

State Health Reform Assistance Network

Charting the Road to Coverage

ISSUE BRIEF
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Boosting Enrollment: Lessons Learned from 2013-2014

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Executive summary

As part of Wakely Consulting Group's (Wakely) participation in the Robert Wood Johnson Foundation's State Health Reform Assistance Network, the authors interviewed staff at five successful state-based marketplaces (SBMs), as well as field personnel under contract to the same SBMs, to learn what could be used from the first open enrollment to improve sign-ups for 2015. While broad educational efforts, such as informing citizens about the Affordable Care Act (ACA) and helping patients navigate the health care delivery system, are certainly worthy objectives, this paper focuses on the challenge of getting low- to moderate-income people to purchase qualified health plans (QHPs). While marketplaces also play a role in Medicaid/Children's Health Insurance Program (CHIP) enrollment, QHP enrollment is uniquely their responsibility, and selling a selection of health plans differs significantly from enrolling beneficiaries in free coverage. This paper focuses on QHP enrollment because improving the ability of SBMs to reach and enroll more people in commercial insurance, especially the uninsured, is so challenging. To the extent that SBMs believe that they should, and can afford to, pursue broader goals than QHP enrollment, they should recognize that the recommendations in this paper relate to only a subset of their outreach and communications mission.

Of course, fixing the basic functionality of SBMs so that consumers, brokers, navigators and insurers can rely on the marketplace to perform its core functions well, and to provide credible and timely information, is the single most important "fix" for improving sales. This is well recognized by all, and there is little that this study has to offer by way of suggestions for doing so. Rather, the authors focus on the marketing and sales efforts that can optimize enrollment, assuming that an SBM's core functions work.

We organize these recommendations based on observations drawn from Colorado, Connecticut, Kentucky, Rhode Island and Washington, plus an occasional reference to other states. We have reviewed the observations and recommendations with staff of the five SBMs in an effort to improve accuracy and ensure validity. Nevertheless, these are qualitative assessments, based primarily on interviews filtered through the authors' experience in operating and consulting with SBMs and private health plans. The recommendations are set forth in this Executive Summary with a brief summary of related observations. The observations are detailed in the associated issue brief.

ABOUT STATE NETWORK

State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit www.statenetwork.org.

ABOUT WAKELY CONSULTING GROUP

Wakely Consulting Group is an actuarial and healthcare consulting firm specializing in government healthcare programs including state and federal reform, Medicaid and Medicare Advantage. For more information, visit www.wakely.com.

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SUMMARY OF OBSERVATIONS

Observation: All five states consider an early start to building public awareness and generating leads to be important to enrollment success. These states feel that they did begin early, but some felt that it was not early enough. Navigators, brokers and issuers generally commented that training on websites and back-office systems was neither adequate nor timely, and the SBMs generally agreed. The states are all concerned about renewals for 2015, and understand that renewal planning should begin as soon as possible and that training for both new enrollment and renewals should be better than it was in 2013.

Recommendations:

1. Evaluate penetration of target markets (neighborhoods, towns, counties, linguistic groups, demographic groups, etc.) as soon as possible, and focus advertising and sales on specific population segments. Coordinate advertising with the ground game of enrollment events, and coordinate both advertising and enrollment events with the brokers, navigators and other enrollment assisters that have special ties to those target markets. End-to-end coordination is key to direct sales.
2. Continue to generate leads for brokers, navigators and other enrollment assisters, but develop less expensive ways than those typically used in 2013 to build awareness. Having built a baseline of awareness, SBMs must continue some use of mass media to maintain awareness, but should carefully target much of the advertising dollars to high-priority segments (e.g., postcards and billboards in certain zip codes, foreign language media, digital advertising).
3. Renewing existing enrollees is a high priority for 2015. SBMs need to develop both subsidy redetermination and QHP re-enrollment processes for renewing enrollees, including decision support and default options. They also need to develop corresponding communications plans with issuers, brokers and navigators. Since these enrollees are also clients and members of brokers, navigators and issuers, they should be included in a joint plan for the renewal process, if only to clarify their respective roles. Doing so as soon as feasible will help in executing a systematic, timely and consumer-friendly renewal process.

Observation: Wrapping a touring RV or bus to generate local buzz increases awareness and visibility, provides recognition to coalition partners and can be used by enrollment assisters to qualify prospects, i.e., to develop lists of potential purchasers. In large cities and densely populated states, walk-in stores and pop-up enrollment centers proved effective, if well located. Enrollment centers physically reinforce the presence of the SBM in target communities, and provide a setting where consumers who feel stymied can get the personal attention they need; and they can be staffed in a cost-effective manner by a combination of brokers, navigators and marketplace employees.

Recommendations:

4. Test and evaluate different ways to establish a cost-effective physical presence in high-priority communities. The experience with stores and vans and buses on tour seems to have been positive, but can be expensive. As the focus shifts from awareness and education to maximizing enrollment with a limited spend, SBMs should track the cost per acquisition (CPA) for different set ups in cities and smaller towns, such as permanent storefronts, roving vans, or pop-up centers, staffed by employees, brokers, assisters or some combination of all three.

Observation: Individual sales are very expensive compared to large group sales, so SBMs will need to focus their resources on the most effective outreach tactics to identify qualified leads and call them to act. For example, to the extent that navigators require grant support from SBMs newly challenged by limited funding, particular scrutiny should be given to their effectiveness as enrollers. Even at the point where a motivated consumer makes contact, there are still many opportunities to lose the sale. For example, Connecticut averaged four 11-minute calls to the contact center before prospects eventually enrolled through this channel. Barriers to enrollment—such as a challenging web experience, long waits to reach a customer service representative, multiple transfers, dropped calls, the inability to resolve problems in one call, different answers from different customer service representatives or glitches in billing—can decrease the ratio of sales closed and exacerbate the general confusion about health insurance. Even with generous federal funding, some SBMs did better than others in generating qualified leads, eliminating barriers to enrollment and integrating the entire marketing and sales effort.

With less time and money for the next open enrollment season, SBMs must increase the efficiency and return on investment of their marketing spend. With far more experience and data, they can develop a more cost-effective sales focus.

Recommendations:

5. Building on the theme of a cost-effective sales focus, integrate all marketing and sales activities. Sales and marketing activities can be most readily integrated by a single, unified management structure under a senior manager responsible for advertising, other promotional activities, internal sales staff and management of external sales channels.
6. Hire commercial insurance expertise and adopt standard industry tools and measures to evaluate and refine the marketing and sales process.
7. Carefully manage the cost of attracting and enrolling members, or the CPA. This requires SBMs to track the cost and results of marketing campaigns and different sales channels in order to compare the costs for enrolling customers in QHPs using standard metrics and techniques for direct marketing and sales.

Observation: The management and training of navigators and brokers is challenging. Because SBMs were all racing to develop their systems for October 1, 2013, there simply wasn't time for adequate, hands-on training. Moreover, the two sets of actors are very different in orientation and expectations. For example, most navigators do not depend upon the volume of sign-ups to determine their personal compensation. They are instead driven by mission to help clients with eligibility determination for public programs and may be most familiar with their state's Medicaid and CHIP programs. Most brokers are "producers," focused on commercial enrollment and coordination with the health insurance issuer, but are unfamiliar with Medicaid and CHIP. Typically, navigators know the Medicaid/CHIP programs far better than brokers, and typically brokers know commercial insurance far better than navigators. Moreover, many navigators view their role as supportive, with or without enrollment, whereas brokers define their productivity in terms of enrollments (and renewals) per month. These and other differences, as well as brokers' fears that marketplaces intend to replace them with navigators, sometimes led to mutual suspicion and distrust between brokers and navigators. While far from entirely dissipated, over time some brokers and navigators found ways to overcome distrust and work together productively, recognizing their complementary strengths and knowledge.

Recommendations:

8. Recognize and accommodate the different roles of navigators and brokers. Do this by: (a) introducing and helping brokers and navigators work together or make referrals to each other; and (b) developing data collection tools that allow both to share credit for cooperating on enrolling a client.
9. Focus navigator and broker training programs less on the basics of the ACA, and more on the specifics of the insurance application and the operational support available for problematic cases or application glitches. While timing of systems development for 2014 delayed hands-on training, in-person, hands-on training on the SBMs' systems in advance of November 15, 2014 will be critical.
10. First and foremost, SBMs must fix their systems, and a systematic assessment would be very helpful. Evaluate the obstacles to enrollment and ensure execution of those components critical to an easy and simple enrollment experience.

Observation: Navigator programs were most successful when tailored to a specific region or community. Particularly for linguistic and ethnic communities with high rates of uninsured, use of navigators with roots in the community was very helpful. Similarly, certain brokers in some areas proved very effective, whereas many certified brokers did not produce much enrollment, at least in the initial open enrollment period. To maximize productivity across the state, it will be important to identify and work with effective navigators and productive, motivated agents in each region. The concept of lead entities for navigators by region seems equally applicable to lead brokers by region.

One of the most credible and widely cited sources of information about SBMs was local news stories. They can be relatively inexpensive to generate. Similarly, issuers will be advertising in advance of the next open enrollment season, and should have a strong interest in joint marketing activities.

Recommendations:

11. Focus marketplace's limited human and financial resources on the navigators most effective at enrolling individuals and families, particularly in QHPs. On the one hand, this may necessitate culling navigators focused more on mission-based outreach and less on QHP enrollment; on the other hand, continuing support for some of them will be especially important for enrolling hard-to-reach target segments and for maintaining politically important alliances.

12. To maximize the use of brokers as a free resource (excluding a few “non-brokered” markets), consider developing local marketing and sales plans built around lead agents for each community. Identify those producers across the state that are committed to, and capable of, retaining and enrolling many new clients—initiate a campaign early to recruit them, and focus sales resources and planning on supporting their efforts. Joint planning should aim to drive qualified prospects to them and support their efforts to develop highly productive enrollment processes.
13. To maximize the use of other free or low-cost resources, focus on generating as much earned media and marketing support from issuers as possible.

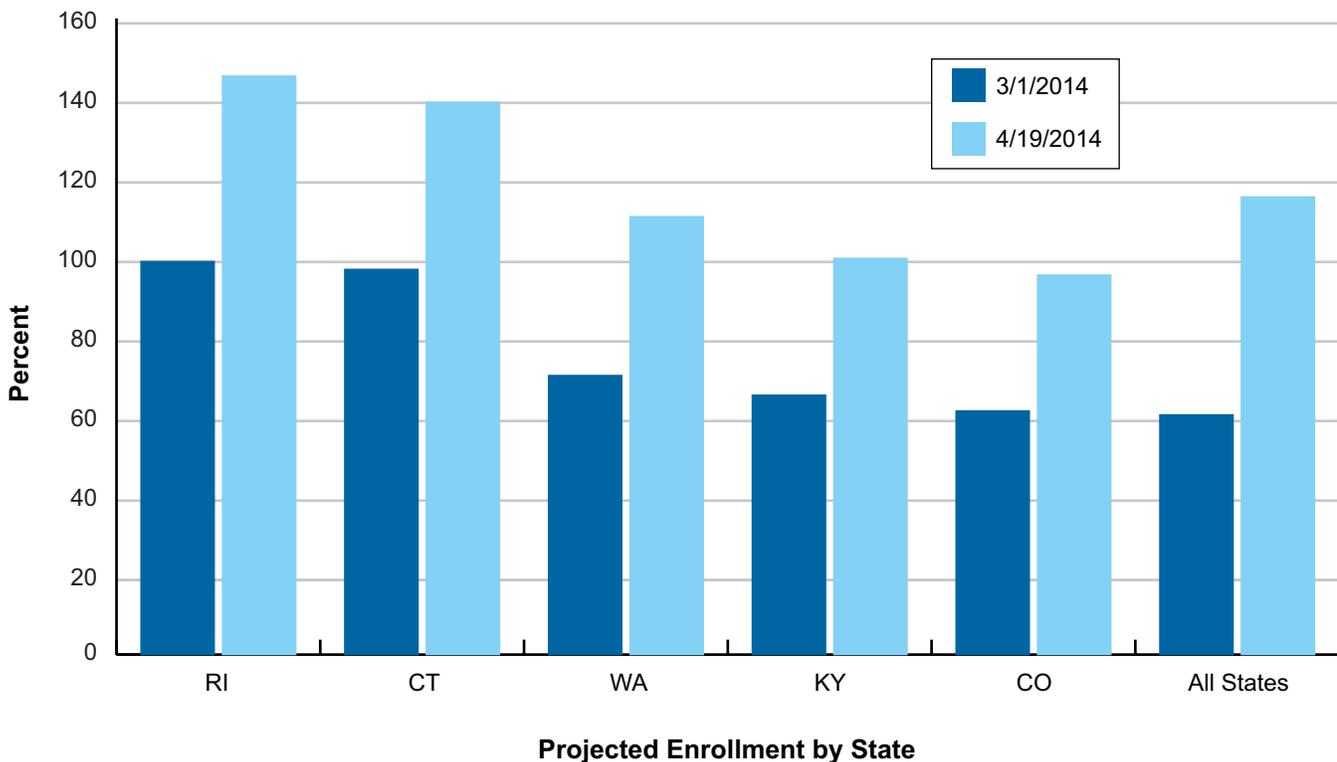
Introduction

In all, Wakely conducted approximately 100 interviews between February and June of 2014 in Colorado, Connecticut, Kentucky, Rhode Island and Washington. These interviews are the basis for most of the observations in this report, and are not individually cited. These states were selected for their early success—as of March 1, 2014, all five states had exceeded the national average of enrollments as a percentage of projections—and the generous willingness of SBM staff to facilitate our research. Primarily, we interviewed the SBM personnel directly involved in outreach and enrollment, plus navigators and in-person assisters (collectively, “navigators”), health insurance agents and brokers (brokers), and marketing and sales personnel for QHPs. We did not interview certified application counselors (CACs) because they are generally not under contract to SBMs, but several SBMs noted that they were also very effective in enrolling consumers in QHPs as well as into Medicaid.

The enrollment success of these five states can be measured by comparing actual to projected growth using the Urban Institute’s Health Insurance Policy Simulation Model (HIPSM).

Based on enrollments started before April 1, 2014, and completed by April 19, 2014, four states exceeded their QHP enrollment targets for 2014, and the fifth, Colorado, achieved 96.4 percent of the projection:

QHP Enrollment as Percent of Projected¹



Not shown above, but worthy of note, are these states' robust increases in Medicaid and CHIP beneficiaries. While Medicaid/CHIP enrollment increases averaged 8 percent from third quarter 2013 to March 2014 in all Medicaid expansion states that reported to the Centers for Medicare & Medicaid Services (CMS), Colorado reported a 29 percent increase, Kentucky 34 percent, Rhode Island 28 percent and Washington 23 percent (Connecticut did not report).² Most of the QHP enrollment reported by SBMs has been in the individual market, which is the focus of this report.

For simplicity, we use the term “navigator” to refer to any type of in-person assistance excluding agents and brokers. In reality, each of the five states organized their in-person assistance networks differently and the resulting terminology has specific meaning for each state. In Connecticut, navigators are community-based organizations responsible for spearheading outreach efforts in six designated regions. They can put consumers in touch with an “in-person assister,” who can help them understand all of their options. Kentucky recognizes “kynector” entities for designated regions, and affiliated individual “kynectors” to provide face-to-face assistance. Washington organized their in-person assistance program by selecting 10 lead organizations to manage partner entities and in-person assisters affiliated with each entity (some lead organizations also provide direct in-person assister support). Colorado chose a network of community-based organizations to provide in-person assistance to consumers, with “health coverage guides” providing the face-to-face services. Rhode Island selected one administrator to manage their statewide network, comprised of both community health centers and community-based organizations that utilize individual navigators to provide assistance. Additionally, Rhode Island promotes in-person assistance at its Contact Centers, and does not use the navigator moniker for this staff. While terminology, organization and funding strategies differ from state to state, we include both navigators and in-person assisters under our references to “navigators” to distinguish these non-commissioned assisters operating under contract with marketplaces from commissioned brokers.

Recommendations & observations

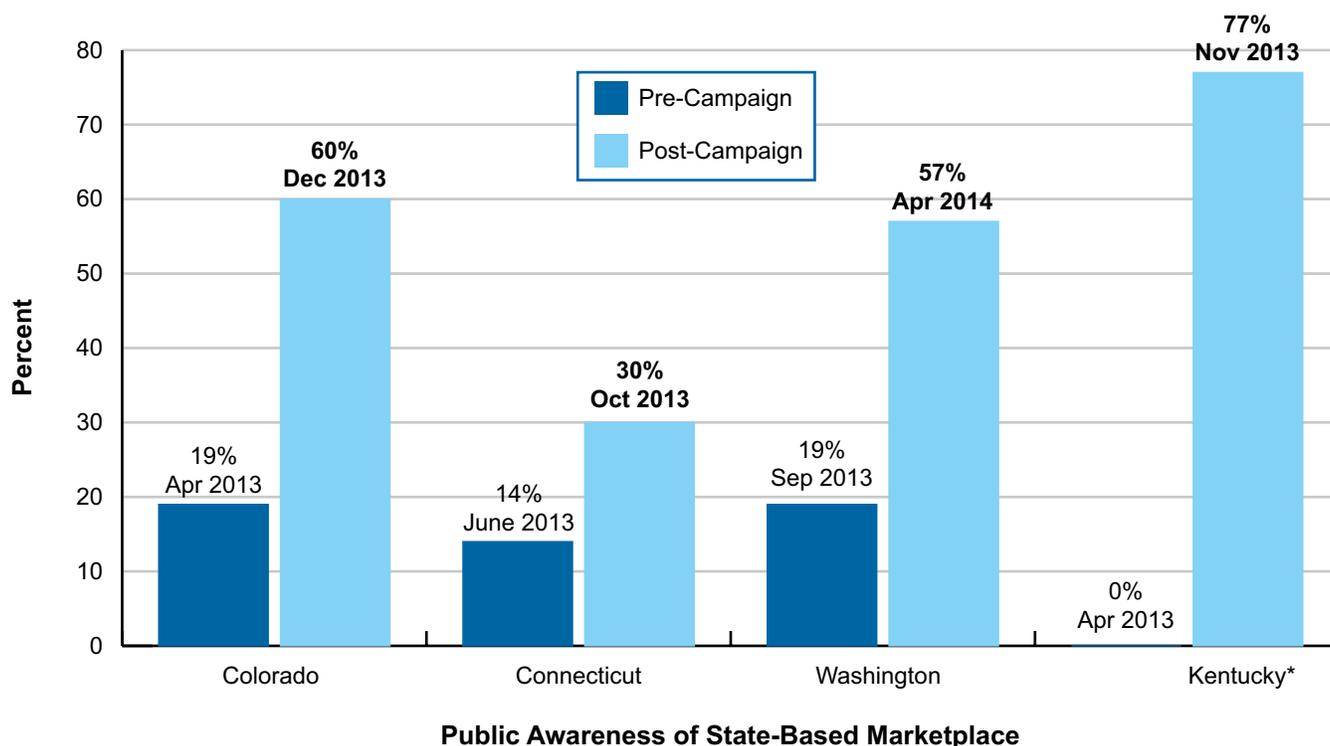
1. Integrate and execute as early as possible the next marketing and sales campaign. *Evaluate penetration of target markets (neighborhoods, towns, counties, linguistic groups, demographic groups, etc.) as soon as possible, and focus advertising and sales on specific segments. Coordinate advertising with the ground game of enrollment events, and coordinate both advertising and enrollment events with the brokers, navigators and other enrollment assisters that have special ties to those target markets. End-to-end coordination is key to direct sales.*

The SBMs interviewed for this project cite early outreach and advertising as the most important instrument for educating consumers on the changing health insurance marketplace and the new options available to consumers through state health benefit marketplaces. While the states differed in their approaches to building awareness, many of them utilized creative strategies that moved beyond standard government outreach practices by adopting flexible campaigns that targeted populations with low rates of being insured. Campaigns typically succeeded at raising awareness of the marketplace, reform, subsidies, etc., with a multi-pronged campaign that relied heavily on paid and earned mass media, and then by adding other forms of outreach—local ads, enrollment events, mall intercepts, digital advertising, billboards, direct mail, etc.—as well as a focus on enrollment. Connecticut, for example, raised public awareness (unaided) from 14 percent in June 2013 to 30 percent by October.³ Washington took a broad approach with a universal message—“Here’s a new way to get insurance and you should check it out.” Unaided awareness of Washington’s marketplace increased from 19 percent in September 2013 to 49 percent in November 2013 to 57 percent in April 2014.⁴

Beyond mass messaging, each state contracted with a vendor to conduct research to better understand its own population profile and segments, what they wanted from the SBM and if/how the SBM could best position itself to serve them. Washington used these data to get navigators to take messages to specific target segments. Connecticut purchased Thompson-Reuter’s data on insurance rates by town to target most of its enrollment events and its two storefronts in communities with the highest numbers of uninsured.

Most SBMs targeted young adults (especially males), low-income households and Hispanics. For example, Colorado ran a young adult campaign with ads featuring young people during broadcasts of Colorado Rockies baseball games. In addition, they created specific messaging and videos for young adults, placed paid media on Hulu, aired radio spots on Pandora, Facebook, and cable and network stations that are popular among this demographic and conducted mobile phone texting advertising for young adults. Colorado also sponsored a rap concert at Red Rocks, giving out branded hand warmers, beanie hats and brochures. In addition, Colorado fielded “Street Teams” at approximately 230 locations, focusing on places where young adults congregate—including pubs and shopping areas—and as a result, spoke with more than 64,000 people.

Public Awareness of State-Based Marketplaces and Advertising Campaigns: Pre- and Post-Outreach⁵



*Kentucky's percentage reflects aided public awareness (comparative data was unavailable pre-campaign). This means that the interviewer mentioned the name of the SBM (kynect), described what it does and then asked if the respondents had heard of it. All other data is reflective of unaided awareness where the interviewer simply asked the respondents if they were aware that they could get health insurance through the new state-run insurance marketplaces.

Washington partnered with the concert promoter Live Nation to tie education efforts with select Live Nation concerts across the state. Kentucky focused on establishing a physical presence at events frequented by young people, including regional sporting events, the Kentucky Bourbon Festival, Newport Oktoberfest, the Bourbon and Blues Festival and several half marathons in various locations around the state. Connecticut also hit the beaches over the summer, knowing that young adults would congregate there.

While these activities built awareness among young people, it is hard to know whether they generated a great deal of enrollment (in pre-/post-campaign metrics, young adults' awareness generally increased after the campaign, but still lagged behind awareness among those older than 30). Connecticut tried to go one step further with its outreach to young people. It partnered with Clear Channel to sponsor raffles with concert tickets as prizes for listeners who actively engaged with the marketplace (e.g., by visiting its website or tweeting about the ACA or the SBM). Washington also used free tickets to the concert series it sponsored with Live Nation as a draw to call prospects to act—many online pieces promoting the concert series linked to *Washington Healthplanfinder's* Facebook page, which hosted a promotional contest for free tickets to the Sasquatch! Music Festival Launch Party and V.I.P. tickets to both weekends of the Sasquatch! Festival.

Rhode Island took a somewhat different approach by targeting segments on their propensity to purchase health insurance, rather than relying on demographics or geographic profiles. The state reasoned that traditional market segmentation strategies are less helpful when it comes to defining what motivates core buying groups. Under this approach, Rhode Island developed a model built on the basis of who wanted the coverage most and who the marketplace needed the most, and then projected the costs of reaching these audiences efficiently. To best gauge the level of need for insurance, Rhode Island began by dividing its population into two groups, the insured and the uninsured, but took care to focus on those uninsured individuals who would be eligible to purchase subsidized coverage. In the final analysis, Rhode Island determined that small businesses were their first priority because they represented the largest pool of potential enrollees. Employers who currently offer coverage are seen as the more likely sale, but non-offering businesses are also part of the Small Business Health Options Program (SHOP) target

audience. Rhode Island is intent on converting as many non-offering businesses as possible because sales will build SHOP membership and many uninsured are likely to gain coverage in the process.

Rhode Island's second priority group is individuals and families in the 36 to 65 age group, who are likely to have dependents and find the choice and customer service features of Rhode Island's marketplace most appealing. In targeting this age cohort, Rhode Island acknowledged that enrollees under the age of 36 are certainly attractive from a risk perspective, but are also a small and more challenging market segment to convert.

All SBMs agreed that it is important to start efforts well before open enrollment season begins. Washington enjoyed a big head start, beginning in 2010, the same year that the ACA was signed into law, with their efforts to get the word out about a new way for the uninsured to find coverage. Connecticut began a series of "Healthy Chat" meetings around the state and other promotional efforts in November 2012. Colorado and Kentucky formally launched their marketing and outreach campaigns in May 2013, including television and radio ads, digital and print ads, as well as in-person outreach events across the state. In July of 2013, Rhode Island kicked off their "39 in 3" campaign to hold an outreach and education event in all 39 of the state's cities and towns within a three month period. In early 2012, Kentucky partnered with two stakeholders (Kentucky Voices for Health and the Kentucky Health Cooperative) to develop an issuer neutral health insurance literacy seminar, titled "Health Insurance: How it Works," to successfully raise advance awareness. ***Starting early allowed these marketplaces to blanket the community with information about the ACA and the benefits of a state-based marketplace, raising awareness and collecting "qualified leads" well before open enrollment.*** Many stakeholders felt that the early start allowed states to get ahead of some misinformation, and therefore focus outreach efforts in the summer and fall of 2013 on driving enrollment.

The earlier a state began its campaign, the better it was able to coordinate with partners on the ground to help increase awareness and provide trusted intermediaries for hard-to-reach groups. All five states found that working with entities that interact with residents on a day-to-day basis was especially effective in getting the word out. These partners included the small market media, drugstores, grocery stores, food pantries, post offices, public transit, libraries, community health centers and tax preparation firms, just to name a few. Some more unique partnerships seen in Kentucky were navigators holding enrollment sessions in beauty salons or experts being invited to answer questions at local restaurants and bars.

Key to converting this outreach and promotion from mere awareness building into a step towards actual enrollment was using these educational opportunities to identify and capture contact information for prospective customers. Well before open enrollment began, Colorado generated approximately 12,000 leads, and Connecticut generated a total of 20,000 leads (8,000 from various enrollment events plus another 12,000 from its websites). Connecticut deployed a calculator on its website early in 2013, with various hypothetical household scenarios to engage visitors and illustrate how much they could save by enrolling and how much it might cost to go without coverage. Those who engaged with the calculator turned out to have a high probability of later enrolling.

Of course, these qualified leads needed to be kept warm by continuous outreach until they enrolled. Connecticut used what its ad agency, Pappas MacDonnell, refers to as a constant drip of emails, robo-calls, outbound live calls and mailings to refresh and try to convert leads to sales (see graphic on next page).⁶ It tracked the efficacy of different outreach media and messages using vanity telephone numbers to track response rates, i.e., a different telephone number for each tactic, so that response rates could be measured for specific tactics. Direct mail turned out to be especially effective, so Connecticut used more and more of it.

Local entities, especially in smaller towns, can reach into a community without having to expend staff resources or additional advertising dollars. Anecdotally, many enrollees identified the people in their community as the best sources for information: family, friends, neighbors, clergy, physicians, pharmacists, hospitals and local government leaders. Word of mouth referrals were cited by many interviewees as the most influential and potent form of advertising. Kentucky recognized this early and made it a policy to never decline a request for a speaker or more information, no matter how small the event or the audience. Staff reported speaking to parishioners during or after services as a particularly effective way to establish contacts within a community. One navigator in Colorado mentioned a community listserv (unknown to outsiders) as the best and least expensive way to reach the residents of her town; another discovered through trial and error that inexpensive advertising at the local movie theater was incredibly effective. More than a few Washington brokers relied on simple poster boards in their local communities or chats on local radio programs to get the word out. If these local entities are there to follow up on such outreach efforts with active assistance in enrolling, then the integration needed to ensure that marketing leads to closing sales is also much easier to achieve.

Connecticut experience: Enrollments were made possible by multiple touches, from awareness and education through engagement.



2. Move from a shotgun approach for building awareness to more targeted marketing. Continue to generate leads for brokers and other enrollment assisters, but develop less expensive ways than those typically used in 2013 to build awareness. Having built a baseline of awareness, SBMs must continue some mass media to maintain it, but should target advertising dollars to high-priority segments (e.g., postcards and billboards in certain zip codes, foreign language media, digital advertising).

With a higher percentage of the population now aware of the ACA and with fiscal sustainability of increasing concern, SBMs should build on the less costly outreach tools that provided the most measurable success during the first open enrollment season, such as direct mail and enrollment centers. One of Kentucky's most successful initiatives was sponsoring the Cabinet for Health and Family Services area at the Kentucky State Fair. SBM staff manned a booth during all 12 days of the fair and gave away an estimated 50,000 *kynect* tote bags with informational brochures. Before handing out the branded bags, marketplace staff would answer questions and provide background information. The brochures were inexpensive to produce and many applicants referred to them when speaking with the call center during first few weeks of open enrollment. For the next open enrollment period, these events should focus on disseminating low-cost informational material, enrolling on-site or referring qualified leads to brokers, navigators and CACs in their communities.

In Washington, Kentucky and Rhode Island, partnerships with local libraries were regarded as particularly successful, low-cost venues for outreach and enrollment events. Public libraries are trusted institutions that often provide outreach and programming for a multitude of interests and people of all ages, ranging from tax assistance, to job labs, to language services for non-English speaking citizens. In Washington, many libraries also provided an extra supply of laptops with internet access for enrollment events, and some libraries promoted the availability of coverage on their own websites (for one example, see the Fort Vancouver Regional Library page designed to help people navigate state-specific ACA-related information: <http://mylibrary2.fvrl.org/AffordableCare.html>). Kentucky held two "Sign-up Saturday" events where they had navigators in libraries in



Kentucky residents receive *kynect* tote bags at the Kentucky State Fair.

almost all 120 counties across the state. The two events, held in December and March, garnered good earned media and successfully enrolled high volumes of individuals and families.

Providing a place for motivated shoppers to get their questions answered, their problems addressed, and to shop and enroll, and orienting outreach around these enrollment centers, clearly connects the entire process flow. Connecticut realized a 50 percent close ratio at its two stores from heavy daily traffic, most of which was unscheduled walk-ins. Rhode Island ascribes approximately 17 percent of its 70,000 enrollees (QHP and Medicaid/CHIP) to walk-ins. Colorado sent over 700,000 emails to account holders during open enrollment informing them of deadlines, enrollment events and walk-in sites in their communities. Colorado achieved a 42.7 percent open rate on emails, far higher than industry standards on email campaigns.

Social media and digital integration will continue to be an important channel for SBMs to reinforce their brand and call prospective clients to action. Many consumers will go to a search engine first to find health insurance information or their state's marketplace website. Searchable and shareable online content should be in place prior to open enrollment, and this content should be more and more self-generated, i.e., testimonials from enrollees and news/announcements created to be shared through social media channels. With the success of in-person outreach, this may also include more interactive community events or publicized online events. Video testimonials from enrollees, online Q&A sessions and TV ads seemed to be the most popular materials on social media. In addition to television ads, [Connecticut](#), [Colorado](#), [Washington](#) and [Kentucky](#) released informational videos on YouTube for targeted populations including the self-employed, small business owners, families and the unemployed. While the unique views of some of videos remain low, states should continue to grow these low- or no-cost information channels.

SBMs may also find that coordination with CACs located at hospitals and health centers is a productive, low-cost enrollment channel.⁷ Connecticut found that CACs actually accounted for more enrollees than navigators, and cost the SBM nothing (for obvious reasons, health services providers are strongly motivated to help with outreach and enrollment activities). States should focus on those delivery sites with large proportions of the uninsured and find ways to partner with them. The social workers or discharge planners on staff at these facilities may be an excellent untapped resource for the marketplace to work with to understand what enrollment barriers continue to exist for the uninsured. Providers themselves also need education. A properly informed physician's office staff can offer not only great care to consumers, but also peace of mind about the marketplace itself. In one state, local boards of health were encouraged to conduct meetings between representatives from the SBM, health clinics and several medical and community organizations to coordinate efforts to implement the health law locally. As a result, area hospitals reached out to uninsured patients who frequented emergency rooms for routine conditions or who arrived very sick because they had forgone care. If there weren't CACs on staff, patients were provided information on the SBM and contacts for navigators to help them enroll.

3. Develop a simple, effective renewal process in conjunction with brokers, navigators and issuers. *SBMs need to develop both subsidy redetermination and QHP re-enrollment processes, including decision support and default options. They also need to develop corresponding communications plans. Since these enrollees are also clients and members for brokers, navigators and issuers, they all should be included in joint planning for the renewal process, if only to clarify their respective roles. Doing so as soon as feasible will help in executing a systematic, timely and consumer-friendly renewal process.*

After the abundance of operational challenges that SBMs confronted in the first open enrollment, none should be surprised by the need to adequately prepare for 2015 renewals. SBMs should develop, communicate, test and finalize their processes for renewals as early as possible and begin to train partners on these new processes.

To support a smooth renewal process, an SBM should develop routine processes for standard, easy renewals, including a balance between easing auto-redetermination and encouraging active consumer shopping within the regulatory framework provided by CMS.⁸ This will be challenging enough, including both operational readiness and making decisions on important policy issues, such as automatic re-enrollment. In addition, adequate planning includes identifying and preparing for special problem cases, such as those families that may need in-person assistance because their members are covered by different programs, enrollees in QHPs with double-digit premium increases or reductions in service areas. Using filing data from health insurance carriers, the SBM should project the impact of changes in the second lowest-cost silver plan (in each rating region) and which enrollees will be most adversely affected by such swings. Identifying these groups as far ahead as possible will allow time to develop ways to cushion the impact, and to provide support through brokers, navigators and call center staff trained on handling these more difficult situations.

SBMs should be thinking now about whether and how they want to impact choice dynamics for QHP renewals. Some states will have new entrants to the market that require changes to comparison tools and education materials, and new plans need extra exposure and explaining. For example, Connecticut's co-op did not feel that it was given an adequate opportunity to explain itself to navigators, and Connecticut expects to offer more issuers in 2015 and 2016. Explaining these new options to consumers, and deciding on how to balance the benefits of auto-re-enrollment (increased enrollment) against its anti-competitive impact is something SBMs should decide soon. Specifically, the SBM should consider a default option of a passive renewal scenario versus requiring active redetermination and enrollment, and should seek buy-in to its preferred approach.

The SBM should also reach out to people who started accounts during the initial open enrollment period, but failed to complete the process. The easiest group to reach out to would be those individuals who selected a plan, but did not pay their first month's premium. Estimates show that they represent 10 percent to 20 percent of enrollees, but Kentucky estimates 32 percent and Colorado recently estimated 35 percent did not pay. Even at 10 percent to 20 percent of enrollees, this is a large target market. While some of these people may be unable to enroll again until November 2014, it may be useful to begin communicating with them once 2015 marketplace rates are public, especially if some rates decline.

The other group to contact consists of those individuals who never completed their applications. During the first open enrollment period, resolving application problems was often difficult. Consumers didn't know where to go for help and sometimes were unable to get issues resolved even when they went to the right place. As a result, many consumers abandoned their applications. Of course, improving the process for resolving their application problems would also help. SBMs that have email addresses for these individuals should survey or meet with them to assess what roadblocks prevented these consumers from completing enrollment.

SBMs are generally aware that the risk is high for confusing enrollees in this first renewal anniversary, both because of the absence of prior experience with renewals and because they represent an important source of enrollment for 2015. The partnering entities—brokers, issuers and navigators—will have maintained a stronger communications link with many enrollees than the SBM has, simply because enrollees are likely to turn to these parties for answers to coverage, claims and billing questions throughout the year, especially if the issuers collect premiums directly. These parties share an interest in renewing eligible individuals, simplifying messaging and redetermining subsidy levels as accurately as possible. Therefore, SBMs should seek to leverage and coordinate their partners' activities, including early consultation, planning and training.

As the issuers and brokers are accustomed to renewal procedures, and some of the navigators have experience with annual redetermination issues, SBMs can learn a lot from their partners about how to plan for this fall. Actively engaging them in an open dialogue about any issues from the first open enrollment period, coupled with their questions and concerns about the next enrollment season, is a good way to build trust.

4. Develop a cost-effective physical presence in communities. *Test and evaluate different ways to configure walk-in sites located in densely populated, high-need areas of the state. The experience with stores and vans and buses on tour seems to have been positive enough to justify this tactic. As the focus shifts from awareness and education to maximizing enrollment with a limited spend, SBMs should track the cost per acquisition for different set ups in cities and smaller towns such as: permanent stores, roving vans, or pop-up centers, staffed by the SBM's employees, brokers, assisters or some combination of all three.*

Wrapping a touring RV or bus to generate local buzz increases awareness and provides coalition partners with opportunities for outreach and recognition. Better yet, for population centers, walk-in stores or pop-up centers proved very effective for enrollment, particularly if well located. Enrollment centers physically reinforce the presence of the SBM in target communities, and provide a setting where consumers who feel stymied can get the personal attention they need; and the centers can be staffed by a combination of brokers, navigators and paid marketplace staff.

Both Colorado and Washington used a vehicle wrapped with their branded graphics to stop in cities and towns on designated days during the open enrollment season. Typically, local media was used to promote these enrollment events or at least turned out to cover them. In Washington, each of the 10 navigator-lead organizations was given its own date for an appearance by the SBM's bus. While the number of on-site enrollments varied at each stop, virtually all of the entities reported significant earned media from their events, and the partnering agencies received a promotional boost for their efforts in staffing and endorsing the event. The five-week tour secured more than 60 stories across various outlets, and a media monitoring service estimated that the coverage generated the equivalent of \$1.4 million in paid advertising.⁹



The exterior and interior of Washington's enrollment bus.

Colorado partnered with a large grocery chain, King Soopers, often parking the RV in its parking lots, and setting up its information and enrollment tables inside the stores near the check-out counters. The RV was driven by staff, and the enrollment tables were staffed by a combination of local navigators and employees. (Brokers said they attended a few stops, but found them to be relatively less efficient compared to other venues for enrollment. A general complaint from agents in several states was that many SBM-organized events were not optimally organized for efficiently processing as many enrollments as possible.) Colorado's RV Tour in December 2013 included an earned media campaign that generated over 20 media stories, including print, radio and television. The December RV campaign was so successful that Colorado chose to keep leasing the RV through the end of open enrollment, driving over 3,300 miles across the state to dozens of events.



Connect for Health Colorado RV in Grand Junction during the enrollment tour.

Both SBMs consider these vehicles to have been successful. While enrollment directly at these events was modest, they generated media attention and attracted considerable local foot traffic.

Based on the recent Enroll America survey¹⁰ suggesting that local news was the top source of information about the new insurance options, high-visibility events that attract local news coverage may be cost-justified for outreach. For the next open enrollment season, *as the focus shifts from building awareness to renewal and enrollment, it will be important to evaluate the cost-effectiveness of continuing this effort; in particular, can inexpensive, local advertising be used to drive a large number of qualified leads to these events, and can the events be used efficiently to enroll large numbers?*

Interestingly, Connecticut used their advertising spend somewhat differently than Colorado during the earlier months of the open enrollment season. Connecticut spent advertising dollars driving people to their enrollment centers and their website. For example, it not only advertised on Clear Channel radio to reach young adults, but raffled off free concert tickets to listeners

who visited the SBM's website or attended an enrollment event. On its website, Connecticut used a calculator to engage visitors in figuring out how little it would cost to buy coverage versus how much it might cost to forego insurance. Of course, the website itself was an almost no-cost vehicle for engaging consumers, and at the enrollment centers—far more so than at enrollment events—enrollments could be processed very efficiently. In March, Colorado switched a portion of its radio, digital and TV advertising to promote five newly developed walk-in sites. Colorado also conducted countdown campaigns on digital and outdoor media (10 days left to enroll) to drive the message about the deadline.

Enrollment Centers

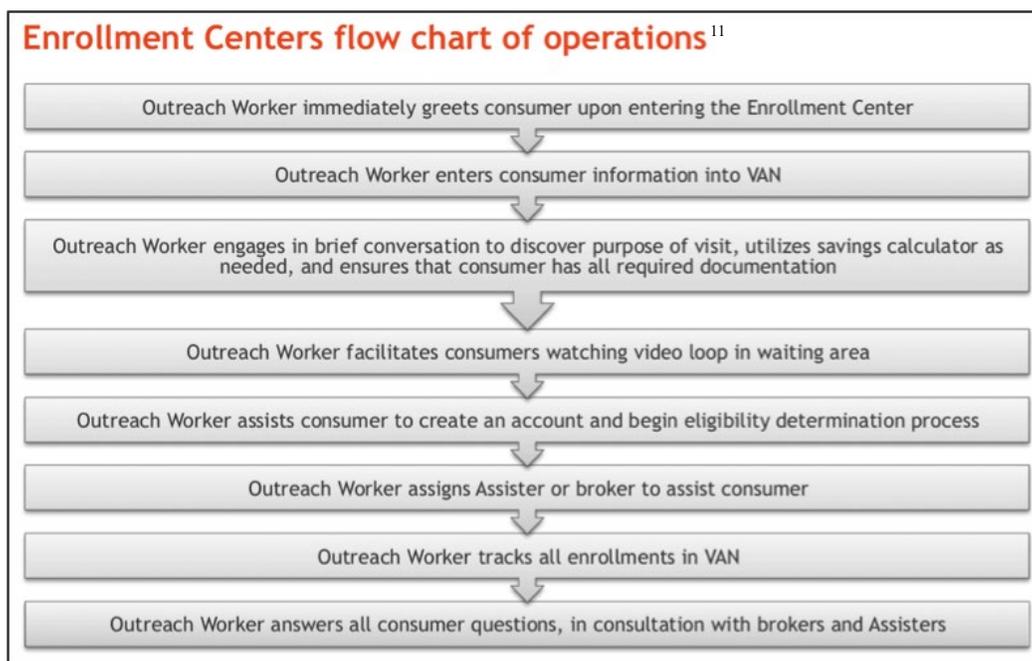
- One-stop shops for consumers to utilize technology, receive in-person help, and access services of brokers and Assistors
- Locations
 - New Britain (200 Main St.)
 - New Haven (55 Church St.)
- Hours
 - Monday - Friday: 12 pm - 8 pm
 - Saturday: 10 am - 4 pm
 - Sunday: 12 pm - 4 pm



On the other hand, stores represent a major investment: Connecticut planned to develop a half-dozen, but opened only two in New Haven and New Britain. Modeled loosely on Apple stores, both drew a lot of foot traffic from their own cities and surrounding towns. They were productive, but that was not their only benefit: like RVs and buses, they also generated considerable earned media, and presented the public face of the marketplace. In addition, brokers, navigators and staff interacted and learned from each other at the stores. They will also be used as training sites later in 2014.

An employee who had previously managed bookstores opened and managed Connecticut's two insurance stores. One storefront is 2,100 square feet, the other is 3,000. Each site is leased for one year and took about six to seven weeks to build out and open. Over time, Connecticut worked out an effective staffing arrangement, with greeters to help triage walk-in or scheduled visitors, navigators to work on eligibility applications and Medicaid enrollments and brokers to help qualified prospects understand their options, enroll and make plans for premium payment. The SBM also learned to open stores earlier (10 a.m., rather than noon, as originally scheduled) to capture the heaviest foot traffic, and moved from scheduled appointments (with many no-shows) to heavy reliance on walk-in traffic.

The stores have about 50 percent close ratios, meaning that half the customers who walk in actually enroll; by comparison, contact centers handled 10 to 20 times as many separate calls during open enrollment as actually enrolled in total. In March, their combined enrollments averaged over 100 *per day*, and they were open seven days a week. A broker could come in for part or all of a day, process 10 or more enrollments, and conduct other business out of a private office in between enrollments. One very supportive broker said she eventually stopped attending enrollment fairs altogether in favor of staffing the stores because they were so efficient and productive. She added 1,000 new clients during this open enrollment period, and these same clients are now calling her back for homeowners, auto and life insurance.



The cost of building out both stores was \$149,000, and the cost of operating both of them was \$23,600 per month, including rent, staffing, signage, utilities, etc. New Haven was actually 30 percent more expensive to operate than New Britain, yet it produced far fewer enrollments. Staff ascribes the difference in performance to site selection of the store, rather than differences in the regions they serve. For example, New Britain seems to have had more success being located in a more secure neighborhood with adequate parking. While far from inexpensive to operate, the CPA for both stores was moderate—far higher than brokers and a few other channels, but considerably lower than some channels. As a result, Connecticut plans to maintain its stores for 2015, but not to expand this approach. Rather, it is considering ways to work with “lead” brokers and other, more cost-effective alternatives for establishing a branded, semi-permanent presence in communities across the state.

| | NEW BRITAIN ¹² | | | | | | |
|---------------------|---------------------------|-----|------|-----|-----|-------|-------|
| Months in Operation | OCT | NOV | DEC | JAN | FEB | MARCH | TOTAL |
| Total Enrollments | 10 | 320 | 1143 | 772 | 760 | 1941 | 4946 |

| | NEW HAVEN ¹³ | | | | | | |
|---------------------|-------------------------|-----|-----|-----|-----|-------|-------|
| Months in Operation | OCT | NOV | DEC | JAN | FEB | MARCH | TOTAL |
| Total Enrollments | – | 105 | 538 | 427 | 369 | 1307 | 2746 |

Other states learned from experience that their clientele liked to walk in and enroll in person. So, in addition to its walk-in office in Providence, in March, Rhode Island opened another walk-in center in Warwick. Interestingly, both sites are not located in a retail or otherwise consumer-friendly area, yet both were extremely successful. Walk-in enrollments in Rhode Island totaled 11,800, or about 17 percent of their 70,000 enrollments for Medicaid and QHPs. Similarly, Colorado recognized the value of walk-in centers as open enrollment built to a crescendo in March, quickly setting up five different venues. Colorado staffed the pop-up centers with a combination of employees, brokers and navigators, inviting the most productive to participate. In total, they accommodated 2,600 customers, generated over 700 enrollments on the spot and hundreds of applications for completion at a later point. Sites were staffed by brokers (75), navigators (11) and employees (22).



Providence, Rhode Island walk-in center.

5. Integrate all marketing and sales activities into a coordinated effort focused on enrollment. *Sales and marketing activities can be most readily integrated by a single, unified management structure under a senior manager responsible for advertising, other promotional activities, internal sales staff and management of external sales channels.*

SBMs organized their outreach and enrollment efforts along a number of different models:

- By stakeholder groups, with separate managers of SHOP/brokers, of navigators and of QHPs and issuers, each reporting up the line separately;
- By function, with separate managers of communications, of enrollment, of customer service and of operations, each reporting up the line separately; and/or
- By end-goal, with managers of related processes all reporting to one director of sales and marketing.

If the SBM does not already have a fully integrated sales and marketing team under one accountable manager, it may have good reasons not to. However, this model has some obvious advantages. Because sales do not occur until a prospect completes all the steps in the process, and because so many different stakeholders or partners might touch the prospective customers, having one senior manager accountable for overseeing most of the steps and most of the external relationships in this marketing and sales process should increase coordination and facilitate timely prioritization of tasks and focus on a common goal.

By contrast with some SBMs, for example, Kentucky invited brokers and navigators early on to an advisory group to get to know each other and jointly advise the marketplace on how to differentiate their roles. Connecticut put all functions related to marketing and sales (except management of the call center) under one senior manager, and used the same database of the state's uninsured trial to drive the placement of advertising and the location of enrollment events and its stores. To further integrate marketing and sales, Connecticut hired approximately 30 full-time enrollers to staff outreach events, retail intercepts (e.g., malls) and stores. These were generally young people with political campaign experience, who were brought in for the intense outreach and enrollment work that began in July 2013 and ended in April 2014.

6. Leverage commercial insurance sales expertise on-staff and adopt standard industry measures. *SBMs need to understand, measure and manage their various enrollment channels—stores versus broker, versus navigator, versus website, versus call center—and they also need to manage diverse marketing and sales tools effectively. This requires analytic depth and experience on-staff with commercial health insurance.*

The key to long-term customer sales planning and budgeting is the cost of acquiring a customer and the longevity of lives acquired through various marketing efforts and sales channels. What do storefronts cost per enrollee, versus brokers, versus navigators, versus the website, versus the call center? Because the same customer may well receive information from multiple sources and be served by more than one sales channel, there is an art as well as a science to the measurements. Both begin with building systematic data collection and reporting all marketing and sales-related activities. For SBMs which did not do this last time, building the capability to do so going forward will be critical to managing the return on their investments. For illustrative purposes, we include links to a series of reports that Connecticut uses to manage marketing and sales activities. (See Appendices: [A.I – Summary Report](#); [A.II – Enrollment Activity and Penetration Report](#); [A.III – Enrollment and Cost Projections for First Open Enrollment Season](#); [A.IV – Enrollment Results by Month](#); and [A.V – Cost Per Acquisition Analysis](#))

Advertising and communications expertise can be contracted through agencies—although managing any vendor requires considerable expertise on the client’s end—but broker management in particular requires in-house experience with this specialized sales channel. Building trust with agents is critical. Brokers in several states said that they worked with SBMs because they knew and trusted the former broker who had been hired to organize and support the broker sales channel. Connecticut hired three brokers on staff, and insisted that the outsourced call center hire brokers as well. Connecticut also contracted with another broker in the field to help recruit and train her colleagues. In fact, the majority of Connecticut’s sales and marketing staff, including its Executive Director, had experience in sales and marketing of commercial insurance.

Washington hired four support staff members to work with brokers in the field, and all four are licensed brokers with health insurance experience. A fifth position is being contemplated for the next open enrollment season when the state plans to expand SHOP. (In 2014, SHOP was only available in two of the state’s 39 counties due to a lack of carrier participation.) Rhode Island also leveraged the use of licensed brokers in staffing for their SHOP exchange (brokers do not play any role in the individual market in this state). The broker liaison is a licensed broker with prior experience in the sales department of the state’s largest carrier, and the manager of the contact center’s broker relations team is a licensed broker who previously worked at several regional carriers.

7. Carefully manage the cost of acquiring enrollees. *To evaluate acquisition costs, SBMs should track the cost and results of marketing campaigns and sales channels in order to compare the costs for enrolling customers in QHPs, using standard metrics and techniques for direct marketing and sales.*

Individual sales are very expensive compared to group sales. With federal grant support winding down, SBMs must be more conservative in budgeting for marketing and sales; Colorado and Connecticut have budgeted to spend about half as much for this function next year as they did last year, and major reductions are expected for all SBMs. The challenge of efficiency in sales now takes on far greater significance.

Marketing may have to begin by building awareness and brand, but eventually it must focus on priming the pump of the sales process, i.e., identifying qualified leads and/or calling the retail customer to access a sales channel (walk-in visit, contact a broker or navigator, call the SBM or visit the website). Even at the point where a motivated customer initiates contact, there are still many opportunities to lose the sale. Barriers to enrollment, such as a challenging web experience, long waits to reach a customer service representative (CSR), multiple transfers, dropped calls, time-outs, inability to resolve problems in one call, different answers from different CSRs, glitches in generating bills, etc., will decrease the close ratio. Efficiency requires integration and operational excellence from end-to-end.

A standard metric of efficiency in retail sales of this nature is the CPA, meaning the dollars spent to attract and enroll a subscriber. The total CPA typically includes advertising, other promotional expenses, website maintenance, shopping and enrollment through the contact center(s), sales and marketing staff, support for navigators, premium billing and collection and broker commissions. To the extent that these costs are borne by issuers rather than the marketplace, they can be excluded from the SBM’s own CPA, but they still affect premiums.

The average CPA can be compared for different sales channels, as a way to measure their relative efficiency. For example, Connecticut calculates that the average CPA for its stores is a little under \$180 per subscriber. This is more efficient than brokers (if their commissions are included), navigators or the call center. However, customers often use multiple channels for shopping, especially the website and the call center, in addition to using a broker or navigator. So care must be taken in comparing these costs. Some of these channels serve multiple purposes, in which case their costs cannot be attributed solely to customer acquisition. A classic example is the call center, for which it is helpful to divide calls and costs into pre- and post-enrollment contacts.

CPA can also be compared for different channels against the revenue stream over the average lifetime of an enrollee, i.e., the monthly user fees or premiums. Channels will differ in the average household size that they deliver and the tenure of the enrollees they bring in. For example, brokers in Connecticut's individual market brought in slightly larger households, on average, than other channels. Several of the states captured data from every channel on each encounter, including race/ethnicity, length of interaction, referral source and problems with enrollment. Using these kinds of tools to evaluate and adjust marketing and sales strategies is standard procedure in direct-to-consumer sales. They can be used, for example, to test one advertising strategy against another, or to adjust the mix of direct communications and enroller capacity in a locale. They do require collecting key measures as a matter of routine reporting by channel. Not every SBM was able to collect these data systematically, and without such data, undertaking efforts to approve efficiency will be somewhat like flying blind.

8. Recognize and accommodate the different roles of navigators and brokers. *Do this by: (a) introducing and helping brokers and navigators work together or make referrals to each other; and (b) developing data collection tools that allow both to share credit for cooperating on enrolling a client.*

Navigator and broker management is challenging, and the two groups differ in mission, experience, prior training and expectations. Importantly, navigators do not generally depend upon the volume of enrollments to determine compensation, and are oriented by mission and licensure status (or lack thereof) to fulfill a different role than most health insurance agents. Many navigators expect to help clients with income-related eligibility determination, are familiar with Medicaid and CHIP and help in accessing a variety of social and economic supports. By contrast, brokers are paid by carriers as producers (of enrollment), and focus on coordination with the health insurance issuer and ongoing service issues with commercial insurance, but are generally unfamiliar with Medicaid, CHIP and other support programs. Many navigators may view their role as supportive, with or without enrollment, whereas brokers define their productivity in terms of enrollment and renewal.

These and other differences led to some mutual suspicion and distrust between brokers, navigators and the marketplaces. For one, brokers expressed fear that marketplaces intended to replace them with navigators, or to sell directly to prospective customers without any intermediary for enrollment. For example, one broker complained of massive advertising by the marketplace, and that such ads never mention brokers; another broker in a different state complained that the marketplace's website almost seemed to hide the names of brokers. This broker did admit that as open enrollment proceeded, the marketplace made more frequent and more prominent mention of brokers for consumers who wanted their help. Other brokers stated that the marketplaces should promote the broker's role in assisting consumers and explain that using a broker does not cost the enrollee anything. (Brokers pointed out that many prospective enrollees simply do not understand that commissions are included in premium costs and shared by all enrollees, regardless of whether an enrollee uses a broker or not.)

Some navigators mentioned that they had never worked with brokers in their areas, and only happened to meet at enrollment events sponsored by the marketplace. Many more expressed a concern that the navigator's duty to remain issuer-neutral precluded them from working with brokers who are perceived as biased in favor of whatever issuer pays the highest commission. In fact, health plans (not brokers) establish the broker compensation programs, which tend to be competitive, if not exactly the same, but (a) there are differences in compensation from plan to plan, and (b) there are some plans that do not use brokers or that have a very different broker footprint and program than competing plans. (Similarly, CACs work for providers affiliated with some health plans and not others.) Some SBMs, including Colorado and Oregon, require all issuers that use brokers to pay fees and commissions in effect to any willing broker, but depending on the market such requirements can backfire on SBMs. Bias in the sales channel by any type of assister can be a problem for marketplaces and consumers, but whether and how SBMs should intervene to promote even-handed consumer assistance remains a topic for debate.

Still other navigators complained that when they make referrals to brokers, the broker gets full credit for the enrollment and the marketplace is unaware that the navigator helped educate and determine eligibility for these enrollees. Because the broker is paid by the health plan and the navigators are supported by grants, it should be possible to work out these sorts of obstacles to referrals.

Where collaboration and collegial relationships were encouraged, experience and exposure seemed to reduce these barriers, to the point where brokers who were active and wanted to participate felt that their services were valued by the marketplace; *some brokers and navigators expressed appreciation of their complementary roles and desire to work together*. The differences in roles between many brokers and navigators, their access to specific linguistic, ethnic and other communities, and their contacts among and appeal to insured versus uninsured residents, can tend to obstruct cooperation. Alternately, these complementary strengths can be harnessed to promote enrollment in QHPs and Medicaid/CHIP if the marketplace can identify the most productive and cooperative brokers and navigators in each area, work with them to develop complementary roles, training and other supports and actively facilitate cooperation. For example, providing an electronic application form that allows both a navigator and a broker to share credit for an enrollment would recognize and encourage such cooperation. Triaging through the call center and website requests for assistance between brokers for QHP selection and navigators for Medicaid enrollment and special complex household eligibility cases can help as well.

9. Refocus broker and assister training for 2015 on hands-on enrollment issues. *Focus navigator and broker training programs less on the basics of the ACA, and more on the specifics of the insurance application and the operational support available for problematic cases. While the rush to ready operations for October 1, 2013, may have prevented timely, hands-on training last year, in-person training in advance of November 15, 2014, on the systems to be used for enrolling—and renewing—clients will be critical.*

Both navigator and broker training were challenging for the first open enrollment period. In one state, outreach to the brokers began early and training was conducted by two experts, one of them an active broker who specialized in helping applicants who were denied coverage for pre-existing conditions. The SBM also hired several brokers well in advance of the fall to manage broker relationships by answering their questions on the fly, inviting them to enrollment events, overseeing their training, etc. By contrast, this same state only identified and began training navigators in October of 2013.

Ironically, the brokers in this state expressed more concern than the navigators about the inadequacy of training because it was more theoretical than hands-on. They particularly hungered for training on the system that they would actually use to enroll consumers. In another state, brokers articulated this same issue, but added that it was because the IT system was evolving in real-time throughout the enrollment season that their hands-on training was not very useful. Of course, this SBM (like all others) was in the difficult position of trying to understand its own role, while simultaneously understanding the roles of its outreach and enrollment partners, building and testing its systems and training all its partners on the system. As a result, training was considered wanting, especially by brokers. They did, however, understand the difficulty the SBM faced, but hoped for substantial improvement in training for 2015.

In addition, both brokers and navigators in several states specifically referenced the lack of adequate training to help self-employed individuals calculate their modified adjusted gross income (MAGI) correctly. Others cited difficulty in providing direction on how to report the number of people in a given household and suggested more pop-up information boxes to provide enrollees tips on this calculation. Many brokers and navigators noted that the application itself suggested that both enrollees and assisters were more knowledgeable about the basics of tax filings than they were prepared for. And importantly, both brokers and navigators reported that some of the most perplexing application-related issues could not be answered by anyone they contacted at the SBM (some issues remain open to this day).

For SBMs that have experienced one enrollment season, and are modifying existing systems, there is an opportunity this fall to revamp training and recoup support from brokers and navigators. A remedial course in all the basics of the ACA and marketplaces can be provided online, but personal support (or real-time, online training) in using the eligibility determination and enrollment systems would likely be very welcome and would provide an early venue for feedback from the field. Other skills in need of sharpening might include teaching elementary health insurance literacy, use of the SBM's decision-support tools and the likely financial impact on beneficiaries total spend of various cost-sharing features.

10. Identify the obstacles to enrollment and ensure their correction. *First and foremost, SBMs must fix their systems, and a systematic assessment would be very helpful. Evaluate the obstacles to enrollment and ensure delivery of those components critical to an easy and simple enrollment experience. Flexible, scalable call center staffing will be critical.*

The user experience with the website and call center is a critical element of the enrollment experience, and improving it is crucial to reputation management. Kentucky's operational readiness paid off when midway through its first full day of operation, nearly 60,000 individuals seeking information about affordable health care had visited its website. By day 10 of open enrollment, nearly 10,000 Kentuckians had enrolled, and the pace of enrollment actually picked up for the rest of the month, averaging just over 1,000 Kentuckians a day.

By contrast, long wait times on the telephone were typical in other states during the first weeks and months of open enrollment. After hours and weekend access were necessary just to sustain even low levels of customer service. And now, stakeholders are wary as they begin to hear about the next generation of systems capabilities before the most basic problems with the existing systems are fully repaired. This time, the fixes should be rolled out and tested serially, so that programmers can identify which fixes have failed or have created new problems.

During the last open enrollment period, SBMs increased staff to compensate for IT deficiencies and cumbersome processes. For example, Colorado eventually hired eight trainers to go into the field to work with brokers and their employers who could not get through the SHOP enrollment process. Colorado estimates that it could take 20 hours to enroll a small group of five employees in SHOP. Clearly, systems need to be improved to remove these kinds of impediments to enrollment.

Kentucky highlighted the benefits of partnering with willing navigators and brokers in evaluating changes needed to customer service or the enrollment process. Kentucky relied on these entities to test the online application prior to going live, to provide daily feedback on consumers' experiences, and to record needed system changes. Kentucky credits these front-line resources as a key source of information about what worked well and not so well for consumers using the website or contact center.

Some SBMs are now considering adding a responsibility to their contracts with navigators to drive program improvement. In several states, assisters complained that the “one front door” policy for prospective enrollees did not seem to apply to brokers and navigators trying to get both QHP and Medicaid answers; SBM and Medicaid staffs were unable or unwilling to assist callers with questions they viewed as “belonging” to the other side. Assisters felt caught in the middle and struggled to find an efficient way to get answers to their questions.

SBMs must staff to and plan for surges in application/enrollment volume via multiple channels during open enrollment. After experiencing challenges during the initial weeks of open enrollment, Kentucky worked with its IT vendor to plan in advance for surges in application volume. This meant that no matter what was working (or not), and even during technical releases, the system had to be prepared to handle a planned number of applications. Surge planning focused the vendor on what was critical—getting applications through the system—and set expectations for server bandwidth. It also focused the SBM on funneling applicants to the website during these surge periods, both through organized triage at the contact center and by alerting navigators and brokers on when to expect these high-performance intervals.

Flexible, scalable staffing at the call center should allow SBMs to use data from the first open enrollment (call volume, wait time, call length, call type, walk-in numbers, verifications and turn around on paper applications) to plan for surges in consumer support at the next open enrollment. Customer service resources will need to adjust for renewal communications, open enrollment deadlines, tax season questions, IT/website releases, mailings, advertising, etc. Similarly, resources should also be adjusted to support navigators and brokers. Perhaps most importantly, SBMs will need to be very mindful of the shortened open enrollment season for 2015, particularly in light of the holiday season, the competing priority of the Medicare and group open enrollment seasons likely impacting many brokers in November and December, and the large number of early 2013 renewals that will be terming late in 2014.

11. Prioritize limited resources for the support of navigators. *Focus limited human and financial resources on the most effective navigators for enrollment. On the one hand, this will necessitate culling navigators; on the other hand, continuing support for the more effective ones may be especially important for enrolling hard-to-reach target segments and for maintaining politically important alliances.*

Navigators can vary considerably in their productivity. For example, one navigator in Southwest Colorado seemed content to schedule four clients per day, and to refer those who were Medicaid eligible to a Medicaid/CHIP enrollment specialist. By contrast, another agency hired and trained 14 part-time navigators (7.5 full-time equivalents) for five locations north of Denver (Laramie County), and booked up very quickly. This agency developed an online scheduling system to process clients more efficiently: in addition to scheduling a time to come in, clients pre-populated the intake tool with information on household size, income, language spoken, current coverage status, etc.

Although no doubt working very hard, some navigators take pride in their focus on developing relationships and helping clients with a broad array of issues, distinct from the more transactional focus of the SBM's staff. “We take our time and build personal relations,” said one navigator in Connecticut. By contrast, she further stated that “... the outreach staff allows no more than one hour per consumer.”

The most successful navigators are already integrated into the communities they serve. When it comes to enrolling hard-to-reach populations and the uninsured, a localized approach can be very effective. For example, Kentucky organized and managed its program in accordance with the state's eight Medicaid managed care organization (MCO) regions. With many established organizations already serving Medicaid recipients, this structure was intended to align with the current outreach process, and to address specific needs of residents. Kentucky identified the demographics of each region and highlighted those population segments with the highest need. Responders were required to identify one hard-to-reach population that they had a history of working with, and what program customizations and accommodations they would undertake to make information and services especially relevant and accessible to this population.

In addition to assisting with individual applications and enrollments, navigators in Kentucky are required to work primarily in the community, facilitating outreach and enrollment at consumer locations and assisting Kentucky with local community events. Navigators must report their total driving time monthly, the number of locations/events attended and the ratio of total drive time to total number of hours spent on enrollment activities. In addition to reporting on the number of events attended (including venue, date/time and materials distributed), they must also provide a photograph of the booth or poster from the specific events to prove the accuracy of the report.

Kentucky also established a payment schedule and metrics tailored to each region. Fixed payments are made monthly to the navigator entities based on the entity's size and the region's demographics, with additional incentive payments made at the SBM's discretion. The number of applications each navigator entity is expected to process monthly is based on its size and the expected enrollment for that region. Outside the open enrollment season, navigators are still expected to facilitate outreach events and assist with any application or enrollment changes the consumer needs.

By contrast, utilizing a lead organization model, whereby the SBM contracts with regional organizations which then select and subcontract with multiple navigators in their region, seems to have had mixed results. Washington used this model with good success when enrollment was used as the measure. The state selected 10 regional lead organizations from across the state through a competitive request for proposal (RFP) process to manage the program. Lead organizations picked community partners to provide outreach and managed navigators' efforts. The RFP process forced organizations to think through participation requirements very early and carefully. Washington meets with all lead organizations monthly and maintains close coordination to handle issues. Compensation is based on both day-to-day activities and meeting performance targets. By April 2014, each of the 10 lead organizations had exceeded its enrollment target established for December 2014, and in the aggregate, navigator assisted enrollments were more than three times the target.

Similarly, Connecticut broke its small geography down into six substate regions, with a single lead organization for each region, including one Hispanic entity with both its own region and statewide responsibilities for Spanish speakers. However, Connecticut selected and trained its navigators, bypassing the six lead organizations, and navigators underperformed in meeting the SBM's QHP enrollment targets in the state (albeit this group achieved much success in other important measures, such as reducing health disparities and providing enrollees with other forms of social assistance).

We observed considerable variance in approach to managing navigators and in their individual performance. However, no single preferred approach to managing the program emerged from our observations.

12. Consider building local marketing and sales plans around lead brokers for each community. *To maximize the use of brokers as a free resource (excluding a few "non-brokered" markets), consider developing local marketing and sales plans built around lead agents for each community. Identify those producers across the state that are committed to, and capable of, retaining and enrolling many new clients, initiate a campaign early to recruit them, and focus sales resources and planning on supporting their efforts. Joint planning should aim to drive qualified prospects to them and support their efforts to develop highly productive enrollment processes.*

In most states, brokers are compensated for enrollments in the individual market through a sales commission that is "baked" into premium rates, both inside and outside the marketplace (Rhode Island is a notable exception, where carriers do not pay nongroup commissions). So long as issuers continue to pay commissions in and outside the marketplace, SBMs do not incur a separate cost for brokers, with an exception for the administrative cost of managing and servicing this sales channel. In this sense, brokers are a "free" resource—although clearly commission levels affect premiums.

In all four states where brokers are already active in the individual market, they produced far more QHP enrollment than did

navigators. In Washington, brokers assisted over 42,000 QHP enrollees and almost 29,000 Medicaid enrollees.¹⁴ By comparison, navigators assisted less than 30,000 QHP enrollees, but approximately 244,000 Medicaid enrollees.¹⁵ Brokers were cited by Connecticut as a major factor in exceeding its enrollment target; they accounted for 31 percent of the QHP enrollment. In Kentucky, brokers accounted for 44 percent of total QHP enrollment, about three times as much as navigators produced. In Colorado, brokers accounted for approximately one-third of QHP enrollment.

While many brokers in the individual market are qualified, only some appear to be interested and willing to work with SBMs. Among those who are, only a few in each state aggressively pursued this opportunity for 2014 enrollment by adding staff, developing new record-keeping systems, learning the details of the ACA and actively recruiting new clients. The broker in Connecticut who helped train her colleagues estimates that only 20 or so brokers—out of 750 who started the training and 250 who produced any enrollment volume—fit this mold. Working closely with a handful of such brokers in each region of the state could be a very cost-effective way for SBMs to field a professional sales force that will not simply convert previously insured clients who qualify for subsidies, but will reach out to the uninsured.

A number of brokers interviewed expressed an interest in developing such partnerships with their SBMs, and some have already placed big bets on health reform. In Connecticut, for example, an individual who was interested enough in health reform to become licensed as a broker built his brokerage entirely around the SBM. An agency southeast of Denver expanded from 6 to 10 employees in preparation for open enrollment, conducted seminars throughout 2013 in libraries and other venues, opened its own enrollment center, sent out 90,000 postcards, spent another \$50,000 to \$60,000 on local ads and enrolled 1,000 clients. Of these, about 250 to 300 were conversions of existing clients, but the majority were new, often previously uninsured clients.

In Kentucky, a few of the larger brokerages began creating and disseminating information on the ACA as early as 2012. As the SBM formalized its policies on brokers and agents, these groups were able to publicize their services in lockstep with marketplace developments. Clearly, these were groups who saw the ACA as a business opportunity and, while many other brokers were still skeptical, took advantage of any opportunity to participate. Many successful smaller brokers in the state turned to the web to create an online presence for themselves as a primary channel serving SBM customers. Early difficulties with the website drove volume to these brokers who were offering “expertise” and “convenience” for shoppers.

In Washington state, the top selling brokers used a variety of ways to grow their book of business, leveraging the availability of premium subsidies to attract prospective buyers. Some brokers reported using “guerilla” marketing techniques, such as posting signs advertising low-cost coverage (“Obamacare is very affordable—call or visit me to see how you can sign up”). Others tapped into social media outlets or went on talk radio to tell people in their community about “Obamacare.” (A majority of brokers reported that “Obamacare” resonated with prospective enrollees, while the “Affordable Care Act” or “ACA” meant virtually nothing.) *Word of mouth—particularly in hard-to-reach communities—was extremely effective in bringing in large groups of people who were personally encouraged by a highly satisfied friend or family member to sign up.* In particular, many of the word of mouth brokers stated that they expect such referrals to increase for the next open enrollment season.

When asked, the more productive brokers expressed interest in looking for ways to partner actively with their SBMs. One agent suggested that he could organize and host group enrollment sessions for up to 20 clients an hour, four sessions per day during open enrollment, if Colorado’s SBM would help him reach out to prospects. He even offered to invite competing agents to participate in group enrollments at his site, similar to how Connecticut’s stores in New Haven and New Britain function.

Working with just a few such highly motivated brokers in each region of the state, an SBM could develop joint sales plans, organize cost-efficient ways to process high volumes of enrollees and create a cadre of “champions” among small business people who can recruit other brokers, as well as enroll many individual households. Developing a lead sales agent strategy and plans around such brokers seems a plausible strategy for effectively decentralizing outreach and sales, with high performance at minimal ongoing cost to the SBM. Working closely with such brokers on jointly funded outreach and servicing could generate even better results for 2015.

Some SBMs have already started to support top producers. Connecticut was successful in using their two stores to generate leads for brokers. Brokers could sign up for specified blocks of time to serve qualified prospects in the two sites. In Colorado, several brokers observed a progressive warming in their relationships with the SBM. Over time, they were invited to help staff enrollment events, it became easier to find them on the SBM’s website and the call center representatives would more readily refer customers to brokers for assistance. Eventually, the SBM identified the top 20 percent who wrote 10 plus sales, and referred clients looking for a broker to them.

Some brokers who were successful in enrolling large numbers of people over the last six months are now thinking about how they can further reconfigure their office staffing to take advantage of the next enrollment season. These are the brokers who have figured out the most efficient ways to bring people through the process and they want to expand their ability to service more enrollees and keep existing clients enrolled.

To clarify, the authors do not recommend that an SBM stop working with brokers who want to enroll smaller numbers of people, nor that SBMs base future arrangements only on past performance. Some brokers simply took a wait and see approach during this first open enrollment season, and others were interested, but were put off either by problems with the enrollment process or the bad press generated by HealthCare.gov. If an SBM uses a lead agency model, this role should be open to brokers who can make the requisite commitments. It will be important for the SBM to be both transparent and open to all brokers willing to work to achieve lead agency stature.

For brokers who *are* enthusiastic, there should be many ways to encourage participation and productivity: a broker-dedicated team at the contact center; a broker portal for self-service; appointment to an advisory council on policy development and broker performance standards; modest credits against commissions (perhaps administered by the SBM's ad agency) to help defray upfront advertising and collateral costs in advance of enrollment; inclusion on a referral list of experienced brokers; access to qualified leads at enrollment centers; links from the SBM's website; and promotion of ancillary broker services. As noted elsewhere, SBMs might also help brokers and navigators collaborate. Of course, the biggest single opportunity is to improve the brokers' own customer experience with the SBM.

A few cautions about working with brokers are also worth noting. First, some agencies may have reported high numbers the first year, but only enrolled existing clients in the SBM if they were subsidy-eligible. Unsubsidized clients were not enrolled through the SBM because: (a) there are more health plans (or provider networks) available outside the SBM, (b) there are administrative hassles to enrolling through the SBM, and (c) there was no advantage to doing so. If brokers only enroll their existing, subsidy-eligible clients, can they deliver many more enrollments next fall?

Second, brokers acknowledged that many navigators are far more familiar than they are with Medicaid, and on average navigators helped many more Medicaid than QHP enrollees. Many brokers ignored Medicaid, but some want to help clients with Medicaid, especially if they can be at least modestly compensated for this work. Others would just as soon refer those clients to navigators. Indeed, a few brokers and navigators found ways to cooperate effectively, despite little encouragement, or even active discouragement from the SBM.

Finding ways to introduce navigators and brokers and help them partner effectively should improve the enrollment effort for both programs. In Connecticut, the two states did serve to connect a few brokers and navigators. Colorado eventually sponsored some pilot events where brokers and navigators were brought together to help support each other. (One SBM not directly interviewed for this paper actually conducted "mixers" to help introduce brokers and navigators to one another.) In Washington, two of the lead organizations had greater interactions with the broker community: in one, the head contact is a licensed broker, and in the second, a member of the lead organization board is a licensed broker.

Third, brokers operate businesses, and time is money for them, with critical implications for those on commission. The majority of brokers interviewed reported an unacceptably low level of support from the SBM, often citing average hold times exceeding an hour or more as the top complaint. A second common concern among brokers was a general lack of sufficiently trained, experienced and dedicated staff for support services. Brokers who produce a high volume of enrollment for carriers are accustomed to receiving top service and carriers usually staff broker support teams with their most experienced personnel. Carriers are known to incent brokers in two ways: one is through the sales commission program, and the second is through a package of services intended to reward the best producers. Brokers expect SBMs to meet industry norms of servicing this sales channel.

While brokers were generally understanding of challenges over the first several months of operations, they are unlikely to demonstrate similar patience next fall. For many brokers, it was the collective impact of poor service, long wait times, late or missing commissions and the lack of financial consideration for Medicaid enrollments that turned them off. Adequate service levels are likely to be regarded as nonnegotiable. In addition, brokers would appreciate even nominal compensation for Medicaid enrollments (Covered California provided brokers with a one-time stipend of \$58 for Medicaid applications).¹⁶ With the next open enrollment season just around the corner, states should consider this issue in the near term.

13. To maximize the use of other free or low-cost resources, focus on generating as much earned media and marketing support from issuers as possible. *Earned media, a powerful enrollment tool, will be tougher to get in the second open enrollment period, but is achievable with planning and creativity. Issuers now have a stake in the game and may be more willing to co-market to renew and build their market share.*

SBMs generally did a masterful job at generating earned media. Consumer surveys often ranked local news media among the top sources of their information on the ACA and marketplaces. Unavoidably, some of the news coverage was negative, both because of the troubled launch of the federally-facilitated marketplace and particular problems in some states. Overall, the local coverage was generally positive or turned positive as problems were resolved and enrollment climbed in the five states examined. And “free media” is both cheaper and more impactful than most paid advertising.

Because the SBMs are no longer new, this level of free coverage will be challenging, if not impossible, to sustain in 2014. On the other hand, the ACA promises to be a focus of the 2014 elections, and in “blue” and “purple” states with SBMs, earned media can be quite positive. Moreover, the SBM’s experience and history will present new opportunities for earned media, particularly to celebrate success. For this purpose, a coalition of supporters to raise the flag can be invaluable.

SBMs can promote earned media by releasing data and policy briefs on enrollment trends, new issuers and new QHPs, celebrating key milestones, releasing various kinds of lists and working with partners in the community on promotions related to external events and the editorial calendar. Tax season, graduation, back-to-school time and Labor Day all represent earned media opportunities. Partnering with state and local officials is another way to generate local news coverage. The SBMs we studied were very successful last year in capitalizing on and creating these opportunities.

Given the hesitancy of some carriers to participate, the uncertainty confronting most participating issuers and the focus of SBMs on their own federally-funded outreach and marketing campaigns, it is not surprising that co-marketing with issuers was not the highest priority in 2013. However, in theory, issuers and marketplaces share an interest in maximizing enrollment. Building on some of the tentative steps taken in 2013, SBMs should reach out to issuers in order to leverage multiple marketing campaigns all gearing up for the fall of 2014.

For example, health fairs in the community where navigators, CACs and other assisters can get to know the issuers better, where consumers can talk to plan representatives and compare options and where the press can literally see the insurance marketplace, provide a good opportunity for joint promotion. Indeed, a commitment by issuers to participate in such events should be incorporated into their contractual obligations (if need be). Joint sponsorship with issuers of other community events and concerts represents another opportunity to leverage carriers’ marketing funds, and to convey the message that the SBM is a “store” for their products.

Summary

Based on observations and interviews with brokers, navigators, insurers and SBM staff in five states, we recommend that SBMs consider these 13 strategies for improving the productivity of their outreach and enrollment efforts. Some will fit one SBM better than another, and some may not fit at all with an SBM's other priorities or a particular insurance market. These 13 strategies represent learnings based on what is working and what those in the field suggest might work better.

1. Integrate and execute the next marketing and sales campaign as early as possible.
2. Move from a media shotgun approach to more targeted marketing to build awareness.
3. Develop a simple, effective renewal process in conjunction with brokers, navigators and issuers.
4. Develop a cost-effective physical presence in target communities.
5. Integrate all marketing and sales activities into a coordinated effort focused on enrollment.
6. Leverage commercial insurance expertise on staff and adopt standard industry tools and measures.
7. Carefully manage the CPA.
8. Coordinate complementary roles for navigators, brokers and CACs.
9. Refocus broker and assister training for 2015 on hands-on enrollment issues.
10. Identify the SBM's operational obstacles to enrollment and ensure their correction.
11. Prioritize limited resources for the support of navigators on the most effective, productive ones.
12. Consider building local marketing and sales plans around lead brokers for each community.
13. Generate earned media and solicit marketing support from issuers.

¹ Linda J Blumberg et al, "Measuring Marketplace Enrollment Relative to Projections," Urban Institute, April 2014 accessed at <http://www.urban.org/UploadedPDF/413087-Measuring-Marketplace-Enrollment-Relative-to-Enrollment-Projections.pdf>; Linda J Blumberg et al, "Measuring Marketplace Enrollment Relative to Projections: Update," Urban Institute, May 1, 2014 accessed at <http://www.urban.org/UploadedPDF/413112-Measuring-Marketplace-Enrollment-Relative-to-Enrollment-Projections-Update.pdf>.

² Vikki Wachino, Samantha Artiga and Robin Rudowitz, "How Is the ACA Impacting Medicaid Enrollment?" May 5, 2014 accessed at <http://kff.org/medicaid/issue-brief/how-is-the-aca-impacting-medicaid-enrollment>.

³ "AccessHealth CT: Tracking Survey of Awareness and Interest among Connecticut Residents," Pappas MacDonnell, Inc., November 15, 2013, page 6.

⁴ "A Tracking Survey of Awareness and Interest among Washington Residents," PerryUndem Research/Communication, April 2014.

⁵ "Connect for Health Colorado Awareness Report," Connect for Health Colorado, January 2014. "AccessHealth CT: Tracking Survey of Awareness and Interest among Connecticut Residents," Pappas MacDonnell, Inc., November 15, 2013, page 6. "A Tracking Survey of Awareness and Interest among Washington Residents," PerryUndem Research/Communication, April 2014. "Awareness high about state's insurance marketplace," The Foundation for a Healthy Kentucky and Interact for Health, January 2014. Available at: <https://www.interactforhealth.org/kentucky-health-issues-poll>.

⁶ "Access Health CT 2013 Review, Q1 2014 Plan of Action," Pappas MacDonnell, Inc., January 8, 2014.

⁷ NY State of Health Marketplace reported CACs enrolled 16 percent of QHP enrollments while brokers enrolled 12 percent and navigators enrolled 8 percent (NY State of Health 2014 Open Enrollment Report, dated June 2014).

⁸ CMS Center for Consumer Information & Insurance Oversight, Guidance on Annual Redeterminations for Coverage for 2015, June 26, 2014. Available at: <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014-0626-Guidance-on-annual-redet-option-2015-FINAL.pdf>; Patient Protection and Affordable Care Act; Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs; Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges, Proposed Rule, published July 1, 2014. Available at: <http://www.gpo.gov/fdsys/pkg/FR-2014-07-01/pdf/2014-15362.pdf>.

⁹ Washington Healthplanfinder Mobile Enrollment Tour, January 22, 2014, Memorandum from GMMB to Washington Health Benefit Exchange.

¹⁰ Voices from the Newly Enrolled and Still Uninsured, A Survey about the Affordable Care Act's First Open Enrollment Period, PerryUndem Research Communication for Enroll America, July 2014.

¹¹ "GO TIME Plan: Access Health CT Open Enrollment," Access Health CT & Pappas MacDonnell, Inc., September 27, 2013.

¹² See Appendix.

¹³ See Appendix.

¹⁴ Health Coverage Enrollment Report, October 1, 2013 – March 31, 2014, Washington Healthplanfinder, accessed at http://www.wahbexchange.org/files/2713/9888/1218/WAHBE_End_of_Open_Enrollment_Data_Report_FINAL.pdf.

¹⁵ Health Coverage Enrollment Report, October 1, 2013 – March 31, 2014, Washington Healthplanfinder, accessed at http://www.wahbexchange.org/files/2713/9888/1218/WAHBE_End_of_Open_Enrollment_Data_Report_FINAL.pdf.

¹⁶ <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/OEWorkgroupFAQinperson.aspx>.