The Affordable Care Act (ACA) is expected to cover millions of newly insured Americans through Medicaid expansion and new health insurance marketplaces. During the marketplace’s first open enrollment period, which began September 1, 2013 and ended March 31, 2014, the federal Department of Health and Human Services (HHS) estimated that 8 million Americans obtained coverage through the marketplaces. These marketplace enrollment numbers will change as people who qualified for an extension gain coverage and are added to the rolls and those that signed up for coverage but failed to provide payment are dropped. HHS also reports that an additional 4.8 million people enrolled in Medicaid from Sept 2013 to February 2014 — about 4.2 million of these enrollees live in states that opted for the Medicaid expansion. The next open enrollment period begins on November 15, 2014.

The Congressional Budget Office (CBO) estimated that six million Americans would enroll in private health insurance plans through the marketplaces and eight million people would enroll in Medicaid and the Children’s Health Insurance Program (CHIP) in 2014. By 2017, the CBO predicts that 24 million people will enroll in private health insurance plans through the marketplaces and another 12 million in Medicaid and CHIP. An individual mandate with penalties for not obtaining insurance and new coverage options are intended to extend coverage to unprecedented numbers of Americans.

Yet, we know from prior Medicaid expansions and early experiences with the federal law that reaching and enrolling newly eligible individuals can be a challenge. Attracting young, healthy people, improving consumer understanding about new rules and coverage options, and bolstering enrollment when there are relatively small penalties for non-participation are just some of the factors that hamper efforts to enroll people in coverage. To address these challenges, the federal government and many states are adopting a wide assortment of strategies to facilitate enroll-
Outreach and Enrollment Options for States

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This brief discusses outreach and enrollment requirements under the ACA and highlights common challenges, and promising outreach and enrollment strategies and options. It is intended to help legislators identify potential roles and opportunities to ensure that federal and state investments are helping states achieve objectives.

**Things to Know About Enrollment in Your State:**

- What are my state’s enrollment numbers (see Figure 1 for enrollment numbers as of April 19, 2014)?
- Enrollment in private plans vs. Medicaid?
- How do these numbers match up with projections?
- Is my state on target for enrolling young adults (ages 18-34)?
- Where are people enrolling in my state?
- What are my state’s outreach strategies?
- How are these strategies being evaluated?
- Did my state upgrade its Medicaid enrollment system?
- If so, how is it working?

**Overview: Outreach and Enrollment Requirements and Resources**

Many Americans can benefit from information about the law’s coverage requirements and the process for obtaining coverage. The ACA does not include specific requirements for marketing and outreach activities for health insurance marketplaces, and, as a result, states have a great deal of flexibility to develop approaches that meet their specific needs. The law requires states that opt to expand Medicaid to conduct outreach to low-income and vulnerable populations and to ensure that materials developed by the state marketplace and Medicaid agency are culturally and linguistically appropriate.

The federal law contains several provisions to support individuals through the application and enrollment process. Namely, marketplaces are expected to help consumers navigate the enrollment process by offering:

- **Integrated eligibility and enrollment systems.** The ACA required states to create a single, streamlined process that enables consumers to apply for, receive a determination and enroll in health coverage for which they are eligible. The law requires one single application for Medicaid and the health insurance marketplace, and an interface between the systems, so people can apply for either and enroll in the right coverage.

- **Multiple avenues to apply for coverage.** The ACA requires marketplaces to offer multiple methods and locations for completing applications, including online, by mail, over
FOR YOUR CONSIDERATION: LEGISLATIVE ROLES AND OPPORTUNITIES

As described in this report, states are adopting a variety of strategies and policies to facilitate enrollment in coverage options. Regardless of the political climate in the state regarding implementation of the federal law, policymakers can play an important role in outreach and enrollment, especially in minimizing the risks and maximizing the benefits for your state.

- Monitor and track state investments to ensure that they support cost-effective and evidence-based outreach and enrollment strategies. (See What Works on page 6 for a list of tested strategies).
- Require data collection and reporting on marketing and outreach costs and outcomes.
- Regulate navigators and assisters, for example, by considering the adequacy of training, certification and patient privacy protections.
- Ensure that stakeholders are leveraging public and private outreach and enrollment resources to eliminate unnecessary duplication of effort and cost, and ensure a coordinated approach across sectors. Assess current funding for outreach and enrollment, including navigator programs, and identify opportunities to leverage and align resources.
- Identify opportunities to streamline the enrollment process and meet consumers where they are. In addition to simplifying procedures and ensuring smooth transitions between agencies, states can consider placing navigators or assisters in non-traditional, high-need community locations.
- Foster and build relationships and strategic partnerships. As described in this brief, outreach and enrollment assistance involves partnerships with health plans, faith-based organizations, foundations and other organizations.
- Use the role of community leader to help with outreach and enrollment in their own districts.
- Extend the principle of “No wrong door,” which refers to advising and directing applicants to multiple program options including Marketplaces, Medicaid or CHIP, to additional state and local health services, such as convenient locations and other services, as allowed by ACA rules.
participated in a state-federal partnership. In 2014, “hybrids” in three states offer a federally run marketplace for the individual market and a state-run small business (or SHOP) marketplace.

The ACA expanded Medicaid coverage for low-income adults with incomes up to 133 percent of federal poverty guidelines; with an “income disregard provision,” the effective eligibility level is 138 percent. A 2012 Supreme Court decision, however, effectively gave states the option of expanding Medicaid or not. As of March, 2014, state actions were split, as shown in Figure 2, with 27 states and the District of Columbia opting to expand Medicaid and 23 states declining to expand Medicaid.

State decisions about marketplace oversight and Medicaid expansion have several implications for outreach and enrollment. For example, states that run their own marketplace are responsible for consumer assistance activities, including operating a web portal, call center and navigator program, while in states that deferred to the federal marketplace, HHS is responsible for these functions. States that run their own marketplace have significantly more funding for consumer assistance through the federal grants that they received to establish their marketplace than those states with federally facilitated marketplaces.

OUTREACH AND ENROLLMENT
ISSUES AND CHALLENGES

As has been demonstrated at the federal level and in states that operate their own marketplace, there are myriad issues and challenges that impede efforts to inform, assist and enroll individuals in health insurance marketplaces.

- **Systems challenges and “handing-off” information between multiple systems represents an ongoing challenge for all states.** Although many of the initial problems that thwarted enrollment in the federal online marketplace in late 2013 have been addressed, work remains to ensure smooth enrollment, as well as seamless exchange of information between federal and state Medicaid programs and insurance marketplaces. With multiple agencies and databases involved in determining eligibility and other functions, the smooth and accurate exchange of information between systems is an ongoing technical challenge.

- **Low enrollment and adverse selection** — i.e., the disproportionate enrollment of sicker, higher-cost individuals, relative to enrollment by healthier, lower-cost individuals — have hampered prior Medicaid expansion initiatives and early indications suggest that it remains a challenge with the Affordable Care Act. Drawing healthy people, including young adults, to the marketplace requires ongoing marketing, outreach and enrollment assistance to get the word out and continually address enrollment barriers.

- **Consumer confusion is a persistent problem.** In a February 2014 poll, half of those surveyed said they did not understand how the law would affect them and two-thirds said they knew nothing or very little about the health insurance marketplaces. States and the federal government are addressing this through effective education, outreach and assistance efforts.
**Reaching diverse populations.** A wide range of individuals who are more likely to be uninsured can obtain coverage through marketplaces, including low-income adults, working families, young adults, and ethnic and culturally diverse populations. Developing communication and health care workforce strategies to meet the language and other needs of this diverse population is a challenge.

**Workforce policy issues.** States are also examining policy ramifications stemming from the regulation and oversight of navigators and assistants. For example, through their work with consumers, navigators have access to Social Security numbers and other sensitive information, and some states have expressed concerns about the potential for misuse.

**Special challenges in states not expanding Medicaid.** These states, although not expanding to all Americans with effective incomes up to 138 percent of the federal poverty level, will still see their Medicaid enrollment grow due to the federal marketplaces’ outreach and enrollment campaign and personal incentives to obtain coverage. This increased enrollment will place greater strain on state Medicaid budgets, because the state does not receive an enhanced federal match for those who were already eligible but not enrolled. States not expanding Medicaid are also still required to ensure a seamless partnership with the marketplace. Moreover, these states may experience additional challenges related to a coverage gap for adults with incomes under the poverty level (described below).

**ADDRESSING CHALLENGES: STATE OUTREACH AND ENROLLMENT ACTIONS**

States are not starting from scratch with their outreach and enrollment plans. Rather, states are drawing from the lessons learned from Medicaid and CHIP expansions that preceded the ACA, as these experiences offer important lessons and best practices that can inform current state outreach and enrollment strategies.

State outreach and enrollment activities vary considerably depending on a number of factors, including marketplace oversight, the state’s decision regarding Medicaid expansion, political support and buy-in, and other factors. As described below, states are applying these lessons in their current outreach and enrollment work.

**Design outreach campaigns that combine broad public awareness campaigns with community-based, grassroots efforts.** States that manage their own marketplace typically include a mix of broad-based informational and communication strategies to inform the public, as well as targeted messages and resources to reach specific population groups. While there is great variation within states — even among states that chose the same oversight structure — states that operate their own marketplaces have tended to develop more state-specific outreach materials and messages, while states that defer to the federal government tend to have more general outreach strategies. State-run marketplaces use a variety of tools, such as social media, partnerships with community groups, in-person outreach (through door-to-door campaigns) and retail locations, as well as websites to support campaigns and facilitate enrollment. For example, consumers can learn about and enroll in coverage in multiple settings in Connecticut. In addition to a call center that offers help in multiple languages, and a navigator/assister program, Access Health CT provides storefront enrollment centers in two of the highest-need cities in the state; it plans to open four additional storefronts in other locations. In the final months of the open enrollment period, these storefront locations were enrolling between 300 and 400 people per day according to Access Health CT. In New York, the State Department of Health hired a firm to develop a campaign with television, print, online and transit advertising.

In states with federally run marketplaces, health plans, nonprofits and other community and faith-based organizations often play a significant role in outreach and enrollment efforts.

- Recognizing the important role that faith and community leaders play in educating others about health coverage options, HHS maintains an online toolkit with links to fact

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### What Works

Researchers have studied Medicaid and CHIP expansions and identified several lessons that inform current outreach and enrollment initiatives.

- Marketing and public education—delivered through materials in multiple languages—raises awareness of new coverage options.

- A combination of community-based or grassroots outreach and broad marketing campaigns have proven effective at educating families about coverage, but targeted messages are needed to reach and enroll hard-to-reach individuals.

- Trusted community groups (e.g., nonprofit agencies, faith-based organizations, WIC programs, schools) connect with individuals who are traditionally hard-to-reach. Given the trusted role that most doctors have with their patients, local health care providers and community health centers are effective partners.

- In-person, one-on-one application assistance can have a significant impact on enrollment. One study in Boston found that more children received coverage if assisted by a counselor; they obtained coverage faster, and were more likely to have continuous coverage and satisfaction with the enrollment process than individuals who did not work with a counselor.

- Simplifying enrollment policies and procedures facilitates enrollment; coordinating program rules between Medicaid and CHIP and offering multiple enrollment methods contribute to increases in enrollment among Medicaid-eligible groups.

Contributing sources: “Reaching and Enrolling the Uninsured: Early Efforts to Implement the Affordable Care Act,” Robert Wood Johnson Foundation and Urban Institute (October 2013); and “Key Lessons from Medicaid and CHIP for Outreach and Enrollment Under the Affordable Care Act,” The Kaiser Commission on Medicaid and the Uninsured (June 2013)
POSSIBLE COVERAGE GAPS

In states that have not expanded Medicaid to adults with incomes effectively below 138 percent of the poverty level, there will be a “coverage gap” for certain low-income people, including young adults and childless adults. Individuals with incomes between 100 percent and 400 percent of the poverty level will be eligible for tax credits through the marketplaces. However, individuals with incomes below 100 percent of the poverty level may not be eligible for any coverage assistance if they live in a state that did not expand Medicaid. In effect, they earn too much to qualify for Medicaid under their state’s rules, but they do not earn enough to qualify for help buying coverage in the marketplace. This is because the ACA provides for subsidies only to people with incomes above the poverty level, and provided that others would be covered by the Medicaid expansion, which then was affected by the Supreme Court’s ruling that made the Medicaid expansion optional for states.

POSSIBLE COVERAGE GAPS

<table>
<thead>
<tr>
<th>Federal Poverty Level (FPL)</th>
<th>States that have expanded Medicaid to adults with incomes at least 100% FPL</th>
<th>States that have not expanded Medicaid to adults with incomes at least 100% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>400% FPL</td>
<td>Marketplace Subsidies*</td>
<td>Medicaid</td>
</tr>
<tr>
<td>138% FPL</td>
<td>ACA Expansion 400% FPL, $46,680 for an individual</td>
<td>Medicaid</td>
</tr>
<tr>
<td>100% FPL</td>
<td>Marketplace Subsidies*</td>
<td>Coverage Gaps</td>
</tr>
<tr>
<td></td>
<td>In some areas people without coverage can still access care via community health centers, free clinics, or health providers. States often support these efforts through direct funding or supportive regulation.</td>
<td>Medicaid</td>
</tr>
<tr>
<td></td>
<td>*Median (47%) Medicaid Eligibility for Parents.</td>
<td>There is wide variation among states with regard to adult coverage.</td>
</tr>
<tr>
<td></td>
<td>*Marketplace subsidies are available only to people with incomes between 100% and 400% FPL.</td>
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</tr>
</tbody>
</table>

SOURCE: KAISER FAMILY FOUNDATION

sheets, talking points and other resources.

- Blue Cross Blue Shield of North Carolina sponsors two mobile units that travel around the state, as well as seven retail stores to promote awareness and enroll consumers in health insurance. 9

- Blue Cross Blue Shield of Texas educates consumers about the federal marketplace through a website, texting campaign and partnerships with churches, clinics, non-profit and other community organizations. 10

Engage partners early and continually to facilitate outreach and enrollment. Active involvement of a wide array of partners is an effective strategy for disseminating information and linking people to coverage. Most states running their own marketplaces created workgroups of diverse stakeholders — state officials, insurers, health plans, health care providers, community health centers, consumer advocates and others — to plan and conduct outreach and public education. For example, Colorado conducted numerous public meetings with individuals and orga-
nizations across the state to build partnerships and obtain stakeholder buy-in.

Faith-based organizations play an important role in connecting communities of faith to information about health coverage. For example, the Maryland Citizen’s Health Initiative created a Faith Ambassadors’ Program to train ambassadors to provide health insurance education in multiple languages. In Alabama, the Arise Citizens’ Policy Project partners with congregations, gospel radio stations and others to inform the uninsured about coverage options. 11

**Remove enrollment barriers and meet consumers where they are.** States have established web portals, call centers, and developed navigator programs to help individuals enroll. Every state has a website to promote awareness and facilitate enrollment. These websites typically provide subsidy calculators, educational videos, and resources to ease the enrollment process. To meet the varying levels of assistance needed by consumers, states have created a tiered approach that involves websites with real-time “chat” options, call centers and hands-on assistance. In January 2013, 35 states had stationed assisters in hospitals, federally qualified health centers, public health offices or schools. 12

- Connect for Health Colorado helps consumers compare options through a website designed to resemble popular travel websites.
- In Mississippi, workers assigned to reservations helped increase enrollment among American Indians. 13
- In Utah, enrollment specialists in clinics assist families through each step of the application and enrollment process. An evaluation found that 74 percent of children in families that were provided application assistance were successfully enrolled compared to 26 percent of children at a comparison clinic in which families were provided an application but no direct enrollment assistance.

**Develop training programs and requirements for navigators.** Navigators (and counselors and assisters who perform similar duties) help consumers complete applications, compare options and select coverage. These functions are not only complex, but they also involve handling sensitive, personal information. In response, states have considered a wide range of legislation aimed at regulating and licensing navigators, defining the scope of their activities, and establishing training requirements.

In recent years, 16 states enacted laws restricting navigators from negotiating health insurance or enroll an individual or employer for individual or employer coverage. For example, four states — Georgia, Missouri, Ohio and Tennessee — have enacted laws restricting navigators from giving advice about the benefits, terms and features of a particular health plan. It’s worth noting that courts found two of these laws, in Missouri and Tennessee, to be preempted by federal regulation.

- **Scope of practice.** Some laws address or restrict the type of information that navigators can provide to clients. For example, four states — Georgia, Missouri, Ohio and Tennessee — have enacted laws restricting navigators from giving advice about the benefits, terms and features of a particular health plan. It’s worth noting that courts found two of these laws, in Missouri and Tennessee, to be preempted by federal regulation.

**Other requirements and limits.** Some state legislation addresses the ability of navigators to sell insurance. Maine allows only licensed insurance producers to sell, solicit or negotiate health insurance or enroll an individual or employer in coverage through the marketplace. Similarly, New York defines navigators as individuals who, among other things, do not sell insurance.

In addition to enacting legislation, some state marketplaces have engaged insurance agents and brokers in the development of marketplace policies. Maryland has a Producer Advisory Council to provide input. 18

**Streamline enrollment procedures, including fast-track enrollment.** Some states have adopted “fast-track enrollment” for individuals whom they know to be Medicaid-eligible through their participation in other programs. States can apply to the Centers for Medicare and Medicaid Services (CMS) for a fast-track waiver through December 2015. 19 CMS enabled states to identify Medicaid-eligible individuals by using data that states already have through the Supplemental Nutrition Assistance Program (SNAP) and Medicaid databases. 20 Using this data, states can reach out to people who are likely to qualify for Medicaid and encourage them to enroll in health coverage. Alternatively, states can inform new applicants for other services that they may...
also be eligible for enrollment in Medicaid. As discussed earlier, using data from programs such as SNAP, Medicaid and unemployment insurance compensation, states could reach more than half the Medicaid-eligible, uninsured young adults. While targeted enrollment strategies such as fast-track enrollment offer an effective way to identify newly eligible individuals, they also raise concerns about the use of sensitive and confidential financial and household information.

- **South Carolina** uses eligibility information from other programs (e.g., SNAP and Temporary Assistance for Needy Families) to expedite renewals of Medicaid. The move resulted in an estimated savings of $1 million in direct administrative costs and 50,000 staff hours.

- Other states that have adopted fast-track eligibility include **Arkansas, Illinois, Oregon** and **West Virginia**.

**CONCLUSION**

States are engaged in a continuum of outreach and enrollment strategies, some taking primary responsibility for those functions, while others rely at least in part on federal agencies to perform those activities. Despite the variation among states, opportunities exist for interested policymakers to engage with the outreach and enrollment activities to ensure that the process meets the state’s needs and supports its coverage goals.

**Endnotes**

1. Open enrollment ended on March 31, 2014 for individuals; special enrollment continued through April 19, 2014. Small businesses may continue to enroll through 2014. There is no deadline for enrolling in Medicaid.


3. Ibid.


12 Jessica Stephens and Samantha Artiga, “Key Lessons from Medicaid and CHIP for Outreach and Enrollment Under the Affordable Care Act,” Kaiser Commission on Medicaid and the Uninsured, June 2013, 8.
13 Ibid, 9.
14 NCSL Research, March 2014.
15 Ian Hill, Brigette Courtot and Margaret Wilkinson, Reaching and Enrolling the Uninsured: Early Efforts to Implement the Affordable Care Act (Princeton, N.J.: Robert Wood Johnson Foundation and Urban Institute, October 2013), 11.
20 Ibid.