Successfully Engaging Hard-to-Reach Populations in Health Insurance: A Focus on Outreach, Sign Up and Retention, and Use

by

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Introduction

Health care is undergoing profound changes including the rise of a patient-centered approach; the development of new forms of health care delivery such as the patient-centered medical home and accountable care organizations; widespread implementation and use of health information technology; and, of major importance, the expansion of health care insurance to millions of Americans. Many of these changes were fostered by the passage of the Patient Protection and Affordable Care Act (ACA), which was signed into law on March 23, 2010. Perhaps none of the provisions of the ACA have received as much attention or as fierce a debate as the provisions related to increasing access to health care through the provision of health insurance.

Two major ACA mechanisms to achieve increased access to health insurance are Medicaid expansion and the creation of health insurance marketplaces. As of September 29, 2014, 23 states expanded Medicaid in ways outlined in the ACA, 3 states expanded Medicaid using an alternative approach, 22 states did not expand Medicaid, and 1 state has applied for a waiver from the Centers for Medicare and Medicaid Services (CMS).[1] State run health insurance marketplaces were established in 17 states[2], federally run marketplaces exist in 27 states, and 7 states have a jointly run exchange.

The law requires that every marketplace establish a call center and provides for marketplaces to hire people to help consumers enroll in insurance plans through the marketplaces. The law also provides for a Consumer Assistance Program (CAP) to help consumers understand and use health insurance after enrollment. Congress has not appropriated funds for this program and, at the time of this writing, only 13 states are operating CAPs (CMS, 2014).

The legislation also specifies a number of different positions that comprise the workforce for identifying and enrolling individuals and families through the marketplaces. The workforce outlined in the legislation includes a variety of titles, which are largely determined by the source of funding for the position (Table 1). The terms "navigators," "in person assisters," and "certified application counselors" have specific meanings under the law but are often used interchangeably in the vernacular. In this paper we use the umbrella term "assisters" to encompass all of these outreach and enrollment workers.

Despite achieving total enrollment figures that met or exceeded projections, many states encountered difficulties in reaching their enrollment goals for specific population groups such as African Americans, Asian and Pacific Islanders, and Latinos. Many observers fear that the failure to enroll the most vulnerable and needy may lead to greater inequities in health care access and health. In response to concerns about enrollment figures for these populations, Blue Shield of California Foundation provided funding for a project that would identify and interview

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[1] See https://www.statereforum.org/Medicaid-Expansion-Decisions-Map?gclid=COze9beqrMECFW4F7AodRBAAuw

[2] This number includes 14 state based marketplaces (SBM) and 3 federally supported marketplaces, which are marketplaces that are run as SBMs but rely on the federal information technology platform for enrollment (http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/).

individuals from states or cities that had particular success in enrolling individuals from these populations to find out what worked and what did not.

TABLE 1 Types of Assisters, Scope of Work, Work Locations, and Funding Source

Type of Assistance	Scope of Work	Where They Work	Funding Source
Navigators	• Serve as experts on eligibility, enrollment, and Marketplace plans • Conduct outreach and education activities to raise awareness about Marketplaces • Facilitate enrollment into Marketplace plans, including financial assistance, in a fair, accurate, and impartial manner • Refer consumers to applicable entities to assist with post-enrollment questions • Provide information that is culturally and linguistically appropriate to the populations they serve	SBM[1] FFM[2] FPM[3]	Marketplace grants (state and federal)
In-person Assisters	• Similar to Navigators	SBM FPM	Federally funded Marketplace establishment grants
Certified Application Counselors	• Facilitate enrollment into Marketplace plans, including financial assistance • Provide information on Marketplace plans, and other coverage options like Medicaid or CHIP[4]	SBM FFM FPM	Some operate without funding; Federal grants available for FQHCs[5] only
Agents and Brokers	• Facilitate enrollment into Marketplace plans, including financial assistance • Provide post-enrollment assistance with coverage problems	SBM FFM FPM	Insurers
Consumer Assistance Programs (CAP)	• Assist with filing complaints and appeals, including providing information about the external appeals process • Collect data on consumer problems and questions • Educate consumers about their rights and responsibilities with health insurance • Assist with enrollment into Marketplace plans • Resolve problems related to obtaining tax credits	11 grantee states	Federal CAP grants

[1]State based Marketplace, [2]Federally facilitated Marketplace, [3]Federal partnership Marketplace, [4]Children's Health Insurance Program, [5]Federally Qualified Health Centers
Source: Volk et al, 2014

This paper reports that project's findings, and recommendations. Numerous reports and articles have been written about barriers and challenges encountered during the first period of enrollment. This report is based on interviews the authors conducted with individuals from states

and cities that were active in engaging and enrolling specific hard-to- reach populations and focuses on strategies that worked.

METHODS

We began by reviewing the recent literature and the lessons learned from previous work in this area that employed a health literate approach to the preparation and testing of information for consumers about the ACA. We reviewed a number of publications from organizations that were evaluating enrollment of hard-to-reach populations. These publications often contained recommendations and lessons learned which we gathered and grouped by theme. We also conducted searches of peer-reviewed literature and reports released by entities such as CMS and Covered California.

The backbone of the research, however, was key informant interviews conducted over the course of three months. Because the focus of this project is on strategies that produced positive results in outreach and enrollment among hard-to-reach populations, we looked for organizations and individuals that had achieved success in this area by overcoming challenges and adapting to the situation on the ground in positive ways.

We used peer-to-peer networking to identify individuals who had a wide variety of roles and experiences with the first open enrollment period, with the unifying principle that all of them had experienced success with the process and had targeted hard-to-reach groups. This was, of course, context specific. We spoke with people from politically supportive and politically unsupportive environments with varying numbers of uninsured individuals within the wider population. We spoke with people who had approached enrollment from national, regional, or local perspectives, as well as those who concentrated on certain demographic groups across and within jurisdictions. For example, efforts to enroll Asian-Americans were particularly successful despite the challenges associated with such a culturally and linguistically diverse population. We wanted to be sure to capture some of the strategies for this success so we interviewed a number of individuals who worked with these populations.

The marker of success was not only total enrollment numbers but whether outreach and enrollment were better than expected for the populations of interest. We chose interviewees on the basis of objective enrollment and demographic information obtained from CMS and state marketplaces as well as subjective judgments from the authors and others in the field based on contextual knowledge. We focused on statewide and metropolitan efforts as well as people with specific viewpoints to share, such as the view from a national level or lessons learned from activities in a largely rural state. Our goal was to capture as many perspectives as possible in the limited time available.

Potential interviewees were contacted via e-mail and invited to participate in the project. Interviewees were given the following questions prior to the interview:

- Who did you consider to be your hard-to-reach populations?
- What were the major lessons you learned, with a focus on main successes?
- Did you use different strategies to target different populations?
- If you could do something differently, what would it be?
- What barriers do you see for future efforts?
- Is anyone in your state (or area) conducting an analysis of lessons learned, what worked, and what didn't?

These questions provided broad parameters for each interview, but the interviews were designed to be open-ended conversations rather than surveys. We thought that this was the best way to capture the depth and breadth of each interviewee's experience. We took extensive notes during the interviews and then summarized the content into a standardized format for analysis. The results were tabulated across interviews to identify successful strategies and approaches. We created a conceptual model that incorporated these strategies and approaches. The model, discussed in Chapter 3, envisions successful engagement of hard-to-reach populations as a three-step process of which enrollment is only one part. The model is a graphic representation of a successful process. Our recommendations are based on our findings and analysis of successes in the field as indicated from our interviews.

Literature Review

Most of the recommendations and lessons learned from the literature review fall into three broad categories:

- resources, including funding, workforce, and community partners and collaborators;
- language and cultural messaging in both materials and services; and,
- trust.

It is not surprising that adequate resources have been routinely identified as necessary for successful outreach and enrollment. Every source that we examined noted that in-person assistance and "touches" or contacts were vital to the enrollment effort, particularly among hard-to-reach populations, and our interviews confirmed this conclusion. Enroll America reported that individuals who received in-person help with enrollment were twice as likely to complete the process successfully and that African-Americans, Latinos, and young adults were more likely to enroll after the third follow-up from an outreach or enrollment contact (Enroll America, 2014). They also found that that in-person assistance was particularly important for communities of color and communities with limited English proficiency. The Greenlining Institute noted that enrollment personnel often provided outreach and education services as well, for which they were not compensated. This also left less time for enrollment personnel to do the job that they were hired and paid to do (Medina and Saporta, 2014). Others reported that counselors were often contacted after enrollment by consumers (see Box 1) asking for help using their health insurance or because they had payment or other issues with their insurers (Artiga et al., 2014; California Pan-Ethnic Health Network, 2014). A report issued by Jahnke and colleagues (2014) recommended formalizing this role for navigators and assisters noting that this would make the most of the investment in training for these individuals and the work they had done to gain trust within communities. The need for more and better-trained assisters as well as the need to maintain this workforce between open enrollment periods was a common recommendation (California Pan-Ethnic Health Network, 2014; Enroll America, 2014; Jahnke et al., 2014; Medina and Saporta, 2014). As noted in a report released by Volk and colleagues (2014) "consumer assistance works" and is crucial to the enrollment process and thus the ability of people to gain access to the health care system.

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Box 1

Results from a Kaiser Family Foundation Survey of Assister Programs

The Kaiser Family Foundation conducted an extensive survey of enrollment assistance programs immediately following the first open enrollment period. Their results reinforced a number of things we found in other publications and when speaking with interviewees. For example the survey revealed that most assisters were involved in more than just the sign-up phase of enrollment—82 percent of assisters surveyed reported that they engaged in outreach and education activities and 77 percent reported that they had provided help for post-enrollment questions. The survey also found that the most hard-to-reach consumers sought in-person help; the top reasons for seeking the help of an assister were a lack of understanding of the law and insurance and a lack of confidence in navigating the system alone. Almost 90 percent of consumers who sought in-person assistance were uninsured and more than 70 percent needed help understanding the language used by insurers and the marketplace. Further, the survey revealed that across the board, providing in-person assistance is time consuming and that organizations struggled to provide help to all who needed it.

SOURCE: (Pollitz et al., 2014)

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Community partnerships were also an important resource for enrollment efforts to reach hard-to-reach populations. Partnerships with longstanding and trusted community organizations provided access to hard-to-reach communities and served as trusted sources of information and trusted spaces for enrollment to occur. Community partnerships also provided opportunities for sharing of best practices and lessons learned (Jahnke et al., 2014). A number of organizations recommended strengthening existing partnerships and working to form new ones for the next open enrollment period (California Pan-Ethnic Health Network, 2014; Jahnke et al., 2014; Volk et al., 2014). Finally, many reports on the open enrollment period noted the importance of doing research and groundwork before open enrollment began in order to get to know the community and the people. One report that examined the successes of three states' open enrollment period noted that although conducting consumer and demographic research beforehand required a sizable investment of time and funds, this effort allowed outreach and enrollment workers and the marketplaces to make better decisions later on. Another found that although outreach and assistance provided necessary support to enrollment, many marketplaces, both state and federally run, are decreasing their investment in these activities (Volk et al., 2014). On the basis of our findings, we believe that upfront investment leads to a more efficient use of resources overall.

Linguistic and cultural accessibility of materials and services were also key elements to successful enrollment. Every source that examined issues related to language and cultural competence recommended that marketplaces work harder to ensure that they have in-person help and materials available in the languages spoken by their target populations (Enroll America, 2014; Jahnke et al., 2014; Medina and Saporta, 2014). We also found that these materials and translations must be of high quality to be useful (Medina and Saporta, 2014). Technology played an important role in outreach and enrollment in languages other than English and a number of recommendations addressed the lack of language diversity in websites and at call centers. The California Pan-Ethnic Health Network noted that long waits for multilingual call center representatives and dropped calls constituted a significant barrier to enrollment for populations with limited English proficiency. It recommended offering call back options in other languages and internal quality control testing of the system (California Pan-Ethnic Health Network, 2014).

Community partnerships were also important for providing language accessibility for smaller communities with limited English proficiency and some sources recommended seeking out and building relationships with organizations within these communities (Jahnke et al., 2014).

Both in the literature and throughout the interviews, we found that trust is a foundational and cross-cutting issue. Gaining and protecting the trust of the community is a vital component of outreach and enrollment. As noted above, linguistically and culturally appropriate assistance, often delivered in-person, is key to successful outreach and enrollment in hard-to-reach populations. But there is more to it than that. It is important to know where the community gets its health information and who its trusted messengers are for that information (Enroll America, 2014; Jahnke et al., 2014; Medina and Saporta, 2014). For example, Enroll America found that women tend to be the health care decision makers. Thus Enroll America's outreach efforts were targeted toward that population. They also noted that there was deep skepticism about health insurance plans among low-income and minority individuals and recommended that outreach and enrollment workers be diverse and understand the communities they serve (Enroll America, 2014). It is also important to understand that different groups have different needs. Young adult and English-speaking populations tend to get more of their information from the Internet than others, so it is important that online source be easy to access and contain accurate information (Wong et al., 2014).

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Qualitative Interviews

The complete process of health insurance enrollment involves effective education and outreach, signing-up for and retaining a plan, and effectively using health insurance. Those interviewed for this project were asked to identify key strategies for maximizing success for each of these steps in the enrollment process. The following is a summary of strategies identified during the interviews.

STRATEGY #1: BUILD A FOUNDATION OF TRUST WITH THE CONSUMER

The need to create trust among consumers is the foundation upon which successful strategies rest. First and foremost, it is essential to identify community partners who are trusted resources in the population at which enrollment efforts are aimed. All of the interviewees said that the most important and successful method in reaching their intended audiences was approaching consumers through a trusted source; such an approach could occur either through their own organization, if it was a community-based trusted source, or through a partnership with groups and individuals who were trusted in the community. Although every community has different trusted sources, each community organization and coalition interviewed highlighted that identifying and working with trusted sources is key to a successful outreach and enrollment process.

Trusted sources varied by community and culture and included advocacy groups, social services and community support groups, faith-based groups, and federally qualified health centers. Although different, these trusted community partners had all been active in the communities prior to the enrollment process and were either already aware of or uniquely positioned to identify population-specific challenges and sensitive issues in the targeted populations.

Interviewees shared approaches taken to build trust. One organization provided outreach and education grants to 21 community-based organizations. Another organization that was working to enroll individuals from the lesbian, gay, bisexual, and transgender (LGBT) community worked through groups that were already community advocates for LGBT issues and used certified application counselors who themselves were members of the LGBT community. Another organization that was targeting hard-to-reach youth in transition or homeless youth used well-established community based groups that were already trusted sources for these groups. Across all successful approaches, the key for building trust was identifying the populations to be reached, assessing who would be a trusted community partner, and using these partners to reach out and educate the populations in trusted locations.

STRATEGY #2: USE DATA TO UNDERSTAND THE CHARACTERISTICS OF HARD-TO-REACH, HIGH NEED POPULATIONS

Knowing the characteristics (e.g., culture, ethnicity, language, age, gender, literacy, income) of the consumers one is attempting to engage is critical to devising approaches across the spectrum of outreach and education, sign up, and use and retention. Many organizations

noted that regional or more localized demographic data helped identify geographic areas in which to focus efforts, as well as how to segment efforts on the basis of other demographic data. Interviewees with access to demographic data reported that they were able to devise strategies to target their outreach and education efforts to areas of high need for health insurance as well as prepare approaches tailored to the culture, ethnicity, and language of the populations within those high need areas.

STRATEGY #3: HIRE AND TRAIN THE RIGHT PEOPLE

Partnering with trusted community-based groups is important but of equal importance is selecting and training the individuals who will be interacting on a one-to-one basis with the consumers. Key identified characteristics of these workers include selecting those who speak the necessary language and understand it and, preferably, are from the same culture. Other critical characteristics are to select individuals who are friendly, engaging, and supportive. Considering special needs, such as language, of the targeted population is important to identifying and training assisters.

STRATEGY #4: RETAIN SUCCESSFUL WORKERS

Retaining the services of individuals who are effective at interacting with and engaging hard-to-reach populations is key. Tremendous resources are invested in this training, experience brings even greater understanding and effectiveness, and continuing relationships with consumers are important to the entire process. Questions do not end with successful sign up, however. As related over and over to us, consumers return after enrollment with such questions as how to find a provider, what communications from insurers mean, and a host of other concerns. Having well-trained individuals who can provide consistent communication with consumers is a critical need. Unfortunately, funding to support this effort is not provided on a widespread basis. Sustainable funding that extends beyond periods of enrollment are important for retention as well as successful planning for future years; such models exist sporadically but lessons can be learned from other programs in health care such as public health initiatives, health information exchanges, and delivery system reforms such as community health workers. One interviewee said that private funding was found and used to retain certified application counselors so that their expertise would be available for the next enrollment period and throughout the year as questions from consumers arose.

STRATEGY #5: PROVIDE ASSISTANCE IN LOCAL SITES AT CONSISTENT AND CONVENIENT TIMES

Interviewees reported using different approaches to provide outreach and education, such as canvassing door-to-door, staffing tables at local fairs and farmers markets or rallies, and conducting other mass outreach campaigns. Some posted workers at transportation hubs, and others actually had workers board and travel on mass transit to distribute information. Interviewees reported that each of these approaches worked with varying degrees of success.

One group reported that holding workshops at a local site was a good approach. During such workshops, people of like culture provide an overview of what is involved in the enrollment process and answer questions. Counselors are available to help with applications. Another

interviewee partnered with a local university that has a large nontraditional and commuter student population. Many of these students were immigrants or first-generation Americans with a large uninsured population. Reaching out to these students, their families, and social networks provided access points to hard-to-reach and hidden populations. Still another interviewee reported placing assisters in an urban public hospital, where the hospital financial counselors referred eligible consumers to the assisters.

Interviewees generally agreed that finding safe and neutral locations in the neighborhoods where assistance could be obtained at known and consistent times was a successful approach.

STRATEGY #6: DIAGNOSE AND FILL GAPS IN KNOWLEDGE IN THE TARGET POPULATIONS

Interviewees identified several challenges and critical gaps in knowledge in populations they were attempting to engage, including understanding the concept of health insurance, health insurance literacy, and cost.

Interviewees reported that the concept of health insurance proved to be an unexpected challenge among many immigrant communities. For individuals who had come from countries that do not have a health insurance system or for those who are used to accessing the U.S. health system through free clinics or uninsured programs, health insurance was a foreign concept. Helping consumers understand the need to purchase health insurance in order to access health care in the United States is an important step in activating consumers to sign up and is a key piece in helping them become more health literate.

Health insurance literacy was a commonly identified issue for many different populations. Educating communities on the general concepts of health insurance was key to successful enrollment. Helping consumers understand such insurance terms as premiums, deductibles, co-pays, and benefits was identified as an important component of providing successful outreach and education.

Another sensitive but common challenge was the issue of cost and affordability of health insurance. Many of those who sign up base their decision about signing up on the cost of the premium. For many consumers, especially those who qualified for government subsidies, choosing to buy health insurance was viewed as a choice between paying the insurance premium or buying food, clothing, and other necessities. Yet the premium is only a part of the cost, a component of affordability, which consumers need to understand in order to have realistic expectations.

One of the most important approaches interviewees used to address these gaps in health insurance literacy centered on having in person conversations and using understandable and actionable analogies (e.g., paying for car insurance) that consumers understood. Collecting and sharing these analogies with other assisters could help build a "story bank" for commonly encountered difficult conversations.

STRATEGY #7: FACILITATE THE DEVELOPMENT OF CULTURALLY SENSITIVE, WELL-TRANSLATED HEALTH LITERATE MATERIALS

Interviewees highlighted the importance of well-translated, culturally appropriate, and consistent materials. Several groups noted issues with the materials translated to different

languages, for example, inconsistent translation of concepts and terms, contextually inappropriate or insensitive translations, and inappropriate grade level of language. One group noted that in its state, there were several Spanish speaking populations that came from different places and different cultures. Unfortunately, the enrollment commercials that aired were a simple straight translation from English to Spanish and, as a result, were not effective in reaching these different communities.

Several groups did their own review of translated material to determine whether the materials were appropriate to use. Review and comment on translated materials prior to their release provided the opportunity for revisions and led to much more successful educational materials. This approach was key to producing useful and actionable information for consumers. Providing high quality materials at appropriate reading levels across many languages was a fundamental input that had a direct impact on the success of outreach and sign up for these communities.

STRATEGY #8: CREATE OPPORTUNITIES TO ENSURE MULTIPLE IN-PERSON CONTACTS FOR HARD-TO-REACH POPULATIONS

Interviewees identified several approaches as successful in activating consumers to move from outreach and education to sign-up. The most important of these were the need for multiple contact points and for in-person assistance for as many of these encounters as possible. In fact, 60 percent of all Latino enrollees in California enrolled in person (Gorn, 2014). Consumers returned to trusted advisors multiple times to obtain more information and to understand the benefits of health insurance and the process for signing up. Multiple contact points were also needed to actually complete the sign up process.

Recognizing the need for multiple contact points and follow-up, several groups developed processes to help navigators and certified application counselors accommodate multiple encounters. For communities that were willing to share information, enrollers who were able to collect follow-up contact information noted higher success rates in completing the sign-up process. In addition, collecting and organizing follow-up through well-maintained databases was an important tool for creating opportunities for enrollment. Some states had regulations limiting the ability of assisters to contact consumers for follow-up; alternatives included establishing appointment systems so individuals could sign up for multiple in-person meetings as needed. Holding regular office hours in trusted and safe spaces (Strategy #5) was instrumental for many groups in being able to have multiple contact points. The key for successful sign-up was to identify and put in place processes that would allow consumers to have easy access and multiple contacts for in-person assistance.

STRATEGY #9: EQUIP YOUR ASSISTER WITH THE RIGHT MATERIALS FOR THE RIGHT CONSUMER AT THE RIGHT ENCOUNTER

As discussed earlier, outreach and education and actual sign-up for a health plan were conducted by different groups in different locations, often with little coordination or interaction. Also, it was not anticipated that after successful sign-up, consumers would return for additional assistance in figuring out how to understand and use their health insurance, and, therefore, assisters were ill-prepared to provide the kind of assistance needed. Equipping an assister with the right type of material for each kind of encounter was identified as critical for success. For

those unfamiliar with health insurance, providing materials that helped explain the value of and need for health insurance was key. For those ready to sign up, having an accurate enrollment checklist that clearly defined what an individual needed to bring to an enrollment appointment was instrumental in helping each applicant complete the sign-up successfully.

The adoption of user-friendly and actionable checklists that walked consumers through the process was one approach taken. One group used pre-sign-up checklists that included such directions as "Ask your doctor what insurance plan they take." Other groups used or designed checklists that clearly listed what documents were needed for a sign-up appointment. Whether through conversations, anecdotes, or printed materials, constantly assessing whether a consumer was receiving the user-friendly, actionable information designed at the right time was key.

STRATEGY #10: IDENTIFY, INVOLVE, AND EDUCATE TRUSTED ADVISORS TO BE EXTENSIONS OF OUTREACH

Another key approach is to identify who the trusted advisors are in the various communities of interest—that is, who do people in these communities turn to for advice about what is correct information and what to do with it? Groups focusing their efforts on Latino communities noted that community health workers, or *promotores*, were often seen as neutral and trusted advisors. African American and rural communities often saw their faith leaders as trusted advisors. Interestingly, one group that worked with the Asian and Pacific Islander communities initially built its approach around the idea of females as the gatekeepers to health, which is the case in many populations. However, they quickly discovered this was not the case for many Asian communities.

Immigrant communities with limited English proficiency often relied on neighbors and friends for information. Providing accurate information to these trusted advisors allowed some groups to take advantage of word-of-mouth communication in their communities. Trusted advisors were also identified in industries that have heavy representation in hard-to-reach communities. For example, some efforts were aimed at leaders of taxicab drivers or beauty and nail salon owners as trusted advisors to help engage specific populations.

Another approach used was to ask all the consumers who they considered to be their trusted advisor. In some instances, identified trusted advisors were spreading misinformation to potential consumers as they themselves were misinformed. Efforts were then tailored to provide outreach and education for these advisors who, in turn, helped spread the word within their communities. For many communities and harder-to-reach populations, trusted and well-informed advisors can become surrogate voices for outreach in their communities.

STRATEGY #11: DEVELOP A STANDARDIZED PROCESS FOR INFORMATION EXCHANGE WITH BOTH LOCAL COMMUNITY PARTNERS AND WITH STATE OR FEDERAL EXCHANGE REPRESENTATIVES

Another key to success is to facilitate the transfer of knowledge by sharing best practices and troubleshooting difficult cases. Thus there is a need for a forum in which local coalitions and community advocates can discuss challenges and share best practices locally, regionally, and statewide. These forums can be in-person meetings (often easiest for local efforts) or via conference calls or webinars. It is also important to have a standardized and consistent approach for disseminating new information. Many interviewees identified the collaboration of community

partners throughout the state as key to maximizing the reach and success of each group's efforts. Creating a forum and process for local community groups to communicate and work directly with representatives from state and federal exchanges was also deemed essential to successful enrollment completion.

One state uses a bimonthly conference call so that community organizations can talk directly with enrollment supervisors and directors from the federal marketplace to troubleshoot specific enrollment questions and complex cases. Often similar issues were happening throughout the state, and having troubleshooting sessions helped to transfer knowledge surrounding enrollment throughout the navigator and assister community.

LIMITATIONS

The above strategies are distilled from our qualitative approach, which was not designed to gauge quantitative effects because it is difficult to detect and measure the quantitative effect of these strategies. For groups that did measure outcomes, success was often measured simply in number of contacts or number of enrollments.

Certainly, given that all communities and the populations living in those communities are very heterogeneous, tailoring broad strategies to fit the unique needs of one's community is a challenge. Throughout these interviews, the focus was to identify common themes and strategies that were similar in concept but tailored in implementation. Thus, one major limitation of these findings is that the success of the identified strategies is contextual to the community that is being served. Therefore, although the nuance of each of these strategies was informative and robust, the highlighted methods still must be applied in the context of a specific community.

Finally, key markets were identified and representatives sought from those areas to help speak to these enrollment strategies. Yet again, because of the diversity of hard-to-reach populations throughout the country, many more interviews could have been conducted to build the robustness of these strategies.

A Model for Successfully Engaging Consumers in Getting and Using Health Insurance

Most people are overwhelmed by the process of learning about health insurance options, making the right choices for themselves and their families, navigating the application process, and then figuring out how to use what they signed up for. Members of hard-to-reach populations, most of whom are uninsured, face additional challenges. In addition to profound financial challenges, many also do not trust the system to advocate for them or to help them successfully navigate complex content and tasks that are inherent parts of getting and using health insurance. In previous writings we noted that listening to and amplifying the voice of the underserved while at the same time simplifying paths to obtaining and using health insurance is really about empowering underserved communities to take their health needs into their own hands (Patel et al., 2013). We noted the importance of three key factors: the messages and messengers; limited English proficiency language needs and cultural context in both content and processes; and consideration of trust and confidence as performance measures.

After conducting key informant interviews for this current research effort, we created a conceptual model to capture critical domains to demonstrate not *if* but *how* to enhance efforts to sign up and retain those currently uninsured. This model is intended for those involved at all levels---community, state, and federal---as they strive to improve rates of coverage for those who lack health insurance.

Figure 1 provides a visual framework for considering the complicated, multistep process needed for successful sign-up and retention of hard-to-reach populations in health insurance. Findings from our research indicate that this process is influenced by numerous variables, including individual factors, environmental settings, and social and cultural norms. Therefore, we created a socioecological model that is informed by theories of change. Because the process of obtaining health insurance involves a set of behaviors, we highlight the critical role of enhancing readiness in the model.

The model shows that three main components work synergistically to successfully engage consumers in getting and using health insurance. The three components are as follows: providing outreach to the target populations; helping with sign-up (i.e., successfully completing an application) and retention (i.e. paying the monthly premium or renewing coverage); and informing populations about the use of health insurance. Each of these steps requires close attention, and each has associated inputs and activities. All three components must attend to the language and cultural needs of the populations at which efforts are aimed, and those assisting at each step must be known for their helpful, friendly, and supportive tone and attitude.

The entire process, as well as its components, requires ongoing monitoring and evaluation. Specific inputs and activities are needed at each step of the process, and ongoing monitoring and evaluation provide feedback on successes as well as areas where change is needed. The components of the model are described below in more detail. The lists of inputs and activities are offered for local adaptation and use.
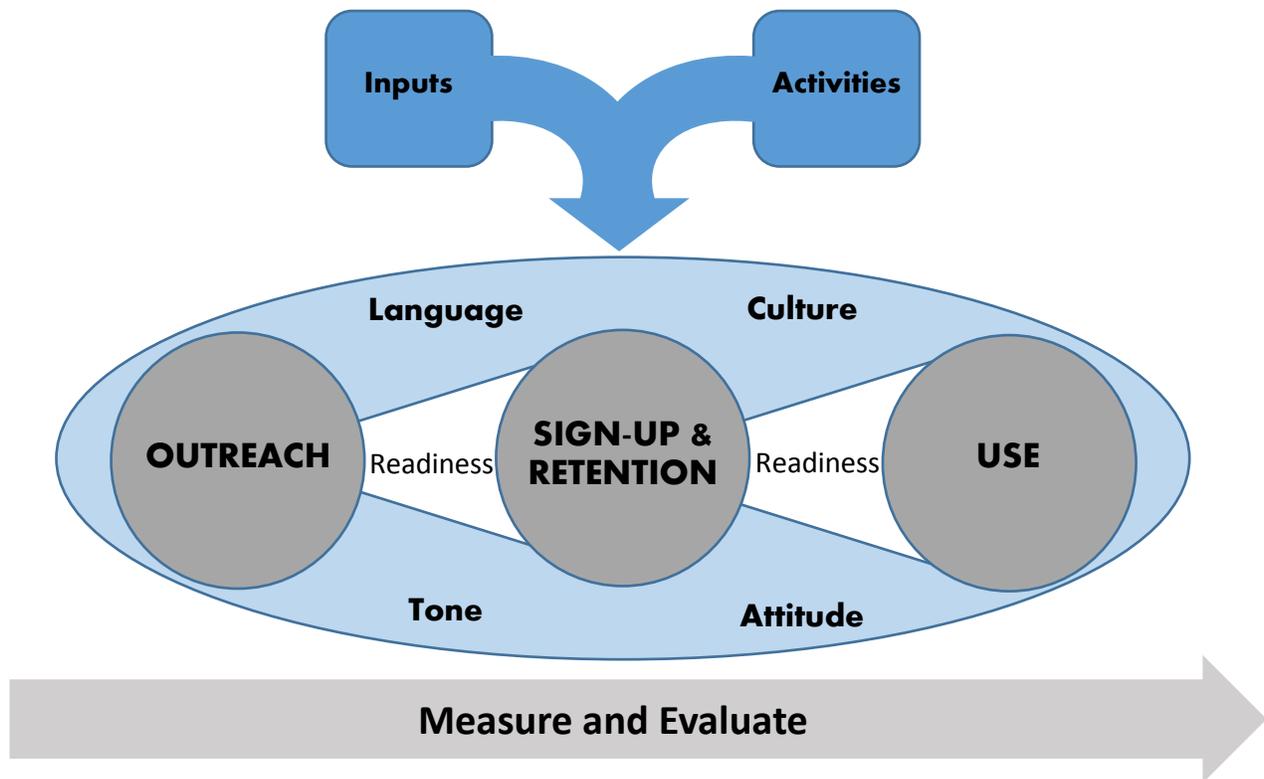
Figure 1: A model for engaging consumers in getting and using health insurance

OUTREACH, SIGN UP AND RETENTION, AND USE

Our research documented the need for multiple contact points in outreach and the importance of both the messages and messengers for informing hard-to-reach populations. During outreach, assisters need to help people to understand *why* they should get health insurance and tell them that help is available as they work their way through the complicated, cumbersome process. This process includes learning about their choices, signing up and keeping health insurance, and understanding how to use health insurance effectively. Message content and messengers must be accurate, reliable, and trusted voices who are understood across the languages and cultures of the uninsured. In addition, their tone must be helpful and friendly, and their attitude must be one that encourages questions.

Sign-up is the second step in the model, and its success is enhanced by outreach efforts to increase the readiness of applicants. Research documented the importance of in-person assistance, the ease of finding and using established application sites, the use of translators and interpreters, and help in the lengthy process of completing an application. In addition, many individuals need to learn and understand what they need to do to keep their insurance once purchased. Findings also documented that after sign-up, many people return with questions about how to use their newly acquired insurance. Ideally, completing an application should build readiness to learn how to use newly acquired health insurance. Just as outreach builds readiness for signing up, successful completion of an application through sign-up should build readiness for learning to use health insurance.

Everyone needs to be clear on what they need to know and do to use health insurance. Ensuring that accurate, understandable, navigable, and useful information is presented as part of the process is critical. The steps of outreach, sign-up and retention, and use all work synergistically to engage people in successfully enrolling and using health insurance. Our model also illustrates how language and cultural needs, as well as a kind, positive, and helpful tone and attitude, define all phases of outreach, sign-up, and use of health insurance.

INPUTS

We created a list of inputs that should inform outreach, sign-up and use. Key inputs include information content, data, influencers, and the creation and scripting of sensitive conversation. Content must be accurate and focus on facts that everyone needs to understand and what everyone must do to enroll and retain health insurance. For example, as part of outreach everyone must know that having health insurance is the law in the United States and that one must sign up every year to get health insurance. For sign-up and retention, people need to know where to go and what documents to bring for their application. Sources of content facts include the Centers for Medicare and Medicaid Services, state health exchanges, and the Kaiser Family Foundation.

Our research also documented the importance of knowing demographic information about target populations, identifying and engaging community influencers, and developing protocols for having difficult conversations around such issues as costs, affordability and immigration status.

ACTIVITIES

The inputs noted above feed into the activities. The main activities focus on being sure to have the right materials, processes, workers, and plan for all three components in the model. Materials must have accurate and up-to-date content and be understandable and usable, and their format needs to follow principles that promote use and understanding. A checklist for developing such health-literate materials can be found at http://centerforhealthguidance.org/health-literacy-principles-checklist.pdf. Including the target audience in material development and testing is essential and is an often overlooked step in material development. We suggest that materials be developed first in English. Then those with expertise in the languages and cultures of target audiences should be engaged to ensure adequate translation and interpretation of content, format, and layout.

Processes, including the specifics of what actually happens during each step, must likewise be health literate. Again, including members of the target audience in planning the specifics of each of these steps can make them more understandable, accessible, usable, and consumer-centered. Our research documented the need to ensure that the conversations and materials describing specifics of what people need to do (i.e., where to go, what to bring, and what to do once there) need to be reliable and consistent to help prepare hard-to-reach populations for sign-up and use of health insurance, as well as retaining that insurance.

Assisters for the three steps need consistent training about how to use the materials and the logistics of all phases of enrollment and retention. Specifically, those working in outreach need to understand what happens during sign-up and how to help new enrollees learn to use their health insurance once they get it. Finally, assisters must understand that successful sign-up and

retention rely on their participation in a systematic approach—a plan—that includes the three components in Figure 1 and its inputs and activities. The plan should also detail realistic options for using various types of media, noting specifics regarding which messages are communicated; the timing and frequency of the messages; and the language, voice, and faces of the best messengers.

MONITORING AND EVALUATION

The conceptual model illustrates ongoing monitoring and evaluation of outreach, sign-up, and use. Regularly capturing key variables and strategies for success can be used to enhance ongoing activities and can be shared with others targeting hard-to-reach populations. Performance measures should include trust and confidence of those participating in the outreach, sign-up, and use of health insurance.

SUMMARY

Though the conceptual model we describe is intended for those delivering services for outreach, sign-up and retention, and use of health insurance, we see a need to advance a parallel model for the target populations. Those needing health insurance should have a clear understanding that there are three steps to enrolling and retaining health insurance. These steps are as follows: understanding their choices for health insurance and how to get it (outreach); signing up for health insurance by completing an application and how to keep it (enroll and retain); and finding out how to use their health insurance (use). Each of these steps should likewise be informed by inputs and activities aligned with the currently uninsureds' needs to know and do. Both those needing insurance and those working to provide help in understanding how to choose a plan, sign up and keep health insurance, and how to use it need to share a common framework and be able to engage in a clear conversation on the three key components for engaging consumers in getting, using, and retaining health insurance.

4

Recommendations and Implications

RECOMMENDATIONS

Our nation is undoubtedly undergoing a transformation in how we engage the public in their understanding of how to obtain health insurance and access health care. What had largely been limited to those who are employed or part of specific targeted outreaches is now open for almost all Americans. Despite exceeding expectations in the numbers of Americans who signed up for health insurance, many state health exchanges have had difficulty enrolling individuals from specific population groups, such as African Americans, Asian and Pacific Islanders, and Latinos. Many fear that failure to enroll individuals from these groups may result in greater inequities in health care access and health. Our research findings indicate that there are a number of opportunities to influence the process of getting health insurance, especially for hard-to-reach populations. We identified several key recommendations that have implications for various stakeholders; these recommendations, along with the context within which they are made, are listed below.

Recommendation #1

The three major components of health insurance "enrollment" (outreach and education, sign up and retention, and assistance in how to use health insurance) should be integrated into a mutually supportive and iterative approach.

Context

Although emphasis and activity in each of these areas has occurred to varying degrees across all marketplaces, viewing each of these three steps as a continuum that is deliberately integrated is essential to successfully engage and retain hard-to-reach populations in health insurance (Figure 1). Incorporating explicit conversations about obtaining and using health insurance are just as important as signing up. Separating outreach and education from sign-up and post-sign-up use is a barrier to successful and health-literate consumer engagement. Thus, we recommend allowing consumers the opportunity to engage and revisit each of these conversations as frequently as needed and in any order necessary, ideally with a consistent group of assisters and in consistent settings.

Recommendation #2

Assisters need to engage in conversations about the value of health insurance, the options available, how to use the insurance, and what it will cost. Providing consistent messages on these topics is essential for these targeted populations. Efforts such as *Let's Ask 4: Questions for Consumers and Providers about Health Insurance* (Wu et al., 2013) and *From Coverage to*

Care Roadmap (CMS, 2014) are significant steps and should be viewed as starting points, not end points.

Context

Knowledge and attitudes about health insurance and its value vary and are particularly wide ranging across difficult to reach populations. Immigrant populations, for example, are often unfamiliar with the concept of health insurance. Other populations may have never obtained care from the U.S. health system, whereas others may have had extensive health care experiences or familiarity with uninsured programs and free clinics. Assisters should look for opportunities to engage consumers in the upstream conversations of why health insurance is important as well as the downstream consequences of how obtaining insurance will impact a consumer's life both in terms of cost and use.

Recommendation #3

Comprehensive conversations regarding the cost and affordability of health insurance must be constructed and incorporated to help ensure successful sign up and retention.

Context

Consumers (even those who are insured) lack a full understanding about the multiple costs involved in having and using their health insurance. The health insurance premium is only one component of the cost of buying and using health insurance. Cost is a particularly challenging issue, especially for harder-to-reach populations. Communicating that health insurance is important and that it is required can create frustration and stress among those who believe they cannot afford it. Talking to people about something they believe they cannot afford requires heightened sensitivity and training. Carefully constructed conversations with consumers about this issue are needed.

Recommendation #4

Identify data describing uninsured populations, preferably by zip code, and make these data available to assisters.

Context

Robust standardized sources of data on uninsured populations are difficult to find, often leaving communities to develop their own. Box 2 provides an example from Florida about the use of such data. However these discrete, community specific approaches underscore the need for a more standardized approach that is transparent and available to assisters. Accordingly, assisters will require resources that can allow for data analysis; this is critical in developing effective approaches for reaching consumers since the process of enrollment requires detailed information about the populations one is attempting to engage. Key information/variables include: culture, ethnicity, language, age, gender, literacy, and income. Data identifying these

parameters are needed to guide the development of approaches and strategies that allow for most effective engagement.

Box 2

A Community Health Needs Assessment

In 2013, prior to the open enrollment period, the Health Council of South Florida completed a community health needs assessment household survey.[1] The survey was unrelated to the efforts to enroll consumers in health insurance but planners and in-person assisters were able to use the data to guide their efforts during the open enrollment period. The survey results provided ZIP code level data on health and insurance status, access to health services, as well as income and demographic information. This information allowed in-person assisters to tailor their messages to various consumers and to anticipate the needs of different populations. Surveys of this nature are resource intensive so partnerships with organizations that have access to this kind of data are vital.

[1] The survey is available at http://www.healthcouncil.org/wp-content/uploads/2013/12/2013_PRC_Miami_Dade_County_CHNA_Report_Reduced.pdf (accessed December 17, 2014).

Recommendation #5

Processes must be intentionally designed to build trust with targeted populations and provide actionable steps for consumers. Furthermore, the following steps should be adopted:

- Identify and use trusted sources, including culturally and language-appropriate social networks, advocacy groups, social services, community support groups, and faith-based groups. Recruit assisters who are culturally and linguistically aligned with target populations. All assisters should be friendly, engaging, and supportive and should encourage questions and concerns.
- Establish convenient and consistent times and locations where assistance is available (e.g., public libraries, places of worship).
- Create health-literate educational materials and messages.[3]. Be sure that messages are action oriented (e.g., what to do and where to go) and consider such things as language; literacy levels; numeracy skills; cultural context; and knowledge, skills, and attitudes about access and use of health care.
- Engage trusted local and ethnically appropriate individuals and organizations to provide reliable information about each step of the process. Such sources may include media outlets in minority populations and individuals in organizations that have high community buy-in, such as barber shops, hair salons, and schools.

Context

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[3] For example, see *Health Literacy Principles: Guidance for Making Information Understandable, Useful and Navigable* (http://iom.edu/Global/Perspectives/2014/HealthLiteracyGuidance.aspx) and the *Health Literacy Principles Checklist* (http://centerforhealthguidance.org/health-literacy-principles-checklist.pdf).

As mentioned throughout this report and in many other organizations' reviews of outreach efforts, being trusted by the targeted community is foundational to all implementation efforts. Deliberately considering and practically planning on how best to foster trust must be considered throughout all activities.

Recommendation #6

Assister training needs to incorporate learning about each component of the process depicted in Figure 1. Training needs to address the following:

- Teaching consumers what they need to know and do to move through the process of outreach, sign-up, use, and retention
- Learning how to engage in difficult conversations with consumers about such issues as cost, affordability, and immigration status.
- How to encourage questions and offer useful and accurate answers to them
- How to remain patient and supportive with people who often feel frustrated and overwhelmed by the complexities and demands of the process
- How to motivate and activate a consumer through each of the three steps to obtaining and using health insurance.

Context

Current training programs involve basic information on how best to explain aspects of enrollment with a focus on the questions surrounding eligibility and how to choose a plan, but as illustrated throughout this paper, it is just as important to discuss issues around the use of health care. All assisters need a broad understanding of what a consumer needs for successfully navigating and completing all steps of the process. Ideally, all assisters are able to offer consistent, accurate, and consumer-friendly information that guides those seeking to choose a plan, sign up, and use health insurance. As processes and content evolve based on on-going monitoring and evaluation, those offering assistance need ready access to updated information and how best to communicate that information to those who need it. Appropriate language, culture, tone and attitude are persistent targets for assister training.

IMPLICATIONS FOR STAKEHOLDERS

As the 2015 enrollment begins, focus and attention will be on how this year compares with the inaugural year of the health insurance exchange marketplaces across the country. But on the basis of our findings and research efforts, we hope that a more relevant conversation will take place about how to continuously enhance and improve efforts from year to year and about how these efforts will improve the overall health of our nation.

Policymakers

There is no clear sustainable funding model for assisters. Yet our research and that of other organizations document that successful sign-up and retention are directly related to mobilizing the efforts of community-based organizations and individuals who undertook

outreach and education, sign-up, and post-sign-up assistance. Policy makers should consider how to encourage sustainable funding models that ensure continuity and resources beyond the enrollment periods. Models from other sectors such as telecommunications and education might serve as important examples; for example in telecommunications, private and public entities came together to develop a viable business model which could support broadband technologies while extending access to hard-to-reach populations at a heavily subsidized rate. In a similar fashion, perhaps part of the premium dollar which is dedicated to marketing could also be allocated for assisters (which potentially includes brokers). In addition, there is a need to use opportunities for private-public partnerships to help consumers, particularly hard-to-reach populations, better understand how to use health insurance and make health care decisions. Such efforts are important in reducing health disparities and improving health outcomes.

In addition to funding and sustainability issues, discrete policy actions are needed to address the flexibility of state regulations around enrollment burdens, uniform standards across states for assisters, and, where appropriate, standardized guidance for accessibility to services that are health literate in their content and approach.

Providers

Providers of care play an important role, but they are often seen as being involved only at the end of the process rather than as partners throughout it. Providers should be engaged in outreach and education to build trust (as discussed in recommendation 5) as well as to help consumers understand how to make the best decisions for their health. Many organizations have begun to focus on helping consumers understand how to use health care, but providers have largely been left out of this process. As we described in our research findings, successful sign-up should build readiness to learn how to use health insurance, including participation in conversations about affordability and culturally sensitive health issues that might otherwise be barriers to access and use.

Patient Advocacy Organizations

Helping hard-to-reach populations with successful outreach, sign-up, and use is an ongoing process that requires a continuous presence at the community level. Advocacy organizations are critical to providing the necessary continuity. Problems related to verification and follow-up questions about how to use health insurance were frequently cited as important issues by those we interviewed. Advocacy organizations were frequently identified as the trusted source of answers for these questions, often because they were also the same entities that helped to enroll people in health insurance.

For organizations that are involved actively in the three-step process depicted in Figure 1, considerations of what expertise or skills are necessary to answer questions beyond the enrollment period are important. This is also true for patient advocacy organizations or other similar entities that were not directly involved in enrollment. For example, consumers with specific diseases or health conditions (for example, diabetes, asthma, or cancer) might approach respective advocacy organizations to attempt to understand how new health care options might be relevant for their specific health concern. The patient advocacy organizations should be informed about the three steps and be able to orient their constituents to the process and tell them what they need to do to connect to outreach and education, sign-up, and use of health insurance.

Unintentional gaps in information create the potential for consumers to feel frustrated or uncertain and, perhaps even worse, marginalized. As stated throughout this report, trust is foundational. Populations of color and racial and ethnic minorities are likely to have greater trust in communication and outreach efforts of organizations with which they are familiar. Finally, advocacy organizations, as we have learned, are important links to trusted outlets such as media and community role models and as such can help to place the needs of special populations on the forefront of their agendas.

Insurance Plans

A great deal of information in the form of advertising and marketing has been disseminated from health insurance plans, yet only a minority of this information deals with all aspects of outreach, sign-up and retention, and use. Most information is focused on specific aspects of sign-up and benefit considerations. Certainly the insurance industry, although highly regulated, can be an important voice in helping consumers understand sign-up and use; outreach efforts also benefit from having insurance companies who are offering options on marketplaces to keep them apprised of relevant changes.

State-based or Federally Facilitated Marketplaces

Marketplaces are, by default, intended to facilitate sign-up for health insurance. Yet as we have seen from user experience, as well as from interviewee feedback, experiences have been mixed, with some expressing increased confusion and frustration. Aside from the importance of eliminating technical glitches, our findings emphasize the need for marketplaces to synchronize their efforts with a health-literate strategy, including attention to tone, language, and culture. Web-based materials should be aligned with other media, such as print and radio. Messaging should reinforce all three components of the framework shown in Figure 1—outreach and education, sign-up, and use. One potential solution to ensure this alignment is to enlist local, regional, and national health literacy expertise. Many health promotion activities are rooted in the attributes of health literacy, which in turn can be a resource for marketplace leaders. These attributes are especially important when considering the needs of hard-to-reach populations as well as the formidable barriers posed when language, culture, tone, and even attitude are not taken into consideration during such a compressed time frame (such as a several-week sign-up period).

CONCLUSION

Our research and background work illustrate the important implications of a proposed framework to enhance enrollment and retention, particularly in hard-to-reach populations. But this framework is also applicable to a broad population of persons who are trying to access health care. Our country's ability to translate this framework into actionable steps is certainly a very difficult task but one that has begun to be addressed, in part, with the launch of last year's enrollment efforts and continued improvements this year and into the future. It is our hope that this paper, along with contributions of others, can build on these efforts and truly bring together outreach, enrollment and informed use of the health care system.

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