



# Certified Application Counselor Program: Early Lessons

**This brief examines the role that the Certified Application Counselor (CAC) program played during the first open enrollment period. This new program allowed various organizations to serve as enrollment assisters — including community health centers (CHCs), hospitals, legal aid services, and others. With relatively few federal requirements, each CAC organization had the freedom to tailor the scope and design of their program to match the resources the organization had available as well as the needs of the community the organization served. This piece examines the different funding, training, and program design decisions CAC organizations made during the first open enrollment period, and offers recommendations for strengthening these programs going forward.**

## Introduction

The Affordable Care Act envisioned a central role for enrollment assistance programs to help consumers learn about and enroll in their new health coverage options. The law and initial policy guidance outlined standards for Navigator and In-Person Assister (IPA) programs (although not the CAC program). Each state would design and pay for a Navigator program to provide impartial enrollment assistance. States also had the option to obtain federal block grants to create an IPA program to perform similar duties as Navigators, particularly during the first open enrollment period when marketplaces would not have had operating funds available to support Navigator programs.

However, many states ultimately chose to have a federally facilitated marketplace (FFM) rather than a state-based or partnership marketplace. Comparatively fewer resources were available to support assister programs in FFM states: only \$67 million was made available for Navigator programs in FFM and partnership states,

and FFM states were not permitted to have a separate IPA program.<sup>1</sup> This meant that 63 percent of uninsured people lived in FFM states, while half of total consumer assistance funds went to state-based marketplace (SBM) states.<sup>2</sup>

To help mitigate this funding gap and create opportunities for supplemental consumer assistance, the Centers for Medicare and Medicaid Services (CMS) issued regulations creating the CAC program in July 2013.<sup>3</sup> CMS specified that the CAC program would supplement existing consumer assistance options in each state's marketplace by allowing additional organizations to provide application and enrollment assistance.

The CAC program differed in several key ways from the other types of consumer assistance programs. Unlike other certified assisters, CACs are not funded by the marketplace, although they can seek financial support from federal, state, and/or private funders.<sup>4</sup> Additionally, unlike Navigators and IPAs, CACs are not required to conduct outreach as part of their enrollment assistance responsibilities.<sup>5</sup> CACs are

## *Just like other assister programs, the value of CAC programs cannot be measured purely by successful enrollments.*

also not bound by any specific performance metrics, such as a minimum number of individuals to assist. This new CAC role provided a flexible opportunity for additional organizations to provide enrollment assistance.

### **Background**

CAC organizations help people understand their health coverage options, and apply for and enroll in health coverage through the marketplace. Federal regulations allow various organizations and individuals to participate in the CAC program. Examples of organizations that can serve as CACs include CHCs, hospitals, health care providers, Indian health providers, Ryan White HIV/AIDS providers, behavioral or mental health providers, and social services agencies. CAC organizations and individuals must disclose potential conflicts of interest, comply with privacy and security standards, act in the best interest of consumers, and undergo federal and any applicable state-specific training.<sup>6</sup> In FFM states, CACs are required to complete a five-hour online training. Training requirements in SBM states vary: some marketplaces hold purely web-based training, some conduct training solely in-person, and others require a hybrid of online and in-person training. The length of SBM trainings ranges from four to 24 hours.<sup>7</sup>

CHCs from around the country were given the opportunity to obtain federal grant funding through the Health Resources and Services Administration (HRSA) to support outreach and enrollment efforts.<sup>8</sup> These grantees also technically became CACs. CHCs in FFM states were required to be designated as CACs, and those receiving funding were required to conduct outreach and at a minimum add

one full-time employee to strengthen their capacity. However, participation in the CAC program was otherwise entirely voluntary.<sup>9</sup> CAC organizations often chose to participate despite having limited financial resources. With whatever resources they were able to harness, they stepped up to fill an important space to meet the needs in their community and advance organizational missions. Many CAC organizations brought in some degree of new funding for their enrollment work, but others repurposed existing budgets and employees.

Compared to the Navigator and IPA programs, which are tightly controlled by the marketplace, the CAC program is relatively loosely structured. The lack of a rigid structure for CACs creates some uncertainty, but at the same time has allowed various models to flourish in response to community needs.

### **The CAC Landscape: An Initial Assessment**

The exact number of CAC organizations operating across the country during the first open enrollment period is unknown. Due to the more fluid nature of CAC programs, organizations were not required to fully report or track the specific details of their work. Some organizations became designated to serve as CACs without having a concrete plan in place for identifying consumers in need of assistance or goals for how many consumers they aimed to help.

Even if there was a way to know how many consumers enrolled with CACs, this would only tell part of the story; just like other assister programs, the value of CAC programs cannot be measured purely by successful enrollments. The most vulnerable populations and those people lacking awareness about

***CAC organizations were able to increase efficiency by building on existing strengths, community partnerships, and strong volunteer networks.***

their health care options were less likely to enroll during the initial open enrollment period.<sup>10</sup> These individuals needed to hear about their new coverage options multiple times from multiple sources before they were ready to enroll. CACs — especially those in health center settings, who were required to participate in outreach — were part of this outreach and education network that helped build consumers' confidence and knowledge of health insurance concepts and the enrollment process. Productive conversations and the resulting trust built within the community by a CAC organization may not have translated to immediate enrollment, but it contributed to overall enrollment gains.

In the race to meet deadlines and stand up complex technical systems, several SBMs decided to concentrate on the other certified assister programs specifically funded through the marketplace (e.g., Navigators). California, Rhode Island, and Washington, DC, operate SBMs that intend to ramp up their CAC programs for the next open enrollment period. This will bring new CAC organizations to the table and provide more options for consumers that want enrollment assistance.

The flexible roles and varying expectations of CAC organizations create distinctive ways for CACs to engage their communities. Below are key findings on CAC funding, assistance to underserved populations, training programs, and coordination and collaboration with other enrollment stakeholders, based on an initial scan of CAC activity during the first open enrollment period gathered through conversations with SBM officials and CAC organizations and stakeholders in both FFM and SBM states.<sup>11</sup>

## **Funding**

During the initial open enrollment period, organizations interested in serving as CACs had several ways to maximize available funding and resources that would enable them to help consumers. Some CAC organizations received new funding from existing sources to allow them to increase their focus on enrollment or start to work on health coverage enrollment for the first time. Many organizations also identified new funding streams to enhance their ability to reach certain populations. Those CACs without new funding chose to refocus existing budgets and employees to support their enrollment activities. For example, many hospitals already maintained full-time employees who concentrated on in-reach to help uninsured patients enroll in health coverage, and this work provided a foundation for their CAC activities.

CAC organizations adapted their scope to reflect available resources. CACs that did not receive federal or private funding for enrollment work reported that, even in the absence of additional resources, the program allowed them to enroll individuals and make an impact in their community. With minimal resources to support enrollment work, CAC organizations were able to increase efficiency by building on existing strengths, community partnerships, and strong volunteer networks. For instance, CAC organizations that started with an existing consumer/patient base or network concentrated resources on in-reach, whereas other organizations focused on outreach or partnered with organizations that conducted outreach.

## Foundation Communities

Foundation Communities — a nonprofit organization serving low-income residents in Austin, Texas — first had a difficult time securing funding and decided the community need for enrollment assistance was important enough to fund its efforts through its existing operating budget until external funds could be raised. By November, it leveraged private funding (from both existing and new partners) to expand its outreach and enrollment campaign, “Insure Central Texas.” The \$835,000 in funding from Central Health, Community Catalyst, Neighborworks America, Seton Healthcare Family, and St. David’s Foundation allowed Foundation Communities to finance 18 months of operations, manage five enrollment locations, and hire new staff needed to oversee 128 CACs (mainly volunteers). Building upon its model of volunteer-based, large-scale free tax preparation, Foundation Communities provided enrollment assistance to more than 10,000 households across 36 counties — more than half of whom were Spanish speakers — during the first open enrollment period.

*Successful CAC organizations identified the needs of their population and built upon existing partner relationships to effectively reach individuals most in need of coverage.*

### Assisting Underserved Populations

Because many CAC organizations already devoted their energy and resources to engaging underserved communities, they were well positioned to provide enrollment assistance, and, while not required, were also appropriately situated to conduct in-reach and outreach. CAC organizations engaging vulnerable communities faced unique challenges. Many people they interacted with had low awareness of their health coverage options and financial help available. Others had limited or no experience with private insurance, or feared that completing the marketplace application could jeopardize members of their family without an eligible immigration status. Latinos, in particular, valued and sought in-person assistance.<sup>12</sup> As noted earlier, the success

of CAC organizations should not be judged solely on enrollment numbers. Increasing awareness and developing trust are also important achievements.

In working with minority communities, especially among immigrants and non-native English speakers, CAC organizations pursued several strategies, such as large-scale enrollment events with native-speaking assisters on site, and personalized counseling and enrollment sessions. CACs situated near state borders found ways to support clients or consumers living in rural or different marketplace service areas. Successful CAC organizations identified the needs of their population and built upon existing partner relationships to effectively reach individuals most in need of coverage.

### **Lenox Hill Neighborhood House**

The Lenox Hill Neighborhood House — a nonprofit organization providing an array of social services with five locations between 54th and 102nd and serving clients from 14th Street to 143rd Street on the East Side of Manhattan — is a trusted messenger within its community, and became a CAC organization with the help of funding from the New York State Health Foundation to connect immigrants and others in need of health insurance to coverage.<sup>13</sup> With one full-time staff member designated as a CAC, Lenox Hill built an enrollment program with the help of committed volunteers, who engaged in more than 300 individual counseling sessions to explain coverage options to clients, close to 60 of whom were from solely Spanish speaking and immigrant households.

### **Benewah Medical & Wellness Center**

The Benewah Medical & Wellness Center, a tribally owned and operated CHC based in Idaho with a patient base that includes a significant tribal population across the northwest, received funding from HRSA to conduct outreach and enrollment. Benewah became certified as an IPA in Idaho and a CAC in Washington State in order to conduct in-reach to get their existing patients enrolled and outreach to enroll other individuals and families.<sup>14</sup> They partnered with other tribal and community organizations, reaching more than 1,200 people and enrolling 315 in coverage.

## **Training Programs**

Marketplaces have latitude to design their own CAC training programs, and as a result, they vary from state to state in both content and structure. CACs in FFM states were required to complete five hours of online training, whereas those in SBM states may have had training online, in-person, or both. Some states' laws imposed additional trainings, certification processes, and fees on assisters. CMS regulations finalized in May 2014 specify that such non-federal standards related to CACs cannot prevent them from fulfilling their enrollment assistance duties.<sup>15</sup> Successful trainings not only reinforced the relevant eligibility and enrollment policies needed, but also helped to identify promising practices and enrollment strategies to help CACs provide comprehensive consumer support.

Unfortunately, many CACs and enrollment stakeholders expressed concerns that required marketplace trainings were generally not informative or interactive enough. Some CACs pointed out that trainings needed to better prepare them to assist underserved communities and non-English speakers. Others wanted better support to help consumers complete the plan selection process through the marketplace. Some CACs and partner organizations, such as MeHAF and CAHC, addressed training gaps through proactively setting up additional venues where CACs could ask questions and supplement their formal training.

CACs indicated the desire to work with marketplaces so that in the future, formal and informal trainings are more appropriately tailored to provide relevant information and consumer assistance tools. Specifically,

CACs are interested in stronger training and interactive options to test marketplace websites and applications.

### **Collaboration and Coordination**

CACs are one among many different types of in-person assisters that aim to ensure consumers learn about and enroll in coverage. As noted above, Navigators and IPAs often undertook greater responsibilities than many CACs. CACs needed to maintain an open line of communication with the marketplaces as

a result of dynamic IT systems to navigate updates and application troubleshooting. Additionally, given the diversity of enrollment stakeholders across a state and region, CACs often engaged with other assisters in order to learn from each other and advance their enrollment goals.

Many CACs vastly expanded their reach through coordinating with other assisters and local partners. Some CACs noted there was sometimes competition between assisters from different organizations.

### **Access Health CT**

The Connecticut marketplace (Access Health CT) trained CACs online to teach the basic policy concepts that they wanted assisters to internalize, but also required in-person training to reinforce practical application of knowledge. Their training provided a strong focus on health equity, adult education strategies, and other avenues to engage community health workers. The Navigator and In-Person Assister Outreach Program at Access Health CT also provided a meaningful online community for Navigators, IPAs, and CACs to supplement their trainings and encourage collaboration during open enrollment through biweekly newsletters, monthly regional meetings, webinars, and a website during the initial open enrollment period.

### **Maine Health Access Foundation/Consumers for Affordable Health Care**

The Maine Health Access Foundation (MeHAF) funded efforts by the Consumers for Affordable Health Care (CAHC), Maine's Consumer Assistance Program to supplement the formal FFM CAC training in their state. CAHC held a day-long conference on the successful implementation of the Affordable Care Act in Maine before the initial open enrollment period started. During the initial open enrollment period, CAHC conducted seven regional roundtables for Navigators and CACs across Maine to provide in-depth review on issues, such as eligibility for financial help, and to let assisters listen to insurance companies explain the specific policies they offered. CAHC also provided additional topic-specific resources and trainings during the initial open enrollment period through which they addressed complex situations and shared marketplace application screenshots that occurred more frequently among rural and limited-English speaking communities. CAHC also shared information and updates using a group email list for Maine's assister community.



However, many CACs engaged more consumers as a result of successful collaboration with the marketplace and other assisters. Efficient partnerships allowed CAC organizations to appropriately help consumers when possible, and connect individuals elsewhere when needed. Effective approaches to maximize resources varied from informal referrals between assisters to more formal efforts, such as developing and using a statewide assister scheduling line. CACs can also seek out local government

officials and other organizations that otherwise may not be directly working in the enrollment arena, but have access to valuable resources and other tools within the community. Active communication with marketplaces also allowed CAC organizations to stay current on technical updates and take advantage of resources that marketplaces developed to help their communities. Aligning the efforts of CACs with other assisters and enrollment stakeholders can make each CAC organization stronger individually.

### **Kentucky Primary Care Association**

The Kentucky Primary Care Association frequently engaged the Kentucky marketplace (kynect) regarding any technical questions and clarifications that arose. Understanding the utility in working with other assisters to further their own efforts, the Kentucky PCA collaborated with other assister groups to streamline the intake and referral process, allowing their member organization CACs to assist nearly 100,000 consumers. They intend to work with kynect to develop a more formal and centralized communications plan for all CACs during the next open enrollment period.

### **Northern Virginia Family Service**

Northern Virginia Family Service (NVFS), a nonprofit community service organization, made the most out of the private funding it received by relying on partnerships and allies across the region. NVFS collaborated with local nonprofits and county governments to find available weekend office spaces and computers, helping them staff 13 different locations with volunteer CACs that could be used for private enrollment appointments. In-kind donations from county governments also allowed NVFS to reach uninsured consumers through bus advertisements in English and Spanish. Furthermore, through teaming up with Navigators in their region, NVFS could help meet consumer demand and increase awareness of coverage options.

### **HealthNet Gaston**

The North Carolina statewide assister scheduling line permitted selected CACs, such as HealthNet Gaston, to partner with Navigators and CHCs across the state to coordinate managing appointments for consumers calling the toll-free number. This enabled CACs not only to more effectively schedule appointments, but also to share resources when assisters were overwhelmed with demand and ensured that assisters were positioned to most efficiently serve consumers in their local communities.

*Efficient partnerships allowed CAC organizations to appropriately help consumers when possible, and connect individuals elsewhere when needed.*

## Conclusion and Recommendations

The experiences of CACs across the country demonstrate that there is not a “one size fits all” strategy to conducting enrollment work, and, depending on the community being served, different approaches are necessary to achieve positive outcomes for uninsured consumers. Whether through in-reach or

increasing awareness more broadly in the community, during the initial open enrollment period, CAC organizations implemented various models to meet consumer needs. Moving into the next annual open enrollment period, and for years to come, CAC programs will play a critical role in ensuring adequate consumer assistance is available.

## Recommendations

- **Tailor resources:** Those CACs that work carefully to tailor their resources and capabilities to the individual communities they serve will maximize their effectiveness in helping consumers enroll.
- **Increase number of CACs:** More CACs are needed to ensure outreach efforts can match interested consumers with timely and convenient enrollment assistance. Enroll America will focus on recruiting new groups and individuals to serve as CACs during next open enrollment period. Increasing resources and capacity for existing CACs and expanding the universe of CACs through recruitment will ensure that CAC programs can have maximum impact during the next open enrollment period.
- **Leverage power of small grants:** Public and private funders will continue to play an important role in ensuring CAC sustainability. Through volunteer structures and connections to larger enrollment efforts, CAC programs can leverage small grants to make significant enrollment gains.
- **Boost training:** As marketplaces move to update their CAC training programs to be more comprehensive and dynamic next year, CAC organizations and community partners should move in tandem to boost their own training efforts to ensure CACs are well-armed with the knowledge they need to be successful.
- **Coordinate with other assisters and local partners:** Coordinating with other assisters and local partners to share resources and promote greater efficiency and cost-effective programmatic activities will be a crucial component to ensure the success and longevity of the CAC program.



## Acknowledgments

This piece was written by Jessica Burnell, Fellow, Best Practices Institute, and Zachary Baron, Senior Policy Analyst, Best Practices Institute.

Assistance was provided by Sophie Stern, Deputy Director, Best Practices Institute, and Jennifer Sullivan, Director, Best Practices Institute.

The authors wish to thank Heather Bates, Melanie Herrera Bortz, Mimi Garcia, Tony Garr, Nicole Oehmke, Liz Perry, Sorien Schmidt, and Ezra Watland from Enroll America; Emily Brostek, Consumers for Affordable Health Care; Elizabeth Colvin, Foundation Communities; Eva Rose Davison and Molly Schnebly, Benewah Medical & Wellness Center; Donna Grissom, HealthNet Gaston; Morgan Hynd, Maine Health Access Foundation; Mia R. Kandel, Lenox Hill Neighborhood House; Lindsay Nelson, Kentucky Primary Care Association; Ken Sharma and Terry Goplerud, Northern Virginia Family Service; and Denise Smith, Access Health CT for their input and guidance.

## Endnotes

<sup>1</sup>For more information on the different types of assisters, you can download Enroll America's *Navigating the New Health Insurance Marketplaces: In-Person Assistance Options for Consumers*, September 2013, available online at [https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/12/Enrollment\\_Assisters.pdf](https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/12/Enrollment_Assisters.pdf).

<sup>2</sup>See Robert Wood Johnson Foundation and the Penn Leonard Davis Institute of Health Economics, *Deciphering the Data: State-Based Marketplaces Spent Heavily to Help Enroll Consumers*, April 2014, available online at [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2014/rwjf412855](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf412855).

<sup>3</sup>Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel; Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors; Final Rule, July 17, 2013, 78 FR 42824.

<sup>4</sup>See Enroll America's *Navigating the New Health Insurance Marketplaces*.

<sup>5</sup>See Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel; 78 FR 42829. An exception applies to those Community Health Centers receiving outreach and enrollment funding through HRSA, which are required to conduct outreach as part of their CAC responsibilities.

<sup>6</sup>Enroll America, *The Certified Application Counselor (CAC) Program: Facts about the CAC Designation for Organizations*, September 2013, available online at [https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/12/Enrollment\\_CAC.pdf](https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/12/Enrollment_CAC.pdf). Organizations that have been designated by CMS (for FFM and partnership marketplaces) or a SBM itself as meeting the CAC requirements are referred to as CAC organizations. In FFM and partnership marketplaces, individuals must be affiliated with CAC organizations to undergo training, be certified, and assist consumers themselves.

<sup>7</sup>Center on Budget and Policy Priorities, *Health Reform: Designing a Marketplace*, (accessed in May 2014), available online at <http://apps.cbpp.org/DesigningAMarketplace/>.

<sup>8</sup>In July 2013, HRSA awarded \$150 million to CHCs as part of Outreach and Enrollment (O/E) supplemental funding, and followed up with a one-time boost of \$58 million. Excluding the one-time funding boost, HRSA anticipates to maintain the relevant funding at the same level for the 2015 fiscal year. See HRSA, *Health Center Ongoing Outreach and Enrollment (O/E) Assistance Frequently Asked Questions (FAQs)*, (accessed in May 2014) available online at <http://bphc.hrsa.gov/outreachandenrollment/oefags05012014.pdf>.

<sup>9</sup> See HRSA, *Health Center Outreach and Enrollment Assistance Fiscal Year 2013*, May 2013, available online at <http://bphc.hrsa.gov/outreachandenrollment/hrsa-13-279.pdf>.

<sup>10</sup> PerryUndem Research & Communication, *The Affordable Care Act's First Enrollment Period: Why Did Some People Enroll and Not Others?*, May 2013, available online at <https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2014/05/EA-PerryUndem-Survey-Report.pdf>.

<sup>11</sup> In developing this issue brief, we spoke with stakeholders from California, Colorado, Connecticut, the District of Columbia, Idaho, Kentucky, Maine, North Carolina, Rhode Island, Virginia, and Washington.

<sup>12</sup> See PerryUndem Research & Communication, *The Affordable Care Act's First Enrollment Period*.

<sup>13</sup> New York State Health Foundation, *Lenox Hill Neighborhood House* (accessed in May 2014) available online at <http://nyshealthfoundation.org/our-grantees/grantee-profile/lenox-hill-neighborhood-house>.

<sup>14</sup> The May 2014 CMS final rule allows CACs greater flexibility to assist consumers across multiple states. Although CACs do not need to maintain a physical presence in a marketplace when helping consumers, Navigators and IPAs are required to maintain such a physical presence in a state where providing consumer assistance. See 45 CFR § 155.210(e)(7) and 45 CFR § 155.215(h).

<sup>15</sup> See 45 CFR § 155.225(d)(8).

