



# Vermont Navigator Program: Capacity, Compensation and Performance Metrics

November 2012

Final Draft

## **Executive Summary**

The first section of this report provides a range of estimates for funding navigators in the first year of the exchange, based on resource need and affordability for Vermont's Health Benefit Exchange. The second section describes and discusses the advantages and disadvantages of several different methods of compensating navigators and measuring their performance.

### **Resources Needed for Navigators**

In order to project needed financial support for navigators, Wakely has had to make assumptions about the functions of navigators that the exchange will support and the population to be assisted. We begin by suggesting a focus for navigator support that seeks to optimize the exchange's financial resources and budgetary trade-offs. States enjoy wide latitude under the ACA in defining navigators' roles and how they will support these functions financially. Because federal grants are available to support a variety of outreach and consumer assistance functions conducted by Vermont's exchange during the crucial start-up years of 2013 and 2014, but excluding direct payments to navigators, we recommend that Vermont focus its financial support of navigators on those functions which community-based organizations and a host of other navigator-like entities are uniquely situated to perform.

While these activities should include a modest amount of outreach and education, necessary to inform the most hard-to-reach and non-English speaking groups about national health reform and to promote awareness generally of assistance from navigators, navigators are uniquely situated to assist those who seek eligibility determination and/or help with enrolling in QHPs (and Medicaid). For applicants who do not feel comfortable relying on the exchange's Call Center for assistance, navigators can help them use the web for eligibility determination and enrollment. We assume for purposes of this analysis that such assistance constitutes the bulk of navigator activities which the exchange (and the Medicaid program) will help finance.

We also assume that navigators will focus their assistance on individual enrollment as well as enrollment in Medicaid, especially of the uninsured. Ideally, in helping applicants use new, automated eligibility determination processes, navigators should understand and serve the full array of Vermont's subsidized healthcare coverage programs. Again, for budgetary and programmatic reasons, we assume that the exchange will contract primarily with existing organizations that have institutional knowledge of the full array of subsidized coverage programs, and that navigator grants support adding resources for the navigator role. Financial support from the exchange, as distinct from Medicaid or CHIP, would be for applicants who ultimately enroll through the exchange in QHPs. Medicaid would continue to support assistance provided to Medicaid enrollees, with state funds presumably matching the Medicaid level of funding (i.e., 50/50 cost share).

These assumptions underpin our assessment of the needed financial support for navigators, and are explained below. If the exchange chooses to support additional navigator functions and/or assistance for additional population, a higher level of support is probably appropriate. However, estimating the

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level of resources required for broad outreach and education, for example, is very difficult. Navigators can be supported to perform these functions at almost any budget level that is made available to them.

Based on both Vermont and Wakely projections of the target population eligible for individual enrollment in QHPs in 2014 (69,283) and assumptions about the percentage of that population who will need navigators' services to help determine eligibility and ultimately enroll them in QHPs, we estimate that navigators should be supported to assist some 10,000 to 17,000 enrollees in 2014, at a cost of \$50 to \$100 per application (we further assume an average of two people per application). Additionally, we estimate that navigators will assist some 6,000 to 11,000 new Medicaid enrollees in 2014, and while the \$50 to \$100 per application cost will also apply to Medicaid enrollees, we assume that Medicaid will reimburse 50% of these costs. When both the exchange and Medicaid population needs are taken together, our projections generate a range of financial support for incremental navigator functions of almost \$340,000, to just over \$1,132,000, with a "likely case" estimate of approximately \$680,000. (See table on p.17 and 18). In addition, Vermont may decide to contribute toward overhead costs for existing navigator entities, and to start-up costs in geographies not currently served by navigator-like organizations which meet the exchange's standards.

We also look at a number of different measures of need, by geographic distribution: population, number of uninsured and under-insured, and income. We conclude that the correlation of these different measures is close enough that, with the possible exception of Chittendon County, population is a reasonable basis for allocating navigator funding across the state.

### **Compensation Methods and Performance Measurements**

We look at two different compensation methods: grants and payments per enrollee or application. Grants can be competitive or prescriptive in nature, and can be based on services to be provided in pre-determined geographies or for specified dollar amounts (i.e. \$50k, \$75k or \$100k grants). Grants have the advantage of predictable budget costs and can be structured to encourage innovation or the likely number and type of grantees. Grants also provide the navigator entity with funding for start-up costs and hiring, and are generally the preferred compensation model of the people interviewed for this report.

Payments for successful enrollments represent another compensation approach. The exchange would pay the navigator for each completed and accepted enrollment, basing payment on either a per person or per application basis (a per application basis assumes an average of two enrollees). The key advantage of the per enrollment model is its focus on results but the ability for both the exchange and the navigators to predict the resulting budget is limited. The exchange doesn't know what their maximum costs are likely to be and the navigator cannot necessary predict what it will earn for its efforts.

A third possible model combines the best of the grant approach with the added incentive of a payment per successful application of the most challenging enrollees.

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Regardless of the compensation model utilized, the exchange will want to establish meaningful performance requirements that can be measured and verified. The most compelling performance standards will look at the number of successful “assisted” and “referral” applications, as well as the impact of outreach meetings and events. “Assisted” applications are done by the navigator whereas “referral” applications are facilitated by the navigator but actually completed by either Call Center staff or the applicant him/herself.

To maximize performance, navigators should be rewarded for helping to achieve broader goals of the reform, and these goals should drive performance measurement and compensation. Unfortunately, neither grants nor per-enrollee payments alone are likely to fully meet this standard. For this reason, we recommend a hybrid compensation model embracing both a grant and a bonus payment per successful enrollment, especially of “high need” populations. This approach offers both a predictable revenue base and incentives to perform, is likely to be well-received by existing navigator-type entities, and accommodates performance requirements that can be both measured and verified.

## Introduction and Approach to Estimating Reasonable Funding for a Navigator Program

In order to develop a range of funding for navigators, we begin by reviewing the role and funding of navigators within the larger context of the exchange, other subsidized coverage programs in Vermont, and the external interfaces with customers and the public. This review suggests the advisability of focusing funding support for navigators on those functions which cannot be done as effectively and efficiently by other assistors, and (to the extent possible) on supplementing the capacity of navigator-like entities which are already working with needy populations to access subsidized coverage or obtain free care. Supplementing the capacity of existing, navigator-like entities should require less incremental funding than developing entirely new resources, and should help coordinate access to multiple coverage programs in Vermont. If the exchange offers “no wrong door” access to coverage, then navigators should provide “no wrong doorman” assistance to applicants.

The exchange is a marketplace where individuals and small businesses in Vermont can go to determine their eligibility for government-subsidized coverage to select and enroll in health insurance, beginning October 1, 2013. It is also charged with an outreach and education role to inform the public about health reform and the need for coverage, including penalties for not obtaining coverage when affordable. A primary objective of the exchange is to promote the availability of coverage and access to tax credits and cost sharing subsidies for many enrollees who will meet federal guidelines. The first year of full implementation will be a critical period for outreach and education, and federal grants are available to Vermont through to 2014 to support this mission. While federal grants may be used for advertising, promotion and consumer assistors (i.e., call center representatives and customer support service staff) these funds cannot be used for navigators.

So the budgetary imperative is to focus spending on navigators where they are most needed, supplementary to mass media and other first-year outreach activities that can be funded by federal grants, and to ongoing operations for customer support. This assessment looks at the need for focused navigator activities in year-1 for those individuals that are eligible for enrollment in qualified health plans (QHPs) offered by the exchange. Separate funding estimates include navigator capacity for the known segments of Vermont’s population that will qualify for Medicaid, as it is recommended that the same navigator-like organizations be used for both the exchange and Medicaid program.

Also, we assume that navigator resources will focus on direct, individual enrollees, rather than Vermonters who enroll in employer-sponsored insurance (ESI). (Such applicants cannot be precluded

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from using a navigator but the exchange will likely want to discourage this practice.) Small group eligibility and plan selection is distinctive to employer-specific set-up rules which are very different from the eligibility and enrollment processes in the individual market. Vermont has proposed an “in-person” assistance program to CMS that would subsidize the use of brokers to support the enrollment needs of small group employers and their employees. As there may be some employees with complicated eligibility questions within their households that a broker cannot address, broker referrals to navigators may occur but should be very infrequent.

### The Navigator Role

The ACA names five functions for navigators:

- Conduct public education activities to raise awareness of the availability of QHPs;
- Distribute fair and impartial information concerning enrollment in QHPs, and the availability of premium tax credits and cost-sharing reductions;
- Assist applicants with QHP plan selection;
- Provider referral to any applicable office of health insurance consumer assistance or health insurance ombudsman or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or determination under such plan or coverage; and
- Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange

There is some overlap in these five functions – e.g., the first two bullets, and providing information in a culturally and linguistically appropriate manner qualifies the other functions – so there are actually only three distinct roles: (1) educate and inform, (2) facilitate eligibility determination and QHP plan selection and (3) provide referrals for appeals and grievances. The ACA does not prescribe any required level of support for these three roles, and states have broad discretion to shape the navigator program to their own budgetary constraints and programmatic goals. Because federal funds are available through 2014 to support other means of outreach and education than navigators, we recommend that Vermont define the navigator role primarily as facilitating eligibility determination and assistance with plan selection, at least for late 2013 and 2014. The approach recommended below is neither austere nor extravagant; instead, it makes a best effort at sizing a reasonable navigator program that maximizes the impact of federal and state dollars.

How will navigators assist applicants to determine their eligibility for subsidized coverage and enroll in health plans? The exchange website will allow applicants to (1) determine their eligibility for coverage as well as tax credits and cost sharing subsidies, usually in real time, and (2) compare health plans pre-qualified by the exchange in order to select and enroll in the plan that best meets their needs. Navigators can meet face-to-face or over the phone with applicants and go thru the website process with them, or if the assistance is over the phone and the applicant doesn't have access to a computer, the navigator can serve as their proxy. If the applicant requires translation services, then the exchange

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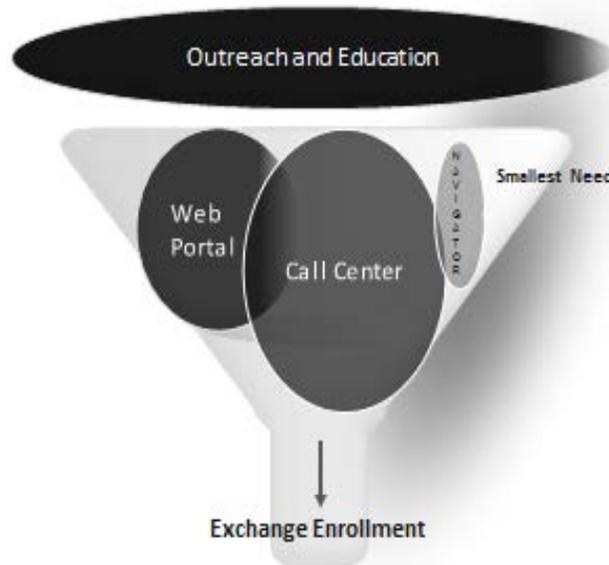
will want to identify a same-language navigator or, if unavailable, a telephonic interpreter service. The Community Health Center of Burlington uses such a telephonic service today with success and the company is able to provide interpreters in 180 languages for the health care market.

Navigator-like work is usually thought to be part of a grassroots campaign, best left to those entities and community advocates already in positions of trust or familiarity with the needs of various segments of the hard-to-reach population. However, unlike the other avenues the exchange has of interfacing with the public outlined above, navigator programs are not federally funded. Either the exchange or the state must fund these efforts, before, during and after the first year of operation. As such, the exchange is financially incented to use navigator resources as judiciously as possible and to make the most of the federally funded interfaces (outreach and education, web portal, Call Center) to achieve enrollment goals.

Moreover, navigator resources cannot be purchased as a “commodity,” nor are they readily scalable. For many enrollees, a well-designed website, plus telephone customer service will be the preferred way of applying for subsidized coverage and enrolling in the exchange. While the exchange’s own Call Center services can be readily purchased, navigators by most definitions come from trusted organizations rooted in local communities with strong mission statements to help the underserved. And while community-based organizations can inform and educate some hard-to-reach residents, conventional communications channels are generally more efficient and qualify for federal support. Identifying and training a sufficient number of navigators to assist the most vulnerable or needy applicants will be challenge enough, without supporting navigators to duplicate Call Center functions or mass outreach. For all these reasons, we project the need for navigators and corresponding budget to provide a relatively narrowly defined set of services that cannot be provided as well by a Call Center or other customer service staff.

Visually, it is helpful to think of exchange users as applying through several different channels, as shown below in Figure A, whereby only the most vulnerable need the specialized services of a navigator:

Exhibit A:  
Enrollment Funnel



Mass outreach and education are the overarching means of connecting with potential applicants, with the web portal positioned as the hub of all activity. Call Center support may be in conjunction with a web site visit; precipitate a visit to the website, or even supplant the need for an individual to use the web portal directly. (In these instances, Call Center staff can enroll an individual over the phone, through a written application or by an in-person visit to a Call Center location.) Similarly, navigators can assist applicants and enrollees over the phone or in person, to answer questions, clarify options and/or help them apply and enroll via the exchange website. To be sure, the navigator element is a critical one; it should not, however, be thought of as the “best” way to educate and assist **the majority** of enrollees.

## Estimating the Number of Enrollees

In June of this year, Vermont’s Agency of Human Services prepared a preliminary ACA transition plan as part of their plan to extend and consolidate their Global Commitment to Health Section 1115 Demonstration beyond the current December 31, 2013 expiration date. The Demonstration serves as the foundation for Vermont’s model for health reform and provides the state with the flexibility to improve access to health coverage based on need. Vermont plans to seek federal authority to extend the Global Commitment Demonstration and intends to request a single Demonstration waiver that

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consolidates existing programs and authorities. The Special Terms and Conditions (STCs) of the Demonstrations require Vermont to develop a transition plan consistent with the provisions of the ACA for individuals currently enrolled in the Demonstration. This initial work (“Transition Plan”) has been used to inform much of the expected enrollment in exchange QHPs as explained below. Additionally, we relied on enrollment data and transition paths as shown in a state document provided to Wakely on August 10, 2012 which is appended to this report as Appendix E. Last, updated data on Vermont’s uninsured population was provided in early November and incorporated into this report.

To make a projection on the number of individuals who are likely to need (or want) the assistance of a navigator, we first look at the expected eligible population of Vermont’s exchange. There are essentially six groups that warrant closer inspection:

1. Current enrollees in the Vermont Health Access Plan (VHAP) or VHAP-ESIA (Employer Sponsored Insurance Assistance)
2. Current enrollees in the Catamount Health Premium Assistance Program (CHAP) or Catamount-ESIA (Employer Sponsored Insurance Assistance)
3. Current enrollees in Catamount Health (no state assistance)
4. Current enrollees in private pay individual market insurance (sometimes called direct-pay)
5. Current enrollees in Employer Sponsored Insurance Programs (ESI) whose small group employers drop ESI coverage on or after 1/1/14; or ESI eligible employees from either small or large group employers who drop ESI coverage in favor of exchange subsidized coverage
6. Currently uninsured

Some of these eligible enrollees will enroll in Medicaid/CHIP, and we recommend that navigators serve this population as well. However, for purposes of budgeting support for navigators, we also assume that the state will want to allocate the costs of serving Medicaid/CHIP enrollees to those programs, where these costs would be eligible for federal matching dollars. Therefore, in our Medicaid projections we assume only half of the cost of enrolling Medicaid enrollees will be borne by either the exchange or the state for the purpose of estimating the exchange’s budget to support navigators.

### Current VHAP Enrollees

VHAP is an expansion program available to adults age 18 and older who do not meet the eligibility requirements of Medicaid, and who have income less than 150% of the Federal Poverty Level (FPL) if childless or 185% of the FPL if there are minor children in the home.<sup>1</sup> VHAP ESI is for people who otherwise meet the eligibility criteria for VHAP but who receive premium assistance to enroll in employer-sponsored coverage when it is more cost-effective for the state than enrolling them in VHAP. Beneficiaries enrolled in VHAP-ESIA pay a monthly premium equivalent to that paid by beneficiaries in VHAP, and receive wrap-around coverage for cost-sharing required by their employer-sponsored plan.

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<sup>1</sup> State of Vermont: Global Commitment to Health (11-W-00194/1) & Choices for Care (11-W-00191/6): Preliminary ACA Transition Plan. State of Vermont, Agency of Human Services. June 28, 2012.

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In the post-exchange world, VHAP is expected to be discontinued. Current enrollees will either qualify for Medicaid or be eligible for premium tax credits and cost sharing subsidies to make the purchase of a qualified health plan (QHP) offered by the exchange affordable. There are 38,039 current enrollees with potential exchange and Medicaid enrollment as follows:

Service Category	Population	SOV Expects Transition to:	Exchange/Medicaid Impact:
VHAP<133%	28,804	Medicaid	28,804 (assume 100% Medicaid)
VHAP 133-200%	8,395	Medicaid/Exchange +Wrap	8,395 (assume 100% QHP)
VHAP-ESIA<133%	370	ESI/Medicaid	370 (assume 100% Medicaid)
VHAP-ESIA 133-200%	470	ESI/Medicaid/Exchange +Wrap	470 (assume 100% QHP)
Total Current VHAP	38,039		8,865 potential QHP/exchange enrollees and 29,174 Medicaid enrollees

While not all of the VHAP 133-200% and VHAP-ESIA 133-200% populations will necessarily enroll in QHPs offered by the exchange, we assume for purposes of estimating the greatest possible need for navigators that 100% will do so. We use a similar assumption (100% application or enrollment) below for other populations for which Vermont plans to collaborate with CMS to preserve access to affordable coverage for individuals with incomes between 133-300% of FPL who are currently enrolled in VHAP or Catamount plans.<sup>2</sup>

### Current CHAP and Catamount ESIA Enrollees

Catamount Health is a private health insurance plan offered by Blue Cross Blue Shield of Vermont (BCBSVT) and MVP Health Care, in cooperation with the state of Vermont. People who have income below 301% of the FPL may qualify for premium assistance (based on a sliding scale) for coverage in Catamount or Catamount-ESI. Like VHAP, CHAP is expected to be discontinued in 2014. Current enrollees will either qualify for Medicaid or be eligible for premium tax credits and cost sharing subsidies to make the purchase of a qualified health plan (QHP) offered by the exchange affordable. There are 11,613 current enrollees with potential exchange and Medicaid enrollment as follows:

Service Category	Population	SOV Expects Transition to:	Exchange/Medicaid Impact:
CHAP<133%	1,158	Medicaid	1,158 (assume 100% Medicaid)
CHAP 133-200%	6,614	Medicaid/Exchange +Wrap	6,614 (assume 100% QHP)
CHAP 200-300%	3,128	Exchange +Wrap	3,128 (assume 100% QHP)
Catamount-ESIA <133%	22	ESI/Medicaid	22 (assume 100% Medicaid)

<sup>2</sup> State of Vermont: Global Commitment to Health (11-W-00194/1) & Choices for Care (11-W-00191/6): Preliminary ACA Transition Plan. State of Vermont, Agency of Human Services. June 28, 2012.

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Catamount-ESIA 133-200%	454	ESI/Medicaid/Exchange +Wrap	454 (assume 100% QHP)
Catamount-ESIA 200-300%	237	ESI/Exchange +Wrap	237 (assume 100% QHP)
Total Current Catamount	11,613		10,433 potential QHP/exchange enrollees and 1,180 Medicaid enrollees

For purposes of estimating the need for navigators, we assume that 100% of the CHAP 133-300% and Catamount-ESIA 133-300% populations could potentially enroll in QHPs offered by the exchange.

**Current Catamount Health (no state assistance) and Private Pay Individual Coverage**

Catamount Health is available to people with incomes equal to or more than 300% of the FPL but no state premium assistance is provided. There are 3,014 “full price” Catamount enrollees. Full pay individual coverage in private commercial plans (such as BCBSVT and MVP) is available to individuals who are not eligible for ESI and who can afford the premium. There are 4,466 people in the private pay individual market (also called direct-pay). All are likely to enroll in exchange products as follows:

Service Category	Population	SOV Expects Transition to:	Exchange/Medicaid Impact:
Catamount Full Price	3,014	Exchange/Exchange +Wrap	3,014 (assume 100% QHP)
Individual Private Pay	4,466	Exchange/Exchange +Wrap	4,466 (assume 100% QHP)
Total Individual	7,480		7,480 potential QHP/exchange enrollees

**Current Enrollees in ESI Who May Transition to the Individual Market (Employer Drops Group Coverage and/or Lower Income Employee Elects Tax Credits and Cost Sharing Over ESI)**

There are a total of 61,545<sup>3</sup> individuals enrolled in either Small Group coverage or Association-based plans for small employers (small employers are defined as those with 50 or fewer employees). Across the country it is anticipated that some percentage of small employers will drop coverage once the exchanges open in 2014. While estimates vary widely, particularly based on the type of study (employer surveys and micro-simulations are the most prevalent forms of analysis), four of five employer surveys that provide results by employer size indicate the drops in ESI for small employers as follows: Fidelity (22% ), McKinsey (9%), Mercer (5%) and Willis (4%)<sup>4</sup>. The micro-simulation studies generally predict little net change in the prevalence of ESI in the short term (half of the studies indicate a small drop in ESI and half indicate a small increase). While not statistically valid, a survey done with 50 Vermont employers done earlier this year indicates that one in three employers (34%) will drop ESI if they believe

<sup>3</sup> D. Martini, Department of Financial Regulation, State of Vermont, confirmed in an 8/22/12 email message that the Small Group market enrollment (including association lives) is 61k and not 80k.

<sup>4</sup> <http://www.gao.gov/assets/600/592411.pdf>

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their employees can obtain good coverage thru the exchange. Given that Vermont’s long term plan is to decouple health care coverage from employment, it is highly likely that more Vermont small employers will drop group coverage in 2014 than we are likely to see happen nationally, but we also don’t see a full and immediate 34% drop as indicated in the survey. For the purposes of estimating the high end need for navigators for employees whose employers stop providing coverage, we are projecting a “drop rate” of 30% in the Vermont small business community, and that this entire change happens in 2014. This drop rate may not correspond with an enrollment increase of the same size in the number of individuals who are likely to select QHPs—some will enroll in Medicaid and some will not enroll at all—but, again, to project the largest potential enrollment in QHPs, we assume that all 30% will enroll as individuals in QHPs.

Within the small group market (including associations), there will also be a fair number of employees who will enroll in the exchange despite continued availability of ESI due to either the affordability or minimum coverage tests under the ACA. We estimate this impact to be about 4%.

Last, a very small number of employees in Large Group ESI will elect to enroll in the individual exchange due to the affordability and minimum coverage tests. Wakely actuaries estimate that less than 1% of the 279,641 enrollees in Large Group ESI eligible under these tests will do so.

Service Category	Population	SOV Expects Transition to:	Exchange/Medicaid Impact:
Small Group	40,829	Small Business (SHOP) or Individual Exchange	13,821 (30% lose ESI and all go to the exchange); an additional 4% retain ESI eligibility but may enroll in the individual exchange instead of the small business exchange due to the affordability/minimum coverage tests.
Associations (excluding VEHI/VADA)	20,716	Small Business (SHOP) or Individual Exchange	7,012 (30% lose ESI and all go to the exchange); ; an additional 4% retain ESI eligibility but may enroll in the individual exchange instead of the small business exchange due to the affordability/minimum coverage tests
Large Group Migration	279,641	Individual Exchange (Wakely estimate)	1,748 (1%) may enroll in QHPs in the individual exchange due to affordability/minimum coverage tests
Total Small Group/Assoc/Large	341,186		22,581 potential QHP enrollees in the individual

			exchange (excludes small business exchange enrollees)
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**Currently Uninsured**

Vermont’s uninsured population is estimated at 44,568, or 7.1%<sup>5</sup> of its population, making it one of lowest uninsured states in the nation. As shown below, almost one of every three uninsured will qualify for Medicaid as of 2014, while 56% of the uninsured will qualified for tax credits and/or cost sharing subsidies for QHP enrollment. The remaining 15% with incomes over 400% of the FPL will not qualify for tax credits or subsidies but are eligible to enroll in the exchange at full cost. It is unreasonable to assume that all of the uninsured will enroll in health care coverage by the end of 2014 (while Massachusetts was ultimately able to reduce its uninsured rate to less than 2%, it took several years to achieve this milestone). As Vermont has one of the deepest state commitments to reducing the ranks of the uninsured, we posit a goal of reducing the uninsured rate from 7.1% to 2.0% in the first year of operation. While this goal is very ambitious, Vermont believes that it is an appropriate target for the purpose of determining the magnitude of the navigator resources needed. The overall reduction in the uninsured, then, is estimated to result in 12,436 Vermonters remaining without coverage as of the end of 2014.

Service Category	Population	SOV Expects Transition to:	Exchange/Medicaid Impact:
Uninsured<133%	12,889	Medicaid	12,208 (assume Medicaid)
Uninsured 133-150%	2,934	Medicaid/Exchange +Wrap	2,347 (assume QHP)
Uninsured 150-200%	7,060	Medicaid/Exchange +Wrap	5,295 (assume QHP)
Uninsured 200-250%	5,645	Exchange +Wrap	3,952 (assume QHP)
Uninsured 250-300%	4,286	Exchange +Wrap	2,571 (assume QHP)
Uninsured 300-400%	5,025	Exchange +Wrap	2,513 (assume QHP)
Uninsured >400%	6,729	Exchange	3,246 (assume QHP)
Total Uninsured	44,568		19,924 potential QHP/exchange enrollees and 12,208 Medicaid enrollees

**Projected 2014 Exchange Enrollment (excluding Small Group enrollment that is more likely to use an broker-based in-person assistance program under consideration)**

The projected total of first year enrollment in exchange QHPs (excluding Small Group Enrollment) is 69,283:

Projected First Year QHP Exchange Enrollment (excluding most Small Group)						
From	From	From	From	From Small	From	TOTAL

<sup>5</sup> Uninsured data provided by P Hochanadel on November 12, 2012.

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VHAP/VHAP ESIA	CHAP/Catamount-ESIA	Catamount Full Pay	Individual Full Pay	Group, Associations and Lg Group	Uninsured	
8,865	10,433	3,014	4,466	22,581	19,924	69,283
13%	15%	4%	6%	33%	29%	100%

Projected First Year Enrollment of <i>New</i> Medicaid Enrollees
42,562

**Dimensions of the Navigator Program: Preferred Enrollment Pathways**

To project the navigator resources needed to support the expected exchange and Medicaid populations, we next look at the enrollment pathways people prefer.

A study conducted for CMS in late 2011 to inform CHIP and Medicaid outreach and education found that most low-income parents prefer online, telephone and mail-in application processes over face-to-face assistance<sup>6</sup>:

- 62% of parents say they would be much more or somewhat more likely to apply for Medicaid or CHIP if they could fill out an application online. About half (55%) say the same about sending in an application by mail and filling out an application by telephone (47%).
- 34% say they would be more likely to apply if it meant going to a government office to fill out an application.
- 35% say the same about getting help from someone in a community group or their child’s school (39%).

In March of this year, Lake Research Partners surveyed 1,004 adults age 18 and over in Vermont. These state-specific results also support the willingness of uninsured Vermonters to use a web portal to obtain information about the exchange:

- 75% responded that they would be very or somewhat comfortable in using the exchange website to find and compare available health plans if they were uninsured; this number increased to 86% after interviewees were told more about the exchange and asked again how interested they would be in using the web portal to find and compare health plans.
- 79% responded that being able to call upon trained specialists anytime they had a question about their health insurance or needed help applying for coverage would be a motivating factor and a reason to use the website if they were uninsured (“trained specialists’ were not defined further as either navigators or Call Center/customer service representatives).

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<sup>6</sup> “Informing CHIP and Medicaid Outreach and Education.” Topline Report: Key Findings from a National Survey of Low-Income Parents Conducted for CMS. Ketchum and Lake Research Partners. November 2011.

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- When asked their preferred means of “getting help” to compare plans or sign up for coverage, 59% of respondents would want in-person help; 47% telephonic help and 30% online. While the 59% response is high, multiple responses were allowed and drove up this number.

The data above reinforces the operating premise of the diagram on enrollment channels, with its reliance on the web portal and Call Center as major pathways to membership in the exchange. This corresponds to the experience in Massachusetts, where the vast majority of eligibility applications and enrollment in Commonwealth Care was done without the direct intervention of community-based organizations.

This outreach and education data also aligns with the estimates made by Vermont subject matter experts interviewed for this report. In August more than a dozen people were interviewed for their thoughts on how Vermont’s navigator program should be resourced. The majority were asked for their estimate on how many QHP enrollees would need (or want) face-to-face or one-on-one application assistance *from a navigator* specifically. Responses ranged from a low of “5-10%” to a high of 25%. When all responses were averaged, the interviewee estimates suggests that 16% of exchange applicants might need or want one-on-one navigator assistance (16% was also the estimate when the highest and lowest numbers were discarded with the remainder averaged). While this number is lower than the Medicaid survey results, it suggests that one-on-one navigator assistance will be needed far less than Call Center/customer service support.

## Sizing the Needed Navigator Resource

Community-based organizations and other navigator-like entities are already helping Vermonters apply for subsidized medical coverage, and we have reviewed the local “assistor” landscape for the purpose of developing an estimate of need that takes into account existing resources and use patterns. For example, eligibility and social workers in the eight federally qualified health centers across the state are likely to be one of the richest sources of experienced navigators. Collectively, the centers provide care to 1 in 6 Vermonters, including 1 in 4 Medicaid enrollees, 1 in 8 commercially-insureds and 1 in 4 of the uninsured<sup>7</sup>. Each center assists patients with health insurance applications today on a one-on-one basis but each center differs in the amount of time such staffers currently spend on this one aspect of their job.

A key organization like the Vermont Campaign for Health Care Security Education Fund (VCHCSE) will likely be central to the navigator program and this non-profit organization generally employs field staff working out of home offices to perform outreach in the communities they know best. This group, which worked on Catamount outreach and education, also offers a telephone hotline that can be called 24/7, with calls being returned at a time most convenient to the caller. The Bi-State Primary Care Association

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<sup>7</sup> FQHC data from UDS 2010 VT Roll-up; Statewide data from 2009 BISHCA Household Health Insurance Survey (as reported in Bi-State’s online Primary Care Sourcebook.

## DRAFT ONLY

is mission-driven to improve health care access and is currently under contract with the Department of Health Care Access (DVHA) to coordinate and direct outreach efforts for the state's Green Mountain Care family of health plans. Bi-State enjoys a broad membership of thirty-five organizations in Vermont (and NH) that provide and/or support community-based primary care service. These are just a few of the types of organizations that might be well suited to provide navigator services (Bi-State members include the health centers, rural health clinics, private and hospital-supported primary care practices, the community action program, Health Care for the Homeless programs, Area Health Education Centers, clinics for the uninsured, rural primary care practices and women's reproductive health clinics).

While it is not the intent of this report to identify the most appropriate navigator-type entities, this very brief description of some existing resources informs our estimates below. We project the optimal need for navigators i.e., both efficient and effective use of this scarce, highly client-centered and customized resource, by estimating the number of eligible exchange users and new Medicaid enrollees for 2014, and apply a range of factors to determine the proportion of eligible enrollees that are likely to actually enroll in a QHP or Medicaid with the assistance of a navigator. We then develop a total navigator budget, using a range of costs per assisted enrollee or per completed application. The target budget can then be used to allocate resource dollars by navigator entities, by geographical area based on need, or a combination of both.

The 20% "likely cost" estimate for the number of enrollees needing navigator services is generally consistent with data from Massachusetts, and estimates for several other states. From 2006 through 2007 when 430,000 Massachusetts people enrolled in coverage, community-based organizations assisted 92,000 individuals with application assistance (21%)<sup>8</sup>. A navigator report completed last fall for the New York Health Benefit Exchange based its estimate on the need for navigator assistance on this assumption and used a factor of 20% based on this data. In California, navigator assistance ranges include factors of 16.5%, 25% and 37.5% of eligible enrollees, with budgeting based on the highest point of the range.<sup>9</sup> And last, 20% navigator assistance exceeds the average estimates provided by people interviewed for this report who collectively suggested that an average of 16% of the expected enrollees might require some form of one-on-one assistance from navigators. We perform a sensitivity analysis around 20%, projecting the use of navigators at 15%, 20% and 25% of exchange and Medicaid enrollees.

The number of enrollees per application assumes an average "contract size" of two people enrolling on each application. Based on comparable enrollment fees for successfully completed applications by navigator-like entities, we used a level of navigator support or fee per application ranging from \$50 to \$100, with a mid-point or best estimate of \$75.

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<sup>8</sup> *Connecting Consumers to Coverage: The Role of Navigators and Consumer Assistance Programs in Implementing Health Reform in New York*. Empire Justice Center. September 2011.

<sup>9</sup> *Phase I and II Statewide Assisters Program Design Options, Recommendations and Final Work Plan for the California Health Benefits Marketplace*. RHA. June 26, 2012.

**DRAFT ONLY**

<b>State</b>	<b>Program</b>	<b>Compensation</b> (per successful application)
Federal	Pre-Existing Condition Insurance (PCIP) brokers <sup>i</sup>	\$100
Maryland	MHIP Broker <sup>ii</sup>	\$100
Illinois	All Kids Application Agents <sup>iii</sup>	\$50
California	Enrollment Entities and Certified Application Assistants <sup>iv</sup>	\$60
Oregon	Healthy Kids Application Assisters <sup>v</sup>	\$75

The chart below summarizes this approach:

**DRAFT ONLY**

Projection of Exchange and Medicaid Enrollees Requiring/Requesting Navigator Assistance	Best Case			Likely Case			Worse Case		
	Low Navigator Need			Expected Navigator Need			High Navigator Need		
Target Exchange Enrollment:	69,283			69,283			69,283		
Eligibility and Enrollment Pathway Assumptions:									
Use Website Only <sup>1</sup>	65%			50%			35%		
Use Call Center (or Chat & Website) <sup>1</sup>	30%			40%			75%		
Need Navigator Assistance	15%	10,392	Enrollees	20%	13,857	Enrollees	25%	17,321	Enrollees
Target Exchange Applications (assumes a 2-1 individual-to-application conversion factor) <sup>2</sup>	5,196 Apps			6,928 Apps			8,660 Apps		
<b>Projected Cost (QHP):</b>									
\$50 per application	\$259,811			\$346,415			\$433,019		
\$75 per application	\$389,717			\$519,623			\$649,528		
\$100 per application	\$519,623			\$692,830			\$866,038		
Target <b>NEW</b> Medicaid Enrollees	42,562			42,562			42,562		
Need Navigator Assistance	15%	6,384	Enrollees	20%	8,512	Enrollees	25%	10,641	Enrollees
Target Exchange Applications (assumes a 2-1 individual-to-application conversion factor) <sup>2</sup>	3,192 Apps			4,256 Apps			5,320 Apps		
<b>Projected Cost (Medicaid):</b>									
\$50 per application*50%=\$25 <sup>3</sup>	\$79,804			\$106,405			\$133,006		
\$75 per application*50%=\$37.5 <sup>3</sup>	\$119,706			\$159,608			\$199,509		
\$100 per application*50%=\$50 <sup>3</sup>	\$159,608			\$212,810			\$266,013		
<b>Total Projected Costs to Exchange/(State): QHP &amp; Medicaid</b>									
\$50 per application <sup>3</sup>	\$339,615			\$452,820			\$566,025		
\$75 per application <sup>3</sup>	\$509,423			\$679,230			\$849,038		
\$100 per application <sup>3</sup>	\$679,230			\$905,640			\$1,132,050		

## DRAFT ONLY

### Notes:

1. Website and Call Center assumptions provided as suggested reference points only and should not be used for staffing assumptions.
2. Application conversion factor validated with Vermont specific data.
3. Assumes 50% of cost paid by Medicaid and 50% by the Exchange or State

We have generated a range of budgets for supporting navigators, using a range of estimates for the population in need. Rounding off, Vermont could reasonably budget between \$340,000 and \$1,132,000 for the first year of its navigator program, with about \$680,000 as our best “likely cost” scenario. Importantly, these figures do not include any monies planned for statewide education and outreach, nor do they include the operational expenses to the exchange of supporting a navigator program (collateral, navigator application support systems, exchange staffing to oversee the program, errors and omissions type insurance, etc.).

Our best “likely case” estimate of \$519,623 for QHP only enrollment (i.e., excluding any estimate for Medicaid enrollment) is somewhat higher than the funding that Massachusetts provided to community-based organizations serving navigator-like roles in the early years of implementing near-universal coverage. Massachusetts provided \$3.5 million annually to fund navigator-like organizations to play all three roles referenced in the ACA: (1) outreach and education; (2) to assist applicants and enrollees; and (3) to facilitate filing grievance and appeals. Given that Massachusetts’ population is roughly ten times Vermont’s, as was its uninsured population in 2006, on a per capita basis \$519,623 is roughly 60% above the level of support provided in Massachusetts.

Nevertheless, this estimate is rough at best. One way to gain further insight into the required and appropriate budget level and the specific navigator resources that various funding levels can support would be to issue an RFI for the consideration and response of interested navigator entities. This would be a prudent way of gaining input on a host of questions related to the level of interest, current functionality and support for navigators.

### **Additional Considerations**

Regardless of the budget ultimately selected for the program, the exchange should also consider how various factors will contribute to (or detract from) a productive and cost efficient navigator model. To the extent that navigators are more productive, fewer navigator resources will be needed. Productivity and effectiveness of each navigator will depend on:

- Navigator training – thorough, accurate and timely training are key
- Primary outreach and education campaign – navigators need to build off of an awareness campaign, not start their own; similarly, a certain level of navigator support needs to be in place

## DRAFT ONLY

when the outreach and media campaign begins. Navigators must be educated on the campaign before it begins and must have appropriate collateral to build upon the messaging. Navigators are also a good “test” audience (although only one such audience).

- Timing – the sooner outreach starts, the better, although it is critically important that outreach be carefully coordinated with a call to action and actionable steps. A successful launch requires pre-planning and coordination.
- Ease and speed of web portal – if the web portal is well-received, fewer people will need navigator assistance
- Call Center staff – staff must be equally well-trained as navigators and staffing levels must be sufficient to provide “on demand” support (i.e., no long wait times; representatives must not be incented with productivity targets such that calls are concluded before all needs are thoroughly addressed)
- Appropriate access to exchange systems – navigators must be able to “see” the systems the same way a Call Center representative can
- Reporting requirements and ease of reporting must be manageable – performance measurement and tracking are important to the exchange, the individual navigator and navigator entity). A cumbersome paper process will slow navigators down (and slow the flow of information as well); the exchange should build a navigator application that is fully integrated with the eligibility and enrollment system.
- Applicant tracking – navigators should be able to track the progress of any applicant so that they can intercede when necessary to keep an individual on track
- Strong referral service – the Call Center (and website) should be able to provide appropriate navigator referrals whenever a caller is better served by such support or asks for such support
- Ready access to collateral – navigators need informational materials to be readily available
- Navigator support - navigators must be able to “get through” to the right exchange person when an issue needs to be escalated
- Navigator feedback is encouraged – navigators may be the best “eyes and ears” for exchange management and frequent opportunities for both sides to share what is working (and what is not working) need to be encouraged
- Strong start – to the extent that the program runs well, navigators will not be unnecessarily encumbered by “damage control” activities

### Lessons Learned from the Introduction of Catamount Health

Several people interviewed for this report referenced Catamount when voicing their thoughts on how navigator resources need to be considered to support the exchange’s enrollment goals. A common theme in several interviews was the need for a manageable number of plan choices and clear distinctions between them. While Catamount essentially involved the introduction of only four plans (VHAP-ESIA, CHAP, Catamount-ESIA and Catamount Health), several people mentioned that the four programs caused a fair amount of confusion among enrollees. Additionally, virtually everyone

## **DRAFT ONLY**

suggested that more plans mean more time is needed to explain the differences to potential enrollees. If there was one common plea in most of the interviews it was a request to keep the plan choices as few as possible.

Lack of sufficient training for Call Center representatives was cited as an issue by several. Two individuals suggested that the state was not as nimble as they needed to be when issues came up (for example, no literature was available for several weeks).

In a Vermont Legal Aid report prepared in August by the Health Care Ombudsman (HCO), consumer complaints for the last several years were reviewed to inform exchange planning. The Catamount lessons cited include a host of educational efforts that need to improve, for example: how enrollees are educated on how a subsidy works; the ramifications of late premium payments (is there a grace period, how can payments be made quickly), and how cost-sharing works. All of these topics represent opportunities for navigators to help re-educate enrollees in order to reduce complaints.

One of the key trends in the Ombudsman's report is the significant and sustained spike in HCO calls regarding eligibility. Calls regarding eligibility picked up in the quarter before Catamount began, a development the report attributes largely to the intense news coverage prior to the start of Catamount, as well as the comprehensive outreach and media campaign the state launched to educate Vermonters on the Catamount programs. The report states that this increase in eligibility calls has continued through the present time but acknowledges that the greater number of calls is also probably due to the start (and ongoing nature) of the Great Recession and the continuing increases in the high cost of obtaining private health insurance. Nonetheless, the report supports interviewee comments that eligibility questions and challenges became a focus of outreach support in the community. Its relevance to the navigator resource issue for the exchange is straightforward: while complexity is inherent in health care eligibility determinations, navigators must work with enrollees to simplify their understanding of and participation in the process as much as possible.

## **Geographic Resource Allocation Assessment**

In this section we recommend a method for assessing need across the state by region. This analysis can help determine how navigator programs should geographically focus their efforts and how the exchange should allocate resources.

### **Methodology**

We begin by identifying the primary determinants of need for application assistance that can be quantified and collected at the county level. We then develop weighted indices of these measures, and compare them with a simple allocation formula based on population alone. We conclude that population alone is reasonably accurate by comparison with more complex measures, with the possible exception of "over-counting" need in Chittendon County.

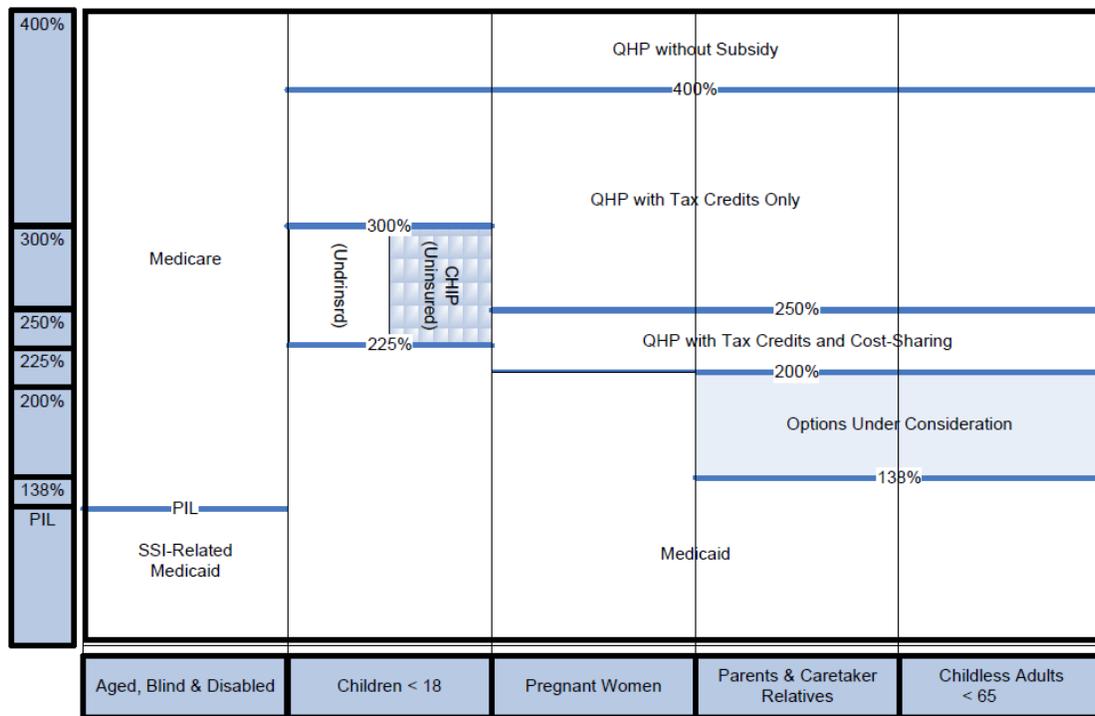
Income data for Vermont and the state's 14 counties were derived from the 2010 American Community Survey (ACS) 5-year estimate. The ACS divides income distribution into four categories; Households,

**DRAFT ONLY**

Families, Married-Couple Families, and Nonfamily Households. We decided that the Household category is the most encompassing and more relevant to our analysis.

We examine three significant FPLs: 138%, 250%, and 400% FPL. These particular levels were chosen based on their potential relevance to navigator programs, as seen in Figure 2. While this report is focused on exchange QHP eligibles, we assume that the navigators will serve both Medicaid/CHIP eligible and exchange individuals, so these categories can give us insight into the level of assistance needed. We are making an assumption that individuals who apply for cost-sharing subsidies (from 100-250% FPL) will need more assistance than individuals whose income is above 250% FPL. We are also assuming that those who qualify for tax credits (under 401% FPL) will require more assistance from navigators than those who are above 400% FPL.

Figure 1: ACA Program Categories for 2014



(Source: "Act 48 Integration Report: The Exchange", Vermont Agency of Administration, January 17, 2012)

Given that the ACS provides 2010 income levels, we based our analysis on 2010 FPL levels, which were sourced from HHS:

**The 2010 Poverty Guidelines for the  
48 Contiguous States and the District of Columbia**

<b>Persons in family</b>	<b>Poverty guideline</b>
1	\$10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010

For families with more than 8 persons, add \$3,740 for each additional person.

(source: <http://aspe.hhs.gov/poverty/10poverty.shtml>)

The ACS household income data do not distinguish size of household. While we acknowledge that this lack of distinction means that the *actual* number of households categorized by FPL group would differ from the numbers presented in our analysis, we believe that the *relative* number of households in each FPL category across counties and regions in Vermont is close to the numbers we present here. The ACS notes that the average Vermont household has 2.34 people and that the average family in Vermont consists of 2.90 people. Using this information, we conservatively assumed that all Vermont households contained 3 people and calculated FPL accordingly. The HHS poverty guideline information listed above indicates the FPL for 3 individuals is \$18,310. We assumed 138% of FPL to be \$25,000, 250% of FPL to be \$50,000, and 400% of FPL to be \$75,000. While these can be viewed as rough assumptions, the ACS provides income data by county for specific income brackets. Our analysis focuses on proportions and these assumptions will not affect outcomes.

**Uninsured and Underinsured**

To extend our analysis, we have also utilized the 2009 Vermont Household Health Insurance Survey, which provides the percentage of Vermont residents by county that are uninsured or underinsured. Based on this study, an adult or child is considered underinsured if their deductible exceeds 5% of their family’s income, health care expenses exceeded 10% of their family’s income, or a combination of both high deductibles and high health care expenses.

**Geographical Regions**

We divided Vermont counties into four geographical regions based on the approach of the 2009 Vermont Household Health Insurance Survey. We applied our analysis to these regions in conjunction with a county-by-county analysis:

**Burlington Area**  
Chittenden County

**Northeast VT**  
Caledonia County

**Southwest VT**  
Addison County

**Southeast VT**  
Orange County

## DRAFT ONLY

Franklin County  
Grand Isle County

Essex County  
Lamoille County  
Orleans County

Bennington County  
Rutland County

Washington County  
Windham County  
Windsor County

### Analysis

Utilizing the data from the 2010 ACS and 2009 Vermont Health Insurance Survey we derived two indices, which can help analyze how navigator resources should be distributed.

A Simple Needs-Based Index provides a measure of the Vermont population that likely requires the most navigator assistance. For this index, we used what we consider to be the two strongest indicators of need for education and outreach about the new coverage programs available under ACA and for help in applying for eligibility and enrolling in health plans. This index is calculated by applying an equal weighted average of population count below 251% FPL and uninsured population:

Component	Weight	Definition
1. Population below 251% FPL	50%	Household population below 251% FPL in region or county
2. Uninsured	50%	Household population that is uninsured

The Simple Needs-Based Index for each region or county is calculated in the following manner:

$$\frac{(\text{Population below 251\% FPL} * 50\%) + (\text{Uninsured} * 50\%)}{(\text{VT Population below 251\% FPL} * 50\%) + (\text{VT Uninsured} * 50\%)} \quad | \quad \times 100$$

### *Broad Needs Based Index*

The Broad Needs-Based Index is an expanded measure of the need for navigators. We created a weighted average that also includes overall population and the underinsured. The following four components and weights are used to calculate the index:

Component	Weight	Definition
1. Population	20%	Household population in region or county
2. Population below 401% FPL	40%	Household population below 401% FPL in region or county
3. Uninsured	30%	Household population in region or county that is uninsured
4. Underinsured	10%	Household population in region or county that is underinsured

## DRAFT ONLY

Based on the above weights, the Index for each region or county is calculated in the following manner:

$$\frac{(\text{Population} * 20\%) + (\text{Population below 401\% FPL} * 40\%) + (\text{Uninsured} * 30\%) + (\text{Underinsured} * 10\%)}{(\text{VT Population} * 20\%) + (\text{VT Population below 401\% FPL} * 40\%) + (\text{VT Uninsured} * 30\%) + (\text{VT Underinsured} * 10\%)} \quad | \quad \times 100$$

We also compare both indices to simply allocating resources based purely on the population of each county and region. The following tables provide all three measures of need for each Vermont county and region. See Appendix A for additional data relevant to the index calculations.

### Measures of Vermont Navigator Needs by Region

Region	Portion of VT Population	Simple Needs Based Index	Broad Needs Based Index
Southeast VT	31.5%	32.2	31.9
Burlington Area	32.4%	27.4	30.2
Southwest VT	21.8%	23.4	22.5
Northeast VT	14.2%	17.0	15.5

### Measures of Vermont Navigator Needs by County

County	Portion of VT Population	Simple Needs Based Index	Broad Needs Based Index
Chittenden	24.0%	19.6	22.0
Rutland	10.3%	11.3	10.6
Windsor	9.7%	10.3	9.9
Washington	9.6%	9.0	9.4
Windham	7.6%	8.4	7.9
Franklin	7.2%	6.7	7.0

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Bennington	6.1%	6.6	6.3
Addison	5.5%	5.5	5.5
Caledonia	4.9%	5.8	5.3
Orleans	4.2%	5.3	4.7
Orange	4.7%	4.5	4.7
Lamoille	4.0%	4.3	4.2
Essex	1.1%	1.5	1.3
Grand Isle	1.2%	1.1	1.2

**Findings**

With the possible exception of Chittenden County, the three measures of need do not differ appreciably. Arguably, the Broad Needs Based Index is a more comprehensive measure of need, but it is so close to the simple population measure that Wakely suggests this straightforward measure, using data that are readily available, be used as a guide for reasonable resource allocation across the state. If Vermont chooses to allocate Navigator resources based on a different categorization of regions or districts, we continue to recommend using population as a measure. Both our region and county analysis shows that our index measures do not differ much from a population measure. These results will not likely differ if an alternate categorization is used.

**Additional Considerations**

In addition to population, income, and health insurance status, other regional differences may affect the need for navigators. We examine three such variables: foreign languages spoken, lack of internet access, and sparseness of population. These factors can be viewed as challenges to navigators and additional resources may be required for navigators who serve populations with a high prevalence of these challenges.

The 2010 American Community Survey (ACS) 5-year estimate provides information on household languages spoken and ancestry (see Appendix B for language and ancestry statistics). Based on the household information sourced from ACS earlier in this report and land area data obtained from [vermont.gov](http://vermont.gov), we calculated population density statistics as shown in Appendix C.

The absence of broadband internet connection likely indicates additional navigator requirements in a given area. For example, navigators may need to apply more resources, such as written communication and increased personal assistance, to areas that lack broadband connection. Vermont’s Broadband Mapping Team (BMT) has applied broadband coverage maps to estimate that 94.6% of Vermont’s

## **DRAFT ONLY**

buildings fall within areas that have broadband coverage, as of December 31, 2010.<sup>vi</sup> While, the majority of Vermont has broadband coverage, Vermont may want to consider broadband access when determining Navigator resource allocation. As a reference, Vermont's broadband coverage map as of June 30, 2011 is provided in Appendix D.

While linguistic needs in Chittendon may argue for increased resources, both population density and relatively good broadband coverage argue for less. This county has the lowest English proficiency factor of all counties (91.5%) and is by far the least rural (114.24 population density). If a simple population distribution were used instead of broader, more nuanced indices of need, then a small decrement in resource allocation for Chittendon County or the larger Burlington area may be advisable.

### **Compensation Models and Performance Measurements**

This section is devoted to a discussion of compensation models appropriate to the navigator program and different ways for the exchange to establish and measure performance requirements.

The compensation plan should align with and reinforce the goals of the exchange. For example, the state will want to align performance measurement and incentives with such enrollment goals as maximizing exchange enrollment, and/or minimizing the number of uninsured, and/or informing hard-to-reach populations. The state should also seek alignment with its preferred pathways for enrollment, such as use of its website exclusively, Call Center and website together, walk-ins, and/or outsourcing enrollment to navigators. Additional considerations include the state's larger health care reform agenda, the availability of navigator-like resources across the state, the desire for transparency, necessary protections against fraud, waste and abuse, and timing/volume of peak load. Enrollment goals can be broadly stated (e.g., reduce the percentage of uninsured Vermonters by X % by X dates), or include specific objectives tied to various demographic sub-groups (e.g., reduce the percentage of Vermonters who have been consistently uninsured for five or more years).

Within the compensation structure there should be meaningful performance expectations that can be both measured and verified, and the compensation plan must be affordable without federal dollars. A challenge facing all states is how to pay for this required program, and while this report does not address how the navigator payments will be funded, it does assume that costs must be tightly managed as funding is likely to come from scarce state dollars, exchange operating revenues, private foundation monies or some other source(s) where cost efficiencies are paramount.

There are two basic options for supporting navigators. The exchange can utilize a grant approach or elect to support navigators through a compensation model that would pay a fixed per application fee for successful enrollment activity. There are advantages and disadvantages to both, and each model can include variations. (The ACA refers to navigator "grants" only, but this term has not been defined so narrowly as to exclude performance-based incentives.)

## DRAFT ONLY

The grant option entails providing navigator-like entities with pre-determined funding amounts for an agreed upon set of services, perhaps in a specific area of the state. For example, a grant could be awarded through a competitive RFP to which entities respond by describing how they would provide services in a given geographic area. Entities would compete to be appointed as the navigator entity (or entities) for each area. Or, the state could stipulate the amount of the grants, and entities would submit proposals on how and where they would provide outreach and enrollment services for the particular grant amount. Competition is a key element in this approach. From the exchange's perspective, this approach is likely to encourage innovation and disciplined thinking, as entities hone their plans for outreach and enrollment, and it gives the exchange more control up front in negotiating terms and conditions with applicants. On the other hand, this process favors organizations that are more capable of writing grant applications. This may result in greater funding for more established or larger entities. From the applicant's perspective, a major advantage of grant funding is that it allows grantees to hire staff and cover start-up costs, with predictable revenues. On the down side, an underperforming entity will generally receive all or most of the grant monies; the greatest risk to the entity is non-renewal of the grant in a future year while the risk to the exchange is less than optimal resourcing of scarce dollars.

Another variation on the grant approach is one in which the exchange specifies a grant in the amount of X dollars for providing a set of services. The approach is much more prescriptive than competitive, and any entity that "meets standards" can be awarded funding. Smaller entities that lack the resources to prepare a competitive bid are more likely to be attracted to this approach, and more diversity among grantees is likely to result. The "meets standard" grant could also be combined with a special bonus or incentive that provides entities with an additional payment for every successful enrollment of a member of a particular group (hybrid model). For example, in Vermont, 23.8% of the uninsured captured in the 2009 Household Health Insurance Report were without coverage for five years or longer. As there may be particular challenges in finding and enrolling these individuals, the exchange may want to consider an added bonus when such an individual is enrolled in a QHP through the efforts of a navigator.

The advantages and disadvantages of grant funding are shown in the attached compensation chart.

The second type of model entails the payment of a specified dollar amount for every successful enrollment that can be attributed to the efforts of a navigator entity. In its simplest form, this type of "pay for performance" model may sound attractive, but has some disadvantages. First, from a budgeting perspective, per enrollment fees are much less predictable to both the exchange and the navigators. Second, there may be a temptation for navigators to "cherry pick" easier enrollments, including those that could have been done without their assistance. Third, as the approach rewards actual enrollments, navigators may do less outreach, particularly in the early days when enrollments may be easier to find. Also, navigator entities may resist linking support to achieving specific enrollment targets.

The subject matter experts in outreach and enrollment interviewed for this report strongly favored grant funding over a payment model that would provide a fixed amount of dollars for each successful enrollment.

## DRAFT ONLY

There are also cash flow implications to the two main approaches. Grant funding allows front-loading payments, although the exchange may decide to pay out grants on a quarterly basis. Per enrollment fees cannot be paid in advance although this approach can be combined with cash advances.

Regardless of which compensation model is adopted, the exchange should also consider two supplemental approaches to expanding the reach of the navigator program. First, some organizations with navigator-like expertise may not need or expect added funding to assist Vermonters with enrolling in the exchange. For example, hospitals and physician offices have a built-in incentive to connect patients to health insurance in as much as they financially benefit when they can receive reimbursement for covered care. Such provider groups may be excellent sources of navigator-like support without explicit funding. Another source of unpaid assistance might be state employee who interfaces on a regular basis with the public. These employees would not be expected to be fully versed in all aspects of the eligibility and enrollment processes but they could be tapped to provide referrals to navigators, promote the Call Center 800 telephone number and distribute literature.

Secondly, there are likely to be individuals in Vermont who want to volunteer their time to help connect their fellow citizens with coverage. Provided such volunteers meet certification and training requirements, the exchange should encourage their participation, especially to meet peak-load needs and to encourage a perception of health reform in Vermont as a shared community vision. Volunteers can save the program money in direct support, but they do require oversight and can complicate administration.

Speaking of administration, Vermont could decide that it wants to outsource management of the navigator program to an outside entity, as some states do. It may be politically appealing, easier and less costly to engage an outreach organization embedded in the community to manage the program. Alternatively, the exchange may want more direct control and believe that internal staff is better suited to meeting this objective. Outsourcing would depend upon the capability and reputation of existing resources. If the same outside organization is hired to both run the navigator program and to provide navigator services, Vermont will want to ensure that this approach does not dissuade other navigator-like entities from participating given that their efforts will be overseen by an organization they may regard as a competitor.

Regardless of the compensation model favored, the funding method(s) should incorporate meaningful performance measures to: (1) establish expectations; (2) attain better results; and (3) increase accountability and transparency. A combination of performance measurements should best address these objectives. We offer several measurements for consideration and highlight their advantages and disadvantages in the chart that follows.

The most obvious performance measurement is one that tracks the successful enrollment of applicants into a QHP. There are two variations: (1) an “assisted application” is done in person or over the telephone directly by a navigator; while (2) a “referral” application” can be linked to the initial efforts of a navigator but is completed by Call Center (or customer service) staff or the applicant him/herself. Neither type of assistance should necessarily be valued more but it is important to recognize that both

## DRAFT ONLY

types of help will result in enrollment and therefore need to be factored into the compensation formula. The second most meaningful activity of the navigator is related to the quantity and quality of the outreach and education performed, which can be measured by the number (and location) of outreach events scheduled by the navigator and the number of attendees at each event.

Navigators should also be expected to distribute literature and post signage for the exchange but this is a “soft” requirement that does not lend itself well to formal measurement. Additionally, most navigator entities will have a “grass-tops” representative who should be encouraged to promote the exchange through local speaking engagements and such media events as print, radio and television interviews (a common term in Vermont, “grass-tops” refer to influential, visible leaders of community-based, grassroots organizations). While these efforts cannot be formally measured, they may merit support from the exchange. Performance expectations should include a requirement that if the navigator entity has an existing website that it be used to promote its schedule of activities, forms of assistance, and provide a link to the exchange website. Last, navigator entities should be encouraged to utilize social media (i.e. Facebook, Twitter) to promote the exchange and access to health insurance. While measurement of this type of activity should not be formal, navigators should provide some type of assessment as to how they have utilized it as part of their outreach efforts.

Ideally, the exchange will build (or buy) a navigator application system that is integrated with the eligibility and enrollment system and tracks performance metrics online. While a paper system can be used if needed, it will be far less effective. The exchange needs the ability to run frequent, standard reports on navigator activity to monitor the program effectively, and navigators need the ease and convenience of an online application to track their work.

### Summary

To maximize performance, navigators should be rewarded for helping to achieve broader goals of the reform, and these goals should drive performance measurement and compensation. Unfortunately, neither grants nor per-enrollee payments alone are likely to fully meet this standard. For this reason, we recommend a hybrid compensation model embracing both a grant and a bonus payment per successful enrollment, especially of “high need” populations. This approach offers both a predictable revenue base and incentives to perform, is likely to be well-received by existing navigator-type entities, and accommodates performance requirements that can be both measured and verified.

## Appendix A

Table 3: Vermont Household Data by Region

Region	Households	Households Below 401% FPL	Households Below 251% FPL	Uninsured Households	Underinsured Households
Burlington Area	83,140	52,671	35,246	6,343	19,689
Northeast VT	36,553	28,397	20,677	5,158	10,845
Southwest VT	56,044	39,461	28,385	7,148	18,307
Southeast VT	80,875	56,469	39,287	9,596	22,507
<b>Vermont Total</b>	<b>256,612</b>	<b>176,998</b>	<b>123,595</b>	<b>28,245</b>	<b>71,348</b>

Table 4: Vermont Household Data by County

County	Households	Households Below 401% FPL	Households Below 251% FPL	Uninsured Households	Underinsured Households
Addison	14,080	9,462	6,280	2,112	4,090
Bennington	15,559	11,094	8,137	1,867	6,201
Caledonia	12,581	9,826	7,360	1,510	3,431
Chittenden	61,581	37,872	25,433	4,311	15,595

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Essex	2,842	2,387	1,813	483	894
Franklin	18,482	12,753	8,557	1,663	3,602
Grand Isle	3,077	2,046	1,255	369	492
Lamoille	10,345	7,459	4,893	1,655	2,917
Orange	11,967	8,329	5,732	1,077	3,826
Orleans	10,785	8,725	6,611	1,510	3,602
Rutland	26,405	18,906	13,968	3,169	8,016
Washingt on	24,621	16,471	11,030	2,708	6,303
Windham	19,483	14,281	10,345	2,338	5,528
Windsor	24,804	17,388	12,179	3,473	6,851
<b>Vermont Total</b>	<b>256,612</b>	<b>176,998</b>	<b>123,595</b>	<b>28,245</b>	<b>71,348</b>

Table 5: Vermont Household FPL Distribution

<b>FPL Range</b>	<b>Households</b>	<b>% of VT Households</b>
<b>All income levels</b>	256,612	100%
<b>&lt; 138% FPL</b>	58,379	23%
<b>139% FPL to 250% FPL</b>	65,216	25%
<b>251% FPL to 400% FPL</b>	53,403	21%
<b>139% FPL to 400% FPL</b>	118,619	46%

Table 6: Household FPL Distribution by Region

<b>Region</b>	<b>FPL Range</b>	<b>Households</b>
<b>Burlington Area</b>	<b>All income levels</b>	83,140
	<b>&lt; 138% FPL</b>	16,059
	<b>139% FPL to 250% FPL</b>	19,187
	<b>251% FPL to 400% FPL</b>	17,426
	<b>139% FPL to 400% FPL</b>	36,613
<b>Northeast VT</b>	<b>All income levels</b>	36,553
	<b>&lt; 138% FPL</b>	10,460
	<b>139% FPL to 250% FPL</b>	10,217
	<b>251% FPL to 400% FPL</b>	7,719

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	<b>139% FPL to 400% FPL</b>	17,937
<b>Southwest VT</b>	<b>All income levels</b>	56,044
	<b>&lt; 138% FPL</b>	12,945
	<b>139% FPL to 250% FPL</b>	15,440
	<b>251% FPL to 400% FPL</b>	11,076
	<b>139% FPL to 400% FPL</b>	26,516
<b>Southeast VT</b>	<b>All income levels</b>	80,875
	<b>&lt; 138% FPL</b>	18,916
	<b>139% FPL to 250% FPL</b>	20,371
	<b>250% FPL to 400% FPL</b>	17,182
	<b>138% FPL to 400% FPL</b>	37,554

Table 7: Household Distribution by County

<b>County</b>	<b>FPL Range</b>	<b>Households</b>
<b>Addison</b>	<b>All income levels</b>	14,080
	<b>&lt; 138% FPL</b>	2,605
	<b>138% FPL to 250% FPL</b>	3,675
	<b>250% FPL to 400% FPL</b>	3,182
	<b>138% FPL to 400% FPL</b>	6,857
<b>Bennington</b>	<b>All income levels</b>	15,559
	<b>&lt; 138% FPL</b>	3,765
	<b>138% FPL to 250% FPL</b>	4,372
	<b>250% FPL to 400% FPL</b>	2,956
	<b>138% FPL to 400% FPL</b>	7,328
<b>Caledonia</b>	<b>All income levels</b>	12,581
	<b>&lt; 138% FPL</b>	3,586
	<b>138% FPL to 250% FPL</b>	3,774
	<b>250% FPL to 400% FPL</b>	2,466
	<b>138% FPL to 400% FPL</b>	6,240
<b>Chittenden</b>	<b>All income levels</b>	61,581
	<b>&lt; 138% FPL</b>	11,639
	<b>138% FPL to 250% FPL</b>	13,794
	<b>250% FPL to 400% FPL</b>	12,439
	<b>138% FPL to 400% FPL</b>	26,234
<b>Essex</b>	<b>All income levels</b>	2,842
	<b>&lt; 138% FPL</b>	986
	<b>138% FPL to 250% FPL</b>	827
	<b>250% FPL to 400% FPL</b>	574

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	<b>138% FPL to 400% FPL</b>	1,401
<b>Franklin</b>	<b>All income levels</b>	18,482
	<b>&lt; 138% FPL</b>	3,918
	<b>138% FPL to 250% FPL</b>	4,639
	<b>250% FPL to 400% FPL</b>	4,195
	<b>138% FPL to 400% FPL</b>	8,834
<b>Grand Isle</b>	<b>All income levels</b>	3,077
	<b>&lt; 138% FPL</b>	502
	<b>138% FPL to 250% FPL</b>	754
	<b>250% FPL to 400% FPL</b>	791
	<b>138% FPL to 400% FPL</b>	1,545
<b>Lamoille</b>	<b>All income levels</b>	10,345
	<b>&lt; 138% FPL</b>	2,545
	<b>138% FPL to 250% FPL</b>	2,348
	<b>250% FPL to 400% FPL</b>	2,566
	<b>138% FPL to 400% FPL</b>	4,914
<b>Orange</b>	<b>All income levels</b>	11,967
	<b>&lt; 138% FPL</b>	2,513
	<b>138% FPL to 250% FPL</b>	3,219
	<b>250% FPL to 400% FPL</b>	2,597
	<b>138% FPL to 400% FPL</b>	5,816
<b>Orleans</b>	<b>All income levels</b>	10,785
	<b>&lt; 138% FPL</b>	3,343
	<b>138% FPL to 250% FPL</b>	3,268
	<b>250% FPL to 400% FPL</b>	2,114
	<b>138% FPL to 400% FPL</b>	5,382
<b>Rutland</b>	<b>All income levels</b>	26,405
	<b>&lt; 138% FPL</b>	6,575
	<b>138% FPL to 250% FPL</b>	7,393
	<b>250% FPL to 400% FPL</b>	4,938
	<b>138% FPL to 400% FPL</b>	12,331
<b>Washington</b>	<b>All income levels</b>	24,621
	<b>&lt; 138% FPL</b>	5,294
	<b>138% FPL to 250% FPL</b>	5,737
	<b>250% FPL to 400% FPL</b>	5,441
	<b>138% FPL to 400% FPL</b>	11,178
<b>Windham</b>	<b>All income levels</b>	19,483
	<b>&lt; 138% FPL</b>	5,007
	<b>138% FPL to 250% FPL</b>	5,338

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	<b>250% FPL to 400% FPL</b>	3,936
	<b>138% FPL to 400% FPL</b>	9,274
<b>Windsor</b>	<b>All income levels</b>	24,804
	<b>&lt; 138% FPL</b>	6,102
	<b>138% FPL to 250% FPL</b>	6,077
	<b>250% FPL to 400% FPL</b>	5,209
	<b>138% FPL to 400% FPL</b>	11,286

Table 8: Uninsured Rate by Region

<b>Region</b>	<b>Uninsured Rate</b>
Burlington Area	6%
Northeast VT	12%
Southwest VT	10%
Southeast VT	10%

Table 9: Uninsured Rate by County

<b>County</b>	<b>Uninsured Rate</b>
Addison	15%
Bennington	12%
Caledonia	12%
Chittenden	7%
Essex	17%
Franklin	9%
Grand Isle	12%
Lamoille	16%
Orange	9%
Orleans	14%
Rutland	12%
Washington	11%
Windham	12%
Windsor	14%

Table 10: Underinsured by Region

<b>Region</b>	<b>Underinsured Rate</b>
Burlington Area	24%
Northeast VT	29%

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Southwest VT	32%
Southeast VT	28%

Table 11: Underinsured by County

County	Underinsured Rate
Addison	25%
Bennington	34%
Caledonia	24%
Chittenden	23%
Essex	8%
Franklin	18%
Grand Isle	0%
Lamoille	21%
Orange	23%
Orleans	30%
Rutland	28%
Washington	20%
Windham	17%
Windsor	26%

**Appendix B**

Table 12: Language spoken at home, population over 5 years old – By Region

Region	English only	Language other than English		Spanish		Other Indo-European languages		Asian and Pacific Islander languages		Other languages	
		Total	Speak English less than "very well"	Total	Speak English less than "very well"	Total	Speak English less than "very well"	Total	Speak English less than "very well"	Total	Speak English less than "very well"
<b>Burlington Area</b>	#	1832	14,873	2,138	673	9,195	2,616	2,765	1,625	775	352
	%	92.5%	7.5%	1.1%	0.3%	4.6%	1.3%	1.4%	0.8%	0.4%	0.2%
<b>Northeast VT</b>	#	7995	4,057	709	170	3,127	730	168	33	530	14
	%	95.2%	4.8%	0.8%	0.2%	3.7%	0.9%	0.2%	0.0%	0.6%	0.0%
<b>Southwest</b>	#	1243	5,35	1,41	414	3,15	621	549	183	23	29
	%	95.2%	4.3%	1.1%	0.3%	3.7%	0.9%	4.0%	1.3%	0.2%	0.2%



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				%	%	%	%					
Orange	#	26,862	700	140	237	60	378	49	59	31	26	0
	%	97.5%	2.5%	0.5%	0.9%	0.2%	1.4%	0.2%	0.2%	0.1%	0.1%	0.0%
Orleans	#	24,084	1,722	410	209	68	1,470	323	250	8	18	11
	%	93.3%	6.7%	1.6%	0.8%	0.3%	5.7%	1.3%	0.1%	0.0%	0.1%	0.0%
Rutland	#	57,339	2,052	364	548	126	220	163	141	53	43	22
	%	96.5%	3.5%	0.6%	0.9%	0.2%	2.1%	0.3%	0.1%	0.1%	0.2%	0.0%
Washington	#	53,634	2,591	794	552	109	1,671	548	304	112	64	25
	%	95.4%	4.6%	1.4%	1.0%	0.2%	3.0%	1.0%	0.5%	0.2%	0.1%	0.0%
Windham	#	40,260	2,055	324	785	97	974	148	180	75	16	4
	%	95.1%	4.9%	0.8%	1.9%	0.2%	2.3%	0.3%	0.4%	0.2%	0.3%	0.0%
Windsor	#	52,044	2,049	552	649	230	1,143	241	231	81	26	0
	%	96.2%	3.8%	1.0%	1.2%	0.4%	2.1%	0.4%	0.4%	0.1%	0.0%	0.0%

Table 14: Ancestry Population by County

Ancestry	County													
	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
American	7.5%	5.9%	4.9%	6.7%	7.4%	8.5%	10.3%	4.6%	7.3%	8.3%	5.7%	4.6%	8.2%	8.3%
Arab	0.3%	0.7%	0.3%	0.6%	0.0%	0.4%	0.4%	0.2%	0.3%	0.1%	0.2%	0.6%	0.4%	0.3%
Czech	0.6%	0.6%	0.1%	0.4%	0.1%	0.2%	0.1%	0.4%	0.5%	0.1%	0.7%	0.3%	0.5%	0.5%
Danish	0.5%	0.3%	0.2%	0.4%	0.1%	0.3%	0.1%	0.2%	0.4%	0.3%	0.3%	0.4%	0.5%	0.1%
Dutch	3.0%	2.3%	0.9%	1.7%	0.5%	1.3%	1.3%	0.8%	1.2%	0.9%	1.7%	0.8%	1.5%	2.2%
English	18.1%	17.1%	21.2%	15.3%	23.1%	14.8%	18.0%	18.3%	22.4%	23.4%	16.1%	16.9%	21.7%	23.2%
French (except Basque)	17.8%	14.8%	16.3%	13.6%	24.5%	25.2%	18.3%	15.2%	14.7%	14.9%	17.2%	13.2%	12.3%	13.5%
French Canadian	7.2%	5.5%	9.9%	9.1%	10.2%	12.4%	10.6%	7.7%	7.1%	19.2%	5.2%	8.0%	4.9%	5.6%

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German	12.0%	13.9%	8.5%	10.9%	6.6%	7.4%	10.3%	10.2%	10.4%	7.4%	10.0%	9.0%	11.7%	11.8%
Greek	0.4%	0.8%	0.6%	0.6%	0.2%	0.1%	0.0%	0.1%	0.7%	0.1%	0.3%	0.2%	0.5%	0.4%
Hungarian	0.4%	0.6%	0.3%	0.5%	0.0%	0.2%	0.1%	0.2%	0.4%	0.1%	1.2%	0.4%	0.6%	0.6%
Irish	17.2%	18.8%	16.6%	19.1%	15.8%	16.2%	14.2%	16.5%	16.5%	11.2%	22.6%	14.4%	21.8%	17.3%
Italian	5.9%	9.8%	4.9%	8.5%	4.1%	4.7%	4.6%	4.9%	6.5%	4.2%	10.7%	7.7%	8.6%	7.6%
Lithuanian	0.3%	0.4%	0.3%	0.6%	0.2%	0.2%	0.3%	0.3%	0.2%	0.2%	0.2%	0.3%	0.6%	0.3%
Norwegian	1.1%	0.9%	1.0%	0.9%	0.4%	0.2%	0.9%	0.6%	1.2%	0.6%	0.8%	0.8%	0.8%	1.2%
Polish	3.1%	3.9%	2.4%	4.3%	1.9%	2.4%	2.1%	4.1%	3.5%	1.5%	6.7%	2.4%	5.5%	4.9%
Portuguese	0.3%	0.2%	1.1%	0.4%	0.7%	0.3%	0.3%	0.8%	1.1%	0.3%	0.4%	0.2%	0.8%	0.9%
Russian	1.4%	1.6%	0.8%	1.7%	0.1%	0.6%	0.7%	1.1%	1.0%	0.6%	0.9%	1.6%	2.1%	1.5%
Scotch-Irish	2.1%	2.8%	3.1%	2.4%	2.9%	1.6%	2.5%	3.3%	3.3%	2.2%	2.8%	3.0%	3.2%	3.2%
Scottish	5.3%	4.2%	6.7%	4.4%	5.8%	4.2%	6.9%	4.2%	6.5%	5.0%	3.6%	6.0%	4.5%	6.1%
Slovak	0.1%	0.2%	0.2%	0.3%	0.1%	0.0%	0.3%	0.4%	0.2%	0.1%	0.1%	0.1%	0.2%	0.1%
Subsaharan African	0.3%	0.2%	0.1%	0.7%	0.0%	0.1%	0.0%	0.1%	0.2%	0.0%	0.1%	0.2%	0.2%	0.2%
Swedish	1.5%	1.7%	1.7%	1.6%	1.4%	0.8%	1.9%	1.5%	2.6%	0.9%	2.7%	1.7%	3.0%	2.3%
Swiss	0.3%	0.3%	0.3%	0.4%	0.2%	0.2%	0.3%	0.1%	0.5%	0.2%	0.2%	0.3%	0.4%	0.5%
Ukrainian	0.3%	0.5%	0.4%	0.3%	0.0%	0.1%	0.2%	0.0%	0.2%	0.2%	0.2%	0.2%	0.7%	0.2%
Welsh	1.6%	1.3%	0.7%	1.2%	0.5%	0.7%	0.9%	0.6%	1.4%	0.5%	2.9%	0.9%	1.2%	1.1%
West Indian (excluding Hispanic origin groups)	0.1%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%

**Appendix C**

Table 15: Population Density by Region

Region	Population Density		
	Households	Square Miles	(Households/ sq. mile)
Burlington Area	83,140	1,259	66.05
Northeast VT	36,553	2,474	14.77
Southwest VT	56,044	2,379	23.56
Southeast VT	80,875	3,137	25.78
<b>Vermont Total</b>	<b>256,612</b>	<b>9,250</b>	<b>27.74</b>

Table 16: Population Density by County

Population Density
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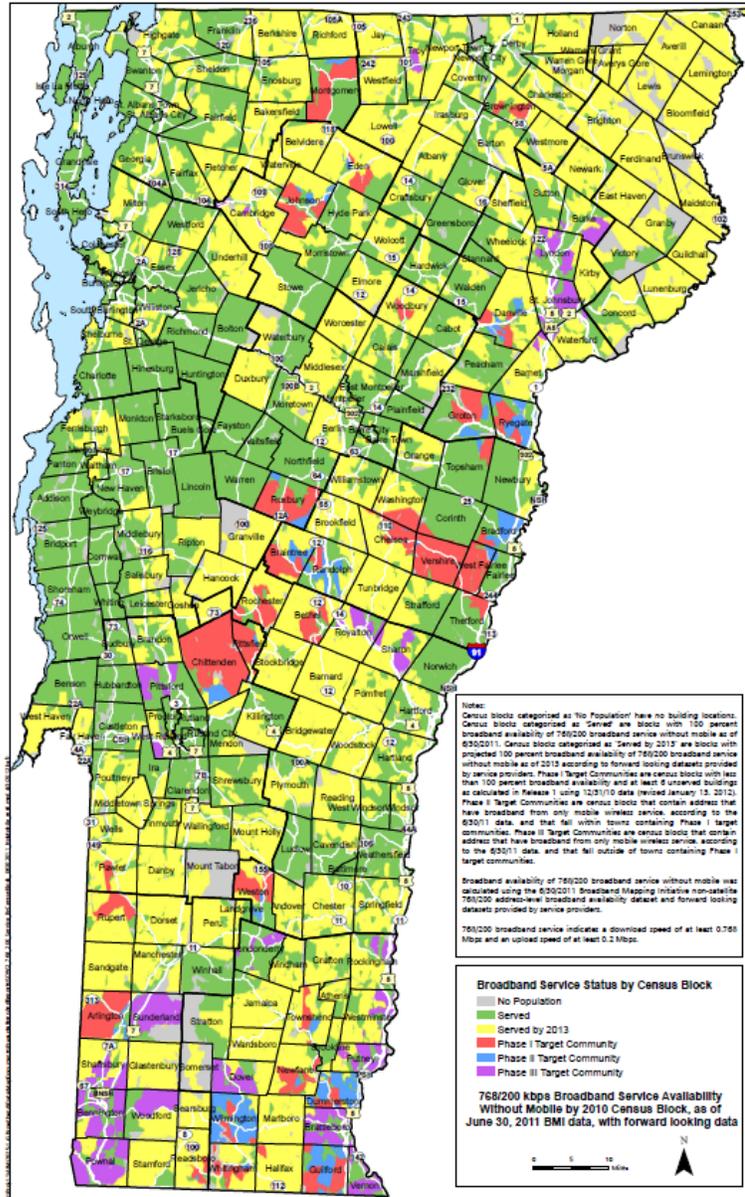
<b>County</b>	<b>Households</b>	<b>Square Miles</b>	<b>(Households/ sq. mile)</b>
Addison	14,080	770	18.28
Bennington	15,559	676	23.01
Caledonia	12,581	651	19.34
Chittenden	61,581	539	114.24
Essex	2,842	665	4.27
Franklin	18,482	637	29.01
Grand Isle	3,077	83	37.24
Lamoille	10,345	461	22.44
Orange	11,967	689	17.38
Orleans	10,785	698	15.46
Rutland	26,405	933	28.32
Washington	24,621	689	35.73
Windham	19,483	789	24.70
Windsor	24,804	971	25.55
<b>Vermont Total</b>	<b>256,612</b>	<b>9,250</b>	<b>27.74</b>

(Source of land areas: <http://libraries.vermont.gov/sites/libraries/files/html/townareas.htm>)

# Appendix D

## Broadband Coverage Map

768/200 Kbps Broadband Availability Excluding Mobile Service Served, Projects in Progress, and Target Communities Mapping Initiative Release 2



Source: This dataset was developed by Stone Environmental using the non-satellite 768/200 address level broadband availability dataset without mobile developed by the Broadband Mapping Initiative (BMI). The BMI, a collaboration of VCCS, the VT DPS, and the VTA, is funded through a USDO grant from the NITA. Forward looking data was provided by broadband service providers. 2010 census blocks (US Census Bureau), Wire center boundaries (VCCS), Administrative boundaries, VCCS. Release 2, April 3, 2012.

STONE ENVIRONMENTAL INC  
produced for the State of Vermont

(Source: [http://www.broadbandvt.org/sites/www.broadbandvt.org/files/v2%202012ConnectVT\\_map.pdf](http://www.broadbandvt.org/sites/www.broadbandvt.org/files/v2%202012ConnectVT_map.pdf))

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<sup>i</sup> Zane Benefits, “PCIP Kills Broker Referral Program”

<http://www.zanebenefits.com/blog/bid/135326/PCIP-Kills-Broker-Referral-Program> (20 Jun 2012).

<sup>ii</sup> Maryland Health Insurance Plan. <http://getmdhealthcare.com/navigators/>

<sup>iii</sup> Cohen, Mindy and Coughlin, Teresa. “A Race to the Top: Illinois’s All Kids Initiative”. Kaiser Family Foundation, August 2007. <http://www.kff.org/uninsured/upload/7677.pdf>

<sup>iv</sup> California Health Families Program. “Enrollment Entity (EE) Reimbursements.”

[http://www.healthyfamilies.ca.gov/EEs\\_CAAs/Reimbursement.aspx](http://www.healthyfamilies.ca.gov/EEs_CAAs/Reimbursement.aspx).

<sup>v</sup> Evers, Mark; McGee Jeanne. “Suggestions for Improving the Health Kids Application Process: A Summary of Findings from Four Evaluation Research Studies”. April 2011.

<sup>vi</sup> “VT Broadband Statistics: Statewide Statistics – Service as of December 31<sup>st</sup>, 2010” Version 1b (Final), 5/9/2011.

[http://www.broadbandvt.org/sites/www.broadbandvt.org/files/file/pdfmaps122010/BroadbandStats\\_12312010\\_Statewide\\_768\\_200\\_v1b\\_Final.pdf](http://www.broadbandvt.org/sites/www.broadbandvt.org/files/file/pdfmaps122010/BroadbandStats_12312010_Statewide_768_200_v1b_Final.pdf)