
# EXECUTIVE SUMMARY

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

### Introduction

Health insurance marketplaces, established by the Affordable Care Act (ACA) of 2010, have created an unprecedented opportunity to bridge longstanding disparities in access to health insurance by race, ethnicity, language, and other socioeconomic factors. Intended to offer individuals and families accessible and affordable choices of health insurance plans, marketplaces as a whole have generally been a success, enrolling/re-enrolling by the end of the second open enrollment period nearly 11.7 million individuals—or half of the 24 million expected to have marketplace coverage by 2019. The number of uninsured has also declined nationally, from 48.6 million in 2010, to 37.2 million in 2014—the lowest level in more than 15 years. Despite this momentum, however, and notwithstanding gains experienced virtually across all racial and ethnic groups, disparities remain with Hispanics/Latinos, African Americans, and other groups being disproportionately more likely to be uninsured than their White counterparts. In recognition of these longstanding disparities and the importance of community-tailored initiatives, the ACA contained several provisions from the start to explicitly assure that marketplace planning and operations, including the navigator and assister programs, would be tailored to diverse populations. Our March 2013 report entitled "Implementing Cultural and Linguistic Requirements in Health Insurance Exchanges" examined how these provisions were initially incorporated into state-based marketplace planning and operations in seven case study states.

This report builds on our 2013 report and describes the evolution of marketplaces and their approaches to planning for, engaging, and enrolling diverse populations. The report tracks and shares adaptations, lessons, and promising practices from the initial seven case study state-based marketplaces (California, Colorado, Connecticut, Maryland, New York, Oregon, and Washington), as well as offers a first-hand look at emerging experiences across select partnership (Arkansas and Illinois) and federally facilitated marketplaces (Florida and Texas). This report is intended to both inform as well as foster a dialogue across states to improve and enhance future programs, advocacy, and policy for advancing health equity in the marketplaces.

### Methods

This report is based on an extensive review of the literature, including reports, articles, and policies on health insurance marketplaces and advancing health equity, in addition to 17 key informant interviews conducted with state and federal marketplace officials, navigator organizations, national nonprofits, and advocacy groups to gather accounts of accomplishments, progress, and challenges during the first and second open enrollment periods. Findings from the review and interviews have been analyzed and synthesized with the intent of sharing common and distinct themes around adaptations, lessons learned, promising practices, and remaining challenges for reaching and enrolling diverse populations.

## Summary of Adaptations and Practices for Reaching and Enrolling Diverse Populations in State-Based, Federal, and Partnership Marketplaces

| | In-Person Assistance Programs and Adaptations from First to Second Open Enrollment (OE) | Examples of Promising Practices for Reaching and Enrolling Diverse Populations |
|---|---|---|
| **State-Based Marketplaces**<br><br>***Study states:***<br>***California***<br>***Colorado***<br>***Connecticut***<br>***Maryland***<br>***New York***<br>***Oregon***<br>***Washington*** | • Most states experienced a decrease from OE1 to OE2 in the number of assisters compensated by the marketplace<br>• Almost all states had both navigators and IPAs for both OEs, except California, where the navigator program started in OE2<br>• 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)<br>• All states had sizable numbers of agents/brokers and CACs (CAC program started after OE2 in California) | • Marketplaces partnered with trusted community organizations that had existing relationships with diverse communities<br>• Assisters offered enrollment assistance at locations such as places of worship, English classes, community venues, and offices, often in non-English languages<br>• Many marketplaces increased outreach to Latinos and other diverse communities that remained uninsured in OE2<br>• Marketplaces used print, TV, and radio ads in ethnic media and in multiple languages<br>• Covered California partnered to create fact sheets for immigrants in five languages, explaining usage of personal information<br>• Connect for Health Colorado produced telenovelas and transcreated materials for Spanish-speakers<br>• Washington Healthplanfinder developed health literacy materials in eight languages and customized for different Indian tribes<br>• Many marketplaces divided their states into regions for better targeting of different populations |
| **Federal Marketplace**<br><br>***Study states:***<br>***Florida***<br>***Texas*** | • Funded navigator grants in 34 states for both OEs, with a decrease of15 organizations and $7 million from OE1 to OE2<br>• Navigator groups selected based on criteria including experience with underserved populations, with many targeting diverse communities<br>• Agents/brokers and CACs also certified to enroll in all FFM states (no IPAs) | • Separate Spanish federal enrollment website<br>• Navigator and assister training offered in Spanish as well as English (not seen in state-based marketplaces)<br>• Translated application in 33 languages, more than in state-based marketplaces<br>• Aired ads on ethnic media such as Telemundo, Univision, Latin Grammys, BET, sporting events, and Radio One<br>• 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<br>• 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<br>• A navigator grantee in South Texas employed Community Health Workers and bilingual *promotores* to serve as navigators to reach and enroll Hispanics |
| **Partnership Marketplaces**<br><br>***Study states:***<br>***Arkansas***<br>***Illinois*** | • Federal government funded navigators in partnership states<br>• 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<br>• Agents/brokers and CACs available in partnership states | • 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)<br>• Get Covered Illinois partnered with faith leaders on hundreds of enrollment events in both OEs<br>• A navigator organization in Illinois targeted outreach to migrant farmworkers in rural communities through events at farms, libraries, and churches |

## Interview Findings: 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. Reasons for this included 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.

***Community and in-person approaches to reach and enroll diverse populations.*** Marketplaces and enrollment organizations agreed that the best ways to reach culturally and linguistically diverse populations are to use trusted community organizations, in-person assistance in consumers' preferred languages, and culturally competent written and oral messages. None of the key informants endorsed one specific method as the best way to engage diverse communities, instead describing approaches that "pushed all the buttons" while scaling up activities that were observed to be effective in the first open enrollment, such as advertisements in ethnic media, in-language materials, and more direct e-mail and telephone follow-up. The use of census data, enrollment data, and other analytics enhanced the ability of marketplaces and navigators to identify regions or populations with the highest numbers of uninsured and target outreach to those communities.

***Enrollment venues***. Several interviewees expressed a sense that consumers preferred making appointments at permanent office locations that kept consistent hours, which reduced wait times and allowed customers to arrive prepared with the correct documentation. Other interviewees noted that large enrollment events worked well, provided that they included activities not solely focused on marketplace enrollment. For example, health fairs that included health screenings and education, ethnic food and music, and activities for children successfully attracted diverse customers in some states. Faith-based institutions were important partners for reaching diverse populations in many states, as well as other trusted and familiar locations such as schools, libraries, health clinics, and neighborhood shops.

***Targeting subpopulations in addition to broader racial and ethnic groups.*** Some states and the federal marketplace made an extra push to reach Hispanics/Latinos in the second open enrollment period, feeling that they were lagging in enrollment. However, several interviewees mentioned the need for attention to subpopulations that are often not captured in broad outreach efforts to diverse populations, for example, the Marshallese community in Arkansas or Somali communities in Oregon.

***Consumer awareness of the marketplace.*** Key informants provided mixed responses when describing how consumer awareness of the marketplace has changed. Some felt that word-of-mouth and advertising led to heightened consumer awareness in the second open enrollment period, while others felt that awareness appeared to decrease due to diminished media attention on the ACA along with continuing cultural and linguistic barriers faced by many of the remaining uninsured. Most agreed that marketplace awareness is not yet ubiquitous in diverse communities and continued efforts are needed to educate customers.

***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 who had positive experiences

enrolling with certain navigators or brokers were much more likely to spread the word to their communities and recommend those assisters than were other families. Conversely, if individuals from diverse communities experienced cultural, linguistic, or technological barriers that hindered their ability to enroll, they were more likely to spread that message as well, fostering a negative reputation that may have inhibited others from trying.

***Building a sustainable in-person assistance program.*** Many interviewees noted that it took much more time than expected during the second open enrollment to assist individuals with renewing health plans. 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 assisters year-round to continue to help individuals enroll, maintain, and use their health plans.

## Interview Findings: Marketplace Concerns and Challenges

There are several 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. Most marketplaces reported a significantly smoother technology experience in the second open enrollment compared to the first, although a handful of platforms continued to experience software difficulties, many related to the transfer of consumer information between different 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.

***Enrolling immigrants.*** Key informants described several ACA- and enrollment-related issues unique to immigrant populations. Many heard of concerns among immigrant families that personal information could be used to identify them as a public charge or to deport undocumented family members. Other issues included difficulties in identity verification due to a lack of credit history and problems uploading immigration documents. Another concern was the low level of awareness of marketplace subsidies available for certain low-income new immigrants in states enforcing a five-year bar on Medicaid eligibility. This option is often not known or is confusing for consumers and assisters. Furthermore, even if an individual is eligible, enrollment systems often do not recognize this exception to the general rule and cause delays.

## 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. While considerable progress has been made, there is much more to be done to close longstanding gaps in coverage and access to care within and across states as well as certain populations and subpopulations. This discussion includes important considerations in the ongoing dialogue to better meet the needs of diverse populations and bridge the divide in coverage and access to care.

***Advancing health insurance literacy.*** Many individuals, especially low-income populations and immigrants from countries with different health care systems, have little to no experience with health insurance and are not familiar with the U.S. health care system. Health insurance literacy encompasses an enrollee's knowledge, ability, and confidence in using health insurance terms, comparing and selecting health plans, and using coverage once enrolled. Low health insurance literacy tends to disproportionately affect diverse populations, and can lead to confusion and hardships for consumers as well as inefficiencies in the health care system. Many marketplaces and other organizations are taking steps to promote health insurance literacy, developing resources such as multilingual interactive websites, instructional videos, and toolkits for assisters. However, ongoing efforts to educate newly insured consumers will be needed.

***Assuring sustainable marketplace and navigator funding.*** 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 and sustain indefinitely, even as technology barriers improve. To this end, federal navigator grants for the third open enrollment period will last for three years instead of one year. State-based marketplaces have implemented fees on health plans in order to have continuing revenue, and some have explored additional sources such as state appropriations or private foundation funding. However, it is unclear if these options will provide enough revenue to sustain operations long-term, pointing to the importance of exploring and advocating for opportunities that cut across the for-profit, nonprofit, and public sectors.

***Supporting and transitioning trained assisters.*** With an increasing body of research emphasizing the importance of culturally competent, in-person assistance in consumers' preferred languages, it is critical that marketplaces consider how to sustain and harmonize the different types of enrollment assisters, including agents/brokers, CACs, navigators, and IPAs. Agents/brokers and CACs greatly outnumber other types of assisters, and as such have enrolled more consumers. Their role will also remain important as they are not compensated by marketplace funding. New federal funding for state-based marketplaces has ended, resulting in attrition of experienced assisters. Thus, it is 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.

***Improving population-specific data collection and reporting.*** Although the collection and reporting of enrollment data by race, ethnicity, and language is crucial to evaluating progress, gaps, and areas for improvement in better reaching and enrolling diverse populations, these data points are often lacking. As many as one third of consumers elect not to indicate their race or ethnicity on the application, calling into question the validity of the data that is collected. As such, many marketplaces—pushed in large part by advocates—are considering ways to encourage better collection of these data from enrollees. As they do so, considering ways to standardize such collection will also be important. Section 4302 of the ACA may offer marketplaces guidance on collecting and reporting standardized race, ethnicity, and language data for comparability over time, across communities, and states.

***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 and care for a variety of reasons such as administrative delays, discontinuity of health plans, or changes in

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.

***Marketplace progress and the remaining uninsured.*** Marketplaces around the country enrolled significantly more of the estimated eligible population in the second open enrollment period than the first, from 28% to 42%. However, continued gains going forward are expected to become smaller and more incremental. Research on the remaining uninsured shows that many feel they cannot afford coverage even with subsidies, are unaware of the subsidies, are in the coverage gap in states not expanding Medicaid, or are not interested in buying health insurance at any price. Diverse populations are likely to be overrepresented among those remaining uninsured. These circumstances will require greater innovation and investment in educating potential enrollees and enrolling the remaining uninsured.

***Questions for further study.*** We identified from interviews and literature reviews other key questions that will influence the ultimate value of insurance for diverse populations. Are health plan networks "adequate" in linguistic and cultural competency? Do insurance companies maintain updated lists of network providers and can consumers search for them by language and ethnicity? Related issues affecting many lower-income enrollees, not just diverse individuals, include 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 due to possible changes in prices and benefits, and if reconciling advance premium tax credits (subsidies) with income at tax time is causing financial burdens due to the difficulty in projecting income for those with fluctuating incomes. 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 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, assets and strengths, funding constraints, and political climates. 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.

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