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MANAGING HEALTH REFORM

WEST VIRGINIA: ROUND 1

State-Level Field Network Study
of the Implementation of the
Affordable Care Act

August 2014

Rockefeller Institute of Government
State University of New York

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Contents

- Part 1 – Setting the State Context 1
 - 1.1 Decisions to Date 1
 - 1.2 Goal Alignment. 6
- Part 2 – Implementation Tasks. 8
 - 2.1 Exchange Priorities. 8
 - 2.2 Leadership – Who Governs? 8
 - 2.3 Staffing 9
 - 2.4 Outreach and Consumer Education. 10
 - 2.5 Navigational Assistance 11
 - 2.6 Interagency and Intergovernmental Relations. 14
 - 2.7 QHP Availability and Program Articulation. 15
 - 2.8 Data Systems and Reporting. 17
- Part 3 – Supplement on Small Business Exchanges 17
 - 3.1 Organization of Small Business Exchanges 17
- Part 4 – Summary Analysis 17
 - 4.1 Policy Implications 17
 - 4.2 Possible Management Changes and Their
Policy Consequences. 20
- Endnotes 21

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MANAGING HEALTH REFORM

WEST VIRGINIA: ROUND 1

State-Level Field Network Study of the Implementation of the Affordable Care Act

Part 1 – Setting the State Context

1.1. Decisions to Date

The rollout of the Affordable Care Act (ACA) in West Virginia is a tale of two reforms. One is a story of how a state, which was one of the earliest to adopt legislation for creating an exchange, decided instead to abandon plans for a state exchange and to passively participate in a federal-state partnership. Thus did West Virginia go from embracing the exchange concept to keeping an arm's-length relationship with the ACA and the Obama administration. The other is a story of how, after much hesitation and trepidation, the state decided in the eleventh hour to expand Medicaid. In doing so, it launched a proactive and apparently successful effort to reach out to and enroll qualified individuals. The contrasts are clear and abundant and they tell us much about the politics involved in health care reform and the harsh practicalities and realities that states face in dealing with serious and pressing needs and issues in health care services.

To understand the decisions that have been made to date, it is essential to provide some political context. The past four years have been some of the most dynamic in what has otherwise been a rather stable state political environment, which has long been dominated by a conservative Democratic Party. It is now argued that a sea change is afoot, and that West Virginia is becoming a red state.¹ Two of its three House of Representatives members are Republican. While both senators are Democrats, one, Joe Manchin,

is conservative and has been a critic of the Obama administration. The other, the soon-to-be-retired Jay Rockefeller, is an old-school liberal who has been a champion of health care expansion for decades. The state's new attorney general, elected in 2012, is deeply conservative and anti-Washington and is the only Republican in the state's plural executive that is made up of governor, attorney general, secretary of state, and others. The Republican Party has made significant inroads in the state house, and for the first time in decades there is a real possibility that the Democrats will lose power in the House of Delegates after the 2014 elections.

Whether a sea change is pending is still uncertain, but the political waters in the state are turbulent without question. Adding to these complications have been changes in executive leadership, which will add an intriguing chapter to the history of West Virginia politics. The state's deliberations over the health insurance exchange model occurred during one of the more dynamic (and confusing) periods in West Virginia politics. The death of Senator Robert Byrd in summer 2010 set into motion a series of political events that saw the sitting governor, Joe Manchin, first appoint a placeholder to the senator's seat, then step down to run successfully in a special election to fill Byrd's unexpired term, and then successfully run for a full six year term in 2012.

When the governor resigned, a small constitutional crisis ensued since the West Virginia Constitution does not provide for a lieutenant governor. Instead, succession fell to Senate President Earl Ray Tomblin, who assumed office on an interim basis while maintaining his Senate seat. The senator ran successfully for governor in a special election to fill the unexpired term and then ran successfully again for a regular term of office in 2012. During this period, there was leadership change in the Office of the Insurance Commissioner (OIC) and the Department of Health and Human Resources (DHHR) — two of the agencies most vested in developing and implementing health care reform under the ACA's provisions.

Thus, the ACA emerged and unfolded in a state where Democratic leadership was concerned about inroads made by the Republicans and was reluctant to be seen as too closely tied to the Obama administration. In addition, it was considered during a time of uncertainty over executive and party leadership. As a result, the ACA has not been warmly embraced by West Virginia's political leaders, but it has not been rejected either. Acceptance has been qualified, conditional, and contingent.

West Virginia has currently elected to operate its individual health insurance marketplace through a state-federal partnership, in stark contrast to an original stance taken by state leaders. This is the product of both political and practical circumstances. At this juncture, it is appropriate to characterize the state as a "passive" or "weak" partner in this arrangement.

Enabling legislation to establish a health benefits exchange was passed into law in March 2011, and the state submitted a state

partnership plan to the U.S. Department of Health and Human Services (HHS) in February 2013. West Virginia was the second state, after California, to pass enabling legislation to create an exchange.² While there was some initial interest in developing a state-run exchange, the final decision was to enter into a partnership.³ Originally called the Health Benefit Exchange, West Virginia's program is now called the Healthcare Marketplace.

Development of the state health insurance exchange was placed in the hands of the Office of the Insurance Commissioner. The state received a \$1 million federal planning grant in 2010. It also received a \$9.7 million Level One Establishment grant in 2011 to be used for program assessment, forecasting, and other planning functions.⁴ To assist in plan development, the OIC utilized stakeholder meetings but did not establish a formal health insurance exchange board as was authorized in the original state legislation.

At the same time, the ACA's fate seemed far from settled as a result of U.S. Supreme Court challenges and continuing partisan resistance to the new law. While West Virginia was not on the front lines of this debate, resistance from conservative interests — both Republican and Democratic — emerged in the state house.

Illustrative of this was the state's response to one of the first provisions of the ACA to be implemented — the Pre-Existing Condition Insurance Program, known as for PCIP for short. States had the option to administer their own PCIP or to allow for federal administration of the program. West Virginia was one of thirty-five states that already had existing state-operated high-risk insurance programs that could serve as platforms for the new PCIP. It was anticipated that the state would utilize its high-risk program as the vehicle for PCIP implementation, and this approach appeared to have support in the governor's office. However, it ran into opposition in the West Virginia legislature, and plans for state administration of PCIP were abandoned. This low-level conflict revealed deep-seated resistance to "Obamacare" and the use of federal dollars to potentially fund abortions (though it must be stressed that most high-risk insurance recipients are beyond childbearing years).⁵

As a result, West Virginia continued to operate its own high-risk pool program at the same time the federal government offered the PCIP program in the state. West Virginia extended benefits for its high-risk beneficiaries through March 2014 as part of a close-out process for its program and to ensure continuity of coverage for policyholders, given the initial difficulties with the federal web-based enrollment process.

Throughout 2011 and 2012, the state tentatively explored development of a state-run insurance exchange. By April 2012, the planning process had stalled. The exchange's Board of Directors had yet to be constituted. State officials expressed concern about moving toward a state-run program due to technical complexities and fiscal uncertainties. They also faulted the federal government

for not providing clear and consistent guidance on exchange development. The governor's press secretary noted that it would not be "prudent" to move forward while the constitutionality of the ACA was being challenged in the Supreme Court.⁶

In June 2012, the OIC produced an analysis that recommended against a separate state exchange "due to the projected financial burden created from IT infrastructure/administrative operations on the insurance industry, consumers, and state government." The report also concluded that the relatively small numbers of participants in the exchange did not warrant a separate state system.⁷

By December 2012, it was clear that the state would be pursuing the federal-state partnership option. The governor's chief of staff announced that this would be the most economical and risk-averse approach given the continuing uncertainties of the ACA's rollout. State officials also reiterated the technical and fiscal difficulties of establishing an exchange in a small state with limited resources. Participating in a state-federal partnership would allow the state to hedge its bets and take a wait and see posture toward future decisions on whether to join multistate partnerships or to develop its own stand-alone program.⁸

On February 15, the state formally announced in a letter to HHS Secretary Kathleen Sebelius that West Virginia would participate in a state partnership exchange. In qualifying language telegraphing the state's lukewarm embrace of the exchange, the governor noted:

West Virginia retains the ability to modify the stated intent to proceed in a State Partnership Exchange until appropriate State analysis of forthcoming federal rules and guidance occurs. In addition, the State will only proceed with SPE operations as long as sufficient federal funding is available to cover all SPE costs. Furthermore, West Virginia will continue to evaluate all available options concerning the Health Benefit Exchange as to ensure that the most fiscally prudent and consumer-conscious approach is adopted in West Virginia.

The Health Benefit Exchange and other provisions of the Patient Protection and Affordable Care Act will have significant implications for West Virginia. My administration is committed to maintaining the sound fiscal stewardship that has been the hallmark of our State for 25 years. We are also committed to improving population health so as to enhance the quality of life of our citizens and to reduce the cost from poor health felt by families, businesses, and taxpayers.⁹

In October 2013, a visitor to the state's health care exchange web page and affiliated websites was left with the impression that implementation had been defaulted to the federal government. There was little context to lead consumers to believe that this is a

state-federal partnership. While the state is not actively resisting the ACA's exchange system, it is not actively embracing the model either.

The case of Medicaid expansion is a much different story that represents the advantages of having a broad-based coalition of support for policy action. After deliberating on the political, fiscal, and practical issues involved, the governor announced in May 2013 that West Virginia would participate in Medicaid expansion.

Throughout the late winter and spring of 2013, there was speculation as to whether West Virginia would participate in expansion. In practical terms, expansion would mean reaching a population that had long been underserved in health coverage. Among the states, West Virginia has traditionally had very restrictive access to Medicaid for low-income adults without dependents. For well over a decade, various study groups convened by the governor had recommended expanding Medicaid to these adults. However, continued concerns over program costs had held back such action. Major players in the health sector had long been supportive of expansion to help offset the costs of uncompensated care. Over time, the state sought to control program costs and not expand Medicaid to new populations. These decisions were primarily the purview of the governor and the Department of Health and Human Resources. So, too, was the decision to expand Medicaid, which did not require legislative approval.

Nonetheless, Tomblin held off announcing a decision on expansion until after the 2013 legislative session. Ostensibly, but also genuinely, he needed this time to gather more information on the fiscal implications of Medicaid expansion. A major report by an actuarial firm that has long done business with state agencies was commissioned. This also bought some time for the governor. The probability was high that there would be bipartisan resistance to Medicaid expansion in the state house given the ACA's and the Obama administration's unpopularity. There was little reason to stir a legislative hornet's nest during a session that would either challenge the governor's decision or displace other items on his policy agenda.

The governor was able to enjoy broad-based support for expanding Medicaid in West Virginia. Health care advocates were vocal in their support and conducted many meetings and events across the state to advocate for expansion. Significantly, hospitals were supportive of Medicaid expansion as was the state's Chamber of Commerce. Expansion was seen as a means of offsetting charity care and reducing the number of uninsured. By moving eligibility for adults otherwise not qualified for Medicaid from approximately 25 percent of the federal poverty level (FPL) to 138 percent of the FPL, significant gains could be made with minimal short-term costs.

Rather than a quiet letter to HHS outlining the state's plans for exchange participation that received little attention or fanfare, the governor trumpeted the Medicaid expansion in a news conference

held at a major hospital in Charleston. Speakers at the news conference included a representative of the health advocacy community (a minister), as well as a hospital chief executive officer and Senator Rockefeller.

The state's Department of Health and Human Resources has the lead role in Medicaid expansion. At both the secretarial level and within its Bureau for Medical Services (BMS), Medicaid expansion has been made a high priority. Those applying for Medicaid can do so through the federal exchange portal – but most significantly, they can do so directly with the state by telephone, web, or in person. Initial indications suggest a high take-up rate for those newly eligible for Medicaid. As a press report noted, the DHHR conducted immediate outreach efforts by reviewing existing administrative files for people receiving services who might also be eligible for Medicaid. As noted by a DHHR official in October 2013, more than 40,000 requests were made by this targeted population to enroll in Medicaid. This was approximately one-half of the total anticipated enrollment base that has been identified to enter Medicaid over the next three years from this income group.¹⁰ The DHHR has achieved much of this by contacting families receiving food stamps who would likely qualify for Medicaid under its more generous income eligibility provisions.

From a practical standpoint, Medicaid expansion is more important and relevant to West Virginia than is the individual insurance exchange. According to an analysis conducted for the state government, as of 2011 there were approximately 250,000 uninsured West Virginians out of a population of approximately 1.8 million. It was anticipated that with the implementation of the ACA, approximately 85,000 to 90,000 new beneficiaries would be added to Medicaid, bringing total enrollment to approximately 277,000 by 2016. For the same time period, it was anticipated that the number of those in the individual insurance market would increase from 28,000 to approximately 110,000.¹¹ It was also anticipated that movement into the insurance exchange would be gradual, while enrollment in Medicaid would be more immediate. This seems to be bearing out given the high level of response to Medicaid expansion in the state. Because of glitches with the federal web portal and reluctance by the Obama administration to provide enrollment data, it was unclear what the application and enrollment trends were in the individual marketplace during fall 2013. On the other hand, there is considerable evidence that Medicaid expansion applications and enrollment has already been substantial in West Virginia.

1.2. Goal Alignment

West Virginia's posture toward the ACA reflects the complexities in balancing pragmatic realities with political maneuvering. In many ways, the ACA is a tale of two reforms in West Virginia. After initial signals that the state would operate its own exchange,

the state has backed off significantly from involvement in the individual market health exchange. At present, individual market reforms, which include the individual mandate, are the most contentious elements of the ACA and the features of health care reform that are most closely tied to President Obama. As a result, the Tomblin administration is keeping an arm's length relationship with the Obama administration. In essence, the state's exchange is less a partnership than a default to the federal government. This step back has been eased by the fact that the one function of the OIC, to review insurance plans, has been simplified because there is only one carrier participating in the marketplace (Highmark Blue Cross Blue Shield). This long-established plan has traditionally dominated the individual insurance market in West Virginia. In addition, the number of covered lives anticipated in the individual exchange will be fairly small. It is anticipated that approximately 110,000 West Virginians will be in the individual insurance market.¹²

The ACA was an omnibus bill and represented a collection of different provisions, mandates, and revisions to a broad array of federal programs and policies relating to health delivery and financing. On those points that touch on intergovernmental relations, West Virginia has neither been wholly oppositional nor affirming in its response to the ACA.

Politics often trumps policy logic, but practicality usually is the high card that trumps all. West Virginia elected to expand Medicaid in order to reach vulnerable populations that would otherwise not been insurable. As noted in a Robert Wood Johnson Foundation study, West Virginia, along with Michigan and Kentucky, stands to have greater benefit per capita from the ACA than all other states. The Foundation estimates that "81 percent of currently uninsured residents will receive some sort of financial help in getting health insurance, either through Medicaid or through subsidies in the health marketplace."¹³

The state's conflicted position on the ACA is perhaps best illustrated in Washington, D.C., where the state's two U.S. senators stand on opposite sides of the merits of the Affordable Care Act. Rockefeller, the state's senior senator, has been a strident supporter of ACA implementation and has been very public in his endorsements. For example, he stood side-by-side with the governor when the announcement was made that West Virginia would expand Medicaid. In an op-ed piece in the *Charleston Gazette*, the senator emphasized that "I want to be clear — you can't transform a health-care system, especially one that's as inefficient as ours, in an instant. But I am confident that this is that path forward, and that as legislators, we've got a responsibility to make the law work the best it can for the well-being of the American people."¹⁴

In contrast, Manchin, the state's junior senator and former governor, has been a critic of the ACA in toto while providing lukewarm support of specific provisions — such as Medicaid

expansion. The senator did not make a public appearance at Tomblin's announcement and sent an aide instead. Manchin has advocated for a delay of up to a year in requiring the individual mandate, although key stakeholders in the state, such as health care advocates and Highmark Blue Cross Blue Shield (hereafter Highmark) stressed that implementation should proceed or risk undercutting the purposes of broad participation and increase the probability of adverse selection into the individual marketplace.¹⁵

Part 2 – Implementation Tasks

2.1. Exchange Priorities

West Virginia was one of the first states to enact legislation authorizing development of an insurance exchange. As previously explained, political changes at both the national and state level prompted state leaders to instead opt for a state-federal partnership. As one of only seven states in a partnership, West Virginia's posture toward the exchange has been very passive. It is not an active partner in the exchange relationship and limits its role to reviewing insurance carriers participating in the exchange. In communications with the federal government, Tomblin has expressly noted that the state would not publicize or market the exchange and would leave these functions to the federal government.

2.2. Leadership – Who Governs?

In considering leadership, we must take into account politics and role. A great degree of political calculation went into the state's adoption of the ACA through the state-federal partnership and through the Medicaid expansion option. Politics continues to play a role in shaping the attitude and posture of key elected principals. We also need to take into account the different functions that elective leadership plays in policy development, implementation, and regulation. Tomblin, a conservative Democrat, has both embraced the ACA in terms of Medicaid expansion and distanced himself from the ACA in terms of the state's rather passive involvement in the individual health insurance market. As noted above, the two key agencies involved in state oversight of ACA are the Department of Health and Human Resources' Bureau for Medical Services and the Office of the Insurance Commissioner. The center of activity has shifted to the DHHR and away from the OIC as greater emphasis is being placed on Medicaid expansion. In addition, one the state's top experts in the ACA moved from the OIC to the DHHR to oversee Medicaid expansion. Previously, he had been the chief facilitator and expert in exploring state plans to develop a health insurance exchange.

Although the state legislature authorized the creation of a Health Exchange Governing Board, which would have been comprised of ex-officio voting members from key public agencies, as well as representatives from the insurance industry, health providers, and the public, the Board has not been established. In the

present political and policy environment, it is unlikely that this will move forward. The OIC retains the authority to review applications for Qualified Health Plans seeking to operate in the exchange. Initially, two well-established insurers were approved for the marketplace. However, one of these, Carelink/Coventry, which is owned by Aetna, withdrew from the marketplace.¹⁶ The remaining insurer is Highmark, which has long been a major player in the individual insurance market. In short, the OIC is currently playing a very passive role in the insurance marketplace.

Because West Virginia has a plural executive, it is not unusual for top elected officials in the executive branch to be at odds with each other. The state's current attorney general has publically decried "Obamacare." Through regulatory authority, the attorney general's office has interjected itself into the implementation process in a manner that calls into question the political motives of the attorney general. Senator Rockefeller referred to the actions of the attorney general as bullying organizations that might have an interest in serving as navigators. As quoted in a newspaper article, "Our attorney general, who hates all of this Affordable Health Care Act, has intimidated one of the groups, so they've withdrawn, and it is really something that should be investigated." The nonprofit in question had already received notice that it had been awarded a federal navigator grant, but withdrew in the face of scrutiny from the attorney general regarding queries into the organization's personnel and hiring policies and its capacity to protect the private information of those it might serve in its navigator role.¹⁷

2.3. Staffing

In terms of the health insurance marketplace, the state has invested relatively little in staffing. Through 2014, it is using federal funds to hire approximately up to 170 assisters who are stationed primarily at local state-operated social service offices across West Virginia. As of October 2013, approximately ninety assisters had been hired.¹⁸ Within the OIC, no significant changes have been made in staffing.

In the state's Medicaid agency, the Bureau for Medical Services, existing administrative and staffing structures have been utilized to conduct outreach and enrollment. The state relied primarily on mass mailings to inform potential enrollees that they might be eligible for Medicaid. This was done by sending mailings primarily to those in the Supplemental Nutrition Assistance Program (SNAP) who were not eligible for Medicaid under the old income standards.

An important footnote in the West Virginia experience is that much of the knowledge about the ACA has been localized to a few individuals. One of these individuals worked for the OIC during the development of the state's planning for its exchange options. Subsequently, he left to join the DHHR as the key staffer for Medicaid expansion.

2.4. Outreach and Consumer Education

Following the main narrative in this report, the state's administrative posture toward outreach and education is a tale of two programs. In regard to the individual insurance exchange, the OIC has been passive in its activities. The OIC maintains a website that is dedicated to the ACA, but navigating to it is not intuitive and it includes the following disclaimer: "This site provides a resource for the public and other interested parties concerning the planning and development of Marketplace policies and is NOT the actual Marketplace for insurance purchases." (However, the site does host a link to the HealthCare.gov marketplace portal). This posture is in alignment with Tomblin's priorities, which were communicated to Sebelius in early 2013, that "West Virginia does not intend to develop a large scale marketing campaign promoting the health benefit exchange. Additionally, West Virginia does not intend to manage the day-to-day activities of the federal Navigators."¹⁹ As previously noted, West Virginia did not apply for federal funds that would have assisted in outreach and education. In September 2013, one senior state official quoted in a newspaper interview noted:

The federal government has not adequately explained to the public what is taking place. This is a federal law and it is the responsibility of the feds to fulfill this mission and for the most part this effort has been a failure.²⁰

The story of Medicaid is much different. Here the state has been proactive and aggressive in reaching out to potential enrollees. Initial indications suggest a high take-up rate for those newly eligible for Medicaid. The DHHR-BMS (Bureau for Medical Services) scoured its SNAP and other support services roles to identify potential beneficiaries and contacted them by mail. In doing so, the DHHR-BMS smoothed the application process by inviting applications online or in person at local DHHR offices across the state. As will be detailed later, the DHHR-BMS also worked to ensure that those who got caught up in glitches with the federal exchange website received assistance in applying for Medicaid.

Outreach and enrollment activities are progressing on many fronts. As a small, rural state, West Virginia has a surprisingly robust network of advocates and intermediary organizations that are committed to encouraging enrollment. One group, West Virginians for Affordable Health Care, has a high degree of visibility and credibility in state policy circles and among providers and citizen groups. Apart from advocating health care reform for well over a decade, it has also been involved in helping to facilitate ACA enrollment in both the Medicaid and health insurance exchange. For example, it has disbursed \$130,000 it received from various foundations to provide mini-grants to health departments, churches, and community-based organizations to play the

role of “community-assistors” who can help direct individuals to more formal “individual assistors” and navigators.²¹

In other states, implementation of the ACA has been actively resisted. In some places, this has been manifested in government actions to impede the role of navigators and others involved in outreach and enrollment. While the West Virginia governor and state agencies are behind ACA implementation, especially the Medicaid expansion, press reports suggest that the state’s new attorney general, who some would characterize as part of the tea party wing of the Republican Party, has sought to block implementation. Among state legislators, criticism and concern has been muted. In the 2014 legislative session, health care reform did not surface as a major issue. Apart from traditional matters relating to nondiscretionary issues such as budget approval and perennial issues such as teachers’ raises, the legislative agenda was displaced by a major environmental and public health crisis associated with a chemical spill that affected much of the state’s water supply.

2.5. Navigational Assistance

The initial implementation of the ACA has introduced us to a new set of designations and terms for intermediaries who guide and counsel people inquiring about and seeking enrollment in Medicaid and the individual health insurance exchanges. Formally, these include what are called navigators, assisters, and certified application counselors. Informally, other parties have been involved as well, such as insurance agencies and community-based organizations and others that are assisting in getting word out. There is not a tight hierarchical structure or coordinative structure involved. In West Virginia, there are two crucial observations to share:

1. Navigators are playing a limited role in the enrollment process. Assisters and certified application counselors appear to have a more active role. However, it appears that all are concentrating on niche or target populations. In addition, their roles tend to be reactive and focused on those who are seeking medical services. A typical approach is to place eligibility workers in hospitals to help patients apply for insurance – most likely Medicaid.
2. By far the most significant outreach and navigation have been proactive efforts by the state’s Department of Health and Human Resources’ Bureau for Medical Services to contact those presumed eligible for Medicaid and to provide easy pathways to enrollment through mail and web-based application procedures.

State Responses: Assisters

The state has stationed assisters in forty-six field offices of the DHHR across West Virginia’s fifty-five counties (some DDHR

field offices serve multiple counties).²² There are mixed perceptions as to how proactive and assertive the state has been in setting up the infrastructure of outreach and support for those who would make use of the individual insurance market or who might be eligible for Medicaid. In late October 2013, there were concerns that the OIC was dragging its feet in hiring assisters and had scaled back the number of hires it had originally planned to make. At that time, the state had hired about eighty assisters and had reduced the number of hires from 270 to 170. This prompted criticism by some in the advocacy community. The OIC defended its actions by noting the federal government had taken up much of the outreach slack through its various programs and grants to nongovernmental entities. And a spokesman pointed out that the office had received \$14 million in federal funding for these positions and would apply all funds towards outreach and not return any monies to the federal government by the time the grant expires at the close of 2014.²³

Health Provider Responses: Certified Application Counselors

In a rural, low-income state like West Virginia, one of the primary sources of health care is the state's twenty-eight federally qualified health centers (FQHCs). On the eve of the ACA's implementation of Medicaid expansion and the individual health exchange, it was estimated that these FQHCs served 91,000 uninsured West Virginians. Through the West Virginia Primary Care Association, these centers received \$1.7 million in federal funding to hire personnel to be "certified application counselors" who help people navigate the new health system. These outreach efforts also include "hosting health fairs" and "strategizing with local staff members in the Department of Health and Human Resources to help enroll people."²⁴ A good example of this function could be found in a remote rural FQHC located in the state's mountain highlands of Webster and Nicholas counties, which offered both phone counseling and in-person appointments in five locations.²⁵

The state's two major tertiary hospitals – and their far-flung health networks – have also gained status as certified application counselor organizations. Their role has the potential to be highly significant for directing individuals to Medicaid and the insurance exchange. The Charleston Area Medical Center (CAMC) has twenty-three counselors to assist patients and their families. These counselors have lengthy experience in helping "uninsured patients finance their care, but the counselors have undergone training from the federal government on the health insurance marketplace."²⁶ In the northern part of the state, West Virginia University Healthcare is also a certified application counselor organization. The counselors are explicitly focused not on outreach, but on assisting patients to sign up for health coverage in the event that they are uninsured.²⁷

The Limited Role of Navigators

As described earlier, establishing navigator functions in West Virginia has been complicated by politics. The attorney general's pressure on one northern West Virginia-based nonprofit led to that organization turning down a \$365,000 grant to operate as a navigator. This group, West Virginia Parent Training and Information, Inc., withdrew based on inquiries from the attorney general's office regarding hiring and personnel practices — a move that was soundly criticized by Senator Rockefeller.²⁸ Another organization, Advanced Patient Advocacy, received a \$276,000 grant at the same time, and two subsequent awards were made. As various press reports have noted, these groups have been slow to gain traction.²⁹

Currently, the navigator role is being carried out by three organizations under a total of approximately \$640,000 in federal funding. One navigator is TSG Consulting, which is headed by a past secretary of administration and a high-level lobbyist in West Virginia. Located in Charleston, it has a portfolio of health policy-related activities and communication strategies, but is a newcomer to such work. A December 2013 newspaper article described some of TSG's outreach and education efforts, including making presentations at local free clinics. The firm also hosts a website to assist those making inquiries regarding Medicaid and the individual health insurance exchange.³⁰

The National Healthy Start Association, based in Washington, D.C., received a \$190,000 grant that it subcontracted to West Virginia University Health Systems.³¹ The West Virginia Healthy Start Project focuses on eight counties in the northern part of the state.³² The initiative has a special focus on serving expectant mothers and newborns. Much of the service area is rural.

The other navigator, Advanced Patient Advocacy located in Richmond, Virginia, received a \$276,000 grant from Centers for Medicare & Medicaid Services (CMS) and is placing navigators in four hospitals across the state. It has a long track record of working with health providers to connect patients to publically funded health insurance programs, thus offsetting their charity care costs. Placing privately hired eligibility workers has become the norm in many hospitals. The firm will place navigators in four significant regional hospitals in the southern part of the state.

Informal Intermediaries

Outreach and assistance is being provided by informal intermediaries as well. For example, an advocacy group, West Virginians for Affordable Health Care, has become the clearinghouse for \$130,000 in funding from various foundations and makes mini-grants of up to \$5,000 to assist churches, nonprofits, local health departments, and others to serve as "community assisters" to connect individuals to formal "in-person assistors," who can take on enrollment responsibilities.³³

Other nonprofits have been involved as well, often focusing on specific constituencies. For example, a reproductive rights organization, WVFREE, established a website to encourage enrollment by younger people.³⁴

Another set of informal intermediaries are insurance agents or brokers. While national media coverage has revealed how some insurance agents have sought to take advantage of confusion in health marketplaces across the country, there has also been coverage on the proactive role that agents are playing in the process as well.³⁵ In West Virginia, one press report detailed how agents have assisted individuals and small business in providing information about the ACA and the individual insurance marketplace.³⁶ According to documents posted on the OIC website, as of February 2014 there were approximately 330 insurance agents who are CMS certified to provide market insurance assistance for individual, SHOP (Small Business Health Options Program), or both programs under the ACA.

The Big Story: Medicaid Expansion and Enrollment

As detailed throughout this report, the big story in West Virginia involves Medicaid expansion. By late October 2013, approximately 40,000 West Virginians had been added to the rolls through expansion. The state started an aggressive outreach effort in late summer to reach potential enrollees by reviewing SNAP (food stamp) enrollment and caseload data for families where children, but not parents, were receiving Medicaid. In the initial phase of contact, 118,000 letters were sent out. The DHHR-BMS invited enrollment through its website or through visits to county DHHR offices.³⁷ By December 2013, it was estimated that approximately 75,000 West Virginians had enrolled in Medicaid due to the program's expansion the previous October.³⁸ By January 2014, this number stood at 82,000, with another 10,000 likely to be enrolled immediately.³⁹

It is estimated that by 2016 more than 133,000 additional West Virginians will be covered through Medicaid expansion.⁴⁰ We can speculate that both formal and informal intermediaries will have an important role in connecting individuals to Medicaid. It appears that the approach being used for both navigators and in-person assisters will reinforce this. Many are based in hospitals and they will likely refer low-income individuals seeking emergency and primary care to Medicaid.

2.6. Interagency and Intergovernmental Relations

2.6(a) Interagency Relations. All agencies have their turf and their interests to protect, but generally in West Virginia agencies play well together. The two primary agencies involved in ACA implementation are the Department of Health and Human Resources' Bureau for Medical Services and the Office of the Insurance Commissioner. There is a mutual dependence on sources of information and support from a stable of consultants, third-party

administrators for billing and claims, and actuaries. The principals in both the DHHR-BMS and the OIC know each other. As noted earlier, one of state's chief experts on the ACA moved from the OIC to the DHHR-BMS and has been a principal architect in managing the state's Medicaid expansion.

The relatively passive approach to the health insurance exchange displayed by the OIC and the active involvement in Medicaid expansion by the DHHR-BMS is a study of contrasts but it is not a study of conflict. Both agencies seem to be on script in carrying out the governor's health reform agenda.

It is worth noting that OIC and DHHR-BMS are mutually dependent on each other for outreach and enrollment functions. The OIC is responsible for hiring "in-person assisters" and these individuals are primarily stationed at DHHR field offices found throughout the state.

2.6(b) Intergovernmental Relations/2.6(c) Federal Coordination. Because West Virginia is involved in a state-federal partnership for the insurance marketplace and because it has decided to expand Medicaid, it is appropriate to respond to 2.6b and 2.6c together.

Like other states, West Virginia experienced glitches and delays with the implementation of the federal web portal for the health insurance exchange. As mentioned in press reports, this created significant challenges for people trying to access the system. However, the state was able to provide an alternative for Medicaid enrollment with its own outreach and enrollment systems. As reported in newspaper coverage, early on in the web crisis a DHHR official noted that this arrangement, "had really been a blessing....credit to the staff at DHHR for all the hard work they did. It eases the burden on the consumer significantly and also eases the burden on the state system."⁴¹

2.7. QHP Availability and Program Articulation

2.7(a) Qualified Health Plans (QHPs). There is only one insurance carrier operating in the health insurance marketplace. This is Highmark Blue Cross Blue Shield, which serves West Virginia, Pennsylvania, and Delaware. Initially, the OIC also approved Carelink/Coventry, which is affiliated with Aetna, for the marketplace, but it pulled out of the exchange in September 2013.

In West Virginia, thirteen policy choices are being offered, ranging from catastrophic coverage to "gold plans." No high-end "platinum" policies are offered. Eleven of the plans are state-specific; two plans are multistate options. According to an analysis by the Robert Wood Johnson Foundation, exchange premiums in West Virginia are among the lowest in the United States.⁴² As is detailed in the discussion of government and markets later in this report, there are concerns that a lack of competition might prove counterproductive.

According to press releases posted on the OIC website, in February 2014 Highmark announced enrollment figures of individuals

who purchased ACA-compliant individual coverage. In West Virginia, 11,937 had done so, with 8,711 using the exchange and the remainder dealing directly with Highmark. This represents a 57 percent increase in new members for Highmark.

2.7(b) Clearinghouse or Active Purchaser Exchange. West Virginia does not operate its own exchange, and instead relies on the federal insurance marketplace.

2.7(c) Program Articulation. Writing from the vantage point of February 2014, it is interesting to note how West Virginia had to fill in gaps and adapt to complications in the rollout of the federal exchange information and enrollment process. In essence, the state decided to move unilaterally to ensure that potential Medicaid enrollees were aware of their opportunities to apply for benefits. In January 2014, the state launched an effort to make certain that 18,000 West Virginians who had slipped between the cracks due to a lack of interoperability and sufficient data transfers were given assistance in applying for either Medicaid or insurance. Specifically, DHHR-BMS officials noted that the federal exchange did not provide adequate information to the state to process some 10,000 Medicaid applications. Conversely, there were difficulties in the state transferring information from 8,000 ineligible Medicaid applicants to the federal exchange. Officials have expressed optimism that these glitches can be worked out.⁴³

As noted elsewhere in this report, because of the difficulties associated with the federal web-based enrollment process, the OIC authorized the extension of benefits for the state's high-risk pool beneficiaries through March 2014.

2.7(d) States That Did Not Expand Medicaid. West Virginia expanded its Medicaid program.

2.7(e) Government and Markets. In essence, the individual insurance market has been reformed through the ACA to provide "guaranteed issue" for those with pre-existing conditions and has been regulated to reduce disparities in rate-setting based on age and sex. This is essentially an incremental adjustment of policy that has been underway for some time in the private insurance market. (Many states, especially in the Northeast, have had guaranteed issue regulations in lieu of high-risk insurance pools for years.)

Highmark, the only insurer participating in the state exchange, has traditionally been the largest insurer in the individual marketplace. On the eve of the launch of the exchange, it already covered approximately 70 percent of those in the individual market. Individuals can still purchase insurance outside of the marketplace that meet ACA underwriting requirements. However, if potential beneficiaries qualify for subsidies, purchasing outside of the exchange will work to their disadvantage.

While press reports note that the Highmark plans are among the least expensive in the country, the presence of only one insurance carrier in the individual exchange has been a concern for some. One concern is that by dominating the market, the carrier

might be able to dictate terms of negotiated prices with health care providers.⁴⁴ As a senior state administrator quoted in a newspaper article noted:

One proposed benefit of the marketplace was to leverage competition amongst issuers to drive premiums down in the market. Absent competition, this effective market driver will no longer exist, and instead the market will depend on regulatory mechanisms to ensure premiums are at adequate levels. This is far from ideal and fails to capture one of the initial proposed benefits suggested by the federal government.⁴⁵

In another news article, the state's attorney general was quoted as saying, "West Virginia needs more competition in the health insurance market. Is a one insurer health exchange the change we have been waiting for?"⁴⁶

2.8. Data Systems and Reporting

The cost, complexity, and the administrative burdens of information technology (IT) functions for a state exchange system were explicitly cited as a reason why West Virginia moved to a federal-state partnership option.⁴⁷ The state relies on its existing Medicaid management information systems, especially its INROADS system, for Medicaid eligibility and enrollment data. The DHHR's management information systems were also used as a means of identifying potential Medicaid enrollees through an analysis of SNAP and other public assistance program enrollment data.

Part 3 – Supplement on Small Business Exchanges

3.1. Organization of Small Business Exchanges

Delays and deferral at the federal level means that small business exchange activity has been limited in terms of policy attention and implementation in West Virginia. According to the federal exchange site (HealthCare.gov), enrollment in the exchange cannot be done via the web and instead relies on interaction with brokers, agents, or insurance carriers.

Approximately 300 insurance agents or brokers in West Virginia have been ACA certified by CMS. The vast majority of these individuals are certified for SHOP enrollment activities.

The small business exchange has not had much visibility in West Virginia. Undoubtedly, the policy uncertainties surrounding SHOP at the federal level resonate at the state level as well.

Part 4 – Summary Analysis

4.1 Policy Implications

The implementation experience to date (February 2014) confirms some of our longstanding knowledge and assumptions

about policy implementation in an intergovernmental context, but also highlights some dynamics that are more specific to the ACA and contemporary politics. Here are some general policy implications that bear further study and assessment in the months ahead.

- The ACA implementation experience in West Virginia and elsewhere reminds us of our longstanding appreciation that implementation is difficult; the devil is in the details. The troubled rollout of the federal health insurance marketplace gives proof to this. These difficulties had real consequences at the state level. As detailed here, in West Virginia this resulted in approximately 18,000 individuals not being properly matched to Medicaid or to insurance options on the health exchange.
- Related to the point above, the ACA implementation experience in West Virginia also illustrates how state officials and administrators can be nimble and adaptive in the face of adversity. Like a number of other states, West Virginia decided to adjust and adapt to the slow rollout by extending health coverage for individuals in the state's high-risk insurance pool. This was decided even though the state had planned to cease operation of its high-risk program as of January 1, 2014. The extension was made out of a concern that both providers and policyholders would face hardship in a gap of coverage.
- One of the most interesting storylines to appear in the ACA implementation narrative involves intermediaries — those formal navigators, assisters, and community assister organizations, as well as informal parties who help guide individuals as they negotiate the new insurance and Medicaid landscape. In West Virginia, much of this function appears to be focused on more specific populations and paths than on a more general approach. Thus, most of the state's in-person assisters are assigned to local welfare offices and are enrolling individuals primarily in Medicaid. The three entities that have received federal navigator funding have essentially carved out niches and targets for their operations. One is focusing on expectant mothers and newborns; another is focusing on placing eligibility workers in a few hospitals that will help guide patients to insurance coverage; still another is involved in relatively passive outreach and education efforts in rural West Virginia. Informal intermediaries are also concentrating on specific populations. What is most notable is that many of these are engaged in enrolling individuals, most likely for Medicaid, only when a precipitating event motivates the individual to seek health services and thus coverage. This is not unfamiliar to those who study and work in the world of Medicaid, as on-site enrollment and eligibility intermediaries have long been a feature of major health care settings like hospitals.

- As noted throughout this report, West Virginia's experience is a tale of two reforms or experiences. The state has adopted a hands-off, but nonhostile, posture toward the health insurance exchange. Unique policy and political dynamics contributed to the state first embracing the concept of its own exchange and then moving toward a very passive role in a state-federal partnership. In contrast, the state has been proactive in reaching out and enrolling those newly eligible under Medicaid expansion. As ACA implementation gains traction and best practices are discovered and shared, West Virginia's aggressive approach of utilizing SNAP enrollment lists as a means of reaching potential Medicaid applicants may be one of those stories that come to the fore.
- State-level attitudes and perceptions toward the ACA and Obamacare cannot be explained by politics alone. West Virginia is a red state masquerading as a blue state in macro-level analyses and descriptions of American politics – especially in the fly-over states. Yes, the governor is a Democrat, all but one of the state's elected executives are Democrats, both the House of Delegates and the State Senate are dominated by the Democratic Party, and both U.S. senators are Democrats. However, West Virginia is a very conservative state. Many of these Democrats are on record as having reservations about the ACA. West Virginia has not voted Democratic in a presidential election since Bill Clinton's reelection in 1996 and has had tense relationships with the Obama administration over environmental regulation. By many accounts, one would expect the state to be oppositional – but it is not. Practical needs rule the day, as is clearly demonstrated in the state's expansion of Medicaid.
- More generally, the ACA experience suggests the emergence of a new type of federalism, which might be called "Hedge Your Bets Federalism." This operates on both the state and the federal level and the implications can be problematic. At the state level, there was very much a wait-and-see approach as to whether key provisions of the ACA would be deemed unconstitutional or would be amended in the interregnum between March 2010 and October 2013. Yet at the same time, many of the smaller pieces of ACA needed to be implemented. Few states rushed forward. Somewhat reminiscent of the wait for clarifying federal regulations during the implementation of the Temporary Assistance for Needy Families (TANF) program, the states were also reluctant to create the administrative infrastructure of reform. Yet a stark difference is that the Personal Responsibility and Work Opportunity Reconciliation Act and TANF seemed to change the climate of public assistance programming and implementa-

tion, whereas the ACA appears to be overly sensitive to surrounding administrative and political conditions. Hedging your bets meant not expending political capital or public finances for something that might not materialize in the end.

At the federal level, oppositional forces hoped for deliverance either through court action or the electoral cycle. The Obama administration appeared too fearful and timid about pushing the implementation schedule for fear of political losses at the ballot box. What is particularly interesting about the hedging approach to federalism is the soft infrastructure that has accompanied the rollout of the ACA. In West Virginia, this has been manifested in (1) reliance on existing administrative structures for Medicaid expansion; (2) deferral to the federal government to operate the exchange and to thus shoulder the burden of responsibility; (3) confidence that word will get out through intermediaries with tangential ties to government – links that have been created either through contracts or mutual interests; (4) down-to-the-wire policy decisions about exchange options and Medicaid expansion; and (5) an attitude of contingency, best expressed in the governor's February 15, 2013, letter to the HHS secretary noting that West Virginia still reserved the right to change its mind as implementation progressed.

4.2. Possible Management Changes and Their Policy Consequences

The initial months of ACA implementation do not suggest major management changes on the horizon. Both the OIC and the DHHR-BMS have been actively involved in ACA implementation. The former clearly defined its regulatory role, but has also shown flashes of innovation and resolve by extending health coverage for those in the state's high-risk pool and by toeing a hard line against revisiting rating and underwriting standards in the wake of Obama's U-turn on applying ACA standards to individual insurance products. The DHHR-BMS has been proactive in reaching out to potential beneficiaries under Medicaid expansion. While there has been some criticism of the OIC for not being more aggressive in hiring in-person assisters, the general impression is that the state has been effective in handling Medicaid expansion. While anecdotally there has been some discussion among individual legislators to create a stand-alone state exchange to clean up the mess that Washington has made, this is unlikely to gain traction.

Endnotes

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