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Robert Wood Johnson Foundation

OCTOBER 2014

Report from the First Year of Navigator Technical Assistance Project: Lessons Learned and Recommendations for the Next Year of Enrollment

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Support for this report was provided by a grant from the Robert Wood Johnson Foundation

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CHIR faculty and staff study health insurance underwriting, marketing and products, as well as the complex and developing relationship between state and federal rules governing the health insurance marketplace. CHIR provides policy expertise and technical assistance to federal and state policy-makers, regulators and stakeholders seeking a reformed and sustainable insurance marketplace in which all consumers have access to affordable and adequate coverage.

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As part of the University's McCourt School of Public Policy, Georgetown CCF provides research, develops strategies, and offers solutions to improve the health of America's children and families, particularly those with low and moderate incomes. In particular, CCF examines policy development and implementation efforts related to Medicaid, the Children's Health Insurance Program (CHIP) and the Affordable Care Act.

Introduction

The Affordable Care Act (ACA) ushered in the largest coverage expansion since the creation of Medicare and Medicaid in 1965. The Congressional Budget Office estimates the ACA will reduce the number of uninsured by 26 million by 2024.[1] More than 8 million people enrolled in private coverage through the Health Insurance Marketplaces in the initial open enrollment period that ended March 31, 2014, and 4.8 million enrolled in Medicaid and CHIP.[2] At the same time, the ACA imposed new rules for employer-sponsored coverage and insurance sold to individuals, and instituted new responsibilities for individuals and employers.

While previous large coverage expansions relied on publicly administered coverage programs such as Medicare and Medicaid, the ACA expands coverage through both publicly administered Medicaid and private insurance plans offered in new Marketplaces, with the aim of seamless coverage for individuals, no matter their income, age, health, or employment status. Merely processing applications for the millions who enrolled in coverage this first year was an enormous undertaking. The eligibility and enrollment rules are complicated, taking into account income, household size, tax-filing status, immigration status and, in the case of eligibility for premium tax credits, access to other coverage. In addition, health insurance is an inherently complicated product; applicants for the private insurance plans of the Marketplaces have to weigh differences in cost-sharing, provider networks, benefit design and drug formularies. As a result, enrolling in Marketplace coverage is complicated even for individuals and families with the simplest, most straightforward circumstances.

The rules governing eligibility for Marketplace plans, premium tax credits, and Medicaid are, by necessity, designed for the generic applicant and cannot possibly address the myriad ways in which households are formed, income is gained, and coverage is accessed. The first open enrollment period for the Marketplaces made clear that many people require intensive assistance to navigate the coverage options and applicable rules of the ACA.[3]

With support from the Robert Wood Johnson Foundation, Georgetown University policy experts provided technical assistance to Navigators and assisters in five states–Arkansas, Arizona, Florida, Georgia, and Ohio–during and after the 2014 open enrollment season, as they fielded questions from consumers about eligibility and enrollment. This report draws on that work to provide a picture of how applicants' lives align–or often don't align–with eligibility rules and application requirements, and shares lessons learned during the first year of enrollment regarding what is required to help people understand their coverage options and successfully enroll.

Background

Throughout the first year of enrollment into new coverage options under the ACA, various types of consumer assisters have worked to ease the transition of millions of individuals into appropriate health insurance coverage. While the availability and extent of consumer assistance varies, recently issued reports showcase the importance of consumer assistance for the approximately 10.6 million individuals who sought help enrolling in health insurance coverage through a Marketplace in its first year.[4]

The ACA includes a number of provisions to support effective outreach and enrollment of consumers into coverage. As implemented, these programs may vary depending upon the type of Marketplace model, federally facilitated (FFM), state based (SBM), or a federal partnership (FPM), but all Marketplaces must maintain some form of assister program.

All Marketplaces must have a call center, accessible to those with disabilities and limited English proficiency, and websites, with health plan and related cost information.[5] Rules and guidance implementing the ACA also contemplate in-person consumer assistance in the form of Navigators, In-Person Assisters (IPAs), Certified Application Counselors (CACs), and agents and brokers during the pre-enrollment and enrollment phases.[6] For purposes of this paper, Navigators, IPAs and CACs are referred to generally as "assisters." In addition, the ACA appropriated $30 million in funding for Consumer Assistance Programs (CAPs), which in addition to enrollment assistance are tasked with helping consumers

once they are enrolled and using their coverage, for example, assisting consumers with appeals when an insurer denies coverage for a service.[7]

Regardless of label, assisters were all charged with helping consumers understand their options and enroll in coverage. For the 2013-2014 enrollment season, the FFM awarded $67 million in Navigator grants to 105 organizations, and federally qualified health centers (FQHCs) received $208 million to serve as CACs.[8,9] SBM states determined the level of funding for their assister programs and ran their own processes for selecting grantees. During the 2013-2014 enrollment season, SBMs outspent FFMs on consumer assistance, accounting for 50 percent of spending, even though they only had 31 percent of all uninsured.[10]

Assisters must complete a minimum level of training on Marketplace eligibility and enrollment rules, available health plan options, other available insurance programs like Medicaid or CHIP, and eligibility and benefit rules.[11] Other standards or requirements may apply to the range of assisters depending on the type of Marketplace and state law.[12]

While the ACA envisioned that Navigators would largely be limited to helping with enrollment, the vast majority of enrollment assisters, including Navigators, have been called upon to address post-enrollment questions from consumers about their coverage and benefits.[13] Yet consumer assisters are neither trained nor funded to handle these questions, with the expectation that they would be able to refer consumers to CAP or consumer ombudsman programs. The ACA funded states in 2010 to establish or support the CAPs, specifically designated to handle post-enrollment questions, but Congress has not appropriated funding for this program since then.[14] The lack of funding has caused 22 of the 33 states that had CAPs to discontinue their programs. As a result, consumer assisters have an additional burden of providing consumers with post-enrollment help without financial support for training and operation. State Departments of Insurance have consumer support divisions to answer consumers' coverage questions and help resolve problems, but few consumers know they exist and they are often under-resourced. Many consumers, once they've established a relationship with an assister to help them enroll in coverage, are likely to return to the assister when

Type of Assister	Scope of Work	Where they Work	Funding Source
Navigators	• Serve as experts on eligibility, enrollment, and Marketplace plans • Conduct outreach and education activities to raise awareness about Marketplaces • Facilitate enrollment into Marketplace plans, including financial assistance, in a fair, accurate, and impartial manner • Refer consumers to applicable entities to assist with post- enrollment questions • Provide information that is culturally and linguistically appropriate to the populations they serve	SBM FFM FPM	Marketplace grants (state and federal)
In-person Assisters	• Similar to Navigators	SBM FPM	Federally funded Marketplace establishment grants
Certified Application Counselors	• Facilitate enrollment into Marketplace plans, including financial assistance • Provide information on Marketplace plans, and other coverage options like Medicaid or CHIP	SBM FFM FPM	Some operate without funding; Federal grants available for FQHCs only
Agents and Brokers	• Facilitate enrollment into Marketplace plans, including financial assistance • Provide post-enrollment assistance with coverage problems	SBM FFM FPM	Insurers
Consumer Assistance Programs	• Assist with filing complaints and appeals, including providing information about the external appeals process • Collect data on consumer problems and questions • Educate consumers about their rights and responsibilities with health insurance • Assist with enrollment into Marketplace plans • Resolve problems related to obtaining tax credits	11 grantee states	Federal CAP grants

they have a coverage problem. Enrollment assisters will continue to be stretched thin as they start preparing for the second year of enrollment.[15]

Year One of the ACA: Who Needed Consumer Assistance and Why?

While the ACA has saturated the news, many Americans are unfamiliar with key provisions of the health reform law and health insurance in general.[16] Prior to the start of open enrollment, the uninsured and low-income adults had a very low knowledge of the Marketplaces and Medicaid expansion.[17] Younger, Hispanic, low-income and uninsured individuals also have very low understanding of basic health insurance concepts. Almost two out of three adults targeted for Marketplace enrollment had difficulty understanding terms like "provider network," "deductible," and "premium."[18]

As predicted, most consumers during the first year of Marketplace enrollment were lower-income and an estimated six in ten were previously uninsured, with little knowledge of how health insurance works.[19] Consumers' limited understanding of, and confusion about plan choices was one of the primary reasons they sought personal assistance during the 2014 open enrollment period, and ninety percent of individuals seeking help were uninsured.[20] Another reason consumers sought personal assistance was to get help applying for premium tax credits and cost-sharing reductions.[21] Eight out of 10 consumers using the Marketplaces were eligible for a tax credit or cost-sharing reductions, with incomes between 100 percent and 400 percent of the federal poverty level.[22] While the FFM and most states have not yet released data on the income ranges of enrollees, one state–New York–has reported that 53 percent of its enrollees were below 200 percent of federal poverty.[23] Families living below 200 percent of the federal poverty line are more likely to have fluctuations in income because of unstable or intermittent employment, "shared" households that include non-immediate family members, low educational attainment, and more frequent changes in address. These circumstances tend to require additional assistance with enrolling into Medicaid or Marketplace coverage with tax credits and cost-sharing assistance.[24]

Another characteristic of the Medicaid and Marketplace populations is that many consumers will switch among various types of coverage–Medicaid, Marketplace, and employer-sponsored insurance (ESI)–throughout the year because of changes in income or family circumstances, referred to as "churning." Churning already occurs between Medicaid and CHIP and is expected to increase under the ACA.[25] Half of low-income adults who do not receive ESI will likely experience a change in income or family circumstance that switches their eligibility between Medicaid and Marketplace coverage throughout the year.[26] Although the data currently do not tell us the extent of "churning" during the first year of Marketplace coverage, churning among eligibility for Medicaid, Marketplace, and ESI could affect nearly 29.4 million people a year.[27]

This snapshot of the first year's market consumer translated into a need for consumer assistance. Sixty-four percent of assisters spent, on average, one to two hours helping each consumer, but many required more time and multiple sessions–nearly a quarter of assisters reported spending more than 2 hours on average with each consumer.[28] In addition to the time needed to explain eligibility rules, the different forms of financial assistance, and plan options, assisters faced technical difficulties with Marketplace websites and long wait times with call centers; these all translated into a significant amount of time spent with each consumer.[29]

Project Overview

During the first year of enrollment, Georgetown policy experts supported assisters in four FFM states (Arizona, Florida, Georgia and Ohio) and one FPM state (Arkansas), providing technical assistance for the more complex cases and questions among the many answered by assisters. This brief draws on some of those questions to illustrate the complex nature of the eligibility and enrollment process for many individuals and families.

The questions presented in this brief are just a subset of the most challenging questions assisters sent to Georgetown for technical help. Although the assister programs were organized differently across the five states and had different levels of financial support, we observed that the same types of questions came up often and across the five states, suggesting that assisters nationwide were grappling with many of the same issues.

Georgetown worked primarily with certified Navigators and application counselors in FQHCs. However, there were many others providing enrollment assistance to consumers, including insurance agents and brokers, tax preparers, Medicaid agencies, providers, and many others who volunteered in their communities. Our work did not capture the experiences of these assisters. Nonetheless, the questions presented in this brief illustrate the diverse and complicated situations that assisters faced when helping consumers, and they highlight the critical need for a sustained investment in personalized assistance to help ensure people obtain the right coverage at the right cost. Answers to the below questions are provided in Appendix A.

Consumer Assistance in the First Year: Observations from the Field

The ACA provides financial assistance for qualified individuals to purchase Marketplace plans. It is this assistance, provided in the form of premium tax credits and subsidies for out-of-pocket costs, that helps put coverage in financial reach for millions of low- and moderate-income families. However, determining eligibility for financial help is also one of the most complicated aspects of the enrollment process, with nuances that aren't always adequately captured by the application. As a result, Navigators and assisters are finding it necessary to gain mastery over complex rules for income calculation, household size and definition, tax filing status, and eligibility for other coverage. Other rules, such as those related to open and special enrollment periods and the ability to keep or change health plans, evolved over the course of the year, requiring assisters to stay regularly abreast of the ever-changing landscape of federal and state policymaking.

Determining Household Size

An initial step in the application process for premium tax credits is to first screen for Medicaid eligibility; if an applicant is eligible for Medicaid, they are ineligible for premium tax credits. However, there are differences between key definitions in the eligibility process for Medicaid and premium tax credits. Both Medicaid and premium tax credit eligibility are based on Modified Adjusted Gross Income (MAGI), a measure of income created by the ACA, which is consistently applied for most tax filers. However, Medicaid uses different ways to establish the size of an applicant's household for purposes of determining eligibility for non filers and for individuals who meet specific exceptions. To determine household size for premium tax credits, the Internal Revenue Service (IRS) includes in the household anyone who is a dependent for tax filing purposes, regardless of family relationship or whether they live in the home. For non tax filers, Medicaid takes a different approach, and does not include in the definition of household dependents who are not immediate family members, even if they live in the home. Exceptions to the tax-filer rules further complicate Medicaid eligibility determinations for some tax dependents.[30]

In real life, it can be difficult for applicants and their assisters to figure out how these nuanced differences in program rules apply to often complicated family relationships and tax filing status. For example, one assister had to evaluate a household in which a 22-year-old was living with his grandmother and applying for Medicaid. The grandmother claims her grandson as a tax dependent, which would make him part of her household in applying for premium tax credits. However, under Medicaid rules, because he is claimed as a dependent by

Determining "Household"

Parent as dependent: Alice* is a 50-year-old woman who lives with her 28-year-old daughter, Jane, and cares for Jane's two children (Alice's grandchildren). Jane claims Alice as a dependent on her taxes. Jane has insurance from her employer that covers her and her children, but it won't cover Alice. When Alice applies for coverage, should she include her daughter's income and list all four members of the household?

Non-custodial parent: Robert wants to buy a Marketplace plan for himself and his son, John, who lives with his ex-wife. His divorce agreement requires him to provide coverage for John, but he doesn't claim him as a dependent on his taxes. What are Robert's options to buy a plan that covers them both?

**All names used in this and later examples are pseudonyms used to protect the identity of the individuals seeking assistance.*

someone other than a spouse or parent, he is evaluated on his own based on non filer rules.

Calculating Income

Determining income is also complicated. The MAGI income methodology is used to determine eligibility for most children and non-disabled, non-elderly adults, but the pre-ACA non-MAGI income methodology still applies to people who are aged or disabled. Further complicating the process is that Medicaid looks at an individual's current income in determining eligibility, while premium tax credits are based on projected income for the tax year.

Individuals applying for premium tax credits must understand what income to count in defining "household income," project income over the course of the tax year, and provide acceptable documentation to substantiate the estimate if federal data sources cannot verify the projected annual income. Those who get the estimate wrong and project a lower income than they actually earn will have to repay any excess tax credits received during the year when they file their taxes. On the other hand, those who overestimate their household income may pay more out-of-pocket than they should if they are wrongly found ineligible for cost-sharing reductions or receive less cost-sharing reductions than they should.

Estimating Uncertain Income

Jessica is a dog walker and paid hourly. She projects income over 100 percent of the federal poverty level, qualifying her for premium tax credits. But she's worried that if she gets less work than she expects, and her actual income is less than 100 percent of the federal poverty level, she'll have to pay those tax credits back.

The rules themselves are complicated, and so too are people's lives. Individuals may be part of a multi-generation household or live apart from their parents or children. Many individuals have uncertain or fluctuating income over the course of the tax year, particularly those who work part time, have seasonal work, or are between jobs. Others may receive income from sources other than wages. For example, assisters helped consumers sort through the rules as they applied to the many different ways applicants for coverage received financial help from family members:

- Jackie gets help on her rent from a family member who lives with her. Without the assistance, she couldn't afford the rent. Must she count the rental assistance in her household income?
- Frank and Ellen are retired and don't file taxes. Their children contribute to their household costs, but none claim the parents as dependents. When Frank and Ellen apply, do they list the financial help from their children as part of their income?
- Shauna and Bob live with their adult son, Bill, who claimed them as dependents on his 2013 tax return. Bill provides them shelter but they pay their own food and health care costs. Shauna and Bob make less than 133 percent of the federal poverty level and would qualify for Medicaid. Does Bill's help and tax filing affect their Medicaid eligibility?
- Grace is a 63-year-old woman whose family pays her $500 per week to care for the 98-year-old family matriarch. Should Grace count the family's payments as earnings when applying for coverage?

Access to other coverage

Consumers applying for tax credits must also provide information about any other coverage to which they may have access. Those who are eligible for other coverage may be ineligible for premium tax credits. But even here, there are variations on the rules that make it difficult for individuals to evaluate their other coverage options and understand what it may mean for eligibility for premium tax credits.

Generally, those eligible for and enrolled in employer-sponsored coverage, Medicare, Medicaid, high risk pool coverage, a student health plan, COBRA, or retiree coverage are considered to have minimum essential coverage (MEC) and cannot qualify for premium tax credits. However, if the employer plan is unaffordable or inadequate, an individual can turn down their employer plan and enroll instead in a Marketplace plan and get premium tax credits. To be "affordable" under the ACA, the employee's share of the premium for self-only coverage in the lowest cost plan must be less than 9.5 percent of household income. But what was "affordable" to congressional drafters may not be considered affordable by many low- and moderate-income people with many other bills to pay. Some consumers who have sought assistance are not enrolled in their employer plan because it costs too much. Others have asked if they can opt out of an employer plan that doesn't cover providers in their area, won't cover a procedure they need, or doesn't include key

Questions about Other Coverage and Premium Tax Credits

Student Health Plan: An older PhD student, Anna, is told her student health plan won't cover her shingles vaccine or a colonoscopy. Is that allowed? Can she get a Marketplace plan instead?

Retiree plan: Sandra retired at 55 and has an offer of retiree coverage for herself and her husband and 19-year-old son. The plan would be a good deal for her, but is too expensive for her husband and son to join. If Sandra enrolls in the retiree plan, can her husband and son still apply for Marketplace coverage with premium tax credits?

Medicaid Breast and Cervical Cancer Program: Jane was uninsured when she was diagnosed with breast cancer and was found eligible for the Breast and Cervical Cancer Program (BCCP) under Medicaid. She wouldn't qualify for Medicaid based on her income. Does enrollment in the BCCP program make her ineligible for Marketplace coverage because it's Medicaid coverage?

benefits. Still others have coverage that is affordable for the employee, but get no employer contribution for family coverage. For premium tax credit eligibility, however, none of these situations factors into the Marketplace evaluation of whether an employer plan is unaffordable or inadequate.

In other cases, merely being eligible for qualifying coverage does not disqualify an individual for premium tax credits; it is only if the individual is enrolled in the plan–such as student health coverage or a retiree plan–that they are ineligible for financial help. However, eligibility for most but not all categories of Medicaid makes an individual ineligible for premium tax credits.

Immigrants

Eligibility for the Marketplace is limited to citizens and nationals of the U.S. and lawfully-present immigrants. Throughout open enrollment, immigrants faced technical difficulties with the processes for verifying identity and immigration and citizenship status, and for submitting documentation of their immigration and citizenship status when it could not be verified electronically.[31] But there was also confusion about who was eligible for marketplace coverage. Most lawfully present immigrants with income under 100 percent of the federal poverty level, who were ineligible for Medicaid based on their immigration status, are eligible for premium tax credits even though their income is below the federal poverty level. However, because of system flaws, many of these individuals received incorrect eligibility determinations that resulted in denials of the premium tax credits and cost-sharing reductions and were referred back to Medicaid even though they did not meet Medicaid's immigrant eligibility requirements.

The application process for immigrant families is further complicated for mixed status families, which are households in which different family members have different immigration or citizenship statuses. For example, one parent may be undocumented, another may be in the U.S. on a visa, an adolescent child is in the Deferred Action for Childhood Arrivals program, and a younger child may be U.S.-born. A report published in 2010 estimated one quarter of children in the United States is in a household with at least one foreign-born parent.[32] In addition to the technical issues that arise with mixed status families, the differences in immigration status may lead to mixed program eligibility.

Mixed Status/Mixed Program Families

A family applying for coverage includes two parents who have been lawfully residing in the U. S. for three years and two children, Esteban, who has been lawfully residing in the U.S. for three years, and a daughter, Celia, who is U.S.-born. The parents and Esteban are eligible for a Marketplace plan, but only Celia is eligible for Medicaid. Why can't both children get Medicaid? Or can they add Celia to the Marketplace plan with premium subsidies?

Changing Plans

Under the ACA, health insurers selling individual coverage are required to sell a plan to all applicants, with certain limited exceptions. One of the most important exceptions allows insurers to limit the amount of time during the year that policies are available. Once enrolled in a plan, an individual is also limited in their ability to change plans. For the most part, only those who experience life changes, such as marriage, loss of job, or the birth or adoption of a child can qualify for a special enrollment period (SEP), which gives them the right to sign up for a plan or change plans outside of the open enrollment period.[33]

Navigators and assisters heard from consumers who wanted to change plans, typically because they discovered after they enrolled that their providers are not in-network, that their providers left the network for the plan they chose, or their health needs changed and they wanted

access to providers they hadn't anticipated. Under federal rules, individuals can change plans only under limited circumstances. Once they have paid the first premium and the coverage has taken effect, an enrollee cannot change plans. For most people, changing plans is only possible if the coverage hasn't taken effect and it is still within the open enrollment period.

Throughout the initial open enrollment period, CMS issued guidance designating new "limited circumstance" special enrollment periods. Navigators and assisters had to stay abreast of these new special enrollment periods, understand to whom they would apply, and help consumers navigate through the process to request a SEP. One such SEP was allowed for those who enrolled in a plan with a network that wouldn't meet their needs. However, the SEP was very limited; it only applied where the individual was changing to a plan with the same insurance company, within the same metal level, to gain access to a broader network, and the change would occur within open enrollment.

Changing Plans

Brenda selected a plan knowing that the hospital in her area was not on the plan, but her primary care doctor was. She had not yet heard from the plan about her enrollment and had not yet paid her first premium when she was diagnosed with cancer and was referred to specialists and an oncologist that are not covered under her plan. Can Brenda change to a different carrier that would include the providers she needs?

Other SEPs were enumerated in the final push to enroll in Marketplace coverage prior to the end of the initial open enrollment period on March 31st. One such SEP applied to those who applied for Medicaid prior to March 31st but were then denied Medicaid after March 31st. These individuals were granted a 60-day SEP to apply to the Marketplace following their Medicaid denial.

In other cases, consumers needed help transitioning to a Marketplace plan from other coverage, such as a job-based plan, retiree coverage, or a student health plan. An update to the federal rules this year allows individuals who are losing minimum essential coverage (MEC) to qualify for a SEP that begins 60 days prior to the loss of MEC and continues for 60 days after the loss, which is helpful in avoiding a gap in coverage. Many individuals losing access to job-based coverage are eligible for both COBRA and Marketplace coverage, but under federal rules enrollment in COBRA disqualifies an applicant from receiving Marketplace financial assistance. However, because of concerns that many consumers were not aware of these rules, federal officials later determined that COBRA enrollees could qualify for a short-term enrollment period for subsidized Marketplace coverage through June 30, 2014. But most consumers don't know about these special enrollment opportunities and are unable to effectively use them to avoid gaps in coverage, without personalized assistance. For those who are seriously ill, even a small gap in coverage can lead to substantial costs or a threat to their health.

Avoiding a Gap in Coverage

Sally lost her job and her insurance coverage at the end of April and got a new job with coverage that wouldn't begin until July. In the meantime, she was diagnosed with breast cancer and was scheduled for surgery in early May. Would she be able to get Marketplace coverage in time for her surgery or would she have a gap in coverage? Should she enroll in COBRA to fill the gap between job-based plans?

Post-Enrollment Issues

Although Navigators and assisters do not technically have within their scope of work a responsibility to assist consumers with questions that come up about their coverage, most have been called upon to provide this help. In a survey of assisters conducted after open enrollment, 90 percent of assister programs reported being re-contacted by consumers with post-enrollment problems and questions.[34] In some cases, consumers returned with questions about their plan, i.e., if they hadn't received their insurance card or a premium invoice. In other cases, consumers had questions about using their coverage. Of those surveyed, 44 percent of assister programs were contacted by consumers who didn't understand how to use health insurance, and 37 percent were contacted by consumers who discovered that their providers weren't in their plan's network.[35]

Many consumers were concerned about access issues– how to access out-of-network providers, or what does it mean if a drug is not covered under the formulary. Other consumers wanted to understand what would happen if they missed a premium payment. Still others had questions about why their non-Marketplace plan would not pay for benefits they expected to be covered, often hoping such a problem would qualify them for a special enrollment opportunity to enroll in a better plan.

Post-Enrollment Questions

Drug formulary: Jack purchased a plan through the FFM that does not cover a specialty tier drug that he needs for a chronic condition. Does that mean Jack is responsible for the full cost of that prescription drug, and the out-of-pocket cost will not be included as part of his out-of-pocket maximum?

Provider network: Janice has learned that her health plan no longer includes the county hospital. The closest hospital that takes the insurance is 26 miles away. What are her options?

Benefits that fall short: Mary is pregnant and has learned that her insurance does not cover maternity care. Can she apply for a SEP since this is a required essential health benefit?

Surveys indicate many people still are unaware of key features of the ACA, including the availability of financial help to buy coverage.[36] This is particularly a problem among the uninsured who have the most to gain from expanded coverage options under the ACA. A recent study of low-income individuals who remain uninsured after the first open enrollment period found only three out of five had heard of the Marketplaces and only two in five had heard about the subsidies.[37] It is not likely these consumers would be able to understand what is required to apply for financial help and choose a plan without the kind of intensive help that is provided through Navigators and assisters.

Lessons for Open Enrollment Round Two

The next open enrollment period will bring new challenges to this already complicated enrollment process. An estimated 5 million more people will enroll in coverage in the open enrollment period that begins November 15, 2014.[38] The remaining uninsured, including those who are projected to enroll for the first time this fall, may be more difficult to reach than those who sought and enrolled in coverage during the first open enrollment. They are also more likely to be Spanish speakers and to have less than a high school education. They are more likely to live in the South, where most of the Marketplaces are federally run and have, to date, had fewer resources for consumer assistance than states operating their own Marketplace or in partnership with the federal government.[39]

In addition, the more than 8 million individuals currently enrolled in Marketplace plans will need to renew their coverage. Under federal rules, most can be automatically renewed in their current plan with the same amount of tax credits as they received in 2014 and based on projected rather than actual 2014 income.[40] But all may–and probably most should–revisit the Marketplace to compare plan options for 2015 and update their household and tax information to ensure they receive the right level of financial assistance. Even individuals and families whose income and household information has not changed could be renewed with an incorrect amount of premium tax credits, simply because the price of the benchmark plan in their area has changed. Equally important, some consumers–even those without an income change–may miss out on lower cost-sharing if they don't update their eligibility because the federal poverty levels are updated each year.

To compound the challenge of enrolling 5 million more individuals, including hard-to-reach populations, and re-enrolling millions more, this effort must take place within a shorter period than the first open enrollment. Open enrollment for coverage that begins in 2015 runs from November 15, 2014 to February 15, 2015–half the time of the 2014 open enrollment period, and with the major end-of-year holidays competing for consumers' attention.

A key finding of the first open enrollment period is that consumer assistance works, particularly to help enroll those who are hardest to reach and previously uninsured. Those who sought information and help from sources other than the website–including Navigators, application assisters, and insurance agents–were more likely to enroll in coverage.[41] Building upon this successful feature of the first open enrollment period will be essential in tackling the next one successfully.

Wanted: More Predictable Funding and Technical Support

It is penny wise and pound foolish for Marketplaces not to heavily invest in consumer outreach and assistance. Yet both the FFM and many SBMs are reducing the level of support. The second round of federal grants was awarded in mid-September, and the level of support has

dropped from $67 to $60 million. Colorado's 2015 budget for consumer assistance is $12.3 million less than the marketplace spent in 2014, and Connecticut's assisters are seeing an 80% cut in funding.[42]

In addition to providing adequate resources, state and federal policymakers should seek to professionalize Navigators through sustainable and predictable funding, and with enhanced training and support. The first-year grants for federal Navigators ran through August 15, 2014, and were non-renewable. Because of limited resources and the uncertainty of future funding, many organizations may have laid off Navigators or cut back on their hours soon after the close of the first open enrollment. Navigators from SBM states are similarly struggling with funding challenges. Most FFM Navigator entities received a second year of funding, but as many as one-third are new. Even for those with renewed funding, many will need to hire and train new individuals to serve in this critical role prior to November 15th. At a minimum, navigator grants should be renewable at the option of the Marketplace or should be awarded on a multi-year basis, with new grant opportunities offered with sufficient lead time to avoid gaps in funding and subsequent layoffs of trained navigators.

The Marketplaces should also offer multiple levels of training. The first level would be for new assisters who have not been through training before. The second level should be designed for assisters who have already served and have a good foundation in Marketplace and Medicaid operations and rules. This second tier of training should be more advanced, allowing assisters to build expertise in complex federal tax rules, the definition of household, immigration-related issues, and the rules for consumers with access to other coverage. A third level of training could be designed to develop an elite cadre of experts who could provide in-house, real-time support on some of the more complex, difficult questions presented to assisters in the field. Marketplaces should work to professionalize these roles to encourage retention, ensure continuity, and build a strong base of knowledge within the assister community.

In the short term, while in-house expertise is being developed, Marketplaces could provide assisters with real-time policy expertise and technical assistance to ensure full understanding of federal and state rules as they apply to consumers' individual circumstances. In some cases, assisters will be helping families in unique situations, and will face complicated questions that may only come up once or twice during an enrollment season. In other cases, they may need assistance to understand how a new federal or state rule will affect a much broader range of clients.

Assisters have many demands on their time and the first year's enrollment was particularly difficult for assisters to stay up to speed on a constantly evolving set of federal rules and procedures. One Navigator described the process as "learning to fly the plane while it is being built." Support could be provided through programs such as Georgetown's, or by the Marketplaces themselves, through a dedicated call-in line, or web portal. For example, New York's Marketplace had a twice-weekly call with lead assister organizations, allowing assisters to get answers and address individual issues as well as systemic problems as they arose. Other SBMs allow organizations to serve a coordinating role for assisters to help funnel complex questions and cases to the right technical experts, similar to how Georgetown offers its support. But in the FFM states, federal rules require all Navigator entities to perform all the required functions of a Navigator. This leads to significant inefficiencies in the program and allocation of resources. Organizations that would be best positioned to play a policy support or technical assistance role are not eligible grantees because they do not have the staff or capacity to perform the other required functions, such as outreach and education. Likewise, organizations that could help reach niche populations with effective outreach may not have the capacity to provide assistance with applying for financial assistance or plan selection.

Furthermore, Navigators and assisters are not trained or resourced to provide extensive post-enrollment help, but consumers are returning to Navigators and assisters with questions about their coverage. Marketplaces should provide support for Navigators and assisters on post-enrollment issues such as benefit denials and questions about networks, formularies, and covered services. States should also encourage their Departments of Insurance (DOIs) to better coordinate with Navigators. These agencies have traditionally provided assistance to consumers with coverage problems and oversee all commercial plans sold in the state, including those sold through the Marketplaces. Consumer assisters could become important sources of information for state regulators and help them perform their oversight role.

Wanted: Improved Enrollment Process

Assisters could also be more efficient and cost-effective if the process for enrolling was simplified and streamlined. For example, a simplified, consumer-tested application would not only help assisters move through the process more quickly, it might also make it possible for more people to enroll on their own so assisters can focus on the most complex cases that require individualized help. For

example, applicants may be confused about whether they are "eligible" for minimum essential coverage through their employer if they are not enrolled and their plan is not currently open for enrollment. Help text and rewording of questions would guide consumers on accurately projecting annual income by including non-tax social security benefits but excluding key deductions and pre-tax contributions, such as child care or retirement savings.

In addition, Marketplaces can improve enrollment tools for assisters. Assisters should be able to provide phone application assistance, with access to co-browsing capability to work with consumers logging in from a different location. Also, the system should alert assisters and consumers when and why an application fails for reasons not related to eligibility so that the consumer can correct and resubmit the application. Doing so could reduce the number of consumers who file an eligibility appeal, a labor-and time-intensive process that may result in critical gaps in coverage.

Marketplaces could also simplify consumers' selection among plan options by limiting the number offered within a benefit tier and/or requiring standardized benefit design. Several SBMs have already done so to help streamline the shopping experience for consumers.[43]

Wanted: Leveraging a Broader Range of Consumer Assisters

Meeting the challenges of this next open enrollment period and beyond may require a broader view of consumer assistance. Federal resources are limited and states are struggling to identify stable and sufficient sources for funding for consumer assistance. In light of this, policymakers must tap into a broader array of people with an incentive to help enroll individuals in coverage, such as insurance agents and brokers, providers, and tax preparers.

Brokers may provide an effective complement to Navigators in a time of constrained federal and state funding. While Marketplaces have to devote a portion of their budget to Navigator programs, they are not required to fund brokers; brokers earn their income from health plan commissions. There are benefits to using brokers to assist individuals in enrolling in coverage. Whereas Navigators are prohibited from recommending a plan, brokers can recommend a plan for a consumer that has complicated health needs and limited ability to understand their plan options. But there are also potential downsides to relying on brokers for Marketplace enrollment. Many will not be affiliated with all the plans offered in the Marketplace and so may steer consumers only to those plans for which they will receive a commission.

Providers have an existing pathway to promote enrollment as certified application counselors. Many have pursued this pathway because they have an interest in enrolling their patients in coverage in order to get reimbursed for the services they provide. They are important partners for enrollment efforts because they have specialized knowledge of consumers' needs, and in many cases a prior relationship with the consumers who would most benefit from the ACA's subsidized coverage options.

Consumers can also benefit from other professionals with specialized knowledge. Tax preparers can help consumers understand how their federal tax filing status can affect eligibility for premium tax credits, and family law attorneys can provide advice for non-custodial parents who have an obligation under a divorce agreement or medical support order to provide health coverage to their children.

Policymakers should consider ways in which a broader set of enrollment partners could get training and be certified to enroll individuals in Marketplace coverage–and provide incentives for them to do so. These incentives do not have to be financial. For example, one common complaint among agents and brokers was that their time spent enrolling people into a plan was not always or accurately reported to the insurer, preventing them from being appropriately compensated. Marketplaces should work to ensure that brokers' enrollment assistance is correctly attributed to the applications of consumers they've assisted.

Conclusion

The first open enrollment period was challenging for assisters and consumers. Changing rules, balky websites, and consumers' unfamiliarity with key provisions of the ACA all contributed to a difficult first year. But consumer assistance helped make it more successful than experts predicted it would be, resulting in a significant decline in the uninsured after the first year of enrollment into Marketplace coverage.[44] Marketplaces have an opportunity to build upon that success and strengthen and extend consumer assistance to help people understand their plan options and enroll in coverage.

Acknowledgments

The authors gratefully acknowledge the editorial contributions of Kevin Lucia, Karen Pollitz, Judy Solomon and Mara Youdelman.

Appendix A: Examples of Consumer Assistance Questions in the First Year

Determining Household Size

Parent as dependent:

Alice* is a 50-year-old woman who lives with her 28-year-old daughter, Jane and cares for Jane's two children (Alice's grandchildren). Jane claims Alice as a dependent on her taxes. Jane has insurance from her employer that covers her and her two children, but it won't cover Alice. When Alice applies for coverage, should she include her daughter's income and list all four members of the household?

Answer: Since Alice is claimed as a dependent on Jane's taxes, Jane (i.e., the tax filer) should complete the application because eligibility for Alice will be based on Jane's income and household size. Since Jane and her children have employer-sponsored insurance, she should indicate that she is NOT applying for herself and her children, only for her mom who is a tax dependent. She should also indicate NO when answering whether Alice has access to employer sponsored insurance. If the state in which this family resides has expanded Medicaid, Alice would likely qualify for Medicaid because she has no income.

Non-custodial parent:

Robert wants to buy a Marketplace plan for himself and his son John, who lives with his ex-wife. His divorce agreement requires him to provide coverage for John, but he doesn't claim him as a dependent on his taxes. What are Robert's options to buy a plan that covers them both?

Answer: Robert can buy a plan for himself and his son through the Marketplace, but since he doesn't claim John as a dependent, he is ineligible to receive premium tax credits for John's coverage.

Calculating Income

Lower than projected income:

Jessica is a dog walker and paid hourly. She projects income over 100 percent of the federal poverty level, qualifying her for premium tax credits. But she's worried that if she gets less work than she expects, and her actual income is less than 100 percent of the federal poverty level, she'll have to pay those tax credits back.

Answer: Jessica would not have to pay back premium tax credits if her income goes down from what she projected for the year. In fact, she may get money back when she files her taxes once the tax credits she received based on projected income are reconciled with what she should have received based on actual (lower) income. As long as her eligibility for the premium tax credit was based on a determination that her income would be between 100 and 400 percent of the federal poverty level, she won't be required to pay back credits if it turns out her actual income is below 100 percent of poverty. The reconciliation process provides for a tax refund if her income goes down.

Rental assistance:

Jackie gets help on her rent from a family member who lives with her. Without the assistance, she couldn't afford the rent. Must she count the rental assistance in her household income?

Answer: Probably not. Rental assistance from her family member would be considered a gift. If Jackie claims this rental assistance as part of her income, then it should be reported.

Retired with financial help from children:

Frank and Ellen are retired and don't file taxes. Their children contribute to their household costs, but none claim the parents as dependents. When Frank and Ellen apply, do they list the financial help from their children as part of their income?

Answer: No, the financial help that Frank and Ellen receive from their children would not be counted as income.

Adult child with dependent parents:

Shauna and Bob live with their adult son, Bill, who claimed them as dependents on his 2013 tax return. Bill provides them shelter but they pay their own food and health care costs. Shauna and Bob make less than 133 percent of the federal poverty level and would qualify for Medicaid. Does Bill's help and tax filing affect their Medicaid eligibility?

Answer: No, although Bill claims his parents as dependents, for Medicaid eligibility purposes, Shauna and Bob meet an exception to the rules because they are claimed by someone who is NOT their parent or spouse. Their eligibility for Medicaid will be based on

their household and income, using the rules for non tax filers. Their household would include Shauna and Bob and their income will be whatever source of income the two of them receive. They would have had to earn less than $3,900 each for Bill to have claimed them on his tax return, and would have had to indicate they were claimed as tax dependents by someone else.

Family payments:
Grace is a 63-year-old woman whose family pays her $500 per week to care for the 98-year-old family matriarch. Should Grace count the family's payments as earnings when applying for coverage?

Answer: Yes, if Grace is reporting the $500 per week as taxable income then it should be counted when she applies for coverage on the Marketplace. Grace should seek tax advice on whether she should be reporting it as income.

Access to Other Coverage and Eligibility for Premium Tax Credits

Student Health Plan:
An older PhD student, Anna, is told her student health plan won't cover her shingles vaccine or a colonoscopy. Is that allowed? Can she get a Marketplace plan instead?

Answer: It depends on whether or not her student health plan is self-funded. In general, under the ACA, student health plans are required to cover preventive care with no cost-sharing, including colonoscopies and the shingles vaccine (if she's over 50). Self-funded student health plans, however, do NOT have to comply with the preventive services standard under the ACA. A self-funded student plan is one in which the risk is borne by the college or university. These plans are notoriously skimpy.

Yes, Anna could get a Marketplace plan and may also be eligible for financial assistance. If she wants to apply for a Marketplace plan, she will have to wait for Open Enrollment unless she qualifies for a special enrollment period.

Retiree plan:
Sandra retired at 55 and has an offer of retiree coverage for herself and her husband and 19-year-old son. The plan would be a good deal for her, but is too expensive for her husband and son to join. If Sandra enrolls in the retiree plan, can her husband and son still apply for Marketplace coverage with premium tax credits?

Answer: Yes, her husband and son can still apply for Marketplace coverage with premium tax credits as long as their household income is less than 400 percent of federal poverty level ($78,120 for a family of three in 2013). The test for affordability and adequacy of employer-based coverage does not apply to retiree coverage.

Access to Medicaid:
Jane was uninsured when she was diagnosed with breast cancer and was found eligible for Breast and Cervical Cancer Program (BCCP) under Medicaid. She wouldn't qualify for Medicaid based on her income. Does enrollment in the BCCP program make her ineligible for Marketplace coverage because it's Medicaid coverage?

Answer: No. Although not specifically listed in regulations, the BCCP is not considered a type of comprehensive health insurance that would be considered minimum essential coverage. Jane is eligible for Marketplace coverage and could qualify for premium tax credits, assuming she meets the income and eligibility requirements.

Immigrants

Mixed Status/Mixed Program Families:
A family applying for coverage includes two parents who have been lawfully residing in the U. S. for three years and two children, Esteban, who has been lawfully residing in the U.S. for three years, and a daughter, Celia, who is U.S.-born. The parents and Esteban are eligible for a Marketplace plan, but only Celia is eligible for Medicaid. Why can't both children get Medicaid? Or can they add Celia to the Marketplace plan with premium subsidies?

Answer: Under Medicaid, there is a five year waiting period for lawfully residing children before they can be eligible for Medicaid, so Esteban is currently not eligible. The family cannot add Celia to the Marketplace plan with premium subsidies because she would be enrolled into Medicaid.

Changing Plans

Provider not in network:
Brenda selected a plan knowing that the hospital in her area was not on the plan, but her primary care doctor was. She had not yet heard from the plan about her enrollment and had not yet paid her first premium when she was diagnosed with cancer and was referred to specialists and an oncologist that are not covered under her plan. Can Brenda change to a different carrier that would include the providers she needs?

Answer: Yes, Brenda has not technically enrolled into her plan because she has not paid her first month's premium, and it is before the effective date of coverage. Given her diagnosis, however, she should be careful to make sure she gets into another plan (i.e., pays her first month's

premium to get enrolled) before she terminates coverage so that the specialist and oncologist visits are covered.

Avoiding a Gap in Coverage

Waiting for new job-based plan to start:

Sally lost her job and her insurance coverage at the end of April and got a new job with coverage that wouldn't begin until July. In the meantime, she was diagnosed with breast cancer and was scheduled for surgery in early May. Would she be able to get Marketplace coverage in time for her surgery or would she have a gap in coverage? Should she enroll in COBRA to fill the gap between job-based plans?

Answer: Yes, Sally could get Marketplace coverage since loss of her employer-sponsored insurance (minimum essential coverage) would trigger a special enrollment period. In this scenario, if she applied for a Marketplace plan at the end of April, her coverage would be effective on the first day of the following month, May 1st. Since Sally's timelines are so close to May 1st and the consequences for NOT getting coverage by May 1 are severe, Sally should get confirmation of coverage from both the call center and the insurer with whom she chooses to enroll.

If there is any reason this doesn't work, COBRA is an option for her. She has 60 days to enroll, and her coverage would be retroactive. She would have to pay the full premium until her new employer coverage kicks in, but that is still preferable to going uninsured for the month she has her surgery. Also, to the extent she has a treating provider she wants to continue to see, COBRA allows her to keep her same network of providers, while plans on the Marketplace may have different provider networks.

Last but not least, she may not be eligible for Medicaid based on income, but she MAY be eligible for the Medicaid Breast and Cervical Cancer Treatment Program (BCCTP) based on her diagnosis. State laws on this program vary in terms of who is eligible and what it covers so Sally should check with her state's Medicaid agency and also ask about how long the enrollment process will take.

Post-Enrollment Issues

Drug formulary:

Jack purchased a plan through the Federally Facilitated Marketplace that does not cover a specialty tier drug that he needs for a chronic condition. Does that mean Jack is responsible for the full cost of that prescription drug, and the out-of-pocket cost will not be included as part of his out-of-pocket maximum?

Answer: Non-covered drugs do not count toward the out-of-pocket limit and even if covered, specialty tier drugs could come with significant cost-sharing if it requires co-insurance rather than a fixed dollar co-payment. Under current federal rules, however, all Marketplace plans must have procedures in place to allow enrollees, like Jack, to request and to gain access to clinically appropriate drugs not covered by the plan, especially in exigent circumstances. The rule requires that a health plan make coverage determinations within 24 hours of receiving a request, and in the meantime, requires the health plan to provide the drug during the duration of the exigent circumstance.

Consistent with the Medicare Part D program, the Centers for Medicare and Medicaid Services (CMS) suggests that a drug is clinically appropriate, and should be covered, if an oral or written supporting statement is submitted by a prescriber, and establishes that the requested prescription drug is clinically appropriate to treat the enrollee's disease or medical condition, based on one or more of the following criteria:

i. All of the covered drugs on any tier of the plan's covered drug list for treatment for the same condition would not be as effective for the enrollee as the requested drug, and/or would have adverse effects for the enrollee, or

ii. The number of doses available under a dose restriction for the prescription drug:
   a. Has been ineffective in the treatment of the enrollee's disease or medical condition or,
   b. Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or

iii. The prescription drug alternative(s) listed on the covered drug list or required to be used in accordance with step therapy requirements:
   a. Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely

to be ineffective or adversely affect the drug's effectiveness or patient compliance; or

b. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.

Provider network:

Janice has learned that her health plan no longer includes the county hospital. The closest hospital that takes the insurance is 26 miles away. What are her options?

Answer: According to federal guidance, Janice can change plans if all of the following criteria are met:

1. She's changing to another plan by the same insurer;
2. She's changing to another plan offered at the same metal level and cost sharing reduction level, if applicable;
3. She's changing in order to move to a plan with a more inclusive provider network or for other isolated circumstances determined by CMS, and
4. She's requesting the change within the initial open enrollment period.

Janice must go to the insurer and initiate the change.

Benefits that fall short:

Mary is pregnant and has learned the insurance she has does not include coverage for maternity care. Can she apply for a special enrollment period since this is a minimum essential health benefit?

Answer: No. Under current rules, pregnancy is not a qualifying event that would trigger a special enrollment opportunity. The birth of her child, however, is a qualifying event for a special enrollment period and she can enroll her child with an effective coverage date of her child's birth date. There are a few things to note for Mary's coverage and health plan. If her current plan is an individual plan, she should know that she'll have a 30-day window from when her policy renews to find a new plan either on or off the Marketplace. She will want to find out when her policy renews. Note that all plans on the Marketplace must cover maternity as an essential health benefit.

Also, if her health plan is through her employer, she should know that under federal law (the Pregnancy Discrimination Act), large employers are required to cover maternity services in parity with other medical services. If the employee's health plan is skimpy on coverage, however, the maternity will also be skimpy. One available option is to contact the U.S. Department of Labor because it's possible the employer is in violation of the Pregnancy Discrimination Act. She can contact the Dept. of Labor's Employee Benefits Security Administration (EBSA) at http://www.dol.gov/ebsa/contactEBSA/consumerassistance.html.

**All names used in these examples are pseudonyms used to protect the identity of the individuals seeking assistance.*

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