



**Examining California's Office of AIDS Health Insurance Premium
Payment Program**

**Barriers and facilitators to establishing and maintaining comprehensive
insurance coverage for Californians living with HIV/AIDS**

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In 2011, the California State Office of AIDS (OA) launched the Office of AIDS Health Insurance Premium Payment Program (OA-HIPP) to assist HIV-positive Californians in establishing and maintaining health insurance by subsidizing their monthly health insurance premium payments. The OA reformulated an existing premium payment program with more restricted eligibility requirements (the Comprehensive AIDS Resources Emergency/Health Insurance Premium Payment Program, or CARE/HIPP), and expanded program eligibility for OA-HIPP in anticipation of increased enrollment in private insurance under the Affordable Care Act (ACA). OA-HIPP is funded through California's AIDS Drug Assistance Program (ADAP), which utilizes the Health Resources and Services Administration's (HRSA) Ryan White Part B funds. Part B-funded programs are considered payers of last resort. OA-HIPP is available only to consumers with adjusted gross incomes up to \$50,000 a year, who are enrolled in ADAP and are not also enrolled in or eligible for Medicare or full scope Medicaid (called Medi-Cal in California), or premium coverage through an employer. Consumers who are eligible for premium tax credits under the ACA must also accept the full tax credit available to them in order to be eligible.

Eligible consumers complete and submit an application to the OA-HIPP program that verifies their program eligibility, ADAP and health insurance plan enrollment, and payment information for their monthly health insurance premium. Consumers can apply independently, but most apply with the assistance of an enrollment worker. For applications received before the 15th of the month, OA-HIPP can begin payment in time to cover premiums owed two months later (for example, coverage can begin March 1st for an application submitted before January 15th). Until OA-HIPP payment begins, consumers are expected to pay their premium payments out of pocket to secure health insurance coverage; they may request reimbursement from their insurer once OA-HIPP assistance begins. OA-HIPP pays individual monthly premiums on an ongoing basis, often in larger batches every quarter, depending on insurers' preferences. Consumers are responsible for—with or without the assistance of an enrollment worker—monitoring their insurance enrollment, reporting changes, re-enrolling annually in OA-HIPP and ADAP, and recertifying six months after each enrollment.

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EXECUTIVE SUMMARY

Under the Affordable Care Act, many people living with HIV (PLHIV) are moving out of healthcare coverage under Ryan White programs and into the private health insurance market place. To enable PLHIV to purchase insurance in the private marketplace, programs like California's Office of AIDS Health Insurance Premium Payment (OA-HIPP) program are being implemented nationally, using funds from AIDS Drug Assistance Programs (ADAP) to help offset the costs of monthly insurance premiums for ADAP-eligible PLHIV. In California, OA-HIPP is available to PLHIV whose adjusted gross annual incomes do not exceed \$50,000, and who are not eligible for full scope Medicaid, Medicare, or premium coverage through an employer.

The rapid response core of the California HIV/AIDS Policy Research Center at the Center for AIDS Prevention Studies at the University of California, San Francisco, selects research topics in collaboration with our community partners, Project Inform and the San Francisco AIDS Foundation, as well as with input from the members and Executive Committee of the Policy Research Advisory Council (PRAC). Since its launch in 2011, advocates have observed that the OA-HIPP program has become an increasingly vital tool for HIV-positive Californians to establish and maintain affordable, comprehensive healthcare coverage. In light of this prominent role, we launched a rapid response study to examine the barriers and facilitators to an optimally functioning OA-HIPP program. From March to June, 2014, the rapid response team interviewed a sample of key informants, including enrollment workers, advocates, and public health department workers. Findings are presented in this report.¹

The OA-HIPP program is appreciated, and it expands coverage access

Nearly all participants were grateful that the program exists. In combination with the ACA, the program increases the affordability of coverage, and can expand access to coverage choices and specialty care. By altering eligibility requirements that limited enrollment under OA-HIPP's predecessor, CARE/HIPP, the Office of AIDS (OA) has increased access to premium assistance for PLHIV in California.

The enrollment workers we spoke with noted a few existing procedures and program improvements they found to be helpful. Several interviewees reported positive interactions with OA-HIPP staff (called "analysts"), or offered negative comments regarding the program with the caveat that some issues may be out of analysts' control. Relationships between stakeholders facilitated solutions to payment issues and made it easier to retain or restart insurance when there were issues with consumers' accounts.

Outreach around the program is a challenge

Too few eligible consumers and relevant providers and institutions are aware of OA-HIPP. Participating consumers are usually informed of the program's existence directly by a medical or service provider, or a peer. The Health Resources and Services Administration (HRSA) has not clarified who should lead outreach efforts or how intensively eligible consumers should be pursued by premium payment programs, as payers of last resort. Unfortunately, enthusiasm for OA-HIPP expansion has been somewhat dampened by issues with the program.

¹ Please see Appendix A for a tabular summary of major findings.

Eligibility and enrollment procedures need to be clarified and streamlined

Consumers whose incomes fluctuate may not be consistently eligible for the OA-HIPP program, and many enrollment workers reported that consumers whose incomes are just over the current eligibility threshold of \$50,000 a year may have significant difficulty paying their premiums. Also, although the State OA has issued guidance stating that premium assistance is available for separate dental plans, as well as vision plans included under medical benefits, several enrollment workers were not clear whether or when vision or dental care coverage is eligible for premium payment assistance.

The OA-HIPP website does not offer readily accessible, consumer-friendly guidance and resources for consumer self-enrollment. During open enrollment, consumers and enrollment workers encountered difficulty obtaining the documentation needed to enroll in OA-HIPP from the Covered California (California's health insurance exchange) portal and from insurers, who were overwhelmed with new applicants.

Enrollment workers and consumers do not receive confirmation that enrollment applications have been received. They are not provided with updates as to the status of the application, nor are they consistently notified if an error or omission has delayed processing of an application.

Initial and ongoing payment procedures face major challenges

The process the State must go through to generate an initial premium payment for new enrollees is complex, including multiple approvals and extensive documentation, and involving a number of employees in both the OA and the State Accounting Office. For both initial and ongoing payments, insurers may request specific payment procedures, some of which conflict with State procedures, and may force the State to individualize payment processes by insurer. As a result, initial payment can be sent slowly even under the best of circumstances, and is often sent much later than is expected.

All payments are sent out as paper checks, which many insurers no longer have infrastructure to quickly process. Initial and ongoing payments for consumers with the same insurer may be combined into one larger, batched check, and may also be combined into quarterly payments. While these combined payments speed processing time and reduce workload at the State, some insurers will not accept combined payments. Insurers may process combined payments slowly and make crediting errors.

Most enrollment workers advise new OA-HIPP applicants to expect to pay their own premium for one or two months following their application while their enrollment is processed; this can cause financial hardship. Several interviewees relayed stories of initial OA-HIPP payments beginning three or more months after applications were submitted. Consumers can request reimbursement for their out-of-pocket payments from their insurers once OA-HIPP begins payment, but obtaining reimbursement has proven difficult.

Ongoing payment processing can take as much as four times longer than initial payment to complete, making it difficult for the State to respond to billing statements issued late in the month. Quarterly payments and processing demands prevent the State from issuing supplemental checks, thereby

reducing the program's flexibility to respond promptly to premium increases or decreases. Internal and insurer-requested processing demands can cause OA-HIPP to send ongoing payments in the grace period following the actual premium payment due date.

OA-HIPP analysts do not consistently send notification emails to enrollment workers when they issue payment, making it hard to detect when a payment may be late. Some consumers rely on calling their insurance every month to determine whether the premium has been paid. Others have received cancellation notices multiple times. Delayed OA-HIPP payments can interfere with billing cycles for medical providers and pharmacies and with ADAP recertification grace periods.

Communication problems need to be addressed

Communication issues were the most frequently cited concern in our interviews. Issues included OA responsiveness and availability, technical problems, and communication content.

Responsiveness and availability: Communication from the OA is inconsistent and often insufficient: faxes are not confirmed, telephones are not consistently answered, and emails and voicemails are not always returned promptly, if at all. It can be difficult to reach the correct analyst for each insurer. Interviewees acknowledged that analysts experience heavy workloads and are not always able to respond quickly, but noted that generally, the burden is placed on the enrollment worker and consumers to repeatedly seek assistance.

Technical problems: There is currently no modern-era, user-friendly communication infrastructure in place to allow consumers and enrollment workers to keep track of crucial participation information. Existing communication methods include telephone, fax, and a cumbersome, secure email system.

Communication content: Some enrollment workers did not have a clear understanding of certain OA-HIPP policies and procedures that the OA has issued guidance on, indicating that guidance had not reached them. In a few cases, enrollment workers reported that program guidance turned out to be misleading. When the program does not consistently follow its own policies in some areas, such as the timeline for issuing initial payment, it does not appear predictable to workers and consumers.

Programmatic challenges burden consumers

While many consumers can and have increased their financial security and access to comprehensive coverage through OA-HIPP participation, program issues can negatively impact consumers' financial and behavioral health, and can undermine stable continuation of insurance coverage.

Financial burden: It can be difficult to predict how long a consumer will need to pay premiums out of pocket. Many consumers can barely afford these payments: some borrow money, use emergency funding, or use credit cards. Consumers have not consistently been able to get this money back from their insurers once OA-HIPP issues payment. Some consumers cannot pay or cannot keep paying their premiums, and risk insurance cancellation.

Consumer capacity and behavioral health: Consumers can experience significant stress while waiting for payment, resolving payment issues, or monitoring ongoing payments. Participation in the OA-HIPP program can be very challenging for lower-functioning consumers who lack the ability or resources to pursue errors or monitor their insurance regularly. Many enrollees previously received services under Ryan White and are not well-versed in traditional insurance language and responsibilities.

Delays and disruptions in care: Several interviewees reported instances in which issues with OA-HIPP caused consumers to lose their insurance, or delay needed care because they were not sure of the status of their insurance. Those who were not able to reinstate their insurance had to rely on a variety of safety net services for care until open enrollment began in November 2014.

Programmatic challenges and rapid growth impacted personnel

Enrollment worker capacity: OA-HIPP enrollment has increased alongside the implementation of the ACA, and changes to other benefits programs have also increased the responsibilities of enrollment workers. Because it does not function optimally, OA-HIPP requires a level of regular monitoring that many workers do not have the capacity to support. Enrollment workers who are not benefits counselors may not be adequately prepared to manage highly specialized, benefits-related issues. Enrollment workers are less able to attend to their other duties because of the increased burden of benefits issues and monitoring. Finally, many thought that they were supposed to be reimbursed for their activities under OA-HIPP, yet generally they have not received compensation for their effort.

State worker capacity: The program has vastly increased the workload of OA staff. Analysts are aware of communication issues but at current staffing levels, do not have the capacity to be more responsive.

Policy implications

The OA-HIPP program needs improvements to function optimally in a complex, evolving health insurance landscape, but it has played a vital role in allowing many consumers to secure more comprehensive health insurance coverage, and it should be maintained. More outreach around the program is still needed. Positive aspects of the program and program improvements should be built upon and promoted to generate stakeholder engagement and enthusiasm around expansion.

Enrollment workers' feedback could be extremely valuable in improving program policies and should be solicited. Enrollment workers need greater support to work in an increasingly challenging field: benefits counseling now requires significant time and expertise. Enrollment workers need accessible, timely, and complete program guidance, and could benefit from feedback on the program's performance.

Increasing collaboration between the insurers, the State, and advocates could help to standardize third-party payment processes. Expedient check generation should be supported so coverage is not threatened, and so consumers pay as few premiums out of pocket as possible. Greater advocacy is needed to identify and remove the barriers to consumer reimbursement by insurers.

Expanded support for self-enrollment is needed. Self-managing consumers can take a more direct role in their own coverage, and may lighten the burden placed on enrollment workers, who then have greater capacity to support lower-functioning consumers and those who are new to private insurance.

Reliable communication with consumers and enrollment workers facilitates prompt identification and resolution of problems. An online portal for consumers and enrollment workers to access key participation information could improve and simplify communication.

The public healthcare safety net, especially Ryan White clinics, is still crucial to maintaining care and treatment for PLHIV. When a consumer loses private insurance coverage through program issues outside of open enrollment, they have few care options outside of the safety net.

INTRODUCTION AND BACKGROUND

The rapid response core of the California HIV/AIDS Policy Research Center at the Center for AIDS Prevention Studies at the University of California, San Francisco, selects research topics in collaboration with our community partners, Project Inform and the San Francisco AIDS Foundation, as well as with input from the members and Executive Committee of the Policy Research Advisory Council (PRAC). Since its launch in July 2011, advocates have observed that the California State Office of AIDS (OA) Health Insurance Premium Payment program (OA-HIPP) has become an increasingly vital tool for HIV-positive Californians to establish and maintain affordable, comprehensive healthcare coverage. In light of this prominent role, the rapid response core launched a study in early 2014 examining the barriers and facilitators to an optimally functioning OA-HIPP program.

With the implementation of national strategies to identify HIV-positive individuals, link, and retain them in care, ensuring access to high quality comprehensive health insurance for people living with HIV (PLHIV) has become more central to effectively managing the HIV epidemic. Comprehensive health insurance allows PLHIV to maintain their own individual well-being and be treated for both HIV and other medical conditions, and provides a vital public health benefit because PLHIV that access care and treatment can achieve viral suppression and reduce their likelihood of transmitting HIV.

Before the implementation of the Affordable Care Act (ACA), many PLHIV in California obtained HIV care through Ryan White-funded programs, including the AIDS Drug Assistance Program (ADAP). Now, a significant number of these PLHIV have access to private healthcare coverage under the ACA. Despite this increase in access to coverage, many moderate-income, non-Medicaid-eligible PLHIV (whose adjusted annual gross incomes do not exceed \$50,000) may not necessarily be able to afford the premium payments needed to purchase high-quality, comprehensive, private insurance coverage, even with the support of federal subsidies. Premium payment programs have emerged in states across the country to meet this need, using ADAP funds to pay for consumers' premiums. In California, an existing insurance premium payment program, known as CARE/HIPP, was reformulated into OA-HIPP prior to the implementation of the ACA.

Despite the continued need for safety net services and tailored infrastructure to support PLHIV, the future of Ryan White and public programs that fund community-level services are unclear. California has entered its second health insurance open enrollment period, and the OA-HIPP program is expected to grow as more PLHIV seek access to comprehensive health insurance through the private marketplace. Our findings from this rapid response study detail barriers and facilitators to an optimally-functioning insurance premium payment program.

METHODS

The UCSF team included Dr. Emily Arnold, a medical anthropologist, Ms. Valerie Kirby, a policy analyst, and Dr. Wayne Steward, a policy expert. Our community partners, Ms. Anne Donnelly from Project

Inform, and Ms. Courtney Mulhern-Pearson from the San Francisco AIDS Foundation, both policy advocates, also significantly contributed to the rapid response study. The team developed a qualitative interview guide that covered: familiarity with OA-HIPP, experiences with eligibility, enrollment, and payment processes, perceived strengths and weaknesses of the program, recommendations for future premium payment programs, and consumer experiences with OA-HIPP. We sought to interview approximately 25 participants, selected through advocate recommendations, a list of enrollment workers posted on the OA-HIPP program website, and snowball sampling. The sample included enrollment workers and public health department workers, as well as a national level advocate who was knowledgeable about insurance premium payment plans in several states. We aimed for a regionally diverse sample, although response from rural areas was minimal.

The project director, Ms. Kirby, sent an initial email to invite potential participants, which yielded a sufficient sample. The study team scheduled interviews over email and conducted them over the phone or in person when the participant resided in the San Francisco Bay Area. Interviews were conducted between March and June, 2014. Each interview lasted between 45-90 minutes and was recorded. Interviews were semi-structured, allowing for follow-up questions and discussion of related topics. Interviewers offered an honorarium of \$50.00 to all participants to help offset time and travel expenses. All participants provided verbal consent, and the University of California San Francisco's Institutional Review Board, the Committee on Human Research, reviewed and approved the protocol.

Ms. Kirby wrote up extensive summaries following each interview, sent out recordings for transcription, and reviewed and cleaned transcripts, removing any identifying information. Dr. Arnold and Ms. Kirby identified pertinent themes which were developed into a preliminary codebook with definitions and examples for applying each code. They then coded five transcripts, revising the codebook as necessary. A finalized version of the codebook was used to code the remaining transcripts in Dedoose, an online analytic software tool. The team compared the data across different types of participants, finding that the data set was very consistent across the entire sample. Dr. Arnold and Ms. Kirby used the analytic mixed methods tools in Dedoose, including the frequency of code application and code co-occurrence, and pulled related excerpts for deeper analysis. The UCSF team periodically consulted with advocates and members of the PRAC Executive Committee throughout the analysis period.

Some limitations to this study do exist. Due to the limited presence this program has online and in the lay press, our understanding of OA-HIPP's mechanisms, policies, and procedures was predominately shaped by our interviews; it was not always possible to substantiate information through secondary sources outside interviews. We spoke predominately with enrollment workers, and did not interview participating consumers. Although we did invite a number of state workers to be interviewed, our data collection with state workers was limited and therefore less robust than with other types of participants interviewed for the report. Lastly, some of the program's policies and procedures have changed since we completed data collection in June, 2014. However, the challenges that this program encountered, as well as the changes that were made in response, may be informative to similar programs in earlier stages of development.

Major themes, findings, participant recommendations, and implications are presented below, and are also summarized in the Appendix.

FINDINGS

Positive findings

Across our sample, study participants reported that the OA-HIPP program can relieve financial burden on consumers, and that they and the consumers they work with are thankful that program exists. With the passage of the ACA's individual mandate, there has been increasing demand for the program.

In combination with the ACA, **the program allows consumers to maintain coverage they are required to purchase under the individual mandate, but may not have been able to afford without assistance.** Here, an enrollment worker describes the impact of the program on consumers who had previously fallen into a gap in which no assistance was available to support their insurance coverage:

In my county, people had been eligible for free or cheap medical care, if their income was at or below 300 percent of the federal poverty level [through a county-based program]. So for everybody who I knew who had incomes between 300 and 400 percent [which is approximately \$50,000] ... they didn't [qualify for the county program] – I had no sort of subsidy to offer to them. So [offering the OA-HIPP program] – for everybody who was purchasing their own health insurance who was between 300 and 400 percent, this was amazing. A gentleman I met only last week or the week before, who came in and said, I work full-time, couldn't afford the health insurance that his employer offered him, said, I haven't taken care of myself since I pretty much tested positive, I had no health insurance, and now I do. So I'm going to a lot of doctor's appointments now. So it's pretty amazing to think about that. Just being able to tell people that they can elect this level of health care and can have the lowest possible payments for them, and they don't have to pay attention to the monthly premium, so they don't have to be scared of getting too many bills and things, it's such an upgrade for people [from] the health insurance that they have had in the past. And they couldn't afford it if it was employer-sponsored or if they were purchasing it individually. (Enrollment worker, Northern California)

When consumers are enrolled in OA-HIPP and the program is running smoothly, HIV service providers are able to shift their focus from consumers' need to secure health insurance coverage to supporting their use of that coverage: service providers are able to help ensure that clients are seeing doctors regularly, getting appropriate care, and access to treatment.

Having access to insurance and OA-HIPP has given some consumers more coverage choices, and even employment choices: they no longer need to keep a particular job in order to maintain insurance.

Similarly, consumers who had a doctor that they liked were able to keep seeing that provider even when they became unemployed and faced maintaining insurance through COBRA.

OA-HIPP and the ACA also give many consumers access to specialty care that was not previously accessible under their Ryan White coverage, provided that their new insurer's specialist network is robust. With a few Covered California plans, our interviewees reported that the specialist networks were smaller than is desirable. The availability of premium assistance does, however, at least provide the opportunity for PLHIV to enroll in a more comprehensive plan than they might have been able to afford on their own.

[Consumers] not only have comprehensive coverage, but have this benefit of OA-HIPP, or – premium payment assistance, because the premiums, if they had to pay them, because they are high – they're all people living with HIV so they're high utilizers, right? ... [So without OA-HIPP], either they wouldn't be able to afford a plan at all, or they would probably have gotten maybe a bronze or silver [level plan] – a plan that was maybe more affordable, but that would have been inadequate for what they need. (Enrollment worker, Southern California)

Finally, the ACA and the OA-HIPP program have allowed consumers enrolled in local insurance and safety net programs, such as Healthy San Francisco, to have more comprehensive, regional coverage. These consumers can now travel outside of their county, for example, and not fear that they would encounter a medical emergency and be uninsured.

Participants commented positively on several existing OA-HIPP program processes. For example, most enrollment workers found the application itself to be short and straightforward. **A number of our participants also felt positively towards OA-HIPP staff. Many felt that systematic challenges encountered with the program—particularly in processing timely payments—may be out of analysts' control.** Some expressed sympathy for OA-HIPP staff members and noted that the rapid growth of the program must have been overwhelming. Some of our participants felt that analysts are aware that they serve a vulnerable population, and work hard to maintain coverage for consumers.

...the state went the extra mile to negotiate with the payee in order to reinstate the client into their coverage [when the OA-HIPP premium payment had arrived late]. So I mean, that piece, just to keep things in balance, when possible, they do go the extra mile to get things fixed. (Enrollment worker, Southern California)

Enrollment workers also appreciated the opportunity to communicate directly with the program's management during monthly calls for ADAP workers, which provide a much-needed forum for enrollment workers to communicate directly with the OA. **Additionally, our participants reported that both they and the consumers they serve appreciate it when OA-HIPP analysts communicate directly with them,** such as by sending out notifications when payment has been made. These communications

help allay concerns regarding consumers' insurance status, and may help remind enrollment workers to take additional action on behalf of consumers, such as reviewing who is in need of recertification.

Participants described several improvements that the OA has made to the program that were helpful. **Expanding eligibility beyond the more limited requirements of CARE/HIPP, and aligning eligibility with ADAP requirements have streamlined eligibility and increased access to more stable and comprehensive coverage.** By removing a CARE/HIPP requirement that consumers be considered disabled in order to be eligible, the State has helped consumers access needed assistance without having to progress to a level of impairment that would qualify as disabled. Participants cited other adjustments the OA has made that eased programmatic barriers, including: clarifying coverage for family members, removing a tax ID number requirement from the application and generally updating forms to reflect changes under the ACA, and staffing changes. Several interviewees described the program's policy of allowing consumers to self-enroll and self-monitor their participation as positive, and reported that some consumers feel the same.

...but one thing the clients really like is that they are allowed to call OA-HIPP on their own... they don't have to call and make an appointment to see us for questions. They have the ability to call [OA-HIPP] on their own. (Enrollment worker, Southern California)

rapport, relationships, and partnerships formed between stakeholders—especially those formed between OA-HIPP and insurers—have improved outcomes for consumers. When OA staff members have a good relationship with an insurer, it facilitates finding solutions to problems with a consumer's account. Recognizing this, the OA re-assigned analysts to specific insurers (instead of by consumer last name) in order to support the development of relationships and expertise with each insurer.

But we still have that relationship with them, and so that way, if we ever encounter an issue where someone's payment wasn't applied, we can contact this person – I could call her right now and say, hey, look, turn this guy back on, and it'll be done in a matter of minutes. So those relationships have been extremely helpful. (State worker)

A national level advocate also noted the importance of relationships, asserting that in other states, relationships have been useful to ADAP and insurance purchasing programs.

I would say that [relationships are] probably like the X factor. ... Kansas talked about their relationships with – I think it was Blue Cross-Blue Shield in their state, where ...they were given leeway, so yeah, your coverage effective date was this date, you have to have the check in – but they got leeway to [say] the check's on the way, because they had a contact. So that has been really important. (National advocate)

Overall, participants were grateful that the OA-HIPP program exists to support HIV-positive Californians' access to care. As with many programs that experience high demand and quick scale up, there were also some challenges reported. These are detailed in the next section.

Challenges

Engagement around OA-HIPP

Greater outreach, coordination, and education are needed to increase and improve engagement with the OA-HIPP program. There was broad consensus among our participants that not all eligible consumers and relevant providers and institutions are aware of the program, and that more outreach is needed. Other states have also struggled to spread awareness of premium payment programs. This may be because premium payment programs, as payers of last resort, are expected to rule out other forms of payment before they provide coverage. Current federal regulations do not clearly define how much outreach is reasonable under this expectation, or who is responsible for leading outreach efforts.¹

The State OA reported conducting broad outreach prior to the launch of the OA-HIPP program in 2011. A few interviewees developed their own outreach materials around OA-HIPP and the ACA, and reportedly, some COBRA administrators include information on OA-HIPP in welcome packets. A small number of consumers read about the program on the OA website. **However, it appears most consumers find out about OA-HIPP directly from a service provider, medical provider, or a peer.**

A lot of the way I hear about the dissemination, in terms of how people know about the program is, typically, word of mouth. They'll say, oh, a friend told me about this program that they're on. (Enrollment worker, Northern California)

One interview participant also noted that some consumers still relied on service providers for information on OA-HIPP after receiving public outreach materials because they did not speak English, or because they did not understand what they received.

If providers are some of the main conduits through which eligible consumers are informed of OA-HIPP, their awareness of the program must also be increased. **Several interviewees spoke of service providers, medical providers, and institutions not knowing of the program's existence.** A few interviewees mentioned that their own colleagues were unaware of the program. Some noted that for consumers who primarily receive care through medical providers in private practice, the opportunities to be informed of OA-HIPP—and ADAP—may be limited because private practice providers may be less aware of public programs, or of the need to discuss how consumers pay for care.

Most enrollment workers themselves found out about OA-HIPP either through involvement in its predecessor, CARE/HIPP, or through a direct request from the OA for ADAP enrollment workers to train to become OA-HIPP enrollment workers. **Some of the more seasoned enrollment workers reported that the challenges they have experienced around OA-HIPP have acted as a disincentive to increased engagement with the program.** Some of their peers—including some who completed enrollment worker training—view OA-HIPP responsibilities as too burdensome and refuse to offer this service.

Despite these concerns, very few of the enrollment workers we interviewed reported significant communication with advocates regarding OA-HIPP. Most did not know what advocacy has been done

around the program. **Also, while most enrollment workers acknowledged that not all those eligible for OA-HIPP are aware of the program, several expressed ambivalence or hesitation regarding its expansion, or suggested that improvements must be made to the program before it can be expanded.**

...at this point I don't even know if I'd really recommend the program to people, because it's been so problematic...I feel like it's a risk for the patients to even trust them.
(Enrollment worker, Northern California)

Enrollment in OA-HIPP

To become OA-HIPP enrollment workers, ADAP enrollment workers complete an online webinar and examination. Some of the enrollment workers we spoke with reported that, following this training, they were able to master enrollment and monitoring tasks through practice, or with support from a more experienced peer. However, our interviewees also reported that enrollment workers could benefit from more extensive training than the OA currently offers. **New enrollment workers—particularly those without significant benefits counseling experience—may not be fully prepared to manage issues that can accompany enrollment and ongoing monitoring.**

Enrollment workers have found it relatively simple to complete the forms needed for OA-HIPP enrollment. However, it is not always easy for enrollment workers to determine who is eligible: consumers' incomes may fluctuate around the eligible income threshold, or their eligibility may vary based on how their income is calculated. Also, a few interviewees felt the income eligibility threshold for OA-HIPP is outdated, when compared to the rising cost of living and given the difficulty consumers just above the threshold may have paying their premiums.

In addition, some **enrollment workers were not sure whether supplemental insurance plans are eligible for premium payment.** The State OA issued guidance stating that vision plans must be combined with dental or medical benefits to be eligible for premium payment, and that separate dental plans require separate OA-HIPP applications.ⁱⁱ However, some interviewees asserted that supplemental coverage is not eligible for payment, some said that it is only eligible as a part of COBRA, and a few reported that OA-HIPP has inconsistently approved supplemental coverage.

For eligible consumers, it can be difficult to document their insurance coverage and premium amounts. This was particularly true during open enrollment, when Covered California and participating insurers were hit with larger-than-expected enrollment, and were much delayed in sending out insurance cards, welcome letters, and initial account statements that could be used for consumers' OA-HIPP applications. Consumers also encountered difficulty obtaining documentation of insurance enrollment and premiums owed from Covered California; while those who knew to do so captured this information in a screen shot during online enrollment, those who did not know this was needed found it difficult to find the information again when logging in later. Interviewees reported that Covered California enrollment information is somewhat limited to the enrollment worker; if OA-HIPP enrollment workers did not themselves enroll a consumer in Covered California, they were not always able to later access enough of the consumer's account information to apply to OA-HIPP. In particular, little

information was available to retrieve on behalf of consumers who enrolled in Covered California using paper or telephone applications, because an online account had not been clearly established for them.

Although our interviewees had a general understanding of what supporting documentation is needed for enrollment, some noted that the OA-HIPP website does not make a detailed checklist of the necessary documentation prominently accessible; some of this information can be found in the text of guidance memos on the site, but it is not immediately evident that this is where one should look. Not all interviewees were confident that they knew exactly which documents were needed. This confusion also presents a barrier to consumers who attempt to self-enroll without the assistance of an enrollment worker. **Several interviewees reported that both enrollment workers and consumers are interested in increasing self-enrollment by consumers, but the OA-HIPP website does not offer substantial consumer resources to support this option.** Some workers have created their own consumer guidance materials to deal with this need. In particular, more self-enrollment guidance needs to be made available because some enrollment workers do not have the capacity to perpetually monitor OA-HIPP participants' insurance, so they support self-enrollment in lieu of formally signing applications as an enrollment worker.

Because people really need to be able to monitor their own insurance, and that's why there are not that many people who will be OA-HIPP workers, because there's no way – you would have to have so many hours in the day to monitor people's insurance that there's no way anyone really can do it. (Enrollment worker, Northern California)

At the time of data collection, no system existed to allow enrollment workers or consumers to verify the status of an OA-HIPP application, apart from directly contacting the OA. Applications must be faxed to the OA, but enrollment workers and consumers do not receive confirmation that the application has been received, nor are they consistently notified if an error or omission has delayed processing of an application.

We understand that they were totally inundated. Totally. And so we didn't expect to hear confirmations, but it became a real problem when we had numerous people that we discovered [whose] applications hadn't even been processed. (Enrollment worker, Southern California)

Initial Payment Issues

Initial payment problems are common to premium payment programs nationwide. In California, OA guidance states that initial payments for applications received before the 15th of the month can be made in time to cover premiums owed two months later (for example, OA-HIPP coverage can begin March 1st for an application submitted before January 15th).ⁱⁱⁱ In a few interviews, participants reported that initial payment is issued within this time frame. However, **the process the State must go through to generate an initial premium payment for new enrollees is complex**, including multiple approvals and extensive documentation, and involving a number of employees in both the OA and the State Accounting Office. One state worker described the labyrinthine process required to generate initial payment:

...all those [application] faxes are routed to a secure electronic inbox, and then there's a rotating schedule, where staff will monitor that inbox, and they'll print the documents and distribute them to the appropriate staff member, who will then – ultimately, they have to analyze the information, make sure if the information's there or not, if there's an follow-up, they'll contact the enrollment worker directly and work with him or her to get the needed information. And then once it's been determined that the information is there, then we add the client information into ARIES [AIDS Regional Information and Evaluation System], which is our database. So pretty much all the information on the application is inputted there, and there's a series of documents that need to be created in order for a check to be written, and so they have to fill out those documents, and then they build a file, a manual file, for the person...Then the [file is reviewed and check request approved] and then that would go to our fiscal analyst, who would just do a second QC [Quality Control] check, make sure the information's accurate and complete, and then she would add the information into an Access database, and we use that to keep track of all the individual payments, and then usually there's – on a given day, there's probably 30 or 40 checks, and so she would enter all those, and then she's required to make numerous copies for our accounting office, so she creates a batch, and those go to Accounting. And then Accounting...there's seven different desks that each one of those requests has to go through. And then also, the end result's with the check being written, assuming it's a revolving fund. And then if it's a revolving fund check, we'll get a check back a week later, and then the fiscal analyst will make copies of that check, give the staff member a copy, and that lets them know that the check is complete, it's ready, and then they need to at that point add the check number and the check date into the ARIES system, and then they would generate a letter– and then they give the letter to the fiscal analyst, and then the fiscal analyst will send the check and the letter to the insurance company. (State worker)

Partially as a result of these involved State-level payment generation processes, many interviewees reported that **initial payment is sent slowly under the best of circumstances**, and can be so delayed that the insurers receive it much later than is expected, based on the OA guidance described above.

At the time of data collection, OA-HIPP did not have a mechanism to issue electronic payments, so both initial and ongoing premium payments were sent out as paper checks. These checks can be lost in the mail, and **many insurers no longer have infrastructure to quickly process physical checks**. Initial premium payments for several consumers with the same insurer may in some cases be sent out by the State Accounting Office in one larger, batched check. In addition, checks may also be combined into larger, quarterly (or “lump-sum”) payments made to cover three months at a time. Although combined checks are sent to insurers with a list of the accounts the payment is intended to cover, payment crediting errors do occur. In addition, while these combined payments speed processing time and reduce workload at the State, some insurers will not accept one or both forms of combined payments. If individual insurers' payment procedure requests conflict with State Accounting Office procedures, OA-

HIPP must negotiate a solution, which in many cases means that payment procedures must be individualized in some way to an insurer. Both State and insurer staff members must then be relied upon to follow this procedure correctly in order to support timely payment and crediting.

So I mean, there's just a lot of this planning, working with the insurance company, to figure out exactly what they'll do, what they'll accept, and then making sure we give them exactly what they will accept, and then we had to work with Accounting and make sure we get exactly what they'll accept. And then, you know, somewhere along the line...staff turnover and – things. The insurance company doesn't process it the way they told us they would process it. (State worker)

In combination, these **issues can significantly delay crediting payment** to consumer's accounts.

There is no formal, established procedure for enrollment workers and consumers to receive notification that the OA-HIPP office had received and processed the enrollment application, which makes it difficult for consumers to know the status of their insurance premium payments.

...so after I submit the application through fax, and all the paper work, I haven't heard from Office of AIDS since the last – since the first application that I did at the end of February. ...And I tried to contact them by email and I haven't received any response yet. So basically, I just keep doing the applications, but I don't know what is happening with these applications. (Enrollment worker interviewed mid-May 2014, Northern California)

Based on the formal timeline for initial payment issued by the program, most enrollment workers advise new OA-HIPP applicants to expect to pay their premium out of pocket for at least one month following enrollment. However, because in practice, it can be difficult to predict when initial payment will be sent, **many workers advise consumers to expect to pay two or more months' premiums out-of-pocket**; some interviewees reported cases in which OA-HIPP did not begin payment for three or more months after applications were submitted. Initial OA-HIPP payments include months consumers paid out of pocket. Consumers are then expected to request reimbursement from their insurer; these reimbursements are often difficult to obtain. **Making out-of-pocket payments—particularly for an unpredictable length of time—and seeking reimbursement from insurers can be financially and emotionally challenging for consumers.** These impacts will be discussed in greater detail below in the section, **“Cross-cutting issue: consumer burden.”**

Ongoing Payment Issues

Ongoing payment generation for enrolled consumers is also complex, and, at the time of data collection, took up to four times longer than initial payment to complete. Some insurers issue billing statements later than the State needs to receive this information in order to issue monthly payments on time.

But the problem is, the communication that's sent by [an insurer] says, if you don't pay by the first, your insurance will be cancelled. ...Well, we didn't even get [the invoice] 'till the 26th, 27th, takes us a week to get the check back... (State worker)

Like initial payments, ongoing payments may be batched or combined into quarterly payments, or both, if the insurer will accept combined payment. As with initial payments, some insurers may request a specific payment process that is different from the process the State uses for other insurers, which may make payment generation more complex. **Some of the enrollment workers we spoke with reported that following initial payment, OA-HIPP may pay premiums in the grace period, after the actual premium payment due date has passed.**

Similar issues have caused premium payment programs across the country to struggle to issue timely, ongoing payments. The success of both individual and combined payments has also varied across the country. **Individual, monthly checks require more administrative effort, but combined payments may not be accepted by all insurers, and can delay insurer processing or increase crediting errors.** As a result of delayed payment or crediting, some consumers receive cancellation notices multiple times.

I have a guy right now who the state says they sent a check, and there's no record at the insurance of it being received. So I give the patient the check number, and he calls with the check number, and hopefully they eventually find it and then they credit it to his account. And unfortunately, this poor guy's had this happen to him at least three times. (Enrollment worker, Northern California)

Quarterly payments also reduce the program's flexibility to respond to premium changes, which can occur throughout the year for individuals enrolled in COBRA or other plans outside of Covered California. For example, when a premium increases shortly after a new quarterly check has been requested, the State will not be able to adjust payment until the next quarterly check is requested; the consumer must pay the difference and later be reimbursed, or run a deficit.

OA-HIPP analysts may send payment notification emails to enrollment workers or self-enrolled consumers when payment is issued. However, these **notifications of payment are not sent consistently or are sent late, making it hard to detect when a payment may be late.**

I've been doing this for almost a year, and I think I've seen one [payment notification email] in the year that I've been doing it. (Enrollment worker, Southern California)

For both initial and ongoing payments, the potential for delays in issuing and crediting payment indicate that consumers and enrollment workers cannot assume that premiums have been paid, and must monitor insurance accounts on a regular basis. **In the absence of a more reliable verification system, many enrollment workers recommend consumers rely on calling their insurance every month to determine whether the premium has been paid.**

A few interviewees reported some issues with ongoing payments that result from how the program interacts with related entities. For example, during ADAP recertification, consumers may be permitted a grace period to obtain needed documentation, but this has sometimes caused the OA-HIPP program to believe the consumer is no longer enrolled in ADAP (as they are required to be), and withhold premium payment. The delayed schedule of OA-HIPP payments can also interfere with billing cycles for medical providers: if a consumer's insurance account is in the grace period and the insurer has not yet received payment, the consumer can appear not to be insured when he or she accesses care, and may be billed for the full cost.

So, because there's a 30-day grace period for payment, frequently, the payment doesn't go out until almost the end of the month, for the current month. ...The problem is, the patient has gone to the doctor in the month. If the doctor submits that bill, it shows that they don't have any insurance 'cause the premium hasn't been paid. You show up at the pharmacy, the pharmacy tries to run your [insurance], it shows you have no insurance. (Enrollment worker, Northern California)

Cross-Cutting Issue: Communication

Communication issues occur across all aspects of the OA-HIPP program, and were the most frequently cited concern in our interviews. Issues included OA responsiveness and availability, technical problems, and communication content.

Responsiveness and Availability

Our interviewees frequently reported that **communication from the OA is inconsistent and often insufficient: faxes are not confirmed, telephones are not consistently answered, and emails and voicemails are not returned promptly, if they are returned at all.**

I would really like to say that it's improved. But there are still lapses of several days to a week before I get a response, and I've had to go to the head of the program a couple of times, because I'm not getting any responses. ...Email is virtually useless. ... So phone calls work better, but it's a case of leaving a message and waiting for them to call back. (Enrollment worker, Southern California)

Several participants told stories of contacting every analyst in the OA-HIPP office, and often even their manager, before receiving a response. Participants acknowledged that analysts experience heavy workloads and are not always able to respond quickly, but felt that it was not appropriate that enrollment workers and consumers should have to repeatedly seek assistance, or that important information—such as processing delays—is sometimes not conveyed unless they do so.

As a result of the specialized needs many insurers have around third-party payment, OA-HIPP assigned analysts to manage consumer accounts associated with specific insurers, and created a list of these assignments for enrollment workers. **However, it can be difficult for enrollment workers to access the correct analyst for each insurer** because analysts are frequently out of the office. Although other

analysts are assigned to back up work with a particular insurer, they are not always able to adequately or quickly address issues.

And so, for instance, [some analysts are] off by like two o'clock ...and if I have a problem that happens at three, then I can't talk to her and I can leave her a voice mail, but she almost never calls back. ... I have called a backup [analyst], and they say, can you call the person that you're supposed to call, because my computer's not working right, or, I can't help you, or, I don't know that answer. (Enrollment worker, Northern California)

Technical Problems

At the time of data collection, there was no modern-era communication infrastructure in place to allow consumers and enrollment workers to keep track of crucial OA-HIPP participation information, such as whether an application has been received, if additional documentation is needed, application status, whether payment has been made, or when recertification is due. Many interviewees expressed the sentiment that the OA-HIPP program is out-of-date in this regard. Existing communication methods include telephone, fax, and secure email. However, as stated previously, analysts are not consistently responsive to telephone calls. **A number of interviewees reported cases of faxed applications being lost or misplaced.** In some cases, this has led to a loss of coverage.

And in this particular time, because I know [that] they've hired [other] people since then – but...[at the time] the application didn't get processed, or it was lost and I had to resubmit it, and it was too late. By the time things got turned around, the person could not make the initial payment and they just lost coverage and had to go to [the public hospital]. (Enrollment worker, Northern California)

While interviewees acknowledged the importance of maintaining consumers' confidentiality, several noted that **the secure email system OA-HIPP uses is cumbersome** and that because they contain as little identifying information as possible, the emails appear so cryptic that they can even be missed by enrollment workers because they do not look important, or because they are captured by spam filters.

Communication Content

Our interviews indicated that the procedural guidance the OA has issued around OA-HIPP may not always be sufficient, and may not be reaching all stakeholders. Some of the enrollment workers we interviewed reported confusion regarding certain OA-HIPP policies and procedures, or had an understanding of policies that differed from the understanding of other enrollment workers we interviewed or with guidance the OA has itself issued (such as guidance issued around supplemental insurance coverage). This pattern indicates that guidance has not reached all enrollment workers equally.

In a few cases, enrollment workers reported that initial guidance issued around the program turned out to be misleading. For example, OA-HIPP guidance issued in December 2013 describes initial payment for Covered California plans as follows:

For all OA-HIPP application packages that are received between the 1st and 15th day of the month and contain all required documentation, OA will process and issue premium payments for approved applications so the client's [Covered California] coverage will start the first day of the second month that the application is received. For example, [for an OA-HIPP application received February 10th, Covered California coverage will begin April 1st.] The initial payment will cover the first month the client's insurance becomes effective plus three additional months. If the client would like his/her coverage to start sooner, the client will have to pay the first month's premium. For example, if a client submits a complete application to Covered California and OA by January 15, the client would need to issue payment to his/her insurance company by January 27 in order for his/her coverage to start February 1. After the insurance company receives payment from OA, the client can contact the insurance company and request a refund for the month they paid. The enrollment worker must notify OA if the client intends to make the initial payment.^{iv}

In practice, some consumers lost their new insurance while waiting for OA-HIPP payment to begin because they had not begun paying their premiums promptly after enrollment. They may have believed it was optional to that pay the first month's premium while waiting for OA-HIPP coverage to begin. One interview participant described this scenario when asked about disruptions in coverage:

So, with one client, he had signed up for a Covered California plan, under my advice, and then didn't make his payment because we were trying to get him into ADAP and then into OA-HIPP ... I think that some problems have been because it was my misunderstanding that people could enroll in a plan and just not pay for a while. ...and I must have gotten that from somewhere. (Enrollment worker, Northern California)

In another instance, the OA issued guidance in December 2013 regarding which tier of Covered California plan (known as Bronze, Silver, Gold, or Platinum) they recommended consumers select. The guidance encouraged the Enhanced Silver plan for consumers who earn between 138 and 200 percent of the Federal Poverty Level.^v After this, the OA determined that this tier sometimes resulted in higher costs for consumers. Despite this correction, the guidance available on the OA-HIPP website was not clearly updated.

...they've crunched some numbers and then ascertained that even if they're eligible for an Enhanced Silver, there are some other costs, and some of these people might be better off with the Platinum. ...And then they say in these calls, oh, the recommendations are outdated, but we're not changing them. (Enrollment worker, Northern California)

In addition, some OA-HIPP policies and procedures, such as the timeline for issuing initial payment, do not seem to some enrollment workers to be consistently followed by the OA.

They do have some kind of time frame [for issuing payment], but I don't really pay attention to it because it's not exactly accurate. So ... I'm telling [my clients that] you can't count on a specific period of time. (Enrollment worker, Northern California)

Cross-Cutting Issue: Consumer Burden

While participation in OA-HIPP can and has increased financial security and access to comprehensive coverage for many eligible individuals, issues that occur during enrollment and throughout ongoing participation can negatively impact consumers' financial and behavioral health, and can undermine stable continuation of insurance coverage.

Financial Burden

Until OA-HIPP begins paying monthly premiums, consumers must pay these premiums out of pocket in order to maintain their coverage. As stated previously, **it can be difficult to predict how long a consumer will need to pay out of pocket.** This insecurity is compounded by the fact that many consumers can barely afford to pay their premium once, let alone multiple times. In order to meet these payments, many consumers borrow money, which some enrollment workers advise them to do.

I basically tell them, look: do you have friends, do you have family members, that would be willing to provide you with the money that you would need to pay the first month's premium, under the promise that once the state begins to pay, you will ask for that month to be reimbursed to you and you can give them their money back? (Enrollment worker, Southern California)

Other consumers use credit cards that they may not be able to pay off, or apply for emergency funding from service organizations, limiting the emergency funding available for other purposes. **Some consumers—particularly those with expensive COBRA, family, or platinum plan premiums—cannot afford to pay their initial premiums at all, or pay for one or more months but then cannot keep paying if OA-HIPP has not issued premium payment.** Consumers who do not pay risk insurance cancellation.

...we have a couple of the patients that, because of family coverage, they're paying a lot more money, and they're using credit cards, and actually, one of the families, this month they weren't able to send the monthly premium... it will be I think this is the third payment. [So three months, and they weren't able to do it?] Yes, because it's almost a thousand dollars a month. (Enrollment worker, Northern California)

Other consumers utilize care while their insurance is not stable and functioning, such as when they are not sure that OA-HIPP has made a payment. This leaves these consumers vulnerable to medical debt.

When OA-HIPP payment begins, it back-pays the insurer premiums for the months the consumer initially paid. **Consumers' payments are then supposed to be reimbursed by the insurer, but several enrollment workers reported that this is either not done, or is difficult to do.**

[Refund processing] can be quite a challenge for folks. I don't know if folks will be reluctant to do this kind of thing in the future if they change insurances, basically, but – I have a client who's been a Kaiser member since January, he's still not seen his refund check. (Enrollment worker interview conducted early June 2014, Northern California)

In some cases, the insurer will only issue a credit on consumers' accounts, or will issue reimbursement to parties it believes to be the payer, such as OA-HIPP or service organizations that provided emergency funding.

...in theory, you would think that the insurance company would give the patient their money back, since the state has now paid it. We haven't found that to be so true in most cases. Mostly the insurance company just wants to hold onto it and credit their account ... But for some people, they've had to borrow that money, and they really need to get that money back to whoever they borrowed it from. (Enrollment worker, Northern California)

The OA cannot compel the insurance companies to make these reimbursements, but State workers reported that they did receive assurance from insurers that the reimbursements would be made.

Consumer Capacity and Behavioral Health

Consumers can experience significant stress and anxiety while waiting for OA-HIPP to kick in, while resolving payment issues, and while monitoring ongoing payments. Some consumers have full-time jobs and limited time to monitor their insurance regularly. Other consumers are managing behavioral or physical health issues that limit their capacity to engage with OA-HIPP responsibilities. Consumers with low literacy and those without access to a computer may also struggle to monitor their insurance. Several interviewees noted that **participation in the OA-HIPP program can be very challenging for lower-functioning consumers** who lack the ability or resources to pursue errors or monitor their insurance regularly. Higher-functioning consumers have greater capacity to engage with the program and manage or avoid issues, while lower-functioning consumers, however eligible, do not. Enrollment workers reported that they have generally been too busy to support lower-functioning consumers to the degree that would be necessary to avoid issues.

So it's very hard for them to monitor their insurance, and they absolutely have to monitor it, because it's something that a worker can't do. They have a connection with their insurance, and they have to actively monitor their insurance to make sure that they don't get cut off and money is credited properly. So...it's a very labor-intensive program, so it's not for everybody. ...it's kind of high-stress for the participants, even though they get the benefit of having insurance, they have to work really hard to make sure that money is credited. (Enrollment worker, Northern California)

There are many consumers who received services in Ryan White-funded settings until the ACA, and are not well-versed in the terminology and responsibilities associated with their new insurance and

OA-HIPP. This learning curve can impede engagement with OA-HIPP and private insurance. In theory, enrollment workers can be a link between OA-HIPP and consumers, providing consumer support and educating them on insurance terminology, monitoring, and use. In practice, however, this kind of education takes a great deal of time. Many of the enrollment workers we spoke with were inundated with technical and procedural issues associated with their expanding benefits counseling duties, and were left with little time to familiarize their clients with their new, comprehensive coverage.

Delays and Disruptions in Care

Several interviewees reported instances in which issues with OA-HIPP caused consumers to lose their insurance. Disruptions in care occur for eligible consumers who do not know about OA-HIPP and are not able to afford their premiums, while consumers are waiting for initial payment from OA-HIPP, and as a result of issues with ongoing payment.

Most people find out that their insurance isn't activated when they go to the pharmacy. Because then they can't pick up their meds. ...and then I call OA-HIPP, and then they'll say, oh, well, we – the check is coming, or we were supposed to send it, we sent the check ... [but] they don't necessarily want to call the insurance themselves. ... [While some consumers were reinstated] ...a couple times ... it's just been like – there's nothing more we can do, they dropped you. ...I've had such anger. I've actually sent a few people to [legal services], because at that point there's nothing more I can do but I feel like OA-HIPP should have some responsibility for those patients because they've lost their care.
(Enrollment worker, Northern California)

Most consumers who lost their insurance due to OA-HIPP issues prior to the end of open enrollment were able to have their coverage reinstated, but reinstatement sometimes took time, potentially delaying access to care. **Others do not have disruptions in coverage, but do delay needed care because they are not sure of the status of their insurance.**

...he should have a colonoscopy, but is just waiting for the insurance stuff to pan out. ... So I'm worried that his care will definitely be affected... (Enrollment worker, Northern California)

When disruptions in care have occurred, some insurers proved more willing than others to reinstate. **Relationships with insurers helped to facilitate reinstatement.** Other consumers were not reinstated and relied until Covered California's second open enrollment period on a variety of safety net services for care, including full ADAP coverage; utilizing publicly-funded hospitals, community health centers, and Ryan White clinics; enrolling in public programs such as Healthy San Francisco; and utilizing discount programs at county clinics. **Without the availability of safety-net support, consumers who lost their insurance would have no access to care until the next open enrollment period begins.**

[So that's the backup plan right now, until open enrollment, people get deferred to the Ryan White clinic?] People get deferred to [public clinics] and they get deferred to ADAP. (Enrollment worker, Northern California)

When there are disruptions in care, a few interviewees reported that it is essential that consumers' ADAP designations be changed promptly to allow access to full ADAP coverage. In addition, if an initial payment has been sent but the insurer has not yet received it, consumers who have been waiting for their insurance to be initiated by OA-HIPP payment may be unable to continue to utilize full ADAP coverage while they still need it if their designation has been changed. **Aligning ADAP designations and confirmed enrollment in an active insurance plan and OA-HIPP is necessary to achieve more continuous coverage for consumers.**

Finally, interviewees reported that even for consumers who successfully established insurance coverage under the ACA, the comprehensive services previously available to them through Ryan White clinics are not matched by their new coverage. While this change is not caused by the OA-HIPP program, specifically, it is nonetheless an important evolution in HIV/AIDS care.

So [through Ryan White] they can see a social worker, benefits counselor, certain therapies that they can get, housing, food, even dental if they have no dental coverage. But what they don't get is getting that where their medical care is, or integrating it. So they have to basically get their medical care elsewhere and then coordinate that with us as much as they can, seeing that's outside of it. And that decreases the frequency with which we see them, commonly, to provide those other services. So they're eligible for those services, but receive them less accessibly and probably less frequently. Because it's just a lot to do if you're working and you have to get your medical care and you have to make extra time for the kind of adjunct services that you would normally get [in the same site as your medical care]. (Enrollment worker, Northern California comprehensive HIV clinic)

Cross-Cutting Issue: Enrollment and State Worker Capacity

OA-HIPP personnel, including enrollment workers and State OA staff, have been impacted by both significant growth in the OA-HIPP program and the demands of insurance provision under healthcare reform, as well as the time and effort needed to triage issues with the OA-HIPP program.

Impacts on Enrollment Workers

Enrollment Worker Capacity

OA-HIPP enrollment has increased alongside the implementation of the Affordable Care Act, which increased patient volume in clinics across the state. Recent changes to ADAP, Medicare, and Medi-Cal have made these programs more complex, increasing the need for enrollment workers to assist clients in managing their coverage. In combination, **changes to the landscape of comprehensive coverage have greatly increased the responsibilities and time demands shouldered by enrollment workers.**

[Benefits counseling has] gotten much worse. ...Medicare is very complicated to navigate. You've got [Medi-Cal for Aged and Disabled Persons] and you've got people who want to talk to you about different Advantage plans. Medi-Cal has become increasingly difficult, with home clinics, with managed care. Covered California is a whole skill in itself. ...In the nine years I've been an ADAP worker, the work that they put on the enrollment worker has doubled. And now OA-HIPP just expects ADAP workers to become their enrollment workers, and there's just no incentive. ...They really need to have financial benefits counselors. (Enrollment worker, Northern California)

Enrollment workers who were originally hired into roles not focused on benefits counseling, such as nurses, clinical social workers, and case managers, expressed that **their ability to address non-benefits-related issues has been reduced by the increasing demands of benefits counseling duties**. These workers, along with less experienced enrollment workers, may also not be adequately prepared by current OA-HIPP training to manage the kind of time-intensive, highly specialized issues that benefits counseling can entail. In addition, errors and communication issues with OA-HIPP create additional work for enrollment workers: **because it does not function optimally, OA-HIPP requires a level of regular monitoring that many workers do not have the capacity to support**. Some enrollment workers reported decreased their satisfaction with their jobs.

I have to go through this sort of laborious process with each individual, receiving their emails or calls and forwarding them to OA-HIPP and wait for a response, and then when a response comes back to me, then I have to forward it to the client. ... So it creates an added work flow impediment for me, since I do more than just ADAP and OA-HIPP. (Enrollment worker, Southern California)

Some enrollment workers do not have the capacity to manage expanded caseloads, so they complete initial enrollment with consumers but at recertification, move the consumer to self-enrollment or monitoring, so that the enrollment worker is no longer responsible for following their account.

Some other organizations...this is too much for them. This is a lot of administrative work that, say, if someone's a social worker, this is really not part of their role. And so in those cases, they'll just kind of let the person, the individual [consumer], know – I'm doing the initial enrollment, but you have to continue with the monitoring and the re-enrollment... (Enrollment worker, Northern California)

Many enrollment workers reported that, in the absence of more active guidance and support from the OA, they have developed a variety of strategies to reduce the burden of engaging with this program, including such things as: creating written guidance for consumers, seeking peer support by voluntarily conducting outreach and training with other providers, supporting self-enrollment, and redirecting consumer communication directly to OA-HIPP analysts.

I forward my client's email to them So they're aware of the client's language, and I'm putting the responsibility of responding to the client's angst on them. And that's my way of separating, objectivizing the process because it's very problematic and it consumes a lot of time. (Enrollment worker, Southern California)

Enrollment Worker Reimbursement

Many of our interviewees reported that enrollment workers are supposed to receive reimbursements from the OA for the enrollment and recertification activities they perform for OA-HIPP and ADAP, and that these have not been received, or have not been received regularly. Several expressed confusion regarding this process and could not explain it clearly, or noted that these payments may be diverted to county officials during certain times, but could not explain when. **A few noted the impression that, because they do not regularly receive reimbursements for their work, they believe the State does not monitor enrollment worker activity.**

This lack of clarity around reimbursement for work related to OA-HIPP enrollment appears to contribute **to a sense among the workers we interviewed that increasing demands of OA-HIPP enrollment and monitoring are being placed upon enrollment workers with little support or incentive for performing this work.** Here, one enrollment worker describes some issues encountered around reimbursement:

This is a service to our clients that originally we were to be paid \$25 for every enrollment and \$25 for every re-cert. I don't think I've gotten paid many \$25. Right now I consider this to be an unreimbursed service... I think the check actually came payable to me, which was crazy. ... I think that really...they don't keep track of how many applications or re-certs we do. The two times that I got reimbursed, it was up to me to [notify] my director, two levels up, [to] send a memo to the supervisor of that group to say, hey, send us \$250, we did ten of these. (Enrollment worker, Northern California)

Impacts on State Workers

State Worker Capacity

OA-HIPP analysts and management receive heavy call and email volume from consumers and enrollment workers. Several interviewees reported that OA-HIPP representatives have told them they are aware of communication issues with the program, but that current staff do not always have the capacity to respond to questions. As with enrollment workers, it appears **analysts have varied in how they cope with the increased workload.** Some are more responsive than others, while some are responsive in some ways—such as answering the phone—but not in others—such as addressing notes attached to applications.

When people's payments are missing, then...I know that some [analysts] I know will follow up and other [analysts] – hmm, I'm not sure. (Enrollment worker, Northern California)

Some rely heavily on enrollment workers to interface with consumers, increasing the demands placed on enrollment workers. **More clarity is needed around the roles enrollment workers and analysts should play in resolving consumer issues.**

Most interviewees agreed that both the number of new OA-HIPP enrollees and the time and energy required to manage issues with the program may have exceeded the State's expectations. **The workload of OA-HIPP staff has increased significantly, and the office has not consistently had enough staffing to triage it.** At the time of data collection, ten analysts were serving roughly 1800 consumers, and not all analysts were full time. **Additional staff are needed but the State hiring process is not expedient.** Check generation for OA-HIPP has increased the workload for staff members at the State Accounting and Controller's Offices, as well.

Interview Participants' Suggestions for Improvement

Program Management

Many interviewees expressed interest in management of the OA-HIPP program moving from the State OA to Ramsell, the Pharmacy Benefit Management (PBM) company that currently manages California's AIDS Drug Assistance Program (ADAP). Interviewees supported this idea in part because the consumer population enrolled in ADAP is often the same: consumers must be enrolled in ADAP to qualify for OA-HIPP.

Most supporters of integration with Ramsell did not view Ramsell's management of ADAP as perfect, but still recommended that the programs be combined because **many aspects of the program infrastructure of ADAP was viewed as more workable than the current OA-HIPP system.** For example, enrollment workers seemed to have greater confidence that Ramsell will respond to communication within a predictable length of time. Also, **the ability to access consumers' account information through an online system was appealing to our interviewees.** In cases in which Ramsell is not responsive, enrollment workers have some redundancy: they can seek needed information through the online system Ramsell uses. They can access this independently and are not wholly dependent on reaching a Ramsell worker in order to assist consumers.

Nationally, states have selected a variety of management structures for their insurance purchasing programs, although it appears to be less common for a state to manage such programs using only state resources and personnel. Some states have struggled to manage separately-run ADAPs and premium payment programs. **Illinois benefitted from integrating its separately-managed programs.** Others are considering the idea.

...when you contract out these bits and pieces of the insurance purchasing services to different contractors, like PBM on one side, and you're doing the premium payments either with another ISO [Insurance Services Office] or another contractor, it does create, in some ways, separate systems. So Illinois had that issue, too, and they're not the only state that has bifurcated their full-pay ADAP medication program from what they call

the Illinois Continuation of Health Insurance coverage. But they decided to merge those two programs a couple years ago. And I think that has made administration a lot simpler and streamlined the application process. ... But I think the conversation about Ramsell and about whether one entity can do everything is one that is happening elsewhere.
(National advocate)

Although many interviewees recommended that Ramsell manage OA-HIPP, they also identified a number of areas in need of improvement in Ramsell’s management of ADAP. Many reported that documentation needed for ADAP enrollment and recertification can be burdensome to obtain. In some cases—such as verifying HIV status and state residency during recertification—ADAP documentation feels redundant to enrollment workers, and could be made more sensible. As with OA-HIPP, some enrollment workers felt that they need more guidance around Ramsell’s policies and procedures. Although training is provided, not all questions are addressed completely or in a timely manner. **A few enrollment workers asserted that Ramsell is not as flexible as they think is appropriate to promote consumers’ access to care.**

Seasoned enrollment workers reported that **ADAP work has grown more complex over time**, and, as a result of changes to the recertification process, is likely to grow more complex. The responsibilities and time demands placed on enrollment workers have grown accordingly. At the same time, staffing capacity at Ramsell may be more limited, and **Ramsell staff have become less responsive.**

And I think Ramsell is getting to the point where, if you can’t get a live person – and they’re really understaffed, too – then the program doesn’t work. You can’t – if you get transferred to voicemail at Ramsell, you will not get a call back. So they are understaffed as well. And it’s just gonna get more – and they’re talking about doing the six-month ADAP re-certification [instead of recertifying annually]... it’s going to be a disaster... (Enrollment worker, Northern California)

Outreach and Engagement

The majority of interviewees agreed that OA-HIPP stakeholders need to increase the visibility of the program. Many thought that since consumers must be enrolled in ADAP to qualify for OA-HIPP, **Ramsell should contact all ADAP enrollees regarding their potential eligibility for OA-HIPP.** Others suggested that **Covered California should take a more active role in promoting the program**, by training Covered California enrollment workers to screen for eligibility, and even building screening for OA-HIPP into the Covered California application. The pool of consumers seeking to establish comprehensive coverage has grown under the ACA, so interviewees felt outreach should be done outside the known HIV community to expose non-traditional partners to the existence of these programs. By **intensifying outreach around the time of open enrollment**, OA-HIPP stakeholders may reach a more attentive audience, and could create greater synchronicity with Covered California processes.

... I think that outreach could be concentrated around the time of – Covered California open enrollment. It’d be a more perfect time to do a blast to – you could do a blast to

everybody on the ADAP ... I think it was effective with – the ADAP Medicare Part D program to sort of blast it out to all ADAP participants. I think this is equally worthwhile annually. “You need this!” you know? (Enrollment worker, Northern California)

Although it is desirable to utilize any available stakeholders to increase outreach, some interviewees cautioned that **outreach should only be done by eligibility workers or other highly knowledgeable parties, to promote the dissemination of accurate information.**

Other states have adopted creative solutions to this issue, limiting enrollment worker burden by training consumers on these programs, so that they were aware of their eligibility for premium payment, and were prepared to enroll when they met with an exchange enroller.

So the other model has been for those states to develop relationships and a referral system with navigators and CACs [Certified Application Counselors]. So those navigators and CACs weren’t necessarily HIV experts, didn’t know anything about the Ryan White or ADAP programs, but instead of – so what the HIV programs did was offer trainings and information and making sure that clients went to a CAC or navigator with the appropriate material. So that was another way that states have kind of leveraged other resources where there just weren’t enough case managers to do all of the outreach, enrollment, and application assistance. (National advocate)

Using the opposite approach, states such as Colorado increased synchronicity between aspects of comprehensive coverage enrollment by certifying ADAP enrollment workers as insurance exchange navigators.

So maybe Colorado is a really good example there, too, because they are one of the only states that I know of, where their ADAP [enrollment worker] actually was a certified patient navigator in the state. So they were a state-based marketplace, and the State’s ADAP Part B program worked real closely with the marketplace to get that designation. They didn’t get any money, but what they got was through the State imprimatur of, “You’re a navigator,” and the training from the State, and with that, they became the on-the-ground, all across the State, doing outreach to different ASOs [AIDS Service Organizations]. And I think they actually had a network of ASOs where case managers were located and were able to do that direct client outreach and enrollment, and I think what really helped there was that because it was ADAP, they had a list of ADAP clients, they had names and income that they could have. Each case manager was in fact responsible for their own list. These clients are yours, you have to make sure they get from Point A to Point B. (National advocate)

While this approach would be difficult to adopt for use in a state as populous as California, it is one successful approach to engaging the ADAP-eligible population in comprehensive coverage.

Documentation and Eligibility

As noted previously, a few interviewees **advocated for an increase in the eligible income threshold** for OA-HIPP, noting both that \$50,000 is now a much smaller income to live off of in California than it once was, and that consumers who make a little over that amount still have tremendous difficulty paying their premiums. Also, more support is needed from the OA to facilitate ease of access to required OA-HIPP documentation from Covered California, particularly for consumers who did not apply for Covered California online.

Technology

At a minimum, interviewees requested that OA-HIPP staff more diligently attend to faxes received so that applications are received and attended to in a timely manner. In addition, several expressed interest in developing an email communication system that maintains privacy but is easier to use than the current, secure email system OA-HIPP uses. However, most interviewees went further, **suggesting that the OA-HIPP program be maintained through an online system or portal for application and monitoring.** Suggested models included ADAP, Medi-Cal, and online bill payment systems.

It is possible to build supportive infrastructure around premium payment programs: Illinois successfully built its own data system that encapsulates its ADAP program and has the potential to sync with other relevant programs. This system includes an online portal that was developed with the input of consumers, service providers, and other stakeholders to better reflect users' needs.^{vi}

They've really built an entire electronic database, so their entire ADAP application process is electronic, which I think is very unique. I have not seen that in very many states. And they built that system themselves. And that system is able to talk to the state Medicaid program to do a cross-check of eligibility as well. And they're in conversation about thinking through, at some future date, will that system be able to talk to the marketplace in some way to share data for the private insurance population.
(National advocate)

Program Procedures

While interviewees did have specific procedural recommendations, they also expressed the general feeling that the OA-HIPP program is not predictable, as it currently functions. To better support coverage for consumers, **the program needs to adopt procedures that increase the predictability of the program, and create greater redundancies to prevent or detect errors.**

Interviewees expressed strong interest in improving payment timeliness and flexibility. Many shared the sentiment that paper checks are cumbersome and outdated, and **expressed interest in electronic payment**, which was viewed as more reliable. Electronic payment methods were also viewed favorably for their ability to reduce the processing time currently needed to send a paper check from the State.

Several participants requested that the program begin issuing supplemental checks again when premiums change, as was done under CARE/HIPP. This issue has come up in other states, some of which have not been able to adjust payment procedures to issue supplemental checks, and instead rely on strongly reminding consumers signing up for the program of their responsibility to promptly report income and premium changes.

Communication and Education

Interviewees were very interested in OA-HIPP becoming more forthcoming and more responsive to requests for assistance from both enrollment workers and consumers. One enrollment worker pointed out that because it is time-intensive to communicate with OA-HIPP, consumers end up having to take time off of work to manage issues or meet with an enrollment worker. She suggested that more consumer-friendly, responsive communication tools, such as a consumer hotline, be made available.

I think – if there was like a hotline for clients, for us to give them something – hey, you could call here, we don't have the answer – and maybe the clients would not have to maybe miss a day of work, or – because as great as it is to see them – people got different things in their lives, right? (Enrollment worker, Northern California)

Most participants felt that communication from OA-HIPP needs to be systematic, predictable, and standardized. **Reliable communication allows enrollment workers to better support the consumers they work with and reduce their stress.**

Something like that would be really nice, if OA-HIPP was able to provide that piece of communication, automated, and it would just have to be an email – that the application has been received, please expect processing to take this period of time, you will be notified when a payment is ready to be mailed to the cover payee, or whoever the payee is. Those pieces, as benign as they sound, when I forward them to clients, it helps them cope with their anxiety of whether the payment's going to be made, if they're going to keep their insurance or not... (Enrollment worker, Southern California)

According to our interviewees, **a good communication system would, at minimum, include timely, automated or standardized confirmations for faxed applications and recertifications, regular notifications regarding application and enrollment status, and recertification reminders.**

Guidance

Policies and Procedures

Enrollment workers and consumers need greater clarity around several procedural issues discussed in this report, including (but not limited to) coverage for vision and dental plans, the mechanism for enrollment worker reimbursement, and the roles and responsibilities of enrollment workers. The OA has, in fact, issued guidance on some topics that interviewees requested clarification on, indicating that the guidance is not easily accessed in its current form. Some earlier guidance is now in need of revision, including guidance regarding the optimal Covered California plan selection for OA-HIPP participants.

Enrollment workers also requested that OA-HIPP inform them of changes to analysts' insurer caseload assignments on a regular basis, so that enrollment workers and consumers do not spend time contacting the wrong analyst. One interviewee suggested that analysts develop more general familiarity with insurance plans they are not assigned to so they can better respond to insurer-specific questions when the assigned analyst is not available.

...but just maybe [analysts should learn] a general overview of something, if I have to call you as a backup, and I called you as the fourth backup, because now at this point nobody's answering their phones, [you could] just have a general idea. (Enrollment worker, Northern California)

Training and Enrollment Worker Support

A few enrollment workers expressed interest in an OA-HIPP training format that could be more interactive and allow questions, including trainings offered in person. Enrollment workers felt that training should be provided on an ongoing basis to support quality control. Guidance and updates on other, related programs is communicated to enrollment workers regularly, and enrollment workers felt they would benefit from this same level of attention from OA-HIPP.

...[The State should] at least update [us], if there's any changes in the program or ... they implement another extra step in the process of the application. We have – from other programs we have ... webinars every week, and they send a lot of emails, almost every day we receive emails saying something. ... And we are able to get information from them and also we are able to ask questions of them. (Enrollment worker, Northern California)

Enrollment and Consumer Self-Management

Both enrollment workers and consumers need clear, prominently-placed check lists or step-by-step guidance for application and recertification. Other states' programs have also found this to be necessary. In particular, these processes need to be made clear in order to better support self-enrollment. **Across our study, participants reported that many consumers are capable of and interested in self-enrollment and self-management, but have not been equipped with easy-to-use tools to allow them to do so.** Since some guidance does exist on the OA-HIPP website, this indicates that existing resources are not sufficient, or are not being provided in a manner that encourages consumer use. Helping consumers become well-informed and able to independently manage their coverage allows enrollment workers to focus on the needs of lower-functioning consumers, and empowers consumers and equips them to advocate for themselves. In addition to tools and guidance, our interviewees felt that **consumers—whether self-managed or not—need to be included more directly in the program.** For example, interviewees suggested newly-enrolled consumers should receive welcoming greetings and information, and that recertification reminders, payment notifications, and ongoing communication about consumers with enrollment workers should also be sent to the consumer.

...look, when I put a client's phone number and email on that application, I expect you to use it! I expect you to be cc'ing the client when you're sending payment information out to me. Send it to the client as well. ... I'm not your customer. I'm the agent through which this is flowing. The client is your customer. (Enrollment worker, Northern California)

A few interviewees also suggested that some consumers are capable of self-enrollment in ADAP, and should have that option.

Personnel

Most interviewees recommended increasing personnel across the OA-HIPP program, citing deficits in one or more of three categories: OA-HIPP analysts at the State OA, enrollment workers, and financial benefits counselors. **In particular, participants across our sample expressed that benefits counseling has become a specialty skill that requires extensive experience and training.** A few emphasized the view that it would be more supportive for more devoted benefits counseling positions to be funded across California, rather than continue to increase demands on enrollment and state workers. To support existing enrollment workers and incentivize new worker participation, **the procedures for reimbursing ADAP and OA-HIPP enrollment workers for their services should be clarified and followed.**

OA-HIPP enrollment workers can encounter a broad range of issues in their benefits counseling duties, but may not always be clear how much assistance they are expected to give. **The role of OA-HIPP enrollment workers and their responsibility to manage issues need to be clarified**, as the role of ADAP workers has been. It may be reasonable to have higher expectations of benefits counselors, specifically.

...they do these ADAP trainings, they're very clear about what the role of the enrollment worker is, what they can and can't do... With OA-HIPP, it's still a bit nebulous. So I think that would be another great thing, if OA-HIPP can also provide more guidelines or clarification of – what is the – if someone is an enrolled OA-HIPP enrollment worker, what is their responsibility, and what does it entail? In terms of – so for instance, when people do have issues or problems, what is our response? How much do we respond? ... 'Cause again, for me particularly, I think it kind of works out where, as my role as a benefits coordinator and advocate for [consumers], that's kind of what I do, is coverage issues. As well as benefits. So I feel that I can help people a little bit more than, say, different types of OA-HIPP enrollment workers, because I have that flexibility and access to coverage information. (Enrollment worker, Northern California)

Partnership and Systems of Care

Many study participants requested that the OA-HIPP program demonstrate greater transparency and accountability to its stakeholders. In particular, interviewees requested that the program track certain performance metrics (such as number enrolled, processing time or payment timeliness, disruptions in care) and report back to stakeholders.

Partnering with Enrollment Workers

Enrollment workers have invested a tremendous amount of effort in OA-HIPP and have developed growing expertise in the program and how it relates to a complex, changing health insurance landscape. However, several of the enrollment workers we spoke with felt that more opportunities are needed for them to offer feedback back to the program, and to participate in the development of policies and procedures. **One suggested that the program directly reach out to enrollment workers for feedback, treating them as valued colleagues.**

...it's not a terrible idea for them to do some kind of a survey of workers once in a while as well. It seems meaningful. ...And giving some [weight to enrollment worker input]– and sort of reflecting that back to the workers as well ... If we got the feeling they were interested in our feedback, then we'd probably feed back more to them. (Enrollment worker, Northern California)

Engaging Consumers as Partners

As stated previously, many consumers are or are capable of self-enrollment and self-management, and **all enrolled consumers stand to be empowered by more direct access to and communication with the program.** Our interviewees reported that consumers have both questions and feedback for the program, but do not have a proper forum to communicate. One suggested that the program host consumer forums, noting that currently, the program feels remote to participants.

Also, maybe, if there was like a forum- like one big forum – clients – anyone would be invited, bring your questions, then I think it would help people feel... that – OA-HIPP was something that you could see, or – not something that people think exists, but you don't know if it exists or not because now you're paying your second month's premium... (Enrollment worker, Northern California)

Enhancing Relationships with Other Institutions

Across our interviews, we heard stories of relationships between stakeholders as the key factor that mitigated issues and promoted stable coverage. Interview participants approved of some of the formalized relationship structure that exists around the ADAP program and creates designated points of contact and response between relevant parties. They suggested that **participating insurers be asked to designate a contact person or steward that develops OA-HIPP expertise and problem management.** Other states' programs have benefitted from similar relationship-building between insurers and the program. **Nationally, premium payment programs could benefit from developing best practices and standards for relationships between insurers and third-party payers.** For some states, the Department of Insurance has been a supportive partner to the HIV community in negotiating with insurers.

IMPLICATIONS OF THE FINDINGS

By developing and expanding premium assistance eligibility under the OA-HIPP program, the State of California has increased access to more stable, comprehensive coverage for Californians living with HIV/AIDS. The OA-HIPP program needs improvements to function optimally in a complex, evolving

health insurance landscape, but it has played a vital role in allowing many consumers to maintain more comprehensive health insurance coverage, and it must be maintained. Greater collaboration between stakeholders is needed to help the program perform optimally; when OA-HIPP works at its best, consumers have greater opportunity to fulfill the purpose of the program by fully utilizing their insurance in pursuit of better health.

Relationships are vital.

Relationships are key to resolving program issues and promoting coverage. OA-HIPP has performed at its best so far when stakeholders have built and leveraged relationships around the program to support stable coverage. Consumer outcomes stand to be improved by enhanced relationships between the State, enrollment workers, consumers, insurers, advocates, and related programs and parties.

Relationships with enrollment workers

Enrollment workers are a significant program resource. Feedback on their on-the-ground experience, as well as the internal resources enrollment workers have developed, could be extremely valuable in improving program policies; this information should be brought to the table. Enrollment workers need greater support and incentives to work in an increasingly challenging field: they are, in a sense, colleagues of OA-HIPP staff and stand to feel more valued through active, solicited participation. An advisory group that would routinely communicate with OA-HIPP administrators would help to connect the broad constituency of OA-HIPP enrollers to policy makers who can seek to clarify or change program policies as necessary.

As the program currently functions, OA-HIPP staff and enrollment workers are often overburdened by triaging payment, monitoring, and communication issues. In addition, enrollment workers must often manage other financial benefits and consumer support tasks. There was a sense among our study participants that as the healthcare insurance landscape has shifted, financial benefits counseling has become an increasingly distinct job that requires significant time and expertise. Consumers may be better assisted by increasing the number of specialists in this field as the health insurance landscape grows more complex. In addition, there is a need for collaboration between program staff, consumers, and enrollment workers to clarify the roles and responsibilities of all stakeholders in managing coverage and dealing with problems as they arise.

As partners in program delivery, enrollment workers should regularly receive accurate, complete, and timely program information. Enrollment worker feedback is needed to determine what the best, most accessible forums and formats to present guidance are, and how guidance should be made user-friendly and independently accessible for consumers and enrollment workers. Guidance and programmatic information—such as analyst-insurer assignments—should be shared in a regular, predictable manner and should be kept very up to date. Accessible guidance is currently needed to clarify supplemental coverage, enrollment worker reimbursement, and Covered California plan tier recommendations.

Alongside guidance, consumers and enrollment workers could benefit from feedback on the program's performance. It would encourage engagement in and improvements to the program if quality performance metrics were monitored and disseminated regularly.

Relationships with insurers, advocates, and related parties

In particular, when program issues cause disruptions in consumers' insurance enrollment, relationships with insurers can be crucial to reinstating coverage. Thus far, relationships with insurers have helped to resolve payment and coverage issues, and to remove impediments to more timely payment on an individual basis. While these individual relationships are significant and should continue to grow, there is room for broader partnership between the program and California's insurers, as a whole. As a third-party payer, the program could benefit from seeking improved standards for insurer participation in California's market—standards that facilitate secure insurance coverage for vulnerable populations who rely on third-party payers. While much can be resolved on an individual insurer level, greater, broad-based advocacy and education around third-party payment could help facilitate such things as: guarantees that insurance for consumers enrolled in third-party payment programs will not be discontinued should the payments for their policies be late; that funds paid upfront by consumers must be reimbursed back to consumers once third-party payment begins; and that payment format and processes be standardized across the market.

State-run payment generation—particularly when not electronic—is complex and therefore tardy in programs across the country. As is, payment in California does not have the flexibility needed to respond to premium changes so that consumers' accounts stay up-to-date. Increased collaboration between insurers, the State Department of Insurance, advocates, enrollment workers, consumers, and related programs can help create opportunities for smoother, more standardized payment handing and provide a forum for advocacy on behalf of patients who rely on third-party payers.

Relationships with consumers

There is room for the program to increase its direct relationship with consumers, and to empower them as stewards of their own healthcare coverage. In particular, expanded support for self-enrollment is needed. Simple, consumer-friendly instructions and checklists should be made easily available online, and should be structured to support self-enrollment. With additional resources at their disposal, more consumers may be able to complete this process on their own without having to take time to interface with an enrollment worker. Consumers who are empowered to successfully manage their participation reduce the monitoring and management burden placed on enrollment workers and State analysts. It would be ideal if enrollment workers' caseloads could be reduced enough to facilitate their support of more time-intensive, lower-functioning consumers, for whom this program presents more challenges. If the program works better, enrollment workers will have more time to educate consumers on how to understand and best utilize their coverage. There is no current mechanism to support this kind of training, despite the fact that many participants are first-time private insurance enrollees.

More needs to be done to safeguard the mental, physical, and financial well-being of consumers enrolled in this program. Consumers are eligible for this program precisely because they do need financial help to pay their premiums and maintain insurance. Paying premiums out of pocket can jeopardize consumers' financial standing and insurance status. In particular, if consumers are encouraged to enroll in COBRA or expensive Covered California plans under the promise of premium payment assistance, they may not be able to meet the expense of a premium payment for long, if at all.

Expedient check generation should be supported so that initial payment from OA-HIPP can be issued on time, and within a predictable length of time after application. Greater advocacy is needed to identify and remove the barriers to consumer reimbursement by insurers.

Reliable, robust communication around the program is essential.

In the more than three years since OA-HIPP was launched, the program has grown significantly, but essential stakeholders remain unaware of the program. There are still eligible Californians who are struggling to pay their premiums without assistance. More outreach is needed, especially to service and medical providers as the conduits through which many consumers learn of the program. Some of the outreach suggestions made by enrollment workers overlap with outreach the State reports having already performed; this indicates that outreach efforts are not visible to enrollment workers, perhaps because they did not reach consumers. In turn, this indicates that a more diverse outreach toolbox must be employed to reach eligible consumers, including multiple contact methods and outreach venues. Clear leadership and defined outreach strategies may maximize the impact of outreach. Positive aspects of the program and program improvements should be built upon and promoted in outreach to help counter any negative impressions of the program that have created some current barriers to engagement, and to generate stakeholder enthusiasm for expansion.

When it happens now, direct communication between the program and consumers and enrollment workers is greatly appreciated. Consumers and enrollment workers find predictable, direct, accessible communication with the program to be reassuring and positive, and such communication facilitates prompt identification and resolution of problems. Our interviewees emphasized that reliable communication patterns help consumers and enrollment workers identify payment issues in advance of disruptions in care. Systematic, timely communication should be increased to alleviate consumers' anxieties and engage them more directly in participation, and to reduce the call and email burden currently placed on enrollment workers and state analysts.

There was consensus among our study participants that one of the best ways these communication objectives could be achieved would be through the creation of an online program portal for program participants and enrollment workers, accompanied by automated confirmations and recertification reminders. To reduce the communication burden currently placed on enrollment workers, analysts, and consumers, consumers or their enrollment workers should be able to independently have access to key participation information, such as application and enrollment status, recertification dates, and payment processing status.

The safety net is still needed.

The public healthcare safety net, including and especially Ryan White clinics, is still crucial to maintaining options for care and treatment for PLHIV. While it is obvious from our interviews that much effort has gone into developing new, supportive pathways to comprehensive coverage, these systems are new and can break down. When a consumer loses private insurance coverage through program issues outside of open enrollment, they have no care options outside of the safety net.

Appendix A: Major Findings and Stakeholder Responsibilities

Finding	Stakeholder engagement level		
	Program	Policy	System
Program Management:			
Participants suggested Ramsell manage OA-HIPP but identified a number of areas in need of improvement with Ramsell's current management of ADAP.	X	X	X
Outreach and Engagement:			
Need to clarify how much outreach is expected of payers of last resort.		X	
Not all eligible consumers or relevant providers and institutions are aware of this program.	X	X	X
The work of enrollment workers is not currently well incentivized and is viewed as burdensome.	X	X	X
Documentation and Eligibility:			
The income eligibility threshold is too low; those above it are still in need of assistance.	X	X	
It can be difficult to get needed documentation from insurers and Covered California.	X		X
Technology:			
There is no system, such as an online portal, to allow consumers and enrollment workers to independently review key program participation.	X		
The State cannot issue electronic payment, but paper checks can be hard for insurers to process.	X	X	X
The secure email system used by the State is necessary for privacy, but is cumbersome.	X	X	X
Program Procedures:			
Complex State payment procedures delay issuing payment	X	X	
Combined payments are easier for the State to generate but may be difficult for insurers to apply, and can decrease the State's flexibility to respond to premium changes.	X		X
The program does not clearly employ, monitor, or disseminate quality measures.	X		
Enrollment workers do not have a clear understanding of the system that may reimburse them for their OA-HIPP activities, and they do not generally report having received reimbursement.	X	X	
Because the program does not function optimally, participation can be high-stress for consumers, particularly lower-functioning consumers, and requires close monitoring.	X		
Delayed payment can threaten consumers' financial wellbeing or stable enrollment in insurance.	X	X	X
Communication and Education:			
Communication between OA-HIPP and consumers and enrollment workers is inconsistent and often insufficient; participants wish for communication to be predictable and reliable.	X		
It can be difficult for enrollment workers to contact the analyst they need to speak with, and backup analysts are not always familiar enough with an insurer to be of assistance.	X		
Some consumers are not well-versed in private insurance responsibilities and terminology.	X		X
Guidance:			
Guidance needs to be clear, up-to-date, and presented in a way that better reaches stakeholders.	X		
Many consumers are capable of and interested in self-enrollment and self-management, but need more easily-accessible, consumer-friendly resources to support this.	X		
Personnel:			
Financial benefits counseling has become more demanding and complex. Benefits programs should develop staffing models that better reflect these demands.	X	X	X
Enrollment workers are overburdened and do not always have the capacity to support lower-functioning consumers to the extent that would be desirable.	X	X	X
State workers are overburdened by the rapid growth in program enrollment and the administrative inefficiencies of the program, as it currently functions.	X	X	
Partnership and Systems of Care:			
Safety net programs still play a critical role when consumers lose their insurance.	X	X	X
Relationships between stakeholders facilitate stable insurance enrollment.	X	X	X
More clarity is needed around the roles that enrollment workers, consumers, analysts, and insurers should each play in resolving issues with consumers' accounts.	X	X	X
The program should be more accountable and transparent to stakeholders.	X		
Enrollment worker input should be solicited for policy and procedure development.	X		X
Insurer infrastructure and preferences conflict with State payment procedures.	X	X	X
Insurers do not consistently facilitate reimbursement of consumer out-of-pocket payments, and do not always offer reimbursement in a form that is desirable to consumers	X	X	X
Stakeholders should develop best practices for insurers' work with third-party payers.	X	X	X

ⁱ “Grantees and subgrantees must assure that reasonable efforts are made to secure non-RWHAP funds whenever possible for services to individual clients. Grantees and their subgrantees are expected to vigorously pursue eligibility for other funding sources (e.g., Medicaid, CHIP, Medicare, other state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance, etc.) to extend finite RWHAP grant resources to new clients and/or needed services.” HRSA HIV/AIDS Bureau. HIV/AIDS Bureau Policy Clarification Notice #13-02: Clarifications on Ryan White Program Client Eligibility Determinations and Recertifications Requirements. Available at <http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1302clienteligibility.pdf>. Last verified on October 28, 2014.

ⁱⁱ “OA-HIPP will cover dental and vision premiums for eligible clients and their family members if applicable. However, the vision benefits must be included with the medical or dental benefits. OA will not pay for stand-alone vision policies. If the insurance carrier for dental coverage is different than that of the client’s medical coverage, a separate OA-HIPP application must be submitted along with the corresponding billing statement.” California Department of Public Health: Office of AIDS, Insurance Assistance Section. (February 14, 2014). Management Memorandum 2014-01. Available at <http://www.cdph.ca.gov/programs/aids/Documents/OA-HIPPFamily-Dental-VisionPolicyFINAL2014-02-13.pdf>. Last verified on October 30, 2014.

ⁱⁱⁱ California Department of Public Health. (December 3, 2013.) Office of AIDS Insurance Assistance Section Management Memorandum. Memorandum number 2013-04. Available at http://www.cdph.ca.gov/SiteCollectionDocuments/IAS_MM_CC_PPs2013-12-03a.pdf (last visited October 24, 2014).

^{iv} California Department of Public Health: Office of AIDS, Insurance Assistance Section. (December 3, 2013). Management Memorandum 2013-04. Available at http://www.cdph.ca.gov/SiteCollectionDocuments/IAS_MM_CC_PPs2013-12-03a.pdf. Last verified on October 30, 2014.

^v “Individuals who earn from 138 percent up to 250 percent FPL (which is approximately \$15,856 - \$28,725 for individuals) may be eligible for additional subsidies that will reduce out-of-pocket health care expenses, including copays and deductibles. The cost-sharing subsidy is only available if the client selects a silver plan (known as the “Enhanced Silver” plan.) Enhanced Silver Plans – Clients who earn between 138 - 200 percent FPL (approximately \$15,971 - \$22,980 for individuals) will have the lowest out-of-pocket costs by choosing the “Enhanced Silver” plan.” California Department of Public Health: Office of AIDS, Insurance Assistance Section. (December 3, 2013). Management Memorandum 2013-04. Available at http://www.cdph.ca.gov/SiteCollectionDocuments/IAS_MM_CC_PPs2013-12-03a.pdf. Last verified on October 30, 2014.

^{vi} For more on the Illinois ADAP data system and portal, please consult the following issue brief: National Alliance of State and Territorial AIDS Directors. (June 2013). Case study: Illinois AIDS Drug Assistance Program. Available at http://www.nastad.org/Docs/104634_Illinois%20Case%20Study%20Report%20.pdf. Last verified on December 9, 2014.