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Marketplace Consumer Assistance Programs and Promising Practices for Enrolling Racially and Ethnically Diverse Communities

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May 2014

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This report can be found online at <http://www.texashealthinstitute.org/health-care-reform.html>

I. Executive Summary

Introduction

State-based health insurance marketplaces, established by the Affordable Care Act (ACA) of 2010, represent an unprecedented opportunity to curtail longstanding racial and ethnic disparities in health insurance and access to care. By 2019, it is expected that at least 24 million individuals will obtain health insurance coverage through marketplaces in the U.S., of which nearly half will be non-white and one in four will speak a language other than English at home.

In California, an estimated 5.3 million residents are eligible for health plans through the marketplace and 2.6 million qualify for tax subsidies to make the insurance more affordable. Of those eligible for tax subsidies, nearly two-thirds are non-white and two out of five have limited English proficiency. The first enrollment period (from October 1, 2013 to March 31, 2014) was an overall success for California, especially as the state led the nation in number of enrollees at almost 1.4 million and exceeded its enrollment projections. However, not all groups fared equally. For example, a smaller proportion of Latinos, African Americans, and limited English proficient populations enrolled than were eligible, whereas twice as many Asians enrolled than expected. Central to advancing equity in health insurance access is assuring that outreach and enrollment efforts are adequate, effective, and culturally and linguistically appropriate to enable individuals to understand, make decisions, and ultimately buy and use coverage.

This report identifies and reviews emerging enrollment assistance programs from across the country to highlight practices that have demonstrated promise and success in reaching and enrolling racially, ethnically, and linguistically diverse populations. While application of emerging practices and lessons are discussed in context of California and the San Francisco Bay Area, this information is intended to be broadly applicable to other settings across the country as well.

Design and Methods

Findings included in this report have been drawn from a review and analysis of reports, peer-reviewed literature, key informant interviews, federal rules and regulations, news articles, and other related sources of information with the intent of coalescing experiences, lessons, and models for reaching and enrolling diverse populations. Priorities were enhanced with input obtained during a day-long community forum we convened in Oakland, California, on April 10, 2014. Our research focused on six key areas related to outreach and enrollment programs:

1. Structure and funding of navigator and assister programs;
2. Community engagement and collaboration;
3. Navigator and assister training;
4. Communication strategies supporting education and enrollment;
5. Outreach and enrollment activities; and
6. Data and evaluation.

Marketplace Assisters: Definitions, Rules, and Regulations

While the ACA explicitly authorized the establishment of navigator programs, many different types of enrollment assisters have emerged in the marketplaces depending on marketplace type (whether run by states, the federal government, or in partnership); funding mechanisms

(federally or state-funded); and differing roles and responsibilities. Some of these roles—such as navigators—were originally defined in the ACA and some were added in later regulations, with varying responsibilities, training, and cultural and linguistic requirements.

Types of marketplace enrollment assisters:

- **Navigators** are organizations and individuals who provide outreach and education on health insurance options in every state and help people enroll in the marketplace or other programs for which they may be eligible. Navigators are present in all three types of marketplaces, though specifics of their duties may vary in different states, and they cannot be funded from federal grants in state-based marketplaces.
- **Non-navigator assistance personnel** (also called **in-person assisters** or IPAs) perform the same duties as navigators but can be funded using federal funds. They are part of an optional program in states that have state-based or partnership marketplaces. As of 2014, the five partnership marketplaces operating their own assistance programs and all 17 state-based marketplaces have established in-person assister programs.
- **Certified application counselors**, present in all three types of marketplaces, are workers who perform many of the same functions as navigators and IPAs such as education and enrollment but who are not compensated from new grants through the marketplace, such as staff already employed by community health centers and hospitals, and volunteers.
- **Licensed health insurance agents and brokers** enroll individuals and small businesses in health insurance provided through the marketplaces, if states allow it, and can be compensated by the consumer or by the insurance company as allowed by state laws.
- **Call centers** (or **customer service centers**) are present in all marketplaces, answering questions and enrolling people via telephone and sometimes other methods such as online chat. States with federal marketplaces all use the federal call centers, and other states have either established their own call centers or outsourced them.
- **State consumer assistance programs** (CAPs) are health insurance ombudsman programs funded by federal grants under the ACA that help to educate and advocate for consumers, and assist people in filing complaints and appeals with their insurance companies (for all insurance plans, not just in the marketplaces). Washington, D.C., and 35 states (including California) currently have CAP grants.

The ACA and related regulations explicitly require navigators and non-navigator assistance personnel to “provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange [or Marketplace].” Final regulations issued in March 2012 also state that marketplaces and their outreach and consumer assistance programs must be accessible, including to those who are limited English proficient, by providing free language services that include “(o)ral interpretation; written translations; and taglines in non-English languages indicating the availability of language services.” Final regulations from July 2013 further specify requirements around culture and language in training and standards for assistance personnel. In particular, any assistance personnel funded through federal grants (including the federal exchange establishment grants) must follow the National Standards on Culturally and Linguistically Appropriate Services (CLAS) issued by the Office of Minority Health.

Outreach and Enrollment Programs in California and the Bay Area

California’s marketplace, Covered California, provides outreach and enrollment assistance through two primary programs: the Outreach and Education Grant Program and the Enrollment

Assistance Program. The Outreach and Education Grant Program awards grants to community-based organizations and to medical providers to conduct outreach. The Enrollment Assistance Program consists of two parts, the In-Person Assistance Program and the Navigator Program, both of which are comprised of Certified Enrollment Entities and the individuals working for them, called Certified Enrollment Counselors. The main differences between the IPA and navigator programs are timing and funding—the IPA program started in 2013 and can use federal funds while still available, while the navigator program started in 2014 and cannot, so it will use funds generated from fees on health plans sold in the marketplace or from other sources.

Findings: Promising Practices and Lessons Learned

The focus of our review was on six outreach and enrollment components within the marketplace. For each area, we describe emerging experiences, lessons, and promising practices for reaching and enrolling diverse communities in health insurance programs, summarized below.

1. Structure and funding of navigator and assister programs. While the ACA initially authorized establishing navigator programs in all marketplaces, evolving programmatic needs introduced the creation of other consumer assisters, varying largely in structure and funding but aligned in the purpose of educating and enrolling. State-based marketplaces—including Covered California—have each established their own consumer assistance programs designed to meet state needs. Federal funding is a central source of support for these programs. While federal establishment grants are available through the end of 2014, some states are looking to private foundations to assist in targeting outreach and enrollment to diverse populations.

2. Community Engagement and Collaboration. The ACA states that marketplaces “shall consult with stakeholders relevant to carrying out the activities under this section, including... advocates for enrolling hard to reach populations.” Many state-based marketplaces are engaging and consulting with relevant stakeholders and incorporating their feedback in planning, design, and implementation of outreach efforts. Emerging promising practices across states for community engagement in the marketplace include:

- Convening community engagement forums or meetings locally around the state;
- Assuring an ongoing process for soliciting feedback from stakeholders and the public;
- Creating advisory groups with members from and reflective of the community; and
- Establishing a formal Tribal Consultation Policy in regions with sizeable tribal populations or federally recognized tribes.

3. Navigator and Assister Training. The effective design and execution of navigator/assister training programs is important for developing a cadre of outreach workers who have the skills and knowledge to successfully educate and enroll diverse populations in the marketplace. The federal government has established a 20-30 hour online training program that the federally-run and partnership states are using, including a module explicitly on cultural competence and language assistance. State-run marketplaces have taken different approaches to integrating content on culture and language in their assister training programs, with some addressing the topic separately and others in combination with overall marketplace concepts. Some states have taken a “train-the trainer” approach, with regional hub organizations taking on the responsibility of training, as opposed to the marketplace itself. States have also supplemented the required training with additional webinars, phone conferences, and meetings to address unforeseen questions and barriers that may have emerged during enrollment activities.

4. Communication Strategies. While the federal government and many states offer enrollment applications in commonly spoken languages other than English, only a handful of marketplaces offer online enrollment in another language—namely, in Spanish. Most states offer taglines or call center numbers for assistance in additional languages. Some states offer online searching for consumers to locate in-person assisters by specific languages spoken—a useful tool for identifying language help in local communities. In addition to the website, many states have worked to make printed materials available in other languages. Community groups and advisory committees have played important roles in many states to review translations for accuracy and cultural and linguistic appropriateness. In addition, some states have used *transcreation*—a process for adapting messages or concepts to another language or culture by keeping the same intent but not using a literal word-for-word translation if it would not be as culturally relevant. Finally, many states learned valuable lessons during the first enrollment period about messages, emphasizing the importance of assuring that they are in plain language and culturally and linguistically appropriate, while delivered through trusted messengers.

5. Outreach and Enrollment. Many lessons and promising practices have emerged to more effectively enroll diverse populations. Many states have built on their existing foundation of education and outreach efforts from Medicaid, CHIP, and other health-related programs. States are learning that the best places to conduct outreach and enrollment are those familiar to and trusted by community members, such as faith-based institutions, child care centers, health centers, and libraries. Some states are breaking down outreach target areas into smaller regions and neighborhoods. In addition, outreach venues are being tailored by ethnic group. For example, direct mail and language-specific newspapers have shown promise in reaching Asian-American populations, while Latinos respond well to information in schools, and Koreans and African Americans are open to information from the churches they attend. A key lesson learned during the first period was that enrollment takes time and multiple interactions before an individual is ready to buy into coverage. Proactively setting up follow-up appointments can be a key to assuring ongoing outreach and ultimate enrollment.

6. Data and Evaluation. Using data and conducting evaluations allows assistance programs to effectively target resources for reaching diverse populations, to document how well programs are working, and to suggest modifications for improving current and planned activities. To this end, many states are undertaking the following efforts:

- *Conducting needs assessments*, either by analyzing data from publicly available sources such as the U.S. Census Bureau, or collaborating with researchers in the state to identify uninsured populations by geography, race, ethnicity, and language, among other factors.
- *Collecting information on consumer race, ethnicity, and language.* Federal and state marketplace applications include optional questions on race and ethnicity. Some states tailored their specific racial and ethnic categories depending on their population.
- *Monitoring and evaluation.* Many states intend to build performance measures to evaluate the effectiveness of their marketplaces and identify areas for improvement. Among the measures are number of applicants enrolled, rate of completed enrollments relative to applicants assisted, number of referrals, and customer satisfaction overall and by race and ethnicity. Less formally, some organizations and marketplaces are sharing tips and best practices for outreach and enrollment through ongoing means such as calls and meetings.

Discussion

Low literacy, limited English proficiency, mistrust of government, and limited access to technology are some of the barriers to enrolling diverse populations. Reaching mixed-immigration status families is a major concern in some communities, as is low health insurance literacy among many immigrant and low-income groups. Other challenges included unexpected delays, such as the late launch of federal and state Spanish websites and applications. In California, the Spanish application was not functional until early January 2014, and some said the Spanish website was not user-friendly. Spanish advertising and messaging was considered off the mark too. Delays in training and certifying enrollment counselors and insurance agents in California during the first few months of open enrollment also slowed down enrollments initially. Numerous questions remain to be resolved such as what constitutes sufficient training generally and around race, culture and language; offering training in languages other than English; and whether to allow individuals with prior convictions to be assisters.

There are at least *five key lessons learned* during the first enrollment period for more effectively reaching and enrolling diverse communities:

- Assure that in-person assistance is provided in a culturally and linguistically appropriate manner, through trusted people and sites.
- Recognize that enrollment is not a one-time matter, but a process requiring “multiple touches” or proactive follow-up by assisters.
- Assure that outreach is ongoing, from facilitating understanding about health insurance to assisting with its utilization and access to care.
- Provide outreach and materials in languages other than English and assure information is in plain language and culturally and linguistically appropriate.
- Consider the use of information technology and that many from diverse communities access online information through their cell phones.

Moving Forward

Building on emerging models and lessons learned, both nationally and in California, our review and community forum findings identified at least six points of focus for improving planning and implementation of outreach and enrollment efforts for racially and ethnically diverse communities in the San Francisco Bay area and generally.

Continue to build capacity to serve limited English proficient populations. Enhancing access to in-language services and materials was identified as a priority both in our interviews and at the community forum. As such, the marketplace may work to enhance partnerships with relevant community organizations to translate materials with a less time-consuming review process by the marketplace. Foundations and private organizations may be able to play a role in funding such efforts to address language services that may be falling short due to limited resources. The marketplace may also consider establishing dedicated staff to address equity priorities.

More fully engage and involve diverse communities on an ongoing basis. Community advocates in California suggest there is a need to more fully engage diverse communities, particularly to review and vet messages and information not only for translation accuracy, but to assure they reflect appropriate cultural contexts. Community engagement and involvement is also

necessary as the marketplace works to evaluate its outreach and enrollment activities following the first enrollment period, particularly identifying reach, what worked, and what did not work.

Assure that long-term, sustainable funding is available for outreach and enrollment programs, and that assisters continue to be involved between open enrollment periods.

Once it is determined what the optimal and reasonable level of assistance is on an ongoing basis, stable funding is needed so that organizations that target diverse and vulnerable populations can continue to do their work without disruptions. In addition to the current health plan assessments, foundation grants and corporate sponsorships could be explored for supplemental funding. Recognizing that outreach and enrollment are long-term efforts, consumers already enrolled will need help with renewals, changing plans, and using the insurance.

Monitor disparities and enrollment data by race, ethnicity, and language. As the success of the marketplaces largely hinges on the successful enrollment of diverse communities, it is important to monitor the reporting of enrollment data by race, ethnicity, and language, and understand which communities are less likely to supply this information and why. The rollout of enrollment efforts must be monitored to assure they do not unintentionally widen disparities by focusing strategies in one community at the expense of another.

Continue to improve training programs for outreach and enrollment assisters. Our conversations with assisters and other community stakeholders suggest a need to enhance training by including more role-playing with a diverse set of consumer scenarios, more hand-on computer practice, and more ongoing education opportunities through webinars and phone conferences, among others. Also, the use of train-the-trainer could be explored in order to help train more assisters quickly instead of waiting on additional marketplace training sessions.

Encourage sharing of lessons and best practices locally and regionally within the state. Stakeholders agreed on the importance of coalescing information and experiences from across the state to avoid waste of resources, duplication of ineffective outreach efforts, and importantly to encourage practices that are culturally and linguistically appropriate. Many emphasized that there needs to be collaboration of groups working with the same populations and languages, and some suggested the creation of a state “brain trust” of cultural/ethnic organizations and resources, whereas others saw value in regional convenings of assisters to discuss their experiences.

Conclusion

Around the nation, community organizations are banding together as they never have before to try to reach uninsured populations. Though many consumers have enrolled in health plans, many others, especially culturally and linguistically diverse populations, remain unaware or confused about their options and have not signed up. As Enroll America and others say, enrolling consumers is a “marathon and not a sprint,” and this undoubtedly is even truer for diverse communities and limited English proficient individuals. But with continued perseverance, steady funding, and research-driven strategies, states and community organizations can work toward the goal of educating and enrolling almost all eligible uninsured into health insurance plans.

II. Introduction

One of the centerpieces of the Affordable Care Act (ACA)¹ of 2010 is the creation of health insurance marketplaces, also called exchanges, which will expand coverage for millions of uninsured, underinsured, and low-income individuals and families in the U.S. These new entities are intended to make available a choice of easily comparable and affordable insurance plans for individuals and families, offering premium tax credits and cost-sharing subsidies to lower costs.

Marketplaces represent an unprecedented opportunity to curtail longstanding racial and ethnic disparities in health insurance and access to care. By 2019, it is expected that at least 24 million individuals will obtain health insurance coverage through marketplaces, of which nearly half will be non-white and one in four will speak a language other than English at home.² In some states, such as California, a much larger racially and ethnically diverse population is projected to be eligible for marketplace coverage. In recognition of this reality, the ACA included many important provisions to support outreach and enrollment activities. In particular, it established support for enrollment assisters called navigators to help educate and enroll uninsured individuals and families in marketplace health plans, and additional types of assisters have developed since then as well. Marketplace assistance personnel, both navigators and non-navigator assisters, are central to reaching and enrolling individuals and families into the new health insurance marketplaces, especially marginalized populations and those who have never had health insurance before.

A growing body of research documents that many consumers will need the help of assisters to enroll in individual health insurance plans, and that direct hands-on assistance is associated with higher enrollment rates.³ This is especially true for culturally and linguistically diverse communities. Hispanics and Latinos are one key group that must be targeted for outreach and enrollment for the marketplaces to be considered successful, as they account for about a third of the uninsured while representing only 17% of the U.S. population.⁴ In California, an estimated 5.3 million residents are eligible for health plans through the marketplace—2.6 million who qualify for subsidies and 2.7 million who do not. Of the uninsured and subsidy-eligible residents in

Top Five Languages Spoken in the Bay Area

English: 64.2%
Spanish: 14%
Chinese: 7.1%
Tagalog: 3.7%
Vietnamese: 1%

California, 47% are Hispanic or Latino, 33% are White, 12% are Asian, 5% are Black or African American, and 3% are other ethnicities. The Greater Bay Area has about 390,000 subsidy-eligible residents.⁵

In addition, nearly 40% of the subsidy eligible population in California—over 1 million people—have limited English proficiency. Many languages are spoken in the state, and the San Francisco metropolitan area is one of the nation's most diverse areas in terms of language: Census data shows 112

languages spoken at home, most with very small populations. The top five languages spoken at home in the Bay Area are English (64.2%), Spanish (14%), Chinese (both Mandarin and Cantonese) (7.1%), Tagalog (3.7%), and Vietnamese (1%).⁶

This issue brief identifies and reviews emerging consumer assistance programs from across the country—both navigator and non-navigator assisters—to highlight those that have demonstrated promise and success in reaching and enrolling racially, ethnically, and linguistically diverse individuals and families. While application of emerging practices and lessons are discussed in context of California and the San Francisco Bay Area, this information is broadly applicable to

other settings across the country. In particular, models, practices, and guidance embedded within this brief offer a unique opportunity to address a central national priority—that is, the successful enrollment of diverse individuals in the marketplace to not only reduce disparities in coverage and access to care, but to offer a sufficient mix of enrollees to assure the long-term viability of marketplaces for all populations.

To our knowledge, this is the first report to focus broadly on the rollout of consumer assister programs in marketplaces and describing experiences, lessons, and models related to reaching and enrolling diverse populations. While this issue brief is intended for a broad array of health care players involved with marketplace outreach, enrollment, and implementation, there are at least five specific audiences who will find this information helpful: marketplace managers and administrators, navigators and in-person assisters, community-based organizations, community advocates, and safety-net providers. The emphasis is on models and promising practices to make outreach and enrollment programs more culturally and linguistically appropriate to effectively reach and enroll diverse populations.

This issue brief is organized into nine sections. Following the executive summary and this introduction, the next section describes our overall approach and framework for review of marketplace consumer assister programs. Section IV discusses the different types of assisters that have emerged, along with related federal rules and regulations that have been issued to guide implementation. Section V offers a background on California’s marketplace—Covered California—and its different consumer assistance programs. Section VI shares specific models, practices, and lessons from across the country for effectively reaching and enrolling diverse communities, and the final sections offer a discussion and recommendations for considering the application of emerging models from across the country for California and the San Francisco Bay Area. We reiterate that while these recommendations are tailored to California and the Bay Area, we believe they can be more broadly applicable to other states and communities across the country as well.

Who Will Find this Issue Brief Helpful and How?

- **Marketplace Navigator Program Managers and Administrators** will find helpful information drawn from experiences and lessons learned from leading states on designing effective outreach and education programs, including information on funding, staffing, training, building community partnerships, venues for outreach, messaging and marketing, and program evaluation. This information may inform activities leading up to and during the next marketplace open enrollment period.
- **Navigators and In-Person Assisters** can learn from experiences and lessons on strategies that work or do not work for communicating with and enrolling diverse individuals and families, including venues for outreach, specific messaging, and how to build and sustain trust.
- **Community Organizations** will find examples of how they may partner or work with the marketplace in developing, reviewing, or vetting culturally/linguistically tailored outreach and education materials, serve as venues or sites for outreach, as well as other ways of getting involved.
- **Community Advocates** may be able to utilize this report to advocate for outreach and enrollment priorities that may require additional attention, support, or state/local policies to more effectively reach and enroll racially and ethnically diverse communities.
- **Safety-Net Providers** playing a key role in facilitating outreach and enrollment may find helpful information on staff training, effective messaging, where to find materials, and related guidance to help racially and ethnically diverse and uninsured patients get coverage.

III. Design and Methods

Findings included in this report have been drawn from an extensive review and analysis of reports, peer-reviewed literature, federal rules and regulations, news articles, and other related sources of information with the intent of coalescing experiences, lessons, and models for reaching and enrolling diverse populations. Our review was guided by an analytical framework we developed with key themes from our 2013 health insurance marketplace report⁷ and other related resources documenting primary characteristics and functions of effective outreach and enrollment assistance programs. As such, following are six key marketplace outreach and enrollment functions our review focused on:

1. Structure and funding of navigator and assister programs;
2. Community engagement and collaboration;
3. Navigator and assister training;
4. Communication strategies supporting education and enrollment;
5. Outreach and enrollment activities; and
6. Data and evaluation.

While a state-by-state review of each of the functions above was beyond the scope of this study, we conducted an extensive review of literature, reports, and the latest news updates to identify states and localities with leading initiatives across each of these functions in the context of reaching and enrolling diverse communities, novel ways to address challenges, and initial promising results. Information from reports and other sources is supplemented by interviews with select state marketplace personnel and community-based organizations leading activities around outreach and enrollment for diverse communities. See Appendix A for the list of informants interviewed (participants were told they would not be quoted or cited in the endnotes). Priorities and recommendations were enhanced with input obtained during a day-long community forum we convened in Oakland, California, on April 10, 2014. See Appendix B for an overview of this meeting, including agenda and keynote presentations. Appendix C contains the findings from the structured group brainstorming exercises from the meeting, including the resulting priorities and recommendations for California and the Bay Area.

Findings from our research, interviews, and the community forum are not intended to be representative of the country, but offer practical, real-time examples of experiences, lessons learned, and promising practices for reaching and enrolling diverse populations. We note that as regulations and navigator/assister programs continue to evolve, this issue brief offers a point-in-time status report with information and resources that may inform planning and activities leading up to and occurring during the second open enrollment period starting in November 2014.

IV. Marketplace Assisters: Definitions, Rules, and Regulations

While the ACA explicitly authorized the establishment of navigator programs, many different types of enrollment assisters have emerged in the marketplace depending on marketplace type (whether run by states, the federal government, or in partnership); funding mechanisms (whether federally- or state-funded); and differing roles and responsibilities that have created the need for several different types and names for enrollment assistance functions in the marketplaces. Some of these roles—such as navigators—were defined in the ACA and some were added later, with varying responsibilities and training requirements. *Our discussions and recommendations on how*

to effectively reach culturally and linguistically diverse populations generally refer to all types of assisters.

This section is organized into two subparts: the first describes the different types of consumer assistance programs that have emerged to help with outreach and enrollment, and the second part describes related rules and regulations for implementation. These programs, including their differing roles, characteristics, and regulations related to assuring cultural and linguistic appropriateness are summarized in Table 1.

A. TYPES AND DEFINITIONS OF MARKETPLACE ENROLLMENT ASSISTERS

Navigators are organizations and individuals originally defined in the ACA who provide outreach and education on health insurance options in every state and help people enroll in the marketplaces or other programs they may be eligible for such as Medicaid. Navigators are present in all three types of marketplaces, though specifics of their duties may vary in different states. In state-based marketplaces, navigators are funded from grants using marketplace-generated funds (they are not allowed to use federal funding, except for administration), and training and certification is handled by the states, though they may follow the federal training guidelines if they wish. In partnership and federally facilitated marketplaces, federal grants have been given to organizations chosen to be navigators, and they must undergo federal training and certification.⁸ In California, navigators and non-navigator assistance personnel are both termed Certified Enrollment Counselors.

Non-navigator assistance personnel (also called ***in-person assisters*** or ***IPAs***) perform the same duties as navigators but can be funded using federal funds (state grants that are funded with exchange establishment grants). They are part of an optional program in states that have state-based or partnership marketplaces that need to use federal funds for consumer assistance before their marketplace funding begins to fund their navigator programs. As of 2014, the five partnership marketplaces operating their own assistance programs and all 17 state-based marketplaces have established IPA programs.⁹ Federally facilitated exchanges do not have this type of assister since the federal government is funding their navigator programs directly. In state-based marketplaces, IPAs will receive state training and certification, and states may choose to use the federal training programs. In partnership marketplaces, IPAs will receive federal training and certification, which can be supplemented by the state.¹⁰ IPA programs will either be phased out by 2015 when federal establishment grants end, or will have to find new sources of funding from the marketplaces or private sources.

Certified application counselors (CACs) are workers who perform many of the same functions as navigators and non-navigator personnel such as education and enrollment but who are not compensated from new grants through the marketplace, such as staff already employed by community health centers and hospitals, and volunteers. These assisters are present in all three types of marketplaces, and may receive other funding through states or Medicaid. In state-based marketplaces, the CACs are undergoing state training and certification, and in partnership and federally facilitated marketplaces, they are receiving federal training and federal designation of their organizations.¹¹

Licensed health insurance agents and brokers also have a role in the marketplaces if states allow it. They may enroll individuals and small businesses in health insurance provided through

the marketplaces, and can be compensated by the consumer or by the insurance company as allowed by state laws. If in a state-based marketplace, they are undergoing state training and certification, and for partnership and federal marketplaces, they are undergoing federal training and registration.¹²

All marketplaces must have a *call center* or *customer service center* to serve consumers via telephone, and sometimes other methods such as online chat. States with federal marketplaces all use the federal call centers, and other states have either established their own call centers or outsourced them to a private company to operate. Call center personnel are trained and are responsible for answering questions and enrolling people into marketplace plans.¹³

The ACA also introduced *state consumer assistance programs (CAPs)*, health insurance ombudsman programs funded by federal grants that started in 2010. These programs help to educate and advocate for consumers and assist people in filing complaints and appeals with their insurance companies (for all insurance plans, not just in the marketplaces).¹⁴ Marketplace assisters can refer consumers to CAPs if needed, however, not all states have established CAP programs— Washington, D.C., and 35 states (including California) currently have CAP grants.¹⁵

B. FEDERAL PROVISIONS AND REGULATIONS ON ASSISTANCE PROGRAMS

According to the ACA, navigators, and non-navigator assistance personnel as established in later regulations, have the following duties:

1. “Conduct public education activities to raise awareness of the availability of qualified health plans;
2. Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits... and cost-sharing reductions;
3. Facilitate enrollment in qualified health plans;
4. Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman... or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and
5. Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges.”¹⁶

Final regulations issued in March 2012 establish that among other duties, navigators will be trained to have expertise in “the needs of underserved and vulnerable populations” and to “provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange, including individuals with limited English proficiency.”¹⁷ These regulations also state that marketplaces and their outreach and consumer assistance programs must be accessible, including to those who are limited English proficient, by providing free language services that include “(o)ral interpretation; written translations; and taglines in non-English languages indicating the availability of language services.”¹⁸

Final regulations in July 2013 provide more information on training and standards for navigators and non-navigator assistance personnel funded through federal funds, including on ways to meet the cultural and linguistic service requirement. Navigators and non-navigator personnel in the federal marketplace, as well as state non-navigator personnel funded by exchange establishment grants, must follow and be trained on the National Culturally and Linguistically Appropriate

Services (CLAS) Standards.¹⁹ Navigators in state-based exchanges and non-navigator personnel not using federal funds are not required to follow these standards, though the federal government encourages state marketplaces to use them as they may find them to be helpful.²⁰ These standards are listed in the regulations:

“(c)Providing Culturally and Linguistically Appropriate Services (CLAS Standards)... To ensure that information provided as part of any consumer assistance functions... is culturally and linguistically appropriate to the needs of the population being served... any entity or individual carrying out these functions must:

- 1) Develop and maintain general knowledge about the racial, ethnic, and cultural groups in their service area, including each group’s diverse cultural health beliefs and practices, preferred languages, health literacy, and other needs;
- 2) Collect and maintain updated information to help understand the composition of the communities in the service area, including the primary languages spoken;
- 3) Provide consumers with information and assistance in the consumer’s preferred language, at no cost to the consumer, including the provision of oral interpretation of non-English languages and the translation of written documents in non-English languages when necessary or when requested by the consumer to ensure effective communication. Use of a consumer’s family or friends as oral interpreters can satisfy the requirement to provide linguistically appropriate services only when requested by the consumer as the preferred alternative to an offer of other interpretive services;
- 4) Provide oral and written notice to consumers with limited English proficiency, in their preferred language, informing them of their right to receive language assistance services and how to obtain them;
- 5) Receive ongoing education and training in culturally and linguistically appropriate service delivery; and
- 6) Implement strategies to recruit, support, and promote a staff that is representative of the demographic characteristics, including primary languages spoken, of the communities in their service area.”²¹

The Centers for Medicare and Medicaid Services (CMS) released a Navigator Standard Operating Procedures (SOP) manual in August 2013 to provide guidance and requirements for navigators in federally-facilitated marketplaces. The SOP manual has a brief section on limited English proficiency (LEP) populations and states that navigators must follow CLAS standards, provide written translations of key documents, provide signs with taglines in other languages, have bilingual staff members, and refer consumers as needed to interpretation services (in-person or through the call center). The appendices also contain a section of helpful Internet links to resources on cultural and linguistic competency.²²

Finally, the ACA and related regulations also provide guidance on engaging and working with community partners in the marketplace. According to federal regulations, at least one navigator group in each marketplace must be a “community and consumer-focused nonprofit group,” and at least one must be another type of organization from the following list:

“Trade, industry, and professional associations;

- Commercial fishing industry organizations, ranching and farming organizations;
- Chambers of commerce;
- Unions;
- Resource partners of the Small Business Administration;
- Licensed agents and brokers; and

- Other public or private entities or individuals that meet the requirements of this section.” This includes tribal organizations and others.²³

Navigator entities cannot be a health insurance company, an association that lobbies for or includes health insurance companies, or anyone who gets direct or indirect compensation from a health plan for enrolling consumers. Licensed agents and brokers are allowed, but cannot get paid by both an insurance plan and a navigator grant. Besides being able to carry out the duties of a navigator listed above in the section on federal regulations, navigator entities must also “(d)emonstrate to the Exchange that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be eligible for enrollment in a QHP” (qualified health plan).²⁴

Table 1. Summary of Different Enrollment Assistors by Marketplace Type, Funding Source, and Cultural and Linguistic Competency Requirements

	Type of Marketplace where Present (State, Federal, or Partnership)	Funding Sources	Cultural and Linguistic Requirements
Navigators	All three types (required)	<ul style="list-style-type: none"> • State marketplaces: state, private, or marketplace-generated funds (no federal funds) • Federal and partnership: federal funds 	Marketplaces and navigators required to provide culturally and linguistically appropriate information; if receiving federal funds must follow CLAS standards
Non-navigator personnel (In-Person Assistors)	State and partnership: optional program (all have established); not present in federal marketplaces	Marketplace grants/ contracts that can be funded with federal funds (establishment grants)	Must provide culturally/ linguistically appropriate information; if receiving federal funds must follow CLAS standards
Certified Application Counselors	All three types (required)	Not paid through state or federal marketplace-related funds (could be funded through Medicaid or other sources)	Must provide culturally/linguistically appropriate information
Insurance Agents/ Brokers	All three types (if states allow them)	Not paid through state or federal marketplace-related funds (paid by insurance companies or consumers as allowed by state law)	Marketplace as a whole must provide culturally/ linguistically appropriate information, but some states do not require training on this for agents/brokers
Call Centers	All three types (required)	<ul style="list-style-type: none"> • State marketplaces: marketplace funds (establishment grants) • Federal and partnership: federal funds 	Must provide culturally/linguistically appropriate information

Note: Federal exchange establishment grants will end at the end of 2014, so federal funding for consumer assistance programs as noted in this table will no longer be an option after that except in states that are using the federal marketplace and partnership states not doing their own consumer assistance. Thus non-navigator assistance personnel may no longer exist after that and may be rolled into the navigator programs in state-based marketplaces and partnership marketplaces handling their own consumer assistance.

V. Outreach and Enrollment Programs in California and the Bay Area

California's marketplace, called Covered California, provides outreach and enrollment assistance through two primary programs: the Outreach and Education Grant Program and the Enrollment Assistance Program. The Outreach and Education Grant Program started first and formed a foundation for the Enrollment Assistance Program, which consists of two parts, the In-Person Assistance Program (IPA) and the Navigator Program. Both the IPA and Navigator Programs are comprised of Certified Enrollment Entities (CEE) and the individuals working for them, called Certified Enrollment Counselors (CEC).²⁵ Thus to the public, navigators and non-navigator personnel will be indistinguishable, as both will be called Certified Enrollment Counselors. The main differences between the two are timing and funding—the IPA program can use federal funds while still available, while the navigator program cannot use federal funds and will use funds generated from fees on health plans sold in the marketplace or from other sources. In California, the Outreach and IPA programs started in 2013, while the navigator component is starting in 2014. This section describes the role and scope of California's Outreach Program as well as the IPA and Navigator Programs, including how they are working to reach and enroll diverse communities.

A. OUTREACH AND EDUCATION GRANT PROGRAM

Established in advance of open enrollment in 2013, Covered California's Outreach and Education Grant Program has awarded more than \$40 million to various organizations to conduct outreach and education activities through December 2014. In grant cycle I starting in summer 2013, \$37 million was awarded to 48 lead organizations with more than 250 subcontracting organizations around the state, and an additional \$3 million was set aside to help with future efforts in reaching underserved populations. Grantees are required to have previous experience with outreach and education, and to have cultural and linguistic knowledge of target populations. Additionally, the program offers education in all 12 Medi-Cal threshold languages and others.²⁶ Trained outreach workers with grantee organizations are called Certified Educators.

Outreach grantees in grant cycle I included many organizations targeting racially and ethnically diverse communities:

- 37 organizations focused on Hispanics or Latinos,
- 32 organizations focused on African Americans,
- 20 organizations focused on Asians, and
- 11 organizations focused on the Middle-Eastern community.²⁷

Many other types of organizations were also funded for outreach and education, such as unions and medical providers. In addition, grantees were given flexibility to target more than one audience and encouraged to partner with a variety of community organizations targeting different populations. Ten of the grantees are located in the Bay Area, though the work of some extends to counties outside of this area, and other organizations' outreach will extend into the Bay Area, especially the seven statewide organizations.²⁸ See Appendix D for a list of the 10 outreach and education grantees located in the Bay Area and what counties they cover, as well as a list of the seven statewide grantees whose reach includes the Bay Area.

In Outreach and Education grant cycle II, which started in September 2013, the Provider Education Grant Program awarded \$3.1 million to four medical associations to help health care providers of all types learn about the Affordable Care Act and the marketplace, and to educate

their patients. The California Academy of Family Physicians, the California Medical Association Foundation, the California Society of Health-System Pharmacists, and the National Council of Asian Pacific Islander Physicians intend to reach over 200,000 providers around the state.²⁹ These provider groups as well as the other outreach and education grantees are raising awareness among consumers and laying the groundwork for enrollment activities. Several organizations are participating in both the Outreach and Education Grant Program and the IPA Program, which is discussed in the following section.

B. IN-PERSON ASSISTANCE PROGRAM

Covered California's IPA Program began training and certifying CECs for the program in summer 2013. The first CECs began helping consumers when the marketplace opened on October 1, 2013, while additional individuals and entities continued to be reviewed and certified during the open enrollment period. The IPA Program pays the CEE \$58 per successful application and enrollment into marketplace plans or Medi-Cal and \$25 per successful renewal, and the entity determines how to compensate the individual CECs.

Many types of organizations are eligible to be CEEs, including faith-based organizations, American Indian tribes, Chambers of Commerce, nonprofit organizations, and school districts. Several types are not eligible for compensation, such as licensed health providers and institutions and county health departments, since these will receive a direct benefit from enrolled individuals. However, some health providers that serve the uninsured and underserved are allowed to receive compensation for enrollments, such as community health centers, free clinics, and Indian Health Service facilities.³⁰ A Certified Application Counselor (CAC) program is currently under development to certify enrollment assisters who are not paid from the marketplace.³¹

C. NAVIGATOR PROGRAM

The Navigator Program, originally slated to start training in fall 2013 and start assisting consumers in January 2014, has been pushed back to start later in 2014 to afford the opportunity to integrate lessons learned from the IPA Program as well as to offer additional time to generate needed fees from marketplace health plans to cover program costs. The navigator grant application was issued in February 2014 and was due in March. Grants will be awarded in May, with training and certification occurring soon thereafter with navigator organizations scheduled to start assisting consumers in July 2014.³²

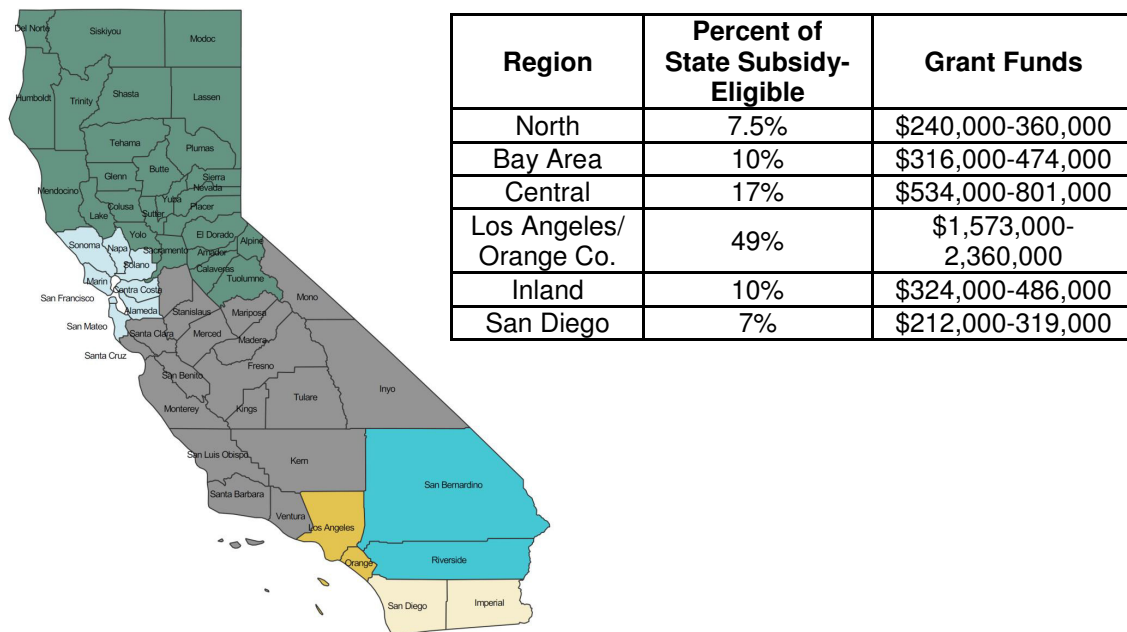
Covered California's Navigator Program will award up to \$5 million in competitive grants each year to qualifying organizations for enrollment, outreach, and education. The stated goals of the navigator program are as follows:

1. "Maximize enrollment of eligible consumers in subsidized and unsubsidized Covered California Plans.
2. Prioritize enrollment assistance to areas with the largest concentrations of uninsured individuals.
3. Engage entities that maintain trusted relationships with target markets as defined by geography, employment sector, culture, language, or other shared characteristics, and possess the capacity to serve as an integral part of Covered California's service delivery channels.
4. Maintain a cost effective grant program, given the \$5 million available in funding.

- Coordinate with the In-Person Assistance Program and Outreach and Education Grant Program to ensure alignment and cost effectiveness.”³³

The navigator program proposes to help eligible populations through two main funding strategies: (1) a targeted funding pool (\$1-2 million) intended to award smaller grants to organizations that target hard-to-reach uninsured populations within one or more regions, and (2) a regional funding pool (\$3-4 million) that encourages regional collaborations to submit joint proposals under a lead organization to reach target markets in one or more regions.³⁴ The targeted funding pool will award 2-8 grants of \$250,000-\$500,000 to organizations serving a targeted segment of the uninsured population—such as individuals with limited English proficiency or younger adults—and demonstrating an existing relationship with the target population. The organizations can propose to serve their targeted populations within any geography, whether city, county, regional, or statewide. However, they are asked to reach populations not being adequately served by other programs based on a review of enrollment data. A maximum of six grants will be awarded from the regional funding pool, one for each of the six regions, to lead entities that will work with established partners to implement the activities throughout the region.³⁵ See Figure 1 for a map of the six regions and a table of the navigator grant ranges for each area.

Figure 1. Map of California Navigator Grant Regions and Funding Ranges



Source: Covered California, “Navigator Program Grant Webinar” (Feb. 2014, p. 13), available at <https://www.coveredca.com/hbx/stakeholders/navigator-program/documents/2%202024%2014%20Navigator%20Grant%20App%20Webinar.Final.pdf>.

The Outreach and Education and IPA programs will be evaluated after the first open enrollment period ends. Following that evaluation, Covered California intends to assess the feasibility of continuing these programs without federal funds. No state budget funds can be used for marketplace operations, so if the marketplace decides to continue these programs, along with the navigator program which is required by law, it will need to find additional funding sources. There is a possibility these programs may be merged with the navigator program instead of remaining separate given their aligning missions, but questions around limited funding may still remain.

VI. Findings: Promising Practices and Lessons Learned for Reaching and Enrolling Diverse Populations through the Marketplace

Our review of outreach and enrollment efforts targeting racially, ethnically, and linguistically diverse communities focused on identifying promising practices and lessons learned across six broad features and functions of marketplace enrollment assistance programs:

- Structure and funding of navigator and assister programs;
- Community engagement and collaboration;
- Navigator and assister training;
- Communication strategies;
- Outreach and enrollment; and
- Data and evaluation.

For each of these functions, we describe experiences, models, and promising practices drawn from our review of leading state marketplaces, the federal marketplace, national outreach programs, interviews, and recent reports on effective strategies for reaching and enrolling diverse communities in health insurance programs.

A. STRUCTURE AND FUNDING OF NAVIGATOR AND ASSISTER PROGRAMS

The successful enrollment of uninsured individuals and families across all marketplaces, whether federal, partnership, or state-based, depends on carefully designed and executed navigator and other assister programs that can tailor their efforts to reach culturally and linguistically diverse populations and others needing extra help. While the ACA initially authorized the establishment of navigator programs in all marketplaces, evolving programmatic needs introduced the creation of many other consumer assisters, varying largely in structure and funding but aligning in purpose (i.e., to educate and enroll people). State-based marketplaces—including Covered California—have each established their own consumer assistance programs designed to meet state needs. This section discusses emerging models and shares experiences from select states across the country on how they are designing, structuring, and funding their enrollment assistance programs.

Structure. State-based and partnership marketplaces responsible for assisting consumers have more flexibility than federally facilitated marketplaces to design their outreach and enrollment assistance programs to meet their needs, and as such are using varying models. Many states are applying a “hub and spoke” design where the marketplace contracts with several lead organizations that manage the assistance program in their regions and subcontract with smaller organizations to target different populations. Examples of such a model include the states of Maryland and Washington, which are contracting with six and ten hub organizations, respectively.³⁶ Other states have contracted directly with a number of assistance organizations and individuals around the state along with several main regional organizations to assist in management and training. These include Colorado, which awarded 57 assister grants, including grants to six organizations that serve as regional hubs, and Oregon, which has over 1,200 paid and unpaid assisters overseen by several community partner organizations.³⁷

Other examples are found in Connecticut and New York. The Connecticut marketplace (Access Health CT) gave grants to six organizations to serve as navigators and about 300 individual in-person assisters speaking a total of 32 languages. The navigator entities each manage a separate

region of the state, and the number of assisters hired in each region was based on the proportion of uninsured in that area.³⁸ In New York, the marketplace (NY State of Health) gave navigator and in-person assister grants to 50 organizations that have subcontracted to 96 organizations around the state, consisting of over 430 assisters speaking 48 languages.³⁹ In California, the In-Person Assister Program is reimbursement-based and not competitive grant-based, allowing over 500 organizations to participate, as mentioned in the next text box (the number of organizations in the forthcoming Navigator Grant Program will be much more limited). As mentioned previously, the Outreach and Enrollment Grant Program in California awarded grants to 48 lead organizations with more than 250 subcontracting organizations.

Selection of Navigators and Assistors. Many state marketplaces are making careful considerations in selecting organizations to serve as part of the navigator and assister programs to assure they represent, are well connected with, and are trusted by hard-to-reach populations, including those who are culturally and linguistically diverse. This is especially the case as regulations require navigator and assister entities to provide information in a culturally and linguistically appropriate manner and demonstrate that they have or can form relationships with the populations they are serving. For example, a variety of organizations in the 34 states with federal or partnership marketplaces received federal navigator grants, and the list of these organizations shows that many are health-related or that have specific experience or a mission of serving specific populations such as Hispanics, immigrants, or the disabled.⁴⁰ Some of these organizations, especially in the larger or more diverse states, also contract with smaller organizations to reach targeted communities.

Navigator and/or assister organizations chosen in state-based marketplaces show this variety as well, including in Connecticut,⁴¹ Colorado,⁴² New York,⁴³ and Maryland.⁴⁴ Many organizations in these states cater to serving culturally and linguistically diverse populations, whether with health care as the focus or other services, and some also have equity as a mission as well as a diverse staff including bilingual individuals. For example, Hispanic Health Council, a navigator organization in Connecticut, has a mission statement "... to improve the health and social well-being of Latinos and other diverse communities."⁴⁵ In addition, many community organizations that have received marketplace grants have a history and track record of enrolling diverse populations into Medicaid and the Children’s Health Insurance Program (CHIP). This is particularly the case in states such as New York, Colorado, and Oregon, where previous organized outreach and enrollment networks existed. In California, the in-person assister program has certified many organizations and enrollment counselors serving different cultures and speaking a number of languages.

In-Person Assistors in California		
Navigator organizations in California have not been selected yet, but as of January 2014 there are 583 Certified Enrollment Entities and 3,696 Certified Enrollment Counselors in the In-Person Assister Program. About 60% of assisters speak Spanish, and the numbers of organizations serving populations speaking other languages include (some have more than one language): ⁴⁶		
English: 559	Cantonese: 63	Russian: 45
Spanish: 510	Mandarin: 63	Arabic: 45
Farsi: 97	Hmong: 51	Armenian: 42
Vietnamese: 91	Korean: 46	Other: 67
Tagalog: 88		

A report on designing navigator programs notes that “(r)esearch indicates that the lowest income and rural consumers prefer the kind of high-touch in-person services offered by community-based organizations while more moderate-income individuals may be comfortable with using a website or applying over the telephone with assistance from the exchange’s call center.” Since resources are always limited, the best strategy is to “target navigator services through community-based groups that are best able to reach the most vulnerable, uninsured populations, focusing on those who are less likely to maneuver the eligibility and enrollment process on a self-service basis.” It also recommends to “(b)uild on existing infrastructures and assistance networks. By building on existing outreach and assistance activities, states can tap the knowledge, experience and relationships of organizations that currently help consumers.”⁴⁷ Currently, navigator and assister organizations in both the federal and state marketplaces have experience in reaching targeted vulnerable communities.

A report by the Center on Health Insurance Reforms at Georgetown University Health Policy Institute suggests that:

The real starting point is selecting the right navigators; organizations that can hit the ground running to serve either broad or targeted constituencies; organizations that share the state’s vision of coverage and will be mission-oriented. It’s true that training can heighten awareness of the barriers that consumers face, but it takes on-the-ground, hands-on experience to truly connect with consumers, to earn their trust and, more importantly, to understand their plight. For example, cultural competency means much more than connecting with a language line to provide translation. It also means overcoming fear factors that mixed immigration families face.⁴⁸

This contention is borne out by our project interviews, where several informants suggested that selecting community organizations that have longstanding experience working with specific communities, have a level of trust, and can communicate in the languages spoken are more effective in reaching and enrolling diverse populations than organizations not well connected with communities.

Funding. All of the 27 states with federally facilitated marketplaces as well as the seven state-federal partnership marketplaces have navigator programs that are federally funded. In August 2013, the U.S. Department of Health and Human Services awarded \$67 million to 105 organizations to be navigators in these states.⁴⁹ The state-based marketplaces have navigator programs that are not federally funded, as well as in-person assister programs that can be funded with federal exchange establishment grants through 2014 (five of the partnership marketplaces also have in-person assister programs).

This has resulted in more funding for enrollment assistance being available in the state-based and partnership marketplaces than in the federally facilitated marketplaces, where fewer funds have been spread among more states. When available navigator and in-person assister funds for the first open enrollment period are measured by the number of uninsured people below age 65 in each state, states with federally facilitated exchanges have by far the least funding per person, at \$2.06, while state-based marketplaces have an average of \$13.77 per person, and the partnership marketplaces doing their own consumer assistance have an average of \$18.73 per person.⁵⁰ All states also have additional resources to help with enrollment that are not counted here such as

state or federal marketplace call centers, volunteer assisters, insurance agents, and the \$150 million in federal grants given to community health centers in 2013 to hire eligibility workers.⁵¹

Currently, navigator and in-person assister programs can be funded through the following sources:

1. Federal grants (navigators in federally facilitated and partnership states only);
2. State grants that are funded with federal establishment grants through 2014 (for in-person assister programs only);
3. State funds appropriated from state budgets (prohibited in some states such as California);
4. Funds from operational fees on health plans in the marketplaces (navigator programs in state-based marketplaces); and
5. Private funding from nonprofits, foundations, or other sources.

State grants funded by federal exchange establishment grants seem to provide the highest levels of funding out of these five categories, but this source of funding is available only through the end of 2014 when the grants end (the ACA requires that marketplaces be self-sustaining by 2015). After that, marketplaces that depended on these funds for prior grants will need to turn to other funding sources if they wish to keep the same programs in place. Few, if any, state budgets are in the position to provide funding, and funds from marketplace plans or user fees may not be enough to sustain outreach and enrollment programs at close-to-current levels. Thus supplemental private funding may become a necessity in many states.

Connect for Health Colorado is an example of a marketplace that has used private foundation grants to supplement funding for outreach and enrollment programs. The Colorado Health Foundation awarded over \$2 million in grant funding to the marketplace to support consumer assistance activities for which federal grants could not be used.⁵² Connect for Health Colorado will also receive some of the reserve funds held by CoverColorado, the state's high risk pool program, when it closes this year, so the marketplace has not implemented an assessment on health plans at this time.⁵³ Access Health CT in Connecticut has also raised more than \$200,000 in funding from three private foundations and may receive more. State-based marketplaces will need to continue to explore creative funding efforts such as these to be sustainable after 2014.

Funding in California

From 2010-2014, California received federal marketplace grants totaling \$1,065,212,950.⁵⁴ Since state general funds cannot be used for the marketplace, Covered California is trying to save some of this funding to offset possible budget deficits in future years after federal grants stop at the end of 2014. Covered California currently receives \$13.95 per health plan sold in the marketplace,⁵⁵ and may explore private funding to supplement enrollment programs in the future.

B. COMMUNITY ENGAGEMENT AND COLLABORATION

The ACA states that marketplaces “shall consult with stakeholders relevant to carrying out the activities under this section, including... advocates for enrolling hard to reach populations.”⁵⁶

Many state-based marketplaces are engaging and consulting with relevant stakeholders and incorporating their feedback in planning, design, and implementation of outreach efforts. States such as California, New York, Colorado, Maryland, Connecticut, and Washington held forums and focus groups around the state soon after their marketplaces were established to meet with a

variety of stakeholders, including groups representing diverse communities, and obtained input on planning for outreach programs and other marketplace operations.⁵⁷ This section describes different approaches that states are using to engage community stakeholders in planning and implementation of the marketplace. In addition, we discuss strategies that states are undertaking to consult American Indian tribes.

Stakeholder Advisory Groups. Many states have created more formal stakeholder advisory groups to obtain input on various topics as the marketplace planning progressed. For example, Connect for Health Colorado has established four advisory groups to provide feedback on various topics—including Individual Experience, Outreach and Communications, Small Business Health Options Program, and Health Plans. These groups have also been surveyed to provide input on how they can improve the advisory group process in the future.⁵⁸ The Colorado marketplace also has an ad hoc advisory group of Hispanic organizations that it consults with for feedback on Spanish materials and other related outreach concerns. It has also worked closely with several nonprofits and coalitions in developing the marketplace.

Access Health CT has four advisory committees made up of stakeholder partners—Consumer Experience and Outreach; Health Plan Benefits and Qualifications; Brokers, Agents and Navigators; and Small Business Health Options Program—and the committee webpage states they “represent a broad array of interests in Connecticut” and assist in “establishing policy, refining goals, delineating functions, and providing ongoing program evaluation.”⁵⁹ NY State of Health took a regional approach instead of by topic, and has five advisory committees made up of a variety of stakeholders from each of the five regions of the state: Western New York, Central NY/Finger Lakes, Capital District/Mid-Hudson/Northern NY, New York City/Metro, and Long Island.⁶⁰ It has also worked closely with several advocacy groups in the state.

Emerging Strategies for Community Engagement

- Hold meetings around the state during planning stages
- Continually solicit feedback from stakeholders and the public
- Create advisory groups of community members
- Formally consult with Indian Tribes

After the California marketplace was formed in September 2010, staff met with stakeholders around the state, held webinars, and publicized board meetings, with many advocacy groups being active in giving feedback. Covered California formed several advisory groups and work groups on different topics during the planning process, and once open enrollment began it formed additional advisory groups of Latino, African American, and Asian stakeholders from which the marketplace continues to solicit and receive feedback. Recently, the marketplace took into account advice from stakeholders when it changed its initial plan to organize the navigator program by three regions into six regions, accepting feedback that the three regions were too large and diverse to be effective.

Consulting American Indian Tribes. Federal rules in March 2012 added federally recognized American Indian tribes to the groups that marketplaces must regularly consult,⁶¹ and the federal government consults with tribes about the ACA and other health-related programs.⁶² Some state-based marketplaces have Indian representatives on their advisory committees, and states with federally recognized tribes have also developed formal tribal consultation policies.

For example, Colorado created a consultation policy in December 2011 and continues to participate in meetings, update tribal leaders, train Indian enrollment assisters, and develop

materials specific to Indians.⁶³ Oregon finalized a tribal consultation policy in April 2012 that was used as a model by several other states, and was the first state marketplace to hire a tribal liaison to work with Indians.⁶⁴ Washington Healthplanfinder worked with tribes and the American Indian Health Commission for Washington State to develop its tribal consultation policy, and it continues to collaborate with tribal governments and tribal organizations on their unique needs.⁶⁵ Covered California has a Tribal Advisory Group that it regularly meets with, and a Tribal Consultation Policy was finalized in November 2012.⁶⁶

C. NAVIGATOR AND ASSISTER TRAINING

The effective design and execution of navigator and assister training programs is important for developing a cadre of outreach workers who have the skills and knowledge to successfully educate and enroll diverse populations in the marketplace. But recognizing the differences affecting who, how, and in what way engagement and enrollment might best occur, training and certification requirements vary by type of marketplace, organization involved, and their role. This section describes the different navigator and assister training programs that have emerged in the marketplace, highlighting specifics around design, content, and format for such programs, and how they explicitly integrate race, culture, and language priorities.

Training Content and Format. Training provided to navigators and in-person assisters must cover content related to the “needs of underserved and vulnerable populations,” as well as other aspects of the marketplace, such as procedures for eligibility and enrollment, available health plans, subsidies, and privacy and security standards.⁶⁷ Training provided by the federal government to the navigators it funded in 34 states is online and takes 20-30 hours of reading and quizzes.⁶⁸ One of the 14 training modules addresses cultural competence and language assistance, and consists of 75 slides on topics such as definitions of culture, how to avoid bias and stereotypes, language services available, how to plan for limited English proficient services, legal considerations such as nondiscrimination, and practice scenarios. A shorter training program is available for certified application counselors.⁶⁹

At least 17 states with federally facilitated or partnership marketplaces have passed legislation mandating additional training or requirements for navigators and assisters in their states,⁷⁰ though some of those have been challenged as too restrictive, such as in Missouri, where a federal district judge determined in January 2014 that a law passed in 2013 adds too many burdens and obstructs the federal purpose of the navigators in that state.⁷¹ Texas mandated an extra 20 hours of training for navigators, but some local agencies found a loophole when they realized the regulations apply only to the federally funded navigators, so their certified application counselors funded from other sources do not have to comply with the additional state training and requirements, which some feel are not necessary and were politically motivated.⁷²

Training requirements in states with state-based marketplaces vary, and some have been modified from initial plans and continue to be adjusted as needed. In general we have found that a training program lasting several days, often with both online and in-person components and with a test at the end, is required for navigators and other in-person assisters who do both outreach and enrollment, and that the training length may be reduced somewhat for other types of assisters. For example, training duration may be less for personnel whose only function is outreach, which in some states is a separate function as it is allowed to be funded by federal grants in 2013-2014, or for assisters performing enrollment only, such as insurance agents/brokers and certified

application counselors who do not perform outreach. Information and training on cultural and language issues may be contained in stand-alone sessions and also interspersed in other modules, and may not be required for agents and brokers. Some state-based marketplaces have contracted with outside vendors to develop and/or provide their training programs.

Covered California has a three-day training program that includes a module on cultural and linguistic competency. This training program is required for certified enrollment counselors (both IPAs and the forthcoming navigators), call center staff, and insurance agents; outreach grantees receive less training since they are not responsible for enrollment. After attending the training sessions, applicants must score at least 80% on the certification exam, and must renew their certification annually.⁷³

Promising Practices in Format of Navigator/Assister Training Programs

- Have combination of in-person and online components over several days
- Must pass tests to measure knowledge
- Cultural and linguistic competency and anti-discrimination addressed in both a separate module and integrated into others
- Informal updates such as through topical webinars and calls to allow training to continue
- Using train-the-trainer methods to allow additional assisters to get trained faster

In Connecticut, Access Health CT offers 35 hours of training for navigators and assisters, with a majority of it in-person along with several online parts, including one 40-minute module on the CLAS standards and the Americans with Disabilities Act.⁷⁴ Cultural and linguistic competency topics are also mentioned in other parts of the training, totaling about 5 hours. Training for certified application counselors lasts for two days.

In Colorado, training for the assistance network includes 16 hours in person and 16 hours online.⁷⁵ There is one online module on CLAS standards that takes about an hour and includes cultural sensitivity, the definition of cultural competency, language support available, immigrants and related barriers, and legal obligations such as laws on nondiscrimination. Cultural issues are also mentioned in several other modules, such as the special eligibility requirements concerning American Indians and Alaska natives.

Some states are using a train-the-trainer model, such as in Washington, where the 10 lead assistance organizations undergo training from Washington Healthplanfinder and are then responsible for training their community partners.⁷⁶ The 24 hours of training consists of 6 modules, including a 2-hour module on serving American Indians and Alaska natives, and a 3-hour module on the role of navigators that includes cultural and language access needs.⁷⁷

Connect for Health Colorado is also implementing train-the-trainer, so the regional hubs and medical facilities can take the training from the marketplace and then use the same materials to train others without having to wait for the marketplace to offer the in-person portions again. In all states, marketplaces and lead assistance organizations also use more informal means such as phone calls and webinars to train and inform navigators and assisters on marketplace issues and website improvements on an ongoing basis.

The Center on Health Insurance Reforms at Georgetown University Health Policy Institute reports on some important considerations for training programs, including that “(t)raining can be

viewed as a discrete activity but it's certainly not a one shot deal," and that it needs to be "an ongoing, interactive process." It is ideal to conduct part of the training in person, so it can involve role-playing to help the assisters learn what to do in different situations they may encounter. Programs can also include regional training coordinators that work with assisters in the field, and can provide routine policy updates via phone calls or meetings. Another recommendation suggests that navigators and assisters "share best practices, lessons learned and what's working or not working on the ground level."⁷⁸

"Training can be viewed as a discrete activity, but it's certainly not a one shot deal...[it is] an ongoing interactive process."⁷⁹

Our interviews with selected states and community-based organizations revealed that training on cultural and linguistic competency is not of major concern for many community organizations conducting outreach and enrollment as by their very nature and mission, they have a history of working with and reaching diverse communities. However, there was a recognition that consumer assisters from these organizations do need to be thoroughly trained on the topics specific to the marketplace and the ACA, and how eligibility may vary by income, immigration status, and other factors.

Language of Training. The federal website offers training materials for navigators and certified application counselors in Spanish, but no state-based marketplaces appear to offer training in languages besides English. Advocates such as the National Health Law Program have recommended that training be offered in additional languages, but one state we interviewed commented that they decided against it because they wanted to make sure their assisters were truly bilingual. They believe navigators and assisters need to be fluent in English as well as the language they are assisting in, in order to be able to attend meetings and conference calls and understand the updated information on technical and policy issues and other matters that are required for them to be effective, since all ongoing updates and information cannot practically be made available in multiple languages.

D. COMMUNICATION STRATEGIES

Appropriate communication tools are essential to educating and enrolling consumers, especially culturally and linguistically diverse communities. Translated and culturally sensitive websites, print materials, and messages, as well as call center features and capacity, are important facets of the marketplace infrastructure that must be in place in order for outreach and enrollment to be at their most effective. Many of these resources are also required by law to be culturally and linguistically competent, as mentioned previously.

Website Enrollment and Content in Non-English Languages. For states with federally facilitated marketplaces, the web portal for insurance information and enrollment, Healthcare.gov, has some information and translated applications available in 13 languages besides English, but the only languages for online enrollment are English and Spanish.⁸⁰ The Spanish enrollment application at CuidadoDeSalud.gov went online in December 2013, several months after open enrollment had begun.

A few state-based marketplaces also offer online enrollment in Spanish, including Colorado, Washington, California (early January 2014), and Connecticut (February 2014) though no states seem to offer other languages. About half of the state marketplaces have their consumer websites in Spanish, even if they do not have actual online enrollment available in Spanish. Some

marketplace websites list a message and the call center phone number in additional languages so consumers know they can call and have an interpreter help them enroll. For example the New York State of Health website has a tagline and the phone number in seven languages,⁸¹ Vermont Health Connect has a tagline and the phone number in 10 languages,⁸² and Kynect in Kentucky has this information in eight languages.⁸³

One useful feature of some marketplace websites is the ability to search for enrollment assisters by language as well as location. For example, in Connecticut, the Access Health CT website allows consumers to search for assisters by language, with 19 languages listed on the web portal,⁸⁴ and 32 languages listed on the assister website.⁸⁵ Similarly, New York's website has a page to find brokers and navigators by several criteria such as languages supported, though it only lists seven languages,⁸⁶ while the navigator program says it includes assisters speaking 48 languages.⁸⁷ Connect for Health Colorado allows searching by 22 languages,⁸⁸ while Cover Oregon lists 36 languages plus American Sign language in the search features on its partner page.⁸⁹ On the Covered California website, consumers can search for Certified Enrollment Counselors by over 200 languages, though some of them do not return any results.⁹⁰ Other marketplace websites such as Nevada's and Kentucky's list all the certified assisters and their locations and contact information, but not what languages they speak.

Translated Printed Materials. In an effort to provide materials about the marketplace that are “culturally and linguistically appropriate” as required by law, marketplaces and consumer assistance organizations are providing materials in languages besides English. There are some materials, such as a health plan's summary of benefits and information on claims appeals, that the ACA requires be distributed in different languages when 10% or more of the population in a county are literate in the same language. This estimate will be determined annually from census data. Currently, in addition to English, other languages meeting this threshold in certain counties are Spanish, Chinese, Tagalog, and Navajo.⁹² But some marketplaces are producing marketing materials in many additional languages as well.



The federal marketplace has informational materials online for assisters to use in 34 languages, with the most documents in Spanish,⁹³ since it is the most commonly spoken language after English, and fewer documents in other languages—some of which have a translated application only.⁹⁴ It has also published taglines in 25 languages that provide a toll-free number for the marketplace along with this translated message: “If you, or someone you’re helping, has questions about the Health Insurance Marketplace, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-318-2596.”⁹⁵

State-based marketplaces also have materials available in other languages, depending on their demographics. In Connecticut, flyers on the marketplace are available in English and Spanish, and enrollment checklists are available in seven languages, with more in development.⁹⁶ There are also several event announcement templates online that navigators can customize to distribute for their events, and navigators and assisters are allowed to create additional materials in other languages if they wish, but they cannot have the official Access Health CT logo on them if the

materials did not come from the marketplace. In the New York marketplace, educational materials including definitions, fact sheets, posters, and rack cards are available online for printing in seven languages besides English.⁹⁷

The Colorado marketplace has all informational materials in Spanish, with some such as flyers and posters in 12 other languages as well, and assisters can create additional materials. Washington Healthplanfinder has fact sheets and rack cards available for download online in eight languages, along with other outreach materials such as talking points, flyer templates, posters, and computer files of the logo so partners can create their own materials, within the usage guidelines.⁹⁸ The Oregon marketplace has materials online in seven languages, plus some materials in English especially for American Indian tribes.⁹⁹

Covered California has fact sheets online translated into 12 languages, and there is a separate page for Certified Enrollment Entities to order additional materials in different languages.¹⁰⁰ The paper application is translated into 10 languages.¹⁰¹ Community groups and advisory committees play important roles to review translations for their accuracy and cultural and linguistic appropriateness and provide feedback to Covered California for any necessary modifications.

Selected Online Resources for Making Materials More Accessible to Individuals with Limited English Proficiency¹⁰²

Language Access Checklist for Marketplace Implementation by Families USA and the National Health Law Program offers tips on activities such as conducting needs assessments, translating outreach materials and applications into the most common languages in the state, sending communications in consumers' preferred language, gathering feedback from assisters and limited English proficient clients, and having the marketplace's homepage include taglines about the availability of language services in the top 15 languages.¹⁰³

Language Mapper at the U.S. Census Bureau is available to help states and community organizations identify commonly spoken languages in their area to target and prioritize language-specific resources and activities.¹⁰⁴

The Migration Policy Institute website contains helpful resources on language access planning and evaluation, ensuring translation quality, best practices for multilingual websites, certifying multilingual employees, and drafting contracts for language access services.¹⁰⁵

Enroll America has a publication called "Translations that Hit the Mark" that discusses characteristics of a good translation and how to choose a translator.¹⁰⁶

Public Health - Seattle and King County, one of the 10 lead assister organizations in Washington, has a detailed translation policy and manual, links to language resources, and lists over 25 languages in which various health-related materials are available.¹⁰⁷

Transcreation. One approach that can help diverse communities and limited English proficient populations in this process is "transcreating" the messages and materials into other languages or formats to make them more appropriate and understandable. Transcreation entails adapting messages or concepts to another language or culture by keeping the same intent but not using a literal word-for-word translation if it would not be as appropriate. It is often undertaken for different languages to incorporate different idioms and graphics that make the most sense in that

language and in the cultural context, instead of literally translating from English. It is also often applied for English-language materials, for example to adapt messages to different cultural groups such as American Indians or African Americans who may speak English but would respond more effectively to tailored educational and marketing materials with situations and pictures more familiar to their communities and cultures.

Connect for Health Colorado transcreated its Spanish-language outreach materials, including those on its website such as “10 Reasons to Learn What Connect for Health Colorado Offers,” using a translation firm and its ad hoc committee of Spanish speakers.¹⁰⁸ Its materials currently available in other languages besides Spanish were generally just translated and not transcreated. Similarly, Access Health CT found that traditional outreach and marketing works to reach consumers who already want insurance and just need to know where to get it, but does not work well for people who have never had insurance before, do not understand it, or do not know that they need it, as is the case in many diverse communities. To educate more uninsured individuals effectively and convince them to enroll, the marketplace started using messaging from Enroll America¹⁰⁹ and the federal marketplace.¹¹⁰ It started the “Because I Got Covered” campaign to appeal to diverse groups, and materials were made available in Spanish and English. The graphics show people from different ethnic groups, and some of the messages are titled “Find a Plan that Fits Your Budget,” “Get Back in the Game,” “Peace of Mind,” and “Pre-Existing Conditions.”¹¹¹

Messaging. Marketplaces have found that the messages contained in their print materials and media campaigns need to be culturally and linguistically appropriate to the target audiences, and that the focus of the message may need to be different from previous outreach and enrollment campaigns where there was often just one product, such as Medicaid or CHIP, and not multiple choices of health plans and other complex features of the marketplaces. Even though there are similarities with previous efforts that can help to guide current programs, staff involved with consumer assistance programs in the marketplaces have remarked that in some ways it is a new and unprecedented effort and that everyone, both marketplaces and community organizations, are learning as they go as to what messages and methods work best to educate and encourage individuals from different cultures to enroll.

Besides the variety of products available in the marketplace and new ACA rules such as the requirement that almost everyone carry health insurance, another difference is that many community organizations have a history of working primarily with the lowest-income populations; but with the new marketplaces, subsidies are available to those earning from 138% to 400% of the federal poverty level (100% to 400% in states not expanding Medicaid), and those with higher incomes can enroll as well. Thus they now have new working class and middle class uninsured populations that need to be reached for the marketplace and educated on the availability of tax subsidies, as well as those with lower incomes who may qualify for Medicaid, especially in the states that are expanding eligibility up to 138% of poverty. As such, messaging may need to be modified to accommodate circumstances.

The federal marketplace produced several research-driven publications such as “Talk About the Health Insurance Marketplace,” which shows messages that worked best and those that did not work as well in research with different consumer demographics. The top three messages for all demographic groups, which were shown to be “both highly motivational and highly believable,” are:

1. “You can get lower costs.

2. You can find out if you're eligible for a free or low cost health insurance premium.
3. You can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll."¹²

Some of the messages and terms determined to be most understandable or motivating to the uninsured are using specific and realistic dollar amounts whenever possible—since “affordable” is a relative term—mentioning the health care law to provide a context, saying that consumers have control over their options, and mentioning “Information about prices and benefits is written in simple terms you can understand” and “You could lower your monthly premiums right away.”

Messages that were found to not be as effective include mentioning only families (single and childless people may not identify), “low cost plans” (may look like lower quality), and “one-stop shopping” (respondents liked information in one place but thought this term was too trivial or too sales-oriented). Also, it is not as effective to mention travel sites like Orbitz (too trivial, health insurance more important than picking a hotel), or say not to worry about the fine print (some individuals want to understand the details of what they are buying).¹³

Following is a summary of what Enroll America describes are effective strategies and messages for reaching Latino and African American communities:

Basic Messages Found to be Effective for Motivating Consumers

- You can get lower costs.
- You can find out if you're eligible for a free or low cost health insurance premium.
- You can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll.
- If you or a family member gets sick, you won't have to worry about big medical bills or going bankrupt.
- The insurance plan you choose will be there to cover all of the care you need.
- You will be able to find a plan that fits your budget.
- Best messengers: Doctors, family members, people who have been through the process.

- **Latinos.** Enroll America's Latino Engagement Toolkit has a section on effective messaging to Latinos that includes information such as “motivators” and best messengers. It states that the “top three messages that motivate Latinos to learn more about the new health coverage options available through the Health Insurance Marketplace (are):
 1. If you or a family member gets sick, you won't have to worry about big medical bills or going bankrupt.
 2. The insurance plan you choose will be there to cover all of the care you need.
 3. You will be able to find a plan that fits your budget.”¹⁴

It states that the best messengers for Latinos are family members such as mothers, doctors, and “someone who has been through the process and knows how it works,” and it contains several scenarios of what to say to Latino consumers.¹⁵ Latino customers who speak Spanish and want more details may also appreciate the Spanish version of Enroll America's Get Covered Guide.¹⁶

- **African Americans.** Enroll America also has an African American Toolkit, and the section on messaging shows the top three best messages to motivate this population to learn more are the same as the aforementioned Latinos recommendations. The best messengers are doctors, “someone like them,” and “someone who has been through the process and

knows how it works.” It also has several basic scenarios on what messengers should consider saying to prospective African American enrollees.¹¹⁷

Health Literacy. A barrier related to consumers not understanding outreach messages is low health literacy, meaning many do not have the knowledge, skills, and experience to fully understand health information and health insurance information. Enroll America has a publication on health literacy and enrollment that shows the importance of designing clear and accessible materials and websites, and recommends that “translations (be) adapted for readers with limited literacy skills.”¹¹⁸ It also has a related publication on using plain language, which is a requirement in the ACA, and gives tips for making sure all materials are in plain language. This helps everyone, whether low literacy or not, to understand the information more fully. The publication has this helpful summary of plain language:

Plain language is written communication that is clear, concise, user-friendly, and organized with the reader in mind. Plain language highlights key messages and is written in the more personal, active voice. It uses words that are familiar to most adults, including those with limited literacy. Its tone is informal, friendly, and conversational. Plain language is straight-forward, precise, and easy to read and understand.¹¹⁹

Notwithstanding these new and emerging initiatives, how to best convey messages is a priority within cultural competency that can continue to benefit from further research in order to develop and refine the most effective ways to reach and inform culturally and linguistically diverse populations.

Call Centers. Call centers or customer service centers are not a main focus of this project since the personnel hired for them are not out in the community targeting diverse populations to enroll in the way that navigators are, but they have some features that aid culturally and linguistically competent enrollment. Consumers in all states can call toll-free call centers, whether state-run or federally run, to ask questions and enroll over the telephone. In addition to hiring a certain number of bilingual employees, the federal marketplace and most or all state marketplaces have contracted with telephone-based language interpretation services such as LanguageLine Solutions that offer real-time interpretation in more than 175 languages.¹²⁰ This is useful for less common languages, but is not as helpful as having trained call center staff available who can speak additional languages with customers directly without having to wait for a third party to interpret each statement, which is the case for many call centers. The federal call center is open 24 hours a day, while the call centers for state-based marketplaces are open days and evenings, but are not usually open all night.

In Covered California’s customer service center, there is a main toll-free number plus separate dedicated phone numbers for each of the 12 Medi-Cal languages, and access to the AT&T Language Line for additional languages. There are also dedicated lines for enrollment counselors and small businesses. About 10% of call center workers speak Spanish, and the marketplace recently hired several hundred new representatives to work on reducing wait times and decreasing the number of abandoned calls, and to expand the use of online chat to answer questions.¹²¹ In January 2014, 85% of calls were handled in English, 12% in Spanish, 3% in Asian languages, and less than 1% in other languages. Of the non-English calls, about 60% were handled by call center representatives and about 40% by the language line.¹²²

Several organizations have developed performance standards and best practices for marketplace call centers, including answering calls quickly (within 30 seconds), minimal hold time and no busy signals, requesting information from consumers only once, and obtaining feedback, including from non-English-speakers, in order to improve operations.¹²³ It is important for call centers to be able to accept spoken recorded signatures from telephone applicants in order to complete their applications during the call, since it can be problematic for consumers, especially lower-income clients, to mail or fax their written signatures later.¹²⁴ The federal government issued related guidance in 2013, saying that states can use their own processes but must be able to record and store a telephone signature and provide confirmation to the applicant.¹²⁵ Many call centers are continuing to add staff through the first open enrollment in order to meet demand.

E. OUTREACH AND ENROLLMENT ACTIVITIES

Low literacy, limited English proficiency, mistrust of government, and limited access to technology are significant barriers to enrolling individuals from culturally and linguistically diverse communities. While there is no magic bullet to overcome all of these complex challenges, we have identified and compiled examples of useful practices and lessons learned from interviews and the literature of ways that organizations are coping with the barriers and making progress in enrolling diverse communities into marketplace plans.

Building on Past and Successful Outreach and Enrollment. Many state-based marketplaces conducted large marketing campaigns including television, radio, and print components to raise awareness of coverage through the marketplaces before open enrollment started, including Nevada, Maryland, Washington, Colorado, which all had English and Spanish versions of advertising.¹²⁶ Some states added additional languages and more targeted media in later campaigns. In California, multiple marketing campaigns were introduced before and after open enrollment began, including TV, radio, print, and billboard ads in several languages.¹²⁷

These methods aid in awareness, but many diverse individuals and families prefer a personal touch in getting further information, and want to interact with people they trust in order to complete the process and enroll in a health plan. Marketplaces anticipated this and created consumer assistance programs, as required by law, with many states using previous outreach and enrollment efforts as guides and leveraging the experience of the trusted organizations involved. In Colorado, for example, state and federal grants allowed for a large statewide outreach effort for Medicaid and CHIP that used culturally literate organizations within targeted communities, greatly increasing enrollment since 2007.¹²⁸ Oregon also increased outreach efforts in 2009 when it expanded Medicaid and CHIP eligibility for children, and the state worked with partners to develop multicultural materials and hire bilingual staff in communities.¹²⁹

In New York, the state already had several relevant programs in place due to earlier state health care reforms that it could use to build ACA programs. New York Health Options, a call center serving various public health programs and employing bilingual staff, was expanded to handle ACA calls, and Community Health Advocates, a program assisting consumers including in other languages, was funded with exchange establishment grants after its previous funding expired. The state has also administered a facilitated enrollment program since 2000 that uses community organizations and others to help consumers enroll in Medicaid and other programs, and includes a capacity for offering multiple languages to them.¹³⁰ In Connecticut, Access Health CT worked

closely with the State of Connecticut Office of the Healthcare Advocate to design the navigator and assister programs, since this office has experience in assisting consumers in areas such as choosing health plans and resolving complaints and appeals.¹³¹

These prior efforts and experiences have helped states to prepare for enrollment into marketplace health plans under the ACA.

Outreach and Enrollment Venues and Tools. Surveys have found that the best places to conduct outreach and enrollment are those familiar to community members, such as child care centers, community health centers, libraries, and welfare offices. Surveys also showed some particular differences by ethnic group, finding that direct mail and language-specific newspapers were often best for reaching Asian-American populations, Latinos respond well to information in schools, and that Koreans and African Americans are open to information from the churches they attend.¹³² The Office of Minority Health at the U.S. Department of Health and Human Services is partnering with Latino groups, schools, churches, and other organizations to reach Latinos, and says that surveys show two of the most trusted sources of information for Latinos are people in their communities and Spanish-language media.¹³³

Hispanic Access Foundation, based in Washington, D.C., has organized education and enrollment events around the country for Hispanics, including workshops that combine ACA information with tax information from H&R Block, and they count the following as their lessons learned:

1. “Start with very basic background, assume no prior knowledge.
2. Be sensitive to political context.
3. Provide on-site navigators or direct support for enrollment process.
4. Be prepared to tactfully address mixed status families.
5. Printed materials are valued by the audience.”¹³⁴

Promising Venues for Outreach and Enrollment

- Community health centers
- Mobile health units
- Public schools
- Adult classes
- Consulates
- Small neighborhood businesses
- Pharmacies
- Faith-based institutions such as churches, mosques, and synagogues
- Barbershops and hair salons
- Civic organizations
- Low-income workplaces
- Community health fairs and other temporary sites
- Organizations offering tax help and other social services

The Latino Toolkit from Enroll America contains sections with tips on topics such as cultural competency, preferred language, laborers, young people, women, and faith communities.¹³⁵ In the case of mixed-immigration-status families, some assisters have found it helpful to inform consumers of the memo issued by U.S. Immigrations and Customs Enforcement on October 25, 2013, stating that information used to determine health insurance eligibility will not be used for law enforcement actions,¹³⁶ though some mistrust may still remain.

Outreach to uninsured Asian American communities is proving to be harder than to Latinos in some ways, due to the diversity of languages spoken. Some groups are more likely to be in poverty than other groups, and messages need to be customized.¹³⁷ The White House Initiative on Asian Americans and Pacific Islanders, which helps these communities by facilitating access to federal programs, held several video chats about the ACA in different Asian languages, which helped to raise awareness.¹³⁸ The first, in August 2013, was in Korean, an

Asian group with the highest uninsured numbers.¹³⁹ The Asian & Pacific Islander American Health Forum developed a toolkit for educating Asian American, Native Hawaiian, and Pacific Islander communities that has some tips on how to hold community events.¹⁴⁰

There are also several coalitions of organizations working to serve Asian American, Native Hawaiian, and Pacific Islander communities. Action for Health Justice (AHJ) is a coalition of more than 70 national and local community-based organizations and Federally Qualified Health Centers in more than 20 states working to educate and enroll these populations in health plans.¹⁴¹ Health Justice Network (HJN) is a coalition of Asian American, Native Hawaiian, and Pacific Islander community-based organizations in California.¹⁴² Both AHJ and HJN bring together in-person assisters that serve these communities across wide geographic distances to help close gaps for small populations by coordinating language and other resources and sharing best practices.

Enroll America's African American Toolkit contains topics such as cultural competency, women, immigrant communities, civic organizations, faith communities, and small businesses.¹⁴³ It points out that issues involving immigration status do not just affect those of Latino and Asian descent, but also some individuals of African and Caribbean descent that are in the U.S., and assisters should not assume whether someone has citizenship status or not by what language they are most comfortable speaking.

The toolkit also mentions that many African American families, especially in urban areas, have connections to civic organizations such as sororities and fraternities, professional associations, parent organizations, and financial literacy centers, and that these can serve as trusted sources of information. Small businesses owned by African Americans such as beauty salons, restaurants, book stores, coffee shops, nightclubs, and laundromats can be utilized, and there are tips for approaching businesses to leave materials or hold events.

Promising Practices in States. There was a Pledge to Enroll campaign in Colorado that drew the involvement of multiple organizations and this effort provided a number of opportunities for personal interaction and gathering contact information of individuals who wanted to enroll. This initiative allowed organizations to follow up with consumers individually, through personal letters, brochures, and calls, and could set appointments with bilingual staff if needed. Acknowledging that education and enrollment can take a lot of time and require several "touches," at least one assistance organization in Colorado has started making two appointments up front with consumers who seek help. This way the first meeting can be informational, telling consumers what documents to bring back, with follow-up questions and formal enrollment taking place during the second visit.

An innovative program in Colorado called C.C.A.R.E.S. (Coalition for Culturally Appropriate Response and Enrollment Services) involves a collaboration of six organizations experienced in outreach to the Latino community (through methods such as door-to-door canvassing and media personalities) and additional enrollment assisters who were hired due to their experience and bilingual skills.¹⁴⁴ Having staff with previous Medicaid, CHIP, and other related experience has been very helpful, as has the engagement of a media coalition with newspaper, radio, and television entities that support targeted messaging to Latinos. These initiatives have allowed opportunities to print ads, talk on the radio, and develop enrollment-related segments for TV such as health programs and telenovelas.

In Connecticut, Access Health CT created “microregions” within its six state navigator regions to further target different populations and organize assisters and community partners in those areas to reach different neighborhoods. They have found that this approach results in greater collaboration between partners than if everyone was trying to reach an entire region, and that groups that may have never spoken before are now working together to customize their efforts to reach different populations more effectively. The marketplace and its partners have also found it effective to give short presentations at the work sites of low-wage employers and take appointments for later enrollment, and to provide information through pharmacies, especially family-owned pharmacies in lower-income areas, since they are often a main source of health information. Some pharmacy employees have become certified application counselors.

Another culturally competent source of trusted information is *promotoras*, people who provide health information in Spanish-speaking communities.¹⁴⁵ The Latino HealthCare Forum in Texas is one organization that has hired *promotoras* to educate and enroll consumers into marketplace plans, and has found that many Latinos need five to seven touches (from flyers, conversations, and other methods) in order to enroll. “Affordability” is a subjective and vague term so they use words like “security” instead.¹⁴⁶ In states such as Texas that are not expanding Medicaid eligibility, many of the uninsured fall into the “coverage gap” of making too much to qualify for Medicaid, but not enough to receive a subsidy in the marketplace. So if assisters cannot help these individuals obtain affordable insurance at this time, some, such as those working in the *colonias* in south Texas, are at least helping them apply for hardship waivers so they do not owe a penalty on their taxes.¹⁴⁷

In addition to these outreach efforts, and the navigator and assister programs in the marketplaces, there are other enrollment assisters available to help, such as certified application counselors at Community Health Centers. These workers have become an important source of enrollment assistance, especially to diverse populations, since many centers are in diverse communities and provide culturally competent care. Almost 1,200 CHCs in all 50 states and four U.S. territories received federal grants totaling \$208 million in 2013 and 2014 to hire additional workers for in-person enrollment assistance to consumers eligible for the marketplaces and other programs.¹⁴⁸

In areas with high rates of uninsured populations and lower funding, community groups and health care providers are trying other approaches to reach residents and encourage greater collaboration—initiatives that may also be applicable to California’s priority populations. For example, the Enroll Gulf Coast initiative in Texas, consisting of 14 organizations in the Houston and Harris County area,¹⁴⁹ decided that the 1.1 million uninsured individuals in Harris County could be considered a public health emergency, and mobilized as they might during a disaster. They created an

Promising Practices Emerging Across States for Outreach and Enrollment

- Use data and maps to identify where concentrations of uninsured populations by race, ethnicity, and language reside to target and tailor efforts.
- Collaborate with trusted community organizations locally and at the neighborhood level.
- Communicate through ethnic and native-language media (including ethnic television, radio, and newspapers).
- Provide information and take appointments at workplaces and other places potential enrollees are likely to be.
- Plan on making two or more appointments with consumers for assistance.
- Work with *promotoras* and other familiar, culturally competent contractors and staff.

“incident command structure” to coordinate activities between the organizations and a committee created maps showing neighborhoods with greater concentrations of uninsured and the best access points in them. Another committee uses the information to plan for activities and enrollment events in targeted areas, and the organizations share and track data online. The Houston Health Department is working with other cities to expand the strategy around the state.¹⁵⁰

In California, some specific outreach and enrollment methods that have been found to be successful so far in the assistance programs are 1) conducting outreach while people are waiting at mobile clinics and health fairs, 2) creating a process at events where consumers talk to outreach workers first and are then referred to on-site enrollment counselors to facilitate enrollment, 3) refining presentations and materials to target populations with culturally specific examples, and 4) having smaller and more tailored community events instead of large events.¹⁵¹ Other promising practices seen in California are offering outreach at the Mexican Consulate, which is considered a trusted place, and providing information at citizenship ceremonies, as they have found that new naturalized citizens are eager to comply with the laws—enrollment does not take place at ceremonies, but a pre-approved announcement is made and appointments are taken for later dates. They have found that native language newspapers seem to work well for East Asians, and that radio personalities can help reach Latinos. Providing information at adult classes and at low-income workplaces is also effective.

It is harder to reach consumers who do not speak one of the more common languages, or who have limited literacy or proficiency in their own native language. However, organizations are reaching out to these communities as well. For example, in California, the Pan-Ethnic Health Network and several other organizations collaborated to hold an event in the Central Valley where workers who speak both Spanish and Mexican indigenous languages translated health insurance information for immigrants from Oaxaca, Mexico, who do not speak Spanish. Since Latinos are less likely to have home computers and internet access, the Latino Community Foundation in San Francisco found an inventive way to help Latinos access health information, by raising funds to train families on computer usage and provide them with computers and internet connections—1,000 computers have been provided so far.¹⁵²

In the Bay Area, the Chinese Community Health Plan has a large percentage of enrollment for a small health plan, and has been reaching Asian Americans and others through culturally competent staff (who know, for example, not to ask for first names or personal information right away since it is not considered polite) and low prices.¹⁵³ There has also been a push in California to reach Filipino immigrants, the state’s largest Asian population, with advertisements in Tagalog and other methods.¹⁵⁴ Outreach workers have also found success reaching Koreans in the East Bay through churches.

Role of Faith-Based Institutions. Faith-based outreach and enrollment initiatives are proving to be an effective way to convey trusted information to communities that identify and participate in different faith traditions. Enroll America’s Health Care from the Pulpit guide contains tips for outreach workers to engage churches and other places of worship in outreach and enrollment efforts, such as making sure of the primary language spoken, knowing the titles of the different faith leaders (for example pastor, minister, preacher, priest, deacon, or rabbi), and understanding the appropriate names for services and buildings (such as mass, sermon, church, temple, or mosque).¹⁵⁵ It contains guidance including the following points:

1. Research different congregations, identify where they are located, and learn their history and level of activism in order to contact and visit the most active ones first.
2. Dress and behavior: dress professionally and conservatively, silence your cell phone, and arrive early to speak with staff and volunteers.
3. Things to do: smile and be polite, shake hands, provide information to as many people as possible after the service, and maintain contact afterwards to build relationships.
4. Things not to do: discuss politics or religious views, show bias, arrive late, or interrupt.¹⁵⁶

The ACA is one priority area of the U.S. Department of Health and Human Services’ Center for Faith-based and Neighborhood Partnerships, and it has published a toolkit online that includes an ACA fact sheet for faith and community leaders, talking points about health insurance, a guide for planning enrollment events, and other information.¹⁵⁷ The Center, in collaboration with Enroll America and other partners, established the National Faith Week of Action from March 7-15, 2014, where Muslim, Jewish, and Christian organizations performed outreach on the marketplaces and the importance of health insurance to their respective communities.¹⁵⁸ Muslim organizations held a marketplace enrollment weekend during this time, from March 7-9, that included health enrollment fairs and sermons by Muslim leaders. The American Muslim Health Professionals organization published materials to help with the weekend outreach to Muslim communities.¹⁵⁹

In Maryland, the Maryland Citizens’ Health Initiative convened a summit of state officials, community groups, and more than 150 faith leaders in May 2013 to share information and discuss health insurance outreach and enrollment and how they could work together, since faith leaders are more likely to be trusted—and culturally competent—sources of information. They recruited faith leaders to be Health Ambassadors and give short presentations to other congregations, with great success.¹⁶⁰

Outreach and Enrollment Resources. There are many more successful initiatives and enrollment activities happening around the country than can fit in one report, but those cited give a picture of the range of useful innovations and models, both large and small, that are taking place as states and communities try to increase enrollment in health insurance and reach individuals and families who may have never had insurance before. The following text box lists several additional resources on developing navigator and assister programs, including from the federal government and national advocacy groups.

Resources on Navigator and Assister Programs

- Federal marketplace resource website¹⁶¹
- Enroll America’s In-Person Assistance center¹⁶²
- Enroll America’s Outreach Planning guide¹⁶³
- FamiliesUSA’s Navigators and In-Person Assisters Resource Center¹⁶⁴
- State Health Reform Assistance Network guidance on navigator and in-person assistance programs¹⁶⁵
- Georgetown University Health Policy Institute report on designing navigator programs¹⁶⁶
- Massachusetts’ Health Reform Toolkit Series¹⁶⁷

There are no easy answers for enrolling hard-to-reach populations, since they are by definition harder to reach, but organizations in the field are finding that planning and targeted communication are key, as well as collaborating with different community partners, and visiting

diverse communities instead of waiting for them to come to enrollment offices. A motto in Connecticut is “be where people are, then bring them to where they need to be,” which is similar to California’s mantra of reaching people where they “live, work, play, and pray.” Limited funding was often cited as a challenge, as more resources allow for more staff and materials to help reach targeted communities, but since this is a reality that is unlikely to significantly improve, marketplaces and community organizations are learning how to best use what resources they have to reach and enroll the most uninsured consumers.

F. DATA AND EVALUATION

Effective outreach and enrollment programs will require developing and using data and conducting evaluations to target resources for reaching culturally and linguistically diverse populations, to document and demonstrate how well programs are working, and to suggest modifications for improving current and guide planned efforts. Also, as mentioned in the regulations section, such activities are often a requirement since assistance programs receiving federal funds must follow CLAS standards such as having “general knowledge about the racial, ethnic, and cultural groups in their service area, including each group’s diverse cultural health beliefs and practices, preferred languages, health literacy, and other needs.”

Data and Needs Assessments. Data for needs assessments are available from various sources, including information on the uninsured from the U.S. Census and the Centers for Medicare & Medicaid Services.¹⁶⁸ Enroll America uses these sources and the Census’ Public-Use Microdata Areas (PUMAs) to create interactive maps of the uninsured in each state, including the ability to see the distribution by income and race/ethnicity.¹⁶⁹ PUMAs contain at least 100,000 residents, so the number of PUMAs in an area depends on the population—thus there are more PUMAs in the Bay Area than the entire state of Wyoming.

Many states and organizations have gathered data and conducted needs assessments to fine-tune their outreach and enrollment efforts, and continue to do so. In Washington, for example, the strategy of the main assister organization in Seattle is to “identify the uninsured and the barriers they face” by population group and geographically and to “develop tailored strategies for reaching the uninsured,” including in their languages.¹⁷⁰

In Connecticut, the state was divided into six regions, each coordinated by a navigator entity, and the number of assisters hired in each region depended on the number of uninsured individuals residing in that area according to the data.¹⁷¹ As mentioned previously, the six regions were later divided into smaller microregions so outreach and enrollment assistance could be further targeted to different areas. For example, Hartford County is one region, and it was subdivided into smaller areas that take into account such demographics as the concentration of Jamaican-Americans on the north side of the city of Hartford, so culturally appropriate assisters and partners can be deployed to that area for outreach events and enrollment assistance.

Data for Consumer Assister Programs in California

Planning for the Covered California outreach and enrollment programs was informed by data from CalSIM and from the National Opinion Research Center (NORC). CalSIM (California Simulation of Insurance Markets) was created by the UCLA Center for Health Policy Research and the UC Berkeley Center for Labor Research and Education, with funding from foundations, and provides data on the uninsured in California and the potential impact of the ACA.¹⁷² NORC conducted surveys and polling in different languages to test approaches and strategies by market segment, including different languages and ethnicities.¹⁷³

Race, Ethnicity, and Language Data. The federal marketplace application, as well as those of states, collects data on race, ethnicity, and language preference of applicants for tracking purposes; however, race and ethnicity data is optional so it not always captured. The question on language asks, “What is your preferred spoken or written language (if not English)?” The questions on race and ethnicity on the federal application read as follows, and can differ somewhat between states:

- “If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)
 - Mexican, Mexican American, Chicano/a, Puerto Rican, Cuban, Other ____
- Race (OPTIONAL—check all that apply.)
 - White, Black or African American, American Indian or Alaska Native, Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Other Asian, Native Hawaiian, Guamanian or Chamorro, Samoan, Other Pacific Islander, Other ____”¹⁷⁴

On the Covered California application, the categories are similar to the federal application except under Hispanic/Latino, “Mexican, Mexican American, and Chicano” were combined into one category, and Salvadoran and Guatemalan were added. Under race, Cambodian, Hmong, and Loatian were added, and Other Asian and Other Pacific Islander were removed (there is still an Other category).¹⁷⁵ This allows covered California to closer track its unique demographics, since for example Fresno has one of the two largest Hmong communities in the U.S. Covered California has released enrollment data for main ethnic groups but has not yet released data that show the full breakdown of all the races and ethnicities consumers may have indicated.

Since providing the race and ethnicity data is optional, not all applicants provide it, thus enrollment numbers reported by race/ethnicity may not be completely accurate. At this time, the federal government and most state marketplaces have not yet publically reported enrollment figures broken out by race and ethnicity, making it harder for organizations planning outreach and enrollment to see the progress and target their efforts to different populations.

Monitoring and Evaluation. As one national policy report on designing navigator programs notes, “It is important to develop performance measures to evaluate the program’s effectiveness and use these data to make improvements and re-target resources to persistent or new areas of need over time.”¹⁷⁶ Another resource identifies several potential performance measures for navigator/assister programs, including the following:

- “Number of applicants enrolled;
- The rate of completed enrollments relative to applicants assisted;
- Number of referrals (or enrollments) made to Medicaid;

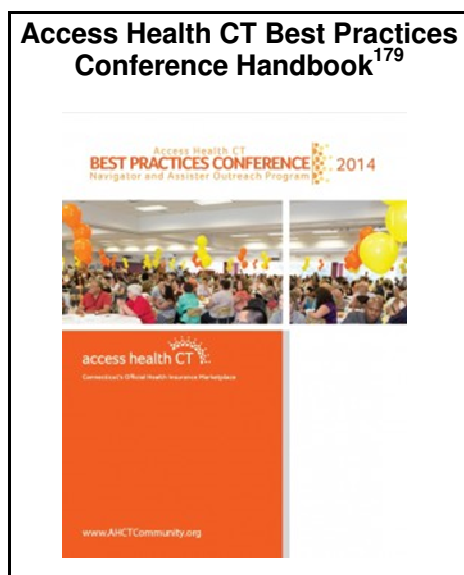
- Number of applicants in various target populations (those with language barriers or who have been uninsured for a longer time) assisted and enrolled;
- High scores on customer satisfaction surveys;
- High use of the web portal;
- Rates of continuous coverage (efforts to prevent coverage disruptions due to a change in program eligibility);
- Enrollment patterns (to ensure consumers are not being overly steered to one plan or another); and
- Accuracy of the applications submitted.¹⁷⁷

Enroll America has published guidelines for measuring and evaluating outreach programs. The checklist for data tracking includes the follow steps:

1. Create processes for how often to collect data and how (automated or manually),
2. Develop systems and outcome measures to track (such as number of events held, number of people who attended, number of people who enrolled), and
3. Ask customers how they heard about the assistance organization (flyer, radio, newspaper, community event, etc.), so as to monitor which communication methods work best.

It also has identified steps for developing an evaluation program, including to decide how often to evaluate, determining what methods to use (whether a database that can run reports or a manual process), and to consider including qualitative methods such as surveying staff and volunteers on effective strategies, including what works with different ethnic groups and what activities need to be improved.¹⁷⁸

There are a variety of reviews and evaluations planned for navigator and assister programs in state marketplaces. Many of the more formal evaluations will take place after the first open enrollment that ended on March 31, 2014, though more informal monitoring and sharing of information is happening sooner. On the informal side, many organizations and state marketplaces are sharing tips and best practices for outreach and enrollment through ongoing means such as conference calls and meetings, and some are contracting with outside organizations for more formal reviews.



In Connecticut for example, besides regular phone calls and webinars, Access Health CT took feedback and worked with experts such as Enroll America to organize a Best Practices Conference in January 2014 for navigators, assisters, and certified application counselors in the state. This one-day event featured updates from marketplace officials, time for peer networking, and concurrent sessions on topics such as Latino outreach, African American outreach, and engaging small businesses.¹⁸⁰ They may organize another conference after open enrollment is over to share more lessons learned.

Access Health CT has a short survey online for enrollees who applied via the website to give feedback on their experiences, and a graduate student is taking these comments as well as interviews with other participants and health plans to see where improvements can be made. Data are also gathered from assisters, who have a special

webpage where they report information after helping each applicant such as how long the process took, any problems encountered, race and ethnicity data as reported on the application, and whether the person applied for a marketplace plan or Medicaid (private information is not tracked). These data points are populated to spreadsheets that the marketplace can access, allowing for real-time monitoring of statistics from the assister program, since it takes much longer to receive reports from the IT vendor.

For an external evaluation of Access Health CT, the Yale School of Public Health CARE program¹⁸¹ is partnering with several foundations in the state to review the assister program and other aspects of the marketplace. It will conduct in-person and telephone surveys of consumers, interviews with each of the six navigator organizations, and focus groups of assisters from each region.

Connect for Health Colorado is also tracking marketplace operational data,¹⁸² and is working with an external organization for evaluation. Spark Policy Institute helped the marketplace implement a quarterly reporting structure for assistance program activities, and they analyze those reports as well as gather information from other sources such as weekly phone calls with assistance organizations and surveys. Spark Policy Institute will produce quarterly reports for the marketplace containing quantitative and qualitative data, along with recommendations for improvement. The first report was released in December 2013.¹⁸³

In California, Richard Heath and Associates, Inc., administers the outreach and assistance programs for Covered California and collects monthly reports from these programs with tracking data and best practices for internal monitoring. The company will do a larger evaluation after open enrollment ends, and the marketplace will be required to perform evaluations for its federal grants as well as annual reports to the state.

Navigator organizations in states with federally facilitated marketplaces must submit quarterly and final progress reports and financial reports, and undergo an evaluation by the Department of Health and Human Services.¹⁸⁴ State-based marketplaces receiving federal grants also have reporting and evaluation requirements, so a number of reports should be issued later in 2014 after the first open enrollment ends, and in 2015 after establishment grants expire in 2014, on the performance of navigator/assister programs.

VII. Discussion

The role of consumer assisters has evolved and grown since the enactment of the ACA, especially with the recognition that outreach and enrollment will be core to the success of health insurance marketplaces across the country. Whereas the law initially authorized the establishment of navigator programs across states, other kinds of assistance programs were also introduced varying in structure, funding, and scope, but united in their mission to effectively educate and enroll hard-to-reach populations, including those racially and ethnically diverse. While many promising initiatives and programs have emerged, population- and program-specific challenges remain for many states and localities. In this section, we discuss what have emerged as major lessons around promising practices and strategies for reaching and enrolling diverse communities, along with remaining challenges at the population, program, and policy levels.

What are Key Lessons for Effective Outreach and Enrollment to Diverse Communities?

Research and previous experience with enrollment efforts make a strong case for having in-person assistance for enrolling consumers into health insurance programs, especially trusted assistance that is culturally and linguistically competent. National organizations playing a leading role in outreach and enrollment have also reiterated the importance of in-person assistance. For example, Enroll America has found regarding enrollment that, “most people want in-person assistance, ‘multiple touches’ are often necessary, strong social networks are important to leverage, language matters, people associated with health care are trusted, and family members are important.”¹⁸⁵ People often hear about health care programs through multiple sources, and this education is important but does not necessarily lead to increased enrollment without community-based partners and health care providers following up and providing personal assistance.

Experience with programs such as Medicaid and the CHIP provides strong evidence of the importance of in-person assistance programs and this concept of “multiple touches.” As one research study on Medicaid and CHIP enrollment found, a “combination of broad and targeted outreach strategies is key for reaching eligible families.”¹⁸⁶ The study also emphasized that one-on-one enrollment assistance must be provided by trusted individuals within the community to be successful.¹⁸⁷ And while, personal assistance is correlated with higher enrollment rates, community-based organizations can facilitate the enrollment process by providing trusted and culturally appropriate information at convenient locations. Our report highlights many trusted organizations and locations for education and enrollment assistance, such as faith-based institutions, advocacy groups, schools, ethnic grocery stores, and community health centers or clinics.

Lessons learned from Massachusetts are helpful since the state implemented health care reforms and coverage expansion similar to the ACA starting in 2006. One study in Massachusetts pointed to four key findings: “1) intensive outreach and enrollment assistance is crucial to connect low-income, uninsured people with coverage; 2) assistance is not a one-time matter—it is needed at all stages of the enrollment process and to ensure continued coverage; 3) immediate access to enrollment assistance boosts the effectiveness of outreach efforts; and 4) even when health reform is mature, the need for aggressive outreach and enrollment assistance remains high and the resource demands remain significant.”¹⁸⁸

Using plain language and multiple languages on applications and outreach materials helps to reduce barriers to enrolling populations with low literacy and limited English proficiency by allowing them to understand and learn about the process. Experience shows that many individuals have low health literacy and understanding of health and insurance issues, and often want to see written information before committing to purchasing health insurance.¹⁸⁹ Some community organizations we interviewed commented that the populations they serve do not

Key Lessons for Effective Outreach and Enrollment to Diverse Communities

- Trusted, culturally competent in-person assistance is needed
- Multiple touches are required
- The need for in-person assistance is ongoing during enrollment and afterwards
- Using multiple languages and plain language helps reach those with low health literacy and limited English proficiency
- Consider use of information technology and that many access the Internet through cell phones

always understand the available marketplace materials, either due to language barriers or because the concepts were not explained in a basic enough manner, and that clearer materials in more languages would help them be able to educate and enroll more individuals.

Finally, to reach younger, racially and ethnically diverse populations, the use of information technology may prove promising. For many young and diverse communities, smart phones are their main connection to the internet, so some organizations have developed apps to educate them on insurance through the marketplace, but others do not want to encourage too much use of mobile applications, especially for applying, since it is harder to see all the details of health plans and to enroll this way. They would rather individuals visit enrollment assisters with computers so they can see all their health plan options. Using cell phone apps and text messages may prove useful for other aspects of insurance such as renewals and locating providers.

What Population-Specific Challenges Remain to Enrolling Diverse Communities?

Low literacy, limited English proficiency, mistrust of government, and limited access to technology are some of the barriers to enrolling culturally and linguistically diverse populations. Translating previous experience and lessons learned with enrollment assistance into practice with the new health coverage expansion programs under the ACA is a large and challenging undertaking, but is essential in order to decrease the number of uninsured individuals and meet the health needs of communities that have often been overlooked in the past. Lessons not only

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|--|
| <p>Population-Specific Challenges</p> <ul style="list-style-type: none">• Low health insurance literacy and literacy in general• Awareness of tax subsidies and individual mandate• Limited English proficiency• Immigration status, mixed-status families, and resulting fears• Limited access to technology |
|--|

from current marketplace experiences, but previous programs such as Medicaid and CHIP as well as Massachusetts' health reform program, shed additional light on what remain as significant barriers or challenges to enrollment among diverse communities.

Immigration status is one such largely entrenched challenge, and a topic of concern and fear among many immigrant communities. Focus groups with Medicaid and CHIP outreach workers serving immigrant communities identified two main fears within these populations: 1) "that receiving health care benefits will jeopardize their immigration status... and prevent them from obtaining permanent residence," and 2) within mixed immigration status families, that "applying for coverage for eligible family members may expose other family members

to risk of deportation."¹⁹⁰ Talking to trusted resources who have a shared background and/or are familiar with the culture—for example someone who may live in a mixed immigration status family—can help to dispel inaccurate information about coverage and provide assistance that immigrants and others are willing to accept. These assisters need to be well-trained and knowledgeable about coverage options and government laws.

The federal and state marketplaces did not anticipate the level of information technology problems that would occur after the first open enrollment began on October 1, 2013. Though website problems have made enrollment more difficult and time-consuming for many assisters and consumers around the country, surveys show that the main barrier to enrolling more uninsured individuals is not technology problems, but many consumers' lack of awareness of how the tax subsidies (and Medicaid expansion) make health insurance affordable to those with lower

incomes. Affordability is the main reason that people give for not seeking out insurance, and a survey in December 2013 showed that 65% of white respondents, 68% of Black or African American respondents, and 76% of Hispanic or Latino respondents did not know financial help is available for purchasing insurance. Also, 26% of whites, 40% of black or African Americans, and 35% of Latinos did not know about the insurance mandate. Those eligible for subsidies or Medicaid were also less likely to know about financial help than those with higher incomes.¹⁹¹

Another notable challenge is health literacy, or in the case of marketplaces “health insurance literacy.” A major difference between the Medicaid and CHIP programs and the marketplace is that the latter requires individuals to take greater financial responsibility in making health care decisions and covering costs. While educating communities about the importance of health insurance is one step in the outreach process, a more daunting task is convincing them of the value of paying into health insurance as well as helping them understand how health insurance works, including concepts of premiums, tax credits, deductibles, and cost-sharing arrangements. Compounded by culture and language differences—especially for people who have emigrated from countries where health insurance is nationalized or does not involve such complex payment schemes—this becomes an even more targeted undertaking requiring not only translation of concepts, but their “transcreation” to address differing cultural contexts.

What Program and Policy Challenges Have Emerged to Enrolling Diverse Communities?

Many unexpected events such as the Supreme Court cases, delays in federal regulations, and resulting shorter timelines have caused later implementation of some ACA features, such as federal and state delays in launching Spanish websites and applications. In California, the Spanish application was not functional until early January 2014, and some said the Spanish website was not user-friendly and Spanish advertising and messaging was off the mark.¹⁹² A majority of the in-person assisters speak Spanish, but only 10% of call center representatives.¹⁹³ Delays in training and certifying enrollment counselors and insurance agents in California during the first few months of open enrollment also slowed down enrollments initially.¹⁹⁴ For example, many sources have documented the lower enrollment rate of Latinos around the country, and the need to reach this group that makes up about 25% of the uninsured nationwide and 60% of the uninsured in California.¹⁹⁵

Other questions that have emerged concern navigator and assister training programs—how much training should they receive generally, and more specifically how much around race, culture, and language? And should this training be offered in languages other than English? Some advocacy groups have suggested that limited English proficiency has posed a barrier for some community members who are willing but unable to get certified to assist their community with outreach and enrollment as training materials have only been available in English. However, others have argued the need for navigators and assisters to be not only representative of their cultural communities, but to be fully bilingual and fluent in English to be able to attend meetings and understand important policy updates. Central to this discussion is the recognition that there

Program and Policy Challenges
<ul style="list-style-type: none">• Unexpected events and delays in ACA and marketplace implementation• Delays in language resources• Questions around assister training programs (length, content, language)• Questions around certification standards for assisters and how to balance cultural competence with possible negative backgrounds

is no “one-size-fits-all” approach to training, and that programs offering training in other languages—or not—will need to weigh pros and cons. For example, for certain harder-to-reach or linguistically isolated communities, there may be a need to further tailor training and monitoring so that trusted and able outreach workers, while not as proficient in English, may be employed to reach these residents.

Another question that has emerged across states is whether to allow individuals who have had prior convictions to be assisters, because in some low-income communities, a number of residents have convictions or may have served time in prison, but they are culturally competent and want to help. Some groups have pushed for looser certification standards so such individuals can become assisters, while others have lobbied for stricter standards in the interest of public safety and protecting private information. Future decisions may consider reasons for prior convictions (e.g., violent vs. nonviolent crimes, type of drug conviction), recidivism, and other individual-specific issues.

An unprecedented amount of effort has been expended so far to reach and enroll people, including cultural and linguistically diverse communities, into health insurance plans in California and other states. Though efforts are paying off and many from diverse racial and ethnic groups have been educated and enrolled, many more eligible individuals from these groups remain who have not. Reaching and enrolling these communities is no longer a niche problem, it has become an important goal of marketplaces and a mainstream priority mentioned by many health officials and media outlets. However, there is no magic formula to reach everyone; outreach and enrollment assisters in the marketplaces and other programs will need to keep raising awareness and educating people one by one to show them the importance of insurance to themselves and to their families’ health and well-being.

VIII. Moving Forward

In California, marketplace enrollments by the end of January had surpassed projections for the whole first open enrollment period. After open enrollment ended on March 31, 2014, consumers who started applications but could not finish were given until April 15 to complete their applications and choose a plan; counting these late additions, 1,395,929 people enrolled in Covered California plans during the first open enrollment period, 88% of whom were eligible for subsidies. Regionally, the Greater Bay Area had 289,022 enrollees, a 323% increase over the base projection of 89,599.¹⁹⁶

About 78% of enrollees responded to the optional questions on race and ethnicity: 28% of those who answered specified they were Latino, and 21% were Asian, a larger share than seen in the uninsured population. Almost 3% were Black or African American, about 6% were mixed race, and about a quarter of a percent were American Indian/Alaskan Native. About 91% of respondents indicated a language preference, with the following languages shown:

- English: 81%
- Spanish: 12%
- Asian and Pacific Islander Languages: 7%
- Indo-European Languages: 0.2%¹⁹⁷

In efforts to boost the number of Latino enrollees, Covered California and local organizations increased outreach to Latinos toward the end of open enrollment through certifying more

Spanish-speaking counselors and agents, making more Spanish materials available, improving the Spanish website, and spending \$8.2 million on targeted Spanish advertising.¹⁹⁸ Nationally, the administration is making a push to reach more Latinos and other diverse groups, including advertising with Spanish media outlets and a town hall meeting with President Obama in March 2014 that was televised on Spanish TV stations, broadcast over the radio, streamed over the internet, and shared on Spanish social media. This event was hosted by the Asegúrate campaign, which is a partnership between Covered California, the California Endowment, and U.S. Spanish media stations such as Univision, Telemundo, and La Opinion-impreMedia.¹⁹⁹ The White House is also involved in outreach to other groups such as African Americans and Asian Americans and Pacific Islanders.

While altogether these efforts represent unprecedented attention to the priority of reaching racially and ethnically diverse communities through health insurance reform, critical to their success is assuring that moving forward these efforts remain ongoing, are sustainable, and are improved when needed to maximize enrollment among diverse communities. While as of this writing the first open enrollment period for marketplaces has ended, much work must be done in the interim and leading up to the next enrollment period for improving participation of diverse communities in the health insurance marketplace nationally, and within California—especially as some communities were underrepresented in final enrollment figures.

Building on emerging models and lessons learned, both nationally and in California, we identify several areas for improving planning and implementation of outreach and enrollment efforts for racially and ethnically diverse communities. We also reflect on findings from the community forum we convened in Oakland on April 10, 2014, integrating common and distinct perspectives provided by local health care stakeholders for further enhancing outreach and enrollment to diverse communities in the San Francisco Bay Area (see Appendix C). Participants identified the following five priorities, which are also reflected in the recommendations discussed in greater detail below:

- Assure continuity in consumer assistance provided through the marketplace, whereby navigators and assisters not only connect individuals to health insurance, but also on ways to use and access health care.
- Assure that Covered California has dedicated staff devoted to working with community-based organizations to increase enrollment and retention across hard-to-reach and diverse populations.
- Assure ongoing dedicated funds for outreach, education, and enrollment to diverse communities, including to those with limited English proficiency.
- Consider how to address future challenges that may arise, such as insurance utilization, retention of enrollees, tax implications, and training.
- Enhance training programs to incorporate more role-playing and scenarios that speak to diverse family structures and situations, such as LGBT, mixed/complicated immigration status families, and others.

While the priorities and recommendations below are tailored to California and the San Francisco Bay Area, they have broader relevance and application for other states and localities facing similar circumstances and challenges.

► **Continue to build capacity to serve limited English proficient populations.** Building capacity to enhance access to language services for individuals with limited English proficiency is

critical to reaching and enrolling this group. While Covered California made available translated materials in 12 Medi-Cal threshold languages, there is a need to expand availability of basic explanatory materials in other languages,²⁰⁰ especially to reach linguistically isolated communities or populations speaking a language that may not have a major presence in the state, but may have large representation in certain cities or neighborhoods. As such, the marketplace may partner with community organizations that have a history of working with certain language communities to translate the materials to fit their circumstances, with a less time-consuming review process by the marketplace. Other marketplaces allow this with some stipulations, such as in Washington, where organizations must follow the usage guidelines for content and logo placement, and in Connecticut, where navigator organizations are free to create their own outreach materials but cannot use the marketplace logo if not originating from the marketplace.

In addition to assuring availability of materials in different languages, an explicit effort must be made to assure that all marketplace letters, notices, and other materials are in plain language and have tag lines in as many languages as possible stating the number to call for written and oral language services, as required by law.²⁰¹ This was especially reiterated by health care stakeholders at the community forum who suggested that materials need to be available in more languages; materials need less text and more culturally appropriate pictures or information graphics; some materials may need to be reexamined for reading level; and terminology and messaging should be made more consistent when communicating in certain languages. Foundations and private organizations may be able to play a role in funding such efforts, in collaboration with the marketplace, to address language access services that may be falling short due to limited funding and capacity.

Another way to build capacity in this area and improve services is to assure dedicated marketplace staff to address cultural/linguistic competency priorities. Recognizing that a sizeable population that is eligible for the marketplace is racially and ethnically diverse and many have limited English proficiency, there is a need to assure that addressing health equity and cultural/linguistic competency is an organizational priority. To this end, marketplaces should consider hiring a dedicated staff person to plan and coordinate equity, diversity, and cultural/linguistic competency efforts across all marketplace functions. Covered California has stated in the past that instead of having a dedicated position, this responsibility was integrated into multiple functions. While helpful in raising awareness of the issues in the organization, this also means that no one person or department is responsible or accountable for its rollout. Having a dedicated staff person or department—or, alternatively, individual position responsibilities that specifically incorporate related tasks and goals—would afford the opportunity to assure all functions of the marketplace are considering or integrating equity priorities, while monitoring the marketplace's compliance with federal requirements around diversity and cultural/linguistic competency. In addition, advocacy groups for culturally and linguistically diverse populations in California have voiced that having a cultural competency position would give them a liaison with the marketplace to provide support and help them address issues more quickly such as problems with translations and targeted media.

► **More fully engage and involve diverse communities on an ongoing basis.** As most marketplaces recognize, the engagement and involvement of diverse communities must be an ongoing process from planning and implementation to evaluation. Covered California has consulted several advisory committees from diverse communities, especially as it has worked to plan and roll out its marketplace, its various consumer assistance programs, and its initial

outreach and education programs. However, community advocates in California suggest there is a need to more fully engage these communities, particularly to review and vet messages and information not only for translation accuracy, but to assure they reflect appropriate cultural contexts. For example, advertisements that mentioned that insurance plans cannot deny people for pre-existing conditions did not resonate with people who have never applied for insurance, and ads that only gave a website address did not help people who wanted in-person assistance or do not have access to the web. An ad campaign with the message “Welcome to a new state of health. Welcome to Covered California” lost some nuance and meaning when translated to Spanish,²⁰² and could have benefited from community feedback for transcreation before its launch.

Community engagement and involvement is also necessary as the marketplace works to evaluate its outreach and enrollment activities following the first enrollment period, particularly identifying reach, what worked, and what did not work. Community representatives may be able to add depth and dimension around “why” certain strategies did not work in communities, and what are ways to overcome barriers and improve efforts. Covered California currently performs monitoring and receives feedback from outreach and assistance organizations through its vendor Richard Heath and Associates, and this process should continually be examined for opportunities for improvement, for example, some community organizations stated that the reports they are required to submit do not have much space for listing feedback and examples of effective outreach strategies and activities they have participated in.

Other factors that community representatives may be able to review and vet for any future improvements are the adequacy and value of outreach and enrollment venues, the effectiveness of part-time versus full-time enrollment assisters, which organizations are best to partner with to target certain populations, and how best to address the questions of immigrants and overcome their specific concerns about enrolling. Finally, and importantly, community representatives and advocates must remain involved and engaged in the interim period between the first and second enrollment periods as this time is crucial for evaluating and improving efforts, continuing to raise awareness, education, and understanding of the marketplace, to take advantage of experiences and lessons learned, and to provide continuity in what will be a long-term process.

Active and ongoing community engagement was a resounding theme among stakeholders we convened in Oakland, particularly to test and vet messages and materials to assure their cultural and linguistic appropriateness, but also to garner and maintain trust in some of the hardest to reach populations. As such, many emphasized the need for greater and perhaps more formal collaboration with trusted community partners (beyond existing outreach grantees) to libraries, schools, faith-based institutions, and others “anchored” in local communities.

► **Assure that long-term, sustainable funding is available for outreach and enrollment programs, and that enrollment assisters continue to be involved between open enrollment periods.** Some of the assistance programs may need to be combined or scaled back in 2015, but once it is determined what the optimal and reasonable level of assistance is on an ongoing basis, stable funding is needed so that organizations that target diverse and vulnerable populations can continue to do their work without disruptions. Health plan assessments, as has been implemented, is the basis of ongoing funding in California, but in addition, foundation grants and corporate sponsorships could be explored for regional or statewide supplemental funding.²⁰³ There is an active community of foundations and corporations in California, but the

downside is these resources can fluctuate with the economy and other situations, so they may not be a long-term source of funding, at least individually.

Outreach and enrollment is a long-term effort, and consumers already enrolled will need help with renewals, changing plans, and using the insurance. Also, some individuals will be able to enroll between marketplace open enrollment periods, if they are eligible for Medi-Cal, are Native Americans, or have qualifying events allowing them to join or change marketplace plans. Covered California and other marketplaces may find that they can scale back somewhat between open enrollments, especially after the second period ends in 2015, in order to save funding, but research shows that some assistance will always be needed.

Also, it is advantageous to retain an experienced workforce as much as possible, whether in-person assisters, call center representatives, certified application counselors, or brokers/agents. After 2014, it may be most practical to combine the outreach program with the navigator program, since both outreach and enrollment are required roles of navigators, and the outreach program will undoubtedly have a much smaller budget if one at all. The in-person assistance program could be combined with the navigator program in 2015 as well, since both are enrollers, though there may be advantages to keeping both a per application reimbursement model as well as a competitive grant model for enrollment assisters, as per application reimbursement allows more community organizations and part-time assisters to participate. Either way, the programs are likely to need much more funding after federal grants end in order to continue to reach vulnerable populations.

Finally, and as was intimated by a majority of stakeholders at the community forum, there may be a longer-term role for trained navigators and assisters in connecting enrolled individuals to health care services. As one participant voiced, and others reaffirmed, “let navigators help people from insurance to access.” Essentially, these newly trained professionals, who in many cases have gained the trust of their communities, can play an important role in educating newly insured individuals on how to use health insurance and navigate the health care system. They may also be able to promote healthy behaviors and prevention in some communities.

► **Monitor disparities and enrollment data by race, ethnicity, and language.** As the success of the marketplace in California, and across the country, largely hinges on the successful enrollment of diverse communities, it is important to monitor the reporting of enrollment data by race, ethnicity, and language, and understand which communities by geographic locality are less likely to supply this information and why. In some geographic locations, a large proportion of completed applications without race or ethnicity specified may indicate a community where trust may be of paramount importance, whether it be related to immigration status or general mistrust of government. Identifying such communities and their potential resistance may assist future efforts to encourage the reporting of this information. In fact, recognizing that in this enrollment period, race and ethnicity information was not reported by many enrollees, the marketplace may consider designing specific messages for navigators and assisters to use in the next enrollment period and beyond to encourage individuals to provide this information. For example, Covered California may encourage people to supply this optional information such as by specifically stating on the application or by an in-person assister that this information is for recordkeeping purposes only, that no individual information or identifiers will ever be reported, and that such information will help the marketplace to respond to the needs of different groups of people.

In addition, the rollout of enrollment efforts must be monitored and evaluated to assure they do not unintentionally widen disparities by focusing strategies in one community, while leaving another behind. For example, only about 3% of enrollees in private coverage plans through Covered California identified as African American, whereas 17% of African Americans lack coverage in the state.²⁰⁴ Some advocates suggested that the “state’s efforts to target Latino residents might have taken resources away from outreach efforts focused on African Americans and other populations.”²⁰⁵ Being informed of such data and understanding why differences may have occurred can inform the development of strategies for the next enrollment period. Furthermore, close monitoring and sharing of data on such differences in enrollment take-up on a real-time basis can help to address gaps as they emerge, assuring a balance of resources and assistance across diverse communities.

Stakeholders from the community forum shared additional insights on data and measurement, stressing the importance of assuring that any data revelations are looped back to community-based organizations, assisters, and others on the ground level to make improvements to outreach, enrollment, and related programs. They discussed the kinds of data that may facilitate improvements—such as consumer behavior research to identify consumer preferences and experiences related to utilization of various marketplace resources. They also reiterated the importance of community assessments to identify who is and not enrolling in certain geographic or ethnic communities, and why—possibly a role that can be filled by foundations in collaboration with on-the-ground community organizations.

► **Continue to improve training programs for outreach and enrollment assisters.** Feedback on the training programs in Covered California indicate some improvements have been made but that there are still opportunities for further enhancements. This includes using more role-playing in order to show what to do in various situations, including with diverse communities, and having more hands-on computer practice in the actual portal before assisters are ready to enroll. Also, the use of train-the-trainer could be explored in order to help train more assisters quickly instead of waiting on additional marketplace training sessions, and training programs could use more background information for workers new to enrollment and more experts who can answer questions, as opposed to having trainers who are good presenters but not experts in the field.

Community stakeholders discussed training for Certified Enrollment Counselors and others at length, suggesting many ways in which it may be further enhanced to more effectively reach and enroll diverse communities. Some specific recommendations that came forth were:

- Developing a wider collection of scenarios and specific trainings addressing differing family situations and structures (e.g., mixed immigration status families, divorced or separated parents, single-parent, LGBT parents, foster care, elderly immigrant parents, among many others).
- Recognizing that there is “diversity among diverse groups.” For example, many stressed the need for more specific training and guidance for different Asian communities as well as more training on how to reach and gain trust among African Americans.
- Need for more information related to the role of the Internal Revenue Service (IRS) and how tax-related issues are of relevance to enrollment.

Among other feedback on training that can be found in Appendix C, stakeholders also emphasized the importance of consolidating training information and resources in a user-friendly, go-to site. As one participant stated, “not everyone needs to know everything,” but

making available resources, information, as well as experiences and lessons learned from assisters in an accessible manner may better prepare outreach workers for the different scenarios they are likely to face.

► **Encourage sharing of lessons and best practices locally and regionally within the state.**

There was overwhelming consensus among stakeholders of the importance of coalescing information, resources, and experiences from across the state on what works, what works exceptionally well, and what does not work at all in different communities to avoid waste of resources, duplication of ineffective outreach efforts, and importantly to encourage practices that are culturally and linguistically appropriate. Specifically, many emphasized that there is a “need for meetings, coordination, and collaboration of groups working with the same populations and using the same languages.” Some suggested the creation of a state “brain trust” of cultural/ethnic organizations, resources, and materials, whereas others saw value in county/regional convenings of assisters and navigators to discuss their experiences and lessons, whether in-person, via web-conferencing, or online forums (depending on resources). While a wealth of ideas were shared on how best to exchange or create a central clearinghouse of lessons, best practices, and resources for outreach and enrollment of diverse communities, this was certainly seen as a priority and a potential effort that could be supported by local philanthropies or foundations.

IX. Conclusion

A common theme that emerged from our research and conversations with state marketplaces and community organizations, even the ones considered most successful, was that all feel like they are “flying the plane while still building it.” Though some marketplaces and websites are operating better than others, no organization was completely prepared for the first open enrollment of this brand-new program. Most are rapidly catching up, but there is still much work to be done and aspects to evaluate and modify. Some major areas that are still being determined at this writing are how to ensure marketplace activities have sustainable funding in future years, how to best reach and enroll the remaining uninsured diverse populations, how to design messages that convince individuals to “buy into” health insurance, how to design optimal training programs, how to best track data for evaluations, how much assistance will be needed between open enrollment periods when fewer people are eligible to sign up, and how to ramp up for the second open enrollment that starts November 15, 2014. Continued research and experience will help to inform these decisions.

In California, where the official navigator program is starting after the first open enrollment period ends, some lessons and data from the first enrollment period can be applied, though others may not be as relevant due to the low funding for this program as compared to the other outreach and assistance programs that could use federal grant funds. The navigator program and its grantees will need to use methods that are highly effective and targeted for the lowest cost in order to be able to reach the remaining uninsured and diverse populations. Applicable information in this report may be useful in this program.

Around the nation, community organizations are banding together as they never have before to try to reach uninsured populations. Though many consumers have enrolled in health plans since open enrollment started, many others, especially culturally and linguistically diverse populations, remain unaware or confused about their options and have not signed up. As Enroll America and others say, getting consumers enrolled in health insurance is a “marathon and not a sprint,” and

this undoubtedly is even truer for diverse communities and limited English proficient individuals. But with continued perseverance, steady funding, and research-driven strategies, states and community organizations can work progressively toward the goal of educating and enrolling almost all eligible uninsured into appropriate health insurance plans.

Appendix A: Project Interviews

Tamika L. Butler, JD
California Director
Young Invincibles

Natalia Chavez
Policy Analyst
Covered California

Grace Damio, MS, CD/N
Director of Research & Service Initiatives
Hispanic Health Council (Connecticut)

Fabiola DeCaratachea
Senior Program Manager, Grants
Richard Heath and Associates, Inc. (California)

Adela Flores-Brennan, JD, MA
Assistance Network Manager
Connect for Health Colorado

Kate Gervais
Manager, Navigator and Assister Outreach
Program
Access Health CT

Janelle Hu, JD, MPP
Health Program Manager
Asian Americans Advancing Justice - Los
Angeles

Linda Leu, MPH
California Research and Policy Director
Young Invincibles

Amy Lin
National Organization Director
Young Invincibles

Mirna Ramirez-Castro
CCARES - ENTRA Manager
Health Coverage Guide/Navigator Programs
Servicios de La Raza (Colorado)

Cary Sanders, MPP
Director of Policy Analysis and The Having
Our Say Coalition
California Pan-Ethnic Health Network

Sofia Segura-Pérez, MS, RD
Associate Director, Center for Community
Nutrition
Hispanic Health Council (Connecticut)

Emilia Skene
Recruitment Coordinator, Navigator and
Assister Outreach Program
Access Health CT

Sarah Soto-Taylor, MPH
Deputy Director of Community Relations
Covered California

Leslie Toy
Policy Advocate
Asian Americans Advancing Justice - Los
Angeles

Willie Walton
Enrollment Assistance Manager
Covered California

Mary Watanabe
Community Relations Division Manager
Covered California

Doreena Wong, JD
Project Director
Asian Americans Advancing Justice - Los
Angeles

Anthony Wright
Executive Director
Health Access California

These individuals participated in semi-structured interviews conducted over the telephone (sometimes with more than one participant per conference call), and one via e-mail. We would like to acknowledge and thank all interviewees for their time and assistance.

Appendix B: Summary of Community Forum

The Texas Health Institute (THI), with support from The San Francisco Foundation (TSFF), convened a community forum of nonprofit leaders, health professionals, community advocates, enrollment entities, funders, and other stakeholders involved in health insurance outreach and enrollment in the San Francisco Bay Area on April 10, 2014. The primary objective of this forum, entitled “Advancing Health Equity through Marketplace Navigator and Assister Programs,” was to share and discuss promising practices for reaching and enrolling racially, ethnically, and linguistically diverse populations in the health insurance marketplace, and identify local area challenges and opportunities for action.

Community Forum Design

The six-hour forum was divided into two sessions—a morning didactic session with lessons from other states and localities and an afternoon session intended to engage stakeholders in a meaningful, action and advocacy-oriented dialogue. Exhibit A contains the meeting agenda.

Morning Session. The morning session was focused on presenting experiences nationally and from other leading localities in reaching and enrolling diverse communities. To this end, there were three featured presentations.

- The Texas Health Institute presented findings from its national review and report on marketplace assister initiatives targeting diverse communities from across the country;
- Access Health CT (the Connecticut marketplace) presented on its promising programs and lessons in designing outreach, marketing, and enrollment efforts for diverse populations; and
- Asian Americans Advancing Justice-Los Angeles and the Korean Community Center of the East Bay shared California-based experiences, challenges, and successes in reaching Asian populations.

A total of 38 local stakeholders attended the morning session.

Exhibit A.

Community Forum Meeting Agenda April 10, 2014, 9:00 AM – 3:00 PM

9:00 AM - Welcome and Introductions

*Myra Chow & Shalini Iyer
The San Francisco Foundation
Dennis Andrulis, Texas Health Institute*

9:30 AM - Marketplace Consumer Assistance Programs: Charting Progress and Sharing Promising Practices for Enrolling Racially and Ethnically Diverse Communities

*Dennis Andrulis & Nadia Siddiqui
Texas Health Institute*

10:00 AM - Break

10:15 AM - A Leading State's Experience in Reaching and Enrolling Diverse Communities

*Victoria Veltri, CT's Healthcare Advocate
Kate Gervais, Access Health CT*

11:30 AM - Reaching Asian Americans and Others in California

*Doreena Wong, Asian Americans Advancing Justice – Los Angeles
Yeri Shon, Korean Community Center of the East Bay*

12:15 PM - Lunch

12:45 PM – Small Group Breakout Session:

Considering Application of Emerging Lessons and Practices for Outreach and Enrollment of Diverse Communities in the Bay Area and California

2:00 PM - Large Group Discussion:

Charting Priorities Moving Forward for Improving State/Local Outreach and Enrollment Efforts for Diverse Communities

2:50 PM - Closing Remarks

Dennis Andrulis, Texas Health Institute

3:00 PM - Adjourn

Afternoon Session. The purpose of the afternoon session was to engage local health care stakeholders to discuss the San Francisco Bay Area outreach and enrollment experience and consider how lessons and successes described in the morning session could be applied locally to improve and enhance enrollment across diverse populations. To this end, there were two brainstorming activities that occurred in the afternoon, engaging a total of about 30 participants:

- **Small Group Breakouts:** Participants were arranged into three small groups with each having a mix of sectors, priorities, and populations represented. We utilized the Nominal Group Technique (NGT), a structured small group decision-making methodology which combines qualitative and quantitative processes to drive consensus. Each group was posed the following question: “Recognizing how the first enrollment period has played out in California and challenges that may have emerged, what are key actions for improving and enhancing outreach and enrollment to racially and ethnically diverse communities in the San Francisco Bay Area?”

Participants were asked to consider key challenges that played out in outreach and enrollment generally, and more specifically for different racial, ethnic, and linguistic groups; ways in which these challenges were or could have been overcome; any successful strategies already in place that may require further support and enhancement; and any successful strategies from other states/localities that may be applied to the Bay Area. The NGT’s brainstorming and round-robin activities offered each participant the equal opportunity to share their expertise, unique perspectives, and ideas with the group, limiting domination by a few outspoken individuals and maximizing the number of distinct recommendations that were generated. The quantitative aspect of NGT—i.e., ranking of recommendations by most to least important by each individual—provided a systematic, yet simple and fair approach to reaching consensus and drawing common ground among the groups.

- **Large Group Discussion:** Once the small-group brainstorming was complete and a set of priorities identified per group, each group presented their top findings to the larger group. These top findings were further discussed by the larger group, and using the NGT’s ranking process, we asked all meeting participants to rank what they considered their top three priorities for the region and California.

Findings from both the small and large group discussions are presented in Appendix C.

Keynote Presentations from Morning Session

In addition to the Texas Health Institute’s presentation of its report, *Marketplace Consumer Assistance Programs and Promising Practices for Enrolling Racially and Ethnically Diverse Communities*, there were two keynote presentations that offered perspective on promising strategies and lessons for reaching diverse communities. We summarize these two presentations here, highlighting information that may be of greatest value to California and the Bay Area.

1. A Leading State’s Experience in Reaching and Enrolling Diverse Communities

Victoria Veltri, Connecticut’s Healthcare Advocate, and Kate Gervais, Manager of Navigator Programs at Access Health CT presented on their unique efforts and experiences in building

efforts for reaching and enrolling racially and ethnically diverse communities. They began their talk by setting the context of Connecticut’s demographic and health landscape. Connecticut, though small, is “one of the most racially, ethnically, and culturally diverse states in the country”—there are over 60 languages spoken in some counties. “Yet the state performs unacceptably on many population health and quality of care measures when one compares results by race, ethnicity, geography and income.” Approximately 9% of Connecticut’s population is uninsured, with 80% of the uninsured residing in three counties: Fairfield, New Haven, and Hartford. Nearly 45% of the uninsured are non-white.

Connecticut’s Navigator and In-Person Assister (NIPA) Program was established with the purpose of engaging and enrolling uninsured consumers in Medicaid and Qualified Health Plans and creating a sustainable movement for improved community health. In efforts to achieve this, NIPA works to:

- Provide culturally and linguistically appropriate access points;
- Engage community leaders and influences to promote access to health insurance;
- Use data, measureable outcomes and open communication with consumers; and
- Educate consumers so they can make informed decisions and self-advocate.

The program also aims to overcome key barriers to health insurance in the state, which include cost of coverage, previous ineligibility, complexity of enrollment processes, transportation, low health and insurance literacy, cultural and linguistic barriers, misinformation and “noise,” immigration-related barriers, digital divide, and mistrust. Among their key tactics for addressing these barriers are:

- **Developing a regional navigator structure** with robust criteria for navigator selection including various geographic and demographic measures, along with experience, capacity, and alignment with Access Health CT and the NIPA program.
- **Engaging local stakeholders**, such as faith institutions, pharmacists, small businesses, and low-wage businesses, among others, in facilitating outreach, influencing communities, building partnerships, and establishing micro-regions for further tailoring of efforts.
- **Educating consumers and small businesses** through multiple mediums and partners as well as addressing culture and language. For example, Access Health CT has developed an enrollment checklist in 10 languages that includes all the information that consumers need to enroll, created culturally diverse outreach materials, and created an advertising campaign focusing on the 16 urban centers with the highest numbers of uninsured.
- **Holding events for outreach and enrollment.** Access Health CT has held more than 500 events throughout the state. Each of its NIPA regions plans their own events, with each micro-region planning more focused events as well. These events are typically held in culturally and socio-economically sensitive locations with accessible transportation.
- **Providing one-on-one assistance.** There are 160 assister organizations in Connecticut, with 239 assisters providing enrollment assistance. Assisters speak a total of 33 languages, and one-third speak Spanish.
- **Assuring interactivity.** Access Health CT has taken explicit steps to assure navigators, assisters, and consumers have access to a range of information and resources both online and in-person. Through its program website (www.ahctcommunity.org), Access Health CT provides the ability to search for assisters by location and language and a list of all enrollment events by county, among other accessible information.

Through these various tactics and strategies, Access Health CT has many lessons learned, as summarized in Exhibit B.

<p style="text-align: center;">Exhibit B. Connecticut’s Outreach and Enrollment Lessons Learned</p> <ul style="list-style-type: none">• Need to weigh the costs and benefits of part-time assisters.• Identify incentives both for outreach and enrollment work as well as for the community.• Maintaining status quo may be a challenge in itself and at times; helpful to think out of the box.• Understand organizational challenges that may exist within the marketplace.• Promote collaboration, and understanding of what worked and did not work.• Utilize multi-media outlets, both mass and micro.• Identify potential new partners.• Voice of assisters on the radio and in the community to facilitate outreach.

In moving forward, Access Health CT is considering a few options for restructuring its NIPA program. For example, they are exploring the feasibility of developing NIPA into a sustainable workforce including increasing brokers among communities of color, and identifying opportunities for transforming the program to bridge to community health workers.

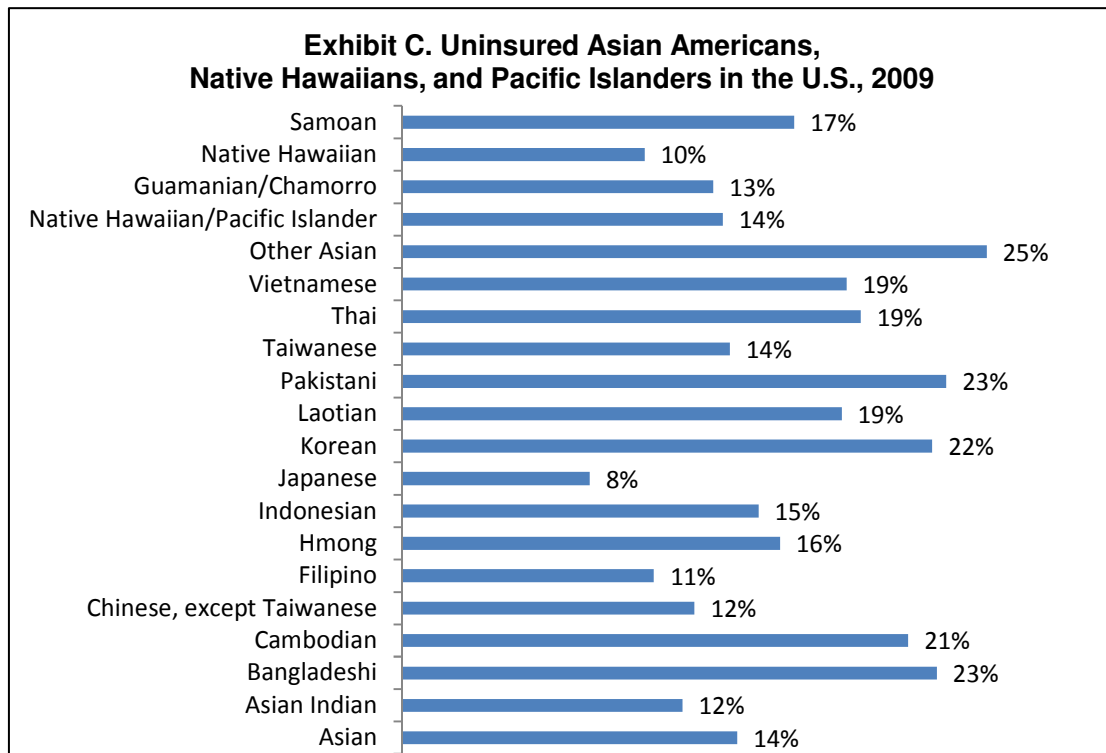
2. Reaching Asian Americans and Others in California

Doreena Wong, Project Director of Health Access Project at Asian Americans Advancing Justice in Los Angeles (AAAJ-LA), and Yeri Shon from the Korean Community Center of the East Bay presented on experiences and challenges faced in reaching and enrolling Asians in California. Ms. Wong began the talk by sharing a brief history of AAAJ-LA, founded through an affiliation of three key Asian American civil rights groups. The mission of AAAJ is “to create a more equitable, affordable health care system for the Asian American, Native Hawaiian and Pacific Islander (AANHPI) communities throughout California and the U.S. through outreach, education and advocacy.” The organization’s main goals are to address the health care needs of the AANHPI communities and to increase access to affordable, high quality, and culturally and linguistically competent health care for underserved communities.

Ms. Wong then set the context for understanding diversity within the AANHPI community. In particular, she documented health insurance disparities that exist for different AANHPI groups, citing high uninsured rates among communities such as Koreans (27%), Tongans (25%), Thais (22%), and Cambodians (21%) (see Exhibit C).

Ms. Wong cited that in California nearly 6 million uninsured Californians would be eligible for health care coverage through the ACA, of which 1.4 would be newly eligible for Medi-Cal, the state’s Medicaid Program, 2.6 million eligible for tax credits through Covered California, and another 2.7 million eligible for Covered California coverage without tax credits. Among the Medi-Cal population, 7% or 99,400 newly eligible will be AANHPI and 67% or nearly a million will have limited English proficiency. Through Covered California, it is estimated that nearly 600,000 AANHPI are eligible. And among the subsidy eligible population only, two out of five will have limited English proficiency. Ms. Wong emphasized, that “without appropriate and effective multilingual outreach and education efforts, only 46% [of LEP individuals] are expected to

enroll...Although most enrollees are predominantly Spanish-speaking, a large number speak other languages, including 95,000 Chinese, 15,000 Vietnamese, and 10,000 Korean.”



Source: 2009 American Community Survey, 1-Year Estimates.

After a brief primer on the scope and importance of reaching the AANHPI communities in California, Ms. Wong described the Outreach and Education Grant that her organization received from Covered California. The goal of this grant is “to increase awareness and understanding about health coverage options; to promote the value of purchasing health coverage; to change attitudes, and to motivate individuals to take the next step to enroll; and to provide outreach and education in language that is culturally appropriate to the AANHPI communities throughout the state of California.” AAJ intends to reach 135,000 AANHPIs through this initiative which is geared toward outreach and education only (and not enrollment).

Ms. Wong also shared several collaborative efforts from the across the state and nationally that offer promise for reaching and enrolling diverse populations, such as Health Justice Network; Action for Health Justice; The California Endowment’s Medi-Cal, Outreach and Enrollment funding for low-income, African American, Latino, and AANHPI communities; and the Walter H. Coulter Foundation’s outreach and enrollment support for six organizations serving Southeast Asian communities in the Central Valley region in California. She also shared examples of promising pilot projects, such as the Chinatown Library Branch Pilot described in Exhibit D.

Ms. Wong also spoke about her organization’s collaborative partnership with the Korean Community Center of the East Bay (KCCEB), which offers services such as immigration integration, domestic violence help, and a community health access program for Koreans. Yeri Shon of KCCEB described their initiatives and lessons further related to marketplace outreach and enrollment.

Exhibit D. Chinatown Library Branch Pilot

- **Partners:** LA City Public Library, LA County Department of Public Social Services (Medi-Cal Program), Chinatown Service Center, Legal Aid Foundation of Los Angeles, and Chinatown Community for Equitable Development (Covered CA has other library partnerships)
- **Funders:** UniHealth Foundation, Weingart Foundation, and The California Endowment
- **Staff Support:** AAAJ-LA 's Certified Health Educator/Enrollment Counselor devoted four days per week to provide in-person assistance, education, and enrollment in Mandarin and Cantonese
- **Outcomes:** Outreach provided to 1,340 individuals, educated almost 500 Chinese-speaking clients, and enrolled over 250 individuals.
- **Lessons Learned:**
 - ▶ Clients more interested in enrollment than general information from workshops. While the initiative began with the idea to provide workshops, it later realized that clients were more interested in getting help with their particular circumstances.
 - ▶ Clients interested in learning about how to use health coverage to access care and in understanding the difference between health plans, benefits, and providers included.
 - ▶ Most time needed to pick out health plan; explanations about certain terms, like preventive care, managed care plans, primary care provide.
 - ▶ Follow-up is necessary (e.g., clients seen 2-3 times; clients need help when notices are only in English, and not translated).

Ms. Shon set the context by describing Bay Area demographics, highlighting percent limited English proficient within the region. In particular, she cited that certain AANHPI groups have a large proportion of people with limited English proficiency—e.g., 39% of Koreans in the Bay Area are LEP. As such, she described four main strategies her organization put into practice to reach this group (described in Exhibit E).

Ms. Shon also shared lessons learned in crafting messages around the marketplace to communities with limited English proficiency. Recommendations include:

1. Emphasizing that Obamacare, the Affordable Care Act, Covered California, and Health Care Reform are generally the same;
2. Reiterating the mandated, standardized, and affordable aspects of the marketplace (e.g., individual mandate and penalty, standardized benefits, and affordable health insurance through tax credits and subsidies);
3. Reaching out to owners/employees of small businesses and assuring they understand that they too are eligible for coverage through the marketplace; and
4. Reaffirming that “lawfully present” immigrants are eligible for Marketplace and Medi-Cal coverage.

In her closing remarks, Ms. Shon reflected on key barriers and challenges that remain to reaching Asian, limited English proficient, and other diverse populations. In particular, there is continuing confusion about health care reform given the abundance of misinformation and a lack of specific information on issues such as eligibility by different immigrant situations and family structures. There is also less information on programs outside of Covered California (e.g., transition from Healthy Families to Medi-Cal or the Low Income Health Program to Medi-Cal, and eligibility for other health programs such as those that are county-based). Cultural and linguistic access was

also identified as a remaining challenge given interpreters, translated materials, and other language services are still very limited. Finally, data collection and fraudulent representations have also posed challenges, as well as issues with the website and delays across the board.

**Exhibit E. Successful Outreach and Education Strategies
of the Korean Community Center of the East Bay**

► **Strategy 1: Customized and specific message to each ethnicity and/or subgroup provided at trusted community settings and through trusted messengers.** The key point is working through the most utilized networks within these communities and subgroups to disseminate information efficiently. Possible community venues depend on the subgroup, but may include health fairs, community forums, places of worship, homes, nail and hair salons, and others. Smaller outreach efforts have shown greater promise than large events for reaching LEP populations.

► **Strategy 2: Assuring language capacity and cultural competency.** Any outreach effort must be in the preferred language of consumers, with information provided through multiple mediums, such as interpreters and translated print materials. Materials must be in very simple language.

► **Strategy 3: Strong collaboration and partnerships between Certified Health Educators to educate and make appointments and Certified Enrollment Counselors to help complete applications.** This can be achieved through building referral systems and attending events together for outreach, education, and enrollment pre-screening. One promising approach is to build a complementary relationship between educators and enrollment counselors where the educators provide conceptual and context information, and enrollment counselors provide individualized, tailored, and tangible guidance.

► **Strategy 4: Assuring consistency.** There is considerable recognition for the need for “multiple touches” to raise awareness and understanding among consumers. To this end, a key lesson has been the delivery of consistent information and messages through multiple forms of communication, from press releases and print materials to social media and individual outreach. Also important is the need for consistent timing, such as regular times for education and enrollment activities in communities, and with the evolving nature of the ACA rollout, continually updating information in outreach messages and materials.

Appendix C: Community Forum Priorities and Recommendations

The afternoon session of the community forum on April 10, 2014, engaged participants in a dialogue to chart next steps, actions, and priorities for California and the Bay Area. This question was posed to participants: Recognizing how the first enrollment period has played out in California and challenges that may have emerged, what are key actions for improving and enhancing outreach and enrollment to racially and ethnically diverse communities in the San Francisco Bay Area?

Using the Nominal Group Technique process, meeting participants discussed a range of strategies and priorities for enhancing marketplace outreach and enrollment to diverse communities, from improving communication, language access, and training to identifying ways to leverage limited funding, build effective data and measurement systems, more fully engage communities, and share best practices. **Five leading priorities and recommendations for California and the Bay Area** resulted from this discussion, as follows (not in any particular order):

- Assure continuity in consumer assistance provided through the marketplace, whereby navigators and assisters not only connect individuals to health insurance, but also on ways to use and access health care.
- Assure that Covered California has dedicated staff devoted to working with community-based organizations to increase enrollment and retention across hard-to-reach and diverse populations.
- Assure ongoing dedicated funds for outreach, education, and enrollment to diverse communities, including to those with limited English proficiency.
- Consider how to address future challenges that may arise, such as insurance utilization, retention of enrollees, tax implications, and training.
- Enhance training programs to incorporate more role-playing and scenarios that speak to diverse family structures and situations, such as LGBT, mixed/complicated immigration status families, and others.

Below we share all responses that emerged from the nominal group exercises. These have been grouped by common themes including communication, structure and funding, data and measurement, community engagement, training, and sharing resources and best practices. While these are not listed in any rank or priority order, these responses offer the breadth of concerns from stakeholders in California and areas for potential future action for improving outreach and enrollment to diverse communities.

COMMUNICATION: Language, Literacy, Media, Messaging

- Need closer media relations to non-English populations, especially Chinese newspapers.
- There is a lack of coordination between the identified language and follow-up communication with enrollees—need consistency with languages.
- Need a renewed focus on technical issues and social media to engage people who don't have assisters.
- Covered California should ask health plans to communicate to enrollees in their primary language/language of choice.

- Reexamine reading level for all materials—some are too high.
- Materials need less text and more culturally appropriate pictures or infographics; also need to also use other media like videos and novellas.
- Need more culturally appropriate materials targeting the African-American community; rethink the overall outreach strategy to the African-American community, as it had the lowest relative percentage of enrollments.
- Make Covered California materials available in more languages.
- Hire culturally competent behavioralists to write messaging and notices.
- Need consistent messaging and terminology, and a well-trained regional liaison and communication point person to meet with enrollers.
- Use transcreation more when creating and translating materials.

STRUCTURE AND FUNDING: Assister Application Process, Extending Role, Resource Needs, Staffing, Coordination

- Educators should be an ongoing referral source for issues raised by new enrollees to help sustain engagement and enrollment.
- Let navigators and assistors have a more prominent voice in having input and shaping policy for future issues.
- Have dedicated Covered California staff whose job it is to work on how to intentionally and effectively target communities of color based on lessons learned from CBOs and individuals from these communities.
- Be intentional about using infrastructure (county-CBO relationships) to empower longer-term outcomes—how else can we use these relationships beyond enrollment.
- Should have continuity of care for utilization: let navigators help people from insurance to access.
- Certified educators are asked what languages populations they are reaching speak but they don't have a comprehensive language list.
- Reduce administrative barriers in certification, training, and reporting—all take too long.
- Need ongoing funding for assister programs.
- Need dedicated staff at Covered California working with CBOs to increase enrollment and retention.
- Ensure dedicated funding for educators and enrollers in order to continue the capacity that has been developed; need to advocate for continuing funding.
- Address utilization issues and future challenges, such as retention, and how to ensure positive word of mouth.
- More support for enrollers, such as no long hold times when calling the call center, and an online board for enrollers to help each other.
- Make the Covered California Certified Enrollment Entity Application process easier, so that more organizations are willing to apply that reflect communities of color.
- Need greater flexibility to address cultural competency issues; need a cultural and linguistic coordinator in each region.
- Need to clarify income questions on the application.
- Need clarification of Medi-Cal and Covered California qualifications and eligibility in correspondence and notifications.
- Need to educate newly insured people about how to use their coverage.

- Improve online and mobile payment systems, and overall technology system; for example, Alameda County does not have an online payment system for insurance.

DATA AND MEASUREMENT: Types of Data, Collection, Feedback, Reporting

- Need to dig deep into the data we have and see what are the limitations of these data—how do we build it into improvement tactics?
- Need consumer behavior research, e.g. did people prefer calling Covered California or a community representative? Did literacy and numeracy levels cause issues?
- Provide better data at various levels (such as city and county) to better plan outreach, enrollment and retention strategies.
- Develop a more systematic feedback loop from CBOs that work with communities of color and low-income communities to make regular improvements to the enrollment process.
- Need better data on who is and is not enrolling and why, particularly for those without a navigator.
- Improve collection and reporting of data, such as on race and ethnicity.
- Get feedback from enrollees on what worked and improvements to make.
- Need more information from Covered California to counselors about enrollees—general information regarding follow-up.
- Need ongoing feedback loops for assisters and those overseeing them to ensure best practices.

COMMUNITY ENGAGEMENT, OUTREACH, AND ENROLLMENT

- Need to increase the number of Certified Enrollment Counselors in culturally relevant locations, such as churches and community centers.
- Allow groups to customize materials and pay for it, including allowing use of the Covered California logo; allow materials to be community-generated and community-tested.
- Accept feedback from CBOs and people on the ground, not just grantees.
- Increase alignment with grassroots CBO roles in education and linkage to enrollment.
- Need more flexibility in enrollment spending to be more relevant/tailored to community.
- Form better partnerships with schools, libraries, the criminal justice system, and other places where people go to get better enrollment numbers.
- Consider how to better address mixed status families.
- Incentivize reaching hard-to-reach populations, not just quantity enrolled.

NAVIGATOR/ASSISTER TRAINING: Culturally Specific and Consistent Training, IRS Information, Background Checks for Certification

- Need less focus on detailed training of assisters and more focus on having resources to assist with detailed questions—not everyone needs to know everything.
- Need more culturally specific trainings (such as for Asians and African-Americans) for educators and enrollers.
- Need consistent training for all stakeholders.
- Speak to diverse family structures and situations (such as LGBT), and improve training on mixed/complicated immigration status families for everyone involved—Certified Enrollment Counselors, Covered California, and others.

- Recognize there is diversity among diverse groups.
- Need more IRS information (tax resources and training), and to improve communication about tax implications.
- Ideal to use re-entry population for enrollment assistance in some communities, but they have challenges with background checks.
- Conduct fingerprinting and background checks before training, so if someone did not pass they would not have wasted time on the training classes.
- Need to clear delays in background checks as it can take several months to get certified.

MEETINGS, BEST PRACTICES, RESOURCE DEVELOPMENT

- Need best practices summits for diverse communities.
- Need meetings, coordination, and collaboration of groups working with the same populations and using the same languages; would help to have an advisory group to Covered California on this, and a glossary of terms in different languages.
- Need place for organizations working on the ground in regions and throughout the state to share best practices.
- Create a state “brain trust” of cultural/ethnic organizations, insurance information, Covered California materials, officials, and other resources.
- Have county/regional convenings to talk about issues and best practices.
- Move Covered California board meetings to communities.

Appendix D: Covered California Outreach and Education Grantees (Located in Bay Area and Statewide)

<i>Bay Area Grantee Organization</i>	<i>Counties Reached</i>
Asian Pacific American Legal Center	Alameda, Kern, Los Angeles, Orange, Sacramento, San Diego, San Mateo, Santa Clara, Solano, Yolo
California NAACP	Alameda, Contra Costa, Fresno, Kern, Los Angeles, Madera, Merced, Monterey, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Solano, Sonoma, Stanislaus
California School Health Centers Association	Alameda, Stanislaus, Los Angeles, Merced, San Luis Obispo, Santa Clara, Fresno, San Francisco, Santa Clara, Contra Costa, Napa, Del Norte, Placer, Glenn
East Bay Agency for Children	Alameda
Planned Parenthood Mar Monte	Alameda, Fresno, Kern, Madera, Merced, Monterey, Placer, Sacramento, San Benito, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Stanislaus, Sutter, Yolo
Redwood Community Health Coalition	Lake, Marin, Sonoma, Mendocino
Solano Coalition for Better Health	Solano
St. Francis Medical Center of Lynwood Foundation	Los Angeles, San Mateo, Santa Clara
The Actors Fund	Los Angeles, San Francisco, Alameda, San Diego, Sacramento
The Regents of the University of California	Alameda, Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Lassen, Los Angeles, Orange, Shasta, Sierra, Mono, Merced, Modoc, Placer, Plumas, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, Santa Barbara, Siskiyou, Solano, Stanislaus, Sutter, Tehama, Tuolumne, Ventura, Yolo, Yuba

<i>Statewide Grantee Organizations for the Individual Market</i>
Access California Services
California Health Collaborative
California Black Health Network
SEIU Local 521
SEIU United Long Term Care Workers
The Los Angeles Gay and Lesbian Community Services Center
Visión y Compromiso

Source: For a list of all Cycle I Outreach and Education Grant recipients in California and the counties they serve, see Covered California, “Outreach and Education Grant Program, Grant Recipients by Region” (May 2013), available at <http://board.coveredca.com/meetings/2013/05%20May-23%20Meeting%20Materials/PDFs/COVERED%20CA-Grantees%20by%20Region.pdf>.

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