

Achieving Equity by

Building a Bridge

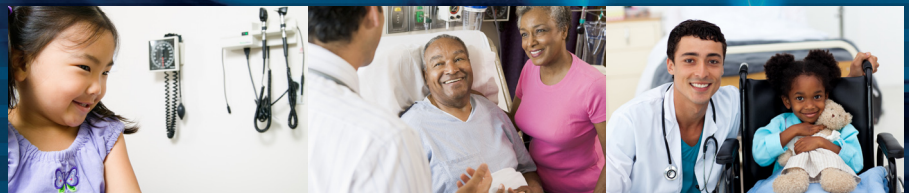
from

Eligible

to

Enrolled

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California Pan-Ethnic Health Network

Building on 20 years as a champion for health equity

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California Pan-Ethnic Health Network

CPEHN works to ensure that all Californians have access to quality health care and can live healthy lives. We gather the strength of communities of color to build a united and powerful voice in health advocacy. You can find additional resources on advancing health equity at www.cpehn.org.

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The development of the California Simulation of Insurance Markets (CalSIM) model was supported through the generous funding of:

- The California Endowment
- California Health Benefit Exchange
- California Pan-Ethnic Health Network

Funding for this policy brief was provided by:

- The California Endowment
- The California Wellness Foundation
- The San Francisco Foundation

We wish to thank the following people for their valuable contributions:

- Anna Davis, UCLA Center for Health Policy Research
- Shana Alex Lavarreda, UCLA Center for Health Policy Research
- Caroline Sanders, California Pan-Ethnic Health Network



Summary

As we draw closer to 2014 and the full implementation of the Patient Protection and Affordable Care Act (ACA), we continue to increase our understanding of its full potential and its implications. In California, about 6.7 million nonelderly adults will be eligible for coverage under the law, through either Medi-Cal or tax credits to purchase insurance through California's new Health Benefit Exchange.¹

This policy brief, developed with support from the California Pan-Ethnic Health Network (CPEHN), highlights findings from the UC Berkeley Center for Labor Research and Education and the UCLA Center for Health Policy Research's California Simulation of Insurance Markets (CalSIM) model. The CalSIM model estimates the effects of specific provisions of the ACA on family and employer decisions about insurance coverage in California.

People of color and those who speak English less than very well (Limited English Proficient, or LEP) could benefit greatly from implementation of the ACA. However, although the LEP population represents a considerable portion of those eligible, without effective multilingual outreach and enrollment efforts, language barriers may result in a difference of 110,000 fewer LEP individuals enrolled in the Exchange.² To fully realize the potential of the ACA and California's Health Benefit Exchange, resources need to be allocated for culturally and linguistically appropriate outreach and education to facilitate enrollment in coverage among all those who are eligible.

Background

In January 2011, California became the first state in the country to establish a health insurance exchange that will provide individuals and small businesses an opportunity to shop for and buy affordable, comprehensive health insurance. To increase the affordability of coverage for low- and moderate-income families and individuals, federal tax credits are available to help purchase insurance through California's Health Benefit Exchange (the Exchange).

An essential component of the ACA, the Exchange has the potential to dramatically reduce California's uninsured population, control the cost of health insurance premiums, and improve quality of care. However, California will only realize the full potential of the Exchange if all those who are eligible for the benefits know that they qualify and know how to enroll.

People of color represent roughly 60% of California's population. Additionally, nearly 7 million Californians are considered Limited English Proficient (LEP), more than twice the LEP population of any other state.³ Research has shown that people of color and those who speak a language other than English are often less informed of the ACA's benefits, but more enthusiastic about the

law's provisions once they become aware of them.⁴ Language barriers currently impact participation in public programs nationwide. A national survey found that nearly half of Spanish-speaking parents who began an application for Medicaid reported that they did not complete the enrollment process because the forms and information were not translated into their language (46%). Further, half of Spanish-speaking parents (50%) said that their

belief that application materials would not be available in their language discouraged them from even trying to enroll their child.⁵

There has been some progress in making public programs accessible to LEP populations, and bilingual outreach has been proven to improve LEP population enrollment in California. A study of Medi-Cal (California's Medicaid program) participation

found that access to bilingual application assistants increased new enrollment among Latinos and Asians.⁶ With people of color and LEP individuals representing such a significant part of California's population, the successful implementation of the ACA hinges in large part on how well the state conducts culturally and linguistically competent outreach and enrollment efforts.

"Without multilingual enrollment efforts, language barriers may result in a difference of 110,000 fewer LEP individuals enrolled..."

Findings: The California Health Benefit Exchange

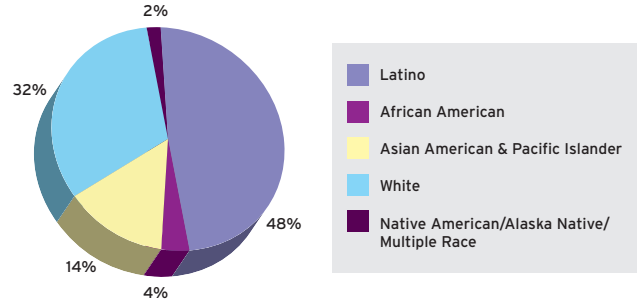
The California Health Benefit Exchange will help both individuals and small businesses looking for health coverage make informed decisions by providing comparative information on the cost, quality, and value of the health plan options available.

Citizen or legal resident families with low to moderate incomes — between 133% and 400% of the Federal Poverty Level (FPL)⁷—will be eligible for tax credits to help keep the costs of coverage affordable in the Exchange. The vast majority of Californians eligible for these premium tax credits (94%) will be from working families.⁸

Over one million LEP adults will be eligible for subsidies in the Exchange.

Over 2.60 million nonelderly adult Californians will be eligible to receive federal tax credits to purchase affordable health coverage in the Exchange in 2013.⁹ Of these, 67% (approximately 1.73 million) will be people of color, and 40% of the adults (or roughly 1.06 million individuals) will speak English less than very well (Figures 1 and 2).^{10 11}

Figure 1: Eligible Population for Subsidies in the California Health Benefit Exchange by Race/Ethnicity (2013)

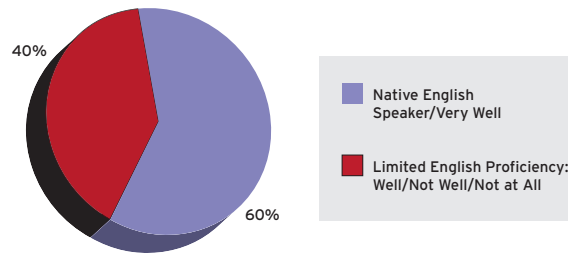


Source: UC Berkeley-UCLA CalSIM Version 1.5 projections

Language barriers may reduce LEP participation.

Eligible LEP Californians are projected to enroll at lower rates than their non-LEP counterparts. Of the 1.06 million LEP individuals eligible for subsidies in the Exchange, 53% are predicted to enroll by 2019 if language is not a barrier. However, without appropriate and effective multilingual outreach and education efforts, just 42% are expected to enroll (Figure 3). The difference between these two estimates shows that there is the potential to enroll upward of 110,000 more LEP individuals in the Exchange if enrollment is conducted with proactive outreach efforts directed toward the LEP population.

Figure 2: Eligible Population for Subsidies in the California Health Benefit Exchange by English Proficiency (2013)

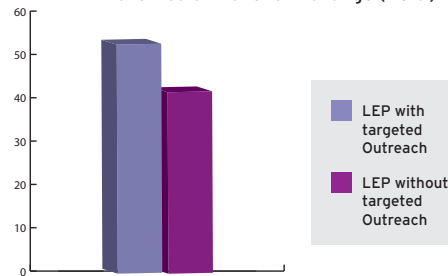


Source: UC Berkeley-UCLA CalSIM Version 1.5 projections

Projected languages spoken.

CalSIM also provides insight into the LEP population projected to receive subsidies in the Exchange in 2019. Though these enrollees are predominantly Spanish-speaking, a significant number speak other languages. Nearly 95,000 people speak a language other than English or Spanish at home, with roughly 31,000 speaking Chinese, 13,000 Vietnamese, and 9,000 Korean (Figure 4).

Figure 3: Percentage of Eligible Population Enrolled in the Health Benefit Exchange (2019)



Source: UC Berkeley-UCLA CalSIM Version 1.5 projections

Figure 4: Language Spoken at Home Other than English Among Nonelderly LEP Adults Projected to Enroll in the California Health Benefit Exchange, 2019

Projected Insurance Coverage, 2019	Language Spoken at Home Other than English Among Nonelderly LEP Adults Projected to Enroll in the California Health Benefit Exchange, 2019					
	Spanish	Chinese	Vietnamese	Korean	Other Asian Language	Other Non-Asian Language
Subsidized Exchange	355,000	31,000	13,000	9,000	4,000	31,000

Source: Original analysis of 2009 California Health Interview Survey applied to UC Berkeley-UCLA CalSIM Version 1.5 projections

Note: MEPS-HC reports foreign language preference as "Spanish" or "Other." Therefore, the Spanish language distributions represent the MEPS-HC reported data, and the remaining language distributions are estimated using a weighted application of CHIS data to the MEPS-HC reported "Other" language population.

Recommendations

Our health care system must adapt to meet the needs of California's diverse population. To ensure that all eligible Californians are enrolled in the appropriate insurance programs, have equal access to affordable coverage and care, and receive quality services, the following recommendations should be implemented:

1. Target resources for consumer assistance to those with the highest needs.

We must provide the newly eligible with the information they will need to navigate the Health Benefit Exchange. Online information about enrollment in California's health programs should be made available, at a minimum, in the 13 current Medi-Cal Managed Care threshold languages.¹²

With so many ways to apply for health coverage — online, by phone, by mail, or in person — it will be especially important for the state to target resources for in-person assistance to communities with the highest needs, including low-income populations, immigrants, the Limited English Proficient, and persons with disabilities who may lack access to the Internet and other traditional forms of enrollment and/or need more one-on-one assistance to navigate the system.

2. Invest in culturally and linguistically appropriate marketing and outreach.

Research shows that communities of color are less likely to know about the ACA but are very enthusiastic when they are the intended audience for outreach efforts.¹³ With limited resources, the state will have to carefully target funds for marketing and outreach efforts to reach the communities that constitute a majority of those eligible to receive subsidies in the Exchange. The state should conduct multiethnic focus groups and focus groups in threshold languages to better target messages and outreach efforts to those communities. Additionally, the state should contract with experts on marketing to California's diverse communities and set aside significant funds for marketing efforts in multiple language.

3. Involve communities of color in decision-making processes.

Communities of color need to be part of the planning, development, and implementation of health reform. For example, the California Health Benefit Exchange is seeking stakeholder input on a variety of critical policy decisions, including marketing and outreach, developing the criteria for health plans participating in the

Exchange, and finalizing the enrollment technology and infrastructure. The state is also engaged in a stakeholder process aimed at developing a simplified enrollment process by 2014 for all health programs, including the Exchange. Communities of color must be an integral partner in these processes to inform policy decisions that will have a huge impact on access to coverage and care.

4. Strengthen data collection efforts to help identify and address disparities.

The ACA requires states to adopt new federal standards for collecting data on race, ethnicity, and primary language and to report back on the progress made toward eliminating health disparities.¹⁴ This is a good first step; however, the tremendous diversity of our state necessitates adopting the additional data categories for California's subpopulations, as recommended by the Institute of Medicine (IOM) and encouraged by the Office of Management and Budget (OMB).¹⁵ These additional categories will more accurately represent California's demographics and allow the state to identify and address health disparities. Now is the ideal time to adopt these standards as the state develops a new and simplified enrollment form to be used for online, mail, phone, and in-person enrollment efforts. The expansion of electronic health records also provides an opportunity to improve efforts to collect self-reported granular data on race, ethnicity, and primary language for a more accurate picture of the health needs of our communities.

5. Invest in primary care and workforce diversity in underserved areas.

The ACA provides funds to enhance workforce diversity and increase access to quality care in underserved areas. For example, the law provides \$11 billion for community health centers, with the goal of doubling patient capacity by 2015. Funds have also been allocated for training primary care physicians in underserved communities. We must protect these funds during federal budget negotiations to ensure that our communities have access to the care they need, when they need it. At the state level, California should consider

ways to meet the new demands on the health care system by making the temporary Medi-Cal provider reimbursement rate increases in 2013 and 2014 permanent and by strengthening the capacity of safety net providers to serve those left out of health reform. The state should also consider addressing the needs of enrollees through new practice and financing models, including patient-centered health homes. Finally, the Health Benefit Exchange should use its certification process for health plans to strengthen health care quality by requiring health plans to demonstrate their capacity to offer culturally and linguistically appropriate services, particularly in underserved areas, as well as to develop a plan to identify and address disparities in utilization, access, and health outcomes among their diverse members.

6. Ensure collaboration between state and local government agencies and providers across public programs to maximize enrollment.

The successful transition from the current system with multiple application processes for publicly funded programs to a seamless “no wrong door” application system will depend on a strong collaboration between the state, counties, and providers. Eligible individuals in publicly funded programs, as well as those who may be losing health coverage due to life transitions (e.g., job transition or divorce), should be identified, and

fast, confidential, and effective transition methods should be developed to ensure timely enrollment using methods such as pre- and auto-enrollment. Programs such as the Low Income Health Program, CalFresh, and others already collect data on citizenship, income, and eligibility criteria that could accelerate enrollment in Medi-Cal and the Health Benefit Exchange and put people in touch with the right resources for their individual or family situation.

7. Promote prevention and wellness.

The ACA originally allocated \$15 billion for the federal Prevention and Public Health Trust Fund. However, the ultimate amount remains uncertain, given repeated threats to reduce the funding. The goal of the fund is to transform our health care system into one that invests in keeping people well, not just in treating the sick. To achieve this goal, these funds must be kept intact. In addition, California should take the lead in promoting health and wellness by ensuring that funds for Community Transformation Grants are disbursed to populations with the highest need, and that California’s Health Benefit Exchange uses its market role to fulfill its mission of transforming our health care system into a system that promotes prevention and wellness — for example, by giving preference to health plans that contract with hospitals that serve healthy foods and encourage breast feeding.

Conclusion

As California leads the way in health reform implementation, outreach and enrollment strategies that maximize participation by members of California’s diverse communities should be developed. Policy decisions and proactive planning between now and 2014 will support the fulfillment of the ACA, contribute to California’s success in reducing the number of uninsured, and ensure that all Californians have access to the care they need.



Methodology

The California Simulation of Insurance Markets (CalSIM), developed by the UC Berkeley Center for Labor Research and Education and the UCLA Center for Health Policy Research, is a micro-simulation model that estimates the effects of the ACA on the enrollment of individuals in insurance coverage in California. CalSIM is a California-centric model, using four data sets to model employer and individual behavior, including both national and state survey data.¹⁶ Immigration status and English proficiency are integrated into the model to generate “take-up” predictions. The CalSIM model then simulates the coverage decisions of employers to offer insurance and of individuals to take up in private markets and public insurance programs.

The CalSIM model also estimates the behavior of California’s limited English proficient (LEP) population, defining LEP as “those speaking English less than very well.” The core data set supplying individual-level data for CalSIM does not contain data on English proficiency but does contain information that indicates comfort level with speaking English. Individuals reporting that they were uncomfortable speaking English were classified as LEP. To determine LEP for the remainder of respondents, the CalSIM uses a probabilistic model fit to the 2009 California Health Interview Survey (CHIS). The model includes a variety of factors associated with LEP populations as predictors, including language spoken at home, survey interview language, race/ethnicity, level of education, and age at which the individual moved to the United States (if not U.S. born). This model also controls for gender, income, employment status, employer company size, ability to understand primary care provider, and immigration status.

To account for the effect of LEP status on insurance coverage take-up, CalSIM incorporates the findings of a 2006 study on insurance take-up among Asians and Latinos.¹⁷ The LEP-specific effects found in this study are used to model the difference in insurance take-up among Latino and Asian populations due to LEP. Using 2009 CHIS data, we estimated the specific distribution of Spanish and Asian languages (including Chinese, Vietnamese, Korean, and other Asian languages.)

CalSIM findings presented in this brief are based on CalSIM Version 1.5. For further details on methodology, please visit www.healthpolicy.ucla.edu.



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Suggested Citation

Gans D, Kinane CM, Watson G, Roby DH, Graham-Squire D, Needleman J, Jacobs K, Kominski GF, Dexter D, and Wu E. Achieving Equity by Building a Bridge from Eligible to Enrolled. Los Angeles, CA: UCLA Center for Health Policy Research and California Pan-Ethnic Health Network, 2012.

1 Projections using the UC Berkeley Center for Labor Research and Education and UCLA Center for Health Research California Simulation of Insurance Markets, Version 1.5 for 2013. The projections in this brief include all nonelderly adults expected to be eligible for coverage, regardless of current coverage status, and therefore may differ from previous estimates.

2 Ibid.

3 U.S. Census Bureau. American Community Survey 2010: 1-year estimates. 2010.

4 Field Research Corporation. Majorities of Californians Support the Nation's New Health Care Law, But Think More Health Care System Changes Are Needed. Just One in Three Believes the Law Should Be Reversed. The Field Poll. June 3, 2010.

5 The Kaiser Commission on Medicaid and the Uninsured. Medicaid and Children: Overcoming Barriers on Enrollment. Findings from a National Survey. The Henry J. Kaiser Family Foundation. January 2000.

6 Aizer A. Low Take-Up in Medicaid: Does Outreach Matter and for Whom? American Economic Review. 92(2): 238-241. 2003.

7 In 2011, 400% of the Federal Poverty Level was \$43,584 for a single adult and \$89,424 for a family of four.

8 Families USA. Lower Taxes, Lower Premiums: The New Health Insurance Tax Credit in California. September 2010.

9 This does not include nearly one million Californians who are prohibited from purchasing coverage with their own money due to their citizenship status.

10 These estimates represent the population eligible as of December 31, 2013, to enroll in Medi-Cal and the subsidized Exchange on January 1, 2014.

11 Data on English proficiency are only for adults 18 and older.

12 The 13 threshold languages for Medi-Cal Managed Care are Arabic, Armenian, Cambodian, Cantonese, English, Farsi, Hmong, Korean, Mandarin, Russian, Spanish, Tagalog, and Vietnamese.

13 Field Research Corporation. Majorities of Californians Support the Nation's New Health Care Law, But Think More Health Care System Changes Are Needed. Just One in Three Believes the Law Should Be Reversed.

14 Section 4302: Understanding Health Disparities: Data Collection and Analysis. Patient Protection and Affordable Care Act. H.R. 3950, 111th Congress, March 23, 2010.

15 Institute of Medicine (IOM). Race, Ethnicity and Language Data: Standardization for Health Care Quality Improvement. August 31, 2009.

16 The four data sets used in the CalSIM model are:

- 2004-2008 Medical Expenditure Panel Survey Household Component (MEPS-HC) and the Person Round Plan data files

- 2009 California Health Interview Survey (CHIS)

- Analysis from the California Employment Development Department 2007

- 2010 California Employer Health Benefits Survey (EHBS)

17 Alegria et al. Health Insurance Coverage for Vulnerable Populations: Contrasting Asian Americans and Latinos in the United States. Inquiry. 2006; 43(3): 231-256.

