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Navigators: A Background Paper

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Table of Contents

Introduction

The Affordable Care Act (ACA) requires states to either establish and operate a Health Insurance Exchange by 2014 or participate in the federal Exchange. On April 12, 2011, Governor O'Malley signed the Maryland Health Benefit Exchange Act of 2011, which establishes Maryland's Exchange as an independent unit of the state government. The Exchange will provide a marketplace for qualified health plans and assist individuals and employers in accessing these health plans and accompanying tax credits. The Act also establishes a Board of Trustees to oversee the Exchange. The Act requires the Exchange to study and make recommendations on a specified list of topics to the Maryland General Assembly by December 23, 2011. One of these required topics is "the design and operation of the Exchange's Navigator Program and any other appropriate consumer assistance mechanisms, including:

1. The infrastructure of the existing private sector health insurance distribution system in the state to determine whether private sector resources may be available and suitable for use by the Exchange
2. The effect the Exchange may have on private sector employment in the health insurance distribution system in the state
3. What functions, in addition to those required by the ACA, should be performed by Navigators
4. What training and expertise should be required of Navigators, and whether different markets and populations require Navigators with different qualifications
5. How Navigators should be retained and compensated, and how disparities between Navigator compensation and the compensation of insurance producers outside the Exchange can be minimized or avoided
6. How to ensure that Navigators provide information in a manner culturally, linguistically, and otherwise appropriate to the needs of the diverse populations served by the Exchange, and that Navigators have the capacity to meet these needs
7. What other means of consumer assistance may be appropriate and feasible, and how they should be designed and implemented (Maryland Health Benefit Exchange Act of 2011, §5)."

The Exchange Board issued a request for proposal (RFP) in July 2011 for a vendor to conduct a study on the design and operation of the Exchange's Navigator Program that addresses the seven items listed above. The Exchange Board will use the results of this study to make recommendations to the Maryland General Assembly.

The purpose of this report is to provide background information on Navigators to the Maryland Exchange Board Navigator and Enrollment Advisory Committee and to provide foundational support for the analysis conducted by the vendor selected to perform the study. This report first

provides an overview of Navigator eligibility criteria, duties, and standards as outlined in the ACA and the associated proposed regulations recently issued by the U.S. Department of Health and Human Services (HHS). It then describes information and assistance programs in other states that may inform Navigator design discussions, Navigator legislation recently enacted in other states, and selected information and assistance programs in Maryland. The report concludes with a brief discussion of other issues related to Navigators as identified in the literature.

ACA Requirements

A key provision of the ACA is the creation of American Health Benefit and Small Business Health Options Program Exchanges as new mechanisms for individuals and small businesses to purchase health insurance (Kaiser Family Foundation, 2010). The Exchanges will offer a choice of health plans to individuals and small businesses and will provide information to help these consumers understand their health plan options (Kaiser Family Foundation, 2010). The ACA outlines multiple requirements for Exchanges, including the development of Navigator Programs that provide information and assistance to individuals and businesses about qualified health plans.

Specifically, the ACA outlines funding requirements, eligibility criteria, duties, and standards for Navigators. Navigators will be funded through grants from the operational funds of the Exchange (ACA §1310 (i) (6)).[1] The ACA requires Navigators to perform the following duties (ACA §1310 (i) (3)):

- Conduct public education and awareness about qualified health plans.
- Distribute fair and impartial information about enrollment in qualified health plans and the availability of premium tax credits.
- Facilitate enrollment in qualified health plans.
- Provide referrals to appropriate state agencies for enrollees with grievances, complaints, or questions about their health plan or coverage.
- Provide information that is linguistically and culturally appropriate to the populations served by the Exchange.

In order to be eligible for Navigator grant funding, organizations must demonstrate existing relationships (or the ability to readily establish relationships) with employers, employees, consumers (including the under- and uninsured), and self-employed individuals (ACA §1310 (i) (2)).

[1] Federal funds provided to states to establish Exchanges may not be used to fund navigator grants (ACA §1310 (i)(2)).

The following types of organizations may receive Navigator grant funds:

- Trade, industry, and professional associations
- Commercial fishing industry associations
- Ranching and farming organizations
- Community and consumer-focused nonprofit groups
- Chambers of commerce
- Unions
- Resource partners of the Small Business Administration
- Other licensed insurance agents and brokers
- Other entities that are capable of carrying out the Navigator duties and that meet other standards for the Navigator

Health insurance issuers are explicitly prohibited from being Navigators, and Navigators may not receive any direct or indirect consideration from any health insurance issuers in connection with enrollment in qualified health plans (ACA §1310 (i) (4)). The ACA directs the Secretary of HHS to issue further standards for Navigator Programs—including provisions to ensure the selection of qualified Navigators, avoid conflicts of interest, and ensure that the information provided by the Navigator is fair, accurate, and impartial (ACA §1310 (i) (4) and (5)).

Proposed Regulations

On July 11, 2011, HHS issued its first set of proposed rules for public comment on the minimum standards for Exchanges, including the Navigator Program. This section of the report summarizes the proposed rules related to Navigators. These proposed rules codify the ACA Navigator requirements listed above and include some new requirements as described below.

Related to Navigator eligibility, the proposed regulations include the following additional requirements (HHS, 2011b):

- Navigators must meet any licensing, certification, or other standards prescribed by the state or Exchange, if applicable.
- Navigators may not have any conflict of interest during the term as Navigator.

The proposed regulations further specify that Navigator Programs must include entities from at least two of the eligibility categories listed in the ACA. The proposed regulations add the following eligible entities to the list in the ACA: Indian tribes, tribal organizations, urban Indian organizations, and state or local human service agencies (HHS, 2011b).

The proposed regulations also include the following additional duties of the Navigator (HHS, 2011b):

- Maintain expertise in eligibility, enrollment, and program specifications and conduct public education activities to raise awareness about the Exchange.
- Provide information and service in a fair, accurate, and impartial manner. Such information must acknowledge other health programs.
- Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange, including individuals with limited English proficiency, and ensure accessibility and usability of Navigator tools and functions for individuals with disabilities.

HHS (2011b) specifically requested public comment on the following related to the Navigator regulations:

- Whether HHS should propose additional requirements on Exchanges to make determinations about conflicts of interest.
- Whether HHS should require that at least one of the two types of entities serving as Navigators include a community and consumer-focused nonprofit organization.
- Whether HHS should require that Navigator grantees reflect a cross-section of stakeholders.
- Current provisions do not preclude Navigators from receiving compensation from health insurance issuers for enrolling individuals and employers in non-qualified health plans. HHS seeks comment on this issue and whether there are ways to manage any potential conflicts of interest that might arise.
- HHS is considering standards related to the content of information shared, referral strategies, and training requirements to include in grant award conditions. HHS seeks public comment on potential standards to ensure that the information provided by Navigators is fair, accurate, and impartial.

Lessons from Other States

Prior to the enactment of the ACA, other states, including Massachusetts and Utah, established health insurance marketplaces similar to Exchanges and created their own consumer assistance programs to assist with the operation of these marketplaces. Since the enactment of the ACA, other states have passed legislation related to the implementation of Exchanges that make reference to Navigator Programs. These states have considered some of the same issues that Maryland will need to consider when creating its Navigator Program. This section of the report discusses the experiences of other states in designing consumer assistance programs. Appendix 1 provides a summary description of these programs in other states.

Massachusetts

In 2006, Massachusetts passed a comprehensive health care reform bill that, among other things, created the Commonwealth Health Insurance Connector Authority (Connector). The Connector is a Health Insurance Exchange in which individuals and small businesses can purchase health insurance and obtain premium subsidies. Commonwealth Care and Commonwealth Choice are two insurance programs offered through the Connector. The Commonwealth Care program offers premium subsidies to individuals with household income up to 300 percent of the federal poverty level (FPL) (Lischko, Bachman, & Vangeli, 2009). Commonwealth Choice offers commercial health insurance plans to individuals who are not eligible for these premium subsidies and small businesses that have up to 50 workers (Corlette, Alker, Touschner, & Volk, 2011). Massachusetts typically uses outreach workers to perform consumer assistance functions for its Commonwealth Care program (Cabral et al., 2010). This section of the report describes key components of the outreach worker program.

Criteria Used to Identify

According to the Massachusetts Executive Office of Health and Human Services (EOHHS) (n.d.), to identify organizations that can supply outreach workers, Massachusetts looks for the following qualities:

- Local, consumer-focused groups with strong reputations in the community
- Knowledgeable about health reform and health insurance plans available to the public
- Culturally competent and linguistically capable
- Ability to contact and connect to people who are difficult to reach through traditional outreach methods
- An information source for Massachusetts about community needs, successful outcomes, and barriers to care

Mechanisms for Acquisition

Massachusetts' Medicaid and Children's Health Insurance Program (CHIP), MassHealth, uses a competitive procurement process to award grants to outreach workers (Raymond, 2011). These grants—called the MassHealth, Commonwealth Care, and Commonwealth Choice Enrollment Outreach Grant Program—are managed by MassHealth, with support from other public organizations, including the Connector (EOHHS, n.d). MassHealth awarded one-year grants in 2006 and 2007 and multi-year grants in subsequent years to allow grantees to design longer-term outreach projects (Raymond, 2011).

Assigned Functions

Cabral et al. (2010) states that outreach workers have an array of functions. They work for communities with populations that are hard to reach, have low income, and/or have diverse racial/ethnic and linguistic backgrounds. Outreach workers visit schools, community and cultural events, health fairs, and places of worship to promote the Connector and MassHealth programs (Cabral et al., 2010). Furthermore, Cabral and colleagues (2010) say that outreach workers counsel individuals on health insurance options available in the Connector and MassHealth. They also provide in-person assistance with the application and annual redetermination processes, including obtaining necessary documentation (such as birth certificates and pay stubs) and help individuals understand written communication from MassHealth and other insurers (Cabral et al., 2010). After individuals are approved for Medicaid, CHIP, or state-subsidized insurance, outreach workers help them identify primary care providers (Cabral et al., 2010).

Expected Training/Expertise

To train outreach workers and community organizations to complete these functions, MassHealth and the Office of Community Programs, a division of the University of Massachusetts Medical School, sponsor the Massachusetts Health Care Training Forum (MTF) (EOHHS, n.d). MTF distributes information through its website, e-mail updates, and quarterly meetings, at which grantees receive training on outreach and assistance—including methods to reach special populations—and receive updates on health care reform and insurance options (EOHHS, n.d). In terms of expertise, EOHHS (2008) states that grantees must have knowledge and demonstrated experience with helping applicants understand the eligibility criteria, application and enrollment processes, and the annual eligibility review for MassHealth and the Connector. Grantees should also be able to complete program evaluations and track applicants (EOHHS, 2008). When bidding for a grant, organizations must describe their experience in completing these activities and how they fulfill the qualifications (EOHHS, 2008). If MassHealth determines that there is a potential conflict of interest, the organization is required to submit relevant information about its financial, legal, contractual, or other business interests (EOHHS, 2008).

Ways to Retain/Compensate

In 2008, 51 outreach grantees were each awarded up to $41,000 per year (Cabral, et al., 2010). This funding may be used for staffing, project operations, equipment, information technology, marketing and communications, training, and for a portion of indirect costs (EOHHS, 2008).

Mechanisms for Oversight and Accountability

According to EOHHS (2008), grantees must provide monthly reports to the Office of Community Programs that describe their outreach and application assistance activities and submit self-assessments on performance benchmarks. Massachusetts uses this information to

determine whether the grantee is performing at an acceptable level and can receive future grants (EOHHS, 2008).

Methods to Address the Needs of Diverse Populations

Outreach workers serve communities with populations that are hard to reach, have low income, and/or have diverse racial/ethnic and linguistic backgrounds (Cabral et al., 2010). These communities are identified using the U.S. Census Bureau's estimates of areas with a high percentage of uninsured individuals and a low number of health care providers (EOHHS, 2008). Individuals in these areas typically qualify for Commonwealth Care or MassHealth.

Program Funding

Massachusetts authorized $11.5 million in grants between 2006 and 2010 for community organizations to employ outreach workers (Raymond, 2011). The Blue Cross Blue Shield of Massachusetts Foundation also provided $2.4 million in its own outreach grants since 2006 (Raymond, 2011).

Other Means of Consumer Support

In addition to the community outreach grants discussed above, Massachusetts' Exchange has additional consumer information and support vehicles. These include a call center system for customer service issues and a website (Lischko et al., 2009). The website—MAhealthconnector.org—allows consumers to shop for and compare health insurance plans, use tools to help determine eligibility for premium assistance, read application instructions, and buy and enroll in insurance plans (Lischko et al., 2009).

Insurance brokers also perform consumer assistance functions in Commonwealth Choice, the unsubsidized portion of the Connector. Pender (2010) states that brokers provide information and enrollment assistance to small businesses that want to participate in the Connector. The commission for brokers selling coverage within the Connector is $10 per employee per month for businesses with 1 to 5 employees and 2.5 percent of the total premium amount for businesses with 6 to 50 employees (Pender, 2010). Brokers are given four days of training on Commonwealth Choice (Pender, 2010). Small employers can buy their own health coverage from the Connector without the help of a broker, and employers can buy coverage outside of the Connector (Pender, 2010).

Utah

The Utah Health Exchange was established in 2009 as a health insurance marketplace for small businesses with up to 50 workers. The Exchange provides consumers with information about health care, allows consumers to compare and select health insurance plans that meet their needs, and offers a standardized electronic application and enrollment system. The Exchange does not

provide premium subsidies, negotiate on prices, set quality standards, or limit variation on the types of plans (Corlette et al., 2011). Brokers provide consumer assistance to small businesses in the Exchange. This section of the report describes key aspects of these consumer assistance functions in Utah.

Criteria Used to Identify

The Utah Health Exchange (n.d.) requires brokers working in the Health Exchange to:

- Have a producer license with the Utah Department of Insurance.
- Be appointed with all the insurance carriers that provide a defined contribution plan on the Exchange.
- Register with Health Equity, the vendor that pays broker compensation.
- Report any associations with agencies.
    - If a broker is associated with an agency, that agency's name will appear next to the broker's name in the search database.

Assigned Functions

When the Utah Health Exchange began operating, small businesses could only participate through insurance brokers (Pender, 2010). Beginning in 2011, employers do not need to choose a broker to select a plan in the Exchange; however the Exchange encourages employers to collaborate with a broker to ease the process of selecting and applying for coverage (Pender, 2010). A broker helps businesses obtain and complete insurance applications, assists with the enrollment process, and works as a customer service agent between employers/employees and the Exchange (Pender, 2010). In a state survey administered after the launch of the program in September 2009, 74 percent of employers said that a broker or agent assisted them with choosing a plan (Corlette et al., 2011).

Expected Training/Expertise

Because the Exchange's administrators see broker outreach as a priority, they hold weekly educational training sessions for brokers (Gardiner & Perera, 2011). Additionally, brokers are required to complete defined contribution market training courses, which include premium assistance training (Utah Health Exchange, n.d.).

Ways to Retain/Compensate

Brokers are compensated based on a fee paid by employers who use the Exchange. Broker commission is set at $37 per employee per month (Pender, 2010).

Other Means of Consumer Support

In addition to brokers, individuals can receive assistance from a vendor-operated interactive customer service center (Pender, 2010).

Exchange Bills in Other States

According to the National Conference of State Legislatures (NCSL) *Federal Health Reform State Legislative Tracking Database* (2011), at least 26 states enacted or adopted legislation in late 2010 and 2011 that mentions Exchanges. Some of these bills established state Exchanges; others required studies related to Exchanges; and others placed requirements/restrictions on Exchanges if implemented, such as prohibitions on abortion coverage (NCSL, 2011). Of these 26 states, only 7[2] (including Maryland) mentioned Navigators in their legislation.

Of the six states other than Maryland that mention Navigators in their Exchange legislation, most only mention Navigators briefly. The following list summarizes these bills by state:

- Oregon's legislation states that one of the duties of the Exchange is to establish a Navigator Program. Oregon's legislation also authorizes the Exchange to enter into contracts with Navigators and establishes the funding stream for the Navigator grants. To fund the Navigator grants and the ongoing administrative and operational expenses of the Exchange, the Exchange Board will collect an administrative charge from all insurers and state programs participating in the Exchange. This assessment will be based on the number of individuals enrolled in each plan/state program offered through the Exchange. The charges must be sufficient to cover the cost of the Navigator grants and the administrative and operational expenses of the Exchange. The charge may not exceed 5 percent of the monthly premium per enrollee if the plan covers 175,000 or fewer enrollees through the Exchange; 4 percent of the premium if the plan covers between 175,000 and 300,000 enrollees; and 3 percent of the premium if the plan covers more than 300,000 enrollees. If the charges exceed the amounts needed for the Navigator grants and expenses, the excess may be used to offset future losses or reduce administrative costs. The maximum amount of excess funds that may be held for this purpose is the total expenses anticipated for a six-month period. Any excess above that amount must be applied to reduce future charges.
- California's legislation also states that one of the duties of the Exchange is to establish a Navigator Program, and the legislation restates the duties of the Navigator outlined in the ACA (California Assembly Bill 1602).

[2] California, Colorado, Connecticut, Maryland, Oregon, Vermont, and Washington

- Connecticut's legislation also states that one of the duties of the Exchange is to establish a Navigator Program, and the legislation restates the duties of the Navigator outlined in the ACA. It also requires the Exchange Board to establish a form for the Navigator grant applications, develop Navigator performance standards, establish Navigator accountability requirements, and determine maximum Navigator grant amounts (Connecticut Senate Bill 921).
- Vermont's legislation also states that one of the duties of the Exchange is to establish a Navigator Program, and the legislation restates the duties and eligibility criteria of the Navigator outlined in the ACA. In addition to these duties, Vermont's legislation requires Navigators to distribute information to health care professionals, community organizations, and others to facilitate enrollment of eligible individuals (Vermont House Bill 202). It also requires the Exchange to ensure that Navigators are able to provide assistance in-person or through interactive technology to individuals in all regions of the state in a manner that complies with the Americans with Disabilities Act (ADA).
- Colorado's legislation does not list any specific duties or requirements of the Navigator Program. It only mentions Navigators in reference to the composition of the Exchange Board. The Exchange Board is required to have experience in at least two areas from a specified list. One of these areas is "health care consumer navigation experience" (SB10-200).
- Washington's legislation does not list any specific duties or requirements on the Navigator Program. The legislation requires a report by January 1, 2012, that includes, among other things, an analysis and recommendations on "the role and services provided by producers and Navigators, including the option to use private insurance market brokers as Navigators (Washington SB 5445)."

Maryland Consumer Assistance Programs

Several consumer information and assistance programs currently exist in Maryland. These include, but are not limited to, the Medicaid enrollment broker, other health insurance agents and brokers, and the State Health Insurance and Assistance Program (SHIP). Each of these programs is discussed briefly below. The vendor selected to conduct the legislative study will be required to conduct key informant interviews with representatives from these and other relevant programs.

Medicaid Enrollment Broker

The Maryland Department of Health and Mental Hygiene (DHMH) contracts with an enrollment broker to facilitate enrollment and disenrollment in the state's Medicaid managed care program, subsequent to eligibility determinations. This section of the report summarizes various aspects of the Medicaid enrollment broker.

Criteria used to Identify/Mechanisms for Acquisition

DHMH implements a competitive procurement process to acquire the Medicaid enrollment broker. The award is made to a single vendor, and the contract is awarded for a three-year period with the option of three subsequent one-year renewals (DHMH, 2005).

Assigned Functions

Maryland's Medicaid enrollment broker has numerous assigned functions, including (DHMH, 2005):

1. Implementing the process of enrollment and disenrollment

    - Providing a telephone unit to enroll and educate recipients and developing a corresponding Desk Reference Guide for call handling procedures and responses. The enrollment line must be staffed from 7 AM to 7 PM Monday through Friday, and an after-hours message must be provided at all other times that includes call-back information.
    - Operating and monitoring an automated call distributor system that supports toll-free enrollment help line activities.
    - Developing and mailing enrollment packets to each recipient.
    - Processing all enrollments and transmitting the information to the managed care organizations (MCOs) and DHMH daily.
    - Distributing program identification cards to all enrollees and explaining the use of the different cards.
    - Assisting enrollees with the selection of a primary care provider (PCP) for each member of the family.
    - Handling and notifying DHMH of discrepancies in enrollment information and updating information as necessary.
    - Automatically assigning enrollees to an MCO and/or PCP for those who fail to make a selection within the required time frame.
    - Reviewing and approving/denying requests for changing MCOs for cause (outside of the annual right to change).
    - Notifying enrollees of their annual right to change MCOs and providing information about each MCO in the enrollee's service area at that time.
    - Administering the Health Risk Assessment survey to new enrollees.

2. Developing and maintaining information systems

   - Performing ongoing enrollment database management.
   - Creating an MCO plan and participating provider database that includes information on participating physicians, including office locations, schedules, phone numbers, and other special requirements or services.
   - Maintaining a printer or printing system to generate letters and other required correspondence.
   - Providing sufficient staff to ensure adequate access for special populations, such as children with special needs and individuals with disabilities.

3. Conducting outreach and education

   - Making education and outreach services available to every recipient at initial enrollment.
   - Developing expertise in managed care and the Maryland Medicaid delivery system and familiarizing itself with the goals of the Medicaid program.
   - Meeting with each MCO to obtain detailed information on its individual operations.
   - Developing understandable and culturally sensitive materials to be approved by DHMH.
   - Taking a proactive role in reaching out to enrollees to assure that they have the information needed to make an informed choice of an MCO and to understand what is expected after enrollment has taken place. Since many enrollees cannot and do not read, or may not attend an information session, the broker must conduct outreach to groups in the community who interact with enrollees.
   - Coordinating with social service and community organizations to schedule meetings and presentations upon request. The broker must keep a log of these requests and attendees.
   - Working with statewide communities to generate interest in the program and initiating contacts with various organizations.

4. Evaluating enrollee services

   - Designing and maintaining s a “recipient service checklist” for each enrollee to ensure that all necessary enrollment services are delivered.
   - Developing a satisfaction survey to be administered as part of the enrollment process.
   - Participating in problem resolution activities, such as the Enrollee Action Line for solving problems enrollees have with MCOs.

Expected Training/Expertise

DHMH (2005) requires the enrollment broker to have the following expertise and staff:

- The broker must have sufficient staff and organizational components to comply with all broker requirements and standards
- Functions must be performed by staff who have expertise in specific functions and in numbers appropriate to support the program
- At a minimum, the broker must have the following staff for enrollment activities:
    - A project manager who has management experience and knowledge of Medicaid and MCOs
    - Information system staff who have knowledge of and experience in the hardware used by the broker
    - Project supervisors who have adequate management experience and knowledge of Medicaid and MCOs to direct the work of staff
    - Benefit consultants, outreach workers, and telephone enrollment staff who have customer service experience and knowledge of Medicaid and MCOs
    - A portion of the outreach staff must be multilingual
    - A portion of the outreach staff must include individuals who are receiving, or have formerly received, Temporary Cash Assistance (TCA) benefits

The broker is required to develop and maintain a training program for new employees. The program is required to emphasize the importance of objectivity toward all MCOs, treating enrollees with dignity, and respecting enrollees' privacy (DHMH, 2005). As DHMH (2005) states, the content of the training program must include the following:

- General orientation to the role of benefit consultant
- Orientation to MCOs, Medicaid, and the Maryland Children's Health Program
- Orientation to the health care needs of individuals with disabilities and chronic illnesses
- Orientation to the needs and concerns of homeless and homebound individuals and individuals with physical, sensory, and cognitive disabilities
- Orientation to consumer advocacy agencies and community resources
- Cultural sensitivity
- Customer service standards and phone etiquette
- Computer systems used by the broker

- Confidentiality
- Enrollment, disenrollment, and complaint and grievance policies
- Assistance with the completion of the Health Risk Assessment form

Mechanisms Used for Oversight and Accountability

DHMH imposes significant reporting requirements on the enrollment broker. These requirements include daily enrollment reports to DHMH and various weekly and monthly reports (DHMH, 2005). Weekly reports include: a help line activity log; an enrollment activity report; transfer/disenrollment reports; an education and outreach report; a list of recipients who choose their MCOs and those who are auto-assigned; the incidence of requests for disenrollment; and a status report on any problems that may affect program operation and suggestions for resolution (DHMH, 2005). Monthly reports must include: health risk assessments; enrollment checklists; satisfaction surveys; language line reports on the frequency and time of non-English speaking callers; the number of group outreach sessions held; the number of mailings released; community outreach activities; recipient outreach/education; and a report documenting the broker's recruitment efforts to hire individuals who are receiving, or have formerly received, TCA benefits (DHMH, 2005).

Methods to Address the Needs of Diverse Populations

DHMH (2005) requires the broker to conduct the following activities to ensure that the needs of diverse populations are addressed:

- Recruit bilingual staff are for any language representing at least 5 percent of the population in any county or Baltimore City
- Provide bilingual material to single-language minority households if approximately 5 percent or more of households with low income in a geographic region are of a single-language minority
- Fill a minimum of 20 percent of all entry level positions with TCA recipients
- Provide access to telephone-based translation services and Maryland Relay Service
- Ensure that the special communication needs of all clients with disabilities are addressed
- Provide monthly reports to DHMH on the frequency and time of non-English speaking callers to the enrollment hotline

Health Insurance Agents and Brokers

Health insurance agents and brokers help individuals and consumers identify and obtain health insurance coverage, and they are specifically listed in the ACA as entities eligible for Navigator grants. In Maryland, there are approximately 20,000 licensed health insurance

brokers/underwriters (Sage Policy Group, 2011). Approximately 50 percent of non-group insurance is purchased through brokers/intermediaries or through the web; the other 50 percent is purchased directly through the insurance carrier (Carey & Gruber, 2010). In the small group market, over 90 percent of health insurance is purchased through brokers (Carey & Gruber, 2010; Health Care Reform Coordinating Council, 2011).This section of the report describes various aspects of health insurance agents and brokers in Maryland.

Assigned Functions

Health insurance agents and brokers in Maryland provide individuals and small businesses with information about their health insurance options and available plans, assist them with the application and underwriting process, and submit health insurance applications to carriers (Carey & Gruber, 2010). Intermediary companies provide brokers with databases that contain information for most health plans offered by most health insurers in the state; these databases allow the brokers to compare health plans for consumers, obtain premium quotes across multiple health plans, and process enrollment (Carey & Gruber, 2010). The broker can enter information about the consumer into the database to obtain rate quotes and lists comparing detailed benefit and cost-sharing information about multiple plans (Carey & Gruber, 2010). These intermediary databases are not publicly available to consumers who do not use the services of brokers (Carey & Gruber, 2010). Agents and brokers place the business directly with the insurance carrier, a third party administrator, or other intermediaries, such as wholesalers (Healthcare Reform Coordinating Council, 2011).

Expected Training/Expertise and Credentialing Mechanisms

Agents and brokers must be licensed by the Maryland Insurance Administration (MIA) in order to do business in the state of Maryland (MIA, n.d.; Md. Insurance Code Ann. §10-103). In order to obtain a license, brokers must:

- Be aged 18 years and older
- Enroll in pre-licensing education (individuals with following designations are exempt from this requirement: Registered Health Underwriters, Registered Employee Benefit Consultants, Certified Employee Benefit Specialists, Health Insurance Associates, and attorneys in good standing with the Maryland Court of Appeals)
- Pass a licensure exam that determines the competence of the applicant in the line of health insurance and familiarity with applicable state laws
- Pay an application fee
- Submit a licensure application (MIA, n.d.; Md. Insurance Code Ann. §10-103, §10-109)

The broker license expires every other year, and brokers must complete continuing education requirements, submit an application, and pay a fee in order to renew their license (Md. Insurance

Code Ann. §10-115). Agents and brokers must also have appointments with the insurance carriers for the policies they sell (Healthcare Reform Coordinating Council, 2011).

Ways to Retain/Compensate

As Carey and Gruber (2010) explain, agent and broker commissions vary by plan type, insurance carrier, and market (non-group or small group); that is, some insurance carriers pay brokers based on a percentage of premiums, but they are increasingly shifting to paying brokers a flat fee per subscriber per month. They further explain that insurance carriers that use the premium methodology typically pay brokers a commission of approximately 4 to 5 percent of the premium, while insurance carriers that use the monthly payment methodology typically pay brokers $20 to $25 per subscriber per month. It should be noted that the ACA precludes Navigators from receiving compensation from health insurers.

Mechanisms for Oversight and Accountability

MIA is responsible for regulating insurance brokers in Maryland and may deny, revoke, or refuse to reinstate licenses (Md. Insurance Code Ann. §10-126).

SHIP

SHIP is administered by the Maryland Department of Aging (MDA) and is funded by state general funds, grants from the federal government, and local governments. The 19 Area Agencies on Aging in the state receive grants from the MDA to operate SHIP programs in their geographic areas (MDA, n.d.).

According to the MDA (n.d.), SHIP uses a network of volunteers to offer counseling services to Medicare beneficiaries on:

- Medicare Prescription Drug Coverage Program (Part D)
- Medigap
- Assistance for Medicare beneficiaries with disabilities (under age 65)
- Medicare Advantage
- Long-term care insurance
- Medical Assistance programs
- Assistance for Medicare enrollees with low income
- Assistance with denials, appeals, and grievances
- Billing issues
- Health care fraud and abuse

As the MDA (n.d.) explains, the volunteers:

- Provide telephone and in-person assistance to Medicare beneficiaries at counseling sites or clients' homes
- Administer intake interviews to ascertain a client's health benefits, finances, and personal situation
- Screen clients for programs that help them receive or afford health care
- Assist clients with completing benefit applications
- Use the Internet to help clients identify and compare health and prescription plans
- Perform data entry and other clerical tasks
- Assist with organizational activities, such as making copies and filling packets
- Design flyers and other outreach activities

According to the MDA (n.d.), to work for SHIP, volunteers submit applications indicating their skills and interests, language abilities, volunteer and work experience, availability, and the type of work they prefer. The application also asks the individual to describe any affiliations with 1) insurance companies, agencies, or brokers; 2) financial planning services; 3) health insurance claims or billing services; or 4) law firm or legal services associations. Due to possible conflicts of interest, persons employed as insurance agents, insurance brokers, financial planners, or health care providers may not volunteer with SHIP (MDA, n.d.).

All volunteers are required to complete a training program and must sign an agreement that they will keep clients' information confidential (MDA, n.d.). While working for SHIP, volunteers cannot promote their own interests through activities, such as market research (MDA, n.d.). As the MDA explains, volunteers may not encourage clients to enroll in a specific health insurance plan, visit a specific health care provider for treatment, or use a specific insurance agent or broker. Volunteers send monthly documentation of their activities to their local SHIP coordinator (MDA, n.d.).

Issues Identified by Associations and Stakeholders

In addition to the state experience and legislation discussed above, national associations and stakeholder groups are also developing ideas to assist states as they develop Navigator Programs. This section of the report discusses Navigator Program guidance issued by the New American Foundation and the Insure the Uninsured Project, the National Association of Insurance Commissioners (NAIC), and the National Academy of Social Insurance (NASI).

New America Foundation and Insure the Uninsured Project

The New America Foundation and Insure the Uninsured Project (referred to as the Foundation) have collaborated to identify issues and make recommendations specifically about California after passage of the California Assembly Bill 1602, which authorized the creation of the California Benefit Exchange.

The Foundation recommends that California build its Navigator Program from the current organizations that assist with outreach and enrollment activities for public programs. These groups include county social service offices, community clinics, hospitals, health insurance agents, and consumer organizations. California's Certified Application Assistor program could also be a useful tool for the Navigator Program to follow (Weinberg & Sarkin, 2011b). For California's Navigator Grant Program, the Foundation suggests that grants be given to organizations that have language-speaking abilities, are culturally competent, and have an understanding of the local health care environment of the community. Navigators who work with the small business Exchange and with individuals with higher incomes will need these skills, as well as relationships with employers and knowledge of the private insurance market (Weinberg & Sarkin, 2011a).

The Foundation envisions the following functions for Navigators:

- Act as an information resource for individuals and small businesses
- Educate about health coverage offered through the Exchange, including public and private programs
- Direct consumers to have their problems addressed and complaints heard
- Be able to recruit people of different ages and health statuses into the Exchange to prevent adverse selection (Weinberg & Sarkin, 2011b)

The Foundation suggests that funding for Navigators come from the "reasonable charge" tax on health plans in California's Exchange as noted in California Government Code 100503(n). The Foundation explains that Navigator grants can be distributed through one of the following approaches (Weinberg & Sarkin, 2011a):

1. Initiate an annual grant program in which coalitions formed in each county apply for a grant, and the county then distributes the money among coalition members
2. The Exchange Board awards annual grants to potential Navigators based on community need and grantee's skill
3. Grants can be paid as reimbursements for consumer education and plan enrollment. A combination of the above approaches could be used

The Foundation's analysis notes that questions about impartiality of advice, conflicts of interests, and a new certification process for Navigators will require policy attention from California's Exchange (Weinberg & Sarkin, 2011a, 2011b).

National Association of Insurance Commissioners

The NAIC has identified issues related to the structure and function of the Navigator Program, including how agents and brokers (collectively called producers) should be connected with Navigators. NAIC (2011) urges states to deploy Navigators and producers in a complementary manner to support individuals and small employers.

If Navigators and producers perform the same functions, NAIC (2011) proposes that both groups should have the same licensure and certification procedures, including educational requirements, accountability standards, criminal background checks, and a defined list of services that can be provided. NAIC recommends that Navigators be subject to the same regulations that producers must follow, including consumer privacy laws such as the Health Insurance Portability and Accountability Act and the Gramm-Leach-Bliley Act.

NAIC encourages states to oversee organizations that are awarded grants to detect and stop waste, fraud, and abuse. States should have a process for individuals to submit complaints if they are dissatisfied with a Navigator (NAIC, 2011). Navigators should carry professional liability insurance that protects them and consumers if an error occurs (NAIC, 2011). To inform consumers, NAIC suggests Navigators provide a description of the services they can perform for consumers and how they will be compensated for those services.

As set forth in the ACA, Navigators are designed to serve individuals who secure coverage through the Exchange. NAIC supports the idea that Medicaid and CHIP should help fund Navigators because Navigators will help enroll individuals into these programs (NAIC, 2011).

The National Academy of Social Insurance

With support from the Robert Wood Johnson Foundation, NASI identified strategies for states as they implement Health Insurance Exchanges. NASI (2011) urges states to assure that a sufficient number of Navigators are available to assist disadvantaged, hard-to-reach, and culturally isolated populations. Counseling implies a more significant duty than simply providing information; and this higher standard of performance could present liability concerns. As an approach to resolving this issue, NASI recommends certification. NASI (2011) suggests that states expect Navigators to counsel Exchange-eligible persons about public sector options—including Medicaid or CHIP—because there will be many transitions of enrollees between the Exchange and public programs.

The initial funding of Navigators is an issue that states should address because federal start-up funds may not be used to support Navigators. If a state chooses to rely on fees from insurance

premiums as a funding source, then the fees may not be available until after the Exchange begins operation. How to best match the role of Navigators with the continuing roles of brokers and agents is another important issue for states to consider (NASI, 2011).

Summary

One of the key provisions of the ACA is the creation of American Health Benefit and Small Business Health Options Program Exchanges as new mechanisms for individuals and small businesses to purchase health insurance (Kaiser Family Foundation, 2010). The ACA outlines multiple requirements for Exchanges, including the development of Navigator Programs that provide information and assistance to individuals and businesses about qualified health plans. The ACA broadly outlines the funding requirements, eligibility criteria, duties, and standards for Navigators, and HHS recently issued proposed regulations for Exchanges that outline several additional broad requirements for Navigators. The statute and proposed regulations provide states significant flexibility in designing their own Navigator Programs.

The Maryland Health Benefit Exchange Act of 2011 established Maryland's Exchange and an advisory board to oversee it. The legislation requires the Exchange to study and make recommendations on a specified list of topics—including the design and operation of the Exchange's Navigator Program—to the Maryland General Assembly. Consumer assistance strategies undertaken prior to the ACA through the Massachusetts and Utah insurance Exchanges provide some guidance for Maryland policymakers. Laws in six other states directing implementation of Health Insurance Exchanges refer to the Navigator function, but none of the laws provide specifics about the design or scope of the Navigator role. Many organizations and stakeholders have considered Navigator issues and have offered diverse perspectives. The upcoming study to be undertaken by the Exchange Board will be essential in the design and implementation of a well-functioning Navigator Program in Maryland.

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Appendix. Summary of Consumer Assistance Programs in Other State's Exchanges

Program Characteristics	Massachusetts		Utah
	Outreach Worker Program	**Insurance Broker Program**	**Exchange Insurance Brokers**
Criteria to Identify	▪ Local, consumer-focused, non-profit groups with a strong reputation in their community ▪ Knowledgeable about health reform and health insurance plans available to public ▪ Culturally competent; linguistically capable ▪ Ability to contact and connect to people who are difficult to reach through traditional outreach ▪ Information source for the state about community needs, successful outcomes, and barriers to care		▪ Have a producer license with the state ▪ Are appointed with all insurance carriers that provide a defined contribution plan in the Exchange ▪ Registered with HealthEquity, which pays broker compensation
Mechanisms for Acquiring	▪ Competitive procurement process ▪ Annual grants awarded in 2006-2007 ▪ Multi-year grants awarded after 2007		
Assigned Functions	▪ Education on insurance options ▪ Outreach ▪ Application/renewal assistance ▪ Assistance with eligibility documentation ▪ Assistance with written communication to state	▪ Education on insurance options ▪ Application/renewal assistance	▪ Assistance with Exchange application form ▪ Serve as a customer service agent between employers/employees and the Exchange ▪ Help with the enrollment process

Program Characteristics	Massachusetts		Utah
	Outreach Worker Program	**Insurance Broker Program**	**Exchange Insurance Brokers**
	staff ▪ Helping consumers find providers once enrolled in a plan		
Expected Training/Expertise	▪ Grantees are trained by the Massachusetts Health Care Training Forum (MTF) ▪ MTF provides information in monthly meetings, email updates, and its website ▪ Monthly meetings include training sessions on approaches to outreach/assistance and information on health reform and insurance programs	▪ Expected to attend 4 days of training	▪ Must take defined contribution market training courses, including premium assistance trainings ▪ Exchange administrators hold weekly educational training sessions for brokers
Credentialing Mechanisms			
Ways to Retain/Compensate	▪ 51 grantees received up to $41,000 per year in 2008	▪ $10/employee/month commission for businesses with 1-5 employees ▪ 2.5% of total premium commission for businesses with 6-50 employees	▪ $37 commission per employee per month
Methods to Assure Needs of Diverse Populations	▪ Diverse groups of outreach workers are hired to work in their own communities with people from similar racial/ethnic and linguistic backgrounds ▪ State provides training sessions on working with unique populations		

Program Characteristics	Massachusetts		Utah
	Outreach Worker Program	**Insurance Broker Program**	**Exchange Insurance Brokers**
Oversight and Accountability	▪ Grantees give reports to the state on outreach and enrollment activities		▪ Agencies are not allowed to sell on the Exchange. ▪ If an individual is associated with an agency, the agency's name will appear next to the individual's name in the database
Program Funding	▪ Between 2006-2010, $11.5 million in grants to community groups were awarded by the state ▪ Since 2006, Blue Cross Blue Shield of Massachusetts provided $2.4 million in outreach grants		▪ Brokers are paid through a fee on employers using the Exchange
Other Consumer Support	▪ Telephone help lines and a call center to respond to consumer needs ▪ Website provides information on insurance options, eligibility, and application assistance ▪ Connector contracts with a vendor who assists with services in the Commonwealth Choice program, such as eligibility and enrollment, customer support, and premium billing, collection, and remittance services		▪ Customer interactive service center offers support to businesses participating in the Exchange

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