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Successful Health Insurance Outreach, Education, and Enrollment Strategies for Rural Hospitals

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Key Findings

- Based on their experiences during the first Affordable Care Act (ACA) open enrollment period, five of 11 surveyed rural hospitals reported positive outcomes likely related to their enrollment success: decreases in proportions of self-pay / uninsured patients, charity care, and/or bad debt. Of the remaining six hospitals, one reported no significant changes and five had not yet begun to assess the consequences of their efforts.

Strategies and approaches cited by hospitals included the following:

- Designate a project manager to handle open enrollment who can dedicate time to it.
- Leverage partnerships with local organizations to boost enrollment, resources, and referrals.
- Get involved with planning groups and committees at state and regional levels to see what is and is not working at other facilities.
- Pursue a multi-faceted, targeted approach in outreach and marketing efforts.
- Employ Certified Application Counselors (CACs) and make them as accessible as possible.
- Use names of state marketplaces or generic terms rather than "Obamacare."

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Purpose

This policy brief aims to inform rural hospitals, health systems, policy and program decision-makers, and other stakeholders about the best practices for successful enrollment, as identified by 11 rural hospitals in nine states nationwide.

Introduction

The Affordable Care Act (ACA) expands insurance coverage for individuals through the creation of health insurance marketplaces (also known as exchanges), the provision of tax subsidies to make insurance coverage more affordable, and the option for states to expand Medicaid. Implementation of ACA-facilitated coverage has strengthened local health care infrastructure, generating revenue for providers by potentially reducing bad debt and/or charity care, linking consumers to primary care physicians, and expanding the scope of covered services available for quality care.1 Successful outreach, education, and enrollment of rural residents in new insurance coverage options requires substantial coordination involving a broad cross-section of stakeholders.[1-2] Understanding best practices in outreach, education, and enrollment from the initial ACA enrollment period can help identify how to improve future enrollment periods.[1]

Hospitals and providers in a number of states have greatly benefited from the guides, toolboxes, and statewide coordination provided by their State Hospital Associations (e.g., California, Kentucky, Montana, Washington, Wisconsin, and Wyoming).[3-7] However, of the reports to date about the first enrollment, only a very small portion even mention rural providers' experiences, except when discussing the difficulties of remote and lower-income consumers broadly. This lack of attention becomes more concerning when one considers that rural residents have historically been more likely than urban residents to be uninsured or underinsured, and are less likely to have employer-based coverage.[8-11]

Approach

This project used a case study approach to collect primary data. We conducted structured telephone interviews with administrators and staff representing 11 small rural hospitals located in nine states: Indiana, Kentucky (two hospitals), Maine, Minnesota, New Mexico (two hospitals), Pennsylvania, South Carolina, Washington, and Wisconsin. Additionally, we conducted in-person site visits at two of the hospitals (Bay Area Medical Center in Marinette, Wisconsin, and Marcum & Wallace Memorial Hospital

in Irvine, Kentucky) to delve deeper into what made their enrollment experiences a success.

During the site visits, we interviewed hospital, network, and community representatives involved with open enrollment, including Certified Application Counselors (CACs), project managers, hospital administrators (CEOs, CFOs), and marketing managers. As a result, the more-detailed descriptions of the strategies, best practices, and lessons learned focus predominantly on these two hospitals. Additionally, two forthcoming companion case studies focus on the Wisconsin and Kentucky hospitals, elaborating on their enrollment experiences.

The 11 rural hospitals were selected as exemplary models of rural enrollment, based on their recognition by state hospital associations, State Offices of Rural Health, the Federal Office of Rural Health Policy (ORHP), hospital networks, and other experts. In addition, the hospitals were selected to represent states in all four U.S. Census Regions, and state positions regarding Medicaid expansion or non-expansion for added diversity of state environments (Table 1). Eight of the 11 hospitals are Critical Access Hospitals (CAHs), including the two site visit hospitals, and three are non-CAH rural hospitals ranging in size from 65 to 75 beds.

Protocols for the phone interviews were based on a review of the literature and discussions with stakeholders; in-person interviews during the site visits were tailored to explore and expand on issues identified from their initial telephone interview responses. Most interview questions were open-ended to encourage in-depth responses. Following the interviews, respondent comments were transcribed, coded, and entered into a spreadsheet format for qualitative analysis to identify key policy-related themes. Follow-up phone calls were made to clarify any issues or fill information gaps identified during transcription.

Results

Five of the 11 hospitals reported positive outcomes that were likely related to their enrollment success: four cited decreases in their self-pay / uninsured populations, and the fifth noted that their charity care and bad debt figures had decreased. One of the former group focusing on self-pay decreases noted decreases every month since January 2014, another pointed out a reduction in self-pay from 9 percent to less than 2 percent; and a third pointed out that their self-pay patient populations decreased from 22 percent in 2013 to 8 percent in 2014 in the ED and from 28 to 6 percent for outpatient procedures. The fifth hospital reporting positive outcomes associated with enrollment noted that compared to 12 months prior, their charity care and bad debt had decreased by $68,000 and $57,000, respectively, between July 2013 and July 2014.

Of the remaining six hospitals, one reported no significant changes that could be associated with their enrollment efforts and five others had not yet begun to assess possible consequences of their efforts. They reported that not enough time had elapsed for them to quantify any financially-related changes.

When asked whether or not they intend to claim the resources used for Open Enrollment efforts as part of their community benefit figures on their IRS 990 forms, only one hospital responded "yes"; six did not feel that their enrollment expenditures warranted reporting on their 990 forms, and the remaining hospitals were undecided. Clearly, however, assisting community members with obtaining health insurance falls within the scope of community benefit.

Planning

Hospitals initiated planning efforts as early as eight months and as late as one month before the ACA open enrollment period began (October 1, 2013). Six of the 11 hospitals relied primarily on their internal resources to support their enrollment efforts, while the remaining five were able to take advantage of Federal (two hospitals), state (one hospital), or private (one hospital) grant funds, or support from their hospital system (one hospital).

When asked to describe key elements of their preparations for open enrollment, respondents cited appointing or hiring a project manager, using their own staff as Certified Application Counselors (CACs), purchasing or reallocating computer terminals (kiosks, in some cases) to provide added capacity for self-enrollers, and having a conduit for the receipt of information about regional and state level efforts.

In the Wisconsin hospital, the Project Manager selected to head up enrollment efforts participated in state and regional planning groups with the full support of the hospital's CEO. His membership in the Wisconsin Hospital Association (WHA) Enrollment Action Council, charged with guiding the development

of enrollment activities among WHA member hospitals, proved to be critical in helping local providers avoid using strategies employed elsewhere that relied more on urban characteristics than rural circumstances (e.g., overconfidence in public media campaigns that have worked in larger cities and underutilization of using core rural values to reach consumers such as the high value on personal connections with a trusted information source).

Enrollment efforts at one of the two Kentucky hospitals were developed to take advantage of an existing network established with the help of federal funding from ORHP. Member organizations participating in this project had been collaborating for over three years to assist the area's uninsured. Network members included two Local Health Departments, three Federally Qualified Health Centers (FQHCs), a CAH, behavioral health providers, substance abuse providers, and three Rural Health Clinics, among others. The network director worked in tandem with the initial healthcare navigator from the project to retool their efforts and develop a coordinated strategy for enrollment. The director had extensive experience in network development and operation, and the navigator had been working for years to connect people with a source of medical care. It was a natural partnership.

Staffing

Hospitals reported having between one and 11 CACs on-site and/or on-staff. Most named a project coordinator / manager for the hospital's open enrollment efforts and provided employees with a consistent message to give to interested consumers. Personnel involved in planning and enrollment implementation worked closely with each other to identify how best to circumvent common enrollment issues.

The Wisconsin hospital utilized an internal multidisciplinary team (Project Manager, Director of Marketing, Chief Financial Officer, and Director of Finance) to coordinate planning and act as a quick response team for any unexpected enrollment challenges. The hospital was able to provide four CACs stationed within the hospital; two were Financial Counselors for the hospital and worked full time to address consumer assistance needs, while the other two were Patient Service Representatives and worked as CACs on a part-time basis to help with overflow. A FQHC in the area also had two CACs stationed on site and two additional CACs working a couple of days a week on the road assisting consumers in its five-county service area. Overlap with the hospital's efforts was minor because of their different service areas.

The Kentucky hospital's enrollment effort benefited tremendously from the prior existence of the rural health network, and from supplemental Outreach Grant funds to help cover expenses. Two CACs were used in the CAH, with one stationed in a financial counseling office and the Navigator (now referred to as a "kynector") in the Emergency Department (ED). Additional CACs were available in each of the three FQHCs serving the Bluegrass region of the state. One of the two counties in that region, Lee, had one of the highest rates of enrollment in the state.

Partnerships

Nearly all of the responding hospitals reported working with other organizations in their areas to facilitate enrollment for rural residents in their service areas. The nature of these partnerships covered a wide range of activities, including patient referral, sharing CAC time, hosting events for public outreach and education, providing equipment and other resources, and/or advising the hospital with respect to target populations and enrollment strategies. Cited partnerships included the State Offices of Rural Health, State and local health departments, health care systems and provider networks, clinics, schools, county government, community action groups, insurance brokers, public libraries, Farmers Union, Salvation Army, advisory groups, chambers of commerce, and YMCA. Respondents repeatedly referred to their partners when describing other elements of their hospital's enrollment success, suggesting that "going it alone" would not appear to be an effective strategy for rural hospitals.

The WHA worked with the Wisconsin Primary Care Association, the Milwaukee Health Care Partnership, the Enrollment for Health (E4Health) initiative, and the University of Wisconsin Population Health Institute (among others) on outreach and education efforts. In addition to co-hosting regional presentations across the state with the Director of the State Medicaid Program, the WHA created its Enrollment Action Council (EAC) to guide the development of enrollment activities. Toward the end of the enrollment period, the EAC formed a Network Adequacy Council to address concerns identified during enrollment.

The state of Kentucky had a tightly-coordinated campaign spearheaded by the Kentucky Office of Health Benefit Exchange and its online marketplace, Kentucky's Healthcare Connection (called "kynect"). Public education and awareness efforts promoting kynect employed the use of regional meetings, links on the kynect website to locate insurance agents or kynectors, live streaming and call-in programs by the state's public media outlet, a toll-free contact center, and links through the Governor's website. Unlike in Wisconsin, which had less state government support, the organization and planning of Kentucky's program was significant. The Kentucky Hospital Association (KHA) explored the possibility of providing Navigators but decided to educate their membership mostly through meetings, news stories, and informational emails. The KHA devoted much of its time collecting and disseminating information to hospitals on specific barriers for the Medicaid population seeking coverage.

Outreach

All interviewed hospitals engaged in some form of community outreach, intended to boost enrollment numbers and awareness of open enrollment. When asked which methods had been most successful for them, more than half of the respondents mentioned speaking about open enrollment at community events (e.g., at the local YMCA, food pantries, rural health and free clinics, schools, and fraternal organizations). This leveraging of community resources aligns with recommendations made by the National Advisory Committee on Health and Human Services.1 Advertisements and Public Service Announcements (PSA's) in radio, television, and newspapers were also frequently used in coordination with posters, flyers, and brochures. Three hospitals reported success with direct mailings to previous self-pay and/or sliding-fee patients, and another three hospitals collaborated with local schools and churches to distribute information about open enrollment to families and congregations.

A significant amount of outreach was reported to have taken place via word-of-mouth in rural communities and it became readily apparent that engagement to action is greatly facilitated by face-to-face encounters with trusted members of the community. Interestingly, only one hospital reported using electronic media (email, website, Facebook, Twitter) for marketing and outreach activities; during the Wisconsin site visit, CACs reported difficulties enrolling consumers because many lacked access to the internet.

Hospitals noted the importance of offering materials and presentations in multiple languages as appropriate, maintaining a consistent schedule for CACs, having someone on-site to schedule patient appointments with CACs, and adding a dedicated phone line for patients to reach CACs directly. The Kentucky hospital used Federal Outreach Grant funds to purchase mobile phones for CACs so that patients could reach them anytime.

Two hospitals mentioned that delays in obtaining official certification for CACs were a challenge for outreach efforts. The Kentucky hospital's CACs did not complete their training until December 2013 because of state priorities to train by region and insurance brokers first. In Wisconsin, CAC training was delayed by multiple factors: processors were overwhelmed by the number of CAC training requests, the Federal government shutdown, and the decision by the hospital to hold their training on-site because the project manager and hospital administration considered it to be more effective and timely than allowing their financial counselors and patient service representatives to use the self-paced online training.

Education

All hospitals distributed printed materials to educate target populations about open enrollment dates, regulations, benefits, and procedures (i.e., letters, posters, fliers, brochures, toolkits, banners, postcards, pamphlets, summary packets). Respondents again mentioned various media outlets (i.e., radio, newspaper ads and interviews, billboards, television), speaking engagements, and word-of-mouth. One hospital reported success with a handout that listed the specific documents that patients would need to bring to their appointment with a CAC to complete their enrollment.

The Wisconsin hospital's marketing department developed materials which provided a consistent message calling individuals to action, which were emailed to other area partners as PDFs. This distribution method lowered the hospital's production costs, provided a timely process for updating materials with changing circumstances, and reinforced the area's personal face-to-face engagement

efforts. The marketing department subtly changed the content of these promotional documents to match the timeline of enrollment activities; for example, basic CAC contact information was framed with messages that, at first, introduced the concept of enrollment ("What Does that Mean for You?"), but changed later as time was getting short ("There May Still Be Time for You to Enroll").

Enrollment

When asked about effective strategies to enroll patients, respondents focused primarily on the methods they employed to obtain appointments and the activities of the CACs. Outreach occurred through marketing strategies but education really did not commence until a consumer sat down with a CAC to begin an application. Hospitals emphasized that they found CACs were more effective when they had prior working relationships with prospective enrollees and/or previous experience and success in a similar role (e.g., as a hospital financial counselor or patient service representative). Ensuring that CACs were accessible (in terms of their physical location and hours of availability) was also key to enrollment success: three hospitals mentioned the importance of having a CAC onsite, another located a CAC directly in the ED to enroll patients at the bedside, and a third offered extended CAC hours, scheduling them to work at times when the ED was busiest (evenings, weekends). An area FQHC participating in the Wisconsin enrollment had two CACs on site and scheduled appointments for two other CACs who traveled around the FQHC's service area enrolling people in a local health department, a University of Wisconsin Extension Office, and a public library.

Most hospitals offered some alternative arrangements to enroll patients without working directly with a CAC in person. Allowing patients to fax their information to avoid in-person or repeated visits worked well for one hospital (they would scan it into their computers and upload it directly into their file on the state marketplace); two others created self-service computer kiosks; and another two found success with phone enrollments, setting up a 24-hour call center or dedicated phone line. One responding hospital provided transportation for patients who had difficulty getting to an in-person meeting with a CAC.

Multiple respondents mentioned that the term "Obamacare" often takes on negative connotations for prospective enrollees; they recommended referring to a state health marketplace ("kynect" in Kentucky, for example, or "MNSure" in Minnesota) or using some other generic terminology.

Seven of 11 hospitals cited technical difficulties with the Federal website as the biggest obstacle they faced during open enrollment, particularly during the first several weeks. The Wisconsin hospital also conducted follow-up calls and appointments with patients who could not enroll because of the early website problems. One hospital reported receiving different answers from Centers for Medicare and Medicaid Services (CMS) officials requiring them to double check with CMS or state officials to accommodate the consumer receiving assistance. Two surveyed hospitals reported difficulties accessing the online CAC training modules.

Hospital interviewees mentioned that some patient enrollments took a lot longer than others; contingent upon enrollees' knowledge of health insurance terminology, computer literacy level, and/or preparation for enrollment appointments (e.g., not bringing required documentation). Some hospitals' efforts were hindered due to a lack of support from administration / board members and a lack of awareness of which insurance carriers offered a marketplace plan (requiring extra legwork on the part of the CACs to dig for information). However, most hospital administrators were supportive; for example, authorizing overtime needed to handle fluctuating demands for assistance that occurred although CACs were careful to schedule consumers to avoid times when the federal website was most likely to experience overload issues. Staff at the Kentucky hospital reported that attending meetings about the state marketplace often provided an opportunity for CACs from other areas to discuss issues they were facing in common (e.g., long wait times on the phone with CMS or figuring out how to address which parent would claim the children when the couple was not divorced but not living in the same home).

Lessons Learned

When asked to identify the most important lessons learned during the first Open Enrollment period, respondents focused on the importance of collaborative partnerships, having trained staff on-site, community awareness, educating prospective enrollees, and successful outreach and marketing efforts.

Collaborative Partnerships

Nine of the surveyed hospitals reported a reliance on area partners to either assist or provide referrals to their enrollers as a key to their engagement successes. Six of these nine hospitals reported that the partner relationships extended beyond just receiving referrals and involved joint planning and education efforts channeling consumers to the enroller sites in their area. For some hospitals, these relationships took years to gel. However, as the arrangements matured and successes built, a firm foundation was laid that could support future joint activities like those needed in successful enrollment efforts. For others with looser organizational arrangements that are relatively new and focused primarily on enrollment, the arrangements were just beginning to take shape. It will be interesting to see if less-formal arrangements will work smoothly during the coming second enrollment period.

Trained On-Site Staff

Having on-site enrollers was critical for engaging consumers who were identified while they were in the building for services. One respondent noted that time was their biggest challenge to getting people enrolled. One of the more effective strategies was implemented by an FQHC participating in the Wisconsin effort: it kept two CACs on-site and had two others travel a couple of days each week to locations throughout the center's service area. Appointments for the off-site efforts were scheduled using a centralized phone number. Some of the on-site staff were hospital financial counselors who conducted enrollment in their regular offices while others were strategically placed in hospital emergency rooms. Emergency departments were good locations for identifying self-pay patients and handing them off to on-site enrollers following their treatments.

Community Awareness

In rural communities, word-of-mouth provides an extra boost to local engagement efforts and can potentially make or break the success of a hospital's enrollment efforts. The Kentucky site visit highlighted the value people place on having face-to-face encounters with trusted community members who express a passion for taking care of the people they know. One respondent suggested trying to "figure out big-name families in the community" to help spread the word about enrollment. It is important to tailor outreach and education strategies to the values and culture of the target populations and community at large: "market it in a way that appeals to their values," stated one respondent. Another observed that healthcare "hasn't been marketed with the right incentives," placing too much emphasis on penalties (i.e., what will happen if you don't enroll vs. what benefits you may experience if you do). Every rural community is different, and a one-size-fits-all approach to marketing and outreach is not likely to be effective.

Education

The two aspects of pre-enrollment-period education that surfaced in lessons learned were educating prospective enrollees and educating provider staff. The first component, focusing on the consumers needing assistance, highlighted the need to remain flexible and preparations for thinking on the spot. A number of consumers exhibited insurance illiteracy and surprised healthcare staff members, who had assumed that the consumers understood the nature and value of healthcare insurance. Another hospital noted, however, that they had expected to see more consumers than they did who required basic instruction.

Aware that hospital staff are seen every day and are people community members have come to trust about health and hospital issues, the Wisconsin hospital conducted special training sessions for their entire workforce as part of a strategy that would maintain a consistent marketing message. Several respondents agreed with this approach and its importance for ensuring that prospective enrollees receive the same message and contact information that is being made available through public media and printed materials. "Educating our entire hospital staff helped a lot," one stated.

Outreach

Most respondents recommended putting more effort into outreach and marketing efforts: "take every opportunity to get the word out," one stated. "Start talking to people early," said another. Identifying target populations and gearing marketing and outreach strategies to maximize the likelihood that these populations are aware of upcoming enrollment periods is central to success. They also suggested that some people simply cannot retain that message over time, regardless of marketing efforts, and will need to be engaged and enrolled using a more hands-on approach with face-to-face outreach conducted on a more personal level.

Successful marketing, such as the strategy used in Wisconsin, takes a multifaceted approach: employing a variety of media, addressing the perspectives of all target populations, and combining it with more personal face-to-face person contacts. One core strategy in particular whose value is virtually universal in rural communities is using the social leverage of trusted community members to weave messages into an approach that sparks people to action, such as the educated hospital employees and human service-related providers found in the Wisconsin site visit. In order to monitor efforts and adjust for challenges or opportunities uncovered during enrollment, providers need to institute a data-collection system that records consumer and provider feedback to identify where strategies need to be modified or replaced to achieve program goals. ■

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