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From Coverage to Care

Strengthening and Facilitating Consumer Connections to the Health System

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As a result of the Patient Protection and Affordable Care Act, and as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act), millions of Americans have obtained health insurance, some for the first time. Yet reducing the number of uninsured is only part of the law's goal. It also aims to improve population health and lower health care costs. To date, most Affordable Care Act implementation efforts have focused on getting individuals enrolled in health insurance coverage. Less attention has been paid to the critical next steps of confirming that the newly insured obtain appropriate health care and maintain a long-term relationship with a health care provider. To support this more-holistic and consumer-centric view, this perspective describes lessons learned from conversations with a variety of stakeholders in the health care industry that characterized consumer engagement in health care as phases along a continuum, from applying for coverage and selecting a plan to finding a provider, accessing care, and engaging in care over time. Each of these phases requires a specific set of actions by consumers and poses new challenges for them to overcome. Stakeholder efforts to help consumers often focus on just one point along this continuum, at the expense of the bigger picture, and often occur in isolation, with little coordination across stakeholder groups. Additional strategic and holistic thinking is needed about ways to support consumers as they move both within and across phases. Without this "connective tissue," consumers are at risk of becoming disengaged and falling through the system's cracks.

Context and Motivation

Since the enactment of the Affordable Care Act in March 2010, comprehensive insurance reforms designed to improve access to health care, strengthen consumer protections, improve quality of care, and lower health care costs have been implemented. Millions

of Americans, many of whom had never been insured, obtained health coverage either through the health insurance marketplaces or through expanded Medicaid eligibility, if available in their state.

Although the short-term goal of the Affordable Care Act was to increase the number of individuals with health insurance coverage, expanded coverage alone is not sufficient for realizing some of the longer-term anticipated benefits of the Affordable Care Act, such as improved population health and lower health care costs. However, efforts to date have focused on implementing processes and programs to support enrollment. Less attention has been given to the important next steps of ensuring that consumers connect to care and remain engaged over time.

From the beginning of the Affordable Care Act's implementation, the Centers for Medicare & Medicaid Services, Office of Minority Health (CMS OMH) recognized that simply enrolling individuals in coverage was only the first step, and that achieving better health and reduced health care costs would require individuals to take an active role in their health care and regularly use primary and preventive care services. In 2013, CMS OMH contracted with the RAND Corporation and the MITRE Corporation to help develop the *From Coverage to Care* Initiative. *Coverage to Care* was designed to help consumers understand what it means to have health insurance coverage, how to find a provider, when and where to seek appropriate health services, and why prevention and partnering with a provider is important for achieving optimal health (Centers for Medicare & Medicaid Services, 2014). It was also designed to equip health care providers and stakeholders in the community who support consumers' connection to care with the tools needed to promote consumer engagement and to promote changes in the health care system that improve access to care. For example, "A Roadmap to Better Care and a Healthier You," is an eight-step booklet that teaches consumers how, when, and where to access services (Centers for Medicare & Medicaid Services, 2014).

To help inform future directions of *Coverage to Care*, we sought to capture the insights and perspectives of each of three sectors—payers, providers, and other consumer support organizations who work directly with consumers (henceforth called *coalitions*). Potential organizations were identified as part of an environmental scan, and each was classified on a number of key characteristics, including its geographic area of focus (e.g., regional, statewide), whether it served a rural population, whether it was not for profit, whether there was a focus on underserved populations or health disparities, and whether it was actively supporting consumers' access to coverage or access to care. These last two points were used to ensure that the group of organizations selected was not skewed toward or limited to only those who were actively working on these issues.

In February and March 2015, the RAND team conducted a total of 27 phone-based interviews (nine interviews per sector), with stakeholders from four states chosen to represent diverse popu-

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lations, geographies, and policy contexts with respect to support of the Affordable Care Act: Connecticut, Kentucky, Texas, and Washington. The goals of these conversations were to

- assess perceptions of consumer barriers to understanding and using health coverage
- identify current activities that aim to support consumers as they connect to care
- identify barriers to supporting consumers as they navigate the health system
- identify opportunities to better support consumers as they connect to care.

The interviews were semistructured in that each interviewee was asked about the four key objectives noted above, but the conversations centered on their organization's specific perspectives and activities. Although this effort did not include direct discussions with consumers, most participants worked directly with consumers or held a position focused on consumer engagement. The conversations revealed a fairly comprehensive and consistent picture of the steps consumers must undergo to fully engage in their own health care, which have been grouped into four critical phases, or points of engagement (Figure 1). These include (1) applying for coverage and selecting a plan, (2) gaining coverage and understanding plan benefits, (3) finding a provider and accessing care, and (4) engaging in care over time. Figure 1 provides a high-level illustration of this framework.

Consumers approach the health care system with very different backgrounds, personal experiences, literacy levels, language preferences, cultures, and beliefs about health. The type of health plan consumers have and where they live can also affect their ability to navigate within and across each of these phases. Many consumers move through the phases sequentially, although others may take different routes as depicted by the dashed arrows (Figure 1). This perspective summarizes key lessons from discussions with stakeholders as they relate to each phase along this continuum. Its goal is to catalyze strategic thinking of the system as a whole and ways to help consumers transition across these four phases as they navigate the complex health care system and connect to care.

Phase I: Applying for Coverage and Selecting a Plan

The emphasis for the first two open enrollment periods for the health insurance marketplaces was on mass outreach and enrollment (Courtot and Coughlin, 2012; The Kaiser Commission on Medicaid and the Uninsured, 2013; Federal Office of Rural Health Policy, 2014; Hill, Wilkinson, and Courtot, 2014; Martin, Bharmal, et al., 2014; Medina and Saporta, 2014). These efforts helped reduce the number of uninsured individuals by 16.4 million between the end of 2013 and March 2015 (Assistant Secretary for Planning and Evaluation, 2015). While the focus of these early efforts was on enrolling as many consumers as possible, less attention has been given to the plan selection process and whether consumers are choosing a plan that meets their health and financial needs. Selecting the right plan is important because it is a key determinant of whether and how consumers connect to care once insured. Stakeholders noted that consumers who select a plan that does not meet their needs and expectations with respect to out-of-pocket costs or provider availability, for example, may be less likely to connect to care and remain engaged over time (phases 3 and 4 of the engagement framework).

Figure 1. Engagement Framework for the *From Coverage to Care* Initiative

Figure 1 depicts the four steps consumers must undergo to fully engage in their own health care. The dashed arrows represent potential paths for consumers as they navigate through these four phases. Many consumers may move through these phases sequentially, as depicted by the topmost dashed arrow, but others may take different paths. For example, some individuals enroll in health insurance (phase 1) only after seeing a provider who was able to offer enrollment assistance (phase 3).

In many cases, consumers are left to select their plans on their own, but many struggle with low health literacy and an incomplete understanding of important insurance concepts (Martin and Parker, 2011; Koh et al., 2012). This makes it difficult to understand plan benefits and select plans that best meet their needs. A number of educational resources have been made available to help consumers with their plan selection and enrollment decisions. However, stakeholders noted that much of that information continues to be presented in ways that are still too complicated for many consumers to understand, citing that many of the existing materials use dense text rather than pictures or infographics that consumers may find easier to understand. Furthermore, the terminology and concepts relevant for understanding the details associated with health insurance coverage—*copays*, *coinsurance*, *deductible*, *in network*, and *out of network*, among others—are complex. Yet these terms and concepts are what tell consumers where they can receive care under a given plan and how much it will cost. Stakeholders noted that, when consumers do not understand the terms, they cannot understand important details of their plans, such as covered benefits and out-of-pocket costs and, as a result, often select plans based on the cost of premiums alone.

Although increasing efforts have been made recently to help improve consumer understanding of health insurance terminology and to highlight factors consumers should consider when selecting a plan, stakeholders felt that this information is often still not specific or clear enough to help consumers choose among available plans. An important next step is to develop informational materials and decision tools that help consumers more easily weigh their plan options and that a variety of consumers can understand clearly. The development of these materials will require a better understanding of how consumers make insurance choices. For example, while stakeholders believed that many consumers select plans based predominantly on the cost of premiums, it is not yet clear exactly what proportion of consumers does so, the other driving factors in their decisionmaking process, and what information would be particularly useful for helping consumers better understand their options and make optimal insurance choices. Although several insurance calculators and other decision tools based on behavioral economics and other decision sciences have been developed and although federal and state health officials are currently contemplating adopting these tools for federal and state marketplaces (Pear, 2015), more research may be warranted on the accuracy and effectiveness of these types of tools to help improve consumer decisions on plan selection.

Another challenge in plan selection stakeholders noted is that, despite a range of educational activities to support consumers in this phase, such efforts are often uncoordinated and duplicative. There may thus be opportunities for partnerships and joint development of standardized educational materials that diverse audiences can use. Also, the majority of materials designed to educate consumers are currently available only in English or have perhaps been translated to Spanish, but stakeholders confirmed that little attention has been paid to the many other languages spoken by

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individuals who may be looking to select health insurance plans. This is a significant gap in efforts to support consumers in this phase; one projection estimates that almost a quarter (23 percent) of exchange enrollees will speak a language other than English by 2019 (The Henry J. Kaiser Family Foundation, 2011).

Finally, stakeholders emphasized a need to sustain in-person supports for consumers, noting that consumers value the one-on-one enrollment support they get from navigators and in-person assisters in their community. These services were viewed as particularly beneficial for individuals with low health literacy, limited English proficiency, or nontraditional family structures in which each individual in the family may be eligible for different health insurance plans. It is important to note that navigators and other in-person assisters help many consumers sign up for insurance but, because of the variety of eligibility, training, and conduct standards designed to promote the delivery of fair, accurate, and impartial information to consumers, cannot offer guidance in terms of plan selection (Giovannelli, Lucia, and Corlette, 2014). Given the perceived benefits of in-person assistance, it may be worth considering how such in-person assistance may be sustained and perhaps leveraged to facilitate plan selection.

Table 1 summarizes the primary challenges and our recommendations for addressing the challenges related to the consumer's experience in the first phase of the engagement process.

Phase 2: Gaining Coverage and Understanding Plan Benefits

The connection to care does not occur immediately after the enrollment forms have been submitted. In most cases, time passes between the enrollment process (phase 1) and that initial con-

Table 1. Challenges and Recommendations for Phase 1: Applying for Coverage and Selecting a Plan

Challenges	Recommendations
Consumers struggle with low health literacy and low health insurance literacy	• Refine existing educational materials to make information about plan options and insurance terminology easier to understand. • Develop additional materials specific to the plans available in the consumer's market rather than high-level or general educational pieces. • Pursue additional opportunities for coordination of consumer support efforts and joint development of educational materials to minimize duplication. • Ensure materials and decision support tools are developed in multiple languages, beyond English and Spanish, to meet the needs of diverse audiences. • Increase in-person assistance to support plan selection.
Consumers often base plan selection only on the cost of premiums	• Gain a better understanding of the consumer decisionmaking process to inform the development or refinement of consumer plan selection supports or tools.

nection to care (phase 3) as consumers wait for confirmation of coverage from their payers and receipt of their insurance cards. This phase of the engagement process is one of uncertainty and transition that involves challenges and risks for consumers, payers, and providers.

Despite a range of educational activities to help consumers understand covered benefits, as well as payer policies that allow some consumers to access services while their applications are being processed, challenges remain in helping consumers move through this phase of engagement as efficiently as possible. As noted in phase 1, many consumers struggle with understanding health insurance terminology, and consumers continue to face that barrier even after signing up for coverage. However, in this phase, many consumers also start to experience the implications of that barrier as they attempt to gain a better understanding of plan benefits and prepare to connect to care. For example, stakeholders noted that some consumers believe (incorrectly) that the anticipated subsidies or other tax credits will cover the out-of-pocket costs associated with their new benefits and are unaware of insurance-related costs other than premiums. Other stakeholders expressed concern that some consumers discover in this phase that their preferred provider is not included in their plan network and that others struggle to fully understand covered services and plan-specific benefits, such as whether certain specialty care or dental services are included.

Despite improvements in the enrollment process during the second open enrollment season, stakeholders reported that long lag times often remain between when consumers submit their enrollment materials and when they are officially enrolled in a health insurance plan. Delays in eligibility determinations are problematic for consumers with more-pressing medical needs who sign up for insurance but are not clear about what to do if they need care before they have received documentation verifying that they have health insurance coverage. Payers and providers noted that, in many cases, consumers can be reluctant to seek care because of concern about out-of-pocket costs if they are not officially enrolled, with an insurance card in hand.

These findings suggest possible avenues to better support consumers through this phase. First, given the barriers related to health and insurance literacy, there is a need to continue to educate consumers about health insurance in general and about how health insurance works, to help them understand what happens after they complete their enrollment materials. Assistance can be helpful in managing expectations during this phase. Helping consumers understand what they can expect between submitting the application and first meeting with a provider and what they need to do to activate their coverage (pay their premium) can help to minimize concern and confusion as they wait and may reduce the number of consumers who lose coverage at this phase. Doing so may also promote consumer engagement if they feel more comfortable moving forward and accessing needed care knowing that the services are going to be covered.

A second possible way to help consumers understand their plan designs (in addition to the approaches to strengthen health insurance literacy noted in phase 1) is to simplify the allowable designs of the plans themselves. Stakeholders noted that the terminology used to describe health insurance plans and consumer costs is complex because the underlying financial designs of health insurance plans are complex. For example, in addition to monthly premiums, most plans charge copays for some services and coinsurance for others, with different shares of fees covered, depending whether

a provider is in or out of the network. Complicating this is that, for some plans, none of those benefits kick in until a deductible is met (the consumer must pay a certain amount out of pocket before benefits begin), and plans also may have out-of-pocket maximum amounts that reflect the total amount consumers can be charged in a year. The algorithms underlying these plans can result in myriad plan designs. Some stakeholders believed that simplifying health insurance directly could improve consumers' ability to understand their plan benefits and total out-of-pocket costs. Although the implications for payers would need to be carefully considered, there may be opportunities to streamline the allowable designs and cost structures that payers may adopt, which may make it easier for consumers to understand the plans.

Table 2 summarizes the key consumer challenges in this phase and our associated recommendations for addressing them.

Phase 3: Finding a Provider and Accessing Care

A consumer's ability to find a provider and connect to primary and preventive care services is a critical step toward longer-term engagement with the health system and improved health. This is a particularly important transition for consumers who were previously uninsured; data from 2012 suggest that over one-half (54 percent) of uninsured consumers lack a usual source of care, compared to about 10 percent of those who were insured (National Center for Health Statistics, 2013). Challenges in this phase of the engagement process may cause frustration and distress for the consumer and, perhaps of more concern, could result in disengagement with the system altogether if consumers give up and drop out of care. Yet despite the importance of consumer support, less emphasis has been placed on supporting consumers as they access care. Much of the assistance available to help consumers gain coverage does not extend to helping them locate a provider and make a first appointment.

Table 2. Challenges and Recommendations for Phase 2: Gaining Coverage and Understanding Plan Benefits

Challenges	Recommendations
Consumers do not often understand health insurance, covered benefits, or out-of-pocket costs	• Strengthen educational materials about health insurance in general and about how it works, in addition to clarifying complex terminology. • Develop materials for consumers to manage their expectations for the transition period, clarifying key points of confusion, including accessing care prior to receiving formal documentation of health insurance coverage. • Continue to address issues related to low health and insurance literacy, as noted in phase 1. • Consider simplifying allowable insurance plan benefit and cost-sharing designs as a way to increase consumer understanding of plan options and benefits.

Consumer barriers in this phase that stakeholders noted include a lack of appreciation for the value of primary and preventive care services; challenges related to provider shortages; concern about out-of-pocket costs; and traditional social and structural barriers, such as language barriers and lack of transportation. While these barriers are long standing, two notable shifts over the past two years have been related to these issues. First, given that many newly insured consumers are lower income, the number of consumers facing these barriers has increased. Second, the influx of new consumers has increased the stress on provider networks and existing community supports designed to help overcome these barriers.

One challenge, not limited to the newly insured, is that many consumers may not be fully aware of the importance of primary and preventive care services and, as a result, do not engage with their providers for regular checkups. Stakeholders noted that most consumers will seek care for acute medical needs, but it needs to be made clear that providers offer important services to consumers even when they feel well—often at no cost to them. Regular monitoring of weight, blood pressure, and other markers of health can allow providers to identify health conditions early on and, potentially, address them with lifestyle changes or other moderate measures of prevention before these issues become more acute and require more invasive and costly care.

When consumers want to connect to care, provider shortages may prevent them from doing so and may occur for a number of reasons. In some regions, particularly in rural or underserved areas, stakeholders reported a general lack of primary care and specialty providers. In other regions, where providers are more prevalent, consumers may still experience a shortage if the providers are not accepting new patients. Payers and providers felt that this is a particular challenge for Medicaid enrollees, as fewer providers accept Medicaid than accept other plans, in part because reimbursement rates are lower, and those who do accept Medicaid are often overwhelmed by the influx of new patients. Medicaid reimbursement rates for primary care services were raised to be equivalent to those of Medicare for the first two years following the Affordable Care Act's implementation. This helped alleviate some provider shortages for Medicaid patients (Polsky et al., 2015). However, the elevated rates expired at the end of 2014. Finally, payers noted that they often limit the providers a consumer can see to those who are "in network," which reduces the number of potential providers available to consumers. Provider shortages are not a challenge just for consumers: Payers also report struggling with provider shortages when trying to connect consumers to providers. Similarly, primary care providers report challenges related to provider shortages when trying to connect consumers to needed specialty care or when trying to divert consumers from the emergency department (ED) to routine care.

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Even if a consumer is able to identify a provider and make an appointment, stakeholders noted that a lack of transparency about out-of-pocket costs for a given visit tends to dissuade some consum-

ers, particularly those on high-deductible plans, from utilizing care until they absolutely need it. Although many preventive visits are provided at no cost, consumers—particularly those who have not regularly sought routine care in the past—may require additional medical services or tests that are not covered in full and will not know the cost of these services until they receive a bill in the mail. Stakeholders reported that consumers on limited or fixed incomes consider this financial risk too great for nonacute visits and, as a result, many opt not to pursue these services.

Finally, such issues as lack of transportation, limited office hours, language barriers, and lack of cultural or social support for seeking care have traditionally affected the ability of lower income and minority populations to access care. While some communities offer support to low income and minority individuals to help overcome these barriers, the influx of new consumers needing such assistance increased the stress on the existing resources, making them more difficult to access.

Stakeholder efforts to support consumers in this phase include a range of educational activities, such as "A Roadmap to Better Care and a Healthier You" (Centers for Medicare & Medicaid Services, 2014), and other materials developed by state marketplaces and community coalitions. Other efforts include fostering linkages to providers by employing community health workers to help consumers connect to care after enrolling in coverage and joint stakeholder efforts to redirect consumers from the ED to primary care settings. However, these efforts have faced challenges; stakeholders noted that most are supported by shorter-term grant funding, with less attention and fewer resources devoted toward longer-term sustainability or the spread and uptake of successful models for supporting the consumer in this phase.

These findings point to a number of potential ways stakeholders can help increase consumer access to care. First, some newly insured consumers have a long history of seeking nonemergent care from EDs or urgent care settings. Consumers may seek care at the ED, rather than a primary care provider, for a variety of reasons. Some go because of a provider shortage that leaves them without an alternative location for care; some are used to accessing care this way; some simply do not know they should go to their primary care doctor first or do not know who their primary care provider is; and some simply find the ED more convenient because it is always open and they can get the tests they need for a diagnosis at that time, as opposed to requiring an additional office visit. Changing these norms will require a concerted effort. There may be an opportunity to further develop training materials for providers and other stakeholders to help them become better equipped to have (often impromptu) conversations with consumers about the importance of preventive care and connecting with a regular provider. Similarly, consumer education efforts could be strengthened and expanded to increase awareness of the value of preventive care.

Second, there is a need to encourage the spread, uptake, and exploration of additional innovative means of delivering care,

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such as telehealth and virtual health care delivery models to reach underserved or rural areas. This may include reimbursing for such services or investing in the infrastructure to support these newer models of care delivery. Although the use of such models is relatively new and although many issues remain to be settled on the best ways to implement them, such models may be able to help directly address the issue of provider availability. Another possibility would be to increase the use of "physician extenders," such as nurse practitioners and physician assistants, to help alleviate provider shortages. There may also be an opportunity to consider whether existing medical student loan repayment programs or other incentive programs for health care providers could be expanded beyond the additional supports provided through the Affordable Care Act, perhaps extending to higher-need specialty care to incentivize locating in rural or underserved areas.

Third, there may be an opportunity to increase provider insurance literacy. Although insurance literacy is often thought of as an issue consumers face, providers noted that they also do not always understand the complexities of the various financial designs of plans. This is important because consumers may turn to their providers for assistance in helping to understand costs and covered services. Although it may not be feasible for all providers, particularly solo practitioners or those with smaller practices, to gain a solid understanding of every plan they accept, developing ways to support providers and their office staffs gain a better understanding of plan benefits may help providers, in turn, better support consumers and develop care plans that align with consumers' health needs and covered benefits. Alternatively, providers and office staffs may benefit from educational materials to address consumer concerns about out-of-pocket costs; such materials can, at a minimum, help clarify that many preventive services can be received at no cost to the consumer.

Finally, many consumers can find it hard to focus on health when their basic needs are not being met. This requires a strategic focus on the "whole" consumer and consideration of the wrap-around and social services they need, such as housing and food support. These services are also important for health and affect a consumer's ability to prioritize their health and make the decision to connect with a provider.

We summarize these challenges and our recommendations in Table 3 (see page 12).

Phase 4: Engaging in Care Over Time

While finding a provider and having an initial visit are important steps in the consumer engagement process, the initial visit is not the end goal. Ideally, consumers remain engaged in their own care by making regular preventive visits, pursuing courses of treatment and follow-up care that are mutually acceptable to consumers and providers, and building relationships with their providers over the long term. This is more likely to result if consumers are satisfied with their health care experiences and if providers deliver high-quality care in a way that meets the needs of consumers.

The barriers consumers face in this phase of the engagement process are similar to those they face when trying to find a provider and access care: a lack of appreciation for the value of primary and preventive care services; challenges related to provider shortages; concern about out-of-pocket costs; and traditional social and structural barriers, such as language barriers and lack of transportation. Stakeholders noted that the same concerns around costs and access that preclude many consumers from making that first visit may be

Table 3. Challenges and Recommendations for Phase 3: Finding a Provider and Accessing Care

Challenges	Recommendations
Reliance on ED as a usual source of care	• Develop talking points for providers to emphasize the importance of preventive care and a usual source of primary care to help providers become better equipped to have these conversations with consumers.
Consumers not fully aware of the value of preventive care	• Strengthen and expand on educational materials for consumers that discuss the importance of preventive care and connecting with a regular provider.
Provider shortages	• Encourage the spread, uptake, and exploration of additional innovative means of delivering care, such as telehealth and virtual health care delivery models. • Consider whether existing loan repayment programs or other incentive programs for health care providers could extend to include specialty care.
Consumer concern about out-of-pocket costs	• Develop additional educational materials that address consumer concerns about out-of-pocket costs and education about the fact that many preventive services can be received at no cost to the consumer. • Strengthen provider insurance literacy to help providers gain a better understanding of the complexities of the various financial designs of plans.
Traditional social and structural barriers	• Think more strategically and more holistically about consumers and consider the social services that they need, such as housing and food support, which are critically important for health and affect consumers' ability to prioritize their health and decide to connect with a provider.

even more of a barrier for consumers who require subsequent or follow-up visits, particularly for specialty care. Social and structural barriers were also cited in this phase and may be particularly problematic for patients who have chronic conditions or health concerns that require more-intensive care, more frequent visits, or coordination across multiple providers or health care settings. Minority or low-income consumers, who comprise a disproportionate share of the newly insured, often experience such barriers more acutely. These social and structural barriers can pose real-world tensions for many consumers that may affect their ability to prioritize their health and remain fully engaged over time if competing needs take precedence.

This phase in the engagement process is different from the previous ones because it is longer term. This means that the consumer experience over time and how consumers are supported in this phase are likely to be affected by changes in how care is delivered and financed. The recent movement, largely brought about by the Affordable Care Act, toward alternative value-based payment

models and accountable systems of care is, in the long run, likely to have secondary benefits for consumers in the form of improved focus on quality of care and better coordination of care. Because the ultimate goal of these value-based payment models is to optimize consumer health outcomes, these models should, in theory, improve the consumer experience of care in the long run. However, stakeholders noted that such anticipated consumer benefits are, at times, stymied in the short term by outdated and incompatible provider medical records and billing systems. These systems limit the ability of providers to coordinate patient care among themselves, placing the burden on consumers to serve as the link between their primary and specialty providers and ensure that each has complete and up-to-date medical information.

Another barrier stakeholders noted is that, in the midst of the transformation, nobody really knows what the "right" system or model looks like. This lack of specificity creates anxiety, particularly among providers, who are uncertain how they will be paid under these future payment systems. As a result, stakeholders reported that, in some cases, payers and providers are focusing more resources and attention on their own needs and organizational survival through these changes, as opposed to investing in efforts to help consumers remain engaged in care over the longer term. This lack of attention may result in lower consumer satisfaction and may result in consumers becoming disengaged over time if such inattention continues.

This issue points to a need to find ways to establish real-time data sharing and streamlined communication across providers and payers, among providers, and between providers and their patients. For example, if providers could learn, in a timely way, which of their patients have been admitted or readmitted to the hospital and who has been using the ED in lieu of primary care, providers could support such consumers more proactively. Communication across systems and providers would also make care coordination that much more efficient. Federal law provides incentives for providers to adopt electronic health record systems, which may improve the data infrastructure, although such improvements are not yet widespread.

Much about the changing health care landscape aims to positively affect consumer health and the consumer's experience while in care. However, until they have a clearer sense of their own fate, payers and providers may not have the resources or support to develop or implement additional consumer supports in this phase. Still, efforts to ensure consumers feel comfortable and respected, including implementing culturally or linguistically appropriate services, where they are lacking, and encouraging consumer input in care decisions, are likely to strengthen consumer engagement over time.

Table 4 (see page 14) summarizes these challenges and recommendations for this phase.

Next Steps in Support of the Consumer

Since the implementation of the Affordable Care Act, millions of individuals have become enrolled in health insurance coverage. While a promising first step, enrolling individuals is not enough. To realize the longer-term goals of the Affordable Care Act—improved health and lower health care costs—consumers must take an active role in their health care and regularly use primary and preventive care services. Since its national launch in June 2014, *Coverage to Care* has emerged as a valuable asset to consumers and

Table 4. Challenges and Recommendations for Phase 4: Engaging in Care Over Time

Challenges	Recommendations
Systems and information technology infrastructure not aligned and often outdated	• Establish real-time data sharing and streamlined communications across providers and payers and among providers.
Providers focused on the changing health care landscape rather than on supporting consumers in the short term	• Strengthen the development and implementation of culturally competent and linguistically appropriate services. • Encourage consumer participation in care decisions, to reflect personal preferences and health beliefs. • Develop educational materials for consumers about the value of longer-term engagement that includes actionable steps for how to remain engaged.

stakeholders, laying the foundation for thinking about consumer engagement in care more broadly.

Much of the focus of these valuable efforts has been on enrolling individuals in health insurance coverage. Less attention has been paid to the later stages of the engagement process: finding a provider, navigating the health care system, and engaging in medical care over time. Each phase requires consumers to take certain actions, and many different barriers can stand in the way at each phase. Stakeholders similarly face barriers in their efforts to support consumers at each phase. Addressing the identified barriers is likely to alleviate the burden on consumers to navigate the complex health system alone and will minimize the likelihood of consumers becoming disengaged in the process. Efforts to address the barriers are particularly important for consumers with low health literacy or limited English proficiency, for whom navigation is even harder.

In addition to strengthening supports *within* each phase, there is a critical need to consider ways to support consumers' transitions *between* these phases of engagement as they navigate the complex health care system and progress along this continuum. Although achieving this is more difficult to do, concerted effort and well-designed policies that align incentives across sectors while maintaining a focus on consumers may make it possible. This will likely require more and better coordination across payers, providers, consumer groups, and policymakers. Forming these connections and ensuring that consumers can move seamlessly within and across phases as they connect to care and engage in the health system over time could help achieve the original motivation and vision of *Coverage to Care*.

References

Assistant Secretary for Planning and Evaluation, "Health Insurance Coverage and the Affordable Care Act," Washington, D.C.: U.S. Department of Health and Human Services, May 5, 2015.

Centers for Medicare & Medicaid Services, "From Coverage to Care Resources," web page, 2014. As of June 15, 2015:
http://marketplace.cms.gov/c2c

Courtot, Brigette and Teresa A. Coughlin, *Best Practices in SHAP Outreach, Eligibility, and Enrollment Activities*, Washington, D.C.: Urban Institute, May 23, 2012.

Federal Office of Rural Health Policy, "Best Practices Guide in Rural Outreach and Enrollment," Rockville, Md.: Health Resources and Services Administration, December 2014.

Giovannelli, Justin, Kevin Lucia, and Sabrina Corlette, "State Restrictions on Health Reform Assisters May Violate Federal Law," *The Commonwealth Fund Blog*, June 25, 2014. As of June 15, 2015:
http://www.commonwealthfund.org/publications/blog/2014/jun/state-restrictions-on-health-reform-assisters

Health Care and Education Reconciliation Act of 2010.

The Henry J. Kaiser Family Foundation, "A Profile of Health Insurance Exchange Enrollees," *Focus on Health Reform*, Menlo Park, Calif., March 2011.

Hill, Ian, Margaret Wilkinson, and Brigette Courtot, "The Launch of the Affordable Care Act in Selected States: Outreach, Education, and Enrollment Assistance," Washington, D.C.: The Urban Institute, March 2014.

The Kaiser Commission on Medicaid and the Uninsured, "Profiles of Medicaid Outreach and Enrollment Strategies: Helping Families Maintain Coverage in Michigan," Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, 2013.

Koh, Howard K., Donald M. Berwick, Carolyn M. Clarncy, Cynthia Baur, Cindy Brach, Linda M. Harris, and Eileen G. Zerhusen, "New Federal Policy Initiatives to Boost Health Literacy Can Help the Nation Move Beyond the Cycle of Costly 'Crisis Care,'" *Health Affairs*, Vol. 31, No. 2, February 2012, pp. 434–443.

Martin, Laurie T., Nazleen Bharmal, Janice C. Blanchard, Melody Harvey, and Malcolm Williams, *Barriers to Enrollment in Health Coverage in Colorado*, Santa Monica, Calif.: RAND Corporation, RR-782-COHF, 2014. As of June 15, 2015:
http://www.rand.org/pubs/research_reports/RR782.html

Martin, Laurie T., and Ruth M. Parker, "Insurance Expansion and Health Literacy," *Journal of the American Medical Association*, Vol. 306, No. 8, August 2011, pp. 874–875.

Medina, Jordan, and Carla Saporta, "Covered California's First Year: Strong Enrollment Numbers Mask Serious Gaps," Berkeley, Calif: The Greenlining Institute, June 2014.

National Center for Health Statistics, *Health, United States, 2013: With Special Feature on Prescription Drugs*, Hyattsville, Md.: Centers for Disease Control, 2013.

Patient Protection and Affordable Care Act, 2010.

Pear, Robert, "White House Moves to Fix 2 Key Consumer Complaints About Health Care Law," *New York Times*, May 8, 2015.

Polsky, Daniel, Michael Richards, Simon Basseyn, Douglas Wissoker, Genevieve Kenney, Stephen Zuckerman, and Karin V. Rhodes, "Appointment Availability After Increases in Medicaid Payments for Primary Care," *New England Journal of Medicine*, Vol. 372, February 2015, pp. 537–545.

About This Perspective

To date, most Affordable Care Act implementation efforts have focused on getting individuals enrolled in health insurance coverage; indeed, millions of Americans, many of whom had never been insured, have since obtained health coverage, either through the health insurance marketplaces or through expanded Medicaid eligibility, if available in their state. Yet reducing the number of uninsured is only part of the law's goal. It also aims to improve population health and lower health care costs. Less attention has been paid to confirming that the newly insured obtain appropriate health care and maintain long-term relationships with their health care providers, which are critical steps to help achieve these latter goals. This perspective describes lessons learned from conversations with a variety of stakeholders in the health care industry. These conversations covered the gamut of steps consumers must undergo to become fully engaged with their health care, from applying for coverage and selecting a plan to finding a provider, accessing care, and engaging in care over time. In each phase of the process, consumers must take specific actions and overcome new challenges. Stakeholder efforts to help consumers often focus on just one of these phases, at the expense of the bigger picture, and often occur in isolation, with little coordination across stakeholder groups. Thinking more strategically and holistically can help provide the "connective tissue" that can help prevent consumers from becoming disengaged and falling through the system's cracks.

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