
# Improving the Road to Coverage: POLICY RECOMMENDATIONS FOR ENROLLMENT SUCCESS

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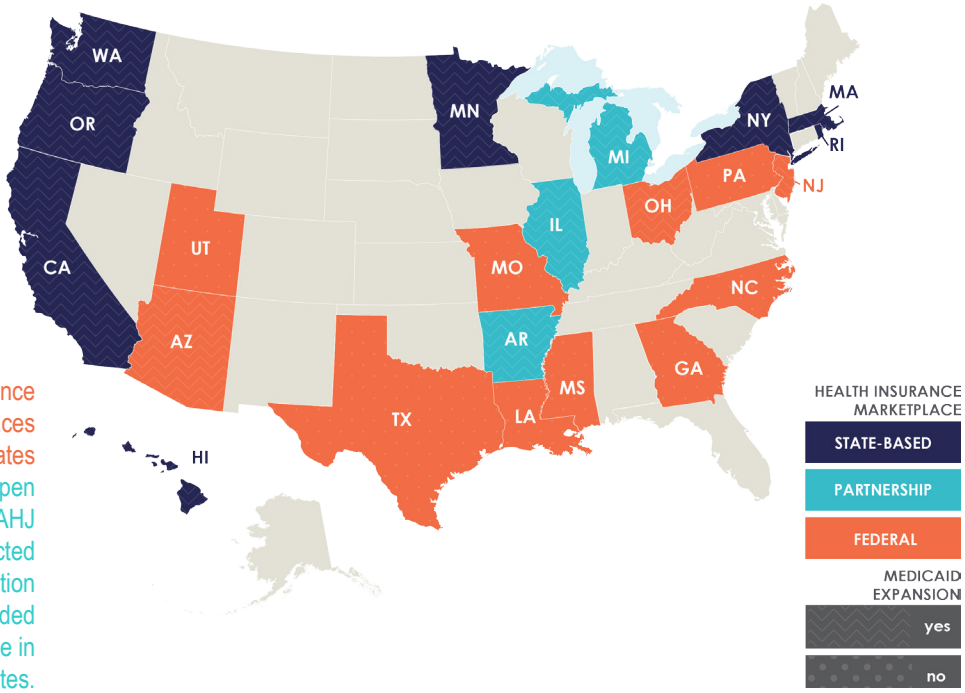
## INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) presents a historic opportunity to provide affordable, quality health insurance and coverage to millions of uninsured and underinsured Americans. Many organizations and collaboratives, including Action for Health Justice, have been actively involved in implementing the ACA across the country. This brief highlights some of the major barriers Asian American, Native Hawaiian, and Pacific Islander (AA and NHPI) communities faced during the first Open Enrollment Period, followed by recommendations to build upon and improve outreach, education, and enrollment efforts in the future.




Health Insurance Marketplaces in AHJ Partner States During the first Open Enrollment Period, AHJ partners conducted outreach and education activities, and provided enrollment assistance in 22 states.

## ACTION FOR HEALTH JUSTICE

Action for Health Justice (AHJ) is a network of organizations established in July 2013 to reach and educate Asian Americans, Native Hawaiians, and Pacific Islanders (AAs and NHPIs) about their health insurance coverage options under the ACA, and to maximize enrollment in the Federally-facilitated Marketplace (FFM), state partnership marketplaces, state-based marketplaces, and Medicaid. AHJ focuses on hard-to-reach AA and NHPI communities, particularly individuals who are low-income, limited-English proficient (LEP), or in mixed immigration status families, as well as small business owners and employees and young adults. AHJ builds the capacity of local, state, and national organizations to serve, advocate for, and engage with AA and NHPI communities and improve their health.

AHJ consists of four national organizations (Asian & Pacific Islander American Health Forum, Association of Asian Pacific Community Health Organizations, Asian Americans Advancing Justice | AAJC, and Asian Americans Advancing Justice | Los Angeles), and more than 70 Asian American, Native Hawaiian and Pacific Islander national and local community-based organizations and Federally Qualified Health Centers dedicated to educating, empowering, and enrolling AAs and NHPIs in health coverage. ZeroDivide serves as the initiative's technology counsel.

## Impact of AHJ Partners in the First Open Enrollment Period

**333,794**

Outreach & Education

**207,065**

Enrollment Assistance


**1,255**

Outreach Conducted with Media Outlets *(Newspaper, radio, and television)*

Outreach, Education, and Enrollment Assistance in

**41 languages**

| | | | |
|---|---|---|---|
| Arabic | French | Laotian | Tagalog |
| Bangla (Bengali) | Hindi | Mandarin | Taiwanese |
| Bhutanese | Hmong | Marshallese | Tibetan |
| Bosnian | Ilocano | Mien | Teochew |
| Burmese | Indonesian | Nepali | Thai |
| Cantonese | Japanese | Portuguese | Toisanese |
| Chamorro | Karen | Punjabi | Tongan |
| Chin | Khmer (Cambo-dian) | Russian | Urdu |
| Chuukese | Korean | Samoan | Vietnamese |
| English | Kurdish | Spanish | |
| Farsi | | Swahili | |

## BARRIERS AND CHALLENGES TO ACCESSING AND PROVIDING INFORMATION AND ENROLLMENT SERVICES

During the first Open Enrollment Period, AHJ identified major barriers that significantly hindered the enrollment of AA and NHPI consumers in the marketplaces. Systems put in place to assist and enroll consumers fell short of servicing consumers that had limited English language proficiency, low levels of health literacy, and immigration-related verification challenges. The demographic profile of AAs and NHPIs shows why providing language assistance services and culturally and linguistically appropriate materials should be a top priority for policymakers.

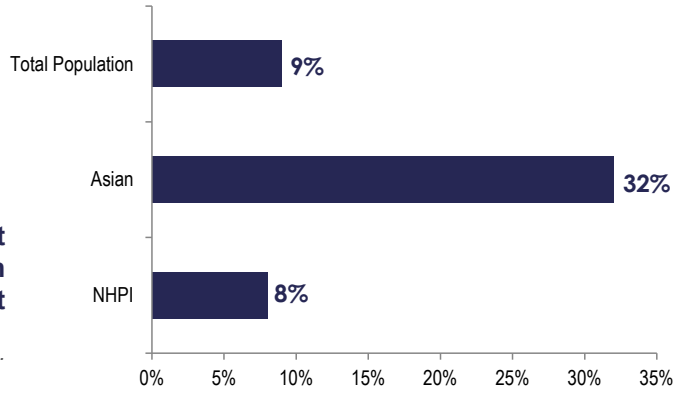
Sixty percent of Asian Americans and fourteen percent of Pacific Islanders are foreign-born, representing a range of immigration statuses.[1] Thirty-two percent of AAs are limited English

[1] Asian Americans Asian Americans Advancing Justice (formerly Asian American Center for Advancing Justice), A Community of Contrasts: Asian Americans in the United States: 2011, at 17, available at http://www.advancingjustice.org/sites/default/files/CoC%20National%202011.pdf.

proficient,[2] meaning they do not speak English as their primary language and have a limited ability to read, write, speak or understand English.[3] Twenty-nine percent of NHPIs speak a language other than English at home. Twenty-three percent of Asian American households are linguistically isolated, meaning all household members 14 years old and older speak English less than "very well."[4]

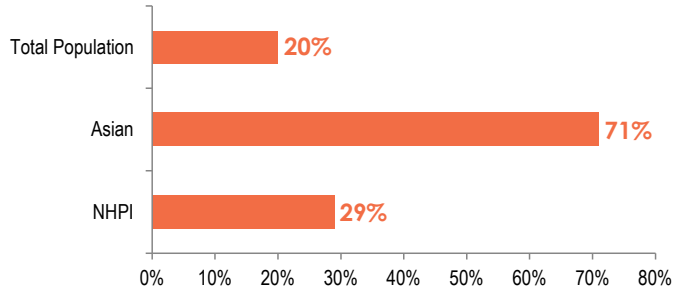
**Populations that are Limited English Proficient**

*Source: See footnote [1].*



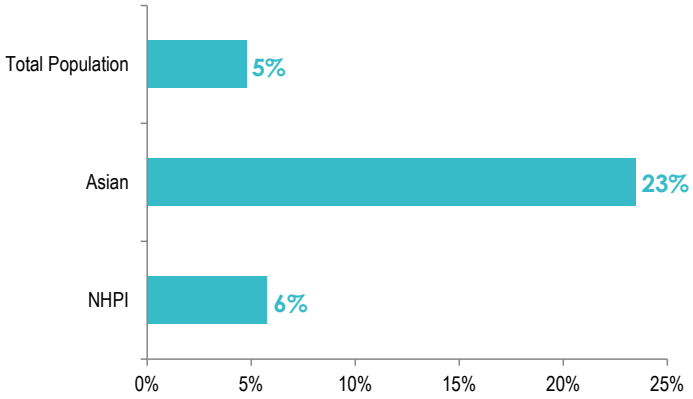

**Populations that Speak a Language Other than English at Home**

*Source: See footnote [1].*




**Populations that are Linguistically Isolated**

*Source: 2006-2010 American Community Survey Selected Population Tables*




[2] Id. at 27. As used here in the context of Census data, "limited English proficient" describes a person who speaks English less than "very well." See U.S. Census Bureau, About Language Use (2013), https://www.census.gov/hhes/socdemo/language/about/index.html.

[3] U.S. Dep't of Health and Human Servs., Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47,311, at 47,313 (Aug. 8, 2003) [hereinafter HHS LEP Guidance].

[4] Asian Americans Advancing Justice, supra note 1, at 29.

## Limited English Proficiency

State and federal agencies provided insufficient language assistance, including inadequate interpreting services by call centers and limited translated resources for LEP consumers. The lack of adequate language assistance led to increased consumer confusion and deterrence from enrolling in the marketplaces and/or Medicaid altogether. Translated materials were not easy to read, required a high level of literacy, and used literal and phonetic translations which made concepts more confusing for consumers. In most states, posters, fact sheets, websites, government presentations, and budgets for media engagement targeting English-speakers were not similarly provided for immigrant and LEP communities. Online application portals were not available in any Asian, Native Hawaiian, or Pacific Islander languages. This required community-based organizations and Federally Qualified Health Centers to fill in the gaps by translating and/or correcting existing marketplace materials and creating their own materials, often without financial support. In-person assisters also spent additional time helping LEP consumers because there were no translated applications, it was difficult to understand English applications, and consumers were discouraged from submitting paper applications (even in the handful of states where translated applications were available).

## Low Health Literacy[5]

LEP consumers and immigrants needed tools to understand health insurance terminology. AHJ partners reported that LEP and immigrant consumers knew very little about key insurance concepts such as deductibles, premiums, and co-payments. They often returned to AHJ partners for additional assistance and expressed frustration at being unable to find culturally and linguistically accessible providers and the inability to access out-of-network specialty care services.

## Immigration-Related Concerns

Concerns about the potential impact of enrollment on immigration status delayed and deterred enrollment for many immigrants. Lawfully present immigrants mistakenly believed that applying for coverage would have an adverse affect on their ability to adjust their immigration status in the future. This belief is understandable given the rise of the anti-immigration sentiment in some parts of the country and existing policies that make immigrant participation in some government-operated public programs (though not participation in the marketplaces or Medicaid) subject to a "public charge" determination. Mixed immigration status families, where at least one family member has a different immigration status from another family member, were particularly fearful and confused.[6] As a result,

[5] The Institute of Medicine (IOM) defines health literacy as "the product of the interaction between individuals' capacities and the health literacy-related demands and complexities of the health care system. Specifically the ability to understand, evaluate, and use numbers is important to making informed health care choices." Inst. of Med., Health Literacy and Numeracy: Workshop Summary, at 1 (The Nat'l Academies Press 2014), available at http://www.nap.edu/openbook.php?record_id=18660&page=1.

[6] There are about 1 million undocumented immigrants from Asia residing in the United States. Asian Americans Advancing Justice, supra note 1, at 22.

undocumented head-of-households often did not apply for coverage for other eligible immigrant or U.S. citizen family members due to fear of deportation.[7]

When eligible immigrants applied for marketplace coverage, they encountered multiple hurdles throughout the enrollment process including difficulties with identity proofing, verification of immigration and citizenship status, and calculating income and household size. As a result, many immigrant consumers were not able to complete the enrollment process or have been stuck in limbo for months waiting for their cases to be resolved.

## Lack of Disaggregated Data

Without adequate collection and reporting of disaggregated race, ethnicity, and primary oral and written language data for the extraordinarily diverse AA and NHPI population, it will be extremely difficult to develop targeted efforts to address gaps in outreach, education, and enrollment efforts. Clear data is needed to track the effectiveness of outreach, education, enrollment, and utilization activities of hard-to-reach groups. For example, preliminary disaggregated data from the Covered California marketplace confirmed that some sub-groups within AA and NHPI communities such as Cambodians, Hmong, and Pacific Islanders are underrepresented within the marketplace's enrollee population.

[7] A memo was issued by the U.S. Office of Immigration and Customs Enforcement clarifying that the information from the application would not be shared and no immigration proceedings would be triggered when applying for health coverage through the Marketplace. However, the clarification information did not reach many mixed status families due to lack of in-language outreach. Even those who were aware of this memo continued to be fearful of deportation and many chose not to apply for coverage through the marketplaces. U.S. Immigration and Customs Enforcement, Clarification of Existing Practices Related to Certain Health Care Information (Oct. 25, 2013), available at http://www.ice.gov/doclib/ero-outreach/pdf/ice-aca-memo.pdf.

## RECOMMENDATIONS

Based on the experiences of community partners across the country, AHJ proposes several recommendations to address the barriers and challenges that AAs and NHPIs faced and improve the enrollment process going forward.

### Improve Training for Call Center Operators, Interpreters, Navigators, and Other Enrollment Assisters to Better Serve LEP Consumers and Immigrants

Individuals who provide outreach, education, or enrollment assistance services need additional training to understand the needs of LEP consumers and immigrants.

- Call center operators should undergo cultural and linguistic competency training. This includes training on the following: (1) identifying the language needs of LEP callers; (2) treating LEP callers with dignity and respect; and (3) connecting with and working with third party telephonic interpreters. Many LEP consumers and their assisters experienced problems and delays when trying to access interpreting services through the federal and state call centers.

- Call center operators should be trained to have a thorough understanding of the following topics: (1) immigrant eligibility rules for health plans in the marketplaces and Medicaid; (2) required immigrant documentation for enrollment; and (3) verification processes and workarounds to complete enrollment. Alternatively, call centers should hire technical assistance advisors who can help operators on these matters.

- Third party interpreters who provide their services through the call centers should receive training on basic information about the marketplaces, health insurance terminology, and other commonly encountered topics so they can accurately interpret the context and content of the information to consumers. Consumers often received incorrect interpretations and varying quality of service from interpreters.

- Trainings for Navigators, Certified Application Counselors, and other officially designated marketplace assisters for consumers (collectively, "Assisters") should include information on cultural and linguistic competency issues, including how to work with LEP consumers.[8] Assisters should be required to work together within a state or region to connect consumers with in-person assistance in their preferred language. The marketplaces should facilitate these collaborations and information sharing by creating in-language locator tools that list the language capacity of all Assister entities. Assisters should also receive training to help them understand the intricacies of verifying immigration status, identity, and income for immigrants.

**IMPROVE TRAINING**

- Train call center operators to better assist LEP consumers and immigrants.
- Train interpreters to better understand marketplace concepts.

[8] These recommendations supplement existing requirements for Navigators to "[r]eceive ongoing education and training in culturally and linguistically appropriate service delivery." 45 C.F.R. § 155.215(c)(5).

## Create More Useful Translated Resources and In-Language Tools

Assisters working with LEP populations need adequate in-language educational and enrollment materials to help consumers learn about coverage options and enroll. Materials should explain concepts in plain language,[9] at the appropriate literacy level, be accurately translated, and avoid literal and phonetic translations.

- The Centers for Medicare & Medicaid Services (CMS) and state-based marketplace administrators should create readable and accurate in-language educational and enrollment materials for publication on federal and state marketplace websites, preferably at a fifth grade level of education, using visual aids such as videos and alternatives to written materials. CMS and state administrators should also work with community partners to review materials for accuracy and readability.

- CMS and state administrators should translate marketplace websites, online applications, and paper applications to allow LEP consumers to enroll either online or by mail.

- Consumers should be permitted to upload completed paper applications through the websites for submission instead of requiring applications to be mailed in.

**TRANSLATE RESOURCES**

- Make in-language materials more accurate and understandable for consumers.
- Translate websites, online applications, and paper applications into multiple languages.

## Make Call Centers More Accessible to LEP Consumers and Assisters

Federal and state call center functions and features should be changed to improve effectiveness and efficiency for LEP consumers.

- Call centers should offer prompts in multiple languages and allow for automatic transfer to the appropriate language. For example, when a consumer contacts a call center, there could be in-language messages, such as “For Korean, press 1” which would directly connect callers to a Korean bilingual representative or signal an operator to connect with a Korean interpreter. This will save time and resources both for consumers and the call center. For the Federally-facilitated Marketplace, these prompts could be in the 12 most widely spoken languages of the uninsured across the country. For State-based marketplaces, the prompts can be offered in the Medicaid identified languages or at least the five most widely spoken languages of the uninsured in that state.

[9] Already, CMS requires the marketplaces to provide information to applicants and enrollees in plain language. 45 C.F.R. § 155.205(c) (2013) (“Information must be provided to applicants and enrollees in plain language and in a manner that is accessible and timely . . . .”); cf. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, § 1311(e)(3)(B) (2010) (requiring Qualified Health Plans to make information available in plain language to the public and defining plain language as “language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing”).

- Call centers should hire and train more bilingual staff who can speak directly with callers and utilize dedicated language lines. Bilingual language ability should be made a priority for hiring purposes, especially for the most common languages in each marketplace.

- Call centers should implement a "tiered structure" where certain call center representatives receive additional, more complex training on certain issues. If representatives are unable to answer questions from consumers, they can refer them to these issue specialists, who will have more training on complex topics such as immigrant eligibility.

- CMS should also include a dedicated service line for Assisters to answer questions without requiring them to go through the regular federal call center. For example, California and New York created dedicated Assister lines which helped dissipate call center volume and wait times for Assisters and subsequently for consumers as well.

**IMPROVE CALL CENTER SERVICES**

- Offer prompts in multiple languages.
- Hire bilingual staff and issue specialists.

## Create Additional Funding Opportunities to Support In-Person Assistance

Assisters who provide in-person education and enrollment services need adequate funding to account for the additional time needed to help LEP and immigrant consumers. During the first Open Enrollment Period, consumers needed several visits of one to two hours per visit (or sometimes longer) with Assisters to learn about insurance, explain the application process, explain required documentation and personal information requests, guide them through the enrollment process, and select a health plan. Moreover, many Assisters in both federal and state marketplaces (other than Navigators) did not receive any public funding during the first Open Enrollment Period despite conducting vigorous outreach, education, and enrollment services.

- State and federal governments should allocate and increase funding and resources for in-person assistance entities. Many immigrants and LEP consumers preferred using face-to-face services from trusted organizations to learn about their options.

**IMPROVE FUNDING OPPORTUNITIES FOR IN-PERSON ASSISTANCE**

- Prioritize funding for community organizations that have experience working with LEP, immigrant, and hard-to-reach populations.

- State and federal governments should prioritize funding opportunities for small community-based organizations that have experience working with hard-to-reach and underrepresented populations and can provide culturally and linguistically appropriate services. Assisters must be adequately compensated and need sufficient funding to help them in these efforts.[10]

## Improve the Enrollment Experience for Immigrants

Many immigrants had difficulties enrolling in marketplace coverage or were unable to enroll because of complicated, inefficient, and unclear policies and procedures that uniquely affected eligible immigrants.

- CMS should continue to work with the U.S. Department of Homeland Security (DHS) to issue clarifying guidance to address enrollment fears and assure eligible immigrants and their families that it is safe to apply for marketplace coverage. U.S. Immigration and Customs Enforcement provided this type of assurance in a memo issued on October 25, 2013, reinforcing existing federal policy regarding the use of personal information.[11] DHS should provide similar assurances and public education campaigns to address public charge fears and other information to clarify uncertainties and confusion about the potential immigration consequences of receiving health coverage from the marketplaces or Medicaid.

- CMS and state agencies overseeing state-based marketplaces should engage trusted sources, such as immigrant-serving Assisters and community organizations, to conduct a review of marketplace websites and associated technical issues related to the enrollment process. Website fixes should be in place well before November 15, 2014 to ensure a smooth enrollment process for immigrants.

- CMS should relax the identity proofing requirements to allow persons without established credit histories to proceed with online applications. While we commend CMS for expanding the list of acceptable documents, the process for providing proof of identity is flawed and must be improved for immigrant consumers. If using a credit agency to verify identify, CMS and states should require the credit agency to provide adequate in-language assistance.

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[10] At the time of publication, the Office of Minority Health issued a grant opportunity of $2.7 million for community organizations to "assist and educate minority populations about [Marketplace] and coverage opportunities made possible by the Affordable Care Act." Office of Minority Health, U.S. Dep't of Health and Human Servs., 2014 Grants: Partnerships to Increase Coverage in Communities Initiative, http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=1#sthash.4RMBhV6L.dpuf (last accessed June 17, 2014). Additionally, on June 10, 2014, HHS announced a funding opportunity totaling $60 million for Navigators in the federally-facilitated and state partnership marketplace with an anticipated award date of September 8, 2014. Press Release, Centers for Medicare & Medicaid Servs., CMS Announces Opportunity to Apply for Navigator Grants in Federally-facilitated and State Partnership Marketplaces, (June 10, 2014), http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-06-10.html. In comparison to Navigator grants issued for the 2013 to 2014 period, HHS indicated this new grant will place a larger emphasis on community organizations that are connected to targeted populations..

[11] U.S. Immigration and Customs Enforcement, Clarification of Existing Practices Related to Certain Health Care Information (Oct. 25, 2013), available at http://www.ice.gov/doclib/ero-outreach/pdf/ice-aca-memo.pdf.

- CMS should create a tracking system that allows consumers and Assisters to easily track the status of pending applications and verification checks. This system should also allow consumers and Assisters to submit summaries of applicants' situations to ensure critical information and application histories are accurately conveyed to call center operators and CMS case workers.

**IMPROVE THE ENROLLMENT EXPERIENCE FOR IMMIGRANTS**

- Ensure identity and immigration status processes on marketplace websites are functional by November 15, 2014.
- Relax identity proofing requirements.
- Create accessible tracking system for pending applications.

## Monitor and Enforce Nondiscrimination Laws

The marketplaces must comply with several nondiscrimination laws and standards including Title VI of the Civil Rights Act of 1964, Executive Order 13166, and Section 1557 of the ACA.[12] The Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS) is charged with monitoring and enforcing these laws to ensure that LEP consumers are not excluded from participation in the benefits of the ACA and have meaningful access to the marketplaces and Medicaid.

- OCR, in conjunction with CMS, should monitor how federal and state marketplaces, Navigators and Assisters are providing public education, outreach activities, and enrollment services that are culturally and linguistically targeted at LEP groups.

- Based on the systemic issues identified in this brief and information HHS has gleaned from meetings with community advocates, OCR should initiate a compliance review of the marketplaces, particularly in states where there are suspected violations. For example, by examining uninsured and enrollment data, precipitous drops in enrollment or sustained uninsured rates of consumers from certain racial, ethnic, or langauge groups in a service area may indicate that there are barriers to enrollment that OCR should investigate. Where language access plans do not already exist, OCR should work with entities overseeing the marketplaces to develop them. If violations are identified, OCR should provide technical assistance to these entities on developing compliance measures to address cultural and linguistic barriers faced by consumers. [13]

[12] Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin, which includes immigration status and language proficiency. Executive Order 13166 further clarifies that recipients of federal funding, which here includes the marketplaces and their affiliated services, to ensure meaningful access for LEP individuals to federally funded programs and activities. Section 1557 of the ACA applies Title VI and other nondiscrimination laws to the Marketplace and programs established by the ACA.

[13] See Office for Civil Rights, U.S. Dep't of Health & Human Servs., Case Resolution Manual for Civil Rights Investigations 80 (2009), http://www.hhs.gov/ocr/civilrights/complaints/crm2009.pdf (explaining OCR's authority to conduct compliance reviews and their objectives).

- HHS should clarify its standards for language assistance services related to consumer access to the marketplaces and Medicaid. Clarifying standards are needed to establish detail on literacy levels, thresholds for translation of written information, languages in which "taglines" (informing individuals how to access marketplace-related services) are provided on websites and other materials, and other access issues that have been identified by stakeholders in public comment responses to the agency's marketplace regulations.

- HHS should finalize the definition of "limited English proficient" used in marketplace guidance.[14] AHJ recommends adopting the definition used by the U.S. Census Bureau and HHS LEP Guidance, which describes "limited English proficient" individuals as those who speak English less than "very well"[15] and "individuals who do not speak or read English very well and who have a limited ability to read, write read, write, speak or understand English."[16]

- HHS should expeditiously promulgate regulations on the interpretation and enforcement mechanisms of Section 1557, the ACA's nondiscrimination provision which prohibits discrimination on the basis of race, color, national origin, and other protected categories.

**MONITOR AND ENFORCE NONDISCRIMINATION LAWS**

- Assess the provision of marketplace services for LEP consumers.
- Clarify standards and definitions for language assistance services in the marketplace and Medicaid.
- Promulgate regulations for Section 1557 of the ACA.

## Implement Strategies to Address Health Literacy

LEP consumers need appropriate health literacy tools to navigate the complexities of the healthcare system and insurance plans.

- State and federal agencies should work with health plans participating in the marketplace to require that they develop culturally relevant and linguistically appropriate patient and consumer materials, including satisfaction surveys that account for different health literacy levels.

- The marketplace should be required to develop culturally relevant and linguistically appropriate health literacy tools, such as cost-benefit comparison charts of the most common plans.

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[14] 77 Fed. Reg. 18,310, at 18,314 ("In the final rule, we do not adopt a definition for the phrase 'limited English proficient.' We anticipate issuing future guidance that will interpret this term and will provide best practices and advice related to meaningful access standards for limited English proficient individuals.").

[15] See U.S. Census Bureau, supra note 1.

[16] See HHS LEP Guidance, supra note 3.

- CMS should support and promote the development of health risks assessment tools designed to help consumers of varying health literacy levels understand their health risks, needed health services, and recommended health care utilization patterns.

- States should ensure that translated health literacy tools are available to help consumers select appropriate health insurance plans and obtain culturally and linguistically competent health care services.

### INCREASE CONSUMER HEALTH LITERACY

- Issue consumer materials and satisfaction surveys at appropriate health literacy levels.
- Develop cost benefit comparison charts of health plans, health risk assessments, and other health literacy tools at appropriate literacy levels and in different languages.

## CONCLUSION

Despite the challenges many AA and NHPI consumers faced during the initial Open Enrollment Period, including learning about the health insurance options provided through the ACA and enrolling in coverage, AHJ partners worked together to successfully assist the enrollment of AA and NHPI consumers. Through the creation of culturally and linguistically appropriate materials, direct in-person assistance to consumers, and shared strategies for enrolling AAs and NHPIs, AHJ partners were able to work in local and state-based collaboratives to overcome some language, immigration, and health literacy barriers. Full implementation of AHJ's recommendations will ensure that many more AAs and NHPIs can enroll in coverage to get the care they need, and achieve the true success of health care reform for all communities.

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Educate, Enroll, and Empower Asian Americans, Native Hawaiians, and Pacific Islanders