

ACA Implementation—Monitoring and Tracking

Public Education, Outreach and Application Assistance

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010 (ACA). The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. This report is one of a series of papers focusing on particular implementation issues in case study states. Reports that have been prepared as part of this ongoing project can be found at www.rwjf.org and www.healthpolicycenter.org. The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access and premiums in the states and nationally. For more information about the Robert Wood Johnson Foundation's work on coverage, visit www.rwjf.org/coverage.

EXECUTIVE SUMMARY

This analysis of public education and application assistance during the 2014 open enrollment period is based primarily on

- results from the Health Reform Monitoring Survey (HRMS), a quarterly national survey of the nonelderly population; and
- interviews in 24 states with diverse informants—policy-makers, consumer advocacy groups, navigators, application assisters, insurance brokers and agents—conducted by researchers from the Urban Institute and other organizations during January through May 2014.

In addition to describing general trends involving public education and application assistance, this analysis describes promising practices used by particular states as well as suggestions offered by stakeholders and researchers. Such practices and suggestions focus primarily on state-based and partnership marketplaces, but many could also apply to federally facilitated marketplaces.

Public education and outreach

Most of the public, including 66 percent of adults in the income range qualifying for subsidized coverage in health insurance marketplaces, reported hearing “some” or “a lot” about such marketplaces, according to HRMS results from June 2014. Given mass media's difficulty delivering complex

messages, the ACA's many complications, and uninsured consumers' unfamiliarity with basic health insurance concepts, many state-level informants supported limiting public education to simple messages that drove consumers to seek more specific information.

However, according to HRMS data, 61 percent of surveyed adults who remained uninsured in June 2014 had heard “little” or “nothing” about subsidies to help pay for marketplace coverage. According to many informants, subsidy recipients in most states were typically unaware of tax reconciliation and thus did not know that they may lose anticipated tax refunds in 2015 or even incur tax liabilities if they turn out to have received excess subsidies because they underestimated their 2014 income. Informants throughout the country reported that educating consumers about the ACA's rules, including available subsidies, was made much more difficult by a longstanding and constant barrage of anti-ACA misinformation.

Certain states found certain messages particularly effective in generating enrollment:

- According to Minnesota informants, the most powerful message for the uninsured was, “If you don't sign up by March 31, you can't get coverage until next January.”

- In both Minnesota and Colorado, advertisements in which real people—not actors—told how they had been helped by the ACA persuaded many to explore their options and then enroll.
- Many states reported that the legal requirement to obtain coverage was motivating for numerous consumers, who wanted to see themselves as law-abiding citizens.
- Kentucky’s motto—“Kentucky Proud”—illustrates a branding strategy that distinguished the state’s marketplace from national reform, lessening the effects of anti-ACA misinformation.

Other promising state strategies involved information dissemination methods. For example,

- Washington let navigators modify state-developed materials to fit local conditions.
- Kentucky and Minnesota used “grass-tops” education strategies focusing on clergy and other community leaders, who were equipped to educate their grassroots constituents.
- Many states used trusted community groups to reach immigrant networks.
- California law requires the provision of information about coverage options to people undergoing life transitions that often cause insurance loss, such as divorce or layoff.
- Maryland’s exchange is calling all subsidy beneficiaries to educate them about changes to benchmark premiums in 2015 and encourage them to consider all coverage options.

Other education and outreach suggestions for marketplaces include the following:

- Prioritize public education about subsidies for marketplace coverage.
- Reduce tax reconciliation risks by
 - directing education at both subsidy beneficiaries and tax preparers, explaining reconciliation risks and describing possible steps to ameliorate them;
 - in the future, giving subsidy beneficiaries the option to have the marketplace automatically adjust subsidy amounts midyear to prevent later reconciliation problems; and
 - increasing the role played by tax preparers in helping consumers (1) apply for subsidies and (2) adjust them during the year if household circumstances change.

Application assistance

Informants in numerous states agreed that one-on-one application assistance was often essential to helping the uninsured enroll. Such assistance could address the ACA’s complexity, many uninsured consumers’ lack of knowledge about the basics of health insurance, and the procedural glitches sometimes experienced on marketplace Web sites.

HRMS data are consistent with the importance of application assistance. In June 2014, among previously uninsured adults, 54 percent of those enrolling through the marketplace used application assistance, compared with 32 percent of those who did not enroll.¹

Despite evidence of the importance of application assistance, many states experienced problems:

- Many states underestimated the average time required to complete applications and so underfunded application assistance, despite federal grants available to cover all marketplace administrative costs through the end of 2014. This was a particularly serious problem with immigrant communities, which present uniquely complex eligibility and enrollment issues.
- In most states, informants reported major problems with the quality of assister training.
- In some states, officials concerned about consumer privacy barred assisters and brokers from accessing consumer records unless consumers were physically present. This limited the help that assisters and brokers could provide, including through proactive problem solving on behalf of clients. This prevented some eligible uninsured from receiving coverage, according to informants.

Several states used effective approaches to structuring application assistance:

- Minnesota secured consumer groups’ buy-in by engaging them in shaping application assistance programs before the start of open enrollment, holding weekly statewide conference calls with application assisters during open enrollment, and selecting from among consumer groups a special liaison to application assisters.
- Several states contracted with undercapitalized community-based groups in underserved communities, using up-front payments that allowed the hiring of dedicated staff.

- Connecticut employed a regional structure through which one community-based group, dubbed a “Navigator,” managed a small number of others, called “assisters.” Navigators regularly convened assisters, used Web tools to coordinate work, identified poor performers, and helped them improve.
- In Minnesota, highly expert community groups were funded to train less knowledgeable groups and then provide technical assistance.
- The District of Columbia brought together tax preparers and application assisters at a single site, letting consumers get tax refunds and enroll in health coverage at the same time.
- D.C. also created smart phone apps for marketplace enrollment.
- Several states created portals letting certified assisters and brokers access client eligibility records directly, without going through marketplace Web sites. This increased their capacity for proactively intervening to solve enrollment problems. If such portals could also be used to streamline initial applications, finite assister resources would help more consumers.

Particular application assistance practices that proved helpful included

- providing “what to bring to your appointment” materials that let consumers enroll in one session;
- training assisters by using specific scenarios to illustrate general principles;
- using nontraditional settings for enrollment, such as libraries, bus stops, bars and laundromats;
- convening three to six consumers at computers at a single site and having assisters circulate among them, providing help as consumers worked on their applications; and
- ensuring that application assisters go out into the community rather than stay in their offices.

Many informants emphasized the importance of continuing or increasing the total level of application assistance consumers receive. Such assistance could help the remaining uninsured enroll, teach the newly insured how to use coverage, and prevent disenrollment by helping subsidy beneficiaries make renewal decisions that avoid unexpected premium increases in 2015.

Brokers and agents

Brokers and agents—collectively termed “producers” by many in the insurance industry—generated significant

marketplace enrollment in some but not all states. Marketplace officials in nearly every state acknowledged producers’ importance by the end of 2014 open enrollment. Most producers nevertheless felt generally unappreciated, according to informants from most states.

Compensation was often a problem. Producers are typically paid by the insurers with which their clients enroll. Helping people with Medicaid enrollment thus generates no income. Also, whether a client enrolls with a carrier inside or outside the marketplace, the producer’s compensation is the same. Much more work is typically required for marketplace enrollment, however, because it may include an application for insurance affordability programs. Producers thus usually make more money enrolling individuals outside rather than inside the marketplace.

Several states have achieved particular success with producers:

- In Kentucky, where more than 40 percent of qualified health plan (QHP) enrollees used producers, one notable promising practice targets employers that do not sponsor health insurance for their workers. Producers worked with such employers to help their employees enroll in individual coverage through the marketplace. This achieved win-win results: employers earned good will from their workers, producers gained significant income, and many uninsured received coverage. To illustrate this approach’s tremendous potential if replicated widely, 46 percent of all QHP-eligible uninsured adults in the U.S. work for companies that do not offer health insurance, as do 23 percent of all uninsured Medicaid-eligible adults.
- Both Kentucky and Connecticut achieved significant producer engagement. Kentucky did this by partnering with producers to design marketplace systems. Connecticut retained a broker to act as liaison. The liaison recruited producers to sell marketplace coverage and acted as a go-between to help the marketplace address producers’ emerging concerns.
- In Connecticut, consumer groups uniformly reported positive experiences with producers. The marketplace encouraged assisters and producers to build strong local partnerships, including referral relationships that took advantage of complementary areas of expertise.

Many informants recommended having Medicaid programs reimburse producers for successfully enrolling clients in Medicaid, a practice long used by many child health programs. However, it is not clear that Medicaid would pay enough to change producer behavior. Some recommended

increasing funding when producers enroll consumers in marketplace plans rather than insurance outside the marketplace, given the higher cost to producers of the former enrollment.

Marketplace call centers

Call centers played a central role as the first contact point for consumers seeking information about marketplace coverage. States greatly underestimated consumer demand for call center services and so allotted insufficient resources. Callers thus experienced long delays early during 2014 open enrollment. Inadequate training also led to many consumers receiving incorrect information. Most states then ramped up funding, greatly cutting delays. Answer quality likewise improved during open enrollment, though it remained inconsistent in some states, according to informants.

A number of states used various practices to strengthen call center operations:

- While most states developed special lines for application assisters and producers, some states structured these lines to guarantee short waits and strong expertise.
- In Minnesota, call center staff developed specialized areas of knowledge. Calls requiring such expertise were routed to the relevant staff.
- Most states kept call centers open on weekends, on holidays and in the evening.
- Colorado's call center (1) made outbound calls to finish incomplete applications and (2) retained brokers on staff to help callers with plan choice.
- To solve information technology (IT) issues in D.C, video conferencing linked call centers to marketplace IT staff.

As a final suggestion, federal officials could provide states with models of effective call center operation, including information about best practices.

INTRODUCTION

This paper focuses on efforts to educate eligible consumers about individual coverage offered through health insurance marketplaces, Medicaid and the Children's Health Insurance Program (CHIP) under the Patient Protection and Affordable Care Act (ACA) and to help them enroll. It relies mainly on two sources of information:

- *Health Reform Monitoring Survey (HRMS) results from 2013 and the first two quarters of 2014.* HRMS is a quarterly national survey of the nonelderly population conducted to analyze the ACA's effects.²
- *State-level interviews* with a broad range of stakeholders, including policy-makers, consumer advocacy groups, navigators, application assisters, insurance brokers and agents, and some health plans and providers. Informants were recruited from 24 states, including 22 that used state-based marketplaces (SBMs) or marketplaces administered jointly by the federal and state governments, as well as two states with federally facilitated marketplaces (FFMs). Using semistructured protocols, such interviews were conducted primarily between January and May 2014 by researchers from the Urban

Institute and, in some cases, Georgetown University's Health Policy Institute or the Institute for Health Policy Solutions. To distinguish the stakeholders interviewed through this process from survey respondents interviewed for the HRMS, such stakeholders are termed "informants" throughout this report.

This paper covers two general topics: (1) public education outreach; and (2) application assistance provided by a broad range of sources, including navigators, in-person assisters, marketplace call centers, and insurance agents and brokers. For each topic, the paper discusses overall trends observed in multiple states, promising practices implemented by particular states, and suggestions from stakeholders or researchers. This report seeks to help state-level policy-makers and stakeholders refine their approaches to the 2015 open enrollment period while laying the groundwork for long-term efforts to increase participation by eligible consumers. The promising practices and suggestions described here arose in the context of state-based and partnership marketplaces, but some may be helpful for FFMs as well.

PUBLIC EDUCATION AND OUTREACH

Overall trends

Almost without exception, informants reported that most of the general public learned that marketplaces were a place to get health coverage and that health coverage was important. Beyond those key facts, initial public education efforts rarely communicated much. That minimalist approach made sense to many informants. In their view, the ACA is complex, mass media cannot effectively deliver fine-grained information, and the target audience includes many people with little knowledge of such basic health insurance concepts as deductibles, premiums and copayments. Accordingly, many informants felt that a reasonable goal of initial mass media campaigns was simply to encourage the uninsured to go to the right place to obtain detailed information about their coverage options.

Our informants' conclusions are consistent with several HRMS findings. Illustrating the underlying lack of knowledge about key health insurance concepts, one study examined adults in June and July of 2013, just three months before the start of open enrollment. Those who were somewhat or very confident in their understanding of five basic health insurance financial terms, such as "premiums," "copayments," and "coinsurance," included just 35.9 percent of uninsured whites, 14.8 percent of uninsured Hispanics, and 25.7 percent of uninsured adults who were neither white nor Hispanic.³

One year later, in June 2014, HRMS data showed that most of the affected public had learned about marketplaces, even while missing other key information about the ACA (figure 1):

- Two-thirds (67 percent) of all nonelderly adults heard "some" or "a lot" about health insurance exchanges. They included 66 percent of adults in the income range for marketplace subsidies (138 to 400 percent of FPL), 57 percent of Hispanics, 66 percent of formerly uninsured adults receiving insurance by June 2014, and 58 percent of formerly uninsured adults who remained without coverage.⁴
- Unfortunately, less than half (48 percent) of all nonelderly adults had heard some or a lot about subsidies available to help pay premiums and out-of-pocket costs in marketplaces. The proportion of uninsured adults learning about subsidies included 48 percent of those with incomes between 138 and 400 percent of FPL, 41 percent of Hispanics, 51 percent of formerly uninsured adults receiving insurance by June 2014, and—most troubling—just 38 percent of formerly uninsured adults who remained uninsured in June 2014.

Even though most of the target audience learned about marketplaces, public education and outreach efforts faced challenges. One of these challenges is illustrated by figure 1: namely, the failure of most remaining uninsured adults to learn about available subsidies that can make marketplace coverage more affordable. Among those uninsured, 61 percent reported hearing "little" or "nothing" about subsidies. In addition, a longstanding and ongoing barrage of anti-ACA misinformation led to confusion that was hard to overcome, according to informants in multiple states. Moreover, consumers were often confused about the difference between federal and state Web sites. In many states, SBM messages were not tailored to meet the needs of low-income consumers and those who qualified for Medicaid. This was problematic, since the marketplace was typically the main portal through which consumers could enroll into expanded Medicaid. Some SBMs undermined their own credibility through ad campaigns of unrelenting cheerfulness that contrasted with newspaper headlines decrying dysfunctional rollouts.

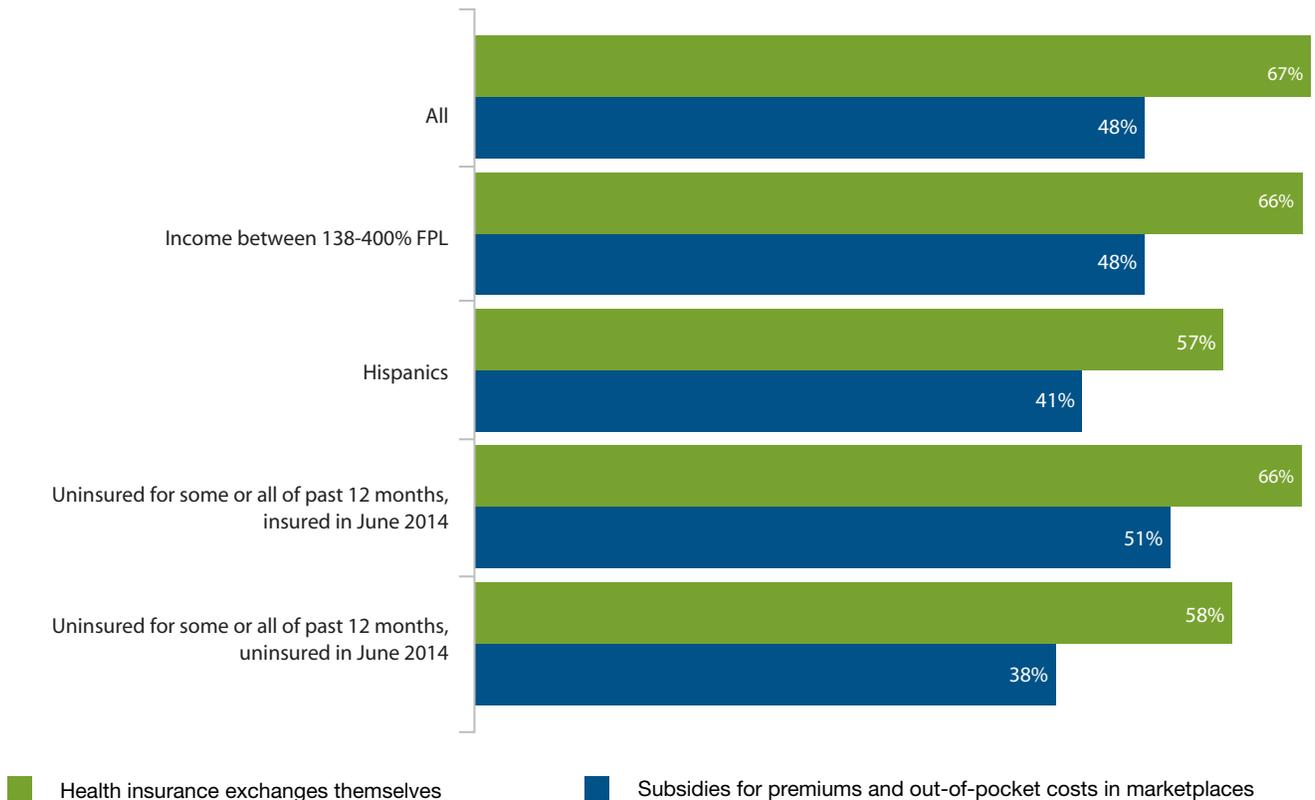
One particular issue on which most consumers received little information was tax reconciliation for beneficiaries of advance payment of premium tax credits (APTCs). In most states, informants reported that, unless APTC beneficiaries were helped by brokers or unusually sophisticated application assisters, they rarely learned that when they file their 2014 federal income tax returns, they may lose anticipated tax refunds or even incur tax liabilities if they turn out to have received excess APTCs because they underestimated their future 2014 income.

Promising practices

In several states, particular messages galvanized sign-ups, often late during open enrollment:

- Minnesota informants reported that, during February and March, the most powerfully motivating message for most uninsured was, "If you don't sign up by March 31, you can't get coverage until next January."
- In both Minnesota and Colorado, advertisements in which real people—not actors—told how they had been helped by the ACA persuaded many to explore their options and then enroll.
- Many states reported that the legal requirement to obtain coverage was motivating for numerous consumers, who wanted to see themselves as law-abiding citizens.
- Kentucky's motto—"Kentucky Proud"—illustrates a branding strategy that distinguished the state's

Figure 1. Percentage of adults under age 65 who had heard some or a lot about certain topics related to health insurance exchanges (June 2014)



Source: HRMS June 2014.

marketplace from national reform, lessening the effects of anti-ACA misinformation. In August 2014, Kentucky residents disapproved of the Affordable Care Act by a ratio of 51 percent to 34 percent, while approving of the state marketplace, KyNect, by a 34 percent to 27 percent margin.⁵

Other promising state strategies involved information dissemination methods, rather than messages:

- *Washington State allowed regional tailoring to fit local conditions, which informants found quite effective. A bus tour with highly publicized local events was well received. Notably, the state gave local navigators materials that they could modify to fit local circumstances and perspectives, which varied considerably in different parts of the state.*
- *Kentucky and Minnesota used “grass-tops” education strategies. These efforts focused on clergy and*

other community leaders, who in turn educated their grassroots constituents.

- *Many states used trusted community groups to reach immigrant and Native American communities, which can be hard to reach effectively through other methods.*
- *California law requires situational targeting during life transitions. For example, people going through divorce, job loss or other life changes that often cause coverage losses must be given information about available health insurance options.*
- *Maryland is proactively communicating with subsidy beneficiaries to educate them about changes to benchmark premiums and to encourage them to consider coverage options when the new open enrollment period begins. In that state, as in many others, many consumers who enrolled in the two cheapest silver plans in 2014 will find them to be the third and fourth least expensive silver plans in 2015. If they had not received information from the state and had simply stayed with their 2014 plans, many such consumers*

may have been surprised by increased premium charges in January 2015. Some could have dropped coverage, particularly if they did not have serious health problems. This would have increased the number of uninsured and worsened risk pools.⁶

Suggestions

Some informants suggested innovative methods of communicating with QHP enrollees about renewals, including text messages from marketplaces and authorizing brokers and QHPs, which have a financial stake in continued enrollment, to contact enrollees and encourage renewal. Other informants noted the importance of communicating simply, without jargon, and educating consumers about the value of health insurance and basic health insurance concepts. Further approaches are possible on two core issues: educating uninsured consumers about subsidies and addressing tax reconciliation risks for APTC recipients.

Given the widespread lack of knowledge about subsidies among the remaining uninsured, public education efforts should provide information about subsidies—for example, as part of “real people” stories like those used in Minnesota and Colorado, described above.

To address tax reconciliation issues, several strategies are possible:

- Marketplaces can educate APTC beneficiaries about tax reconciliation and the importance of reporting changed circumstances.
- Other public education efforts can focus on tax preparers. Many tax preparers are worried about

the burden of ACA-related tax filings this coming tax season, including time required for tax reconciliation. Making correct initial APTC claims and then adjusting such claims during the calendar year to fit changing circumstances reduces the need for year-end reconciliation. If an APTC beneficiary stays with the same preparer from one year to the next, measures to prevent reconciliation problems can save the tax preparer time and money during tax season.

- APTC beneficiaries and tax preparers can be encouraged to work together, both at the end of 2014 and the start of 2015,⁷ to consider tax planning strategies that could lessen or prevent potential tax reconciliation problems.
- Going forward, marketplaces could give APTC beneficiaries the option to reduce reconciliation risks. For example, beneficiaries could be given the choice to authorize the marketplace to quickly lower the consumer’s APTC whenever data matches or consumer information suggest that such reductions are needed to prevent adverse reconciliation effects. The marketplace would provide notice of such reductions, which the consumer could revoke. But unless they are revoked, the reductions would go into effect, avoiding delays that could otherwise worsen reconciliation problems.⁸
- More generally, increasing tax preparers’ role in claiming and adjusting APTCs would likely have a positive impact on reconciliation. Such preparers can help overcome consumer fears about tax reconciliation, thus encouraging eligible, uninsured consumers to use APTCs to purchase coverage. Moreover, tax preparer involvement could increase the accuracy of APTC claims, lessening the total level of adverse reconciliation outcomes.

APPLICATION ASSISTANCE

Application assisters—including navigators and in-person assisters (IPAs), brokers and agents, and marketplace call centers—played a crucial role in helping consumers successfully enroll, as explored below.

Navigators, IPAs and general application assistance

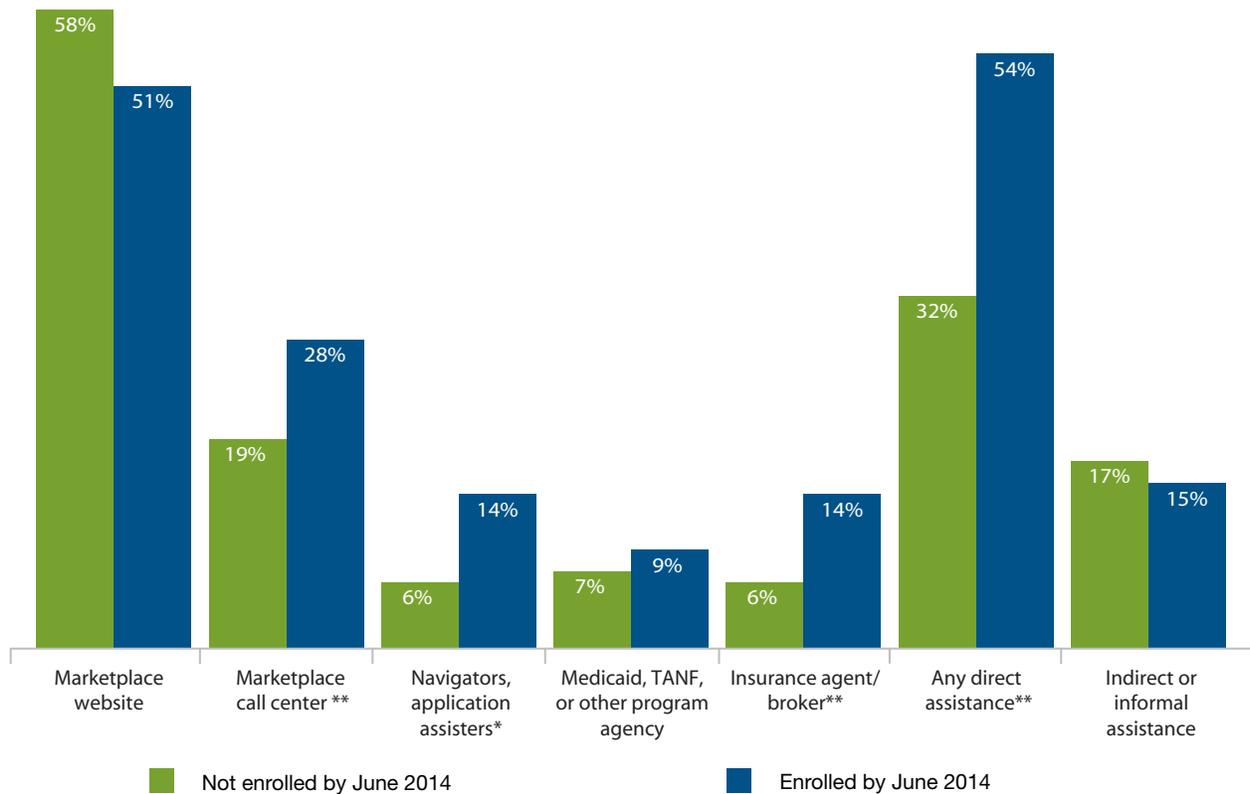
Overall trends

One-on-one application assistance made an important difference helping consumers enroll. Such assistance helped overcome the ACA’s complexity and many consumers’ lack of knowledge about the basics of health insurance as well as the procedural glitches often created by marketplace Web sites. Many consumers with health problems had the grim

determination to persist and enroll, even without help. But for the healthy uninsured, application assistance was often essential to participation, according to many informants. Assistance thus played a role increasing coverage while lowering average risk levels within individual markets.

HRMS data are consistent with our informants’ reports about the importance of individual assistance. In June 2014, among adults who had been uninsured for some or all of the previous 12 months, those who enrolled into coverage offered through a marketplace were much more likely to receive some form of individual assistance than those who did not enroll. The following differences were statistically significant (figure 2):

Figure 2. Sources of information and assistance used by previously uninsured adults who visited a marketplace, by enrollment through the marketplace (June 2014)



Source: HRMS June 2014. Notes: Consumers included in this figure were uninsured during some or all of the 12 months before the survey and attempted to enroll in coverage through the marketplace. In distinguishing between the percentage of those who enrolled and those who did not enroll in coverage available through the marketplace, **/** indicates statistically significant differences at the .05 and .01 levels, respectively, using two-tailed tests. Other differences shown in this figure were not statistically significant. Results are limited to adults under age 65. The category listed here as “navigators, application assisters” also includes certified application counselors and community health workers. “Any direct assistance” includes call centers; navigators and assisters; Medicaid, TANF, or other program agencies; and agents and brokers.

- Among adults who enrolled through a marketplace, 28 percent used a call center. Only 19 percent of those who did not enroll used a call center.
- Use of community-based application assisters and private insurance agents and brokers also had a strong association with successful enrollment through the marketplace. Among previously uninsured adults who enrolled into marketplace coverage, 14 percent received help from assisters and 14 percent were helped by brokers. For previously uninsured adults who did not enroll, just 6 percent were aided by assisters and 6 percent by brokers.
- Altogether, 54 percent of the formerly uninsured who enrolled through a marketplace used some form of direct assistance. Among those who did not enroll, only 32 percent obtained such assistance.

In contrast, adults who did not enroll in marketplace coverage were more likely to obtain information from Web sites or to receive indirect or informal assistance than were those who became insured, although those differences were not statistically significant.⁹

Certain groups were particularly helped by in-person assistance. Our informants found this to be the case for many Latinos, for people with complex health conditions or eligibility situations, people uncomfortable with computers, and people without easy internet access.

Many states did not fully meet consumers’ need for assistance, resulting in waiting lists for help, particularly during high-demand periods. Most states underestimated the time applications would require and thus provided insufficient resources for application assisters, despite the availability of federal grants to cover administrative costs

through the end of 2014 in SBMs and many partnership exchanges.¹⁰ Some states did not pay assisters in advance, instead reserving payment until after successful enrollment; this prevented many undercapitalized community groups from serving their uninsured constituents. Informants in some states reported that the assistance network had particularly large gaps in rural areas.

Immigrant communities faced unique issues requiring high per capita application assistance resources that few states provided. With many immigrants, assisters must address anxieties about whether health coverage applications will be used against them or family members in immigration enforcement. Many immigrants could not have their identity verified via the Federal Data Services Hub, forcing assisters to use more time-consuming methods. Documenting immigration status can require much more effort than verifying citizenship. Moreover, assisters must often take the time needed to explain the ACA's complex rules involving immigration.¹¹

Several problems affected *both* for-profit brokers and nonprofit application assisters:

- Informants in nearly every state described training for both groups as substantially deficient.
- In some states, concerns about consumer privacy led officials to bar assisters and brokers from accessing consumer records unless consumers were physically present. Consumers having trouble enrolling online could not get help by calling their assisters. And when enrollment obstacles arose after applications were filed, consumers often did not understand what was happening. Assisters and brokers frequently did not learn about such obstacles, could not diagnose them, and could not proactively intervene to solve them. As a result, some eligible consumers needlessly remained uninsured, according to informants.

Promising practices

Several states used effective structural approaches to provide assistance, including the following examples:

- Minnesota pursued a multifaceted strategy of engaging consumer groups that resulted in application assisters being deeply committed to enrollment efforts. That commitment helped Minnesota cut uninsurance by 40.6 percent during the 2014 open enrollment period, despite a deeply flawed rollout.¹²
 - The strategy began with engaging consumer groups to shape application assistance programs long before open enrollment began.
- During open enrollment, weekly conference calls between assisters and the exchange let assisters flag emerging problems as officials noted new developments and announced future changes.
- The marketplace appointed a special liaison to application assisters, selected from that community, who spotted issues and brokered solutions.
- In many states, contracting with established and trusted community-based groups, including up-front payments that allowed the hiring of dedicated staff, proved effective in furnishing immigrants and other underserved populations with education and application assistance.
- Connecticut employed a regional structure, through which one navigator managed a small number of assisters. Multiple community organizations within a relatively homogenous region employed both navigators and assisters. Navigators convened assisters regularly, used Web tools to coordinate work, identified poor performers, and helped them improve.¹³
- In Minnesota, highly expert community groups, some with legal services backgrounds, were funded to train less expert assisters. Afterwards, when consumers came to the latter groups with hard questions, the trainers were available to provide backup technical assistance.

Particular application practices also proved helpful:

- In several states, assisters or marketplaces developed “what to bring to your appointment” materials that let enrollment occur in one session rather than two.
- Informants in several states reported that scenario-based training of assisters was effective. Such training went beyond stating abstract rules and principles to include specific fact patterns that illustrated the application of those principles.
- Successful nontraditional settings for outreach and enrollment included libraries in Minnesota and bus stops, bars and laundromats in the District of Columbia (D.C.).
- D.C.’s other innovative strategies included a smart phone app for enrollment and combining tax preparers and application assisters at a single site, so consumers could get tax refunds and enroll in health coverage at the same time.
- A number of assisters found it useful to convene three to six consumers at a single site’s computers, circulating among them to troubleshoot as consumers completed applications.
- Many successful assisters reported that achieving high enrollment numbers requires going out into the community, investing significant time in advance to

ensure successful events. In their view, assisters who wait in their offices for clients to call will enroll many fewer people.

Suggestions

Most informants strongly emphasized the importance, during the 2015 open enrollment period and beyond, of continuing or increasing the overall level of application assistance that consumers receive. Assisters are needed both to enroll the remaining uninsured and to help new QHP members learn how to use their coverage effectively. Application assistance could also help address an emerging challenge involving renewal. In counties where the QHP benchmark plan changes or the benchmark premium rises, subsidized consumers who keep the same plan or do not change their APTC amount may find themselves surprised to pay more for coverage starting in January 2015. Some could become uninsured as a result. During the 2015 open enrollment period, application assisters could help APTC beneficiaries change QHPs or APTC amounts to prevent unexpected and potentially unaffordable increases in family premium payments.

In states that limited assisters' and brokers' ability to access client records, informants recommended modifying those limits. Given consent, assisters and brokers could access client records, co-log in to help clients on the phone, receive notice that lets them help solve problems (like nonpayment of premiums or missing verification), track the status of their clients' applications, and diagnose and overcome enrollment obstacles proactively.

Several states even created special portals through which certified assisters and licensed brokers could directly access their clients' eligibility records after applications began.¹⁴ This let assisters and brokers obtain information about their clients without going through consumer-facing marketplace Web sites, which can be glitchy and contain consumer-friendly features that often slow access by experts. Such special portals for certified assisters and licensed brokers could potentially be used to help them submit new applications as well, letting application resources reach more consumers by streamlining the enrollment process when assisters are involved.

Brokers and agents

Overall trends

Insurance brokers and agents (often called "producers" within the insurance industry)¹⁵ played different roles in different states. In states like California, Connecticut and Kentucky they enrolled many consumers in QHPs. In other

states, their contribution to QHP enrollment was modest. In most states, marketplace staff came to acknowledge the value of producers by the end of open enrollment, even where that understanding was not evident at the start. Despite that acknowledgment, broker informants almost universally reported that they did not feel particularly valued by marketplaces, including through communications to the public.

Compensation was typically a problem:

- Private insurers pay producers by commission, as a percentage of premiums. However, if a broker spends time enrolling a client in Medicaid, the broker goes unpaid.
- Whether a client enrolls with a carrier inside or outside the marketplace, the producer's gross compensation is the same. Much more work can be required for marketplace enrollment, however, because it typically includes an application for insurance affordability programs. As a result, brokers can make more money on a consumer who enrolls in a private plan outside the marketplace.
- Brokers in numerous states reported that marketplace glitches made it hard to attribute particular clients to particular brokers, thus preventing payment.

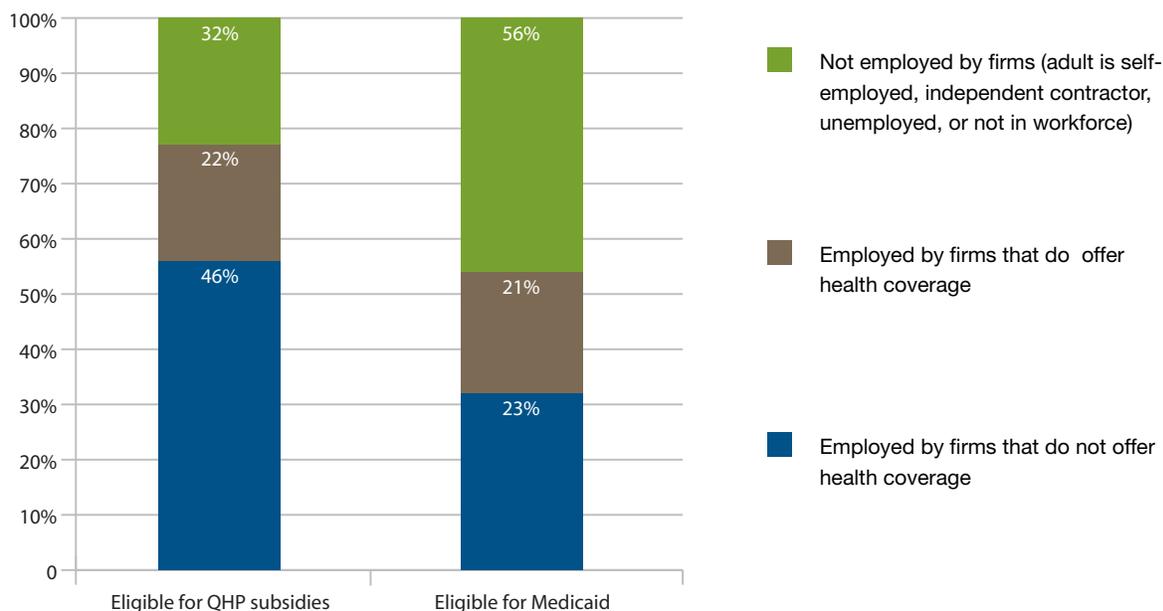
Promising practices

Kentucky, where more than 40 percent of QHP enrollees used brokers and agents, took several important steps to facilitate their effective involvement:

- Some brokers worked with firms not offering employer-sponsored insurance (ESI) and helped their workers enroll in individual coverage, including through the marketplace. According to broker informants, this arrangement led to win-win results: employers were pleased at the impact on worker morale, brokers earned significant income, and many uninsured not offered ESI received coverage. If replicated more broadly, this practice offers great potential for reaching many uninsured who qualify for insurance affordability programs. Among all uninsured adults who qualify for QHP subsidies nationally, 46 percent work for firms that do not offer ESI; such firms also employ 23 percent of Medicaid-eligible uninsured adults (figure 3).
- Kentucky officials partnered with brokers in designing marketplace mechanisms. This promoted buy-in and resulted in systems that brokers found effective.

Connecticut likewise achieved significant success with brokers:

Figure 3. Uninsured adults who qualify for insurance affordability programs, by employers that do and do not offer health coverage



Source: Urban Institute Health Insurance Policy Simulation Model 2014. Note: Figure displays, among adults uninsured before ACA implementation, the percentage who would qualify for insurance affordability programs in effect during 2014, taking into account state decisions on Medicaid implementation either implemented or federally approved by September 2014.

- The marketplace hired a liaison to the broker community, who was himself a broker. The liaison in turn recruited other brokers, who played a major role in QHP enrollment.
- Consumer groups in Connecticut uniformly reported positive experiences with brokers, despite their considerable initial skepticism. With marketplace encouragement, application assisters and brokers developed strong local partnerships, building referral relationships that took advantage of complementary areas of expertise.

Suggestions

Many informants recommended having Medicaid programs reimburse brokers for successfully enrolling their clients in Medicaid programs—a practice commonly used by child health programs for more than a decade. However, some

experts suggested that the amounts Medicaid programs provided in the past (such as one-time payments of \$50 to \$75 per enrollee) would not be enough to motivate most brokers. Some suggested that brokers and agents should receive higher payments for enrolling clients in QHPs than insurance outside the marketplace, given the additional work required to complete marketplace applications.

Marketplace call centers

Overall trends

Call centers played a central role as the initial contact point for consumers seeking information about marketplace coverage and enrollment, including those having difficulty submitting their own applications. In almost every state, consumers encountered serious problems with call centers early during the 2014 open enrollment period. Most states

greatly underestimated consumer demand for call center services and so allotted insufficient resources. As a result, callers experienced long delays. Inadequate training also led to consumers often receiving inconsistent or incorrect information, according to informants from almost every state.

In nearly all states, informants reported significant improvement after the initial months of open enrollment, as added resources greatly cut wait times. In some states, however, consumers still encountered significant delays during periods of peak demand. Answer quality likewise improved, though it remained inconsistent in a number of states, according to informants.

In some states, callers who did not speak English had difficulty finding staff who knew the right answers to their questions and were linguistically and culturally competent.

In many states, initial respondents had limited authority to take action. As a result, they promised to call back, but often failed to do so.

In some states, having multiple call centers rather than a single place to call obstructed enrollment. One center might handle Medicaid, while another helped with marketplace questions. Some states had separate federal and state call centers. Either way, consumers calling the wrong center were told to call the other number. Rather than being seamlessly transferred, such consumers would need to make a second call, perhaps experiencing two waits before speaking to someone at the right call center.

Promising practices

Most states developed special lines available to application assisters and brokers, which leveraged marketplace resources efficiently. In states that structured these lines to guarantee short waits and strong expertise, many consumers received help as call centers efficiently provided necessary information to their assisters and brokers.

Other effective strategies included the following:

- In Minnesota, call center staff developed specialized areas of expertise. Calls requiring such expertise were routed to the relevant staff.
- Most states kept call centers open on weekends, on holidays and in the evening, particularly during periods of peak demand.

- Colorado's call center made outbound calls that finished the enrollment process for consumers whose applications remained incomplete.
- Colorado also kept brokers on staff at the call center to answer questions about plan choice.
- D.C. used video conferencing to link call centers to marketplace information technology staff, so call centers could address the consumer's technological issues during calls.

Suggestions

Informants suggested that states with multiple call centers could provide for "warm hand-offs." Consumers who called the wrong center would not be required to redial. Instead, they would be transferred to the other center, after the first call center provided the second with a brief summary of the call, thus expediting subsequent call handling.

A second suggestion is far broader—that is, federal officials could provide states with call center information, including best practices and model approaches. Using existing literature as a starting point,¹⁶ such information could include elements like the following:

- *Model request-for-proposal documents for vendor contracting.* These documents would be accompanied by analyses of strategies for dealing with state competitive procurement laws so that high-performing vendors can retain contracts in preference to new bidders who offer lower prices based on an inadequate understanding of performance needs.
- *Rubrics for analyzing trade-offs* associated with (1) operating call centers in-house, rather than through outsourcing and (2) having multiple states share call-center operations.
- *Guidance on staffing structures*, including policies for routing complex problems to the most knowledgeable staff and ensuring linguistic/cultural competence.
- *Protocols* for training, performance measurement, performance reporting, quality assurance, contact management and ticket tracking, and knowledge management.
- *Recommendations about careful design of metrics to avoid untoward incentives.* For example, some informants reported that call centers were rewarded for hanging up on callers, because that could count as resolving a call promptly.

- *Plans for addressing variable demand*, avoiding the need to recruit and retrain inexperienced staff before each peak periods. Options include
 - retaining core staff during slow periods, during which they provide consumer assistance (e.g., helping consumers use coverage appropriately, helping with renewals, helping consumers enroll during special enrollment periods) and
 - developing an ongoing cadre of largely seasonal skilled workers, perhaps using the tax preparation industry as a model.

CONCLUSION

During the ACA's first open enrollment period, many states achieved notable progress educating uninsured consumers and providing them with help enrolling in coverage. These factors contributed to a nationwide reduction in the number of uninsured. However, important work remains unfinished. Further public education and intensive application

assistance will be required for the number of uninsured to continue declining during the 2015 open enrollment period and beyond. In structuring such efforts, states and the federal marketplace can learn from and build on the efforts that have taken place thus far.

ENDNOTES

1. These consumers reported having been uninsured during some or all of the 12 months before the survey. Direct application assistance included assistance provided by call centers; navigators, application assisters, certified application counselors or community health workers; Medicaid or other program agencies such as Temporary Assistance for Needy Families or the Supplemental Nutrition Assistance Program; and insurance agents, brokers and insurance companies.
2. Funding for the core HRMS is provided by the Robert Wood Johnson Foundation, the Ford Foundation and the Urban Institute. For further information, see <http://hrms.urban.org/>.
3. Long SK and Goin D. *Large Racial and Ethnic Differences in Health Insurance Literacy Signal Need for Targeted Education and Outreach*. Washington, D.C.: Urban Institute, 2014, <http://hrms.urban.org/briefs/literacy-by-race.html>. Estimates presented here are regression-adjusted. The covariates included in the regression analysis are age, self-reported health status, gender, marital status, education, family income, homeownership and urban or rural status.
4. By “formerly uninsured adults,” the text refers to adults who reported lacking insurance for some or all of the previous 12 months.
5. Public Policy Polling. *McConnell Leading in Re-Election Bid*, August 12, 2014, <http://www.publicpolicypolling.com/main/2014/08/mcconnell-leading-in-re-election-bid.html>.
6. The state’s communication effort was prompted both by the desire to help consumers make informed decisions about 2015 coverage and by the marketplace’s need to obtain information about subsidy eligibility directly from consumers. The latter resulted from serious problems with the state’s information technology (IT) contractors. The marketplace IT system used in 2014 could not communicate with the system planned for use in 2015.
7. Most tax planning strategies to reduce adjusted gross income (AGI), thereby lessening potential tax reconciliation liabilities, require action during the year in which APTCs are received. However, contributions to Individual Retirement Accounts (IRAs) that are made during the following year but before the April 15 due date for federal income tax returns can be taken as deductions to AGI. This applies even in the case of an IRA that is first established at the time such contributions are made. Internal Revenue Service. *Publication 590 (2013), Individual Retirement Arrangements (IRAs)*, <http://www.irs.gov/publications/p590/index.html>.
8. See, for example, 45 CFR §§155.330(c)(1), (e)(2)(i)(B), (e)(2)(ii)(A) and (C), (f)(1)(i), (f)(2) and (3); see also 45 CFR § 155.315 (f)(2)(ii), cross-referenced in §155.330.
9. Previous analysis of HRMS data from June 2014 found, among those who were uninsured during some or all of the previous 12 months, a similar relationship between receipt of direct enrollment assistance and having coverage of any sort as of June 2014. See table 1 in Zuckerman S, Karpman M, Blavin F and Shartz A. *Navigating the Marketplace: How Uninsured Adults Have Been Looking for Coverage*, Washington, D.C.: Urban Institute, 2014, <http://hrms.urban.org/briefs/navigating-the-marketplace.html>.
10. Such grants were available to partnership marketplaces where states assumed enrollment responsibilities.
11. For example, young people whose deportation had been suspended are forbidden from enrolling in marketplaces and are not penalized if they are uninsured; immigrants with pending, unresolved asylum applications can enroll in marketplaces and be penalized if they are uninsured; and undocumented parents of U.S. citizen children are not penalized if they are uninsured themselves, but are penalized if their children are uninsured.
12. Sonier J, Lukanen E and Blewett L. *Early Impacts of the Affordable Care Act on Health Insurance Coverage in Minnesota*. Minneapolis: State Health Access Data Assistance Center, 2014, <http://shadac.org/MinnesotaCoverageReport>.
13. This structure did not work well when navigators were asked to manage large numbers of assisters that served heterogeneous communities.
14. Pollitz K, Tolbert J and Ma R. *Survey of Health Insurance Marketplace Assister Programs: A First Look at Consumer Assistance under the Affordable Care Act*, Washington, D.C.: Kaiser Family Foundation, 2014.
15. Technically, an agent sells for a particular insurance company at which he or she is appointed. A broker sells for multiple insurers at which he or she is appointed. The term “producer” covers both groups.
16. Many useful documents come from efforts to inform the effective and efficient operation of telephone hotlines to help smokers stop using tobacco (so-called quitlines). See, for example, Reynolds P. “Call Center Metrics: Best Practices in Performance Measurement and Management to Maximize Quitline Efficiency and Quality,” *NAQC Issue Paper*, Phoenix: North American Quitline Consortium, 2010, http://c.ymcdn.com/sites/www.naquitline.org/resource/resmgr/issue_papers/callcentermetricspaperbestpr.pdf and Reynolds P. “Call Center Metrics: Fundamentals of Call Center Staffing and Technologies,” *NAQC Issue Paper*, Phoenix: North American Quitline Consortium, 2010, http://c.ymcdn.com/sites/www.naquitline.org/resource/resmgr/issue_papers/callcentermetricspaperstaffi.pdf. See also Holman D, Batt R and Holtgrewe U. *The Global Call Center Report: International Perspectives on Management and Employment*. Ithaca, NY: Cornell University, Global Call Center Research Network, 2007, <http://www.ilr.cornell.edu/globalcallcenter/upload/gcc-intl-rept-us-version.pdf>.

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