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Research Report

Task 9: Opinions of Non-Profit Organizations in Vermont on Implementation of the Patient Provider and Affordable Care Act

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Key Findings

Engagement

The representatives at non-profits we spoke with were generally enthusiastic about the Patient Provider and Affordable Care Act and are anxiously anticipating the expansion of heath insurance affordability in 2014.

Familiarity with the Act

Representatives were mostly somewhat to very familiar with the Patient Provider and Affordable Care Act.

Some were already assisting clients with taking advantage of new features such as the expansion of coverage to adult children or the disallowance of pre-existing conditions as a reason the deny coverage to children.

Some were familiar with the Act because of their organization's involvement in the national debate on the Act as Congress was developing it.

Others were involved in the process to implement the Act in Vermont.

Impact of the Act on Non-Profit Organizations Involved with Under and Uninsured

Most were pleased that the Act was intended to increase the options for insurance and the affordability of insurance. They anticipated that their organization would be involved in some way in educating, encouraging or enrolling the uninsured and underinsured.

For those that are currently assisting the uninsured or underinsured there was both anticipation and trepidation. They thought that insurance offerings would change significantly, creating the need to both transition the insured to the new system and to educate and enroll a new population: those who were not now insured.

Those that currently work with the uninsured were concerned that policy makers not underestimate the difficulty of enrolling the uninsured. They point out that the uninsured tend to think of health insurance in very simple terms (coverage and cost) but the details of eligibility and insurance are actually quite complex.

Providing Information to the Under and Uninsured.

All thought that there needed to be wide ranging approaches to providing information, including a web portal, a call in phone bank and face-to-face assistance. Most did not think that a web portal would be successful in meeting most needs. One-on-one assistance was thought to be necessary for most of the under and uninsured.

Some thought that it was best to provide this one-on-one assistance over the phone. They noted that an enrollee would probably not bring all the necessary documents (Social Security numbers, pay stubs, income tax returns, etc.) to a face-to-face visit. These same people could call in, determine what information was needed, find the information and provide it.

Those that thought that many would want and need a face-to-face visit pointed out that working with an advocate (or navigator) required trust and this could best be built face- to-face. Others noted that in their experience, older enrollees preferred meeting directly, and some of the uninsured would find the enrollment process so complicated that they would not enroll without personal face-to-face assistance.

There was agreement that the web be used to supplement the information provided on the phone or in person. It was noted that some the uninsured might not be computer or web savvy or might not have computer access.

It was suggested that all information about the plans and enrollment should be available online. This would allow enrollees to become familiar with the information before they call and would allow an advocate at a call center to refer to information immediately. They suggested that information be printable, so those that wanted to see hard copies could do so.

Information Challenges

Non-profits that had worked with the uninsured and underinsured suggested that helping enrollees understand their options and to understand their eligibility were the key challenges. They suggested that changes to state health insurance programs would present all the same challenges as enrolling individuals new to health insurance. Both those changing insurance and those becoming insured will need education and assistance.

The task will be made more difficult by the inexperience of the uninsured with the language and structure of health insurance. The uninsured look at health insurance from the straightforward perspective of their own needs – primarily three things,

1. What the insurance would cost them
2. What would be covered
3. Whether they could see a doctor of their choosing or whether choice was somehow restricted

The aspects of plans that can affect these three priorities will need to be explained in simple language and individuals will need assistance making the choice that is best for them.

Providing Information on Subsidies

Since information on health insurance subsides, tax credits and other assistance may be complex and based on individual income, it was thought that this information needed to be provided by or with an advocate's assistance.

Those with experience serving the under and uninsured noted that many have irregular income streams that vary by season, rely on part-time jobs, or include income from self employment. Having an experienced advocate providing assistance sorting through the income eligibility criteria will be necessary.

Post-Enrollment Customer Service

Suggestions for providing after enrollment customer service included insurance companies, a public agency or a mix of the two. Some recognized that insurers served this function well and existing organizations such as the Vermont Office of Health Care Ombudsman help to protect consumers. Some preferred that all customer service be provided by public entities that did not have a financial interest in denying payment. Some noted that the navigator would naturally become an option for those who enrolled through them.

The Navigator Role

All participants in the research agreed that the navigator role was a critical one. They agreed that insurance and fit with individual needs was too complex to be handled without one-on-one assistance.

Most described the navigator as an advocate, distinguishing navigators from just information providers or clerks that assemble applications. Advocates were seen as providing whatever assistance is necessary to help an insurance enrollee make a decision. Since the uninsured are unfamiliar with the health care systems and resources, some thought that an advocate should also steer individuals to providers or to other health care services once enrollment was complete.

Qualifications for Navigators

Common expectations for navigators included:

1. Detailed understanding of options for eligibility and for coverage of state and government health care programs; Medicaid, VHAP and Catamount. This would allow a navigator to represent all options and understand the difference between new and existing insurance programs.

2. Experience serving the uninsured. This would give the navigator an understanding of the kind of questions to expect and how to address frequent problems. One common problem is the variable nature of income streams for the uninsured. Many work part time or seasonal jobs or are partly or wholly self-employed. This makes it difficult to determine eligibility.

3. Experience serving as an advocate. This assures that the attitude of the navigator is one of a helper, not just providing information but helping potential enrollees sort through options and pick the one that best meets their need.

4. Impartiality. Most thought that the navigator should have no financial stake in or benefit from the insurance chosen. For this reason, most thought insurance brokers or those who worked for an insurance company should be disqualified from the navigator role.

Organizations that could be Navigators

Only some of the non-profits could mention an agency that might be appropriate to be navigators. If a respondent could not think of a non-profit to perform this function, they thought of a government agency. Some thought that there could be more than one navigator with each serving the population that they customarily provide services to. An example is an organization serving disabled clients. Some suggested that organizations providing healthcare services should have a role as they have an incentive to process. Those that were currently assisting the uninsured with obtaining access, nominated themselves for this role. Two organizations, Vermont Campaign for Health Care Security and the Coalition of Clinics for the Uninsured (or rural and free health care clinics) were mentioned by two or more non-profits as potential navigators.

- *Vermont Campaign for Health Care Security*. Has experience enrolling the uninsured through its work with Catamount.

- *Coalition of Clinics for the Uninsured*. Is often the first contact for the uninsured as they look for health care. Has intake staff to assist uninsured with enrolling in state programs. They also steer clients to appropriate providers.

- *Vermont Psychiatric Survivors*. This organization currently provides services to enroll clients in state health insurance programs.

- *Bi-State Primary Care Association*. Represents rural health care clinics that identify individuals at the time care is sought and match them with programs they may be eligible for.

- *National Education Association – Vermont*. This organization provides insurance for all public schools, which may be superseded by the Exchange. If so, they can bring a staff that is trained in enrolling individuals to healthcare.

Coordinating Enrollment in New Programs with Existing Programs

There was general agreement that adding new heath insurance programs to the existing programs (Medicaid, VHAP and Catamount) will add confusion. Some enrollees now move from VHAP to Catamount as their income changes, and this creates gaps in coverage. All potential enrollees to health insurance would in the future need to be screened for eligibility in several insurance options. The difficulty of this underscores the need for the navigator function.

Role of the Exchange in Setting Health Care Policy

Most agreed that the Exchange should inform health care policy. Those on the ground assisting the uninsured will bring practical lessons that should be used to improve the programs. Most saw an ongoing need for program improvement driven by field experience.

Coordinating Non-Profit Enrollment Activity

It was widely agreed that many different non-profit organizations will be contact points for the uninsured and that making them part of the enrollment "system" would be helpful in reaching different parts of the uninsured population.

Respondents suggested training to bring them up to speed about the insurance options and some kind of facilitating staff or organization to keep them informed. One respondent described coordinating non-profits as a "Holy Grail" and concrete suggestions on how to assure coordination were limited.

Funding the Exchange

Most thought that the Exchange ought to be funded through multiple sources. Some mentioned a premium on health insurance and others mentioned health taxes such as the tobacco tax and a new sugar sweetened drink tax. Some thought that funding should come from general appropriations, though this was thought to be the least stable source and the one most affected by politics.

Methodology

Data collection for this research consisted of a series of fourteen (14) in-depth interviews among staff at non-profits in Vermont that were considered stakeholders to the expansion of health insurance to the uninsured. Most of the organizations either provided service to the uninsured or supported organizations that did.

A list of twenty-one (21) stakeholders was provided by the state and Market Decisions staff contacted each by e-mail and telephone to set up interviews.

A total of fourteen interviews were completed with the following organizations:

1. American Cancer Society
2. American Civil Liberties Union
3. American Heart Association – Vermont Chapter
4. Bi-State Primary Care Association
5. Central Vermont Adult Basic Education
6. Coalition of Clinics for the Uninsured
7. Consultant & Author
8. National Education Association – Vermont
9. Planned Parenthood of Northern New England
10. Vermont Center for Independent Living
11. Vermont Legal Aid
12. VT Campaign for Health Care Security
13. VT Office of Health Care Ombudsman
14. VT Psychiatric Survivors

Only those that cancelled their scheduled interview times or did not return repeated phone calls and e-mails were not interviewed. These organizations include:

1. American Association of Retired Persons
2. Health Care is a Human Right Campaign
3. National Alliance on Mental Illness
4. Vermont Health Care for All
5. Vermont Workers Center
6. VT Citizens Campaign for Health
7. VT Public Interest Research Group

The interview questions were developed by Market Decisions and reviewed by the state. Curtis Mildner and Brian Brinegar conducted all interviews, which ranged in length from about 20 minutes to more than an hour. All interviews took place between March 21 and April 8, 2011.

Interviews were recorded with respondents' permission and then reported in a "notes style" format as the detailed findings in this report.

Detailed Findings

Background of Participants in Research

Q1: Please tell me a bit about how your organization serves or has interaction with the uninsured in Vermont.

- *Have uninsured members, people we call educational support, para-educators, clerical staff, bus drivers, etc. Founding member of Vermont Campaign for Healthcare Security.*

- *Healthcare Ombudsman Project, help with individual cases of uninsured how they could be covered and policy advocacy to improve the system.*

- *I'm not connected with an organization: I work independently. I have written about health care, co authored books, and I advised governors on it. It has been something of serious interest for the last 20 years.*

- *In existence since 2006. Help Vermonters learn about and get enrolled in state heath care programs. Originally had staff around the state and gave presentations to non-profits. Have statewide toll free numbers to talk to staff about enrolling in state programs. We have a website, detailed and organized about all the programs. One can download an application or they can link to the state website to apply online. We provide help over the phone or in person if the person needs it.*

- *Our mission is to improve access and the quality of care for low income underserved individuals. Our membership included federally qualified health centers, area health education centers and free clinics.*

- *Our office helps Vermonters with any kind of problem with health insurance, health care problem. We were created by the legislature. We help the insured and the uninsured. Most callers have insurance – our name is on commercial notice.*

- *We are a free clinic program, over 70% uninsured patients or the rest are underinsured they have high deductible plans and can't afford healthcare. They come to see us because they know us. We also see Medicaid VHAP patients who have fallen off. Or we see dental patient who are not covered.*

- *We are a statewide disability rights organization. These are folks that are trying to get back in the workforce, they lost Medicaid and they have a gap in coverage.*

- *We are focused on meeting the needs of cancer patients. We provide support for those in treatment, we provide transportation to treatment, we provide lodging for patients receiving outpatient treatment and we have a patient navigator who works individually with cancer patients through their treatments. Some 8% of our patients are uninsured or on Medicaid.*

- *We deliver adult education and literacy services in Washington and Lamoille County Vermont. These are free programs sponsored by the state, towns and private donors. We see the correlation between literacy and health – reading health care documents, understanding doctor's orders is a problem.*

- *We have an advocacy role, lobbying for policy.*

- *We have little interaction with the uninsured. Our organization handles constitutional issues, and health care is not a constitutional right. We do get involved when a class of people are adversely affected.*

- *We operate ten facilities in Vermont that provide reproductive health services. All of them have sliding fee scales and 70% of patients are at 150% of poverty level and below.*

- *We work with people with mental health issues. Often when they come to us they are uninsured so we work with them to find ways to get the services they need.*

Awareness and Understanding of Patient Provider and Affordable Care Act

Q2: Overall, how familiar would you say you are with the new Federal Health Insurance Act called the Patient Provider and Affordable Care Act? What have you heard?

- *Between somewhat and very; have heard nothing from our members except those who have benefits from extended dependency coverage for adult children up to age 26. That demographic is very grateful. Have heard nothing negative. NEA strongly involved. NEA did a series of Webinars.*

- *Somewhat familiar, close to very familiar, but it's a big bill. I know states need to set up Exchanges or the feds will set one up for them. There are some patient protections that have already been put into place. We get a grant under the Act to provide consumer assistance. There is a timeline for when things have to happen.*

- *Somewhat familiar. I followed the debate in congress. My wife is involved in health care policy work. As an employer I have to deal with health care benefits.*

- *Somewhat familiar. I know about the health Exchanges. I know about the federal Medicaid matches. I know about pre-existing conditions clauses. The health insurance mandates.*

- *Somewhat familiar. My retention varied depends on the part of the bill. The intention to improve access would be accomplished through the health benefit Exchange and through subsidies. There will be choice of plans. We're interested in the quality improvement aspects of the bill.*

- *Somewhat familiar. Most familiar with pieces that affect us. A lot of it is a moving target. New – we're trying to figure it out.*

- *Somewhat unfamiliar. The Act will help a lot with folks with disabilities, the things that are covered, pre-existing conditions would be covered. There's a provision for ADRCs, and there's a provision about physician-assisted suicide, which we are concerned about. We know it covers young adults longer.*

- *Somewhat/modestly familiar. I haven't poured through the Act.*

- *Very familiar*

- *Very familiar*

- *Very familiar. I have been tracking it.*

- *Very unfamiliar. I'm very far away from being close to an informed person about health insurance options. I know parents can keep children on their health plans until they are 26, and health plans can't refuse coverage to children with pre-existing conditions.*

- *Very/pretty familiar. Since part of our mission is increasing access to healthcare to decrease cancer deaths, ACS was involved on lobbying at the federal level. We are concerned about what will happen in the state. We want to see mandates stay in place.*

Impact of Patient Provider and Affordable Care Act on Non-Profit

Q3: What do you see as the impact of the PPACA on those for which your agency/organization/business provides services?

- *Anytime there is change it is hard for people. Depending on how they are set up, if it is easier for people to use then it would be a good thing. Otherwise I'd be apprehensive. We have a lot of people struggling with computer stuff rather than person-to-person.*

- *Because Vermont has been so progressive I don't see much effect. But if we get the waivers we are seeking for a single payer system we will see more of an effect, a gradual effect. Biggest problem is that people who are uninsured tend to have unstable incomes. If we don't stabilize income streams – we will have problems.*

- *For heart and stroke patients this will be very significant.*

- *For us it will have a big impact. We see a lot of folks at the 150% of poverty level so these people will be able to access insurance through the Exchange. The expansion of Medicaid will be huge. We see a lot of patients for whom we don't get paid. Now many of our patients will have a payer source.*

- *Involved mainly through policy work, how it would help people, how it would be implemented. Already helping people with new provisions, coverage for young adults, children with pre-existing conditions. When coverage comes in it will cover a different group of people –Medicaid expansion programs would have to be changed. People will be moving to different coverage, those who are not covered will be covered for the first time. There will be lot of questions, eligibility and access.*

- *It's a good thing for Vermont consumers, but I am worried about the complexity. Ultimately it could help quite a few people, but the level of confusion could be high.*

- *It's the law, we didn't lobby but once it became law we suggested that Catamount Health became the high-risk pool. That's why we became involved in the act. Eventually the Exchange will be created, that will affect what we offer. It has already affected us, insurance to age 26, no pre-existing conditions for children under 19. Those specific requirements now apply to Catamount. We are looking forward to the time, 2014, when 28,000 people will be looking to sign up for a health plan. We want to help planning for the outreach and enrollment to see that that works for people.*

- *Its primary purpose is to cover more Americans. I am not convinced that the budget they have put together will reduce the cost of health care. There are short-term provisions that will be helpful like eliminating pre-existing conditions, expanding coverage to young people age 26. It required much of the states with deadlines.*

- *On a positive note we have expanded coverage to Children under 26. We are a founding member of VEHI, or Vermont Education Health Initiative, largest insurance pool covers every school in Vermont, 42,000. Includes 4400 retirees. We are ourselves on the school demographic. Setting up Exchanges will have impact on VEHI – concerned whether VEHI will continue after Exchanges. Bill has less of an impact – rather than how it is being implemented in Vermont.*

- *The pre-existing condition piece will be great. This has been a barrier for so long. There are provisions in the Act for home and community based services things that keep people living in their homes as apposed to nursing homes and institutions.*

- *We are excited about the Act. [It] will expand access to a vast majority of the state. We have Catamount Health, which is a pre-existing conditions clause. Being able to leverage federal dollars for the Exchanges will be good. Providing more options expanding Medicaid to 133% of the federal poverty level will be good. We are concerned about Green Mountain Care and rolling Catamount into VHAP. We are most concerned about affordability.*

- *We would expect it to enable more people to have insurance. We hope that it will improve primary health care access.*

- *What I am hoping for is that there is true accessibility, not only providing health care coverage but that it is not out of reach due to cost or a lack of information on how to use it.*

- *Yes, potentially. There is a great deal of confusion between the federal Act and the work in Vermont to create a single payer universal access plan. There would be potential equal protection issues that they might bring to us.*

<u>Awareness and Understanding of Health Exchanges</u>

Q4: How familiar are you with the requirement for Heath Insurance Exchanges, which would be created under Federal Act? What have you heard?

READ: Health Insurance Exchanges are in the process of being designed. They are intended to provide one-stop shopping for health insurance for those who are now uninsured or underinsured. They would provide information on different plans, allow comparisons of plans from different companies, allow the use one standard application for all available plans, and provide information on tax credits and subsides.

- *I am not familiar.*

- *In the middle because you provided the handout. The functions it will perform and the subsidies.*

- *Somewhat familiar.*

- *Somewhat familiar. I know that it is a system to get accurate cross comparisons of different health plans. Everyone who does not have health insurance will be able to access the Exchanges and will in some cases be given subsidies.*

- *Somewhat familiar. I know the Exchanges have to be designed in state. Vermont will do its own Exchange. They have to be approved by the Feds. I am familiar with the timeline.*

- *Somewhat to very familiar. I'm getting more involved; we're invited to the meetings to develop this. We're an interested party.*

- *Very familiar*

- *Very familiar*

- *Very familiar*

- *Very familiar with health Exchanges part because we have something similar in Vermont that we have to build on. It's a place where there are going to be plans available with specific offerings for those who can't access insurance through an employer. Gives small employers an option to offer a good plan on their own.*

- *Very familiar. There's a basic benefits package. Private insurance companies will set up the Exchanges. There is a prescription for how consumers can evaluate various plans. Abortions can't be paid for except by a separate check for the patient.*

- *Very familiar. We have to do it or the Feds will do it. We will get some federal monies. People will get subsidies and premium assistance thorough the Exchange. You set up an Exchange so you can bring in federal dollars.*

- *Very/pretty familiar. We are really excited about moving forward. We want to see comprehensive and affordable plans. We need transparency with rate review process.*

<u>Information Exchanges Should Provide</u>

Q5a: The information provided by Health Insurance Exchanges could be provided online, in written materials or through phone representatives in a call center. Based on your experience providing health insurance, what information and assistance should the Exchange have to provide?

- *Anything that is above and beyond the regulations for disabilities. We are concerned about usability. Making sure that information on the computer and the phone is accessible. For example, see that someone does not have to push a lot of phone buttons before they reach a live person. And then in the materials to use people first language. Language talks about the person not the disability.*

- *Call centers in my estimation don't work, websites work only partially. A number of people that come in here don't know how to use computers. I would like to see an option for a person-to-person explanation with back-up of information that is easy to read. A real human being.*

- *Definitely have to provide what the benefits packages are, information about eligibility. It's an Exchange of information and a place where people can sign up for health insurance.*

- *Have to provide online AND in person, will have to do everything. A lot of public education meetings, public meetings before things start. It's going to be a harder transition in some ways because of the tax credit status. Every communications technique will be necessary – online, written materials. Phone calls, call-ins will have to be used.*

- *I am not sure what is necessary, going beyond what was described.*

- *I know that there is a tremendous number of decisions and actions that need to be taken between now and full implementation. We are looking for guidance on what kinds of services are going to be covered and how we would be able to conduct outreach.*

- *It's required to provide all the detailed information about the plans, what they cost. How people access the subsidies, Medicaid.*

- *No I don't know.*

- *The struggle is that we don't want to create too many options – we don't want to create such extensive detail [for those] who don't have much basic knowledge of what is in their insurance plans. Keeping the costs what the premium would be, what the ultimate cost sharing would be including the deductible, co pays for the range of prescription drugs, going out of network are important.*

- *They should have to do all, the call center, online and written material. They should have some potential for face-to-face.*

- *They would have to provide online and the phone. Cost information. Coverage information.*

- *When you read this it sounds like part D which scares the hell out of me. I know they'd like to offer many plans, but I would like to see plans be more similar – patients are constantly second guessing themselves when they choose a plan. I'd like to see the plans include dental. What it's going to cost is the big question. It must be affordable.*

Information Challenges for the Exchange

Q5b: What challenges in providing information and assistance will the Exchange have to overcome?

- *A number of people in Vermont will switch from VHAP and Catamount into the Exchange. There needs to be more coordination with public programs.*

- *Choosing a health care plan is a complex task and most people will shy against that. Even people who are literate and well educated are going to have to be encouraged to take advantage of the Exchanges and to utilize the benefits of the plans.*

- *Eliminate buzz words, terminology that is not part of every day communications. Information must be provided in easy to understand language.*

- *It's going to be very complex so it's going to be a huge challenge to make the information understandable, what their choices are, how to enroll, what the best plan is for them. There is a huge need for people to have one-on-one assistance. It's not enough to go to a website, to read all the information no matter how clear and detailed it is and to understand what their choices are and the ramifications are of the choices. They need someone to meet with and talk to. We get a lot of self-employed, when we ask what they earn, they can't tell you. They are not going to be able to go to a website and plug in their numbers. People's income is very complicated in Vermont. They can't handle it on their own. Everyone is going to need personal assistance at first. It's a completely new system. Catamount touched just a few people – and they were so confused. Just explaining the choice between Blue Cross and MVP. People wait until they will lose their insurance in ten days and they can be quite frantic.*

- *Need to accommodate people who can't read and don't speak English.*

- *No, it seems pretty straight forward.*

- *Not being too complicated or too technical for the man on the street. I see people who are smart or intelligent, 40% of those we see have college degrees, and it is very confusing to them even when they are switching from VHAP to Catamount. We have to be clear about differences between plans and keep them similar.*

- *Our concern is that for existing programs there is a website, there is a phone center, they have tried to do electronic enrollment, and certain populations have trouble using the enrollment systems that are in place. We provide back-up so people can find their way through the process of enrollment. I would hope the Exchange could simplify what plans there are, the costs and how they access these. Individual assistance is really important. It's complicated. That individual assistance is really critical. We get a lot of calls from parents about their adult children – living at home. Parents get very anxious if their kid has a health problems or some kind of accident, that their kids aren't covered.*

- *Our experience personally, through VEHI, people understand heath insurance concerns as health care concerns. They want to know what their benefits are in clear simple language. The Exchange needs to communicate in a language that most Vermonters can understand – and takes into account literacy issues. They also want to know if they can see the doctors that they want to see. They want to know what things are going to cost. Offices are going to need to be set up so people can get face-to-face counseling. We have found this with our education fund work and our retirees that this is necessary. We are*

not against online or written information but there needs to be a strong emphasis on face-to-face. It needs to be done by people with a strong commitment to public service. By that I mean I don't want brokers running it.

- *The challenge is that one segment of the population is going to have online access. Here in Vermont a significant number that do not have online access – and you are talking about a lot of information for someone to make an educated decision. I shudder to think of how that is going to work given the volume of information.*

- *The complexity of the whole thing, making it simple enough for people not to be overwhelmed will be hard. The subsidies and tax credits and choices are going to be confusing.*

- *The complexity. Insurance is not administratively simple. If they have too many decisions to make and too many options they don't want to make a decision. Being able to put it in the most clear, most readable way possible would be best.*

- *There will be huge challenges because it's complicated and people don't understand it. Insurance companies are horrible at making that kind of information clear especially for low income and those for whom English is a second language.*

Non-Profit Functions Transferred to Exchange

Q6: What functions does your organization/agency/business currently perform that the Exchange could or should perform?

- *(Respondent does not provide services)*

- *Every year we compare plans for our organization, so perhaps we can use the Exchange for that information.*

- *Explaining to consumers all their potential options at some length. In-depth counseling, for example, explaining the state's current programs. I hope they can take over the lengthy explanation that we now do.*

- *Having access to a hotline that is staffed by a live person and doesn't have an intricate phone tree, which turns a lot of people off. People don't know what they want – they just need to talk to a live person. We respond to hotline calls past the traditional hours; lots of people need to talk before or after work or on weekends. That's a big help for people.*

- *Hopefully we would be able to provide information at the Exchange level to understand the needs of the people using the Exchange and help the people using the Exchange to have a good experience.*

- *I don't get the difference between the federal and the state piece. If there is any way to make the different parts of government talk to each other.*

- *No.*

- *No real change for us. We will have an extra layer of consumer issues because of coverage.*

- *Not knowing how the Exchange is going to perform and knowing that it's supposed to simplify the process to make it easier for people to understand plans and enroll in them - it's hard to say now how we would be affected. We get calls from people who are frustrated with Maximus the electronic enrollment, huge problems so we keep getting calls from that.*

- *Only in this way. Many of our students are mystified by forms and these become the textbooks for our lessons. Some forms are so dense we can't even get a handle on them.*

- *To a certain extent they have to walk a fine line. You can't tell a patient what to sign up for, but you can provide objective information so that they can make a decision. But you also need to provide guidance so that they can analyze the information.*

- *We currently do counseling and register people for Medicaid. So we have dedicated staff for this. Whatever could be done to simplify that process would be enormously helpful.*

- *We have a program to help people understand their insurance. The Exchange could learn from our program. Maybe there could be a referral to our program when people call in. They are talking to a cancer specialist.*

- *When the Exchange is in operation by 2014, the structure of VEHI could be very different. We hope that we will be a navigator. We represent 7% of the population. VEHI has been a kind of Exchange since 1993. School districts come into our marketplace. We design and sell them health insurance. We take care of their claims problems with Blue Cross, we handle wellness. We know how to talk about health insurance, we provide customer service, we provide communications material. We have been doing it for a long time. We don't need to have someone come and do this for us. Exchanges would require small employers to enroll in the Exchange. Most schools in Vermont would have to enroll and would leave VEHI. Current population is well served now by VEHI so we are anticipating significant disruption all in the name of health care reform. The state is trying to do what VEHI does – to create a significant risk pool.*

Navigator & Customer Education and Service

Q7: The Health Insurance Act allows for designation of a public, non-profit or private organization, to serve as a "Navigator."

A Navigator would:

- **Provide education to consumers about health insurance options. Distribute information about health insurance plans.**
- **Provide information on subsidies available and the cost of health plans after subsidies.**
- **Assist with enrollment in a health insurance plan.**
- **Refer consumers with questions, problems or grievances to the organization that can help or resolve the issue.**

Q8: Is there a need for the Navigator role? Why do you say that?

- *Absolutely, there is a need for someone to guide them through the process, especially among the patient population we always have, low income, low education, difficulty of accessing information technology.*

- *Absolutely, Yes. It's going to be confusing to people and they are going to need help. The navigator role is critical.*

- *Absolutely. I can only tell you from doing this over the years; the discussion begins in a very human way, benefits, doctors and costs. They don't understand insurance: how premiums are calculated, deductibles, co insurance, co pays, formularies and tiers. It gets complicated and when it does, especially for those who do not have a lot of education and who are inherently distrustful of brokers or state government, this can be a very intimidating process. To navigate you have to have someone who knows the system very well. One thing VEHI has established is trust – we have built relationships. I know when I call this navigator I am going to get good information and they are going to follow through.*

- *I do! If the commitment to explaining things well is committed to, what could be better? The navigator needs to be accessible.*

- *The navigator could be good in the ability to go through the system to find out what you need. Many of the people we serve have problems reading or writing. They get frustrated pushing buttons on a phone. Many of our people have cell phones with limited minutes and they can use these up being put on hold.*

- *There is a need for that. If you want to provide full information and options the navigator role makes a lot of sense.*

- *There is definitely a need for that type of assistance, should be across Exchanges and other programs. People need to understand more than just Exchanges to make decisions, for example, Medicaid.*

- *Yes, absolutely. The benefit of our patient navigator is really great. People can feel overwhelmed. For us who live and breath this work it is easy enough but for most people this can be a benefit.*

- *Yes, I do – especially with any new program. We had peer navigators for programs and it was very helpful. It provided hand holding in the beginning.*

- *Yes, it is difficult for most people to choose health insurance coverage.*

- *Yes, people are not going to understand what their choices are, what the cost of their choices are, how to access their federal subsidies. They are going to need help with that to help them figure it out. It won't be like Travelocity where in one minute all the questions are answered. We served as a resource for others – from the clinic intake staff, even the state's own staff. We were training other people.*

- *Yes, that's what we do now. In addition, we find a primary care physician after they are insured.*

- *Yes, there is. Assuming that the navigator can provide that role effectively. One concern that providers have is the extent to which you have control over the quality of that role.*

- *Yes, there needs to be an independent body other than health insurers and providers to help people navigate. I believe that insurance companies have only their own interests in mind.*

<u>Additional Consumer Assistance Necessary</u>

Q9: Is there consumer information or assistance in addition to the items described earlier that a Navigator should provide? What information or assistance?

- *A lot of the navigation work is how to get into a plan. There isn't a lot of discussion about once you are in a plan, how to access benefits in the plan in a way that is beneficial. This could be a role for the navigator.*

- *Depending on how the plan is structured, there is a set of information on how to use the plan that is necessary.*

- *Have to be sure it's not just about health insurance in the Exchanges but other coverage that might be available.*

- *I think that the more options there are for getting explanations out the better.*

- *It is important that whatever agency provides this service has to have sterling credibility among consumers. It cannot be seen as having any bias. It cannot be seen as discouraging anyone from accessing insurance from the Exchange. They need to be incredibly patient and understanding and can relate to people very well.*

- *Navigator should help them get into a primary care doctor. You have to be entrenched in individual systems to be a navigator.*

- *Navigators should be advising the state about how navigators are functioning generally. How they are doing with various age groups or regions. Navigators need to have a voice in the Green Mountain Board. If there is a single payer system, the role for navigators may be reduced. Navigators and state regulators of the insurance industry need to be communicating. Also need trouble shooting for people bumping up against problems getting insurance. Need to help people solve problems.*

- *No, I can't think of anything.*

- *No, the list was comprehensive.*

- *The accessibility is our interest.*

- *The description covers it.*

- *The functions mentioned are all reasonable for a navigator.*

- *We want to make sure that the navigator really understands low income healthcare, we do not want to see people who are eligible for Medicaid go into a private Exchange plan by mistake. Vermont has a lot of non-profits. Support for those groups is really important.*

- *Yes, to make sure that the person applying is receiving an answer from someone who is knowledgeable. For people to be able to find someone that can give them the services they need. What the options are from insurance to free clinics. If they don't have the money, to be able to find the most feasible services and the most economical way to reach those services.*

<u>Information to be Provided on Web Portal</u>

Q10: Are there services and information related to health insurance that should primarily be provided by a web portal? What?

- *A lot of businesses are using the web. In the last couple years we are seeing more video.*

- *Alerts and changes should be on the web.*

- *Basic high level information, such as the comparisons should be provided by a web portal.*

- *I don't think so, you can't assume online access.*

- *Ideally, whatever is being offered should be offered thorough a call center and a website. The website clarifies what was said.*

- *If the system is designed the way it can be, it will be simpler than what exists today but it will never be simple. But we are still talking about multiple products, about subsidies structures that people will need to master and understand. They will still need assistance. You cannot serve the uninsured and under insured with a web vehicle. Some of these folks don't have computers and won't understand what they are reading. Everything needs to be on the web, but there is no substitute for face-to-face.*

- *Many Vermonters do not have access to high speed Internet. There has to be planning for those that don't. We have told a lot of people we can email an invitation and many want it mailed. The portal is a nice way of introducing people, but honestly, very few people have the capacity to go to a portal and get themselves into a program. You have to have the web portal – but [they] are not sufficient. Most uninsured are below the poverty level and may not have the capacity to enroll on their own. Most low income Vermonters have very untraditional income sources, a couple jobs, part-time, seasonal. They are not easy cases.*

- *No.*

- *Some people work better on the computer than over the phone so whatever is available over the phone should also be available on the web. It should be plainly written, it should be well organized. It's also important to be able to print things off.*

- *That I am not sure of. The web portal needs to be functional and assessable, it needs to have all the information.*

- *The law provides that it could be provided on the web in person and in a call center, and they should use any of these mechanisms.*

- *The web portal is the baseline, you absolutely have to have that. But you really need assistance too. I am reluctant to say primarily.*

- *The word "primarily" is a hard one. Information should be there, but there are some people who can't or won't use online services. With the Exchange you will see more who can't or won't use the web, than current health care programs. Can't utilize just the web.*

- *Well some people gravitate to the internet and some will want to go in to talk with somebody. Some will differ rural vs. urban and socio economic status. There will be a period of trial and error.*

Information to be Provided In-Person

Q11: Are there services and information related to health insurance that should primarily be provided face to face or one on one? What?

- *For certain people they need face-to-face and I don't know if the navigator should be providing this if they should be referring to other agencies.*

- *I can imagine specific cases where people are less comfortable with computers and where they would prefer a one-on-one relationship. The consumer ought to have the option to take whatever channel is the easiest and that they feel will be the most responsive.*

- *Individual services to people should be one on one.*

- *Information on the web and face-to-face should duplicate each other.*

- *No I don't think so.*

- *No it should be provided in both ways.*

- *There are going to be certain people that will need face-to-face; the elderly and less sophisticated.*

- *There are pockets in Vermont that don't have high speed internet. The underserved population isn't even an option.*

- *There is going to be a need to a lot of information: television, news media, forums in different areas. Working with service programs to keep them informed.*

- *When you get into unique extenuating circumstances, which may alter what plan is right, face-to-face is necessary. Especially for older patients presented with a change. Older patients tend to be much more engaged as compared with the 20-year-old spectrum.*

- *With individual clients it's all over the phone. Face-to-face is to train others, non-profits. Most people need to have access to information; it's almost impossible to do that face-to-face, unless someone comes really prepared. Like who has their kid's Social Security numbers with them? You are better off doing it over the phone. It takes more than one conversation.*

- *Yes, almost all of them should be available face-to-face. For those that are competent and familiar with the web, that's great. But for folks that aren't, who don't have access, who may not read, face-to-face is critical. I would pick face-to-face or phone if I had to pick one.*

- *Yes, there is a continuum between the general descriptions and then there are specific detailed questions. It would be confusing to address these on a website. Having an 800 number of offices for one-on-one contact would be the way for those to be responded to.*

Providing Information on Subsidies

Q12: How can information about potential subsidies for health insurance be best provided?

- *Again, through the web and face-to-face. Again, a lot of folks are not comfortable using web based services and they do like written materials and asking questions and getting answers from an individual face-to-face or usually on the phone.*

- *Emails and a website.*

- *Faced this very problem when, 14 years ago, it redesigned the property tax system. The system included a new system of subsides for low-income people. How you get the word out to those who are eligible for subsidies, to assure that people apply for them is a real challenge. TV, radio and print ads were used. There are still people who don't apply for the subsidies.*

- *For us the best way is the web and handouts.*

- *In personal deliveries. Subsidies are going to be available based on personal activities. There are going to be a significant number that fall in between qualification parameters. They will need to talk to someone.*

- *In Vermont, with other programs there have been real problems with the self-employed, incomes can change – it's hard to figure out current eligibility. I understand that the system will require people to true up and that will be quite difficult. Self-employed need more one-on-one help.*

- *It has to be done face-to-face, or at least over the phone.*

- *It should be provided by the existing agencies that are already out there. The media and outreach are critical. We have been advocated for the Ladies First program, but so many women are eligible but it's not being used. They just don't even know that the mammograms and pap smears are free. People need to be driven to the programs.*

- *It's best communicated one-on-one. So we can say, "Oh, this is how much income you make, well did you know…?" It's hard to explain. Is this possible with everyone – maybe not, but it's the best way. Phone is very important when you have someone on the other end that is knowledgeable.*

- *Online, in person and over the phone. Over the phone will be more relevant.*

- *Through the Exchange.*

- *You are going to have to use all the same mechanisms and some advertising to say that subsidies are available.*

- *You need to help people figure out what their income is, then help them figure out what their subsidy might be – then tell them "it looks like your income would qualify you for a premium subsidy of 'x' amount; this is how it is going to work." You have to caution people about reporting changes in income. Many people have fluctuating income. Some people will be exempted from the mandate because of their income. You have to be able to help people calculate their income. We don't want to tell people they have to enroll in a program when they don't. This is what we do now, we help people figure out their income and give them a general range of what their premium would be. And we say what the benefits package is. People want to know, what they will pay, what they will get and where they can go to the doctor. It has to be on the web portal, but if the professionals have trouble with it, most people will need assistance. On the state helplines, they have poorly paid people who turn over a lot and give people incorrect information. For the Exchange, you want very competent well paid people that understand what they are doing. You can't have people making 12 bucks and hour doing it. We have had people call us saying that they are on their employers insurance and the state said they were not eligible for state insurance when they were on COBRA. People are just confused. COBRA is not legally considered employer insurance.*

<u>Handling Customer Service</u>

Q13: How and by whom should customer service and questions be handled after the uninsured are enrolled in a plan? PROBE: By the Exchange, by the insurer, some mix?

- *A mix of responsibilities. I'm seeing the Exchange as an ombudsman. My acquaintance with insurance companies is that they don't provide good clear understandable information.*

- *Handling consumer contact should be by the Exchange, particularly in Vermont where the insurer may be changing.*

- *I like the Exchange idea. The Exchange will have the knowledge but what happens is that budgets get tighter, so local community services organizations will end up doing the work. If that could get built in from the beginning that would be great.*

- *Ideally it would not be handled by the insurer, by definition the insurer has a conflict of interest. They have a fiduciary responsibility to the shareholders. An independent agency, a non-profit or an office of the state government that is free from political pressure, such as an ombudsman office would work.*

- *Insurer must have some customer service capacity. Most people, if they are having an issue, want to deal with a more independent group than the insurer.*

- *It should be a shared responsibility. The insurance company shouldn't say, "It's not our problem." Similar to the Medicare Advantage programs – some people get confused. You also need to make exit as easy as entry so that folks move to alternative plans when it fits them better.*

- *It will be a mix. I haven't thought about that.*

- *It's a mix. If the issue is about coverage, start with the insurers. If it's about subsidies, you'd probably start with the Exchange. One of my concerns is that if someone calls Blue Cross, is the person on the line going to know if the person is eligible for Medicaid? If they are already enrolled, if someone calls up to see if something is covered, they need to call the insurer.*

- *It's going to have to be a mix. From a cost standpoint you don't want duplication of services, but the reality is folks will call the navigator.*

- *Since enrollment and payment will go through the Exchange, questions about these should go through the Exchange. And then coverage issues would go to the insurance plan. This is the differentiation now between DCF and DHVA.*

- *Some mix.*

- *The insurer has to be the first line. It's going to be hard to train people in the nuances of different insurers. However, once people are insured, there has to be a mechanism in place to be sure we have some control over the quality of the assistance. Many people don't know how the whole thing works together.*

- *The VEHI model is that we provide direct customer assistance with the insurance companies. Many customers will call customer service at the insurer and resolve things there. Many others will call us because we are trusted. Peter Sterling and his staff do the same thing. Within every navigator there needs to be an ombudsman.*

- *There should be someone there to answer any questions; the Exchange and insurers should share this responsibility.*

Qualifications for Navigator

Q14a: What criteria would you use to select, or what qualifications should be required for the Navigator?

- *A sterling reputation for dealing with people. Content knowledge. Familiar with health care questions. Can use its knowledge to translate information into a form that the average person can understand.*

- *Hands on practice than a degree. We do a lot of peer-to-peer support so you don't have to have an educational background for that. If someone has that knowledge that's enough.*

- *Have to have a statewide presence, or to work with people statewide. Maybe they could serve just a region so long as the whole state was covered. They need to be able to meet one-on-one with people. They should be non-profit with no financial motivation for enrollment. I also believe that they should be educational entities. They should be there to serve the public.*

- *Have to have experience with all the existing programs. They have to have demonstrated interest in serving patients holistically. They have to have navigators located in each district with local knowledge of the resources, the providers, the hospitals, because it's not going to only be about the health insurance. There are still going to be gaps. People are going to decide they don't want to pay this month. If people are ill and they have fallen off insurance we don't want to have them wait.*

- *Having experience in clinical setting, experience in social work. If they have experience within heath insurance, that would be OK, but they should be more of an advocate.*

- *Individuals or organizations that have a track record of functioning like navigators. Advocates that are accustomed to working with people and have those trusted relationships.*

- *It should be a literacy teacher! It should be someone who understands where problems in understanding may exist. Can break down and simplify information.*

- *It should be governmental approved, don't know that the criteria could be.*

- *It would be based on the level of experience someone has in implementing this in the real world. They must have some experience serving people [who] have been under served. I question whether a Blue Cross Blue Shield would be successful.*

- *The capacity of a teacher to distill information and then to simplify information and engage with an audience in a friendly way is important. Adapting to individual needs is also important.*

- *There shouldn't be any conflicts of interest. I've been pretty worried about brokers. If they have financial interest in steering people one way or the other.*

- *They should have some background for low income folks with access issues, a clear understanding of the different programs.*

- *You want to have someone who is independent. I know there has been a discussion about using brokers, but brokers would not have an easy transition. They have been tied too much to particular products. You have to have someone who can describe the system and be seen as impartial. They would have to have skills understanding the system and communications skills. Pretty sophisticated knowledge but also be able to help people and explain to them in a pretty basic way.*

Potential Navigator Organizations.

Q14b: Is there an existing organization or entity in Vermont could serve as a Navigator?

- *211 has been very helpful for us. The existing peer programs for the elderly and those with disabilities would be good places to look.*

- *Campaign for Healthcare Security, they would be a viable candidate. They have done a good job with handling Catamount Health.*

- *Free clinics could do this. They were started because individuals didn't have a doctor and had no way of paying. So they provide care but they also do screening and referral, first of all for coverage they may be eligible for, then for access to providers. This population is often the 18-29 year olds. Social agencies don't have as much of a stake as health care providers; if people aren't enrolled, they don't get paid.*

- *I don't know. A part could be part of the state government.*

- *I don't know. I think about AARP because they are a resource for the elderly.*

- *Like us. Like Peter Sterling's Group, the Vermont Ombudsman. Community Actions. There are some intake staff at hospitals that do this kind of work for Medicaid population. The state retirees' staff at the treasurer's office is an option.*

- *Not really. I'm not familiar with one.*

- *Not that I know of.*

- *State government itself and a competent insurance company like Blue Cross Blue shield.*

- *The Campaign for Health Care Security could do this. We could do this. You need to have a lot of navigators. Agencies on Aging. Maybe a business organization could help small businesses if they did not have a conflict.*

- *There is a state ombudsman's office that contracts with the state. That kind of mechanism would be most viable.*

- *Vermonters for Healthcare Security does a lot of enrollment and provides basic information for Catamount. That's a good model because none of the people that work there have any tie to insurer or products. They just try to help people understand who's eligible and if they should sign up. This is an expansion of that. There are different groups that work with different age groups. No one statewide organization, just those who work with seniors or the disabled.*

- *We do, we're statewide. We operate a hot line and we've had staff working in 10 of the 13 counties. We're the only organization that is doing this already. Community Actions with proper training are well positioned. Clinics for federally qualifying clinics are another candidate. Most of their familiarity is with public programs but they have intake staff.*

- *Yes the free clinics, the VCCU. We are located more broadly around the state than community health centers. We work within practices and we have the knowledge.*

<u>Insurance Agents as Navigators</u>

Q14c: Could insurance agents or brokers who currently represent health insurance companies serve as Navigators?

- *Are you kidding me? They have product knowledge, what they lack is patient knowledge. Spend a few days in a free clinic and you will learn so much about the people, we don't serve Medicaid, it's the self-employed, its businesses going down the tubes. They are there to see product. They don't have a view of what it means when they sell a high deductible plan to a factory worker who is making $400 a week and has to spend $2500 out of pocket before they get care. Well guess what happens, they have to wait a year until they have enough in their savings account. It's a conflict.*

- *Brokers get paid by insurance companies when they get a group to sign up with a particular insurance company. That's how they make their living so they have an inherent conflict. We just try to get the maximum benefit that is available to them. How would I know when a broker is talking to someone that could be eligible for Medicaid that they are not trying to get them into a private plan that nets them some money. There's no way to know that. Brokers are educating about public plans with the same enthusiasm they are educating about private plans.*

- *I can't think of one.*

- *I don't and not because they are not competent, but because of the changing role. They have a lot at stake right now. It could be awkward.*

- *I don't think so. Individual attention is not the forte of insurance agents.*

- *I don't want to be too hard with those folks. I know there are businesses with trusted relationships with brokers. I think the key distinction is the role of a broker and the role of an advocate. As an advocate I don't have a for-profit motive. It's a different mindset. We'd like to see navigators be committed to the highest principles of good advocacy. If there are brokers in the mix, I'm not going to be losing any sleep over it. But they should not be leading the pack. But we talk to people all the time – we deal with people with a host of medical issues, we are always timely, we are always up to date and we speak to people in a language they understand. I am convinced that state employees are capable of doing that, too.*

- *Insurance brokers are more likely to be able to serve small businesses. I'm thinking Vermonters for Healthcare would be better for individuals.*

- *Never say never. It would be contingent on having some experience in the area.*

- *No.*

- *No.*

- *Not as well as an independent entity that was not tied directly to the financial future of the insurance agencies.*

- *Not if they continue to have a financial relationship with insurance companies.*

- *Yeah they could. The caution is that you need a piece that is unbiased. You have to build that in to procedures.*

Interest in Serving as Navigator

Q14d: Would your agency/organization/business be interested in serving in the role of navigator? If so, what services and support could your agency/organization/business provide?

- *(Not a relevant question for the respondent)*

- *For a certain population (people with disabilities) and as long as there was money attached, we would.*

- *I don't think so. We're a step up if they have trouble, helping people with appeals.*

- *No.*
- *No.*
- *No, it would be out of our realm. We'd like to receive referrals for folks that need assistance reading and keeping up with things.*
- *No, it's outside our mission.*
- *Right now we have a contract with DHVA to provide eligibility assistance, they can call in if they have problems and we do regional trainings. We would want to continue this as it meets the needs of members and fits our mission.*
- *We haven't thought about that. We are proud of our cancer support navigator. We are focused in on cancer. If there was an opportunity to engage given our cancer focus, we would be interested.*
- *We're not appropriate for a navigator.*
- *Well, we kind of do this now. We call this information and referral. We have had trainings with 211.*
- *Yes, for education but open to other options such as union people.*
- *Yes, we already do. We are committed to getting people insured. Every patient we see if screened for eligibility in Catamount and other programs. Patients that won't go to anyone else, come to us.*
- *Yes.*

Role of Exchange in Health Care System Design

Q15: Do you see a role for the Exchange in overall health care system design? What role should the Exchange play? PROBE: Payment reform and potential for single payer model)?

- *Absolutely. It seems that there is a concept of working with real people so feedback from the Exchange can help in the design of policies and programs.*
- *By definition it plays a role in the process.*
- *I am so confused about how it will be implemented, I'd say yes. But I don't know what this would look like. No matter what is designed, there needs to be evaluation and not be afraid to change if that doesn't work.*

- *I would hope so. Here in Vermont we have become confused between the Exchanges and what is going on the legislature. I see a joint role between the Exchanges and what the state is doing.*

- *In order to have a system that is designed appropriately, it needs to have the input of the people that are out there now and the issues that they are having.*

- *No, not really, I see the Exchange as just that – an Exchange of benefit information and processes for enrollment, but not for design of insurance packages or eligibility.*

- *The Exchange is a place to grant access, but we need to have options priced in such a way that people want to get insured. If patients see that it's going to cost them $474 a month, which is what it costs for Catamount, they are not going to get insured. They will think, "Gee, my medical bills last year didn't total that."*

- *The Exchange would be fairly prescriptive so the Exchange has a lot of roles to play. I think the Exchange has to coordinate with variously boards.*

- *We need to avoid the adverse selection. We need a diverse pool. So the Exchange will play an important role this. It would be great for all of us to go through the plan.*

- *What is the Exchange? It's website, staff at a state agency? Presumably those that work at the Exchange will have some role.*

- *Within the Exchanges, there is language that specifies what a plan has to do to be qualified. You could set minimum standard for quality and access that would drive more attention to these issues among plans. I think the Exchanges can set these minimum standards.*

- *Yes I think so. When the legislature looks at data about the programs, we know what the data means. We helped, for example, to streamline the Catamount application. We can help the legislature think about what's next.*

- *Yes, the plan that Vermont is moving toward right now.*

- *Yes, they would bridge the gap of access. To continue to improve access for folks that can't afford or can't get care.*

Coordinating Non-Profits

Q16: How can services and communications related to Health Exchanges be coordinated among the many non-profits that provide services to the uninsured?

- *Coordinating service between non-profits is always a problem. I don't know how this can be done.*

- *Getting more non-profits working together more effectively has been a holy grail. Many are small and we do little in common. There are subsets of non-profits in health care issues so a number of them are in contact on a regular basis. We're not tied into those networks.*

- *I don't know. There are silos in state government, and I'd like to see them better coordinated.*

- *In two ways, some partners can be accessed on the state level, they can meet periodically. But you also need to do it on the regional level. You have to recognize the strengths and the systems that are in place locally.*

- *Meeting with them about it. Looking at the different coalitions and getting information to them.*

- *Non-profits that provide services would be customers of the Exchange. They could use the Exchange to get information.*

- *Some sort of web portal would be helpful. An online clearinghouse for organizations.*

- *That will be critical. There should be some sort of task force or work group that the Exchange helps to run. When Medicare Part D was implemented there was this kind of group.*

- *There are a few groups that could help. In Vermont there is "Common Good Vermont" that is just getting off the ground. Within the aging and disabled we have the disability resource connection the ADRCs. I don't know if there is one umbrella or one would have to be developed with something like a conference.*

- *There needs to be a central body, agency or person that coordinates the work of the navigators and stays in touch with navigators, and getting feedback from the navigators. Peter Sterling sent out people all across the state, and he got feedback from those folks and that would feed the next round of outreach. They don't have to be larger or bureaucratic but they need to be talking with each other.*

- *There should be meetings or coordination but you can't tell a group they shouldn't exist. Overlap should be avoided.*

- *We have an expectation for information Exchange, but we are far behind identifying issues of privacy and data Exchange.*

- *Wow that's tough. We set up trainings – we like face-to-face, the problem is that people don't show up. We're trying to use tele-meeting equipment in our sites but the technology isn't there yet. We do need to do this with community agencies that work with people.*

- *You want to set up meetings and connect with groups that help people with health care, whether or not they are official navigators. Regular feedback and meetings. In-person presentations work for a lot of people. The help line information for one-on-one is good but face-to-face presentations with other non-profits are also important. The state of Vermont had one person responsible for outreach for Catamount. That was helpful. Maybe the Exchange could have an outreach coordinator. Whoever is the coordinator can't wait for people to contact them.*

Coordinating Enrollments in Exchange with State Programs

Q17: What difficulties or conflicts do you see between enrollment in the Exchange and existing state programs? PROBE: Issues such as; maintaining insurance coverage with job changes, changes in eligibility due to changes in income (possible churning on and off state health insurance programs and eligibility for tax credits for the Exchange

- *Changes in income will be the biggest one, and then these who are self-employed and then have a reduction in income. Unless the entire Medicaid population is in the Exchange and they can readily switch back and forth, at the end of the day the individual may get screwed. There is a lot of disconnect in coverage.*

- *I don't see conflicts, because we are just enlarging the pool and providing more options. Job changes are a problem. It's easier if they lose their job, instead of someone who has an inconsistent income stream. The revolving door is a huge issue. But with the Health Exchange it's not tied to a particular job. The problem would occur as income changes.*

- *I hope that it will simplify that process, as the Exchange will be the single place where these things occur. The Exchange will offer VHAP, Catamount and private insurance. It will be the one common denominator.*

- *I think this is going to be terrible. It's already hard. People moving back and forth between Catamount and VHAP. Then you stick commercial plans on top of this. People who have fluctuating income – its going to be hard.*

- *If it's the same as Vermont state programs, it's a problem – you can't go in and talk to anyone and the phone system has all these options when you call in. When a person is making changes, having someone that can make the changes for them. Make sure that at they are working properly and coordinated.*

- *It's going to be a big change for our members that have to get insurance on the Exchange, but we will manage it because that's what we do. We rate our pool based on our unique claims experience, when you eliminate the pool it is likely that schools will be looking at higher costs.*

- *None of us are sure what state programs will look like once the Exchange is in operation. VHAP may be gobbled up in the Medicaid rate. Catamount may or may not be offered on the Exchange. All the problems we have now will be magnified. People will move from one program to another. Incomes change, eligibility changes. In some ways it will be more complicated since it will be a new system. Nothing goes away.*

- *Right now our RC has an emphasis on home based services and so does the new health care act. At what point does the state stop paying for things because they anticipate the feds will pay for it. We are already seeing this in the budget. I worry about shifting the burden back and forth.*

- *Subsidies could change. The ombudsman will have a better idea about churning. People end up lapsing in coverage and that's a problem.*

- *The conflicts that come in are from the employer side, whether we use the Exchange or use the brokers that have been serving us in the past.*

- *There could be problems but I don't know what these are.*

- *They are going to tell us about this as we go forward, but I don't see any conflicts necessarily. They are looking toward a simplification of how people are covered. A lot of what is being proposed is an automatic enrollment. We hope that federal requirements for the state to be eligible for dollars doesn't impede our progress.*

- *Yes, there are conflicts with eligibility. If you are eligible for VHAP and your situation changes and you switch to Catamount. The funding piece is going to be critical.*

<u>Funding the Exchange</u>

Q18: How do you think the costs of the Exchange should be funded? PROBE: Premiums solely, state general revenue, assessments on health plans, of a combination of these mechanisms?

- *As an employer we give good insurance because we think it's important. We have more of the burden of spouses as they select our plan. In some way having everyone to pay into it is a good thing. I fear that employers will pay more so that others can be insured.*

- *I have not looked at what the Exchange will cost. But I can't imagine it being a significant part of the cost of healthcare in Vermont. There are several options, appropriations, federal support or a cost to the overall health system.*

- *I think premiums.*

- *It should be an assessment on the health plans. We don't want to rely on the budget. With the budget going up and down. The navigator shouldn't have to go begging to the legislature every year to make sure they are funded properly.*

- *It's going to have to be a combination. The state plays a big role.*

- *Many people don't have such great cash flow that they can pay a premium and get a tax subsidy later. I don't know what all the options are to see that Exchanges run smoothly.*

- *Some sort of combination. Spreading out the pain will be palatable.*

- *The state is running out of revenues, then adding provider taxes to pay for the uninsured. Provider taxes are a problem. They may look at a per claim tax that would fund the uninsured. I lean toward this rather than general fund. I prefer dedicated taxes and funding.*

- *There are premium taxes or taxes when benefits are paid out. I assume that the Exchange will be paid for by a tax on the system itself, the premiums or the benefits.*

- *There is the premium part and then the subsidies. Affordable to me means unaffordable to someone else. We have said roughly 10% of your income going to health insurance – but you are really underinsured. We need to define what affordable really means, based on income. We put the tobacco fund into Catamount and there is a bill to charge a tax on sweetened beverages with the proceeds going to pay for insurance.*

- *This is the big killer for single payer. Everyone has to bear some cost for their healthcare – otherwise they don't value it. Medicaid, Medicare regularly have to contribute. People don't put value on stuff they get for free. Also, that means how much we need to run the system.*

- *We build the administrative cost into the pricing structure. At some point the states are going to have to foot the bill for the Exchange.*

- *We need to raise revenues, we can't cut programs. I favor raising the tobacco tax. There's a proposal for sugar-sweetened beverages. They need to look at ways to revise income taxes. Perhaps there should be a health tax on businesses.*