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Preparing For Outreach and Enrollment under the Affordable Care Act: Lessons from the States September 24, 2013

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DIANE ROWLAND, SC.D.: Good morning, and welcome to this Kaiser Family Foundation event, here in our Barbara Jordan Conference Center. I'm Diane Rowland, the Executive Vice-President of the Kaiser Family Foundation, and the Executive Director of our Commission on Medicaid in the Uninsured. Today we're very pleased to be continuing our series of getting into gear, preparing for implementation of the Affordable Care Act.

Today, we're really going to be looking at the preparations for outreach and enrollment under the Affordable Care Act, and some of the lessons from the states. As everyone has come to know, open enrollment for coverage, especially in the healthcare Marketplaces, formally known as Exchanges, will begin on October first, and many states are busily preparing for the outreach and enrollment efforts that are needed to help connect millions of uninsured Americans with the coverage offered under the Affordable Care Act, either through coverage in the Exchange Marketplaces, or through the expansion of the Medicaid program. We know that effective outreach and enrollment efforts will be key to ensuring that people understand their benefits under the law, and that we can translate opportunities for coverage into actual increased coverage.

Today, we're going to look at some of the on the ground work, and we're going to look at some of the lessons for how to

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move forward, as well as some of the challenges and the ways those have been resolved in three leading states: Maryland, Nevada, and Oregon. We're also going to look at the experience in Massachusetts of the outreach and enrollment conducted by some of the community health centers during their implementation of the State Health Reforms, so that we'll really gain a number of insights into how to do it right, and how it works when it's being done right on the ground.

We're going to start today by having a series of presentations from key people who have been involved, and we're going to kick it off first by going over some of the key findings from a report we're releasing today that looks at how to do the on the ground efforts in the three states that I mentioned, Nevada, Maryland, and Oregon. Then we're pleased to be joined by individuals from those states to talk about their efforts, and finally to hear from Massachusetts about the community health center efforts. Your packets have all of the reports that we're releasing today in them. We're actually releasing four reports, so we've given you a lot to read.

For those who are not in the room, those are all going to be available on the Kaiser Family Foundation website, kff.org. The first, and the one we will highlight today, is insights from three states leading the way in preparing for outreach and enrollment in the Affordable Care Act. The second is providing outreach and enrollment assistance, lessons

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learned from community health centers in Massachusetts. The third is an early look at branding and marketing of the new health insurance Marketplaces, and the fourth is helping hands, a look at state consumer assistance programs under the Affordable Care Act. Each of these will give you a real overview of some of the efforts going on to make sure that October first comes and the open enrollment period that lasts until the end of March will be able to really help people to connect to coverage.

We are going to start first with the three leading states report and Samantha Artiga of our Kaiser Commission on Medicaid and the Uninsured is going to present those findings. Then, we're going to turn to a panel discussion, and I'm very pleased that we have with us Kathleen Westcoat, the President and CEO of HealthCare Access, Maryland, who can talk about the navigator entity challenges to enroll folks in the state of Maryland.

We're going to be joined by teleconference by Samantha Shepherd, the outreach and enrollment strategist for Cover Oregon, joining us from Portland, Oregon via a teleconference. Then, we're going to turn back to Niki King, who is with us today, the Executive Vice-President for Member Experience from Access to Healthcare Network in Reno, Nevada. Our last, but not least panelist is Manny Lopes, who's going to reflect on the Massachusetts experience and their earlier expansion

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efforts. He is the CEO of the East Boston Neighborhood Health Center.

I am going to turn now to ask Samantha to highlight some of the key findings from our report, and then we'll continue our discussion, leaving lots of time at the end for your comments and questions. Samantha-

SAMANTHA ARTIGA: Thank you, Diane, and thank you all for joining us here today at this very exciting time. Before I jump into the key findings from the case study report, which focuses on the experiences in Maryland, Nevada, and Oregon, I just wanted to provide some national context on the ACA coverage expansions.

As I think everyone in this room knows, one primary way the Affordable Care Act expands coverage is through the creation of new health insurance Marketplaces, which will provide individuals a choice of qualified health plans and offer tax credit subsidies to moderate income individuals who do not have access to affordable employer sponsored health coverage, to help purchase coverage through these new Marketplaces. As Diane noted, these new Marketplaces will open for enrollment on October first in all states, with coverage becoming effective on January first. That open enrollment period will last through the end of March.

Looking across the country, we see that 17 states have established their own state-based Marketplaces that they will

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operate, while consumers in 27 states will utilize the federally facilitated Marketplace, and in seven states, the Marketplace will be operated in partnership between the Federal Government and the States.

The other primary coverage expansion vehicle in the ACA is the expansion of Medicaid eligibility to adults with incomes through 138-percent of the federal poverty level, which was about 16,000 dollars for an individual today. This expansion would make millions of parents and other adults newly eligible for the program. As was enacted in the ACA, this expansion was intended to occur nationwide, starting on January first.

However, the Supreme Court ruling on the ACA effectively made that expansion a state option, and currently 26 states are moving forward with the expansion, while 22 are not moving forward at this time, and debate remains ongoing in three. However, I would emphasize that there is no deadline by which states have to make a decision to implement the expansion. States still can decide to come in and expand their coverage at a later date. Moreover, it's important to recognize that individuals can enroll in Medicaid at any time throughout the year, and they're not limited to the same open enrollment period as individual enrolling through the Marketplaces.

Regardless of what type of Marketplace a state is operating and whether the state is moving forward with the

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Medicaid expansion, the ACA also establishes a new integrated technology-driven enrollment process for Marketplace and Medicaid coverage. States are building new eligibility and enrollment systems, as well as making major upgrades to their existing Medicaid systems to implement these processes, with the help of significant federal funding for these efforts.

Next, I want to turn to our case study findings, but before jumping into the project, I did want to acknowledge my co-authors in this report, who include my colleague here at Kaiser, Jessica Stephens, and our wonderful collaborators over at the Perry Udem Research and Communication, Michael Perry and Sean Dryden. I really also wanted to extend our very deep appreciation to all the individuals who participated in the case study interviews. They all share their time during an incredibly busy time to meet with us and discuss their experiences, and the project would not have been possible without them, so thank you again for those efforts.

Now turning to what the project is, really, the goal was to gain insight into preparations for outreach and enrollment in the ACA coverage expansions in Maryland, Nevada, and Oregon. These are all states that have established a state-based Marketplace, decided to move forward with the Medicaid expansion, and have emerged as among the states leading the way in preparing for outreach and enrollment.

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The findings that I'll be presenting here today and that are in the report in your packet are based on interviews with a broad range of stakeholders in each of these states. These include state officials, Marketplace officials, navigators and other assistors, community-based organizations, insurance brokers, providers, and consumer advocates. We really were trying to get a broad community and local level view of preparations happening in each of these states. The interviews were conducted in July 2013 in collaboration with our team at Perry Udem Research and Communication, and the findings really highlight, I think, the challenges that the states have encountered, as well as the successes they have achieved, and key lessons learned to help inform efforts, moving forward.

The first set of findings I want to highlight from the report are the work among the states to establish the Marketplaces and prepare for the Medicaid expansion. You'll see here that all three states moved very quickly to establish their State-based Marketplaces, with Maryland establishing legislation in April 2011, to set up their Marketplace, and Nevada and Oregon moving soon after in June 2011. Moreover, all three structured their Marketplaces as quasi-governmental organizations, or public corporations, and respondents told us that that structure had advantages, such as the ability to hire

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and pay vendors more quickly than typically allowed under usual state processes.

In terms of preparing for the Medicaid expansion, the three states are in very different starting places with their Medicaid coverage, so the scope of the expansion is going to vary across the three states. Specifically, Maryland and Oregon have already expanded coverage to some low-income adults, while Nevada does not currently provide any coverage to low-income adults without dependent children. There will be a more significant increase in eligibility in that state.

To prepare for the increased Medicaid enrollment that these states are expecting, Oregon and Nevada are hiring additional Medicaid eligibility workers. Moreover, all three states are in an intense process of training their eligibility staff, and really focusing on culture change among the staff to implement the new enrollment processes that will be going into place moving forward.

In terms of implementing the new eligibility and enrollment systems that will help states utilize these new enrollment processes, the states are taking somewhat varied approaches. Oregon and Nevada are each building new systems that will make all Marketplace and Medicaid coverage determinations within a single system, whereas Nevada is linking together several systems, which include two new systems that are being built separately. However, we did hear

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consensus among all three states that building these systems has been one of the most challenging aspects of preparing for the expansions, and that in each of the states, they were not able to build in all of the desired capabilities they hoped to have in place by October first. As such, they have developed contingency plans and workarounds where needed and are devoting resources so that they're available to troubleshoot problems that may arise when open enrollment begins.

We did also hear definitive plans in all three states to continue to move forward with system enhancements and improvement over time, so continuing improvements will occur, even after open enrollment begins in October. I think this quote here from a Maryland advocate just captures a lot of what we heard, in terms of the challenges associated with system builds, looking forward to the expansions.

The next set of findings I want to highlight relate to the marketing campaigns that will introduce consumers to the new Marketplaces, and encourage them to enroll. All three states conducted extensive consumer research to help inform the Marketplace branding and marketing campaigns, and they each plan to conduct broad campaigns across multiple platforms. Respondents did indicate that these media campaigns will be primarily focused on reaching the population that is eligible for the Marketplaces, although there was recognition that they would likely reach many individuals eligible for Medicaid.

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However, I think many respondents also emphasized the important role that community-based organizations and assistors will have in connecting the Medicaid eligible population to coverage.

While all three marketing campaigns are really focused on building awareness among individuals and encouraging them to enroll, each of the three states varies in the messages and approaches it is using for its campaign. Rather than trying to describe those distinctions to you, I thought it might be more instructive for to an ad for each Marketplace, so that you can get a feel for those distinctions yourselves.

ADVERTISEMENT ONE: It's a new day. There's a brand new way. Get the health coverage you need. Total health coverage indeed. Got to have it, going to get it. Convenience and love at Marylandhealthconnection.gov. Now's the time, put your worries behind. Get your coverage online. Best peace of mind, Got to have it, going to get it. Convenience and love at Marylandhealthconnection.gov. Enroll October through March. Visit Marylandhealthconnection.gov or call 18556428572. Got to have it, going to get it. Convenience and love at Marylandhealthconnection.gov.

ADVERTISEMENT TWO: A nice hike with my wife, Thursday softball games, a good meal, that's what I work for. Life is pretty good, and you know, my health has never really slowed me down. I now have Type 2 diabetes. That can get expensive without health insurance, and the thought of not being able to

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pay for more insulin when I need it, that really would slow me down.

The new healthcare law requires all of us to have health insurance by 2014. Nevada Health Link is here to protect you from a fine on your taxes by helping you purchase State-approved health insurance plans that are high-quality and based on your income, regardless of a previous health condition or the amount you pay. Learn about the changes now by visiting Nevadahealthlink.com or by calling 855-7NV-LINK, 855-768-5465. Plans will be available for purchase starting in October. Learn about the changes now by visiting Nevadahealthlink.com. Sponsored by the State of Nevada.

ADVERTISEMENT THREE: I'll sing for the place that my heart has called home, where the salty sea air meets the cold mountain snow, where I'm free to be to healthy and happy and strong, and live long in Oregon. Long live our Oregon spirit. Long live the Oregon way to care for each one, every daughter and son, live long in Oregon.

SAMANTHA ARTIGA: Obviously, those are very different approaches taken by the three states, but they are all really focused on building awareness and directing consumers to the Marketplace websites and phone lines for more information. I also wanted to note that in your packets, you also have that new brief that Diane referenced, which looks at branding and marketing across all 17 states operating state-based

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Marketplaces, as well as the Federal Government. If you're interested in more on this topic, that brief would be a great resource for you to take a look at.

The next set of findings I want to highlight relate to outreach and enrollment assistants. While marketing campaigns will help build awareness, we know from past experience in Medicaid and CHIP, as well as from the earlier coverage expansion in Massachusetts that targeted outreach and direct assistance will be key for enrolling eligible individuals. We'll be hearing more about the Massachusetts experience from our panel, but I did want to highlight again that there is a brief in there that touches on that topic, as well as a second brief that looks at the development of consumer assistance programs in the Marketplaces. Those are additional resources on this topic.

In terms of our case study findings, in looking at our three states, they all have adopted a regional approach to their consumer assistance programs, wherein they're contracting with a limited number of entities, who will then go out and hire the individual navigators and assistors to provide assistance. The number of navigators and assistors varies across the three states, as do their training requirements, but in all three states, a wide array of organizations with close ties to their local communities will be serving the functions of providing assistance. Moreover, respondents emphasized that

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the assistors will really have a broad focus on reaching individuals who are both eligible for the Marketplaces and Medicaid, and noted that insurance brokers will also play a role in connecting certain segments of the populations to coverage.

With regards to outreach strategies, respondents identified a wide range of strategies that will be used, including several key strategies, which I've highlighted here. The first is trying to utilize and maximize existing data to facilitate or automate enrollment into Medicaid. For example, Maryland and Oregon plan to automatically transfer adults that are already enrolled in their expansion programs into full Medicaid coverage, and Oregon is also looking at utilizing eligibility information from The Supplemental Nutritional and Assistance Program to facilitate enrollments into Medicaid.

The second key strategy that is identified is really reaching out to uninsured parents who already have children enrolled in Medicaid and CHIP, since many of those parents will either be eligible for the Medicaid expansion or the Marketplace subsidies. All three states discussed targeted outreach plans to certain segments of the population, including communities of color, and those with limited English proficiency.

I would highlight Nevada, for example, really emphasized their plans to do significant outreach to Spanish

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speaking Hispanics in the state, who make up a large segment of their eligible population. Similarly, in Oregon and Nevada, those states are working directly with the tribes to conduct targeted outreach to American Indians, and provide assistance with enrollment. Across all three states, we really heard the important role of the faith community and plans to conduct outreach and efforts through the faith community and faith leaders.

The last set of findings I wanted to touch on relate to political leadership and stakeholder collaboration. Really, what we heard from respondents in all three states was that close collaborative working relationships among a number of state agencies were really key for successful preparations. In particular, some of these agencies included the Medicaid agency, the new Marketplaces—was the Department of Insurance—in all three states, they are talking amongst these agencies everyday and really working as a team to move forward with the expansion preparations.

Moreover, we heard consistently that strong state leadership has been important for moving efforts forward, and spurring that collaboration among different groups within the state. Similarly, all three states really invested very early on in gaining stakeholder input from a wide array of stakeholders, which we heard contributed to the ongoing support

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and participation of these stakeholders throughout the process of preparing for enrollment.

Lastly, all three states described a positive relationship with their federal partners on implementation, but noted that the lack of final regulations and delays in some of those has been a real implementation challenge, and in some cases, the states have had to move forward while still waiting for final rules from the Federal Government.

Just to wrap up, I think the experiences from these three states show us that states that are committed to moving forward have really achieved significant progress in preparing for the expansions, and that strong political leadership, close collaborative relationships, as well as creativity, adaptability, and a willingness to continue to improve over time, have all been key components of their success.

Looking ahead, October first will mark the start of the opportunity for individuals to begin accessing coverage that will begin in January. Some people are going to enroll right away, while others are going to take some time to explore their options. However, since coverage will not begin until January, individuals can take some time to research their options without missing out on coverage. Moreover, the six-month-long enrollment period will give states the opportunity to continue to improve their systems, and I think we'll see that consumer

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experiences with enrollment will likely continue to improve over time.

Lastly, while marketing campaigns will help educate individuals and raise awareness, enrollment efforts will really be driven at the local level through on-the-ground work, and I look forward to hearing from our panelists, who I think are going to have some great perspectives for you on what those efforts will look like in their respective states. Thank you.

DIANE ROWLAND, SC.D.: Now we are going to our panelists, and we're going to start with the State of Maryland and with Kathleen.

KATHLEEN WESTCOAT: Hi, thank you for having me here today. Again, I'm Kathy Westcoat, from HealthCare Access Maryland. I thought it was important to provide just a brief overview of our organization, so you can realize why becoming a connector entity in the State of Maryland was really a natural fit for us. We've been in operation for 17 years and we were the key agency in Baltimore City who enrolled children into the Maryland Children's Health Insurance program. We've got lots of experience with outreach and enrollment, and we also provide a wide variety of case management to vulnerable populations in the greater Baltimore areas. Individuals who are homeless, children in foster care, pregnant postpartum women, immigrants, you name it, we are working very, very closely with vulnerable populations.

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As Samantha mentioned, Maryland, we are—I live in an amazing state and we are really far ahead of the game. I think that our tremendous leadership with our Governor, Lieutenant Governor and Health Secretary, it's just been remarkable to watch. They've really invested a lot of time, energy, and resources into making sure that this goes well.

HealthCare Access Maryland was recently awarded a connector grant for the central region. The State of Maryland divided the state up into six regions. HealthCare Access Maryland has the central region, which is Baltimore City, Baltimore County, and Anne Arundel County. There're approximately 220,000 people who are uninsured in that region, and we have established partnerships with 17 different partners, which I'll talk a little bit about later.

I'm just going to keep the remarks focused on our outreach and enrollment strategies, as requested. More globally, we are looking to capitalize off of the state marketing campaigns. The state has invested two and a half million dollars in the statewide campaign, which included commercials, TV ads, radio ads, bus ads, bus shelters, so on and so forth.

They've also developed some partnerships with grocery stores, Safeway, GIANT, CVS, and also the Baltimore Ravens. They did research and found that seven out of 10 people in the State of Maryland watch the Raven's game, so they're going to

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have commercials during the Raven's games, as well as on their big screen. Our staff will go into GIANT and Safeway, and CVS, and meet people where they are, to help with some of the enrollment processes.

Let me talk a little bit about our connector program. As I mentioned, we have a 7.9 million dollar grant. We have just recently hired 107 navigators and assistors. When you break it down, it's one navigator to about 2,000 people. One hundred and seven people sounds like a lot of people, but when you look at it from that ratio, you kind of shake your head a little bit. We have developed a wide variety of partnerships with formal partners and informal partners. Our 17 partners, what we call formal partnerships, are where there is monetary exchange, meaning we have given them funds to hire their own navigators and assistors in their organizations.

We're working with hospitals, federally qualified health centers, and a wide variety of community-based organizations, to hire their own navigators and assistors in our region. Some of our informal partners, which means there's no monetary exchange, we plan to embed our staff into these venues. Libraries, we think libraries are very, very important place to go. The YMCAs in central Maryland-we're working very closely with all the school systems in each county. For instance, in the Baltimore City public school students, on their very first day of school, brought home information about

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the Affordable Care Act and how their parents can enroll and sign up. Eighty-five thousand kids took a flyer home, and we've gotten lots of calls already from that outreach.

Working with community colleges as well, we think that that's a really great place to go in all three of the regions, and working very, very closely with the faith-based community. We also feel talking to high school seniors is very, very important, so in May, for those who are graduating, their M-CHIP will likely expire; they are a really good population, I think, to talk to, as they enter college and are looking for other resources.

We really are going to capitalize on our existing infrastructure. There is really is a lot of infrastructure that's already in place, working very closely with the local Departments of Social Services, where people already go to obtain benefits and services, working with local Health Departments in their WIC clinics, immunization clinics, also working with our own in-house home visiting programs. For instance, we provide case management to about 80,000 people every year.

HealthCare Access Maryland serves about 150,000 people a year, but we are in the homes, and often when we're outreaching a child or a pregnant woman, there are several other people in the home that qualify for benefits. We plan to

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the in-reach in their homes, to spread the word about the Affordable Care Act and how people can enroll.

It's very important to understand with our staff, we will not be sitting in the offices. All of the staff do have technology. They will have laptops. They will have scanners and printers, all portable, so we can outsource them. We do not envision them sitting in the office. We really do hope to put them in a wide variety of locations in our jurisdiction.

One other important thing is HealthCare Access Maryland has—we've already had a health insurance hotline since 2008. We already get 5 to 7,000 calls a year on that hotline. We are continuing to market that hotline and hope that more people will call through, this three-pronged approach that we have.

DIANE ROWLAND, SC.D.: Thank you, Kathy. Now we are going to turn to the other side of the country, to Oregon, via telephone. I'd like to welcome Samantha Shepherd, to offer some comments to us on behalf of the State of Oregon.

SAMANTHA SHEPHERD: Hello, again, this is Samantha Shepherd. Thank you so much for having me here today. I'm sorry I can't join you in person, and I'm joining by phone. It's a pretty busy time here on the ground in Oregon and hard to step away. Thank you so much for highlighting many of the wonderful things we're doing here, and some of the challenges we've faced, and how we've tried to face those challenges.

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In Oregon, for outreach and enrollment assistance, we have established a community partner program. We put under one umbrella navigators, in-person assistors, application counselors, and existing eligibility workers at provider entities, like health departments, safety net clinics, and hospitals. We had a pretty robust program already here in Oregon. We had about 200 organizations who already did application assistance for Medicaid and CHIP for a number of years. We were able to build off of that foundation with our community partner program, bring them under the umbrella, and then invite new entities to join as well.

We have administered some grants to outreach and enrollment grantees, and now have a few other opportunities that just closed, and we're getting to final agreements. Most of our partners will be unfunded by Cover Oregon. Cover Oregon will only be funding about 25 to 30-percent of our partners, overall. The rest of them are provider entities that receive general fund dollars from the state or the Federal Government, or received further grants to do this work, and we're not treating them any differently. We think that's a really strong program to just have everybody in one bucket, and teaching everybody the same thing, and walking the same walk, and it makes it easier from a staffing perspective.

One of our key strategies here in Oregon is to have ongoing staffing for our community partner program. We have

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regional outreach coordinators that are assigned to be the frontline in communities across Oregon to make sure our community partners and insurance agents are coming together to collaborate and offer the best customer service possible to Oregonians.

Those frontline workers, our regional outreach coordinators, deliver all of the training. They also host monthly collaborative meetings, where people that are doing outreach and enrollment, or insurance agents, health directors, can come together and talk about best practices, what's working, and what's not, what opportunities might be coming up in the community they can partner on, and et cetera.

Those regional outreach coordinators on staff also have an online social networking tool, called Group Site, that we've put together for our community partners and agents, where we can stockpile resources for them, and fact sheets, and flyers, and handouts, that they can access, download, and print, or references they need to, while they're doing the work in the field.

We know that it's hard to give every community partner and every agent what they need on September 30th, to go live on October first, so we wanted to make sure we had these ongoing resources available to them. Not everything is going to stick in a training. Not everything makes sense until you're

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actually hitting the buttons yourself, so we knew that having this ongoing technical assistance would be key.

We also know that collaboration is key between community partners and agents, and have tried to raise them together. The functionality in the system for agents and community partners is exactly the same; how they work with the consumer, how they access client accounts, how they find someone eligible and then help them enroll, is the same functionality. We're able to have them have conversations on the same plane. I think that's strong.

Outside of community partners and agents, of course, we do have our overall marketing campaign. You heard our ad. We have had several musicians write us music songs that we are using as our key strategy right now. It's a great way to get stuck in young people's minds. We've even been in iTunes and Pandora.

We've been doing some Google hangouts, and using Reddit, and a lot of other social media, to try to reach young people, but also the geographically isolated areas of our state. If anyone's ever travelled to Oregon, you know that about one-half of our population lives in the Portland metro area. To reach the rest of the state using social media actually creates a great forum. Of course, we've also done community meetings for the public and other things like that as well.

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We do have a very strong relationship with our state Medicaid agency to Cover Oregon as a public corporation, but we are streamlining our application with the Medicaid State Agency, the Oregon Health Authority, as well as our outreach program, which, again, just reinforces the overall system.

We expect on day one to have about 250 community partner organizations that are doing this work. We don't certify any individuals to do application assistance. We only certify organizations. We have contracts with them, and that's where the liability is held, and accountability. They hire staff or bring on volunteers that they are responsible for. We train the volunteers. We make sure that they jump through all the appropriate hoops, and the organization makes sure that they go through criminal histories, fingerprints, and et cetera, so we can get them into the system, and make sure Oregonians' privacy and security is protected.

I think that's a pretty good overview. I think I would add that, again, as I said earlier, we were able to build off of an existing program, here in Oregon, for application assistance, but also for outreach. We have a really strong stakeholder and advocate community that has been doing outreach and public awareness for years, and we saw no reason to recreate the wheel, so we often tried to steal it and make it a new wheel for Cover Oregon. As I like to say, we just like put fancier rims on it.

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We have been trying to build off the strategies we know that works, which includes the school flyer, as Maryland mentioned, as well as making sure that we're using integrated outreach strategies, things like, at provider clinics, having people just ask a question of are you uninsured, can I refer you for assistance. Simple things like that are a really great way to bring in easy strategies that are a low dollar cost, and something that's really sustainable, too, for years to come.

Thank you so much for your time.

DIANE ROWLAND, SC.D.: Thank you, Samantha, and I know you're going to be with us for the Q and A. We're going to now turn back to someone here, Niki King, who came from Nevada. She does also represent the other side of the country, which we're always pleased to have. Niki.

NIKI KING: Thank you for having me. My name's Niki King. I'm with Access to Health Care, in Nevada. We are one of the only statewide nonprofits, which is quite a feat, because it takes 9 hours to drive from Reno to Vegas, so Nevada is huge. What do we do? I wanted to provide you with a little background on who we are, because I'm coming here from a perspective not of a macro, we're not affiliated with the Exchange or the Marketplace in Nevada. I'm here for the micro. We operate a medical discount plan. We've been serving the uninsured before it was called to serve to the uninsured.

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For seven years, we've been serving the uninsured with a medical discount plan. We built a network of providers. Primarily, it looks like an insurance product, but it's not. We built the network of providers, 2,000 providers. Our members are between 100 and 250-percent of the FPL. They pay us a low-cost monthly membership fee of 35 dollars, which gives them access to the network and access to care coordination, which has been huge for their success. They pay the providers at the time of service a vastly discounted rate. Each member gets to choose a primary care provider. That visit is 45 or 40 dollars.

We have every kind of specialty, we have hospitals, we have every healthcare service that someone would need, all at vastly reduced rates. Our hospital rate is 400 dollars a day, with a 3,000 cap. Specialty to care is 65 dollars, and MRI costs 260 dollars. We have flat rates for everything. It has been a lifesaver in Nevada, where essentially, if you are a single adult female or male, you cannot get on Medicaid. We are very services, apart from our safety net services, but we are the only entity in Nevada that has been serving the uninsured with a comprehensive program, so we are really well positioned to continue this effort.

About 40-percent of our members will go on Medicaid, because for once in our history, Nevada did something right; we're not at the bottom. We are expanding Medicaid and we do

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have our Marketplace, so we're going to assist that 40-percent onto Medicaid, partnering with our navigators that are with our community health clinic. Then, okay, so the rest of them, 60-percent, we have grown to know and love our members on an individual basis because of the care coordination.

Most of our members have never had access with dignity to the healthcare system, and that's what we have provided for them. We literally have had people crying in our enrollment room, because finally they're going to be able to get the care that need at a price that they can pay with their dignity. We give them a card that looks just an insurance card, and they access the care just like the rest of us who have the privilege of having insurance.

We felt very strongly that we needed to continue to serve our population. What we've done is partnered with an insurance company, a local Nevada insurance company. They will provide the health insurance, and we will continue to provide the care coordination.

What does outreach and enrollment look like for us? Well, it's completely one-to-one, because we are using our care coordinators, who already have a relationship to-first, the message is health care reform is here. Most of our members are not aware that it actually did pass. We do use the term "Obama Care", because it does resonate, and while it is negative for some, at least we don't have to explain what healthcare reform

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is. We did through robocalls, e-blasts, Facebook, and then just the one-to-one, because our members pay a monthly memberships fee, and they like to come in and pay with cash, because we're really a cash economy in Nevada, with the tips, because of the service industry. They come in a lot and pay, so we have a lot of contact with our membership, a lot of opportunity to tell them what's happening.

Then beyond that, they're like okay, it's coming, how much does it cost? Cost is everything to this group, everything, and health plans are not used to publishing cost. It has been a real challenge for our health plan to get comfortable with putting in writing what it's going to cost. There's only four rating criteria, so we can give an example. If you're a woman that lives in Washoe County, that makes 32,000 dollars a year, and you have three children, this is how much your premium will be.

Finally, we're able to release cost to our membership, which is all they care about; just tell me how much it's going to cost. They don't have any idea, are you talking hundreds of dollars, or are you talking 40 dollars? This has been a huge breakthrough for us, in terms of our outreach. Enrollment will be with brokers. We have become a brokerage. We have a for-profit side, because that's the only legal way to do it, and it will be one-on-one. We're already booked out for the entire month of October with our members, to enroll them one-on-one

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with brokers that we've hired. It's been an incredible ride. Probably the biggest challenge we are facing is misinformation. It's really hard to get the right information in a timely manner, because everything is so new. Thank you.

DIANE ROWLAND, SC.D.: Thank you very much, Niki. Now, we will return to the East Coast, to the experience of Massachusetts, with Manny Lopes.

MANNY LOPES: Thank you. It's great to be here. Once again, my name is Manny Lopes. I'm the CEO of East Boston Neighborhood Health Center. We are a large federally qualified health center located right in the heart of Boston. We operate out of a single location, 100 million in revenue, over 60,000 patients, and 300,000 patient visits. We're also unique as we operate one of the only 24 by seven emergency departments in a community health center, and I'll get back to that in a second.

First, to take you back to 2006 when Massachusetts passed the Healthcare Reform Law, Chapter 58, which required every resident of Massachusetts to have health insurance coverage. That meant expanding Medicaid, but it also meant creating an organization called the Connector Group, which is responsible, not only for the Exchange, but also providing subsidized health insurance plans to those that do not qualify for Medicaid.

The Connector was also responsible for the enrollment and marketing campaign for the state, and they spent millions

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of dollars on PSAs, including, if you're familiar with Boston, you know we're big sports fans and just my colleague to the left here—I think just about one out of two, 50-percent of the populations, you need to be a Red Sox fan to live in Massachusetts, thank you, Claire [misspelled? 00:43:21]. A lot of ads at Fenway Park, using our star athletes, to let folks know that this was coming, particularly for our younger adult, who were not interested in carrying health insurance.

The Connector also made available 3.5 million dollars to community-based organizations, such as community health centers. That money was used to expand the enrollment staff. For many of you, who are familiar with community health centers, know that we've been doing this for a long time. Over 40 years, we've had financial advisors, we've enrollment reps in our centers, a non-reimbursable expense, but helping our patients and anyone who walks through the door identify the right coverage for them, or connect them with a primary care provider.

With this money, we were able to expand that staff to exact 20 individuals. We also used the money to train the entire organization of what was coming, and that was important because we felt that this was truly a team effort, that at any one point, our patients would be asking the front desk staff, their medical provider, nursing staff, and we wanted to make

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sure everyone was educated at some level that was appropriate to their position about what was coming.

Then, of course, intensive training to the enrollment staff, so they could be truly the experts on the stick, in this area. We did our own community outreach, knowing that our patients were not attending Red Sox games at a hundred dollars a ticket, that we needed to go out to the churches, we needed to go out to the parks, to the train stations, and where they lived, worked, and spent their leisurely time, to let know what was coming. Of course, we provided direct one-on-one assistance throughout the process, to make sure they were enrolled.

For us, this has been an ongoing effort. Although we've been doing this for the last five to seven years, it doesn't stop there, because many of our patients have experienced break in coverage, or need to go through a redetermination process. We've maintained that staff and they still remain busy, making sure folks who either have a break in coverage, get back on the appropriate plan, or those that have never signed up, make sure they do get signed up. Thank you.

DIANE ROWLAND, SC.D.: Thank you very much. Now, I'm going to ask Samantha to be available for questions by phone. If the audience wants to ask questions, and direct them towards Samantha, we need to—well, we have two Samanthas, but I'm talking about Samantha Shepherd in Oregon. I'll let us recognize the individuals who have questions, if you would

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identify yourself first by raising your hand, so we can get a mic to you, and then second, identify the group that you're with, and then pose your question.

DAN GOTTHEIMER: Hi, Dan Gottheimer Maryland State Education Association. Yesterday, *The New York Times* ran an article saying that in order to keep costs down, a lot of the plans that were going to the Exchanges had a very limited number of doctor and hospitals incorporated, some as low as 50 or 40-percent of the surrounding area, and that is a huge concern, that people who go on the Exchanges are going to have very limited choices as far as doctor groups and hospital groups et cetera. I wanted to ask each of your states what your experience has been with that, so far.

DIANE ROWLAND, SC.D.: Okay.

KATHLEEN WESTCOAST: I'd like to preface this by saying I'm not a network expert, but I do know that the Maryland Insurance Administration did establish benchmarks for network adequacy. I know that all the products on the Exchange did have to meet certain benchmarks, in order to be able to make their products available on the Health Insurance Exchange. To the best of my knowledge, all of the networks on the Exchange are adequate.

NIKI KING: I can really only speak intelligently about the plans that we're affiliates with, which is Saint Mary's Health Plan. Quite to the contrary, it's a broad network, with

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multiple facilities. The one unique thing that they have done though is they've built what they call a pen network, for the primary care side, and they are really going to work closely with them, along with us and our care coordinators, to do more.

They're trying to keep most of the care at the primary care level that can be kept there, and they're doing incentives, where a cost-sharing incentive, with the primary care network. The specialty care network is the same that they have with their other small group plans, so it is quite broad.

MANNY LOPES: In Massachusetts, I think similarly to Maryland, the insurance commission made sure that there was adequate coverage throughout the state, but the reality of this healthcare reform is that there will be limited networks for particular groups or insurance programs. We're seeing that in Massachusetts as we have some very expensive academic teaching hospitals in Massachusetts. Some health plans have limited their members from those groups, or have required members to pay higher deductibles or copays if they still prefer to get their care there.

DIANE ROWLAND, SC.D.: Which is also true of general health insurance as well, not just that available through the Marketplace. We've a question over here.

HANNAH WEINBERGER-DIVACK: Hi, this is Hannah Weinberger-Divack. I'm with the National Senior Citizens Law Center. This is a question really for anyone; how you're

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dealing with the senior population? I know, Niki, you mentioned that the biggest problem that you face is misinformation, and I know that they're getting a lot of misinformation, and if you're doing anything to counter that. Also, more specifically, if you're talking at all about the dual demonstrations that some of the seniors might be eligible for, and how that might change things for them.

KATHLEEN WESTCOAT: Yes, I would just like to make a comment about the senior population. It's been very interesting on the work forums how many senior citizens are attending the healthcare forums, but the reality is this law is not applicable to them at all, in terms of—they have Medicare, so many of them, this does not apply to them at all. Now, the dual eligibles is a completely separate topic, but the vast majority of people who are coming to us, it is just not applicable.

NIKI KING: I'm glad you asked that. We run the SHIP Program, the Medicare counseling program. We have over 40 volunteers throughout the state of Nevada, and we administer that program. Last week I spoke with the director of that and there is a lot of misinformation amongst the seniors. They're very confused on when they enroll, and do they get to enroll all the way through March, or they confined to their open enrollment with Medicare.

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What we are doing is we've set up town halls throughout the State of Nevada, and our volunteers are going out to educate our senior population that everything stays the same for them, but yes, you are right, there is a lot of confusion about what's happening, how the two work together.

SAMANTHA SHEPHERD: If I can chime in from Oregon, we are also partnering with our SHIP program here, and it's called SHIBA. We have been cross-pollinating our community partners with SHIBA to make sure they know each other, and inviting them to our online collaboration tools, so they can meet each other and begin that working and developing referral systems, so we can send that population to where they'll get the best service. We've also been incorporating some fraud messaging into our marketing campaign and our messaging campaign. We've been making sure people know what Cover Oregon will and will never ask for.

We actually ran a press release last week, a media advisory, and then also ran out messaging to our list about we will never call you and ask you for your credit card number. We will never call you and ask you to give us payment to apply. A community partner or agent will never ask for payment to apply. Also made sure folks know how to call our customer service center and affirm that they are working with a certified community partner or insurance agent, and not

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somebody that is not certified to do this work. We're aware of the concern, and definitely trying to address it head on.

TONY HAUSNER: Hi, I'm Tony Hausner with Enroll America, just started as State Coordinator for Maryland. One of the things to the audience who are looking for people to be volunteers and appreciate any help in Maryland, recruiting volunteers, I guess my question to several of you is what ways can volunteers help you? That's one of the questions, having just started this, I don't know the answer to yet so I'd be glad to hear what kind of needs you have that we could provide help with.

DIANE ROWLAND, SC.D.: Well, let's have Kathy take it, since you're in Maryland.

KATHLEEN WESTCOAT: The connector entities really need as much help as possible to get the word out, just simply about the law and who to call about enrollment. Not only do people not understand the law, but a lot of people don't understand where to go to enroll. Hopefully the marketing campaign and the local media, the local campaigns, will help inform individuals, but to the extent possible, if you're able to do a regional approach in your volunteer approach, working with the connector entity in the geographic region, and having ties in with them would be tremendously helpful.

MALE SPEAKER: [Inaudible 00:53:33].

KATHLEEN WESTCOAT: Great.

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DIANE ROWLAND, SC.D.: Okay, question over here.

KELLY MACK: Hello, my name is Kelly Mack [misspelled? 00:53:40], and I'm from Environics Communications. We do a lot of health communications work. One of my questions came from the slides; you mentioned challenges with IT. Can some of you describe what those challenge, or what the biggest challenges have been, setting up the IT and the solutions or things that have been helpful for surmounting those challenges?

DIANE ROWLAND, SC.D.: Samantha.

SAMANTHA ARTIGA: I'm probably going to kick this off to the other Samantha in Oregon, because she can probably speak more directly to their experiences there, but in terms of what we heard when we conducted the case studies, I think in many cases, it's that they were building new systems. There's just a lot of effort involved in getting those systems off the ground. I think, sometimes, communicating complex policy to the individuals actually building the systems. There was a learning curve for the IT folks to learn how to communicate with the policy folks.

The other issue is that, because the systems are doing integrated determinations for Medicaid, as well as the Marketplaces, it involves the coordination of a lot of different folks at the state-level. I think what we heard is that the states really needed to establish strong close collaborative working relationships among folks in those

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different agencies to get those systems built. The other challenge, which I referenced at the end, was that a lot of the final rules from the Federal Government came out slower than I think some states would like, because they needed to meet certain target deadlines in order for their systems to be ready to go on October one.

In many cases, I think at some points, states had to move forward with builds while they were still awaiting those final rules. They would just stay in close contact with CMS to let them know what direction they were going and making sure that everyone was comfortable with where they were going.

I think that because the IT build has been such a significant challenge, as I mentioned, at least from these three states, we heard that the systems are not exactly what they want them to be on October one. They had to prioritize what was the most important thing to have built in on October one, but they all are planning to continue to enhance those capabilities over time, and are building in workarounds until they can get those capabilities built in. Samantha, I don't know if you want to touch on the Oregon experience a little more directly.

SAMANTHA SHEPHERD: Yes, I'm happy to, and I think you hit it straight on. I think I would add that there are a lot of cooks in the kitchen when it comes to something like this, and so we actually have to be able to communicate with all of

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the state systems, so various legacy systems we have to build interfaces with, and those legacy systems can be anywhere from 10 to five years old, to 15 years old, and have a myriad of data in them from various programs.

We also have to be able to transmit information with all of the carriers, as well as the Federal hub. We can build receptors and we don't always have control over the information coming to us. There's also a lot of ways information can be interpreted, and all of the carriers have their own systems as well on all their ITs. I think just getting all the different developers and all the different IT geniuses to speak the same language and develop it the same way on the same timeline for testing is really hard.

There's also the idea that we can develop the communication, but we can't transmit any information on a lot of these interfaces yet. Knowing the connection is there, and knowing it can communicate and develop a correct eligibility determination or shopping environment; those two things are often a little bit different. A lot of the pieces were developed, but then, just over the past few months, have they all been connected? You can test different segments, but until you get end to end, some of those gaps won't be identified. I think that's just the way it is.

We actually have a slide in our general presentation that we show that our executive director told this story; Rocky

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King is a very personable person. If anyone had a chance to meet him, he has some great stories. He always tells the story of a 1972 Honda. Basically, our goal for October, we want to drive across our state and make sure we're picking up all the Oregonians possible, and we want to do it for the best gas mileage, and we don't want to break down.

We're going to keep building that Honda, and we're going to get to having leather interior, and sunroofs, and CD players, and cruise control, and all that fun stuff. On day one, there's no radio, there's no air conditioner, there's no power locks, no power windows, and that's okay. If we all think about Medicaid and Medicare, there have been hundreds of applications since 1965, in every one of our states. We aren't supposed to get it right on day one. We want the opportunity to make it better and better, and we need to start with what can do, and do it well, and then we can keep building, keep perfecting and make it better and better as time goes on.

DIANE ROWLAND, SC.D.: That's terrific; that would be a great ending for this session, but instead, we're going to take the next question.

JOENEL JOHNSON-OMANI: Sorry. Joenel Johnson-Omani, Hemophilia Federation of America. My question is based on something that you mentioned, Mr. Lopes, but I'd like the panel to comment as well. You mentioned breaks in coverage. I wanted to know what are the primary reasons for breaks in

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coverage, the duration, and the what the other states, including you, Samantha in the Honda, are thinking about, to anticipate those from happening, or how to prevent those from happening.

MANNY LOPES: The duration question is difficult to answer, because I think it varies based on the individual's situation. The breaks that we've seen have been seasonal workers, those that are not in permanent employment, or employment like migrant workers, employment based on the seasons.

Others are just communication, that's where we've seen most of our breaks come in, folks not responding to mailings that are coming from the state or the private insurance companies, and folks generally don't understand—it's a much different reading level, and the states doing a lot to try to standardize these letters, and try to make it at a reading level that's appropriate for that population, or even in the language that's necessary.

What we try to do is encourage our patients to—whenever they receive any one of those mailings or letters, or communication from the state or the private entities, to please bring those in and, again, we use our enrollment or financial advisors to help them help interpret the letters, and then take action if one is necessary.

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SAMANTHA SHEPHERD: I would agree with everything that was just said. I think transient populations, the populations that fall between the cracks in many programs, are those that are most likely to turn and fall off of coverage, and that's why we think having community-based organizations involved, and ongoing relationships with service providers like health departments and safety net clinics are really key, because those people often walk back in the door again, and can help with that assistance.

We also—in the portal, we have the ability for community partners and agents to maintain a relationship with the clients they served. They will actually have a renewal date eventually, not on day one, a renewal date that they can see in their dashboard for everyone they've ever helped, and they can reach out to those people and send reminders. As well as the notifications coming from Cover Oregon, and if they're on CHIP or Medicaid from the state, there may also be an email coming from the person that helped them enroll, which is that local connection, which is really important.

DIANE ROWLAND, SC.D.: Next question.

ABORASH ERVASTIVA: Hi, I'm Aborash Ervastiva [misspelled? 01:01:27]. I'm actually a navigator at Community Clinic, Inc. [misspelled? 01:01:30], and now we're an FQHC in Prince George in Montgomery County, so Maryland. My question is that some of you mentioned that you had existing programs,

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or you had a clinic setting, or a community outreach setting. How did you reconcile having an existing system, and then incorporating this big change, in detail? What were some of the biggest challenges, and while things are, it's all pilot and sometimes state and county officials, they're busy, and they're not communicating.

What is internally something we can do like, I guess play on our strengths, rather than just waiting for communications? Some things you would have to wait to get directions on, but what are some things that you were able to—either your existing staff, or other programs that you were just able to pick up on, and what were that?

DIANE ROWLAND, SC.D.: Manny.

MANNY LOPES: I would recommend that you look at your workflows very carefully. This can be overwhelming and what you will find is increase in volume in that area. We went all the way to redesigning the actual waiting room space, office space for the enrollment advisors, and again, looking at the workflows, adding a triage greeter at the front to identify what is the issue up front, and making sure that we're directing the patient to the right enrollment rep. Really take a look at the physical space and the work flow.

NIKI KING: That's a great question, because it's really easy when you're building a program in startup to just lay the track. It's really hard to lay another track on top of

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when the trains going a thousand miles per hour. That's been my job, to head that up.

We've been very strategic about what we can do and what we can't do. My main goal is managing the expectations of my staff, and letting them know it's okay to not do everything right, out the gate, and giving them a lot of freedom to make decisions and the comfort to fail, because when you're doing startup, and without the right information, no one has the right answer. It has to be, in my opinion, done in a team approach, and that's the way that we've approached it.

I wanted to go back to your question about the breaks in coverage because this is key. We do a monthly membership fee, which you could liken to a premium, a monthly premium. Ten percent of our membership drops every month. This is something that we talk about on a daily basis, retention. How are these insurance companies going to retain their membership and therefore their profit to keep going?

I think they're in for a really rude awakening, and this is one of the reasons why Saint Mary's Health Plan's partners with us, because retention for this group comes down to relationship. If you don't have a relationship with them, there's no reason why they're going to select to pay their premium, over gas or food. It's not going to happen.

We are constantly encouraging our members through relationship that the value of their health, and putting their

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funding toward their health, their limited resources towards their health. If you don't have a relationship with them, if you're just a piece of paper, then they will drop. I see it every day in our company; they will drop. That's what we're doing, is that retention starts with enrollment, that's where it starts. Even further back, it starts with outreach. If they know you care about them, they will stay with you.

DIANE ROWLAND, SC.D.: Next question.

REBECCA WEINER: My name is Rebecca Weiner. I'm also a navigator at the same organization. My question is specifically for Maryland, but if anybody else wants to chime in, I've heard some very directly conflicting things about what's going to happen to the resources for uncompensated care. Some times people are saying that, actually, there's going to be more money going towards that as well. I've heard other places say that because, with the assumption that more people will be covered, those resources are going to get cut. I don't know if any of you would like to speak to that.

KATHLEEN WESTCOAST: I've heard conflicting information as well. I heard with the Affordable Care Act, there may be more people who newly do have health insurance, but aren't necessarily sure how to navigate the health care system, who inadvertently utilize emergency rooms or other sources of high-cost care. All of this is really anecdotal, the things that I've heard, so I think it remains to be seen.

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I think the key with enrollment, just piggy-backing on what Niki was talking about, insurance enrollment is very critical and important, but helping people understand how to navigate the health care system, how to utilize a managed care network, and to understand all the nuances of the plan are critically important, and that is part of the navigator's role. I just think it's really critical to have that relationship building, and to help people understand how to use insurance. It may be their first time they've ever had it.

DIANE ROWLAND, SC.D.: I think we all know that as much as this outreach and the enrollment will be important, there will still be people who remain uninsured, and that uncompensated care will not go away from the system, but hopefully it will be less as more people gain coverage. We have a question here.

CLARKE ROSS: Hi, I'm Clarke Ross [misspelled? 01:07:21], American Association of Health and Disability. In every state, we have a designated state mental health agency, we have a designated state substance abuse agency, and we have a designated intellectual and development disability agency. A number of you have talked about Medicaid and insurance collaboration. What are your experiences in working with these special disabilities sub-population agencies?

KATHLEEN WESTCOAST: Well, as part of our connector grant applications, it was critical that we worked with a wide

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variety of stakeholders and community-based organizations that serve vulnerable hard to reach populations. We have partnered with disability agencies, mental health agencies. HealthCare Access Maryland, currently we're already embedded in 20 drugs treatment sites in Maryland. We felt it was very, very important to have a focus. We did invest resources in community-based organizations that serve the disabled, mentally ill, and those who are on drug treatment.

DIANE ROWLAND, SC.D.: Okay, next question.

KRISTEN LEE: Hello, my name is Kristen Lee [misspelled? 01:08:27]. I'm from the Truman Foundation, and I really appreciate the emphasis and importance on one-to-one consumer assistance. Think about, specifically, vulnerable populations and the large geographic distances, rural populations in particular, where 40-percent of households, on the national average, don't broadband Internet connections, how do we think about reaching them through the Marketplaces, which is very web-based?

DIANE ROWLAND, SC.D.: Maybe we'll turn to Samantha in Oregon, to start that question.

SAMANTHA SHEPHERD: Sure, so I think, again, having community-based organizations that have existing relationships in those communities helps a lot, also working with country governments in those communities that are delivering services, and getting creative to think about Meals on Wheels, and summer

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food sites, and all of the other things that bring people out of their homes and into the community where you can interact with them.

We have one county here in Oregon that has about 500 people in it, and they have a crab fest every spring. It is an event where you can shake hands with almost every single person in the county. I think finding events like that, where people do come out and you can try to get a hold of them is great. We also have several partners that will be phone banking membership lists and donations lists that they have from previous campaigns, as well as neighborhood canvassing, which can be hard in the geographically isolated area, amongst ranches, but it is another way to get out and make that connection.

I think, lastly, finding decision makers and community leaders that can be a spokesperson within the community is important; perhaps the safe leader that can come out and make a statement on a Sunday or Saturday at services, and endorse, for lack of a better term, what is happening, and how folks should get covered and get in play, as well as using mayors, Chambers of Commerces, people that are really a voice in the community. Here in Oregon, as we say, the I5 corridor, we can't talk to everybody in the state. We need to go to those places and listen to what their needs are, and listen to how they best reach their communities, and then empower them to do so.

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DIANE ROWLAND, SC.D.: Okay, we have a question in the back of the room.

DAVE CAVANAUGH: Hi, my name is Dave Cavanaugh I'm a public health policy consultant, working now with a leading disorders community. My question has to do with some things that are going on in other states, far more than in yours, and I'm glad to hear that it's not going on in yours, where navigators are, by state law, required to be insurance agents, and take an additional 40 hours of training and pay for it yet. That's the worst that I can think of right now, but it is a case similar to what the women over here said.

When you're coming in and creating a new system, where there was a system, you'd have to negotiate roles. Obviously, the uninsured community didn't occupy a lot of insurance agents' time, but still the issue's there, from the top down especially. I'd be interested in hearing what you have to say about the role of assistor, navigator, agent, and broker. Thanks.

SAMANTHA ARTIGA: I would say I think the situation is going to be slightly different in every state. The states are still in the process of setting up what their assistance programs are going to look like, and the brief that's in your packet goes through a little bit about some of the variation we're seeing in the structure and design, and approaches used in each state. I think, as is clear from the comments today,

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access to this assistance is really going to have key implications for the success of enrollment efforts.

Just drawing on the case study findings, I'm going to talk about how, at least Nevada, has dealt with this issue. We went out there and spoke directly with insurance brokers in the state and heard very clearly that in the beginning, they were very adversarial to the changes coming, felt like it was a threat to their market share. We're unsure about what it would mean for them, but over time, and I think through a lot of outreach from the state and the Marketplace, to the broker community, they have since come around and feel that they will have a role, a defined role, and recognize that the target population that is being reached in this state is very broad, and that the navigators and assistors will likely be assisting different segments of the population than the brokers themselves will be assisting.

I think many are now looking at it as an opportunity to increase their market share, since so many people will be eligible for coverage. I think, at least in that state, they've worked out an arrangement, where I think those assistors, including the brokers, are working together, recognizing that they will each be targeting slightly different segments of the population.

KATHLEEN WESTCOAST: I just wanted to add, I'm not sure about my counterparts, but in Maryland, it is required that

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navigators and assistors are certified and sit through a training. You have to take a 40-hour class and pass a test, and all of our navigators took a test on Friday, so hopefully I'll hear soon that they did well.

DIANE ROWLAND, SC.D.: Did you charge for that?

KATHLEEN WESTCOAST: There was a small charge, yes.

NIKI KING: In Nevada, you do have to go through a training. They are charging for it, and for the brokers, navigators, and assistors—in the beginning, we were told that we could be assistors, because assistors could direct to one plan, and this comes down to that misinformation, where the Exchange is telling us one thing, the DUI is telling us another thing, and then the law says something else.

It wasn't until three weeks ago that our insurance commissioners just said emphatically, you have to become a brokerage and you have to have brokers on staff, so that's why we had to do that. We didn't want to do that, because that's weird for us, as a nonprofit, but to be legal, that's what we have decided to do. The training—the brokers just went through the training. We don't even have our application yet. We don't even know what it looks like, how long it is. The brokers haven't even had the opportunity to play around with it. It's going to be really interesting on October first.

DIANE ROWLAND, SC.D.: It's that car rolling without a lot of extra equipment. One more question here.

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BARBARA DIPIETRO: Hi, Barbara DiPietro with the National Healthcare for the Homeless Council, or we're FQHC, as it serves homeless populations. Kathy, I know you had mentioned specifically working with homeless populations, and Samantha in Oregon, you had mentioned working with transient populations, but Niki, you had mentioned your program starts at 100-percent of FPL.

I'm curious what your state is doing to reach the homeless, which is typically a zero to 50-percent FPL population, and Manny, what has worked in Massachusetts to reach a really marginalized population that doesn't have stable addresses, and tends to use healthcare in a different way, a lot more haphazard, and just-population's not traditionally being eligible, so just reaching them, and what worked and what you're trying. Thank you.

NIKI KING: I wish I could speak to that, I can't, I don't know, and we have a huge homeless population in Las Vegas. There's only two agencies in Vegas who got the navigators, so I'm a little bit fearful that they will be left out.

MANNY LOPES: For us, we have a large health center that services the homeless population, and they do a great job at going out and finding these individuals, and bringing the information to them. Of course, when they are being serviced at the health center, I know they're similar to us; they have

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enrollment reps and financial advisors there to help them. This is also the population from Massachusetts that's also covered under the Uncompensated Care Pool.

For those individuals that don't have stable addresses or cannot produce any documents to be eligible for Medicaid or any other services, these individuals are covered under the Uncompensated Care Pool, which in Massachusetts was cut in half, but still remains, I think, higher than the national average of many states, so we are very fortunate in Massachusetts, there's just a lot of them.

KATHLEEN WESTCOAST: If I could just chime in, I know Barbara is well aware of HealthCare Access Maryland, but we've had tremendous success in enrolling homeless individuals into our limited health insurance plan, the primary adult care program. Last year, we were able to link about 85-percent of our homeless population to health insurance, and with Medicaid going into full effect January first, about 75,000 people, including many of the homeless, will roll under full benefits on January one. It can be done, is my point in all of this.

SAMANTHA SHEPHERD: If I can chime in for Oregon, we are doing, not through Cover Oregon, but through state Medicaid agency, the Oregon Health Authority, they have received a state plan amendment from the Federal Government, to use the SNAP data as it was mentioned in the presentation, to fast track enroll people that are eligible for Medicaid or likely eligible

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for Medicaid. Families and individuals that are found eligible for SNAP will actually receive a fast track letter in the mail that say call this number and you will be auto-enrolled in health coverage.

We're trying to take a swath of the population out of using the online application and the portal that don't really need to, because we already have their eligibility information from another program, and are able to fast track enroll them with that data. That's one key element, but from an outreach standpoint, I wanted to add that we have our assistors, we have our community partners that are going to be the boots on the ground, offering application assistance, but we also have a lot of entities that are just going to do outreach and public education.

Making sure that states are reaching out to community action programs and Project Access Now, and Homeless Connect, when folks do the homeless count in February, which happens in all states, there's great opportunities to hit resources in every community that are doing outreach, that can then refer to enrollment sites.

We also have a big connection with all the homeless liaisons due to the McKinney-Vento program in our school districts. There is someone appointed in every school district to help homeless kids' access resources, and that is another

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great connection, to make sure folks know where to refer families, and where they can get help or assistance.

DIANE ROWLAND, SC.D.: Of course, I think we've just heard from three states that have elected to expand the Medicaid roles. Obviously, those who live in the states that have not chosen would be the most left out, because of their income, putting them well below the poverty line.

We have one more question here.

JENNY GOLD: Hi, my name is Jenny Gold. I'm a reporter with Kaiser Health News. I have two questions. The first one is can you walk us through the process of an assistor or a navigator helping someone enroll in coverage? There seems to be some confusion about what they are and aren't actually allowed to do, in terms of giving advice and entering personal information, and whether you think any of those limits are going to hinder enrollment for people who don't know much about insurance.

The second question is what happens to all of these consumer assistors, be they navigators or in-person assistors, after open enrollment ends? There's going to be a six-month period after March when you're not going to have really jobs for them, and then they have to come in again for three months the following year. How does that work, are these seasonal employees, or what happens?

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KATHLEEN WESTCOAT: I'll answer your first question, which in Maryland, I'm not sure about other states, but there is a distinction between assistors and navigators. Assistors in the State of Maryland can enroll people into the Medicaid program. They do not have the ability or authority to enroll people into the qualified health insurance plan side. If they come into contact with somebody who is over income, over 138-percent of federal poverty level, they must hand that person off to a certified navigator.

The navigator is able to do subsidies, Medicaid, as well as enroll people on the qualified health plan side, explain subsidies, tax credits, so on and so forth, and help them select a very specific plan.

As to your second question, we were banging our heads against the wall too, what are we going to do after open enrollment is over. They are full-time employees. We will really boost up our education campaign. This is going to be a few years, I really think, to get people to understand what is going on. We do plan, after open enrollment ends in March to—we are going to hit the high schools, we are going to hit the community colleges and do a very robust education effort during the non-enrollment months.

DIANE ROWLAND, SC.D.: I think it's important to remember that there is no open enrollment period for Medicaid. People can sign up for Medicaid throughout the course of the

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year. It's really only the access to insurance through the Marketplace.

Well, we have, I think, had a very rich discussion here. I think it cannot be understated what an important role commitment at the state level to making this work is, in terms of being able to move forward and get people connected to insurance. We've also seen from all of our individuals here that we are really building on the experience of the CHIP program, where we learned to do outreach to children and use various mechanisms to reach people in the community.

I think all enrollment activity is really going to be local, and so it really does depend on the on-the-ground work, and certainly, Ravens and Red Sox help in their particular markets. I think the most important thing we've learned today is that it also takes a real partnership between people working at the state level, inside of state government, outside of state government in the navigator organizations, and especially with providers and community-based partners.

This is a big effort going forward 'til the first of October starts open enrollment, but it doesn't stop the effort to get many, many people the kind of coverage that they need, either through the Medicaid program or through some of the available coverage in the individual market, through the Exchanges that are now called Marketplaces.

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Remember that a lot of people will also be getting their coverage and continue to get their coverage through the employer-based system. For them and for the Medicare population, this is not an effort to move them to something new. It's an effort to help them be part of a sustainable health coverage system for all Americans.

Thank you for joining us today and especially thank you to Samantha in Oregon for joining us by phone, and to our panelists, and to the Kaiser team that helped put this together. Thank you very much.

[END RECORDING]

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