BREAKING BARRIERS

Improving Health Insurance Enrollment and Access to Health Care in Idaho

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Idaho Community Action Network

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ALLIANCE FOR A JUST SOCIETY

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"People are desperate for care, especially in rural areas," says Idaho Community Action Network organizer Terri Sterling. "I've seen people with really difficult medical situations leave their families and move to Washington or Oregon... just to get health care."

LIKE GOVERNORS IN OTHER REPUBLICAN-CONTROLLED STATES, IDAHO'S GOVERNOR BUTCH OTTER reiterated his emphatic "no" to Medicaid expansion at the beginning of 2015, stranding over 78,000 Idaho residents in the coverage gap—ineligible for Medicaid absent expansion but with incomes too low for a subsidy to buy insurance. However, an intense enrollment effort by nonprofit and community groups, coupled with Idaho's creation of a state Affordable Care Act (ACA) exchange, *Your Health Idaho,* produced 76,000 enrollees, almost twice the state's initial enrollment projections of 40,000. As a staff person of the Idaho Primary Care Association (IPCA), observed, "IPCA in-person assistors were zealous about their jobs. They were highly motivated to work through complicated determinations of eligibility so that families could get coverage. IPCA's success was linked to our ability to hone in on the uninsured population, because it is the population we see in the clinics and where we have long standing and trusting relationships. IPCA did enrollment in 58 communities, with 250 events touching over 40,000 people."[1]

However, while hard-working advocates produced higher-than-expected enrollment outcomes, data reporting problems emerged. As Idaho legislator John Rusche observed, "all of the enrollment and purchasing was done through healthcare.gov, the federal site. That is why we were dead in the water when enrollments first started. We rapidly built work-arounds, but nothing that allowed us to capture demographics—all that had to go through Healthcare.gov."[2] People who had informal assistance from community volunteers faced different issues. One volunteer recalls his experience helping a middle aged woman enroll: "I wanted to help people and I wanted to see what the system was like and I was surprised at the level of question. This one woman was excited that she was going to get health insurance. The process was long and complicated, they asked about income and tips. She had no documentation about tips and was nervous to answer the questions because she didn't have good documentation. The process was intimidating and she was afraid to mess up because if you made a mistake you had to go back to the beginning and start over."[3]

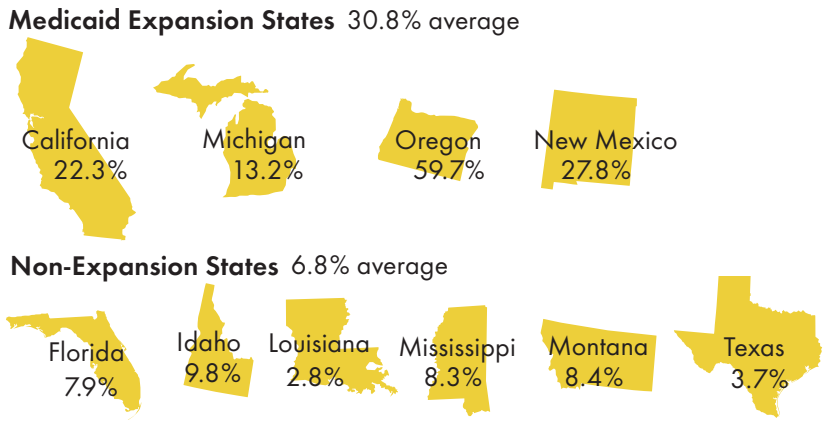
"People are desperate for care, especially in rural areas," says Idaho Community Action Network organizer Terri Sterling. "I've seen people with really difficult medical situations leave their families and move to Washington or Oregon… just to get health care."

Idaho ranks 50th among states in primary care physicians per capita, 46th in per capita income, and 44th in the state's rate of suicides,[4] so the issue of Medicaid expansion looms large. As Delmar Stone, Executive Director of the National Association of Social Workers (NASW) observes, "The legislature has taken an ideological stand against expanding Medicaid. No argument, even

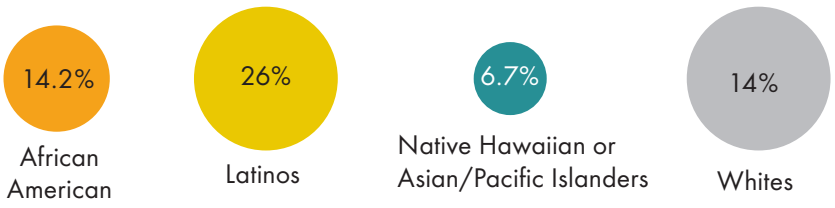
that it will save money, has moved them. The governor put together a good bipartisan board to evaluate Medicaid expansion and make a recommendation for Idaho. The board made recommendations, the biggest of which was to expand Medicaid, but the governor opposed it. No matter how well enrollment has gone, without Medicaid expansion, it is meaningless for thousands of Idahoans."[5]

This report, part of a 10-state study, reviews Idaho's enrollment efforts and consumers' attempts to access health care in the state's low-income communities. The methodology includes key actor interviews with Idaho-based navigators, policy and health care professionals, and advocates, as well as 169 surveys in Spanish and English with low-income community residents at food pantries, health clinics, and homeless service centers. The report compares and contrasts the enrollment and "coverage-to-care" trends shown through the interviews and surveys to reported Idaho outcomes and, when appropriate, to national trends. Analyses of these results serve as the basis for the report's recommendations.

Percentage Medicaid and Chip Enrollment increase from 2013 pre-enrollment to August 2014[6]



Percent uninsured



[W]hile the high enrollment of whites in marketplace insurance programs reflects both the white percentage of the state's population and the high percentage of uninsured whites, the enrollment effort was significantly less successful in Latino communities, where one in four Latinos is uninsured and only 8.7 percent of marketplace enrollees were Latino, and in the African-American community, where 14 percent were uninsured but which comprised only half of 1 percent of marketplace enrollees.

Race/Ethnicity	Percent of state population	Percent of marketplace enrollees (through April 2014)*[7]
African-American	0.8%	0.5%
Native American	1.7%	0.5%
Latino/Hispanic	11.8%	8.7%
White	83.1%	86.5%

* where race/ethnicity is known.

According to the Gallup-Healthways Well-Being Index, the percentage of uninsured Idahoans decreased from 19.9 in 2013 to 15.2 by April 2014. And, despite Idaho's rejection of Medicaid expansion, Medicaid and children's health insurance program (CHIP) enrollment had increased 9.8 percent by July 2014. However, while the high enrollment of whites in marketplace insurance programs reflects both the white percentage of the state's population and the high percentage of uninsured whites, the enrollment effort was significantly less successful in Latino communities, where one in four Latinos is uninsured and only 8.7 percent of marketplace enrollees were Latino, and in the African-American community, where 14 percent were uninsured but which comprised only half of 1 percent of marketplace enrollees.

SURVEY RESPONSES

Chart 1. Medical Coverage

Do you have medical coverage?

Percent Yes

Chart 2. Difficulty of Enrollment

Did you find the enrollment process easy, somewhat difficult, or very difficult?

Race/Ethnicity	Percent who responded somewhat difficult or very difficult
Latino/Hispanic	33%
White	25%

Chart 3. Help with Enrollment

Did anybody help you enroll?

Race/Ethnicity	Percent Yes
Latino/Hispanic	50%
White	38%

Chart 4. Electronic Access

Do you have internet access at home?
Percent with Internet at home

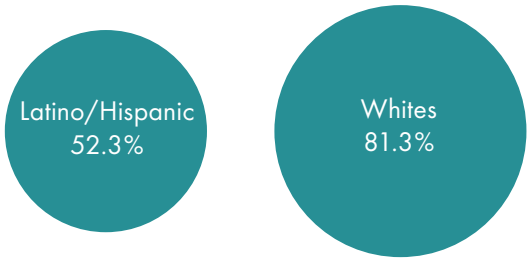


Chart 4a

Do you have an email address?
Percent of respondents who have an email address

Although more Latino survey respondents than white respondents had help in enrolling, 85 percent of whites had insurance coverage – compared to only 55 percent of Latino survey respondents, a difference of 30 percentage points. A number of factors explain this gap, with electronic access being one of the most obvious. While home Internet access is not an absolute prerequisite to enrollment, there was a significant difference between whites who had Internet access at home (81.3 percent) and Latinos who had such access (52.3 percent). And, while home Internet access is not a prerequisite to online enrollment, an email address is. Significantly, 69.1 percent of white survey respondents had an email address – a rate more than double the 34.1 percent for Latino respondents.

Electronic access, however, was not the only barrier; language access played a significant role as well. Although there is now a Spanish language version of the website, initially internet access was only available in English. "And,"recalls one navigator, "if we had a problem with an application and we had to use the federal call center, it was often difficult getting a bi-lingual staff person on the line."[8] In addition, understanding both the medical terminology and the

For Latino applicants, the complicated language was compounded by other factors. Says Delmar Stone of NASW, "Language is a barrier – lack of education, poverty, access to computer and mixed status families all come together to make it difficult for the large Latino population in Idaho to enroll. People were afraid because they might expose undocumented family members and I think many of these families just stayed away."

"I still see a challenge around costs. Take my kids' experience. Billy (her 21-year-old son) could pay $118 a month for his plan – and he still feels like he can't pay. This coupled with the fact that he hasn't had to use insurance also undercuts his motivation to purchase it. Then there is my daughter Wendy who only pays $38 a month. She signed up."

insurance terms was challenging for many new enrollees. As David Chase of the Mountain States Group observed, "this was hard even in English; people who'd never had insurance, or who hadn't in a really long time, didn't understand health insurance lingo and had to be educated."[9] For Latino applicants, the complicated language was compounded by other factors. Says Delmar Stone of NASW, "Language is a barrier – lack of education, poverty, access to computer and mixed status families all come together to make it difficult for the large Latino population in Idaho to enroll. People were afraid because they might expose undocumented family members and I think many of these families just stayed away."[10]

Chart 5. Knowledge of Plan Benefits

Many of these health plans are complicated; do you know which services are included in your coverage and which aren't? (asked of respondents whose first language was not English)

Race/Ethnicity	Percent no
Latino/Hispanic	70%

Chart 6. Knowledge of the Availability of Financial Support

When you enrolled in a health plan, were you informed that financial support was available for low-income people?

Percent Yes

The compound barriers of medical and insurance terminology, having a primary language other than English, and a general lack of experience with medical insurance resulted in 70 percent of respondents who did not speak English not knowing what services they had bought and were paying a monthly premium for. In addition, knowledge about the availability of financial assistance can only be described as thin, with only 54 percent of white survey respondents voicing receipt of this information and an even lower percentage of Latino respondents – 38 percent – saying they were informed about financial support. These responses underscore our earlier point about language, terminology, and cultural barriers but miss another important barrier: cost. As ICAN organizer Terri Sterling points out, "I still see a challenge around costs. Take my kids' experience. Billy (her 21-year-old son) could pay $118 a month for his plan – and he still feels like he can't pay. This coupled with the fact that he hasn't had to use insurance also undercuts his motivation to purchase it. Then there is my daughter Wendy who only pays $38 a month. She signed up."[11]

II. COVERAGE TO CARE

"I personally wasn't able to get coverage before the ACA passed. I was denied because of a gap in coverage and a pre-existing condition. I have money. It is only now that the law has passed that I can get coverage with my pre-existing condition."[12]

Beyond the enrollment question, however, insurance coverage does not necessarily translate into quality care, which includes access to providers, a 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 examine some key issues related to access and treatment.

State of Health

Chart 7

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

Race/Ethnicity	Percentage with chronic conditions by race
Latino/Hispanic	39.2%
White	38.9%

Chart 8

In the last 6 months, did you have an illness, injury or condition that needed care right away?

	Percent Yes
Latino/Hispanic	31%
White	43%

Chronic diseases cause seven of every 10 deaths. In addition, health care costs for an individual with one or more chronic diseases are five times those for an individual without chronic disease.[13] According to the United Health Foundation's health rankings, Idaho has high levels of air pollution, low immunization rates among teens, limited availability of primary care physicians and the 7th highest suicide rate in the country.[14] Thirty-nine percent of both white and Latino survey respondents indicated that they had one or more chronic illnesses (medical conditions that have affected them more than three months) and 43 percent of whites and 31 percent of Latinos indicated that they'd had an urgent condition in the last six months.

General Access to Care

Chart 9

A personal doctor (also called primary care provider) is the one you would regularly see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?

Race/Ethnicity	Percentage with personal doctor
Latino/Hispanic	72.0%
White	89.9%

Chart 10

Where do you go for your primary health care needs?

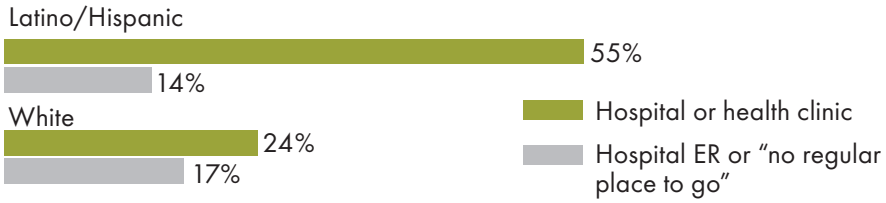


Chart 11

In the last 6 months, did a doctor or other health provider order a blood test, x-ray, or other test for you?

Race/Ethnicity	Percent yes
Latino/Hispanic	70.8%
White	80.8%

Chart 12

When was the last time you saw your doctor or health care provider?

Race/Ethnicity	More than a year ago
Latino/Hispanic	24%
White	15%

Chart 13

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?

Percent sometimes/never

Significantly more whites (90 percent) than Latinos (72 percent) say they have a personal doctor. White survey respondents (24 percent) were significantly less likely than Latinos (55 percent) to use a hospital or health clinic for their health needs, and whites were slightly more likely than Latinos (17 percent versus 14 percent) to use the ER for medical care or to have "no regular place to go." A quarter of Latino respondents (24 percent) reported not having seen a doctor in more than a year (versus only 15 percent of whites) and overall were less likely than whites to have had blood tests or x-rays in the last six months. In ranking their satisfaction with the availability of urgent care, 8.1 percent of whites and 22.2 percent of Latinos reported that they "sometimes or never" got care when they thought they needed it.

As one advocate observes, "just because most of us have coverage we don't really get good care. We have low incomes and it is rural and not many doctors go to these areas. So there still remains a gap in getting the care that you need." The U.S. Department of Health and Human Services has designated all but five of Idaho's counties as primary care Health Professional Shortage Areas. With a major doctor shortage, and many doctors expected to retire in the next five years, Idaho currently ranks 49th in the number of doctors per capita.[15]

As one advocate observes, "just because most of us have coverage we don't really get good care. We have low incomes and it is rural and not many doctors go to these areas. So there still remains a gap in getting the care that you need."

Alternative Health modalities

Chart 14

In the last 6 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?

Percent Never

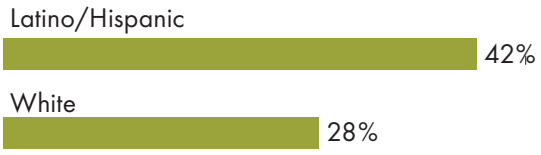


Chart 15

Of the doctors that discussed non-medical methods, how many ONLY discussed diet and/or exercise?

Race/Ethnicity	Percentage of health providers who discussed ONLY diet and/or exercise
Latino/Hispanic	69%
White	62%

Although the ACA makes provision for insurance networks to include alternative modalities, 28 percent of white respondents and 42 percent of Latino respondents did not have a doctor or health provider discuss non-medical modalities like acupuncture, chiropractic care, meditation, diet, or exercise in the last six months.

Significantly, while the percentage of providers who mentioned alternative modalities is relatively small, of those who had the discussions at all over 60 percent limited their mention of alternative medical modalities to the two most common "self-care" practices: diet and exercise.

Chart 16. Extra Costs

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

Race/Ethnicity	Percent who have had to pay extra
Latino/Hispanic	33.3%
White	47.1%

Almost half of white respondents and a third of Latino respondents have had to pay extra for doctor visits or medicines. While this study did not go into depth about the availability of in-network specialists and costs for medications, this question elicited many comments from survey respondents. One middle-aged male respondent in Nampa was disappointed to find that his doctor was "not part of the only network I could afford." Two young unemployed men, one white and one Latino, were adamantly opposed to the insurance mandate. Said the young Latino, "I'm not sick and the insurance would take more than half of my check. I'm not doing it."[16]

Chart 17. Internet Communications for Heath Access

Do you use the Internet to communicate with health providers or your insurance company?

Race/Ethnicity	Percent of those with insurance who use the Internet for health needs
People of Color*	25%
White	55%

* Includes African American, Asian-Pacific Islander, Latino and Native American respondents

The racial differential between whites and people of color who use the Internet to communicate with health providers or their insurance companies was even more acute. One young woman told our surveyors that she "communicated by texts and didn't even know" the email address she'd gotten when she enrolled. Another respondent told us the sign-up process was "too damn complicated. Luckily, my doctor's office makes appointments by phone."[17] While it is not absolutely necessary that new enrollees communicate with providers or insurers via the Internet, the web is an important tool for tax certification of fulfillment of the insurance mandate, reenrollment, and experiments with electronic doctor-patient visits.

SUMMARY OF FINDINGS

Medicaid expansion remains the largest political barrier to enrollment in Idaho. Despite problems with the website, Idaho community and advocacy organizations launched significant outreach efforts and were able to exceed the state's enrollment goals. However, with an estimated 78,000 people in the coverage gap, the single biggest barrier to enrolling low-income people in the state is the rejection by the governor and legislature of Medicaid expansion.

Enrollment data reflect racial disparities. Whites comprise 83.1 percent of the state's population and 86.5 percent of those enrolled through the marketplace. One in four Latinos are uninsured and Latinos make up 11.8 percent of the state population, but 8.7 percent of those enrolled through the marketplace were Latino. The African-American community also has a lower rate of enrollment than their share in the total state population. A number of factors account for these outcomes: **1) The digital divide,** evidenced by the fact that white survey respondents communicate electronically with insurers or health providers at more than twice the rate of people of color; whites are twice as likely to have an email address and more than 1 and a half times as likely to have Internet access at home; **2) Legal, language, and cultural barriers:** the combination of limited language access, fear of legal reprisals for mixed-status families, and lack of familiarity with culturally-specific insurance and medical terms add up to significant obstacles to enrollment.

The shortage of health care providers could exacerbate the problem of limited health access in the near future. Increasing the number of people with medical insurance without expanding the health care infrastructure could lead to difficulties in obtaining care—particularly for new enrollees.

Pathways to alternative health modalities are highly limited, with just over half of doctors talking with patients about non-medical approaches to health. When doctors do mention alternatives, 65 percent of the time the emphasis is on the standard patient self-help recommendations—diet and exercise.

Premium costs. Although this study did not focus on premium costs, it is significant that our inquiries about extra costs elicited many comments about the high costs for insurance premiums.

To improve enrollment and care options, we recommend the following:

I. SAFEGUARDING ACCESS TO HEALTH INSURANCE

Increase enrollment and federal funding by expanding Medicaid. We concur with the recent recommendation (February 6, 2015) of the Governor's Work group on Medicaid to expand Medicaid, thereby insuring 78,000 Idahoans who are in the coverage gap and saving the state $173 million over ten years.[18]

Target for enrollment low-income residents already enrolled in income-based programs. The state should immediately increase low-income health insurance enrollment by automatically enrolling in Medicaid people who already receive need-based benefits like SNAP (food stamps),

Supplemental Security Income (SSI), WIC, or free or reduced-price school meals, as well as people released from incarceration with no immediate source of income or assets.

Ensure complete multilingual application materials and website access. Multilingual application materials and website access are not readily available. To address these issues, Idaho should establish a right to enroll in health coverage in the enrollee's primary language. Implementing this policy would require multilingual applications, literature, websites, and interpreters, consistent with the requirement in § 1311(i)(3)(E) of the Act to "provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges." The state should require plans to give enrollees notice of their right to language services, as California does (Cal. Code Regs. tit. 10 § 2538.3), and regularly assess plans' compliance with language access requirements, as New York mandates (N.Y. Pub. Health Law § 4403). Idaho 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.

Simplify the insurance-shopping experience and keep provider information current. The state should simplify print and electronic descriptions of plans and benefits, especially deductibles, co-pays, preventive services available at no cost, and the significance of providers being in- or out-of-network, making costs transparent and ensuring easy comparison of services available with no co-pay. It should also require plans to continually update information about which providers are in their networks.

Make faster decisions on enrollment applications. 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 community health outreach workers. 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 an acclimation. Navigators are in an ideal position to perform this role. The state should extend the role of outreach workers 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. Idaho 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. The state should impose penalties, including exclusion from the exchange, against plans that do not succeed in reducing disparities within established target timeframes.

Require plans to include in their networks at least one full-time primary care provider for every 2,000 patients and ensure that enrollees are able to make appointments with their primary care providers within 10 business days of seeking an appointment.

Increase payment rates to primary care physicians. Federal support for increased Medicaid payment levels ended on Dec. 31, 2014. Since payment levels strongly affect providers' willingness to see Medicaid patients, Idaho should use state funds to continue Medicare-level payments to primary care physicians who serve Medicaid beneficiaries as a number of states plan to do.

Require that new enrollees have the opportunity for a free physical exam and appropriate screening tests within 60 days of enrollment.

Require plans to adopt geographic access standards ensuring that, for at least 90 percent of enrollees, primary care providers are available within 10 miles or 30 minutes average driving or public transit time and specialists within 45 miles or one hour, whichever is less, as New Jersey does (N.J. Admin. Code § 11:24A–4.10). Enrollees who live farther from providers should be offered free transportation.

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.

Expand and standardize preventive services, ensuring that non-grandfathered plans offer preventive 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.

Require plans to track health outcomes, disaggregated by race, ethnicity, primary language, gender, disability, and sexual orientation.

III. BUILDING AN INFRASTRUCTURE TO PROMOTE PREVENTIVE HEALTH CARE

Offer incentives to plans that adopt a broad view of health benefits and tackle underlying social determinants of health. Idaho is a poor state with 15.5 percent of its residents living in poverty. 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 low-income rural communities.

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 10 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 school-based health centers. Seek funds from HHS' Health Resources and Services Administration or use state funds to expand school-based health centers, especially in medically-underserved communities (where 16.7 percent of state residents reside), to mitigate the lack of other health care options (Section 4101 of the ACA, 42 U.S.C. § 280h-4).

ENDNOTES

1. Interview with AJS staff, May 2014.

2. Interview with AJS staff, May 2014.

3. Interview with AJS staff, June 2014.

4. America's Health Rankings, United Health Foundation, accessed at: http://www.americashealthrankings.org/ID.

5. Interview with AJS Staff, June 2014.

6. "Medicaid & CHIP: August 2014 Monthly Applications, Eligibility Determinations and Enrollment Report," U.S. Department of Health & Human Services, October 17, 2014 (Table 1: Medicaid and CHIP: July and August 2014 Preliminary Monthly Enrollment), accessed at: http://medicaid.gov/medicaid-chip-program-information/program-information/downloads/august-2014-enrollment-report.pdf.

7. "Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period," U.S. Department of Health & Human Services, May 1, 2014 (Appendix Table C3: Distribution of Individuals Who Selected a Marketplace Plan through the FFM, by State and by Race/Ethnicity, 10-1-2013 to 3-31-14), accessed at: http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf.

8. Interview with AJS staff, May 2014.

9. Interview with AJS staff, May 2014.

10. Interview with AJS staff, June 2014.

11. Interview with AJS staff, May 2014.

12. Interview with AJS staff, June 2014.

13. "The Impact of Chronic Disease on Healthcare," Partnership for Solutions, accessed at: http://www.forahealthieramerica.com/ds/impact-of-chronic-disease.html.

14. America's Health Rankings, United Health Foundation, accessed at: http://www.americashealthrankings.org/ID.

15. Emilie Saunders, "Why Idaho's Doctor Shortage Won't be Easy to Solve," StateImpact Idaho, October 2, 2012, accessed at: http://stateimpact.npr.org/idaho/2012/10/02/why-idahos-doctor-shortage-wont-be-easy-to-solve/.

16. Conversation with author, June 2014.

17. Conversation with author, June 2014.

18. Bill Dentzer, "Governor's panel again urges Medicaid expansion in Idaho," Idaho Statesman, February 6, 2015, accessed at: http://www.idahostatesman.com/2015/02/06/3631140_governors-panel-again-urges-medicaid.html?rh=1.