On Track and Moving Forward: Lessons Learned from the Implementation of Consumer Assistance for the New Hampshire Insurance Marketplace October 1-December 31, 2013

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Executive Summary

Project Purpose: Provide a report of New Hampshire's (NH) progress in implementing the health insurance marketplace between October 1 and December 31, 2013. This report provides a complete picture of what is happening in the state, across organizations. Key findings may be used to tweak plans and practices to increase the efficiency of future enrollment periods.

Key Findings from October-December 2013:

1. *Outreach and enrollment efforts were complicated by three external factors:* technical difficulties associated with HealthCare.gov and the rollout of the Affordable Care Act (ACA), the decision not to expand Medicaid eligibility, and the concurrent transition to Medicaid managed care in NH. As a result of the complications with HealthCare.gov, partners focused on building outreach and enrollment infrastructure until December, when enrollments began to rapidly increase.
2. *With 11,446 enrollments, NH was one of ten states that met the Center for Medicare and Medicaid Services (CMS) projected number of enrollments during the first three months.* This amounts to 60% of the 19,000 enrollments projected between October 1, 2013 and March 31, 2014. NH compared favorably with national statistics on total enrollment, but a smaller percentage of NH enrollees were young (22% vs. 24%) and NH experienced a slower rate of new Medicaid enrollments due to the lack of Medicaid expansion.
3. Slightly less than three-quarters (72%) of new enrollees in NH received federal financial assistance, compared to 79% at the national level, suggesting a *need for outreach to lower-income NH residents.* With one insurance issuer, the average monthly premium for the lowest cost Silver plan in NH is $359 compared to $310 at the national level.
4. An early effort by NH Health Plan to place assisters in all areas of the state was apparently successful. Partners report that *all regions of the state are adequately reached by outreach efforts,* a fact which has also been made possible by collaborations between partners.

Action Items for February-March 2014:

1. *Prepare appropriate communication strategy to respond to questions* from consumers (regarding coverage details, narrow network, and information security) and businesses (regarding the viability of SHOP plans)
2. *Seek out existing collaborations* between partner organizations to streamline outreach and enrollment efforts
3. *Ensure media firm provides timely materials* to partners
4. Expand access to assistance resources by *seeking out partners with financial interests* in increased coverage
5. *Streamline news updates and reporting* in one organization, who can then respond to publicity requests from a number of sources (e.g. government, media)

Conclusion: Despite a slow start and early disappointments, partners feel that efforts to implement the insurance marketplace are on track, and are optimistic about the next three months.

Introduction

Many organizations in New Hampshire (NH) are involved in providing consumer assistance to residents, both in the form of outreach and education and direct enrollment assistance. The purpose of this evaluation is to summarize the overall progress that has been made in the state in implementing the insurance market. Providing a complete picture of progress, lessons learned, and next steps may help partners maintain a high level of efficiency in educating and enrolling residents during the enrollment periods. This report begins with a brief background of the existing efforts and key partners. Next, the report explores the environmental factors that influenced the progress to date. Third, progress to date is documented including an update on what key partners have done in the first three months, data on enrollment numbers and demographics and on insurance affordability. The report concludes with lessons learned and an assessment of the overall progress to date, in light of the results.

Background: Consumer Assistance in NH Before October 1, 2013

The health insurance marketplace is a key component of the Patient Protection and Affordable Car Act (ACA). Health insurance marketplaces are designed to be one-stop-shops for consumers. Consumers can search the health insurance options available to them, read about the plans in simple language, and ultimately select a plan that fits their needs. Through the ACA, states were provided an option to design their own marketplace or use the federal marketplace, HealthCare.gov. New Hampshire (NH) is one of 34 states that opted to use the federal marketplace. Specifically, NH chose to take part in a federal-state partnership marketplace, where the state and the federal government share responsibility for the insurance marketplace. NH's insurance marketplace, as part of HealthCare.gov, was launched on October 1, 2013. Consumers had between October 1, 2013 and December 24, 2013 to enroll in a plan in order for coverage to begin January 1, 2014. The first enrollment period ends March 31, 2014.

As a partnership marketplace, NH oversees consumer assistance, which includes educating consumers about plan options and providing them the tools and help they need to enroll. Efforts to provide consumer assistance for the NH insurance marketplace were delayed by the legislature and funding issues. However, an earlier review of stakeholders involved in consumer assistance between September and December 2013 indicated that many partners in the state were engaged in consumer assistance efforts independently and often without funding.[1] The earlier review revealed that efforts fell, and continue to fall, into two categories: outreach and education, and in-person enrollment assistance.

Outreach and education includes all activities that are designed to increase awareness of and generate accurate information about the insurance marketplace. Broadly defined, it includes activities such as exhibiting at community events, radio announcements, social media campaigns, etc. Many organizations at the state, regional, and local levels sponsor and take part in a variety of these activities.

In addition to outreach activities, organizations offer direct enrollment assistance, which refers to providing consumers with the assistance they need to enroll. Using federal funds to train Marketplace Assisters (MPA), the New Hampshire Health Plan (NHHP) awarded funds to Service Link, Bhutanese Community of NH, Foundation for Healthy Communities (FHC), Planned Parenthood of Northern New England (PPNNE), Greater Derry Community Health

Services, and North Country Health Consortium. Two organizations – Bi-State Primary Care Association (in conjunction with North Country Health Consortium) and PPNNE – received federal funding to host Navigators at their health centers. Other organizations are training Certified Application Counselors (CACs), and finally, previously certified producers exist to walk consumers through the process of selecting and enrolling in a plan.

A complete description about the existing activities in the state can be found in full report, *State of the State: Baseline assessment of implementation of the New Hampshire insurance marketplace.* It is available on the John Snow Inc. (JSI) website. The report was produced by JSI under contract to the Healthy New Hampshire (HNH) Foundation, with data from the Urban Institute.

Project Purpose

While individual organizations and programs report on their own progress, state partners will benefit from a complete picture of the overall progress in implementing consumer assistance for the insurance marketplace at the state level. The purpose of this evaluation – the first in a planned series of status updates – is to track NH's progress in achieving the goals of the insurance marketplace. In the larger context, the evaluation will track progress in achieving the goals of the ACA, which for the purpose of this evaluation are interpreted as:

1. Reduce the number of uninsured and underinsured
2. Increase the affordability of health insurance
3. Improve the quality of health care
4. Improve health by focusing on prevention and healthy lifestyles
5. Increase efficiency of health care delivery by focusing on value and controlling costs

This first status update reports on the first half of the first open enrollment period, from October 1 to December 31, 2013. Therefore, the focus of this report is the implementation of the marketplace and early efforts for outreach and enrollment. In addition to providing key findings that may be leveraged to increase efficiency in future enrollment periods, the results of this first evaluation may be used as a baseline assessment for future evaluations.

Key Evaluation Questions

Being so early in the implementation of the marketplace, it is impossible to expect that longer-term goals of the ACA (i.e. improving quality of health care, improving health status, and increasing efficiency) will have already been impacted. Thus, the key evaluation questions for this status update focus on two goals of the ACA: increasing the number of insured residents and increasing affordability of insurance. Questions that this evaluation seeks to answer include:

- Were outreach and enrollment efforts implemented as planned?
- How successful have efforts been to increase coverage in the first enrollment period?
- To what extent is health insurance becoming affordable for newly enrolled residents?
- How is NH doing compared to the nation?

- Within the state, how are counties doing comparatively?
- Using lessons learned, how can we change practices to increase efficiency and effectiveness of enrolling individuals in future enrollment periods?

Indicators of Success

The following indicators of success are from the Congressional Budget Office (CBO), Center for Medicare and Medicaid Services (CMS), and the U.S Department of Health and Human Services (US DHHS). The Commonwealth Fund has indicated that these benchmarks are appropriate measures for assessing the marketplaces.[2] These indicators include:

1. Operational marketplace. Although officially launched on October 1, the federal insurance marketplace, HealthCare.gov, struggled with technical difficulties in October and November. Thus, the first indicator of success was to have a fully functioning marketplace by December 15.

2. Number of uninsured. The CBO estimates that 13 million fewer people will be uninsured as a result of new coverage options through the ACA. This constitutes 32 percent of the 41 million uninsured Americans. If the number of uninsured in NH drops by 47,040 (32 percent of 147,000), then NH will have proportionally contributed to the overall drop in the uninsured. However, this indicator will not be assessed until September of 2014, when the Centers for Disease Control and Prevention (CDC) will release the updated statistic of the proportion of Americans who are uninsured.

The number of uninsured does not necessarily correspond to the number of enrollees in the marketplace, as currently insured individuals may opt to switch their coverage to a marketplace plan to reduce costs or gain better benefits.

3. Number of marketplace enrollees. The CBO projected that 7.1 million people would enroll in qualified health plans (QHP) through the marketplace between October 1, 2013 and March 31, 2014.[3] In September 2013, the CMS released monthly enrollment projections for each state, maintaining the CBO projection of 7.1 million enrollments over the entire first open enrollment period. Between October 1, 2013 and December 31, 2013, CMS projected that 3.3 million people would enroll in QHPs.[4] CMS projected that 47 percent of enrollments – both nationally, and in each state – would occur between October 1 and December 31 (Table 1).[5] In NH, CMS projected that 8,930 people would enroll between October 1 and December 2013 and that 19,000 people would enroll between October 1, 2013 and March 31, 2014.[6]

Table 1. CMS projected cumulative enrollment in NH and Nationally from 10/1/13 to 3/31/14

Number of enrollees as of:	10/31/13	11/30/13	12/31/13	1/31/14	2/28/14	3/31/14
NH	1,330	3,230	8,930	11,780	15,200	19,000
National	494,620	1,201,220	3,321,020	4,380,920	5,380,920	7,066,000
Monthly enrollment projection (Cumulative %)	7	17	47	62	80	100

Previously, the US DHHS indicated that if 2 million of the new enrollees were young adults, or 29 percent of the seven million new enrollees, then the first enrollment period would be successful.[7] To match enrollment of young adults in NH, 29 percent of 19,000 enrollees or 5,510 new enrollees between October and March need to be young adults. Between October and December, 29 percent of 8,930 enrollees, or 2,590, need to be young adults.

Finally, CBO projected that in addition to the 7 million enrollees in QHPs through the marketplace, 9 million people would enroll in Medicaid, nationally.[8] Thus, CBO projected Medicaid enrollments would outpace QHP enrollments at a rate of 1.3 between October 1, 2013 and March 31, 2014. However, because NH decided not to expand Medicaid eligibility, NH will likely have a slower rate of new Medicaid enrollments than the national rate.

Methods

The first status update report was completed between January 1 and January 31, 2014. The primary data sources for the status report included:

- **Partner interviews**. Interviews were sought with ten key partners. Interviews were conducted with seven key partners including NH Health Plan (NHHP), which oversees grants for marketplace assisters (MPA) and media related to the marketplace; Service Link and the Foundation for Healthy Communities, both recipients of MPA grants from NHHP; New Hampshire Association of Health Underwriters (NHAHU), the NH chapter of the National Association of Health Underwriters; NH chapter of the U.S Small Business Administration; Anthem, the only insurer offering plans in the NH insurance marketplace in 2014; and Bi-State Primary Care Association, a recipient of a federal grant to become a Navigator organization. See the Appendix for the interview guide.
- **Document review**. A NHHP reporting system provided aggregate data on applications and appointments for the six MPA organizations. Additionally, federal reports from the US DHHS and the Assistant Secretary for Planning and Evaluation (ASPE) included federal and state-specific enrollment data. Data sources for analysis on state and federal data included local newspapers, Kaiser Health News, Health Affairs and other peer-reviewed journals.

Results

This section reports the key findings of the analysis. First, external factors are assessed, for it is within the environmental context that the results must be viewed. Second, there is an update on implementation of the marketplace, using first-hand accounts from key partners. The section concludes with some key lessons learned that may be applied to future enrollment periods.

External Pressures Complicate Implementation

The implementation of the health insurance marketplace in NH has been influenced by three environmental factors. First, technical difficulties associated with HealthCare.gov have provided an additional challenge for partners in consumer assistance, forcing them to spend time

rebuilding the image of the ACA among consumers and potential partners. Second, the decision not to expand Medicaid left a number of NH residents in a coverage gap, which all partners in consumer assistance feel to be detrimental to the success of the ACA. Finally, the concurrent transition from the current fee-for-service system to Medicaid managed care has overwhelmed potential partners in consumer assistance and limited the role of NH Department of Health Human Services (NH DHHS) in the implementation of the marketplace.

Rocky rollout of HealthCare.gov undermines credibility of ACA

As one of the 34 states that relied on HealthCare.gov to host the state's insurance marketplace, the launch of HealthCare.gov is synonymous with the implementation of the health insurance marketplace in NH. The launch of the website on October 1, 2013 was immediately followed by nearly two months of challenges. The federal government posted information on HealthCare.gov that did not match the information submitted to them by the insurers in some states, and was unable to accurately transfer enrollment information to insurance companies.[9] The website was not initially designed to handle the high traffic of consumers.[10] Staggering the launches of the marketplaces in each state over a period of time may have mitigated some of the initial volume challenges faced by HealthCare.gov.[11]

According to a report by National Public Radio, the underlying cause of the problems associated with the website was the "waterfall approach" in designing the system.[12] In this model, a client first delineates a list of requirements and functionality, and then the developers build the product, test it, and launch the complete product. However, in the case of HealthCare.gov, the critical testing phase was essentially eliminated due to time restraints before a hard October 1 launch date. As a consequence, some of the pieces of the product did not work together as anticipated at the time of launch. The contrasting "agile" method – which is preferred although not often used for government projects – involves developing and testing small pieces of a system in phases. The product is able to be launched much sooner, because fixes can be made while the product is live. When McKinsey & Co. was hired in March of 2013 to forecast potential problems with HealthCare.gov, they highlighted this underlying flaw in the development plan. It appears, however, that by then it was too late to change pathways.[13]

By the beginning of December, the HealthCare.gov had fixed many issues. In an interview with Anthem, they reported that in December they finally began to receive accurate information from the website so they could begin processing enrollment applications. The website was able to handle large consumer traffic. However, although many of the most pressing problems with HealthCare.gov were solved, the bumpy rollout had a serious negative effect on partners in consumer assistance. Interviewees agreed that the problems with HealthCare.gov undermined their ability to conduct outreach and complete enrollments because of lost credibility with both consumers and other potential partners. Partners reported having to spend time rebuilding the image of health reform with the public, and also that some potential partners (e.g. sites for enrollment events) were unwilling to join the effort, wanting to wait and see what other problems arose before agreeing to partner for enrollment work.

While many problems with HealthCare.gov have been solved, some problems remain and those problems may continue to pose barriers for partners. HealthCare.gov still does not have full functionality for the automated payment system, and there is no reported timeline for this to be in place.[14] Additionally, the system is still unable to collect data on who has paid for their insurance.[15] Although the government recently reported passing all of the security tests, many are unconvinced about the safety of HealthCare.gov. Two house committees held recent hearings

about the cyber security of HealthCare.gov. This concern was echoed in an interview with the New Hampshire Association of Health Underwriters (NHAHU), the NH chapter of the National Association of Health Underwriters.

The report that insurance companies were sending out letters to cancel plans that did not meet ACA regulations sparked a political debate in late 2013. For the most part, interviewees felt this posed only a minor barrier for partners working directly with consumers. One interviewee suggested that the effect of the reports was that some consumers were more hesitant about looking at options on the marketplace, and they opted to wait until after the December 24 deadline to choose a plan.

The glitches with the rollout of HealthCare.gov provided opponents of the ACA with the basis for arguing for changes to the law. The immediate storm has apparently passed, with reports of transmitting accurate information and significantly improved user experience since October 1; however, it is unlikely that the shaky rollout is completely behind those partners working to implement the ACA in NH.

In addition to the development plan flaws and subsequent technical issues, another complication for partners in enrollment was frequent alterations to the implementation of the law. The deadline by which plan selections had to be made for coverage effective January 1, 2014 was pushed back several times, ultimately to December 24. Most partners in NH agreed that this was a positive change, giving consumers more time to consider their options. On the reverse side, however, Anthem faced a serious challenge in turning around the applications, as there was a massive surge of application in the final days before the deadline. In response, Anthem also pushed back the deadline by which they must receive payment for retroactive coverage to January 31st.

A second alteration to the implementation came with the announcement from US DHHS that people enrolled in high-risk insurance pools would have until March 15 to choose a different plan option.[16] Previously, the high-risk pools were going to end at the end of 2013. For the NHHP, which runs the high-risk pool in NH, this means that they will continue to run the pool until March 31st. An interview with NHHP revealed that those in the high-risk pool are taking advantage of this extra time, opting to take the time to continue searching their options rather than moving to a new plan by the end of 2013.

Lack of Medicaid expansion leaves many in coverage gap

A key issue in NH has been the decision to accept or not accept federal funding to expand eligibility for Medicaid. NH did not immediately choose to expand, opting to establish a commission to study the effects of an expansion of Medicaid. In October 2013, the commission released a report that supported an expansion of Medicaid eligibility for adults under 65 up to 138 percent of Federal Poverty Level (FPL).[17] They proposed that NH should seek a federal waiver to provide public assistance using Medicaid dollars to help individuals purchase private insurance, and mandate that a person stay on a private insurance plan when it is cheaper than Medicaid.[18] As is the case for all states that choose to expand Medicaid, the federal government will cover the cost of expansion in NH for the first three years. It is estimated that the expansion of Medicaid would cover 49,000 NH residents.[19]

A compromise Medicaid expansion bill passed the House but was struck down in the Senate on November 21, 2013.[20] According to the Associated Press, the dividing issue was when to use the federal marketplace to purchase private insurance: Republicans in the Senate insisted on implementing the private option immediately, whereas Governor Hassan and Democrats in

the legislature felt it was more feasible to implement the requirement after other insurers join the marketplace.[21] An amendment by Senator Peggy Gilmour was also struck down, but some lawmakers were hopeful that her amendment could be a starting point for discussions in early 2014. Her amendment set deadlines for the federal waiver request, to make sure that the waiver for private health coverage is received in a timely manner.[22]

The expansion of Medicaid is inextricably linked to the implementation of the health insurance marketplace. In NH, individuals are able to enroll in all types of insurance – including Medicaid – through the online marketplace, HealthCare.gov. In the event that an expansion does pass in 2014, those eligible should be able to seamlessly move between private insurance and Medicaid on the federal insurance marketplace. If a bill to expand Medicaid fails again, an estimated 35,000 NH residents will not have access to affordable insurance as they fall in an uncovered gap: those under 100 percent of FPL are ineligible for federal subsidies for premiums, and may opt to forgo insurance because it is cost prohibitive.

Partners were in agreement that the decision not to expand Medicaid has been detrimental to NH's people because many are left without an affordable insurance option. Assisters feel helpless during appointments when they are unable to provide options to individuals not eligible for Medicaid or financial support, and are concerned about supporting those individuals that fall into this coverage gap. While many NH residents have been impacted at an individual level, interviewees noted that the lack of Medicaid expansion has not deterred individuals from seeking insurance options, or other partners from joining the effort to provide consumer assistance.

Concurrent transition to Medicaid Care Management competes for resources

At the same time that NH is implementing the health insurance marketplaces under the ACA, the state is transitioning Medicaid from the current fee-for-service model to a managed care system. Under the managed care system, the state of NH will provide prospective payments to managed care plans and, in return, the plans will provide all services for Medicaid enrollees. NH DHHS hopes that NH Medicaid Care Management (MCM) will improve care coordination for Medicaid recipients.[23] According to a report in the Union Leader, the first few days of the implementation of the MCM program went smoothly.[24] By December 3, 2013, 104,000 of the 130,000 Medicaid enrollees in NH had been transitioned to Medicaid managed care organizations.[25]

One consequence of the concurrent transition to MCM has been that some potential partners in consumer assistance have been hesitant to join the effort, suggesting that the transition to MCM was overwhelming enough to prevent them from taking on an additional role in consumer assistance. For example, one assister organization found that when they sponsored trainings for CACs, some organizations refused to send people because they had recently sent employees to trainings for MCM. Some organizations that were originally excited about helping with enrollment efforts and had previously agreed to help with the consumer assistance effort have since scaled back on their commitments due to concern over trying to simultaneously transition to managed care.

Another consequence has been that NH DHHS has had to focus time, energy, and resources on transitioning clients to managed care. There is evidence to suggest that this focus has had an unintended negative effect on the effort to provide consumer assistance in NH. For example, interviewed partners were concerned that the HealthCare.gov system has not worked seamlessly with the NH Medicaid eligibility system, causing significant delays in enrollment for children potentially eligible for Medicaid.

State Progress in Implementation: Partner Update and Enrollment Statistics

This section provides an overview of progress in implementing the insurance marketplace, including an overview of what partners in consumer assistance have accomplished in the past few months, the number and demographics of enrollees in the marketplace, and early evidence on changing affordability of health insurance.

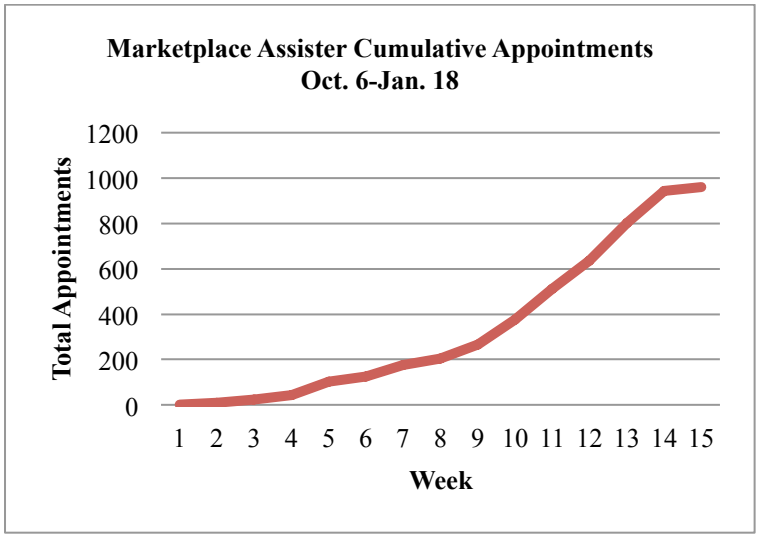
NH partners establish infrastructure and launch enrollment efforts

In late September, the **New Hampshire Health Plan** (NHHP) was awarded a federal grant to launch a marketplace assister (MPA) program and to hire a firm to oversee media efforts related to the marketplace. On behalf of NHHP, Public Consulting Group (PCG) spent the first month of the grant period (September – October) writing the Request for Proposals, reviewing grant applicants, and awarding funding to grantees. At the end of October, Louis Karno & Company was awarded the grant to oversee media efforts. Louis Karno & Company launched the state website for marketplace activities, www.coveringnh.org, in late December. The role of the media firm will include publicizing the marketplace, coordinating messaging, and maintaining the state website. An updated website is expected soon.

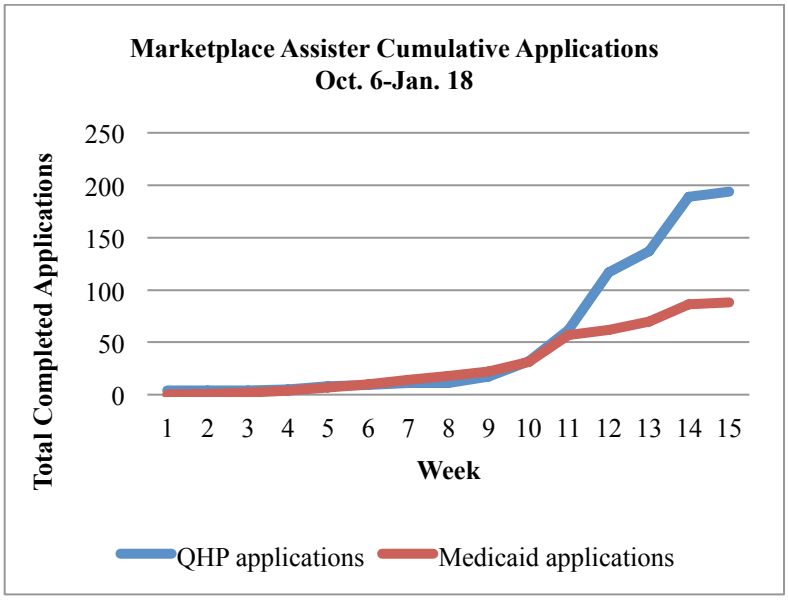
NHHP awarded funds to six organizations in the marketplace assister (MPA) program: Service Link, Bhutanese Community of NH, the Foundation for Healthy Communities, Planned Parenthood of Northern New England, Greater Derry Community Health Services, and North Country Health Consortium. Interviews with the **Foundation for Healthy Communities (FHC)** and **Service Link** reveal that the first two months were primarily spent establishing infrastructure. Main efforts included signing contracts, and hiring and training assisters. With the near completion of these activities in December, the organizations transitioned efforts to focus on enrolling individuals. FHC has a well-established enrollment effort in Manchester and Nashua, with bi-lingual MPAs with regular hours at a number of locations. Current efforts are focused on establishing regular schedules at hospitals in other regions of the state. The majority of people scheduling appointments are patients of the hospitals where they enroll; FHC is working on outreach to the broader community. Meanwhile, Service Link is now focused on building collaborations with other organizations and developing coordinated outreach plans.

MPA organizations report to NHHP on a weekly basis, so that NHHP is able to track the process of building infrastructure. Now that most organizations have completed building the infrastructure, NHHP is starting to focus more on tracking MPA performance and efficiency. Evaluation metrics include the number of work hours and applications per assister, the proportion of time spent conducting outreach versus enrollments etc. NHHP will continue to focus on increasing the efficiency of assisters through March 31. As part of this effort, they are offering professional development meetings and opportunities for assisters to increase their skills and knowledge, network and share best practices. For example, planned trainings scheduled for assisters will address the mechanics of Medicaid and strategies for reaching young adults.

According to the tracking system, the marketplace assisters at the six MPA organizations have hosted nearly 80 outreach events and attended nearly 140 events between October 6 and January 18. During the same time, MPAs at the six organizations conducted a total of 961 appointments with consumers. The rate of appointments increased significantly in the latter part of the enrollment period, after HealthCare.gov became functional (see figure on the next page).



Between October 6 and January 18, MPAs completed 200 applications for qualified health plans (QHP) offered through the marketplace and100 determinations for Medicaid. Again, the rate of completed applications increased significantly in November and December, leading up to the December 24 deadline (see figure below).



Across the six MPA organizations, 52 percent of time has been spent on outreach and education, and 48 percent has been spent helping consumers complete applications. However, between December 1, 2013 and January 18, 2014, the proportion of time spent completing applications increased substantially to 55 percent, reflecting the influx of application in the few weeks leading up to the deadline. Not all MPA organizations have consistently reported their weekly performance suggesting that the number of completed applications may be understated.

Along with Planned Parenthood of Northern New England (PPNNE), **Bi-State Primary Care Association** receives federal funding for Navigators. Bi-State also implements the Navigator program in Vermont, a state-based marketplace, so they were able to capitalize on this

previous knowledge in NH. In October and November, Bi-State focused on educating Navigators and conducting outreach efforts to consumers. When HealthCare.gov became functional, they focused primarily on completing applications for enrollment. After the push to get applications in by the December 24 deadline ended, Bi-State began refocusing on outreach efforts, in addition to continued enrollment efforts. Particularly successful events have included partnerships with libraries, rotaries, and the dining staff at the University of New Hampshire. Bi-State has also relied on the earlier HNH Foundation report on the demographics of the uninsured to shape their outreach and education efforts. Bi-State and other assister organizations report that assisters have between two and three contacts with each consumer. The consumer then completes the enrollment at home, either online or over the phone. The only people who are physically enrolled by assisters are residents without access to, or who have difficulty with, a computer.

On the business front, the NH chapter of the U.S **Small Business Administration (SBA)** has spent the past three months speaking at events for businesses, and plans to continue. Events have taken place throughout the state; the most successful event was a panel of SBA, Anthem, and Delta Dental that took place at Southern New Hampshire University. Although the U.S Treasury Department announced a delay in the Employer Shared Responsibility provision until 2015, the event was very popular among businesses. SBA interprets this interest as an indication of a strong desire among businesses and individuals to understand the changes related to health reform. Successful events have had a range of presenters including assisters who can complete enrollments, health care providers, and those that understand the legal issues with the bill.

Since SBA focuses on outreach, it is unclear the extent to which these events have translated into enrollments among the business community. From outreach events and conversations with businesses, SBA representatives perceive that at least some businesses are exploring marketplace options, although the responses from businesses are mixed. For every one business that reports having a negative experience with the marketplace to SBA representatives, another business reports that they were able to find coverage at a lower cost for their employees.

The **New Hampshire Association of Health Underwriters** (NHAHU) has ensured that their licensed producers are also certified to complete enrollments through the marketplace. Like SBA, NHAHU is providing information to businesses about the process of choosing insurance through the SHOP marketplace. They have also worked with individuals to conduct enrollments through November and December. In partnership with their national organization, NHAHU is lobbying for changes to the federal law, including issues related to what is covered and for whom, plan designs, and choices available through the marketplace.

Partners felt that all areas of the state are appropriately covered by consumer assistance efforts. SBA participates in events throughout the state for businesses. Producers are available statewide, and although assisters are established in some areas more than others, partners were not concerned that any area of the state was left uncovered by efforts. Earlier, NHHP used an analysis conducted by JSI under contract to the HNH Foundation to place assisters in some areas of the state with apparent insufficient supply of assisters. The reports from partners suggest that this move successfully met the demand of in-person assistance. Additionally, collaborations between partners have sprung up in some areas, and these groups have worked to spread the efforts across regions in order to maximize efficiency.

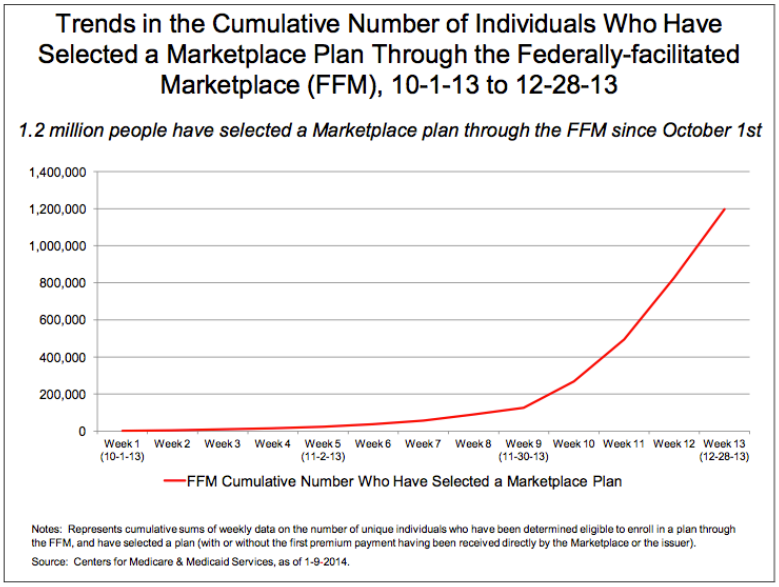
Anthem was challenged during the first two months by the glitches with HealthCare.gov. One of the primary problems was that the federal system was not providing the necessary information (via the 834 form), and then provided inaccurate information to Anthem. By December, the HealthCare.gov system was finally sending accurate forms. According to an

interview with Anthem representatives, 50 percent of all applications through the marketplace came in the last two weeks of December. Anthem worked in January to process applications, accept and process payments, and send identification cards, as premium payments were accepted until January 31[h]. These efforts will continue with continued enrollment through March. Anthem allowed people to make payments online and over the phone, and extended the hours for call centers to accept additional flow. Not surprisingly, there was a mass influx of calls to the Anthem system. Although they added staff to meet extra demand, the demand on the call center has far exceeded expectations; Anthem reported that they received more calls in two days at the end of December than they receive in an average month.

Over 11,000 NH residents enroll by December 28, 2013

Total enrollment: Enrollment data comes from monthly reports from the Assistant Secretary for Planning and Evaluation (ASPE) in the US DHHS. The first report covered the period of October 1 through November 2. The challenges with HealthCare.gov during this time resulted in low enrollment numbers. Although 1.1 million people were determined eligible to enroll in a marketplace plan, just over 100,000 actually selected a plan.[26] This amounted to 20 percent of the CMS projected enrollment for the first month and just 1.4 percent of the 7.1 million enrollees.[27, 28] In NH, 269 people selected plans in October, which amounted to 20 percent of CMS's projected enrollment for NH in the first month.[29] Thus, NH kept pace with the national enrollment during the first month, although nationally and in NH the pace of enrollment was much slower than originally anticipated.

The most recent ASPE report, released January 13, 2014, revealed that over the entire period of October 1 to December 28, 2013, a total of 2.2 million people selected plans from the state and federal marketplaces.[30] This translates to 31 percent of the CBO projection of 7 million enrollees QHP by the end of March 2014. It also corresponds to 69 percent of the projected 3.3 million enrollments between October 1 and December 31, 2013, a significant improvement over October, where 20 percent of projected enrollments were achieved. In the federal marketplaces, there was a 7-fold increase in the number of plan selections in December, from 140,000 in October and November to 1.2 million in December (see figure below).

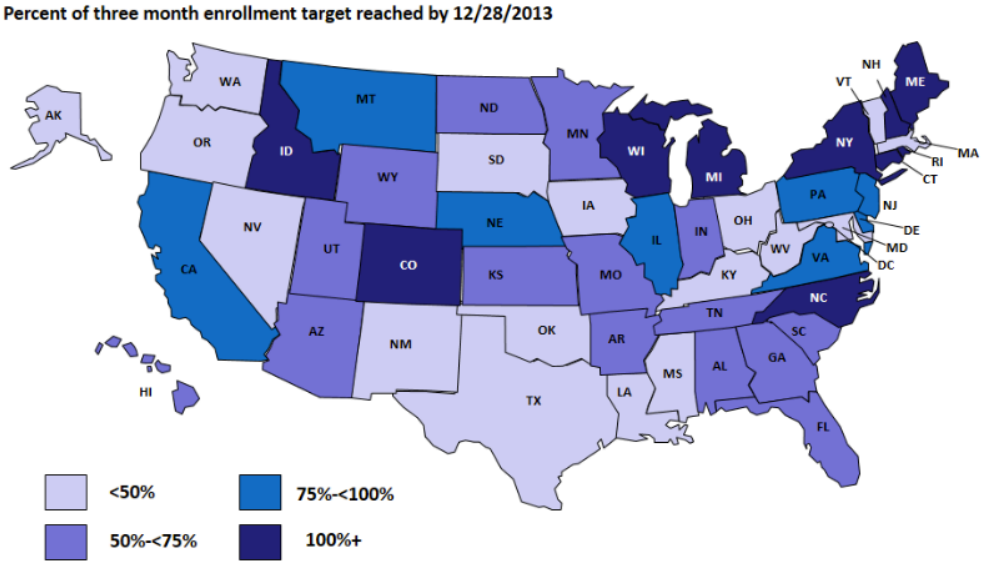


Between October and the end of December, there were 4.3 million applications through the marketplaces in all states. From these applications, 5.1 million individuals (an average of 1.2 individuals per application) were determined eligible to enroll in a marketplace plan. Since a total of 2.2 million people selected plans from the state and federal marketplaces, the balance of 2.9 million people are in the system in the marketplaces and are eligible to select a plan when they wish, but opted not to select a plan by the end of 2013. [31]

In NH, 11,446 NH residents had selected plans by the end of December. This translates to 60 percent of the CMS projected number of enrollees during the first year.[32] Thus, NH has gone from matching the federal rate of projected enrollments to doubling the national rate by the end of December. CMS projected that NH would achieve 8,930 enrollments before December 31, 2013. NH actually exceeded CMS projected enrollments by 28 percent for the first three months (Table 2). In NH, 26,621 people were determined eligible to select plans in the marketplace, which means that 15,175 residents are registered in the marketplace and eligible to select a marketplace plan, but chose not to do so by the end of 2013.

Table 2. National vs. NH total enrollment numbers (10/1/13 – 12/28/13 cumulative)		
	All states	New Hampshire
Number of people determined eligible to select plan in marketplace	5.1 million	26,621
Number of people selecting plans	2.2 million	11,446
Percent of projected enrollments (10/1/13 – 12/31/13)	69	128
Percent of projected enrollments (10/1/13 – 3/31/14)	31	60

In fact, NH was one of just ten states that met or exceeded the CMS goal for the number of enrollments in the marketplace between October and December 2013 (see figure below). The other states that met the projected number of enrollments included five state-run marketplaces in Colorado, Connecticut, Idaho, New York, and Rhode Island; three federally-facilitated marketplaces in Maine, North Carolina, and Wisconsin; and one partnership marketplace in Michigan. NH is also a partnership marketplace.



Source: Memo from Marilyn Tavenner, CMS Administrator, *Projected Monthly Enrollment Targets for Health Insurance Marketplaces in 2014*, September 5, 2013, http://waysandmeans.house.gov/uploadedfiles/enrolltargets_09052013_.pdf; *Health Insurance Marketplace: January Enrollment Report, For the Period: October 1, 2013 – December 28, 2013*, ASPE Issue Brief, U.S. Department of Health and Human Services, January 13, 2014, http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Jan2014/ib_2014jan_enrollment.pdf

Medicaid enrollment in NH is low compared to QHP enrollment

Medicaid enrollment: CBO projected Medicaid enrollments would outpace QHP enrollments at a rate of 1.3 between October 1, 2013 and March 31, 2014. In a US DHHS report of Medicaid enrollment data from October 1 to November 30, 2013, there were a total of 3.9 million new determinations for Medicaid in all fifty states.[33] This included those newly eligible for Medicaid in states that chose to expand Medicaid, and those eligible for Medicaid under prior state law but not previously enrolled.[34] This corresponds to 1.8 times the number of QHP enrollments (2.2 million), more than the projected rate of 1.3 times the number of QHP enrollments. As expected, the rate of Medicaid enrollments was much lower in NH, where there is no Medicaid expansion. In NH, 3,332 (1,763 people in October and 1,569 in November) people were determined eligible for Medicaid in the first two months of the open enrollment period.[35] The number of Medicaid enrollments was 30 percent of the number of QHP enrollments in NH (Table 3).

Table 3. National vs. NH Medicaid enrollment numbers (10/1/13 – 11/30/13 cumulative)		
	All states	NH
Number of people determined eligible for Medicaid	3.9 million	3,332
Medicaid enrollments as a fraction of QHP enrollments (projected at 1.3)	1.8	0.3

Compared to all marketplace visitors, enrollees in NH are similar but slightly older

The success of the ACA relies on the demographics of those that enroll in insurance. Diverse demographics balance the risk pool, and balanced risk controls the cost of premiums. The most recent ASPE report on enrollment data included state-specific information on several demographic indicators, including gender, age, and plan metal level. At the national level (54 percent) and in NH (54 percent), enrollees were disproportionately female (Table 3).[36] In contrast, females make up 50 percent of the US population.

Healthy enrollees are especially important for balancing risk in the insurance pool. Age of enrollees has been a closely watched demographic because it is often seen as a proxy for health status; young people are generally healthy. While health status would be a more accurate indicator of balanced risk, there is no data on the health status of enrollees. Of those selecting plans between October 1 and December 28, 24 percent nationally were between 18 and 34 years. This was comparable to their percentage of the total non-elderly population (26 percent). [37] However, it was lower than the US DHHS goal that 29 percent of new enrollees be young adults. Of note, the rate of enrollment by young adults increased faster than enrollment among other age groups in federally-facilitated marketplaces; enrollment was seven-fold greater in December compared to October and November for all age groups, and eight-fold greater for those between 18 and 34.[38] Additionally, 37 percent of enrollees were between 35 and 54 years of age and 33 percent of enrollees were between 55 and 64 years of age.[39]

In NH, enrollees were slightly older, with 38 percent of enrollees between the ages of 55 and 64. A smaller proportion of new enrollees (22 percent) were young adults, between 18 and 34, in NH.[40] However, NH has a relatively old population. In 2012, 21 percent of NH residents were under 18, compared to 24 percent nationally.[41] Additionally, 15 percent of NH residents were over 65, compared to 14 percent nationally. Similar to national numbers, the proportion of young adults enrolling was less than the US DHHS projection of 29 percent.

The breakdown of plans selected by their metal level demonstrates the degree to which new enrollees will be adequately covered by their insurance plans. Silver-level plans are the second lowest coverage plans available through the marketplace (after Gold and Platinum plans) and cover 70 to 80 percent of health care costs. Bronze plans cover less, between 60 and 70 percent of health care costs, and have the lowest monthly premiums. Platinum plans cover 90 to 100 percent of all health care costs, but have the highest monthly premiums. Cost-sharing can differ under plans of the same Metal level.[42] Finally, there are catastrophic plans, which are available to people under 30 years of age, or to those whose insurance was cancelled because the plans did not meet ACA regulations. Only people who select plans at the silver level or above are eligible to receive premium tax credits and cost-sharing.

At the national level, 60 percent of people selected a silver-level plan, 20 percent selected a bronze-level, 13 percent selected a gold-level plan, and 7 percent selected a platinum-level plans (Table 3). Finally, 1 percent of all people selected a catastrophic plan. In NH, the breakdown of plan selection was similar to national numbers. More than half (57 percent) of NH enrollees selected a silver-level plan and 22 percent selected a bronze-level plan. More NH residents selected a gold-level plan (21 percent compared to 13 percent). However, this was because there are no platinum-level insurance plans offered in the NH insurance marketplace so all those who would have purchased a platinum-level had to purchase a gold-level plan instead. Similar to the national estimate, 1 percent of NH enrollees selected a catastrophic plan.

In general, the national data looked similar to data from the 34 states implementing a federally-facilitated marketplace (FFM) as compared to the 16 states implementing a state-based marketplace (SBM). The main exception was that SBMs had a slightly lower proportion of adults between 55 and 64 years of age (Table 4).

Table 4. National, FFM, and SBM vs. NH enrollment characteristics (of those selecting a plan)

	All states	FFM (34 states)	SBM (16 states)	NH
Number selecting plans (10/1/13 – 12/28/13)	2,153,421	1,196,430	956,991	11,446
Gender (% of those selecting a plan)				
Female	54	55	53	54
Male	46	45	47	46
Age (% of those selecting a plan)				
18-34	24	23	24	22
35-54	37	36	38	36
55-64	33	35	30	38
Plan metal level (% of those selecting a plan)				
Platinum	7	7	6	Not available
Gold	13	15	10	21
Silver	60	61	57	57
Bronze	20	17	25	22
Catastrophic	1	1	1	1

Compared to all marketplace enrollees, fewer NH enrollees receive federal assistance

According to a September 2013 report from ASPE, there are 12 qualified health plans (QHP) offered in NH in 2014, all through one insurance issuer: Anthem Blue Cross Blue Shield NH. [43]

In the 36 states included in the analysis, there were an average of eight insurance issuers offering an average of 53 plans. Almost all (95 percent) Americans have two or more issuers offering plans in their state.[44] The weighted average premium cost is $359 for the lowest cost Silver plan and $360 for the second lowest cost Silver plan in NH.[45] This is slightly higher than the average of the 36 states included in the analysis, ($310 and $328, respectively).[46] The evidence supports the finding that more competition is associated with lower average premiums.[47] NHAHU is optimistic that more differentiated and affordable insurance products will be available through the marketplace when Harvard Pilgrim Health Care joins in 2015.

The number of people receiving financial assistance is one indicator of affordability of insurance for the consumer. Financial assistance for consumers comes in two forms: premium tax credits and cost-sharing. Premium tax credits are available from the federal government to low- and middle-income individuals and families who meet four eligibility criteria.[48] Recipients of premium tax credits must be U.S citizens or lawfully present in the U.S, not eligible for public insurance programs, and not have access to employer-sponsored insurance (ESI) that is adequate and affordable.[49] ESI is deemed to be adequate if it covers at least 60 percent of expected total costs for covered services; it is affordable if the portion of the annual premium that the individual must pay is less than 9.5 percent of household income.[50] Tax credits can only be applied to insurance purchased through the newly established health insurance marketplaces.

Finally, to be eligible for a premium tax credit, the individual or family must earn an annual income between 100 percent and 400 percent of the Federal Poverty Level (FPL). For an individual, this translated to an annual income between $11,490 and $45,960 in 2013. For a family of four, annual income must have been between $23,550 and $94,200 in 2013.[51] As a comparison, the median individual income in 2012 was $26,989.[52] For a four-person family, the estimated median income was $75,845 in 2013.[53] Approximately 47 percent of Americans live in households with incomes between 100 and 400 percent of FPL.[54]

National Spotlight on NH: The White House Blog released ten stories of what health reform has meant for Americans. The stories included one from Gayla W., from NH. She says, *"I lost my job last April. My partner and I both have pre-existing conditions so our only option was to COBRA my employer-provided plan -- at a cost of $1,676 a month. It was a good plan, but now we have a comparable plan through the ACA for $87 a month. I can't describe just how life changing this is for us. We can afford to live again."*

Source: Simas, David. *You Can Say This Better Than We Ever Could.* The White House Blog. January 10, 2014

In addition to premium tax credits, individuals and families with incomes between 100 and 250 percent of FPL can receive cost-sharing subsidies which decrease the amount that individuals pay at the point of service. To be eligible for cost-sharing subsidies, individuals and families must enroll in a Silver, Gold, or Platinum plan through the marketplace.[55] Individuals and families up to 150 percent of FPL are expected to contribute 6 percent of costs, individuals and families between 151 and 200 percent of FPL are expected to pay 13 percent of costs, and individuals and families between 201 and 250 percent of FPL are expected to pay 27 percent of costs.[56] The federal government then pays insurance plans directly for out-of-pocket expenses.

According to the ASPE report on cumulative enrollment between October 1 and December 28, 2013, 79 percent of those people selecting plans will receive financial assistance in the form of premium tax credits and cost-sharing (Table 5). This percentage of total

enrollments was consistent with earlier projections.[57] In NH, the percent receiving financial assistance was slightly lower than the national average at 72 percent of all enrollees.[58] The lower percentage of those receiving financial assistance could be related to the fact that NH is a relatively wealthy state. The median household income in NH between 2008 and 2012 was $64,925, compared to $53,046 at the national level.[59]

Table 5. National vs. NH enrollment characteristics (of those selecting a plan)		
	All states	NH
Number selecting plans (10/1/13 – 12/28/13)	2,153,421	11,446
Percent receiving financial assistance	79	72

There are several provisions in the ACA that are projected to increase the affordability of insurance for NH residents, although the exact impact of these measures has yet to be seen. Health insurance companies now have to spend 80 cents of each dollar consumers pay for premiums on health care or improvements to care. If insurance companies fail to do so, they must provide a refund to their consumers. According to the US DHHS, 15,407 residents in NH with private insurance coverage were projected to receive $1.7 M in refunds from insurance companies in 2013.[60] This amounts to approximately $147 per family covered. Additionally, NH received $4.6 M in federal funding to address premium increases. Under the ACA, insurance companies must publically report why they are increasing premiums by more than 10 percent.[61] Thus, the implementation of the ACA not only provides financial benefits to those newly enrolled, but also those with existing private coverage.

The affordability of insurance for NH residents must be seen as part of an overall effort to control health care expenditures. CMS recently reported that national health expenditures grew 3.7 percent in 2012, marking the fourth consecutive year of low growth in national health expenditures.[62] Health spending decreased from 17.3 percent of the Gross Domestic Product in 2011 to 17.2 percent in 2012.[63] The major contributors to the decline in growth were slow growth in prescription drugs, nursing home, private health insurance, and Medicare costs. CMS concluded that the ACA had a limited impact on the reported controlling of health care costs, largely because the major provisions of the bill had not yet been implemented in 2012. [64] Regardless, the early success in bending the cost curve suggests that as the rest of the ACA is implemented over the next few years, health care expenditures may be even further controlled.

Lessons Learned and Action Steps for February – March 31, 2014

Interviews with stakeholders provided six lessons learned from the first three months. Action steps were derived from what interviewees believed worked well, and challenges they expect to face in the remaining months of open enrollment.

Prepare appropriate communication strategy to respond to questions from consumers related to coverage details, narrow network, and information security. Consumers will likely have questions about what and how much is covered by the insurance plan they selected. NHAHU and Anthem are both concerned that consumers' expectations of what they purchased may differ from the actual product, especially with regards to cost –sharing (i.e. the deductible and copays). This will be especially true for those who have never had insurance. Consumers may also need assistance understanding the narrow network, and what providers they are able to

see. Consumers may be concerned about the security of their personal information stored and processed by HealthCare.gov, due to reports about potential lapses in security strength, despite the fact that HealthCare.gov has passed the security tests. NHAHU is also concerned about information security, indicating that concern from consumers is not unfounded. Finally, there will likely be confusion when consumers think they have enrolled in a plan but there is no record of them in the system. As foreseeable issues, assisters should prepare to address these concerns. Media efforts should be designed to preempt these issues and to inform consumers about where to access answers to these and other questions. Included in the media strategy should be education for providers about what to do in a situation where a consumer incorrectly believes he or she is covered.

Prepare appropriate communication strategy to respond to questions about viability of SHOP plans. Through the SHOP marketplace, employers receive a tax credit if employees meet a certain income threshold. According to a representative of NHAHU, few employers will meet this criterion, and those that do may opt to not offer insurance. Partners should be wary that employers may have questions about the viability of plans offered through the SHOP marketplace. NHAHU is prepared to answer these questions. Media efforts should also address this issue from the perspective of businesses.

Seek out existing collaborations between partner organizations. Some partners have come together in work groups, which include assister organizations, providers, and other community organizations. The diversity of partners has been a key to the early success of these work groups. During the regular meetings, the group of organizations discusses best practices for outreach, identifies areas in the community for each organization to focus on to avoid duplicative efforts, and develops outreach plans. These collaborations have shown early success and those involved laud their potential. Interviewees agreed that more communication is needed between assisters, producers, and other community organizations, and these collaborative teams are a promising venue for filling this need.

Partners also lauded certain regular meetings including the Voices for Health meeting of the Consumer Assistance Task Force (CATF). The meetings provide an opportunity for members to share ideas and resources. Similarly, the Exchange Advisory Board meeting is viewed as a good forum for disseminating information about marketplace progress.

National Spotlight on NH: In an effort to demonstrate the positive impact of the ACA, HealtCare.gov is collecting personal stories of new enrollees. In one of the first fifteen stories profiled nationally, Deborah, a 54-year old from Portsmouth, NH, demonstrates the story of an older adult who, for the first time, is able to afford insurance for herself and her husband. According to Deborah, they were able to pick a plan that saves them hundreds of dollars each month and "has better coverage, lower deductible, and lower co-pays."

Source: Zymet Salim. *Deborah's Story: Finding Affordable Coverage With a Pre-Existing Condition.* Department of Health and Human Services. October 22, 2013

Ensure media firm provides timely materials to partners. Partners greatly anticipate materials and information from the media firm. Although partners understand that things are moving as swiftly as possible, partners feel that this should be an immediate priority. Many partners

reported that there was still confusion among many consumers. Unfortunately, it is not just consumers of the marketplace who are unaware of the options; some potential partners are still confused, and therefore not able to appropriately counsel their clients. Partners need media efforts and materials to address concerns from both consumers and potential partners.

Partners are particularly interested in marketplace educational materials, radio and television advertisements. Among other topics, educational materials should refer to covered services and where to find out more about what services are covered and to what extent. Partners involved in enrollments of individuals are also interested in regular contact between assisters and the media firm. NHHP reports that media efforts will be among the primary focuses between now and March 31.They are working on implementing paid media, and will be conducting additional polling for where to conduct media efforts and outreach events.

Seek out those with financial interests in increased coverage. FHC has sought out financial assistance counselors at the hospitals to become champions of enrollment. Given the financial interest of the hospitals to have insured patients, the counselors have taken on the role of calling patients to schedule appointments to discuss insurance opportunities with CACs and MPAs. This takes the onus of scheduling appointments off of the assisters, freeing up their time to focus on completing enrollments and conducting outreach.

Streamline news updates and reporting for publicity. Currently, partners receive regular requests from many sources for information on progress to date, success stories, and barriers to implementation. Partners spend a great deal of time responding to these requests, often providing the same information to a number of sources. It would increase efficiency if partners were able to submit stories and reports for publicity to one centralized location. NH Voices for Health has implemented a system to collect success stories. Partners suggested that they could expand this effort to host answers to multiple questions and then partners could direct requests for information to this one location.

Conclusion

Largely due to external factors, outreach and enrollment efforts between October and December 2013 were not implemented as originally planned. October and November were characterized by the delayed start of and continued problems with rolling out HealthCare.gov. The technical difficulties posed a major challenge for assisters in an effort to enroll individuals. Moreover, the problems with the rollout undermined the credibility of the law, and assisters had to rebuild the image of HealthCare.gov, in addition to helping navigate the system for applicants. The delayed start was made more difficult by the concurrent rollout of Medicaid managed care and the late decision not to expand Medicaid in NH. Finally, the fact that the state has had a minimal role in implementing the ACA meant that efforts at the state level did not begin until September 1. Thus, many partners were focused on establishing infrastructure during the first three months, whereas other states were able to build infrastructure prior to October 1.

Despite barriers and disappointments, efforts in October through December were successful in increasing insurance coverage of NH residents. Moreover, the rate of enrollments in NH compared favorably with national statistics. NH appears to be on track according to the benchmarks set by CBO, CMS, and US DHHS (Table 6). The first benchmark was achieved

when HealthCare.gov became functional in early December. Progress on the remaining two benchmarks must be viewed in light of the fact that the first benchmark was achieved late in enrollment period. NH was one of ten states that met the benchmark of enrollments achieved by December 31, 2013; US DHHS projected that 8,930 residents would enroll, and 11,446 actually selected plans through the marketplace. While US DHHS projected that 47 percent of enrollments would happen in the first three months, NH has already achieved 60 percent of the 19,000 total projected enrollments. Since the number of applications increased exponentially in the last few weeks of 2013, it is possible that continued high levels of enrollment could result in meeting the CMS projection.

NH did not compare as favorably with the national statistics on demographics of enrollees and the rate of Medicaid enrollments (Table 6). NH did not achieve the goal that 29 percent of total enrollments would be young adults, but came relatively close with 22 percent. However, this was lower than what was achieved at the national level, suggesting that a higher rate of enrollments among young NH residents is possible. As expected, NH did not match the rate of Medicaid enrollments as a proportion of QHP enrollments that was achieved nationally. The third benchmark is not yet possible to assess, as it will require updated information on the proportion of NH residents that are uninsured. This information is due to be released in September 2014.

Table 6. Reconciliation of NH Benchmarks

Benchmark		Met in NH?
Functional marketplace	Residents able to select plans and enroll in insurance through HealthCare.gov by 12/15/13 (Commonwealth Fund)	Yes
Number of enrollees	8,930 NH residents enroll in QHPs between 10/1/13 and 12/31/13 (CMS)	Yes; NH was one of 10 states that met or exceeded projected QHP enrollments in first three months
	29 percent of new enrollees are between 18-34 (US DHHS)	No; 22 percent of enrollees were between 18-34
	Medicaid enrollments match QHP enrollments at rate of 1.3 (CBO)	No; rate was 0.14, likely due to lack of Medicaid expansion
Number of uninsured	Number of uninsured in NH drops by 47,040 (32 percent of 147,000) in 2014 (CBO)	Unknown until September 2014

With regards to affordability, NH does not compare favorably with the national statistic. Nationally, 79 percent of enrollees accessed federal assistance for premiums. In contrast, only 72 percent of enrollees in NH were eligible for federal assistance. This suggests that further efforts to reach lower-income groups are needed in NH. Partners were optimistic that the introduction of Harvard Pilgrim Health Care insurance plans in 2015 will positively affect the marketplace by providing more plan diversity and more competition to control the costs of premiums. While lower-income groups appear to be underrepresented, it seems that all geographic regions are adequately covered by efforts. Interviewees did not feel that any county or region was underrepresented by efforts, and partner collaborations now exist to ensure that this remains true.

Some partners believed that the progress achieved was possible because many partners had taken initiative to begin consumer assistance efforts before there was state involvement. Prior to September 1, organizations had begun conducting outreach events, training staff to become CACs, and planning enrollment efforts. In addition to independent – and often unfunded

– efforts, HNH Foundation contracted with JSI in September and October to analyze the uninsured populations and provide a baseline gap analysis; this information has been critical for partners like NHHP and the assister organizations.

Lessons learned from the first three months of the open enrollment period yielded seven action items for February and March 2014. First, assisters should prepare to answer questions from consumers related to coverage details, the narrow network, and information security. Furthermore, the media firm should prepare a communication strategy to respond to, and if possible, preempt confusion about these issues. Similarly, assisters and the media firm should prepare for concern from businesses about the SHOP marketplace, and particularly questions about the viability of SHOP plans. General media materials and messaging should be made available to partners in a timely fashion.

There have been a number of successful strategies that have developed in the first three months that should be leveraged and promoted in the future. For example, collaborations between partner organizations have emerged; other partner organizations looking to streamline outreach efforts should seek out these existing collaborations. Partners should also seek those with a financial interest in increasing insurance coverage to assist with outreach efforts. Finally, partners would benefit from an organization taking the initiative to serve as a collector and distributor of news updates and success stories. Given the demand for such stories, having one organization that could respond to media requests would free up time and energy of assister organizations to focus on reaching consumers.

Certainly, not all problems with the website have been solved, and partners foresee some serious areas of confusion with regards to the extent benefits are covered, the narrow network, information security, and the SHOP marketplace. However, despite these issues and the slow pace of the initial rollout of the insurance marketplace, partners agreed that the state of the implementation of the insurance marketplace has improved drastically and are optimistic about the progress that can be made in the next three months.

Appendix

Interview Guide - Status Update on Implementing Health Insurance Marketplace

Introduction

Thank you for taking the time to speak with me today. As I mentioned in my email, HNH Foundation has contracted with JSI to document the progress to date in implementing the insurance marketplace in NH, and to identify any ongoing gaps. The findings of this interview will be summarized with other interviews with key partners in a status update report. The report is intended to provide a complete picture of what is happening in the state and will be made available to partners so they can use the information to make any necessary changes before March 31st.

Do you have any questions before we begin?

Progress to date

- What activities have been the primary focus of [ORGANIZATION] between October 1 and December 31?
- With regards to [ORGANIZATION], what have been the major milestones in implementing the insurance marketplace since October 1?
- Do you report or collect data on enrollment activities?
    - To whom do you report? What information do you report?
    - OR What do you collect? From who and how do you collect?
- Did you/[ORGANIZATION] use the materials developed by JSI during this period, including the map of the uninsured, the directory of assisters, the analysis of where additional resources were needed, the list of best practices etc.?

Successes

- Were outreach and enrollment efforts generally implemented as planned?
- What specific activities that [ORGANIZATION] has participated in or conducted have been most successful in enrolling individuals or small businesses?
- How would you rate the overall progress to date in enrolling individuals in the marketplace, and why?

Barriers

- Between October 1 and December 31, what have been the major barriers to increasing enrollment for you/[ORGANIZATION]?
- (If necessary/relevant) What has been the impact of the following issues on increasing enrollment?
    - The federal rollout of the marketplace/website
    - Changing cut off dates for enrollment/payment
    - Medicaid managed care
    - Medicaid expansion debate
- To what extent are these previously discussed barriers ongoing?

- Are there any other ongoing barriers to increasing enrollment?
    - Who is currently not being reached by efforts?
    - Is there any sense of areas (i.e. counties) in the state that are left underserved?

Next Steps

- What activities does [ORGANIZATION] have planned between now and March 31?
    - How are your planned activities designed to address the gaps you've identified?
- What information or additional resources would be useful to you before March 31?
- What advice do you/[ORGANIZATION] have for increasing the efficiency and effectiveness of enrolling NH residents before March 31?

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