Getting Health Care Consumers the Help They Need: Streamlining California's Fragmented Consumer Assistance Systems

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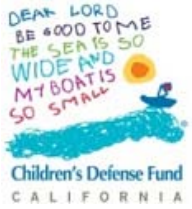

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Introduction

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (ACA), the largest expansion of health coverage since the passage of Medicaid in the 1960's. Wide-ranging and broad in scope, the ACA seeks to provide health coverage to the millions of uninsured Americans, including the over 7 million uninsured in California.[1] The ACA expands Medicaid (Medi-Cal in California) and creates a purchasing pool, called the Exchange, in order to provide access to health insurance coverage that is easily comparable, meets minimum standards, and is competitively priced. The Exchange will also offer tax credits for monthly premiums and subsidies for cost sharing to people with an income below 400% of the Federal Poverty Level (approximately $89,400 annually for a family of three).

California has been a trendsetter and was the first state in the nation to establish its Exchange under the new law - an important building block to expand coverage to millions of uninsured Californians. Other key components of health reform implementation include expansion of the Medi-Cal program, guaranteed issue of health coverage, and greater regulation of health plan benefits and pricing.

Considering that 4.7 million of those who will become eligible for health insurance through the ACA have been uninsured for at least a year,[2] California must meet the needs of this population. Many are low-income, have not had access to employer-based coverage, do not currently meet the criteria to qualify for public health coverage, and have limited English proficiency. The newly-eligible will need additional assistance in obtaining answers to general questions about coverage, helping to get enrolled in the right program, choosing the most appropriate health plan for their needs, accessing care, and staying enrolled. In fact, all Californians will need these services.

The state and many private organizations currently provide a patchwork of services to offer assistance to individuals seeking health coverage or with problems with their health coverage, but the systems of delivery are siloed and fragmented. Therefore, a central means of connecting consumers to assistance is needed at the state level. A unified, streamlined, and consolidated approach provides the blueprint for keeping Californians covered and healthy.

Existing Structures Have Holes and Lack Coordination

California has two different government bodies that regulate health coverage products - the Department of Managed Health Care (DMHC), which oversees managed care plans (e.g., HMOs and some PPOs) and regulates the vast majority of health plans in the state and the California Department of Insurance (CDI), which oversees life, home and auto insurance regulation, in addition to health insurance, and represents just under 11% of the insured population.[3] DMHC's chief officer is appointed by the Governor and CDI's is publicly elected.

In addition to DMHC and CDI, two agencies oversee public health benefit programs - the Department of Health Care Services (DHCS), which administers the Medi-Cal program and the Managed Risk Medical Insurance Board (MRMIB), which administers California's Children's Health Insurance Program (known as Healthy Families), Access for Infants and Mothers (AIM), as well as the Pre-existing Condition

[1] Kaiser Family Foundation, California State Health Facts. 2009. Available at: http://www.statehealthfacts.org/profileglance.jsp?rgn=6&rgn=1

[2] Pourat, Nadereh, Christina M. Kinane & Gerald Kominski, *Who Can Participate in the California Health Benefit Exchange?* UCLA Center for Health Policy Research, May 2011. Available at: http://www.healthpolicy.ucla.edu/pubs/Publication.aspx?pubID=500

[3] Kelch, Deborah Reidy, Brent Barnhart & Margaret Ballo, *Ready for Reform? Health Insurance Regulation in California Under the ACA*. California Health Care Foundation, June 2011. Available at: http://www.chcf.org/publications/2011/06/health-insurance-regulation-aca

Insurance Plan (PCIP) and Major Risk Medical Insurance Program (MRMIP). Medicare is also available to seniors and some persons with disabilities, but is a federally administered program. Consumers in self-insured plans must go to the Department of Labor and federal employees to the Federal Employee Health Benefit Program.

Each of these entities provides information and resources to consumers with questions about or problems with their health coverage and each program has a different application as well as different grievance and appeals processes. In some instances, private vendors are used to determine eligibility or collect premiums, activities where errors can occur and cause a consumer to be improperly denied or overcharged. Even within the Medi-Cal program, several options exist for consumers when they experience problems, need to find a provider, or have eligibility and enrollment questions. A Medi-Cal consumer enrolled in a managed care plan with a service problem can either go to the Medi-Cal Managed Care Ombudsman or the Department of Managed Health Care. These entities do not have streamlined processes for communicating amongst and between the agencies about the problems or questions consumers have. Medi-Cal beneficiaries in the fee-for-service system have nowhere within the governmental agencies to go for help with problems accessing care. This fragmented system for consumer assistance is far too complicated for consumers and creates too many places for people to fall through the cracks.

Government Entities Providing Consumer Assistance on Health Care:

- HMO HelpLine: Assists consumers in managed care plans and some PPO plans
- Medi-Cal Managed Care (MCMC) Ombudsman: Assists Medi-Cal consumers in managed care plans
- Department of Insurance (DOI) Consumer Hotline: Assists consumers in some PPO plans, as well as auto, life, property, and personal insurance
- Department of Labor (DOL), Employee Benefits Security Administration: Assists consumers with their job-based coverage
- 1-800-Medicare: Assists Medicare beneficiaries
- County welfare offices: Assists consumers in public health programs administered through the county, such as Medi-Cal, CalFresh, CalWORKs, and others
- Office of the Patient Advocate (OPA): Provides educational resources on health plans regulated by the Department of Managed Health Care
- California Health Benefits Exchange: Starting in 2014, will help consumers with questions and complaints regarding health plans administered by the Health Benefits Exchange
- Federal Employees Health Benefits Plan for federal employees

In addition to the government agencies that provide assistance, several existing nonprofit entities help consumers at the community level, providing assistance in locations, cultures, and languages that are appropriate for the consumers. However, ongoing funding problems have made it difficult to expand services to all areas of the state or simply maintain existing services.

Private, Community-Based Consumer Assistance Programs:

- Health Consumer Alliance (HCA): Provides start-to-finish assistance for low-income health consumers, regardless of how they get their health coverage. Can provide a full range of assistance with public programs such as Medi-Cal and Healthy Families or commercial coverage. Assists with enrollment, grievances, and medical requests, eligibility counseling and problems, billing problems and other issues

- Health Insurance Counseling and Advocacy Program (HICAP): Provides comprehensive assistance to Medicare beneficiaries
- Certified Application Assistors (CAAs): Generally based in community settings like family resource centers, schools, and churches, CAAs provide a range of enrollment and education services for children's public health plans like Medi-Cal and Healthy Families, among others. Some CAAs are based in Children's Health Initiative organizations, which are county-based non-profit organizations that are dedicated to covering all children in that area.

A New Vision for Comprehensive Consumer Assistance

California's fragmented system of health consumer assistance is long overdue for reorganization. In order to serve the variety of consumers who need health coverage, there should be one convening body that does not supplant, but rather complements the existing sources of assistance. In September 2011, California Governor Jerry Brown signed AB 922, which increases the duties of the existing Office of the Patient Advocate (the Office) and provides the Office with the authority to coordinate consumer assistance responsibilities so that all Californians have access to the "one stop shop" they need when looking for help with their health plans. As envisioned in the enacted bill, the Office will operate a statewide toll-free hotline and website, and provide referrals to community -based organizations to assist health consumers, as well as to existing state agencies that have regulatory authority over germane health plans.

The Office's duties will include:

- Developing educational guides for consumers describing their rights and responsibilities and informing them of effective ways to exercise their rights to secure health care coverage and services. The office should make extra efforts to inform hard-to-reach populations, such as those people who are limited English proficient, persons with disabilities, and the homeless.
- Compiling data from other state and local entities and preparing an annual publication to be made available online that provides a quality of care "report card." The report card should include ratings on quality for health plans, provider networks and hospitals, and should come from a consumer-based perspective that includes information on the number and types of grievances and resolutions, language services, and timely access to care.
- Providing outreach and education about health care coverage options, including but not limited to information regarding the cost of coverage and education about how to navigate the health care arena, including what health services a plan or insurer offers or provides, how to select a plan or insurer, and how to find a doctor or other health care provider.
- Advising consumers regarding eligibility for health care coverage and directing them to the proper offices or agencies for enrollment and retention in, and transitions between, health coverage programs.
- Advising and assisting consumers with problems related to health care services, including care and service problems, denials, delays, and claims or payment problems. The Office will explain how to resolve these problems and provide direct assistance, if needed.
- Advising and assisting consumers with filing of complaints and appeals, including both internal and external grievance and appeals processes.
- Advising and assisting consumers with resolving problems with obtaining premium tax credits or cost-sharing subsidies in the Exchange.
- Additionally, the Office may oversee a training and certification program for the non-profit and community-based organizations that are authorized to contract with the Office

to provide direct consumer assistance. There should be training and certification standards in place that organizations would have to meet. This should include an overview of health programs and agencies, remedies for problems, finding provider networks, tools for helping consumers with grievances, and requirements for reporting data back to the Office. The Office would be able to sever a relationship or agreement with these organizations should they not meet certain benchmarks or make serious errors.

The Importance of Local Assistance

While a number of Californians will have no problems accessing the Office via the phone or internet, many health consumers will need an in-person encounter in order to adequately serve their needs – or will need to talk to a bilingual advocate who works in the community and can help them navigate local resources. A need will remain for access to in-person and locally-based assistance with enrollment and eligibility questions, and problem solving. Community-based organizations throughout California already perform many of these services and are well-suited to do so with increased responsibility.

The best way to receive these services is through independent consumer assistance that can provide vigorous advocacy and can utilize the individual experiences to identify and address systemic barriers that will help many people at once. The Office of the Patient Advocate should prioritize the use of referrals to existing high-quality, locally-based programs to provide some consumer assistance, and make it a priority to refer certain vulnerable populations for this assistance. Independent consumer assistance should be provided by organizations that have a history of successfully working on health care access issues for these populations, have capacity for providing legal assistance, and can address system-wide barriers.

The value of local assistance is that by working on individual cases, local advocates can identify and address systemic barriers, both at the locally and through a strong alliance across the state and federal levels. When employing independent organizations in the provision of consumer assistance programs, the most successful and effective models have been based on three principles: independence, legal advocacy, and a focus on systems change. Consumer assistance must be focused on the consumer and cannot be governed by or under the control of any party with a financial interest in the provision of care. Legal champions play an integral role as well, as consumers could need a range of assistance including help with applications, addressing problems with utilization, and ensuring due process for federally entitled benefits. Lastly, consumer assistance requires the capacity to identify barriers within the structure and operations of the health care delivery system and to advocate for systems changes that will address those barriers. Consumers must have an effective voice at the table with the capacity to take affirmative actions that will protect and enforce consumers' rights.

Over three million of the newly-insured in California will be eligible for Medi-Cal.[4] Many of those otherwise eligible will have little to no experience with the public or private insurance markets or existing systems of coverage. The Office should take into consideration the specific needs of this population by contracting with community-based organizations that help people locally who might not be comfortable with using the internet or a statewide hotline to seek assistance. The "hub and spokes" approach has been effective in other states throughout the country. In such a model, one main agency coordinates with other community organizations to assist health consumers. There is a central database administered by a main non-profit that is used for data and information sharing that is secure and password-protected. The staff within the central agency work closely with other community-based organizations to coordinate program work, provide technical assistance, training, case review, data collection, and facilitating multi-agency

[4] Pourat, Nadereh, Christina M. Kinane & Gerald Kominski, *Californians Newly Eligible for Medi-Cal under Health Care Reform*. UCLA Center for Health Policy Research, May 2011. Available at: http://www.healthpolicy.ucla.edu/pubs/Publication.aspx?pubID=501

meetings to discuss trends and systemic issues. The central agency also operates a help line for consumers to call when they have pressing problems or need referrals to local assistance.

New York's "hub and spokes" model is just one example of how community-based organizations throughout a large geographic area can maintain uniform standards for service and stay in contact with referring and data-collecting agencies. Although the vision presented here includes a publicly-based, government-administered "hub" as opposed to a private, non-profit group, this is a valuable way to think about the design of a consumer assistance model that needs to serve approximately 36 million Californians from all areas of the state.

Locally-based consumer assistance duties should include, but not be limited to, the following:

- Assisting consumers in navigating the local health care system
- Advising consumers regarding their health care coverage options and helping enroll consumers in and retain health care coverage
- Assisting consumers with problems in accessing health care services
- Serving consumers with special needs, such as those with limited English language proficiency, people requiring culturally competent services such as refugees and elderly immigrants, low-income communities, persons with disabilities, consumers with low literacy levels, homeless individuals and persons with multiple or chronic health conditions
- Collecting and reporting data on the consumers they assist. Important data elements include: information on subgroup categories of race, ethnicity, language preference, income, and information on the types of health care coverage problems consumers face, the resolution of their problems, and timeliness of responses to requests for help
- Furnishing independent legal assistance and providing input and feedback to health policy decision makers at the local, state, and federal levels; ensuring that consumers are the focus, and that those consumers have access to legal opinion and representation should serious problems arise

Quality and Accountability

High-quality training and certification are necessary components of any consumer assistance program. Assessing and determining eligibility, pricing, benefits packages, and grievance processes are complicated activities which many health consumer groups can perform. The accountability of community-based organizations is vital in ensuring high-quality assistance that is timely, thorough, and completely accurate.

There are a large number of health coverage programs which have different eligibility prerequisites. Eligibility rules will change with the implementation of the ACA, so it is important to keep locally-based health consumer assistance centers up-to-date with program changes, and training must be a critical component of any consumer assistance program. In Los Angeles County, the Department of Public Health (DPH) executes a joint contract with a community-based advocacy organization that has policy expertise and a legal services provider. These groups serve as the experienced trainers to conduct an in-depth training curriculum, known as "the CORE", for other community-based organizations that is more comprehensive than the state-required training for Certified Application Assistants.

The two-day training is in addition to California's requisite online certification training. For organizations that are contracted to perform consumer assistance duties, the Los Angeles curriculum is part of each staff member's individual requirements to maintain a contract through DPH. Agency coordinators are

responsible to ensure that their staff attends updated trainings every two years or sooner if new program requirements are established. These requirements were created by Los Angeles County DPH-Children's Health Outreach Initiatives (CHOI) in consultation with community stakeholders.

The training is provided to staff of health and social service organizations, such as clinics, schools, hospitals, community agencies, and insurance brokers who need to know how to guide people through enrollment and use of health care programs that are increasingly complex and reliant on managed care. The CORE curriculum is presented from an advocacy perspective and covers eligibility criteria, the enrollment process, how to stay enrolled, the scope of services provided, how the programs interact (or do not) with each other and how to advocate for oneself and for another person when problems exist. The forms and other paperwork used are included.

Those who take the training then have access to technical assistance from the lead agencies. Additionally, the lead agencies provide updated training, direct outreach and enrollment services, and extensive troubleshooting and advocacy, and staff have the ability to provide assistance to contractors and outside organizations experiencing problems with specific client cases. In so doing, community groups can identify and address systemic issues that need attention from the state, county, or other administrative bodies."

Los Angeles County's in-depth training program provides a model for accountability and reliability as California attempts to enroll millions of new consumers in health care. As previously stated, many of the newly insured will have had limited access to health care delivery and coverage systems, and dependable assistance will ensure their transition from uninsured to insured. This model can be adopted in California as a similar public-private partnership, overseen through a state-based office that is duty-bound to consumers.

Interaction with the Affordable Care Act

Over the next several months, consumers and consumer advocates will have the opportunity to weigh in on important regulations promulgated by the federal government dealing with the establishment of Exchanges and the implementation of the ACA. Large decisions impacting millions of Californians are at stake, including policies on how to establish income and eligibility in the Exchange, what benefits will be required, as well as what consumer assistance functions will be required in the Exchange.

Within the consumer assistance functions of the Exchange, there is considerable room for flexibility in how the state creates a consumer assistance program. Navigators, whose role is explained in detail below, will comprise just one component of this, but states have the opportunity to go beyond the minimum federal requirements and use available funds to leverage and expand existing consumer assistance programs. It is important to remember that the Exchanges are but one component of the Affordable Care Act, and though consumer assistance programs must be embedded in the Exchange, those programs should be linked to health coverage options outside of the Exchange.

Distinguishing the Role of Navigators

The ACA requires that Exchanges establish a "navigator program" and award grants to "navigator entities" to help connect consumers to the Exchange. Various entities are likely to qualify for such grants. To qualify to be a navigator under federal law, an individual or entity must be able to demonstrate existing or readily established relationships with stakeholder groups in the Exchange such as employers, employees, consumers (including uninsured or under-insured), and/or self-employed persons. As outlined in draft regulations for the Exchange, navigators may also likely come from specialized perspectives such as trade industry and provider associations, chambers of commerce, unions, insurance

agents or brokers, and community-based organizations. No one entity or group of individuals should have exclusive responsibilities for the navigator role. Given the large number of newly-insured consumers, it is particularly important that navigators have broad knowledge of the full range of health care options, though navigators will likely not assist the full range of consumers envisioned in the comprehensive model outlined in this brief.

Navigators must be able to perform the required duties under section 1311(i) of the ACA such as:

- Provide education and outreach
- Distribute fair and impartial information about qualified health plans and availability of cost-sharing reductions and tax credits
- Facilitate enrollment in qualified health plans
- Provide referrals for grievances, complaints or questions about health plans, coverage or determinations made under plans or coverage
- Provide culturally and linguistically appropriate information for consumers

These requirements are mirrored in California's Exchange statute, Government Code section 100503.

The new Office could serve as a home for the federally-required navigator program and provide that assistance for individuals eligible for coverage through the Exchange. For example, the requirements to certify qualified navigators can be included as part of the oversight, certification and training functions of the Office. The training functions of the Office could provide the breadth of understanding of health care options necessary for all navigators to have, despite their specialized focus on products offered through the Exchange.

The training can be adapted and expanded for the Navigator Role and include a more detailed legal and ethics component. Many of the organizations likely to serve as navigators, such as community organizations, consumer groups, and legal services programs, can be connected to potential Exchange enrollees through the Office's referral system, while the navigators can also refer people who need higher levels of assistance to the Office for further help with grievances and other problems with health access.

California can lead the way in developing a navigator program that works with the Office in meeting the new obligations of health reform. As further guidance emerges from the federal government, the Office could provide a strong foundation by which the Exchange Board could base its design of the navigator program.

Pulling It All Together

Health consumer assistance does not have to be the complicated, multi-layered system it currently is. The ACA requirement that consumers obtain health coverage begs the question: how can existing models work together to help health consumers get the help they need? Establishing a central office that provides coordinated assistance to consumers and uses trained community-based advocates is the right step for California to help over 36 million Californians obtain the health care for which they qualify.