ADVANCING HEALTH EQUITY IN THE HEALTH INSURANCE MARKETPLACE:

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

December 2016

Developed by:
Texas Health Institute
In collaboration with Health Access and California Pan-Ethnic Health Network
Supported by The California Endowment and W.K. Kellogg Foundation

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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ACKNOWLEDGEMENTS

Texas Health Institute acknowledges and thanks The California Endowment and the W.K. Kellogg Foundation for supporting this project. In particular, we are grateful for the support and guidance provided by Dr. George Flores and Richard Figueroa. We also thank our partners, Anthony Wright at Health Access, and Sarah de Guia and Cary Sanders at the California Pan-Ethnic Health Network for their insights and contributions to this effort. We further thank the executive leadership and staff of Covered California who have expressed their interest in this important initiative and their commitment to advance health equity.

Finally, we are grateful for the invaluable contributions of the following organizations whose leadership and staff provided important perspective and feedback in the early stages of this project as we worked to develop and tailor the Marketplace Health Equity Assessment Tool for California.

Asian & Pacific Islander American Health Forum
California LGBT Health & Human Services Network
California-Pan Ethnic Health Network
California Primary Care Association
California Rural Indian Health Board
Community Health Councils
Health Access
Latino Coalition for a Healthy California
UCLA Center for Health Policy Research

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INTRODUCTION

The Patient Protection and Affordable Care Act of 2010 (ACA) created health insurance marketplaces to make available a choice of easily comparable and affordable health insurance plans for individuals and families without public, employer-sponsored, or other coverage. Now in their fourth year of enrollment, health insurance marketplaces together with Medicaid expansion and other health insurance reforms have reduced the national uninsured rate to a historic low of 9.1% or 28.6 million persons of all ages.[1] While virtually all population groups have benefited from coverage expansion, those from racially and ethnically diverse, limited English proficient (LEP), and other hard-to-reach communities represent the largest numbers of remaining uninsured.

In California, the uninsured rate declined to an estimated 8.1% by the end of 2015—below the national average uninsured rate.[2] Since the ACA's enactment, 4.4 million Californians have gained new coverage, including 1.4 million through Covered California, and 3 million through Medi-Cal, the state's Medicaid program.[3, 4, 5] However, certain populations continue to be disproportionately represented among the uninsured. For example, while non-Whites represent 62% of the state's population, they comprise a much larger share of the uninsured (73%).[6] Others including lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ), those living in rural parts of the state, and those with limited English proficiency continue to face challenges to obtaining coverage. Assuring the overall success of health insurance marketplaces—and coverage expansion in general, especially given the uncertain fate of marketplaces under a new Administration—will require concerted efforts to assure the inclusion and participation of hard-to-reach communities.

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.

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—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.

The M-HEAT was designed to help marketplaces and their stakeholders take stock of the extent to which the health insurance marketplace, together with its stakeholders and community partners, is working to advance enrollment, retention, and access to care for all populations, and especially those historically disenfranchised. Findings from the M-HEAT are intended to inform the marketplace, its stakeholders, and policymakers on areas of strength, improvement, and priority to inform future programs and policies fostering coverage and access for all populations. The M-HEAT also serves as a monitoring tool to track programs and progress over time.

BACKGROUND

The M-HEAT's definition of diverse populations includes individuals from different racial, ethnic, and linguistic heritage as well as LGBTQ populations. The vision of the M-HEAT is based on the National Partnership for Action to End Health Disparities' definition of ***health equity***:

> *Health equity is attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.*[7]

To this end, the M-HEAT serves as a health equity inventory and assessment tool. It orders, organizes, and solicits data from the health insurance marketplace and survey data from community stakeholders to document and gauge how and how well the marketplace is working to assure equal opportunities for enrollment and access to care for all populations.

The marketplace component of the M-HEAT compiles public data (and where available self-reported data) on health equity programs, progress, and performance. A parallel version, administered to community advocates and representatives within a state, intends to offer an external reference point for the marketplace to measure how well they have worked to reach communities and advance equity. As such, a common set of M-HEAT questions on both components are designed to determine areas of agreement and disagreement between the marketplace and its community stakeholders about progress and performance toward health equity. In cases where self-reported data from the marketplace are not available, progress and performance are gauged based on publicly available data.

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.

The M-HEAT's content draws from the expertise of representatives from communities of concern and extensive information in the literature on state-based health insurance marketplaces in California and around the country. Through these resources, six marketplace functions were identified as concrete areas of opportunity for advancing health equity.

The M-HEAT and this report are organized around the following six functions:

1. Organizational commitment;
2. Plan management;
3. Community engagement and collaboration;
4. Navigator and assister programs;
5. Marketing and communication; and
6. Enrollment outcomes.

Each of the six sections in the M-HEAT includes a set of structure, process, and outcome questions to measure progress toward health equity, both point-in-time as well as over time, to chart successes as well as identify near-term and long-term opportunities for improvement. The M-HEAT seeks not only to inform efforts to improve enrollment and retention, but with questions on access to care, also seeks to take stock of "coverage to care" progress for diverse and other hard-to-reach communities.

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.

M-HEAT's Six Content Areas

Part 1: Organizational Commitment to Advancing Health Equity. This section includes three sub-parts that intend to measure the extent to which the marketplace has made a commitment to health equity in (1) organizational policies, (2) leadership and staff, and (3) allocation of financial resources.

Part 2: Plan Management and Health Equity. This section focuses on three key aspects of plan management that offer an important opportunity for advancing health equity—(1) active purchasing, (2) racial, ethnic, and language data collection, and (3) health plan access and network adequacy.

Part 3: Community Engagement and Collaboration. This section focuses on the process and progress of diverse community engagement and is divided into three sub-parts: (1) community stakeholder engagement, (2) tribal consultation, and (3) cross-sector collaboration.

Part 4: Navigator and In-Person Assistance Programs. Questions in this section address navigator and assister programs that are intended to educate and enroll communities in marketplace plans. The section covers sub-topics including (1) scope and reach of programs, (2) navigator and assister training, (3) language and interpreter services, and (4) the enrollment application.

Part 5: Marketing and Communication. This section captures the range of ways in which marketing and outreach explicitly targets diverse populations, overall and by specific media channels. In addition, the section addresses availability of interpreter and language services.

Part 6: Marketplace Outcomes. This section includes questions on enrollment outcomes, such as number enrolled, renewed, and churned, as well as health care access measures.

DESIGN & METHODS

The M-HEAT was developed and administered through a multi-stage process involving the ongoing engagement of representatives from the health insurance marketplace and diverse communities in California to help inform and ground the initiative in local priorities. In this section, we describe the formation and engagement of our stakeholder advisory group, the development of the M-HEAT and its content, the administration of the tool, and data analysis.

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. The first stakeholder meeting was convened on October 28, 2014 with three primary objectives:

1. To share THI's national M-HEAT framework;
2. To explore and discuss ways to tailor the national M-HEAT framework for California, including specific questions, measures, and processes for collecting data from Covered California and community stakeholders; and
3. To discuss the value of results and opportunities for driving a meaningful marketplace and health equity agenda in the state.

The October 2014 meeting was attended by representatives from 12 community stakeholder organizations including advocates from various communities of color, researchers, and others who have had a history of working closely with Covered California to inform and guide its implementation and rollout. Attendees candidly shared their perspectives on the marketplace's early progress and challenges to reaching and enrolling diverse populations; identified priority questions and measures for the assessment; and discussed the potential value of the M-HEAT in monitoring commitment and progress toward health equity.

Following the initial meeting, members of the Stakeholder Advisory Group were engaged via e-mail on an ongoing basis, especially to offer feedback on various drafts of the marketplace and community versions of the M-HEAT. Both tools were finalized with specific feedback on priority questions from community stakeholders.

MARKETPLACE ENGAGEMENT

In addition to engaging community stakeholders, equally important was the involvement of members of the health insurance marketplace to assure that the initiative would offer data to meaningfully inform and advance their equity actions. To this end, we first briefed Covered California about this initiative in October 2014, followed by conversations that helped to streamline the tool to assure the inclusion of practical and measurable questions. Following the administration of the community stakeholder survey in late 2015 and compilation of public data on the marketplace in 2016, we shared early results of the assessment with Covered California and offered them an opportunity to provide data and information to help ground or round out the M-HEAT's findings. During two separate briefings in September and November 2016, members of Covered California's leadership and executive staff provided feedback and contributed additional guidance and recommendations for inclusion in the final report.

M-HEAT ADMINISTRATION

Two versions of the M-HEAT were developed: a marketplace self-assessment and a community stakeholder survey. While the national framework for both versions was developed based on an extensive review of the literature on state-based marketplaces and existing health equity evaluations,[8, 9] California's version was tailored and developed with feedback from state advocates, stakeholders, and the marketplace. In this section, we describe our methods for administering each of these tools.

Marketplace assessment. The 87-item marketplace version of the M-HEAT includes a combination of questions that intend to pair self-reported data from the marketplace with more objective data on outcomes to gauge commitment and progress toward health equity. While self-reported data by Covered California are not available at this time, we compiled a breadth of publicly available data to complete approximately 70% of the assessment.

Objective data and information (e.g., enrollment and retention estimates) were compiled through internet-based searches of publicly available reports and documents, including but not limited to: Covered California Board of Directors meeting recordings and minutes, data files, financial statements, requests for proposals and contracts, advisory group proceedings, and internal briefs or reports. A majority (about 90%) of data was sourced from Covered California itself, while the remaining 10% originated from external reports and evaluations produced by groups such as NORC at the University of Chicago, Kaiser Family Foundation, UCLA Center for Health Policy Research, UC Berkeley Center for Labor Research and Education, Health Consumer Alliance, and more. In several cases, these external reports were commissioned by or produced with input from Covered California and/or its stakeholders.

All secondary data were catalogued according to the M-HEAT's six content areas and organized chronologically within each section. Thematic and chronological organization enabled point-in-time and over-time analyses of performance and progress, while also shedding light on areas of relative data scarcity or abundance. Covered California's detailed reporting of public information produced especially robust data on plan management activities and requirements, evolution of navigator and assister programs, marketing and outreach strategies, and highly granular race/ethnic and language breakdowns of enrollment outcomes. However, we found relatively less data on M-HEAT items pertaining to leadership and staff diversity, the marketplace's financial allocations toward health equity objectives, and coverage to care activities.

Community stakeholder survey. The 46-item, abridged community version of the M-HEAT was administered online via Survey Monkey between October and December 2015 to capture stakeholder perceptions of marketplace health equity progress since Covered California's establishment. Recognizing that community stakeholder organizations represent many voices and constituents, the survey was sent to individuals at 341 organizations across the state. The target sample was compiled with feedback from our project partners to assure representation of stakeholders across the state with a history of working with or advising Covered California. In particular, individuals receiving the survey included Certified Enrollment Entities, members of the Community Outreach Network, members of Covered California's stakeholder and advisory groups, advocates, and others. Roughly one-third of those receiving the survey were from the Los Angeles region, another third from the greater San Francisco Bay Area, one in ten from the Sacramento and San Joaquin Valleys each, and the remaining from regions including San Diego, Northern and North Bay, Inland Empire, and other parts of California.

DATA ANALYSIS

Data on both versions of the M-HEAT were analyzed descriptively. In addition, common questions on both tools were reviewed and analyzed together to identify points of mutual agreement and difference between the marketplace and community stakeholders on progress and performance toward health equity. With respect to the community stakeholder survey, questions pertaining to knowledge of Covered California policy, procedures, or actions were reported to include 'don't know' responses. However, for questions of opinion or perception, 'don't know' responses were excluded from analysis. We excluded data on questions where greater than 75% of respondents reported 'don't know'. Rates of 'don't know' were particularly high for questions pertaining to LGBTQ populations.

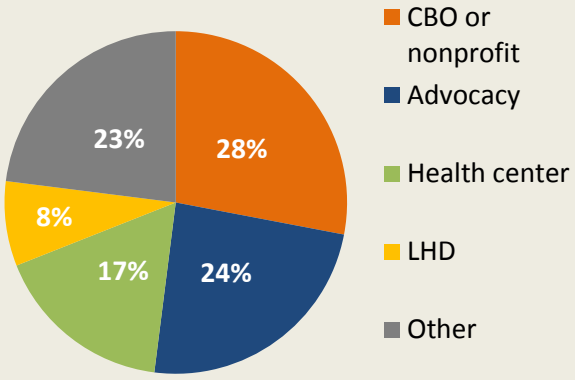
BRIEFINGS ON PRELIMINARY FINDINGS

We presented initial findings from our analysis to community stakeholders on October 13, 2016, and to Covered California leadership and executive staff on November 4, 2016. Feedback from these discussions helped to add depth and dimension as well as ground findings in California's marketplace reality. We have incorporated substantive feedback from these meetings into our discussion and recommendations.

M-HEAT COMMUNITY SURVEY RESPONDENTS

Responding Organizations. The survey was sent to individuals at 341 community stakeholder organizations, of which we received responses from 76 organizations (22% response rate). Responding organizations self-identified as: 28% community-based or non-profit organizations; 24% advocacy groups; 17% health centers or clinics; 8% local health departments; and the remaining 23% comprised of "other" respondents including brokers, libraries, schools, and churches (Figure 1). Over 80% of organizations reported working in some capacity with Covered California on outreach, education, or enrollment. Over 60% said they were a navigator grantee or enrollment entity. In terms of other involvement with Covered California, 44% reported providing stakeholder input; 35% were engaged in marketing; 23% reported involvement in strategic planning discussions; and 16% provided some level of language interpretation or translation assistance.

Figure 1. Profile of California's M-HEAT Community Survey Respondents



Populations Served by Responding Organizations. Surveyed organizations were asked to specifically identify which population groups they serve or target. An overwhelming majority reported working with multicultural populations. Specifically, 83% of respondents said they target Hispanics and Asians and 80% said they target Whites and Blacks/African Americans. Fewer reported that they explicitly worked to reach LGBTQ communities (68%).

RESULTS

PART 1: ORGANIZATIONAL COMMITMENT TO HEALTH EQUITY

STRATEGIC COMMITMENT TO HEALTH EQUITY

Central to achieving health equity is a strategic commitment to disparities reduction at an institutional level, including the establishment of goals, policies, and accountability measures infused throughout an organization's planning and operations.[10] Since establishment in 2010, Covered California was among a handful of leading states with a strategic commitment to health equity as exhibited through their vision and mission. The overall mission of Covered California has been to "to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value."[11] Three of the marketplace's six value statements also explicitly reinforce its equity commitment (Figure 2).[12]

From the outset, Covered California adopted a data-driven approach to planning for diverse populations, grounded in findings from the California Simulation of Insurance Markets (CalSIM) produced by the UCLA Center for Health Policy Research and the UC Berkeley Center for Labor Research and Education.[13] CalSIM projects the composition of the state's Medi-Cal and marketplace eligible population overall and by race, ethnicity and language. California's projected marketplace eligible population numbers around 5 million annually, of which approximately half are eligible for subsidies provided to those earning incomes between 100-400% of Federal Poverty Level (FPL) (Table 1). Breakdowns by race, ethnicity, and language show clear differences between populations eligible and ineligible for subsidies (Table 2). In particular, non-White racial/ethnic groups comprise a larger share of the subsidy-eligible population (67%) as compared to Whites (33%). Forty percent of the subsidy-eligible population is estimated to have limited English proficiency, of whom 25% are Spanish-speaking and the remaining 15% speak Asian languages.[14] In contrast, far fewer subsidy ineligible individuals (15%) have limited English proficiency. Building on these and other CalSIM estimates, Covered California generated sophisticated sociodemographic models of enrollee segments, which were subsequently used to inform communication strategy, outreach, consumer assistance and translation needs, and grantmaking.

Figure 2. Health Equity in Covered California Value Statements

Three of Covered California's six core values contain explicit references to health equity.

- ***Consumer Focused.*** Covered California will offer a consumer-friendly experience that is accessible to all Californians, recognizing the diverse cultural, language, economic, educational, and health status needs of those we serve.
- ***Catalyst.*** Covered California will be a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality affordable health care, promoting prevention and wellness, and reducing health disparities.
- ***Results.*** Covered California will be measured by its contributions to expanding coverage and access, improving health care quality, promoting better health and health equity, and lowering costs for all Californians.

Source: Covered California. (January 2014). *Addressing Health Equity and Health Disparities*. Brief prepared for Covered California Board of Directors.

Despite this explicit and strategic health equity commitment, many community stakeholders, including those on the ground charged with educating and enrolling marketplace consumers, reported not knowing that Covered California has a mission to address disparities or advance health equity. In fact, while 60% of community respondents were aware of this strategic commitment, 40% reported not knowing (Figure 3). And when asked to report how well they felt Covered California had communicated its commitment to health equity, fewer than half (43%) of respondents said this was communicated well or very well (Figure 4). While programmatically based on our review, Covered California's commitment to health equity has grown since establishment, just over half (56%) of community stakeholder respondents recognized this growth (Figure 5).

Table 1. Covered California Marketplace Eligible Population

	2013-14[15]	2014-15[16]	2015-16[17]
Total Eligible	5.3 million	4.5 million	4.8 million
Subsidized	2.6 million	2.5 million	2.6 million
Unsubsidized*	2.7 million	2.0 million	2.2 million

Table 2. Covered California Marketplace Eligible Population Composition, by Race/Ethnicity and Subsidy Eligibility*

	2013-14[18]		2014-15[19]		2015-16[20]	
	Subsidized ≤ 400% FPL	Unsubsidized > 400% FPL	Subsidized ≤ 400% FPL	Unsubsidized > 400% FPL	Subsidized ≤ 400% FPL	Unsubsidized > 400% FPL
Hispanic/Latino	46%	25%	37%	31%	38%	33%
White	33%	54%	33%	49%	33%	48%
Black/African-American	4%	5%	5%	4%	5%	4%
Asian	14%	13%	20%	11%	20%	11%
Other**	3%	3%	4%	4%	3%	4%
Limited English Proficient	40%	11%	39%	13%	38%	15%

*Unsubsidized projections assume some with incomes above 400% FPL will access other forms of coverage.
**Includes Native Hawaiian/Pacific Islander, American Indian/Alaska Native, multiple races, other race

Figure 3. Stakeholder Knowledge of Formal Commitment to Health Equity

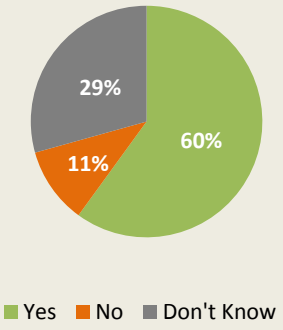


Figure 4. Stakeholder Perception of How Well Covered California has Publicly Communicated its Commitment to Health Equity

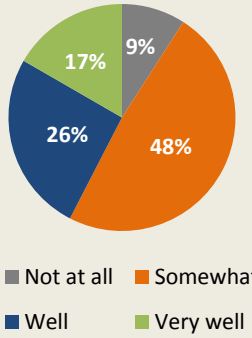
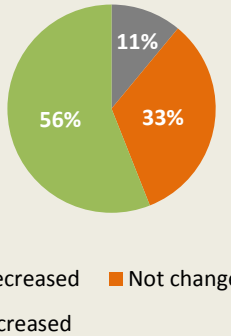
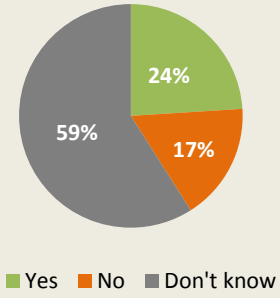


Figure 5. Stakeholder Perception of Change in Covered California's Formal Commitment to Health Equity since Establishment



GOVERNANCE, LEADERSHIP, AND WORKFORCE

Figure 6. Stakeholder Knowledge Whether a Health Equity-specific Staff Position Exists at Covered California



California state lawmakers formed the marketplace with a vision of diversity in governance, enacting legislation requiring its marketplace board to be generally representative of different races/ethnicities in the state.[21] As Covered California's first cohort of employees took shape during the early stages of hiring, stakeholders expressed concerns that the selection of executive staff in particular may not adequately reflect the racial and ethnic diversity of the marketplace eligible population.[22] At the urging of several community groups, Covered California affirmed the need to focus efforts on hiring a diverse staff that possessed experience serving people of color and limited English proficient populations.[23, 24] Several stakeholder groups offered to assist Covered California with recruitment efforts to ensure a diverse and qualified applicant pool.[25] In March 2015, Covered California hired a Health Access and Equity Officer, the first equity-centric leadership position in any state marketplace.[26] By November 2015, the position had been vacated and according to our review no longer remains on the May 2016 Covered California organizational chart.[27] Because this personnel transition occurred during the survey administration period, it may in part explain why only one-quarter of stakeholders said they knew of an existing staff position dedicated to health equity, while three-quarters either did not know or did not believe one existed (Figure 6).

Covered California's call center locations (Fresno, Rancho Cordova, and Contra Costa) were selected with diversity and representativeness of the local population in mind, as over 1,000 total service center staff were expected to be hired in these areas.[28] Covered California's contracts with service center vendors have stipulated that 15-20% of center staff should be bilingual in English/Spanish, and five percent should be bilingual in English/Asian languages including Korean, Hmong, Mandarin, Cantonese, and Vietnamese.[29, 30] In addition, Covered California began providing updates at advisory group and board meetings on the cultural and linguistic diversity of enrollment assisters and service center staff, though we did not locate such updates on the diversity of its leadership and staff.

Responses from community stakeholders revealed a general acknowledgement that Covered California is a racially and

Figure 7. Stakeholder Percpetion of Marketplace Staff Representativeness of Racial and Ethnic Diversity of Eligible Populations

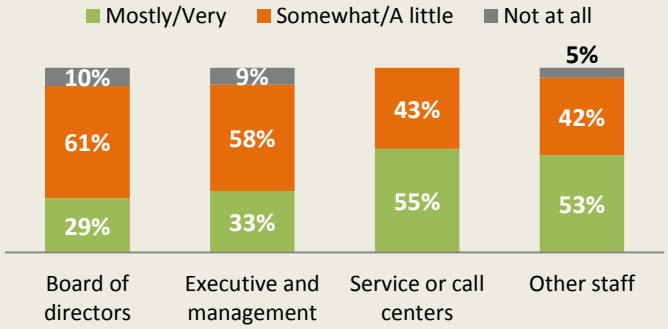
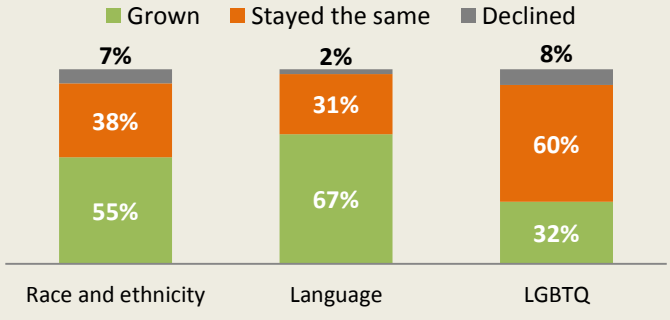


Figure 8. Stakeholder Perception of Change in Marketplace Leadership and Staff Diversity Over Time



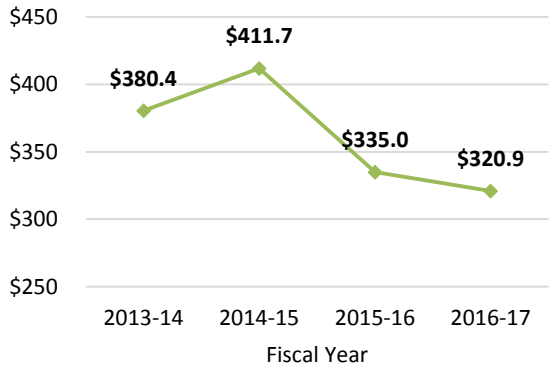
ethnically diverse organization, with very small percentages feeling diversity did not exist at all in staffing or call centers. Yet, while more than half of stakeholders perceived Covered California's non-executive and managerial staff to be mostly or very representative of the racial and ethnic diversity of marketplace-eligible populations, fewer than one-third felt this was the case for Covered California's executive staff and Board (Figure 7).

More than half (55%) of community stakeholders reported that they felt that Covered California's staff and leadership diversity by race and ethnicity had grown since establishment. Two-thirds (67%) felt it had grown more linguistically diverse. In contrast, the majority of respondents (60%) felt that diversity by gender identity and sexual orientation had changed little over time (Figure 8).

FINANCIAL COMMITMENT TO HEALTH EQUITY

Covered California's proposed budget for fiscal year (FY) 2016-17 was $321 million dollars, the smallest budget proposed in the last four years of marketplace operations (Figure 9).[31, 32, 33, 34] The budget reductions from FY 2014-15 onward reflect a planned decline in spending due to the termination of federal establishment grants that supported the marketplace throughout its launch. Covered California received an extension from the federal government to continue spending establishment grant dollars through FY 2015-16, marking the final year the marketplace used any federal dollars.[35] For the first time, Covered California will operate under a fully self-sustaining financial model in FY 2016-17, collecting revenues from fees assessed on health plans sold through the marketplace.[36]

Figure 9. Covered California Annual Budget (in millions of dollars)



Source: Covered California Financial Reports.

Like many other marketplaces, Covered California's accounting procedures limit the ability to assess how much of its annual spending is dedicated to specific populations and toward health equity objectives generally. At this time, Covered California does not forecast, allocate, or record overall spending across all marketplace functions by population, although spending in individual departments (Marketing, for example) is occasionally broken out this way. Many departments for which spending is reported do have explicit health equity objectives, and marketplace financial reports note that efforts intended to serve the population at-large are inclusive of diverse communities. As current accounting practices include line-items related to marketing, outreach, plan management, service center, and technology, there may be future opportunity for Covered California to build in an ability to measure dollars devoted specifically to different diverse population groups within these activities.

Stakeholders were asked to report the extent to which they perceived Covered California had shown a financial commitment to health equity. Nearly 100% said the marketplace had shown at least some financial commitment, and 41% believed this commitment had been demonstrated mostly or to a great extent (Figure 10). Stakeholder organizations resoundingly affirmed the importance of allocating resources toward diverse population segments: more than 80% of respondents felt it was important to dedicate financial resources to racially/ethnically diverse, LGBTQ, and limited English proficient

populations (Figure 11).

Figure 10. Perception of Extent to which Covered California has shown Financial Commitment to Health Equity

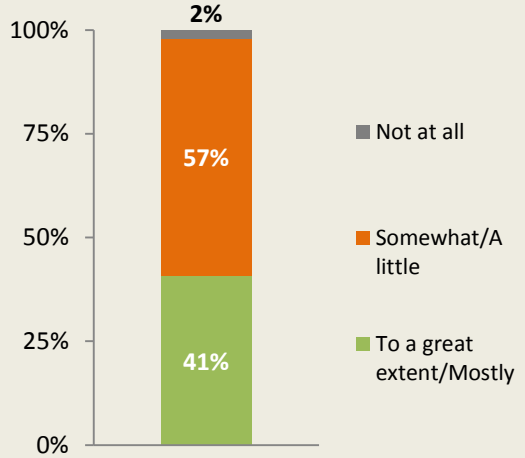
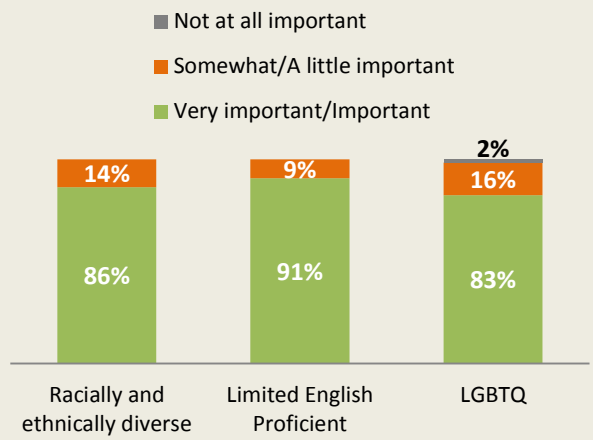


Figure 11. Perception of Importance for Covered California to Allocate Resources to Diverse Population Groups



PART 2: PLAN MANAGEMENT AND HEALTH EQUITY

ACTIVE PURCHASING

Covered California's founding legislation granted the Board of Directors authority to decide whether the marketplace would actively purchase health plans, which the board ultimately instructed the marketplace to do.[37] In general, active purchasing marketplaces are defined as those that "selectively contract with carriers, set tougher participation criteria than federal standards, and/or negotiate price discounts" to cultivate a selection of plans that the marketplace believes optimize access, quality, and and/or value to consumers.[38] In contrast, marketplaces that do not take an active purchasing approach open their marketplaces to any willing carrier whose plans meet minimum federal standards.

Of the nation's six active purchasing marketplaces, Covered California asserts perhaps the most rigid and selective criteria for participation.[39] Covered California solicits proposals from interested insurers in advance of each open enrollment cycle. The solicitation explicitly states that plans must ensure access to care for individuals with varying health statuses and conditions and include essential community providers. For its inaugural solicitation in May 2013, Covered California reviewed 33 proposals, selecting 13 insurers that were deemed to offer "the best options for California consumers" based on price, networks, plan designs, and administrative capacity.[40] To preserve consumer choice, Covered California included a mix of non-profit and commercial insurers, plus well-known Medi-Cal managed care and regional plans. In each geographic rating region, Covered California offered a mix of at least two carriers, and residents of the state's larger metropolitan areas could select from up to six different carriers.[41] More recently, as carrier participation in ACA marketplaces nationally has declined with average premium prices increasing sharply in many states, California's active purchasing marketplace has emerged in relatively stable position.[42] In the 2016-17 enrollment cycle, 11 carriers are offering plans on the marketplace with an average rate increase of 13.2%, less than observed in several other states.[43]

Three of California's carriers are expanding their coverage areas from previous years, and 93% of customers are expected to be able to choose among plans from at least three carriers when they shop.[44]

DATA REQUIREMENTS AND INCENTIVES

Covered California's contracts with insurers require plans to undertake delivery system reform efforts the marketplace expects will improve quality, access, and affordability for enrollees.[45, 46] Based on a strong push from advocates and stakeholders, these have included activities with a disparities reduction focus. Perhaps chief among Covered California's early equity-focused activities was building out robust data collection capability for tracking and targeting health disparities. All qualified health plans in California had been required to collect race, ethnicity, and language data under state law since 2003,[47] and beginning in 2013 all Covered California carriers were required to use the same tool (eValue8) to collect this data.[48] A standard tool enables Covered California to easily aggregate, compare, and report uniform demographic data for all enrollees.

Prior to the 2016-17 open enrollment period, stakeholders called upon Covered California to redouble its commitment to targeting disparities by following through on its stated intent to strengthen the data collection requirements it imposes on plans.[49] Specifically, stakeholders had asked for the marketplace to provide high granularity on applicant race and ethnicity response options (requesting collection and reporting on nine different Asian subpopulations, three Native Hawaiian/Pacific Islander subpopulations, and six Hispanic subpopulations), high granularity on written and spoken language response options, collection of sexual orientation and gender identity data, and reporting of stratified data by race, ethnicity, gender, and language for all enrollment outcomes.[50]

In response, Covered California substantially strengthened its data collection and disparities reduction requirements in the 2017-19 contract period. This contract requires all plans to achieve a response rate of 80% or above on self-reported race and ethnicity questions by 2019, and plans must attempt to fill any gaps in race/ethnic identity data through the use of ZIP code and surname proxies.[51] Covered California ultimately adopted 80% self-reporting as an ambitious but attainable target for carriers, noting that before the change 73% of enrollees voluntarily reported race and ethnicity data and two carriers had already surpassed 80% self-reporting.[52] Plans are not yet required to collect data on limited English proficiency, sexual orientation, or gender identity, but must agree to work with Covered California to determine how disparities may be identified and improved for these groups in future years.

In addition, health plans will be rewarded with incentives if they can demonstrate racial/ethnic health disparities reductions across four health outcomes: diabetes, hypertension, asthma, and depression.[53] Health plans must also continue to provide Covered California with details on existing or planned efforts to move toward integrated systems of care and value-based purchasing models, including number and percent of enrollees covered under Accountable Care Organizations (ACOs).[54] Covered California establishes targets for percentages of enrollees attributed to ACOs, and carriers must work with Covered California to provide data on their non-Covered California plans to assess relative performance.[55] Finally, health plans are encouraged to seek National Committee on Quality Assurance (NCQA) Multicultural Health Care Distinction certification so that Covered California may offer this information to consumers as a comparison point when they shop.[56] Advocates applauded the strengthening of requirements with an explicit focus on health equity, and re-stated their commitment to helping Covered California explore future data requirements, incentives, and equity initiatives not presently feasible.[57]

Our stakeholder survey administration period preceded Covered California's 2016 adoption of new population health improvement incentives and data collection standards. However, at that time, the vast majority of community stakeholders did not know definitively whether Covered California encouraged its health plans to participate in value-based payment and delivery models such as ACOs (92%) or incentivized plans for demonstrating improvements in population health (88%).

HEALTH PLAN ACCESS AND NETWORK ADEQUACY

Covered California has placed great importance on assuring plan offerings adhere to its guiding principles of network adequacy and essential community provider adequacy (Figure 12). Covered California's 2017-2019 qualified health plan contract provisions require plans to maintain a "sufficient" number and geographic distribution of essential community providers (ECPs) in their network. Sufficiency is determined according to the nature, type, and distribution of ECPs under contract with the carrier, extent to which federally qualified health centers, county hospitals, and at least one ECP hospital are included in-network, and whether at least 15% of ECP entities participate in programs that limit the price of prescription drugs.[58]

Figure 12. Covered California's Guiding Principles for Network & Essential Community Provider Adequacy

- Promote affordability
- Improve health care quality
- Offer choice among Qualified Health Plans
- Ensure access for low-income, medically underserved individuals
- Adhere to California regulatory requirements
- Ensure access to a mix of provider types
- Support inclusion of FQHCs, county hospitals, and Tribal/Urban Indian Clinics
- Include providers who have demonstrated service to low-income individuals

Source: Covered California. (September 2014). Plan Management and Delivery System Reform Advisory Group Meeting.

The California Department of Insurance and the California Department of Managed Health Care together regulate all plans sold on the marketplace. Each enforces similar standards for provider/enrollee ratios, travel distance to providers, and timely appointment scheduling to ensure enrollees do not experience unreasonable obstructions to obtaining care using their plan (Table 3). For example, under California law, plans are required to have one full-time physician for every 1,200 enrollees and one full-time primary care physician for every 2,000 enrollees.[59] Furthermore, travel distance to a primary care doctor or hospital cannot exceed 15 miles or 30 minutes from enrollees' workplace or residence.[60] Primary care providers must be able to accommodate a patient's request for a non-urgent appointment within 10 business days, and specialists must offer non-urgent appointments within 15 business days.[61] For urgent care, appointment requests must be accommodated within 48 hours if no pre-authorization is required.[62] Covered California reviews and reports on the geographic distribution of providers in its qualified health plans, mapping the location of providers against population density to determine where geographic access to care may be most limited.[63]

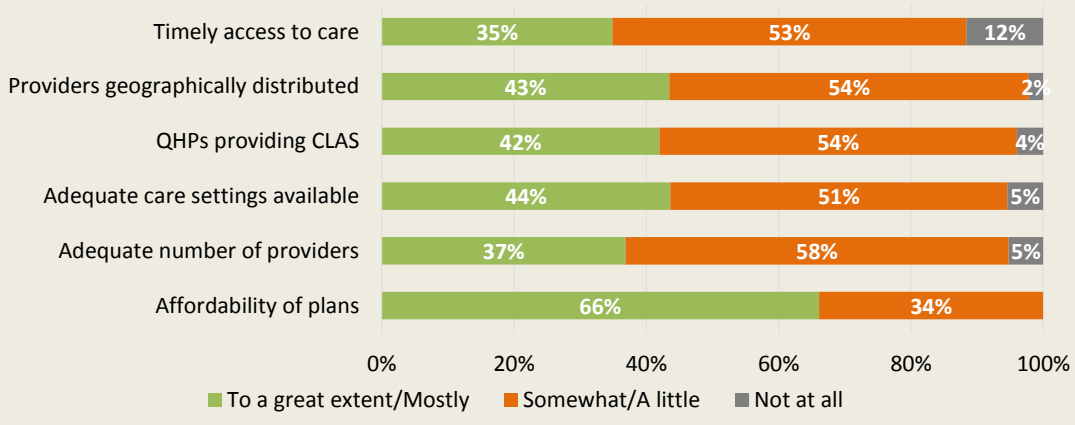
Covered California also includes language in its QHP contract requiring culturally and linguistically appropriate communications, including oral interpretation services and translated materials, to be made available to enrollees at no cost.[64] Plans must monitor and report periodically to Covered California on the accessibility and quality of these services.

Table 3. California Departments of Insurance & Managed Care Standards for Network Adequacy

Capacity[65]	Geographic Access[66]	Timely Availability[67, 68]
Standards for provider/enrollee ratio	Standards for maximum travel distance to a provider	Standards for maximum wait time for an appointment
• **Primary care:** One full-time equivalent primary care physician for every 2,000 enrollees • **All physicians:** One full-time equivalent physician (primary or specialty) for every 1,200 enrollees • **All other providers:** Sufficient to provide timely access	• **Primary care:** 15 miles or 30 minutes from work or home • **Hospitals:** 15 miles or 30 minutes from work or home • **Specialists:** 30 miles or 60 minutes from work or home or "reasonable" distance • **Mental health:** 15 miles or 30 minutes from work or home or "reasonable" distance • **Lab/Pharmacy:** "Reasonable" distance from primary care provider	• **Primary care:** 10 days* • **Specialty care:** 15 days* • **Mental health:** 15 days for non-urgent psychiatrist, 10 days for non-urgent non-physician mental health provider* • **Lab/Pharmacy:** 15 days for non-urgent services *48 hours for urgent care not requiring preauthorization

We asked stakeholders to share their knowledge of Covered California's efforts to assure marketplace plans feature adequate networks and permit reasonable access to care (Figure 13). Stakeholders clearly recognized Covered California's efforts to preserve affordability of plans; two-thirds of respondents (66%) reported that Covered California assured affordability mostly or to a great extent, and none of the responding organizations perceived that plans were not at all affordable. However, Covered California's efforts to promote other dimensions of network adequacy were not as widely recognized. Only 42-44% of respondents felt providers were geographically distributed, adequate types of care settings were available, and that plans provided culturally and linguistically appropriate services. Stakeholders seemed particularly concerned about narrow networks in Covered California's plans, with just 37% of respondents saying they feel plans have adequate numbers of providers. In addition, respondents expressed concerns with enrollees' ability to access care in a timely manner; just 35% felt this was mostly or to a great extent assured under Covered California plans.

Figure 13. Stakeholder Perceptions of the Extent to Which Covered California Assures:



PART 3: COMMUNITY ENGAGEMENT AND COLLABORATION

COMMUNITY STAKEHOLDER ENGAGEMENT

Since its inception, Covered California has publicly affirmed the value of stakeholder perspectives in informing, monitoring, and shaping marketplace policies and practices. In September 2012, Covered California developed a Stakeholder Engagement Plan to formalize stakeholder relation efforts and transparently communicate them to external partners. Covered California identified four distinct objectives it hoped the Stakeholder Engagement Plan activities would reflect: [69]

1. Gathering general and topic-specific input on policy issues;
2. Building and sustaining partnerships;
3. Fostering better understanding of the [marketplace]; and
4. Understanding how [marketplace] policies impact stakeholder partners.

The plan describes a variety of opportunities for stakeholders to advise the marketplace, primarily through engagement with its Board of Directors and participation in one of the marketplace's four advisory groups. Covered California invites stakeholders to attend monthly board meetings in-person, providing webcast and call-in capability for remote participants. Stakeholders may submit written comments pertaining to Board agenda items, which are then reviewed and assembled for Board and executive staff consideration in advance of meetings. Opportunities for public comment occur during meetings, and stakeholders are occasionally invited to present on relevant issues or policies.[70]

The marketplace also convenes four stakeholder advisory groups – the Plan Management and Delivery System Reform Advisory Group, the Marketing, Outreach, and Enrollment Assistance Advisory Group, the Small Employer Health Options Program (SHOP) Advisory Group, and the Tribal Advisory Group.[71] Each group is comprised of 12-15 appointed stakeholder members, many representing community advocacy organizations, providers, agents and brokers, businesses, and other marketplace partners. The advisory groups convene quarterly to provide the marketplace with feedback and recommendations on plans, policy, and strategy pertaining to their respective topic areas. Covered California considers equity in group member selection, "striv[ing] to ensure that advisory groups represent California's cultural, geographic, and economic diversity."[72] The Marketing, Outreach, and Enrollment Assistance Advisory Group is also divided into African American, Latino, Asian/Pacific Islander, and LGBTQ subcommittees, which meet in breakout groups for portions of full advisory group meetings.[73, 74] Regular webinars, marketplace e-mail

Figure 14. Advocacy Groups Engaged with Covered California

Advocacy groups representing diverse populations frequently submit Comments to the Board and participate in other forms of formal stakeholder engagement. Some of these organizations include:

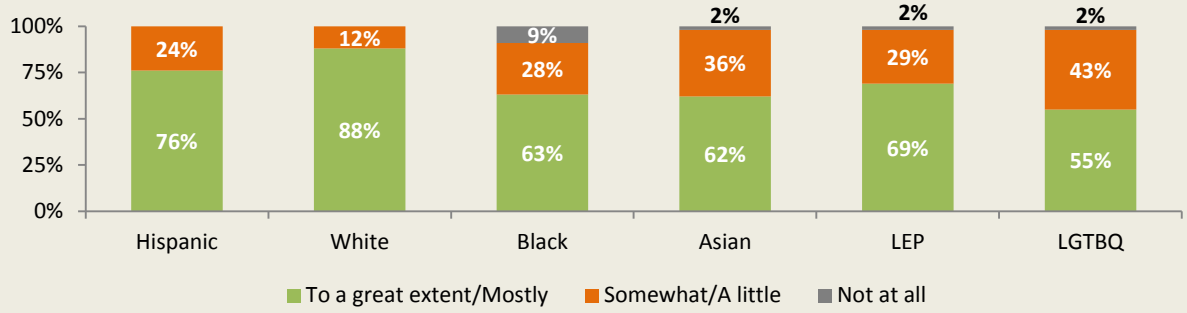
- California Pan-Ethnic Health Network
- Health Access
- California Black Health Network
- Asian Americans Advancing Justice – LA
- Asian Law Alliance
- South Asian Network
- Having Our Say
- SEIU California
- Korean Community Center of the East Bay
- Alameda Health Consortium
- NICOS Chinese Health Coalition
- Korean Resource Center
- Taulama
- Asian American Drug Abuse Program
- Families in Good Health
- California Coverage and Health Initiatives
- Latino Coalition for a Healthy California
- Western Center on Law and Poverty

Source: Signatories on comment letters to Covered California Board of Directors. 2012-2016.

distribution, and one-on-one or *ad hoc* stakeholder meetings round out the marketplace's stakeholder communication activities.

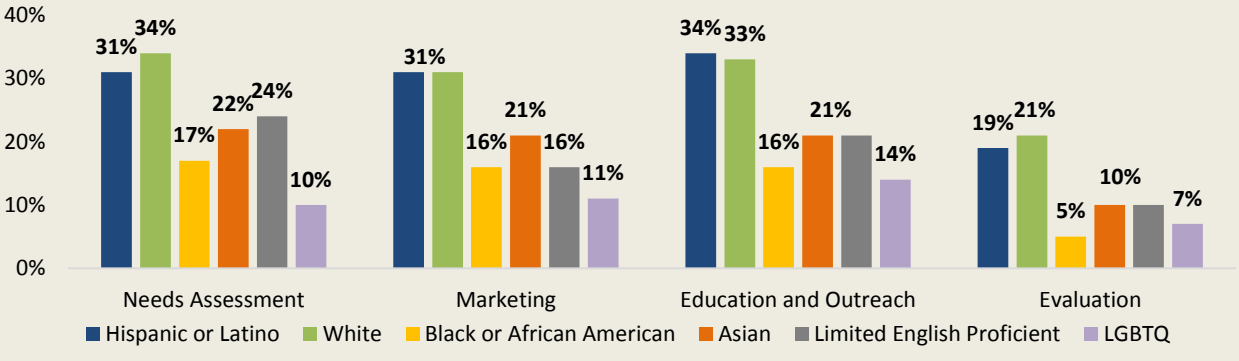
Community stakeholders were asked to report the extent to which they felt that Covered California engaged representatives from diverse communities to inform plans, policies, and decisions of the marketplace (Figure 15). While almost all respondents agreed that diverse stakeholders were engaged at least a little or somewhat to inform the marketplace's plans, policies, and decisions, some differences in perceived engagement by population emerged. Whereas 88% and 76% of community stakeholders reported that they felt Whites and Hispanics, respectively, were mostly or to a great extent engaged, under two-thirds reported this was the case for Blacks, Asians, and LGBTQ populations. Perception of "not at all" being engaged was highest for Blacks (9%).

Figure 15. Perception of Covered California's Engagement of Diverse Representatives to Inform Plans, Policies, and Decisions



In an effort to further understand the nature of stakeholder input and engagement in Covered California activities, we asked respondents to report the extent to which diverse community stakeholders were engaged across functions such as identifying community needs/preferences, marketing, education and outreach, and evaluation. Overall, White and Hispanic representatives were perceived to be more often engaged than other racial/ethnic and LGBTQ representatives across all functions (Figure 16). Among racial/ethnic groups, African Americans were identified as least often engaged. For example, whereas 34% and 31% of stakeholders perceived that Whites and Hispanics were always or very often engaged to identify community needs and priorities, only 22% and 17% felt this was the case for Asians and Blacks, respectively. Rates of engagement were perceived to be lowest across all groups for evaluation activities, yet still higher for Whites and Hispanics.

Figure 16. Community Stakeholders Reporting that Covered California Always or Very Often Engages Community Stakeholders by Population Group and Marketplace Function



INCORPORATION OF STAKEHOLDER FEEDBACK

Covered California has worked to cultivate a feedback loop with its community partners. For example, on some occasions the marketplace presents public comment summaries, displaying aggregated stakeholder comments on items the marketplace Board or executive leadership is taking under consideration (Figure 17). The summary displays each issue, comments the marketplace has received, and ways Covered California has, has not, or plans to integrate community stakeholder feedback.[75]

Figure 17. Public Comment Summary with Covered California Responses

2017 DRAFT APPLICATION – PUBLIC COMMENT SUMMARY

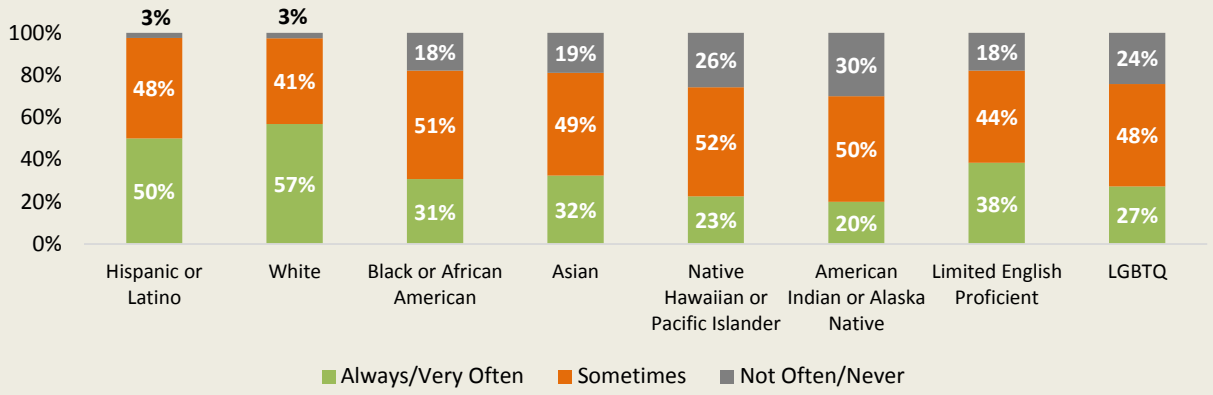
Issue #	Section	Issue Area	Consolidated Comment	Covered California Response
6	Global	State and Federal law	Covered CA should state Applicants are required to comply with specific state laws in applicable questions and requirements.	Covered CA does not intend to re-state requirements dictated by federal or state laws.
7	3	Networks	"Preferred and non-preferred networks" could be construed to mean PPO network design.	Covered CA will remove "preferred and non-preferred networks" from language prohibiting tiered networks.
8	4.4.1	Networks	Covered CA should require demonstration of Applicant capacity to comply with SB 137 requirements related to provider directory updates. Covered CA should require the submission of additional information in Applicant provider data submissions.	Determination of the provider data elements currently requested is a result of extensive collaborative discussions to identify elements that can be consistently and accurately captured across a range of issuers. Covered CA will continue to defer to the applicable regulator for compliance with provider data regulations.
9	4.4.5	Networks	Covered CA should not require disclosure of provider contract details.	Covered CA does not intend to change the requirement of issuers to disclose contract provisions that prevent transparency.
10	5	Essential Community Providers	Importance of maintaining complete and accurate ECPs, and reviewing annually.	Covered CA is committed to regular review and maintenance of the ECP list in accordance with policy adopted by the Exchange Board. The ECP list remains publicly available for review and comment.
11	6.3.5	Customer Service	Applicants should be required to provide customer assistance in all threshold languages.	Final application requirements will include all threshold languages.
12	8	eValue8	Suggestions to revise information requested in the eValue8 tool, including reading level and language services.	All Applicants will complete the same eValue8 tool. The eValue8 tool can be modified for application to Exchange QHPs, including removal of references to tiered networks, but the questions embedded in the tool are standardized for use across all health plans.

Source: Covered California. (February 2016). Policy and Action Items.

A recent example of one occasion where stakeholder feedback figured prominently into Covered California's decision-making is the spring 2016 adoption of standards for health plan race/ethnicity data collection and quality improvement initiatives. Covered California initially proposed requiring plans to achieve an 85% response rate to self-reported race/ethnicity questions by 2019. Some stakeholder comments expressed concern that the target was too ambitious and pace of implementation too fast, while others felt it may not be fast enough. Stakeholders also cautioned that proposed quality improvement initiatives may carry the risk of widening health disparities without careful monitoring. After evaluating the full balance of stakeholder input, which included more than 25 areas of comment, Covered California reduced the self-reported race/ethnicity response rate target to 80% by 2019, while also incorporating balancing measures that will alert Covered California to instances where quality improvement initiatives may unintentionally aggravate disparities.[76]

While Covered California has established a written process for soliciting and documenting stakeholder feedback around key issues, there is uncertainty to the degree to which feedback pertaining to and from advocates and representatives from diverse communities is ultimately incorporated in final plans and programs. When we asked stakeholders to report how often they felt feedback from diverse community representatives was incorporated into marketplace plans and programs, surveyed stakeholders identified considerable differences by population. Based on their experiences, they felt that feedback from White and Hispanic stakeholders was more often incorporated by the marketplace than feedback from those representing Blacks, Asians, and other diverse populations (Figure 18). Specifically, whereas more than half of stakeholders reported feeling that feedback from White (57%) and Hispanic (50%) representatives was always or very often incorporated, less than one-third felt this was the case for Asians (32%) and Blacks (31%), even fewer for other diverse groups.

Figure 18. Perception of How Often Covered California has Incorporated Feedback from Diverse Community Stakeholders into its Decisions and Programs



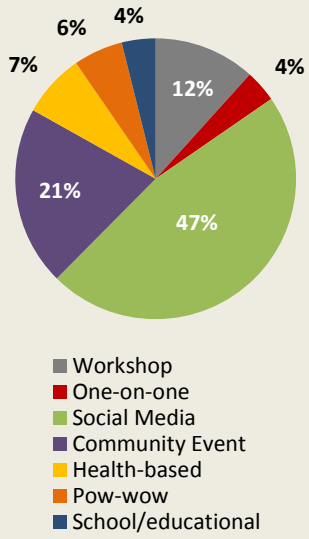
These results seem to align with public input shared at marketplace board meetings that Covered California has been relatively less responsive to African-American advocates compared to White and Hispanic groups. Prior to the second open enrollment period, several African-American advocacy groups expressed a common concern that Covered California lacked a plan or willingness to invest strongly in African-American engagement. They noted that Covered California did solicit their suggestions for outreach strategies to this population, but those suggestions ultimately were not used.[77]

TRIBAL CONSULTATION

Covered California adopted its Tribal Consultation Policy in 2012, in alignment with the ACA requirement for marketplaces in states with at least one federally recognized Indian Tribe to engage in "regular and meaningful consultation" on marketplace policies that may have implications for tribal nations.[78] Covered California's policy calls for annual tribal consultation with best efforts made to engage representatives of Tribal leadership, Tribal health programs, urban Indian health programs, and other interested Indian health organizations from diverse geographic areas of the state. In addition, the Tribal Consultation Policy established the Tribal Advisory Workgroup, which meets quarterly. Workgroup members work more closely with the marketplace to deliver feedback and recommendations that may inform marketplace policy development and operations.[79] The Tribal Consultation Policy was scheduled for re-evaluation in December 2014, at which time tribal stakeholders would consider whether to sustain the terms of the consultation policy and continue convening the Tribal Advisory Workgroup.[80] During tribal consultation, tribal advocates recommended – and Covered California agreed – that the Tribal Consultation Policy had been instrumental in ensuring that Covered California meets its legal obligations to American Indian/Alaska Native (AI/AN) populations; however, we found no public record of Tribal Advisory Workgroup meetings after July 2014, nor any publicly documented amendments to the Tribal Consultation Policy's initial terms.

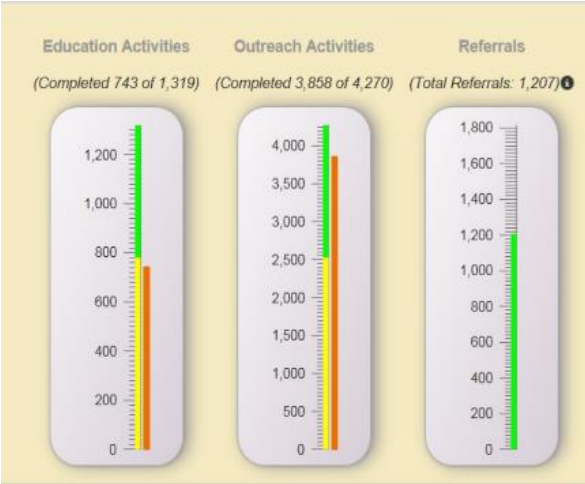
Covered California monitored the volume of its tribal education, and referral activities, overall and by setting (Figures 19 and 20). Social media comprised the bulk of Covered California's outreach to AI/AN populations, complemented by appearances at tribal community events, pow-wows, and workshops. The marketplace relied on regular tribal engagement to illuminate and share best practices.

Figure 19. Covered California Outreach to American Indian/Alaska Natives, by Setting, 2014



Source: Covered California. (2014). Tribal Consultation.

Figure 20. Volume of Outreach to American Indian/Alaska Natives, 2014



Source: Covered California. (2014). Tribal Consultation.

According to the marketplace, a collection of best practices that emerged from tribal consultation included:[81]

- Establishing a presence (i.e., through tabling) at tribal events, meetings, and conferences throughout California;
- Providing culturally appropriate print, media, and display materials;
- Operating patient kiosks at Indian health clinics;
- Providing training for providers and clinic staff;
- Developing a resource guide summarizing the impact of relevant laws and regulations on American Indian/Alaska Native populations;
- Compiling a directory containing a comprehensive contact list of Tribes, Tribal health programs, urban Indian programs, and other state-based tribal organizations; and
- Explicitly designating Tribal health programs and urban Indian clinics as Essential Community Providers, which must constitute at least 15% of any health plan's provider network.

Tribal consultation also provided a forum for Tribal advocates to pass along concerns and challenges to the marketplace, working alongside Covered California to identify solutions. For example, during tribal consultation, advocates alerted Covered California to a so-called mixed tribal family "glitch" that caused members of federally recognized tribes to lose unique protections afforded to AI/ANs under the ACA when their enrollment application contained other family members who do not belong to a federally recognized tribe. Advocates also described instances in which AI/AN enrollees received insurance cards with erroneous benefit information that did not reflect their AI/AN status. Consequently, many AI/AN consumers experienced confusion when using their insurance and were occasionally asked to make payments they may not have owed.[82] Covered California has prioritized these concerns for correction, though it remains unclear whether the issues have been fully rectified.[83, 84]

Only seven respondents offered feedback on Tribal Consultation and Tribal Advisory Workgroup questions. Half either did not know about the effectiveness of tribal programs or reported they were

only somewhat effective to foster trust between tribal communities and Covered California, educate and reach out to tribal communities, and facilitate enrollment.

CROSS-SECTOR COLLABORATION

Many provisions of the Affordable Care Act emphasize the importance of consultation and partnerships with multi-sector stakeholders to inform marketplace policies and operations. Covered California has embraced the ACA's charge on this account, not only with regard to engagement of advocacy groups and community-based organizations but also with health sector stakeholders, faith-based entities, small business, and media. Covered California has engaged faith communities and small businesses in target geographic areas (e.g., barbershops) to disseminate information about the value of enrolling in health insurance and where consumers can go for help.[85] Faith communities have been key partners in building local trust and rapport with Covered California, and since 2015, 4% of Covered California's Navigator grantees have been classified as faith-based organizations.[86] Leveraging the reach of ethnic media and LGBTQ media outlets has also been important to Covered California's marketing strategy.[87, 88]

We asked community stakeholder organizations to rate how important they felt several types of multi-sector partnerships were to furthering Covered California's efforts to reach and enroll diverse populations (Figure 21). In addition, we asked them to reflect on their knowledge of existing cross-sector collaborations involving Covered California and assess how effective they perceive these partnerships have been to date to reach and enroll diverse populations (Figure 22).

Figure 21. Stakeholder Perception of Importance that Covered California Works with Different Types of Multi-Sector Stakeholders

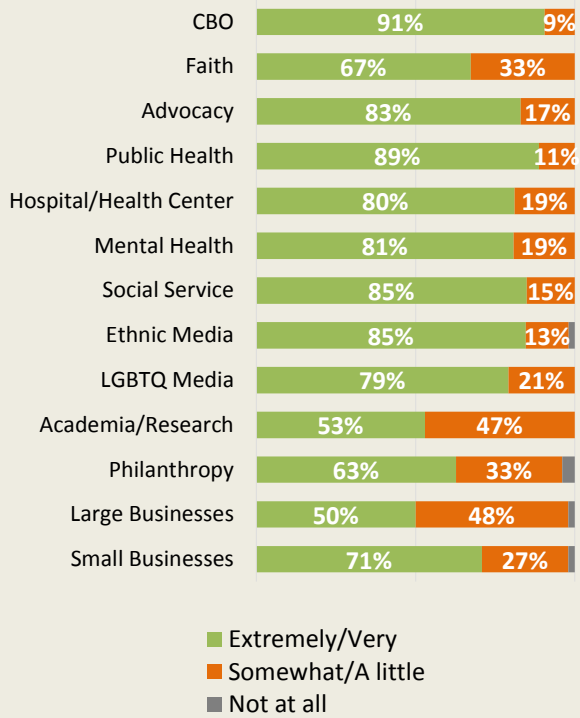
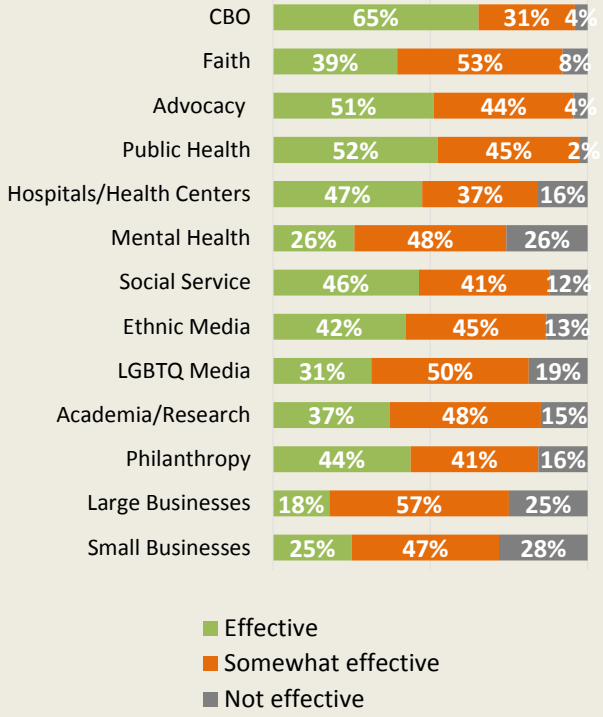


Figure 22. Stakeholder Perception of Effectiveness of Existing Partnerships between Covered California and its Multi-sector Stakeholders



The vast majority of stakeholders felt that multi-sector partnerships were very or extremely important – especially with regard to community-based organizations, health sector partners, and media including ethnic and diverse media outlets. Of Covered California's existing partnerships, stakeholders most often rated those with community-based organizations as effective, followed by public health and advocacy groups. Despite recognizing the importance of partnerships with ethnic media, LGBTQ media and faith organizations, stakeholder respondents suggested there may be room for strengthening such partnerships as only 42%, 31% and 39%, respectively, reported existing partnerships had been effective in reaching and enrolling diverse populations.

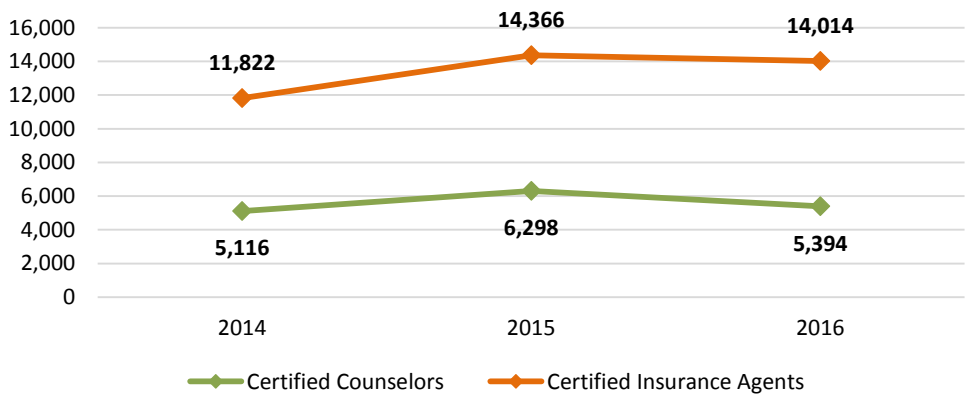
PART 4: NAVIGATORS AND IN-PERSON ASSISTERS

OVERVIEW OF ENROLLMENT ASSISTANCE PROGRAMS

Covered California's enrollment assistance programs are distinct in structure, financing, and personnel from any other marketplace in the nation. The ACA authorized state-based marketplaces, such as California's, to design and implement their own enrollment assistance programs, requiring enrollment assisters to "provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange [or Marketplace]."[89] Marketplaces must also provide oral interpretation, written translations, and taglines to indicate the availability of language services at no cost to the consumer.[90]

Covered California and its enrollment partners have worked to cultivate and sustain a robust cohort of enrollment assisters which collectively include certified and licensed agents and brokers, Certified Enrollment Counselors (CECs), Certified Application Counselors (CACs), Certified Educators, Plan-based Enrollers (PBEs), Certified Medi-Cal managed care enrollers, call center staff, and others. Despite incremental reductions to Covered California's enrollment assistance budget, the size of the enrollment assister cohort has increased slightly since 2014 (Figure 23).[91, 92, 93] In 2016, Covered California had 14,014 Certified Insurance Agents and 5,394 Certified Counselors (including 1,924 CECs, 2,228 CACs, 1,199 PBEs and 43 Medi-Cal managed care plan enrollers).[94] Refer to the Spotlight on p. 26 for a complete description of consumer assistance personnel in California and a comparison of activities they each perform.

Figure 23. Number of Enrollment Assisters, by Type



Source: Covered California. (2014-2016). Executive Director's Reports.

Spotlight: Marketplace Consumer Assisters in California

The following personnel receive training and certification from Covered California to carry out consumer assistance activities:

- **Certified enrollment counselors.** Individuals who are trained to provide outreach, education, and face-to-face assistance with enrollment in marketplace health insurance or other health insurance programs for which they may be eligible, such as Medi-Cal. While CECs may explain the differences between plans, they must remain neutral and may not dispense advice on which plan a consumer should select.
- **Certified application counselors.** Workers who perform many of the same functions as CECs, but are not compensated by the marketplace or its certified enrollment entities. Often, these individuals are already employed by and embedded in health care settings, such as hospitals or community health centers.
- **Certified educators *(ended July 2015)*.** Persons trained to disseminate information about Covered California to prospective enrollees and encourage them to obtain coverage. Unlike CECs, certified educators cannot assist consumers with filling out an application.
- **Licensed insurance agents and brokers.** Individuals who may be compensated by consumers or health insurance carriers for enrolling individuals or small businesses in marketplace plans in accordance with California law. Certified agents and brokers may advise consumers what plan is best for them.
- **Call center or service center representatives.** Personnel who are available to answer questions and provide enrollment support via telephone or online chat.
- **Plan-based enrollers.** Representatives directly affiliated with carriers who sell plans on the marketplace.
- **County eligibility workers.** Employees of county programs who are trained to provide enrollment assistance for safety-net health insurance programs such as Medi-Cal and CHIP.

	Paid for by Marketplace (as of 2016)	Provides outreach and/or education	Can assist with completing application	Can advise on plan selection	Can collect premium payments
Certified Enrollment Counselor	✓	✓	✓	✗	✗
Certified Application Counselor	✗	✓	✓	✗	✗
Certified Educator	✗	✓	✗	✗	✗
Insurance agent or broker	✗	✓	✓	✓	✓
Call center representative	✓	✓	✓	✗	✗
Plan-based Enroller	✗	✓	✓	✓	✓
County Eligibility Worker	✗	✓	✓	n/a	n/a

Sources:

1. Contra Costa County Employment & Human Services. (2015). Glossary of Healthcare Terms.
2. Jahnke L.R., Siddiqui N.J., and Andrulis D.P. (2014). Marketplace consumer assistance programs and promising practices for enrolling racially and ethnically diverse communities.
3. Jahnke, L. R., Siddiqui, N. J., and Andrulis, D. P. (2015). Evolution of Health Insurance Marketplace Experiences and Progress in Reaching and Enrolling Diverse Populations.

FUNDING AND SCOPE OF ENROLLMENT ASSISTANCE PROGRAMS

Covered California established several consumer assistance programs and personnel designations in its early years of operation, each varying by function and funding source. Among its early programs was the Outreach and Education Grant Program which provided $43 million in funding through February 2015 for training Certified Educators tasked with outreach and education, but not enrollment.[95] A set of parallel programs—the In-Person Assistance Program and Navigator Grant Program—funded organizations called Certified Enrollment Entities (CEEs) to assist consumers with application and enrollment. The In-Person Assistance program operated using federal establishment grant dollars when they were available through June 2015. The Navigator program started in July 2015, funded with fees assessed on health plans sold through the marketplace once enrollment began.[96]

As part of a planned transition away from expiring federal establishment funds, Covered California ended its Outreach and Education Grant Program and transitioned its In-Person Assistance Program to a non-compensated Certified Application Counselor program in 2015. As of July 1, 2015, the Navigator Grant Program has remained Covered California's sole program for compensating CEEs.[97] Covered California selects its CEEs through a competitive solicitation process each year, evaluating applicants in large part on their readiness to serve culturally and linguistically diverse groups.[98] Organizations who do not receive navigator grants but are willing to provide non-compensated enrollment assistance are encouraged to transition to the Certified Application Counselor program.[99] Similarly, outside stakeholder groups that wish to provide outreach and education on behalf of Covered California can join Covered California's Community Outreach Network, which provides access to free resources, trainings, collateral, staff consultation, event coordination, and other support.[100]

Table 4. Navigator Grant Program Funding for CEEs, 2014-17

Year	Number of Lead Organizations [101, 102, 103]	Total Funding [104, 105, 106]
2014-15	66	$14.6 M
2015-16	68	$10.0 M
2016-17	47	$7.25 M

Prior to the first open enrollment in 2013-14, Covered California's In-Person Assistance program awarded $5 million in enrollment assistance grants[107] that were ultimately disbursed among 538 different CEEs (both lead organizations and subcontractors).[108] For the second open enrollment in 2014-15, Covered California tripled funding for its Navigator Grant Program to nearly $15 million, which was disbursed among 68 lead grantees in amounts ranging from $34,000 to $750,000.

Since the 2014-15 open enrollment cycle, a stepwise decline in funding for the Navigator Grant Program occurred, commensurate with reductions to Covered California's overall budget (Table 4). Covered California proposed a 50% cut in the Navigator Grant Program budget between 2015-16 and 2016-17, a reduction advocacy groups remarked would be "a terrible waste [of] experience and knowledge developed by the Navigator Program's culturally and linguistically competent Certified Enrollment Counselors."[109] After considering stakeholder comments, Covered California revised its budget, easing cuts to the Navigator Program from 50% to 25%. Over $7 million in Navigator grants were recently awarded to 47 lead CEE organizations for the fourth (2016-17) open enrollment period. The number of lead organizations selected dropped by roughly 30% compared to the two previous enrollment periods, a change which allowed the marketplace to keep the average size of each award comparable to previous years' levels.

Covered California's CEEs receive compensation based on the number of assisted individuals who successfully enroll and pay their first monthly premium (called *effectuation*). In the first open enrollment CEEs were paid a rate of $58 per effectuated enrollee,[110] while in subsequent enrollment periods Covered California opted to disburse Navigator grant payments incrementally upon each CEE attaining 25%, 50%, 75%, and 100% of their pre-established enrollment targets.[111] The marketplace also introduced incentive payments for CEEs exceeding their goal by 100 or more effectuated enrollees. Medi-Cal enrollments do not count toward effectuated enrollment totals, nor are CEEs paid for time spent performing consumer education and outreach.[112] Many CEEs have encountered challenges related to the effectuation-based payment structure, with advocates noting hard-to-reach individuals and families are more likely to require multiple "touches," or multiple unique instances of assistance, in order to successfully enroll.[113] Without direct financial support for upstream activities necessary to shepherd a high volume of enrollees across the finish line, several CEEs did not attain enrollment targets or receive the full amount of their Navigator grant awards.

DIVERSITY OF ENROLLMENT ASSISTANCE PROGRAMS

Covered California tracks and reports the number of CEEs serving diverse racial/ethnic, linguistic, and LGBTQ populations (Table 5). The marketplace also monitors the allocation of Navigator grant funding by race/ethnicity, with more granular breakdowns for Asian and Other populations (Table 6). Since 2014, nearly 100% of Covered California's Navigator grantees and program dollars have gone to organizations explicitly targeting culturally and linguistically diverse populations. In the second (2014-15) enrollment period, $7.6 million (52%) of Covered California's $14.6 million Navigator program budget was allocated toward supporting Latino enrollment, while $1.9 million (13%) each was allocated for African/African-Americans and Asians.[117] In addition, over half of Covered California's CEEs reported serving LGBTQ populations, though the marketplace did not report what amount of funding was allocated to those groups. In comparing the proportion of navigator funding by race/ethnicity to the proportion of subsidy eligible population by race/ethnicity, some differences emerge. For example, whereas Latinos comprised 38% of those eligible for marketplace coverage in 2014-15, a larger share (52%) of total navigator funding was dedicated to reaching this group. And while Asians comprised 20% of the subsidy eligible population, only 13% of navigator funding was dedicated to reaching and enrolling this group.

Table 5. Number of Lead CEEs Serving Diverse Populations, 2014-2017

Population Served*	Number of Lead CEEs		
	2014-15[114]	2015-16[115]	2016-17[116]
Hispanic/Latino	62	66	47
Black or African American	54	61	42
Caucasian	52	60	43
Asian	47	53	26
Native Hawaiian/Pacific Islander	--	6	--
American Indian/Alaska Native	15	6	2
Other races	40	32	--
Linguistically diverse	63	--	--
LGBTQ	7	--	23
TOTAL	**66**	**68**	**47**

*Not all populations reported in all years. Entities may serve more than one population.

We asked community stakeholders (83% of whom said they work with Covered California to provide outreach, education, or enrollment) to reflect on their knowledge and experience with the diversity of CEEs and CECs. Responding stakeholders generally affirmed the diverse composition of Covered California's CEE organizations (Figure 24). When asked to report how racially, ethnically, and linguistically representative CEE organizations were of marketplace eligible populations, nearly two-thirds of respondents felt they were representative or very representative, 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. A similar response pattern emerged when community stakeholders were asked to report how representative they felt the cohort of CECs has been of diverse communities; the majority agreed these individuals generally reflected the races/ethnicities (65%) and languages (60%) of consumers they served, although fewer (42%) perceived this was the case for LGBTQ populations (Figure 25).

Table 6. Allocation of Navigator Funds by Race/Ethnicity, 2014-15

Ethnicity	Lead CEEs*[118]	Navigator Funds Awarded[119]	% of Total Funding	% Subsidy Eligible Population
Latino	**62**	**$7,567,468**	**51.7%**	**38%**
Caucasian	**52**	**$2,360,174**	**16.1%**	**33%**
Asian	**47**	**$1,903,061**	**13.0%**	**20%**
Cambodian	10	$98,805	0.7%	-
Chinese	23	$382,068	2.6%	-
Filipino	30	$247,926	1.7%	-
Hmong	15	$126,666	0.9%	-
Japanese	7	$19,641	0.1%	-
Korean	21	$713,566	4.9%	-
Laotian	10	$23,356	0.2%	-
Vietnamese	27	$291,033	2.0%	-
African/ African American	**54**	**$1,854,756**	**12.7%**	**5%**
African	17	$313.470	2.1%	-
African-American	44	$1,541,286	10.5%	-
Other	**40**	**$902,290**	**6.2%**	**3%**
Middle Eastern	20	$64,127	0.4%	-
Russian	9	$50,114	0.3%	-
Ukrainian	5	$6,981	<0.1%	-
Other	28	$727,017	5.0%	-
American Indian	**15**	**$61.740**	**0.4%**	**-**
TOTAL	**66**	**$14,649,490**	**100.0%**	

*Entities may serve more than one population.

Figure 24. Community Stakeholder Perception of How Representative CEEs are of Populations Served

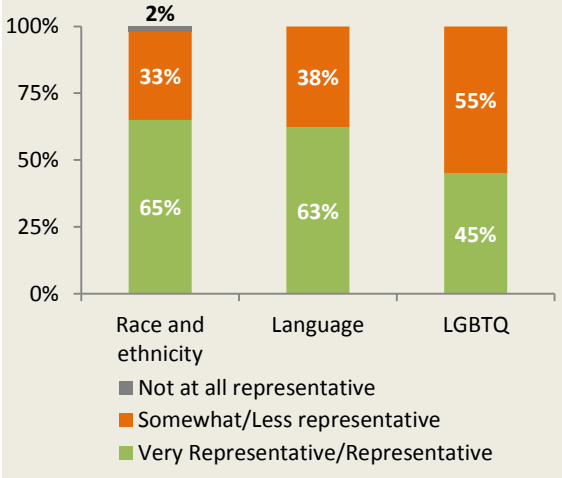
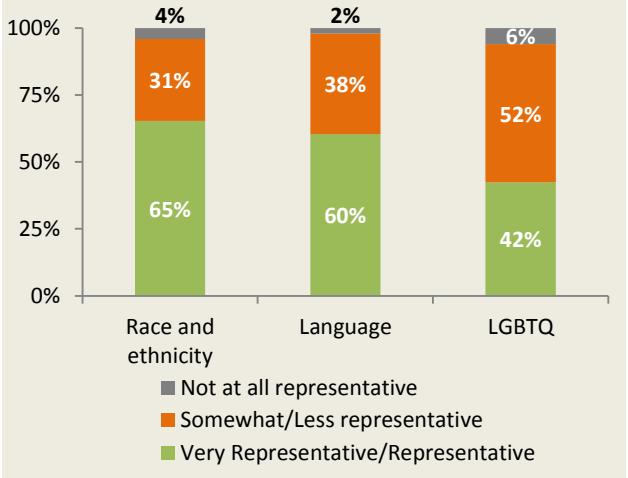


Figure 25. Community Stakeholder Perception of How Representative CECs are of Populations Served



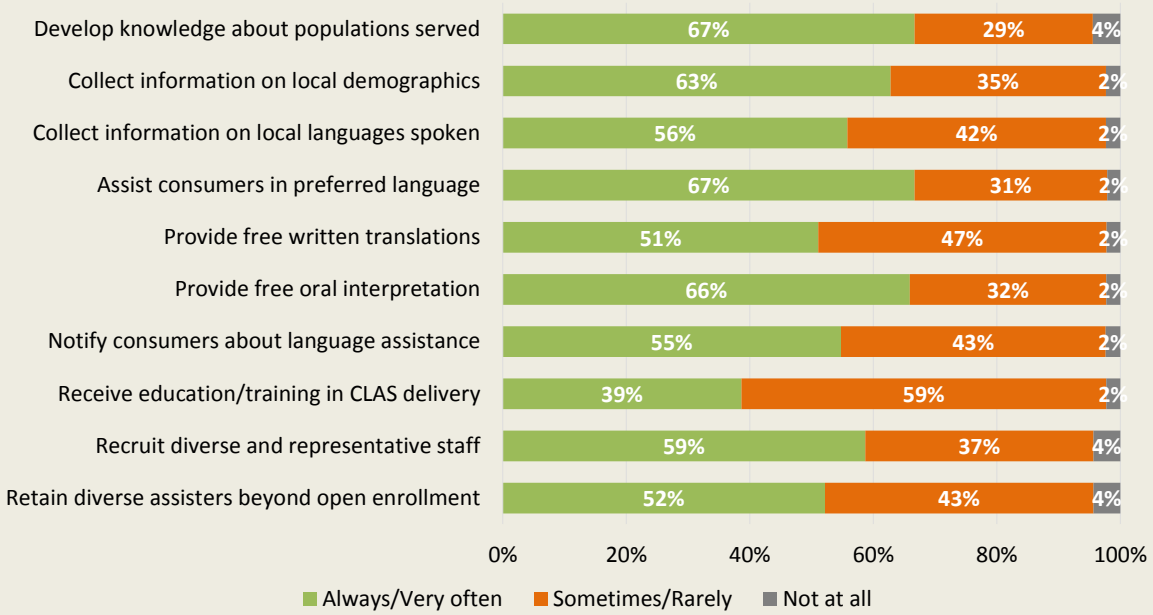
CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

The ACA regulations pertaining to accessibility of marketplaces and their consumer assistance programs specify requirements to deliver free "(o)ral interpretation, written translations, and taglines in non-English languages indicating the availability of language services."[120] As a marketplace that emphasized equity from an early stage, Covered California adopted requirements for Navigator program entities that align with its health equity goals. Covered California's Navigator program requirements state that all entities must, at minimum, "provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the [Marketplace], including individuals with limited English proficiency."[121] The Navigator program regulations further enumerate activities that all certified enrollment entities shall perform to ensure culturally and linguistically appropriate service delivery, including:[122]

- Develop and maintain general knowledge about the racial, ethnic, and cultural groups in their service area, including each group's diverse cultural health beliefs and practices, preferred languages, health literacy, and other needs;
- Collect and maintain updated information to help understand the composition of the communities in the service area, including the primary languages spoken;
- Provide consumers with information and assistance in the consumer's preferred language, at no cost to the consumer, including the provision of oral interpretation of non-English languages and the translation of written documents in non-English languages when necessary to ensure meaningful access;
- Provide oral and written notice to consumers with limited English proficiency informing them of their right to receive language assistance services and how to obtain them;
- Receive ongoing education and training in culturally and linguistically appropriate service delivery; and
- Implement strategies to recruit, support, and promote a staff that is representative of the demographic characteristics, including primary languages spoken, of the communities in their service area.

Community stakeholders were asked to report how often they perceived that enrollment entities carried out activities consistent with culturally and linguistically appropriate service delivery as specified in California's Navigator program regulations (Figure 26). In general, respondents agreed that these activities are occurring with at least some regularity: for nearly all measures at least half of stakeholders believed these activities were occurring always or very often, and fewer than 5% felt these activities were not occurring at all on any measure. According to roughly two-thirds of community stakeholders, enrollment entities had always or very often worked to collect information on the demographic composition of the community they serve, developed general knowledge about how to best serve these groups according to their cultural beliefs and preferences, assisted consumers in preferred language, and provided free oral interpretation. In contrast, only 39% reported that enrollment entities received adequate training and education on delivering culturally and linguistically appropriate services (CLAS).

Figure 26. Stakeholder Perception of How Often Enrollment Entities Carry Out Functions to Assure Culturally and Linguistically Appropriate Services



LANGUAGE ACCESS

Table 7. Proportion of Enrollment Assistance Personnel Speaking Languages Other than English, 2016

Language	Certified Insurance Agents[123]	Certified Counselors*[124]
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 (CECs, CACs, PBEs, etc.)

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 (Table 7). In contrast, the proportion of agents and counselors who speak Asian languages is more comparable. Seven percent of agents speak Cantonese, 7% speak Mandarin, 4% speak Korean, and 4% speak Vietnamese; each of these proportions except Mandarin corresponds to the approximate midpoint of the range of counselors who speak those same languages. In addition, Covered California's contracts with its service center provider have required at least 15-20% of call center representatives to be bilingual in English and Spanish, and staffing minimums for Arabic, Armenian, Cambodian, Cantonese, Farsi, Hmong, Korean, Laotian, Mandarin, Russian, Tagalog, and Vietnamese have also been stipulated.[125]

When asked to report based on experience how often community stakeholders felt that Covered California was able to provide interpretation services in a consumer's requested language, slightly more than half (54%) believed Covered California delivered interpretation sometimes or rarely, while just under half (46%) said interpretation in a consumer's requested language occurred always or very often (Figure 27). Of note, none of the respondents said interpretation services were never provided.

Figure 27. Community Stakeholders Reporting How Often Covered California Provided Interpreter Services in Consumers' Requested Languages

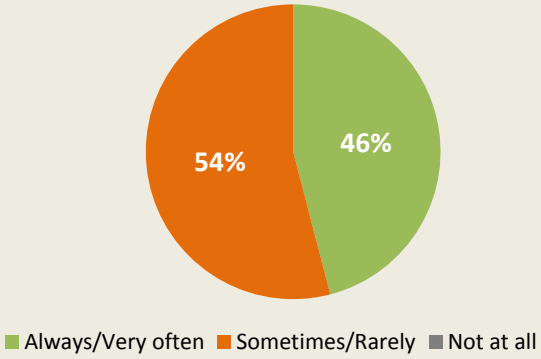
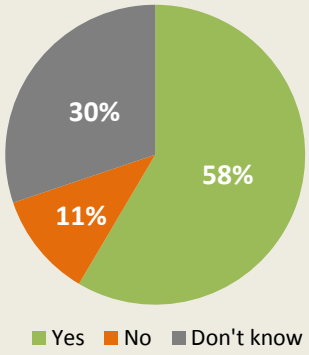


Figure 28. Stakeholder Knowledge of Year-round Availability of Culturally and Linguistically Appropriate Services for Consumers



In May 2016, advocates commented to the board that "for over two years, Covered California has failed to provide written translations as the law requires."[126] Spanish is usually provided but the other 13 Medi-Cal languages are often not provided. Advocates called this an "impermissible distinction."[127] They noted that when newly qualified immigrants are provided Medi-Cal eligibility, the need to translate will become more urgent. 129,000 Covered California applications reported speaking a language other than English or Spanish. In advocates' opinion, taglines currently provided are insufficient because it requires consumers to take an extra step to understand the information.[128]

Covered California has emphasized the importance of sustaining its cohort of diverse enrollment assisters not only during open enrollment periods, but during special enrollment periods and throughout other times of the year to assist consumers who may be eligible to enroll because of a qualifying life event. The marketplace's 2015 report to the California Governor and legislature stated "Covered California will continue to focus its planning on how to transition from an entity focused primarily on open enrollment 'seasons' to one that establishes a year-round presence.[129] Advocates and researchers have also noted the importance of Covered California placing a greater emphasis on maintaining year-round efforts.[130, 131]

We also asked stakeholders to share whether they were aware of the availability of culturally and linguistically appropriate services year-round, including times outside of the designated open enrollment periods. Over half (58%) of respondents said they were aware such services were available (Figure 28).

TRAINING FOR ENROLLMENT ASSISTERS

Under the ACA, training provided to navigators and in-person assisters must provide instruction on content related to the "needs of underserved and vulnerable populations," as well as procedures for determining eligibility and explaining differences between various qualified health plan options and affordability programs.[132] Additional regulations further specify requirements around culture and language in training and standards for assistance personnel. [133]

Figure 29. LGBTQ Training Webinar for Covered California Assisters

Source: Covered California. (September 2015). Reaching and Assisting LGBT Communities.

California law explicitly requires all types of enrollment assisters to receive training on providing culturally and linguistically appropriate services, as well as delivering effective customer service to vulnerable populations, individuals with limited English proficiency, and persons of any sexual orientation or gender identity (Figure 30).[134] Covered California requires all CECs to complete a two- to three-day training program, including one module on cultural and linguistic competency,[135] while certified insurance agents must complete eight hours of training from Covered California.[136] CACs, PBEs, and Medi-Cal managed care plan enrollers are also required to receive training.[137] [138] In order to achieve certification, all enrollment assisters must annually pass a certification exam with a score of at least 80%. [139, 140, 141, 142, 143, 144, 145] In addition to the required assister training, Covered California has made numerous continuing education training webinars available online.[146] One such webinar included an LGBTQ-specific enroller training that included an emphasis on LGBTQ health disparities (Figure 29).[147] Given the requirements and an explicit module on cultural and linguistic competency, 98% of community stakeholders who were surveyed acknowledged that such training was provided to some degree to enrollment entities and their counselors, but only 39% felt it was offered always or very often (Figure 26).

Figure 30. Covered California Assister Training Curriculum Components with Health Equity Implications

1. Affordable Care Act (ACA)
- ACA fundamentals
- Covered California overview
- Essential benefits

2. Assister Role
- Overview, guidelines, and responsibilities
- Monitoring reporting and evaluation procedures
- Covered California Marketing and Outreach Program overview

3. Uninsured Demographics
- California's uninsured/underserved
- Cultural and linguistic needs
- Motivations and challenges
- Implications for education, outreach, and enrollment support

4. Eligibility
- Understanding open enrollment
- Eligibility for Medi-Cal and Covered California
- Subsidy requirements
- Advance premium tax credits
- Cost sharing reductions
- Monthly premiums
- Native American/Alaska Native populations
- Verification process

5. Plan Options
- How to choose and compare plans
- Medi-Cal plans and cost sharing

6. Enrollment Support
- Enrollment process overview
- Completing the enrollment form
- How to select a provider

7. Post Enrollment
- Renewal and disenrollment
- Understanding important documents
- Consumer support

Source: Covered California. (2013). Assisters Program: In-Person Assistance and Navigator Webinar.

ENROLLMENT APPLICATION

Prior to the first open enrollment in 2013-14, Covered California worked with the Department of Health Care Services and with stakeholder advocacy groups to review and solicit feedback on the single-streamlined paper application. The application was tested in English, Spanish, Mandarin, Cantonese, and Vietnamese. Most recently, English and Spanish applications were available in print and online, while print applications were available in other languages (Vietnamese, Armenian, Russian, Chinese, Tagalog, Korean, Arabic, Hmong, Lao, Farsi, and Khmer).[148]

Covered California collects data on applicant race/ethnicity and preferred written and spoken language, but these questions are optional on its application. Response rates to these questions are shown in Table 8 and reflect the challenges in using the data collected from these optional questions. The application does not collect information on English language proficiency, sexual orientation, or gender identity, aside from the binary categories of male and female.[149]

Table 8. Non-response Rates to Covered California Race/Ethnicity and Language Questions, by Enrollment Cycle

	2013-14[150]	2014-15[151]	2015-16[152]
Race and ethnicity	19.2%	23.6%	25.9%
Preferred written language	6.2%	7.4%	8.0%
Preferred spoken language	5.3%	6.7%	7.3%

PART 5. MARKETING AND OUTREACH

OVERALL MARKETING STRATEGY

Throughout the first three open enrollments, Covered California's communication and marketing strategy has emphasized communities of color (Latinos, Asians, and African Americans in particular) while striving to reach many diverse subpopulations of enrollees, including bilingual, white, millennial, and LGBTQ consumers.[153] In advance of the first open enrollment, Covered California developed a marketing plan explicitly incorporating diversity components into several marketing and outreach functions, including research, creative engagement, social and paid media campaigns, and accessibility of the marketplace website (Figure 31).[154] Despite its plans, Covered California faced resistance to enrollment from specific populations such as Hispanic/Latinos.[155] Early learnings pointed to Covered California's need to provide more culturally-tailored and translated marketing, while also working to produce culturally appropriate information to address population-specific barriers such as fear of deportation among mixed-immigration status families.[156] Building on a series of such lessons, adjustments, and promising

Figure 31. Covered California Marketing Plan Components to Address Health Disparities

- Conduct focus groups in multiple languages
- Develop communication material for radio, newspaper, and magazine to reach diverse communities
- Develop educational collateral on coverage options
- Implement social media campaigns including multi-lingual text responses
- Use paid media to target diverse audiences
- Ensure web accessibility for individuals with disabilities and limited English proficiency

Source: Covered California. (March 2013) Promoting Health Equity and Reducing Health Disparities. Presentation to Board of Directors.

strategies, by 2016, Covered California won the PR News Diversity Heroes award in acknowledgement of its "outstanding public relations practices, strategies, and tactics aimed at reaching diverse audiences as well as efforts to help promote diversity in the public relations industry."[157]

In FY 2013-14, of $57.5 million in gross media spending, Covered California directed approximately 44% 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.[158] Covered California has indicated that media spending is not entirely proportional to the corresponding marketplace eligible population share (as shown in Table 9) because of differential costs of media and consumption patterns, but that it intends to reach all cultural segments by its general market media spending.[159, 160]

Our findings from community stakeholders show many perceived Covered California media spending has not been allocated by eligible racial/ethnic population need (Figure 32). Eighty-six percent and 78% 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%). Focus groups with diverse community members conducted in the early years in California also pointed to the importance of "allocating sufficient resources" to reach diverse communities through marketing and outreach. [161]

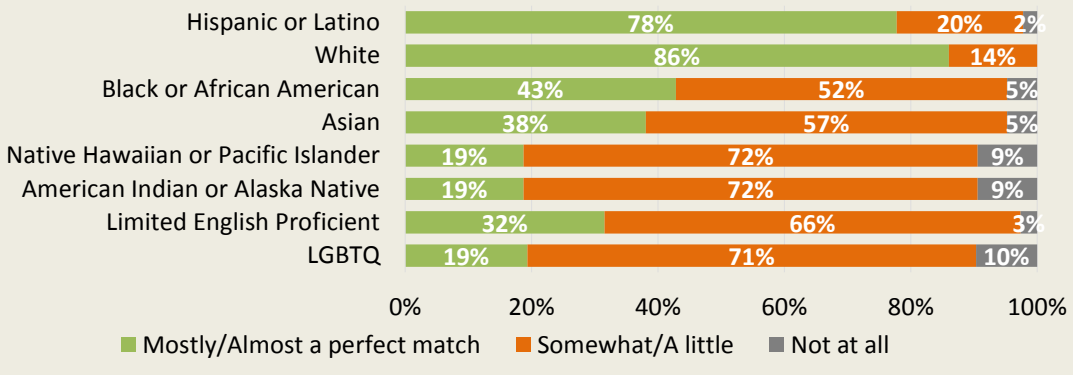
Table 9. Covered California Media Spending by Segment vs. Eligible Population, 2013-14

	Media Spending Allocation[162]	Estimate of Eligible Population[163]
Multi-segment/ General Market	44%	--
Latino	39%	37%
Asian	10%	20%
African American	7%	5%

Figure 31. Paid Media Channel by Segment, 2015

Source: Covered California. (October 2015). Marketing, Outreach, and Enrollment Assistance Advisory Group Meeting

FIgure 32. Stakeholder Perception of Match Between Covered California's Marketing Resource Allocation and Corresponding Percentage of Marketplace Eligible Population



STAKEHOLDER/CONSUMER ENGAGEMENT TO INFORM MARKETING

Covered California relied on research and guidance from its marketing partners to strategize outreach and messaging to diverse populations. After the first open enrollment period, Covered California noted the particular importance of culturally appropriate messaging in consumers' preferred languages, and planned for increased dissemination of multi-lingual, culturally tailored materials.[164] Subsequently, Covered California worked with four different marketing firms before the second and third open enrollment cycles to engage consumers in research and testing to increase capacity to develop and disseminate appropriate messaging.[165, 166] In addition, Covered California contracted with Maximus, Inc. in 2015 to conduct translation, readability, and focus group testing of outreach materials, including collateral and notices to consumers, to ensure compliance with translation requirements.[167] Covered California's required process for producing and approving translations includes "community review" by stakeholders and advocates, ensuring representatives of diverse groups have an opportunity to evaluate cultural and linguistic appropriateness of messages for populations they serve and recommend changes as needed prior to dissemination.[168]

Covered California's marketing partners convened consumer focus groups across the state for both general market and segment-specific marketing, and implemented online consumer message testing.[169] Responses from consumers revealed high awareness of Covered California across diverse populations, and reinforced the importance of affordability and perceived value in consumers' decision to purchase insurance. Further, eligible consumers who remained uninsured generally wanted to be able to have insurance but often faced difficulties or barriers to purchasing it, including understanding the enrollment process.[170]

Based on their findings, Covered California's marketing partners recommended increasing outreach in churches, barbershops, Mexican consulates, community colleges, African-American Chambers of Commerce, business groups, health care workers at group homes and residential facilities, and school districts, using trusted messengers from these settings such as faith and community leaders to spread awareness about the value of purchasing health coverage through Covered California.[171] Additional effort was made to align outreach and enrollment activities with cultural gatherings, such as African American History Month or Martin Luther King, Jr. Day events.[172] During the first open enrollment, many CEEs and enrollment assisters heard prevalent concerns from consumers that their enrollment application information could potentially call attention to family members' undocumented status. In response, immigration-related collateral materials were produced in English, Spanish, Chinese, Korean,

Figure 33. Media Consumption Behavior by Segment, 2015

Source: Covered California. (October 2015). Marketing, Outreach, and Enrollment Assistance Advisory Group Meeting

Figure 34. Media Outlets by Segment, 2015

Source: Covered California. (October 2015). Marketing, Outreach, and Enrollment Assistance Advisory Group Meeting

and Vietnamese to assure consumers their application information would not be used for immigration enforcement.[173] Covered California's marketing research also produced specific behavioral insights about media consumption patterns by race and ethnicity that informed selection of media channels and outlets to most effectively target African Americans, Latinos, and Asians (Figures 31, 33, and 34). [174]

Shortly after the ACA was passed, a report from UCLA's Center for Health Policy Research and California Pan-Ethnic Health Network found that California's communities of color expressed interest and desire to be "involved in designing marketing strategies and messages to promote new coverage options," and based on the marketplace's community review requirement for translated outreach materials, this review confirms Covered California has taken steps to engage diverse community representatives to inform and vet messages and strategies.[175] To measure the extent to which these efforts were recognized by stakeholders, community stakeholder respondents were asked to reflect on their experiences and perceptions of involvement to review or inform marketing materials for cultural and linguistic appropriateness and reach. When asked to what extent they perceived marketing materials were vetted by diverse community members, respondents felt that Hispanics/Latinos (60%), Whites (56%), and Asians (52%) were most often engaged in this process (Figure 35). Fewer reported engagement of other diverse groups, such as Blacks (42%) and LGTBQ populations (38%). 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 (Figure 36).

Figure 35. Stakeholder Perception of Being Engaged Very Often or Always to Vet Marketing Materials, by Population Group

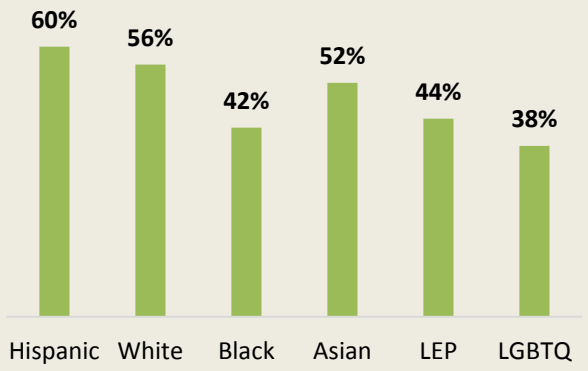
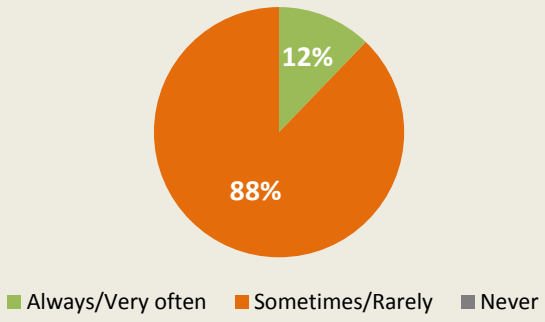


Figure 36. Stakeholder Perception of How Often Feedback from Diverse Stakeholders on Cultural and Linguistic Appropriateness of Marketing and Outreach Messages was Incorporated



PART 6. MARKETPLACE OUTCOMES

OVERALL ENROLLMENT

California's enrollment totaled 1,173,930 after the first open enrollment, 91% of whom received Advance Premium Tax Credit subsidies. The remaining 9% enrolled without financial assistance, most likely earning incomes too high to qualify for tax credits. Enrollment increased by about 149,000 from the first to second open enrollment, and rose by nearly 65,000 after the third open enrollment. Little change occurred in the proportion of subsidized versus unsubsidized enrollees throughout the first three

enrollment periods. In 2016, 69% of California's subsidy-eligible population (138-400% FPL) and 12% of California's non-subsidy eligible population (>400% FPL) had enrolled in a Covered California plan (Table 10).[176]

Table 10. Persons Enrolled in Covered California Plans, by Subsidy Status, 2013-2016

	2013-14[177]	2014-15[178]	2015-16[179]
Total Enrolled	1,173,930	1,322,870	1,387,540
Subsidized	1,069,160	1,195,200	1,231,970
Unsubsidized	104,770	127,670	155,570

Table 11. Covered California Proportion Subsidy-eligible Enrolled* vs. Estimated Eligible, by Race/Ethnicity and Language, 2013-2016

	2013-14		2014-15		2015-16	
	Subsidized Enrollment[180]	Estimated Subsidy Eligible[181]	Subsidized Enrollment[182]	Estimated Subsidy Eligible[183]	Subsidized Enrollment[184]	Estimated Subsidy Eligible[185]
TOTAL	1,069,160	2,600,000	1,195,200	2,500,000	1,231,970	2,600,000
Hispanic or Latino	29.1%	46%	29.6%	37%	29.5%	38%
White	36.4%	33%	37.3%	33%	37.6%	33%
Black or African American	2.5%	4%	2.3%	5%	2.3%	5%
Asian	24.3%	14%	23.1%	20%	23.1%	20%
Native Hawaiian/ Pacific Islander	0.2%	3%	0.2%	4%	0.2%	3%
American Indian/ Alaska Native	0.3%		0.3%		0.3%	
Two or More Races	2.0%		2.0%		2.1%	
Other Race	5.2%		5.0%		4.7%	
Spoken language other than English**	23.2%	40%	22.2%	39%	21.5%	38%

*Subsidy-eligible enrollment percentages are based on the subtotal of enrollees who provided their race/ethnicity and preferred spoken language (not shown). Non-response rates are provided in Table 8.
**Covered California reports persons with preferred spoken languages other than English, while CalSIM projects persons with limited English proficiency.

Subsidized enrollment data from the first three open enrollment periods show that enrollment by race and ethnicity among the subsidy-eligible population 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 (Table 11). However, differences are larger among some groups. In 2015-16, 29.5% of subsidized enrollees in Covered California plans were Hispanic/Latino, falling short of the proportion of Hispanic/Latino subsidy eligible population by nearly ten percentage points. In contrast, subsidized enrollment among Whites (37.6%) and Asians (23.1%) in 2016 exceeded the estimated proportion of those groups in the subsidy eligible population (33% and 20%, respectively). Covered California does not report enrollment outcomes by sexual orientation or gender identity, other than binary options of male and female.[186]

Of note, Covered California reported that roughly one-fifth (240,000) of its enrollees in each enrollment period indicate a preferred spoken language other than English, the category in which the widest differences between those eligible and enrolled are observed. In 2015-16, CalSIM projections estimated 38% of the subsidy-eligible population had limited English proficiency, while just 21.5% of Covered California's subsidized enrollees indicated a preferred spoken language other than English. Although

some caution should be used when directly comparing these two proportions due to a slight difference in how they are defined, Table 11 shows they differ by nearly 17 percentage points.

Over three enrollment periods, Covered California's enrollment data show their enrolled population demographics have grown more reflective of the racial/ethnic and linguistic characteristics of the subsidy-eligible population since the first open enrollment period.[187] A modest increase occurred in the proportion of Whites and Latinos enrolled and a modest decrease was observed in the proportions of Asian enrollment, with enrollment remaining steady across all other race/ethnic groups. As with previous enrollment periods, in 2015-16, a smaller percentage of Hispanics/Latinos and Blacks enrolled in marketplace coverage than were projected eligible by CalSIM. While the percentage of those enrolled with a preferred spoken language other than English has decreased slightly over time, it has matched a similar decrease in the proportion of persons with limited English proficiency who are subsidy eligible.

Marketplace enrollment outcomes according to service channel are also presented in Figures 37 and 38, with substantial variation apparent by race/ethnicity and language. Among those who enrolled through insurance agents, nearly one-quarter (24%) were Hispanic/Latino, 32% were White, and 35% were Asian. For Asians, the proportion who enrolled by insurance agent was higher than any other service channel. In contrast, a much higher proportion of those enrolled by CECs were Hispanic (64%), while White and Asian consumers comprised just 15% each of CEC-enrolled consumers. The 64% of CEC-enrolled customers who were Hispanic is two to three times higher than the share of Hispanics enrolled through any other service channel. Over half (52%) of those who enrolled without any assistance were White, with Hispanics (23%) and Asians (15%) comprising the next highest shares. Across all service channels the proportion of Black enrollees remained low, but was highest (3%) in service center and unassisted enrollment. Among those speaking a language other than English, 50% enrolled with the help of a CEC, 24% used an insurance agent, 16% enrolled through the service center, and 7% enrolled without assistance. These data appear to align with findings from the literature which suggest populations of color and those with limited English proficiency are more likely to desire or require face-to-face assistance to enroll successfully,[188, 189] pointing to the critical role of navigators and assisters.

Figure 37. Service Channel used to Enroll, by Race/Ethnicity, 2015-16

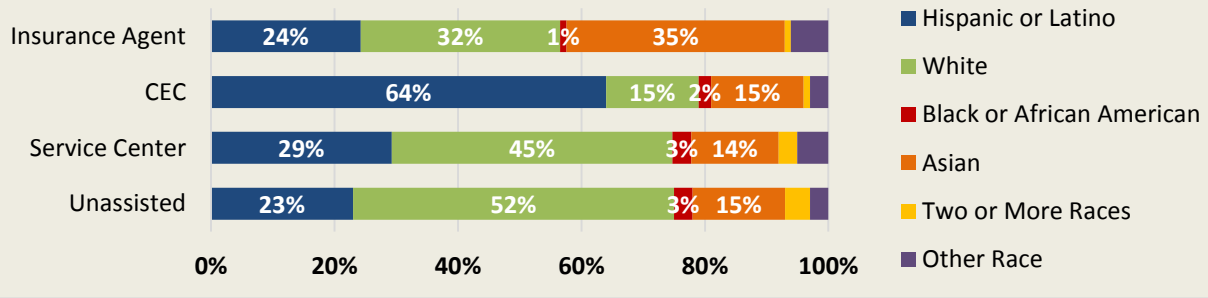
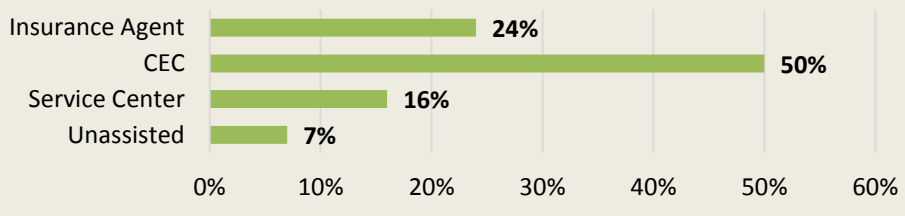


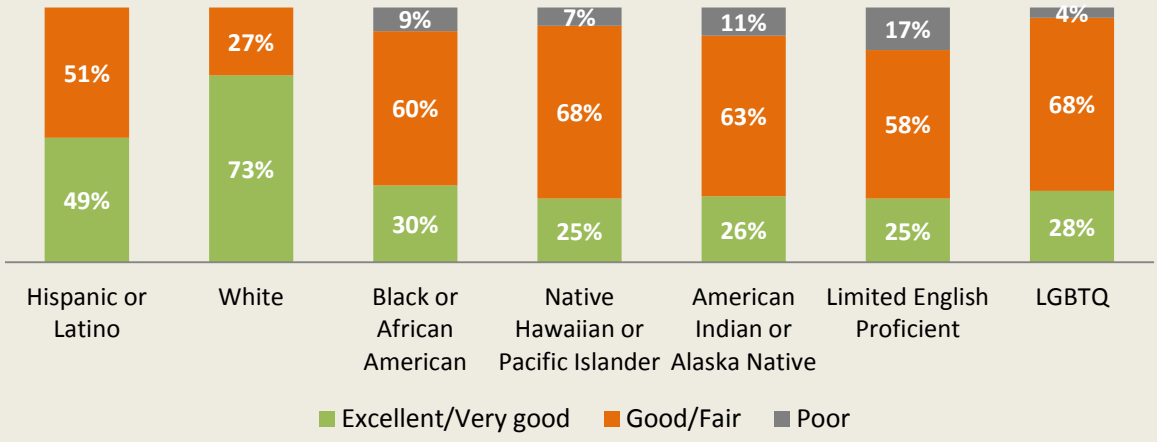
Figure 38. Service Channel used to Enroll by Persons with Preferred Spoken Language other than English, 2015-16



Source: Covered California. (March 2016). Active Member Profiles.

When we asked community stakeholders to reflect on the previous two enrollment periods to report on how they perceived Covered California's performance in reaching and enrolling diverse population groups, their feedback seemed to highlight continuing gaps in reaching diverse populations. Whereas 73% of respondents reported progress being very good/excellent for reaching and enrolling Whites, far fewer felt this was the case for non-White individuals. In fact, a minority of respondents reported very good/excellent performance for reaching and enrolling Hispanics (49%), Blacks (30%), and other diverse groups as compared to Whites (Figure 39).

Figure 39. Stakeholder Perception of Covered California's Performance in Reaching and Enrolling Diverse Population Groups



Note: Asian data not reported due to missing data during data collection.

MARKETPLACE RETENTION AND CHURN

Central to the success of health insurance marketplaces is assuring that coverage is stable and sustained over time. Particular attention has been paid to retaining individuals in coverage and preventing churn, defined as the "tendency for people to cycle on and off coverage as a result of changing work, family, and other life circumstances."[190] Overall, 944,000 enrollees renewed from 2013-14 to 2014-15[191] and another 1,132,682 renewed from 2014-15 to 2015-16.[192] While these data were not yet available by race/ethnicity or language, Covered California has indicated that it was "in the process of seeking to better understand the extent to which there may be demographic differences in rate of effectuation, special enrollment utilization, and disenrollment and post-disenrollment coverage."[193]

Covered California previously commissioned a Market Planning and Analysis report, which analyzed marketplace churn. This report found the average tenure of a Covered California enrollee was 25 months, with an average of 26 months for subsidy-eligible members and 21 months for those ineligible for subsidies. The most common reason for disenrollment was the acquisition of employer-based coverage, though roughly 15% of disenrolled members became uninsured.[194] Granular analyses of churn by race, ethnicity, and language were not available, but recently Covered California has expressed an intent to analyze differences in effectuated enrollment, enrollment during special enrollment periods, and churn by race/ethnicity.[195]

MARKETPLACE "COVERAGE TO CARE" ACTIVITIES

While education and enrollment were among primary responsibilities of health insurance marketplaces, more recently the focus has shifted to "coverage to care"—that is assuring that enrollees have knowledge, skills, and confidence to use their coverage in a health care setting, establish a usual source of care, and access services when needed. When community stakeholders were asked to report their knowledge of marketplace education and assistance provided to enrollees on understanding and using coverage, half said they knew of such initiatives offered by Covered California (Figure 40).

Covered California provides enrollees with a brochure designed to help consumers learn how to use coverage and explain key terms.[196] The brochure defines key health insurance terms, lists several preventive services that are fully covered under all policies, reminds consumers of their rights under the ACA, and provides guidance and contact information for those needing additional assistance.[197] The marketplace is printing and mailing this guide in California's 13 Medi-Cal threshold languages, and the brochure is also available in English and Spanish on Covered California's 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) (Figure 41).[198]

Figure 40. Stakeholder Knowledge whether Covered California Educates and Assists Enrollees with Using Coverage

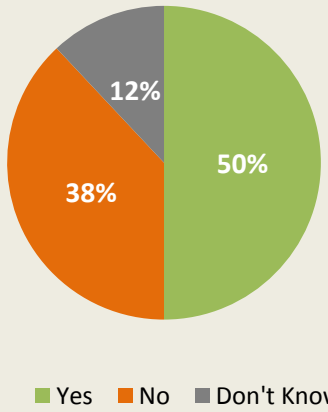
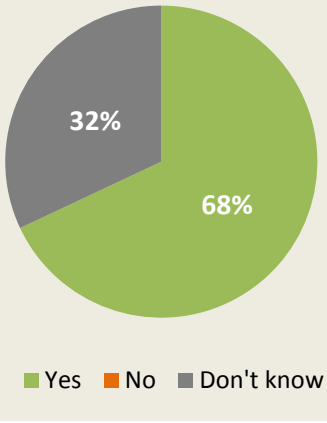


Figure 41. Stakeholder Knowledge whether Covered California Provides Assistance with Using Coverage in Languages other than English



Results from a Kaiser Family Foundation study conducted after the third open enrollment period indicate that over half (57%) of the newly insured had a usual source of care that was not the emergency room, an improvement from 48% prior to the first open enrollment period. Likewise, 74% of the newly insured reported visiting a doctor or health clinic in the prior 12 months. Despite these efforts, accessing care remains a challenge for some newly insured with 25% reporting having to wait an unreasonable amount of time for a medical appointment and 12% being told they would not be accepted by a doctor's office or clinic as a new patient.[199]

COVERED CALIFORNIA WEBSITE

With respect to usability, Covered California's Consumer Tracking Survey, performed by NORC at the University of Chicago, asked survey respondents about "ease of purchase" using the Covered California website in the first open enrollment (2013-14), and "satisfaction" with the website in the second open enrollment (2014-15). No findings from the third open enrollment had been released at the time of this report's publication. Only the 2013-14 Consumer Tracking Survey responses was broken into granular race/ethnic and language reporting categories. Results from this survey indicate that nearly one-third of Spanish-speaking respondents found it difficult to purchase insurance on the Covered California website, while 29.2% of English speakers found the site difficult or very difficult.[200]

In addition, the Health Consumer Alliance (HCA), an independent group available to assist consumers who are having problems with Covered California, documented instances of consumer-reported "problems" with Covered California by race, ethnicity, and language. These problems may include but are not limited to using the website, eligibility, service problems, and billing problems. 2016 HCA data indicate that 31% of consumers who reported problems were Hispanic, while 11% were Asian. Likewise, 27% spoke Spanish and 3% spoke an Asian language, most commonly Korean, Vietnamese, Hmong, Cantonese, or Mandarin.[201]

DISCUSSION

THI designed the Marketplace Health Equity Assessment Tool to assist health insurance marketplaces and their community stakeholders mutually identify strengths, gaps, and areas of opportunity for assuring that all eligible individuals and families, regardless of their race, ethnicity, gender, or other personal and community circumstances, have the opportunity to obtain health insurance and to access care. Our review of marketplaces across the country, and our pilot application of the M-HEAT in California (and Connecticut) 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 eligible people in the state.

STRENGTHS AND SUCCESSES

In this section on ***Strengths and Successes***, we summarize and reflect on four points that both our review of the marketplace and stakeholders agree have yielded positive progress toward health equity in the state's marketplace. These include:

- Strong and growing organization-wide commitment to health equity;
- Robust active purchaser role positioned to advance health equity;
- Movement to align resources with health equity objectives;
- Collaboration with community stakeholders; and
- Working to assure transparency in programs and progress.

Strong and growing organization-wide commitment to health equity. Covered California established a strong commitment to health equity from the outset, weaving it into the founding mission and vision as well as across many of its functions, from plan management to marketing and outreach. Unlike many exchanges that have made a written commitment to health equity with less extensive follow-through, Covered California is among few states that has "walked the talk" translating its vision and mission into action. This "walk," however, has been a continuing journey for Covered California together with its many partners and stakeholders who have collectively worked to build on the marketplace's early lessons—such as challenges to reaching Latino and African American communities and providing translated information to limited English proficient populations in the first open enrollment. Strongly encouraged in large part by a robust advocacy community, the state and the exchange built on such lessons and experiences to continue advancing its efforts toward health equity, including actions such as: adding diversity to the Board of Directors; establishing a first-of-its-kind Health Access and Equity Officer position dedicated to equity objectives; aligning financial resources with navigator diversity and multicultural media; monitoring and publicly reporting on the marketplace's health equity-specific initiatives and progress; and using its active purchasing status to incentivize disparities data collection and reduction. Beyond such efforts, Covered California's Board voted in April 2016 to approve an Affordable Care Act Section 1332 Waiver to allow undocumented residents to purchase unsubsidized coverage through the marketplace—an unprecedented effort that if implemented would ground Covered California's health equity intent in reality.

Robust active purchaser role positioned to advance health equity. Covered California is the only state exchange to build on its position as an active purchaser to focus explicitly and directly on reducing disparities and advancing health equity. As prescribed in Attachment 7 to the Qualified Health Plan

contract issued in April 2016, plans are required to achieve a response rate of 80% or above on self-reported race/ethnicity questions by 2019. As part of their incentive plan, health plans will be recognized if they demonstrate racial/ethnic health disparities reductions for diabetes, hypertension, asthma, and depression. Beyond these specific efforts, Covered California's broader role as an active purchaser has worked to protect consumers from rising premiums that have affected most others nationally, in essence assuring and maintaining "equity" in affordability for the majority of eligible Californians. Our review reaffirmed this contention especially in comparison to findings in Connecticut. In California, two-thirds of responding stakeholders reported that based on their knowledge and experience, plans offered on the exchange were mostly or to a great extent affordable. No stakeholder felt that plans were not at all affordable. By comparison, in Connecticut, 51% of responding stakeholders reported they felt plans offered on their exchange were mostly or to a great extent affordable. Other studies also reaffirm these findings. For example, according to Kaiser Family Foundation's October 2016 brief comparing marketplace premiums across major cities in each state, Los Angeles, California was expected to see a 5% increase in premiums from 2016 to 2017 for the second-lowest cost silver plan before tax credit.[202] (The national average for premium increases based on this report was 24%, premiums rose by 27% in Hartford, Connecticut, with the largest increase seen in Phoenix, Arizona at 145%). Further leveraging its active purchaser role, Covered California is the only exchange that standardizes benefits and excludes health plans that deviate from the standard design, affording consumers an opportunity to more fairly compare plan prices for standard benefits. These and other efforts driven by its active purchaser role represent the many unique ways that California's exchange has positioned itself to innovatively and meaningfully impact longstanding health disparities in coverage and the health system.

Movement to align financial resources with health equity objectives. Central to achieving health equity is assuring that those most disadvantaged and hardest-to-reach receive their due share of support and services, requiring not only allocation of sufficient financial resources but also monitoring and reporting to assure accountability. Over 80% of California stakeholders in this study reported that the marketplace should be allocating financial resources according to diverse population needs, and 41% reported this is mostly or to a great extent happening. Specifically, Covered California has provided granular data on navigator funding by ethnicity—including navigator dollars awarded for Latinos, Caucasians, eight Asian groups (Cambodian, Chinese, Filipino, Hmong, Japanese, Korean, Laotian, and Vietnamese), Africans and African Americans separately, and other ethnicities such as Middle Eastern, Armenian, Russian, Ukrainian, and American Indian—as well as for LGBTQ, young adults, and faith-based communities. It also monitors and reports on media spending by cultural segments. Its existing infrastructure within departments and programs along with more robust race/ethnic data as prescribed by Attachment 7 provide an important precedent for the state marketplace to more directly align the organization's financial resources to its health equity objectives and outcomes.

Collaboration with community stakeholders. Covered California has taken to heart that the success of the marketplace is strongly related to and dependent on how well it works with organizations that represent their populations. While there is room for improvement, well over 50% of surveyed community stakeholders reported that representatives from diverse communities were mostly or to a great extent engaged. Meetings with stakeholders on the M-HEAT's findings also affirmed how constructive relationships with Covered California have worked to create important opportunities for dialogue and to provide external guidance. Such positive collaborative relationships have also led many advocates to acknowledge the leading progress of the marketplace while also encouraging constructive and open feedback on monitoring effectiveness and recommending actions to further advance equity.

Working to assure transparency in programs and progress. One of the unique features of Covered California has been transparency in reporting data and progress overall and as it pertains to addressing disparities. Community stakeholders in this study at least in part acknowledge this strength while also pointing to opportunities for improvement: 43% reported that Covered California has communicated its health equity intent and progress well. The marketplace has undertaken a number of reviews and issued information to meet this goal. Through a series of reports and materials produced by the marketplace and other partners such as UCLA and UC Berkeley, NORC at the University of Chicago, Health Consumer Alliance, and Kaiser Family Foundation, Covered California provides its stakeholders, advocates, and other states an opportunity to track progress for diverse communities, identify promising practices, and lessons learned to help build a more responsive marketplace that functions for all. In doing so, it provides helpful equity-advancing resources that include but are not limited to: progress reports on achieving health equity; data on navigator funding and grantees by race, ethnicity, and language; detailed marketing and media spending data by race/ethnic groups; and many measures of outreach and enrollment by race, ethnicity, and language including channels of service.

AREAS OF OPPORTUNITY AND ACTION

In addition to its many strengths and assets for working to advance health equity, our review reveals specific opportunities to build on Covered California's initial promise to more fully assure the marketplace is available and accessible to all eligible persons – including the hardest-to-reach. At the same time, our review of marketplaces in other states including Connecticut, brings to light the unique position that Covered California is in to operate as a national leader, innovator, and resource on advancing health equity in the health insurance marketplace, offering its learnings and best practices to federal and other state marketplaces.

The following narrative identifies four potential ***Areas of Opportunity and Action*** that emerged from our review and discussions with stakeholders and advocates in the state as important considerations moving forward for Covered California and its partners. These areas remain relevant and important regardless of the uncertainty facing the future of exchanges. That is, any effort to expand health coverage and access to care for low- and moderate-income individuals within and across states must work to assure the following priorities remain a focus:

- More fully engaging diverse communities and their constituents;
- Assuring adequate language access to meet the needs of limited English proficient and linguistically isolated communities;
- Advancing health insurance literacy to empower individuals with knowledge and skills to utilize coverage and access care; and
- Positioning the exchange to build on its progress and participate in broader social determinant initiatives to advance health equity.

We recognize that Covered California is not alone in assuming responsibility and related work. Rather, its efforts will be stronger and more sustainable through collaborative engagement with other key players already active in health, health insurance, and health care: community stakeholders, advocates, health plans, philanthropies, policymakers, and health care providers.

More fully engaging diverse communities and their constituents. Covered California has worked with direct intent to assure the inclusion of diverse communities across its many functions. Nonetheless, our stakeholder survey findings suggest uneven progress in reaching and engaging the broad spectrum of diverse and LGBTQ communities. Specifically, community stakeholders recognized greater marketplace

involvement of those representing Whites and Hispanic/Latinos, while engagement of representatives of other diverse populations was, as respondents reported, less robust. This finding, which for the most part occurred across several engagement functions—marketing, outreach, education, evaluation of effectiveness and reach—suggests a divergence, whereby the largest proportions of populations in the state including Whites and Hispanic/Latinos have drawn the greatest attention compared with Black, Asian/Pacific Islander, Native American and other populations. For example while 60% and 56% of stakeholders reported that Hispanic/Latinos and Whites, respectively, were always or very often engaged to vet marketing messages and materials, far fewer reported this was the case for Blacks (42%), limited English proficient populations (44%), and LGBTQ (38%). These findings may be especially timely and relevant since engaging and enrolling hardest-to-reach populations, including outreach efforts, education and retention, continues to be a significant challenge for Covered California despite enrollment progress. As such, more meaningfully engaging diverse population representatives who are trusted and anchored within their communities, especially ethnic subgroups and indigenous populations, will be of paramount importance. In doing so, Covered California may draw on examples and lessons from other states to further advance its efforts to partner with communities that remain isolated from insurance or the health system:

- **Illinois'** marketplace, Get Covered Illinois, has focused efforts on attracting recently resettled refugees and asylum seekers (such as survivors of war and human trafficking) who are marketplace eligible due to their refugee status. The marketplace convened eight refugee placement agencies throughout the state providing resettlement support and case management for these individuals, including personnel from the government offices that process refugee status applications. Through the efforts of this workgroup, a streamlined process was established to incorporate enrollment assistance as part of resettlement support, ensuring smooth enrollment for this population.[203]

- Several staff within the **Washington State Department of Health** developed a health equity analysis tool to systematically assess the positive and negative impact of internal and external policies on populations disproportionately impacted by health disparities, including the state's 29 federally recognized tribes. The goal of the tool was to enable identification of policies that, while well-intentioned, may inadvertently widen disparities between priority groups and the population at-large. The Department delivered tailored health disparities trainings for each of its divisions that included health equity and tribal health components, and developed a one-page health equity quick reference guide to promote organizational decision-making from an equity perspective across all functions. The heightened focus on equity agency-wide has already led to significant revisions of the Department's approach to monitoring policies that potentially impact its relationships with Tribal nations.[204]

- **In greater Houston, Texas,** a 13-county area with 1.3 million uninsured residents, local leaders activated a version of the region's Incident Command System (ICS) to facilitate health insurance enrollment among many of its hard-to-reach communities. A highly coordinated interagency network normally deployed in disaster or emergency response, the region's ICS operations and communication structure lent itself favorably to reaching the least engaged groups in great need of outreach and assistance to become enrolled.[205] Fourteen of greater Houston's ICS participant agencies agreed to form the Gulf Coast Health Insurance Marketplace Collaborative, constructing an efficient approach to high-volume outreach that leveraged an established best-practice with existing capacity and relationships.[206] Over half a million in-person contacts were

made and 197,650 enrollments were achieved, surpassing federal government projections by over 50,000 enrollees.[207]

Finally, in the face of declining financial support for navigator and other outreach and enrollment programs, as well as the changing federal policy landscape, greater collaboration among philanthropies to direct resources in coordination, if not concert, may only increase in importance for filling gaps where support falls short in engaging and reaching most vulnerable communities in the state, and responding to changing times.

Assuring adequate language access to meet the needs of limited English proficient and linguistically isolated communities. Covered California has made significant progress in offering a range of language access services and resources for its many ethnically and linguistically diverse populations. Whereas stakeholders and individuals cited major concerns around lack of translated materials and personnel in the early enrollment years, more recently Covered California has demonstrated concerted attention and significant progress in making available additional resources to meet demand. Examples include translated print application materials, notices to consumers, immigration fact sheets, and redesigned website landing pages, all of which have streamlined education, application, and enrollment activities for linguistically diverse consumers by reducing the number of steps they must take to understand and act upon information; or by directing applicants to resources where they can receive additional help. However, advocates recognize a continuing need to improve language access services and resources especially for smaller proportions of limited English proficient or linguistically isolated communities. Our findings reaffirm this contention, as 54% of surveyed stakeholders felt that Covered California only sometimes or rarely provides services in a consumer's requested language. Our data also suggest that many stakeholders are not aware of the availability of year-round language assistance. Whereas 59% of surveyed stakeholders reported knowing about year-round language assistance, 30% said they don't know and 11% said they believed these services were not provided. Continuing to build language capacity will be important for Covered California especially as it works to reach the remaining hard-to-reach communities as well as to assist those already enrolled retain their coverage. This priority will also be important should the state be able to proceed with implementation of its ACA 1332 Waiver, potentially granting many linguistically diverse undocumented immigrants the ability to purchase marketplace health insurance.

In a current environment of persistent need, policy transition, and scarce resources, institutions like Covered California and its community partners will likely need to innovate or draw upon untapped resources to enhance language assistance while balancing quality with cost-effectiveness. The National Council on Interpreting in Health Care provides a compendium of models for the provision of language access in health settings, and although Covered California is not a direct provider of health services, these models may provide a general framework for Covered California to consider in next-phase planning for building out language capacity. Across the U.S., many hospitals and provider organizations have trained individuals recruited by refugee resettlement agencies or ethnic community organizations for capacity to augment interpreter resources, especially to serve linguistically isolated communities. In one model in Des Moines, Iowa, for example, the Iowa Bureau of Refugee Services recruited interpreters from one community it serves and supplied about 70% of interpretation services for refugee patients at one local hospital. And while effective volunteer interpretation/translation programs are less common, two hospitals, Yale New Haven Hospital in Connecticut and Primary Children's Hospital in Salt Lake City, Utah administered effective cohorts of skilled and trained volunteer interpreters comprised of bilingual students from local universities and/or bilingual volunteers from local churches who have achieved proficiency in other languages from extended mission trips abroad.[208] Promising practices from the

health sector – including the engagement of uncommon partner cohorts or organizations – may prove useful as the marketplace seeks to meet new and changing language needs.

Advancing health insurance literacy to empower individuals with knowledge and skills to utilize coverage and access care. Health insurance literacy is defined as "the capacity to find and evaluate information about health plans, select the best plan given financial and health circumstances, and use the plan once enrolled." [209] Recognizing that coverage does not equate to health care access, advancing health insurance literacy is central to retaining newly insured, while continuing to enroll new consumers. It is also critical to providing individuals with the information they need to understand coverage options, motivate enrollment, maintain coverage, and encourage proper utilization and access to care. Additionally, health insurance literacy is positively correlated with confidence in ability to pay and retain coverage.[210] While health insurance literacy was identified as an important priority in discussions with stakeholders in California, national research has also confirmed its importance in marketplaces. A recent Commonwealth Fund issue brief, for example, found that nearly half of state-based marketplaces considered improving "consumer understanding of the value and mechanics of health insurance" as an ongoing priority. [211] Many of these states reported that "consumer confusion about premiums, cost-sharing terms, and the ACA's tax credits [were] inhibiting enrollment and lamented the spread of misinformation on these topics."[212] And in research that surveyed newly insured individuals in South Sacramento, two-thirds of respondents reported that education on basic health insurance terms, finding a health care provider, and how to use coverage would help them better use their insurance card and access care.[213]

Many health insurance marketplaces have established programs to address and advance health insurance literacy. For example, Washington's state marketplace explicitly undertook a health literacy project in 2014 to produce plain language materials in eight languages to help consumers buy and use coverage. The marketplace also developed a Health Literacy toolkit for assisters.[214, 215] The Colorado Consumer Health Initiative created an interactive website called CoveredU that included easy-to-understand information in English and Spanish on buying and using insurance. [216] Nationally, many organizations have developed health insurance literacy tools such as Enroll America's *Health Insurance Literacy Hub*, Alliance for Health Reform's *Health Insurance Literacy Resources*, and Kaiser Family Foundation's *Cartoon Series*. These and other resources offer a common set of promising strategies that may inform Covered California's related efforts going forward including: [217]

- ***Meeting consumers where they are:*** providing information on coverage options, how to enroll, and how to use health insurance in trusted, accessible venues (where they live, work, pray, and play) such as faith organizations, schools, libraries, and through ethnic or social media platforms.

- ***Educating through trusted voices:*** providing education and information through trusted messengers, such as community-based organizations or community health workers. An Enroll America survey found that consumers want to learn about their coverage and how to use it from their health insurance company (54%), in-person assister (42%), and non-profit organizations (33%).[218] Trusted voices typically vary by race/ethnic group. For example, a recent South Sacramento study found that Asians preferred health insurance related information from community-based organizations, African Americans more often relied on family and friends, Hispanics relied on both community-based organizations and social networks, and Whites tended to seek information from their health care providers. [219]

- ***Assuring culturally and linguistically appropriate and tailored education:*** What motivates consumers, the barriers they face, and a priori judgments are often driven by historical experiences, cultural norms and beliefs, and language. As such, education and orientation on coverage and utilization must be tailored for culturally and linguistically diverse consumers.

- ***Recognizing that many individuals require "multiple touches"***: A resounding theme year after year following open enrollment is that many individuals, especially those unfamiliar with health insurance and with low literacy or numeracy require "multiple touches" or interactions before they can fully grasp the concept of health insurance and how to use it to access care.[220]

Positioning the exchange to build on its progress and participate in broader social determinant initiatives to advance health equity. In addition to a commitment to health equity, Covered California has identified its commitment to the "Triple Aim" that is, lowering costs, improving quality, and improving health outcomes, while continuing to assure good choice of plans for consumers. Central to achieving the Triple Aim is recognizing and addressing the broader social determinants that profoundly shape the opportunity to access coverage and care, affect the ability to lead healthy lives, and influence the potential to achieve positive health outcomes.[221] A growing body of work documents that clinical care accounts for a much smaller proportion (20%) of modifiable variation in health outcomes, whereas the majority (80%) is due to social and economic determinants, health behaviors, and the physical environment.[222] Community services that address these health-related social and economic needs—such as transportation, unemployment, food insecurity, unstable housing, and language access—have the potential to improve access to care, reduce preventable emergency visits and hospitalizations, and reduce unnecessary costs.[223, 224, 225, 226, 227]

Given its landmark disparities reduction initiatives, Covered California has a unique opportunity to take this intent and promise even further to address the underlying social determinants central to achieving health equity (and the Triple Aim). In doing so, Covered California should consider extending Attachment 7 to include data collection goals for other historically disenfranchised communities such as LGBTQ populations, those with limited English proficiency, and others as identified. Future iterations of Attachment 7 may also consider expanding measures to monitor and incentivize plans to show year-over-year reduction in disparities beyond the four targeted chronic conditions (diabetes, asthma, hypertension, and behavioral health) and add depth to more fully capture preventive measures.

In addition, Covered California may be uniquely positioned to partake in regional and collaborative delivery reforms such as Accountable Communities for Health (ACHs). ACHs have gained increasing momentum to shift the focus and accountability of improving population health from health care providers only to a consortium of community, social service, health care, health plan, and public health providers. Many ACHs were conceived through State Innovation Model (SIM) grants—as is the case in California, which was among states who received two rounds of SIM grants to establish and test the ACH model. Stemming from this initiative and a collaborative of foundations, the state established the California Accountable Communities for Health Initiative (CACHI) in July 2016, funding six local communities to advance common health goals and create a vision for a more expansive, connected, and prevention-oriented health system. Covered California's mission, health equity intent, and role as a catalyst for change in California's health care system may very well present opportunities to more fully align CACHI and other community-based accountable care initiatives in the state with the exchange.

CONCLUSION

Our report has documented the significant success of Covered California in institutionalizing equity, developing strategies and focusing on outcomes that recognize how essential a focus on eliminating health disparities is to its success. The marketplace's direct outreach to consumers as well as engagement with advocates for priority populations have been key drivers of this process. The strength and collaborative spirit of Covered California's approach is apparent in the marketplace's outcomes in enrolling and retaining diverse populations to date. Our findings and recommendations for advancing health equity are intended to both reflect Covered California's marketplace leadership and offer guidance for building on this 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, but may also increase in importance should the need grow for a strong body of literature documenting processes in support of institutionalizing health equity and supporting the effectiveness of equity-focused alliances.

Given the strength of California's commitment to deliver insurance to its people, the state's energy, resources and voices will be critical to retaining the great gains achieved to date. Should greater responsibility be given to states, California may assume even a more prominent role in insurance programs and policies. Building on the commitment demonstrated to date by working to assure that equity remains central during uncertain times will be an essential part of the significant adaptations and adjustment likely to come.

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