

Summary of Consumer Assistance
Program Grant Data from
OCTOBER 15, 2010 through OCTOBER
14, 2011

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Summary of Consumer Assistance Program Grant Data from OCTOBER 15, 2010 through OCTOBER 14, 2011

Introduction

To help consumers with a wide range of private health insurance questions and complaints, the Affordable Care Act created the Consumer Assistance Program Grants (CAP). CAP Grants provide nearly \$30 million in new resources to help States and territories establish or strengthen consumer assistance programs. CAP Grants were awarded in October 2010 and 38 States and Territories are using these resources to empower consumers and provide direct services to answer health insurance questions.¹ Data reported for the first year of the program (October 2010- October 2011) demonstrate the significant impact these programs have already made. In just one year, CAP grantees have:

- Provided individual assistance to **207,460** consumers;
 - Approximately 58 percent (120,806) of consumers during the first year of the grant period received case management services.
 - Approximately 42 percent (86,654) of consumers who contacted a CAP grantee received education and/or referral services
- Assisted 22,814 consumers (76 percent of all closed cases) in successfully challenging their issuer's decisions, finding coverage, and resolving their private health insurance problems;
- Obtained more than **\$18 million** in savings on behalf of consumers in addition to the unquantifiable benefits from finding more affordable health care and getting the benefits that consumers need; and
- Reached hundreds of thousands of consumers through outreach and education efforts.

This paper provides additional background and highlights of the consumer data collected by CAP grantees between October 15, 2010 and October 14, 2011. It also details how federal grant funds have allowed CAP grantees to start or expand consumer assistance services in their State and provides real-life examples of how these programs have helped consumers.

¹ 40 CAP grants were awarded to 35 States, the District of Columbia, and four U.S. Territories. In early 2011 two States, Wisconsin and Ohio, terminated their grant awards. A list of the original CAP grantees including their goals for the grant award can be found at: http://www.healthcare.gov/news/factsheets/capgrants_states.html.

Background

CAP grants support various State agencies including: Departments of Insurance, Offices of the Governor, Attorney General Offices, and independent consumer assistance offices. Approximately 10 grantees have also partnered with non-profit organizations to increase the visibility and accessibility of these programs to residents in their States.

As required by statute, CAP grantees provide a wide range of consumer services, including:

- Assisting consumers with filing appeals of claim denials or complaints against health plan practices;
- Helping consumers enroll in health coverage, including the Pre-Existing Condition Insurance Plan;
- Educating consumers about their rights in getting and keeping health insurance;
- Tracking consumer complaints to help identify recurring problems and strengthen oversight; and
- Starting in 2014, programs must help consumers resolve problems with obtaining premium tax credits.

Grantees must provide periodic detailed reports to the Department of Health and Human Services (HHS) on the types of problems and questions consumers have experienced with health coverage, and how these problems and questions are resolved. Analysis of this data helps the Centers for Medicare & Medicaid Services (CMS) identify patterns of practice and potential noncompliance in the insurance marketplaces.

CAP Reporting Requirements

Section 2793 of the Public Health Service Act, added by section 1002 of the Affordable Care Act, directs States and Territories awarded CAP grant funds to collect, track, and quantify consumer problems and inquiries, and to report these data to the Secretary of HHS. Section 2793 also gives the Secretary the authority to use these data to strengthen oversight of the health insurance market and to identify trends of behavior affecting individuals' and families' access to health care coverage.

The 2010 CAP Funding Opportunity Announcement (FOA) provided additional guidance for data collection and reporting. CAP grantees were expected to submit an initial data collection report to HHS within six months of the award date. After the initial data collection report submission, grantees were directed to file quarterly data collection reports. As outlined in the CAP Grant Programmatic Terms and Conditions, these quarterly reports were due 30 days after the end of each quarter, as follows:

- Data from October 15, 2010 – April 15, 2011: due May 16, 2011
- Data from April 16, 2011 – July 15, 2011: due August 15, 2011
- Data from July 16, 2011 – October 14, 2011: due November 14, 2011

The consumer data submitted to CMS is not representative of all consumers' insurance issues. This data only represents the consumers that contacted a CAP grantee for direct assistance and the consumer information collected by the CAP grantee for reporting to CMS.

CAP Grantees Began Operations at Different Times

During the early phase of the grant period, CAP grantees were in various stages of operation. Most CAP grantees were hiring staff to meet the responsibilities of the grant, developing or enhancing database systems to capture consumer inquiries and outcomes, developing staff training on how to provide consumer assistance and collect data, and developing processes for providing assistance to consumers. While some of the programs receiving CAP grants were ready to begin operations at the beginning of the grant period, others needed time to build program operations before accepting consumer inquiries.

CAP GRANTEES PROVIDED DIRECT ASSISTANCE TO OVER 200,000 CONSUMERS DURING THE FIRST YEAR

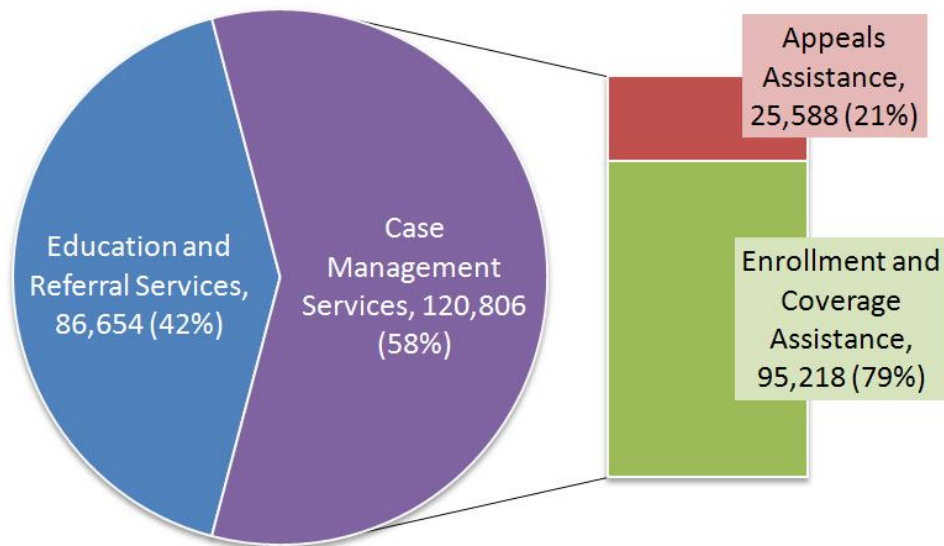
Between October 15, 2010 and October 14, 2011, 35 CAP grantees provided assistance to 207,460 consumers. Assistance was provided to these consumers in one of two ways:

- Case management services – Help filing appeals, resolving private health insurance problems, or enrolling into private or public health insurance; or
- Education and referral services – Respond to general insurance-related inquiries or refer consumers with coverage other than private coverage to appropriate State or Federal agencies for assistance.

Figure 1 illustrates a breakdown of the types of services provided to consumers during the first year of the grant award period. The bar graph to the right of the pie chart provides a breakdown of the types of assistance provided under case management services.

Figure 1: CAP Grantees Provided Assistance to More than 200,000 Consumers in First Year of Funding

Source: Data reported, October 15, 2010 through October 14, 2011



Appeals Cases

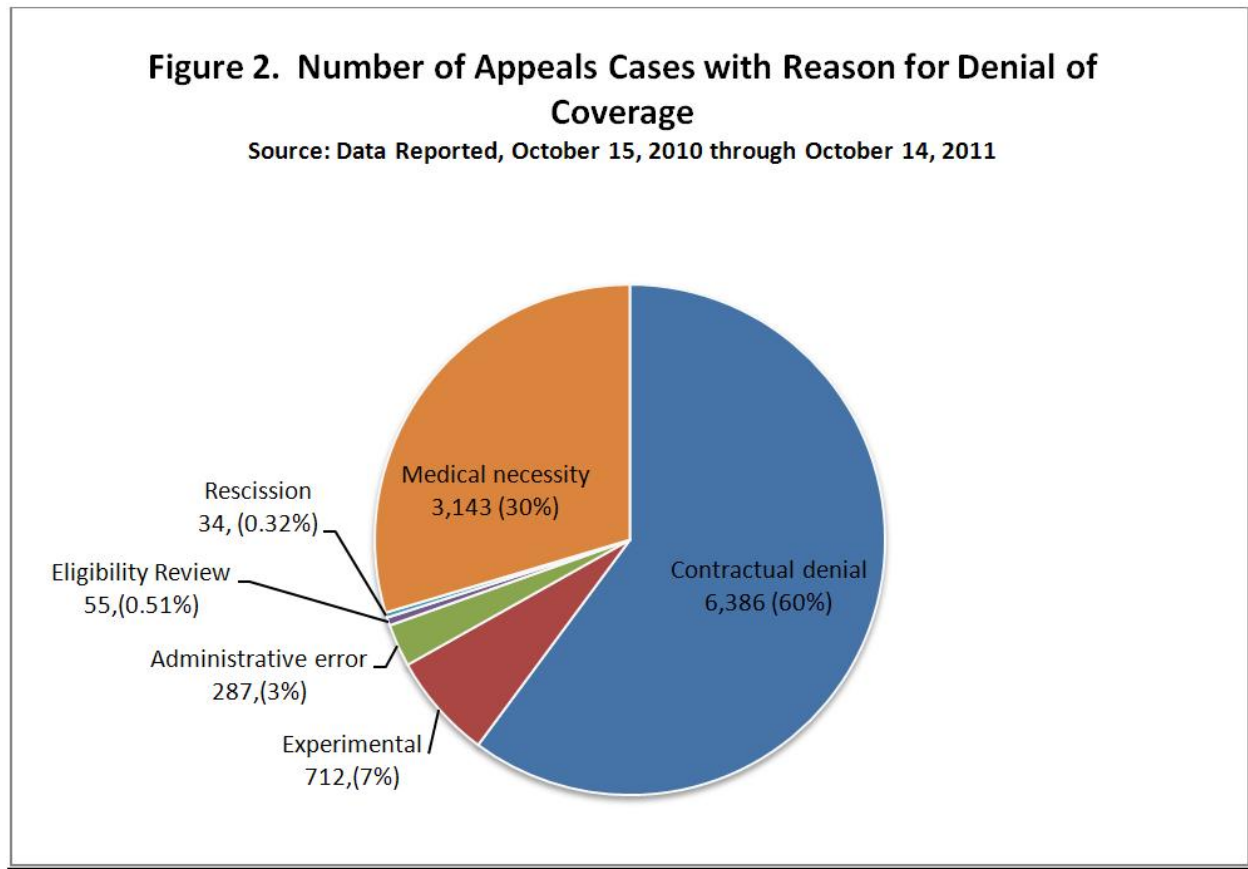
The appeals data in Figure 1 represents the number of consumer contacts in which the CAP grantees assisted the consumer in filing an appeal for an adverse coverage determination or denial of benefits. Of the 25,588 appeals cases reported during the first year of the grant period, CAP grantees included the following claim denial reasons as the substantive reason for consumers seeking assistance for approximately 10,617 or 41 percent of the appeals cases:²

- Medical necessity—claim was denied because service was determined to be not medically necessary
- Experimental/investigational—claim was denied because services were determined to be experimental/investigational
- Rescission—plan rescinded after issued
- Incorrect claim/adjudication/administrative error—claim denied as a result of an administrative error
- Contractual denial—claim denied because the plan specifically excludes coverage for a specific service

² A case can have more than one reason for denial.

- Eligibility review—consumer is seeking review of an eligibility determination

Figure 2 provides a breakdown of the denial reasons for the cases reported by the CAP grantees.



The issuers' decisions were overturned, in full or in part, in approximately 48% (2,005) of the closed appeals cases regarding denials of coverage or benefits.³

Case Management

Approximately 58 percent (120,806) of consumers during the first year of the grant period received case management services. Case management is a multi-step, collaborative process used to ensure that the consumers' information, coverage, and health care needs are addressed quickly and fairly. Depending on the complexity of needs, consumers may require direct, individual assistance over an extended period of time. As a result, providing comprehensive case management services can be a time consuming and resource intensive process. Case management activities include helping

³ CAP grantees reported a reason for denial of coverage for both open and closed appeals cases. Cases that were closed without a resolution can be attributed to incomplete data entry and/or difficulty with mapping the data.

consumers understand their insurance coverage, educating them on their rights and protections, and coordinating resources with other entities, such as HHS, the U.S. Department of Labor, State Medicaid Agencies, and non-profit organizations. Examples of case management services provided by the CAPs include:

- Helping privately insured consumers appeal their insurers' decisions to deny benefits or coverage;
- Helping privately insured consumers when they are experiencing an affordability or adequacy problem not subject to appeal;
- Helping insured consumers when they are losing their current coverage; and
- Helping uninsured consumers look for affordable coverage in which they could enroll.

Of the 120,806 consumers who received case management services, 95,218 consumers (79 percent) received assistance with enrolling into coverage or with an insurance problem that did not involve an appeal. An additional 25,588 consumers (19 percent) received help in filing private health insurance appeals.

How CAP Grantees Help Consumers through Case Management: A Case from the Michigan CAP

In February 2011, the Michigan CAP was contacted by a consumer after her employer-sponsored health insurance dropped her 25-year-old daughter on November 1, 2010, claiming that the daughter was no longer eligible for coverage because she had turned 25. The daughter has rheumatoid arthritis and needs prescription medications and medical care that cost approximately \$2,500 a month. Although the insurer had agreed to implement the Affordable Care Act's requirement to extend dependent coverage to age 26 before the requirement's September 23, 2010 effective date, the consumer's employer said that the daughter wouldn't be eligible to re-enroll in the plan until open enrollment in September 2011.

Michigan CAP staff contacted the employer-sponsored plan on behalf of the consumer, discussed the issues with the plan, and was able to get the daughter re-enrolled retroactive to November 1, thus avoiding any gap in coverage and making the plan compliant with the Affordable Care Act provision related to dependent coverage for young adults.

The Michigan Health Insurance Consumer Assistance Program (HICAP) is run by the Michigan Office of Financial and Insurance Regulation.

Education and Referral

Approximately 42 percent (86,654) of consumers who contacted a CAP grantee received education and/or referral services. These consumers were not requesting assistance with an immediate private health insurance problem. For these consumers, the CAP grantees provided education on general health insurance inquiries or provided information to the consumers on how to contact the appropriate agency to help them resolve their problem. These consumers included, for example, Medicare or Medicaid beneficiaries having problems with their public health coverage for which the CAP grantee provided referrals to the appropriate State Medicaid office or Medicare State Health Insurance Program (SHIP).

Affordable Care Act-Related Inquiries

CAP grantees reported receiving 3,180 Affordable Care Act-related inquiries from consumers during the first year of the grant period. Approximately 44 percent (1,413) of Affordable Care Act-related inquiries concerned appeal and grievance protections. Please see Table 1 below for the full list.

Table 1: Affordable Care Act-Related Consumer Inquiries, by Affordable Care Act Issue

ACA Issues	Number of Cases with Inquiries
Appeals/grievances protections	1,413 (44.43%)
Pre-existing condition insurance plan	427 (13.43%)
Premium rate increases	412 (12.96%)
Dependent coverage for young adults	173 (5.44%)
Out-of-network emergency care	171 (5.38%)
Pre-existing condition exclusion or denial for children	148 (4.65%)
Prevention services	116 (3.65%)
Rescissions	103 (3.24%)
Annual benefit limits (including all issues with mini-med policies)	83 (2.61%)
PCP/Pediatrician choice	81 (2.55%)
Lifetime benefit limits	17 (0.53%)
Wellness programs	16 (0.50%)
Discrimination based on salary	7 (0.22%)
OB/GYN access	7 (0.22%)
Early retiree reinsurance	5 (0.16%)
Medical Loss ratio rebates	1 (0.03%)
Total	3,180

CAP GRANTEES CLOSED 30,012 CASE MANAGEMENT CASES WITH RESOLUTION; 22,814 WERE RESOLVED IN FAVOR OF THE CONSUMER

Providing comprehensive case management services means CAP grantees work with consumers on their coverage issues until there is a resolution. Of the 120,806 consumers CAP grantees provided with case management services, 30,012 cases were closed with a resolution.⁴ The resolution for these cases may or may not have been in the consumer's favor. The CAP grantees helped consumers positively resolve their coverage issues by:

- Enrolling the consumer in health insurance;
- Assisting the consumer with an appeal that overturned or partially overturned the issuer's decision; or
- Working with the consumer and their health plan to resolve a problem.

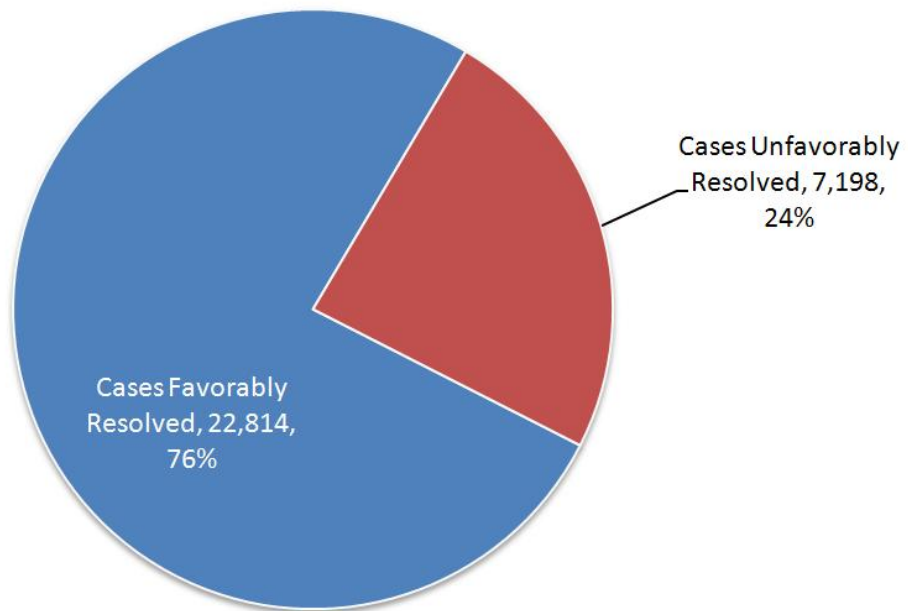
Resolutions

Figure 3 illustrates the proportion of closed cases by the type of resolution by the CAP grantee handling the case. Of the 30,012 closed cases, CAPs assisted 22,814 consumers (76 percent) in successfully challenging their issuer's decisions, finding coverage, and resolving their private health insurance problems. See Appendix A for examples of how CAPs helped consumers to get a positive resolution of their private health insurance problems.

⁴ CAP grantees reported both open and closed cases, the open cases accounting for a portion of the cases without a resolution. Cases that were closed without a resolution can be attributed to incomplete data entry and/or difficulty with coordinating data.

Figure 3: Of Closed Cases, CAP Grantees Resolved the Majority in Favor of the Consumer

Source: Data reported by 35 CAP grantees, October 15, 2010 through October 14, 2011



Consumer Savings

Typically, consumer savings represent the costs of healthcare services, procedures, and claims that would have been the responsibility of the consumer had the CAP grantee not intervened on the consumer's behalf. During the first year of the grant period, CAP grantees recovered more than \$18 million in savings on behalf of consumers. Of this total figure, more than \$13.2 million or 73 percent of the amount was related to cases that did not involve a formal appeals process and over \$4.8 million or 27 percent of the recovered dollar amount was directly related to appeals cases. This quantification is incomplete because it does not take into account the unquantifiable benefits from finding more affordable health care and getting the benefits that consumers need.

MANY STATES AND TERRITORIES WERE ABLE TO SHIFT THEIR APPROACH TO CONSUMER ASSISTANCE TO PROVIDE COMPREHENSIVE CASE MANAGEMENT SERVICES AND EXPAND SERVICES TO CONSUMERS

Before the CAP grants, some States had established independent offices of health insurance consumer assistance or ombudsman programs for their residents. Few of these programs, however, were providing all of the services required under the CAP program. CAP funds allowed these existing programs to expand their services, while allowing other States and Territories to establish

new, independent consumer assistance or ombudsman programs. Based on CMS' analysis, an increase in the capacity for and type of consumer assistance services provided by the CAP grantees is evident.

Expanded Capacity

From the time grant awards were announced to the end of the first year grant period, many States and Territories were able to institute comprehensive case management services, a model not previously used. CAP grantees also used grant funds to offer new or expanded services:⁵

- 31 programs created new capacity to assist consumers with appeals and filing appeals on behalf of consumers;
- 32 programs created new capacity to provide enrollment assistance to consumers who were uninsured or experiencing coverage transitions;
- 26 programs built new capacity and expertise to serve vulnerable and underserved populations;
- 35 programs expanded data collection and increased reporting capabilities at the State and Federal Level in order to analyze consumer experiences and trends; and
- 32 programs planned, developed, and established outreach and education initiatives statewide.

How CAP Grants Helps States Help Consumers: North Carolina's Experience

Before receiving a CAP grant, North Carolina's Department of Insurance logged complaints and problems from consumers covered by self-funded employer plans, but did not have the regulatory authority to intervene. With CAP funding, the North Carolina Department of Insurance provides a wide range of consumer assistance, including inquiries from consumers in employer plans. A case in point: the CAP helped a woman who was seven months pregnant continue to receive care from her physician, after her insurer's network of providers changed.

The North Carolina Consumer Assistance Program is run by the Health Insurance Smart NC in the State's Department of Insurance.

See Appendix B for more on the North Carolina experience and other examples of how CAPs have expanded capacity and services with CAP grant funds.

⁵ Based on CMS' analysis of CAP grant activities as of October 14, 2011

CAP GRANTEES REACHED HUNDREDS OF THOUSANDS OF CONSUMERS THROUGH OUTREACH AND EDUCATION EFFORTS

CAP grantees conducted outreach events and provided information to consumers, ranging from distributing brochures to the public (often in multiple languages), to more intensive outreach such as one-on-one counseling, and targeted outreach and information to specific groups. For example, Texas Consumer Health Assistance Program (CHAP) conducted a statewide media/education campaign, using multilingual materials (English, Spanish, Chinese, Korean, and Vietnamese) and held over 200 community outreach events with a focus on counties with the highest percentage of uninsured residents. During this process, Texas CHAP distributed over 15,000 toolkits containing information on programs and services such as the Pre-existing Condition Insurance Plan, Texas CHAP, and other State resources to consumers and consumer assistance advocates. In addition, Montana and Nevada conducted bus tours in rural areas of the state to ensure consumers were aware of and had access to their assistance. Some CAP grantees convened larger events such as “town hall meetings” to educate consumers on the services the grantee provides. The New York CAP, for example, used community presentations as its main mechanism for education and has conducted numerous presentations to consumers and advocates throughout the State, describing the availability of consumer assistance and the new protections afforded under the Affordable Care Act. Many programs also reported using social media outlets such as Facebook and Twitter to reach their communities.

Conclusion

During the first year of the grant period, CAP grantees provided direct services to over 200,000 consumers. In addition, many CAP grantees expanded their data collection and reporting capabilities, specifically building or enhancing database systems and developing protocols for entering consumer data for reporting.

While the CAPs were able to directly assist over 200,000 consumers, they were able to reach hundreds of thousands more through outreach and education efforts. In addition to direct case management services, communities were able to benefit from the fact sheets, toolkits, and brochures developed by the CAPs. Key community outreach events such as town hall meetings and bus tours allowed CAPs to make a significant impact in ensuring customers were apprised of the important work being done through the CAP program and the Affordable Care Act.

Appendix A – Selection of Consumer Stories from CAPs

Georgia CAP expanded services to assist consumers with enrolling into coverage, helping a father find coverage for his daughter.

A father contacted the Georgia CAP because his daughter was uninsured and needed health coverage. Both parents were unable to access health insurance in the individual market due to their medical histories and therefore were applying to Pre-existing Condition Insurance Plan (PCIP). CAP staff educated the father on his daughter's coverage options, including the daughter's potential eligibility for PCIP as a result of changes to eligibility requirements for children in States without child-only policies.

The Georgia Consumer Assistance Program is run by the State Office of Insurance and Safety Fire Commissioner.

Massachusetts' CAP assisted a father with obtaining coverage for his newborn child.

The Massachusetts CAP was contacted by a distraught father, who said he inadvertently forgot to submit a Benefits Enrollment/Change Form to add his newborn to his employer-sponsored insurance until 41 days after the baby's birth. The employer's policy states any change in enrollment must be submitted within 30 days of the qualifying event, and the father had received a notice from the employer dated August 23, 2011, stating that the child has been denied coverage until their next open enrollment period in June 2012. The father attempted to find coverage for the newborn in the individual market, but was told by various insurers in the State that they were not accepting applications for new coverage until July 2012. The Massachusetts CAP staff contacted the State's Division of Insurance to clarify the eligibility of the newborn for enrollment in an individual market health insurance policy outside of open enrollment. After reviewing the details of the situation from the CAP, the Division of Insurance determined that the father had received incorrect information from the health insurers and that the newborn was eligible to apply for an individual market health insurance policy. Next, the CAP staff contacted the Massachusetts Health Connector, on behalf of the father, to ask for their assistance in obtaining coverage for the newborn. The Health Connector, the State's health insurance exchange, agreed to the request, offered to reach out to the father directly, and assisted him in choosing the best policy for his newborn.

The Massachusetts CAP is overseen by the Massachusetts Executive Office of Health and Human Services, a cabinet-level State agency, and operated by the non-profit organizations Health Care for All and Health Law Advocates.

New York CAP helped a consumer who was left with \$30,000 in medical debt after her husband passed away, winning an appeal of the insurer's decision and avoiding financial devastation.

The New York CAP assisted a consumer whose husband was terminally ill. The husband was treated with intravenous immunoglobulin (IVIG) therapy at home after his wife checked with their

insurer three times to be sure the service would be covered. She also kept records of her contacts with the insurer. Several months after the husband's death, the wife received medical bills totaling \$30,000 from two different providers. The wife contacted the insurer but was given conflicting information about the bills. When she contacted the New York CAP, she gave the CAP caseworker permission to review the information relevant to the case and to assist her by contacting the insurer on her behalf and with her appeal and follow up. Through the CAP staff's efforts, the insurer's decision to deny coverage of the husband's IVIG therapy was overturned and all of the medical bills were covered.

New York's CAP is run by the non-profit Community Service Society of New York (CSS) under a contract with the State's Department of Health. CSS operates a statewide network of 24 community-based non-profit organizations, known as Community Health Advocates (CHA).

Appendix B – Examples of How CAPs Expanded Services as a Result of Federal Funding

Maine expanded capacity to provide consumers with assistance filing appeals

The Maine CAP used grant funds to increase its ability to file appeals on behalf of consumers. One of the CAP's cases involved a woman who had approximately \$34,000 in unpaid hospital bills for a mastectomy and reconstructive surgery that her insurance company refused to pay. The CAP staff filed a first level internal appeal on her behalf, which was turned down. CAP staff then forwarded the appeal to the State Bureau of Insurance, and the CAP's intervention ultimately resulted in the insurer reversing its decision and paying 70 percent toward the woman's medical bills.

The Maine Office of the Attorney General, in coordination with the Maine Bureau of Insurance, runs the Maine CAP in partnership with the non-profit Consumers for Affordable Health Care Foundation.

Georgia built capacity and expertise to serve vulnerable and underserved populations

Since receiving the CAP grant, the Georgia Office of Insurance and Safety Fire Commissioner developed more robust working relationships with other government agencies to let them know of the newly expanded services available to consumers having insurance problems. These other government agencies include GeorgiaCares, a State agency that assists Medicare-eligible persons with problems related to their Medicare or Medicare Advantage plans, the Georgia Department of Community Health, and the Georgia Department of Public Health, which has a program that helps pay insurance premiums for patients with HIV/AIDS. CAP staff assisted the Georgia Department of Public Health in trying to get coverage re-instated for three consumers living with HIV/AIDS after their premium checks were sent out late by the Georgia Department of Public Health.

The Georgia CAP is run by the State Office of Insurance and Safety Fire Commissioner.

Michigan is producing Affordable Care Act educational materials in multiple languages to best serve their State's consumers.

The Department's acquisition of a language translation line is being leveraged by the Department's consumer hotline, its insurance analysts, and all other divisions within the Department to provide interpreter services to consumers in more than 240 languages. CAP staff are also conducting outreach to vulnerable and underserved populations through stakeholder engagement, community events, and speaking engagements.

The Michigan Health Insurance Consumer Assistance Program (HICAP) is run by the Michigan Office of Financial and Insurance Regulation.

Connecticut CAP was able to conduct significant outreach and education activities.

Prior to the grant, the CAP had relied mostly on advertising through word-of-mouth, its website, and social networking efforts. New funding under the CAP grant enabled staff to present at numerous community forums, conduct a media campaign, and create educational materials around the CAP and new insurance benefits available to consumers. In particular, the CAP has been able to advertise their services through bus panel advertisements; newly-developed pamphlets that were distributed to community groups and providers; and media coverage, most notably a 60 second public service announcement that ran more than 300 times on a local television channel. All of these efforts proved worthwhile, as the CAP reported doubling their call volume over the past year.

The Connecticut CAP is run by the Connecticut Office of the Healthcare Advocate, an independent State agency.

Oregon established a consumer-friendly entry point for insurance assistance.

Before the CAP grant, the Oregon Department of Consumer and Business Services' Consumer Advocacy Unit provided health insurance assistance along with numerous State agencies. Hundreds of non-profit community organizations promote these State programs, as well as their own health advocacy services. The CAP grant provided a means of connecting State health insurance assistance and advocacy programs through a new tool, Oregon Health Connect, a consumer-friendly website and toll-free hotline.

The Oregon CAP, called Oregon Health Connect, is a joint project of two State agencies: the Department of Consumer and Business Services and the Oregon Health Authority.

Washington published an Appeals Guide.

Washington developed a consumer outreach campaign that includes public service announcements, printed materials available in English, Spanish, and Chinese, and a detailed Appeals Guide for consumers. The Washington Appeals Guide was published in 2011 funded with the CAP grant and is helping thousands of residents use the information. The updated guide includes information on new laws that became effective on January 1, 2012 and is published in English, Spanish and Chinese. Since April 2011, more than 2,300 visitors viewed the Appeals Guide online and more than 220 copies have been downloaded.

The Washington CAP is run by the State's Office of the Insurance Commissioner, Consumer Protection Division.