Report:
Evaluation of the Consumer Voices for Coverage Initiative, Phase 3

December 2015

Program and
Policy Decisions

Feedback
Loop

Consumer
Experiences

Mary Harrington
Sheila Hoag

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ACKNOWLEDGEMENTS

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I.   INTRODUCTION

In 2007, when national action on health reform looked unlikely, several states were on the verge of adopting or implementing policies to provide comprehensive health insurance coverage to their residents (Strong et al. 2010). To increase the odds that these policy changes would occur, support similar efforts in other states, and increase consumer voices in state policy debates, the Robert Wood Johnson Foundation (RWJF) launched a new program, Consumer Voices for Coverage (CVC).

CVC was aimed at building integrated consumer health advocacy networks that would advocate for increased state coverage. This approach was based on a study showing that such networks could be effective in consumer health advocacy if they possessed specific advocacy capacities (Community Catalyst 2006, Strong et al. 2010). The first CVC grants were awarded through a competitive solicitation process in February 2008 to applicants representing networks of consumer groups from 12 states out of 40 that applied; these initial grants ran for three years. RWJF also funded Community Catalyst, a national nonprofit advocacy organization dedicated to promoting high quality and affordable health care for all, to manage the program and provide technical assistance to the grantees.

With passage of large-scale expansions nationally through the Affordable Care Act (ACA) in March 2010, the program's focus shifted to supporting state and local efforts to reach and inform eligible people about the new coverage options, ensure that they have a positive enrollment experience, and help them stay connected to coverage over time. Although passage of the ACA established a national framework for expanded health insurance, state-based advocates had critical roles to play in making coverage expansion a reality by shaping states policies and programs required to implement ACA coverage provisions, identifying the challenges and problems that consumers faced in securing health coverage, and using this feedback to propose solutions to those problems. To support this work, RWJF continued and expanded CVC, with current grants to advocates in 18 states with varying political and policy environments (Table I.1).

Table I.1. Political environment, health policy characteristics and coverage statistics in current CVC states

State	State political environment, September 2015			Key health reform policies, September 2015		Marketplace enrollment as a percentage of the potential eligible population, June 2015	Percentage uninsured, 2014	
	Governor	Senate control	House control	Marketplace type	Medicaid expansion		Children	Adults[e]
Alabama	R	R	R	FFM		28	3.9	18.1
Arkansas*	R	R	R	Partnership	X[d]	20	4.8	17.5
Colorado	D	R	D	SBM	X	25	5.6	13.9
Florida*	R	R	R	FFM		50	9.3	23.8
Georgia*	R	R	R	FFM		36	7.6	22.1
Illinois	R	D	D	Partnership	X	36	3.4	14.0
Maryland	R	D	D	SBM	X	31	3.2	11.0
Michigan	R	R	R	Partnership	X[d]	39	3.7	12.3
Minnesota	D	D	R	SBM	X	15	3.8	7.9
New Jersey	R	D	D	FFM	X	35	4.5	15.5
New Mexico	R	D	R	FFM[a]	X	33	7.4	20.6
New York	D	R	D	SBM	X	36	3.2	12.3
Ohio*	R	R	R	FFM[b]	X	27	4.8	11.6
Oregon	D	D	D	FFM[c]	X	36	4.6	13.9
Pennsylvania*	D	R	R	FFM	X[d]	45	5.2	11.7
Rhode Island	D	D	D	SBM	X	38	3.3	10.3
Texas*	R	R	R	FFM		31	11.0	25.7
Virginia	D	R	R	FFM[b]		34	5.7	14.9

Source: Kaiser Family Foundation 2015a, 2015b, 2015c, 2015d; American Community Survey 2015.

Notes: D = Democrat, FFM = federally facilitated Marketplace, HHS = U.S. Department of Health and Human Services, Partnership = federal-state partnership Marketplace, R = Republican, SBM = state-based Marketplace.

* Grantees in these 6 states received an initial grant of $210,000 for the October 2014-September 2015 period; grantees the other 12 states received $300,000.

CVC states and grantees have changed over time; initial grants in 2008 went to advocates in 12 states (California, Colorado, Illinois, Maine, Maryland, Minnesota, New Jersey, New York, Ohio, Oregon, Pennsylvania, Washington); as the table shows, groups in California, Maine, and Washington are no longer CVC grantees, and the advocates currently funded in Illinois and Pennsylvania are different groups than those funded in 2008.

[a] New Mexico has a hybrid exchange: the state exchange offers coverage to small business owners, while using the FFM for enrollment and eligibility purposes. It plans to eventually operate a state-based Marketplace when the systems are ready (Giovannelli and Lucia 2015).

[b] Although these states use the FFM, Ohio and Virginia have approval from HHS to conduct plan management activities to support certification of qualified health plans in the state (Kaiser Family Foundation 2015b).

[c] Oregon initially ran its own exchange, but operational problems led the state to use the FFM for Marketplace enrollment and the state exchange portal for Medicaid enrollment (Dickson 2015).

[d] Arkansas, Michigan, and Pennsylvania have approved Section 1115 waivers for the Medicaid expansion. Coverage under the Pennsylvania waiver went into effect January 1, 2015, but it is transitioning coverage to a state plan amendment (Kaiser Family Foundation 2015d).

[e] Non-elderly adults (under age 65).

Evaluation of CVC and key research questions

RWJF has contracted twice with Mathematica Policy Research to evaluate CVC. The first evaluation, which ran from 2007 to 2011, examined (1) how the advocacy networks were structured and operated, (2) whether their advocacy capacity increased over the life of the initiative, and (3) how they influenced state health coverage policy. It found that most of the coalitions formed cohesive networks, that participants improved their ability to advocate effectively, and that consumers became more involved and effective in shaping state health policy (Strong et al. 2010, Strong et al. 2011).

The current evaluation focused on the activities and outcomes reported by the 18 current CVC grantees in what is expected to be the final phase of the CVC program.[1] As noted earlier, work in this phase has shifted to outreach, education, and enrollment activities designed to directly help consumers obtain and keep coverage, and to using the experience and feedback from these activities to identify problems or gaps in coverage and raise these issues with state officials for resolution. The evaluation is designed to answer the following questions, which are addressed in this report:

1. What is the CVC program's **theory of change**? What are the major project components and associated activities? What outcomes would we expect from these efforts?

2. Did the **coalitions** function as expected? What factors contributed to more and less successful coalition efforts? What role should coalitions play in future efforts?

3. What **activities** did the CVC grantees undertake during the 2014–2015 grant period to engage and support consumers? What indicators of progress did grantees report?

4. How did the **feedback loops** work to tap consumer experiences with ACA implementation to identify problems and bring them to the attention of state officials? What were the results and outcomes of these efforts?

5. How did **technical assistance** provided through the program influence implementation experiences and related outcomes? What worked well and what could have been improved?

6. What aspects of the CVC approach are more **sustainable** through other funding sources and why?

Data sources and methods

The evaluation used a mix of data sources, including (1) grant applications and related program documents; (2) phone interviews with the lead staff at all 18 CVC grantees during the summer of 2015; (3) phone interviews with 12 frontline workers—either Navigators or certified application counselors whom the grantees helped us identify—to understand common consumer problems during the second open enrollment period[2]; and (4) data from quarterly reports submitted by the CVC grantees, which summarize their activities, interim outcomes, key accomplishments, and challenges over the past grant year (October 2014 to September 2015).

We started by reviewing grantee application materials and related program documents to develop an initial set of logic models showing, for each project, the structure and organization, the main activities proposed and the outcomes expected. In refining the logic models, we introduced common terms to capture similar activities and outcomes across all the projects and developed a summary logic model capturing the full range of activities and outcomes that provided a roadmap of the things that needed to be measured in order to evaluate the CVC

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[1] In Spring 2015, RWJF decided not to extend the program beyond the current grant period ending in September 2015. After this, the grantees received smaller grants for an additional year to support sustainability and related transition activities.

[2] We had resources to support interviews with 12 frontline staff and focused on 12 states where the grantee had a stronger connection with enrollment assistors.

intervention. We used this summary model to inform development of a set of tables for tracking different types of activities that the grantees began completing in January 2015, to cover the last three quarters of the grant.

Based on key topics in semistructured protocols developed to explore the key research questions, we identified the main themes and overarching concepts and developed a coding scheme that was applied to all transcript notes in Atlas.ti, a software tool used to managed and analyze qualitative information. We reviewed and analyzed the queries to inform our findings. To enrich this analysis, we also gathered and reviewed independent sources on state health policy developments and the latest statistics on coverage and the uninsured to provide context.

Organization of this report

In the remainder of this report, we present descriptive findings that address the key research questions. In Chapter II, we review the theory of change for the program and present a logic model with more detail on the specific types of outcomes associated with core CVC activities. In Chapter III, we describe the role and composition of CVC coalitions; in Chapter IV, we review the core activities grantees and coalitions conducted to help consumers gain coverage; and in Chapter V, we discuss how grantees operationalized the feedback loop between consumers and state officials regarding problems and solutions. In Chapter VI, we review the role of technical assistance in CVC; and in Chapter VII, we conclude with a discussion of grantee perceptions about the sustainability of these efforts after the grants end, and reflections on lessons for future consumer health advocacy efforts related to coverage.

II. CVC'S THEORY OF CHANGE

CVC is the centerpiece of RWJF's efforts to support consumer engagement, one of three distinct yet complementary areas of focus in the Foundation's strategic goal of ensuring that 95 percent of all Americans have stable and affordable coverage by 2020.[3] The theory of change for the CVC program is depicted in Figure II.1. At its core, CVC is about ensuring that consumer experiences inform and benefit from state program and policy decisions. The supporting framework for consumer advocacy is a **coalition or network** of organizations led by CVC grantees that work together to plan, coordinate, assess, and support efforts to find and engage consumers; help them get connected with coverage; and establish feedback loops between consumers and program and policy officials.

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[3] The other components are providing technical assistance to help states address implementation challenges of ACA coverage expansion and monitoring and analyzing the effects of the ACA.

Figure II.1. CVC theory of change

CVC coalitions/networks
Plan, coordinate, share information, strengthen capacity, identify and promote best practices

Build coalitions and strategic alliances with diverse stakeholders

Identify and advocate for achievable policy options

Program and policy decisions

Feedback loop

Consumer experiences

Mobilize and engage consumers and CBOs

Generate resources to sustain efforts

Design and implement strategic communication

Interim outcomes

Consumer engagement and support
- Consumers identified, informed, motivated, engaged
- Consumers get assistance they need
- Consumers have outlet to share their experiences

Advocacy feedback loop
- Gather input on consumer experiences on regular basis
- Access and influence agenda-setters and program and policy decisionmakers

Responsive policies
- Program and policy officials value input about consumer experiences
- Policy and program changes identified and adopted to improve consumer experiences

Ultimate outcomes

Enrollment and retention
- Consumers get enrolled in the right coverage, fewer uninsured
- Better continuity, less churn and fewer gaps in coverage

Access and quality of care
- Consumers understand their coverage
- Consumers get care when needed
- Care is affordable, culturally sensitive, person-centered, and coordinated

Health and health care outcomes
- Improved population health
- Health equity, reduced disparities
- Better value

Fiscal, political, program, advocacy environments. Community needs & capacity. Technical assistance.

CVC coalitions establish the infrastructure for developing and maintaining the feedback loop, with mutually reinforcing **activities in five core domains**: building alliances with diverse stakeholders, mobilizing and engaging consumers, identifying achievable policy options to address issues arising from consumer experiences, designing and implementing communication strategies, and securing the resources needed to sustain all of these efforts.

The premise behind the **feedback loops** is that coverage programs will be most successful when state policy and program officials have a way to quickly learn from and adapt policies to the actual experiences of people the programs are trying to reach. Similarly, consumer experiences will be most successful when they have a way to connect with and learn from program and policy officials so they understand how the programs work, the consumer's role and responsibilities, and the supports available. For the feedback system to work well, relationships must be built with the right set of program and policy stakeholders and with a range of groups and individuals who can represent the diverse perspectives and experiences of consumers.

When the feedback infrastructure works as intended, we would expect to see certain **outcomes**: consumers are informed, motivated and engaged; get the assistance they need; and have an outlet to share their experiences. Evidence about consumer experiences would be gathered on regular basis and used to inform efforts to identify program and policy solutions and to influence agenda-setters and decision makers, who would come to value such evidence. Some of the solutions involve rules and procedures in the application and enrollment process; others deal with ensuring timely access to covered services and providers and making coverage as affordable as possible. Ultimately the CVC work is intended to increase enrollment and retention in available coverage programs, with particular focus on people who face greater obstacles to obtaining coverage because of poverty, language, culture, location, or discrimination.

Influencing every aspect of the CVC work and its intended outcomes are numerous **contextual forces** at the state and local level, including political support for coverage expansion and related reforms and the particular mix of community resources and population characteristics that collectively define the starting point of coalition efforts. Many of the CVC grantees are in states that have opposed the ACA, some of which prohibit state government agencies from participating in any form of outreach, education or enrollment assistance for ACA coverage expansions. In more supportive states, state agency and other leadership changes, along with budget and other economic constraints, influence the work of CVC coalitions and the results of their efforts. **Technical assistance** was specifically designed to help CVC grantees adapt their advocacy and outreach strategies to fit these different contexts.

Figure II.2 presents a general logic model showing in greater detail the types of activities CVC grantees planned to undertake during phase 3 and the outcomes expected to flow from those activities. In the following chapters, we describe grantee experiences implementing these plans, highlight some of the key factors influencing those experiences, and offer lessons to inform future advocacy efforts.

Figure II.2. Logic Model for CVC

Consumer Voices for Coverage: Logic Model Depicting Phase 3 Plans

	CVC Sphere of Influence ▷	Interim Outcomes ▷	Policy Goals ▷	Ultimate Impacts
Build and maintain coalition/ network	• Recruit new members and foster partnership • Build and strengthen relationships with related organizations and networks • Coordinate and collaborate on relevant work • Share information and resources, reports, other materials with coalition and OEE partners • Assess needs/gaps • Identify best practices	• Number of new members added • Number of coalition/network meetings • Number of coalition members actively participating • Types of materials shared with partners • Needs and gaps identified, documented • Best practices identified and documented	• Coalition/network represents diverse stakeholders • Coverage and access gaps, and best practices are identified • Feedback guides coalition and OEE activities • Coalition and OEE activities are planned and coordinated	• Application, enrollment, renewal processes are consumer friendly • Consumers take steps to inquire about and apply for coverage or renew coverage, remain enrolled
Strengthen capacity	• Develop training and related materials • Train OEE partners and staff • Recruit and train diverse spokespersons • Recruit and train consumer representatives • Expand staff involved in OEE activities	• Number of consumers recruited, trained • Number and types of training events held • Number of partner organizations and staff trained	• Consumer representatives are actively engaged in OEE efforts • OEE staff capacity is adequate and targeted appropriately	
Policy analysis and policy-focused advocacy	• Track, monitor, and respond to policy issues/changes • Conduct policy research/analysis on specific issues; estimate impacts • Produce policy-focused fact sheets, reports, whitepapers • Make policy recommendations	• Types of policies tracked/assessed • Materials prepared • Number and types of recommendations made	• Coverage and access-related policy issues are identified and options explored • Policy recommendations are made to relevant stakeholders	
Communication	• Develop content for communication campaigns • Implement communication activities	• Specific content or messages developed • Number and types of media events/spots • Number of people reached or targeted by communication efforts	• Consumers are aware of coverage options and how to apply for coverage • Stakeholders are aware of consumer needs and policy issues	
Develop and support feedback loop	• Obtain input on consumer barriers and experiences with enrollment and retention process and systems • Provide feedback about consumer experiences to program and policy officials	• Number and types of consumer stories obtained • Input provided to stakeholders • Number of meetings with stakeholders • Types of stakeholders participating	• Stakeholders are engaged, responsive, supportive • Feedback influences program/policy decisions	
Connect consumers with coverage	• Hold educational events/sessions for consumers/general public • Identify eligible consumers • Provide information to consumers about coverage • Assist consumers with application, enrollment, renewal, appeals	• Number of educational events held • Number of participants in events • Characteristics of participants • Number of consumers identified • Number of consumers assisted	• Eligible consumers, especially under-represented groups, are identified • Consumers understand coverage options and how to apply for coverage	

OEE = Outreach, education and enrollment

III.   CVC COALITIONS/NETWORKS

Coalitions or networks have always been central to CVC, and grantees were required to form a core leadership team, which typically included 5 to 10 organizations responsible for setting the strategic direction and coordinating the efforts of a larger number of partner organizations. Coalitions in the earlier phases of the CVC initiative tended to involve a broad array of organizations with a stake in coverage expansion and related health reforms. In recent years, as CVC began focusing more on outreach and enrollment to support implementation of the ACA, it was especially important for coalitions to include those with a direct connection to consumers potentially eligible for coverage through ACA and related Medicaid expansions.

Composition of CVC coalitions

The mix of organizations involved in each coalition or network varies greatly across states and is influenced heavily by historical alliances, the specific objectives of each state's grant, and the political environment in the state related to ACA implementation. Some of the coalitions have been operating since the first CVC grants were awarded in 2008 and involve a fairly steady core group of organizations that meet regularly. Other coalitions are more loosely structured, with engagement of particular groups depending more on how aligned the CVC work is with the organization's primary mission. In states with Medicaid expansion in place or with more progressive coverage policies or both, the coalitions tended to include representatives from state and local government, health care providers and the insurance industry, along with Navigators, Certified Application Counselors (CACs), health care providers, and grassroots community organizations doing outreach and enrollment work. At least one grantee in a supportive state is also a contracted CAC and has a direct link and a strong relationship with the state. This grantee and several others also subcontract with many community organizations to support their efforts to engage with and assist consumers, providing a ready source of input on consumer experiences.

Greater role for CBOs and financial advisors

In 2015, nearly every CVC grantee proposed to expand their coalition or network to include organizations with expertise in and connections with one or more population group or region with larger numbers of remaining uninsured. People who remain uninsured, especially in states with Medicaid expansion, tend to be those harder to reach through mainstream avenues, making it even more important for coalitions to diversify their membership to fully represent the needs of these groups. Most of the grantees succeeded in adding new partners, such as faith-based organizations and groups representing people facing greater access challenges because of race, ethnicity, immigration status, sexual orientation, or gender identity. CVC coalitions also found that to support Marketplace enrollment they needed to tap the expertise of tax preparers, insurance brokers, and accountants to help explain some of the more complicated financial and benefit design aspects of new plans and cost reduction programs, to help those working with consumers understand how the coverage program would work. One grantee noted, *"We had no idea before starting the Affordable Care Act work that immigration and tax information, never mind insurance information, would be some of the most important stuff...we had to learn and had no idea that tax experts and tax accountants and CPAs would be our best friends!"*

Challenges in building coalitions or engaging certain groups

In some states, where the political environment is less supportive of ACA implementation, legislation prohibits the use of state or federal funds for outreach and restricts the number and types of entities that can serve as Navigators and what they are allowed to do. Coalitions in these states sometimes faced challenges engaging Navigators and CACs in formal coalition work. Instead, they interacted with these stakeholders less formally and sought to support and supplement those networks. For example, one CVC grantee found that rather than creating a distinct coalition of enrollment stakeholders and risking *"stepping on the toes"* of existing Navigator networks, it would instead engage the main Navigator grantees through the leadership team and *"work with them to figure out what the missing pieces were that they either couldn't provide because it was out of scope or they didn't have the skills set or the bandwidth to provide."* Consequently, CVC efforts in this state focused on creating an online resource network to provide resources to support navigator groups, which in many ways served the purpose originally envisioned for regular meetings of a broad coalition of enrollment stakeholders.

While most CVC grantees reported having the right groups represented in their coalitions, several mentioned having trouble connecting with certain groups. For example, several reported difficulty engaging small business groups due to the lack of an existing organization representing small businesses or limited support from state and local chambers of commerce. A few grantees struggled to engage groups connected with immigrant populations, in part because their focus is largely on policy efforts to expand coverage to those not eligible under existing programs. Grassroots organizing groups that proved helpful to coalition efforts in previous years were not as active in 2015 in many states because it was not an election year.

Notably, in nearly every state the CVC coalition was not the only coalition that grantees and their partners were engaged with. These other coalitions tended to be focused on particular program reforms (e.g., Medicaid expansion or delivery system reforms) or populations (e.g., children, disabled, minorities, immigrants). To avoid "coalition fatigue, some grantees tapped into these other existing coalitions to support the feedback loops, using the smaller CVC leadership team to focus on planning and operational work specific to the grant. *"We realized with all the overlapping meetings, a lot of the meeting content was getting redundant…so now the CVC meetings are more about the activities and obligations around the grant and the broader conversations about policy we're working on mostly take place in other venues."*

Balancing competing interests

Another tension faced in some of the networks was finding the right balance between policy-focused advocacy work and the targeted, intense efforts directed at advancing outreach and enrollment. Some coalitions started out very strong on the policy side and had to work a bit harder to build the right connections with groups involved in frontline outreach and enrollment work. *"It took a while for us to get our sea legs on that, but I have to say that the ACA outreach and enrollment work has been an invaluable conduit of policy information for us … and it has brought to the table many, many groups who typically would maybe never have thought of joining the coalition."* Another fairly common challenge was tension about the role of the CVC coalition versus other groups in supporting consumer enrollment efforts. These turf issues surfaced most often with respect to contracted Navigator and CAC entities, in some cases

because state rules prevented their sharing of information about consumer experiences with noncontracted organizations. The CVC grantee in one state had to convince two other entities who viewed themselves as the primary conveners for the enrollment community that the grantee was not trying to compete with them for this role but rather wanted to collaborate and share resources to maximize the effectiveness of their collective efforts. As one grantee observed, *"When you are the new kid in town, sometimes people get a little territorial, so you just have to do the good work and be collaborative, and [then] things work out."* While generally the CVC coalitions had strong working relationships with Enroll America organizations in their state, the grantee in one state described tensions early on because the Enroll America approach tends to focus on events whereas the CVC approach focuses on establishing a lasting infrastructure within community-based organizations that requires building relationships and financial and other supports.[4]

The coalition advantage

By far the most important benefit of the CVC coalitions noted by many of the grantees is that they provided a forum to connect diverse stakeholders. The particular types of stakeholders involved and the manner in which this relationship building played out differed across the states largely because of the importance of tailoring the approach to the political, sociodemographic, and general policy environment. In less supportive state environments, success sometimes involved working somewhat behind the scenes to form alliances with diverse consumer groups and making sure that program and policy officials could tap input from these stakeholders when the right opportunity arose. Often the CVC coalitions provided the only meaningful opportunity for state agencies, providers, and consumers to all be at the same table. Especially as the focus of CVC work broadened following the ACA to include the full spectrum of consumers eligible for coverage under the ACA, the coalitions were able to bring together groups representing all ages and types of consumers. Since consumer engagement is so critical to the success of efforts to promote coverage and access to care, stakeholders from many sectors benefited from participating in CVC coalitions.

IV.   CVC GRANTEE ACTIVITIES TO ENGAGE AND SUPPORT CONSUMERS

A central focus of the CVC work this past year was providing outreach, education, and enrollment support to consumers. Not only does this work directly help consumers understand or obtain coverage, but such activities are a key source of information about coverage obstacles, helping the grantees relay consumer problems, and possible solutions, to administrators. In this chapter, we review the main outreach, education, and enrollment support activities grantees undertook in the past grant year.

Prevalence of activities by type

From January through September 2015, CVC grantees conducted over 800 activities and events to (1) conduct outreach to and educate consumers, (2) provide enrollment assistance

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[4] Enroll America did not have staffed operations in every CVC state; states where CVC and Enroll America overlapped include Florida, Georgia, Illinois, Michigan, New Jersey, North Carolina, Ohio, Pennsylvania, and Texas.

directly to consumers, (3) expand the skills and capacities of individuals who assist consumers, and (4) obtain consumer input.

- **Consumer outreach and education activities** account for almost half of all activities grantees conducted, with 408 such activities between January and September 2015 (Figure IV.1). In general, these activities were similar across the 18 states; examples include canvassing; hosting information fairs at churches, day care centers, and schools where groups could offer education, distribute materials, and sign consumers up for enrollment appointments; and providing outreach at public events such as city festivals, among others. As expected, consumer outreach and education activities were most intense in the second quarter of the grant (Q2), January to March 2015, when open enrollment was ongoing, although these activities continued at nearly the same intensity during subsequent quarters, suggesting recognition that education and outreach are year-round activities.[5]

Figure IV.1. CVC grantee activities, January–September 2015
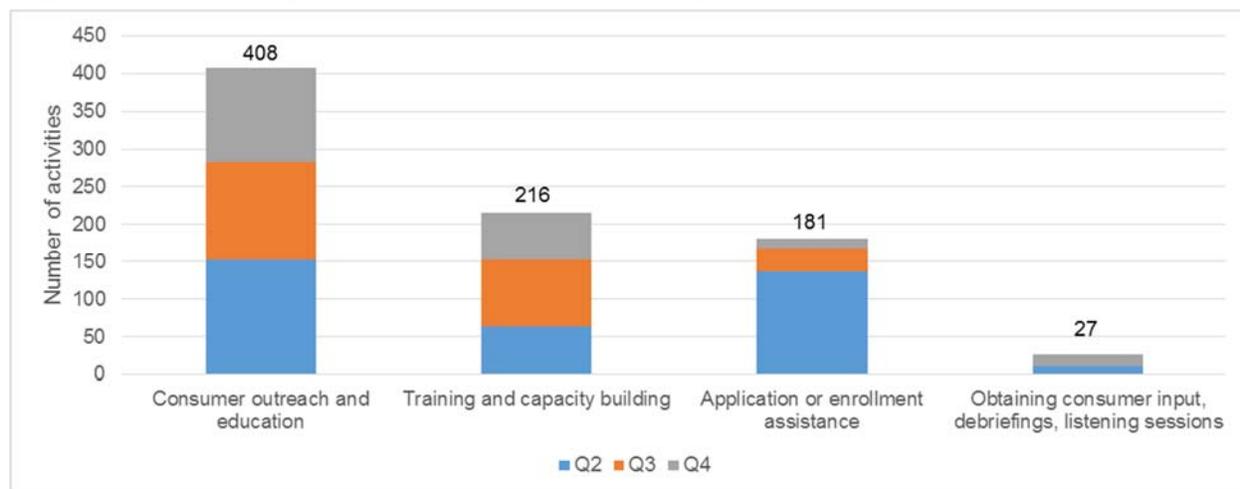
Source: Mathematica analysis of grantee quarterly reports, November 2015.

Note: Q2 = January–March 2015, Q3 = April–June 2015, Q4 = July–September 2015. These are the CVC grant quarters; grants were awarded in October 2014 and run through September 2015. Grantees were not required to submit this data for the first quarter of their grants (October–December 2014). As of this writing, the Pennsylvania grantee has not submitted their fourth quarter report; therefore this figure excludes Q4 activities for that grantee.

- **Over 200 training and capacity-building events** were held during the period from January to September 2015. These events encompassed a wide variety of activities and target audiences, such as: continuing education for Navigators; training sessions for multilingual students to do outreach and education activities; train-the-trainer events for other consumer advocates; conferences and education sessions about coverage and ACA policy issues; webinars on troubleshooting complicated cases and appeals processes; training sessions for volunteers on how to become enrollment assisters; training sessions for tax-preparers; and a

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[5] The second open enrollment period ran from November 15, 2014, to February 15, 2015. There was a special open enrollment period that ran from March 15, 2015 to April 30, 2015; this extra time was meant to help people who had not enrolled avoid a fee for not obtaining health insurance on their taxes filed for 2014 (ObamaCareFacts.com 2015).

speakers bureau training, to train consumers how to share health care stories with policymakers. In a few states, grantees combined enrollment assister trainings with debriefing events, typically in Q3, to identify lessons from the second open enrollment period on how to improve the enrollment process and to identify best practices for the next open enrollment period.

- **Application and enrollment assistance** was most intense in Q2, with the 18 grantees reporting 137 events that quarter. These events typically included making Navigators available to assist with enrollment; grantees reported that although open to all uninsured individuals, these events commonly targeted special populations such as African Americans, the LGBT communities, Latinos, immigrants, and other low-income groups. In subsequent quarters, enrollment events declined and appear to be limited primarily to states that adopted Medicaid expansion, since enrollment for Medicaid is not limited to the open enrollment period.[6]

- **Obtaining direct consumer feedback** was the least intense activity. Grantees from 8 states—Illinois, Maryland, Michigan, Minnesota, New Mexico, New York, Texas, and Virginia—held 27 events aimed at directly obtaining consumer feedback. Typically, these were story-gathering events, listening sessions with Navigators and assisters, or opportunities to obtain feedback from specific types of consumers, such as those living in a rural area. As discussed in Chapter V, grantees used this information to inform their feedback to state and federal program administrators.

Communications work to support grantee activities

To support all four types of activities described above, grantees used multiple methods, including social media outlets, earned media, emailing, and blogging, to communicate with consumers about coverage and enrollment. From January to September 2015, grantees invested heavily in posting on social media—primarily Facebook and Twitter—about various aspects of the ACA and enrollment opportunities. Activity was most intense during the second and third quarters (shown in the blue and red bars on Figure IV.2). They also took advantage of earned media opportunities, including television, radio, and print coverage in each of the three quarters (with earned print media representing 75 percent of all earned media across the three quarters [data not shown]). Other communications included email blasts—in some instances to thousands of consumers on their email lists, while in other cases, smaller email blasts to assister networks—blog posts on their own or other consumer-oriented websites, and some paid radio and television ads. Webinars were sparsely used; grantees that used them did so primarily to train on particular issues, such as on tax credits or out-of-network surprise billing and how to handle it.

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[6] Consumers also can enroll in the Marketplace at times outside of the regular open enrollment period if they have certain life circumstance changes such as losing coverage, adopting a child, or getting married.

Figure IV.2. CVC grantee communication activities, January–September 2015
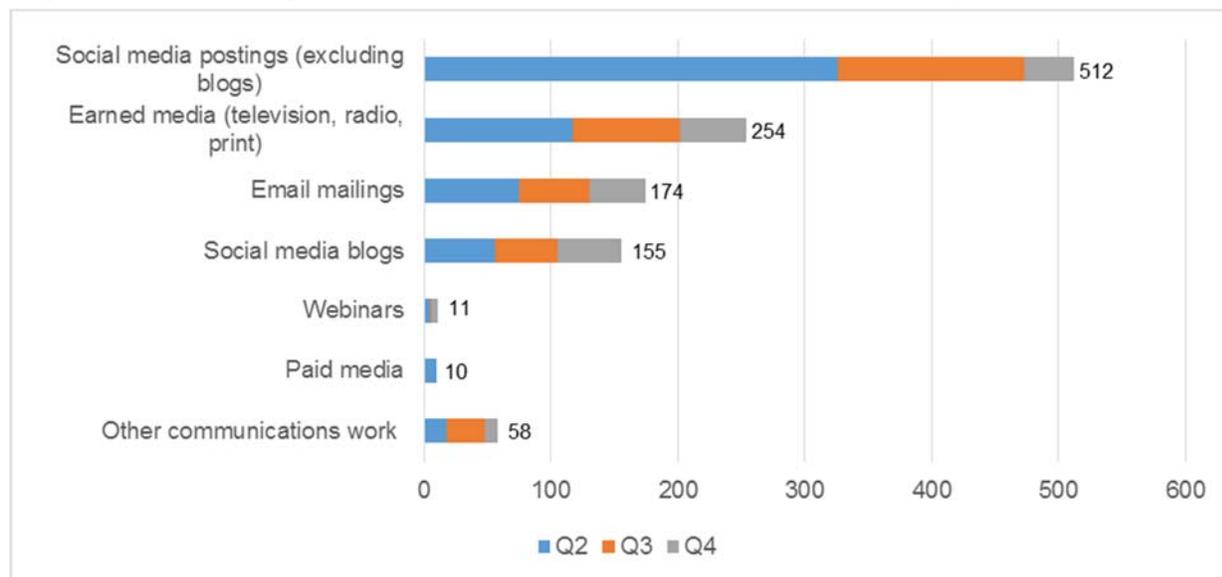
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Influence of state political environment on CVC activities

State political environments affected grantees' perception of what was achievable through their work, but they did not substantially alter activities they conducted. Only two grantees called their states "highly supportive," of CVC grantees' work and objectives; eight said their state governments were at least "somewhat supportive" of CVC work and objectives, two said their state governments were "unsupportive" of CVC work and objectives, and the remaining six said state support for their work was mixed (depending on the particular issue).

When asked how these various environments influenced their work or grant goals, most CVC grantees said they had little effect; even when the environment was unsupportive, they stuck to their original grant goals and conducted activities as planned. However, some grantees said environmental changes made them more cautious about whether their goals were achievable. For example, new governors elected in a few states in late 2014 created more uncertainty about support for reform, how exchanges would operate, and what resources might be available to support outreach and enrollment activities. Typically, these political changes did not lead to changes in grantees' work plans but rather underscored the link between the political environmental and their ability to achieve coverage goals.

Other changes to activities

In addition to the political environment, grantee activities sometimes were modified from what had originally been planned as a result of changed circumstances or to revise an approach that did not work as expected. For example, in one state a new grant director was hired after the

work plan was developed, and her assessment of the environment led her to shift toward more communications and grassroots activities and to implement fewer policy advocacy activities than originally planned. When another grantee was unable to recruit as many university students to do outreach as planned, it scaled back this effort. One grantee had initially planned to collaborate with voter registration groups on providing health insurance outreach and enrollment support, but discovered that after the 2014 elections, these groups lost interest in taking on work outside their core mission and were difficult to engage, and the activity thus lost momentum. The original plan in another state called for making subgrants to six groups, but between the development of the work plan and the grant award, two of the planned subgrantees lost their state-supported funding to do in-person assistance. Because of this shift, the grantee used the funds for advertising and communication instead (after getting approval to do so).

Results and indicators of progress toward coverage gains.

Grantees viewed their outreach and enrollment work, as well as their shift to identifying and addressing post-enrollment needs, as largely successful. Markers of success they pointed to varied from reported jumps in Marketplace enrollment to effective use of phone-banking that led to high attendance at enrollment events. For example, one grantee, with support from Spitfire Strategies, a communications consulting firm, used Facebook analytics to verify that their messaging was reaching its intended targets of women and young people. Another grantee hosted a telephone town hall session that drew in 3,300 callers to learn about ACA enrollment, and another tested an outreach campaign focused on public transit system users, successfully reaching out to those waiting for trains and buses. The grantee in one state helped coordinate a radio ad featuring a local professional football player that led to 5,000 hotline calls and the biggest spike in traffic at the state's health insurance exchange recorded during the second open enrollment, and in another state the grantee launched a social media campaign during the tax special enrollment period to help consumers understand the connection between health insurance and tax filing.

V.   ADVOCACY FEEDBACK LOOPS

As shown in Figure II.1, feedback loops are central to grantees' work: extracting lessons from consumer experiences is a key strategy to developing advocacy goals for consumer-friendly coverage policies and procedures that respond to consumer needs. In this chapter, we summarize grantee and frontline worker reports on how these feedback loops worked during the past program year, including discussions of how grantees obtain consumer input, the common types of consumer problems identified, how that information was communicated to state or federal officials, and successes and challenges related to this approach.

Sources of consumer feedback

CVC grantees gathered input about consumer experiences from multiple sources. The most common source was grantees' regular coalition meetings with their partners, typically on a monthly basis, although a few groups reported weekly or biweekly meetings (especially during open enrollment). At such meetings, a Navigator partner might summarize problems that their organization has been tracking with enrollments. Several CVC grantees reported that they had used their CVC funds to sub-contract with groups that focus on particular hard-to-reach groups in their communities, as those voices would otherwise be missing from the feedback loop. These

include groups that work with or conduct outreach to particular populations; examples include groups focused on the LGBT community; people with HIV; the Latino, African American, and Vietnamese communities; people with substance abuse problems; women; and immigrants. The mechanisms for obtaining feedback from these groups is the same as for other populations; typically they are reported to grantees through their regular coalition meetings.

Some grantees also mentioned other mechanisms for obtaining feedback. For example, in one state the grantee operates an Internet hub where the state's 2,000 Navigators post questions daily when they have problems; in another state the grantee conducted a survey of an estimated 35 assister and enrollment stakeholder groups and did follow-up interviews with 10 of the groups; and in another state, the grantee organized workshops at which assisters can offer feedback directly to state officials. Sometimes the process is more informal: for example, in one state the grantee received calls from Navigators asking for help with a consumer issue when needed, reportedly about twice monthly. A few grantees noted they had federal Navigator grants or certified Navigators on staff, so they could easily obtain feedback from their colleagues about consumer problems.

Although most of the input grantees received came through coalition partners who work with consumers, some grantees noted that they obtained input directly from consumers. For example, grantees in five states noted that they conducted story-banking activities as part of their outreach activities in order to document consumer experiences. One grantee contracted with a professional group to conduct focus groups with consumers on coverage issues, and another ran the statewide consumer assistance program, giving it a rich data source for directly identifying consumer problems and trends.

Common types of consumer problems identified

During the second open enrollment period, frontline workers interviewed identified six common types of problems for consumers (Table IV.1). The most frequent problems were hard to understand enrollment materials, lack of consumer health insurance literacy, and problems with the renewal process. Some of the issues are interrelated: for example, while frontline workers from nine states reported problems translating state, federal, or insurance company mailings into plain English for consumers, these problems seemed more exacerbated in the four states in which immigration-related problems were more prominent, which often had language barriers for consumers.

Table V.1. Common consumer problems identified by frontline assisters

Consumer problem	Number of frontline workers reporting (N = 12)	Sample quote
Communications: Difficulty understanding documents, translation problems, misinformation being spread about ACA, etc.	9	*"The notices that consumers get are horrible… When you send notices that have six and seven pages of unneeded text and the relevant information is buried a paragraph or two deep [, problems arise] ... I really want them to send consumers a notice that has just the action item on the front page in big print. 'We need you to do this by this date. For more information, see the last fifteen pages of this.' Consumers don't understand what they are being asked to do."*
Lack of consumer health insurance literacy: Confusion over terminology (e.g., co-insurance, cost sharing), low understanding of premiums versus co-payments, etc.	8	*"As a Navigator, I ended up having to spend a lot of time with consumers making sure that they understood what their out-of-pocket cost actually meant for them. If you are buying a plan with a lower premium, your deductible is higher. Really that concept for people was pretty hard to grasp."*
Renewals: Confusion about the renewal process, problems with passive and active renewals	6	*"When they did do the initial enrollment, some had applied directly through healthcare.gov, and their information was sent to the state, and the state contacted them. Well, for their renewal, they thought that they were supposed to go back to the federal website again, which didn't work at all. Then, they weren't sure about what information they had to take. Many of them didn't receive their letter in a sufficient time frame for them to go get the information that they needed to take to the Department of Human Services Office."*
Technical issues not related to immigration: Proof of income documents not linked to accounts, username or password issues, system glitches, etc.	4	*"We had a little glitch in the system that sent out denial letters to about thirty thousand people. It was just a glitch in the system. They were, in fact, really not denied or cancelled, they just got these notices. The state's computer system had to go back in and straighten it out….Also, the state system didn't have an easy renewal access; if they had forgotten their username or password, they were stuck."*
Financial: Providing proof of income and reporting income changes	4	*"Consumers are already frustrated when we say 'How much are you going to make in 2016?' They say, 'I have no clue. I don't know how much I am going to make next week.' That is a conversation we have every day. So, now not only do you have to know, you have to prove what hasn't happened yet. And if you don't prove it, your tax credits will be cancelled. That is a big challenge that we are facing."*
Immigration: Process is more complicated and therefore slower for immigrants or families with mixed immigration status	4	*"During the application process, the main issue we come across is problems with identity verification, which can be tricky. Especially with individuals who are new to the country. If you have never had a credit card or never had a mortgage, the system can't verify your identity and that makes it a little bit more complicated. You can't do it online; you have to do it over the phone."*

Source: Interviews with 12 frontline assisters, summer 2015.

The **renewal process** was new this year, and frontline workers from six states noted problems with it. Although HHS tried to streamline renewal by automatically renewing coverage in the same health plan for consumers who did not take action, some assisters noted that this could be problematic: because they had not shopped for second-year coverage, some consumers saw unexpected premium increases. Other renewal problems included consumers not receiving

renewal notices and lack of alignment between Medicaid renewal dates and the open enrollment period, which sometimes resulted in lapsed coverage.

CVC grantee staff also reported on **broader consumer issues** they worked on this year. Generally speaking, the issues grantees addressed reflected a maturing Marketplace, which generally let grantees turn to addressing substantive coverage policies and the way those policies functioned for consumers. Examples of policy issues grantees focused on this year included network adequacy, network transparency, surprise billings and out-of-network coverage issues, essential community providers, and insurers dropping out or merging. Procedural issues addressed included the processes for Marketplace determinations, appeals, and transitions between Medicaid and the Marketplaces, among others. Some grantees identified and supported needed improvements to enrollment websites, such as implementation of a bilingual Marketplace website in one state, while a few continued to focus on needed information technology improvements to integrate eligibility determination systems across programs. A few grantees focused on advocating for further coverage expansions, proposing either Medicaid expansion to all low income residents or state coverage of undocumented immigrants.

Mechanisms to relay consumer experiences to state officials

All CVC grantees have established processes to relay feedback to program officials. For example, CVC grantees collectively reported nearly 450 meetings between January and September 2015 with representatives from state offices of insurance, Medicaid, exchange boards, and exchange administrators; with legislative and senate committees; and with regional CMS staff (in states using the FFM), among others.[7] In addition, 11 grantees reported using ad hoc phone calls or emails because of personal relationships they have developed with program administrators. As one grantee said, "*One area we've really focused on is [developing relationships] with our [state] Department of Insurance…. When we see themes and trends, we inform them.*" She added, "*The feedback loop takes some time to cultivate, and it takes some savvy to cultivate.…We've had to really look for angles and opportunities to get the information to policymakers in a way that doesn't set off certain alarm bells for them, and that is usable for them. So, it's in some ways informal but also something that we attend to on a very regular basis.*"

Several CVC grantees reported they use both formal and informal routes to try to communicate consumer concerns. As one grantee said, "*We have a formal monthly meeting with state Marketplace officials, but we also have informal but regularly scheduled face time with regulators and administrators. Regularly scheduled means we're not just contacting them when we have a problem. That makes it more collaborative, less antagonistic.*" One grantee tried, unsuccessfully, to establish a formal feedback loop process with the state, which frustrated her: "*Agency bureaucrats ought to be accountable to the consumers they serve. And they should not be fearful of listening and responding in public.*" However, she used her appointed role on the state's Health Insurance Advisory Board to raise consumer issues, and also relied on her ability

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[7] For the second through fourth quarters of the grant (January-September 2015), grantees reported on all policy meetings that they held or attended, including the names of policy officials with whom they met with and the topical focus of each meeting.

to phone program administrators informally, which state officials responded to "*as long as those calls were off the record.*"

Changes in enrollment procedures and coverage policy

All CVC grantees pointed to at least one specific success in using the feedback loop to correct enrollment or renewal problems. Most often, states addressed problems by making procedural changes. For example, two grantees noted problems with incorrect renewal notices, and two other grantees identified problems with how income was being incorrectly counted for certain consumers; both issues were resolved once brought to the state's attention. One grantee cited a problem with the transition to the Marketplace when pregnancy-related Medicaid coverage ends; the state fixed this problem for all women making such transitions. Another grantee helped to resolve a problem for very low-income residents applying online: "*When people applied through the online portal, if they had income that fell below 25 percent of the federal poverty limit, their application was referred to a county welfare agency for processing. Often that meant the application never surfaced again. We asked that the department process the application received online the way they would any other application, and with the eligibility determination also send a written notice that the person could be eligible for other things and refer them to a county welfare agency. But in the meantime the consumer would have their insurance. So that in fact did happen; the department started doing this several months ago.*" Two grantees cited important changes to state policy after grantees explained to state leaders the problems faced by certain consumers in gaining coverage: one state implemented a special enrollment period for victims of domestic violence, and the other implemented a special enrollment period for pregnant women.[8]

Challenges in creating effective advocacy feedback loops

Establishing feedback loops between consumer experiences and policymakers can be challenging. Six grantees noted resource challenges, including the time and skill required to set up the feedback loop and the limits of staff capacity both at the grantee organization and state agencies to address all of the problems. As one grantee said, "*I think the feedback loop itself is fine, it's just what happens with that feedback once it's delivered ... it's the state's bandwidth.*" Three others noted that feedback loops require grantees to be diplomatic, because grantee priorities and state priorities often are not aligned. As one grantee reported, "*We've come to realize, we can't raise too many issues to the state, because if we push too hard they'll just stop answering your phone calls.*" Another commented, "*There are an overwhelming amount of issues, and people tend to get focused on the issues that they care about. So sometimes we have to help state administrators see the big picture. Other times we have to help state administrators understand the importance of not only fixing an [individual's] immediate problem but also addressing the underlying policy problem so others in the future don't find themselves in the same situation.*" Three grantees pointed to problems getting consumers to give feedback, concerns that they did not have a mechanism in place to get feedback directly from consumers, and even concerns about Navigators potentially violating consumer privacy protections when

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[8] See Get Covered Illinois (2015) and New York State Assembly (2015) for more information on these new policies.

providing feedback. One grantee mentioned a specific problem with staff turnover at the state's exchange, which required the grantee to establish new relationships and re-explain old problems.

Like grantees' advocacy staff, frontline staff we interviewed also noted some frustrations with the feedback process. For example, a frontline worker in a state using the federally facilitated Marketplace (FFM) said, *"CMS and the Marketplace are big and slow to react sometimes with fixes, and it was frustrating to wait for improvements, especially as it neared the end of the open enrollment period."* Two other frontline staff said they would like to see more direct consumer feedback mechanisms. As one said, *"I think we need to do more work around facilitating community members into speaking up about what their issues are with the health insurance system. Because [having the information] coming from a Navigator perspective is different than coming from the actual client perspective."*

Improvements to advocacy feedback loops

CVC grantees suggested several ways that feedback loops between consumers and policymakers could be improved. The most common suggestions were to develop mechanisms for consumers to provide direct feedback to state officials and to engage consumers to tell their stories. One grantee suggested the loop would be more sustainable if the Navigators themselves were directly involved in providing feedback, rather than the grantee serving as a middle-man.

VI. ROLE AND VALUE OF TECHNICAL ASSISTANCE TO CVC GRANTEES

From the inception of CVC, technical assistance (TA) to grantees has been a key component of the program. Community Catalyst, the advocacy group that administers the program for RWJF, is the primary provider of technical assistance to the grantees. In this past program year, TA was also provided by Spitfire Strategies (on strategic communications) and Spark Policy Institute (on self-evaluation). The types of TA provided to CVC grantees by these organizations are summarized in Table VI.1 Nearly all grantees praised the TA they received, saying that TA providers had the right expertise and the capacity to tailor TA to grantees' environments, with strengths in a variety of complementary areas.

Table VI.1.TA providers and TA content

Technical assistance provider	Types of TA provided to CVC grantees
Community Catalyst	Coaching on policy, advocacy tools, implementation; updates on federal policy; monthly or bimonthly check-in with advocates on progress, problem identification, and development of solutions; development of peer network, connecting advocates to those in other states dealing with similar issues; hosting annual conference to bring grantees together and provide latest policy updates and insights on upcoming issues
Spitfire Strategies	Primary coach on communications, messaging and messaging strategies, strategic communications, digital communications tools; group TA and one-on-one TA available
Spark Policy Institute	Coaching on evaluation and development via group webinars, as well as one-on-one TA calls for individual coaching on particular evaluation topics, such as data collection to support evaluation or developing evaluation tools

Source: Interviews with CVC grantees, summer 2015.

TA = technical assistance.

Community Catalyst

Community Catalyst, the lead TA provider, held either monthly or bimonthly calls with each grantee. These calls provided regular opportunities for grantees to report on progress and for Community Catalyst staff to provide relevant updates on recent policy developments, guidance on how to deal with particular problems grantees were facing, and connections to advocates in other states who had successfully dealt with similar problems. One grantee discussed how Community Catalyst's TA was highly responsive to her needs, providing a basic primer on consumer issues related to an important topic that emerged in the state: "*They've been amazing. For example, during the last legislative session, when the network adequacy issue emerged here, it emerged really quickly. The medical association gave us two days to provide some information to policymakers about what some of the risks might be of narrow networks for consumers and what they should be thinking about from the consumer perspective, and it was a lot to put together in a two-day window. And Community Catalyst was wonderful in assembling a lot of good policy information that I could read and say, 'Okay, I can take this and work with this, and frame it up and make some compelling statements that draw attention to why policymakers should think about provider networks within insurance plans.'*"

Several grantees commented that the TA providers tailored information to their state environment; the fact that the TA was not generic made it much more useful compared to other similar TA projects they currently are or had been involved with in the past. As one grantee said, "*The TA providers are sending us stuff all the time, they send us anything that they think might be helpful to us. At the same time, they also make sure that we set the agenda for our TA calls with them and make sure that it's responsive and targeted, as opposed to some TA providers, [which] might be very generic like, 'Here's a menu of things. Choose what you want. Messaging, coalition building.' This is much more in tune to us, not generic, and I really appreciate that.*" Another added, "*The Community Catalyst folks are just incredible listeners. They have this capacity to tailor their support to our specific needs. Not just in terms of answering technical questions, but then really structuring and developing things [in response to our questions or concerns].*"

Spitfire Strategies

Of the 10 grantees that specifically noted working with Spitfire on communications or messaging, several reported the value of the sample press releases, social media tweets, op-ed pieces, and other messages that Spitfire provided. Some mentioned that they didn't need Spitfire staff to help with day-to-day needs but noted that Spitfire helped them with bigger picture strategy approaches. As one grantee said about Spitfire staff, "*We talk to them on a biweekly basis. It's really good to have a group like that to run ideas by. They're really good at not pushing an agenda on us. We wanted to do a messaging campaign around Medicaid successes, without folks advocating for and against the (state) waiver. Spitfire has really helped us with this. It's not necessarily that they wrote anything for us, it's really helping us think through strategy.*" Three grantees noted that, although they thought Spitfire's TA could be helpful, it wasn't necessarily help they needed; these grantees characterized themselves as being "at the vanguard" on communications and digital capacities, and so they did not have as much use for Spitfire's TA compared to other grantees.

Spark Policy Institute

Only four grantees reported that they took advantage of Spark Policy Institute's TA on evaluation. All of them said this TA was very helpful, whether it was participating in a webinar training on evaluation or one-on-one evaluation support, helping the grantees develop customized evaluation and reporting tools. As one grantee said, "*Spark staff have been really helpful. We already have some really good strategic thinkers [on our staff], but participating in Spark's evaluation training gave everyone a common language about evaluation and strategy.*" One grantee reported that Spark helped it prepare for an internal evaluation of its story-banking process, although it had not implemented the evaluation due to resource constraints.

Some grantees said they were not initially aware that the evaluation TA was available in 2015, so when they allocated their budget, they did not devote time to self-evaluation activities. Three grantees felt that this was a missed opportunity and suggested issuing a "grant FAQ" at the start of the project to avoid this from occurring.

VII. SUSTAINABILITY AND LESSONS FOR FUTURE CONSUMER ENGAGEMENT AND ADVOCACY

One of RWJF's primary goals for the CVC program was to help build state-based consumer health advocacy capacity that would eventually be sustained through other funding sources. RWJF built the CVC program on an emerging evidence base about six core advocacy capacities that are needed to be successful: (1) coalition building, (2) generating grassroots support, (3) analyzing issues and identifying health policy proposals, (4) designing and implementing health policy campaigns, (5) crafting media and communication strategies, and (6) fundraising (Community Catalyst 2006; Strong and Kim 2012). That fundraising came last did not connote lower importance; indeed, RWJF expected grantees to secure other funding sources to sustain their coalitions and advocacy activities after the grants ended.

Consistent with the previous evaluation, we found that CVC grantees in this final phase generally demonstrated strong capacity in most of the core capacity areas but have had more difficulty with fundraising to support some important aspects the work after the grant ends. While a few grantees had secured funding for specific activities or some level of coalition work after CVC funding ends, many struggled to secure enough support for continuing the full range of activities. In particular, cultivating relationships with organizations that have credibility within certain communities is central to reaching certain populations, but funding for that work is harder to come by. "*One of the most important parts [of the CVC work] that we don't have replacement funding for is working with the community groups that have credibility and a level of trust within the various communities we are trying to reach.*" The funding outlook seemed better for well-established, broad-based coalitions in several states, where the coalition work was expected to be supported by one or more partners. Larger partners, especially those in bigger cities, are often able to build the consumer advocacy work into ongoing efforts, but smaller partners often lack the staff capacity and resources to contribute meaningfully without additional support. A few grantees had secured local funding to continue coverage-related work focused on particular consumer groups of geographic areas. At the time of this report (December 2015), several others were still hoping to sustain the outreach and enrollment work through state and local foundation

sources. No grantee was optimistic about being able to secure funding for work focused on further coverage expansions.

Several grantees see potential for new funding sources by seeking support for consumer health advocacy work focused on issues other than enrollment. Grantees reported that many local, state and national funders are interested in "next generation" access issues involving delivery system and payment reforms, provider networks, health literacy issues and the like. Several grantees had already secured or were in the process of trying to secure funding to focus on health care delivery system transformation, and a few had applied for funding to support outreach and education efforts focused on minorities. *"We are finding that funders are very interested in health systems and delivery system and cost containment stuff, but not the coverage work."* Other topics identified as future priorities included making sure that insured populations are able to access care by attending to rate setting, network adequacy standards, and provisions related to contracting with Essential Community Providers.

Importance of evaluation

Several grantees noted that they could use additional help in making the case that consumer health advocacy work is valuable to potential funders. This could include assistance in showing how their coalitions, policy analysis skills, media connections, and advocacy feedback loops can help foundations achieve the outcomes and results that funders care about. While many of the activities consumer advocates engage in are difficult measures, grantees need to be able to describe in concrete terms why engaging consumers and establishing feedback loops between consumers and policy makers is so important, what the work involves, and the kinds of outcomes they could expect. *"I think it's harder for some funders to see the outcomes side of the equation when you're an advocacy group or when you are doing the outreach and education work that isn't directly enrolling people."*

Relevance of advocacy feedback loops to other health policy issues

While the current phase of the CVC initiative uses consumer engagement strategies in the service of better enrollment outcomes, the basic framework can be used to advance a range of related health and health care outcomes where relevant program and policy efforts would benefit from a stronger link to actual consumer experiences. This type of approach is used by the Center for Medicare Rights to ensure access to affordable health care for older adults and people with disabilities (http://www.medicarerights.org/). Efforts to measure and improve quality of care and to support value-based payment programs would also benefit from a stronger connection with and understanding of consumer needs and experiences. The general approach to advancing these other types of outcomes will be similar to coverage-focused work, but the specific partner organizations involved in the coalitions and key program and policy stakeholders will likely differ, as would the specific type of input sought from consumers. All types of stakeholders could potentially benefit from work that builds and cultivates relationships with consumers, but the CVC approach requires time, skill, and ongoing attention to foster strong relationships with program and policy officials and to engage the right partners with links to the hardest to reach consumers.

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