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What Worked and What's Next? Strategies from Four States Leading ACA Enrollment Efforts
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Samantha Artiga: Thank you. Hello and welcome, all, to our Kaiser Commission on Medicaid and the Uninsured web briefing, What Worked and What's Next? Strategies from Four States Leading ACA Enrollment Efforts. Thank you, all, so much for joining us today. My name is Samantha Artiga with the Kaiser Commission on Medicaid and the Uninsured.

Today, we really look forward to sharing the findings from a new report we released last week that highlights the experiences and lessons learned from four states with leading ACA enrollment efforts including Connecticut, Colorado, Kentucky, and Washington State. We're really thrilled for our panelist discussion today - we have representatives from each state joining us including Kevin Counihan, CEO with Access Health in Connecticut; Lisa Lee, Deputy Commissioner with the Kentucky Department for Medicaid Services; Taylor Roddy, Marketing and Communications Manager at Connect for Health Colorado; and Rudy Vasquez, Managed Care Operations Director at Sea Mar Community Health Centers of Washington.

I'm going to begin today's briefing by highlighting some key findings about what worked to achieve enrollment success across these states and then we're going to turn to each of our panelists to share some of their perspectives on their current priorities looking ahead. We're then going to

open the discussion up for a question-and-answer period. I Please note that today's presentation will touch on the findings that are high-level, so I would really encourage you to take a look at the full report that today's briefing is based on for lots more additional details and information beyond what we will be able to share today and that report is available on our website at www.kff.org.

Before I jump into the key findings I just want to go over a few housekeeping items. The first is that slides and a recording of this webinar will be made available after the event on our website at kff.org and second is that we will hold our question and answer session after all panelists have provided their remarks but you should feel free to submit questions as we proceed. We have a lot of folks listening in today so it’s unlikely we’ll be able to get through all of them, but we're going to do our best to get through as many as possible.

Now to get started, let's take a look at what worked to achieve enrollment success in these four states. Today's findings are based on the experiences in Connecticut, Colorado, Kentucky, and Washington State. Each of these states established a state-based marketplace, implemented the ACA's Medicaid expansion, and achieved success enrolling eligible people into both Medicaid and Marketplace coverage. To learn

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about what worked in these states, in May we went out to conduct interviews with a range of stakeholders in each state including Medicaid and Marketplace officials, enrollment assisters, consumer advocates, and providers.

I think one of the biggest things that we learned is it wasn't any single strategy but really a combination of strategies across several domains including marketing and branding, outreach and enrollment, consumer assistance, and systems and operations that were really key to these states' success and underlying all of these strategies was strong leadership promoting coverage efforts.

Next, I want to focus in on each of these areas a bit. Turning first to marketing and branding, one real key element of success for these states was that they branded the coverage expansions for both Marketplace and Medicaid coverage as state initiatives. As a result, many consumers in these states really identified the coverage as a state approach rather than something specific with the Affordable Care Act or sometimes referred to as Obamacare. Moreover, they really invested in broad state-wide marketing campaigns across diverse channels and in some states' cases particularly, as I think Lisa Lee can tell you from Kentucky, consumer giveaways were really key for creating brand awareness and Lisa can tell you about their

famous Kynect bags in Kentucky, which were really successful there for brand awareness.

While broad marketing helped raised consumer awareness of coverage options, it was really direct outreach and enrollment efforts at the local community level that were key for helping to educate consumers and encouraging them to enroll in coverage. In all four of these states extensive outreach was conducted through numerous local avenues. They basically used every avenue that was available to connect with consumers; where they live, work, play, and pray. I think we also identified some really affective, innovative initiatives in some of the states. For example, in a couple of the states, they conducted outreach by traveling across the state in a branded RV, which allowed them to touch every area of the state with their messaging. Some of the state also established walk-in enrollment sites in heavily trafficked areas of communities and in each of the states they really used large community events such as the State Fair to reach a significant number of consumers and in some cases created their own enrollment events to reach large numbers of consumers.

This outreach and enrollment assistance was supported by a very strong network of consumer assistance in each state. There are few key elements that really stuck out about the consumer networks in these states, the first is that the

marketplaces in these states really helped facilitate strong working relationships between insurance brokers and other enrollment assisters and we heard that that was really key for supporting coverage efforts. Second, they all utilized a regional hub-and-spoke structure to organize the consumer assistance networks, which was really effective in helping to coordinate assistance activities and to facilitate the sharing of information back and forth between assisters and the marketplaces. Lastly, each of these marketplaces established really strong resources to support their assisters. For example, in Colorado there were several marketplace stops that were dedicated specifically for helping assisters and they were readily accessible to answer questions and provide assistance particularly during those first few weeks of open enrollment when we heard from a number of assisters that they were basically ready and available at any time they needed them.

I think it's also worth noting that in every state we heard that demand for call center assistance far exceeded their original expectations and they each increased their capacity as quickly as possible to try and meet those demands. I think when we hear about what states are looking at in the future maybe they can speak to how they're planning to address to those needs moving forward.

The last area I want to focus on is on systems and operations. I think we all know that a lot of enrollment success hinged upon having a functioning enrollment system and each of these states faired relatively well in terms of the status of their systems at the outset of those enrollment. However, beyond that they also employed a number of strategies to overcome system problems they did encounter. For example, they each had data and feedback loops in place to help them quickly identify system problems and then deploy workarounds or make incremental fixes to address those problems as they were identified.

On the operational side, one commonality across all the states is that there was very close coordination among key agencies including Medicaid and Marketplace staff as well as the Department of Insurance and they all engaged community stakeholders early and often throughout the planning and implementation process and responded to the feedback they received from the stakeholders.

We'll hear from our panelist some of the details of what they're really focused on looking ahead. In the report we do identify a range of current and future priorities that really fall into three areas. The first, is getting more people enrolled, continuing to improve those enrollment systems, and keeping people who have already enrolled covered.

The second, is really ensuring that there's adequate consumer assistance to support the next open enrollment period. Third is how to help newly insured consumers connect to care, especially recognizing that many of those who have gained coverage have limited experience with health insurance and need a lot of education to learn how to use it and access the care they need.

Now, I want to turn to each of our panelists to hear their perspectives on what their current areas of focus are and as a reminder we will be moving to the Q&A after we hear from the panelists but feel free to submit your questions as we go. We'll begin by hearing from Kevin Counihan with Access Health CT in Connecticut. Thanks, Kevin.

Kevin Counihan: Thank you and thanks so much for having us all and also for your report. I think it was a really helpful summary of last year for all of us. It's funny, our peers get together about every couple of weeks for a therapy session and one of the things I think that it feels, in some respects is, that given the challenges of this fall and the timing and such, my gut tells me we're going to look at last year as the good old days.

With respect to current priorities for us, and I don't think we're any different than any other state in addition to the ones that you've mentioned. System stabilization and enhancements are clearly one of our top three. We've recently

put our system through a code review, which is essentially having an independent firm come in and audit our entire systems to find any holes, bugs, patches, things that needed to be enhanced. We've fixed 60-percent of the recommendations over the weekend and the other 40-percent are going to be done before open enrollment. Our goal, like I'm sure everybody else, is to make sure that that system remains as stable, workable, easy, and simple as possible for the enrollee.

We are also heavily promoting this new mobile application that we introduced about two months ago because we found as we track enrollment and we track it in real time that—by device and a bunch of different segments of information, that after 7 o'clock at night, roughly 25-percent of our enrollment during last year's open enrollment came on through smart phones and tablets. It was about 9 to 12-percent during the day but in the evenings it really kicked up. The research showed that it was very much segmented by age. For example, it was largely dominated, 87-percent, by people under age 40. We think a very good way to make sure that our enrollment is both retained and also enhanced among younger folks is to make sure that this mobile application works well so we're very excited about that and it's been available for downloading for free from iTunes now for a couple of weeks. It's also available on Android as well.

The third on the system side is we're introducing an avatar that will pop-up automatically—each time of the 14 most common questions that we're asked during the open enrollment period and so this avatar will pop-up, restate the question, and give the most common answer for that question. We've enhanced it also for adding specific responses around renewals. We, like everybody else, I think, are looking for ways to again make this enrollment and renewal process as easy and simple as we can.

Open enrollment is obviously the number one priority for all of us. I think you did a really good job of touching on the key elements there so I'm not going to repeat those. I I do think that this is very complicated for our enrollees. We're expecting roughly a 35-percent churn off our enrollment and, however, with re-determinations coming from Medicaid we're finding between 15 to 20-percent of them are actually being re-determined off of Medicaid and into QHP so we think that's going to be a helpful means to replace some of that membership.

Finally, we are working very hard to promote what our research is showing is the most effective form of marketing, which is word-of-mouth and colleague endorsement. We found when we queried people in eight types of marketing channels, whether they be from brokers and personal assisters, earned media, unearned media, all that stuff that the number one

influencer for enrollees in our state was word-of-mouth, references, and recommendations by friends or colleagues.

The second was unearned media or—excuse me, earned media from favorable press stories and things of that sort. We've developed a story-core type of repository of favorable stories that people have had with the ACA and with Access Health Connecticut that we positioned in the key areas of our state because we know how important that type of objective communication could be.

Samantha Artiga: Thank you so much, Kevin.

Kevin Counihan: Thank you.

Samantha Artiga: It sounds like some really great stuff in the works for the coming open enrollment period. Now, we're going to turn to Lisa Lee, Deputy Commissioner, Kentucky Department of Medicaid Services who can give us some perspective on what's on the top of her plate every day from her Medicaid perspective; thanks, Lisa.

Lisa Lee: Thank you for the opportunity to allow me to spotlight some of the things Kentucky's doing. You already stole my thunder though by talking about our great bags we gave out during our outreach campaigns. Kentucky did have a very successful outreach campaign. We went across the state and spoke to individuals at an personal level. We had these great looking Kynect bags that were very colorful and we handed them

out and as we talked to individuals we would say, do you have health insurance, and if they said yes we would say do you know someone who doesn't? That got the conversation started and we made so many great connections and were so successful in our enrollment efforts that we now have over 1.1 million individuals enrolled in Medicaid in the State of Kentucky and our population is about 4 million so that kind of gives you an idea of the number of individuals in our state who actually live at or below the poverty level.

Our outreach was so great in bringing all these individuals in. What we want to do going forward is make sure that those individuals receive the healthcare needs that they require and also we want to continue to focus on the triple aim for our traditional Medicaid members as well as our expansion population. Of course, the components of the triple aim are better care for individuals, better health for populations, and financial stewardship. We have this increase in members so we need to make sure that we are fiscally responsible with all of their money to make sure that we can stretch our dollars as far as they need to go.

Basically, we want to drive change in the health status of our members by using this massive amount of data that we have at our fingertips from their claims information. We mine our data, our claims information, on a routine regular basis

and look for trends. We look to see who's providing service, who's receiving services, how much is it costing to provide those services. We're going to continue to do that going forward and one particular area of interest for us is behavioral health and substance use treatment.

Just to give you a little bit of background, prior to January 1st of 2014 in Kentucky treatment for substance use was limited to pregnant women and children under the age of 21 but beginning on January 1st of 2014 those services became part of our Medicaid benefit package. Monitoring these trends over time is of particular interest to us because here we're introducing a new population, that's the childless adult expansion population, and we also have a new service, the behavioral health substance use services for that population, so we have very little historical information to forecast our expenditures and predict utilization trends.

In addition to that, prior to January 1st, treatment for these services was limited to very few providers throughout the state; it was mainly our community mental health centers. Knowing that we were bringing on more population and we were concerned about the behavioral health service and access, we also opened up our provider network to allow providers who had previously not been allowed to enroll in Medicaid to enroll and bill directly.

For example, we have enrolled licensed clinical social workers, licensed managed and family therapists and psychologists just to name a few, to help increase access to the behavioral health services. In addition to this our Medicaid director, our Medical Director, meets with the medical directors from all five MCOs that operate in Kentucky. They go over information; they discuss areas of interest and what we may need to do to improve services.

One example is our ER utilization. We looked at ER trends and we identified individuals that we thought were high utilizers. We worked with managed care organizations and a lot of those individuals were assigned case managers to help them manage their healthcare needs and it eventually ended up in reducing the ER in what we believe was inappropriate ER utilization before those case managers were brought onboard.

Another issue that we want to focus on in the State of Kentucky going forward is the use of psychotropic medications in children. Currently Kentucky has one of the highest rates of psychotropic medication prescribed to children in the US. We want to use data-driven interventions to reduce inappropriate prescribing for our children. Our pharmacy director is also involved in this so we have brought together the pharmacy directors and the medical directors from all the

MCOs to put our heads together and see what we can do to make a difference for our children.

Sometimes what it means is making a difference. Change not only means educating their members but, in this case, it looks like it may mean providing education to providers as well. With the initiatives that we have been doing we have been seeing improvement. For example, we show a 15.8-percent increase in dental visits from 2013 to 2014. We also show a 36.7-percent increase in preventive services from 2013 to 2014. Looking ahead, these are the sort of things we want to make—we want to increase preventive services, reduce inappropriate ER, and make sure that individuals in Medicaid know what services are available to them and how to access those services.

In conclusion, looking ahead Kentucky's priority includes using data to drive change, continued collaboration with our managed care partners, and working to achieve better care for individuals, better health for populations, financial stewardship, and we believe that the steps we're taking will result in appropriate utilization of services and contain costs over the long run. Thank you.

Samantha Artiga: Thank you, Lisa. It sounds like you guys are already making some great strides in achieving some of those utilization gains that you're speaking of.

Now, we're going to turn to Taylor Roddy, Marketing and Communications Manager at Connect for Health Colorado to hear what's on her focus looking ahead; Taylor?

Taylor Roddy: Thanks, Samantha. It's a pleasure to speak with you and be with you all this morning. It's been really nice to hear about all of your experiences and how those really relate to what we did in Colorado. We've enrolled to-date more than 141,000 Coloradans and counting in health insurance through Connect for Health Colorado and while we celebrate that we certainly know there's more we can do to improve our efforts in the next open enrollment period.

I'd say we're focused on three priorities for next year. One is from a systems and application standpoint. We worked hard last year and we're fortunate to have a system that launched on-time and worked 99-percent of the time for our customers. This year what we're focused on is really enhancing that system. Kevin mentioned building the avatars and what we heard from our stakeholders and our customers is that we needed more of that help text to help aid the customers in the online experience and help self-service them through the application process. This year we're focused on that system and building a single application system with our partners at the state.

Second, I'd say what we're focused on is the data aspect, and mining the data and learning from what we did last

year and how to re-focus those for this year. Last year we did a lot of targeted outbound communication using the data we had. This year we'll continue to do that to our enrollees who have not yet enrolled. Last year we sent over 500,000 e-mails and made over 100,000 calls to our account holders who had not yet enrolled letting them know of those in-person events in their area by geographical zip code.

We actually had people show up in droves to those in-person events with the actual e-mails printed out. We thought that that was a effective way to reach them. Using also that same data, we really want to expand our mobile and walk-in presence. One way we did that last year was with a branded RV. We drove that RV all across the state. We found it was an effective way not only to show our commitment to the rural communities but also to build a face to the name and have that one-on-one personal enrollment help. This summer, I'm trying to polish up on my RV driving skills so come the winter time we can continue to have that presence in the corners of the state that we had last year.

I think the last thing that we're focused on is bringing the state together and convening in a pre-enrollment and rally kickoff event to help build energy and momentum for our state-wide efforts. We know not only one group is focused and responsible for enrolling Coloradans; it takes the whole

state to bond together. Leading up to it we have several focused training events with all of our stakeholders, with our brokers, with our assistant sites and then following centrally, we will help coordinate state-wide enrollment events with all of our partners across the state. Certainly the brokers and the assisters are doing events all throughout the summer but I think what we saw last year is bringing them together in the same walk-in site helped our customers and that was very powerful to have both of those very strong channels working together to help our customers get enrolled in a plan.

I guess to summarize again, we're working on the systems, making the application process more smooth for our customers, we're working to build in that educational text to help people understand how they need to get enrolled. We're looking at data, as is everybody else. Then, thirdly, we're working to bring together all of our stakeholders in one committed, concerted effort to kick off this next open enrollment period.

Samantha Artiga: Great. Thanks, Taylor. It sounds like that kickoff enrollment event will be great for getting the energy going.

Now, we're going to hear from Rudy Vasquez, Managed Care Operations Director at Sea Mar Community Health Centers of Washington, who will be able to give us some perspective as a

provider and assister on what his priorities are looking forward; thanks, Rudy.

Rudy Vasquez: Thank you; appreciate the time and the ability to share with all of you what we're doing. Early this summer we really focused on going back to educate all of those folks that we enrolled earlier this year. We found quite a few of them, while were in a hurry to enroll, really didn't understand what they were enrolling onto so we've spent a lot of time just calling a lot of those that we've helped or assisted to make sure that they clearly understand how to navigate their health plan system or the provider system.

Secondarily, we've focused also early this summer on looking at special population groups where we're experiencing disparities, specifically around the Latino population, tribal groups, and African American communities and also the rural communities; we're monitoring what's going on in rural communities and what the impact is out there.

Currently we're really focused on solidifying our referral networks. What we did was, early on, we – we each assumed that this was one year of funding and so we were going to maximize whatever we could to build an infrastructure for future work. Early on all the presentations and activities that we engaged in we began identifying who our partners would be out in the community and as you mentioned earlier, in the

categories of work, play, pray, shop, and eat. So, early on we started identifying at least a minimum of five organizations under each one of those categories that potentially could be a referral base for us in the future if funding decreased or if staffing decreased and so that’s currently what we're working on.

We service eight counties and in each of the counties we've had staff identify five to 10 referral partners that we're maintaining relationships with who can redirect those in need to our sites for assistance. As Kevin mentioned earlier, word-of-mouth plays a big part so we are now preparing to send out thank you notices to all those folks that we enrolled and reminding them that we're still here to assist them and if they have any referrals that they can send them to us and we'll be happy to help them.

We're currently re-engaging in larger events. To get ready for Community Health Center week in August and then back to school, we're seeing an increased demand by a lot of these organizations requesting more information and assistance at the events in preparation for the upcoming open enrollment time period.

Finally, where we're really moving our entire structure is from moving from managed care to care management. We're looking at how we can, from the initial contact with the

individual make sure that they're linked to services at the completion of our work. Currently in the system that we're developing, we're looking at enrolling the individual, if the individual will be approved or not approved, almost on real time. If they are approved and if they selected Sea Mar as they're provider and they've selected their health plan, we'll go ahead and register within our database system and actually schedule them for their initial visit, either medical or dental.

In the course of that enrollment process if we identify that they are potentially in a high-risk population group, or they fall into the high-risk population group, we will move over to a term manager. We will schedule an appointment with a care manager who will assist them in ensuring that they get all the appropriate paperwork ready for the physician for their initial visit. Our whole paradigm is that we are going to be providing this soft case management so from the initial contact with the individual they remained a part of the caseload of the managed care department until they have actually kept the first visit.

If they no-show the first appointment, our navigators will actually be engaging in home visits to determine what impediments there are for that individual in regards to keeping that first initial appointment. They are not actually coming

off our caseload per se until they have kept that appointment. Part of what we will also be looking at is ER utilization; those that are constantly using the ER will be redirected back in and will be incorporated in our care management process.

Right now we're gearing up and trying to get the framework in place. We anticipate there will be a high demand. We seem to have many folks coming forward with more questions, more so than they did last year and are looking more prepared to enroll this year.

Again, thank you very much for allowing us the time to share with you and look forward to questions.

Samantha Artiga: Wonderful to hear about all the continued improvements building on the great success everyone already had during the previous open enrollment period in these states. Look forward to seeing what happens in the coming year. We are now going to shift to the question-and-answer period and we have some questions lined up to go but if you have additional questions that you want to add into the queue, feel free to ask those through the chat function on your screen.

To get started, maybe can you talk a little bit about who still needs to be reached and enrolled in your states and maybe how you know who those people are?

Kevin Counihan: This is Kevin from Connecticut. We have detailed data of the uninsured by zip code and so we actually target the 10 communities and 43 zip codes in our state that result in about 73-percent of the uninsured.

Samantha Artiga: Any thoughts from the other states on how you're figuring out who to target this next time around and who they might be?

Lisa Lee: Hi, this is Lisa in Kentucky. I don't have the exact numbers but we have mapped out our uninsured prior to the ACA and then after our outreach and we'll continue to focus on those counties that appear to have a high rate of uninsured; but we'll continue an aggressive outreach campaign across the state because there's some things you just never can rest on. Like I said, in Kentucky we have 4 million people, currently 1.1 million of those are enrolled in Medicaid, so it's almost like looking for a needle in a haystack at this point. We will continue our aggressive outreach campaigns just to make sure that any new people moving into the state are aware of the programs and services that we offer.

Rudy Vasquez: Hi, this is Rudy from Washington State. One of the things that we came across with the Latino population specifically was that a lot of them were confused, especially when you get into mixed immigrant families. It became a challenge because early on they did not get sufficient

information. They got confused about the information they did get and it allowed time for misinformation to take hold in their minds; to the point that they were not coming forward. I know this is probably older than most of the folks listening in but we started the Tupperware model: we are inviting families to come together and bring their relatives in large groups - about 20, 25. We are working with the health plans that are helping us with this process to hold focus group sessions to understand where they are at and what they know. Then we are trying to make sure they have accurate information and get them to move from that point forward.

In addition, we are also recruiting them to help us bring more groups together for us.

Taylor Roddy: Hi, this is Taylor from Colorado. I will echo what everybody said: we focused on the communities that we know we did not quite reach as well. We have enrollment data that compares the population to the enrollees that we know we have so we can easily see, by filtering that data, where we need to focus the next round.

From the community standpoint, we know, from uninsured data just available through reports that are public, that our Hispanic and Latino community is certainly underserved. We are focused on partnering with community partners to have those relationships. We are helping to build the in-person assistance

and education, so when it comes to partnering with different communities and media, we have that special one-on-one relationship. That is what we are focused on right now: to reach that population, as well as also reaching our small businesses in Colorado that we know definitely could be served well by the financial aid available to them and the choice that we offer in our Marketplace.

Samantha Artiga: A few questions have come in related to service capacity to help address and meet the continuity involved in both Medicaid and the Marketplace. Can you all speak to the extent to which there has been adequate capacity to meet that need on both the Medicaid and Marketplace side and, specifically on the Marketplace side, the extent to which or how you are ensuring that the networks are adequate to meet the needs and include all the specialties needed.

Lisa Lee: Hi, this is Lisa. I think that in my presentation I talked a little bit about how we expanded our provider network particularly for the behavioral health services. I can't speak to our Marketplace capacity. Prior to the expansion in Kentucky, we did a workforce development study to see where we lacked adequate provider network so that was one of the reasons that we used that data to identify those provider types that we wanted to enroll.

Currently we have had very little complaints or issues with individuals who have experienced access to care issues. We also allow our external quality review organization to do a network adequacy for each managed care organization. Currently we are not hearing of any significant problems with access.

Samantha Artiga: How about someone from the Marketplace side? Any insights into how service capacity is meeting need?

Kevin Counihan: This is Kevin from Connecticut. We have a fairly, I guess, aggressive network adequacy standard so the carriers need to have 85-percent of their most popular commercial networks of primary care docs and specialists in our network for the standardized. We offer accommodation of standardized and customized plans, so for the standardized plans they have to have 85-percent of their most popular commercial network and the [inaudible 00:37:43] on the formulary. The standardized plans have to be the formularies of their most popular commercial plans.

Samantha Artiga: Combined with service capacity ensuring folks can get the healthcare they need will depend on, in part, them understanding their health insurance and how to use it. I think when we came out and conducted these interviews, we heard in all four of your states that healthcare and health insurance literacy was a big challenge that you were

facing among your newly insured population. Can you speak to some efforts you may have underway to help educate consumers and really increase health insurance and healthcare literacy?

Taylor Roddy: This is Taylor from Colorado. I can talk a little bit to that. You actually showed one of the pieces we have been using in our social channels. It is a jargon busting campaign so we simply take most of the glossary terms of insurance and try to break those down into digestible pieces that people will understand and we have a campaign on our Facebook page, and via Twitter, as well, that we do weekly on that. Then we supplement that with some examples on our website as how that plays out as people are accessing their care.

I can also say that Sea Mas recently put out a good piece on coverage to care so there is a series of videos. There is also a series of PDFs and roadmaps that we've leveraged in Colorado both from the [inaudible 00:39:20] side but also via our brokers and our health coverage guides in helping to promote that information to the customers. We know we need to help them access care and understand it because we know that is how they are going to renew and find value in their health plan through us.

Samantha Artiga: Rudy, maybe any thoughts on what you're seeing in terms of what kind of help consumers need most to understand how to use their coverage?

Rudy Vasquez: Just same thing everybody else is saying. The health benefits exchange is looking into this and we noticed that early on, and we knew that was going to be a challenge. There were just too many new words and things or concepts to try to absorb and we had difficulty with it on our own so we knew that our population group that we primarily serve would also.

That's why we moved to these community talk sessions just to see what resonated with them and to make sure that the concept was in there before we started giving them any information because you can give all the information you want but if the concept isn't there, they won't know where to start or what to do with it. A lot of it is going be happening orally for us. We did find some visual pieces, which were helpful but even the visual pieces can get somewhat complex.

Hopefully, with a lot of education—and we're doing education constantly. For the moment we meet with them, we're walking them through the process, we're checking to make sure they understand the next steps. We have a 1-800 line if they have a question pop up. We have an e-mail address where they can write to us. We're constantly on as those questions

surface for them because it varies from individual to individual. We're hoping that in our community dialogue that we'll be able to get the appropriate phrasing that resonates with that population group that we're working with.

Samantha Artiga: We're also having some questions now come in related to consumer assistance. Can a few of you maybe speak to what efforts are underway to help ensure or to sustain the strong network of consumer assistance you had previously during this open enrollment period and maybe what initiatives are underway to help strengthen that network, for example maybe through training or other improvements? Taylor, can you maybe speak—go ahead, Kevin. Kevin, were you going to say something?

Kevin Counihan: No, it was not me. It was Rudy.

Samantha Artiga: Go ahead, Rudy.

Rudy Vasquez: Okay, internally we trained most of our staff to be of assistance, and they're all sharing in various roles as far as educating the public about—or educating at least the consumers that are coming in. Historically, we've always had customer service reps at our medical sites. What's changing now is that we're using our navigators to be placed at our other sites; our behavioral health sites, our dental sites, and our ancillary service sites. What they're required to do is what I call a milk run: they are required to spend a certain amount of hours consistently at each one of those sites so that

the public is aware that they can go to those specific locations for help.

What we're finding with a lot of the consumers is they used the Department of Health and Social Services for renewal assistance and for other things. Of course, in our states, they're not doing some of those things anymore; but they're wanting to have a physical location to go to on a regular basis, if they know it's going to be there. That's why we've kind of tried to institutionalize some of those days and hours so that they know that on Monday afternoons from 12:00 to 5:00 at the dental building there will be someone there to assist them.

Samantha Artiga: Great. In terms of system upgrades I think Kevin and Taylor as well as Lisa; you talked about continuing system improvements. Can you speak a little bit to what some of the key features were that really helped consumers with your systems during this last enrollment period, for example maybe some of the shop-around features and how those were used and what types of features you're really focused on adding to improve the consumer experience this time around?

Lisa Lee: This is Lisa. I think the key features that assisted consumers in Kentucky of course was the ease and just the overall appearance. It's a very friendly site. You didn't have to buy anything. Individuals could go in and put in a

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

fake family if they wanted to that looked just like theirs. They didn't have to enter their name. They didn't have to enter anything until they actually wanted to enroll and search for a product.

Upfront, we had a little tool that individuals could go in and enter the number in their family and their household income. It would say you will potentially be eligible for either Medicaid/CHIP, or a product on the exchange. I think that that was very helpful for them to know right off the bat that they would qualify for something.

Then going forward, of course, we're going to be focusing on just listening to our members and individuals who applied for benefits. If they have issues we will make the site as friendly as we can, but it's pretty easy right now. The biggest thing going forward for us, of course, right now we only have the [inaudible 00:45:43] population on the exchange. We have a joint application process with their exchange so you can apply for Medicaid/CHIP or a health product on there. Going forward we'll upgrade that system to allow other individuals such as their aged, blind, and disabled population to enroll online as well. Currently they're not on our system.

Taylor Roddy: Hi, this is Taylor from Colorado. I was just going to weigh in on a few things that you had asked, Samantha. I think some of the tools that worked well for us

were the estimate drug and out-of-pocket costs so people that were new to the system could get an idea of what type of drug they are currently on what they need going forward and possibly how much those would cost so they could buy the appropriate plan.

We also had an “Estimate Your Tax Credit” tool that would quickly give you an estimate based on household and size and where you're located, what you might be eligible for and I think that was important to at least peak curiosities and let somebody know that they were eligible or could be eligible. Once they knew that then that made the process much easier to apply.

What we're looking to do, I think, is try to find a better way to communicate the formularies and have those as a searchable function so people can understand which plans will cover their drugs and which will not. That’s what we're focused on in the new system.

Samantha Artiga: Looking a little bit more broadly at what you anticipate with this coming open enrollment period, is there anything you anticipate will be different in terms of will it be harder, will it be easier, will there be different challenges than you faced the first time around? What are you expecting? Any thoughts there?

Taylor Roddy: This is Taylor from Colorado. I can weigh in just real quickly. I think last time around we were so heavily focused on acquiring new customers and that was an intense focus for the six months of open enrollment and even beyond that. This year I think certainly we need to focus on acquiring new customers to get more people back into the system but we also have to take care of the customers we currently have. We all know it's easier to retain a customer than it is to acquire a customer so that’s where the educational portion comes in and really building those feedback loops and high levels of service in our customer service center and all of our touch points so we continue to retain our current base of customers.

Samantha Artiga: Any other thoughts on what might be different this next time around and to the extent it might be harder or easier to reach people who are left out there? There's been a couple of questions related to reaching people in rural areas. Can any of you speak to what has been effective where reaching folks in those communities in particular?

Lisa Lee: This is Lisa in Kentucky. We have 120 counties in our state, and I believe about 98 of those counties are considered rural; but it's actually the boots on the ground going to all those little State Fairs and connecting with

individuals, in their home and in their communities. That's the biggest, I think, success for us because that's the only way you're going to reach some of those individuals.

You may not reach an individual directly, but like I said, when we went to the fairs or we went to the little community festivals, and we talked to individuals on the street and we asked them do you have health insurance; if they said yes but my daughter doesn't but this one doesn't, we would give them information to take back. It just started spreading quickly through word-of-mouth. In those small rural communities, that's what you're going to have to do and have somebody in that community that's going to be your champion.

Samantha Artiga: I'm looking at current outreach and enrollment efforts, what kind of initiatives are underway to reach out to people who might be eligible for the special enrollment period, and how to maybe help communicate that Medicaid enrollment remains open all year around.

Taylor Roddy: This is Taylor in Colorado. I can help answer a few of those at least from what we're doing. Close to the college graduation time frame as we know people turning 26 can no longer be on their parent's plans so we targeted some of the more non-traditional students at college graduation time and did a big outreach effort both socially, online, and as well as on campuses. That was one of our focuses and also in

our social media campaign calendar we have a weekly if not two times a week a mention of special circumstances and at least just asking the question gets people thinking.

For us, small businesses can also enroll all year around so small businesses in that outreach effort is something that’s continuous for us as well.

Samantha Artiga: Kevin, in your remarks you had mentioned that you were expecting a significant rate of churn. Can you speak a little bit more to what that would be due to and any measures you're putting in place to try and address that?

Kevin Counihan: Well, I think that when you look at the population with the income range that we're all serving that it's not uncommon to see that income fluctuate and that individuals within certain income ranges can fluctuate back between Medicaid eligibility and QHP eligibility. I gave an example earlier of roughly 15 to 20-percent of the re-debts from Medicaid being re-debted off Medicaid and going into QHP and so conversely we're expecting a similar, if not higher, percentage going into Medicaid.

I think that we're going to see ourselves so joined at the hip with Medicaid because we're really serving a common population in many respects at that lower income range of QHP. We can't change people's income obviously but what we can do is

try to make the transition between the two programs as easy and simple as possible. We're not there yet. We actually have a ways to go but that's one of our core objectives.

Samantha Artiga: As I mentioned in my remarks, I think one strategy we heard that was very successful in your states was developing close working relationships between the insurance brokers and other enrollment assisters. Taylor or Lisa, could you maybe speak to how you've facilitated some of those connections between those individuals?

Lisa Lee: Hi, this is Lisa. We were very fortunate in Kentucky, all of our organizations pretty much fall under the same umbrella except for the Department of Insurance but our executive director of the Kentucky Health Benefit Exchange is Carrie Banahan. Carrie actually worked in the Department of Insurance and she served as deputy commissioner in the Department for Medicaid Services. When she was selected to head up the Office of Health Benefits of Kynect, the Health Benefit Exchange, she pulled resources from all of her previous jobs. I think that her knowing all of those systems, insurance and Medicaid and how everything worked was really a key to one of our successes because we collaborated on everything. Medicaid would actually sit in the room with the staff from the Exchange and we would design the application and answer questions. I

think just choosing the right people and knowing that we're all in this for the same reason was one of our successes.

I have to give much of the credit to our secretary, Audrey Haynes; and Carrie Banahan as the executive director for the Exchange; was just the right selection because she had all of that background.

Samantha Artiga: Taylor, any comments on how brokers and assisters worked together in Colorado?

Taylor Roddy: I would just echo what Lisa said. It really came down to the relationships. Our broker managers and our assistant network managers are very, very well tied in with their certified channels and have weekly touch points so it really was just a call of sending out the event information and asking for help. Then also once we got everybody in the same room really talking about each of their experiences and what each could focus on. When you're triaging people coming into a walk-in site, you as a triage person know exactly what books can help with what situation or what help coverage guide can help as well and then help facilitating that pass-off between the two.

Samantha Artiga: Kevin, can you speak to how creating your own state exchange facilitated your ability to coordinate Medicaid and QHP coverage and how that might have been different in another arrangement?

Kevin Counihan: That's a good question. I haven't really thought about that. I'm kind of two minds of that whole thing anyway just because I think that exchanges because of the sustainability issue they're not state agencies and I think they have to be more entrepreneurial, more business like than a typical state agency needs to be or maybe even should be.

I think because of that the DNA of the exchange versus a state agency has to be by definition has to be a little different. That's why the coordination I think as someone said within Medicaid is just so critical but I'm not necessarily sure that the – what makes a good state agency necessarily makes a good exchange and vice versa.

Samantha Artiga: We just have time for maybe a couple more questions. I guess one question is I mentioned how having a functioning enrollment system was really key to success in these states and we know that that did not occur in all states. Can maybe Kevin and Taylor maybe you can speak to what allowed you to have a functioning enrollment system and Lisa as well in Kentucky, you all I know were up and running very well. What really allowed you to get there and be operational during this open enrollment period?

Lisa Lee: This is Lisa. Lots and lots of testing prior to. We went through so may dry runs with our system, I mean, you just had to do that and again close working

relationship between Connect and Medicaid and the technology folks.

Kevin Counihan: This is Kevin in Connecticut. I would agree with that. I know in our state less is more was a clear mantra. We ended up scaling back 30-percent of our desired functionality in January of 2013 thinking that we were better off building a Ford Focus than a Maserati and we also, to be frank, had to draw a line with some of the rules and regulations that kept changing. I actually called federal officials on March 1st to say with all due respect, any new laws, regs, MPRMs that you pass we're not going to do. We can do in a year but we have to—the goalposts can't keep getting moved.

We're saying as of March 1st if the goalposts are where they are we're going to build to those goalposts and with all due respect if you change the goalposts we're not moving our own. I think it was focus, it was trying to be disciplined on doing fewer things consistently well and that probably helped us at least.

Samantha Artiga: With that we are just at our 2 o'clock hour out here on the East Coast. I want to thank, everyone, for spending this past hour with us and hearing about the experiences in these four states about what worked and what they're looking ahead to in the future. I would again

encourage you to go take a look at the full report that's available on our website at kff.org, which has many more details beyond what we were able to cover today. If you need follow-up information or have questions, you have contact information here on this slide to reach our communications folks here at KFF.

You should also be able to connect in if you want to receive future information about upcoming events and web briefings. Thanks again. We hope this web briefing was useful and informative for your work and we look forward to sharing more information with you again soon.

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