BREAKING BARRIERS

Improving Health Insurance Enrollment and Access to Health Care in California

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ALLIANCE FOR A JUST SOCIETY

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Following passage of the ACA, California was the first state to create a health benefit exchange, Covered California, with a mandate to increase the number of Californians with health insurance, improve the quality of health care, reduce health care coverage costs, and ensure that California's diverse population has fair and equal access to quality health care.

IN 2011 CALIFORNIA, SIGNALING ITS COMMITMENT to increased access to health insurance even before the Affordable Care Act (ACA) took full effect, initiated a Low Income Health Program. Designed to cover 600,000 childless uninsured adults, the program required insurance companies to spend the majority of premium dollars on medical care and quality improvement.[1] Following passage of the ACA, California was the first state to create a health benefit exchange, Covered California, with a mandate to "increase the number of Californians with health insurance, improve the quality of health care, reduce health care coverage costs, and ensure that California's diverse population has fair and equal access to quality health care."

Recognizing early that the state's diverse population added to the complexity of the task, and that mobilizing key actors in low-income communities of color would be essential, Covered California worked with a range of partners, including private foundations, university-based outreach programs, religious groups, and community and labor organizations, to develop and implement plans for broad outreach and enrollment. As the first enrollment period began in October 2013, Covered California had both significant partnerships and a website that ranked among the top three of the 16 state-run marketplace portals.[2]

During the first open enrollment period, from October 2013 through April 2014, potential enrollees reported language barriers, particularly in Asian-Pacific Islander communities; daunting requirements for documentation of income, residence, and immigration status; and numerous electronic glitches when trying to compare costs, copayments, and benefits among plans.[3] However, despite these setbacks, Covered California reported significant enrollment progress: more than 1.4 million California consumers enrolled in the private insurance market and an additional 1.93 million enrolled in Medi-Cal, the state's Medicaid program. California had more enrollees than any other state.

This report, part of a 10-state study, reviews enrollment efforts and attempts to access health care by low-income African-Americans, Latinos, Asian-Pacific Islanders, and, where applicable, Native Americans. The methodology includes key actor interviews with California-based navigators, policy and health care professionals, academics, and funders, as well as 153 surveys of residents speaking Spanish, English, and Cantonese in three low-income communities. The report compares and contrasts the enrollment and "coverage-to-care" trends shown through the interviews and surveys to reported California outcomes and, when appropriate, to national trends. Analyses of these results serve as the basis for the report's recommendations.

ENROLLMENT

At the end of the first enrollment period, Covered California announced enrollment figures that topped many optimistic projections; as a result of new enrollment, Gallup polling shows the percentage of uninsured people in the state was reduced from 21.6 percent to 16.3 percent.

CHART 1
California Population and Percentage Uninsured by Race/Ethnicity

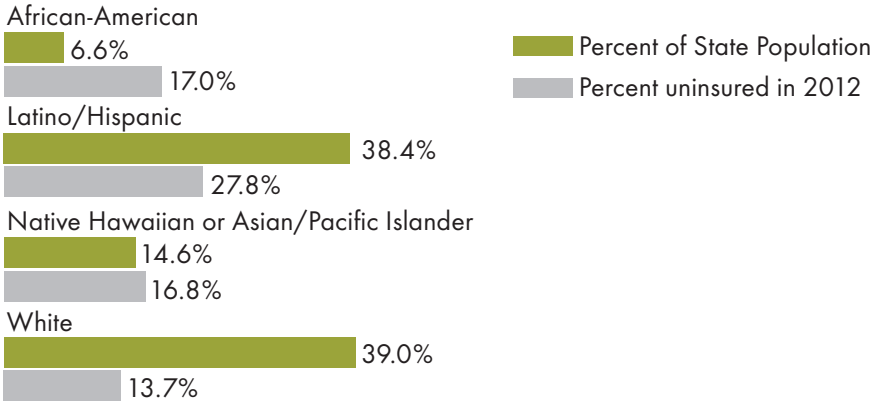

CHART 2
Demographics of New Enrollees in Covered California Marketplace Plans Through April 2014, by Race

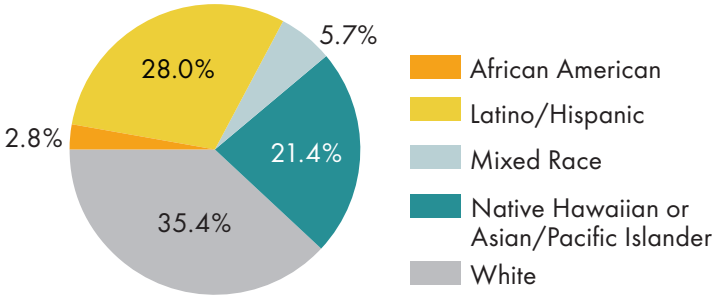

CHART 3
Insurance Coverage of Survey Respondents

Do you have medical coverage?

	Percent No	Percent Yes
CA	**26%**	**74%**
People of Color	30%	70%
White	5%	95%

Of the ACA enrollees reported by Covered California through April 2014, 35.4 percent were white, 28.0 percent Latino, 21.4 percent Asian-Pacific Islander, and 2.8 percent African American. Among our survey respondents, three of four had medical coverage. However, as Chart 3 illustrates, a 25 percentage point gap separates whites surveyed, insured at a rate of 95 percent, from people of color, insured at a rate of 70 percent. Charts 4-7 below examine state demographics and enrollment data for specific racial groups in comparison to racial outcomes for survey respondents.

Of the ACA enrollees reported by Covered California through April 2014, 35.4 percent were white, 28 percent Latino, 21.2 percent Asian-Pacific Islander, and 2.8 percent African American.

Between 50 and 60 percent of the state's uninsured population is estimated to be Latino.

CHART 4
Latino Enrollment

Percent of state population	38.4%
Percent of Covered California enrollees	28.0%
Percent of survey respondents who are new enrollees	61.0%

Latino enrollment in California picked up considerably toward the end of the first enrollment period, but only after Latino political leaders criticized the initial enrollment outcomes in the Latino community. Between 50 and 60 percent of the state's uninsured population is estimated to be Latino.[4] Reasons for lower enrollment among Latinos vary, ranging from the oft-cited complaints about Covered California's woeful underestimation of the need for Spanish-speaking call center operators and counselors[5] to lack of Internet access and the complexity of enrolling mixed-status families (comprising both documented and undocumented members).[6] Miscalculations in preparation produced initial enrollment that failed to meet the needs of the most heavily uninsured demographic group. Lisa Castellanos, Organizing Director with Sacred Heart Community Service in San Jose, pointed out that "the people we work with are primarily Latino and there is a lot of fear about information that is submitted in the application getting used by Homeland Security."[7] Of our Latino survey respondents, 70 percent of those without health insurance did not apply.

CHART 5
White Enrollment

Percent of state population	39.0%
Percent of Covered California enrollees	35.4%
Percent of survey respondents who are new enrollees	52.6%

White enrollment approximately matched whites' proportion of the state's population. In our survey, just over half of white respondents were new enrollees—a lower percentage than for any other group. White survey respondents were the most likely to have Internet access (77.8 percent) and email (70.6 percent), and only a third had assistance in enrolling.

An Oakland survey respondent suggested another reason: "Affordable health care is not really affordable."

CHART 6
African American Enrollment

Percent of state population	6.6%
Percent of Covered California enrollees	2.8%
Percent of survey respondents who are new enrollees	55.6%

When comparing enrollment of African Americans to their percentage in the state population, the group's under-enrollment is clear. Polling indicated a 69 percent awareness of the ACA among African Americans in December 2013. But despite Covered California's outreach and education and enrollment events, an increased paid-media budget for outreach in the African American community, and partnerships with church-based outreach programs, the numbers are still low. In terms of enrollment barriers, even though 50 percent

of African American survey respondents had assistance during enrollment, one in four still found the enrollment process difficult. Only 27.5 percent of African American survey respondents had home Internet access; only half had email addresses.

Dr. Brownell Payne with Crenshaw Health Partners in Los Angeles suggests that the raw enrollment numbers may not accurately portray African American enrollment because the data fail to include enrollment in Medi-Cal, California's Medicaid program. In an interview with California Black Media, Payne said, "With every insurance enrollment we make in the African-American community we will enroll two to three people in Medi-Cal because a lot of people didn't know that they were eligible."[8] An Oakland survey respondent suggested another reason: "Affordable health care is not really affordable." A seasonal construction worker who is often paid in cash, Reid, 34, says "the minimum for me to have any real coverage is about $240 a month, not to mention coverage for my daughter. I talked to a counselor, but given the fact that I did not see a way to come up with the money, I didn't apply."[9]

CHART 7
Asian-Pacific Islander (API) Enrollment

Percent of state population	13.0%
Percent of Covered California enrollees	21.4%
Percent of survey respondents who are new enrollees	63.2%

Covered California exceeded API enrollment projections by over 50 percent. Interestingly, the fewest API enrollees (11 percent) signed up using service center and certified enrollment counselors and the highest proportion (54 percent) used insurance agents, compared to 19 percent for African Americans and 28 percent for whites and Latinos. Covered California reports that "within certain Asian-American groups, the percentage of enrollments through agents is much higher: 57 percent for Chinese-Americans; 65 percent for Vietnamese-Americans; 70 percent for Korean-Americans."

In a well-documented report on national enrollment efforts, a consortium of Asian-Pacific Islander organizations criticized ACA outreach and enrollment efforts in the API community. The September 2014 report found that "state and federal agencies provided inadequate language assistance services despite federal and state laws mandating the provision of culturally and linguistically appropriate information and services in the health insurance marketplaces."[10] Interviews with API navigators underscored these findings. As an experienced navigator from the Los Angeles office of the National Korean American Service & Education Consortium noted, "although the Covered California site claims materials in 17 languages, the material available in each language is not the same. Most languages have the application but not necessarily the supporting or explanatory documents. And, if we need help over the phone, sometimes we get someone who is knowledgeable, other times we don't and have to start over with a new person. It is very time consuming."[11] Francis Calpotura, Executive Director of the Oakland-based Transnational Institute for Grassroots Research and Action, cites another issue: "the ID e-verify system is set up for middle-class people with a pretty standard credit profile. If you have to submit documents you can wait days for a reply. And if you don't get verified, the process is even longer. Add translation and the enrollment can take weeks. This is not an immigrant-friendly process—even if you have papers."[12]

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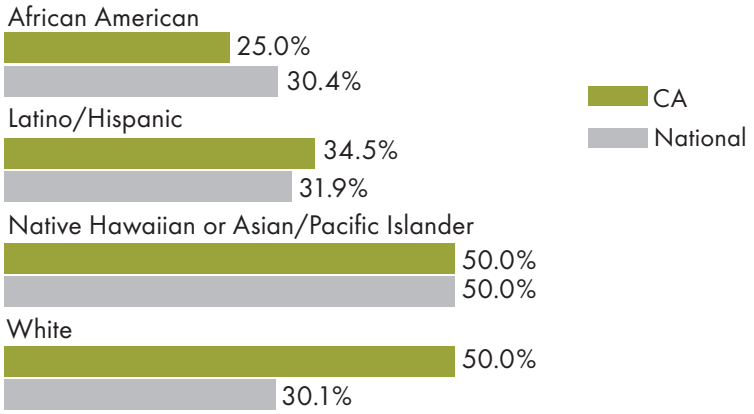
Difficulties cited included: “I was not sure, really, what my options were”; “I still don’t know how much they charge for blood tests, so I haven’t gotten any”; “The Internet blinked off. It just blinked off and we had to start all over”; “Not all of the forms were translated into my language”(Farsi).

BARRIERS TO ENROLLMENT

CHART 1
Difficulty
In general, was the enrollment process somewhat or very difficult:



Forty percent of California’s new enrollees (50 percent of whites, 34.5 percent of Latinos, and 25 percent of African Americans) found the enrollment process “somewhat” or “very” difficult, compared to 30.2 percent nationally. Difficulties cited included: “I was not sure, really, what my options were”; “I still don’t know how much they charge for blood tests, so I haven’t gotten any”; “The Internet blinked off. It just blinked off and we had to start all over”; “Not all of the forms were translated into my language” (Farsi)[13].

CHART 2
Email Access
Do you have an email address?

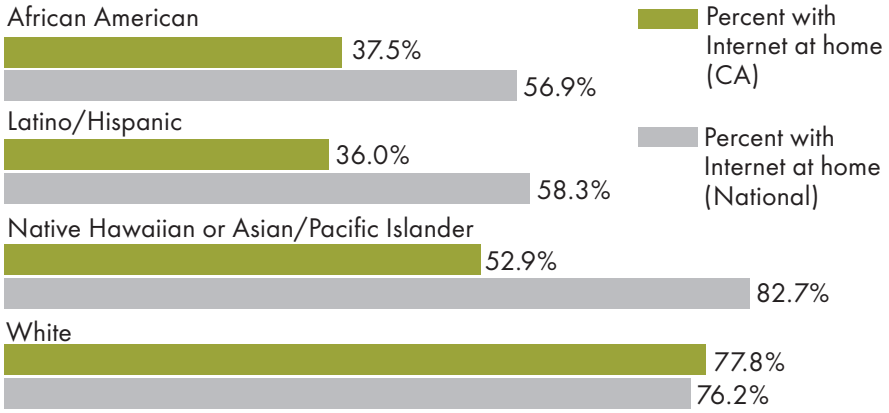
Race/Ethnicity	Percent who have email address
African American	50.0%
Latino/Hispanic	26.0%
Native American or Alaska Native	25.0%
Native Hawaiian or Asian/Pacific Islander	44.4%
White	70.6%

An email address is a necessary component of the enrollment process. Although relatively easy to get, *not* having an email address suggests that the potential enrollee has minimal familiarity with Internet communications. As the figures above indicate, the racial divide is significant. Whites have an email address at almost three times the rate of Latinos and Native Americans, 25 percentage points more than Asian-Pacific Islander respondents, and 20 percentage points more than African Americans.

CHART 3

Internet Access

Do you have Internet access at home?



Although Internet access is not absolutely necessary for ACA enrollment, without it a potential enrollee must either use a public Internet access point, such as a library, or get assistance from a private insurance broker or an organization with navigators. The chart above suggests several things: 1) Internet access for African American, Asian-Pacific Islander and Latino survey respondents is much lower in these low-income communities than for these same racial groups nationally, and 2) the racial differential, or gap between whites and people of color, is more significant in California, where the nearly 78 percent of white respondents who have access is almost double the 42 percent average in communities of color.

CHART 4

Help with Enrollment

Did anybody help you enroll?

Percent Replying "Yes"

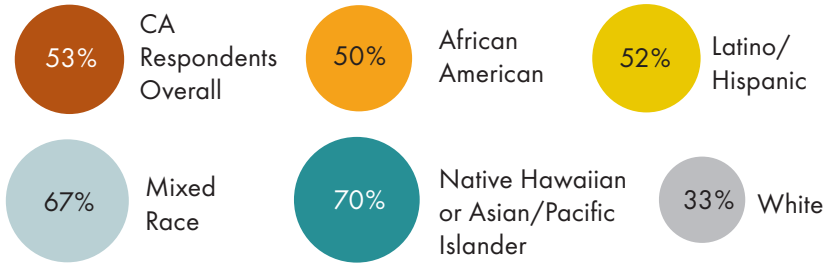
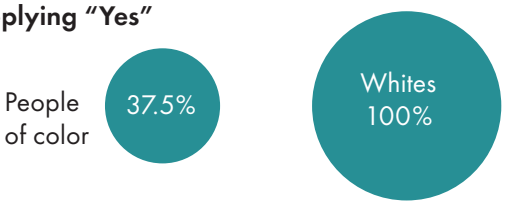


CHART 5

Do you know what services are included in your medical coverage and which you'll have to pay extra for?

(asked of respondents whose first language was not English)

Percent Replying "Yes"



Just over half of our survey respondents had help with enrollment overall, including 52 percent of Latino respondents and 50 percent of African American respondents. In terms of understanding costs, only 37.5 percent of enrollees

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of color whose first language was not English understood which services are included in their medical service and which they'll have to pay extra for.

COVERAGE TO CARE

OVERALL ENROLLMENT DATA POINTS TO SIGNIFICANT INCREASES in health insurance in California. However, insurance coverage does not necessarily translate into quality care, which includes access to providers, a reciprocal relationship with a personal doctor, and access to both medication and other forms of treatment. Although the ACA infrastructure is still developing, in this section we'll examine some key issues related to access and treatment.

CHART 1
State of Health

Do you have one or more medical conditions that have affected you for more than 3 months?

Race/Ethnicity	Percent with chronic conditions by race
CA Respondents Overall	**53.1%**
African American	70.0%
Latino/Hispanic	54.8%
Native American or Alaska Native	80.0%
Native Hawaiian or Asian/Pacific Islander	30.8%
White	52.4%

To tackle chronic diseases, the health care system must expand its scope of care to include community education, group clinical activities, and additional health modalities.

If the incidence of chronic conditions is any indication, the ACA may have arrived just in time. Chronic diseases cause seven of every ten deaths. In addition, health care costs for an individual with one or more chronic diseases are five times the costs of an individual without chronic disease.[14] Eighty percent of Native American respondents reported chronic conditions, as did 70 percent of African Americans and 54.8 percent of Latinos. Asian-Pacific Islanders reported the lowest percentage of chronic conditions (30.8 percent) as did 52.4 percent of whites. To tackle chronic diseases, the health care system must expand its scope of care to include community education, group clinical activities, and additional health modalities. As herbalist and acupuncturist Brian O'Dea observes, "many traditional approaches to medicine, including ayurvedic, chiropractic, meditation, acupuncture, and many herbal traditions for centuries have successfully addressed chronic conditions. The ACA is an opportunity for us to finally work on some complementary approaches to addressing disease. But I'm not sure the insurance companies will really integrate us into any of the provider networks."[15]

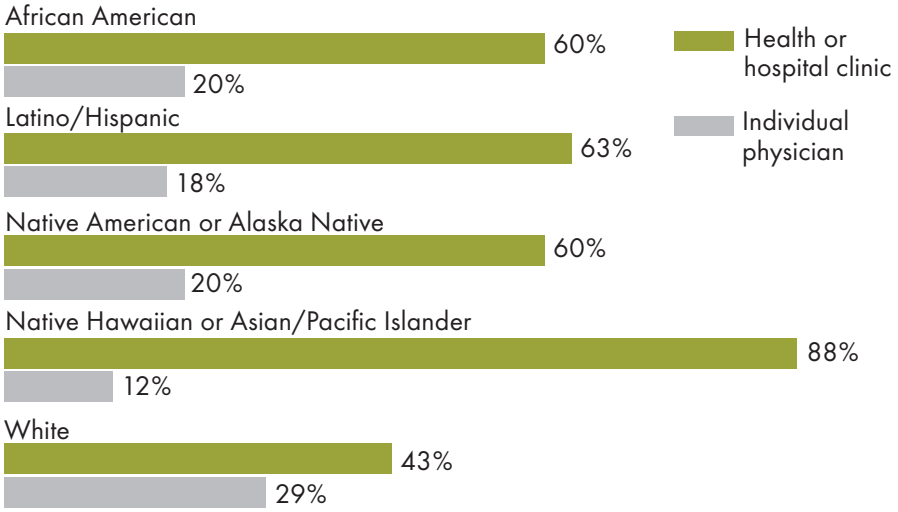
CHART 2
Personal doctor

Do you have a personal doctor?

Race/Ethnicity	Percent replying "yes"
African American	50%
Latino/Hispanic	71%
Native Hawaiian or Asian/Pacific Islander	78%
White	67%

CHART 3
Clinic versus Individual Physician

Percentages of respondents who go to a clinic or individual physician for their primary health needs, by race.



Development of a doctor-patient relationship is a key emphasis of the ACA. Charts 2 and 3 suggest that while seven of ten new enrollees have personal doctors, only 30 percent of whites and less than 20 percent of people of color visit them for regular health care needs. As survey respondent Beatrice Acosta explains, "it's like this. I have insurance, because I have to. But the deductible is like $4,000. So I go to La Clinica (a public clinic in Oakland) and they see me on a sliding scale that I can afford."[16]

CHART 4
Urgent Care

In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed it?

Race/Ethnicity	Percent "Sometimes" or "never"
Whites	36%
People of color	35%

CHART 5
"Medical Home"

Percentages of respondents who go to an emergency room or "no regular place" for their primary health needs, by race.

Race/Ethnicity	Hospital ER or "no regular place"
African American	10%
Latino/Hispanic	20%
Native American or Alaska Native	20%
Native Hawaiian or Asian/Pacific Islander	0%
White	28%

As survey respondent Beatrice Acosta explains, "it's like this. I have insurance, because I have to. But the deductible is like $4,000. So I go to La Clinica (a public clinic in Oakland) and they see me on a sliding scale that I can afford."

"I get my insurance through work. It's subsidized by my employer. But you never know what anything is going to cost. The cost of my medications and my doctor visits have gone up three times in the last five years. I get a lot of my medications from Mexico because it's cheaper. The best thing about Obamacare is that I can keep my daughter on my insurance for another two years and hope that she finishes college. Finally, I'm saving some money."

Rounding out the picture of health access, we find that urgent care is sometimes or never available to whites and respondents of color approximately 35 percent of the time, while almost 30 percent of whites, 20 percent of Latinos and Native Americans, and 10 percent of African Americans either utilize the emergency room or have "no regular place" to go for their health care needs.

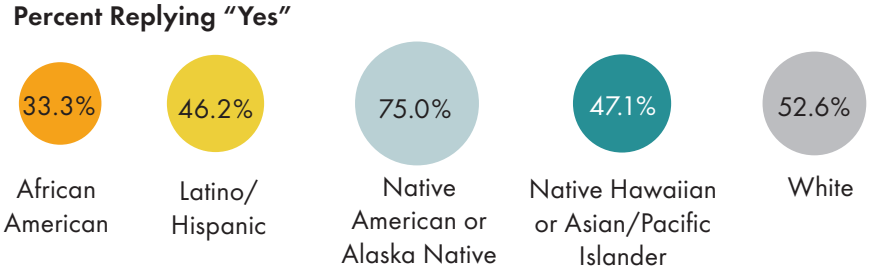
CHART 6
Availability of financial aid/subsidies

Did you know about financial support available to low income people when you were enrolling?

Race/Ethnicity	Percent replying "yes"
African American	50%
Latino/Hispanic	70%
Native American or Alaska Native	50%
Native Hawaiian or Asian/Pacific Islander	42%
White	67%

CHART 7
Extra payments

Not including copayments, have you ever had to pay extra for doctor visits or medicines that your plan doesn't cover?

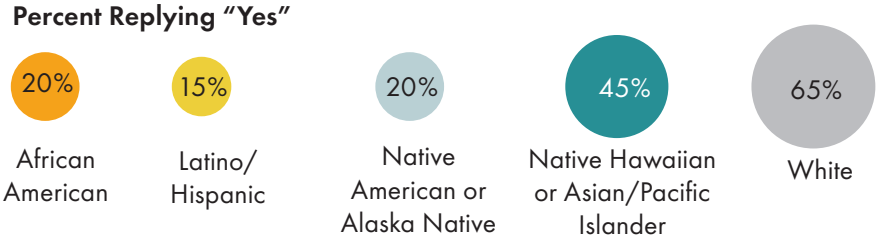


Even as respondents answer in the affirmative when asked about their knowledge of subsidies (two-thirds of whites and 70 percent of Latinos, versus 50 percent of African Americans and Native Americans and only 42 percent of Asian-Pacific Islanders), an average of 51 percent of respondents have had to pay out-of-pocket for doctor visits or medicines. As one respondent in San Jose said, "I get my insurance through work. It's subsidized by my employer. But you never know what anything is going to cost. The cost of my medications and my doctor visits have gone up three times in the last five years. I get a lot of my medications from Mexico because it's cheaper. The best thing about Obamacare is that I can keep my daughter on my insurance for another two years and hope that she finishes college. Finally, I'm saving some money.[17]"

CHART 8
Internet use for health needs

Do you use the Internet for health needs? (communication with provider, insurance company, Covered CA)

Percent Replying "Yes"



As the chart above illustrates, whites are four times as likely as Latinos, three times as likely as African Americans and Native Americans and nearly one and one-half times more likely than Native Hawaiians/Asian-Pacific Islanders to use the Internet for health needs. As we note in the enrollment section, Internet access is not absolutely necessary for ACA enrollment but it is fast becoming "the way of the world." In addition, the Internet will be useful for reenrollment, using electronic forms to prove that individuals are either insured or exempt from the insurance mandate for tax purposes, and communicating with providers.

CHART 9
Access to Alternative Health Modalities

In the last six months, how often did a doctor or other health provider talk with you about non-medical things like diet, exercise, meditation, or chiropractic care to treat or prevent illness?

Race/Ethnicity	Percent replying "always or usually"
CA Respondents Overall	**41%**
African American	62%
Latino/Hispanic	43%
Native American or Alaska Native	62%
Native Hawaiian or Asian/Pacific Islander	25%
White	31%

Of those whose doctors discussed non-medical methods, percent who discussed only diet and/or exercise, by race

Race/Ethnicity	Percent "only diet or exercise"
African American	57%
Latino/Hispanic	59%
Native American or Alaska Native	100%
Native Hawaiian or Asian/Pacific Islander	91%
White	44%

Very few practitioners mentioned non-medical or alternative medical modalities. However, Native Americans and African Americans, the two groups with the highest incidence of chronic diseases, were also more likely to hear mention of alternative treatment, while whites and Asian-Pacific Islander respondents, who reported a lower incidence of chronic disease, heard less mention.

KEY CHALLENGES TO FUTURE ENROLLMENT AND ACCESS TO CARE IN CALIFORNIA

1. Addressing Racial Disparities: In terms of enrollment, news reports indicate that as of January 2015 enrollment figures for Latinos were on-par with 2014 enrollment percentages. Although Covered California has spent more money on translators and, in the African American community, on advertising, it is unclear that the ratio of one-on-one contact work will improve enrollment. Language barriers and translation of materials, particularly for Asian-Pacific Islanders, are obstacles to both enrollment and treatment, while the digital divide in Internet access will continue to have negative impacts for people of color in both enrollment and ongoing communications with insurers and health providers.

2. Cost: Of our survey respondents who did not apply for medical insurance, the two reasons cited the most were immigration status and cost. Even among insured respondents, however, the cost of premiums was an ongoing issue, as was the size of deductibles. One respondent had foregone a visit to the doctor because he thought he would "have to pay the whole deductible up front."

3. Availability of Doctors: While seven of ten new enrollees have personal doctors, only 30 percent of whites and less than 20 percent of people of color visit them for regular health care needs; overall 23 percent of our survey respondents had not seen a doctor for over a year. A report in the New York Times noted that only about 57 percent of doctors in California accept new Medicaid patients (the second lowest rate in the nation) while doctors' fees for Medicaid patients were cut ten percent at the end of 2014. According to former Alameda County Public Health department Director Arnold Perkins, "this is a serious crunch. Docs may not drop patients, but given the cut in fees, it is unlikely that they will accept new patients."

SUMMARY OF FINDINGS

Racial Disparities in Enrollment: The majority of the Californians who remain uninsured are Latino; most of them are men. The percentage of uninsured whites (13.7 percent) is less than half the rate of Latino uninsured (27.8 percent). However, in the enrollment period ending in April 2014, the percentage of new enrollees who were white was 7.4 percent higher than Latinos, 14 percent higher than Asian-Pacific Islanders, and more than 12 times higher than African Americans. These outcomes are built, at least in part, on two factors:

- **The digital divide:** Survey responses indicated that Latino and African American respondents had Internet access at less than half the rate of white respondents, and Asian-Pacific Islanders at two thirds the rate of whites. These issues of access were compounded by general website difficulties and particular failures on the Spanish language website.

- **Legal, language, and cultural barriers:** While outreach, particularly in Spanish, may not be an overwhelming barrier, the combination of language, fear of legal reprisals for mixed-status families, and lack of familiarity with culturally-specific insurance and medical terms adds up to significant obstacles to enrollment. Only 37.5 percent of enrollees of color whose first language was not English understood which services are included in their medical coverage and which they'll have to pay extra for. Combining difficulties of language access with legal status, Covered California was sending out notices to thousands of enrollees requesting documentation of immigration status promising that "they will not be used for immigration purposes." At the same time, the federal website (Healthcare.gov) did not have a path to upload a green card—the document that shows enrollees are lawful permanent residents.

Chronic Disease: More than half of our survey respondents had one or more chronic diseases: Native Americans and African Americans at 80 percent and 70 percent, respectively, compared to significantly lower rates among Latinos (55 percent), whites (52 percent), and Asian-Pacific Islanders (31 percent).

Coverage to Care: Although seven of ten new enrollees had personal doctors, only 30 percent of whites and less than 20 percent of people of color visited them for regular health care needs; 28 percent of whites, 20 percent of Latinos and Native Americans, and 10 percent of African Americans either used the emergency room or had "no regular place" for their primary health needs. Significantly, about 35 percent of both whites and respondents of color said they were not able to get urgent care for their conditions as soon as they thought they needed it.

The digital divide also appears to contribute to disparities in access to care: there was a large gap between the percentage of whites who used the Internet for health communications with their provider or insurer (65 percent) and the 45 percent for Asian-Pacific Islanders, 20 percent for African Americans and Native Americans, and 15 percent for Latinos.

RECOMMENDATIONS FOR IMPROVING OUTREACH, ENROLLMENT, AND COVERAGE TO CARE IN CALIFORNIA

Covered California made a reasonable calculation about what it would take to initiate and sustain the important first round of enrolling all Californians in health care. At this writing, Covered California has announced an additional 592,000 successful applicants as of December 15, 2014.[18] However, while the electronic component of the enrollment process has improved, some areas still need attention. These include

I. SAFEGUARDING ACCESS TO HEALTH INSURANCE

Improve language access. Although California has made great strides, culturally appropriate language access is still not an everyday reality in the state. Complete multilingual application materials and website access are still not readily available. Although California has recognized enrollees' right to language services (Cal. Code Regs. tit. 10 § 2538.3), Covered California should expand its pool of interpreters and require plans to continually update information about which providers are in their networks. Provider directories must be available in multiple languages and list addresses, phone numbers, languages spoken, hospital affiliations, and specialties. The state should regularly assess plans' compliance with language access requirements. New York and Washington have adopted such requirements.

Simplify the insurance-shopping experience. Simplify print and electronic descriptions of plans and benefits, making cost information transparent and communicating clear information about deductibles, co-pays, preventive services available at no cost, and the significance of providers being in- or out-of-network to allow for easy comparisons of different plans.

Faster decisions on enrollment applications. At one point in the first enrollment period, California had a backlog of 900,000 pending Medi-Cal applications. Besides cost, the biggest complaint survey respondents articulated about the enrollment process was the amount of time it took for an application to be approved. The state should require decisions on ACA and Medicaid applications within two weeks of filing.

II. MOVING CONSUMERS FROM COVERAGE TO CARE

Expand and extend the role of navigators. Many enrollees are new to health insurance coverage. Not only are they unfamiliar with medical terminology, they have had little interaction with the medical system or the insurance system and may need both an introduction and acclimation. Navigators are in an ideal position to perform this role. The state should extend the role of navigators to encompass teaching new enrollees how to use insurance coverage and recruiting enrollees to participate in marketplace-sponsored evening and weekend clinics focusing on health education, specific mobile services (exams, immunizations, etc.), and access to different medical modalities (e.g., acupuncture, chiropractic care).

Address racial health disparities. Among new enrollees of color in our survey, 58 percent faced one or more chronic conditions. Covered California should enforce ACA statutory provisions that require insurers to act to reduce racial disparities and continually monitor implementation of insurers' disparity-reduction plans and programs, especially outreach and outcomes, and impose penalties, including exclusion from exchanges, on insurers that do not succeed in reducing disparities within required timeframes.

Increase payment rates to primary care physicians. Both Blue Shield and Anthem Blue Cross – the largest Covered California providers with 30 percent of enrollees each – have reduced their payments to doctors and narrowed their networks.[19] Since payment levels strongly affect providers' willingness to see Medicaid patients, California should use state funds to continue Medicare-level payments to primary care physicians who serve Medicaid beneficiaries after federal support for increased payment levels ended on Dec. 31, 2014 as 15 states (AK, AL, CO, CT, DE, HA, IA, MD, ME, MI, MS, NE, NM, NV, SC) planned to do.

Strengthen geographic access standards. California has established standards for distance or time between providers and the enrollee's residence for Medicaid enrollees: primary care providers should be within 30 minutes or 10 miles. This standard should be extended to marketplace plans and, as New York and Colorado do, California should require all plans to establish the same standards for enrollee access to specialists: 30 minutes or 30 miles. Enrollees who live farther from providers should be offered free transportation—the practice in Ohio.

Reinforce the ACA-mandated women's right to no-cost "well-woman preventive" care by ensuring that all plans available through the marketplace include reproductive health care services, including all FDA-approved forms of contraception.

Standardize introductory care. Require that new enrollees have the opportunity for a free physical exam and appropriate screening tests and other preventive care within 60 days of enrollment. Expand and standardize preventive services, ensuring that non-grandfathered plans offer services (yearly check-ups, immunizations, counseling, and screenings) at *no out-of-pocket cost* and penalize plans in which fewer than 70 percent of enrollees receive these services.

Assess and publicize outcomes. Require plans to track health outcomes, disaggregated by race, ethnicity, primary language, gender, disability, and sexual orientation, and publish results annually.

III. BUILDING AN INFRASTRUCTURE TO PROMOTE PREVENTIVE HEALTH CARE

Expand medical-legal partnerships as an avenue toward the broad array of issues that lead to poor health in low-income communities (e.g., mold in housing, domestic violence). While three-quarters of states and seven of the ten states studied already have at least one such partnership, through which medical and legal professionals collaborate to look holistically at barriers to health and wellness and work jointly to remove the barriers, the partnerships already in place cannot begin to meet the need.

Invest in innovative treatment options. Seek funds from HHS' Health Resources and Services Administration or use state funds to expand school-based health centers, especially in medically-underserved communities, to mitigate the lack of other health care options (Section 4101 of the ACA, 42 U.S.C. § 280h-4).

Align incentives to address social determinants of health. Offer incentives to plans that adopt a broad view of health benefits and tackle underlying social determinants of health. Insurance is one step toward better health but in order to address the prevalence of chronic diseases, the state must encourage innovation and experimentation to address the underlying causes of poor health – particularly in poor communities.

ENDNOTES

1. 2013 Report to the Governor and Legislature, Covered California, pp. 3-4, http://www.coveredca.com/PDFs/2013_leg_report.pdf.

2. Evaluating the Consumer Window-Shopping Experience in Health Insurance Marketplace Websites: A Comparative Analysis, Jan. 2014, http://familiesusa.org/sites/default/files/product_documents/state-website-analysis.pdf.

3. "In Their Own Words,"California Healthcare Foundation, p. 4, April 2014, http://itup.org/wp-content/uploads/downloads/2014/06/CHCF-InTheirOwnWordsCoveredCA.pdf.

4. California Healthcare Foundation, California Health Care Almanac, p. 2, 2010 http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/C/PDF%20CaliforniaUninsured2010.pdf.

5. Tracy Seipel, "California health insurance exchange aims to increase Latino enrollment," Mercury News, Dec. 14, 2014, http://www.mercurynews.com/health/ci_27136261/health-insurance-exchange-aims-increase-latino-enrollment

6. Why Are Latinos Lagging On Health Insurance Enrollment?, Feb. 26, 2014, accessed at: http://hereandnow.wbur.org/2014/02/26/latino-health-enrollment.

7. Interview with author, July 2014.

8. Carter, James, California Black Media, Revamped Covered California Campaign Seeks Greater Minority Enrollment, Sept. 17, 2014, http://www.sacculturalhub.com/entertainment-and-news/4638-revamped-covered-california-campaign-seeks-greater-minority-enrollment.

9. Interview with author, July 2014.

10. Action For Health Justice, Improving the Road to ACA Coverage, Lessons Learned on Outreach, Education, and Enrollment for Asian American, Native Hawaiian, and Pacific Islander Communities, p. 10, Sept. 2014, http://www.apiahf.org/sites/default/files/2014.10.14_Improving%20the%20Road%20to%20ACA%20Coverage_National%20Report.pdf.

11. Conversation with author, December 2014.

12. Conversation with author, August 2014.

13. Surveyors field notes, Oakland and San Jose, California, July 2014.

14. Partnership for Solutions, The Impact of Chronic Disease on Healthcare, accessed Nov. 23, 2014, http://www.forahealthieramerica.com/ds/impact-of-chronic-disease.html.

15. Interview with author, Sept. 2014.

16. Conversation with author. Aug. 2014.

17. Surveyors field notes, Oakland and San Jose, California, July 2014.

18. Covered California and Department of Health Release Early Results, Dec. 17, 2014, http://news.coveredca.com/2014/12/covered-california-and-department-of.html.

19. How Obamacare Leaves Some People Without Doctors, Kathleen Miles, Huffington Post, April 10, 2014 accessed at: http://www.huffingtonpost.com/2014/04/10/obamacare-patients-without-doctors_n_5044270.html