Promoting Access to Health Insurance through a Multistate Extension Collaboration

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This paper describes a multistate project that addressed the growing need for health insurance information for individuals by focusing on the Affordable Care Act (ACA) and health insurance education and outreach efforts in targeted areas of the country in federally-facilitated marketplaces with high numbers of uninsured and underinsured individuals. Specifically, the project provided ACA and health insurance information to individuals in formal and informal settings to assist them in choosing a health insurance plan through the Marketplace. Education and outreach activities included group workshops and presentations, Q&A sessions, and panel discussions; one-on-one in-person consultations, phone consultations, and email consultations; and information provided through websites, blog posts, Facebook posts, tweets, YouTube videos, email blasts, newsletters, newspaper articles, and radio and TV programs. Health insurance enrollment assistance was provided by volunteers and some Extension educators or referrals were made to Navigators or Certified Application Counselors for enrollment assistance.

Keywords: Affordable Care Act, health insurance education, Marketplace, uninsured, underinsured

Having health insurance coverage is considered an important necessity because the lack of coverage can have severe physical and financial consequences on the individual such as prolonged illness, bankruptcy, and even premature death (Gius, 2010). However, before the enactment of the Affordable Care Act (ACA), research showed a declining trend in the percentage of insured persons over the past decade and varying indicators for lack of coverage among households including age, employment, income status, cost, and health status (Callahan & Cooper, 2005; Collins, Davis, & Ho, 2005; Gruber, 2008). Reports from the Kaiser Family Foundation (2015) showed that 55% of nonelderly Americans had employer-sponsored coverage in 2013 compared to 63% in 2004. The reports also showed that in 2013, an estimated 48% of

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the total U.S. population had employer coverage, 6% had private coverage, 33% had public coverage, and the remaining 13% were uninsured (Kaiser Family Foundation, 2015). With the rising cost of healthcare and the ACA requirement to purchase health insurance or face penalties, most U.S. households are confronted with the complex decision of choosing affordable health insurance coverage.

Research also shows many individuals have literacy and numeracy limitations that make navigating the health care system difficult when trying to find and use information to assist them in choosing a health insurance plan. Very few individuals understand basic health insurance concepts such as coinsurance, premiums, and deductibles (Kenney, Karpman, & Long 2013; Long, Shartzer, & Politi, 2014). Buying health insurance is especially a challenge for individuals with limited financial, health, and health insurance literacy (Huston, 2010; Tennyson, 2011). According to Quincy (2012), health insurance literacy is "the degree to which individuals have the knowledge, ability, and confidence to find, use, and evaluate information in health insurance plans, choose the plan that best meets their and their family's needs based on their financial situation and health status, and use the health insurance once purchased" (p. 7). Given that limited health insurance literacy can lead to challenges in choosing a health insurance plan, there is a growing need for health insurance education and outreach. Health insurance literacy of individuals, especially uninsured and underinsured individuals who are just starting to select health insurance plans, is more important than ever.

This paper describes a multistate project funded through a competitive grant from U.S. Department of Agriculture National Institute of Food and Agriculture (USDA NIFA) with the goal of assisting as many uninsured and underinsured individuals as possible with purchasing a health insurance plan through the Marketplace. The Marketplace is where individuals shop and enroll in health insurance plans. It is operated by the federal government in most states, but is state-run in some states (Centers for Medicare & Medicaid Services, 2016).

To achieve this goal, Extension educators and volunteers provided both informal and formal outreach to provide individuals with ACA and health insurance information that would be helpful in this process. Volunteers and some Extension educators provided enrollment assistance. When it was not possible to provide enrollment assistance, Extension educators referred individuals to Navigators and Certified Application Counselors (CACs). Navigators and CACs were hired by organizations and agencies who applied and received grant funds from CMS to provide enrollment assistance to individuals purchasing insurance in the Marketplace. The project targeted areas of the country with high numbers of uninsured and underinsured individuals in federally-facilitated marketplaces. The specific objectives of the project were to 1) educate uninsured and underinsured individuals about health insurance terminology and their healthcare options, 2) provide individuals with resources to make informed decisions regarding their health insurance coverage, and 3) provide information about new options that are the result

of passage of the ACA, as well as enhancements to existing programs such as Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

Project Overview

During the first open-enrollment period (2013–2014), 12 states in federally-facilitated marketplaces, identified as having high uninsured and underinsured populations, were selected to participate in the project. These states were Alabama, Florida, Georgia, Kansas, Michigan, Missouri, North Carolina, Pennsylvania, Tennessee, Texas, West Virginia, and Wisconsin. Project participants were Cooperative Extension state specialists, county and regional educators, and volunteers. The University of Georgia (UGA) Cooperative Extension served as the lead institution, and Extension at universities in other states were partnering institutions. The person who served as the project coordinator in each state was required to attend a one-day training in Washington D.C. facilitated by the project coordinator at the lead institution and USDA NIFA. Ongoing training was provided throughout the project by the lead institution via webinars and weekly conference calls. After the one-day training, project coordinators recruited Extension educators and/or volunteers to work with consumers in their respective states. Approximately 300 Extension educators and volunteers across the 12 states were recruited to provide ACA and health insurance education and/or information and outreach in 500 counties across the nation. Project coordinators, Extension educators, and volunteers were required to complete the CAC online training provided by CMS prior to participation in the project.

The funding agency encouraged project coordinators to use the ACA and health insurance resources already developed by CMS. However, because Extension is different in each state and the needs of audiences varied, each state could use additional resources that worked best with their audiences and the types of education and/or outreach provided. Some project coordinators used their own resources, while others used resources created by the project coordinator in the lead state, *Smart Choice Health Insurance*© (University of Maryland Extension, 2016), *Making a Smart Choice for Farm Families* (Riportella & O'Neill, 2015), and AARP resources. Each project coordinator facilitated statewide education, outreach, and enrollment activities in his/her state; conducted in-person and/or online training events for Extension educators and volunteers; and provided ACA and health insurance resources, materials, and support.

Both direct and indirect education and outreach was provided to individuals. Direct education and outreach for groups included educational workshops and presentations, Q&A sessions, and panel discussions. Individual outreach was done through one-on-one in-person consultations, phone consultations, and email communication. Indirect education and outreach consisted of providing information through websites, blog posts, Facebook posts, tweets, YouTube videos, email blasts, newsletters, newspaper articles, and radio and TV programs. Educators and volunteers collaborated with state and local agencies to provide enrollment assistance events and

educational information sessions, as well as to disseminate educational materials. Flyers and other materials were also distributed at community events such as health fairs, job fairs, etc. Enrollment assistance was provided by volunteers and Extension educators in one state. However, Extension educators were not allowed to provide enrollment assistance in the other states. In these states, consumers were referred to Navigators or CACs for enrollment assistance.

Both ACA and health insurance information were provided to consumers. ACA topics included the requirement to purchase health insurance; major provisions of the ACA; and information about the Marketplace, coverage options, penalties for not obtaining coverage, exemptions available, premium tax credits, and cost sharing subsidies. Health insurance topics included types of health insurance plans; important health insurance terms and concepts such as deductibles, coinsurance, copayments, etc.; and examples of how health insurance works.

The funding agency required weekly reports. Project activities were measured using an online survey (Qualtrics) link that was sent to all participating universities to complete each week. Each university provided weekly data for aggregation to the lead institution on types of education and outreach conducted, number of consumers reached at each event, consumer referral or enrollment assistance, distribution of materials, consumers' comments, key successes, and problems and obstacles. Each university also reported on additional counties served, educators and volunteers recruited and trained, supplemental materials used in addition to CMS materials, and expanding partnerships and collaborative events. Data to determine the impact of the education and outreach on consumers' knowledge and behavior were not obtained.

Project Outcomes

A total of about 4,820 direct health education and outreach activities reached 39,303 individuals from all participating universities. Of the consumers reached, 10,749 were young adults (18–35 years old), and 3,470 had a primary language other than English. These activities included direct group educational and collaborative events such as workshops and presentations, Q&A sessions, panel discussions, and other community education and outreach events. In addition to group activities, individuals were reached through direct one-on-one activities such as in-person, phone, and e-mail consultations.

Health insurance information was provided to another 60,000 people through dissemination of materials including information tables at health fairs, job fairs, Volunteer Income Tax Assistance (VITA) sites, and other similar events. Over 2.5 million individuals were also reached indirectly with educational and enrollment assistance and referral information through websites, blog posts, Facebook posts, tweets, YouTube videos, email blasts, local TV and radio programs, newsletters, and newspaper articles. Further, 39,357 individuals were provided direct health insurance enrollment assistance through volunteers, and Extension educators in one state or referred to

health insurance Navigators, CACs, or agencies for enrollment assistance if Extension educators were not allowed to provide enrollment assistance.

Extension educators were asked to provide success stories when they did their weekly reporting, but there was no systematic process for collecting comments from individuals who participated in the education and outreach. However, educators shared many positive comments from participants in their education and outreach. Based on the comments, some individuals could obtain health insurance for the first time in as many as 10–15 years, and some had premiums as low as $25 per month. Some expressed a better understanding of the premium tax credit, cost-sharing subsidy, penalties for not obtaining coverage, and exemptions for certain groups of individuals as well as how the ACA impacts their individual or family's financial decisions. Some positive comments received from educators follow:

- *A consumer who attended a Smart Choice workshop said she was so confused and scared in the past that doing nothing and going without health insurance was easier than trying to buy it, but now she has confidence in how to compare plans and was ready to purchase health insurance.*
- *A small business owner was able to enroll at a reasonable premium with the help of a Navigator who visited his church to offer enrollment education and assistance. He made an announcement about the Navigator's help at a church meeting, and a dozen others also announced they were able to enroll with the help of a Navigator.*
- *A college student who was losing her health insurance and just found out she was pregnant was very grateful for the information provided and the referral to a Navigator.*
- *A consumer had previously been uninsurable due to pre-existing conditions and was very excited to have affordable health coverage.*

Limitations and Recommendations

There were challenges and limitations to implementing the project that are important to note. Program evaluation is an important component of any education and outreach, but with this multistate project, impact data were not obtained. The design, development, implementation, and evaluation of the project was substantially coordinated by the funding agency, and the type of data reported by the partnering institutions to the lead institution was very specific and did not allow for evidence-based conclusions. Data had to be reported quickly, and time did not allow for data collection to determine impact. In addition, there was no systematic method used to collect the qualitative data. Educators were only asked to report success stories. The inability of some Extension educators to provide health insurance enrollment assistance was another limitation. Because of the political nature of the ACA in most states, Extension educators in all states except one were not allowed to provide enrollment assistance and were only able to refer

individuals to enrollment assisters. Another limitation was recruiting attendees for in-person group workshops and presentations.

Even with the limitations of the project, some recommendations can be made to overcome limitations such as in-person access to deliver education. Extension educators can continue to provide ACA and health insurance education and outreach to individuals and assist with health insurance enrollment. If educators are allowed to provide education, but not enrollment assistance, recruiting and training volunteers and/or referring individuals to Navigators or CACs may be options. Educators can work with Navigator and CAC agencies to offer health insurance education and enrollment sessions together similar to what is done at some VITA sites. Tax return preparation is an optimal time to provide financial education as individuals will be present. Likewise, individuals are more likely to show up to obtain assistance with health insurance enrollment providing an opportunity for health insurance education to be provided at that time. Working with Navigators, CACs, and other community groups will assist educators in finding audiences to teach about purchasing and using health insurance. Educators can teach about choosing a health insurance plan at the education and enrollment sessions and follow up with individuals later to provide a workshop or presentation on how to use health insurance. Both quantitative and qualitative data could be collected at the education and enrollment session and later at the follow-up to evaluate the effectiveness of the educational sessions.

Conclusions

Some low-income households did not qualify for the premium tax credit and were exempt from the penalty for lack of health insurance because their incomes fell below the Federal Poverty Line (FPL). Most of these consumers who resided in states that expanded Medicaid eligibility qualified for Medicaid coverage. However, there were still many eligible individuals who did not enroll in a health insurance plan. Although it was not clear, at the time of the project, why many eligible individuals remained uninsured, lack of knowledge about their eligibility and historic enrollment barriers could offer some possible explanations. Future education, outreach, and enrollment efforts could play an important role in assisting households and individuals in gaining more competence in making health insurance purchase decisions.

This multistate project has ended, but Extension can continue to play a vital role in promoting health insurance literacy. Kim, Braun, and Williams (2013) conducted a health insurance curricula and material review and found that Extension in only a few states had curricula for adults. They also found that nonprofit organizations, foundations, and state and federal governments also created health insurance educational programs and information. The materials created by these entities were primarily informational and not skills-based, the development and testing of materials were not usually based on research, and a standardized evaluation instrument was not available to evaluate their effectiveness.

Extension in several states, including Maryland, Missouri, and Wisconsin, began health insurance initiatives and programs before this multistate project was funded, and these initiatives and programs continue. For example, the University of Maryland created the *Smart Choice Health Insurance*© curriculum and trained educators throughout the U.S. to deliver the program. The University of Missouri created the *Health Insurance Education: Options for You and Your Family* program, and The University of Wisconsin had initiatives called *Covering Kids and Families* and *Covering Wisconsin*. The *Smart Choice* health insurance curriculum in Maryland provides important evidence of continued educational efforts by Extension educators and changes in health insurance literacy among individuals who participate in the program. According to Brown et al. (2016), between August and November 2013, 89 educators in 25 states were certified to teach the *Smart Choice* curriculum, and in 2015, almost 200 educators in 31 states had been trained. Data collected from 994 participants of the *Smart Choice* program in seven states between September 2013 and April 2014 showed that participation in the program increased participants' confidence and capability to make a smart health insurance choice for their family (Brown et al., 2016). Although impact data were not collected during the multistate project reported in this article, data from the *Smart Choice* program provide evidence that education and outreach can be effective in increasing the health insurance literacy of individuals (Bartholomae, Russell, Braun, & McCoy, 2016).

Because individuals must re-enroll in health insurance coverage each year and learn how to effectively use their coverage, there is still a lot of work that Extension needs to do nationally to assist individuals with choosing and using their health insurance coverage. The role of Extension in addressing the health insurance literacy needs of consumers is so important that the Cooperative Extension National Framework for Health and Wellness identified health insurance literacy as one of six priorities (Braun et al., 2014). To assure that the priority was put into action, the Extension Committee on Organization and Policy (ECOP) appointed a Health Insurance Literacy Action Team. In early 2016, the team submitted recommendations on health insurance literacy education and outreach for the national Cooperative Extension system.

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