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Providing Outreach and Enrollment Assistance: Lessons Learned from Community Health Centers in Massachusetts

EXECUTIVE SUMMARY

Six years ago, Massachusetts implemented a broad expansion of health coverage to the uninsured population in the state. Understanding that outreach and enrollment assistance would be essential to the success of the expansion, state policymakers provided for public education campaigns, but also for person-to-person, hands-on assistance, especially in communities with large numbers of uninsured people. Community health centers play a central role in this effort. As states and communities gear up to provide outreach and enrollment assistance under the ACA, the experience of the Massachusetts health centers offers lessons that can help inform current efforts to reach and enroll millions of low-income, uninsured Americans in health insurance. Recent interviews conducted with a sample of Massachusetts health centers point to four key findings:

Finding #1: Intensive outreach and enrollment assistance is crucial to connect low-income, uninsured people with coverage.

Finding #2: Assistance is not a one-time matter – it is needed at all stages of the enrollment process and to ensure continued coverage.

Finding #3: Immediate access to enrollment assistance boosts the effectiveness of outreach efforts.

Finding #4: Even when health reform is mature, the need for aggressive outreach and enrollment assistance remains high and the resource demands remain significant.

The Massachusetts health center experience demonstrates that, in addition to broad public education about affordable insurance options and how to enroll, intensive one-on-one assistance is a vital complement to help disadvantaged populations and communities obtain and keep coverage that meets their needs. The intensive support they require, and ongoing rather than occasional needs for assistance, suggest the importance of sustained investment in outreach and enrollment efforts conducted by health centers and other organizations.

INTRODUCTION

In 2006, major health care reform legislation was enacted in Massachusetts. In many ways a prototype for the Affordable Care Act (ACA), the Massachusetts law required nearly all state residents to obtain health insurance, and made insurance accessible and affordable by reforming the health insurance market and providing subsidies for coverage through expansions of Medicaid and CHIP and a new program for low-income adults who are not eligible for Medicaid, known as Commonwealth Care. The law also created the "Connector," which, like the ACA's health insurance Marketplaces, is designed to facilitate and simplify access to insurance for individuals, families, and small businesses. In addition, the law established a Health Safety Net (HSN) Fund that finances health care for residents who remain uninsured permanently or on an intermittent basis.

Understanding that outreach and enrollment assistance would be essential to the health reform law's success, Massachusetts policymakers launched high-profile public education campaigns, but they also provided for person-to-person, hands-on assistance, especially in low-income communities with large numbers of uninsured residents, many of whom have no previous experience signing up for insurance subsidies or selecting and enrolling in a health plan. Community health centers – a critical source of comprehensive primary health care and many other services for medically underserved populations and communities in Massachusetts – have played a central role in this outreach and enrollment effort.

To help inform current outreach and enrollment efforts associated with the ACA's coverage expansion, the Kaiser Commission on Medicaid and the Uninsured asked researchers at The George Washington University to examine the enrollment assistance experience of Massachusetts health centers six years into that state's health reform program.[1] Because of their safety-net role, health centers are uniquely aware of and knowledgeable about the challenges and requirements of assisting uninsured individuals and communities disadvantaged by poverty, minority race/ethnicity, poor health status, language barriers, homelessness, and other factors. As states and communities nationwide gear up to provide outreach and enrollment assistance for the first time under the ACA, the experience of Massachusetts health centers offers valuable lessons to health centers nationally, and to other community-based efforts to reach and enroll millions of low-income uninsured Americans in health coverage.

METHODS

Telephone interviews were conducted with staff at a sample of nine health centers, selected to capture diversity in the location and size (total patients) of the 36 health centers in Massachusetts, as well as variation in the number of their patients who were uninsured in 2007 (the year that coverage was expanded in the state), and variation in the change in the uninsured rate over the period 2007-2011. Data from the Uniform Data System (UDS), which health centers that receive Section 330 funding from the federal Health Resources and Services Administration must file annually, were used to identify the sample of health centers.[2] Interviews were conducted August 12-20, 2013 with health center CEOs or COOs and staff who oversee health centers' outreach and enrollment efforts. Key staff were identified with the assistance of the Massachusetts League of Community Health Centers. The open-ended interviews were guided by questions developed in consultation with the League.

KEY FINDINGS

FINDING #1: INTENSIVE OUTREACH AND ENROLLMENT ASSISTANCE IS CRUCIAL TO CONNECT LOW- INCOME, UNINSURED PEOPLE WITH COVERAGE.

The individuals and communities served by health centers face a host of poverty-related disadvantages that pose unique challenges to enrollment efforts. Poverty frequently translates into residential instability or homelessness, which can make the generally easy task of documenting a place of residence difficult. Limited access to Internet service curtails the potential of online strategies to connect low-income people with coverage. Low literacy and large immigrant populations best served in a language other than English (one health center reported 75 distinct languages) also present special challenges to providing assistance.

Separate from the barriers associated with socioeconomic disadvantages, health center staff underscored the fact that many of the people they assist have no experience with health insurance and do not understand concepts like premiums and deductibles, provider networks, formularies, or coverage exclusions and limitations – all important considerations in selecting a health plan. Making the concept of provider networks even more difficult to grasp is health plan information that is so general that consumers cannot ascertain whether their physicians are included in a given network. Further, in Massachusetts, a health plan name may appear as a coverage option even if it has no network in the community in which a person lives. At a loss to assess the confusing array of health plans and trade-offs, overwhelmingly, health center patients tend to focus more narrowly on comparing plans' monthly premiums. One-on-one help is essential to overcome the challenges of connecting people who lack resources and familiarity with health insurance to coverage that meets their needs.

FINDING #2: ASSISTANCE IS NOT A ONE- TIME MATTER – IT IS NEEDED AT ALL STAGES OF THE ENROLLMENT PROCESS AND TO ENSURE CONTINUED COVERAGE.

Health center staff emphasized that intensive assistance is necessary on an ongoing basis to help individuals and families navigate the process of enrolling in coverage and later renewing it. They highlighted multiple points at which these processes can break down, such as when enrolling in a subsidy program, selecting a plan, and providing documentation to verify current eligibility for coverage.

- *Application*. Applying for subsidized coverage is challenging because of the amount of documentation required to verify eligibility. Consumers need assistance securing and filing documents, responding to requests for additional documentation, and restarting the process if an initial application failed for lack of documentation. Health center staff noted the importance of having direct access to documents (e.g., wage information from employers) that require special training in privacy and confidentiality. The investment of time required to assist individuals with the application for a subsidy program alone was reported to range from 15 minutes in a simple case, to more than one hour in the case of families, in which eligibility may vary by family member, multiplying the complexity of the task.
- *Official notices.* Assistance with reading and interpreting official correspondence is crucial. Staff at one health center reported that their enrollment assisters routinely advise clients not even to attempt to read the official letters they receive concerning their subsidy applications. They cited dense and obscure language that is particularly difficult for those with low literacy, and wording that suggests a negative disposition of the application even though virtually every low-income uninsured resident can qualify for one of the state's four

subsidy programs. For example, one standard notice begins with the words "not eligible" on page 1, and only on page 4 states that the applicant has been found eligible for another subsidy program. To prevent clients from tossing notices out after reading page 1, health center staff instruct them to bring in the correspondence they receive. The notices are complicated and confusing as well. One health center that conducted a systematic review of 530 state letters brought in by patients reported that roughly half of them involved denials under one or more subsidy eligibility categories, and staff counted 36 separate bases of denial pertaining to one or more members in a family (different family members may be eligible through different eligibility pathways).

- *Managing delays*. Health center staff widely agreed that calls to the Commonwealth's call center created problems because of extremely long waits to speak to a call center staff person (a finding also noted by other researchers in a recent study).[3] Also, many applicants experience lengthy delays in obtaining coverage because, according to health center staff, it can take the state anywhere from a few days to several months to process an application. Respondents reported that these delays necessitated frequent contacts with state officials, especially in the case of clients with significant health problems at the time of application who are in more urgent need of coverage.
- *Plan selection and enrollment*. Following enrollment in insurance, many clients must select and enroll in a health plan. In Massachusetts, those who qualify for Medicaid are automatically assigned to a plan, and individuals covered by the HSN program obtain their care from a designated network of hospitals and clinics. But those eligible for coverage through the Connector must select a plan. Because, as discussed earlier, many clients have no prior health insurance experience, one-on-one assistance with plan selection can become as important as assistance with applying for a subsidy. Educating individuals about how to consider and compare plan features other than premiums – in particular, provider networks and cost-sharing requirements, which have important implications for their access and out-of-pocket exposure – is both challenging and time-intensive.
- *Renewal/redetermination*. Special vigilance, including intensive counseling, is needed to avert breaks in coverage that often occur at redetermination time. Some provisions of the ACA can be expected to ease renewal and reduce lapses in coverage. In particular, the use of "passive redetermination," which permits automatic renewal of coverage if household circumstances have not changed, is expected to improve retention. At interview time, Massachusetts was in the midst of a major overhaul of its renewal process, but training had not yet begun and the paper-based system still in place involves many of the same documentation, notice, and other issues that impede initial application and enrollment. These persistent challenges, along with the fact that low-income people experience substantial income volatility that can change their subsidy eligibility, point to the importance of maintaining intensive assistance over time.

Finding #3: Immediate access to enrollment assistance boosts the effectiveness of outreach efforts.

Health center staff stressed that the ability to deploy enrollment technology in community locations is important to the effectiveness of outreach and communications campaigns. Without the means to enroll people where they are, the impact of public information efforts is likely to be dampened.

- *Mobile technology*. To broaden the reach of their enrollment assistance efforts to include not only their own patients but also the larger community, some health centers were "pushing out" their enrollment assistance into the community through the use of mobile technology, for instance, by bringing wheeled computers or laptops into emergency departments. Mobile technologies were viewed as especially valuable in settings that attract many potentially eligible people, such as health fairs, clinics embedded in places such as college campuses, homeless shelters, job training programs, unemployment offices, and other strategic locations.
- *Self-serve kiosks*. One health center is exploring the potential of self-serve kiosks to expand the reach of enrollment efforts. These kiosks might be attractive to applicants who have online skills but lack Internet access. Staff noted, though, that it is not clear how much kiosks would reduce the need for one-to-one assistance because the application and enrollment process is complex, especially when subsidies are involved, and does not lend itself to the simple types of functions that kiosks are good tools for carrying out.
- *Educational materials*. To address low literacy and low health literacy, some health centers have prepared special client education materials as part of their assistance efforts. For example, one center had developed a 4-page picture pamphlet that depicts each stage of the process and other helpful information in a non-verbal format.

FINDING #4: EVEN WHEN HEALTH REFORM IS MATURE, THE NEED FOR AGGRESSIVE OUTREACH AND ENROLLMENT ASSISTANCE REMAINS HIGH AND THE RESOURCE DEMANDS REMAIN SIGNIFICANT.

Health center staff were unanimous in their praise for the major impact of health reform – a sharp reduction in the uninsured rate among Massachusetts residents, including health center patients. They emphasized, though, that realizing the potential of the coverage expansion to reach a largely low-income population that faces an array of challenges has required intensive outreach and enrollment assistance, even as the program has matured. Multiple coverage pathways, documentation requirements, opaque and discouraging correspondence from subsidy programs and insurers, and the surpassing complexity of health insurance itself, pose significant barriers to participation in coverage, especially for the poor. As the experience in Massachusetts demonstrates, those barriers can be surmounted with robust in-person assistance. With an uninsured rate among Massachusetts health center patients still exceeding 20%, and the risks of coverage loss at renewal time, intensive assistance will continue to play a vital role in expanding coverage, and sustained investment to support this effort will be needed.

CONCLUSION

The Massachusetts experience points to the importance of several of the ACA's most far-reaching reforms, including a single, streamlined application form for all subsidy programs, simplified documentation requirements, passive renewal, and investment in outreach and enrollment assistance. But it also reveals the vital role of in-person help to navigate what remains a new and unfamiliar process for many and an important process for all. Broad public education about affordable insurance options and how to enroll is essential to the success of the ACA's expansion of coverage. In addition, for medically underserved populations and communities disadvantaged by poverty and other hardships – who stand to benefit most from coverage – one-on-one assistance is a crucial complement. The intensive support they require, and ongoing rather than

occasional needs for assistance, suggest the importance of sustained investment in outreach and enrollment efforts conducted by health centers as well as other organizations.

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ENDNOTES

[1] A previous study examined the early experiences of health centers following implementation of the Massachusetts health reform law. See Ku LK, Jones E, Finnegan B, Shin P, and Rosenbaum S, *How is the Primary Care Safety Net Faring in Massachusetts? Community Health Centers in the Midst of Health Reform*, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, March 2009. http://www.kff.org/health-reform/report/how-is-the-primary-care-safety-net/

[2] George Washington University, IRB #071357

[3] Siefert R and Littell-Clark A, *Enrollment Volatility in MassHealth: A Progress Report* (Massachusetts Medicaid Policy Institute, April 2013) http://bluecrossmafoundation.org/publication/enrollment-volatility-masshealth-progress-report. Accessed online September 7, 2013.