Assessing the Role of State and Local Public Health in Outreach and Enrollment for Expanded Coverage

A Case Study on Eagle, Garfield, and Pitkin Counties, Colorado

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Key findings

- Local health departments play important roles as key members of the West Mountain Regional Health Alliance. During the first open-enrollment season (2013–2014), the alliance's outreach and enrollment activities consisted primarily of certified health care coverage coverage guides providing one-on-one support to individuals and families looking for health insurance through Connect for Health Colorado. Alliance members secured funding; hired all health care coverage guides; provided infrastructure, training, and staff support; facilitated organizations' access to uninsured populations; created a broad network of local health departments and other providers of social services; and supplied trusted expertise in health.
- Outreach and enrollment efforts face challenges, such as inconsistencies between national and state enrollment processes, the fact that a major grant was not actually awarded until just before open enrollment began, underestimations of the time required to complete enrollments, and high insurance costs.
- Some factors—such as a long history of partnership, trust, and strong communication; complementary, not competing, interests; strong community presence; the ability to influence policy; and shared decisionmaking across the alliance—help local health departments' efforts.

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA)[1] laid the groundwork for a substantial increase in the number of people who have access to health insurance through Medicaid expansion or health insurance marketplaces.[2] During the first open-enrollment season, states used a variety of strategies to reach out to and enroll newly eligible people. Typically, federal and state funding was used to develop navigator programs in each state. The design of these programs differed by location,[3] and, although many stakeholders were involved in these efforts, state and local health departments (LHDs) were, and remain, a relatively untapped resource.[4] This is somewhat surprising, given that LHDs serve as trusted entities in communities, can reach the most-vulnerable populations, and have access to data and resources that might facilitate ACA outreach and enrollment.

This is one in a series of reports designed to highlight innovative models and best practices that leverage LHD involvement in ACA outreach and enrollment and to facilitate knowledge transfer to other geographic regions looking to leverage the full range of roles for LHDs in ACA outreach and enrollment. Potential roles include serving as a coordinator for community activities, being a trusted source of health care information for consumers, and leveraging community partners to increase capacity for outreach and enrollment. These reports identify compelling models for how LHDs can implement similar activities in their own communities. Further, they provide guidance and insight into the role LHDs can play now, and help redefine that role in the future, as states continue to enroll residents in health insurance coverage. Each case study

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was designed to capture nuanced differences in how health departments support these efforts in their communities, identify facilitators and barriers to these approaches, and develop lessons learned from these activities.

CONTEXT OF HEALTH CARE REFORM IN COLORADO

Prior to the passage of the ACA, Colorado initiated health care reform efforts in 2009 by expanding the state's Medicaid program under the Colorado Health Care Affordability Act.[5] However, because of budget constraints, implementation was limited. The passage of the ACA in 2010 supported states electing to expand Medicaid for adults living at up to 138 percent of the federal poverty level. In 2012, an estimated 65.8 percent of uninsured adults (258,000) in Colorado were eligible for, but not enrolled in, Medicaid. As of May 2014, roughly 179,000 Coloradans had signed up for health insurance through Medicaid.

In 2011, Colorado established a state-based health insurance marketplace called Connect for Health Colorado. Marketplaces, which are sometimes known as exchanges, are the ACA-created programs that allow consumers to shop for health insurance during open enrollment. Some states rely on the federal Health Insurance Marketplace, at HealthCare.gov; other states set up their own. Prior to enrollment, approximately 294,118 people were eligible for health insurance through the Colorado marketplace. As of April 2014, 129,000 Coloradans had signed up for qualified health plans through Connect for Health Colorado.

Between 2013 and 2014, the federal government awarded the State of Colorado more than $17 million to establish a network of navigator and in-person assister (IPA) programs across 57 grantees, which ranged from county health departments to local clinics and community centers.

METHODS

Identifying Case-Study Sites and Activities

RAND researchers and National Association of County and City Health Officials (NACCHO) staff identified state and local health departments that represented a range of models for participation in outreach and enrollment activities. An initial environmental scan, which included literature reviews, website analysis, and semistructured interviews with national and local stakeholders, identified a range of activities. Discussions with key staff at 15 health departments were conducted to learn more about their specific approaches and to understand more about the community and population context. In consultation with staff at the Office of the Assistant Secretary for Planning and Evaluation (ASPE), we selected seven sites that highlight a variety of models of LHD involvement and contexts in which the public health departments were operating. The sites reflect differences in expansion status, urbanicity, region, use of public health data, participation of public health in partnerships, and leadership by public health: Boston, Massachusetts; Eagle, Pitkin, and Garfield counties, Colorado; Houston, Texas; Illinois (state and local); New Orleans, Louisiana; Tacoma and Pierce County, Washington; and West Virginia (state).

Site Visits

Site visits were conducted over two- or three-day periods between June and October 2014 with LHD leadership or staff and other key players in regional outreach and enrollment efforts (e.g., health care systems, social services, community-based organizations, or state or local government officials). RAND and NACCHO staff conducted four of the case studies; RAND staff alone conducted two; and NACCHO staff alone conducted one. Prior to arriving on site, RAND and NACCHO staff conducted telephone and email discussions to coordinate logistics and plan the topics to be covered in the in-person meetings. The discussions used an open-ended discussion guide that provided a consistent structure to each interview while allowing sufficient flexibility to capture all relevant

information from participants. Discussions focused on implementation strategy (e.g., outreach and enrollment activities, funding, partnerships, and resources), evaluation, sustainability, and replicability. In a few cases, follow-up phone calls were made to staff who could not attend the in-person meetings.

Eagle, Garfield, and Pitkin Counties Case Study

The case study for Eagle, Garfield, and Pitkin counties took place in June 2014. Our team, which included staff from both RAND and NACCHO, conducted eight meetings with representatives of the health departments' network involved in outreach and enrollment activities.

Rationale for Selecting This Case Study

Eagle, Pitkin, and Garfield counties were selected for two primary reasons. First, they provided a model of public LHD engagement as a valued and strong partner in a coalition that includes other governmental human services agencies and health care organizations. The departments of public health and of human services, though now separate, were once combined as a single health and human services agency within each community. Consequently, they maintain deep functional and relational ties.

Second, this case study highlights the value of LHD outreach and enrollment efforts in rural areas. In these communities, LHDs aligned themselves with key partners to accomplish their goals. The counties highlighted in this case study—Eagle, Pitkin, and Garfield—are geographically connected and cover terrain that includes areas that are impassable during some periods of the year. Within this public health and human services structure, many services are provided across counties by one of the three county agencies, sometimes via contract or memorandum of understanding (MOU). As one discussant stated, "We smaller communities tend to band together because we don't have many resources and we need to build off of one another's capacity." As a result, an existing structure for the partnership among the three counties supported outreach and enrollment efforts. A history of collaboration also supported many of the mechanisms needed to execute the ACA outreach and enrollment strategy across the three-county region.

The region experienced unique challenges in expanding health care coverage because the three counties are home to several major ski and recreation areas, resulting in a population that fluctuated significantly in size and in insurance coverage between seasons, with people "churning" on and off of health insurance during periods of employment and nonemployment. There was also a shared sense of community in that a resident might live in one county, work in a second, and use the public health services of the third.

MODEL OF LOCAL HEALTH DEPARTMENTS' INVOLVEMENT AND HOW THEY CAME TO BE IN THIS ROLE

The county departments of public health and human services are part of the West Mountain Regional Health Alliance, which was formed in 2010 to address the issue of prenatal care for low-income women in the region. Other members of the alliance include health care providers, local governments, and community agencies. In 2013, the alliance received a grant from Connect for Health Colorado to establish its Assistance Network to provide outreach and enrollment services in the three-county region. Although the Eagle County Department of Human Services (Economic Services Division) took the lead role, all alliance members contributed and viewed the administration of the grant as a joint activity. The Economic Services Division led because all the partners agreed that, among the three counties, Eagle has the strongest infrastructure to manage the program and track outcomes and because Economic Services, which also houses the Medicaid program,

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has greater involvement in issues related to low-income families. Discussants suggested that this approach reflected the regional practice of deciding on the leadership of programs based on resources, organizational structure, and a consensus about what makes the most sense for implementation and outcomes.

The figure illustrates the relationships between the West Mountain Regional Health Alliance members and the way they came together to support outreach and enrollment. As the figure shows, a lead health care coverage guide,[6] who oversaw five health care coverage guides, led the outreach and enrollment efforts. She communicated regularly with the alliance on the organization of its efforts, successes, and challenges, and she communicated changes in policy from Connect for Health Colorado and the alliance to the guides.

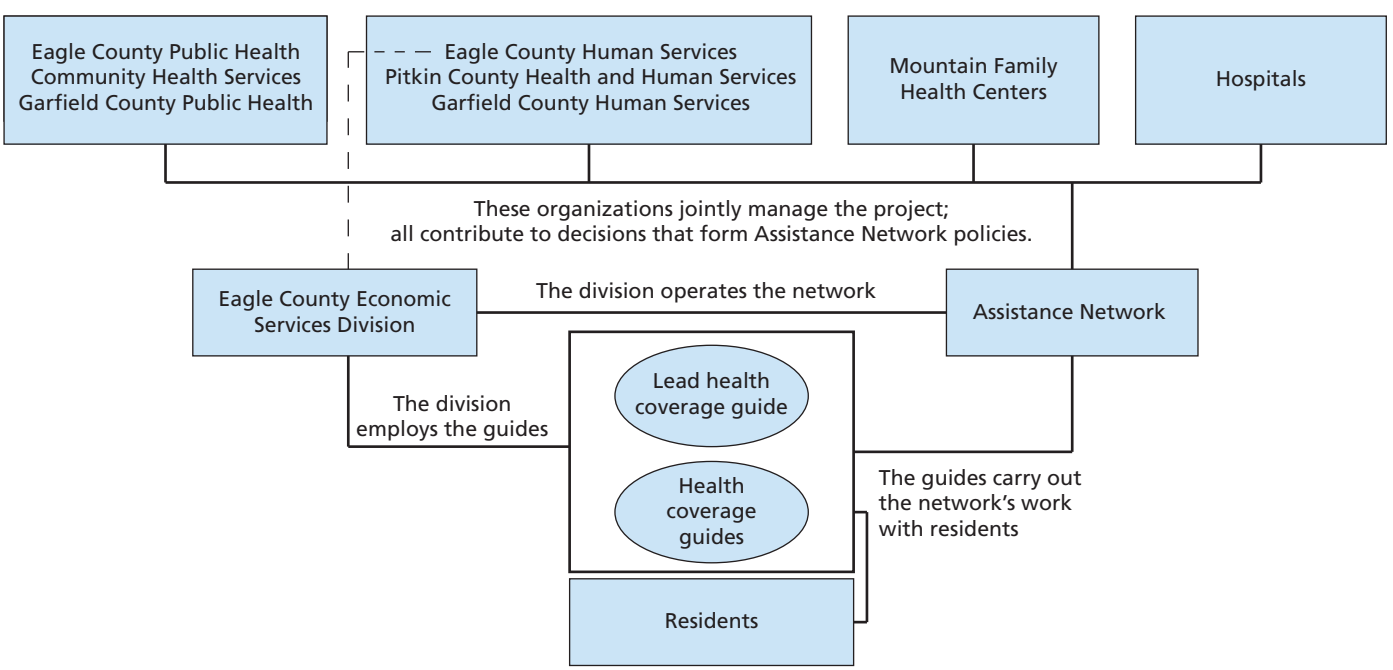
OUTREACH AND ENROLLMENT OVERVIEW

During the first open-enrollment season (2013–2014), outreach and enrollment activities conducted by the alliance consisted primarily of certified health care coverage guides providing one-on-one support to individuals, families, and small businesses looking for health insurance through Connect for Health Colorado. The alliance also conducted outreach events to raise awareness about expanded insurance options. Each health care coverage guide (along with one supervisor) took responsibility for a smaller geographic area within the three counties. Although the Eagle County Department of Human Services employed the coverage guides, they met with clients at the alliance member organizations (e.g., the other public health and human services departments, local hospitals, and family health centers). Each guide was given permanent office space in one of these agencies, but he or she could enroll clients at any location because each guide was equipped with mobile equipment (e.g., phone, laptop, printer, and scanner). This provided the guides with the flexibility to meet the needs of their diverse rural population in the three counties.

The guides provided one-on-one enrollment support, often by appointment. In addition, outreach about the availability of insurance and enrollment was conducted at large sponsored gatherings. These were often shared events in which staff at all the partner agencies participated. Hospital-sponsored events involved participation by guides and staff at partner agencies. All guides were bilingual in English and Spanish in order to connect with the growing Latino population in the region.

The alliance was able to use limited grant funds to purchase newspaper and radio ads. In addition, the alliance asked

West Mountain Regional Health Alliance Member Relationships for Outreach and Enrollment, 2013–2014



NOTE: Pitkin County contracts out its public health services to Community Health Services. Eagle County Economic Services, part of Eagle County Human Services, serves both Eagle and Pitkin counties. Mountain Family Health Centers are federally qualified health centers (FQHCs).

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[T]he grant [from Connect for Health Colorado] dramatically increased the scale of reach into the community. As one discussant suggested, "It would have been impossible to do what we did without this funding."

for special permission to conduct outreach via bus advertisements, which was seen as an effective way to reach residents in all three counties. Staff at the FQHCs and local hospitals were also available to enroll uninsured persons who sought health care at their institutions.

One of the innovative components of the program was an electronic calendar that was used by the health care coverage guides and accessible to everyone in the county. The calendar could be used to set individual enrollment appointments and to identify where enrollment events were occurring. Staff at all the agencies in the alliance were trained to identify persons eligible for various insurance programs and to refer them to the guides. As each site identified uninsured clients, staff made a referral (and often an appointment through the calendar) with one of the guides. The electronic calendar helped the guides track demand for services across this broad geographic area. It also gave residents direct access to a guide and information about enrollment.

Local Health Department and Alliance Roles to Support Outreach and Enrollment

Case-study participants suggested that, because of the unique structure of the departments of public health and of human services, it is difficult to delineate the roles that the LHD plays relative to the other alliance members. In this sense, the relationship of the organizations represented a true partnership, not just in name but also in action. In addition, although the grant from Connect for Health Colorado supported all the outreach and enrollment activities, all partners invested in-kind support for grant activities. In this section, we discuss these roles in more detail.

Secured Funding

The alliance's members jointly wrote and submitted the grant proposal for outreach and enrollment activities. Specifically, the alliance contracted with the former chief executive officer (CEO) of Mountain Family Health Centers to write the original proposal. Although the discussants all suggested that health insurance outreach and enrollment are central to their missions as public health, health care, and human services organizations, they felt that their involvement in these activities would have been considerably less without this funding. For example, the FQHC has benefit specialists on staff who would likely have been working with uninsured patients to enroll them in the plans for which they were eligible, such as Medicaid. Likewise, the Economic Services Division is tasked with Medicaid enrollment, but case-study participants suggested that the grant dramatically increased the scale of reach into the community. As one discussant suggested, "It would have been impossible to do what we did without this funding." As the alliance considers new roles moving forward, its members will likely apply for additional funding sources jointly.

Made Hiring Decisions

Alliance members jointly hired all the health care coverage guides. The alliance felt that the only way to reach the diverse population in the three counties was to hire culturally competent health care coverage guides who understood how best to reach the different populations in the region, including the growing Latino population. However, because the guides worked closely with several different agencies (in many cases, taking office space at the organizations), each member of the alliance had a stake in hiring them. As a result, alliance members jointly interviewed and made decisions about whom to hire to fill those positions.

Provided Infrastructure

All alliance members contributed office space for the guides to conduct enrollments and space for outreach and enrollment events. Further, technical support was provided to the guides while they were on site at partner agencies. Eagle County espe-

cially had the depth of infrastructure to support grant activities, including these:

- human resources and information technology (IT) staff to coordinate hiring and placing health care coverage guides and managing their IT needs
- legal staff to develop appropriate MOUs with the other involved agencies
- communication infrastructure to provide grant-specific messaging and marketing
- data collection and analysis to track program activities.

Provided Training and Staff Support

Staff at each agency were trained on how to connect clients to the guides for formal assistance. This included making referrals and using the calendar to create coverage appointments. Moreover, staff time at the various agencies was used to help organize, participate in, and advertise outreach events and enrollment events. This was a very important role for the LHDs, which offer programs to many residents who lack insurance. Making the link to the health care coverage guides was important for LHDs' clients.

Facilitated Organizations' Access to Uninsured Populations

The LHDs, along with the other alliance members, all contributed to the health and human services safety nets of the three counties. As a result, they interacted with a large number of low-income and uninsured persons. In some cases, these populations were eligible but had not yet signed up for insurance. Through these contacts, the alliance was able to reach a large number of uninsured people. Although many private providers do not participate in the alliance, these providers could make referrals for enrollment either to the website or to the health care coverage guides. As one case-study participant from an LHD stated, in reference to the ability to enroll clients on site,

> It's helpful when our guide is here on site; it helps if clients can easily access care. It does make a difference for clients. We provide a lot of direct services, so we are seeing the consumers [whom] we need to enroll.

"The involvement of public health [was] important because we have links to community partners. [LHDs are] really good at linking people to people, so that was our role."

Created a Broad Local Health Department and Social Service Network

Alliance members also had numerous links to other organizations in the three counties. As a result, outreach occurred through a larger network than the alliance partners alone. This was especially salient for the LHDs. As one discussant suggested, "The involvement of public health [was] important because we have links to community partners. [LHDs are] really good at linking people to people, so that was our role." Overall, the broad network of partners in all three counties supported outreach and enrollment in multiple ways, including advertising or hosting enrollment events, making referrals, and directly linking clients to the health care coverage guides through the appointment calendar.

Supplied Trusted Expertise in Health

The LHDs in particular also brought a specific understanding of the health and health care impacts of the ACA, as well as the needs of vulnerable populations. One benefit of this was in helping to shape the messaging to uninsured people based on LHDs' experience working with these clients on other issues. To address these needs, the LHDs and their key governmental partners sought to involve a trusted advocate in the form of the hired coordinator, who led outreach and enrollment activities and oversaw the bilingual guides. Together, the LHDs and the trusted advocates were able to understand client needs and translate them effectively for the alliance to inform decision-making. Another benefit was that the LHD staff could help

communicate more broadly about issues related to the ACA to facilitate understanding of the program.

CHALLENGES TO OUTREACH AND ENROLLMENT

The alliance confronted a variety of barriers to its outreach and enrollment activities. Case-study participants suggested that primary among these was inconsistency at the national and state levels around enrollment processes. For example, a major state policy change occurred just prior to open enrollment, requiring those seeking insurance through the Colorado marketplace to apply first for Medicaid. Those who were rejected because of high income could then apply for insurance through the marketplace. Accommodating this policy change meant that additional training for enrollment staff was needed. In addition, the new policy placed particular strain on Economic Services, which processes all new Medicaid applications. In Eagle County, this was an important problem because Economic Services was the lead agency for outreach and enrollment. The policy change also created delays in enrollment. During the first open-enrollment period, a determination of Medicaid eligibility could take up to 45 days. As a result, people who tried to enroll sometimes failed to return to complete the second step of the application process, or they might have been confused about where their applications stood. Because some participants felt strongly that they did not want to apply for Medicaid and might not have understood that their incomes would preclude it, the policy served as a deterrent to some participants enrolling at all.

The timing of the award from Connect for Health Colorado to the alliance was also a barrier to implementation. Although the grant was approved early in 2013, the award was not made until very close to the beginning of open enrollment. As a result, case-study participants suggested that it was difficult to implement the broader outreach strategy that had been detailed in the proposal and that this might have reduced the number of clients reached through its outreach strategy. The alliance had planned a long outreach period leading up to open enrollment and continuing through the enrollment period. However, by the time the grant was awarded and once the state policy changes were implemented, the focus became almost entirely on enrollment. Staff at the alliance also expressed concern that it was not possible to track changes in enrollment in the counties as they moved through the year. Data on enrollment and insurance rates at the state level might have been helpful in planning outreach strategies geographically but were too old to be useful for planning. Rather than rely on data to plan enrollment activities, the alliance continued to focus on the geographic regions covered by the guides.

The alliance underestimated the time needed to complete each enrollment, and staff felt that this constrained their ability to enroll larger numbers of participants. Though the two-step application process contributed to delays, low health literacy and low education, combined with poor computer skills among some populations, also played a role because navigators had to spend more time than anticipated explaining how insurance works. In response, assistance guides changed their messaging to be as clear as possible in explaining how the process of enrollment occurs. Staff also worked to overcome challenges by helping set up email addresses and using strategies to help remind clients of important next steps. As one discussant explained,

> The entire time [we're with them in the enrollment session], we're taking notes and giving them index cards with all their information. We're having to write down the information for them and tell them that they have to keep track of certain pieces.

Finally, the high cost of insurance was a shock to some participants and deterred them from completing the enrollment process. Stakeholders noted that many people would go through the process and then simply refuse to enroll in an option because of cost. Reaching people was also made difficult by both national media attention about the failures of the HealthCare.gov website at the beginning of enrollment and negative attention surrounding the ACA in general. In response, the alliance network intensified individual outreach efforts to clients who had started but not completed enrollment.

ENABLERS TO THE LOCAL HEALTH DEPARTMENTS' ROLE IN OUTREACH AND ENROLLMENT

To help overcome these challenges, the partners relied on several factors:

- trust and strong communication
- complementary, not competing, interests
- strong communication
- strong community presence

- the ability to influence policy
- shared decisionmaking across the alliance.

The outreach and enrollment activities of the Assistance Network relied on the infrastructure and resources that were provided by the alliance partners. Funding was especially important because several case-study participants noted that, although many of the partners would likely have worked to identify enrollment options for their clients, the extent to which they accomplished this across the three counties depended on their grant. But navigating the hurdles of planning these activities, acquiring resources, and coordinating across agencies in both the public and private sectors also required clear communication and trust that had been honed over several years of working together on issues that included health but also extended to infrastructure, land, water, and other environmental issues. This led to contracts and formal relationships among the participating organizations, and, from the point of view of case-study participants, it resulted in a mind-set of "how do we attack this problem" rather than one of competitive interests. The alliance had been considering several health care reform–related activities even prior to passage of the ACA, so when it passed, an opportunity was created.

Strong communication (e.g., ongoing updates on activities) that, in turn, supported shared decisionmaking across partners was also important. The lead health care coverage guide was in constant communication with partners about their activities, and they met regularly both in person and by telephone. This meant that partners were informed about challenges as they arose and were prepared to make decisions. Working together built mutual trust in each other's capacity and commitment to overcome problems arising during implementation: In our discussions, many alliance partners said that they know whom to contact when problems arise and that they are always available to one another. For example, one of the county agencies supporting the health care coverage guides with office space was able to provide them with security badges to access the county office building despite the fact that they were technically employed by a different county. As case-study participants noted, there is a shared understanding of the value of public health and human services in the political and health care leadership of the counties and specifically of the value of health insurance. As one discussant said, "We don't have a sense of competition. Here, it is less about jurisdiction and more about, 'are we doing this as a community?'" According to several case-study participants, these attitudes run so deep that political leaders in the counties typically follow the recommendations made by their departments of health or human services and rarely create roadblocks. Moreover, the history of prior engagement and partnership means that the alliance partners were used to working together and were often in alignment on their approach to addressing these types of issues. This made it easier for the partners to make decisions about outreach and enrollment and to solve problem as they arose. All together, the partnership reported that it helped enroll more than 9,000 lower-income Coloradans in affordable commercial insurance, Medicaid, or both.

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FUTURE PRIORITIES: WHAT COMES NEXT?

For the 2014–2015 open-enrollment season, the alliance planned to continue with outreach and enrollment pending additional funding from Connect for Health Colorado. A primary focus will be identifying methods of working more closely with consumers to provide assistance in choosing among health insurance options. The alliance is also considering adding a focus on improving utilization of services among newly insured people.

One additional area of emphasis is on further expansion of the partnership network. First, the alliance is considering how to reach small businesses to support employee enrollment in the marketplace. Second, it is examining ways to work with brokers, insurers, and private physicians to reach more uninsured persons seeking care.

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DISCUSSION

Although all three LHDs in Eagle, Pitkin, and Garfield counties were instrumental in active outreach efforts, the Eagle County LHD was an especially active participant and leader in a communitywide effort to engage in outreach and enrollment. This role reflects the approach that many health departments have taken across the country. However, one of the unique aspects of this community is the strong integrated partnership used to address outreach and enrollment across a three-county region. This case study provides useful ideas about how LHDs can participate in outreach and enrollment. Specifically, the LHD was able to leverage its network of partner organizations to implement each aspect of outreach and enrollment.

The LHDs and their partner governmental agencies administered the grant in a way that made it easy to work across county lines and facilitate the work of the health care coverage guides in an efficient manner. These activities were supported in turn by a long-standing history of partners working together on a host of related health and social service activities, as well as the broad support that county leaders in all three counties had for these types of joint efforts. Other health departments might use this case study to identify how to leverage their own existing partnerships to achieve the goals of outreach and enrollment and to begin developing relationships with local social service, health, and other community-based organizations that likely take on the lion's share of outreach and enrollment activities in their communities. Notably, rural communities could learn from this approach of placing IPAs in key locations across the region (supplemented with an automated calendar for making enrollment appointments) and sponsoring enrollment events around the three-county area to help facilitate client engagement. All communities could learn from the success of centralizing the planning and implementation outreach and enrollment events around a single coordinator.

LHDs can serve as critical partners and, in some cases, as leaders of these key activities. However, some aspects of this community make it unique and could preclude exact replication of the partnership in other communities. Specifically, not all LHDs partner with one another regionally to provide services to residents like these LHDs have. Also, although many LHDs have strong working relationships with community partners, the breadth and depth of relationships evident in these three counties could not be replicated in other communities. Finally, others LHDs might not have access to the type of funding that was used in this project to support outreach and enrollment. Similarly, funding at some LHDs might preclude activities, such as training staff, not directly covered by the grant. This is especially important in communities in which LHDs have faced recent and large budget cuts and have less capacity overall. Nevertheless, many facets of this partnership and its work in outreach and enrollment can be replicated.

NOTES

[1] Public Law 111-148, Patient Protection and Affordable Care Act, March 23, 2010. As of February 13, 2015: http://www.gpo.gov/fdsys/granule/PLAW-111publ148/PLAW-111publ148/content-detail.html

[2] A health insurance marketplace, also sometimes called an exchange, is a resource to help consumers choose and enroll in health insurance plans. Some states operate their own marketplaces, and others use the federal marketplace, called the Health Insurance Marketplace, to help their residents get coverage.

[3] Enroll America, "Certified Application Counselor Program: Early Lessons," Washington, D.C., June 2014. As of February 13, 2015: http://www.enrollamerica.org/certified-application-counselor-program-early-lessons/

[4] National Association of County and City Health Officials, *Role of Local Health Departments as Navigators: Findings from 2014 Forces of Change Survey*, Washington, D.C., May 2014. As of February 13, 2015: http://www.naccho.org/topics/research/forcesofchange/upload/Navigators.pdf

[5] Colorado House Bill 09-1293, Concerning a Hospital Provider Fee, and, in Connection Therewith, Authorizing the Department of Health Care Policy and Financing to Charge and Collect a Hospital Provider Fee, Specifying the Allowable Uses of the Fees, Requiring a Post-Enactment Review of the Implementation of This Act, and Making an Appropriation in Connection Therewith, April 21, 2009. As of February 13, 2015: http://www.leg.state.co.us/clics/clics2009a/csl.nsf/fsbillcont/D71C48DD229F80CD872575540079F3A0?Open&file=1293_enr.pdf

[6] *Health coverage guide* is the Assistance Network's name for certified IPAs who assist individuals, families, and small businesses in evaluating health plan options, applying for insurance affordability programs, and enrolling in health care coverage.

About This Report

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