Implementing the Affordable Care Act: Examining Outreach and Navigation Contracting in State-Based Exchanges

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INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010. Its primary goal was to extend affordable and quality public and private health insurance coverage as widely as possible and to contain growth in health care spending through new regulations on consumer protections, creation of insurance marketplaces, individual mandates for purchasing health care, Medicaid expansion, and other reforms. The implementation of the ACA involves a complex system of formal and informal arrangements among federal, state, nonprofit, nongovernmental, and private institutions. One of the key requirements of the law was the establishment of healthcare marketplace exchanges through which individuals could review and purchase health care coverage (Sebelius Testimony, October 30, 2013). To enroll qualified people, states were given the option to construct their own exchanges or use the federal exchange – Healthcare.gov. Thirteen states opted to create their own marketplaces, while the rest rely on the federal marketplace exchange, which provides portals for state-specific plans and premiums.

Importantly, the ACA has generated significant state contracting activity for various functions including the exchanges. Successes and failures of the information technology contracts awarded by state and federal agencies to implement health exchange web sites have been widely publicized in the media and investigated in the academic literature. Less is known about another key aspect of the ACA implementation that involved significant contracting activity: outreach and enrollment services designed to “take-up” eligible uninsured individuals. Regardless of states’ decisions on type of marketplace exchange, the law required all to establish navigator programs for outreach and education, and gave the option to establish separate IPA
(in-person assistance) programs to help individuals with applications and enrollment.¹ All states received substantial federal funding to support their outreach and enrollment programs, and most states contracted these functions to nongovernmental organizations, many of which in turn subcontracted with other entities.

The ACA is unique in terms of scope, political visibility, legal context, and the roles of tax incentives and private insurance companies. The objective of this study is to analyze the implementation of this landmark law with a particular focus on states’ contracted outreach and enrollment services. We examined these dynamics in six states. All six states constructed their own state marketplace exchanges, and each expanded Medicaid, as originally required in law, to “capture” individuals with incomes above existing Medicaid eligibility levels, but below ACA premium subsidy thresholds. While the requirement for Medicaid expansion was eliminated due to the Supreme Court’s 2012 National Federation of Independent Business v. Sebelius decision, our sample states retained Medicaid expansion voluntarily as an essential element of their insurance expansion strategy. In order to capture the contractual elements relevant to implementation, we collected state-level data on outreach and enrollment systems’ administrative infrastructure and contract design. We also gathered perceptual data from key implementation actors, on the strengths and weaknesses of state implementation experiences and the quality of outreach and navigation services.

In the next section, we review the existing scholarship on government contracting with a focus on the context of intergovernmental programs. Next, we describe our research methods,

¹ In some states, navigators do both, in others, navigators are restricted to outreach and education but contract with assisters for enrollment, and in some states, both types of programs cover all elements of outreach, education, and enrollment (Kaiser Family Foundation, 2013). Private insurance brokers also served as assisters through marketplace exchange contracts (Corlette et al 2015). Our analysis did not distinguish among the formal types of outreach/educators/assisters, but focused instead on each state’s overall system for reaching, educating, and enrolling eligible individuals.
followed by brief introductory summaries of the marketplaces for each state included in this study. Next, we present our findings. The discussion section synthesizes the preliminary results from all participating states and identifies emergent patterns. Our objective is to draw some preliminary conclusions so that, as we continue our data collection and analysis, we can proceed to formulating testable hypotheses about how the ACA’s implementation was shaped, why it has evolved as it has since its inception, and how it explains variation in states’ enrollment patterns.

BACKGROUND

**Contracting and Intergovernmental Programs**

The United States has a long tradition of reliance on the private sector for the delivery of public services (Savas 2000), and currently spends over $530 billion annually on federal, state and local contracts (Amey 2012). Intergovernmental programs, administered jointly by the federal and state governments generate significant contracting/outsourcing activity. Much of this manifests in the area of social welfare policy through contracts for services and case management for welfare to work programs, child welfare, Medicaid and other health and human services. The ACA – the largest social welfare and health policy in decades – also relies heavily on contracts, including those for the insurance marketplace exchanges that generated high-profile federal and state failures upon initial implementation. Responsibility for key aspects of the law’s implementation was delegated to states, which in turn contracted with a variety of public and private actors to implement these functions. Many of these actors then entered into subcontracts. This phenomenon is sometimes referred to as “contractual devolution” (Nathan and Gais 1998). Accelerated use of private service delivery and the consequent “hollowing out” of government
capacity, often even for critical functions such as program design, has been argued to reduce
government’s role to program oversight and coordination (Milward and Provan 2000).

There is a substantial body of research that examines the dynamics of third party
governance and privatization in a variety of areas such as nonprofit nursing homes
(Amirkhanyan et al 2008; Amirkhanyan 2008, 2007), local transit systems (Zullo 2008), child
welfare and other social welfare systems (Johnston and Romzek 2008; Romzek and Johnston
2005), municipal services (Johnston and Girth 2012; Girth et al 2012; Brown and Potoski 2003)
and mental health systems (Milward et al 2010). This research indicates that privatization
challenges are often related to the accountability barriers and transaction costs inherent in
network management (Williamson 1999; Frederickson and Stazyk 2010; Johnston and Romzek
2010; Romzek and Johnston 2005). While one ostensibly positive feature of contracting is a
higher degree of flexibility, the management and oversight of contractual arrangements are often
complex yet inadequately planned, measured, or understood, undermining the purported cost
savings of contracting out and simultaneously raising the salience of accountability structures
that may have been weakened and “hollowed” (Milward and Provan 2002; Kelman 2002;
Johnston and Romzek 2010; Johnston and Girth 2012; Amirkhanyan, Meier, and O’Toole 2016).

Scholars have also provided insights into specific aspects of contract performance
(Fernandez, 2009; Amirkhanyan, Kim and Lambright, 2008; Amirkhanyan 2009). While
performance contracting might help to mitigate agency problems, in fact many contracts are
more collaborative in nature yet generate high transaction costs (deHoog 1981; Johnston and
Romzek 2010) related to the oversight of “incomplete” contracts that lack the clarity, in terms of
production processes and outcomes, characteristic of private sector contracts. Aligning the
incentives of the contract agency with governmental objectives is particularly demanding, and
amplifies the management barriers cited in the literature on street-level bureaucracy and bureaucratic discretion (Lipsky 1980). However, the common mission shared by the ACA and many of the navigator/assister organizations – the expansion of health insurance coverage to uninsured individuals – has the potential to mitigate some of this concern and to facilitate a more cooperative approach to contracting while moderating contract transaction costs through formal and informal collaborative strategies (Romzek et al 2012; 2014).

**Government Contracting in the Context of the Affordable Care Act**

For contracts in intergovernmental programs, complexity is an inevitable consequence of grafting new regulatory and administrative infrastructure onto already complex frameworks that encompass a multitude of organizational entities, programs, and individual actors across sectors and governments; in the context of the ACA, these include institutions related to Medicaid, public health, and state-regulated health insurance industries, among others. Further, the many pathways for individuals to acquire health insurance for states operating exchanges has produced numerous informational hurdles that defy simple remedies or facile formulae for linking contractor performance with enrollment outcomes. As data become available on states’ performance in “taking up,” or enrolling eligible individuals, policy-makers will benefit from clarity on how and why some states do better than others on this essential program element.

Another salient feature of the ACA implementation environment is the level of uncertainty surrounding the future political and financial direction of the program. As the initial federal grants for navigation and outreach expire, states with market exchanges are grappling with both the mechanics and level of funding of future navigation and outreach services. The uncertainty of funding and the short-term nature of navigation and outreach contracts with nonprofits may be pertinent to the initial planning and implementation of outreach and
enrollment assistance services (Johnston and Romzek 2005), and to subsequent state success in enrolling eligible individuals.

Government contracting has important implications for the size and the scope of the public sector and public programs. The ACA provides a compelling case to analyze policy implementation by examining the effectiveness of the full range of state contracts for essential program services, such as outreach and enrollment, and ultimately, the construction and operation of marketplace exchange infrastructures.

Against this backdrop, our inquiry focuses on several key elements of the ACA implementation in the states, including states’ administrative or management infrastructure for ACA navigation and outreach; the range and types of contracts used; elements of contract design (length; subcontractor provisions, etc); the strength, weaknesses and best practices of implementation experiences, and subjective assessments of outreach and enrollment systems’ quality by key implementation actors.

METHODS

Study Sites

We examine the ACA’s implementation in a sample of six states: Colorado, Connecticut, Kentucky, Maryland, Minnesota, and New York. We selected these states from the population of thirteen states that created their own exchanges, based on geographic diversity as well as variation in the initial performance of the ACA state-based marketplace exchanges. Our interest in the law’s implementation and the impact of contracting led us to consider states that had different initial experiences with their contracted marketplace exchanges, with the expectation that the performance of outreach and enrollment contracts might be related. The six sample states vary on several dimensions, yet the small number of states that constructed their own
exchanges reduced our capacity to select states with similarities, such as size or socio-economic factors, that could serve as “controls.” Nonetheless, in the context of this research, our sample does for a key source of potential implementation variation – namely the expansion of Medicaid eligibility as encouraged by the ACA. Connecticut, Kentucky, and New York have been widely judged as successful in terms of the initial launch of the marketplace exchange, through which insurance purchases were made. In terms of enrollment success, one evaluation of exchange and enrollment effectiveness is provided by the Urban Institute’s (2015) data on state enrollments as a percentage of Urban’s enrollment projections, which presents Colorado and Minnesota as performing below average. In Tables 1 and 2, we first present a snapshot of essential elements of the six states’ ACA implementation structures, and then more detailed descriptions.

[Tables 1 and 2 about here]

**Interview Strategy and Instrument**

Within each state, we sought to maximize the range of perspectives captured in our sample by reaching out to exchange staff, state employees representing departments that interfaced with the exchange, organizations that contracted with (or received grants from) the states to deliver navigation and outreach services, as well as subcontractor agencies, when possible, and advocacy organizations. We employed a snowball sampling strategy. To date, we have completed 40 interviews across the 6 states. Interview data collection began in December 2015 and is still underway. Most interviews have been conducted by phone. All interviews were recorded, transcribed, extracted, coded, and analyzed using NVivo10. Table 3 provides details on interview respondents.

[Table 3 about here]
The interview instrument (Appendix A) consists of open-ended questions designed to capture the perspective of the respondent on the implementation of ACA related navigation and outreach services within the context of the broader state ACA implementation experience. The instrument is built around the key question identified at the end of the preceding section. Although our approach is preponderantly inductive by nature, we include deductive elements as well (in the form of questions the answers to which we expect to correlate with perceptions of overall effectiveness).

FINDINGS

We begin the findings section by discussing the basic administrative and management infrastructure related to the ACA implementation in each state. This background elaborates on the information presented in Tables 1 and 2, based on our interviews. Next, we present information on the states’ experiences with contracting for outreach/enrollment services. We then describe the perceived strengths, weaknesses and overall quality of these implementation efforts.

Administrative and Management Infrastructure Related to ACA Implementation

**Colorado.** Connect for Health Colorado (CHC), Colorado’s exchange, is a quasi-governmental agency, governed by an oversight board, and funded primarily through assessment on private health insurance plans in Colorado. In Colorado, numerous state agencies have been involved in the ACA implementation, outreach and navigation services, including the Department of Human Services, Department of Regulatory Affairs, Department of Public Health and Environment, and the Colorado Department of Health Care Policy and Financing, which administers Colorado’s Medicaid Program.

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2 This premium fee is modeled on one that existed prior to Connect for Health Colorado, used for funding a health insurance subsidy program – CoverColorado - which was phased out with the enactment of the ACA.
Within the CHC marketplace, the Community Based Assistance Program played a key role through an **assistor’s network manager** (overseeing a network of partnerships with coverage guides – the navigators – and community based organizations that managed assistor sites) and a **certified application counselor/coordinator** (overseeing community based organizations with several hundreds of assisters (known in Colorado law as certified application counselors). The Community Based Assistance Program was supported by CHC as well as the Colorado Health Foundation, a large philanthropy in the state supporting ACA-related outreach and enrollment activities.

CHC relied on several types of entities to implement the ACA: navigators, certified application assistance sites, private health insurance brokers, eligibility sites, and Medicaid enrollment assistance sites. Navigators educated the consumers about health coverage options, shared information, and assisted with enrollment and/or referred to other assisters in the local area. The county governments, the Medicaid assistance sites, the brokers and certified application counselors were all encouraged to provide outreach to eligible unenrolled persons. The majority of the navigators were not certified to provide Medicaid enrollment services, while Medicaid enrollment assistance sites were typically not certified by CHC as navigators or as assisters. The certified application assistance sites, staffed with assisters trained by the Medicaid Program, provided information and assistance with the CHC marketplace application process.

The Colorado Department of Health Care Policy and Financing (HCPF) awarded contracts to over sixty counties in the state to administer CHC eligibility determination. The Colorado State Department of Public Health and Environment, while not directly dealing with health insurance coverage, used local public health officers to spread information about enrolling
in expanded Medicaid or marketplace coverage. Thus, the local public health officers also represented “some of the boots on the ground.”

The presumptive eligibility sites, also administered by the Medicaid Program, provided assistance to individuals with emergent medical needs, such as pregnant women and children. Some assistance sites were not contracted, but received certification and training to provide unpaid assistance with Medicaid and other health plans. On the private insurance side, Connect for Health Colorado had a broker network of approximately 3,000 brokers across the state.

**Connecticut.** In Connecticut, outreach and enrollment functions were handled by the Office of Healthcare Access, as well as the Office of the Healthcare Advocate, in partnership with the marketplace, Access Health Connecticut. Initially, a team of four staff members worked on acquiring funding, developing a training program, collecting data, planning outreach, and coordinating other efforts. The Office of Healthcare Access, as well as the Office of the Healthcare Advocate handled contracts with the navigator and assister organizations: they prepared a request for proposals and came up with criteria for selecting the navigator and the assister organizations. Connecticut relied on six regional navigators (with contracts of around $65,000 each) that played a critical role in educating and enrolling individuals. Each navigator organization managed several counties and served as a coordination point for neighborhood-based assisters based in individual community-based organizations. The assister groups were mapped and selected based on the number of uninsured in each zip code. The navigators were in charge of convening the assisters within the region. They served as central hub for information distribution and support for the assisters in the field. Navigator coordinators based in the navigator organizations (hired by Access Health CT) ensured additional supervision for the
activities of navigators and helped fix day-to-day problems. A special web site for the navigators and assisters was created for communication and information sharing.

Navigator organizations certified their staff as well as community-based assisters through specialized training. While some assisters worked under contracts, a range of community stakeholders signed up to help consumers as volunteers. Persons working at community health centers, hospitals, barber shops, salons and spas, church secretaries, staff at sports organizations, were recruited to provide outreach. Additionally, some bricks-and-mortars stores focusing on information technology assisted individuals with the enrollment process.

Navigator services were funded by a federal grant received in response to a joint proposal from the Office of the Healthcare Advocate and Access Health Connecticut, as well as by funding from private foundations: Connecticut Health Foundation and Universal Healthcare Foundation. Also, federal funds were used to equip assisters with laptops and Wi-Fi (allowing them connect to the portal) and to compensate them for enrolling individuals. Several respondents commented on tensions and issues associated with enrolling people in the Medicaid Program as opposed to Access Health CT.

Kentucky. With the creation of the Kentucky Office of Health Benefit and Information Exchange (KOHBIE), the Board of Public Health formed an ACA Committee, as well as subcommittees targeting areas such as enrollment, health literacy, and others. The Enrollment Subcommittee brought numerous state-level players together monthly to strategize on the emergent issues, discuss the implementation of the ACA, and troubleshoot problems. The staff of the Department for Community Based Services and the Department of Medicaid Services were closely involved in case management for eligible community members. The ACA Committee implemented enrollment, outreach and education through regional contracts. Finally,
the Office of Kentucky's Health Exchange includes (among others) the Division of Education and Outreach, responsible for consumer assistance efforts related to the Exchange.

Outreach, education, and enrollment were implemented with the help of state navigators: Kynectors. Kynectors performed outreach and education to raise awareness of the ACA and the Kynect exchange. They also assisted individuals in comparing health coverage options and facilitating enrollment. Respondents noted that the Kynector contracts, as well as the coordination, resources and materials provided to them, were a real strength of Kentucky’s efforts to educate and enroll more citizens. Kynectors spent a significant amount of time in the communities, reaching people “out in the trenches.” Kynectors were assigned to eight separate regions of the state. They reached out to numerous local entities: social service providers, human service providers, medical healthcare agencies, and other organization to recruit certified application counselors. These included local organizations – hospitals, community health centers and other providers – whose staff and volunteers facilitated enrollment, provided information about the range of health plans and assisted with the acquisition of coverage. These entities were reaching people in their local environments. Certified application counselors often held community events and visited employers to discuss the details of the ACA mandate. Finally, the health insurance brokers were a key part of the system representing private health insurance through Kentucky's exchange. Also trained by the state, they educated the consumers about their rights under the ACA. Several respondents commented on the partnerships and collaboration occurring between government and private organizations, such as the Kentucky Hospital Association, Kentucky Primary Care Association, and numerous state leaders from human services, health services, and health insurance industries, who worked hard to reduce the uninsured population.
**Maryland.** Maryland Health Connection serves as Maryland state’s Official Health Insurance Marketplace. The outreach, enrollment, and navigation work is widely distributed across public and private sector organizations. While the Maryland Health Connection has occasionally communicated information to consumers directly through the media or by phone, with its small staff, it has mainly relied on its extensive network of local partners to reach the different populations in the state. The regional navigator groups – local connector entities listed online for consumer review – provide outreach education and enrollment in public and private health insurance plans. Directly, or through authorized assisters, navigators provide information and one-on-one assistance with decision-making and enrollment. They also work with authorized insurance brokers, licensed by the Maryland Insurance Administration, to guide citizens in choosing an appropriate insurance plan. Additionally, local Health Departments and Social Service offices provide advice, assistance and technology to help residents get health insurance coverage. Our respondents stressed Maryland’s strategy to rely on community-based providers that had long-term presence and reputation and deep connections within the communities allowing them to reach all of the groups. Local networks have been established and operated through grants, contracts, and partnerships. In certain instances, the state relied on private sector advertising platforms to communicate the message about the importance of gaining health coverage. As an example, the Super Health Sunday event involved multiple churches and targeted African-American residents. Other partnerships included events co-organized with public libraries, substance abuse coordinating councils, and other entities. Statistical data or mailings conducted by private vendors were also used to spread the word about the ACA mandate and ways to enroll. Some private vendors distributed informational materials, while others were willing to put electronic links for the Marketplace on their web sites.
**Minnesota.** MNSure, Minnesota’s Health Insurance Marketplace, is governed by a board, and Chief Executive Officer and a team of staff members who oversee navigation and assister relations, among other issues. Additionally, the Board relied on numerous advisory groups representing community organizations and citizens. MNSure has separate groups working with different stakeholders, such as the broker stakeholder group, certified application counselor (CAC) stakeholder groups and navigator stakeholder groups. These groups meet monthly to discuss any emergent issues with outreach and enrollment, They also maintain separate telephone lines for each constituency. Additionally, an Assistance Resource Center has been established to assist the navigators and the CACs with their work with consumers. Several respondents noted their initial concerns with the state’s administrative and management capacity, and the associated lack of trust, collaboration, and adequate supervision. However, these issues were generally addressed within a year of the marketplace launch.

The Department of Human Services played a key role in the implementation of MNSure by administering MinnesotaCare (Minnesota’s expanded Medicaid program established before the ACA) and Medical Assistance, Minnesota’s Medicaid program. Individuals eligible for public assistance programs were often referred to the Department of Human Services that administers those programs. Several respondents commented on the difficulty of coordinating the MNSure and Minnesota Care systems from the standpoint of consumer assistance and navigation. Eventually, some Department of Human Services staff were physically relocated to MNSure to help bridge the gap.

The implementation of navigation and enrollment assistance involved numerous private entities. As one respondent put it, “public-private partnership is sort of the ethos of how we operate here.” The Navigator program operates with the staff of five people, concluding two
outreach grant specialists, all of whom work closely with the Assisters’ Resource Center. MNSure grant managers and the Assisters’ Resource Center are instrumental in coordinating the work of navigators, the insurance brokers and assisters, as well as in designing and coordinating the training, resources, and certification to support their work.

County governments were closely involved in providing assistance with enrollment. A respondent commented on the how the counties’ world was “shaken up” by the new policy due to changes in Medical Assistance eligibility, which often necessitated follow-ups and conversations between the state and the counties. Numerous nonprofit organizations have been involved by providing financial support and other functions, such as the Blue Cross Blue Shield of Minnesota Foundation, and the Minnesota Community Measurement. The latter is a nonprofit organization engaged in measuring and establishing quality and outcome measures.

Summary. The analysis of the administrative infrastructure pertaining to navigation and enrollment functions at the state level suggests that all states relied on extensive networks of public and private, paid and unpaid entities. Most states relied on paid staff within the exchange or within other state programs to help coordinate the selection, training, certification, and coordination between private entities. With a combination of federal, state, and private funding, networks of navigators and enrollment assisters were built by partnering with community organizations. Private organizations – community-based nonprofit organizations or for-profit vendors – were also used to provide outreach and to disseminate information. Clearly, implementation of outreach and navigation went beyond managing within, and primarily involved managing across organizations: building administrative capacity, enlisting other entities, training/educating them, triaging and solving complex problems involving multiple entities, resolving consumer complaints and issues, sharing information, measuring performance,
and coordinating with the existing public programs. In numerous states, tensions between the Medicaid Program and Obamacare marketplace enrollment process arose from using two systems of eligibility managed by two different state entities. In some instances, structural modifications subsequently reduced these tensions.

**States’ Navigation and Outreach Contracting Experiences**

**Colorado.** Respondents discussed several key facets of contracting in Colorado. On the public side, encompassing Medicaid and CHP plus (Colorado’s SCHIP program), the Department of Health Care Policy and Finance (HCPF) has contracts with counties to administer eligibility determination. At the time of the initial open enrollment it also held a contract with a private firm, Maximus, to provide services related to payment, trouble-shooting, and payment management of CHP plus. In addition, there are 200 assistance sites that were not contracted but were trained by HCPF to provide application assistance to Medicaid and CHP plus. On the private side, the CHC exchange contracted with to approximately 50 community-based assistance sites to provide guidance to applicants during the initial enrollment period. CHC also relied significantly on a network of private insurance brokers, also trained through the exchange. (Colorado’s brokers, unlike those in other states, have worked in tandem with assisters, and have been an essential element in enrolling applicants; in other states, competitive barriers between brokers and assisters are more typical.) Outreach activities were also configured to target specific audiences. As summarized by one of our interviewees:

“So the combination of the navigation network, if you will, it was mix of paid and unpaid, both sides of the house. Different entities had different responsibilities for outreach; it was part of the contract for the assistance site. The brokers and certified application counselors [assisters] were encouraged to do outreach but I don’t think there were any incentives given to them. The assistance sites were required to do outreach. On
the Medicaid side, counties and Medicaid assistance sites are encouraged and I think required to do outreach to the eligible but unenrolled. But certified application assistance and [Medicaid] presumptive eligibility sites were not paid; they were just encouraged to provide outreach services” (CO#8)

In terms of the contracting process, the state health exchange, CHC initially issued an RFP for 2-year grants for lead navigator organizations. For the first enrollment period, 25 organizations were awarded grants. These grants were not typical performance based-grants. Rather, the recipient organizations were awarded a lump sum with the expectation of enrolling a certain number of members. One problem that surfaced was that while “there were a lot of expectations for how navigators were supposed to report their enrollment … during enrollment [years] one and two”, the system “didn’t really allow them to gain attribution for a significant number of enrollments that they had assisted on” (CO#4). For the outreach component, the CHC worked with a variety of vendors to develop a branding strategy, including targeted campaigns for specific minorities, such as a Latino campaign and an African-American community campaign. In the current configuration, CHC

“…conducts outreach separately from the navigator program. The navigator organizations have their responsibilities, their own outreach, contractually as part of their work. But the [CHC] headquarters has staff in place and contracts with vendors to do outreach as well, and that’s all generally done through a competitive bid process” (CO#5).

**Connecticut.** For Connecticut’s initial open enrollment, the state’s health exchange, Access Health CT, contracted navigation and enrollment services to six community-based organizations, each serving a specific ethnic group or geographical area. In turn, these groups oversaw the work of 17-30 agencies that had in-person assistors located on site. The six regional agencies were awarded approximately $80,000 in funding following a competitive bid process. In-place assistors had to apply for funding to the health exchange as well. Each contract award
of $6,000 entailed an expectation that 200 people would be enrolled. As related by one respondent:

“We were told that nobody is going to this job for $6,000…it’s not enough, but we were looking for organizations that were already doing this work, that possibly it could be sustained in the future, just as mission work… So, we were building a structure on top of an existing structure, and the groups that were the most successful were the groups that were already out on the streets enrolling people for other things or their beauty salon was already open anyway, and they want to get more customers and they cared about the health of their clients anyway... We found that most people really wanted to do it, they just were stuck and we helped them get unstuck. And some people just didn’t want to do anything and they didn’t do anything… So, we held back $1,000 of their contract and we didn’t pay the last thousand. So, we paid them $5,000 and we held back $1,000. So, some people didn’t get the last thousand and they were sort of mad but you know it’s life” (CT#3).

Nearly all respondents from Connecticut lauded the community-driven approach to navigation and outreach conducted during the first open enrollment period, as well as the relationships that developed among staff of Access Health CT, six grantee organizations, and the approximately 160 assistor organizations. Inadequate attribution for partial work contributed to enrollment applications was cited as a limiting factor. In addition, the curtailment of funding for community-based navigation and outreach beginning in year 2 was noted as a negative development by several respondents.

Kentucky. In Kentucky, a host of health exchange services were contracted out. For example, Doe-Anderson, an advertising agency, was contracted to assist with marketing, survey research, and focus groups. As noted by one respondent, this arrangement enabled the health care exchange to be more flexible and nimble in conducting outreach – for example, by enabling the exchange to participate as event sponsors (including a local music festival) to promote health insurance options, which would have been impossible “to do … as a state agency, to be able to get through all the red tape to get that approved, on a short period of time when we had the
opportunity to be the sponsor” (KY#4). In addition, Kentucky contracted with Deloitte Consulting to provide training for assisters, IT systems development, and casework services; Xerox also contracted with the state to provide call center services.

Navigation services were contracted out, based on a competitive RFP process, with the initial contracts lasting two years. Three organizations were selected to provide a range of navigation outreach services, including education. These organizations then subcontracted out services to other organizations that were embedded in their local communities. As related by one navigation subcontractor, quality and productivity are measured on several dimensions, including applications started, applications completed, application renewals, the conversion rate (ratio of applications started to applications completed) and the cost-effectiveness of mobile enrollment. Even so, contractually required reporting is hampered by system limits. One respondent noted this as perhaps the biggest point of frustration:

“The truth is, the data system [exchange enrollment application] is not designed to give any sort of report, and what the Health Benefit Exchange can receive in data information, is very different than what we ourselves can see in our information. There are even title differences … Like a social security number, are three different things and three different reports. …So, there was a lot of questions back and forth about where are you getting that data. Why are you asking us that? Why don’t you have that? That kind of thing, because this system wasn’t designed to give reports. So, that’s been probably our number one frustration with the whole thing” (KY#2)

Overall, several respondents commented on the positive collaborative efforts among contractually connected actors in Kentucky navigation and outreach, particularly in sharing information and joint problem solving.

**Maryland.** Consistent with the other States, Maryland’s health exchange contracted out navigation and outreach services from the outset. The first year of funding was awarded via an RFP process, and included substantial startup funding for developing a navigator network. As
described by one navigation organization that contracted with the health exchange, the second year entailed a cut and the organization was “reboarded [renewed] for that subsequent 2 years in a non-competitive way” though the state has issued a new RFP for the next 3 years of funding” (MD#3). Again, consistent with other states’ experiences, navigator organizations we talked to in Maryland subcontracted out services at the community level. Like Kentucky, Maryland contracted out its call center. However, in Maryland, the call center operations were perceived as a major problem:

“Yeah, I think, I mean the one thing I would say I guess, I mean one of the big challenges and this goes to contracting with contract management has been a call center that was initially when I first came in and continued to be a real challenge in terms of a big part of the problem is just not having the resources that we just simply don’t have enough money to put enough people on the phones to handle the volume. But it’s a more complex story. It’s really been a journey to try to figure out how to manage that vendor in such a way that we get the kind of performance out of them that we feel like we ought to have them and part of this problem and I think is that even companies that were pretty well versed in running call centers had never run one like this” (MD#1).

**Minnesota.** In Minnesota, the state has moved towards funding a small number of regional organizations (currently six entities) with navigation and outreach grants awarded based on a competitive RFP process. These organizations, in turn, subcontract out navigation work at the local level. Several respondents remarked upon the collaborative nature of relationship that had developed between partners over time:

“That [experience with subcontractors] has been great. We have had the same … core group of partners since the first year and so … we are all kind of in a rhythm to [where] we meet quarterly to discuss how we are doing in terms of reaching our goals and in terms of numbers of clients served and enrolled and things like that. We provide a lot of training and support to those partners as well. Now that we have 3 years working together, we are really familiar with the different services and languages, language capacity that each different organization has and so we are able to really facilitate successful referrals between the networks. We work the Vietnamese social services and so when we work with a family who speaks Vietnamese, we always certainly get an interpreter, but we know VSS is just at the street we work really closely with them. We
feel comfortable offering […] options to those people [to] receive assistance in their own language” (MN#2).

In addition to the regional hubs, Minnesota’s health exchange also contracts directly with organizations at the community level to provide navigation services and reimburses them for every successful enrollment -- $25 for Medical Assistance (Medicaid) and $70 per enrollment in MinnesotaCare [the state’s pre-existing Medicaid program] or a Qualified Health Plan. Almost universally, respondents described the reimbursement as inadequate for the effort involved, as well as unfair in the large discrepancy between reimbursement for Medicaid versus non-Medicaid enrollment. Another common complaint was the exchange’s reliance on 1 year contracts. As described by a respondent from a regional grantee, this inevitably resulted in a rush to a quick proposal and could create staffing issues due to the gap between the end of one contract and the signing of the new contract.

New York. Due to a lack of data, we were unable to learn much about New York’s contracting experiences beyond a general broad depiction of health exchange as working closely with the State’s vibrant non-profit community to reach out at the local level.3

Summary. Overall, several cross-state themes emerged in our analysis of navigation and outreach contracting arrangements. First, all health exchanges relied on contracting as a means to leverage existing expertise (in areas such as marketing) and community relationships to develop and implement navigation and outreach strategies and programs. Second, many of the exchanges implemented a hub network approach to navigation and outreach, awarding grants based on an RFP process to a small number of regional organizations to develop navigation networks at the community level. The duration of these grants has varied by state and by

3 We were able to interview only a small number of New York implementation actors, primarily because they have all been asked to avoid sharing information on the state’s program details.
enrollment period, with several navigators commenting on the detrimental impact of the single year funding model. Further, while some states (such as Minnesota and Maryland) have continued with this model, other states have opted to abandon it (Connecticut) or consider moving away from this approach (Colorado) due to financial constraints. And finally, data exchange and reporting requirements were a common feature and, often, a stumbling block for the contracts implemented in all the states we studied. In general, the requirements tended to become more precise with the passage of time, as did the capabilities of contractors and subcontractors to provide the information requested. However, system limitations, such as inability to attribute individual contributions to enrollment beyond who worked on the application last or enrolled an individual, continue to impede progress on this front.

Perceived Strengths and Weaknesses of ACA Navigation and Outreach Functions

**Colorado.** The overarching success story described by all respondents was the state’s ability to reach out to and enroll eligible individuals. As one respondent put it, the state has seen “huge success in terms of getting the word out and getting folks enrolled” (CO #7). This is supported by data collected by the Urban Institute (2015), which show that Colorado initially lagged in terms of enrolling eligible individuals, but has been improving in the latest enrollment period. Another strength described by all respondents was the extent of collaboration and coordination demonstrated by the various stakeholders involved in navigation and outreach. This was said to improve as implementation progressed, from a more “silod” structure (CO #8) during the first enrollment period, to one marked by a “more collaborative stakeholder environment than many states” (CO #4) in subsequent years.
Respondents attributed the high level of coordinated efforts to a number of factors, including a positive “climate of political engagement” (CO #7) amongst an already “very robust” (CO #4) and well-established—and well-connected—network of community-based organizations. One person we interviewed noted, “…our ability to help each other and collaborate and be on the same page and leverage our resources - that’s even more important today, because we have fewer resources than we had in the early days” (CO #5). This point about dwindling resources was echoed by another respondent, who pointed out, “our number of navigators or navigator sites has shrunk by about half because funding has decreased basically for that assistance network” (CO #4). In this resource-constrained environment, collaboration and coordination become paramount.

In terms of perceived weaknesses, a common refrain from respondents was the need for a unified approach to navigation and outreach across all stakeholders. While collaboration and coordination were cited as strengths, respondents felt that the absence of a single, guiding plan and clear goals from the state was a notable weakness, particularly in the first year. This is highlighted by the following two quotes:

“There isn’t a single statewide outreach and enrollment plan. There isn’t a unified plan that we can all go towards, work towards, with intentional and measurable goals and tactics associated with those goals” (CO #8).

“…Getting the right people together on the same page working underneath a common state goal is important. And we didn’t have that the first year, we had different organizational goals that we were all working toward, and I think that’s ultimately hurt our customers…Having the entire state, all agencies that are involved, operating and working under a coming goal together is important and I think would have been helpful” (CO #1).

**Connecticut.** As in other states, a key strength identified by most Connecticut officials was a community-oriented, collaborative approach toward outreach and enrollment. One
respondent characterized this as a “sticky web where we touched so many people and everybody was informed about the project” (CT #5). Others described the benefits of this strategy:

“[A] key lesson is really engaging key partners and stakeholders that are at the community level, that can connect them to the community at a faster rate, rather than try to build relationships from nothing” (CT #7).

“Another [strength] would be …to be very neighborhood focused. I think we did a lot with community among the assisters…We had a best practices conference where we had a way for them to meet each other and talk…building community among them…Some of them said it was the most meaningful things they’d ever done in their lives…We were very worried that we weren’t going to make our numbers because the assisters were struggling…So, through our meetings and through working with the navigators… we started grouping it together and they started going out in teams and going to neighborhoods and small business areas and we started seeing real success…That’s the informal free stakeholder around the table all working towards one goal in ways that we’ve never had before. It has been just a sustainable thing that came out of it. It may sound intangible but I actually think it’s probably one of the better things that came out of it now that I think about it…We had so many people talking to each other and communicating client needs in a way that was unique and that had been done for the first time in Connecticut, because Connecticut is not a regional state. Everything is done a town by town, and we have 109 town or 106 towns. I forget exactly. Each town is an entity of its own…We have all these organizations that never talked to each other before. Now they are talking to each other and just amazing things began to happen. Then the assisters themselves became very creative to streamline the enrolment process because it’s a lengthy process and they started, my… team could do an enrollment from A to Z in about 30 minutes” (CT #2).

Unlike Colorado, Connecticut benefitted from strong central exchange leadership and coordination, most likely due to particularly strong and uniform political support, and these factors were cited as important implementation strengths as well.

“I think one of the key things is, at least in the early phases is the ability to prioritize. I know that [steps the exchange director] Counihan took was to not try to be perfect at everything but try to be good at the important things and really had a clear sense of what were the important things to address…[Counihan is] one of the thought leaders and most experienced people in the country in terms of how exchange is operated. So, that also coupling that sort of experience of talents base with the sort of the general sort of healthy policies and social receptiveness to the exchange really made it an ideal environment for implementation” (CT #1).
Connecticut respondents mentioned very few weaknesses, and most were rectified fairly quickly, including initial realizations that assisters were sometimes not used to working in collaboration with other groups, and exchange security systems that locked assisters and applicants out. One respondent noted that outreach/enrollment training protocols:

“have not changed since initial enrollment. They have not adopted some of the national curriculums that have been constructive tools and resources in other states. So that’s something they can consider improving” (CT #7).

Kentucky. Kentucky has been lauded for implementing a simple, straightforward outreach and enrollment system that generated high enrollment rates. State interview respondents noted several strengths, including a successful integrated Medicaid/ACA eligibility system that was cited as “the best thing [that] we’ve done as a state” (KY #4). Another strength relates to the community-centered outreach strategy that helped the state to tailor its efforts:

“So we have Louisville which is not considered part of Kentucky, and is our biggest concentration of people. Then we have the eastern part of the state which is more open to federal program, and we have the western part of the state which does not like federal program…We have our Northern Kentucky area which everybody considers Ohio…We had to have the advertising that and navigation and outreach that was very individualized to the particular area of the state that we were working in. So what we try to do, is we have the people who are our navigators, who are our kynectors are people from those communities, so that has been a big help for us. So it’s somebody you know or somebody you know their second cousin mother’s sister. So I think that’s been a big help for us. We try to take a very neighbor approach, community approach” (KY #4).

Another strength cited by officials had to do with the opposition of most state residents towards “Obamacare.” In essence, the state branded its program in a manner that effectively disguised the source of expanded insurance.

“So, even though it’s sometimes called Kynect which is what it is and sometimes it’s called KY Net and Kentucky Kynect, even though people don’t know how to pronounce it they all know it…We gave out these great tote bags that we have, and we are very friendly, I don’t know whether you’re familiar with …politics in Kentucky which is across the state…very anti president Obama…A lot of people in Kentucky don’t even know that we are Obama Care. They think we’re something different… Kentucky didn’t
like Obama Care but they loved Kynect so…We did such a good job of branding our work as being entirely a Kentucky program and really disconnecting it from the affordable care act…” (KY #4)

Respondents mentioned few weaknesses. As in other states, strengths and weaknesses were sometimes related. An official commented on the branding outreach success, noting that the hard political work of building support for the program among the legislature never took place. The current uncertainty, due to the election of a new governor committed to ending Kentucky’s program and its Medicaid expansion, was noted as a direct result. Another respondent characterized the state’s call center as fairly ineffective, but also noted that in-person assisters were generally able to compensate the shortcomings of the call center serving as a source of information for citizens.

Maryland. Maryland suffered from a widely publicized weakness including the crash of its ambitious integrated (Medicaid and ACA) marketplace exchange website. This failure greatly complicated the work of outreach and enrollment programs. The strengths of the outreach/enrollment systems, combined with a fairly quick decision to scrap the failed exchange website and adopt Connecticut’s exchange software, allowed Maryland to enjoy some success in the first two years of its implementation. Among the strengths cited by respondents was the response to the failure among outreach and enrollment programs:

“Year one was a bust for the website but on the ground we manually enrolled everybody with guidance from our exchange and so we adjusted and we got that problem” (MD #2)4.

Like most states in our sample, Maryland partnered with community-based organizations through one central agreement with six regional navigation/outreach/enrollment entities. As noted by one respondent,

4 NY #2 respondents also participated in this interview.
“[t]he umbrella organizations in each region of the state was the extent to which they could show that they had partnership and relationship with other smaller community based organizations within their region that were targeted, more targeted even for certain populations that we are trying to reach…We really have benefited from the local connections that connector entities have and their knowledge of their regions that you know they have a familiarity with people and…they have a relationship that we wouldn’t have been able to have on our level” (MD #1).

Maryland also enjoyed a particularly unified and robust level of political support, with more resources than typically available. Combined with a progressive and policy-savvy governor, this helped to construct systems that, aside from the exchange website, were well-staffed and well-planned.

“[Governor O’Malley] who has just dropped out of the presidential race, was very technologically oriented and was very much behind the affordable care act and why Maryland want to be a fore runner in how it approached it…It was a sort of his sweet spot of his agenda as Governor including the technological piece” (MD #3).

“Two weaknesses emerged in our interview data. First, as noted in many studies of contract and network management, the complexity of the subcontracting relationships overwhelmed state and exchange managers.

There is a complexity that you add to the administration of the program when you have a lot of, like the capital regions for example have and a sense of region both have. I don’t know the exact number but you know 20, 25 partnerships and it just, it gets unreal” (MD #1).

The state’s call center was described as inadequate, consistent with what we heard from other states. Additionally, enrollments among the state’s Hispanic population remained disappointingly low, despite initial planning that included culturally/linguistically-targeted marketing. The state responded with a fix that appears to be working:

“Towards the end of the second year we hired a bilingual outreach coordinator and she helped us a great deal; we had her working with … the existing Hispanic groups…She was able to do interviews both in print and on broadcast, probably 9 or 10 of them…Our numbers I think have been really quite dramatic for this third year because of it” (MD #3).
**Minnesota.** Respondents cited the state’s leveraging of existing networks of non-profit organizations and collaboration across these networks as two key, interrelated strengths of the state’s navigation and assistance efforts. Most of our respondents observed that the state was able to leverage the resources and knowledge of a large network of deep-rooted community-based organizations throughout Minnesota. The quotes below illustrate this dynamic:

“We have a very strong nonprofit network in general. And, specifically, there are leading organizations who have been working on these issues for 20 years, and that expertise, and willingness to share that expertise, has been critical to the support of the expanded navigator network” (MN #7).

“I would say we have taken a slightly different tactic to that (navigation and outreach) than other states. We have traditionally a really strong non-profit, community-based…organization out there… we based it off what we already and what was working really effectively in our state… I think it’s been working very effectively for us. There are community-based organizations, some for-profits, but all of them usually have really strong connections already in the community and the populations that we are seeking to serve, and have a lot of proven outreach strategies. So, they were able to very quickly get on the ground and reach people” (MN #3).

“(MNsure) built on an existing infrastructure but also leveraged existing partners. So these groups, many of them were doing this work in the community already… by doing that, they (MNsure) really took some strengths that had been around for many years and built on them” (MN #1).

“What we have are trusted organizations within our communities that have great relationships already with low income people and people of color primarily” (MN #5).

Two respondents characterized this high level of collaboration and coalition-building as possibly unique to “Minnesota culture,” illustrated by two respondents who described the state’s successes:

“I think in some ways we really love this, really wide open doors, that they really work in Minnesota culture, but I can see how in other states that might not be (the case)… I got very familiar with other states, too, and their non-profit world, and Minnesota always has really stood to be one of the strongest non-profit sectors in the United States. So it was something unique for us to build on” (MN #3).
“I think (what) we have, it’s very collaborative, it’s a collaborative relationship among agencies throughout the state as well as with MNsure. I feel that that’s a Minnesota quality in some ways” (MN #5).

In addition to leveraging the existing networks, several respondents referenced MNsure’s strong coordination role. One respondent highlighted what they characterized as a successful effort by the state to unify its network of navigation and assister organizations, something that some respondents in other states (i.e., Colorado) felt was lacking:

“We're connected, organizations are connected and I think MNsure has done a nice job in trying to bring certainly some of the larger organizations, some of the bigger providers, together. I think it's working to create a system that is unified; basically we're all part of that big system as opposed to being just a whole bunch of little independent systems out here working separately and independently, and I think that’s a really good thing” (MN #6).

Some respondents pointed out that, in spite of the strength of the existing networks in the state, in some geographic areas, outreach and navigation services were weaker in part because of the state’s reliance on existing networks. This respondent explained:

“One of the things, the strengths, is contracting with local agencies, as I mentioned; but I think one of the weaknesses is that we have several rural areas within our state that are underserved with navigator resources… I think there’s part of the state where nobody even probably applies via navigator organization or contract with MNsure, so I think that’s one of the weaknesses of the system” (MN #5).

Another weakness had to do with aspects of MNsure’s technology that navigators found cumbersome. One respondent described these technical challenges and their effects on the navigators’ work in the following quote:

“I think it really hampers navigators’ ability to be effective. I think overall what the navigators found is that…when they initially signed on to be navigators in the beginning, they were told that this will be a fairly easy system. They just needed to understand how the application works so that they could help people through the application, just complete the application and then their work will be done. But that’s just not the way we found out in the amount of time and effort that navigators need to put in in order to be
successful and help individuals successfully enroll is much greater than what we were meant to believe” (MN #6).

**New York.** Data in New York were extremely limited, and suggested strength in the area of coordination between the state and navigator entities, and a possible weakness in terms of the state being rigid regarding innovation on the part of the navigator entities.

**Summary.** Overall, respondents in nearly all states gravitated quickly to some common strengths of their implementation experiences with outreach and enrollment. First, all interviewees noted the importance of community-based organizations as essential partners in reaching, educating, encouraging, and enrolling individuals. Decentralized outreach and enrollment systems were the norm. There were certain drawbacks to this approach including the absence of a central coordinating leader in some cases, and the challenges of working with many contractors and subcontractors. Nonetheless, neighborhood-oriented efforts by organizations familiar with needs on the ground were key to implementation success.

A second theme was also uniform across the states – all emphasized the collaborative dynamics that dominated the implementation landscape. Despite the number of organizations and individuals involved in implementing outreach and enrollment programs, it is clear that these formal and informal networks created important synergies that generated, at least perceptually, net benefits for states. Respondents were very positive about the extent of stakeholder engagement, both in planning outreach and enrollment services, and during the implementation phase. Collaboration was also mentioned as a critical element of the adaptations that dominated the early implementation phase.

Reported weaknesses had to do primarily with technological glitches, uneven success in outreach across states with diverse geographical and demographic areas, and diminishing
resources. Overall, the state implementation actors described significant enrollment and outreach program strengths and reported primarily positive implementation experiences. They were satisfied with how outreach and enrollment had performed in the early highly complex, politically charged, and technologically challenged phase of a program.

**Perceived Quality of the ACA Navigation and Outreach Implementation**

**Colorado.** In Colorado, all respondents referred to the quality of navigation services as very high to extremely high. Their assessment was often supported by numbers. As one respondent noted, “we were at 15.6% uninsured, we’re down to 6.8% as a state, 5.2% [in] Boulder and Bloomfield counties” (CO #8). Respondents noted three important aspects while describing their positive performance. Some stressed the networked nature of service delivery, the effort and dedication of multiple actors from state agencies to the local partners. Others noted that achieving the outcomes had been a long process from 2011, when the first conversations about the ACA implementation began, to today’s efforts to continuously track improvement. Finally, several respondents noted that success came in the context of limited resources (both financial and human) and from that perspective, the outcomes could be viewed as outstanding.

**Connecticut.** In Connecticut, the assessments have also been favorable. Like in Colorado, respondents reflected on the long process of implementation. One respondent noted: “I wish we’d have been able to spread things out and realize this was a marathon and not a sprint” (CT#2).” Several respondents commented on the future of policy implementation: while some expected continued success with late adopters’ joining and agencies’ becoming smarter, more targeted and data-driven in their efforts, others shared concerns about the future uncertainties, especially in the context of possible rate increases by health insurance companies. Here, also, the
achievements were stressed in the context of limited resources and relentless dedication of the staff involved:

“I thought it was a very tight operation and very, the people who worked on it just threw their heart into it. I mean people worked the, people who were very dedicated to it totally worked every moment of that open enrollment. They took no time off. They were available every moment of that time.” (CT#3)

Kentucky. In Kentucky, public and private managers we interviewed ranged more in their assessments of the quality of navigation and outreach infrastructure and implementation. Yet, many provided strong and positive assessments. These assessments were supported by numeric indicators and well as the referrals to government reports highlighting how the policy has made a difference in their state. Similar to the reports in other states, respondents viewed performance and quality of navigation services as a continuous process, when modifications ought to be constantly made. The assessments within this state also tended to go beyond a single organization, but referred to the performance of the entire network. The following two quotes highlight that.

“On the scale of one to ten, I would probably give it an eight or a nine. I would rank it pretty high in terms of quality, but then again, I face that my staff experience in the 16 counties that we cover, I do work some with the other 2 entities to implement who our kynect or agencies as well there is 2 other organizations who cover the rest of Kentucky. I would have to say that they probably would rank it relatively high too. I can’t speak for them but overall I would rank us pretty high…” (KY #2).

“I think the quality of both our outreach and enrollment is fantastic, I think that connectors have really owned their roles and have I think found ways to exceed that expectation or exceed what we even originally imagined those roles to be, to really develop ongoing relationships with the people that they enroll as well as just all of the different organizations within a community or businesses. They’ve really developed a lot of links between their respective organization and other local organizations that I think has been beneficial in many respects, just to have stronger working relationships, sharing resources or just coordinating more closely sort of developing that network in different communities. I think that’s been a really positive result” (KY #5).
**Maryland.** In Maryland, respondents gave fewer direct referrals to the high quality of navigation services, and reflected more on the gradual improvement that has been achieved. Thus, respondents referred to the absolute number of enrollees, and did note that a significant number of persons have been reached and enrolled. For instance, one respondent noted that the agencies and parties involved in the ACA implementation have all gone through significant adjustment and thought hard about the problems experienced. Another respondent stressed ongoing efforts to improve the coordination with the “connector” entities through more frequent meetings, as well as efforts to achieve better integration of local programs into the state-level strategies.

**Minnesota.** In Minnesota, the assessments of the quality of ACA navigation and outreach infrastructure and implementation varied considerably, from indicating a decline in uninsured rates (both among the general population and among minorities), to remarks about “seeing improvement” in performance (e.g., serving more people than last year) or “barely adequate” performance. Numerous respondents noted specific areas for improvement, such as exchange staff lacking the necessary knowledge, absence of coherence between MinnesotaCare and Medicaid enrollment systems, or IT related breakdowns. Similar to other states, all respondents noted the hard work and commitment of the “people on the ground.” The following two quotes highlight that:

“The navigators in our network are busier than ever, and I think that actually is a success indicator, because one of things we were interested in supporting was, especially those who were new to the work, and in our greater Minnesota region, helping them to become … to build the expertise and then become known as the go-to, as the trusted and capable resource for people in need” (MN #7).

“I would just expand on that to say that I think because we partner with established community organizations who have been doing similar or identical work years before us but the commitment of our partners is mind blowing and I think I can’t say what is like in other states where just a couple organization get federal grants to do navigation work.
There is so much accountability on the part of our partners sometimes I feel more than our own content than we think. Just like so much accountability with every consumer that they are serving, and that you just know that there, we empower them not just with grant dollars but I mean there are spokespeople for the media to legislators to, they do speak in engagements for us because they are truly are the best advocates of this work and incredibly committed to the people that they are serving. I think that is, I don’t what that is like in other states but that certainly what makes this program shine as bright as I think it does” (MN #3).

**New York.** Data from New York were limited, and suggested some adequate operation “at base line” with some reflections on the possible areas for improvement.

**Summary.** Overall, public and private respondents involved in the implementation of ACA navigation and enrollment services reflected positively on the quality of their efforts. While some of them cited quantitative data (such as the % of uninsured) in substantiating their claims, others provided more qualitative assessments. As shown in Table 1, later-stage “take-up” rates have not necessarily corresponded with these assessments, some of which could certainly be attributed to the positivity or social desirability bias. What is notable, however, is that across all states, outcomes were considered in the context of very limited resources and dedicated effort of numerous stakeholders. More importantly, all respondents tended to view performance not statically, but as a long-term process: they reflected on the past achievements and thought about future steps and possible uncertainties. More importantly, across states, respondents’ assessments pertained to the network of actors rather than their individual organizations. Numerous comments detailed collaborative/joint efforts, acknowledged the contribution of other parties in the state, and focused on community-level, rather than organizational-level outcomes.

**CONCLUSION**

This study examines the ACA’s implementation in six states in the context of contracting for outreach and enrollment services. We focus on specific elements of outreach and enrollment
in the early years of implementation: namely, states’ administrative infrastructures, contracting practices, implementation system strengths and weaknesses, and perceived service quality. Our data are primarily perceptual, derived from interviews with a wide range of implementation actors in government, marketplace exchange agencies, and contracting organizations. To obtain a more complete and in-depth picture of each state’s experience, we limited our sample to six of the thirteen states that opted to construct their own marketplace exchanges. All six states expanded Medicaid, which was consistent with strong political support for the law’s mission and a state-based exchange strategy. We used these similarities to help isolate specific implementation elements and their impacts on program success.

Our results are decidedly preliminary. We are continuing to collect and analyze interview data. At the same time, state performance data on enrollment take-up, insurance coverage, and other more quantifiable measures of program success, are now emerging. These new data will be combined with our interviews to build a systematic examination of how and why some states have reduced the rates of the uninsured more effectively than others. We nonetheless observed some emergent patterns in the states’ outreach and enrollment programs.

One clear pattern is that this landmark law has generated state programs built around extensive networks of public and private institutions. These networks consist in part of regional, or “hub” contractors for state outreach and enrollment, together with countless subcontractors – both individuals and organizations – and other formal and informal entities engaged in seeking out and assisting uninsured individuals. Most networks involve community-based organizations that have deep local ties that facilitated outreach. These observations confirm that, at least for outreach and enrollment services, there has been significant inter-organizational management devoted to facilitating implementation.
Further, the implementation of ACA outreach and enrollment in this six state sample has been expedited by contracts that are highly collaborative in nature. The collaborative relationships created in the implementation phase were critical to trouble-shooting problems that emerged early on. Data from multiple actors in our six state sample indicate the importance of collaboration in buffering against uncertainty and diminishing resources. The shared mission embedded in the ACA and dominant contracting entities has mitigated the transaction costs typically encountered in contract and network management. Collaboration has also allowed some states to supplement funding resources by tapping into supportive foundations as federal outreach/enrollment support began to diminish.

This analysis has clear limitations. It relies on a small sample of states. The rationale is that a small-scale qualitative strategy will help reveal key dynamics in the implementation environment that can then be explored in a larger context. Again, eliciting the views of key implementation actors is consistent with identifying implementation factors that may help explain the performance of outreach and enrollment services. As we incorporate performance data beyond that reported here, we plan to test hypotheses built around the data patterns described above. Does the level and quality of collaboration in outreach/enrollment contracts help to explain states’ success in enrolling eligible uninsured individuals? Do specific contractual elements – such as performance contracting, or per-enrollee-reimbursement - play an explanatory role? How might these relationships hold up in examining the implementation of the market place exchange systems used to purchase insurance? Our hope is to build on this study with these questions in mind.

Table 1. Characteristics of Exchanges.

<table>
<thead>
<tr>
<th>State</th>
<th>Name</th>
<th>Creation Date</th>
<th>Mechanism</th>
<th>Governance Structure</th>
<th>Uninsured Rate</th>
<th>Take-Up Rate*</th>
<th>Enrollment Success**</th>
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<tbody>
<tr>
<td>State</td>
<td>Exchange Name</td>
<td>Implementation Date</td>
<td>Type</td>
<td>2013</td>
<td>2014</td>
<td>2015</td>
<td>Note</td>
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<td>-------</td>
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<tr>
<td>CO</td>
<td>Connect for Care Colorado</td>
<td>07/2011</td>
<td>legislation</td>
<td>Quasi-govt.</td>
<td>14%</td>
<td>13%</td>
<td>10%</td>
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<tr>
<td>CT</td>
<td>Access Health CT</td>
<td>08/2011</td>
<td>legislation</td>
<td>Quasi-govt.</td>
<td>12%</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>KT</td>
<td>Kentucky Health Benefit Exchange</td>
<td>08/2012</td>
<td>Executive Order</td>
<td>Within State Agency</td>
<td>16%</td>
<td>8%</td>
<td>7%</td>
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<td>MD</td>
<td>Maryland Health Benefit Exchange</td>
<td>03/ 2011</td>
<td>legislation</td>
<td>Quasi-govt.</td>
<td>13%</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>MN</td>
<td>MNSure</td>
<td>03/ 2013</td>
<td>legislation</td>
<td>Quasi-govt.</td>
<td>8%</td>
<td>8%</td>
<td>7%</td>
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<tr>
<td>NY</td>
<td>New York Health Benefit Exchange</td>
<td>04/2012</td>
<td>Executive order</td>
<td>Within State Agency</td>
<td>11%</td>
<td>9%</td>
<td>8%</td>
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* As of March 2016. Data include individuals who have enrolled in a Marketplace plan, have paid their first month’s premium (“effectuated” enrollment), and who have an active policy. The take-up rate is calculated based on potential marketplace enrollees; this includes all individuals eligible for tax credits as well as other legally-residing individuals who are uninsured or purchase non-group coverage, have incomes above Medicaid/CHIP eligibility levels, and who do not have access to employer-sponsored coverage. The estimate excludes uninsured individuals with incomes below the poverty level who live in states that elected not to expand the Medicaid program. These individuals are not eligible for financial assistance and are unlikely to have the resources to purchase coverage in the Marketplace. Source: Kaiser Family Foundation, *Marketplace Enrollment as a Share of the Potential Marketplace Population* (n.d.). Retrieved October 24, 2016, from [http://kaiserf.am/2ecEEILB](http://kaiserf.am/2ecEEILB).

**Compared to Urban Institute’s (2015) Enrollment Projections as of 2015.”
### Table 2. The Details of State Implementation Structures.

<table>
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<th>Implementation Structure Details</th>
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<tbody>
<tr>
<td><strong>COLORADO.</strong> Colorado’s market exchange was established by state law in 2011. Although created as quasigovernmental agency, the exchange was registered as an independent nonprofit entity in March 2012. Connect for Health Colorado is governed by a Board of Directors appointed by the governor and the state majority and minority leaders in the Colorado legislature. Navigation and outreach services are outsourced to a variety of organizations in the community. The constellation of organizations connected to this effort are commonly referred to as the ‘assistance network’ while navigators are known as ‘health coverage guides’. Colorado’s marketplace exchange launch was complicated by issues related to its use of funds.</td>
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<td><strong>CONNECTICUT.</strong> In 2011, Connecticut adopted legislation authorizing the creation of market exchange. Known as Access Health CT, Connecticut’s exchange functions as a quasi-governmental entity. Its governance structure consists of a 14-member governing board, headed by the lieutenant governor. The board members are selected according to their positions in state government, including the commissioner of social services, secretary of policy and management, and the state healthcare advocate, or are appointed by elected officials (specifically, the governor, and the majority and minority leaders of the Connecticut House and Senate). Connecticut’s exchange code has been viewed as a model and acquired by other states with failed launches, including Maryland.</td>
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<td><strong>KENTUCKY.</strong> In 2012, Governor Steven L. Beshear (D) issued Executive Order 587 establishing the Kentucky Health Benefit Exchange (KHBE) within the Cabinet for Health and Family Services. In 2013, the state announced that its online Marketplace would be called Kynect. Navigators and in-person assisters are known as “Kynectors.” Kentucky’s exchange launch has been associated with few concerns, and its success has been attributed in part to its simplicity. Following the 2015 election of Republican Governor Matt Bevin, whose election campaign platform included promises to dismantle Kynect and the state’s Medicaid expansion, the future of the state exchange is unclear.</td>
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<tr>
<td><strong>MARYLAND.</strong> In 2011, Governor Martin O’Malley (D) signed SB 182/HB 166 into law establishing the Maryland Health Benefit Exchange (MBHE). In August 2012, the state announced that the name for the new insurance Marketplace would be Maryland Health Connection. The law defines the MBHE as a quasi-governmental organization, specifically, a “public corporation and independent unit of state government.” The MBHE is governed by a nine-member board, including the Executive Director of Maryland’s Health Care Commission as the Chair, Secretary of Health and Mental Hygiene, Commissioner of Insurance, and six members appointed by the Governor and with consent from the Senate. Maryland’s exchange launch was associated with highly visible problems for the consumers, similar in many ways the issues of the federal exchange, in part due to its ambitious plan to integrate ACA and Medicaid data systems.</td>
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<tr>
<td><strong>MINNESOTA.</strong> Minnesota’s market exchange, MNsure, was created through legislation passed in 2013. MNsure is a state entity governed by a Board of Directors appointed by the governor and confirmed by the Minnesota House and Senate. Members serve four-year terms and the composition of the board is subject to requirements related to geographical and area-of-expertise representation. Minnesota’s exchange launch encountered problems early on.</td>
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<tr>
<td><strong>NEW YORK.</strong> The New York Health Benefit Exchange (NYHBE) was created by Executive Order within the NY Department of Health. The Exchange was given the authority to work in conjunction with the Department of Financial Services and other agencies to carry out the requirements of the ACA. Although the Executive Order did not create an independent governing board for the exchange, it established regional advisory committees, consisting of consumer advocates, small business representatives, health care providers, agents, brokers, insurers, labor organizations, and other stakeholders, to advise and provide recommendations on Exchange operations. Over 180 members were appointed to five regional advisory committees. New York’s exchange launch has been seen as quite successful.</td>
</tr>
</tbody>
</table>

Sources for Tables 1 and 2: Kaiser Family Foundation reports (the rates of uninsured retrieved from http://kaiserf.am/2eNPk54; Rockefeller Institute of Government, ACA Implementation Research Network reports.

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5 The other seven state-based exchanges are in California, District of Columbia, Idaho, Massachusetts, Rhode Island, Vermont, and Washington.

6 The name of the exchange was changed from Colorado Health Benefit Exchange to Connect for Health Colorado in March 2013.
## Table 3. Interview Respondent by Organization Type

<table>
<thead>
<tr>
<th>State agency</th>
<th>Contractor</th>
<th>Other*</th>
<th>Totals by state</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorado</td>
<td>4</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Connecticut</td>
<td>4</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Kentucky</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Maryland</td>
<td>3</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Minnesota</td>
<td>2</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>New York**</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Totals by type</strong></td>
<td><strong>14</strong></td>
<td><strong>21</strong></td>
<td><strong>5</strong></td>
</tr>
</tbody>
</table>

*Other* includes advocacy organizations and academic researchers who authored Rockefeller Center-sponsored studies of states' ACA implementation approaches.

**New York's low response rate owes to a rule placed on contractors by the state that restricts them from speaking to external entities regarding their work for the exchange. Repeated attempts to interview respondents from contracting organizations and state agencies, including the exchange, were unsuccessful. Our findings section includes observations from New York respondents when possible.
REFERENCES


Appendix A. Interview Instrument.

Note to the Interviewer. Read: “Thank you for agreeing to participate in our study.”

Turn on the voice recorder and identify interview ID and location, e.g., “This is Washington DC interview number one.”

Begin the interview.

1. I would like to begin by asking about your agency (for nonprofit respondents, use “organization”). What does your agency (organization) do? What is its role in the implementation and operation of the ACA?

2. What is your position and your role with respect to the implementation of the ACA?

3. Please describe your state’s experience with the ACA. We are especially interested in your view of the strengths and weaknesses of your ACA navigation and outreach services.

   Probe: What makes your state’s experience unique?

4. Can you describe your state’s administrative or management infrastructure for ACA navigation and outreach?

   a. Has the state conducted (or have plans to conduct) any customer satisfaction surveys that you are aware of?

5. Some states tend to contract out services and functions associated with ACA navigation and outreach. Can you tell us about your state’s contracting related experiences? (ask about design - sole-source, competitive contracts? Performance based? How many cycles so far?)

   a. Follow up for contractor/sub-contractors: How has your experience as a contractor/subcontractor been?
6. What is your perspective on the adequacy of state fiscal and human resources for implementation and operation of your state’s navigation and outreach services?

7. To what extent has state or local politics play a role in implementation?

8. What do you think your state did and/or does particularly well?
   
   Probe: Are there “best practices” that could be shared with other states?
   
   Probe: What resources or support have been important in the implementation of the Affordable Care Act?
   
   Probe: What are some of the key lessons you have learned from your state’s experience?

9. What have been the biggest challenges in implementing the ACA in your state?
   
   Probe: How were these challenges addressed?

10. Are you aware of any documentation or data collected on your state’s ACA navigation and outreach contracts? Sub-contracts?

11. In your opinion, as of today, how would you evaluate the quality of the ACA navigation and outreach infrastructure and implementation in your state?

12. Looking ahead, what challenges do you anticipate?

13. Is there anything else you would like to tell me that may be important for my study? Is there anything we did not ask about that you think is important?

14. Can you suggest other people or groups I should talk to in your state about these topics?