

Addressing Barriers to Online Applications: Can Public Enrollment Stations Increase Access to Health Coverage?*

November 2011

Introduction and Summary

As a result of The Patient Protection and Affordable Care Act (ACA) more than 30 million Americans are expected to enroll in health care coverage by 2019.¹ In California, alone, it is expected that most of the 6.4 million non-elderly adults and children currently uninsured will be eligible to enroll in new coverage.² In order to ensure that people eligible for coverage obtain it, the ACA supports a streamlined eligibility and enrollment system that will be accessible and easy for consumers to use. To that end, the ACA requires that people be able to enroll in coverage a variety of ways: in person, on the telephone, by mail or online.³

While the ACA proposes to provide an easy way for individuals to access online applications from the privacy of home, many individuals still are not able to take advantage of the online option. Some individuals do not have the “hardware” that would enable them to apply from home, e.g. computers, printers or scanners; others are challenged by language barriers, low English proficiency, disability or additional reasons that prevent them from comfortably being able to complete an online application without some level of assistance.

In addition to the above-named barriers, a number of key consumer issues arise and need to be addressed in order to ensure that the more streamlined, high-technology application process is accessible to all who may be eligible for health coverage programs. States and agencies developing or enhancing their online application systems need to consider that:

- Collecting robust data to track and evaluate the online application experience is essential in order to determine the efficacy of online application systems for improving enrollment in health coverage programs;

* Funding for this paper was made possible by a grant from The California Endowment. The authors are solely responsible for the views expressed in this report. Copyright to Consumers Union of United States, Inc.

- The availability of real-time assistance may be an essential component of any eligibility and enrollment system in order to ensure that all people eligible for programs have access;
- Online software needs to be fully integrated into public benefit program IT systems to ensure efficiency and accuracy in eligibility and enrollment determinations;
- Targeting outreach to ensure those who need coverage have information is critical to ensure that access to health care is available to all who need it; and
- The privacy and data security issues that are unique to online systems have to be addressed in order to ensure that they do not create barriers to applying for and enrolling in health coverage programs.

In an effort to bring online applications to more people, some agencies have begun to explore the use of Public Enrollment Stations (PE Stations). “PE Stations” is a generic description of the many models agencies and policymakers are using to provide computers or kiosk stations in public places in order to bring a streamlined application system to a larger enrollee population.

Consumers Union set out to identify the opportunities and challenges associated with publicly available application stations to help policymakers understand the opportunities that exist to design systems that will meet the needs of the new population entitled to health coverage in 2014. A variety of models piloted across the country have started to test and address the problems associated with online applications through the use of PE Stations. In states as diverse as Alabama, California, Maryland and New Mexico, pilot sites have been setup to allow applicants access to online systems at public sites.

The issues we have identified can assist agencies and other decision makers as they seek to establish the most effective online application systems, including those that launch PE Stations, and help them to anticipate and address the challenges prior to January 2014.

Applying for Health Coverage in the 21st Century

With more than 30 million Americans expected to be eligible for new coverage in 2014 through new marketplaces (known as “Exchanges”) and expansion of Medicaid, it is imperative that states undertake a variety of strategies to make enrolling in coverage easy and efficacious. At the same time, protections need to be put in place to ensure that strategies used meet consumer expectations. We know that the ACA envisions a customer-centric application and enrollment system, with a high level of service and support at its heart.⁴ It envisions a robust consumer assistance network, including a navigator program, where individuals and/or organizations are paid to promote, educate and facilitate enrollment in health coverage, much like assistants in some states do today.

Recognizing that online engagement allows people to access goods and services from the convenience and privacy of their own homes, the ACA requires states to offer consumers the ability to apply for health coverage online. Online applications are to be an integral part of a streamlined, efficient application and enrollment process.⁵

The U.S. Department of Health and Human Services (HHS) has issued specific recommendations about how states’ online application and enrollment systems should work.⁶ Specifically, HHS requires that the enrollment process be customer-friendly and transparent to applicants. Consumers should be able to get real-time help in applying for coverage and be able to complete the process quickly – within 15 to 20 minutes.⁷ The eligibility and enrollment process should allow consumers to supply pertinent information for eligibility determinations and enroll in a selected plan on the same visit, providing applicants with descriptions of their health plan options and a preliminary tax credit eligibility determination.

With these goals in mind, states are moving forward with plans to implement online application systems. However, no state has a fully operational, ACA-compliant online application in place as of this date. With further research and development needed in every state as they implement Exchange systems, many issues have yet to be addressed, including determining how states will proceed with the task of modernizing and linking existing and developing information technology systems.⁸

As states work toward getting the online components of their Exchanges up-and-running, many observers are looking to online government benefits applications as models for how the Exchange application and enrollment systems might work.⁹ Online applications for public assistance, unemployment insurance and SNAP have been in use in some states for almost a decade. More

recently, 32 states have begun to offer applicants the ability to apply online for Medicaid and/or a variety of benefit programs at one time.¹⁰

In placing applications online, states are seeking to achieve multiple goals. An oft-cited goal is to make applying and enrollment easier for individuals by making the application more accessible and streamlined.¹¹ Online applications allow at least some applicants to avoid the trek to a county office for a paper application; individuals can apply anytime, from anywhere with an Internet connection. Through the use of online benefits applications, states also are seeking to reduce the administrative burden on Medicaid and other support programs. The hope is that through automation and system integration, states can achieve reduced workloads for eligibility workers, speedier and more consistent eligibility determinations for consumers, and generally streamline the application and enrollment process.¹²

While the online application process may make it easier for some people to apply for and receive health coverage, not all people can avail themselves of this option. There are still many people eligible for public programs who do not have access to a computer at home. Close to 40 percent of families with income between \$25,000 and \$35,000 who use the Internet do not have a computer with Internet access at home. For lower-income families, more than 60 percent who use the Internet do not have Internet access at home.¹³

Having a computer and Internet access may not be enough to get applicants to apply for benefits online. Even those with computers may not have a printer to print out a copy of their application for future reference. Even fewer people have scanners at home to scan in supporting documentation, which some states still require for certain public programs. In some rural communities, it may be impossible to access the Internet consistently, making it difficult to go online and complete an application without losing the connection.

Another hurdle to the use of online applications is the fear some people still have that their personal information is not secure on the Internet. In a leading survey of Americans, conducted by the Pew Internet & American Life Project, trust and security online were of great concern to the majority of survey respondents. For example, eighty-four percent of respondents were concerned that businesses and people they did not know would be able to get personal information about them or their families through the Internet. While sixty percent of respondents stated that they were very concerned about privacy, women, African Americans, older Americans, and those with less online experience expressed greater concern than the average (64 percent, 72 percent, 67 percent, and 62 percent respectively).¹⁴ A more recent survey by the California HealthCare Foundation looking specifically at health information technology and the electronic sharing of

personal and medical information with physicians or other providers found that two thirds of the public continue to be concerned with the privacy and security of their health information.¹⁵

In addition to technological barriers and the lack of trust in the Internet, many of those individuals who may be eligible for health coverage may not be able to utilize online systems from home due to language access barriers, low literacy (including health literacy), physical or mental health disabilities, and low computer literacy. Recognizing the lack of access to home computers and/or challenges in using home computers to apply for benefits online, states have initiated pilot programs to bring computers, printers and scanners to more public places in an effort to increase availability of the online application process.

Enhancing Access to Online Enrollment

As states begin to create or update their eligibility and enrollment systems in anticipation of implementation of the ACA in 2014, there are a number of issues to consider as they develop streamlined, online application systems. In addition to technology and access problems for many consumers described above, other barriers may prevent eligible individuals from applying online for health coverage. States must address the barriers in order to ensure that the high tech application processes envisioned under the ACA are accessible to those who may be eligible for health coverage programs.

States are perfectly situated in 2011 to begin to identify and address these issues while moving forward to establish Exchanges by 2014. As IT systems are developed and strategies are considered, steps need to be taken to track what works and what does not work, as well as to establish strong consumer protections and accountability measures to ensure millions of dollars of investments are not wasted and that target populations are served.

Collecting robust data to track and evaluate the online application experience is essential in order to determine the efficacy of online application systems for improving enrollment in health coverage programs

In order to determine the effectiveness of online systems in terms of their ability to increase or improve enrollment opportunities for consumers, it is vital that agencies evaluate the systems with a variety of measures. At a minimum, agencies should collect and evaluate aggregate information about:

- How many people applied for coverage during a specific time period;
- The final disposition of the case;

- How many applications were rejected/dropped for being incomplete;
- The demographics of those applying, including age, gender, geography, race, primary language spoken, education level; and
- The demographics of those deemed eligible, including age, gender, geography, race, primary language spoken and education level.

While aggregate information is essential, equally important is the need to evaluate data that is specific enough to understand barriers to access that might arise for specific populations – to be able to determine whether language barriers, age, or other demographics are impacting successful use of online systems; and to be able to determine whether certain localities are hindered by weak Internet signals or other access barriers.¹⁶ In addition to aggregate information, at a minimum, states should be collecting the following information, encrypted and de-identified, to ensure application and enrollee privacy:

- How did the person apply for benefits: online, in-person, by phone or paper application;
- What time of day did the person initiate the application;
- If online, did the person apply via a home computer, work computer, or public enrollment station;
- Did the person ask for assistance;
- Did the person receive assistance;
- If so, what form did the assistance take: in-person assistance from community organization, in-person assistance from county or state staff, live web chat, or audio/visual prompts online;
- How many online applications were abandoned;
- What was the ultimate disposition of the case (determined eligible for Medicaid, CHIP, the Exchange), including reasons for ineligibility (over income, incomplete application, lack of verification, immigration status) – with a breakdown by demographic.

Without detailed, encrypted data to evaluate the efficacy of online applications, evidence will be lacking to determine whether the systems are working and their differential impact on the populations that states are trying to serve. Currently, few, if any, agencies collect data comparing the outcomes for individuals applying online with assistance versus those who apply

online themselves. What little information exists about online applications comes from programs that have been in place only a short time.

For example, there are several studies of Wisconsin's online application system that indicate that people who apply online for Wisconsin's health care programs are less likely to end up enrolled in the programs compared to those who applied in-person or on the telephone (presumably with assistance).¹⁷ However, since the online application has become available, there has been a net gain in enrollment.¹⁸ Study authors noted that "[t]he adoption of online application mechanisms remains uneven across demographic subgroups, with the lowest-income, rural, and non-English-speaking populations least likely to choose an online method."¹⁹ Study authors raised the concern about the "target efficiency" for the online program (i.e., the "proportion of system users that actually become enrolled"). The Wisconsin system offers an online "Am I Eligible" function to enable potential applicants to self-screen for eligibility, which was underutilized. Twice as many online users applied than those who used the screening tool.²⁰ Information from Wisconsin indicates that the ease of applying online has increased the number of applications for public health coverage programs. Yet, the state did not collect enough information for the study authors to understand why those in Wisconsin applying online are less likely to be eligible for coverage.

Measuring the use of real-time assistance is important to determine its significance as a factor in achieving successful online enrollment

Many studies of public program eligibility and enrollment systems indicate that the availability of real-time assistance can increase the likelihood of a person obtaining coverage.²¹ Throughout many public benefit programs, including Medicare and the Children's Health Insurance Program (CHIP), agencies have increased enrollment by offering direct consumer assistance to those applying for benefits. Small businesses heavily rely on assistors, in the form of brokers and agents, to help employers and employees decipher insurance options and make decisions about coverage.

Consumer assistance can range from making brochures and fact sheets available to potential beneficiaries to providing step-by-step, in-person help in filling out an application. Studies indicate that more thorough assistance contributes to more positive outcomes.²² It is not enough to simply provide consumers with information.²³ The most successful assistance programs not only provide consumers with information, but also guide applicants through the process, help ensure necessary documentation is submitted, set up initial physician appointments, and provide help with renewal of coverage.²⁴

Application assistants can play an important role even when a state has an online application, as Massachusetts' experience demonstrates. As part of its effort to enroll all Massachusetts residents in health coverage, when the state's health reform bill passed, the state conducted a massive outreach, education, and enrollment campaign.²⁵ One component of the Massachusetts effort was to continue to fund application assistants to help residents apply online for coverage through the "Virtual Gateway" program.²⁶ Paired with other outreach and enrollment efforts, including provider outreach, automatic enrollment for recipients of the state's uncompensated care pool, and an individual mandate, within two years of the bill passage, the state had increased its enrollment, such that 97% of Massachusetts residents were covered.²⁷ More than half of the successful online applications for Massachusetts health coverage were completed and filed online by health care providers and community-based organizations acting on behalf of consumers.²⁸

Online application systems need to be fully integrated into IT systems to ensure efficiency and accuracy in eligibility and enrollment determinations

While the ACA envisions a robust IT system that is streamlined and allows local, state, and federal systems to integrate readily and easily with one another, attaining that vision will be challenging given the current state of the relevant IT systems. While the front end of online and PE Station application tools have been created to be user-friendly, behind the scenes the technology is varied, erratic, and often incredibly outdated and time-delayed.

In May 2011, the Centers for Medicare and Medicaid Services (CMS) issued its "Guidance for Exchange and Medicaid Information Technology (IT) Systems, Version 2.0." Clearly stated, CMS calls on states to implement business architecture to support "seamless coordination between Exchanges, Medicaid, and CHIP and between the Exchanges and plans, employers, Navigators and brokers and community-based organizations and providers providing enrollment assistance."²⁹ The assumptions and goals behind the seamless coordination include an experience where:

- Customers should experience a high level of service, support and ease of use;
- States provide the same customer experience to all individuals seeking coverage, regardless of their income status or the programs they qualify for;
- States make it simple for individuals to explore information about health coverage options and provide real-time enrollment for most people;
- Individuals will be evaluated for eligibility for all programs using a coordinated set of rules;

- States do not operate a “shadow eligibility system” to deal with differences in Medicaid eligibility pre-2014 versus post-2014;
- The federal data services hub will support functions and responsibilities of the Exchange, Medicaid, and CHIP; and
- IT systems will generate data in support of performance management, public transparency, policy analysis, program integrity, and program evaluation.³⁰

The laudable goals set forth by CMS *should* be achievable for most states by 2014. And, yet in 2011, most are far from meeting these goals. While much of the online software is state-of-the-art, the biggest challenge systemically is that few of the software programs currently are fully integrated into state public benefit programs’ enrollment and eligibility systems. Most state data systems are outdated;³¹ public benefit programs often are run on separate systems wholly disconnected from one another; and they often do not communicate between systems smoothly or efficiently.³² In most cases, the online system is not the same as the state’s overall enrollment and eligibility system. In some agencies, the systems are partially compatible – where two systems can communicate with each other without human intervention. With some state IT systems, the information gleaned through the online process can be integrated into the state system via one additional step required by agency staff. Still other IT systems require responsible agencies to download information from a public computer into the statewide system. In many instances, to get the systems to fully communicate with one another requires significant human intervention (including manual data entry).

Under the ACA, however, not only are states required to integrate their public programs’ IT systems, but, for the first time, those public programs need to be able to functionally connect to the commercial insurance market given the new coverage under state Exchanges. Currently, not one state’s online eligibility and enrollment system is as fully developed as the ACA requires.³³ For example, a recent report from The Lewin Group and Social Interest Solutions reviewed New York’s IT infrastructure and identified gaps in the current eligibility and enrollment system. The report found “limitations in terms of scalability and interoperability and the absence of an automated rules engine of the current human services eligibility and enrollment system.”³⁴

The ACA envisions an online application system that uses the latest technology to determine eligibility for Medicaid or tax credits by making electronic data matches.³⁵ As of today, many states lack computer systems capable of making such matches. The problem is that local computer systems are not capable of seamless communication with the larger systems at either

the state or federal level.³⁶ Although there are a few notable exceptions, state systems overall will require significant investments of planning and resources to meet ACA's requirements by 2014.³⁷

HHS has recognized the challenging work ahead for states to comply with ACA requirements for IT systems. In February 2011, the government announced the award of seven grants totaling more than \$240 million, to help the group of "'Early Innovator' states to design and implement the Information Technology (IT) infrastructure needed to operate Health Insurance Exchanges."³⁸ Key states like New York received millions of dollars to help assess current capacity and design models for IT infrastructures that can be replicated in other states.

In order to realize the vision of the ACA and make online applications streamlined, simple and straightforward, resources need to be invested in integrating PE Stations and online application tools, but more importantly, to link online application tools to the commercial insurance market and eligibility determination systems for all public benefit programs.

Making online applications “universally accessible” and using multiple social networks for outreach and education, are critical to ensure that access to health insurance is available to all who need it

For those who do not have the hardware to access an online system, simply providing public access to computers, scanners and printers can increase the use of online applications. However, for most people, the barriers to successfully completing an online application are less about access to the hardware, and more about other challenges such as limited computer literacy, low literacy, limited English proficiency, physical or mental health disabilities, and additional barriers that diminish the success of online systems for a significant proportion of the population eligible for health coverage in 2014.

The most obvious barrier is the limitation many online application systems have in terms of language access. While states have public benefit forms and applications translated into many different languages (e.g., California has, at a minimum, translation into twelve different languages), online applications are often only available in English, with some states offering them in both English and Spanish. At the same time, Medicaid programs require the provision of oral interpretation in any language. Without phone, video, or in-person assistance nearby to help answer questions, and with online applications only in English and Spanish, states cannot guarantee equitable access through online systems. Research supports the need for creating special outreach to address the needs of specific populations, including culturally- and linguistically-specific social marketing tools.³⁹ Similarly, on-line systems and PE Stations can be helpful to consumers with physical disabilities, eliminating the need to go to a specific office, but their needs must be built into the design of the PE Stations from the outset.

Studies also indicate that negative perceptions about public health programs can create an impediment to achieving enrollment of all eligible individuals.⁴⁰ Lack of trust, confusion, and concerns about access to high quality care can inhibit people's ability to initiate and complete the eligibility and enrollment process. Online applications accessed alone at a computer do not address these barriers. Robust and innovative outreach efforts, as well as overall simplification of program requirements under the ACA, will be required. Research shows that Exchanges should build on relationships in communities in order to build the trust required for applying for public benefits, including health coverage.⁴¹

Strong privacy and data security standards play a critical role in supporting consumer confidence and lowering potential barriers to effective use of online application systems

While more and more individuals in this country are developing greater facility with the Internet, hesitation and wariness persist about entering personal information into Internet-based systems. Online application systems raise that specter, even more so for those that are accessible in public places. At the same time, electronic systems provide for greater ability to protect confidential information than paper-based methods, by enabling encryption of data that cannot happen in paper format.

The ACA imposes strict limitations on the collection and use of personal information,⁴² limiting the information to that which is "strictly necessary" to authenticate identity, determine eligibility and the amount of tax credit or reduction. While draft federal regulations governing Exchanges propose that they follow the Fair Information Practice Principles (FIPP)⁴³, in order for people to feel comfortable supplying personal information online requires a great deal of trust. With the new push toward online and electronic data sharing, different privacy protections may be required.

Most website portals that host online applications state that the data is encrypted and adheres to all federal privacy standards. At the same time, many of the online application systems are designed and administered not by states, but commercial vendors. Providing third party access to personal information is not an issue associated only with online application systems. In many parts of the country, states contract with outside, third-party vendors, to administer public benefit programs.

For online systems to work and be trustworthy, contractors responsible for designing and implementing IT systems need to be held to the same, or higher standard, than the government agencies that oversee the programs. For example, in the draft regulations proposed by HHS, contractors are required to adhere to the same privacy and security standards applicable to the Exchange.⁴⁴

CMS' Guidance for Exchange and Medicaid IT Systems (Guidance) envisions that HIPAA Privacy and Security Rules govern HIPAA-covered entities and business associates.⁴⁵ As more information sharing will be conducted electronically and online, agencies not only have to ensure that they are meeting HIPAA requirements, but also state laws that restrict sharing of health information. While much of the information that is anticipated for online applications is not health status information, other information required to determine eligibility may have strict privacy standards. An example articulated in the Guidance is the Internal Revenue Code, section 6103, which has more strict privacy and safeguards for tax return information.

Public Enrollment Stations (PE Stations) for Improving Health Coverage: Addressing the Challenges or Perpetuating Them?

With the advent of online Medicaid applications, several states have tried to make applying online more accessible and attractive to applicants by setting up work stations where people can apply through a public computer for Medicaid coverage. While most states can direct their residents to public computers, a few localities have begun to offer more, providing specific locations with distinct stations to provide direct online access to apply for Medicaid and other public programs.

Sometimes known as kiosks, the technological capacities of these PE Stations are quite varied. While some PE Stations are the most bare bones – simply a computer with Internet access available on a desk for applicants to use – other models strive to create a one-stop-shop that allows a consumer online access to apply and/or track applications, as well as the ability to print, copy or scan documents. Other models have looked to expand access by providing PE Stations in partnership with community-based organizations and state or county staff, where individuals and families can obtain in-person support and assistance applying for benefits.

When evaluating the variety of models in play in many states, it is important to consider whether the PE Stations are actually solving some of the barriers associated with online enrollment or, rather, are PE Stations as they are currently configured simply perpetuating the problems inherent in any online application system?

Most state Medicaid agencies provide basic access to online applications by making available computers with public access. Some PE Stations are located in public health departments or in the waiting rooms of welfare offices, while others are located in non-agency settings that health care consumers frequent, including pharmacies and health clinics. Still others are available in more generic public places, such as libraries.

In each of the distinct PE Station locations, the set-up is unique in its configuration, use and location, even when located in the same state. For example, California's Los Angeles Unified School District (LAUSD) hosts PE Stations, called Public Access Stations (PAS locations), which are like private offices located on campuses or school-based health centers where parents, secluded from public view, may apply for Medicaid and other public programs through a customized program called One-e-App. Kiosk users in Merced County's pilot program, also in California, encounter a very different set-up. A Merced County PE Station looks more like a stand-alone machine, with a computer, printer and scanner attached to a molded desktop. Merced's PE Stations are located in a number of public places, including a public library and a local pharmacy, and use the C-IV Systems' C4Yourself online application.

At self-service stations, applicants stand or sit alone at a computer to fill-out an online application; this approach has been described by one researcher as "the computer in the lobby method of reaching potential users."⁴⁶ In this type of set-up, computers branded with the name of the local Medicaid application program are placed in public locations such as libraries, pharmacies, food pantries or government offices. At these self-service PE Stations, applicants may only use the computer to access a screening tool or application program. Staff of the host entity, public or private, are not available to assist the applicant.

At a partial or full-service PE Station, applicants can receive help in completing an application. The stations are more often out of public view, usually a workstation located in a separate room or space from the host organization. In general, assistants are available if needed, often nearby, but do not sit alongside the applicant; after the applicant has input his/her information, the assistant is available to step in and help the applicant submit the application, usually by copying, faxing or scanning the applicant's required paperwork. Follow-up with the applicant varies by site, which is noted in Table 1. With some full-service stations, applicants are seated in private offices and receive shoulder-to-shoulder help with the application process. Howard County, Maryland, described below, has established a separate office set-up where applicants can get help using the online screening and application tools for public benefits in a department setting.

The opportunity to keep from public view the application process itself varies. In Howard County, individuals meet privately in cubicles with their assistor. A similar set-up awaits applicants in Los Angeles schools, where applicants step away from the regular business space in which the PAS is located to use computers out of public view. In contrast, kiosks in New Mexico are located in community centers and other quasi-public spaces.

Most PE Stations have specific software that is designed to directly link users to applications for public programs, including Medicaid and other health programs. Most PE Station computers are

not open for users to go online to surf the web via “Google” or “Bing,” but are limited for use in applying for public benefits. Because the software has been specially designed for these purposes, it often contains the most up-to-date, desirable features, such as individual account creation, dynamic questioning and the use of e-signatures.⁴⁷ Taken together, these software features make using an online application more customer-friendly. Most use website portals for customers to access the Medicaid application online, while others, such as Alabama, use a software system that is integrated directly into the state public health department network.

Although many of the PE Stations are stand-alone systems, they do not actually store data onsite, but rather information entered at a public computer is immediately transmitted through website portals, except for Alabama, which draws the data straight into the state database. As a further precaution, it is our understanding that most PE Station data is encrypted. The privacy and security issues raised by PE Station computer systems are the same for online applications systems. Some of the servers hosting the data are located and controlled by the agencies administering the benefit programs, where other offsite servers are controlled by private vendors who then link the information to the state or county agency.

The online applications, except in limited examples, are not part of the same IT system as the state health coverage program eligibility and determination systems. In some cases, the online system is compatible with the state health coverage programs, so can easily transfer information and have it integrate into the state database system. In other situations, the compatibility depends on the specific health coverage program. In California, for example, the One-e-App offers a single point of entry application for children applying for health coverage, whether it be Medicaid or the Children’s Health Insurance Program (CHIP). While an application screened for public benefits for One-e-App is able to directly link to the online application and screening for the CHIP program, the system is not as smooth for the Medicaid application. Rather the online application for a child potentially eligible for Medicaid is printed out (by the vendor managing the CHIP program) and mailed to the county (based on the applicant’s zip code), then mailed to the regional center within the county, and then manually re-entered into the statewide eligibility determination system.

Table below provides an overview, comparing PE Station features for seven different sites throughout the country

Public Enrollment Station Models								
State	Locations	Equipment	In Public View?	Data Security*	Programs included	Available Languages	Software	Assistance Available?
Alabama	County health departments and Federally Qualified Health Centers	Computer, printer/scanner, fax machine. Some sites have Audio Visual Application Assistor (AVAA) program	Yes	Yes	Health programs only	Spanish and English at AVAA kiosks; English only at all other kiosks	State agency	Limited human assistance. AAVA system walks the applicant through the application via audio/visual technology
California: Los Angeles Unified School District	Ten School-based Health Centers, Healthy Start programs, and Wellness Centers	Computer, printer, fax/scanner within a private work space	No	Yes	Multiple benefit programs	Spanish and English	Third-party vendor	Yes
California: Merced County	Five stand-alone kiosk locations, including a public library, WIC office, and pharmacy	Stand-alone cabinet-like office station that contains a molded desk and chair; a computer and scanner are anchored to the desktop	Yes	Yes	Multiple benefit programs	Spanish and English	Third-party vendor	No in-person assistance. "Click to chat" available online
Florida	Department of Children and Families offices and community partner sites	Computers and fax machines	Yes	Yes	Multiple benefit programs, but not CHIP	Spanish, English, and Creole	State agency	Only in some community partner sites
Maryland: Howard County	County healthy departments	A separate office space with computer, printer, scanner/fax	No	Yes	Health programs only	Spanish and English	Third-party vendor	Yes
New Mexico	Twelve sites located in tribal health centers, chapter houses, community centers in border towns, and public libraries throughout the state	Stand-alone, ATM-like, fortified kiosks, with computer, printer, scanner incorporated	Yes	Yes	Health programs only	Spanish and English	Third-party vendor	Yes
Washington	Washington Department of Social and Health Services Community Service Offices and community partners	Computers +	Yes	Yes	Multiple benefit programs	Spanish and English	State agency	Yes

*Data security measures in place including encryption and offsite data storage

Alabama is a relatively small state with a total 2010 population of more than 4.8 million people,⁴⁹ with 17.5% of Alabamians living below the federal poverty level.⁵⁰ Alabama has two different state agencies that oversee health coverage programs – the Alabama Medicaid Agency and the Alabama Department of Public Health (ADPH), which runs the state's Children's Health Insurance Program (CHIP)- known as "All Kids."

In 2004, ADPH initiated its online, joint application, www.InsureAlabama.org, for ALL Kids, SOBRA Medicaid (Medicaid for children and teens under 19), Plan First, and Medicaid for Low Income Families. At that time, potential applicants could fill-out an application online, print and sign the signature page, and then mail to the appropriate agency address based on the predetermination. In July 2008, the state initiated use of e-signature, no longer requiring families to print and return signature pages to complete submission of applications. For both agencies, this enhancement significantly increased the number of applications received for processing via the web.

The web application software for the joint application is housed and maintained by ADPH, so applications for All Kids coming through the web are automatically integrated into the technology infrastructure of ADPH. This allows ALL Kids-eligible applications to be immediately available for processing into the CHIP Eligibility and Enrollment System. For Medicaid applications, the system is not integrated, however ADPH sends the applications through a nightly data exchange which exists between the two agencies, referred to as the automated data integration system.

Also in 2008, ADPH established kiosk stations in select county health departments (currently in 6 locations) as another point of access to apply for public health insurance. These kiosks at the county health departments offer a specialized electronic application that provides

computer-assisted help to applicants in English and Spanish using the Audio Visual Application Assistor (AVAA) program. The AVAA system features interactive audio and video capacity in English and Spanish, intended to lower barriers to applying online due to language and literacy.⁵¹ The AVAA system captures the same information as the joint online application. Once the applicant presses "submit," application information is sent from the kiosk via web service directly to ADPH and the application is processed as any other online application.⁵²

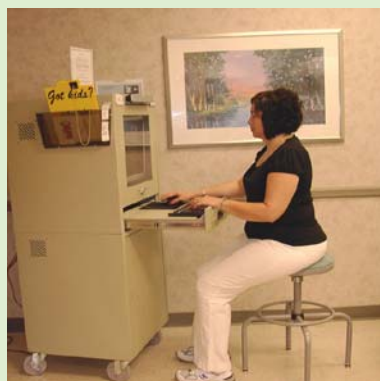


Photo courtesy of the Alabama Department of Public Health

In September 2010, the Alabama Primary Health Care Association (APHCA) installed kiosks in select federally qualified health centers (FQHCs) throughout the state containing an online version of AVAA supported by the Children's Health Insurance Program Reauthorization (CHIPRA) Outreach and Enrollment Grant funding. The same developer of the state's AVAA software developed the online AVAA product used at the FQHC kiosk stations. The online version of AVAA functions identically to the standalone version currently on the ADPH kiosks with future plans to have all kiosks utilizing the online version. The APHCA stations feature a molded table-chair combination with a large computer screen anchored to the desktop. One observer described the stations

as "a cross between a video game and an ATM on steroids."⁵³ The APHCA stations are also intended to reach English or Spanish speakers already accessing services at the health centers, to make it easier for them to enroll in Medicaid and All Kids.

Between 91 and 97 percent of those individuals applying at county health departments or Federally Qualified Health Centers are eligible for health coverage. Since the inception of the online joint application, ADPH has integrated a series of questions for consumers to reflect back to the agency how the application is working. The results indicate that most people applying online are doing so from their home or work computers. Most consumers are reporting that the online process takes less than thirty minutes to complete (75 percent) and that the majority of applicants (89 percent) need no help whatsoever.⁵⁴

In an effort to continue to enhance enrollment experiences and process, ADPH has several additional plans underway. For the user, additional kiosks are being installed in all 66 County Health Departments, offering another venue for accessing the online, joint application, with future plans to allow access to AVAA through these same kiosks. Additionally, a new online joint application is currently under development that will allow users to create accounts, renew coverage or update information throughout the coverage period. The new online application will also be made available in Spanish and is tentatively slated for implementation in 2012. ADPH is currently implementing a new document imaging and workflow management system to enhance processing and archiving of applications. Alabama Medicaid is also implementing a document imaging and workflow solution over the next year. Many of these activities have been initiated as part of the Maximizing Enrollment Grant funded in part by the Robert Wood Johnson Foundation.

Los Angeles is the largest county in the state of California, with over 9 million residents. Boasting an extremely diverse population, Los Angeles County also has more than 15% of the population living below the federal poverty level.⁵⁶ It is home to one of the largest uninsured populations in the country. In Los Angeles County alone, there are more than 195,000 uninsured children, with more than 60% of those uninsured children eligible for public health coverage programs.⁵⁷

The Los Angeles Unified School District (LAUSD), the nation's second largest school district, uses "One-e-App," a one-stop-shop for screening and applying for public benefits, developed by Social Interest Solutions. It was first introduced in several Bay Area counties in 2003 and is now used in a number of additional California counties, including Los Angeles.⁵⁸ As originally envisioned, One-e-App was created by the California Healthcare Foundation to allow assistors and applicants themselves to use an online application to access a variety of public benefit programs. In Los Angeles, during the application's pilot stage, agencies and community-based organizations could use One-e-App at no cost through dedicated grant funding. In 2011, access to One-e-App software now is available for a fee for those no longer receiving grant funds for pilot projects.

Beginning in 2009, LAUSD initiated a pilot project to bring public benefits coverage to families in the school system. Funded by a three-year grant, the district established ten dedicated locations where parents and guardians could go to use a computer to apply for public benefits. These Public Access Stations (PAS) are located in

school-based health clinics, Healthy Start Centers, and Wellness Centers across the school district. The PAS sites are separate, dedicated spaces outside of public view. Each PAS site contains a computer, fax machine or scanner, and printer for applicants to use. Onsite staff is available during office hours to help applicants apply through an online system, mostly with scanning documentation and submitting paperwork. The computers at each PAS run a customized version of the One-e-App program.

In July 2010, LAUSD determined that the PAS were not being utilized as much as expected, so the district opted to open an online application system through a website link, allowing individuals to complete a full application online from the privacy of their home or work computers. At the time, the District undertook a significant direct mail campaign to inform families in the District of this new opportunity.

The system works by allowing an applicant or assistor to enter personal data into the One-e-App program, which then filters that data through a rules engine to screen for eligibility for up to 15 public benefit programs. The applicant then can choose to apply to those programs identified as applicable – or opt out if they desire. The entire screening and application process can take up to one hour because applicants are screened and able to apply for a multitude of public benefit programs. Applying may take the form of electronic transfer, digitally faxing application forms, or printing and mailing or delivering applications for programs that will only accept applications in that manner.

For some programs, the data obtained through One-e-App is directly submitted electronically and integrated into a second program application for children's health programs (e.g., an online application, Health-e-App, for Medi-Cal for Children and Healthy Families, California's CHIP program). For other programs the data is referred to the public benefit system – information is pre-populated from One-e-App information, printed out and mailed to meet program requirements. Other programs require fax submission, while still others share referral information electronically.

Through tracking applications, the District has found that there is a higher volume percentage of applications filed through the website, rather than the PAS program at schools. They have not yet initiated tracking to identify the percentage of applicants who are eligible coming through each of the distinct systems, nor have they tracked demographics to help them identify specific populations or sub-populations that may be benefiting from the online application or the PAS access. However, the District has initiated a process to assist individuals who start an application at a PAS but abandon it. Applications started at a PAS and left pending for three days are assigned to an assistor for follow-up.

Another challenge for LAUSD and other organizations using the One e-App system is that for some, the costs of using the system are prohibitive. For LAUSD, the grant covers the cost of using the software, but in the 2012-13 school year after the grant is complete, the District may no longer be able to afford the costs of continuing to use One-e-App.

California: Merced County⁵⁹

Merced County, California is a relatively small, agricultural county.⁶⁰ The county is located in the middle of California's Central Valley and is home to a diverse population. The county has a large percentage of low-income households and close to 82,000 people enrolled in the state Medicaid program.⁶¹

The Merced County Human Services Agency uses the C-IV System, an online system developed by several California counties that are part of the Statewide Automated Welfare System (SAWS) Consortium IV. The C-IV System is now used in 39 out of 58 California counties.⁶² The C-IV System allows individuals and families to apply for several public benefit programs, including CalFresh (SNAP), Medi-Cal (Medicaid) and temporary financial assistance (CalWORKs) using a single online internet application, "C4Yourself,[®]" a "self-service, public facing, web-based portal."⁶³

Merced County began using C4Yourself in 2007. People using C4Yourself can create an online account in English or Spanish that can be accessed and updated from any computer with internet access. The C4Yourself application assists users through the application process by presenting a series of questions related to the individual's personal situation. Online users can apply for, renew, and update their information used by the benefit programs.

Merced County's public enrollment kiosk program is a county initiative with the C-IV System that uses C4Yourself. Kiosk users experience the same online application in English and Spanish at a public enrollment station as they would if

accessing C4Yourself as a home user. In addition, for those applicants who do not have printer or scanner capabilities at home, the public enrollment station allows users to print or scan documents and upload them to include with their applications from the kiosk. "Click to chat" is a new feature to dialogue with county staff.

Merced rolled out its kiosk program in 2010 and now has five stand-alone self-service kiosks in a variety of locations throughout the county, including a WIC office, public library and private pharmacy. Each kiosk is composed of a stand-alone cabinet-like office station that contains a molded desk and chair; a computer and scanner are anchored to the desktop. The computers limit access to the C4Yourself application and a number of other public benefit education or referral systems. Kiosk users, like users at home, can access their account online to check the status of their applications or to submit necessary recertification information.⁶⁴



Photo from C-IV Yourself promotional video: Self-service kiosk located at San Joaquin Drug (Plenada, California).

The Merced County self-service kiosks are in public view, often tucked into a corner or along the wall of the organization within which they are located. Applicants can sit at a computer to fill out their application. (See photo.) No

onsite help is provided to applicants at this time, although future plans are for installation of a web-cam that users can access to receive real-time assistance. At the end of the session, applicants can print a reference page that contains a personalized file number.

In Merced County, the data entered into the kiosk is not stored onsite. It is immediately encrypted and transferred offsite to the C-IV System. County workers then review the information that comes through C4Yourself and submit the electronic data into the C-IV System immediately after review

The ability to scan documents at the kiosk site is new as of September 2011. Users can submit any required documentation by scanning it and uploading the electronic record. The C-IV System has an integrated imaging system, so when the user uploads the document at the kiosk, the worker will be able to see it in their case file.

The number of applications in Merced County has increased since the introduction of C4Yourself, though that may be related to the economic downturn, rather than availability of online application capabilities. For Merced County, the denial rate has not gone up appreciably since the online application has been available. Over the past year, the number of applications submitted via kiosks has been small. The county's next step is to undertake outreach and education to make the community more aware of kiosk availability. Additionally, they are developing a tracking system that will allow them to identify applications submitted by each specific kiosk site.

That State of Florida's Department of Children and Families (FDCF) modernized their service delivery model in 2004 as a result of legislative mandate. At the time, FDCF had service centers throughout the state, most of which were closed during the modernization process. The new service delivery system virtually eliminated face-to-face interviews and downsized staff by 48 percent.

Branded as ACCESS – Automated Community Connection to Economic Self-Sufficiency – the program developed a streamlined application process using current technology, policy and verification requirements, call centers and community partnerships with public and private entities that serve as additional portals to services. Originally piloted in the Tampa area, known as the Suncoast Region, by the end of 2004 ACCESS was adopted statewide. Florida's new service delivery model focuses on customer self-service. Most of the eligibility staff works from home or are housed in regional processing centers. Most customer contact is conducted by telephone.

The online ACCESS application is available in English, Spanish and Creole. It allows applicants to use the system 24/7 for public assistance benefits: Temporary Cash Assistance, Food Assistance, and Medicaid. Individuals can apply from any

location with internet access. Approximately 90% of all applications received by the Department are via the web. Moreover, the state anticipates adding several additional public benefits to the ACCESS system in 2011/2012, including the Medicaid Savings Program (Medicare buy-in), Medicaid for Pregnant Women, Nursing Home Medicaid, Wavier Medicaid and Hospice Medicaid. The new application will also be more user friendly, as only questions pertinent to the applicant's benefit selection will appear.

In addition to the online application, there is a customer portal, MyACCESS Account, which allows individual applicants to establish an account, check eligibility status, request additional benefits, and request changes in coverage. Applicants can also apply for additional benefits or recertify their current benefits through MyAccess. Future enhancement to the MyAccess Account portal includes online notices and e-mail notifications.

Florida's Children's Health Insurance Program is not administered by FDCF. Rather, Florida's Healthy Kids has its own website portal for online applications. Florida Healthy Kids determines if an applicant is potentially eligible for Medicaid and through a file transfer, submits the applications to FDCF nightly to the state's ACCESS Kidcare computer system, which then transfers the files to the

state's legacy system, known as FLORIDA, where the application is processed for eligibility and enrollment determination.

In addition to online applications via home or work computer, at the FDCF service centers and "storefronts" that remain open (FDCF sites offering access to computers and telephones, but with limited staff assistance available), individual applicants are provided access to a dedicated computer, printers, fax machines and scanners in order to apply online.

Additionally, FDCF has a network of community partners, currently more than 3,400, located in social service agencies, food banks, clinics, medical providers, faith-based organizations and others, which also provide access to computers for applicants to go online to apply for benefits.⁶⁶ In some community partner sites, applicants simply have access to computers or fax machines,⁶⁷ while in other sites, partner staff are available to provide assistance going through the application process, answering questions, and helping identify needed documentation. To track the number of applications coming from a partner site, each partner is issued a unique URL and partner ID number. The level of service provided by a partner organization is based on their individual agreement with the Department.

In the Fall of 2008, the state of Maryland funded Social Interest Solutions (SIS) to develop an online screening and application tool for Howard County's "Healthy Howard Health Plan," a county-specific coverage program for eligible low-income residents in the area that is administered by Healthy Howard, Inc., a non-profit bureau of the Howard County Health Department. The program, Health-e-Link, used a customized version of One-e-App, the public benefits software that is also used in parts of California, Arizona, and Indiana.

The Health-e-Link program enabled county staff to submit an online application for the Healthy Howard Health Plan on behalf of the applicant. For individuals ineligible for Healthy Howard, the system would identify the other health coverage programs a person could apply to separately, but the software only allowed an application to be submitted for the Healthy Howard Health Plan. Paper applications had to be submitted for other public health programs directly to those programs.

In the Fall of 2010, as a result of a \$1 million CHIPRA grant from CMS, the State of Maryland initiated an agreement with SIS to make improvements to the system. The software evolved to enable online applications for four public health care programs. In addition to the county program, the Healthy

Howard Health Plan, the online tool supported applications for Medical Assistance for Families (Medicaid Parent Expansion), MCHP (Maryland Children's Health Insurance Program), and the PAC (Primary Adult Care Program). The program was renamed "Healthy Maryland."

Healthy Maryland is not universally accessible online, even in Howard County. To use the system requires a password, which is available to county staff only. Staff can access the program from their desktop computers or through a special public station located in the county health department, where they can meet with applicants. In this way, staff can assist clients in-person, as well as over the phone.



ABOVE: Howard County Maryland's Door to Health cubicles, where assistants meet with clients to fill out online health coverage applications.

Howard County's program, "Door to Health," is a standalone office carved out of the larger county health department building space. The Door to Health in Howard County is by

appointment only. Applicants meet with county staff in private cubicles, where staff help applicants fill-out the online application, scan and electronically attach documents, and officially submit the application online. The hope is that Healthy Maryland will make access to public health care faster by streamlining the application process.⁶⁹

The software designed for Healthy Maryland can transfer data into the state's eligibility systems, though it does so differently depending on the program. In some cases, the Healthy Maryland software transfers the applicant's information into the Medical Assistance electronic application, Service Access Information Link (SAIL). County staff upload daily the SAIL electronic application into the statewide eligibility determination system, Clients' Automated Resource and Eligibility System (CARES), which is used by counties for eligibility determinations and processing. In other cases, the Healthy Maryland software transfers the applicant's information to PAC's eligibility system. While all systems talk to each other "one way" (from Healthy Maryland to SAIL and onto CARES, or from Healthy Maryland to PAC), only the PAC linkage involves two-way communication. When an eligibility determination is made in CARES, the system does not communicate that decision back to the county staff for tracking.

New Mexico⁷⁰

New Mexico is unique in that it is the only state we reviewed that currently does not have an online application system. Yet, it does provide public enrollment stations where applicants can use a computer-like console to apply for health coverage programs.

In 2009, the New Mexico Human Services Department received a federal CHIPRA grant to provide computer access to health coverage programs for hard-to-reach populations. The program was proposed in order to make the application process for public health coverage more accessible, particularly to Native Americans and Latinos living far from state enrollment sites.⁷¹

The kiosks allow applicants to apply for health coverage through "Insure New Mexico Solutions!" Insure New Mexico Solutions! includes coverage for NewMexiKids and NewMexiTeens (the state's CHIP/ Medicaid programs for children) and the JUL program (providing family Medicaid coverage to lower income families). When it was first initiated, Insure New Mexico Solutions!⁷² provided applicants the ability to apply for a special state insurance program for small businesses and self-employed individuals, but that program is no longer accepting applications due to loss of funding.

During the life of the grant (October 2009 to September 2011) New Mexico placed twelve stand-alone, 1980's video game-like consoles in place at tribal health centers, tribal chapter houses, community centers in

border towns, and public libraries throughout the state. (See photo.) New Mexico's kiosk system uses Software, iReach, which was developed by InfoComSystems. iREACH was being used by the Community



Photo courtesy of DynaTouch

Action Agency of Southern New Mexico to help screen clients for potential Medicaid and County indigent fund eligibility. The state adapted the iREACH program for the stand-alone kiosks, creating an interface for users that resembles the paper application for New Mexico Insure Solutions! The application available at each site is static, deliberately developed to replicate New Mexico's paper application in the hope that applicants likely familiar with the paper application, would feel more comfortable using the kiosk to apply.

When applicants arrive at the site, they can go directly to the computer and start entering their personal information. They are asked to create a personal PIN number and enter personal information, income and other relevant data. When they have

completed the process, the computer sends them a message telling them to find an "agent" onsite to take the next step. The trained assister then logs into the iREACH system and assists the client by reviewing the application and ensuring that the client signs the application. Signatures are captured via the kiosk's built-in signature pad and then uploaded and populated on to the application. Once the application is signed by the client, the agent hits the submit button. Only the agent has the authority to submit the application. If a person is applying to a program that requires paper documentation, the agent will also scan and upload the documents and link them electronically to the application. The scanner necessary for this task is also built into the kiosk.

For those individuals in need of assistance, the agents are available to help fill-out the application. The computer applications are available in Spanish and English, but are not translated into Navajo. In most kiosk locations, agents speak Navajo and other languages, including Spanish, and are available to assist anyone using the kiosk.

The kiosk computer is linked to a website portal, administered by a third-party vendor, where all the information is stored. Because New Mexico has no online application process, state employees, not the third-party vendor, have to go to the website portal, print out the kiosk applications, and then manually input the applications individually into the state eligibility system.

New Mexico (continued)

New Mexico keeps statistics to track the data on applications through kiosks. They have found that the kiosks were not being utilized very much in the community areas such as libraries or tribal chapter house. This may be due in large part to the fact that the kiosks only allow applicants to apply for health coverage. Since people are still required to go to eligibility offices for other public benefit programs, using a community-based kiosk does not save time, unless the applicant only needs health coverage. The paper application, however, allows a person to apply for all public benefit programs on one application.

In April, 2011, New Mexico placed a kiosk unit in one of its state eligibility offices. While the community-based kiosks were not getting as much use as anticipated, the one located in

the human services department eligibility office was being used extensively. Onsite staff at eligibility offices are trained to direct applicants to the kiosks if they are applying solely for health coverage, which saves them wait time for staff person for assistance.

The 2009 grant funding and all agreements with community partner locations ended on September 30, 2011. Beginning Oct 1, 2011, all kiosks were relocated to state eligibility field offices. According to state agency staff, in just a few short weeks, usage of the kiosks in these locations has been far greater than the usage at the community locations over several months. Staff report that clients are pleased with the short amount of time that it takes to complete and submit a kiosk-generated Medicaid application. Staff at the field

offices are happy with the efficient process and the decreased workload within their offices.

In August 2011, the state was awarded a second round of CHIPRA outreach funding. The plans for the 2011 grant are to expand the program by creating an online application, based on iREACH, which will allow community-based organizations, Head Start staff, school-based health centers, and other providers trained and certified to assist children and families, to determine presumptive eligibility directly through their desk or office computers. The grant also provides significant funding that will allow the state to develop its IT system so that the iREACH software can directly import data from the iREACH application into the state database system.

In 2001, the state of Washington was the first in the nation to offer an online application for public benefits. Although the application was available via the Internet, potential clients could not submit it online. They needed to print the application, then mail, fax or take it to the local Community Services Office (CSO) to have it processed.

In 2009, the technology was improved so applicants could submit their online applications electronically through a web portal. This public benefit enrollment system was designed by Washington Department of Social and Health Services' (WDSHS) IT staff to be compatible with their existing Automated Client Eligibility System (ACES), allowing data to be transferred seamlessly between the website portal and ACES. Over the last several years WDSHS significantly overhauled its public benefit enrollment system,⁷⁴ offering an updated online application, now called "Washington Connection," making it more versatile for both staff and applicants. Applicants can use Washington Connection to apply for public benefits online, including Medicaid, Temporary Assistance for Needy Families (TANF), and a variety of other programs.⁷⁵

Not only did WDSHS augment its online application process through the "Washington Connections" benefit portal, it also expanded online access by providing both computer stations and staff support in the offices and lobbies of their CSOs.⁷⁶

These sites provide in-person, walk-in assistance with public benefit programs, including public health coverage. The stations include a computer with dedicated (locked down) access to Washington Connection. Staff can print applications for a client if requested. In some offices there are scanners available to scan or fax verification information.

With the assistance of staff, applicants can use the computer stations at CSOs to access Washington Connection and apply for benefits online. The computer stations provide dedicated online access solely to the Washington Connection benefit portal. The online application is available in both English and Spanish, while paper applications in eight languages are available onsite. For any language not immediately available, the state offers interpreters and translation services using the AT&T language service line.

For applicants who need assistance completing an application or understanding what is being asked of them, staff is available through the CSO walk-in system or through contacting the statewide Washington Connection call center. For programs that require an interview, applicants often can get the interview completed in person or by phone the same day as filling-out the information via the web portal.

In addition to the computer stations at CSOs, WDSHS has partnered with a wide range of community-based organizations (CBOs) to provide direct access or assistance to clients applying for these organizations' programs. There are more than 550 partner organizations supporting their communities by offering outreach services through Washington Connection. The partner CBOs often have trained staff or volunteers who can assist individuals or families with online or general questions, applications and recertifications. WDSHS has also established a pilot project with 24 CBO sites in four counties. With the support from federal funds, WDSHS furnished and installed computer equipment in locations where staff could assist individuals applying for coverage. The state is in the process of expanding that project to additional sites in those counties.

In Spring 2011, WDSHS initiated a marketing campaign to encourage a broader range of CBOs to utilize the online application system on behalf of their clients. As that effort got underway, WDSHS initiated a number of data tracking measures to better understand the efficacy of their online system as time goes on. They are tracking applications that come in through their partnership program with CBOs, and anticipate further evaluation to look at demographics of users, as well as to undertake consumer surveys to better understand how the users interface with the system.

Lessons Learned

States' early efforts to bring online applications to a broader range of individuals and families throughout the country by making PE Stations available can teach us a great deal about what we need to put in place to be successful at enrolling the more than 30 million who will be eligible for coverage in 2014.

While some of the inherent problems that arise from the use of online systems that are available only from home or office computers can be addressed through PE Stations, states have yet to successfully implement programs that ensure smooth and seamless ability to apply for health coverage.

Many of the pilot projects that have established PE Stations have been funded through private foundation grants or initial start-up investment by state agencies. While some states invest additional dollars into community assistance by paying organizations and individuals to provide in-person support, other states rely on the mission and vision of these organizations to help people without additional state funding. Regardless, the costs associated with introducing and supporting PE Stations have to be considered and weighed next to the value of helping more consumers access health coverage.

Data collection and evaluation must be robust and thorough in order to determine the efficacy of PE Stations for improving enrollment in health coverage programs

While some agencies, such as LAUSD, have recently begun to track the data about the use of PE Stations in their regions, in other programs, such as Healthy Howard, the programs have not been in effect long enough to track and evaluate the data.

In those cases where data monitoring is taking place, oftentimes an agency evaluates the entire online system, without differentiating enrollment applications that come through a distinct location where consumer assistance is available, making it difficult to determine whether PE Stations are actually helping people obtain health coverage.

For those agencies that are tracking experiences at PE Stations, the data collection process does not necessarily track the important differences amongst consumers applying unassisted through PE Stations, those offered general assistance via phone or online chat functions, and those where in-person, real-time assistance is available in concert with access to a public computer.

Tracking data, including the use of consumer assistance, can help states to determine how important having in-person or more targeted assistance is and to whom PE Stations have provided the most benefit. To assess the value of PE Stations, we urge states to consider the following:

- Few states are tracking key information needed to determine efficacy of PE Stations for enrolling people in health coverage;
- Those states that are tracking information are not necessarily tracking key factors that would help in evaluating and improving systems by 2014:
 - Data collection is needed to allow agencies to compare statistics of those enrolling online from home or work versus those accessing computers from a public site;
 - Data collection is needed to allow agencies to compare statistics of those enrolling with the aid of individuals, including the level of aid used (live chat on computer, a/v assistance, in-person help with using system, in-person help with substantively filling out applications, etc.), versus those applying self-service;
 - Demographic information is needed to target the use of PE Stations at sites in order to determine how to reach those that data indicates can be helped by PE Stations' availability; and
 - Information about how consumers experience online interfaces needs to be included to understand better the intersection of consumers with both online applications and PE Stations.

Public enrollment stations can provide states with the ability to offer a robust consumer assistance model for helping people apply for coverage

The evidence indicates that assistance enhances successful enrollment in health coverage. The ACA emphasizes and supports consumer assistance to enroll millions of eligible consumers in health coverage come 2014. When considering the use of PE Stations for applications and re-enrollment, policymakers would do well to consider the following in order to evaluate the role real-time assistance plays in improving the efficacy of PE Stations:

- PE Stations located in county or state public benefit offices with trained staff may speed up the in-person application process, saving administrative costs and making the application process more accessible to a wide variety of people who would not benefit

from web-based application system, but tracking and data evaluation are needed to determine if this is borne out in practice;

- Locating PE Stations in places where consumers go for health care reasons – immunization clinics, etc. – may be a more successful approach than locating them in other public places. People in need of health services may be more motivated or otherwise inclined to take the time to apply for health coverage, but tracking and data evaluation are needed to determine if this is borne out in practice;
- Locating PE Stations in community-based organizations can provide a network of trained, trusted, and accessible consumer assistance for those most in need;
- PE systems can assist those with low English proficiency access benefits through online applications by providing translated information in a variety of languages (not just English and Spanish) and offering interpreter services at targeted sites.

Technology and infrastructure need to be fully integrated across health coverage program IT systems to ensure efficiency and accuracy of information

States that design PE Stations and original online applications to be an integral part of the state legacy system may have fewer adaptations to meet the goals of ACA by 2014. Currently most states do not have fully integrated IT systems, but rather segregated health coverage IT infrastructures, often run by different agencies, making it difficult to meet the streamlined and efficient standards established under the ACA.

Additional barriers exist when PE Station IT systems are designed and implemented by third-party vendors, creating challenges to maintain systems over time. In order for online systems to work and be accessible to the variety of organizations ready and able to provide assistance, the systems need to be available at no cost to the community-based organizations or local agencies utilizing them.

Focusing on providing “meaningful access” and targeting outreach to ensure those who need coverage have information is critical to ensure that health care coverage is available to all who need it

It is essential that states recognize that “meaningful access” means more than providing a public computer and other hardware. Ideally, those designing new systems for online and PE Stations should build in foundational elements to support the diverse set of individuals eligible for health coverage. Additional support is likely needed for people with disabilities and those facing

language barriers, including those with low English proficiency and low English literacy. States should consider how PE Stations can bring better access to those unable to use traditional online systems, including offering a greater range of languages, larger fonts, and direct in-person assistance.

States that set-up PE Stations have found that they were underutilized without concerted outreach efforts to targeted communities. While the use of PE Stations may be limited, they may be critically important vehicles for applying for benefits for certain populations and in certain geographic areas. Coupling robust data collection with information about hard to reach populations can help target outreach to meet the needs of people who otherwise have difficulty applying for coverage (e.g., opening up a PE Stations with an application in Hmong in a high percentage Hmong-speaking community public health department).

The privacy and data security issues that are unique to online systems have to be addressed in order to ensure that they do not create barriers to applying for and enrolling in health coverage programs online and at PE Stations

Electronic enrollment systems provide for greater ability to protect confidential information than paper-based methods, by enabling encryption of data that cannot happen in paper format. Yet, consumer wariness persists about entering personal information on Internet-based systems. Online application systems in public places may raise even greater hesitation by consumers. Research is needed to assess whether there are unique aspects to privacy or security triggered via an online application model available at a public site and whether certain public sites or set-ups raise greater privacy and security issues ((i.e., open PE Station at a pharmacy) than others (i.e., a private room in a county health department).

In some models, third party vendors may have access to a great deal of personal information. In this scenario, it is important to ensure that there are protections in place to ensure that neither applicants nor application systems are vulnerable to third party malicious tampering. Agencies need to identify whether there are limits in place to protect against data mining or vendor use of collected data for other purposes and put in place those protections when working with vendors. Contractors and consultants need to be held to the same, if not more stringent, privacy and security standards than the government agencies responsible for the public programs.

The Federal Fair Information Practice Principles (FIPP) provide a strong floor, but do not, themselves, protect consumers, because they have no force of law. All public health programs

need to have strict limits in statute and/or regulations that delimit the ability to collect, use, disclose or retain personal information that is disclosed online, in-person, or by mail.

Conclusion

Online applications can open the door to streamline eligibility and enrollment systems and help more people obtain health coverage with greater facility. At the same time, policymakers need to recognize the limitations of online systems and provide supplemental help and alternatives that address those limitations. While PE Stations can be targeted to enhance the online process and provide greater access to health coverage for specific populations, they should be utilized carefully, thoughtfully, and based on sound data and metrics.

In order to effectively use PE Stations as tools for enrolling people in health coverage, specific structures and accountability measures must be in place to ensure that there is adequate integration and oversight of the system. Currently, no ideal PE Station model exists in any locality in the country that can be replicated. Each model has been developed to address its unique circumstances. Yet, the standards and steps described above can be adapted and metrics gathered and evaluated, as states move forward to create the most effective online systems to meet and consider needs and expectations.

Acknowledgements

Julie Silas is Senior Policy Analyst for Consumers Union; Christina Tetreault is a third year law student at Golden Gate University and was a legal intern with Consumers Union from May through August 2011.

The authors wish to thank the many agency staff and advocates who helped us understand how their public enrollment stations worked for consumers. We are also grateful for the helpful comments on earlier drafts from DeAnn Friedholm, Betsy Imholz, Michael McCauley and Laurie Sobel of Consumers Union, Suzie Shupe of California Coverage and Health Initiatives, Cary Sanders of California Pan-Ethnic Health Network, Michael Odeh and Kelly Hardy of Children Now, Beth Capell of Health Access, and Alice Weiss of the National Academy for State Health Policy. Thanks to Evaluz 'Ven' Barrameda of Consumers Union for the design and layout.



POLICY & ACTION FROM CONSUMER REPORTS

Consumers Union has a long history of advocating for improvements in the consumer marketplace. Since our creation in 1936, we have worked for safer, more affordable, and better quality of products and services at both the state and federal levels. We are a non-profit organization with an overarching mission to test, inform and protect.

WWW.CONSUMERSUNION.ORG

Headquarters

101 Truman Avenue, Yonkers, NY 10703
Phone: (914) 378-2000 Fax: (914) 378-2928

Washington DC Office

1101 17th Street NW, Suite 500, Washington, DC 20036
Phone: (202) 462-6262 Fax: (202) 265-9548

Southwest Office

506 West 14th Street, Suite A, Austin, Texas 78701
Phone: (512) 477-4431 Fax: (512) 477-8934

West Coast Office

1535 Mission Street, San Francisco, CA 94103
Phone: (415) 431-6747 Fax: (415) 431-0906

¹ Rosenbaum, Dorothy and Stacy Dean, "Improving the Delivery of Key Work Supports: Policy & Practice Opportunities at A Critical Moment," Center for Budget and Policy Priorities, February 2011, page 7. <<http://www.cbpp.org/files/2-24-11fa.pdf>>. See also, Dorn, Stan, "Implementing National Health Reform: A Five Part Strategy for Reaching the Eligible Uninsured," The Urban Institute, May 2011, page 2 <<http://www.urban.org/UploadedPDF/412335-Reaching-the-Eligible-Uninsured.pdf>>.

² Lavarreda, Shana Alex and E. Richard Brown, "National Health Care Reform Will Help Four Million Uninsured Adults and Children in California," University of California, Los Angeles Center for Health Policy Research, October 2009, page 1 <http://www.healthpolicy.ucla.edu/pubs/files/HCR_FS_10-09.pdf>.

³ "Guidance for Exchange and Medicaid Information Technology (IT) Systems Version 2.0," Department of Health and Human Services Centers for Medicare & Medicaid Services, May, 2011, page 4 <<http://www.cms.gov/Medicaid-InformationTechnologyMIT/Downloads/exchangemedicaiditguidance.pdf>>.

⁴ Guidance for Exchange, page 4.

⁵ "Patient Protection and Affordable Care Act Section 1561 Recommendations," U.S. Department of Health and Human Services Health Information Technology Policy and Standards Committee, September 17, 2010, page 1 <<http://healthit.hhs.gov/pdf/electronic-eligibility/aca-1561-recommendations-final2.pdf>>.

⁶ Guidance for Exchange 2.0.

⁷ Guidance for Exchange 2.0, page 5.

⁸ Weiss, Alice M. and Laura Grossman, "Paving an Enrollment Superhighway: Bridging State Gaps Between 2014 and Today," National Academy for State Health Policy, March 2011 <http://www.nashp.org/sites/default/files/bridging.state_gaps_.pdf>.

⁹ Weiss, Ibid. and Gonzales, Shelby and Samantha Artiga, "Online Applications for Medicaid and/or CHIP: An Overview of Current Capabilities and Opportunities for Improvement," The Henry J. Kaiser Family Foundation, June 2011 <<http://kff.org/medicaid/upload/8203.pdf>>.

¹⁰ Gonzales.

¹¹ Gonzales.

¹² Gonzales. See also: "Enrollment Modernization," Presentation by Peter Cervinka, Program Director, Benefits and Services, California Department of Social Service, February 18, 2010.

¹³ U.S. Census Bureau, Table 1155, 2010, <<http://www.census.gov/compendia/statab/2012/tables/12s1155.pdf>>

¹⁴ Susan Fox et. al., "Trust and Privacy Online: Why Americans Want to Rewrite the Rules," The Pew Internet & American Life Project, August 2000

http://www.pewinternet.org/~media/Files/Reports/2000/PIP_Trust_Privacy_Report.pdf; See also, Wang, Diana Ye and Henry H. Emurian, "An Overview of Online Trust: Concepts, Elements, and Implications," *Computers in Human Behavior* 21 (2005), pages 105-125, February 2004 <<http://nasa1.ifsm.umbc.edu/cv/TrustCHB.pdf>>

¹⁵ Lake Research Partners and California Healthcare Foundation, "Consumers and Health Information Technology: A National Survey," California Healthcare Foundation, April 2010 <<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/C/PDF%20ConsumersHealthInfoTechnologyNationalSurvey.pdf>>

¹⁶ Summer, Laura, et al., "Successful Outreach Strategies: Ten Programs that Link Children to Health Services," Health Resources and Services Administration, US Department of Health and Human Services, Public Health Service, January 1999 <<http://ihcrp.georgetown.edu/agingsociety/pdfs/CHIP%20Outreach%20paper.pdf>>

¹⁷ Leininger, Lindsey, Donna Friedsam, Kristen Voskuil and Thomas DeLeire, "The Target Efficiency of Online Medicaid/CHIP Enrollment: AN Evaluation of Wisconsin's ACCESS Internet Portal," SHARE (State Health Access Reform Evaluation), February 2011 <<http://www.rwjf.org/files/research/71923.pdf>>, and the issue brief drawn from it: "Online Application for Medicaid and BadgerCare," University of Wisconsin Population Health Institute, Volume 10, Number 2, May 2011.

¹⁸ Leininger.

¹⁹ Leininger, page 6.

²⁰ Leininger, page 7.

²¹ "Food Stamp Program Client Enrollment Assistance Demonstration Projects: Final Evaluation Report," Office of Analysis and Evaluation, Food and Consumer Service, United States Department of Agriculture, July 1999, pages 46-47 <<http://www.fns.usda.gov/oane/MENU/Published/snap/SNAPPart-OtherArchive.htm> >; Bitterman, Jodi, Edwards, Jennifer, and Ellis, Eileen, "Maximizing Enrollment in New York: Results from a Diagnostic Assessment of the State's Enrollment and Retention Systems for Kids," National Academy for State Health Policy, February 2010 <<http://www.healthmanagement.com/files/HMA%20website/MaxEnroll%20New%20York%20-%20FINAL-%20for%20posting.pdf>>; Stevens, Gregory, Seid, Michael, Tsai, Kai-Ya, West-Wright, Carmen, Cousineau, M, "Improvements in Access to Care for Vulnerable Children in California Between 2001 and 2005," *Public Health Reports*, Volume 24, September-October 2009, pages 689-690 <<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2728660/pdf/phr124000682.pdf>>; Donna Cohen Ross and Ian T. Hill,

-
- “Enrolling Eligible Children and Keeping Them Enrolled,” *The Future of Children*, Volume 13, No. 1, Spring 2003 <http://www.futureofchildren.org/futureofchildren/publications/docs/13_01_04.pdf>
- ²² Thompson, Jennifer and Laura Summer, “Best Practices to Improve Take-Up Rates in Health Insurance Programs, Final Report,” U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, Office of Health Policy, August 18, 2008, page 12 <<http://www.aspe.hhs.gov/health/reports/08/bestpractices/report.pdf>>
- ²³ Dorn, Stan, “Implementing National Health Reform: A Five Part Strategy for Reaching the Eligible Uninsured,” The Urban Institute, May 18, 2011, page 6 <<http://www.urban.org/UploadedPDF/412335-Reaching-the-Eligible-Uninsured.pdf>>
- ²⁴ Thompson, page 12.
- ²⁵ “Medicaid Enrollment and Eligibility Practice Opportunities,” Center for Healthcare Research & Transformation, June 28, 2011, page 4. <http://www.chrt.org/assets/policy-papers/CHRT_Medicaid-Enrollment-and-Eligibility-Practice-Opportunities.pdf>
- ²⁶ Medicaid Enrollment and Eligibility, page 4.
- ²⁷ Dorn, Stan, Ian Hill, M.P.A., M.S.W. and Sara Hogan, M.H.S., “The Secrets of Massachusetts’ Success: Why 97 Percent of State Residents Have Health Coverage” State Health Access Reform Evaluation, a national program of the Robert Wood Johnson Foundation® and The Urban Institute, June 2009 <http://www.urban.org/UploadedPDF/411987_massachusetts_success.pdf>
- ²⁸ Dorn and Hill, page 1.
- ²⁹ Guidance, 2.0, page 3.
- ³⁰ Guidance 2.0, page 4.
- ³¹ Weiss, page 20.
- ³² Weiss, page 20.
- ³³ Weiss, page 12.
- ³⁴ Social Interest Solutions, “Preparing New York’s Information Technology Infrastructure for Health Reform: A Gap Analysis,” May 2011, page 6. <http://www.nyshealthfoundation.org/userfiles/file/NYSHealth_Gap_Assessment_5_12_FINAL.pdf>
- ³⁵ Rosenbaum, page 7.
- ³⁶ Weiss, page 12
- ³⁷ Weiss, page 12.
- ³⁸ “States Leading the Way on Implementation: HHS Awards ‘Early Innovator’ Grants to Seven States,” February 2011. <<http://www.healthcare.gov/news/factsheets/2011/02/exchanges02162011a.html>>
- ³⁹ Sutter, Delight E., et. al., “Improving Health Insurance Coverage for American Indian Children and Families under Healthy Families (SCHIP),” UCLA Center for Health Policy Research, February 2002 <http://www.healthpolicy.ucla.edu/pubs/files/AIAN_report_062002.pdf>; Zambrana, Ruth and Olivia Carter-Pokras, “Improving Health Insurance Coverage for Latino Children: A Review of Barriers, Challenges, and State Strategies,” *Journal of the National Medical Association*, vol. 96, No. 4, April 2004 <<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2594984/>>
- ⁴⁰ Zambrana, 513; See also Kenney, Genevieve, Jennifer Haley and Frank Ullman, “Most Uninsured Children are in Families Served by Government Programs,” Urban Institute, December 1999 <http://www.urban.org/UploadedPDF/anf_b4.pdf>, citing: Lake Snell Perry & Associates, “Barriers to Medi-Cal Enrollment and Ideas for Improving Enrollment: Findings from Eight Focus Groups with Parents of Potentially Eligible Children,” Kaiser Family Foundation, 1998. <<http://www.kff.org/medicaid/1436-index.cfm>>
- ⁴¹ Long, Peter, “Local Efforts to Increase Health Insurance Coverage among Children in California,” Medi-Cal Policy Institute, February 2002, page 5 <<http://www.chcf.org/publications/2002/02/local-efforts-to-increase-health-insurance-coverage-among-children-in-california>>; Summer at pages 29 and 30.
- ⁴² ACA Section 1411(g)(1).
- ⁴³ Fair Information Practice Principles are a set of eight principles that are rooted in the tenets of the Privacy Act of 1974, Privacy Act of 1974, 5 U.S.C. § 552a, as amended.
- ⁴⁴ Proposed §155.260(b)(5) of Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Notice of Proposed Rulemaking, Issued July 2011.
- ⁴⁵ Guidance 2.0, pages 9 and 10.
- ⁴⁶ Rigganbach, Jennifer and Marcus White, “Using Online Tools to Improve Access to Assistance Programs,” Workforce Central and Milwaukee Area Workforce Funding Alliance, September 2010, page 62.
- ⁴⁷ See, Gonzales.
- ⁴⁸ Information on Alabama’s online and public enrollment system is based on interviews with Bonnie Bradley, Central Regional Manager, and Viki Brant, Director, Division of Program Operations, Bureau of Children’s Health Insurance, Alabama Department of Public Health, July 19, 2011 and August 30, 2011 (respectively).
- ⁴⁹ Alabama Department of Medicaid, <http://www.medicaid.alabama.gov/documents/2.0_Newsroom/2.3_Publications/2.3.1_Annual_Report_FY10/2.3.1_FY10_Eligibles_Utilization.pdf>
- ⁵⁰ US Census website <<http://quickfacts.census.gov/qfd/states/01000.html>>

-
- ⁵¹ Framework for the Annual Report of the State Children’s Health Insurance Plans Under Title XXI of the Social Security Act <<http://www.adph.org/allkids/assets/CertifiedAnnualReport08.pdf>>
- ⁵² Insure Alabama online application <<https://insurealabama.adph.state.al.us/>>
- ⁵³ Phone interview with staff from the Decatur, Alabama county wishing to remain anonymous.
- ⁵⁴ Internal data for the month of July 2011 from ADPH, shared with Consumers Union on August 30, 2011.
- ⁵⁵ Information on Los Angeles Unified School District’s public enrollment stations is based on interviews with Dale Reinert, Program Coordinator at Los Angeles Unified School District and Claudia Page, Co-Director, Social Interest Solutions, July 1/ September 9 and August 24, 2011, respectively.
- ⁵⁶ U.S. Census Bureau (2009).
- ⁵⁷ 2009 California Health Interview Survey. U.C.L.A. Center for Health Policy Research (Published 2011).
- ⁵⁸ One-E-App, Social Interest Solution’s website <<https://www.socialinterest.org/solutions/solutions/access/california-one-e-app>>
- ⁵⁹ Information on Merced County’s public enrollment stations is based on interviews and e-mail with Scott Pettygrove, Deputy Director, Administrative Services Branch, Merced County Human Services Agency, June 17 and September 6, 2011.
- ⁶⁰ US Census website <<http://quickfacts.census.gov/qfd/states/06/06047.html>>
- ⁶¹ “California Children’s Health Coverage,” Children Now, March 17, 2011 <http://www.100percentcampaign.org/publications/?_c=zyskdeznsypyay>
- ⁶² California SAWS Consortium IV, History of Statewide Automated Welfare System <<http://www.c-iv.org/HistoryofSAWS.shtml>>
- ⁶³ California SAWS Consortium IV, C4Yourself <<http://www.c-iv.org/C4YourselfOverview.shtml>>
- ⁶⁴ C4Yourself website.
- ⁶⁵ Information on Florida’s online and public enrollment system is based on an interview with Barbara Roglieri, Database Administrator, ACCESS Technology Program Office, Florida Department of Children and Families, September 14, 2011.
- ⁶⁶ Cody, Scott, et. al, “Simplification of Health and Social Services Enrollment and Eligibility: Lessons for California from Interviews in Four States,” Mathematica Policy Research, Inc., November 4, 2010, page 15 <<http://www.chcf.org/publications/2010/11/simplification-enrollment-eligibility-lessons>>
- ⁶⁷ Taken from a survey of the ACCESS sites listed on the Florida Department of Children and Families website (last retrieved July 6, 2011) <<http://www.dcf.state.fl.us/programs/access/servicecenters.shtml#svcctrs>>
- ⁶⁸ Information on Maryland’s online and public enrollment system is based on interviews with Lena Bloom Hershkovitz, Eligibility Services Manager, Healthy Howard, Inc. June 18 and September 9, 2011 and Ryan Benson, Alice Middleton, and Jill Spector, staff at the Maryland Department of Health and Mental Hygiene on September 14, 2011.
- ⁶⁹ Testimony of Claudia Page, Social Interest Solutions, before the US Senate Health, Education, Labor and Pensions Committee, “Healthy Howard: Improving Health Through Innovation” February 17, 2009: “The current climate offers a perfect storm of opportunity and demand to make the process more rational for families and to create a more efficient and cost-effective process for administrators.”
- ⁷⁰ Information on New Mexico’s public enrollment stations is based on an interview with Kathy Slater-Huff, Marketing & Outreach Manager at New Mexico Department of Human Services, June 23 and August 7, 2011
- ⁷¹ New Mexico: Outreach Grant Funding for Enrollment Kiosk. The Commonwealth Fund, May 19, 2010.
- ⁷² Insure New Mexico! Solutions <<http://www.insurenewmexico.state.nm.us/default.aspx>>
- ⁷³ Information on Washington State’s public enrollment is information obtained from Economic Services Administration staff at the Washington Department of Social and Health Services, Economic Service Administration, Community Services Division, August 25 and September 15, 2011
- ⁷⁴ Cody, page 47.
- ⁷⁵ See list of programs offered through Washington here: <http://www.dshs.wa.gov/onlineco/services.shtml>
- ⁷⁶ Cody, page 48.