VIEWS FROM THE FIELD
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GRANT MAKERS IN HEALTH

Supporting ACA/Medicaid Expansion Enrollment in Essex County, New Jersey

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The goal of the Affordable Care Act (ACA)—to provide access to health care to virtually all Americans through affordable health insurance that covers all essential services—coincides with The Healthcare Foundation of New Jersey's (HFNJ) mission to bring quality, affordable health care to the most underserved and vulnerable people in our community. New Jersey opted to become a federally facilitated exchange state and, at the same time, to expand Medicaid eligibility. These decisions posed both challenges and opportunities for those on the ground working to bring insurance to the greatest possible number of the state's 650,000 uninsured.

PRE-ENROLLMENT CONTEXT

Prior to the beginning of open enrollment in the fall of 2013, polls showed that most New Jersey residents were not knowledgeable about what opportunities might exist for them under the ACA or how they could access benefits to which they had become entitled. Like other federally operated exchange states, New Jersey received a minimal amount of funding for outreach/marketing activities, and, in the opinion of key informants, insufficient numbers of federal navigators and funding for certified application counselors and their training. According to a study of early enrollment results by Rutgers Center for State Health Policy, New Jersey received only $6.00 in federal outreach and enrollment funding per uninsured person as compared to an average of $17.15 in state marketplace states (Hempstead and Cantor 2014; Polsky et al. 2014). To help meet this challenge, HFNJ began work to facilitate public education and outreach by local agencies and support enrollment activities throughout the greater Essex County community.

EDUCATION/OUTREACH/ENROLLMENT FUNDING

HFNJ issued a request for proposals, and in the fall of 2013 awarded five major grants and 12 mini-grants totaling more than $550,000 to agencies in greater Newark representing discrete and varied communities to support outreach, education, and enrollment and to mobilize clients to action. An additional grant of approximately $117,260 was made in the spring of 2014.

Grants provided funding for additional staff, training, information technology upgrades, and marketing/outreach efforts. Grantees consisted of:

- a local health care coalition to provide communitywide ACA information and enrollment coordination;
- social service agencies working with low-income, African-American, Hispanic, and Portuguese-speaking populations;
- area hospitals, health centers, and Family Success Centers working with uninsured inpatient and outpatient clients and residents of local housing authority buildings;
- agencies providing outreach and enrollment on local college campuses;
- a public television producer to conduct three public forums in neighborhoods with large numbers of uninsured, bringing experts to educate participants, respond to questions, and enroll people on site, and to conduct a media campaign to raise public awareness;
- a public radio station to provide in-depth reporting and conduct a community engagement project that is examining implementation of the ACA and its impact on the delivery of health care in Essex County over the course of the year; and
- an online New Jersey media company to add an ACA-specific page to its website (http://www.njspotlight.com/aca) with frequent articles and information about enrollment.

LESSONS LEARNED

Prior to the beginning of open enrollment and again at its close, HFNJ brought our grantees together to share experiences, challenges, and strategies for success. Here are some of the things we learned:

- Virtually all of our grantees were challenged by the time they needed to spend with each client. They discovered that, in addition to information about the ACA itself, many clients were completely unfamiliar with the parlance of insurance: copays, deductibles, and the like were foreign to them, as was the concept of having to pay yearly premiums to keep the insurance valid. When clients were seen four separate times, enrollment went up by 33 percent.
- Because signing up for insurance and providing the infor-

mation necessary for enrollment are intensely personal, people respond most positively to people they know from their community—people with whom they have a relationship and who speak their language. The stronger the relationship, the more the likelihood of enrollment.

- Clients often came without the documentation needed to enroll. Agencies learned that reminder calls before appointments were necessary to minimize this problem and follow-up appointments were often needed.
- The great majority of people seen by HFNJ grantees were eligible for coverage under NJ FamilyCare/Medicaid expansion.
- Some clients thought that the charity care they had been receiving when visiting emergency rooms or clinics was insurance, and did not want to change to a system unfamiliar to them. They did not realize that they might no longer be eligible for charity care if they are eligible for insurance under the ACA or Medicaid expansion. And here in New Jersey there is an additional rub: institutions that provide charity care are often not permitted to treat people who are insured, and people do not want to lose their current health care provider.
- Stigma and class issues played a major role in some populations, where people who could not afford to purchase policies under the exchange without subsidies or who were eligible for expanded Medicaid did not want to sign up because they felt ashamed to receive public funds. They wanted to self-pay, even if that meant foregoing well care or paying out medical debt over time.
- Stories are effective. Immigrant populations, who were very reluctant to provide the personal information that is necessary to enroll for fear of deportation of a family member, responded to videos made by one of our grantees depicting Latino clients who had enrolled, sharing their problems and talking about the positive impact that having insurance has had on their lives. The agency used those videos on its website and in faith-based and community settings to break down barriers and encourage enrollment.
- Women play an important role as gatekeepers for uninsured family members. Appealing to women and giving them the tools and the key messages they need to convince young adult children or spouses are effective ways to reach those difficult groups.
- Dental care is an essential ACA health benefit for children, but not all policies in New Jersey's exchange include dental care. (NJ FamilyCare/Medicaid does cover eligible children.) In addition—and perhaps even more importantly—copays for health coverage must be exhausted before policies pay for dental services. This leaves many families still unable to afford dental care.
- Affordability is still a key issue. Some people are willing to take the penalty rather than pay insurance premiums. Others who purchased insurance may not fully understand what is covered and what is not. We are concerned that as enrollees begin to receive bills for the premiums due or to access care and find they have high copays or insufficient coverage, some will not pay and will return to the roster of the uninsured.

MOVING FORWARD

Despite the challenges, New Jersey enrolled 161,775 people in marketplace insurance—achieving 137 percent of its year one target of 113,000 enrollees (Castro 2014; Torres 2014). And there is more good news: most opted for Silver Plans, avoiding the less expensive but lower-coverage Bronze alternatives. In March, the last month of open enrollment, there was a surge in young enrollees. NJ FamilyCare/Medicaid exceeded its enrollment goal by 86 percent as of April 2014 (Castro 2014). By April, combined enrollment in marketplace coverage and Medicaid stood at 317,000, and some estimate that full enrollment (of all uninsured in New Jersey) should take two to three years.

But the road will not be easy, and enrollment is only the beginning of the story. Re-enrollment education will be key. Moreover, ensuring that a sufficient number of primary care providers are accessible and willing to see patients, and connecting patients to those providers, will be an important challenge in the coming years. Foundations will need to address workforce capacity issues, licensure changes to expand the ability of nurses or dental hygienists to practice to the extent warranted by their education, and the low Medicaid reimbursements and gnarly bureaucracy that discourage physicians from seeing low-income patients. It will surely be an interesting and exciting time.

SOURCES

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