ACA Implementation—Monitoring and Tracking

Factors That Contributed to Low Marketplace Enrollment Rates in Five States in 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** 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.

INTRODUCTION

In September 2015, the U.S. Department of Health and Human Services (HHS) released data indicating that an estimated 9.9 million people have obtained coverage in qualified health plans (QHPs) throughout the country.[1] The results (Table 1) show that 92 percent of the population projected by the Urban Institute to enroll in 2015 was enrolled.[2] But underneath this encouraging national number was considerable variation among the states. At the high end, Florida enrolled 143 percent of Urban Institute 2015 projections. Maine and Vermont had enrollment of 129 percent and 137 percent respectively. In other words, those states were well ahead of predicted enrollment in the second year of the reforms. At the other end of the spectrum, Hawaii and Minnesota had very low enrollment rates relative to projections of 31 and 36 percent respectively. 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 state plan management marketplace).

In light of these varied enrollment outcomes, we identified five states that, based on its projections (explained below), 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 in each state including: state officials; health plans; health care provider organizations; brokers and agents; consumer advocates; and marketplace assisters, to ascertain what factors may have contributed to these different enrollment outcomes. The Urban Institute is releasing two papers analyzing the enrollment outcomes in those states' marketplaces based on those interviews and review of materials documenting enrollment efforts in these states. This paper focuses on the experiences of five states—Colorado, Iowa, Minnesota, Washington, and West Virginia[3] —that had low marketplace enrollment by the end of the second open enrollment period (OE2) relative to projections.

The Urban Institute's Projections and Estimates of Marketplace Enrollment Rates

The Urban Institute uses a detailed microsimulation model to estimate the impact of the Affordable Care Act (ACA) on health insurance coverage. The model enables researchers to estimate anticipated enrollment in QHPs in every state when the law is fully implemented.[4] Because new health coverage programs generally take several years to reach their full enrollment levels, the model assumes a "ramp-up" in enrollment from 2014 to 2016: one-third of full projected enrollment in 2014; two-thirds of full enrollment in 2015; and full enrollment in 2016.

The HHS data release mentioned above provided data on the number of consumers who had "effectuated enrollment," meaning that they had paid at least the first month's premium, not just selected a plan at the end of the application process. A total of 9,949,000 consumers had effectuated enrollment and were enrolled in a marketplace plan as of June 30, 2015, a 15 percent drop from the 10,858,000 consumers who had selected a plan at the end of open enrollment.[5] Table 1 shows effectuated enrollment in all states and calculates effectuated enrollment as a percentage of the Urban Institute's 2015 enrollment projections.

Table 1. 2015 Effectuated Marketplace Enrollment as a Percentage of Urban Institute Projections

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

Table 1 Continued...

	2015 Effectuated Enrollment			2015 Effectuated Enrollment as Percentage of 2015 Urban Institute Projections		
	Total	With APTC	Without APTC	Total	With APTC	Without APTC
Texas	943,000	805,000	138,000	85.9%	105.8%	41.0%
Utah	127,000	83,000	44,000	102.5%	100.4%	106.8%
Virginia	327,000	274,000	53,000	116.6%	155.0%	51.2%
West Virginia	31,000	27,000	4,000	70.6%	81.8%	38.7%
Wisconsin	184,000	165,000	19,000	111.5%	156.7%	32.1%
Wyoming	18,000	17,000	1,000	68.6%	98.7%	15.0%
States Not Using Healthcare.gov in 2015 [a]	**2,733,000**	**2,147,000**	**554,000**	**84.7%**	**109.5%**	**43.8%**
California	1,394,000	1,228,000	166,000	92.0%	134.9%	27.4%
Colorado	123,000	68,000	55,000	54.6%	53.7%	55.7%
Connecticut	92,000	72,000	20,000	93.4%	142.8%	41.9%
District of Columbia	15,000	1,000	13,000	129.8%	33.3%	193.5%
Hawaii	9,000	5,000	3,000	30.8%	29.4%	33.4%
Idaho	86,000	70,000	16,000	106.7%	126.2%	63.2%
Kentucky	89,000	62,000	27,000	71.5%	72.9%	68.4%
Maryland	121,000	85,000	35,000	77.2%	98.2%	50.9%
Massachusetts	156,000	114,000	42,000	97.7%	144.4%	52.1%
Minnesota	49,000	27,000	22,000	36.2%	42.2%	31.0%
New York	370,000	264,000	106,000	93.4%	89.3%	105.1%
Rhode Island	32,000	**	**	102.7%	NA	NA
Vermont	33,000	21,000	12,000	136.6%	136.3%	137.0%
Washington	164,000	128,000	37,000	68.5%	85.8%	40.1%

*NOTES: ** Insufficient data supplied; n.a. = not applicable; APTC = Advanced Premium Tax Credit.*

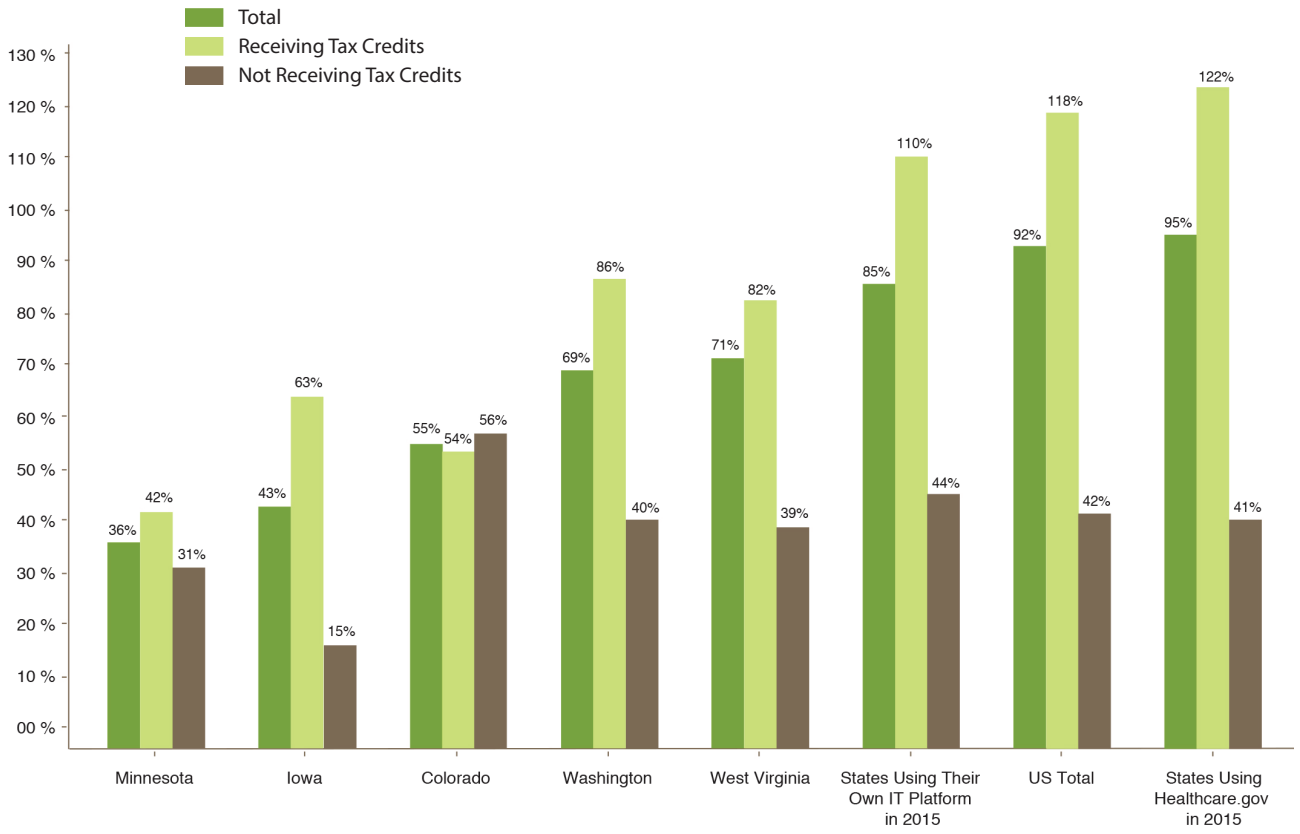
[a] Rhode Island is not included in the enrollment subcategories because the relevant data were not available.

[b] *https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-08.html*

Table 1 shows that several states, including Arkansas, Iowa, Colorado, Nevada, New Mexico, Minnesota, Washington, North Dakota, Ohio, and West Virginia, had enrollment rates relative to projections well below the national average. In this paper, we focus on Colorado, Iowa, Minnesota, Washington, and West Virginia. Two of these—Iowa and West Virginia—used Healthcare.gov in 2015 and Colorado, Minnesota, and Washington used their own Information Technology (IT) platforms for enrollment.

In 2015, HHS also released data showing how many consumers who selected plans and effectuated coverage received advanced premium tax credits (APTC) to partially 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 (FPL) (consumers with household income between 138 and 400 percent FPL in Medicaid expansion states) are eligible to receive APTCs on a sliding scale, with the amount of the tax credit decreasing with the rise in their income level. 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.

Figure 1. 2015 Effectuated Enrollment by Category, as Percentage of Urban Institute Projections



NOTE: Rhode Island is not included in the Receving Tax Credits vs not breakouts for "States Using Their Own It Platform "or the "US Total " due to a lack of relevant data from HealthSource RI.

Summary of Findings from the Five Low Enrollment States

The key findings for the five low enrollment states are as follows. First ***each of the low enrollment states had pre-ACA uninsurance rates that were near the average for the nation*** of 17.3 percent; if not well below.[6] These states did not have the opportunity that states with high uninsurance rates, e.g. Florida or Texas, had to make inroads with a large pool of uninsured people. For states like Minnesota and Iowa, 2013 uninsurance rates were quite low, 9.5 percent and 9.7 percent respectively, and progress was very challenging. Each of the five states, including West Virginia, had a large and successful Medicaid expansion. Thus each lowered their uninsured rates over the 2014 to 2015 period by a considerable margin. Those who now remain uninsured may be disproportionately comprised of those who are ideologically opposed to the law, as well as the young and healthy, and the immigrant population. In each case, these groups have proven difficult to reach.

The second issue that was consistent across states is that of affordability. For those individuals with very low incomes, coverage is easily affordable either because of Medicaid or because of substantial tax credits and cost-sharing reductions. But the financial assistance phases out as incomes increase. In virtually all five states studied, ***high premiums for higher wage groups were thought to be making coverage unattainable for many***. Premium contributions increase rapidly as income increases and tax credits are tied to the second lowest cost silver plan, a coverage tier with substantial deductibles and other cost-sharing requirements. The combination of higher premiums relative to income and high cost-sharing obligations create an affordability issue at higher income levels e.g. above 250 percent FPL. In Minnesota and Iowa, premiums were low enough that the Advanced Premium Tax Credits (APTC) did not apply to some with incomes in the upper income part of the eligibility range (i.e., the full premium was lower than the percent of income cap that applied); as a result, some respondents reported that individuals did not see that the ACA was helping them.

Each of the states with their own IT platforms reported problems that have created difficulty and have negatively affected enrollment. There are examples of individuals who went through the enrollment process but then discovered there was no record of coverage when they went to providers. There were problems with the backend transmission of information from the marketplace to insurers. There have also been problems at the 2015 renewal period where individuals were auto enrolled into their 2014 plans and had difficulty switching when they wanted to. Other IT problems include immigration status determination, and delays in communication between marketplaces and other public agencies. The IT problems were exacerbated by negative media attention. Local media wrote extensively about the problems the IT systems were having, which reflected poorly on the marketplace. The perception of the ACA as a whole was affected. Even after IT problems were largely fixed, the negative attitude lasted in progressive states such as Minnesota, Washington, and Colorado.

Finally, there was a shortage of navigators and assisters in all or parts of these states. Funding was an issue and this affected the training of the workforce. In some major urban areas, navigators and assisters were considered excellent, but access to well-trained assistance was considered poor elsewhere, particularly in sparsely populated areas. The limited advertising in Iowa and Washington were cited as a problem affecting enrollment. Call centers were frequently problematic, with inadequate training, lengthy delays, incorrect responses, and general mismanagement. This too was widely reported in the media and affected enrollment. There is concern over the ability to correct these problems in the future when funding will decline.

Other issues emerged as well. There was ***strong political opposition in West Virginia, Iowa, and in the east and southern parts of Colorado***. The anti-Obamacare sentiment adversely affected enrollment. In West Virginia and Iowa, there was little or no state assistance with outreach and enrollment. In Minnesota political support following the problematic IT rollout waned.

The ***lack of insurer participation in Iowa and West Virginia*** was cited as a reason for low enrollment. Individuals were not happy with the limited choice of insurers and blamed the lack of competition for higher prices. Insurers in less competitive markets did relatively little to market aggressively. This was also true of the Mountain areas of Colorado where insurance is extremely expensive.

Safety net providers were very pro-ACA. But while they were actively pushing enrollment, their efforts largely affected Medicaid enrollment, a lower income population typically served by these providers.

The issue of financing of the marketplace was cited as a looming issue; assessments only on plans that participated in the marketplace put these plans at a disadvantage to those who are outside.

Overall, these states illustrate how difficult it may be to reach certain populations and achieve close to universal coverage. As uninsurance rates fall, enrolling the remaining uninsured populations will be progressively difficult to enroll. The limits on premium tax credits and cost-sharing subsidies are also likely to continue to make coverage prohibitively expensive for many. In states with their own IT platforms, as well as states using HealthCare.gov, there is a need for continued operation and maintenance of IT systems. Finally, there is an essential need for human assistance, including navigators, assisters, brokers, and call centers. Funding for these is likely to decline in the future, which will exacerbate these enrollment barriers.

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.

FINDINGS FROM THE FIELD

COLORADO

Overview

As of June 2015, enrollment in non-group Qualified Health Plans (QHPs) in Colorado was approximately 123,000. About 55 percent of those who enrolled received premium tax credits, while the remaining 45 percent paid for their insurance without financial assistance. While Colorado only met 55 percent of 2015 enrollment as projected by the Urban Institute, the percentage of the uninsured in the state still appears to be declining. According to Gallup, the percentage of Coloradans without health insurance fell from 17 percent in 2013, to 10.6 percent in 2015.[7]

Although marketplace enrollment numbers were lower than expected, and stagnated during OE2, respondents in Colorado still reported a largely positive assessment of marketplace enrollment in their state. One reason is that the majority of respondents expressed a high level of pride in their state-based marketplace—Connect for Health Colorado. Between 2011 and 2014, state officials invested a great deal of energy and resources into designing and developing a marketplace that "met the needs of Colorado." The marketplace gained broad bi-partisan support and also represented a strong public-private partnership. Respondents also attributed Colorado's progress to its robust insurance market, supportive broker community, strong enrollment assistance network, and extensive public education campaigns. Finally, the high success of Medicaid enrollment – 19.9 percent of Coloradans were covered by Medicaid in 2015, compared to only 11.6 percent in 2013 – may have contributed to the heightened sense of success among respondents.[8]

Despite these assets, higher enrollment in Colorado was not achieved due to ongoing challenges with the marketplace's enrollment website and IT system, including a change in eligibility systems between OE1 and OE2, and a glitchy renewal process in OE2. Unaffordable marketplace plans in certain parts of the state, overwhelmed call centers and inadequate funding for and training of navigators were also cited as barriers to enrollment in Colorado.

Eligibility System/Information Technology Issues

Challenges with enrollment began in OE1 surrounding the state's bifurcated enrollment system that required applicants to be rejected from Medicaid before they could apply to the marketplace – a process that often proved cumbersome for many consumers. To address this IT challenge, major adjustments were made to the system for OE2. Specifically, Colorado rolled out a new, integrated eligibility system that immediately determined eligibility for either Medicaid or marketplace coverage based on modified adjusted gross income (MAGI) income levels. However, while this change was intended to increase interoperability and integration between the two systems, it ultimately possessed its own glitches—such as consumers receiving conflicting eligibility determinations, or not being able to enroll in Medicaid despite being eligible to do so, as a result of incorrectly reported income — that required manual overrides to clear up.

Multiple respondents also described a recurring problem experienced during OE2 in which families were found to have children who qualified for the Children's Health Insurance Program (CHIP) and parents who qualified for premium tax credits on the marketplace, a situation that forced navigators or brokers to work in two different enrollment systems. Given the difficulties associated with the new system, consumers were forced to rely heavily on advice from in-person assisters (IPAs), navigators and brokers —many of whom were equally confused and/or frustrated, as their prior knowledge only pertained to the system used in OE1. Such high demand for their services made it difficult to book an appointment with an IPA, or involved a long wait time on the phone for those relying on call centers.

Finally, the renewal process presented its own set of challenges in that any consumer who wanted to browse for (but not select) a different plan during the renewal period was automatically removed from the queue for auto-renewal. Many Coloradans didn't realize they had done anything to remove themselves from the auto-renewal system, as browsing does not necessarily entail a final selection or purchase of a new plan. As such, thousands of people did not know their coverage had not been renewed. Once this glitch was identified it took several weeks before it was fixed, which likely affected enrollment totals during OE2. Respondents indicated that while nearly 90 percent of consumers did not experience issues with the auto-renewal process, the problem still received a significant amount of media attention, which could have deterred eligible consumers from enrolling in the marketplace.

Outreach and Advertising Efforts

Almost all respondents commended the strength of marketing and media efforts orchestrated by the marketplace, health plans, and the philanthropic foundation community. Though some respondents reported an initial challenge in distinguishing Colorado's marketplace as separate from the federal marketplace, many successful marketing and media campaigns emerged during OE1. The first set of ads was designed to promote a general awareness of the ACA, while later ads were deemed more successful in that they specifically highlighted the state's marketplace and helped inform consumers whom to contact for local or regional enrollment assistance. Connect for Health advertised the marketplace through TV, print, and radio ads. Other organizations, such as the Colorado Consumer Health Initiative, designed their own print campaigns, while many insurers ran product-specific advertising in hopes of raising brand awareness and ultimately attracting more consumers.

Because many Coloradans believed coverage was too costly and, therefore out of reach, ads simply instructing consumers to buy insurance were reportedly ineffective. As a result, outreach efforts encouraged consumers to shop around on the marketplace to see what was available to them, and which plan would be most affordable for their lifestyle. In addition, community health centers organized enrollment events across the state during the fall of 2014. These events sought to

screen potentially eligible consumers and enroll them in the marketplace on the spot. Respondents noted that data indicate that 25,000 Coloradans were enrolled during such "walk-in" events.

Although advertising of the marketplace decreased significantly during OE2, ads that did run during this time adopted a noticeably urgent tone, advising consumers to purchase insurance "now" so they could avoid penalties. Furthermore, these ads often featured the "success stories" of Coloradans who purchased insurance during OE1 in hopes of incentivizing the remaining eligible-but-not-enrolled population in the state to do so themselves. While outreach efforts were relatively strong during OE1 and slightly less so for OE2, many respondents voiced concerns regarding the marketplace's lack of funding to continue outreach and enrollment efforts during OE3 and beyond.

Regardless of what was viewed as a relatively successful set of campaigns, a minority of Coloradans have been vocal opponents of "Obamacare," and therefore refused to purchase insurance based on their political ideologies. Political opposition to the ACA persists in some rural regions of the state, particularly in eastern and southern Colorado, and certainly suppressed enrollment to some degree, which may continue in the future.

Strong Application Assistance Network, Including Brokers

On the whole, respondents described the state's application assistance network as a well-organized and multi-faceted one that built on existing networks (such as Covering Kids and Families) formed under previous Medicaid and CHIP expansion initiatives. During OE1 there were 54 assistance sites across the state, staffed by 417 application guides. In addition, there were 1,300 independent brokers available to help consumers. Furthermore, grants from the state marketplace were assigned by geographic region; ensuring assistance was well distributed across the state. Focus group data show that consumers were generally pleased with the assistance they received, and found both navigators and IPAs to be positive and helpful.

Colorado's broker community played a key role in maintaining the success and strength of the assistance network. Unlike in many other states, where brokers and navigators saw each other as competitors, brokers in Colorado were interested in coordinating and cooperating with local navigators. Based on their own knowledge and expertise, brokers and navigators exchanged clients with one another depending on who was more familiar with the enrollment process for Medicaid versus the marketplace. It is likely that Colorado will increasingly rely on brokers to be the main assisters in the state seeing as their services are technically "free" for the state, while funding for navigators is dwindling.

However, application assistance was not without its challenges. Due to the pent-up demand for insurance, call centers in Colorado were described as overwhelmed, and were frequently operating over capacity. This resulted in long wait times on the phones, which was a significant problem for low-income consumers who could not afford to miss time at work. Additionally, some respondents explained that not only had funding for navigators been reduced, but training for navigators (primarily concerning which consumers may be eligible for tax credits, and how to apply for them) was also often lacking.

The Insurance Market and Affordability

The insurance market in Colorado was described as notably robust. Insurers are well represented across the state and all participate in the state marketplace thereby providing consumers with a wide variety of plans from which to choose when purchasing coverage. However, some respondents cautioned that so many options may leave consumers overwhelmed by their choices, therefore dissuading them from enrolling in marketplace coverage.

Despite the large number of insurers competing in the state, very few offer plans in the "mountain communities" or resort areas. The reduced competition in these parts of the state has driven up premium costs, leaving very few affordable options available for local residents. Kaiser is expected to enter the market in these regions prior to the beginning of OE3 which should help to increase competition and reduce premium costs, but affordability still remains an issue for many Coloradans, especially those who are not eligible for Medicaid and aren't aware that they may qualify for financial assistance. In fact, respondents noted that of those who remain uninsured, it is likely that some do understand the need and value of health insurance, but simply cannot afford it.

Going Forward

While Colorado has built a solid foundation on which to grow, there is still much to be done to reach the previously projected marketplace enrollment levels. Perhaps most important, there was a notable lack of concern among respondents that enrollment between OE1 and OE2 had stagnated. In fact, the majority of respondents expressed satisfaction that the marketplace had been able to retain almost all of its enrollees, and little emphasis was focused on how to best recruit new consumers.

Looking ahead, the sustainability of the state-based marketplace is a concern. Cuts in funding for navigators and other outreach and enrollment efforts have led to financial

strain. Therefore, the future of Connect for Health Colorado may be contingent upon its success in OE3.

While some respondents presume that the improved IT system, more experienced leadership, and enhanced broker involvement will allow the marketplace to finally flourish during OE3, others are not so sure. Instead, they fear that if the marketplace does not improve relative to its performance during the previous enrollment periods, trust in the state-based marketplace could decline. According to some respondents, if enrollment numbers do not increase during OE3, both consumers and stakeholders may begin to believe that joining the federal marketplace could be a better, more affordable and sustainable option for Coloradans.

Iowa

Overview

Effectuated enrollment in non-group QHPs in Iowa's State Partnership Marketplace, operated through HealthCare.gov, in 2015 was 39,000 individuals, slightly under half of The Urban Institute projection of 92,000. Of these, 34,000 (87 percent) received APTCs. The percentage of enrollees receiving premium tax credits was much closer to The Urban Institute projection of 53,000, reaching 64 percent of projected enrollment. The enrollment shortfall is concentrated in the unsubsidized portion of the population with only 6,000 individuals enrolling, or approximately 15 percent of The Urban Institute projection. According to Gallup, Iowa had an uninsurance rate of only five percent in 2015, the fifth lowest in the nation.[9]

Respondents provided a number of potential reasons for the lower-than-projected enrollment in Iowa during the second open enrollment period. These include : the low uninsurance rate; the affordability of the plans; the shortage of navigators and funding; low insurer participation in the marketplace; significant enrollment in grandmothered plans outside the marketplace; low awareness about the ACA ; and IT problems.

Low Uninsurance Rate/Affordability

Respondents consistently noted that even before the ACA, Iowa had a very low uninsurance rate, and as such there were not many "low hanging fruit" for enrollment. In 2013, according to Gallup, Iowa had an uninsurance rate of 9.7 percent, the fifth lowest in the nation.[10] This implies a reduction in the uninsured rate of about 48 percent. Iowa has expanded Medicaid under the ACA and has been successful in enrolling eligible individuals, with over 100,000 new enrollees, either newly eligible or previously eligible but not enrolled individuals.[11]

Some respondents noted that the state's residents are educated about the positive effects of health insurance and as a result, treat having insurance as a personal responsibility. Respondents also noted that this strong sense of responsibility suggests that the bulk of the remaining uninsured are those who do not feel they can afford the coverage available to them. Affordability was a common concern, particularly for those eligible for only a small amount of assistance via the tax credits, those with incomes approaching 400 percent of the FPL. At this income level, the tax credits have a minimal or no impact on the consumer's premium price. For example, a 40 year old non-smoking individual living in Des Moines with a yearly income at 350 percent of the FPL would not receive a tax credit because of the low premium and would therefore have to pay full price for a QHP.[12]

The remaining uninsured, many in rural areas, tend to be older and have less comfort with and access to the internet.

Navigators/Assisters

Respondents noted that there was a severe navigator shortage both in terms of quantity of navigators and in funding to support their efforts. In the entire state there were 12 full-time navigators who were tasked with covering Iowa's 99 counties. Respondents noted that navigator funding was insufficient given the amount of travel that was necessary to cover the large geographic region to which each navigator was assigned.

There was no budget dedicated to advertising, and none was done by the state itself or the federal agencies. Navigators utilized public events that were organized for other purposes for enrollment and recruitment. As a result of the limited outreach opportunities and absent advertising, awareness and understanding was relatively low among the uninsured population. This lack of funding also affected the establishment of an effective outreach network. Without the necessary funding and time, it was difficult to build relationships between hospitals, community organizations, and the navigators that could have increased the effectiveness of outreach and enrollment efforts. Respondents also indicated that brokers have been hesitant to enroll people into marketplace plans since they are familiar with Wellmark, the state's largest non-group insurer and one that does not participate in the marketplace. We also heard that brokers receive higher compensation for enrolling consumers in Wellmark plans as compared to marketplace plans, further dissuading them from selling marketplace products.

Awareness/Understanding

The lack of general advertising by navigators, the state, and the federal government meant that the awareness raising opportunities were restricted to the limited outreach events held by navigators and the willingness of media to report on

the enrollment opportunities. With little participation by media, understanding of the marketplace and its available financial assistance was low.

During the first open enrollment period, the Iowa Insurance Division solicited proposals for outreach and advertising grants. Nine organizations received grants for outreach and advertising but these grants were extremely restrictive. For example, contracted organizations were not permitted to give information on materials provided to the public regarding where consumers could go to seek assistance. Consumers in Iowa had a poor understanding of the tax credit eligibility levels, with most assuming that it was only for those with extremely low incomes. In addition, the state reimbursed the grantees after the fact instead of prospectively providing them with funding, a decision that created tremendous financial strain for these organizations. As a result, none of them applied for similar grants in the second year of reform.

Insurer Participation and Wellmark

In 2015, there are only three insurers (Coventry, Avera, and Gundersen) that participate in Iowa's marketplace and only one (Coventry) which offers coverage across the state. In the vast majority of the state, including Des Moines, consumers do not have a choice of insurer. Respondents also noted that in many parts of the state the provider networks are inadequate; in some cases a consumer would have to travel hours to reach the nearest provider. In addition, by one respondent's estimate, no marketplace coverage is available to roughly 25 percent of the state's population. The largest insurer in Iowa, Wellmark, with 83 percent of the non-group market before the first open enrollment period in 2013, does not offer coverage on the marketplace. Iowa has permitted insurers to continue their grandmothered plans, those which are non-ACA compliant, through the 2016 plan year. Wellmark has maintained these medically underwritten policies, and still has the lion's share of the non-group market, all off marketplace. As of August 2015, Wellmark had approximately 137,000 covered lives in off marketplace plans, compared to 39,000 total enrollment in the marketplace.[13] Our respondents speculated that once the grandmothered plans are discontinued, Wellmark will enter the marketplace, but the insurer has not made any public statements about its intent. During the first open enrollment period, there was a second statewide insurer, CoOpporunity Health (discussed below) which was liquidated by the Iowa Insurance Commissioner in January of 2015.

CoOpportunity Health

CoOpportunity Health was a health insurance co-op set up under the ACA. The first year of the ACA's coverage reforms, CoOpportunity offered coverage statewide, offered the lowest priced marketplace plan in most of the state, and was the insurer receiving the most enrollment. However, the co-op suffered catastrophic losses during 2014 and went bankrupt during the second open enrollment period. In addition to enrolling a large share of marketplace business, the co-op enrolled a large segment of the newly expanded Medicaid population. The expansion population enrolling in state marketplace plans consisted of those with incomes between 100 and 138 percent of the FPL, and apparently had high average utilization of services in the first year. While CoOpportunity Health expected to be paid fee for service for their Medicaid enrollees, they were instead added to their marketplace risk pool, a decision that was at least partly responsible for their large losses. Respondents also mentioned that the risk corridor and reinsurance payments were delayed, creating a liquidity problem that aggravated the financial situation for the co-op.

Respondents noted that consumers were considerably happier with the co-op than with Coventry, the former having a broader selection of providers and considered to provide better coverage. Many of those losing their co-op coverage were consequently disinclined to take up coverage through Coventry instead.

IT Problems

While there were not as many consumers facing problems with HealthCare.gov in the second year of open enrollment as there were in the first year, some issues remained. Many individuals either forgot or misplaced their log in information and had difficulty recovering this information. Without it, people had to create new accounts, which led to consumers being enrolled in multiple plans as a result of the automatic re-enrollment process. This problem was eventually solved but it presented an additional, unnecessary step to enrollment. Call center expertise was again mixed, although wait times improved. There was a dedicated navigator line, but there was confusion as to who was allowed to use it (many navigators were told, for example, that they had to call the main line first), adding time to the enrollment process, since only the call center could fix technical issues with applications.

Going Forward

Significant amount of progress will be necessary in Iowa to reach Urban Institute projections. First and foremost, additional funding needs to be provided for outreach, advertising, and enrollment assistance. With Iowa's low uninsurance rate, outreach efforts become all the more important in reaching the remaining, difficult to reach, uninsured. A substantial mass marketing campaign would likely lead to higher awareness about the marketplace and its competitive advantage over off

marketplace plans for those with incomes between 138 and 400 percent FPL.

The more significant hurdle to increased enrollment, at least in the near term, is the lack of choice and competition in the marketplace. With the collapse of the co-op, the vast majority of the state only has one participating insurer. If a consumer's doctors are not in Coventry's provider network, then they will likely look off marketplace for coverage. Once Wellmark can no longer sell grandmothered plans, it is possible that marketplace enrollment will increase. However, Wellmark is not forced to do this until the 2017 plan year, and if they do not choose to participate in the marketplace at that time, enrollment is likely to continue to suffer. Respondents did indicate, however, that two insurers may be joining the marketplace this year, UnitedHealthcare and Meridian, a former Medicaid-only plan. It is not known at this time how widespread their participation will be or whether they will offer competitive premiums, but it could provide options for some of the state's population. If more insurers begin to participate in the marketplace, this would increase participation by brokers as well, another potential avenue for increasing enrollment.

Navigators mention that they will make targeted efforts at outreach to workers in small firms and the self-employed in the next enrollment period. Reductions in IT errors and improvements in call center wait times could also encourage the uninsured who are technology averse to participate. The state would also benefit from an entity that could foster and facilitate improved communication among the state agencies, assisters of all types, insurers, and health care providers to coordinate strategies, clarify policies, and thus maximize reach in enrollment efforts.

Minnesota

Overview

Enrollment in Minnesota's state based marketplace - MNsure – was low relative to Urban Institute projections and compared to enrollment in other states. For example, Minnesota enrolled 49,000 individuals in 2015, well below projected enrollment of 135,000. In Minnesota, unlike other states, the Urban Institute projections are based upon the eligible population from 200 to 400 percent FPL. Relatively low enrollment can be attributed to several factors. First, Minnesota boasted one of the nation's lowest uninsured rates prior to implementation of the ACA's coverage provisions. Only 9.5 percent of the state's population was uninsured in 2013, the fourth lowest rate in the country, behind only Massachusetts, Vermont, and Hawaii.[14] Additionally, Minnesota operates a joint state- federal funded program called MinnesotaCare, which offers subsidized health coverage with very low cost-sharing requirements and premiums to low-income individuals with incomes between 138 and 200 percent of the FPL; this program is separate from the state's ACA marketplace and operates under a Section 1115 waiver.[15] Individuals with incomes at 200 to 400 percent of FPL group without affordable employer offers of coverage are eligible for the marketplace's premium tax credits, but since the value of the tax credits decreases as income increases, tax credits for this relatively higher income group are minimal which negatively impacted enrollment. These may improve over time as the health insurance premiums grow, however. Enrollment in MNsure also suffers from poor IT performance, inconsistent navigator and assister efforts, and waning political support.

Medicaid and Minnesota Care

Enrollment in both MinnesotaCare and traditional Medicaid (called "Medical Assistance" in Minnesota) was relatively high in 2014 and 2015[16]– nearly 100,000[17] individuals enrolled in either MinnesotaCare or Medicaid during the 2015 open enrollment period. This high enrollment meant that the remaining marketplace target population was limited to individuals with incomes between 200 percent and 400 percent of the FPL. Within this higher income group, however, enrollment levels were low relative to our projections.

Tax Credits

The value of the APTC available to those with incomes between 200 and 400 percent of the FPL are, by policy design, smaller than those available to the lower income population who in Minnesota, unlike most other states, are enrolled in a separate program. This affected marketplace enrollment in both years 1 and 2 of reform. In year 1, premiums for MNsure's products were the lowest in the country – so low in fact that tax credits were either non-existent or insignificant at best for the eligible population. The population for which the tax credits would have had the most benefit were those individuals with incomes between 138 and 200 percent of the FPL, and these individuals were eligible for MinnesotaCare. Some respondents reported that consumers felt they had been misled by promises of tax credits in the marketplace, only to find that the "sticker price" of products was actually what they would be required to pay, i.e. they received no benefit from the tax credit. The limited reach of the tax credits reduced the marketplace's competitive advantage, and this fact, combined with serious technological challenges (see below) resulted in many consumers choosing to purchase coverage directly from insurers, outside the marketplace, keeping marketplace enrollment below expectations.

In year 2 of the reforms, premiums significantly increased, mainly due to the lowest priced insurer, PreferredOne,

exiting the marketplace. PreferredOne offered extremely low premiums in year 1 and received considerable enrollment from individuals who were previously covered under the state's high-risk pool. The combination of high claims, i.e. utilization, with low premiums led to PreferredOne sustaining near catastrophic financial losses, and it could not continue to support itself with the marketplace population. It subsequently withdrew its products from the marketplace and continued to offer plans on the outside market, albeit with significantly higher premiums; increases ranged from 65 to 150 percent.

One potential benefit from the higher premiums in the second year and those proposed for year 3 is that tax credits will become larger, providing a stronger enticement for individuals to purchase coverage through MNsure rather than outside the marketplace. Even so however, only 55 percent of individuals enrolled in marketplace plans received advanced premium tax credits in 2015.[18] Nationally, about 84 percent of individuals who enrolled in coverage through their states' marketplaces were eligible for APTCs that year.[19] Some respondents remained concerned about the affordability of these higher priced products, even with available tax credits and cost-sharing reductions. In Minnesota however, the cost-sharing reductions have limited impact because of MinnesotaCare. Only those with incomes between 200 and 250 percent FPL would be eligible for a cost-sharing reduction in Minnesota, and even then that is only to 73 percent Actuarial Value, up from 70 percent.

Information Technology (IT) Problems

Many respondents cited MNsure's struggling IT system as a significant factor in poor enrollment. Operations in the first year were plagued by a bevy of technological roadblocks – from critical consumer-facing issues like website crashing and error messages, to back-end problems like inconsistencies in eligibility determinations, long delays in communication between MNsure and other public agencies, communication problems between MNsure and commercial insurers, and the inability to establish proof of identity. Additionally, handoffs between MNsure and county agencies responsible for administering Medicaid were very slow – taking up to ten months in some cases. Respondents reported that consumers were frustrated with the long application process and the occasional errors. As a result, many elected to purchase insurance off the marketplace, or to remain uninsured.

At the same time, the media circulated stories about these poor experiences, which evidently hurt the marketplace's image, and some respondents estimated that this negatively affected enrollment in the second year. Although most of the consumer-facing issues have been resolved, there are still back-end problems that negatively impact application processing times and continue to breed dissatisfaction. At this point, assisters are aware of a number of known issues with the IT system, and have developed certain workarounds to keep applications moving through the system.

Navigators and Assisters

Overall, navigators were portrayed as generally successful – having built upon existing grassroots networks that were in place prior to 2014, when Minnesota implemented the Medicaid expansion. However, their presence and performance was uneven throughout the state. Generally assister networks were characterized as strong and competent in the Twin Cities area, but significantly thinner in outlying areas of the state. For example, at least one medium-sized city had only one application assister. Additionally, multilingual assisters were needed but unavailable in many areas of the state. There were also concerns about reductions in funding for assisters going forward.

Outside of quantity concerns, there were issues with navigator quality throughout the state. Navigator training was described as uneven and in some cases inadequate, and many navigators found that the reality of using MNsure did not match their expectations of how the site would work after training. For example, one respondent reported that many navigators were not experts in eligibility criteria, because they believed that MNsure would automatically make an eligibility determination based on available information. In reality, that process rarely worked smoothly.

In terms of enrollment, assister efforts tended to be targeted toward the public program eligibility categories – Medicaid and MinnesotaCare. Outreach efforts have been tailored toward these communities, and respondents generally agreed that assisters had been largely successful in improving enrollment in public programs. Respondents representing assister groups reported that outreach efforts had been focused on a diverse group of underinsured populations: rural communities, students and young adults, immigrant populations, Latinos, and the state's sizable Hmong population.

Some respondents described a "turf war" between assisters and brokers, especially during the first open enrollment period, although no one believed that brokers were having a significant impact on marketplace enrollment. Health plans pay a 3.5 percent assessment on products inside the marketplace, but not outside; and this could be affecting the share purchasing in the marketplaces because of the premium difference the assessment creates. Respondents report that health plans have been somewhat active in outreach, but that this has not had a major impact on enrollment.

Political Leadership

Despite strong political support for MNsure leading up to its launch, the relationship between political leaders and the marketplace has become more tenuous. Respondents believe that the widespread frustration with IT problems may have led political leaders to distance themselves from the marketplace. The media exacerbated this frustration by enthusiastically reporting IT failures, leading to a lack of confidence among many consumers.

Safety Net Providers

Safety-net hospitals and community health centers (including Federally Qualified Health Centers) have taken active efforts to enroll uninsured individuals in their networks. This outreach has led to considerable enrollment in Medicaid and MinnesotaCare, but does not seem to have had a significant impact on QHP enrollment.

The Low Uninsured Rate

A final issue is that Minnesota's initial low uninsurance rate meant that much of the "low hanging fruit" have already been covered. Many of the remaining uninsured individuals are harder to reach, and require more intensive and targeted outreach and enrollment strategies.

Going Forward

IT problems and the perception that tax credits provided no relief hampered MNsure's success in the first year of reform, resulting in a sizable market outside the marketplace. Going forward, if the state allows the competitive advantage to purchasing coverage outside the exchange to persist, enrollment is likely to continue to lag. Most notably, ongoing IT issues and the plan assessment will need to be addressed if enrollment figures are to be reversed, and consumers may be more likely to be drawn in with premium tax credits that are available on marketplace products as premiums increase. The state, however, expects to struggle in increasing enrollment because the uninsured rate is already so low, with the remaining uninsured tending to be reluctant to participate. Outreach efforts must be specially targeted to the characteristics of these populations – including residents of rural areas and immigrant groups.

Washington

Overview

Effectuated enrollment in non-group QHPs through Washington's Healthplanfinder in 2015 is about 164,000, roughly two-thirds of the enrollment projected by The Urban Institute. About 78 percent of that enrollment is attributable to those receiving advanced premium tax credits; the remainder is those purchasing insurance fully with their own funds. The 2015 enrollment of those receiving tax credits reached 86 percent of the Urban Institute's projection while enrollment for those paying with their own funds reached 40 percent of the projection. Still, survey results from Gallup indicate that the share of uninsured non-elderly adults in Washington fell from 16.8 percent in 2013 to 6.4 percent in the first half of 2015, a relative reduction of 62 percent.

Contributing issues that were raised by respondents asked about the lower than expected QHP enrollment include a disproportionate focus on enrolling Medicaid eligibles, challenges with the IT system and associated negative media coverage, a reduced advertising effort, a complicated renewal process, changing policy decisions, a low rate of uninsured, affordability, and a need for greater broker participation/ coordination.

Medicaid/Apple Care

The efforts of navigators and other assisters and a broad-based outreach campaign resulted in more Medicaid (called Apple Care in Washington) enrollment than state officials thought possible. Respondents variously attributed this high enrollment to easier access to lower income uninsured through safety net providers (e.g., federally qualified health centers) and a marketing campaign that focused on the opportunity for free insurance coverage. A number of respondents felt that the marketing attention to the availability of free coverage was a signal for Medicaid eligibles that might have dissuaded tax credit eligibles from seeking coverage, knowing that they would not qualify for free insurance.

In addition, navigators' enrollment targets were set for total enrollment of Apple Care and QHP coverage, targets which many were able to meet within a few months enrolling only Apple Care eligibles, given their experience working with very low income populations. Over 90 percent of navigators' enrollment was attributable to Medicaid, and even brokers' enrollment was 60 percent Medicaid by one report. Respondents did indicate, however, that they expect separate enrollment targets for Medicaid and QHP plans for the next enrollment period.

Information Technology (IT) Problems

Although the state's IT system improved between the first and second years of reform, problems with back-end functions remained and negative media coverage from the first year likely affected consumer behavior in the second year. The marketplace collected premiums from consumers in 2014 and

2015, aggregating them for payment to insurers. However, the IT system supporting this premium aggregation was fraught with problems which led to billing errors and situations where individuals sought treatment from providers only to discover there was no record of them having coverage. Much negative media coverage followed, creating what respondents considered to be a broader perception of problems with the marketplace than was warranted, and multiple people thought this attention dissuaded enrollment. By the end of 2014, the main takeaway from the media coverage for many consumers was that the marketplace billing process was faulty, people were owed money but never received refunds, and information transferred from the marketplace to insurers was frequently incorrect. So while the marketplace had been largely successful, the media attention focused on the negative IT-related experiences.

While the IT system had fewer downtimes in 2015 than it did in 2014 with fewer crashes, changes to the system made it more sensitive to different categories of eligibility. As such, categories of individuals had more challenges enrolling than had been the case the previous year. Many people also felt that individual's decisions to enroll in 2015 reflected what they heard from the media and experienced about IT system problems in 2014. One specific IT glitch mentioned by multiple respondents is that individuals who indicated in the system that they had insurance coverage currently through an employer, were prohibited from qualifying for premium tax credits since the system had no way for the applicant to indicate that they would be losing that coverage on a specified date in the future. This problem alone, they felt, reduced the number of enrollees if assisters were not available to counsel applicants to lie to the system. In addition, glitches left people stuck in the app when they tried to pay their premiums, a frustration which likely pushed more people to purchase coverage outside the marketplace.

When assisters encountered enrollment problems within the IT system with complex situations, they reported that they were too frequently unable to find well-trained support staff in the marketplace. Some felt that the marketplace was not making a sufficient effort to retain well-trained professional staff, losing experienced personnel by treating them as seasonal or intermittent employees.

Advertising Effort

Most respondents felt that the advertising budget for the marketplace had been reduced substantially in the second year of reform and that they did not see advertising specifically directed to the marketplace. Combined with the fact that the newness of the marketplaces had worn off and so media paid less attention to the second open enrollment period in general, positive public attention paid to the marketplace was considerably lower. Awareness generated by TV coverage was thought to play a substantial role in getting people into the marketplace, and the lack of coverage and paid advertising in OE2 seemed to have a significant effect. Respondents noted that insurers were not advertising for their marketplace plans specifically, although they advertise for their insurance coverage in general.

One respondent noted that the open enrollment period necessitates advertising during the holidays, a time period in which advertising is substantially more expensive. This makes it unaffordable for the marketplace to purchase TV advertising from Thanksgiving through January, and not worthwhile to produce advertising for the couple of weeks remaining after the holidays.

Renewal Process

The 2015 renewal process for those enrolled in coverage in 2014 was also problematic. Information sent out to enrollees indicated that they would be auto re-enrolled in their coverage, yet the process was more complex than those notices suggested. Some plans had significant premium increases or other changes that interfered with auto re-enrollment or caused dissatisfaction. Enrollees whose family circumstances changed also could not be auto re-enrolled. Consumers being placed into plans that they did not want, for example those with substantial premium increases, sometimes did not realize that they had the opportunity to choose a different plan, leading some to drop out of the marketplace altogether. Some people never received notices that they needed to choose another plan, due to address changes, email changes, or simply missing the notice.

Seventy percent of enrollees in 2014 were estimated to re-enroll in 2015, substantially lower than the 90 percent renewal rate that is the general target for brokers. Some assisters found that the IT system had wiped out all their dashboard data on the individuals they had enrolled in 2014, making them unable to check in with their past clients. Assisters also complained that the data system for the marketplace did not provide them with information on those who had not renewed until the last two weeks of the 2015 open enrollment period, at which time it was too late to reach out to all of those who had not renewed.

Broker Participation and Coordination

While Washington brokers do sell marketplace coverage, there was a widespread sense that their engagement in that market could be improved significantly, that the brokers were far from being fully engaged both technically and operationally. Multiple sources noted that there were significant problems related to marketplace coverage sales being attributed correctly

to brokers, leading to some not being compensated for their work, and dissuading many from participating. For example, if a navigator or other assister went into an application started by a broker, the broker would be thrown off the application and lose his/her commission. The system did not seem to be built to accommodate brokers, its focus was consumers, and as such is not user-friendly for the brokers.

Some felt that the ACA unintentionally created an almost adversarial relationship between the navigators and brokers at worst, and a confusing relationship at best. For example, rules over the interactions between navigators and brokers are unclear – a navigator cannot recommend a broker to a client, can provide a list of brokers, but cannot provide a set of brokers, yet there is no definition of what constitutes a list versus a set. Respondents hoped that there could be some way of allowing greater collaboration between the navigators and brokers, with brokers getting commissions for purchases but navigators also receiving credit for enrolling their clients. There is recognition that other states have had greater success in interactions between navigators and brokers, but the widespread confusion over the legal contours is a substantial barrier to such alliances in Washington. Respondents strongly indicated that greater broker buy-in to selling marketplace plans was critical to improving enrollment.

The Low Uninsured Rate and Affordability

Respondents noted that Washington is already a low uninsurance rate state. According to a Gallup Poll,[20] the share of non-elderly adults in Washington uninsured fell from 16.8 percent in 2013 to 6.4 percent in the first half of 2015, a reduction of 62 percent. About one-third of the remaining uninsured are thought to be Medicaid eligible. For those for whom QHPs are the best coverage option, this may imply that they are quite reluctant to purchase coverage, and thus the hardest to enroll. Respondents noted that affordability is still considered the greatest barrier to enrolling the uninsured in QHPs, even with the available financial assistance; this is particularly true for older adults near the 400 percent of the FPL income level. The family "glitch" was noted as a significant affordability issue as well.[21] Political opposition, anxiety related to entering personal information (e.g., social security numbers) into websites, and lack of email access were also mentioned as significant barriers facing enrollment of the remaining uninsured.

Going Forward

Respondents mentioned hopes and some plans for greater targeting of outreach efforts in the third open enrollment period, including focusing on workers in small firms, self-employed taxi and Uber drivers, and specific ethnic groups, including Samoans, Vietnamese, and Spanish. Greater use of zip code data for targeting the remaining uninsured by their characteristics was noted by a number of assisters, some more confident than others in the accuracy of the data they had received, but all putting high value in additional data to guide their efforts, particularly race/ethnicity data. Efforts were underway to improve public education campaigns using new materials that had been produced at the end of the second open enrollment period. New enrollment targets separating Medicaid from QHP enrollees will be used, and many hoped this would provide stronger incentives to increase marketplace enrollment.

Improvements are clearly needed in follow-up by call centers when consumers submit incorrect documentation, as these applications did not seem to be prioritized, likely leading to lost enrollment. Additional data on those who do not re-new and provision of data to navigators at least six weeks prior to the end of the open enrollment period to allow them to follow-up would also be a significant advance. There is a strong sense that the time necessary to enroll additional individuals into marketplace coverage will be greater per person, as these are the individuals who are most difficult to reach.

Further attention to those enrolled in non-marketplace non-group coverage may prove worthwhile, as there is a perception that many of them may be eligible for premium tax credits but are unaware of that fact; shifting their enrollment into the marketplace could help the consumers financially and strengthen the base of the marketplace. Insurers could be enlisted in this effort, as the pay assessments per member per month for non-marketplace enrollees that they can avoid by encouraging their enrollees to switch to the same plans offered through the marketplace.

West Virginia

Overview

In June 2015, West Virginia had 31,000 marketplace enrollees while the Urban Institute projected that enrollment would be 44,000 that year.[22] In addition, due to previously high rates of uninsurance in the state and large percentages of low-income individuals, there is a poor understanding of insurance, how it works, how to choose providers within a network, and the concept of open enrollment. In many parts of the state there is limited computer usage, making individuals reliant on the call center, which continued to experienced considerable delays during the second open enrollment period. In addition, premiums are considered high and many do not consider the premium tax credits sufficient to make coverage affordable. There was little market insurance competition in the state, and respondents attribute this and the relatively high premiums to

the market dominance of Highmark. The navigator and assister process has been relatively strong in some parts of the state but weak in others, making the distribution of enrollment uneven. Finally, a relatively intense dislike of President Obama in the state, largely because of his positon on coal, has translated into opposition to the ACA. The political structure in the state has been very supportive of the Medicaid expansion but has been unsupportive of the marketplace, which it associates more directly with the Obama Administration.

The State's Focus was on the Medicaid Expansion

West Virginia made the expansion of Medicaid a top priority but was generally unsupportive of the ACA as a whole. Respondents noted that following the expansion of Medicaid, enrollment in the program has been very high – 165,000 out of an estimated 176,000 eligibles are currently enrolled. Largely because of the Medicaid expansion, the uninsured population has been reduced by half, from 17.6 percent in 2013 to 8.3 percent in 2015.[23] While many respondents were surprised by the Medicaid expansion's success, certain factors in West Virginia helped to promote enrollment. For example, Earl Ray Tomblin, the governor of West Virginia was an early proponent of expansion, which prompted strong outreach efforts by the state. Secondly, any individuals enrolled in the Supplemental Nutrition Assistance Program (SNAP) were automatically enrolled in Medicaid. In addition to SNAP, the state sent letters to parents whose children were in CHIP indicating that the parents qualified for Medicaid and encouraged them to enroll. To complete the enrollment process, parents simply had to return the letter.

To date, Medicaid expansion has not proved to be controversial in West Virginia. There seems to be a tendency not to associate Medicaid with the ACA. As much of the state's population is low income , many residents were already enrolled in Medicaid – expansion only increased these numbers. The media in West Virginia, as well as hospitals and providers have all been largely supportive of Medicaid expansion; in fact, no group in the state appeared particularly hostile toward it, likely because the business interest of hospitals took precedence over any partisan differences. Health centers and hospitals that provide a significant amount of uncompensated care also helped with enrollment.

Finally, some officials in West Virginia acknowledged that the incentives to understate one's income were strong, though no one was willing to state whether this was widespread e.g. "West Virginians are very honest people." For individuals at 140 percent of the FPL, premiums could be substantial – whereas Medicaid would be free. To the extent this is happening, it would be increasing Medicaid numbers but reducing marketplace enrollment.

Political Opposition within the State

In contrast to Medicaid, the marketplace in West Virginia assumed an entirely different reputation. While there wasn't a great deal of debate over the implementation of the marketplace, Governor Tomblin did not want to be associated with it and his administration opted for a partnership model with the federal government. Currently, the state legislature is dominated by Republicans who openly oppose the ACA, which further hinders successful marketplace enrollment. For the most part, Republican opposition in the state stems from the fact that many regard premium tax credits as "handouts" from the federal government, and are generally wary of the government mandate to purchase insurance. The hope is that with more education, people will come to view the ACA as insurance, and not as a government-sponsored program. In fact, many respondents expressed an expectation that the ideological opposition to the ACA will fade over time as people become more accustomed to the law.

Obama's anti-coal stance has made him deeply unpopular in the state which, in turn, has made his legislation unpopular as well. The fact that Governor Tomblin turned down federal money to run a statewide media campaign promoting the marketplace may also have impacted enrollment.

While the business community has generally supported Medicaid expansion, they are thought to be neutral, if not antagonistic toward the marketplace. The business community's support for Medicaid seems to rest on its recognition of the large uncompensated care burden the state faced. However, the main preoccupation of the business community has been the coal industry, which has shaped their attitudes toward the ACA and the function of the marketplace in West Virginia. The Chamber of Commerce has been strongly opposed to the ACA. Respondents indicated they have been difficult for the navigators and IPAs to work with, although if they were engaged in a constructive way they had the potential to facilitate enrollment of uninsured workers. There is recognition within the business community that the state would stand to benefit financially by embracing the ACA. This mentality may eventually influence their actions, but conservative ideology currently overpowers economic interest.

In 2014, the state enrolled around 20,000 individuals in QHPs. In 2015, the number of enrollees rose to 31,000 out of a 2015 Urban Institute projection of 44,000. Respondents noted that of those enrolled in QHPs in 2014, relatively few dropped their coverage – only 4,000 out of the original 20,000. Many suspect that those who are in greatest need of health care services are those who are signing-up, as Highmark has reported a significantly higher cost population than expected. It is thought that once the individual mandate penalties begin to increase,

more people will be respond to the incentive to purchase insurance.

Affordability

Many modest income consumers consider premiums in West Virginia to be high despite available premium tax credits. The fact that cost-sharing reductions do not extend beyond 250 percent of the federal poverty line has made accessing care even with a policy feel unaffordable for many who would face substantial cost-sharing burdens if enrolled. Furthermore, the benefits of cost-sharing subsidies are not well understood, and this lack of understanding may be decreasing enrollment among those who could benefit from them.

IPAs cited affordability as the main reason they struggled with increasing marketplace enrollment. Many argue it was cheaper for many West Virginians to pay the penalty for not purchasing health insurance, rather than paying a more costly premium – particularly for young and healthy individuals who had little or no incentive to sign up. It is thought that as penalties for remaining uninsured increase, some will begin to consider purchasing insurance, despite its high deductibles, as a better option than paying a penalty and receiving nothing in return. But even if that occurs, many enrollees will find it difficult to access care in the event of medical need given the large cost-sharing requirements many would face relative to their incomes.

Poor Understanding of Insurance

Confusion over the function of the marketplace and insurance more generally is another factor limiting enrollment. The marketplace is a much more abstract concept to state residents than is Medicaid, and, as a result, people are slower to understand it and reluctant to endorse it. But, as people become more familiar with the law, utilization of the marketplace is likely to improve. Furthermore, there seems to be a considerable need for more education of state residents on how insurance works, how to use it, and how to choose providers within one's network. The target population for the marketplace is simply unfamiliar with many insurance concepts, since many have never had private insurance before. For example, many West Virginians do not understand the process of open enrollment – that there was only a certain time period during which they could enroll – nor do they understand that special qualifying events may allow them to purchase insurance at other points in the year. The advocacy community in West Virginia has also experienced difficulties in connecting with people, decreasing their ability to educate consumers and facilitate the enrollment process.

Computer Access and Call Center Delays

Finally, the lack of internet and computer usage throughout the state has significantly limited enrollment in the marketplace, even after many of the technical issues with HealthCare.gov were resolved. For those without email or internet access, the only option was to call the 800 number and enroll via the telephone. This process took a considerable amount of time due to delays at the call center – time which many West Virginians could not afford to lose due to inflexible work schedules.

Even for those with internet access, the online enrollment process was problematic due to the complexity of purchasing health insurance. Those who had already enrolled in year one of the reforms encountered problems. During the renewal process, for example, some forgot their account information and passwords and were forced to open a new account, yet their original policy was still renewed. This meant that people were enrolled in multiple policies, causing billing and payment issues. While this problem was identified quickly enough that it did not seem to affect the overall number of enrollees, the correction process was hugely time-intensive for the marketplace and may have reduced personnel available to assist potential new enrollees.

Lack of Insurance Market Competition

Highmark is the only insurer participating in the marketplace in 2015. They contract with almost every provider in the state. Highmark has been able to negotiate reasonably good rates with providers, particularly in bigger cities and towns. However, in certain remote or rural parts of the state where the numbers of providers are very limited, every provider is a "must-have" provider, meaning Highmark's ability to negotiate is constrained.

It is difficult for other insurers to compete in the marketplace due to Highmark's dominance. Because they are the largest insurer in the state, they have a strong network, attractive contracts with most providers, and good relations with insurance agents in the area. Many respondents in the state believe that high premiums can be attributed to Highmark's dominance, and would welcome more competition. However, the chances of another insurer entering the marketplace are slim given how difficult it would be for them to build and develop their own network at attractive reimbursement rates and thus be able to actively compete with Highmark. Furthermore, insurers may be hesitant to enter the marketplace given that West Virginia is not thought to be a particularly attractive market due to the low incomes, obesity, and other health problems that afflict much of the state's population.

The Medicaid managed care insurers in the state have certainly enrolled more individuals in the last couple of years as a result of the Medicaid expansion, but they have not shown any interest in operating within the marketplace and selling to a broader population. There was an effort by a co-op from Kentucky to enter the market, but it did not happen in 2015. There is the possibility of CareSource, a Medicaid insurer in Indiana and Ohio joining the market in 2016. If CareSource or another insurer was to come in and compete in the market, it is likely that Highmark would respond by offering a more limited provider network option in an effort to offer a more price competitive product. However, there are limits to how much a network can be narrowed in West Virginia, given the relative shortage of providers in the state.

Navigators and Assisters

The navigator and assister network has been relatively strong in certain regions of the state, but weak in others. Generally, respondents feel that the in-person assistance effort is considerably underfunded. Further complicating matters, the state has provided minimal support to the navigator function. Several church and consumer advocacy groups have been actively working to get people enrolled in the marketplace, but their efforts have been limited by their knowledge of the ACA, health insurance, and familiarity with the online enrollment process. Funding for in-person assistance is expected to decrease in the future, which is likely to affect the ability of the state to sustain enrollment.

REMAINING CHALLENGES

The five states in this paper have achieved considerable success in reducing their uninsured rates, largely through their Medicaid expansions. The populations that remain uncovered are likely to be disproportionately comprised of harder to reach groups - e.g., the young and healthy, legal immigrants, rural populations, and those ideologically opposed to the law. There is a need for intensified targeting of outreach efforts and enrollment assistance for marketplace eligible participants, and, if the high enrollment states are useful indicators,[24] such targeting will necessitate the involvement of trusted community members in each subpopulation of interest. The individual mandate penalties will increase in size in 2016, and this could affect enrollment and reduce the uninsured rates further. Additional improvement promises to be a struggle.

The issue of affordability, particularly for those with incomes above 250 percent of FPL, will remain a problem. Ideally, the federal government would improve premium tax credits to something more like those adopted in Massachusetts.[25] But this is unlikely to occur in the near term, given political tension at the federal level. States could supplement the premium tax credit schedule on their own, as has been done in Massachusetts and Vermont, to make coverage more affordable. This combined with the increases in penalties would likely result in increased take-up rates for those between 250 percent and 400 percent of the FPL.

States face continuing challenges in maintaining and improving their IT systems. Overcoming these challenges will be central to improving the enrollment process, and for facilitating annual renewals e.g., making it easy to switch to lower cost plans. Finally, there will be a continued need for human assistance of all kinds. This includes call centers, navigators, assistors, and brokers. Funding for these functions is declining, which will make it harder to maintain their efficacy. In addition, improved training and financing approaches are critical to allow for retention of high quality, trained personnel from plan year to plan year. There is a great deal of work remaining to reach the full potential of the ACA. These challenges will prove more difficult in states where political support never existed or has evaporated.

ENDNOTES

1. Centers for Medicare and Medicaid Services. "June 30, 2015 Effectuated Enrollment Snapshot." Washington: Centers for Medicare and Medicaid Services, September 8, 2015. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-08.html. Accessed September 2015.
2. The estimated rates of enrollment relative to projections are also available at: http://datatools.urban.org/features/marketplace-enrollment/
3. The companion paper looks at the enrollment experiences in five states with relatively low marketplace enrollment rates: Colorado, Iowa, Minnesota, Washington, and West Virginia. Wishner JB, Hill I, Benatar S, Gadsden S, and Upadhyay D. *Factors that Contributed to High Marketplace Enrollment Rates in Five States in 2015*. Washington: The Urban Institute; 2015. http://www.urban.org/research/publication/factors-contributed-high-marketplace-enrollment-rates-five-states-2015
4. For more information on Urban Institute's Health Insurance Policy Simulation Model (HIPSM) see http://www.urban.org/research/data-methods/data-analysis/quantitative-data-analysis/microsimulation/health-insurance-policy-simulation-model-hipsm. Accessed September 2015.
5. Centers for Medicare and Medicaid Services. "June 30, 2015 Effectuated Enrollment Snapshot." Washington: Centers for Medicare and Medicaid Services, September 8, 2015. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-08.html. Accessed September 2015.
6. Gallup, "In U.S., Uninsured Rates Continue to Drop in Most States." August 10, 2015. http://www.gallup.com/poll/184514/uninsured-rates-continue-drop-states.aspx?version=print. Accessed September 2015.

7. Triedman et al., 2015. "Colorado Health Access Survey, A New Day in Colorado," Colorado Health Institute: Denver. http://www.coloradohealthinstitute.org/uploads/postfiles/CHAS/2015_CHAS_for_Web.pdf
8. Triedman et al., 2015. "Colorado Health Access Survey, A New Day in Colorado," Colorado Health Institute: Denver. http://www.coloradohealthinstitute.org/uploads/postfiles/CHAS/2015_CHAS_for_Web.pdf
9. Gallup, "In U.S., Uninsured Rates Continue to Drop in Most States." August 10, 2015
10. Ibid.
11. Medicaid.gov. "State Profile- Iowa" http://www.medicaid.gov/medicaid-chip-program-information/by-state/iowa.html. Accessed September 2015.
12. Authors' calculations based upon premium data from HealthCare.gov
13. Patane M. "Wellmark, Coventry Double Digit Rate Increases Approved" August 28th 2015, The Des Moines Register. http://www.desmoinesregister.com/story/news/health/2015/08/26/wellmark-coventry-double-digit-rate-increases-approved/32431385/. Accessed September 2015.
14. Gallup, "In U.S., Uninsured Rates Continue to Drop in Most States
15. Minnesota Department of Human Services . "Demonstration Year 19 Annual Report July 1 2013 through June 30, 2014."
16. http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_194027
17. Bowring McDonough J. "159,000 Minnesotans Enroll through MNsure During the 2015 Open Enrollment Period" February 18th 2015. MNsure https://www.mnsure.org/news-room/news/news-detail.jsp?id=486-156688
18. Centers for Medicare and Medicaid Services. "June 30, 2015 Effectuated Enrollment Snapshot."
19. http://aspe.hhs.gov/sites/default/files/pdf/83656/ib_2015mar_enrollment.pdf
20. Gallup, "In U.S., Uninsured Rates Continue to Drop in Most States
21. See Blumberg and Holahan for a discussion of this issue in the context of affordability. Blumberg LJ and Holahan J. *After King v. Burwell: Next Steps for the Affordable Care Act*. Washington DC : The Urban Institute, August 2015. http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000328-After-King-v.-Burwell-Next-Steps-for-the-Affordable-Care-Act.pdf. Accessed September 2015.
22. http://datatools.urban.org/features/marketplace-enrollment
23. Gallup, "In U.S., Uninsured Rates Continue to Drop in Most States
24. Wishner JB, Hill I, Benatar S, et al. *Factors that Contributed to High Marketplace Enrollment Rates in Five States in 2015*
25. Blumberg LJ and Holahan J. *After King v. Burwell: Next Steps for the Affordable Care Act*

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