

The Affordable Care Act (ACA) will extend coverage to uninsured individuals as well as to firms that have traditionally not offered insurance. Both are likely to need education and assistance to understand the changes involved with reform, including the role of health insurance exchanges and the coverage options they offer. This issue brief reviews some past efforts at educating and engaging audiences about selected reforms and coverage expansions launched prior to the ACA.

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Past experience indicates that state education and outreach activities are key drivers of participation in reforms and coverage expansions. Some past education and outreach efforts have included:

- Engaging thought leaders who can help influence public opinion about reform and educate key groups;
- Involving stakeholders in designing and implementing reform so that they are fully invested in its success; and
- Implementing effective communications that highlight opportunities under reform, as well as how to effectively navigate changes.

A closer look at Massachusetts and Utah—states that implemented two distinct exchange models prior to enactment of the Affordable Care Act—suggests efforts to engage and educate key stakeholders were critical to realizing their objectives. Outreach and education have been keys to the success of other state-based reform efforts as well. Lessons also can be drawn from the experiences of state health insurance purchasing cooperatives, those that have been both successful and not.

The Massachusetts Experience

Massachusetts gained support of multiple stakeholders during the legislative process for its 2006 reform package. Jon Kingsdale, former Executive Director of the Massachusetts Connector describes the passage and implementation of reform in Massachusetts as a “continuous campaign” built around a theme of “shared responsibility,” to achieve consensus or buy-in on critical issues.¹ Stakeholders participating in the process included community advocacy organizations, faith-based coalitions, business groups, health plans and provider associations. Following enactment of the legislation, these groups continued to be engaged in

implementation decisions through representation on the Commonwealth Health Insurance Connector Authority (analogous to a health insurance exchange governing board), as well as through involvement with the Health Care Quality and Cost Council—the body that helps design consumer information and recommended cost controls. Efforts to continually involve these stakeholders helped invest them in the success of reform, driving them to help educate their own constituencies about the new health care system and their role in participating in it. An independent review of lessons from the Massachusetts experience highlights the critical role ongoing and widespread engagement and education played.²

A broad public education campaign helped mainstream Massachusetts reform. Education and outreach in Massachusetts were led by the Connector Authority and the State’s Medicaid agency (which established a special Health Care Reform Outreach and Education Unit), in partnership with business, labor, civic and faith-based organizations. The campaign encompassed a wide range of approaches (see sidebar). It adopted a balanced message featuring personal stories to highlight the value of coverage for preventive care and financial protection from catastrophic events, as well as the benefit of avoiding income tax penalties. The Connector’s marketing message highlighted the choice of plans available, the ability to comparison shop online and its “seal of approval” for quality and value. Some campaign and outreach highlights included:

- A \$3 million integrated marketing campaign—*Cover Your Base—Connect to Health*—launched in partnership with the Boston Red Sox featured the Red Sox logo on all informational materials, a theme night at Fenway Park, announcements during pre-game ceremonies, an information booth at Fenway park, advertisements and interviews on the New England Sports Network during games and use of Red Sox “ambassadors” in ads and enrollment efforts. Along with mainstreaming the program, the sports tie-in helped reach younger males, who are more likely to be uninsured.
- The Massachusetts Health Care Reform Coalition—a nonprofit partnership involving business, labor, provider, insurer and advocacy groups—sponsored a complementary \$3 million public relations campaign to raise

Massachusetts Campaign Elements

- Paid and pro bono advertising and public service announcements using television, radio and print media (including community, ethnic and college newspapers)
- Direct mail using existing state agency distribution channels
- Online marketing (pay-per-click) and social media
- Speaking engagements and workshops around the state
- Electronic billboards
- Corporate partnership announcements (including grocery and pharmacy in-store announcements, circulars, window signs, and messages on receipts)
- Grassroots outreach in partnership with elected officials, community groups, hospitals, community health centers, health plans and schools
- A separate toll-free information hotline (distinct from enrollment centers)
- A Website to compare plan choices

awareness about reform among the general public. Business groups sponsored reform workshops to educate their constituencies. These efforts allowed the Connector to carefully focus on specific target audiences.³

- The Massachusetts Legislature provided \$11.5 million in grants (roughly \$3.5 million annually) to community groups for targeted, culturally-appropriate outreach and enrollment assistance.⁴ Foundations, providers and Medicaid managed care plans supplemented these efforts. Grantees engaged outreach workers conversant with the needs of underserved communities. MassHealth and the Connector held joint training sessions across the state for community outreach and enrollment workers. Along with providing education, they found that consumer “helplines” accompanying these efforts served as an “early warning system” in identifying consumer issues with reform.
- Other state agencies also supported the campaign through their existing distribution channels. For example, the Division of Unemployment Assistance placed inserts in mailings to employers. The Registry of Motor Vehicles sent notices to residents when they registered their vehicles. And the Massachusetts Bay Transportation Authority placed ads on buses, subway cars and trains.

Together, these efforts helped pave the way for more than 400,000 individuals to gain coverage between 2006 and 2010. Massachusetts’s uninsured rate declined from 6.4% to 1.9% during that period. The Connector has been much less successful, however, in attracting small businesses to purchase coverage, with some onlookers citing conflicts with carriers and brokers in the small group market as a key barrier toward broader participation.⁵

The Utah Experience

Established in 2009, Utah’s Health Exchange is an online purchasing portal offering comparative plan information, defined employer contributions, a universal application and risk-adjusted premiums (a premium aggregation capability is under development). The vision for the exchange is to foster consumer empowerment, product portability and predictable premiums by serving as a clearinghouse for the state’s health insurance market. It is currently targeted toward meeting the needs of small employers and their employees, holding lessons for the small business health options program (SHOP) exchanges envisioned under the ACA. Creation of the exchange followed years of reform discussions culminating in a legislative task force that “relied heavily on input and ideas from a broad base of Utah stakeholders” and a “process involving extensive research, public input and consensus building,” according to David Clark, Speaker of the Utah House of Representatives.⁶

The Exchange currently serves about 70 small employer groups (between 2 and 50 workers) with 2,000 covered lives, offering more than 100 plan choices that can be purchased through online shopping, from carriers or with broker assistance. Employers can filter choices available to their employees. Offerings for larger employers are also being tested.

Utah's Exchange, run through a small staff within the Governor's Office of Economic Development, relies on contractors, having a minimal marketing budget (reportedly \$10,000), supplemented by pro bono marketing efforts from health insurance brokers and business organizations.⁷ Its advisory board includes state agency representatives, insurers, producers and consumers. Exchange staff pay particular attention to good relationships with brokers, who are viewed as key distribution points. To become certified to enroll clients in the exchange, brokers must attend a training course approved by the state's insurance department. While some have criticized limited resources as stunting participation in the Exchange, others applaud how the model has leveraged existing resources and compensated for limited marketing by enabling convenient enrollment.⁸

Lessons from Experience with Small Group Health Insurance Purchasing Cooperatives and Alliances

One relevant lesson from the mixed success of health insurance purchasing cooperatives (HIPCs), which have been experimented with across a number of states, underscores the importance of exchanges attracting and retaining a critical mass of plans in order to be viewed as a viable shopping option for small employers. Experts note that some HIPCs scared away health plans by almost promoting themselves as high-risk pools or places of last resort for those who could not find coverage elsewhere.⁹

Another lesson from these experiments is the importance of drawing the support of agents and brokers. Many HIPCs initially sought to save administrative costs by excluding producers from the process, not recognizing the extent of influence these individuals wield on purchasing decisions in the small group market. In contrast, adopting a strategy of cultivating good relationships with brokers is considered a success factor for the Connecticut Business and Industry Associations' Health Connection, a private purchasing alliance serving 6,000 small employers (between 3 and 100 workers) which has attracted 888,000 members in the state.¹⁰

Experience with CHIP and Other State Coverage Expansions

Following enactment of the State Children's Health Insurance Program (CHIP) in 1997, "unprecedented resources" were invested in outreach, pairing media campaigns to raise overall public awareness with more targeted community-based efforts to reach and enroll families.¹¹ Some states later enacted further coverage expansions to reach more lower-income children, adults and families.

In support of these expansions, the Robert Wood Johnson Foundation sponsored a *Covering Kids and Families* program, which involved conducting and coordinating outreach, simplifying enrollment and renewal processes, and coordinating existing health care coverage programs. In a survey conducted as part of an evaluation of this program, grantees reported that outreach activities were their highest priority and achieved the greatest success in increasing coverage.¹²

Among the outreach activities implemented, both state and local coalition leaders most frequently cited school-based outreach (typically conducted through “back-to-school” campaigns), along with partnerships with other organizations, as most successful—speaking to the need to identify analogous, trusted locations for single adults. In citing barriers to their outreach efforts, grantees spoke of the difficulty of sustaining media interest over time and in gaining access to business audiences, who were often hesitant to endorse a state program.

Two separate studies of outreach efforts in California point to the power of implementing a range of approaches and boosting the intensity of outreach. The first study, reviewing outreach efforts in 25 California counties over seven years, found the effectiveness of implementing more strategies. Enrollment increased by 54% among counties using seven or eight strategies (versus no strategies) compared to 24% among counties using five or six strategies. Technologies helping to facilitate enrollment were associated with an 11% increase in take-up (regardless of the number of strategies used). The second study showed that higher per-child spending on outreach (excluding media) was associated with higher enrollment, with an additional outreach dollar increasing the likelihood of take-up by 7%. Findings from this latter study paired with a similar enrollment study done in New Jersey point to the importance of linking outreach and marketing with adequate infrastructure to handle increased demand in enrollment, enabling those individuals newly-exposed to public coverage to have positive enrollment experiences.¹³

A Brief Glimpse at State Efforts Since Enactment of the ACA

According to the National Conference of State Legislatures (NCSL), more than 30 states have created designated entities (like commissions, boards, special committees or task forces) to study and make recommendations on state responsibilities in implementing the ACA.¹⁴ As part of these efforts, several states are planning for robust education, outreach, marketing or communications related to reform generally, and exchanges in particular. Some sample state activities are outlined below.

Maryland. To guide its efforts, Maryland’s Outreach and Education Workgroup has developed a list of target audiences, key topics to be addressed through outreach and education (such as eligibility, enrollment, effective dates, and wellness promotion), as well as considerations to be undertaken in addressing these topics (new responsibilities and penalties under the ACA, the value of coverage, and how to use insurance). To guide its efforts, Maryland compiled its own set of lessons learned from the Massachusetts experience (listed below).

New Mexico. New Mexico’s Health Care Reform Leadership Team has created an education, outreach and communication plan which includes engaging the public in policy development and implementation through a Website (currently available), along with progress reports and public meetings. In addition to educating consumers about their rights and responsibilities under the ACA, plans also include developing a consumer protection system to safeguard against misinformation and potential fraud.

Lessons Learned from Prior Education and Outreach Initiatives

- It takes a community effort
- Build partnerships and keep them alive
- Partner with elected officials to help gain media attention
- Maintain message consistency through train-the-trainer approaches
- Continue education and training as programs evolve
- Segment the audience
- Communicate “news you can use”
- Ensure messages are simple and linguistically and culturally appropriate
- Be accessible to answer questions, even when answers are not yet known
- Use venues appropriate to the target audience, and adapt materials to the site and audience
- A variety of approaches is critical
- There is need for basic information, as well as more detailed reference information
- Opportunities for outreach are everywhere, from ballparks to churches, to pharmacies and grocery stores

Source: Maryland Health Care Reform Coordinating Council, Outreach and Education Workgroup, White Paper, October 31, 2010

Colorado. Colorado has developed a Roadmap for Implementing Health Care Reform. The State’s Website houses resources for reform, including Frequently Asked Questions and a fact sheet designed specifically to educate businesses about reform.

Pennsylvania. Pennsylvania’s Health Care Reform Implementation Advisory Committee final report emphasizes outreach and marketing messages to convey the benefits of insurance and regular care, as well as the importance of developing varying formats for sharing information—from town halls, to webinars for small businesses and individuals. The Committee also stressed the importance of presenting subsidized coverage as insurance products, rather than welfare programs.

Notes

¹ J. Kingsdale, “Implementing Health Care Reform in Massachusetts: Strategic Lessons Learned,” *Health Affairs*, May 2009, 28(4): w588-w594. Background on Massachusetts gathered from: A.G. Raymond, *Lessons from the Implementation of Massachusetts Health Reform* (Boston: Blue Cross Blue Shield of Massachusetts Foundation, March 2011), <http://bluecrossfoundation.org/health-reform.aspx>, J. Fallon, “Public Education and Outreach Campaign: The Massachusetts Experience” (Massachusetts Health Insurance Connector Authority, MA Conference on National Reform and State Exchanges, January 21, 2010), www.statecoverage.org/node/2164; K. Counihan, “Commonwealth Choice and the Health Connector Exchange; Design Issues and Lessons Learned” (Massachusetts Health Insurance Connector Authority, MA Conference on National Reform and State Exchanges, January 21, 2010), www.statecoverage.org/node/2161; Executive Office of Health and Human Services, “Chapter 58 Implementation Reports (State of Massachusetts, various dates).

² A.G. Raymond, *Lessons from the Implementation of Massachusetts Health Reform* (Boston: Blue Cross Blue Shield of Massachusetts Foundation, March 2011), <http://bluecrossfoundation.org/health-reform.aspx>.

³ <http://www.masshealthreform.org>.

⁴ Executive Office of Health and Human Services, “MassHealth Enrollment Outreach Grants” (State of Massachusetts, various dates).

⁵ A. Lischko, *Drawing Lessons: Different Results from State Health Insurance Exchanges* (Boston: Pioneer Institute, December 2009), [www.pioneerinstitute.org/pdf/drawing lessons pb.pdf](http://www.pioneerinstitute.org/pdf/drawing%20lessons%20pb.pdf); S. Corlette, J. Alker, J. Tuschner, J. Volk, *The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned* (Washington, DC: Georgetown University, March 2011), <http://www.rwjf.org/coverage/product.jsp?id=72105>.

⁶ Testimony of Honorable David Clark, Majority Leader, Utah House of Representatives to the Committee on Health, Education, Labor and Pensions (United State Senate, April 28, 2009) <http://help.senate.gov/imo/media/doc/Clark.pdf>.

⁷ A. Lischko, *Drawing Lessons: Different Results from State Health Insurance Exchanges* (Boston: Pioneer Institute, December 2009), [www.pioneerinstitute.org/dr/drawing lessons pb.pdf](http://www.pioneerinstitute.org/dr/drawing%20lessons%20pb.pdf)

⁸ For example, see: G. Girvan, “Consumer Power: Five Lessons from Utah’s Health Care Reform” Backgrounder No.2453 (Washington, DC: The Heritage Foundation, August 19, 2010), <http://report.heritage.org/bg2453> and S. Corlette, J. Alker, J. Tuschner, J. Volk, *The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned* (Washington, DC: Georgetown University, March 2011) <http://www.rwjf.org/coverage/product.jsp?id=72105>.

⁹ E.K. Wicks and M.A. Hall, “Purchasing Cooperatives for Small Employers: Performance and Prospects,” *Milbank Quarterly*, 2000, 78(4), <http://www.milbank.org/quarterly/7804feat.html>.

¹⁰ A. Lischko, *Health Insurance Connectors and Exchanges; A Primer for State Officials* (AcademyHealth and the Robert Wood Johnson Foundation, State Coverage Initiatives, September 2007) <http://www.statecoverage.org/node/165>.

¹¹ L. Dubay, I. Hill and G. Kenney, “Five Things Everyone Should Know about SCHIP,” Assessing the New Federalism Policy Brief, Series A, No. A-55 (Washington, DC: The Urban Institute, 2002), http://www.urban.org/UploadedPDF/310570_A55.pdf.

¹² B. Lavin et al., *Covering Kids and Families Evaluation: An Analysis of CKF Coalitions* (Princeton: Robert Wood Johnson Foundation, July 2004), www.rwjf.org/files/research/coalitions%20Synthesis.pdf.

¹³ J. Kincheloe, J. Frates, and E.R. Brown, “Determinants of Children’s Participation in California’s Medicaid and SCHIP Programs,” *Health Services Research*, April 2007, 42(2):847-66. And C. Trenholm et al., *Case Study of New Jersey: Exploring Medicaid and SHIP Enrollment Trends and Their Links to Policy and Practice* (Princeton: Robert Wood Johnson Foundation, May 2006), www.rwjf.org/files/publications/otherCKFcaseStudy0507.pdf.

¹⁴ National Conference of State Legislatures, *Health Reform State Implementation Entities*, <http://www.ncsl.org/?TabId=21995>.

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