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State-Based Marketplaces Spent Heavily to Help Enroll Consumers

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Abstract
The Affordable Care Act required that consumers have access to in-person or on-call assistance to understand their choices and "navigate" the complexities of the new health insurance marketplaces. One consequence of each state's decision about whether to run its own marketplace is an extreme variation in the time-limited funding available for consumer assistance programs. This Data Brief looks at the types of assistance available and the level of funding for each state in the first year of marketplace operations.

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Deciphering the Data: State-Based Marketplaces Spent Heavily to Help Enroll Consumers

In-Brief

The Affordable Care Act required that consumers have access to in-person or on-call assistance to understand their choices and "navigate" the complexities of the new health insurance marketplaces. One consequence of each state's decision about whether to run its own marketplace is an extreme variation in the time-limited funding available for consumer assistance programs. This Data Brief looks at the types of assistance available and the level of funding for each state in the first year of marketplace operations, and analyzes the components of that variation.

BACKGROUND

Recognizing that health insurance is a complex product and that consumers would need help understanding their options and navigating a health insurance marketplace, the Affordable Care Act and subsequent regulations created a number of consumer assistance programs. This was especially important given that a key target population was the uninsured, many of whom were unfamiliar with the basics of health insurance.

Here we focus on programs that trained or certified people and organizations to directly assist consumers in enrolling in the marketplaces. The assister programs had outreach responsibilities, but are distinct from the broader education and outreach efforts conducted by public and private groups (for example, Enroll America).

The assister programs were intended to operate at the state level with funds going directly to community centers or other entities already operating within the state. States with a state-based marketplace (SBM) took on the role of funding and selecting Navigator organizations, while the federal government took on this role in states with a federally facilitated marketplace (FFM). The partnership states could decide whether to take on consumer assistance functions or rely on the federal government.

Consumer assistance programs fall within three categories: Navigators, In-Person Assisters (IPAs) and Certified Application Counselors (CACs). While the duties of Navigators and other in-person assisters are fairly straightforward, with three types of marketplaces and three categories of programs, the scope and implementation of consumer assistance varies considerably across states.

As initially conceived in the ACA, "**Navigators**" would be funded and trained to conduct outreach and facilitate enrollment in the new marketplaces. The ACA also specified standards to ensure Navigators are qualified, free of conflicts of interest, and providers of fair and impartial information and services. A wide range of entities could run a Navigator program, such as community non-profit groups, trade, industry, and professional organizations, ranching and fishing associations, chambers of commerce, and unions. This broad array of potentially qualified entities reflects the recognition that the success of Navigators would depend on the extent to which they are trusted by the people using the marketplaces.

In the 29 FFM states, as well as two partnership states, the federal government distributed $67 million in Navigator funding, using a specific formula based on the number of uninsured residents under age 65. Each state received a minimum of $600,000, with the remainder allocated by the state's share of the number of uninsured in FFM and partnership states. A total of 105 organizations received one-year, non-renewable Navigator grants in August 2013.

The ACA required that SBM Navigator programs be funded by revenues generated by the operations of the marketplace. States could not pay Navigators from their federal Exchange Establishment block grants (although the grants could be used for training and administrative expenses). As a result, the SBM states had a timing problem in funding their Navigator programs: they needed to conduct outreach and enrollment before their marketplaces started generating revenues to become self-sustaining. Thus, the Department of Health and Human Services (DHHS) created a similar, optional "**In-Person Assister (IPA)**" program that states could fund through the federal block grants,

which totaled more than $3 billion. The 16 SBM states and DC could decide how much to spend on IPAs and how to disburse the funds through September 2015. The five partnership states with consumer assistance functions were required to have IPA programs. Other than funding streams, there was little difference, in training or duties, between the Navigators and the IPAs.

By rule, all marketplaces were required to have a third type of assister, called "**Certified Application Counselors (CACs)**." Many states have existing CAC organizations that help people enroll in Medicaid. CACs have similar functions to Navigators and IPAs, but have less stringent training requirements. Unlike Navigators and IPAs, they are not required to conduct consumer education and outreach activities. CACs were not funded by these consumer assistance programs. However, they could receive funding through other state or federal programs, such as Medicaid, and thus, funding varied by state.

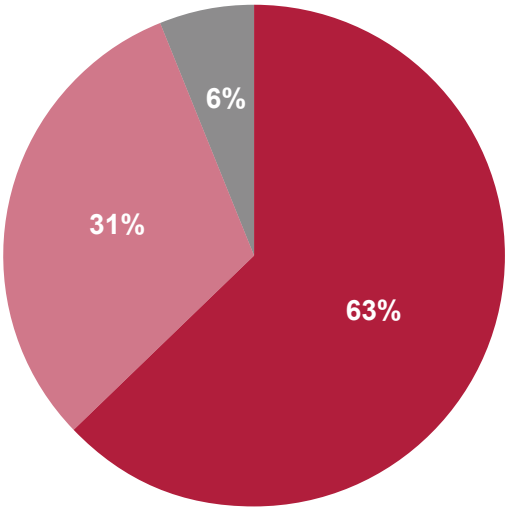
In July 2013 the federal government awarded $150 million to fund consumer assistance in community health centers, allocated proportionately among federally-qualified health centers in each state. More than 1100 centers received funds, at a base funding level of $55,000, and an additional amount allocated by the grantees' proportion of uninsured patients. In FFM and partnership states, health centers receiving this funding were required to become designated CAC organizations; SBM states had the option of imposing this requirement on health centers in those states.

The ACA specifically foresaw a role for licensed insurance agents and brokers in enrolling consumers in the marketplaces. In FFM and partnership states, agents and brokers could register and receive marketplace-specific training; SBM states had the option of adding state-specific requirements for agent and broker participation in the marketplace. Although agents and brokers played a large role in some marketplaces, we were unable to measure the scope of these activities, and confine our analysis to the three consumer assistance programs.

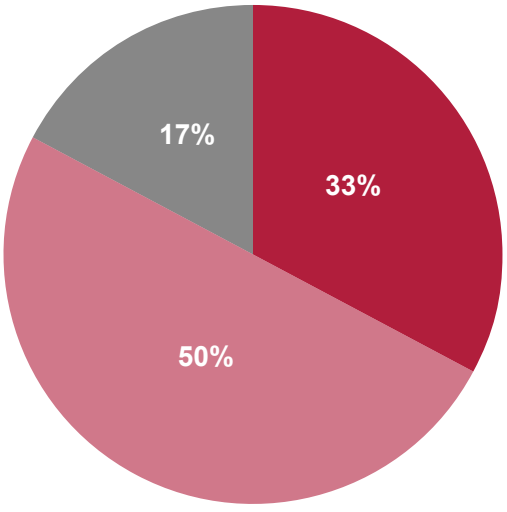
WHAT WE DID

We gathered data from various sources on state-level funding of consumer assistance programs and rates of uninsurance. The source of Navigator-specific funding for FFM and partnership states was the Centers for Medicare & Medicaid Services (CMS). SBM spending on IPAs/Navigators came from September 2013 data from the Kaiser Family Foundation (KFF). We also reviewed public documents and websites to update IPA information on states that had not yet funded their programs when KFF gathered its data. We obtained data on Community Health Center funding for consumer assistance from the Health Resources and Services Administration (HRSA), and the size of the eligible uninsured population under 65 in each state from CMS, who derived estimates from the Census Bureau's American Community Survey. Using these data, we calculated aggregate and per-uninsured funding levels. We looked at aggregate funding by type of marketplace, as well as the breakdown of funding by funding source. HIX 2.0, a database of exchange information, is a one-stop-shop for all the data we used for this brief. We relied on the HIX 2.0 for its delineation of marketplace types to ascertain the consumer assistance responsibilities of the partnership states. For these purposes, we included the two partnership states not running their own

Distribution of Eligible Uninsured Population, by Marketplace Type



Distribution of Consumer Assistance Funding, by Marketplace Type



Federally Facilitated Marketplaces | State-Based Marketplaces | State Consumer Partnership Marketplaces

consumer assistance programs (Iowa and Michigan) in the FFM category.

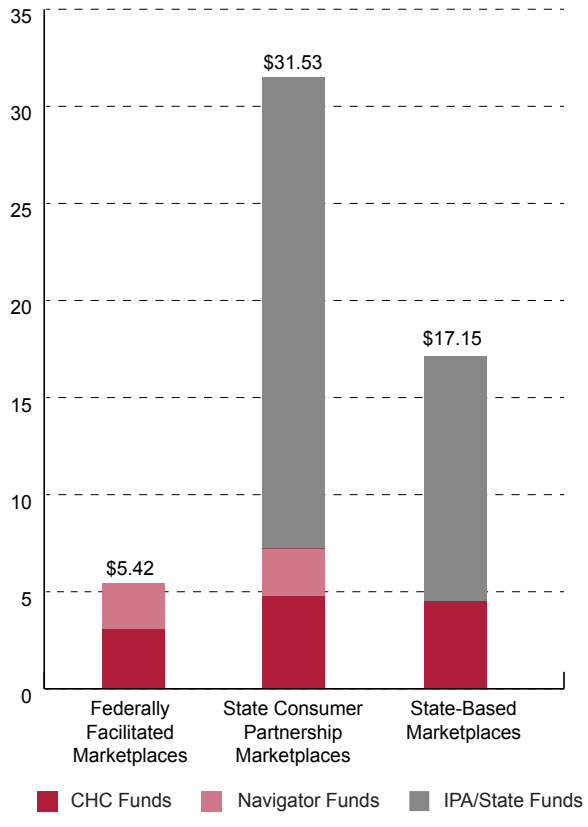
WHAT WE FOUND

By comparing consumer assistance funds to the uninsured, we found consumer assistance funds to be more concentrated in SBM states. SBMs accounted for 50% of total consumer assistance funds, although they have just 31% of all uninsured. In contrast, 63% of the uninsured live in FFM states, which accounted for 33% of the funding. The five partnership states in charge of consumer assistance functions were home to just 6% of the uninsured, but garnered 17% of the funding.

We then calculated the total consumer assistance funds per uninsured by marketplace type and found that states that run their own marketplaces, on average, spent much more on consumer assistance than states that opted to defer to the federal government to run their marketplace ($17.15 per uninsured for SBMs vs. $5.42 per uninsured for FFMs). The highest spending was in the five partnership states responsible for consumer assistance ($31.53 per uninsured).

The differences by marketplace type correspond to the differences in funding eligibility. The five partnership states with consumer assistance functions were the only ones with access to all three funding streams: federal Navigator funding, IPA funding from exchange establishment grants, and community health center funding. As a result, they had, on average, the highest per-uninsured funding levels. The FFMs were not able to draw on exchange grants for the more generous IPA funding and the SBMs were not eligible for the less generous federal Navigator funding. Looking at the components of funding, we can see the importance of the community health center funding in the FFM states, where it accounted for 57%, compared to 26% in SBM states and 15% in partnership states.

Consumer Assistance Funding Per Eligible Uninsured, by Marketplace Type



On a state level, we found relatively small variations in FFM funding for consumer assistance, ranging from $4.24 per uninsured in Georgia to $17.22 per uninsured in Alaska. This is not surprising, given that the FFM funds (beyond certain minimums) were allocated based on the number of uninsured.

Much larger differences exist in SBM and partnership states, because these states had great discretion as to how much from the large pool of Exchange Establishment grants they would devote to consumer assistance. SBM states ranged from a per-uninsured low of $6.18 for Nevada to highs of $87.86 in Hawaii and $163.93 in DC. The highest per-insured spenders have small uninsured populations, which suggests that fixed costs in launching these programs might explain some of the differences.

The five partnership states with consumer assistance functions were higher on average than the SBMs even though the range between the highest and lowest partnership states was much less than for SBMs. Funding ranged from $25.76 per uninsured in Illinois to $67.39 in Delaware.

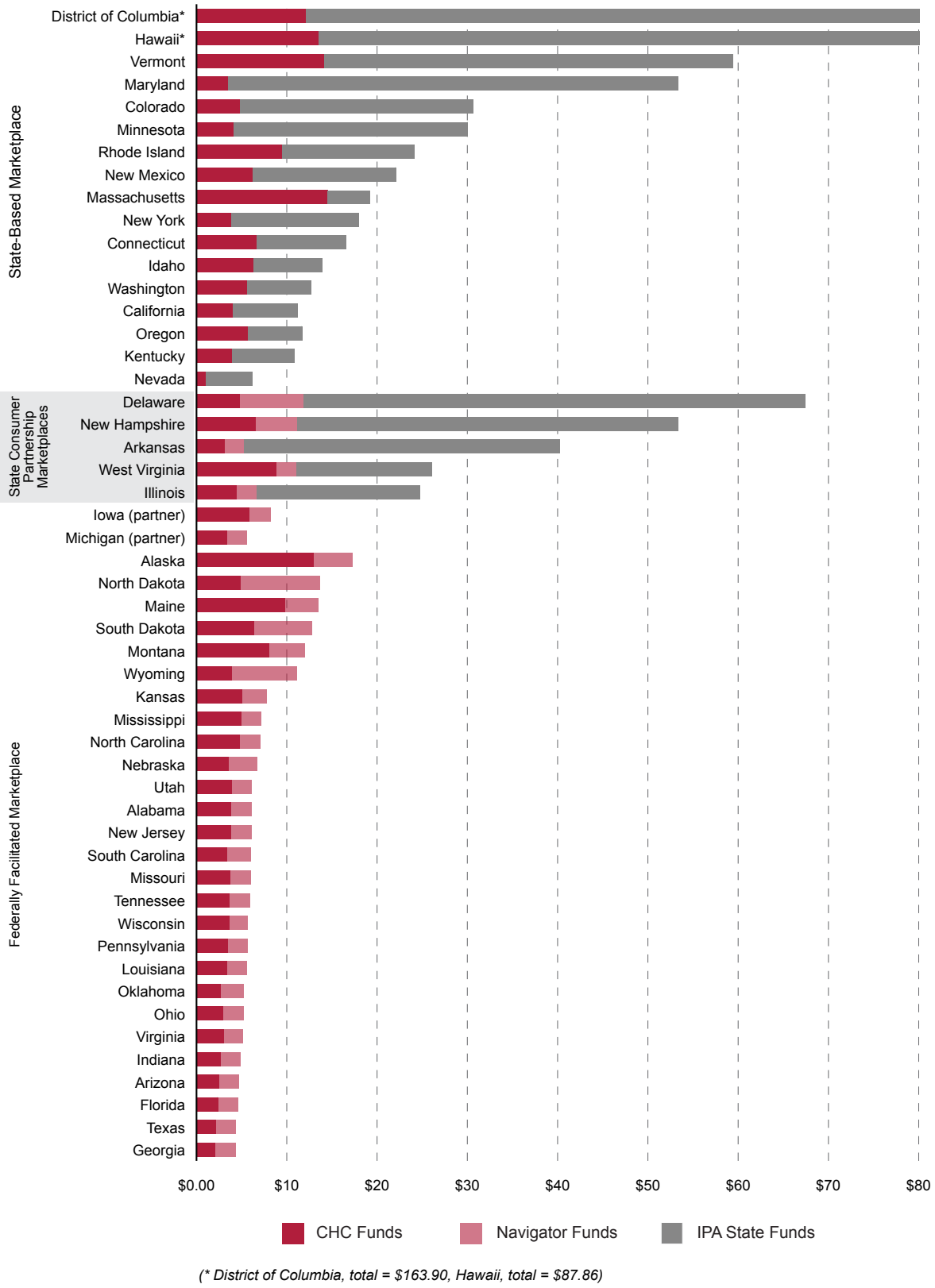
WHAT DOES IT MEAN?

This analysis reveals extreme differences in the amount of funding available to states to help consumers enroll in the new marketplaces. Enrollment data to date suggests wide variations in how successful states were in enrolling their eligible populations in private plans, with SBMs and partnership states, in general, having more success than FFMs. It is still too early to tell how much of this success can be ascribed to the greater levels of consumer assistance available to the SBMs and partnership states as they were launching their marketplaces.

Many other factors could be at play here. Our analysis does not account for marketplace funds spent on broad marketing campaigns or call centers, nor does it account for insurer initiatives to enroll new customers. For example, some states and insurers used enrollment buses and enrollment telethons.

The effectiveness of the Navigators themselves might have differed from state to state, especially in states that create barriers to assister programs. Many states passed laws to restrict activities of consumer assistance programs, sometimes requiring assisters to

Consumer Assistance Funding per Eligible Uninsured, by State



(District of Columbia, total = $163.90, Hawaii, total = $87.86)*

obtain credentials beyond federal requirements. A number of these laws have been overturned in federal courts.

It is also unclear how the variation in consumer assistance funding interacted with each state's decision whether or not to expand Medicaid. The combination of funding for community health centers and extensive use of CACs might have been especially helpful in reaching and enrolling the uninsured in states that expanded Medicaid.

This natural variation in first-year funding provides an excellent opportunity to study, both qualitatively and quantitatively, the outcomes of one of the largest outreach and consumer assistance efforts the United States has ever undertaken. Such research could give us insights into the most effective use of resources, both public and private, financial and non-financial, as states prepare for subsequent open enrollment periods in the health insurance marketplaces. These insights will be critical as these large pools of resources for consumer assistance run out and are replaced next year by much smaller amounts generated by marketplace revenues.

The future funding of consumer assistance is uncertain. Two funding streams—the federal Navigator and IPA grants—account for nearly two-thirds of the funding we report here and are scheduled to run out at the end of the year. The establishment grants that SBM states used to fund IPA programs will not be awarded beyond 2014. The FFM Navigator grants were one-time only, and subsequent funding beyond revenues raised by each marketplace is unclear. Going forward, it is likely that community health centers will continue to be central in consumer assistance efforts. For 2014, the Department of Health and Human Services (DHHS) awarded $58 million in one-time funding to community health centers for outreach and enrollment assistance (not included in our present analysis). For FY 2015, it has stated its commitment to outreach and enrollment as an ongoing health center activity, and anticipates annualizing its July 2013 funding amounts into each center's base funding.

About the Authors

This Data Brief was written by Daniel E. Polsky, PhD, MPP, Janet Weiner, MPH, Christopher Colameco, and Nora Becker.

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The Leonard Davis Institute of Health Economics (LDI) is the University of Pennsylvania's center for research, policy analysis, and education on the medical, economic, and social issues that influence how health care is organized, financed, managed, and delivered. LDI, founded in 1967, is one of the first university programs to successfully cultivate collaborative multidisciplinary scholarship. It is a cooperative venture among Penn's health professions, business, and communications schools (Medicine, Wharton, Nursing, Dental Medicine, Law School, and Annenberg School for Communication) and the Children's Hospital of Philadelphia, with linkages to other Penn schools, including Arts & Sciences, Education, Social Policy and Practice, and Veterinary Medicine.

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