IMPROVING ENROLLMENT

Technical, Procedural and Policy Recommendations to Maximize Enrollment, Improve Implementation of the Affordable Care Act: Lessons from Pennsylvania

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EXECUTIVE SUMMARY

The passage of the Affordable Care Act (ACA) accomplished a century-long goal of reforming our broken, disparity-ridden health care system, and the marked success of the first open enrollment period -- with more than 8 million enrolled nationally, including 318,077 in Pennsylvania -- illustrates the pent-up demand for the quality, affordable choices the law provides. However, as with most historic advances in our nation's history, the road was rocky, at times littered with obstacles that delayed or denied access to coverage for consumers who were most in-need. In this document, Navigators and Certified Application Counselors providing in-person assistance to diverse communities across the Commonwealth offer "lessons learned" from challenges met and overcome during this first open enrollment period with the goal of making the enrollment process smoother, simpler and more efficient in years to come:

TECHNICAL INFRASTRUCTURE

To a significant extent, Healthcare.gov and the call center are the public face of the ACA. After a tumultuous start, the enrollment process improved considerably to accommodate increasing traffic, for which credit should be given to the CMS technical team. However, more improvement is needed to ensure:

- **ACCESSIBILITY:** System capacity should allow consumers to complete a telephone application in 30 minutes or less, experience wait times of 5 minutes or less, and view or modify applications submitted via phone or mail online. Alternatives for consumers who do not have or wish to have emails or cell phones should be offered.
- **RELIABILITY:** Consumers should be able to trust that information given over the phone or online will not be lost due to a system error, and be supported with a call center structure that prioritizes prompt callbacks when connections are lost, expedient escalation of application problems and timely resolution of complex cases.
- **CONSISTENCY**: Knowledge and application of the ACA's provisions should be consistent across call center representatives and in-person assisters. Stronger quality assurance measures, coupled with enhanced and more interactive training materials (e.g. realtime "dummy applications") for assisters would benefit consumers.
- **SIMPLICITY:** Streamline application questions and better prepare consumers to provide accurate answers by providing interactive support inside the website application. Offer indicators of progress during the application, and provide more tools to help consumers compare plans (e.g. explain provider networks, cost-sharing, terms).

ENROLLMENT EXPERIENCE

Ideally, individuals seeking health coverage should know what they are signing up for and have an experience free of confusion. At the point of choosing a plan, an applicant should understand its terms, including whether its provider network allows access to their preferred physicians and if certain services can be accessed before the plan's deductible is met, and trust that the transfer of information to the insurer is completed promptly, without error.

To achieve this end, improvements should concentrate on: providing culturally competent outreach and a broader set of health literacy resources that are sensitive to regional, ethnic and socioeconomic differences in uninsured populations; streamlining the process to allow a consumer to complete an application in one sitting (e.g. eliminate redundancies, simplify identity verification); enabling a tracking system for appeals and complex cases with specific points of contact for follow up; making status records, account information and eligibility results available across all platforms; training call center and field assisters to the same standard; and improving communication with insurers and providers to ensure a smooth transition to coverage.

POLICY ISSUES

Certain policy elements of the ACA have posed challenges to enrollment efforts. Immigration policies have introduced complex navigational workarounds, as have those relating to families with complicated tax households (e.g. non-tax-dependent young adults). The lack of Medicaid Expansion has caused a perception of unfairness among those with incomes too low to qualify for financial assistance and confusion surrounding what individuals in the gap need to do to secure an exemption; and the interface and problematic communication between the FFM system and other state-based programs like Medicaid and CHIP has required assisters to walk consumers through two application processes, each of which carry different definitions of household size and income. To address these issues, improvements should be made to: clarify and streamline information required of immigrants; clarify the process for consumers in the expansion gap of reporting an exemption at tax time in 2015; and ensure accurate intra-agency communication.

The ACA's first open enrollment period has provided valuable information on what systems can be improved to ensure even more success in its implementation. It is in everyone's interest to strive for user-friendliness, clarity, quality, and consistency, and it is in that cooperative spirit that we offer these recommendations.

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INTRODUCTION

Open enrollment in the Federally Facilitated and State-Based Insurance Marketplaces closed at the end of March, with eight million people having enrolled in a health plan through the new mechanisms created by the Affordable Care Act (HHS, 2014). In testimony before the House Committee on Energy and Commerce on May 7, the heads of several national insurance companies confirmed that over 80% of those who enrolled in Marketplace insurance have paid at least their first month's premium (NYT, 2014). In other words, the Affordable Care Act (ACA) and the health insurance exchanges it created have allowed substantial numbers of Americans to gain access to health insurance at rates that are aligned with their household income.

Demand for coverage was high, as was the need for accurate, timely and actionable support for individuals and families looking to purchase coverage. Enrollment assisters and Marketplace representatives worked to provide that support, but faced significant challenges accessing and applying information to help consumers navigate the Marketplace and successfully enroll in coverage.

In the seven months between the close of open enrollment for 2014 and the start of open enrollment for 2015, assisters and advocates have taken stock of which outreach strategies were successful, what support systems worked well, and where more improvement is needed to ensure a quality, consumer-friendly enrollment experience moving forward. The Pennsylvania Health Access Network (PHAN) coordinated resource sharing and support among enrollment assisters throughout the open enrollment process, and this document synthesizes the "lessons learned" and recommendations for adjustments to that process in future years from Certified Application Counselors, federally-funded Navigator organizations and health advocacy groups who have been providing in-person assistance, education and support in Pennsylvania since September 2013.

Experience and insight is drawn from the experiences of enrollment assisters who worked in rural, urban, and semi-urban settings, through health clinics and hospitals, with non-profit community agencies, and through local universities. Our objective is to provide recommendations that can increase the efficiency and inclusivity of the enrollment process for consumers in both the Federally Facilitated Marketplace (FFM) and State-Based Marketplaces.

APPROACH TO GENERATING RECOMMENDATIONS

Our recommendations focus on three aspects of the enrollment process – technical infrastructure, enrollment experience, and policy elements – and offer experiences and proposals for change that address each aspect.

- **TECHNICAL INFRASTRUCTURE** includes both the call center and the website interface and processes necessary to utilize them. Because our experience has been within Pennsylvania, a state that used the FFM, our discussion of technical infrastructure is generalizable to all 27 states using the FFM.

- **ENROLLMENT EXPERIENCE** focuses on observations and experiences with roadblocks encountered by consumers during the enrollment process that hampered their ability to accurately and efficiently complete the application and understand the range of their coverage options.

- **POLICY ELEMENTS** identify statutory and regulatory aspects of the ACA that affect different types of consumers, and make recommendations for policy changes that could expand access for them.

- In addition, because of our cumulative experience, we offer suggestions on **RESOURCES FOR ENROLLMENT ASSISTERS**, as an additional opportunity to address some of the challenges associated with enrollment.

The information and recommendations presented in this document were gathered through a survey of enrollment assisters in PHAN's CAC/Navigator Network. PHAN conducted bi-weekly phone calls throughout the open enrollment and post-enrollment period, as a way to connect enrollment assisters to one another and to regional and national resources to support continued learning and effective outreach and enrollment strategies.

One organization participating in the PHAN network was the Central Susquehanna Affordable Care Act Project, which included faculty and students from liberal arts universities in the central region of the state who provided enrollment assistance as CACs and kept field notes of their experiences as enrollment assisters. Where appropriate, we have changed identifying details of consumers and enrollment assisters, to ensure anonymity and to highlight the broad application of these recommendations.

CONTEXT AND BACKGROUND

With expansive rural areas, dense pockets of urban poverty, and burgeoning refugee communities, a widely diverse set of Pennsylvania families posed unique challenges to outreach and education for ACA enrollment. Enrollment assisters across the state created novel and complimentary approaches for overcoming the lack of financial and administrative support from the state. The $2 million provided to the state via the federal government for Navigator organizations proved to be too little to meet the demand. In this gap, many of us as volunteers, worked alongside individuals and families on the social margins to provide enrollment support to those most in need of increased access to healthcare services afforded by having insurance.

As of June 2014, Pennsylvania is one of the five states in which Medicaid Expansion is being openly debated (Kaiser Family Foundation, 2014). We view this lack of expansion as a major hurdle to all residents being able to gain full access to quality healthcare. It shaped the experiences we each had in trying to provide enrollment assistance. As assisters, we each have stories of sessions ending with an inadequate explanation to the person we sought to help that they made too little to qualify for help. However, even in light of these challenges and limited resources, we are proud to have contributed to the enrollment of nearly 320,000 PA residents who did select a marketplace plan (HHS, 2014).

It is important to note that we each found ourselves doing more than providing one-on-one enrollment assistance. We gave public talks to diverse audiences about the ACA. We created grassroots advertising campaigns with donated resources and placed educational brochures in churches, libraries, and CareerLink offices. Members who helped to write this set of recommendations have been on local television and radio programs to educate Pennsylvanians on new options available under the ACA and where to find in-person assistance. Members have also voiced opinions through editorial pages and have generated newspaper coverage throughout the state. We are openly oriented toward providing recommendations to improve this process, as we want more residents to have access to care.

The following sections offer recommendations for improving the enrollment process for consumers and assisters. We have divided our recommendations into three aspects of ACA enrollment: technical infrastructure, enrollment experience and policy elements. In addition, we build on our experiences as in-person assisters to offer suggestions about how to better support and utilize enrollment assisters to improve the enrollment process in the future.

TECHNICAL INFRASTRUCTURE

Improving the FFM Call Center

Many of the challenges with the call center have been raised by assisters in FFM states and, to the credit of CMS and HHS, work has been ongoing to address them.

We seek to highlight here, important issues that may not have been identified as problematic, and those areas where slight modifications could have a significant impact in preventing future obstacles for consumers and assisters.

1

GIVE OPTION TO WAIT WITHOUT HOLD MUSIC: Understanding that it is not feasible to eliminate wait times entirely, add the option to mute hold music. This feature, adopted by many insurers, will allow assisters to use wait time to educate and prepare consumers to move efficiently through the process once connected to a representative.

2

CONNECT ASSISTERS WITH CASEWORKERS: To better resolve complex cases, ease consumer anxiety and prevent duplicative work, provide assisters with contact information for specialists in their region so they may connect with the appropriate office or division directly.

3

ENSURE "AUTHORIZED REPRESENTATIVE" DESIGNATION STICKS: To better aid consumers needing the support of an assister to complete an enrollment or report life changes, make sure the call center computer system saves a designation requested to add an assister as an "authorized representative" for the agreed-upon timeframe.

4

OFFER ALTERNATE LANGUAGE PROMPT FOR NON ENGLISH OR SPANISH SPEAKERS: Offer call center language translation services earlier in the teleprompt structure so that non-English or non-Spanish speaking consumers do not have to understand and respond to English or Spanish prompts to progress to the application or to request language services.

Improving the FFM Website Application

1. **REMOVE EMAIL REQUIREMENT, TECHNOLOGY BARRIERS FOR CONSUMERS:** Remove the requirement for consumers to have an email address to create an account and submit an application by providing alternative technological and verification options. Allow a consumer to request to receive both paper and electronic notifications, via mail and email.

2. **ENSURE APPLICATIONS COMPLETED VIA CALL CENTER ARE EASILY ACCESSIBLE ONLINE:** A consumer should be able to create an online account and find their application -- to make changes, correct information or complete the enrollment, regardless of how it was submitted.

3. **SIMPLIFY IDENTITY VERIFICATION PROCESS:** The identity verification process for all consumers should be streamlined by allowing enrollment assisters to testify to the validity of primary identity documentation. A consumer should be able to move forward and complete their enrollment while waiting for final proofing (similar to the current process with income verification).

4. **MAKE APPLICATION EDITABLE WITHOUT RETURNING TO THE START OF A SECTION:** Update the website interface to allow changes to be made inside a consumer's application without having to restart the entire section or application.

The mandatory use of email to create an online Marketplace account and submit an application through the website was reported by 75% of enrollment assisters surveyed as being a frustrating, time-consuming process for many consumers.

In both rural and urban areas, many consumers did not have an email address, and creating an account took extra time and added an additional layer of complication by creating two usernames and passwords for the consumer to remember.

Many (40%) enrollment assisters surveyed reported difficulties linking applications submitted over the phone to web or mobile phone accounts, which creates challenges for consumers who want to return to and review the insurance plan options before making a decision.

Once consumers began the application process, many were frustrated by the inability of the website to allow changes to be made without starting a new application or having to review every single page.

Just 1 in 6 people who tried to enroll online and did not get in-person assistance successfully enrolled.

[Enroll America Research, December 2013]

ENROLLMENT EXPERIENCE

Improving Education and Support

1. **EXPAND AND ENHANCE EDUCATIONAL MATERIALS FOR CONSUMERS:** Better educational materials that are sensitive to literacy levels, regional differences (urban, rural) and the unique needs of particular groups (e.g. unemployed, self-employed, immigrants, women, the LGBT community) are needed to adequately inform consumers about the ACA, basic health insurance terminology, and how to apply that knowledge to their situation. Materials should be culturally competent, utilize more pictures with less text, and be available and accurately translated into a variety of languages.

2. **EDUCATE CONSUMERS INSIDE THE MARKETPLACE APPLICATION:** Help consumers understand why certain information is being requested, how to provide accurate answers (e.g. estimating income, tax household), and how a given answer may impact their eligibility as they move through the application. This could be accomplished by adding a brief video explainer on each page or by adding hover-text pop up bubbles with simple, clear information similar to what's currently done in other areas of Healthcare.gov.

Assisters face a variety of challenges to providing an efficient, effective and educational enrollment experience. The most obvious barrier is time; assisters report average session appointments of 1.5 hours per individual or family and there is a low ratio of assister to community members in need.

Another significant barrier is public perception of ACA and the prevalence of myths that lead to hesitation to enroll. This and barriers to communication contribute to the long assistance sessions needed to address each consumer's educational needs prior to successfully enrolling.

Many consumers in need of assistance possess low-literacy. In addition, many community members have limited English proficiency. Assisters know that health insurance has a language of its own that is difficult and takes time to understand and that is challenging, but imperative, to teach.

Consumers and enrollment assisters also reported frustration with the lack of information available within the website application about how specific answers could impact an applicant's eligibility. Not knowing enough to be able to provide accurate information about income, tax filing status, family size or the availability of job-based coverage often lead to difficult situations for consumers and assisters to untangle.

Improving Education and Support

3 **SIMPLIFY THE APPLICATION AND ASK FOR INFORMATION IN A UNIFORM MANNER:** To the extent possible, remove redundant questions and condense optional questions onto a single page. Ask for income information in a standardized way, for every applicant: either require individual sources and amounts for each household member, or ask for an estimate for the household.

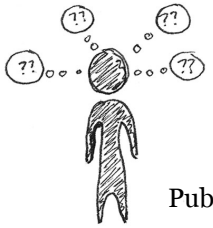
4 **ENSURE ELIGIBILITY RESULTS ARE ACCURATE AND EASY TO READ:** Applicants should be able to count on receiving eligibility results that are accurate and to be able to understand them, without becoming overwhelmed. Eligibility results should be written for lower-literacy levels and prominently flag or feature what steps a consumer needs to take, if they are required to send in supporting documents.

5 **DEVELOP BETTER TOOLS TO PREPARE CONSUMERS TO SELECT A PLAN:** Consumers' experience choosing the best plan for them would be enhanced by providing more explanation of basic insurance terms within the plan selection screens, and by ensuring that insurance providers offer easily accessible, complete information about plan details like provider networks, services covered before the deductible is met, and prescription drug formularies for every plan.

While in some cases there is too little information available about the questions within the application, in other cases there are redundant or unnecessary questions that can be confusing and time consuming.

The eligibility results that consumers receive through the FFM website are difficult to read. They present an overwhelming amount of general information and not enough detail on the applicant's specific situation and steps necessary to complete enrollment.

Consumers need to have a clear understanding of what to look for before choosing an insurance plan, and how to apply that knowledge to their specific situation. Confusion remains over basic insurance terms, provider networks, and cost-sharing reductions. One solution would be to include definitions of basic insurance terms, provider networks, and cost-sharing reductions in a consumer's eligibility notice.



Only 31% of the uninsured feel confident in their understanding of basic health insurance terms.

Public Understanding of Basic Health Insurance Concepts on the Eve of Health Reform, Urban Institute (Sept. 2013)

6 **ENHANCE PREVIEW TOOL TO SHOW TOBACCO SURCHARGE, HIGHLIGHT COST-SHARING REDUCTIONS:** Build on the success of the plan preview tool on Healthcare.gov by adding the ability to see true prices for consumers who smoke. To help ease consumer anxiety over affordability, enable a more prominent display of Silver plans that offer lower co-pays and deductibles, when a consumer is eligible (e.g. "SAVE MORE: In a Silver plan, you are eligible for a $100 deductible). Currently, a consumer is shown steep Bronze-level deductibles first, unintentionally reinforcing fears of having no affordable options.

POLICY ELEMENTS

Regulatory action to ensure fairness

1

HOLD INSURERS ACCOUNTABLE: Work with insurers to see that information provided to consumers through online provider directories and in Summaries of Benefits and Coverage are clear and presented in a much simpler format, for lower literacy levels. Searching for providers through an insurer's website was extremely difficult for consumers to do on their own, and often, information provided was not current or correct.

2

REVISE STANDARD FOR CALCULATING PREMIUM TAX CREDITS WHEN SKEWED BY INSURER BATTLES: To prevent an insurer from circumventing the ACA's intent to enhance consumer choice, consider using a different standard than the second-lowest cost Silver plan when determining premium credits in areas where insurer battles result in large differences between the cost of the second and third lowest-cost Silver plan. The federal government should leverage the purchasing power of new enrollees and harness the impact of new subsidies, ($2,322 per enrollee for a total of $600 million in 2014) to ensure ethical, fair and consistent behavior by participating insurers.

258,455 of the 318,077 Pennsylvanians enrolled in private health plans offered by insurers operating in the Commonwealth are receiving financial assistance, made possible by the ACA. In other words, insurers operating in the Commonwealth have benefited significantly from the law's subsidies. As such, it's important that insurers treat newly-insured enrollees fairly, providing clear, accurate information in a timely fashion both pre and post-enrollment.

Unfortunately, however, consumers are already reporting a number of problems to assisters, including: having payments not processed properly, leading to unfair cancellations of coverage and receiving confusing communication that verifies a consumer is enrolled, *but listing the higher non-subsidized price as their monthly premium.*

Further, contract disputes by entities that dominate both the insurer and provider landscape threaten to disrupt consumers' care and eliminate choice. Highmark offers a Community Blue plan at a much lower cost than every other insurance product available in the Marketplace. However, it is excluded by the region's largest provider -- and the only provider in some rural areas -- UPMC. The low price of Community Blue plans has skewed the effect of premium tax credits, making Highmark's product the only affordable option for most consumers.

Regulatory action to ensure fairness

3

APPLY TOBACCO SURCHARGE FAIRLY: To ensure that the tobacco surcharge is not so high that it nullifies affordable coverage, institute a sliding scale surcharge based on income or a cap for income ranges. Provide public notification about how the surcharge is calculated and applied to allow consumers and enrollment assisters to anticipate the adjusted cost of coverage and help monitor for incorrect applications. Transparency in how the surcharge is calculated would also establish greater public accountability for insurance companies in applying the surcharge responsibly and consistently.

4

AMEND EXISTING REGULATIONS TO ELIMINATE FAMILY GLITCH: Modify current regulations to simplify the rules surrounding employer-based coverage. One option would be to require that employers only provide single coverage, rather than the current complex rule that they provide to dependents, but not a spouse. If an employee's cost is more than 9.5% of the wages paid to them by their employer (rather than household income, which increases the burden on consumers to afford, and to calculate) and they opt for subsidized Marketplace coverage, the employer would make a shared responsibility payment. If the cost of family coverage offered by the employer is more than 9.5% of wages paid by the employer (or is not at least at a Bronze level of coverage), the family is free to secure subsidized Marketplace coverage (if income qualifies) and the employer would not need to make a shared responsibility payment.

Enrollment assisters in Pennsylvania working with tobacco users reported consumer feelings of alarm, injustice and in some cases inability to afford premiums after the tobacco surcharge had been applied to the plan costs. In many instances, the surcharge increased the premium amount for consumers by more than $100 and for many, made tax credit subsidized coverage unaffordable.

Assisters from across the state also reported inconsistent and unpredictable surcharge amounts applied to the premium cost, raising concerns that different formulas were being used to calculate the tobacco surcharge or worse, that it was being applied arbitrarily. This also made it challenging for consumers looking at plans through the window-shopping tool to estimate their premium rate, as there was no consistent way of anticipating the cost of the surcharge.

One of the most widely-publicized policy "glitches" with the ACA, and one that assisters dealt with frequently is the "family glitch." The Kaiser Family Foundation estimates that 3.9 million non-working dependents do not have affordable coverage. These individuals would be eligible for income-based subsidies, if not for the "family glitch" that sets the price of individual coverage offered by an employer as the threshold to determine what's affordable -- even if family coverage is needed. Dependents are blocked from getting financial help in the Marketplace, and priced out of securing it through the employer, leaving them uninsured and faced with a complicated process to obtain an affordability exemption from the penalty.

RESOURCES FOR ASSISTERS

Tools Needed to Better Serve Consumers

1. **CREATE A WEB PORTAL FOR NAVIGATORS AND CACs ON HEALTHCARE.GOV:** Enable Navigators and CACs to efficiently provide application assistance, in person or over the phone, through a dedicated portal, similar to ones that are already used by community-based organizations through state-based online application systems. This much needed case management system could help resolve application challenges such as identity verification and uploading documents as well as reduce the burden on the federal call center.

2. **PROVIDE ASSISTER ORGANIZATIONS ACCESS TO "DUMMY APPLICATIONS" TO PRACTICE, WORK THROUGH COMPLEX SITUATIONS:** To facilitate the most effective hands-on learning for Navigators and CACs, give each assister organization the ability to create dummy applications. This would allow assisters to become fluent and skilled at navigating the application (which is different based on the type of consumer assisted -- e.g. immigrants, non-tax-dependent young adults, tax-dependent adults of other relatives) before working one-on-one with consumers.

Recognizing the complex nature of the enrollment process, and the critical role that enrollment assisters play for many consumers with limited technological skills or background knowledge of health insurance and health care systems, the enrollment process could be enhanced by giving assisters more tools to support and serve consumers. Providing assisters with a special portal to submit and manage changes with applications, with a consumer's consent, would allow for faster enrollment, re-enrollment, updating of income and other application details, and enhance consumer experience.

Increased initial training on issues affecting enrollment like: *who can be claimed as a tax dependent, how to read a tax return to pull out MAGI, what unique income sources can or cannot be counted as income (e.g. Social Security Survivor benefits, child care income from the state, adoption income), and -- especially important for 2015 enrollment: how reporting and reconciliation of premium credits received in 2014 will occur, and how to help consumers keep that distinct from projecting income and applying for 2015 coverage* will better prepare assisters to efficiently handle complex cases.

More training on the technical aspects on insurance plans offered, like: definitions of "medically necessary" care, and dental plans is also needed to adequately support consumers.

IMPLICATIONS AND CONCLUSION

The Affordable Care Act has opened the door to better health, economic stability and greater peace of mind for millions of working and middle-income Americans. It is already saving lives, protecting families from financial ruin, and securing a healthier future for our families. Prying open that door was a difficult task, but even more important is clearing the road ahead of obstacles that threaten to interfere with the law's intent to put affordable, quality health care within reach of every American and legal resident.

Estimates show that 482,000 uninsured Pennsylvanians became eligible for new financial assistance under the ACA, and in year one of open enrollment, 258,455 (or 53% of the subsidy-eligible uninsured) used that help to buy a qualified health plan in the Marketplace. These figures highlight the enormous demand for the protections and quality options the law puts in place, and brings into sharper focus the success of assistance, outreach and enrollment efforts despite the challenges encountered. They also highlight the amount of work yet to be done:

- 281,290 of uninsured, low-income Pennsylvanians remain trapped in the coverage gap -- not eligible for Medicaid or subsidized Marketplace coverage.
- Just 4% (8,047) of uninsured Latinos got covered during this first open enrollment period, compared with 12% (28,965) of uninsured African Americans and 18% (172,849) of uninsured whites.
- Of those that didn't enroll, nearly half (48%) cited perceptions of not having affordable options as the top reason for not trying to obtain coverage, followed by "not wanting Obamacare" and not being aware they were eligible.

Research also shows that 6 in 10 of those who did not enroll actually did want coverage, but needed more support to explore and understand their options.

Through our experience, we've learned what tools and changes are needed to better provide that support and trust that our partners at HHS and CMS will be responsive in considering the recommendations we've offered here. Given the tremendous effort already underway to address glitches and problems occurring in year one by federal officials, we have every confidence no workable solution to improve the enrollment process for consumers will be discarded.

As Navigators and Certified Application Counselor organizations that have put in thousands of hours of on-the-ground effort educating, supporting, and connecting the uninsured to coverage, we are committed to applying the lessons we learned in this first year of open enrollment to meet the challenges that lie ahead and see that the promise of health reform is made real for every Pennsylvanian.

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PHAN's CAC/Navigator Network has worked to connect more than 100 assisters from across the Commonwealth leading into and continuing throughout the ACA's first open enrollment period. While these recommendations were formed from the experiences of many participating assister organizations, several took a leadership role in the crafting and refining of this document:

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APPENDIX A: Recommendations to Improve FFM Website Application [Previously Submitted]

Pennsylvania CAC/Navigator Network

Recommendations on Improving the Federally-Facilitated Marketplace (FFM) Website Application

Submitted on May 16, 2014 to the Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Health and Human Services (HHS)

Prepared by participating Navigator and Certified Application Counselor organizations in the Network's Improving Enrollment Workgroup.

The recommendations below focus specifically on the website application experience for applicants and assisters, and are a piece of a fuller set of recommendations to be delivered in June. They have been expedited to ensure that the valuable comments contained within are received before decisions on which aspects of the website application are finalized.

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TOP PRIORITIES FOR IMPROVING CONSUMER EXPERIENCE

I. EDUCATE CONSUMERS INSIDE THE APPLICATION: The Marketplace affordability application does not currently include explanations for consumers on the impact their answers may have on their eligibility determination. This can lead to difficult situations for consumers and assisters to untangle through a specialist, caseworker, or re-doing the application to get accurate results for the applicant, adding on hours of time and unnecessary hardship for consumers. Some problematic examples:

- There is no explanation that if a person indicated they don't plan to file taxes, they will not be determined eligible to receive a premium tax credit. This may seem like a simple concept, but many consumers are new to the tax and application process.
- If a person is married but filing separately, there is no explanation that this will automatically determine them ineligible for tax credits.
- Consumers who fall into the coverage gap that apply through the FFM application to gain an exemption from the shared responsibility penalty -- an exemption that will also provide them with a Special Enrollment Period should their income increase midyear -- will not be able to obtain one if they indicate they are not going to file taxes, which many of them are not used to doing as their incomes are often below the tax filing threshold. There is no indication that answering "no, I don't plan to file" will make it more difficult for them to obtain an exemption and the opportunity to enroll through an SEP if their income increases. Further, since many consumers in the Medicaid Expansion eligibility range have not filed taxes before, the language on the application should be amended to make the question less intimidating, like: "Even if you've never filed before, you can file in the future."
- When an applicant is asked about the availability of job-based coverage, there is no explanation about how that information relates to the consumer's eligibility for premium credits and cost-sharing help. The application as it currently stands does not help consumers understand how to accurately answer the questions (many consumers will answer "No, I don't have job-based coverage" because it's been offered for years, but they've never enrolled due to the cost). Choosing "I don't know" to the question of whether a consumer's job-based plan meets minimum value will delay a decision on their eligibility for financial help, which is often delayed, even after the required documents are obtained and uploaded.
- There is no explanation of how enrollment in COBRA or retiree coverage impacts eligibility for premium credits and cost-sharing help, or that a consumer can dis-enroll from those types of coverage during Open Enrollment and, if canceling that coverage at the month's end, can enroll in a Marketplace plan for the following month.
- Consumers are often confused about tax household vs. actual household, and about who they'll claim as a dependent in the upcoming year. This is a particularly difficult issue for divorced parents who claim their children in alternating tax years.
- Adult dependents of a live-in relative cannot do the application in their name and complete the enrollment process. The application needs to be done in the tax filer's name, but this is not indicated anywhere on the application.

1

ADD BACKGROUND INFORMATION IN CLEAR, SIMPLE TERMS TO HELP A CONSUMER UNDERSTAND WHY CERTAIN QUESTIONS ARE REQUIRED AND HOW THEIR ANSWER WILL IMPACT THEIR ELIGIBILITY: At every stage in the Marketplace application, there should be a small graphic or text ("see why we need this information" or "find out how to answer this question") which would pull up an explanation bubble (similar to the feature on Healthcare.gov where you can hover over a term and see it defined) to clearly and in plain language describe why that bit of information is needed, how to give an accurate answer, and how your answer may impact your eligibility. A short video explainer for each page in the website application that provides this type of background information and prepares consumers to accurately answer all questions would also be helpful, as a replacement for or supplement to the "live chat" feature. Providing information in the same window, rather than having to go to another page on Healthcare.gov is also important, especially for less technologically-savvy consumers or those with slow internet connections.

2

ADD A PROGRESS STATUS BAR INSIDE THE APPLICATION, SO CONSUMERS CAN SEE HOW CLOSE THEY ARE TO COMPLETING THE APPLICATION: Particularly for consumers with large households or job-based coverage, the application can become lengthy. Seeing how close they are to the "finish line" would help ease an applicant's frustration if they're having difficulty getting through the application.

II. REMOVE EMAIL REQUIREMENT, TECHNOLOGY BARRIERS FOR CONSUMERS:

Many consumers did not previously have email accounts but were required to set one up before applying for health coverage. This required the person to set up two accounts and remember two different passwords for an account they did not need except for this application process. The change implemented in January to make account creation easier by allowing a consumer to use their email as their username was helpful, but the email requirement and account creation process still took up significant time and often, got the consumer frustrated before even getting into the application.

Often, setting up a new email address either required: 1) having a current email, or 2) being able to verify that "you're not a robot" (Google's requirement) by responding to a text message. Consumers should not have to have a cell phone or email address to apply for health insurance. Further, if a consumer picked a username that was already in use and linked it with their primary email, they could not use that email with their Marketplace account, since that username was already taken. A consumer was also not notified until they'd completed all account creation screens that their chosen username was taken, and they'd be forced to start over.

3

REMOVE TECHNOLOGICAL BARRIERS TO ENROLLMENT BY PROVIDING THE OPTION TO:

- Create a username and password for Healthcare.gov that could be verified with a cell phone
- Use an applicant's Social Security number and identity verification questions during the account creation process, if they don't have a cell phone or email.

Further, the functionality needs to exist in the application to allow the consumer to request eligibility results in the mail and see them online. The system currently does not allow for this.

III. ENSURE APPLICATIONS SUBMITTED VIA CALL CENTER OR PAPER MAIL CAN BE EASILY FOUND ONLINE: Every assister organization experienced problems helping consumers "find an application" through Healthcare.gov that was initially submitted through the call center. Entering the consumer's Application ID exactly as it appeared on an eligibility notice generated through a call center or paper application frequently resulted in the message: "this application cannot be found." Entering it multiple times resulted in a complete lockout: "We're sorry, you've tried to find an application too many times."

This added significant time and frustration for consumers and assisters, preventing expedient resolution of issues like: changing the misspelling of a consumer's name (something that could easily be done through the report a life change feature, but impossible if the application made through the call center "could not be found"; the only alternative was to take consumers through extraordinary wait times for a specialist at the FFM call center to make these changes), updating income information or household information, or changing plan selection.

4

ENSURE ALL MARKETPLACE APPLICATIONS, REGARDLESS OF HOW THEY'RE SUBMITTED, CAN BE EASILY FOUND AND SYNCHED UP WITH A CONSUMER'S MARKETPLACE ACCOUNT: This was likely a technical glitch, not an intentional policy, but it is critical to resolve it in the future. Hours of time for consumers, assisters, and FFM Call Center representatives could be freed up for new enrollments if every consumer was able to easily access and make changes to their application or complete their enrollment by selecting a plan through their Healthcare.gov account.

IV. IMPROVE AND ENHANCE PLAN SELECTION TOOLS: As it stands currently, the "plan selection" screens in the Marketplace application do not adequately prepare consumers to make an informed decision. Many assister organizations reported spending significant amounts of time with consumers searching for and explaining important plan details that were not apparent or easily understood as laid out in the application. Some examples:

- In some areas of the state, insurers grouped hospitals and providers using a "tier system," which was complex and difficult for consumers to navigate on their own. In general, it was not easy for an applicant to find out if their preferred doctor or hospital was included in a plan. Every insurer's provider directory is different, but all tend to be designed for highly-functioning, web-savvy consumers, and some had incomplete or inaccurate information.
- On both the preview tool, and the Marketplace application, cost-sharing reductions were not prominently advertised. A consumer eligible for a $100 deductible would instead see a Bronze plan with a $6,000 deductible first. That structure is counter-intuitive and creates anxiety in the consumer that an affordable plan is not available.
- The pop-up screens before all plan options are displayed that show the differences in metal levels are helpful, but do not adequately explain what an applicant's choice will mean in practical terms. They also do not address cost-sharing reductions and how, for most eligible consumers, cost-sharing reductions mean that a Silver plan will provide the best value at the lowest overall cost.

- There is no transparency in how the smoker surcharge is applied, and no ability to confirm with any accuracy how the surcharge will be calculated and applied. Many assister organizations reported smoker surcharges that more than doubled an applicant's price, while others reported that it added just a few dollars onto the final price.

- The accuracy and user-friendly nature of Summaries of Benefits and Coverage provided by insurers varies drastically. In some cases, SBCs do not list cost-sharing reductions at all, seeming to contradict the information on Healthcare.gov and making consumers fearful that they cannot be sure of their costs in a plan. SBCs are also unclear about which services apply to a plan's deductible, how co-pays and other out-of-pocket expenses are applied.

5

PROVIDE MORE TOOLS AND LOW-LITERACY, CLEAR INFORMATION TO EDUCATE CONSUMERS INSIDE THE APPLICATION ON THE KEY VARIABLES THEY NEED TO CONSIDER BEFORE SELECTING A PLAN: Consumers need to have a clear understanding of what to look for before choosing a plan, and how to apply that knowledge to their specific situation. That could be accomplished by:

A. Including a short video explainer in place of or in addition to the pop-up screens that precede the plan comparison section of the application that explains, in simple terms, what choosing a specific metal level will mean for their monthly premium and out-of-pocket costs.

B. Working with insurers to provide low-literacy Summaries of Benefits and Coverage documents that accurately describe cost-sharing reductions across plan tiers. Ensure that all SBCs give simple examples, with pictures, of what services count toward a deductible and which do not, and how a maximum out-of-pocket limit is met.

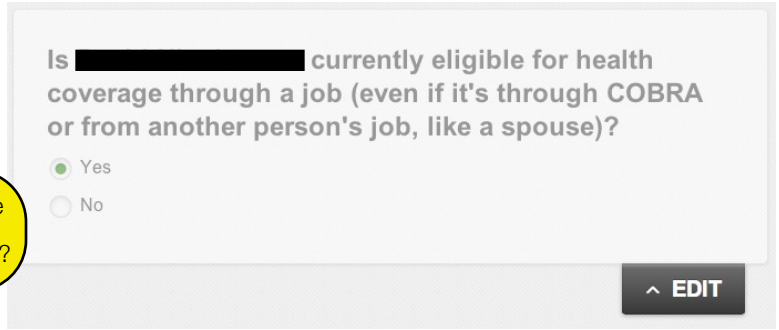
C. Adding a feature to the Healthcare.gov preview tool and the application that will highlight Silver plans as the top choice -- the first thing an applicant sees -- if they are eligible for cost-sharing reductions.

D. Ensuring that the smoker surcharge is accurately calculated and applied in a fair manner by all insurers, and that consumers can see that calculation by using the preview tool and inside the application.

E. Adding an "expense calculator" to the plan selection part of the application that gives consumers the ability to enter information about typical health care events and find out, in each plan, what it would cost and how it would effect their deductible and out-of-pocket maximum.

F. Allowing for greater comparisons between plans in the same level, and between plans in different levels. Add the ability to print out the plan details for two plans to enable side-by-side comparison. Ensure consumers have the ability inside the application to compare the yearly difference in total cost (premiums plus out-of-pocket maximum) between one plan and another.

HOW TO EDUCATE CONSUMERS INSIDE THE APPLICATION: AN EXAMPLE WITH JOB-BASED COVERAGE QUESTIONS



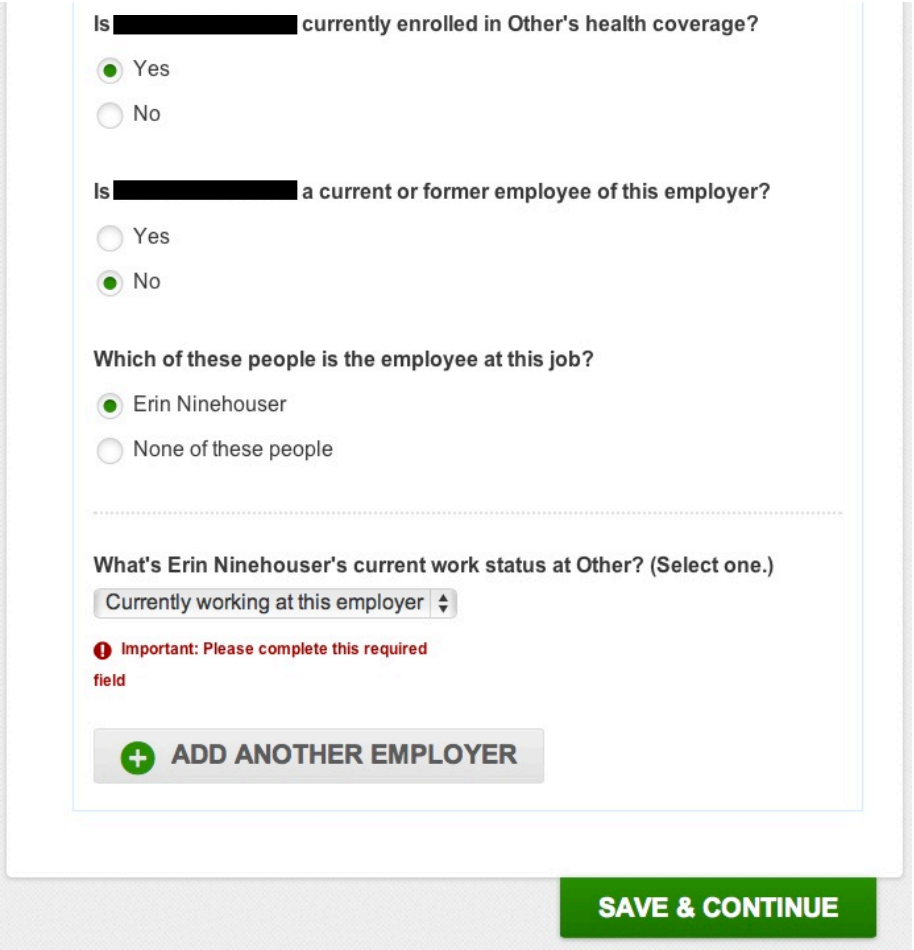
SAMPLE TEXT FOR HOVER-POP UP OR VIDEO EXPLAINER:

The health care law works to help people who cannot get insurance through their jobs.

Most of the time, if your job, or your spouse's job offers insurance, it will stop you from getting financial help.

There are some times this rule does not apply. This is why you are asked questions about your job-based coverage costs and what level of coverage is offered.

If you now have COBRA or retiree coverage, you must drop it during Open Enrollment so you can get financial help to buy a Marketplace plan.



APPENDIX B: SURVEY RESULTS

75%

FRUSTRATED BY EMAIL REQUIREMENT TO APPLY ONLINE

"By far the most difficult issue for consumers who came to me for assistance was just getting logged on."
"Most people that need assistance enrolling are not computer savvy and do not have an email."

HAD INTERACTIONS WITH POORLY-TRAINED CALL CENTER REPRESENTATIVES

70%

"Representatives are not able to get the right information from consumers because they don't understand the definition of household or income (as it applies to the marketplace)."

"The information provided by CMS is often very helpful when working through complicated issues. However, the system was not always updated to reflect the latest information and more often than not, call center representatives were not aware of policy clarifications."

40%

REPORTED PROBLEMS LINKING PHONE APPLICATIONS TO ONLINE ACCOUNTS

"During the entire time of the enrollment process we were never successful in linking an ID application number to the online account to see plans after consumer completed application over the phone."

HIT ROADBLOCKS IN IDENTITY VERIFICATION PROCESS

40%

"As navigators and CAC's, we should be able to attest to these documents being legitimate."

"Identity verification should be treated the same as application inconsistencies to allow someone to enroll and verify their identity after the fact by sending in supporting documents."

35%

WERE DISCONNECTED OR HELD UP BY WEBSITE GLITCHES, SITE OUTAGES

"The site going down due to heavy traffic was a big problem since I helped most clients during a scheduled appointment, so I just hoped it would be up when they came."

"I have never had success receiving a call back from Advanced Resolution Center, specialists, supervisors, or Casework. I have never had any information about appeals being processed or responded to. The system does not allow for conversation."