BRIDGING THE DIVIDE:

Designing the Navigator System for California's Health Benefits Exchange

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Executive Summary

With the passage of the Affordable Care Act (ACA), more than two-thirds of California's uninsured—an estimated 4.7 million nonelderly adults, children, and individuals with disabilities—will be eligible for coverage through the expansion of Medicaid eligibility or health insurance products sold in the California Health Benefits Exchange.[1] The ACA includes many provisions to improve care delivery, contain costs, and expand access to quality care, particularly through the Exchange. The achievement of these goals through the State's Exchange will largely depend on whether or not individuals, families, and small businesses owners are able to: (1) find a plan that is both affordable and meets their medical needs; and (2) can navigate the system and successfully enroll in a healthcare plan.

Enrolling millions of individuals and small businesses into coverage will be a daunting task. Faced with the federal mandate for coverage, individuals and small business owners will grapple with the fiscal implications of purchasing health insurance and an otherwise complicated system of eligibility subsidies.

The ACA requires each state to establish a third party assistor system to help both individuals and small businesses enroll in public and private coverage options. ACA calls these third party assistors "Navigators." The roles Navigators play in helping individuals enroll in coverage will revolutionize how individuals and small business owners experience the search for coverage. Unlike today's enrollment pathways, Navigators will provide individuals and small business owners with information about ALL coverage options available to them. Silos between information about public coverage and private coverage programs should cease to exist, and consumers will enroll in a program based on eligibility.

The Exchange Board has delineated several questions on the scope, design, and financial policies for the Navigator program. This issue brief will focus on California's Medicaid (Medi-Cal), Children's Health Insurance Program (Healthy Families) as well as private individual and private small group coverage and will respond to the Exchange Board's questions by describing the newly eligible populations and current enrollment pathways followed by recommendations for building a successful Navigator program. The brief will review:

I. California's uninsured populations
II. Transitions from uninsured to insured in 2014
III. Current enrollment pathways
IV. Designing a successful Navigator program.

The Exchange is one of the most important "public utilities" to be established in decades. Its success will not only ensure access to healthcare coverage for millions of uninsured, but transform the cost and quality of the healthcare insurance system for all Californians. It lays out following recommendations for the structure and design of the proposed Navigator grant funded program and other third party efforts.

1. The Navigator program should leverage the current public and private third party assistor system.
2. Navigators must provide a full range of services to all consumers including outreach, enrollment, retention, and utilization assistance.

[1] Lavarreda SA and Cabezas L. Two-Thirds of California's Seven Million Uninsured May Obtain Coverage Under Health Care Reform. Los Angeles, CA: UCLA Center for Health Policy Research, 2011.

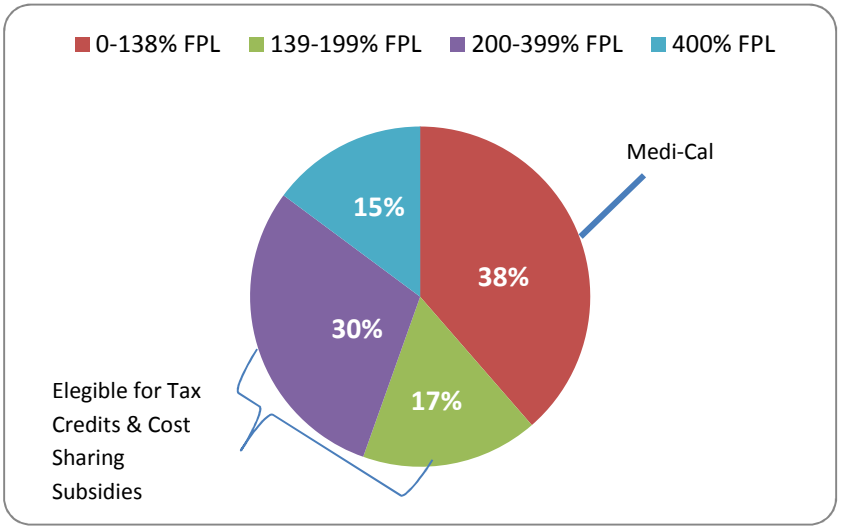
3. The Navigator network should provide broad geographic access and be fully integrated in other enrollment pathways under the Exchange.
4. Navigators should be required to provide services in line with existing state and federal Cultural and Linguistic Standards.
5. Other enrollment pathways should be strengthened and trained to work with Navigators to ensure individuals get the support they need to enroll in coverage.
6. The Navigator program should coordinate with other consumer assistance groups to provide effective, non-redundant services.
7. Navigators should help individuals obtain information about non-health social services programs they may be eligible for.
8. Navigator entities should have previous experience and expertise in enrolling individuals or small businesses in coverage.
9. Navigator entities should reflect the diversity of the populations they serve to ensure appropriate access to care for all populations.
10. Navigator entities should be exempt from licensing requirements.
11. Entities serving as Navigators must meet a minimum set of criteria and training/certification requirements.
12. Navigator entities should abide by clear and strict conflict of interest standards that ban steering practices and compensation outside the Exchange.
13. Licensed brokers and agents should exhibit a strong knowledge of both public and private health programs in the State to help individuals enroll in the appropriate coverage.
14. Brokers and agents enrolling qualified individuals and small businesses into non-qualified health coverage should be required to obtain written verification from the consumer acknowledging that he/ she was informed of and willfully declined public coverage, qualified coverage, tax credits, and cost-sharing assistance (presuming one is eligible).
15. The Exchange should provide significant funding to support community-level outreach and enrollment activities in advance of open enrollment.
16. Navigator programs must receive ongoing and adequate funding that will help organizations provide comprehensive services, follow a set of standards and guidelines, and retain and build their workforce.
17. The Exchange should capitalize on the ability to draw down additional federal dollars through Medi-Cal Administrative Activities (MAA).
18. Payment for enrollment assistance should be performance based.
19. Compensation to brokers and agents for enrolling individuals and businesses into qualified and non-qualified health plans should adhere to a standardized policy.
20. The Exchange should provide a fee-for-service compensation to entities <u>without grant</u> funding for enrolling small businesses or individuals into the Exchange.

California's Uninsured

Nearly twenty-two percent of California's population is uninsured. Of this 7 million uninsured, 4.7 million nonelderly adults, children, and individuals with disabilities will become eligible for coverage under the ACA. California's uninsured cross the full spectrum of the State's population in terms of employment, income, and legal residency. Individuals and families go without coverage as a result of barriers that include cost, income, eligibility requirements, and lack of employer coverage, and these barriers contain implications for the pathways, design, and structure of future enrollment systems under the Exchange.[2]

The uninsured are not simply unemployed or low income. As indicated in the chart below, 15% of the uninsured have incomes in excess of 400% of the FPL ($43,560 for an individual and $89,400 for a family of four) and an additional 30% have incomes between $30,843 and $89,400 for a family of four. Approximately 14% of the uninsured are under the age of 18 and 86% are between the ages of 18 and 64.[3] Single childless adults account for 50% of the uninsured and 50% are families.[4]

Exhibit A—California's Uninsured by Income in 2009

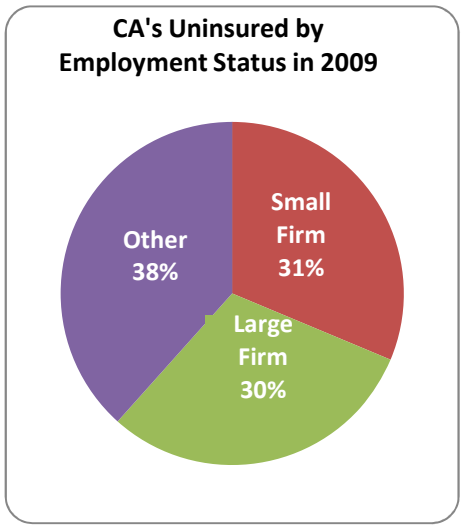


Employment status adds a level of complexity to the Exchange with both an employer and individual mandate for coverage under the ACA. In 2010, almost one in four workers in California was uninsured. Approximately 60% of uninsured individuals worked for a small firm or large employer. Thirty-one percent of uninsured individuals worked for a small firm (between 2 and 50 employees) and another 30% worked for a large firm (more than 50 employees).

Public sector organizations and firms with more than 500 employees had the lowest rates of uninsured workers at 8.6% and 14.5%, respectively. Self-employed individuals were also over-represented among the uninsured with 30% lacking coverage. While the percentage varies based on the sector and size of

[2] California HealthCare Foundation. California's Individual and Small Group markets on the Eve of Reform. 2011.
[3] California HealthCare Foundation. California's Uninsured. 2011.
[4] California Health Interview Survey. Insurance Coverage in 2009 by Family Type. www.chis.ucla.edu.

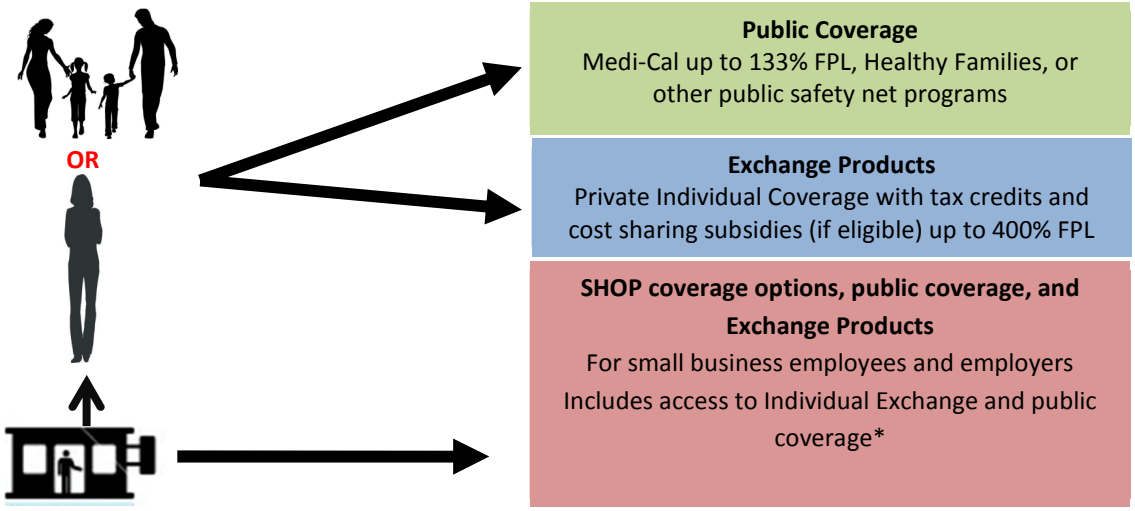
the company, the "working uninsured" are found across all types of employers and will be eligible for a variety of programs under the Exchange.



California is at a critical juncture in the implementation of key provisions of the Affordable Care Act. With 2014 just around the corner, the pathways and design of the Exchange enrollment system should be built upon the strengths of the general patterns of insurance coverage in the State today.

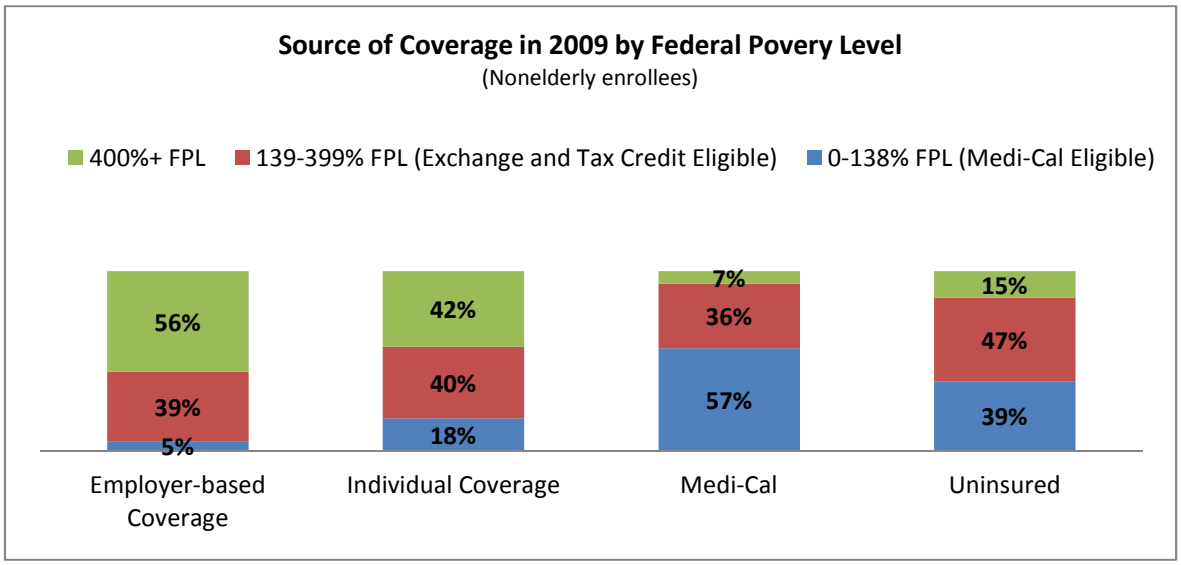
From Uninsured to Insured in 2014

The Exchange is designed to provide access to healthcare coverage for different groups of individuals. These include: (1) individuals eligible for coverage under the expansion of Medi-Cal and other public programs; (2) individuals who are employed and do not qualify (based on hours of employment) or who cannot afford coverage through their employer and exceed the income limits for Medi-Cal eligibility; (3) small employer groups. Beginning in 2017, states can opt to (4) allow employers with 100 or more employees to purchase coverage through the small business Exchange.[5]



[5] Kaiser Family Foundation. Summary of New Health Reform Law. April 2011.

To design an effective enrollment system under the Exchange, it is critical that we understand what the demand for services will be based upon program eligibility. Beginning in 2014, 38% of the uninsured are expected to be eligible for coverage under the expansion of Medicaid and another 47% may be eligible for individual coverage through the commercial plans available in the State's Health Benefits Exchange. Forty percent of enrollees in the individual market will be eligible for tax credits and 14% will be newly eligible for Medi-Cal.[6] New tax credits available to firms with less than 100 employees will help small business owners pay for coverage for their employees. When employer coverage is not an affordable option (meaning employee costs for coverage are more than 8-9.5% of adjusted gross income or if the employer decides not to provide coverage), Medicaid coverage and the Exchange will provide quality, affordable options for care.[7]



Approximately 36% of Medi-Cal beneficiaries with incomes between 138% and 400% of federal poverty guidelines may qualify for coverage, tax credits, and cost sharing subsidies in the Exchange.[8] Of the employer-based coverage population, 39% will be Exchange eligible and 5% will be eligible for coverage under Medi-Cal.[9] In 2014, these populations will enroll in coverage through systems that may look radically different from what they've experienced to date.

Current Enrollment Pathways

While options for coverage vary based on geographic location, income, and immigration status, broadly speaking Californians have a wide range of options when selecting coverage for themselves and their families including on-line systems and existing third party assistors.

[6] Note: These provisions only apply if the individual is not offered coverage through their employer.
[7] For Medicaid, assuming individuals/children meet eligibility requirements.
[8] This likely includes individuals receiving pregnancy services or families currently accessing share of cost Medi-Cal services.
[9] California HealthCare Foundation. Insurance Markets on the Eve of Reform. 2011.

Current Enrollment Pathways for Public and Private Insurance Products

	Do-It-Yourself	3rd Party Assistor
Public Coverage	• Mail • Phone • Online (Health-e-App, county SAWS, etc.)	• **County eligibility workers** • **Certified Application Assistors (CAA)** • **Community-based Organizations**
Private Individual Insurance	• Mail • Phone • Online (Benefitscafe, ehealthinsurance, etc.)	**Broker or Agent**
Private Group Insurance	• **Mail** • **Phone** • **Online (Benefitscafe, ehealthinsurance, etc.)**	**Broker or Agent**

Public Coverage Program Assistors:

People eligible for public coverage can get help completing an application by visiting a local/state agency or community organization to obtain information and receive assistance throughout the enrollment process. Generally speaking, eligible individuals and children can enroll in Medi-Cal through a county eligibility worker. Enrollment is often facilitated through referrals to the county when a child or individual is applying for other social service programs such as the Temporary Assistance to Needy Families program, the Supplemental Nutritional Assistance Program, the National School Lunch Program or the Women, Infants, and Children program. With the implementation of the federal State Children's Health Insurance Program (SCHIP) in 1998, California began utilizing a strong network of Certified Application Assistors (CAAs) to provide enrollment support for families and children in the Healthy Families and Medi-Cal for Families programs. CAAs are trained and certified by the State to enroll families into the Healthy Families and Medi-Cal programs. CAAs are generally employed through local Enrollment Entities (EEs) in each of the State's fifty-eight counties including community-based organizations, clinics, school districts, and local brokers. In March 2011, California had close to 4,000 enrollment entities (EE) and 23,000 Certified Application Assistants (CAA).

Historically, CAAs have been an effective pathway to enrollment for thousands of families and children. In 2011, of the 212,102 applications processed for Medi-Cal and the Healthy Families Program, 75,684 were processed with the assistance of a CAA.[10] Of the 102,855 applications submitted using Health-e-App, almost half (45,283) were submitted by a CAA. CAAs work in and reflect the diversity of the populations they serve. The CAA model brings a level of unsurpassed cultural and linguistic competency that has been critical in eliminating barriers, particularly for hard to reach populations. Many EEs/CAAs offer families a full complement of outreach, enrollment, retention, and utilization services that include comprehensive case management as well as access to and promotion of the health and social service programs available in the community. CAAs assist families in navigating the enrollment process by

[10] Healthy Families Program Enrollment Summaries January 2011 through December 2011. http://www.mrmib.ca.gov.

assessing their eligibility for various coverage programs and helping them file applications. CAAs ensure individuals submit all necessary supporting documentation and provide continued support by following up with families throughout their first year of coverage to confirm enrollment, ensure utilization of services, and assist with retention of health coverage services.

Other public coverage options such as the Child Health and Disability Prevention Program and the Access for Infants and Mothers Program require different enrollment processes that may include enrollment by a paper application only or enrollment through a visit to a provider or a county facility.

While online applications for public coverage have increased in recent years, a strong demand for personal assistance continues. A recent survey of 487 public program consumers in Stanislaus found 29% of respondents felt applying in-person would expedite their application. Another 28% of respondents did not know other enrollment pathways existed and 18% of respondents did not have access to a computer or the internet. Respondents listed other reasons for applying in-person such as needing help with paperwork and having questions they wanted answered in-person or that required in-person assistance.

While CAAs and county eligibility workers provide much needed support for children and families eligible for public coverage, currently neither provide enrollment assistance to individuals seeking private coverage or to small business owners who are seeking coverage for their employees.

Commercial Coverage Assistors:

Similar to the role played by Certified Application Assistors and county eligibility workers in public programs, accident and health agents and brokers help business owners and individuals seeking coverage in the private insurance market to navigate, understand, and enroll into coverage. An important difference exists between health insurance brokers and agents. Agents are individuals or companies that have a contract with a health plan or insurer and act on behalf of and have a fiduciary responsibility to the plan or insurer. Brokers, on the other hand, may also have contracts with health plans or insurers but they officially act on behalf of and have a fiduciary responsibility to the client.[11] In 2011, the California Department of Insurance licensed 203,000 accident and health agents.

California law requires that individuals selling accident and health insurance be licensed by the State. Current licensure requirements vary based on where the agent or broker lives, how long the agent or broker has been in the business, and whether the entity seeking to be licensed is an individual or a business. The pre-licensing education objectives for accident and health agents and brokers focus on various issues. However, agents and brokers are not required to get comprehensive training on Medi-Cal and safety net services' screening and enrollment. As a result, agents and brokers have provided most of their services and assistance to individuals in the group (both small and large) and individual markets. Beyond enrollment, brokers help individuals and employers troubleshoot issues with their health plans. Brokers and agents "provide guidance and assistance with claims issues, service questions, and other quality enhancement and compliance matters."[12]

[11] Legislative Information Center. Senate Bill 615 Bill Summary and Analysis. www.leginfo.ca.gov.
[12] Insurance Brokers & Agents of the West. Letter to the CA Health Benefits Exchange Board: Exchange Comments on Proposed Federal Rules for Establishment of Exchanges and Qualified Health Plans. October 2011.

Many small business owners rely on health insurance brokers and agents to provide coverage to their employees. Focus groups and survey results from interviews with over 800 small business owners (2 to 9 or 10 to 19 employees) in California highlight the essential role insurance brokers and agents play in the small group market.[13] According to research conducted by Pacific Community Ventures, 75% of small businesses rely on an insurance broker when purchasing health insurance and 88% use a certified public accountant. Twenty-seven percent of small business owners indicate that they would rely on their broker/ accountant to obtain information about coverage options available under health reform in 2014. Of the 25% of small businesses that did not use a broker, owners relied on business organizations, accountants, and chambers of commerce for information.

Designing a Successful Navigator Program

The reality is all consumers will require assistance in 2014 to enroll into coverage. Federal law requires Exchanges to establish a Navigator program and provide grants to Navigator entities to facilitate and ensure enrollment into coverage for consumers. According to proposed federal rules:[14]

- Navigator entities should be individuals or organizations who can demonstrate existing relationships, or could establish relationships with "employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be eligible for enrollment in a qualified health plan."

- Navigator entities are required to meet any licensing or certification requirements established by the State or Exchange and must not have a conflict of interest during the course of being a Navigator entity.

- Exchanges must provide Navigator grants to at least two of the following entities: community and consumer-focused nonprofit groups; unions; other licensed insurance agents and brokers; trade, industry, and professional associations; commercial fishing industry organizations, ranching and farming organizations; chambers of commerce; resource partners of the Small Business Administration; and other public or private entities that meet Navigator requirements.

- Navigators cannot be health insurance issuers or receive any consideration directly or indirectly from a health issuer for enrolling qualified individuals and employees into qualified coverage. Proposed rules do not preclude a Navigator entity from receiving compensation for enrolling qualified individuals into non-qualified insurance products options outside the Exchange.

- Navigators must: (1) maintain expertise in eligibility, enrollment, and program specifications and conduct public education activities to actively raise awareness about the Exchange; (2) fairly and impartially provide information and services to consumers about health coverage programs; (3) facilitate enrollment into qualified health plans; (4) refer enrollees with a grievance, complaint, or question about their health plan, coverage, or a determination under that plan or coverage, to appropriate State agencies; and (5) present information in a culturally and linguistically-considerate manner to people using the Exchange.

[13] Pacific Community Ventures. Health Care and Small Business: Understanding Health Care Decision Making in California. October 2011.
[14] Federal Proposed Rules. 45 CFR Parts 155 and 156 [CMS-9989-P] Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans. Federal Register Vol. 76. No. 136.

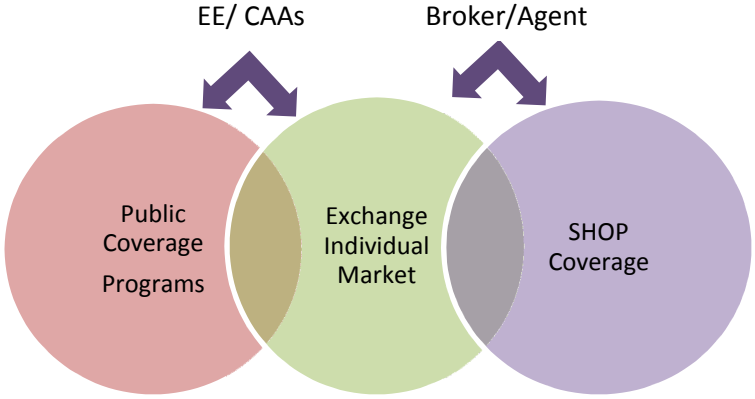
However, the needs of individuals eligible for public coverage or Exchange coverage will vary greatly from the needs of small employers. Each pathway to coverage comes with its own set of complexities: public coverage programs include stringent eligibility requirements; individuals seeking coverage through the Exchange will need to understand the regulations pertaining to available premium tax credits; and small businesses will need to understand and comply with regulations regarding their responsibility, options and costs for covering employees. The success of a Navigator program should be defined by its ability to provide meaningful access to and utilization of coverage for individuals, small business owners, and the most underserved and under-resourced communities in our State. Therefore, a successful Navigator program should:

- Provide customized yet equitable services to meet the needs of both individuals and employer based groups in the public and commercial coverage options
- Meet the needs of all consumers regardless of language, culture, disability, or literacy level
- Eliminate the racial and ethnic disparities in coverage
- Ensure enrollment of individuals and small businesses into coverage does not result in barriers to enrollment into public programs, adverse selection against the Exchange, or steering of individuals and employers into certain health plans
- Include strong conflict of interest provisions that protect the Exchange against steering and adverse selection.

Recommendations for California's Navigator Program

The Navigator program should leverage the current public and private third party assistor system. It is clear that the Navigator system needs to be bifurcated given the projected number and program eligibility of the 4.7 million uninsured who will be covered under the ACA in 2014. The Navigator system should leverage and expand the current role of the broker/agent as Navigator and the CAA as Navigator and require both to serve the individuals seeking coverage through the Exchange and through their respective areas of expertise. This draws a logical and practical distinction between the roles that brokers and agents currently serve for small businesses and the roles that CAAs as potential assistors or Navigators serve while providing the needed capacity.

California's Potential Navigator Entities



California's network of certified application assistors (CAAs) and enrollment entities (EEs) provide an extremely successful model for getting children and families enrolled in coverage. With anywhere between 1.7 million and 3 million individuals eligible for coverage through the expansion of Medi-Cal in 2014,[15] it will behoove the State to invest in programs and systems with a proven track record of enrolling individuals into public coverage. We believe building upon the existing CAA and EE model is a logical first step in making sure California can meet the wave of screening and enrollment demands to come in October 2013.

The CAA network of more than 23,000 trained individuals has an established and trusted relationship in the community. CAAs have been successful in educating members of the community about coverage and helping families overcome enrollment challenges in California's public healthcare systems. The CAAs' experience and understanding of the systematic and common barriers facing enrollment will be beneficial to help educate, enroll, and assist families and individuals with the new healthcare options available under ACA. The CAA structure also affords the "arm's length" transaction distance to prevent steering and ensure unbiased communication and information is provided to the public. This makes the inclusion of EEs and CAAs as qualifying categories essential to the integrity, scope and impact of the Navigator program.

Much like CAAs, accident and health insurance brokers and agents will be a needed resource to help insure individuals and small business owners. Agents' and brokers' expertise in assisting small and large employers obtain and manage coverage products for their employees will be of major value to the Exchange. Oftentimes, small businesses rely on agents and brokers to help them deal with claims and other insurance related problems after purchasing coverage.[16] Agents and brokers may also provide assistance directly to employees facing problems with their insurance coverage. Taking into consideration the value brokers and agents bring to the group market, it makes sense to explore opportunities to utilize the agent and broker network in California to assist with individual and SHOP Exchange enrollments, provided stringent conflict of interest requirements are met and additional training is provided regarding public coverage options.

Navigators must provide a full range of services to all consumers including outreach, enrollment, retention, and utilization assistance. Understanding that a significant portion of populations eligible for coverage under health reform may never have had access to coverage or had limited access to health insurance, Navigators must provide comprehensive outreach, enrollment, retention, and utilization supports to enroll and educate them about using their coverage. This expectation draws a distinction between those who serve as Navigators under the grant program requirement outlined in the ACA and the potential fee-for-service system of reimbursement discussed later in this report. To reinforce this distinction, the grant portion of the Navigator program should be based on performance standards. While performance standards should be consistent across product lines, the metrics, such as the one for CAAs throughout the State relative to enrolling individuals into the Exchange, would need to be modified for small group enrollment:

[15] Public Policy Institute of California. Expanding Medi-Cal: Profiles of Potential New Users. August 2011.
[16] Vimo Research Group. How Agents Empower Health Insurance Shoppers. August 2007.

Enrollment and Retention Assistance: Navigators should screen and help individuals and small group employers apply for and successfully enroll in the appropriate healthcare program. Navigators should play the role of an ombudsman or advocate for applicants experiencing difficulty with the timely completion of the enrollment process resulting from outstanding eligibility questions and administrative processing problems. Navigators should also help applicants with any post enrollment and renewal activities to ensure they are able to maintain coverage.

Example of Performance Standard: Navigators should assist a minimum of 40 individuals per FTE/month with a 75% successful enrollment rate within 3 months of an application's submission. Navigators must attempt to assist enrollees during redetermination at 11-12 months and achieve at least a 65% successful renewal rate.

***Case Management & Client Support*:** Upon completion of the initial application assistance, Navigators should follow-up with clients at prescribed intervals to ensure successful enrollment, determine utilization status, identify barriers, and work with them to resolve issues.

Example of Performance Standard: Navigators should conduct follow-up for:

- A verified enrollment within 60 days of application
- Utilization at 6 months following enrollment to determine if the enrollee has experienced any difficulty accessing services
- Redetermination or renewal at 11 months
- Retention at 14 months to verify continued coverage.

Information and Outreach: Navigators should provide information on all available health programs including enrollment procedures, required documentation, benefits, any applicable cost sharing, and appeals processes. Navigators should provide information to communities about coverage options in a variety of settings (e.g., fairs, schools, farmers markets).

Performance Standard: Navigators should communicate with individuals or families interested in applying for healthcare coverage within 5 days of the initial contact and make at a least 3 attempts to connect with the family for follow-up.

Support Clients in Accessing Other Non-Health Social Service Programs: Considering the multiple factors that impact health, such as access to healthy food, a safe living environment, and income security, navigators should provide families with as much support as they need to have a healthy quality of life. At a minimum, Navigators should provide consumers with basic information about eligibility for other non-health social services programs and refer patients to local or state resources. The Exchange website should help Navigators assess an individual's eligibility for other social services.

Example of Performance Standard: Navigators should be knowledgeable about and refer individuals to social service resources in the community.

The Navigator network should provide broad geographic access and be fully integrated in other enrollment pathways under the Exchange. With close to 5 million residents enrolling into coverage in 2014, some for the first time in a very long time, California must utilize the grant program to maximize access to Navigators based on population and demand throughout the State. The network of grant-funded Navigators must be fully integrated within other enrollment resources and pathways available through the Exchange. This should include the call center, web portal, health plans and program administrative structures and procedures. These resources should make lists of Navigators available by location, language, any special areas of expertise (e.g. tax credits, residency requirements) and hours of service. The State must also provide supplemental materials to answer more technical questions

consumers have about their coverage (e.g., application status, tax credit information, plan information) through the online website or by phone through voice-automated information. When more complex questions about coverage arise, consumers should be able to reach a Navigator who can provide the necessary information and address their needs whether by phone, in-person, or online through email or chat functions on the Exchange website.

Navigators should be required to provide services in line with existing state and federal Cultural and Linguistic Standards. California has some of the most robust language access standards in the nation. Therefore, California's Navigator program should adhere to existing state managed-care language access standards. This will require the Navigator program to provide information in threshold languages based on the Exchange, Medi-Cal, Healthy Families, and small business populations. Navigators must collect information from enrollees regarding spoken language and written language preferences and should capture information regarding an enrollee's literacy level. All documents should be written in plain and simple-to-understand language.[17] Additionally, California Navigators should adhere to the 14 cultural and linguistic access standards (CLAS) outlined by the Office of Minority Health, which set standards for delivering culturally competent care, language access services, and organizational supports for cultural competence.[18] Organizations applying for Navigator grants should be required to provide research that identifies the unique needs and barriers of the populations they intend to serve and to provide a plan for eliminating barriers in enrollment (e.g., language, literacy, geographic location, disability).

In addition, California should monitor aggregated demographic data and performance under the overall grant-funded Navigator system to ensure equitable representation across racial and ethnic groups. Funding should be allocated to increase enrollment of under-represented populations.

Other enrollment pathways should be strengthened and trained to work with Navigators to ensure individuals get the support they need to enroll in coverage. Consumers currently enroll into coverage through various means beyond what may be appropriate through the grant-funded Navigator program including healthcare providers, public agencies and health insurance brokers. These systems can play an important role in getting people covered.

*Community and Consumer Groups, Counties, and Providers and Community Clinic*s: All of these entities must continue to help uninsured individuals understand the various options and obtain health coverage. California should provide free training materials and information materials to help each of these entities inform consumers about ways to enroll including the Navigator program and available coverage, both for individuals and small businesses. Community groups, counties, small business associations/ organizations, and clinics can partner with Navigator programs to conduct education and enrollment events or make Navigator staff available in clinics, county offices, and community organizations by partnering with local Navigator entities.

Health Insurance Brokers and Agents: Recognizing the value and expertise that health insurance agents/brokers can offer the future Exchange-eligible population, especially small businesses owners, outside of a grant based program, the State should require that agents and brokers undergo comprehensive training regarding public coverage programs and Exchange coverage, including premium

[17] Centers for Disease Control and Prevention. Health Literacy Guidance and Standards. http://www.cdc.gov/healthliteracy/DevelopMaterials/GuidanceStandards.html.
[18] Office of Minority Health. National Standards on Culturally and Linguistically Appropriate Services (CLAS), http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15.

tax credits and cost-sharing subsidies. Steering is a central issue with agents and brokers who are not Navigator entities. Given that brokers and agents are not barred from receiving compensation from health insurance issuers for enrolling individuals into qualified coverage (unless they are a grant-receiving Navigator entity), California must create a monitoring system to prevent steering and adverse selection against the Exchange (i.e., a system that reviews broker/ agent compensation for enrollments into qualified and non-qualified health plans). While some agents and brokers may elect to become Navigator entities, not all will. At a minimum, the State should require brokers and agents to provide an assurance that they informed the applicant or small business owner about their eligibility for Exchange and public coverage options and will refer them to Navigators if they elect not to provide enrollment assistance.

Health Plans: Health plans should be required to undergo training on the public coverage options available in California and refer consumers to the Navigator program. In terms of private coverage, health plans should be required to provide consumers information about the Exchange, the Small Business Health Options Program, and available tax credits and subsidies if the individual is deemed eligible for such benefits. The Exchange should establish a process whereby qualified health plans are allowed to educate and assist consumers with enrollment much like the Healthy Families Marketing Guidelines established by the Managed Risk Medical Insurance Board. When possible, the Exchange and health plans should coordinate such outreach, education and enrollment activities.

The Navigator program should coordinate with other consumer assistance groups to provide effective, non-redundant services. Navigators should be required to have and demonstrate a strong knowledge of local and state consumer assistance resources to maximize their ability to serve consumers. As part of the application to become a Navigator entity, organizations should demonstrate the relationships and knowledge they have of other consumer assistance programs/ groups and highlight ways they intend to collaborate with those entities or utilize those resources in their work. One of the new duties of the Office of Patient Advocate should be to create a system for coordination and communication between consumer assistance programs (including Navigator entities) to share information about services, best practices, and to support consumers in enrollment, utilization, and retention of coverage.

The Exchange and other agencies (e.g., Health and Human Services, Department of Health Care Services, Managed Risk Medical Insurance Board, Department of Managed Health Care) should pool resources to provide funding for consumer assistance services. Ideally, this will help ensure ongoing and sustainable funding for customer support, eliminate redundancies, and encourage collaborative communication and consumer assistance strategies regarding various health services available to the State's residents.

Navigators should help individuals obtain information about non-health social services programs they may be eligible for. Considering the multiple factors that impact health, such as access to healthy food, a safe living environment, and income security, Navigators should provide families with as much support as they need to have a healthy quality of life. At a minimum, Navigators should provide consumers with basic information about eligibility for other non-health social services programs and refer patients to local or state resources. The Exchange website should help Navigators assess an individual's eligibility for other social services.

Qualification of Navigators

While we have recommended building upon the current third party assistor networks in California, the regulations provide the opportunity for numerous organizations to qualify for Navigator grants.

Whether California decides to distribute Navigator grants to entities in each of the categorical groups listed in the proposed federal rules or concentrate resources with a few select types of entities based on their work enrolling specific populations (e.g., groups working with small businesses, groups working with Medi-Cal beneficiaries, groups working with underrepresented communities), there must be an overarching requirement that all enrollment organizations undergo comprehensive training and demonstrate competency in the full range of at least public and individual coverage program eligibility and requirements.

Navigator entities should have previous experience and expertise in enrolling individuals or small businesses in coverage. Potential Navigator entities must be able to document their expertise and experience in enrolling individuals and/or small businesses into coverage. All enrollment organizations should be demonstrate strong knowledge of public and private coverage options available to consumers.

Navigator entities should reflect the diversity of the populations they serve to ensure appropriate access to care for all populations. Navigator entities must have cultural and linguistic competency. Grant-funded organizations must have experience assisting consumers and/or small businesses in different ethnic, cultural, and business sectors. They should have the capacity or ready access to resources for interpretation and translation, assist applicants with low or limited literacy, and help vision and hearing impaired individuals and those with disabilities.

Navigator entities should be exempt from licensing requirements. Federal guidelines give states the option of certifying or licensing entities selected to be Navigators. Navigator requirements in California should simply build upon local trainings and requirements for CAAs to establish a certification program that all enrollers must successfully complete to be authorized to enroll individuals in the Exchange. Navigators should be exempt from licensure requirements as it would create a cost disincentive and reduce the pool of individuals or entities eligible to serve as Navigators.

Entities serving as Navigators must meet a minimum set of criteria and training/certification requirements. Whether a community-based organization, a clinic, a broker or agent or a union, all Navigator entities must receive the same basic training regarding public coverage programs and other consumer assistance programs in order to provide assistance. The Exchange should only exempt training requirements if an entity can show that it has already met the requirements. The minimum training requirements should include:

- Program eligibility and application requirements
- Eligibility and process for receiving tax credits
- Consumer rights
- Scope and limits of basic program benefit
- Grievance and appeals procedures
- Selecting plan and providers
- Program premium, deductibles and cost-sharing requirements
- Application process, structure, and tracking systems
- HIPPA and confidentiality requirements
- Renewal and open enrollment procedures
- Consumer assistance services (local and state)
- Data management system training (statewide, county)
- Non-health data systems basic overview training

- Reporting standards
- Referral and troubleshooting protocols
- Cultural and linguistic standards
- Access standards for individuals with disabilities
- Conflict of interest standards
- Ethics training.

The State should also provide ongoing training in areas such as utilization of coverage (i.e., prevention and wellness), medical home education, interpretation assistance, and so forth.

Navigator entities should abide by clear and strict conflict of interest standards that ban steering practices and compensation outside the Exchange. As noted previously in this brief, while Navigators are barred from receiving compensation for enrolling individuals into qualified health plans, nothing precludes Navigators from receiving compensation for enrolling individuals into non-qualified health plans outside the Exchange. To prevent adverse selection against the Exchange, Navigators should be barred from receiving compensation for enrolling any qualified individuals into coverage outside the Exchange. Additionally, explicit rules against steering practices should be outlined in Navigator contracts. The Exchange or another designated entity should monitor enrollment practices by Navigators and take the necessary action (e.g., decertifying Navigators, eliminating contracts, instituting penalties) against entities found to be steering enrollment into a certain health plan.

Insurance Brokers and Agents

With millions of individuals turning to multiple sources to gain information about Medicaid, the Exchange, and local safety net services, the Exchange should actively seek to engage licensed brokers and agents in outreach, education, and training activities for the new consumer plans available in 2014.

Licensed brokers and agents should exhibit a strong knowledge of both public and private health programs in the State to help individuals enroll in the appropriate coverage. Acknowledging that not all brokers and agents will apply for or receive Navigator grant funding for enrollment activities in 2014, it is critical that brokers and agents be required to have an understanding of the coverage options available to consumers to promote the "culture of coverage" envisioned by the ACA. Agent and broker licensing requirements should be updated to include comprehensive training on Medi-Cal screening and enrollment, particularly for complex cases. The Exchange should provide continuing education credits to brokers and agents who complete this training. While the duties of Navigator grant funded and non-Navigator grant funded brokers and agents may vary, both should be required to give consumers information about *all* coverage options and at the very least refer individuals to the appropriate agency for enrollment support follow-up.

Brokers and agents enrolling qualified individuals and small businesses into non-qualified health coverage should be required to obtain written verification from the consumer acknowledging that he/she was informed of and willfully declined public coverage, qualified coverage, tax credits, and cost-sharing assistance (presuming one is eligible). Recognizing that not all brokers and agents will be Navigator entities, it is critical to ensure that individuals and businesses who qualify for but decline coverage do so willingly after receiving information about all available options. This will help protect consumers and prevent adverse selection against the Exchange.

Financial Guidelines

The ACA requires Exchanges to fund Navigator programs to help individuals enroll into coverage. Proposed federal regulations note that if Navigators provide direct assistance with Medicaid & Children's Health Insurance Program enrollment, states could seek a federal match for approved activities. The recommendations below relate to Navigator funding and compensation for health insurance brokers and agents both inside and outside the Exchange to prevent steering and adverse selection against the Exchange.

The Exchange should provide significant funding to support community-level outreach and enrollment activities in advance of open enrollment. With enrollment into the Exchange scheduled to begin in October 2013, financial support for community-level outreach activities in advance of open enrollment MUST be part of the Exchange's public outreach campaign. The Exchange, the Department for Health Care Services, the Managed Risk Medical Insurance Board, and departments overseeing other public programs (e.g., CalFresh, WIC, public schools) should ALL work collaboratively to educate consumers about coverage options that will exist in 2014. To the extent that these departments can pool funds for a broad-based outreach campaign, departments should work together to create resource materials that highlight multiple programs clients may be eligible for including health coverage options. By pooling resources, California will be better able to leverage federal and state dollars for outreach and create a wave of outreach assistance. The Exchange should consider launching these outreach and education activities by the summer of 2013 at the latest.

Navigator programs must receive ongoing and adequate funding that will help organizations provide comprehensive services, follow a set of standards and guidelines, and retain and build their workforce. To determine the amount and distribution of funding for Navigator programs, the State and Exchange should analyze what it would take to provide comprehensive services to the various populations eligible for coverage in 2014. Grants should be based on factors such as uninsured but Exchange-eligible populations, projected enrollment numbers, and other geographic concerns (e.g., "hard to reach" populations). Potential payments to enrollment entities should vary only in the degree to which organizations and agencies require additional support to meet the needs of the populations being served (e.g., interpretation, translation, transportation support, rural vs. urban settings).

Given the number of potentially eligible in California and their geographic concentration, it may be best for the State to take a county approach similar to the 2006 Children's Outreach, Enrollment, Retention and Utilization (COEUR) grants. In 2006-2007, the State allocated $19.68 million for counties to support outreach, enrollment, retention, and utilization (OERU) support for the Healthy Families and Medi-Cal program.[19] Contracts included collaboration requirements, a focus on the full spectrum of OERU services, and reporting requirements. Funding was allocated on two levels:[20]

> Level 1 allocations, which accounted for about 87% of the funds, were divided between the 20 counties who had the highest number of eligible but not enrolled children and the highest Healthy Families and Medi-Cal caseloads. Funds were distributed based on these figures.
>
> Level 2 allocations were given to counties that did not meet the level one criterion but could prove they had a coalition devoted to children's outreach and enrollment in existence for more than 12 months. Twelve counties received funding at varying amounts up to $288,000.

[19] State of California Department of Health Services, Healthy Families Program and Medi-Cal for Families Outreach Plan April 2006.
[20] State of California Department of Health Services, Healthy Families Program and Medi-Cal for Families Outreach Plan April 2007.

The COEUR model provides a tried method for distributing funds for OERU activities. The State should implement this model or a similar one to distribute funds across all 52 counties. Additionally, the State should allocate funding for broad training of organizations at varying levels of preparedness to become Navigator entities. Funds should also be set aside to support marketing and evaluation of the Navigator program.

The Exchange should capitalize on the ability to draw down additional federal dollars through Medi-Cal Administrative Activities (MAA). Federal proposed regulations note that if Navigators provide direct assistance with Medicaid & Children's Health Insurance Program enrollment, states can seek federal match for any approved activities. Currently, many counties and local schools are drawing down MAA funds to enroll children and families into coverage. MAA funds can be captured for Medi-Cal outreach, facilitating applications for Medi-Cal referral, coordinating and monitoring Medi-Cal services, and program planning and integrity coordination related to Medi-Cal services. The Exchange should maximize the amount of funds available for Navigator grants in order to make the program more robust.

Payment for enrollment assistance should be performance based. All enrollment work performed by entities, whether community/consumer groups, counties, health insurance agents/general agents, or providers/community clinics, should be funded through performance-based grants. Grants should be distributed to entities based on the enrollment demands (pool of uninsured individuals) in an area and the number of potential Exchange, Medi-Cal, Healthy Families and Basic Health Plan enrollees. Entities must show evidence of successfully engaging a certain percentage of the population in enrollment activities as well as providing the scope of work required of Navigator entities as outlined in this brief. Health plans should not be allowed to receive funding for enrolling qualified individuals and small business owners into qualified health plans.

Compensation to brokers and agents for enrolling individuals and businesses into qualified and non-qualified health plans should adhere to a standardized policy. As is the practice now, health insurer payments to brokers and agents should be allowed under the condition that the agent is not a Navigator. The Exchange should require health plans to standardize compensation for enrolling qualified individuals into qualified and non-qualified plans. Additionally, the Exchange should require health plans to provide the same compensation per benefit plan (see following chart). This will deter steering individuals into products outside the Exchange and will prevent steering individuals into certain health plans. Health issuers found in violation of this requirement would be fined or prohibited from selling insurance products in California.

Example of Broker and Agent Compensation Inside and Outside the Exchange

(Amounts listed are examples of compensation, not recommended or actual compensation levels.)

	Qualified Health Plan (Inside the Exchange)		Non-Qualified Health Plan (Outside the Exchange)	
	Bronze Plan A	**Bronze Plan B**	**Bronze Plan A**	**Bronze Plan B**
Qualified Individual/ Business	$20	$20	$20*	$20*
Non-Qualified Individual/ Business	Up to Health Plan		Up to Health Plan	

** Broker/ agent would be required to obtain consent from the individual/ small employer acknowledging he/she willingly and knowingly chose to forgo tax credits and cost-sharing subsidies offered by the Exchange for coverage outside the Exchange in non-qualified health plans*.

The Exchange should provide a fee-for-service compensation for enrolling small businesses or individuals into the Exchange. The Exchange should establish a fee-for-service compensation model to incentivize eligible non-grant funded organizations (i.e., CAAs, brokers/ agents, CBOs, etc.) to assist consumers with enrollment ONLY if the Exchange has a surplus of funds after fully funding the State's Navigator program. The Exchange may establish a model similar to CAA reimbursements provided by the State under the Medi-Cal and Healthy Families managed care program prior to 2010. The fee would not be payable for enrolling small plans or individuals in plans outside the Exchange. Should a fee-for service policy be implemented, the Exchange should regularly monitor and evaluate enrollment completed by brokers and agents taking into account compensation by plans to guard against steering.

Conclusion

The historic passage of the Affordable Care Act in 2010 gave millions of Californians the peace of mind that they would be able to get the coverage they need, when they need it. California's uninsured encompass all walks of life across all ages, races, ethnicities, family size, employment status, income, and immigration status. To realize the promise of reform for 4.7 million uninsured residents, California must develop a strong and sustainable enrollment system that meets the varying and particular needs of individuals and small business owners.

While a number of new tools will be available to consumers to facilitate enrollment, Navigator entities will be the face of enrollment not only in 2013 but beyond. Policymakers must ensure that the Navigator program leverages and strengthens existing enrollment pathways. Even more importantly, the Navigator program must expand the support provided to consumers and businesses to ensure meaningful access for all, particularly low-income communities and communities that have traditionally gone without care because of the lack of adequate enrollment assistance. Only by developing an active and robust Navigator program will California truly be able to establish a culture of coverage for all Californians.

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