ADVANCING HEALTH EQUITY IN THE HEALTH INSURANCE MARKETPLACE:

Results from Connecticut's Marketplace Health Equity Assessment Tool (M-HEAT)

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ABOUT TEXAS HEALTH INSTITUTE

Texas Health Institute (THI) is an independent, nonpartisan, nonprofit organization with the mission of improving the health of communities in Texas and nationally. As a respected leader in Texas, THI acts as a neutral convener, facilitates balanced health care dialogue, creates a vision of improved health care, addresses health disparities, and develops feasible solutions to health problems through collaboration. Nationally, THI's Health Equity Team has been monitoring the evolution of health care reform since 2008, and has undertaken a singular national, multi-year, multi-funder initiative to monitor and report on the implementation progress of the Affordable Care Act from a health equity and cultural competency perspective. These efforts are intended to increase awareness and education among stakeholders and practitioners while also facilitating dialogue, advocacy, and policy. To find this report online, as well as other related reports on health care reform and health equity, please visit www.texashealthinstitute.org/health-care-reform.html.

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INTRODUCTION

The Patient Protection and Affordable Care Act of 2010 (ACA) created health insurance marketplaces to make available a choice of easily comparable and affordable health insurance plans for individuals and families without public, employer-sponsored, or other coverage. Now approaching the fourth year of enrollment, health insurance marketplaces together with Medicaid expansion and other health insurance reforms have reduced the national uninsured rate to a historic low of 9.1% or 28.6 million persons of all ages.[1] And while virtually all population groups have benefited from coverage expansion, those from racially and ethnically diverse, limited English proficient, and other hard-to-reach communities represent the largest numbers of remaining uninsured.

In Connecticut, the uninsured rate declined to an estimated 4.9% by the end of 2015—making it among states with the lowest rate.[2] However, the proportion of non-Whites that comprise the uninsured population more recently was much larger than previous enrollment years. Whereas non-Whites made up nearly half (47%) of the uninsured in late 2015, they made up roughly one-third (34%) of the uninsured in 2012.[3] Recognizing this demographic shift in the composition of the uninsured, working to reach and enroll those without coverage while also retaining new and existing members will be far more challenging than previous years. As such, concerted efforts to reach and enroll racially, ethnically, and linguistically diverse, and other hard-to-reach communities will be critical to the overall success of the marketplace, and ultimately the health of the state.

With support from the Connecticut Health Foundation and W.K. Kellogg Foundation, Texas Health Institute developed and administered the Marketplace Health Equity Assessment Tool (M-HEAT) to measure Connecticut's progress toward advancing health equity in its marketplace. Health equity is defined as the attainment of the highest level of health for all people. Central to this goal is the assurance of health insurance coverage and access to care for all.

In this report, we feature findings from the pilot administration of the M-HEAT in Connecticut between October 2015 and April 2016. Findings combine public and self-reported data from Connecticut's health insurance marketplace—Access Health CT (AHCT)—with data on perceptions of progress from community stakeholders and advocates. Results shed light on areas where AHCT is leading as well as opportunities to build on significant initial progress and promise to reach, enroll, and retain all in coverage, regardless of race, ethnicity, spoken language, and gender identity.

The M-HEAT was designed to help marketplaces and their stakeholders take stock of the extent to which the health insurance marketplace together with its stakeholders and community partners are working to advance enrollment, retention, and access to care for all populations, and especially those historically disenfranchised. Findings from the M-HEAT are intended to inform the marketplace, its stakeholders, and policymakers on areas of strength, improvement, and priority to inform future programs and policies fostering coverage and access for all populations. The M-HEAT also serves as a monitoring tool to track programs and progress over time.

BACKGROUND

The M-HEAT's definition of diverse populations includes individuals from different racial, ethnic, and linguistic heritage as well as lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) populations. The vision of the M-HEAT is based on the National Partnership for Action to End Health Disparities' definition of *health equity*:

> *Health equity is attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.[4]*

To this end, the M-HEAT serves as a health equity inventory and assessment tool. It orders, organizes, and solicits self-reported data from the health insurance marketplace and survey data from community stakeholders to document and gauge how and how well the marketplace is working to assure equal opportunities for enrollment and access to care for all populations.

The marketplace component of the M-HEAT compiles self-reported and public data on health equity programs, progress, and performance. A parallel version, administered to community advocates and representatives within a state, intends to offer an external reference point for the marketplace to measure how well they have worked to reach communities and advance equity. As such, a common set of M-HEAT questions on both components are designed to determine areas of agreement and disagreement between the marketplace and its community stakeholders about progress and performance toward health equity.

The M-HEAT's content draws from the expertise of representatives from communities of concern and extensive information in the literature on state-based health insurance marketplaces in Connecticut, California, and around the country. Through these resources, six marketplace functions were identified as concrete areas of opportunity for advancing health equity. The M-HEAT and this report are organized around these six functions:

The Marketplace Health Equity Assessment Tool (M-HEAT)

What is the M-HEAT?

The M-HEAT is a tool to help measure health insurance marketplace progress and performance toward health equity. It compiles and orders data from two perspectives: the health insurance marketplace *and* community stakeholders. As such, the tool contains two components:

- An 87-item health insurance marketplace assessment administered electronically; and

- A 46-item community stakeholder survey administered online.

What are the M-HEAT's Objectives?

- To take stock of the marketplace's *actual health equity initiatives*;

- To understand the marketplace's *perceived progress and performance* toward equity; and

- To provide *external, community-based validation* of the marketplace's progress and performance toward health equity.

1. Organizational commitment;
2. Plan management;
3. Community engagement and collaboration;
4. Navigator and assister programs;
5. Marketing and communication; and
6. Enrollment outcomes.

Each of the six sections in the M-HEAT includes a set of structure, process, and outcome questions to measure progress toward health equity, both point-in-time as well as over time to chart successes as well as identify near-term and long-term opportunities for improvement. The M-HEAT seeks not only to inform efforts to improve enrollment and retention, but with questions on access to care, also seeks to take stock of "coverage to care" progress for diverse and other hard-to-reach communities.

What Does the M-HEAT Tell Us?

- Level of **commitment** to health equity across marketplace functions;

- Point-in-time and over-time **progress** toward health equity;

- Program **strengths and gaps** toward health equity; and

- Marketplace and community-based **opportunities** for improving efforts to advance health equity.

M-HEAT's Six Content Areas

Part 1: Organizational Commitment to Advancing Health Equity. This section includes three sub-parts that intend to measure the extent to which the marketplace has made a commitment to health equity in (1) organizational policies, (2) leadership and staff, and (3) allocation of financial resources.

Part 2: Plan Management and Health Equity. This section focuses on three key aspects of plan management that offer an important opportunity for advancing health equity—(1) active purchasing, (2) racial, ethnic, and language data collection, and (3) health plan access and network adequacy.

Part 3: Community Engagement and Collaboration. This section focuses on the process and progress of diverse community engagement and is divided into three sub-parts: (1) community stakeholder engagement, (2) tribal consultation, and (3) cross-sector collaboration.

Part 4: Navigator and In-Person Assistance Programs. Questions in this section address navigator and assister programs that are intended to educate and enroll communities in marketplace plans. The section covers sub-topics including (1) scope and reach of programs, (2) navigator and assister training, (3) language and interpreter services, and (4) the enrollment application.

Part 5: Marketing and Communication. This section captures the range of ways in which marketing and outreach explicitly targets diverse populations, overall and by specific media channels. In addition, the section addresses availability of interpreter and language services.

Part 6: Marketplace Outcomes. This section includes questions on enrollment outcomes, such as number enrolled, renewed, and churned, as well as health care access measures.

DESIGN & METHODS

The M-HEAT was developed and administered through a multi-stage process involving the ongoing engagement of representatives from the health insurance marketplace and diverse communities in Connecticut to help inform and ground the initiative in local priorities. In this section, we describe the formation and engagement of our stakeholder advisory group, the development of the M-HEAT and its content, the administration of the tool, and data analysis.

STAKEHOLDER ADVISORY GROUP

In early 2015, THI worked with the Connecticut Health Foundation to assemble a Community Stakeholder Advisory Group to help inform and guide the development, administration, and evaluation of Connecticut's M-HEAT. The first stakeholder meeting was convened for a half-day in Hartford on April 7, 2015, with three primary objectives:

1. To share THI's national M-HEAT framework;
2. To explore and discuss ways to tailor the national M-HEAT framework for Connecticut, including specific questions, measures, and processes for collecting data from AHCT and community stakeholders; and
3. To discuss the value of results and opportunities for driving a meaningful marketplace and health equity agenda in the state.

The April 7 meeting was attended by representatives from 19 community stakeholder organizations— including advocates, service providers, brokers, foundations, researchers, and others who have worked closely with AHCT to inform and guide its implementation and rollout. Attendees candidly shared their opinions and experiences on marketplace effectiveness in meeting health equity objectives, identified priority questions and measures for the assessment, and discussed the potential value of the M-HEAT.

Following the initial meeting, members of the Stakeholder Advisory Group were engaged via e-mail on an ongoing basis, especially to offer feedback on various drafts of the marketplace and community versions of the M-HEAT. Both tools were finalized with very specific feedback on priority questions from community stakeholders.

MARKETPLACE ENGAGEMENT

In addition to engaging community stakeholders, equally important was the ongoing involvement of members of the health insurance marketplace to assure that the initiative would offer data to meaningfully inform and advance their equity actions. Their feedback was also central to assuring that the M-HEAT included measurable and practical questions on health equity (as opposed to aspirational questions that cannot be measured at this stage). Our first in-person meeting with leadership and staff of AHCT took place on the afternoon of April 7, 2015, at the AHCT offices in Hartford. Following this initial meeting, we continued to stay in touch with staff at AHCT via telephone and e-mail to give them an opportunity to review and comment on the M-HEAT, particularly to inform data availability. These conversations helped to streamline the M-HEAT to include a practical set of measurable questions.

M-HEAT ADMINISTRATION

As previously mentioned, THI developed two versions of the M-HEAT: a marketplace self-assessment and a community stakeholder survey. While the national framework for both versions was developed based on an extensive review of the literature on state-based marketplaces and existing health equity evaluations,[5,6] Connecticut's version was tailored and developed with considerable feedback from state-based stakeholders and staff at AHCT. In this section we describe our methods for administering each of these tools.

Marketplace self-assessment. The 87-item marketplace version of the M-HEAT was sent to AHCT for data collection in early October 2015. Through a series of phone and e-mail conversations with staff representing various departments at AHCT, the marketplace version of the M-HEAT was completed in May 2016. Responses to questions on perceived health equity progress and performance were provided by designated AHCT staff. Objective data and information (e.g., enrollment and retention estimates) were provided by AHCT as well as compiled through publicly available reports and documents such as the PERT Group reports and AHCT Board of Directors meetings and updates. Data compiled from these sources were intended to reflect on progress and performance over the last three enrollment periods.

Community stakeholder survey. The 46-item, abridged community version of the M-HEAT was administered online via Survey Monkey between October and December 2015 to capture stakeholder perceptions of marketplace health equity progress since AHCT's establishment. Recognizing that community stakeholder organizations represent many voices and constituents, the survey was sent to individuals at 143 such organizations in the state. The target sample was compiled with feedback from the Connecticut Health Foundation as well as select advisory members to assure representation of stakeholders that have had a history of working with or advising AHCT. In particular, individuals receiving the survey included organizations on our advisory group, members and participants of AHCT's Consumer Experience and Outreach Advisory Committee, members of Connecticut's State Innovation Model (SIM) Community Advisory Board, navigator and in-person assister organizations as listed on AHCT's website, and organizations that have presented at or been involved with AHCT's Board of Directors meetings.

DATA ANALYSIS

Data on both versions of the M-HEAT were analyzed descriptively. In addition, common questions on both tools were reviewed and analyzed together to identify points of agreement and disagreement between the marketplace and community stakeholders about progress and performance toward health equity. With respect to the community stakeholder survey, questions pertaining to knowledge of AHCT policy, procedures, or actions were reported to include 'don't know' responses. However, for questions of opinion or perception, 'don't know' responses were excluded from analysis. We excluded data on questions where greater than 75% of respondents reported 'don't know'. Rates of 'don't know' were particularly high for questions pertaining to LGBTQ populations.

IN-PERSON BRIEFINGS

We presented initial findings from our analysis to AHCT's Board of Directors and to our Stakeholder Advisory Committee on May 19, 2016. Feedback from these discussions helped to add depth and dimension to as well as ground findings in Connecticut's marketplace reality. We have incorporated substantive feedback from these meetings into our discussion and recommendations.

M-HEAT COMMUNITY SURVEY RESPONDENTS

Of the 143 organizations invited to participate in the stakeholder survey, 64 (45%) responded. To maintain the confidentiality of respondents, we did not collect any 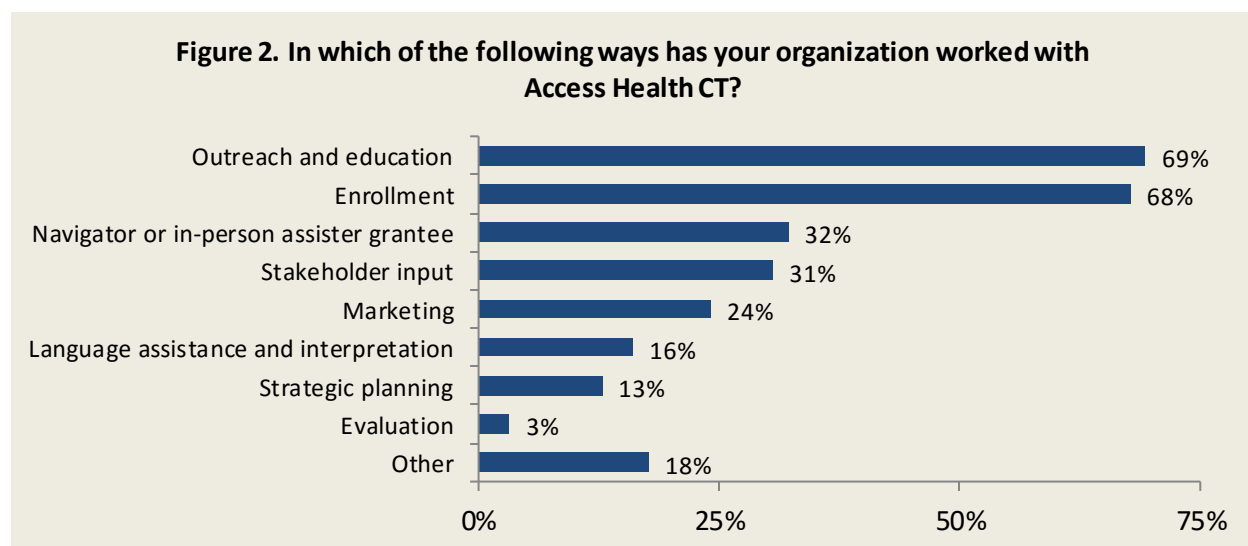personal identifying information. However, we did ask respondents to share information about their organization and its involvement with AHCT. Over one in four (27%) of respondents indicated an affiliation with community-based or non-profit organizations, 23% with health centers or clinics, 22% with advocacy groups, 9% with hospitals, 8% with state or local agencies, and the remaining 11% comprised of respondents from research, academia, health insurance, foundation, and other groups (Figure 1).

Figure 1. Organizations Responding to M-HEAT, by Type
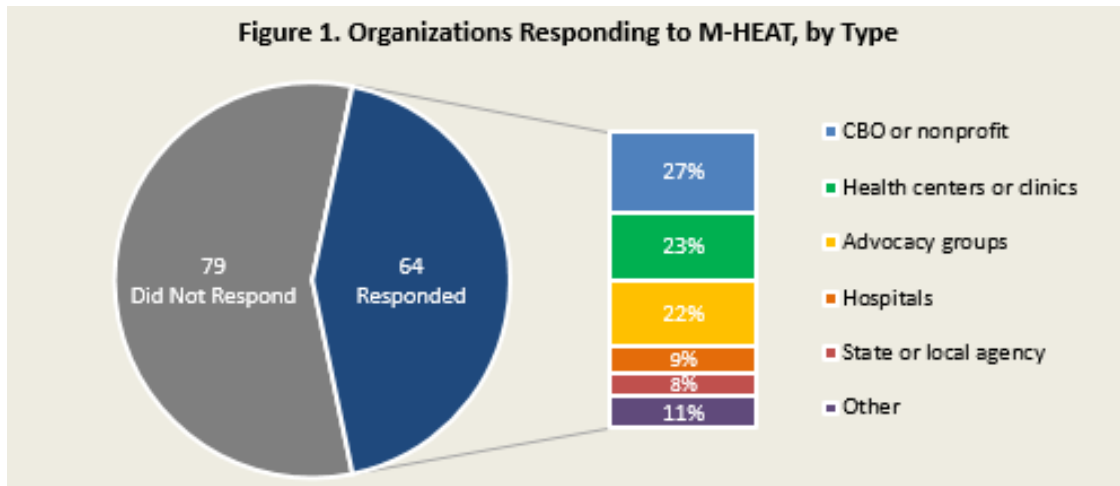
Nearly 70% of organizations reported working in some capacity with AHCT on outreach, education, or enrollment and one in three organizations said they were a navigator or in-person assister grantee of AHCT's at some point over the last three years (Figure 2). In terms of other involvement with AHCT, 31% reported providing stakeholder input, 24% were engaged in marketing, 16% provided some level of language interpretation or translation assistance, and 13% reported involvement in strategic planning discussions.

Figure 2. In which of the following ways has your organization worked with Access Health CT?

Outreach and education	69%
Enrollment	68%
Navigator or in-person assister grantee	32%
Stakeholder input	31%
Marketing	24%
Language assistance and interpretation	16%
Strategic planning	13%
Evaluation	3%
Other	18%

Surveyed organizations were asked to specifically identify which population groups they serve or target. Over 75% said they work with or target non-White populations. An overwhelming majority reported targeting Blacks (94%), followed by Hispanics (89%), Whites (79%), and Asians (76%). Far fewer (66%) reported that they worked to reach LGBTQ communities (Figure 3).

Figure 3. Which of the following populations does your organization work with or represent?

Population	Percentage
Hispanic/Latino	89%
White	79%
Black or African American	94%
Asian	76%
Native Hawaiian/Pacific Islander	60%
American Indian/Alaska Native	58%
LGBTQ	66%
Limited English Proficient	81%
Other	23%
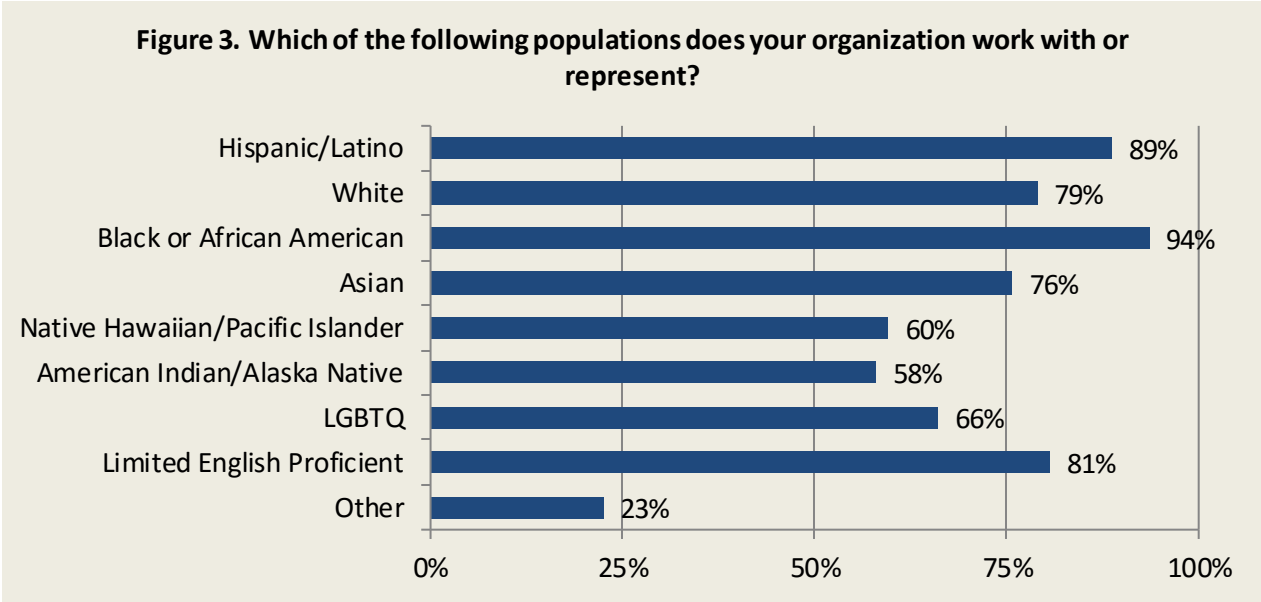
RESULTS

In this section, we present data compiled from AHCT and community stakeholders on marketplace progress and performance toward health equity. Results are organized into six sections corresponding to the six content areas of the M-HEAT. Within each section, we first present objective data and information compiled from AHCT or through publicly available resources on programs and progress toward equity. We then share AHCT's perception of how well they are working to advance health equity across the functions, followed by a discussion of community stakeholder perceptions. Where data on common questions exist, we compare how AHCT's perception of performance compares to stakeholder perceptions.
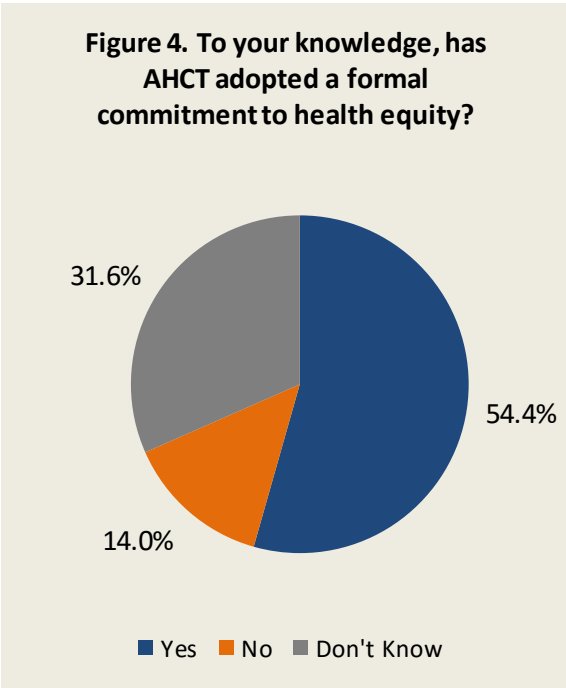
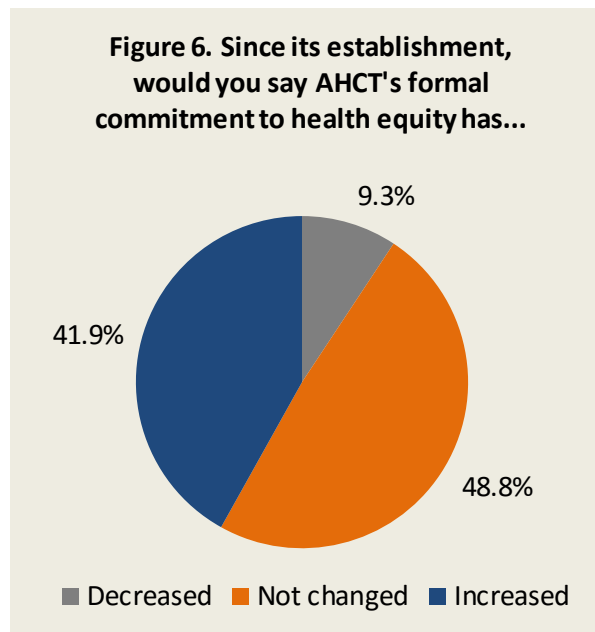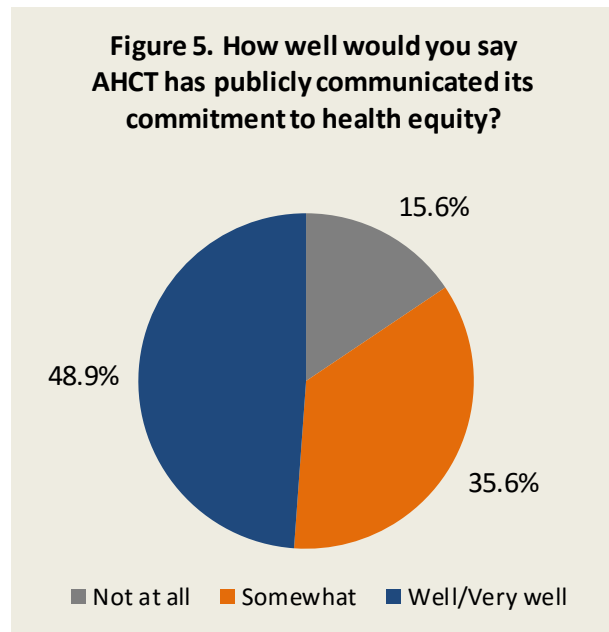## PART 1: ORGANIZATIONAL COMMITMENT TO HEALTH EQUITY

STRATEGIC COMMITMENT TO HEALTH EQUITY

Since establishment in 2011, Access Health CT was among a handful of leading states that reflected health equity tenets through its mission: "to increase the number of insured residents in our state, promote health, lower costs and *eliminate health disparities*."[7] Their guiding principles also underscored this priority: "the Exchange should work to *address longstanding, unjust disparities* in health access and outcomes in Connecticut."[8]

Despite this explicit commitment, many community-based organizations (CBOs)—including those on the ground charged with educating individuals on the marketplace—reported not knowing that AHCT has a mission to address disparities or advance health equity.

Figure 4. To your knowledge, has AHCT adopted a formal commitment to health equity?

54.4%

14.0%

31.6%

■ Yes ■ No ■ Don't Know

Among stakeholder respondents, only 54% were aware of this strategic commitment (Figure 4). And when asked to report how well they felt AHCT had communicated its commitment to health equity, just under half (49%) of the respondents said this was communicated well or very well (Figure 5). While AHCT reported that its commitment to health equity increased since its creation, only 42% were aware of this growing focus as compared to 58% who felt the focus remained stagnant or declined (Figure 6).

Figure 5. How well would you say AHCT has publicly communicated its commitment to health equity?

15.6%
48.9%
35.6%

Not at all · Somewhat · Well/Very well

Figure 6. Since its establishment, would you say AHCT's formal commitment to health equity has...

9.3%
41.9%
48.8%

Decreased · Not changed · Increased

In efforts to intentionally raise awareness around this priority, AHCT released a new three-year strategic plan, which included among its five pillars the goal of reducing health disparities in the state. Among the efforts highlighted in the plan were to:

- Build strategic alliances with organizations to address consumer concerns;
- Utilize the All-Payer Claims Database (APCD) and demographic risk factors to understand customer disparities;
- Facilitate healthcare disparity research through the use of APCD in Connecticut;
- Partner with state agencies to address disparities in health care; and
- Target marketing efforts to assure access to quality, culturally competent care for underserved and hard to reach populations.
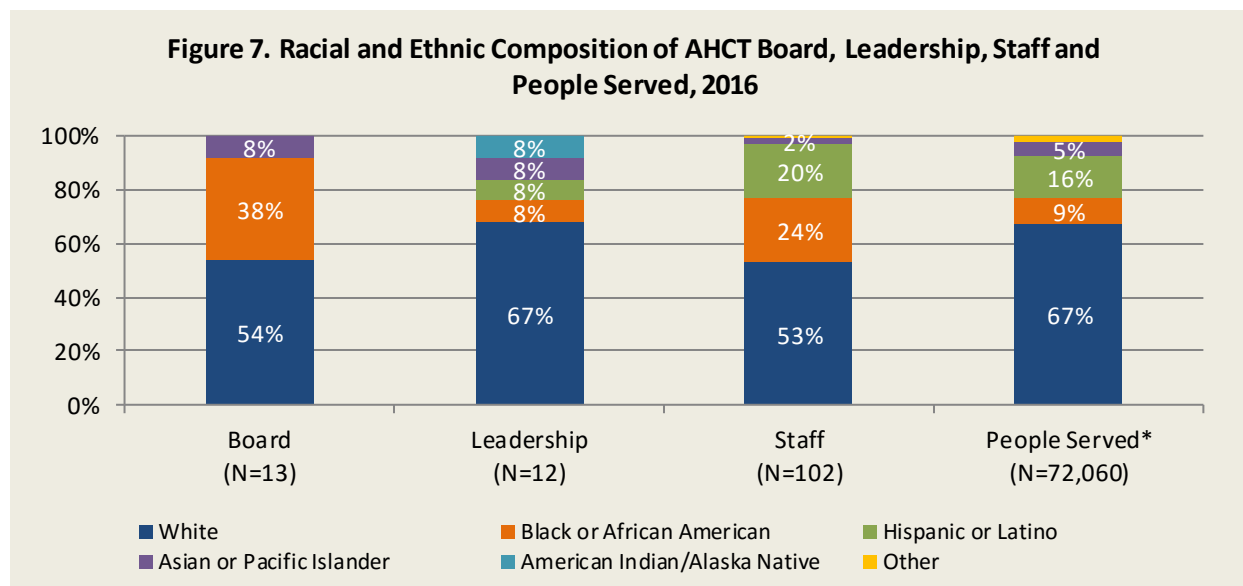
GOVERNANCE, LEADERSHIP, AND WORKFORCE

AHCT has been among leading marketplaces working to assure diversity in its workforce, as its 2012 Annual Report documents:

> *The Exchange will attempt through recruitment efforts to increase the number of highly qualified female and minority applicants who apply for each vacancy with the ultimate goal that the Exchange's workforce will mirror the diversity of the labor pool. Additionally the Exchange will attempt to reach a greater number of Hispanic, African American, Asian/Pacific Islander and Native American potential applicants by contacting organizations and educational institutions that promote the interests of such individuals and attending job fairs and other events where potential exposure to qualified female and minority applicants is high.[9]*

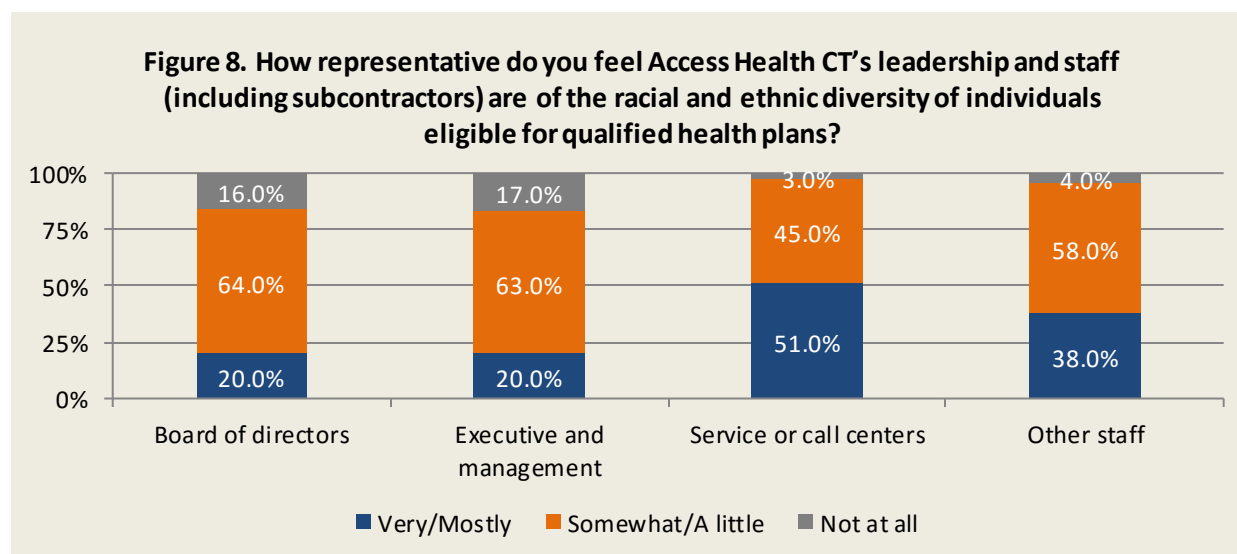***Board, Leadership, and Staff Diversity.*** When asked to reflect on the diversity of its workforce, AHCT reported that its board of directors and executive leadership were only somewhat representative of the individuals covered by qualified health plans. However, the diversity of its staffing and call center personnel was closely aligned with people served (see Figure 7 for AHCT-reported data on staff and

service population diversity by race/ethnicity). AHCT reported not collecting data by other measures of diversity, such as gender identity or sexual orientation.

Figure 7. Racial and Ethnic Composition of AHCT Board, Leadership, Staff and People Served, 2016

	Board (N=13)	Leadership (N=12)	Staff (N=102)	People Served* (N=72,060)
White	54%	67%	53%	67%
Black or African American	38%	8%	24%	9%
Hispanic or Latino		8%	20%	16%
Asian or Pacific Islander	8%	8%		5%
American Indian/Alaska Native		8%		
Other			2%	

*Note: Race/ethnicity of "people served" is measured by race/ethnicity of primary applicant in the household.
Source: Data provided by AHCT in May 2016.

When community stakeholders were asked the same question on marketplace workforce diversity, their responses were somewhat in line with AHCT's in that they too felt that staff and call center personnel were more reflective of target populations than the board or leadership. Whereas 51% and 38% of respondents felt that service center and other staff, respectively, were very or mostly reflective of racial/ethnic composition of target populations, only 20% felt this was the case for board and leadership (Figure 8). **Importantly, there was at least some acknowledgement among stakeholders that AHCT was a racially and ethnically diverse organization with very small percentages feeling diversity did not exist at all in staffing or call centers.** When asked to report their perceptions about LGBTQ workforce diversity at AHCT, the majority reported not knowing.

Figure 8. How representative do you feel Access Health CT's leadership and staff (including subcontractors) are of the racial and ethnic diversity of individuals eligible for qualified health plans?

|	Board of directors	Executive and management	Service or call centers	Other staff
Very/Mostly	20.0%	20.0%	51.0%	38.0%
Somewhat/A little	64.0%	63.0%	45.0%	58.0%
Not at all	16.0%	17.0%	3.0%	4.0%

AHCT and stakeholders were also also asked to report on whether workforce diversity changed since establishment. AHCT indicated that racial/ethnic and linguistic diversity had increased (reporting no information on LGBTQ representation). About one-third of stakeholder respondents agreed while the majority felt that leadership and staff diversity had generally stayed the same (Figure 9). Fewer than one quarter of respondents provided an answer to the question about change in LGBTQ diversity in leadership and staff (not reported here).

Workforce Diversity Policies. Beyond its strategic commitment to workforce diversity, AHCT reported having policies and procedures in place to recruit and retain a diverse and culturally competent workforce. In particular, in 2012, AHCT implemented an Equal Employment Opportunity and Affirmative Action policy and also put into place various recruitment strategies to assure diversity—e.g., working with recruitment agencies that routinely search for diverse candidates.[10] AHCT also publicly reports metrics on staff diversity on a quarterly basis including male/female ratio of staff along with percentage by ethnicity.[11]

When asked how effective these policies have been in achieving their goals, AHCT felt they were very effective. By comparison, nearly 86% of community stakeholders were unaware of these policies (Figure 10).

Dedicated Staff for Health Equity. AHCT reports that it does not have an explicit position dedicated to equity objectives. Instead they suggest that "resolving health care disparity takes a multi-pronged approach requiring coordination of marketing, operations, human resources, and other functional areas within AHCT. The senior leadership is all involved in coordinating this effort." This is likely the reason why the majority of respondents said they did not know whether AHCT had a dedicated point person on health equity issues.

Figure 9. To what degree would you say AHCT's leadership and staff diversity has changed since establishment by:
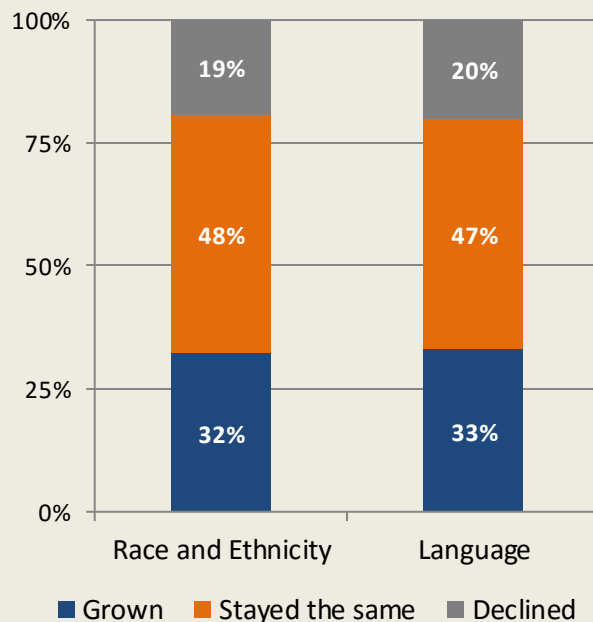
Figure 10. Are you aware of any current policies and procedures in place at AHCT to recruit and retain a diverse and culturally competent staff?
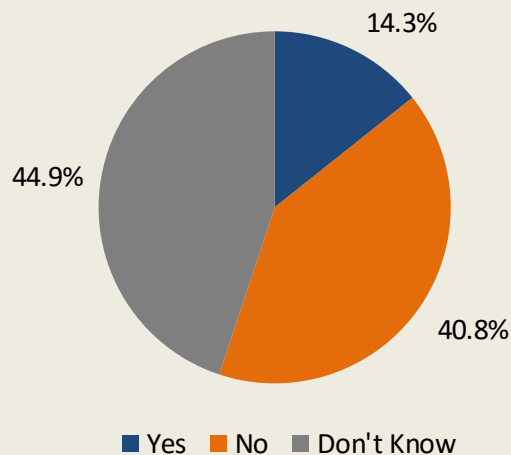
FINANCIAL COMMITMENT TO HEALTH EQUITY

We asked AHCT to report whether it forecasts, allocates, or records spending by populations of need—specifically, racial/ethnic, limited English proficient, and LGBTQ. AHCT reported that accounting procedures made it difficult to assess how much of its annual spending was dedicated to these populations specifically and for the health equity priority generally. In addition, AHCT shared that their efforts generally work to reach the population at-large, and in so doing are inclusive of working to reach specific communities of concern.

We asked stakeholders to report the extent to which they feel that AHCT has made a financial commitment to health equity. Nearly one-third of respondents perceived this commitment to be notable as compared to 68% feeling the commitment was small or nonexistent (Figure 11).

When asked to share their perceptions on the importance of allocation of financial resources by diverse population groups, an overwhelming majority (over 90%) said this was important by race/ethnicity, language, and for LGBTQ populations (Figure 12).

AHCT's budget in fiscal year (FY) 2016 was $32.6 million.[12] While the initial establishment of the marketplace was supported by federal funding, the requirement to be self-sustaining by January 1, 2015,[13] modified AHCT's sources of support from being primarily federally funded to relying heavily on Marketplace Assessment Revenue, as is expected for state-based marketplaces across the country. AHCT was the first marketplace in the nation to become financially self-sustaining.[14] By 2017, grants will comprise only 6% of AHCT's funding sources (including a final federal grant that culminates on December 15, 2016). As current financial accounting includes line-items related to marketing, outreach, training, and other functions there may be opportunity for AHCT to build in the ability to measure dollars within these functions devoted specifically to educate, enroll, and retain different diverse population groups.

Figure 11. To what extent has Access Health CT shown a financial commitment to health equity?

- ■ To a great extent/Mostly
- ■ Somewhat/A little
- ■ Not at all
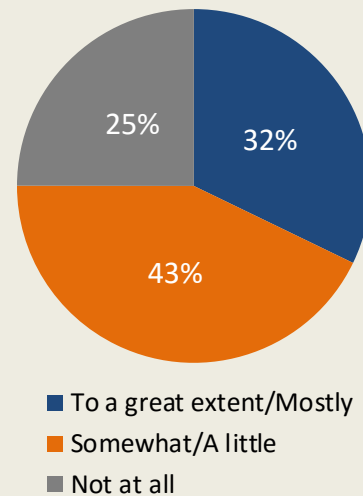
Figure 12. How important do you feel it is for Access Health CT to allocate resources by the following populations…

- ■ Not at all important
- ■ Somewhat/A little important
- ■ Very important/Important
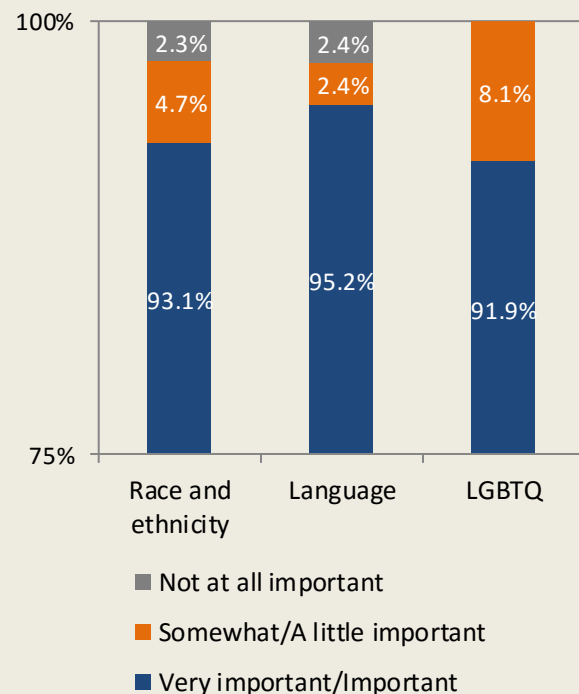
PART 2: PLAN MANAGEMENT AND HEALTH EQUITY

ACTIVE PURCHASING

We sought to understand whether AHCT was an active purchaser and what plan management-related initiatives it has in place to address disparities. Active purchasers are often defined as marketplaces that engage in "selectively contract[ing] with carriers, set[ting] tougher participation criteria than the federal standards and/or negotiat[ing] price discounts in order to effectively serve consumers."[15] AHCT documents that "Connecticut's [qualified health plan] certification requirements reflect a strong 'active purchasing' approach on the part of the Exchange, meaning requirements and participation guidelines have been structured to make sure carriers offer products and services that align with the needs and interests of the State's residents and small business owners."[16] However, because AHCT does not negotiate rates, it does not consider itself as an active purchaser. For this reason, specific questions around active purchasing were not asked of community stakeholder groups.

DATA REQUIREMENTS AND INCENTIVES

We asked AHCT to describe its programs and progress to collect and monitor health disparities data. AHCT reported that it asks applicants to self-report their race, ethnicity, and primary language spoken on the AHCT enrollment application. However, over the past three years, this question has yielded a very high non-response rate (estimated at 35% in the third enrollment period). When asked whether members are asked to report their gender identity or sexual orientation, AHCT shared that this question is not on the enrollment application.

In efforts to improve demographic data collection, many states are establishing All-Payer Claims Databases (APCD)—databases or repositories that collect health insurance eligibility and claims information from all health care payers statewide, including private health insurers, Medicaid, Medicare, and children's health insurance, among others. Connecticut is among 18 states that have established an APCD as of early 2016.[17,18] Connecticut's APCD is estimated to include 3.02 million covered lives (of the 3.58 million total population).[19] However, AHCT acknowledges that race and ethnicity data in eligibility and claims files will likely be limited and available for only an estimated 1.6 million individuals.[20] AHCT is working with foundations, academic institutions, and other partners to explore ways to better collect and, in some cases, impute race/ethnic eligibility and claims data.[21]

HEALTH PLAN ACCESS AND NETWORK ADEQUACY

In efforts to learn the extent to which AHCT sought to ensure "network adequacy," the M-HEAT asked a series of questions of both AHCT and community stakeholders on this topic, including availability of affordable health plans in each region; adequate number, types, and distribution of providers; assuring timely access to care; and assuring health plans provide access to culturally and linguistically appropriate services. AHCT responded that it wholly works to advance affordability and accessibility largely as Connecticut is among states with specific statutes that set standards or definitions related to network adequacy.[22] As such, the following standards are in place at AHCT regarding network adequacy:
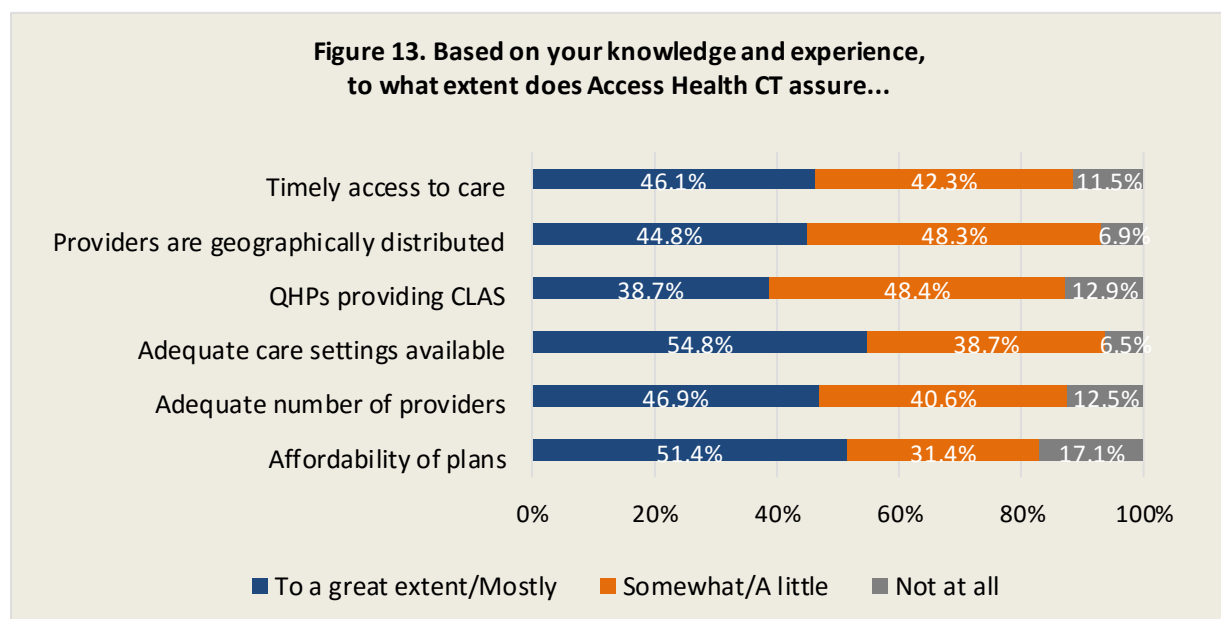
- **Essential community providers:** By January 1, 2015, plans sold on AHCT were required to include 90% of federally qualified health centers (FQHCs) and 75% of essential community providers as part of their networks.[23] For any carrier not meeting these standards, AHCT

requires a written justification and a plan moving forward for the carrier to meet these standards.

- **Adequate geographic distribution of providers:** In late 2014, AHCT reported subscriber access to providers—that is the percent of subscribers with at least one provider within 5 and 10 miles of subscriber's address. Its assessment suggests that while over 90% of subscribers across all carriers in AHCT have access to primary, pediatric, and behavioral health within 5 miles of a subscriber's address, this is not the case for many carriers offering specialty care—with greatest 5-mile access gaps seen for oncology services. [24]

- **Availability of affordable health plan options:** In 2013, AHCT's board undertook revisions to standard plan designs that would secure the affordability of care in the marketplace. [25] The marketplace generated affordability impact projections for various plan designs for families at incomes between 133-400% of the federal poverty level (FPL), and the board approved plan designs that maximized affordability for these subsidy-eligible families. In particular, staff and board sought to minimize potential exposure to exorbitant out-of-pocket costs for families enrolled in low-premium/high-deductible plans, recognizing the impact of high out-of-pocket spending is substantially more severe at lower income levels.

When stakeholders were asked to offer their knowledge of network adequacy and access-related concerns, nearly one-third reported not knowing (Figure 13). However, among those who had knowledge of these concerns, about half felt that AHCT assured that plans were affordable and included a range of care settings, including FQHCs and other essential community providers. Between 45-47% of respondents felt that qualified health plans assured timely access to care and provided an adequate number and geographic distribution of providers. Less certainty was voiced about plans providing adequate culturally and linguistically appropriate services—only 39% felt this was mostly or to a great extent assured.

Over 17% of respondents felt that AHCT has not assured the availability of affordable plans and another 31% said that they feel AHCT has only somewhat or a little assured affordability.

Figure 13. Based on your knowledge and experience, to what extent does Access Health CT assure…

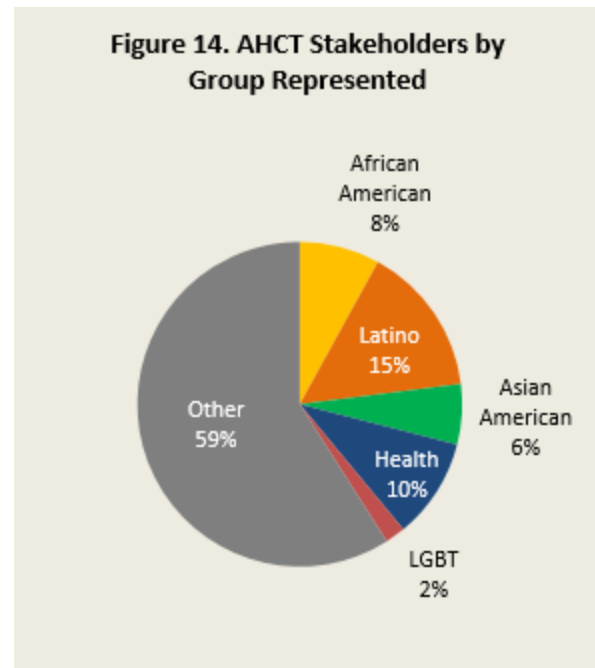|	To a great extent/Mostly	Somewhat/A little	Not at all
Timely access to care	46.1%	42.3%	11.5%
Providers are geographically distributed	44.8%	48.3%	6.9%
QHPs providing CLAS	38.7%	48.4%	12.9%
Adequate care settings available	54.8%	38.7%	6.5%
Adequate number of providers	46.9%	40.6%	12.5%
Affordability of plans	51.4%	31.4%	17.1%

PART 3: COMMUNITY ENGAGEMENT AND COLLABORATION

COMMUNITY STAKEHOLDER ENGAGEMENT

The ACA requires that marketplaces consult with certain groups of stakeholders as they establish and implement their programs. One such group of stakeholders are "advocates for enrolling hard-to-reach populations," including individuals who need culturally and linguistically appropriate services. When asked about these efforts, AHCT reported that it had formed several committees comprising diverse representatives from various racial/ethnic backgrounds and organizational affiliations. Recently, it reported building relationships with over 305 community organizations, leaders, and influencers representing and/or serving diverse population groups. [26] Figure 14 provides a racial and ethnic breakout of populations served by partnering organizations.[27] In addition to engagement with community stakeholders, AHCT made efforts during the second enrollment period to engage with the public through a variety of promotional avenues, including community events, social media platforms, and a series of radio advertisements promoting family activities across the state.

Figure 14. AHCT Stakeholders by Group Represented

Data source: AHCT Board of Directors Meeting, March 17, 2016. Note: 'Other' includes YMCA/YWCA, Boys & Girls Club, Big Brothers Big Sisters, Jewish Family Services, women's centers, community centers, etc.

Beginning in 2012, AHCT conducted a series of statewide events called Healthy Chats, which were renamed Community Chats by the end of the third open enrollment period. The ***Healthy Chats/Community Chats Series*** has been geared toward "educat[ing] community leaders and organizations about the exchange so they can promote AHCT's mission to the constituents and communities they serve and to establish long term relationships with the community."[28] Community Chats are delivered throughout the state in one-hour sessions, starting with a 20- to 30-minute PowerPoint presentation on AHCT and its enrollment process, followed by questions and a public comment period. As many as 15 Healthy Chats/Community Chats have been convened each year since the initiative was launched.[29,30] Following the transition to Community Chats in early 2016, AHCT had engaged 129 community leaders and influencers at 11 Community Chats, with six more Community Chats scheduled through January 2017. In June 2016, the marketplace announced plans to host a Community Conference featuring networking opportunities, workshops, and strategy development sessions to engage community groups in planning to help residents obtain coverage and remain enrolled.[31,32]

Recognizing the many community engagement programs in place, we asked AHCT and community stakeholders to reflect on their experiences and perceptions of the nature and frequency of engagement across a range of marketplace functions. We were particularly interested in understanding perceptions of engagement for different racial/ethnic groups as well as for limited English proficient and LGBTQ populations.
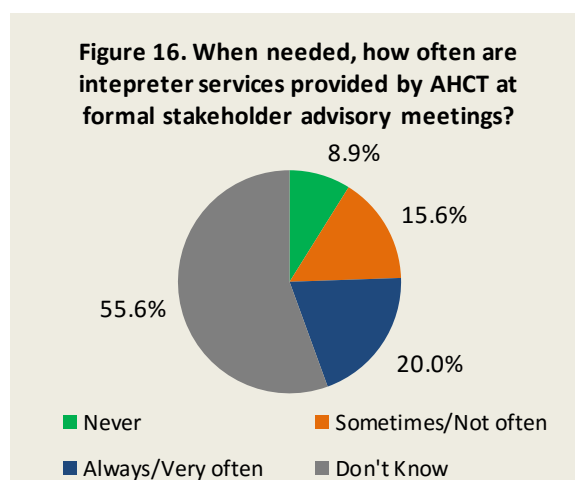
Overall engagement to inform marketplace policies and decisions. We asked AHCT to report the extent to which it engages specific diverse population groups to inform marketplace plans, policies, and decisions. Staff reported that it mostly or to a great extent engages representatives from the following communities: White, Hispanic or Latino, Black or African American, Asian, multi-racial, and LGBTQ. AHCT acknowledged opportunities for improvement in further engaging representatives from Native Hawaiian/Pacific Islander and American Indian/Alaska Native communities by indicating that it only somewhat engages these populations.

We also asked community stakeholders to report the extent to which they felt that AHCT engaged representatives from diverse communities to inform plans, policies, and decisions of the marketplace. **A majority of surveyed stakeholders felt that Whites were more often engaged to inform AHCT's policies and decisions than other non-White groups (Figure 15).** For example, whereas 87% reported that Whites were engaged, just below two-thirds reported that Hispanics and Blacks were engaged and 39% reported that Asians were engaged. Moreover, fewer than half who responded felt that limited English proficient populations were mostly or to a great extent engaged, and even fewer (just one in three) reported that LGBTQ populations were engaged to inform AHCT's policies and decisions.

Figure 15. To what extent do you feel AHCT has engaged representatives of the following diverse communities to inform plans, policies, and decisions of the marketplace?
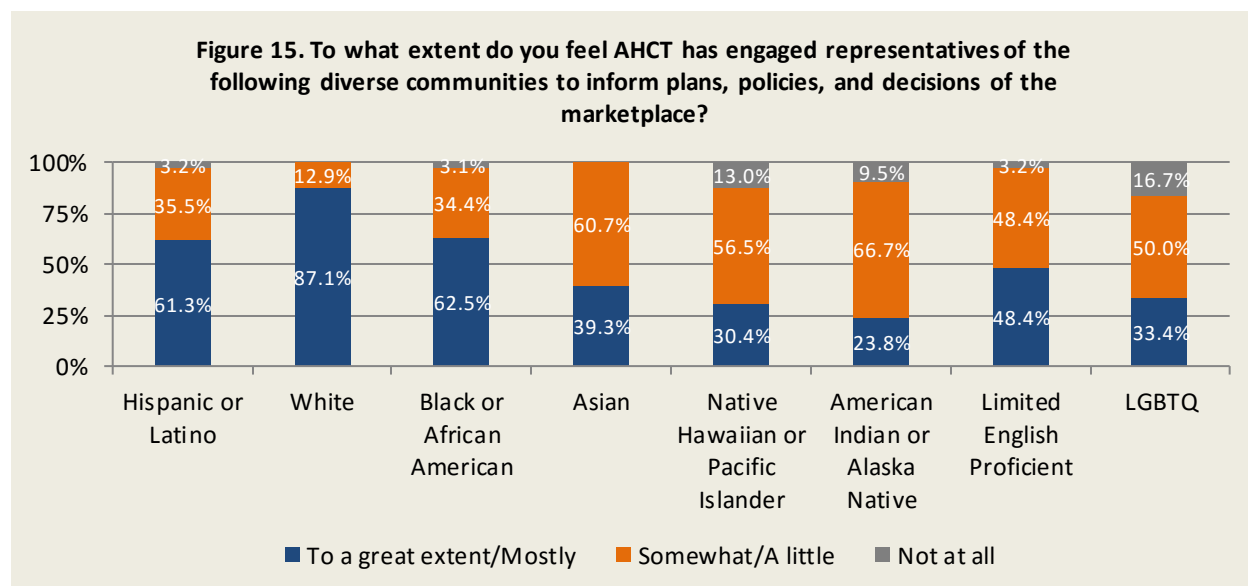
We asked AHCT to report the avenues by which it engages diverse community representatives and how often it does so to inform overall marketplace planning and decisions. It reported at least monthly engagement through public AHCT Board of Directors meetings, presentations, and written letters. Weekly interactions were reported generally with stakeholders via one-on-one stakeholder meetings, e-mail distributions, and related phone conversations. When asked whether interpreter services were provided at stakeholder engagement meetings, AHCT reported this was always provided for Spanish. By comparison, only 20% of surveyed stakeholders

Figure 16. When needed, how often are intepreter services provided by AHCT at formal stakeholder advisory meetings?

- Never — 8.9%
- Sometimes/Not often — 15.6%
- Always/Very often — 20.0%
- Don't Know — 55.6%

reported that interpreter services were provided at stakeholder meetings, with more than half saying they were unsure of whether interpreter services were available (Figure 16).
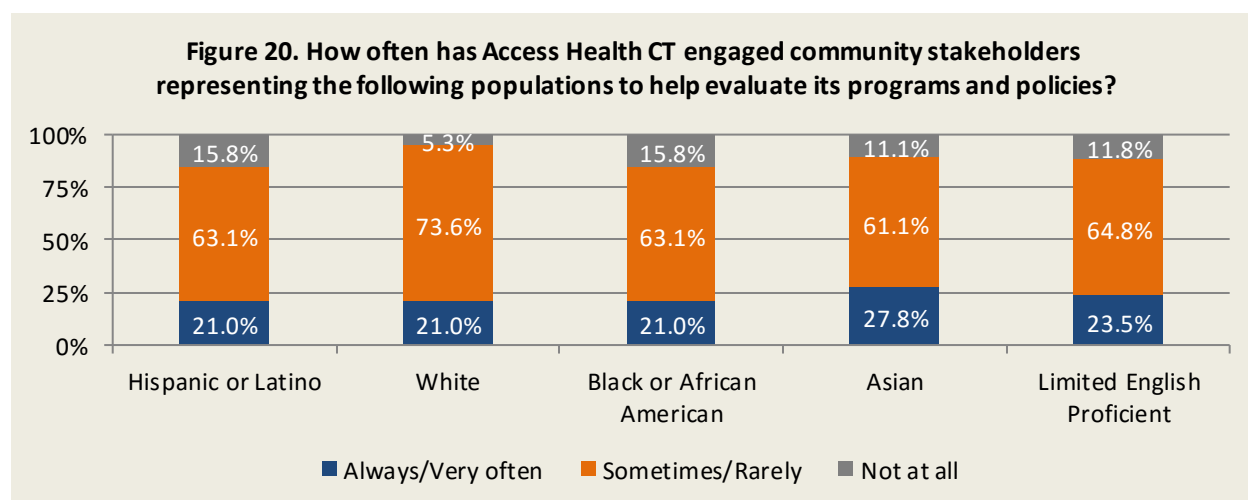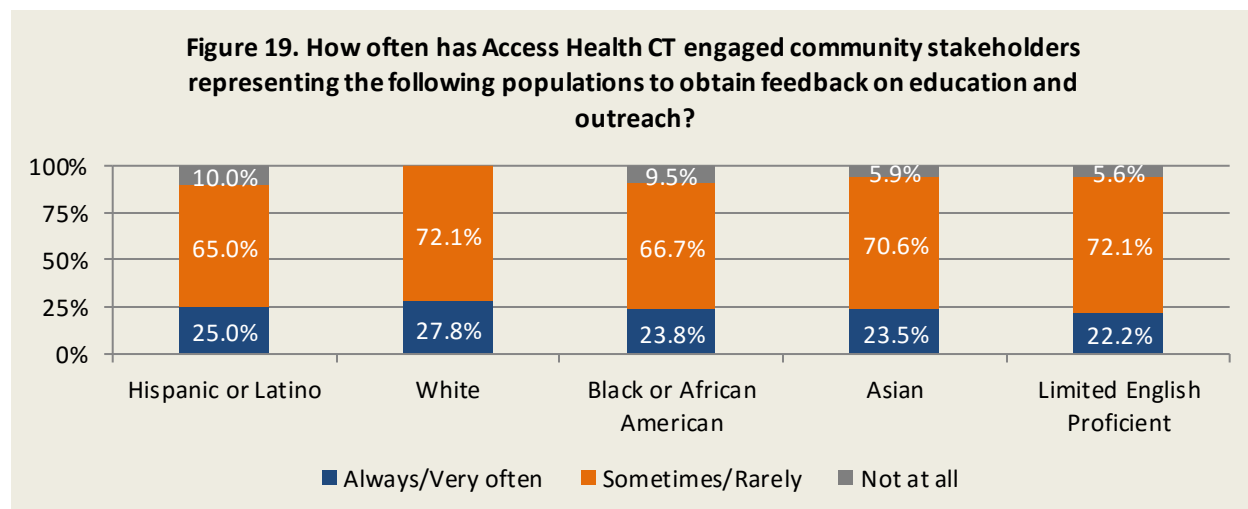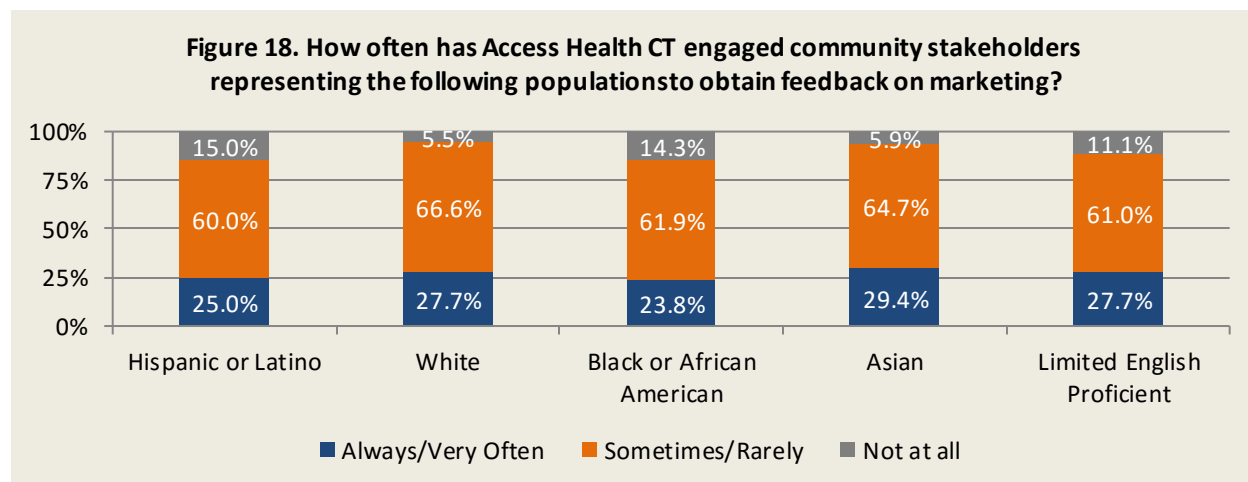
Community engagement on needs assessments. AHCT reported engaging all groups of diverse racial, ethnic, limited English proficient, and LGBTQ stakeholders very often to assess and identify relevant community needs. **However, when community stakeholder groups were asked how often AHCT engaged them to identify community needs and information, only between 32% to 42% across the various groups agreed with AHCT's perception (Figure 17).** Further, there was variation in responses by race and ethnicity. Whereas 42% of stakeholders felt that Whites had been engaged to identify community needs, 37% felt this was the case for Asians, 35% for Hispanics or Latinos, and 32% for Blacks or African Americans (Figure 14). However, across the board, surveyed community stakeholders were more likely to report that diverse stakeholders were sometimes/rarely engaged than very often/always.

Figure 17. How often has Access Health CT engaged community stakeholders representing the following populations to obtain feedback on community needs, preferences, and barriers related to coverage and access?

Legend: ■ Always/Very often ■ Sometimes/Rarely ■ Not at all

	Hispanic or Latino	White	Black or African American	Asian	Limited English Proficient
Not at all	4.4%		4.0%		4.8%
Sometimes/Rarely	60.9%	58.4%	64.0%	63.1%	57.2%
Always/Very often	34.8%	41.7%	32.0%	36.8%	38.1%

Community engagement to inform marketing. When it came to AHCT's perception of community stakeholder engagement on marketing, the marketplace again reported that they engaged diverse community representatives very often across all racial, ethnic, limited English proficient, and LGBTQ groups. **The proportion of respondents agreeing with AHCT's perception was even smaller for this question, with only between 24% and 29% feeling that AHCT very often engaged diverse community representatives to inform marketing (Figure 18).** Stakeholders felt that Hispanics or Latinos and Blacks or African Americans were least engaged in marketing conversations as 15% and 14%, respectively, noted no engagement of these groups in marketing (as compared to 5% and 6% saying Whites and Asians, respectively, were not at all engaged).

Community engagement on education and outreach. AHCT also reported that they very often engaged community stakeholders to obtain feedback on education and outreach. However, only one in four stakeholder respondents agreed with this perception (Figure 19). In fact, by comparison, roughly three times this number reported engagement on education and outreach occurring never, rarely, or sometimes. Perceptions of engaging Hispanics or Latinos and Blacks or African Americans to inform outreach and education once again trailed behind all other groups.

Community engagement on evaluation. AHCT reported its engagement with stakeholders to evaluate programs and policies also occurred very often. The majority of community stakeholder respondents indicated that they did not know how often this occurred. Of those with knowledge or experience, between 21% to 28% across all groups felt that diverse stakeholders were engaged to inform program evaluation (Figure 20).
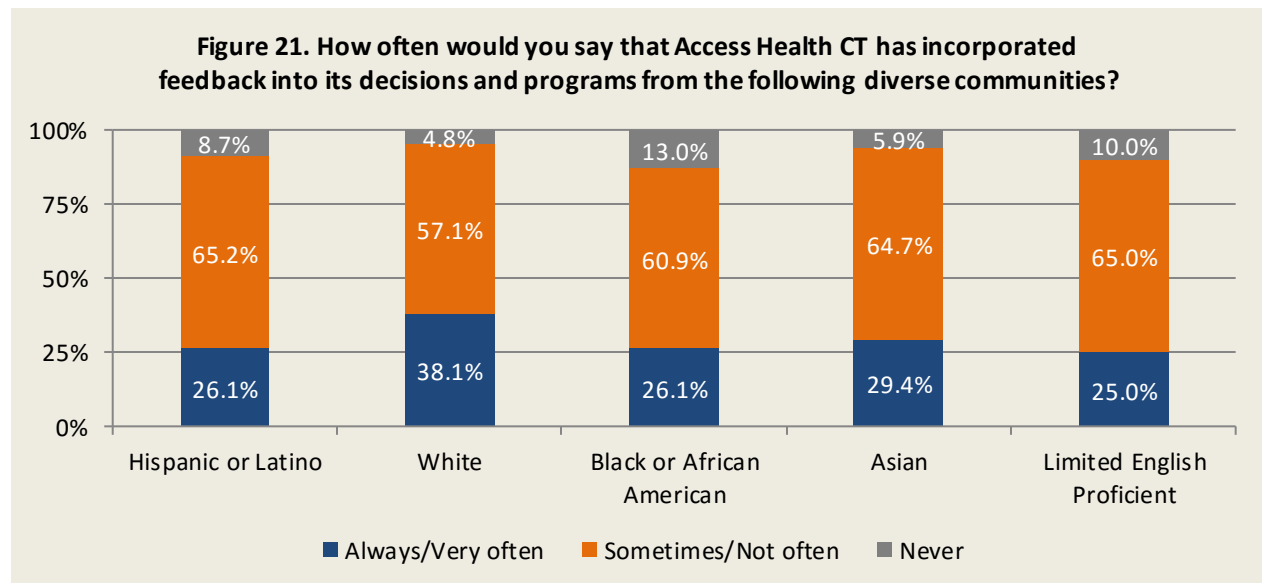
Figure 18. How often has Access Health CT engaged community stakeholders representing the following populations to obtain feedback on marketing?

Population	Always/Very Often	Sometimes/Rarely	Not at all
Hispanic or Latino	25.0%	60.0%	15.0%
White	27.7%	66.6%	5.5%
Black or African American	23.8%	61.9%	14.3%
Asian	29.4%	64.7%	5.9%
Limited English Proficient	27.7%	61.0%	11.1%

Figure 19. How often has Access Health CT engaged community stakeholders representing the following populations to obtain feedback on education and outreach?

Population	Always/Very often	Sometimes/Rarely	Not at all
Hispanic or Latino	25.0%	65.0%	10.0%
White	27.8%	72.1%	
Black or African American	23.8%	66.7%	9.5%
Asian	23.5%	70.6%	5.9%
Limited English Proficient	22.2%	72.1%	5.6%

Figure 20. How often has Access Health CT engaged community stakeholders representing the following populations to help evaluate its programs and policies?

Population	Always/Very often	Sometimes/Rarely	Not at all
Hispanic or Latino	21.0%	63.1%	15.8%
White	21.0%	73.6%	5.3%
Black or African American	21.0%	63.1%	15.8%
Asian	27.8%	61.1%	11.1%
Limited English Proficient	23.5%	64.8%	11.8%

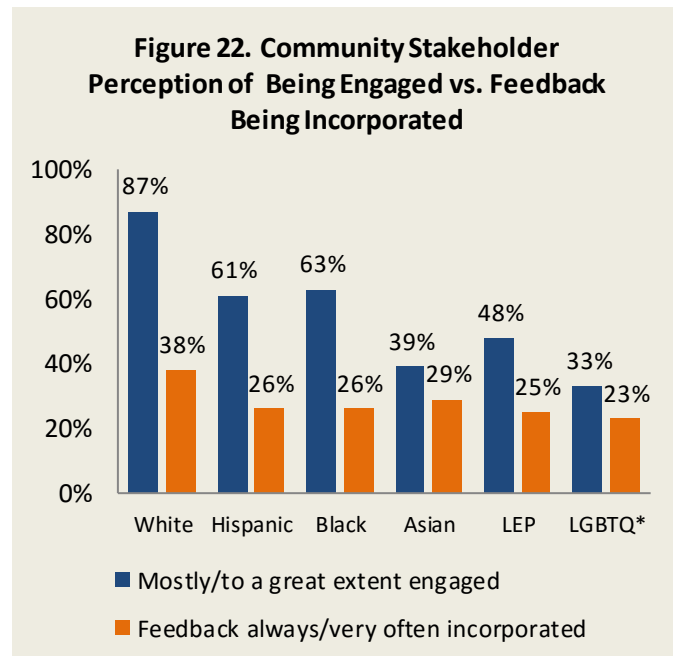# INCORPORATION OF STAKEHOLDER FEEDBACK

Following questions on scope of engagement, AHCT was asked how often it incorporated feedback from diverse communities into future decision-making and programs. **AHCT's response was that feedback was incorporated very often. Few community stakeholder respondents agreed with this assessment. In addition, perceptions of feedback incorporation varied by race/ethnicity.** Whereas 38% of stakeholders felt that feedback from Whites was incorporated, just 29% felt this was the case for Asians, and 26% for Hispanics or Latinos and Blacks or African Americans (Figure 21). One in four reported that they felt that feedback from limited English proficient populations was incorporated into AHCT decisions and programs.

Figure 21. How often would you say that Access Health CT has incorporated feedback into its decisions and programs from the following diverse communities?

	Hispanic or Latino	White	Black or African American	Asian	Limited English Proficient
Never	8.7%	4.8%	13.0%	5.9%	10.0%
Sometimes/Not often	65.2%	57.1%	60.9%	64.7%	65.0%
Always/Very often	26.1%	38.1%	26.1%	29.4%	25.0%

■ Always/Very often ■ Sometimes/Not often ■ Never

In comparing stakeholder perceptions of engagement to inform AHCT's overall programs and policies side-by-side with perceptions of being heard (or feedback being incorporated), there was a strong feeling that while stakeholders are being brought to the table, their feedback is integrated far less often (Figure 22). There was also variation by race/ethnicity. Perceptions of White engagement and incorporation of feedback was much higher than that for non-White groups. While only a few respondents shared their perceptions about LGBTQ populations, those few responses suggest that this group is likely least engaged and heard in the engagement process.

Figure 22. Community Stakeholder Perception of Being Engaged vs. Feedback Being Incorporated

	White	Hispanic	Black	Asian	LEP	LGBTQ*
Mostly/to a great extent engaged	87%	61%	63%	39%	48%	33%
Feedback always/very often incorporated	38%	26%	26%	29%	25%	23%

■ Mostly/to a great extent engaged
■ Feedback always/very often incorporated
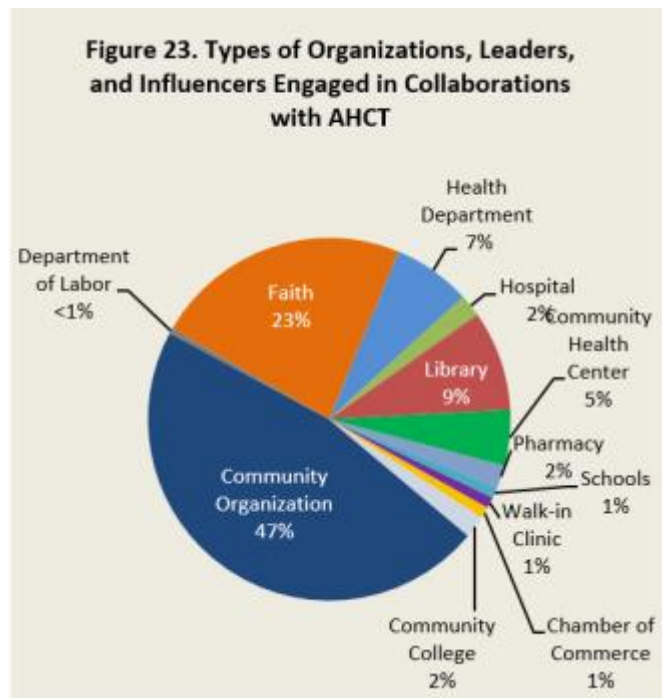
TRIBAL CONSULTATION

The Affordable Care Act and federal regulations require states with federally-recognized American Indian Tribes located within a marketplace's geographic area to engage in regular and meaningful consultation and collaboration with such tribes and tribal officials on all marketplace policies that have tribal implications. AHCT confirms having such a plan and stated that early on it met with Indian tribes on a monthly basis. However since 2015 and pursuant to its tribal consultation policy, AHCT has been consulting tribes as issues arise for either the marketplace or the tribes. From AHCT's perspective, the tribal consultation policy has been effective at fostering tribal trust of AHCT, raising awareness about the special marketplace provisions among tribal communities, informing tribe members of marketplace policies affecting them, and facilitating the enrollment of American Indian tribes.

In addition to its tribal consultation policy, AHCT also employs a tribal liaison tasked with engaging with tribal representatives at least quarterly, informing each tribe of relevant policies and recommendations, and receiving information from each tribe to assure that AHCT's policies reflect the requirements of the ACA and each tribe's needs. AHCT described the liaison as being responsive to the needs of the tribe and reported that the liaison had been effective in informing and advising AHCT on the unique health care coverage needs of the tribes, strategies to engage the tribes in culturally and linguistically appropriate ways, strategies to foster trust between the tribes and AHCT, outreach and education programs to raise awareness on ACA's special marketplace provisions among tribal communities, and strategies to facilitate enrollment of members of American Indian tribes.

Due to a small number of respondents answering these questions, we are unable to report consumer stakeholder perceptions on AHCT's tribal consultation policies and initiatives.
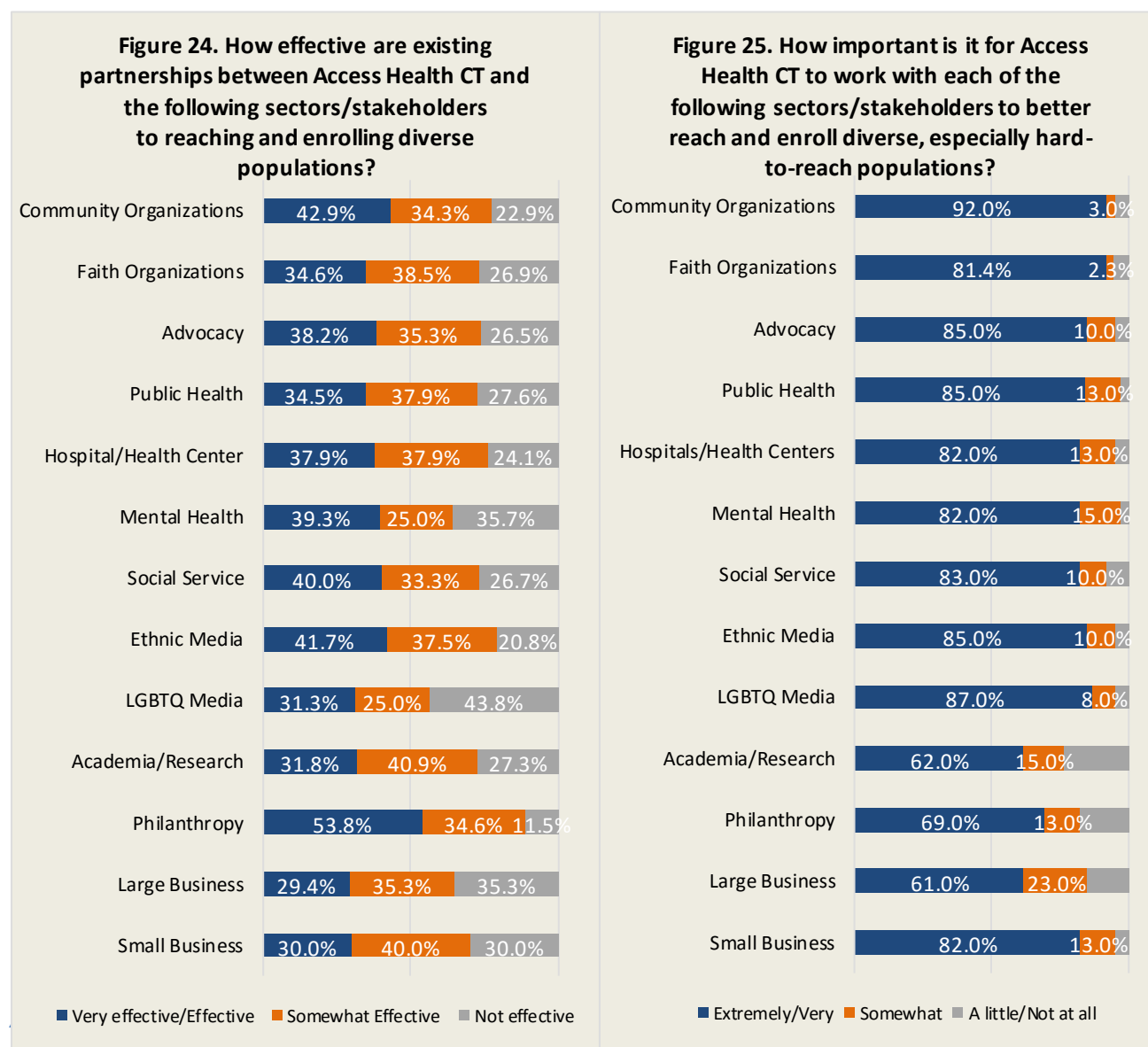
CROSS-SECTOR COLLABORATION

Beyond community stakeholder engagement, the ACA and related regulations emphasize the importance of consulting and working with stakeholders representing a range of sectors to inform planning and operation of the marketplace. AHCT reported doing so very often with most stakeholder categories, but only sometimes with behavioral and mental health organizations, universities and research institutes, foundations and philanthropies, and large and small businesses. **AHCT responded that its most effective partnerships have been with community-based organizations, faith-based organizations, ethnic media, universities and research institutes, and foundations and philanthropies.** The marketplace further indicated that it could do a better job engaging hospitals and media in languages other than Spanish and English, among others. AHCT reported that it has cultivated a diverse mix of

Figure 23. Types of Organizations, Leaders, and Influencers Engaged in Collaborations with AHCT

Health Department 7%
Hospital 2%
Community Health Center 5%
Pharmacy 2%
Schools 1%
Chamber of Commerce 1%
Walk-in Clinic 1%
Community College 2%
Community Organization 47%
Faith 23%
Department of Labor <1%
Library 9%

Data source: AHCT Board of Directors Meeting, March 17, 2016.

partners through its continuous efforts toward community engagement and outreach. Nearly three quarters of its documented organizational collaborations are with community organizations (47%) and faith organizations (23%). Clinics, pharmacies, and hospitals represent approximately 10% of AHCT's collaborative partnerships. Public institutions such as health departments, schools, libraries, and the Connecticut Department of Labor comprise the remaining share of partner groups.

When community stakeholder organizations were asked to rate the effectiveness of AHCT's partnerships and collaboration with other sectors, there was some acknowledgement of the need to do better (Figure 24). The most effective collaboration was cited with philanthropies and foundations, where 54% reported these partnerships were effective or very effective. Further 43% felt partnerships with community-based organizations were also effective as compared to 34% reporting they were somewhat effective and 23% saying they were not at all effective. Over two-thirds of respondents felt that partnerships with other sectors were only somewhat or not effective (Figure 25). Surveyed stakeholders felt that cross-sector collaboration was very important to better reach and serve diverse populations, with linkages to community organizations being most important, followed by collaboration with ethnic and LGTBQ media, advocacy groups, public health, health care providers, mental and social services, and small businesses.

Figure 24. How effective are existing partnerships between Access Health CT and the following sectors/stakeholders to reaching and enrolling diverse populations?

	Very effective/Effective	Somewhat Effective	Not effective
Community Organizations	42.9%	34.3%	22.9%
Faith Organizations	34.6%	38.5%	26.9%
Advocacy	38.2%	35.3%	26.5%
Public Health	34.5%	37.9%	27.6%
Hospital/Health Center	37.9%	37.9%	24.1%
Mental Health	39.3%	25.0%	35.7%
Social Service	40.0%	33.3%	26.7%
Ethnic Media	41.7%	37.5%	20.8%
LGBTQ Media	31.3%	25.0%	43.8%
Academia/Research	31.8%	40.9%	27.3%
Philanthropy	53.8%	34.6%	11.5%
Large Business	29.4%	35.3%	35.3%
Small Business	30.0%	40.0%	30.0%

Figure 25. How important is it for Access Health CT to work with each of the following sectors/stakeholders to better reach and enroll diverse, especially hard-to-reach populations?

	Extremely/Very	Somewhat	A little/Not at all
Community Organizations	92.0%	3.0%	
Faith Organizations	81.4%	2.3%	
Advocacy	85.0%	10.0%	
Public Health	85.0%	13.0%	
Hospitals/Health Centers	82.0%	13.0%	
Mental Health	82.0%	15.0%	
Social Service	83.0%	10.0%	
Ethnic Media	85.0%	10.0%	
LGBTQ Media	87.0%	8.0%	
Academia/Research	62.0%	15.0%	
Philanthropy	69.0%	13.0%	
Large Business	61.0%	23.0%	
Small Business	82.0%	13.0%	

PART 4. NAVIGATORS AND IN-PERSON ASSISTERS

EVOLUTION OF AHCT'S ENROLLMENT ASSISTANCE PROGRAMS

AHCT's navigator and in-person assister (NIPA) program has evolved with time, as is generally the case with many other marketplaces faced with dwindling federal funding. In 2013, AHCT awarded more than $3 million in grants to six organizations to serve as navigators (performing coordination but not enrollment) and nearly 300 in-person assisters for the first open enrollment, including organizations reaching diverse communities. The marketplace divided the state into six regions, with each navigator entity managing a separate region, and with the number of assisters hired in each region based on the proportion of uninsured in that area.[33] The navigator organizations created micro-regions to better target different populations and races/ethnicities in their regions, which helped encourage collaboration between community groups in those areas. Overall, this program achieved approximately 636,727 engagements, 31,769 enrollments, and outreach in 33 languages during the first open enrollment period.[34]

In addition to IPAs, the marketplace supported call center representatives, insurance agents/brokers, and certified application counselors (CACs, often at pharmacies and other healthcare settings) who were trained and certified by the state and available for enrollment assistance. A Best Practices conference in January 2014 offered assisters the opportunity to share lessons learned, and the marketplace created regular newsletters and webinars.[35] The Connecticut Office of the Healthcare Advocate helped the marketplace design the assister programs, handle difficult cases and problems, and write federal grants.[36]

However, by the second enrollment period as federal grants expired, the NIPA program was downsized by 90%, from $3 million in financial support to $180,000, covering 20 to 30 IPAs.[37] Two navigator organizations were appointed that had offices and assisters in multiple cities around the state. Since there were not as many assisters available to visit communities, the marketplace elected to create more enrollment centers for people to visit for assistance, for a total of 15. These included two permanent storefronts along with 13 enrollment sites at libraries, agencies, and other public places (these sites were called Community Enrollment Partners, or CEPs). Three foundations, the Connecticut Health Foundation, the Hartford Foundation for Public Giving, and the Foundation for Community Health, provided supplemental funding to support an additional 35 assisters at community organizations around the state, choosing individuals whose valuable role in enrollment was firmly established during the first open enrollment period.[38]
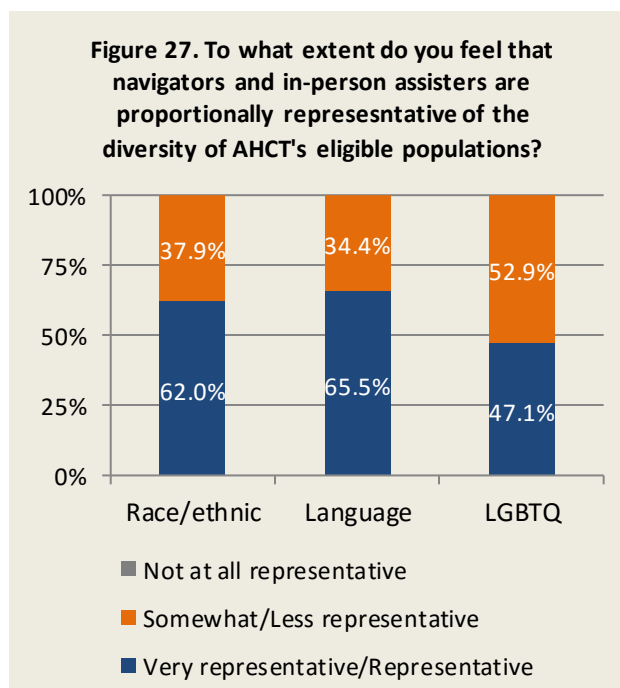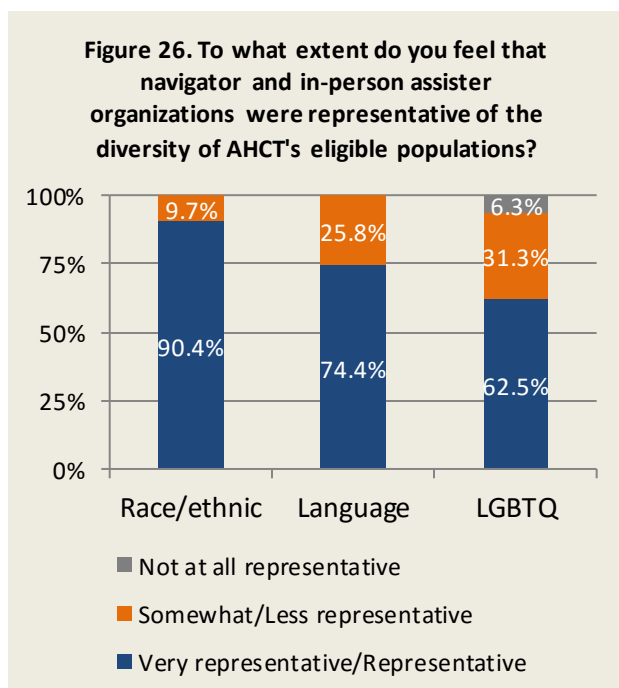
By the third enrollment period, AHCT's enrollment assistance program had evolved and become primarily centered in brick-and-mortar enrollment centers as opposed to in-person assisters embedded in communities. Essentially, the focus shifted to having consumers come to AHCT instead of AHCT going to consumers across communities. At the same time, the marketplace has seen a growing role for its thousands of certified brokers. After budget reductions to the NIPA program between the first and second open enrollment, AHCT and the Office of the Healthcare Advocate identified a key role for brokers to sustain connectivity between AHCT and communities of color.[39] More recently, as AHCT moves along a trajectory toward financial self-sufficiency, it has remained interested in supporting brokers for their potential to attract non-subsidized customers into the marketplace.[40] Through a competitive request-for-proposals process in advance of the third open enrollment period, AHCT formalized certified broker participation

at enrollment events and storefront enrollment centers, selecting a cohort of certified brokers to deliver at least 20 hours per week of services as assigned in these locations.[41] Ability to assist customers in languages other than English and a previous history of successful AHCT enrollments were considered in the selection process.

Reductions to NIPA program capacity were borne out in reduced NIPA enrollment figures, but broker enrollments remained a consistent resource for in-person help. In the first and second open enrollments, 15% of qualified health plan enrollees completed their enrollment through an insurance broker, compared to 9% completing enrollment through a navigator or in-person assister in the first open enrollment, and just 4% in the second open enrollment.[42]

NAVIGATOR AND ASSISTER DIVERSITY

We asked AHCT and community stakeholder groups to reflect on their experiences and perspectives with AHCT's enrollment assistance efforts—including the initial NIPA program as well as the more recent shift to enrollment centers. **When asked to report how representative the outreach and enrollment assister organizations have been of culturally and linguistically diverse populations, AHCT reported they were very representative across all three years. A large majority of community stakeholders generally agreed with this statement when asked about racial/ethnic representation of navigator and other enrollment assistance organizations (Figure 26). However, there was a feeling that representation was somewhat lower by language, and particularly for LGTBQ communities.**

Figure 26. To what extent do you feel that navigator and in-person assister organizations were representative of the diversity of AHCT's eligible populations?

	Race/ethnic	Language	LGBTQ
Somewhat/Less representative	9.7%	25.8%	31.3%
Not at all representative			6.3%
Very representative/Representative	90.4%	74.4%	62.5%

■ Not at all representative
■ Somewhat/Less representative
■ Very representative/Representative

Figure 27. To what extent do you feel that navigators and in-person assisters are proportionally represesntative of the diversity of AHCT's eligible populations?

	Race/ethnic	Language	LGBTQ
Somewhat/Less representative	37.9%	34.4%	52.9%
Very representative/Representative	62.0%	65.5%	47.1%

■ Not at all representative
■ Somewhat/Less representative
■ Very representative/Representative

When asked to reflect on the diversity of in-person assisters and other individuals providing enrollment assistance, there was a perception among community stakeholders that these individuals were less representative of populations being served than the organizations themselves. Nearly two-thirds felt

that in-person and other assisters were representative of populations being served, whereas far fewer (just below half) felt this was the case for LGBTQ populations (Figure 27).

CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

Final ACA regulations state that marketplaces and their outreach and consumer assistance programs must be accessible, including to those who are limited English proficient, by providing free language services that include "(o)ral interpretation; written translations; and taglines in non-English languages indicating the availability of language services." [43] Additional regulations further specify requirements around culture and language in training and standards for assistance personnel.[44] In addition, Connecticut's legislation (Conn. Gen. Stat. 38a-1087) also requires culturally and linguistically appropriate services.

We asked AHCT and community stakeholder groups to reflect on CLAS services offered through the marketplace. AHCT reported it has been doing so since inception and across the last three enrollment periods. However, only half of community stakeholders reported being aware of this (Figure 28).

Figure 28. To your knowledge, are culturally and linguistically appropriate services such as language assistance and interpreter services available year round?

- Yes — 50.0%
- No — 20.0%
- Don't Know — 30.0%
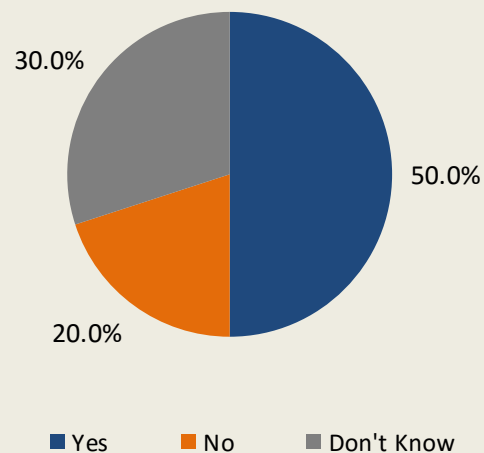
TRAINING FOR NAVIGATORS AND ASSISTERS

In preparation for the first open enrollment, AHCT offered 33 hours of training for navigators and in-person assisters, with topics explicitly covering achieving health equity in Connecticut, health insurance literacy, and culturally and linguistically appropriate access, among other important themes (Figure 29).[45] In the latest enrollment period, however, training for new or first-time navigators and in-person assisters supporting AHCT was reduced to 22 hours with varying number of hours for other types of assisters and enrollers—service center staff were required 20 hours of training, certified insurance agents or brokers required 14 hours, certified application counselors required 13 hours, and other staff were required to receive 14 hours of training. The reductions in training hours coincided with AHCT's transition from instructor-led trainings conducted in classroom settings to an online learning management system with modules designed for self-paced, convenient, and more efficient delivery of training content.[46]

Training covered content including the following: ACA 101; AHCT 101; assuring cultural and linguistic appropriate access; ethical guidelines for community engagement; outreach, education, and enrollment; and other topics.[47] In addition, AHCT reported that training continues to explicitly cover the CLAS standards including the following questions:

- Ways to build trust with the consumer;
- Culturally and linguistically appropriate communication;
- Non-discrimination;
- Timely access to language services and working with interpreters;
- Avoiding bias and stereotype;
- Maintaining general knowledge about diverse populations; and
- Working respectfully with diverse consumers.

When asked to rate the effectiveness of training in advancing knowledge and skills to serve diverse, underserved, and hard-to-reach populations, AHCT reported these efforts were effective especially as evidenced by results from proficiency testing and certification completion. Just six weeks after the launch of AHCT's new online learning management system in September 2015, 96% of lead brokers, 44% of individual brokers, and 25% of certified application counselors were able to complete the trainings.

LANGUAGE ACCESS

One of the promising features of Connecticut's NIPA program during the first open enrollment was that in-person assisters spoke a total of 32 languages, with the ability to search online assisters by language.[48] Call center representatives spoke a total of about 15 languages, and had access to a language line service with ability to assist callers in 30 different languages.[49]

Figure 30. How often would you say AHCT was able to provide interpreter services in a consumer's requested language?

39.1%

60.9%

■ Not at all ■ Sometimes/Rarely ■ Always/Very Often
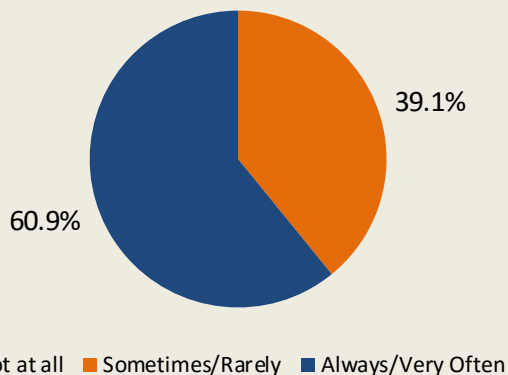
Figure 29. AHCT Navigator and In-Person Assister Training Content by Topic, 2013

Topic: Achieving Health Equity in CT
a. Define the term social determinants of health;
b. Determine the impact of the social determinants of health on CT's uninsured, underinsured and vulnerable populations;
c. Clarify how the Navigators and In-Person Assistor Program can improve health access and coverage goals; and
d. Outline key principles of community capacity building.

Topic: Health Insurance Literacy
a. Recognize the essential benefits of having health insurance;
b. Classify key terms used in health insurance (copay, premium, deductible, etc.);
c. Summarize how consumers can use health insurance to access healthcare and find a medical home;
d. Differentiate the costs versus benefits of having or not having health insurance;
e. Clarify the appropriate usage of the Summary of Coverage and Benefits Tool; and
f. Select the appropriate tool to use based on given consumer engagement scenarios.

Topic: Cultural & Linguistic Access
a. Summarize the definition of Culturally and Linguistically Appropriate Services Standards (CLAS);
b. Select relevant policies and/or procedures that demonstrate an organization's compliance with CLAS;
c. Recognize various forms of literacy;
d. Predict the potential barriers to consumers caused by various forms limited to or low literacy in given scenarios;
e. Recall the process to assess potential literacy barriers;
f. Use the appropriate tool to address literacy barriers in given scenarios;
g. Identify appropriate methods to improve health literacy among consumers;
h. Deconstruct one's own cultural biases that may impact your interaction with consumers.

Source: Access Health CT Navigator & In-Person Assister Training, May 16, 2013. Available at: https://www.statereforum.org/sites/default/files/ct_nav_and_ipa_course_syllabus.pdf

Many outreach materials were available in Spanish as well as English, and enrollment checklists that specified documents to bring for enrollment were provided in more than 10 languages. [50] Online enrollment was available in Spanish as well as English in each open enrollment period. **When we asked community stakeholders to share their experience with interpreter services, nearly 61% felt that interpreter services in a consumer's requested language were very often or always available (Figure 30).**

PART 5. MARKETING AND OUTREACH

OVERALL MARKETING STRATEGY

AHCT has made explicit efforts to address diversity, culture, and language in their marketing and outreach initiatives. Before the first open enrollment began, the marketplace launched outreach and marketing campaigns including direct mail, social media, events, television, print, and other media. Staff also attended events such as fairs, concerts, and Healthy Chat forums.[51] In fall 2013, the marketplace focused marketing on Spanish-speakers and young people, and launched a campaign called Mercado de Salud CT that included bilingual electronic and print ads, Spanish advertising on major Hispanic television networks, and question-and-answer sessions with Spanish-speaking employees from the marketplace on TV and radio shows.[52] Marketplace staff found messages were initially appealing mainly to those already wanting insurance, so they shifted to using more messaging from Enroll America and HealthCare.gov on the value of insurance, and transcreated selected materials to appeal to more diverse communities that were targeted the last few months of open enrollment.

AHCT conducted surveys and focus groups after the first open enrollment period, including with Spanish-speakers, and used the results to refine its outreach strategies for the second enrollment period. Most of the remaining uninsured were located in several large cities, were young Hispanic or African-American males, and were less likely to use traditional media like daily newspapers and mainstream TV networks. As such, the media budget was adjusted to target local resources like ads in community newspapers and local TV and radio stations. The messages were also tailored according to feedback, such as including more information on affordability.[53,54]

The marketplace introduced a mobile app for Android and iOS smartphones that more than 18,000 people downloaded and used to create accounts and buy unsubsidized plans.[55] It also introduced "Tina" on the first day of the second open enrollment period, a virtual assistant on the website to help guide and answer questions in English and Spanish. Analytics showed that individuals who engaged with Tina were nine times more likely to enroll than those who did not.[56]

Marketing activities in the third enrollment period and plans for the next open enrollment have focused more and more on transitioning consumers from coverage to care. In contrast to the first and second open enrollment, when 100% of marketing messages were structured around acquisition of new members, AHCT's mix of messaging shifted in the third open enrollment to 50% acquisition of new members and 50% retention. These messages featured an increased emphasis on member testimonials on the importance of care they have obtained through their coverage, and encouraging customers to engage with AHCT's library of resources to help consumers learn more about using their coverage. In advance of the fourth open enrollment, the message mix is expected to comprise only 15% new member acquisition and 85% retention, for the first time incorporating an explicit disparities focus and emphasizing health insurance literacy and the affordability of covered services once enrolled. For example, some AHCT advertisements contained the message "Did you take advantage of your *FREE* annual check-up?" (emphasis original). AHCT specifically designated African-Americans, Asians, and Hispanic/Latinos as target audiences for marketing around the 2016-2017 open enrollment cycle.[57]

AHCT invested its $4.1 million marketing budget for FY 2016 in a multitude of media types to continue reaching diverse communities effectively. Single-sheet advertising inserts were purchased in Hispanic newspapers including *Tribuna CT*, *La Voz Hispana*, and *El Sol*, and African American/Caribbean newspapers including *Inquiring News*, *Inner City News*, and *Northend Agents*. A 19-station radio

campaign was launched for African American and Hispanic audiences, using familiar local DJs as endorsers. Despite a $1 million television spending reduction from the second to the third open enrollment, television advertising remained the largest share of AHCT's marketing budget. Hispanic television stations airing 30-second Spanish-language AHCT commercials included Telemundo, Univision, and UniMas.[58]
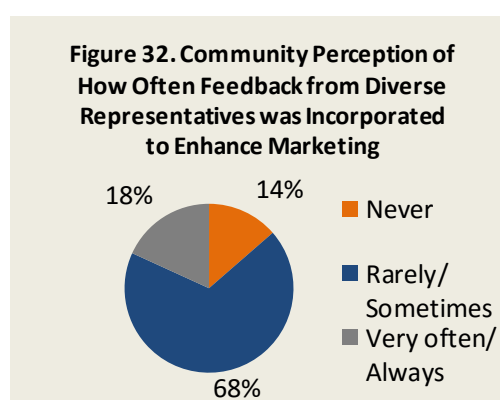
STAKEHOLDER ENGAGEMENT TO INFORM MARKETING

We asked both AHCT and community stakeholders to share their experience and perceptions about the vetting process. When asked to report how often marketing messages and materials were vetted by community members or representatives to ensure cultural and linguistic appropriateness, the marketplace acknowledged variation by population group by responding as follows:

- Always for Whites;
- Very Often for Hispanics, Blacks, and limited English proficient populations;
- Sometimes for Asians and LGBTQ populations; and
- Not at all for Native Hawaiians/Pacific Islanders and American Indians/Alaska Natives.

When community stakeholders were asked the same question, they too agreed that vetting of marketing messages and materials varied by diverse population group. **In general, stakeholders confirmed that Whites were more often engaged to inform marketing than non-Whites (Figure 31). Of the 39 respondents who offered their perspectives on LGBTQ populations, only 18% felt this group was engaged to vet marketing materials and messages.**

Figure 31. Community Stakeholder Perception of the Degree to Which Marketing Messages and Materials Were Vetted by Diverse Representatives
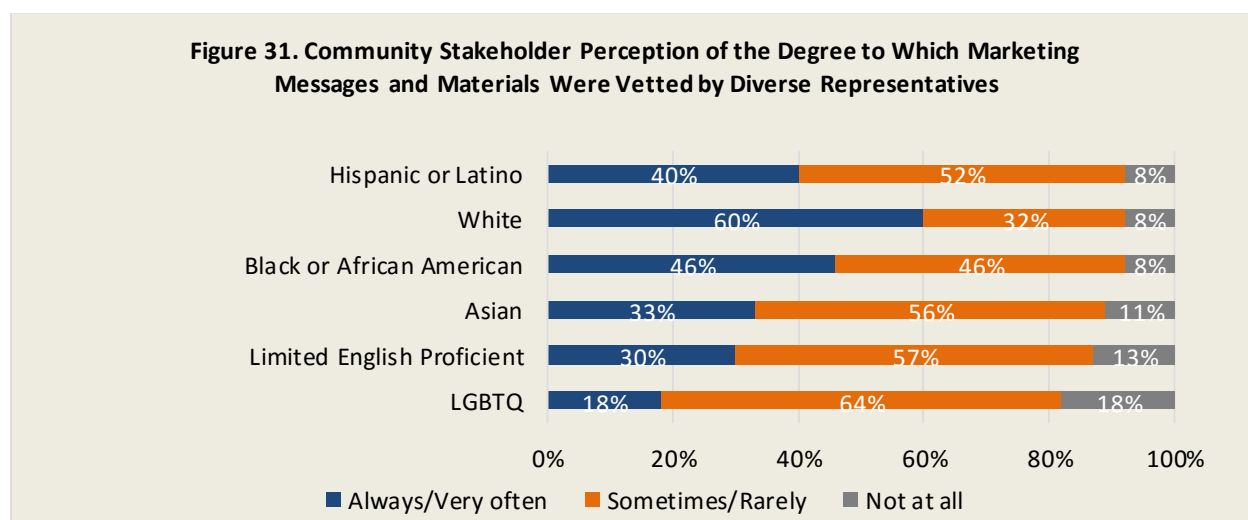
Asked to report how often community stakeholder feedback on vetting marketing messages was incorporated, AHCT felt they did so very often. In contrast, less than 1 in 5 community stakeholder respondents agreed with this assessment (Figure 32). **The majority of stakeholders (68%) felt that marketing-related feedback to improve cultural and linguistic appropriateness was rarely or only sometimes incorporated.**

Figure 32. Community Perception of How Often Feedback from Diverse Representatives was Incorporated to Enhance Marketing

PART 6. MARKETPLACE OUTCOMES

OVERALL ENROLLMENT

A total of 116,019 people enrolled in qualified health plans offered through AHCT by the end of the third open enrollment. However, as of April 2016, enrollment had dropped by nearly 11,000 to 105,437, including roughly 8,000 customers who failed to effectuate their coverage by making their first payment.[59] An additional 17,000 enrollees were given a 90-day grace period to verify personal information by submitting supplemental documentation, which some enrollees may not have completed by the deadline.[60] Data presented in this section are based on AHCT's initial report of enrollment numbers.

Connecticut's enrollment totaled 80,081 after the first open enrollment, 77% of whom received Advance Premium Tax Credit subsidies. The remaining 22% enrolled without financial assistance, most likely earning incomes too high to qualify for tax credits. Enrollment increased by over 30,000 from the first to second open enrollment, and rose by an additional 6,000 after the third open enrollment. Virtually no change occurred in the proportion of subsidized versus unsubsidized enrollees throughout the first three enrollment periods. See Table 1.

Table 1. Number Enrolled in Subsidized and Unsubsidized Health Plans
by Enrollment Period

	Open Enrollment 1	Open Enrollment 2	Open Enrollment 3
Total Enrolled	80,081	110,095	116,019
Subsidized	61,939	85,179	90,619
Unsubsidized	18,079	24,916	25,400

Source: Data for Open Enrollment 1 from Access Health CT Board of Directors Meeting, May 22, 2014; Data for Open Enrollments 2 and 3 provided by AHCT.

Two of AHCT's four carriers will no longer be selling plans through AHCT in the fourth open enrollment, a change which could further threaten enrollment totals. UnitedHealthcare, which has 1,477 AHCT customers currently enrolled in its plans, announced its intention to depart AHCT beginning in the 2017 plan year.[61] In addition, 11,300 more AHCT customers covered by the HealthyCT co-op plan are now set to lose their coverage on December 31, 2016, after the co-op was deemed financially unsustainable by the Connecticut Insurance Department and ordered to cease operations at year's end.[62] In both cases, enrollees will have to return to the marketplace, shop, and actively renew in order to avoid becoming uninsured.
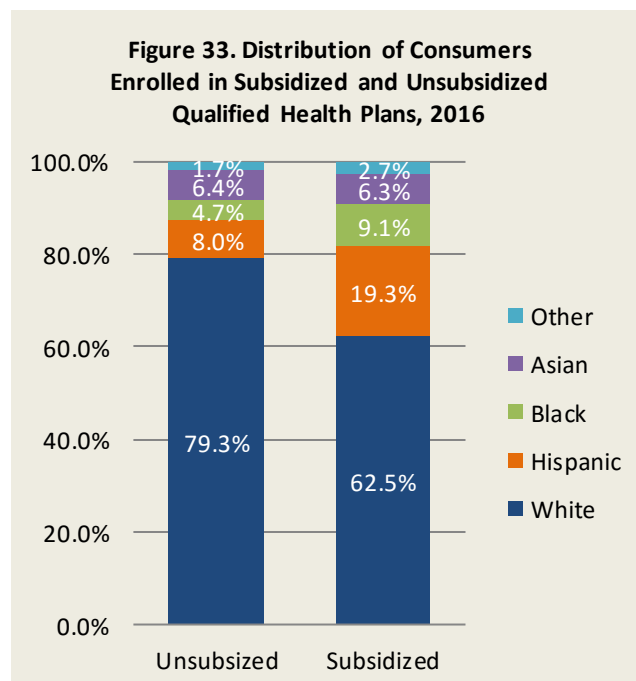
Figure 33. Distribution of Consumers Enrolled in Subsidized and Unsubsidized Qualified Health Plans, 2016

Unsubsized: White 79.3%, Hispanic 8.0%, Black 4.7%, Asian 6.4%, Other 1.7%
Subsidized: White 62.5%, Hispanic 19.3%, Black 9.1%, Asian 6.3%, Other 2.7%

Data source: AHCT, 2016 Note: Respondents with missing race/ethnic data are not included in the denominator.

Enrollment by Race and Ethnicity. Enrollment in subsidized and unsubsidized plans varied largely by race and ethnicity. **As of the third open enrollment, a greater proportion of Whites were enrolled in unsubsidized (79%) plans than subsidized (63%) when compared to their non-White counterparts (Figure 33). Over twice as many Hispanics and Blacks were enrolled in subsidized coverage than unsubsidized. For Asians as a whole, their rate of enrollment was near equal between unsubsidized and subsidized.**

However, when broken out further by Asian subgroups, differences in enrollment in subsidized and unsubsidized plans emerged (Figure 34). For example, the rate of enrollment in subsidized plans for Vietnamese (87%) was considerably higher than all other Asian subgroups and comparable to rates of subsidized coverage among Hispanics (89%) and Blacks (88%). Such a finding is often masked when only considering enrollment for the overall Asian population (77% of whom were enrolled in subsidized plans). Asians of Indian descent had the highest rate of enrollment in unsubsidized plans (28%).
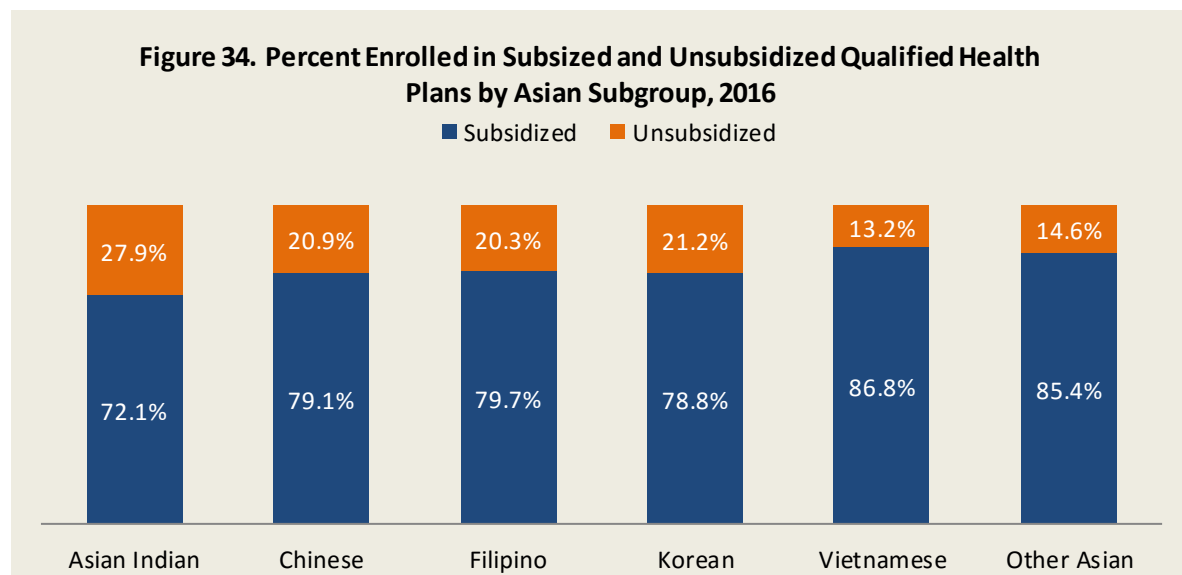
Figure 34. Percent Enrolled in Subsized and Unsubsidized Qualified Health Plans by Asian Subgroup, 2016

	Subsidized	Unsubsidized
Asian Indian	72.1%	27.9%
Chinese	79.1%	20.9%
Filipino	79.7%	20.3%
Korean	78.8%	21.2%
Vietnamese	86.8%	13.2%
Other Asian	85.4%	14.6%

Data source: AHCT, 2016
Note: Respondents with missing race/ethnic data are not included in the denominator.

Enrollment by language. Data from the third open enrollment were available for public reporting by 12 languages including English, Spanish, Polish, Mandarin, Portuguese, Russian, Vietnamese, French Creole, Albanian, Arabic, French, and Cantonese. Nearly 70% of enrollees reported data on their preferred language. Among those preferring a language other than English, the large majority spoke Spanish (82%), followed by Polish (5%), Mandarin (2%), and Portuguese (2%) (Figure 35). Publicly reported data by language and subsidy status were only available for English and Spanish. **Generally, Spanish-speaking individuals (96%) were far more likely to be enrolled in a subsidized plan as compared to English-speaking (Figure 36).**

Figure 35. Percent QHP Enrollees Reporting Language Preference other than English, 2016

- Spanish — 82%
- Polish — 5%
- Mandarin — 2%
- Portuguese — 2%
- Other — 9%
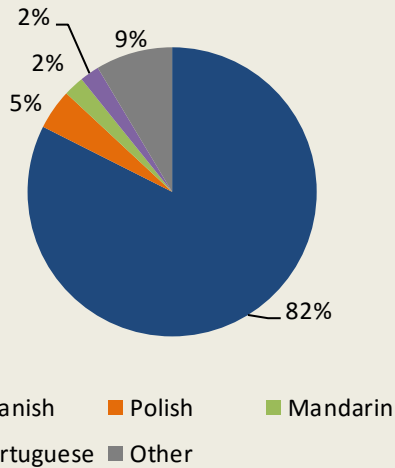
Figure 36. Distribution of Subsidized and Unsubsidized QHP Enrollees by Language

Legend: ■ Subsidized ■ Unsubsidized

English: Unsubsidized 20.3%, Subsidized 79.7%
Spanish: Unsubsidized 3.6%, Subsidized 96.4%
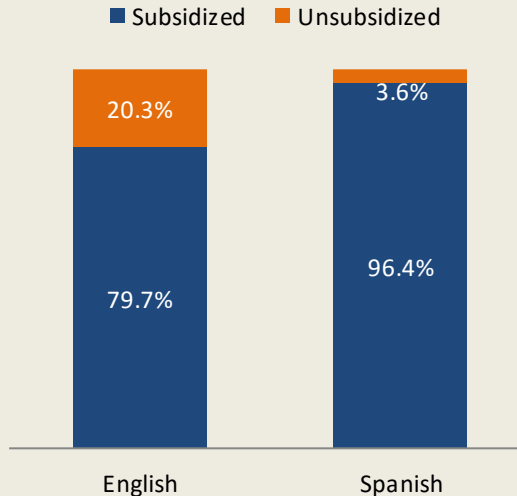
Data source: AHCT, 2016 Note: Respondents with missing language data are not included in the denominator.

MARKETPLACE RETENTION AND CHURN

Central to the success of health insurance marketplaces is assuring that coverage is stable and lasting over time. Particular attention has been given to retaining individuals in coverage and preventing churn, defined as the "tendency for people to cycle on and off coverage as a result of changing work, family, and other life circumstances."[63] AHCT monitors and reports retention and churn data, including asking related questions on their consumer satisfaction survey that ask respondents to reflect on their satisfaction, behaviors, and attitudes toward enrollment and coverage.

In 2015, AHCT's consumer survey was administered by phone among 1,142 primary enrollees (including new, renewed, and leavers).[64] Of the total respondents nearly one in four reported leaving AHCT, of which 37% remained uninsured. **Whites who left AHCT were more likely to have other insurance rather than remaining uninsured (68% vs. 44%, respectively).[65] In contrast, a larger proportion of Hispanics (24% vs. 16%), Blacks (13% vs. 9%), and others (11% vs. 4%)**

Figure 37. Percent Leavers with Other Insurace Vs. Leavers Who Remain Uninsured by Race/Ethnicity, 2015

Legend: ■ Other ■ Black ■ Hispanic ■ White

Leavers with other insurance: White 68%, Hispanic 16%, Black 9%, Other 4%
Leavers with no other insurance: White 44%, Hispanic 24%, Black 13%, Other 11%
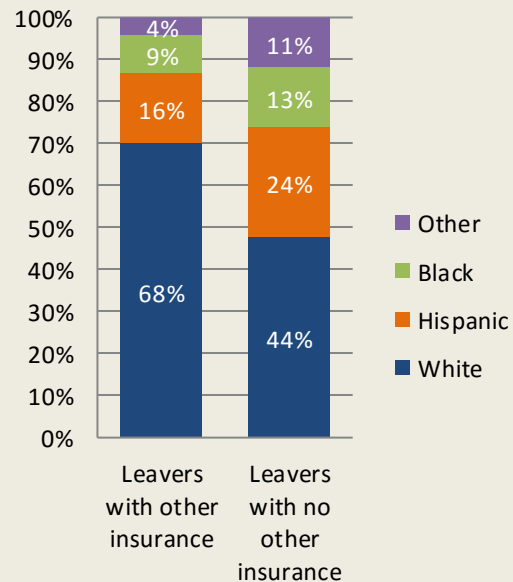
Data source: The PERT Group. Access Health CT: Enrollee/Leaver Satisfaction and Understanding Study. July 2015. See page 78.

were uninsured than covered by other health insurance once they left AHCT (Figure 37).[66] In addition, leavers without any other health insurance were more likely to have less education. Whereas 25% of those with a high school diploma or less churned into some other health insurance, nearly 45% remained without coverage.[67] In addition, in considering populations who were least likely to re-enroll in a qualified health plan offered through AHCT, variation existed by race and ethnicity, where one in five Black respondents said they were unlikely to re-enroll (a rate considerably higher than all other groups).[68]

The report suggested that "those who indicate the strongest likelihood of re-enrolling have more positive perceptions of AHCT than those who are not likely to re-enroll. Efforts to close some of the larger gaps in perception may help secure stronger re-enrollment numbers."[69]

COMMUNITY STAKEHOLDER PERCEPTION OF ENROLLMENT

Recognizing the sizeable racially, ethnically, and linguistically diverse population in the marketplace service area, we asked community stakeholders to report how well they felt AHCT performed in reaching and enrolling specific diverse populations. **Stakeholder responses varied by race and ethnicity, with two-thirds feeling that performance was at least very good for Whites as compared to only one-third feeling performance was very good for Hispanics, Blacks, and limited English proficient (Figure 38). Rating of performance was lowest for LGBTQ.**

Figure 38. Community Perception of AHCT's Performance in Reaching and Enrolling Diverse Population Groups
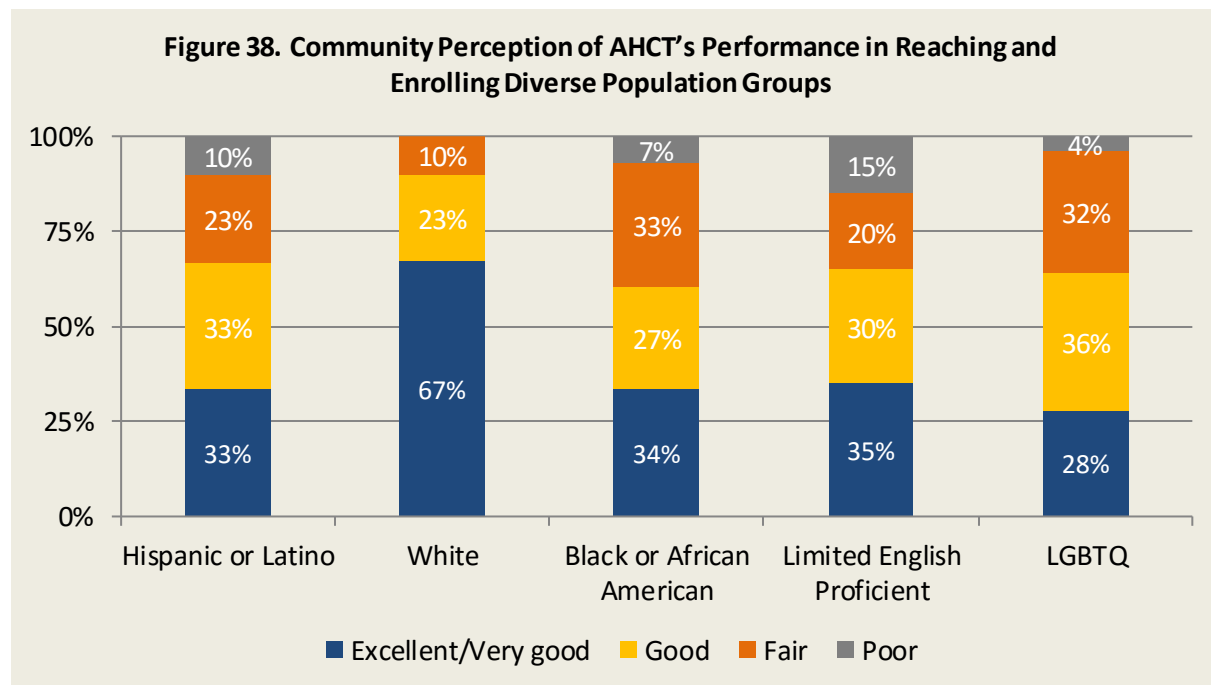
Note: Data on Asians not reported due to missing data during data collection.

MARKETPLACE "COVERAGE TO CARE" ACTIVITIES

While education and enrollment were among primary responsibilities of health insurance marketplaces, more recently the focus has shifted to "coverage to care"—that is assuring that enrollees have the knowledge, skills, and understanding on how to use their coverage and establish a usual source of care to access services when needed. Through their consumer surveys, AHCT monitors the extent to which

enrollees have accessed care, along with the knowledge and satisfaction with related education received. Data from these surveys over the last two enrollment periods suggest some interesting patterns. First, that in 2015, while nearly two-thirds of surveyed consumers reported using their health insurance, nearly one in three reported not doing so. Secondly, health insurance usage from 2014 to

Figure 39. AHCT Customers who Used Health Insurance

	2014	2015
No	26%	36%
Yes	74%	64%

■ Yes ■ No ■ Don't know/refused

Figure 40. AHCT Customers who Visited a Primary Care Physician

	2014	2015
Don't know/refused	2%	1%
No	23%	36%
Yes	76%	71%

■ Yes ■ No ■ Don't know/refused
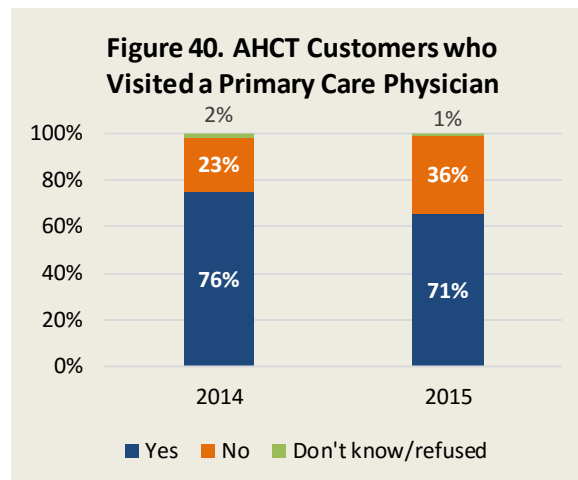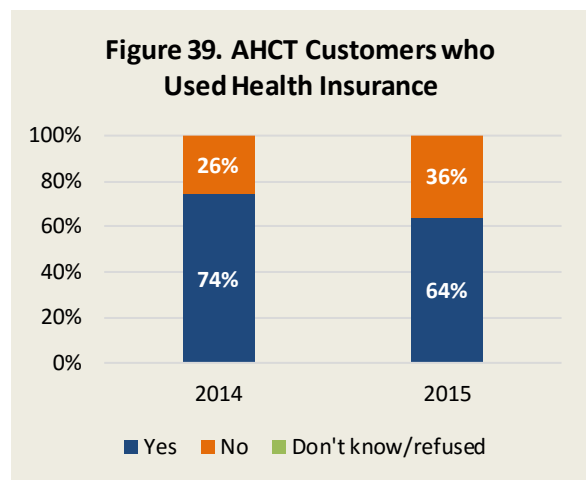
Data source: The PERT Group Enrollee/Leaver Satisfaction and Understanding Study, 2015

2015 declined among those enrolled in qualified health plans. Whereas 75% of those surveyed used their coverage in 2014, that rate dropped to 64% in 2015. Trend in declining utilization is further supported by the survey's question on whether consumers have a usual source of care (or primary care physician). Whereas 76% reported having a primary care physician in 2014, that proportion dropped to 71% in 2015.[70]

While a complex host of barriers may be playing out in impacting access to care once covered, education and assistance to help consumers understand and use their coverage may also have a role. **AHCT's 2015 consumer survey found that non-White individuals were less engaged customers than their White counterparts. In fact, fewer (30%) of non-Whites (Blacks, Hispanics, and Others) reported both having used health insurance and having a primary care provider as compared to nearly double (54%) saying they have not used health insurance and do not have a primary care provider.[71]**

Figure 41. AHCT Customer Engagement, by Race/Ethnicity

	Used insurance / Have primary care physician	Used insurance / No primary care physician	Have not used insurance / Have primary care physician	Have not used insurance / No primary care physician
Other	7%	11%	8%	7%
African American or Black	5%	9%	4%	9%
Hispanic	15%	48%	17%	38%
White or Caucasian	70%	32%	69%	46%

■ White or Caucasian ■ Hispanic ■ African American or Black ■ Other
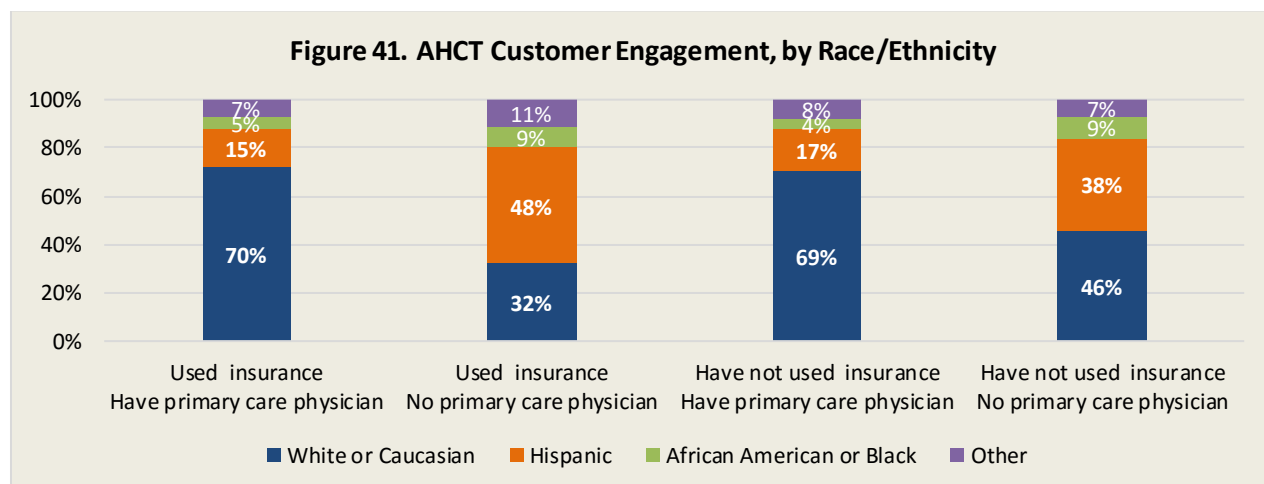
Data source: The PERT Group Enrollee/Leaver Satisfaction and Understanding Study, 2015

AHCT reported providing education and assistance to help consumers understand and use their health insurance, including a growing shift in marketing messages to push education and understanding of health insurance. They shared specific examples of education-related efforts including educational webinars, community chats, educational collateral and mass media, consumer decision tools, among others to advance knowledge and understanding of consumer coverage. In addition, they reported assistance being offered in English, Spanish, and over 100 languages over the phone. When we asked community stakeholders to respond to these questions, we received mixed responses. Whereas 41% of stakeholders reported knowing about AHCT's education and assistance to help consumers understand their health insurance and how to use it, 59% are unaware of such efforts. Of those who know about these programs, over two-thirds are aware that assistance is available in languages other than English.

Figure 42. To your knowledge, does Access Health CT provide education and assistance to individuals who need help understanding how to use their coverage?

33.3%

41.0%

25.6%

■ Yes ■ No ■ Don't know
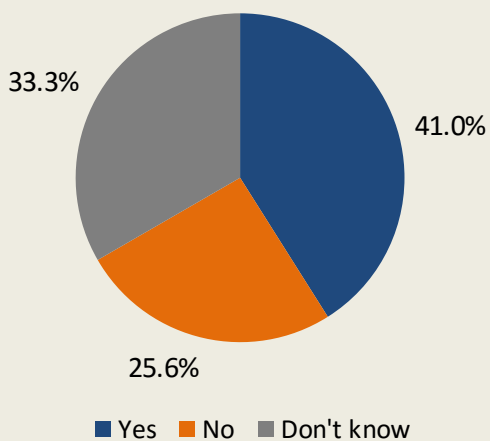
Figure 43. Is this education and assistance on how to use coverage provided in languages other than Engilsh?

25.0%

6.3%

68.8%

■ Yes ■ No ■ Don't know
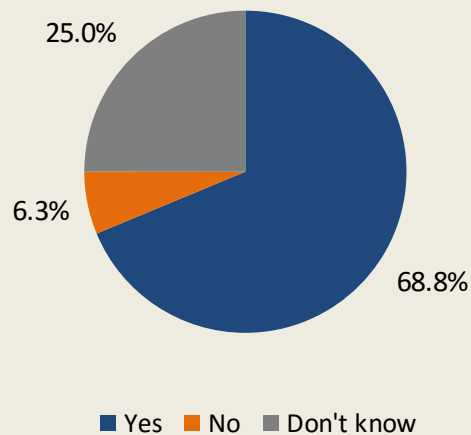
DISCUSSION

The Marketplace Health Equity Assessment Tool was designed with the purpose of helping health insurance marketplaces and their community stakeholders mutually identify strengths, gaps, and areas of opportunity for assuring that all eligible individuals and families, regardless of their race, ethnicity, gender, or other personal and community circumstances, have access to coverage and care. The pilot administration of the M-HEAT in Connecticut between October 2015 and May 2016 revealed a plethora of key findings that suggest that AHCT is well on its way—and among leading state marketplaces—in working explicitly to advance health equity. At the same time, there are many opportunities to fill gaps and improve coverage and access, while assuring a healthier Connecticut.

In this section, we summarize and organize key findings into two broad areas: ***Mutually Identified Strengths and Successes,*** reflecting on points on which both the marketplace and stakeholders agree have seen positive progress advancing health equity; and ***Differing Perceptions and Realities***, describing where the marketplace and stakeholders differ in their perceptions of health equity progress. The section that follows discusses a third theme, ***Areas of Opportunity Moving Forward*** for AHCT and its community stakeholders, building on our discussions from the May 19, 2016, in-person briefings with various state players. Finally, we reiterate that our findings are not only intended to inform Connecticut's progress and next steps, but also to serve as a reference for other states around the country working to better integrate, monitor, and advance health equity priorities.

MUTUALLY IDENTIFIED STRENGTHS AND SUCCESSES

As M-HEAT results suggest, there are at least three areas that AHCT and community stakeholders both acknowledge are strengths and successes of the marketplace in advancing equity. These include a strategic commitment to health equity; commitment to staff diversity; and AHCT's cutting-edge technology, education, and resources.

Strategic commitment to health equity. Central to working to advance health equity is a strategic commitment to this priority, including the establishment of goals, policies, and accountability measures that are infused throughout an organization's planning and operations.[72] AHCT has been among leading health insurance marketplaces across the country to explicitly address and advance health equity. Our previous reports have documented this commitment over the years since 2013.[73,74,75] And more recently, AHCT has strengthened this focus by infusing health equity and disparities reduction objectives across its primary functions (plan management, data and analytics, customer support, finance, human resources, information technology, legal and policy, and marketing and sales) as presented in its new three-year strategic plan. Many of AHCT's community stakeholders recognize this commitment especially as our survey found that more than half agreed that this focus existed. However, nearly half of the stakeholders also suggested that there was a need to better communicate this commitment publicly. In discussing these findings in person with many of the stakeholders, there was a feeling that while committing to health equity in written plans and procedures is a foundational first step, more must be done to assure this priority is reflected in action.

Leadership and staff diversity. There was considerable agreement between AHCT and stakeholders about the importance of and progress toward achieving diversity within the workforce —including board of directors, executive leadership, staff, call center personnel, and others in the front lines working to assist and enroll individuals in coverage. Both AHCT and stakeholders agreed that frontline staff—

including call center personnel, those helping at enrollment centers, and individuals who once assisted as part of the in-person assister program—were all very reflective of the demographic composition of marketplace-eligible populations. There was also agreement, however, that the organization's leadership (including board and executive staff) was somewhat less reflective of the populations being served—and both acknowledged opportunities to do better to increase diversity. These findings, and mutual acknowledgement, are important as research strongly suggests that provider and consumer concordance especially in health care leads to better communication, satisfaction, and adherence.[76],[77] As AHCT grapples with concerns over retention and its "leavers," especially among non-White individuals who disproportionately leave and remain uninsured, there may be some value in further strengthening the diversity of the organization to publicly reflect a commitment and sensitivity to the needs of these hard to reach and retain groups.

Cutting-edge technology, education, and resources. AHCT has been on the cutting edge of offering consumers a range of educational and technical resources to improve understanding and enrollment in coverage. Innovative enrollment tools like "Tina," AHCT's online virtual assistant, help minimize roadblocks for those completing enrollment on their own through the website. AHCT's independent innovations are complemented by a robust network of community partners, storefront facilities, call center staff, and other personnel equipped to provide efficient, culturally competent, and linguistically accessible services in person or via telephone. AHCT has anticipated the growing need to transition customers from coverage into care, especially those who had been chronically uninsured in the past and have minimal experience navigating the health care system. AHCT's web resources for those seeking to learn how to use their coverage, some mailed to consumers and even more available on the AHCT website, provide a plain language orientation to basic insurance terms, explain the process of locating a doctor, and remind consumers of the affordability of many essential preventive services. Many stakeholders acknowledge the promise of these efforts, and have expressed eagerness to help AHCT cultivate a culture of coverage among diverse consumers by seeking opportunities to advise in the development of new efforts or enhancement of existing efforts (such as health fairs, community events, and other outreach initiatives) in partnership with AHCT. They also reiterate the important role that community stakeholders can play to bridge to underserved and hard-to-reach communities—a need that was most recently reflected as the marketplace sought to reach 14,000 individuals transitioning out of Medicaid.[78] With no attendees at their first transition fair in Danbury, AHCT acknowledged the need to "get word out" and do more.[79]

DIFFERING HEALTH EQUITY PERCEPTIONS AND REALITIES

While AHCT and community stakeholders acknowledged many strengths and assets for working to advance health equity objectives, the two had differing perceptions about the importance and progress in three key areas: community stakeholder engagement and feedback loop, communication and marketing, and financial commitment to equity. As many members of our Community Advisory Group reiterated these concerns, we also incorporate their feedback in this section.

Community stakeholder engagement and feedback loop. Perhaps the greatest difference in perception and reality existed on the topic of community engagement. Whereas AHCT perceived its efforts to be very effective in engaging and incorporating feedback from stakeholders representing diverse population groups, stakeholders had a much different perspective. Surveyed stakeholders in this study consistently reported that they felt that engagement by AHCT varied by population—with Whites being engaged at a greater level than all other racial/ethnic groups; and LGBTQ representatives being least engaged across all processes. And while AHCT reported that they very often integrated feedback from

community stakeholders in their programs, policies, and decisions, stakeholders again felt differently. Stakeholders felt that when brought to the table, their feedback was far less incorporated and that level of incorporation varied by race/ethnicity. In particular, a large proportion felt that White voices were more likely heard and incorporated than voices from other communities.

When we discussed this issue in person with stakeholders, there was overwhelming acknowledgement of the need to better engage and improve communication with diverse community stakeholders. They also felt the need for AHCT to strengthen the feedback loop with stakeholders. Following are sentiments that stakeholders shared:

> There is no feedback loop. There are so many clients that never know resolution. So many who have dropped out who never received responses back from AHCT… Feedback loop for brokers and CACs must be created. And there's another feedback loop needed for stakeholders.

> Communication and feedback loop is a key one. And I also feel we need to have productive, constructive, and transparent conversations. Need for accountability on both ends.

> Advocacy groups have become unengaged due to AHCT's lack of interest in providing true outreach.

Communication and marketing. The overall disconnect in perception and reality between AHCT and community stakeholders on a number of questions suggests that there may be an underlying communication gap between the two groups that may be straining what could otherwise be a very strong, trusting, and productive relationship. As one stakeholder reiterated:

> Perception is reality. If you have a group of community gatekeepers who have a negative perception that is grounded by data, then that means that AHCT needs to do better or that there is information-sharing that needs to be done.

Whereas half of the stakeholders felt a commitment to equity explicitly existed, the other half did not have knowledge of this focus and less than half said that the equity commitment was communicated effectively. On many other knowledge questions that were asked about AHCT programs, a large proportion of surveyed stakeholders seemed to report a lack of knowledge or awareness suggesting that while AHCT may have promising efforts in place, there may be greater opportunity to shine light on these efforts for greater utility and impact.

In addition to improving communication, many stakeholders felt that marketing to diverse audiences could also be improved. Whereas AHCT felt its marketing strategy was working to reach target audiences, stakeholders felt the need for greater engagement and involvement of diverse populations to vet messages to assure their cultural and linguistic appropriateness and resonance with communities.

Financial commitment to equity. Financial commitment to health equity is central to advancing related programs and policies, while also building financial accountability toward strategic and organizational objectives that work to advance health equity. This was reiterated by stakeholders, one of whom stated:

> This [financial alignment] is critical to measure and assure accountability. Essentially, how will we know that the marketplace is effectively utilizing resources to reach, enroll, and retain particularly hard-to-reach populations?

Building financial commitment and accountability often involves the allocation, accounting, and reporting of organizational, departmental, or program dollars by communities of need, whether they be racial/ethnic or some other target population group. While most at AHCT and among community

stakeholders agreed about AHCT's overall strategic commitment to health equity, there seemed some concern that this focus did not wholly translate to a financial commitment which ultimately is necessary to drive targeted programs and actions. Whereas over 90% of community stakeholders recognized the importance of assuring that financial resources are allocated and accounted according to population need, AHCT acknowledged that its current financing system did not allow for it to tease out resource allocation or spending by specific population groups.

AREAS OF OPPORTUNITY

The M-HEAT is not only intended to establish a baseline for the ongoing monitoring of progress on health equity, but also to pair independently collected data and perceptions from the marketplace and its stakeholders to drive a meaningful dialogue to identify assets and strengths as well as gaps and opportunities to inform future policies and actions to make improvements. This initiative has uniquely revealed a number of opportunities for the marketplace and community stakeholders to address in collaboration to improve outreach, enrollment, and retention—especially of hard-to-reach, diverse populations who comprise a larger proportion of those remaining uninsured and churning out of coverage in Connecticut. In this section, we identify five areas of opportunity that build on both the gaps identified through the M-HEAT as well as our discussions with AHCT's Board of Directors and community stakeholders during the May 19, 2016, in-person briefings.

Embracing health equity as an organizational priority. AHCT has been among a handful of leading states with an explicit commitment to health equity as written into its charter since establishment. And following the third open enrollment period, AHCT worked to further solidify this focus in its new, three-year strategic plan that infused disparities reduction objectives across its primary functions. While a formal, written commitment is a key first step, assuring that health equity is embraced by the organization—including its people and in its resources—is critical to making progress and establishing accountability. As experience from the health care field suggests, organizations successful in advancing health equity are not only those that understand and engage local communities, but those that build organizational capacity by providing education and training on health equity to board members, leadership, and staff, building health equity related measures into data collection and reporting, and aligning funding and resources to health equity objectives.[80] Also important is the understanding of baseline readiness and progress of organizations to advance health equity—much like the M-HEAT served to do to take stock of strengths, assets, and gaps, while also offering a benchmark by which to compare future progress. Community stakeholders also offered their thinking on ways that AHCT could more fully embrace health equity:

> Looking at its mission, AHCT has a mission to health equity. There should be accountability. There should be a challenge to AHCT to measure progress toward their mission.

> It's important to ask and understand questions like: How are you aligning the organization to be health equity focused? Is it incorporated into your trainings? That's really important.

> It is important to have AHCT investigate and evaluate their levers. That is one way they can work to better advance health equity.

Bridging the communication divide between AHCT and community stakeholders. The M-HEAT's results and in-person conversations in the state revealed a deep communication divide between AHCT

and its community stakeholders. We particularly identified a need to strengthen trust and understanding between AHCT and community stakeholders. Such efforts can be achieved in at least two ways, as our review of initiatives and discussions with stakeholders in Connecticut revealed: (1) A stakeholder and marketplace retreat, mediated and facilitated by a neutral party, and allowing for open, candid dialogue that reinforces the strengths and assets that each group brings to the joint effort to achieve health equity, and (2) an intentional and ongoing feedback loop established by the marketplace to provide regular, in-person opportunities for stakeholders to interact with marketplace staff, leaders, and board members in a forum devoted to improving health equity in Connecticut. In addition, stakeholders in Connecticut reiterated the need for AHCT to build relationships with community leaders "by approaching them, going to community events, and having dedicated AHCT leadership staff who will follow up with leaders' suggestions and ideas for improvements." Cultivating such community relationships, as many reinforced, will require time, energy, respect, and humility on the part of the marketplace. The following suggestions from stakeholders reiterate options for improving communication and dialogue between the marketplace and its community stakeholders:

> My suggestion would be to have a "retreat" with stakeholders, executive leadership, and board members. Do a presentation, have a discussion on what's our role? What can we do? We would need to make sure it is facilitated, and not facilitated by someone who is biased from either side but a neutral convener.

> Bringing AHCT to the table with community members and having a community dialogue about perceptions versus reality.

> AHCT also needs to invest significant time and resources into nurturing ongoing relationships with leaders to help them feel like influencers.

> [A] way to advance health equity is the education piece, and we know that communities often look to certain leaders—whether they be religious, community, or political figures to help them. AHCT needs to focus its resources on educating these community leaders so that they can in turn help their communities.

> One way to meet the community where they are at is to encourage AHCT to cultivate their social capital within communities, to spend quality time with community leaders—who are connecting with consumers in meaningful ways and respond quickly to their feedback with SMART goals and specific action steps.

> AHCT needs to set up a feedback loop so they hear and understand why their perceptions do not match reality, and also for AHCT to hear directly from consumers about issues, in order for consumers to feel like their voice and suggestions make a difference and will influence change.

Restoring a focus on in-person assistance and meeting people where they are. The remaining uninsured are in many cases less informed, may be more socially, culturally, and linguistically isolated, and may need additional assistance to fill knowledge gaps. Already hesitant and reluctant consumers may not be inclined to seek out help at storefronts, health fairs, and other generally targeted events. In addition, the ACA has introduced a new risk of churning for individuals and families whose income fluctuates between eligibility levels for Medicaid and subsidized marketplace coverage, with estimates suggesting that nearly half of those with incomes below 200% FPL are expected to churn in any given year.[81] These individuals are more likely to be receptive to education from trusted, culturally and linguistically representative messengers. While the state's large scale in-person assistance program (better known as the NIPA program) may not return—especially in the face of dwindling and almost non-existent federal support—there may be an opportunity for the marketplace to work with

foundations and philanthropies to reinstate a very targeted in-person outreach program. Such a program can work to target not only the many racially/ethnically and other diverse uninsured, but also those who have left the marketplace and remain uninsured, a large proportion of whom are non-White and have less than a high school diploma. Lessons from other parts of the country, such as California, shed light on the promise of meeting communities where they are through in-person assistance:[82]

> California, a state with a large Latino population, has worked to meet its hard-to-reach populations where they are. On Families USA's teleconference call, Peter Lee, the executive director of Covered California, said that 85 percent of Californians know about the state-based marketplace. He credits that in large part to the significant outreach that enrollment experts have done to raise awareness in communities of color and other hard-to-reach populations. This includes sending insurance agents to Vietnamese communities, sending enrollment assisters to clinics serving Latino communities, and reaching out to African Americans at their local churches."[83]

The marketplace may consider enhancing its initiatives currently centered in enrollment centers by adding targeted efforts to meet hard-to-reach people where they are and provide in-person assistance. Achieving this will require the marketplace to work with community stakeholders, health plans, brokers, and other groups who can help identify how, where, and when in-person, one-on-one assistance would be most beneficial to underserved communities. Through their strategic use, such efforts would serve to further engage diverse communities generally as well as insure and retain individuals for years to come.

Improving data collection by race and ethnicity. Another important avenue to advancing health equity is the collection and reporting of accurate, reliable, and granular demographic data. The ACA furthered this priority by authorizing in Section 4302 the standard collection of data by race, ethnicity, language, sex, and disability status, in compliance with standards created by the Office of Management and Budget (OMB). While not a requirement for state-run health insurance marketplaces, many are looking to these standards to improve the collection and reporting of their enrollment and claims data especially in efforts to monitor and evaluate cost, quality, and health disparities. Some marketplaces are also beginning to explore ways to incentivize health plans to better collect race and ethnicity data. For example, Covered California requires health plans to increase the percentage of self-reported demographic data annually, with a goal of 80% by the end of 2019.[84] When we asked whether AHCT has ventured in this direction (or has any plans to), they reported not doing so at this time. We believe that a well-rounded commitment to health equity requires the collection and analysis of data by an assortment of demographic factors. Data, after all, is the necessary cornerstone of identifying inequity and measuring progress towards equity. Health insurance marketplaces should be consistently reviewing and improving their data collection capabilities at the most granular level possible. In concert with the aforementioned health equity feedback loop, a robust system of data collection and analysis will allow marketplaces to proactively identify and respond to inequity in coverage.

Monitoring health equity progress over time. The M-HEAT served an important role to help the marketplace and its many community stakeholders understand their baseline programs and progress toward health equity, illuminating areas of strength and success as well as opportunities for improvement. In particular, the tool has provided a unique platform for mutual discussion of common concerns among the marketplace, community stakeholders, and others. This was especially reiterated by community members who stated that the M-HEAT was a "good frame to start the conversation" and a way for the marketplace to understand their differing perception and reality. As such, AHCT and its partners may consider utilizing the tool in part or whole to continue to monitor progress toward health

equity. There may be an opportunity to integrate components of the M-HEAT into existing AHCT consumer or stakeholder surveys, quality initiatives, and other organizational assessments. In addition, the M-HEAT might help AHCT establish metrics toward their disparities reduction objectives included in their new three-year strategic plan—an objective that many stakeholders also reiterated toward building accountability. Finally, as the fourth open enrollment period looms ahead, AHCT and its partners and stakeholders may also consider ways to re-administer and expand on the M-HEAT to evaluate progress and improvements. As one stakeholder suggested, "Do it again and pull in Medicaid. [There is] intractable turf between Medicaid and Marketplace that impedes progress on so many fronts." And as another stakeholder affirmed, the M-HEAT "can be an agent for change."

CONCLUSION

AHCT has pursued extensive efforts to advance health equity, a commitment first reflected in its original mission and values and sustained through the continued pursuit of equity initiatives across numerous marketplace functions. This report offers insights on how AHCT's efforts have been received in the community, highlighting achievements to date as well as remaining opportunities for AHCT to build upon its initial years' work. Refining messages and methods of communication with diverse populations, including a renewed emphasis on in-person connections, emerged as a potential priority area for the marketplace to explore. Adding dimensions to outreach and engagement that leverage the existing capacity and social fabric of communities – such as neighborhoods, trusted local leaders, associations, or advocacy groups – may also represent an important step toward cultivating the marketplace's positive image and opening channels for honest and constructive communication. AHCT now looks toward the future with an explicit disparities focus in its strategic plan, and these findings suggest that AHCT is well positioned to adapt and extend its current successes in serving diverse populations. With sustained effort, AHCT can solidify an equity focus throughout marketplace operations and continue to provide a leading example to other states and the nation.

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