# 1. Introduction

The Patient Protection and Affordable Care Act (ACA)[1] was signed into law in March 2010, putting into place comprehensive insurance reforms designed to improve access to health care, strengthen consumer protections, improve quality, and lower health care costs. The ACA laid the groundwork for a substantial increase in the number of people who will have access to health insurance through either Medicaid expansion or the health insurance marketplaces.[2] In states that opt to participate in the Medicaid expansion, almost any adult with an income at or below 138 percent of the federal poverty level (FPL) will now be eligible for Medicaid. And in all states, individuals with incomes from 138 percent to 400 percent of FPL may receive tax credits to offset the costs of health insurance, and may purchase health insurance through the exchange markets. Over the first two open-enrollment seasons, millions of Americans, many of whom had never been insured, obtained health insurance coverage.[3] By 2019, 13 million to 16 million people are expected to enroll in Medicaid, and 20 million people are expected to purchase insurance through the exchange markets.[4, 5, 6]

In order to experience some of the longer-term expected benefits of the ACA, including better health and lower health care costs resulting from access to regular primary and preventive services, states first have to reach out to those who are uninsured and support their enrollment into health insurance plans.[7, 8, 9] Failure to enroll eligible individuals will reduce the potential impact of the ACA, particularly among those with the greatest need.[10]

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[1] Public Law 111-148, Patient Protection and Affordable Care Act, March 23, 2010.

[2] A *health insurance marketplace*, also sometimes called an *exchange*, is a resource to help consumers choose and enroll in health insurance plans. Some states operate their own marketplaces, and others use the federal marketplace, called the *Health Insurance Marketplace*, to help their residents get coverage.

[3] Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report*, Washington, D.C., U.S. Department of Health and Human Services, 2015.

[4] John Holahan, Matthew Buettgens, Caitlin Carroll, Stan Dorn, *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*, The Henry Kaiser Family Foundation: The Kaiser Commission on Medicaid and the Uninsured, Washington, D.C., November 2012.

[5] Congressional Budget Office, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision*, July 2012.

[6] Benjamin Sommers, Katherine Swartz, and Arnold Epstein, "Policy Makers Should Prepare for Major Uncertainties in Medicaid Enrollment, Costs, and Needs for Physicians Under Health Reform," *Health Affairs*, Vol. 30, No. 11, October 2011.

[7] Peter Long and Jonathan Gruber, "Projecting the Impact of the Affordable Health Care Act on California," *Health Affairs*, Vol. 30, No. 1, January 2011, pp. 63–70.

[8] Henry J. Kaiser Family Foundation, *Health Reform Roundtables: Charting A Course Forward—Key Issues to Consider for Outreach and Enrollment Efforts under Health Reform,* Washington, D.C.: February 2012.

While a number of state and local factors, such as financial constraints, political context, and geographic diversity, can reduce capacity for enrolling newly eligible people, outreach and enrollment are also affected by a multitude of barriers that eligible individuals face including

- lack of knowledge, including how and where to enroll, and misunderstanding of eligibility requirements
- lack of experience navigating the health care system
- difficulty completing the enrollment process, due to language barriers and low literacy levels
- fears about jeopardizing their ability to obtain permanent status and/or exposing undocumented family members or missing or incomplete documentation; and
- costs.[11]

These barriers can be exacerbated by the other vulnerabilities that some populations may face in accessing care, such as low English proficiency[12] or mental illness.[13]

During the first open-enrollment season, states used a variety of strategies to reach out to and enroll newly eligible individuals. The success to date of these outreach and enrollment efforts was driven in large part by the collective efforts of state and local organizations that worked together to identify individuals eligible for coverage, and support them in the application process. Typically, federal and state funding was used to develop navigator programs in each state. What the models of outreach and enrollment looked like, and who the key partners were, varied considerably across the country and were tailored to reflect the population demographics, local resources and political contexts.[14]

While some outreach efforts across communities involved LHDs, they were, and remain, a relatively untapped resource[15] in these endeavors. This is somewhat surprising, given that LHDs

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[9] Benjamin Sommers, and Arnold Epstein, "Medicaid Expansion—The Soft Underbelly of Health Care Reform?" New England Journal of Medicine, November 2010.

[10] Laurie Martin, and Ruth M. Parker, "Insurance Expansion and Health Literacy," *The Journal of the American Medical Association (JAMA)*, Vol. 306, No. 8, pp. 874–875. August 2011.

[11] The Henry J. Kaiser Family Foundation, "Key Lessons from Medicaid and CHIP for Outreach and Enrollment Under the Affordable Care Act," June 2013.

[12] Lisa Clemens-Cope, Genevieve M. Kenney, Matthew Buettgens, Caitlin Carroll, and Fredric Blavin, "The Affordable Care Act's Coverage Expansions Will Reduce Differences In Uninsurance Rates By Race And Ethnicity," *Health Affairs*, Vol. 31, No.5, May 2012, pp. 920–930.

[13] Victor Capoccia, Colette Croze, Martin Cohen, John P. O'Brien, "Sustaining Enrollment In Health Insurance For Vulnerable Populations: Lessons From Massachusetts." *Psychiatric Services,* Vol. 64, No. 4, April 2013, pp. 360–365.

[14] Enroll America, "Certified Application Counselor Program: Early Lessons," Washington, D.C., June 2014.

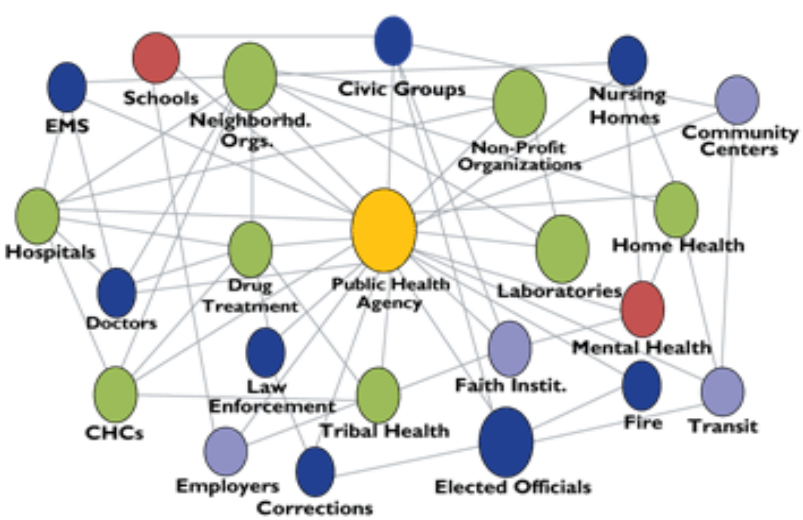
[15] National Association of County and City Health Officials (NACCHO), *Role of Local Health Departments as Navigators: Findings from 2014 Forces of Change Survey*, Washington, D.C., May 2014.

serve as trusted entities in communities, can reach the most-vulnerable populations, and have access to data and resources that might facilitate ACA outreach and enrollment.

## What Is Public Health?

According to the World Health Organization, "public health refers to all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole."[16] To achieve these goals, public health is often structured at the local level as a network of interconnected agencies including local public health agencies. LHDs are unique within this system as they are the only organization that interacts with most, if not all, of the health-related agencies in the community (see Figure 1.1). The connecting role of public health is due, in part, to the broad activities of public health departments that monitor the health of the community, educate and mobilize individuals and communities to improve health, and ensure that health and safety standards are met. In these roles, LHDs interact with a range of community health services (e.g., clinics, hospitals), community well-being and social services (e.g., nonprofit organizations, human services organizations), other community services where health is an important but not primary mission (e.g., schools, public safety, transportation and planning, or employers), and other trusted local organizations in which health-related messages may be disseminated (e.g., faith-based organizations).

**Figure 1.1. The Public Health System**




Source: Centers for Disease Control and Prevention

Despite the fact that LHDs sit "at the heart" of the public health system, they do not always lead or play a central role in every public-health-related initiative. Often, they play more of a

[16] World Health Organization, *Trade, Foreign Policy, Diplomacy and Health: Public Health*, web page, undated.

supporting or facilitating role, but, given their content expertise, skills, assets, community partnerships and trusted relationships with vulnerable populations, their potential value-added cannot be underestimated for the success of health-related initiatives.

## Core Functions of Public Health: Relevance to Identification, Outreach, and Enrollment

Though outreach and enrollment activities under the ACA may not seem on the surface like a traditional public health initiative, increasing the number of individuals with health care coverage and access to health care and preventive services is very much in line with the core mission of public health: to prevent disease and promote the health of a population. It is also in alignment with the three core public health functions:

- The assessment and monitoring of the health of communities and populations at risk to identify health problems and priorities.
- The formulation of public policies designed to solve identified local and national health problems and priorities.
- The assurance that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services.[17]

Table 1.1 summarizes how the three core functions of public health and public health services align with and may be leveraged to support ACA outreach and enrollment efforts. For example, LHDs may leverage data to identify priority populations among the unenrolled; mobilize their existing partnerships to ensure that outreach and enrollment activities are being conducted in a robust way throughout the community; develop policies to support these practices; and contribute directly to these efforts by contributing staff to enrollment efforts and evaluating progress. LHDs are also trusted entities in their communities: They are able to provide culturally competent and trusted assistance for a broad number of health related issues through various programs and supports.[18, 19] LHDs also maintain flexible schedules to increase access to eligible uninsured populations.[20] Moreover, these organizations also provide sustained

[17] Centers for Disease Control and Prevention, *The Public Health System and the 10 Essential Public Health Services: The Public Health System*, July 3, 2013.

[18] The Henry J. Kaiser Family Foundation, February 2012.

[19] Philip Chung, Tia A. Cavender, and Debbi S. Main, *Trusted Hands: The Role Of Community-Based Organizations In Enrolling Children In Public Health Insurance Programs*, issue brief, The Colorado Trust, Denver, Colo., February 2010.

[20] The Henry J. Kaiser Family Foundation "Covering Uninsured Children: Reaching and Enrolling Citizen Children with Non–Citizen Parents," The Kaiser Commission on Medicaid and the Uninsured, Washington, D.C., January 2009.

contact with individuals, helping to minimize disenrollment and drop out from existing health insurance coverage.[21]

[21] The Henry J. Kaiser Foundation, February 2012.

**Table 1.1. Core Functions and Services of Public Health**

| Core Functions and Services of Public Health | Potential for Identification, Outreach, and Enrollment |
|---|---|
| **Assessment** | |
| • Monitor health status to identify and solve community health problems.<br>• Diagnose and investigate health problems and health hazards in the community. | • Leverage public health data to identify vulnerable communities who may benefit from targeted outreach and enrollment efforts. |
| **Policy Development** | |
| • Inform, educate, and empower people about health issues.<br>• Mobilize community partnerships and action to identify and solve health problems.<br>• Develop policies and plans that support individual and community health efforts. | • Leverage existing partnerships and strategies to inform and educate residents about available health insurance options, facilitate enrollment, and empower them to access care<br>• Identify gaps in outreach and enrollment efforts<br>• Work on policies that support “no wrong door” efforts for enrollment; work with human services and social services to facilitate enrollment. |
| **Assurance** | |
| • Enforce laws and regulations that protect health and ensure safety.<br>• Link people to needed personal health services and assure the provision of health care when otherwise unavailable.<br>• Assure competent public and personal health care workforce.<br>• Evaluate effectiveness, accessibility, and quality of personal and population-based health services. | • Leverage expertise to facilitate linkages with organizations/direct services offering enrollment services<br>• Identify workforce needs for outreach and enrollment and work with partners to increase workforce capacity<br>• Leverage expertise to assess and evaluate the effectiveness of outreach and enrollment strategies. |

As a result, LHDs may be leveraged in a number of ways from basic sharing of institutional knowledge, to using existing public health programs for outreach, to partnering with other community organizations to design and implement outreach and enrollment approaches. Public health data may also be used to assist with more targeted and, as a result, cost-effective outreach strategies, and may offer a potential way to assess the success of certain outreach and enrollment strategies.

Despite the clear links to public health core functions, the extent to which LHDs have participated in outreach and enrollment and fulfill these roles is not clear. Though LHDs can be instrumental in identifying newly eligible populations (via other health programs) and leading outreach activities (due to other community engagement efforts), their role in outreach and enrollment has not been well-defined. The role of LHDs is particularly unclear in the context of

their relationship with other state agencies such as Medicaid and other health entities, including hospitals and community health clinics that tend to play a more-prominent role in these efforts. s

To help clarify these roles and current LHD activities, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) within the U.S. Department of Health and Human Services (DHHS) contracted with RAND and NACCHO to identify innovative models and best practices that leverage public health investments in outreach and enrollment efforts. The specific goals of the study were to:

- explore how state and local public health entities (e.g. government as well as other nongovernmental organizations such as community-based organizations) can aid in identifying those newly eligible for coverage (e.g., Medicaid or the Health Insurance Marketplace);
- assess what is known about current and previous outreach and enrollment efforts at the state and local levels in the context of using public health agencies for outreach and enrollment; and
- identify promising practices that achieve high levels of enrollment through public health agencies that can inform other states' efforts.

The central feature of the research reported herein was to engage in case studies of seven distinct communities to identify compelling models for how LHDs can implement outreach and enrollment. This research provides guidance and insight into the role LHDs can play now, and helps redefine that role in the future, as states continue to enroll residents in health insurance coverage. By comparing current practices with this framework, we can identify the ways in which LHDs contribute to identification, outreach, and enrollment efforts. We can also highlight where there may be missed opportunities for involving or leveraging public health to strengthen existing lessons learned.

In the next chapter, we discuss the methods we used to answer the questions outlined by ASPE. In particular, we lay out our process for engaging in the focus groups and analyzing the data that came out of them. In the subsequent chapters, we highlight the results of these case studies, and then conclude with an overall discussion of our findings.