September 2014

REPORT

CARE

Research For Community Health

Evaluation of the Access Health CT Enrollment Experience in Connecticut:

Raising up the Voices of Urban Consumers, Assisters and Navigators

KEY FINDINGS

- **High rates of consumer satisfaction:**

  95 percent of all participants reported application and enrollment processes were definitely or somewhat easy.

  90 percent would definitely recommend Access Health CT (AHCT), and an additional 9 percent would probably recommend AHCT.

  Latinos and blacks and those with less education had higher rates of satisfaction.

- **In-person assistance stands out:** In-person assistance provided a critical service for consumers who were unable to navigate the helpline and website. Consumers found it easier to get and use information from in-person assistance, and rated information from in-person assistance significantly better compared to information from the helpline or website.

- **Information needs:** Consumers most often wanted to learn about the cost of plans and the availability of financial assistance for insurance premiums. Of consumers who did not enroll, the most common reason was the need for more information.

- **Effective outreach through peer networks:** Consumers mostly heard about AHCT through 'word of mouth' and 'family and friends'.

- **Awareness among the uninsured:** In a telephone survey of previously uninsured Connecticut residents, 35% had never heard of AHCT, 25% applied for new insurance coverage, and 40% did not apply.

- **Infrastructure:** Website function, as well as helpline availability, timeliness, and expertise, posed challenges to both consumers and in-person assistance staff. Some problems were resolved over the enrollment period.

- **Resource limitations:** Lack of resources for in-person assistance, such as Wi-Fi access, marketing materials and real-time support for complex applications, impeded enrollment and outreach efforts in the field.

SUMMARY OF RECOMMENDATIONS

- Raise awareness of AHCT among hard-to-reach populations through systematic, culturally competent, targeted outreach.

- Maintain a coordinated, effective year-round program of in-person assistance in all regions of the state of sufficient size and strength to meet the needs of underserved populations.

  Improve management and coordination of those providing in-person assistance.

  Enhance training and support of those providing in-person assistance, including improved technology, real-time troubleshooting and language translation services.

  Ensure year-round availability of in-person assistance to provide enrollment support as well as help consumers to use and maintain their coverage.

INTRODUCTION

The Affordable Care Act (ACA) offers an unprecedented opportunity for Connecticut to increase the number of people covered by health insurance. An important measure of the ACA's success in Connecticut is its ability to enroll underserved populations through Access Health CT (AHCT) — the state's new health insurance marketplace — into private insurance plans or Medicaid.

This evaluation focuses on the consumer experience of the AHCT enrollment effort, with emphasis on underserved urban areas, in order to understand the experience of these populations. The primary aim is to evaluate the AHCT outreach and enrollment process from the perspective of consumers and program staff, including navigators and in-person assisters (assisters), who facilitated enrollment in underserved communities. Findings identify factors that facilitated or impeded enrollment and outreach. We examine variations in consumer experience and satisfaction by enrollment mode (in-person, telephone, on-line). We describe consumer characteristics that influence the enrollment experience (e.g., race, sex, socioeconomic status), while documenting technical and logistical factors of the Navigator and In-Person Assister (NIPA) Program to better understand the enrollment processes. Finally, we provide recommendations to enhance targeted outreach and enrollment efforts during the 2014-2015 open enrollment period.

This project provides an example of the importance of evaluating health reform efforts to foster continuous learning and system enhancements. Results can guide improvements of ACA enrollment and outreach efforts, particularly those aimed at Connecticut's underserved communities, with the aim of enrolling new – and maintaining current – consumers. Furthermore, because Connecticut is a national leader in the implementation of the US health insurance marketplace, the Connecticut experience may inform policy in other states and at the federal level.

MULTI-METHOD EVALUATION DESIGN

The evaluation was conducted and designed by CARE: Community Alliance for Research and Engagement at the Yale School of Public Health, using a multi-method approach:

1) In-person surveys (n = 164) were conducted in English (n = 113) and Spanish (n=51) among a convenience sample of consumers who visited community-based organizations and AHCT enrollment centers in New Haven, Bridgeport and New Britain between December 2013 and March 2014. These individuals were interviewed by CARE staff immediately after interactions with in-person assistance.

2) Telephone surveys (n = 121) were conducted with a sample of uninsured residents during February and March 2014.

3) Assister focus groups were held with a total of 49 assisters in March 2014 in the six designated regions of the state: Hartford County; New Haven County; Fairfield County; Litchfield County; New London and Middlesex Counties; and Windham and Tolland Counties.

4) Key informant interviews were conducted in April 2014 with one navigator/navigator coordinator from each of the six regions.

The in-person and telephone surveys of consumers were based on a draft version of a consumer experience survey that will be launched nationally by the Centers for Medicare and Medicaid Services. Assister focus group and navigator interview questions were designed to explore themes identified in this survey.

IN-PERSON SURVEY: CHARACTERISTICS (n=164)

59% women

48% Latino/a
26% African American (non-Latino)
23% White (non-Latino)

31% completed surveys in Spanish

Age
19-36: 28% 36-55: 46% 56+: 26%

57% high school degree or less
88% income <$30K

Number of participants by location
New Haven: 90 Bridgeport: 51 New Britain: 23

Public libraries: 45 participants
Health enrollment fairs: 40
Community health centers: 41
AHCT enrollment centers: 19

Number of participants by insurance coverage
Enrolled in Medicaid or Husky: 78
Enrolled in private insurance plan: 46
Enrolled in insurance with no subsidy: 11

Health characteristics
Overall health mostly 'excellent,' 'very good,' or 'good'

23% reported 1 chronic disease
18% reported ≥ 2chronic diseases
High blood pressure: 24%
High cholesterol: 18%
Asthma: 9%

Needing/taking prescription medication: 47%
Received health care ≥ 3 times for same health issue in last six months: 31%

RESULTS: IN-PERSON SURVEY

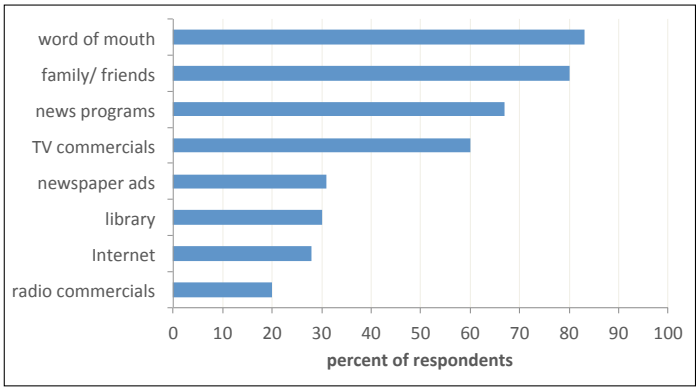
Reaching consumers: outreach and marketing

A crucial component of AHCT's success is creating awareness about opportunities to enroll in health insurance through outreach and marketing efforts. Survey participants reported that they heard about AHCT most often through 'word of mouth' and 'family and friends' (Figure 1), emphasizing the importance of grassroots community outreach, particularly among the Latino population. Television (i.e., news, commercials) was also a regular source of information about AHCT. African Americans and those younger than 35 were less likely to hear about AHCT through the news.

Satisfaction with components of Access Health CT

Satisfaction with the AHCT application and enrollment processes was high among survey participants. Ninety-five percent of respondents reported that the application and enrollment process was definitely or somewhat easy. However, more than one-quarter (29 percent) of consumers reported some dissatisfaction with the amount of time required to enroll in a health plan.

Figure 1: How Respondents Heard About AHCT



Satisfaction with in-person assistance extremely high

Survey participants were asked to rate experiences with the various points of entry into AHCT: in-person assistance, phone helpline, and website. In-person assistance received the highest ratings (Figures 2-4).

Figure 2: Average Rating of Information Provided (0 = worst, 10 = best)

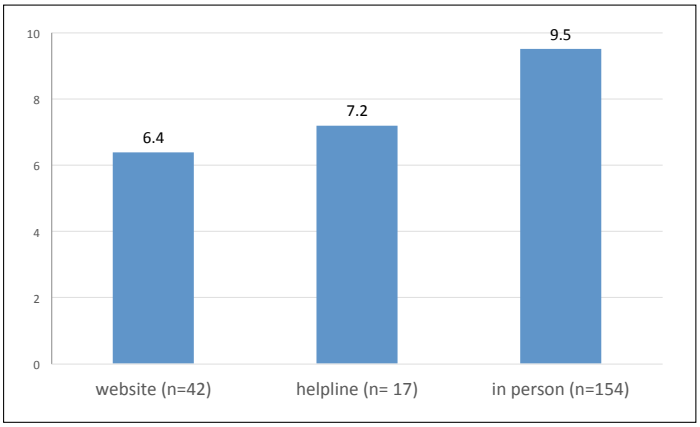
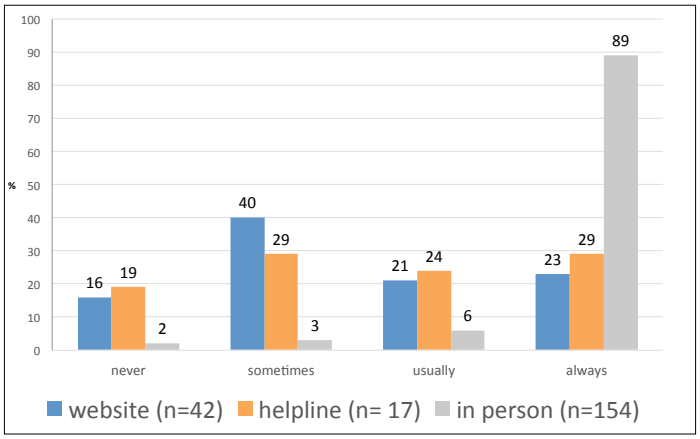


Figure 3: Easy to Use by Source



TYPES OF IN-PERSON ASSISTANCE

1) In-person assisters (assisters) were often well-trusted members of their communities, drawn from non-profit, faith or social service organizations as well as labor unions, municipalities, local health departments, and other organizations. Each assister was assigned to one of six designated regional navigator agencies.

2) Navigator agencies (navigators) were contracted community-based organizations responsible for organizing the outreach and enrollment effort in a given region. They monitored and supported the assisters assigned to them and served as a central point of communication to and from AHCT and the NIPA program office. At least one employee of each navigator agency was certified to provide direct enrollment assistance. A navigator coordinator, employed by AHCT, was also assigned to each navigator agency.

3) Certified application counselors (CACs) work mainly for community health centers and hospitals but also include community-based volunteers. CACs were trained by AHCT but did not have the same reporting requirements or formal relationships with navigators.

4) Outreach and marketing staff hired directly by AHCT provided enrollment assistance at AHCT enrollment events and in AHCT-managed store fronts in New Haven and New Britain.

5) Insurance brokers often worked with those listed above, sometimes taking consumers through the entire process, other times focusing on qualified health plan (QHP) selection and final submission of enrollment applications that had been started by others.

Those who received in-person assistance were very satisfied with both the process and outcomes. Rating interactions with in-person assistance, 94 percent of survey respondents reported that they were always helpful, and 99 percent reported that they were always treated with courtesy and respect – reflecting excellence in customer service. Consumers reported 96 percent of the time that they were 'usually' or 'always' able to get the information they needed using in-person assistance. Seventy-five percent of respondents reported needing only one meeting with in-person assistance staff to sign up for coverage.

Comparing in-person assistance to website and helpline

When asked to rate the information they received on a scale of one to ten, those using in-person assistance gave higher ratings to this mode of enrollment: 9.5 compared to 7.2 for the helpline and 6.4 for the website ($p<0.05$, indicating a statistically significant difference; Figures 2-4). These consumers were less satisfied with their phone and Internet experiences: only 57 percent of those who used the helpline and 47 percent of those who used the website reported that they were 'usually' or 'always' able to get the information they need (compared to 96 percent among those using in-person assistance). With the helpline, a common complaint was hold time, and nearly one in five participants reported that they never spoke to a person when they called. When consumers did reach helpline staff members, they were generally satisfied with the help and reported being treated well. These consumers reported that, when they were on the website, information was often hard to find and, when found, perceived as confusing.

Information needs

Consumers most often wanted to learn about the cost of plans and the availability of financial assistance for insurance premiums. They were less likely to ask for information about provider networks and prescription drug benefits. Of consumers who did not enroll into any plan, the most common reason was the need for more information (Figure 5).

Figure 5: Who Enrolled? Who Didn't?

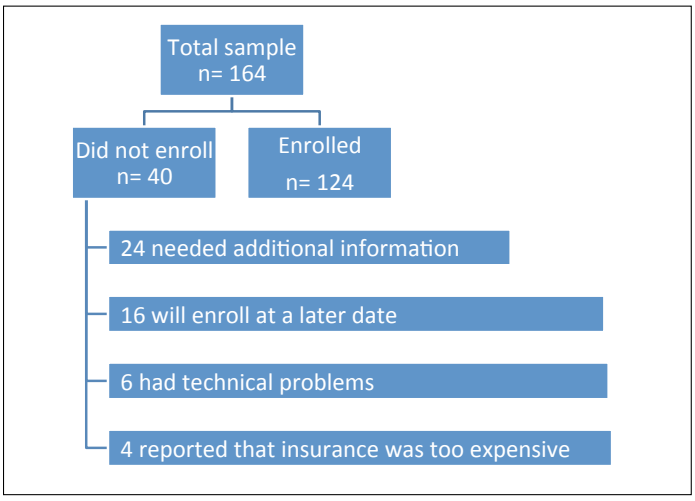
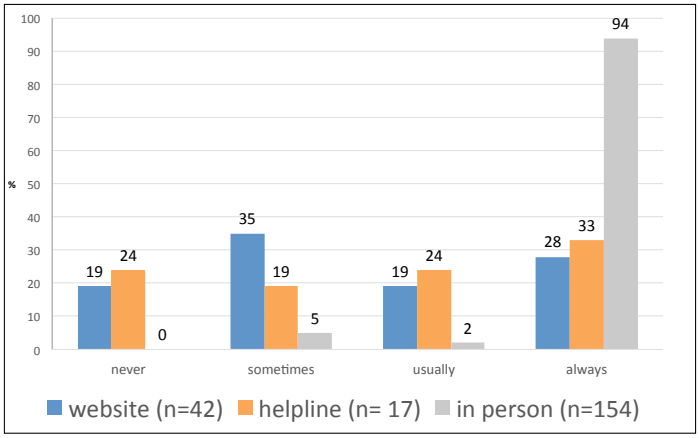


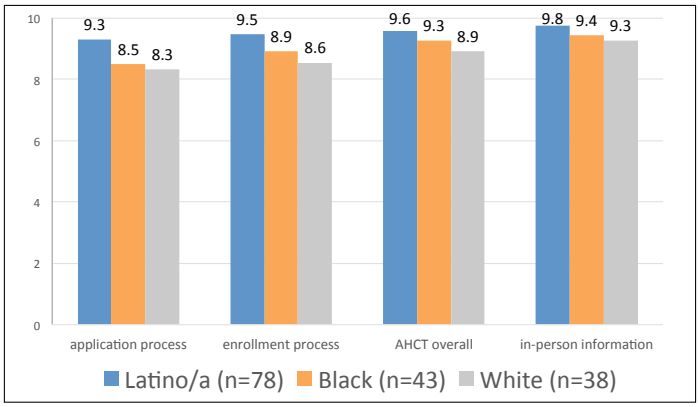
Figure 4: Ability to Get Needed Information



Race, education and age: variation in AHCT experience

Participants' feedback about enrolling into AHCT varied by sociodemographic characteristics. Latinos and Spanish speakers reported the highest rates of satisfaction. One hundred percent of Spanish-speaking consumers needing interpreters reported that they were always able to get them; and 92 percent reported that forms were always available in their preferred language. Non-Latino White consumers were somewhat less satisfied. Satisfaction with AHCT declined as education level increased. Likewise, consumers 25 years and younger reported lower satisfaction (Figures 6-9).

Figure 6: Differences in Satisfaction by Race
(0 = worst, 10 = best)



Medicaid and Qualified Health Plans: few differences in satisfaction

Overall, consumer satisfaction was high, whether consumers enrolled into Medicaid or a Qualified Health Plan. Individuals who qualified for Medicaid reported slightly higher satisfaction with information provided through the helpline and with AHCT overall (Figure 10). Consumers enrolling into a QHP expressed more frustration with the length of the application and enrollment process: 37 percent of QHP consumers found the application and/or health plan enrollment process took too long compared to only 23 percent of

Figure 7: Differences in Satisfaction by Language Preference (0 = worst, 10 = best)

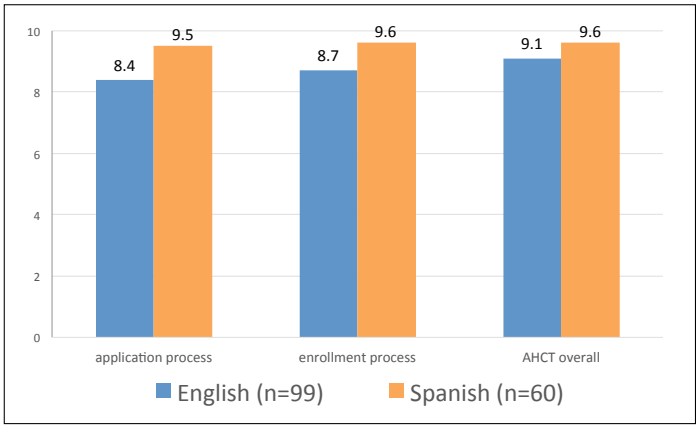


Figure 8: Differences in Satisfaction by Highest Level of Education Attainment (0 = worst, 10 = best)

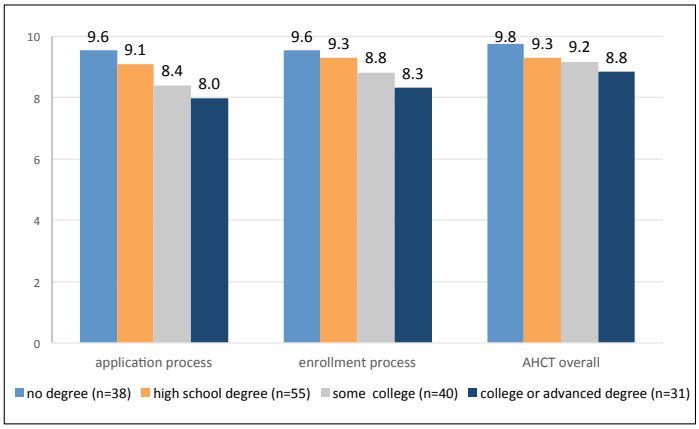


Figure 9: Differences in Satisfaction by Age (0 = worst, 10 = best)

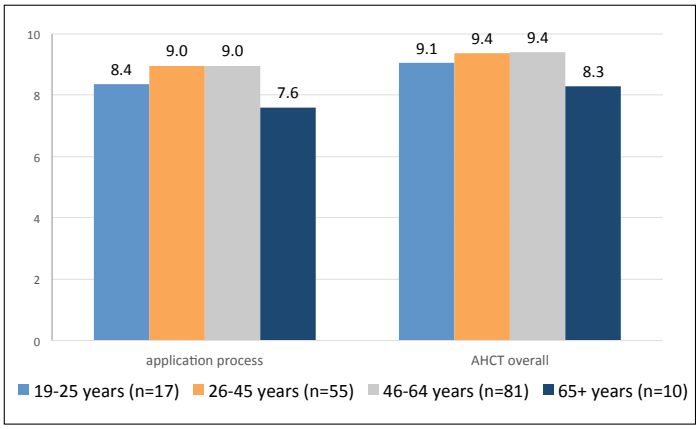
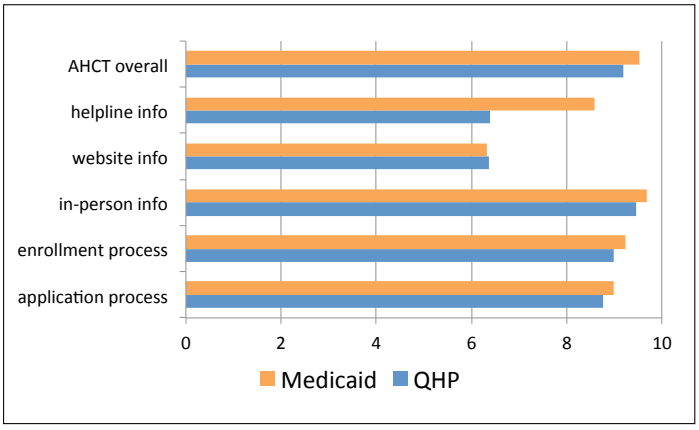


Figure 10: Consumer Satisfaction Rating: Qualified Health Plan (QHP) vs. Medicaid (0 = worst, 10 = best)



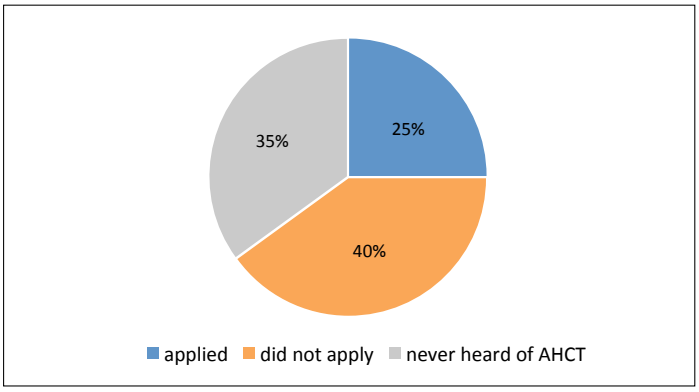
Medicaid consumers. This difference may be explained by the fact that QHP enrollees must choose among health plan options, whereas Medicaid consumers have only one plan option. Making a final decision about choosing a health plan can be confusing and prevent people from actually enrolling, as evidenced in final enrollment numbers. At the time they were surveyed, 94 percent of participants who qualified for Medicaid or Husky enrolled in a health plan through AHCT (n=73), versus 58 percent of participants eligible for a QHP (n=42).

RESULTS: TELEPHONE SURVEY

Telephone surveys were conducted with 121 adults in Connecticut who were uninsured as of 2012. In comparison to the sample participating in the in-person survey, the phone sample included more White consumers with higher income and more education.

One third of the respondents (n=43) had never heard of AHCT (Figure 11), indicating the need for more outreach among those who are uninsured. Those most likely to have not heard of AHCT included Spanish speakers, men and people with less education.

Figure 11: Awareness of AHCT Among Uninsured Respondents



Of the 30 participants who did enroll, satisfaction rates were high but not as high as shown in the in-person survey findings. Average ratings on a scale of 0-10 include: 8.0 for application process, 8.2 for the health plan enrollment process, and 7.9 for AHCT overall. The lower satisfaction ratings likely are reflective of consumer experience with the website and helpline; phone survey participants were more likely to have completed their applications using these modes when compared to in-person survey participants (77 percent vs. 9 percent of respondents, respectively). As with the in-person survey, average rating of information provided through in-person assistance among phone survey respondents (9.6/10) was higher than through the helpline (7.7/10) and website (7.3/10). Health plan enrollment rates were higher among respondents eligible for Medicaid/Husky (12/12 enrolled) compared to respondents eligible for a QHP (10/14 enrolled).

TELEPHONE SURVEY: CHARACTERISTICS
55% women
20% Latino/a
21% African American (non-Latino)
52% White (non-Latino)
50% high school degree or less
55% income <$30K

RESULTS: NAVIGATOR AND ASSISTER FOCUS GROUPS AND INTERVIEWS

To learn more about the enrollment experience from those assisting consumers, focus groups and key informant interviews were conducted with a convenience sample of the navigators and assisters who made up the Navigator and In-Person Assister (NIPA) Program. The NIPA Program, designed to assist consumers with enrollment needs, was overseen jointly by AHCT and Connecticut's Office of the Healthcare Advocate (OHA). The main source of funding was federal grant money, which was used to support administrative staff for the program and compensate assisters. Several private foundations also provided grants to specifically support the Navigator agencies.

Navigators and assisters described a dynamic experience with AHCT that consistently improved over time, yet included myriad challenges. The early phase of the enrollment period (October – December 2013) was characterized as frustrating, with communication and technology problems hampering efforts to launch the program. However, these issues diminished in early 2014 as additional resources became available and AHCT helpline and website functionality improved. Throughout the experience, navigators and assisters reported that their efforts were sustained and inspired by the support of their in-person assistance colleagues and regional navigators, as well as the gratitude of consumers. See Figure 12 for a "word cloud" created using the transcripts from the focus groups; larger words give greater prominence to words that appeared more frequently in the transcripts.

Enrollment experiences

Positive enrollment experiences were described by assisters as ones in which: they were able to work independently, drawing from their own competence without having to turn to the helpline or navigators for support; AHCT technology functioned (laptops, website) without interruption; and consumer enrollments were successful.

Figure 12: Assister Feelings About the Enrollment Experience

"It's a good day [when] you log on…and you can do what you've been hired to do. I enjoy it when a person sits down and they're initially very anxious about the process and about what they might possibly have to pay … and by the end of the application they're feeling very happy, very relieved."

Conversely, **negative enrollment experiences** included frustrating delays that left navigators, assisters and consumers feeling confused and overwhelmed. While upgrades to the AHCT website and expansion of helpline capacity helped overcome these challenges, assisters often felt that their training was insufficient and failed to keep pace with changing enrollment systems and regulations. Interactions with consumers that did not result in enrollment – whether due to technical problems or unaffordable premiums – were deeply disappointing for navigators, assisters and consumers.

"After finally getting over the hurdle of my computer working – and it took like, it took three, four times just to set up the account – and we finally went through the application and he had to pay… I believe monthly was like, a hundred dollars… The consumer was like, extremely upset…because he was under the impression that it would be free."

Problems with the **AHCT-issued laptops and the functionality of the AHCT website** presented major challenges to the enrollment process, especially in the early months of the program. Limited Wi-Fi connectivity created difficulties in consistently establishing a secure connection to the AHCT website from the field, and confined navigators and assisters to specific agency and enrollment locations. In addition, the inability to use a mouse with laptops made for cumbersome computer use. Several issues with the website were identified, including difficulties with the login process, especially interpreting CAPTCHA* screens and remembering passwords; website service interruptions for extended periods; and navigation issues that caused the missing of key fields and difficulty in correcting errors. Given these complications, navigator and assister expertise could be critical to correctly processing consumer applications.

"I've found that sometimes when I'm enrolling somebody that tried to do it themselves and they came up with, you know, some very high premium, and it just didn't jive for what I would normally see for someone with that income…and in some cases it turned out…they skipped a couple sections. And so by…reporting a change we were able to get into a qualified health plan with a subsidy."

The process of **selecting an insurance plan** for those consumers who were enrolling into a Qualified Health Plan could be challenging and time-consuming. Assisters reported trouble ascertaining differences between plans and felt they had not been sufficiently trained to help consumers with this selection process.

"I have had someone there, like the longest one has been almost three hours. Because once they do have those health plans in front of them, it's a big decision for them. And even though we can refer them to brokers, and I do, they just, they want to sit with you and they want to go through it… I don't blame them for wanting to see the details of each plan, but it's like ridiculously time consuming."

Navigators and assisters reported that Medicaid enrollment was generally more efficient than QHP enrollment since Medicaid offers only one plan option. There is also no premium and no cost sharing in Connecticut's Medicaid program and the plan includes dental and vision benefits. However, the stigma associated with Medicaid "as a handout" was a barrier for some consumers who, although qualified, declined coverage in favor of an unsubsidized QHP plan, ultimately opting to pay much more. Others also declined because their health care providers did not accept Medicaid. There was also some confusion when eligibility among families was split, with some members qualifying for Medicaid and others for QHPs. Finally, the transfer of Medicaid enrollment responsibility from Connecticut's Department of Social Services (DSS) to AHCT was an administrative change that was confusing to some consumers and assisters.

* CAPTCHA = Completely Automated Public Turing Test to Tell Computers and Humans Apart; protects websites by generating and grading tests that humans can pass but current computer programs cannot, such as reading distorted text and typing in what the reader sees.

With **dental coverage**, assisters reported that very few QHP consumers took advantage of the option to enroll in dental coverage through AHCT. The plans were perceived as too expensive and the enrollment process was unclear. Assisters also described consumers as having 'enrollment fatigue' – not wanting to spend more time or money after the lengthy QHP enrollment process.

The **final step of the enrollment process** – after eligibility is determined and a specific plan is selected – requires that consumers pay their premium (if any), after confirmation letters are received. These letters often brought consumers, who were confused by the language and premium requirements, back to navigators and assisters. Consumers also brought concerns to navigators and assisters about how they could receive care in the time between their eligibility determination/enrollment and receipt of their health insurance cards. These visits raise concerns about the barriers to finalizing enrollments, linking to care, and maintaining coverage.

Training experiences

Navigators and assisters reported three major trainings: their initial assister training (Fall 2013), a state-wide in-service training (January 2014), and ongoing webinars.

In describing the **initial training**, the challenges of organizing a complex training for the first time in the midst of ACA roll-out nationally were recognized, especially by navigator staff. This training was characterized as *'poorly planned,' 'last-minute'* and *'largely irrelevant.'* Assisters and navigators reported that training focused too much on historical background and the Affordable Care Act law. Training in diversity and working with vulnerable populations seemed outdated and unnecessary, given the experience of many navigators and assisters as social service professionals – some with years of involvement working in their communities. The timing and location of the training also was cited as inconvenient. Navigators and assisters recommended that more 'hands-on' computer time working with the AHCT website would have been helpful, but conceded that the website may not have been fully functional at the time of these trainings.

Feedback about the **January 2014 in-service training** was mixed. Some dimensions of the event were helpful, especially the networking opportunities and recognition by AHCT for their work. However, the trainers' interactions with the assisters were perceived as dismissive and their inability to manage the group effectively led to unproductive debate. Navigators and assisters felt the event would have benefited from a more structured discussion and exchange of ideas. Finally, while feedback about the webinars was positive, navigators and assisters reported that they did not have time to take full advantage of this resource.

Navigators and assisters identified several topics about which they would have liked to receive more information including insurance options and terminology, working effectively with insurance brokers, interpreting and using information on tax returns, dental coverage options, and Medicare. In addition, they expressed interest in receiving specific training on challenging enrollment scenarios, such as immigration issues and working with those experiencing divorce/separation. Consumers who experienced domestic violence also presented issues which assisters felt unprepared to address.

Support and problem-solving experiences

When faced with enrollment questions or roadblocks, navigators and assisters had several resources available: the AHCT helpline; regional navigators, including navigator coordinators; and other assisters. Assisters relied heavily on the support and expertise of the regional navigators and the network of assisters. Insurance brokers stationed at enrollment centers/events also offered help to assisters and consumers selecting insurance plans. While assisters described being wary of insurance brokers at first, they later grew to appreciate and use brokers' expertise to facilitate the plan selection process.

The expertise of personnel at the **AHCT helpline** and their access to a special portal made them instrumental in helping navigators and assisters to solve enrollment problems. However, wait times were often onerous. And, the helpline was often unavailable during the evening and weekends when enrollment events were taking place. Navigators and assisters reported problems connecting with the appropriate representatives on the helpline (i.e. special expertise), calls were sometimes dropped, and the representatives' capacity and training varied, especially as new staff was brought on. At times, helpline staff did not recognize the assisters' role with the AHCT system, confusing them with consumers and speaking in what assisters perceived as a condescending manner.

Regional **navigators** provided two types of support. First, they offered logistical support and technological expertise, providing assisters with everything from posters and flyers to specific tips on working with the website and handling complicated enrollments. Secondly, navigators provided much needed moral support and encouragement for assisters who were feeling overwhelmed or unsupported by the AHCT organization.

"I don't know if I'd still be here if it wasn't for [the navigators]. I don't know if I wouldn't have tossed the towel and said, 'screw it…those two [navigators] are superior…they're wonderful how they work magic to get around, behind, through whatever it is. I have no idea what they're paid, but it can't be enough."

Navigators and assisters also provided each other with logistical expertise and moral support. Their camaraderie and mutual-respect was evident in both their words and their actions during the focus groups. They listened to each other and stepped up to share their knowledge and experience.

"I think that we've formed…a team that works. And it just kind of organically took place and, and happened and it feels good…I mean I know I can pick up the phone if I have a particular type of problem that I know that they're [another assister] kind of more well versed in than maybe I am…it's more tangible than calling the call center sometimes and having to sit on hold for however long. That's made a big difference so you don't feel like you're out there alone trying to figure it all out…"

Marketing experiences and reaching diverse populations

Navigators and assisters described using their own community networks and working with the AHCT outreach team to reach consumers. **Enrollment events**, organized by the outreach team, could be an opportunity to reach large groups of consumers at once and conduct enrollments alongside other assisters and navigators who could help if needed. However, not all of these events were adequately promoted and technical problems during events led to frustration.

"We had an enrollment event where we had like nine people scheduled to come in. And we had to call all of them because the system was down. And so they were great about it though because they heard in our voice that we were, like 'it was beyond our control…But, yeah, that crashing is not fun."

Navigators and assisters also expressed frustration about not receiving enough **promotional materials** from AHCT and not being able to develop their own area-specific flyers to conduct outreach.

"I was actually appalled at the marketing in this.…We have not had a single piece of marketing material and at first we were told even when we made the announcements or the press release, we could only use theirs and it was some generic statement that didn't mean anything and nobody understood it."

Navigators and assisters perceived the AHCT enrollment benchmarks as unfair. The mechanisms for measuring and reporting their activities seemed inadequate because they didn't capture work on applications that could not be completed for technical reasons, and differences in population density across CT regions. Time spent conducting education and outreach was also not tracked. Modifications to these systems over the course of the enrollment period were appreciated, but still assisters felt that their efforts were being discounted because of factors beyond their control.

"I truly believed that I was gonna sign up an awful lot more people and I didn't. I think it had more to do with them being confused...Well, where I work is in one of the poorest places [of CT]. So I wish that…some [more] education could have been done, to just enlighten these people who I know still don't have insurance and I know need it. But I know they just, they can't afford it and they don't understand it."

Indeed, navigators and assisters recognized the challenge of reaching underinsured communities, although overall they seemed satisfied with the program's reach. They described enrolling a population of clients who were diverse in gender, race, ethnicity, and age. Having ready access to written materials in Spanish and Spanish-speaking translators was helpful in enrolling Spanish-speaking consumers. While translators were available to help in other languages as well, this support was not as readily available when needed through the helpline. Assisters reported they cumulatively spoke >30 languages as a group; these skills could be leveraged to expand language services for more and diverse consumers.

Other groups that navigators and assisters felt the program may have failed to fully engage included African Americans, young adults, and people with very limited computer skills. Challenges in reaching working people were also identified because of the lengthy application process and enrollment hours were inconsistent with workers' hours.

Navigator insights

Feedback from navigators about their experiences included additional insight into enrollment barriers. Their observations about the assisters' work highlighted the importance of the one-on-one individualized support that these personnel could provide. The assisters' existing relationships with the very communities that AHCT sought to engage lent credibility to the program. The different organizational cultures between assisters and AHCT central office sometimes created a 'culture-clash.' The non-hierarchical, grassroots structure of the assister program differed greatly from the more corporate culture of the central AHCT office. As navigators, they worked hard to facilitate communication between these two dimensions of the program – NIPA and AHCT central office – and noted improved coordination as the enrollment period progressed. Navigator agency staff pointed out that the AHCT navigator coordinator position embedded in each agency was key to fostering this communication and having enough capacity to service assisters.

Moving forward, the navigators suggested a need for larger NIPA grants to support assisters' efforts and expand local marketing and outreach. They also suggested more local on-going in-person trainings, to supplement the current webinar system, and proposed exploring the option of allowing assisters a portal to the AHCT website like that provided to the helpline and the navigator staff. Improvements to systems for tracking enrollments and outreach were recommended. Overall, navigators recommended that the program anticipate and plan for complicated clients, with an understanding that, even with extensive planning and experience, the unique variations of people's lives mean that some will fall outside the program's normal capacity. Having processes in place to address these circumstances will allow the program to more fully reach and enroll Connecticut's diverse communities.

RECOMMENDATIONS

The value of in-person outreach and assistance is overwhelmingly supported by the evidence in this evaluation. Yet, the availability of sufficient funding to operate a robust navigator and in-person assistance program during the next open enrollment period and beyond is unclear. These recommendations are offered within the context of this uncertain future, with the hope that ways will be found both to preserve and improve the provision of in-person assistance and outreach, particularly to underserved populations.

Two overall recommendations, along with more specific suggestions for improvement, follow.

I. Raise awareness of AHCT among hard-to-reach populations through systematic, culturally competent, targeted outreach.

II. Maintain a coordinated, effective year-round program of in-person assistance in all regions of the state of sufficient size and strength to meet the needs of underserved populations.

I. TARGETED OUTREACH

1) Target consumers less likely to have heard of the marketplace.
The evaluation points to the need to improve outreach to consumers. The telephone survey of previously uninsured residents found that 35 percent had never heard of Access Health CT and identified Spanish speakers, men and those with less education as possible groups to target.

2) Adopt a grassroots outreach strategy, targeting populations that were more likely to hear about AHCT from family and friends or word of mouth.
The in-person survey found that people were most likely to hear about AHCT from family and friends or word of mouth. Latinos, African-Americans and young adults under age 35 were most likely to have heard of AHCT through these informal networks.

3) Improve marketing support for enrollment events.
Assisters and navigators pointed to the need for website and/or social media promotion, as well as flyers and on-site printed materials tailored to target populations.

Recommendations are just beginning to emerge about how to run successful, data-driven, systematic grassroots operations to target and ultimately enroll hard-to-reach populations. One important resource is Enroll America's report, *State of Enrollment: Lessons Learned from Connecting America to Coverage, 2013-2014 (June 2014).*

II. COORDINATED, EFFECTIVE IN-PERSON ASSISTANCE

Integrated, customer focused, culturally competent in-person assistance that meets consumers where they are is crucial to increasing and maintaining enrollment in QHPs and Medicaid. This assistance requires an adequate supply of trained in-person assisters who understand their communities, and a well-coordinated system to manage and support them. Specific recommendations are listed below in three main categories: management and coordination, training and support and year-round operation.

A. Improve management and coordination

1) Improve communication and coordination among Access Health CT (AHCT), Department of Social Services (DSS), Office of the Healthcare Advocate (OHA) and those providing in-person assistance.

Assisters and navigator staff reported frequent instances of poor coordination and collaboration among the key agencies overseeing their work. It was not always clear which agency should be consulted to get an answer to a question or a solution to a problem. Together, these agencies are accountable for enrollment results. Yet there is an ongoing lack of clarity about where authority and responsibility lie and about how relationships with those in the field are to be managed. Given that multiple agencies are involved, the development of standard processes, regular means to share information and ways to collaborate to improve processes will be crucial to ongoing success.

With federal in-person assistance grants less available, the role of certified application counselors will become even more important. Integrating certified application counselors into the enrollment effort poses even greater challenges, as they are a diverse group, with few formal ties to AHCT beyond initial training; no formal ties to OHA; and varying ties to DSS, depending on previous involvement with Medicaid enrollment. To learn more about the CAC role, see Enroll America's report, *Certified Application Counselor Program: Early Lessons (June 2014).*

2) Fund and strengthen the ACA-required navigator function to serve as a regional coordinating entity.

Navigator organizations that both understood the needs of traditionally underserved populations and were well-versed in the complexities of eligibility, enrollment and ongoing health insurance issues proved to be an invaluable resource for the enrollment effort. They fulfilled an important intermediary role, supporting community-based outreach and enrollment and linking assisters on the ground to AHCT. At present there is no ongoing funding to maintain the current navigator agencies and central office support. Every effort must be made to develop reliable, ongoing funding sources and identify management authority to shore up and maintain a network of region-based navigator agencies.

3) Foster productive working relationships among assisters and between assisters and insurance brokers.

The evaluation points to the value of peer support to foster learning among those providing in-person assistance. Regional and statewide mechanisms should be established to promote peer interaction and sharing of best practices.

Assisters and brokers bring different skill sets and experiences. They have much to learn from each other. Over time, assisters found certain brokers to be important resources for consumers with complicated health or family concerns who were having difficulty making a QHP selection. On the other hand, some resentment was expressed in the assister focus groups that an application that had largely been completed by an assister, but in the end submitted by a broker, was often credited only to the broker and did not become part of an assister's enrollment statistics. Enrollment efforts would benefit from intentional development of closer working relationships between these two groups, and from system reporting improvements.

4) Streamline the reporting process.

The method for reporting enrollment activities was seen as very cumbersome and time-consuming, preventing real-time collection and analysis of data that could be used to monitor and improve the enrollment process. Assisters raised concerns that data were collected in a way that did not recognize time and effort involved in developing applications. Instead, the last person to submit the application got "credit" for the enrollment. Also, conducting outreach activities was not clearly recognized or valued through the reporting mechanism. Assisters operating in rural areas, where more travel time was required, did not feel that this extra time was considered in the development of enrollment goals. Since comprehensive efforts are needed to enroll hard-to-reach individuals, the reporting system should be

designed to document both enrollment and outreach activities in order to acknowledge and measure both types of efforts.

B. Enhance training and support

5) Improve training.
Better training is needed to enable assisters to handle complex family, tax, and health situations including:

- Tax and insurance terminology
- Health plan options and variation in benefit design (including co-pays, deductibles, co-insurance, prescription drug costs and access, etc.) and provider networks among different plans and metal tiers (e.g. bronze, silver, gold)
- Dental coverage options for both children and adults
- Added challenges posed by specific populations including: immigrants, those who are divorced or separated, and women in domestic violence situations

In-person assisters require instruction regarding when they should seek help for handling more complex situations. This includes where to find real-time help while the consumer is with the assister, as well as where consumers with challenging or complicated life circumstances should be referred, if necessary, to complete enrollment.

The need for more hands-on training with the online application system, either in the classroom or via webinar, was also raised. Assisters and navigator staff also requested more frequent updates during open enrollment as issues arise and system changes are made.

6) Ensure reliable technological access.
Assisters and navigator staff reported many problems with both the laptops and the enrollment application itself. While some of these technological challenges abated over time, they were still raised as a serious concern in the focus groups and interviews. Some assisters had weaker technology skills and would have benefited from more training on the use of their laptops and how to navigate without the use of a mouse. Lack of wireless access in the field was a particular source of frustration.

7) Provide those offering in-person assistance with real-time access to helpline and IT support, particularly during the open enrollment period.
Expedited access to helpline or other resources is clearly needed, so that those providing in-person assistance can provide real-time help and complete applications even for customers with more complex needs. Expanding the hours when real-time, expert support is available is also crucial, as many enrollment events occur during evenings and weekends.

8) Expand access to translation assistance for languages other than Spanish or English.
Lack of timely access to interpreter services was cited as a barrier to completing enrollment. Better harnessing the language skills of the assister network could be one approach to addressing this problem.

C. Ensure year-round availability of in-person assistance

9) Provide ongoing in-person enrollment assistance.
Those enrolling in Medicaid can do so at any time. In addition, QHP enrollment is possible outside the open enrollment period for consumers who have a "qualifying life event" such as getting divorced or losing health coverage due to a lay off or job change. Given the evaluation's findings about the effectiveness of in-person enrollment assistance over other modes for underserved populations, in-person assistance should be available year-round.

10) Provide year-round in-person assistance to help consumers successfully use, maintain and renew insurance coverage.
The evaluation showed that consumers were less likely to seek information on key items such as hospital and physician networks, and prescription drug benefits, forecasting the need for assistance once consumers begin to use their insurance. Assisters also reported that consumers returned to them, asking for help with understanding correspondence they received from either AHCT, the Department of Social Service (DSS) or private health insurers. Assisters can support consumers in their interactions with health plans. Ongoing support and consumer education is needed to help consumers — particularly those new to health insurance coverage — on such issues as:

- Health insurance terminology
- Deductibles, co-pays, co-insurance, pharmacy costs, and out-of-pocket limits
- Provider networks and implications of receiving out-of-network care
- How to access specialists in their plans
- Formularies

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