2011

iHealth:

How to Ensure the Health Benefit Exchange Reaches all Californians

CARLA SAPORTA and ERIN DELANEY | The Greenlining Institute

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About the Greenlining Institute

The Greenlining Institute is a national policy, research, organizing, and leadership institute working for racial and economic justice. We ensure that grassroots leaders are participating in major policy debates by building diverse coalitions that work together to advance solutions to our nation's most pressing problems. Greenlining builds public awareness of issues facing communities of color, increases civic participation, and advocates for public and private policies that create opportunities for people and families to make the American Dream a reality.

About the Bridges To Health Initiative

The Bridges to Health program employs a holistic approach by supporting and developing policies that affect and improve health outcomes. Health is more than just the absence of disease. Issues such as health workforce diversity, education, community investment, and our surrounding environment impact the well being of the communities we serve. By way of research, leadership development, coalition building and public-private partnerships we educate stakeholders to create policies that improve access to care and mitigate health disparities.

About the Authors

Carla Saporta, Greenlining Institute Health Policy Director
Carla is the health policy director for the Bridges to Health team at Greenlining, focusing on developing a racially equitable framework for increased health care access and the implementation of the Patient Protection and the Affordable Care Act. Carla also leads efforts to develop public/private partnerships in the health care sector as a means to mitigate health disparities. Carla graduated from Occidental College with a Bachelor of Arts in Urban and Environmental Policy. She completed her Master's in Public Health, with an emphasis in Health Policy and Management, through the Oregon Masters in Public Health Program at Portland State University. Prior to Greenlining, Carla worked as a legislative analyst for Oregon State Senator Laurie Monnes-Anderson, Chair of the Senate Health Committee and was an organizer for the California Nurses Association. Her work at Greenlining is informed by the understanding that every policy is health policy.

Erin Delaney is the legal associate at The Greenlining Institute, and works on a variety of issues ranging from increasing supplier diversity in Californian companies to implementation of the Patient Protection and Affordable Care Act, focusing on how to ensure equal access to its provisions. Erin has worked for the city government of La Mesa, as well as the 9th Circuit Court of Appeals, and has served as the chairperson of the city of La Mesa's Youth Commission, which advocated for the interests of the city's young. Currently, Erin is in her second year at the University of California, Berkeley where she is pursuing her B.A. in both Political Science and Rhetoric.

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Design: **Vandy Ritter Design,** San Francisco

The Greenlining Institute
1918 University Avenue, Second Floor,
Berkeley, California 94704
www.greenlining.org | T: 510.926.4001

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Executive Summary

- The Patient Protection and Affordable Care Act (ACA) aims to make healthcare more affordable and attainable for all people.
- In California alone, an estimated 4.7 million uninsured or underinsured people are expected to become eligible for healthcare. Most of them will be from communities of color.
- In order to make enrollment as easy as possible, the ACA creates a Health Benefit Exchange (Exchange) which will start in January 2014. The Exchange will provide consumers with a way to compare health plans and obtain an effective and affordable option. The main means of accessing the Exchange will be online.
- Communities of color and low-income communities have disproportionately low access to the Internet, and are more likely to depend on smartphones for their online access. The Exchange board must consider these and other potential barriers in order to ensure that all communities have equal access to the Exchange.

Recommendations:

- The Exchange board should conduct a regional needs assessment to better determine the specific needs of low-income and diverse communities, and use this assessment to create an effective outreach campaign.
- The board should make sure that the outreach campaign, which should describe not only the ACA itself but also methods for enrollment, is tailored to communities that face more barriers to enrolling.
- Federal law requires that a program of Navigators – community organizations, professional associations, non-profit groups, etc. – be developed to help people obtain information about the ACA and enrollment, and also assist with the actual process of enrolling. This provides an incredible opportunity to bring together organizations from communities of color to help specifically target outreach efforts.
- 71% of people ages 18-34 use social networking sites. These sites should be utilized to promote information about the ACA and enrollment.
- The board should emulate the model developed in Merced County, where kiosks have been placed in various public areas (libraries, pharmacies, etc.) which allow people to sign up for welfare and Medi-Cal. Kiosks in public locations will make it easier to enroll in the Exchange and will help circumvent unequal Internet access in low-income and diverse communities.
- Because smartphones are the primary means of Internet access for many, the Exchange should consider creating an application for smartphones that would allow people to compare and apply for coverage through their phones.
- The Exchange should also use cell phones to send out informative text messages with information about the Exchange and enrollment, or with reminders about renewing coverage.
- It is key that all materials or resources be available in multiple languages, for fair access for the millions of Californians whose primary language is not English.

Introduction

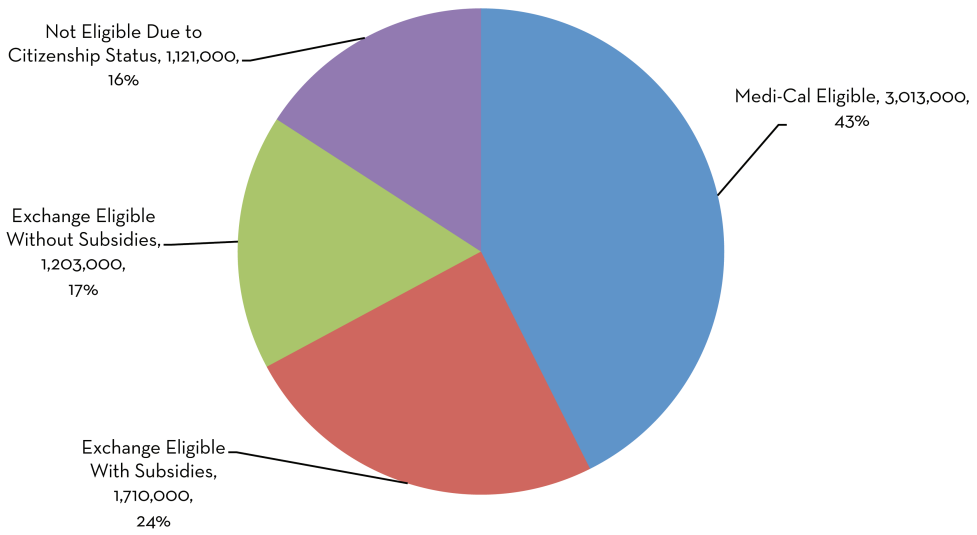
The signing of the Patient Protection and Affordable Care Act (ACA) in March 2010 provides states with the opportunity to bring health insurance to millions who have been ineligible for or unable to afford it in the past.[1] In California alone, an estimated 4.7 million uninsured and underinsured residents, many from communities of color, are expected to gain access to health insurance through the ACA's provisions.[2] One of the most important of these is the creation of the Health Benefit Exchange (Exchange).

This is an exciting opportunity that also presents a tremendous challenge. The state has until January 2014 to put in place the systems and infrastructure to enroll millions of new consumers.[3] A key element of this will be the creation of a Web portal, which will allow consumers to determine what programs they are eligible for and to enroll in an insurance plan, all in real time.[4] Although applying for the Exchange will be possible by mail, phone, and in person, the expectation is that most people will use the Web.[5] The web portal has the potential to be a tool to efficiently enroll millions of consumers in health insurance, but inequalities in access to broadband and the Internet in general may be a serious barrier to fully accessing the Exchange for communities of color. Solutions must be found to ensure that when health coverage expansion begins in 2014, communities of color can fully benefit from the outset.

Health Coverage Expansion Under the ACA

The ACA is expected to create insurance eligibility for as many as two-thirds of California's seven million uninsured.[6] Most of this increased coverage will come through Medi-Cal, while millions more will be eligible for the Exchange.[7] For both programs, communities of color will make up the majority of the population eligible.[8]

Figure 1: Most Californians Newly Eligible for Health Insurance Coverage in 2014 Will Be Eligible for Medi-Cal



Total Uninsured All or Part of Year: 7,073,000

Note: Estimates are based on children and adults under 65 years of age in California who were uninsured for all of 2009.
Source: UCLA Center for Health Policy Research

Key Provisions of the ACA

Expanded Coverage:

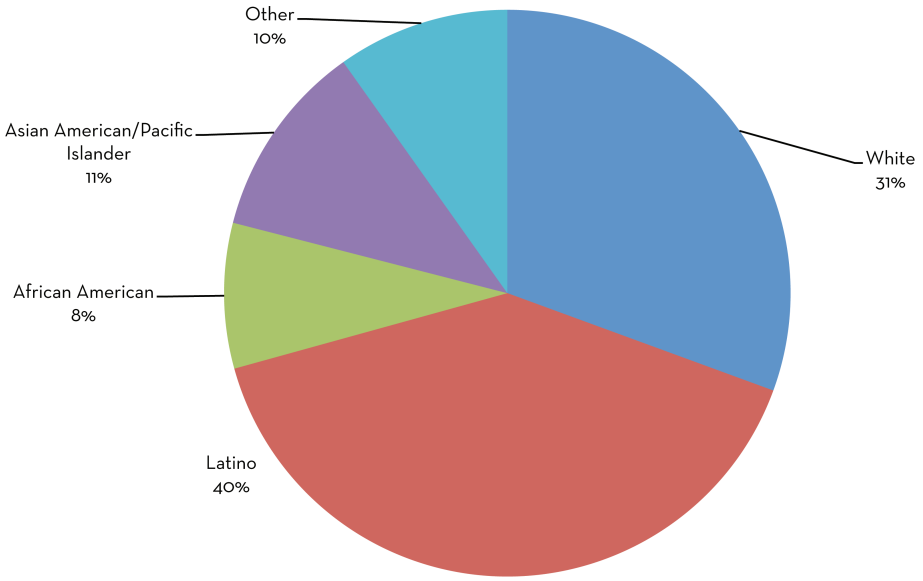
- Medi-Cal will be expanded to 138% of the federal poverty level for all residents under age 65 years of age.
- Creates exchanges where subsidies for health insurance premiums will be provided to families and individuals below 400% of federal poverty level who do not qualify for Medi-Cal or Healthy Families and do not receive employer sponsored insurance.
- Seniors with Medicare will see their "donut hole" for prescription drugs closed.
- Young adults can stay on their parent's employer sponsored health insurance until they are 26.
- Tax credits will be offered to small businesses (less than 25 employees) who contribute at least 50% of premium costs for their employees' coverage.

Other Reforms:

- Prevents health insurers from denying consumers coverage because of a preexisting condition.
- Lifetime limits on coverage are prohibited.
- Requires insurance companies to have a minimum medical-loss ratio of 80% for individual and small group plans and 85% for large group plans.
- Most Americans will be required to have health insurance beginning in 2014, or face a fine.
- Creates the Small Business Health Options Program (SHOP), an exchange for small businesses.[9]
- Businesses with more than 50 employees will face fines if they do not offer health insurance to their employees.

Source: The Henry J. Kaiser Family Foundation

Figure 2: Medi-Cal Expansion Will Primarily Benefit Communities of Color



Total Uninsured All or Part of Year Newly Eligible for Medi-Cal: 2.13 Million

Note: Estimates are based on children and adults under 65 years of age in California who were uninsured for all or part of 2009. "Other" includes American Indian and Alaska native and mixed/multiracial individuals.
Source: UCLA Center for Health Policy Research

Of those newly eligible for Medi-Cal, 70% are people of color, and 22% do not speak English well or at all.[10] Additionally, the population is disproportionately young, with 31% of the population between 18 and 26 years old, and mostly single without children (57%).[11]

While the Healthy Families program will not expand, there are nearly 200,000 children that are currently eligible whose families may enroll in order to avoid fines.[12]

The Health Benefit Exchange

The Health Benefit Exchange (Exchange) will be a competitive, transparent marketplace where consumers have the opportunity to compare benefits, costs, and services of one insurance option to another.[13] The Exchange is intended to reduce costs by pooling consumers together in order to increase market leverage, pool risk, and increase efficiency, and is also the mechanism through which federal subsidies will be provided to help to make coverage affordable.[14]

Program	Eligibility
Medi-Cal	Children, parents and individuals not eligible for ESI with income up to 138% of FPL. ($15,028 for an individual, $30,843 for a family of 4 in 2011)
Healthy Families	Children up to age 18 not eligible for ESI with income between 138% and 250% of FPL ($55,875 for a family of 4 in 2011)
Health Benefit Exchange	Anyone not eligible for Medi-Cal or Healthy families and not eligible for ESI can purchase a policy in the Exchange. Those with income between 138% and 400% FPL ($43,560 for an individual and $89,400 for a family of 4 in 2011) are eligible for a subsidy.
Sources: ACA, Managed Risk Medical Insurance Board, and California Budget Project.	

California's Exchange is governed by a five person board, which will act as an active purchaser of health plans, meaning they will set criteria for the plans, and contract with the plans that offer "the optimal combination of choice, value, quality, and service."[15] It will also oversee the development and implementation of the Web portal, which will serve as the main point of access to enroll and purchase a health plan through the Exchange.[16]

Massachusetts Health Connector

The 2006 Massachusetts health care reform law was the model that Congress used to design the ACA. The Massachusetts program, known as the Health Connector, implemented many reforms included in the federal law, such as creating an Exchange, expanding Medicaid, and placing requirements on some employers to offer reasonable health coverage. Many details in the design of the state exchanges created by the ACA – such as the levels of coverage, personal mandate, and incremental subsidies – mirror Massachusetts' Health Connector model closely.

Massachusetts is much different from California demographically. It is wealthier, with fewer people in poverty, and less racially diverse. Massachusetts has a much smaller foreign-born population than California, with less than half as many residents who speak a language other than English at home.

Still, there are lessons the Board can learn from Massachusetts' experience in reaching out to its uninsured residents. For example, when the Connector held focus groups with uninsured people, the uninsured made it very clear that they wanted information in writing as well as the ability to talk to someone to help them with enrolling and decision-making.

California and Massachusetts Demographics		
	California	Massachusetts
White Population	40%	76%
Median Household Income	$59,000	$64,000
Poverty Rate	14%	10%
Foreign Born Population	27%	14%
Language Other Than English Spoken at Home	42%	20%
Source: US Census, 2010 [17, 18]		

While Massachusetts is a majority white state, the uninsured in the state were disproportionately people of color. In 2006, before the law took effect, Hispanic and black adults had an 18% uninsured rate while white adults had an uninsured rate of only 7%. Uninsured adults were also disproportionately young, male, and tended to be single, all characteristics that California's uninsured share. Massachusetts' health care reform law included a personal mandate, which took effect in 2007. The adults who were still uninsured at the end of 2007 were still disproportionately young, male, single, black and Hispanic, which suggests that California may be able to learn from what the Connector did and failed to do in its effort to enroll these demographics.

As part of its outreach efforts, the Connector sponsored dozens of forums around the state at which attendees could begin the enrollment process. It also worked with state agencies like the Department of Revenue to mail information to millions of taxpayers about their new responsibilities, the registry of Motor Vehicles to provide information and advertising at its offices, and public transportation agencies to provide advertising. The Connector also found ways to partner with corporate and civic organizations to assist in its education campaign by providing information to customers or constituents (for example, brochures at CVS pharmacies), as well as advertising.

The team in charge of implementation efforts in Massachusetts, aware that these efforts have acted as a national model, has released a guide to important aspects of the state's program. Some of the guide's key points are:

- Massachusetts recommends using a strong base of community organizations to reach out to vulnerable groups. Their efforts should include helping the uninsured sign up for and maintain coverage.

- Successful implementation requires high levels of awareness and understanding from individuals and businesses, so an ongoing communications campaign which utilizes public and private sector resources is needed.

- Health reform implementation is an ongoing process that requires continuous improvement based on feedback from consumers, employers, providers, and other stakeholders. This means that avenues for feedback need to be planned into the Exchange's structure, and methods for changing policies need to be fluid enough to respond to this input.

What is the Web Portal?

Federal guidance envisions that most people eligible for health insurance expansion, both for public programs and the Exchange, will enroll through Web portals that each state will create.[19] By designing a Web portal that consumers find easily accessible, the Board can potentially draw in more consumers, including some that may have intended to enroll in Medi-Cal or Healthy Families, but learn they are Exchange eligible. Young, male, single adults of color, most of whom are healthy, will be the largest population newly eligible for Medi-Cal and the Exchange, and thus will presumably make up the bulk of the users of the web portal. The Board will need to carefully target this population, because having healthy people in the insured pool helps keep the cost of insurance down for all.

The Centers for Medicare & Medicaid Services (CMS) has already begun to provide some guidance to states on what is expected. CMS expects states to have web portals that provide a high quality customer experience and that users will be able to check eligibility and enroll in a program in real time.[20] Additionally, consumers will have resources available to help with their decision, such as a tool to calculate their costs and data on consumer ratings and quality of plans.[21]

Web Portal Design: UX 2014

One way that California is attempting to create a high quality customer experience is by participating in a multi-state design effort for the Web portal called the The Enrollment User Experience 2014 (UX 2014).[22] UX 2014 is a national public/private partnership between federal agencies, including CMS; states, including California; insurance companies; foundations; and a private design firm named IDEO.[23] The goal is to create a design that focuses on the user experience from application to enrollment to reenrollment, and all of the processes in between. The design that is created from this effort can be used by states to enroll consumers in both public programs and the Exchange.[24] The project is intended to consider differences among the users including demographic differences, levels of technological sophistication, and behavioral differences.[25]

E-App Experience

The Health Benefit Exchange's website is not California's first experience with moving the application process for health programs online. Two of California's earlier experiments with online application systems, the Health-e-App and the One-e-App may provide some lessons for designing a web portal.

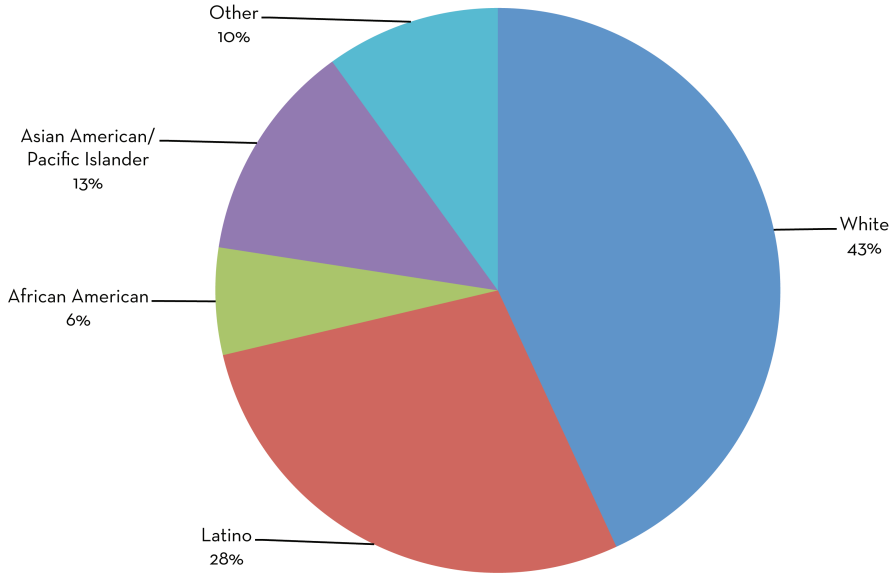
The One-e-App is a Web-based application intended to screen an applicant for multiple programs at once, from health programs like Medi-Cal and Healthy Families; to social service programs like food stamps and WIC; tax programs such as the Earned Income Tax Credit and the Child Tax Credit; and other benefits such as energy or insurance programs.[26] The system is used in more than a dozen counties across the state.[27]

The Health-E-App is also a Web-based application that an applicant can use to apply for Healthy Families and Medi-Cal for children and pregnant mothers.[28] The online application was recently made available to the public to apply online.[29]

These programs can shorten the application process, decrease the time it takes for an applicant, reduce errors in the application, improve approval rates, improve retention in programs and streamline the process.[30] Challenges include the complexity of the databases and applications for these programs.[31]

The Board could benefit from an analysis of the population that accessed the Health-e-App since it was made available to the public, as well as the demographics of the consumers that preferred to keep using traditional application methods (mail, in person, phone). The Board may also draw lessons from the experience of the One-e-App, including lessons from training county staff to use the application and technical experience in integrating it with county databases.

Figure 3: Most of those Eligible for the Exchange Are From Communities of Color

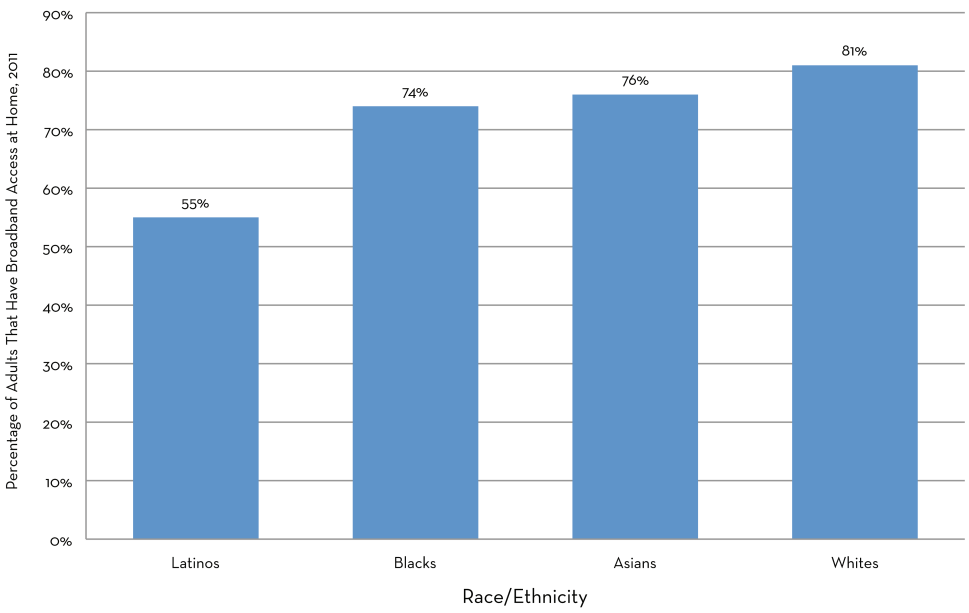


Note: Includes those uninsured all or part of year, and those eligible for a subsidy that are currently covered with individual insurance.
Source: UCLA Center for Health Policy Research

Digital Inequality and Challenges to Access and Enrollment Through the Web Portal

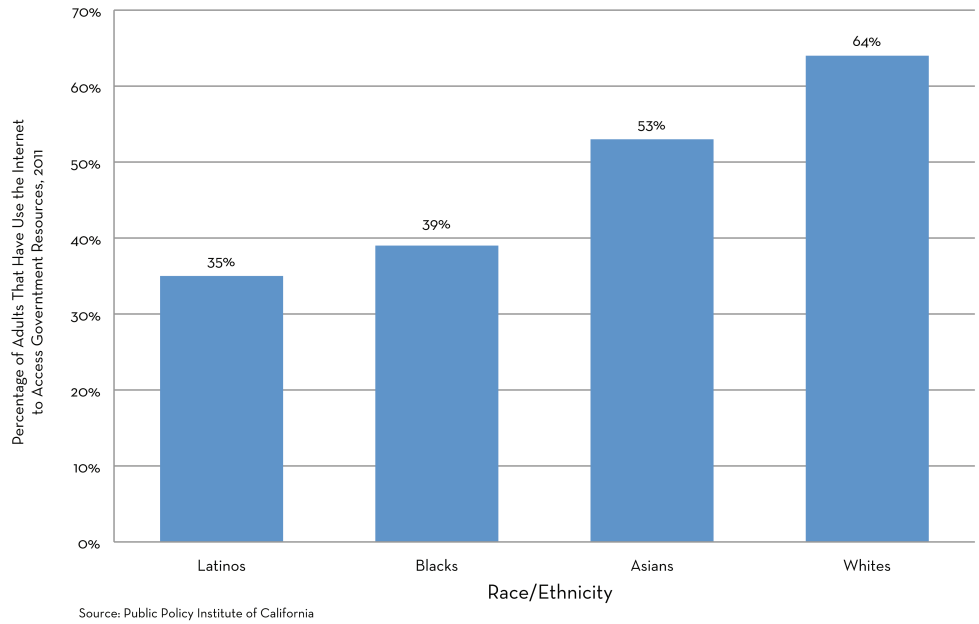
California is arguably the most tech-savvy state in the U.S., and yet it suffers from profound digital inequality. That is, California's communities vary widely in their ability to access and make maximum use of digital communications technologies in their daily lives,[32] variations that often mirror real-life racial and socioeconomic inequities. In California, digital inequality manifests itself in several ways. For example, while Californians use the Internet more on average than the rest of the country, access breaks down along income and racial/ethnic lines. In households that make $80,000 or more, 98% of adults use the Internet, as compared to 72% of adults in households making less than $40,000.[33] In looking at a racial/ethnic breakdown, 92% of whites use the Internet, as opposed to 86% of Asians, 85% of blacks, and 70% of Latinos.[34]

Figure 4: Latino Households Are Still Far Less Likely Than White Households to Have Broadband Access at Home



Source: Public Policy Institute of California

Figure 5: Whites Are More Than 80% More Likely Than Latinos to Use the Internet to Access Government Resources



Source: Public Policy Institute of California

This discrepancy is even more pronounced when looking at the racial breakdown of California households with broadband, as 81% of whites have broadband at home, compared to 76% of Asians, 74% of blacks, and only 55% of Latinos.[35] Given the need to enroll healthy, young adults, it is of particular concern that these discrepancies are pronounced in the young adult population. For example, only 57% of young Hispanics have broadband, compared to 75% of all young adults. It is clearly not safe to assume that all consumers will have the Internet access necessary to apply for health insurance through the Web portal.

Digital inequality can also be seen in the different ways that groups use the Internet. For example, whites are far more likely to visit a government website or to use the Internet to access government resources than any other racial/ethnic group (Figure 5).[36] This begs the question of how to ensure that all groups have access to information about the ACA provisions, such as the Medi-Cal expansion and the Exchange.

Use of Smartphones

Cell phones have become omnipresent amongst adults in California, as more than nine in ten adults have cell phones (93%).[37] Additionally, four in ten Californians have smartphones, including nearly six in ten black adults.[38] Smartphones have emerged as a source of internet access for many Californians. In fact, for 36% of Californians making less than $40,000, smartphones are the primary means of accessing the Internet.[39] Smartphones are also the primary means of Internet access for 42% of young adults aged 18-29 and 38% of African Americans and Hispanics. These are the same demographics that are most affected by the Medi-Cal expansion and the Exchange.

Critically, for many of these individuals, their smartphone is their only means of Internet access. A July 2011 Pew Research Center survey found that one third of these "smartphone mostly" Internet users had no home broadband access.

Recommendations

The following strategies may help maximize the positive role technology can play in enrolling consumers, and minimize the effects of digital inequality on communities of color.

Conduct Regional Needs Assessment

The Board should conduct a needs assessment to understand the differences between consumers that will enroll through the web portal, over the phone, in person and by mail. The Board needs to understand the differences in these populations in order to best focus their resources in outreach and infrastructure. The assessment should include focus groups with people of color; consumers with language and disability needs; community based organizations (CBOs) and advocates; as well as diverse small business owners and representatives.[40] This assessment should also consider regional differences in needs and can help inform all aspects of the Board's work.

SmartPhones

Smartphones present an enormous opportunity to conduct outreach and provide information to consumers, and to possibly even enroll consumers in the Exchange and Medi-Cal. The Board can find countless ways to conduct outreach through cell phones and smartphones. Text messaging is one function that is already widely used by Californians (74% of cell phone users text, including 75% of whites and 73% of Latinos).[41] Text messaging could be a way to remind users to renew their insurance, to complete their applications, or even to make payments.

The board should aggressively pursue development of smartphone applications for a variety of purposes. Among the easiest would be applications to allow consumers to find nearby help with enrollment, for example by locating the closest navigator (navigators are discussed in detail below).

It is appears feasible to develop applications that would allow consumers to apply and enroll through their mobile device without risking privacy or sacrificing a customer-friendly experience. While no exactly comparable applications exist now, many of the features such an application would need have already been developed in other fields. Car insurance applications, for example, provide rate quotes, agent information, and direct links to internet sites/phone numbers for purchasing policies. Travel services like Expedia, Orbitz and Travelocity allow online comparisons and purchasing of tickets, accommodations, etc. Using similar approaches, innovators with the right incentives should be able to develop an application that compares policies and, at the very least, connects young smartphone users with agents or private companies from whom they can purchase the insurance plan they have chosen.

While smartphone screens are small, consumers are already using their phones for more and more tasks. For instance, many consumers are already using their phones to purchase goods. Young people (26%) are more likely to purchase goods and services through their phones than other adults (16% of 35-54 year olds, and only 4.1% of those over 55) and are also far more likely to use their phones to visit a government website than older adults (17% of 18-34 years compared 4% of adults over 55).[42] UX 2014 will also be considering the use of mobile devices, including smartphones.

Cell phones may also be a way to specifically target the young adults identified earlier as a priority population for users of the Exchange. Many young adults (57% of adults aged 18-34) have internet access through their cell phones (compared to 40% of all California adults, and only 17% of adults over 55).[43] Young adults also make up a disproportionate share of the health care expansion population.

Language Assistance

Over 200 languages are spoken in California, and nearly 40% of residents speak a language other than English at home.[44] With that in mind, the legislation that created the Exchange requires the Board to provide interpretation services in any language for individuals seeking coverage through the Exchange, and to provide written information in "prevalent" languages.[45] The legislation further requires the board to conduct outreach and enrollment activities that specifically target those with limited language proficiency in the least burdensome manner.[46] In order to meet those requirements, the online portal should be accessible in the State's top threshold languages, and the Board should follow best practices in translating documents and providing consumer assistance. The Board should seek the input of advocates and CBOs as they develop strategies for language assistance.

Web Portal

In designing the Web portal, the Board should seek input from the populations most likely to be impacted by the design, including communities of color and low-income communities. The Board should keep in mind the varying levels of technological sophistication of its consumers, and focus on making the design intuitive and easy to use. The Web portal should allow for easy renewals by saving user information and not requiring a user to reenter information that has not changed. If consumers need assistance while applying, they should be able to chat online with an Exchange representative, and representatives should be available in top threshold languages.

Outreach

While Californians generally support the ACA, a great deal of confusion remains amongst consumers over what the law means for them, and the Board should not assume that this confusion will ease on its own.[47] An outreach campaign must consider the role ethnic media and CBOs play in communities of color. It should start as early as possible to ease confusion and help consumers understand that health care expansion represents an opportunity rather than a burden.

Most of the consumers eligible for the Exchange and Medi-Cal expansion report being healthy. This combined with the cost of insurance may discourage them from taking advantage of health care expansion . An outreach campaign that begins early, and focuses on the benefits of coverage could help convince consumers of the importance of health insurance. A good place to begin is with health care providers, who could begin sharing information with consumers about the changes and opportunities that are coming soon. Two-thirds of those eligible for the Exchange made an outpatient visit in the past year.[48]

In addition to clinics, hospitals, and other health care centers, the Exchange should involve CBOs in the outreach effort. CBOs already have established trust and channels of communication with their communities and may be able to effectively communicate the message of how people can participate and why they should. Some CBOs may additionally serve as navigators.

Navigators

Federal law requires states to establish a navigator program, but further guidelines have yet to be released. According to the ACA, and state law, navigators will be tasked with providing information to consumers, conducting outreach, assisting consumers with questions and grievances with their health plan, and facilitating enrollment into a plan.[49] Navigators may be a government entity, a non-profit, or a private entity.[50] They are required to have, or be able to make relationships with consumers that are likely to enroll in the Exchange or SHOP and they may not be health insurance companies.[51] The ACA specifically lists the following entities as potential Navigators: professional associations, industry organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, licensed insurance agents and brokers and other entities that can carry out the required duties and meet the required standards.

Determining how the navigator program will function is one of Board's biggest tasks. The funding for navigators has to come out of the operational funds of the Exchange,[52] which will derive from a reasonable charge that health plans will be assessed in order to participate in the Exchange.[53] It will be up to the Board to decide how to disburse grants to navigators. While the possibilities are endless, California has had a similar program in the past connected with Healthy Families: The state certified individuals as application assistants, and paid these application assistants for every person they enrolled. Another possibility would be to distribute grants to organizations to serve as navigators, such as clinics, community based organizations, and counties.

The Board should take advantage of its opportunity to design a navigator program that can reach as many consumers as possible. The input of CBOs and health advocates is crucial. Different regions, communities, ethnic groups, etc, will all have unique needs that can only be addressed by creating as wide a navigator network as possible, and by sincerely seeking and listening to community input.

Social Networking Opportunities

Reaching young, healthy adults and enrolling them in health programs will be a challenge. Young adults are more likely to use social networking than other adults (71% of adults 18-34 compared to 52% of all adults).[54] Communities of color are using social networking at high rates too, including 60% of Asians, 54% of Blacks, and 42% of Latinos.[55] Many young adults even access social networking sites through their phones (47%).[56] Aggressive use of social networking sites can to spread awareness to many Californians for a low cost.

Kiosks

The Board should consider acquiring and installing kiosks where consumers can apply for benefits. This type of technology might be particularly beneficial in central spaces of more rural counties where access to in-home Internet is more limited. This type of project is already being piloted in Merced County on behalf of the C-IV Consortium.[57] Merced County has placed five kiosks, one each at a Women, Infants, and Children (WIC) office, a library, a pharmacy, a health clinic, and at the main social services office in the county.[58] The kiosks allow consumers to apply for welfare and Medi-Cal, and current beneficiaries can update information and submit documents.[59] Beneficiaries can also use the kiosks to scan and print documents, communicate with their caseworkers, and check on the status of their applications.[60] The C-IV Consortium operates in 39 counties, and if this program is expanded, this may be a network already in place that the Exchange could attempt to use to enroll new consumers.

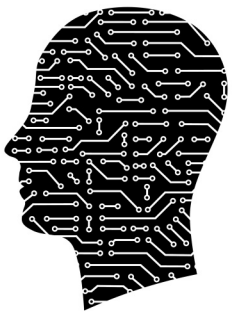
Other Methods of Enrollment

Even if all the above strategies are utilized, there will still remain a population that will not enroll online and will not reach out to navigators or other proxies. In addition to the Web portal, federal guidelines require the Exchange to allow consumers to apply by phone, in person, and by mail.

To provide customer service and allow people to apply over the phone, the Board will need to make investments to ensure that the hotlines are professionally staffed by operators that are culturally competent and that translators are available. The rollout of Medicare Part D demonstrated the danger of what can happen when a hotline does not have staff with cultural or language competency. In one experiment, less than four in ten callers speaking a language other than English were able to access information.[61]

The Board will also need to consider the many opportunities that in-person applications offer. At a minimum, the Board could allow applicants to apply at their county welfare office. But the Board should go beyond the minimum, and consider a more robust program for in-person enrollment. An example of a more ambitious plan for in-person applications could include establishing Exchange offices in major population centers where people could come in to apply. Other possibilities include having Exchange representatives attend health fairs; organizing health forums where consumers receive information about health care reform and have the opportunity to apply at the end; setting up booths at sites and events with lots of foot traffic. In-person applications could also take place through navigators. Navigators could play as big a role as the board is willing to imagine.

The fourth way that the Exchange is required to allow for application is through the mail. The Board will need to make print applications, translated into all threshold languages, widely available to consumers. When the Exchange receives applications with missing information it should make every attempt to obtain the information that is missing through other sources (Social Security, Department of Homeland Security, etc), which would hasten approval.



Conclusion

While the provisions of the Affordable Care Act have the ability to impact millions of people, most of whom are people of color, it will take a very intentional and concerted effort to ensure that outreach is culturally aware in both language and methods of communication and access. Digital inequality creates a barrier to access for these communities, but through outreach efforts of Navigators, creative use of social media and smartphones, and easily accessible and usable alternatives like phone or mail enrollment, the Health Benefit Exchange can reach the people who need it most.

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[1] According to the Congressional Budget Office, the ACA will reduce the number of uninsured by 32 million in 2019. See The Henry J. Kaiser Family Foundation. Summary of Coverage Provisions in the Patient Protection and Affordable Care Act. Menlo Park, CA, 2011.

[2] Lavarreda SA and Cabezas L. Two-Thirds of California's Seven Million Uninsured May Obtain Coverage Under Health Care Reform. Los Angeles, CA: UCLA Center for Health Policy Research, 2011.

[3] Both Medi-Cal expansion and the Exchanges are both effective January 1 2014. See Sec 1321 (b), and Sec 2001 (a) of the ACA.

[4] Proposed federal regulations (45 CFR 155) require exchanges to maintain a website (§155.205(b)) that enrolls consumers (§155205(b)(6). Further, AB 1602 which implements exchange provisions of the ACA in California adds Gov Code §100502(f), which requires the Board to screen applicants to the Exchange for eligibility in Medi-Cal and Healthy Families, and to enroll individuals in those programs if they are eligible.

[5] See for example: http://www.healthExchange.ca.gov/Documents/Meeting-Materials/24MAY2011/Eligibility%20and%20Enrollment%20-%20First%20Class%20User%20Experience%20Design%20for%20ACA%20Enrollment.pdf

[6] Lavarreda SA and Cabezas L.

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[9] The ACA makes reforms to the responsibilities of employers in offering insurance. Employers with 50 or more employees will face a fee if they do not offer coverage to their full-time employees. Small businesses that have fewer than 25 employees, pay an average wage of less than $50,000, and contribute at least half of their employees' premium costs will be eligible for tax credits of up to 50% of premium costs. These employers will be eligible to purchase plans for their employees in a separate newly created Exchange called the Small Business Health Options Program (SHOP). Curtis R and Neuschler E. Small Employer ("SHOP") Exchange Issues. Washington, DC: Institute for Health Policy Solutions, 2011.

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[12] California Health Interview Survey. http://www.chis.ucla.edu

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[14] Ibid.

[15] Weinberg M and Haase L. State-Based Coverage Solutions: The California Health Benefit Exchange. Washington, DC: The Commonwealth Fund, 2011.

[16] The California Patient Protection and Affordable Care Act (2010)

[17] *U.S. Census of Population and Housing, 2010 State and County QuickFacts: California.* Washington: Government Printing Office, 2011.

[18] *U.S. Census of Population and Housing, 2010 State and County QuickFacts: Massachusetts.* Washington: Government Printing Office, 2011.

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[20] Centers for Medicare & Medicaid Services. Guidance for Exchange and Medicaid Information Technology (IT) Systems. May, 2011.

[21] Ibid

[22] The Project Director for UX 2014, Terri Shaw, presented for the California Health Benefit Exchange Board at their May 24, 2011, board meeting. For presentation, see: http://www.healthexchange.ca.gov/BoardMeetings/Documents/24MAY2011/Eligibility%20and%20Enrollment%20-%20First%20Class%20User%20Experience%20Design%20for%20ACA%20Enrollment.pdf

[23] Ibid

[24] Ibid. While this is being designed for individuals, rather than for Small Business Health Options Program (SHOP), the web portal for small businesses to purchase insurance for their employees through the Exchange, its principals may be transferable to the SHOP as well.

[25] Ibid

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[36] Ibid.
[37] Ibid.
[38] Ibid.
[39] Ibid.
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[43] Ibid.
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[46] AB 1602
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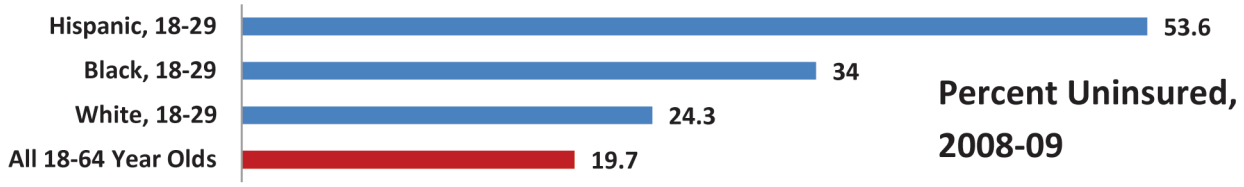
Appendix

Why Young Adults Need Smartphone Access to Health Exchanges

Online exchanges without smartphone accessibility may still lock young people out

1. Young people of color are most likely to be uninsured (see chart below).[1] In 2014, many should have access to Medicaid or subsidies to purchase insurance on an online exchange.



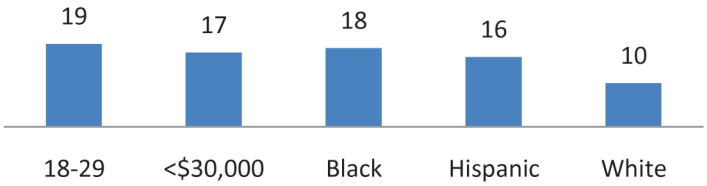
2. People of color are least likely to have home internet access.[2] Many youth do not have high-speed broadband: only 57% of young Hispanics have broadband, compared to 75% of all young adults.[3] Dial-up users access government sites 20% less than people with broadband.[4]

3. Young people of color often access the internet only on their phone. More than half of 18-29 year olds own smartphones, compared to 35% of the population as a whole. And 44% of Blacks and Hispanics own smartphones. As a result, 42% of young smartphone users and 38% of people of color with smartphones primarily access the internet through phones, not computers.[5]

Smartphone owners whose *primary* internet access is through a phone[6]

42% of young adults 18-29
40% of the lowest income bracket
38% of Blacks/Hispanics
33% of the least educated

Percent Who Only Get Wireless Through Cellphones



4. Young people of color are the most likely to say they use their phone for internet access because they don't have access elsewhere.[7] For example, 1 in 10 young Hispanics use the internet on their phone because they don't have home internet access.[8]

5. Conclusion: Failure to create smartphone accessible online exchanges will prevent many low-income and minority young adults from enrolling in insurance at all.

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THE GREENLINING INSTITUTE
1918 University Avenue, 2nd Floor I Berkeley, CA 94704
T: 510 926 4001 I F: 510 926 4010 I www.greenlining.org

Contact: Bruce Mirken, Media Relations Coordinator
T: 510.926.4022 I brucem@greenlining.org