Early State Experiences with the First Open Enrollment under the Affordable Care Act

A Maximizing Enrollment Brief

By

Keerti Kanchinadam
Joanne Jee
National Academy for State Health Policy

January 2014

A product of the Maximizing Enrollment Program

NATIONAL ACADEMY for STATE HEALTH POLICY

Robert Wood Johnson Foundation

Maximizing Enrollment is a national program of the Robert Wood Johnson Foundation with technical assistance and direction provided by the National Academy for State Health Policy.

About Maximizing Enrollment

Maximizing Enrollment has worked intensively with eight states to improve eligibility and enrollment systems, policies and procedures. This report examines how states pursued programmatic change by bringing together three key strategies: providing leadership to achieve culture change, improving data analysis to target and track policy changes, and focusing on coordination across the various state and local entities administer eligibility systems.

About the National Academy for State Health Policy

The National Academy for State Health Policy (NASHP) is an independent academy of state health policymakers. We are dedicated to helping states achieve excellence in health policy and practice. A non-profit and nonpartisan organization, NASHP provides a forum for constructive work across branches and agencies of state government on critical health issues. Our funders include both public and private organizations that contract for our services. For more information, visit www.nashp.org.

About the Robert Wood Johnson Foundation

For more than 40 years the Robert Wood Johnson Foundation has worked to improve the health and health care of all Americans. We are striving to build a national culture of health that will enable all Americans to live longer, healthier lives now and for generations to come. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at www.rwjf.org/twitter or on Facebook at www.rwjf.org/facebook.

For more information, please contact Maureen Hensley-Quinn at mhq@nashp.org or (202) 903-2782.

Acknowledgements

The authors wish to thank the many state officials whose work and reflections informed this brief. In particular, we would like to thank state officials from Illinois, South Carolina, and Washington who shared their experiences on a Maximizing Enrollment Webinar, *State Experiences with ACA Open Enrollment: Early Successes and Lessons*. We would also like to acknowledge the leadership of the Maximizing Enrollment program, Alice Weiss, Maureen Hensley-Quinn, and Catherine Hess at the National Academy for State Health Policy (NASHP), for their guidance and editorial review and Nicole Dunifon for her technical support. Finally, we would like to thank Lori Grubstein and Andrew Hyman at the Robert Wood Johnson Foundation for their continued guidance of the Maximizing Enrollment national program.

Introduction

The Affordable Care Act (ACA) brought significant change to the United States' health insurance landscape with the goals of expanding insurance coverage, streamlining enrollment processes, and increasing access to care. The ACA's foundation is the expansion of coverage to an estimated 14 million previously uninsured Americans with the creation of health insurance marketplaces and the expansion of Medicaid for populations that historically have been ineligible for coverage.[1] To achieve the law's goals, states have developed and implemented streamlined eligibility and enrollment systems and innovative partnerships and policy solutions. States have taken varied approaches to implementing the ACA, particularly in deciding whether to expand Medicaid or to establish a state-based marketplace (SBM), federally-facilitated marketplace (FFM), or a federal-state partnership marketplace (SPM). Despite differences, all states had to build new integrated information technology systems, implement procedures to transfer data among and between state and federal agencies, adopt new income counting methodology, and establish new consumer assistance entities and processes for eligibility staff. Many of these changes had to be implemented by October 1, 2013, with the beginning of the first open enrollment period for health insurance marketplaces, which ends March 31, 2014. This brief describes state experiences from the first three months of the first open enrollment under the ACA. While many states experienced well-publicized challenges during this time, state officials worked to address issues and many employed an array of strategies and workarounds to help consumers apply for and enroll in coverage.

This brief describes components of a number of states' experiences with implementing enrollment systems in the areas of: (1) consumer education and assistance, (2) application and enrollment, and (3) Medicaid and open enrollment. Each of these areas is discussed in turn, highlighting state descriptions of challenges encountered and workaround strategies or solutions developed. In most cases, this brief reflects the *earliest* state experiences. Information was obtained from discussions among senior-level state officials at a number of National Academy for State Health Policy (NASHP) convenings during the first month of open enrollment and was supplemented by publicly available data. Between then and the issuance of this brief, states have made many changes, and taken steps to address challenges and improve the enrollment experience. These changes are important to ensuring that eligible individuals enroll in coverage and that ongoing improvements to state eligibility and enrollment operations occur. However, the early state experiences described in this brief help to document the evolution of health reform in the states and may prove instructive for states at different stages of ACA implementation as well as for planning for the next open enrollment period.

Consumer Education and Assistance

Under the ACA, all states had to implement significant changes to their eligibility and enrollment policies and systems, regardless of the state's choice to host a health insurance marketplace or expand Medicaid. To ensure the success of these changes, many states were challenged to develop and disseminate information that was straightforward for consumers while accurately conveying the complex changes to coverage and consumer assistance options. Although states faced challenges in coordinating their messaging and assistance efforts and managing a high volume of consumer queries, many worked to construct creative and cohesive strategies for assisting and relaying complex state-specific information to the public. The following sections discuss state strategies including media outreach, messaging to existing enrollees, call center operations, and the introduction of new consumer assistance entities.

Media Campaigns. Some states used statewide media and commercial advertising to reach the many individuals newly eligible for coverage through the ACA. For example, Washington's extensive marketing campaign for its state-based Health Benefit Exchange garnered significant earned media and national recognition. Washington's media strategy included memorable TV advertising, a mobile enrollment tour, innovative community partnerships, and a cohesive "Coverage is Here" brand, which was incorporated into all marketing efforts. Washington also specifically targeted the young invincible population—young adults between ages 18 to 29—who are a crucial demographic for health plans wanting to keep costs balanced. Washington created advertisements featuring images and ideas that resonate with this demographic, such as a young person snowboarding and highlighting the launch of a smart phone application. The state also engaged Death Cab for Cutie, a band originally from Washington that has gained national recognition, to increase awareness of new coverage options and encourage enrollment. Washington's media efforts also underscore the importance of flexibility—when the state experienced initial challenges with the debut of its web portal it chose to suspend some of its TV advertising in order to keep from advertising for coverage options that were temporarily unavailable. The state received positive feedback through a consumer brand perception survey and its success is also seen through its early enrollment numbers.[2] While most SBM states participated in similar marketing and branding activities, not all states, particularly FFM states, were as actively engaged as Washington in media campaigns.

Informing Existing Enrollees. In addition to reaching out to newly eligible consumers, some states proactively communicated with individuals who were already enrolled in Medicaid or the Children's Health Insurance Program (CHIP) to help them understand how the ACA affects their coverage. These messaging efforts informed current enrollees that, while the ACA makes significant changes to the way some individuals receive health insurance coverage, for many individuals already enrolled in Medicaid or CHIP, nothing would change. Some states expressed concern that individuals already enrolled may not realize that their coverage would remain the same. To help ease this concern, some states sent targeted information to these individuals. In Montana, the Medicaid agency sent flyers to current Medicaid enrollees explaining that the state would be making major changes to its Medicaid systems as part of the ACA and, while enrollees may experience hiccups, nothing should fundamentally change with their coverage. Similarly, Vermont also targeted existing Medicaid enrollees, advising them that their coverage would remain the same and that no immediate action was required in order to retain it. However, one state official in Vermont reported that these notices actually spurred some individuals to call the call center with concerns about their existing Medicaid coverage.

Managing Call Center Operations. States debuted their new integrated enrollment processes on October 1, 2013 and for many, higher than anticipated volume, website glitches, and challenges coordinating state and federal call centers significantly affected call center operations. Many states faced higher than expected call volume, receiving calls ranging from questions about coverage options and difficulty with downed websites, to those seeking to apply for coverage over the phone. Some states with FFMs also found it challenging to coordinate their state call center efforts with the federal call center. In these states, consumers who were determined ineligible for Medicaid by state call centers were referred to the FFM call center, only to have the FFM refer them back to the state. To address this issue, the federal call center worked to better train its staff about eligibility nuances, particularly around Medicaid, and relay appropriate information to consumers.

Some call centers were inundated with high consumer demand. In Washington, after launching the online application and during the first few weeks of open enrollment, the state received 4-6 times more calls than had been anticipated and experienced wait times as high as 23 minutes. To address these challenges, Washington doubled the number of customer service representatives as of mid-December 2013 and made additional resources available to help triage calls. Washington also continues to work on fixing underlying systems issues, particularly with the marketplace web portal,

which the state cites as a key driver of the high call center volume.[3] Oklahoma call centers experienced lengthier phone calls from individuals who had more questions than usual. Oklahoma increased the number of trained Medicaid call staff prior to open enrollment, which helped manage demand. While lengthy calls persisted, wait time was not an issue for Oklahoma early in the enrollment period.

In anticipation of high but unpredictable demand, Illinois, a partnership-model marketplace state, reorganized its call center infrastructure as part of its cohesive “Get Covered Illinois” strategy. The state advertised a single “Get Covered” call center phone number to initially screen callers and direct them to either the federal marketplace call center or the state’s Medicaid call center, depending on their likely eligibility. Both the “Get Covered” and Medicaid call centers were well-staffed and consumers experienced wait times of less than one minute. Illinois’ call center restructuring allowed the state flexibility to manage caseworker time and caseload, which has been integral to the success of its call center operations thus far. The center is able to re-orient staff between the “Get Covered” call center, which performs the key steps of screening and triaging calls, and the Medicaid call center based on where volume is highest.[4]

Consumer Assistance. Consumer assistance has been a key component of states’ efforts to ensure that the adoption of the marketplace and other new eligibility and enrollment processes are successful. To aid states in helping consumers, the ACA created and funds several new assistance entities, including navigators, Certified Application Counselors, and In-Person Assisters. Most states have adopted a combination of these assister entities, and have had to quickly determine how these new entities will coordinate with existing assistance entities, such as application assisters at Federally Qualified Health Centers (FQHCs) or local health clinics.[5]

To ensure that the many consumer assistance entities in the state were coordinated, Washington formed strong community-based partnerships. The state enlisted ten lead organizations including public health districts, non-profits, and foundations throughout the state, which then subcontracted with other organizations. As of early December, the 10 lead organizations were working with 100 community-based organizations, 1,400 in-person assisters, and 2,000 agents and brokers, giving Washington a broad and community-focused consumer assistance model.[6]

Some states with additional state certification requirements for navigators and other consumer assistance entities found it challenging to meet the demand for consumer assistance in the early weeks of implementation due to delays in navigators and assisters receiving these required state certifications. For example, it was reported that in one state even after the start of the open enrollment period, many FQHC workers who already had completed assister training were still awaiting finalized privacy agreements and identification numbers from the state. Without necessary documentation of completion of the required training, these assisters had to cancel appointments with consumers. Similarly, in another state, two weeks into open enrollment, many navigators were still waiting to complete training, receive state-issued licenses or computer log-in information, or undergo background checks.[7] Despite the delays in some states, all states were able to employ existing consumer assistance workers, particularly at county and local levels, to help answer questions and enroll individuals and families into coverage.

Application and Enrollment

A major component of the ACA is its vision for streamlined application and enrollment processes, which has necessitated systemic changes for state eligibility and enrollment systems and eligibility workers. This vision for seamlessness means that states must be able to process applications, make eligibility determinations, and enroll individuals into Medicaid, CHIP, or the marketplace whether they apply online, by phone, by mail, or in-person. To achieve this "no wrong door" vision, states upgraded, replaced, and integrated eligibility system technology, implemented a simplified eligibility standard based on modified adjusted gross income (MAGI), and built and debuted online web portals that allow consumers to browse plans and purchase one that best suits their needs. States also had to decide whether to implement CMS approved targeted enrollment strategies; whether to use an expanded flat file transfer for individual account transfers or wait for the online system functionality to be ready; how to implement identity proofing; and how to report performance indicators. During the early enrollment period states experienced various challenges with the application experience and with achieving a seamless enrollment process. These challenges and examples of state strategies to address them are discussed in the following sections.

Online Applications. The ability to compare plans, purchase, and enroll through an online marketplace website is one of the core components of the ACA's transformation of an individual's enrollment experience. However, early in the open enrollment period, state and federal marketplace websites experienced well-documented technological difficulties, which delayed many marketplaces' capacity to deliver on the promise of this transformation.[8,9] The federal marketplace website, HealthCare.gov, faced significant technological challenges beginning with its debut on October 1, 2013, with the site down 60 percent of the time for the first few weeks.[10] Since then, the Department of Health and Human Services (HHS) has made significant upgrades and improvements in capacity, and as of December 1, 2013, consumers in the 36 states relying on the federal marketplace were able to more successfully shop for plans, with the website loading quicker and with fewer errors.[11]

Some SBM states also faced troubles with their online marketplace portals but many found workarounds and continued to process applications even when websites were down. Statistics from Covered California, California's health insurance marketplace show that by the end of November the marketplace had made significant improvement in processing applications and enrolling individuals in coverage, overcoming a rollout that had experienced some technical glitches. The marketplace's executive director, Peter Lee, reported that Covered California enrolled 79,981 people as of November 19, 2013 in marketplace health plans, more than doubling October's enrollment of 30,830 in less than three weeks.[12] Similarly, the Washington Health Benefit Exchange web portal experienced several brief periods of outage within the first week of its opening. However, by establishing extra server connections the state was able to relieve bottlenecks and enrolled more than 100,000 individuals in November.[13,14]

Phone, In-Person, and Paper Applications. In addition to developing an online portal for applying for and enrolling in health coverage, states were expected to create a "no wrong door" experience—whereby individuals could apply for marketplace, Medicaid, or CHIP coverage by phone, on paper, or in-person and be seamlessly enrolled in the appropriate coverage program. To help compensate for the difficulties with online applications, many states leveraged these alternative application methods.

For example, Oregon's state-based marketplace portal, Cover Oregon, experienced significant technical troubles during the early enrollment period. As of mid-January, Oregon was unable to enroll consumers into the marketplace using the online portal, and was accepting only paper applications. The state has taken steps to address technical issues with the online marketplace portal, but these

fixes have taken longer than anticipated and despite hiring additional workers to process paper applications, the state experienced a large backlog of applications.[15,16] When websites were briefly down in Michigan, New Jersey, and Washington these states also turned to paper applications as a workaround.[17] Although processing paper applications is a time consuming process, states made progress in enrolling individuals in coverage using this method while their web-based portals were offline. New Jersey, an FFM state, enlisted the aid of federally certified marketplace navigators to help enroll individuals using paper applications when HealthCare.gov was unable to enroll individuals online. Navigators in the state also directed applicants who appeared to be Medicaid-eligible to apply using the state's Medicaid website, rather than the federal website, HealthCare.gov. In Montana, the state recommended that consumers apply for coverage over the phone. Although call center wait times were high, individuals could file applications by phone more quickly than they could online. Washington hired additional eligibility workers and extended office hours in order to handle the larger than anticipated volume of paper applications.[18]

During the early enrollment period, in-person applications were less common than telephone or paper applications. A few states were concerned that local offices might be inundated with people walking in without appointments but this problem did not materialize. In New Jersey, state officials placed freestanding computers in the lobbies of social services offices in order to facilitate individuals applying in-person online rather than using paper to allow for more efficient processing.

Targeted Enrollment Strategies. CMS issued guidance in May 2013, providing states with the option to implement five time-limited targeted enrollment strategies designed to facilitate the enrollment of eligible individuals in Medicaid and relieve administrative burden during the early years of ACA implementation. Among the five strategies was the early adoption of MAGI-based eligibility determinations, which CMS approved in the District of Columbia and 15 states: Colorado, Hawaii, Illinois, Kansas, Louisiana, Missouri, Nevada, New Jersey, Oklahoma, Oregon, Pennsylvania, South Carolina, Virginia, Washington, and West Virginia.[19] This optional targeted enrollment strategy permitted states to adopt MAGI-based eligibility determination rules for *all* eligibility determinations in advance of January 1, 2014, thus avoiding having to operate two sets of eligibility rules for those eligible for Medicaid or CHIP during the marketplace open enrollment period beginning October 1, 2013. States like Virginia implemented early MAGI without much trouble, but other states experienced some technological programming challenges.

CMS' May 2013 guidance also offered states the option to use income data from the Supplemental Nutrition Assistance Program (SNAP) to identify and enroll Medicaid-eligible individuals, many of whom are newly eligible for coverage in 2014. Five states—Arkansas, Illinois, New Jersey, Oregon, and West Virginia—sent letters to SNAP recipients informing them of their opportunity to opt into Medicaid coverage. Using this option, West Virginia successfully enrolled more than 58,000 children and adults in Medicaid and CHIP and Arkansas enrolled 63,465 individuals in Medicaid and 3,000 children in CHIP.[20,21]

Identity Proofing. Identity proofing is a process by which the marketplaces and Medicaid and CHIP state agencies verify an individual's identity. After being verified, the individual can consent to the use of certain federal and state data to make an eligibility determination for coverage in the marketplace, Medicaid, or CHIP.[22] CMS is providing a remote identity proofing (RIDP) service to marketplace, Medicaid, and CHIP agencies through the federal data services hub. Some states, including South Carolina, were initially concerned that the RIDP service would only work for a small subset of individuals in the state. However, a state official in South Carolina reported that RIDP worked successfully during the early enrollment period—most individuals referred for identity proofing moved through the system and obtained a final assessment. In addition, from October to November 2013, South Carolina saw improvement in the RIDP process in the form of a reduced error rate, from 8.1 to

4.7 percent. A state official in South Carolina shared that the early success of RIDP is a good indicator that moving populations towards online applications will be successful in the state.[23]

South Carolina's experience with identity proofing is an example of how RIDP can be useful for states. However, there also have been reports of challenges with identity proofing in multiple states.[24,25] Even in South Carolina, 18.9 percent of individuals applying for coverage were unable to use identity proofing due to a lack of credit history, suggesting that perhaps at its best, identity proofing may be an imperfect tool.[26] An official from one state said that preparing for RIDP was a challenge because the state had not anticipated the level of intensity and resources required to implement it, and had not budgeted accordingly. Another state experienced issues with identify proofing certain populations, namely minors, but was working with CMS to address this.

Account Transfers. As part of the "no wrong door" approach to coverage under the ACA, all states have to coordinate and electronically transfer applicant accounts to ensure eligibility determination for the appropriate insurance affordability program. To facilitate this coordination, Medicaid agencies in FFM or SPM states chose to receive either an initial assessment of Medicaid eligibility or to accept a final Medicaid eligibility determination for individuals who apply through the marketplace. The account transfer is intended to effectuate the seamless "no wrong door" enrollment process by preventing applicants from having to provide the same information more than once for eligibility determinations once they apply for a single health insurance affordability program. However, due to the technological challenges experienced during this first enrollment period, CMS delayed account transfers, which were slated to begin October 1, 2013. This delay meant that states with FFMs were not initially able to enroll individuals either determined or assessed to be eligible for Medicaid or CHIP.

The delay in the account transfers was a concern for many states with FFMs. One state official shared that the delay created messaging challenges in her state, which is not expanding Medicaid. Having to convey what coverage and/or financial subsidies are available to whom, along with changes to coverage programs, and the delayed enrollment timeframes made developing an easily understood message challenging. To work around the challenge of the delayed account transfers, Illinois implemented strategies to minimize the need for transferring applications from one program to another. The state did this by helping individuals seeking coverage to apply directly with the coverage program for which they were most likely eligible. For those calling the "Get Covered" call center, the eligibility screen facilitated this. Consumers in Illinois were informed that they can submit applications for coverage through both the state call center for Medicaid and the FFM website or call center. Messaging around these strategies was complex, but the state wanted to prevent applicants from having to wait for an eligibility determination until the account transfer issues were addressed.

In November 2013, CMS issued guidance providing states with a time-limited option to enroll individuals in Medicaid or CHIP based on an expanded flat file transfer from the FFM. The flat file is not a full electronic account for an individual but does contain sufficient data for states to identify an individual and the FFM's determination or assessment of Medicaid or CHIP eligibility. CMS originally intended for states to use the flat file to simply anticipate staff workload and consumer demand in advance of full account transfer functionality.[27] In January 2014, CMS augmented the personal data that could be transferred as part of the expanded flat file transfer to include both income and gender data, making this information more usable for state processing needs. Once the full electronic account transfer is operational, state application and enrollment processing will occur as originally intended. For states, the option to enroll eligible individuals into coverage based on the flat file transfer must be weighed against the opportunity cost for doing so. For example, states may need to consider what, if any, programming changes need to occur for eligibility and enrollment systems to enroll individuals based on the flat file.

One important consideration for FFM and SPM states is whether they chose to have the FFM assess or determine eligibility for Medicaid. Determination states allow the marketplace to make full MAGI-based eligibility determinations for Medicaid, which are accepted by the state. Assessment states accept only an initial assessment of Medicaid eligibility by the marketplace—applicant files are electronically transferred from the marketplace to the state Medicaid agency in order to conduct an eligibility review and any necessary additional verifications.[28] For FFM determination states, enrollment based on the flat file is complete and will be valid for the full 12-month Medicaid enrollment period. By contrast, for FFM assessment states, enrollment based on the flat file only lasts for 90 days, after which time the state will have to do a new determination.[29] Once the account transfer is available, these states will need to complete processing cases using the full data set. This likely means that assessment states taking up the flat file enrollment option will have to process enrollments twice.

Performance Indicators. In October 2013, states began reporting on a set of 12 eligibility and enrollment performance indicators including enrollment, call center volume, wait times, and call abandonment rates.[30] CMS requested that states provide three months (July, August, and September 2013) of baseline data for the performance indicators, and established a schedule for the weekly and monthly reporting of the performance indicators. Some states were unsure about the usefulness of the baseline data, but reported it as best they could. Other states were unable to report the baseline on some measures because they did not collect that data. For example, some states historically have not collected data on processing time and had to provide instruction to state employees on how to calculate this measure. Some states indicated that in addition to the performance indicator data requested by CMS, they are collecting and analyzing other data such as how long it takes to complete an application (Alabama), complaints from consumers (Rhode Island), and consumer satisfaction (New Jersey) to help assess the state's overall performance during the first open enrollment period. Early analyses of the eligibility and enrollment performance indicator data and associated processes for reporting, analyzing, and interpreting the data find that the indicators mark a significant improvement in timely and high-quality data reporting for Medicaid and CHIP, which has historically been inconsistent.[31]

Medicaid and Open Enrollment

The open enrollment period, which runs from October 1, 2013 through March 31, 2014, has been a critical time for establishing enrollment through the new health insurance marketplaces, but it has also meant a boost in Medicaid enrollment. Although enrollment in Medicaid can occur at any time during the year, this first ever open enrollment period for the marketplaces coincided with significant state and national attention on enrollment, efforts to simplify enrollment processes in Medicaid, and the ACA's "no wrong door" approach, all of which helped to increase enrollment.

All states experienced an increase in Medicaid enrollment during the early open enrollment period—states expanding Medicaid experienced a 15.5 percent increase in the number of applications received in October and states not expanding Medicaid experienced a 4.1 percent increase. A total of 3.9 million individuals were determined eligible for Medicaid and CHIP as of the end of November 2013.[32] The HHS Assistant Secretary for Planning and Evaluation reported that from October 1 to November 30, 268,974 individuals were determined or assessed to be eligible for Medicaid or CHIP by the FFM itself.[33] While many states, particularly those expanding Medicaid, expected an increase in the number of Medicaid eligible individuals, non-expansion states made different assumptions about how many eligible but not enrolled individuals would enter the program. For example, South Carolina projected a 16 percent increase in its Medicaid enrollment, whereas three states (Louisiana, Maine, and Wisconsin) projected a decrease in Medicaid enrollment for FY 2014.[34]

During the first months of open enrollment, Medicaid enrollment outpaced enrollment in qualified health plans (QHPs) and some states experienced an increase in enrollment among those who were previously eligible for Medicaid but not enrolled. For example, in the first week of October, Washington enrolled 5,946 newly eligible individuals—adults with incomes up to 133 percent of the federal poverty level who are newly eligible under the state's Medicaid eligibility expansion—into Medicaid coverage effective January 1, 2014. Washington also enrolled an additional 2,594 individuals who were eligible for immediate Medicaid coverage based on pre-2014 eligibility standards.[35] By the end of October, the state had enrolled a total of 55,367 individuals—about 54 percent were enrolled in Medicaid coverage beginning January 1, 2014, 34 percent were immediately enrolled in Medicaid coverage, and 13 percent enrolled in a QHP in the marketplace.[36] Kentucky had a similar experience with Medicaid enrollment far outpacing marketplace enrollment during the early open enrollment period. As of January 2, 2014, a total of 123,543 individuals had enrolled in coverage, of which 73 percent had enrolled in Medicaid and 27 percent had enrolled in a QHP.[37] The increases in Medicaid enrollment will have implications for state program staffing, strategies to ensure access to providers, and budgets, which will have to be addressed in 2014 and future years.

Conclusion

With the introduction of health insurance marketplaces and the expansion of Medicaid, the ACA expands health insurance coverage options to millions of uninsured individuals, and makes significant changes to how states structure and operate their eligibility and enrollment processes. Given the substantial scope and volume of changes states undertook in preparation for open enrollment, it is not surprising that some states experienced challenges in the early months. Many of the challenges in states have been well-publicized. However, despite the difficulties and glitches, many states rose to the occasion, implementing backup strategies, adjusting approaches, and redistributing resources so that as many of their consumers seeking health insurance coverage could obtain it. As 2013 year-end enrollment data demonstrate, state adjustment strategies helped to promote enrollment for 3.9 million individuals eligible for Medicaid and CHIP and 2.2 million individuals eligible for marketplace coverage.

States have already identified a number of challenges and issues that will warrant attention in the coming months and future open enrollment periods. Ensuring strong and effective communication and coordination with state and federal partners, including call centers, federally certified navigators, and other consumer assistance entities will be critical to success. Building on the lessons learned during this first marketplace open enrollment period—such as anticipating periods of high demand and implementing effective strategies for responding—could help states ensure smooth and efficient open enrollment periods in upcoming years.

State and federal agencies also will want to ensure that the technical tools they are relying on to support enrollment are both functional and effective. While investments have been made to make tools such as the federal remote identity proofing service as effective as possible, South Carolina's experience is an early indication that there are limitations to RIDP's effectiveness for certain individuals. To maximize the integrity of the enrollment process, consideration of alternative methods for identity proofing may be warranted. The reporting of performance measures provides an important opportunity to enable data-driven analysis of the enrollment experience. Over time, with greater state experience with collecting the measures and improved consistency in reporting, there should be opportunities to assess the effectiveness of state enrollment processes and identify areas for improvement.

Since the earliest weeks of the open enrollment period, states have made many systems and operational improvements, and as data are now showing, enrolling millions of consumers into coverage. Despite the rapidly changing landscape, the early experiences of states can offer useful perspectives for understanding current and future approaches for implementing new coverage options and streamlined eligibility systems.

Notes

[1] Congressional Budget Office, *Effects of the Affordable Care Act on Health Insurance Coverage—May 2013 Baseline* (Washington, DC: Congressional Budget Office, May 2013).

[2] "State Experiences with ACA Open Enrollment: Early Successes and Lessons." State Refor(u)m Webinar. *National Academy for State Health Policy,* December 5, 2013. https://www.statereforum.org/node/12553

[3] Ibid.

[4] Ibid.

[5] Katie Baudouin, Christina Miller, and Rachel Dolan, *Designing Consumer Assistance Programs: Resources from the Field*. (Princeton, NJ: State Health Reform Assistance Network, February 2013).

[6] "State Experiences with ACA Open Enrollment: Early Successes and Lessons." State Refor(u)m Webinar. *National Academy for State Health Policy,* December 5, 2013. https://www.statereforum.org/node/12553

[7] "Some Covered California Navigators Still Not Certified to Help Residents," *California HealthLine,* October 15, 2013. http://www.californiahealthline.org/articles/2013/10/15/some-covered-calif-navigators-still-not-certified-to-help-residents

[8] Jane Bornemeier, "Awareness Grows of Online Insurance Exchanges, and Their Problems, Survey Finds," *New York Times*, October 21, 2013. http://www.nytimes.com/news/affordable-care-act/2013/10/21/awareness-grows-of-online-insurance-exchanges-and-their-problems-survey-finds/

[9] Paige Winfield Cunningham, "State health exchanges are showing mixed results," *PoliticoPro*, November 5, 2013. http://www.politico.com/story/2013/11/state-health-care-exchanges-mixed-results-obamacare-affordable-care-act-99346.html

[10] Department of Health and Human Services, *HealthCare.gov Progress and Performance Report.* (Washington, DC: Department of Health and Human Services, December 1, 2013). http://www.hhs.gov/digitalstrategy/sites/digitalstrategy/files/pdf/healthcare.gov-progress-report.pdf

[11] Editorial, "Fast Recovery for Health Care Website," *New York Times*, December 2, 2013. http://www.nytimes.com/2013/12/03/opinion/fast-recovery-for-health-care-website.html?hp&rref=opinion&_r=0

[12] David Gorn, "Exchange Applications, Website, Agents All Hit Higher Marks in Second Month," *California HealthLine*, November 27, 2013. http://www.californiahealthline.org/capitol-desk/2013/11/exchange-applications-website-agents-all-hit-higher-marks-in-second-month

[13] Clint Boulton, "State Exchanges Started Late, Clashed with Vendors," *Wall Street Journal,* November 26, 2013 http://blogs.wsj.com/cio/2013/11/26/state-exchanges-started-late-clashed-with-vendors/

[14] Washington Health Benefit Exchange, "Washington Healthplanfinder Health Coverage Enrollment Grows to Nearly 100,000 Residents," news release, November 19, 2013. http://www.wahbexchange.org/news-resources/press-room/press-releases/nov-19-enrollment-data

[15] Nick Budnick, "Oregon Health Exchange Technology Troubles Run Deep Due to Mismanagement, Early Decisions," *Oregon Live,* December 14, 2013. http://www.oregonlive.com/health/index.ssf/2013/12/oregon_health_exchange_technol.html#incart_river

[16] Jennifer Haberkorn and Jason Millman, "Oregon May Switch to Federal Obamacare Exchange," *PoliticoPro*, January 14, 2014. https://www.politicopro.com/story/healthcare/?id=29754

[17] Dan Gorenstein, "Obamacare limbo land for health care navigators," *Marketplace*, November 6, 2013. http://www.marketplace.org/topics/health-care/diagnosis-camden/obamacare-limbo-land-health-care-navigators

[18] "State Experiences with ACA Open Enrollment: Early Successes and Lessons." State Refor(u)m Webinar. *National Academy for State Health Policy,* December 5, 2013. https://www.statereforum.org/node/12553

[19] Centers for Medicare and Medicaid Services. "Targeted Enrollment Strategies." Retrieved January 13, 2014. http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Targeted-Enrollment-Strategies/targeted-enrollment-strategies.html

[20] West Virginia Department of Health & Human Resources, "Second Round of Medicaid Automatic Enrollment Letters Sent," news release, November 21, 2013, http://www.wvdhhr.org/communications/news_releases/Press%20Release--Secretary%20Bowling%20Announces%20Second%20Round%20of%20Automatic%20Enrollment%20Letters%20for%20Medicaid.pdf

[21] Centers for Medicaid and CHIP Services, *Medicaid & CHIP: October Monthly Applications and Eligibility Determinations Report*, (Washington, DC: Centers for Medicare and Medicaid Services, December 3, 2013).

[22] Centers for Medicare and Medicaid Services, *Guidance Regarding Identity Proofing for the Marketplace, Medicaid, and CHIP, and the Disclosure of Certain Data Obtained through the Data Services Hub.* (Washington, DC: Centers for Medicare and Medicaid Services, June 11, 2013).

[23] "State Experiences with ACA Open Enrollment: Early Successes and Lessons." State Refor(u)m Webinar. *National Academy for State Health Policy,* December 5, 2013. https://www.statereforum.org/node/12553
[24] Robert Pear, "ID Verification Lagging on Health Care Website," *New York Times,* November 25, 2013. http://www.nytimes.com/2013/11/26/us/id-verification-lagging-on-health-care-website.html
[25] Evi Heilbrunn, "ACA Roundup: Open Enrollment Period Extended," *U.S. News and World Report,* October 10, 2013. http://health.usnews.com/health-news/health-insurance/articles/2013/11/26/aca-roundup-open-enrollment-period-extended
[26] "State Experiences with ACA Open Enrollment: Early Successes and Lessons." State Refor(u)m Webinar. *National Academy for State Health Policy,* December 5, 2013. https://www.statereforum.org/node/12553
[27] Centers for Medicare and Medicaid Services, State Health Official Letter: SHO #13-008, *New Flexibility: Using Account Transfer Flat Files to Enroll Individuals in Medicaid and CHIP,* November 29, 2013.
[28] Kaitlin Sheedy, *Coordinating Medicaid Eligibility and Enrollment with a Federally Facilitated Marketplace: Assessment vs. Determination Model.* (Washington, DC: The National Academy for State Health Policy, November 2013).
[29] Centers for Medicare and Medicaid Services, State Health Official Letter: SHO #13-008, *New Flexibility: Using Account Transfer Flat Files to Enroll Individuals in Medicaid and CHIP,* November 29, 2013.
[30] Centers for Medicare and Medicaid Services, *Letter to State Medicaid and CHIP Directors: Medicaid and CHIP Performance Indicators – Reporting Instructions for September Baseline Data Submission; and Instructions for Account Creation for Web-Fillable Form for Initial Data Submission Beginning in October*, September 16, 2013.
[31] The Kaiser Commission on Medicaid and the Uninsured, *An Introduction to Medicaid and CHIP Eligibility and Enrollment Performance Measures,* (Menlo Park, CA: The Henry J. Kaiser Family Foundation, January 2014).
[32] Centers for Medicaid and CHIP Services, *Medicaid & CHIP: November Monthly Applications and Eligibility Determinations Report*, (Washington, DC: Centers for Medicare and Medicaid Services, December 20, 2013).
[33] This number includes those selecting plans in SBMs and FFMs, and includes both those who have and have not paid premiums. Department of Health and Human Services, *Health Insurance Marketplace: December Enrollment Report*, (Washington DC: Assistant Secretary for Planning and Evaluation, December 11, 2013).
[34] Vernon K Smith, et al. *Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014,* (Washington DC: The Henry J. Kaiser Family Foundation, October 2013).
[35]Richard Onizuka. "Washington Health Benefit Exchange." 26th Annual State Health Policy Conference, National Academy for State Health Policy. Seattle, WA. October 10, 2013. http://www.nashpconference.org/wp-content/uploads/2013/presentations/r.onizuka.4.unique.pdf
[36] Pam MacEwan, et al. "Washington Health Benefit Exchange, Status Updates." Washington Health Benefit Exchange Board Meeting. November 20, 2013. http://www.wahbexchange.org/files/9413/8489/6326/HBE_EB_131120_Status_Updates.pdf
[37] Office of Kentucky Governor Steve Beshear. "kynext Statistics, as of January 2, 2014." Retrieved January 10, 2014. http://governor.ky.gov/healthierky/Pages/default.aspx