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Evolution of Health Insurance Marketplaces: Experiences and Progress in Reaching and Enrolling Diverse Populations



Lauren R. Jahnke, MPAff
Nadia J. Siddiqui, MPH
Dennis P. Andrulis, PhD, MPH

Texas Health Institute

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Texas Health Institute | 8501 North Mopac Expressway, Suite 170 | Austin, TX 78759 | 512-279-3910

ABOUT THE AUTHORS

Lauren R. Jahnke, MPAff, has been a freelance health policy consultant, researcher, and writer since 1997 (www.lrjconsulting.com), working mainly on state and federal health care issues including the Affordable Care Act, Medicaid and Medicare policy, the uninsured, public health and local health departments, mental health care, U.S.-Mexico border health, and health care disparities.

Nadia J. Siddiqui, MPH, is Director of Health Equity Programs at the Texas Health Institute, where she manages projects, leads research, writes, and presents frequently on advancing racial and ethnic health equity. She is currently managing and leading research and design of THI's multiple initiatives on the Affordable Care Act, including a health equity and marketplace report card, along with others addressing topics of health care access, the safety net, quality improvement, and workforce diversity.

Dennis P. Andrulis, PhD, MPH, is a Senior Research Scientist at the Texas Health Institute and Associate Professor at The University of Texas School of Public Health. Dr. Andrulis has been a leader in the development of national, state, and community-based research and policy analysis on vulnerable populations, urban and suburban health, racial and ethnic disparities, and cultural competence in health care for over 20 years. Dr. Andrulis is Principal Investigator on THI's major multi-year, multi-funder initiatives on the Affordable Care Act and health equity.

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Introduction

One of the important features of the Affordable Care Act (ACA) of 2010 is the creation of health insurance marketplaces (originally called exchanges), which are intended to make available a choice of easily comparable and affordable health insurance plans for individuals and families.¹ Marketplaces represent a unique opportunity to improve longstanding racial and ethnic disparities in health insurance coverage and access to care, and already have made progress in enrolling diverse populations. By 2019, it is projected that at least 24 million individuals will obtain health insurance through the 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 Texas, California, and Florida, a much larger racially and ethnically diverse population is eligible for insurance through the marketplaces, although eligibility does not guarantee coverage or access to care. In recognition of this diversity, the ACA included a number of provisions to explicitly plan for, educate, and ultimately enroll hard-to-reach culturally and linguistically diverse populations.

Our report released in March 2013 entitled “Implementing Cultural and Linguistic Requirements in Health Insurance Exchanges” reviewed several provisions of the ACA including those related to cultural and linguistic competency in the marketplaces, and tracked related planning activities and progress in seven case study states.³ Among provisions that the report highlighted was section 1311(i) of the ACA, which requires that marketplace operations and information be “culturally and linguistically appropriate,” including the navigator and assister programs that help consumers enroll in health insurance plans.⁴ The purpose of this report is to document how marketplaces have evolved, adapted, and innovated since their early planning and development stages, as reported in our baseline 2013 report, through the first (2013-2014) and second (2014-2015) open enrollment periods, to reach, enroll, and retain culturally and linguistically diverse populations in marketplaces. To this end, it is intended to offer both point-in-time and over-time experiences, lessons learned, and promising practices to inform advocacy, policy, and program development in subsequent open enrollment periods across the country.

This report starts with a national overview of enrollment progress. It is then followed by a description of outreach and enrollment-related activities targeting diverse populations across the three different types of marketplaces—state-based, federally facilitated, and partnership. For each type of marketplace, several states are highlighted to show examples of successful approaches to targeting culturally and linguistically diverse populations in planning, outreach, and enrollment. Challenges and lessons learned are also discussed.

The marketplace sections are followed by an account of the key informant interview findings, a discussion of important points moving forward, and a conclusion section. In presenting this new information this report intends to offer marketplaces and assistance programs practical, ground-level lessons as well as important adaptations and new approaches to effectively enrolling diverse populations.

Methods

Our 2013 report contains details of the ACA provisions on cultural and linguistic competency that affect health insurance marketplaces, and presents seven case studies on state-based marketplaces, as the federally facilitated and partnership marketplaces were not far along in

implementation during the study period. The present report contains updates on those seven baseline states (California, Colorado, Connecticut, Maryland, New York, Oregon, and Washington), along with four other states—two that have partnership marketplaces (Arkansas and Illinois) and two that are federally facilitated (Florida and Texas). As noted, the focus of the review is on tracking experiences, lessons, adaptations, and innovations for explicitly reaching, enrolling, and retaining culturally and linguistically diverse populations.

In developing this report we reviewed the published and grey literature on state actions and assessments. We also conducted 17 interviews with state and federal marketplace officials, national nonprofits, advocacy groups, and navigator organizations to ascertain accomplishments as well as continuing and new concerns or adaptations arising during the first and second marketplace open enrollment periods. (See Appendix A for list of key informant interviews.) Marketplace issues are continually evolving, and information in the report is current as of April 2015, with additional references to the *King v. Burwell* Supreme Court decision added at the end of June.

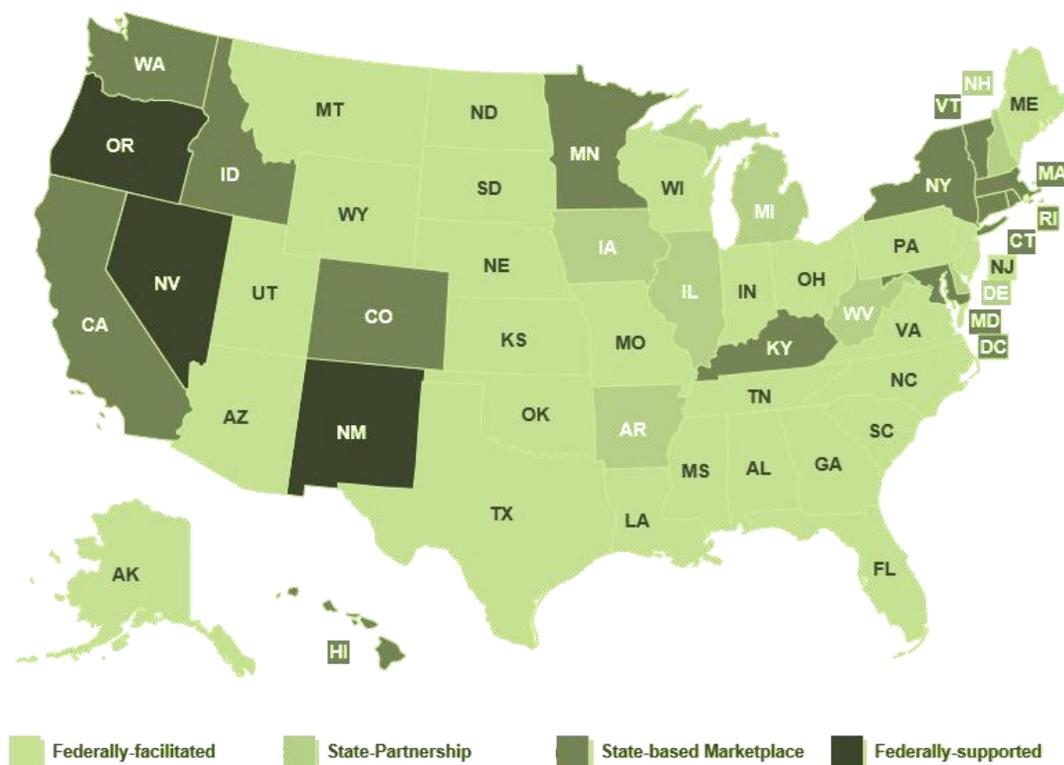
National Overview and Enrollment Experiences

Enrollment Statistics

As of April 2015, 14 states (including the District of Columbia) are operating state-based marketplaces, 27 as federally facilitated marketplaces, seven as partnership marketplaces that are a combination of the two, and three as federally supported marketplaces that are state-based but use federal enrollment software (see Figure 1). These numbers were the same for the first open enrollment period, except that Idaho opted to change from federally supported to state-based, and Oregon and Nevada switched from state-based to federally supported. [Subcategories of marketplaces also exist, such as in Utah where the federal government operates the individual marketplace and the state operates the Small Business Health Options Program (SHOP); however, SHOP marketplaces are beyond the scope of this project.] As states can elect to change their type of marketplace each year, these numbers may continue to vary over time.

Table 1 provides total enrollment and enrollment as a percentage of those eligible nationally and by each state as of February 2015. Nationally, of the 28 million eligible for coverage through marketplace plans, nearly 11.7 million or 42% enrolled through the end of the second enrollment period (estimates include both new enrollees and individuals who renewed coverage gained previously). The second open enrollment period shows an increase in enrollment from the first open enrollment period, where 8.02 million, or 28% of those eligible, enrolled in marketplace plans.⁵ States with the largest number of individuals selecting a marketplace plan in the second open enrollment period include Florida (1.6 million), California (1.4 million), and Texas (1.2 million). In addition, eight states and the District of Columbia have enrolled half or more of their eligible populations in marketplace plans. Among them are Vermont (70%), Florida (64%), Maine (60%), District of Columbia (57%), Delaware (53%), Pennsylvania (53%), New Hampshire (51%), North Carolina (51%), and Georgia (50%). On the other hand, six states are lagging in enrollment with less than 25% of their eligible population enrolled in marketplace plans. These include Alaska (24%), Hawaii (23%), North Dakota (23%), Minnesota (22%), South Dakota (21%), and Iowa (20%).

Figure 1. Types of Marketplaces as of March 2015



Source: Adapted from Kaiser Family Foundation, “Marketplace Enrollment as a Share of the Potential Marketplace Population” (as of Feb. 22, 2015).⁶

Table 1. Marketplace Enrollments and Percentage of Potential by State, February 2015

Location	Marketplace Type	Number of Individuals who have Selected a Marketplace Plan	Estimated Number of Potential Enrollees	Percent of Potential Marketplace Enrollees
Alabama	Federally-facilitated	171,641	450,000	38%
Alaska	Federally-facilitated	21,260	87,000	24%
Arizona	Federally-facilitated	205,666	628,000	33%
Arkansas	Partnership	65,684	254,000	26%
California	State-based	1,412,200	3,245,000	44%
Colorado	State-based	140,327	571,000	25%
Connecticut	State-based	109,839	224,000	49%
Delaware	Partnership	25,036	48,000	53%
D.C.	State-based	18,465	33,000	57%
Florida	Federally-facilitated	1,596,296	2,504,000	64%
Georgia	Federally-facilitated	541,080	1,091,000	50%
Hawaii	State-based	12,625	55,000	23%
Idaho	State-based	97,079	217,000	45%
Illinois	Partnership	349,487	954,000	37%
Indiana	Federally-facilitated	219,185	506,000	43%
Iowa	Partnership	45,162	225,000	20%

Location	Marketplace Type	Number of Individuals who have Selected a Marketplace Plan	Estimated Number of Potential Enrollees	Percent of Potential Marketplace Enrollees
Kansas	Federally-facilitated	96,197	245,000	39%
Kentucky	State-based	106,330	261,000	41%
Louisiana	Federally-facilitated	186,277	524,000	36%
Maine	Federally-facilitated	74,805	124,000	60%
Maryland	State-based	120,145	458,000	26%
Massachusetts	State-based	140,540	385,000	37%
Michigan	Partnership	341,183	689,000	49%
Minnesota	State-based	59,704	275,000	22%
Mississippi	Federally-facilitated	104,538	284,000	37%
Missouri	Federally-facilitated	253,430	639,000	40%
Montana	Federally-facilitated	54,266	121,000	45%
Nebraska	Federally-facilitated	74,152	235,000	32%
Nevada	State-based	73,596	256,000	29%
New Hampshire	Partnership	53,005	104,000	51%
New Jersey	Federally-facilitated	254,316	589,000	43%
New Mexico	State-based	52,358	156,000	34%
New York	State-based	408,841	1,246,000	33%
North Carolina	Federally-facilitated	560,357	1,097,000	51%
North Dakota	Federally-facilitated	18,171	78,000	23%
Ohio	Federally-facilitated	234,341	932,000	25%
Oklahoma	Federally-facilitated	126,115	398,000	32%
Oregon	State-based	112,024	324,000	35%
Pennsylvania	Federally-facilitated	472,697	899,000	53%
Rhode Island	State-based	31,337	73,000	43%
South Carolina	Federally-facilitated	210,331	441,000	48%
South Dakota	Federally-facilitated	21,393	101,000	21%
Tennessee	Federally-facilitated	231,440	579,000	40%
Texas	Federally-facilitated	1,205,174	3,061,000	39%
Utah	Federally-facilitated	140,612	376,000	37%
Vermont	State-based	31,619	45,000	70%
Virginia	Federally-facilitated	385,154	831,000	46%
Washington	State-based	160,732	503,000	32%
West Virginia	Partnership	33,421	106,000	32%
Wisconsin	Federally-facilitated	207,349	478,000	43%
Wyoming	Federally-facilitated	21,092	65,000	32%
United States		11,688,074	28,066,000	42%

Source: Kaiser Family Foundation, “Marketplace Enrollment as a Share of the Potential Marketplace Population” (as of Feb. 22, 2015).⁷

Around the country, in both federal and state marketplaces, online enrollment generally proceeded with fewer problems in the second open enrollment period as compared to the first, making sign-ups easier and faster for consumers, although several problems remained.⁸ The total enrollment of almost 11.7 million exceeded some predictions, and consisted of 51% new consumers and 49% renewing previous marketplace coverage.⁹ These and other estimates given in this report for individual states represent only plans chosen, not effectuated enrollments, meaning enrollees have not necessarily paid the first month’s insurance premium, so enrollment numbers could

slightly decrease. They also include only enrollment in qualified marketplace plans, not Medicaid enrollment through the marketplaces.

The percentage of younger people enrolling slightly increased in the second open enrollment period, while the percentage of Hispanic/Latino enrollees stayed roughly the same and the percentage of African-Americans decreased.¹⁰ See marketplace sections below for more details of diverse population enrollments in the federal marketplace and in selected states.

The number of uninsured individuals declined nationally by almost 11 million, from 48.6 million in 2010 to 37.2 million in 2014, the lowest level in more than 15 years.¹¹ The percentage of uninsured individuals has decreased over this time period in all the major race/ethnicity categories (see Table 2), though there are still wide disparities in coverage. Hispanics/Latinos in particular continue to have the highest uninsured rate, at 25.8%.

Table 2. Uninsured Rates for Persons under Age 65 by Race/Ethnicity, 2010 and 2014

Race/Ethnicity	2010	2014
Asian	16.8%	11.6%
Black/African-American	20.8%	13.7%
Hispanic/Latino	31.9%	25.8%
White	13.7%	10.2%
Other/multiple races	22.4%	12.8%

Source: CDC, “Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–September 2014.”¹²

State-Based Marketplaces

Seventeen states established state-based marketplaces by the time of the first open enrollment period in fall 2013, and 14 remained fully state-based during the second open enrollment period in 2014–2015. The seven states with state-based marketplaces examined in our 2013 report—**California, Colorado, Connecticut, Maryland, New York, Oregon, and Washington**—were all considered leading in marketplace and diversity-related planning and development at that time (2012–2013). Since we have baseline data on these states, this section describes their lessons, adaptations, innovations, and challenges faced from their planning phases through the end of the second open enrollment period in reaching and enrolling diverse populations.

Each state-based marketplace summary begins with a brief overview of pre-launch planning activities concerning diverse populations (summarized from our prior report) to provide context, followed by a discussion of the state’s consumer assistance programs, activities, progress, and lessons in reaching and enrolling diverse populations in each of open enrollment periods.

California

California was the first state to establish a marketplace, created in 2010, and has remained a leader in many aspects of marketplace implementation, including addressing diversity and equity explicitly in its plans and operations. This equity focus largely stems from the need to reach and enroll a very large diverse population—i.e., nearly two-thirds of California’s 38 million individuals

are non-white.¹³ California has the highest percentage of people with limited English proficiency (LEP) in the nation at 19.9 percent.¹⁴

Pre-Launch Marketplace Diversity Planning Activities

California incorporated a focus on health equity from the start, building it into the marketplace's vision, mission, and value statements, as well as enacting state legislation that requires the marketplace board to be diverse and representative of the different races/ethnicities within the state. The marketplace created stakeholder advisory groups and workgroups that included people from diverse heritage, established a formal Tribal Consultation Policy, and elicited feedback and comments from many community and advocacy groups in the state, including those representing different ethnicities. The marketplace also drew on the state's Medicaid program, which makes information and resources available in 13 threshold languages.¹⁵

First Open Enrollment Period: Progress and Issues

Outreach and enrollment programs. California's marketplace, Covered California, established the Outreach and Education Grant Program with workers performing education but not enrollment and a separate In-Person Assistance (IPA) Program to enroll people during the first open enrollment period. It did not establish a navigator program for the first open enrollment period since federal funds could not be used for navigator programs, and marketplace funds were not available for this purpose until after the marketplace opened and began collecting fees.

As federal establishment grants were allowed to be used for IPA programs and outreach, Covered California awarded over \$43 million in the Outreach and Education Grant Program in 2013 to 48 lead organizations with more than 250 subcontracting organizations, including many that specialized in reaching diverse communities, and to four medical associations to help educate health care providers about the ACA and Covered California.^{17,18} Outreach workers who received training and certification were called Certified Educators. Review and assessment of effective outreach methods identified several time-tested as well as new strategies including providing outreach at mobile clinics and health fairs, modifying messages and materials to use culturally targeted examples, working with native language newspapers to reach East Asians, working with radio personalities to reach Latinos, and conducting outreach at adult education classes and low-income workplaces.¹⁹



Assister in California

Source: Asegúrate.¹⁶

Additionally, an innovative partnership between Covered California, The California Endowment, and major Spanish media outlets, called Asegúrate (Get Covered), also helped reach Latinos through television, radio, and other media with information on the ACA.²⁰

Starting in summer 2013, the IPA program trained and certified organizations (called Certified Enrollment Entities, or CEEs) and individuals (called Certified Enrollment Counselors, or CECs)

who wished to enroll consumers. CEEs were paid on a per-application basis. CECs were required to provide culturally and linguistically appropriate in-person enrollment services. A broad spectrum of entities were deemed eligible to apply and become certified including nonprofit organizations, school districts, Indian tribes, community health centers, and city government agencies.²¹ By early 2014, over 580 CEEs were certified, with 510 able to serve clients in Spanish and

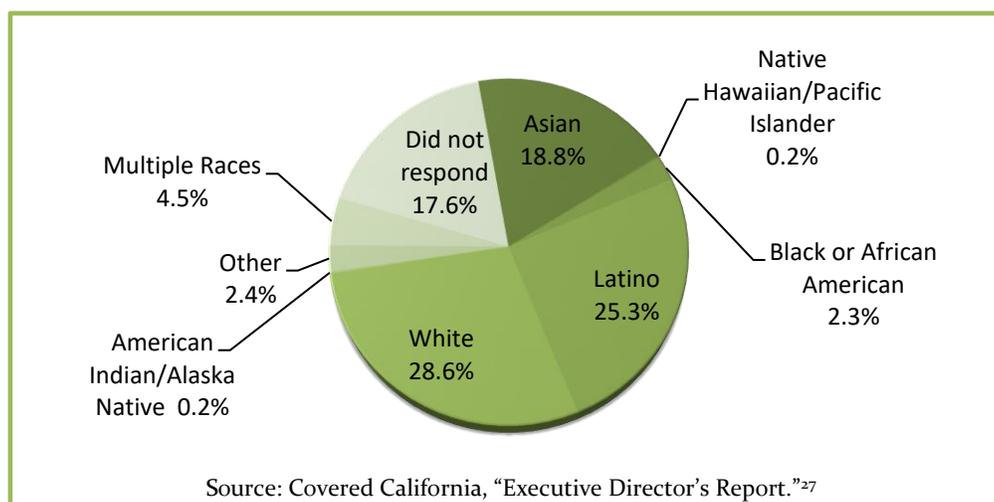
dozens covering other languages; more than 3,600 CECs were certified, about 60% of whom spoke Spanish.²² Enrollment took place at organizations' offices as well as at enrollment events (where smaller customized community events were often found to be more effective than larger events), schools, faith-based institutions, and other places in communities.

Thousands of certified insurance agents/brokers and call center representatives also enrolled consumers. In addition to bilingual representatives, the call centers had access to a language line for interpreters in over 150 languages. In January 2014, for example, call center representatives fielded 85% of the calls in English, and of the 15% conducted in other languages, about 60% were fielded by bilingual call center representatives and 40% through the language line.²³

Media and marketing. Covered California budgeted \$45 million for paid media before and during the first open enrollment period, including TV, print, and radio ads, digital media, and social media. Marketing conveyed messages such that low-cost and no-cost health insurance would be available, that new rules allowed more people to qualify, and that having health insurance brings security. Initial advertising was in English and Spanish, and starting in October 2013 print and radio ads in other languages including multiple Asian languages began as well.^{24,25}

Enrollment outcomes. During the first open enrollment period, nearly 1.4 million individuals enrolled in Covered California plans as of the end of March 2014, surpassing expectations.²⁶ Nearly 80% of these individuals were eligible for premium subsidies for their health plans. Of the individuals who were subsidy-eligible, the percentages of those indicating a racial/ethnic group is shown in Figure 2.

Figure 2. Race/Ethnicity of Subsidy-Eligible Enrollees in California, First Open Enrollment



LEP individuals were greatly underrepresented in the marketplace, as it was estimated that 40% of those eligible for Covered California were LEP.²⁸ However, of the 91% of enrollees who responded to a question regarding preferred spoken language, about 81% of enrollees preferred English, 12% Spanish, 7% Asian and Pacific Islander languages, and less than 1% preferred Indo-European languages.²⁹

Given the enrollment differences by race, ethnicity, and language as well as other issues such as the Spanish enrollment website not being functional until January 2014, many advocates for Latinos, blacks, LEP populations, and other groups were active in providing feedback to Covered California on ways it could improve outreach to and enrollment of diverse populations in future open enrollment periods. Recommendations included increasing the availability of bilingual materials and assisters, and increasing the number of attempts to contact people who need multiple “touches” to trust and feel sufficiently comfortable to enroll.³⁰

Second Open Enrollment Period: Progress and Issues

Progress and improvements. In response to an internal review of Covered California’s efforts in the first open enrollment period³¹ and other feedback, the marketplace made numerous improvements for the second open enrollment period. It added more resources to help enrollment assisters and agents/brokers such as newsletters, webinars, signage, training by experts, and more dedicated call center lines for those assisting with enrollment. The capacity of the marketplace’s call centers was also increased for the second open enrollment period, including hiring more representatives speaking second languages and extending service hours.³² The marketplace divided the state into eight regions and appointed regional coordinators to help oversee activities reaching targeted populations and to connect community organizations.³³ The marketplace also improved notices sent to consumers in English and Spanish to make them easier to understand,³⁴ though advocates have pointed out that it would be helpful to LEP populations if notices were in additional languages as well.³⁵

Outreach and enrollment programs. The Navigator Program began in California in 2014 after its launch was postponed from fall 2013. Covered California awarded \$17.1 million in navigator grants in September 2014 to 66 organizations for the first award period from October 1, 2014, to June 30, 2015. These organizations, which had 161 subcontractors collectively and reached consumers in the 13 Medi-Cal languages and more, were chosen in part on their ability to reach diverse communities in effective and innovative ways. The navigator funds awarded to lead grantees by racial/ethnic group targeted are shown in Table 3.

Table 3. Navigator Funds Targeted to Different Racial/Ethnic Groups in California

Race/Ethnicity Targeted	Number of Lead Grantees (can target multiple groups)	Navigator Funds Awarded	Percent of Total Awards
Latino	62	\$7,567,468	51.7%
Caucasian	52	\$2,360,174	16.1%
Asian	47	\$1,903,061	13.0%
African/African American	54	\$1,854,756	12.7%
Other	40	\$902,290	6.2%

Source: Covered California, “Navigator Grant Funding Announcement Report.”³⁶

Of the 227 navigator organizations and subcontractors, 22 organizations were also Outreach and Education grantees and 66 were in the IPA program.³⁷ The Outreach and Education Grant Program ended in February 2015, so those organizations that did not become navigators had the option of joining the Community Outreach Network. This network is an uncompensated program that started in the first open enrollment where organizations that wish to provide outreach but

not go through the process to become certified for enrollment can sign up to participate and receive outreach materials and updates from the marketplace.

The IPA program is funded through June 30, 2015, and organizations that did not receive navigator grants can apply to the new Certified Application Counselor (CAC) program if they wish to still provide enrollment assistance after this date. The CAC program starts on July 1, 2015, and though uncompensated, CAC organizations will have access to Covered California training, updates, webinars, and infrastructure.³⁸ Over 6,400 certified enrollment counselors (navigators and IPAs) and more than 12,000 insurance agents participated in the second open enrollment period.³⁹

Funding for navigator organizations was divided into four equal payments based on completed marketplace enrollments, and while navigators worked to address the needs of their targeted populations, some fell short of the established milestones. Reviews and feedback identified challenges in reaching hard-to-reach populations and navigators spending more time than anticipated on renewals, Medi-Cal enrollments, education, and other activities that did not result in new marketplace enrollments (which were the only measure included for the payment milestones). Thus many navigator organizations did not receive their third or fourth payments, and several withdrew from the program due to funding issues. Covered California will decide before the third open enrollment period whether to change funding methodologies and amounts available for navigator grants.

A new enrollment method used to reach consumers in the second open enrollment was the storefront program, where assisters set up enrollment centers in about 200 malls and other retail locations to make it more convenient for people to enroll or renew their health plans.⁴¹ Some assisters experienced mixed results with the storefronts, as while they were open extended hours to help working families, there was often less traffic than anticipated and assisters found it more effective to find potential enrollees at other locations they frequented such as places of worship, English classes, and soccer league sign-ups. They found that an important tried and tested strategy for reaching diverse populations is partnering with organizations that are already trusted in the community and have a history of engaging community members.



Languages. Covered California outreach materials were available in at least the 13 Medi-Cal threshold languages, and often more, as some navigator organizations and others translated materials into more languages and shared them with others. The online application was in English and Spanish for enrollment, while translated paper applications were available in 10 additional languages, with several more in development.⁴² The Covered California informational website offered a selection of 12 languages in addition to English, allowing consumers to click on their language of choice.⁴³ Enrollment assisters were available for in-person help in more than 100 languages, though not all languages were available in all locations.⁴⁴

Media and marketing. Covered California had a \$29 million media budget for the 2014-2015 enrollment period and used about 40% of it to target uninsured subsidy-eligible Latinos.⁴⁵ The marketplace also partnered with trusted state and national immigrant-rights organizations to

help reassure mixed-immigration-status families that their insurance application information would be kept confidential and not be used for immigration enforcement.⁴⁶ This partnership included the following six organizations: the Mexican American Legal Defense and Educational Fund, the National Immigration Law Center, Asian Americans Advancing Justice–Los Angeles, the National Association of Latino Elected and Appointed Officials Educational Fund, the Coalition for Humane Immigrant Rights of Los Angeles, and the California Immigrant Policy Center. The partnership developed immigrant fact sheets in five languages for California and for other states.⁴⁷

Advocacy and marketplace issues. Advocates supported expanding Covered California’s board from five to seven members to increase diversity, knowledge, and experience, which some felt would help to improve concerns from the first open enrollment period such as the relatively lower proportions of enrollment of diverse populations and missteps in Latino outreach. In response, a bill was passed in July 2014 that instead of adding members, increased recruitment parameters for board members by encouraging more skills such as cultural competency.⁴⁸ Advocates also requested in 2014 that Covered California consider hiring a diversity/cultural competency specialist to help monitor marketplace communications for cultural competency and to liaison between the marketplace and diverse communities; this position was hired in March 2015.

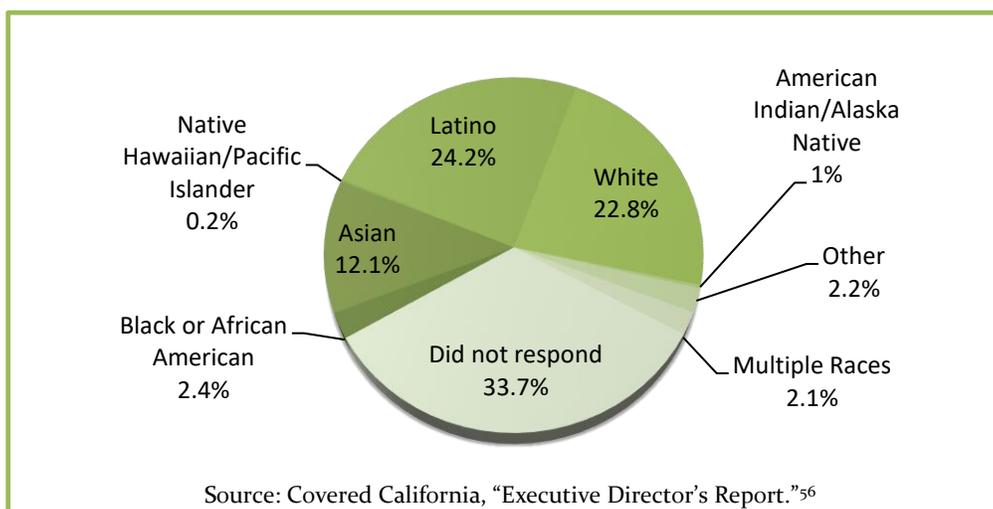
Another issue that advocates monitored and cited was the cancellation of some immigrants’ coverage in October 2014 after they could not provide proper verification of their lawful presence and thus eligibility for Covered California. In August 2014, the marketplace announced that about 148,000 California residents needed to verify their citizenship or immigration status or risk losing coverage. The marketplace mailed and e-mailed notices to consumers, established a help line, and conducted outreach.⁴⁹ About 10,400 people did not respond and had their coverage cancelled, though they were eligible to reapply if they could obtain the proper documentation.⁵⁰

Enrollment outcomes. There were fewer computer problems in the second open enrollment period, which helped many consumers sign up successfully and resulted in strong enrollment numbers,⁵¹ though some individuals who tried to change plans when renewing experienced technical problems.⁵² The total number of enrollments and re-enrollments in Covered California through February 22, 2015 (the extended deadline for the second open enrollment) was slightly over 1.4 million, which includes 495,073 new customers and about 944,000 who renewed their coverage.⁵³ For the almost half a million new enrollees, about 88% were subsidy-eligible. Figure 3 shows the proportion of new subsidy-eligible enrollees by race/ethnicity in the second open enrollment.

Regarding the service channel customers used to enroll, 43% enrolled through certified insurance agents, 13% enrolled through the call centers, 10% enrolled through navigators and CECs, 30% self-enrolled, and less than 5% used plan-based enrollers and county eligibility workers.⁵⁴

Covered California, like most marketplaces, had a special enrollment period for individuals who did not realize they would incur a financial penalty on their income taxes for not having insurance, to give them time to enroll before they have another penalty for their 2015 taxes. California’s special enrollment period for this purpose occurred from February 23 to April 30, 2015.⁵⁵

Figure 3. Race/Ethnicity of Subsidy-Eligible New Enrollees in California, Second Open Enrollment



Colorado

Colorado's marketplace, Connect for Health Colorado, was established in 2011 and renamed in January 2013. The marketplace has incorporated diversity principles into various aspects of marketplace implementation. The state's total population in 2013 was about 5.3 million, of which 29% was non-white and 7.2% was LEP^{0,57,58}

Pre-Launch Marketplace Diversity Planning Activities

The state legislation that established Colorado's marketplace required that the entities appointing the 12 board members consider the racial and ethnic characteristics of the state among other considerations for board membership. The marketplace and several advocacy groups held forums around the state to get stakeholder feedback, and then held focus groups to gather consumer input in English and Spanish. Four stakeholder advisory groups were formed in 2011 to advise the marketplace during implementation, and three more were added in 2012. A tribal outreach and consulting plan was also developed. Colorado passed previous disparities-related legislation such as a 2007 law that promotes health care workforce diversity and reduces language barriers. Additionally, the state developed a useful track record of extensive experience with outreach and enrollment in Medicaid and CHIP building on several grants that funded a large outreach effort using culturally appropriate community organizations and workers.⁵⁹

First Open Enrollment Period: Progress and Issues

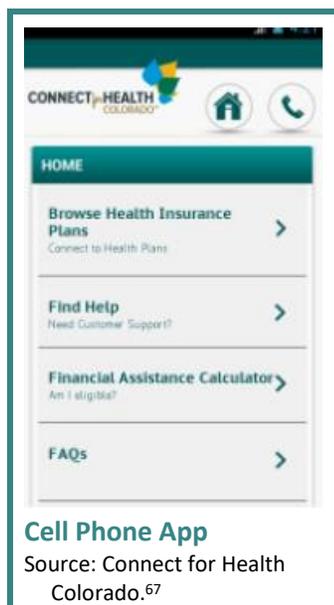
Outreach and enrollment programs. Connect for Health Colorado created the Assistance Network in 2013 by establishing a grant program for community-based organizations to serve as Assistance Sites and Regional Assistance Hubs (providing training and support to other organizations). The Assistance Network was made up of navigators and in-person assisters, which were both called Health Coverage Guides and received the same training. In June 2013, the marketplace awarded \$17 million in grants to 51 organizations to be assistance sites and six to be hubs,⁶⁰ and there were over 75 locations offering assistance.⁶¹ The Colorado Health Foundation

provided \$2 million in grant funding to support enrollment activities that federal grants could not cover.⁶²

Organizations were chosen in significant part based on their experience with LEP and diverse populations. Most of the assistance organizations had some Spanish-speaking staff, and some groups had assisters who could speak other languages as well, depending on their targeted constituent communities. CACs, agents/brokers, and call center representatives were also trained in 2013-2014, and some were bilingual.⁶³ Consumers were able to search online for brokers by English and Spanish⁶⁴ and for assistance sites in 23 languages.⁶⁵

Connect for Health Colorado partnered with organizations around the state to attend events, and performed outreach and education at many locations such as schools, concerts, and sporting events. One practice found to be successful was contacting people by phone or e-mail who had started applications online but did not finish, and directing them to local enrollment events and assistance sites to seek help if needed.⁶⁶

Media and marketing. Marketing efforts for the first open enrollment period included a public awareness campaign with radio, TV, print, social media, and billboard ads in English and Spanish, and an additional campaign closer to the start of open enrollment that gave more information on enrolling.⁶⁸ In an effort to improve its focus on consumers, halfway through the enrollment period the marketplace shifted advertising to mostly feature testimonials from real customers.⁶⁹ To



target diverse and younger adult populations, the marketplace released a free mobile app for cell phones for the purpose of comparing health plans and prices, finding assisters, and enrolling (payments had to be submitted through the website or other means and not through the app).⁷⁰

Connect for Health Colorado hired a Spanish-oriented communications firm, which produced telenovelas to reach Spanish-speakers. The marketplace also worked closely with a translation company and an ad hoc advisory group of mostly Hispanics to produce and transcreate informational materials in Spanish (transcreate refers to translating or tailoring materials to account for cultural expressions, pictures, and colors, as opposed to translating literally). Some materials like fact sheets and flyers were translated into about 12 other languages as well, but only Spanish materials were transcreated. The marketplace website and enrollment portal were available in Spanish as well as English.

Enrollment outcomes. Through April 19, 2014, Connect for Health Colorado enrolled 125,402 individuals into marketplace plans, which was an estimated 22% of those eligible.⁷¹ The racial/ethnic breakdown of enrollees was not available as Connect for Health Colorado did not publish this information except for American Indians and Alaska Natives, of which 760 enrolled in calendar year 2014.⁷² (An estimated 2,300 American Indians and Alaska Natives in Colorado are eligible for subsidized marketplace coverage.⁷³)

The Consumer Engagement Project, a coalition of four advocacy organizations in Colorado, conducted a survey in early 2014 of consumers who enrolled online or received in-person

assistance. Findings revealed that 96% of enrollees felt that information on the website was presented in a manner that was respectful of their culture, 92% said the website language was understandable, and 100% of those who met with a Health Coverage Guide or broker agreed that “the assistance they received was explained in a language they could understand and in a manner that was respectful of their age, culture, gender identity, race and religion.”⁷⁴

A report commissioned by the Colorado Health Foundation after the first open enrollment period conducted focus groups and analyzed the reported barriers preventing remaining uninsured individuals eligible for subsidized marketplace insurance or Medicaid in Colorado from enrolling. Some of the main reasons found were the following:

- *Barriers affecting outreach and awareness:* confusion about options and subsidies, messages not mentioning benefits of having insurance, not enough local outreach;
- *Barriers affecting decision to enroll:* negative attitude toward individual mandate, mistrust of system, coverage perceived to not be affordable;
- *Barriers affecting enrollment process:* complexity of health plans, poor communication, misinformation, website difficult to use, consumers had to apply for Medicaid and be denied before they could apply for private marketplace insurance.⁷⁵

In addition to these general barriers, regional barriers were identified as those specific to different populations. For example, for Spanish-speakers, barriers included confusion about what documentation was required to verify legal eligibility, mistrust of applying in mixed-status families, insufficient numbers of bilingual and culturally competent assisters, and less-than-optimal use of ethnic media for communicating insurance-related information to prospective enrollees.⁷⁶ Recommendations made for the second open enrollment included:

- Expand local outreach and tailored messaging;
- Make marketing be actionable, understandable, and focused on the value of insurance;
- Improve the clarity of insurance, costs, and enrollment; and
- Improve the enrollment website and reconsider the two-step enrollment process, where consumers must apply for Medicaid before they can apply for marketplace coverage.⁷⁷

Second Open Enrollment Period: Progress and Issues

Outreach and enrollment programs. The Assistance Network and the six hub organizations were still in place for the second open enrollment period, as well as the bilingual assisters, enrollment in English and Spanish, and materials in various languages. The Colorado Health Foundation provided an additional \$2.5 million to support enrollment activities that federal grants could not cover.⁷⁸ During 2014 there were 467 certified Health Coverage Guides, over 1,300 brokers, and 35 organizations with 205 CACs. More than 3,000 callers accessed 42 non-English languages from call center, with the top ones being Spanish, Vietnamese, Mandarin, Amharic, and Korean.⁷⁹

Connect for Health Colorado made improvements for the second open enrollment period including implementing “Kyla,” an avatar or virtual assistant that provided education in English and Spanish and helped people navigate the website. A new portal for brokers went online, as did more tools to help consumers compare plans and to automatically renew coverage. The marketplace introduced new statewide marketing and outreach campaigns, and opened new walk-in enrollment centers.⁸⁰ It continued to partner with organizations having deep relationships in diverse communities, including faith-based organizations, and increased outreach

to Hispanics and American Indians. New webinar trainings were developed on the needs facing immigrants, refugees, and LGBT populations. Organizations found that using commitment cards for people to provide contact information to establish a relationship for follow-up worked well in Hispanic communities.

Data analysis to target uninsured. The marketplace increased its use of data review and analysis in the second open enrollment period to identify and target diverse communities and uninsured populations. For example, Enroll America (funded by Colorado Health Foundation) worked with 14 organizations to train them to use Enroll America's Get Covered Data (GCD) database. This allowed organizations, including some targeting diverse communities, to use methods such as postcards and phone calls to reach people who were likely uninsured and had not been engaged previously at events or by other methods, and to track the activities in the database.⁸² Connect for Health Colorado also provided assistance sites with analyses of census data and enrollment data from the first open enrollment to help them identify areas with large Hispanic populations that were uninsured and potentially eligible for subsidies, and target these areas with strategic outreach and events.⁸³

Enrollment outcomes. In the second open enrollment period, Connect for Health Colorado enrolled 140,327 individuals (about 25% of the eligible population), including new customers and renewals,⁸⁴ which was about 10% higher than the first open enrollment. The marketplace published racial/ethnic enrollment data only for American Indians and Alaska Natives, of which 807 have enrolled for 2015 plans. Colorado appeared to have fewer enrollees using subsidies than most states, with 54% qualifying for financial assistance.⁸⁵ In addition, Colorado was one of the few marketplaces that did not add a special enrollment period in April 2015 for people subject to penalties, due to cost and other factors.⁸⁶

Technical problems and other issues. The Medicaid office in Colorado still required all applicants to apply for Medicaid first and if not eligible, then to apply for marketplace coverage, although for the second open enrollment Colorado introduced one integrated application and eligibility system instead of two systems. The new system, jointly developed by the marketplace and by the state Medicaid office, launched five days before the second open enrollment began and encountered numerous technical problems during enrollment, leaving thousands of customers stuck in the determination process and requiring the board to approve emergency funding to address the issues.⁸⁷

Colorado may be the only state to experience more technical problems in the second open enrollment than the first, and it was noted that these problems often had a greater impact on immigrants and other vulnerable populations who were often less likely to self-advocate when technical problems occurred. Given this process, stakeholders and the marketplace are advocating for a more streamlined process for the third open enrollment period that would allow customers to quickly proceed to marketplace enrollment if a few simple income questions show that the customer is not Medicaid-eligible. Connect for Health Colorado experienced other issues as well



including several top executives who resigned in fall 2014, criticism for giving bonuses to managers, and a financial audit in December 2014 that found financial mismanagement and called for a more comprehensive audit.^{88,89,90}

Connecticut

Connecticut's marketplace, called Access Health CT, was established in 2011 and named in December 2012. The marketplace had a goal of reducing health disparities in the state from the beginning. Connecticut has a population of about 3.5 million, with 30% non-white and approximately 8.1% LEP.^{91,92}

Pre-Launch Marketplace Diversity Planning Activities

Access Health CT's purpose and guiding principles explicitly mention reducing health disparities, and its board and advisory committees include representatives of diverse communities. Four stakeholder advisory committees were formed in 2012 to assist in marketplace development, and the Consumer Experience and Outreach Advisory Committee was charged with making marketplace information accessible to all state residents, "recognizing the diverse cultural, language, economic, educational and health status needs of those we serve." The marketplace also established a tribal consultation policy and tribal liaison position. It held forums for public input at various times around the state from 2011 to 2013. Connecticut was chosen to participate in the Health Equity Learning Collaborative in 2011-2012, and received support for reviewing the impact of state policy decisions on diverse populations, integrating health equity initiatives in state programs, and health disparities training for marketplace board members.⁹³

First Open Enrollment Period: Progress and Issues

Outreach and enrollment programs. Access Health CT awarded more than \$3 million in grants in 2013 to six organizations to serve as navigators (performing coordination but not enrollment) and about 300 in-person assisters for enrollment, including organizations reaching diverse communities, in what was called the NIPA (Navigator and In-Person Assister) Program. The marketplace divided the state into six regions, with each navigator entity managing a separate region, and with the number of assisters hired in each region based on the proportion of uninsured in that area.⁹⁵ The navigator organizations created microregions to better target different populations and races/ethnicities in their regions, which helped encourage collaboration between community groups in those areas.

In addition to the IPAs, the marketplace supported call center representatives, agents/brokers, and CACs (often at pharmacies and other healthcare settings) who were trained and certified by the state and available for enrollment assistance. A Best Practices conference in January 2014 offered assisters the opportunity to share lessons learned, and the marketplace created regular newsletters and webinars.⁹⁶ The Connecticut Office of the Healthcare Advocate helped the marketplace design the assister programs, handle difficult cases and problems, and write federal grants.

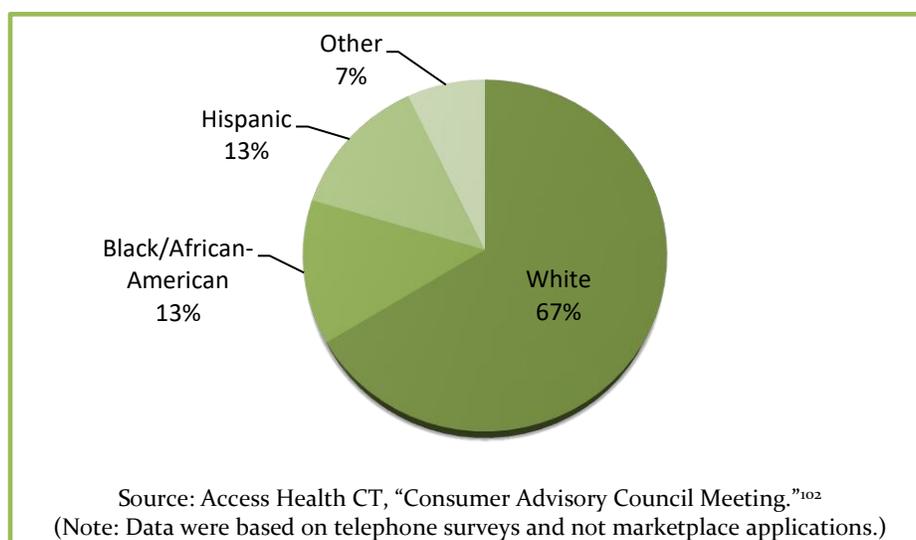


Languages. The in-person assisters spoke a total of 32 languages, and consumers could search for them online by language.⁹⁷ Bilingual assisters worked in two retail storefronts, among other places, which were successful in reaching enrollees.⁹⁸ Call center representatives spoke a total of about 15 languages, and had access to a language line service. Many outreach materials were available in Spanish as well as English, and enrollment checklists that specified documents to bring for enrollment were provided in more than 10 languages. Online enrollment was available in Spanish as well as English after the Spanish portal, which was delayed due to technical issues, went live in February 2014.

Media and marketing. Before the first open enrollment began, the marketplace launched outreach and marketing campaigns including direct mail, social media, events, television, print, and other media. Staff also attended events such as fairs, concerts, and Healthy Chat forums.⁹⁹ In fall 2013, the marketplace focused marketing on Spanish-speakers and young people, and launched a campaign called Mercado de Salud CT that included bilingual electronic and print ads, Spanish advertising on major Hispanic television networks, and question and answer sessions with Spanish-speaking employees from the marketplace on TV and radio shows.¹⁰⁰ Marketplace staff found messages were initially appealing mainly to those already wanting insurance, so they shifted to using more messaging from Enroll America and HealthCare.gov on the value of insurance, and transcreated selected materials to appeal to more diverse communities that were targeted the last few months of open enrollment.

Enrollment outcomes. Through April 19, 2014, Access Health CT enrolled 79,192 individuals into marketplace plans, more than predicted, which was an estimated 34% of those eligible for enrollment.¹⁰¹ Figure 4 shows the estimated racial/ethnic percentages of enrollees. These data were obtained from a telephone survey of a sample of marketplace enrollees in 2014 and not from the enrollment applications as seen in other states.

Figure 4. Race/Ethnicity of Marketplace Enrollees in Connecticut, First Open Enrollment



The survey also showed that black and Hispanic enrollees were more likely to have been uninsured previously than whites, thus marketplace enrollment was helping to close disparities in insurance rates.¹⁰³

The first open enrollment period in Connecticut was considered very successful, partially because enrollees encountered fewer technical problems with online enrollment compared to most other marketplaces, which was partly due to limiting full integration with Medicaid eligibility systems at first and focusing on ensuring the marketplace software was ready.¹⁰⁴ Individuals found to be eligible for Medicaid were directed to a separate application process, which required a vendor to manually re-enter forms into another system.¹⁰⁵

An evaluation of Connecticut consumers' experiences during the first open enrollment period by the CARE program at the Yale School of Public Health found that in-person assisters were rated as more helpful to people than the website or call center, and Latinos and blacks had higher satisfaction with the enrollment process. Most individuals surveyed heard about the marketplace through word-of-mouth, so it recommended a targeted grassroots outreach strategy for Latinos, African-Americans, and young people, and to maintain an effective year-round in-person assistance program to help underserved communities.¹⁰⁶

Second Open Enrollment Period: Progress and Issues

Outreach and enrollment programs. Due to federal grants expiring, funding for the NIPA program was considerably downsized for the second open enrollment period, from \$3 million in the first open enrollment to \$180,000, covering 20-30 IPAs.¹⁰⁷ Two navigator organizations were appointed that had offices and assisters in multiple cities around the state. Since there were not as many assisters available to visit communities, the marketplace elected to create more enrollment centers for people to visit for assistance, for a total of 15. These included two permanent storefronts along with 13 enrollment sites at libraries, agencies, and other public places (these sites were called Community Enrollment Partners, or CEPs). These were found to be beneficial to consumers since they kept consistent hours, unlike mobile health fairs.¹⁰⁸ Access Health CT promoted these community locations in the media and printed materials, which had an additional budget.¹⁰⁹ Three foundations, the Connecticut Health Foundation, the Hartford Foundation for Public Giving, and the Foundation for Community Health, provided supplemental funding to support about 35 assisters at community organizations around the state, choosing individuals whose valuable role in enrollment was firmly established during the first open enrollment period.¹¹⁰

Advocates contended that more IPAs were needed, especially to reach vulnerable populations, though the marketplace pointed out that only 8% of people enrolled through IPAs, 9% at enrollment centers, and 3% at enrollment events in the first open enrollment (45% enrolled by themselves online, with the rest divided among brokers, the call center, and healthcare settings).^{111,112} Call center representatives as well as many assisters not compensated by the marketplace such as brokers and CACs were still available to help consumers in the second open enrollment.

In planning for the second open enrollment period, Access Health CT integrated lessons learned from the first period as well as feedback from constituents. From their experience and recommendations they identified four priorities: 1) to sustain awareness and enrollment including

through customizing communications; 2) to reinforce the benefits of health insurance; 3) to raise awareness of the value of marketplace insurance products; and 4) to increase consumer understanding of how to utilize their coverage.¹¹³

Media and marketing. Access Health CT conducted surveys and focus groups after the first open enrollment period, including with Spanish-speakers, and used the results to refine its outreach strategies for the second enrollment period. Most of the remaining uninsured were located in several large cities, were young Hispanic or African-American males, and were less likely to use traditional media like daily newspapers and mainstream TV networks. As such, the media budget was adjusted to target local resources like ads in community newspapers and local TV and radio stations. The messages were also tailored according to feedback, such as including more information on affordability.^{115,116}

The marketplace introduced a mobile app for Android and iOS smartphones that more than 18,000 people downloaded and used for creating accounts and buying unsubsidized plans.¹¹⁷ It also introduced “Tina” on the first day of the second open enrollment period, a virtual assistant on the website to help guide and answer questions in English and Spanish. Analytics showed that individuals who engaged with Tina were nine times more likely to enroll than those who did not.¹¹⁸

Since the enrollment website in Connecticut worked much better than elsewhere for the first open enrollment and after, other states were interested in the software and Access Health CT created a business unit in 2014 to license its software and offer services.^{119,120} The Maryland marketplace is currently using Connecticut’s marketplace software, and other states have shown interest.¹²¹ Access Health CT’s chief executive officer resigned in fall 2014 to become CEO of the federal marketplace, and several other top officials left before and during the second open enrollment period.



Enrollment outcomes. In the second open enrollment period, 109,834 individuals enrolled, or 49% of those eligible, including renewals and new customers.¹²² This number represented a significant increase from the 34% of those eligible who enrolled in the first open enrollment period, leaving Connecticut with an overall uninsured rate of about 4% by some estimates.¹²³ While enrollment estimates by race/ethnicity are not available as of this writing, the marketplace will conduct research on enrollees to document these numbers and other characteristics.¹²⁴ Access Health CT added a special enrollment period from April 1-30, 2015, for those facing tax penalties for being uninsured.¹²⁵

Though the marketplace enrollment process was mostly smooth, Access Health CT experienced several system problems, such as when several thousand people were incorrectly enrolled into Medicaid or lost marketplace subsidies after notifying the marketplace in summer 2014 of income or life changes that could affect their coverage.¹²⁶ As of this writing, Access Health CT and the state are working to integrate the marketplace and Medicaid eligibility systems, so those found eligible for Medicaid instead of marketplace coverage do not have to wait as long to be enrolled.

Maryland

The Maryland legislature established Maryland's marketplace, Maryland Health Connection, in 2011 and 2012. However, the state had planned for health care reform from the very beginning, with the governor creating the Health Care Reform Coordinating Council the day after enactment of the ACA in 2010 to advise the state on implementation. Maryland has a population of about 5.9 million, of which half is non-white¹²⁷ and 6.3% is LEP.¹²⁸

Pre-Launch Marketplace Diversity Planning Activities

Maryland state legislation requires that the marketplace board represent the racial, ethnic, gender, and geographic diversity of the state, and that three members be experts in some of the given areas such as public health research and health disparities. The marketplace is also required to maintain at least two stakeholder advisory committees, who must represent the diversity of the state. The Health Care Reform Coordinating Council engaged stakeholders and recommended addressing disparities, creating a workgroup that conducted research on state-based issues and priorities. This work informed and helped to pass disparities reduction legislation in 2012 that contains a variety of provisions such as provider incentives, data tracking, workforce training, and an innovation prize. The Maryland Office of Minority Health and Health Disparities oversees the activities in the disparities legislation, produces a disparities elimination state plan, and provides data for disparities reduction efforts for the marketplace and other programs.¹²⁹

First Open Enrollment Period: Progress and Issues

Outreach and enrollment programs. Maryland Health Connection awarded \$24 million in grants to six regional Connector Entities in April 2013 to employ navigators and in-person assisters to reach customers throughout the state, including LEP individuals.¹³¹ Almost 50 subcontracting organizations supported outreach and enrollment efforts, with some hosting navigators and CACs, and some targeting specific diverse communities. Organizations conducted enrollment activities throughout the state at partner locations and at community events.



Connector Entities trained both navigators and IPAs to provide information on the marketplace and Medicaid. Navigators were required to be certified as well, while IPAs, who were not certified for the marketplace, could enroll individuals into Medicaid only and not qualified health plans.¹³² By around the beginning of the first open enrollment period, 164 navigators, 170 IPAs, 1,236

caseworkers, and 1,827 agents/brokers had been trained on the marketplace, and more continued to be added.¹³³ The marketplace also established a call center for telephone enrollment assistance.

Languages. Some enrollment assisters spoke Spanish and other languages, but consumers could not search for them by language on the website. Outreach materials including fact sheets were available in English and Spanish, and some Connector Entities translated materials into other languages as needed in their regions. The marketplace informational website was available in English and many parts in Spanish, though online enrollment was only available in English.¹³⁴

Media and marketing. Based on research that included surveys and focus groups, the marketplace launched an outreach and advertising campaign in English and Spanish in fall 2013 to convey the benefits of health insurance that included social media, TV, radio, print, and digital media, and contained customized music to appeal to different populations in the genres of contemporary, Latin, country, and urban. Maryland Health Connection partnered with the Baltimore Ravens football team, as research indicated 71% of the state's uninsured had watched or listened to a game, and it also partnered with grocery stores and CVS pharmacies to distribute information.¹³⁵ One successful outreach effort involved Maryland Citizens' Health Initiative in conjunction with the marketplace convening a summit of over 150 faith leaders to educate them on the marketplace and the ACA so they could better assist their congregations, as faith leaders are often important resources and trusted community messengers.¹³⁶

Enrollment outcomes. In the first open enrollment period, as of April 19, 2014, Maryland Health Connection enrolled 67,757 individuals, or 15% of the estimated potential marketplace population, one of the lowest percentages in the nation.¹³⁷ Enrollment figures were available by some demographic characteristics, but not by race/ethnicity.¹³⁸

The main impediment to enrollment in the first open enrollment period in Maryland was the poor performance of its website portal. The system crashed at the beginning of open enrollment, and then once back online it experienced numerous problems throughout the enrollment period including consumers not being able to create accounts or access certain pages. Other problems included conflicts between information technology contractors, and the resignation of the marketplace's executive director.¹³⁹

The marketplace required each of the six Connector Entities to conduct a survey on consumer satisfaction of their customers. For five out of the six entities, over 90% of respondents expressed satisfaction with their overall experience with in-person assistance.¹⁴⁰ This assessment also identified a gap in targeting outreach and enrollment assistance to rural areas with high numbers of uninsured.¹⁴¹

Second Open Enrollment Period: Progress and Issues

Outreach and enrollment programs. Maryland Health Connection maintained the six connector entities for the second open enrollment period, and they continued to formally and informally partner with numerous local organizations targeting specific populations for outreach and enrollment. The marketplace continued to have navigators, in-person assisters (who enroll in Medicaid only and refer others), CACs, agents/brokers, and call center personnel. IPAs will gradually be converted to navigators as federal funding ends. Agents/brokers spoke a total of about 20 languages, and consumers could search online by language for agents/brokers but not for navigators during the second enrollment period.¹⁴² Navigators and the call center had access to a language line offering over 200 languages.

A major change occurred for the second open enrollment period as Maryland Health Connection switched from using its original enrollment portal to using Connecticut's enrollment software. The board voted in April 2014 to replace the software and vendors, but the new system did not go online until the beginning of the second enrollment period in November, as it took months (and millions of dollars) to retrofit it to use in Maryland.^{143,144} The new website was reported to be

much more informative, fast, and user-friendly, and there were pages covering common questions, financial help, and testimonial videos.¹⁴⁵ Thus in some ways the second open enrollment period was like another first open enrollment in Connecticut—consumers had a much easier time with the website, though they had to return and re-enroll in the new system in order to keep their subsidies (whether changing plans or not), as information could not be transferred between the previous and new systems, and assisters had to learn a new interface. Spanish online enrollment was added for the second open enrollment period.

Media and marketing. For the second open enrollment period, the marketplace developed new marketing and outreach campaigns that were less focused on awareness and more on bringing back customers to re-enroll, restoring confidence, showing testimonials of people benefiting from insurance, and utilizing digital and social media. It also expanded enrollment events and in-person assistance, especially for Latinos and African-Americans that surveys said wanted more in-person assistance. It distributed additional pamphlets and fact sheets in English and Spanish in many locations such as hospitals, libraries, faith-based institutions, theaters, laundromats, recreation centers, and mercados. The marketplace also partnered with Entravision and Telemundo Spanish broadcasting and the AFRO American Newspaper.¹⁴⁷ This shift in marketing and outreach strategy was largely prompted by two factors: first, less federal money was available for outreach and enrollment; and second, the marketplace had the daunting task of not only reaching the remaining uninsured, but re-enrolling customers into an entirely new system.

Enrollment Outcomes. In the second open enrollment period (through February 21, 2015), Maryland Health Connection enrolled/re-enrolled 120,145 individuals, about 26% of those eligible, which was almost twice the number enrolled in the first open enrollment.¹⁴⁸ Estimates by race/ethnicity were not available, as this was an optional question with a low response rate. The marketplace extended enrollment to the end of February for those who had started but not completed the process, and added a special enrollment period from March 15 through April 30, 2015, for those with tax penalties.



The marketplace plans to meet with outreach coordinators in each of the six regions to see what went well and what changes they would like to see. Feedback from these meetings and other sources will be incorporated into planning for the third open enrollment period.

New York

The marketplace in New York, named New York State of Health in 2013, was created in April 2012 by an executive order from the governor after state legislation to establish a marketplace failed to pass. It does not have a board of directors and resides within the New York Department of Health, so it is not an independent organization as are most state-based marketplaces. New York has a population of about 19.5 million, with 42% being non-white.¹⁴⁹ Approximately 13.3% of the population is LEP.¹⁵⁰

Pre-Launch Marketplace Diversity Planning Activities

The marketplace has five advisory committees comprised of a variety of stakeholders from each of five regions in the state. To assure diverse and regional input, staff convened meetings around the state to get public input on marketplace implementation. Additionally, a public meeting in 2012 focused on health disparities and how best to reduce them, and a policy was created for consulting with Native American tribes. New York had a head start on federal health reform as it had previously enacted state health reform measures such as not denying coverage for pre-existing conditions and expanding Medicaid to childless adults up to 100% of poverty. An executive order that took effect in 2012 requires free language interpretation and translated documents in all state agencies in the six most common languages spoken by LEP individuals in the state.¹⁵¹

First Open Enrollment Period: Progress and Issues

Outreach and enrollment programs. The state awarded about \$27 million in grants to 50 organizations and their 96 subcontractors in July 2013 to serve as navigators and in-person assisters, including many with experience in reaching diverse populations.¹⁵² Navigators and IPAs had the same responsibilities and received the same training, and worked at a variety of community locations. The assistance program was modeled after existing successful programs in the state including the Facilitated Enrollment program, in place since 2000, that involves over 50 community-based organizations and health plans that screen for eligibility and provide enrollment assistance in 60 languages for Medicaid, CHIP, and other programs.¹⁵³

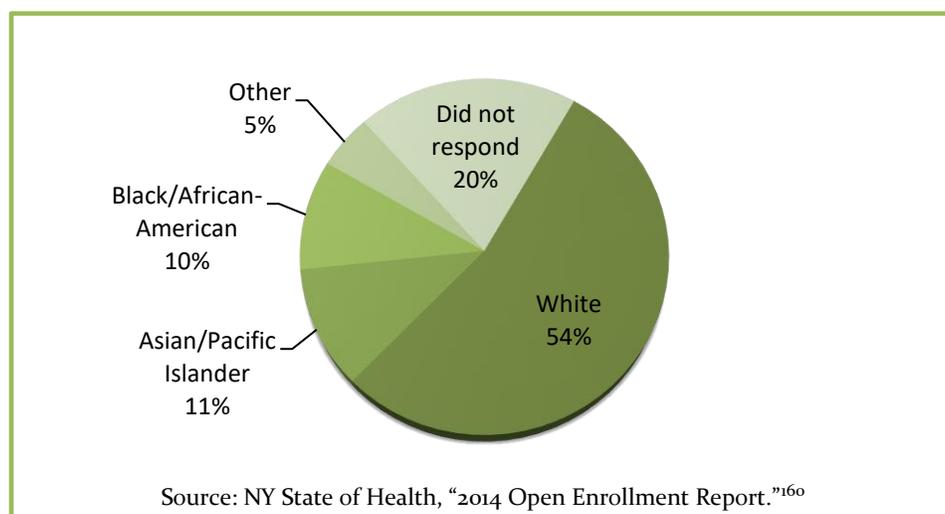
The marketplace also utilized agents/brokers and CACs for enrollment assistance, and established a call center based on the existing New York Health Options call center (handling Medicaid and other programs), with representatives available in at least five languages plus a language line.¹⁵⁴

There were 643 navigators/IPAs assisting in 48 languages, about 4,000 CACs, and over 4,000 certified brokers in New York in 2014.¹⁵⁵ Educational materials were made available in seven languages, with the website and enrollment portal accessible in English and Spanish. The website allowed searching for assisters by language, and had taglines in seven languages to direct LEP consumers to the call center or in-person assisters—marketplace notices also had taglines in these languages to direct consumers to the call center if they had questions.¹⁵⁶ Paper applications were available in these languages as well. Some complaints occurred around long wait times for call center representatives and other issues, but there were no major enrollment problems overall, and the enrollment website performed about as well as expected.

Media and marketing. Marketing was conducted in several phases in 2013 and 2014, with materials and advertising to raise awareness of the marketplace happening first, followed by messaging to prepare people to enroll, then information on enrolling once open enrollment began. Messages were targeted to different populations and methods used included public relations, digital and social media, TV, radio, print, and other advertising. The marketplace also partnered with a variety of organizations in communities including nonprofits, government agencies, and healthcare providers to distribute materials, sponsor enrollment events, and help reach potential enrollees.¹⁵⁷

Enrollment outcomes. New York enrolled 370,451 individuals in marketplace plans in the first open enrollment period, an estimated 31% of potential enrollees.¹⁵⁸ Figure 5 shows the percentages of enrollees by race. Ethnicity was broken out separately, with 14% of marketplace enrollees indicating they were Hispanic (10% did not respond). For preferred spoken language, 91% of marketplace enrollees indicated they preferred English—of the 9% speaking non-English languages, 6% preferred Spanish, 3% preferred Chinese, and less than 1% preferred other languages.¹⁵⁹

Figure 5. Race of Marketplace Enrollees in New York, First Open Enrollment



Second Open Enrollment Period: Progress and Issues

Outreach and enrollment programs. The marketplace in New York was more prepared in the second open enrollment for consumers waiting until near the deadline to enroll, so they could anticipate the needs more effectively. Navigators and IPAs continued to enroll individuals at events around the state during the second open enrollment period and spoke a total of 48 languages. Navigators and IPAs appeared the same to the public and were considered to be in one program with two different funding streams. There were many more IPAs than navigators in the first open enrollment period, but with federal funding ending, IPAs were transitioning to become state-funded navigators during and after the second open enrollment. By the end of the second open enrollment period there were over 750 navigators/IPAs and over 10,000 brokers, CACs, and health plan facilitated enrollers.

The enrollment website continued to improve for the second open enrollment and there were fewer customer problems, especially for immigrants who did not have an I-94 number, which was required in the first open enrollment but not in the second.

Languages. The number of languages for educational and outreach materials increased to 17 languages,¹⁶¹ and there were taglines in 14 languages on the website directing consumers to the call center.¹⁶² Online enrollment continued to be available in English and Spanish, as well as paper

applications in seven languages, but applying via paper application was not encouraged due to the extra time it took to process those applications by hand.

Media and marketing. The state partnered with a more diverse group of media outlets for the second open enrollment, including a range of ethnic media outlets such as print media reaching Indian, Filipino, Latino, Chinese, and Korean communities, and radio ads targeted to African-American and Latino communities. TV outreach focused on Latino and Mandarin Chinese, with an additional digital focus on Latinos. The marketplace made an effort to increase on-the-ground outreach elements and not rely only on media. To this end, it conducted more community presentations, established a presence in retail centers, and sent mobile units around the state in partnership with Marvel Entertainment for appearances by “superheroes” at malls to draw attention and encourage people to attend and enroll.¹⁶⁴



Enrollment outcomes. For the second open enrollment period, 408,841 people in New York selected plans to enroll or re-enroll, which represented 33% of potential enrollees.¹⁶⁵

Estimates by race and ethnicity have not been released as of this

writing. Individuals were granted extensions to the second open enrollment period until February 28 if they had started applications before February 15, and the marketplace added a special enrollment period for people facing tax penalties from March 1 to April 30, 2015.¹⁶⁶

Oregon

State legislation established Cover Oregon, Oregon’s marketplace, in 2011 and 2012. The state has been enacting health reforms for several decades, such as in its Medicaid program in the 1990s, and in 2009 when it expanded Medicaid and CHIP eligibility and access for children. From 2010 to 2012 Oregon enrolled over 100,000 additional children by working with community groups and using targeted efforts and bilingual outreach strategies,¹⁶⁷ forming a foundation that the marketplace could later build on. Oregon has a population of about 3.9 million, of which 23% is non-white and 6.3% is LEP.^{168,169}

Pre-Launch Marketplace Diversity Planning Activities

Oregon has been working on health care reform for many years, including discussion of a health insurance exchange pre-ACA. The Oregon marketplace legislation passed in 2011 mentions improving ethnicity and language-related health disparities as one of its missions. Board members appointed by the governor were required to reflect the diversity of the state, and the advisory committees were directed to be racially and ethnically representative of the state. The marketplace gathered feedback from stakeholders around the state in the planning phases, and met regularly with Indian tribes for their recommendations, including cultural concerns and priorities. Cover Oregon created a tribal consultation policy that was used as a model by other states, and was the first marketplace to create a tribal liaison position. The Oregon Health Policy Board formed the Health Equities Policy Review Committee to make recommendations to the marketplace on cultural and linguistic competency in 2010-2011. The Oregon Health Policy Board

also oversees the Oregon Health Authority, which contains the Office of Equity and Inclusion that works on health disparities and equity issues.¹⁷⁰

First Open Enrollment Period: Progress and Issues

Outreach and enrollment programs. Cover Oregon partnered with the Oregon Health Authority to establish the Community Partners program, which consisted of over 1,200 navigators, IPAs, CACs, and others involved in outreach and enrollment for the marketplace.¹⁷¹ The marketplace awarded \$3.16 million in grants for enrollment assistance, and while these assisters had different funding streams (state, federal, or sources outside the marketplace), they were all under the same program and underwent state training and certification.¹⁷² Many participating organizations had experience with similar activities for Medicaid and CHIP, and some targeted diverse communities. The marketplace also created a call center and certified more than 2,000 agents/brokers as well.¹⁷³

Languages. The marketplace produced marketing materials in seven languages, in addition to English materials created for American Indian tribes.^{174,175} The website had information in Spanish, Russian, Vietnamese, Korean, and Chinese, though consumers could only enroll in English.¹⁷⁶ The marketplace listed 36 languages as well as American Sign Language in the assister search function on the website.¹⁷⁷

Media and marketing. Covered Oregon developed a communications plan and hired a marketing firm and a public affairs agency in 2013, which rolled out TV, radio, print, and online ads that featured the work of local musicians and artists, and targeted ads for different audiences.¹⁷⁸ It also used social media and its community partners, including Indian Tribes, in an outreach campaign, spending about \$20 million total on advertising, marketing, and outreach.¹⁷⁹ The marketplace held enrollment fairs around the state including several targeted to Spanish, Russian, and Somali-speakers.¹⁸⁰

Enrollment outcomes. During the first open enrollment period in Oregon (through April 19, 2014), approximately 339,000 enrolled in marketplace plans, or an estimated 20% of the marketplace-eligible population.¹⁸¹ The marketplace was not able to obtain accurate reports on enrollment by race/ethnicity.

The main factor hindering enrollment in Oregon was the failure of the enrollment website, as there were multiple problems affecting assisters as well as people enrolling on their own. Cover Oregon had to ask assisters to postpone scheduling appointments with consumers while it worked on the technical issues, and eventually converted to a process of transferring information to paper applications that had to be manually processed by hundreds of temporary workers. Some felt that the marketplace's plans for its systems were too ambitious for the timeframe and should have focused on basic functionality first.¹⁸² The executive director of the marketplace went on medical leave during the first open enrollment period and eventually was replaced, several other officials resigned. Other issues also arose including mutual lawsuits by the marketplace and its main contractor, Oracle, due to the failed website.¹⁸³

At a board meeting in July 2014, the new executive director stated that it was challenging to retrieve demographic information from the existing data systems, but that the marketplace would continue to try to understand the enrolled populations and how to better reach diverse

populations.¹⁸⁴ The Center for Outcomes Research & Education at Providence Health & Services conducted a survey of Cover Oregon enrollees from the first open enrollment, which found among other things that that 53% of enrollees were uninsured prior to enrolling, and that diverse groups were significantly more likely to have heard of the marketplace from community partners, employers, and word-of-mouth, and less likely from television.¹⁸⁵

The Cover Oregon board voted on April 25, 2014, to transition to using the federal enrollment portal, HealthCare.gov, for the second open enrollment period, and to transfer the original website to the state to adapt for Medicaid enrollment only.¹⁸⁶

Second Open Enrollment Period: Progress and Issues

Outreach and enrollment programs. For the second open enrollment period, Cover Oregon operated as a federally supported marketplace, retaining consumer outreach and assistance functions and plan management, but using the federal HealthCare.gov website for enrollment and re-enrollment. It also used the federal call center (as well as the Oregon call center, which is being phased out) and federal training for agents/brokers.¹⁸⁸ Community partners were required to complete federal training on the marketplace as well as Oregon-specific training on Medicaid. Oregon Health Authority, the state health agency, continued to assist the marketplace with the Community Partners program, providing Regional Outreach Coordinators who worked with community partners in their regions on disseminating information, training, and hosting collaborative meetings to discuss challenges and best practices.

In the second open enrollment, Cover Oregon organized a series of enrollment events across the state, with most in the Portland metro area, including several that were targeted to Hispanic communities and had bilingual assisters. The marketplace had not originally planned to hold enrollment events in communities, but started during the first enrollment period when there were many technical problems with enrollment. As a result staff found that consumers appreciated the personal assistance in their communities. During the second open enrollment, staff printed out each of the HealthCare.gov paper applications in 33 languages to have on hand at enrollment events, but found that it was usually better to use bilingual in-person assisters or connect to a language line locally or at the federal call center to help LEP individuals, as opposed to having them read a translated application.



Partnerships were very important as the community partner organizations were the main way the marketplace reached diverse communities, supplying trusted leaders with information and materials who could then go to their mosques, churches, tribes, shops, and other locations to promote enrollment to hard-to-reach populations.

Adaptations and languages. Cover Oregon worked with Indian tribes and other culturally specific groups to adapt federal outreach materials to be more relevant to Oregon. This included simplifying some messages as well as modifying some wording as needed such as changing “navigator” to “community partner” and “Medicaid” to “Oregon Health Plan” so as not to confuse consumers. Outreach materials were available in eight languages, and the marketplace translated others by request. There were 21 languages spoken by enrollment assisters at different

organizations, though they were not necessarily hired for some of the less common languages that may not be in demand. Customers were able to search for assisters including brokers by language and zip code online, and Oregon prohibited assisters from turning away customers based on language—they were instead required to refer them to another resource such as a language line.

New technology platform. Given the transition to becoming a federally supported marketplace and having new software, the second open enrollment period in Oregon functioned like another first open enrollment period in some ways. Online enrollment was much smoother, but some new issues arose from the federal system such as problems with identity-proofing in people without credit histories, particularly among young individuals and immigrants, as experienced elsewhere (more details on this issue can be found in the section on the Federally Facilitated Marketplace). Community partners could no longer assist consumers to the same extent and follow their applications all the way through the process in the second enrollment period, since the application was under federal control and required federal follow-up for issues that arose. The marketplace continued to provide resources, webinars, and newsletters to assisters, which were sometimes difficult to keep accurate as technology and issues kept changing.

Enrollment outcomes. For the second open enrollment period, 112,024 individuals in Oregon enrolled in marketplace plans (35% of the estimated eligible population), a marked improvement over the first open enrollment.¹⁸⁹ Estimates by race/ethnicity were not available separately for Oregon as of this writing, but totals are available for all states using HealthCare.gov (see the section on the Federally Facilitated Marketplace for totals).

After the board voted in September 2014 to keep Cover Oregon as a stand-alone public corporation,¹⁹⁰ the legislature passed a bill in February that the governor signed in March 2015 to dissolve Cover Oregon as an independent organization and transfer its functions to the Oregon Department of Consumer and Business Services.¹⁹¹ After several rounds of layoffs, remaining Cover Oregon staff will be employed through June 2015, and the state will hire new staff and form new committees as the marketplace becomes a small division of this state agency.¹⁹² Plans call for the marketplace to remain a federally supported state-based marketplace.

Washington

Washington Healthplanfinder was established by state legislation passed in 2011 and 2012. The state started addressing health equity prior to the ACA, including the creation of the Governor's Interagency Council on Health Disparities in 2006. This group issues a state action plan on disparities, conducts research and meetings, and facilitates collaboration between agencies. Washington's population is about 6.8 million, with 29% non-white¹⁹³ and 7.9% LEP.¹⁹⁴

Pre-Launch Marketplace Diversity Planning Activities

Equity is explicitly mentioned as one of the values in Washington Healthplanfinder's mission statement. The marketplace held meetings and focus groups around the state for input during the planning phase. It formed a technical advisory committee on health equity in 2013 and other stakeholder advisory committees that included culturally diverse individuals. The enabling legislation requires the marketplace to consult with the state's Indian tribes, and it developed a formal policy for consultation, as well as a tribal advisory workgroup to assist with implementation. Washington's Department of Social and Health Services uses eight threshold

languages, and the marketplace planned to use these as well for correspondence with consumers.¹⁹⁵

First Open Enrollment Period: Progress and Issues

Outreach and enrollment programs. Washington Healthplanfinder awarded \$6 million in grants to 10 Lead Organizations (mostly local health departments and coalitions) in June 2013 to manage and train a network of nearly 100 partnering organizations and their IPAs and navigators—including some targeting diverse communities—for the marketplace’s in-person assistance program. It also granted \$420,000 to five tribal-related organizations for outreach and enrollment of tribal members.^{197,198} The marketplace created a call center that included bilingual

employees and a language line, and trained and certified agents/brokers—over 2,000 by the beginning of the first enrollment period—to sell marketplace plans.¹⁹⁹ During the first open enrollment, the marketplace certified 1,773 IPAs and navigators, 61 CACs, and 101 tribal assisters.²⁰⁰ The marketplace also hired a tribal liaison position to interface with the tribes.²⁰¹



The 10 lead organizations were very active in coordinating research and services to target eligible populations in their geographic areas with information and enrollment assistance, through their own assisters and those of their community partners. For example, one lead organization, Public Health-

Seattle & King County, analyzed the uninsured and their barriers in the King County region and tailored strategies to reach them in their communities and preferred languages. Twenty-three partner organizations in this region provided assistance in 34 languages and targeted diverse populations through hundreds of enrollment events at community locations like schools and libraries, ethnic communications and advertising, and “in-reach” at locations such as clinics and jails.²⁰²

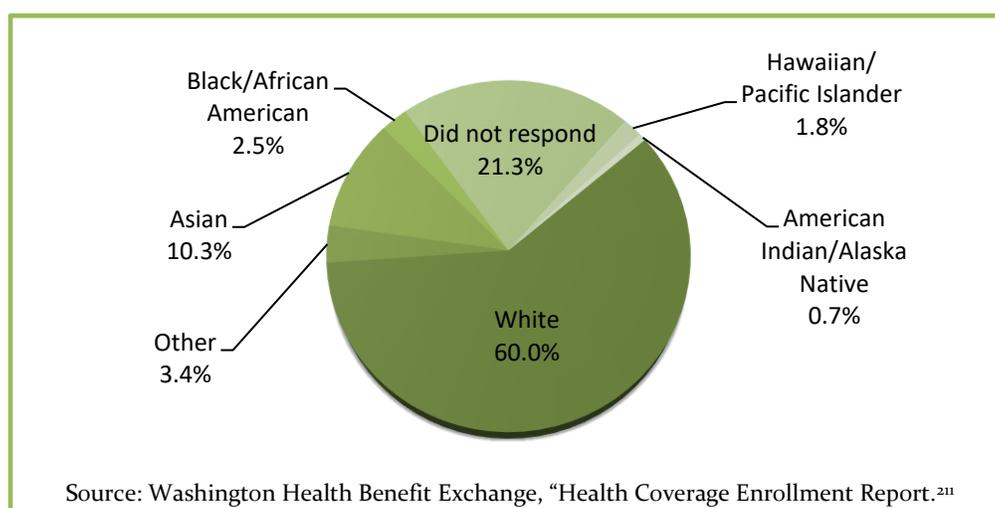
Languages. Core outreach materials were available in eight languages, and the marketplace translated other languages as needed. Some materials were printed and distributed, and others were only available to print on demand from the website.²⁰³ In addition, community organizations could create their own materials using the official marketplace logos, following the usage guidelines.²⁰⁴ Website information and online enrollment were available in English and Spanish, and consumers could search for assisters and brokers online by zip code and language (48 languages including sign language).²⁰⁵

Media and marketing. In fall 2013, Washington Healthplanfinder began an awareness and outreach campaign in English and Spanish that included advertising (such as TV, radio, print, and billboards), social media, and partnerships with media and community groups reaching diverse populations.^{206,207} The marketplace also organized an enrollment tour using a branded Washington Healthplanfinder bus that made visits around the state, coordinating with local assisters.²⁰⁸ A telephone survey after the first enrollment period indicated that the advertising had a very positive impact, and was seen or heard by over half of Washington residents overall. When

broken down by demographics, 53% of whites had heard of Washington Healthplanfinder, compared to only 29% of Latinos.²⁰⁹

Enrollment outcomes. During the first open enrollment period, Washington Healthplanfinder enrolled 163,207 individuals, about 32% of those eligible in the state, which was one of the higher percentages around the nation.²¹⁰ Figure 6 shows the races indicated by marketplace enrollees. Ethnicity was reported separately, and 6% of enrollees reported being Hispanic (65% did not respond to this question).

Figure 6. Race of Marketplace Enrollees in Washington, First Open Enrollment



The enrollment website experienced minor problems compared to most states, including issues with transmitting payment information to insurance carriers and difficulties with electronic verification for citizenship status that required manual workarounds.²¹² The marketplace received some complaints from members of the African-American community and the Health Equity Technical Advisory Committee regarding certain advertisements, and agreed to set aside more time in the future to evaluate ads produced by the marketing firm and to have stakeholders review them.²¹³

Second Open Enrollment Period: Progress and Issues

Outreach and enrollment programs. The 10 lead organizations and their networks of community partners remained in place for the second open enrollment period, and were an important way of reaching diverse communities. Navigators/IPAs were able to conduct more outreach than in the first open enrollment, including targeting diverse populations. There were fewer assisters in the second open enrollment, as the marketplace felt more were needed during the first open enrollment for the new Medicaid expansion, and individuals also needed less assistance in the second open enrollment due to fewer system problems.

IPAs will eventually become navigators officially when federal funding ends in September 2015, but all types were usually called "assisters," including CACs. The marketplace is considering whether to change the boundaries or numbers of the lead organizations for the third open

enrollment period. The call center employed about 500 customer service representatives by the end of the second open enrollment, which was about five times as many as the beginning of the first open enrollment, so the added capacity and decreased wait times helped consumers and navigators.

The marketplace held several large enrollment events, including one in King County (the largest county) that targeted Spanish-speaking populations, though they found that other consumers wanted to come as well. As a result, they worked to assure the availability of navigators speaking several different languages. Some individuals from other counties as well attended these large enrollment events. The marketplace found that having bilingual assisters was very important for reaching diverse populations. For example, several Russian navigators enrolled large numbers of individuals in pockets of Russian communities. The marketplace found that having full-time assisters was preferable to part-time, as the assisters could focus on just marketplace activities and not other job demands, and could gain more marketplace experience. The marketplace is no longer conducting events for the purpose of outreach only, as they found they needed enrollment assisters present to enroll those successfully reached and educated.



Languages. Core outreach materials were available in eight languages (Spanish, Vietnamese, Russian, Somali, simplified Chinese, Cambodian, Korean, and Laotian), and other languages were translated on a case-by-case basis. Online enrollment was available in English and Spanish. People could search for navigators by language online, but navigators could only enter one spoken language in addition to English, even if they spoke more than one.

The Health Equity Technical Advisory Committee (TAC) drove the development of a Language Access Plan (LAP) over many months, as well as advising the marketplace on other issues related to health equity and diversity such as planning outreach and assistance for diverse communities. The LAP, reviewed by stakeholders and finalized in September 2014, was based on the policy that the marketplace “will take reasonable steps to provide limited English proficient (LEP) persons with meaningful access to all Exchange programs or services.”²¹⁵ It lists guidelines related to language accessibility in eight operational areas:

1. Quality Control of Oral and Written Translations;
2. Assessment of Language Access Needs in Washington;
3. Identifying LEP individuals;
4. Metrics and Reporting;
5. Staff Training and Resources;
6. Contracting for Language Assistance Services;
7. Notification of the availability of language assistance services at no cost;
8. Stakeholder Engagement; and
9. Performance Measures and Evaluation.²¹⁶

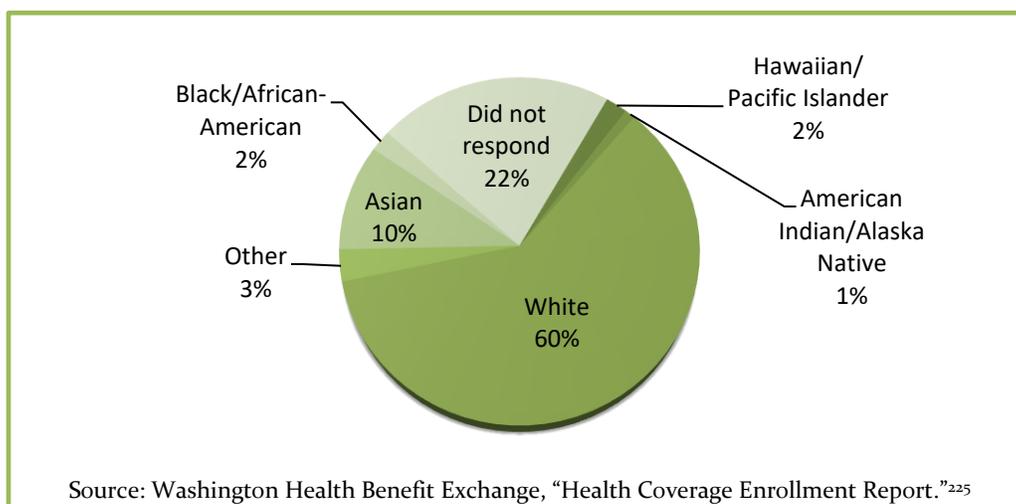
A new TAC was formed in 2014 on outreach in order to address issues such as health literacy, how to reach the remaining uninsured, and how to better reach diverse communities.²¹⁷ In 2014, the

marketplace undertook a health literacy project that resulted in developing new materials using Health Literacy Innovations²¹⁸ software and a design firm for creative work, and these were well accepted. Recommendations during this process included avoiding jargon, using plain language (including in translations), using graphics, and separating marketing from education.²¹⁹ Marketplace materials used clear, simple designs and were produced in eight languages as well as materials customized for different Indian tribes. Information for consumers on buying and using health insurance was available on the marketplace website, as well as a Health Literacy Toolkit for assisters.^{220,221}

Media and marketing. Washington Healthplanfinder again utilized online and TV advertising, including forming a partnership with Univision (Spanish TV), and had educational radio ads in English and Spanish. Print ads in community publications were translated into Chinese, English, Korean, Russian, Spanish, and Vietnamese.²²² The marketplace introduced messaging in the second open enrollment about shopping for a new plan for people who needed to renew, as there were many changes in plans (including changes in silver plans potentially affecting subsidies) around the state, especially in King County.

Enrollment outcomes. In the second open enrollment period, Washington Healthplanfinder enrolled/re-enrolled 160,732 individuals in marketplace plans, or an estimated 32% of those eligible,²²³ which was the same percentage as in the first open enrollment and was short of its goal of 213,000.²²⁴ Figure 7 shows the breakout of races indicated by marketplace enrollees. Ethnicity was asked separately, and 6% of enrollees indicated Hispanic heritage, while 65% did not respond.

Figure 7. Race of Marketplace Enrollees in Washington, Second Open Enrollment



Various technical problems, many involving billing, continued to affect some customers before and during the second open enrollment period.^{226,227} Washington Healthplanfinder is continuing to address many of these, such as discontinuing premium aggregation before the next open enrollment period—meaning they will not be taking payments from consumers, as they have not been able to transmit them to the insurance carriers consistently and accurately. The marketplace held a special enrollment period for people affected by tax penalties from February 17 to April 17, 2015.

Federally Facilitated Marketplace

Overview. Twenty-seven states declined to establish their own marketplaces and have thus defaulted to become federally facilitated marketplace (FFM) states. This number does not include the partnership states and the state-based marketplaces for which the federal government operates enrollment websites (see Table 1 for list). All states except Florida and Alaska applied for and received initial exchange planning grants in 2010, but some states such as Texas used a portion to fund studies and then returned the rest, declining to participate in further federal exchange funding or planning activities.^{228,229}

The federal government contracts with navigator entities to provide enrollment assistance in the FFM states and the other states that it partners with, and in September 2014, the U.S. Department of Health and Human Services (HHS) awarded \$60 million in navigator grants to 90 organizations in 34 states for the second enrollment period, a decline from the \$67 million awarded in the first open enrollment period.²³⁰ Many of the recipient organizations were nonprofits that targeted underserved groups including culturally and linguistically diverse communities.²³¹ HHS strived to ensure that half of the navigators funded for the second open enrollment spoke Spanish.²³²

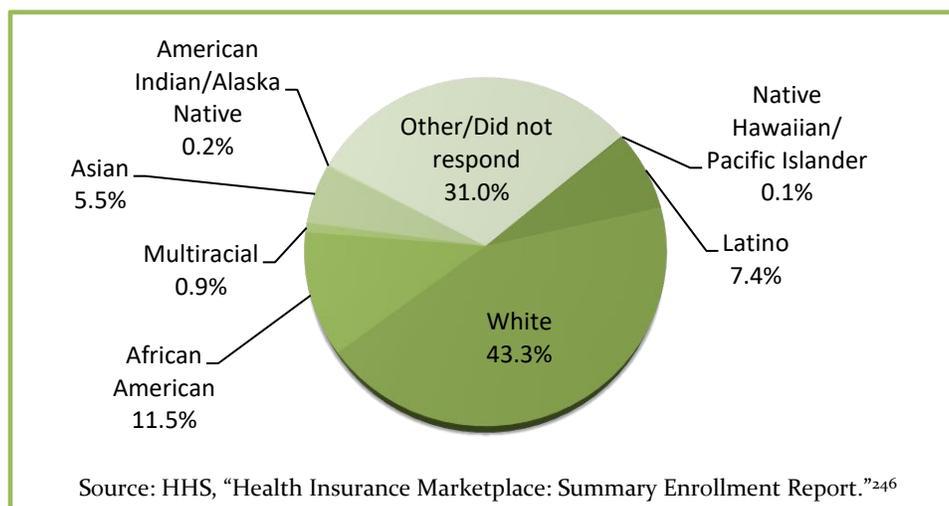
Other organizations conducted or supported consumer assistance in these states as well, including the nonprofit Enroll America, which raised about \$20 million for the second open enrollment compared to \$27 million in the first period, but planned to reach more people in the second enrollment period in its same 11 targeted states (Arizona, Florida, Georgia, Illinois, Michigan, North Carolina, New Jersey, Ohio, Pennsylvania, Tennessee, and Texas).^{233,234} It targeted the FFM and partnership states with the largest uninsured populations for on-the-ground field work like enrollment, outreach, training, and hosting enrollment events, but also offered assistance in all the other states through its regional managers and partner organizations. Campaigns and events targeted a combination of the main groups Enroll America focused on for enrollment: Latino women, young people, African-Americans, and faith-based communities. Families USA, an advocacy group that partnered with Enroll America, also supported enrollment efforts in states through means such as collaborations with the government and nonprofits, media outreach including in Spanish, and the Enrollment Assister Resource Center, which has tools and webinars for assisters to help with enrollment.²³⁵

The following sections discuss the progress and issues encountered in the first and second open enrollment periods in FFM states regarding enrollment from a cultural and linguistic diversity perspective, including efforts targeting diverse communities, and an overview of relevant activities in the two largest FFM states, Florida and Texas.

First Open Enrollment Period: Progress and Issues

Enrollment websites. When open enrollment began on October 1, 2013, residents of the states using the federal marketplace, Healthcare.gov, encountered numerous problems and slow service when trying to establish online accounts and choose health plans. The technological problems were gradually addressed and fixed over several months, and the government extended several deadlines to help those who were having problems buying insurance. The deadline in December for coverage to be effective January 1 was extended, as well as the end of the open enrollment period, which was March 31, 2014, but was extended a week into April for those still in the process of enrolling.²³⁶

Figure 8. Race/Ethnicity of Federally Facilitated Marketplace Enrollees, First Open Enrollment



Second Open Enrollment Period: Progress and Issues

Enrollment websites and changes. The HealthCare.gov website performed much better during the second open enrollment as compared to the first, though it did have some technical problems.^{247,248} A shorter, streamlined application was introduced for the second enrollment period for new applicants without complex eligibility or family situations, which helped speed up enrollment for some consumers—though not for legal immigrants and naturalized citizens, which were considered complex cases.^{249,250} The head of the Connecticut marketplace was hired in August 2014 as Marketplace Chief Executive Officer for the federal marketplace, serving as the contact person for decision-making and one of several new staff members hired to make the federal marketplace operate more smoothly and transparently than the first period.²⁵¹

The federal government made improvements to the Spanish enrollment website CuidadoDeSalud.gov, including better handling of hyphenated names and identity verifications.²⁵² Legal residents also had trouble uploading copies of their green cards and other documents during enrollment, though this issue was later fixed.²⁵³ However, enrollers and advocates still reported that identity verification in the enrollment websites was a problem for recent immigrants, young people, and others without much credit history.²⁵⁴ Identity was confirmed through the credit agency Experian, and if identity could not be confirmed online due to lack of credit history, the system asked the applicant to call Experian, but this would not help if there was no history. In the first enrollment period, this step would hold up the application process, but in the second enrollment period, enrollees could skip this step and continue with the enrollment and try to find a way to verify their identity later.

Languages. The federal marketplace continued to offer enrollment in English and Spanish for the second open enrollment period, as well as translated applications in 33 languages—which were called job aids since the purpose was to help with enrollment and not to be used as the actual application to mail in.²⁵⁵ Consumer information and tools for assisters were available in multiple languages (the number varied by topic). Whereas in the first enrollment period these

materials were first listed by language, then topic, during the second enrollment period materials were first grouped by topic, then made available by languages.²⁵⁶ The federal marketplace sent a tagline document on mailed notices that had instructions in 25 languages for calling the language line at the call center, and worked to improve the instructions for reaching an interpreter in one's language of choice.²⁵⁷

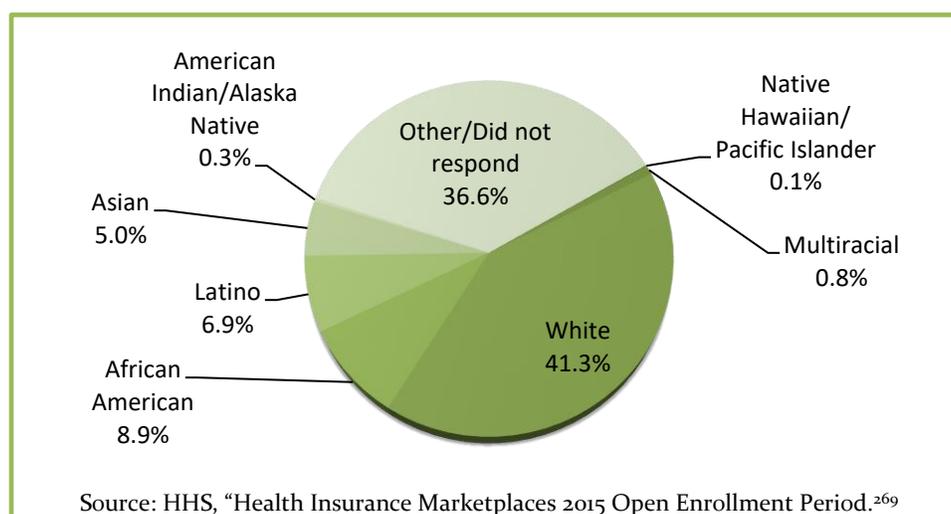
Training. Training for navigators, brokers, and other assisters continued to be available in English and Spanish.²⁵⁸ In September 2014, before the second open enrollment period started, the training program for navigators and other assisters in FFM states was updated to add a new course that included more details on marketplace topics such as immigration issues, counting household income, and helping consumers re-enroll in coverage. The federal training continued to include modules on cultural competence and language assistance and on serving vulnerable and underserved populations, among other marketplace-related topics. The marketplace required all modules to be completed for certification and recertification of navigators and non-navigator assistance personnel, while certified application counselors only had to complete selected modules. The courses on cultural and linguistic competence and underserved populations were not required for CACs but were available if they wished to pursue more in-depth training. In addition, HHS offered ongoing training opportunities such as webinars and newsletters throughout the year.²⁵⁹

Verifying immigration status. Verifying citizenship or residency status to be eligible for insurance through the marketplace continued to be a problem for some immigrants and other applicants. In summer 2014, about 300,000 people who enrolled in health plans in the federal exchange were mailed letters (in English and Spanish, with additional taglines) stating that their coverage could end if they did not provide additional documentation of their legal resident status by September 5, 2014.^{260,261} Over 100,000 did not provide documentation in time, leading immigrant advocacy groups to file complaints that the notices were not sufficient and not available in enough languages, and to try to prevent the ending of coverage.²⁶² Applicants were contacted multiple times, and some sent documents only to have them be lost or have processing delayed.²⁶³ Losing coverage created a special enrollment period, so some individuals reapplied and gained coverage. People who responded and sent documents were able to renew coverage in fall 2014 even if the documents had not been processed yet, and HHS announced in mid-February 2015 that about 200,000 people with insufficient documentation would have their coverage dropped at the end of the month.²⁶⁴

King v. Burwell. A recent significant issue involving the federal marketplace was the Supreme Court case *King v. Burwell* that was heard on March 4, 2015, with a final decision announced on June 25, 2015. The case concerned wording in the ACA that referred to individuals being eligible for subsidies (tax credits) if they bought health insurance “through an exchange established by the state.” In 2012 the Internal Revenue Service interpreted that language to mean people participating in both federal and state-based marketplaces, but this was later challenged by groups believing that this referred only to state-based marketplaces, and not the federal marketplace.²⁶⁵ While a ruling against these subsidies could have been potentially damaging—leading to an estimated increase of 8.2 million uninsured people and premium increases of 35% for the remaining uninsured in states²⁶⁶—the decision in favor of subsidies in the federal marketplace reinforced the intent of the landmark law to make coverage more affordable for all Americans.

Enrollment outcomes. The total number of enrollees in health plans through the federal marketplace (37 states, including partnership states and supported states using the federal portal) reached 8.84 million as of the end of the extended open enrollment on February 22, 2015. These individuals selected plans, but may not have made the first payment yet to effectuate enrollment, so exact numbers continually vary due to this and other factors. This total includes 4.67 million new enrollments and 4.17 million renewals, 53% of which actively chose a new plan or to remain in the same plan, with the remainder automatically renewed into the same plan.^{267,268} Figure 9 depicts the racial and ethnic make-up of enrollees in states using the HealthCare.gov platform.

Figure 9. Race/Ethnicity of Federally Facilitated Marketplace Enrollees, Second Open Enrollment



The second open enrollment period ended February 15, 2015; however, due to several system glitches during the last few days of enrollment, such as problems with verifying income, the enrollment period in FFM states was extended one week to February 22. The federal government also added a special enrollment period from March 15 to April 30, 2015, for consumers who realized that they faced a penalty on their 2014 income taxes for not having insurance, as without additional time to enroll, they would incur a penalty for 2015 as well.²⁷⁰

During the second open enrollment period, the HealthCare.gov website saw an estimated 33.8 million users and CuidadoDeSalud.gov saw about 1.3 million users. During this three-month period, the federal call center received about 15.3 million calls, 9.6% of which were with Spanish-speaking representatives.²⁷¹

Comparing the first and second open enrollment periods, those enrollees not answering the optional race/ethnicity questions or marking "other" increased by over 5%, comprising over one-third of enrollees. Of the other respondents, the percentages of people specifying American Indian/Alaska Native and multiracial slightly increased, while the percentages specifying Asian, African-American, Latino, and white slightly decreased (though absolute numbers may have been higher than in the first enrollment period since overall enrollment was higher). The percent of Native Hawaiian/Pacific Islanders enrolled stayed about the same.

Federal Outreach and Enrollment Efforts Targeting Diverse Communities

The federal government engaged in efforts to enroll more diverse communities in the second open enrollment period, including awarding \$3.2 million to 13 organizations in September 2014 to support minority enrollment in the marketplaces, Medicaid, and CHIP under the new Partnerships to Increase Coverage in Communities (PICC) initiative. Grants were awarded to nonprofits, academic institutions, and other types of organizations in 12 states, including two in Texas and one in Florida.²⁷²

Media and marketing. HHS also conducted targeted outreach such as buying TV and radio advertising tailored to different groups. For example, government marketplace ads aired on the Telemundo and Univision networks, including on the Latin Grammys, to reach Latinos, and ads on BET, sporting events, and Radio One to reach African-Americans.²⁷⁴ President Obama visited several television shows to promote enrollment and deadlines for coverage including sports shows



and *The Colbert Report*, while HHS Secretary Sylvia Mathews Burwell traveled around the country several times including visits to predominantly Hispanic cities in Florida and Arizona and attending African-American church services in Houston.²⁷⁵ HHS, Enroll America, and other nonprofit partners conducted more than 600 enrollment events targeting Spanish speakers in the last month of the second open enrollment period.²⁷⁶

The government used digital media as well to reach different demographics, such as a video posted to YouTube in January 2015 featuring two African-American professional football players talking about enrolling in health insurance that was

linked to posts on Facebook and Twitter.²⁷⁷ Another creative new effort to reach potentially uninsured and unbanked populations was HHS's partnership with the company PayNearMe to print information about HealthCare.gov on all PayNearMe receipts printed at U.S. 7-Eleven stores during the second open enrollment. PayNearMe is a cell phone app that some stores and individuals use to process cash payments for rent, utilities, and other expenses.²⁷⁸

Florida

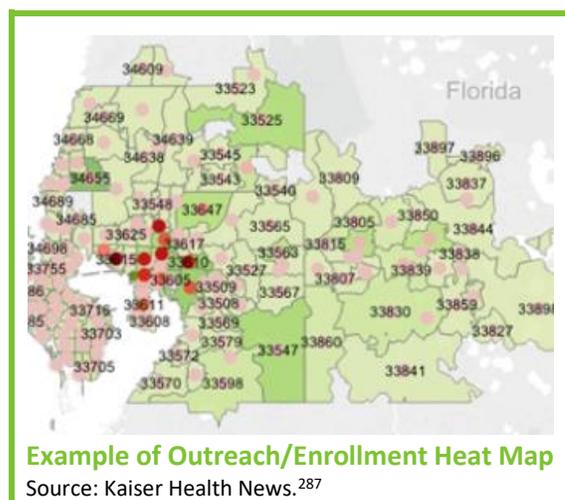
Overview. With a population of 19.5 million and the third-highest nonelderly adult uninsured rate in the nation at 26% in 2013, Florida was an important state for marketplace enrollment efforts.^{279,280} Targeting outreach to diverse communities was key in Florida, as 42% of its population is non-white and nearly 12% are LEP.^{281,282} An estimated 1.6 million individuals in Florida enrolled in marketplace plans by the end of the second open enrollment period, which was higher than anticipated and the highest number in the nation (California, which has a greater total state population than Florida, led for the first open enrollment period).^{283,284} Florida is one of a handful of states that has enrolled more than half of its eligible population (see Table 1). The racial/ethnic estimates of enrollees by state are not available as of this writing.

Navigator activities. Three organizations in Florida received federal navigator grants for 2014-2015, including a \$5.38 million grant—the largest in the nation—awarded to the University of South Florida for its Florida Covering Kids & Families program (FL-CKF).²⁸⁵ FL-CKF, which also received a navigator grant for the first open enrollment, has extensive experience with Medicaid

and CHIP enrollment, and partnered with 12 organizations in a statewide consortium to reach all the counties for marketplace enrollment assistance; one of these partners was the Center for Health Equity, which focused on the elimination of health disparities.²⁸⁶ In the first open enrollment, the consortium worked in 64 counties, and in the second enrollment period it added the remaining three counties (Miami-Dade, Monroe, and Broward counties) to cover the whole state.

FL-CKF oversaw projects that targeted various populations around the state, such as different ethnic and language groups (including outreach in Arabic, Chinese, Russian, Farsi, Cambodian, and other less-common languages as needed, as well as Spanish), rural populations (using mobile services), HIV/AIDS patients, and individuals recently released from prison. They identified existing trusted organizations in each of these communities to partner with, and worked with other groups and assisters such as certified application counselors and community health clinics to coordinate personnel and resources for enrollment events. They divided the state into 11 regions and each region had a “regional lead,” which was an existing organization in each region that helped to coordinate activities there and customize strategies depending on their populations.

FL-CKF tracked and evaluated outreach and enrollment efforts using a data collection system designed by Family Healthcare Foundation in Tampa that allowed all partners to enter daily data on their activities and to visualize collective efforts on a “heat map” by race/ethnicity, age, gender, and language. Green on the map represented outreach, and the darker the color, the more people who received outreach and application assistance. Red dots represented people who were enrolled, and the darker the red, the more people who were enrolled in that locality (enrollment data did not appear in real time like locally entered outreach data did, since enrollment data came from the federal government). Hovering over a dot pulled up more information. This constant feedback from the heat map allowed them to monitor local efforts and target resources to where they were most needed.^{288,289}



The Epilepsy Foundation of Florida also received a federal navigator grant for both open enrollment periods, and focused on reaching Hispanics, African-Americans, Haitians, immigrants, migrant workers, disabled individuals, and other vulnerable groups. The other navigator group in Florida, the Pinellas County Board of County Commissioners, also worked to reach individuals in culturally and linguistically appropriate ways.²⁹⁰ There were about 550 registered navigators in Florida in the second enrollment period, in addition to certified application counselors and insurance agents/brokers.²⁹¹

Texas

Overview. Texas has historically had the highest uninsured rate in the nation—28% for adults 19-64 in 2013, and 50% for those under 200% of the poverty level.²⁹² With a total population of about 26.5 million, with 59% non-white and 14.4% LEP, reaching diverse populations is of paramount

importance.^{293,294} About 1.2 million individuals in Texas enrolled or re-enrolled in marketplace plans in the second open enrollment period, up from 733,000 in the first period.²⁹⁵ About 39% of eligible individuals have been enrolled in Texas (see Table 1). The racial/ethnic estimates of enrollees by state are not available as of this writing.

Navigator activities. Seven organizations were awarded federal navigator grants in Texas for the second open enrollment period (one less than the eight in the first enrollment) for a total of about \$9.7 million, which was 16% of the national budget and the most of any single state.^{297,298} Several grantees have specific experience with diverse communities, including MHP Salud (formerly called Migrant Health Promotion), which received grants for both open enrollments and focused on reaching underserved communities in the Rio Grande Valley, which is largely Hispanic/Latino.²⁹⁹

MHP Salud provided outreach, education, and enrollment at its offices and at sites and events in four counties. About 98% of its clients were Hispanic and about 75% preferred assistance in Spanish. The navigators at MHP Salud were Community Health Workers and bilingual *promotores*.^{300,301} It also participated in Enroll RGV, a coalition of 13 organizations including nonprofits, local clinics and health systems, Enroll America, and several local congressmen’s offices.³⁰² The coalition members met monthly, collaborated to share calendars, resources, and best practices, and worked together on events and media exposure.



Navigator at MHP Salud

Source: MHP Salud.²⁹⁶

MHP Salud received a grant from Community Catalyst between the first and second open enrollment periods to study how to improve outreach and enrollment in immigrant populations. It conducted a community assessment and developed recommendations, including improving health insurance literacy, dispelling misconceptions, increasing

media outreach and in-person assistance, and developing strategies for subpopulations such as refugees and people speaking languages other than Spanish.³⁰³

Another navigator grantee in Texas, the Houston Department of Health and Human Services, received about \$1.8 million, and led the Gulf Coast Health Insurance Marketplace Collaborative, which included 18 organizations.^{304,305} The collaborative, also called Enroll Gulf Coast, formed before the first open enrollment period to share resources and coordinate activities. Recognizing that the over 1 million uninsured people in the 13-county greater Houston and Harris County area was a public health emergency, they established an “incident command structure” to develop, coordinate, and implement outreach and enrollment efforts.³⁰⁶ Using this structure, they identified and mapped areas with the highest concentrations of the uninsured and where to best reach them, including targeting “geographically and linguistically isolated people,” and shared data and tracked activities online.³⁰⁷ Services included outreach events, distribution of educational materials, enrollment appointments and events at community locations, and a call center to answer questions.

Other navigator grantees in Texas targeting diverse communities included Primero Health, Inc., in Austin, which specialized in health promotion and education through churches serving Latino

communities, and Light and Salt Association (based in Houston with services in several other cities), which targeted Asian Americans in multiple languages.^{308,309}

A number of organizations in Texas that did not receive navigator grants also worked to enroll individuals, in addition to national organizations mentioned previously such as Enroll America. The Texas Organizing Project, for example, created coalitions in several major cities and organized events on weekends where people could enroll in English and Spanish.³¹⁰ Cover Texas Now was another coalition of organizations around the state, including nonprofits, faith-based organizations, and Latino organizations, that educated consumers and advocated for coverage expansion.^{311,312} Insure Central Texas is a collaborative enrollment program run by Foundation Communities, which already had experience serving lower-income individuals with tax preparation and financial advice, and used bilingual staff and volunteer CACs to enroll people at sites around Central Texas.^{313,314}

There were 441 registered navigators in Texas as of March 2015,³¹⁵ and 9,790 marketplace-trained agents and brokers.³¹⁶ Agents and brokers certified to sell marketplace plans marketed their services more in the second open enrollment period than the first, with some buying advertising, distributing fliers, or holding events. For example, the Houston Association of Health Underwriters organized two enrollment events using member brokers to help individuals enroll in marketplace health plans.³¹⁷ As in other states, Texas also had a number of CACs who served as volunteers or were funded by Health Resources and Services Administration (HRSA) grants and other sources.

Partnership Marketplaces

Overview. Partnership marketplaces are not mentioned in the original ACA, but evolved through federal guidance issued in 2012 and 2013 when states wanted the option to conduct certain marketplace activities such as plan management functions, consumer assistance, or Medicaid eligibility determinations, and leave other functions to be performed by the federal government. There were seven partnership states during the first and second open enrollment periods, with all performing health plan management and several handling consumer assistance as well.

Partnership states were the following:

- Arkansas;
- Delaware;
- Illinois;
- Iowa;
- Michigan;
- New Hampshire; and
- West Virginia.

Starting in 2015, plan management will no longer be a formal option for partnership states to choose when informing HHS of their marketplace arrangements, but states may still conduct plan management “on behalf of the federal government on an ad hoc basis.”³¹⁸ Arkansas, Illinois, and Iowa all planned to become state-based marketplaces after the second open enrollment, but so far only Arkansas is proceeding as planned as of this writing.³¹⁹

States that operate their own consumer assistance programs in addition to the federal navigator program can oversee assistance activities in their states and tailor their programs for different

populations. We examined the largest two of these states in more detail, Illinois and Arkansas, to provide examples of how partnership states operate and how they worked to reach their culturally and linguistically diverse populations.

The following three subsections discuss the progress and issues encountered in the first and second open enrollment periods in partnership marketplace states, and the experiences and diversity-related activities in Illinois and Arkansas.

First and Second Open Enrollment Periods: Progress and Issues

Since partnership marketplaces are essentially federally facilitated marketplaces where the state assumes one or more distinct operational responsibilities, the partnership marketplaces largely experienced the same issues and successes during the first and second open enrollment periods as detailed above for the federal marketplace. The partnership marketplaces established some state infrastructure and their own informational websites, but used the federal web portal of HealthCare.gov for enrollment. They also used the federal online training program for their navigators and other assisters, in addition to state training in the states providing consumer assistance.

The seven partnership marketplaces enrolled 636,845 people during the first open enrollment period (through April 19, 2014)³²⁰ and 912,978 as of the end of the second open enrollment period (February 22, 2015)—showing a large gain in enrollments the second year.³²¹ These individuals are also counted in the overall federal enrollment numbers in the previous section since they were enrolled through the federal marketplace.

Arkansas

Overview. Arkansas was the first state to decide to pursue a partnership marketplace, at the end of 2012, and it was named the Arkansas Health Connector in mid-2013.³²² The Arkansas Health Insurance Marketplace Act (Act 1500) was passed in 2013 to authorize the creation of a nonprofit state-based marketplace on July 1, 2015, or a later date to be determined by the Arkansas Health Insurance Marketplace Board.³²³ This board is a separate entity from the current partnership marketplace, which is housed within the Arkansas Insurance Department.³²⁴ The population of Arkansas was over 2.9 million in 2013 and the uninsured rate was 15% (23% for ages 19-64).³²⁵ About 38% of the population is non-white and 3.2% is LEP.^{326,327}

Consumer assistance. Two organizations in Arkansas received federal navigator grants for the second open enrollment period, the University of Arkansas (\$749,000), and Enroll the Ridge (\$183,000).³²⁸ The University of Arkansas hosted the Arkansas Navigator Coalition, which consisted of agencies serving African-Americans, Latinos, the homeless, and other populations, and worked statewide to reach areas with the highest uninsured rates. Enroll the Ridge is a nonprofit in northeast Arkansas that worked with another nonprofit on outreach and enrollment in 11 counties, focusing on African-Americans and Hispanic/Latinos.

The Consumer Assistance Advisory Committee, comprised of dozens of stakeholders, was formed in 2012 from prior workgroups to develop recommendations for an In-Person Assister program. Using feedback from the committee and community meetings around the state to develop

guidelines, the state awarded \$5.6 million in IPA grants to 26 organizations in June 2013 for the first open enrollment period, and more than 500 IPAs (called Guides) were hired.³²⁹ These included organizations with experience reaching diverse populations such as the Arkansas Minority Health Commission, the Hispanic Women’s Organization of Arkansas, and the Women’s Council on African American Affairs.³³⁰ The marketplace also worked with the Arkansas Minority Health Commission on informational events for diverse communities under a separate contract.³³¹ Marketplace materials were in English and Spanish, as is the Arkansas Health Connector website.³³²

Through fall 2014, the state had licensed 578 IPA Guides, 349 certified application counselors, 1,634 agents/brokers, and 36 navigators. However, significantly fewer Guides (around 50) were available for the second open enrollment period due to 2014 state legislation prohibiting the Insurance Department from conducting any outreach or in-person assistance for the marketplace in fiscal year 2014-2015.³³⁴ Act 276, the state budget, contains an amendment that prohibits state promotion of the marketplace and obtaining federal grants for enrollment assisters, though the state can release facts about deadlines and other details.³³⁵ The Arkansas Advocates for Children and Families continued some of the outreach and assistance work that the marketplace could no longer perform. Partnering with other organizations, it launched a campaign called Arkansans for Coverage in fall 2014 to reach eligible individuals and families and support enrollment assisters.³³⁶

Marshallese community. Arkansas has a sizeable Marshallese community in its northwest region. These are immigrants from the Marshall Islands in the Pacific who can legally live and work in the U.S. through a compact between the governments.

Numbering over 4,000 people, these immigrants often have medical problems, some due to the lingering effects of U.S. nuclear bomb testing on the islands in the 1940s and ’50s, and while the younger members can speak English some of the older residents speak only Marshallese. The younger individuals born in the U.S. are full citizens and can access U.S. entitlement programs, but the original immigrants are not eligible for Medicaid or Medicare, though they are eligible for subsidies from the marketplace.³³⁷ A Marshallese clinic opened in 2011 with federal and state funding, but there are ongoing challenges in meeting the needs of this population. There are several nonprofits that serve this population, and at least one enrollment assister who speaks Marshallese.



Media and marketing. A marketing firm was hired for the first open enrollment period to conduct outreach and education, including television and radio ads, billboards, and direct mail, and it subcontracted with a firm specializing in outreach to diverse communities.³³⁸ The firm was not retained for the second open enrollment due to the state prohibition on marketing.

Training. All enrollment assisters in Arkansas were required to take state training (in addition to federal training) to be licensed by the state for marketplace enrollment assistance, including navigators, IPAs, CACs, and agents/brokers.³³⁹ State training for the first open enrollment period included an in-person and online training module on “Diversity and Cross-Cultural Interactions,” but it was not offered for the second open enrollment as it was determined to be somewhat duplicative of federal training.

Enrollment outcomes. Enrollment in the first open enrollment period totaled 43,446, representing 17% of eligible individuals,³⁴⁰ while enrollment in the second open enrollment period was 65,684, which equaled 26% of those eligible.³⁴¹ The racial/ethnic breakout of enrollees by state is not available as of this writing.

By January 2015 the Arkansas Health Insurance Marketplace Board planned for the state-based small business marketplace to launch in 2015 for plan year 2016, and the state-based individual marketplace to launch in 2016 for plan year 2017,³⁴² but Act 398 passed in February 2015 added stipulations.³⁴³ This act specified that the formation of a state-based marketplace could not proceed before the decision in the Supreme Court case *King v. Burwell* on marketplace premium subsidies was announced. If the decision had ruled that subsidies were legal only in state-based marketplaces and not the federal marketplace, then additional legislation would have been needed to authorize creation of a state-based marketplace in Arkansas. However, since the Supreme Court determined on June 25, 2015, that subsidies are legal in federally facilitated and partnership marketplaces as well as state-based marketplaces, Act 398 directs that creation of Arkansas' state-based marketplace may proceed according to Act 1500.

Illinois

Overview. The partnership marketplace in Illinois was created in 2012 and named Get Covered Illinois in 2013.³⁴⁴ The governor and advocates hoped to establish a state-based marketplace starting with legislation passed in 2011, but there were hurdles and a partnership marketplace was determined to be the most feasible for the next several years. A new governor was elected in November 2014 and legislation to fund a state-based marketplace failed to pass in December 2014, so it is unclear if the marketplace will become state-based in the future.³⁴⁵ Illinois had a total population of 12.8 million with an overall uninsured rate 11% (16% for ages 19-64) in 2013.³⁴⁶ The proportion of the population that is non-white is approximately 35%, with 9.6% LEP.^{347,348}

Consumer assistance. HHS awarded \$2.9 million in navigator grants to 12 organizations and their partners in Illinois for the second open enrollment, some of which targeted diverse populations.³⁴⁹ For example, Illinois Migrant Council targeted farmworkers, Latinos, and rural communities, and hosted events at farms, libraries, churches, and other community locations. Primecare Community Health, Inc., targeted immigrants, LEP populations, and low-literacy populations in the northwest Chicago area. The Midwest Asian Health Association focused on Asian populations in the south side of Chicago, and also functioned as a navigator grantee in Ohio and Michigan, conducting outreach and education on health coverage in targeted Asian communities.³⁵⁰

As a partnership state conducting consumer assistance, Get Covered Illinois is required to have its own in-person assistance program in addition to the federal navigators. This program is called the In-Person Counselor (IPC) program and is housed in the Illinois Department of Public Health. For the first open enrollment period, Get Covered Illinois awarded about \$27 million in IPC grants to 44 organizations, which were selected in a competitive grant process to assure selection of entities with related experience in their targeted communities.³⁵¹ For the second open enrollment period, \$25.8 million in IPC grants were awarded to 37 organizations including those serving diverse communities such as Latinos, Asians, and American Indians.³⁵² For example, Alivio Medical Center, which targets Latinos in Chicago, received about \$860,000 in IPC grants for 2014-2015,

more than five times what it received in 2013-2014, and expanded its reach to the south side of Chicago and to suburbs with large Latino communities.³⁵³

The marketplace ramped up outreach to diverse communities in the second open enrollment, particularly to Hispanics/Latinos since this group had the lowest rate of enrollment in the first open enrollment period. It worked with community organizations such as school districts, ethnic organizations, and the citywide coalition Enroll Chicago for outreach and enrollment events during the two enrollment periods.³⁵⁵ It convened faith leaders during both enrollment periods to spread information and encourage outreach to their congregations, and partnered with them on hundreds of enrollment events.³⁵⁶ Get Covered Illinois also focused more on recently resettled refugees (including survivors of wars and human trafficking), establishing a workgroup of Illinois refugee placement agencies and state agency representatives so they could coordinate processes to ensure that marketplace and Medicaid enrollments and other services for this population went smoothly.

Get Covered Illinois required all IPC positions in the second open enrollment period to be full-time for maximum productivity and efficiency, while in the first open enrollment positions could be part-time or full-time.³⁵⁷ The marketplace also used CACs (not compensated by Get Covered Illinois) and bilingual call center personnel to assist consumers. The marketplace used insurance agents and brokers as well for enrollment, and created a formal partnership with agents/brokers in January 2015 called the GCI Producer Program to collaborate on marketing and networking.³⁵⁸



Get Covered Illinois In-Person Counselors
Source: St. Louis Post-Dispatch.³⁵⁴

Data analysis. Between the first and second open enrollment periods, Get Covered Illinois divided the state into 10 geographic regions based on the levels of uninsured populations, then used data such as those from the State Health Access Data Assistance Center (SHADAC) and Public Use Microdata Areas (PUMAs) to further identify and prioritize populations to focus on. This helped the marketplace in determining IPC

grants awards in order to reach the identified target populations. Each region had a Regional Outreach Coordinator to help coordinate community engagement, collaboration, and outreach and enrollment activities in the region.³⁵⁹

Training and accountability. Illinois state law requires navigators, IPCs, and CACs to take state-specific training, and the marketplace coordinated with state training partners and the Department of Insurance to develop a two-day, in-person program, which was deemed “one of the most robust navigator training programs in the country.”³⁶⁰ It worked with the School of Public Health at the University of Illinois at Chicago to develop continuing education modules for recertification each year. Get Covered Illinois also provided tools and resources (such as materials, messaging, and webinars) to navigators, IPCs, and CACs to help them coordinate and work together and to avoid duplication of efforts. Several organizations received more than one type of grant for assisters, such as both federal navigator and state IPC grants, and although they may collaborate on activities, the marketplace worked to ensure that the financial elements of the programs were kept separate so that organizations could be held accountable specifically for the state funding.

Languages and marketing. The Get Covered Illinois website was available in English and Spanish, and it produced various fact sheets available in Arabic, Burmese, Chinese, Korean, Polish, Spanish, Swahili, Tagalog, and Russian.³⁶¹ Consumers were able to search for assisters in nine languages besides English and American Sign Language.³⁶² The marketplace hired the same marketing firm for the first and second enrollment periods, which handled targeted and grass-roots marketing, social media, television and radio advertising (including ethnic media), public relations, and other marketing-related duties.³⁶³ Televised roundtables that educated viewers on how to get coverage and the value of coverage were an important component of raising awareness during both enrollment periods, as they were shown on all major TV networks in all markets statewide as well as on Telemundo.

Enrollment outcomes. During the first open enrollment period, through mid-April 2014, about 217,000 Illinois residents enrolled in marketplace plans, which was about 24% of the estimated eligible population and exceeded federal estimates, but did not meet the state goal of 300,000.³⁶⁴ Almost 25% of enrollees did not report their race and ethnicity, but of those who did, Latinos had the lowest enrollment rates. Latino enrollment was estimated to be 5.6% of the eligible Latino population, while 11.7% of eligible African-Americans, 27% of eligible whites, and 33% of eligible Asians enrolled.³⁶⁵

Get Covered Illinois enrolled 349,487 individuals as of the end of the second open enrollment period (February 22, 2015), half of which were new enrollees and half of which were renewals.³⁶⁶ The racial/ethnic estimates of enrollees by state for the second open enrollment period is not available as of this writing.

Get Covered Illinois plans to focus on health literacy after the second open enrollment period and continued outreach and marketing to help consumers understand how to use their coverage, especially for those who may not have had health insurance previously. The marketplace website contains web pages with frequently asked questions on how to use coverage and how to renew coverage.³⁶⁷

Table 4. Summary of Adaptations and Practices for Reaching and Enrolling Diverse Populations in State-Based, Federal, and Partnership Marketplaces in 11 Study States

	In-Person Assistance Programs and Adaptations from First to Second Open Enrollment (OE)	Examples of Promising Practices for Reaching and Enrolling Diverse Populations
<p>State-Based Marketplaces</p> <p><i>Study states: California Colorado Connecticut Maryland New York Oregon Washington</i></p>	<ul style="list-style-type: none"> • Most states experienced a decrease from OE1 to OE2 in the number of assisters compensated by the marketplace • Almost all states had both navigators and IPAs for both OEs, except California, where the navigator program started in OE2 • Navigators and IPAs had the same roles in many but not all states, and sometimes the same name to the public (just different funding streams) • All states had sizable numbers of agents/brokers and CACs (CAC program started after OE2 in California) 	<ul style="list-style-type: none"> • Marketplaces partnered with trusted community organizations that had existing relationships with diverse communities • Assisters offered enrollment assistance at locations such as places of worship, English classes, community venues, and offices, often in non-English languages • Many marketplaces increased outreach to Latinos and other diverse communities that remained uninsured in OE2 • Marketplaces used print, TV, and radio ads in ethnic media and in multiple languages • Many marketplaces divided their states into regions to better target different populations • Covered California partnered to create fact sheets for immigrants in five languages, explaining usage of personal information • Connect for Health Colorado produced telenovelas and transcreated materials for Spanish-speakers • Washington Healthplanfinder developed health literacy materials in eight languages and customized for different Indian tribes
<p>Federal Marketplace</p> <p><i>Study states: Florida Texas</i></p>	<ul style="list-style-type: none"> • Funded navigator grants in 34 states for both OEs, with a decrease of 15 organizations and \$7 million from OE1 to OE2 • Navigator groups selected based on criteria including experience with underserved populations, with many targeting diverse communities • Agents/brokers and CACs also certified to enroll in all FFM states (no IPAs) 	<ul style="list-style-type: none"> • Separate Spanish federal enrollment website • Navigator and assister training offered in Spanish as well as English (not seen in state-based marketplaces) • Translated application in 33 languages, more than in state-based marketplaces • Aired ads on ethnic media such as Telemundo, Univision, Latin Grammys, BET, sporting events, and Radio One • Organization receiving the largest navigator grant in the nation was in Florida, and it used “heat maps” to visualize race/ethnic/language data and track enrollment progress • A large navigator organization in Texas formed an “incident command structure” in Houston region to collaborate with others, map the uninsured, and target diverse communities • A navigator grantee in South Texas employed Community Health Workers and bilingual <i>promotores</i> to serve as navigators to reach and enroll Hispanics in culturally and linguistically appropriate ways
<p>Partnership Marketplaces</p> <p><i>Study states: Arkansas Illinois</i></p>	<ul style="list-style-type: none"> • Federal government funded navigators in partnership states • Most partnership states supplemented federally funded navigators with state-funded IPAs, though state-funded assisters were not allowed in Arkansas for OE2 due to state legislation • Agents/brokers and CACs available in partnership states 	<ul style="list-style-type: none"> • Targeted outreach and assistance to large immigrant and refugee populations in collaboration with community nonprofits (e.g. Marshallese community in Arkansas and resettled refugees in Illinois) • Get Covered Illinois partnered with faith leaders on hundreds of enrollment events in both OEs • A navigator organization in Illinois targeted outreach to migrant farmworkers in rural areas through events at farms, libraries, and churches

Interview Findings

We spoke with marketplace officials and consumer assistance groups in the 11 states highlighted in this report, as well as several national organizations, to ascertain innovations, successes, and challenges in reaching diverse populations through the marketplaces, with an emphasis on experiences from the second open enrollment. The narrative that follows describes important common and distinct themes and observations that emerged from the interviews.

Marketplace Experiences, Lessons, and Adaptations

Overall, states and organizations commented that they experienced fewer problems in the second open enrollment period compared to the first due in significant part to technology improvements; marketplaces and assisters having more experience with outreach and enrollment; and the expansion of activities that were found to be beneficial from the first open enrollment, especially in targeting the remaining uninsured including diverse populations. In the following narrative we highlight what interviewees identified as the successes, lessons, and innovations in reaching and enrolling diverse populations; the next section focuses on challenges that remain as we move into subsequent enrollment periods.

Community and in-person approaches to reach and enroll diverse populations. While details of the methods used may sometimes differ, all marketplaces and enrollment organizations stated that community-based and in-person efforts offered the greatest potential for reaching diverse populations. These include working with trusted community organizations, providing in-person assistance in consumers' preferred languages, and offering culturally competent written and oral messages. While these are not new concepts, especially by the time of the second open enrollment period, their value has been reaffirmed consistently in research and anecdotal experiences.

Marketplaces and enrollment organizations agreed that the best ways to reach diverse populations are by working with trusted community organizations, providing in-person assistance in consumers' preferred languages, and offering culturally competent written and oral information.

Within the parameters of what is known to be effective, most marketplaces and organizations were hesitant to identify any one specific method that was the best way to reach certain diverse populations, instead preferring to “push all the buttons” with a comprehensive approach and increase everything that worked previously as much as possible. This included:

- More advertisements targeted to ethnic TV, radio, and print;
- More publicity through media outlets, social media, and trusted community leaders;
- Increasing the number and breadth of materials in different languages;
- Using direct mail, e-mails, and phone calls for those who provided contact information;
- Greater numbers of bilingual in-person assisters and call center representatives; and
- Trying to find the most convenient and effective locations to make in-person assistance available.

Faith-based institutions as well as other trusted familiar locations such as schools, libraries, health clinics, and small neighborhood shops were important partners for reaching diverse populations

in many states. Marketplaces and navigator organizations often used census data including Public Use Microdata Areas (PUMAs)³⁶⁸ and other analytical methods to identify neighborhoods that were likely to contain more uninsured individuals and to determine what ethnicities were present, such as was seen in Illinois, Florida, Colorado, California, Texas, and other states. Many states were also divided into regions to better coordinate outreach and enrollment activities, such as was the case in California, Florida, Maryland, and Washington. A common sentiment shared among assisters and advocates was that it would be helpful for the federal and state-based marketplaces to release more detailed demographic and geographic data on enrollees, even if some did not respond to all questions. Making available these measures can assist in gauging the effectiveness of outreach efforts in different areas and for different populations as well as in identifying where more work is needed.

Enrollment venues. Some states had fewer in-person assisters in the second open enrollment period than the first, but tried to use them more strategically. Some assisters used their offices and found that consumers preferred making appointments at permanent locations, which worked well as individuals knew that assisters were there every day, knew ahead of time to bring the correct documentation, and did not have to wait for hours. In addition, many interviewees noted that large enrollment events were not the most effective venues for enrollment, as they were not as well attended as in the first open enrollment period, and enrollees often did not bring the correct documents or had to wait for long periods of time to be helped by an assister.



An exception noted by some interviewees was large events that were not solely for enrollment, as Enroll America and some states have had success reaching Hispanics and other groups at large health fairs that also included health screenings and information, ethnic food and music, children’s activities, and other entertainment to draw families. Some interviewees noted that other recreational locations, such as zoos, were not very effective as people were not prepared to engage in enrollment. Some states used storefronts successfully, such as Connecticut, though others such as California were not able to generate as much traffic as hoped.

Targeting subpopulations in addition to broader racial and ethnic groups. During the second open enrollment period, the federal government and many states such as California and Colorado made an extra push to reach Hispanics/Latinos, determining that they were lagging in enrollment numbers; these targeted efforts often paid off. However, some interviewees noted the need to also recognize smaller populations and subpopulations that are often missed when targeting broader racial and ethnic groups. These include, for example, the Marshallese community in Arkansas, Russian communities in Washington, Somali communities in Oregon, and the many subpopulations of Asians and Pacific Islanders in the nation that have significantly different levels of income, health insurance, English proficiency, and literacy. For example, whereas only 7% of Japanese Americans were uninsured in 2012, approximately 26% percent of Tongan Americans reported not having health coverage.³⁷⁰ These population distinctions are often missed when Asians and Pacific Islanders are grouped as one, and therefore point to the importance of targeted, subpopulation-level planning, outreach, and enrollment.

Certain low-income populations also require more targeted efforts. For example, one key informant noted that some lower-income populations tend to move more often, and suggested that a public service announcement from the U.S. Postal Service in the form of a notice inserted in address change kits could remind consumers to update their addresses with the marketplace and their insurance companies to continue receiving important notices. Messages regarding options for health insurance from the Social Security Administration to new applicants for Social Security numbers could also help new immigrants.

Consumer awareness of the marketplace.

Several interviewees felt that awareness of the marketplace and policies like the individual mandate were generally higher than in the first open enrollment period due to advertising and word-of-mouth, while several others thought that awareness seemed lower among many consumers they saw due to the ACA not being front-page news as much in the second open enrollment and as attention turned to engaging harder-to-reach populations. A few interviewees were somewhat surprised to see the amount of effort and education that it continued to take to reach and enroll individuals as they thought awareness would be higher by now, even in diverse communities.

Importance of word-of-mouth. Several interviewees noted that word-of-mouth is important in diverse and immigrant communities for spreading awareness and for helping to overcome fears and mistrust, such as in mixed-status families. Diverse families that had positive experiences enrolling with certain navigators or brokers were much more likely to spread positive word to their communities and send more people to those assisters than families without cultural or language barriers. Conversely, if individuals from diverse communities experienced problems with technology or language/culture issues and were hindered or not able to enroll, they were more likely to spread that message as well, fostering a negative reputation that may have inhibited others from trying. Marketplace focus groups of diverse individuals have confirmed this contention, with many perceiving that the marketplace was

**Common Interview Themes:
Promising Practices for Enrolling
Diverse Populations**

1. Work with trusted, culturally and linguistically competent messengers and in-person assisters.
2. Work to advance positive experiences and word-of-mouth as in certain diverse communities this is important for spreading awareness, dispelling myths, and helping overcome fears.
3. Assure in-person assistance is sustained over time, including between open enrollment periods to provide continued education and support.
4. Continue to make an intentional effort to plan for, reach, and assist diverse and vulnerable populations and subpopulations.
5. Utilize and analyze data to identify communities in need, and target interventions by region, population, community, or other factors.
6. Collaborate with community groups, including non-health-based or non-traditional groups, to reach harder-to-reach diverse communities.
7. Work with bilingual assisters as much as possible, as a language line where the interpreter is not present may not offer the level of assistance needed to help an individual enroll and effectuate.
8. Assure ongoing input from diverse community representatives.
9. Understand that the enrollment process—especially when compounded by language, culture, or lack of trust—can take much more time and “multiple touches” than anticipated to help people renew, answer questions on using insurance, interpret notices, and handle other concerns.

not for them if they were not assisted properly and if they did not feel a personal connection or benefit.

Building a Sustainable In-Person Assistance Program. Many interviewees noted that it took a lot more time than expected during the second open enrollment to assist people with renewing health plans and the accompanying details such as changing subsidy amounts, and to help with questions. Individuals, especially those who were LEP, who used certain organizations or assisters in the first enrollment period often came back to them later bringing mailed notices and tax forms they did not understand or questions they had about using their insurance. These findings reinforce the contention that payments to navigators that are based only upon how many new customers they enroll, such as in California, may not necessarily reflect demand, how effective they were at assisting target populations, or how many individuals they helped retain in marketplace plans.

Several states noted that having full-time in-person assisters was preferable to using those who assisted part-time and had other job duties as well, since devoting full time to in-person assistance afforded the assister the opportunity to gain more experience and become more efficient and productive, and also to be available to see more repeat customers with follow-up issues. Several marketplaces encouraged or required full-time in-person assisters in the second enrollment period, such as in the Get Covered Illinois in-person counselor program where grant-funded assisters were required to be full time and dedicate at least 37.5 hours per week to enrollment activities. Another promising practice for building a skilled assister workforce was to assure regular and ongoing communication between marketplaces and the assisters. In states with successful outreach and enrollment, assisters received ongoing education, training, and materials, whether through e-mails, newsletters, conference calls, webinars, or regional meetings, with marketplace updates, tips, and best practices.

Finally, the first enrollment period overwhelmingly revealed that reaching and enrolling individuals requires time, multiple “touches” or interactions, and ongoing guidance to help individuals understand and appropriately use health insurance. This finding was reinforced in the second round of enrollment, pointing to the need to employ a number of navigators and other assisters year-round to continue to help people with enrollment as well as maintaining and using their health plans. These responsibilities require long-term sustainable funding that may extend beyond fees on health plans since federal grant funding—the primary resource for these positions for the first and second enrollment periods—is ending for state-based marketplaces. Several marketplaces have turned to private philanthropies (for example, the Colorado Health Foundation and the Connecticut Health Foundation) for funding assistance, which have been important resources for ACA-related initiatives in a few states.

Marketplace Concerns and Challenges

In this section, we highlight remaining challenges and gaps discussed by interviewees in reaching and enrolling diverse populations. In many cases, these challenges form the foundation for marketplace improvement moving forward.

Technology. In the context of marketplaces, it is often difficult to separate enrollment problems from technology problems as the systems are so intricately tied together. And while almost all states, as noted above, reported a less problematic online enrollment experience for the second

open enrollment period, recurrent software problems did occur, and in several states (such as Oregon and Maryland) assisters and consumers had to learn new interfaces and create new accounts because the websites were replaced. In many states as well as the federal marketplace, back-end systems were not yet fully integrated, so although initial enrollment was more straightforward to consumers, problems arose in transferring information to carriers, the IRS, or to state Medicaid systems.

These experiences led several states to comment that they had not yet achieved the “no wrong door” goal envisioned in the ACA, where consumers could gain access to insurance through any entry point and apply for any program with seamless real-time eligibility and enrollment. Connectivity between the marketplace and Medicaid seemed to be working in some states such as California and New York, but there were many issues in other states, for example consumers having to be rejected from the Medicaid system before applying for marketplace coverage in Colorado, Medicaid information being transferred to paper and re-entered in Connecticut, consumers in Washington and Maryland sometimes having to be transferred to different assisters, and issues in Washington with payment transfers to insurance companies. States acknowledged that any time consumers have delays or have to be passed to different agencies, they risk losing them from the system altogether, especially diverse and LEP populations that may not understand what else they need to do in order to enroll and may think it is too difficult to pursue. As research has confirmed, resolving this circumstance is of critical importance in maximizing enrollment. A report commissioned by the Connecticut Health Foundation showed that full implementation of “no wrong door” in Connecticut would increase insurance enrollment by 13%, with children and diverse populations seeing the greatest gains.³⁷¹

Enrolling immigrants. Recurring concerns in interviews included the ongoing need for education and health insurance literacy in buying and using insurance, especially in diverse populations (see Discussion section below for more on this topic), and issues in some states that disproportionately affect immigrants. One such issue is the reluctance in some mixed-immigration-status families of enrolling in health insurance or giving family information to government agencies, due to mistrust of government and fear of having undocumented family members exposed and deported, or of being considered a “public charge,” which can affect

Legal immigrants barred from Medicaid for residing in the country for less than five years in states that enforce a five-year bar can receive subsidies in the marketplace, even if their income is below 100% of the poverty level; however, this is often not known or is confusing for consumers and assisters, and enrollment systems often do not recognize this exception.

residency and citizenship proceedings. States such as New York have worked to minimize these fears; for example, its long history of immigrant-focused initiatives includes a state-funded program for immigrants not eligible for Medicaid due to federal rules. Washington developed strategies to communicate widely that information is safe, and it saw many undocumented parents enrolling documented children. Covered California also communicated this extensively through media and fact sheets, and worked with well-known immigrant-rights organizations to spread the message. But immigrant concerns remained significant in other states such as Texas and Arkansas, and in all states it required repeated messaging to reassure families.

Legal immigrants barred from Medicaid due to immigration status, such as for residing in the country for less than five years in states that enforce a five-year bar, can apply and receive

subsidies in the marketplace, even if their income is below 100% of the poverty level.³⁷² However, this option is often not known or is confusing for consumers and assisters, and furthermore, even if an individual is eligible, enrollment systems often do not recognize this exception to the general rule and require work-arounds and delays.³⁷³ For example, in Oregon, HealthCare.gov would direct these applicants to Medicaid due to low income, then when they received a denial notice from the state's Medicaid system due to being ineligible for residing in the country for less than five years, they could call the federal call center, where staff could override the system and enroll them in coverage with subsidies. While the technical issues are ironed out, eligible immigrant populations will require greater strategic outreach to inform them of and navigate this option.

Other immigrant-related information technology issues continue to surface and were mentioned by several key informants including difficulties with identity verification due to lack of credit history and difficulty uploading immigration documents, as reported previously. These complications all reinforce the need for in-person assistance to help individuals resolve these problems and confirm their eligibility so that they can successfully enroll.

Selected Resources for Reaching Diverse Populations

- **Enroll America** has published numerous helpful materials and best practices for outreach and enrollment, including those targeting diverse communities. Its latest report from after the second open enrollment noted that disparities remain in the rates of uninsurance in diverse communities, concluding that “data-driven techniques and partnerships with trusted messengers at the national and local levels were more important than ever.”³⁷⁴ Some of its many online toolkits include those with promising practices on working with faith communities, reaching Latinos, and reaching African Americans.³⁷⁵
- **The Centers for Medicare and Medicaid Services** published best practices for reaching Latino communities, and noted that among the many barriers to obtaining coverage, cost is the top barrier for uninsured Latinos. It lists recommended messaging and education needed for effective outreach to and enrollment of Latinos.³⁷⁶
- An **Urban Institute** study on outreach and assistance interviewed navigators, policymakers, and others in 24 states and developed a number of promising practices and recommendations.³⁷⁷
- **Action for Health Justice** published lessons learned and recommendations for reaching and enrolling Asians and Pacific Islanders and overcoming barriers including language issues.³⁷⁸
- **Kaiser Family Foundation** examined successful strategies used in Colorado, Connecticut, Kentucky, and Washington during the first open enrollment period.³⁷⁹

Points for Consideration Moving Forward

Our in-depth-review of the 11 case study states uniquely reveals how state-based, partnership, and federally facilitated marketplaces have evolved and positioned themselves to better reach and enroll racially and ethnically diverse individuals and families, estimated to comprise nearly half of the eligible population. While considerable progress has been made, as evidenced by the overall reduction in the nation's uninsured rates across all races/ethnicities post-ACA, there is much more to be done to close longstanding gaps in coverage and access to care within states as well as within certain populations and subpopulations. In addition, simply having insurance does not

guarantee that individuals know how to use their health insurance or navigate the system to access health care. And many more have yet to be reached, including some of the hardest-to-reach populations who are often isolated geographically or by language, culture, immigration status, or other factors. This section addresses continuing challenges and describes several important considerations in the ongoing dialogue to best meet the needs of racially and ethnically diverse populations in marketplace outreach, enrollment, and health coverage utilization.

Advancing Health Insurance Literacy

Many key informants and other sources identify health insurance literacy, sometimes just called health literacy (encompassing all types of healthcare-related literacy), to be a broad and significant need that is becoming more evident as outreach and enrollment continues. Many individuals, especially low-income populations and immigrants from countries with different health care systems, have not been covered by health insurance previously and are not familiar with the intricacies of how to navigate the U.S. health system. The numerous choices of plans and details, the need to renew coverage each year, and the different types of health care settings makes understanding how to buy and use health insurance difficult for anyone, and more so for diverse families who have not used insurance before and for whom English is not their first language.^{380,381}

The ACA includes provisions intended to help consumers understand their insurance, such as by grouping plans into actuarial levels and by requiring standardized Summary of Benefits and Coverage documents that include costs for two common conditions—pregnancy and diabetes—for comparison. But more needs to be done to educate consumers, especially as assisters and physician offices often end up struggling to help them understand unanticipated bills and other issues.³⁸² Low health insurance literacy can lead individuals to choose plans with co-payments and deductibles they cannot afford because they notice the monthly premium is lower, for example, or can prevent them from understanding they have to pay the premium even in months they do not receive services or that they may have to pay much more if they see a non-network provider. Such situations create confusion and hardships for individuals as well as inefficiencies in the health care system.

“Health insurance literacy measures the degree to which individuals have the knowledge, ability, and confidence to find and evaluate information about health plans, select the best plan for their own (or their family’s) financial and health circumstances, and use the plan once enrolled.”
-Consumers Union

Many organizations including the marketplaces are attempting to address health insurance literacy. For example, Access Health CT in Connecticut developed step-by-step guides for enrollment and renewals, created a series of short videos on health insurance with a TV station, and is exploring the development of a health literacy curriculum with the University of Connecticut. Connect for Health Colorado e-mails newsletters to customers that include information on health insurance topics and uses social media to explain terminology. It also produced a telenovela targeted to Latinos that shows an uninsured family overcoming barriers and becoming insured.³⁸³ In addition, the Colorado Consumer Health Initiative created an interactive website called CoveredU with easy-to-understand information in English and Spanish on buying and using insurance.³⁸⁴ Washington Healthplanfinder developed materials including short videos on health plans for consumers and a health literacy toolkit for assisters.^{385,386} Other states are working on or considering health insurance literacy activities as well.

On the national front, Enroll America has gathered a large collection of health insurance literacy resources, including fact sheets, videos, and other tools for consumers and assisters, with some available in Spanish.³⁸⁷ The Alliance for Health Reform also published a collection of health insurance literacy resources.³⁸⁸ CMS developed an initiative called From Coverage to Care that includes videos and print resources in English and Spanish, and the “Roadmap to Better Care and a Healthier You” is in seven other languages as well.^{389,390} The Kaiser Family Foundation published a series of cartoon videos in English and Spanish that explains insurance concepts, payments, accessing care, and filling prescriptions.³⁹¹ Families USA also has many helpful documents on its website in English and Spanish for assisters to use with consumers.³⁹²

There are other related categories of low literacy that affect diverse communities as well, such as low technical or computer literacy, which results in some low-income consumers not having an e-mail address or understanding passwords needed to create online accounts for marketplaces; and low numeracy—low math skills—that results in many individuals not being able to easily calculate what their health care costs are when taking into account subsidies, cost sharing, co-payments, and whether or not they have reached their deductibles. These are not easy problems to overcome, as they involve root concerns of education and literacy levels, inequality, and life experiences—and in so doing underline the influence and importance of addressing social determinants in health insurance as well as in health care outcomes.

Assuring Sustainable Marketplace and Navigator Funding

As mentioned previously, in-person assistance has repeatedly proven to be an essential component in the enrollment of certain populations, especially diverse individuals. Marketplaces will likely experience a decrease in the number of assisters as federal funding ends, but some level of community-based in-person assistance is critical to maintain indefinitely, even as technology barriers improve, since insurance plans must be renewed each year and new individuals and families will continue to gain eligibility. A recent development from the federal government will help to maintain continuity in the navigator programs in FFM and partnership states, as the

A recent development from the federal government will help to maintain continuity in the navigator programs in FFM and partnership states, as the navigator grants awarded in 2015 for the third open enrollment period will last for three years instead of one year.

navigator grants awarded in 2015 for the third open enrollment period—slated for November 1, 2015, to January 31, 2016—will last for three years instead of one year.³⁹³ Grants will be funded in one-year increments during the three-year period.³⁹⁴

State-based marketplaces will need sustainable funding sources as well to continue to finance in-person assistance and other services. Marketplaces were supposed to be self-supporting by the start of 2015, but CMS allowed states to carry over unused federal funding into 2015. One important option to create self-sustaining marketplaces is to impose fees on health plans. Some states, such as California, Massachusetts, Oregon, and Washington (as well as the federal marketplace) are charging fees on the number of members and/or premiums paid on plans within their marketplaces, while others such as Colorado, Connecticut, and Maryland charge fees on health plans in the state both within and outside of the marketplace.^{395,396} However, fewer enrollees than expected or higher technology spending than anticipated have contributed to shortfalls in many states.³⁹⁷ Besides fees on health plans, a few states have used other sources such

as state appropriations or philanthropic foundations, but these sources may not be continuous or may not be sufficient to secure budgets over time.

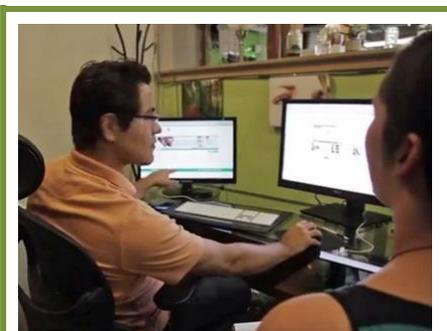
The future of state-based marketplaces is unclear. While several partnership marketplaces are making plans to become state-based, several state-based marketplaces have become more reliant on the federal marketplace, such as Oregon, Nevada, and New Mexico, or are considering it, such as in Minnesota where the governor called for a study on long-term sustainability of the marketplace, and in states like Hawaii and Rhode Island with small populations. Federally supported state-based marketplaces may have to start paying to use HealthCare.gov—CMS has indicated to Nevada that it would have to pay for federal support beginning in 2017, and other states could follow.³⁹⁸ Had the decision in the *King v. Burwell* case been that subsidies were illegal in FFM and partnership states, it would have conferred an advantage to establishing or keeping state-based marketplaces, but since the decision was that subsidies are allowed in all types of marketplaces, this could be a further consideration for states deliberating marketplace changes.

Supporting and Transitioning Trained Assisters

Navigators were originally envisioned to be a main source by which marketplaces would reach uninsured diverse populations, as they are obligated to meet cultural and linguistic competence requirements and the program was designed to use existing trusted organizations. Non-navigator personnel or IPAs in state-based and partnership marketplaces were intended to perform a similar role temporarily, until federal grants ended and marketplaces became self-sustaining. However, insurance agents and brokers (sometimes collectively called “producers”) and CACs at settings such as community health centers have enrolled more consumers than navigators/IPAs around the nation, due to their higher numbers, and are likely to be increasingly important in continuing the work of reaching diverse communities and the uninsured in the future. This is due not just to their prevalence but also that they are not compensated by marketplaces, since federal marketplace grants have ended and some state-based marketplaces are struggling with funding.

CACs and brokers have proved effective as community health centers and other community and health care settings are often trusted resources in diverse communities, and as a greater number of brokers speak more languages than anticipated. As such, they have become a significant source for diverse population enrollment in some communities.⁴⁰⁰ Other types of assisters such as plan-based assisters who work for health plans have enrolled consumers as well, although to a lesser extent. Reports from several states have contended that there is a degree of distrust between navigators and brokers, largely due to the fact that brokers are compensated by health plans and are not required to be unbiased. However, this difference can sometimes be an advantage in that brokers can recommend plans for people concerned about certain health conditions or financial situations, while navigators can only provide general information and application assistance, but not recommendations.⁴⁰¹

While there are many more agents/brokers and CACs than navigators, they are not required to conduct outreach like navigators. Thus marketplaces are likely to benefit from engaging with a



Assister in Colorado

Source: Connect for Health Colorado.³⁹⁹

broad spectrum of in-person assisters going forward—and encouraging them to work together—in order to have the best chance of reaching those needing in-person assistance. Community Health Workers and *promotores* can also perform critical outreach and enrollment functions given their experience and training in health outreach to communities. As such, marketplaces and navigator organizations can benefit by using them as assisters.

In assuring a knowledgeable and competent workforce, it is important to emphasize that all in-person assisters including agents/brokers and others not compensated by marketplaces must be trained and certified to assist with marketplace plans. Many marketplaces provide them with printed materials and support, and some have gone a step further. For example Get Covered Illinois created formal partnerships with agents/brokers, and Access Health CT has two brokers on staff to liaison with independent producers. Marketplaces also provide support to CACs and other types of assisters. As funding decreases, it will be important for marketplaces and assistance organizations to look for ways to transition trained assisters that marketplaces can no longer support to other programs not funded by marketplaces so that their valuable experience is not lost.

Improving Population-Specific Data Collection and Reporting

Although the collection and reporting of data on enrollees' races, ethnicities, and preferred written and spoken languages is crucial in efforts to assure cultural and linguistic competence in reaching and engaging the uninsured and in maintaining insurance status among those newly enrolled, these data points are often lacking. Most or all marketplace applications have long lists of racial and ethnic identifiers for consumers to mark, but marketplaces do not always report or use these data as many people (often a quarter to a third or more) do not answer these questions, and some marketplaces have hesitated to report incomplete data. Other marketplaces have not been able to compile this information from their systems or may not have sufficient staff time to analyze it. Further complicating efforts to collect and report is that the related questions are optional so marketplaces cannot force compliance. Section 4302 of the ACA requires standardized data collection for population surveys and federally funded health programs to help identify and address disparities, but this requirement does not extend to marketplace applications.⁴⁰² Individuals may not see the need for it or may not feel comfortable answering the questions, and anecdotal evidence also points to assisters skipping the questions to save time.

Many advocacy organizations around the nation have called for more detailed race/ethnicity/language data to be published by the federal marketplace and states. Recommendations include disaggregating such data, and including geographic region and plan selection to facilitate analysis of rates and types of coverage of different communities in different locations.⁴⁰³ For the data to be more accurate and useful, the response rates must be higher. Actions to increase responses could include inserting a sentence on applications as to why these data are needed and training assisters in attempting to collect it. One straightforward solution recommended in an evaluation of Covered California calls for the demographic data to be moved from the end of California's application to the beginning in order to increase visibility and likelihood of responses.⁴⁰⁴ Alternatively, the questions could also be embedded in the middle of the process so as not to hinder someone from starting the process, or skipping them in a rush to complete the application.

The states we analyzed reported race/ethnicity/language data in different ways, with some including non-respondents, some reporting Hispanic ethnicity separately from the racial

categories, some including the subsidy-eligible population only, one reporting data from a telephone survey and not from the application, and several not reporting at all. Several states also reported imputed data in addition to raw data, meaning they took the non-respondents and assigned them to different likely racial/ethnic categories by means such as surname and location, in order to deduce a more accurate picture of the racial/ethnic makeup of enrollees including non-respondents. Use of such tools and strategies can change the apparent trends in enrollment. For example, for the first open enrollment period, Covered California reported that Latinos comprised 25% of subsidy-eligible marketplace enrollees with non-respondents included, 29% with the race/ethnicity of non-respondents imputed to assign them to categories, and 31% when only respondents were counted.^{405,406} This shows that accurately comparing data from enrollment period to enrollment period or state to state requires using consistent data methods.

Churn and the Coverage Gap

There are several areas where Medicaid and the marketplaces intersect that affect diverse populations. One is the so-called “churn” that happens when enrollees move back and forth from one type of coverage to another based on changes in eligibility factors such as increasing or decreasing income. Churn can cause temporary loss of coverage due to administrative delays and disruptions in care that could harm health due to the discontinuity of health plans that may have different networks of providers. For low-income enrollees near the income cut-off between Medicaid and marketplace coverage with subsidies, this is a real possibility with just small

changes in income such as fewer hours worked for a period of time or gaining income from a part-time job or a roommate.⁴⁰⁸ One study showed that an estimated half of adults with family incomes below 200% of poverty will likely have to switch between Medicaid and marketplace coverage or vice versa in a year.⁴⁰⁹



Faith Leaders Breakfast in Seattle

Source: Public Health-Seattle & King County.⁴⁰⁷

Disruptions are often lessened in states such as Washington, New York, and Kentucky that have integrated Medicaid and marketplace information technology systems.⁴¹⁰ One option that can help to mitigate churning and its negative effects is to require or encourage carriers to offer plans in both Medicaid managed care and the marketplace so consumers with

changing incomes can move to a similar plan with less disruption. Other options are to use Medicaid premium assistance for private plans, or to implement 12-month continuous eligibility in Medicaid, though all of the options have technical complications.⁴¹¹ In states that decide to expand Medicaid, consumers between 100% and 138% of poverty could be faced with changing from marketplace plans to Medicaid even if their incomes do not change, as expanded Medicaid is intended to cover individuals with incomes up to 138% of poverty, and marketplace subsidy eligibility starts at 100% of poverty in non-expansion states.⁴¹²

In states not expanding Medicaid eligibility to 138% of poverty, the resulting gap in program eligibility between Medicaid—which differs between states but is generally very low and does not include childless adults—and qualification for marketplace subsidies at 100% of poverty in those states has resulted in an estimated 3.7 million people having no access to affordable health insurance.⁴¹³ This coverage gap disproportionately affects individuals from diverse communities,

as the gap is comprised of 57% adults of color,⁴⁴ and in states like Texas nearly three-fourths of those in the gap are non-white.

While these numbers paint a limiting if not bleak portrait for many in the non-expansion states, signs of reassessment are beginning to occur for several reasons: efforts by the federal government to consider “variations on a theme” in Medicaid design; internal state pressure from important constituents such as hospitals and other health care providers as well as advocates; states with Republican governors and legislatures such as Ohio that have voted for expansion; and, due to the potential windfall of funds that would flow, those well aware of the economic benefits. Monitoring and documenting these dynamics and their causes may shed light on how other states may opt to expand.

Marketplace Progress and the Remaining Uninsured

Marketplaces enrolled significantly more of the estimated eligible population in the second enrollment period than the first, from 28% to 42% (see Table 1). However, continued gains going forward may become smaller and more incremental. Research including surveys and focus groups with remaining uninsured individuals around the country shows that many feel they cannot afford coverage even with subsidies, and some remain unaware of the subsidies. Insuring low-income populations is further burdened in states not expanding Medicaid, thereby perpetuating the coverage gap. Finally, there are others who are not interested in buying health insurance at any price. These circumstances and personal decisions affecting insurance will require greater innovation and investment in educating potential enrollees as well as adapting current and developing new strategies to reach and enroll the remaining uninsured. Diverse populations are likely to be overrepresented among those remaining uninsured as they tend to have lower incomes on average, making it harder to purchase coverage, and may have cultural and language barriers that impede understanding of the process.⁴⁵

From reports that have emerged over the past few years and the research conducted for this project, it appears that the marketplaces are making steady progress in reaching and enrolling diverse populations and in following cultural and linguistic competency guidelines as required by the ACA. Community organizations have long known about the barriers in reaching certain groups due to experience working with these populations, and states have learned lessons as well in previous Medicaid and CHIP outreach efforts to diverse communities, but the creation of the health insurance marketplaces added new complexities in reaching these groups and completing the enrollment process with new computer systems and new laws governing costs and penalties. Marketplaces and navigators are generally adapting and are continually attempting to tweak messages and methods to best reach these groups, within current fiscal realities. Some have had more success than others, and while coverage rates are up around the nation, disparities remain. And as discussed in this report, many states, especially those at the marketplace forefront, acknowledge the formidable barriers to broadening insurance access for diverse and other populations that remain uninsured. Identifying and reporting these critical changes and adaptations as well as the extent to which they are successful may serve as a significant resource for other states and the federal government in working to maximize enrollment.

Questions for Further Study

We identified from interviews and literature reviews other important questions that will influence the ultimate value of insurance for diverse populations. Are health plan networks “adequate” in linguistic and cultural competency?⁴¹⁶ Do insurance companies maintain updated lists of providers in their networks and can consumers search for them by language/ethnicity? There are also related issues that affect many lower-income enrollees, not just diverse individuals, including if high deductibles are keeping consumers from seeking needed care, if consumers are aware of the importance of comparing plans every year and not automatically renewing in the same plan due to possible changes in prices and benefits, and if reconciling advance premium tax credits (subsidies) with income at tax time is contributing to financial burdens due to the difficulty in projecting income for those with fluctuating incomes. (A Kaiser study found that an estimated 50% of subsidy-eligible households will owe some amount of subsidy repayment with their income taxes due to changing incomes, and changes in family size can affect subsidies as well.⁴¹⁷) These and other uncertainties lead to perhaps the most trenchant question that still remains: does decreasing disparities in health coverage as envisioned by the ACA ultimately decrease disparities in health outcomes?

Conclusion

No two state marketplaces are alike in their details, differing in many aspects such as names of assister programs, types of materials and languages used, numbers of board members and advisory committees, website interfaces and software systems, and levels of funding. This variability has added much complexity to the original relatively straightforward concept of establishing an online marketplace that consumers in every state could use to compare and buy health plans. Nonetheless, these differences that have developed in conjunction with and response to evolving CMS regulations have allowed states to tailor their marketplaces to their individual demographics and diverse populations, existing resources, funding constraints, and political climates—as politics have had a larger effect than most could have predicted five years ago. Some states performed better than anticipated for the first two open enrollment periods and some have fared worse, but the one aspect that all marketplaces and outreach groups have in common is that all are recognizing the existing disparities in health coverage rates and are making notable efforts to reach uninsured diverse communities. There is still much work to be done, but the efforts of concerned organizations around the nation are helping to advance a vision of equity in health care for all communities in America.

Appendix A: Key Informant Interviews

- Seth Blomeley, Communications and Policy Research Manager, Arkansas Health Connector Division, Arkansas Insurance Department
- Sonciray Bonnell, MALS, Tribal Community Program Analyst, Cover Oregon
- Kelly Boston, Associate Director for Communications, Washington Health Benefit Exchange
- Elizabeth Charlow, MA, Communications Manager, Maryland Health Benefit Exchange
- Cliff Clark, Program Director, MHP Salud (Texas)
- Norberto Gonzalez, Program Coordinator, MHP Salud (Texas)
- Brian Gorman, Director of Outreach and Consumer Education, Get Covered Illinois
- Sinsi Hernández-Cancio, JD, Director of Health Equity, Families USA
- Linda Kanamine, Chief Marketing Officer, Connect for Health Colorado
- Christopher Mele, MS, Exchange Broker Sales Manager, Access Health CT
- José Muñoz, Chief Marketing Officer, Get Covered Illinois
- Rachel Oh, JD, Community Affairs Manager, Cover Oregon
- José Luis Plaza, MS, National Director of Latino Engagement, Enroll America
- Erin Pressley, MS, Director of Creative Services, Office of Communications, Centers for Medicare & Medicaid Services
- Jodi Ray, MA, Principal Investigator and Project Director, Florida Covering Kids & Families, University of South Florida College of Public Health
- Cary Sanders, MPP, Director of Policy Analysis and The Having Our Say Coalition, California Pan-Ethnic Health Network
- Lisa Sbrana, JD, Director, Office of Marketplace Counsel, NY State of Health
- Sofia Segura-Pérez, MS, RD, Associate Director, Center for Community Nutrition, Hispanic Health Council (Connecticut)
- Leslie Lyles Smith, MBA, Director of Operations, Maryland Health Benefit Exchange
- Kecia Stauffer, Associate Marketing Manager, Access Health CT
- Jennifer Sullivan, MHS, Director, Best Practices Institute, Enroll America
- Jennie Sutcliffe, Policy Analyst, Get Covered Illinois
- Heather Taber, Assistance Network Manager, Connect for Health Colorado
- Oliver J. Vera, MBA, Manager Community Partner Program, Oregon Health Authority
- Mary Watanabe, Deputy Director, Sales Division, Covered California

The authors wish to acknowledge and thank these individuals who provided their time for telephone-based semi-structured interviews (note: some conference calls had more than one participant, and several interviews were via e-mail). Views expressed in this report are of the authors only and are not to be attributed to the interviewees.

Endnotes

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