Health Care Foundation
OF GREATER KANSAS CITY

MARKETPLACE COVERAGE INITIATIVE EVALUATION

PROMOTING HEALTH AMONG THE UNINSURED

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A report prepared for the

Health Care Foundation of Greater Kansas City

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HEALTH CARE FOUNDATION OF GREATER KANSAS CITY MISSION…

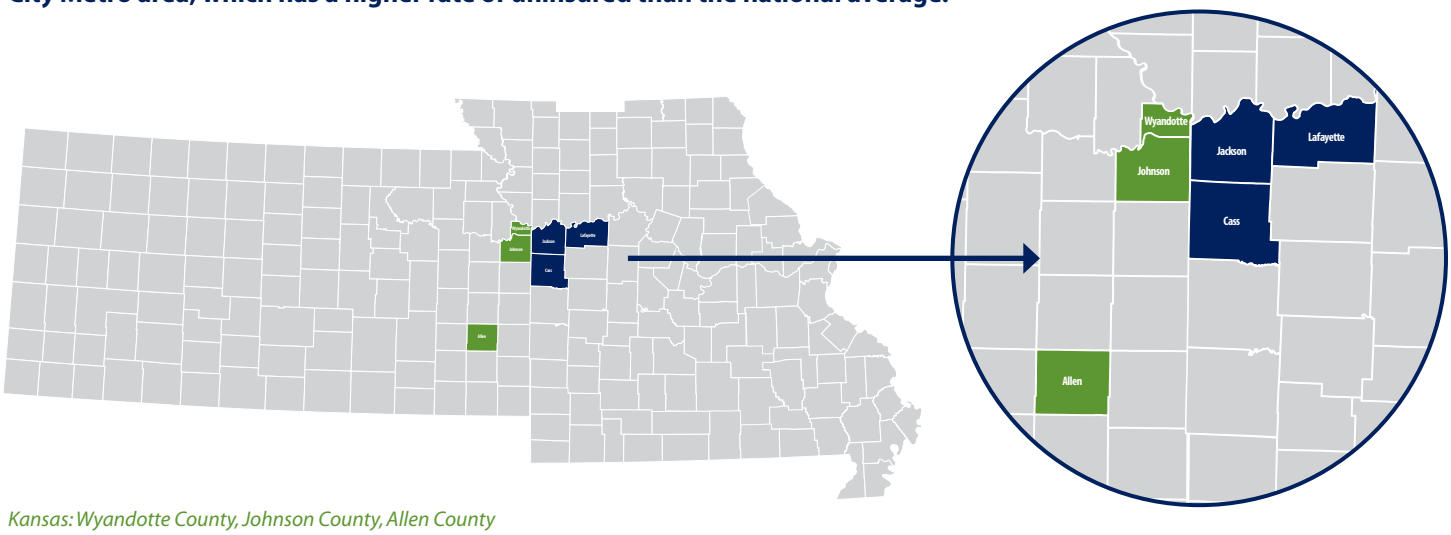
…to provide leadership, advocacy and resources to eliminate barriers and promote quality health for the uninsured and underserved in our service area.

This mission overlaps with a number of public policies aimed toward addressing the health care needs of vulnerable populations including The Patient Protection and Affordable Care Act of 2010 (ACA). With the passage of the ACA most individuals are now required to obtain health insurance, whether it is through an employer, the expansion of Medicaid, or cost-sharing subsidies provided for plans purchased from the Health Insurance Marketplace.

Neither Kansas nor Missouri have chosen to expand Medicaid to 138 percent of the federal poverty line. This left many lower income households in the HCF service area with limited options to obtain health insurance. Those with income less than 100 percent of federal poverty line fall into a health insurance "gap" as their incomes are not high enough for subsidies in the Marketplace but are too high (for those with children) to be eligible for Medicaid.

ACA provisions have the potential to expand health insurance coverage and access to health care for underserved populations, but the complexities of the law including subsidy eligibility and penalties as well as the complex nature of health insurance decision making likely limit the effectiveness of the policy for vulnerable households. Recognizing these issues, HCF undertook outreach efforts to inform underserved, uninsured households about new options available under the ACA. This report outlines the HCF outreach efforts, and lessons learned through implementation and evaluation.

The HCF service area comprises 6 counties in Kansas and Missouri centered on the Kansas City Metro area, which has a higher rate of uninsured than the national average.



Kansas: Wyandotte County, Johnson County, Allen County
Missouri: Jackson County, Cass County, Lafayette County

MCI OUTREACH EFFORTS

The Marketplace Coverage Initiative (MCI) targeted uninsured households and included multiple modes of communication including in-person enrollment assistance, door-to-door canvassing, mail, and internet advertising.

From October 2013 to March 2014, HCF undertook a $750,000 effort to increase insurance coverage and expand awareness of ACA Health Insurance Marketplaces.

A. Certified Application Counselors

Certified Application Counselors (CACs) are trained to assist individuals applying for coverage through the Marketplace. HCF provided $2,000 in incentive funding to local non-profit organizations for each individual who became a certified application counselor. HCF awarded just over $145,000 for 73 CACs in more than 18 organizations.

B. Canvassing

To increase awareness of insurance options and the health insurance Marketplace, canvassers knocked on doors in densely populated areas of Kansas City, MO and Kansas City, KS. Local canvassers knocked on almost 60,000 doors and talked with almost 9,000 individuals. About 30 percent of individuals filled out cards to request more information or help with enrollment.

C. Mail & Internet Efforts

Five mailings were sent to almost 70,000 households. Digital advertising was used to direct consumers to CoverKC.org resulting in 25,349 unique visitors with more than 700 visitors clicking a link to the federal enrollment Marketplace. MCI outreach efforts also included garnering "earned media" by hosting reporters to generate coverage in news outlets, including stories in the Wall Street Journal and The Kansas City Star as well as stories aired on television station Fox4KC and radio station KSHB 41.

KEY RESULTS

In addition to examining processes in real-time, the MCI was evaluated using information from focus groups, a mail survey and information provided to the HCF by CACs. Information about key findings as well as the data and methods are discussed in detail in the following sections.

A. Feedback from Enrollment Counselors

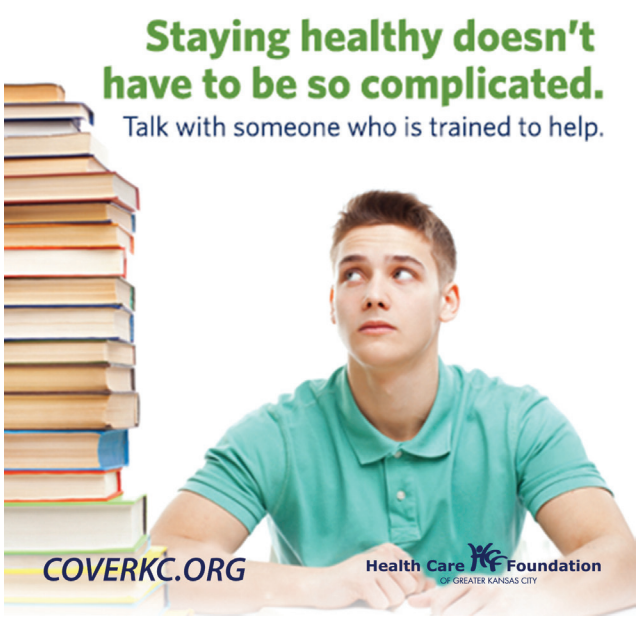
Conversations with CACs and their supervisors revealed opportunities for making the process more effective to better serve the needs of uninsured households. First, CACs felt well-trained in privacy protection, but were not completely comfortable with the application process and were unprepared to assist in complex decision-making regarding individual circumstances. For example, Marketplace enrollment not only involves considering subsidy eligibility and whether the premium is affordable, but also the optimal mix of deductible, co-payments, co-insurance, provider networks, and covered services.

These decisions are further complicated for individuals who are uncertain about their future income levels, employment situations, and health needs. Future enrollment periods will also likely involve discussions of tax circumstances as the 2013-2014 enrollment decisions are reconciled on tax returns filed in 2015.

Partially due to these complexities as well as required enrollment information (e.g. social security numbers and household income information), CACs indicated that enrollment is time-consuming and can take multiple appointments. Additionally, lack of general knowledge about the ACA and health insurance meant that one in five requests for CAC referral were solely for more information, not enrollment. CACs also reported insufficient capacity for the surge of referrals near the enrollment deadline.

Capacity was so low in the last month of enrollment that referrals were no longer transferred as of March 14, 2014, more than two weeks before the enrollment deadline.

One third of those who spoke with canvassers indicated that they wanted further assistance and provided their contact information, which was forwarded to CACs for follow-up.



KEY RESULTS, continued

B. Survey

After low initial responses to phone survey efforts, 500 surveys were mailed to residents in neighborhoods that received door-to-door canvassing and mailings as well as to residents of similar neighborhoods that did not receive such outreach efforts. The survey asked for basic socio demographic information and also included questions about health status, health insurance (pre-Marketplace as well as current insurance status), sources of health insurance and ACA information, enrollment assistance, and general opinions regarding the ACA.

For analysis purposes, the data collected from the survey were divided between individuals who were uninsured prior to the ACA versus those who were previously insured. Individuals uninsured prior to ACA open enrollment represent the group targeted for outreach efforts. This group differed from insured respondents in a number of ways. Those that did not have insurance were more likely to be in fair or poor health rather than good or excellent health. Despite their efforts to access information, the uninsured group was less likely to say that they had all the information they needed.

Uninsured and insured respondents were generally in their early 40s, but differed markedly in their income and education levels. Individuals in the uninsured group were far less likely to have a four-year college degree or to earn more than $44,000 annually, with over half of the uninsured group earning less than $20,000. By comparison, over half of the individuals in the previously insured grouped earn more than $44,000.

Despite these differences, both groups were similar in important ways. Both reported that not having health insurance was a major concern and, moreover, both groups found it difficult to find enrollment help. Consistent with the canvassing referral rates, almost one-third of survey respondents reported that they had asked for a referral to a CAC and half of those that enrolled reported getting help from someone else to make their decision.

Uninsured respondents were more likely to visit a website to learn about or enroll in health insurance during open enrollment period, but were also significantly more likely to say the enrollment website was confusing.

C. Focus Groups

The purpose of the qualitative component of the (MCI) Evaluation was to provide in-depth accounts of individuals' experiences with the initial ACAmarketplace enrollment period.. In particular, this component sought to identify the major barriers to enrolling and to gather suggestions for improving the enrollment process from low-income residents of Wyandotte County, Kansas and Jackson County, Missouri.

Echoing results from the CAC interviews and survey, focus group participants indicated a general lack of knowledge and understanding of the ACA and health insurance. Two-thirds of participants in the second focus group said they were not aware of the ACA (or Obamacare) before participating in the focus group. Others did not understand what health insurance was, its benefit or how it worked; for example, confusing life insurance and health insurance.

Many of the participants also found marketplace information unclear, incomplete, inaccurate, and politically biased. Confusing, contradictory information they could not comprehend coupled with the "bad reputation" of Obamacare led them to stop trying. Participants reported encountering many errors and obstacles on the website leading them to abandon enrollment efforts. Many had no way to connect to the website, couldn't find help through the website or by calling and couldn't move forward. Participants reported fear and distrust of an unknown process and reported that providing personal information up front to an entity they did not trust in a process they did not fully understand made them fearful, skeptical and stopped them from enrolling.

Participants gave a number of suggestions for improvements. One suggestion was to provide information through trusted community organizations and service providers. The examples given included: social service agencies, medical clinics, doctors' offices and hospitals, community centers, churches, DMV, Wal-Mart, libraries, tax preparation providers, and food pantries. Participants also suggested a mobile unit that could travel to neighborhoods and assist interested households with enrollment.

In addition, participants pointed out a mismatch between traditional communication outlets and the ways they themselves commonly received information. Many reported that they did not watch TV (cannot afford cable), listen to the radio (no car) or read mailed flyers. Participants indicated that a trusted place to go for sign up and assistance would be most effective. Finally, individuals reported that one-on-one help is invaluable, but that this help must be accessible in their neighborhoods, from a trusted source and available at times convenient to residents.

Three separate focus groups were convened between June 26 and July 21, 2014.

The 2014 marketplace outcomes of the participants were as follows:

- 18% enrolled through the marketplace
- 55% were interested but not enrolled
- 27% were eligible but not interested

Additional characteristics were that slightly more than half of the participants were female, twice as many were single versus married, and the age of participants ranged from 20 to 63, with a mean of 39.

KEY RESULTS, continued

D. Data and Methods

The MCI made use of cutting-edge data techniques to target and record their canvassing outreach efforts. A national database of more than 280 million persons including 190 million registered voters and 90 million unregistered persons of voting age served as the foundation for targeting outreach efforts.

Each person was then assigned a probability of being uninsured using a model based on public and proprietary data . This information was used to identify neighborhoods for canvassing as well as individuals to receive mailings. Although these methods have proven successful in the context of political campaigns, the MCI revealed significant limitations for their use in outreach to uninsured households.

Notably, one-third of individuals on the canvass list did not receive outreach communications because their homes were inaccessible (e.g. apartment building with an access code, buildings that no longer existed, or residences that could not be canvassed due to safety protocols).

When phone numbers provided in the data were used to contact individuals for a follow-up survey, more than 50 percent of the phone numbers were invalid.

1. For more detailed information see: Gurley-Calvez, Tami, Jessica Hembree, Jane Mosley, Mark K. Zimmerman and Bridget McCandless. 2014. "The Challenges of ACA Marketplace Enrollment: Results from Big Data and Campaign-style Tactics in the Kansas City Area." National Tax Journal 67: 925-940.

SUMMARY OF KEY LESSONS

These complexities arose from factors including transportation barriers,, inability to access the internet, a lack of basic knowledge including not knowing what health insurance is, and not understanding how health insurance might affect their financial well-being and use of health services. Focus group results indicated a critical need for more information after the initial 2013-2014 enrollment outreach activities. Regarding future outreach, MCI experiences suggest that big data models of insurance status are not currently nuanced enough to identify individuals. A more efficient method is needed to find and engage the uninsured.

MCI results suggest other outreach techniques might have more potential in this context than big data techniques, traditional media outlets, and door-to-door outreach from strangers. Focus group participants consistently indicated the need to receive information from trusted sources in or near their neighborhoods. Participants were suspicious of an online process that required a lot of personal information and provided a benefit they did not understand. Further, individuals need one-on-one assistance tailored to their personal circumstances. As stated in the focus groups and evidenced by the survey results, half of individuals required help to complete the process and many more asked for referrals to CACs.

Finally, timeliness is essential to outreach and enrollment efforts. As many as 20 percent of individuals who requested information during the canvassing efforts could not be reached for follow-up due to invalid contact information. This amount of bad information seems stunning given that the amount of time between first contact and follow-up was a few weeks at most. Outreach and enrollment activities should be bundled to avoid delays in making contact and starting the process. Each of the sources of evaluation suggest that there is a great need for ACA enrollment assistance and consumers are interested in learning more, it is a matter of finding the optimal strategies to support enrollment decisions.

Individuals interested in obtaining health insurance under the ACA faced complexities at many different levels and Certified Application Counselors did not feel adequately prepared to address many of these issues.

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