if a broker is a Navigator in the Small Group Navigator-Broker Model #1 that same broker would be precluded by federal conflicts of interests rules from interfacing with the Exchange in the Individual Market Integration Model #1 . The same would be true if brokers operated as Navigators in the Individual #2 Market Consolidation Model, but wanted to interface with the Exchange to conduct business in the Small Group Broker Interface Model #2. Decisions made on Navigator Program designs need to take into account the impact across the both marketplaces.

NAVIGATOR IMPLEMENTATION CONSIDERATIONS

Next Steps

The Navigator Program is critical to the success of the Exchange; designing and implementing such a program will take time and the consideration of a number of issues, not least of which are stakeholder preferences and the impact on the existing market. The MD HBE Act lays out a short-term path to support important but high level decisions, such as the overall program design. However, much of the work will begin once a model is chosen and the various components that need to be implemented, including establishing the necessary contracting mechanisms, developing training programs and working with the legislature on any areas of the law that require revision, are completed.

Below are a number of immediate next steps, followed by a high level timeline of implementation steps that are relevant regardless of the model selected.

1) The Advisory Committee reviews the final study results and develops an options paper, which is submitted to the Exchange.
2) The Exchange reviews the options paper and develops recommendations, which are sent to the Maryland Legislature.
3) The Exchange staff monitors and analyzes pending Federal guidance related to the Navigator Program and revises the options and recommendations accordingly.
4) Additional research is conducted, including on the "reach" and experience of brokers in targeted communities (see *Maryland Insurance Market, Insurance Distribution System & Consumer Assistance Programs*).
5) The Navigator Program model is adopted and an implementation plan is drafted.
6) The Exchange ensures access to IT functionality required to securely and seamlessly coordinate consumer assistance functions across the Navigator Program and between Navigator entities.

Timeframe for Implementation

Below is a high level implementation timeline for key elements of any Navigator Program that can be expanded once key programmatic decisions have been made.

Overall Program Design/Management: The MD HBE has implemented a number of steps towards identifying the key decisions that must be made in designing the Navigator Program, such as commissioning this study and convening the Navigator and Enrollment Advisory Committee. The immediate next step for the MD HBE and state legislature is to review the options and recommendations and determine an appropriate operating model in early 2012. Once a model is established, the MD HBE will need to focus on specific components of the

program, such as training, compensation, licensure/certification and oversight. Each of those components is discussed in more detail below.

Training: As identified in this report, training currently exists in both the private and public markets that can be leveraged. The first step for the MD HBE will be to catalogue the existing resources, and to determine the full scope of training needs and identify any gaps. The MD HBE will need to either develop or procure training to fill the gaps, which should be completed in 2012. The training program should be pilot tested in early 2013 and available in final form by mid-2013 to enable Navigators to prepare for January 1, 2014 launch of the Exchange.

Compensation: The MD HBE will need to determine compensation structures once an overall program model has been selected. Regardless of the model, the MD HBE should anticipate issuing an RFP or other funding opportunity announcement (FOA) in late 2012 to factor in time for pre-award negotiations with Navigator entities in early 2013.

Licensure/Certification: The MD HBE has two immediate steps related to licensure/certification. First, it must work with the MIA to determine when licensure is required by state law within the preferred models and, if so, for what functions and entities. Second, the MD HBE will need to consider, depending on the verdict, whether it needs to work with the MIA and state legislature to revise any state law or regulations. This should be one of the first steps of the MD HBE given the implications for the operating model. The bulk of 2012 should be dedicated to designing the licensure/certification program (which may include pursuing changes to state law) with intentions to implement any new programs in mid-2013.

Oversight: Decisions about oversight will largely come after selection of the operating model. The MD HBE will need to work closely with DHMH – to the extent Navigators serve Medicaid recipients – and the MIA – to the extent Navigators are licensed – to develop oversight responsibilities. It is particularly important that all entities weigh in on any draft RFP or FOA to ensure that all contracts-based requirements are captured.

Figure 12: Navigator Program Implementation Timeline

	2011	2012	2013	Jan 2014
Overall Program Design/ Management	■Convene Stakeholders ■ Conduct Navigator Program Study ■ Develop high level timeline and milestones ■Final Report to MD Legislature	■Select Navigator Program operating model and entities/individuals eligible to apply ■Determine provisions requiring statutory change.	■Implement training, compensation, certification and oversight mechanisms	■Launch Program *Jan 1, 2014*
Training	• Identify stakeholder positions on training needs of Navigators • Begin cataloguing existing training identified through Navigator Study	• Determine full scope of training needs • Identify existing training across public & private sectors • Identify training gaps • Develop or procure additional modules	• Pilot test training in early 2013 • Launch training by mid-2013	
Compensation	• Identify stakeholder positions on compensation mechanism and rates • Consider impact of compensation mechanism and rates on Navigator participation	• Determine compensation mechanisms • Develop and issue RFP or FOA	• Award grants • Engage in post award negotiations, including establishing performance benchmarks	
Licensure/ Certification	• Identify stakeholder positions on licensure/certification • Initiate conversations with MIA about state law with respect to licensure • Consider impact of licensure/certification on Navigator participation	• Work with MIA to establish legal requirements on licensure • Identify whether the state should pursue statutory changes to licensure rules • Establish conditions of licensure/certification	• Implement licensure/certification program	
Oversight	• Identify stakeholder position son oversight mechanisms • Consider impact of oversight on Navigator participation	• Work with MIA, DHMH and Exchange to establish oversight responsibilities • Establish checkpoints and performance criteria	• Launch oversight program	

ATTACHMENT A: ADVISORY COMMITTEE MEMBERS AND CO-CHAIRS

Navigator and Enrollment Advisory Committee

Leigh Cobb, Advocates for Children and Youth (Co-Chair)
Toby Gordon, Johns Hopkins University, Carey School of Business (Co-Chair)
Nancy Bond, The Coordinating Center For Home And Community Care, Inc.
Christopher Culotta, CareFirst BlueCross BlueShield
Michael Cumberland, Keller Stonebraker Insurance
Cynthia Demarest, Maryland Physicians Care
Jay Duke, Waring-Ahearn Insurance Agency
Mary Lou Fox, Maryland Women's Coalition For Health Care Reform
Stephanie Golden, Golden & Cohen, LLC
Thomas Grote, Aetna
Floyd Hartley, Advocate
Yngvild Olsen, Baltimore Substance Abuse System, Inc.
Richard Reeves, United Healthcare
Alma Roberts, Baltimore Healthy Start, Inc.
Jan Ruff, MAXIMUS Health Services
Deborah Trautman, Johns Hopkins Medicine
Cassandra Umoh, Self-employed consultant
Ellen Weber, University of Maryland School of Law
Jennifer Goldberg, Board Liaison

ATTACHMENT B: MEETING PARTICIPANTS AND ATTENDEES[83]

Meeting Participants And Attendees

Salliann Alborn, Community Health Integrated Partnership/Maryland Community Health System
Vincent Ancona, AMERIGROUP Community Care
Patrick Applegate, Maryland Hospital Association
Darlene Arnold, Maryland Insurance Association
Rodger Bayne, Group Benefit Services
Donna Behrens, Maryland Association Of School-Based Health Care
Jean Bienemann, Maryland Insurance Association
Nancy Bond, The Coordinating Center For Home And Community Care, Inc.
Kim Camaratta, AG's Health Education And Advocacy Unit
Matt Celentano, Health Care For All Maryland
Gina Chmielewski, Coventry Healthcare, Inc.
Nicole Christian, Garrett County Chamber Of Commerce
Leigh Cobb, Advocates For Children And Youth*
Denise Croce, Coventry Healthcare, Inc.
Christopher Culotta, CareFirst BlueCross BlueShield*
Michael Cumberland, Keller Stonebraker Insurance*
Susan Delean-Botkin, Nurse Practioners Association Of Maryland
Cynthia Demarest, Maryland Physicians Care*
Lee Diemer, Benefitmall
Barbara Dipietro, Health Care For The Homeless
Van Dorsey, Maryland Insurance Association
Jay Duke, Waring-Ahearn Insurance Agency*
Rebecca Fergusson, Nurse Practioners Association Of Maryland
Jon Fleig, United Healthcare
Mary Lou Fox, Maryland Women's Coalition For Health Care Reform*
Brian Goff, Insurance Solutions
Therese Goldsmith, Maryland Insurance Association
Floyd Hartley, Advocate *
Karen Hornig, Maryland Insurance Association
Anne Hubbard, Maryland Hospital Association
Ken Hunter, Kaiser Foundation Health Plan Of Mid-Atlantic States
Carlissa Hussein, Office Of Minority Health And Health Disparities
Frank Kirkland, Department of Health and Mental Hygiene
Paige Lescure, University Of Maryland School Of Law
Brett Lininger, Coventry Healthcare, Inc.
Gary Livengood, Health Insurance Buyers & Brokers Coalition of Maryland

[83] Additional individuals participated in the public comment period. The compilation of public comments is available at: http://dhmh.maryland.gov/healthreform/exchange/pdf/Compiled-Public-Comments-FINAL.pdf

Jim Livian, PSI
Margaret Loeb, PSI
Sheila Mackertich, Baltimore Health Care Access
Jan Mailer, JD Mailer And Company
Rosemary Malone. Maryland Department of Human Resources
Miguel Mcinnis, Mid-Atlantic Association Of Community Health Centers (MACHC)
Jim Miller, PSI
John Miller, Midatlantic Business Group On Health
Patricia Nowakowoski, Department of Health and Mental Hygiene
Bonita Pennino, American Cancer Society
Susan Phelps, Priority Partners
Fran Phillips, Public Health Services
Susan Pompa, The National Council On Alcoholism And Drug Dependence
Odette Ramos, Board Of The Baltimore Hispanic Chamber Of Commerce
Ann Rasenberger, Planned Parenthood
A. Redd, AG's Health Education And Advocacy Unit
Richard Reeves, United Healthcare*
Alma Roberts, Baltimore Healthy Start*
Jan Ruff, MAXIMUS Health Services*
Steve Salamon, Landmark Insurance
Marc Schaefer, Schaefer Financial Group
Suzanne Schlattman, Health Care For All Maryland
Jai Seunarine, Jai Medical Systems
Kathy Simmons, Group Benefit Services
William Simmons, Group Benefit Services
Jill Spector, Department of Health and Mental Hygiene
Isazetta Spikes, NAACP, Maryland Chair
Mike Strange, PSI
Shekar Subramaniam, Carefirst BlueCross BlueShield
Leahanne Thomas, UHC Community Plan
Don Thompson, Maryland Insurance Association
Cassandra Umoh, Self-Employed Consultant*
Ellen Valentino, National Federation of Independent Business
Deborah Weather, Maryland Department of Human Resources
Valeria Williams, Maryland Insurance Association
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ATTACHMENT C: CONSUMER ASSISTANCE MODELS IN MA, UT AND NY

Experience with Consumer Assistance in Other States

Because the vast majority of states are behind Maryland in terms of Exchange implementation, there are few best practices on Navigator Programs to borrow from other states. However, two states, Massachusetts and Utah, have experience with health benefit Exchanges that pre-date the Affordable Care Act (ACA) and offer options for what a Navigator Program could look like in Maryland. In addition, several states have programs conducting outreach and enrollment in public health insurance programs. One such program, a large scale, multi-stakeholder consumer assistance effort in New York, is also described here. Descriptions of all three Navigator-like programs follow, including information about their contracting or procurement mechanisms, consumer assistance functions, training, certification/licensure requirements, compensation, oversight and program funding. Additional information is available through The Hilltop Institute's "Navigator: A Background Paper."[84]

Massachusetts

In 2006, Massachusetts launched a state-based health insurance Exchange offering two coverage programs: Commonwealth Care and Commonwealth Choice. Insurance coverage is mandatory in Massachusetts and the state offers financial assistance through subsidies for lower income individuals. Commonwealth Care offers premium subsidies to individual with household income up to 300% of the federal poverty level (FPL) paid for with state and federal Medicaid funds. Commonwealth Choice offers commercial health insurance plans to individuals who are not eligible for these premiums subsidies and small businesses with up to 50 workers. As of December 2010, Commonwealth Care had 151,000 enrollees; Commonwealth Choice has 36,133 individuals and 3,942 small group enrollees.

Each program has its own consumer assistance initiative to conduct outreach, education and enrollment (additional duties are described in the table below). These initiatives have distinct attributes to serve the different markets they target.

[84] Folkemer, D., Spicer, L., & John, J. "Navigators: A Background Paper" The Hilltop Institute, UMBC, August 2011, http://www.hilltopinstitute.org/publications/Navigators-BackgroundPaper-August2011.pdf

Figure 1: Massachusetts Exchange Consumer Assistance

	Outreach Worker Program *(primarily for Commonwealth Care)*	**Insurance Broker Program** *(exclusively for Commonwealth Choice)*
Contracting	Competitive procurement process; multi-year grants awarded	N/A
Functions	Education on insurance options; outreach; application/renewal assistance; assistance with eligibility, assistance with written communication to state staff; help find providers when enrolled	Education to insurance options; application/renewal assistance; in particular assistance to small businesses that have up to 50 workers
Training	Trained by the MA Health Care Training Forum (MTF); Monthly meetings, inclusive of training session son approaches to outreach/assistance and information on health reform and insurance programs	Must attend four days of training on the Commonwealth Choice program
Certification/ Licensure	Must be local, consumer-focused, non-profit with a strong reputation; demonstrate knowledge of health reform; culturally competent; ability to connect to people difficult to reach	Need to be licensed by the state; register with the SBSB (Commonwealth Choice operational vendor) to tie compensation to the clients they enroll
Compensation	Grants up to $41,000 per year awarded to over 51 grantees; Grants awarded by the state ($11.5M from 2006-2010); BCBS MA grants ($2.4M since 2006)	$10/employee/month commission for business with 1-5 employees; 2.5% of total premium commission for businesses with 6-50 employees (3.5 to 4.5% outside of the exchange)
Oversight	CBO's provide routine reports to the UMass Office of Community Programs that quantify their outreach and application assistance activities, as well as to communicate promising strategies and challenges	Connector has oversight of program; MA Division of Insurance has oversight of licensure
Program Funding	Ongoing operations are funded through retention of a percentage of the health insurance premiums (3.75%) generating $26.9M in 2010.	Ongoing operations are funded through retention of a percentage of the health insurance premiums (4.5%) generating $3.8M in 2010.

Massachusetts has been successful in lowering its overall uninsured rate to 1.9%[85] across all Massachusetts residents- making it the lowest in the nation. Much of the success of this program has been attributed to the subsidies through the Commonwealth Care program and the mandate to purchase health insurance coverage. The relatively slow start to the small group Exchange is attributed to several factors, including limited insurer participation, limited broker participation in the small group Exchange pilot, initial lack of information for the small group market on the Connector website, a delayed start to small group options and the compensation structure for brokers[86],[87]. Brokers currently receive higher commissions by operating outside of the Exchange market.

Massachusetts manages two distinct consumer assistance programs to meet the needs of their target markets. The Outreach Worker Program helps connect lower income individuals to coverage through community based organizations (CBOs). The small group and higher income individual market is served by the Insurance Broker Program. Although both programs conduct outreach, education and eligibility and enrollment assistance, outreach workers also provide some post-enrollment and care coordination functions,

[85] MA Health Reform Facts and Figures, MA Health Connector, Fall 2011, page 4, https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Facts%2520and%2520Figures/Facts%2520and%2520Figures.pdf

[86] Stergios, J. & Lischko. A.. "Health care fails small business." Boston Globe 12 May 2010. Online. http://www.boston.com/bostonglobe/editorial_opinion/oped/articles/2010/05/12/health_care_fails_small_businesses/

[87] Carey, R. L. & Gruber, J.M. "A Health Insurance Exchange for Maryland? Comparing Massachusetts and Maryland", Maryland Association of Health Underwriters and National Association of Insurance and Financial Advisors of Maryland. Page 16. 2010.

such as aiding individuals locate providers. Licensure and compensation are also managed differently, with CBOs compensated by performance based grants overseen by the Commonwealth. Brokers must be licensed by the state and receive a monthly per contract commission.

The Massachusetts consumer assistance approach for individuals most closely aligns with the Individual Operating Model 1, the Market Integration Model. However it is important to note that in Massachusetts the responsibilities are siloed across the programs, with the brokers serving exclusively Commonwealth Choice applicants and contracted community organizations serving exclusively Commonwealth Care applicants. With the ACA mandating seamless enrollment across all insurance affordability programs, this siloed approach is unlikely to meet new federal requirements.

The Massachusetts approach to assisting small businesses closely aligns with the Small Group Operating Model 1, the Navigator-Broker Model, in which brokers are compensated directly by the Connector for enrolling small businesses into coverage. However, the Connector supplements broker services by offering small businesses the opportunity to enroll directly either online or with the assistance of Connector staff.

Utah

The Utah Health Exchange is a marketplace for small businesses with up to 50 workers. There is no mandate to require individuals to purchase insurance and the Exchange does not provide individual coverage or offer premium subsidies. Currently the Exchange serves 200 employers covering 4,500 lives. Utah allows brokers to sell through the Exchange and also permits small business to go directly to the Exchange if desired. Key components of Utah's Exchange are listed in the Figure below.

Figure 2: Utah Exchange Consumer Assistance

Contracting	N/A
Functions	Helps businesses obtain and complete insurance applications; assists with the enrollment process; works as a customer service agent between employers/employees and the Exchange
Training	The exchange holds weekly educational training sessions for brokers; brokers also required to complete defined contribution market training courses, which include premium assistance training
Certification/ Licensure	Must have a producer license with the Utah Department of Insurance; be appointed with all the insurance carriers that provide a defined contribution plan on the exchange; register with the vendor that pays broker compensation; report any associations with agencies; attend training
Compensation	Commission is set at $37 per employee per month
Oversight	Agencies are not allowed to sell on the Exchange; individual brokers associated with an agency can sell as an individual; Licensure oversight by the UT DOI
Program Funding	Employers pay a fee to use the exchange. $6/month/per employee for general operations; $37/month/per employee for broker commissions

Utah has struggled with participation in the Exchange. Relatively low participation has been attributed to higher premium rates inside the Exchange than were available outside, as well as to an onerous application, rating, and plan selection process.[88]

Brokers serving Utah's Exchange offer marketing and assistance with purchasing Exchange products, and act as a customer service agent between the small business and its employees, and the Exchange and the plans. All insurers pay a set amount to the Exchange to compensate the broker, which avoids the risk of consumer "steering" into plans that are more profitable to the broker. Oversight is shared between the Exchange and the Department of Insurance. This is a similar construct to SHOP Operating Model 1, the Navigator-Broker model, except that Utah, like Massachusetts, permits small businesses to directly enroll with the Exchange without engaging the services of a broker.

New York

New York's Facilitated Enrollment (FE) Program provides application assistance for children and adults seeking coverage in Medicaid, Child Health Plus (New York's Children Health Insurance Program (CHIP)) and Family Health Plus, a Medicaid funded program providing coverage to parents up to 150% FPL and childless adults up to 100% FPL. The functions provided by the selected FE entities largely resemble the ACA-required functions of Navigators under an Exchange. CBOs provide intensive outreach and enrollment support services until the point of eligibility determination, which is the responsibility of local departments of social services. Similar to the ACA requirements, the entities selected must have the ability to reach the target community and provide services in a culturally competent manner. Facilitated enrollers are employed by CBOs, local departments of health, safety net health care providers and Medicaid Managed Care Organizations (MCOs).[89]

[88] Corlette, Sabrina; Alker, Joan; Touschner, Joe and Volk, JoAnn, "The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned", https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/News%2520and%2520Updates/2011/Week%2520Beginning%2520April%252003/MassAndUtahExchangesLessonsLearned.pdf

[89] New York has a waiver of prohibitions under the Balanced Budget Act of 1997 against MCOs serving as enrollment brokers. For a discussion on the BBA rules see http://www.kff.org/medicaid/2102-budget_rep2.cfm?RenderForPrint=1 ("To avoid bias in the enrollment function, which could lead to substantial financial gains for certain MCOs in the form of increased enrollment and higher capitation revenues, the Balanced Budget Act bars any federal matching payments for the cost of an enrollment broker unless three tests are met. First, the broker must be "independent of" any MCO or PCCM participating in the state's Medicaid program and of any health care provider that furnishes coverage or services in the same state in which the broker is under contract to carry out enrollment activities. Second, the broker must not have an owner, employee, consultant, or contractor who has "any direct or indirect financial interest" in any such MCO or PCCM or health care provider. Finally, the broker may not have any owners, employees, consultants, or contractors who have been excluded from participation in Medicaid or Medicare; subject to a civil monetary penalty for violating Medicaid or Medicare rules; or debarred by any federal agency.")

Figure 3: New York's Facilitated Enrollment Consumer Assistance Program

Contracting	The SDOH contracts with 43 facilitated enrollment lead agencies and 72 additional subcontracting agencies, located throughout New York State, are funded to conduct community-based facilitated enrollment
Functions	Screen individuals for eligibility; assist individuals in filling out the application; collect required documentation and certify original citizenship documentation; bundle the applications and submit them to the local district of social services (or health plan for CHIP) and trouble shoot applications with the local districts and assist consumers with redeterminations
Training	The State Department of Health (SDOH) sponsors Basic, Refresher and Self-Employment Training modules and FEs are required to send their personnel to these trainings
Certification/ Licensure	Must be local, consumer-focused, non-profit with a strong reputation; demonstrate knowledge of health reform; culturally competent; ability to connect to people who are difficult to reach
Compensation	The State established a maximum base award for FEs serving only one county. This amount varies depending on the county being served. FEs proposing to serve more than one county may receive a maximum add-on per additional county. For example, for Essex County, $200,00 is the maximum base award and $60,000 is the maximum add-on per additional county. FEs can also be salaried employees of a health plan.
Oversight	FEs are required to track application assistance and submit applicant data on a monthly basis. FEs are also required to monitor all program activities including productivity and accuracy as required by quality review procedures established by SDOH.
Program Funding	New York receives a 50 percent federal financing matching rate and currently spends $8.5 million a year in state funds; health plans are also allowed to employ FEs.

New York's facilitated enrollment has been successful in increasing the number of eligible individuals enrolled in public coverage and reducing the ranks of the "eligible uninsured."[90] In 2010, FEs submitted more than 430,000 applications for public coverage.[91] Today, approximately two-thirds of applicants for Medicaid or CHIP in New York are enrolled through FE.[92]

New York's FE program provides an example of a successful enrollment initiative targeted to public insurance coverage. It resembles Individual Operating Model 2, the Market Consolidation Model, in that all services are provided through contracted entities. However, it utilizes a range of organizations and compensation structures to provide consumers enrollment assistance options. Grants are awarded on a competitive basis to community organizations, provider groups and departments of health. Some grantees operate a hub-and-spoke model, where a lead contractor with institutional capacity to perform quality assurance and oversight responsibilities subcontracts to smaller organizations, enabling greater diversity within the enrollment network. Others administer the grants centrally. MCOs are compensated through their capitation rates. This structure has enabled the state to target hard to serve communities, but has required intensive training and quality oversight to ensure the success of the program.

[90]"Connecting New York City's Uninsured to Coverage", Office of Citywide Health Insurance Access, May 2010, http://www.nyc.gov/html/hia/downloads/pdf/connecting_nyc_uninsured_to_coverage.pdf

[91] "Connecting Consumers to Coverage: The Role of Navigators and Consumer Assistance Programs in Implementing Health Reform in New York", September 2011, http://www.nyshealthfoundation.org/content/document/detail/13047/

[92] Conversation with NYC Human Resources Administration, November 4, 2011

ATTACHMENT D: 50-STATE SCAN ON OTHER STATES NAVIGATOR PROGRAMS

State	Enacted HBE Legislation[93]	Exchange Legislation that mentions Navigator Program[94]	Specific Reports and Program Activity
California	✓	California's legislation states that one of the duties of the Exchange is to establish a Navigator Program, and the legislation restates the duties of the Navigator outlined in the bill. *California Assembly Bill 1602, §6(I)*	Report on "Service Center: California Health Benefit Exchange as a Consumer Destination." http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/C/PDF%20CAExchangeServiceCenter.pdf ▪ Describes the value and features of a "service-center Exchange that would go beyond federal and state legal requirements to provide "premium consumer experience." Report on " Envisioning the Role of Navigators in the California Health Benefit Exchange." http://www.itup.org/Reports/Health%20Reform/Navigator_03022011.pdf ▪ Urges the California Health Benefit Exchange to develop a vision for Navigators that is as broad as possible, includes the successful activities of existing organizations and programs in the state, and is seamlessly complementary to the work of those receiving fees or commissions. California's Health Benefit Exchange (HBE) Level I Establishment Project Narrative refers to the Navigator Program: http://www.healthexchange.ca.gov/Documents/California%20Health%20Benefit%20Exchange%20Level%20I%20Establishment%20Project%20Narrative.pdf ▪ Includes a high-level description of the Exchange Board's plan to engage with stakeholders in developing options for the Navigator Program and to review and assess existing public and private programs and services performing functions similar to the roles and responsibilities proposed for the Navigator Program.
Colorado	✓	Colorado's legislation does not list any specific duties or requirements of the Navigator	None

[93] "State Implement Health Briefs Database," National Conference of State Legislatures, http://www.ncsl.org/?tabid=19023
[94] "Navigators: A Background Paper", The Hilltop Institute, August 11, 2011, p 18-20

State	Enacted HBE Legislation[93]	Exchange Legislation that mentions Navigator Program[94]	Specific Reports and Program Activity
		Program. It only mentions Navigators in reference to the composition of the Exchange Board. The Exchange Board is required to have experience in at least two areas from a specified list. One of these areas is "health care consumer navigation or assistance." *Colorado Senate Bill 11-200, 10-22-105(1)(b)(VIII)*	
Connecticut	✓	Connecticut's legislation states that one of the duties of the Exchange is to establish a Navigator Program, and the legislation restates the duties of the Navigator outlined in the Affordable Care Act (ACA). The following entities are listed as potential Navigators: "(1) A trade, industry or professional association; (2) a community and consumer-focused nonprofit group; (3) a chamber of commerce; (4) a labor union; (5) a small business development center; or (6) an insurance producer or broker licensed in this state." It also requires the Exchange Board to: • Prescribe a form for the Navigator grant applications • Develop Navigator performance standards • Establish Navigator accountability requirements • Determine maximum Navigator grant amounts *Connecticut Senate Bill 921, §§5(c)(15), 6(19), 9*	None

State	Enacted HBE Legislation[93]	Exchange Legislation that mentions Navigator Program[94]	Specific Reports and Program Activity
Hawaii	✓	No language on Navigators. *Hawaii Senate Bill 1348*	None
Illinois	✓	No language on Navigators. *Illinois Senate Bill 1555*	None
Iowa		N/A	Stakeholders convened to discuss the role of Navigators in the HBE Program.
Kansas		N/A	One of the Kansas Insurance Department's eight HBE Planning Work Groups focuses on Agents/Brokers/Navigators. The Work Group developed a series of recommendations that were adopted by the Steering Committee: "Role of Agents/Brokers in the Exchange" http://www.ksinsurance.org/hbexplan/files/adopted/20110927_ADOPTED_role_of_agents_recommendation.pdf ▪ Agents/brokers should be part of the Kansas Insurance Exchange. "Oversight of Navigators" http://www.ksinsurance.org/hbexplan/files/adopted/20110927_ADOPTED_Navigators_FINAL_recommendation.pdf ▪ Oversight should be accomplished via certification, training, and examination and the certification should not require insurance agent licensing. ▪ The Kansas Health Exchange governing body, in conjunction with appropriate state agencies, should have regulatory authority over training and certification. ▪ Training requirements should include annual continuing education. "Training of Navigators" http://www.ksinsurance.org/hbexplan/files/adopted/20111021_ADOPTED_AGENTS_BROKERS_NAVIGATORS_RECOMMENDATION_RE_TRAINING_OF_NAVIGATORS_10-21-2011.pdf ▪ Training and education requirements should be established and monitored by the Exchange.

State	Enacted HBE Legislation[93]	Exchange Legislation that mentions Navigator Program[94]	Specific Reports and Program Activity
			▪ All Navigators should be trained in the functions of the insurance marketplace, including the individuals and entities eligible to purchase policies in the Exchange; the essential benefits package and other covered and non-covered services; enrollment; consumer rights and appeals processes; eligibility for subsidies and tax credits; and Medicaid eligibility, benefits, and enrollment. ▪ In addition to training required for initial certification, Navigators must meet standards for ongoing continuing education and training. ▪ Navigators should be trained in the process of enrolling consumers into qualified health plans (QHPs) including the provision of impartial and unbiased information. ▪ The Exchange should incorporate an evaluation/monitoring function to assess Navigator training/education and performance. "Certification of Navigators" http://www.ksinsurance.org/hbexplan/files/adopted/20111021_ADOPTED_AGENTS_BROKERS_NAVIGATORS_RECOMMENDATION_RE_CERTIFICATION_OF_NAVIGATORS_10-21-2011.pdf ▪ Navigator volunteers should be "certified" and Navigator entities should be "accredited" (this language ensures that the Navigator oversight process is distinctly different than the process of licensing insurance agents and brokers). ▪ The Work Group developed sample forms (memorandum of understanding (MOU), training record, volunteer application form and volunteer interview form) available at http://www.ksinsurance.org/hbexplan/index.php?pgid=17.
Maryland	✓	Requires the Exchange to establish a Navigator Program in accordance with ACA requirements. Directs the Exchange to study and make recommendations regarding the design and operation of the Navigator program. *Maryland House Bill 166/Senate Bill 182, §1 31-*	None

State	Enacted HBE Legislation[93]	Exchange Legislation that mentions Navigator Program[94]	Specific Reports and Program Activity
		108(B)(17), §5 (1)(iii)	
Massachusetts	✓	No language on Navigators. *Chapter 58 of the Acts of 2006*	None
Nevada	✓	No language on Navigators. *Nevada Senate Bill 440*	None
New York		N/A	New York State (NYS)Health report, developed by Empire Justice Center and the Community Service Society presents four major recommendations on how New York should design its Navigator and Consumer Assistance Programs (CAP) to avoid duplication of efforts and best meet the needs of New Yorkers: ▪ The essential functions of Navigators and CAPs should be integrated into a single program; ▪ The Navigator/CAP should use a "Hub-and-Spoke" administrative infrastructure; ▪ The Navigator/CAP should leverage existing resources and organizations by soliciting grant applications, formalizing relationships, and offering technical assistance; and ▪ Financing for the Navigator/CAP should be secured from available federal funds and fees on insurers operating inside and outside the Exchange. http://www.nyshealthfoundation.org/userfiles/NYSHealth%20Navigator%20CAPs%20report%20Sept%202011%281%29.pdf
North Carolina		N/A	North Carolina's HBE Navigator Subcommittee meetings included a presentation on Navigator requirements in federal law; a presentation on the Senior Health Insurance Information Program (SHIIP); discussion on training requirements, data reporting, and various roles and financing arrangements for the Navigator Program; and a period for public comment. Agenda and presentation: http://www.nciom.org/wp-content/uploads/2011/10/Navigator_Agenda_2011-10-24.pdf http://www.nciom.org/wp-content/uploads/2011/10/Navigator-leg-reg-10-24-11.pdf

State	Enacted HBE Legislation[93]	Exchange Legislation that mentions Navigator Program[94]	Specific Reports and Program Activity
North Dakota	✓	No language on Navigators. *North Dakota House Bill 1126*	None
Oregon	✓	Oregon's legislation states that one of the duties of the Exchange is to establish a Navigator Program. Oregon's legislation also authorizes the Exchange to enter into contracts with Navigators and establishes the funding stream for the Navigator grants. To fund the Navigator grants and the ongoing administrative and operational expenses of the Exchange, the Exchange Board will collect an administrative charge from all insurers and state programs participating in the Exchange. This assessment will be based on the number of individuals enrolled in each plan/state program offered through the Exchange. The charges must be sufficient to cover the cost of the Navigator grants and the administrative and operational expenses of the Exchange. • The charge may not exceed 5 % of the monthly premium per enrollee if the plan covers 175,000 or fewer enrollees through the Exchange • 4 % of the premium if the plan covers between 175,000 and 300,000 enrollees • 3 % of the premium if the plan covers more than 300,000 enrollees • If the charges exceed the amounts needed for the Navigator grants and expenses, the excess may be used to	None

State	Enacted HBE Legislation[93]	Exchange Legislation that mentions Navigator Program[94]	Specific Reports and Program Activity
		offset future losses or reduce administrative costs. • The maximum amount of excess funds that may be held for this purpose is the total expenses anticipated for a six-month period. Any excess above that amount must be applied to reduce future charges. *Oregon Senate Bill 99, §3(1)(j) and §17*	
South Dakota		N/A	The Outreach and Communication Subcommittee formed from the Health Insurance Exchange Task Force discussed Navigators at several meetings. Most recent meeting minutes (August 2011): http://healthreform.sd.gov/meetingpages/documents/OutreachCommunication20110816.pdf As of August 2011, the Subcommittee was drafting its final recommendations, which included: ▪ Navigators will need to meet certain federal requirements; and ▪ South Dakota should select Navigator Programs through a Request for Proposals (RFP) process.
Utah	✓	No language on Navigators. *Utah House Bill 133 (2008) and House Bill 188 (2009) (established Utah's small business Exchange)*	None
Vermont	✓	Vermont's legislation states that one of the duties of the Exchange is to establish a Navigator Program, and the legislation restates the duties and eligibility criteria of the Navigator outlined in the ACA.	Bailit Health Purchasing developed a memorandum for the Exchange Advisory Committee on the mandatory and optional functions of the Vermont Health Benefits Exchange relating to 1) marketing and outreach, and 2) Navigators. http://dvha.vermont.gov/administration/hbe-marketing-and-navigator-plan-06-27-11.pdf

State	Enacted HBE Legislation[93]	Exchange Legislation that mentions Navigator Program[94]	Specific Reports and Program Activity
		In addition to these duties, Vermont's legislation requires Navigators to: • Distribute information to health care professionals, community organizations, and others to facilitate enrollment of eligible individuals • Also requires the Exchange to ensure that Navigators are able to provide assistance in-person or through interactive technology to individuals in all regions of the state in a manner that complies with the Americans with Disabilities Act (ADA) *Vermont House Bill 202, §1807*	The memo outlined the following Navigator Program recommendations: ▪ The Navigator Program should play a central role in Vermont's early efforts to educate and outreach to the public about coverage available through the Exchange; ▪ The State will need to determine an overall budget for the Navigator Program, without reliance on federal funds, and should provide enhanced funding during the initial Exchange implementation period; ▪ Navigators should have the capacity to serve clients over the phone, by email, and in person, as most appropriate; ▪ The Navigator function should be well-coordinated with that of State and call center staff; ▪ Navigators will need to utilize different approaches in assisting individuals and small employers; ▪ Navigators must be paid through grants under the ACA, but the State has flexibility in its approach to contract with Navigators; ▪ All Navigators, regardless of how Vermont ultimately contracts for such services, should be required to receive a significant amount of training; ▪ The State should not automatically include or exclude any particular type of entity (within the parameters of the ACA requirements) as Navigators—instead the State should focus on clearly defining the Navigator role in terms of specific skills and outcomes; and ▪ While payment of Navigators must be through grants, some portion of payment should be tied to performance-based measures.
Virginia	✓	No language on Navigators. *Virginia House Bill 2434*	Report on "Consumer Protections and the Navigator Program" in "Creating a Effective Health Benefit Exchange: Key Issues for Virginia" http://www.thecommonwealthinstitute.org/wp-content/uploads/2011/08/110110_creating_an_effective_exchange_REPORT.pdf ▪ Recommended that Virginia should create robust consumer assistance programs, including a Navigator Program, and that assistance should be provided to those with language or other cultural barriers; and ▪ Virginia could look to the Covering Kids and Families program that helped enroll children in Family Access to Medical Insurance Security (FAMIS),

State	Enacted HBE Legislation[93]	Exchange Legislation that mentions Navigator Program[94]	Specific Reports and Program Activity
			funded by the nonprofit Robert Wood Johnson Foundation (RWJF) and run through the Virginia Health Care Foundation, as a potential model.
Washington	✓	Washington's legislation does not list any specific duties or requirements on the Navigator Program. The legislation requires a report by January 1, 2012 that includes, among other things: • An analysis and recommendations on "the role and services provided by producers and Navigators, including the option to use private insurance market brokers as Navigators *Washington Senate Bill 5445, §5(2)(f)*	Issue Brief #3: Washington Health Benefit Exchange Functions and Responsibilities http://www.hca.wa.gov/hcr/documents/issue_briefs/exchange_fr.pdf Key Navigator Program considerations articulated include: ▪ Payment should not create incentives to encourage or discourage certain consumer behavior or preferences; ▪ Information should be provided to consumers in a way that can be understood by the consumer, including presentation of information in a culturally sensitive manner, or for those with low-proficiency English and people with disabilities; and ▪ Different Navigator entities will likely be needed to meet the diverse needs of the Exchange consumers. Identifying how and where various populations seek information and assistance around health insurance issues will be critical in this process.
West Virginia	✓	No language on Navigators. *West Virginia Senate Bill 408*	None

ATTACHMENT E: NATIONAL DIALOGUE ON NAVIGATORS

Manatt conducted a review of issue briefs, white papers and comments on the proposed regulations issued by the United States Department of Health and Human Services (HHS) on July 11, 2011 on the Establishment of Exchanges and Qualified Health Plans (QHPs) (CMS-9989-P) from national stakeholders. Relevant excerpts and summaries follow. Full comments may be found at the links below each excerpt.

Organizations:
American Academy of Actuaries
American Medical Association
Community Catalyst
Families USA
Georgetown University Center for Children and Families
George Washington University, School of Public Health and Health Services
Medicaid Health Plans of America
National Association of Insurance Commissioners
National Association of Insurance Commissioners, Health Insurance and Managed Care Committee
National Association of Insurance Commissioners, Consumer Representatives
National Association of Health Underwriters
National Academy of Social Insurance
The National Academy of State Health Policy

The American Academy of Actuaries Exchanges Work Group, which includes a wide range of health actuaries including consulting actuaries, government actuaries, and health insurance actuaries, submitted a comment letter to HHS on October 6, 2011 on the federal proposed rule on establishment of Exchanges and QHPs released in July 2011. The Work Group recommended consistency between in-Exchange and off-Exchange market environments in areas such as network adequacy, marketing—including roles of agents and Navigators—plan designs, and ancillary offerings to help mitigate adverse selection. The Work Group also highlighted the following as one of the areas of Exchange operations for which specific procedures and infrastructure will need to be established: "agent and Navigator permissions to charge consumers directly for their services (i.e., just not as part of a premium)." Further, relating to auto-enrollment, the letter raised concerns around individuals losing coverage if the QHP in which they are enrolled no longer is offered. The Work Group highlighted the need for proper support from the Exchange website, the Navigator, or similar agent, to ensure consumers are informed and fully understand the process.

Comments to HHS on Proposed Rule:
http://www.actuary.org/pdf/health/Academy_comments_on_NPRM_on_exchanges_100611_final.pdf

The American Medical Association sent HHS comments on October 24, 2011 on the proposed rule on establishment of Exchanges and QHPs issued in July 2011. The letter stated that prohibiting conflicts of interest for Navigators and requiring them to be State-licensed "should offer protections to patients seeking coverage through an Exchange." Additionally, the Association recommended that Navigator duties include assisting patients find their physicians in QHPs' provider networks prior to enrollment. The letter argues that

patients often select health insurance products based on their physicians belonging to the provider network and posits that Navigators are in an "excellent position" to help ensure patients' desired physician-patient continuity of care.

Comments to HHS on Proposed Rule: http://www.ama-assn.org/resources/doc/washington/aca-exchange-rule-comments.pdf

Community Catalyst, a national non-profit consumer advocacy organization, recommended that state and/or federal standards be adopted to ensure that the entities serving as Navigators are the appropriate ones to provide "unbiased, clear, and culturally competent information." In a June 2011 issue brief, Community Catalyst made the following suggestions for "strong Navigators:"

- Have adequate training on the Exchange, Medicaid and other public programs and the private insurance market in the state;
- Be able to explain eligibility, benefits, cost-sharing, and appeals processes to consumers;
- Be trusted by the community to provide appropriate, clear and correct information;
- Be free from conflicts of interest, including payments and incentives from insurers or industry;
- Act in the interest of the consumer as their client, not the insurer;
- Be able to provide information to individuals and families in a way that can be understood, in a culturally sensitive manner, for those with low-proficiency English, and people with disabilities who have special communication needs;
- Be able to effectively serve low-income, disadvantaged, and hard-to-reach populations;
- Be able to help people understand how premium tax credits work, and their potential financial impact; and
- Adequately represent a diverse set of organizations and entities throughout a state in order to effectively serve the large number of people who will be eligible for insurance through the Exchange.

In September 2011, Community Catalyst developed comments to the HHS on the federal proposed rule on Exchange establishment and QHPs issued July 11, 2011. The comments express support for the proposed requirement that Navigator Programs be operational no later than the first day of the initial open enrollment period. Community Catalyst proposed that HHS expand the list of parties that would be considered conflicted for Navigators to include subsidiaries of insurers or insurer associations. Community Catalyst sought confirmation that the proposed restrictions on Navigator compensation would not preclude community-based Navigators from receiving grants from insurers for activities unrelated to enrolling individuals and employees in QHPs. As a measure to minimize adverse selection in Exchanges, Community Catalyst recommended that Navigators be prohibited from receiving compensation from insurers for enrolling individuals or employers in private insurance plans outside the Exchange. Community Catalyst also suggested that Exchanges be required to have at least one consumer-oriented, non-profit organization serve as a Navigator. The comments point to the Massachusetts health reform law and Health Care For All's HelpLine as examples of successful models of consumer-oriented navigation and consumer assistance work. Community Catalyst also endorsed the suggestion that Navigators work with and refer to consumer assistance programs in states and requested that HHS further clarify the coordination between Navigators and consumer assistance functions. Finally,

Community Catalyst made the following recommendations related to cultural and linguistic competency requirements:

- Exchanges should be required to select Navigators with a demonstrated track record of conducting culturally competent outreach to the uninsured and to populations with language barriers;
- Communications used by Navigators must be available in languages common in the community (and Navigators must publicize and post the availability of translated materials and interpretation services); and
- The network of Navigators should be able to provide in-person, online, and telephone support to potential enrollees. In-person support should be accessible by public transportation and ADA-compliant.

Report: http://www.communitycatalyst.org/doc_store/publications/Navigators_June_2011.pdf

Comments to HHS on Proposed Rule:
http://www.communitycatalyst.org/doc_store/publications/Exchange_Regs_CC_Comments_September_29.pdf

Families USA, a national non-profit consumer advocacy organization, argues that while states should require Navigators to be trained and pass competency exams, "today's licensure requirements for brokers or agents are not the appropriate vehicle to ensure Navigators' competency." Navigators will not only need to be knowledgeable on coverage sold through the Exchange, but they will need to have a good understanding of the state's Medicaid and Children's Health Insurance Programs (CHIP), which is not addressed by current producer licensing exams. Additionally, Navigators will not need to know about other forms of insurance (such as life or disability) currently covered in licensing exams.

Families USA points to models of "facilitated enrollment" in other programs that are not handled by agents or brokers—in many states, community-based organizations (CBOs) assist with enrollment in Medicaid and CHIP and also provide Medicare counseling and assist with plan enrollments as part of the federally funded State Health Insurance Assistance Program (SHIP). Because different levels of knowledge might be required for different Navigator Program tasks (e.g., distributing outreach literature versus assisting consumers to complete online applications for the Exchange), Families USA suggests that the Navigator certification program could include different levels of certification depending on the task. Families USA also states that in addition to initial training, Navigators should receive ongoing supervision.

Report: http://www.familiesusa.org/assets/docs/health-reform/Navigators-need-not-be-brokers.docx.

The Georgetown University Center for Children and Families (CCF) drafted comments to HHS on the federal proposed rule on Exchange establishment and QHPs issued July 11, 2011. CCF made the following recommendations related to Navigator Program development:

- Exchanges should be required to conduct a needs assessment of Exchange consumers to inform the design and implementation of their Navigator Programs;
- The number and types of qualified entities required to serve as Navigators should be determined by this needs assessment, and no less than two types should be required, one of which must be community or consumer-oriented nonprofit organizations;
- Exchanges should establish a Navigator training curriculum and certification requirements;
- Exchanges should set quality standards and develop mechanisms to assess Navigator performance and accountability in meeting the standards on an ongoing basis;
- As Navigators do not solicit, negotiate or sell insurance, they should not be subject to traditional licensure requirements and Exchanges should be prohibited from requiring Navigators to "be licensed as an insurance broker or agent;"
- To minimize the risk of conflict of interest, Navigators should be prohibited from receiving direct or indirect consideration from health insurance issuers outside the Exchanges;
- An additional Navigator duty should be to assist individuals in applying for financial assistance through Medicaid, CHIP, Basic Health Plan (BHP) (if applicable) and advance premium tax credits and cost-sharing reductions, and facilitate enrollment in Medicaid, CHIP, BHP or QHPs; and
- Navigators should be subject to the same linguistic and cultural competency requirements and nondiscrimination requirements as Exchanges with regard to translating materials and providing oral assistance to limited English proficiency individuals.

Additionally, CCF recommended that the Exchange website be designed to provide Navigators and other appropriate third party facilitators with direct access to the website and functionality that allows them to assist applicants and enrollees in applying for and managing their benefits. Third party access functionality should include appropriate privacy, security and audit controls and should provide reporting capabilities for Navigators and other assistors to aggregate their assistance activities and outcomes.

Report: http://ccf.georgetown.edu/index/cms-filesystem-action?file=policy/health%20reform/exchange1-comments.pdf

George Washington University (GWU) School of Public Health and Health Services Professor Sarah Rosenbaum outlined key Navigator implementation issues and uncertainties in February 2011. These included:

- State flexibility to develop Navigator criteria and select classes of potentially qualified entities;
- Requirements for minimum existing relationships and capabilities;
- Licensure requirements;
- Definition of "indirect" consideration from insurance issuers;
- Definition of conflict of interest;
- Requirements to assist Medicaid/CHIP- and QHP-eligible individuals; and
- Requirements to provide linguistically and culturally appropriate services to all qualified individuals.

Report: http://www.healthreformgps.org/resources/state-health-insurance-exchange-navigators/

Medicaid Health Plans of America (MPHA), a national trade association representing Medicaid managed care health plans, submitted a comment letter to HHS on October 5, 2011 on the federal proposed rule on Exchange establishment and QHPs issued July 11, 2011. MPHA suggested that, whenever possible, the Navigator Programs "build upon and coordinate with existing Medicaid and CHIP outreach and education efforts rather than operate separate and apart from these activities." The letter recommended that entities currently providing outreach and education services to State Medicaid or CHIP agencies be added to the list of potential Navigator entities. MPHA argued that while Exchanges should clearly articulate the roles and responsibilities of Navigators and hold them to appropriate licensing and/or certification standards based on those definitions, they should avoid creating new, duplicative requirements administered separately from existing standards. MPHA also recommended that Navigators should be required to "demonstrate experience and competency necessary for engagement with culturally diverse, low-income populations." Finally, the letter urged HHS to go beyond the proposed language that states may require or permit Navigator activities to address Medicaid and CHIP administrative functions and instead explicitly require that Navigators be able to provide prospective enrollees information on Medicaid and CHIP program requirements and help facilitate enrollment.

Comments to HHS on Proposed Rule: http://www.mhpa.org/_upload/MHPA_Exchange_Rule_CMS-9989-P_Comment_Letter_Final.pdf

The National Association of Counties (NACo), an organization representing the 3,068 county governments in the country, submitted a comment letter to HHS on October 6, 2011 on the federal proposed rule on establishment of Exchanges and QHPs released in July 2011. NACo made the recommendation that Exchanges be required to "engage a wide range of qualified entities to serve as Navigators, including county agencies that wish to provide such services, and non-profit community groups as well as brokers and agents," so long as there is "transparency and accountability for the performance of their duties." The letter argues that such a policy will help to ensure "consumer confidence" and competition among QHPs as well as to minimize adverse selection. Additionally, NACo highlighted the need for Navigators and other consumer assistance personnel, including county agency staff, to have the ability to maintain records for individuals seeking assistance, as "applications and determinations may take some time and be started and finished in different settings."

Comments to HHS on Proposed Rule:
http://www.naco.org/programs/csd/Documents/Health%20Reform%20Implementation/NACo%20Comments%20Establishment%20of%20Exchanges%20and%20QHPs%2009-23-2011.pdf

The National Association of Insurance Commissioners (NAIC). NAIC, a voluntary organization of state chief insurance regulatory officials, sent a letter to HHS on October 5, 2011 to provide comments on the federal proposed rule on Exchange establishment and QHPs issued July 11, 2011. NAIC concurred with the proposed rule's recognition that "states are best positioned to determine the duties, training and certification that are appropriate" for Navigators. NAIC called for the regulations to ensure that the "duties of Exchange Navigators appropriately reflect the important role of insurance producers who are skilled, knowledgeable, educated and licensed and regulated." Arguing that conflict-of-interest standards should not only address situations where

the Navigator is receiving direct compensation for the sale of QHPs in the Exchange, the NAIC recommended that "monetary or non-monetary compensation or consideration made to the Navigator for sales of QHPs and non-QHPs should be taken into account." Finally, regarding the standardization of the information provided by the Navigators, the referral of questions to state agencies and the types of entities with which the Exchanges must contract, the NAIC letter recommended that states be granted "wide latitude to develop the appropriate standards" as states have the best understanding of consumer needs and the community organizations that are capable serving as Navigators.

Comments to HHS on Proposed Rule:
http://www.naic.org/documents/index_health_reform_111005_naic_letter_centers_medicare_medicaid_services2.pdf

The National Association of Insurance Commissioners (NAIC) Health Insurance and Managed Care Committee. NAIC's Health Insurance and Managed Care Committee issued a draft White Paper on the Role of Navigators and Producers in the Exchange in June 2011. The overarching recommendation from this White Paper was to encourage states to consider how to "deploy Navigators and producers in a complementary manner" so as to reconcile the competing and potentially conflicting role Navigators will play with agents and brokers. NAIC calls for states to be allowed to establish parallel competency requirements for Navigators that include educational and continuing education requirements. NAIC encourages states to require Navigators to carry professional liability insurance, consider subjecting Navigators to the oversight and regulation of state insurance regulators, and develop a process for handling Navigator-related complaints from consumers. NAIC did not take a position as to whether producers could be Navigators: "State should examine the goals of the Navigator program and determine if producers are suited to this function or if it would be more advisable to limit producers' interaction with individuals to simply enrolling them in qualified health plans....An Exchange must consider if there is an inherent conflict of interest if producers desire to function as Navigators for the Exchange." NAIC calls on HHS to issue regulations to help shed light on these issues and provide guidance to states as they work to establish their Navigator programs.

Report: http://www.naic.org/documents/committees_b_110622_navigator_producer.pdf

The National Association of Insurance Commissioners (NAIC) Consumer Representatives. NAIC's Consumer Representative Board consists of 27 consumer representatives who are appointed to advise NAIC. These representatives include academics and national and state health policy consumer advocates. This organization believes that inclusion of licensed brokers/agents as Navigators creates an inherent conflict of interest; they recommend that brokers/agents in no case be considered for the Navigator role. As of October 2011, The group posits "Navigators must have knowledge of the entire marketplace within the exchanges, not just knowledge of commercial insurance products. They should be compensated on the quality of information they provide, not on volume. [The group is] concerned that there is the "potential for abuse or fraud" and "it would be inappropriate and contrary to the intent of the statute to require licensing as is currently done for brokers and agents." The basic tenet of their position is that agents and brokers may be susceptible to steering customers towards particular plans. NAIC Consumer Representatives support "some form of credentialing and performance review of the entities engaged in providing navigator services." The group also posits that "it would be inappropriate and contrary to the intent of the statute to require licensing as is currently done for brokers and agents." NAIC does not directly discuss the role of training as part of the Navigator Program.

Report:
http://www.naic.org/documents/committees_b_exchanges_comments_rcvd_navigators_producers_110318.pdf

The National Association of Health Underwriters (NAHU). NAHU, the principle, national trade association for insurance agents and brokers, advocates for agents and brokers to play an active role through the Exchange in assisting consumers in understanding their health care options and enrolling in coverage. NAHU has not articulated an interest in serving in the Navigator capacity through the Exchange, despite the fact that agents or brokers are listed within the ACA statute as a possible entities who may serve as Navigators. NAHU advocates for agents and brokers to participate in selling and servicing products through the exchange and for an annual exam-based certification process that addresses both private coverage options and public assistance and subsidy-eligible options. The organization proposes to work "in partnership with other appropriate parties to assume responsibility for developing a certification program – the Certified Health Care Access Advisor for agents and brokers who market through an exchange..."

NAHU also proposes to make available a searchable database of insurance professionals who are certified under this program.

NAHU believes the role of Navigators in the Exchange is "duplicative" of the existing role agents and brokers already serve in the marketplace. While they do not want agents or brokers to be Navigators they do seek certain Navigator requirements. NAHU calls for Navigators to be subject to the same licensing and training requirements that are required of agents and brokers. NAHU also recommends limiting Navigators to entities who have experience in assisting consumers in enrolling in coverage such as SHIPS who assist seniors with Medicare.

Report: http://www.nahu.org/legislative/connector/agents_and_brokers_exchange.pdf

The National Academy of Social Insurance (NASI), a non-profit, nonpartisan organization comprising experts in social insurance, espouses a centrist view. The group acknowledges that "Exchanges will have to decide how to best match the roles of Navigators with the expertise and trust that brokers and agents have earned over the years" and that "a state might require that the Exchange review qualifications of entities selected as Navigators." In addition, NASI notes that funding the Navigator Program could be a major issue for states given the fact that they are unable to use federal monies to support this activity. NASI suggests that associations, unions and similar organizations may be certified as Navigators if they meet the standards established by the Exchange and HHS.

In terms of training and certification, NASI also maintains that "A state may require that any individuals or individuals affiliated with any entity selected to be a Navigator must be certified as able to carry out the duties required by Federal law under section 1311(i)(3)." They recognize that it is particularly important "with respect to transitioning between the Exchange and Medicaid or CHIP."

Report:
http://www.nasi.org/sites/default/files/research/Designing%20an%20Exchange_A%20Toolkit%20for%20State%20Policymakers.pdf

The National Academy of State Health Policy (NASHP) State Health Access Program (SHAP) DiaBlog published a post in June 2011 on the role of Navigators in Exchanges. The blog post highlights that many states are considering the role of brokers in the Exchange, as many states have a "long history" with brokers and brokers have a "keen knowledge of laws regulating private insurance." The blog post also provides examples of states that have started engaging brokers groups as part of the Exchange planning process, such as Tennessee.

Report: http://statehealthaccess.wordpress.com/category/exchanges/

ATTACHMENT F: NAVIGATOR PROGRAM MODELS REFERENCE CHART

Navigator Details	SHOP Navigator Model #1: Navigator-Broker	SHOP Navigator Model #2: Broker Interface	Individual Navigator Model #1: Market Integration	Individual Navigator Model #1: Market Integration Alternative A	Individual Navigator Model #2: Market Consolidation Model	Individual Navigator Model #2: Market Consolidation Alternative A
Contracting	Maryland Health Benefit Exchange (MD HBE) contracts directly with licensed brokers.	MD HBE employs a limited number of Navigators to supplement authorized broker enrollment activities.	MD HBE provides performance-based grants or contracts for comprehensive Navigator services. Authorized brokers enroll, but not as Navigators.	MD HBE provides multiple grants or contracts for subsets of Navigator functions. Authorized brokers enroll, but not as Navigators.	MD HBE provides performance-based grants or contracts for comprehensive Navigator services.	MD HBE provides multiple grants or contracts for subsets of Navigator functions.
Functions	Affordable Care Act (ACA) and state-required functions plus post-enrollment support.	ACA and state-required functions plus post-enrollment support.	ACA and state-required functions.	Same as Individual Model #1.	Same as Individual Model #1.	Same as Individual Model #1.
Training	Qualified Health Plan (QHP) offerings and enrollment systems, cultural competence.	QHP offerings and enrollment systems, cultural competence. Employed Navigators also receive training to support employer needs and purchasing decisions.	Public programs, Advanced Payment Tax Credits, QHP offerings, enrollment systems, cultural competence.	Public programs, Advanced Payment Tax Credits, QHP offerings, enrollment systems, cultural competence plus how to manage multiple hand offs.	Same as Individual Model #1.	Same as Individual Model #1A.
Certification/ Licensure*	Full Maryland Insurance Administration (MIA) licensure required as a only brokers would be Navigators.	Full MIA licensure for brokers; unclear for employed Navigators	Limited licensure and/or certification for Navigators engaged in QHP enrollment. May require change in state law.	Same as Individual Model #1.	Same as Individual Model #1.	Same as Individual Model #1.

Compensation	Standardized compensation for Navigator-Brokers administered by the MD HBE at rates designed to mirror those available in the market outside the Exchange.	Employed Navigators compensated as salaried employees of the Exchange. Brokers compensated based on their direct relationships with the carriers, and not as a Navigator or through the Exchange.	Grants/contracts for Navigators given by the Exchange. Compensation for brokers, who are not Navigators would come directly from insurance carriers, similar to the non-Exchange market place.	Same as Individual Model# 1.	Compensation for Grants/contracts for Navigators given by the Exchange.	Same as Individual Model #2.
Oversight	Conducted by the MD HBE in coordination with the MIA.	Employed Navigator oversight conducted by the MD HBE through employee performance requirements. If licensure required, the MIA would be involved. Broker oversight con ducted by the MD HBE in coordination with the MIA.	Conducted by the MD HBE, MIA; (if licensure) and Department of Health and Mental Hygiene (DHMH) (for Medicaid).	Same as Individual Model #1.	Same as Individual Model #1.	Same as Individual Model #1.
Program Funding	Broker commissions would be passed through to Broker-Navigators. Remaining financing through Exchange's operating budget.	Exchange's operating budget and "commissions" from health plans to the MD HBE for enrollments completed by employed Navigators.	Exchange operating budget and Medicaid dollars (including Federal match).	Same as Individual Model #1.	Same as Individual Model #1.	Same as Individual Model #1.

*For the purposes of developing policy recommendations, this report focuses on the range of potential policy options, including those that may require change in the current state law or regulatory guidance.