

ACA Implementation—Monitoring and Tracking

Reaching and Enrolling the Uninsured:
Early Efforts to Implement
the Affordable Care Act

October 2013

Ian Hill, Brigette Courtot, and Margaret Wilkinson
Urban Institute



Robert Wood Johnson Foundation



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 (ACA) of 2010. 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 in Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island, and Virginia to help states, researchers, and policy-makers learn from the process as it unfolds. This report is one of a series of papers focusing on particular implementation issues in these case study states. Cross-cutting reports and state-specific reports on case study states can be found at www.rwjf.org and www.healthpolicycenter.org. The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access, and premiums in the states and nationally. For more information about the Robert Wood Johnson Foundation's work on coverage, visit www.rwjf.org/coverage.

INTRODUCTION

Much of the success of the Affordable Care Act (ACA) will depend on the degree to which states and the federal government can enroll the target population of newly eligible, uninsured persons into health coverage. The law is currently projected to provide health insurance—and by extension, improved access to comprehensive care—to 14 million individuals in 2014 after coverage expansions are first implemented, and to an estimated 25 million by 2016.¹ Such gains are to occur as a result of the ACA's provisions to expand Medicaid to cover poor and near-poor adults, and to create new health insurance marketplaces (referred to in the law as “exchanges”) where individuals will be able to shop for insurance among competing health plans and receive federal subsidies—in the form of premium tax credits and cost-sharing reductions—to help pay for coverage, depending on their level of income.

Meeting enrollment goals will hinge on multiple factors, including whether the new streamlined eligibility and IT systems called for in the ACA are implemented successfully, and whether eligible populations find marketplace premiums affordable. Equally important, however, are two precursors to the ultimate goal of enrollment:

- Outreach and marketing campaigns that effectively raise eligible populations' awareness of the availability of new coverage options and inform them of how to access that coverage; and

- Enrollment assistance structures that provide diverse populations with a variety of ways to get help with the application process.

This issue brief describes early efforts in 10 focal states (see Table 1) to publicize expanded coverage under health care reform, and to design and set up application assistance programs to facilitate individuals' enrollment into health insurance. Data were collected via telephone interviews with state officials during the spring of 2013, supplemented with information obtained from state and media reports during the summer of 2013.

The analysis finds that:

- States establishing state-based marketplaces (as opposed to defaulting to federally facilitated marketplaces) have created comprehensive and innovative marketing campaigns—supported by extensive market research—that are being unveiled this summer and fall in advance of the inaugural marketplace open enrollment period that began October 1, 2013.
- Furthermore, these campaigns appear well-supported by new programs to provide direct enrollment assistance to persons who hear about new opportunities, but need help navigating the application process.
- The federal government, too, is poised to launch its marketing and navigator efforts in the 34 states where federally facilitated marketplaces and federally facilitated

Table 1: Ten Study States, by Marketplace Model and Medicaid Expansion Decision

State	Marketplace Model			Medicaid Expansion
	State-Based (SBM)	Federally Facilitated Partnership (FFM-P)	Fully Federally Facilitated (FFM)	
Alabama			✓	
Colorado	✓			✓
Maryland	✓			✓
Michigan		✓		✓
Minnesota	✓			✓
New Mexico	✓			✓
New York	✓			✓
Oregon	✓			✓
Rhode Island	✓			✓
Virginia			✓ ¹	

Note: (1) Virginia will conduct marketplace plan management on behalf of the federal government, while the federal government operates the remaining core exchange functions.

Source: Robert Wood Johnson Foundation. *Health Insurance Exchanges and State Decisions*. Health Affairs, July 18, 2013.

marketplace-partnerships will operate. And already, national efforts such as Organizing for America and Enroll America are spreading the word about the ACA and enlisting the support of individuals and partner organizations “on the ground” that will help individuals and families enroll in coverage.

- Differences in the intensity of efforts across the states are stark. Those that have chosen to establish their own state-based marketplace have developed state-specific marketing campaigns showcasing unique themes and concerns of residents, and have also targeted substantial resources to support enrollment assistance networks. In contrast, states that have deferred to

federal and national-level efforts to promote coverage (e.g., federally facilitated marketplace states, including many where policy-makers have actively opposed the ACA) will rely on more generic marketing messages that lack state-specific “flavor,” and federal monies supporting marketing and enrollment assistance in those states will be spread thinly. While federally facilitated marketplaces may work just as well as their state-based counterparts, they may not be supported by the same level of marketing and enrollment assistance. These distinctions may contribute to noticeably different experiences in enrollment during the first year of ACA implementation, and perhaps longer term.

CHALLENGES FACING ACA MARKETING AND ENROLLMENT ASSISTANCE

There are many challenges in the way of the ACA’s ability to achieve large and rapid reductions in the uninsured. First, while the U.S. Supreme Court upheld the ACA in June 2012, it made the law’s until-then mandatory Medicaid expansion an option for states. In the ensuing year, just over half the states—26—have opted to move forward with expanded Medicaid coverage up to 138 percent of the federal poverty level (FPL).² Second, just 17 states have thus far established their own state-based health insurance marketplaces (SBM), aggressively embracing and preparing for ACA implementation. Meanwhile, a larger-than-expected number

of states opted not to create SBMs for now, and will instead rely either wholly or in part on the federal government to run a marketplace for their residents. At the time of this writing, the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services (CMS) was setting up federally facilitated marketplaces (FFMs) in 19 states, and collaborating with states to create federally facilitated marketplace-partnerships (FFM-Ps) in 15 states.³ Reflecting these developments, the most recent projections from the Congressional Budget Office (CBO) are that, in 2014, Medicaid/Children’s Health Insurance Program (CHIP)

enrollment will grow by nine million, and enrollment in Health Insurance Marketplaces (HIMs) will top seven million.⁴ By 2017—several years into implementation of the expansions—enrollment in Medicaid/CHIP and the HIMs will have grown by an estimated 12 million and 24 million, respectively.⁵

State-to-state variation aside, ACA implementation also faces significant challenges in overcoming the public's confusion and lack of awareness of the law. According to recent polls, 41 percent of Americans do not realize that the ACA was upheld as the law of the land by the U.S. Supreme Court, 49 percent don't understand how the law will affect them, and perhaps most alarming, fully 78 percent of currently uninsured persons are unaware of the opportunities presented by the ACA to help them gain coverage.^{6,7} Such widespread misunderstanding has certainly been fueled by aggressive efforts to cast the ACA as “a government takeover of your health care,” “socialism,” and as a law that will impose “rationing,” and even “death panels.”⁸ Some question whether the Obama administration has done an adequate job of dispelling misinformation while educating and informing the public about the various provisions of the ACA; they also worry that recent efforts to do so may be too little, too late. But marketing experts testify that it is a mistake to advertise a product before it is ready for purchase (or even window shopping).^{9,10} Thus, federal officials and their state counterparts, faced with the reality of a multiyear, phased implementation schedule, have only recently begun concerted efforts to publicize the availability of new coverage options and the insurance marketplaces that will enable individuals to shop for this coverage. This compressed timeframe within which to raise public awareness of the ACA represents yet another challenge.

Other marketing challenges facing states and the federal government include the sheer complexity of the ACA, with its layers of coverage (across Medicaid and marketplaces), subsidy structure, individual mandate, and the Internal Revenue Services' involvement in determining tax credit eligibility. In addition, extreme diversity among the populations that could potentially gain coverage under health care reform, including low-income individuals who have never before been eligible for Medicaid; working families who have never been involved with public benefit programs; young adults who tend to be healthy and may not think they need health insurance; and populations of huge ethnic and cultural diversity, as well as those with immigrant status. It will be fundamentally important for programs to enroll individuals across this spectrum—and especially, an appropriate mix of individuals with both greater- and lower-than average health care needs—to avoid costly adverse selection. But marketing complex products to very diverse populations is not an easy task.

Finally, potentially insufficient fiscal resources present another challenge to successful marketing and enrollment assistance. Public programs historically have not enjoyed significant support for outreach that, by design, encourages enrollment (and thus invites increased public expenditures). State or federal budgets can vary tremendously based on political support for a given program or initiative. And private donations and philanthropic support, while potentially significant in size, typically do not represent sustainable sources of funding for marketing campaigns.

KEY ACA PROVISIONS RELATED TO OUTREACH AND ENROLLMENT ASSISTANCE

Interestingly, the ACA contains few concrete provisions directly focused on the areas of outreach and enrollment assistance for individuals wishing to enroll in Medicaid and the HIMs. Subsequent regulations have provided more guidance to state officials and policy-makers, but it remains clear that states have a great deal of flexibility to design and implement outreach and application assistance suitable to their particular target populations.

Marketing and Outreach

The ACA establishes HIMs and federal funding for their development, but does not include any specific requirements regarding HIM marketing and outreach activities. The law does include more specific provisions for Medicaid outreach, mandating that—as a condition of participating in and receiving federal funds for Medicaid—states must conduct outreach to low-income and vulnerable populations, particularly the newly eligible, people with disabilities, and underserved minorities. However, the ACA does not specify a minimum effort or designate funds

specifically for such outreach.¹¹ The health reform law also requires that all materials produced by the HIMs and Medicaid agencies are required to be culturally and linguistically appropriate, and available in multiple languages.¹²

Application Assistance

The ACA and subsequent regulations have established three categories of application assistors, as described below and summarized in Table 2. To meet anticipated demands for assistance, the ACA describes Navigators as persons employed and trained by states to educate consumers, facilitate their enrollment into coverage, assist with selection of Qualified Health Plans (QHPs) offered through the marketplaces, and provide necessary referrals (such as when an enrollee has a complaint or question related to their health plan).¹³ As shown in Table 2, each state with a FFM or FFM-P must have at least two navigator entities—one of which must be a community and consumer-focused nonprofit.¹⁴ Navigators are prohibited from having direct ties to insurance organizations; thus, while licensed insurance agents and brokers can act as Navigators, they are precluded from doing so if they receive financial compensation from insurance companies. Aside from administrative costs related to planning and training, SBMs are not permitted to directly fund Navigators with their Exchange Establishment grants. Rather, most SBMs plan to rely on marketplace revenue (e.g., assessments on marketplace-based premiums) to fund their Navigator programs.¹⁵

To give states more flexibility to provide application assistance, the Department of Health and Human Services (DHHS) created the new category of In-Person Assistor (IPAs) in June 2012.¹⁶ While possessing essentially the same responsibilities as Navigators, IPAs are different in that they can be directly funded by states' Exchange Establishment grants, monies that are available currently and through 2014.* SBMs can therefore use IPAs from the outset of marketplace operations—and during the critical first months of open enrollment—while the revenue streams that will eventually support Navigators are still being established.

A third group of assistors—called Certified Application Counselors (CACs)—was established by federal rulemaking in January 2013, to play a similar role as Navigators and IPAs.¹⁷ CACs, however, will not be paid to provide application assistance by the marketplaces and they are expected to be employed primarily by entities that already have a direct self-interest in helping consumers obtain health coverage, including hospitals or other healthcare providers, social service agencies, or even managed care

organizations (which are not eligible to be Navigators or IPAs). Not coincidentally, these are also entities that often already provide application assistance for public coverage programs like Medicaid and CHIP. The responsibilities of CACs are narrower than those of navigators and IPAs (for instance, CACs are not required to do outreach and provide referrals, and conflict of interest standards for CACs are less stringent) and include informing individuals and employees of coverage options available to them, assisting individuals in applying for insurance affordability programs, and helping them choose and enroll in QHPs. Before providing assistance, all CACs must be trained by either the state or the Medicaid agency (in states with SBMs), or by agents of the federal government (in FFM and FFM-P states).¹⁸

Table 2: Application Assistor Types

Navigators

- Marketplaces of all types are required to have Navigator programs
- Navigator programs in SBMs cannot be funded with Exchange Establishment grants
- \$67 million has been awarded to fund Navigator entities in FFMs and FFM-Ps
- All exchanges are required to select at least two entities to serve as Navigators, which may include community and consumer-focused nonprofit groups; trade, industry, and professional associations; commercial fishing industry, ranching, and farming organizations; chambers of commerce; Indian tribes; state or local human service agencies; or other public/private entities or individuals

In-Person Assisors (IPAs)

- IPAs are optional for all states, regardless of marketplace type, but will primarily be found in SBMs
- Can be directly funded using Exchange Establishment grants
- States given flexibility to tailor IPA program to meet the needs of the state

Certified Application Assisors (CACs)

- CACs are optional for states, regardless of marketplace type
- No federal funds available, but Medicaid administrative matching funds may be available
- Any individual can become a CAC, but it is expected that CACs will primarily be employed by hospitals, providers, social service agencies, and managed care organizations

Funding

Federal Exchange Establishment grants represent the primary funding source for the development of marketing and outreach campaigns.¹⁹ In 2010, \$49 million in

* Federally Facilitated Marketplaces, thus, will not have IPAs.

Exchange Planning grants was awarded across 49 states, and over the past two years states have received Exchange Establishment grants totaling \$3.8 billion (\$1.5 billion in Level One grants and \$2.3 billion in Level Two grants). The Level Two Establishment grants required states to describe how they would create sufficient consumer assistance for their marketplaces, among other requirements.²⁰ Specifically, states are permitted to use Level Two grant funds for any necessary activities pertaining to the administration of the marketplace, including the development and implementation of outreach and marketing campaigns.²¹

Federal Exchange Establishment grants are also the main source of support for the development (though not the operation) of SBM Navigator programs, and for activities

related to state IPA programs. The federal government initially earmarked \$54 million to support Navigator programs in the 34 states with FFMs and FFM-Ps, and increased this amount to \$67 million in the summer of 2013. Eligible entities applied and competed for these funds during the spring and summer 2013. In addition, DHHS awarded \$150 million in July 2013 to more than 1,100 Federally Qualified Health Centers (FQHCs)—representing every state—to hire staff to help consumers seeking care at their health centers.²² Each FQHC will receive at least \$50,000 to hire an additional full-time employee to focus on enrollment assistance. Health centers are viewed as being uniquely positioned to reach out to a large proportion of uninsured Americans—last year alone, they treated almost 21 million patients.²³

LESSONS FROM CHIP AND MEDICAID EXPANSIONS

Fortunately, this is not the first time states have faced the dual challenges of raising consumers' awareness of the availability of new coverage options, and providing application assistance to those needing help in navigating the enrollment process. Rather, the Medicaid expansions for pregnant women and infants in the late-1980s gave states their first opportunity to design campaigns to encourage mothers to enroll in Medicaid so that they could receive early and ongoing prenatal care during their pregnancies. A decade later, the enactment of CHIP presented states with the challenge of reaching working families, making them aware of new child coverage options under the law, and helping them enroll their children into coverage. Unfortunately, there is a paucity of research that quantifies the effects of alternative outreach and application assistance strategies.²⁴ Still, available evidence, coupled with myriad policy analyses of "best practices," offer many lessons upon which states and the federal government can draw as they design similar efforts to support ACA implementation.²⁵ Namely, CHIP and Medicaid expansions taught policy-makers that:

1. Marketing and public education is critical to raise awareness of new coverage opportunities.

Under both the Medicaid expansions for pregnant women and child coverage expansions under CHIP, marketing campaigns played a critical role in raising the public's awareness of the availability of new coverage options, and educating consumers about the importance of early and continuous care. Broad, statewide campaigns formed

a strong foundation upon which to build new coverage initiatives, establishing the "brand" identity of new prenatal care and child health programs. Among myriad examples across the states, Utah's *Baby Your Baby* prenatal care campaign used multiple tools for maximum effect—television, radio, and print media, toll-free hotlines, and websites—and achieved over 90 percent recognition among state residents.²⁶ Similar campaigns included *Baby Love* in North Carolina, *Beautiful Babies Right from the Start* in the District of Columbia, and *Healthy Start* in Massachusetts. For CHIP, campaigns carried brand names such as *ALLKids* in Alabama, *Healthy Families* in California, *Child Health Plus* in New York, *PeachCare for Kids* in Georgia, *KidCare* in Florida, Illinois, and New Jersey, and *LaCHIP* in Louisiana. Positive messages about the benefits of coverage—prevention, peace of mind, preparing for the unforeseen, investing in a healthy future—formed the crux of marketing efforts, which also avoided language and associations with government and "welfare" programs. Methods and messages were also conveyed in multiple languages and targeted diverse ethnic communities, in an attempt to be culturally attractive to a broad audience of potential consumers.

2. Community-based outreach and education is a critical complement to broader marketing campaigns.

Medicaid and CHIP expansions also taught policy-makers that broad public awareness campaigns can have more impact when they are coupled with outreach efforts at the community (or "grass roots") level. More direct, face-to-face

contact with consumers is needed to answer questions, overcome confusion, and dispel fears. Under previous expansions, states provided grants to community-based organizations, schools, and health care providers to support staff that could reach out to target populations, work in neighborhoods (often door-to-door), and build partnerships to spread the word about new public coverage options.

3. Hands-on application assistance using trusted community groups and providers puts “teeth” into outreach.

Arguably one of the most significant innovations to emerge from CHIP was the creation of “application assistance” models to support outreach and enrollment. By equipping staff of community-based organizations and providers with shortened, joint Medicaid/CHIP application forms, training them in how to administer these applications, and anointing them as official program representatives certified to help families with enrollment, application assistance put “teeth” into outreach.²⁷ Examples of CHIP application assistance programs currently operating in 48 states include *Certified Application Assistants* in California, *Facilitated Enrollers* in New York, *Satellite Eligibility Determination* sites in Colorado, and *KidCare Application Agents* in Illinois. Whether funded via grants and contracts, or per-application fees, application assistance can have a huge impact on enrollment. Indeed, one study in Boston found that 96 percent of children who received such assistance obtained health coverage, while only 57 percent of children in a control group that received no assistance were able to obtain coverage. Moreover, children who received assistance obtained coverage faster, were more likely to be continuously covered, and were more satisfied with the enrollment process.²⁸ Many certified entities—including providers and health plans—may not require any funding support at all, since it is in their self-interest to enroll more consumers into health insurance so that they can be reimbursed for the care they deliver. Local health care providers, including community health centers, are particularly promising partners, as surveys of parents with uninsured children suggest that doctors are the most trusted messengers in promoting children’s coverage.²⁹

4. Trusted community groups closely tied to ethnic and other communities are most effective in reaching the hard to reach.

CHIP and Medicaid outreach and application assistance efforts also taught policy-makers the importance of enlisting the support and help of trusted community members and organizations—closely tied to ethnic and other communities of interest—in “reaching the hard to reach.” Community

partners can include a broad range of entities, including community-based nonprofit agencies, family resource centers, faith-based organizations, WIC programs and food banks, schools, Head Start, and preschool programs.³⁰ Such organizations were seen as uniquely positioned to reach out to people who do not speak English; from 1998 to 2000, California observed a nine percent enrollment increase among Latino children, and a 27 percent increase among Asian children, after implementing its bilingual community-based application assistance program.³¹

5. Achieving high participation rates will take time

Regardless of the size, breadth, and depth of investments in outreach and application assistance, CHIP taught policy-makers that it takes considerable time to achieve broad participation among eligible consumers in coverage. Keeping in mind that CHIP enjoyed strong bipartisan support, that children were viewed as a high priority population by policy-makers of all political stripes, and that all states adopted CHIP coverage in just over two years, the program *still* did not achieve strong enrollment rates in its early years. It took approximately 14 years—from 1997 to 2011—to reduce the proportion of all children without insurance from 15 percent to 9.4 percent, and to reduce the rate of uninsurance among children below 200 percent of FPL from 24 percent to 14 percent.³² Participation in the program among eligible children climbed slowly but steadily over the years, but it took nearly a decade and a half for CHIP and Medicaid to achieve their current joint participation rate among eligible children of 86 percent.³³ The ACA, in contrast, enjoys little of CHIP’s advantages—in terms of widespread political support or uniform adoption across the states—suggesting that enrollment for the 2014 coverage expansions will climb slowly, perhaps over many years.

As will be described below, state and federal policy-makers appear to be heeding the lessons of Medicaid and CHIP and designing outreach campaigns that combine both broad efforts to raise public awareness and community-based efforts to reach the “hard to reach.” Furthermore, outreach campaigns are being supported by extensive application assistance programs, designed to provide consumers with direct, hands-on help with completing the application process.

PLANS AND PROGRESS WITH MARKETING AND OUTREACH

Based on insights gathered during key informant interviews and subsequent document reviews, states that have embraced healthcare reform, established SBMs, and opted to expand Medicaid are reasonably well-positioned to carry out effective marketing and outreach campaigns that support the ACA's coverage expansions. These states have conducted extensive market research to design appealing logos and themes. Over the summer of 2013, advertisements began to appear in states like Colorado, Minnesota, New York, and Oregon that embrace buoyant themes and images.³⁴ Meanwhile, in states that have opted not to create their own marketplaces and will instead defer to the federal government to manage enrollment, there has been little or no state-organized planning for marketing campaigns. In Alabama and Virginia, for example, political resistance to the ACA has been strong and there has been no state government support for outreach and marketing, though Virginia officials have developed a standardized plan for all entities to make referrals to its FFM.

Details on states' approaches to planning and designing campaigns, their intended tools and messages, and their partners, are provided below.

1. Planning and designing marketing campaigns

Among the states interviewed for this study, those setting up their own SBMs typically engaged in concerted planning efforts to prepare for the launch of their coverage expansions. Each state worked with private-sector firms to conduct market research, hold focus groups with consumers, test alternative brands and messages, and ultimately design marketing campaigns. Of note, most of these states have chosen to promote both HIM and Medicaid coverage in an integrated manner in their campaigns, with common messages designed to reach diverse audiences, and some effort to rebrand Medicaid and broaden its appeal.

As a first step in their broader HIM planning process, most states created special workgroups to focus on outreach, public education and awareness. These workgroups typically included diverse stakeholders, including not only state officials but also insurance carriers, health plans, insurance brokers and agents, representatives of local Chambers of Commerce, health care providers, and consumer advocates. Many states sent workgroup members "on the road" to further build partnerships among stakeholders across their states. New York, for example,

held regional advisory committee meetings every four to eight weeks throughout much of 2012 and early 2013, with the goal of building strong partnerships and gaining buy-in from stakeholders who could serve as partners when its campaign was launched. Similarly, both Oregon and Colorado conducted over 100 public meetings with individuals and organizations across the state.

More concerted planning efforts typically began in the latter half of 2012, or even early 2013, mostly by design; state officials often cited the rationale that it was critical to avoid the mistake of marketing too early, before their "products" were ready. Premature advertising, they explained, would simply frustrate the target audience by raising expectations (and potentially causing confusion) when coverage options were not yet available.

Work across the SBM states progressed similarly, in a series of phases. After hiring private-sector marketing and advertising firms, states initiated the following steps:

- First, they conducted market research to identify and segment various target audiences, test alternative brands and messages with focus groups of consumers, and select those traits that appeared most promising;
- Second, they began "softening" the market by launching websites, brand-names and logos, and establishing the identities of their programs to begin building consumer anticipation;
- Third, they launched the "call to action" phase, involving a mass media "blitz" of advertising to drive interest in enrollment, just prior to and during the open enrollment season; and
- Fourth, they will maintain a steady, sustainable level of advertising over time, as open enrollment winds down and coverage begins.

Meanwhile at the federal level, little detail is known about the marketing plans that are under development and will be launched in FFM and FFM-P states. Within a year after passage of the ACA, the public relations firm Porter Novelli received a nearly \$10 million contract to help DHHS implement the law.³⁵ Since then, DHHS has awarded a total of \$44 million in contracts to the firm Weber-Shandwick—the same firm that helped Massachusetts launch its *Health Connector* and health reform coverage expansions in 2006—to design and conduct a public education and outreach campaign for the 34 FFM/

FFM-P states. But information about the content of this campaign is not yet available, beyond the announcement that it will use a range of communications tactics—with an emphasis on paid media and digital outreach—to make the uninsured aware of available HIM and health insurance options. DHHS recently supplemented its contract with Porter Novelli with an additional \$20 million,³⁶ but no details about the planned activities of the firm were publicly available at the time of this writing.

2. Communicating with consumers

In describing their communications strategies, states generally spoke of developing broad, overarching messages for the population as a whole, as well as more targeted messages to reach “niche” audiences, such as young adults or ethnic minorities. Examples of results from states’ market research included the following:

- Officials in New York, Rhode Island, and Oregon said that people of all income groups responded well to messages such as “everyone wants coverage,” “everybody needs insurance,” and “affordable insurance for all.”
- “Connecting” to coverage was a verb that tested well with most audiences, while the word “exchange,” interestingly, did not since it implied consumers would have to “give up” something in exchange for insurance.
- “Marketplace” tended to test more positively, but did not always resonate well with low-income groups, who have not always fared well in marketplaces.
- Messages that associated coverage with government programs received varied reception, depending on the audience; higher-income groups tended to have negative feelings about government programs, while lower-income groups trusted them.
- Audiences displayed “love/hate” associations with health insurance; consumers generally valued insurance, but had negative opinions of insurance companies.
- Men were motivated by messages that spoke to “financial security,” while women responded better to messages focused on “being prepared for the unexpected.”

Officials also consistently described plans for using a wide range of tools through which to reach consumers, including paid and earned media (including television, radio, and print—such as newspaper and billboard advertising); Internet and social media (including websites, Facebook, Twitter, and YouTube); and in-person outreach to “go where the people are” (and as a means of educating consumers and overcoming confusion and misinformation via trusted messengers “delivering the truth.”) States are also developing marketing materials in multiple languages,

and officials described media strategies that included using various ethnic television and radio outlets.

At the time of this writing, a number of the study states had launched their media campaigns, including their first television commercials. Examples include the following:

- *Connect for Health Colorado* uses a website/marketplace that resembles travel sites like Expedia, with competing insurance companies and a choice of coverage levels. In the state’s first television ad, after actors choose a health plan, the walls of their homes slide away to reveal various celebratory scenes, such as winning the jackpot in a casino, or being sprayed with champagne in a locker room, or standing aside a horse in the winner’s circle. The ad closes with the tag line: “When health insurance companies compete, there’s only one winner: you.”³⁷ The campaign was designed by Pilgrim, a Denver-based advertising and digital marketing agency; the state has set aside more than \$10 million to spend on such marketing and advertising.
- *Cover Oregon’s* new commercials employ a number of amusing folksy and hipster scenes that feel decidedly home-grown. In one, a plaid flannel-shirted young man strums a guitar and sings a Woody Guthrie-esque song called “Long Live Oregonians,” with the verse “We’re free to be healthy, gonna breathe that fresh air, wanna get the best care, that a state can get.” The campaign, developed by North—a Portland-based branding and advertising agency—also features other Oregon-based musicians in television and web-only music videos, as well as visual artists in print ads and on billboards. A promotional budget of almost \$10 million will cover the cost of ad placement, agency fees, and public relations efforts.³⁸
- Minnesota has chosen to play off its state motto—the “Land of 10,000 Lakes”—for the slogan of its SBM, *MNSure*: “Land of 10,000 Reasons to Get Health Insurance.” The state’s campaign—developed by the advertising and marketing organization BBDO Proximity Minneapolis—enlists Minnesota folklore icons Paul Bunyan and his sidekick Babe the Blue Ox as the “faces” of its marketing campaign. Videos and billboards feature Bunyan suffering a series of humorous accidents—while water skiing, playing soccer, and ice fishing, for example—that highlight the various reasons why Minnesotans need health insurance. In one radio spot, Bunyan gets into an argument with an angry beaver that bites him. He’s heard calling out to Babe, “A little help?”³⁹
- *New York State of Health* is the brand name of New York’s marketplace. With a \$40 million budget, the state hired the Manhattan-based DDB Worldwide to develop a campaign with television, print, online, and transit

advertising. The campaign's first YouTube ad plays off the title of Billy Joel's iconic 1976 song, "New York State of Mind," and shows scenes of New York City, Niagara Falls, and various rural and suburban settings, and voiceovers that speak to the "can do" attitude of New Yorkers and encourage residents to explore their options and choose a plan that fits their needs.⁴⁰

Notable is the fact that none of these early ads mention "Obamacare," but rather focus on how each state is about to launch its own online marketplace for consumers. Marketing experts praise this, saying that the strategy avoids the negative controversy that has surrounded the ACA, and instead evokes a more personable and accessible, state-specific feel.⁴¹

Campaigns in every state are well supported by websites that are colorful, attractive, and easy to understand. The sites include such features as subsidy calculators, countdown-to-coverage clocks, educational videos, and testimonials from consumers who have benefited from having health insurance. New Mexico had not launched its campaign yet, as it contracted with a public relations firm just two months before its marketplace is scheduled to open. But officials in that state noted that one strategy would target outreach and education to federally recognized American Indian tribes, including specific websites for these populations.

Once again, for states not establishing their own SBMs, national-level media campaigns and resources will have to suffice for consumers. While the content and message of the federal/Weber-Shandwick campaign is not yet known, outside of the federal government the not-for-profit Organizing for America's first commercials have been aired—on both television and the Internet—reflecting positive, simple, and uplifting messages about new coverage under the ACA. Focusing on community-level outreach, Enroll America (also a nonprofit) launched its "Get Covered America" campaign over the summer by deploying thousands of staff and volunteers to conduct grassroots, door-to-door outreach in 10 states with the largest numbers of uninsured residents to spread the word about new coverage options.⁴² (Nine of these states have Republican governors. Not one has established an SBM although two will operate FFM-Ps. Only a few—Arizona, Illinois, New Jersey, and Michigan—have decided to expand their Medicaid programs.) Outreach workers involved in this campaign are engaging and educating consumers about the ACA and how they can enroll in coverage programs. A particular emphasis is being placed on so-called "young invincibles" so that a significant proportion of new enrollees are younger, healthier individuals to help offset the more likely enrollment of older

populations with greater health care needs. Other private sector efforts to raise public awareness of new coverage options include those announced by drugstore chains CVS and Walgreens earlier this year—both companies will launch outreach campaigns to help educate and assist customers with applying for coverage.⁴³

In June 2013, the Obama Administration also relaunched its healthcare.gov web portal for the FFMs, and opened a 24-hour call center with a toll-free number (1-800-318-2596) to help consumers prepare for open enrollment. To run the call center, DHHS contracted with Vangent, the same Virginia-based firm that provides such support services for the Medicare Part D prescription drug program. With \$530 million in funding, Vangent will run both the Medicare and federal health marketplace call centers, and is expected to receive 42 million calls about the FFMs this year, a daily average of up to 200,000 calls. The firm will also handle responses to an estimated 2,400 letters and 740 emails a day, while hosting 500 web chats daily. It is expected that Vangent's prior experience running the 1-800-Medicare hotline will provide valuable experience as it adds health reform-related calls to its scope of work.⁴⁴

3. Helping marketplaces spread the word

As mentioned above, states closely engaged with a wide range of stakeholders during the early planning processes for SBMs. This collaboration not only gained front-end cooperation and buy-in among diverse groups, but also created "built-in" partners for future outreach. Indeed, most states said they would turn to these partners—community-based organizations, health care providers, brokers and agents, philanthropic foundations, and sports franchises—to help them spread the word about new coverage options. For example, *Connect for Health Colorado* is following the example of Massachusetts (which enlisted the help of the Boston Red Sox to promote the *Health Connector* and new coverage options) by developing partnerships with professional sports teams (e.g., the Colorado Rockies) to promote public education about the marketplace at games this summer and fall. And Michigan officials stated a similar desire to use major sports teams to help them promote their expanded coverage options, when the time came.

Worth noting are two states' particular focus on health plans as marketing partners. Under its *Family- and Child Health Plus* programs, New York has long capitalized on managed care organizations' marketing expertise to help advertise coverage to eligible populations. The state plans to do the same under the ACA, striking a careful

balance between allowing health plans to advertise new coverage and closely regulating these entities to ensure that they don't engage in any inappropriate behaviors that would unfairly steer business their way.⁴⁵ Colorado is working with health plans across the state as well, as it

develops its "culture of coverage" campaign. Specifically, multiple health plans are discussing strategies for pooling resources to purchase media time and present advertisements that promote coverage broadly, without saying anything specific about the participating plans.

PLANS AND PROGRESS WITH ENROLLMENT ASSISTANCE

Once again, the ACA requires the development of integrated eligibility and enrollment systems that enable an easy, seamless, readily-accessible, and consumer-friendly enrollment process. Furthermore, the law stipulates that consumers must be able to apply through multiple avenues, including online, in person, by mail, or by telephone.⁴⁶ Not surprisingly, therefore, state officials interviewed for this study reported that they envision enrollment assistance systems with a number of tiers, to meet different consumers "where they are." Typically, these officials described:

- Websites, where real-time "chat" assistance is available;
- Call centers, where phone assistance can be provided; and
- Hands-on assistance to consumers who need extra help navigating the application process, provided by staff of social and human services agencies, community-based organizations, health care providers, health plans, and a variety of alternative sites such as community colleges, health fairs, and even tax preparers' offices.

Details about states' plans to provide hands-on application assistance are provided below.

1. Three types of assistors, but uniform functions and training

At the time of this study's interviews with state officials, federal guidance regarding different categories of assistors was still emerging. Thus, officials were becoming aware of the distinctions (discussed above) between Navigators, IPAs, and CACs. However, they were much more focused on the goal of creating an enrollment assistance infrastructure with common functions—educating consumers about available options, helping to complete program applications, and assisting with health plan selection—than the details of how each type of assistor would be funded. "We don't want to overthink this..." offered one state official.

To support this infrastructure, officials in the SBM states envisioned setting up a single, centralized training program, with a common vendor and curriculum that would train enrollment assistors on federal rules surrounding enrollment

assistance, how to assist individuals with completing applications, and how to provide effective customer service. While many decisions related to enrollment assistor training were outstanding at the time of this study's interviews, in subsequent months much more information about the study states' training programs has been released. See Appendix A for a table (adapted from an external source) highlighting some key characteristics of states' requirements for training enrollment assistors. States vary in the number of hours of training they will require, for instance, with several requiring no more than 30 hours and one (Maryland) requiring four times that level. There is also variety in the format of training programs in the SBM states. Minnesota and New Mexico will use online training, while Maryland and Rhode Island's trainings will be in-person, and Colorado, New York, and Oregon will use a combination of the two formats. Several states will rely on a "train the trainer" model, in which application assistors are trained and then responsible for disseminating the information within their own organizations or communities. Additionally, in some states it is clear that enrollment assistors will be required to undergo recertification or continuing education on a regular basis; in others, such requirements are still under consideration.

In July 2013, DHHS released its final rules for the Navigator program that will operate in the 34 states with FFM or FFM-Ps. These rules specified that Navigators must be affiliated with certain community organizations, such as churches, and that they must undergo at least 30 hours of training to be qualified as certified Navigators. The rules confirmed that states with SBMs can establish more rigorous selection and training requirements for enrollment assistance entities, which (as Appendix A demonstrates) many have done.⁴⁷ Online consumer assistance training modules have been released by DHHS for use by Navigators. These modules provide a basic framework for interacting with consumers, from the initial assessment of the consumer needs, consumer education, the importance of privacy and security of consumers' personal information, and the eligibility and enrollment process. A more in-depth, 200+ page Standard Operating Procedures manual has

also been shared, which provides step-by-step guides on activities like creating and maintaining a marketplace account, filling out an application, choosing a plan, and assisting consumers with eligibility appeals.⁴⁸

2. States are not starting from scratch in creating enrollment assistance programs

Importantly, state officials reported that they were not “starting from scratch” in setting up their infrastructures for enrollment assistance under the ACA. Rather, all of the states interviewed for this study—including both states with SBMs and those with FFM/FFM-Ps—described their extensive prior experience administering application assistance models under CHIP and Medicaid, and their plans to build off that foundation in creating new systems under the ACA.

Programs such as Alabama’s *Application Assistance Network*, New York’s *Facilitated Enrollment*, Rhode Island’s *Family Resource Counselors*, New Mexico’s *Presumptive Eligibility/Medicaid On-Site Application Assistance (PE/MOSAA)*, Minnesota’s *Community Application Assistance*, Oregon’s *CHIP Application Assistors*, and Virginia’s *Project Connect* have, for years, helped parents enroll themselves and/or their children into Medicaid and CHIP. Typically supported by either grants or contracts, the organizations comprising states’ application assistance networks have included community-based organizations, schools and Head Start programs, health care providers, FQHCs, churches, and health plans, among others.

State officials acknowledged that these programs have traditionally been focused on maternal and child populations, and are therefore insufficient for reaching the new populations that will be eligible for the ACA’s Medicaid expansions or the HIM-based subsidies. Yet they insisted that their precursor application assistance models formed a solid foundation upon which to build broader networks, and consistently reported that years of experience managing these programs provided them a “leg up” on establishing and overseeing new application assistance infrastructures under the ACA.

Most states had written “requests for proposals” at the time of this study’s interviews, released them during the spring of 2013, and had begun making awards and launching training by the time of this writing. Several mentioned the goal of supporting as many as 300 to 400 full-time equivalent staff across entities that would provide application assistance. Similarly, in April 2013, DHHS released its Request for Proposals (RFP) for Navigators in the 34 FFM/FFM-P states.

3. Application assistance models taking shape

At the time of this writing, four study states with SBMs had made awards to groups that would help them provide application assistance to consumers.

- In Maryland, officials divided the state into six regions that are roughly aligned with the state’s Medicaid managed care regions. They then issued six separate RFPs to attract entities that reflected a “local flavor” in each region, and required applicants to describe their regional history and presence, demonstrate their connections to health and human services organizations in their regions, and detail their plans for how they would build, oversee, and coordinate their networks of trusted local organizations that would serve as subcontracted application assistors. Awards totaling \$24 million were made in June to six entities, including local health departments, family support agencies, community-based organizations, and a health care system.
- In June 2013, awards totaling \$17 million were made to more than 50 Assistance Sites that will comprise Colorado’s *Connect for Health Assistance Network*. Six entities were identified as Regional Assistance Hubs, which will take on the responsibility of supporting collaboration, outreach, and training among the Assistance Sites in their respective regions. Grantee organizations include 19 community/nonprofit and faith-based organizations, 18 hospitals and clinics, 13 public health or human services organizations, and two trade associations.⁴⁹ Several of these organizations were identified as catering to specific audiences, such as the Colorado Motor Carriers Association and Denver Indian Health and Family Services.⁵⁰
- Minnesota’s marketplace (*MNsure*) announced 30 Outreach and Infrastructure Grant recipients for its IPA Program in August 2013. The recipients are located “all across Minnesota” and represent “new and existing organizations that have direct connections and experience with key audiences.”⁵¹ Though individual award amounts and contracts have yet to be finalized, *MNsure* plans to award up to \$4.75 million across two phases of grants and will pay a \$70 per-enrollment payment for assistors.⁵² *MNsure* has delegated its Navigator Program to the existing Minnesota Community Application Agent (MNCAA) initiative, which was created in 2007 to assist consumers with applying for public coverage. Like MNCAA, the Navigator program will be funded by an existing appropriation to the Minnesota Department of Human Services.
- In July 2013, *NY State of Health* granted conditional awards totaling almost \$27 million to 50 organizations which will be supported by 96 subcontractors. The

selected organizations must complete the prequalification process per the New York State (NYS) Grants Gateway system and be approved by the Office of the NYS Comptroller in order to receive the grant money. All 62 counties are represented. The organizations include one Urban Indian organization and will offer services in 48 languages in total.⁵³

At the federal level, DHHS announced the 105 recipients of Navigator grants in the 34 FFM/FFM-P states entities in August 2013. With just a month before the first day of open enrollment, these grantees hired and trained staff to prepare them to provide enrollment assistance. While DHHS had originally said that \$54 million in grants would be made, the actual awards totaled \$67 million after it transferred roughly \$13 million from the ACA's prevention fund to bolster the monies available for Navigator grants. Across the three study states with FFM/FFM-Ps—Alabama, Virginia, and Michigan—anticipated grant amounts total approximately \$5.7 million.⁵⁴

The list of Navigator grant recipients includes some surprises. While it includes many nonprofit community-based organizations and providers that traditionally serve vulnerable populations—such as United Way organizations, Planned Parenthood clinics, legal aid societies, and visiting nurse associations—it also includes a significant number of for-profit hospital “recovery” companies, such as Advanced Patient Advocacy LLC, and Cardon Healthcare Network LLC. These companies are generally hired by hospitals to try to recover payments from uninsured and underinsured patients, and in so doing, can have considerable experience helping people sign up for Medicaid, CHIP, and other state and local coverage programs. Still, some analysts are concerned that their primary motivation has historically been to ensure that hospitals get paid, not to act on behalf of consumers, and urge that DHHS carefully monitor all grantees to guard against potential conflicts of interest.⁵⁵

CONCLUSIONS AND FUTURE OUTLOOK

With open enrollment now underway, it appears that states and the federal government have taken many of the steps necessary to successfully promote insurance affordability programs, educate the public about new coverage options coming available under health care reform, and create new infrastructures for providing consumers with enrollment assistance. Following the playbook and lessons learned from previous expansions of coverage under Medicaid, CHIP, and other state coverage initiatives, policy-makers are launching multi-pronged campaigns that combine broad marketing with grass-roots outreach. Critically, they are equipping community-based outreach entities with the tools and training to also provide hands-on application assistance to consumers who need help navigating the enrollment process, typically building on existing networks of application assistors that have operated for years within Medicaid and CHIP programs. The most impressive efforts have involved diverse stakeholders from the beginning of the planning process, to gain their early input and buy-in, and to create long-term outreach partners that can help spread the word as expansions are implemented.

What is striking, however, is that while state and federal policy-makers are both taking many of the right steps, they are doing so at very different levels of intensity. And these differences are likely to result in state-to-state variation in terms of the ultimate measure of success: consumer enrollment into coverage.

Specifically states that aggressively implemented the ACA have not only established their own SBMs, they have also invested millions of dollars (primarily from federal marketplace planning and establishment grants) to implement state-specific marketing campaigns that reflect the input of consumers and showcase unique themes and concerns of state residents. In other words, they are tailored and designed to “work” in their states. What’s more, these states have targeted substantial resources to support enrollment assistance networks that will bolster marketing campaigns by providing consumers with hands-on help with completing the application process.

In contrast, states that have resisted health care reform have typically also chosen not to create their own marketplaces, and instead will rely on FFMs or FFM-Ps to enroll consumers into coverage. By extension, these states have also not engaged in the same kind of robust and enthusiastic planning for the launch of health coverage expansions, including planning for marketing and enrollment assistance. Indeed, political forces have often actively discouraged such efforts. As a result, a majority of states across the nation will defer to federal and national-level efforts to promote the availability of new coverage, coupled with federally funded and volunteer efforts to support enrollment. By definition, such efforts are likely to be somewhat generic in message and tone so that they can be implemented across numerous and diverse states and will thus lack the benefit of uniqueness and state-specific “flavor.” Even more important,

perhaps, is the fact that federal monies supporting marketing and enrollment assistance will be spread thinly across the 34 FFM/FFM-P states, and thus may not be able to match the intensity of investment made by SBM states. In other words, while FFMs and FFM-Ps may work just as well as their state-based counterparts, they may not be supported by the same level of marketing and enrollment assistance support, and thus may not be able to achieve the same level of enrollment.

Of course, one cannot predict at this time how things will actually play out. Regardless, state and federal policy-makers would be wise to consider another set of lessons from prior experiences with program expansions:

- Marketing and outreach are not “one shot” deals. Private-sector commercial advertising is ongoing in nature, designed to keep products highly visible and constantly on the minds of consumers. Thus, it will be critical for state and federal officials to similarly saturate target markets with steady and repeated airings of television, radio, and print advertisements so that consumers become widely aware of, and well informed about, the benefits and options available under the ACA. What’s more, these efforts will need to be sustained over the long term.
- The experiences of early adopters of health reform, and particularly those of states with SBMs that have invested in extensive outreach and enrollment assistance planning, should help other states to adopt effective marketing messages, tools, and strategies, as well as enrollment assistance models. Over time, these strategies and models can be adapted to changing conditions, refined, and improved.
- Marketing and enrollment assistance aside, state and federal policy-makers must ensure that their new eligibility/IT infrastructures work as planned and provide

consumers with a user-friendly and seamless process for enrolling into coverage, selecting qualified health plans, and determining eligibility for subsidies. No amount of marketing or enrollment assistance can compensate if these eligibility systems do not work well. To be sure, there will be glitches and problems upon launch, but fixing and fine-tuning these systems should be policy-makers’ first priority as reform rolls out.

Finally, both the history of prior coverage expansions and the current circumstances of the ACA argue for perseverance. Public education, outreach, and marketing will need to be intensive and sustained. Enrollment and retention procedures will need to be tweaked, refined, and continuously improved. And enrollment assistance networks will need to grow and encompass the full range of partners needed to reach all eligible consumers. Over time, if such continuous improvement occurs, enrollment will increase as state and federal policy-makers work to enroll America’s eligible uninsured into coverage offered by the Affordable Care Act—thereby fulfilling the promise of the most important domestic legislation enacted in nearly half a century.

Appendix A: Enrollment Assistance Training in the Study States

State	Model	Assistor Type Program/ Assistor Name	Awarded Grants?	Training Entity	Training Format/ Curriculum	Hours	Testing	Other Conditions of Certification	Evaluation	Continuing Education
Alabama	FFM	Navigator	Yes	CMS	Online Training module standards in final rule	Up to 30 hours	Pass a test assessing competency in training categories	Information not available	Information not available	Information not available
Colorado	SBM	Navigator Connect for Health Assistance Network (CHAN) (Navigators and IPAs both called Health Coverage Guides)	Yes	Training curriculum provided by Connect for Health Colorado (C4HCO) to assistance sites that will hire, train & supervise Health Coverage Guides	Both online and in person; train the trainer model; available summer 2013	TBD, but likely a total of 43 hours	Pass a training assessment	Employment at assistance site; background check	Evaluated based on metrics such as progress toward expected outreach, service & enrollment outcomes, meeting certification requirements & customer satisfaction	Participate in training updates as necessary
		IPA CHAN								
Maryland	SBM	Navigator Regional Connector Entities	Yes	GP Strategies Corporation	In person; RFP outlines broad headings of Policies and Procedures, Individual Affordability Programs, & Maryland Health Connection	120 hours	Final exam	Information not available	Evaluated based on factors such as 1) impact on enrollment 2) enrollment of vulnerable/hard-to-reach populations 3) whether or not steering is occurring 4) consumer satisfaction 5) level of effort required to enroll an individual (bonuses based on enrollment targets)	Yes, annually
		IPA Assistors	Yes	GP Strategies Corporation	Train the trainer; curriculum for Navigators is to be modified for assistors	60-80 hours	Final exam	Information not available	Information not available	Information not available
Michigan	FFM	Navigator	Yes	CMS	Online Training module standards in final rule	Up to 30 hours	Pass a test assessing competency in training categories	Information not available	Information not available	Information not available

Source: Adapted from the State Approaches to Consumer Assistance Training table available on the State ReFORUM website operated by the National Academy for State Health Policy. Available at: <https://www.statereforum.org/consumer-assistance-training>. Last accessed: September 11, 2013.

State	Model	Assistor Type Program/ Assistor Name	Awarded Grants?	Training Entity	Training Format/ Curriculum	Hours	Testing	Other Conditions of Certification	Evaluation	Continuing Education
Minnesota	SBM	Navigator	Yes; existing Minnesota Dept. of Human Services (MNCAA) Program	Information not available	Online	TBD	Final exam, 70% or better score on each course	Background check	Performance metrics that assess outreach, education & enrollment assistance; specific requirements will be outlined in award; grantees may also be subject to monitoring & audits	Information not available
		IPA <i>In-Person Assistor Program</i>	Yes							
New Mexico	SBM	Navigator <i>Healthcare Guides</i>	No	NM Health Insurance Exchange	Likely to be mostly online; guides will be trained to explain coverage options & refer customers to additional resources	At least 30 hours	Information not available	Background check	Information not available	Information not available
		IPA <i>Healthcare Guides</i>								
New York	SBM	Navigator <i>Facilitated Enroller</i>	Yes	NY Dept. of Health (DOH)	Online (webinar-based) & in person; may include train the trainer; curriculum under development & training module will include topics such as eligibility & enrollment rules & underserved & vulnerable populations	Information not available	Information not available	Information not available	IPA/Navigator contractor will monitor productivity and submit reports; contractors with substandard performance will not be reimbursed	Potential ongoing training
		IPA <i>Facilitated Enroller</i>								
Oregon	SBM	Navigator <i>Application Assistors</i>	Yes	OHA or Cover Oregon	Both online and in person	<1 day online, 8 in person	Complete course	Background check and must have liability & auto insurance	Information not available	Certification & training must be renewed annually
	SBM	IPA <i>Community Partners/ Application Assistors</i>	Yes	OHA or Cover Oregon	Both online and in person; online module	<1 day online, 4 in person	Information not available	Background check and must have liability & auto insurance	Information not available	Certification & training must be renewed annually

Source: Adapted from the State Approaches to Consumer Assistance Training table available on the State ReFORUM website operated by the National Academy for State Health Policy. Available at: <https://www.statereform.org/consumer-assistance-training>. Last accessed: September 11, 2013.

State	Model	Assistor Type Program/ Assistor Name	Awarded Grants?	Training Entity	Training Format/ Curriculum	Hours	Testing	Other Conditions of Certification	Evaluation	Continuing Education
Rhode Island	SBM	Navigators Assistors	Grants to be awarded in September 2013	Network manager entity	In person, train the trainer	Information not available	Pass/fail written exam	Information not available	Performance-based evaluation metrics in process of development but could include enrollment rates of certain demographic groups & customer service	Continuing education will likely be required by the exchange
		IPA Assistors								
Virginia	FFM	Navigator	Yes	CMS	Online Training module standards in final rule	Up to 30 hours	Pass a test assessing competency in training categories	Information not available	Information not available	Information not available

Source: Adapted from the State Approaches to Consumer Assistance Training table available on the State ReFORUM website operated by the National Academy for State Health Policy. Available at: <https://www.statereforum.org/consumer-assistance-training>. Last accessed: September 11, 2013.

ENDNOTES

1. Congressional Budget Office (CBO), staff of the Joint Committee on Taxation. *CBO's May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage*. May 14, 2013. http://cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf.
2. Kaiser Family Foundation, *Status of State Action on the Medicaid Expansion Option, as of September 2013*. Available at: <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.
3. Robert Wood Johnson Foundation. *Health Insurance Exchanges and State Decisions*. Health Affairs, July 18, 2013.
4. The number of enrollees in the nongroup health insurance market is estimated to drop by roughly 2 million individuals, bringing the total number of individuals gaining coverage under the ACA to 14 million. See: Congressional Budget Office, *CBO's May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage*, Available at: http://cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf.
5. CBO, *ibid*.
6. Kaiser Family Foundation. *Health Tracking Poll: April 2013*. Available at: <http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-april-2013/>.
7. Udem, Tresa and Michael Perry. *Informing Enroll America's Campaign: Findings from a National Study*. January 2013. Available at: http://files.www.enrollamerica.org/best-practices-institute/public-education-resources/EA_Final_Report.pdf.
8. Ornstein, Norman. "Death panels' are real—brought on by budget pressures." January 1, 2011. Available at: <http://www.washingtonpost.com/wp-dyn/content/article/2010/12/31/AR2010123102727.html>.
9. Di Benedetto, C. *Identifying the Key Success Factors in New Product Launch*. Journal of Product Innovation Management. Volume 16, Issue 6, pgs. 530–544. November 1999.
10. Kliff, Sarah. (May 8, 2013) *Democrats Say There's a Reason They're Not Selling Obamacare Yet*. Washington, DC: The Washington Post. <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/05/08/democrats-say-theres-a-reason-theyre-not-selling-obamacare-yet/>.
11. Patient Protection and Affordable Care Act, Pub. L. No. 111–148 Section 2201.
12. Patient Protection and Affordable Care Act, Pub. L. No. 111–148 Section 2001.
13. Patient Protection and Affordable Care Act, Pub. L. No. 111–148 Section 1311.
14. Department of Health and Human Services. *Proposed Rule on Navigator Standards* (45 C.F.R. section 155.210). March 5, 2013.
15. Napel, Shelly Ten and Daniel Eckel. "Navigators and In-Person Assistors: State Policy and Program Considerations." Princeton, NJ: State Health Reform Assistance Network, Robert Wood Johnson Foundation. March 2013. Available at: <http://www.statenetwork.org/wp-content/uploads/2013/02/State-Network-Navigators-and-IPAs-State-Policy-and-Program-Design-Considerations.pdf>.
16. Center for Medicare and Medicaid Services, Department of Health and Human Services. *Standards for Navigators and Non-Navigator Assistance Personnel*. July 2013. Available at: <http://www.gpo.gov/fdsys/pkg/FR-2013-07-17/html/2013-17125.htm>.
17. Department of Health and Human Services. *Standards for Navigators and Non-Navigator Assistance Personnel, Final Rule*. July 17, 2013. Available at: <https://www.federalregister.gov/articles/2013/07/17/2013-17125/patient-protection-and-affordable-care-act-exchange-functions-standards-for-navigators-and>.
18. Enroll America. "How Can Consumers Get Help Enrolling in Health Coverage?" Washington, DC: Enroll America. March 2013. http://files.www.enrollamerica.org/best-practices-institute/enroll-america-publications/Enrollment_Assisters_Fact_Sheet.pdf.
19. One of the earliest funding opportunities provided to states were through the Consumer Assistance Programs (CAP) grants, which were authorized for FY2011 (ACA, Section 2793). These funds were designed to "help consumers enroll in self-insured group health plans and collect data about problems encountered by consumers." As of FY2012, over \$45 million has been awarded to states in CAP grants (Kaiser 2012).
20. To qualify for a Level Two Establishment grant, states must also have legal authority to establish and operate a marketplace that complies with federal requirements; a marketplace governance; a budget and initial plan for financial sustainability by 2015; and a plan outlining steps to prevent fraud, waste, and abuse (Healthcare.gov 2011).
21. Kaiser Family Foundation. "Health Insurance Exchange Establishment Grants." 2013. <http://kff.org/health-reform/state-indicator/exchange-establishment-grants/>.
22. Patient Protection and Affordable Care Act, Pub. L. No. 111–148 Section 10503.
23. Gold, Jenny. "Community Health Centers Get \$150 Million to Boost Exchange Enrollment." Washington, DC: Kaiser Health News. May 9, 2013. <http://capsules.kaiserhealthnews.org/?p=19357>.
24. Rosenbach, Margo, Carol Irvin, Angela Merrill, Shanna Shulman, John Czajka, Christopher Trenholm, Susan Williams, So Sasigant Limp-Amara, and Anna Katz. *State Children's Health Insurance Program: A Decade of Expanding Coverage and Improving Access*. 2007. Available at: <http://www.mathematica-mpr.com/publications/pdfs/schipdecade.pdf>.
25. Hill, Ian. *Reaching and Enrolling Children and Pregnant Women under CHIP and Medicaid: Lessons for Affordable Care Act Implementation*. Forthcoming.
26. vanDyck, P.C., B. Nangle, S.P. McDonald, T.J. Wells, and R.L. Betit. *Baby Your Baby: Utah's Program to Enhance Prenatal Care*. Salt Lake City, UT: Utah Department of Health and Family Services Division, 1991.
27. Hill, I., Hawkes, C., Harrington, M. *Final Cross-cutting Report on the Findings from Ten State Site Visits: Congressionally Mandated Evaluation of SCHIP*. Washington, DC: The Urban Institute; and Princeton, NJ: Mathematica Policy Research, Inc., for the Assistant Secretary for Planning and Evaluation, DHHS, 2003.
28. Flores G., Abreu M., Chaisson C.E., Meyers A., Sachdeva R.C., Fernandez H., et al. "A randomized controlled trial of the effectiveness of community-based case management in insuring uninsured Latino children." *Journal of Pediatrics*, 116:1433–1441, 2005.
29. Lake Research Partners. *Informing CHIP and Medicaid Outreach and Education: Key Findings from a National Survey of Low-Income Parents*. 2008. Available at: <http://www.insurekidsnow.gov/professionals/CHIP-Medicaid-Survey-Topline.pdf>.
30. Hill, Hawkes, and Harrington, *ibid*.
31. See Aizer, Anna. "Public Health Insurance, Program Take-Up, and Child Health." *The Review of Economics and Statistics*, 89, no.3:400–415, August 2007; Williams, Susan and Margo Rosenbach. "Evolution of State Outreach Efforts Under SCHIP." *Health Care Financing Review*, vol. 28, no. 4. 2007. Available at: <http://www.mathematica-mpr.com/publications/pdfs/evolutionstate.pdf>; and Lake Research Partners. *Informing CHIP and Medicaid Outreach and Education: Key Findings from a National Survey of Low-Income Parents*. November 2008. Available at: <http://www.insurekidsnow.gov/professionals/CHIP-Medicaid-Survey-Topline.pdf>.
32. U.S. Census Bureau, Current Population Survey (CPS): Annual Social and Economic (ASEC) Supplement Survey, 1998–2011. Note that several changes have been made to the CPS ASEC regarding health insurance status since 2000, including the addition of a health insurance verification and separate CHIP questions, as well as a correction to the assignment of private coverage and improvements to missing data allocation and coding correction.

33. Kenney, Genevieve, Victoria Lynch, Michael Huntress, Jennifer Haley and Nathaniel Anderson. "Medicaid/CHIP Participation Among Children and Parents." Washington, DC: The Urban Institute, December 2012.
34. Newman, Andrew. *Songs and Sunscreen Spread the Health Insurance Message*. New York, NY: The New York Times. August 1, 2013.
35. Begley, Sharon. "It takes an army: Tens of thousands of workers roll out Obamacare." June 21, 2013. Available at: <http://www.reuters.com/article/2013/06/21/usa-healthcare-hiring-idUSL1N0EJOYU2013062>.
36. Baker, Sam. "HHS adds \$33 million to ObamaCare PR Contract." July 17, 2013. Available at: <http://thehill.com/blogs/healthwatch/health-reform-implementation/311817-hhs-adds-33-million-to-obamacare-pr-contract>.
37. Newman, A. August 2, 2013. Videos available at: <http://www.youtube.com/user/ConnectForHealthCO?feature=watch>.
38. Newman, ibid. Videos available at: <http://www.youtube.com/user/CoverOregonVideo?feature=watch>.
39. Lopez, Ricardo. "Paul Bunyan, ox sidekick hired as insurance salesmen in Minnesota." Los Angeles Times, August 19, 2013. Video available at: <http://video.mpr.org/services/player/bcpid55300488001?bckey=AQ~-AAAADLwIGZk-c7TfWQ3MmuAc9-QnpeuM470sI5gb1R6v&bclid=0&bctid=2615261630001>.
40. Galewitz, Phil. "With a Nod to Billy Joel, NY Brands Obamacare Marketplace." Capsules, Kaiser Health News Blog, August 20, 2013. Video available at: <http://www.youtube.com/watch?v=3C1XPRjQPnY>.
41. Galewitz, ibid.
42. Arizona, Florida, Georgia, Illinois, Michigan, New Jersey, North Carolina, Ohio, Pennsylvania, and Texas.
43. Corbett Dooren, Jennifer. "CVS Plans to Help Customers Sign Up for Obamacare." July 25, 2013. Available at: <http://blogs.wsj.com/washwire/2013/07/25/cvs-plans-to-help-customers-navigate-obamacare/?KEYWORDS=medicare>.
44. Jaffe, Susan. "Contractor that handles public's Medicare queries will do same for Affordable Care Act." Washington Post, June 20, 2013.
45. New York State of Health. *NY State of Health Brand Guidelines*. August 28, 2013. Available at: <http://www.healthbenefitexchange.ny.gov/resource/ny-state-health-brand-guidelines>.
46. Patient Protection and Affordable Care Act, Pub. L. No. 111-148 Section 1413.
47. Department of Health and Human Services, July 17, 2013, op cit.
48. Corlette, Sabrina. "Updates on Consumer Assistance: Navigator Grants and Training", Georgetown University Center on Health Insurance Reforms, August 26, 2013.
49. Connect for Health Colorado. "Connect for Health Assistance Network: Update on Assistance Network Grantees." http://www.connectforhealthco.com/?wpfb_dl=735.
50. Connect for Health Colorado. "Connect for Health Assistance Network Assistance Sites and Hubs." http://www.connectforhealthco.com/?wpfb_dl=737.
51. MNSure. "Outreach and infrastructure grant recipients announced." August 23, 2013. <http://www.mnsure.org/news-room/news/index.jsp>.
52. MNSure. "MNSure Funding Announcement: Outreach and Infrastructure Consumer Assistance Partner Grant Program." <http://www.mnsure.org/news-room/news/index.jsp>.
53. New York State Department of Health. "Press Release for In-Person Assistors/Navigators Conditional Grant Awards." July 12, 2013. <http://healthbenefitexchange.ny.gov/news/press-release-person-assistorsnavigators-conditional-grant-awards>.
54. Centers for Medicare and Medicaid Services. "Navigator Grant Recipients." <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/navigator-list-8-15-2013.pdf>.
55. Corlette, ibid

Copyright© September, 2013. The Urban Institute. Permission is granted for reproduction of this file, with attribution to the Urban Institute.

About the Authors and Acknowledgements

This study was funded by the Robert Wood Johnson Foundation. Ian Hill is an institute fellow, Brigitte Courtot is a research associate, and Margaret Wilkinson is a research assistant at the Urban Institute's Health Policy Center. The authors are grateful to Sarah Gadsden for her assistance with preparing this brief, and to reviewers John Holahan and Linda Blumberg for their comments and suggestions.

About the Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to health and health care, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, measurable, and timely change. For more than 40 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit www.rwjf.org. Follow the Foundation on Twitter www.rwjf.org/twitter or Facebook www.rwjf.org/facebook.

About the Urban Institute

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic, and governance problems facing the nation. The views expressed are those of the author[s] and should not be attributed to the Urban Institute, its trustees, or its funders.