ALLIANCE FOR HEALTH REFORM

Navigating the Health Insurance Landscape: What's next for Navigators, In-person Assisters and Brokers?
The Kaiser Family Foundation
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Ed Howard: If I can have your attention, let's try to get started. I am Ed Howard with the Alliance for Health Reform. I want to welcome you to this program on behalf of Senator Blunt, Senator Rockefeller and our board of directors. It is a briefing on the people and programs in place in each state to help consumers understand their health insurance options, help them apply for assistance if they are eligible and help them enroll. Each of the state marketplaces has these programs. There are more than 4,000 of them in the first open enrollment period. The Affordable Care Act provides some funding for them. Traditional insurance brokers and agents are part of the picture as well.

There were more than 10 million people helped by these navigators and other assisters during that six-month open enrollment period last year and early this year. Today, we are going to look at some of the challenges that were faced by those consumer assistance programs, how they responded to them and what the outlook is for the next open enrollment period, which begins less than three months from now. Our partner and cosponsor in this briefing, the Kaiser Family Foundation, is the source of a lot of the best and most relied on health policy analysis around. We are pleased to have co-moderating this discussion, Jennifer Tolbert, who is the director of the State Health Reform Project at the Foundation. Part of her duty is to monitor the implementation of the Affordable Care Act, particularly the efforts to set up insurance exchanges in each state. You will hear from Jen in just a moment.

I am going to take care of the logistics up front, so we can move right through the discussion with as little discontinuity as possible. If you are Tweeting, and we would encourage it, note the hashtag #assisters. If you need to tap into Wi-Fi, there is a sheet on your tables that tells you how to do that. The credentials are on the screen behind us. There is a lot of important information in your packets, background information on the topic, fuller speaker bios and a one-page materials list. If you crank it up on your computer screen, you can click on it. There is going to be a video recording of this briefing available in two or three days, followed by a transcript, both on our website AllHealth.org and on the Kaiser Family Foundation website, KFF.org. At our website, you will find speaker slides and if you are watching on C-SPAN right now and have access to a computer, you can punch up those slides and the rest of the background materials that the folks in the room have in front of them, at AllHealth.org.

Questions are at the appropriate time. There are three ways you can do that. There is a green card in your materials. You can write a question on it. There are microphones you can use to ask your question in person. If you want to Tweet the question, we will snatch it up from the Twitterverse and bring it forward. Prepare for that and we will look forward to your questions. The final little bit of overhead is this. There is a blue evaluation form in your kits that we would very much appreciate you filling out, so that we can improve these programs for you in the future, and to tailor the topics to your needs as well. We turn now to Jennifer Tolbert, from the Kaiser Family Foundation. Jen, thanks for being here. We look forward to your presentation too.

[Unrelated Talking]

Jennifer Tolbert: Thanks Ed. Welcome to everyone, and thanks to our panelists for participating in this briefing today, and what I anticipate will be a great discussion about assisters programs and the role they played during the first open enrollment period, and throughout this first year. I am going to provide a very brief overview, just to make sure that everyone in the room is oriented to these assisters programs, the role they play and the variety of programs that participated in this first year.

There were a variety of programs that provided consumer assistance, outreach and public education during the first open enrollment period. You have probably all heard about the navigators. Those were programs that were established by the ACA and are required to participate in all marketplaces. They provide outreach and public education. They help consumers apply for coverage. They facilitate the selection of QHPs, or Qualified Health Plans in the marketplaces. In-person assisters played a very similar role to navigators. The difference was that they participated only in state based marketplaces. The main distinguishing factor between in-person assisters and the navigators is how they were funded. In-person assisters were primarily funded through Section 1311 Exchange Establishment grants by the states in those state based marketplaces, and in consumer assistance partnership states.

Certified application counselors were another group of the assisters programs. These entities were recognized by the marketplaces, but were not funded directly through the marketplaces. The training and other requirements for these CACs were somewhat less extensive than for navigator and in-person assisters. Primarily, they were not required to do outreach and public education, though many of these programs did.

Federally qualified health centers also played a really important role in helping consumers sign up for coverage. Most FQHCs participated as CACs, though some functioned as navigators or IPAs. Finally, there were two organizations that contracted with CMS to provide supplemental enrollment assistance in select communities in federally facilitated marketplace states and in partnership states, through the Federal Enrollment Assistance Program. As Ed mentioned, through our survey of health insurance marketplace assister programs, we estimate that there were about 4,400 assisters programs that were established and participated in the first year or helping people sign up for coverage.

I should also note that agents and brokers played an important role in helping consumers apply for coverage and enroll in plans. They were not included in our survey, so I cannot actually document their role. I will talk in a minute about what they did.

Healthcare providers, including FQHCs and hospitals, as well as nonprofit community based organizations sponsored the majority of assister programs. This probably is not surprising, because these entities have had a long history of serving low income and uninsured populations. Importantly, other entities also supported assisters programs, including state and local government agencies, primarily local health departments, Legal Aid organizations, churches, colleges and universities, as well trade associations. We estimate that there was over $350 million in federal funding that was available to support the establishment of these programs during the first year. That

funding came primarily through federal navigator funding, as well as the Section 1311 Exchange Establishment grants. As I mentioned, there was the contract that CMS issued through the enrollment assistance program.

In addition, the Health Resources and Services Administration, HRSA, which provided funding to the FQHCs, provided about 44% of the total federal funding. Importantly, this only represents federal funding, to support these programs. We know that there was a great deal of funding through private foundations and other private organizations, as well as funding that was repurposed from organizations' own budgets to support these assister programs. One of the critical issues that I anticipate we will discuss on the panel is future funding for these assister programs. CMS has issued its funding FOA, Funding Opportunity Announcement, for the navigator program at $60 million this year. That represents $7 million less than was available last year. CMS has also not made a decision on whether it is going to extend its contract with the Federal Enrollment Assistance Program, with the two entities that participated in the Federal Enrollment Assistance Program.

States can continue to fund their in-person assisters programs with Section 1311 grant funds this year. Beginning next year, they will have to identify other sources of funding for their programs. I will note that HRSA has indicated that they will continue funding FQHCs at the same level for this next open enrollment period. Finally, as I mentioned, while we could not document the role of agents and brokers during this first open enrollment period, we do know that they played an important role in helping consumers sign up for coverage. Broker agents and brokers have traditionally helped people find and enroll in plans in the individual market, and many registered with the new marketplaces and were able to sell products and help consumers find plans, QHPs, in the marketplaces.

In talking to assisters, I think one area that I hope we discuss today has to do with collaboration between agents, brokers and assisters. In talking to assisters out in the field, some expressed some wariness of working with brokers. They felt like the missions were a little bit different, in part because brokers do receive commissions from the insurance companies for the plans that they sell. However, a number of other assisters found collaborating with brokers and agents to be quite useful, because of the expertise that brokers have with understanding the health plans choices available to consumers. With that introduction and overview, I will turn it back to Ed.

Ed Howard: Thanks Jen. Let me very briefly introduce our panel, with nowhere near what they deserve. We are going to start with Karen Pollitz, a senior fellow at the Kaiser Family Foundation. She is one of the country's leading experts in how consumers fare with their health insurance. She will be sharing with us the results of the Kaiser Family Foundation's survey of the marketplace assisters that Jen was referring to. We are going to hear from two speakers who are working directly to help those who are trying to figure out whether and how to use the marketplaces to get the best coverage for themselves. Jodi Ray is the director of Florida Covering Kids, at the Child's Center at the University of South Florida. She has won a host of awards for her work, enrolling kids and their families into healthcare coverage. Lisa Stein is the vice-president of Work and Family Supports at Seedco, a nonprofit that helps enroll people into coverage in several states, some with state based

exchanges and some with the federally facilitated ones. She is going to describe how navigators and other assisters operate in those different environments.

Finally, we will hear from Jessica Waltman, who is the senior vice-president at the National Association of Health Underwriters, NAHU. Jessica has been with NAHU for 15 years or so. She is going to give us the important perspective of the more than 100,000 brokers and agents that are affiliated with the association, and who are, as Jen noted, deeply involved in most of the activities involved in getting people enrolled and signed up for coverage. Without further overhead, Karen Pollitz, could you take us through the findings of the survey and how that looks to you from your years of experience in this field?

Karen Pollitz: Sure. Thank you Ed, and good afternoon everyone. Thanks to the Alliance for hosting this briefing today. I will take a few minutes to summarize some of the key findings of our foundation survey of health insurance marketplace assisters. We fielded this survey just as open enrollment was concluding this spring, to learn more about the assister programs, their experiences and the kinds of help that consumers sought. To do this, we asked CMS and all of the state based marketplaces to provide us contact information for the directors of their assister programs, who were certified to work in the exchanges. As Jen mentioned, due to some technical difficulties, we could not survey the brokers this year. We hope to be able to do that in the future.

Our first finding of this online survey was the numbers, which Ed has mentioned. We learned that there were 4,445 assister programs that were established in the marketplaces across the United States for the first open enrollment period. They employed 28,000 full-time equivalent staff and volunteers, even more people than that because not all worked full-time. We estimate 10.6 million consumers sought help from these assister programs during the first open enrollment period. Many who sought help ended up enrolling in Qualified Health Plans, most of those with subsidies. Many enrolled in Medicaid and CHIP. Some people did not enroll in anything at all, for example, if they lived in states that did not expand Medicaid eligibility and went to an assister program and found out they were not eligible for any financial help to obtain coverage.

I am going to show you this slide that Jen showed you, to briefly point out that the marketplaces are required, under the ACA, to set up navigator programs for reasons that Jen explained. There was no money to set up navigator programs per se, so these workarounds were established. This slide shows you that only about 30% of the assister programs that were established in the first year were actually funded by the marketplace or with marketplace implementation funds. The other programs, these volunteers, CACs and the FQHC assister programs that were funded by HRSA, comprised most of the programs in the first year. They helped most of the people during the first open enrollment. It will be interesting to see if that changes in the coming year.

[Unrelated Talking]

Karen Pollitz: Assistance was unevenly distributed across types of marketplaces, not surprisingly, because CMS had very limited implementation funds to support navigators in the 29 federal marketplace states, while the state run and partnership marketplace states could apply for these

unlimited exchange establishment grant funds. As a result, there were about twice as many assisters relative to the uninsured population in state and partnership marketplaces, compared to the federally run marketplace states. The number of people helped relative to the uninsured population was about half that in federal marketplace states, compared to state based marketplaces in the first year.

These assister programs were busy. For the entire open enrollment period, one in four programs said they could serve most of the people who sought help, but had to turn some away, while 12% of programs said that they were swamped most of the time. At the end of open enrollment, and remember half of all people who signed up signed up during the last month, half of the assister programs said that they had to turn at least some people away. No Maytag repairmen were waiting for the phone to ring. Providing enrollment assistance was a time intensive activity. Two-thirds of the programs reported that they spent, on average, one to two hours per person, setting up an account, going through the ID proofing process, entering the income and the household information necessary to apply for subsidies, reviewing the plan choices and picking a plan.

Why did people go to these navigators and other assister programs? Overwhelmingly, it was because they just did not know where to begin. Far more than website glitches or busy signals when you called the call center, the assister programs reported that people sought help because they do not understand the ACA, what they are supposed to do, they do not understand health insurance, they needed help walking through the plan choices and understanding them, and they simply lacked confidence to apply on their own. Interestingly, 41% of assister programs told us that most to nearly all of their clients who sought help lacked Internet access. In-person help will probably continue to be very important for years to come. After that, programs told us it was the details of the application process that prompted people to seek help. Remember, to apply for subsidies, you have to report information about your income and who is in your household, not now, but what you expect that to be in the coming year, and also what you expect your tax filing status to be in the coming year. For millions of people, this was not an easy thing to do. They really needed help walking through that. These reasons shed some light on why it took, on average, one to two hours to walk people through the application process.

[Unrelated Talking]

Karen Pollitz: About 90% of programs told us that most to nearly all of the people who sought help were uninsured. About three-quarters of programs told us that most to nearly all of the people who sought help had significant insurance literacy problems. They needed help understanding basic insurance terms like deductible. This is likely another reason why the assistance process was time intensive. Along with basic insurance literacy problems, assister programs told us that plan information provided to consumers on the marketplace websites did not answer all the questions that consumers had. Forty percent of programs told us that this was often or almost always the case. Our survey asked assister programs what they did when this happened. Some of them developed partnerships with insurance brokers, which they reported worked very well. Programs also told us that they hope, in the coming years, marketplaces will provide better plan information, more accurate information and better plan comparison tools. Some also think that insurers should be required, as a condition of offering coverage on the marketplace, to provide briefings for the assister

programs on the products they are offering and to provide a dedicated customer service line for the assister programs.

One other noteworthy finding, just briefly, had to do with how these programs coordinated with each other. Most of them did not. Forty-five percent said they did coordinate with other assister programs in their region, and that this helped them work more effectively and efficiently. Some programs used a central scheduling system, so that consumers could be directed to a program that had available appointments, instead of queuing up at one that was overbooked. They could also help each other solve complex cases. In some states, a kind of super-navigator emerged. I think Jodi was one of those. They helped provide technical assistance to other programs. We asked programs who initiated this coordination. Most often, this was something the assisters did on their own, or was maybe facilitated by an outside third party like a foundation. It will be interesting to see if marketplaces act proactively to help programs coordinate more in the future.

One other important observation was this. Marketplace assister programs are there to get people into coverage, to do outreach and enroll them. Even one week after open enrollment closed, most programs, 90% of programs, told us clients were already coming back with post-enrollment questions and problems. They did not understand how to use their coverage. They could not find a doctor who was in-network. They had a claim denied and they did not know how to appeal. The ACA does provide for state ombudsman programs, also called CAPs, to provide a full range of consumer assistance including help with these kinds of post-enrollment problems. The CAPs are supposed to serve everybody in a state, not just people who buy through the marketplace. Those CAP programs were last funded in 2012. Now the marketplace assisters are being asked to pick up some of the slack.

Finally, I have one word about the learning curve. Seventy percent of the programs that helped consumers in the first open enrollment had prior experience before this year. They mostly had prior insurance experience, enrolling people in Medicaid and CHIP. Only about 16% of programs in the first year reported they had previously helped consumers evaluate private health plan choices and enroll in private coverage. Less than 10% had prior experience with tax issues. This first year represented a steep learning curve for the assister programs, as well as for consumers. The good news is that most assister programs say that it is very likely that they will continue in this role for another year. That experience will surely help programs to work more effectively and efficiently. It will be especially important because millions more people are expected to sign up for coverage in the second year, at the same time that the folks who signed up last year are coming back to re-enroll. Of course, the second open enrollment period will only be half as long. This will be lots of fun. I will stop there and turn it back to Jodi or Ed.

[Unrelated Talking]

Jodi: As you already know, in Florida we participated as part of the federally funded marketplace. We had navigators. The University of South Florida was awarded a grant to provide navigator services. We covered 64 of 67 counties. We needed to look at what our coverage options were going to be. We wanted our navigators on the ground to be ready to not only enroll folks in the

marketplace, but they had to be able to be in a position of connecting them to any available coverage options, which included things like Medicaid and CHIP. In some cases, we did have some county health plans. We were faced with a significant gap, because we did not expand Medicaid. We were able to make a concerted effort to identify where resources were in each of the service areas we were working in. Those that did not qualify for coverage were still directly connected to services that they may be in need of, even if they were not able to obtain coverage.

This is what our outreach effort looked like geographically. As I said, it covered 64 of 67 counties. The only counties we did not have this year were Broward, Miami-Dade and Monroe, which is the Keys. We broke the state up into geographic regions. We designed our outreach initiative to be from the ground up, the grassroots. Instead of the University of South Florida sending in troops to each of these areas, we worked with a consortium of partners in each of the areas. We had about 100 navigators on the ground. We had about 208 project volunteers. Each of these folks reached within their own community to identify a coalition of partners to enhance the efforts they were putting together in the community. One was intended to be reflective of the community. The outreach efforts were comprised by the community, reflective of the community and they knew who their target populations were.

Some of the challenges that we knew we had to be able to address, particularly with the structure we put into place, was the fact that Florida is a very large state. Pensacola and Key West are demographically and geographically very different. Although this time around we did not go as far as Key West, we were in counties like Palm Beach County. We had to be cognizant of the fact that effectiveness had to address the geography that we have in this state. They are also demographically very diverse. In Florida, we had to be able to reach out to hard to reach populations in each of the geographic areas. You had to build a certain level of trust. You had to build public support for directing people to the health coverage. The way we did that was the design of the outreach initiative, being that it broke down the state into regions.

We had a very large uninsured population. Our target was pretty significant. Among those that were uninsured, we saw a huge deficit in their understanding of what having health insurance means. We are still seeing it, because post-enrollment we are addressing questions around how to use health insurance. Now that you have a card, do you go to a hospital to get your care? The most basic of questions are now being answered in follow-up to the open enrollment period, so that we can provide a certain level of health literacy to the consumers that now have health insurance, so they can use it appropriately.

We also had large swaths of rural areas. Transportation was a significant issue. Our outreach efforts had to include a lot of mobile navigators. This could not just be, by design, someone sitting in an office waiting for folks to come to them. We had to go to where the uninsured were. We had to be convenient in terms of hours and physical location, so they could connect to the consumer assistance they needed. We were also dealing with trust issues. Among hard to reach populations and because the area is so wide in terms of their diversity, we had to make sure that we were working with the right trusted stakeholders within each of those communities, who could speak the language and understood the cultural issues, when we were communicating about something like

healthcare coverage, in addition to the lack of coverage opportunities, which I have already addressed in the previous slide, amongst the lowest income populations. While we had lots of people coming in, there were always those that fell into that lowest income range that could not obtain coverage under this effort.

A key element of the outreach efforts that we put into place under this initiative was also in engaging community partners. They were not only there to provide navigator services. Community partners played a significant role in referring folks to enrollment assistance. Part of the navigator duties centered around the education and outreach component, as well as the consumer enrollment assistance piece. It was really important that our navigator initiative took into account that we needed to engage the larger community, even those that were not providing navigator services, so that we were ensuring that populations were getting directed to the right places for navigators. The community knew where the navigators were and who the navigators were. Building those referral networks and those community partners was really important. We utilized networks and partners that we had spent 16 years building, doing outreach for Medicaid and CHIP for children. It was to our advantage to be able to take those community coalitions and collaborations, and say, "We have been enrolling these children over all these years. Now we can go back and enroll the parents too." Up until recently, we had not been able to do that. It was a real advantage for us to go back to those existing networks and those existing partnerships, looking at how we could expand them to reach some of the newly eligible populations. We were able to get this up and running pretty quickly.

Here are some of the outcomes of the grant to date. We have been able to assist, through the outreach education events and the one-on-one navigator appointments, over 78,000 individuals. We have attended over 2,500 outreach events throughout the state. We have held more than 17,000 navigator appointments. Of course, those appointments included things like doing the application and setting up accounts, but then they come back and they want to pick a plan and enroll. That does not always happen with every consumer in that order. Consumer appointments include all of those activities. We had almost 100 navigators trained at any given time, throughout the state. Those navigators not only completed the 20 hours of training that HHS required, but in Florida they were also required to be fingerprinted, background checked and registered with the state. Those 100 navigators covered the 64 counties that were our target region. We were able to assist consumers in a wide range of languages. The top five languages are here, English, Spanish and Creole, which is not atypical for Florida, but in addition we had languages like Arabic, Chinese and so many more that we had to address. We utilized folks who spoke the languages and were part of the communities, but we also made sure that we always had access to translator services.

Reaching folks through media was really important, to be able to get the message out to large numbers of folks throughout the state. The outreach efforts are one thing. The one-on-one assistance helped you get a lot of information to a consumer and helped them through the process. We really needed to get the message out that the program was available. They needed to know things like deadlines. We found that was one of the most effective ways to do it, in some of these larger areas particularly. This just gives you a picture of the outcomes of the work that the navigator initiative under the University of South Florida was able to achieve during the open enrollment period to date. We were able to reach more than 200,000 consumers throughout the state.

[Unrelated Talking]

Ed Howard: Thanks very much Jodi. Now we are going to turn to Lisa Stein.

[Background Noise]

Lisa Stein: Can folks hear me? Great. Good afternoon. It is a pleasure to be here with you all today. Seedco had the honor of serving as a navigator entity in four states. We worked in Maryland and New York, which were state based exchange states that also chose to expand Medicaid. We also worked in Georgia and Tennessee, which were federally funded exchange states that did not choose to expand Medicaid. I would like to take a minute and just thank the U.S. Department of Health and Human Services, the Maryland Health Benefit Exchange and the New York State Health Benefit Exchange. They have been great partners and supporters of our work. We have been honored to be part of this exciting piece of history.

Seedco is a national nonprofit organization, which advances economic opportunity for people, communities and businesses in need. We are based in New York City and have offices in Maryland, Georgia and Tennessee. We have a three-program area focus, workforce, work and family supports and technical assistance. Similar to the slide that Karen shared; our relevant experience prior to open enrollment was CHIP contracts in all four of our states. We currently hold SNAP contracts in all four states where we operate. In New York, we participated in the facilitated enrollment for helping people to enroll in Medicaid. In addition, this last statistic –

[Unrelated Talking]

Lisa Stein: Sorry about that. This last bullet on this slide is a result of our signature tool, Earn Benefits Online, also known as EBO. EBO is a Web based multiple benefits screening tool. With it, trained staff can assist individuals to access multiple benefits in one sitting and can determine eligibility, populate application forms and provide individuals with checklists and resources to greatly facilitate their enrollment into benefits. As a result, from 2005 up until the beginning of open enrollment, Seedco and our network have assisted over 180,000 households, to receive over $300 million worth of benefits.
In all four states, we are both navigator funded and also certified application counselor sponsoring entity. We chose to use an intermediary model. We worked with community partners who have strong affinity group relationships, such as to the LGBT population, immigrant populations and young invincibles. I would like to take this moment to say we had very excellent partners in all four of our states. We are very grateful to them and they are too numerous for me to mention here today. I will highlight a few.

In New York, we worked with a group called COPO. That serves the southeast Muslim population. In Maryland, we worked very closely with two local county health departments. In Georgia, we worked with a partnership between the health initiative and Georgia Equality, which focuses on LGBT communities. We also worked with Boat People SOS. In Tennessee, we partnered with the

Appalachian Mountain Project and Easter Seals. I think similar to Karen's slides earlier; you can see from my slide the differences in terms of resources available in each state. For example, in Maryland statewide, there were 306 funded navigators and assisters. In Georgia, there were 32 funded navigators.

The variance in resources is really at the heart of my next two slides. The resources really dictated our strategy for deployment of the navigators. In New York City, where we were concentrated in the five boroughs with an emphasis on Brooklyn, it was a lot of one to one appointments. As my colleague Jodi indicated, that is not just sitting in an office waiting for people to come to you, but going out to points in the community, not just health sites but workforce sites, food banks, churches and libraries. In Georgia and Tennessee, because there were far fewer resources and much more geographic distribution to cover, we took the show on the road. We would go to regional centers and partner with medical centers or libraries. There were a lot of church cosponsored events. We would bring a group of navigators to the people and do large scale enrollment events.

The resources also dictated education and outreach. In the state based exchange states of Maryland and New York, there were extensive advertising campaigns well in advance of open enrollment, TV ads, radio ads, every subway, every bus, something in your electric bill. Consumers typically had much more awareness of the marketplace and had much more positive association and messaging. In Georgia and Tennessee, because they were federally funded exchange states, it was a big part of the navigator role to provide that education and outreach. The most extensive opportunity for the public to hear something positive and to learn something about the marketplace was through earned media. In both Georgia and Tennessee, we were successful in getting over one million media hits. Those stories would then be reviewed on the Internet. People were really hungry for the information.

We had our own lab. We had state based exchanges. We had federally funded exchanges. We had rural territory. We had urban territory. We had geographic concentrations. We were statewide. Seedco really took the opportunity to take advantage of that. We contracted with the University of Georgia's Center for Health and Risk Communication. They conducted an evaluation of all our programs in all four states. This included evaluation of the data we were allowed to collect in each state. They interviewed navigators in each state. They interviewed consumers who had been served by our navigators in each state. The three bullets on this slide are some key findings that are starting to come out from that research. They are focused on the navigator interaction.

There was generally a low awareness of navigators. People had heard about the marketplace and heard about the ACA, but were not as aware that there was free and unbiased assistance available. Consumers really appreciated that assistance. Oftentimes navigators were the only human face or interaction that someone might encounter as they enrolled into an insurance product. Finally, the interaction between navigators and consumers could overcome negative preconceptions. A lot of individuals that came to us had negative ideas or beliefs regarding healthcare and regarding the marketplace. They felt much more positive and engaged. They said they would go out and tell somebody about their interaction.

There were some challenges. This is not earth shocking news. There were some technology issues. In all four states, there was some amount of technical difficulty with either the online portal or the call center. However, in New York and Maryland, which were the state based exchange portals, navigators and assisters had back end access into the portals. They could see what was happening with an application and really make sure to assist a consumer all the way through enrollment. Furthermore, they had direct contact and regular contact, sometimes daily, with the state exchange leadership. They could really communicate real time information about cases and get real time results back. HHS was operating a federal portal and call center for 34 states. It was a huge task. There was no special back end access for the navigators into the portal. There was no special back end access into the call center. Our primary lines of communication were through our grant officers and regional offices. They were terrific and responsive. The information had to travel through different levels to finally get to the folks who were working the exchanges and working the call centers.

The number two challenge that my colleagues have also talked about was low health literacy. The complexity of choosing a health plan is the greatest challenge a navigator faces. All navigators in all four states, both state based exchanges and federal exchanges, received some combination of training that was required. Seedco really felt committed that their navigators needed more. We provided additional training on health literacy communication techniques, both in advance of open enrollment and continually through open enrollment, as well as additional one on one training regarding complex cases such as immigration status and verifying household income.

Finally, the challenge was around privacy concerns. Seedco has a history of maintaining privacy standards. We were very committed to meeting the challenge in this new healthcare marketplace in all four of our states. We conducted site visits with our partners to make sure they were maintaining strict HIPAA protocols. We observed navigators one to one in their interactions with consumers. We observed navigators presenting in group interactions. We had a very strict policy around making sure we were providing quality services to consumers.

We had some really great successes, similar to my colleague from Florida, fast implementation. While Maryland was an early implementer and we began the process in April, with the three other states we had about ten or 11 weeks working with multiple partners, to get staff hired, trained, certified and ready to go. In Georgia and Tennessee, there were additional state requirements, in addition to the federal requirements, that made that a little lengthier. We did it and our partners were great. We are looking forward to doing it again next year, this year.

I think a really great success was our community relationships. We chose diverse partners that achieved the required geographic and affinity group diversity. In our experience, word of mouth was the most effective outreach strategy. It quickly establishes trust to begin the enrollment process. In results from our research study, all states demonstrated effective outreach and enrollment to culturally and linguistically diverse populations. Finally, I think our infrastructure was really successful. Seedco's model allowed for local flexibility to respond on the ground. At the same time, national coordination allowed us to share best practices and do course correction as needed.

Looking ahead, similar to what Karen indicated, open enrollment is 50% shorter this year, and only overlaps with four weeks of the free tax preparation season. This is a really strategically strong opportunity to reach people that come prepared with their financial information. This will be the first year that folks will understand and face the tax implication of making a choice or not making a choice. However, we have just finished a strategic planning process with all four of our teams. We are working really hard to ensure we can take advantage of every day of the next open enrollment. QHP renewal process will be renewed first in this open enrollment. There is some uncertainty in regards to the online portal functionality, as well as communications with consumers. In the end, this is also a tremendous opportunity to benefit from lessons learned from last year in forums such as today. As I indicated before, we also conducted this study and we look forward to disseminating that information publicly in September. Thank you.

Ed Howard: Great, thanks. Jessica?

[Background Noise]

Jessica Waltman: Thank you. Good afternoon. I am Jessica Waltman and I am here on behalf of the National Association of Healthcare Underwriters. NAHU represents about 100,000 health insurance agents and brokers from all around the United States. Independent agents have been helping people get covered and stay covered through both private coverage programs and also a wide range of public assistance programs for over 100 years. Our members serve everyone, from individual people accessing the marketplace to employer-based plans, Fortune 100 companies. They own or work for their own independent businesses, not the health insurance plans. Using an agent does not cost a consumer any extra money. In fact, the law requires that consumers be charged the exact same amount regardless of what assistance they use. Instead of receiving grants to help consumers like the other organizations, if an agent enrolls someone in an exchange plan, his or her identifying number, which we call the National Producer Number or NPN, should be recorded. The agent is paid a small monthly pass-through fee that goes for the life of the policy by the health insurance carrier. Remember that, because it is going to come back again.

Health insurance agents have been around for decades. They do know a lot of information about plans, as Karen indicated previously, that might not be publicly available. Things like which plans have good cost controls, or if you have asthma which plan has the best disease management plan for asthma, and things like that. They are also good at helping with claims problems. Their business model is a little different than all the other assister models too. They have been around for a long time. They do not just sign you up. Their goal is to provide year round service. They help you when your insurance card never shows up, when you need authorization for surgery or you get a wacky bill at some point during the year that you do not understand. Next year, this upcoming year, when you need to renew, they are there to help you make sure that your health plan still fits your needs, and enroll you again. The good news is that there is really no limitation from the law on how many different types of assistance you use. Agents and brokers can work in concert with other types of assisters. The law intended this. We do have some public policy suggestions, either regulatory or legislative, that could make this a little bit easier to facilitate to those partnerships for consumers. I

think it would also benefit the brokers and the other consumer/assister groups in the year ahead. I will get to those in a second.
This is a little more background about agents and brokers. Because they have been around for so long, they are very highly regulated. All kinds of state and federal privacy and data security laws apply to them, and they may not necessarily apply to the other groups because they were not around when those laws were passed. In addition to any exchange certification, and all the exchanges require broker certification, they also have to be licensed in every state that they do business. They have to complete an additional course of continuing education each year, usually about 24 hours a year annually. They hold malpractice insurance, which they call Errors and Omissions insurance. They are all legally and financially accountable for the advice that they give. They have to answer to their state insurance commissioners, amongst others. All the commissioners I know will tell you that they have people that work for them that have handcuffs.

Last year, or really this year, agents were very excited about participating in helping people with exchange-based coverage. As Karen indicated, the survey data they presented today does not really give a complete source of how many agents and brokers were certified. We have cobbled together a couple of different sources. We estimate it was about 100,000 agents and brokers that were working nationwide to help people with exchange coverage. Not all exchanges collected or have published their data about how many exchange consumers used an agent. We do point to one, which was a recent Urban Institute study, that showed about half of all people that used exchanges did use some type of in-person assistance, including agents and brokers. Of all those assister groups, agents and brokers had the highest customer satisfaction rate, of 83.9%.

Just like everyone, agents did have a few bumps in the road last year with open enrollment. One of those big bumps really had to do with the agents identifying the number. For a variety of reasons, often those numbers were not included in exchange records. To make a long story short, agents, brokers and their consumers did not really have a good way to fix that. That created a payment problem for the brokers, but also created a liability problem. If their number was not recorded, then that could affect their malpractice insurance. It is also a consumer protection issue. We think every interaction a consumer has with any type of assister should be recorded. Finally, it was a big problem for partnerships between agents and brokers, and other types of assister groups, particularly in the federal exchange and a few of the state exchanges. There was only a spot to record one number. If they worked together, somebody's number was not being recorded. We really think that should be corrected for the year ahead.

Agents could also better serve consumers if they had a back end portal on the federal exchange, for year round case management. That is how non-exchange coverage works in all states now, and in most state exchanges. We think the federal marketplace really would be helpful if they could catch up. There was no complete list of certified agents and brokers on the Healthcare.gov website, which would be an important tool for consumers to have access to, and also for other assister groups to partner with agents and brokers. We have long called for a good way to report and follow up with client problems in the exchange, such as the hotline. We would also like to see some technical improvements made to the plan direct enrollment and Web broker mechanisms for independent agents and brokers. That would help agents support their clients throughout the year. A lot of those

issues are specific to the federal marketplace. Most of the state exchanges were a little bit more nimble and had better broker resources. Even the best exchanges for brokers did have a few problems, a lot of times around those identifying numbers.

The good news is that we do think that broker participation in the exchange next year will be high. We do not really know how it is going to be, but anecdotally we are getting good feedback and recertification is ongoing right now. It looks like it might be a little bit lower than last year, perhaps due to the bumps that agents had along the road. Overall, it is looking good. We see high participation rates again. We do have some solutions to help agents and also other assisters better help consumers in the year ahead. I would like to point out that Senator Mary Landrieu and a number of her colleagues have introduced two bills that would require HHS to address most of these concerns. They are Senate Bill 2175 and also Senate Bill 2173. Additionally, there is a bipartisan coalition of more than 74 House members that have formally called on HHS to fix these issues on the regulatory front. Many other senators and House members have also called on the White House and HHS to up these items on the priority list, on a separate basis.

Looking ahead, we do see some great opportunities for 2015. The federal SHOP exchange will be online soon. It appears that it will contain many of the broker services that the individual exchange on the federal level does not currently have available, and may not have available for the open enrollment season ahead. We are hopeful for the SHOP exchange, that it will at least have some of that functionality. We also see new market entrants and new products being put onto market, which will help better meet the needs of our clients. We will be able to learn lessons from open enrollment previously. Some concerns that we do see, and I would love to discuss in the question and answer period because I know we are running out of time, include the new re-enrollment process for existing clients. In particular, we really want to make sure that all exchange enrollees do have ample time to really review their new options for the plan year ahead, and are not redirected into the same plan from last year, if that is not necessarily the most appropriate for them anymore. We want them to be able to check out their choices. Also, we do have ongoing concerns about subsidy determinations, and making sure they are accurate for all applicants, particularly those that are being re-determined and redirected into policies from last year. Many of them may have been offered employer coverage or will be offered employer coverage in the year ahead, because of the employer responsibility requirements. Getting that coverage offer for the first time can affect your subsidy eligibility substantially, or negate that subsidy eligibility. Those are some challenges that I see. Thank you very much. Let's start with the Q&A.

Ed Howard: Great. Thanks very much Jessica. Let's start with something that you actually raised. I should say this. Let me remind you that you can Tweet a question. You can voice a question. You can write a question. You have your options. I would urge you to get involved in the conversation, and also encourage our panelists to offer comments back and forth, if something you have heard has raised a question or made you want to make an observation. You were talking about re-enrollment Jessica, and the challenges that it raises. I wanted to get your reaction and those of the other panelists as well. We have some number, whether it is eight million or six million, even ten million, of people who have signed up for something. They are going to have to sign up for something else, or renew in what they have. We have a prediction that there will be even more people who will be

attempting to enroll this open season, as compared to last. What does that say about the workload of navigators, assisters and brokers? What kinds of difficulties can we anticipate and maybe try to ameliorate?

Jessica Waltman: From the agents and brokers perspective, of course there are always going to be some people whose plan option from last year is still a good fit. It is important to have an easy way for them to get back and renew that coverage. We believe that your health insurance purchasing decision is one of the most important and profound decisions that a family can make. It has significant financial security implications and health security implications. We think that every year, you should take a look and make sure that it still fits, particularly with the new subsidy eligibility, to make sure it is still the right choice for you and is still affordable. Just check out the marketplace and see if there are new entrants out there that might be a better fit.

Ed Howard: Karen?

Karen Pollitz: We did not ask this exact question on our survey, when we asked how long it takes to help people. We did not ask the assister programs to then chunk that up and say how much of that time was involved in actually doing the ID proofing, establishing an account, determining your eligibility for subsidies and how much of it was plan choice. I do not know the answer to that question nationwide. I did spend a little bit of time in open enrollment, observing a program in northern Virginia, just watching the actual process. In just that morning, I did notice that it did take about an hour and a half. That was validating for us, when we found that. Most of that time was in the application process, not in the plan choice process. In fact, one question we did ask our navigators and assisters in the survey was, "Did you even get to that process? Did you see the plan choice?"

Much of the time, they did not. By the time the people got through this whole process of figuring out their income and who was in their household, and whether or not they had availability of job-based coverage, which was not very well explained, this took a lot of time. Sometimes the website was clunky. I think the plan choice is absolutely important. That is the cherry on top. That is what completes the enrollment. All this other stuff was what presented a lot of difficulty and required a lot of assistance for people. That is what the assister program spent a lot of time doing. I think at re-enrollment we are going to learn in real time what the research literature has told us for a number of years, which is that there is a lot of volatility in the lives of low income people. Their incomes change. Their family status changes. Their tax filing status may change. I know assisters struggled a lot when they were helping women who were expecting to get divorced. "Today, I think I am filing married/jointly, but maybe by the end of the year that will not be the case. How do I know? I do not really know."

I think a lot of people are going to be coming in, not only to reevaluate their plan choice, but to reevaluate what they are eligible for, in terms of assistance. We are going to see a lot more about how much of that goes on. That is really a very difficult process. There is guesswork involved when you are projecting all of this going forward for another year, and then reconciling at the same time, what you just did a year ago.

Ed Howard: Anybody else? Okay, yes, go right ahead. I should ask the folks who are standing at the microphones to identify themselves, both personally and institutionally, if there is such an identification.

Dr. Caroline Poplin: I am Dr. Caroline Poplin. I am a primary care physician. My questions are a good follow-up to what you have just been talking about. My questions are for Karen and the follow-up survey that you did. It looks like more than one-third of the people thought they picked the wrong plan. A large number of people were having trouble with the copays and deductibles. One question is this. There was supposed to be a standard form that the plans were supposed to fill out, so that it was easy to compare one plan to another. Before this, when you picked an insurance plan, it was 50 pages long. There was no way to compare one to another. They all talked about different things. The second question has to do with affordability. When the subsidies were set up, they were looking at affordability and also at how much the federal government was going to have to spend, as opposed to how much the people were going to have to spend. I wondered what your post-enrollment survey told you about either one of those.

Karen Pollitz: We did not ask specifically about the summary of benefits and coverage. That is the first thing you mentioned, this standard kind of format that describes in simple terms and no fine print, consistently what a plan covers and how it works.

Dr. Caroline Poplin: Did you have a sense of whether it was useful?

Karen Pollitz: We are actually in the process at Kaiser, of looking at some of these SBCs. I know some other groups are trying to do this as well. Like a lot of things in the first year, they were not all perfect the first time. There are inconsistencies. They are not always produced in a consistent way. In addition, I think there were technical/IT problems with clicking on the link and it not coming up, or them clicking on the link for the provider directory and that not coming up. It did not match the plan that you thought you were clicking on. I think many factors were at work there, to make it trickier in the first year. A lot of these plan designs we are noticing, offered through the marketplace, are really innovative, creative and new cost-sharing designs. A deductible is not always a deductible. Sometimes it is a donut hole. Sometimes you get some stuff and then you hit the deductible. Then you get some more stuff. Sometimes it applies to these services, but differently to those services. I am seeing stuff that I have never seen before. It is kind of interesting to go through and see if we can catalogue it.

I think for many reasons, it was difficult for people to evaluate plan choices, even if they knew a lot about health insurance, coming in. When we asked assisters what kinds of things they would like to have more training on, more training on the QHP choices and in particular, if there are five Bronze plans offered by one company, what is different between plans One through Five. That is the kind of thing that assisters would like to get more briefing on. They do not want to have to be part of the salesforce of the company to get access to that. They would like to be able to see it. That should be more transparent. I think that is one of the things that are definitely still evolving.

Dr. Caroline Poplin: Is Kaiser going to do another report before the next open enrollment period?

Karen Pollitz: On? We do reports every day.

Dr. Caroline Poplin: Right, I know. On follow-up of why people did not like their plans and why more than one-third of people thought they chose the wrong plans?

Karen Pollitz: We do not have anything planned on that. Just as our assister survey came out, we did another survey on individual market participants, which was more involved. That was a telephone survey. That is on our website as well. We were looking at people who had coverage that they purchased on and off the exchange, some of the policies they were renewing that did not conform to the ACA rules, as well as new policies. We did have some satisfaction measures. Interestingly, on that survey, when we asked people questions like, "What is your deductible," we had very high rates of, "I do not know/Not sure." On and off the marketplace, I think insurance is still a little bit of a mystery to people, more than a little bit. I am actually working on another thing on insurance literacy. This is a complicated feature.

Your second question had to do with affordability. I would defer to my assister colleagues, who saw this in real time. I think, and this is something we asked about in our individual market survey, that the subsidies are not comprehensive in the ACA. People do have to contribute a significant amount of money toward the premium, which is pegged to a level of your income. The cost sharing far surpasses what people will have to pay in premiums in many instances. These are mostly high deductible plans, even Silver and Gold plans. They typically have $1,000 deductibles per person, so that we have a little bit of grade inflation in our metal tiers. Gold sounds like everything should be covered, but not so much. There is still a lot of cost sharing where people have to pay for services. I think a lot of what consumers who were not used to private insurance were confused about what after they paid all this money for a premium and they went to the doctor, they still owed $150. I think that was a difficult thing to understand, in addition to a difficult thing to afford.

Ed Howard: Lisa? Jodi? Any comments?

Lisa Stein: What I would like to add is that I think it really depended on where you lived in your community. If you were in a rural area versus an urban area, your choices were far fewer. You may only be choosing from one carrier or a couple of plans from one carrier. In addition, certainly in the states where Seedco worked, there are a lot of porous borders. In Maryland, folks are used to going to Delaware. In Georgia and Tennessee, folks are used to crossing a border. That got much more difficult this go round. I think some of those issues are also really at play, because the map is so crisscrossed. You cross a line and the reality is very different.

Ed Howard: Jodi?

Jodi Ray: I would answer. I just want to say this around affordability. We had to spend a significant amount of time talking about the individual health plans. We saw a lot of time taken up by that. The consumers did not come in necessarily being literate around the idea of co-insurance

versus a deductible versus a copay. How many of those things are coming out of their pockets before the insurance kicks in? When you look at those plans, and I think you mentioned this and called it a donut hole, you really had to tear into the details of the plan with the consumer, so that when they walked away, they were actually making a decision that they were really well informed about making. On its surface, the information was not necessarily all there at a glance.

I think when you are talking about affordability; you had to factor in all of those pieces that were actually going to comprise the out of pocket piece for the consumer, and not just the premium as one factor to look at. If they started adding up some of these other pieces, it was very possible and very likely that certain plans became completely unaffordable. The other issue of affordability we encountered a lot was the family having someone who is employed. That individual who is employed had virtually no premium payments or minimal premium payments, but to enroll the entire family cost $10,000. It did not allow them to enroll in a plan with cost sharing and tax credits. They could only enroll in the marketplace, in most circumstances, without obtaining those additional discounts. That was a real challenge we saw a lot, around affordability.

Ed Howard: All right. Yes, go right ahead.

Margaret McGinty: Margaret McGinty with H&R Block Government Relations. Absent a change or a pushback of the open enrollment date, perhaps Lisa and Jodi can talk about it. We are very concerned. We see a scenario on February 16th. We have our client who comes in to do their taxes. They are being somewhat proactive. They are not waiting until the last minute. They did not enroll last season. They are hit with the small penalty for the first year and they ask how they can fix it on February 16th. Now they cannot. They are hit with a penalty that is three times as much for the following tax filing season. What case management issues are you working with? How are you addressing this with your current enrollees? What are you using in your advocacy, educating and essentially marketing plans for those who did not enroll the first time around and took the $95 penalty?

Jodi Ray: I would say that from our perspective, we saw this a lot toward the end of the last open enrollment period. Talking about the penalty and the deadlines were real key messages to pushing folks to come in for assistance, or to sign up. I think it is going to be really important that we are really putting an effort forth about getting that message out widely and clearly. I think that we saw it was impactful last time. It is obviously even more pressing because it is not going to be quite as simple to take the penalty, because it will be a lot more painful than it was last time. It is going to be really important that we are working with a lot of our partners, a lot of the business partners in the community, to make sure they are equally as informed. I think that is going to be really key to getting this information out to folks. I think working with the partners like an H&R Block and partners like that, who have been helpful in the past when communicating with consumers about coverage issues and have been involved, I think that is really going to be something we are going to have to spend a lot of time on.

Lisa Stein: The emphasis we are taking at Seedco in all four of our states is to really take advantage of the time we have now. All of our navigators and assisters are out there doing

education, doing outreach, trying to pre-schedule people for enrollment appointments and developing even more extensive referral networks to get people in. The real focus in the first open enrollment, which was six months, we did education, outreach and enrollment. I think the focus really shifted in the last three months to just mass enrollment. This time, all the education and outreach, for the most part, is being done front end so that we can really take advantage. We share your concern. We found the tax season to be a very beneficial point of contact. If anyone here is thinking about what might need to happen, it is an extension of the period to have greater overlap with the tax season. That is significant.

Ed Howard: Does that mean that there is any sort of consensus in the community that it would be a good thing to try to align the open enrollment period more closely with the tax season?

Lisa Stein: Yes.

[Laughter]

Ed Howard: Okay. There you go.

Karen Pollitz: Dissent.

[Laughter]

Karen Pollitz: I think this is a problem with this whole concept of delivering subsidies through the tax system. I totally take and agree with all of these concerns, that February and March are when people start gathering their information and they can make a better guess of what they are going to be next year. They are still guessing what they are going to be next year. I think if we moved the open enrollment to always end in April, and if everybody always signs up at the end, we run the risk of building a structural quarter of un-insurance into people's lives. Their coverage will run out last December and they will not sign up again until this spring. If the answer to that is to realign the plan year, now you have moved it around the calendar. Now you have to estimate your tax liability for the coming year, for 2015 and a quarter into 2016, which I think will be even harder for people. I think the real problem here is guessing what your eligibility will be a year in advance. The tax system cannot give you real time take on your eligibility. I am a little nervous about proposals to move it around the calendar, for fear that we will un-insure people for several months on a regular basis.

Lisa Stein: That is a really good point, but people do not focus during the holidays. Last December, there was a little bit of a spike to meet the January 1 deadline for folks who had preexisting conditions and were really waiting for this opportunity, who wanted that coverage on the first. Due to weather and due to holidays, it was very difficult to fill, especially in our states where we needed to do the large-scale enrollment events. I think they are all valid points. I do not speak for the whole community. There are all sorts of timing factors to take into account.

Ed Howard: Jodi?

Jodi Ray: I would just say that there is still the problem, or the challenge. There is still a mental disconnect between the concept of having healthcare coverage and my taxes. Those two do not generally interlink for the average individual. You think of taxes and that falls in one bucket. My health and healthcare access fall in another place. Generally, in people's minds, those two do not interconnect. We are trying to do that. Somehow, I think that is a challenge that is going to take us a while to overcome, for the average person who has to live their everyday life.

Ed Howard: Okay. Yes, go ahead.

Brian: My name is Brian _____ [01:16:41]. I am with Technical Frontiers. I have a couple of general questions about the follow-up that is being done with all of the activity in the field. I know you are all doing follow-up. I am wondering if this process is going to be ongoing as this program continues to evolve? One of the other questions I have is this. Do you have any information about what the beneficiaries themselves, the people who are receiving all this help, are saying about the quality of their experiences, whether they are being served by brokers or by assisters, even navigators? Any comments on that?

Ed Howard: Could I ask you what you mean be ongoing follow-up?

Brian: I guess this is what I was thinking. Do you do these every year? Do you do them within three months following open enrollment seasons?

Ed Howard: Fair enough.

Karen Pollitz: This was our first survey. We have not even decided internally. I am hoping we will do an annual survey, at least for a while, because I expect this will be an evolving process, at least for a couple of years. We do not have any immediate plans for surveys. I know my colleague Jen has been out in the field doing a lot of site visits and focus groups, to find out what has been going on. I think we are looking for other ways to constantly monitor what is going on with outreach and enrollment. We are still figuring this out as well, at our foundation.

Ed Howard: Okay. If I could ask forbearance of the folks who are at the microphones, we do not want to completely diss the people who have written things on cards. We have a couple of Tweets as well. Jen, I wonder if you could interject a couple of these questions. We have about ten or 12 minutes left.

Jennifer Tolbert: Okay. Karen raised this, or began to touch on this issue. We got a couple of questions related to training for assisters, in particular, how adequate it was and what the plans are for improving the training going forward.

[Unrelated Talking]

Lisa Stein: I cannot speak for the exchange entities. The states dictate their training curriculum. In the state based exchanges, and HHS is currently updating the federal curriculum, Seedco continues to maintain as a priority that we will wrap around and do ongoing training with our navigators. They have all been training over the summer. We will train any new employee that is on-boarded. We are going to do some mentoring partnering, veteran navigators with newer navigators. We will continue to do the quality assurance monitoring to make sure that the folks who are out there are equipped to do the job they need to do.

Ed Howard: Anybody else?

[Unrelated Talking]

Karen Pollitz: I would just point you to our survey. We did ask the assisters what kinds of additional training they wanted. Ninety-two percent said they did want additional training. They found the initial training helpful. They wanted more training, not only at the outset when they get certified, but throughout the year, on topics like helping people with their post-enrollment questions and problems, on tax related issues and on immigration related issues. They wanted more training in insurance literacy. They wanted a lot more information on the Qualified Health Plans. They also wanted more training on using the online application and the paper application, and how that differs. They said that they very much appreciated training that both marketplaces offered throughout the year, webinars and conference calls, to provide updates and to refresh. They also appreciated the work of outside groups like Enroll America and Center on Budget and Policy Priorities. I know Georgetown University worked with a number of state programs, to provide additional in-depth training on particularly complex topics.

Jodi Ray: I would say that one of the things that we hope to see in the training going forward would more directly relate to the kinds of priorities that consumers have when they are trying to select plans. It is one thing to walk through the plan choices and key terminology. When consumers are actually sitting there, making plan decisions, they are really focused on how they will use healthcare. That is really key to their decision, very often. It is not solely around cost. A lot of them need healthcare for particular services. Not all the health plans cover the same things. They need particular providers. They need particular prescriptions. You really have to be able to get into the nitty-gritty of what the health plans provide, and really take the time to understand what the consumer's healthcare needs are going to be, so that they make a plan choice that will effectively provide for them access to the care that they are really going to need after they get covered.

Jessica Waltman: From the agent and broker perspective, agents and brokers, in addition to their exchange training, are required by state law to complete extensive additional continuing education each year. They are really the only entity that can truly advise a person about which plan to pick. I think that this need for additional training is great for the assister community, but another way to address this is to further encourage better partnerships between the assister community and the agent and broker community, given their extensive plan knowledge. Also, the focus of agents and brokers is to provide service throughout the plan year. There are no funding issues with that, relative to agents and brokers. They are in place. They are ready to help. If we could further the

partnerships between the two, we could really help provide better information to the consumers, better plan selection advice and also better support to the assister community.

Karen Pollitz: This is one tiny thing. The state of Illinois was a partnership marketplace. They put together a new plan comparison tool for consumers. It is based on what a lot of you may be familiar with. Consumer Checkbook does this. They do a lot of the plan comparison tools for federal employees and their health plans. You can go and look at that site. It has a lot more information about plans. As Jodi was saying, it not just the cost of the premium, but different kinds of scenarios, if you are a low cost person, if you are going to have a baby, and so forth. There is more satisfaction information and more quality information about the doctors who are in the network. I would commend you to take a look at the Illinois marketplace plan comparison tool. It is kind of interesting.

Ed Howard: Very good. Okay, could I ask folks as we go through these last few minutes of questions, to pull out the blue evaluation form and fill it out, so we can get the feedback that you want? We are particularly interested in the opinions of those of you who are on congressional staffs, of course. Yes, go right ahead. You have been very patient.

Casey: Hi. Thanks everybody, for sharing your expertise. I am Casey _____ [01:24:21] with the _____ [01:24:22] Center for Health Solutions. I was interested, given that there is a proposed rule from CMS to auto-enroll people that was talked about earlier in the panel, if there are any plans to segment marketing or outreach to folks who have been enrolled, or may automatically re-enroll, versus people who may be newcomers into the system.

Jodi Ray: Yes. We are certainly going to have to focus on the renewal and recertification process as part of our outreach and education efforts. I say that because in years of experience of doing this, we have tended to see that retention becomes a challenge. We certainly do not want folks losing coverage. We do not want consumers getting confused and making decisions they are not happy with. We are really going to have to, and we are doing this now, as we are still doing special enrollment periods. Consumers are coming in the door and we are getting out in the community. We are using that opportunity to make sure that people are fully aware that this is going to happen, that they are going to have to take steps one way or another and that this is going to involve them actively in some way, so they are not caught by surprise. They know where to get help if they have questions. We are really taking a lot of time now to focus on that, so that people have a heads up that this is coming down the pike, so that we are able to keep the enrollment gains we were able to do during the first open enrollment period.

Lisa Stein: It is important to understand that we are not in control of the renewal process. We are not the ones noticing consumers. There has been a lot of talk about our ability to follow up. If you are operating in a federal exchange state, I cannot follow up. I was not allowed to keep identifiable information. I had to get consent to be able to follow up with a consumer through enrollment, and only for the purposes of enrollment. There is no cold calling. There is no knocking on doors. There are no lists. It is our relationships in the community and people seeing our partners as a trusted source, that they are coming in with their letters.

I think it is also important to understand this. I guess it is my understanding at this point that folks will get a notice from the insurance company, which will have the full cost, 100%, of what the plan was. If they received a subsidy, they then get a second letter with the amount of the subsidy from the government. Imagine having this little health literacy and one letter comes first. Maybe one is a little bit delayed in the mail. You can imagine the heart attack you have at your kitchen table. Those are all challenges that are very real and beyond the control of the navigator entities.

Jessica Waltman: I just wanted to point out that a key difference between the assisters, the navigators and the broker community, because brokers have been around for a really long time and are regulated a little bit differently, is that brokers actually could keep that information. They do have their existing client base that they have been helping all year round. They are able to reach out to existing clients. That is why a partnership can be very beneficial. Lisa can help them, and then refer them to a broker to finish up the process. That person has the year round support, and the year round support with their enrollment. When they get the two conflicting letters, and she does not know how to get back in touch with them to ask if they were confused, our members can. They can help them work out that process. Unfortunately, not everyone had that benefit. We are concerned about the year ahead, with the redetermination process. As Karen pointed out, it is a really volatile population. Their life choices could have changed, their income and what-have-you. We want to make sure they understand those letters, and even that they are just looking at the coverage options and making sure it is the right fit for them.

Ed Howard: We have three folks who are standing at the microphones. We have one substitute who is now standing at the microphone for somebody else. That is okay.

[Laughter]

Ed Howard: We will try to get to you. I am sorry. The gentleman behind the gentleman at the microphone is not going to be able to get his question asked. I would ask you to keep your questions as brief as possible. I know our panelists will be as insightful as quickly as possible. We will try to get through, even if it takes into, in World Cup terms, extra time.

[Laughter]

Ed Howard: Yes sir, you were here.

Audience Member: Hi. My name is _____ [01:29:12] from Senator Gillibrand's office. The data that was presented indicates that there is a lack of coordination among these assisters. Is there going to be some type of federal or third party coordination to incentivize further dialogue between these assister groups? Is it purely a recommendation?

Lisa Stein: I am going to take a little deference with that comment. I think that especially in the federal states, we had no choice but to coordinate. We just did it ourselves. In Georgia and Tennessee, we were in regular communication with state associations of qualified health centers,

with Enroll America, with the other funded entities who were either sponsoring CACs or had federal resources. We had to. We made sure we were not duplicating efforts and that we were supporting each other's events, and making sure there was extensive coverage. In Maryland, the state broke it out into geographic regions. One entity was responsible for a territory, partnership and network within that territory. It was very well coordinated.

In New York, I think New York was probably the most interesting scenario. There were 22 entities funded to provide navigator services in New York City alone. There was a little bit of stepping over each other's feet. With that said, there were weekly calls. There were other forms and formats. There was coordination. It was more informal. While that is different, it is not less valuable. I think that is an important statement to put out there.

Jodi Ray: I would just say that in Florida, in representing the University of South Florida initiative, we actually had some more formalized efforts around coordination. There was a limit to what the navigators could do and how many navigators were on the ground. In a state as big as Florida, 100 navigators are only going to go so far. In a given area, like the Tampa Bay area, which was one of our largest regions, they regularly brought together all the assisters on a regular basis, in a coalition format. They tracked the efforts of where they were reaching consumers. They also coordinated efforts to get in and get out, doing outreach and education events. One man cannot do it all. In an effort to make sure that nothing was left uncovered, they worked with the entire scope of assister partners that were in the given area, including the contracted partners as well. I would say they were all brought to the table. That is a good example. Not only did they coordinate, but they actually tracked the efforts of the coordination in a formalized way.

Ed Howard: Yes.

Maria: Hi. My name is Maria _____ [01:32:01]. I am with the _____ [01:32:04] Center for Health Solutions. My question was relating to the young invincibles outreach. My question is more about what you guys learned when outreaching to this specific population. What were your challenges? This is the other one. Based on some of the studies you have done, if you have collected information, did you find any data on the rate at which they outreached to you guys, the assister programs, versus other demographics?

Jodi Ray: I can answer the question about the outreach. It was interesting. Because we are a university, it made sense that we were reaching out to the young invincible population first and foremost. We really worked with the universities and the local colleges, community colleges. We started realizing that some of those mass enrollment events were actually most effective to getting some of the younger population, specifically to those who were enrolled into classes. We worked with student health services. We worked with the student government folks. This was effective in that we were able to get a lot of students into coverage.

I think one of the challenges we had with that was that if you had students that had part-time jobs and were otherwise supported on student loans, obviously they were at risk of not being qualified for cost sharing and tax credits. They did not have enough income to qualify. In some counties, we

were able to connect them with county health plans and make sure they did not remain uninsured. In a lot of cases, they were having to not get enrolled. I think we found that it was tough starting out, but we were able to use some of those avenues to get to larger numbers of students that were in that 18 to 34 range. They are all over the university. They are enrolled in classes. They worked part-time. They worked full-time. It gave us access to a large number of folks. We utilized those all over the state. That was effective for us.

Ed Howard: Go ahead.

Lisa Stein: We found in all four of our states that about 25% of the people we assisted fell into the age range of young invincibles. It was on par with the national.

Ed Howard: Okay. The last question.

Michael Fulginiti: Hi. I will keep this brief. My name is Michael Fulginiti, from the American Institutes for Research. My question is for Jodi. Were there particular interventions that Florida took, that were better than other interventions, especially because resources were strict because Medicaid was not expanded?

Jodi Ray: I am not sure what you mean by interventions. Do you mean outreach approaches?

Michael Fulginiti: Yes, approaches to enrollment, and to take certain approaches over others, especially with the lower resources.

Jodi Ray: Well, we definitely found that partnering with the hospitals was effective. Clearly, that is an easy way to identify the uninsured. Our enrollment with the hospitals was definitely very effective. We coordinated with health planning councils throughout the state. That also allowed us access to a wide range of partners. We saw the results from that. I think there were certain aspects of each of their initiatives that were specific to their community. I think the partnership with the hospitals; colleges and universities were very effective.

The other thing is recognizing that we did have that Medicaid gap, and knowing where the county health plans existed, so we were able to connect people in certain counties to some coverage, if they fell in that gap, as well putting together an actual concrete resource manual of where all the resources were in the community, so the folks could access the services they needed, despite not having coverage. That meant working with the rural health centers and the qualified health centers. It was working with the county health plans, mental health centers and all of those kinds of resources, so that we were still connecting folks directly to services.

Michael Fulginiti: Okay, thank you. How about approaches that were not successful?

[Laughter]

Michael Fulginiti: Sorry to put you on the spot.

Jodi Ray: I am not sure I can answer that question quickly. I think going back to the work with the universities; it took us a while to get that off the ground. Initially, how we designed those efforts was not initially successful. We certainly had to circle back and figure out how to make those effective, and who were the right partners to work with in a university system or a community college, that connected us better to more students. We initially started off and saw a very small response to what we were doing. We were able to revise that and change who we worked with, within the colleges. I do not know, maybe that is more specific.

Michael Fulginiti: Okay, thank you.

Ed Howard: Jen?

Jennifer Tolbert: Yes. Thank you. Thank you panelists for a wonderful discussion. I think we learned a lot about what worked and what did not during the open enrollment period this first year. I think we talked about some ideas for improving the process and going forward. We also know that there are a lot of challenges that lie ahead for this next open enrollment period and beyond. I think this has been a great discussion. I thank you all for attending. I thank our panelists for participating.

Ed Howard: And as you to join us in doing so.

Jennifer Tolbert: Yes.

[Applause]

[Background Noise]