THE CHALLENGES OF ACA MARKETPLACE ENROLLMENT: RESULTS FROM BIG DATA AND CAMPAIGN-STYLE TACTICS IN THE KANSAS CITY AREA

Tami Gurley-Calvez, Jessica Hembree, Jane Mosley, Mary K. Zimmerman, and Bridget McCandless

In the fall of 2013 the Health Care Foundation of Greater Kansas City (HCF) undertook a major effort to increase insurance coverage among the estimated 200,000 uninsured people in their service area. HCF took a multi-tiered approach, providing direct incentive funding for organizations to train Certified Application Counselors (CACs) and conducting outreach activities through multiple modes of contact. Throughout the open enrollment period, HCF efforts involved knocking on nearly 60,000 doors and mailing communication to 68,000 households. HCF was committed to making real-time changes to their outreach strategies in order to increase effectiveness. Short-term evaluation efforts were canceled due to low response rates and it is too soon to assess the longer term impact of HCF outreach efforts. Overall, the experience highlights the role for local entities in providing education on health insurance and federal policy and the limitations of big data campaign-style tactics for identifying the uninsured and evaluating outreach activities, particularly those using phones as the primary contact. Experience also suggests the need for close collaboration between outreach and enrollment activities.

Keywords: insurance, marketplace, Affordable Care Act, big data, enrollment outreach

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Provide leadership, advocacy and resources to eliminate barriers and promote quality health for uninsured and underserved in our service area.

Mission of the Health Care Foundation of Greater Kansas City

Tami Gurley-Calvez: Department of Health Policy and Management, University of Kansas Medical Center, Kansas City, KS (tgurley-calvez@kumc.edu)
Jessica Hembree: Health Care Foundation of Greater Kansas City, Kansas City, MO (JHembree@hcfgkc.org)
Jane Mosley, Health Care Foundation of Greater Kansas City, Kansas City, MO (JMosley@hcfgkc.org)
Mary K. Zimmerman: Department of Health Policy and Management, University of Kansas Medical Center, Kansas City, KS (mzimmerman@kumc.edu)
Bridget McCandless: Health Care Foundation of Greater Kansas City, Kansas City, MO (BMcCandless@hcfgkc.org)
I. INTRODUCTION

In the fall of 2013 the Health Care Foundation of Greater Kansas City (HCF) undertook a major effort to increase insurance coverage. These efforts were based on campaign-style tactics proven to be successful in recent political campaigns, which utilize available voter and consumer data to target door-to-door canvassing, mail and phone communication, and internet ads. This paper details the lessons learned employing these tactics to increase insurance enrollment in the Health Insurance Marketplaces established under the Patient Protection and Affordable Care Act of 2010 (ACA).

The ACA provided several mechanisms through which uninsured individuals could obtain health insurance coverage, particularly those in lower income households. Many provisions, including Medicaid expansion, health premium and cost sharing subsidies, and guaranteed issue, did not take effect until January 1, 2014, with Medicaid expansion ultimately up to each state. HCF capitalized on the federal policy reform to undertake a sizable Marketplace Coverage Initiative (MCI) aimed at increasing insurance coverage rates and access to health services. The HCF is a philanthropic foundation established through a 2002 court-approved settlement and sale of a nonprofit health care system in Missouri and Kansas. HCF is charged with promoting quality health for uninsured and underserved individuals in a six-county area. HCF determined that ACA policies could substantially benefit their target population, but that the lack of coordinated outreach efforts by state and federal level government entities could decrease their policy impact. To improve awareness among local residents, the MCI was designed to make use of several modes of communication. These efforts and lessons learned for future outreach efforts are described below.

Rates of uninsured in Kansas (13 percent) and Missouri (14 percent) are below the national average (15 percent), but rates in the Kansas City metropolitan area are substantially higher, 26.1 percent in Wyandotte County, KS and 16.8 percent in Jackson County, MO (Katerndahl, et al., 2013). In total, the HCF estimated that there were roughly 200,000 uninsured in their service area. In order to promote insurance in this population, HCF provided funding for Certified Application Counselor (CAC) training and conducted a multi-faceted outreach campaign that included door-to-door canvassing, mail, phone, and digital outreach.

National estimates from the open enrollment period from October 2013 to March 2014 indicate that about 8 million people enrolled through Health Insurance Marketplaces (U.S. Department of Health and Human Services, 2014) and that about one-third of these enrollees are newly insured (Carman and Eibner, 2014). About 57,000 individuals enrolled through the Marketplace in Kansas and over 152,000 in Missouri, but there are no state-level estimates of the number of these enrollees that are newly insured rather than individuals who switched from another insurance provider. After subsidies (i.e.,

1 The HCF service area includes Cass, Jackson, and Lafayette counties in Missouri and Allen, Johnson, and Wyandotte counties in Kansas.

2 The enrollment period was extended to April 19, 2014 for those who had begun the enrollment process by March 31, 2014. These individuals are included in the reported statistics.
The Challenges of ACA Marketplace Enrollment

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tax credits), individuals who selected a Marketplace plan in Kansas have an average monthly premium of $67 (a 77 percent reduction from pre-tax premiums) and Missouri enrollees have an average monthly premium of $59 (an 83 percent reduction from pre-tax premiums). These after-subsidy premiums are considerably smaller than the national average of $82, likely due in part to higher subsidies at lower income levels and the decision in both states not to expand Medicaid to 138 percent of the federal poverty line (FPL). In states that chose not to expand Medicaid coverage, households with incomes of 100 to 138 percent of FPL are eligible for Marketplace subsidies, whereas subsidies start at 139 percent of FPL in Medicaid-expanding states.

The next section of this report details the political environment in which the outreach efforts were conducted, including limits on information sharing, decisions on Medicaid expansions, and type of Health Insurance Marketplace. Section III describes the MCI implementation and actions and the planned survey evaluation that was ultimately discontinued due to low response rates. Section IV concludes with a discussion of results, lessons learned, and the implications for policy as well as future open enrollment efforts.

II. POLITICAL CLIMATE

Both Kansas and Missouri have challenged portions of the ACA and its implementation. Kansas joined a group of 26 states challenging the constitutionality of the individual mandate and Medicaid expansion portions of the ACA in 2010. Following the Supreme Court ruling that allowed states to opt out of Medicaid expansion without jeopardizing their existing federal Medicaid funds, both Kansas and Missouri elected not to expand Medicaid up to 138 percent of FPL as originally required under the ACA.

Under the ACA, not expanding Medicaid creates a “coverage gap” for individuals with incomes too low to qualify for subsidies and too high to qualify for Medicaid. The Medicaid gap affects mainly adult coverage. Children are generally covered through Medicaid or the Children’s Health Insurance Program (CHIP), up to 250 percent of FPL in Kansas and 305 percent of FPL in Missouri. Parents of dependent children qualify for Medicaid with income less than or equal to 38 percent of FPL in Kansas and 23 percent of FPL in Missouri. There is currently no Medicaid coverage for non-disabled adults without dependent children in either state. Under ACA, enrollees with income between 100 and 400 percent of FPL are eligible for federal premium and cost sharing subsidies to limit out-of-pocket expenses to a fixed portion of their income.

In addition to the Medicaid decision, Missouri took additional actions related to ACA implementation. In 2010, Missouri voters passed the Missouri Healthcare Freedom Act, also known as Proposition C, which was intended to prevent the federal government from requiring individuals to purchase health insurance and disallowed punishment for


being uninsured (Blank, 2010). Missouri also passed Proposition E mandating legislative or voter approval to establish a state-based Marketplace (Missouri Foundation for Health, 2012), essentially ensuring a federally-run Marketplace in Missouri; Kansas also has a federally-run Marketplace. The Missouri Health Insurance Marketplace Innovation Act (HIMI) of 2013 placed limits on the information that health insurance “navigators” (individuals paid, trained, and certified by the federal government to assist consumers in the health insurance decisions) could provide, including restrictions on talking about insurance plans not on the Marketplace and advice regarding Marketplace plans (Cowley, 2013).

The federal government did not choose the Kansas City market as a top tier investment for marketing efforts and consequently there was almost no government investment in ACA-related marketing in the Kansas City area. The MCI sought to fill some of this void through its outreach efforts and through earned media, the process of gaining publicity through promotional efforts rather than paid advertising. Outside of the MCI efforts, local media coverage was generally high quality and of good quantity, but the timing was not conducive to encouraging enrollment. Most coverage was early, before enrollment activity had begun, or focused on the technical difficulties in the federal Marketplace website.

Federal grants for in-person navigators were also sparse in the Kansas City area. One organization in Kansas received nearly $200,000 to provide assistance in five counties, including Jackson (Kansas City, MO) and Wyandotte (Kansas City, KS). One organization in Missouri received just over $1 million for state-wide efforts while the other Missouri recipient explicitly excluded the Kansas City area.

III. THE MARKETPLACE COVERAGE INITIATIVE

In order to promote health among the uninsured and underserved, the HCF undertook the $750,000 MCI outreach effort. The MCI sought to accelerate enrollment and expand awareness and was characterized by several key elements: (1) in-person assistance; (2) the use of analytics and “big data” to target efforts toward the uninsured; and (3) multiple contact modes representing varying levels of treatment intensity. Each activity is discussed in greater depth in the following sections and a summary of activities can be found in Figure 2.

A. In-Person Assistance Funding for Certified Application Counselors

Beginning with in-person assistance, the HCF provided $2,000 in incentive funding to local non-profit organizations for each individual who became a certified application counselor (CAC). CACs are trained to assist individuals applying for coverage through the Marketplace while protecting consumer information. During the first open enrollment period, HCF awarded just over $100,000 for 51 CACs in more than 45 organizations. In addition to serving the community through their organizations, these
CACs also processed consumer referrals generated by the HCF in their other outreach activities.

**B. Using Technology and Big Data**

The availability of vast amounts of person-level data and portable technology for real-time data collection has been used with great success in election campaign efforts. The MCI made use of these cutting-edge techniques to target and record their canvassing outreach efforts. Key components of the effort include person-level data, contact data, person-level probabilities of being uninsured, online access to the data, and a software tool for transferring information between the database and canvassers in the field.

The first essential building block for these outreach efforts is the availability of person-level data, including contact information. The MCI project was built from a national database of more than 280 million people, including 190 million registered voters and 90 million unregistered people of voting age. Data obtained for Kansas and Missouri included names, phone numbers, and addresses. These data, made available to 501(c)(3) charitable organizations through an online portal, were linked to an individual score representing the

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**Figure 1**

Civis Uninsured Scores in the Kansas City Metropolitan Area by Census Tract

![Map of Civis Uninsured Scores in the Kansas City Metropolitan Area by Census Tract](http://www.civisanalytics.com/pages/civis-uninsured)

Source: Reproduced from Civis Analytics online mapping tool, http://www.civisanalytics.com/pages/civis-uninsured
probability that an individual does not have health insurance. These scores were generated by a firm specialized in using big data to address problems in education and health and were calculated using a combination of public (e.g., American Community Survey) and proprietary data. As a final step, the MCI project required a data management tool to facilitate information transfers from the database to canvassers in the field. This function was filled by an online data management tool, which provided an interface for searching and selecting data as well as transferring information to and from portable technology devices and to other vendors participating in the project. In essence, the data management tool allowed identification of the target population, transfer of targeted names and addresses to tablets used by canvassers in the door-to-door efforts, and transfer of information from the field, including canvassing outcomes, back into the database. Contact information was also provided to the vendor responsible for outreach-related mail communication.

C. The Canvass

Canvassers knocked on doors in densely populated areas of Kansas City, MO and Kansas City, KS to engage individuals in conversations aimed at increasing their awareness of insurance options and motivating Marketplace enrollment. Neighborhoods were selected for canvassing based on high population density and high rates of uninsurance
in the voting precinct. Based on these criteria, the number of targeted neighborhoods exceeded the scope of the canvass effort and a subset of target neighborhoods was retained as a control group that did not receive any canvassing (or any other outreach including the phone and mail efforts discussed below).

Local canvassers who had some familiarity with the canvass neighborhoods were hired and trained to work in teams. Canvassers were given a script as a guide to their conversations with individuals and collected information cards from individuals who wanted more information or assistance with enrollment in the Marketplace. These cards were then referred to organizations with CACs for further assistance. A goal was set to make three passes through each neighborhood as suggested by previous experience with canvassing campaigns. Second and third passes capitalized on information collected in the previous passes, taking account of addresses that were inaccessible, contacts that were made, or targeted individuals who had moved. Addresses on the list might not have actually received a knock on the door or canvass information for several practical reasons. Addresses were deemed inaccessible if they could not be approached safely (e.g., door not visible to team member) or if the building required an access code or key. Other reasons for not canvassing at a particular address were that the targeted individual did not reside at the address or the individual spoke another language (Spanish-speaking canvassers were sent to predominantly Spanish-speaking neighborhoods).

Data management tools were used to build lists of individuals within each neighborhood that were likely to be uninsured based on individual-specific scores reflecting the probability they were uninsured. Names and addresses were transferred to portable devices for use by canvassers. Thus only addresses that were linked to at least one individual with a high uninsured score received a door knock. Figure 1 is a map of uninsured scores by census tract in the Kansas City metropolitan area. The cluster of high scores (dark gray) on the left side of the figure represent densely populated areas of Kansas City, KS and those on the right side represent urban Kansas City, MO.

Initial testing of 5,842 addresses from November 2013 to December 2013 was used to refine the canvassing script. As a result, the uninsured cut-off score was lowered from 33 to 25, indicating that the estimated probability that the individual was uninsured was 25 percent or greater. Lowering the score involved trading off a higher probability of finding someone without health insurance against the need to have enough locations in a neighborhood to be worth sending canvassers. During the test period, contact was made 6 percent of the time, no one answered 51 percent of the time, and the remaining knocks either resulted in someone who did not meet the inclusion criteria or represented addresses that were inaccessible. Of the 376 contacts, 105 (28 percent) requested more information about enrollment. For the remaining canvassing efforts, door hangers were left at addresses where no one answered and checklists of necessary Marketplace enrollment information were given out following canvass contacts.

A total of 8,839 targeted individuals were canvassed out of 57,772 door knocks. A detailed picture of the canvass results is presented in Figure 3. Panel A includes addresses that were deemed inaccessible in all passes, which represented 35 percent of
targeted addresses, and Panel B excludes the inaccessible addresses. Results in Panel B indicate that no one answered the door at about 60 percent of accessible residences, 8 percent refused to talk with canvassers, and about 30 percent of accessible residences resulted in a conversation.

Aside from the basic statistics, two key results from the canvass seem particularly relevant to any potential future efforts during subsequent open enrollment periods. Getting an answer at the door represented the first hurdle for a productive canvass; however, finding the uninsured proved an additional challenge. About 20 percent of doors on the knock list resulted in a conversation (Figure 3, Panel A), but among the subset of individuals in Kansas who responded to the insurance question, 85 percent reported being currently insured. The uninsured are hard to find, even with the power of big data and sophisticated modeling techniques. Second, unlike election-related campaigning, second and third passes through the neighborhood resulted in lower, not higher, canvass rates (about 14 percent for the first pass and 5 percent for the third pass). Future canvass efforts should consider covering more neighborhoods fewer times.

Consistent with the early testing, about 30 percent of canvassed individuals filled out a referral card requesting further assistance. However, evidence from both those who received the referrals and those who were referred suggests that conversion to insured status is difficult. Moreover, the capacity of CACs to meet referral demand diminished
substantially toward the end of the open enrollment period to the point that referrals were no longer transferred as of March 14, 2014.

A handful of organizations representing over 1,300 referrals (about 50 percent of the total number referred to CACs) reported outcomes back to the HCF. Based on these reports, we estimate that about 21 percent of referrals had bad phone numbers (e.g., disconnected, no longer associated with the person being referred), 9 percent declined further assistance, 23 percent only wanted more information, 9 percent already had insurance coverage, and 9 percent scheduled appointments for further assistance. No show rates for scheduled appointments were greater than 90 percent for some organizations and the reports indicate that 35 percent of appointments (3 percent of referred cases) resulted in an insurance enrollment. It is possible that some of the already insured individuals enrolled because of the canvass efforts between the time they were canvassed and when the referral organization contacted them, but we cannot identify these cases in our data.

Some suggestive data are also available from live calls placed at the end of March 2014 to those who had filled out referral cards. Of the 1,419 phone numbers received, 8 percent proved to be disconnected or wrong numbers, while 34 percent (484 individuals) agreed to answer survey questions about the outcome of their referral (Figure 4). Thirty percent reported that they had received the help they needed and about two-thirds of those receiving help reported being insured. Among those who received help but remained uninsured, most cited cost or not qualifying for a subsidy as the main reason

**Figure 4**
Results from Survey of Consumers who Filled out Referral Cards for In-person Assistance

Source: Authors’ calculations based on survey outcomes data
for not being insured; 36 percent said that they had not received the help they needed and a substantial proportion, 28 percent, refused to answer or were unsure.

A major lesson of the HCF process of outreach and referral is the importance of timeliness. The likelihood of encountering a bad phone number increased dramatically the longer the time interval between data collection and attempted contact. Organizations that provided referral results reported a bad phone number in one out of five attempts. The data suggest that the canvass was effective in generating referral cards, but that this did not necessarily translate into continued motivation to enroll by the time those individuals were contacted by a CAC organization. The option of enrolling consumers at first contact would likely improve conversion rates. Additionally, implementing a process for monitoring referrals and managing workloads across CACs might also facilitate more enrollments by minimizing the amount of time from the canvass to the CAC contact.

D. Additional Outreach Efforts

Campaign-style communication tactics generally involve layering multiple modes of communication. Early in the implementation of the MCI, a strategic decision was made to completely separate the canvass and mail outreach populations. Canvass efforts could not be conducted in less densely populated suburban areas or in the more rural areas of outlying counties. Mail outreach was targeted toward individuals outside the urban core in order to provide outreach efforts in the entire HCF service area. As in the canvass efforts, mail communication was targeted based on individual-level uninsurance scores of 25 and a control group was selected based on the same criteria as the treated sample. The first round of mail was sent February 28, 2014. A total of 68,000 individuals were sent five mailings before the end of open enrollment on March 31, 2014 for a total of 340,000 pieces of mail.

The initial MCI outreach plan called for automated calls to be placed to individuals in both the canvass and mail outreach samples. Automated calls featuring the mayors of Kansas City, MO and Kansas City, KS alerted individuals in the canvass sample that someone would be knocking on their door to discuss health insurance. Automated calls were also used to draw attention to the mailings. Both types of automated calls were discontinued during the MCI outreach campaign. Early reports from canvassers in the field suggested that the calls were not making a difference as most individuals reported never receiving a call. Additionally, the HCF was overwhelmed when some individuals tried to return their automated calls. Two factors — new FCC regulations prohibiting automated calls to cell phones and contact information containing a large percentage of invalid numbers — were also key in limiting the effectiveness of automated phone outreach. Eventually, automated calls to the mail sample were replaced with live calls in which a person could self-identify as uninsured and request a referral for further assistance. Although the live calls did generate a high number of assistance requests late in the outreach period, there was not enough capacity among CACs to service these requests.
Digital advertising was used to “chase” individuals in both the canvass and mail geographic areas. This portion of the outreach did not utilize the same data sources for targeting individuals. Instead, internet communication was targeted based on online behavior of internet users in the geographic regions covered by the MCI. Based on initial testing of several available options, most of the internet outreach was conducted through display ads based on internet activity from mobile devices and Facebook newsfeeds. Following the difficult rollout of the federally-run Marketplace, HealthCare.gov, the MCI plan was adjusted to create a new internet portal, CoverKC, which provided information and linked to the federal enrollment site. Internet advertising directed individuals to the CoverKC website, allowing MCI to collect information on the types of information individuals sought. In total, the CoverKC digital effort resulted in more than 33,000 visits from 25,349 unique visitors at an average cost of $2.92 per visitor. Over 700 visitors clicked through to the subpage linking them to the federal enrollment Marketplace, more than 450 visitors accessed the enrollment checklist (includes English and Spanish versions), and 121 visitors used the Spanish version of the webpage.

MCI outreach efforts also included garnering “earned media” by hosting reporters to generate coverage in media outlets, including stories that were covered by the The Street Journal and The Kansas City Star as well Kansas City broadcast media — WDAF-TV Fox4KC and KSHB radio. These media outlets are relevant for the Kansas City metropolitan area; however, it is not clear whether they are effective for communicating with lower income households.

E. Planned Evaluation Efforts

Evaluating the overall MCI and the relative effectiveness of the MCI was a high priority for the HCF. Accordingly, evaluation needs were considered early in the outreach design. A central part of the evaluation was a follow-up phone survey conducted after the end of the open enrollment period. The survey sample incorporated both treatment and comparable control groups, selected from both the canvass and mail outreach populations. After pre-testing and refining the script, survey calls began in mid-May 2014. Survey callers dialed 1,500 numbers from May 12 to May 16, 2014 resulting in only five completed surveys and one partially completed survey. Calls were suspended on May 16, 2014 due to the low rate of completion. Of all the numbers dialed, 52 percent were disconnected or wrong numbers.

The overwhelming lesson from this exercise is the serious limitations of using data lists based on consumer and voter information for insurance outreach and evaluation efforts. The advantage of receiving this information was lost in most cases due to the low quality of contact information for lower income households. Such households are likely to have a higher percentage of cash transactions resulting in less consumer information and fewer data points for predicting insurance status.
IV. DISCUSSION AND LESSONS GOING FORWARD

Marketplace enrollment is likely to remain a priority for entities interested in increasing access to health services for lower income populations, including government agencies and nonprofit organizations. For example, a substantial number of individuals remain uninsured, individuals newly insured in the Marketplace in 2014 will need to re-enroll in subsequent years, and there is a great deal of uncertainty about what will happen to employer-provided insurance over the next several years. Further, individuals newly insured through Marketplace plans are likely to face a steep learning curve as they utilize their coverage and experience co-pays, co-insurance, deductibles, “in-network” limitations, and out-of-pocket maximums (Culp-Ressler, 2013; Evans, 2013; Long et al., 2014b).

Regarding the number of individuals who remain uninsured, national estimates suggest a substantial reduction in the number of uninsured of between 5.4 million and 9.3 million (Carman and Eibner, 2014, Long et al., 2014a). Carman and Eibner (2014) estimate that about 1.4 million of the 9.3 million newly insured enrolled through the Marketplaces but these numbers do not include the late surge in Marketplace enrollment; if trends in early enrollments persist, the number of newly insured through the marketplaces could double to about 3 million. Despite these reductions in uninsurance, about 30 million people remain uninsured. Lower than anticipated insurance take-up could have both short-term and longer-term implications for health care policy. For instance, high rates of uninsurance undermine the universal access and coverage goals of ACA and might affect perceptions of the policy’s success and longevity. Welfare implications for individuals are likely to be case-specific. Some households might not enroll because they are unaware of the policy and the financial assistance available to them or because they distrust the government’s sign-up process and fear they might be confronted with hidden costs later on. Others might choose not to enroll because they perceive the benefits of insurance as less than the cost. For example, in addition to cost of insurance, enrolling in an insurance plan might disqualify a person from a free or reduced-cost prescription drug programs for the uninsured. Finally, it is important to note that some of these reasons are time sensitive and may be altered in the aftermath of the initial sign-up period. Public perceptions of the ACA regarding whether it is likely to remain in place and the sign-up process is trustworthy, will be clarified as personal experiences accumulate and information is disseminated, especially in low-income communities. Ultimately, the numbers and characteristics of those enrolling in Marketplace plans will determine whether the market is sustainable.

Most predictions suggested that ACA would result in a small change in employer-sponsored insurance, typically ranging from a decrease of 1 million individuals to an increase of 1.7 million — although one dire estimate predicted that more than half of individuals would lose their employer-sponsored coverage.5 In fact, most of

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5 Buchmueller, Carey, and Levy (2013) provide a summary of estimates and a discussion of the factors leading to such broad differences.
the newly insured, 7.2 million, gained insurance through an employer, although 2 million people did lose their employer-sponsored insurance (Carman and Eibner, 2014). It is unclear how much of the gain in employer-sponsored coverage is due to increased take-up and how much is attributable to new employer offerings. Likewise, it is unknown how much of the loss in employer-sponsored coverage is due to job changes.

Experiences from the MCI could be helpful for other organizations planning outreach efforts, particularly nonprofit organizations thinking of using big data. However, there are several caveats. This effort was conducted independent of state or local government agencies and, as noted below, capitalizing on government data and resources could lead to more effective targeting of uninsured and subsidy eligible households. The MCI was also conducted in the first year of Marketplace enrollments in an environment where there likely was considerable lack of knowledge and understanding of the ACA. Early education efforts and greater perceived permanence of the policy might lead consumers to take a more active role in the future. Finally, the Kansas City metropolitan area spans two states, creating a more complex environment with different state policies and levels of government involvement in supporting or discouraging ACA implementation.

The Kansas City effort used big data to target the uninsured; however, even with sophisticated models predicting individual-level probabilities of uninsurance, the uninsured proved hard to find. If the probabilities estimated and addresses identified were perfectly accurate, the likelihood that the person answering the door would be uninsured was estimated to be 25 percent. However, an informal polling of individuals who were willing to answer a question about their insurance status suggests that the probability of finding an uninsured person might have been closer to 15 percent. In survey calls, individuals were 3.5 times more likely to screen out of the survey due to being insured than to complete the survey. More precise predictions are needed for big data to significantly improve the efficiency of targeting outreach efforts to the uninsured.

The difficulty of finding an uninsured individual at the door is minor compared to the challenges of using big data phone numbers as the primary contact information. More than half of calls to 1,500 randomly chosen phone numbers resulted in a disconnected or wrong number. The lack of reliable phone numbers precludes the use of current data lists for phone outreach and evaluation surveys targeted to the uninsured population. Related to this issue, timeliness of contact is essential for using contact information collected in the field. MCI efforts suggest that lags of several weeks between collecting information and contacting individuals can increase the rate of bad numbers from under 10 percent to over 20 percent. Practically, MCI efforts could have been enhanced with a dedicated staff person to enter referral information for in-person assistance on a daily basis and a centralized scheduling system allowing referrals to be targeted to organizations with greater capacity. Another limitation of phone outreach is the prohibition on using cell phones for automated calls or education campaigns. Low-income populations have migrated to cell phone use and are under-represented among landline subscribers (Merchant and Fram, 2011; Blumberg and Luke, 2012). These experiences
suggest that a less-targeted communication strategy might be more effective. They also suggest the dual strategy of using government as well as private, nonprofit organizations with strong community roots. One might, for example, provide information through a neighborhood organization or local government office and ask interested individuals to respond for assistance. Mobile enrollment units stationed in low-income neighborhoods might also be effective for increasing awareness and reducing the transaction costs of enrolling for local residents.

Big data, campaign-style tactics are attractive to many organizations because of the easy availability of data and the possibility of cultivating ground roots support for Medicaid expansion in non-expanding states. However, the MCI experiences highlight that the process of finding and motivating sympathetic voters might not translate to motivating individuals to enroll in insurance. This is perhaps an opportunity to reconsider the optimal role of outreach efforts in the ACA context. Although most of the focus of outreach efforts is to expand access to health services by increasing insurance rates, health insurance is a complex financial instrument and purchasing a private plan through the Marketplace might not be welfare enhancing for all households. Providing accurate and timely information is likely a more valuable service than persuading an individual to act regardless of their life circumstances.

More broadly, the ACA is a federal policy with significant decisions and activities delegated to state governments that may or may not support the policy or have the financial resources to implement it effectively. Further, ACA policies are relevant to many nonprofit organizations focused on lower income households, particularly those with missions related to health care access. This raises interesting questions about the roles played by governmental and non-governmental organizations and arrangements are likely to differ across states. Neither the federal or state governments took an aggressive role in marketing or outreach efforts in the Kansas City area. The HCF took a leadership role in outreach and organizing local efforts; however, nonprofit organizations are likely to be most effective with government cooperation. In this case, the organization undertakes efforts consistent with its mission and the government benefits from lower costs of implementing the program, which likely represents a partially unfunded federal mandate.

One possibility for cooperation would be to use administrative data for a program with income criteria similar to Marketplace subsidy thresholds and frequent data collection for renewal (e.g., the Supplemental Nutrition Assistance Program, SNAP). The feasibility of this option depends on the ability of organizations to develop partnerships and access administrative data for outreach purposes, a process that is likely to be more challenging in states that are opposed to some or all ACA provisions.

The MCI sought to provide information and drive demand to CACs, but information from CAC organizations suggests that most referrals resulted in no immediate enrollment action. It is possible that over time the longer term effects of the MCI efforts will lead to increased enrollment and/or well-being in future enrollment periods. Throughout the MCI awareness levels of ACA and Marketplaces remained consistently low, even in neighborhoods with multiple canvass passes; the MCI likely represents the first and only effort to expand awareness in many neighborhoods.
The high degree of interest in enrollment and the desire for in-person assistance reported to canvassers suggests that these two functions — outreach and enrollment — might be more effective if bundled together. This is challenging logistically as organizations specializing in enrollment operate using a model where consumers approach them for assistance, while outreach efforts would have to involve more training and employees attempting mobile enrollments. Enrollment times among organizations reporting to HCF ranged from 45 minutes up to 7 hours depending on the amount of information collection and rescheduling that was necessary.

Efforts in states without Medicaid expansion face an extra challenge as some of the uninsured fall into the “coverage gap.” This makes the outreach message complicated as some individuals earn too little income to have any affordable insurance options. That is, households in the gap (generally less than 100 percent of FPL) could purchase a plan through the Marketplace but have to pay the full market price without financial subsidies. It is unlikely that an individual below the poverty line ($11,670 in 2014) would choose to purchase an insurance plan with premiums between $2,100 and $3,400 for individuals age 30 to 50, respectively, and sizable deductibles and co-insurance rates.6 Alternatively, households just outside of the gap (101 percent of FPL) would be almost fully subsidized in terms of premiums and out-of-pocket costs, facing largely nominal charges. The MCI canvassers reported a sense of resignation among those in the coverage gap, and this disappointment with health insurance reform might spill over into the enrollment decisions of those who are eligible. On a related note, if open enrollment for 2015 concludes in February as scheduled, individuals who file their taxes in March or April will have to make their health insurance purchase decisions before learning the tax consequences (e.g., penalties, receipt of additional subsidies, or payback of excessive subsidies) of their 2014 decisions.

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