Factors That Contributed to High Marketplace Enrollment Rates in Five States in 2015

October 2015

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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. Reports that have been prepared as part of this ongoing project can be found at [www.rwjf.org](http://www.rwjf.org) and [www.healthpolicycenter.org](http://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.

### INTRODUCTION

Since the launch of the new health insurance marketplaces in 2014, an estimated 9.9 million people have obtained coverage in qualified health plans (QHPs) throughout the country. Although the basic rules governing the marketplaces are the same, states have had very different enrollment outcomes: some states experience very high enrollment rates and others relatively low. Those varied enrollment results do not seem to follow any obvious patterns on the basis of population size, political support for the Affordable Care Act (ACA), or Medicaid expansion status. High and low enrollment rates also cut across geographic regions and the type of marketplace in the state (e.g., whether it is a federally facilitated marketplace [FFM], state-based marketplace [SBM], state partnership marketplace, or plan management marketplace).

In light of those varied enrollment outcomes, the Urban Institute identified five states that, according to its projections (explained later), had high enrollment rates in 2015 and five states that had relatively low enrollment rates in 2015. Researchers conducted in-depth interviews with diverse stakeholders—including state officials, health plans, health care provider organizations, brokers, consumer advocates, and marketplace assisters—to ascertain what factors may have contributed to the different enrollment outcomes. The Urban Institute is releasing two papers analyzing the enrollment outcomes in the 10 states’ marketplaces based on stakeholder interviews and a review of materials documenting enrollment efforts in those states. This paper addresses the experiences of five states that had high marketplace enrollment by the end of the second open enrollment period (OE2): Connecticut, Florida, New Hampshire, Pennsylvania, and Virginia.²

### The Urban Institute’s Projections and Estimates of Marketplace Enrollment Rates

The Urban Institute uses a detailed microsimulation model to estimate the effects of the ACA on health insurance coverage.³ The model enables researchers to estimate anticipated enrollment in QHPs in every state when the law is fully implemented. Because new health coverage programs generally take several years to reach their full enrollment levels, in its enrollment projections Urban assumes the following “ramp-up” in enrollment from 2014 to 2016: one-third of full enrollment in 2014, two-thirds of full enrollment in 2015, and full enrollment in 2016.

In 2015, the U.S. Department of Health and Human Services (HHS) released data about the number of consumers who had “effectuated enrollment,” meaning that they had paid at least the first month’s premium and had an active policy. As of June 30, 2015, a total of 9,949,000 consumers had effectuated enrollment and were enrolled in a marketplace plan, which is a 15 percent drop from the 10,858,000 consumers who had selected a plan at the end of open enrollment.⁴ Table 1 shows effectuated enrollment in all states and calculates effectuated enrollment as a percentage of Urban Institute’s 2015 enrollment projections.

Table 1 shows that several states—including Connecticut, Florida, Georgia, Maine, New Hampshire, North Carolina, Pennsylvania, Virginia, and Wisconsin—had enrollment rates well above the national average. In this paper, we focus on Connecticut, Florida, New Hampshire, Pennsylvania, and Virginia. Four of those states—Florida, New Hampshire,
### Table 1. 2015 Effectuated Marketplace Enrollment as a Percentage of Urban Institute Projections

<table>
<thead>
<tr>
<th></th>
<th>2015 Effectuated Enrollment&lt;sup&gt;b&lt;/sup&gt;</th>
<th>2015 Effectuated Enrollment as Percentage of 2015 Urban Institute Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total With APTC Without APTC</td>
<td>Total With APTC Without APTC</td>
</tr>
<tr>
<td><strong>All States&lt;sup&gt;a&lt;/sup&gt;</strong></td>
<td>9,949,000 8,330,000 1,587,000</td>
<td>91.6% 118.2% 41.6%</td>
</tr>
<tr>
<td><strong>States Using Healthcare.gov in 2015</strong></td>
<td>7,216,000 6,183,000 1,032,000</td>
<td>94.6% 121.6% 40.5%</td>
</tr>
<tr>
<td>States Not Expanding Medicaid by Sept 2015</td>
<td>5,094,000 4,480,000 614,000</td>
<td>103.2% 134.4% 38.3%</td>
</tr>
<tr>
<td>States Expanding Medicaid by Sept 2015</td>
<td>2,122,000 1,703,000 418,000</td>
<td>78.7% 97.3% 44.3%</td>
</tr>
<tr>
<td>Alabama</td>
<td>141,000 128,000 13,000</td>
<td>90.9% 122.5% 25.5%</td>
</tr>
<tr>
<td>Alaska</td>
<td>19,000 17,000 2,000</td>
<td>64.3% 74.6% 30.8%</td>
</tr>
<tr>
<td>Arizona</td>
<td>154,000 118,000 37,000</td>
<td>64.9% 74.9% 45.3%</td>
</tr>
<tr>
<td>Arkansas</td>
<td>51,000 46,000 5,000</td>
<td>54.3% 71.7% 17.0%</td>
</tr>
<tr>
<td>Delaware</td>
<td>23,000 19,000 4,000</td>
<td>106.7% 132.7% 53.3%</td>
</tr>
<tr>
<td>Florida</td>
<td>1,315,000 1,201,000 114,000</td>
<td>143.3% 191.1% 39.4%</td>
</tr>
<tr>
<td>Georgia</td>
<td>418,000 376,000 42,000</td>
<td>106.0% 139.8% 33.4%</td>
</tr>
<tr>
<td>Illinois</td>
<td>297,000 231,000 66,000</td>
<td>82.9% 107.7% 46.0%</td>
</tr>
<tr>
<td>Indiana</td>
<td>167,000 146,000 21,000</td>
<td>72.8% 92.5% 29.4%</td>
</tr>
<tr>
<td>Iowa</td>
<td>39,000 34,000 6,000</td>
<td>42.7% 63.2% 14.7%</td>
</tr>
<tr>
<td>Kansas</td>
<td>85,000 68,000 17,000</td>
<td>83.0% 104.1% 46.1%</td>
</tr>
<tr>
<td>Louisiana</td>
<td>142,000 129,000 13,000</td>
<td>74.0% 101.2% 20.5%</td>
</tr>
<tr>
<td>Maine</td>
<td>67,000 59,000 8,000</td>
<td>128.8% 164.8% 47.8%</td>
</tr>
<tr>
<td>Michigan</td>
<td>289,000 224,000 64,000</td>
<td>99.9% 118.6% 64.5%</td>
</tr>
<tr>
<td>Mississippi</td>
<td>73,000 70,000 3,000</td>
<td>72.5% 96.8% 11.7%</td>
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<tr>
<td>Missouri</td>
<td>212,000 188,000 24,000</td>
<td>99.5% 129.4% 35.3%</td>
</tr>
<tr>
<td>Montana</td>
<td>49,000 40,000 8,000</td>
<td>82.5% 100.4% 44.5%</td>
</tr>
<tr>
<td>Nebraska</td>
<td>64,000 56,000 8,000</td>
<td>80.0% 118.4% 23.5%</td>
</tr>
<tr>
<td>Nevada</td>
<td>61,000 50,000 11,000</td>
<td>64.5% 77.1% 37.3%</td>
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<tr>
<td>New Hampshire</td>
<td>45,000 28,000 17,000</td>
<td>107.1% 105.6% 109.5%</td>
</tr>
<tr>
<td>New Jersey</td>
<td>194,000 161,000 33,000</td>
<td>76.8% 102.1% 34.7%</td>
</tr>
<tr>
<td>New Mexico</td>
<td>44,000 32,000 12,000</td>
<td>63.8% 67.9% 54.8%</td>
</tr>
<tr>
<td>North Carolina</td>
<td>460,000 421,000 38,000</td>
<td>120.1% 165.6% 29.9%</td>
</tr>
<tr>
<td>North Dakota</td>
<td>17,000 14,000 2,000</td>
<td>51.6% 79.0% 16.9%</td>
</tr>
<tr>
<td>Ohio</td>
<td>188,000 158,000 30,000</td>
<td>61.7% 76.1% 31.1%</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>109,000 87,000 22,000</td>
<td>75.1% 84.2% 52.4%</td>
</tr>
<tr>
<td>Oregon</td>
<td>103,000 77,000 26,000</td>
<td>71.0% 80.7% 52.2%</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>398,000 320,000 78,000</td>
<td>111.7% 141.8% 59.6%</td>
</tr>
<tr>
<td>South Carolina</td>
<td>165,000 147,000 19,000</td>
<td>93.3% 118.5% 35.0%</td>
</tr>
<tr>
<td>South Dakota</td>
<td>19,000 17,000 2,000</td>
<td>48.7% 69.2% 15.8%</td>
</tr>
<tr>
<td>Tennessee</td>
<td>177,000 150,000 28,000</td>
<td>75.5% 99.4% 32.8%</td>
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</table>
Pennsylvania, and Virginia—used HealthCare.gov in 2015; only Connecticut used its own web site and information technology (IT) platform for enrollment. As shown in Table 1, in all four states that used HealthCare.gov in 2015, effectuated enrollment exceeded 2015 enrollment projections. In Connecticut (the only SBM in this study), effectuated enrollment did not exceed 2015 projections, but Connecticut exceeded the national enrollment rate and significantly surpassed the enrollment rate for states that used their own IT platforms in 2015.

In 2015, HHS also released data showing how many consumers who selected plans and effectuated coverage received premium tax credits to offset the cost of premiums in the marketplace. Under the ACA, consumers with household income between 100 percent and 400 percent of the federal poverty level are eligible to receive premium tax credits on a sliding scale, with the amount of the tax credit subsidy decreasing as their income levels rise. Importantly, effectuated enrollment rates for those receiving tax credits in 2015 exceeded Urban Institute projections not only in the four study states using HealthCare.gov, but also in Connecticut, which used its own IT platform to enroll consumers. Figure 1 displays the five states’ effectuated enrollment rates as a percentage of enrollment projections for all consumers, for consumers receiving tax credits, and for consumers not receiving tax credits.

Table 1 Continued...

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<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>Total</td>
<td>With APTC</td>
</tr>
<tr>
<td>Texas</td>
<td>943,000</td>
<td>805,000</td>
</tr>
<tr>
<td>Utah</td>
<td>127,000</td>
<td>83,000</td>
</tr>
<tr>
<td>Virginia</td>
<td>327,000</td>
<td>274,000</td>
</tr>
<tr>
<td>West Virginia</td>
<td>31,000</td>
<td>27,000</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>184,000</td>
<td>165,000</td>
</tr>
<tr>
<td>Wyoming</td>
<td>18,000</td>
<td>17,000</td>
</tr>
</tbody>
</table>

NOTES: ** Insufficient data supplied; n.a. = not applicable; APTC = Advanced Premium Tax Credit.
a Rhode Island is not included in the enrollment subcategories because the relevant data were not available.
Summary of Findings from the Five High-Enrollment States

The five case studies described next reveal that a combination of factors—some unique to the state and some shared with other high-enrollment states—best explain the relative marketplace enrollment success of Connecticut, Florida, New Hampshire, Pennsylvania, and Virginia in 2015.

We identified numerous cross-cutting commonalities that transcended state differences. First and foremost, all five states had a **highly collaborative and coordinated outreach and enrollment assistance effort** that led to productive and efficient operations. In most of the states, this finding included having a lead organization that conducted trainings, connected diverse organizations and assisters through regular communications, monitored outreach and enrollment activities, and in some cases redirected those activities to target areas of greatest need and opportunity. Several respondents emphasized the importance of software systems to coordinate scheduling and monitor activities, though not all states had such systems in OE2.

All five states also had **pre-existing outreach and enrollment networks and systems that had functioned successfully in the state**, both before the ACA (supporting the Children’s Health Insurance Program [CHIP], Medicaid, or other low-income coverage programs) and during the first marketplace open enrollment period (OE1). Those networks had a history of collaboration and had experience working in hard-to-reach communities to help enroll people in health coverage. Thus, they were able to build on those relationships in OE2.

Respondents in all five states highlighted the importance of conducting **grassroots community-based outreach in places where people already tend to congregate within their communities**. Those places range from churches and neighborhood associations to community colleges and shopping malls. Several respondents emphasized conducting outreach in less traditional venues so programs could target younger consumers, including concerts and beer festivals. Respondents also emphasized the importance of connecting the outreach and education activities—where consumers were told about the ACA and available financial assistance—to the central web site (where one existed) and to enrollment assisters.
for help, and the importance of following up where possible with consumers who had expressed interest in learning about coverage options.

Several states—Connecticut, New Hampshire, and Virginia—devoted significant resources to statewide marketing and media campaigns, which reportedly succeeded (a) in educating residents about the availability of new health coverage options and (b) in bringing people to a single web site that connected them to information and enrollment assistance. In some states—Connecticut, Florida, and Pennsylvania in particular—insurers conducted significant advertising or other marketing campaigns, often focusing on local areas and particular communities that also appeared to help enrollment.

In several states, respondents emphasized the importance of having assisters who were from and of the communities where they worked, including their speaking the language of residents. Organizations were able to strike a balance by having a strong statewide coordinated effort that relied on local assisters who were free to develop strategies that worked best in their own communities. In all states, respondents emphasized the importance of reaching consumers through familiar and trusted messengers—regardless of whether they were from the consumer’s local community.

In all five states, political context mattered but not always in ways that might be expected. Strong political support for the ACA in Connecticut helped create the environment for the SBM and enrollment to thrive. In Virginia, Governor Terry McAuliffe made ACA implementation and increased health coverage a top priority, thereby reversing the anti-ACA approach of the previous administration, and he was able to obtain additional federal funds to support enrollment. But in Virginia, respondents also noted that anti-ACA media coverage, especially in more Democratic areas of Northern Virginia, had the unintended consequence of raising public awareness of the ACA and coverage options and led many consumers to seek information and coverage. This result was also true in Florida, New Hampshire, and Pennsylvania, where controversy over whether and how to expand Medicaid was in the news leading up to OE2. In those states, local officials who supported the ACA devoted time and resources to promote outreach and enrollment; in Pennsylvania, some officials made their offices available as enrollment sites.

All five states also had high enrollment rates during OE1 and some respondents noted how that earlier success bred greater success in OE2. In Florida and Connecticut in particular, momentum seemed to build during OE2 through word of mouth among consumers and through the experience, skills, and knowledge that was gained in OE1 and leveraged in OE2.

Finally, respondents in Connecticut emphasized how important a high-functioning marketplace and web site were to their state’s successful enrollment outcomes in both OE1 and OE2. Respondents in other states also noted that improvements to HealthCare.gov in OE2 played a role in their states’ high enrollment. The more positive experiences people had, the more consumers checked out the web site. Having a successful web site proved especially significant in Connecticut because online applications by consumers enrolling on their own—rather than through brokers, assisters, or the call center—remained the single largest source of enrollment. This finding—that a high-functioning and reliable web site helps promote higher enrollment—is consistent with the dramatic improvement in enrollment rates in states that used HealthCare.gov in 2015.

Despite such commonalities, unique elements also stand out from the case studies. Connecticut, for example, (a) uses one of the most successful marketplace enrollment web sites and IT systems among the SBMs, (b) has a statewide culture of support for the ACA, (c) brought brokers and assisters together in collaborative enrollment efforts, and (d) is home to an insurance industry that makes up a significant element of the state’s economy.

Florida, for the second year in a row, had the largest and perhaps one of the most coordinated navigator networks in the country. Moreover, despite strong political opposition to the ACA, even in some conservative communities in South Florida, an entrepreneurial spirit seemed to spur many small businesses to serve as brokers and to help enroll consumers in coverage.

New Hampshire was unique in having its outreach and enrollment coordinated by an outside consulting firm. It also stands out as one of the only states in the country to exceed enrollment projections for its unsubsidized population.

In Pennsylvania, the Medicaid expansion coincided with OE2, bringing many low-income consumers into the system looking for coverage, whereas low-cost QHPs appear to have brought more unsubsidized consumers into the marketplace.

And Virginia’s ability to leverage more than $13 million in additional federal funding to host an effective web site and run a statewide media campaign and grassroots outreach—while doubling the number of in-person assisters—clearly helped the state become one of the most successful in OE2 and substantially improve its performance over an already successful enrollment effort in OE1.
Connecticut

Overview

Connecticut, which developed its own marketplace and expanded Medicaid, had reduced its rate of uninsurance from 12.3 percent in 2013 to 5 percent by the middle of 2015. On the basis of Urban Institute projections, in 2014, Connecticut had the fifth-highest plan selection enrollment rate among SBMs and, in 2015, the fourth-highest rate. As of June 30, 2015, 92,000 consumers had effectuated enrollment in a QHP, which is 93 percent of Urban Institute projections compared to the effectuated enrollment rate of 85 percent for all states that used their own web sites to enroll consumers in 2015. Connecticut was particularly successful enrolling consumers eligible for tax credits, with effectuated enrollment of 143 percent of Urban Institute projections compared to effectuated enrollment of 110 percent of Urban Institute's projections for all SBMs that used their own web sites in 2015.

Several factors help explain this strong performance, according to a broad range of stakeholders interviewed for this study. First, strong political leadership and a “culture of support” for health care reform have been pervasive in Connecticut. Second, the state's marketplace—Access Health CT—and its web site were described as very high functioning, effective, and consumer friendly. Third, Access Health CT conducted very intensive marketing campaigns—both statewide and at the community level—that succeeded in raising public awareness of new coverage available through the SBM. Fourth, a very strong, diverse, and well-integrated application assistance network was created to help individuals apply for coverage. Finally, a robust and well-respected private insurance industry in Connecticut provided an important and unique backdrop for successful enrollment.

State Environment Supportive of the ACA

From day one, Connecticut’s leadership embraced health care reform, made it a leading policy priority, and set about aggressively planning and implementing the ACA. With a Democratic governor and a state legislature controlled by Democrats, there was almost none of the anti-ACA political backdrop that existed in many other states. Furthermore, there was little question that the state would create its own health insurance marketplace, nor was there any doubt that it would expand Medicaid.

In fact, Connecticut was one of just a handful of states that sought and received a federal waiver to implement its Medicaid expansion early—in April 2010—so that it could transition persons covered by its state-funded health program into federally matched Medicaid. By January 2014, Connecticut already had a full-fledged Medicaid expansion in place covering approximately 90,000 single adults.

According to respondents, this enthusiastic embrace of health reform carried over to the private sector, where the business community and insurance industry also supported the ACA. Not surprisingly, the state’s advocacy, foundation, and not-for-profit communities were also on board. Together, strong political leadership and broad-based private sector support created an environment in which Connecticut’s marketplace could thrive.

Effective and High-Functioning State-Based Marketplace and Web Site

Respondents uniformly expressed high praise for Access Health CT. Much credit was given to the marketplace's original director, Kevin Counihan, who came to the job from the Massachusetts Health Connector and brought with him many lessons pertinent to the efficient and effective operation of an SBM. According to one respondent, Access Health CT operated “like an efficient start-up company,” with highly skilled staff members who were drawn from the private insurance sector and who were dedicated to data-driven decision-making and continuous quality improvement.

The Access Health CT web site was described by respondents as straightforward and user friendly for consumers. SBM data reinforce this claim: during OE2, 42 percent of all customers who signed up for coverage on the marketplace did so online and by themselves. The fact that the web site worked right from the start was described as critically important. As one respondent explained: “First impressions are huge,” and Connecticut residents were not discouraged or frustrated by a balky web site, as many initially were in states that relied on HealthCare.gov.

While we are confident in the information we have collected, there are limitations to the analysis. The most important is that we limited the number of high enrollment states we examined to five; reasons for high enrollment could be different in some of the others. In addition, we were limited to six to eight well-placed respondents in each state; others could have different views.
The site was not perfect, especially in OE1. But it was continuously refined, simplified, and improved to make the consumer experience as smooth as possible. One noteworthy feature added for OE2 was the virtual assistant, “Tina,” an avatar of a woman who helped consumers complete their applications. By all counts, Tina was very helpful: among all visitors to the web site, consumers who engaged Tina were nine times more likely to complete and submit their applications than were consumers who did not. Another feature added in OE2 was a mobile application that allows consumers to create an account and buy a health plan (for those who do not qualify for a tax credit or Medicaid).

In OE2, consumers could also anonymously browse for coverage by entering their income, age, and household size, and they could quickly see plan options and prices. Respondents also reported that renewal of coverage was very smooth and user friendly.

The only aspect of Access Health CT’s system that was generally criticized was its call center. Consumers reportedly experienced long wait times for assistance from insufficiently trained staff members. Still, according to Health Access CT data, the call center accounted for the second largest proportion of customers who signed up for coverage in OE2: 21 percent.

**Effective Marketing That Raised Public Awareness**

To raise public awareness about the availability of new coverage under the ACA, Access Health CT launched a large-scale, statewide mass media campaign before OE1. The campaign used television, radio, print media, billboards, bus placards, and banners flown behind planes at the beach to introduce residents to the marketplace and its offerings. Not particularly flashy (and even described as “a bit boring” by one respondent), the campaign nonetheless reportedly succeeded in saturating the airwaves before and during OE1 and in establishing strong brand awareness for the SBM.

Mass media efforts were complemented by a significant community-based component, where Access Health CT staff members participated in health fairs, town halls, enrollment events, and concerts across the state. Partnerships were forged with trusted community groups in both urban and rural areas. Staff members shared brochures about Access Health CT coverage options, answered questions about how the system worked, and took names and contact information of people who expressed interest in obtaining health insurance. That information was then used to follow up with consumers and provide them with assistance in completing applications (discussed in the following section).

Connecticut’s investment in marketing for OE2 continued, albeit with less funding and “less fanfare.” OE2’s marketing concentrated on reaching African Americans and Hispanics, youth, and other populations with persistent high rates of uninsurance. With the Access Health CT brand being well established, OE2’s smaller campaign filmed ads in barber shops, diners, homes, and schools, and told stories about families that had been helped by health insurance. Marketplace officials reported that the ads drove significant traffic to the web site.

**Large, Diverse, and Well-Integrated Application Assistance Network**

Underpinning Access Health CT’s marketing was a large and diverse application assistance network—comprising in-person assistors (IPAs), certified application counselors (CACs) in the state’s Federally Qualified Health Centers (FQHCs) and hospitals, and insurance brokers—that provided consumers with numerous options for receiving help with enrollment.

For OE1, the marketplace invested heavily in application assistance—roughly $3 million in federal funds. First, it opened two “stores”—one in New Haven and one in New Britain—designed to function in a manner similar to how Apple Store employees function on the floor: full-time staff members help walk-in customers with questions about health coverage and filling out applications. Second, it funded 300 individuals across the state to serve as IPAs to provide hands-on help to consumers in completing applications in a wide range of community settings. IPAs were, in many cases, bilingual and reflective of the communities in which they lived and worked.

Described by one respondent as possessing “great enthusiasm, but uneven effectiveness,” IPAs were dramatically scaled back in OE2. Citing shrinking federal financial support and data that revealed that just 8 percent of consumers who gained coverage in OE1 had received in-person assistance, Access Health CT funded just 13 locations with two staff members each (while maintaining its two “stores”). The move was met with considerable resistance and controversy, especially from advocates. In response, the Connecticut Health Foundation stepped in to fund additional community-based application assistance locations that were among the top performing application assistance sites in OE1. Despite the controversy and regret that the assistance network was so significantly reduced, respondents generally reported that these high-performing assisters were sufficient to meet the needs of consumers in OE2.

A third important component of Connecticut’s application assistance network was the roughly 400 staff members located in FQHCs and hospitals that for decades had provided enrollment assistance to the uninsured. Those staffers were retrained by Access Health CT as certified application counselors.
The fourth and final component of the network was the cadre of more than 600 certified insurance brokers across the state. Leadership in Access Health CT always considered brokers as essential to the state's effort. Those leaders thought that brokers possessed the highest level of expertise about products offered in the marketplace and thus could be most helpful in guiding consumers to health plans to best meet consumer needs. Unlike IPAs, insurance brokers impose no costs on the state. Brokers were included in early planning, attended health fairs and enrollment events, and accounted for 15 percent of all enrollments in the marketplace during OE1 and OE2. \(^\text{11}\)

Several respondents praised the critical convening roles that Access Health CT and the Connecticut Health Foundation played in facilitating the integration of the application assistance network. Whereas brokers and application assisters competed in many states, they cooperated in Connecticut. At various points during OE1 and OE2, the two organizations brought together brokers, IPAs, and CACs to meet, dispel suspicions, share best practices, and brainstorm about effective ways to share the demand for assistance. IPAs learned they could hand off to brokers cases in which consumers needed help selecting a health plan, while brokers learned they could hand off cases that were Medicaid eligible to CACs and IPAs. Over time, those collaborative relationships helped the network operate smoothly and helped consumers gain appropriate coverage.

**Strong and Well-Respected Insurance Industry**

Connecticut has long been home to several of the United States' major insurance carriers who are well known among consumers and the business community. The state legislature was also described as particularly savvy in the ways of insurance, given the industry's large presence. According to respondents, those factors combined to create an environment in which consumers were more familiar with health insurance and recognized and trusted the names of the major carriers that offered plans in the marketplace. The carriers worked with Access Health CT to design products and networks for the new marketplace that were essentially the equivalent of those in the existing private market. Insurers also engaged in their own marketing campaigns during OE1 and OE2 to promote their brands to consumers who might shop for coverage in the marketplace.

**Looking Ahead**

Connecticut respondents are proud of the success they've achieved through OE2, but they view the third open enrollment period (OE3) as an opportunity to fine-tune and improve the marketplace web site, to help consumers better use their insurance, and to further target outreach efforts to find the remaining uninsured. Brokers and carriers want to work with the marketplace to clarify product offerings and to make choices simpler for consumers. The marketplace and Medicaid need to iron out problems between their IT systems.

FQHCs would like to see the marketplace offer a "worker portal" to allow CACs to track the status of applications, just as brokers do through their "broker portal." And whereas some are concerned that the state might lose ground in OE3 because application assistance will be further scaled back—by the marketplace and by the Connecticut Health Foundation—most are confident that the system can be further streamlined without losing enrollees.

**Florida**

**Overview**

Florida had the highest enrollment rate in the country in 2015, and the 10 zip codes with the highest rates of marketplace enrollment were all in South Florida. \(^\text{12}\) Florida did not develop its own marketplace, and political leaders in the state remain embroiled in an ongoing contentious debate over Medicaid expansion. Yet despite significant political opposition to the ACA, Florida had high marketplace enrollment rates in both 2014 and 2015. As of June 30, 2015, 1,315,000 Floridians had paid their premiums and were enrolled in an active plan. Florida's total 2015 effectuated enrollment was 143 percent of projected enrollment, and its effectuated enrollment of consumers eligible for tax credits was 191 percent of projections. This percentage was the highest in the country.

Interviews with respondents in Florida suggest several factors that contributed to Florida's high marketplace enrollment in 2015. First, many respondents emphasized that the uninsurance rate was so high in Florida that people were highly motivated to obtain coverage. Second, an extensive statewide infrastructure of organizations was able to build on previous experience with Medicaid and CHIP to develop effective strategies for ACA marketplace enrollment.

Third, significant coordination occurred among outreach organizations, navigators, other in-person assisters, and hospitals. Outreach and enrollment assistance organizations relied heavily on local community partners that were known and respected in their communities and that provided outreach and enrollment resources in places where consumers already go. Fourth, the highly publicized debate over Medicaid expansion in Florida appeared to raise consumers' awareness of "Obamacare" and led many consumers to seek help.

Fifth, several respondents emphasized the importance of what one described as "word-of-mouth momentum" in many
communities. Finally, in the areas of South Florida with the highest enrollment rates, respondents reported “pop-up” brokers that saturated communities with flyers and yard signs and worked out of many different local businesses. Some respondents reported that many low-income consumers who were enrolled through those brokers sought help from assisters after the close of OE2 because of numerous problems relating to their applications, including that their income had been erroneously reported as over 100 percent of poverty, which deemed them eligible for tax credits.

Need for Coverage Particularly High

As of 2013, which was before the ACA’s coverage expansions went into effect, Florida had one of the highest uninsured rates in the country. According to Gallup, Florida’s uninsured rate dropped from 22.1 percent in 2013 to 15.2 percent by mid-2015. Several respondents identified the high uninsurance rates and high rates of people eligible for marketplace tax credits as one of the reasons enrollment was so high in Florida. As one respondent commented, the “sheer need” in Florida was so high that it contributed to the high enrollment numbers. This need may have been true in other states in the South, including North Carolina and Georgia, which also had high 2015 enrollment rates and high pre-ACA uninsured rates.

Pre-ACA Outreach and Enrollment Infrastructure

The University of South Florida and its Florida Covering Kids and Families project (FL-CKF), the single largest recipient of federal navigator funds in the country in 2014, had overseen statewide efforts to conduct outreach and enrollment for CHIP and Medicaid since 1999. When the ACA passed, FL-CKF was well positioned to build on its existing infrastructure and on the lessons learned through years of work in diverse low-income communities.

In 2013 and then again in 2014, FL-CKF joined with numerous nationally based organizations to successfully apply for a federal navigator grant. FL-CKF relied on 12 regionally based partner organizations in OE2, which, in turn, subcontracted with other local groups to conduct local outreach and enrollment assistance activities. Florida CHAIN (Community Health Action Information Network), a statewide health advocacy organization, contracted with FL-CKF to do primarily outreach and community education, including (a) providing technical support and assistance to navigators, (b) communicating with them regularly, and (c) organizing an assister network.

Whereas some of this infrastructure existed before the ACA, several respondents commented on the expertise that many organizations and individual assisters developed during OE1 and that was leveraged in OE2. As one person explained, “seasoned and knowledgeable assisters” who had worked in OE1 helped lead to high enrollment outcomes in 2015.

Coordination and Collaboration

Numerous examples of coordination can be found in Florida. FL-CKF tracked appointments and enrollments in all of its regional coalitions during OE2 using a “heat map”—a software program that helped identify where greater efforts were needed and where enrollment might have reached expected levels already. Florida CHAIN conducted webinars and trainings before and throughout open enrollment. Many assister organizations participated in a statewide scheduling system that enabled consumers to make advance appointments. In addition, navigator organizations received training before OE2 to help generate free media coverage of the ACA and enrollment opportunities.

FL-CKF was by far the largest network of navigators in the country, but it was not alone in having an organized presence in Florida. Respondents reported that other navigator entities and Enroll America were also highly organized in targeting their outreach and enrollment assistance in specific areas of the state. The Florida Association of Community Health Centers developed systems for weekly emails and webinars for the network of FQHCs that provided enrollment assistance around the state.

Respondents also reported that many hospitals participated in coordinated enrollment efforts for 2015. In some communities, hospitals invited navigators to train their staff members in enrollment assistance or allowed navigators to be on site to help enroll consumers. Some respondents noted that hospitals became much more involved in marketplace enrollment in 2015 than they had been in 2014 but that hospital participation in enrollment was limited in some communities where strong political opposition to the ACA existed.

Despite the overall high level of coordination among assister entities, in some communities collaboration was mixed, and CACs and navigators were more isolated from each other. And across the board, brokers, assisters, and provider organizations noted that little if any coordination occurred between assisters and brokers throughout the state—a phenomenon that appears to be common throughout the country.

Use of Local, Trusted Community-Based Partners to Provide Direct Enrollment Assistance

The assister systems in Florida were heavily dominated by local organizations and community leaders who were known to community residents, who spoke their language, and who were trusted messengers. Local agencies reportedly hired navigators...
from local communities. Several respondents also emphasized how many assisters and brokers in Florida were bilingual, including Spanish-speakers who were from the diverse Spanish-speaking communities in the state. Organizations also worked with assisters from other communities including those who spoke Ethiopian, Haitian, and Vietnamese, as well as Creole and Hindi.

Several respondents commented on the important role that churches and religious leaders played in encouraging people to enroll, particularly in immigrant communities. Special outreach also targeted migrant workers and families of students at colleges, including community colleges.

Outreach and Enrollment Assistance at Places Where Consumers Ordinarily Spend Time

Respondents described a proactive effort by health plans, navigators, consumer organizations, and brokers and agents to conduct outreach and enrollment where consumers live and engage in day-to-day activities. Respondents reported robust engagement at community events, health fairs, churches, and kiosks at malls. In some communities, community colleges made their computer labs open for enrollment on the weekends.

Some pharmacy retail chains had insurance agents available at their stores. Enroll America focused extensively on back-to-school events, thus leveraging the communication systems that schools had with families. And one respondent described new outreach strategies for 2015 that targeted young adults at less-traditional venues, including music concerts, craft beer festivals, and gay pride parades. Some respondents also emphasized the importance of “off-hour” appointments that were more convenient to working consumers.

Florida Blue, the only insurer that offered QHPs in every county in Florida, also had retail centers for enrolling consumers. Several respondents commented on how strong a presence Florida Blue had in Florida. One described how Florida Blue partnered with local communities and even offered space for events that would bring people in, such as weight loss challenges, gyms, Zumba and yoga classes, and free health assessments. Many Florida businesses also supported outreach and enrollment by agreeing to have drop boxes in their establishments where consumers could leave their contact information if they wanted to learn more about how to enroll.

Respondents generally noted that they were unaware of any major advertising or traditional media campaigns across the state to promote ACA enrollment. But there were pockets of (a) significant social media exposure; (b) local media coverage of ACA enrollment issues, including the Hispanic media; and (c) billboards and signs on buses and in public places, often placed by local agents and brokers.

Medicaid Expansion Debate

Several respondents said that the contentious fight over Medicaid expansion and the anti-ACA buzz in Florida generally had the reverse effect from what ACA opponents wanted: it raised public awareness of Obamacare and coverage opportunities, thereby leading many consumers to find out if they were eligible for marketplace financial assistance. Medicaid expansion was part of the Florida gubernatorial debate in the fall of 2014, thus keeping the issue in the news on the eve of open enrollment.16

Word-of-Mouth Momentum

Several respondents commented on the snowball effect that personal relationships seemed to have on enrollment in Florida. Another called it “the friends and family effect.” In OE2, the marketplace had greater credibility. Respondents talked about the numerous times that consumers came in for help. Those consumers would explain that although they were not sure about the benefits of coverage the first year, their viewpoint changed because a family member had been helped by coverage in 2014. One respondent explained: “If you serve one family member, the next week that person comes in with a relative.” This word-of-mouth marketing created significant energy and momentum, particularly in immigrant communities.

Emergence of Large Numbers of Brokers and Agents in South Florida

As noted previously, the number of people who enrolled with marketplace tax credits was very high in Florida, particularly in certain areas of South Florida in 2015. Respondents described a large number of brokers who were selling QHPs in South Florida and who set up shop in barbershops, shoe stores, and shopping malls.17 Although none of the respondents we spoke to had firsthand knowledge of how those brokers enrolled people, several described how consumers who had enrolled through such brokers later needed assistance. Consumers sought help from navigators and other assisters because they (a) could not find their brokers, (b) did not know their passwords or how to access their email accounts, (c) had received notice to supply documentation to support their stated income, or (d) were enrolled in plans with providers who were not easy for them to access. In numerous cases, respondents reported having to help consumers with income below 100 percent of the federal poverty level—consumers who were in the coverage gap in Florida and therefore were not eligible for marketplace tax credits—who had worked with brokers they could not locate.
and whose applications incorrectly stated their income was above the poverty level.

**Challenges That Remain in Florida**

Despite the high marketplace enrollment rates in Florida, several challenges remain. First, respondents consistently commented that, whereas general consumer awareness of the marketplace and tax credits was better during OE2 than in OE1, consumers still needed significant individual assistance and education about private health insurance and plan selection. Health insurance literacy is very low, and significant effort is required to get consumers to do anything other than buy the cheapest plan. Consumers who had coverage in 2014 tended to be more knowledgeable and would more often ask questions about provider networks and out-of-pocket expenses.

Second, there is still significant resistance to the ACA and a mistrust of government in some communities in Florida. Those views are found particularly in the northern part of the state; such views translate into people not wanting coverage. That phenomenon seemed to lessen somewhat in 2015, and respondents thought it might continue to lessen as people become more aware of the coverage opportunities and the tax penalties. But enrollment remains relatively low in rural and agricultural communities in Florida.

**New Hampshire**

**Overview**

Based on plan selections, New Hampshire had the fifth-highest enrollment rate among states using HealthCare.gov in 2014. That success carried over into 2015 when New Hampshire’s effectuated enrollment rate was 107 percent of enrollment projections. As of June 2015, 45,000 consumers had effectuated enrollment in a QHP in New Hampshire. Perhaps most notably, 17,000 (38 percent) of those consumers enrolled without tax credits. As shown in figure 1, New Hampshire enrolled 110 percent of those who were projected to enroll without tax credits in 2015. This enrollment rate is more than twice the national average rate for enrollment of consumers who pay the full premium directly.

In implementing the ACA, New Hampshire opted to create a state-federal partnership marketplace in which the state controls the functions of plan management and consumer assistance. The state’s politics yielded an alternative management structure: although New Hampshire was granted federal funds for consumer assistance, opposition from Republican legislators prevented the New Hampshire Insurance Department from receiving them. The New Hampshire Health Plan (NHHP)—which previously operated the state’s high-risk pool—received the funds in its place and assumed responsibility for implementing outreach and enrollment assistance programs. NHHP contracted those functions to the Boston-based consulting firm Public Consulting Group (PCG), which conducted a statewide outreach campaign and implemented an in-person assister program branded as Marketplace Assisters (MPAs).

Interviews with stakeholders in New Hampshire highlighted several factors thought to have yielded the state’s strong enrollment outcomes. First, respondents emphasized that assister groups coordinated well with one another and hit the ground running because of previous experience and relationships. Second, respondents also pointed to an effective, statewide outreach and education campaign that targeted the uninsured. Third, debate around the state’s Medicaid expansion was cited as having drawn attention to other new coverage options and, once the expansion was approved, Medicaid outreach materials were coordinated with the marketplace. Finally, controversy over a perceived lack of attractive plan options in OE1 built anticipation for OE2, when four new insurers entered the marketplace.

**Well-Coordinated In-Person Enrollment Assistance That Built on Existing Infrastructure**

Several respondents emphasized coordination across assister groups as a key factor in the state’s success. PCG held several all-day trainings for the entire assister community—including MPAs, federally funded navigators, and CACs—to coordinate efforts to develop partnerships with community organizations. Respondents reported that assisters (a) came together regionally and supported one another in building partnerships, (b) expanded upon each other’s knowledge, and (c) worked together to host fewer but higher-value events. PCG set up a dashboard for MPAs to log applications and outcomes, checked in with MPAs weekly, and conducted biweekly MPA calls.

Stakeholders also emphasized that application assistance built on existing infrastructure and trusted relationships. Although PCG was recognized for playing a role in bringing groups together, one respondent noted that it also largely served to “augment what was already there.” A number of assister groups had extensive experience doing similar work, had pre-existing relationships with consumers and provider networks, and had already begun to coordinate before PCG came on board. For instance, the Hospital Association—one of six MPA grantees—leveraged pre-existing infrastructure from the New Hampshire Health Access Network, a voluntary financial assistance program among hospitals and other providers. The state’s FQHCs—cited for having a deep understanding of their communities’ needs—received navigator funds through the Bi-
State Primary Care Association, a federal navigator grantee for both the first and second open enrollment periods.

**Targeted Outreach Campaign That Streamlined Messaging**

In addition to leading the MPA program, PCG conducted an outreach campaign that received high marks from respondents. The group operates Covering New Hampshire, a health insurance education resource for both marketplace and Medicaid coverage with a corresponding web site and information materials available to assister groups. PCG’s marketing campaign, which included radio, television, direct mail, and phone, was guided by an in-depth survey of the uninsured conducted after the first open enrollment period closed. Assister groups also undertook their own outreach campaigns. For instance, one navigator group promoted its events and services using radio, television, newspaper, fliers, and social media.

Respondents did not note any major marketing efforts by QHPs, but several news outlets reported on the entrance of new issuers to the marketplace in 2015, following consumer dissatisfaction with a very limited choice of plans during OE1. Additionally, one insurer spoke of engaging with community groups and had a presence at local events to educate consumers, although those efforts reportedly emphasized health insurance literacy over the insurer’s brand. The company also used broad-based channels, such as television and social media, for marketing.

**Medicaid Expansion That Boosted Awareness**

Medicaid expansion in New Hampshire was debated into 2014, when the state ultimately opted to adopt a multifaceted approach to expansion. This approach has involved (a) a mandatory Health Insurance Premium Payment program for individuals with access to cost-effective employer-sponsored insurance, (b) a program to cover newly eligible adults in managed care organization plans from August 2014 to December 2015, and (c) a mandatory QHP premium assistance program that will start in January 2016. Once approved, joint outreach campaigns for expanded Medicaid and marketplace coverage were coordinated through Covering New Hampshire, thereby boosting efforts to inform and to assist consumers about enrollment. Moreover, respondents indicated that the ongoing debate surrounding this expansion brought attention to issues related to the ACA and new coverage options.

**Lack of Competition in OE1 That Galvanized Providers and the Public**

During New Hampshire’s first open enrollment period, only one issuer—Anthem—offered plans through the marketplace. By OE2, an additional four issuers (Harvard Pilgrim, Minuteman Health, Assurant Health, and Maine Community Health Options) had joined the marketplace, thus increasing the number of individual plans offered on the marketplace from 11 to 42.

Respondents indicated that this increase had two important effects on OE2. First, the Anthem plans had narrow provider networks that did not extend to the more isolated “North Country”—which geographically represents approximately one-third of the state and is home to several rural, low-income communities. Controversy about overall poor offerings helped to galvanize providers—many of whom were not included in the marketplace plans’ provider networks—as well as to frustrate the public in a way that was cited as contributing to the strength of OE2.

Anthem maintained its narrow network in OE2, although consumers had other options because of the four new marketplace entrants. In addition, dissatisfaction with limited coverage also drove consumers to carefully consider their options during OE2. However, renewals and reenrollment systems were complicated by the proliferation of plans in 2015. Some health plans that entered the marketplace in 2015 specifically credited their strong provider networks for attracting members; the plans did so despite their not being the cost leaders.

The fact that New Hampshire enrolled such a high percentage of people without tax credits would seem to support the perception among respondents that the increased competition in the marketplace—including a drop in premium prices—spurred greater enrollment. The substantial increase in insurer participation is likely one of the driving forces behind the 17.5 percent drop in the premium of the lowest cost silver plan between 2014 and 2015.

**Challenges That Remain in New Hampshire**

With little turnover among the marketplace assister and navigator communities, improvements to materials provided by both the Centers for Medicare and Medicaid Services (CMS) and PCG, and with increased clarity about several ACA-related policies, stakeholders anticipate the third open enrollment period will continue to be successful in reaching people who need coverage. However, the remaining group of uninsured, according to respondents, is dominated by single young...
men who remain ideologically resistant to the ACA and who are perceived to be the most challenging group to engage. Furthermore, sparse coverage in the North Country persists, making engaging those communities more challenging. Finally, some respondents indicated serious concern about the affordability of plans with broad provider networks. They noted that tax credits were depressed in 2015 by the second lowest cost silver plan that was priced significantly below the rest of the market.

**Pennsylvania**

**Overview**

According to Gallup, Pennsylvania’s uninsurance rate had dropped from 11 percent in 2013 to 7.7 percent as of mid-2015. As of June 2015, 398,000 Pennsylvanians had effectuated marketplace enrollment. Of those, more than 80 percent—or 320,000—were receiving premium tax credits, as shown in table 1. Pennsylvania’s total effectuated enrollment was 112 percent of Urban Institute’s 2015 projections, whereas its enrollment of individuals receiving tax credits was 142 percent of projections.

In 2013 and 2014, the state was led by Republican Governor Tom Corbett, who earlier, as the state’s attorney general, had joined in a lawsuit challenging the ACA. Corbett initially opposed Medicaid expansion and opposed creating a state marketplace. He eventually supported expanding Medicaid under certain conditions that required approval from CMS. Despite the initial resistance of state political leadership to the ACA and Medicaid expansion, by September 2015, Pennsylvania had one of the highest marketplace enrollment rates in the country and had enrolled an additional 440,000 in Medicaid, thereby covering a significant portion of its estimated Medicaid expansion-eligible population.

Interviews with stakeholders in Pennsylvania highlighted three primary reasons for the state’s high marketplace enrollment in 2015. First and foremost, there were extensive collaborations among stakeholders across the state and significant coordination of both outreach and enrollment assistance efforts at the community level. Second, Pennsylvania’s QHPs offered attractive premium prices, some of which were among the lowest in the country. This pricing may have been one reason Pennsylvania enrolled a higher percentage of those projected to enroll without tax credits than did most other states in the country. Third, the debate over Medicaid expansion and the launch of Pennsylvania’s alternative program to a standard Medicaid expansion on January 1, 2015, generated significant consumer awareness about enrollment opportunities during OE2 and led many consumers to find out whether they were eligible for coverage.

**Significant Stakeholder Synergy Throughout Pennsylvania That Built on a History of Collaboration**

Stakeholders were consistent in singling out “the culture of collaboration” in Pennsylvania that played a major role in achieving high enrollment rates. The state had an established network of consumer organizations, hospitals, health centers, and health plans that worked together along with state agencies to help enroll children in CHIP. But the same cooperation with state agencies did not occur in the case of the ACA implementation. Despite the “lack of state leadership” in promoting the marketplace, as one respondent put it, volunteers from many consumer organizations led significant community-based outreach. This broad coalition came together to identify and to help enroll the underserved and uninsured population in Pennsylvania.

Organizations such as Enroll America and its partners identified geographic areas with high concentrations of the eligible uninsured population in Philadelphia and the suburbs surrounding it and in and around Pittsburgh and the Lehigh Valley. Once they identified the target populations, consumer organizations partnered with local churches, homeless shelters, food banks and pantries, county events, and fairs to help them reach people.

Volunteers and consumer advocates went door to door or, according to one respondent, had “individual conversations in the quiet corner of a local restaurant,” while also organizing town hall–style events and community fairs for larger audiences. Community health centers and consumer advocates contacted tax preparation agencies and offered them their free services to assist consumers who had unanswered questions related to ACA tax credits and penalties. The collaboration between consumer organizations also helped to avoid duplication of outreach, thus making the most efficient use of the limited number of available volunteers. It also enabled navigators and CACs to work more efficiently on enrollments rather than outreach.

Following up on incomplete appointments or enrollments was another successful strategy to avoid losing potential enrollees. One respondent emphasized that assisters were available evenings and weekends so that it would be more convenient for many consumers: “We would’ve lost [enrollees] if we stuck to 9–5 [schedules].”

The hospital association and its members played an active part in this coalition. One respondent explained that to receive block funding for uncompensated care under the state’s tobacco settlement, Pennsylvania’s hospitals need to demonstrate that they are helping people secure coverage. Thus, hospitals’ financial assistance departments were already helping
individuals enroll in Medicaid, CHIP, or other public coverage. This pre-existing framework proved helpful for hospitals to guide uninsured people to expanded Medicaid as well as to marketplace coverage.

Respondents said that insurers also played an active part in enrollment by setting up retail stores, telesales facilities, information centers, and in some cases a call center. One respondent found the insurer Highmark’s call center more helpful than the FFM call center. Insurers applied aggressive marketing strategies using sales calls, mail, postcards, and distribution channels through retail stores.

Launch of the Medicaid Expansion in Pennsylvania That Coincided with 2015 Open Enrollment

Under pressure from numerous stakeholders after he refused to expand Medicaid under ACA, Governor Corbett announced Healthy PA—an alternate route to Medicaid expansion using a Section 1115 waiver. After long negotiations with the Corbett administration, CMS approved the waiver, and enrollment began on January 1, 2015, coinciding with the beginning of the new marketplace plan year.25

In November 2014, Corbett lost the election to Tom Wolf, a Democrat who supported a standard Medicaid expansion. But enrollment in the Medicaid expansion waiver program began before Wolf took office and coincided with the beginning of OE2 in the marketplace. Governor Wolf has since eliminated the waiver program and transitioned the state to HealthChoices, a standard Medicaid expansion. By September 2015, the state completed its transition from Healthy PA and announced that 440,000 people had transitioned to or enrolled in Medicaid under HealthChoices.26

As one respondent put it, “A rising tide raises all boats.” The debate over and implementation of the Medicaid expansion in Pennsylvania galvanized many consumer organizations and assister groups to enroll Pennsylvanians during OE2. It also raised consumer awareness of the ACA and enrollment opportunities.

Relatively Low Premiums That May Have Promoted Higher Enrollment in Pennsylvania Among Unsubsidized Consumers

Pennsylvania had some of the lowest premiums in the country in both OE1 and OE2. Although premiums rose in 2015, the statewide average premium (population-weighted) for a 40-year-old nonsmoking individual with the lowest cost silver plan in Pennsylvania was $222 per month. Of the 398,000 effectuated enrollments (as of June 2015), nearly 78,000 had enrolled in plans without any tax credits.

As reflected in figure 1, Pennsylvania’s effectuated enrollment is 60 percent of its projected nontax credit enrollment in 2015 compared to only 42 percent in all states. Low premiums are particularly important for attracting the population that is not eligible for financial assistance and that benefits most directly from lower-cost plans.

Challenges That Remain in Pennsylvania

Despite Pennsylvania’s high marketplace enrollment rate in 2015, respondents identified several areas for improvement. First, renewals and re-enrollments were challenging, especially in determining correct subsidy amounts. Second, people in deep pockets of rural Pennsylvania were difficult to reach. The challenge was not just geographic. As one respondent explained, rural residents rarely visit health centers (where they could be approached about ACA enrollment assistance) and seek care only when they have significant needs. Moreover, they tend to prescribe to a conservative philosophy and do not want to depend on welfare. Finally, there were concerns that once consumers have coverage, they need significant help navigating the health care system and accessing providers.

Virginia

Overview

Despite considerable opposition to the ACA in Virginia, the commonwealth had high marketplace enrollment rates in 2014 and 2015. Virginia had a high enrollment rate in 2014, but the commonwealth performed significantly better in 2015 and experienced one of the largest increases in enrollment rates in the country. By June 30, 2015, 327,000 Virginians had effectuated enrollment in a QHP, with 274,000 of them enrolled with tax credits. This number constituted 117 percent of Urban Institute’s total projected enrollment for 2015 and 155 percent of projected enrollment for those eligible for tax credits.

According to respondents, the single most important factor in Virginia’s high enrollment rate in 2015 and its increase over 2014 was the promotion of marketplace enrollment and the injection of $13.4 million in federally awarded funds into outreach, education, and enrollment assistance by the administration of newly elected Governor Terry McAuliffe. Those amounts were in addition to federal navigator grants and federal funding of FQHCs for consumer outreach and enrollment assistance in Virginia in 2015. Moreover, the funding was used (a) to invest in a highly coordinated strategy to educate consumers in diverse communities and (b) to build on existing infrastructures of consumer advocates, health care providers, and legal aid offices that had worked together successfully in OE1 without commonwealth support.
Strong leadership at the state level and among the leading assister organizations further contributed to Virginia’s success in 2015. Respondents also emphasized the competitive insurance marketplace, the use of trusted assisters from local communities, and the highly publicized battle over Medicaid expansion (which raised consumer awareness of the ACA) as having contributed to high enrollment rates in Virginia.

Political Context

Virginia did not build its own marketplace and has not expanded Medicaid. The biggest change from OE1 to OE2 was the transition from Republican Governor Bob McDonnell to Democratic Governor McAuliffe after the November 2013 election. McAuliffe waged a highly publicized but ultimately unsuccessful battle with the legislature to expand Medicaid. In early September 2014, after the legislature rejected the Medicaid expansion, McAuliffe announced his Healthy Virginia Initiative under which he set numerous goals for the commonwealth, including enrolling an additional 160,000 Virginians into marketplace coverage.27 The governor participated in multiple events promoting enrollment and declared the first week after OE2 began “Assister Appreciation Week,” which included promoting the work of marketplace assisters.28 Respondents noted that much of the general tone of the ACA followed suit in Virginia. One respondent noticed fewer negative ACA-related stories on local media.

Strong Commonwealth Support and More Than $13 Million in Additional Funding in 2015

Virginia was among a limited number of states to receive additional federal funding for outreach and enrollment for OE2. The federal government permitted Virginia to use $4.3 million that it had initially received under section 1311 of the ACA to develop its own health insurance marketplace and instead to use it for public outreach and education. In August 2014, McAuliffe’s administration also applied for $10 million to support outreach and enrollment assistance. In October, HHS awarded Virginia $9.3 million to support marketplace enrollment for 2015.29 Funding was used (a) to finance a statewide media campaign, (b) to support grassroots community education, (c) to fund IPAs, and (d) to operate a web site that could connect people to information about and assistance for coverage options. Thus, compared to most FFM states, Virginia had significantly more resources to devote to consumer outreach and enrollment.

The Virginia Department of Medical Assistance Services (DMAS) oversaw both sets of funds and used them for several purposes. First, the commonwealth created an outreach program called the Consumer Health Education Program (CHEP), which was run by the Virginia Poverty Law Center, the lead navigator agency in 2014 and 2015.30 CHEP had 20 full-time equivalent (FTE) staff members who were deployed throughout the commonwealth to educate people about the ACA and the marketplace.

Second, the commonwealth took Cover Virginia, a web site previously used only for Medicaid, and developed it into a resource that provided (a) information about the marketplace and links to HealthCare.gov and (b) information about assisters around the commonwealth.31 Third, the commonwealth launched a major statewide media campaign with clear, consistent messaging and constant references to the Cover Virginia web site. The campaign, which cost approximately $2.7 million including production costs for the ads, ran from October 2014 through the end of OE2. The commonwealth invested in bus, radio, television, and social media advertisements. DMAS monitored traffic to the site; and—according to a commonwealth official—during the peak advertising period in January 2015 alone, 90,000 people visited Cover Virginia.

Finally, the commonwealth used most of the $9.3 million in additional federal funding to partner with two lead assister organizations—the Virginia Poverty Law Center and the Virginia Community Healthcare Association (which includes state FQHCs)—to employ more than 100 additional FTE assisters for OE2. According to one respondent, this funding allowed one assister organization to “double boots on the ground from year one” to assist in enrollment. This collaboration between providers and agencies with legal expertise to address more complex eligibility and coverage issues reportedly worked well.

Collaboration Among Stakeholders

Many respondents identified the extensive collaboration among organizations as contributing to Virginia’s enrollment success. The commonwealth, the Virginia Poverty Law Center, the Virginia Community Healthcare Association, hospitals, and other organizations coordinated their outreach and enrollment. The commonwealth embedded a web-based shared calendar for “everything marketplace enrollment-related” on which stakeholders as diverse as community health care organizations, consumer advocates, and even a tax services company could post their events all in one place.

In Northern Virginia and Hampton Roads, volunteer CACs partnered with navigators and CHEP outreach staff members to enroll people, and numerous organizations cross-referred to one another to help individual consumers. There were also partnerships with a broader variety of community groups including a community college, women’s reproductive health centers, and a public defender’s office (to advocate for special enrollment periods for recently released inmates and inmates’ families).
Organizations also hired assisters from local communities who were trusted and spoke the language of community residents. Multiple stakeholders told us that they had success with Spanish-speaking populations by using bilingual staff members. One had a core staff of native Spanish speakers solely doing outreach to and enrollment of Hispanic consumers. One respondent reported that certain Asian languages were also well covered by assisters in OE2.

**Anti-ACA Messaging and the Battle over Medicaid Expansion That Increased Public Awareness**

Respondents reported that anti-ACA political advertising and heavy coverage of the political battles over the ACA in the media in Virginia might have indirectly helped enrollment in Virginia. As one person explained, opposition to Obamacare was reflected in political advertising and covered in the Virginia media nearly every day, which helped raise consumer awareness of the law. Because Northern Virginia is included in the Washington, D.C., media market, the constant mentions of the ACA in national and D.C. media also may have raised overall awareness of the marketplace in those communities.

Similarly, the public fight between McAuliffe and the legislature over Medicaid expansion also reportedly increased public awareness of the ACA and health coverage. Yet opposition to the ACA and resistance to coverage persisted in some of the more rural areas of Virginia.

**Marketplace Competition**

One key aspect of the Virginia marketplace was its high level of competition; nine insurers participated in the marketplace, and many of them offered plans throughout the commonwealth. This competition received mixed reviews from different respondents, however. Whereas one lauded the level of competition for allowing people to choose a plan that fit their needs more exactly, another respondent called this level of competition “overwhelming” for many consumers, making plan selection more difficult. In Virginia, some hospital systems offered QHPs in the marketplace and worked hard to enroll consumers in their plans. Significant competition in some parts of the commonwealth generated more marketing by health plans and overall awareness of the marketplace in those communities, according to one respondent.

**Challenges That Remain in Virginia**

Respondents identified several areas that they think will remain a challenge going forward. Whereas some of the additional funding for assisters from OE2 will be available for OE3, many respondents expressed concerns about what will happen in the future when those funds are depleted. Respondents also noted that health insurance literacy remains a challenge among consumers in Virginia.

Several respondents said that more needs to be done to enroll people in rural areas, many of whom have decreased access to technology and highly negative views of government programs. Similarly, whereas several respondents noted that outreach to the Hispanic and some Asian communities was effective, they suggested that more could be done, including for certain Northern Virginia populations such as the Vietnamese and Ethiopian communities. Furthermore, high poverty rates in Southwest Virginia and other remote areas of the commonwealth meant that many consumers who sought assistance learned that they fell into the coverage gap—they were not eligible for Medicaid and were too poor to be eligible for marketplace financial assistance. In coal country, coal miners often had good health plans, yet the plans were very expensive for their families who were caught in the “family glitch” and who were ineligible for marketplace tax credits.

Renewals and re-enrollment also posed technical problems. One respondent explained that data mismatches and verification system changes caused premium hikes and even plan cancellations for those consumers whose income, identity, or immigration verification documents did not match up to data processing center standards. Finally, as was true in all states except Connecticut, collaboration between brokers and assisters was low or nonexistent.

**REMAINING CHALLENGES AS STATES APPROACH OE3**

Whereas each of the five states featured in this report achieved high enrollment, respondents almost universally identified ongoing challenges that need to be addressed so states could enroll the remaining uninsured. In every state, respondents raised concerns about (a) the future funding for outreach and enrollment, (b) the low rates of health insurance literacy among marketplace consumers and the remaining uninsured, and (c) the need to provide consumers with assistance after they obtain coverage so they can effectively access services. Several commented about how challenging it is to help lower-income consumers understand that the cheapest plan by premium price might not be the best plan.

Although different states had varied experiences enrolling special populations, all faced challenges in rural communities where geographic isolation was a barrier and where consumers
tended to be more conservative, less trustful of government, and more opposed to the ACA. Concerns also remain about enrolling minority populations and, particularly, immigrant populations that speak a variety of languages.

Recommendations to Improve Consumer Enrollment through HealthCare.gov

In all states, respondents emphasized that much needed to be done to enroll the remaining uninsured and to help ensure that those who are currently enrolled are enrolled in the right plans and can maintain coverage. In the four states that used the FFM in 2014 and 2015 (Florida, New Hampshire, Pennsylvania, and Virginia), several themes also emerged about how to improve systems using HealthCare.gov:

• Develop a specialty call center with experienced staff members who can help navigators, certified application counselors, and brokers with more complex issues and cases.
• Improve systems to verify income and immigration status, including a communications system that confirms when documents have been received after being uploaded or mailed.
• Ensure year-round help for consumers to use their coverage, not just to select a plan.

Brokers also consistently stated that CMS discourages navigators and assisters from working with brokers, although navigators and other assisters generally did not identify this as a problem. Brokers reported that this discouragement makes coordination and collaboration difficult, if not impossible, to the detriment of consumers who may have complex medical needs and considerations in selecting a plan. In light of Connecticut’s apparent success bringing brokers and assisters together more collaboratively, CMS could consider clarifying the role of brokers and identifying situations when navigators and other assisters might coordinate or collaborate with brokers to provide the best assistance to consumers.

CONCLUSION

None of the crosscutting factors identified in this study alone can explain why some states were more successful at enrollment than others were. The fact remains that some states that used the improved HealthCare.gov web site had very low enrollment rates despite the improved IT system, and some SBM states with a strong culture of support for the ACA struggled in OE2. But as all states develop more outreach and enrollment experience and expertise and as consumers become more aware of the marketplace and available financial assistance, opportunities to build on past successes and to leverage experience gained in OE1 and OE2 are available in every state.

As resources for outreach and enrollment activities continue to shrink, leadership and collaboration among outreach and assister networks will likely become increasingly important. For the FFM and state partnership states, the decision by HHS to provide a three-year funding cycle for year-round navigators presents an important opportunity to build and sustain the systems in states throughout the country. Brokers and health care providers will also likely play an increasingly important role, because they will continue to have a financial interest in robust enrollment. Success may also depend on stakeholders’ ability to adapt to new circumstances, including changing marketplaces and political environments.

Although much is to be learned from the experiences of these five states and respondents were proud of their states’ successes, many also expressed concern about the future. Consumers who remain uninsured are among the hardest to reach, yet fewer resources are available to provide the intensive one-on-one education and assistance such consumers likely need. In all states, concerns remain about enrolling people in rural areas and from immigrant and other minority communities. As the ACA provides health care coverage to an increasing number of consumers, the question remains whether the enrollment challenges in some of these communities from OE1 and OE2 will be overcome or whether coverage disparities will remain.
ENDNOTES


7. Counihan’s strong reputation eventually led to his being appointed to direct the Centers for Medicare and Medicaid Services’ Center for Consumer Information and Insurance Oversight, which oversees the federal marketplace, HealthCare.gov.


9. The success of Connecticut’s website became well-known nationally to the extent that numerous states have approached Access Health CT to explore purchasing the software for their own use.

10. Access Health CT, “Enroller/Leaver Satisfaction.”

11. Access Health CT, “Enroller/Leaver Satisfaction.”


23. Witters, In U.S., uninsured rates continue to drop.


25. Under Section 1115 of the Social Security Act, the Centers for Medicare and Medicaid Services of the Department of Health and Human Services may grant states waivers from certain Medicaid requirements and may allow states to operate time-limited demonstrations to experiment with new approaches to Medicaid. Pennsylvania planned, among other things, to charge monthly premiums to certain enrollees in the Medicaid expansion. See Wishner et al., Medicaid Expansion.


About the Authors and Acknowledgements
Jane Wishner is a senior research associate, Ian Hill is a senior fellow, Sarah Benatar is a senior research associate, Sarah Gadsden is a research assistant, and Divvy Upadhyay is a research associate with the Urban Institute’s Health Policy Center. The authors are grateful to John Holahan and Linda Blumberg of the Urban Institute for their comments on earlier drafts of this report and to Erik Wengle, Jacob Rosenblum, and Jeremy Marks for outstanding research assistance. The authors also thank all of the individuals who took time out of their busy schedules to speak with us about marketplace enrollment in their states.

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