Consumer Assistance/Ombudsman Support Options

Summary

The California Health Benefit Exchange is planning a broad range of outreach and support for consumers to help them enroll in coverage and access their benefits, including web-based support, and Service Center and in-person support through Navigators and assisters. Through these outreach and support services, the Exchange will enable consumers to address enrollment and access issues simply and quickly. The Exchange understands, however, that additional assistance for regulators and other partners may be needed to resolve complicated issues. Independent consumer assistance/ombudsman programs can be another important source of help for consumers and a way to identify systemic issues such as problems with eligibility determinations, grievances and appeals, and benefits and coverage. This Board Recommendation Brief focuses on the strategy proposed by Exchange staff to provide assistance to consumers who encounter problems.

Issue

The Exchange believes it is critically important to ensure that individuals who have problems at any point in the process of enrolling in or accessing care get timely resolution to their concerns and have appropriate support. Information on the nature of problems individuals experience can be used for continuous quality improvement. Complaint and problem monitoring systems will be important sources of information for the Exchange to identify system problems. The Exchange will develop a strategy to provide needed problem resolution informed and strengthened by the findings of ongoing monitoring to build a culture of continuous improvement.

Principles for Consumer Assistance/Problem Resolution

For successful consumer engagement and problem resolution, the Exchange proposes the following guiding principles:

- Build systems that foster “one-touch and done” capabilities to quickly resolve consumer concerns and minimize the number of “hand offs” between different entities.
- Resolve problems at the “lowest level”, as often as possible. If a problem is between the consumer and the health plan, the health plan should take responsibility for resolving the issue. Elevation of problems should be the exception, not the norm.
- Collect information on problems and complaints to be used for system improvement (regardless of who handles the problem).
- Consider cost-effectiveness for consumers and purchasers when developing systems. Build on existing consumer assistance programs to lower support costs.
- Ensure that individuals have access to independent assistance when needed. Health plans must be held accountable for problem resolution, but consumers should also have the ability to access help outside of their health plan, including through the Exchange, from regulatory bodies and from independent consumer assistance programs.
- Establish formal appeals processes as appropriate and required in state and federal law.

Under any circumstance, consumer assistance services complement, but do not take the place of, effective and efficient customer service and dispute resolution processes the Exchange must provide for eligibility and enrollment issues.

Background

Existing Consumer Assistance in California

Consumer assistance in California is provided by health plans, plan sponsors (e.g., employers) as well as regulatory and independent non-regulatory entities. Each of these entities provides information and resources to consumers who have questions about, or problems with, their health coverage. The following are examples of existing sources of consumer assistance:

- Health plans provide customer service support to help enrollees resolve problems.
- The California Department of Insurance (CDI) regulates indemnity-based insurance policies and the California Department of Managed Care (DMHC) regulates managed health care plans. Both have consumer assistance functions reachable through the Internet and toll free phone numbers.
- The Medi-Cal Managed Care ombudsman provides consumer assistance to people in Medi-Cal managed care plans, helping resolve issues between Medi-Cal managed care members and health plans including appropriate referrals to DMHC.
- HICAP (the Health Insurance Counseling & Advocacy Program) provides free and objective information and counseling about Medicare.
- Legal Services/Health Consumer Alliance (HCA). HCA is composed of nine health consumer centers serving 13 counties that help low-income consumers with a range of assistance with public programs and commercial coverage including eligibility and enrollment, grievances, medical requests, and billing issues. The National Health Law Program (NHeLP) provides statewide support to the nine centers.

In addition to the formal consumer assistance entities listed above, consumers may receive assistance from other entities including health insurance agents and employers' HR departments. Agents can play a front line role in assisting individuals and businesses with explanations of insurance and health plan coverage and helping resolve claims questions and issues such as claim denials. For group health plans purchased through employers large enough to support in-house human resource staff and departments, HR staff provide employees assistance with health plan choices and enrollment and explaining terms of coverage to employees.

Office of Patient Advocate

In September 2011, Governor Jerry Brown signed AB 922, which effective July 1, 2012, creates Office of Patient Advocate (OPA) within the California Health and Human Services Agency. The role of the OPA is to assist individuals to secure health care services from insurance and health care service health plans and those eligible for Medi-Cal, the California Health Benefit Exchange, the Healthy Families Program, or any other county or state health care program. In

addition, AB 922 requires the OPA to develop in consultation with the Managed Risk Medical Insurance Board, the Exchange and the departments of Health Care Services, Managed Health Care, and Insurance, educational and informational guides for consumers describing their rights and responsibilities and informing them on effective ways to secure health care coverage. AB 922 also requires these entities and other public coverage programs to provide the OPA aggregate data concerning consumer complaints and grievances.

Consumer Assistance Program Funding in the Affordable Care Act

The Affordable Care Act created a $30 million Federal grant program for consumer assistance programs providing health care information and services. In 2010, the DMHC was awarded $4.1 million to support consumer assistance. The grant funds are being used to assist in the creation of a coordinated seamless point of entry for Californians needing consumer assistance regarding their health care. DMHC and the HCA entered into a partnership funded by $2.1 million dollars of the Federal grant covering the period January 11, 2012 to October 14, 2012. Specifically, the funding was distributed to five regional community based organizations (CBOs) that are part of the HCA, which use the funding to:

- Assist consumers in obtaining health coverage;
- Assist consumers with internal and external grievance and appeal processes;
- Accept referrals from the Help Center;
- Conduct outreach to local groups regarding the expansion of health care coverage and programs under the ACA;
- Develop training materials for CBOs and staff of consumer assistance programs;
- Collect and report data on consumers' issues and outreach events.

In August 2012, the federal Center for Consumer Information and Insurance Oversight (CCIIO) awarded DMHC, in partnership with the CDI and the OPA, $4.6 million in a second round of grant funding to continue to support consumer assistance programs for the period of August 23, 2012 to August 22, 2013.

There is the expectation that state-based Exchanges should support their enrollees in getting needed services. In addition, there is an opportunity for state Exchanges to provide limited support for independent consumer assistance activities with establishment grant funding. Guidance released by CCIIO indicated that States may include independent consumer assistance functions and activities in requests for establishment funding, so long as states demonstrate that all such activities are integral to an Exchange. (See reference list below to access the guidance.)

Options for Consideration

Consumer Assistance Service Models

Exchange staff considered four models for assuring consumers have access to robust consumer assistance which range from developing consumer assistance capacity within the Exchange to

partnering with existing regulatory and non-regulatory consumer assistance entities. The options are summarized here and described in more detail in the table below.

Option 1: Refer to existing regulatory entities. Under this option the Exchange would minimize its role in consumer assistance by referring enrollees to existing state regulatory agencies for consumer assistance for matters related to care and services of plans contracted by the Exchange.

Option 2: Establish internal non-regulatory assistance capacity within the Exchange. Under this option, the Exchange would create, fund, and staff its own non-regulatory consumer assistance services for Exchange enrollees but would not support external independent referral or assistance processes.

Option 3: Partner with regulatory entities and provide interim support for non-regulatory independent assistance. Under this option, the Exchange would partner with the DMHC and CDI to expand the scope of existing consumer assistance functions to assure that Exchange enrollees and eligible individuals have access to independent consumer assistance services.

Option 4: Contract directly with non-regulatory independent consumer assistance programs. Under this option, the Exchange would directly fund expansion of the services provided by non-regulatory independent consumer assistance programs to Exchange enrollees and eligible individuals.

Recommendation

Exchange staff recommend adoption of Option 3, with additional implementation steps discussed below. Under Option 3, enrollees who contact the Exchange for assistance in resolving their problem will be served by the Exchange Service Center staff, and may be transferred to their health plan's complaint unit or to the appropriate State regulatory entity. Enrollees of DMHC-regulated health plans would be referred to the DMHC Help Center and those in CDI health plans will be directed to contact the Consumer Hotline.

Complaints and inquiries would be handled consistent with existing state regulatory standards, and the Exchange would work with the regulators to define roles and responsibilities. The Exchange would also provide training to regulatory staff on Exchange-related issues such as actuarial tiers and benefit structure. The Exchange would coordinate with the existing programs to provide common protocols and training materials to train and support program staff to handle issues related to qualified health plans.

As part of this process, the Exchange would partner with DMHC, CDI, OPA and independent consumer assistance programs to develop common metrics related to assessing the types of consumer problems, problem resolution and standards to measure the effectiveness of services provided. The Exchange will also work with these organizations to develop appropriate questions to determine whether the consumer is receiving coverage through the Exchange.

Option 3 builds on the current DMHC review, selection, monitoring and funding distribution process, which has focused on maximizing assistance to low income and non-English speaking communities and is consistent with Exchange priorities and goals. As part of this support, the Exchange would work with DMHC to assure the CAP funding recipients would collect and report on problems faced by Exchange eligible and enrolled individuals – in particular providing for regular updates during the early launch and enrollment processes to provide fast response and inform the quality improvement process.

In support of Option 3, Exchange Staff recommends the Exchange join with the DMHC to provide additional support for CAP-funded community-based organizations. These resources will fund initial infrastructure and capacity building prior to open enrollment in October 2013 and consumer assistance service funding once open enrollment begins. Subject to availability of CAP funding beyond 2013 and approval of federal Exchange Establishment support, the Exchange proposes to request $1.85 million to be allocated as follows:

- $700,000 from January 1, 2013 through September 30, 2013, to support CAP funding recipients in developing capacity to provide assistance with Exchange eligibility determinations and coverage issues prior to 2013 open enrollment; and
- $1,150,000 from October 1, 2013 through December 31, 2014, for CAP funding recipients to provide consumer assistance to Exchange-eligible individuals starting with the Exchange open enrollment period through the end of 2014.

The recommended funding amount is based on the recently-awarded CAP grant of $4.6 million for the 12-month period August 2012-August 2013. While only $2 million of that amount is planned for distribution to community-based groups, staff recommend using the total grant funding as the base for Exchange consumer assistance support. Exchange staff recommend providing 20 percent of the CAP grant amount, or $925,000 annually, to be directed to CAP-funded organizations. (See Table 2 for a discussion of funding considerations.) This funding level is based on the following factors:

- Exchange subsidy-eligible individuals comprise 10 percent of health plan covered lives regulated by DMHC and CDI; and
- Assumption that Exchange subsidy-eligibility individuals will seek services twice as often as individuals with other types of coverage in the initial years of the program.

After the two-year period 2013 through 2014, the Exchange staff will evaluate the consumer assistance program and recommend to the Board any changes deemed necessary in the service model or funding amount. During this period, the Exchange will also provide $40 million in outreach and education grants to community-based organizations to provide additional consumer support in understanding coverage options and enrollment opportunities.

<u>Consumer Assistance Service Models not Recommended</u>

Option 1 was not recommended as it would not provide for sufficient engagement of the Exchange in important consumer assistance functions. Option 2 was not recommended

because while the Exchange must develop some capacity in its Service Center to identify and resolve problems, it should also be sure to use existing consumer assistance functions. Finally, staff concluded that Option 4 was not a viable option because the Exchange did not believe developing its own capacity to screen and assess independent consumer assistance programs and would be better served relying on existing capacity of DMHC to review and select independent consumer assistance programs.

Implementation Considerations

If Option 3 is adopted, the Exchange will work with DMHC, CDI and other partners and stakeholders to:

- Define the roles and responsibilities of each entity with respect to the scope of consumer assistance provided, the capacity developed to serve Exchange subsidy-eligible individuals, data and information to be shared, and processes for tracking cases across systems to ensure appropriate follow up and problem resolution for the consumer.
- Develop common performance metrics for use by the Exchange, regulators and non-regulatory entities in evaluating the effectiveness of consumer assistance services, the coordination among entities and consumer outcomes.
- Develop training and referral protocols for state partner staff and the Exchange service center.

Table 1. Consumer Assistance Options			
Option #1 **Refer to existing regulatory entities**	**Option #2** **Establish internal non-regulatory assistance capacity within the Exchange**	**Option #3** **Partner with regulatory entities and provide interim support for non-regulatory independent assistance**	**Option #4** **Contract directly with non-regulatory independent assistance**
SUMMARY All consumer assistance/ ombudsman functions would be provided by CDI and DMHC.	**SUMMARY** Exchange would create, fund, and staff its own consumer assistance center for Exchange enrollees.	**SUMMARY** Exchange would partners with the appropriate regulatory agencies (CDI, DMHC) to make customer referrals and would expand the scope of existing consumer assistance functions to include Exchange enrollees.	**SUMMARY** Exchange would contract with and provides funding to the HCA to expand its current resources to handle direct referral of Exchange enrollee issues.
PROS ▪ Requires no Exchange resources. ▪ Utilizes existing health plan issuer regulator consumer assistance/ombudsman services.	**PROS** ▪ The Exchange would have a robust and engaged process, along with more control for accountability and outcomes. ▪ Easy to monitor quality of customer service and track performance metrics. ▪ Staff would be trained to focus entirely on Exchange-specific issues. (Non-Exchange consumers directed to the appropriate regulatory agency for assistance).	**PROS** ▪ Cost-effective from the standpoint that the Exchange would utilize existing infrastructure and resources. ▪ Utilizes existing knowledgeable, trained staff that could be further trained on Exchange-specific issues. ▪ Utilizes existing consumer assistance programs prevents further fragmentation of consumer assistance in California.	**PROS** ▪ Provides unique “on the ground” assistance to low-income consumers. ▪ Utilizes existing knowledgeable staff who could receive additional Exchange-specific training. ▪ Lessened administrative burden to Exchange relative to Exchange-provided services.

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CONS ▪ Does not promote Exchange core values of partnership and being consumer-focused. ▪ Does not allow the Exchange to directly obtain information from enrollees on issues and problems they may be encountering with health plans offered through the Exchange, providing useful information for development of health plan issuer conditions of Exchange participation.	**CONS** ▪ Presumably the most costly option, as the Exchange would have to develop the entire infrastructure and provide all administrative resources and training. ▪ October 2013 deadline to be operational may be infeasible with current staff and resources. ▪ Unclear how an Exchange-run system would function alongside existing programs.	**CONS** ▪ Exchange would have to coordinate with other programs to effectively monitor assistance provided to Exchange enrollees and develop common metrics to evaluate performance and service quality. ▪ Exchange would have less ability to directly guide and manage consumer assistance services provided to enrollees in Exchange coverage.	**CONS** ▪ Funding (other than Exchange funds) is uncertain. ▪ Expansion of the Alliance's current resources to absorb the anticipated volume of Exchange enrollees may be unrealistic. ▪ No existing "consumer services center." The HCA is a partnership comprised of community-based legal services organizations in only 13 counties. ▪ Staff accustomed to dealing with primarily one market segment (low income). Considerable training would be necessary. ▪ No IMR process (but could refer to DMHC).

Table 2. Funding Considerations for Partnering with Regulatory Entities		
Reference Amount	**Funding Formula**	**Funding Timing**
CONSIDERATION Exchange staff considered different references amount for the purposes of requesting consumer assistance resources in its upcoming federal establishment grant request which is planned for November 15, 2012. Staff considered using a reference point California's federal CAP grant amount, which provides approximately $4.6 million per year to support community-based consumer assistance. Exchange staff also considered using other state Exchanges as a reference point. For example, Massachusetts received $1.1 million and New York received $5 million through Level 1 Exchange Establishment grants to support consumer assistance activities.	**CONSIDERATION** Exchange staff considered different funding formula options to determine the amount of federal establishment funding it will request to support consumer assistance/ombudsman activities within the broader context of consumer assistance funding available through other government and private entities. Staff considered developing a formula based on the number of Exchange-eligible individuals in 2014 as a percent of all individuals who are covered by regulated health plans in the state (approximately 2.6 million or 10 percent of covered lives). Staff also considered using a formula based on the number of individuals who are expected to enroll in the Exchange in 2014 (approximately 1.2 million or 5 percent of covered lives). In addition, staff considered using a multiplier of their eligible or enrolled individuals to be prepared for a disproportionate high volume of requests for consumer assistance by Exchange eligible individuals in the initial years of the program.	**CONSIDERATION** Exchange staff considered different timing options for providing consumer assistance funding. Funding could coincide with the start of Exchange coverage (January 1, 2014), or the beginning of open enrollment (October 1, 2013), when consumers will be able to received eligibility determinations for the Exchange. Staff also considered funding consumer assistance activities prior to open enrollment to build capacity to serve Exchange customers.
RECOMMENDATION Exchange staff recommend using California's CAP grant as a reference amount for this funding request because the scope of services funded under this grant are consistent with the consumer assistance services the Exchange seeks to fund.	**RECOMMENDATION** Exchange staff recommend using a funding formula based on the number individuals eligible for subsidized Exchange in 2014. This approach is preferred over an enrollment-based formula because eligible individuals may be more likely to seek consumer assistance services in the early years of the program when consumers are still becoming familiar with eligible rules, rights and benefits. Staff also recommend using a multiplier for eligible individuals to prepare for double the normal consumer assistance requests.	**RECOMMENDATION** Exchange staff recommend funding both initial capacity building during the period January – September 2013, and ongoing consumer assistance services from October 2013 through December 2014.

Reference Material

California Assembly Bill 922 (Chapter 552, Statutes of 2011). Accessed at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120AB922&search_keywords

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