ADVANCING HEALTH EQUITY IN THE HEALTH INSURANCE MARKETPLACE:

RESULTS FROM CALIFORNIA'S MARKETPLACE HEALTH EQUITY ASSESSMENT TOOL (M-HEAT)

EXECUTIVE SUMMARY

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Developed by:
Texas Health Institute
In collaboration with Health Access and California Pan-Ethnic Health Network
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ABOUT TEXAS HEALTH INSTITUTE

Texas Health Institute (THI) is an independent, nonpartisan, nonprofit organization with the mission of improving the health of communities in Texas and nationally. As a respected leader in Texas, THI acts as a neutral convener, facilitates balanced health care dialogue, creates a vision of improved health care, addresses health disparities, and develops feasible solutions to health problems through collaboration. Nationally, THI's Health Equity Team has been monitoring the evolution of health care reform since 2008, and has undertaken a singular national, multi-year, multi-funder initiative to monitor and report on the implementation progress of the Affordable Care Act from a health equity and cultural competency perspective. These efforts are intended to increase awareness and education among stakeholders and practitioners while also facilitating dialogue, advocacy, and policy. To find this report online, as well as other related reports on health care reform and health equity, please visit www.texashealthinstitute.org/health-care-reform.html.

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INTRODUCTION

With support from The California Endowment and W.K. Kellogg Foundation, Texas Health Institute developed and administered the Marketplace Health Equity Assessment Tool (M-HEAT) to measure California's progress toward advancing health equity in its marketplace. Health equity is defined as the attainment of the highest level of health for all people. Central to this goal is the assurance of health insurance coverage and access to care for all. The M-HEAT is intended to help marketplaces and their stakeholders identify the extent to which the marketplace is working to advance enrollment, retention, and access to care for all populations, and especially those historically disenfranchised.

In this report, we feature findings from the pilot administration of the M-HEAT in California in October 2015-2016. Findings combine public data on California's health insurance marketplace, known as Covered California, with data on perceptions of progress from community stakeholders and advocates. Results shed light on areas where Covered California is leading as well as opportunities to build on significant initial progress to reach, enroll, and retain all in coverage, regardless of race, ethnicity, spoken language, and gender identity.

METHODS

Following is a summary of key methods undertaken to develop, administer, and analyze results of the M-HEAT:

- **Community Stakeholder Advisory Group.** In Fall 2014, THI worked with The California Endowment to assemble a Community Stakeholder Advisory Group to help inform and guide the development, administration, and evaluation of California's M-HEAT. After an initial meeting, members of the Advisory Group were engaged to offer feedback on drafts of the M-HEAT. An in-person meeting took place in October 2016 to discuss results.

- **M-HEAT Development.** THI developed two versions of the M-HEAT including a marketplace self-assessment tool and a community stakeholder

The Marketplace Health Equity Assessment Tool (M-HEAT)

What is the M-HEAT?

The M-HEAT is a tool to help measure health insurance marketplace progress and performance toward health equity. It compiles and orders data from two perspectives: the health insurance marketplace *and* community stakeholders. As such, the tool contains two components:

- An 87-item health insurance marketplace assessment administered electronically; and

- A 46-item community stakeholder survey administered online.

What are the M-HEAT's Objectives?

- To take stock of the marketplace's ***actual health equity initiatives***;

- To understand the marketplace's ***progress and performance*** toward health equity; and

- To provide ***external, community-based validation*** of the marketplace's progress and performance toward health equity.

What does the M-HEAT Tell Us?

- Level of ***commitment*** to health equity across marketplace functions;

- Point-in-time and over-time ***progress*** toward health equity;

- Program ***strengths and gaps*** toward health equity; and

- Marketplace and community-based ***opportunities*** for improving efforts to advance health equity.

survey, based on an extensive review of the literature on state-based marketplaces and existing health equity assessments. The final tool covered six topics from a health equity perspective.

- **Marketplace Assessment.** While Covered California offered some guidance and feedback, the bulk of data on the 87-item marketplace version of the M-HEAT were collected between January and September 2016 through publicly available reports and documents. We compiled a breadth of publicly available data to complete approximately 70% of the assessment.

- **Community Stakeholder Survey.** The 46-item, abridged community version of the M-HEAT was administered online via Survey Monkey between October and December 2015. The survey was sent to individuals at 341 organizations across the state. We received responses from 76 organizations (22% response rate). Twenty-eight percent of respondents identified as community-based organizations, 24% were advocacy groups; 17% were health centers or clinics, and 8% were local health departments. Over 80% of organizations had worked in some capacity with Covered California on outreach, education, or enrollment. Over 60% were a navigator grantee or enrollment entity.

M-HEAT's Six Content Areas

Part 1: Organizational Commitment to Advancing Health Equity which assesses the extent to which the marketplace has made a commitment to health equity in organizational policies, financial resources, and human resources.

Part 2: Plan Management and Health Equity which asks about active purchasing, disparities data collection, and network adequacy.

Part 3: Community Engagement and Collaboration which focuses on the process and progress of diverse community and stakeholder engagement.

Part 4: Navigator and In-Person Assistance Programs which asks about the scope and reach of programs, training, and language services.

Part 5: Marketing and Communication which asks about the ways in which marketing and outreach explicitly targets diverse populations.

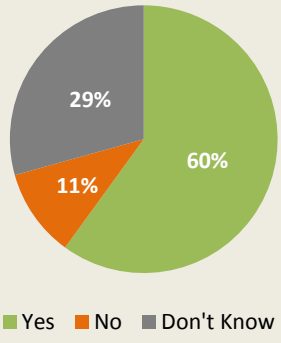
Part 6: Marketplace Outcomes which includes questions on number enrolled, renewed, and churned, as well as health care access measures.

RESULTS

Organizational Commitment to Health Equity

Strategic and Financial Commitment. Since its establishment in 2010, Covered California has reflected health equity principles in its mission and value statements. However, only 60% of community stakeholders were aware of this strategic commitment, fewer than half (43%) felt this commitment had been communicated well. Over time, 56% of stakeholders felt Covered California's commitment to health equity had increased. Covered California generally does not forecast, allocate, or record overall spending across all marketplace functions by population group, limiting our ability to quantify organizational investment in health equity. However, specific programs such as marketing and navigator do allocate and report funding by

Stakeholder Knowledge of Covered California's Formal Commitment to Health Equity



race/ethnic group. Four in five surveyed stakeholders believed it was important to allocate resources to diverse populations, and 98% perceived Covered California had done this at least somewhat.

Leadership and Staff Diversity. Covered California has affirmed the importance of hiring staff that reflect the diversity of the population it serves. Stakeholders generally agreed with this perception, with very small percentages feeling diversity did not exist at all in staffing or call centers. Fewer than one-third, however, felt marketplace Board members and executives reflected California's diversity mostly or to a great extent. In 2015, Covered California hired a Health Access and Equity Officer, the first equity-centric leadership position in any state marketplace, but as of 2016 the position was no longer reflected in the Covered California organizational chart.

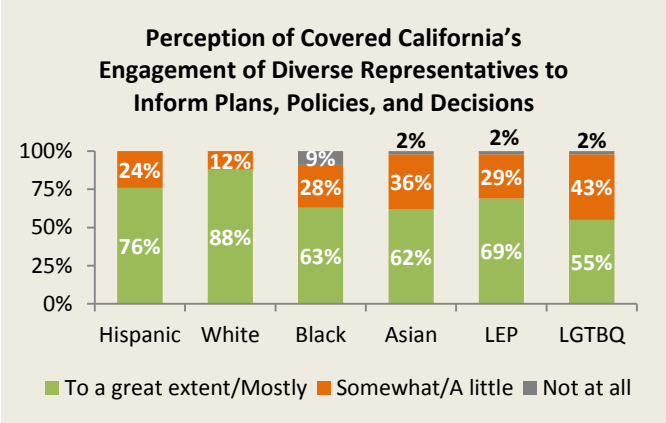
Plan Management and Health Equity

Active Purchasing and Data Requirements. California is one of six states that operate an "active purchasing" marketplace, meaning that plans must meet stringent criteria that optimize access, quality, and value to consumers in order to be sold on the marketplace. Stakeholders clearly recognized the impact of Covered California's active purchasing approach on preserving affordability of plans; two-thirds of respondents (66%) remarked that Covered California assured affordability mostly or to a great extent, and no respondents felt plans were not at all affordable. As of 2016, plan requirements feature a renewed emphasis on equity, including new data collection requirements with a strong disparities reduction focus. Beginning in the 2017 contract period, all plans will be required to achieve a response rate of 80% or above on self-reported race and ethnicity questions by 2019. In addition, health plans will be rewarded with incentives if they can demonstrate racial/ethnic health disparities reductions in diabetes, hypertension, asthma, and depression.

Health Plan Access and Network Adequacy. In alignment with California regulatory requirements, Covered California requires plans to maintain a "sufficient" number and geographic distribution of essential community providers (ECPs) in their network. Culturally and linguistically appropriate communications, including oral interpretation and translated materials, must also be available to enrollees at no cost. Even with requirements in place, advocates have recently challenged their enforcement, noting that while Spanish is usually available other Medi-Cal threshold languages (including many Asian languages, Armenian, Arabic, and more) often are not.

Community Engagement and Collaboration

Overall Engagement and Incorporation of Feedback. In September 2012, shortly after its launch, Covered California developed a Stakeholder Engagement Plan to formalize methods for engaging stakeholders in the marketplace's policies and decisions. The plan details opportunities for stakeholders to advise the marketplace, primarily through engagement at Board meetings and participation in marketplace advisory groups. While a majority of respondents agreed that White (88%), and to a lesser degree Hispanic (76%) stakeholders were engaged mostly/to a great extent, two-thirds or fewer reported this was the case for Blacks, Asians,



limited English proficient, and LGBTQ populations. Stakeholders also felt that feedback from White and Hispanic advocates and stakeholders was more often incorporated by the marketplace than feedback from those representing other populations.

Cross-sector Collaboration. Covered California has collaborated with multi-sector partners to advance its health equity mission and goals. For example, the marketplace funds hundreds of community-based organizations to deliver enrollment assistance, engages faith communities and small businesses in target geographic areas (e.g., barbershops) to conduct outreach, and has relied on ethnic and LGBTQ media for much of its marketing. Of Covered California's existing partnerships, stakeholders most often rated those with community-based organizations as effective, while suggesting there may be room for further enhancing partnerships with ethnic media, LGBTQ media, and faith groups.

Navigators and In-Person Assisters

Funding and Diversity of Navigators and Assisters. Covered California and its enrollment partners have worked to cultivate a robust cohort of enrollment assisters. Since 2014, nearly 100% of Covered California's Navigator grantees and program dollars have gone to organizations explicitly targeting diverse populations. About two-thirds of respondents felt enrollment assistance organizations were representative or very representative of diverse populations, and fewer than 2% felt they were not at all representative. However, there was some sense that representation was relatively less strong for LGBTQ communities compared to racially/ethnically diverse and limited English proficient (LEP) groups.

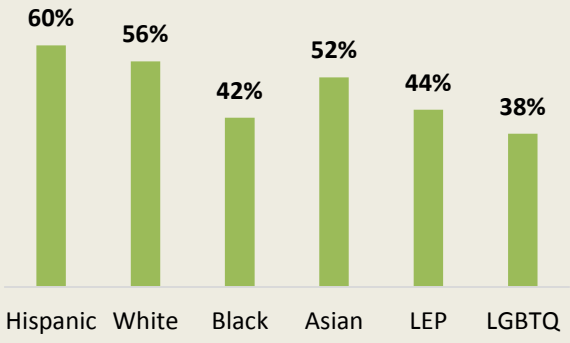
Language Access. Although Certified Insurance Agents outnumber Certified Counselors by a ratio as high as three-to-one, roughly three times as many Certified Counselors are able to assist consumers in Spanish: between 45% and 59% of counselors are Spanish-speaking, while this is true for just 17% of agents. In contrast, the proportion of agents and counselors who speak Asian languages is more comparable.
Slightly more than half (54%) of stakeholders believed Covered California customers received interpretation sometimes or rarely, while just under half (46%) said interpretation in a consumer's requested language occurred always or very often. Further, only 39% reported that enrollment entities received adequate training on delivering culturally and linguistically appropriate services.

Proportion of Enrollment Assistance Personnel Speaking Languages Other than English, 2016

Language	Certified Insurance Agents	Certified Counselors*
Spanish	17%	45-59%
Cantonese	7%	4-10%
Mandarin	7%	2-4%
Korean	4%	1-7%
Vietnamese	4%	1-8%

*The range provided includes multiple counselor types.

Perception of Being Engaged Very Often or Always to Vet Marketing Materials, by Population Group



Marketing and Outreach

Overall Strategy. Covered California's marketing plan explicitly incorporates health equity into marketing and outreach functions, including research, creative engagement, social and paid media campaigns, and accessibility of the marketplace website. Covered California has directed

approximately 44% of its media spending toward the general market or multiple segments, 39% toward Hispanic populations in both English and Spanish, 10% towards Asian populations in multiple languages, and 7% toward Blacks. Seventy-eight percent of surveyed community stakeholders perceived that marketing and outreach resources were mostly or almost perfectly aligned with White and Hispanic/Latino populations needing to be reached, respectively. Far fewer reported this was the case for all other population groups such as Blacks (43%), Asians (38%), and LGBTQ (19%).

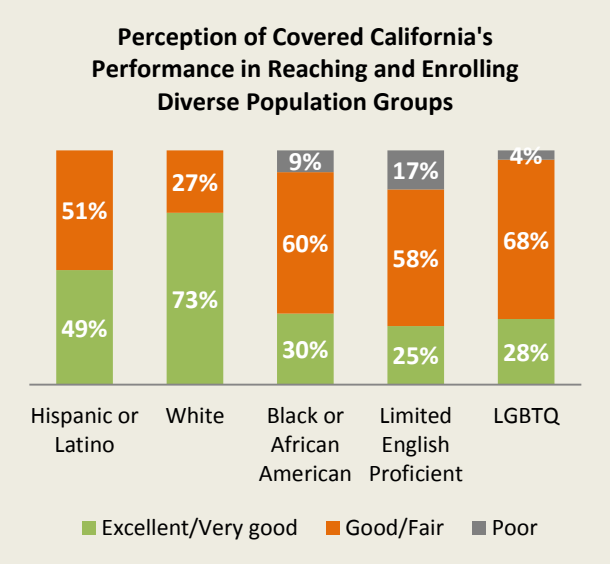
Stakeholder Engagement to Inform Marketing. When asked to what extent they perceived marketing materials were vetted by diverse community members, respondents felt that Hispanics/Latinos, Whites, and Asians were most often engaged in this process. Fewer reported engagement of other diverse groups, such as Blacks, those with limited English proficiency, and LGTBQ populations. When asked to report how often community stakeholders felt that feedback from diverse representatives was incorporated into marketing, all acknowledged that feedback was at least sometimes incorporated. But only 12% felt that feedback from diverse representatives was always or very often incorporated.

Marketplace Outcomes

Enrollment, Retention, and Churn. Covered California enrolled 1,387,540 individuals in the 2015-16 open enrollment cycle, about 91% of whom received subsidies. Roughly one million enrollees have renewed their coverage in the two most recent enrollment cycles. Churn data reveal the average tenure of a Covered California enrollee is 25 months, with 15% of disenrolled members becoming uninsured. Subsidized enrollment by race/ethnicity is generally reflective of the estimated demographics of Covered California's estimated subsidy eligible population, with differences between eligible and enrolled of less than four percentage points for most race/ethnic groups. However, differences are larger among some groups, especially Hispanic/Latinos. Of note, Covered California reported that roughly one-fifth of its enrollees indicate a preferred spoken language other than English, the category with the widest differences between eligible and enrolled. Community stakeholders perceived Covered California performed much more strongly enrolling Whites than other groups; in particular, 30% or fewer perceived excellent/very good performance enrolling Blacks, limited English proficient individuals, and the LGBTQ population.

Covered California Subsidized Enrollment, 2015-16

	Subsidized Enrollment	Estimated Subsidy Eligible
TOTAL	1,231,970	2,600,000
Hispanic or Latino	29.5%	38%
White	37.6%	33%
Black or African American	2.3%	5%
Asian	23.1%	20%
Native Hawaiian/Pacific Islander	0.2%	3%
American Indian/Alaska Native	0.3%	
Two or More Races	2.1%	
Other Race	4.7%	
Spoken language other than English	21.5%	38%



Coverage to Care. Covered California provides enrollees with a brochure designed to help consumers learn how to use coverage and explain key terms. The marketplace prints and mails this guide in 13 languages, and the brochure is also

available in English and Spanish on their website. Two-thirds of our survey respondents said that they were aware that assistance in using coverage was available in languages other than English, and 32% said they did not know.

DISCUSSION

Our pilot administration of the M-HEAT in California affirmed Covered California's strong commitment and reputation as a leader nationally in addressing disparities and advancing health equity, while also pointing to opportunities to leverage this strong position to continue to do more to assure the exchange works effectively for all people in the state.

Strengths and Successes. We identified five points of strength through our review and feedback from stakeholders and advocates in the state. These include: (1) a strong and growing organization-wide commitment to health equity; (2) robust active purchaser role positioned to advance health equity; (3) movement to align resources with health equity objectives; (4) collaboration with community stakeholders; and (5) working to assure transparency in programs and progress.

Areas of Opportunity and Action. Building on our review and feedback from state advocates and marketplace stakeholders, we also identified areas of opportunity and action moving forward. These include: (1) more fully engaging diverse communities and their constituents; (2) assuring adequate language access to meet the needs of limited English proficient and linguistically isolated communities; (3) advancing health insurance literacy to empower individuals with knowledge and skills to utilize coverage and access care; and (4) positioning the marketplace to build on its progress and participate in broader social determinant initiatives to advance health equity.

CONCLUSION

Covered California has achieved significant success in institutionalizing equity, developing strategies and focusing on outcomes that recognize how essential a focus on eliminating health disparities is to its success. Our findings and recommendations for advancing health equity are intended to both reflect Covered California's marketplace leadership and offer guidance for building on a strong foundation to close remaining gaps.

At the same time, we recognize that the 2016 Presidential election results have cast the future of the Affordable Care Act and marketplaces across the country into considerable doubt, as well as potentially created a crisis for those insured under the law. Concerns have already arisen around sustaining the expansion of Medicaid, health insurance subsidies, marketplace eligibility, and the future of California's proposed ACA 1332 Waiver. As such, our recommendations must be considered in an as-yet determined policy environment. Building upon the commitment demonstrated to date by working to assure that equity remains central during uncertain times will be an essential ingredient of the significant adaptations and adjustment likely to come.