

Maine Health Exchange Advisory Committee

Tuesday June 3, 2014

9am

Appropriations Committee Room 228

Draft Agenda

- 9:00 am Welcome and introduction from chairs
- 9:15 am Legislative Update/Information Received from State Agencies
Committee Staff
- 10:00 am Federal Update –conference call
*Christie Hager, Region One Director,
U.S. Department of Health and Human Services*
- 10:30 am State Regulatory Update
*Eric Cioppa, Superintendent,
Maine Bureau of Insurance*
- 11:00 am Health Plan Update
*Representatives of Anthem Health Plans of Maine, Maine
Community Health Options, Northeast Delta Dental*
- 12:00 pm Lunch
- 1:00 pm Consumer Outreach Activities and Enrollment Update
*Representatives of Western Maine Community Action, Maine
Lobstermen’s Association and Maine Health Access
Foundation/enroll207.com*
- 2:00 pm Committee Discussion and Planning---2015 Plan Year
- Review timeline
 - Review duties and recommended discussion items from preliminary report
 - Develop work plan and schedule additional meetings
- 3:00 pm Adjourn

Maine Health Exchange Advisory Committee

Meetings: At least 4 total; 3 additional meetings to be scheduled

Final Report:

- ◆ Due no later than November 5, 2014
- ◆ Must include a review and evaluation of the continued necessity of a state health exchange advisory committee, including the staffing and funding needs of such an advisory committee, recommendations as to whether such an advisory committee should be established by the 127th Legislature and whether any changes should be made to the Maine Revised Statutes governing such an advisory committee.

Issues Identified for Further Discussion in Preliminary Report:

- ◆ Whether Maine's federally-facilitated marketplace is effective for individuals and small businesses
- ◆ Whether the State should transition to a partnership exchange or state-based exchange in 2016;
- ◆ Whether the State should establish a Basic Health Plan
- ◆ Whether the State should consider changes to its designated benchmark plan for essential health benefits to the extent permitted by federal law and regulation in 2016
- ◆ Whether the State should consider changes to its designated rating areas for geographic area to the extent permitted by federal law and regulation
- ◆ Whether health care coverage provided through the marketplace is affordable for individuals and small businesses
- ◆ The impact of "churn" on the effective operation of the marketplace, public health programs and the private health insurance market
- ◆ Whether the risk adjustment programs established under federal law and regulation are operating effectively
- ◆ The impact of federal requirements to provide employer-sponsored health coverage on the health care workforce
- ◆ Whether changes should be considered in federal law or regulation to address dental health coverage available through the marketplace, including but not limited to, premiums and out-of-pocket costs

Duties Specified in Joint Order Establishing Advisory Committee, HP 1136:

- ◆ Advise the Legislature regarding the interests of individuals and employers with respect to any exchange that may be created for this State
- ◆ Serve as a liaison between any exchange and individuals and small businesses enrolled in the exchange
- ◆ Evaluate the implementation and operation of any exchange with respect to the following:
 - The essential health benefits benchmark plan designated in this State under the federal Patient Protection and Affordable Care Act, including whether the State should change its designation;

Maine Health Exchange Advisory Committee

- The impact of federal and state laws and regulations governing the health insurance rating for tobacco use and coverage for wellness programs and smoking cessation programs on accessibility and affordability of health insurance;
 - The consumer outreach and enrollment conducted by the exchange and whether the navigator program is effective and whether navigators or other persons providing assistance to consumers are in compliance with any federal or state certification and training requirements;
 - The coordination between the state Medicaid program and the exchange;
 - Whether health insurance coverage through the exchange is affordable for individuals and small businesses, including whether individual subsidies are adequate;
 - Whether the exchange is effective in providing access to health insurance coverage for small businesses;
 - The implementation of rebates under the federal Patient Protection and Affordable Care Act and the Maine Revised Statutes, Title 24-A, section 4319; and
 - The coordination of plan management activities between the Department of Professional and Financial Regulation, Bureau of Insurance and the exchange, including the certification of qualified health plans and rate review
- ◆ Following the release of guidance or regulations from the federal Centers for Medicare and Medicaid Services addressing the basic health program option, as set forth in Section 1331 of the federal Patient Protection and Affordable Care Act, conduct a study, and make recommendations as appropriate, that examines the potential for establishing a basic health program for eligible individuals in order to ensure continuity of care and that families previously enrolled in Medicaid remain in the same plan. In conducting the study, the advisory committee shall consider the affordability of coverage for low-income populations, the potential cost savings to the state Medicaid program, the systems needed to create a seamless transition between a basic health program and Medicaid coverage, the impact of a basic health program on the negotiation of rates or receipt of rebates and the cost-effectiveness of delivering coverage through a basic health program
 - ◆ Based on the evaluations conducted by the advisory committee pursuant to this order, make recommendations for any changes in policy or law that would improve the operation of an exchange for consumers and small businesses in the State

**PROFILE OF AFFORDABLE CARE ACT COVERAGE EXPANSION ENROLLMENT
FOR MEDICAID / CHIP AND THE HEALTH INSURANCE MARKETPLACE
10-1-2013 to 3-31-2014**

Maine

GENERAL INFORMATION:

Marketplace Type: FFM - Plan Management
 Medicaid Expansion Status: Not Expanding Medicaid

AFFORDABLE CARE ACT ENROLLMENT TOTALS:

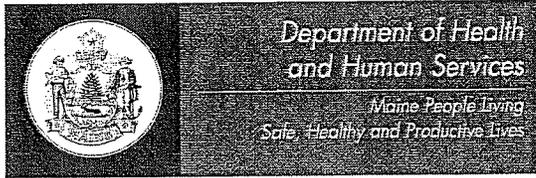
Marketplace Plan Selections:*
 Change in Medicaid/CHIP Enrollment:**

44,258
Not Available

CHARACTERISTICS OF MARKETPLACE PLAN SELECTIONS:

	<u>Number</u>	<u>% of Total</u>		<u>Number</u>	<u>% of Total</u>
By Gender:			By Financial Assistance Status:		
Female	23,819	54%	With Financial Assistance	39,809	90%
Male	20,428	46%	Without Financial Assistance	4,449	10%
<i>Subtotal With Known Data</i>	<u>44,247</u>	<u>100%</u>	<i>Subtotal With Known Data</i>	<u>44,258</u>	<u>100%</u>
<i>Unknown</i>	11	N/A	<i>Unknown</i>	N/A	N/A
By Age:			By Metal Level:		
Age < 18	3,692	8%	Bronze	8,469	19%
Age 18-25	3,362	8%	Silver	32,074	72%
Age 26-34	6,424	15%	Gold	3,420	8%
Age 35-44	6,045	14%	Platinum	N/A	0%
Age 45-54	9,739	22%	Catastrophic	389	1%
Age 55-64	14,935	34%	<i>Subtotal With Known Data</i>	<u>44,258</u>	<u>100%</u>
Age 265	61	0%	<i>Standalone Dental</i>	6,214	N/A
<i>Subtotal With Known Data</i>	<u>44,258</u>	<u>100%</u>	<i>Unknown</i>	N/A	N/A
<i>Unknown</i>	N/A	N/A			
Ages 18 to 34	9,786	22%			
Ages 0 to 34	13,478	30%			

Notes: * Marketplace data represent the cumulative number of individuals Determined Eligible to Enroll in a plan Through the Marketplace who have selected a plan from 10-1-13 to 3-31-14, including Special Enrollment Period-related activity through 4-19-14 (with or without the first premium payment having been received directly by the Marketplace or the issuer), excluding plan selections with unknown data for a given metric.
 ** Medicaid/CHIP data are state reported and represent the difference between March 2014 enrollment and Pre-ACA Monthly Average Medicaid and CHIP Enrollment (July-Sept 2013). Not all changes in enrollment may be related to the Affordable Care Act. Because these data are state-reported, detailed questions about the Medicaid/CHIP data should be directed to the states. The Medicaid/CHIP data required to calculate the difference between March 2014 enrollment and Pre-ACA Monthly Average Medicaid and CHIP Enrollment (July-Sept 2013) is not available at this time.



Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

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Commissioner's Office
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Tel.: (207) 287-3707; Fax (207) 287-3005
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DHHS Update: Maine Health Exchange Advisor Committee

Key Work Completed:

- Modified Adjusted Gross Income (MAGI) rules have been completed
- OFI Eligibility Specialists have been trained and receive continuous training as new functionality is rolled out
- The State of Maine has streamlined and improved the online application
- The paper application has been redesigned to meet the CMS ACA standards and it is being utilized
- Outbound Account Transfer (AT) applicants that are determined ineligible for MaineCare are being notified and their full application is electronically transferred to the Federally Facilitated Marketplace FFM. As of 5/26/14 we have transferred 55,069 applications.

Key Work Still Underway:

- The Department is on track to deploy the FFM → State of Maine Account Transfer (inbound account transfer) in mid-June. Once the automated electronic transfer is implemented we will receive complete applications from the FFM that have either been assessed as likely eligible for MaineCare, requested a full determination of eligibility or a non-MAGI determination.
 - Until the inbound account transfer is complete, we will continue to receive a flat file from the FFM to process manually. As of May 18, 2014 we have received 14,973 identified individuals that have applied for a Qualified Health Plan (QHP) at www.healthcare.gov. Of the 14,973 the file indicates that there were 9,865 unique applications filed at the FFM. Of the total number of individuals 3,740 requested a full MaineCare determination but were also eligible and signed up for a QHP at that time. The "full Medicaid" determination question at the FFM has created some confusion for applicants. Most who were contacted by the Department did not realize they had asked for a MaineCare decision and were not interested in MaineCare but rather a QHP which they had. There are also 4,373 individuals that requested a Non-MAGI MaineCare determination. This did not prevent them from enrolling in a QHP while a non-MAGI determination is being done. Of the 14,973 individuals; 6,860 were assessed as likely eligible for MaineCare and the Department is actively engaging and acting upon information within our eligibility system to either make a determination of eligibility or request that the individual provide the necessary information to determine eligibility. The Department is also engaging FFM applicants sent via the flat file through letters and phone calls.
- The State has implemented the technical solution to Hospital Presumptive Eligibility (HPE) and is currently working with CMS on approval of the State Plan Amendment to finally make it operational.

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Bureau of Insurance
STATE OF MAINE



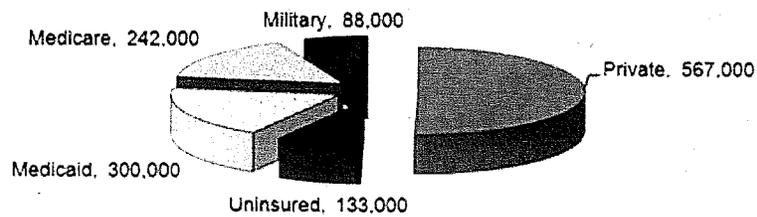
Maine Health Exchange Advisory Committee
6/3/14

AFFORDABLE CARE ACT AND MAINE'S HEALTH INSURANCE MARKET

MAINE'S HEALTH INSURANCE MARKET

2

Mainers with Health Coverage 2011

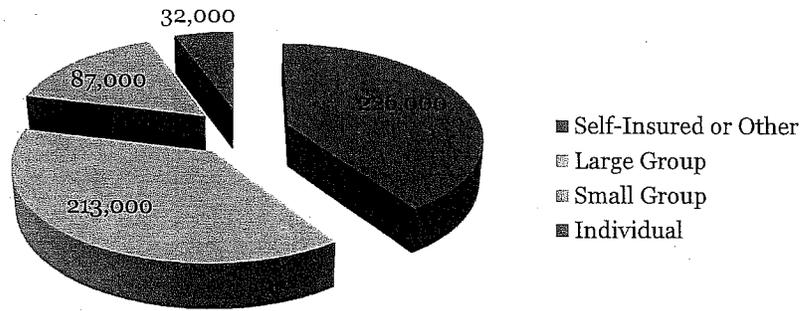


Source: US Census Bureau

MAINE'S 2013 HEALTH INSURANCE MARKET

3

Members



Source: 2013 Financial Results for Health Insurance Companies in Maine.
Self-Insured estimated from most recent US Census Data.



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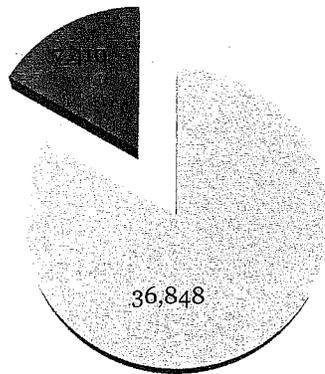
STATE OF MAINE

4

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA)

Marketplace Enrollment May 2014

5



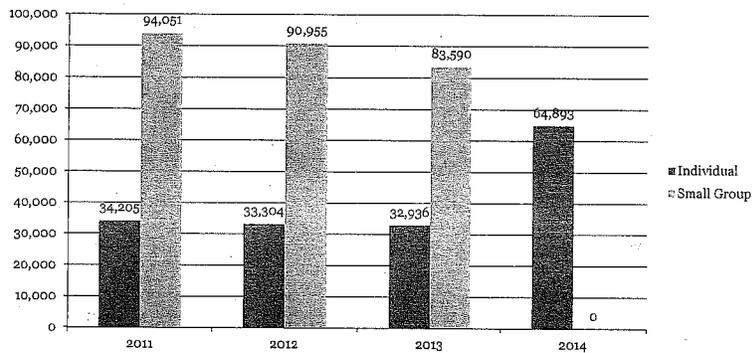
Maine Community Health Options
■ Anthem Blue Cross Blue Shield

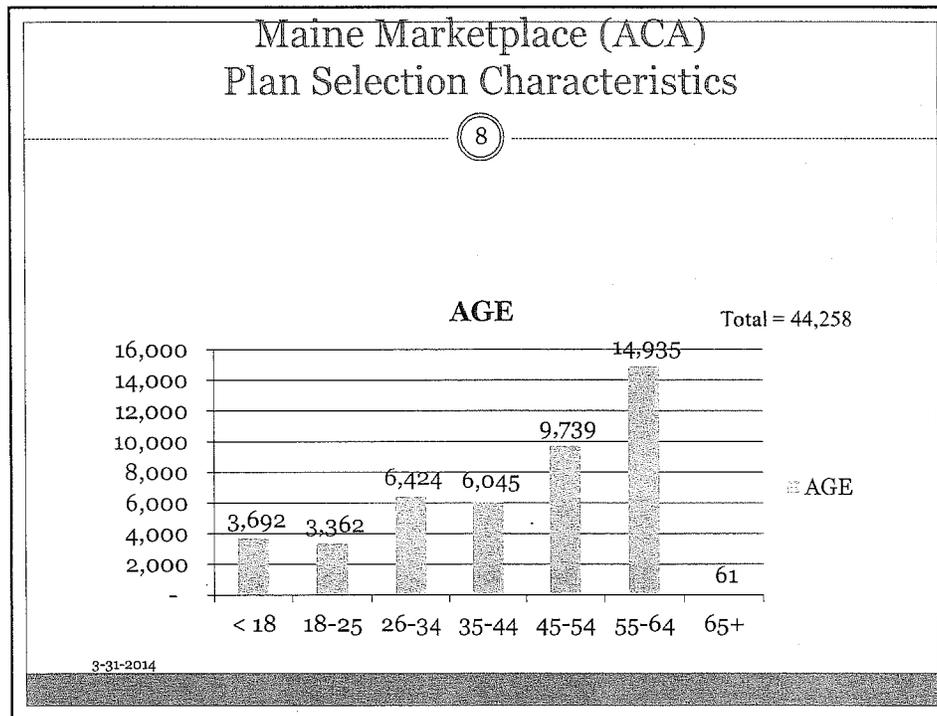
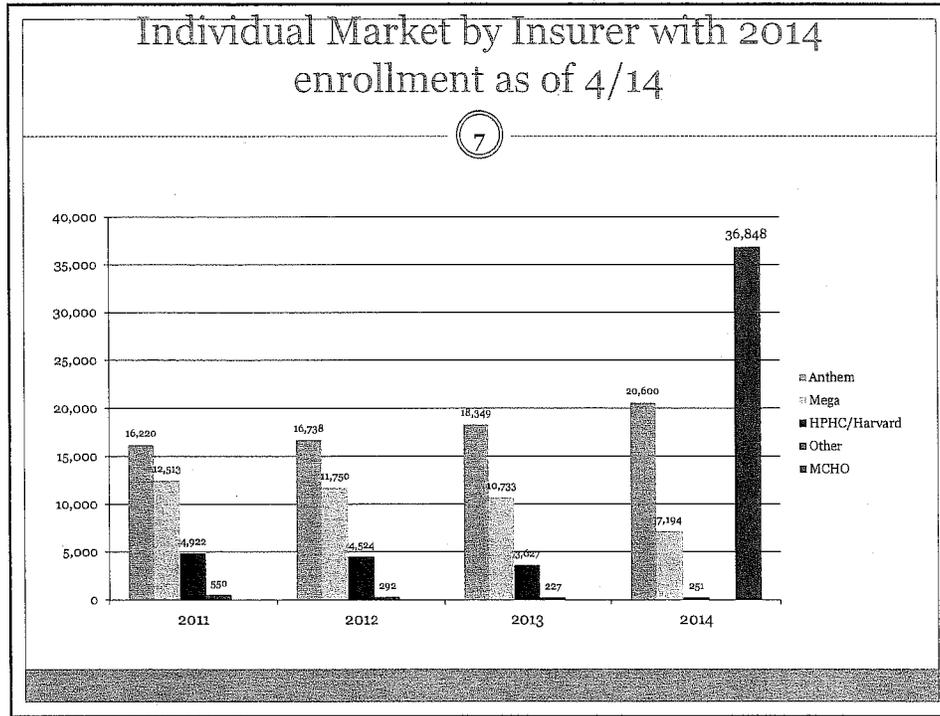
Total Enrollment = 44,258
This number **does not** reflect off exchange individual market enrollment

Health Insurance Market Insured Lives

Small group enrollment for 2014 has not been reported yet.

6

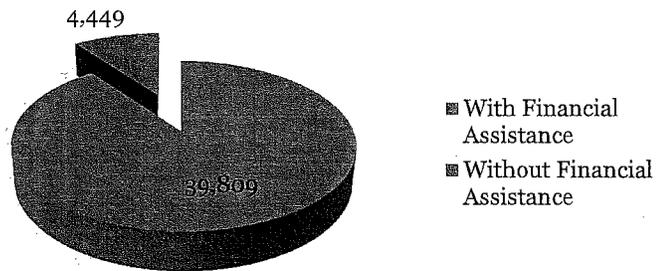




Maine Marketplace (ACA) Plan Selection Characteristics

9

Financial Assistance Status

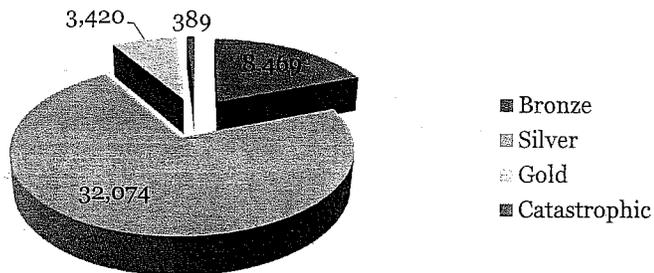


3-31-2014

Maine Marketplace (ACA) Plan Selection Characteristics

10

Metal Level

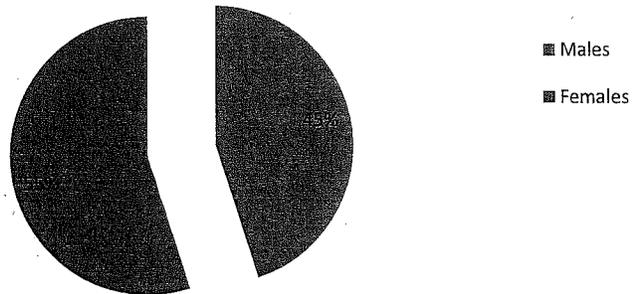


3-31-2014

Maine Marketplace Enrollment 10/1/2013 – 3/1/2014

11

Gender



Anthem Narrow Network

12

- Late May 2013: Anthem filed 2 networks for its QHP application:
 - 6 northern counties: POS with previously established (“broad”) network;
 - No out-of-state coverage unless service is not available in Maine;
 - 10 southern counties: HMO with “narrow” network – included 15 of the 21 hospitals previously in the network – and their related providers. (Hospitals no longer included: Bridgton, CMMC, Inland, Mercy, Parkview, Rumford, York.)

Narrow Network (Cont.)

13

- Decision INS 803-2013 - Anthem is required to give BOI ongoing reports on member experience in the 10 southern counties, including:
 - % of open practices for both primary care and high-volume specialists
 - Results of consumer surveys specifically related to ability to access care as needed
 - Consumer complaints related to accessing needed care
 - Requests for approval for out-of-network services.
 - **Did not approve** moving existing policyholders to a narrow network product.

State Flexibility – Cooperation with CMS/CCIIO

14

- The cooperation shown by CMS/CCIIO staff working through difficult issues. i.e. tobacco rating issue affecting Anthem enrollees has been good.
 - Enrollees received rates for non-tobacco use when they reported they were smokers. Issue of binder submission problems by carriers who submitted dental binder after their medical binder.
 - Result enrollees are able to have their non-smoking rate for this year or until they renew with another issuer.

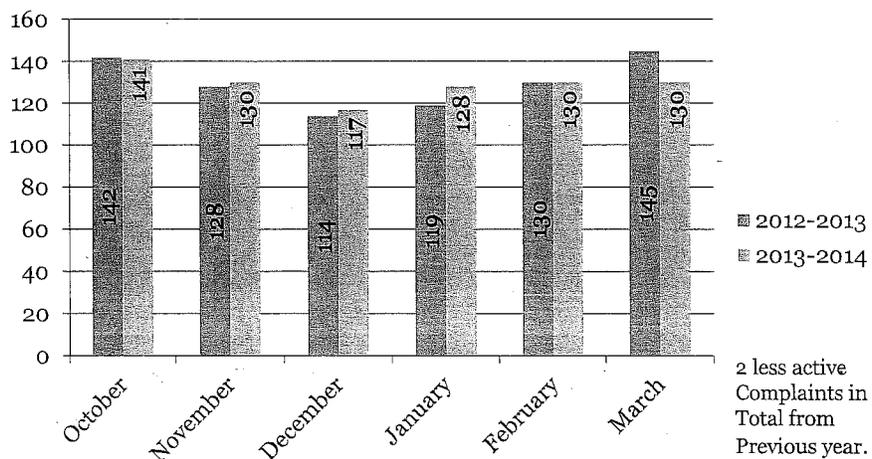
Preventative Services Issue

15

- Coding by medical providers has resulted in enrollees who thought that they were obtaining a preventative service resulted in significant amount of their medical bill being assigned to their deductible amount that they have to pay out of pocket.
- Example is colonoscopy. Individuals obtaining a preventative screening who have (polyp) tissue removed result in a diagnostic coded bill.

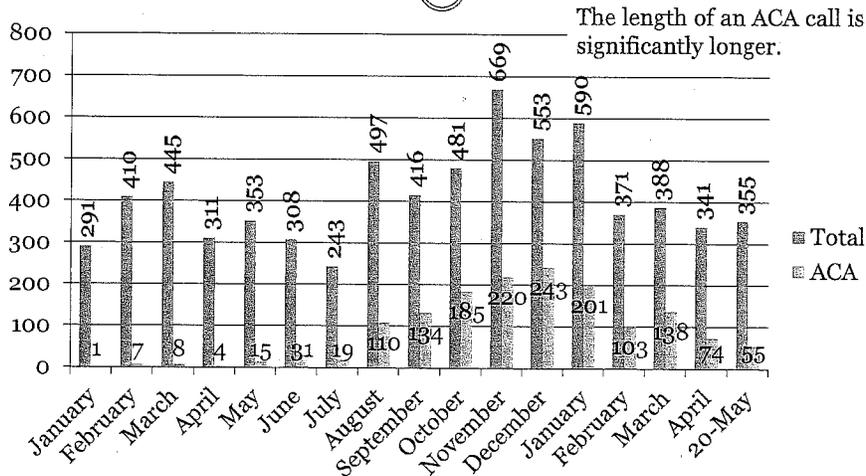
Health Insurance Active Complaints

16



Health Insurance Inquiries January 2013 – May 2014

17



Product Discontinuance and Replacement

18

- Non-grandfathered products on the market prior to 2014 don't comply with the ACA
- Different insurance company approaches to 2014:
 - "Early renewals" in December, 2013.
 - Offer of ACA-compliant replacement policies.
 - President's announcement allowing insurers to renew "transitional" non ACA-compliant policies before October 2, 2013 in both 2013 and 2014. Anthem offers this in the individual market only.*
 - Any cancelled policyholders may seek a hardship exemption to purchase a catastrophic coverage policy for 2014 only.
- Grandfathered plans will be renewed. Grandfathered Plans are plans that have been held since March 23, 2010 without any changes. Insurance companies had to send letters to all enrollees with grandfathered plans; anyone who did not receive such a letter does not have a grandfathered plan.

*The President has extended this to policies issued before Oct. 2, 2016 subject to State permission and carrier discretion.

MAINE'S 2015 HEALTH INSURANCE MARKET

19

Individual Market

- Carriers in the **2015 Marketplace**: Anthem, Maine Community Health Options, Harvard Group
- Carriers selling off the 2015 Marketplace: Anthem, Maine Community Health Options, Aetna and Harvard Group

Small Group Market (SHOP) : Anthem, Harvard Group, Maine Community Health Options (MCHO).

Small Group Market

- Carriers: Anthem, Aetna Group, Harvard Group, and United Healthcare, Maine Community Health Options

Large Group Market

- Carriers: Anthem, Connecticut General, Harvard Group, Nationwide, Aetna Group, and United Healthcare

MEGA is non-renewing approximately 6,000 lives in 2014 and 2015

Filing and Review challenges for 2015

20

- The Maine filing deadline for rates is May 30, 2014.
- Issuers are completing Federal templates on HIOS from 5/2/2014-5/27/14.
- The Federal template validation is 5/27/14 – mid-to-late June 2014.

State Mandate

21

- Public Law 603 – An Act to Require Health Insurers to Provide Coverage for Leukocyte Antigen Testing to Establish Bone Marrow Donor Transplantation Suitability.
 - Rate filings are being monitored by the actuarial unit to determine whether any carrier is including charges for this coverage.

Complexity of Form and Rate Filings

22

- Grandfathered Plans
 - Transitional Plans
 - ACA Plans
 - Templates
 - Binders
- Reclassified a position to hire an additional form review staff to assist in the review of filings.

Complexity of Form and Rate Filings

23

- 5 Medical Filings (Individual and Small Group)
 - 11 Associated Form Filings
 - Generated 42 different plans to review
 - Required the review of 35 HIOS Templates
 - Administrative Data
 - Plan and Benefits
 - Prescription Drugs
 - Network Adequacy
 - Service Area
 - Essential Community Provider
 - Rate Data
 - Rating Business Rules
 - Review of 40 Supporting Documents
 - Network Adequacy Certification
 - Plan and Organizational Charts
 - ECP Supplemental response
 - Attestations
 - Several Justifications
 - Formulary – Class Count
 - Actuarial Value

Additionally 10 individual and 10 small group filings were made off the exchange at the same time.

Complexity of Form and Rate Filings

24

- 7 Dental Filings
 - 11 Associated Form Filings
 - Generated 27 different plans to review
 - Required the review of 49 HIOS Templates
 - Administrative Data
 - Plan and Benefits
 - Prescription Drugs
 - Network Adequacy
 - Service Area
 - Essential Community Provider
 - Rate Data
 - Rating Business Rules
 - Review of 56 Supporting Documents
 - Network Adequacy Certification
 - Plan and Organizational Charts
 - ECP Supplemental response
 - Attestations
 - Several Justifications
 - Formulary – Class Count
 - Actuarial Value Justification

Complexity of Form and Rate Filings

25

- Developed checklists that incorporate both State and Federal Requirements.
- The individual checklist for compliance is 40 pages long.
- The small group checklist for compliance is 44 pages long.

Complexity of Form and Rate Filings

26

- Example of one checklist item.

<p>Extension of dependent coverage to age 26</p>	<p>24-A M.R.S.A. §4320-B</p>	<p>A carrier offering a health plan subject to the requirements of the federal Affordable Care Act that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age, consistent with the federal Affordable Care Act.</p> <p>An insurer shall provide notice to policyholders regarding the availability of dependent coverage under this section upon each renewal of coverage or at least once annually, whichever occurs more frequently. Notice provided under this subsection must include information about enrolment periods and notice of the insurer's definition of and benefit limitations for preexisting conditions.</p>	<p><input type="checkbox"/></p>
<p>Dependent coverage must be available up to age 26 if policy offers dependent coverage.</p>	<p>PHSA §2714 (75 Fed Reg 27122, 45 CFR §147.120)</p>	<p>Eligible children are defined based on their relationship with the participant. Limiting eligibility is prohibited based on: financial dependency on primary subscriber, residency, student status, employment, eligibility for other coverage, marital status.</p> <p>Terms of the policy for dependent coverage cannot vary based on the age of a child.</p>	<p><input type="checkbox"/></p>

ACA Guidance and Regulations

27

- Exchange and Insurance Marketplace Standards for 2015 and beyond. Issued May 16, 2014 (Rule is 436 Pages)
 - Product discontinuation;
 - Product modifications;
 - Standard notice requirements;
 - Product renewal;
 - Fixed Indemnity Criteria;
 - Indemnity Notice
 - Quality reporting;
 - Non-discrimination standards;
 - Certification standards;

ACA Guidance and Regulations

28

- Exchange and Insurance Marketplace Standards for 2015 and beyond. Continued
 - Prescription Drug Coverage;
 - Expedited process for exigent circumstances;
 - Decision within 24 hours;
 - Annual Notice of Coverage Changes
 - Employee Choice on the SHOP

Gold And Silver Plan Benefits

(29)

Company	Plan Level	Deductible	Out of Pocket Maximum	Coinsurance	Monthly Premium Age 40 Kennebec County
Anthem Blue Cross & Blue Shield (Anthem)	Silver	\$2,500	\$4,000	10%	\$357.62
	Gold	\$750	\$6,000	0%	\$453.31
Maine Community Health Options (MCHO)	Silver	\$2,000	\$6,350	30%	\$319.84
	Gold	\$650	\$2,500	20%	\$405.23

Cost Sharing Reductions (CSR) for Silver Plans for a Single Age 40 in Kennebec County

(30)

Company	Income Level	Actuarial Value	Deductible	Out of Pocket Maximum	Coinsurance	Maximum Monthly Premium after Subsidy (Premium can be lower)
Anthem Blue Cross & Blue Shield (Anthem)	400% FPL and above	70% (Standard Silver)	\$2,500	\$4,000	10%	\$357.62
	CSR Plan Level	From 201% to 250% FPL	\$2,200	\$3,500	10%	\$230.65
		From 151% to 200% FPL	\$1,150	\$1,150	0%	\$158.43
		Less than 150% FPL	94%	\$500	\$500	0%
Maine Community Health Options (MCHO)	400% FPL and above	70% (Standard Silver)	\$2,000	\$6,350	30%	\$319.84
	CSR Plan Level	From 201% to 250% FPL	\$2,000	\$4,350	30%	\$192.87
		From 151% to 200% FPL	\$500	\$1,500	20%	\$120.65
		Less than 150% FPL	94%	\$200	\$500	10%

Small Group Composite Rate Structure - Tiers Prior to Affordable Care Act

(31)

- Employee Only
- Employee and Spouse
- Family
- Employee and Children

Small Group Rating in 2014

(32)

- **Member Rating:** The total premium charged to the group is determined by summing the premiums of each employee and their dependents for their individual ages. This is limited to a maximum of 3 children under age 21.
- **Composite Rating:** A carrier may quote to a group premiums that are based on average enrollee amounts, provided that the total group premium is the same total amount calculated by the age of each member covered.

Affordability of Employee-Only Coverage

33

Example 1:

Income: **\$40,000**
 John's share of the
 premium: **\$200/month**

Is the plan affordable?
 Cost: \$2,400
 Share of income: 6%

The plan **is affordable**.

John cannot qualify for
 premium tax credits.



Example 2:

Income: **\$25,000**
 John's share of the
 premium: **\$200/month**

Is the plan affordable?
 Cost: \$2,400
 Share of income: **9.6%**

The plan is **not**
affordable.

John may qualify for
 premium tax credits.

Source: Center on Budget and Policy Priorities

Affordability of Dependent Coverage

34

- Employer offers health insurance to employees including family coverage. Large employer has to offer dependent coverage.
- The plan is determined to be affordable if the contributions are less than 9.5% of **employees** income.
- The dependents are ineligible for the Premium Tax Credit (Subsidy) because of the offer of affordable health insurance.

Affordability of Family Coverage

35

Mom earns \$35,000. Dad earns about \$12,000.

Employee Income: \$35,000

Family Income: \$47,000



Premium Cost for Employee-Only Plan: \$146/mo.
(\$1,750/yr.) *5% of income*

Premium Cost for Family Plan: \$379/mo. (\$4,550/yr.)
13% of income is greater than

Bottom Line:

No one is eligible for premium tax credits because family coverage is considered affordable.

Source: Center on Budget and Policy Priorities

Affordability of Coverage

36

Family Income: \$47,000

Employee Income: \$35,000

Premium Cost for Employee-Only Plan: \$146/mo. (\$1,750/yr.) *5% of income*

Premium Cost for Employee + Kids Plan: \$292/mo. (\$3,500/yr.) *10% of income*

Family coverage is not offered

Mom and Kids

- Employee + kids plan is considered **affordable** because employee-only plan is affordable.
- Mom and kids are **not eligible** for premium tax credits.

Dad

- Dad has **no offer** of coverage.
- He may be **eligible** for premium tax credits.



Source: Center on Budget and Policy Priorities

Affordability of Coverage

37

Employee Income: \$35,000

Employee-Only Plan: \$146/mo. (\$1,750/yr.) 5% of income

Employee + Kids Plan: \$292/mo. (\$3,500/yr.) 10% of income

Family Plan: \$379/mo. (\$4,550/yr.) 13% of income

Any of these plans would be considered affordable because the cost of self-only coverage is <9.5% of income.



Source: Center on Budget and Policy Priorities



DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION

**Bureau of
Insurance**

STATE OF MAINE



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207-624-8475

www.maine.gov/insurance

Insurance.PFR@maine.gov

Bureau of Insurance
#34 State House Station
Augusta, ME 04333-0034

Insurance Carrier Provider Search

39

Anthem Find a Provider:

<https://www.anthem.com/health-insurance/provider-directory/searchcriteria?branding=ABCBS>

Maine Community Health Options Providers:

<http://www.maineoptions.org/Search-provider>

Maine Health Exchange Advisory Committee

June 3, 2014

Anthem Blue Cross and Blue Shield
Exchange Enrollment Information (as of May 20, 2014)¹

Table 1

	Number of individuals selecting a plan and currently enrolled/effectuated ²	Number of individuals selecting a plan but NOT currently enrolled/effectuated ³	Number of individuals receiving some form of exchange subsidy ⁴	Number of individuals that have NOT received some form of subsidy ⁵
Individual Plans	3,159	1,225	3,130	1,254
Family Plans	1,203	274	1,195	282
Total Covered Lives in Family Plans	3,096	757	3,082	771

Table 2

	Under 18	18-25	26-34	35-44	45-54	55-64	65 and older
Number of covered lives for those currently enrolled/effectuated ²	686	413	954	865	1,191	2,030	116
Number of covered lives for those selected a plan but are NOT currently enrolled/effectuated ³	207	195	398	325	380	449	28

¹ These tables provide data for all persons who submitted an electronic or paper on the Federally Facilitated Marketplace from October 1, 2013 through May 20, 2014. The data includes enrollees whose policies have effective dates of June 1 (or later). The premiums for those June 1 policies are generally due on June 10. Thus, the data includes enrollees who have completed the application process but whose first month premium is not yet due. The data does not include off-exchange enrollment in ACA-compliant plans.

² The column labeled "Number of individuals selecting a plan and currently enrolled/effectuated" contains only active members currently effectuated as of May 20, 2014 who have not cancelled their coverage. This snapshot of data as of May 20, 2014 is subject to change due to the inherent variability in the individual market and factors such as grace periods.

³ The column labeled "Number of individuals selecting a plan but NOT currently enrolled/effectuated" includes applicants with June 1 or later effective dates whose first month's premium is not yet due, applicants currently in the premium payment grace period, applicants who failed to pay the first month's premium within the grace period, and those who elected to drop their coverage.

⁴ The column labeled "Number of individuals receiving some form of exchange subsidy" reflects the individuals eligible for some form of subsidy. Anthem only seeks to collect the subsidy from CMS for those individuals it understands have effectuated their coverage by paying their first month's premium.

⁵ The data does not include off-exchange enrollment in ACA-compliant plans.

Maine Health Exchange Advisory Committee
Brief Summary of Related Legislation Considered by IFS Committee
126th Legislature Second Regular Session

LD 1345 Resolve, to Study the Design and Implementation of Options for Universal Health Care Plan in the State That Is in Compliance with the Federal Patient Protection and Affordable Care Act

Final Disposition: Not Enacted; Governor's Veto Sustained

Summary: This resolve proposed to express the Legislature's intent that all Maine residents have access to and coverage for affordable, quality health care. The resolve would have required the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters to solicit the services of one or more consultants to propose design options for creating a universal system of health care in the State. The resolve required the consultant or consultants to submit a proposal by December 2, 2015, containing at least three design options that comply with the federal Patient Protection and Affordable Care Act.

The resolve included a provision requiring the State Controller to transfer \$100,000 from the State Innovation Model grant received by the Department of Health and Human Services pursuant to the federal Patient Protection and Affordable Care Act before June 30, 2015, to fund the study required by the resolve. If funds exceeding \$100,000 are received from other public and private sources before December 1, 2015, the resolve required that the money be transferred back to the Department of Health and Human Services.

LD 1676 An Act To Strengthen Disclosure about Provider Networks to Consumers and Providers

Final Disposition: Became Law without Governor's Signature; Enacted as Public Law 2013, chapter 535

Summary: Public Law 2013, chapter 535 requires a health insurance carrier to disclose information about its provider networks, including whether there are any hospitals, health care facilities, physicians or other providers not included in the provider's network and any differences in an enrollee's financial responsibilities for payment of covered services to a participating provider and to a provider not included in a provider network. The law authorizes the Superintendent of Insurance to adopt rules setting forth the manner, content and required disclosure of the information and specifies that those rules are routine technical rules.

The law also requires a health insurance carrier to disclose upon request from a provider the reason for the carrier's decision not to offer the provider the opportunity to participate or to include the provider in any provider network of the carrier. The written explanation provided by the carrier must indicate whether the reason was related to the provider's performance with respect to quality, cost or cost-efficiency. The law stipulates that a provider has no right of action as the result of such a disclosure.

STATE OF MAINE

IN THE YEAR OF OUR LORD
TWO THOUSAND AND FOURTEEN

H.P. 1199 - L.D. 1676

**An Act To Strengthen Disclosure about Provider Networks in Health
Insurance Plans to Consumers and Providers**

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24-A MRSA §4303, sub-§19 is enacted to read:

19. Information about provider networks. A carrier offering a managed care plan shall prominently disclose to applicants, prospective enrollees and enrollees information about the carrier's provider network for the applicable managed care plan, including whether there are hospitals, health care facilities, physicians or other providers not included in the plan's network and any differences in an enrollee's financial responsibilities for payment of covered services to a participating provider and to a provider not included in a provider network. The superintendent may adopt rules that set forth the manner, content and required disclosure of the information in accordance with this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. 2. 24-A MRSA §4303-B is enacted to read:

§4303-B. Disclosure related to provider networks

1. Disclosure. Upon request, a carrier shall provide to a provider to which the carrier has decided not to offer the opportunity to participate or that the carrier has decided not to include as a participating provider in any of the carrier's provider networks a written explanation of the reason for the carrier's decision. The written explanation provided by the carrier must indicate whether the reason for not offering the provider the opportunity to contract or for not including the provider in any network was related to the provider's performance with respect to quality, cost or cost-efficiency.

2. No right of action. A provider has no right of action as the result of a disclosure made in accordance with this section.



STATE OF MAINE
OFFICE OF THE GOVERNOR
1 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0001

Paul R. LePage
GOVERNOR

28 April 2014

The 126th Legislature of the State of Maine
State House
Augusta, ME

Dear Honorable Members of the 126th Legislature:

Under the authority vested in me by Article IV, Part Third, Section 2 of the Constitution of the State of Maine, I am hereby vetoing LD 1345, "Resolve, To Study the Design and Implementation of Options for Universal Health Care Plan in the State That Is in Compliance with the Federal Patient Protection and Affordable Care Act."

With single-payer healthcare, we know ahead of time that if you like your private health insurance plan, you can say goodbye to it. Instead, you'll get the healthcare your government feels is right for you—designed by the government, implemented by the government and paid for by you (provided you're a taxpayer). Hard-working Mainers could expect to pay unsustainably higher taxes in exchange for even fewer insurance choices and more government bureaucracy, an idea only a Democrat could love.

Additionally, the funding source listed in the fiscal note, the State Innovation Model grant funds, is completely inappropriate. We received funding from the federal government based on a specific approved plan (one that had nothing to do with universal healthcare). The Legislature does not have the authority to appropriate those funds for other uses unless it wants to risk our state losing the entire \$33 million grant. The Legislature may be used to seeking out accounts dedicated to funding existing obligations in order to fund new pet projects, but I cannot consent to such fiscal irresponsibility.

For these reasons, I return LD 1345 unsigned and vetoed. I strongly urge the Legislature to sustain it.

Sincerely,

Paul R. LePage
Governor



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Enacted/Adopted in House/Senate

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L.D. 1345

Date: 3/31/14

Majority

(Filing No. H-771)

INSURANCE AND FINANCIAL SERVICES

Reproduced and distributed under the direction of the Clerk of the House.

**STATE OF MAINE
HOUSE OF REPRESENTATIVES
126TH LEGISLATURE
SECOND REGULAR SESSION**

COMMITTEE AMENDMENT "A" to H.P. 962, L.D. 1345, Bill, "An Act To Establish a Single-payor Health Care System To Be Effective in 2017"

Amend the bill by striking out the title and substituting the following:

'Resolve, To Study the Design and Implementation of Options for a Universal Health Care Plan in the State That Is in Compliance with the Federal Patient Protection and Affordable Care Act'

Amend the bill by striking out everything after the title and before the summary and inserting the following:

Sec. 1. Purpose. Resolved: That it is the intent of the Legislature to ensure that all Maine residents have access to and coverage for affordable, quality health care. While the Legislature supports a national universal system of health care, until such federal legislation is enacted, it is the intent of the Legislature to study the design and implementation of a universal health care plan that complies with the requirements for innovation waivers available to states pursuant to the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, referred to in this resolve as "the Affordable Care Act"; and be it further

Sec. 2. Consultant; proposal. Resolved: That the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters, referred to in this resolve as "the committee," shall solicit the services of one or more outside consultants to work with the committee to propose by December 2, 2015 to the Legislature at least 3 design options, including implementation plans, for creating a universal system of health care that ensures all Maine residents have access to and coverage for affordable, quality health care services that meet the principles and goals outlined in this resolve. By October 15, 2015, the consultant shall release a draft of the design options to the public, including the data used by the consultant to develop the design options, and provide 30 days for public review and the submission of comments on the design options. The consultant shall review and consider the public comments and

4

ROFS

1 revise the draft design options as necessary prior to the final submission to the committee;
2 and be it further

3 **Sec. 3. Design options. Resolved:** That the consultant's proposal under section
4 2 must contain the analysis and recommendations as provided for in this section.

5 1. The proposal must include the following design options:

6 A. A design for a government-administered and publicly financed single-payor
7 health benefits system that is decoupled from employment, that prohibits insurance
8 coverage for the health services provided by the system and that allows for private
9 insurance coverage of only supplemental health services;

10 B. A design for a universal health benefits system with integrated delivery of health
11 care and integrated payment systems for all individuals that is centrally administered
12 by State Government or an entity under contract with State Government; and

13 C. A design for a public health benefit option administered by State Government or
14 an entity under contract with State Government that allows individuals to choose
15 between the public option and private insurance coverage and allows for fair and
16 robust competition among public and private plans.

17 Additional options may be designed by the consultant, in consultation with the
18 committee, taking into consideration the parameters described in this section.

19 Each design option must include sufficient detail to allow the Legislature to consider the
20 adoption of one design and to determine an implementation plan for that design during
21 the Second Regular Session of the 127th Legislature and to initiate implementation of the
22 new system through a phased process beginning no later than January 1, 2018, including
23 the submission of any necessary waivers pursuant to federal law.

24 2. In creating the design options under subsection 1, the consultant shall review and
25 consider the following fundamental elements:

26 A. The findings and reports from previous studies of health care reform in the State,
27 including the December 2002 document titled "Feasibility of a Single-Payer Health
28 Care Model for the State of Maine" produced by Mathematica Policy Research, Inc.,
29 and studies and reports provided to the Legislature;

30 B. The State's current health care reform efforts;

31 C. The health care reform efforts in other states, including any efforts in other states
32 to develop state innovation waivers for universal health coverage plans as an
33 alternative to the Affordable Care Act; and

34 D. The Affordable Care Act; the federal Employee Retirement Income Security Act
35 of 1974, as amended; and the Medicare program, the Medicaid program and the State
36 Children's Health Insurance Program under Titles XVIII, XIX and XXI, respectively,
37 of the federal Social Security Act.

38 3. The design options under subsection 1 must maximize federal funds to support the
39 system and be composed of the following components as described in this subsection:

40 A. A payment system for health services that includes one or more packages of
41 health services providing for the integration of physical and mental health services;

1 budgets, payment methods and a process for determining payment amounts; and cost-
2 reduction and cost-containment mechanisms;

3 B. Coordinated regional delivery systems;

4 C. Health system planning, regulation and public health;

5 D. Financing and estimated costs, including federal financing; and

6 E. A method to address compliance of the proposed design option or options with
7 federal law. Unless specifically authorized by federal law, the proposed design
8 options must provide coverage supplemental to coverage available under the
9 Medicare program of the federal Social Security Act, Title XVIII and the federal
10 TRICARE program, 10 United States Code, Chapter 55.

11 4. The design options under subsection 1 must include the following components:

12 A. A payment system for health services that is aligned with the State's innovation
13 model project to advance delivery system and payment reform initiatives already in
14 place throughout the State and that is consistent with the terms and conditions of any
15 federal grant awarded to the State's innovation model project;

16 B. A benefit package or packages of health services that meet the requirements of the
17 Affordable Care Act and provide for the integration of physical and mental health,
18 including access to and coverage for primary care, preventive care, chronic care,
19 acute episodic care, palliative care, hospice care, hospital services, prescription drugs
20 and mental health and substance abuse services;

21 C. A method for administering payment for health services, which may include
22 administration by a government agency, under an open bidding process soliciting
23 bids from insurance carriers or 3rd-party administrators, through a private nonprofit
24 insurer or 3rd-party administrator, through private insurers or from a combination
25 thereof;

26 D. Enrollment processes;

27 E. Integration of pharmacy best practices and cost control programs and other
28 mechanisms to promote evidence-based prescribing, clinical efficacy and cost
29 containment, such as a single statewide preferred drug list, prescriber education or
30 utilization reviews;

31 F. Appeals processes for decisions made by entities or agencies administering
32 coverage for health services;

33 G. A recommendation for budgets and payment methods and a process for
34 determining payment amounts. Payment methods for mental health services must be
35 consistent with mental health parity. The design options must consider:

36 (1) Recommending a global health care budget when it is appropriate to ensure
37 cost containment by a health care facility, a health care provider, a group of
38 health care professionals or a combination thereof. Any recommendation must
39 include a process for developing a global health care budget, including
40 circumstances under which an entity may seek an amendment of its budget;

41 (2) Payment methods to be used for each health care sector that are aligned with
42 the goals of this section and provide for cost containment, provision of high-

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COMMITTEE AMENDMENT "A" to H.P. 962, L.D. 1345

1 quality, evidence-based health services in a coordinated setting, patient self-
2 management and healthy lifestyles; and

3 (3) What process or processes are appropriate for determining payment amounts
4 with the intent to ensure reasonable payments to health care professionals and
5 providers and to eliminate the shift of costs between the payors of health services
6 by ensuring that the amount paid to health care professionals and providers is
7 sufficient. Payment amounts must be sufficient to provide reasonable access to
8 health services, provide sufficient uniform payments to health care professionals
9 and assist in creating financial stability for health care professionals. Payment
10 amounts for mental health services must be consistent with mental health parity;

11 H. Cost-reduction and cost-containment mechanisms;

12 I. A regional health system that ensures that the delivery of health services to the
13 citizens of the State is coordinated in order to improve health outcomes, improve the
14 efficiency of the health system and improve patients' experiences of health services;
15 and

16 J. Health system planning and regulation and public health.

17 5. The design options under subsection 1 must consider financing and estimated
18 costs, including federal financing. The design options must provide:

19 A. An estimate of the total costs of the design options, including any additional costs
20 for providing access to and coverage for health services to the uninsured and
21 underinsured, any estimated costs necessary to build a new system and any estimated
22 savings from implementing a single system;

23 B. Financing proposals for sustainable revenue, including by maximizing federal
24 revenues, or reductions from existing health care programs, services, state agencies or
25 other sources necessary for funding the cost of the new system;

26 C. A proposal to the federal Centers for Medicare and Medicaid Services to waive
27 provisions of Titles XVIII, XIX and XXI of the federal Social Security Act, if
28 necessary, to align the federal programs with the proposals contained within the
29 design option in order to maximize federal funds or to promote the simplification of
30 administration, cost containment or promotion of health care reform initiatives; and

31 D. A proposal to the federal Centers for Medicare and Medicaid Services to waive
32 provisions of the Affordable Care Act, if necessary, to implement the proposals
33 contained within the design options in order to maximize federal funds.

34 6. The proposal must include a method to address compliance of the proposed design
35 options under subsection 1 with federal law if necessary, including the Affordable Care
36 Act; the Employee Retirement Income Security Act of 1974, referred to in this subsection
37 as "ERISA"; and Titles XVIII, XIX and XXI of the federal Social Security Act. In the
38 case of ERISA, the consultant may propose a strategy to seek an ERISA exemption from
39 the United States Congress if necessary for the design options.

40 7. The proposal must include an analysis of:

41 A. The impact of the design options on the State's current private and public
42 insurance system;

ROFS

- 1 B. The expected net fiscal impact;
- 2 C. The impact of the design options on the State's economy;
- 3 D. The benefits and drawbacks of alternative timing for the implementation of the
- 4 designs, including the sequence and rationale for the phasing in of the major
- 5 components; and
- 6 E. The benefits and drawbacks of the design options and of not changing the current
- 7 system; and be it further

8 **Sec. 4. Additional staff assistance. Resolved:** That, upon request, the
9 Department of Health and Human Services and the Department of Professional and
10 Financial Regulation, Bureau of Insurance shall provide any additional staffing assistance
11 to the committee to ensure the committee and its consultant or consultants have the
12 information necessary to create the design options required by this resolve; and be it
13 further

14 **Sec. 5. Report. Resolved:** That, no later than December 2, 2015, the consultant
15 shall submit a report that includes its findings and recommendations, including suggested
16 legislation, to the committee. The committee may report out a bill to the Second Regular
17 Session of the 127th Legislature based on the consultant's report that adopts one of the
18 design options under section 3 and establishes an implementation plan; and be it further

19 **Sec. 6. Funding; sources. Resolved:** That the committee may accept from the
20 Department of Professional and Financial Regulation, Bureau of Insurance and the
21 Department of Health and Human Services any grant funding made available to the State
22 pursuant to the Affordable Care Act that is received by those state agencies. The
23 committee may also apply for and receive funds, grants or contracts from public and
24 private sources to support its activities. Contributions to support the work of the
25 committee may not be accepted from any party having a pecuniary or other vested
26 interest in the outcome of the matters being studied. Any person, other than a state
27 agency, desiring to make a financial or in-kind contribution shall certify to the Legislative
28 Council that it has no pecuniary or other vested interest in the outcome of the committee's
29 activities. Such a certification must be made in the manner prescribed by the Legislative
30 Council. All contributions are subject to approval by the Legislative Council. All funds
31 accepted must be forwarded to the Executive Director of the Legislative Council along
32 with an accounting record that includes the amount of the funds, the date the funds were
33 received, from whom the funds were received and the purpose of and any limitation on
34 the use of those funds. The Executive Director of the Legislative Council shall administer
35 any funds received by the committee; and be it further

36 **Sec. 7. Transfer. Resolved:** That, notwithstanding any other provisions of law,
37 on or before June 30, 2015, the State Controller shall transfer \$100,000 from the State
38 Innovation Model Grant, Federal Expenditures Fund account in the Department of Health
39 and Human Services to the Miscellaneous Studies-Funding, Other Special Revenue
40 Funds account of the Legislature. If before December 1, 2015 the Legislature receives
41 funds that exceed \$100,000 from other public and private sources as authorized in section
42 6, the State Controller shall transfer \$100,000 from the Legislature to the State Innovation
43 Model Grant, Federal Expenditures Fund account in the Department of Health and
44 Human Services before December 31, 2015; and be it further



126th MAINE LEGISLATURE

LD 1345

LR 117(02)

An Act To Establish a Single-payor Health Care System To Be Effective in 2017

Fiscal Note for Bill as Amended by Committee Amendment 'A' (H-771)

Committee: Insurance and Financial Services

Fiscal Note Required: Yes

Fiscal Note

	FY 2013-14	FY 2014-15	Projections FY 2015-16	Projections FY 2016-17
Appropriations/Allocations				
Other Special Revenue Funds	\$0	\$100,000	\$0	\$0
Transfers				
Federal Expenditures Fund	\$0	(\$100,000)	\$0	\$0
Other Special Revenue Funds	\$0	\$100,000	\$0	\$0

Fiscal Detail and Notes

This bill includes an Other Special Revenue Funds allocation of \$100,000 in fiscal year 2014-15 to the Study Commissions - Funding program in the Legislature to authorize the expenditure for the consulting costs of a study to propose design options to create a universal system of health care in the State.

This bill requires a one-time transfer of \$100,000 from the Department of Health and Human Services' State Innovation Model Grant, Federal Expenditures account to the Legislature's Study Commissions - Funding, Other Special Revenue Funds account in fiscal year 2014-15 to provide resources for the study. It also provides a mechanism to transfer funds back to the State Innovation Model Grant account if the Legislature receives funds from other sources that exceed \$100,000.

10

**Maine Health Exchange Advisory Committee
Brief Summary of Legislation Related to MaineCare Expansion
126th Legislature Second Regular Session**

LD 1487 **An Act to Implement Managed Care in the MaineCare Program, sponsored by Senator Roger Katz.**

Final disposition: Passed House and Senate as amended by Committee Amendment “B,” H-419, vetoed by the Governor and veto sustained on April 11.

As passed with Committee Amendment “B” this bill would have provided for the following:

- MaineCare managed care, phased-in over 3 years, through managed care plans paid on a capitated basis, with a stakeholder process to design and plan for implementation, reporting to the Legislature, rulemaking, and State Plan amendments and waiver applications as required. Effective date contingent on meeting federal Medicaid requirements.
- Expanded eligibility for MaineCare to adults 21 to 64 years of age with incomes up to 138% of federal poverty level (FPL) and to adults 19 and 20 years of age with incomes up to 138% FPL beginning in 2019 (when current eligibility for this age group at 138% FPL runs out).
- Repeal of expanded MaineCare eligibility when federal reimbursement falls below 100%.
- Evaluation of the financial impact of MaineCare expansion on state programs and services and a report on the feasibility of (1) expanding coverage through a health insurance marketplace similar to Arkansas or Iowa and (2) a state basic health program similar to Washington.
- Necessary funding for the MaineCare expansion and authorization to the State Budget Officer to transfer funding by financial order.
- Required notice to MaineCare members of the end date of the newly expanded eligibility and the requirement that the member enroll with a primary care provider.
- A Task Force to Create Opportunities for Stable Employment for MaineCare Members to study disincentives for MaineCare members’ increasing hours of employment or earnings.
- Reforms in programs for adults with intellectual disabilities, adjusted provider reimbursement rates with savings dedicated to serve persons on waiting lists for Sections 21 and 29 services.
- Two new investigators in the Office of the Attorney General to work on MaineCare fraud.

LD 1578 **An Act to Increase Health Security by Expanding Federally Funded Health Care for Maine People, sponsored by Speaker Mark Eves.**

Final disposition: Passed House and Senate as amended by Committee Amendment “A”, H-704 and House Amendment “A,” H-849, vetoed by the Governor and veto sustained on May 1.

As passed this bill would have provided for the following:

- Expanded eligibility for MaineCare to adults 21 to 64 years of age with incomes up to 138% of federal poverty level (FPL) and to adults 19 and 20 years of age with incomes up to 138% FPL beginning in 2019 (when current eligibility for this age group at 138% FPL runs out).
- Repeal of expanded MaineCare eligibility when federal reimbursement falls below 100%.
- Participation of certain MaineCare members in the Private Health Insurance Premium Program.
- Participation of certain MaineCare members in the Maine Marketplace Premium Assistance program after approval by the federal Medicaid program of the required waiver application.
- Evaluation of the financial impact of MaineCare expansion on state programs and services, payments to hospitals as a result of MaineCare expansion any savings and the impact on health outcomes achieved through the SIM grant.

Maine Health Exchange Advisory Committee
Brief Summary of Legislation Related to MaineCare Expansion
126th Legislature Second Regular Session

- Evaluation of and a report on the feasibility of (1) expanding coverage through a health insurance marketplace similar to Arkansas or Iowa and (2) a state basic health program similar to Washington.
 - Necessary funding for the MaineCare expansion and authorization to the State Budget Officer to transfer funding by financial order.
 - Required notice to MaineCare members of the end date of the newly expanded eligibility.
 - Reforms in programs for adults with intellectual disabilities, adjusted provider reimbursement rates with savings dedicated to serve persons on waiting lists for Sections 21 and 29 services.
 - Two new investigators in the Office of the Attorney General to work on MaineCare fraud.
-

LD 1640 **An Act to Enhance the Stability and Predictability of Health Care Costs for Returning Veterans and Others by Addressing the Issues Associated with Hospital Charity Care and Bad Debt, sponsored by Senator Troy Jackson.**

Final disposition: Passed House and Senate as amended by Committee Amendment “A,” S-464, vetoed by the Governor and veto sustained on May 1.

As passed this bill would have provided for the following:

- Expanded eligibility for MaineCare to adults 21 to 64 years of age with incomes up to 138% of federal poverty level (FPL) and to adults 19 and 20 years of age with incomes up to 138% FPL beginning in 2019 (when current eligibility for this age group at 138% FPL runs out).
- Repeal of expanded MaineCare eligibility when federal reimbursement falls below 100%.
- Evaluation of the financial impact of MaineCare expansion on state programs and services and a report on the feasibility of (1) expanding coverage through a health insurance marketplace similar to Arkansas or Iowa and (2) a state basic health program similar to Washington.
- Necessary funding for the MaineCare expansion and authorization to the State Budget Officer to transfer funding by financial order.
- Required notice to MaineCare members of the end date of the newly expanded eligibility.

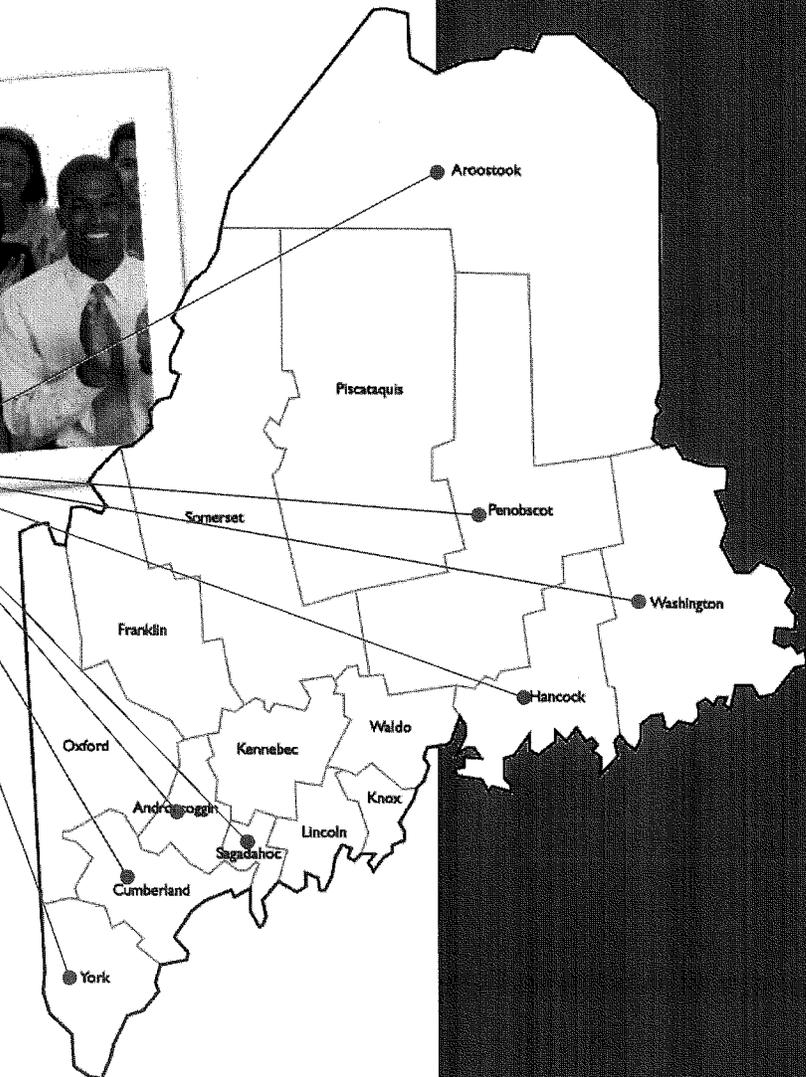


Consumers for Affordable Health Care

Advocating the right to quality, affordable health care for every man, woman and child since 1988.

Regional Assister Roundtables:

Maximizing Enrollment Success by Creating a Community of Assisters



Supported by:

MEHAF
MAINE HEALTH ACCESS FOUNDATION

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THE VOICE FOR HEALTH CARE CONSUMERS



Consumers for Affordable Health Care

Advocating the right to quality, affordable health care for every man, woman and child since 1988.

About Consumers for Affordable Health Care

Consumers for Affordable Health Care is a Maine advocacy organization that strives to ensure a strong consumer voice in decision making at all levels and in all forums in order to advocate for a consumer-oriented health system in Maine and the United States. Since 1988, Consumers for Affordable Health Care has provided leadership and support to consumers, businesses, organizations, and policymakers to specifically advocate for:

- Access to health care for all Maine residents including preventive, acute, chronic and long-term care that is assured through health care coverage
- Affordable health care coverage that is guaranteed for all Maine residents, taking into account an individual's ability to pay
- An individual's right to freely choose her or his provider and method of care within the confines of quality care that is based on objective standards and supported by publicly available data on individual providers and hospitals
- Financing coverage from a broad variety of government and private sources
- Controlling rising costs while preserving quality care

Consumers for Affordable Health Care provides resources to educate consumers and assist them in navigating the existing system.

Consumers for Affordable Health Care works with other organizations to educate them and to advocate our mission before legislative and regulatory bodies.

Consumers for Affordable Health Care
PO Box 2490 Augusta, Maine 04338-2490
1-800-838-0388 www.maine cahc.org

This report was written by:

Emily R. Brostek, MPH, CHES

Associate Director, Consumers for Affordable Health Care (CAHC)

The following CAHC staff assisted in the preparation of this report:

Joseph Ditré, Esq., Technical Editing

Mary Schneckenburger, M.Ed., Technical Editing

Kathryn Ende, Technical Editing

Valérie Clark, Graphic Layout and Design

Acknowledgement and Thanks

The author wishes to thank the more than one hundred navigators, certified application counselors, insurance brokers, and other assisters who attended Consumers for Affordable Health Care's seven regional roundtables to share their experiences and information that formed the basis for this report. Special thanks go to Jacob Grindle, April Gilmore, Susie Beal, Sue Mahar, Robin Bibber, and others for providing their personal insights, experiences, and quotes in this report. The regional roundtables held in Aroostook, Washington/Hancock, Penobscot, Kennebec, Sagadahoc, Cumberland, and York Counties gathered diverse voices and provided community-level details that we would never had known but for your attendance and willingness to share. In so doing, you will help others in communities across the U.S. just like yours to have hope, feel supported and recognized, and have new tools to use in their efforts to make sure that all people have high quality health coverage regardless of income.

The author gives many thanks to all of those individuals who actively participate in the Maine Assister Listserv to pursue eligibility and enrollment issues in greater depth and detail. Also, thank you to Anthem Health Plans of Maine, Northeast Delta Dental, and Maine Community Health Options for participating in these roundtables to provide greater information about your products to Maine's navigators and assisters. The author also wishes to thank Rachel Klein, Director of Organizational Strategy and Enrollment Program Director, and David Lemmon, Director of Communications, at Families USA for their assistance in publishing this report on Families USA's Enrollment Assistance Resource Web page, and sharing it with their extensive network of state consumer health advocates, policymakers, and the media. Additional thanks go to Raising Women's Voices for their support of these roundtables.

The author wishes to specially thank Dr. Wendy Wolf, Barbara Leonard, and Morgan Hynd at the Maine Health Access Foundation (MeHAF), and to MeHAF Board Chair, Sara Gagné-Holmes, and the entire MeHAF Board of Directors for their insightful planning, collaborative work with Maine's advocacy community, and their generous support. This support helped Maine to achieve the highest proportion of enrollees of all Federally-facilitated Marketplace states relative to Maine's total population. The Web site enroll207.com and the TV and radio advertising filled a huge void and made our work easier.

Finally, the author wishes to thank the Consumer Assistance Program staff of Consumers for Affordable Health Care Foundation. We thank Jaime D'Errico, Mary Schneckenburger, Andrea Irwin, Connie McCord, and Kathryn Ende for their incredible work to keep updated on Marketplace eligibility criteria and to assist navigators, assisters, and individuals with complex eligibility and enrollment, and for their commitment and dedication to our mission: to advocate the right to affordable, quality health care for every man, woman, and child!

Table of Contents

About Consumers for Affordable Health Care	2
Introduction and Overview.....	1
BACKGROUND	3
The Outreach and Enrollment Landscape in Maine	3
Maine’s Regional Roundtables: Bringing Maine’s Assisters Together.....	4
LESSONS LEARNED	5
Common Challenges	5
Emerging Best Practices for Outreach	8
The Value of a Supportive Network.....	11
CONCLUSION	14
Appendix 1 – 2014 Maine Health Access Foundation Grantees	15
Appendix 2 – Regional Roundtable Locations.....	16
Appendix 3 – Sample Interest Survey.....	17
Appendix 4 – Sample Invitation to Regional Roundtable	19
Appendix 5 – List of Handouts at Regional Roundtables	20
Appendix 6 – Sample Roundtable Agenda.....	21

Introduction and Overview

On October 1, 2013, a major provision of the Affordable Care Act (ACA) took effect with the opening of the Health Insurance Marketplace. The Marketplace or “exchange” helps people find health coverage. Those who qualify can get financial help that makes this coverage more affordable through advanced premium tax credits or cost-sharing reductions. But finding and enrolling consumers in this new health insurance coverage proved to be a daunting task across the nation.

Maine is one of the nation’s enrollment success stories. In the first open enrollment period (October 1, 2013 – March 31, 2014), 44,258 Mainers enrolled in coverage, exceeding the Department of Health and Human Services’ (HHS) original goal of 23,000 enrollments by 92.4%.¹ This success ranks Maine as the number one state for enrollments per capita in the federally facilitated Marketplace.

Mainers overcame significant hurdles to accomplish this success. At the outset of open enrollment, 133,000 Maine residents were uninsured – 10% of the state’s population.² To achieve near universal coverage, 800 uninsured Mainers would need to enroll each day during the initial six-month open enrollment period. To assist people with enrollment, HHS made \$67 million available nationwide to fund navigators to provide enrollment assistance, but only \$600,000 was allotted to Maine. The pathway to enrollment success was created when the Maine Health Access Foundation funded a statewide public information and enrollment assistance campaign called “enroll207.”

One key aspect of the enroll207 campaign was the development of a statewide network of enrollment assisters who could help Mainers apply for coverage at Healthcare.gov, the online portal to the federally-operated health insurance marketplace. As a rural state with an aging population, individual enrollment assistance was crucial to connect many Mainers with coverage. Many people depended on navigators, certified application counselors, brokers, and other assisters to complete the online application for health insurance coverage. This need was exacerbated by the technical problems that plagued Healthcare.gov’s launch in fall 2013. In the face of these challenges and with limited resources, coordinating the efforts of Maine’s assisters was vital.

Consumers for Affordable Health Care (CAHC), Maine’s designated Consumer Assistance Program, set out to connect Maine’s assister community through a series of regional roundtables with the support of the Maine Health Access Foundation. Roundtable sessions proved to be an effective strategy during Massachusetts health reform implementation, and provided a critical opportunity for enrollment and outreach

¹ http://waysandmeans.house.gov/uploadedfiles/enrolltargets_09052013_.pdf

² 2012-2013 Current Population Survey.

workers to discuss their experiences, share tips, and troubleshoot the challenges they experienced in the field.³

The lessons we learned from these roundtables are summarized in this report. This report is intended to provide consumer advocates, funders, and government agencies with observations about what worked best in terms of consumer outreach. These observations are provided to bring attention to major problems; not all topics or issues discussed in these sessions are covered here.

The roundtables revealed many lessons learned about the common experience of assisters and best practices for outreach and enrollment. But the most important theme that emerged is the value of supporting and connecting assisters through a network. Being part of a network of assisters helps navigators, certified application counselors, and brokers stay connected to the latest changes and updates from the Marketplace, and provide people in their community with the best enrollment assistance possible.



³ Effective Education, Outreach, and Enrollment Approaches for Populations Newly Eligible for Health Coverage
<http://bluecrossmafoundation.org/sites/default/files/Lessons%20for%20National%20Reform%20Outreach%20and%20Enrollment%20Toolkit.pdf>

BACKGROUND

The Outreach and Enrollment Landscape in Maine

In Maine, two groups received federal navigator funding:

- [Western Maine Community Action \(WMCA\)](#), with a consortium consisting of eight of Maine's ten community action programs
- [Fishing Partnership Health Plan](#) in collaboration with the [Maine Lobsterman's Association \(MLA\)](#)

Maine's 19 community health centers also received federal funding to provide outreach and enrollment assistance from the Health Resources and Services Administration (HRSA). Their work was supported and coordinated by the [Maine Primary Care Association \(MPCA\)](#).

Many hospitals, health programs, and other social service agencies and nonprofits also served as certified application counselor (CAC) organizations. Some conducted in-reach to their existing clients, while others provided enrollment assistance to anyone in their community.

The [Maine Health Access Foundation \(MeHAF\)](#) played a significant role in ACA education and outreach in Maine. Recognizing the great need for more awareness of the options available through the Marketplace and the availability of assistance, MeHAF launched [enroll207](#), a coordinated, aggressive marketing campaign to raise public awareness. The campaign used television and radio ads, press events, bus ads, print materials, online ads, social media outreach, and educational forums for communities and small business owners.

The central focus point of the campaign was the website [enroll207.com](#), which provided Maine-specific information and resources, including a zip code locator linking consumers with assisters in their community. Each ad included the enroll207 website, as well as CAHC's toll-free HelpLine for consumers seeking telephone support and additional advocacy.

MeHAF also provided additional support for Maine's assister community. Since 2010, MeHAF has coordinated a diverse group of grantees to educate Maine people about the ACA. This support continued through open enrollment, with MeHAF awarding \$1.5 million in grants to support ACA outreach and education in 2014 (see [Appendix 1](#) for a list of grantee organizations). Recognizing the limited navigator funding awarded in Maine, MeHAF provided CAHC with additional support throughout open enrollment. This support allowed CAHC to serve as a back-up center and resource for assisters, providing accurate information from the trained professionals on its HelpLine. This

dynamic also enabled CAHC to create a feedback loop by gathering real-time information from local assisters to share with national advocates at the Centers for Medicare & Medicaid Services (CMS).

Maine's Regional Roundtables: Bringing Maine's Assisters Together

In early 2014, CAHC convened a series of seven half-day meetings that connected navigators, certified application counselors, and others involved in education, outreach, and enrollment in regions throughout Maine (see [Appendix 2](#) for a map of roundtable locations). These sessions were attended by 106 navigators, certified application counselors, brokers, and other assisters.



The roundtables had three major goals: 1) to provide assisters with eligibility and enrollment training and updates; 2) to build connections between assisters; and 3) to learn more about the challenges and successes assisters were experiencing in their communities.

Approximately one month before the first roundtable, CAHC distributed an interest survey to potential roundtable attendees. The results of this survey helped identify the topics each roundtable would cover (see [Appendix 3](#) for a sample interest survey).

CAHC collaborated with partner organizations to get the word out about these roundtables to assisters across the state. The WMCA navigator consortium and MPCA both shared invitations to their assisters and encouraged their attendance. Enroll207 also sent out an invitation to its contact list, which included many brokers. In addition to sending email announcements and invitations about the event, CAHC reached out to key assisters in each region of the state to inform them about the roundtables, and encouraged them to attend (see [Appendix 4](#) for sample invitation).

The agenda for each roundtable included brief content updates on the Marketplace, as well as opportunities for assisters to troubleshoot the issues they were experiencing in the field. Participants also engaged in a roundtable discussion on best practices for outreach. Each session concluded with a panel discussion with representatives from the three companies selling plans on Maine's Marketplace. Assisters were also provided with a packet of helpful materials and resources (see [Appendix 5](#) for sample list of handouts).

Since building connections with other assisters was another important goal of these

roundtables, each session also included opportunities to network over breakfast, lunch, or breaks (see [Appendix 6](#) for sample agenda).

LESSONS LEARNED

Common Challenges

Assisters in Maine shared similar experiences during the initial open enrollment period that posed challenges for their work. Discussions at roundtables helped identify these shared experiences, which included:

- **“Glitches” on Healthcare.gov, misinformation, and confusion.** The top challenges reported by assisters were related to system failures and glitches in the Healthcare.gov system. Although website functions improved after the first two months of open enrollment, problems with identity verification, eligibility determinations, and other errors persisted throughout open enrollment. Assisters expressed frustration about these ongoing issues, which at times prevented the successful enrollment of the consumers they assisted. Assisters also expressed frustration with communication from HHS about glitches and frequently changing processes to “work around” the glitches. Some stated that they did not receive updates about these changes.



I would say the biggest challenge I found, was the misinformation from different sources. You could call the call center and ask the same question three times and get three answers. And you can't just pick the answer you liked best, it just doesn't work that way.

– A Certified Application Counselor at [Harrington Family Health Center](#)

- **Confusion about complicated eligibility rules.** When open enrollment began many assisters had only been on the job for a short time, and some were hired after open enrollment began. There was significant “on the job” learning, and assisters wanted somewhere to turn for answers to frequent questions, such as:
 - Does divorce qualify someone for a special enrollment period?⁴
 - How do I determine whether a job-based plan is considered affordable?⁵
 - Can someone who has a COBRA plan get financial help on the Marketplace?⁶

⁴ Losing minimum essential coverage due to a divorce is a qualifying event, but divorce itself is not.

⁵ A plan is considered affordable if the employee’s share of the annual premium for self-only coverage is less than 9.5% of the household’s income. The cost of dependent coverage is not included in this calculation.

⁶ During open enrollment, consumers can drop their COBRA coverage and sign up for a Marketplace plan. Outside of open enrollment, consumers can get a special enrollment period if their COBRA coverage ends. However,

- If a job-based plan is affordable for the employee but not for their dependents, can the family get financial help on the Marketplace?⁷
- Does _____ count as income?⁸

Although CMS provided assisters with a weekly newsletter and webinar for technical updates and support, some assisters were not aware of these resources, while others reported that they were still left with unanswered questions. Many assisters also shared experiences with Marketplace call center representatives, who often had inaccurate information about eligibility, such as what income should be reported. Assisters reported feeling frustrated and, at times, overwhelmed. These feelings were compounded by confusion and uncertainty about whether the information assisters had was accurate and up-to-date, given frequent changes in rules, application deadlines, and the application process as Healthcare.gov was fixed.

- **Feeling disconnected from other assisters.** Assisters who were not part of a coordinated consortium or assister group reported feeling isolated and disconnected. Most notably, assisters who were the only staff members providing application assistance at their organization often felt less informed and less supported. This is the case at many hospitals and other health organizations, which have been designated as certified application counselor organizations, but may have only one staff person trained as a certified application counselor. Individuals who only provided enrollment assistance part time, especially those who only did this work infrequently, also shared that they felt ill-equipped to deal with complicated eligibility issues. Brokers and agents, who are not part of the weekly assister calls and emails provided by CMS, also reported feeling isolated and uninformed about the latest updates in Healthcare.gov functions and other changes.

voluntarily dropping COBRA coverage outside of open enrollment does not qualify consumers for a special enrollment period. On May 2, 2014, CMS issued a bulletin describing a special enrollment period for COBRA qualified beneficiaries that ends on July 1, 2014.

⁷ Unfortunately, the cost of family coverage is not included when calculating whether an employer-based plan is affordable. If family members have access to this coverage – that is, if they are eligible to be included in this plan – and it is considered affordable for the employee, they will not qualify for financial help on the Marketplace. This is sometimes referred to as the “family glitch” or “family conundrum.” Depending on the cost of the coverage, they may qualify for an affordability exemption.

⁸ Eligibility for financial help on the Marketplace is based on Modified Adjusted Gross Income, or MAGI. This includes sources of income that are included in Adjusted Gross Income (line 37 on a Form 1040), plus non-taxable Social Security benefits, tax-exempt interest, and foreign earned income and housing expenses. A useful reference from the UC Berkeley Labor Center which was provided at the roundtables may be found here:

http://laborcenter.berkeley.edu/healthcare/MAGI_summary13.pdf

Assisters felt responsible for giving people in their community the right information to help them get coverage; the burden of providing this assistance with little support led to a great deal of stress for some assisters. A number of assisters indicated that this stress has had an impact on their lives, and in some cases keeps them awake at night.

- **Connections between Marketplace and Maine’s Medicaid program.** The application and enrollment on Healthcare.gov was intended to provide consumers with a seamless experience, no matter what they qualified for. Unfortunately, this proved not to be the case for people who were assessed as eligible for MaineCare, Maine’s Medicaid program. Healthcare.gov was unable to transfer income and other data to the Maine Department of Health and Human Services, leaving thousands of Mainers in limbo. Some consumers were incorrectly assessed eligible for Medicaid by Healthcare.gov, an error which often took weeks or months to correct. Assisters quickly learned that they needed to understand MaineCare eligibility, a topic that was not covered in the required federal training for assisters. Fortunately, CAHC has honed its MaineCare expertise over the past 26 years, and regularly provides trainings and workshops on this topic. During each roundtable session, CAHC provided participants with information and materials on MaineCare, including quick reference charts that helped assisters identify which program an individual or family qualifies for.
- **Challenges working with people in or near the “coverage gap.”** Maine has not accepted federal funds to provide low-income Mainers with the opportunity to enroll in Medicaid. This means that thousands of Mainers with incomes below the federal poverty level (\$19,530 a year for a family of three) are left without affordable coverage options, because they are ineligible for financial help with the cost of health insurance in the marketplace.⁹ Many assisters were uncertain about the best way to help these individuals and requested additional resources and support.

These roundtables provided CAHC an opportunity to give assisters guidance and resources that would help them talk with people in this situation. For example, assisters were provided with up-to-date flyers prepared by CAHC about hospital free care, sliding scale clinics, prescription assistance programs, and other safety net programs in communities throughout Maine that can provide care to people in the coverage gap. They were also trained on how to properly screen people to

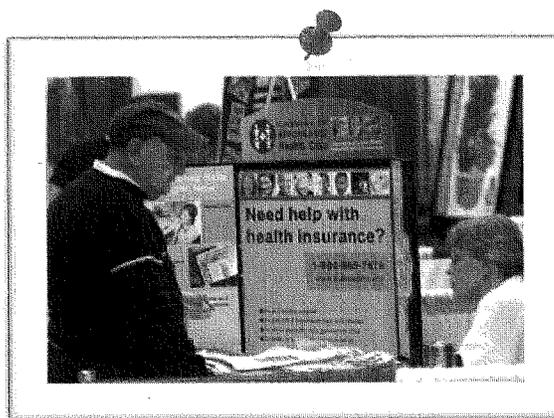
⁹ Advanced premium tax credits for Marketplace plans are available to those with incomes between 100% - 400% of federal poverty (between \$11,490 and \$45,960 a year for individuals). The ACA gave states the option of expanding their Medicaid program so that people with low incomes would get covered that way. Without this expansion, those with incomes below the federal poverty line find themselves in a “coverage gap.”

ensure they were projecting their income accurately. For example, many people who appear to be in the coverage gap based on their wages may assume that other kinds of income, such as social security or unemployment, does not “count,” and so will not mention it when they meet with an assister.

Emerging Best Practices for Outreach

With one round of open enrollment behind them, assisters now have experience with different strategies for finding uninsured consumers, educating them about their new health insurance options, and encouraging them to complete an application. Each roundtable included a discussion about the effectiveness of these different outreach strategies. Assisters reported success with distributing materials and providing informational presentations in a variety of settings, including:

- Churches
- Targeted mailings to specific businesses or groups
- Adult education programs
- Career centers
- Food pantries
- Hair salons
- Professional associations
- Hobby-specific interest groups
- Public libraries
- Public schools
- Hospitals and other health care facilities
- Small businesses
- Local media
- Signs/banners in high traffic areas
- Social media



Assisters reported the greatest success with the following outreach strategies:

- **Word of mouth.** Many assisters found that word of mouth was their most powerful tool in educating people about their new coverage options. This was particularly true in rural areas of the state, where assisters noted that people were less likely to show up at public presentations or forums. However, once people heard that a family member, neighbor, coworker or friend had a successful enrollment experience, they would seek out assisters to learn about their own options. One assister said, “You

need to start conversations with people, wherever you are, and bring stuff with you everywhere.” Assisters reported keeping brochures, applications and other informational materials in their car or purse at all times.

Many connections were forged through informal conversations and existing relationships. For example, an assister in a rural Maine county recounted how she had helped her hairdresser enroll in Marketplace coverage. That hairdresser then helped her to set up an informational session for hairdressers and stylists. Every salon in the area closed for an hour so that their workers could attend. This led to many more individual enrollment assistance sessions.

Once assisters realized how successful word of mouth could be, they began finding ways to encourage this spread of information. An assister with the Harrington Family Health Center shared, “I asked every new enrollee to refer at least 5 friends or family members they knew could use coverage.” Assisters began handing out business cards with other enrollment materials after an in-person assistance session, asking consumers to speak to their friends and family about their experience enrolling and encourage them to set up their own appointment. In some cases, assisters would ask consumers they assisted for a chance to speak with any groups or associations they were part of, and thus gain access to a whole new group of people.



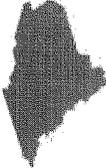
Our best “outreach” came from people who’d used our services and then wanted to spread the word. Amid all the new health coverage options and the rapid pace of change, people were relieved to find a reliable, professional, and friendly source of assistance – and they were also glad to tell their friends about it.

– A Certified Application Counselor at the Portland Community Health Center



For me the best form of outreach was word of mouth. I helped a family enroll in coverage and they were very excited to be able to have a plan that was finally affordable... This couple then told all their friends and as a result many more people in that community were enrolled. I had this happen in several instances – people excited about coverage and sharing how affordable it really was to be covered made a lot of difference.

– A Navigator at York County Community Action



When a client has a positive experience, then it is a great way to spread the word. Even the ones that were disappointed that could not receive help, it’s important to give them options too. Very difficult for some to ask for help

– A Certified Application Counselor at St Croix Regional Health Center

- **Using trusted leaders to gain access to communities.** While some people clamored for Marketplace coverage and readily reached out to assisters for help, other groups were more hesitant. They were distrustful or fearful about “Obamacare” based on what they had heard on the news, or they assumed the help available through the Marketplace would go away with the next election or congressional vote. Still others were simply unaware of the Marketplace or what they might be eligible for.

Going through trusted leaders to gain access to these groups proved crucial. For example, navigators in Downeast Maine initially experienced resistance when they reached out to Maine’s lobstering and fishing communities. However, once an assister was able to successfully enroll one member of the lobstering community, word spread, and they began helping many others in this community based on his recommendation. As one assister shared, “it just takes one person.” Assister groups working with immigrant and refugee communities relied on this strategy as well, using community health outreach workers to spread the word about new coverage options within their own communities.

- **Reach people where they are.** Although many had success with public presentations and forums in community settings, particularly in more urban or densely populated parts of the state, other assisters found that they had the greatest success when they found ways to connect with people where they live, learn, and play. Some assisters staffed informational tables in high traffic areas, such as corner stores or community college dining halls. Others held “open hours” at libraries or other community settings for those needing enrollment help.

Assisters regularly had to conduct outreach or enrollment assistance on nights and weekends in order to reach consumers at times most convenient to them. In some communities, this meant providing enrollment help in some unusual settings. For example, assisters in rural communities were often challenged to find public spaces that were available outside of normal business hours and provided internet access. One assister held an enrollment session at the local McDonald’s, which was the only available space in their community open after 6 pm with internet access.

Young adults proved a particularly difficult group to reach, requiring more out-of-the-box thinking on behalf of assisters. Some assisters reported success attending social networking events and happy hours attended by young adults to provide information and materials on the Marketplace, using scavenger hunts and other activities to engage attendees. Others relied heavily on social media, sharing the stories of those they had helped enroll on Facebook.

- **Educating people about the penalty.** Assisters quickly learned that if they were going to educate people about their new coverage options, they had to educate people about the penalty for those who go without insurance as well. Many consumers mistakenly believed that the most they would pay for being uninsured in 2014 is \$95, despite the fact that many families will end up paying 1% of their income, which may be a much higher amount. Educating people about how much they would pay in penalty based on their own income, as well as how much a Marketplace plan would cost, often helped consumers begin to consider their options more seriously. As a navigator with the Maine Lobsterman’s Association shared, “I tell people, you can give that money away – or you can put it to work for you.”
- **Coordinating and collaborating with other assisters and community resources.** Many of the assisters who reported the most success in enrolling people in their communities had strong ties to other assisters in their area. These assisters would call one another when they had a question about a complicated eligibility issue, share resources and strategies, and invite one another to different outreach events. Some assisters reported that they conducted enrollment appointments at one another’s offices, or provided coverage for one another when their appointments booked up. Doing so kept them from being overwhelmed during what was often a very hectic open enrollment period, and allowed assisters to provide the best enrollment help possible.



Our most successful outreach events were collaborations with partners like CAHC, community health centers, hospitals and libraries. As a state, so many groups worked together during open enrollment and that’s how we were able to really get the word out.

– A Navigator with the Western Maine Community Action Navigator Consortium



My fellow CACs here in Washington County are a HUGE source of help, encouragement and even though we are in 5 different offices, we really are one team.

– A Certified Application Counselor at Harrington Family Health Center

The Value of a Supportive Network

Discussions with Maine’s assisters at these roundtables helped highlight some emerging best practices in outreach and enrollment. While further study of these outreach strategies will be needed to identify which methods are most effective and

yield the most enrollments, these discussions shed light on some of the most promising strategies employed during the first open enrollment period in Maine.

The most important lesson, however, is the value of supporting and connecting assisters. Providing education, outreach, and enrollment assistance is a challenging task which requires in-depth knowledge of a complicated public program. During this initial open enrollment period, assisters were also challenged by the glitches on Healthcare.gov, and by changes in rules and Marketplace application deadlines.

The support of a network of other assisters allows people to do this work successfully. Assisters drove home this lesson repeatedly during these roundtables. Being part of a network of assisters helps navigators, certified application counselors, and brokers stay connected to the latest changes and updates from the Marketplace, and provide people in their community with the best enrollment assistance possible.

Establishing a state-wide network of assisters yielded other benefits, too. A strong, local network facilitates the sharing of important updates, new resources, and other vital information. This network can also help consumer advocates identify emerging trends and issues more quickly, thus serving a sentinel function.

Such local networks and sources of support are crucial to the continued success of Marketplace enrollment in Maine. While many assisters who attended the regional roundtables organized by CAHC stated they were familiar with national resources such as [In the Loop](#), a project of [Community Catalyst](#) and the [National Health Law Program](#), the [Families USA](#) Enrollment Assister Resource Center, or with the weekly assister emails or webinars provided by CMS, these resources lacked the local support that they needed. Many assisters found they needed to understand eligibility for Maine's Medicaid program, MaineCare, in order to guide families to the correct coverage option. They also needed information on local safety net programs for consumers in the "coverage gap."

To help support the development of a statewide network of assisters, CAHC launched a listserv for Maine's assisters following these roundtables, giving assisters a way to stay connected. In the last, hectic weeks of open enrollment, assisters were able to use this listserv to coordinate with others in their region about their availability, helping ensure that all consumers who tried to get enrollment assistance got help.

When CMS announced the availability of a special enrollment period for victims of domestic violence, CAHC was able to quickly update Maine's assister community through this listserv. After open enrollment closed on March 31, CAHC used this listserv to distribute important information on talking with consumers outside of open enrollment,

including details about special enrollment periods.

CAHC has also used the listserv to track emerging trends. For example, when CAHC began to hear reports on its Consumer Assistance HelpLine about consumers who had signed up for coverage on healthcare.gov lookalike sites, we turned to the listserv to find out if other assisters had heard similar stories. CAHC was able to compile these stories and share them with the Maine Bureau of Insurance.

In addition to this assister listserv, CAHC also began promoting its Consumer Assistance HelpLine as a resource for assisters who don't have a network of fellow assisters in their organization or community. Many assisters began using the HelpLine when they were in enrollment appointments to troubleshoot application and eligibility issues.

Having a state-based resource center proved to be a critical tool for assisters. As a representative for the WMCA navigator consortium stated, "Almost all of our navigators used the CAHC Helpline as a resource. It was a place to turn for help with especially complicated situations and to find options for consumers who were falling into 'gaps in coverage.'"



 *I often sent people to the hotline when they were even more completely stuck than I could help with – I still send people to the hotline for the same reason. It's been nice to have you all as a resource with this as at times it seemed like everything was changing quickly – you guys made sure the info about changes was spread efficiently and quickly.*

–A Navigator at [York County Community Action Corporation](#)

 *Our health center often struggled to meet the huge demand for help before monthly enrollment deadlines, and the CAHC HelpLine was an especially crucial resource to which to refer consumers during those "crunch times".*
–A Certified Application Counselor at the [Portland Community Health Center](#)

 *The Consumers for Affordable Health Care HelpLine was extremely helpful with questions about Medicaid eligibility and for resources for the families that fell into the "gap." CAHC was also there to support navigators/CACs around the state with enrollments during high demand.*
–A Navigator at the [Maine Lobsterman's Association](#)

CONCLUSION

Regional roundtables and other in-person meetings at the community level are a valuable tool in ACA outreach and enrollment, providing an opportunity for assisters to connect, gain vital updates and resources, and share trends and ongoing issues. These roundtables provide a way to begin building a strong regional network of assisters, thus providing the ongoing support that assisters need in order to be successful in their work.

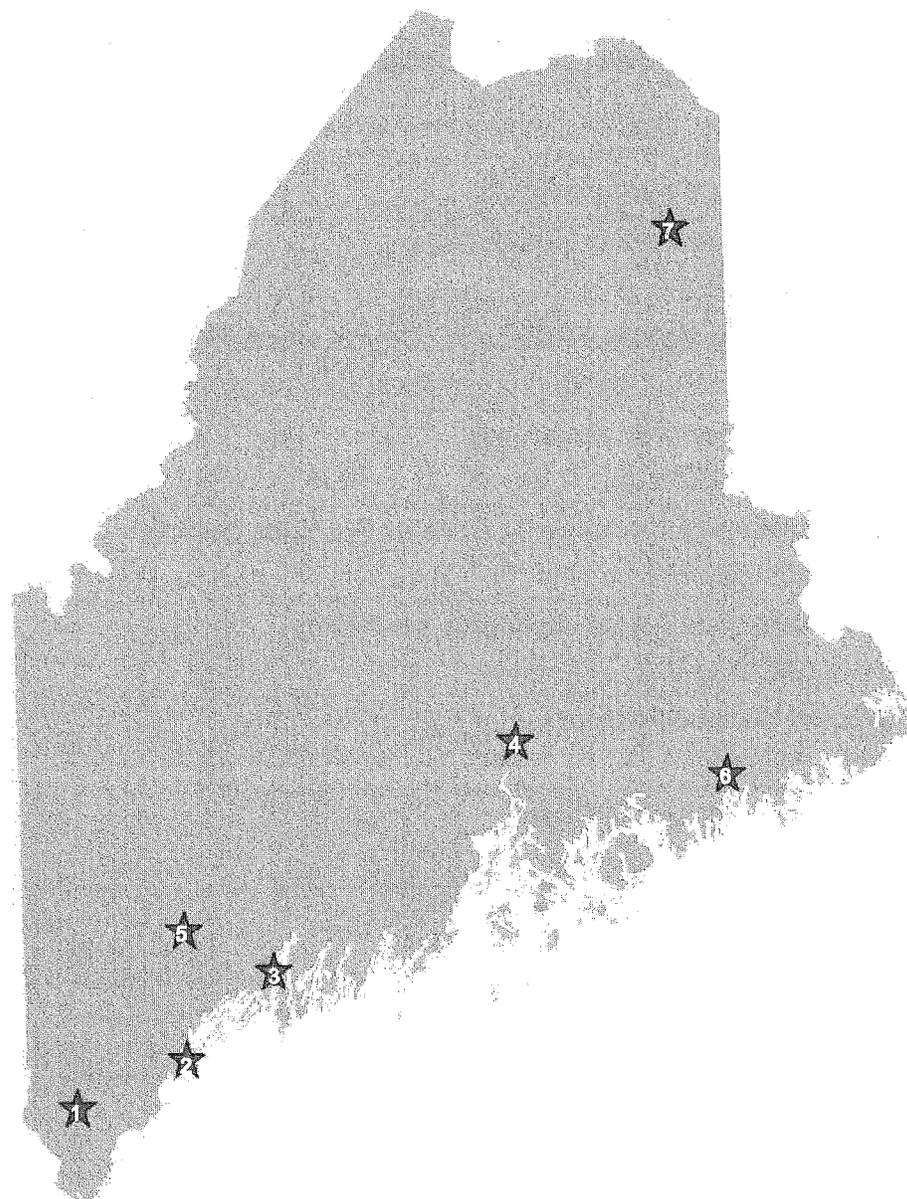
These roundtables also highlighted the value of state consumer assistance programs for successful outreach and enrollment efforts, and the need for greater funding to provide support and resources to assisters. CAHC's Consumer Assistance Program proved to be an invaluable source of local back-up and support for assisters, and provided expertise on Maine's Medicaid program, as well as other state and regional programs, that was not available through national resources and partners. Without funding provided by the Maine Health Access Foundation, this support may not have been possible. Future funding for navigators, CACs, and other assisters should take the importance of regional support and assistance into consideration in order to maximize the number of people who are successfully enrolled into coverage.



Appendix 1 – 2014 Maine Health Access Foundation Grantees

Health Reform Outreach, Education and Enrollment Awards	
Community Concepts, Inc. http://www.community-concepts.org/	(207) 739-6535 Grant: \$120,000
Consumers for Affordable Health Care http://mainecahc.org/	(207) 622-7083 Grant: \$250,000
Division of Public Health, HHS Dept., City of Portland http://www.maine.gov/dhhs/oma/MulticulturalResource/health.html	(207) 874-8773 Grant: \$119,998
Hand in Hand / Mano en Mano, Inc. http://www.manomaine.org/	(207) 598-8926 Grant: \$30,000
Healthy Community Coalition of Greater Franklin County http://www.fchn.org/hcc	(207) 779-2750 Grant: \$120,000
Maine Association of Area Agencies on Aging http://www.maine4a.org/	(207) 592-9972 Grant: \$120,000
Maine Equal Justice Partners http://www.mejp.org/	(207) 626 7058 Grant: \$61,792
Maine Medical Education Trust	(207) 662-3374 Grant: \$85,790
Maine People's Resource Center http://www.mprc.me/	(207) 797-9207 Grant: \$120,000
Maine Primary Care Association http://mepca.org/	(207) 621-0677 Grant: \$25,000
MaineHealth/CarePartners http://www.mainehealth.org/mh_body.cfm?id=3441	(207) 662-7960 Grant: \$119,732
Planned Parenthood of Northern New England http://www.plannedparenthood.org/ppnne/	(802) 448-9736 Grant: \$120,000
Preble Street http://www.preblestreet.org/	(207) 775-0026 Grant: \$120,000
Somali Culture & Development Association http://www.mesom.org/	(207) 233-6014 Grant: \$120,000
Western Maine Community Action http://wmca.org/	(207) 860-4461 Grant: \$25,000

Appendix 2 – Regional Roundtable Locations



1. **Southern Maine** – York County (Sanford)
2. **Greater Portland** – Cumberland County (South Portland)
3. **Midcoast Maine** – Sagadahoc County (Bath)
4. **Penobscot County** (Bangor)
5. **Central Maine** – Androscoggin County (Lewiston)
6. **Downeast Maine** – Washington-Hancock Counties (Harrington)
7. **Northern Maine** – Aroostook County (Presque Isle)

Appendix 3 – Sample Interest Survey

Thank you for your interest in Consumers for Affordable Health Care's Regional Roundtables for navigators, certified application counselors, and others assisting with Marketplace enrollment.

Please answer the questions in this survey to help us understand the topics you would like to discuss and learn about during these roundtables. We will use your responses to plan these sessions.

1. What is your role?

- | | |
|--|---|
| <input type="checkbox"/> Navigator | <input type="checkbox"/> Broker |
| <input type="checkbox"/> Certified application counselor | <input type="checkbox"/> Other (please specify) |

2. How likely is it that you will attend the regional roundtable in your area?

- | | |
|---|---|
| <input type="checkbox"/> I will definitely attend | <input type="checkbox"/> I will probably not attend |
| <input type="checkbox"/> I will probably attend | <input type="checkbox"/> I will definitely not attend |
| <input type="checkbox"/> I am not sure if I will attend | |

3. What county or counties do you serve? You can mark more than one.

- | | | |
|---------------------------------------|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Statewide | <input type="checkbox"/> Kennebec | <input type="checkbox"/> Sagadahoc |
| <input type="checkbox"/> Androscoggin | <input type="checkbox"/> Knox | <input type="checkbox"/> Somerset |
| <input type="checkbox"/> Aroostook | <input type="checkbox"/> Lincoln | <input type="checkbox"/> Waldo |
| <input type="checkbox"/> Cumberland | <input type="checkbox"/> Oxford | <input type="checkbox"/> Washington |
| <input type="checkbox"/> Franklin | <input type="checkbox"/> Penobscot | <input type="checkbox"/> York |
| <input type="checkbox"/> Hancock | <input type="checkbox"/> Piscataquis | |

4. How connected do you feel to navigators, CACs, brokers, and others who are doing outreach and enrollment in your community?

- | | |
|--|--|
| <input type="checkbox"/> Very connected | <input type="checkbox"/> Somewhat disconnected |
| <input type="checkbox"/> Somewhat connected | <input type="checkbox"/> Very disconnected |
| <input type="checkbox"/> Neither connected or disconnected | |

5. What have been your biggest challenges in helping people enroll so far? Please be as specific and detailed as possible.

6. What resources would help you to overcome this challenge? Please be specific.

7. What topics would you most like to learn about or discuss at this event?

- | | |
|--|--|
| <input type="checkbox"/> Helping people with Marketplace appeals | <input type="checkbox"/> MaineCare |
| <input type="checkbox"/> Helping people apply for exemptions | <input type="checkbox"/> Effective outreach strategies |
| <input type="checkbox"/> Qualified Health Plans (QHPs) on the Marketplace | <input type="checkbox"/> Safety net programs for people who can't get coverage |
| <input type="checkbox"/> Troubleshooting common application and eligibility issues | <input type="checkbox"/> Helping people understand health insurance basics |
| | <input type="checkbox"/> Other (please specify) |

8. Is there anything else you would like us to know or consider as we plan this event?

Appendix 4 – Sample Invitation to Regional Roundtable

Are you a navigator, certified application counselor, or broker who is helping people in your community with Marketplace enrollment? Consumers for Affordable Health Care is convening Regional Roundtables for everyone assisting with Marketplace enrollment in seven regions throughout the State: Sagadahoc, Penobscot, Cumberland, Washington/Hancock, Androscoggin, York, and Aroostook counties.

Registration for all Roundtables is now available (see below).

Come to your local roundtable and you will:

- Hear Marketplace updates and enrollment best-practices,
- Troubleshoot problems, and
- Network with other assisters in the area.

Who should attend:

- Navigators
- Certified Application Counselors
- Insurance agents and brokers

Want to learn more about a specific topic? Fill out our roundtable interest survey.

When and where:

Penobscot Regional Roundtable

Penquis
262 Harlow Street, Bangor
Piscataquis Room
9 am- 12:30 pm Tuesday, January 21st
(Snow date: Tuesday, January 28th)
Register now! Preregistration is required.

Androscoggin Regional Roundtable

St. Mary's Medical Center
99 Campus Ave, Lewiston
Potvin Room
9 am- 1 pm Tuesday, February 18th
(Snow date: Thursday, February 20th)
Register now! Preregistration is required.

Cumberland Regional Roundtable

The Opportunity Alliance
50 Lydia Lane, South Portland
Timbers Room
9 am- 12:30 pm Monday, February 3rd
(Snow date: Wednesday, February 5th)
Register now! Preregistration is required.

Washington - Hancock Regional Roundtable

Harrington Family Health Center
50 E Main St, Harrington
Conference Room
9 am- 1 pm Wednesday, February 26th
(Snow date: Wednesday, March 5th)
Register now! Preregistration is required.

Aroostook Regional Roundtable

Aroostook County Action Program
771 E Main St, Presque Isle
Conference Room
9 am- 1 pm Wednesday, March 12th
(Snow date: Thursday, March 13th)
Register now! Preregistration is required.

York Regional Roundtable

Sanford City Hall Annex Building
917 Main St.
Council Chambers
9 am- 1 pm Tuesday, March 18th
(Snow date: Thursday, March 20th)
Register now! Preregistration is required.

Appendix 5 – List of Handouts at Regional Roundtables

1. **Attendee List**, including contact information
2. **CAHC Flyers**
 - a. Hospital free care
 - b. Hospital sliding scale care
 - c. Free clinics
 - d. Sliding scale clinics
 - e. Dental clinics
 - f. MaineCare Spend down
 - g. Help Paying for Health Insurance: What Do You Qualify for?
3. **Modified Adjusted Gross Income under the Affordable Care Act**¹⁰, a flyer created by the UC Berkeley Labor Center
4. **Tips for Immigrant/Refugee Applications in the Health Insurance Marketplace**, a flyer created by Libby Cummings at Portland Community Health Center and Robyn Merrill at Maine Equal Justice Partners
5. **Resource List**, including key websites, toolkits, and consumer materials available online
6. **Marketplace Exemption Applications**
 - a. Hardship exemption
 - b. Affordability exemption
7. **Marketplace Appeal Application**
8. **CMS Tip Sheets for Assisters**
 - a. Helping Consumers Who Have Attempted But Have Not Completed Enrollment: Tips for In-person Enrollment Assisters¹¹
 - b. Helping Consumers with the Application Process¹²
 - c. Helping Consumers with Casework: Tips for In-person Enrollment Assisters¹³

¹⁰ http://laborcenter.berkeley.edu/healthcare/MAGI_summary13.pdf

¹¹ <http://marketplace.cms.gov/help-us/assister-tips-template.pdf>

¹² <http://marketplace.cms.gov/help-us/helping-consumers-with-application.PDF>

¹³ <http://marketplace.cms.gov/help-us/helping-consumers-with-casework.pdf>

Appendix 6 – Sample Roundtable Agenda

Regional Roundtable for Assisters – Androscoggin County

Meeting Agenda

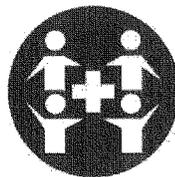
Tuesday, February 18, 2014

St Mary's Regional Medical Center

8:30AM – 9:00AM	Breakfast
9:00AM – 9:15AM	Welcome & Introductions
9:15AM – 10:15AM	Enrollment & Eligibility Updates <ul style="list-style-type: none">• Options for people who do not qualify• Troubleshooting common issues• Other updates
10:15AM – 10:35AM	BREAK
10:35AM – 11:35AM	Roundtable Discussion: Best practices and biggest challenges
11:35AM – 12:35PM	Understanding the QHPs on Maine's Marketplace: Panel discussion with Anthem, Delta Dental, and Maine Community Health Options
12:35PM – 1:00PM	Lunch and Continued Discussions

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Regional Assisters Roundtable Report



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Consumers for Affordable Health Care

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www.maine cahc.org

Community Action Health Marketplace Navigator Program Factsheet

Eight of Maine's Community Action Agencies partnered to provide a statewide network of education, outreach and enrollment assistance for the Health Insurance Marketplace during the 2013-2014 enrollment period.

Eight Participating Agencies:

Aroostook County Action Program, Kennebec Valley Community Action Program, Midcoast Maine Community Action, The Opportunity Alliance, Waldo Community Action Partners, Washington Hancock Community Action, Western Maine Community Action, York County Community Action Corp.

Key Numbers Through 3/28/2014

- Outreach events: 516
- Consumers reached: 21,520
- Enrollment appointments: 2,618
- Completed enrollments (consumer chose plan during appointment): 1,496
- Certified Navigators: 119 (70 staff and 49 volunteers)

Major Challenges

- Problems with the healthcare.gov website were by far the most significant challenge with the first enrollment period. These issues were very pronounced in the first 10-12 weeks of Open Enrollment. Since that time, the website functionality has improved dramatically and it has become rare that these issues prevent an enrollment.
- Maine's non-participation in the Medicaid expansion portion of the Affordable Care Act means that childless adults below 100% of the Federal Poverty Level are not eligible for coverage through MaineCare or for cost savings in the marketplace. This resulted in a large number of consumers who contacted navigators in an effort to obtain coverage but who were unable to access an affordable option.
- The identity verification process used by healthcare.gov relies on credit reporting agencies. As a result, the website is unable to verify the identity of consumers with no or little credit history. It can be difficult and time-consuming to enroll online when this occurs. Low-income families and immigrants are disproportionately more likely to encounter this issue.
- The enrollment process for non-citizens has been particularly challenging. In addition to the identity verification process, verification of immigration status has often been difficult. While some improvement has been made, there are still categories of immigrants who are receiving incorrect eligibility determinations.



Medicaid and Marketplace Outreach and Enrollment Options for States

BY KRISTINE GOODWIN AND LAURA TOBLER

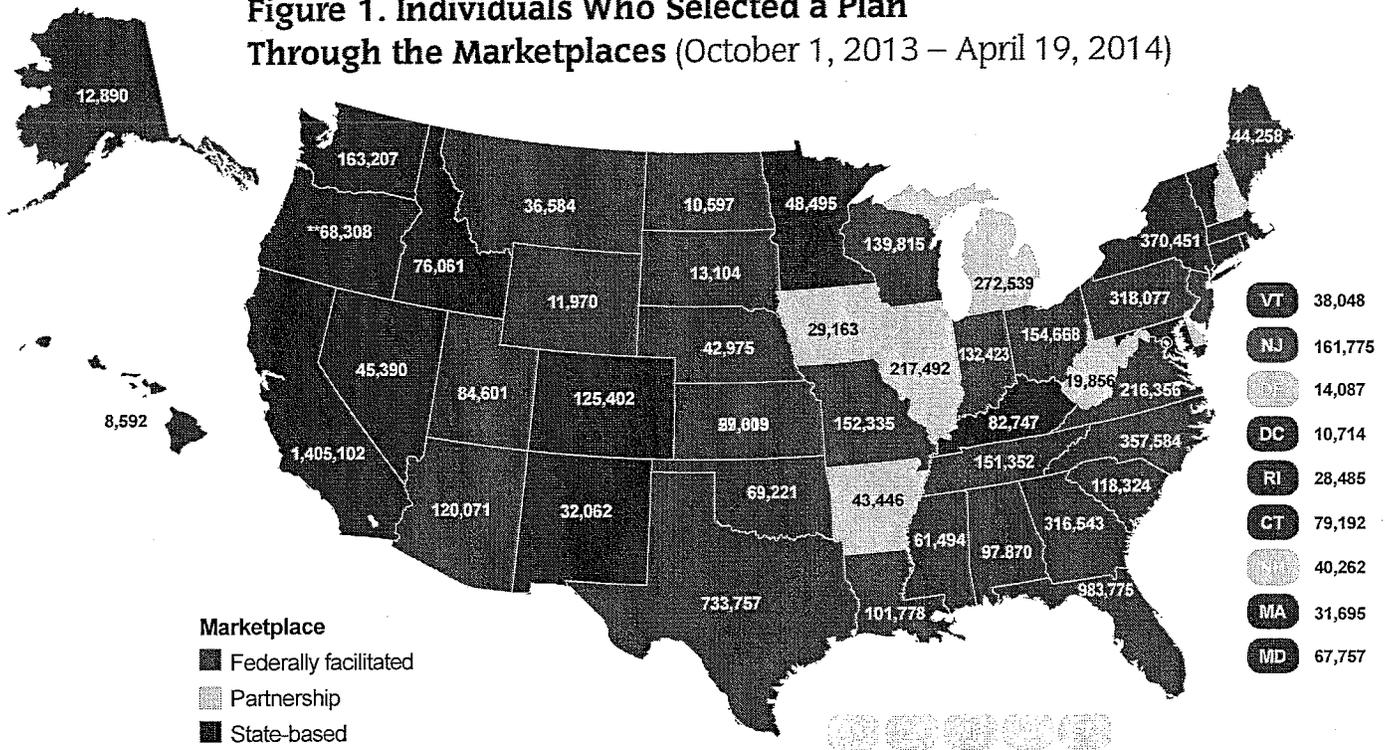
The Affordable Care Act (ACA) is expected to cover millions of newly insured Americans through Medicaid expansion and new health insurance marketplaces. During the marketplace's first open enrollment period, which began September 1, 2013 and ended March 31, 2014¹, the federal Department of Health and Human Services (HHS) estimated that 8 million Americans obtained coverage through the marketplaces. These marketplace enrollment numbers will change as people who qualified for an extension gain coverage and are added to the rolls and those that signed up for coverage but failed to provide payment are dropped. HHS also reports that an additional 4.8 million people enrolled in Medicaid from Sept 2013 to February 2014 — about 4.2 million of these enrollees live in states that opted for the Medicaid expansion. The next open enrollment period begins on November 15, 2014.

The Congressional Budget Office (CBO) estimated that six mil-

lion Americans would enroll in private health insurance plans through the marketplaces and eight million people would enroll in Medicaid and the Children's Health Insurance Program (CHIP) in 2014.² By 2017, the CBO predicts that 24 million people will enroll in private health insurance plans through the marketplaces and another 12 million in Medicaid and CHIP.³ An individual mandate with penalties for not obtaining insurance and new coverage options are intended to extend coverage to unprecedented numbers of Americans.

Yet, we know from prior Medicaid expansions and early experiences with the federal law that reaching and enrolling newly eligible individuals can be a challenge. Attracting young, healthy people, improving consumer understanding about new rules and coverage options, and bolstering enrollment when there are relatively small penalties for non-participation are just some of the factors that hamper efforts to enroll people in coverage. To address these challenges, the federal government and many states are adopting a wide assortment of strategies to facilitate enroll-

Figure 1. Individuals Who Selected a Plan Through the Marketplaces (October 1, 2013 – April 19, 2014)



**Oregon is considering moving to the federally facilitated marketplace for the next open enrollment period which begins November 15, 2014.

Source: U.S. Department of Health and Human Services

ment and minimize barriers that have hindered previous coverage efforts.

This brief discusses outreach and enrollment requirements under the ACA and highlights common challenges, and promising outreach and enrollment strategies and options. It is intended to help legislators identify potential roles and opportunities to ensure that federal and state investments are helping states achieve objectives.

Things to Know About Enrollment in Your State:

- What are my state's enrollment numbers (see Figure 1 for enrollment numbers as of April 19, 2014)?
- Enrollment in private plans vs. Medicaid?
- How do these numbers match up with projections?
- Is my state on target for enrolling young adults (ages 18-34)?
- Where are people enrolling in my state?
- What are my state's outreach strategies?
- How are these strategies being evaluated?
- Did my state upgrade its Medicaid enrollment system?
- If so, how is it working?

OVERVIEW: OUTREACH AND ENROLLMENT REQUIREMENTS AND RESOURCES

Many Americans can benefit from information about the law's coverage requirements and the process for obtaining coverage. The ACA does not include specific requirements for marketing and outreach activities for health insurance marketplaces,⁴ and, as a result, states have a great deal of flexibility to develop approaches that meet their specific needs. The law requires states that opt to expand Medicaid to conduct outreach to low-income and vulnerable populations and to ensure that materials developed by the state marketplace and Medicaid agency are culturally and linguistically appropriate.

The federal law contains several provisions to support individuals through the application and enrollment process. Namely, marketplaces are expected to help consumers navigate the enrollment process by offering:

- **Integrated eligibility and enrollment systems.** The ACA required states to create a single, streamlined process that enables consumers to apply for, receive a determination and enroll in health coverage for which they are eligible. The law requires one single application for Medicaid and the health insurance marketplace, and an interface between the systems, so people can apply for either and enroll in the right coverage.
- **Multiple avenues to apply for coverage.** The ACA requires marketplaces to offer multiple methods and locations for completing applications, including online, by mail, over

the phone or in-person at a variety of locations, which may include health centers, community-based organizations, health care providers and hospitals, public programs and retail storefronts.

- **Navigators, in-person assisters and certified application counselors.** To meet increased demand for application and enrollment assistance, the law called for navigators, in-person assisters and certified application counselors to provide hands-on help for individuals who might need more assistance than is available over a website. All federal and state marketplaces are required to hire navigators — workers hired and trained by states to conduct education and outreach, help consumers enroll in coverage, provide necessary referrals and other duties. In-person assisters and certified application counselors perform similar functions as navigators, but unlike navigators, assisters may be funded by states' exchange establishment grants.

Federal agencies provided grants, as well as training and technical assistance resources to support outreach and enrollment in marketplaces. The Department of Health and Human Services (HHS) has distributed federal exchange establishment grants to establish health insurance marketplaces and support the development of marketing and outreach campaigns. In July 2013, HHS awarded more than \$150 million in grants to 1,159 health centers in all 50 states to help patients gain coverage through the health insurance marketplace, Medicaid or CHIP.

All states, even those choosing not to expand Medicaid, are eligible to receive an enhanced federal match to develop new eligibility systems (90 percent match until Dec. 2015) and to operate and maintain those systems (75 percent match as long as the system meets federal standards and conditions). The Medicaid electronic eligibility systems must be able to pass accounts

between Medicaid and the marketplaces, support a single streamlined application, conduct electronic verifications, support the new method for determining income eligibility (Modified Adjusted Gross Income or MAGI) and support new renewal processes.

In addition to financial resources, the federal Centers for Medicare and Medicaid Services (CMS) maintains a clearinghouse of official marketing and outreach resources, including materials in multiple languages, step-by-step instructions, fact sheets and other resources. States and local stakeholders can use these resources to educate the public about the marketplace. Also, CMS maintains training resources and guides for navigators to help consumers through various aspects of the application and enrollment process.

STATE VARIATION IN ACA IMPLEMENTATION

Health insurance marketplaces operate in every state; state involvement in planning and conducting outreach and enrollment varies however, based on several factors and policy decisions, including state decisions about running the health insurance marketplace and expanding Medicaid.

The ACA required creation of health insurance marketplaces in states to enable consumers to compare and purchase private health plans that meet federal and state standards; allow small businesses and people with incomes between 100 percent and 400 percent of the poverty level to access subsidies; and help facilitate access to public programs such as Medicaid and CHIP. The ACA allows states to establish a state-based marketplace, default to a federally run marketplace, or, states may enter into a state-federal partnership in which each entity has responsibilities for running the marketplace. During the first open enrollment period, 16 states and the District of Columbia had state-based marketplaces, 27 states had federally run marketplaces and seven states

FOR YOUR CONSIDERATION: LEGISLATIVE ROLES AND OPPORTUNITIES

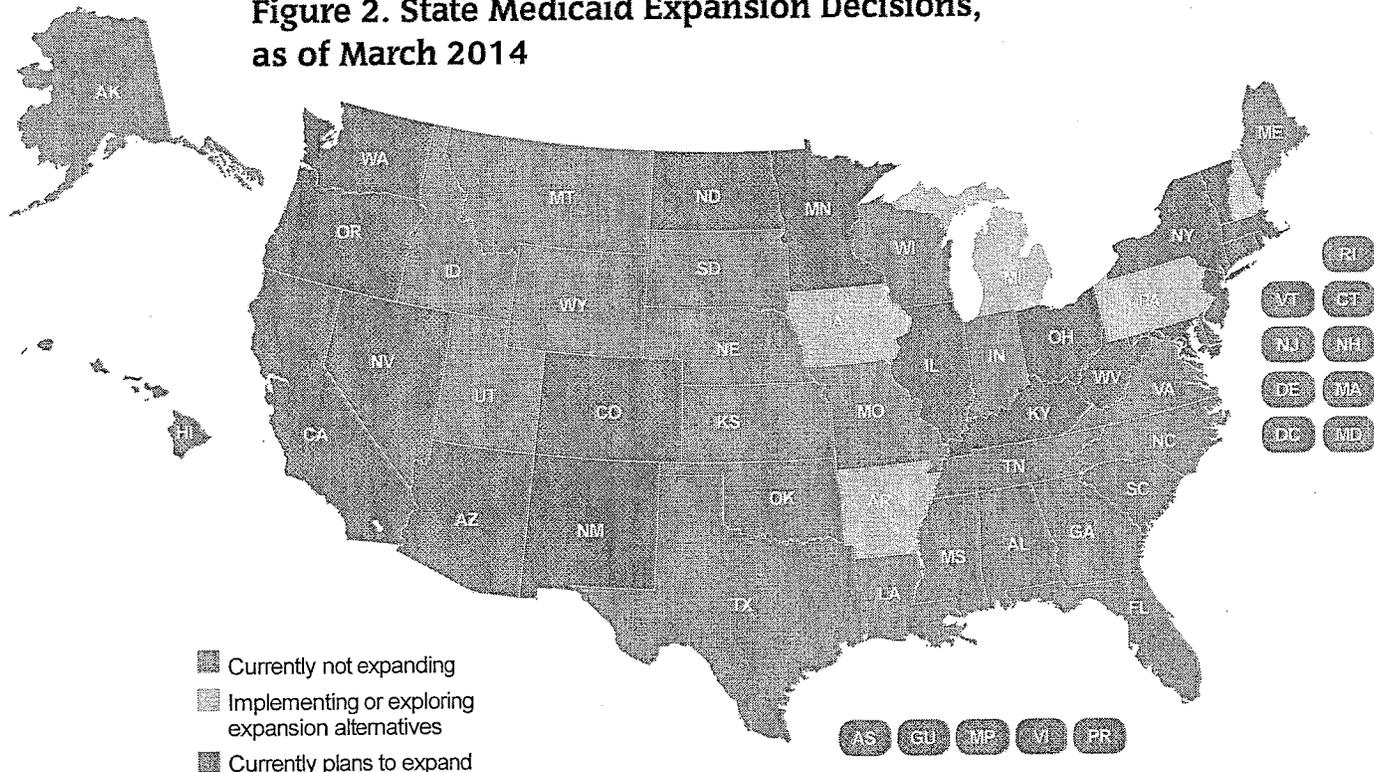
As described in this report, states are adopting a variety of strategies and policies to facilitate enrollment in coverage options. Regardless of the political climate in the state regarding implementation of the federal law, policymakers can play an important role in outreach and enrollment, especially in minimizing the risks and maximizing the benefits for your state.

- Monitor and track state investments to ensure that they support cost-effective and evidence-based outreach and enrollment strategies. (See What Works on page 6 for a list of tested strategies).
- Require data collection and reporting on marketing and outreach costs and outcomes.
- Regulate navigators and assisters, for example, by considering the adequacy of training, certification and patient privacy protections
- Ensure that stakeholders are leveraging public and private outreach and enrollment resources to eliminate unnecessary

duplication of effort and cost, and ensure a coordinated approach across sectors. Assess current funding for outreach and enrollment, including navigator programs, and identify opportunities to leverage and align resources.

- Identify opportunities to streamline the enrollment process and meet consumers where they are. In addition to simplifying procedures and ensuring smooth transitions between agencies, states can consider placing navigators or assisters in non-traditional, high-need community locations.
- Foster and build relationships and strategic partnerships. As described in this brief, outreach and enrollment assistance involves partnerships with health plans, faith-based organizations, foundations and other organizations.
- Use the role of community leader to help with outreach and enrollment in their own districts.
- Extend the principle of "No wrong door," which refers to advising and directing applicants to multiple program options including Marketplaces, Medicaid or CHIP, to additional state and local health services, such as convenient locations and other services, as allowed by ACA rules.

Figure 2. State Medicaid Expansion Decisions, as of March 2014



Source: U.S. Department of Health and Human Services

participated in a state-federal partnership. In 2014, “hybrids” in three states offer a federally run marketplace for the individual market and a state-run small business (or SHOP) marketplace.

The ACA expanded Medicaid coverage for low-income adults with incomes up to 133 percent of federal poverty guidelines; with an “income disregard provision,” the effective eligibility level is 138 percent. A 2012 Supreme Court decision, however, effectively gave states the option of expanding Medicaid or not. As of March, 2014, state actions were split, as shown in Figure 2, with 27 states and the District of Columbia opting to expand Medicaid and 23 states declining to expand Medicaid.

State decisions about marketplace oversight and Medicaid expansion have several implications for outreach and enrollment. For example, states that run their own marketplace are responsible for consumer assistance activities, including operating a web portal, call center and navigator program, while in states that deferred to the federal marketplace, HHS is responsible for these functions. States that run their own marketplace have significantly more funding for consumer assistance through the federal grants that they received to establish their marketplace than those states with federally facilitated marketplaces.

OUTREACH AND ENROLLMENT ISSUES AND CHALLENGES

As has been demonstrated at the federal level and in states that operate their own marketplace, there are myriad issues and challenges that impede efforts to inform, assist and enroll individuals in health insurance marketplaces.

- **Systems challenges and “handing-off” information between multiple systems represents an ongoing challenge for all states.** Although many of the initial problems that thwarted enrollment in the federal online marketplace in late 2013 have been addressed, work remains to ensure smooth enrollment, as well as seamless exchange of information between federal and state Medicaid programs and insurance marketplaces. With multiple agencies and databases involved in determining eligibility and other functions, the smooth and accurate exchange of information between systems is an ongoing technical challenge.
- **Low enrollment and adverse selection** — i.e., the disproportionate enrollment of sicker, higher-cost individuals, relative to enrollment by healthier, lower-cost individuals — have hampered prior Medicaid expansion initiatives⁵ and early indications suggest that it remains a challenge with the Affordable Care Act. Drawing healthy people, including young adults, to the marketplace requires ongoing marketing, outreach and enrollment assistance to get the word out and continually address enrollment barriers.
- **Consumer confusion is a persistent problem.** In a February 2014 poll, half of those surveyed said they did not understand how the law would affect them and two-thirds said they knew nothing or very little about the health insurance marketplaces.⁶ States and the federal government are addressing this through effective education, outreach and assistance efforts.

- **Reaching diverse populations.** A wide range of individuals who are more likely to be uninsured can obtain coverage through marketplaces, including low-income adults, working families, young adults, and ethnic and culturally diverse populations. Developing communication and health care workforce strategies to meet the language and other needs of this diverse population is a challenge.
- **Workforce policy issues.** States also are examining policy ramifications stemming from the regulation and oversight of navigators and assisters. For example, through their work with consumers, navigators have access to Social Security numbers and other sensitive information, and some states have expressed concerns about the potential for misuse.⁷

Special challenges in states not expanding Medicaid.

These states, although not expanding to all Americans with effective incomes up to 138 percent of the federal poverty level, will still see their Medicaid enrollment grow due to the federal marketplaces' outreach and enrollment campaign and personal incentives to obtain coverage. This increased enrollment will place greater strain on state Medicaid budgets, because the state does not receive an enhanced federal match for those who were already eligible but not enrolled. States not expanding Medicaid are also still required to ensure a seamless partnership with the marketplace. Moreover, these states may experience additional challenges related to a coverage gap for adults with incomes under the poverty level (described below).

ADDRESSING CHALLENGES: STATE OUTREACH AND ENROLLMENT ACTIONS

States are not starting from scratch with their outreach and enrollment plans. Rather, states are drawing from the lessons learned from Medicaid and CHIP expansions that preceded the ACA, as these experiences offer important lessons and best practices that can inform current state outreach and enrollment strategies.

State outreach and enrollment activities vary considerably de-

pending on a number of factors, including marketplace oversight, the state's decision regarding Medicaid expansion, political support and buy-in, and other factors. As described below, states are applying these lessons in their current outreach and enrollment work.

Design outreach campaigns that combine broad public awareness campaigns with community-based, grassroots efforts.

States that manage their own marketplace typically include a mix of broad-based informational and communication strategies to inform the public, as well as targeted messages and resources to reach specific population groups. While there is great variation within states — even among states that chose the same oversight structure — states that operate their own marketplaces have tended to develop more state-specific outreach materials and messages, while states that defer to the federal government tend to have more general outreach strategies. State-run marketplaces use a variety of tools, such as social media, partnerships with community groups, in-person outreach (through door-to-door campaigns) and retail locations, as well as websites to support campaigns and facilitate enrollment. For example, consumers can learn about and enroll in coverage in multiple settings in **Connecticut**. In addition to a call center that offers help in multiple languages, and a navigator/assister program, Access Health CT provides storefront enrollment centers in two of the highest-need cities in the state; it plans to open four additional storefronts in other locations. In the final months of the open enrollment period, these storefront locations were enrolling between 300 and 400 people per day according to Access Health CT. In **New York**, the State Department of Health hired a firm to develop a campaign with television, print, online and transit advertising.

In states with federally run marketplaces, health plans, nonprofits and other community and faith-based organizations often play a significant role in outreach and enrollment efforts.

- Recognizing the important role that faith and community leaders play in educating others about health coverage options, HHS maintains an online toolkit with links to fact

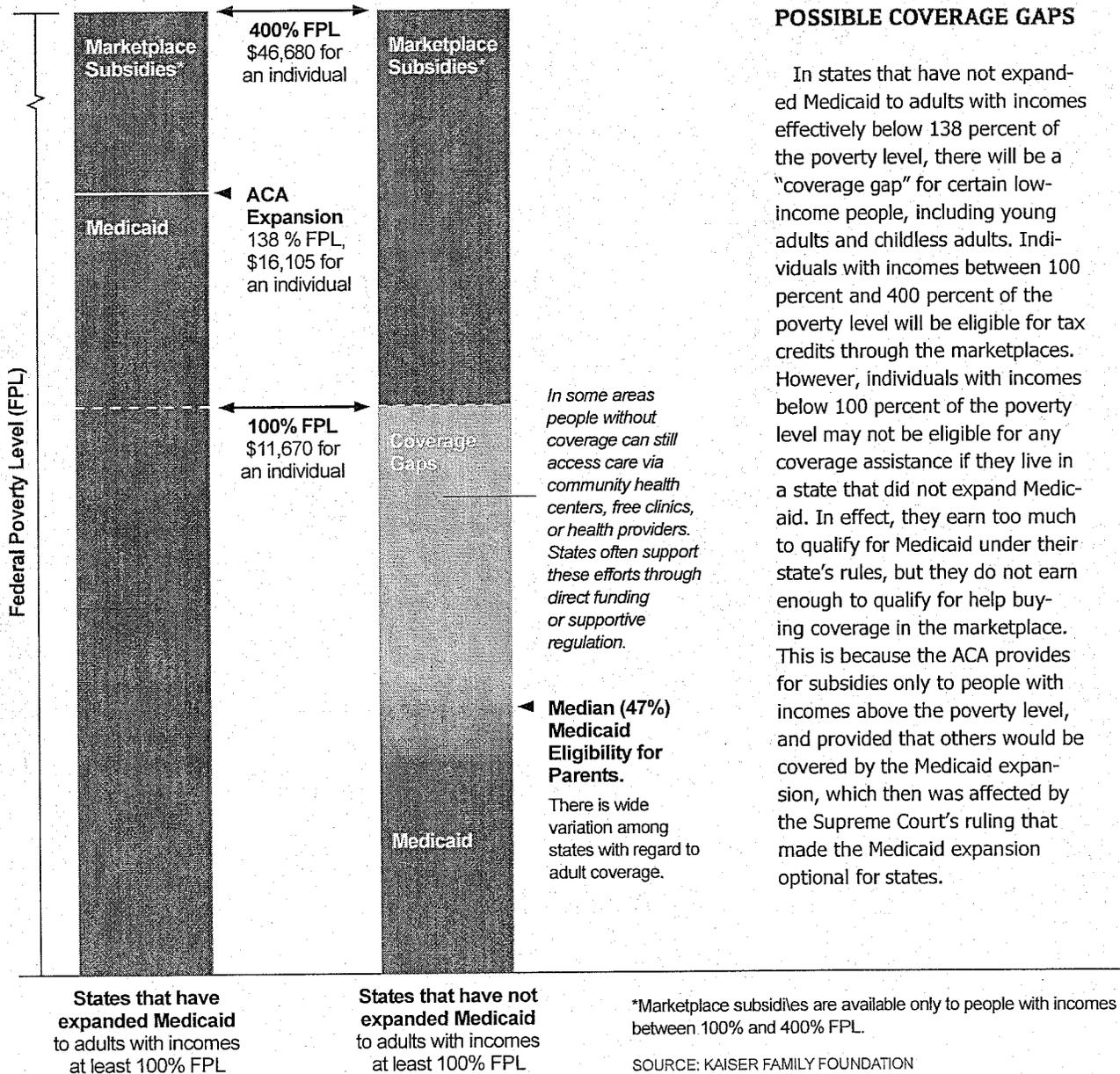
What Works

Researchers have studied Medicaid and CHIP expansions and identified several lessons that inform current outreach and enrollment initiatives.

- Marketing and public education—delivered through materials in multiple languages—raises awareness of new coverage options.
- A combination of community-based or grassroots outreach and broad marketing campaigns have proven effective at educating families about coverage, but targeted messages are needed to reach and enroll hard-to-reach individuals.
- Trusted community groups (e.g., nonprofit agencies, faith-based organizations, WIC programs, schools) connect with individuals who are traditionally hard-to-reach. Given the trusted role that most doctors have with their patients, local health care providers and community health centers are effective partners.
- In-person, one-on-one application assistance can have a significant impact on enrollment. One study in Boston found that more children received coverage if assisted by a counselor; they obtained coverage faster, and were more likely to have continuous coverage and satisfaction with the enrollment process than individuals who did not work with a counselor.
- Simplifying enrollment policies and procedures facilitates enrollment; coordinating program rules between Medicaid and CHIP and offering multiple enrollment methods contribute to increases in enrollment among Medicaid-eligible groups.

Contributing sources: "Reaching and Enrolling the Uninsured: Early Efforts to Implement the Affordable Care Act," Robert Wood Johnson Foundation and Urban Institute (October 2013); and "Key Lessons from Medicaid and CHIP for Outreach and Enrollment Under the Affordable Care Act," The Kaiser Commission on Medicaid and the Uninsured (June 2013)

Possible Coverage Gaps in 2014



sheets, talking points and other resources.

- Blue Cross Blue Shield of **North Carolina** sponsors two mobile units that travel around the state, as well as seven retail stores to promote awareness and enroll consumers in health insurance.⁹
- Blue Cross Blue Shield of **Texas** educates consumers about the federal marketplace through a website, texting campaign and partnerships with churches, clinics, non-profit and other community organizations.¹⁰

Engage partners early and continually to facilitate outreach and enrollment. Active involvement of a wide array of partners is an effective strategy for disseminating information and linking people to coverage. Most states running their own marketplaces created workgroups of diverse stakeholders — state officials, insurers, health plans, health care providers, community health centers, consumer advocates and others — to plan and conduct outreach and public education. For example, **Colorado** conducted numerous public meetings with individuals and orga-

nizations across the state to build partnerships and obtain stakeholder buy-in.

Faith-based organizations play an important role in connecting communities of faith to information about health coverage. For example, the **Maryland** Citizen's Health Initiative created a Faith Ambassadors' Program to train ambassadors to provide health insurance education in multiple languages. In **Alabama**, the Arise Citizens' Policy Project partners with congregations, gospel radio stations and others to inform the uninsured about coverage options.¹¹

Remove enrollment barriers and meet consumers where they are. States have established web portals, call centers, and developed navigator programs to help individuals enroll. Every state has a website to promote awareness and facilitate enrollment. These websites typically provide subsidy calculators, educational videos, and resources to ease the enrollment process. To meet the varying levels of assistance needed by consumers, states have created a tiered approach that involves websites with real-time "chat" options, call centers and hands-on assistance. In January 2013, 35 states had stationed assisters in hospitals, federally qualified health centers, public health offices or schools.¹²

- Connect for Health **Colorado** helps consumers compare options through a website designed to resemble popular travel websites.
- In **Mississippi**, workers assigned to reservations helped increase enrollment among American Indians.¹³
- In **Utah**, enrollment specialists in clinics assist families through each step of the application and enrollment process. An evaluation found that 74 percent of children in families that were provided application assistance were successfully enrolled compared to 26 percent of children at a comparison clinic in which families were provided an application but no direct enrollment assistance.

Develop training programs and requirements for navigators. Navigators (and counselors and assisters who perform similar duties) help consumers complete applications, compare options and select coverage. These functions are not only complex, but they also involve handling sensitive, personal information. In response, states have considered a wide range of legislation aimed at regulating and licensing navigators, defining the scope of their activities, and establishing training requirements.

In recent years, 16 states enacted laws to certify, license or regulate navigators or navigator programs.¹⁴ Other states created regulations to do the same.

Examples of navigator legislation include the following.

- **Licensure.** Six states require navigators to be licensed in the state. For example, **Arkansas** enacted SB 1189 in 2012 that requires applicants to pass an exam with standards set by the insurance commissioner, pass a criminal and regulatory background check, and pay an annual fee in order to qualify for licensure in the state.
- **Training.** States vary in their training requirements for assisters, including length and format of training, as well as requirements for re-certification and continuing education.¹⁵ **Montana** requires navigator and insurance broker and agent certification for health insurance sold in the market-

UP CLOSE: THE CHALLENGES OF ENROLLING YOUNG ADULTS

Traditionally, young adults are uninsured at almost double the rate of older Americans.¹⁶ Several provisions of the ACA—extension of dependent coverage until age 26, Medicaid expansion, premium tax credits and special lower cost "catastrophic" insurance policies—seek to bridge the gap for millions of young adults. One of the goals of outreach is to promote awareness and reduce confusion among this group. According to a March 2013 Commonwealth Fund survey of young adults, only 19 percent of people between the ages of 19 and 29 who were uninsured within the past year were familiar with the marketplaces or the expansion of Medicaid eligibility. Reaching them requires targeted outreach efforts. Because more than half of low-income young adults are already involved in other public programs, targeting outreach through these programs could reach half of uninsured young adults.¹⁷

place, and legislation defines training requirements for workers who help people sign up for coverage through the marketplace.

- **Scope of practice.** Some laws address or restrict the type of information that navigators can provide to clients. For example, four states — **Georgia, Missouri, Ohio** and **Tennessee** — have enacted laws restricting navigators from giving advice about the benefits, terms and features of a particular health plan. It's worth noting that courts found two of these laws, in Missouri and Tennessee, to be preempted by federal regulation.
- **Other requirements and limits.** Some state legislation addresses the ability of navigators to sell insurance. **Maine** allows only licensed insurance producers to sell, solicit or negotiate health insurance or enroll an individual or employer in coverage through the marketplace. Similarly, **New York** defines navigators as individuals who, among other things, do not sell insurance.

In addition to enacting legislation, some state marketplaces have engaged insurance agents and brokers in the development of marketplace policies. **Maryland** has a Producer Advisory Council to provide input.¹⁸

Streamline enrollment procedures, including fast-track enrollment. Some states have adopted "fast-track enrollment" for individuals whom they know to be Medicaid-eligible through their participation in other public programs. States can apply to the Centers for Medicare and Medicaid Services (CMS) for a fast-track waiver through December 2015.¹⁹ CMS enabled states to identify Medicaid-eligible individuals by using data that states already have through the Supplemental Nutrition Assistance Program (SNAP) and Medicaid databases.²⁰ Using this data, states can reach out to people who are likely to qualify for Medicaid and encourage them to enroll in health coverage. Alternatively, states can inform new applicants for other services that they may



also be eligible for enrollment in Medicaid. As discussed earlier, using data from programs such as SNAP, Medicaid and unemployment insurance compensation, states could reach more than half the Medicaid-eligible, uninsured young adults.²¹ While targeted enrollment strategies such as fast-track enrollment offer an effective way to identify newly eligible individuals, they also raise concerns about the use of sensitive and confidential financial and household information.

- **South Carolina** uses eligibility information from other programs (e.g., SNAP and Temporary Assistance for Needy Families) to expedite renewals of Medicaid. The move resulted in an estimated savings of \$1 million in direct administrative costs and 50,000 staff hours.
- Other states that have adopted fast-track eligibility include **Arkansas, Illinois, Oregon and West Virginia.**²²

CONCLUSION

States are engaged in a continuum of outreach and enrollment strategies, some taking primary responsibility for those functions, while others rely at least in part on federal agencies to perform those activities. Despite the variation among states, opportunities exist for interested policymakers to engage with the outreach and enrollment activities to ensure that the process meets the state's needs and supports its coverage goals.

Endnotes

- 1 Open enrollment ended on March 31, 2014 for individuals; special enrollment continued through April 19, 2014. Small businesses may continue to enroll through 2014. There is no deadline for enrolling in Medicaid.
- 2 Congressional Budget Office, Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act, Appendix B in Budget and Economic Outlook 2014-2024 (Washington, D.C., February 2014).
- 3 Ibid.
- 4 Ian Hill, Brigette Courtot and Margaret Wilkinson, Reaching and Enrolling the Uninsured: Early Efforts to Implement the Affordable Care Act (Princeton, N.J.: Robert Wood Johnson Foundation and Urban Institute, October 2013), 4.
- 5 Center for Medicare and Medicaid Services, Department of Health and Human Services, "Medicaid and CHIP FAQs: Enhanced Funding for Eligibility and Enrollment Systems (90/10)," originally released November 2012, accessed on March 17, 2014.
- 6 Sarah Dash, Christine Monahan and Kevin W. Lucia, "Health Policy Brief: Health Insurance Exchanges and State Decisions," Health Affairs, July 18, 2013, 1.
- 7 Liz Hamel, Jamie Firth and Mollyann Brodie, "Kaiser Health Tracking Poll: February 2014," Menlo Park, CA.: Henry J. Kaiser Family Foundation, February 2014).

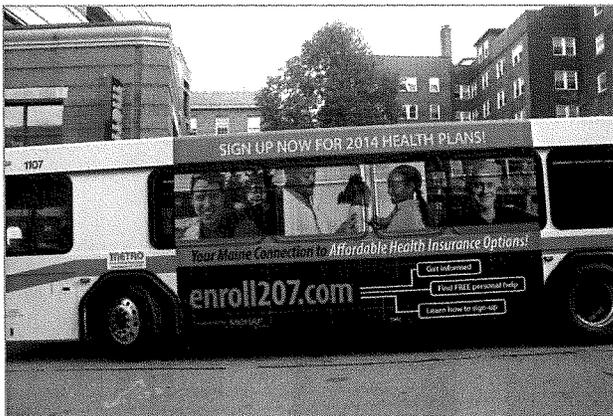
- 8 "Health Policy Brief: Navigators and Assisters," Health Affairs, October 31, 2013.
- 9 T.R. Goldman, "Young Adults and the Affordable Care Act," Health Affairs, December 16, 2013, 3.
- 10 Jay Hancock, "Blue Cross-Blue Shield Gets Big on Obamacare Exchanges," Kaiser Health News, June 21, 2013.
- 11 John Lumpkin, "Engaging Communities of Faith to Help Americans Gain Health Insurance," RWJ Culture of Health Blog, November 13, 2013.
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The objective of this campaign was to build awareness and understanding of the Health Insurance Marketplace and the enroll207.com website among Maine consumers—particularly those who are uninsured or underinsured—and small businesses.

MeHAF's goal was to see 20,000 people or small businesses enroll in Maine's Marketplace by the end of 2014. As of the end of March, over 44,000 Mainers were enrolled!

Transit Ads



Rack Card

Need **AFFORDABLE** health coverage?

Financial help for eligible families

Special plans for under 30s

Incentives for small businesses

Coverage for all your family's needs

Learn more here:
enroll207.com

Your Maine Connection to the Health Insurance Marketplace

Getting covered is as easy as 1-2-3!

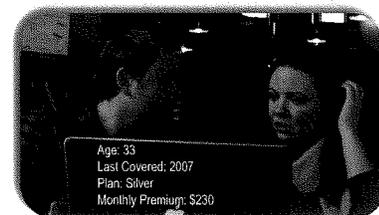
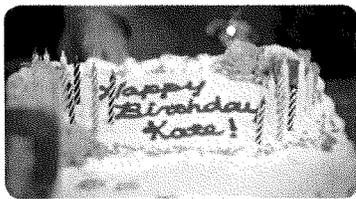
Maine's new Health Insurance Marketplace provides new options for more affordable health insurance—and many Mainers will qualify for financial help that can lower their monthly premiums. Visit enroll207.com and start on the path to affordable health coverage today!

1. Get informed at enroll207.com.
2. Find FREE personal help. Use the FREE tool to find a certified assister near you.
3. Link directly to the Health Insurance Marketplace when you're ready to buy insurance.

enroll207.com
For help by phone, call Consumers for Affordable Health Care at **1-800-965-7476** (TTY: 1-877-362-9370)

▲ Rack card front
Rack card back ▶

TV & Radio Spots



Online Ads

Living without health insurance can keep you on the sidelines.

But Maine's more affordable health insurance options...

To stay healthy, all Mainers need to get covered...

...by health insurance, that is.

Maine families have NEW, more affordable health insurance options. Start here:

enroll207.com

Your Maine connection to the NEW Health Insurance Marketplace

enroll207.com

Your Maine connection to the NEW Health Insurance Marketplace

Small Business Forums

The Affordable Care Act (ACA):

"What's in it for my small business?"

Mobile Ads

Need affordable health coverage?

Learn more at **enroll207.com**

Check out low-cost health plans for under 30s.

Learn more at **enroll207.com**

Check out low-cost health plans for under 30s.

Learn more at **enroll207.com**

Too young for Medicare? You have new options for affordable coverage.

Learn more at **enroll207.com**

Print Ads

"Gimme 1 good reason why I should sign up for Health Insurance!"

Dude: it's time to get covered!

With health insurance, that is.

Dude's not getting stuck with big medical bills if you get sick or hurt.

You can get a new plan on the Health Insurance Marketplace for a lot less than you think — and most Mainers qualify for financial help with their monthly premiums.

Going uncovered in Maine can be pretty nasty — and you'll pay a penalty of 1% of your income (with a \$99 minimum) for not having insurance.

Steak on over to enroll207.com to find FREE local help signing up. *Cause open enrollment for coverage this year ends March 31!

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For help by phone, call Consumers for Affordable Health Care at 1-800-965-7476 (TTY: 1-877-362-9370)

Get the answers you need to make sound business decisions on Wednesday, March 19 from 7-9:15 am

Jeff's Catering & Event Center - East West Industrial Park off Parkway South - Brewer

If you have a Maine business with fewer than 50 employees, you'll want to attend this FREE event designed to help you understand the new law and your options.

Experts on the new health insurance landscape will provide an overview of the ACA and the Small Business Health Options Program (SHOP).

There's no charge, but space is limited, so sign up today: call the Bangor Region Chamber of Commerce at (207) 947-0307, or visit bangorregion.com and click on "Events".

Sponsored by:

MEHAF
Maine Health Access Foundation

BANGOR REGION
CHAMBER OF COMMERCE

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The Maine connection to Affordable Health Care

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Social Media & Facebook Ads

Affordable health plans?

Mainers can now get new lower-cost health plans with financial help for eligible families.

enroll207.com

Affordable health plans?

Mainers under 30 can now get lower-cost health plans. Go to **enroll207.com**

Too young for Medicare?

Mainers under 65 can get new lower-cost health insurance. Go to **enroll207.com**

Affordable health plans?

Mainers under 30 can now get lower-cost health plans. Go to **enroll207.com**

Small Biz Health Plans

enroll207.com/sgcgncommunity.com

Free forum on Affordable Care Act options 7-9:30 am, Jan 21, Lewiston. Call 207-783-2249.

Register here!

Affordable health plans?

Mainers can now get new lower-cost health plans with financial help for eligible families.

enroll207.com

Okay, how about 4?!

- Two words: Face plant!
- You could win \$100
- It's cheaper than you think—and you'll probably get financial help.
- Do it for Mom!

Share your story about signing up, and you'll be entered for a chance to win \$100. But hurry: enrollment this year ends March 31!

enroll207.com

For help by phone, call Consumers for Affordable Health Care at 1-800-965-7476 • (TTY) 1-877-362-9370