

Year One Evaluation of the Health Insurance Marketplace in West Virginia Report Three: Enrollment Numbers and Experiences



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Report Three: Enrollment Numbers and Experiences

Executive Summary

This report was designed to aid organizations and individuals whose goal is to promote the Health Insurance Marketplace in West Virginia and enroll consumers into healthcare plans. Additionally, policy makers, governmental organizations and firms involved in designing the systems used for enrollment (electronic and organizational) will find information for system improvement herein. The report is based primarily on open-ended surveys and discussions with enrollment assisters, satisfaction surveys from individuals who consulted with In-Person Assisters, and call-in exit surveys of West Virginians who purchased healthcare plans using the Health Insurance Marketplace. These techniques were used to give insight into what is happening “in the trenches” from the perspective of those on the front line (i.e., enrollment assisters) and first-hand from consumers who are navigating the Health Insurance Marketplace.

Enrollment assisters stated that affordability continues to be a barrier to enrolling in a health insurance plan. Consumers are concerned about monthly premiums and deductibles. Yet, many consumers, upon finding an affordable plan, experienced strong positive emotions. From the perspective of consumer assisters, consumers had difficulty understanding insurance terms and comparing plans.

Assisters also report that data systems are not coordinated. For example, it was identified that Healthcare.gov and inROADS (the WVDHHR public health benefits and its legacy technology) did not share data well at the beginning of the Marketplace enrollment, although it is reported that some corrections have been made.

Assisters also report that some consumers lacked trust. They mistrusted the website (Healthcare.gov), did not have positive reactions to President Obama, or were concerned about tax implications of taking subsidies. Finally, assisters noted the steep learning curve associated with understanding the enrollment process. From the assisters’ perspectives, there is little transparency in how subsidies are calculated.

Consumer surveys found that West Virginians had many different types of overall Marketplace experiences, ranging from “terrible” to “excellent”. There were also mixed findings

related to www.healthcare.gov, including the usefulness of information, the ability to compare plans, and website load times.

These consumers reported that premium costs was the most important consideration when they purchased insurance on the Marketplace, followed by out-of-pocket expenses, and their personal doctors being included in the health insurance plan. Parents generally did not place great importance on children's dental care coverage.

Most respondents were not worried about making their monthly premium payments. Consumers who previously had insurance stated that, compared to previous plans, the plan they purchased on the Marketplace was less expensive and the majority felt the plan was better or the same as their previous plan, yet the application process was more difficult. Many consumers used person-to-person sources of information, and the vast majority of these interactions were positive.

Finally, most respondents indicated that they were "likely" or "very likely" to use the Marketplace next year to purchase insurance. Those receiving federal subsidies were marginally more likely to plan to use the Marketplace again.

Moving forward, it is important that the federal government address the difficulties with the online system. Such difficulty may result in postponed purchase, negative word-of-mouth, and negative feelings towards the enrollment assisters. It is recommended that, during the time between enrollments, consumers be observed using the website to provide information to programmers that will improve navigability.

Organizations seeking to increase enrollment may wish to focus on the products offered on the website, since many previously insured consumers rated the plan as the same or better than their previous plan as well as less expensive or equivalent in price. The positive emotion experienced when obtaining affordable healthcare could be leveraged in future communications; these happy stories might encourage second year enrollment. Finally, consumer education efforts must continue. Enrollment assisters are critical in helping consumers understand the complexity and vocabulary used in the health insurance industry. Given the steep learning curve and the deep knowledge of these front-line people, directing consumers to assisters may be the best way to address education and enrollment efforts.

Cost of insurance continued to be a major concern; suggesting that the statutory definition of affordable may not be perceived as affordable by the consumer. Additionally, there were relatively common population subgroups (i.e., those with blended or separated family

units, those falling into coverage gaps due to income qualifications, couples in which one spouse has employer coverage but the other does not) experiencing complications with signup and subsidy eligibility whose needs should be considered by policy-makers.

As West Virginia progresses, system interfaces (Healthcare.gov, inROADS, Experian, WVDHHR, carriers, West Virginia Bureau of Child Support Enforcement, enrollment assisters) need continued improvement. Consumers and enrollment assisters should be able to make seamless transitions between electronic systems and organizations. This will require active cooperation of the organizations and the information technology personnel involved.

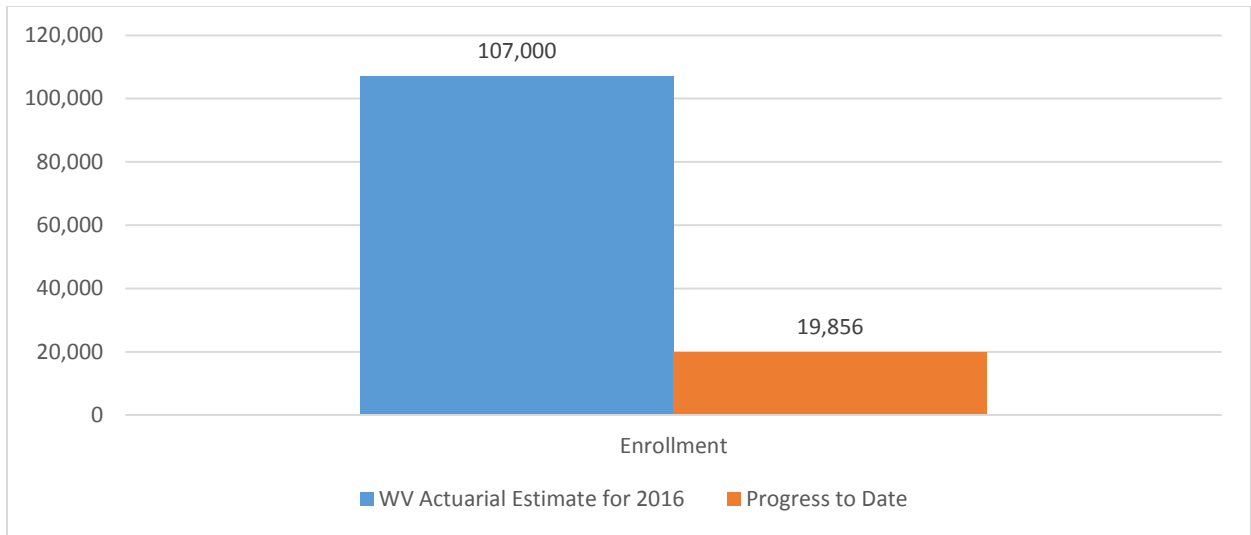
Introduction

One of the key issues surrounding implementation of the ACA was enrollment of participants into the Marketplace. Considerable time and effort was expended at the national and state levels to anticipate the number of individuals expected to enroll in health insurance plans offered on the Marketplace in West Virginia, through the first year of open enrollment. Enrollees were expected to be a combination of previously insured and uninsured people. This report provides information about: (a) the major concerns as well as positive experiences of individuals seeking information about health insurance plans available on the Marketplace in West Virginia, (b) obstacles faced by enrollment assisters as well as their successes, (c) users' satisfaction levels with the enrollment process, (d) consumer perceptions of affordability, and (e) their future intentions regarding purchasing insurance on the Marketplace. Data sources include CMS enrollment reports, focus groups and open-ended surveys with enrollment assisters, exit surveys completed by consumers after they consulted with Maximus In-Person Assistors, and exit surveys of Marketplace plan enrollees. Details of each data source are provided in Report One.

Overall Enrollment Numbers

Exhibit 1 illustrates progress toward the 2016 enrollment estimate based on actuarial reports contracted by the WV Offices of the Insurance Commissioner (WV OIC).

Exhibit 1 West Virginia Progress toward 2016 Actuarial Estimates



Actuarial Data Source: Gruber and Madalena, *State of West Virginia Health Insurance Marketplace Actuarial and Economic Modeling Report*, June 24, 2013. p. 29.

Progress to Date as of May 1, 2014 HHS First Period Enrollment Report.

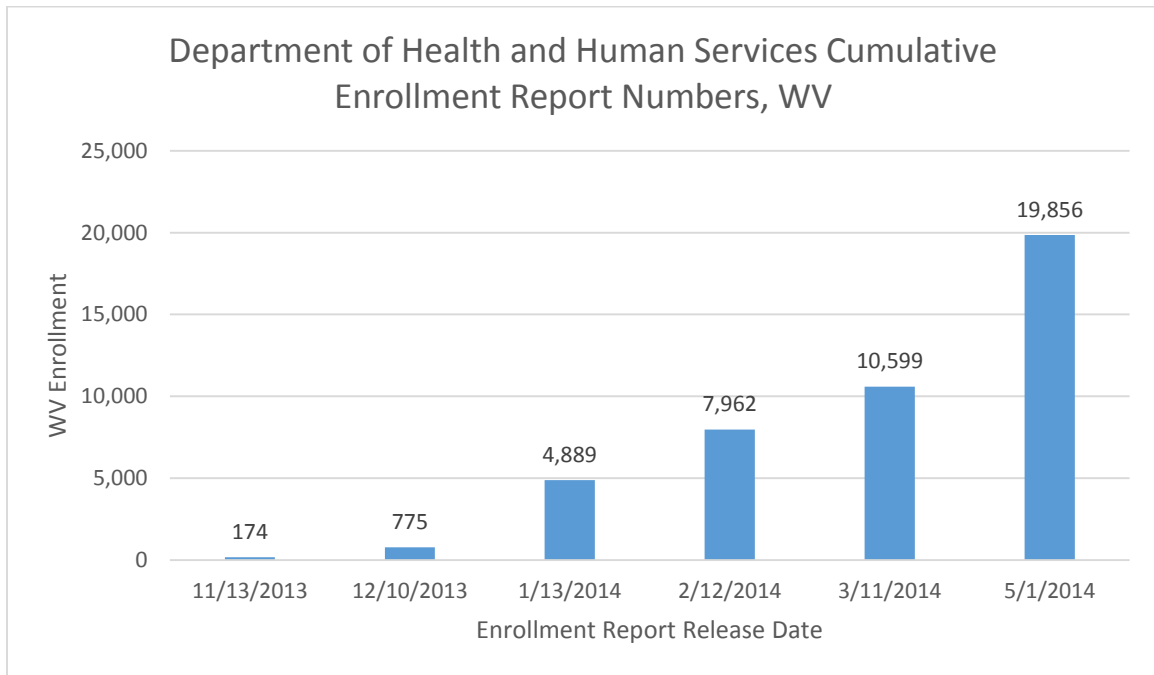
On the most basic level, 19,856 individuals in West Virginia were reported to have signed up for insurance plans on the Marketplace as of May 1, 2014. A complete breakdown of the CMS-provided enrollment numbers is found in Exhibit 2. These numbers demonstrate the need to increase enrollment in order to meet the 2016 actuarial targets. Additionally, there are some potential challenges with the demographic characteristics of enrollees, such as health status and age, which have a potential impact on the Marketplace. Below, we identify the key findings from these data.

CMS Enrollment Reports

Enrollment has advanced toward the projected 2016 numbers, but will need to increase pace over the next two open enrollment periods in order to reach that goal. As of May 2, 2014, 17% of the projected number of West Virginians had signed up for a plan on the Marketplace. The numbers demonstrated here may have a variety of causes, most notably the well-documented issues with the federal online enrollment system, Healthcare.gov. It is unclear how many individuals who faced technical difficulties took advantage of the extension after the initial open enrollment period ended to sign up for plans (the federal government extended the open enrollment period to April 15, 2014). We are also unable to project how many more individuals have signed up for insurance during open enrollment and will still make their first payment.

Finally, individuals may enroll in the Marketplace outside of open enrollment as a result of life-changing events, such as changes in employment, income, marital status, or household size.

Exhibit 2 HHS Enrollment Report Progress



It is important to note that enrollment using the Marketplace in West Virginia increased considerably from the beginning of open enrollment to the end. Exhibit 2 demonstrates the rapid increase across the months in the number of individuals enrolled. This may be a result of a number of factors, including (a) multiplier effects resulting from increased word of mouth among consumers as more and more enrolled, (b) fixes to glitches in the federal website for registration (discussed below), (c) the amount of time it took for individuals to hear about, research, and choose a plan through the open enrollment period, and (d) the fact that motivation increases as deadlines draw nearer.

Enrollment Process

The enrollment process was evaluated using several methods: open-ended surveys and focus groups with enrollment assisters in the northern part of the state, an exit survey completed by consumers who were provided enrollment services by In-Person Assisters hired and trained by Maximus, and a call-in automated phone survey offered to consumers when they received their “Welcome Packet” from Highmark. Thus, we can look at the enrollment process

through the eyes of the enrollment assisters, who are on the front line of the enrollment process and most likely to have a good sense of what is happening in the Marketplace, through the eyes of consumers in the process of choosing a plan, and through the eyes of consumers who have chosen a product from the Marketplace. Individuals who signed up and made the first payment on their plans, while not reflective of those who did not enroll at all, do provide insights into what was important to consumers when choosing plans as well as potential barriers to enrollment.

Insight from the Eyes of Enrollment Assisters

Key Finding: Affordability and costs continued to be perceived as barriers to enrolling in a health insurance plan.

DISCUSSION: A consistent theme among the enrollment assisters in both the survey and the focus groups was concerns about costs—according to one assister, particularly for “those who still cannot afford coverage through the Marketplace even with subsidies and tax credits.”¹

Assisters offered several case studies: young people who perceive themselves as having few medical needs who are unable to afford both the premium and deductible; a grandmother choosing to use her limited discretionary income on “something special,” such as Burger King or a movie for her grandchildren, instead of health insurance; a young couple making tradeoffs between insurance, cars, and homes.

In addition, there was some evidence that the prices are relative to the reference point, meaning that affordability judgments were made based on how much a consumer recalled having paid for health insurance in the past. Thus, a COBRA participant felt that the prices were affordable; however, individuals who may have previously had much of the costs covered by an employer

Enrollment Assisters had the following to say about affordability:

- *Consumers were concerned about “the monthly cost, what it would be and then reaching a huge deductible” (emphasis added).*
 - *When discussing affordable prices “...they [consumers] don’t understand why they’re [prices are] considered affordable.” “Yes, because it’s not affordable to them.”*
 - *“A lot of people find it cost effective to pay the penalty versus paying the monthly healthcare premium.”*
 - *When presented with the deductible and out-of-pocket expenses, consumers think, “If I get sick, I can’t afford all this deductible,’ so they’re in a Catch-22. They don’t know which way to go.”*
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¹ Phrases provided in quotes are directly quoted from enrollment assisters who provided information in the focus groups or open-ended surveys.

(i.e., “The older plans that people had”) perceived prices to be high. Finally, there was evidence that consumers were choosing plans based not only on the premiums, but also on the deductibles.

Key Finding: There were “gaps” in coverage.

DISCUSSION: Several types of “gaps” in coverage were identified by assisters. Three primary situations observed by enrollment assisters that result in coverage gaps include:

- 1) Income eligibility criteria.
- 2) Employers offering insurance to the employed spouse but not the other family members.
- 3) Special circumstances faced by divorced/separated families caught in gap.

Income eligibility: Assistors explained that some working families/individuals “fall in the gap between Medicaid and the affordable coverage, the ones who don’t qualify for the tax credits and subsidies...the ones who don’t meet the under \$30,000 a year.”

Employers offering insurance to only one family member: Assistors also reported problems with affordability that arise when one family member is covered by an employer that only offers coverage to the employee, leaving other family members without coverage.

“Her husband had health insurance provided through his employer. It was for employees only. And it was going to be \$158 a month for her and they’re buying a home. They have two car payments. They ‘this’ and ‘that’ and there is just no way she should afford that.”

Divorced/Separated families: Issues regarding coverage arose when the father and mother were not married and had a formal or informal arrangement regarding money provided for child support as well as which of the parents took the tax deduction for the child (or, alternatively, the deduction alternated year-to-year). There were policies used by the Bureau of Child Support

Enforcement that were perceived by some parents as potentially jeopardizing such arrangements: if a policy was followed, the other parent could interpret the action negatively. In the assister’s words, parents were concerned that they would be “stirring the pot and would anger the other parent that’s voluntarily paying and helping with other bills.” This was felt to put one of the parents’ eligibility for Medicaid, as well as the child(ren)’s eligibility for CHIP, in jeopardy.

There were also concerns about how the new modified adjusted gross income (MAGI) regulations affect the eligibility for split biological families. The general example provided by assisters was that the “mom is eligible for Medicaid income-wise, but because she can’t count her entire household because dad claims the children, she’s not eligible.” A possible fix to this problem, which was based on a CMS information session, requires a series of different applications each with different groupings of parents and children. One assister stated that parents were going back to court to determine a solution.

Key finding: Many who purchased insurance are happy. This was an emotional purchase.

DISCUSSION: Obtaining affordable health insurance was an emotional, happy experience for many. Enrollment assisters discussed enrollees who were happy that they could obtain preventive care with no out-of-pocket expenses, and offered stories of individuals with family histories of breast cancer or those needing blood work or a physical exam. In other public discussions, assisters commented on the large number of hugs they have received from consumers.

Consumers were “*thrilled* that they can have coverage.”

“The ones who have had success stories are referring patients to me. They’re sending their brother, their cousins, and their son.”

Enrollees were happy enough to refer others to the assisters. Additionally, assisters felt that the services they provided enhanced the reputation of the organization in which they worked, stating, “It has built our rapport with everyone in the community and outside the community.”

Key Finding: Consumers sometimes had difficulty understanding insurance terms and comparing plans.

DISCUSSION: Health insurance is a complex product with its own vocabulary and rules. Consumers had difficulty understanding terms and conditions. Assisters pointed out that understanding “in” and “out” of network is also difficult for some.

Assisters had many ways to improve consumer understanding. For instance, one assister explained the subsidies by telling the consumer that the federal government would “send that money to the insurance company and then the insurance company will bill you for the difference.” Assisters compared deductibles to car insurance, used real numbers when explaining possible payment scenarios (e.g., “You go to the emergency room...”), and provided handouts with term definitions for consumers to take home.

“A lot of people...never had insurance. They don’t understand it. They don’t understand what a copay is; they don’t understand what a deductible is; they don’t understand what out-of-pocket expenses are. They don’t understand any of it.”

Several assisters stated that they printed out the plan comparison that was developed by Highmark to help consumers understand plan differences. Specifically, they stated that plan comparison available on Healthcare.gov is difficult to navigate, because “When you are on a computer screen, you have to scroll up and down to see the plan. Instead of being able to see them, instead of having them all in one place, you’re having to scroll. Well, then you have to scroll back up to look again and then scroll back down, instead of having them in columns across.”

Key Finding: Data systems, and sometimes organizations, were not coordinated and cooperative.

DISCUSSION: The enrollment assisters identified several areas in which coordination and cooperation needed improvement:

- a) Healthcare.gov and inROADS (the WVDHHR benefits portal and technology) did not share data.
- b) Assisters sometimes got caught in a loop between Healthcare.gov and Experian, the credit reporting agency.

- c) Data were sometimes not transferred smoothly to Highmark, the only insurance carrier offering insurance plans on the Marketplace.
- d) Representatives who answered questions at the federal 1-800 number were variable—some provided good information and others not.

These items concerned the assisters because they created problems for consumers and reflected negatively on the assister, even when the issue is clearly not under the assister’s control.

Healthcare.gov and inROADS: The lack of connection between these two systems was a critical issue for the assisters, since many assisters were helping consumers who qualified for expanded Medicaid (which is processed using inROADS) and subsidized insurance purchases (processed on Healthcare.gov). Several assisters resolved this problem by verbally qualifying for their clients for Medicaid and then beginning the enrollment process on inROADS, as opposed to beginning their work on Healthcare.gov.

Healthcare.gov and Experian: When Healthcare.gov was unable to verify an individual’s identity based on four key questions, assisters needed to call Experian, a credit reporting agency. However, if Experian was also unable to verify identity, then the assister was told by Experian to call the Marketplace. According to one assister, “Then you call the Marketplace back and they say, ‘Okay, you’re going to have to verify your identity with Experian.’ They send you back and forth.” When the information was verified, occasionally a duplicate application was created which was felt by assisters to slow down Healthcare.gov with unneeded applications.

Transferring Information to Highmark: Sometimes, assisters helped consumers access Highmark, the insurance carrier. This could lead to confusion as well—one consumer was given information that confused the invoice number with the policy number; mailing address information was not appropriately transferred for another, and concerns regarding billing and benefits may have caused problems for the consumer.

“I think the largest issue for all of us is the fact that the websites aren’t talking to each other.”
--Assister commenting on the lack of connectivity between Healthcare.gov and inROADS.

Federal 1-800 Number Representatives: Some federal representatives answering the 1-800 number appeared to be untrained or, as one assister stated, “just following the prompts on their screen.” When the assisters experienced this, they called back in hopes of getting a well-

informed federal representative. According to one assister, she had recently called three times in a row and was still unable to talk to an informed representative. Note that this was not universal. Some assisters experienced no problems; others “resolved” the problem by calling until they found a federal representative who could help. Assisters found it frustrating that, when Healthcare.gov was down, the federal representatives did not have specific information regarding when the system may become available again. Instead of specific information, the federal representatives stated that it could take up to 24 hours for the site to become available. Assisters learned to try different browsers when the system was down, and that sometimes resolved the problem.

Assisters were concerned when they had a problem with a partner (electronic or human), stating that they “lose a little bit of rapport with that [consumer]” and lost trust. Assisters expressed genuine concern about their clients. Some had to reschedule appointments because they were unable to get help from a knowledgeable representative. One assister commented, “That was frustrating for me; I can only imagine what the consumer thought.”

Key Finding: There was a level of mistrust among some consumers.

DISCUSSION: There were several sources of mistrust:

- a) Some consumers did not trust the website.
- b) Some consumers did not have positive reactions to President Obama; others were concerned about tax implications of taking subsidies.
- c) Some consumers were concerned that their premiums and deductibles may change after enrollment.

Healthcare.gov Website: Two primary issues were associated with the website itself. The

Enrollment assisters discussed the difficulty of helping consumers when Healthcare.gov was down—particularly if the delay was “up to 24 hours.” Assisters pointed to clients who took the day off to get insurance, or traveled over an hour to get to the assister. “Those people don’t have an hour to sit there.” “Should they have brought a sleeping bag?” Such statements reflected a concern for the client’s time as well as the assister’s.

first was concerns that arose from the difficulties with the website launch; according to assisters, some consumers were “very skeptical of all the problems with enrollment.” Additionally, the website design might have evoked concerns about consumer privacy.

Assisters discussed the fact that early in the enrollment process, information about the consumer's financial past was presented. One assister stated that the website may have provided feedback to the applicant—for example, "You recently financed or leased a vehicle through, and it may say, Chase Bank, Ford Credit....and that's one of the first questions that is asked when they are opening their account." This may have been perceived as the government knowing too much about the consumer, even though in reality, the information was coming from credit reporting firms, not from the US government.

"Obamacare" and Tax Implications: Assisters experienced, in their words, "a lot of push-back against Obamacare." In fact, assisters tended not to use the term "Obamacare" and used "Affordable Care Act" instead. One assister stated that it was difficult for consumers to understand that ACA was "not an evil socialist take-over bid." Another pointed to the "Obamacare destroyed my life" ads and suggested that, "We need to stop scaring people away."

Several examples arose in which consumers feared that their tax refund would be used to cover their premiums—that they personally would need to pay higher taxes for the subsidies. In other words, these consumers were concerned that, in the end, their personal taxes would be adjusted to cover their personal subsidies.

Premiums and Deductibles: Assisters also relayed stories suggesting that consumers were concerned that their premium would increase or that the deductible would increase during the year. For example, one woman spent what appeared to be much of a day verifying that her deductible would be the lower Silver plan deductible than the Bronze plan she had also considered but rejected.

Key Finding: There was a steep learning curve for the assisters; many acknowledged that they continued to learn. In addition, from the assisters' perspectives, there was little transparency in how subsidies were calculated.

DISCUSSION: A common comment reflected the fact that the system was brand new and that no one was experienced in the beginning. Because the system was new and brought on-line with no previews, assisters started from scratch.

However, assisters used CMS weekly conference calls, Healthcare.gov, the Primary Care Association list-serve (a state-level discussion group), and each other as resources. In fact, during interviews used in this evaluation, the assisters were sharing tips on how to help people enroll. According to them, “It’s a new learning experience every day.”

Assisters reported a lack of transparency, from their perspective, in calculating the subsidies. They interpreted this situation as a lack of consistency: a consumer who appeared to the assister to qualify for subsidies upon completing the application would not qualify; the opposite also occurred when a consumer who appears unlikely to qualify for assistance received it. According to one assister, “There is just no real way to tell someone when they come in the door how their determination is going to

come out.” Another proposed that one solution to this issue was to “remove their application and do their application all over again; you get a different result with the same information.” The evaluation team cannot determine whether such data are actually entered identically or differently (for instance, if the consumer responded to the

same question in a different manner the second time asked, or if zeroes are entered as the letter ‘O,’ or there was simply a typographical error during one of the entries) between two applications for the same consumer. Regardless, the perception of unpredictability is of concern.

In sum, enrollment assisters report both positive and negative aspects of the enrollment process. On the upside, assisters provided vivid descriptions of consumer happiness when consumers bought affordable health insurance. They reported significant learning and progress helping consumers, and appeared to be part of a wide network of assisters helping each other solve consumer problems. They also provided insight into the complex trade-offs consumers report making in determining “affordability.” Shortcomings included failures in communications between people and data, areas in which consumers were confused or mistrustful, and areas in which transparency could be improved.

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- “Not that we are experts because this is all new to everybody.”
 - “It’s all brand new steps. Nobody knows it all.”
 - “There [was] no beta test; you had to go into everything blind.”

--Assister comments regarding steep learning curve associated with enrolling consumers

Survey Results: Seeing the Marketplace from the User's Perspective

As of June 5, 2014, 340 consumers who purchased insurance using the Marketplace volunteered to participate in a phone-in survey after receiving their “Welcome Packet” from Highmark, the only insurance carrier offering plans on the Marketplace in the first year of open enrollment. Appendix E provides a copy of the survey with the total sample results. These responses are unlikely to be representative of all who used the Marketplace in West Virginia; yet, this information is collected directly from those that matter the most—the consumers themselves.

The majority of the respondents (53.4%) reported that they purchased a Silver plan, 23.8% purchased a Gold plan, 15.7% purchased a Bronze plan, and one person (0.6%) purchased Catastrophic coverage. Just over 7% could not remember which level they purchased (See Question 1 (Q1) in Appendix E). About three quarters of the respondents (77.1%) qualified for subsidies (see Question 4 (Q4) in Appendix E). Roughly 40% (39.8%) had not had health insurance coverage in 2013 (Q15).

Key Finding: West Virginia consumers had many different types of experiences, ranging from “terrible” to “excellent” with the Marketplace. About 50% agreed that the website provided useful information and made it easy to compare plans. About 50% also agreed that the website loaded quickly and was easy to use. Most consumers felt that personal information on the marketplace was “somewhat” safe.

Primary questions:

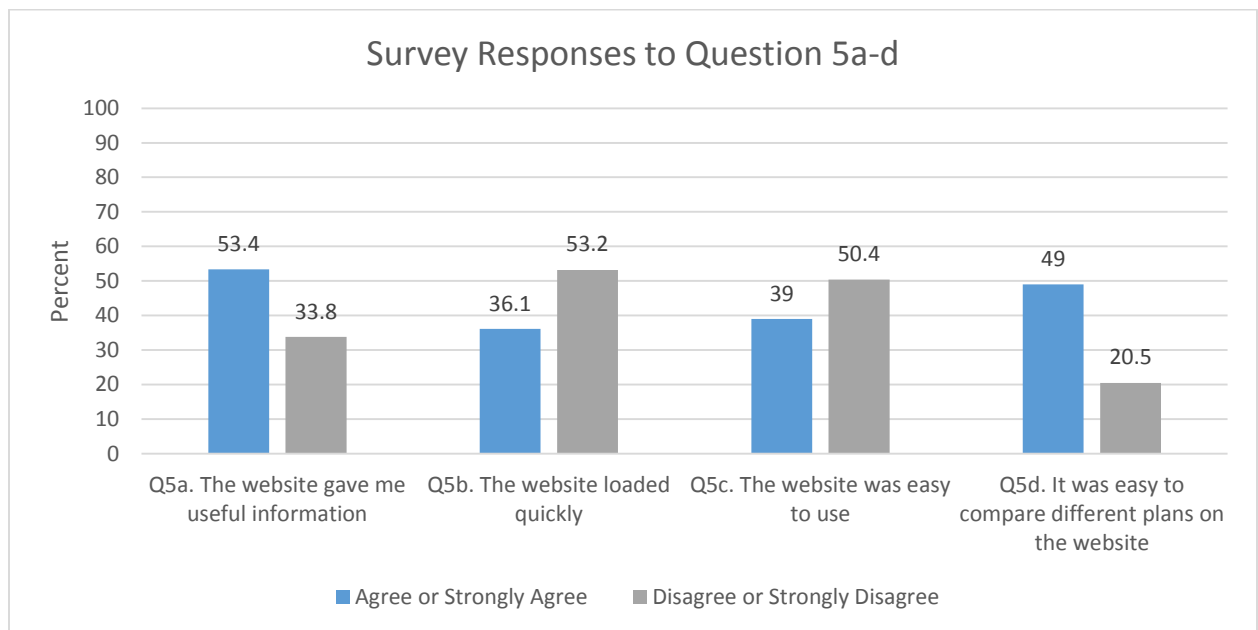
- How would you rate your experience with the Health Insurance Marketplace?
- The website gave me useful information.
- The website loaded quickly.
- The website was easy to use.
- It was easy to compare different plans on the website.
- How safe do you think your personal information is on the Marketplace?

Discussion: The vast majority of respondents (83.9%, Q5) used the Healthcare.gov website when selecting a health insurance plan. Based on the classic “Terrible to Excellence” scale (Q2), a major satisfaction measure in the marketing literature, we found that consumer experiences

were quite varied. Specifically, 24.4% of respondents stated that their experience was “terrible,” while 14.7% stated the experience was “excellent.” If we combine the three negative scales (terrible, very poor, and poor), 43.8% had a negative experience. Combining the three positive scale points (good, very good, and excellent), 56.2% had a positive experience.

There was also a great deal of variability in how consumers viewed the website’s performance. Using measures grounded in research on WebQual,² we asked about four key indicators of website quality: (1) information usefulness, (2) loading speed, (3) ease-of-use, and (4) ability to compare plans. In the table below, we have dichotomized the data to improve the clarity of the results in Exhibit 3.

Exhibit 3 Consumer Assessment of Website



**Note that 20.9% of respondents did not compare plans on the website.*

As can be seen in Exhibit 3, individuals’ experiences were vastly different. Most agreed that the information was useful; however, nearly one-third disagreed with that statement. The majority disagreed that the website loaded quickly, yet over one-third agreed with the statement. About half of respondents disagreed that the website was easy to use. Almost half

²Loiacono, E., et al. (2007). "WebQual: An Instrument for Consumer Evaluation of Web Sites." *Int. J. Electron. Commerce* 11(3): 51-87.

agreed that it was easy to compare plans on the website.³ Interestingly, 41.3% of respondents looked into healthcare plans that were not available on the Marketplace (see Q9).

Finally, we found that consumers were also split on their perceptions that the Marketplace can be trusted to keep personal information safe (Q8). The majority (54.3%) of respondents stated that their personal information was “somewhat safe.” The remaining respondents were roughly equally split between “not at all safe” (22.2%) and “very safe” (23.5%).⁴

In sum, overall website performance needs to be improved. More than 20% stated their overall experience was “terrible.” Additionally, a significant proportion of respondents did not trust the Marketplace to keep personal information safe.

Key Finding: Respondents reported that the cost of premiums was the most important consideration, followed by out-of-pocket expenses and personal doctor being included in the health insurance plan. Parents generally did not place great importance on children’s dental care coverage.

Primary questions:

- How important in your plan selection was:
 - Your doctor is covered by the plan.
 - The cost of the monthly insurance premium.
 - Your out-of-pocket costs when you or your family need care.
 - Availability of children’s dental care.

Discussion: About 90% of respondents indicated that the monthly premium cost was “very important” (Q3a). Respondents also felt that out-of-pocket costs were “very important” (80.4%, see Q3c), as was whether their doctor is covered by the plan (73.1%, see Q3b). Seventy-eight respondents had children; relatively few (about one in five) felt that children’s dental care was “very important” (Q3d).

Key Finding: Most respondents were not worried about making their monthly premium payments. Consumers who previously had insurance (n=180; 58.4%) stated that, compared to

³ There was no statistical difference between early and late responders to the questionnaire with respect to the “terrible” to “excellence” scale, nor the WebQual dimensions (all $p > 0.10$).

⁴ This did not differ between early and late respondents.

previous plans, the plan they purchased on the Marketplace was less expensive. Additionally, among individuals who previously had insurance, the majority felt the plan was better or the same as their previous plan, yet was harder to sign up for than their previous plan.

Primary questions:

- I am worried about whether I will be able to make my monthly premium payments.
- How would you rate our Marketplace plan compared to your previous plan: better, same, or worse?
- Compared to the last time you signed up for a health insurance plan, was signing up easier, same, or harder?
- Compared to your previous plan, how expensive is your Marketplace plan: less, same, or more expensive?

Discussion An individual's level of worry about being able to pay a premium is one measure of affordability (see Q10). Nearly 58% (57.9%) of respondents reported that they were not worried, while 22.7% agreed that they were worried. Individuals who were previously uninsured were significantly more likely to be worried about affording premiums. There was no difference in reported worry level between those receiving and not receiving subsidies ($p>0.10$).

Individuals who were previously insured were asked to compare their Marketplace plan to their previous insurance. A large majority stated that their Marketplace plan was better or the same as their previous plan (73%; Q16b) and that it was less expensive or the same cost as their previous plan (67.4%, Q16d). A slight majority stated that it was harder to sign up for the Marketplace plan than for their previous plan (52%, Q16c). This suggests that the product being offered was quite superior, in the consumers' eyes, to the process used to obtain the product.

Key Finding: Many consumers used person-to-person sources of information, and most interactions were positive.

Primary questions:

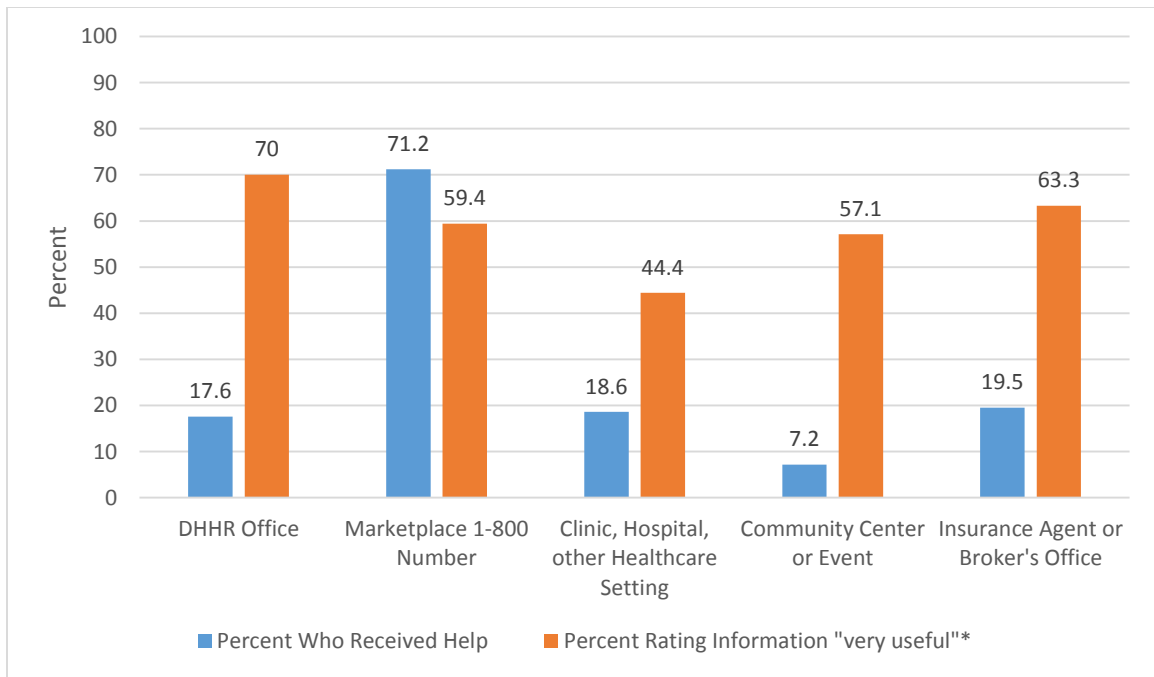
- Maximus Customer Satisfaction Survey (See Appendix D)
- Exit survey (See Appendix E):
 - Where did you get help signing up for your Marketplace plan?

Discussion: Individuals completing the exit survey were asked whether they received help from (1) the WVDHHR office, (2) the 1-800 number, (3) a clinic, hospital, or other healthcare setting,

(4) a community center or event, and/or (5) an Insurance Agent or Broker (See Q6 in Exit Survey). Of these sources, the 1-800 number was most heavily used, with about 71.2% calling the Healthcare.gov helpline. Few used community events. On the whole, however, the majority of consumers felt that the in-person information provided was “very helpful” (see Q6f).

Supporting these results are the results from 1,729 surveys that were completed by consumers who visited with Maximus In-Person Assisters. These short questionnaires were developed in cooperation with the WV Offices of the Insurance Commissioner (WV OIC) and tap essential elements of customer service as identified in SERVQUAL (tangibles, reliability, responsiveness, assurance, and empathy)⁵, along with two more global satisfaction measures. See inset for an overview of this measure. Refer to Report One for a discussion of the methodology and Appendix D for a copy of the questionnaire with the results annotated.

Exhibit 4 Sources and Usefulness of Marketplace Help



* Relatively small numbers of consumers reporting using some of these sources limit the meaningfulness of between-group comparisons.

⁵Parasuraman, Berry and Zeithaml, "Refinement and Reassessment of the SERVQUAL Scale," Journal of Retailing, Winter 1991, pp. 420-50.

Global measures showed that 86.7% of respondents viewed their experience as “excellent,” and another 12% rated their experience as “good.” Additionally, 97.7% felt that they spent the right amount of time with the IPA. IPAs had a professional appearance (over 99% stating “agree” or “strongly agree”) and explained the marketplace clearly (98.6% “agree” or “strongly agree”).

IPAs also performed well with respect to responsiveness. They did a good job answering questions (almost 100% “agree” or “strongly agree” responses); most consumers did not have to wait long (84.2% disagreeing or strongly disagreeing that they had a long wait; 10.6% strongly agreed that they had a long wait), and consumers did not feel rushed (84.2% either “strongly disagreed” or “disagreed” that they felt rushed).

Dimensions of Service Quality Used in In-Person Assister Survey

Global

- Overall my experience today was: terrible, poor, fair, good, excellent.
- The amount of time I spent with the IPA was: too short, about right, too long.

Tangibles

- The IPA had a professional appearance.

Reliability

- The IPA explained the Marketplace clearly.

Responsiveness

- The In-Person Assister (IPA) answered my questions.
- I had to wait a long time to speak to an IPA.
- The IPA rushed through our time talking.

Assurance

- The In-Person Assister (IPA) was polite.
- The person helping me was knowledgeable.
- I felt comfortable providing information to the IPA.
- The IPA acted in a professional manner.

Empathy

- The IPA listened to my concerns.
- The IPA did not pressure me to enroll in a particular health plan.

These IPAs also excelled at assurance. They were polite (almost 100% “agree” or “strongly agree”), perceived as knowledgeable (99.2% “agree” or “strongly agree”), allowed the consumer to feel comfortable providing information (99.0% “agree” or “strongly agree”), and acted in a professional manner (99.2% “agree” or “strongly agree”).

Finally, IPAs showed empathy by listening to the consumers’ concerns (almost 100% of the respondents stating that they “agree” or “strongly agree”) and did not pressure consumers to enroll in a particular plan (98.7% “agree” or “strongly agree”). Note that 57.9% of the respondents actually enrolled in a plan during their visit.

Key Finding: Most respondents indicated that they are “likely” or “very likely” to use the Marketplace next year to purchase insurance (Q18). Those receiving federal subsidies were marginally likely to plan to use the Marketplace again.

Primary Question:

- How likely is it that you will use the Marketplace to buy your insurance next year?

Discussion: Consumer theory suggests that the best indicator of future behavior is behavioral intentions—that is, what a consumer plans to do.⁶ Q18 directly addressed this issue. We found that 43.1% of respondents stated that they were very likely to use the Marketplace in 2015 for their insurance and 26.1% are “likely.” Given that these consumers have already used the Marketplace, these numbers should be more indicative of 2015 behavior than the same question when it was used in the statewide survey measure taken prior to the Marketplace opening (July/August 2013). Consumers who received subsidies reported being slightly more likely to use the Marketplace to purchase their health insurance for 2015 than those who did not received subsidies ($p < 0.05$).

Key Finding: About three quarters of respondents who qualified for federal assistance stated they understand how the subsidies work.

Primary Question:

- How sure are you that you know how the financial help will work?

Discussion: Given that cost is a primary concern for consumers and that federal subsidies directly affect costs, it was important to determine whether individuals understood the mechanics of financial assistance. Thus, Q4 asked, “How sure are you that you know how the financial help will work?” Over a third indicated that they were “somewhat sure” (34.2%) or “very sure” (37.5%) how financial assistance will work. However, this leaves about one-quarter of the respondents feeling little confidence in how their premiums are being subsidized.

⁶ Blair H. Sheppard, Jon Hartwick, and Paul R. Warshaw (1988) “The Theory of Reasoned Action: A Meta-analysis of Past Research With Recommendations for Modifications and Future Research,” *Journal of Consumer Research*, 15 (1988): 325-343.

Implications for Future Open Enrollment

Moving forward, it is important for the federal government to address the difficulties with the online system. Nearly one quarter of users described their experience as “terrible.” Consumers experiencing difficulty may postpone purchase, create negative word-of-mouth, and have negative feelings towards the enrollment assisters and their organizations. Problems included the frequency with which the system was “down,” the speed with which the pages load, and navigability from the consumer’s perspective. It is recommended that, during the time between enrollments, consumers be observed using the website to provide information to programmers that will improve navigability. Additionally, enrollment assisters should have a “Plan B” that allows them to continue serving customers even when there are website difficulties.

Although the website per se was not evaluated positively by many consumers, the products offered on the website were. Approximately 73% of previously insured consumers rated the plan as the same or better than their previous plan and less expensive or equivalent in price. Efforts to increase enrollment may wish to focus on this positive.

Cost of insurance continued to be a major concern; what the ACA defines as affordable may not be perceived as affordable by the consumer. Additionally, there were relatively common population subgroups (i.e., those with blended or separated family units, those falling into coverage gaps due to income qualifications, couples in which one spouse has employer coverage but the other does not) experiencing complications with signup and subsidy eligibility whose needs should be considered.

In the political fray, it is easy to forget that for many consumers, obtaining affordable health coverage is a happy, emotional experience. This emotionality finding could be leveraged in future communications; these happy stories might encourage second year enrollment. Further, these positive emotions may help attenuate the mistrust and the general negative perceptions of “Obamacare” experienced in the state.

Consumer education efforts must continue. Enrollment assisters are critical in helping consumers understand the complexity and vocabulary used in the health insurance industry. There was a significant minority of consumers receiving subsidies, yet they were not sure how these subsidies work. Fortunately, evidence suggests that consumers’ experiences with

enrollment assisters have been positive. Given the steep learning curve and the deep knowledge of these front-line people, directing consumers to assisters may be the best way to address education efforts. It will also be important to retain effective enrollment assisters so that their experience and knowledge can be used during the next open enrollment.

As West Virginia progresses, system interfaces (Healthcare.gov, inROADS, Experian, WVDHHR, carriers, West Virginia Bureau of Child Support Enforcement, enrollment assisters) need to continue improving, with the ultimate goals that consumers and enrollment assisters should be able to make seamless transitions between electronic systems and organizations. This will require active cooperation of the organizations and the information technology personnel involved.

Finally, it should be noted that there was wide variability in experiences and perceptions. For example, over two-thirds of respondents planned to purchase insurance on the Marketplace next year. This number suggests that there are many West Virginians feeling positive about the Marketplace. Yet it also suggests a large minority did not intend to use the Marketplace in the future. Thus, the bottom line is that there are indications of future success, but major caveats and problems that need attention and resolution over the coming months as West Virginia prepares for its second enrollment period.