

# Addressing Structural Racism: A study of efforts to promote health insurance coverage and improve racial equity

## Mathematica

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A report for the [Robert Wood Johnson Foundation](#)

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# Executive Summary



# Executive Summary

## Introduction

RWJF has invested in multiple organizations and initiatives to support outreach and enrollment into Marketplace and Medicaid/CHIP health insurance plans since the start of the [Affordable Care Act](#) (ACA). For example, it has provided technical assistance to states to help them develop their Marketplaces and funded national and local partners to support outreach and enrollment efforts on the ground.

## Partners

RWJF's primary funded partners operate at a national level and include [Community Catalyst](#), [Young Invincibles](#), [Georgetown's Center on Health Insurance Reforms \(CHIR\)](#), and the [Center on Budget and Policy Priorities](#). These funded partners provide extensive training and technical assistance to state and local Navigators and outreach and enrollment assisters. In addition, Community Catalyst subcontracts with and supports community-based organizations to extend enrollment efforts, while Young Invincibles forms extensive coalition partnerships.

## RWJF's focus on health and racial equity

Despite federal support for affordable public and private health insurance options, historical inequities in access to health insurance coverage, which are grounded in systematic and structural racism, present challenges to enrollment for under-resourced and marginalized communities. RWJF is keenly interested in addressing racial equity and how its investments can support an equitable approach to enrollment by helping those who face the greatest barriers to coverage and the greatest effects of structural racism.

## Mathematica role

RWJF contracted with Mathematica and our three community partners to conduct a series of data collection and analysis activities—including key informant interviews, a network survey, and consumer focus groups—to evaluate RWJF's funded partners' efforts and provide insight on consumers' experiences during the 2022 Affordable Care Act (ACA) Marketplace open enrollment period (i.e., OEP 9). Findings in this document build upon previous Mathematica evaluations (for example, Mathematica's [2014-2016 evaluation of Enroll America](#)) of RWJF-funded investments from 2014 through 2019.

# Methods and data sources

## To establish a foundation for the evaluation, we:

1. Systematically reviewed materials provided by RWJF and its funded partners in 2021 to understand current and proposed outreach and enrollment activities and funded partners' approaches to improving racial equity in health insurance coverage.
2. Conducted calls with RWJF's four funded partners to learn more about their goals, planned activities, and partners.
3. Completed semi-structured interviews with 35 key informants, coordinated 11 focus groups with 100 consumers, and analyzed network survey data from 20 respondents.

We followed principles of equitable evaluation for our data collection. For more details on our analysis methods, please see the Appendix.

# Acronyms

<b>ACA</b> Affordable Care Act	<b>ARPA</b> American Rescue Plan Act	<b>CHIP</b> Children's Health Insurance Program	<b>CPO</b> Community power organization	<b>KII</b> Key Informant Interview
<b>LGBTQ+</b> Lesbian, Gay, Bisexual, Transgender, Queer	<b>OE</b> Outreach and enrollment	<b>OEP</b> Open enrollment period	<b>RWJF</b> Robert Wood Johnson Foundation	<b>SEP</b> Special enrollment period



# Context: RWJF's commitment to supporting OE spans many years and focuses on dismantling structural racism and improving health equity

**Affordable Care Act passes (2010)**

When the Affordable Care Act passed, the initial challenge was to build up the nationwide OE infrastructure to identify the uninsured and motivate them to enroll in coverage. RWJF supported the State Network technical assistance program to help states develop their Marketplaces. The foundation was also an early and major funder of Enroll America, a nonprofit organization dedicated to maximizing the number of Americans who enroll in and retain health coverage under the ACA.

**Enroll America (2011 – 2017)**

RWJF never intended to fund Enroll America in perpetuity, so the organization intentionally worked to institutionalize practices and train partners so that the efforts would sustain themselves once RWJF's funding for Enroll America ended. For example, Young Invincibles continued to lead a national OE coalition and supported the Get Covered Connector, an online enrollment appointment scheduling tool.

**Threats to enrollment progress (2017 – 2020)**

Beginning in 2017, the Trump administration made major cuts to OE activities, including cutting \$114 million from Navigator grants and the federal advertising budget, decreasing the length of the open enrollment period (OEP) from 90 to 45 days, providing confusing or mixed messaging around public charge, and repealing the individual mandate.

**New phase of RWJF funding (2017 - present)**

To combat the threats to enrollment, RWJF launched a new phase of funding and supported four primary partners (Community Catalyst, Center on Budget and Policy Priorities, Young Invincibles, and Georgetown's Center on Health Insurance Reforms (CHIR)) to help shore up the enrollment infrastructure. Primary activities include direct consumer outreach and education; education and training for Navigators and assisters; and maintenance of the OE infrastructure.

**COVID-19 era (2020 – present)**

The Biden administration recently allocated \$98.9 million to Navigators for the upcoming 2023 OEP. We are now learning lessons about the results of the pandemic on OE and how groups are connecting with individuals during a public health emergency.



## What we learned

### 1 Which consumer groups are under-resourced and historically more challenging to reach and why?

Funded partners indicate that historically underrepresented and under-resourced groups, including but not limited to African American, immigrant, and LGBTQ+ communities and individuals who are unemployed, require innovative strategies to reach and enroll into health insurance, similar to previous OEPs. Reasons include historical and lived experiences with discrimination in health care settings, mistrust of health care systems or government programs, and lack of awareness about health insurance.

### 2 What factors support outreach and enrollment to under-resourced groups? What factors hinder outreach and enrollment to under-resourced groups?

Partners cited trust as a critical factor to facilitating outreach and enrollment (OE); they reported health insurance literacy, public misinformation, and structural barriers are the primary barriers. Funded partners build trust by hiring within the community, hosting or attending in-person meetings, cultural events, and other community-based events, collaborating with neighborhood businesses, and incorporating a culturally competent and intersectional approach in OE activities that recognizes that consumers' identities are multi-faceted.

### 3 How did COVID-19 influence outreach and enrollment?

Despite record-setting enrollment during the 2022 OEP, COVID-19 influenced OE through higher turnover and burnout in the Navigator and assister community and fewer requests for in-person assistance. However, it also created opportunities for innovation such as a greater reliance on texting and some communities became more interested in learning about coverage.

### 4 What added value do community power organizations (CPOs) bring to outreach and enrollment efforts?

CPOs serve as trusted messengers to communities and help elevate community voice and lived experience. CPOs can play an important role in promoting health insurance by connecting with people about other topics and services they work on—like food access—and using this as a starting point to ask about health coverage.

### 5 How does structural racism manifest, and how have funded partners improved racial equity in outreach and enrollment?

Structural racism manifests in biased medical treatment, unequal access to care and administrative burden, lack of information and translation services, and through disparities in social determinants of health, such as housing, employment, and health insurance literacy. Improving racial equity in OE requires broader systemic action, such as supporting policy change and addressing structural racism and discrimination in health care.

### 6 To what extent do funded and subcontracted partners measure their success and incorporate equity measures into their monitoring efforts?

OE partners are not consistently measuring their efforts, making it difficult to assess their contributions. OE partners vary in whether and how they measure their OE efforts, making it challenging to understand what activities work, what activities could be replicated, and what activities are ineffective.

### 7 What types of organizations are conducting outreach and enrollment in selected communities, and how do they work together?

OE is embedded in larger nonprofit organizations that have been doing OE work for many years; these groups reported working with a handful of trusted partners.



## What role should funders of outreach and enrollment work play in the consumer assistance landscape in the future?

### Build on success – RWJF's current investments are filling a gap and add substantial value to the current OE ecosystem:

- Continue supporting current funded partners. These organizations are engaged and have demonstrated flexibility and ingenuity despite historical threats to enrollment.
- Continue investing in high-quality communications materials that are representative and inclusive, help spread awareness about health insurance, and help consumer groups see themselves in outreach materials.
- Continue investing in high-quality resources and training, which helps new Navigators and assister organizations get up to speed, especially as this workforce has seen significant turnover.
- Continue supporting CPOs to engage in OE activities to bring awareness of enrollment options and support to new communities; encouraging funded partners and CPOs to engage in participatory strategic planning would further align OE activities with communities' needs.

### Build capacity and trust – Funders could bring greater stability to the OE community by:

- Implementing long-term funding arrangements that allow communities to identify, implement and sustain solutions at a local level.
- Convening funded and subcontracted partners, including CPOs, to explore, discuss, and learn about community needs, data sources on health inequities, challenges and strategies for reaching under-resourced communities, and domains of structural racism.
- Investing in coalition-building at the local level to engage communities and spread best practices.

### Dismantle structural racism – To center OE work in dismantling structural racism, funders could:

- Invest in monitoring, evaluation, and learning activities to understand the outcomes from their investments with a health equity lens and move the field forward. This could involve providing resources to fund an equity TA provider to support OE grantees.
- Collaborate to identify, summarize, and disseminate promising practices for OE communication with communities of color and other under-resourced groups, such as developing strategies for non-English speaking, racial, ethnic and gender minority groups, and developing promising practice guides using insights from partners' OE success.
- Invest in efforts to identify how domains of structural racism (i.e., structural racism in housing, employment, medical treatment and care, among others) manifest in communities and strategically plan for how to address it and/or support consumers facing it.
- Support holistic wrap-around services and advocacy to address root causes of inequities, such as enhanced health literacy education, medical language translation, and housing and employment supports.
- Require funded partners to obtain and use data on inequities to identify communities with the largest uninsured rates and to plan outreach efforts accordingly including investing in new partners, if needed.
- Support funded partners in efforts to measure and report OE staffing levels, activities and contacts conducted by staff, and the number of enrollments completed (if applicable), including data on racial, ethnic, and language composition.



# Putting findings in the context of prior evaluations of RWJF investments

Key findings from this study reflect consistencies with prior evaluations and indicate new evaluation findings from the field:



## What is the same?

- **Trust is an essential component in OE work.** Across evaluations, key informants confirmed the importance of building trust with consumers and offering one-on-one enrollment assistance.
- **Federal policy plays a crucial role in facilitating or hindering enrollment.** Policy changes have affected consumers' ability to enroll and partners' capacity to assist under-resourced communities. For example, the American Rescue Plan Act (ARPA) subsidies enhanced insurance affordability for consumers, whereas cuts to Navigator funding in prior OEPs curtailed enrollment assistance.
- **Health literacy education is a key to assisting consumers.** Newly enrolled consumers continue to benefit from education on health insurance literacy, including how to use their insurance to access care.
- **Partners recognized the need for accessible and consumer-friendly communications.** Partners recognize the value of translated and representational materials that reflect the diverse and intersectional communities they serve.



## What is new?

- **CPOs' linkages to communities can facilitate success.** Because they are trusted messengers, CPOs can play an important role in promoting health insurance and will require additional training and onboarding.
- **Structural racism manifests before and after enrollment.** Many consumers face barriers in access to information and health insurance literacy. Despite health insurance options, many consumers lack access to care, which discourages enrollment.
- **COVID-19 created challenges and opportunities.** COVID-19 led to fewer in-person appointments and affected assister staffing levels, but also expanded the use of virtual enrollment appointments and the use of text messaging to communicate effectively and quickly with consumers.
- **OE network partnerships have diminished over time.** Time and resource constraints, among other factors, have affected and reduced partnership collaborations.

## Purpose

This slide document provides summary data on funded partners' efforts and experiences during the ninth annual Open Enrollment Period (OEP) in three communities of interest (Newark, NJ; Greater Detroit, MI, and Broward County/Fort Lauderdale, FL). We also describe the value add of community power organizations (CPOs) for local OE efforts.



## Document Organization

- **Section 1** provides context for RWJF's evaluation of health insurance enrollment efforts and findings from prior Mathematica evaluations.
- **Section 2** presents the learning questions and methods.
- **Section 3** summarizes findings on primary populations of interest, CPOs, challenges and facilitators to enrollment, structural racism, and how organizations are connected in the OE ecosystem.
- **Section 4** cross-walks learning questions, findings, and recommendations for funders of outreach and enrollment work.
- **Appendix** includes interview and focus group topics, information on data analysis, and a glossary.



# I. Introduction





# Introduction



## RWJF supports Marketplace and Medicaid outreach and enrollment.

The Robert Wood Johnson Foundation (RWJF) has a long history of investing in national organizations, known as funded partners, to support Affordable Care Act (ACA) and Medicaid and CHIP outreach and enrollment (OE) efforts for under-resourced communities. RWJF is particularly interested in supporting efforts that reduce racial and health inequities and address systemic racism.



## Funded partners support “boots on the ground.”

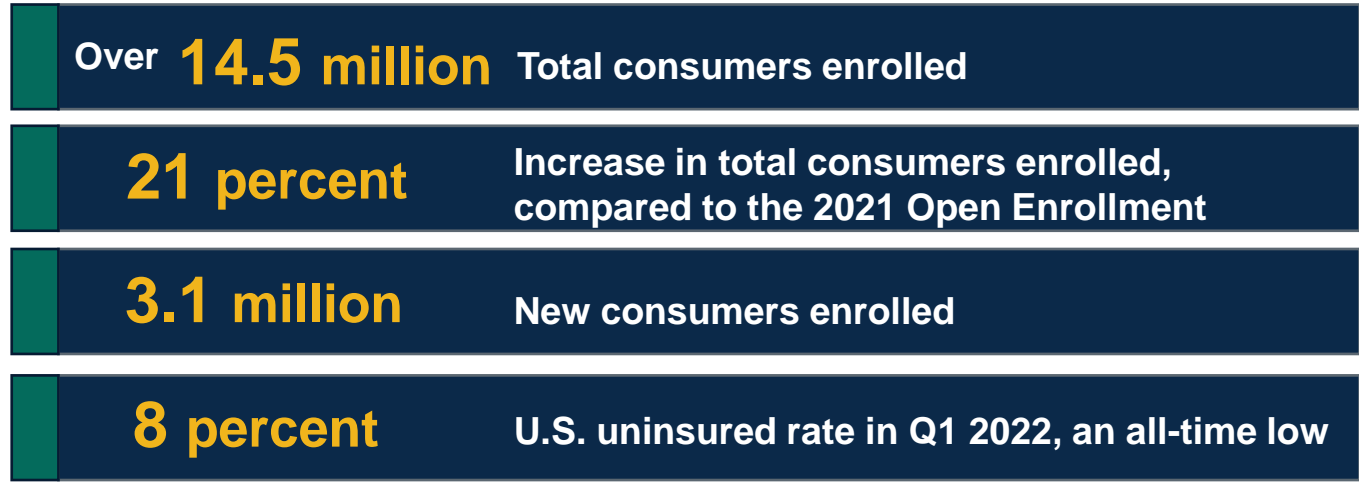
RWJF’s funded partners collaborate with local grantees and Community Power Organizations (CPOs) that interface with communities to connect, educate and assist uninsured individuals and families with enrollment into applicable health insurance programs. Many of these organizations focus on historically underrepresented populations and communities where inequities persist.



## Mathematica evaluates funded partners’ efforts.

RWJF is keenly interested in whether and how funded partners are working to advance their outreach and enrollment goals and address racial and health equity. RWJF contracted with Mathematica to evaluate the efforts of four of its funded partners during the ninth open enrollment season, November 1, 2021 to January 15, 2022.

# 2022 Open Enrollment At-A-Glance<sup>1,2</sup>



## RWJF primary funded partners included in this evaluation

Funded Partner	Activities
<a href="#">Community Catalyst</a>	Contracts with state and national organizations, including community-organizing groups that have reach into communities with high numbers of uninsured individuals, to advance an equitable approach to increasing enrollment in both Medicaid and Marketplace health coverage.
<a href="#">Center on Budget and Policy Priorities</a>	Provide training and support to consumer assisters to help them maximize the number of people they enroll and re-enroll in health coverage
<a href="#">Young Invincibles</a>	Support activities to maximize affordable, comprehensive health coverage and connect the most underserved communities to expert, impartial enrollment help
<a href="#">Georgetown's Center on Health Insurance Reforms (CHIR)</a>	Provide rapid-response policy analysis for health care stakeholders and updating the Navigator Guide for enrollment in 2021



**Context: RWJF's commitment to supporting OE spans many years and focuses on dismantling structural racism and improving health equity**

**Affordable Care Act passes (2010)**

When the Affordable Care Act passed, the initial challenge was to build up the nationwide OE infrastructure to identify the uninsured and motivate them to enroll in coverage. RWJF supported the State Network technical assistance program to help states develop their Marketplaces. The foundation was also an early and major funder of Enroll America, a nonprofit organization dedicated to maximizing the number of Americans who enroll in and retain health coverage under the ACA.

**Enroll America (2011 – 2017)**

RWJF never intended to fund Enroll America in perpetuity, so the organization intentionally worked to institutionalize practices and train partners so that the efforts would sustain themselves once RWJF's funding for Enroll America ended. For example, Young Invincibles continued to lead a national OE coalition and supported the Get Covered Connector, an online enrollment appointment scheduling tool.

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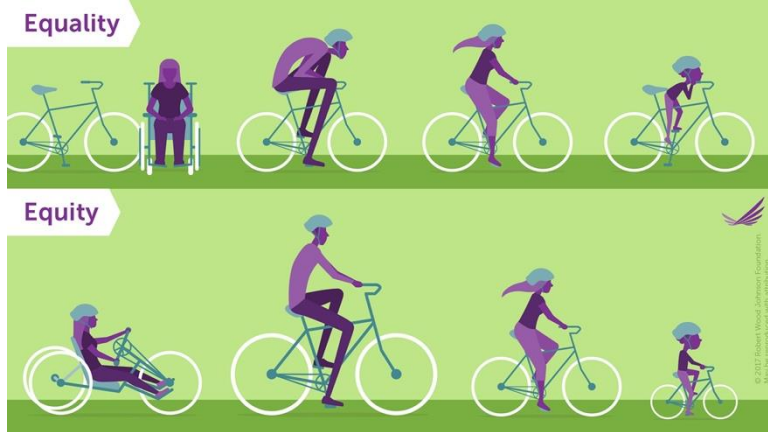
**New phase of RWJF funding (2017 - present)**

To combat the threats to enrollment, RWJF launched a new phase of funding and supported four primary partners (Community Catalyst, Center on Budget and Policy Priorities, Young Invincibles, and Georgetown's Center on Health Insurance Reforms (CHIR)) to help shore up the enrollment infrastructure. Primary activities include direct consumer outreach and education; education and training for Navigators and assisters; and maintenance of the OE infrastructure.

**COVID-19 era (2020 – present)**

The Biden administration recently allocated \$98.9 million to Navigators for the upcoming 2023 OEP. We are now learning lessons about the results of the pandemic on OE and how groups are connecting with individuals during a public health emergency.

**RWJF's focus on dismantling structural racism and improving health equity**



**RWJF is committed to addressing structural racism and reducing inequities in health and health outcomes through their philanthropic support.**

As part of RWJF's current investment in Marketplace and Medicaid/Children's Health Insurance Program (CHIP) health insurance OE, the foundation is interested in how its funded partners' efforts can help dismantle structural racism, which detrimentally affects the economic and health status of individuals and communities. Funded partners can address inequities by focusing on uninsured community members who face the greatest barriers to coverage, such as individuals with mixed immigration status, people of color, English language learners, and members of the LGBTQ+ community, among others. Many of these under-resourced communities lack access to safe and pollution-free neighborhoods, affordable and accessible housing, high quality schools, and affordable, quality health care.



## We reviewed Mathematica's prior evaluations of RWJF's OE investments and identified consistent themes and persistent challenges

### Consistent themes

- Grassroots outreach that emphasizes one-on-one conversations with consumers is effective.
- Partnerships are critical to the work because consumers within their specific communities trust them.
- RWJF's support for developing communication materials such as sample social media posts and handouts that can be distributed has played a vital role in supporting OE; the need for tested, tailored, consistent messaging remains large.
- There remains an ongoing need for resources to support the OE infrastructure, including Navigator and assister salaries, training, and materials.

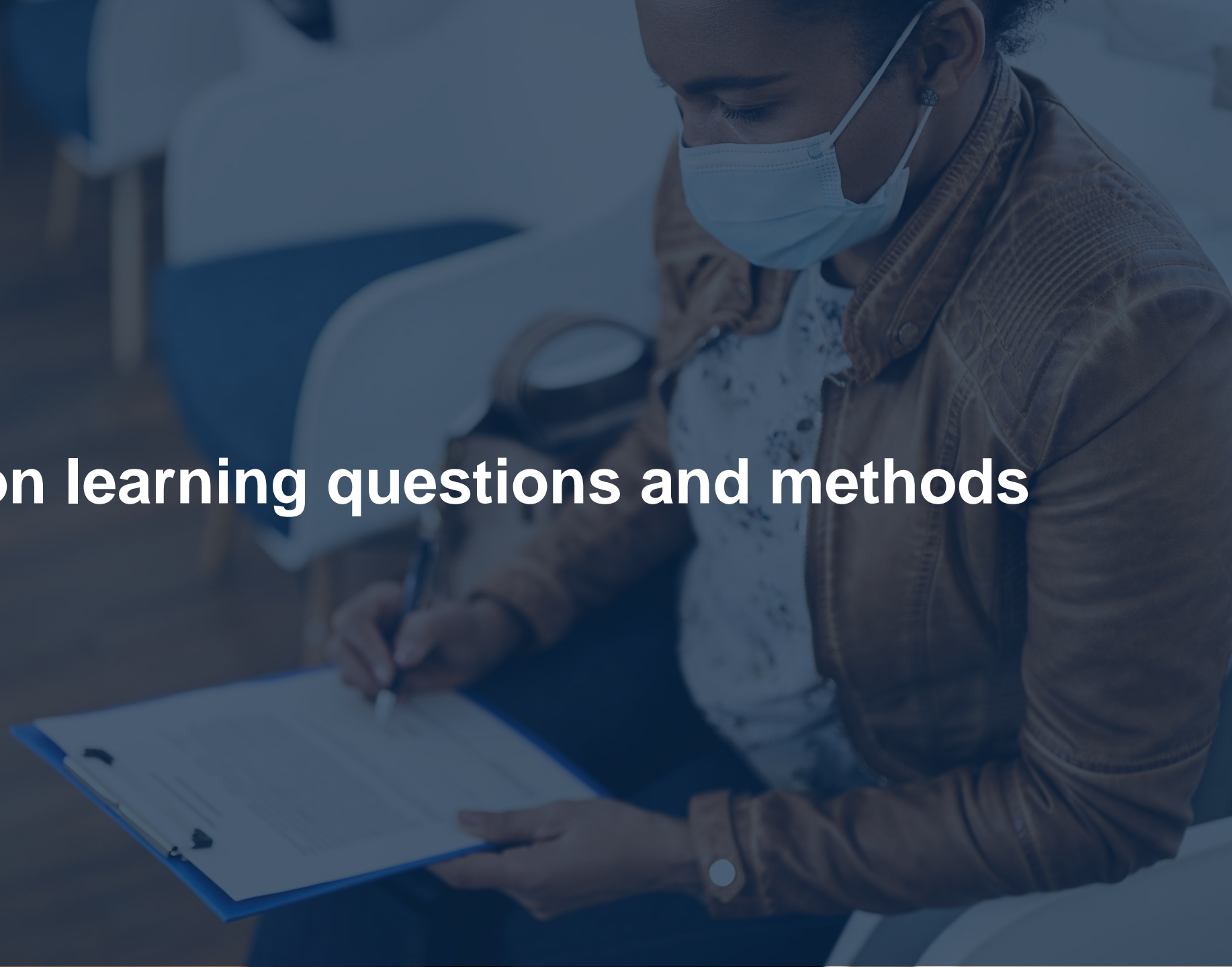
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### Persistent Challenges

- Staffing has been a persistent issue because of the small pool of candidates applying to OE positions and low salaries offered.
- Confusing and inconsistent messaging, as well as changing policy context around eligibility for public programs, have consistently created a chilling effect, especially for immigrant families.
- Some of the of the newly enrolled consumers have low health insurance literacy and thus would benefit from education on health insurance concepts such as networks, premiums, deductibles, and how to access care in order to fully realize their insurance benefits.



## II. Evaluation learning questions and methods





# Learning questions sought to understand RWJF’s funded partners’ efforts to promote enrollment and improve racial equity during the most recent OEP

- 1 Which consumer groups are under-resourced and historically more challenging to reach and enroll in health insurance, and why?
- 2 What factors support outreach and enrollment to under-resourced groups? What factors hinder outreach and enrollment to under-resourced groups?
- 3 How did COVID-19 influence outreach and enrollment?
- 4 What added value do community power organizations bring to outreach and enrollment efforts?
- 5 How does structural racism manifest, and how have funded partners improved racial equity in outreach and enrollment?
- 6 To what extent do funded and subcontracted partners measure their success and incorporate equity measures into their monitoring efforts?
- 7 What types of organizations are conducting outreach and enrollment in selected communities, and how do they work together?

## Methods and data sources

To establish a foundation for the evaluation, we:

1. Systematically reviewed materials provided by RWJF and its funded partners to understand current and proposed OE activities and funded partners’ approaches to improving racial equity in health insurance coverage.
2. Conducted calls with RWJF’s four funded partners to learn more about their goals, planned activities, and partners.

These initial activities informed the remainder of our data collection. We followed principles of equitable evaluation and received expedited IRB approval for the three pillars of data collection described in more detail below. For more details on our analysis methods, please see the Appendix.

	Key Informant Interviews	Focus groups	Survey
<b>Number of respondents</b>	35	100 <ul style="list-style-type: none"> <li>• 30 from Newark, NJ</li> <li>• 31 from Detroit, MI</li> <li>• 39 from Broward County, FL</li> </ul>	20 respondents (18.0% response rate) <ul style="list-style-type: none"> <li>• 9 from Newark, NJ</li> <li>• 6 from Detroit, MI</li> <li>• 5 from Broward County, FL</li> </ul>
<b>Instruments</b>	Semi-structured interview protocols covering topics such as barriers to enrollment, group-specific outreach strategies, and roles for CPOs	Semi-structured focus group protocols covering topics such as consumers’ experiences with receiving assistance, applying for health insurance, and personal experiences with structural racism or barriers to enrollment	Network survey covered topics such as characteristics of the organizations conducting OE, their activities, and how the organizations collaborate within their local communities
<b>Recruitment</b>	We recruited respondents from organizations that conduct OE in three communities of focus (Newark, NJ; Detroit, MI; and Broward County, FL), as well as respondents from RWJF funded partners with a national scope	Evaluation partners recruited and conducted 11 focus groups in the three communities of focus. Focus group participants included respondents who were insured and uninsured	We asked KIIs to refer us to potential survey respondents, but we received fewer referrals than expected. To supplement our sample, we conducted internet searches to identify organizations and individuals conducting OE in the three communities of focus
<b>Incentive payments</b>	\$100	\$25 to \$100*	\$25
<b>Timeline</b>	Conducted two rounds of semi-structured interviews from March 1, 2022, to June 28, 2022	April 13, 2022, to June 30, 2022	The survey was open from April 29, 2022, to June 3, 2022

\*Focus group respondents were recruited via outreach. Those who responded and were screened received \$25. Those who responded, were screened-in, and participated received \$100 total compensation.



## Limitations



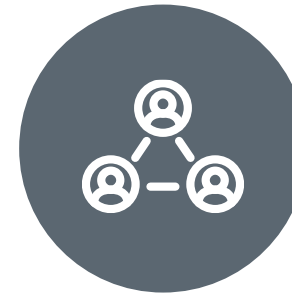
Our study and data collection was limited to three communities and may not be broadly generalizable



Although we asked primary partners and their subcontracted organizations about their commitment to equity, we did not systematically collect data about their equity plans at the organizational or program level.



Because of our study design, we did not gather data on consumers' satisfaction with RWJF funded partners or data on partners' direct engagement with consumers.



We had a lower survey response rate than expected. As a result, we were not able to capture the experience of as many organizations as we had hoped and thus were unable to create a network map.



### **III. Key Findings**



# 1. Which consumer groups are under-resourced and historically more challenging to reach and enroll in health insurance and why?

## Hard-to-reach groups

## Challenges to outreach and enrollment

### Racial, ethnic, and cultural minority groups

- African American communities
- Latinx, Native American and Tribal communities
- Central American, Haitian, Chinese and Thai communities

Historical and lived experiences with discrimination in health care settings, cultural mistrust, language translation, stigma associated with Medicaid or public support, and low health insurance literacy

### Immigrants and Latinx cultural groups

- People who work in seasonal roles
- Families with mixed immigration statuses
- Individuals with temporary visa status

Fear of legal repercussions, misinformation about the public charge rule, lack of time to seek medical care, language translation, and skepticism of government system (for example, sharing Social Security numbers or personal information with government)

### Intersectional and other under-resourced groups

- People who identify as LGBTQ+
- People affected by domestic violence or intimate partner violence
- People who were formerly incarcerated
- People experiencing homelessness or unstable housing

Mistrust due to previous negative experiences with health care system, concerns related to privacy, inconsistent residency status, lack of connections to health and human service systems

### Young, healthy and uninsured

- People working in the service industry
- Young people, including those with COVID
- Individuals who are unemployed

Low health insurance literacy, including awareness of health insurance options, affordability, or need

## Trust matters

*There's a lot of factors making people hesitant to engage in health care. A lot of clients told me they don't want insurance because of discrimination. They feel people look at them weird [in hospitals or doctors' offices]. They would prefer to treat themselves and avoid people looking at them in public.*

- KII respondent, Michigan





## 2. What factors support outreach and enrollment to under-resourced groups? (1)

**Nearly all key informant interview (KII) respondents mentioned “trust” as an important component of conducting outreach and enrollment in under-resourced communities.**

Trusted sources are successful in connecting Navigators to communities. Building trust with communities and individuals was vital to successful outreach and enrollment activities. Vulnerable consumers, especially those who face discrimination or mistreatment by the health care system, can be wary of receiving advice from those viewed as outsiders.

**How do funded partners build trust?**

- *“Start from the community. Don’t try to come in from outside. Try to build capacity within the community, with Navigators, assistors, intermediaries who are of the community they’re being asked to serve. National groups can have an important role to play in being the policy translators... But the real work has to be done in the community, by trusted partners.”*  
–KII respondent, national organization
- *“We try to hire within the community...people want whoever is helping them to be somebody familiar with their face, who knows their street, who might even know their high school...before they give you their social [security number].”*  
– KII respondent, Florida

**Policy changes**

- Increased and expanded marketplace subsidies provided by the American Rescue Plan Act (ARPA) improved affordability of enrollment and brought new consumers to the marketplace. One respondent suggested that the improved affordability of the marketplace plans played a significant role in the increased enrollment seen in the 2022 OE period.
- Special Enrollment Periods (SEPs) allowed for increased flexibility to enroll outside of the traditional OE period. Offering SEPs throughout the year allowed consumers more flexibility and convenience in accessing health insurance.

*Before ARPA, the ecosystem was threadbare, stripped of a lot of its resources. Now, we’re in a rebuilding phase with extending premium tax credits. “People came in [to enroll] last year because they could afford it for the first time.”*  
– KII respondent, national organization

**Guidance, motivation and support from informal sources**

- Most participants of the NJ-based consumer focus group accessed health insurance through word of mouth or self-referral. Participants in this focus group received enrollment assistance from informal sources such as family members who either directed them to resources like the Medicaid office or their primary care physician, or directly assisted them with the enrollment process. Few received enrollment assistance from Navigators or other outreach and enrollment staff. However, several participants pointed out that one-on-one enrollment support would have been helpful in navigating the process.
- Most focus group participants across all locations noted a general need for health care access, as well as a need for financial support with medical costs, as the main motivators for seeking health insurance.

*“Families are our number one recruiters and disseminators of information.”*  
– KII respondent, Florida

*“Navigating through the website is just so difficult, so difficult, so I felt the right thing to do would be to meet with my friend who broke down the necessary details.”*  
– Focus group participant, New Jersey

**Navigator assistance**

- Respondents highlighted the importance of in-person assistance in building trust with consumers and leading to more successful enrollment, since consumers can experience confusion and frustration with the enrollment platform.
- Several respondents mentioned the importance of meeting individuals and communities where they are.
- Emphasizing the organization’s history in the community and dedication to friends and family members can be helpful.

*“We’re here for you. Four years ago, we helped your mom, now we’re here for you.”*  
– KII respondent, Florida

*“You have to get out there, you have to do outreach in communities that already might not trust you. They’re certainly not going to get on a zoom call with you. It’s a personal activity.”*  
– KII respondent (assister), Florida



## 2. What factors support outreach and enrollment to under-resourced groups? (2)

**To address barriers, outreach and enrollment organizations should focus on building trust and tapping into existing community structures.**

**KII respondents shared ideas for how outreach and enrollment organizations can engage under-resourced communities and support them in overcoming barriers to enrollment. For example, they could:**

- Foster trust with the community through relationship building and trusted messengers.
- Host or attend in-person meetings, cultural events, back to school fairs, and other community-based events.
- Conduct on-the-spot enrollment services, especially for homeless communities.
- Collaborate with neighborhood businesses (for example, salons/barbershops) and with other established “safe spaces” or trusted partners.
- Host language-specific health literacy workshops (for example, Spanish, Haitian Creole, Arabic).
- Incorporate a cultural competency approach in outreach and enrollment activities.
- Prioritize language translation needs for materials and conversations with consumers.
- Translate materials and hiring/training multilingual staff for both language and cultural translation.
  - One respondent suggested creating a standardized translation document or glossary, similar to how the IRS provides a document of tax-related terminology translated in many languages.
- Develop plain language/reader-accessible materials matching the health literacy of the community.
- Tailor outreach messages for specific types of coverage.
- Train and deploy “Ambassadors” for under-resourced communities
- Use podcasts to disseminate information.
- Design innovative social media materials and content including intersectional, diverse representation.
- Distribute radio and newspaper advertising in racial/ethnic media (for example, print ads in orthodox Jewish newspaper).

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*“People need to know you are one of them so they can trust you more and trust what you are presenting.”*  
 – KII respondent, Michigan

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*“Individuals with [low English proficiency] may get poorly translated materials, and as a result not trust the information, and not trust the source.”*  
 – KII respondent, national organization

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*“To reach communities of color in Florida, member centers did outreach at barber shops and churches...[we] realized communities of color were not coming to our centers, especially during COVID, so we had to go find them.”*  
 – KII respondent, Florida

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*“If you're doing outreach, include photos that include people with disabilities, and have a diversity of disabilities within those photos... When people are looking for images of people with disabilities, they immediately go to wheelchairs, but it's much more than that. Find photos of people that are using sign language, or maybe you can see that they have a hearing aid on, or maybe they have a guide dog. Make sure that there's diversity about the disability imaging, and that there's racial diversity in the photos as well; it's not just white people in wheelchairs.”*  
 - KII respondent, national organization



### Representation matters in all aspects of outreach and enrollment

A few KII respondents said that, when possible, outreach and enrollment staff should:

- Represent the communities with whom they work, in terms of language, race, culture and other characteristics, to foster trust between consumers and outreach and enrollment organizations.
- Ensure that outreach materials feature images of people representative of the communities being reached instead of stock photos.
- Reflect intersectionality in outreach materials, such as featuring people of color who are visually-impaired, to ensure important messages reach and resonate with diverse audiences.



## 2. What factors hinder outreach and enrollment to under-resourced groups?

### Limited health insurance literacy/understanding of terminology

- Consumers in under-resourced communities often have low health literacy and a limited understanding of the functioning of the U.S. health care system. This poses challenges to outreach and enrollment, plan selection, and ultimately to making good use of their health coverage.
- When asked to identify the most challenging topics for consumers to understand, KII respondents who conduct outreach and enrollment listed several terms, such as: deductible, premium, copay, out-of-pocket maximum, in vs. out-of-network, co-insurance, cost sharing, etc.

### Structural barriers

- Many of the KII respondents who conduct enrollment said that administrative paperwork and required documentation place a burden on consumers.
- A few KII respondents explained that health insurance costs and income thresholds are prohibitive for many consumers.
- Many KII respondents cited structural racism barriers (see more detail in Section 5).
- Several KII respondents noted that many consumers cannot access local health care providers, despite enrolling in health insurance coverage.

### Disinvestment in the outreach and enrollment ecosystem

A few KII respondents cited each of the following barriers:

- Federal budget cuts for OE between 2016-2020 weakened the outreach and enrollment ecosystem and infrastructure.
- Lack of media promotion and awareness of ACA/Medicaid is a barrier to enrolling vulnerable and under-resourced populations.
- The changing length of the OE period and shifting dates across years can be inconvenient and confusing for consumers.

### Stigma and discrimination in the health care system towards communities of color and LGBTQ+ populations has discouraged some in these groups from getting covered

- A few KII respondents explained that stigma and discrimination within the health care system disincentivize some LGBTQ+ individuals and people of color people from seeking coverage based on skepticism that they would easily be able to get covered, and once they have coverage, that they would receive high quality, respectful, culturally-competent care.
- Lack of inclusive gender designation options on enrollment forms excludes those who identify outside of the gender binary.

“Literacy is the biggest need out there.” – KII respondent, Michigan

### Misinformation, skepticism, and mistrust disincentivize participants from seeking coverage

- Most KII respondents described ways that historical and present-day discrimination and mistreatment within the health care system has manifested deep mistrust of health care within marginalized communities. One respondent noted that events like the U.S. Public Health Service Syphilis Study at Tuskegee and the abuse of Henrietta Lacks are still fresh for many consumers and trust in health care systems must be intentionally re-earned.<sup>3</sup>
- A few KII respondents explained that fear of repercussions of disclosing mixed immigration family status dissuades many immigrants from seeking health insurance, even when eligible.
- In February 2020, the federal government implemented the 2019 Public Charge Final Rule, which subjected immigrant families to consequences if they enrolled in public benefits, including health care. That rule was overturned in March of 2021. However, lingering misunderstanding of the public charge rule has caused a “chilling effect” within immigrant communities, instilling fear around seeking public benefits, even when eligible and no longer subject to the 2019 rule.<sup>4,5</sup>

*Many in our local Black population do not “trust the health care system. They don’t trust the doctors. They’re traumatized because of whatever their relatives went through in the past and their ancestors went through in the past...They don’t trust the government. They believe that the health care system wants to utilize them as guinea pigs.”*

– KII respondent, New Jersey

*“[There is] a big barrier for the LGBT community just around trusting the health care system, and wanting to even sign up for health care, because of having had bad experiences within the system in the past, whether it’s discrimination, or not receiving competent care, or in the case of someone who’s transgender, maybe being misgendered.”*

– KII respondent, Florida



### 3. How did COVID -19 influence outreach and enrollment? (1)

#### Most consumers and KII respondents described unique challenges to outreach and enrollment during COVID-19

- Many KII respondents acknowledged that vulnerable and under-resourced communities were disproportionately impacted by COVID.
- "COVID increased our work," as one Michigan KII respondent explained, as some consumers faced job loss and sought health care access. Focus group participants reinforced this idea; participants in eight of the 11 focus groups reported a need for health care access as a major motivator for seeking insurance. Participants in two Michigan focus groups reported the need for financial support as a main motivator for seeking insurance.
- Anecdotal evidence from a few KII respondents suggests that the number of appointments and outreach contacts decreased in the switch to virtual appointments, but time spent with individual consumers increased.
- KII respondents shared mixed feedback about how the [great resignation](#) that occurred alongside COVID impacted their work, but a few found that higher turnover among organizational staff compared to pre-COVID decreased their outreach numbers.
- Nearly all KII respondents said their organizations shifted toward social media outreach and virtual enrollment. A few said this presented some challenges:
  - Some KII respondents felt that the steps to enroll consumers were often more challenging by phone than in person, particularly for populations that are less comfortable with computers. These respondents felt face-to-face interactions were more conducive to building trust.
  - Some KII respondents felt that a decrease in foot traffic at their centers, offices, or events made it harder to reach people.

*"It's easier to guide people through the enrollment process when they are sitting with you and can see your screen; it's harder to get them through the enrollment telephonically."*

– KII respondent, Michigan



### 3. How did COVID -19 influence OE? (2)

#### Despite challenges during the COVID-19 public health emergency, KII respondents also reported “silver linings” and lessons learned for conducting OE work in a post-COVID world

- Sustaining some practices from the COVID-19 public health emergency could help to reach more consumers.  
For example:
  - Staff became more comfortable with texting, the preferred communication channel for certain groups, such as young adults and young parents.
  - For communities such as service industry workers or the elderly, heightened health concerns during COVID-19 can serve as a starting point for conversations about coverage.
  - The public health emergency created new funding opportunities. As one Michigan KII respondent said, “COVID has slowed us, but also opened different grants and opportunities, like this one.”
  - Virtual platforms can be useful additions to outreach and enrollment organizations' toolkits.
    - While virtual platforms made it more difficult to reach some communities (for example, some African American communities with historic precedents for mistrusting health care systems), virtual options made it easier to connect and communicate efficiently with other hard-to-reach groups, such as rural communities or youth on social media.
    - Virtual enrollment appointments increase the likelihood that consumers will have all necessary documents on hand.
- When possible, organizations should pair outreach efforts with other community health care services and events. For example:
  - Find in-person options for communities that are not engaging virtually, such as food distribution centers. One KII respondent recommended “engaging with families at their comfort level of technology, and then offer contactless options.”
  - Share fliers at existing COVID-19 or flu vaccination clinics about enrollment options and outreach support.

*“Virtual assistance was a helpful tool for reaching folks in more rural areas who may not have been able to travel.”*

– KII respondent, Michigan



## 4. What added value do community power organizations (CPOs) bring to outreach and enrollment efforts? (1)

**While seeking coverage, consumers often feel more supported by community members than formal enrollment organizations; indeed, participants in six of eleven focus groups reported receiving assistance from friends in family. As one New Jersey participant explained:**

/ *“Meeting with family and friends makes it easier, they will know the community better.”*

However, in about one-third of focus groups, participants said that they would have liked to have professional, one-on-one support:

/ *“It would’ve been nice, actually if I would’ve gotten an agent, I think it would’ve been an easy direction.”*

One KII respondent from a national organization explained that local and state actors can help address this need:

/ *“Leave it up to state-level partners to use their strategies, know what works. For example, the barber shop and church strategy was working well in a few states, but not in Texas. They were having more success with flyers in food banks.”*



- Most KII respondents said that trust is essential to effective outreach and enrollment, particularly in communities that have faced historic mistreatment in medical settings.
- CPOs can connect with people about other topics and services they work on - like food access - and use this as a starting point to ask about health coverage.
- CPOs think broadly about individuals' social and economic circumstances that impact their ability to get coverage and can be a “one-stop-shop” for community members, offering support around housing, food, or education needs.
- CPOs often speak the language of the communities with whom they work and understand the cultural barriers to enrollment.
- CPOs bring sustainability to outreach and enrollment work by engaging and training community leaders.
- CPOs bring “lived experience” and a unique understanding of what works in communities in terms of outreach and enrollment strategy.



## 4. What added value do CPOs bring to OE efforts? (2)

### Funded partners face some barriers to collaborating with CPOs, such as:

- **Time.** CPOs face competing demands and often have less resources; enrollment training and reporting requirements can be burdensome.
- **Funding.** Many CPOs have trouble accessing funding for their efforts.
- **Supporting volunteers.** Some CPO partnerships involve work with volunteers, which requires additional support and monitoring of volunteers' needs.
- **Trust.** Even for CPOs, building trust between some communities and the health care system remains challenging.

### KII respondents suggested strategies for supporting CPOs that work on outreach and enrollment:

- A few respondents said that partners who work with CPOs should make trainings structured and replicable, create a pipeline of information and resources, and compensate community members.
- A few respondents said that funders can make funding more accessible to CPOs by:
  - simplifying application and reporting processes.
  - offering grant writing support or "pre-funding" to help CPOs apply for funds.
  - providing grants to work with specific communities, rather than "underserved populations."

/ A few New Jersey KII respondents expressed the importance of accessible and sustained funding for CPOs that conduct outreach and engagement work:

*"[Funders should] make it easier for CPOs to participate directly as [a] grantee, instead of waiting for someone to subcontract with them."*

*"I would say multi-year funding is where [funders'] investments would be most useful so that people can build out a program and make plans for future years, because it's not like insurance is going away."*



# 5. How does structural racism manifest in consumer outreach and enrollment and how have funded partners improved racial equity in OE? (1)



**Access to information and services.** Structural racism can influence consumers' access to information about coverage and their ability to use it. Language barriers play a role, both in terms of which languages materials are provided in and how language is used to conduct OE.

Some consumers, such as seasonal workers or those in service industry jobs, lack sick leave to use health care.

Cost of coverage can be a barrier, even with subsidies. As one KII respondent noted, \$10 per month can be a burden for some consumers.

*"The [marketplace] website to be honest with you is extremely confusing. I was very nervous, whatever I clicked. I was able to talk- you know call- and it does take a little bit of time when you call."*

- Focus group participant, Florida



**Health insurance literacy.** Lack of health insurance literacy can be a barrier to both enrolling in and maintaining coverage. Changes in open enrollment dates can be confusing and may discourage some consumers from enrolling or create a barrier for those who would like to.

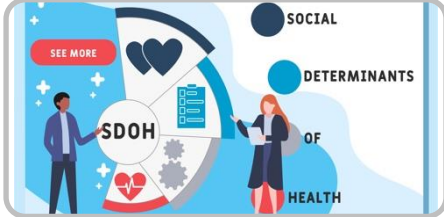
Lack of literacy about different immigration statuses that qualify for coverage can be a barrier.

Several KII respondents noted that health insurance literacy is important for maintaining coverage.

Some focus group participants reported confusion around coverage differences between Medicaid and Medicare and copays and other out of pocket costs.

*"Many people are eligible, but do not use their insurance, and then it expires. You have to let them know or remind them to find a PCP or to have an annual [physical]."*

- KII respondent, New Jersey



**Social determinants of health.** KII respondents pointed out that many of the ways in which structural racism influences enrollment are indirect; larger, systemic inequities manifest in a range of areas, including health coverage.

In two Michigan focus groups, participants generally felt that barriers to accessing health care among the African American community mostly related to other determinants, such as education, housing, home ownership, and income, and that verification processes such as address, income, and state identification can be inequitable due to inability for some to access those pieces of information.

Several KII respondents felt that barriers based on immigration status were rooted in structural racism. Fears or uncertainty around the public charge rule can influence enrollment decisions for immigrants or mixed status households.

*"Getting coverage is never just an issue of affordability or accessibility; there are so many other issues that get in the way... Transportation, housing, domestic violence, community violence, and employment all play a role."*

- KII respondent, Florida



**Health care.** Structural racism in the health care system can influence individuals' decisions about whether to enroll in coverage.

Participants in five focus groups across all three states reported experiencing health care system bias, slights or disrespect. KII respondents shared that this is especially true for consumers from some under-resourced groups, such as LGBTQ+ and African American communities. African American participants in a New Jersey focus group felt that compared to white patients, they receive worse medical treatment.

A lack of local or community providers who accept Medicaid can also discourage some consumers from enrolling.

*"A lot of clients told me they don't want insurance because of discrimination... they feel people look at them weird [in medical settings] and they would prefer to treat themselves and avoid people looking at them in public."*

- KII respondent, Michigan





## 5. How does structural racism manifest in consumer OE and how have funded partners improved racial equity in OE? (2)

KII respondents reported several steps their organizations are taking to try to improve racial equity in OE work:



### Expand the use of assisters and Navigators.

- Increase the number of assister and Navigator organizations that are led by people of color.
- Provide Navigator and assister support outside of regular business hours.



### Adapt outreach and enrollment efforts to communities' unique needs.

- Instead of a one-size-fits-all approach, tailor outreach and enrollment efforts to communities' unique barriers and needs.



### Talk honestly and directly with consumers.

- Be honest with consumers about costs and coverage information.
- Have one-on-one conversations with consumers to counter stigma or shame around Medicaid enrollment.



### Maintain an internal focus on diversity, equity and inclusion.

- Have leadership maintain a focus on and commitment to racial and health equity, for example, by finding and funding internal DEI trainings for staff and hiring diverse candidates.

However, most KII respondents said that addressing structural racism in this work requires broader systemic actions. These might include:



### Supporting and enacting policy changes that expand coverage, such as:

- Rule changes that make undocumented immigrants eligible for coverage, for example, allowing consumers to apply using Individual Taxpayer Identification Number rather than Social Security Number.
- Medicaid expansion and/or universal eligibility.
- 12-month continuous eligibility for Medicaid and CHIP, without redeterminations.



### Addressing structural racism and discrimination in health care:

- Support LGBTQ+ affirming trainings for the medical community.
- Encourage health systems to incorporate social determinant of health screenings in their intake processes.
- Institute more follow up and guidance for consumers about how to access care after they are enrolled.

Short of systemic change, KII respondents shared ideas about how to address the negative impacts of structural racism in OE:



### Improve health insurance literacy to help overcome some structural barriers at the consumer level:

- Continue or expand education about access to health coverage (for example, around coverage options, eligibility, and public charge rule.)
- Promote greater transparency in the marketplace around what is covered. One KII respondent shared that many people with disabilities have specific providers that they prefer for their care or certain medications they take, and select plans based on what is covered.



### Seek answers at a local level:

- Have conversations and education in communities about coverage, delivered by people from the community.
- Encourage national groups to play important and appropriate roles (for example, interpreting policy and disseminating resources) while trusted, local partners lead outreach and enrollment work in communities.
- Engage youth in OE work as a means of educating and encouraging them to advocate for their needs when a system is not meeting them.

*"You have to tailor your efforts to the communities and identify their unique barriers. Can they take the time? Can they take sick leave? If they don't have sick leave, how are they going to use their health insurance? Can they afford the plan? Do they understand how to reconcile this in their taxes?"*

– KII respondent, Florida




*"When outreach and enrollment organizations keep pushing marketplace coverage as amazing, then it's still too expensive, it harms trust. Often, plans on the marketplace just aren't affordable for people."*

- KII respondent, national organization






## 6. To what extent do partners measure their success and incorporate equity measures?

### Types of measures identified

- 
**Outreach**
  - Tracking number of outreach forms distributed
  - Number of referrals
  - Number of consumers attending outreach events
  - Number of enrollment appointments scheduled
  - Engagement with hard-to-reach populations
- 
**Enrollment**
  - Number enrolled in Medicaid and Marketplace
  - Year-to-year enrollment change
  - Year-to-year state insured rates
- 
**Media messaging**
  - Social media impressions on digital ads, such as “likes, comments and shares”

Most funded partners collect data on their efforts but vary in what measures they report. One national partner has started to focus more on racial equity in measuring outreach and engagement with hard-to-reach communities, including frequency of outreach. However, few partners in the field described explicit use of racial analysis or ways of incorporating equity measures in their work.

## Barriers to data collection and equity measurement

- 
**Non-specific and multiple data tracking requirements**
  - Data tracking requirements depend on partners’ funding source (for example, CMS versus other funders).
  - To minimize grantee burden, primary partners are mindful of not putting too much administrative burden on partner organizations for measurement, and encourage partners to report data, based on the organization’s type of work and population of focus.
- 
**Uncertainty over how to measure**
  - One KII respondent explained, “outreach is not easy to measure.” It was tough to track outreach during COVID in a virtual environment.
  - Another KII respondent said, it is hard to measure outreach success numerically: “You never know if an ad causes someone to contact a Navigator.”
  - To measure equity in outreach and enrollment efforts, most KII respondents doing enrollment collected demographic data on consumers reached, including race/ethnicity, and some respondents doing outreach focus on a specific community. However, a few respondents felt that collecting demographic information falls short of truly assessing equity in outreach and enrollment.
- 
**Locating consumers for follow-up**
  - One KII respondent explained that consumers do not necessarily “circle back” to confirm their enrollment.

### Potential solutions

Many of the barriers to data collection and use of equity measures could be addressed through a common set of metrics, such as number of outreach calls and associated meetings, follow-up activities, and enrollments. These metrics should include data on race, ethnicity, and language barriers. These data could be used to inform efforts to address inequities or systemic racism.



# 7. What types of organizations are conducting OE in selected communities and how do they work together? (1)

## Key finding from network survey

## Implications

OE employees are embedded within larger nonprofit organizations with multiple missions and functions.

Sustaining RWJF's investments in high-quality resources and training would be worthwhile, particularly for staff who are embedded in larger organizations with broader missions.

Almost half of organizations surveyed have been doing OE work since the Affordable Care Act passed in 2010.

Identifying new organizations and partners to help find and reach the remaining uninsured will continue to be an important priority.

On average, organizations reported two primary OE partners.

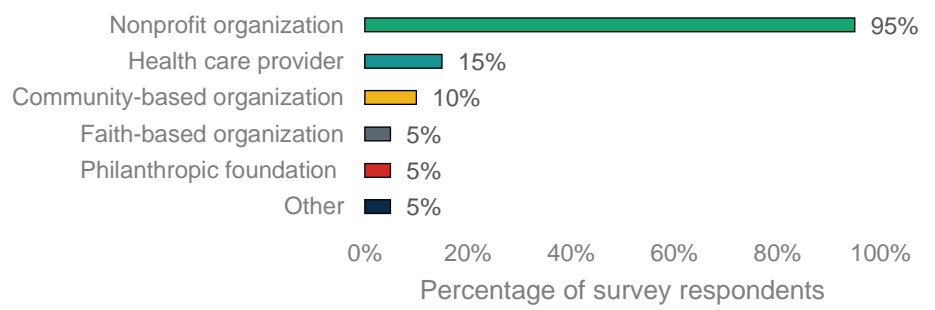
Organizations stretched in many different directions may find it challenging to carve out time for partnerships; thus, it may be worthwhile to invest in organizational infrastructure and coalition-building.

Although many partners were perceived to be promoting health equity, little is known about whether and how organizations are working to dismantle structural racism and whether they have the training and tools to do so.

Support for training, planning, and organizational work on promoting health equity and dismantling structural racism could be an important future priority for funding.

**Characteristics of organizations conducting OE.** Across the three communities of interest, the OE ecosystem is comprised of primarily nonprofit organizations with budgets of over \$1 million, but most organizations had fewer than six employees dedicated to OE.

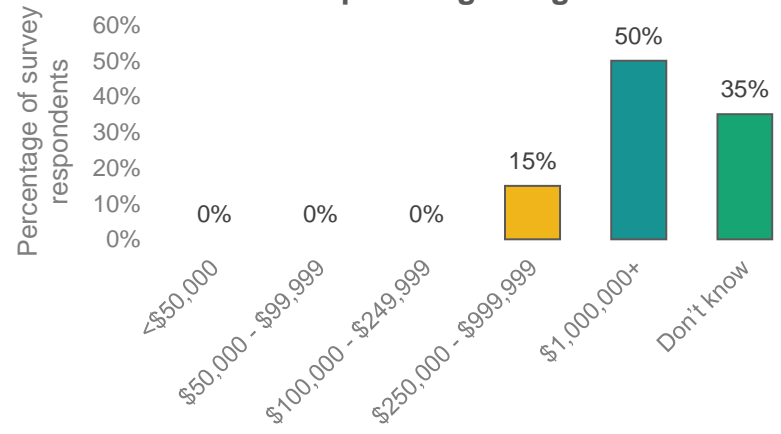
### Organization type



Respondents and their organizations were identified to participate in the network survey during KIIs with RWJF funded partners and subcontracted partners and through subsequent online searches of local Navigators and assisters.

### Annual operating budget

Respondents and their organizations were identified to participate in the network survey during KIIs with RWJF funded partners and subcontracted partners and through subsequent online searches of local Navigators and assisters.

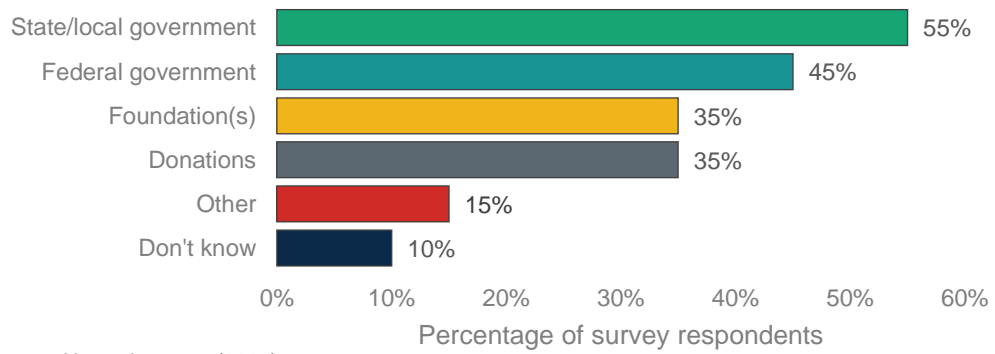




# 7. What types of organizations are conducting OE in selected communities and how do they work together? (2)

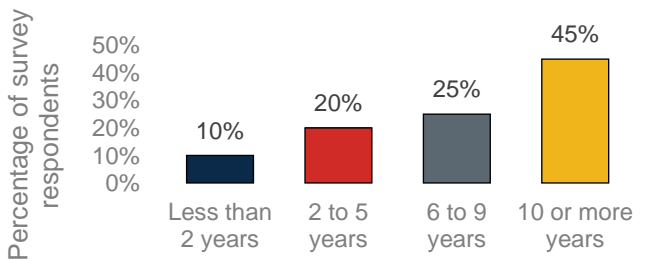
**Funding sources and tenure of organizations.** Organizations conducting OE reported state/local and federal government as their primary sources of funding for this work. Many reported having been engaged in OE for 10 or more years.

### Primary source(s) of funding for outreach and/or enrollment work



Source: Network survey (2022). Notes: N for above figure=20. Figure does not total 100 percent because respondents could select up to three primary sources of funding.

### Number of years engaged in outreach and enrollment work

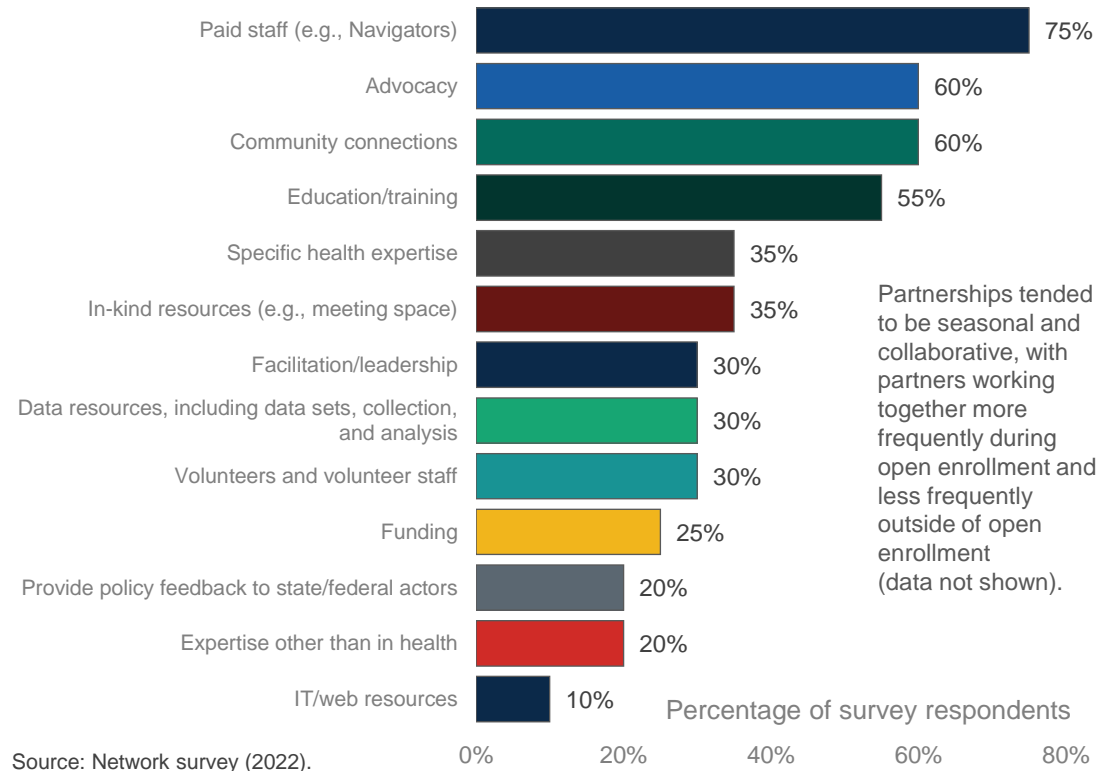


We observed no major differences across communities regarding the characteristics of organizations that we were interested in (i.e., organization type, budget, number of dedicated OE employees, and primary source(s) of funding).

**Organizations' contributions and how they work together.** Organizations reported offering many different contributions to the OE ecosystems within their communities. Nearly half of organizations perceived paid staff to be their most important contribution, and 25 percent reported community connections as their most important contribution (data not shown).

In all, 40 percent of organizations reported only one important partner for their OE work (data not shown).

### Contributions to outreach and enrollment work



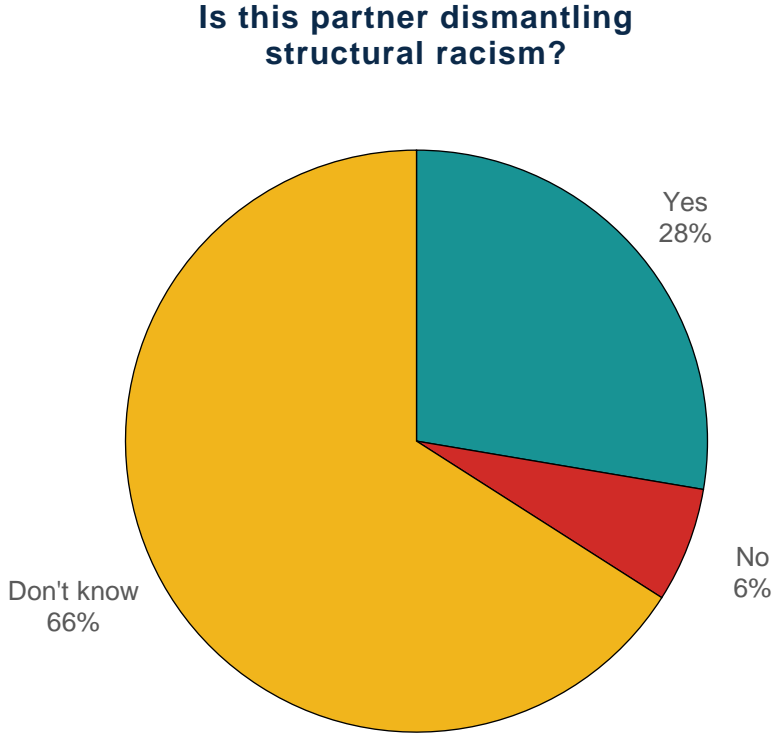
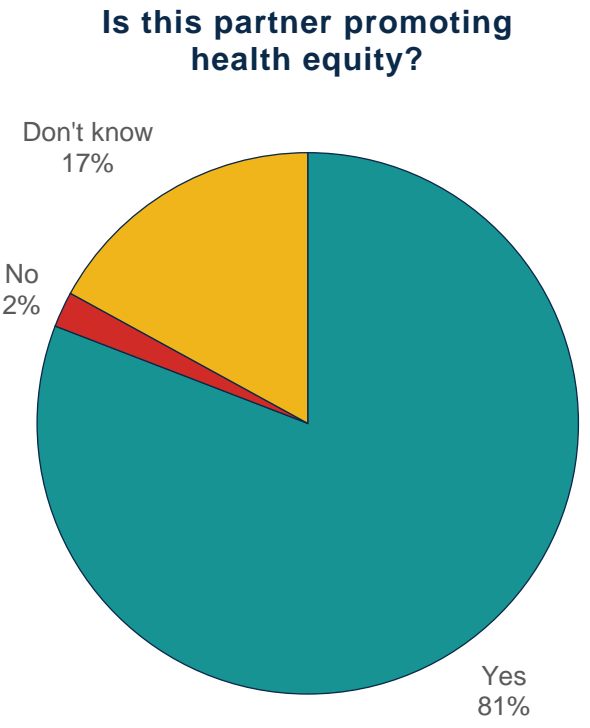
Partnerships tended to be seasonal and collaborative, with partners working together more frequently during open enrollment and less frequently outside of open enrollment (data not shown).

Source: Network survey (2022). Notes: N for above figure=20. Figure does not total 100 percent because respondents could select more than one contribution.



# 7. What types of organizations are conducting OE in selected communities and how do they work together? (3)

**Health equity and structural racism.** We asked the 20 survey respondents whether their 47 partners were promoting health equity and dismantling structural racism. Respondents reported that 80 percent of partners were promoting health equity. A similar percentage reported being unsure about whether the partner was dismantling structural racism. Newark respondents reported lower percentages of partners as addressing structural racism (6 percent, compared to 44 percent for Detroit and 38 percent for Broward County).





## IV. Conclusions and recommendations



## What we learned

### 1 Which consumer groups are under-resourced and historically more challenging to reach and why?

Funded partners indicate that historically underrepresented and under-resourced groups, including but not limited to African American, immigrant, and LGBTQ+ communities and individuals who are unemployed, require innovative strategies to reach and enroll into health insurance, similar to previous OEPs. Reasons include historical and lived experiences with discrimination in health care settings, mistrust of health care systems or government programs, and lack of awareness about health insurance.

### 2 What factors support outreach and enrollment to under-resourced groups? What factors hinder outreach and enrollment to under-resourced groups?

Partners cited trust as a critical factor to facilitating outreach and enrollment (OE); they reported health insurance literacy, public misinformation, and structural barriers are the primary barriers. Funded partners build trust by hiring within the community, hosting or attending in-person meetings, cultural events, and other community-based events, collaborating with neighborhood businesses, and incorporating a culturally competent and intersectional approach in OE activities that recognizes that consumers' identities are multi-faceted.

### 3 How did COVID-19 influence outreach and enrollment?

Despite record-setting enrollment during the 2022 OEP, COVID-19 influenced OE through higher turnover and burnout in the Navigator and assister community and fewer requests for in-person assistance. However, it also created opportunities for innovation such as a greater reliance on texting and some communities became more interested in learning about coverage.

### 4 What added value do community power organizations (CPOs) bring to outreach and enrollment efforts?

CPOs serve as trusted messengers to communities and help elevate community voice and lived experience. CPOs can play an important role in promoting health insurance by connecting with people about other topics and services they work on—like food access—and using this as a starting point to ask about health coverage.

### 5 How does structural racism manifest, and how have funded partners improved racial equity in outreach and enrollment?

Structural racism manifests in biased medical treatment, unequal access to care and administrative burden, lack of information and translation services, and through disparities in social determinants of health, such as housing, employment, and health insurance literacy. Improving racial equity in OE requires broader systemic action, such as supporting policy change and addressing structural racism and discrimination in health care.

### 6 To what extent do funded and subcontracted partners measure their success and incorporate equity measures into their monitoring efforts?

OE partners are not consistently measuring their efforts, making it difficult to assess their contributions. OE partners vary in whether and how they measure their OE efforts, making it challenging to understand what activities work, what activities could be replicated, and what activities are ineffective.

### 7 What types of organizations are conducting outreach and enrollment in selected communities, and how do they work together?

OE is embedded in larger nonprofit organizations that have been doing OE work for many years; these groups reported working with a handful of trusted partners.



## Putting findings in the context of prior evaluations of RWJF investments

Key findings from this study reflect consistencies with prior evaluations and indicate new evaluation findings from the field:

### What is the same?

- **Trust is an essential component in OE work.** Across evaluations, key informants confirmed the importance of building trust with consumers and offering one-on-one enrollment assistance.
- **Federal policy plays a crucial role in facilitating or hindering enrollment.** Policy changes have affected consumers' ability to enroll and partners' capacity to assist under-resourced communities. For example, the American Rescue Plan Act (ARPA) subsidies enhanced insurance affordability for consumers, whereas cuts to Navigator funding in prior OEPs curtailed enrollment assistance.
- **Health literacy education is a key to assisting consumers.** Newly enrolled consumers continue to benefit from education on health insurance literacy, including how to use their insurance to access care.
- **Partners recognized the need for accessible and consumer-friendly communications.** Partners recognize the value of translated and representational materials that reflect the diverse and intersectional communities they serve.

### What is new?

- **CPOs' linkages to communities can facilitate success.** Because they are trusted messengers, CPOs can play an important role in promoting health insurance and will require additional training and onboarding.
- **Structural racism manifests before and after enrollment.** Many consumers face barriers in access to information and health insurance literacy. Despite health insurance options, many consumers lack access to care, which discourages enrollment.
- **COVID-19 created challenges and opportunities.** COVID-19 led to fewer in-person appointments and affected assister staffing levels, but also expanded the use of virtual enrollment appointments and the use of text messaging to communicate effectively and quickly with consumers.
- **OE network partnerships have diminished over time.** Time and resource constraints, among other factors, have affected and reduced partnership collaborations.





## What role should funders of outreach and enrollment work play in the consumer assistance landscape in the future?

### Build on success – RWJF's current investments are filling a gap and add substantial value to the current OE ecosystem:

- Continue supporting current funded partners. These organizations are engaged and have demonstrated flexibility and ingenuity despite historical threats to enrollment.
- Continue investing in high-quality communications materials that are representative and inclusive, help spread awareness about health insurance, and help consumer groups see themselves in outreach materials.
- Continue investing in high-quality resources and training, which helps new Navigators and assister organizations get up to speed, especially as this workforce has seen significant turnover.
- Continue supporting CPOs to engage in OE activities to bring awareness of enrollment options and support to new communities; encouraging funded partners and CPOs to engage in participatory strategic planning would further align OE activities with communities' needs.

### Build capacity and trust – Funders could bring greater stability to the OE community by:

- Implementing long-term funding arrangements that allow communities to identify, implement and sustain solutions at a local level.
- Convening funded and subcontracted partners, including CPOs, to explore, discuss, and learn about community needs, data sources on health inequities, challenges and strategies for reaching under-resourced communities, and domains of structural racism.
- Investing in coalition-building at the local level to engage communities and spread best practices.

### Dismantle structural racism – To center OE work in dismantling structural racism, funders could:

- Invest in monitoring, evaluation, and learning activities to understand the outcomes from their investments with a health equity lens and move the field forward. This could involve providing resources to fund an equity TA provider to support OE grantees.
- Collaborate to identify, summarize, and disseminate promising practices for OE communication with communities of color and other under-resourced groups, such as developing strategies for non-English speaking, racial, ethnic and gender minority groups, and developing promising practice guides using insights from partners' OE success.
- Invest in efforts to identify how domains of structural racism (i.e., structural racism in housing, employment, medical treatment and care, among others) manifest in communities and strategically plan for how to address it and/or support consumers facing it.
- Support holistic wrap-around services and advocacy to address root causes of inequities, such as enhanced health literacy education, medical language translation, and housing and employment supports.
- Require funded partners to obtain and use data on inequities to identify communities with the largest uninsured rates and to plan outreach efforts accordingly including investing in new partners, if needed.
- Support funded partners in efforts to measure and report OE staffing levels, activities and contacts conducted by staff, and the number of enrollments completed (if applicable), including data on racial, ethnic, and language composition.



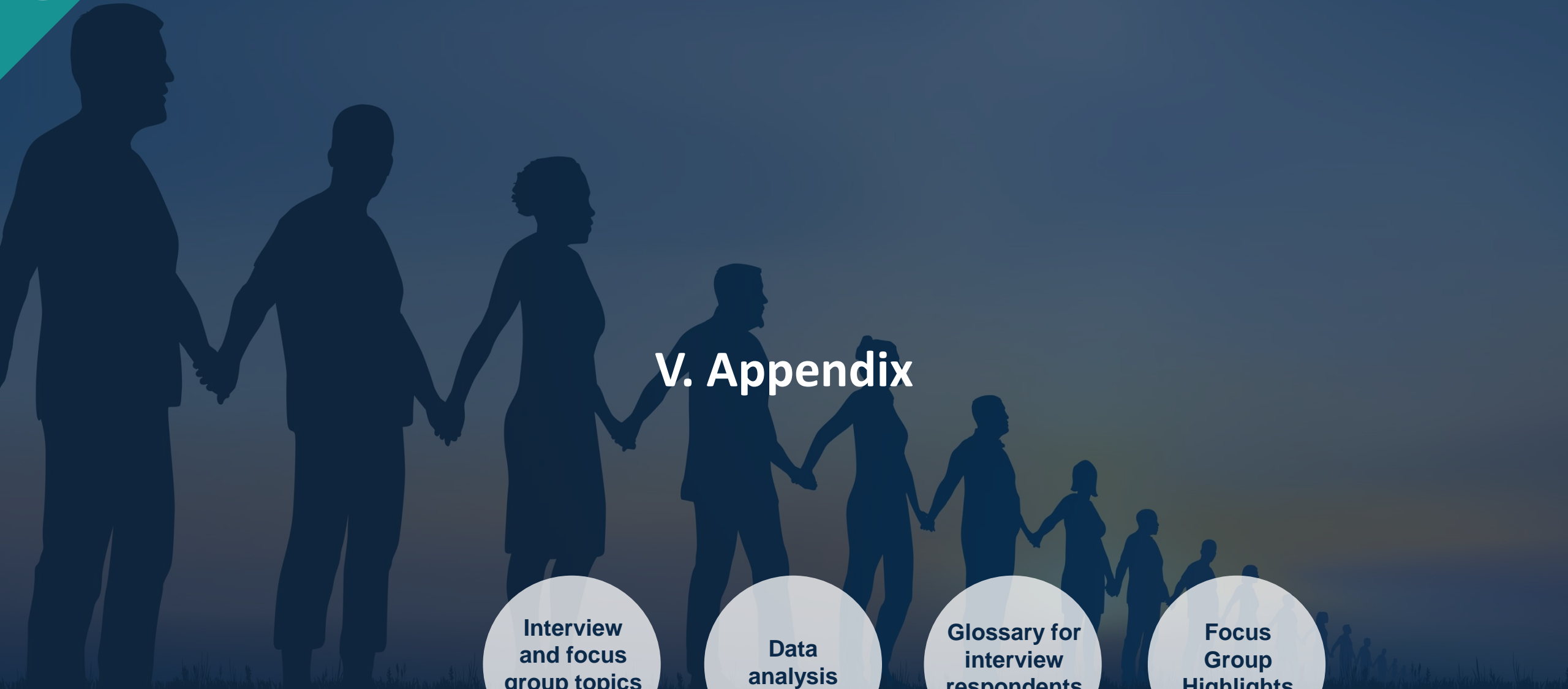
## ACKNOWLEDGMENTS

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# V. Appendix

**Interview  
and focus  
group topics**

**Data  
analysis**

**Glossary for  
interview  
respondents**

**Focus  
Group  
Highlights**



## Interview and focus group topics

### Key informant interview areas of inquiry

- Barriers to enrollment for under-resourced communities
- Strategies for overcoming barriers to enrollment, including COVID-19
- Measuring OE efforts
- Role(s) of CPOs in OE
- How structural racism manifests in OE
- What it would take to address structural racism in OE

### Focus group areas of inquiry

- Consumer experience in outreach and enrollment
  - Challenges to enrollment
  - Support received
- Racial equity in OE
  - Impacts of structural racism on OE in communities of color
- Strategies to improve education about enrollment options and supports

## Data Analysis

The evaluation primarily draws on the key informant, focus group, and network survey data. The survey was administered and analyzed with QuestionPro; we used R to conduct additional analyses. We summarized all interview data for key informant interviews, created an analytic coding rubric, and conducted a thematic analysis. For focus groups, evaluation partners recorded, reviewed, and summarized findings. We used information from each data source to triangulate and elevate key themes and findings for this document.

## Glossary for interview respondents

- **Structural racism** is "a form of racism pervasively and deeply embedded in systems, laws, written or unwritten policies, and entrenched practices and beliefs that produce, condone, and perpetuate widespread unfair treatment and oppression of people of color, with adverse health consequences" ([Health Affairs, 2022](#)).
- "**Health equity** means that everyone has a fair and just opportunity to be as healthy as possible. Further, equity requires removing obstacles to health such as poverty, discrimination, and their consequences (for example, lack of access to good jobs, quality education and housing, safe environments, and health care)" ([RWJF, 2017](#)).
- **Racial justice** is closely related to equity. It refers to efforts to address systemic barriers, racism, and structural racism, which may be underpinning inequities in health and health outcomes. "Racial injustice has resulted in dramatic health and safety disparities for communities of color. Without closing racially unjust gaps in health outcomes, it is a challenge to achieve health equity" ([Prevention Institute, 2021](#)).
- **Community power organizations** are organizations that conduct a range of activities including base-building, and that may be identified by geography, demography, or issue(s). CPOs may also be referred to as grassroots organizing groups, social movement groups, movement-building organizations, community-based organizations, community organizing groups, base building groups ([RWJF website](#)).
- By **community voice**, we mean providing for and engaging in community input, participatory involvement, and open dialogue with affected communities.



# Focus Group Highlights

	Florida	New Jersey	Michigan
<b>Consumers' experience</b>	Most Broward county focus group participants discussed experiences in medical facilities that mostly serve Medicaid beneficiaries. Most participants used informal channels for enrollment assistance, if needed, from friends or family members. Others received assistance from other government programs such as the Special Supplemental Nutrition Program for Women, Infants, and Children and Healthy Start, and from nonprofit organizations.	Most participants in the Greater Newark focus groups did not receive formal outreach for enrollment assistance. Instead, they found information and support from family members, family physicians, and through their own searches. When participants did seek out formal enrollment assistance, they reported receiving poor treatment from disinterested staff.	Almost all participants across the Greater Detroit focus groups reported having insurance, with the most reported barrier to coverage being income verification (that is, earning too much to qualify). Among those that were enrolled, many reported completing the application online with minimal difficulty, and others received enrollment assistance from various sources, including The Michigan Department of Health and Human Services, family and friends, and online resources. Only one focus group mentioned COVID-19 as a barrier to accessing assistance
<b>Enrollment barriers</b>	Several participants who sought out formal assistance reported difficulty reaching a call line, experiencing long wait times, and encountering overworked staff who were unhelpful in assisting with the enrollment process	Another theme consistent across focus groups in New Jersey was the effect of structural racism on outreach and enrollment efforts. Participants felt that Black communities received worse treatment than White communities at health facilities, which further discouraged Black people from seeking enrollment assistance. In addition, the lack of translators and interpreters, particularly for French- and Spanish-speaking communities, was another barrier to seeking support	Across focus groups in Michigan, many did not know enrollment assistance was available and did not recall receiving outreach messaging. Some of the most salient challenges related to understanding coverage included confusion around coverage options (including understanding which services are covered or are not), terminology and medical jargon, and out-of-pocket costs and when to expect them.
<b>Suggestions for improving OE</b>	Participants outlined strategies with potential to improve the enrollment assistance experience, such as increasing outreach efforts through social media and other information-sharing mechanisms such as pamphlets, hiring Navigators to assist enrollees throughout the entire enrollment process, and bolstering call centers to make assistance more efficient and accessible.	Focus group participants highlighted the need for more community engagement in outreach efforts to combat systemic failings. Community initiatives were described as a way to break down barriers for community members and provide accessible and safe sources of information as well as support for enrollment applications.	Two of the focus groups discussed how structural racism disproportionately impacted Black communities. Within those groups, they suggested strategies, such as community outreach and advertisements, and investment in structural determinants, such as education and housing, that could help mitigate these barriers for Black communities.