Successful Health Insurance Outreach, Education, & Enrollment Strategies for Rural Hospitals:
Bay Area Medical Center, Marinette WI

Overview

This report provides information collected from a two-day site visit to Marinette, WI, where researchers met with staff at Bay Area Medical Center (BAMC) and partners who engaged and enrolled rural residents during the first Open Enrollment period for state and federal health insurance marketplaces established by The Patient Protection and Affordable Care Act (ACA): October 1, 2013 to March 31, 2014. This case study describes the experiences of a number of local service providers serving the area as reported during in-person interviews with key participants and a review of enrollment-related documents related to outreach, engagement, education, and enrollment activities.

A second, companion case study by the University of Minnesota RHRC focuses on a hospital and its partners in Irvine, KY. A related policy brief summarizes our findings.

Background

The ACA and Health Insurance Marketplaces

The Patient Protection and Affordable Care Act (ACA), signed into law in 2010, enabled the creation of a health insurance marketplace (or “exchange”) in each state by January 1, 2014. Through these marketplaces, individuals and families receive information on their insurance options, compare and purchase Qualified Health Plans (QHPs), apply for financial subsidies, and (when applicable) obtain an eligibility determination for coverage under public programs such as Medicaid or the State Children’s Health Insurance Program (CHIP).1-3 States were given the option to create their own state-based health insurance marketplace, work with other states to establish a regional marketplace, run a marketplace in partnership with the federal government, or (following the Supreme Court decision) have a federally-facilitated marketplace.4

By the beginning of the first Open Enrollment, 16 states and the District of Columbia had elected to operate a State-Based Marketplace (SBM), with three of them electing to use the federal website (healthcare.gov) for enrollment.5 Seven states entered into a State-Federal Partnership (SFP) and the remainder elected to have a federally-facilitated marketplace (FFM).5 These
same marketplace structures remained in place during through the second Open Enrollment (Nov 2014 – Feb 2015) and into the summer of 2015.5

Federal law does not prohibit states from modifying their marketplaces, as long as they have obtained the approval of the Centers for Medicare and Medicaid Services (CMS) in the Department of Health and Human Services. Legislative proposals have been introduced in 14 states thus far to change a FFM or SFP to a SBM,7 and a number of states have proposed strategies to shore-up vulnerable marketplaces.7,8

The Supreme Court’s June 2015 ruling in favor of the ACA (King v. Burwell) upheld the legality of states offering Federal tax subsidies for eligible residents’ insurance premiums.9,10 Following the ruling, several SBM states initiated steps to explore and consider an expanded role for the federal government in their marketplace operations.11,12

The First Open Enrollment under the ACA
(October 2013 – March 2014)

During the first Open Enrollment period, 8 million people were enrolled by commercial QHP insurers selling through the new state insurance marketplaces; an additional 6 million were enrolled through Medicaid.13 One study examining insurance coverage trends found that the proportion of people uninsured dropped from 17.1 percent in the fourth quarter 2013 to 15.6 percent in the first quarter of 2014.14 Another study demonstrated that the net gain in insured Americans (after adjusting for those who lost their insurance coverage during the same time period) grew to more than 20 million: 9.6 million covered by Medicaid and another 11.2 million covered through QHPs.15

A critical element behind the success of the first Open Enrollment was the availability of trained and certified individuals to help consumers complete their applications for insurance coverage. Over 4,000 Marketplace Assister Programs were in place before October 2013; while some organizations did not receive approval to train assistants until after the opening date, more than 28,000 full-time staff and volunteers were assembled to make the Open Enrollment a success. In June 2014, a national roundtable on consumer assistance identified six critical areas in which assistants faced significant challenges to educate and enroll individuals (see Appendix A, “Challenges to Consumer Assistance”).13,14 For more information about Marketplace Assister Programs, see Appendix B, “The Role of Assister Programs in Open Enrollment.”

An Opportunity for Rural Uninsured

Of the more than 40 million individuals estimated to be uninsured at the beginning of the first Open Enrollment period in October 2013, 7.8 million resided in rural communities.16 Decades of research have demonstrated that rural residents are more likely to be uninsured and to experience longer spells of uninsurance than their urban counterparts.16-19 Rural families, on average, pay almost one-half of their total health care costs out-of-pocket; one-in-five farmers are in medical debt.14 The implementation of the ACA provides a tremendous opportunity to expand health insurance coverage among rural populations, offset the bad debt and charity care burdens many rural providers have carried for years, and improve their capacity for serving the needs of their communities.18,19 Rural hospitals and primary care practices are in an excellent position to serve as anchor organizations around which other interested stakeholders can add their support.

The June 2012 Supreme Court ruling allowing Medicaid expansion to take place on a state-by-state basis made the challenges facing the rural poor and uninsured more complicated. Prior to the first Open Enrollment, twenty-five states had expanded Medicaid coverage and four others tightened their eligibility criteria for the program.20 As of June 22, 2015, all but one SBM state have continued with their expanded programs. Two states expanded after the close of the first Open Enrollment, three additional states are in the process of expanding, and another has passed legislation to expand but requires federal waiver approval before it can go into effect.21

A Case Study of Rural Enrollment

In the summer of 2014, the University of Minnesota Rural Health Research Center conducted studies on the role of rural hospitals and rural communities in the first Open Enrollment. Participants in that earlier telephone survey were recommended by State Offices of Rural Health, State Hospital Associations, and other rural experts as representing successful and exemplary models for enrolling rural residents. Bay Area Medical Center (BAMC) participated in that survey, and was selected for this site visit for two main reasons. First, the telephone interview suggested that a more-detailed exploration of hospital and community-partner enrollment experiences could foster further successes in rural enrollment efforts.
Second, Wisconsin did not elect to expand its Medicaid program (“BadgerCare”) and in fact made the eligibility criteria for participation in the public insurance program more restrictive, by tightening eligibility requirements for single adults. The state also defaulted to a FFM, which limited the amount of financial and administrative assistance that would be provided through federal funding (the second site visit, profiled in a companion case study report, was conducted with a hospital in Kentucky, a state with a SBM as opposed to Wisconsin’s FFM).

Located alongLake Michigan’s Green Bay, Marinette is considered a Wisconsin-Michigan Micropolitan Statistical Area that includes all of Marinette County (WI) and Menominee County (MI) and has a population density of 23 persons per square mile.

**Planning for Open Enrollment**

*Bay Area Medical Center (BAMC)*

Planning for the 2013 – 2014 Open Enrollment was a multi-tiered process involving state, regional, and local discussions. At the time, BAMC’s Chief Executive Officer (CEO) was serving as the Chair of the Wisconsin Hospital Association’s (WHA’s) Council on Rural Health and was also slated to become the Board Chair of the WHA in 2014. This provided an excellent vantage point to be aware of statewide enrollment preparations and to begin planning for enrollment in the rural communities in BAMC’s service area. Although state outreach, education, and enrollment (OE&E) efforts were facilitated by a number of organizations including the Wisconsin Department of Human Services, the Wisconsin Hospital Association, the Wisconsin Primary Care Association, and others, for many rural communities much of the work was left to the localities.

The core question facing BAMC was whether the hospital should take a leadership role in local enrollment efforts or step back and provide support for the enrollment efforts of other organizations. In June 2013, the hospital CEO and Chief Financial Officer (CFO) began sorting through possible OE&E strategies. The hospital CFO quickly tasked the financial Project Manager to begin a due-diligence assessment that would weigh the options available to BAMC, conduct a thorough review of the ACA and state regulations, and make contact with people having specialized knowledge that could aid in making a decision, such as WHA representatives. At the advice of the CFO, the Project Manager contacted a finance person in the WHA who provided very valuable information; this later led to the Project Manager becoming a member of the WHA’s Enrollment Action Council (EAC) — one of only two rural representatives on the Council.

The Project Manager then convened a multidisciplinary hospital committee including the CFO, Marketing Director, and Finance Director to review the due diligence assessment findings and develop recommendations on how BAMC should proceed. This multidisciplinary committee brought critical expertise to the table with respect to outreach strategies, knowledge of the frontline staff (financial counselors) that would eventually educate and enroll consumers, and resource availability to support OE&E efforts.

The committee’s recommendation was for BAMC to take an active role in providing enrollment assisters (Certified Application Consultants, or CACs) and engaging service area providers in a collaborative strategy that would channel clients to organizations having CACs. Consistent with BAMC’s mission to provide compassionate, cost-effective care for the community, and with a promise for added financial stability through a reduction of self-pay patients, bad debt, and charity-care costs, these recommendations were approved for action by BAMC senior management and supported by the hospital’s Board of Directors. In time, BAMC would submit an application to become a CAC Organization.

**State Planning and Preparations**

Around this time, the WHA – in partnership with the state Department of Health Services (DHS) – took a leadership role in the planning and preparation of the state’s health insurance marketplace. The goal of the state’s plan was straightforward: reduce the number of uninsured Wisconsin residents by enrolling them in either the state public health insurance plan (BadgerCare Plus), a CHIP, or one of many Qualified Health Plans (QHPs) available from commercial insurance companies. Efforts to achieve this goal were complicated because the state did not expand Medicaid and its tighter eligibility criteria for participation in BadgerCare Plus left over 60,000 residents without public health insurance. Approximately 19,000

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*BadgerCare Plus provides coverage for low-income children and families as well as reimbursement to safety-net providers. A large proportion of covered individuals receive care at Community Health Centers.*
of these individuals were able to enroll in a QHP and 5,000 were able to rejoin the ranks of BadgerCare enrollees. The remaining 39,000 no longer eligible for BadgerCare Plus were left to their own devices to find coverage or remain uninsured.

In July 2013, the WHA and WI Department of Health Services’ (DHS) Director of Medicaid began conducting educational outreach sessions for the state providers. The WHA also worked with others to provide educational events, webinars, and stakeholder summits to discuss and disseminate strategies and models for OE&E. Collaborating agencies included the Wisconsin Primary Care Association, Milwaukee Health Care Partnership, the Enrollment for Health (E4Health) Initiative, and the University of Wisconsin Population Health Institute (UWPHI). During this time, the Milwaukee Health Care Partnership also distributed examples of an enrollment worksheet, enrollment posters, and flyers as well as a FAQ section on BadgerCare Plus for 2014 to aid local OE&E efforts.

The WHA Enrollment Action Council (EAC) was established in July, and soon became a key statewide council for developing enrollment activities. The explicit purpose of the EAC was to:

- Disseminate information as hospitals planned enrollment assistance activities;
- Foster coordination among hospitals health systems and other external organizations engaging in enrollment efforts;
- Identify key issues and potential responses around Medicaid/marketplace enrollment; and
- Provide feedback on guidance and planning from state agencies pertaining to enrollment.

The EAC provided a broad spectrum of member representatives — including CEOs, CFOs, and Project Managers working directly with CACs — with a forum to discuss enrollment barriers and potential solutions. Rural-related concerns were not uncommon during discussions (many of these same concerns were occurring in non-rural markets as well), but it was decided to hold off addressing them until the close of enrollment. These local and regional issues may have been overshadowed by more pressing issues such as the rapid change in CMS updates issued over the short period before markets opened on October 1st, a glitchy computerized sign-up system during the first Open Enrollment, and the delays in CAC training (described below, under “Enrollment 2013-2014”). Eventually, the EAC formed a Network Adequacy Council to follow market closures and address issues and concerns raised during the Open Enrollment period.

**Regional Planning and Preparation**

E4Health was launched in May 2013 to begin coordinating statewide OE&E functions and to facilitate statewide communication about the Wisconsin marketplace. By the time the EAC held their first meetings (late July), the state expanded the enrollment and case management responsibilities of its eleven multi-county Health and Human Service regions, renaming them “Regional Enrollment Networks” (RENs) to coordinate efforts, disseminate a consistent message about the marketplace, mobilize local grassroots resources, and provide general OE&E assistance.

RENs partnered with a wide range of community organizations, including health care providers, income maintenance consortia, managed care entities, and other key stakeholders. Each REN formed a steering committee to maximize enrollment, facilitate the identification of CACs and enrollment mobilizers, and monitor and document regional enrollment efforts. The majority of the BAMC service area is contained within the Bay Lakes REN which includes the five counties of Brown, Door, Marinette, Oconto, and Shawano.

**The Bay Lakes REN**

A key role of the Bay Lakes REN was to disseminate effective strategies used in other parts of the state, minimizing duplication of services and ensuring that scarce resources were allocated efficiently. Having each county represented at REN meetings was critical to fulfilling its role and achieving the goal of enrolling as many uninsured or under-insured residents as possible during the Open Enrollment period.

The BAMC Project Manager was invited to become a member of the REN’s Steering Committee, a move that opened up opportunities to disseminate effective strategies to the BAMC service area. One of the key challenges facing outreach efforts across the REN was the need to appeal to a variety of target population needs and circumstances (e.g., differences in health and insurance literacy, poor access to marketing methods, and rural isolation). This required the Steering Committee to develop outreach messages and materials that could connect with different groups and stir people to take action and obtain health insurance coverage.
The REN Steering Committee was charged with arranging events to educate the public about the value of having insurance coverage and how Open Enrollment was going to help people find that coverage. These meetings were poorly attended, however, and were quickly dropped from the committee’s outreach strategies. Failure of these early efforts foreshadowed that engagement would not be a simple task and that multiple strategies would need to be considered for program success to be possible.

The Local Roundtable Discussion Group

BAMC’s Multidisciplinary Committee identified a need to engage area residents who were not likely to have access to the more traditional methods of public marketing such as radio, television, newspapers, and the internet. Service providers in the area with these people as clients (e.g., Free Clinic, Salvation Army, United Way, and Food Pantries) could provide an important connection. This not only provided a way to close the marketing gap but also involved area providers that might not have the resources to support a CAC on staff and/or on-site. The group decided that it was important to integrate these service providers within their more comprehensive approach of engagement and education and to identify the important components of such a strategy.

Eleven organizations attended a meeting in September 2013 and formed what came to be known as the local Healthcare Roundtable Discussion Group. With the exception of BAMC, none of the members had decided on a set of strategies for participating in the coming enrollment nor had they progressed much in identifying supply and demand needs. With Open Enrollment less than a month away, the Roundtable members quickly decided to adopt the general strategy promoted by BAMC. Subsequent discussions focused on how best to coordinate organizational efforts and develop a system for county providers to refer uninsured people to locations that had CACs.

During the site visit, several Roundtable members commented on the importance of these meetings opening their eyes to the larger picture facing area residents and the roles that their organizations could serve in the larger enrollment process. Roundtable discussions laid out the plans and expectations of others serving the community and helped members identify areas to avoid duplication and to coordinate their efforts.

Four providers were identified as likely to offer CACs: BAMC, the two multi-specialty clinics of Aurora Healthcare and NorthReach Healthcare, and a Federally Qualified Health Center (Northern Health Centers). BAMC has been the sole source of acute and emergency care for the area since the mid-1980s, and through a variety of expansions and joint ventures has broadened the availability of clinic services for area communities. Aurora Healthcare, part of a fifteen-hospital system operating over one hundred clinics in eastern Wisconsin, delivers primary care services for the Marinette County area. NorthReach Healthcare, a joint-venture network with BellinHealth in Green Bay, provides Family and Internal Medicine as well as Pediatrics and Women’s health services for Marinette and Menominee counties and the communities of Crivitz and Peshtigo in Wisconsin and Daggett in Michigan. Northern Health Centers, located in Oconto County, employs nineteen physicians offering a full range of medical and dental services with sliding fee scales and pharmacy services under the 340B program for qualified patients in Wisconsin’s Forest, Florence, Langlade, Oconto, and Marinette counties.

Adjacent State Issues: Michigan

One key challenge for Bay Area enrollment efforts was that almost forty percent of BAMC’s patient population came from Michigan. BAMC’s CACs would need to understand both states’ Quality Health Plans. Prior to January 1, 2014 (when Michigan’s Medicaid expansion became law), the Medical Access Coalition of Michigan (MACM) was engaged in area planning and provided enrollment support for low-income and uninsured Michigan residents. Located in Menominee, MACM served many BAMC patients.

Discussions about state and regional outreach and enrollment strategies required an understanding of the demand for coverage to estimate potential volume and staffing needs to meet that demand. Fewer than 2,400 Wisconsinites in BAMC’s service area were estimated to be eligible for the state’s Marketplace, including approximately 1,000 patients who were expected to be disenrolled from the state’s Medicaid program, 570 childless adults to be newly-eligible for BadgerCare Plus, and 800 uninsured individuals. BAMC lacked similar estimates of the number of Michigan residents that would be newly eligible for
Medicaid as part of the state’s planned expansion.

The assistance provided by the CACs in the MACM office in Menominee lasted only until the first of the year when HealthyMichigan, the state’s expanded Medicaid program, took effect. The loss of support from Menominee was worrisome, but proved beneficial for BAMC because one of the CACs working in the Menominee office transitioned her employment to BAMC. Although she was not certified by Wisconsin to take part in the first Open Enrollment, her knowledge about Michigan’s insurance landscape was expected to be a considerable resource during the second Open Enrollment and provide some relief from the pressure that BAMC CACs had experienced because of a lack of a working knowledge of Michigan markets.

Understanding plan differences in coverage, network providers participating in those plans, and the financial requirements of those plans made for a very active enrollment encounter. The Michigan Medicaid Program includes forty different program options, depending on the applicant’s circumstances. Five commercial QHPs were offered in Wisconsin and two were offered in Michigan, totaling 82 different variations of coverage available.

Challenges such as these that arose during Open Enrollment were documented by the EAC and were later turned over to the EAC’s Network Adequacy Council, mentioned earlier.

A Feeder System for Enrollment

One of the area providers unable to provide a CAC was the Twin Counties Free Clinic. The Clinic was established with on-going donations and volunteer staff from Aurora Healthcare and BAMC. Both Aurora Healthcare and NorthReach Healthcare physicians provide volunteer services while Aurora Healthcare donates the physical space for the clinic and BAMC donates business space and laboratory services. The Free Clinic and other Roundtable members unable to provide CACs comprised an effective feeder system for referrals to BAMC’s CACs because their clientele consisted of low-income and uninsured residents. These referrals were an important reason for BAMC’s success.

Strategies for Engaging Multiple Populations

BAMC’s Marketing Department had considerable experience and thus was elected to take the lead in developing messages and materials. When asked how this process worked compared to the broader events sponsored across the state, the BAMC Project Manager commented that the “Milwaukee Model touted across the state was not directly adaptable for us in the Marinette and Menominee area. Enrollment and marketing strategies needed to be better-tailored to the rural population (e.g., using a feeder system involving as many community organizations as possible, using friendly trusted faces to engage and enroll negative and skeptical consumers, reaching isolated low income homeless individuals through the service organizations they commonly use, and employing marketing materials that resonate with the guiding beliefs and values ideals specific that are typical for rural communities) to increase the likelihood of program success.”

Information available to the Project Manager in his role as a member of the EAC and REN Steering Committee and of a Northern Health Clinics representative as head of the Bay Lakes REN allowed the local group to avoid dead-end efforts and to adopt those strategies that seemed to be working in rural communities and urban approaches that would not require substantive modification to work in their more rural community.

Marketing materials aimed to break key information into digestible elements that partners could then disseminate to their clients. Once documents were developed, PDFs were shared with area providers electronically. This method saved BAMC on material costs and also enabled the local providers to personalize their materials in ways that best engaged their particular clientele (e.g., updating messages to reflect the approaching enrollment deadline, including specific contact information).

Many consumers in BAMC’s service area had a negative or skeptical attitude about enrollment, making it more difficult to educate consumers about the importance and usefulness of using the marketplace to obtain insurance coverage. One successful strategy to get past these negative associations with the ACA and “Obama Care” was to connect with consumers on a more personal level, focusing on the greater ease of access, expansion of the scope of services that would become available with coverage, and the availability of tax subsidies to help pay premium costs.

When meeting with area partners and stakeholders, the BAMC Project Manager made a point of reminding them to be sensitive to consumers’ differing needs and comfort levels. He noted that “you could have someone who never had insurance before and another who has been paying for private insurance for years who just wants to
get into the marketplace because it might be more affordable.” Tailoring materials to target population needs and circumstances made it more likely that consumers would be able to see their decision about obtaining coverage as a personal choice to protect themselves and their families rather than an expression of a political point of view.

Messages to the public stressed that people had three options to enroll: scheduling an appointment with a CAC, calling the federal 1-800 phone number, or completing their application online. Factual information about the federal Marketplace was provided from information available on the Centers for Medicare & Medicaid Services (CMS) website, while local information focused on how to arrange an appointment with a CAC. Regardless of the medium, the message was designed to be consistent and unambiguous to steer people to action. The PDFs of flyers, brochures, and posters distributed to Healthcare Roundtable partners were distributed directly to clients, posted in waiting areas, and disseminated at events unrelated to health care such as food distribution days at a local food pantry.

Posters and flyers were regularly updated and replaced to reflect the changing timeline of the enrollment effort. One month prior to Open Enrollment, materials provided general marketplace and CAC contact information with messages announcing “What Does that Mean for You?”; during the last months of enrollment, these materials stated “There May Still be Time for You to Enroll” (See Appendix C for examples).

Enrollment information was also available on the hospital’s website, although it was decided not to link to the federal website for online enrollment (healthcare.gov) out of concerns that glitches in the system could have a collateral effect and give the wrong impression of the hospital’s capacity to launch a local effort. Even with these broad efforts to educate the public, post-enrollment discussions highlighted the need to expand these efforts for the next enrollment and to begin much earlier than was possible for the first enrollment period. Delays in getting the marketing materials out soon enough was thought to contribute to consumers’ general lack of understanding about where to go and who to contact. This underscores the importance of person-to-person contact and the risk of placing too much faith in printed media. As more people in the service area were engaged by service providers face-to-face, the understanding and acceptance of the general population grew and marketing for enrollment expanded by word-of-mouth.

In a small town like Marinette, consumers view hospital personnel as trustworthy sources of information. Recognizing this, BAMC held sessions for staff to reinforce the consistent message made available in the marketing materials. An effort was also made to keep employees updated during departmental meetings and via the hospital’s “Monday Morning Memo” issued to all BAMC staff by its Marketing Department. Through this process of education and updates, hospital employees were prepared when approached during school events, church functions, shopping trips, and so forth. Interviewees reported that employees were motivated to provide good information because they understood the consequences that non-coverage could have for their neighbor, parents, and family.

This strategy built upon publicly-available information and reinforced a consistent message about the importance of the Marketplace and role of BAMC through a trusted and familiar personal connection. The value of face-to-face encounters with people of trust was mentioned throughout the site visit as a highly-effective way to educate and motivate consumers to take action. Hospital personnel were seen as people with information about the comings and goings of the hospital and were personally known and trusted by local residents.

Enrollment 2013-2014

Capacity for CAC Support

CACs provided enrollment assistance for this portion of the Bay Lakes REN service area. Two of the original four organizations expected to provide CACs were unable to do so. NorthReach, representing the largest primary care physicians group in the area, was acquired by BellinHealth and it was consequently decided to refer their clients to BAMC for assistance. Aurora Healthcare had planned to provide a CAC from their Corporate Office in Milwaukee once a week, but due to difficulties with the federal website as well as numerous cancellations, fewer than ten clients were enrolled through Aurora’s enrollment process.

The bulk of enrollments for the area were accomplished by the CACs at the Northern Health Centers FQHC and BAMC. Referrals to those key enrollment centers were made by other members of the Roundtable Discussion Group. One member, the Twin Counties Free Clinic, not only referred clients to CACs but also modified their
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patient eligibility, requiring them to demonstrate their attempt to enroll and either their denial of coverage or evidence that they would face economic hardship to pay premium costs (≥ 10% of their income) to remain with the clinic. Although a difficult position to take, the policy change was made to counteract the incentive to do nothing and continue to receive free medical care. Enrollment efforts were able to reduce the Free Clinic’s patient population by over forty percent, from a total of 300 down to 167 patients.

Northern Health Centers, located over 50 miles northeast of Marinette in Oconto County, was able to field four CACs with two stationed at the facility and another two traveling two days a week to scheduled appointments at offsite locations. Potential enrollees were educated about the enrollment effort through posters and brochures available at the FQHC as well as through mailers addressed to clients who were below 400% FPL and likely to be eligible for BadgerCare. Information was also distributed to parents through home mailings given to students at local schools. Taking advantage of the Centers’ working relationship with BAMC, overflow was referred to the hospital to manage the wait time for their clients. When their CACs suspected that an individual had a false eligibility resulting from their tax filing (e.g., based on household size and income not reflective of eligibility), they called the CMS 1-800 phone number to resolve the issue. The FQHC also tracked its enrollment encounters using an Encounter Documentation Form. Over the course of the enrollment period, the FQHC provided 1,320 people with information, determined the eligibility of 585 people, and enrolled 232 people residing in their five-county service area.

BAMC’s Certified Application Counselors (CACs)

The hospital’s application to become a CAC Organization was submitted in August 2013 with the hope of being ready to provide enrollment assistance in September. Their application was not approved, however, until October, a delay blamed on a combination of factors: the 2013 federal government shutdown, overwhelmed officials receiving numerous requests, and BAMC’s decision to have its CACs trained in person rather than online. Consequently, the first CAC appointment at BAMC was not completed until October. Start-up costs for enrollment efforts were reduced because the hospital’s prior-year budget had accommodated adding a second Financial Counselor. This advantage was particularly important for BAMC because of the tight timeline involved and the inability to seek outside funding sources to offset enrollment costs.

Four BAMC employees provided CAC services: two Financial Counselors and two Patient Service Representatives. In many ways, these employees were perfectly suited to the challenges encountered by CACs: they possess experience facing patient-related catastrophes that require tact, empathy, understanding, a calm demeanor, and the ability to identify creative solutions. The majority of patients seen by financial counselors or patient service representatives are low income uninsured self-pay patients who are also the target of enrollment efforts. Financial counselors help patients understand their fiscal obligations and identify a path of action often plotted through an evolving landscape of circumstances. Their goal is to help lower patient anxiety and at the same time find options that are less detrimental to the hospital’s financial status. Patient Service Representatives (also called Patient Advocates, Patient Access Specialists, or Service Coordinators) work in a similar environment and face comparable challenges helping patients face the emotional and fiscal issues related to their care. They are consumer advocates that are trained to remain calm under stressful encounters and to creatively discuss available options while at the same time smoothing out the emotional and mental jolts associated with addressing such issues.

The hospital’s CACs were expected to work overtime to meet their previous work responsibilities. Enrollment assistance was provided primarily by the Financial Counselors on an appointment basis, but they also took walk-ins, time permitting. Each provided assistance four days per week, handling hospital financial counseling on Fridays and during enrollment downtime. The Patient Service Representatives were scheduled to handle overflow on a part-time basis; the majority of their work involved helping hospital patients with emotional and financial challenges. All four CACs worked at their original workstations.

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6 Individuals with incomes greater than 400% of the Federal Poverty Level were not eligible for BadgerCare Plus or Federal tax credits to help cover premium costs for plans acquired through the state’s Marketplace.

7 The information publicly available from these enrollments does not specify county of residence so it was not possible to determine how many BAMC service area residents were given assistance and enrolled by the FQHC.
Appointments, made through the phone number identified in all area marketing efforts, were arranged to meet client availability. Walk-ins were assisted according to CAC availability with some seeing a CAC that day and others scheduled for a future appointment.

While some prospective enrollees were responding to marketing efforts, others were engaged during a hospital visit unrelated to enrollment (once the patient was treated they were engaged and, if possible, immediately handed off to one of the CACs for immediate assistance or scheduling for a future date). Self-pay or under-insured patients were identified during free health screenings and through record reviews. The latter were targeted with a direct mailing providing educational and contact information for arranging an appointment with a CAC. Some enrollees came for assistance to complete an application they had already begun but needed help to change information or complete their application.

The goal was to engage and enroll immediately when the potential applicant was ready to take action to obtain coverage.

**CAC Challenges**

Several respondents (including one of the CACs) noted that they were unsatisfied with the degree to which training prepared them for the challenges of enrollment, particularly during early months. The Project Manager commented that there probably was not a CAC in the country who could confidently say they were ready for that first appointment for enrollment.

Glitches with the federal website during the first Open Enrollment period increased frustrations during enrollment encounters; one CAC noted that “sometimes the enter key on the federal website [the “submit” button] took up to thirty minutes to function.” Appointments sometimes needed to be canceled and rescheduled “three weeks out to avoid long wait times.” Insurance illiteracy or not having all of the required information available at an enrollment visit also lengthened enrollment appointments and/or necessitated additional visits. As these issues were being resolved, the enrollment process became smoother, especially from February through March 2014.

Many patients seeking enrollment assistance did not have an email account, which was needed to receive a confirmation code in order to establish their account online. CACs at BAMC would create free email accounts for them using clients such as Gmail and Yahoo; however, those require telephone numbers and have a limitation on the number of accounts that can be associated with a single number. CACs resorted to using their personal cell phones to create email accounts for these clients, then began using land lines, and eventually had to enlist family members of the enrollee to obtain the needed codes.

**Tracking and Monitoring**

BAMC used an encounter form based on one developed by Northern Health Centers which collected information to determine an applicant’s needs, preferences, and plan eligibility. Once personal information was collected, the CAC helped the applicants identify plans that matched the features they considered important and were within their financial constraints.

The hospital Multidisciplinary Committee developed a monitoring system that matched the encounter form, recording the nature of the consumer encounters, number of visits needed, insurance status, the plan selected for coverage, and more. This information was aggregated to a spreadsheet and proved useful when responding to state and regional requests, identifying local issues creating barriers to obtaining coverage, and linking applicants’ information with that of each of their immediate family members.

**Results**

BAMC provided 299 individuals with information about the ACA and enrollment; CACs enrolled 388 people. Out of those 388 individuals, 273 were previously uninsured and 49 had transitioned from BadgerCare to a commercial plan. Almost 60 percent (231) of the 388 enrollees completed the application process in one appointment.

The hospital CACs also assisted 320 individuals with determining their eligibility. Although these people did not enroll, they were made aware of their eligibility and qualifications for a tax subsidy as well as the healthcare insurance plans that most closely met their needs and preferences should they elect to continue their application elsewhere:

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*The majority of the newly-covered residents were insured by either Wisconsin or Michigan Medicaid programs.

Due to privacy rules, there is no way to determine how many of these individuals elected to obtain insurance coverage outside of the hospital.
It is difficult to determine the total number of enrollees who lived within BAMC’s service area — people used different ways to enroll (e.g., online, by phone, or in-person enrollment), while the hospital and other providers collected different data elements to meet reporting needs and/or had overlapping service areas. Total enrollment is scrambled into different federal, state, and insurance company data systems with varying degrees of access requirements; for example, only two of the five counties served by the Northern Health Centers FQHC were also within the BAMC service area and the FQHC did not retain residency information in its database. Michigan residents enrolled by BAMC CACs could be assumed to be former patients or current and future patients of the hospital. Therefore, the combined-but-unverified number of people enrolled by members of the Health Care Roundtable Discussion Group is 620; the number engaged and educated is a little over 1,500; and the number informed of their eligibility for tax subsidies and plans is 900.

Reasons for not Enrolling
CACs reported the following as reasons why some did not enroll despite receiving notice of their eligibility:
• Financial issues (unaffordable premiums, difficulty understanding or having faith in tax credits).
• Negative perceptions of the ACA in general
• Belief that a future job would provide them with insurance coverage.
• View that paying the penalty for not having insurance coverage was cheaper than paying premium costs.
• Desire to discuss their decision with their significant others before completing enrollment.

Financial issues can certainly become a problem for those earning too much for patient assistance programs but not enough to afford monthly premiums. Difficulty understanding the complexities of insurance and its related jargon can only be addressed with better outreach and education efforts.

There is no doubt that many people experienced their enrollment process as an emotionally-charged event that could easily overwhelm the uninformed or could create an intimidating environment. Some of the reasons given may have simply been a polite way to exit the enrollment process without lengthy discussions. While records do not detail the reasons for not enrolling, future efforts may benefit from this knowledge to refine engagement and marketing strategies.

Strategies that Worked
BAMC’s most effective strategies covered all three issue areas of engagement, education, and enrollment:
• State and Regional Involvement: The Project Manager’s involvement with both state and regional planning groups allowed BAMC to adapt their strategies in response to what worked and didn’t work elsewhere and tailor their efforts to local needs.
• The “Feeder” System: BAMC’s feeder system that referred potential enrollees to specific locations was an excellent way to reach clients in most need and those living in remote rural areas without regular access to engagement efforts using printed and broadcast media.
• Free Clinic Eligibility: By altering their client eligibility criteria, the Twin Counties Free Clinic prompted its patients to at least attempt to enroll, a particularly innovative and meaningful strategy.
• Strategic Marketing: BAMC kept the message on printed and broadcast materials consistent and action-oriented and modified content to reflect the progressing timeline of enrollment. The impact of these efforts may have been diminished by the late start. It was mentioned that future marketing efforts will aim to incorporate individual stories into campaigns and present cases where people benefited from their coverage and others where those who delayed had pressures placed on them and/or their families because they were not covered.
• Face-to-Face Interactions: CACs claimed that face-to-face encounters enabled them to educate people uncertain about the process because of the negative publicity surrounding the ACA and the efforts of Congress to repeal the law. Taking the time to listen to people’s issues first-hand also enabled CACs to provide key information about how insurance worked and why it was of value.
• Depoliticize: Refraining from mentioning phrases like “Obama Care” helped to bypass negative thinking about the program.

Lessons Learned
Interviewees at BAMC cited a number of important lessons learned:
• Start Early: The majority of the respondents during the site visit reported that engagement efforts needed to be initiated sooner during the next enrollment to circumvent potential misunderstandings and illiteracy.
BAMC plans to refine marketing efforts to reach more people. Mention was also made of beginning the education process earlier for local Roundtable members so that when their clients came back to them with misinformation they could recognize the issues and continue to support their clients by setting up another appointment.

- **Anticipate Glitches**: It is important to prepare for challenges and barriers that can interrupt or delay enrollment efforts. Website issues, and potential confusion over enrollment and insurance coverage will likely still be present to some degree in future enrollments.

- **Be Flexible**: There will always be a need to be flexible during enrollments to accommodate problematic enrollment encounters and to continue to keep those people motivated and interested in staying with the application process until the process is completed.

- **Target Outreach Efforts**: During the next enrollment BAMC plans to target their emergency department by seeing potential enrollees in the waiting area and providing more efficient hand-offs to CACs. They also plan to engage potential enrollees where low-income and uninsured residents go for essential assistance for food, heating, and social services.

- **Tracking**: To determine enrollment effectiveness and coverage of their service area, BAMC intends to adopt a better strategy for tracking where referrals originated.

- **Educate the Public**: The Twin Counties Free Clinic noted that donors who had supported them in the past were beginning to question the need for further funding because of an unsubstantiated belief that with Open Enrollment there are no longer any people in need of free medical care. There will always be people who have conflicting financial priorities and may either not qualify for public assistance or lack the financial resources to pay premiums. The general lack of affordable drug coverage presents another barrier to some people. Poor compliance due to the unaffordability of prescriptions may exacerbate the medical and social costs of chronic conditions and create crises for this already underserved population.

- **Find a full time project manager** to coordinate efforts among the service providers in a given service area, keep everyone up to date on any changes introduced by CMS, and provide a bridge between what is going on at state and regional levels to inform local planning and project implementation.

- **Allocate time and resources** so that the project manager can accomplish those goals.

- **Face-to-face interactions** are powerful, valuable ways to motivate people to act. The key is not just educating people and disabusing them of misinformation but helping them see the personal aspect of having healthcare coverage and taking action to protect themselves and their loved ones. This can only be effective when there is a level of trust between the CAC and the consumer, which takes time to develop.

- **Every effort should be made to support CACs** to minimize the time between engagement and enrollment, hopefully avoiding the opportunities for changing circumstances or other barriers to come between the CAC and the consumer.

- **Get involved and network** with other organizations using CACs to develop discussion groups where CACs can talk with each other about typical issues that arise in the course of their work and identify ways of handling such problems/barriers.

- **Develop a tracking system** to monitor peak volumes, those who were determined to be eligible, the number of encounters needed to conduct a successful enrollment, referral sources, and common challenges.

- **Meet early with other area providers** to understand their plans for enrollment, where the enrollment centers will be located, and what resources they have to coordinate efficient referrals and efforts ahead of time. It is equally important to establish on-going communications with area providers to stay informed on issues as they arise and to identify mutually-beneficial solutions.

### Impact of Enrollment

At the close of the first Open Enrollment, BAMC had been able to provide information on the ACA and insurance enrollment to 299 individuals and determined the eligibility and qualifications for tax subsidies of another 320 area residents. Although this latter group did not enroll at BAMC, they were prepared for enrollment else-
where because of their knowledge of plan availability, eligibility for coverage, and qualification for tax subsidies. Another 388 people were enrolled under a plan at BAMC. A little over 270 persons were uninsured prior to Open Enrollment and 49 needed help to find a QHP following their loss of BadgerCare coverage. Almost 60 percent (231) of the 388 enrollees completed the application process in one appointment.

It is difficult to determine how many of those enrolled by BAMC were residents of the hospital’s service area because the hospital did not record data on enrollee residence (BAMC did capture this information during the second Open Enrollment period). It is also difficult to obtain consistent figures for the number of individuals who enrolled in public or private coverage plans because of the many different venues for application (e.g., paper, on-line, through publicly available or privately available enrollment assistance). Numbers collected by network organizations also were complicated by overlapping service areas and collection of incompatible data elements.

The best estimates for the BAMC service area, including individuals who received OE&E services from BAMC and those who received them from partner organizations, were totals of 1,500 people who were engaged and educated on the ACA, 900 people who received plan and subsidy eligibility information, and 620 people who enrolled in a plan. Public tax records available to enrollment staff indicate that as of June 2014, a total of 1,313 residents of Marinette County claimed a tax credit available because of enrollment in a QHP. Approximately 300 people living in the county who were known to have lost their BadgerCare coverage were uninsured and were identified as a priority target for the next enrollment.

In addition to the benefits for enrollees, BAMC has observed an ongoing reduction of self-pay patients from 8.5 percent in January 2014 to 4.1 percent in July. Previous yearly averages for self-pay patients ranged from 5.7 percent in 2007 to 7 percent in 2013. The number of Medicaid beneficiaries using hospital services exhibited a gradual but steady increase over the same period. Those with commercial coverage rose from 14.4 percent in January 2014 to 18.9 percent in June.

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*Due to privacy rules, there is no way to determine how many of these individuals elected to obtain insurance coverage outside of the hospital.

h The majority of the newly-covered residents were insured by either Wisconsin or Michigan Medicaid programs.
References


Appendix A: Challenges to Consumer Assistance

1. Insurance Literacy and Community Engagement
   - In-person approaches and developing trust to get attention and educate
   - Health insurance education to meet information, linguistic, and cultural needs
   - Partnership with community-based nonprofits to support education and engagement
   - Use front-line assisters to educate and engage target populations on fulltime basis
   - Use generic marketing materials that can be branded with local contact information

2. Managing Early Implementation Glitches and Shortfalls
   - Prepare for fast pace of emerging state/federal information about implementation
   - Use regular meetings and conference calls with state or regional staff to stay up-to-date
   - Develop process for follow-up and on appeals on ineligibility determinations
   - Use call centers as a built-in resource for timely resolution of emerging consumer issues
   - Use “no wrong door” approach - single application to avoid eligibility transfer issues

3. Complicated Eligibility Requirements
   - Prepare for complex issues on tax rules, immigration and family law, and evolving policy
   - Single referral point for consumers with complex issues needing specialized knowledge
   - Use spoke and hub models to link assisters together for rapid turnaround consultation
   - Use a team model with specific, coordinated areas of expertise to speed referrals
   - Use assister feedback to analyze lessons, strengthen systems and avoid similar issues

4. Matching Consumer Needs with Coverage
   - Use plan comparison tools with consistent metrics on cost sharing, provider networks
   - Comparison tools for in-plan providers and coverage costs based on health status
   - Plan information on coverage/service needs for disabled and seriously ill consumers
   - Use data collection tools to log complaints and/or consumer satisfaction information
   - Special attention to enrollees with special or chronic health needs that test coverage

5. Post – Enrollment
   - Be ready for a “boomerang” effect with post-enrollment questions and issues
   - Referrals for help with post-enrollment issues to Consumer Assistance Programs
   - Prepare for questions/issues about using new coverage, pay premiums, appeal denied claims and resolve complaints
   - Be aware of referral requirements and oversight to ensure clients have timely referral

6. Consumer Assistance Infrastructure
   - Need for assister programs that adapt to the transitional aspect of health reform
   - Collect data for quality improvement, professional development in a learning setting
   - Centralize scheduling for shorter wait times and even workload distribution for assisters
   - Train assisters on specific issues – training modules on consumer needs and questions
   - Use performance monitoring, assess impact on target groups and follow-up issue cases
   - Document assister time/effort to build data base for evidence-based practice guidelines
   - Use long-range plans for improving coordination adopting advances and building a knowledge base on year to year experiences
Appendix B: The Role of Assister Programs in Open Enrollment

Assister Programs played a critical role in obtaining high enrollment outcomes during the first and second Open Enrollments and will be hard-at-work during the third Open Enrollment between November 1, 2015 and January 31, 2016. Consumer assistance is critical for engaging, educating, and enrolling consumers. The ACA provides resources to support an infrastructure for training, certification, technical assistance, and planning support to successfully engage and enroll consumers in health insurance plans the meet their circumstances, needs, and preferences.

Many types of organizations sponsored Assister Programs during the first Open Enrollment including nonprofit Community Service Organizations (38%), Federally Qualified Health Centers or FQHCs (28%), Hospitals and other health care providers (15%), State, County, or Local Government Agency (8%) with the remainder from for-profit organizations (3%), Faith-based Organizations (1%) and others. The distribution of resources across states to support such activities was uneven. States operating their own marketplace received almost twice as much as those with federally facilitated or state-federal partnership marketplaces.

Assisters for consumers come from largely from five types of Assister Programs including: (1) Navigator Programs; (2) In-Person Assister (IPA) Programs; (3) Certified Application Counselor (CAC) Programs; (4) FQHC-based Assister Programs, and; (5) Federal Enrollment Assistance Programs. CAC programs which provided assistance without marketplace funding, and Programs sponsored by FQHCs (45% of all programs) provided trained CACs but received no direct funding from the state marketplace. They provided services free of charge and operated under federal rules that were somewhat less extensive than for Navigators or IPAs. They typically did not provide outreach and education services. However, states were give flexibility to require additional standards if deemed necessary.

2. In-Person Assister (IPA) Programs (26% of all programs) were contracted directly by state-run marketplaces or a state-federal partnership marketplace. The duties of an IPA mirror those of a Navigator. The IPA program was established by federal legislation to make federal exchange establishment grants available for state-based and state-federal partnership exchanges. Unlike Navigators operating under a standard set of rules across states, IPA programs have more variation in size, structure, and function. In some states they are paid on a per-enrollment basis while in others they are funded through grants.

3. Certified Application Counselor (CAC) Programs (45% of all programs) provided trained CACs but received no direct funding from the state marketplace. They provided services free of charge and operated under federal rules that were somewhat less extensive than for Navigators or IPAs. They typically did not provide outreach and education services. However, states were given flexibility to require additional standards if deemed necessary.

4. Federally Qualified Health Center (FQHC) Programs (26%) received federal funding to provide comprehensive primary care services regardless of the ability of the client to pay and generally serve patients that are low-income and uninsured. HRSA awarded $150 million in July 2013 to over one thousand health centers in every state and DC to facilitate enrollment of uninsured people and another $58 million in December of that year to support the anticipated surge in enrollment assistance needs. HRSA awarded an additional $6.4 million to state and regional Primary Care Associations to provide technical assistance and other support to FQHC Assister Programs. Some of those programs also applied to be Navigators or IPAs and received additional direct funding from marketplaces.

5. Finally, Federal Enrollment Assistance Programs (FEAP) (1%) contracted with CMS to provide supplemental enrollment assistance services within federally facilitated and state-federal partnership marketplaces serving select communities with large numbers of uninsured consumers. The duties of these individuals was similar to those for the Navigator except they were reserved for “surge” assistance.
Appendix C: Samples of BAMC's Phased Marketing

Successful Health Insurance OEE Strategies for Rural Hospitals
Case Study: Bay Area Medical Center, Marinette WI

For general questions regarding the Health Insurance Marketplace, please visit www.healthcare.gov or call 1-800-318-2596.

HEALTH INSURANCE MARKETPLACE

The Healthcare Insurance Marketplace opens on October 1.

What does that mean for you?

IF YOU CURRENTLY HAVE:

WISCONSIN MEDICAID
Some Wisconsin Medicaid enrollees will be notified that they will no longer have health coverage after January 1, 2014 and will now need to enroll in the Health Insurance Marketplace.

MICHIGAN MEDICAID
Although there will be some changes with Michigan Medicaid, current enrollees will not lose coverage.

MEDICARE

• The creation of the Health Insurance Marketplace will have no impact on Medicare enrollees.

NO HEALTH INSURANCE

• Beginning Oct. 1, 2013 you can obtain health insurance even if you previously did not qualify or could not afford the cost of insurance.
• In order to have coverage beginning January 1, 2014 you must enroll in a plan by December 15, 2013.
• Michigan Medicaid rules and limits have changed. You may now be eligible for benefits.

UNDER THE NEW NATIONAL HEALTHCARE LAW

• Pre-existing conditions can no longer keep you from getting health insurance.
• With one application you can compare plans and see if you qualify for any free or low cost plans.
• Individuals who choose not to obtain health insurance by March 31, 2014 may be subject to a federal fine of up to 1% of your annual income.

If you need help in enrolling in the Health Insurance Marketplace, call 715-735-4202 to schedule an appointment with one of Bay Area Medical Center’s certified counselors.

HEALTH INSURANCE MARKETPLACE

The Healthcare Insurance Marketplace Is Now Open!

What does that mean for you?

IF YOU CURRENTLY HAVE:

WISCONSIN MEDICAID
Some Wisconsin Medicaid enrollees will be losing their health coverage after March 31, 2014 and will now need to enroll in the Health Insurance Marketplace.

MICHIGAN MEDICAID
Although there will be some changes with Michigan Medicaid, current enrollees will not lose their coverage.

MEDICARE
The creation of the Health Insurance Marketplace will have no impact on Medicare enrollees.

NO HEALTH INSURANCE

• You can now obtain health insurance even if you previously did not qualify or could not afford the cost of insurance.
• The deadline to enroll by December 24 for insurance coverage to begin January 1st, 2014 has passed. However you still have until March 31, 2014 to obtain insurance for 2014 and avoid the 2015 Federal tax penalty.
• Michigan AND Wisconsin Medicaid rules have changed. You may now be eligible for benefits beginning April 1, 2014.

For general questions regarding the Health Insurance Marketplace, please visit www.healthcare.gov or call 1-800-318-2596.

If you need help in enrolling in the Health Insurance Marketplace, call 715-735-4202 to schedule an appointment with one of Bay Area Medical Center’s certified counselors.
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