ENROLL ALL ELIGIBLE

Enroll all eligible people in the health insurance marketplace or existing public health insurance programs.

REACH healthcare foundation

STRATEGY 1

Navigators and other assisters and community initiatives to assist eligible consumers to enroll in health insurance.

Navigators and Certified Application Counselors (CAC) and other assisters play a vital role in helping consumers establish eligibility and enroll in coverage through the Federally-Facilitated Marketplaces in Kansas and Missouri and obtain premium assistance for coverage plans. Assisters also increase awareness about the marketplace, and refer consumers to consumer assistance programs when necessary. Navigators are funded through federal grants and must complete comprehensive federal navigator training, criminal background checks, and state training and registration (when applicable).

STRATEGIC FOCUS

Use trusted assisters such as navigators, CACs, community health workers and Promotores de salud (i.e., Promotora) to conduct outreach and enrollment in the REACH service area to educate and enroll uninsured consumers in health plans offered through the health insurance marketplace. REACH will invest in health care and community organizations to expand insurance navigation services in order to increase enrollment of eligible consumers. In addition, REACH will engage the payer/insurance community to discuss strategies to expand CAC services into communities with high uninsurance rates.

TARGET POPULATION

Reduce the number of uninsured in our service area by deploying trained assisters in organizations who have extensive connections to uninsured and other vulnerable and marginalized populations in our service area.

BARRIERS THE STRATEGY ADDRESSES

In general, there are significant barriers to participating in health insurance. Uninsured persons often have little or no experience with any kind of insurance and are unfamiliar with the language, the requirements and obligations, and the appropriate use of health insurance. Studies of immigrant and migrant populations suggest that fear of deportation continues to be associated with receiving public health benefits, despite recent US Citizenship and Immigration Services guidance stating that use of non-cash public benefits does not affect immigration status. Other barriers to health insurance include the complexity and the lack of translation of outreach, application, and redetermination materials, the lack of bilingual outreach workers and the stigma of receiving public assistance.

Studies in various states[1,2] implementing health insurance exchanges have documented a number of systemic barriers that make enrollment challenging for consumers:

BARRIERS RELATED TO OUTREACH AND AWARENESS

- There is significant confusion and little understanding about Medicaid and private insurance subsidies through the health insurance marketplace.
- Messaging about insurance has not been compelling nor has discussed the health benefits of insurance.
- There are not enough funds or data to support local outreach and education

BARRIERS RELATED TO THE DECISION TO ENROLL

- Many consumers have unfavorable attitudes toward the individual mandate.
- There is significant mistrust of the system.
- Messaging was often not tailored or actionable.
- Health insurance coverage is not affordable for many uninsured.

BARRIERS RELATED TO THE ENROLLMENT PROCESS

- The complexity of plan materials makes plan selection difficult.
- There were lag times and poor communication about eligibility-related decisions.
- There was misinformation across stakeholders.

[1] California Healthcare Foundation (April, 2014). *In their own words: Consumers' and enrollment counselors' experiences with Covered California.* CA: Author.

[2] Martin, Laurie T., Nazleen Bharmal, Janice C. Blanchard, Melody Harvey and Malcolm Williams. Barriers to Enrollment in Health Coverage in Colorado. Santa Monica, CA: RAND Corporation, 2014. http://www.rand.org/pubs/research_reports/RR782.

RATIONALE/SUPPORTING EVIDENCE FOR STRATEGY

The US has one of the most complicated systems in the world for accessing and financing health care. As our country grapples with reforms designed to improve access to health care, the role of health insurance is changing as are consumers' responsibilities with respect to finding and selecting health insurance.

Many enacted and proposed reforms envision a competitive health insurance marketplace whereby consumers act as informed shoppers, driving health plan competition based on quality and value. The reality is that private health insurance, as well as Medicare and Medicaid, feature many complex provisions and rules for enrollment. Consumers' ability to understand, shop for and use their health insurance plans is varied and, for some, extremely limited. When consumers don't understand health insurance, it undermines not only the well-intentioned efforts of policymakers, but also a health plan's ability to communicate with its enrollees. This situation can create frustration among consumers and undermine their coverage selection and thereby access to health care.

Results from the first open-enrollment period for the health insurance marketplace found that consumer-friendly online enrollment systems made it easier for Americans to sign up for health coverage at their own pace and on their own time. However, simply creating an online system for enrollment does not mean that those who are uninsured will be able to access or understand it easily. When asked about enrollment preferences before the open enrollment period began, three out of four newly eligible consumers claimed to want in-person assistance to learn about and enroll in coverage.[1]

Although enrollment rates during the early months of open enrollment were relatively low overall, consumer experiences confirmed the important role that assisters played in a successful enrollment experience. Among consumers who attempted to enroll during the first three months of the first open enrollment year, those who reported having in-person assistance were approximately twice as likely to successfully enroll in a health plan as those who attempted to enroll online without any help. Nearly one out of three (31 percent) of those who exclusively or partially had in-person help with the application and enrollment process successfully enrolled. Only one in six (16 percent) of those who tried to enroll online and did not get in-person assistance successfully enrolled.[2] This confirms recent surveys that found uninsured consumers would be more likely to apply for health coverage if they could receive in-person assistance in their area.[3]

Early research conducted by Enroll America indicates that African Americans and Latinos are seeking in-person enrollment assistance at particularly high levels. One in 10 consumers from these communities who tried to enroll used in-person assistance, while only one in 14 (7 percent) whites seeking to enroll used in-person assistance. Since we know that consumers seeking help enroll at higher rates, this further emphasizes the need to ensure

that African Americans and Latinos continue to have access to the full range of assistance options.[4]

[1]Lake Research Partners, Informing Enroll America's Campaign: Findings from a National Study.

[2]Enroll America Research, December 2013. The finding is based on responses from a large-scale online survey about recent health insurance experiences that included 3,468 consumers who indicated that they were either uninsured or looking for better coverage and who had tried to sign up for coverage since October 1. This includes individuals who signed up for Marketplace plans, Medicaid, CHIP, employer-sponsored coverage, and other forms of private insurance.

[3] See PerryUndem/Robert Wood Johnson Foundation's Checking in on Enrollment: Communicating to Uninsured Consumers Midway through Open Enrollment available online here.

[4] Enroll America Research, December 2013.

DEFINITIONS

NAVIGATOR: An individual or organization trained and able to help consumers, small businesses and their employees consider health coverage options through the marketplace, and complete eligibility and enrollment forms. Per the ACA, navigators may be community- and consumer-focused nonprofit groups; trade, industry and professional associations; commercial fishing industry organizations; ranching and farming organizations; chambers of commerce; unions; partners of the Small Business Administration (SBA); licensed insurance agents and brokers; and other entities capable of carrying out the required duties. However, navigators must apply and be approved to provide navigation services. Their services are free to consumers.

CERTIFIED APPLICATION COUNSELOR (CAC): An individual (affiliated with a designated organization) who is trained and able to help consumers, small businesses and their employees as they consider health coverage options through the marketplace, and complete eligibility and enrollment forms. Their services are free to consumers.

PROMOTORES DE SALUD (PROMOTORA): Promotores de salud, also known as "promotoras," is the Spanish-language term for "community health workers." The Hispanic community recognizes promotoras as lay health workers who work in Spanish-speaking communities to provide basic health education and guide people on how to access community resources associated with health care.

INDICATORS OF EFFECTIVE IMPLEMENTATION

1. Increased rate of individuals selecting a qualified plan during the open enrollment period and become newly insured (by paying the first premium payment).
2. Increased rate of individuals who re-enroll in health insurance during subsequent open enrollment periods.
3. Increased numbers of consumers who enroll after the open enrollment period closes.
4. Changes in the uninsured rate at the county-level for each county in the Foundation's service area.

TARGET GOAL

Reduce *the percentage of uninsured in the foundation's service area from 11% in 2014 to less than 5% by 2020.*

ENROLL ALL ELIGIBLE

Enroll all eligible people in the health insurance marketplace or existing public health insurance programs.

REACH healthcare foundation

STRATEGY 2

Advocacy, outreach and media campaigns to increase the number and types of consumers enrolled in health insurance.

This strategy includes investing in local outreach and enrollment services provided by organizations that have existing relationships with the target population. This includes Federally-Qualified Health Centers (FQHCs), rural health coalitions, and geographic-specific health care provider organizations and health councils.

STRATEGIC FOCUS

Partner with proven national coverage advocacy organizations such as Enroll America, state-wide navigator coalitions, regional community support agencies, and local navigator organizations in both Kansas and Missouri to increase enrollment of our target population in the REACH service area. Each of our counties in the Foundation's service area will benefit from some level of outreach, enrollment and media/advertising support.

REACH's national advocacy partner, Enroll America, will provide media outreach and advertising, data-based tools for coordinating enrollment efforts at a local, regional and state-wide level. In addition, REACH will partner with state-wide coverage coalitions to support coordination, training and implementation of tools designed to facilitate enrollment and outreach in navigator and CAC organizations.

TARGET POPULATION

Investing in this strategy is designed to impact the most disconnected and marginalized populations in our service area, including rural and urban uninsured, persons living in poverty, migrant workers, transitioning youth, homeless individuals and families, and most importantly, individuals who are working but have no affordable options for health insurance.

The 2013 American Community Survey data for the REACH service area indicates that 212,503 individuals were uninsured. Of the uninsured, 46% were unemployed, 26% were employed making less than $25,000 annually, and 21% were employed with income less than $50,000. About 18% were not US citizens. MARC estimates that if Medicaid expansion up to 138% of the FPL were to occur in our service area the uninsured rate would drop at least 3% and as high as 6% in REACH counties.

After open enrollment period 2 (fall 2014-winter 2015), the best estimates of uninsurance rates in the Foundation's service area suggest that approximately 145,000 individuals remain uninsured (212,500 uninsured in 2013 – 67,215 plan selections in 2014 and 2015 = 145,285 remaining uninsured).

BARRIERS THE STRATEGY ADDRESSES

This strategy is designed to address inequitable access to health insurance coverage for people of color and other vulnerable populations. In their recent report on the health status of the Greater Kansas City region, MARC reports

that by the end of 2013 the populations most likely to be uninsured in the Kansas City MSA include: non-citizens (54% uninsured), unemployed (46% uninsured), Latinos (34%), those who are under-educated (no high school diploma – 33%), living below the Federal Poverty Level (30%), part-time employee (26%) and African-American (20%). It is worth noting that white, non-Hispanics in Kansas City were the least likely to be uninsured (9% uninsured). This barrier is reinforced by resistance on the part of state government leaders to pass expansion of the Medicaid program in Kansas and Missouri. More broadly, restrictive Medicaid coverage and ineligibility for subsidized health insurance through the marketplace contribute to a highly disenfranchised segment of the population in the REACH service area.

RATIONALE/SUPPORTING EVIDENCE FOR STRATEGY

According to the Kaiser Family Foundation, "Adults of color are more likely to be uninsured than Whites. Nationally, more than one-quarter of adults of color are uninsured compared to 14% of Whites. Hispanic adults are at the highest risk of lacking coverage, with more than one in three (34%) uninsured, while more than one in five (22%) Black adults are uninsured. People of color face longstanding and persistent disparities in accessing health coverage that contribute to greater barriers to care and poorer health outcomes. "

Medicaid expansion for adults with incomes at or below 138% of the federal poverty level (FPL) creates the opportunity for low-income, uninsured adults to become eligible for the program, which would increase their access to care and promote greater health equity. In states that do not implement Medicaid expansion, poor adults fall into a coverage gap and will likely remain uninsured. Without expansion, they are likely to remain ineligible for Medicaid and not earn enough to qualify for premium tax credits through marketplace plans, which begin at 100% FPL." [1]

REACH's strategic approach is to engage our community partners in each of the counties in our service area to conduct outreach and enrollment for the health insurance marketplace leading up to, during, and following the annual open enrollment period. The Foundation believes that to have the greatest impact on enrolling the remaining eligible uninsured we must invest in a.) Community organizations that already have trusted relationships with large numbers of the uninsured and contact with these consumers; b.) Increase the extent of awareness and education for uninsured consumers who may be unaware of the subsidies or their eligibility for insurance coverage; c.) Continue advocacy and policy work with state elected and appointed leaders to encourage Medicaid expansion; and d.) Target outreach and enrollment toward the most vulnerable, disconnected and marginalized persons in the Foundation's service area.

Latino and African-American persons continue to lag behind whites in recent open enrollment periods. Of the roughly 67,000 individuals who enrolled in the past two enrollment periods in REACH's service area, only 4% of recent enrollees were Latino and 10% were African-American. Yet we know that the region's Latino population is rapidly growing and in 2013 represented 8.3% of the Kansas City metropolitan statistical area's population. In 2013 African-Americans in the Kansas City region made up 14% of the population. The vast majority of the recently insured through the marketplace were white (49%) and 31% did not report their race or ethnicity. It is likely that some unknown percentage of Latino and African-American enrollees are represented in this 31%.

Missouri recently expanded their Medicaid managed care program. House Bill 11 included appropriation authority to implement Medicaid managed care to the remaining 61 Missouri counties where it has not yet been implemented. Currently, 48 percent of Missourians who are enrolled in Medicaid do so through a private managed care provider. State statute (Section 208.950) prevents the state from requiring managed care for Medicaid beneficiaries who are aged, blind or disabled.[2] Managed care in Missouri currently covers nearly 440,000 out of 893,000 Medicaid enrollees in the state. The counties currently using managed care are located along Interstate 70. Individuals who are disabled, elderly or blind are exempt from managed care and remain exempt despite the expansion, meaning that only 200,000 of those not currently using managed care services will be shifted away from fee-for-service care and into the expanded Medicaid managed care program.[3]

According to recent research produced by the Kansas Health Institute, "Medicaid and the Children's Health Insurance Program (CHIP) serve roughly 420,000 Kansans at an annual cost of more than $3.2 billion. The Brownback administration sought to address growing costs by implementing comprehensive managed care in 2013 through a program called

KanCare. KanCare was designed to control the cost of Medicaid and CHIP while ensuring access to services and improving quality of care. Over the last six years, total enrollment in Kansas Medicaid and CHIP has increased 36.8 percent (from 308,821 in 2009 to 422,562 in 2014). Enrollment grew 6 percent during KanCare's second year (2014); this is nearly three times the growth rate (2.1 percent) during KanCare's first year (2013). Almost all enrollment growth during 2014 can be attributed to children and families under Temporary Assistance for Needy Families (TANF), TANF Extended Medical, Poverty Level Eligible (PLE) infants and programs for PLE Children ages 6–17. The reason for the growth in children and families is likely attributable to policy changes occurring before the implementation of the Kansas Eligibility and Enforcement System (KEES), reductions in eligibility for TANF, and changes in CHIP and Medicaid eligibility."[4]

[1]Source: *http://kff.org/disparities-policy/issue-brief/the-impact-of-the-coverage-gap-in-states-not-expanding-medicaid-by-race-and-ethnicity/?utm_campaign=KFF%3A+The+Latest*

[2] *https://governor.mo.gov/news/archive/gov-nixon-signs-fy2016-budget-bills-making-investments-public-education-economic*

[3] *http://health.wolterskluwerlb.com/2015/05/managed-care-expansion-gets-a-green-light-in-missouri/*

[4] *John Allison and Scott C. Brunner (September, 2015). KANSAS MEDICAID AND CHIP ENROLLMENT CONTINUES TO GROW. Kansas Health Institute. Available online at khi.org/policy/article/Medicaid-CHIP-grows.*

DEFINITIONS

ADVOCACY: Defined as any action that speaks in favor of, recommends, argues for a cause, supports or defends, or pleads on behalf of others.

OUTREACH: An activity of providing services to populations who might not otherwise have access to those services. A key component of outreach is that the groups providing it are not stationary, but mobile; therefore, outreach should touch consumers where the needs exist. Outreach also has an educational role of increasing awareness of existing services within the target population.

HEALTH INSURANCE MARKETPLACE: A resource where individuals, families and small businesses can learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The marketplace provides information on programs that help people with low to moderate income and resources to pay for coverage. This includes ways to save on premiums and out-of-pocket costs of plans, and information about Medicaid and the Children's Health Insurance Program (CHIP). The marketplace encourages competition among private health plans and is accessible through web sites, call centers and in-person assistance. The marketplace may be state-run or federally facilitated (as is the case in Kansas and Missouri).

PUBLIC HEALTH INSURANCE PROGRAMS: Includes the federal programs Medicare, Medicaid and other medical assistance programs, VA Health Care; the Children's Health Insurance Program (CHIP); and individual state health plans.

MEDICARE is a federal program which helps pay health care costs for people age 65 older, and for certain people under age 65 with long-term disabilities.

MEANS-TESTED HEALTH CARE: One method for targeting services and resources to a population of consumers. Means testing is an administrative mechanism for assessing a person's or a family's eligibility to receive benefits, based on income or other income-related characteristics of an individual or family.

MEDICAID OR MEDICAL ASSISTANCE is any kind of government-assistance plan for those with low incomes or a disability.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) is a state-level program providing health care to low-income children whose parents do not qualify for Medicaid.

STATE-SPECIFIC PLANS: Some states have their own health insurance programs for low-income or for high-risk, uninsured individuals. These health plans may be known by different names in different states.

VA HEALTH CARE is a Department of Veterans Affairs program that provides medical assistance to eligible veterans. Those who have ever used or enrolled in VA Health Care are considered covered to have VA coverage.

INDIAN HEALTH SERVICE (IHS) is a health care program through which the Department of Health and Human Services provides medical assistance to eligible American Indians at IHS facilities. In addition, the IHS helps pay the cost of selected health care services provided at non-IHS facilities.

NAVIGATORS: In April 2013, the Centers for Medicare and Medicaid Services (CMS) announced a cooperative agreement to support navigators in Federally-Facilitated Exchanges or State-Partnership Exchanges. Under the ACA, a health insurance marketplace is required to develop and fund a navigator program. The navigator's primary role, as defined in Section 1311, is to educate the public on information about health care plans, facilitate enrollment into health plans, and provide information for tax credits and cost-sharing reductions. The education and information provided by navigators must be culturally and linguistically appropriate and provided in a fair and impartial manner. Navigators are required to meet standards and core proficiencies established by the Secretary of Health and Human Services. Navigators are also called "patient navigators," "insurance navigators" or "in-person assisters" who have defined roles under the ACA. Although their roles might overlap, navigators are not community health workers or health advocates.[1]

[1] T. Brooks & J.Kendall (July, 2012). Countdown to 2014: *Designing Navigator Programs to Meet the Needs of Consumers.* Washington DC: Georgetown University, Health Policy Institute, Center for Children and Families.

INDICATORS OF EFFECTIVE IMPLEMENTATION

1. Increased rate of uninsured individuals selecting a qualified plan during the open enrollment period and making the first premium payment thereby becoming newly insured.
2. Increased rate of individuals who re-enroll in health insurance during subsequent open enrollment periods.
3. Increased numbers of consumers who enroll after the open enrollment period closes.
4. Changes in the uninsured rate at the county-level for each county in the Foundation's service area.

TARGET GOAL

Reduce *the percentage of uninsured in the foundation's service area from 11% in 2014 to less than 5% by 2020.*

ENROLL ALL ELIGIBLE

Enroll all eligible people in the health insurance marketplace or existing public health insurance programs.

REACH healthcare foundation

STRATEGY 3

Health insurance literacy programs to educate and inform uninsured and newly insured consumers.

This strategy is designed to educate uninsured and newly insured consumers of the value and importance of health insurance and to assist the newly insured in the appropriate and effective use of health insurance.[1]

[1] *Consumers Union, University of Maryland College Park and American Institutes for Research (Feb, 2012). Measuring Health Insurance Literacy: A Call to Action. A Report from the Health Insurance Literacy Expert Roundtable.*

STRATEGIC FOCUS

Use knowledgeable and trusted assisters such as navigators, CACs and Promotora to provide education about health insurance before and following enrollment to increase the health insurance literacy of consumers.

TARGET POPULATION

This strategy is designed to impact the uninsured and newly insured in the REACH service area by deploying more trained assisters (i.e., navigators, Promotora, CACs, care coordinators) in organizations that are serving uninsured consumers and have experience conducting outreach to vulnerable and marginalized populations. The 2013 American Community Survey data for the REACH service area indicate that 212,503 individuals were uninsured. Of the uninsured, 46% were unemployed, 26% were employed making less than $25,000 annually, and 21% were employed with income less than 50,000. About 18% were not US citizens. MARC estimates that if Medicaid expansion up to 138% of the FPL were to occur in our service area the uninsured rate would drop at least 3% and as high as 6% in REACH counties.

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BARRIERS THE STRATEGY ADDRESSES

The US has one of the most complicated systems in the world for financing health care. As our country grapples with reforms designed to improve access to health care, the role of health insurance is changing as are consumers' responsibilities with respect to finding and selecting health insurance.

Many enacted and proposed reforms envision a competitive health insurance marketplace whereby consumers act as informed shoppers, driving health plan competition based on quality and value. The reality is that private health insurance, as well as Medicare and Medicaid, feature many complex provisions and rules for enrollment. Consumers' ability to understand, shop for and use their health insurance plans is varied and, for some, extremely limited. When consumers don't understand health insurance it both undermines the well-intentioned efforts of policymakers and limits a health plan's ability to communicate with their enrollees. This can cause consumer frustration and undermine their coverage selection and access to health care.

RATIONALE/SUPPORTING EVIDENCE FOR STRATEGY

Consumer testing conducted by Consumers Union,[1] a literature review conducted by the American Institutes for Research® (AIR®), and the experiences of the REACH grantees confirm two key facts: 1.) Consumers have serious difficulties understanding and using health insurance; and 2.) There is a lack of usable information on the precise barriers facing consumers. These health insurance difficulties take a toll on consumers' health and financial well-being, and have cost implications for health plans and the nation.

- Consumers struggle with cost-sharing terminology, e.g., terms such as coinsurance, allowed amount, annual benefit limit, and out-of-pocket maximum (Quincy, 2010, 2011-A, 2011-B).[2,3,4]
- Consumers struggle with some medical services terminology, e.g., the difference between screening and diagnostic tests (Quincy, 2010, 2011-A).[2,3]
- Consumers often stay in the same plan year after year, even when better choices are available to them (Gruber, 2009).[5]
- People struggle to use certain types of informational formats, e.g., 88% of US adults cannot calculate an employee's share of health insurance costs, using a table based on income and family size (Kutner et al., 2006).[6]
- Consumers' ability to choose the "optimal" plan declines as the number and complexity of the choices increases (Shaller 2005; Wood, 2011).[7]
- Problems exist with self-efficacy—consumers do not like shopping for health insurance and lack confidence in their ability to assess their choices (Issacs 1996; Quincy, 2010, 2011-A).[2,3,9]
- Problems with numeracy affect consumers ability to comprehend health plans (Greene et al., 2008; Wood, 2011).[8,10]

[1] Consumer's Union, University of Maryland – College Park, and American Institutes for Research (2012). *Measuring Health Insurance Literacy: A Call to Action. A Report from the Health Insurance Literacy Expert Roundtable.* Author: Washington, DC.

[2] Quincy, L. (2010). Early Consumer Testing of New Health Insurance Disclosure Forms. Washington, DC: Consumers Union & People Talk Research.

[3] Quincy, L. (2011-A). Early Consumer Testing of the Coverage Facts Label: A New Way of Comparing Health Insurance. Washington, DC: Consumers Union & Kleimann Communication Group.

Measuring Health Insurance Literacy: A Call to Action

[4] Quincy, L. (2011-B). Early Consumer Testing of Actuarial Value Concepts. Washington, DC: Consumers Union & Kleimann Communication Group.

[5] Gruber J. *Choosing a Medicare Part D plan: are Medicare beneficiaries choosing low-cost plans?* Washington, DC: Kaiser Family Foundation, March 2009.

[6] Kutner, M., Greenberg, E., Jin, Y., and Paulsen, C. (2006). The Health Literacy of America's Adults: Results From the 2003 National Assessment of Adult Literacy (NCES 2006–483). US Department of Education. Washington, DC: National Center for Education Statistics.

[7] Shaller, D. (2005). *Consumers in health care: The burden of choice.* California Healthcare Foundation. http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/C/PDF%20ConsumersInHealthCareBurdenChoice.pdf.

[8] Wood, S., et al. Numeracy and Medicare Part D: The Importance of Choice and Literacy for Numbers in Optimizing Decision Making for Medicare's Prescription Drug Program, Psychology And Aging, Volume 26, No. 2, pages 295-307 (June, 2011).

[9] Isaacs, S. L (1996). Consumers' information needs: Results of a National survey. Health Affairs (Winter, 1996): 31-41.

[10] Greene, J., Peters, E., Mertz, C. K., et al.: Comprehension and Choice of a ConsumerDirected Health

DEFINITIONS

HEALTH INSURANCE LITERACY: The degree to which individuals have the knowledge, ability and confidence to find and evaluate information about health plans, select the best plan for their own (or their family's) financial and health circumstances, and appropriately use their plans once enrolled.

TRAINING PROGRAMS: Programs offered by community organizations or higher education to prepare navigators, CACs, community health workers and other connectors to provide education programs or coaching to uninsured and newly insured consumers.

NAVIGATOR: An individual or organization trained and able to help consumers, small businesses and their employees as

they look for health coverage options through the Federally-Facilitated Marketplace, including completing eligibility and enrollment forms. These individuals and organizations are required to be unbiased. Their services are free to consumers.

CERTIFIED APPLICATION COUNSELOR (CAC): An individual working through a designated organization that is trained and able to assist consumers, small businesses and their employees as they search for health coverage options through the marketplace, including helping them complete eligibility and enrollment forms. Their services are free to consumers.

PROMOTORES DE SALUD (PROMOTORA): Promotores de salud, also known as "promotoras," is the Spanish term for "community health workers." The Hispanic community recognizes promotores de salud as lay health workers who work in Spanish-speaking communities. Promotoras may receive specialized training to provide basic health education in the community without being a professional health care worker. While most of their work entails educating target audiences about health issues affecting their community they also provide guidance on accessing community resources associated with health care.

INDICATORS OF EFFECTIVE IMPLEMENTATION

REACH will invest in organizations with the capacity to enroll large numbers of consumers and organizations already serving the target population that could be enrolled. REACH will collect information on the number of individuals who receive health insurance education before and after enrollment and the number of organizations that deliver health insurance education, and ask grantees to measure the following indicators of consumer health insurance literacy:

Consumers should be able to:

1. Compare the key features of several health plans; understand the scope of covered services and the cost-sharing provisions associated with broad categories of services;
2. Assess the adequacy and fit of the provider network for his or her (or family's) health and financial circumstances;
3. Assess the quality of each plan in terms of measures that are important to him or her, such as processing claims or customer service;
4. Understand an Explanation of Benefits (EOB);
5. Understand his or her appeal rights; and
6. Know where to turn for more information and help.

TARGET GOAL

Reduce *the percentage of uninsured in the foundation's service area from 11% in 2014 to less than 5% by 2020.*