Three Innovative Strategies
King County's Quest to Cover the Uninsured

Master's Paper

A master's paper submitted to the faculty of The University of North Carolina at Chapel Hill in partial fulfillment of the requirements for the degree of Master of Science in Public Health in the Department of Health Policy and Management, Gillings School of Global Public Health.

Jasmine Hutchinson, MSPH 2014

TABLE OF CONTENTS

Abstract 3
Research Aims 3
Background 4
Methods 7
Data 7
Participants 7
Procedures 8
Data Analysis 8
Findings 9
Coverage Landscape Prior to Implementation 9
Enrollment Initiatives: History, Strategies, and Perceived Successes 13
Geo-Targeting 14
Cross-Agency Enrollment Team 18
Leadership Circle 20
Cross-Cutting Barriers and Challenges 23
Factors Enabling Enrollment Initiatives 31
Preliminary Outcomes of Enrollment Efforts in King County 39
The Next Phase for the Countywide Effort 40
Discussion 43
Best Practices from King County 43
Study Limitations 46
Appendix 47
A: References 47
B: Acronyms and Abbreviations 51
C: Participant Fact Sheet 52
D: Key Informant Interview Questions 54
E: Characteristics of Key Informants 59
F: Detailed Description of Numerical Calculations 60

Copyright © April 2014. Jasmine Hutchinson. All rights reserved. Permission is granted for reproduction of this file, with attribution to Jasmine Hutchinson. For questions, please contact jasmine.hutchinson@gmail.com.

Think about your community broadly. Don't just focus on the government website and the advertising to drive people to it because the way you're going to reach the folks that need to get signed up is by engaging the communities in which they live—in which they participate. So we had a website and it worked pretty well. But we also had hundreds of in-person assisters and this huge network of organizations that was helping us. And each one of these organizations had a little bit different constituency and they had people with whom they had a unique or uniquely close relationship. And the ability to talk with them—to get their attention—and talk with them about what it really means to them individually and to the community. And that's what I think is the difference between us doing an adequate and serviceable job and really succeeding at what we set out to do.

- County Executive Dow Constantine

ACKNOWLEDGEMENTS

A special thank you to Professors Pam Silberman and Jonathan Oberlander for their expert guidance and support throughout this project. I would also like to thank the key informants who graciously shared their time and experiences with me. Finally, I would like to thank Public Health – Seattle & King County and the King County Executive's Office for helping to make this research possible.

ABSTRACT

Study Purpose: This exploratory research identifies innovative strategies for facilitating enrollment of uninsured residents eligible for coverage under the Affordable Care Act (ACA). With strong political support and public health leadership, the experience in King County, Washington, represents a best-case scenario for health reform implementation. The county has developed a multi-faceted coverage strategy with a focus on reducing existing health insurance disparities.

Design and Methods: This study uses in-depth data from thirteen semi-structured interviews. Interviewees represented a diversity of experiences, sectors and leadership roles from across the countywide enrollment effort. Transcripts were coded to identify recurring themes and patterns in responses.

Findings: This study shows how King County developed their enrollment strategies and how their effort unfolded during the first six-month open enrollment period. Analyzing interviewee responses, I describe the barriers and enabling factors that affected one or more enrollment strategies.

Implications: Innovative strategies gleaned from King County's approach could potentially serve as models for other locales in the United States. In addition, I propose six best practices derived from King County's experiences that are applicable to a broad range of health reform environments, including regions experiencing greater hostility towards the ACA and those with limited capacity or implementation resources.

RESEARCH AIMS

Aim 1: Describe King County's approaches to developing a collaborative outreach and enrollment strategy.

Aim 2: Interview members of the partnership network to determine perceived barriers and enabling factors to enrollment; document any strategies used to address problems that arose.

Aim 3: Identify perceptions of best practices for building and supporting an effective partnership network.

BACKGROUND

Across the United States, an estimated 25 million uninsured residents will enroll in health insurance coverage by 2017 as a result of the Affordable Care Act (Congressional Budget Office, 2013). However, currently many uninsured persons remain confused and uncertain about how the health care law can potentially benefit them (Hill, Courtot, & Wilkinson, 2013, p. 4). According to a March 2014 poll, about half of all uninsured US residents still do not know that the ACA gives states the option to expand their existing Medicaid programs to cover more low-income adults. In addition, 43 percent of the uninsured are unaware that financial assistance is available to help low to moderate income residents gain coverage (Kaiser Family Foundation, 2014b). Overcoming these informational barriers requires strong government and community collaborations to help uninsured persons understand the law and enroll in coverage.

Implementation efforts and approaches vary tremendously across the nation. Some states with strong political support for ACA implementation have enthusiastically developed customized enrollment plans that have embraced a large network of partner organizations (Hill et al., 2013, p. 12). These states have also opted to create their own state-based health benefit exchanges and expand the Medicaid program to cover low-income adults (Kaiser Family Foundation, 2013a; Kaiser Family Foundation, 2013c).In other states, intense political opposition to the ACA has stunted plans to cover the uninsured and prevented Medicaid expansion (Alvarez & Pear, Robert, 2013; Tavernise & Gebeloff, 2013). The wide regional variation provides an opportunity to see how reform unfolds in different parts of the country depending on states' receptiveness to the ACA. Sharing lessons learned from innovative approaches as they unfold will enable states and cities to strengthen local enrollment efforts (Kaiser Family Foundation, 2013b, p. 3).

Washington is among those states that have actively embraced health reform. State government, local governmental and community leaders have voiced strong support for expanding health coverage. In addition, the state has opted to create and manage its own state-run health benefit exchange, the Washington HealthPlanFinder. During the six-month open enrollment period spanning from October 1st, 2013 to March 31st, 2014, the state enrolled 423,205 persons in Medicaid[1] and 164,062 in Qualified Health Plans[2] through the Washington HealthPlanFinder (Washington HealthPlanFinder, 2014a). This represents roughly 50% of the state's eligible uninsured population, though we do not yet know how many of these enrollees were previously uninsured in Washington or elsewhere. Still, Washington's enrollment numbers are impressive even

---

[1] This number includes those who were newly eligible, as well as people who were previously eligible for Medicaid but not enrolled. It does not include renewals for existing Medicaid enrollees, of which an additional 416,852 people renewed their Medicaid eligibility through the Exchange.
[2] Only people who paid their first month's premium are included in this number.

compared to the fifteen states that actively embraced health reform by creating their own exchanges and opting to expand Medicaid to uninsured adults (see figure 1 below). Furthermore, the Evergreen State has been called "one of the brightest success stories in the rocky national rollout of the ACA" (La Ganga, 2013). A variety of factors likely contribute to the state's high enrollment figures, including: a functioning marketplace website, few political constraints to ACA implementation, strong state leadership, state agency policies to reach uninsured, and an environment that fosters creativity and innovation in local program design.

Figure 1: Marketplace enrollment for the fifteen states that opted to expand Medicaid and create a state-based exchange, expressed as a percentage of the State's potentially eligible residents: October 1st, 2013 to March 31st, 2014.

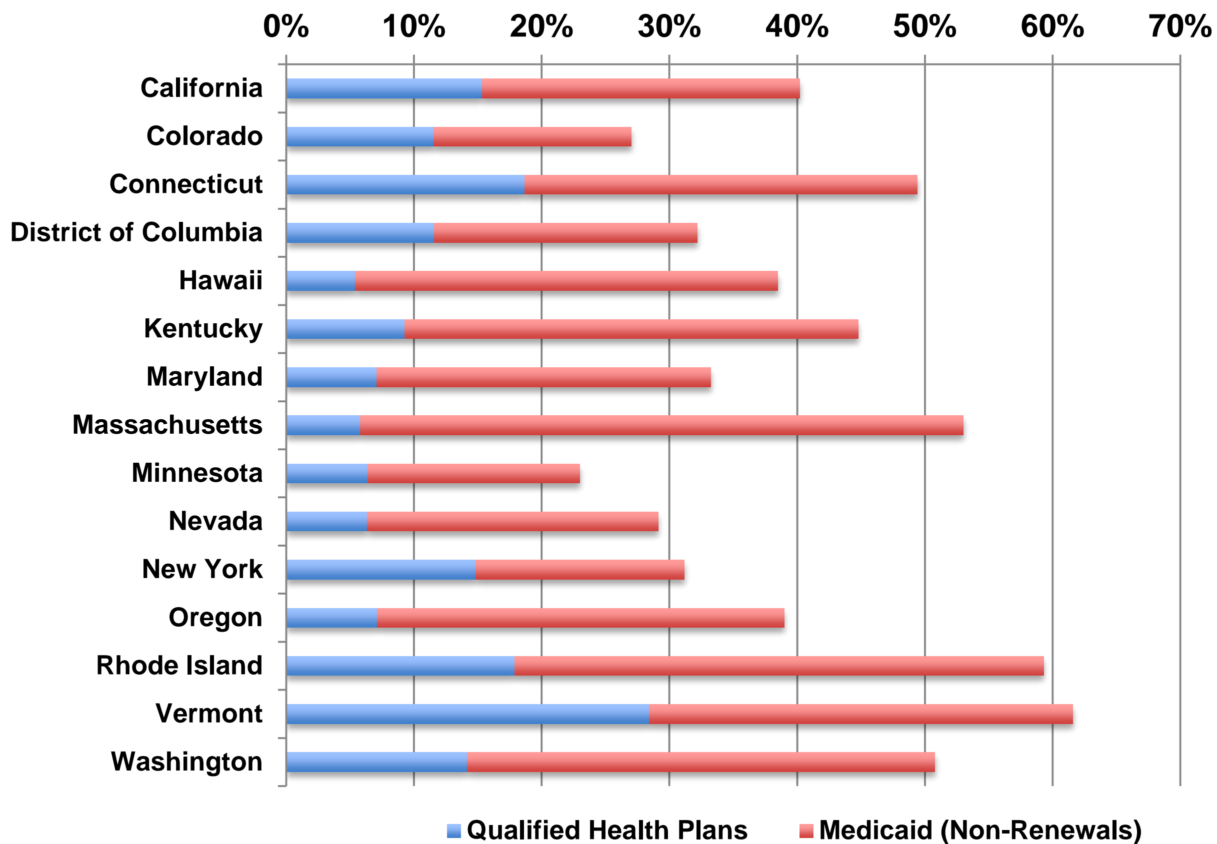


Figure Legend: *Total enrollments are presented as a percentage of the total number of legally present uninsured residents and the private non-group market. The number of legally present uninsured residents and private non-group market are from Kaiser Family Foundation (Kaiser Family Foundation, 2014a, Kaiser Family Foundation, 2014c). The analysis and a detailed explanation of all state enrollment numbers are included in Appendix F. On average, the states that expanded Medicaid and created their own state-based exchanges have enrolled a higher proportion of their uninsured populations than states that did not expand Medicaid and are using federal or partnership-based exchanges.*

Within Washington, King County is at the vanguard of health reform implementation. The state's largest county encompasses the Seattle Metropolitan area and more than 180,000 uninsured residents who became eligible for Medicaid or subsidized coverage opportunities on January 1st, 2014 as a result of the ACA (Public Health - Seattle & King County, 2013g). An additional 24,000 uninsured residents have incomes above 400% of the federal poverty level and will not receive subsidies to help them afford coverage, but may benefit from other ACA opportunities (Center for Medicare and Medicaid Services, 2013). During the 2013 State of the County address, Executive Dow Constantine announced that King County's goal is "nothing less than full enrollment of those uninsured who will become eligible for health insurance next year" ("Washington Health Benefit Exchange selects Public Health – Seattle & King County to lead enrollment efforts in King County," 2013).

To achieve this ambitious goal, King County has embarked on an innovative approach to develop strategic partnerships that build on past community collaborations, outreach campaigns, and strong state and local cooperation. Their approach includes three important strategies: (1) *geo-targeting* with community organization partnerships to reach uninsured residents where they reside; (2) a *county agency mobilization* effort to leverage existing government channels that serve the public; and (3) a *Leadership Circle* comprised of cross-sector leaders tasked with spreading information; (Public Health - Seattle & King County, 2013d, p. 180180, Public Health - Seattle & King County, 2013f).

These three initiatives place special emphasis on enrolling vulnerable and underserved populations, including homeless, low-income, and racially/ethnically diverse populations. Prior to the implementation of the exchanges, Latinos were nearly four times as likely to be uninsured as white residents; Blacks were twice as likely to be uninsured (Public Health - Seattle & King County, 2013g). Furthermore, low-income households were 16.1 times as likely to be uninsured as higher-income households (<$15,000 vs. >$75,000) (Public Health - Seattle & King County, 2013a). An additional 7,000 homeless residents lacked health insurance (Public Health - Seattle & King County, 2013g). County efforts aim to reduce these existing coverage disparities through targeted outreach and community partnerships. King County's approaches provide insights for other states, counties and cities committed to enrolling "hard-to-reach" populations and alleviating coverage disparities.

King County's three initiatives could provide lessons for other US regions looking to invest in low-cost, yet potentially high-impact outreach and enrollment models. This paper explores the strategies, tactics, resources, barriers, and enabling factors that formed part of the countywide effort to enroll uninsured residents. Ultimately, I identify six best practices derived from King County's experiences that are applicable to a broad spectrum of health reform environments.

METHODS

Data

Three types of data were collected and analyzed for this study: (1) existing administrative data such as progress reports and meeting notes; (2) semi-structured key informant interviews, de-identified to protect participant confidentiality[3]; and (3) publicly available data from the Washington State's health exchange and Public Health – Seattle & King County (herein referred to as "Public Health"). The administrative data provided a partial history of King County's enrollment initiatives with insights from a broad swath of participating organizations. It also informed the design of the interview questionnaire and participant selection process. To generate a deeper understanding of the King County's enrollment approaches, I conducted thirteen key informant interviews with local leaders tasked with designing and executing enrollment initiatives. All interviews took place between February 21st and April 7th, 2014 and lasted approximately one hour. In addition, one of the interviews included two participants, for a total of 14 participants. I analyzed publicly available data to determine Washington and King County's overall enrollment performance.

Participants

Participants reflected a diversity of experiences, sectors and leadership roles from across the countywide enrollment effort (see Appendix E for a summary of participant characteristics). I received five in-depth perspectives about each of the three initiatives: geo-targeting, cross-agency effort, and Leadership Circle. (Two interviewees had leadership roles in more than one of the initiatives). Leaders included one elected official, six officials from across four county government departments, and seven leaders from non-governmental organizations. Approximately two thirds worked for organizations receiving federal, state or local government funding to carry out enrollment activities. Two of the participants worked for government agencies with no traditional connection to health services, but had become involved in the enrollment effort through the county's Equity and Social Justice Initiative. Non-governmental organizations included community-based, nonprofit service providers and other agencies where individuals and families turn to for assistance.

---

[3] The only exception is the County Executive, who granted me explicit permission to attribute quotations to him.

Procedures

Study protocols and interview questions were reviewed and approved by the University of North Carolina Institutional Research Board. I also requested and received permission to use administrative data belonging to Public Health to inform my research. This data included: monthly progress reports from agencies and partner organizations; reports from Public Health staff reporting on enrollment efforts; data and maps related to the uninsured in King County; and meeting agendas and minutes/notes, when available. I used this data to understand the county's context, to inform design of the interview questionnaire and to avoid redundancies (e.g. asking interviewees questions for which they had already provided written responses to Public Health). Names and position titles were held confidential for all administrative data sources.

I developed a semi-structured interview guide that included minor tailoring for each of the three initiatives (See Appendix D). I sought to identify participant perceptions of enrollment best practices, challenges and next steps. Specifically, I asked all participants questions about:

- Strategies used to reach uninsured residents and their effectiveness
- Factors that have helped the initiative in achieving its goals
- Barriers that have hindered the initiative, including whether and how those barriers were overcome
- Recommendations for strengthening the initiative
- Expectations and hopes for how the initiative will evolve in the future
- Advice for other counties or states interested in implementing similar initiatives

Interviews were conducted primarily in-person, with one over the phone. Although most interviews lasted one hour, they spanned from .5 to 1.25 hours. I recorded and transcribed all interviews to be used for analysis.

Data Analysis

During the data collection phase of the study, I developed notes on key themes using an inductive approach. Following data collection, transcripts were uploaded into ATLAS.ti Version 7.0 for additional analysis. I first generated tentative codes to categorize each idea. After finishing the first assignment of codes, I reviewed the quotations a second time for consistency and re-assigned quotations as needed. Then, I grouped codes (and linked quotations) together into larger theme "families". I mapped concepts using the network view option and generated compilations of coded themes for writing my analysis.

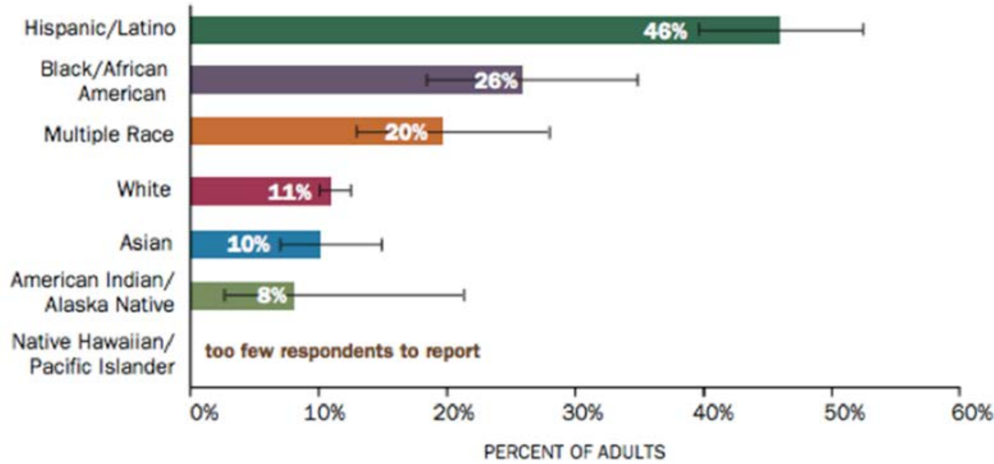
FINDINGS

Coverage Landscape Prior to Implementation

The ACA's focus on expanding coverage to low and middle-income adults has the potential to fundamentally alter the coverage landscape in King County. Prior to the implementation of the exchanges, roughly one in six adults ages 18-64 living in King County, about 217,000 persons, lacked health insurance (King County Government, 2013, p. 27). A closer examination of insurance rates reveals large racial/ethnic, income, education, employment, and geographic disparities. Approximately half of all Latinos and one quarter of Blacks/African Americans were uninsured (see figure 2) (King County Government, 2012, p. 15). Among people living on incomes of less than $25,000, roughly four in ten lacked coverage (see figure 3). Those who did not complete high school were more than eight times as likely to be uninsured compared with people who graduated from college (see figure 3). Similarly, people who were unemployed were 3.5 times more likely to be uninsured than people with employment. Furthermore, rates of uninsurance in some cities were nearly 10 times as high as other cities, ranging from 3.6% to 29.6% (see figure 4). Urban communities in South King County were disproportionately more likely to be uninsured. More importantly, local implementers anticipated that the vast majority of people living in communities with high rates of uninsured would become eligible for Medicaid expansion or marketplace subsidies as a result of key provisions in the Affordable Care Act.

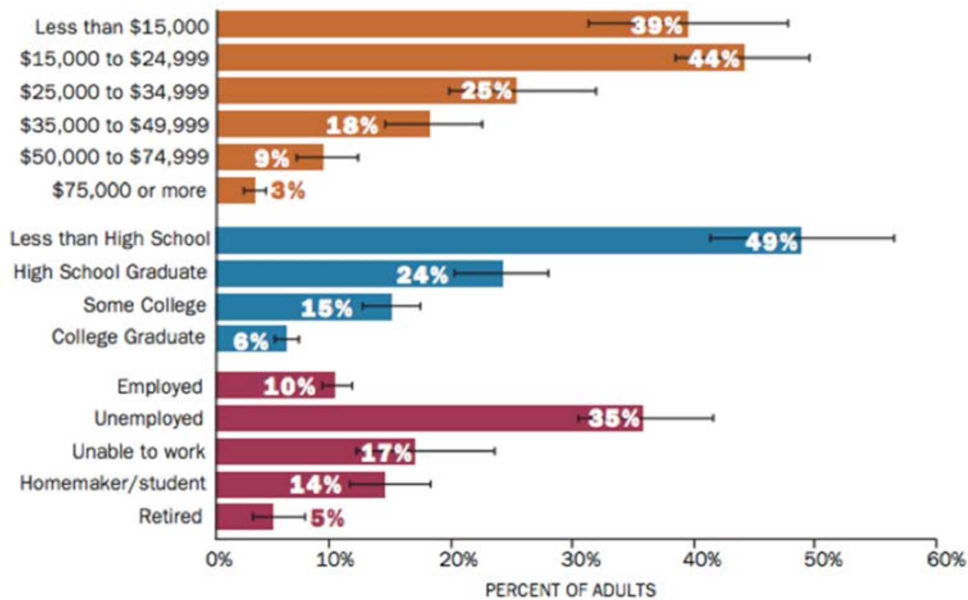
Health reform presents an unprecedented opportunity in King County to improve access to health care for all residents and create a more equitable society. Local government agencies and community organizations aim to eliminate existing coverage disparities by focusing on communities disproportionately affected by uninsurance. With innovative strategies and a strong network of partners, they aspire to profoundly change the map of uninsured in King County (see figure 5).

Figure 2: Percent of Adults Ages 18-64 Without Health Insurance by Race/Ethnicity.



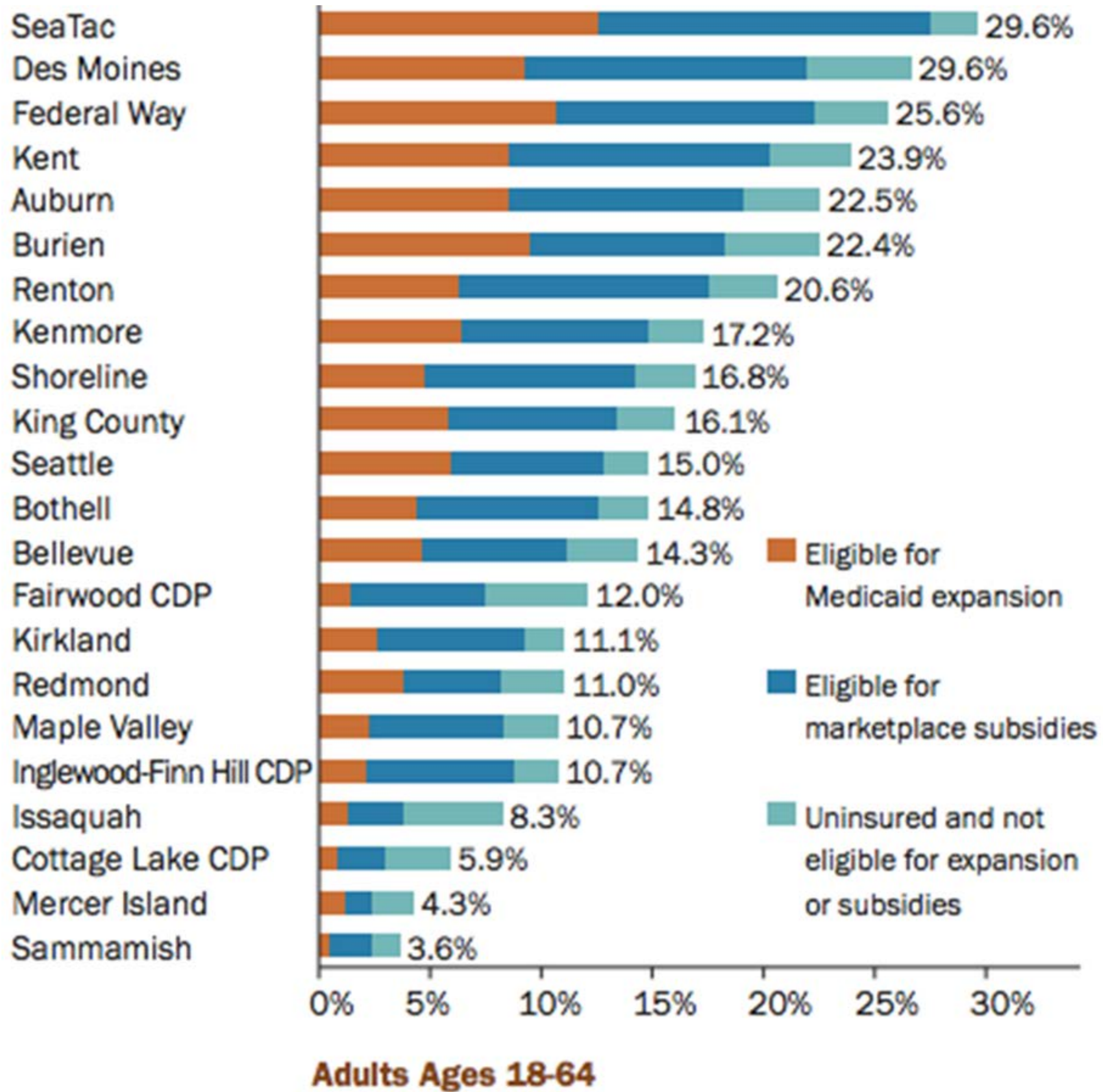
Graph Source: King County Equity and Social Justice Annual Report, 2012 (p. 15). King County Three-Year Average 2008-2010. Data Source: Behavioral Risk Factor Surveillance System. Produced by Communities County, 2011.

Figure 3: Percent of adults ages 18-64 without health insurance by income, education, and employment status.



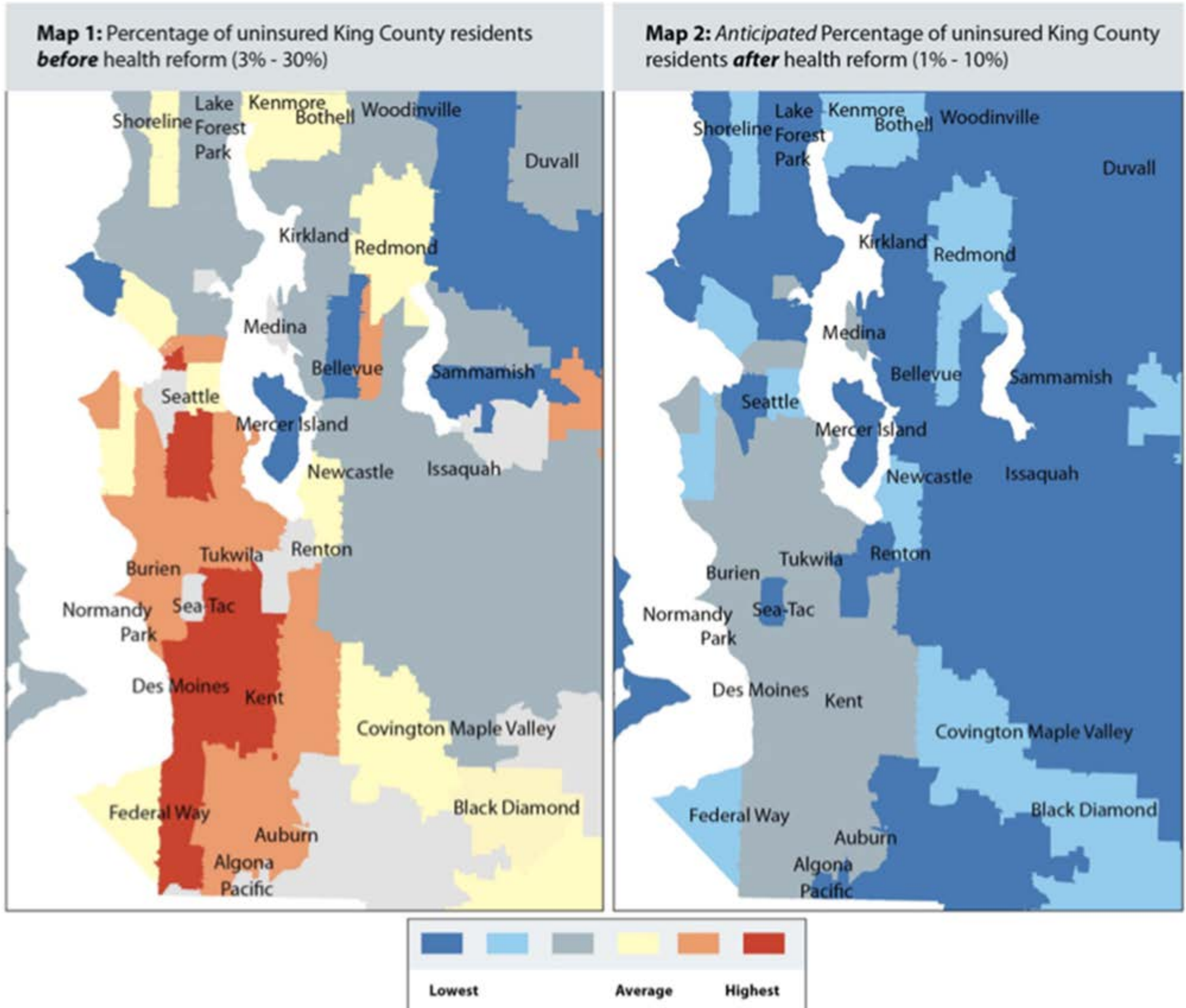
Graph Source: King County Equity and Social Justice Annual Report, 2012 (p. 15). King County Three-Year Average 2008-2010. Data Source: Behavioral Risk Factor Surveillance System. Produced by Communities County, 2011.

Figure 4: The percent of uninsured adult residents ages 18-65 by King County city and eligibility status.



Graph Source: King County Equity and Social Justice Annual Report, 2013 (p. 28). Data source: US Census Bureau, American Community Survey, 2009-2011 combined. Data are only available for areas with populations of at least 20,000 persons. Numbers include undocumented immigrants and people not meeting residency requirements.

Figure 5 (maps 1 & 2): The percent of uninsured adult residents ages 18-65 by King County city and eligibility status.



Map source: Public Health - Seattle & King County (2013e). "King County maps strategy to reach 180,000 uninsured people."

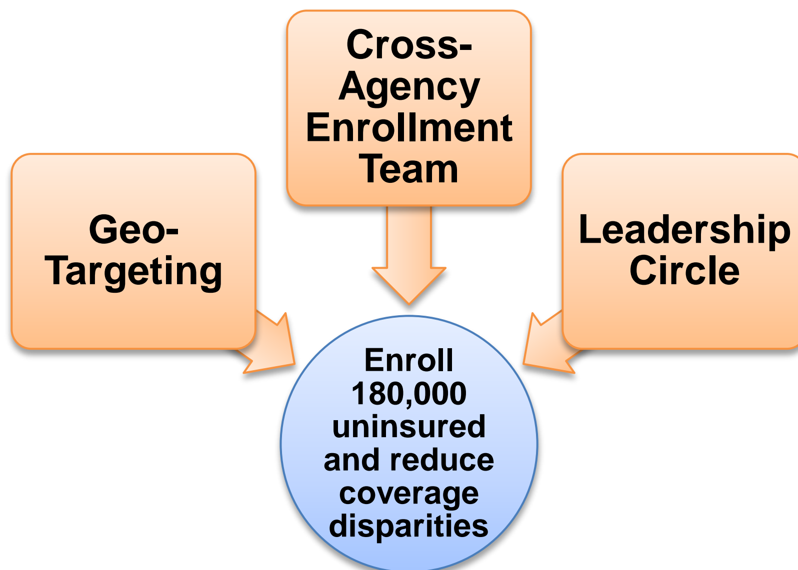
Enrollment Initiatives: History, Strategies, and Perceived Successes

With support from the Washington State government, Public Health serves as the lead county organization responsible for developing a tailored outreach and enrollment strategy to reach the county's uninsured residents ("Washington Health Benefit Exchange selects Public Health – Seattle & King County to lead enrollment efforts in King County," 2013). The campaign, entitled *Coverage is Here King County*, embraces multiple types of community and governmental partnerships. This research explores three primary strategies (see figure 2 below):

1. The geo-targeting approach leverages community-based partnerships to help enroll vulnerable and underserved populations. It also includes a large in-person assister network of 23 trusted community agencies with experience working with target populations. The model establishes hundreds of enrollment events across the county in locations easily accessed by the public (Public Health - Seattle & King County, 2013f). It is partially funded with a grant of $1.6 million from the Washington Health Benefit Exchange.
2. The cross-agency enrollment effort reaches uninsured through the county's public services. As part of the county's equity and social justice Initiative work, all county agencies and departments have committed to providing coverage information or enrollment assistance to the populations they serve (Public Health - Seattle & King County, 2013d).
3. The Leadership Circle brings together leaders from across all of these sectors to generate awareness of new coverage opportunities among the uninsured.

These three strategies are intended to work synergistically to cover the uninsured. The geo-targeting strategy forms the foundation of the *Coverage is Here King County* campaign. The cross-agency enrollment effort and Leadership Circle leverage existing networks to spread enrollment information through communities. Each of the organizations participating in the coverage campaign has developed uniquely close relationships with community populations over the years. They aim to leverage these existing relationships to reach populations with higher rates of uninsurance including communities of color, low-income residents, young adults, and homeless persons.

Figure 6. *Coverage is Here King County*: Three Innovative Strategies



Geo-Targeting

King County's geo-targeting initiative aims to provide targeted outreach and enrollment assistance to uninsured county residents across every geographical region in the county's domain. Public Health has partnered with a network of trusted community organizations across the county to create hundreds of enrollment events in areas easily accessed by the uninsured. The initiative incorporates epidemiological assessment (an analysis of the distribution of the uninsured in King County) to provide concentrated efforts in areas with disproportionately high numbers of uninsured residents. Partner organizations embedded in the community help customize outreach plans to ensure that they meet the language, cultural and special needs of residents. The geo-targeting approach is the most active and complex of the county's three initiatives.

Existing partnerships and robust epidemiological datasets facilitated the development of the county's geo-targeting strategy. For nearly 20 years, a collaborative of community organizations, government agencies, hospitals and social service organizations have been gathering during the first Friday of every month to collectively learn about publicly sponsored programs, share updates and solve problems. The

forum had traditionally focused on the Medicaid and Basic Health[4] programs—both of which would be heavily impacted by health reform. By March 2013, "First Friday Forum" had grown to more than 70 organizations and served as the county's largest venue for conversations on health reform among implementing organizations (Public Health - Seattle & King County, 2013e). Instead of developing a plan at the county government level and trying to find partners to implement it, Public Health pulled together a core planning team from First Friday Forum to engage community partners in the planning phase.

This team used a series of local epidemiological maps and datasets estimating the distribution of uninsured residents to inform their strategy. During the assessment phase, they asked the following questions:

- Where do the uninsured live by zip code? Which areas have the highest concentrations of uninsured residents?
- Where are there high concentrations of certain racial and ethnic groups?
- Where do immigrant populations live? Which ethnicities are represented?
- Where are multiple languages spoken? Which languages are spoken?
- Where are there concentrations of residents with disparate situations (i.e. homelessness, disabilities that require unique targeting)?

As a result of this exercise, the planning team decided that the county's outreach strategy would first focus on disproportionately affected communities, including urban areas in South King County and rural communities in East King County. After developing targeted approaches for these areas, the team expanded their strategy to create tailored plans for all sub-jurisdictions, covering all 39 cities and unincorporated areas. The goal was to ensure that all uninsured residents had easy enrollment access. Next, the planning team assessed the existing infrastructure and resources in each community. They first evaluated common elements present across communities such as libraries, community centers, food banks and government social service agencies. Then they analyzed which community-based organizations and government agencies were already working in each of the regions. By the time state exchange announced grant opportunities for lead in-person assister organizations in March 2013, most of the county's plans were already developed:

> [G]oing in, we started early. We made sure we were prepared and ready to go. We knew what we wanted to do. We knew the areas we wanted to target and why because we'd done an analysis of the uninsured and where they live. When the grant came out, we continued to finesse that plan. So, when we got funded, we were ready to go. It was a matter of just moving forward.

---

[4] Washington's Basic Health program is a state-subsidized insurance program offered to low-income people (between 0-200% of the Federal Income Guidelines) who would otherwise be ineligible for Medicaid, including childless adults. (Cody, n.d.)

Public Health responded to the state's formal solicitation for lead agencies and received approximately $1.6 million[5,6] to build and oversee a network of organizations that would provide in-person assistance to the county's uninsured residents ("Washington Health Benefit Exchange selects Public Health – Seattle & King County to lead enrollment efforts in King County," 2013). They were able to quickly turn the community-developed plans into a Request for Proposals (RFP). Of the 50 organizations that responded to the RFP, Public Health selected 23 community organizations that met the criteria for communities, geographic areas, and population needs to provide outreach and enrollment assistance. Together the 23 diverse agencies:

- Cover all geographic areas in King County.
- Have many years of experience serving diverse populations including all racial and ethnic groups, low-income clients, homeless adults and youth, immigrants and refugees, young adults, and those with complex barriers (e.g. social, disability, medical and psychiatric needs, and chemical dependency).
- Have experts who speak 31 different languages present in King County (Public Health - Seattle & King County, 2013b). See Table 1 for a full list of languages spoken within the network.

As lead, Public Health was primarily responsible for training all in-person assisters, keeping the in-person assister (IPA) network informed and monitoring progress against targets. They also played a key role in brokering relationships between partner organizations and site locations, and organizing large events. Many unfunded partners such as libraries and food banks also supported enrollment activities by hosting events or informing their clients.

Together, the network hosted a series of large and small community events at locations throughout the county. Large-scale enrollment events often targeted specific communities, such as Latinos or African Americans. Public Health organized the event logistics and worked with community sponsors (e.g. consulates or organizations prominent in that community) to advertise the events in the target communities. In-person assisters from the network of community agencies staffed the events. In addition to the large events, the county's

Table 1: Number of Funded In-Person Assister Partner Organizations with Language Expertise

Language Expertise	Number
Amharic	3
Arabic	2
Bhutanese	1
Burmese	2
Cantonese	4
Cambodian	2
Chao-Jo	1
Eritrean	2
French	2
Indonesian	1
Japanese	2
Karen	1
Korean	4
Laotian	2
Mandarin	4
Malay	1
Mien	1
Punjabi	1
Russian	5
Spanish	14
Somali	6
Swahili	1
Tagalog	2
Taiwanese	1
Teochew	1
Thai	2
Tigrigna	3
Toisanese	2
Ukranian	2
Uzbek	1
Vietnamese	6

[5] Most of this funding was pushed out to local community-based organizations.
[6] Washington received a total of $6 million from the Health and Human Services to support the IPA network across the state. ("Washington Health Benefit Exchange selects Organizations for In-Person Customer Support Program," 2013)

enrollment efforts included hundreds of smaller enrollment events managed by the individual partner organizations. These smaller recurring enrollment events took place at clinics, libraries, community centers, food banks, shopping centers, social service agencies and other locations frequented by uninsured residents. Each funded network agency had specified outreach and enrollment targets.

Notably, Public Health left much of the decision-making up to their community-based partners:

> We don't necessarily monitor how [IPA organizations are] tweaking their own [activities], like how they do Saturday work. They are free to just do that. They don't need to report it to us. We just need to know how many they get enrolled and all that. So, we haven't tried to control that. We've left the flexibility up to them.

Many of the most innovative and effective strategies arose from this flexible culture. Community organizations had access to data and opportunities that may not have been known to the lead organization. For example, one community health center generated a list of all patients that had not visited the clinic within the past 12 months, but had previously attended for an uninsured visit. The clinic called the patients, combining enrollment information with access to services:

> That was an effective strategy because not only were they saying, "we want to make sure you get enrolled", but they were also saying, "you haven't been into the clinic in over a year and we're really concerned about your primary health care. Let's schedule you to come in".

Community partners with multiple sites also discovered that some communities responded better to certain outreach strategies than others. For example, one Federally Qualified Health Center with multiple clinic sites said that phone calls were very effective in getting people to come in for enrollment for some clinics, while mailings were more effective in others.

Over time, Public Health and partner agencies honed their strategies. During the initial open enrollment months, Public Health worked with partners to increase the number of recurring events. With regular events, partner organizations could direct uninsured people to these events, "instead of dealing with everything on a one-on-one basis". However, the partnership network soon discovered that regular events were not equally effective across the site locations. For example, some libraries would have only one or two people attend an enrollment event during the four-hour time period, while others would already have a line of 20-30 people waiting at the time the event started. For locations where attendance was low, Public Health transitioned the sites from a fully staffed enrollment location to a 'materials only' site. One Public Health manager was quick to note that an exit strategy was implemented in each of these locations. It consisted of a referral process to help connect the client to enrollment resources. Uninsured people who visited the site were also provided an opportunity to call a 1-800

number and become enrolled over the phone. With additional staff resources freed up, Public Health was able to increase enrollment capacity at locations with the highest demand. During the second half of open enrollment, the IPA network began to expand into government offices called Community Service Offices.

> It took us a little while to figure out how to get in there, but it was sort of one of those "duh" moments—of course people are going to be coming here looking to enroll…there are some one-offs that work well, but overall having these hubs in the community where people go is probably the most sustainable way. It also takes less effort if you're not always negotiating these new partnerships in these new locations.

King County's geo-targeting initiative tailors enrollment efforts to each city according to the community demographics and population needs. The city-by-city approach relies on a network of trusted community partners with experience working with target populations. In counties with high diversity such as King, this approach aims to ensure that all eligible uninsured residents have a chance to enroll in coverage—regardless of race, ethnicity or language.

Cross-Agency Enrollment Team

The Cross-Agency initiative mobilizes every county department and agency to promote health enrollment opportunities to the public (see Table 2) (Public Health - Seattle & King County, 2013c). All government entities are tasked with developing and executing plans that connect uninsured residents to enrollment resources. These plans aim to leverage existing government resources including personnel, physical locations, and communication channels used to reach the public (King County Government, 2013, p. 27). Executive Dow Constantine describes the value of this approach and how it differs from traditional methods:

> The traditional model would have been to have this be a Public Health project. And Public Health would do this and we'd all say, "Good, King County is doing this because there is an Office in the corner of Public Health that's the Office of Health Care Enrollment". But we are not taking that approach. We're taking the approach that this is everyone's responsibility and while Public Health is coordinating this and doing the difficult administrative work, this belongs to every department, and division, and office, and every employee who works for those programs and has any connection with the public—any contact with the public. And by doing that, we leveraged and expanded Public Health's work many fold.

Table 2: Departments and Agencies Participating in the Cross-Agency Equity and Social Justice Health Enrollment Team

Department/Agency
Assessor
King County Council
Dept. of Adult and Juvenile Detention
Dept. of Community and Human Services
Dept. of Executive Services
Dept. of Judicial Administration
Dept. of Natural Resources and Parks
Dept. of Permitting and Environmental Review
Dept. of Public Defense
Dept. of Transportation
District Court
Elections
Executive Office
King County Information Technology
Office of Economic & Financial Analysis
Office of Performance, Strategy and Budget
Prosecuting Attorney's Office
Public Health – Seattle & King County
Sheriff
Superior Court

The cross-agency enrollment effort forms part of the county government's commitment to equity and social justice. In late 2012, the county's Equity and Social Justice Interbranch Team[7]—a cross-agency team dedicated to promoting fairness and leading the county's equity activities—prioritized health enrollment as one of five priority areas for cross-agency work starting in 2013 (King County Government, 2013, p. 27). This was the first year that the Interbranch Team selected shared goals. Prior to 2013, the county agencies' equity and social justice work had been more siloed as each department focused on learning to use an equity lens in their work, becoming familiar with the tools, and reporting on their individual activities. In late 2012, the team began to really coalesce and embarked on a joint goal-setting process to generate "broader impact on particular issues". The timing of new health enrollment opportunities aligned naturally with the Interbranch Team's desire to work more collaboratively as "One King County". Under King County's equity and social justice framework, the determinants of equity are linked with one another. King County's approach aims to expose the connections between health enrollment and other public services such as law enforcement, licensing, transportation and housing to develop comprehensive strategies that address the root causes of inequities.

The decision to make health enrollment a priority for cross-agency work excited many of the key informants. One respondent working for a non-health-related department described her thoughts at the time enrollment was selected:

> So, I thought: "wow, something that's very focused and concrete where we can actually measure how we are doing". I pictured a United Way-type campaign where there's some sort of thermometer and people can stay enthusiastic and motivated by getting reports that say we're doing great, keep it up, and look how many people we've signed up. It didn't take anybody really doing anything differently. They didn't have to organize their partners differently. They didn't have to hire additional staff or redeploy staff. They just had to say, "we're already doing all these things, here's where we can promote this".

Notably, none of the five cross-agency respondents witnessed any resistance towards this effort from within their departments or agencies.

Public Health led and supported the effort. They solicited activity commitments from each department and agency using a collaborative approach:

> We didn't necessarily say that we had all the answers…We didn't just tell them "you're doing this" and "you're doing that". Generally, it was soft asks: "what can you do? What can you commit to?" And letting them have some of those conversations and come up with some of those strategies.

---

[7] In October 2010, the King County Council passed Ordinance 16948 which required them to put together the Equity and Social Justice Interbranch team.

Through the participatory approach, departments examined their own operations for opportunities to promote enrollment. Examples of successful outreach activities carried out across multiple departments include:

- Internal education for employees
- Materials dissemination (e.g. posted in customer service windows, flyers available in waiting areas)
- Information added to outgoing publications (e.g. newsletters, mailings)
- Public Service Announcements in busy public places
- Links to the public health enrollment webpage added to departmental websites.

The cross-agency effort overcame several key challenges to working as "one King County". At first, some departments with little contact with the public and no natural connection to health care struggled to figure out how to conduct health outreach activities in their context. However, over time they developed creative strategies such as focusing in on a couple of key programs within their operations where outreach could have a positive impact on their existing clients (e.g. launching enrollment events in drug courts). In addition, nearly all respondents said that they faced time constraints and competing priorities. As one respondent noted:

> We're stretched very thinly and people are very, very busy. We tell them a lot of things are priorities. Then, they have many bosses that are also telling them priorities. We didn't have to work to convince them, but they needed to carve out the time and think creatively.

Despite these challenges, all county departments succeeded in working together to spread health enrollment information across the county through existing government channels. This was no small feat:

> Given that this is being asked as a priority, above and beyond what folks are already doing, if you look at anybody, it's not like people have tons of time on their plates and are looking for different things to do. So, really this is going above and beyond in many ways. And given that that was the case, it is quite remarkable given what folks have been able to do.

Leadership Circle

The County Executive's Leadership Circle emerged as a strategy to engage key community leaders and build community awareness of health reform. The Leadership Circle is comprised of local leaders from across sectors including business, health care, labor, education and government. These leaders are tasked with helping to spread word of coverage opportunities and to advise the County Executive on the enrollment

initiative (Public Health - Seattle & King County, 2013d). Public Health provides staffing capacity to the Leadership Circle, which includes organizing meetings, informing members of progress against targets, and following up on commitments from members.

The Executive Office, with input from Public Health, selected three co-chairs to lead the Leadership Circle. These co-leads held high-level positions at the Seattle Metropolitan Chamber of Commerce, Swedish Medical Center, and Solid Ground (a non-profit organization dedicated to helping households overcome poverty). As co-chairs, their first task was to pull together a group of the "movers and shakers in the community" from across sectors. To achieve this goal, they worked with Public Health staff to define what sectors needed to be included and then submitted recommendations for the person who could best represent that sector—either the titular head or the leader recognized by the community. They reviewed the list of names and invited leaders from each of the sectors to serve on the Leadership Circle. Throughout this process, they continued to ask themselves whether all sector perspectives were represented. The interest from some sectors—particularly health care providers—greatly outweighed the number of positions available. However, the Leadership Circle and Public Health wanted a way include them and leverage their interest. As a result, the Leadership Circle expanded into two factions: (1) a core group of Executive Committee members who agreed to attend four quarterly meetings in-person and (2) the general body membership that attends online webinars to keep up-to-date with enrollment efforts.

At the time of the Leadership Circle's first meeting in July 2013, many of the county's enrollment strategies and plans were already well underway. Some conveners voiced concerns that bringing together a team of leaders could generate conflict by changing existing plans. One respondent said, "We had to spend some time clarifying that [their role was not to develop the plan] because I wasn't going to allow them to get us off our mission of doing this from a community level."

Instead, the Leadership Circle's role was to provide ideas for how to advance enrollment efforts, while working within the existing constructs. The Leadership Circle's conveners described the group's mission, vision and context—providing data on King County's uninsured residents and existing enrollment efforts. Members were asked how they could step up to the plate to strengthen current enrollment efforts or to help fill gaps. Several of the organizations created their own plans that respected existing strategies. United Way, for example, wanted to use their tax preparation sites to support the effort "without pulling resources away from the community-based strategy". Working with Public Health, they developed a plan to share written information at all tax preparation locations and to provide in-person enrollment assistance at the largest sites.

Most of the strategies focused on spreading accurate enrollment information through each sector's network. The focal points became the Exchange's website and Public Health's enrollment-specific website, which listed every scheduled public

enrollment event countywide. Perhaps the Leadership Circle's most visible success was the rapid dissemination of information. Many members spread enrollment information through their organizational websites, newsletters, or just said to their networks, "I know about this if you need an answer". In particular, several key informants also highlighted the positive impact the Leadership Circle had on the business community by addressing confusion and preventing resistance. Leaders from the Seattle Metropolitan Chamber of Commerce had an active conversation with large and small business members to provide them with accurate information and to answer their questions. In the words of one respondent:

> I think it was really important that businesses were really hearing the facts and the data, not just the media…Even before the president delayed the employer mandate, there was not a lot of resistance. There has been confusion, but not out-and-out opposition. I think having a representative body learn about it and bring it to the private sector helped a lot.

The Leadership Circle meetings became a forum for sharing ideas and the latest news on health enrollment. Keeping the Leadership Circle informed of the county's enrollment efforts created an opportunity for cross-sector strategy reinforcement. For example, one key informant described his actions after learning that the county would be sending health enrollment information to a list of 75,000 county residents with food handler permits ("Notes: Executive Constantine Remarks King County Health Care Enrollment Leadership Circle," 2014):

> I went down to Local 8 [the union serving hotel and restaurant employees] and I said, "You guys have got to do a double hit on this. [The workers] will be getting something from Dow [the County Executive] about their food handler cards. What if you guys shot something out [to encourage them to get enrolled]?"

Not every member took such an active approach to cross-sector support. However, respondents contended that just being part of the Leadership Circle and endorsing the group's efforts was enough to generate positive outcomes across sectors: "To be honest, there were some people who didn't do a whole lot, but their endorsement meant everything. They were people that the community really looked to for answers. Just them saying that they were on board was really important."

The Leadership Circle brings together a well-connected group of community leaders tasked with build awareness of enrollment opportunities across their sectors. Its diversity of sectors and networks has the potential to inform individuals who may not otherwise hear of the county's enrollment efforts. One respondent summarized his perception of the Leadership Circle's value:

> If you didn't have the Leadership Circle and weren't able to use [the member] organization's names, it would have been like a prophet crying into the wind [referring to Public Health]: The words that are coming out are really important…but nobody is listening because it's coming from the prophet that's always talking.

Cross-Cutting Barriers and Challenges

Following an analysis of interview responses, I uncovered several barriers and challenges that affected more than one initiative. These include: website glitches and a long list of error codes; requiring existing Medicaid patients to renew their eligibility through the portal; the quality, quantity and timing of written materials; training delays, bottlenecks, and content deficiencies; insufficient real-time data; and negative stories from the national media.

Website glitches and a long list of error codes hindered enrollment efforts. Many clients have received cryptic error messages while completing their online applications. The Washington HealthPlanFinder's attempts to verify client data submitted on the online application against other government databases, including those from the Internal Revenue Service and the Department of Social and Health Services. If the information provided on the application does not match what is listed in other databases, the applicant will receive an error message that has to be resolved before they can proceed. Immigrant populations and those with complicated income situations are especially likely to experience an error message. One respondent, who manages a group of in-person assisters serving low-income patients, said that at least 50% of their clients' applications were getting stopped during the early phase of open enrollment because of error messages. Even some patients who have traditionally been approved for coverage quickly, such as pregnant women, have faced long waiting times and error codes.

In addition, certain populations have been excluded from the enrollment process altogether. For example, the system automatically assumes that people younger than 18 years old should qualify for coverage through their parent's insurance. However, this system assumption has prevented emancipated teens—many of which are homeless—from gaining coverage. One respondent clarifies the scope of the problem: "It's not large populations that have this, but it's very problematic that there are certain populations that the system is not designed to allow us to help".

Some applicants experienced incorrect eligibility determinations as well. An in-person assister explains:

> I would have people that were clearly eligible for [Medicaid], but would get a determination of a [Qualified Health Plan] with no subsidy, which they clearly can't afford. We'd work on it and I'd finally get them to a [Qualified Health Plan] with tax credit. This person would be unemployed, no income whatsoever. It took mountains to follow up on those and finally get them to work. Or we'd wait for the system to get fixed and finally the application would go through.

For IPAs, time spent fixing error codes is time that could have been spent helping other clients—detracting from overall enrollment efforts.

Several respondents also pointed to random errors with the system that required applicants to furnish documents that made no sense:

> You'd get a status ID error, which is saying that basically the patient should have a student visa and they've never been a student. That's not how they came here…Even when it's asking for it, there was no place to enter any information.

> She signed her daughter up and [the system] wanted her to address her daughter's prison record. Her daughter is 12 years old.

In addition to creating a physical enrollment barrier, technical errors can also undermine client confidence and trust. As one key informant inquired: "How do you explain to somebody it's a glitch when it feels really personal?" Clients may not have the time or energy to continue following up with their application after facing obstacles.

> It's the people with privilege who have the time and the capacity to debate how bad it is. The people that need Medicaid and the young people that we want to be healthy so this whole thing works—they don't have this privilege. They're the same ones clamoring for a $15 minimum wage. They're the same ones that have thousands or hundreds of thousands of dollars of debt. They don't have the privilege or time to debate 'is it working or not?' So you're just going to push them further away.

The website errors overwhelmed the Exchange's customer service team. During March 2014, the call center received 194,213 calls; the average wait time after menu selection for that month was 73 minutes (Washington HealthPlanFinder, 2014b).

The Washington Exchange website also experienced several outages for hours or days at a time. Most of these outages occurred during the first month of Open Enrollment. However, there were several days leading up to the December 23rd deadline and several hours on March 31st, where the website was also not working.

Despite these challenges, respondents overwhelmingly agreed that they had seen improvements in the website's functionality since the early days of open enrollment. The website's rocky start had a silver lining in King County:

> [It] required everyone to step up and work together…[With 20 minds working on a challenge], we can figure out the workaround and send it back out to this network. So, more people gain by coming together and talking about these issues. I think through that [experience], it actually created a stronger network.

In-person assisters now have a long list of error code workarounds at their disposal to help clients overcome glitches. For example, IPAs are now permitted to verify a client's identification manually to move forward if they are stopped by an identity error code. Respondents highlighted Public Health's troubleshooting guides and the monthly First

Friday Forum as valuable resources for learning workarounds and overcoming technical barriers. *(See facilitators below* for more information). One respondent summarized the website's status in the following way: "All-in-all I think that it's getting better. And when it works, it works incredibly well."

Requiring existing Medicaid patients to renew their eligibility through the new Exchange strained support resources and resulted in many patients losing coverage. Washington State requires all Medicaid patients to recertify that they are financially eligible once each year. Without undergoing this redetermination process, their coverage is cancelled (Bauman, 2013). Starting in November 2013, the state Medicaid office decided to shift all Medicaid renewals to the new state-facilitated Washington HealthPlanFinder. This decision, coupled with a glitch-prone website and already burdened in-person assisters, resulted in many people losing coverage precisely at the time when the state aimed to make huge strides in reducing the number of uninsured:

> Hindsight is 20/20. Running another 100,000 people on the website this year [in King County] when we're having trouble getting basic things through has caused a significant number of people to not be successfully qualifying for continuing on Medicaid. That's not even about finding new people. That's about people who deserve to stay on Medicaid and are losing their insurance. That's a really bad thing. The state is aware of it, but they're relying on us on top of everything else to try to find those people and make sure they get re-engaged. It's a huge, huge problem.

Moreover, King County's IPA network had no time to prepare for the additional Medicaid clients, as they only learned of the decision in November 2013.

Applicants renewing their Medicaid eligibility faced many of the same technical glitches as those enrolling for the first time. For example, if the name they provided on their application did not match the name the Exchange was using to verify their eligibility, the applicant would receive an error code. Applicants experiencing enrollment barriers their in-person assisters often sought help from the Exchange's call center—exacerbating already lengthy wait times. Furthermore, IPA organizations now had to grapple with trying to prevent previous Medicaid enrollees from losing their coverage at the same time that they were helping to enroll uninsured residents. In February 2014, one respondent said:

> I am worried in the near future about all of those renewals. We do have all of those people dropping off. On the list that we get from our [Medicaid Managed Care Organizations], every month there is a huge drop of people that didn't get renewed.

Many of the persons that successfully transitioned from the state's Basic Health Program in December 2013 to Apple Health in January 2014 (Apple Health is the state's Medicaid Program) were not re-assigned back to the managed care plan they had

before. For some patients, their primary care physicians (or main providers) were not contracted under the new managed care plan. Medicaid enrollees who did not take steps to correct the plan assignment could lose their primary care providers. One key informant describes the challenges that arose:

> Some of [of our patients] were assigned to plans that we weren't contracted with. Then we had to explain to them what that means—that they have the right to choose. It gets really muddy because people don't understand what managed care is. It's very difficult for people to grasp that concept.

From October 2013 through March 2014, Medicaid renewals accounted for 42% of the state's total enrollments (416,852 of 992,810) (Washington HealthPlanFinder, 2014a, p. 2). Similarly, 35% of King County enrollments were Medicaid redeterminations (Washington HealthPlanFinder, 2014a, p. 4).

Written materials did not meet quality, quantity or timing needs. *The* State's Exchange was responsible for developing all written materials in eight languages: English, Spanish, Vietnamese, Russian, Somali, Chinese, Cambodian, Korean and Laotian ("Fact Sheets," 2013). These written resources included fact sheets, brochures, flyers, and posters to help spread the word of health coverage opportunities. Eight key informants identified problems with materials as a major barrier that threatened success of the enrollment campaign. Public Health, other county government departments and partner organizations did not receive materials until after well after October 1st—the start of open enrollment. As a result, the enrollment initiatives missed an important timing opportunity: "We got off to a late start because of delays in getting materials…It seemed like people's excitement or enthusiasm about it peaked and then started going down by the time I got the materials to them." Another respondent confirmed the impact of these delays:

> With some of these campaigns, you have to hit something when people want it…if they're asking for something, we need to be able to provide that. If you miss that wave, it's harder to generate some attention and interest a month later or a couple months later.

When the materials did finally arrive, the formatting and quality did not cater to reaching uninsured populations in King County. For example, most materials available initially were printed on a full size sheet (8.5" x 11"), when outreach workers preferred smaller materials that they could post in customer service windows or hand out to patients. In addition, the materials received initially were poorly translated into the eight languages and written for clients with a higher reading level. Public Health wanted to expand the written materials to another ten major languages, but did not "have a good place to start" because of the poor initial translations. While those materials may have

sufficed for counties with more homogenous populations, they did not satisfy the needs of King County's diverse ethnic populations. In King County, 39% of uninsured residents newly eligible for Medicaid do not speak English as a first language (Public Health - Seattle & King County, 2014). The initial materials were also written for a middle school reading level, when a fifth grade level was more appropriate for the uninsured patient populations—many of whom struggled with English or were poorly educated. To overcome this barrier, one Federally Qualified Health Center used their own (non-grant) funding to develop materials at a fifth grade reading level.

The Exchange also did not have enough resources to meet the quantity of materials requested. Instead, they posted materials online, sent out PDF versions and encouraged partners to print their own. However, many partner agencies and departments also did not have the resources to print their own or replenish—leaving a shortage that undermined efforts to reach more vulnerable populations:

> When we work with our vulnerable populations, written materials can be really important. A lot of them don't have computers or online access. A lot of these folks are middle-aged or older and are used to written materials—stuff they can look at and take home with them and read. They have a hard time remembering things perhaps and may be a bit disorganized…There just wasn't enough written materials.

Material delays, shortages, and quality assurance shortcomings left Public Health scrambling to meet partner organization's needs. Public Health respondents believed these interruptions could have been avoided with advance warning of the Exchange's challenges: "If we had had a better idea from the beginning what were going to be some of the challenges [with materials]…we might have done things differently, or planned differently or looked for some other kinds of approaches potentially."

Training delays, bottlenecks and content deficiencies left organizations scrambling for months after open enrollment began. Before an individual can become certified as an in-person assister, he or she must complete a state-certified training and take a test on the lesson materials. As lead agency in King County, Public Health was responsible for training anyone interested in becoming an in-person assister. These included hospital employees, staff from the formal IPA network, and other interested community members.

However, a series of delays at the state and federal levels meant that Public Health could not start training until August.

> [W]e ended up scrambling. As lead organization, we got trained first and then we had to start training our contracted providers and all their networks and everyone they wanted certified. We ended up having these trainings—sometimes two a week with over 100 people (our IPAs and hospital staff that needed to be trained). We're bumping up against this Oct. 1st deadline. Here we are trying to get people trained, certified. That was one of

> the biggest barriers—how it rolled out from the state and the feds and for us to push this out quickly was a huge challenge.

Once staff completed the training, they still needed to wait for the certification from the Exchange before they could begin enrolling uninsured residents. Informants described long wait times between training completion and certification. One said, "It would have been great if all the IPAs who were working on these contracts had been certified by Oct. 1st." Someone who completed the training in August often did not receive their certification until late October or early November.

Two additional factors contributed to the certification delays. First, neither the State Exchange nor Public Health had anticipated the high level of training interest from the general community—especially from those who did not have ties to IPA organizations or hospitals. The larger influx of trainees put pressure on the new certification process. Secondly, there was no system of prioritizing trainees:

> The priority of who was trained when and how people got their logins was off. If the state had said, "we're going to first prioritize training for IPAs who are receiving funding because they're being paid to do it", that would have been great. We want to train a lot of people in the community. But there were so many folks flooding the system to take the test. It was hard to prioritize who actually is doing this work. Who do we know is going to be out there for 8 hours a day this work? Why can't they get their login and their test?

Fast-tracking the certification process for IPAs hired to provide full-time enrollment assistance would strengthen the current process.

Several informants commented that the relatively short training omitted important content. As a result, certified IPAs struggled without the knowledge required to meet client needs. Informants recommended several ways to strengthen the training curriculum and experience. These include: developing an online forum for IPAs with different topic threads; adding more advanced training modules to complement the preliminary training (these would not be required for the initial certification); and creating an online module that allows trainees to practice using the system.

Without sub-county real-time enrollment data, implementing partners lacked the performance feedback required to evaluate and strengthen strategies. King County's three strategies focus on reaching uninsured in areas where they live to reduce existing coverage disparities. Despite repeated requests from Public Health, the Exchange had not provided King County with any sub-county data on the number of people enrolled by zip code or city as of the end of open enrollment (March 31st, 2014). The Exchange cited several reasons for not providing the data including concerns around enrollee privacy and lack of staff time. Regardless of the reasons, the Exchange was clearly overwhelmed by other challenges at hand. One respondent cited this as a reason why she gave up on requesting data: "Right away, knowing the chaos the

Exchange was in, I did not think it was worth it, pushing and pushing and pushing to get data when I knew it wasn't going to be possible." Instead, the partnership network had to estimate their sub-county impact based on where they knew partners were enrolling people.

Although county level enrollment data gives the network a sense of overall performance, it does not provide enough information to really assess what strategies are working and which ones need to improved or abandoned. Data on income-levels and racial/ethnic groups that have enrolled in Medicaid or Qualified Health Plans would also have really helped to redirect resources towards specific populations. One cross-agency respondent described the final campaign push as "a bit wimpy" because they lacked sub-county data to highlight which populations had gained coverage and which ones needed additional attention. Key informants expected to receive a lot of data eventually, but not while they were "desperate" for it.

Negative stories from the national media impacted local outreach messaging—propagating misconceptions and creating confusion locally. National media covering enrollment efforts focused heavily on the struggling federal exchange website. Since Washington opted to create its own state-based exchange, local enrollments should have been immune to the federal website troubles. Despite initial glitches and ongoing errors, the Washington's HealthPlanFinder has remained one of the top performing state-based exchange websites (Haberkorn, 2014; Kliff, 2014; La Ganga, 2013; Vestal & Ollove, 2013). However, the national media's negative stories crept into the local discourse, spreading misinformation and threatening to undermine enrollment efforts: In the words of one Leadership Circle member:

> I was getting irritated by all of the false arguments that were in the national media. You don't see a lot of it here, but there's still a lot of bashing of Obamacare and I'm worried that we'll gain really good traction with the expanded Medicaid, but that we might miss our targets with regards to the Qualified Health Plans.

In an effort to combat the negative media, he created an email signature block that directs readers to the county's public health website.

The federal website's poor performance, coupled with reactions from political leaders, politicized health reform efforts in King County. All three of the non-Public Health government officials I interviewed described the negative press nationally as a barrier to their local departmental efforts to reach uninsured residents. One respondent said:

> It made it feel a little more political. There was such a political stance being taken by the Republicans and Democrats…It could be awkward. When Washington State is being very successful and you're just being pounded with all the negative of the federal effort, I found that to be difficult to separate from and keep going forward.

Another county government employee echoed those concerns: “I think that really confused people about whether Obamacare was good...It caused confusion for the public at large, so I think it caused confusion for the people in our departments.” This confusion was met with silence from those managing outreach efforts:

> We were silent on [the state’s website glitches and the political attacks] and pretended like that wasn’t going on…We weren’t doing anything to debunk [the rumors and misinformation]. We were just asking employees to have faith that we wouldn’t be trying to sign people up if it wasn’t the best thing since sliced bread.

To combat the confusion, the respondent thought an effective strategy for addressing this in county government departments would have been to: (1) acknowledge any glitches; (2) inform employees of which ones would soon be fixed; (3) acknowledge that detractors exist; and (4) reassure county employees that their efforts are having a meaningful impact on people’s lives.

The influence of negative media stories nationally was not limited to conservative opposition and website errors. Criticisms from the political left hit home harder for some in King County. One respondent explains:

> I can’t remember where I read it or heard it, but a number of unions are having issues with the program. For me, that was like, “are you kidding me? Then there must be something wrong”. Yeah, they engage in hyperbole and exaggeration, but I trust that if a prominent labor leader is raising concerns about something, then there’s something there to be concerned about.

The critiques coming from union leaders far away[8] caused her to begin questioning the positive impact of health coverage expansion efforts in King County that she had taken for granted. In addition, the Affordable Care Act’s complexity and uneven implementation across states made it especially challenging to sift through the arguments. The respondent raised her concerns with high-level leaders within the county government—asking whether they were aware that prominent labor leaders were saying critical things about the Affordable Care Act. Her question was met with a “non-response”. She highlights the importance of addressing employee concerns head-on: “If we’re battling for the hearts and minds of our employees, then we’ve got to get real with them. Not pretend like the rest of the world isn’t happening and that we’re in this little [Equity and Social Justice]-loving bubble.”

---

[8] Labor leaders in King County have been vocal supporters of health coverage expansion.

Factors Enabling Enrollment Initiatives

In addition to exploring barriers, I also asked key informants about the factors that facilitated enrollment in King County. I then coded, analyzed and selected themes based on the frequency of responses. The themes that emerged across multiple initiatives include: the county's progressive history and political environment; the County Executive's prioritization of health enrollment; a strong backbone organization and preexisting capacity; a strong culture and tradition of community partnerships; a well-established monthly forum; and the decision to frame health enrollment as an equity issue.

The county's progressive history and political environment aided health care enrollment initiatives. King County resides in a Democratic-leaning state and is home to Seattle, one of the most liberal cities in the nation. In past federal elections, King County has overwhelmingly supported Democratic candidates. For example, during the 2008 and 2012 presidential elections, Barack Obama and Joe Biden received more than 68% of the King County votes (King County Elections, 2008, King County Elections, 2012). In contrast, Republican presidential candidates received fewer than 29% of county votes in both elections. One Leadership Circle respondent said:

> King County, when you look at the demographics or follow the politics, is a progressive community…Health care reform and the Affordable Care Act are perceived to be a product of a progressive and democratic president. That meant that there was an awareness of the Affordable Care Act and less of a resistance in King County than you might have seen in other parts of the country.

Across the nation, more Democratic-governed than Republican-governed states opted to expand their state Medicaid programs and launch state-based exchanges. Washington's decision to create a state-based health benefit exchange attracted additional federal funding for enrollment initiatives. Approximately $1.6 million in funding supported King County's geo-targeting initiative through the IPA network ("Washington Health Benefit Exchange selects Public Health – Seattle & King County to lead enrollment efforts in King County," 2013). Furthermore, the state's decision to expand Medicaid also facilitated enrollment efforts because a much larger proportion of low-income residents became eligible for affordable coverage.

The county government has also committed itself to a progressive agenda, which includes environmental sustainability, promoting equity and social justice, and health care reform implementation. The county's strategic priorities, coupled with the liberal political environment, fostered health reform awareness and support. Furthermore, supporters in King County faced little political risk in backing the initiatives.

> We're a very liberal county; we're all going to get behind this. It wasn't like people were out there saying, "this was a stupid program and Obama's an idiot". So, there was no downside to this at all as it was being launched.

King County's progressive nature helped enable maximum flexibility in enrollment innovation strategies because implementers did not have to expend resources defending the law.

The County Executive made enrollment a priority—bringing attention and resources to the enrollment effort. Nearly everyone I interviewed highlighted the King County Executive's instrumental role in health coverage efforts. This theme was prominent across both governmental and non-governmental respondents. The Executive, Dow Constantine, is an experienced and well-respected elected leader in the community. He not only committed his Executive Office to the enrollment work, but also affirmed his personal commitment. He identified health enrollment as a countywide priority in his 2013 State of the County Address, which generated sustained intensity and focus to the enrollment campaign. During that address, he also announced the cross-agency enrollment effort and the launch of the Leadership Circle ("State of the County 2013," 2013). These initiatives aligned well with the county's equity and social justice work. Respondents overwhelmingly agreed that his high-level prioritization of this issue helped make it successful. As three respondents explained:

> One of the reasons I think the county's efforts were so successful were that there was not only support from the very top, but the Executive was making it very clear that this was high profile, high priority. His expectation was that departments would be supporting it. I always feel that on any kind of initiative like this, that the more visible support there is from the top—genuine, sincere support and prioritization—really signals to the organization that the boss cares about this.
>
> And the support from the Executive I think was really key. Folks didn't see this necessarily as coming from Public Health, they saw this as a priority for the Executive and that makes a huge difference.
>
> An important element for it to work is leadership is on board. I think that's one reason why [enrollment efforts] worked. Leadership was very much on board. Executive Constantine made this a major priority for the county. He made it clear, under no uncertain terms, that this was an important effort.

Executive Constantine also demonstrated his commitment in other ways. He attended enrollment events, visited with the IPA network's call center workers, and spoke with the state and federal audiences about the county's enrollment. His vocal support generated attention from the media, the Governor's Office and the White House Administration. Citing these reasons, one key informant described a synergy between

Executive Constantine's work and the other enrollment efforts: "It wasn't 1+1 = 2. It was 1+1 = 5."

Key staff from the Executive's Office also helped maintain focus throughout the enrollment planning and execution phases. Written updates from the Executive's Office in the form of newsletters and emails kept county staff informed of the enrollment efforts. Sustained messaging from sources outside of Public Health helped employees in other agencies and departments stay connected. In some cases, persistent requests from Executive Office staff generated surprising outcomes. For example, one respondent explained that her county department has a very restrictive policy about offering free advertising. Employees working for the department did not have any control over this policy. However, they wanted to satisfy the Executive Office. She explains the impact of the Executive Office's sustained pressure,

> [Executive Office staff] pushed on it and we were asked to work harder to find a way to [provide free advertising]. We had to continue to say "no", but because people were relentless about it [*laughs*], our marketing person who works with our advertiser had a conversation and what they agreed to do was…double the advertising that was available for the same purchase price. So, that was very well-received and appreciated.

Executive Constantine believes that expanding health coverage will benefit individuals, businesses, communities and the economy in King County. His motivation for making health enrollment a major county focus stemmed from three primary drivers: principles of equity, the economic toll of uninsurance, and personal knowledge of what it feels like to be uninsured.

> Being physically healthy is almost really a prerequisite to success in life. We don't want people to be stuck in the circumstances into which they were born or which they find themselves because they aren't able to access relatively simple services that all of the rest of us have access to. So, I'm able to see that as part of this bigger picture from a professional point of view—from my view as the Executive—trying to promote a community in which everyone has the opportunity to succeed and fulfill their potential.
>
> The impact on the individual is also the impact on the collective—on the economy. Absenteeism, extraordinary costs that are shifted onto others because simple conditions are allowed to become serious conditions and eventually end up in the emergency room where people receive treatment whether they are able to pay or not. And the inability of people because they are ill to contribute to society—all those things and a million other associated problems—all those are a drag on the economy. Regardless of whether you care about the individual's ability to succeed or not, everybody needs to worry about this. Having so many individuals uninsured is bad for business and bad for our economy.
>
> When I was an attorney in private practice, I was able to scrape the money together and make payroll for employees, but I certainly wasn't able to buy health insurance for myself. I had to go on for quite a while with the insecurity of not having health care coverage. So, I'm aware of what that feels like and I'm also aware that it's an impediment to people taking the risks to change a career or start a business—the notion that you or your family

> will do without health care coverage. And that is really counter to what we say we want to see as Americans, which is people being able to bring their talents to bear, to take risks, and succeed. You shouldn't have to take a risk that you are going to become ill or injured and go bankrupt or worse. That's not one of the risks that should come along with starting a small business.

All three of these motivating factors aim to maximize individual and societal potential—an argument that resonates with a broad range of King County audiences. Executive Constantine's vocal and sustained commitment to enrollment positively impacted coverage efforts.

A strong backbone organization, preexisting capacity and additional resources facilitated a smooth launch. Public Health served as the backbone organization for the enrollment campaign, providing a strategic vision and continuous support to the network of partners.[9] Public Health was not only a large and "well-trusted" organization, but they had preexisting capacity to plan, implement, and support the effort. One Public Health respondent explained,

> We'd already been doing Medicaid trainings and had been doing them for years. We already had training curriculums and staff who knew how to facilitate. We already had a venue for the First Friday Forum where we could push out materials. We already had a website.

In addition, many Public Health staff not funded by the lead agency grant served on the core planning team. They provided expertise across a broad range of subjects including communications, policy, and evaluation. Furthermore, Public Health and the Executive Office had preexisting relationships to enable collaboration across sectors.

Prior to open enrollment, many non-governmental partner organizations had substantial experience in connecting uninsured to community resources or enrolling them in health plans. In the months preceding open enrollment, these organizations dedicated a lot of staff time to designing their own strategies and activities. For example, one health care organization created a special webpage[10] with customized fact sheets for their staff and uninsured patients seeking coverage. Their outreach strategies and concise fact sheets became a model for other health care organizations—including members of their national parent organization and the Washington State Hospital Association.

The partnership network received additional funding and dedicated their own resources to implementing the coverage strategies. In addition to receiving funding from the Exchange and allocating "unfunded" staff time to the enrollment efforts, Federally

---

[9] As discussed earlier, the Exchange had also selected Public Health as lead agency for the county.

[10] The website also contained links to the Public Health county enrollment website and the Washington HealthPlanFinder.

Qualified Health Centers received substantial funding directly from the federal government to enroll uninsured.[11] Boeing, a private company, also provided funding to multiple community organizations in King County. Preexisting capacity and strong interest in health reform locally bolstered resources for enrollment.

A strong culture and tradition of community partnerships facilitated health reform implementation. Working together toward common goals appeared to be a natural and comfortable process for many of the respondents—particularly those involved in the Leadership Circle and geo-targeting initiatives. Several informants pointed to a deeply entrenched sense of community collaboration in Seattle.

> You're looking at a model in a community that has partners out to wazoo forever. We are a partnering community. If you don't partner in this community, you don't get squat done. It doesn't work. You're a lone ranger and the worst thing in this community is to be a lone ranger…I mean, you want to do something—you better get the city, the county, labor. You better get everyone around the table. That's our natural instinct.

> There's a sense of collaboration in Seattle that's phenomenal. It's across other things too. I've worked on a lot of community health things where we had speakers come in and talk about that they can't even believe the collaboration that takes place in Washington State and in western Washington. So, it's part of the culture to reach out to one another…So, that's one of the things that's unique here. I've been in Minnesota and California, where there isn't that sense of collaboration.

During the interviews, it was striking how many of the relationships between key partners pre-dated health reform. Many respondents involved in the Leadership Circle and geo-targeting initiatives highlighted other community projects that they had worked on with many of the same organizations. For example, one IPA organization also currently serves as the basic food lead agency for King County. This organization sub-contracts basic food work to Public Health and four other IPA organizations. Because of this overlap in partnerships, the basic food lead agency utilized an existing basic food outreach forum to discuss working together on food and health. In developing their strategies, Public Health also seized on opportunities to pair organizations with a history of working together. Aligning agencies with a common history builds on existing infrastructure and trust.

Compared with other counties and social service projects, respondents thought health reform implementation in King County was more collaborative. One respondent worked for an organization serving as IPA contractor in two different counties. She believed that population density in King County contributed to a more favorable experience.

---

[11] This funding is not unique to King County.

> For King, it's such a population dense area that you're just going to have overlap. "Here are these other agencies. Work with these other agencies." That's just part of the deal. Whereas you don't have that physical pressure up north to interact with other agencies—to see how they do things and to learn from those experiences.

Community-based organizations in King County have seen first-hand the inequities around health care in their daily work. The ACA's unprecedented opportunity to expand coverage to most of the county's uninsured energized the network of implementing agencies.

> One of the things I would say with the new ACA work is that the culture is definitely more collaborative than basic food work in the past (which is also contractual)…everyone has been working in this field for years and have seen so many people who need health and dental insurance. Everyone is really excited to work together to get uninsured people enrolled finally.

A well-established monthly forum expedited enrollment planning and facilitated communication. For nearly 18 years, First Friday Forum (FFF) has served as a venue for communicating information related to publicly funded health programs, including Medicaid and Basic Health. The coalition members utilize FFF to advocate for change, share information and provide feedback to state and local agencies. The meetings are highly technical, focusing on the operational and policy details of state health programs.

FFF naturally became the primary venue for discussing health reform among a broad group of key stakeholders. Through FFF, organizations had already cultivated relationships with each other and the health reform conversation was well underway—accelerating planning efforts. In late 2012 and early 2013, Public Health and trusted community partners from First Friday Forum worked together to create plans for the geo-targeting initiative.

Over time, the open forum swelled in size due to intense community interest around health reform. As of February 2014, nearly 200 people attended the meetings from approximately 70 different organizations. The forum gets its strength in part through the diversity of attendees: local government agencies, community-based organizations (including the IPA network), the state Medicaid office (i.e. Health Care Authority), the Washington Department of Health, and the Health Benefit Exchange. Members use the forum to share best practices, learn strategies for overcoming barriers, and celebrate successes. Across the board, respondents spoke very highly of the forum. These are a few excerpts:

> First Friday Forum has been an excellent venue. We do get so much information even before this all came about. It's been a great opportunity for us to assess how things are going (even though it turns into more of a rant sometimes). It's really great to be part of a community that knows what you're going through and has the same questions, and also

> to be able to share workarounds that we all might come across. That's been extremely helpful.
>
> [W]e try not to pull our [IPAs] from the clinics at the same time, except for First Friday Forum because we think that's a really important place to get updates.
>
> It's really great because people can come there and hopefully get their questions answered. They need to understand the system. The state needs to understand the impact of their policies. It started out as the state knows how to write policy, but we need to help them understand how it affects communities…All the policy makers are there. We get emails all the time saying, "we need to come to First Friday Forum because we're going to make a law change." Ok, great. They come there because they need to hear.

The open dialogue between policymakers and grassroots organizations benefits both groups. The state Medicaid Office and Health Benefit Exchange attend all meetings and present at most. Other organizations ask questions and share their experiences.

Framing health enrollment as an equity issue resonated deeply with the local community. The county's health enrollment campaign exposed existing disparities in health coverage, life expectancy and other health indicators. It also emphasized the unique opportunity that health reform brings to reduce long-standing inequities.

Equity has been a key theme across the King County government's work for many years. The county had set up work groups to identify existing inequities and to develop ways to address them. In addition, all county employees receive orientation so that they can use an equity lens in their work. Executive Constantine describes the county's progress and values behind this work:

> The good news is that more and more people are internalizing what it is that we're trying to do. It's not something new or novel, quirky or offbeat. These are fundamental American principles, shared by virtually everyone: fairness, and justice, and the notion that if you work hard, and are energetic and driven that you should have a chance to succeed.

In addition to the county government, the primary purpose of most community-based organizations involved in the enrollment effort is to advance equity. These organizations serve a wide range of populations including people with low-incomes, the homeless, people with disabilities, people of color, and immigrants. The county's decision to frame enrollment as an equity issue inspired support from a broad range of partners and quelled potential resistance:

> "[My sense is that this was all sort of holistic, organic and reflective of the county's values. Having it be framed [as an equity issue] took a lot of the politics out of it. Who

> could stand up and say, “I don’t think this is a good program because I don’t think people should have the right to have access to medical care”?

Public Health had the data to help frame enrollment as an issue of equity. They created a series of county maps highlighting stark geographic inequities related to health. These maps created a persuasive and powerful argument for health reform efforts in King County (see maps 1 and 2 of figure 6 illustrating uninsurance rates before enrollment began and anticipated improvements after enrollment). They helped translate a national law into a local opportunity and generate a sense of urgency. Two informants describes the power of these maps:

> The data was so dense, but after putting it into a map (which is why humans like maps), you immediately look at it and can analyze whether it’s relevant to you (you can look at where you live, work or where somebody you care about lives). So, maps draw people’s attention. Also, the message is “if we do this now, this map will get better”. That’s not a hard thing to understand. There’s a whole algorithm behind it, but that’s the promise. If we work together, if you sign up for this (it’s not going to cost you a lot of money), this community is going to get better over time. That’s important to make it relevant to people. [They can’t just say] “This is just Democrats and Republicans talking about this in Washington, DC”. No, this is relevant to our community. That helped a lot to have a group beyond Public Health – Seattle & King County saying this is something special (and for people to listen to it). It’s a unique opportunity.

> When I first saw the health outcomes and health indicators maps…it made quite an impression on me…I think it does vividly and dramatically make the point that even within our area (which is pretty progressive), we have some serious inequities. Not just in terms of who has insurance, but in who feels well and who doesn’t feel well and in a lot of different health indicators. This [enrollment] effort could really take some positive steps towards mitigating or limiting these inequities. I thought it was a powerful argument.

The visualization of health reform on a county map served as an effective tool for talking about health as an equity issue. In very few words, the maps also conveyed where the uninsured lived and where enrollment efforts needed to focus in order to advance equity.

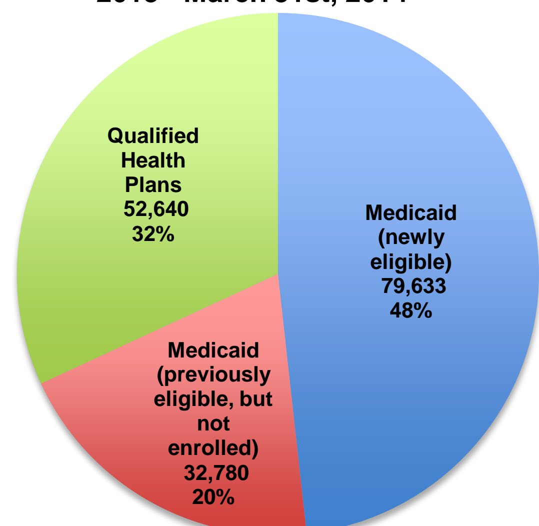
Preliminary Outcomes of Enrollment Efforts in King County

One month following the end of Open Enrollment, we lack important data required to draw conclusions on King County's performance, including: comparative data across states; sub-jurisdiction data on the number of people who enrolled by race/ethnicity, income, and geographic region; and the number of people in the county who purchased insurance outside of the Exchange. This means we cannot yet compare King County's enrollment performance against large counties in other States; estimate the number of people who remain uninsured; or conclude that King County's strategies reduced coverage disparities. However, preliminary data and anecdotal information suggest that King County's enrollment strategies have been successful.

In particular, it is clear that King County had a very strong launch to open enrollment. During a meeting Executive Constantine had with President Obama in early 2014, Valerie Jarrett, Senior White House Advisor, enthusiastically announced to the President that, "King County had signed up at that point more people than any other county in the country for health care". Another indicator that King County had a strong start is the in-person assister network. King County's IPA network had a target of enrolling 19,180 people between October 1st, 2013 and December 31st, 2014 set by the State Exchange. They surpassed that goal in late December 2013—*more than 12 months early*.

Prior to open enrollment, Public Health estimated that 80,000 residents would become newly eligible for Medicaid, 100,000 for subsidized Qualified Health Plans, and 24,000 for unsubsidized Qualified Health Plans in King County. During open enrollment, a total of 112,413 King County residents enrolled in Medicaid and 52,640 enrolled in Qualified Health Plans (see figure 7) (Washington HealthPlanFinder, 2014a, p. 4). Furthermore, 90,494 people renewed their existing Medicaid coverage. Across the state, an additional 178,981 people enrolled in individual health insurance plans outside of the Exchange (Washington State Office of the Insurance Commissioner, 2014b). Although we do not yet know the totals for King County, all of these ACA compliant plans offer a standard set of essential benefits (Washington State Office of the Insurance Commissioner, 2014a).

Figure 7: King County Enrollments through the Exchange: October 1st, 2013 - March 31st, 2014



The Next Phase for the Countywide Effort

Despite many initial successes, questions remain about how enrollment strategies will unfold in the future. Looking ahead, respondents across all three initiatives highlighted threats to future enrollment, opportunities for expansion, and aspirations for sustainability. The specific challenges and opportunities varied considerably across initiatives (these are discussed below). However, common themes also emerged. For example, respondents felt motivated and inspired by the initial results of the three strategies. They believe that a successful history will create an opportunity to invite broader participation from across the community. Maintaining and expanding the scope of work is essential for addressing access issues. For many key informants looking ahead to the future, the focus shifts from "how are we going to enroll these people?" to "oh, my goodness, how are we going to serve these people?"

For the geo-targeting strategy, all respondents expressed a strong desire to continue the community-based work. However, an impending funding cliff threatens to severely reduce the scope and impact of the work: "Most realistic is we're going to be facing a big, dramatic shift in funding next year and we'll have to make some hard decisions—and the geo-targeting may almost totally go away because of lack of funding." All funding for the IPA network is scheduled to end in December 2014—right in the middle of next year's Open Enrollment period. Uncertainty around funding "makes the whole system unsure and hesitant". Without continued external funding, several organizations planned to scale back to just serving internal clients. One organization working on outreach expected to transition from presenting to audiences to handing out leaflets when people ask for information on enrollment. Another key informant expressed hope that the Health Care Authority (the State Medicaid Office) and the Exchange would find a way to cobble together funding so that the network could continue their work. Both agencies are currently trying to do so. She said, "We don't expect to have the level of funding that we have now, but nothing doesn't seem to be rational".

In addition to sustained funding, another best-case scenario for the geo-targeting initiative would be if some organizations stepped up to own enrollment for their communities—hosting events and imbedding enrollment into their current work practices. Public Health has invited a number of new organizations—including consulates and community organizations working with specific populations—to help lead enrollment events with the intent of creating sustainability for enrollment in the future. Whether these organizations will "pick up the banner" is still unknown.

Many geo-targeting respondents also viewed enrollment as just the first step towards accessing affordable care. They highlighted opportunities for the network to expand its scope to the next steps in ensuring access to health services for enrollees. Potential expansion ideas include: educating enrollees on how to use their insurance

(many have no experience using insurance); creating awareness among providers that many newly enrolled patients do not understand how to use their insurance and providing them with strategies for addressing this issue; and encouraging more providers to accept Medicaid enrollees. Ultimately, alleviating inequities in health outcomes requires that individuals not only have health coverage, but also use the insurance to see providers.

For the cross-agency initiative, key informant perceptions of whether and how future enrollment work would unfold varied widely. Departments with a traditional health focus voiced a strong commitment to sustaining and building on current efforts to improve access. One respondent said,

> [Our department] director was able to allocate a significant amount of money in January 2014 to our mental health and substance abuse providers to increase their intake capacity in anticipation of these newly eligible folks coming in. I think the work will continue in terms of how to enroll folks and enrolling them, but I think that's starting to become something that agencies are comfortable with after five months. I'm sure we will continue to talk about that, but more and more, we're going to be talking about capacity issues and serving these folks.

In contrast to the geo-targeting initiative, many of the government agencies involved with the cross-agency strategy do not have a traditional health focus. Participants working for non-health-related departments and agencies expressed uncertainty about whether they would continue to have a role in future enrollment efforts. One respondent explained,

> I have the sense that our work as a department is pretty much done. If somebody thinks that's not the case, then I need to know and consider what that means on an on-going basis. I know that sign-up continues for Medicaid. I don't really know what's next for enrollment. We don't really have a role in [ongoing Medicaid enrollment]. Our job was to help with this big initial effort to help meet target enrollment numbers by April. We need to know what this looks like in the future and whether other departments besides Public Health play a role.

Diverging expectations are likely attributable in large part to the fact that this is one of the first times that departments have embarked on a common goal to advance equity across county government agencies. Therefore, there is no precedent to how the work should continue. To close the loop, Public Health is planning to convene the cross-agency enrollment team after open enrollment ends to de-brief on past efforts, thank team members for their support, and talk about next steps. (Initial plans to meet were delayed because of the lack of real-time sub-county level data.) Their hope is that departments institutionalize enrollment strategies into their daily work. They are very conscious that there could be potentially negative consequences if they do not report back to the team.

Although the Leadership Circle originally had a sunset clause[12] built into it, members see value in continuing to collaborate across sectors. One respondent thought that reviewing data from open enrollment would help answer the question of "how much longer should we exist and to what end?" Decisions about next steps with regards to enrollment will take place once the data reveal how well the county succeeded in reaching various communities. Across the board, members of the Leadership Circle expressed a desire to see the team (or a subset) continue working together in other areas. Potential opportunities suggested by respondents included: spreading enrollment information prior to the next open enrollment period; encouraging people to see their health care providers; creating awareness of the many mental health initiatives taking place (and soliciting community support); and brainstorming on workplace wellness programs.

Many respondents across the initiatives emphasized the need for cross-sector participation in the future. Executive Constantine explained the anticipated role of government in the future and highlighted the importance of sustained community collaboration:

> I actually think that moving into the next phase when enrollment re-opens in the fall, the need for these partnerships becomes greater because we need more people to own the challenge, own the problem, and own the solution. We don't have the resources or the capacity here in King County government to sustain this ongoing effort. We can do our part, but once all the initial excitement is gone, we can't just have everyone wander off and go say, "Ok, they've got this now". We need the business community. We need the non-profit community and our fellow governments to recognize that this is an ongoing obligation. We're glad to provide the resources and continuity of thought and message/direction, but this is everybody's business.

[12] Members of the Executive Council were asked to attend four meetings over roughly a year period. As of April 2014, three of the four meetings had taken place.

DISCUSSION

In this thesis, I examined three innovative approaches to enrolling the uninsured in King County, including: (1) *geo-targeting* with community organization partnerships to reach uninsured residents where they reside; (2) *a county agency mobilization* effort to leverage existing government channels that serve the public; and (3) a *Leadership Circle* comprised of cross-sector leaders tasked with spreading information. Through in-depth interviews, I explored common barriers and enabling factors emerging across the three initiatives. These findings not only provide an opportunity to understand how health reform unfolded in King County, but also have important implications for other regions across the country. Sharing best practices from innovative approaches as they transpire will empower states and cities to strengthen local health coverage efforts.

Best Practices from King County

King County's environmental conditions and enabling factors represent a best-case scenario for health reform implementation. Other regions with similarly progressive environments, strong leadership, preexisting capacity, and sufficient resources may be able to successfully replicate one or more of King County's innovative approaches. In addition, I have gleaned six best practices from King County's experiences that are applicable to a broad range of health reform environments, including regions experiencing greater political hostility towards the ACA and those with limited capacity or implementation resources. The best practices described below provide insights into convening a strong network of partner organizations, inspiring community ownership, and enhancing communication. Implementing these best practices can help to maximize enrollment of the uninsured across a diverse spectrum of health reform environments.

1. Solicit active support from local leaders and create opportunities for them to lead. As King County's experience reveals, strong sustained support from local leadership can greatly impact the success of enrollment efforts. High-level elected leaders who champion coverage goals can facilitate necessary cooperation among public agencies. These leaders can also help promote a culture shift within public agencies to bolster outreach efforts. Support from other community leaders across sectors can also help spread accurate enrollment information through existing networks. Elected and community leaders often have limited time to allocate to the effort personally. Just voicing support for enrollment can bring attention to outreach efforts and prevent opposition. To solicit and maintain support from leaders, health reform implementers should: (1) offer to educate leaders on the issues (e.g. conduct briefings at city council meetings, create a leadership forum); (2) specify opportunities for

leadership; (3) create space for leaders to advise on existing and new enrollment efforts; (4) keep leaders informed of progress and activities; (4) and show appreciation for their support.

2. Defer detailed decision-making to grassroots organizations to build community ownership and sustainability.[13] Organizations leading enrollment efforts must avoid the temptation to control all aspects of the enrollment campaign process. Instead, their role is to bring attention to the issues, set the agenda, convene partner organizations, solicit commitments, offer support, and share data. Recognizing and respecting the past contributions of community organizations builds trust among implementing organizations. In King County, the most innovative strategies and tactics for enrolling the uninsured emerged from organizations with direct contact with uninsured populations. Decentralization created an environment that fostered local adaptation. Community organizations examined internal operations for opportunities to reach the uninsured, leveraged existing resources, and incorporated past experiences working with target communities. Moreover, many of the most contentious times arose when a higher-level organization attempted to control the details of how a community-level organization carried out local plans. At the center of the conflict was often a struggle between consistency in messaging[14] and promoting community ownership. While lead organizations have a responsibility to prevent misinformation from spreading and to generate brand recognition, aiming for "perfect" messaging at all levels risks undermining local ownership. After federal and state funding ends, strong local ownership may be the determining factor in sustaining outreach efforts.

3. Frame enrollment in terms that will resonate with the community. The general premise of health coverage expansion—to get uninsured residents enrolled in health insurance plans—does not inspire active participation from across a broad range of organizations. Instead, lead implementing organizations should identify opportunities to tap into the community's culture to create a sense of urgency and excitement around health enrollment. In King County, framing enrollment as an opportunity to advance equity generated broad community support and leveraged past equity work. A series of maps using local health indicator and outcomes data created a compelling argument for why health reform was important and how it could benefit the local community. Other regions around the United States may benefit from framing enrollment efforts in terms that generate a sense of local significance.

---

[13] Ultimately, the success of decentralization depends on the capacity, resources, and dedication of grassroots organizations. For agencies struggling to develop strategies and tactics, organizations leading enrollment efforts should offer to provide technical assistance and the required tools.

[14] Both the Washington Health Benefit Exchange and Public Health – Seattle & King County established strict branding/messaging requirements.

4. Invite participation from organizations without a health focus. Soliciting participation from a broad range of non-health organizations such as businesses, labor unions, universities, and government agencies can extend the reach of coverage efforts many fold. Non-health partners have different constituencies and can help spread enrollment information through their existing networks. In King County, many of the organizations and government agencies involved in the Leadership Circle and cross-agency enrollment effort did not have a traditional role in health services. These partners helped to reach uninsured residents that were not connected to health organizations. In addition, non-health partners can help anticipate where resistance might occur, debunk negative stories, fight misinformation and reinforce positive messages. They can also play important roles in routine future efforts to cover the uninsured. For instance, labor unions that incorporate health enrollment information into routine presentations to newly dislocated workers could help prevent breaks in coverage. Ultimately, the experience in King County demonstrates the important contributions non-health partners can make to coverage efforts.

5. Utilize existing partnership networks and bring all organizations to the table—especially smaller ones. Creating a broad network of partners is essential for reaching diverse uninsured populations. Any organization showing an interest should be given an opportunity to participate in outreach or enrollment efforts. While smaller organizations do not have the reach of large community organizations with multiple site locations, their focused attention addresses existing disparities by reaching targeted vulnerable populations that may otherwise be excluded. In King County, for example, the partnership network's smaller organizations included an African-American breast cancer survivor support organization and a multicultural gay men's health organization. Other locales interested in strengthening outreach efforts within certain populations or geographical regions, but without existing relationships, should ask their existing partnership network for ideas and contacts. In addition, lead agencies should pair partner organizations together that have a history of working together whenever possible. Aligning organizations with a history of working well together builds on existing trust, easing implementation of enrollment activities. Ultimately, the most effective partnership networks inspire broad participation and ownership, and leverage past relationships.

6. Convene a regular forum focused on addressing technical issues to share solutions. Even the best exchange websites, whether state or federal, are a long way from perfect. Overcoming technical barriers and transitioning smoothly to new policy changes requires structured communication at regular intervals. King County's *First Friday Forum* served as a powerful venue for rapidly disseminating important information throughout health reform implementation networks. Representatives from

the Washington Health Benefit Exchange, the Health Care Authority (the state's Medicaid Office), the state and county health departments, and members of the in-person assister networks attend every meeting. Other regions should establish similar ongoing meetings to strengthen dialogue between policymakers and community organizations working directly with clients. For policymakers, this type of forum is a valuable tool for gathering feedback on policy changes and communicating new requirements. For community-based organizations, the meeting provides an opportunity to highlight problems that require attention from policymakers, to get clarification on technical issues, and to share effective strategies with other implementers. Equally important, the forum should also be used as a venue to celebrate the group's successes and recognize the hard work of all contributors.

Study Limitations

King County's strategies have been deployed within the county's unique historical, social and political context. The county benefits from a progressive political environment, strong leadership, robust preexisting community organizations and government agencies, and considerable resources allocated to enrollment efforts. For all of these reasons, the case study represents a best-case scenario for health reform implementation. Replicating the three strategies may be challenging, if not impossible, in other settings. Moreover, since I did not examine the health reform implementation experiences of other localities, it remains unclear how King County compares to others and to what extent these strategies are unique and responsible for its enrollment success.

In addition, this research does not attempt to quantify or attribute enrollment to the specific strategies. King County's enrollment performance depends on numerous factors beyond the scope of outreach initiatives, including functionality of the state's marketplace website, statewide marketing and local policies. In addition, unknown variables may contribute to health coverage enrollment. For example, King County's population may be more computer literate than many other regions around the state or country. There may also have been other community-based organizations or health care institutions developing parallel and effective approaches for enrolling residents in health coverage in King County. Furthermore, it is not possible to tease apart the individual impact of initiatives due to potentially synergistic effects.

Finally, findings and conclusions of this paper are based primarily on interviews with fourteen key informants. This accounts for a small proportion of the hundreds of people across King County that been involved in enrolling uninsured residents. Therefore, the study results may not be representative of a broader respondent audience.

APPENDIX

A: References

Alvarez, L., & Pear, Robert. (2013, September 17). Florida Among States Undercutting Health Care Enrollment. *New York Times*. New York, NY. Retrieved from http://www.nytimes.com/2013/09/18/us/florida-among-states-undercutting-health-care-enrollment.html

Bauman, V. (2013, December 12). Health exchange's tech problems result in lost Medicaid coverage. *Puget Sound Business Journal*. Retrieved from http://m.bizjournals.com/seattle/blog/health-care-inc/2013/12/health-exchanges-tech-problems-result.html?page=all&r=full

Center for Medicare and Medicaid Services. (2013). *The Number of Estimated Eligible Uninsured People for Outreach Targeting*. Retrieved from https://data.cms.gov/dataset/The-Number-of-Estimated-Eligible-Uninsured-People-/pc88-ec56

Cody, P. (n.d.). *Washington State Basic Health Plan*. Presented at the Council of State Governments. Retrieved from http://www.csg.org/policy/documents/WAStateBasicHealth.PDF

Congressional Budget Office. (2013). *CBO's May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance*. Washington, DC. Retrieved from http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf

Fact Sheets. (2013). *Washington Health Benefit Exchange*. Retrieved March 25, 2014, from http://www.wahbexchange.org/news-resources/press-room/fact-sheets/

Haberkorn, J. (2014, March 31). Obamacare in Washington state: "No frills" success. *Politico*. Retrieved from http://www.politico.com/story/2014/03/washington-state-obamacare-no-frills-success-105188.html

Hill, I., Courtot, B., & Wilkinson, M. (2013). *Reaching and Enrolling the Uninsured: Early Efforts to Implement the Affordable Care Act* (pp. 1–19). Urban Institute. Retrieved from http://www.urban.org/UploadedPDF/412917-Reaching-and-Enrolling-the-Uninsured.pdf

Kaiser Family Foundation. (2013a). *Current Status of State Medicaid Expansion Decisions, as of November 22, 2013*. Retrieved from http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/

Kaiser Family Foundation. (2013b). *Key Lessons from Medicaid and CHIP for Outreach and Enrollment Under the Affordable Care Act.* Menlo Park, CA. Retrieved from http://kff.org/health-reform/issue-brief/expanding-medicaid-to-low-income-childless-adults/

Kaiser Family Foundation. (2013c). State Decisions for Creating Health Insurance Marketplaces. Retrieved December 2, 2013, from http://kff.org/health-reform/state-indicator/health-insurance-exchanges/#

Kaiser Family Foundation. (2014a). *Interactive: A State by State Look at How the Uninsured Fare Under the ACA*. Menlo Park, CA. Retrieved from http://kff.org/interactive/uninsured-gap/

Kaiser Family Foundation. (2014b). *Kaiser Health Tracking Poll: March 2014*. Retrieved from http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-march-2014/

Kaiser Family Foundation. (2014c). *State Profiles: How will the Uninsured Fare Under the Affordable Care Act?* Menlo Park, CA. Retrieved from http://kff.org/state-profiles-uninsured-under-aca/

King County Elections. (2008). *November 4, 2008 General Election*. Retrieved from http://your.kingcounty.gov/elections/200811/Respage3.aspx

King County Elections. (2012). *November 6, 2012 General: US President and Vice President*. Retrieved from http://your.kingcounty.gov/elections/200811/Respage3.aspx

King County Government. (2012). *King County Equity and Social Justice Annual Report 2012* (pp. 1–26). Seattle, WA. Retrieved from http://www.kingcounty.gov/exec/~/media/exec/equity/documents/EquityReport2013.ashx

King County Government. (2013). *King County Equity and Social Justice Annual Report 2013* (pp. 1–32). Seattle, WA. Retrieved from http://www.kingcounty.gov/exec/~/media/exec/equity/documents/EquityReport2013.ashx

Kliff, S. (2014, February 3). Seattle has a great football team--and an awesome Obamacare Exchange. *Washington Post Wonkblog*. Retrieved from http://www.washingtonpost.com/blogs/wonkblog/wp/2014/02/03/seattle-has-a-great-football-team-and-an-awesome-obamacare-exchange-too/

La Ganga, M. (2013, November 12). Washington State is making health exchange work. *Los Angeles Times*. Los Angeles, CA. Retrieved from http://www.latimes.com/nation/la-na-washington-obamacare-20131113,0,4963580.story#axzz2kXoT4Cgt?CFID=299634&CFTOKEN=5a6cb091a9e628f3-09F1D4A3-7054-D27B-4A6998E5AF09457B

Notes: Executive Constantine Remarks King County Health Care Enrollment Leadership Circle. (2014, January 24). Public Health - Seattle & King County.

Public Health - Seattle & King County. (2013a). *Cover King County: Increasing access to health coverage in King County* (pp. 1–2). Seattle, WA. Retrieved from http://www.kingcounty.gov/healthservices/health/partnerships/HealthReform/~/media/health/publichealth/documents/healthreform/AffordableCareActFacts.ashx

Public Health - Seattle & King County. (2013b). *Coverage is Here King County: Campaign Plan*.

Public Health - Seattle & King County. (2013c). *Cross-Agency Equity and Social Justice Health Enrollment Team*. Retrieved from http://www.kingcounty.gov/employees/Coverage/implementation.aspx

Public Health - Seattle & King County. (2013d). *Health enrollment campaign will spread the word to every neighborhood in King County*. Retrieved from http://www.kingcounty.gov/healthservices/health/news/2013/13091801.aspx

Public Health - Seattle & King County. (2013e). *Health Reform Planning Team Meeting Minutes*. Retrieved from http://www.kingcounty.gov/healthservices/health/partnerships/HealthReform/~/media/health/publichealth/documents/healthreform/HCRminutesMar2013.ashx

Public Health - Seattle & King County. (2013f). *King County maps strategy to reach 180,000 uninsured people*. Retrieved from http://coverkingcounty.com/2013/08/17/king-county-maps-strategy-to-reach-180000-people/#more-28

Public Health - Seattle & King County. (2013g). *The Impact of the Affordable Care Act on Uninsured Adults in King County* (pp. 1–2). Seattle, WA. Retrieved from http://www.kingcounty.gov/healthservices/health/partnerships/HealthReform/~/media/health/publichealth/documents/healthreform/AffordableCareActFacts.ashx

Public Health - Seattle & King County. (2014). *Leadership Circle's focus zooms in on those eligible for subsidies*. Seattle, WA. Retrieved from http://coverkingcounty.com/2014/03/11/leadership-circles-focus-zooms-in-on-those-eligible-for-subsidies/

State of the County 2013. (2013, February 4). Retrieved April 8, 2014, from http://www.kingcounty.gov/elected/executive/constantine/initiatives/state-of-the-county/2013-sotc.aspx

Tavernise, S., & Gebeloff, R. (2013, October 2). Millions of Poor Are Left Uncovered by Health Law. *New York Times*. New York, NY. Retrieved from http://www.nytimes.com/2013/10/03/health/millions-of-poor-are-left-uncovered-by-health-law.html

Vestal, C., & Ollove, M. (2013, December 10). Why Some State-Run Exchanges Worked. *Stateline: The Daily Service of the Pew Charitable Trusts*. Retrieved from http://www.pewstates.org/projects/stateline/headlines/why-some-state-run-health-exchanges-worked-85899525479

Washington Health Benefit Exchange selects Organizations for In-Person Customer Support Program. (2013, June 5). *Washington Health Benefit Exchange*. Retrieved April 22, 2014, from http://www.wahbexchange.org/news-resources/press-room/press-releases/washington-health-benefit-exchange-selects-organizations

Washington Health Benefit Exchange selects Public Health – Seattle & King County to lead enrollment efforts in King County. (2013, June 5). *Public Health - Seattle & King County*. Retrieved November 6, 2013, from http://www.kingcounty.gov/healthservices/health/news/2013/13060501.aspx

Washington HealthPlanFinder. (2014a). *Health Coverage Enrollment Report: October 1, 2013 - March 31, 2014*. Retrieved from http://www.wahbexchange.org/files/2713/9888/1218/WAHBE_End_of_Open_Enrollment_Data_Report_FINAL.pdf

Washington HealthPlanFinder. (2014b). *Washington Healthplanfinder Open Enrollment Closes with 146,000 Enrolled in Qualified Health Plans*. Retrieved from http://www.wahbexchange.org/news-resources/press-room/press-releases/april-1-enrollment-report

Washington State Office of the Insurance Commissioner. (2014a). *Buying an Individual Plan*. Retrieved from http://www.insurance.wa.gov/your-insurance/health-insurance/individuals-families/buying-individual-plan/

Washington State Office of the Insurance Commissioner. (2014b). *Individual health insurance market expands to almost 325,000*. Retrieved from http://www.insurance.wa.gov/about-oic/news-media/news-releases/2014/4-16-2014.html

B: Acronyms and Abbreviations

ACA: The Affordable Care Act

FFF: First Friday Forum

IPA: In-Person Assister

QHP: Qualified Health Plan

US: United States

C: Participant Fact Sheet

DEPARTMENT OF HEALTH POLICY AND MANAGEMENT

1101 MCGAVRAN-GREENBERG HALL
CAMPUS BOX 7411
CHAPEL HILL, 27599-7411

T 919.966.7350
F 919.966.6961
www.sph.unc.edu/hpm

SANDRA GREENE, PhD
Interim Chair

IRB Study #: 14-0232

Title of Study: Three Innovative Models: King County's Quest to Cover the Uninsured

Principal Investigator: Jasmine Hutchinson, MSPH candidate (jasmine7@live.unc.edu)

UNC-Chapel Hill Department: Health Policy and Management/School of Public Health

Faculty Advisors: Pam Silberman, JD, DrPH (pam_silberman@unc.edu)

Study Contact Telephone Number: 818-317-7110

Study Email Contact: jasmine7@live.unc.edu

FACTSHEET FOR POTENTIAL PARTICIPANTS

Summary: The purpose of this exploratory research is to identify innovative strategies for facilitating enrollment of those uninsured residents who will become eligible for coverage under the Affordable Care Act (ACA). King County has developed a multi-faceted coverage strategy with a strong focus on reducing existing health insurance disparities. This study will explore three of King County's initiatives to enroll uninsured residents: (1) the *Leadership Circle* comprised of cross-sector leaders tasked with spreading information; (2) the county agency mobilization effort to leverage existing government channels that serve the public; and (3) geo-targeting with community organization partnerships to reach uninsured residents where they reside. I aim to describe these initiatives, how they have been implemented, and identify best practices for building and maintaining an effective partnership network. Data will be collected from multiple sources, including interviews with key stakeholders from across all three initiatives, reports and publications. Generalized findings gathered during this study will be used in my masters' thesis. The final masters' thesis will be shared with interested King County organizations as well as study participants. Lessons from King County's experience may also be published or shared with organizations implementing health coverage enrollment efforts in other states. Only de-identified data collected from key interviews will be included in the final masters' thesis and lessons from King County's experience, unless a participant has granted specific permission to attribute a quote to him or her.

Who is conducting this study: Jasmine Hutchinson is the principal investigator for this study. She is a Masters candidate in the Department of Health Policy and Management, Gillings School of Global Public Health, University of North Carolina at Chapel Hill. Her faculty advisor is Professor Pam Silberman, JD, DrPH (pam_silberman@unc.edu).

Funding: This study is self-funded by the principal investigator.

Participant Selection: You were selected to be interviewed for this research because of your role in managing and/or implementing one or more of the following King County enrollment initiatives: the Leadership Circle, county agency mobilization or geo-targeting effort.

More about what it means to participate: Interviews will be conducted in-person or by phone (depending on your preference) and take approximately 45 to 60 minutes. At the time of your interview, you will be asked for verbal consent to be interviewed and to record the session. If you choose not to be recorded, you may still proceed with the interview. Transcriptions will be made of recorded interviews. All recordings, transcriptions and other electronic or hardcopy storage of data will be designed to assure the integrity of the data. Participation is completely voluntary. If you agree to be interviewed, you may choose to not answer any question for any reason and my also withdraw your consent at any time for any reason.

Risk related to participating in this study: The most serious risk is emotional distress and frustration in the very rare event that confidentiality is breached. All other risks are expected to be no more than you would encounter in the course of your normal professional activities.

Benefits related to participating in this study: As a participant in this study, you will not receive any compensation for your time or any other specific benefit as an individual. However, final results of this study will be broadly shared with you and other participants in the hopes that all partner organizations may gain a broader perspective of the collective effort in King County to enroll newly eligible residents in health coverage. Moreover, this study is expected to be of direct benefit to Public Health – Seattle & King County and King County Government, which aspire to enroll every resident newly eligible for coverage opportunities under the Affordable Care Act.

Confidentiality: Both your name as a participant and your position title will be held confidential. General information about the characteristics and types (e.g. clinical, governmental, education, business, etc) of organizations involved in each of the three initiatives will be presented as results are disseminated. Participants are not obligated to grant permission to have any quotes made public. However, your responses will be anonymous unless you grant specific permission to attribute a quote to you.

What if you have questions about this study? You have the right to ask, and have answered, any questions you may have about this research. If you have questions, or concerns, you should contact me at 818-317-7110 or jasmine7@live.unc.edu. You may also contact my advisor, Pam Silberman, JD, DrPH, at pam_silberman@unc.edu.

What if you have questions about your rights as a research participant? All research on human volunteers is reviewed by a committee that works to protect your rights and welfare. If you have questions or concerns about your rights as a research subject you may contact, anonymously if you wish, the Institutional Review Board at 919-966-3113 or by email to IRB_subjects@unc.edu.

D: Key Informant Interview Questions

Leadership Circle Initiative Questions

Background & Model Structure

1. Please briefly describe your role within the Leadership Circle.
2. What types of commitments and investments (financial, time, material, etc.) has your organization made to the effort to reach uninsured residents?
   a. *Probe: Concrete examples? What is the magnitude of these investments?*

Overall Impact

3. What Leadership Circle strategies for reaching the uninsured do you believe have been particularly effective?
   a. *Probe: Concrete examples?*
4. What strategies do you believe have not been as effective and why?
5. What factors have helped the Leadership Circle in achieving its goals? (e.g. facilitators)?
6. What barriers has the Leadership Circle faced in achieving its goals?
   a. *Probe: Were those barriers addressed? If so, how? Concrete examples?*
7. Based on your experience, what would you say are the strengths of the Leadership Circle?
8. What about the weaknesses?
9. What do you think have been the key results of the Leadership Circle thus far?
   a. *Probe: Concrete examples? Types and magnitude?*
10. If you could suggest one way in which this initiative could be strengthened, what would it be and why?
11. Are there any organizations or interest groups not currently represented on the Leadership Circle that you believe should be?
    a. *Probe: If yes, which ones and why?*

Looking Ahead

12. What are your expectations for how the Leadership Circle will evolve during the next two to three years?
13. How would you like to see the Leadership Circle evolve during the next two to three years?
14. If another county or state were to implement a similar initiative, what advice would you give them?

Closing

15. Is there anything else I should know about that I haven’t asked you?
16. In closing, do you have any questions for me?

County Agency Mobilization Initiative Questions

Background & Model Structure

1. Please briefly describe your role within the county agency mobilization effort to reach uninsured residents.
2. What types of commitments and investments (financial, time, material, etc) has your county agency made to the effort to reach uninsured residents?
    a. *Probe: Concrete examples?*

Strategies & Impact

3. [*Organizers*] What strategies have county agencies employed to participate in the enrollment effort? [*Member Organizations*] What strategies has your county agency employed to participate in the enrollment effort (e.g. methods for referring/assisting)?
    a. *Probe: Concrete examples?*
4. [*Organizers*] In your view, which of the strategies employed by agencies have been most effective? [*Member Organizations*] In your view, which of the strategies employed by your agency has been most effective?
    a. *Probe: Concrete examples?*
5. What strategies, if any, do you believe have not been as effective and why?
6. [*Organizers*] Have you observed any resistance from departments/agencies to take part in the effort to reach the uninsured? [*Member organizations*] Have you observed any resistance from within your department/agency to take part in the effort to reach the uninsured?
    a. *Probe: What types? At what stage? Why (e.g. political barriers, limited resources)? Concrete examples.*
7. What factors have helped the county agency mobilization effort? (e.g. facilitators)
    a. *Probe: Concrete examples?*
8. What barriers has the county agency mobilization faced in achieving its goals?
    a. *Probe: Were those barriers addressed? If so, how? Concrete examples?*
9. Based on your experience, what would you say are the strengths of the county agency mobilization effort?
10. What about the weaknesses?
11. What do you believe have been the key results of the county agency mobilization effort thus far?
    a. *Probe: Concrete examples? Types and magnitude?*
12. If you could suggest one way in which the county agency mobilization initiative could be strengthened, what would it be and why?

Looking Ahead

13. What are your expectations for how the county agency mobilization effort will evolve during the next two to three years?
    a. *Probe: is your agency/department willing and able to sustain these efforts?*
14. How would you like to see this initiative evolve during the next two to three years?

15. If another county or state were to implement a similar initiative, what advice would you give them?
    a. *Probe: Getting stakeholder buy-in?*
    b. *Probe: Formalizing commitment?*

Closing

16. Is there anything else I should know about that I haven't asked you?
17. In closing, do you have any questions for me?

Geo-Targeting Initiative Questions

Background & Model Structure

1. Please briefly describe your role in helping to enroll uninsured King County residents in the areas where they live.
2. [*For Organizers*] What was the process of engaging partner organizations? [*For Partner Organizations*] How did your organization become involved in the countywide effort to reach uninsured where they live?
    a. *Probe: Who reached out to your organization and how?*
3. [*For Organizers*] What type of support or resources do you provide to partner organizations? [*For partner organizations*] What type of support or resources do you receive from Public Health – Seattle & King County?
    a. *Probe: To what extent do you believe this support/resources meets the partner needs? Are there areas where needs are not met?*
4. What types of commitments and investments (financial, time, material, etc.) has your organization made to the effort to reach uninsured residents as part of this geo-targeting initiative?
    a. *Probe: Magnitude?*

Strategies & Impact

5. [*For Organizers*] What strategies have partner organizations employed to reach or enroll uninsured residents (e.g. methods for referring/assisting)? [*For partner organizations*] What strategies has your organization employed to reach or enroll uninsured residents (e.g. methods for referring/assisting)?
6. [*Organizers*] In your view, which of the strategies employed by partner organizations have been most effective? [*Member Organizations*] In your view, which of the strategies employed by your organization has been most effective?
    a. *Probe: Concrete examples?*
7. [*For Organizers*] How have partner organization's strategies changed over time (if at all)? [*For partner organizations*] How have your organization's strategies changed over time (if at all)?
    a. *Probe: Types of modifications? Reasons for modifications? Concrete examples.*
8. [*For Organizers*] What factors have helped the geo-targeting initiative to reach and enroll uninsured residents in communities where they reside? (e.g. facilitators). [*For partner organizations*] What factors have helped your organization to reach and enroll uninsured residents in communities where they reside?
    a. *Probe: Concrete examples?*
9. [*For Organizers*] What challenges has the geo-targeting initiative faced in reaching and enrolling uninsured residents in communities where they reside? [*For partner organizations*] What challenges has your organization faced in reaching and enrolling uninsured residents in communities where they reside?
    a. Probe: Were those challenges overcome? If so, how? Concrete examples.
10. Based on your experience, what would you say are the strengths of the geo-targeting initiative?

11. What about the weaknesses?
12. What do you have been the key results of the geo-targeting initiative thus far?
    a. *Probe: types and magnitude?*
13. If you could suggest one way in which the geo-targeting initiative could be strengthened, what would it be and why?

Looking Ahead

14. What are your expectations for how the geo-targeting initiative will evolve during the next two to three years?
15. How would you like to see this initiative evolve during the two to three years?
16. If another county or state were to implement a similar initiative, what advice would you give them?
    a. *Probe: Selecting partners? Managing partners? Supporting partners? Strategies to reach target groups?*

Closing

17. Is there anything else I should know about that I haven't asked you?
18. In closing, do you have any questions for me?

E: Characteristics of Key Informants

The chart below provides a high-level summary of key informant characteristics. To protect participant confidentiality, informants are not listed in the order of interviews.

	Strategy			Organization		
Participant	**Geo-Targeting**	**Cross-Agency**	**Leadership Circle**	**Health Focus**	**Government**	**Receives government or private funding for outreach/enrollment**
Key Informant 1	✓		✓	✓	✓	✓
Key Informant 2	✓			✓	✓	✓
Key Informant 3	✓			✓		✓
Key Informant 4	✓			Partial		✓
Key Informants 5 & 6	✓			✓		✓
Key Informant 7		✓		✓	✓	✓
Key Informant 8		✓		✓	✓	
Key Informant 9		✓			✓	
Key Informant 10		✓			✓	
Key Informant 11		✓	✓		✓	
Key Informant 12			✓	✓		
Key Informant 13			✓	Partial		✓
Key Informant 14			✓			✓

***Chart Legend**. Organizations with a main mission that spanned beyond health, such as poverty reduction and eliminating racism, were classified as "partial" if they had some health-related programs. The organizational category "Receives government or private funding for outreach/enrollment" is defined as any external funding—regardless of amount. Funding that was allocated internally to enrollment efforts was excluded from this category.*

F: Detailed Description of Numerical Calculations

Enrollment and Potential Enrollees: October 1st, 2013– March 31st, 2014

This chart and the corresponding State Notes below describe the calculations used to generate the graph in Figure 1. Enrollment numbers from Massachusetts and Nevada are estimates due to the lack of published reports from 3/31. Connecticut, District of Columbia and Massachusetts may over-estimate the true enrollment. Washington's enrollment numbers are likely under-reported. (See state details below.) Estimates of uninsured undocumented immigrants could not be broken out in Kentucky, Massachusetts, and Vermont because of "insufficient statistical reliability" (Kaiser Family Foundation, 2014a). All data for the "Potential Enrollees" comes from Kaiser Family Foundation.

	Enrollments (Numerator)			Potential Enrollees (Denominator)				Estimated Proportions		
State	**Qualified Health Plans (QHPs)**	**Medicaid (Non-Renewals)**	**Total = QHPs + Medicaid**	**Total Uninsured (2011 - 2012)**	**Private (Non-Group)**	**Uninsured Undocu-mented (Estimate)**	**Total = Uninsured + Private - Undocumented**	**QHP / (Legal Uninsured +Private)**	**Medicaid / (Legal Uninsured +Private)**	**Total = (QHPs + Medicaid) / Potential Enrollees**
California	1,190,244	1,930,000	3,120,244	6,992,400	2,217,900	1,449,000	7,761,300	15%	25%	40%
Colorado	118,628	158,521	277,149	736,900	367,600	79,000	1,025,500	12%	15%	27%
Connecticut	78,713	129,588	208,301	285,800	170,900	35,000	421,700	19%	31%	49%
District of Columbia	9,838	17,489	27,327	49,800	42,100	7,000	84,900	12%	21%	32%
Hawaii	7,596	46,605	54,201	102,200	48,600	10,000	140,800	5%	33%	38%
Kentucky	77,027	293,802	370,829	647,100	181,300	N/A	828,400	9%	35%	45%
Maryland	63,002	232,075	295,077	755,900	258,700	127,000	887,600	7%	26%	33%
Massachusetts	30,544	248,030	278,574	242,900	282,600	N/A	525,500	6%	47%	53%
Minnesota	47,046	122,205	169,251	462,500	312,600	39,000	736,100	6%	17%	23%
Nevada	41,823	150,326	192,149	620,800	122,000	83,000	659,800	6%	23%	29%
New York	412,108	453,386	865,494	2,220,900	831,500	276,000	2,776,400	15%	16%	31%
Oregon	55,000	245,000	300,000	559,400	264,000	54,000	769,400	7%	32%	39%
Rhode Island	27,961	64,590	92,551	125,000	47,100	16,000	156,100	18%	41%	59%
Vermont	22,220	25,930	48,150	47,800	30,400	N/A	78,200	28%	33%	62%
Washington	164,062	423,205	575,958	947,700	312,700	104,000	1,156,400	14%	37%	51%

State Notes:

CA: Numbers reflect only those signed up through 3/31/2014 because those were the most recent Medicaid numbers available. California granted an extension until 4/15/2014 to anyone who tried to sign up for QHPs, but faced barriers. An additional 205,685 people signed up for private Qualified Health Plans between 4/1/2014 and 4/15/2014. Source: State Exchange website at http://news.coveredca.com/2014/04/covered-californias-historic-first-open.html, accessed 4/26/2014.

CO: These numbers only reflect those who completed enrollment by 3/31/2014. Colorado granted an extension until 4/15/2014 to anyone who tried to sign up for QHPs, but faced barriers. Between 4/1-4/15/2014, an additional 8,608 signed up for QHPs and 19,987 people signed up for Medicaid (Totals as of 4/15: QHPs = 127,233; Medicaid = 178,508). Source: State Exchange website at http://connectforhealthco.com/news-events/metrics/, accessed 4/26/2014.

CT: According to state news sources, these figures include the 5,000 people who faced difficulty signing up through the Exchange by 3/31 and were granted an extension to complete their enrollment by 4/15. No totals were available for 3/31 and no breakdown of the 5,000 enrollees was provided (QHP vs. Medicaid). Therefore, these numbers slightly over-report CT's totals as of 3/31 in comparison to other states. Sources: State news at http://www.theday.com/article/20140417/NWS12/140419751/1047, http://www.nhregister.com/general-news/20140417/connecticut-enrolls-total-of-208301-in-health-coverage, and http://ctmirror.org/obamacare-exchanges-final-tally-208301-people-signed-up/, all accessed 4/26/2014. (The Exchange did not publish a report with the final numbers on their website).

DC: DC granted an extension until 4/15/2014 to anyone who tried to sign up by 3/31/2014, but faced barriers. The DC Exchange only reports those who were "determined eligible" for Medicaid, not actual enrollees. Therefore, these figures may over-report the true enrollment in comparison to other states. An additional 12,902 people enrolled in coverage through the DC Health Link small business marketplace by 3/31/2014 (13,118 by 4/15). These are not accounted for in the chart above. Sources: State Exchange at http://hbx.dc.gov/release/dc-health-link-enrollment-tops-40000 and http://hbx.dc.gov/release/enrollment-update, both accessed 4/26/2014.

HI: These numbers are only through 3/31/2014. Hawaii granted an extension until 4/30/2014 to individuals needing extra time to complete the enrollment process. (The State's Exchange website has been plagued by technical glitches). An additional 996 people signed up for QHPs through 4/19. Sources: State Exchange at http://www.hawaiihealthconnector.com/connector-updates-march-31-2014/ and http://www.hawaiihealthconnector.com/connector-updates-april-19-2014/, both accessed 4/26/2014.

KY: These numbers are through 4/1/2014. Kentucky not only granted an extension until 4/15/2014, but also allowed people to start the application process until 4/11/2014. On 4/22/2014, the state announced that a total of 82,792 people had enrolled in QHPs and 330,615 people in Medicaid. Source: State News at http://www.kentucky.com/2014/04/01/3173570/kentucky-extends-deadline-for.html, http://www.kentucky.com/2014/04/22/3207241/beshear-says-more-than-413000.html, and http://www.courier-journal.com/story/news/politics/ky-legislature/2014/04/22/obamacare-enrollment-tops-kentucky/8015079/, accessed 4/26/2014.

MD: These numbers are only through 3/31/2014. Maryland granted an extension until 4/18/2014 to individuals who started their application by 3/31. (The State's Exchange website has been plagued by technical glitches). By 4/18/2014, a total of 66,200 people had signed up for QHPs and 263,000 for Medicaid. Sources: State Exchange at http://marylandhbe.com/wp-content/uploads/2014/04/MHC_UPDATE_040414.pdf and http://marylandhbe.com/wp-content/uploads/2014/04/MHC_UPDATE_041814.pdf, accessed 4/26/2014.

MA: QHP numbers include 29,775 unsubsidized plans and 769 unsubsidized plans. They are through 4/8/2014 because no numbers were available as of 3/31/2014 or 4/1/2014. The Medicaid numbers are reported through 3/14 because that is the latest available information. To calculate the totals through 3/14/2014 (since this information is not provided), I added the Commonwealth Care, Commonwealth Choice, Transitional Coverage, and Medical Security Plan together (103,801 + 29,010 + 84,000 + 10,55 = 227,361. To try to account for the fact that they only provide numbers through 3/14/2014, I multiplied the total Medicaid enrollment by 12 two-week periods and divided by 11 two-week periods to generate an estimate through 3/31. Therefore, both the MA QHPs and Medicaid numbers may be over-reported. Massachusetts granted an extension until 4/15/2014 to anyone who had trouble signing up by 3/31/2014. (The State's Exchange website has been plagued by technical glitches). Sources: State Exchange and State news sources at https://bettermahealthconnector.org/wp-content/uploads/2014/04/Weekly_Dashboard_041014.pdf, https://bettermahealthconnector.org/wp-content/uploads/2014/03/OEPresentation_031714.pdf and http://www.benefitspro.com/2014/04/17/bay-state-exchange-traffic-cools , accessed 4/26/2014.

MN: Numbers are through midnight on 3/31/2014. The Medicaid enrollments include 34,219 people who enrolled in MinnesotaCare and 87,986 who enrolled in Medical Assistance. Minnesota has extended their QHP enrollment for individuals until 4/22, if they started the application process by 3/31. As of 4/15/2014, the total QHP numbers were 48,157 and 140,678. Source: State Exchange at http://content.govdelivery.com/accounts/MNsure/bulletins/ae66f4 and https://www.mnsure.org/images/bd-2014-04-16-discussion.pdf, accessed 4/26/2014.

NV: Numbers are through 4/1 for QHPs. Nevada has not released Medicaid numbers past 3/1/2014. I estimated the total Medicaid numbers by multiplying the Health and Human Services total of 125,272 for 10/1/2013 – 3/1/2014 by 6 and divided by 5 to estimate the numbers through 3/31/2014. It is important to note that I am unable to tell whether these Medicaid enrollments include redeterminations. One factor that complicates the enrollment numbers is that people can submit applications for Medicaid through both inside and outside the Exchange. People who started their applications by 3/31/2014 have until 5/30/2014 to enroll. (The Exchange experienced many technical glitches). Sources: State Exchange's Twitter Feed: https://twitter.com/NVHealthLink/status/451509549623570432, https://twitter.com/NVHealthLink/status/456906645126131712, and http://aspe.hhs.gov/health/reports/2014/marketplaceenrollment/mar2014/ib_2014mar_enrollment.pdf, accessed 4/26/2014.

NY: Enrollment continues until 4/15/2014 for people who attempted to enroll by 3/31/2014. By 4/15/2014, 525,293 had enrolled in Medicaid coverage and 435,479 signed up for QHPs. Sources: State Exchange and news sites at http://www.healthbenefitexchange.ny.gov/news/press-release-more-865000-new-yorkers-enrolled-ny-state-health-april-1, http://www.healthbenefitexchange.ny.gov/news/more-960000-new-yorkers-enrolled-ny-state-health, http://www.newsday.com/news/health/enrollment-on-ny-

health-insurance-exchange-tops-865-000-1.7575758, and
http://www.nydailynews.com/news/politics/state-obamacare-sign-ups-top-960k-article-1.1759267, all accessed 4/26/2014.

OR: Enrollments through 4/2/2014 and numbers are rounded. (The State did not publish any data for 3/31 or 4/1). Furthermore, they are estimates from a 4/3/2014 testimony for congressional committees. The Medicaid numbers include 120,000 people who enrolled in Medicaid after applicant's information was forwarded from the Exchange to the state for processing and another 125,000 who enrolled directly using a set up to bypass the State's Exchange web portal. Oregon extended their full open enrollment period until 4/30/2014. (The State Exchange has experienced many technical glitches). Sources: State news and congressional testimony at
http://www.oregonlive.com/health/index.ssf/2014/04/kitzhaber_adviser_will_tell_co.html and
http://media.oregonlive.com/health_impact/other/Van%20Pelt-OR.pdf, accessed 4/26/2014.

RI: Enrollments through 3/31/2014. Residents who attempted to enroll by 3/31/2014 qualify for a special enrollment period and have until 4/23/2014 to pay for plans. Source: State Exchange at
http://www.healthsourceri.com/press-releases/healthsource-ri-releases-enrollment-demographic-and-volume-data-through-march-31/, accessed 4/26/2014.

VT: Enrollments through 3/31/2014. These Medicaid numbers exclude 33,549 people who were previously covered by the Vermont Health Access Program and Catamount Health who the state enrolled automatically in Medicaid based on income information on record (these should not be included in the numerator if the denominator is uninsured + private market). Source: State news at http://www.burlingtonfreepress.com/story/news/politics/2014/04/18/vermont-house-panel-still-gets-complaints-health-exchange/7887491/ and
http://www.burlingtonfreepress.com/story/news/politics/2014/03/31/open-enrollment-on-vermont-health-connect-closes/7124285/, accessed 4/26/2014.

WA: Enrollments through 3/31/2014. There are at least two reasons why Washington's numbers may be under-reported. First, 178,981 people enrolled in ACA-compliant plans outside of the Exchange. The total private non-group market may be as high as 343,043 (or roughly 29.6% of the potential uninsured market and private non-group market, instead of 14.2%). Secondly, Washington's QHP numbers include only those who've paid their first month's premium. All other states include both those who paid and did not pay their first month's premium. Source: State Exchange and Office of Insurance Exchange at
http://www.wahbexchange.org/news-resources/press-room/press-releases/april,
http://www.wahbexchange.org/files/2713/9888/1218/WAHBE_End_of_Open_Enrollment_Data_Report_FINAL.pdf, and http://www.insurance.wa.gov/about-oic/news-media/news-releases/2014/4-16-2014.html