

Assessing the Role of State and Local Public Health in Outreach and Enrollment for Expanded Coverage

A Case Study on Illinois

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Key findings

- Partnerships and strong links between the state and local health departments characterize outreach and enrollment in Illinois.
- Outreach and enrollment efforts face such challenges as difficulties with the federal Healthcare.gov website, the amount of information in-person assisters had to convey during enrollment appointments, low levels of literacy, weak understanding of insurance, inadequate computer experience, and clients choosing lowest-premium plans for expediency even though those plans might not be the most cost-effective for them in practice.
- Trust, partnership, and the availability of federal resources for enrollment help outreach and enrollment efforts.

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA)¹ laid the groundwork for a substantial increase in the number of people who have access to health insurance through Medicaid expansion or health insurance marketplaces.² During the first open-enrollment season, states used a variety of strategies to reach out to and enroll newly eligible individuals. Typically, federal and state funding was used to develop navigator programs in each state. The design of these programs differed by location,³ and, although many stakeholders were involved in these efforts, state and local health departments (LHDs) were, and remain, a relatively untapped resource.⁴ This is somewhat surprising, given that LHDs serve as trusted entities in communities, can reach the most-vulnerable populations, and have access to data and resources that might facilitate ACA outreach and enrollment.

This is one in a series of reports designed to highlight innovative models and best practices that leverage LHD involvement in ACA outreach and enrollment and to facilitate

knowledge transfer to other geographic regions looking to leverage the full range of roles for LHDs in ACA outreach and enrollment. Potential roles include serving as a coordinator for community activities, being a trusted source of health care information for consumers, and leveraging community partners to increase capacity for outreach and enrollment. These reports identify compelling models for how LHDs can implement similar activities in their own communities. Further, they provide guidance and insight into the role LHDs can play now, and help redefine that role in the future, as states continue to enroll residents in health insurance coverage. Each case study was designed to capture nuanced differences in how health departments support these efforts in their communities, identify facilitators and barriers to these approaches, and develop lessons learned from these activities.

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CONTEXT OF HEALTH CARE REFORM IN ILLINOIS

The state of Illinois expanded Medicaid coverage to adults in households earning up to 138 percent of the federal poverty level (FPL) and offers health coverage through a state-partnership marketplace. In this model, the state can coordinate in-person assistance efforts, and the federal government administers the marketplace through Healthcare.gov.⁵ The Illinois marketplace is called Get Covered Illinois.

METHODS

Identifying Case-Study Sites and Activities

RAND researchers and the National Association of County and City Health Officials (NACCHO) staff identified state and local health departments that represented a range of models for participation in outreach and enrollment activities. An initial environmental scan, which included literature reviews, website analysis, and semistructured interviews with national and local stakeholders, identified a range of activities. Discussions with key staff at 15 health departments were conducted to learn more about their specific approaches and to understand more about the community and population context. In consultation with staff at the Office of the Assistant Secretary for Planning and Evaluation (ASPE), we selected seven sites that highlight a variety of models of LHD involvement and contexts in which public health departments were operating. The sites reflect differences in expansion status, urbanicity, region, use of public health data, participation of public health in partnerships, and leadership by public health: Boston, Massachusetts; Eagle, Pitkin, and Garfield counties, Colorado; Houston, Texas; Illinois (state and local); New Orleans, Louisiana; Tacoma and Pierce County, Washington; and West Virginia (state).

Site Visits

Site visits were conducted over two- or three-day periods between June and October 2014 with LHD leadership or staff and other key players in regional outreach and enrollment efforts (e.g., health care systems, social services, community-based organizations, or state or local government officials). RAND and NACCHO staff conducted four of the case studies; RAND staff alone conducted two; and NACCHO staff alone conducted one. Prior to arriving on site, RAND and NACCHO staff conducted telephone and email discussions to coordinate logistics and plan the topics to be covered in the in-person meetings. The discussions used an open-ended discussion guide that provided a consistent structure to each interview while allowing sufficient flexibility to capture all relevant information from participants. Discussions focused on implementation strategy (e.g., outreach and enrollment activities, funding, partnerships, and resources), evaluation, sustainability, and replicability. In a few cases, follow-up phone calls were made to staff who could not attend the in-person meetings.

Illinois Case Study

Unlike other case studies in this series that focused on LHDs alone, the case study for Illinois was unique in that it included discussions with staff at the state level, as well as with staff and partners at the LHDs in Winnebago and Lake counties. In September 2014, our team, which included staff from RAND, conducted 11 meetings with representatives of the health departments' networks involved in outreach and enrollment activities.

Rationale for Selecting This Case Study

As noted above, this case study differs in that it examined outreach and enrollment activities at both the state and local levels. We based the decision to expand the scope of this one on several factors. First, it provides insight into how a state health department was involved in outreach and enrollment activities. Second, it highlights a model in which state and local health

departments work together to conduct these activities. Third, it provides an opportunity to examine outreach and enrollment activities in both urban and rural settings across the state.

MODEL OF HEALTH DEPARTMENTS' INVOLVEMENT AND HOW THEY CAME TO BE IN THIS ROLE

In 2013, Get Covered Illinois created the in-person counselor program. Its purpose was to provide grants to community-based organizations and coalitions across the state to create a network of organizations with trained in-person counselors to educate community members about new insurance options under the ACA, assist them in sorting through the coverage options, and help them complete the application and enrollment process.

The federal navigation grant was awarded to the Illinois Department of Insurance, which partners with Get Covered Illinois. Get Covered Illinois is housed within the office of the governor. However, neither the governor's office nor the Illinois Department of Insurance had direct experience with making grants to community-based organizations. To augment their grant-making capacity, Get Covered Illinois and the Illinois Department of Insurance partnered with the Illinois Department of Public Health (IDPH) because IDPH already had a rigorous grant-monitoring system in place and IDPH's mission to promote health through the prevention and control of disease and injury was a strong fit with the goals of the ACA to promote wellness and increase access to health care. More-

over, IDPH's director at the time, LaMar Hasbrouck, had an established record of serving as a spokesperson for public health issues, including the ACA.

OUTREACH AND ENROLLMENT OVERVIEW

IDPH's primary functions were in coordinating the grant, ensuring the delivery of grant information and support, and ultimately making payments to grantees to engage in outreach and enrollment services. IDPH worked with Get Covered Illinois on other program-related activities, such as policy updates related to enrollment goals, documentation of activities, and program processes, as well as statewide outreach activities and providing technical support to the grantees. In addition, the organizations hired ten regional outreach coordinators to support all of the regional activities across the state.

In-Person Counselor Grant Program in Illinois

In July 2013, IDPH and Get Covered Illinois released the in-person counselor program request for applications. They received more than 160 applications from hospitals, community clinics, other community-based organizations, and LHDs, as well as coalitions made up of these organizations. To ensure adequate coverage of the state and key vulnerable populations and to ensure that outreach activities were relevant to the needs of Illinois' diverse local communities, IDPH and Get Covered

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IDPH and Get Covered Illinois encouraged all grantees within each region to network with one another, share lessons learned, and update one another on progress. To facilitate this, they employed regional outreach coordinators to work with all of the funded coalitions and organizations.

Illinois divided the state into ten outreach regions based on geography and population size and awarded grants within each region. According to several discussants, IDPH's primary goal was to fund trusted established organizations in each region. To evaluate the grant applications, IDPH created a scoring team made up of leadership from several different state agencies and awarded 44 grants to applicants that included approximately 260 different organizations. All of the scorers had expertise on statewide program implementation and community-based outreach, but some were not ACA subject-matter experts. However, they all received training on the ACA. In addition, some organizations that were not funded directly were offered information on how to access certified application counselor training because IDPH wanted to ensure that as many organizations as possible were included in the enrollment process. In addition, some organizations that were not selected for state funding did receive federal navigator funds. IDPH and Get Covered Illinois included these organizations in all general in-person counselor grant communications sent to all grantees.

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in those regions where grantees worked well together, the grantees exceeded their goals for outreach and enrollment.

Links Between the State and Local Health Departments

IDPH funded LHDs in two different ways. First, IDPH made direct grants to six LHDs—DuPage County Health Department, Kendall County Health Department, Lake County Health Department, McHenry County Health Department, Will County Health Department, and Winnebago County Health Department. These were typically larger LHDs in the state with greater infrastructure for engaging in larger-scale outreach and enrollment efforts. Second, IDPH funded the Illinois Association of Public Health Administrators to administer grants to the other LHDs across the state. The purpose of this grant was to fund smaller LHDs that had less capacity for writing their own proposals. In this way, most health departments in the state received funding to participate in local outreach and enrollment efforts.

IDPH emphasized funding to LHDs for several reasons. First, according to several discussants, both IDPH and Get Covered Illinois recognized that LHDs have demonstrated a history of being trusted organizations in many of these communities, especially with respect to health issues. Second, LHDs serve all communities in Illinois, and, by funding these organizations, IDPH and Get Covered Illinois leveraged this reach into every community. This is especially important in rural communities, where the LHD is often the only organization providing services to residents. According to one discussant, the LHD in these cases serves as the “on ramp” to health and social services for populations in need. Third, LHDs have existing capacity that can be leveraged for outreach and enrollment. Many see clients who lack health insurance and so have a direct

link to vulnerable populations. Others have long-standing relationships with community-based organizations with which they can partner for outreach and enrollment efforts. Finally, IDPH had prior successful experiences funding LHDs to engage in other public health initiatives.

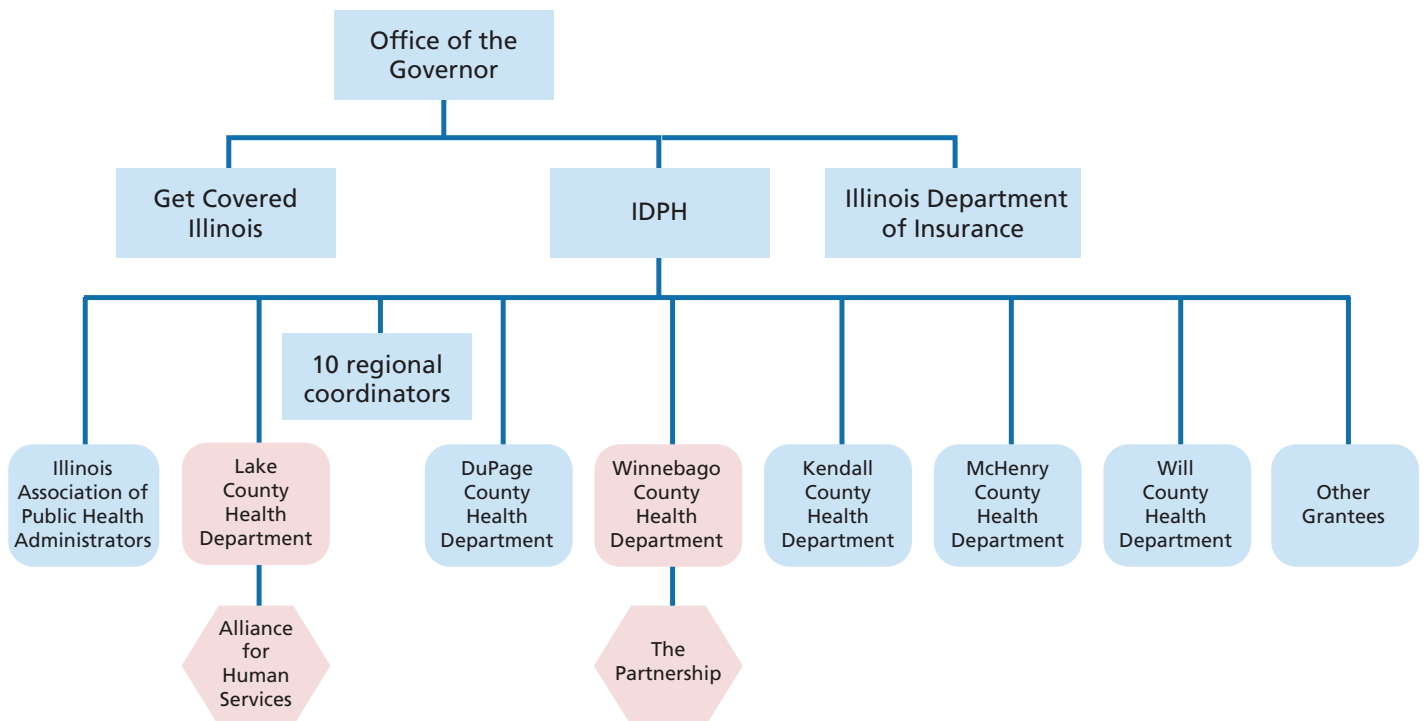
In the figure, we illustrate the relationships between IDPH and other state agencies with which they partner for outreach and enrollment and their link to LHDs through the in-person counselor grant program. As the figure shows, Get Covered Illinois, the Illinois Department of Insurance, and IDPH work together to administer grants to local organizations for their outreach and enrollment activities in ten different regions of the state. During the case study, we visited two LHDs, in Winnebago and Lake counties, both of which applied for funding jointly with other local partners. In this section, we provide more detail on how the relationship of the state and local health departments is structured and on the activities of the two LHDs.

Outreach and Enrollment Implemented in Lake County, Illinois

Lake County is situated along Lake Michigan just north of Chicago. To the north, it is bordered by the state of Wisconsin. The county has a diverse set of communities; the suburbs of Chicago are to the south, but the county becomes increasingly rural as one travels north. The Lake County Health Department and its community partner, the Alliance for Human Services, applied for and received a grant from the state for their outreach program, which they called Enroll Lake County. The Alliance for Human Services is a coalition of 37 member organizations that seeks to improve the delivery of human services in Lake County.

During the first open-enrollment period, in 2013 and 2014, Enroll Lake County largely focused on three target cities within the county that Get Covered Illinois identified as having the highest proportions of uninsured populations in the county: Waukegan, Round Lake, and Antioch. Enroll Lake County is a partnership of 27 community-based organizations, faith and civic groups, library networks, schools, business representatives, hospitals, and primary care providers funded to engage in outreach and enrollment in these communities. Among these agencies, 15 were funded specifically to hire and

State and Local Organizations Involved in Outreach and Enrollment in Illinois



train enrollment specialists to assist consumers through the enrollment process. In addition, five local hospitals helped to enroll uninsured patients, and the Lake County Health Department hired and trained five navigators to support outreach and enrollment activities in that county.

The consortium also includes seven community- and faith-based organizations that served as awareness and referral partners. Although these organizations did not receive any funding, they nevertheless contributed by communicating about outreach events, referring uninsured people to in-person counselors, and hosting public events.

The LHD and its partners engaged in several activities that highlight the roles that LHDs can play in outreach and enrollment. We describe these in the next section.

Outreach and Enrollment Events in Lake County

Because each agency received separate funding from Enroll Lake County, each implemented its own plan for outreach. As a result, the agencies reached people at various locations across the county, including libraries and churches. They also held outreach events at various community events, such as street cleanups and Halloween festivals. The focus of these events was to share information with people who did not know much about the ACA.

Early in the enrollment period, outreach and enrollment were separate activities. First, funded organizations across the county would plan and host an outreach event, during which appointments for a later date would be scheduled to conduct the enrollment process. The outreach presentations were phased out over time because attendance waned. According to the discussants, focus then turned to one-on-one informational sessions and enrollment. This revised model also helped to address barriers in more-rural areas of the county related to transportation. To better serve these populations, Enroll Lake County contracted with one community-based organization that already provided services to this population to assist in outreach. Its staff then focused on door-to-door outreach and enrollment. Although Enroll Lake County did not specifically target outreach by race, ethnicity, or other characteristics, such as English-language proficiency, the different funded agencies had various reach into these subpopulations. Each navigator tracked his or her enrollment figures daily and adjusted his or her approach according to these data. If, for example, a navigator learned that the team was successful in enrolling a larger

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number of people in an area, the navigators would extend their stay longer than originally planned.

Outreach and Enrollment Implemented in Winnebago County, Illinois

Winnebago County is about 90 miles northwest of Chicago. Like Lake County, it borders the state of Wisconsin. Rockford, Illinois, is the largest city in Winnebago and the third-largest city in the state. During the 2013–2014 outreach and enrollment period, Winnebago County Health Department served as the lead agency for outreach and enrollment. It partnered with several local social service and health care organizations to apply for the grant from Get Covered Illinois and IDPH. The Winnebago County Health Department led this initiative to engage in outreach and enrollment by engaging in a variety of key activities, each of which is described in more detail in the rest of this section.

Partnerships in Winnebago County

The Winnebago LHD chose to form a partnership with a diverse set of social and health care organizations because it believed that it would be able reach more uninsured patients by working with a strong set of community-based organizations.

The partners were drawn from social services and health care institutions and included the University of Illinois at Chicago College of Medicine, OSF Saint Anthony Medical Center, Rockford Health System, SwedishAmerican Health System, Rock Valley College, Lifescape Community Services, United Way of Rock River Valley, Rockford Health Council, YWCA of Rockford, City of Rockford Human Services Department, La Voz Latina, and Treatment Alternatives for Safe Communities (TASC). According to several discussants, the hospitals were key partners because they had staffing and an existing outreach and enrollment process that could be leveraged for ACA-related enrollment. For example, prior to the implementation of the ACA, hospitals had employed patient financial navigators to connect uninsured patients to Medicaid or charity care programs. As part of ACA outreach and enrollment efforts, these same navigators received training to enroll uninsured patients in either Medicaid or one of the marketplace plans.

Reaching Hard-to-Reach Patients in Winnebago County

Given the high number of uninsured individuals (about 24,000, or 14.5 percent of the county population in 2012),⁶ the county knew that reaching everyone with in-person assistance would be difficult. In order to use its resources as efficiently as possible, it targeted broad public outreach about how to use the marketplace website to populations it thought would be better able to enroll on their own with less support (e.g., people with higher levels of reading, computer, and health literacy). But, among harder-to-reach populations, such as people with low literacy, Latinos, and recently released inmates, it leveraged its partnerships to conduct more-focused outreach and in-person assistance.

To support low-literacy populations, the partnership reduced the reading level of written materials and created new processes, such as asking enrollers to provide simpler explanations and, in some cases, reading the consent forms aloud to ensure that clients understood what they were signing. In addition, the LHD created a computer lab in its office and hired enrollment specialists to support uninsured residents to walk in during specified hours and use the computers to research and choose insurance plans. The LHD also funded other subgrantee organizations to conduct outreach activities in other harder-to-reach communities. For example, TASC provides reentry case-management services across Illinois that help parolees successfully transition to their communities. TASC set up outreach

and enrollment events at libraries to reach homeless people, and it educated parole officers about enrollment opportunities so that they could refer parolees to TASC for enrollment. La Voz Latina is a nonprofit resource center for the Latino community of Rockford. It served as the primary organization reaching eligible immigrants broadly, with specific emphasis on the Latino population. The LHD partnered with La Voz Latina because it had a history of working with this community by providing interpretive services for the county court. La Voz Latina hired two navigators who focused their efforts on providing information about enrollment at community restaurants and grocery stores. La Voz Latina also provided educational presentations to help people understand the importance of health insurance and how to choose among their different options.

Generating Media Attention in Winnebago County

One goal of the LHD's plan was to focus specific attention on encouraging higher-income residents to purchase insurance through the marketplace. According to discussants, this meant that the LHD had to generate significant press coverage about its efforts. To accomplish this, it hosted more than 180

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media events. It also created English- and Spanish-language commercials that ran for six months, and it made continuous announcements of its efforts through social media. In the Latino community, its outreach strategies also included television advertisements; however, staff suggested that radio advertisements appeared to reach more Latinos than television or promoting open enrollment at health fairs.

CHALLENGES TO OUTREACH AND ENROLLMENT IN ILLINOIS

According to discussants across the three sites, one of the most-significant barriers to enrollment during the first open-enrollment period (2013–2014) was the failure of the Healthcare.gov website launch. Although both the state and county levels focused on directing people to use the website for enrollment in the marketplace, when that resource was unavail-

In addition, some in-person assisters reported that many people signed up primarily to avoid paying a penalty; as a result, they would sometimes choose the plan with the least-expensive premium. Discussants were concerned that this was not always the best decision because it can result in higher out-of-pocket costs overall.

able, residents stopped the enrollment process. The discussants with whom we spoke were concerned that many residents never returned to complete enrollment. In their view, this, combined with confusion created by the changes in the actual program enrollment deadline, negatively affected the number of people who would have participated early in the program.

A second significant hurdle was the amount of information in-person assisters had to convey during enrollment appointments. New clients' low levels of literacy and lower understanding of insurance surprised some discussants. In addition, discussants mentioned that many residents they encountered had little experience with computers. Grantees and program planners at IDPH and Get Covered Illinois expected that an in-person counselor would be able to complete an enrollment during a one-hour appointment. In reality, however, many appointments took several hours and, in some cases, could not be completed in one sitting. This then meant that residents needed follow-up appointments to complete their enrollments. This increased the time that in-person assisters spent with clients and, as a result, reduced the number of enrollments they could complete. In some communities, enrollment staff simply could not accommodate the increased numbers of hours necessary to enroll residents given these delays. Residents were also less likely to complete the process if enrollment required more than one appointment session. In addition, some in-person assisters reported that many people signed up primarily to avoid paying a penalty; as a result, they would sometimes choose the plan with the least-expensive premium. Discussants were concerned that this was not always the best decision because it can result in higher out-of-pocket costs overall.

A third challenge was enrolling eligible immigrants and people living in families with mixed legal status. Discussants highlighted that the early process of applying for coverage through the ACA was very confusing for people who had been legal permanent residents with five years of residency, and this might have resulted in fewer residents with this status enrolling. Although some did not apply, Healthcare.gov incorrectly denied coverage to other legal permanent residents because of errors on enrollment materials. This meant that navigators and enrollees had to dedicate time to tracking down reasons for the errors and work toward correcting them, but not always successfully. This confusion was fixed in July 2014 for the second open-enrollment period by adding a question about legal permanent residency to the marketplace enrollment application. Discussants also pointed out that a common concern was that some immigrant residents live in households with multiple

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families and completing their applications was difficult because assessing the number of people in the family for income and other calculations was difficult. In addition, many had difficulty navigating the Spanish-language telephone line because of confusing instructions and, in some cases, poor interactions with operators.

Discussants at the state level observed that grantees across the state, including some of the LHDs, had varying degrees of experience. Some had little experience with the basic outreach and enrollment tasks and, as a result, had to learn from their peers or contract out these activities to accomplish them. For example, some LHDs had less experience providing direct education to residents, while others had experience providing educational services but not outreach activities (e.g., advertising, networking with other organizations, and hosting outreach events). Although many LHDs collaborated with different agencies in their communities, not all did, and some LHDs had difficulty developing and maintaining relationships with other organizations when working on these efforts. State- and regional-level discussants also noted that many consumers could schedule their enrollment appointments only for the evenings, and, although some LHDs could accommodate the staffing necessary to stay open later and offer a range of working hours, not all could do so. This left some imbalances in the experiences of residents of different communities.

There were also barriers specific to the local communities we visited. Some discussants at the local level thought that the in-person counselor grant program had a lot of administrative and reporting requirements. At the height of outreach and enrollment activities, some suggested, they were having difficulty striking a balance between spending time doing outreach and reporting their activities to stay compliant.

In Lake County, discussants noted some confusion among residents about the ACA. They suggested that the negative media attention resonated more with residents than positive coverage that promoted open enrollment. As a result, in-person assisters felt that they had to continuously remedy misinformation while refraining from appearing political. This made discussions about enrollment more complicated and difficult. In addition to challenges around consumer perception, another barrier in Lake County was that, even though some residents spoke only Spanish, there was insufficient capacity to translate materials and messages that had been developed locally.

In Winnebago County, discussants stated that Get Covered Illinois provided media advertising until later in the enrollment period than expected, so the LHD and its partners had to ramp up their own media efforts. Discussants were also concerned that the Get Covered Illinois advertising always guided consumers to the website for enrollment, but many in the region's target populations did not have access to the Internet. Others noted that some national media describing the ACA were present in Rockford but did not promote Medicaid expansion, which was a critical access lever for residents. Once open enrollment in the marketplaces ended, discussants noted, media coverage about enrollment dropped, even though Medicaid enrollment is year-round.

ENABLERS TO OUTREACH AND ENROLLMENT IN ILLINOIS

Despite the barriers faced by organizations working to enroll residents into various options under the ACA, several factors in Illinois facilitated enrollment. The primary facilitators were

trust, partnership, and the availability of federal resources for enrollment.

Trust was particularly important. IDPH and Get Covered Illinois chose to work with LHDs across the state in part because they saw them as trusted institutions in many local communities. They also valued the capacity that some LHDs had to communicate information about health and health care issues authoritatively and in a way that residents trusted. As one discussant described, a range of organizations discussed enrollment in her community. But, because of the sensitive information that was needed to complete the enrollment process, some residents were concerned about sharing this with organizations they did not know and that did not have an obvious connection to health and health care. In particular, residents were concerned about whether these organizations could protect their private information. As a result, they believed that some residents simply felt more comfortable coming to the LHD because they perceived that that organization had experience with collecting and protecting private health-related information. In one of the communities we visited, the partnership between the LHD and several local hospitals that were also trusted agencies bolstered this perception of trust.

Despite some variation across the state, LHDs were a key component of the outreach and enrollment plans of IDPH and Get Covered Illinois because these institutions could leverage their existing partnerships with other community-based organizations to increase their outreach to residents. Discussants at the LHDs we visited described how their efforts relied on relationships with key partners that jointly applied with them for the grant. In Lake County, the LHD further expanded its network of partners by funding a variety of community-based organizations to conduct outreach and enrollment and reached out to additional partners by sending letters to local ministers, public officials, and schools to advertise enrollment events and highlight options for enrollment in insurance under the ACA. Some of the discussants with whom we spoke who were subgrantees of the LHDs attributed their commitment throughout enrollment in part to maintaining their strong working relationships with the LHD.

Discussants also cited existing federal resources produced as part of the Centers for Medicare and Medicaid Services (CMS) From Coverage to Care initiative as facilitators to outreach. Discussants in both communities noted that some residents lacked understanding of what health insurance is and how important it is to maintaining health. The CMS materials provided this guidance, and both health departments modeled

some messaging around these materials to overcome confusion about the ACA, increase resident understanding of how to use health insurance, and help them understand how to choose among options.

In Winnebago County, one discussant noted that the LHD received a great deal of positive media attention about its enrollment efforts, ranging from television interviews to print and radio coverage of its outreach events. This differed remarkably from Enroll Lake County, which received relatively little media attention about its activities. This was likely due to differences in proximity to Chicago. Lake County is, in part, a suburb of Chicago, and, as a result, ACA coverage focused on larger national and state issues or Chicago-specific activities when local outreach and enrollment was covered. Winnebago County has its own media in the city of Rockford. So all local outreach and enrollment events were covered, and the enrollment staff at the LHD often served as local media experts for interviews and discussion.

FUTURE PRIORITIES: WHAT COMES NEXT?

Get Covered Illinois and IDPH expected to make several changes in policy based on feedback from the grantees. Software and systems were being developed that would provide a method for scheduling the work of the in-person assisters in the different regions. Get Covered Illinois aspires to be a data-driven effort. Some discussants suggested that grantees had been able to work with communities that have the highest need for outreach and enrollment, but no agency was able to track in real time how efforts are going across the state without the infrastructure and capacity to collect and analyze data. Moreover, Get Covered Illinois and IDPH would like to be able to produce estimates about whether grantees' efforts are reaching benchmarks, especially to share with media and policymakers. In addition, Get Covered Illinois and IDPH found that those working full time exclusively on this work provided a better return on investment than those in-person assisters who spent half their time on this work and half their time on other projects. For the 2014–2015 open-enrollment period, the organizations required that the in-person assisters hired by grantees spend a minimum of 37.5 hours per week on outreach and enrollment activities. Get Covered Illinois and IDPH also considered the feedback from consumers about extending their office hours and are requiring some locations to stay open

later to meet the needs of residents. In addition, Get Covered Illinois was making efforts to simplify its outreach and enrollment materials in order to be more accessible to lower-literacy populations.

Because both counties projected fewer enrollments in 2014–2015, they each reduced the number of funded staff and altered hours to have more full-time than part-time positions. In Winnebago County, the LHD is considering focusing more on the messages about how to use health insurance in order to generate greater interest in enrollment.

DISCUSSION

IDPH's involvement as the centralizing entity was a unique model for public health's involvement in outreach and enrollment. In other communities, LHDs typically participate in or lead outreach and enrollment efforts independently of state health department efforts. However, IDPH was considered the best fit to lead the state's outreach and enrollment efforts because it had the infrastructure and experience to operate a sizable grant program. Because LHDs serve every community

in the state, IDPH and Get Covered Illinois leveraged this reach by funding LHDs to engage in outreach and enrollment. IDPH made training and supports available to LHDs and other organizations in order to sustain efforts statewide. LHDs directly funded by IDPH were responsible for implementing local outreach and enrollment activities and eliciting support from organizations and assistance from subgrantees they contracted. These LHDs secured funding for themselves and for their partners and made hiring decisions based on need and adjusted to meet demand. They tapped into their broad local networks to reach uninsured populations and even provided support and resources to organizations that were not being funded to do this work. Overall, public health's lead added a level of trust to a new system in which consumers faced multiple and significant hurdles to understand and secure health coverage. Although not every state can have greater involvement of the state health department in outreach and enrollment activities, this case study highlights the unique relationship between state and local health departments and how this relationship was leveraged in one state for greater LHD participation in outreach and enrollment.

NOTES

¹ Public Law 111-148, Patient Protection and Affordable Care Act, March 23, 2010. As of February 13, 2015:

<http://www.gpo.gov/fdsys/granule/PLAW-111publ148/PLAW-111publ148/content-detail.html>

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

³ Enroll America, "Certified Application Counselor Program: Early Lessons," Washington, D.C., June 2014. As of February 13, 2015:

<http://www.enrollamerica.org/certified-application-counselor-program-early-lessons/>

⁴ National Association of County and City Health Officials, *Role of Local Health Departments as Navigators: Findings from 2014 Forces of Change Survey*, Washington, D.C., May 2014. As of February 13, 2015:

<http://www.naccho.org/topics/research/forcesofchange/upload/Navigators.pdf>

⁵ Henry J. Kaiser Family Foundation, "State Health Insurance Marketplace Types, 2015," June 2015. As of June 22, 2015:

<http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/>

⁶ Stephani Becker, *Landscape of Illinois' Uninsured and Underinsured: What Do We Know and What Else Do We Want to Know Before 2014?* Illinois Health Matters and Health and Disability Advocates, October 23, 2012. As of June 22, 2015:

http://illinoishealthmatters.org/wp-content/uploads/2012/10/Slides-for-EnrollAmerica.October23.FINAL_-21.pdf

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