GETTING PEOPLE TO MAKE THE RIGHT CHOICE UNDER THE ACA: THE MOST IMPORTANT "SALES PITCH" OF OBAMA'S PRESIDENCY

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I. INTRODUCTION

"[I]n early June, President Obama began in earnest his sales pitch for U.S. residents to enroll in health insurance provided under the ACA" reported a *California Healthline* article.[1] This notion of Obama making a sales pitch for enrollment may seem odd for a couple of reasons. The primary goal of the Patient Protection and Affordable Care Act (ACA)[2] is to improve healthcare access through expansions of public and private insurance, and a focal point of the private insurance expansion has been the "individual coverage requirement" or "mandate."[3] Most of the debate about health reform has centered on opposition to the mandate, and the idea that people would be forced to buy insurance has helped galvanize opposition to the law.[4] The reality, however, is that there is no true legal mandate for people to purchase insurance. As the United States Supreme Court emphasized in its decision to uphold the ACA, at most the government can assess a penalty for the failure to buy insurance,[5] but, according to the government's own

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1. Matthew Wayt, *The Many Ways to Sell Obamacare*, CAL. HEALTHLINE (July 3, 2013), http://www.californiahealthline.org/road-to-reform/2013/the-many-ways-to-sell-obamacare.

2. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

3. *See* Ezra Klein, *Unpopular Mandate: Why Do Politicians Reverse their Positions?*, NEW YORKER (June 25, 2012), http://www.newyorker.com/reporting/2012/06/25/120625fa_fact_klein?currentPage=all (explaining that President Obama realized that health care reform had to include an individual mandate).

4. *See id.* (explaining that polling showed the individual mandate to be one of the ACA's least popular elements).

5. The applicable provision in the ACA is titled "Requirement to maintain minimum essential coverage" and it provides that "an applicable individual shall . . . ensure that the individual . . . is covered," but individuals can meet their legal obligation either by purchasing

estimates, this penalty is too low to force anyone into buying insurance. The Court held that the penalty functions more like a tax that preserves consumer choice to buy or not buy insurance.[6] It is up to the federal government and its state partners to help convince people to make the right choice.[7]

The idea of being pitched at also triggers negative connotations of salespeople who use a "hard sell" to pressure one into buying something the buyer does not want or need, that may not be in the buyer's best interest, and that ultimately the buyer comes to regret.[8] Even sales professionals acknowledge that sales are often thought of in this unfavorable light: that salespeople merely talk at consumers, act in a purely self-interested way that shows no genuine regard for consumers' needs, and use tricks and pressure tactics to make sales at the expense of the consumer.[9] Indeed, reform opponents use this negative association in their attempts to suppress enrollment. Opponents try to stoke opposition by playing on the mandate rhetoric and people's objections to being "forced" to do anything by the government.[10] Republicans lawmakers have also criticized and attempted to thwart the federal government's use of "unconventional" methods and partners to educate the public:

qualified insurance or by making a "shared responsibility payment," also referred to as a penalty. Requirement to maintain minimum essential coverage, 26 U.S.C.A § 5000A (2010). There are several exemptions to the coverage requirement: these include exemptions for financial hardship, individuals with incomes below the tax filing threshold, and those for whom the lowest cost plan option exceeds eight percent of the individual's income. *Summary of the Affordable Care Act*, KAISER FAMILY FOUND. 1 (last modified Apr. 23, 2013), http://kaiserfamilyfoundation.files.wordpress.com/2011/04/8061-021.pdf.

6. *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S.Ct. 2566, 2596 (2012) (explaining that the "penalty" for failing to purchase insurance functions more like a tax because it is not high enough or punitive enough to deprive consumers of a real choice to not buy insurance).

7. *See, e.g.*, Jim Forsyth, *Castro, Doggett to Attempt to Convince Young People to Buy Health Insurance They Don't Need*, WOAI (Sept. 23, 2013, 6:00 AM), http://www.woai.com/articles/woai-local-news-119078/castro-doggett-to-attempt-to-convince-11674605/ (showing that the federal government has organized events nationwide to convince people to buy health insurance).

8. *See* Edward C. Bursk, *Low-Pressure Selling*, 84 HARVARD BUS. REV. 150, 152 (2006) (describing "high-pressure selling" as driving the prospective customer into a buying decision, which means that the customer feels pressured into buying something he does not want, does not need, and will ultimately make him feel dissatisfied).

9. *Id.* This is also reflected in the definition of "sales pitch" as a "popular term for an inflexible 'formula' or 'canned' sales presentation delivered in every sales situation without regard to the needs of the prospect." *Sales pitch*, BUSINESSDICTIONARY.COM, http://www.businessdictionary.com/definition/sales-pitch.html (last visited Nov. 12, 2013).

10. *See* Lake Research Partners, *Preparing for 2014: Finding From Research with Lower-Income Adults in Three States*, ROBERT WOOD JOHNSON FOUNDATION 14 (June 2012), http://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2012/rwjf73113 (stating that many of the individuals surveyed express a strong opposition to the idea of being forced to buy health insurance); *see also Bachmann: 'I Lost My Insurance Under Obamacare,' Will Be Forced Into Exchange*, CNN (Nov. 14, 2013, 9:05 PM), http://politicalticker.blogs.cnn.com/2013/11/14/bachmann-i-lost-my-insurance-under-obamacare-will-be-forced-into-exchange/ (reporting that opponents are stating that the ACA's mandate will force people to buy insurance via a healthcare exchange).

they have questioned the legitimacy of funding for "Edutainment", one means through which the government has enlisted the help of popular entertainers, like Jay-Z, to urge people to sign up for coverage;[11] they have attacked (unsuccessfully) the legality and ethics of the Department of Health and Human Services (HHS) Secretary Kathleen Sebelius's partnership with consumer advocacy groups, like Enroll America;[12] and they have used scare tactics to try to discourage others from helping, such as warning the National Football League (NFL) and the National Basketball Association (NBA) that helping the Obama administration would hurt their brands.[13] Unsuccessful at repealing reform or preventing implementation, reform opponents are now trying to suppress enrollment.[14] By reiterating anti-reform messaging about job loss and rising health costs,[15] opponents are painting a

11. *See* Sam Baker and Justin Sink, *Obama Asks Hollywood Celebrities to Help Pitch ObamaCare Enrollment*, THE HILL (July 23, 2013, 4:11 PM), http://thehill.com/blogs/healthwatch/health-reform-implementation/312747-obama-asks-hollywood-celebs-to-help-pitch-obamacare (showing that the Obama administration recruited celebrities to support the Affordable Care Act); *see also* Elise Viebeck, *Republican Lawmaker to NFL and NBA: Don't Do ObamaCare's 'Dirty Work*,*'* THE HILL (June 27, 2013, 7:25 PM), http://thehill.com/blogs/healthwatch/health-reform-implementation/308297-gop-lawmaker-advises-nba-nfl-against-obamacare-dirty-work (stating that Republican lawmakers are pressuring the NBA and NFL not to promote healthcare reform); *see also* Wayt, *supra* note 1 (revealing the contents of a letter from the Republican Study Committee, stating that the NFL and NBA will lose their fan base if they support ObamaCare).

12. *See* Robert Pear, *Potential Donors to Enroll America Grow Skittish*, N.Y. TIMES (May 19, 2013), http://www.nytimes.com/2013/05/20/us/politics/potential-donors-to-enroll-america-grow-skittish.html?_r=1& (explaining the backlash Secretary Kathleen Sebelius experienced from Republican lawmakers as she tried to raise private money to supplement the ACA).

13. *See* David Morgan, *NFL's Help Sought in Promoting Obama Health Plan as Outreach Begins*, REUTERS (June 24, 2013), http://www.reuters.com/article/2013/06/24/us-usa-healthcare-outreach-idUSBRE95N0LW20130624 (noting that HHS was in the midst of negotiating advertising campaigns and a potential partnership, and specifically mentioning the NFL as "actively and enthusiastically engaged"); *see also* Elise Viebeck, *GOP Senators Warn NFL, NBA Against Promoting ObamaCare*, THE HILL (June 28, 2013, 7:00 PM) http://thehill.com/blogs/healthwatch/154929-gop-senators-warn-nfl-nba-against-promoting-obamacare (reporting that Rep. Steve Scalise told the NFL and NBA not to do Sebelius's "dirty work" and warning that supporting outreach would damage their brands).

14. *See* Tony Pugh, *Obamacare Enrollment Efforts, and Message Wars, Heat Up*, YOUNG INVINCIBLES (Aug. 1, 2013), http://younginvincibles.org/2013/08/obamacare-enrollment-efforts-and-message-wars-heat-up/ (explaining that opponents of the law have spent $400 million on television since the law passed to urge people not to buy coverage through the exchanges).

15. These messages are contradicted by the recent evidence. *See, e.g.*, *New York Approves Significantly Lower Premium Rates for Exchange*, CAL. HEALTHLINE (July 18, 2013), http://www.californiahealthline.org/articles/2013/7/18/new-york-approves-significantly-lower-premium-rates-for-exchange (stating that the seventeen insurance plans that New York approved as a result of healthcare reform have rates that are more than fifty percent lower than the rates of similar plans offered in the past year); *see also Covered California Health Plan Contracts Signed*, COVERED CAL. (Aug. 7, 2013), http://www.healthexchange.ca.gov/Documents/Individual%20markets%20SignedContracts_PressReleaseFINAL.pdf (noting that plan premiums are lower than expected).

picture of President Obama as trying to "sell" something that no one wants or needs.

Except that we know people want insurance. Polling shows that people consistently rank health care as a top concern in elections.[16] Most people understand that in order to get the health care they need, they need health insurance, and people who do not have insurance tend to list cost, job loss, or lack of understanding about how to get it as reasons for not having it.[17] Although opinion polls reflect division about the best way to achieve health reform, overwhelmingly people have viewed government intervention as necessary.[18] Remarkably, the Obama administration overcame formidable political and legal hurdles, and the ACA is now law. Opponents' characterization of the government's health reform messaging as an unwanted sales pitch seems anathema to the legitimate and important role of government in educating consumers about the new law, especially considering the important individual and societal interests at stake.[19]

16. *See, e.g.,* Sarah Cho et al., *What Issues Are Most Important to Voters in This Election? The Answer Depends on the Question*, KAISER FAMILY FOUND. (Nov. 1, 2012), http://kff.org/health-reform/perspective/what-issues-are-most-important-to-voters-in-this-election-the-answer-depends-on-the-question/ (showing that health care was the second most important issue for voters in the 2012 election).

17. *See, e.g.*, Sarah Kliff, *Do You Understand Health Insurance? Most People Don't*, WASH. POST (Aug. 8, 2013, 11:28 AM), http://www.washingtonpost.com/blogs/wonkblog/wp/2013/08/08/do-you-understand-health-insurance-most-people-dont/ (highlighting the reasons many people do not understand health insurance terms); *see also QuickStats: Reasons for No Health Insurance Coverage Among Uninsured Persons Aged <65 Years*, CTRS. FOR DISEASE CONTROL AND PREVENTION (Jan. 14, 2011), http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6001a9.htm (citing cost and job loss as the two biggest reasons why people do not have health insurance).

18. *See, e.g.*, Patricia Zengerle, *Most Americans Oppose Health Law But Like Provisions*, REUTERS (June 24, 2012, 1:13 AM), http://www.reuters.com/article/2012/06/24/us-usa-campaign-healthcare-idUSBRE85N01M20120624 (stating that although most Americans oppose health care reform, they support most of the ACA's provisions); *see also* J.D. Harrison, *Mixed Emotions: Small Business Owners, Advocates Respond to Health-Care Ruling*, WASH. POST, June 28, 2012, http://www.washingtonpost.com/business/on-small-business/mixed-emotions-small-business-owners-advocates-respond-to-health-care-ruling/2012/06/28/gJQAALaI9V_story.html (showing the differing views on the ACA among small business owners); *NPF/Kaiser/Harvard Survey: The Public on Requiring Individuals to Have Health Insurance*, KAISER FAMILY FOUND. (Feb. 2008), http://kff.org/uninsured/poll-finding/nprkaiserharvard-survey-the-public-on-requiring-individuals-2/ (showing a nearly even split among people who were asked whether they would support or oppose a proposal like the ACA); *Poll Finds Bipartisan Public Support for Creating State Insurance Exchanges Despite Continuing Party Divisions Over the ACA*, KAISER FAMILY FOUND. (Jan. 24, 2013), http://kff.org/medicaid/press-release/poll-finds-bipartisan-public-support-for-creating-state-insurance-exchanges-despite-continuing-party-divisions-over-the-aca/ (stating that over half of the public, including majorities of Republicans and Democrats, support the creation of state health care exchanges, despite party divisions over the ACA).

19. *See Health Care Reform Outreach Campaign Kicked Off By Obama Administration*, REUTERS (June 24, 2013, 8:45 AM), http://www.huffingtonpost.com/2013/06/24/health-care-reform-outreach_n_3489823.html?view=print&comm_ref=false (demonstrating that large numbers of uninsured individuals will need to sign up for health insurance); *see also* Jeffrey Young, *Obamacare Outreach Recruits Libraries*, HUFFINGTON POST (July 1, 2013, 2:28 PM),

And yet, understanding President Obama's task as one of effective selling is both descriptively accurate and normatively useful. It is descriptively accurate, in part, because although the idea of health insurance as a good thing does not need to be sold, some people do need to be convinced to buy insurance *now*. The specific "sell" that most policy makers are concerned about, and that is getting increased media attention, is to the "Young Invincibles."[20] This term refers to younger people with healthy histories, who are likely to not have dependents, and for whom the cost of insurance likely represents a significant financial investment, even with a subsidy, due to a lack of disposable income.[21] Even though many people acknowledge the importance of insurance and favor health reform, there is a difference between broad public support for insurance reform, and an individual's decision to buy insurance in light of that person's resources, motivations, and priorities.[22] Selling insurance to someone with a healthy history and not a lot of disposable income may require a greater sales effort to help the person understand the value or worth of the financial investment.

This is especially true now that the law prevents denials of coverage based on risk and preexisting exclusions.[23] Consumers may want to wait to purchase insurance until the need is imminent. "Healthy" people are the least likely to know how to value insurance, and the most likely to underestimate their need for health care; a cost-benefit analysis may cause people to forego insurance for now.[24] For this reason, the Young Invincibles appear to fit the opponents' narrative of consumers being sold something they do not want or need. Indeed, this perception

http://www.huffingtonpost.com/2013/07/01/obamacare-libraries_n_3529849.html (explaining that the Obama administration is using local public libraries to improve the public's low understanding of the ACA).

20. *See* Christopher Weaver, *New Health-Care Law's Success Rests on the Young; Will Young and Healthy Give Up Disposable Income to Pay for Insurance*, WALL ST. J. (July 25, 2013), http://online.wsj.com/news/articles/SB10001424127887324263404578613700273320428 (stating that the success of health care reform depends on whether young, healthy people decide to buy insurance).

21. *See id.* (demonstrating the reluctance of young people about buying insurance due to the cost); *see also* Anna Gorman, *Affordable Care Act's Challenge: Getting Young Adults Enrolled*, L.A. TIMES (June 2, 2013), http://articles.latimes.com/2013/jun/02/local/la-me-young-adult-insure-20130603 (stating that the participation of young, healthy individuals is necessary to balance out the older, sicker patients who are more likely to sign up for health insurance immediately); *see also* Morgan, *supra* note 13 (noting public skepticism about the worth of plans, especially among young and healthy consumers).

22. *See* Lake Research Partners, *supra* note 10, at 10 (noting that although people may value health insurance, wanting insurance and being able to purchase it are separate matters).

23. 42 U.S.C.A. § 18001 (2010); *see What if I Have a Pre-Existing Health Condition?*, HEALTHCARE.GOV (last visited Nov. 12, 2013), https://www.healthcare.gov/what-if-i-have-a-pre-existing-health-condition/ (explaining that, under the ACA, insurers cannot refuse to cover individuals due to their pre-existing conditions).

24. *See* Christopher Weaver & Timothy W. Martin, *Young Avoid New Health Plans*, WALL ST. J. (Nov. 4, 2013), http://online.wsj.com/news/articles/SB10001424052702303661404579178231174626314 (explaining that younger healthier individuals are less likely to buy health insurance).

permeated the rationale of Chief Justice Roberts, and Justices Scalia, Kennedy, Thomas, and Alito in their respective decisions in *National Federation of Independent Business v. Sebelius* (*NFIB*), that a legal mandate to purchase insurance could not be justified under the commerce clause.[25]

Thinking about the government's task as a challenge in effective selling may also provide a particularly apt and useful tool for assessing the potential effectiveness of the government's enrollment outreach and design of its new virtual health insurance markets.[26] Contrary to the negative image of the hard sell, modern theories of effective selling emphasize an approach that is low pressure, and depends on building a relationship of trust with customers based on genuine empathy and an understanding of their motivations and needs.[27] In this model, the salesperson acts as more of a guide and educator, rather than using high pressure tactics to drive the sale. The salesperson provides customers with education that helps them understand their needs and identify which products best meet these needs, creating a pleasant and meaningful shopping experience that "lets consumers buy."[28] In this way, modern theories of effective selling provide a model for government interaction with all sorts of health care consumers, which is better than the existing complex and frustrating bureaucratic process typical of government agencies that administer public benefit programs.[29]

This article uses this theory of effective selling to critique the government's approach to implementation so far and to identify the provisions of the ACA that are consistent with each aspect of this theory. Reform success—the creation of a private market in which consumers can afford quality health insurance—depends on robust enrollment and retention of young and healthy consumers to help spread the risk and make insurance premiums affordable.[30] Robust enrollment by these

25. *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2646 (2012) (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting) (stating that allowing Congress to force young and healthy individuals to buy health insurance grants Congress unlimited power under the Commerce Clause, and thus cannot possibly be justified under the clause).

26. *See, e.g.*, Carol Gorga Williams, *Virtual Health Care Gaining Ground*, USA TODAY (May 6, 2013), http://www.usatoday.com/story/news/nation/2013/05/06/virtual-health-care-digital-doctors/2138521/ (explaining the changes that technology is having on health care in the United States).

27. *See infra* Part II.

28. *See infra* Part II.

29. *See infra* Part II.

30. The ACA prohibits insurance companies from denying or pricing policies based on an individual's risk in order to make insurance more accessible, but this also increases the risk of adverse selection by consumers; adverse selection is the process of waiting until one is sick or in need of insurance before entering the pool. *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2614 (2012) (explaining the relationship of the mandate to the rest of the private insurance reforms). An individual mandate guards against adverse selection by ensuring that healthy people are part of the insurance pool, so they can help spread the risk and keep premiums affordable for all participants. *See id.* (explaining that the states that tried the individual mandate approach succeeded in ensuring that insurers would not be left solely with sick customers). Requiring insurance companies to cover everyone at generally comparable pricing without a mandate could

healthy consumers, in turn, depends on an ability to generate consumer interest, ensure that consumers have the information they need to make informed shopping decisions easily, and minimize attrition or churning due to changes in individuals' circumstances. Part II gives an overview of the modern theory of effective selling and its relevance to achieving each of these goals. The remainder of the article fleshes out the application of this theory in greater detail. Part III highlights the importance of knowing and understanding potential customers' needs and motivations. Part IV identifies the factors that create resistance to buying insurance. And Part V describes effective tools for overcoming this resistance.

As this article was in the editing process, the federal exchange and many state exchanges began enrolling consumers; but the initial enrollment period has been plagued with complaints about accessing and navigating the exchange website, consumer frustration with inaccurate information about plan networks, and challenges in recruiting healthy consumers.[31] Even as the federal government reports exceeding its target of 7 million enrollees, questions remain about who is not yet enrolled and whether current enrollees will stay enrolled.[32] Consequently, the questions raised and the recommendations offered in this article are still relevant—that is, if the states and federal government are willing to learn from

lead to a "death spiral" of insurers fleeing the market, undermining access goals. Indeed, this is exactly what happened in states that tried this without a mandate. *See* Neera Tanden & Topher Spiro, *The Case for the Individual Mandate in Health Care Reform: A Comprehensive Review of the Evidence*, CTR. FOR AM. PROGRESS 1, 1–2 (2012), http://www.americanprogress.org/wp-content/uploads/issues/2012/02/pdf/individual_mandate.pdf (discussing the premium increases and enrollment decline in states that enacted health care reform without an individual mandate). Massachusetts has been successful because its health care reform included a mandate, which is why it served as the model for the ACA. *Id.* at 2.

31. *See, e.g.,* Juliet Eilperin, *Analysis: Obamacare Glitches Scare Off Many Web Site Users*, WASH. POST (Oct. 15, 2013), http://www.washingtonpost.com/blogs/post-politics/wp/2013/10/15/analysis-obamacare-glitches-scare-off-many-web-site-users/; Victoria Colliver, *State Health Care Website Recovering From Glitches*, S.F. CHRONICLE (Oct. 27, 2013), http://www.sfgate.com/health/article/State-health-care-website-recovering-from-glitches-4927390.php (noting that California's exchange experienced slowness at the beginning of the enrollment period and has had trouble with its on-line provider directory). *See also* Chad Terhune and Eryn Brown, *California Health Insurance Exchange Struggling to Enroll Latinos*, L.A. TIMES (Dec. 13, 2013), http://articles.latimes.com/2013/dec/13/business/la-fi-exchange-latinos-20131214 (describing Covered California's failure to hit enrollment targets for Latinos and how "missing out on this relatively young and healthy population could threaten the viability of the state exchange.").

32. *See* Robert Pear, *Not All Health Care Premiums are Paid Up, House Panel Says,* N.Y. TIMES (Apr. 30, 2014), http://www.nytimes.com/2014/05/01/us/politics/not-all-health-care-premiums-are-paid-up-house-panel-says.html (noting that some are questioning the accuracy of enrollment numbers based on the fact that some people who have signed up have failed to pay their premiums); *see also* Ezra Klein, *Obamacare Won't Get 7 Million Enrollees in 2014 – and That's Okay,* WASH. POST (Nov. 26, 2013), http://www.washingtonpost.com/blogs/wonkblog/wp/2013/11/26/obamacare-wont-get-7-million-enrollees-in-2014-and-thats-okay/ (explaining why the more important measure for reform's success is not the number of people enrolled, but the percentage of healthy people enrolled; also explaining that the Obama administration understood that getting the right ratio of healthy enrollees might take a couple of years).

early mistakes in order to improve their recruitment techniques and enrollment processes going forward.

II. WHY THE SALES ANALOGY IS USEFUL

The sales analogy seems particularly apt because the framework of reform depends significantly on an expansion of private insurance, sold through an exchange, also described as a virtual marketplace.[33] Through regulated market competition, consumers are supposed to have a meaningful and affordable choice of plans.[34] In fact, one of the outreach tools to inform consumers about the law and its benefits is a YouToons video developed by the *Kaiser Family Foundation* that likens the exchanges to shopping malls and explains how these new "malls" will give consumers affordable options and make shopping easy.[35]

Based on this design, the importance of effective selling comes into play at two critical junctures: in the initial, broad-based outreach to generate consumer interest in and knowledge about the law, which hopefully will lead them to visit the new exchanges; and in the selling that occurs at the exchange itself, where individuals receive more specific information about plan options and then purchase a plan. However, selling insurance is only part of what happens at the exchanges. Exchanges are also the place where the government will screen individuals for eligibility for free public programs and for subsidies to help pay for private insurance.[36] In addition, the exchanges, in conjunction with other regulatory agencies, can play an active role in regulating the quality and design of the plan products.[37] While this article focuses on the exchange as a virtual shopping mall for private insurance sales, it is very important to construct a theory of the government's selling role that is consistent with and reinforces its other public functions.

33. *See* Sabrina Corlette et al., *Plan Management: Issues for State, Partnership and Federally Facilitated Health Insurance Exchanges*, THE CTR. ON HEALTH INS. REFORMS & NAT'L ACAD. OF SOC. INS. 3 (2012), https://gushare.georgetown.edu/xythoswfs/webui/_xy-8409729_2-t_aPsiEpMD (describing the exchange as the "lynchpin" of the ACA's provisions to expand access to quality and affordable coverage).

34. *See id.* (listing the minimum certification requirements for qualified health plans, such as providing "enrollees with a sufficient choice in providers" and serving low-income and medically underserved populations).

35. *New Animation Explains Changes Coming for Americans Under Obamacare*, KAISER FAMILY FOUND. (Jul. 18, 2013), http://kff.org/health-reform/press-release/new-animation-explains-changes-coming-for-americans-under-obamacare/. The federal government uses a shorter animation to explain the new insurance marketplace specifically, likening it to shopping in a grocery store where it is easy to compare products and prices on its revamped health care reform information website. HEALTH INSURANCE MARKETPLACE, https://www.healthcare.gov/families/ (last visited Nov. 12, 2013).

36. Corlette et al., *supra* note 33.

37. *Id.* at 1 (explaining the level of responsibility and oversight that the states will continue to have for the design of plans offered in the exchange).

A. Theory of Effective Selling

The *Harvard Business Review on Sales and Selling*, a compilation of essays by business scholars and leading executives, offers an alternative theory to the kind of high-pressure selling that turns most people off.[38] In one essay titled "Low-Pressure Selling", Edward Bursk, former editor of the *Harvard Business Review on Sales and Selling*, describes a more effective and ethical approach to selling that does not attempt to "drive the prospect into a buying decision, but let[s] him reach the decision himself: not selling him, but letting him buy."[39] This is not a "weakening of the degree of selling effort", he explains, but rather a different way to try to influence the consumer to buy that requires a great deal of effort devoted to understanding the customer.[40] It involves asking the right questions, actively listening to understand consumers' needs, and providing truthful information that helps the consumer understand the product and its benefits, and in some cases helps them better understand their own needs.[41] The goal is to create a mutually beneficial relationship, or a "win-win", as salespeople like to say.

These sales techniques are based on studies about behavior and persuasion, but many proponents of this approach emphasize the importance of ethics, distinguishing between ethical methods for helping to uncover consumers' genuine needs and psychological tricks to make consumers want something that they do not need or that is not in their best interest.[42] Low pressure selling depends not only on the salesperson knowing how to uncover customers' needs, motivations, and desires; but the salesperson should also have a sincere interest and empathy for the customer that helps her find the right product to fit her needs.[43] While not all salespeople are concerned about this ethical distinction, it is important to those desiring a long-term relationship with their customers, a relationship that depends on customer trust.[44]

38. HARVARD BUSINESS REVIEW ON SALES AND SELLING (Harv. Bus. Press, 2009).

39. Bursk, *supra* note 8, at 152.

40. *Id.* at 152–53.

41. *Id.* at 160–61. *See generally* THOMAS A. FREESE, SECRETS OF QUESTION-BASED SELLING: HOW THE MOST POWERFUL TOOL IN BUSINESS CAN DOUBLE YOUR SALES RESULTS (2000) (discussing the benefits to the technique of "question based selling," which is based on the needs of the consumer).

42. Bursk, *supra* note 8, at 154, 158–59.

43. *Id.* at 154 ("[L]ow-pressure techniques will defeat their own purposes unless animated by a substantial degree of sincerity."); *see also* David Mayer & Herbert M. Greenberg, *What Makes A Good Salesman*, 84 HARVARD BUS. REV. 164, 166 (2006) (stressing the importance of empathy in effective selling).

44. Bursk, *supra* note 8, at 161. Bursk warns against the pyrrhic sale—where a shortsighted salesperson focuses on making a sale despite knowing that it is not really in the customer's interest. *Id.* This undermines trust and reduces the chance that the customer will return. *Id.* A salesperson may think that it is worth it under circumstances where the purchase is viewed as a big one-time purchase and the seller does not rely on a longer-term relationship and subsequent purchases. *Id.* But where sellers are seeking to build up trust to maintain longer term relationships, honesty is the more effective route. *Id.* Being honest about which products or

Diagnosing customers' motivations is not as simple as it may seem because customers may be motivated by a number of different needs—financial, personal, social or even political.[45] Moreover, some customers' needs may be latent.[46] It does not matter how likable a salesperson is, or how great the product is that she is selling; if the customer does not think he has a need for it, it will be very difficult to make a sale, especially in the case of a purchase that is as costly and complex as an insurance product.[47] Thus, in some cases, a salesperson must also act as a kind of educator—helping the consumer to uncover these latent needs so they become active. Only in this way can the consumer accurately value the product.[48]

Although the cost and value of a product are particularly salient factors in purchasing decisions,[49] other factors may make customers resistant to buying a product. When people say they cannot afford to buy something, it does not always mean that the person really cannot afford it; rather, customers may use this to rationalize a decision based on a far more complex set of emotional, social, or other reasons for avoiding the purchase, such as fear or doubt.[50] If such feelings are influencing the decision-making process, then merely highlighting a product's benefits will not work; a salesperson must use a more interactive or question-based approach to selling in order to identify, and then effectively address, the sources of resistance.[51]

The more complex the product, the more important the assistive and educative role that salespersons must serve.[52] Possessing an abstract understanding

services the customer does not need helps the salesperson build the kind of trust that can lead to a longer term relationship and even greater sales. *Id.*; *see also* Benson P. Shapiro, *Manage the Customer, Not Just the Sales Force*, 52 HARVARD BUS. REV. 127, 132–33 (1974) (The Pyrrhic sale is "one that immediately benefits the company but jeopardizes its future relationship with the account.").

45. *See* Thomas V. Bonoma, *Major Sales: Who Really Does the Buying*, 84 HARVARD BUS. REV. 172, 179 (2006) (detailing the varying reasons why customers purchase health insurance).

46. *See id.* (explaining that due to some buyers' uncertainty about their own needs, "buyers ordinarily are not certain that purchasing the product will actually bring the desired benefit.").

47. *See* Shapiro, *supra* note 44, at 133 (noting that salespeople are both merchandisers and ombudspersons for the customer).

48. *See* FREESE, *supra* note 41, at 72–78 (explaining how important it is for the salesperson to expose the customer to latent needs and help transform them into active needs, thereby increasing sales); *id.* at 68 (explaining how important it is that the customer feels that there is a "need," for the product, as "without needs there are no solutions; and without solutions, it's virtually impossible to establish value.").

49. *See generally id*. at 68.

50. *See generally id.* at 82–86 (discussing the importance of a relationship between salespeople and their customers, because without one, customers are "reluctant to openly share" their "thoughts, feelings, and concerns with someone they don't know.").

51. *See generally id*. at 79 (discussing the importance of asking questions in order to gather information and establish credibility, and detailing which questions to ask and how to properly ask those questions).

52. *See* Shapiro, *supra* note 44, at 134 (noting that "[w]hen the selling task is complex, the salesperson may actually be called on to 'design the product' for the customer").

about why a product is useful is not the same thing as having the ability to understand and evaluate the quality of a product, the ability to make a cost-benefit determination based on one's individual circumstances and need for that product, or the ability to make an informed comparison between different product brands. A customer's ability to do these things depends on the seller's ability to effectively educate consumers without overwhelming them with too much information; that is, an effective seller can provide product information in a simplified but meaningful way that empowers consumers to make an informed choice.[53] Like diagnosing customers' motivations, understanding how to help customers easily navigate product choices and make informed choices depends on a customer-centered approach to the selling process that identifies and is mindful of customers' needs and ability to process information.[54] The more customers must rely on salespersons' technical knowledge to aid decision-making, the more important trust becomes.

In light of these principles of effective selling, there are at least three special circumstances in which low-pressure selling is particularly effective: when continuing goodwill is necessary; when specialized knowledge and technical help are particularly valuable to consumers; and when the purchase is of more than ordinary significance, monetarily or otherwise.[55] The selling of health insurance fits all three.

B. Selling Insurance as Part of Health Reform

Several characteristics of the individual insurance market suggest that this theory of effective selling may provide important tools and lessons that can enhance enrollment results. The first is the complexity of the insurance product. In order to make informed purchasing choices, most consumers will need assistance in understanding and evaluating insurance products.[56] Politically salient refrains from reform proponents about how the ACA will preserve and enhance consumer choice are now bumping up against the reality that many consumers may not know how to exercise this choice once the exchanges are up and running.[57] The details of

53. *Id.* (explaining that "the salesperson operates in a customer-oriented, client-centered, problem-solving mode"); *see also* Bursk, *supra* note 8, at 159 (describing how a customer's feeling of confidence in the salesperson can produce sales, particularly when specialized knowledge about a particular product or topic is valued).

54. *See* Bursk, *supra* note 8, at 161 (identifying how essential it is for a salesperson to think about the customer's specific and individual needs when attempting to sell a product).

55. *See id.* at 159.

56. *See* INST. OF MED., FACILITATING STATE HEALTH EXCHANGE COMMUNICATION THROUGH THE USE OF HEALTH LITERATE PRACTICES: WORKSHOP SUMMARY 2, 16–17 (2012) [hereinafter HEALTH EXCHANGE COMMUNICATION] (describing the difficulty consumers face when shopping for insurance in the individual or small business markets, and the extent to which they rely on brokers or simply opt into the default plan).

57. *See, e.g.*, Sarah Dash, et al. *Implementing the Affordable Care Act: Key Design Decisions for State-Based Exchanges*, THE COMMONWEALTH FUND (July 11, 2013),

implementation are getting more attention as people ask questions such as how many plans will be offered, how will consumers get information about the plans, how will they learn about whether they qualify for subsidies, and how easy will it be for consumers to compare the benefits and costs of different plans.[58] Notably, a recent *Washington Post* article titled, "Do You Understand Health Insurance? Most People Don't",[59] describes the not-so-promising results from a study published in the *Journal of Health Economics* of consumers' ability to understand the insurance products that will be offered on the exchanges.[60]

Second, in light of this complexity, the relationship between the seller and customer is very important. In sales, there is a general presumption that people want to buy and that they enjoy the idea of the thing or service they are purchasing;[61] but we know from studies of consumers that many people dread buying insurance, while others are skeptical about its value.[62] Moreover, as already noted, the most desirable customers—the young and healthy—may be the most challenging to reach because their perceived need may not be significant enough to overcome this dread.[63] One cannot successfully sell insurance without overcoming

http://www.commonwealthfund.org/Publications/Fund-Reports/2013/Jul/Design-Decisions-for-Exchanges.aspx (discussing the importance of the Marketplace design and architecture of plan options for ensuring meaningful consumer choice); *Creating a Usable Measure of Actuarial Value*, CONSUMERS UNION, 1–3 (Jan. 12, 2012), http://consumersunion.org/pub/pdf/CU_Actuarial_Value_2012_Report.pdf (summarizing a meeting on how actuarial value will be employed under the health reform law and how to craft a measure usable by consumers); Kliff, *supra* note 17 (explaining that deciding between different health care insurance options is "inherently complicated," and therefore, there is a general lack of understanding amongst potential healthcare insurance customers).

58. *See* Bruce Jaspen, *Americans Don't Understand Insurance, Let Alone Obamacare, Research Shows*, FORBES (Aug. 10, 2013, 10:35 AM), http://www.forbes.com/sites/brucejapsen/2013/08/10/americans-dont-understand-insurance-let-alone-obamacare-study-shows/ (explaining that "research is mounting that shows consumers don't understand health insurance, let alone key aspects of the landmark health law"); *see also* Amanda Gengler, *Obamacare: Your 12 Biggest Questions Answered*, CNN MONEY (Sept. 23, 2013, 4:15 PM) http://money.cnn.com/2013/10/01/pf/obamacare-insurance.moneymag/ (discussing the public's top questions concerning Obamacare and its policies).

59. Kliff, *supra* note 17.

60. *See id.* (noting that in a study of people who were already insured and responsible for making insurance decisions, only fourteen percent were able to correctly define four basic insurance terms and even fewer were able to figure out the cost of a four-day hospital stay based on a hypothetical insurance plan).

61. *See* Kit Yarrow, *Why "Retail Therapy"* Works, PSYCHOLOGY TODAY (May 2, 2013) http://www.psychologytoday.com/blog/the-why-behind-the-buy/201305/why-retail-therapy-works (describing the positive psychological effects of making purchases as found by a marketing study).

62. HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 28, 52.

63. *See id.* at 49–51 (describing the many challenges involved with attempting to educate consumers about the value of health care in order to overcome widespread aversion to entering the health care market); *see also* Gorman, *supra* note 21 (noting the reluctance of young people to enter the health care market due to a perceived lack of necessity).

this resistance, and this may take a great deal of effort.[64] Based on the effective sales principles articulated above, a salesperson has the best chance at overcoming this resistance if she has a genuine desire to understand the consumer's motivation and resistance, uses education and other tools to make the shopping experience easier and more pleasant for the consumer, and is able to engender the kind of trust that makes consumers more willing to rely on the seller's expertise. Based on the theory of low-pressure selling, empathy, honesty, and trust are critical for building long-term relationships.[65]

Third, several elements of the low-pressure theory of selling—the customer-centered approach, techniques like active listening and strategic questioning, and empowering consumers to make meaningful purchasing decisions—echo the recommendations of those addressing a different, yet related problem of low health literacy.[66] There has been a slow, but growing recognition among government health agencies, health policy analysts, consumer and patient advocates, educators, insurers, and providers of the problem of low health literacy and its impact on people's access to care. Health literacy experts have worked with these groups to improve consumers' health literacy skills, in part by improving our health care delivery and financing systems to make them more accessible and navigable.[67] Most of this work has focused on health care delivery and patients' self management of disease; however, in the last few years, as health reform has become a reality, the focus has turned to improving consumer insurance literacy and creating health literate insurance markets.[68] As developed further in Parts III, IV and V, studies on health literacy provide insight into a variety of consumer behaviors that are relevant to the success of selling insurance, such as why consumers find purchasing insurance so dreadful, what skills are needed for understanding and valuing insurance, and how exchange design, consumer assistance, and the choice architecture for plans can make consumers' experiences simpler and less unpleasant.[69]

64. *See generally* HEALTH EXCHANGE COMMUNICATION, *supra* note 56 (detailing problems and potential solutions involved with health care exchanges necessary for the operation of the ACA).

65. *See* Bursk, *supra* note 8, at 152–60 (describing low-pressure sales tactics, and the justifications for using the same); Ramana Kumar Madupalli, SALESPERSON BEHAVIORAL DETERMINANTS OF CUSTOMER EQUITY DRIVERS: MEDIATIONAL ROLE OF CUSTOMER TRUST 16, 19 (2007) (referencing personality traits that have a positive effect on sales).

66. *See infra* Part IV.A.

67. OFFICE OF DISEASE PREVENTION & HEALTH PROMOTION, U.S. DEP'T OF HEALTH & HUMAN SERVS., NATIONAL ACTION PLAN TO IMPROVE HEALTH LITERACY 3–6 (2010) [hereinafter NATIONAL ACTION PLAN].

68. *See* HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 2 (describing the Institute of Medicine's goals in convening the Roundtable on Health Literacy as an attempt to educate the public, press, and policy makers on the issue of health literacy).

69. *See id.* at 28, 52 (describing studies that have indicated fear on the part of insurance shoppers).

Finally, trust is critical in health reform because the goals of reform are not to achieve a one-time sale of a product, but rather to build a relationship and influence behavior in the long term: the government wants people to get and stay insured as a means of providing individual financial security and health care, as well as to ensure adequate support for health care infrastructure. Indeed this is why reform includes efforts to expand and streamline Medicaid enrollment, and to try to prevent disruption in care that often results from churning.[70] Importantly, government views insurance as a behavioral tool:[71] it wants people to use their insurance to get the *right kind of care* at the *right time;* it also wants to reduce or eliminate the costs resulting from preventable emergency care and bankruptcies due to medical debt.[72] Insurance is simply a means to an important and complex end.

Trust is also critical because of the broader role that government serves as policy setter, educator, regulator, and benefit provider. To the extent that government is acting partly as a seller, or at least as putting its imprimatur on the sale of private insurance through the exchanges, it is asking people to trust the government's capacity and willingness to use its regulatory power to ensure access to affordable and quality care. Even though private insurance plans are being sold on the exchange, the government has made promises about the quality of the insurance product (how affordable and meaningful it will be),[73] about how the exchanges will work (how seamless and streamlined they will be),[74] and about the fact that everyone will be required to share in the responsibility for this new system (plans, providers, government, employers, and individual consumers) in order to make it work.[75] The government has to be particularly mindful of its relationship with consumers given that the ultimate service relationship is between the insurer and the consumer; how well the insurer serves the consumer could ultimately impact consumers' trust in government. And we know that lack of trust in the

70. *See* Dash et al., *supra* note 57, at 10–11 (describing state attempts to simplify Medicaid eligibility); *see also* Cindy Mann, *Letter to State Health Officials and State Medicaid Directors Regarding Facilitating Medicaid and CHIP Enrollment and Renewal in 2014*, DEP'T OF HEALTH & HUM. SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS. 1, 1–2 (May 17, 2013), *available at* http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-003.pdf (suggesting strategies and guidance for states in attempting to increase Medicaid enrollment eligibility).

71. *See* Cass R. Sunstein, *Social Norms and Social Roles*, 96 COLUM. L. REV. 903, 913 (1996) (explaining that governmental regulations are often tailored to alter behaviors and norms). This is consistent with the government's health literacy goals to improve a patient's ability to get important health information and properly self manage care. NATIONAL ACTION PLAN, *supra* note 67, at 1.

72. *See* Katherine Brandon, *The President on Health Care: "We are Going to Get this Done"*, WHITE HOUSE BLOG (July 17, 2009, 5:42 PM), http://www.whitehouse.gov/blog/The-President-on-Health-Care-We-are-Going-to-Get-this-Done (referencing President Obama's remarks on the goals of health care reform).

73. *Id.*

74. *Id.*

75. *Id*.

government can be particularly dangerous in the area of health.[76] The relationship and trust so essential to a successful sale of insurance are precious assets in their own right—assets that the government cannot afford to lose.

III. DIAGNOSING MOTIVATION IN THE UNINSURED

A key concept underlying the theory of low-pressure selling is to know your customer.[77] Through techniques such as strategic questions and active listening, salespeople learn about their customers' needs and motivations, as well as any factors, such as fear or doubt, that make people reluctant to buy even when they have a need.[78] This helps sales people become more effective because they can determine what information is important and necessary for customers to be effective shoppers.[79] It is also important so that the person develops a genuine empathy and trust, which increases the likelihood of building a longer term relationship that yields continuing business in the future.[80]

When sales books provide tips for getting to know your customer, they tend to focus on the one-on-one interactions between the salesperson and buyer, but health reform is a massive undertaking by the federal government, in partnership with some states. The initial sales pitch is targeting millions of the uninsured to educate them about the law and to direct them to the exchanges where they can get more specific information and personalized assistance.[81] Although the more intimate relationship building between salesperson and prospect is not feasible at this stage, it is important to have a general understanding of the uninsured and what matters to them in order to effectively communicate with them. And we do have useful information about the uninsured that should inform outreach. Some of this information comes from surveys and polling of the general public, while some comes from more in-depth studies of consumers' health literacy and experiences in

76. *See, e.g.*, RANDY SHILTS, AND THE BAND PLAYED ON, xxii–xxiii (1987) (describing how discrimination and neglect of the LGBT community created mistrust of the government, which subsequently undermined their early HIV education and prevention efforts).

77. This theme underlies the recommended approaches to effective selling. *See, e.g.*, FREESE, *supra* note 41, at 31–34 (emphasizing the importance of question-based selling to uncover customers' needs and then educating customers on how that product may help them solve those problems); Bursk, *supra* note 8, at 155 (explaining why sales people should use question-based strategies for learning more about their customers' problems and then respond by helping to solve those problems).

78. *See* FREESE, *supra* note 41, at 31–34 (describing the theories behind question-based selling); Bursk, *supra* note 8, at 157 (explaining how these selling techniques can overcome resistance to sales).

79. *See* FREESE, *supra* note 41, at 31–34 (noting the potential sales to be gained by using question-based selling); Bursk, *supra* note 8, at 155–59 (describing reasons for the effectiveness of low pressure sales tactics).

80. *See* Mayer & Greenberg, *supra* note 43 and accompanying text (stressing the importance of empathy in effective selling).

81. Gorman, *supra* note 21 (describing efforts to educate and enroll people in health care exchanges).

buying insurance on exchanges similar to the model in the ACA.[82] With so many sources of information about a large and diverse population, it can be challenging to generalize in a meaningful way, but there are some important themes, which are described more fully in this Part.

A. Why People Do Not Have Insurance

The legislative history of the ACA cites to the fact that prior to the ACA over 47 million people were chronically uninsured, and when people experiencing temporary periods of unemployment are included, the number almost doubles.[83] The top reasons people give for being uninsured include job loss or employer's failure to provide insurance; and for those relegated to the individual insurance market, many report being refused coverage due to a preexisting condition or bad health history, or being unable to afford insurance.[84] This suggests that most people would buy insurance if they could, but that there is some structural barrier in their way. Such barriers, in theory, should be easily fixable through health reform—the exchanges should help ensure the availability and accessibility of a product for which there is already demand. In other words, the product should sell itself. But polls and studies of consumers' buying practices suggest a much greater challenge.

According to polls, many people are still unaware of important aspects of health reform.[85] For example, the latest Gallup poll shows that while eighty-one percent of U.S. residents are aware of the law's mandate, "about 43% of uninsured individuals don't know about it."[86] A 2012 survey by a Democratic polling firm

82. *See infra* Part III.

83. *See New Health Insurance Survey: 84 Million People Were Uninsured for a Time or Underinsured in 2012; Nearly Decade-Long Trend of Rising Uninsured Rates Among Young Adults Reversed*, COMMONWEALTH FUND (Apr. 26, 2013) http://www.commonwealthfund.org/~/media/Files/News/News%20Releases/2013/Apr/Biennial%20Release%2042613%20FINAL%20rev%202.pdf.

84. *See id.* (describing problems that the uninsured face with receiving medical care and the impact of medical debt) *see also The Clock is Ticking: More Americans Losing Coverage*, FAMILIES USA 1–4 (July 2009), http://www.familiesusa.org/assets/pdfs/health-reform/clock-is-ticking.pdf (providing statistics on the numbers of uninsured during 2007–2008 and estimates on the number of people expected to continue losing coverage); John Graves & Sharon K. Long, *Why Do People Lack Health Insurance?*, URBAN INSTITUTE 1 (2006), http://www.urban.org/UploadedPDF/411317_lack_health_ins.pdf (explaining that "[t]he recent rise in uninsurance has been attributed to a number of factors, including rising health care costs, the economic downturn, an erosion of employer-based insurance, and public program cutbacks"); Alison Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 AM. J.L. & MED. 7, 8–9, 17–19, 60–63 (2010) (describing why the fragmented healthcare market has left so many uninsured and critiquing whether the ACA can effectively address this problem).

85. *See* Anthony Wilson, *Health Reform Polls Are Inconsistent and Confusing. Should We Still Pay Attention?*, CAL. HEALTHLINE (July 24, 2013), http://www.californiahealthline.org/road-to-reform/2013/health-reform-polls-are-inconsistent-and-confusing-should-we-still-pay-attention (noting that health reform poll results fluctuate and indicate confusion among the population).

86. Wayt, *supra* note 1.

found that seventy-eight percent of the "uninsured Americans who likely would qualify for subsidies were unfamiliar with the new coverage options."[87] And in research of lower-income adults in three states, none of the participants had heard of the Exchange or associated it with health reform.[88] This reveals a serious knowledge gap, for which education is critical. In sales, it does not matter if you have a great product if no one knows about it.[89] And as already explained, the consequences for health reform are more serious because the quality of the product depends on how consumers behave in the market—the market can only offer quality and affordable coverage if enough healthy people enroll to help spread the risk and keep insurance rates affordable.[90]

Equally important is what polling fails to elicit about what people actually mean when they say that insurance is too expensive. In some cases, most obviously the case of someone with a preexisting condition and risky health history, plans are priced at prohibitively expensive rates to offset the degree of risk that plans believe they will be assuming. But prior to health reform, a number of comparatively healthy consumers—the desirable consumers that plans want and need to attract—also reported being priced out of the market.[91] While insurance plans may indeed have priced plans at unreasonably high rates for these consumers, there is no clear consensus on what price would be affordable or reasonable to any given consumer.

When a consumer says that a plan is unaffordable, it could mean several things. It could mean that the consumer does not have any extra money to spend on health insurance because all of his income is being used for more important necessities. But what about those with a small amount of disposable income: might consumers have enough money if they cut back on non-necessities? How does one determine what is a luxury or necessity, and where insurance should fall in the list of priorities? If one has to forego other things, how does this factor into the "cost" part of a consumer's cost-benefit analysis of insurance? What about the "benefit" side - how do consumers understand and value the benefits of insurance?

87. *Id.*

88. Lake Research Partners, *supra* note 10, at 18.

89. *See* Tara Gustafson & Brian Chabot, *Brand Awareness*, 105 CORNELL MAPLE BULLETIN 1 (2007), http://www.nnyagdev.org/maplefactsheets/CMB%20105%20Brand%20Awareness.pdf (noting the importance of consumer brand awareness in relation to the likelihood of sales).

90. *See supra* note 30; *see also* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2585 (2012) (describing the importance of preventing adverse selection where only those with a higher risk enter the individual insurance market, driving risk up so much that insurance becomes unaffordable or insurers leave the market).

91. *See* Sy Mukherjee, *Most Young Americans Want to Buy Health Insurance, But They Can't Afford It*, THINKPROGRESS (June 19, 2013,3:50 PM) (showing that Americans' number one barrier to getting coverage is cost, and explaining how reform could allow a young, healthy adult who was previously priced out of the market to afford coverage).

To complicate things further, a consumer's own perception of affordability may change depending on the way information is presented.[92] For example, in one research study by *PerryUndem Research*, when asked whether a $210 premium was affordable, only twenty-nine percent of participants said yes.[93] But when researchers rephrased the question to explain how, with tax credits, the participants would save "$1,908 a year compared to what they would pay on their own," forty-eight percent of the participants said they thought the same plan was affordable.[94]

The above questions and examples illustrate the difficulty of predicting consumer behavior. As a foundational matter, consumers must have the ability to understand and assign a *quantitative* value to the benefit and cost of insurance, enabling the consumer to make a rational decision about whether to purchase insurance and to compare different plan choices based on the estimated out-of-pocket cost and financial savings. But there are a number of cognitive or emotional factors that can influence the *qualitative* value and priority a consumer places on insurance. Recall that the statement that one cannot afford something can mask some other emotional or social reason for avoiding the purchase.[95] Admittedly, identifying every factor that influences insurance valuation is difficult, but Part IV explores some of the more common ones.

B. Why People Buy Insurance

Some people view insurance as a means for helping them get the care they need to stay healthy or deal with sudden illness, as well as providing financial protection against unexpected medical bills.[96] But many consumers either question or do not fully appreciate the benefit of the latter goal:

> Many view [insurance simply] as prepaid health care rather than health insurance—thus . . . [i]f the anticipated annual out-of-pocket expenses for health care are less than the cost of insurance premiums and the plan deductible, consumers often feel that insurance is not a good value. The critical concept that is missing is that insurance protects individuals and families from *unexpected* health crises. Many

92. *See Kaiser Health Tracking Poll – March 2011*, KAISER FAMILY FOUND., (Mar. 28, 2011), http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-march-2011/ (describing how respondents' opposition to the mandate fell significantly after being told that most Americans would automatically satisfy the requirement through employers' coverage, and also fell when told that, without the mandate, people might wait until they get sick to buy insurance).

93. Ezra Klein & Sarah Kliff, *Obama's Last Campaign: Inside the White House Plan to Sell Obamacare*, WASH. POST (updated July 17, 2013), http://www.washingtonpost.com/blogs/wonkblog/wp/2013/07/17/obamas-last-campaign-inside-the-white-house-plan-to-sell-obamacare/.

94. *Id.*

95. *See supra* note 50 and accompanying text.

96. Lake Research Partners, *supra* note 10.

> consumers do not understand this basic principle of insurance. . . . Consumers will not be in a position to choose a plan if they do not understand the basic value and purpose of health insurance.[97]

Although there is no magic formula for predicting how any one consumer will value insurance, we do know why certain groups of the uninsured are likely to devalue insurance in ways that could undermine enrollment goals. To the extent that insurance is viewed primarily or solely as a means to pay for predictable health care needs, insurance will likely be perceived as less valuable where there is not an immediate or active health need, as in the case of the young and healthy. To be fair, this is not true of all young adults, and in fact some take offense to the characterization that they think of themselves as invincible.[98] Indeed there is a movement among younger adults, ironically called "the Young Invincibles," to educate others about the need for insurance and to encourage enrollment.[99] Nonetheless, there are enough examples of young people citing good health as a reason for not having insurance, suggesting that generally they do not value it as highly as others. Government will have to work harder to educate many of these consumers in order to help them understand why they need and should want to buy insurance now.[100]

The act of selling can be very difficult when it serves a need that a prospective consumer may not yet realize. Freese makes this point in the *Harvard Business Review on Sales and Selling* when he talks about "latent needs," which "are needs that do exist but haven't yet surfaced as problems or desires."[101] Freese uses life insurance as an example, which functions in much the same way as the traditional *insurance* function of health insurance as future protection against an unexpected event (as opposed to its facilitation of access to health care).[102] Freese notes that latent needs may exist due to ignorance or the failure to appreciate why a potential event creates a current need for a particular product.[103] Indeed, both may be a serious challenge for enrollment efforts based on health care polling demonstrating a knowledge gap about health reform specifically and insurance generally.[104] Consumers are likely not armed with the kind of information they

97. HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 28.

98. Klein & Kliff, *supra* note 93.

99. Gorman, *supra* note 21; *see also Why Get Covered*, YOUNG INVINCIBLES (last visited Nov. 21, 2013), http://younginvincibles.org/issues/health-care/why-get-covered/ (providing more information about social activism to encourage young adults to sign up for health insurance).

100. Gorman, *supra* note 21.

101. FREESE, *supra* note 41, at 72.

102. *Id.* at 72–73.

103. *Id.*

104. *See* Dave Ranney & Mike Shields, *Knowledge Gap: The ACA Is Coming But Who Knows?*, KAN. HEALTH INST. (May 13, 2013), http://www.khi.org/news/2013/may/13/knowledge-gap-aca-marketplace-coming-who-knows/ (discussing how an overwhelming number of people expected to benefit from health reform still know very little about the law behind it or how it will

would need to appreciate and quantify the risk that an unexpected illness or accident might occur. Similarly, most health consumers lack data or experience with how much a given illness could cost – that is, the cost to treat and the other financial consequences of illness, like lost income.[105] This creates a challenge from a sales perspective to not only educate young adults about the law, but to increase their sense of urgency by raising their awareness of these risks.[106]

One wonders how effectively the government will be able to do this on a massive scale, given this underestimation of need among younger adults. Reinforcing this view, the oft-repeated label "young and healthy" suggests a link between youth and health, ignoring the many unpredictable events that can rob one of health instantly, regardless of age; the label also implicitly suggests that whether one is healthy or unhealthy is an easily identifiable state of being. As noted in the introduction, reform opponents reinforce this perception through their characterization of reform as an unwanted or unneeded product. Even five Supreme Court justices—Roberts, Scalia, Kennedy, Thomas, and Alito—embraced this characterization, despite having been presented with statistics about the incidence and cost of emergency care for the uninsured, as well as the other longer term costs for those of all ages who are disabled by unexpected illness or accidents.[107]

Even assuming that the government's outreach efforts are successful in helping younger and healthier people better *understand* future risks and current needs for health insurance, an important question remains about how these groups *value* the health and financial benefits in light of their individual circumstances. Certainly these benefits are likely to be valued more highly by people with children and assets to protect. But will educating younger adults about the link between bankruptcy and medical debt make them more likely to value insurance if they have not amassed much yet? If they do not have kids? If they view their future as uncertain?

work in practice); *see also* Robert Joiner, *Scholars Pinpoint Gaps in Consumer Knowledge of Health Insurance Jargon*, ST. LOUIS BEACON, Oct. 21, 2013, 6:52 AM, https://www.stlbeacon.org/#!/content/33298/health_care_jargon_101713 (discussing recent research showing that many consumers new to purchasing health insurance are unable to understand concepts and terms integral to insurance itself, such as "deductible" and "co-payment").

105. *See, e.g.*, Allison K. Hoffman & Howell E. Jackson, *Retiree Out-of-Pocket Healthcare Spending: A Study of Consumer Expectations and Policy Implications*, 39 AM. J.L. & MED. 1, 53–57, 2013, *available at* https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2214643 (finding that a disproportionate number of survey respondents underestimated their future spending on health care costs).

106. *See* FREESE, *supra* note 41, at 74 (explaining how transforming latent needs into active ones will escalate a prospect's sense of urgency and thus motivate his decision to go through with a purchase).

107. *See* Nat'l Fed. of Ind. Bus. v. Sebelius, 132 S. Ct. 2566, 2646 (2012) (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting) (holding that a legal mandate to purchase insurance could not be justified under the Commerce Clause).

IV. FACTORS THAT CREATE RESISTANCE TO BUYING INSURANCE

One reason given for the effectiveness of low-pressure selling techniques is the assumption that people *like* to buy. According to Bursk: "[T]he act of buying gives the normal person a sense of pleasure. There is a certain feeling of power in being able to acquire things, entirely apart from any anticipation of enjoying the products or services bought."[108] Bursk and other experts acknowledge, however, that there are many reasons why people may be resistant to buying.[109] Bursk defines "resistance" as "the emotional state of mind—fear, doubt, caution, or whatever it may be—that in a particular sales situation keeps the prospect from buying as readily as he otherwise would."[110] He excludes from this concept of resistance "any 'holding off' due to a rational consideration of the wisdom of the purchase."[111]

Insurance is probably one of the best examples of a product that triggers this kind of resistance. Unlike many other items, there is nothing inherently pleasurable in thinking about the benefits of insurance since having it means confronting the reality of illness or injury, as well as huge medical bills that could be financially devastating. Depending on one's level of awareness or concern about health and financial security, getting insurance may bring a sense of relief, but the notion that someone would anticipate *enjoying* insurance is unrealistic. Moreover while *having* insurance may bring relief, we know that *shopping* for insurance causes dread. Even where consumers recognize a need for insurance and can afford it, there are other factors that may make consumers resistant to buying insurance.[112] This Part takes a closer look at these factors.

A. Complexity & the Challenge of Health Literacy

Insurance is a complex product, and the ability to understand insurance and compare the values of different plans assumes a level of health literacy that most people do not have. The concept of health literacy may sound simple, but it is not as easily defined or measured as one might expect.[113] HHS defines health literacy as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."[114] This includes the ability to read and understand materials relating to

108. Bursk, *supra* note 8, at 156.

109. *See, e.g.*, *id.* at 157 (identifying some of the many deterrents that a buyer might face, such as conflicting claims on a prospect's limited time, past unfavorable experiences, and mere habit).

110. *Id.*

111. *Id.*

112. *See infra* Part IV.

113. *See, e.g.*, INST. OF MED., HEALTH LITERACY A PRESCRIPTION TO END CONFUSION 5 (2004) [hereinafter PRESCRIPTION TO END CONFUSION] (explaining that health literacy is a shared function of many factors, which are further mediated by larger societal influences).

114. *Id.*

health insurance.[115] The Institute of Medicine (IOM) provides a more expansive definition of health literacy as "a shared function of social and individual factors . . . mediated by [] education,. . . affected by culture, language, and the characteristics of health-related settings, [and] shaped by a health context [that] includes the media, the marketplace, and government agencies."[116] Thus health literacy is not only determined by a person's own literacy skills; it is shaped by the level and complexity of relevant reading materials, the communication skills of the person crafting the message, and the design of media and information technology used to disseminate the information.[117]

Health literacy is determined in part by one's basic literacy skills: both require comprehension skills relevant to reading and understanding health insurance information, and numeracy skills necessary for estimating cost and savings.[118] But health literacy refers to a more comprehensive set of skills and ability to process the kind of information that is typically required for health care decisions, including those relating to insurance.[119] Among the various kinds of health-related information one must digest, insurance documents can be the most complicated. Many of these forms are written at a level that is much higher than other kinds of consumer materials and much higher than is recommended by health literacy experts.[120]

This gap between the level of information presented and consumers' health literacy is serious enough that the government has labeled poor health literacy a public health problem and a silent epidemic.[121] According to the 1992 National Adult Literacy Survey of English-speaking adults in the U.S., approximately ninety million people have literacy below a high school level, lacking the literacy skills

115. *Health Literacy Fact Sheets*, CTR. FOR HEALTH CARE STRATEGIES (Oct. 2013), http://www.chcs.org/usr_doc/CHCS_Health_Literacy_Fact_Sheets_2013.pdf [hereinafter *Health Literacy Fact Sheets*].

116. PRESCRIPTION TO END CONFUSION, *supra* note 113, at 5.

117. *See id.* at 5, 12 (discussing the many factors that affect health literacy, such as the skills of those providing information and services, culture and media, and education).

118. *See id.* at 7 (explaining how current health literacy measures are indicators of ordinary reading skills, such as reading comprehension and numeracy, whereas health literacy incorporates a broader range of skills).

119. *See Health Literary Fact Sheets*, *supra* note 115 (explaining that health literacy means the skills necessary for an individual to participate in the health care system and maintain good health, such as understanding insurance paperwork).

120. *Compare id.* (explaining that easily understood information is roughly at a fifth-grade level, and that newspapers and magazines are generally at the tenth and twelfth-grade levels, respectively), *with* PRESCRIPTION TO END CONFUSION, *supra* note 113, at 8–11 (explaining how many studies have shown that most health-related materials far exceed the reading skills of the average high-school graduate).

121. NATIONAL ACTION PLAN, *supra* note 67, at 3, 4, 7; PRESCRIPTION TO END CONFUSION, *supra* note 113, at xiii.

necessary to successfully navigate an insurance system.[122] The 2003 National Assessment of Adult Literacy (NAAL) survey found not much improvement in the literacy rates, and for the first time it tested health literacy specifically. Of 19,000 adults surveyed, only twelve percent were considered proficient, fifty-three percent had intermediate health literacy, twenty-two percent had basic health literacy, and fourteen percent were below basic.[123] Someone with an intermediate, basic, or even below basic level of health literacy may be able to perform some tasks relating to the health care treatment process. But insurance-related activities, such as locating the definition of a medical or insurance term by searching a complex document, or calculating one's share of health insurance costs for a year by using a table of cost based on income and family size, are the kinds of skills that require "proficiency"—the highest level of health literacy, which only twelve percent of those surveyed met.[124] The picture is even bleaker because the NAAL survey focused only on health literacy *skills*, as opposed to the level of *knowledge* people have about certain health-related facts and terminology.[125] This knowledge and familiarity of terms is just as important an influence on one's ability to comprehend insurance information.

Although the government has been relatively slow in identifying health literacy as a serious barrier to health care access and good health outcomes, it has sharpened its focus on this problem as a potentially significant barrier to consumer enrollment in the exchanges that must be addressed if reform is to be successful. Part V will describe some proposed solutions, but first this part highlights the specific health literacy challenges presented by our new virtual shopping insurance malls. Much of the information that we have on these challenges comes from studies that were compiled and reviewed as part of a workshop held by the IOM titled "Facilitating State Health Exchange Communication Through the Use of Health Literate Practices" (Exchange Communication Workshop).[126] The Exchange Communication Workshop focused on the health literacy of the target demographic for the exchanges—the uninsured. The IOM also held workshops and produced helpful summaries on related topics, such as "How Can Health Care

122. IRWIN S. KIRSCH ET AL., ADULT LITERACY IN AMERICA: A FIRST LOOK AT THE FINDINGS OF THE NATIONAL ADULT LITERACY SURVEY, NAT'L CTR. FOR EDUC. STATISTICS, xv–xvii (2003), *available at* http://nces.ed.gov/pubs93/93275.pdf.

123. MARK KUTNER ET AL., THE HEALTH LITERACY OF AMERICAN'S ADULTS RESULTS FROM THE 2003 NATIONAL ASSESSMENT OF ADULT LITERACY, NAT'L CTR. FOR EDUC. STATISTICS, U.S. DEP'T OF EDUC., iii, v (2003), *available at* http://nces.ed.gov/pubs93/93275.pdf.

124. *See id.* at 5–7 (explaining the literacy levels and the key abilities associated with each level).

125. *See id.* at 3–4 (demonstrating that the health literacy scale only included tasks that fit "the definitions of prose, document, or quantitative literacy," and "none of the NAAL health tasks required knowledge of specialized health terminology.").

126. HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 1–3.

Organizations Become More Health Literate?"[127] and "Health Literacy Implications for Health Care Reform."[128]

Before exploring health literacy challenges, it is important to understand the demographic profile of the uninsured. First, the Exchange Communication Workshop reports that Medicaid and Medicare Managed Care enrollees have health literacy levels similar to those of the uninsured, which means we can glean useful health literacy information from studies of these enrollees as well.[129] Second, the Exchange Communication Workshop report and other studies reveal an uninsured population that is ethnically diverse and includes a significant number of people with limited English proficiency (LEP).[130] LEP populations present additional challenges because they may require interpretation or translation services; but not all health care providers or public insurance programs are good at providing this assistance, despite legal requirements to do so.[131] Moreover, there is not as much information about the health literacy of LEP individuals, but there is information suggesting that LEP individuals tend to have lower health literacy and less knowledge of common health terms, even when their literacy is measured in their native languages.[132] This is due to a number of factors, especially less access to

127. INST. OF MED., HOW CAN HEALTH CARE ORGANIZATIONS BECOME MORE HEALTH LITERATE? 1–2, (2011) [hereinafter HEALTH LITERATE ORGANIZATIONS].

128. INST. OF MED., HEALTH LITERACY IMPLICATIONS FOR HEALTH CARE REFORM: WORKSHOP SUMMARY, 1–3 (2011).

129. HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 20.

130. *See* Klein & Kliff, *supra* note 93 (suggesting that the exchanges will attract "a diverse group of insurance buyers"); *see also* Kathy Robertson, *UC Davis will Use Covered California Grant for Spanish-Language Outreach*, SACRAMENTO BUS. J., May 17, 2013, http://www.bizjournals.com/sacramento/news/2013/05/17/uc-davis-covered-calif-grant-spanish-out.html (explaining how UC Davis plans to educate the almost 133,000 Latinos in California who are uninsured); Elizabeth Stawicki, *Connecting Minnesota's Latino Community to Health Care*, KAISER HEALTH NEWS (Jul. 12, 2013), http://www.kaiserhealthnews.org/Stories/2013/July/12/Uninsured-Latinos-In-Minnesota-and-Obamacare.aspx?utm_source=medicaretop&utm_medium=email&utm_campaign=071813 (explaining that one in eight Minnesota Latinos lacks health insurance and that health insurance "can be a foreign concept" that is difficult to understand for Latino immigrants).

131. *See* HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 8 (noting that states are not good at providing appropriate and health literate translation services for persons with limited English proficiency); *see also* Jimmy Vielkind, *Report: Language Access Isn't Great,* CAPITAL CONFIDENTIAL (Aug. 7, 2013, 5:38 PM), http://blog.timesunion.com/capitol/archives/192747/report-language-access-isnt-great/ (noting that despite an executive order to offer language assistance, sixty-three percent of citizens using state-operated facilities covered by the order did not receive language assistance).

132. *See* CTR. FOR HEALTHCARE DECISIONS, SHARING IN THE COST OF CARE: PERSPECTIVES FROM POTENTIAL HEALTH PLAN USERS OF THE CALIFORNIA HEALTH BENEFIT EXCHANGE 13–14 (June 15, 2012), *available at* http://www.healthexchange.ca.gov/BoardMeetings/Documents/CHCD_HBEX_Reportfinal.pdf [hereinafter SHARING IN THE COST OF CARE] (noting that in recent research about cost-sharing, some of the Spanish-language participants had never had health insurance, and though some were business owners or had high levels of education, they were unfamiliar with health insurance terms and concepts).

primary sources of important health information, such as regular doctor visits, mainstream media, and other public educational efforts that tend to be in English.[133]

Low health literacy is likely to make several aspects of buying insurance difficult for most, if not all, consumers. First, confusion about cost-sharing terms is a big problem. Consumers have trouble understanding terms like co-insurance, benefit maximum, allowed amount, and out-of-pocket maximum.[134] Consumers also have difficulty deciphering the differences between certain commonly used insurance terms like "preventive" versus "primary" care, "diagnostic" versus "screening" tests; or the term "specialty" drugs—terms reflecting differences in coverage and thus relevant to one's ability to accurately calculate or predict out-of-pocket costs.[135] Health literacy experts caution against using jargon and recommend the use of plain language instead of complicated terms of art where possible;[136] but participants in the Exchange Communication Workshop lament that they have not found plain language substitutes for these key cost-sharing principles yet.[137]

Confusion about terms is not the only problem; consumers also have trouble understanding how to apply the terms to accurately value a plan and compare it with others.[138] The Exchange Communication Workshop reports that most consumers do not have the skills or knowledge to apply cost-sharing terms in a meaningful way: "The computations that consumers must undertake to assess a plan's value are enormously complicated. Many consumers do not have the skills, health insurance familiarity, and confidence needed to calculate their share of costs."[139]

This knowledge and skills gap proved to be a challenge for Covered California (California's health benefit exchange) in its attempt to use stakeholder input to determine the optimal designs for the standardized plans offered through its exchange.[140] Covered California officials wanted to understand which aspects of insurance were most important to consumers.[141] Officials also wanted to understand the trade-offs consumers were willing to make—for example whether

133. *See, e.g.*, NAT'L COUNCIL ON DISABILITY, THE CURRENT STATE OF HEALTH CARE FOR PEOPLE WITH DISABILITIES 62 (2009) (explaining that the Deaf community faces similar barriers to information about health care as other minority groups due to their limited access to mass media).

134. HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 29; *see also* SHARING IN THE COST OF CARE, *supra* note 132, at 9–10 (noting the difficulty among some participants in understanding cost-sharing terms and their impact on cost).

135. *See* HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 29.

136. *Id.* at 29, 50.

137. *Id.* at 29.

138. *Id.*

139. *Id.*

140. *See* SHARING IN THE COST OF CARE, *supra* note 132, at 1–2 (noting that participants in the study found decisions regarding cost-sharing to be difficult).

141. *Id.* at 1–2.

consumers preferred a plan with a smaller deductible and greater co-insurance. The exchange contracted with the Center for Healthcare Decisions to design and conduct ten discussion sessions with uninsured Californians who were potential customers of the exchange.[142] As part of these sessions, researchers educated participants about the meaning of cost-sharing terms;[143] nonetheless, participants still had difficulty understanding the terms and how to use them to calculate their financial exposure (total out of pocket expenses) under a particular plan.[144]

This research also showed that consumers' trade-off preferences depended on their assumptions about the kind of care they might need, how much it might cost, and when they would need it.[145] Although this reasoning made sense in theory, some of the assumptions on which consumers based their decisions were not consistent with statistical information about the type of care people use. Once consumers were provided greater information about their specific concerns (for example, how likely it was that they would need hospital care versus other kinds of care), their insurance product design preferences changed.[146] This highlights the important role that health care knowledge plays in consumers' ability to make informed choices and choices that best meet their needs. At worst, if consumers do not have this information and feel unable to make an informed choice, they may simply not enroll. At best, if consumers are operating on the wrong information, they may choose a plan that is not the best one for their needs.

Beyond consumers' understanding of the insurance product itself, studies have been done to learn how the design of the exchange, and the choice architecture from which consumers must select and compare plans, can influence the shopping experience.[147] The IOM's Exchange Communication Workshop participants gleaned useful information from surveys of consumers who already had experiences with insurance exchanges in Massachusetts and Utah.[148] Market research showed that in both states consumers initially found the experience

142. *Id.* at 1. The Center for Healthcare Decisions is a nonpartisan, nonprofit organization based near Sacramento, California. Its website explains that it works with employers, policymakers, healthcare providers, government agencies, professional associations and community organizations to understand the public's views on health care, and to facilitate public deliberation around issues such as setting healthcare priorities and designing a fair benefits package. More information is available at http://www.chcd.org/whoweare.htm.

143. *See* SHARING IN THE COST OF CARE, *supra* note 132, at 1.

144. *Id.* at 17.

145. *Id.* at 10–13.

146. *See id.* at 10 (noting that "[w]hen participants were told that approximately 7–8% of all adults under age 65 are hospitalized each year, most were surprised by the low number" and it led to most of them to change their preference for plan design).

147. *See, e.g.*, HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 27 (explaining that exchange designers must first understand how consumers shop for health insurance).

148. *See id.* at 18 (noting that health insurance exchanges in Utah and Massachusetts learned from their experiences and were making changes).

overwhelming and difficult.[149] In Massachusetts, consumers cited the overwhelming number of choices, while Utah consumers reported frustration due to burdensome and time consuming requirements, especially in light of the short time frame consumers were given for enrollment.[150] In Utah, "fifty-five percent of people reported that choosing a plan was not an easy process";[151] "[s]eventy-four percent needed the help of a broker or agent to complete the process";[152] and many simply enrolled in a default plan that was similar to the one they had been in before.[153] These figures highlight the fact that the shopping experience was not an easy or meaningful one for consumers, as well as the fact that consumers depended heavily on others to help them through the process.

B. Fear & Doubt in the Health Insurance Market

Many consumers either dread buying insurance, are skeptical about whether they can find affordable and good quality coverage, or both. These feelings can be powerful barriers to the Obama administration's initial pitch to get consumers to visit the exchanges in the first place, let alone its ability to actually "close the deal" by getting people enrolled. Fortunately there is information that gives us insight into the reasons for these feelings, and this insight can help the government figure out how to overcome the resistance such feelings create.

1. Fear: Why Consumers Dread Buying Insurance

The feeling of dread is likely tied to many of the factors discussed in earlier sections.[154] Low health literacy, combined with highly complex documents, make it difficult for people to understand insurance products. Consumers are expected to play an active role in choosing insurance; health care providers and insurers have assumed an unrealistically high level of health literacy among patients and consumers, putting the onus on consumers to disclose their lack of understanding or to request additional help.[155] For people with low health literacy, this may be particularly discouraging because they may feel shame and be afraid to reveal that they cannot read or understand a particular document. As a result, consumers may try to avoid this discomfort by not asking questions at all and simply deferring to another's recommendations.[156] This is consistent with reports that in prior exchanges, consumers depended heavily on brokers and others with expertise in choosing insurance. One gets the sense that consumers were not so much relying

149. *Id*. at 15–16.
150. *Id.*
151. *Id.* at 16.
152. *Id.*
153. *Id.* at 17.
154. *Id.* at 28.
155. PRESCRIPTION TO END CONFUSION, *supra* note 113, at 3.
156. *Id.*

on brokers for *assistance* in their decision-making process, but rather were *delegating* the decisions to them.

Feelings of shame can be exacerbated by a climate in which people are rushed and seem impatient, which is common in certain health care settings and public benefits offices.[157] The result is that those who need the most help are the least likely to seek it. We have seen evidence of this among patients who have trouble reading or understanding other health-related documents, such as informed consent forms, guarantees of payment, or even physician instructions.[158] And these documents tend to be much simpler than the application forms or explanation of benefits manuals used by insurance plans.

A related concern is that the new exchanges will require time-consuming paperwork that many people find overwhelming.[159] Consumers with prior experience in public programs in particular may have this expectation. While such concerns may sound trivial, they are not; we know that bureaucratic hurdles can discourage people from signing up for even free care.[160] This is especially true for people who may work multiple jobs and have little time to navigate a complex bureaucracy—indeed those likely to fall into the category of healthy and uninsured who are being targeted for enrollment. People with lower literacy levels are less likely to be able to satisfy burdensome or layered documentary requirements, or to effectively challenge adverse eligibility determinations, especially without assistance.

Studies documenting the challenges and dread that consumers face in trying to shop for insurance is not isolated to any particular demographic, but appears to be pervasive across different ages, races, genders, those with varying education levels; it is even present in those with some familiarity with health insurance.[161]

157. *See, e.g.*, *id.* (describing how the effects of shame will not be diminished without improvements in health literacy and the health care system).

158. *Id.* at 176.

159. *See generally* TRESA UNDEM & MICHAEL PERRY, INFORMING ENROLL AMERICA'S CAMPAIGN: FINDINGS FROM A NATIONAL STUDY 25 (Jan. 2013), http://www.enrollamerica.org/best-practices-institute/public-education-resources/ EA_Final_Report.pdf. (noting that people who shop for insurance tend to stop because they do not "understand all of the details and fine print in the plans" and "need help figuring out what is the best plan for them.")

160. *See, e.g.*, Sarah Kliff, *Why New Health Group Enroll America Matters*, WASH. POST (Sept. 14, 2011, 2:19 PM), http://www.washingtonpost.com/blogs/wonkblog/post/why-new-health-group-enroll-america-matters/2011/09/14/gIQAAmGMSK_blog.html (noting that the Congressional Budget Office expects that nearly 6 million of those newly-eligible for Medicaid simply will not sign up for the program); *see also* LAURIE K. ABRAHAM, MAMA MIGHT BE BETTER OFF DEAD: THE FAILURE OF HEALTH CARE IN URBAN AMERICA 46–59, 167–168 (describing this problem with respect to prevention programs for low income children and describing the difficulty adults have navigating the various eligibility requirements and bureaucracy in trying to access public health benefits).

161. *See* HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 28 (discussing a study of a diverse group of people, of various education levels, ages, races and ethnic backgrounds, which showed that consumers dread shopping for health insurance).

Nonetheless, LEP individuals' fear may be particularly acute due to prior discrimination. For example, LEP individuals seeking out translation or interpretation services report negative reactions from personnel including frustration, anger, and annoyance.[162] In one of the most egregious examples of this, the Office of Civil Rights (OCR) cited a hospital for failing to provide appropriate care, including epidurals, for non-English speaking pregnant women.[163] The failure to provide important information to LEP individuals has been a pervasive problem in health care delivery and public insurance programs for some time.[164]

A political and social climate that has been hostile to immigrants and restricted immigrants' access to benefits exacerbates fears of discrimination based on immigration-status and fears about the immigration-related consequences of attempting to access care. Even LEP individuals who are citizens or lawful permanent residents avoid seeking health care and signing up for government benefits to which they are entitled, for fear that it might trigger scrutiny that could expose documented and undocumented family members to immigration enforcement and deportation.[165] In fact, the OCR has cited hospitals for Title VI violations because of their attempts to discourage immigrants from seeking care by requiring hospital security personnel to wear uniforms that resemble border patrol[166] and questioning suspected immigrants about their status as soon as they arrive at the hospital.[167]

2. Doubt: Why the Public is Skeptical About Health Reform

As already mentioned, trust is key to the effective selling of complex products like insurance because of the extent to which consumers must depend on salespersons for their specialized knowledge and help in identifying the best product to meet consumers' needs. The government's sales pitch has focused on generating participation in the new private insurance market, but trust for health

162. Mary Re Knack & Jennifer M. Gannon, *Health Care and Limited English Proficiency Patients*, MED. LIAB. AND HEALTH CARE LAW 47, 48 (2005).

163. Thomas Perez, DIR. OFFICE FOR CIVIL RIGHTS, DEP'T OF HEALTH & HUMAN SERVS., ADDRESS AT THE NEW ENGLAND REGIONAL MINORITY HEALTH CONFERENCE (Apr. 13, 1999).

164. *See id*. at 47–49 (noting the difficulties associated with finding interpreters for persons who speak a language other than English when they visit health care providers).

165. *See, e.g.*, Nina Bernstein, *Recourse Grows Slim for Immigrants Who Fall Ill*, N.Y. TIMES (Mar. 3, 2006), http://www.nytimes.com/2006/03/03/health/03patient.html?pagewanted=all&_r=0 (noting that immigrants are fearful of seeking health care because they have heard that "if you go to the emergency room or go to the doctor, they . . . [will] deport you.").

166. *See* Perez, *supra* note 163.

167. Julia Preston, *Texas Hospitals Reflect the Debate on Immigration*, N.Y. TIMES (July 18, 2006), http://www.nytimes.com/2006/07/18/us/18immig.html?pagewanted=all&_r=0 (discussing incidents in Texas where foreign-born patients must provide immigration documents prior to receiving "financial assistance in nonemergencies").

insurers is very low.[168] This is not surprising in light of longstanding criticism of insurer greed at the expense of consumers' health needs, and more recent attention to the role that insurers' profit motives have played in premium increases and the growing numbers of uninsured. Indeed, President Obama invoked this negative perception of insurers to galvanize support for reform, highlighting insurers' practices of denying coverage or pricing plans at prohibitive costs based on one's health history, as well as the fact that plans had been repeatedly increasing rates even for those healthy consumers until they could no longer afford coverage.[169] But other troubling practices have received a great deal of attention as well, such as illegal tactics to dump insureds once they do get sick and need expensive care and wrongful denials of medically necessary treatment.[170] When it comes to purchasing insurance, consumers say they "worry about the 'fine print' because health insurers are 'tricky.'"[171]

Certain groups may also be more prone to mistrust insurance companies because of past discrimination. For example, women have had to pay higher premiums than men, and they have been denied coverage because of undergoing certain necessary reproductive-related care (like a Caesarian section) or being a victim of domestic violence.[172] Insurance exclusions or caps on certain kinds of reproductive health services, mental health treatment, and treatment related to HIV/AIDS have also made insurance less meaningful for women and people suffering from these conditions.[173] Consequently, these groups may have more difficulty trusting private insurers to offer a plan that provides meaningful coverage

168. *See* HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 33 (discussing the low levels of trust between consumers and health insurers); *see also* UNDEM & PERRY, *supra* note 159 (emphasizing the importance to buyers of being able to speak with someone about the insurance plan).

169. *See, e.g.*, Victoria Colliver, *Lawmakers Seek Probes of Anthem Blue Cross*, S.F. GATE, Feb. 10, 2010, 4:00 AM, http://www.sfgate.com/news/article/Lawmakers-seek-probes-of-Anthem-Blue-Cross-3200959.php (discussing President Obama's warnings to the public that without reform increases in health insurance coverage costs will continue).

170. *See, e.g.*, Lisa Girion, *Anthem Blue Cross Sued Over Rescissions*, L.A. TIMES, Apr. 17, 2008, http://www.latimes.com/business/la-fi-insure17apr17,0,3901131.story (noting a lawsuit filed in Los Angeles accusing Blue Cross and WellPoint of rescinding policies after a claim has been filed).

171. HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 33.

172. Press Release, Health Care Law Gives Women Control Over Their Care, Offers Free Preventive Services to 46 Million Women, U.S. DEP'T OF HEALTH & HUMAN SERVS., (July 31, 2012), *available at* http://www.hhs.gov/news/press/2012pres/07/20120731a.html.

173. Perhaps for this reason, the Obama administration has targeted some of its outreach and education about reform to address the specific needs of these groups. *See id.*; *see also Secretary Sebelius Announces Innovative Public-Private Partnerships to Turn the Tide Together in Fight Against HIV/AIDS*, U.S. DEP'T OF HEALTH & HUMAN SERVS., (July 22, 2012) http://www.hhs.gov/news/press/2012pres/07/20120722a.html [hereinafter *Public-Private Partnerships to Turn the Tide Together in Fight Against HIV/AIDS*]; *Health Care Law Increases Number of Mental and Behavioral Health Providers*, U.S. DEP'T OF HEALTH & HUMAN SERVS., (Sep. 25, 2012), http://www.hhs.gov/news/press/2012pres/09/20120925a.html.

worth the cost. There seems to be a prevailing assumption that private insurance guarantees better access and higher quality of care than public programs like Medicaid. But groups that have historically depended on government funding, like people needing HIV medication and other HIV-related treatment or women seeking reproductive health care and family planning, are questioning whether private insurance will provide the kind of comprehensive coverage they need.[174]

Despite the public's frustration with government bureaucracy in programs like Medicaid, surveys suggest that consumers of public programs generally trust the government agencies providing these benefits, especially when consumers receive personalized assistance.[175] In works on public trust and governance, scholars note that the public typically has greater trust in those who work at the state and local levels because they work most closely with the people.[176] And in most public health and welfare programs, administration is delegated to those at the state and local levels.

Although the public may trust the government in its role as a *provider* of benefits, the extent to which people are willing to trust the government as a *regulator* of health insurance is less clear. Many of the troubling practices by health insurers have persisted, in part, because of state regulatory neglect due to a lack of political will to police insurance companies, inadequate expertise by regulatory officials, and in some instances a lack of robust legal authority.[177] But with health reform the regulatory climate has been changing in certain states: even before the ACA was enacted, state regulators who were emboldened by the prospect of reform began scrutinizing insurance rates more closely, and some were able to leverage what regulatory authority they did have to pressure insurance companies into withdrawing or significantly reducing proposed rate increases.[178] Since implementation, regulators have used their authority to try to prevent rate increases, get them reduced, and scrutinize insurer filings to determine when consumer rebates have been due under federal law.[179] And most recently, various

174. *Public-Private Partnerships to Turn the Tide Together in Fight Against HIV/AIDS*, *supra* note 173.

175. *See* UNDEM & PERRY, *supra* note 159, at 24 (noting that despite numerous complaints with how Medicaid offices are run, the local Medicaid office is considered a trustworthy messenger to study respondents).

176. *See* Cass R. Sunstein, *On The Expressive Function of Law*, 144 U. PA. L. REV. 2021, 2049 (1996) (suggesting that those who attempt to move social norms must earn trust from "the people whose norms are at issue.").

177. *See generally* Hoffman & Jackson, *supra* note 105.

178. *See* Scott Paltrow, *Wellpoint Raising Rates by Double Digits in at Least 11 States*, CTR. FOR AM. PROGRESS ACTION FUND (Feb. 24, 2010), http://www.americanprogressaction.org/issues/healthcare/report/2010/02/24/7254/wellpoint-raising-rates-by-double-digits-in-at-least-11-states/ (discussing a large insurance provider's attempts to significantly increase premiums in a number of states and the actions of state legislatures to prevent or reverse these increases).

179. *See* Chad Terhune, *Health Insurers Owe Rebates to Many California Policyholders*, L.A. TIMES (June 2, 2012), http://articles.latimes.com/2012/jun/02/business/la-fi-insure-rebates-20120602 (citing many instances in which California policyholders received rebates because of

states and the federal government announced plan premiums that were lower than predicted.[180]

The point here is that the public's mistrust of insurers may be linked to skepticism of the government's regulatory promises, which means that the government will need to do serious work in order to be viewed as a trustworthy player in the new private health insurance exchanges. To get and maintain robust consumer participation in the health insurance exchanges, exchange officials cannot simply rely on the existing trust that some people have in Medicaid program officials. And government certainly does not want to allow the existing mistrust of private insurance companies to taint people's view of these new insurance exchanges. Federal and state officials must work hard to help the exchange cultivate its own image as a reliable source of information, a trusted facilitator of informed decision-making and purchasing of insurance, and as an effective regulator (or regulatory partner to existing insurance regulators) that is willing and able to protect consumers' interests. If successful, this can help overcome the initial mistrust that many consumers may feel.[181]

Consumer education is an important piece of building this trust. For example, through announcements about how reform has already expanded coverage and reduced rates, the government has already earned greater public trust, which it can leverage in its pitch to get consumers to the exchanges. But this is not enough. The troubling image of insurers, coupled with the complexity of the insurance product, means that consumer assistance will also play an important role. The fact that exchanges have the government's imprimatur, and are supposed to facilitate eligibility determinations for public programs and subsidies, may engender trust in the exchange staff initially. But the exchange's ability to maintain trust will depend heavily on how customer assistance personnel - navigators and assisters – carry out their duties. This means that government must ensure that assistance is provided in an unbiased and accurate manner, and that assisters are viewed as having consumers' best interests in mind.[182] If not, the frustration and

unnecessarily high premiums that were not being spent on those who paid them); Reed Abelson, *Health Insurers Raise Some Rates by Double Digits*, N.Y. TIMES (Jan. 5, 2013), http://www.nytimes.com/2013/01/06/business/despite-new-health-law-some-see-sharp-rise-in-premiums.html?pagewanted=all&_r=0 (discussing how the new health care law requires regulators to review health insurer requests to increase their rates by 10 percent or more).

180. *See* Kelly Kennedy, *State Health Exchange Rates Vary, But Lower Than Expected*, USA TODAY (Sept. 23, 2013), 2:50 PM, http://www.usatoday.com/story/news/politics/2013/07/28/rates-differ-state-by-state/2590723/ (noting that rates are lower than expected in many regions, but that state and regional issues will influence rates).

181. HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 33.

182. A number of consumer advocates have voiced this concern to exchange officials. *See*, *e.g.*, CAL. HEALTH BENEFIT EXCHANGE, STAKEHOLDER INPUT: CONSUMER-CENTRIC EXCHANGE SERVICE CENTER (July 11, 2012), http://www.healthexchange.ca.gov/StakeHolders/Documents/ConsolidatedStakeholderCommentsServiceCenter_7-5-12.pdf (summarizing stakeholder comments about the exchange's proposed Service Center Principles). For example, in California,

disappointment consumers experience could undermine the trust that got consumers to the exchange in the first place, causing them to seek insurance outside of the exchange or to not enroll at all.

Finally, there is still the problem of intense ideological opposition to reform, which some reform opponents have linked to a more general ideological objection to government intervention in health care decision-making and mistrust of government. Although opponents have not been successful at repealing the law, they have tried to stymie its progress.[183] In states that refuse to participate in health reform, by not expanding Medicaid or cooperating in an insurance exchange, state and local officials have tried to leverage their closer relationship to their residents to sow seeds of mistrust and prevent the public's participation in the federal exchange.[184] This approach is not necessarily working, but this is because of community-based organizations and local health care advocates who seem to be in a better position than federal officials to make an effective pitch for participation in the exchange. These organizations are more likely to have the trust of the public than federal officials who are further removed and have been vilified by political opponents.[185]

V. UNCOVERING NEEDS & OVERCOMING RESISTANCE

The ability of salespeople to overcome consumer resistance is important to effective selling and is critical to ensuring adequate enrollment. The challenges presented in Parts III and IV can be largely overcome if addressed effectively and at each level of the pitch: from the initial outreach, to the design of the insurance exchange, to the quality of the consumer assistance—there are many opportunities for the government to win over consumers or to lose them. This Part identifies some key tools for overcoming resistance and notes which aspects of the ACA enhance or undermine effective selling techniques.

A. Helping Consumers Uncover Latent Needs

Health Access noted that "the most glaring omission is that the list of Potential Service Center Principles does not include a principle that requires a high standard for the accuracy of the information given to consumers." *Id.* at 7. It further commented that "even beyond the accuracy of the information given to the consumer, the principles should capture the high level of trust that should be earned by their service center staff." *Id.* at 8.

183. *See* Pugh, *supra* note 14 (explaining that opponents of the law have spent millions of dollars on anti-Obamacare advertising).

184. *See* Norm Ornstein, *The Unprecedented—and Contemptible—Attempts to Sabotage Obamacare*, NAT. J. (July 24, 2013), http://www.nationaljournal.com/columns/washington-inside-out/the-unprecedented-and-contemptible-attempts-to-sabotage-obamacare-20130724 (describing actions Senate Republicans had taken to hinder the implementation of Obamacare).

185. *See* Sarah Kliff, *Inside the Obamacare Resistance*, WASH. POST (updated Aug. 1, 2013), http://www.washingtonpost.com/blogs/wonkblog/wp/2013/08/01/inside-the-obamacare-resistance/ (explaining the task that nonprofit groups and local health-care providers face in encouraging people to sign up for health care).

As already noted, younger adults without health care problems will likely be the hardest group to convince to buy insurance because of the likelihood that they do not yet appreciate the need for health insurance.[186] If you ask this group whether they would want to be able to obtain health care if they needed it, they would certainly say yes. And if you ask them if they would like financial protection against debt from catastrophic illness, they would also most certainly say yes. The problem is not that these "Young Invincibles" do not want insurance; rather, it is that their need for it is not pressing enough yet. And the part of the new law that prohibits plans from denying people on the basis of preexisting conditions likely fuels their belief that they can wait to enroll.

The government's task (and that of its partners) is to help uncover these latent needs and turn them into active ones. This requires doing two things: (1) educating people about the legal and practical realities that should shape their assumptions about present need, and (2) helping to make the abstract link between insurance, health, and financial security more concrete and relevant to people's individual circumstances. Take, for example, the educational tools mentioned earlier—*Kaiser Family Foundation's* Youtoons video and the information on the HealthCare.gov website—aiming to educate people in a clear and simplified way about the law and their choices.[187]

The Youtoons video gives an overview of the impact of health reform, for many different groups, with a special focus on the uninsured—whom the government is targeting for enrollment in the new health exchanges.[188] The clip tries to highlight the health care and financial benefits of insurance generally, including for those who are currently healthy.[189] And it explicitly deals with the apparently rational response by some healthy people who believe that there is no need to sign up now that the law prevents insurance companies from discriminating against people based on preexisting conditions: the video asks, "Why not just wait until you get sick?"[190]

The HealthCare.gov site provides written information and animated videos that are shorter and more targeted to specific aspects of reform. The video about the marketplace itself was mentioned earlier, but the site also provides links to information for other questions that customers may have, including "Why should I have health coverage?"[191] This video uses actors that reflect a racially diverse

186. Weaver, *supra* note 20.

187. *New Animation Explains Changes Coming for Americans Under Obamacare*, *supra* note 35; HEALTH INSURANCE MARKETPLACE, *supra* note 35.

188. *New Animation Explains Changes Coming for Americans Under Obamacare*, *supra* note 35.

189. *Id.*

190. *Id.*

191. *Why Should I Have Health Coverage*, HEALTHCARE.GOV (July 18, 2013), https://www.healthcare.gov/why-should-i-have-health-coverage/ [hereinafter *Why Should I Have Health Coverage?*].

group of young individuals, showing them running, biking and enjoying life without an apparent care in the world.[192] Implicitly the video is targeting the people who may be the hardest sell—the young and healthy—stressing the important health care and financial benefits of insurance.

The form and content of the communication in each video is accessible and should be easily understandable by people with lower health literacy, but both videos may fall short in their attempts to counter assumptions about lack of need. The Youtoons video tries to answer the question of whether someone should wait until getting sick before enrolling by mentioning the law's limited enrollment period,[193] but it is so simplistic and abstract that the video may inadvertently feed into the very assumptions it needs to challenge. For example, after mentioning briefly the limited enrollment period, the video almost simultaneously shows medical bills raining down as an example of the key risk to not signing up now—medical debt.[194] This implicitly suggests that people could still get care, but that they would have to bear the cost. While it is true that hospitals cannot deny screenings or stabilizing treatment for emergency care, the video fails to note that truly emergent care is only one type of treatment that an unexpected illness or injury may require.[195] There are many serious conditions that may not be immediately life threatening, but where the delay of non-emergency care could cause more serious physical problems or crises, or prevent someone from being able to work or function normally for some period of time. The HealthCare.gov video does not address this explicitly either; it too focuses on medical debt which may send the same implicit message as the Youtoons video.

Importantly, both videos do mention the *health* benefits of having insurance, and the HealthCare.gov video gives as examples vaccines and medication.[196] But this may not be compelling enough to help people truly understand what is at stake if they cannot afford timely healthcare for a serious medical condition or accident. The videos could do more to make this risk concrete, such as providing additional videos giving a more personal account of "Why buy now?" These could present a few simple, yet compelling vignettes of the health risks of failing to buy insurance during the initial enrollment period: someone diagnosed with an aggressive form of cancer or other condition, needing expensive treatment that does not qualify as emergency care; or someone injured in a severe car accident who, in addition to requiring emergency care, requires on-going care, including pain treatment, additional surgeries and rehabilitation to increase the chance of total recovery and avoid longer term disability—the kind of care hospitals would not necessarily be

192. *Id.*

193. *New Animation Explains Changes Coming for Americans Under Obamacare*, *supra* note 35.

194. *Id.*

195. *Id.*

196. *Why Should I Have Health Coverage?*, *supra* note 191.

required to provide under emergency treatment laws. After showing how long one might have to wait for the next enrollment period, each video could end with a simple question that asks "How long would you be willing to wait for treatment?" This may help make consumers' needs for insurance more active, and thus help them better value the benefits of coverage. This is particularly important because early in the health reform debates, we witnessed wrong information being disseminated about how easy it is for people to get treatment even without insurance, including some lawmakers incorrectly suggesting that people could get their needs met in an emergency room.[197] Government must tackle such false information head-on.

Although both the Youtoons and HealthCare.gov videos mention the inability to access care and financial exposure as consequences of being uninsured, they fall short in helping consumers to fully appreciate these risks. One cannot appreciate either risk without more information about how much care actually costs, the likelihood that one might need certain kinds of health care, and the real life consequences of incurring significant medical debt. To help consumers better understand this risk, the government must first quantify the risk since most consumers do not know what health care costs.[198] The Youtoons video did not provide any cost information; just pictures of medical bills raining down on the uninsured patient.[199] The more recent iterations of the HealthCare.gov video do a better job, presenting costs for two scenarios—treatment for a broken leg ($7,500) and a three-day hospital stay ($30,000).[200] But the video does not provide any statistical information about the likelihood that certain illnesses or accidents might occur.

Second, government must translate the abstract idea of there being bad consequences from mounting medical debt into more a concrete picture of these consequences: for example, using a video to explain how amassing this kind of debt can hurt one's credit or ability to get credit, can lead to increased interest rates on existing credit cards, and can make it difficult to qualify for housing, car loans, and maybe even employment.[201] Financial security is an abstract idea that many young people have not had to think about in depth or face in a serious way. Given the importance of the financial security benefit of insurance, policymakers should

197. *See*, *e.g.*, Greg Sargent, *Romney: Let Them Go to Emergency Rooms*, WASH. POST (Sept. 24, 2012), http://www.washingtonpost.com/blogs/plum-line/post/romney-let-them-go-to-emergency-rooms/2012/09/24/3ac90b0e-0680-11e2-afff-d6c7f20a83bf_blog.html (discussing Romney's comments made during a CBS interview).

198. *See* FREESE, *supra* note 41, at 139–141 (describing the importance of "implication questions" in selling).

199. *New Animation Explains Changes Coming for Americans Under Obamacare*, *supra* note 35.

200. *Why Should I Have Health Coverage?*, *supra* note 191.

201. *Cf.* David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741, 743 (2009) (explaining the connection between medical bills and bankruptcy among Americans).

heed the lessons learned about consumer literacy challenges in the financial context, and create an education tool that will help increase awareness of this risk in the health care context.[202] An animated video of medical bills raining down on consumers is not enough.

The videos also fail to challenge another implicit assumption underlying the belief that people can sign up later—that is, that the insurance will be there later when the healthy person decides to sign up. I am not referring to the limited enrollment period this time (although as noted above, this does need to be explained more clearly to consumers). Rather, I am talking about a more important and subtle message that President Obama and policymakers have tried to make about the need to mandate public participation—i.e., that enough people must participate in the system, especially the healthy, in order for promises of affordable and meaningful coverage to be realized.[203] Consumers should be reminded that without healthy members to help spread the risk, rates could eventually skyrocket and/or insurers may ultimately flee the market. Admittedly, it is not clear how effectively this message would influence individual decision-making. And there is the risk that this message may unintentionally reinforce the doubt reform opponents try to sow about whether the market will work. Some may wonder, "If I sign up now, will it still be there for me later?" Or like many healthy people who tried to do the responsible thing by purchasing insurance in the individual market prior to the ACA, will they ultimately get priced out and lose insurance without reaping any benefit?

Although the law does not mandate that people buy insurance, it does force people to confront this choice in ways they might otherwise avoid due to inertia.[204] The law creates a deadline and penalty for failure to meet this deadline that mandates some choice: if one chooses not to buy insurance now, there are consequences—people will have a responsibility to either pay the penalty or determine whether they qualify for an exemption. The law's requirements and deadline mean that the government has a particularly powerful bully pulpit for its "sales pitch" and a defined time within which people's attention must be focused on the decision. By using the educational tools discussed in this section, the government can help individuals uncover their latent health and financial protection needs; and this, in turn, may cause younger and healthier individuals to value the benefits of insurance more highly right now.

202. HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 28–32 (describing various tools for helping consumers better understand health care costs and the value of insurance).

203. *See* Ana Radelat, *White House: ACA Costs Lower Than Expected; Connecticut Among Highest*, CT MIRROR (Sept. 24, 2013), http://www.ctmirror.org/story/2013/09/24/white-house-aca-costs-lower-expected-connecticut-among-highest (showing that this view has been expressed by Robert Zirkelbach, a spokesman for America's Health Insurance Plans, the trade association for health insurers).

204. *See* Lake Research Partners, *supra* note 10, at 10 (noting that survey respondents reported that learning about the mandate would motivate them to get insurance).

B. Tapping Into Social Needs: #IAMCOVERED

Many polls and media stories have emphasized people's opposition to the mandate. Missing from many of these stories, however, is the fact that when survey participants were educated about how the mandate would help ensure affordable health care for *all*, people tended to view the mandate more favorably.[205] In fact, some indicated that they would be willing to pay more for insurance if it meant that others would be able to afford it.[206] This evidences that, for many people, participation in the health care market may be driven by their concern for the broader community benefits and social needs, not only their own individual health or financial needs.

This is consistent with the communitarian spirit and shared moral obligation, which, I have argued elsewhere, animates the mandate rhetoric in the ACA.[207] The individual mandate is actually part of a new moral mandate and norm of shared responsibility reflected in the law.[208] In defending the mandate, President Obama emphasized the fact that in order for this system to work—that is, to ensure that everyone would be able to access affordable care—there must be broad participation from many different sectors and by many individuals, especially the healthy.[209] President Obama's defense of the mandate seemed to presume that people could be motivated by more than their own economic benefit or fear of penalty; people's decisions may be influenced by their sense of moral obligation to act responsibly and in ways that benefit the common good.[210] To the extent people

205. *See, e.g.,* ISABELLA FURTH ET AL., HEALTH COVERAGE FOR ALL CALIFORNIANS: CATCHING UP WITH THE PUBLIC: A REPORT ON DIALOGUES WITH THE PUBLIC AND WITH BUSINESS AND CIVIC LEADERS 29 (2006), *available at* http://www.viewpointlearning.com/wp-content/uploads/2011/04/Health_Coverage_for_All_Californians.pdf (determining public views on health reform through education and dialogue that considered significant health care reforms, rather than simply polling people about piecemeal aspects of reform).

206. *See, e.g.*, *id.* at 37.

207. *See* Brietta R. Clark, *A Moral Mandate & the Meaning of Choice*, 6 J. OF HEALTH L. & POL'Y 267, 273–80 (2013).

208. *See id.; see also* Tom Baker, *Health Insurance, Risk, and Responsibility after the Patient Protection and Affordable Care Act*, 159 UNIV. PENN. L REV. 1577, 1621 (2011).

209. *See Healthcare that Works for Americans*, THE WHITE HOUSE, http://www.whitehouse.gov/healthreform/healthcare-overview (last visited Jan. 15, 2014) (explaining how access to healthcare is better for many Americans under the new law, including young people and people with pre-existing conditions).

210. For a discussion of the expressive theory of law generally, *see* Sunstein, *supra* note 177. Expressive law theorists believe that people comply with certain laws or norms in the absence of legal or financial sanctions because they fear that failure to comply with a particular rule or norm will harm one's reputational status. *Id.* at 2032–33. A common example used to illustrate this is the dog walker that picks up after her dog despite lack of enforcement of the rules; she may be motivated by wanting to avoid her neighbors viewing her as inconsiderate. *Id.* But she may also have internalized a particular norm and be motivated simply by the urge to act in a moral way that is consistent with her internal sense of fairness or justice; the dog walker may believe it is morally wrong to not clean up after her dog. *Id.*

internalize this shared moral obligation, the government can leverage the ACA as a powerful expressive tool for recruiting new enrollees.

In fact, this kind of social consciousness may be particularly strong among the group most desired by the exchanges: young adults. We see this in the increased use of social media to raise awareness and solicit support for different causes.[211] We also see it with the rise in dual-purpose buying—purchases that are linked to benefitting some specific cause or charity.[212] Whether this sense of moral obligation would serve as a significant enough motivator for a decision as financially significant and potentially complicated as buying health insurance is hard to predict. But to the extent such moral obligation exists, this may be an important motivating factor that government should not ignore.

Indeed, sales theory tells us that an effective sales person acknowledges and taps into a person's human needs as well,[213] but surprisingly the federal government has not leveraged reform's expressive power to its full potential. Again the Youtoons and HealthCare.gov videos are good examples of where this could happen.[214] A video could be used to challenge assumptions about the consequences of signing up later by explaining what it takes to make reform work—illustrating in a simple yet visually pleasing way the message that we all have to participate, and building upon the "we're all in this together" message from President Obama's 2012 campaign.[215] At the same time that people learn about the benefits that insurance can provide for them, the government could emphasize how their participation is helping others—that they are part of a community that pools its resources to ensure affordable and meaningful access for all.[216] A message that

211. *See, e.g.*, Elizabeth Woyke, *Apps That Change the World*, FORBES (July 12, 2010, 6:00 PM), http://www.forbes.com/2010/07/12/iphone-android-blackberry-technology-mobile-apps.html (discussing some of the many apps that are created to raise awareness of important causes, such as the 2010 oil spill in the Gulf of Mexico); *see also* Lucy Smeddle, *Successful use of Social Media Helps Bolster Movember Brand*, CHARITY DIGITAL NEWS (Nov. 3, 2013), http://www.charitydigitalnews.co.uk/2013/11/06/successful-use-of-social-media-helps-bolster-movember-brand/ (discussing the success of the "Movember" charity, due in large part to its use of social media and popularity among young adults).

212. *See, e.g.*, Woyke, *supra* note 211 (claiming that the apps serve a dual purpose of increasing awareness about a cause and enabling users to take action in support of it); Stacy Palmer, *Mothers and Young People Are Most Likely to Buy Products Tied to a Cause*, PROSPECTING (Sept. 16, 2010), http://philanthropy.com/blogs/prospecting/mothersyoung-people-are-most-likely-to-buy-products-tied-to-a-cause/26986 (stating that young adults are highly likely to buy products that benefit a cause or charity).

213. Thomas V. Bonoma, *Major Sales: Who Really Does the Buying?*, *in* SEEKING CUSTOMERS, 87, 88 (Benson P. Shapiro & John J. Sviokla eds.,1993).

214. *See New Animation Explains Changes Coming for Americans Under Obamacare*, *supra* note 35 and accompanying text.

215. Eugene Robinson, *The Tale of Two Conventions*, WASH. POST (Sept. 6, 2012), http://articles.washingtonpost.com/2012-09-06/opinions/35494315_1_tale-of-two-conventions-defeat-romney-president-obama.

216. *See* Deborah Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity*, *in* EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY 52, 54 (Tom

enrolling now helps you, your friends, your family, and those in the community who really need care, but might otherwise be excluded, may provide an even greater incentive to purchase insurance, similar to the kind of dual purpose buying we see in other areas.[217] Such a message may tap into a strong emotional desire to be a part of the community and contribute in a positive way; this alone may not be enough to close the deal, but it may at least help counter the other emotional feelings of dread and frustration that could otherwise discourage participation. Invoking moral arguments that highlight our collective responsibility to share risk, in combination with arguments about the individual health and financial benefits reform can yield, may strengthen one's sense of urgency to enroll now.

This is also where partnerships with influential people and groups can be particularly effective. The government has long understood the power of peer-to-peer education and the moral suasion that popular celebrities can use to influence young adults.[218] Peer and celebrity messengers can influence the public's perception of a problem and how they understand their moral and practical obligations to help solve it.[219] The Young Invincibles is the perfect example of a movement among young adults to educate the community about the law and its benefits, helping people learn how to get covered.[220] The group has created an on-line presence encouraging people to share their stories about care, and it includes resources, such as a health care app and toolkit, to facilitate enrollment.[221] It is using social media in savvy ways to keep people informed and encourage enrollment, and they have even created apps to help people locate health care providers in their area.[222]

Baker & Jonathan Simon eds., 2002) (suggesting that insurance is a social institution and invites shared responsibility among the public).

217. *See id.* at 53 (claiming that thinking of insurance as risk-pooling that helps not only yourself, but others who might suffer a loss, helps to create moral opportunity to help others).

218. *See, e.g.*, Baker and Sink, *supra* note 11 (discussing the government's use of celebrities to help sell the ACA); Morgan, *supra* note 13 (discussing the Obama administration seeking out the help of the NFL to persuade young adults to sign up for medical insurance).

219. *See generally* Thomas F. Tate, *Peer Influence and Positive Cognitive Restructuring*, CYC-ONLINE (Jan. 2006), http://www.cyc-net.org/cyc-online/cycol-0106-tate.html (arguing that there are positive and negative effects of peer influence on adolescents); Laurence Steinberg, *How Peers Affect the Teenage Brain*, PSYCHOL. TODAY (Feb. 3, 2011), http://www.psychologytoday.com/blog/you-and-your-adolescent/201102/how-peers-affect-the-teenage-brain (claiming that peers affect adolescent decision-making); Michelle Wilkinson, *How Celebrities Affect Society*, LIFEPATHS (Oct. 6, 2013, 11:13 PM), http://www.lifepaths360.com/index.php/how-celebrities-affect-society-4191/ (stating that celebrities influence the media and people's aspirations).

220. *See generally* Maria Beltran, *Class of 2013: How to Keep Living the Good Life*, YOUNG INVINCIBLES (Sept. 12, 2013), http://younginvincibles.org/category/health-care/ (providing information on California's insurance marketplace for young adults).

221. *See id.* (including a form where young adults can "Take Action" by sharing their story on why health care is important to them).

222. *Young Invincibles: There's an App for That!*, YOUNG INVINCIBLES (last visited Nov. 6, 2013), http://younginvincibles.org/promotion/young-invincibles-theres-an-app-for-that/.

C. Creating Health Literate Markets: Empowering Consumers to Buy

Studies of consumer behavior and health literacy tools provide important insights about how exchange design and choice architecture can enhance or undermine reform enrollment goals.[223] And based on this information, the federal government has directed more of its attention to these challenges. This focus has intensified in the last few years as the implications of these challenges for the success of health reform has become more acute. News articles have appeared regularly raising doubts about health reform's success due to consumers' lack of understanding of insurance and reform,[224] but the federal government and its state partners have been given tools to address these knowledge gaps.

The IOM's work in this area is particularly useful because it draws upon health literacy studies and lessons learned from prior exchanges in proposing guiding principles and recommendations for ensuring that the new health insurance marketplace is health literate.[225] Simply, a health literate organization is defined as "an organization that makes it easier for people to navigate, understand, and use information and services to take care of their health."[226] But this has very specific and multifaceted implications for how a virtual insurance exchange market should be designed. Although some of these principles are reflected in the basic outline of the private insurance expansion in the ACA, the law leaves a tremendous amount of discretion in the design of federal and state exchanges.[227] Governments and insurers that want to maximize enrollment success should pay close attention to several reports recently published by the IOM that identify health literate practices and principles for health reform implementation.[228] These reports provide a wealth of valuable information about creating health literate marketplaces, but I will highlight just a few of the most relevant recommendations.

223. *See* HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 50 (stating that using simple language, designing consumer-friendly tools, presenting information using standardized insurance plans, and personalizing to diverse, low-literacy consumers can help consumers understand health coverage).

224. *See e.g.*, Patricia Zengerie, *Most Americans Oppose Health Law but Like Provisions*, REUTERS (June 24, 2012, 1:13 AM), http://www.reuters.com/article/2012/06/24/us-usa-campaign-healthcare-idUSBRE85N01M20120624 (demonstrating that fifty-six percent of Americans are against a healthcare overhaul); Bruce Japsen, *Americans Don't Understand Insurance, Let Alone Obamacare, Research Shows*, FORBES (Aug. 10, 2013, 10:35 AM), http://www.forbes.com/sites/brucejapsen/2013/08/10/americans-dont-understand-insurance-let-alone-obamacare-study-shows/ (claiming that Americans do not understand the ACA or health insurance generally).

225. *See* HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 50.

226. HEALTH LITERATE ORGANIZATIONS, *supra* note 127, at 2.

227. *See* Theodore Ruger, *A Year Later, State Powers Remain Vital after the ACA Decision*, CONSTITUTION DAILY (Aug. 27, 2013), http://blog.constitutioncenter.org/2013/08/a-year-later-state-powers-remain-vital-after-the-aca-decision/ (stating that the ACA allows states to decide many implementation choices).

228. *See* HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 2–3 (identifying multiple IOM reports from workshops held by roundtables to address health literacy issues).

As a foundational principle, the IOM aims to disabuse sellers of the idea that shopping for insurance is like shopping in any other market:

> [E]xchanges must start with a nuanced understanding of how consumers shop for health insurance to successfully attract consumers, manage their expectations, and allow them to make a meaningful choice among health plan options. . . . [T]he image of a careful shopper who is capable of weighing the myriad costs and benefits associated with their health insurance options must be abandoned. [229]

Exchange designers must increase the appeal of shopping and minimize the aspects of the experience that cause dread.[230] The IOM highlights the connection between individuals' willingness and ability to make informed decisions about insurance and the way in which product information is presented and made available to consumers.[231] Although it may be difficult to identify exactly what it means for any particular organization to be health literate, there are several critical markers relevant to the design of the new health insurance marketplaces.

1. The Enrollment Superhighway

Because the ACA marketplaces depend on a notion of an "enrollment superhighway" which consumers access through the new virtual exchanges,[232] a critical measure of effectiveness is the navigability of the exchange—that is, how easily one can get the information one needs. This seems to be a simple concept because we know that the more complicated something is to find, and the more steps one must take to get information, the more likely people are to become discouraged and to give up.[233] Many of the uninsured consumers being targeted for enrollment have definite expectations for what a consumer-friendly website looks like based on other shopping experiences—so to the extent the exchanges do not meet consumers' expectations, they will leave the site.[234] The principles of exchange design established in the ACA seem to reflect an understanding of the importance of a simplified approach to insurance shopping, in that the exchange is

229. *See id.* at 27, 28 tbl. 3-1 (citing to studies conducted by Consumers Union).

230. *Id.*

231. *See* HEALTH LITERATE ORGANIZATIONS, *supra* note 127, at 74 (stating that organizational leaders should raise awareness about health literacy by making clear statements about the patient's responsibilities to make informed decisions about health care).

232. *See* HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 6 (describing the notion of an "enrollment superhighway" as a unified application that guides consumers through the enrollment process).

233. *Cf.* HEALTH EXCHANGE COMMUNICATION *supra* note 56, at 27 (stating that a single application that can be used to apply to any program is better than an array of public programs that are burdensome to navigate).

234. *Id.* at 53.

expected to operate as a centralized and streamlined source for consumers to find and compare private and public options.[235]

The realization of this goal in the implementation is challenging, however, because success depends significantly on the investment in, and quality of, information technology (IT) systems and maintenance.[236] Many states have poor IT infrastructure, which has already thwarted previous attempts to use on-line systems for enrollment and other customer service needs for public programs; existing systems may be slow and difficult to navigate, and investing in a new system can be expensive.[237] Moreover, states currently treat different public programs as silos, with separate websites and systems used for eligibility determinations and enrollment for different state programs.[238] To attempt to bridge the existing public databases that currently operate as silos, and then to try to integrate this information to create a system that can also determine consumers' eligibility for public subsidies on the exchange, presents a significant operational and financial challenge for states.[239] Even in California—one of the first states to embrace reform, begin exchange implementation, and obtain federal financial support—exchange officials seemed to view the IT requirements and deadlines as the most daunting aspects of implementation.[240] Indeed, as this article was in the editing process, numerous reports of computer glitches in the new federal marketplace led

235. *Id.*

236. *See* U.S. GOV'T ACCOUNTABILITY OFFICE, PATIENT PROTECTION AND AFFORDABLE CARE ACT: STATUS OF CMS EFFORTS TO ESTABLISH FEDERALLY FACILITATED HEALTH INSURANCE EXCHANGES 33 (June 2013) (explaining the technical difficulties and complexities of developing the HealthCare.gov website).

237. *See* HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 7, 22 (discussing states' transition to on-line systems); Lena H. Sun, *Maryland Struggling with Technological Problems with Online Insurance Exchange,* WASH. POST,, Nov. 20, 2013, at A01 (discussing technological problems with the state run insurance exchange and noting that the less complex on-line exchanges are more likely to succeed)*; see also States' Insurance Exchange Website Cost Taxpayers 1.1 Billion; Contractors Often Paid To Do Same Job In Different States*, CBS NEWS, (Oct. 31, 2013, 8:11 AM), http://www.cbsnews.com/8301-505263_162-57610154/ (discussing the amount of money spent to create state run health exchanges).

238. *See* HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 7 (describing most state systems as "antiquated" and "not integrated"); Jeffrey Young, *Health Insurance Exchanges, Heart of Obamacare, Rest in Hands of Skeptical States*, HUFFINGTON POST, Nov. 15, 2013, http://www.huffingtonpost.com/2012/11/15/health-insurance-exchanges_n_2138576.html (discussing how the lack of coordination between exchanges may lead to difficulty in enrollment into Medicaid for many citizens).

239. *See* RICHARD HEATH AND ASSOCS., INC., PHASE I AND II STATEWIDE ASSISTERS PROGRAM DESIGN OPTIONS, RECOMMENDATIONS AND FINAL WORK PLAN FOR THE CALIFORNIA HEALTH BENEFITS MARKETPLACE 2 (2012) (noting that developing a customer assistance program "that results in 'no wrong door' and integrated consumer experience is hampered by several factors [including the fact that] . . . [p]ublic and private distribution channels are currently segregated.").

240. *See* Colliver, *supra* note 31 (noting the technological glitches that occurred in the California exchange even though the State spent vast sums of money and started implementation early).

to speculation that these problems would undermine the government's enrollment goals.[241]

2. Choice Architecture & Other Tools to Reduce Cognitive Overload

Information on the exchange website and provided by plans should be readily accessible and easily understandable to consumers. The choice architecture adopted by the exchange can facilitate this by reducing consumers' cognitive overload at a number of points in the shopping process.[242] Governments should focus on simplifying the buying process at *each* of these points—given the complexities of insurance and the multi-layered decision-making that is required, it is easy for a consumer to get discouraged and decide not to enroll at any one of these points.

First, exchanges should provide cognitive shortcuts for consumers to facilitate understanding and comparisons among plans. Standardizing certain terms of the insurance product and using more familiar, less jargon-laden terms are two effective means for creating such shortcuts.[243] The law already requires this to some extent. For example, in 2010, President Obama signed into law the Plain Writing Act, whose purpose is "to improve the effectiveness . . . of Federal agencies by promoting clear Government communication that the public can understand and use."[244] The ACA also requires states to choose a benchmark plan that defines the minimum benefits that must be covered, mandates the use of standardized actuarial value tiers, and uses familiar labels—Bronze, Silver, Gold and Platinum—to convey the relative value of each tier.[245]

Even with these shortcuts, it may still be challenging for consumers to understand exactly how much difference there is between the different tiers and what this means in terms of one's out of pocket costs. This becomes even more challenging to the extent there are variations within the different benefit tiers, so states should consider using their discretion under the ACA to standardize plan options to make it easier for consumers to compare plans.[246] California provides a good, but not perfect, example for how states can use their discretion and health literacy tools to facilitate consumer understanding.

First, Covered California went beyond what the ACA required by standardizing and limiting the number of options that plans could offer within a

241. *See, e.g.*, Eilperin, *supra* note 31 (noting the many technical problems with the HealthCare.gov website and how it dissuaded users of the website).

242. HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 28–29.

243. *Id.* at 50.

244. 5 U.S.C. § 301 (2010).

245. *See* 45 C.F.R. § 156.140 (2013) (describing the different plan tiers); *see also* 26 C.F.R. § 1.5000A-2 (2013) (providing the minimum benefits required).

246. *See* HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 32 (noting the importance of a tiered benefit plan structure in the insurance markets to provide cognitive shortcuts to consumers so that they can easily understand the products that they are buying).

tier.[247] As already noted, officials used market research of consumers to learn more about their preferences for, and understanding of, certain insurance concepts, such as deductibles, co-insurance, and co-pays. Once these were standardized, the Covered California website provided a nice clear benefits summary of the different plan options, highlighting the most relevant information for consumers.[248] Because Covered California's officials understood that consumers had difficulty understanding how to apply certain insurance concepts in order to come up with an actual dollar figure that represented one's out-of-pocket costs,[249] the exchange created a series of materials and calculation tools that do a lot of this work for consumers. For example, the exchange site provides examples of the cost of care for particular conditions; comparisons for what one would likely have to pay out of pocket for a particular condition under different plans; and an easy to use on-line calculator that helps consumers determine whether they qualify for Medicaid and estimate their private insurance premium (taking subsidies into account) just by filling in a few blanks.[250] These are precisely the kinds of tools health literacy experts recommend because they not only simplify the choices presented, they empower consumers to make more meaningful choices by helping to educate consumers on the true cost and benefit of insurance.[251]

There are two other structural factors that exchange officials should consider in making health marketplaces more health literate. First, as noted earlier, consumers attempting to buy insurance on exchanges in Massachusetts and Utah found the number of choices overwhelming.[252] Exchanges should use the flexibility provided under federal law to limit plan options, so that consumers have a manageable number of vetted choices. This strategy led Massachusetts to reduce the number of plan choices offered on its exchange from twenty-seven to nine.[253] Second, certain aspects of the ACA and its implementing regulations attempt to address consumers' frustration with the overwhelming paperwork and bureaucracy

247. *2014 Standard Benefits for Individuals*, COVERED CAL., https://www.coveredca.com/PDFs/English/CoveredCA-HealthPlanBenefitsComparisonChart.pdf (last visited Nov. 6, 2013).

248. *Id.*

249. *See* Mark Miller, *Do You Need an MBA Degree to Figure Out the New Health Insurance Exchanges?*, REUTERS (Oct. 17, 2013), http://www.reuters.com/article/2013/10/17/us-column-miller-healthplan-idUSBRE99G13020131017 (describing the difficulty of figuring out which insurance policy to choose once inside the exchange).

250. *Estimate of Total Costs*, COVERED CAL., https://www.coveredca.com/shopandcompare/#totalCosts (last visited Nov. 6, 2013).

251. *See* Lake Research Partners, *supra* note 10, at 12, 51 (studying the aspects of the ACA that appeal to low-income individuals and the best way to implement the exchanges to address their needs); *see also* HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 28 (noting that health insurance education will have to be provided in a compelling, multilayered, just-in-time approach).

252. HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 16, 33.

253. *Id*. at 33.

they experience with public benefits programs.[254] The law attempts to eliminate this burden by creating a streamlined enrollment process, including a standardized and simplified enrollment form that will work for any plan on the exchange, and by authorizing presumptive Medicaid eligibility under certain circumstances.[255] The efficacy of this approach, however, will still depend on the accessibility of the website itself and the quality of information sharing between private and public programs.

Finally, the ACA seems to contemplate a consumer-centered approach to selling insurance that is consistent with lessons learned from the theory of effective selling and health literacy studies discussed previously. The recent IOM workshop on health literacy and reform emphasizes that "participatory design can result in products that meet the needs of the target population," and such an approach is critical for the design of the health insurance exchanges.[256] Once again, California seemed to take this seriously in its outreach to the uninsured, consumer advocates, and policy analysts for help in designing the new exchange. Even prior to reform, California officials were mindful of the importance of involving different demographics in the development of health-related materials. For example, pursuant to state language assistance requirements,[257] officials reached out to seniors and people with disabilities on Medi-Cal to elicit their participation in developing a guidebook in English, Spanish, and Chinese, in order to help these populations understand their choices under the program.[258] An evaluation of the guidebook, which included accurate cultural adaptations, showed that it increased understanding of enrollment options and the capacity to make choices.[259] And as mentioned above, Covered California officials have taken a customer-centered approach to various aspects of reform implementation: from the naming of the website, to product standardization and design, to the development of best practices for consumer outreach and assistance, to the development of marketing strategies.[260] Although the ACA requires stakeholder consultation and thus

254. *See* 45 C.F.R. § 155.1040 (2012) (requiring the exchanges to provide information that tells the consumer what the plans cover and that is communicated using plain language).

255. 45 C.F.R. § 155.405 (2012) (requiring a single application to determine eligibility for enrollment in a qualified health plan).

256. HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 60; CINDY BRACH ET AL., TEN ATTRIBUTES OF HEALTH LITERATE HEALTH CARE ORGANIZATIONS 9 (June 2012).

257. *See* CA. CODE REGS. tit. 28, § 1300.67.04 (2007) (describing the language assistance programs that insurers are required to provide consumers).

258. HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 38–39.

259. *Id*. at 39, 41–42 (discussing the use of guidebooks and the need to have effective translations in order to improve enrollment in health insurance).

260. *See, e.g.,* THE CALIFORNIA PATH TO ACHIEVING EFFECTIVE HEALTH PLAN DESIGN AND SELECTION AND CATALYZING DELIVERY SYSTEM REFORM: STAKEHOLDER INPUT ON KEY STRATEGIES, CALIFORNIA HEALTH BENEFIT EXCHANGE (May, 18, 2012) *available at* www.HealthExchange.ca.gov; STAKEHOLDER INPUT: CONSUMER-CENTRIC EXCHANGE CUSTOMER SERVICE CENTER, CALIFORNIA HEALTH BENEFIT EXCHANGE (Jul. 11, 2012), *available at* www.HealthExchange.ca.gov; STATEWIDE MARKETING, OUTREACH & EDUCATION

acknowledges the importance of public participation in the implementation process, the law does not regulate the form this must take and thus leaves states a lot of discretion to determine how robust participation will be.[261]

3. Customer Assistance: The Role of Navigators, Assisters, & Brokers

As already noted, the complexity of the insurance product itself, as well as the multiple functions of the exchange, make personal assistance critical to the success of health reform.[262] Pursuant to federal streamlining and enrollment requirements, the exchange is supposed to be the site where consumers can determine their eligibility for public insurance and subsidies, as well as the cost of private plan options.[263] Continued reliance on this public and private patchwork of options means that the government must also be concerned about churning—people losing insurance temporarily due to changes in eligibility.[264] Having qualified people to assist customers can help facilitate the initial enrollment decision (or sale), but it is also important for building and nurturing the kind of relationship that helps people stay enrolled consistently over time.

Providing consumers with personal assistance is not enough to accomplish both of these goals; the people offering help must also be trained in health-literate practices and know how to use health-literate tools that enhance customer understanding.[265] They need to have a realistic expectation of customer knowledge, be sensitive to the various factors that may create buyer resistance, and be able to recognize and accommodate additional barriers to communication.[266] One barrier identified in Part IV was limited English skills, and federal civil rights law requires recipients of federal funds, such as the new exchanges, to provide translation and interpretation services for program participants.[267] This is

PROGRAM: FINAL DESIGN OPTIONS, RECOMMENDATIONS AND WORK PLAN FOR THE CALIFORNIA HEALTH BENEFITS MARKETPLACE (Jun. 26, 2012) *available at* www.HealthExchange.ca.gov.

261. *See* Dash, *supra* note 57.

262. *See* UNDEM & PERRY, *supra* note 159, at 24 (emphasizing the importance to potential buyers and public benefits recipients of being able to get personal assistance from an insurance company representative in signing up for insurance).

263. Dash et al., *supra* note 57, at 9.

264. *See* Benjamin Sommers & Sara Rosenbaum, *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid And Insurance Exchanges*, 30 HEALTH AFF. 228, 228–29 (2011).

265. *See* BRACH ET AL., *supra* note 256, at 8 (arguing that all individuals in a health care organization must have an understanding of health literacy in order to communicate with patients and customers, and that individuals tasked with providing education or outreach need to receive specialized training in educational techniques).

266. *See* HEALTH LITERATE ORGANIZATIONS, *supra* note 127, at 7–15 (charting nineteen attributes of health literate organizations, for example, promoting health literacy as an organizational responsibility and distributing resources to better meet the needs of the populations served).

267. Title VI of the Civil Rights Act provides that no person shall "on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be

particularly important in light of the demographics of the uninsured population being targeted for enrollment. The federal government is clearly mindful of this because in addition to its HealthCare.gov site, which the administration is using to educate the public about health reform, it is offering the same information through a Spanish language website, CiudadDeSalud.gov.[268] In California, health plans were already required to assess the linguistic needs of their members and provide language assistance for populations meeting certain thresholds, prior to the ACA.[269] The state's largest Medi-Cal managed care plan, LA Care Health Plan,[270] had partnered with Hablamos Juntos to produce three glossaries of terms—one in Spanish, one in simplified Chinese, and another in traditional Chinese, which consists of 237 health plan terms, their definitions, parts of speech, and a recommended translation standard.[271]

Health literacy studies also tell us that it is not enough to try to overcome obvious communication barriers. Those helping to sell a product must work actively to create an environment that invites questions from customers and uses questions to assess customer understanding and motivation in a way that is not shaming or dehumanizing.[272] Like the customer-centered, problem-solving approach to effective sales, health literate organizations and their representatives take a consumer-centered approach to system design and assistance.

subjected to discrimination under any program or activity receiving Federal financial assistance." 42 U.S.C. § 2000(d). Pursuant to this provision, the federal government has promulgated regulations prohibiting the utilization of "criteria or methods of administration which have the effect of subjecting individuals to discrimination" on these grounds. 45 C.F.R. § 80.3(b)(2). The U.S. Department of Health and Human Services (HHS) has also issued specific policy guidance for federally funded program recipients regarding when recipients must provide language assistance and what constitutes adequate language assistance. *See generally* Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47311 (Aug. 8, 2003). *But see* Joel Teitelbaum et al., *Translating Rights into Access: Language Access and the Affordable Care Act*, 38 AM. J.L. & MED. 348, 358 (2012) (noting that a recent Supreme Court decision has limited patients' ability to enforce Title VI; they must file complaints with the HHS Office for Civil Rights, despite chronic understaffing of enforcement personnel).

268. U.S. DEP'T OF HEALTH & HUMAN SERVS., CTRS. FOR MEDICARE AND MEDICAID SERVS., CUIDADODESALUD.GOV, https://www.cuidadodesalud.gov/es (last visited Nov. 20, 2013).

269. CAL. HEALTH & SAFETY CODE § 1367.04 (West 2013).

270. L.A. CARE HEALTH PLAN, 15TH ANNIVERSARY REPORT: 15 YEARS AND ONE MILLION MEMBERS STRONG 8 (2012), *available at* http://www.lacare.org/Content/15_Anniversary_Report/pubData/source/LA0640%20Anniversary%20Report%20WEB_flash.pdf.

271. HEALTH EXCHANGE COMMUNICATION, *supra* note 56, 38–39.

272. *See* HELEN W. WU ET AL., NAT'L QUALITY FORUM, IMPROVING PATIENT SAFETY THROUGH INFORMED CONSENT FOR PATIENTS WITH LIMITED HEALTH LITERACY 2–3, 15–18 (2005) (detailing the benefits seen at hospitals that implemented a "talk back" program using questions and repetition to gauge patient understanding of health care information); *see also* BARRY D. WEISS, AM. MED. ASSOC. FOUND., HEALTH LITERACY AND PATIENT SAFETY: HELP PATIENTS UNDERSTAND, MANUAL FOR CLINICIANS 34 (2nd. ed. 2007) (encouraging clinicians to create a shame-free environment in order to foster effective communication with patients).

Moreover, the persons assisting consumers must be able to provide accurate information or to quickly and easily connect consumers with someone who can. Customers will not only need general information about plan costs and benefits, they may have more specific or difficult questions, such as how their plan choice will impact their ability to get a particular service or see a particular provider, or how changing eligibility will impact their tax liability. To the extent customers receive inaccurate and contradictory information or are sent on a wild-goose chase to try to track down information on their own, they will likely become frustrated and give up altogether or make an initial choice that is not right for them. Ensuring this kind of help is especially challenging for exchange officials who may only be familiar with operating public programs and thus do not have a good private customer service model from which to draw. They will have to undergo a culture change with respect to how they treat prospective enrollees, learning to act more like salespeople who want to attract and serve customers, and less like bureaucrats in a public system often characterized as indifferent to those it serves, or worse, making it more difficult for people to navigate the system.[273]

The importance of this kind of assistance is reflected to some extent in the ACA's statutory provisions and implementing regulations, but the framework leaves a lot of discretion to states or exchange officials to regulate this assistance. All exchanges must establish a navigator program, consisting of at least two entities, responsible for helping individuals and small employers with the application and enrollment process.[274] Navigators also conduct public education activities to increase public awareness about the exchange and other resources, and at least one entity must be a community-based and consumer-focused nonprofit.[275] Although the law attempts to minimize certain conflicts of interest, by prohibiting health plans from serving as navigators and prohibiting navigators from receiving enrollment-related compensation from health plans,[276] it does not specify the qualifications or training required.[277]

According to the exchange blueprint issued by the Center for Consumer Information and Insurance Oversight (CCIIO), states that operate exchanges in partnership with the federal government are required to establish a program of "In-

273. *See* HEALTH EXCHANGE COMMUNICATION, *supra* note 56, at 7 (noting that many of the targeted uninsured will have different expectations for customer assistance than those who have traditionally relied on public programs).

274. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18310 (proposed Mar. 27, 2012) (to be codified at 45 C.F.R. pt. 155).

275. *Id.*

276. *Id.*

277. *See* FATIMA MORALES ET AL., BRIDGING THE HEALTH DIVIDE: DESIGNING THE NAVIGATOR SYSTEM IN CALIFORNIA 1–4 (May 2012), http://www.chc-inc.org/downloads/ PB%20Navigator%20Report.pdf (making recommendations for the design of the navigator program and ways to assure maximum enrollment in response to questions from California officials).

Person Assisters" (IPAs);[278] states operating their own exchanges (like California) are not required to do so, but can choose to operate IPAs.[279] The rules governing IPAs are even more flexible than those of navigators, but many states are modeling their IPA program on the navigator program.[280] Finally, CMS has promulgated federal regulations authorizing certified application counselors (CACs) as a third type of assister.[281] These are entities certified to provide application assistance for people applying to Medicaid, but this certification will be broadened to include application assistance for plans sold through the exchange.[282]

There are both benefits and challenges to this patchwork approach. Many of the entities that will provide these services are community-based organizations that already have a trusted relationship with the target customers, understand their specific needs and challenges, and have a sincere interest in helping them find the product that is right for them. On the other hand, such a patchwork could generate confusion among other members of the public who may not know where to turn. The fact that plan agents and brokers also may be registered with exchanges to provide consumer assistance[283] not only adds to this confusion, but to the extent these brokers steer customers toward particular products or do not provide accurate and unbiased information, this patchwork could undermine the public's trust in the exchange.

This part of the article provides only a glimpse of some of the tools the government can use to effectively recruit consumers, empower them to make meaningful enrollment decisions, and to build a lasting relationship of trust between the exchanges and the public—all of which are essential to reform's success. Despite the challenges that the federal government and states have faced in this initial enrollment period, they still have time to learn from their mistakes and to become more effective sellers of reform going forward.

VI. CONCLUSION

278. *Assistance Roles to Help Consumers Apply & Enroll in Health Coverage Through the Marketplace*, CTRS. FOR MEDICARE AND MEDICAID SERVS. (Apr. 22, 2013), http://www.cms.gov/CCIIO/Resources/Files/Downloads/marketplace-ways-to-help.pdf.

279. *Id.*

280. SHELLY T. NAPEL & DANIEL ECKEL, ST. HEALTH REFORM ASSISTANCE NETWORK, NAVIGATORS AND IN-PERSON ASSISTORS: STATE POLICY AND PROGRAM DESIGN CONSIDERATIONS 1–2 (Mar. 2013), http://www.rwjf.org/content/dam/farm/reports/issue_ briefs/2013/rwjf404796.

281. 45 C.F.R. § 155.225 (2013).

282. *Id.*; *see also* Tricia Brooks, *Assister Types Abound: Introducing the Certified Application Counselor*, GEO. UNIV. HEALTH POL'Y INST. CHILDREN'S HEALTH POL'Y BLOG (Feb. 19, 2013), http://ccf.georgetown.edu/all/certified-application-counselors (explaining the roles of Certified Application Counselors compared to in-person assisters and health navigators).

283. *See* Timothy Jost, *Implementing Health Reform: A Final Rule On Health Insurance Exchanges*, HEALTH AFF. BLOG (Mar. 13, 2012), http://healthaffairs.org/blog/ 2012/03/13/implementing-health-reform-a-final-rule-on-health-insurance-exchanges/.

Even though the ACA has already overcome some formidable challenges—political polarization, a Supreme Court decision that was one vote away from invalidating the entire law, and President Obama's reelection in a persistently troubled economy—Obama's latest sales pitch to convince people to buy insurance on the new health exchanges is arguably his most important yet. But is this as difficult as the other challenges he has faced? It does not have to be. Despite numerous polls and media stories questioning the potential success of the new insurance marketplace in attracting consumers, the federal and state governments can be effective sellers. Various provisions of the ACA reflect an awareness of the challenges that the exchanges face and they help to lay the initial framework for overcoming these challenges; but the ACA leaves many gaps to be filled. State and federal exchange officials will need to use their flexibility under the ACA to design the new marketplaces to enhance consumer choice and buying power. By applying the basic principles of effective selling—that is, by using existing knowledge about what motivates prospective buyers, and by implementing effective techniques for overcoming consumer resistance, building trust, and creating health literate organizations that empower consumers to buy—the Obama administration and its state partners can achieve their enrollment goals.