SPARK POLICY INSTITUTE
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Connect for Health Colorado:
Assistance Network Evaluation Findings

August 2014

Assistance Network Final Evaluation Report

Prepared by Spark Policy Institute on behalf of Connect for Health Colorado

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EXECUTIVE SUMMARY

In the fall of 2013, sixteen states and the District of Columbia launched state-led health insurance exchanges. Connect for Health Colorado (C4HCO) is the Colorado-specific health insurance marketplace that opened in October 2013 to help individuals, families and small employers purchase health insurance and apply for new cost reductions and subsidies though federal financial assistance. C4HCO offers a website for shopping and purchasing insurance plans as well as a statewide network of support via customer services representatives, health coverage guides and licensed brokers and agents. C4HCO is a non-profit entity and its mission is to increase access, affordability and choice for individuals and small businesses when purchasing health insurance coverage.

The Assistance Network, a collection of more than seventy organizations across the state, was created to provide free, locally based, in-person education and help with enrollment for individuals and small businesses. Assistance sites were tasked with hiring and managing health coverage guides, as well as managing the day to day operations of a site, including the physical space and infrastructure. Health coverage guides were expected, per federal guidelines, to assist individuals and small businesses with education and application for health insurance coverage. Regional Hubs were also selected, and awarded enhanced grant funding, to support assistance sites via information sharing, collaboration, training on outreach and education and technical assistance services.

In the report that follows, the activities and outcomes of the assistance network are evaluated in detail. The analysis indicates that the assistance network played a unique and critical role in helping Coloradans enroll in health coverage. While outreach and enrollment strategies varied across the state, it is evident that assistance sites and health coverage guides were able to tailor activities to the needs of local populations, reaching many individuals most in need of health coverage. While data shows that much work remains to be done in the 2014-2015 open enrollment period to reach new and previously challenging audiences, this report identifies some effective strategies for consideration moving forward. The evaluation report concludes with specific recommendations to support the reach and capacities of the health coverage guides and the overall assistance network.

EVALUATION

The evaluation had the dual purpose of comprehensively assessing what happened over the past ten months and providing concrete action items for improving the process for the coming year. The overall approach was to collect data that outlines the basic elements of sites' outreach and enrollment strategies, while digging deeper into a subset of sites' activities for a more thorough data collection and analysis. This evaluation was somewhat limited by the types of data available through C4HCO's Marketplace database, and there were significant and unplanned barriers to accessing data through the enrollment database due to technical difficulties. The C4HCO evaluation was framed through four major, overlapping levels of analysis: the role, experience and expertise of health coverage guides; the specific strategies used for outreach and enrollments across health coverage guides and assistance sites; the structure and operations of Assistance Sites, including

quality assurance, team building and client management protocols; and the broader network of Assistance Sites and their external partners.

The evaluation sought to answer the following five questions:

1. In what ways were people were reached, assisted and enrolled via the Assistance Network? How did the experience and expertise of health coverage guides contribute to the process, including outreach and enrollment outcomes and customer satisfaction?
2. What effective practices (including outreach to specific target populations, enrollment strategies, quality assurance and internal program management) were reported by Assistance Sites that should be integrated or scaled up for broader use?
3. How did partnerships, both within and outside the Assistance Network, contribute to the effectiveness and efficiency of the enrollment process at the site level?
4. Overall, what were the strengths and weaknesses of the Assistance Network model?
5. Moving forward, what are the opportunities to improve the Assistance Network's activities and outcomes during the 2014-2015 open enrollment period?

Evaluation Question 1: In what ways were people were reached, assisted and enrolled via the Assistance Network? How did the experience and expertise of health coverage guides contribute to the process, including outreach and enrollment outcomes and customer satisfaction?

Across the state of Colorado, nearly 140,000 people signed up for health care in the first open enrollment period of the Colorado Health Exchange. Our research estimates more than 400,000 people were made aware of Connect for Health Colorado via myriad outreach efforts and between 7,000 – 14,000 people were assisted during the enrollment process by a health coverage guide. Overall, two critical themes emerged from the analysis of outreach strategies:

- Grantees were creative and sought to find new ways to present information, capture audiences and reach new populations; and
- Grantees tailored their efforts to the needs of their communities.

Our findings also suggest there are additional audiences that have not been reached. Despite best efforts by many sites, reports indicate Latinos, younger people and the politically opposed remain under-enrolled. In some cases, more fully developed outreach strategies, including word of mouth campaigns, will be necessary to reach these populations. In others, the upcoming increase in penalties will drive new clients into the marketplace. Strategies honed over the past year will support efficient enrollment of these new individuals, but grantees will need to continue to be dynamic and nimble in their work. Research findings suggest a large portion of the current health coverage guides are well-equipped, with a background in health insurance and customer service, and experience with the local population and a personal passion and enthusiasm for getting clients access to quality health coverage. Moreover, findings confirm that a positive experience with a health coverage guide had a significant impact on an individual's overall satisfaction with Connect for Health Colorado.

Evaluation Question 2: What effective practices (including outreach to specific target populations, enrollment strategies, quality assurance and internal program management) were reported by Assistance Sites that should be integrated or scaled up for broader use?

Interviews with a subset of assistance sites across the state highlighted two important areas of effective practices, both internal and external. First, more effective sites had efficient, team-oriented work practices, including a common scheduling system, weekly check-ins, trouble-shooting opportunities with leadership and quality assurance strategies built in to monitor their work. Externally, effective sites were also highly connected to partners, capitalizing on those relationships to bring clients into the marketplace. Specific practices that could be scaled to all assistance sites include:

- Consistent use of tracking tools, common forms and internal monitoring processes by all team members;
- Community enrollment events that include local brokers, Medicaid techs and local assistance sites for one-stop-shopping for clients;
- Creative outreach strategies that build on word of mouth, cultivating community champions and gaining access to populations not typically connected with traditional media or social media outreach;
- Enrollment systems that offer space for health care literacy or language interpretation needs, starting clients in the application process where they are most comfortable;
- Internal and external customer satisfaction data collection for use in updating and adapting strategies based on community feedback; and
- Development and maintenance of partnerships with local health and human services departments, other local government bodies, and critical community partners.

Evaluation Question 3: How did partnerships, both within and outside the Assistance Network, contribute to the effectiveness and efficiency of the enrollment process at the site level?

Partnerships offered a great deal to assistance sites, including avenues for sharing information about the health exchange; locations from which to build a client base; opportunities to advertise, co-host, co-sponsor outreach and enrollment events; and referrals to and from partners for clients and services. In addition, partners were able to provide support for troubleshooting enrollment, moving applications through the process, assisting with finding an individual the right coverage, providing language assistance, etc. Partners, as seen in the network map in Appendix C, included a variety of organizations such as local schools, churches, and recreation centers to local health departments and community-based organizations. Evidence suggests that sites that were able to capitalize on their relationship with the local health organization were better equipped to handle complicated or problematic applications. Fostering those relationships for the future will be critical to on-going support for the enrollment process. The evaluation also revealed that organizations that were strategic about their partnerships were often able to reach an audience or target population that might have been otherwise out of their reach. These strategic linkages provided avenues into communities and populations that would not have existed in any other form. Finally, many of the partners highlighted by assistance sites were a key driver of clients, either from within the membership of the partner organization or from the partners' network. During the next round

of open enrollment, it is vitally important that assistance sites continue to cultivate deep partnerships as well as develop new ones in order to reach new populations and to continue to capture clients from within existing channels.

Evaluation Question 4: Overall, what were the strengths and weaknesses of the Assistance Network model?

A key strength that emerged from the evaluation was the unbiased nature of the assistance offered by health coverage guides. Rather than sell particular plans, or funnel individuals into one or two specific options, health coverage guides were able to listen to and support individuals making health coverage choices that best met their family's needs. Moreover, health coverage guides are able to provide extensive information and answer client questions. As the evidence from the marketplace data suggests, clients have a better understanding of cost sharing reductions and subsidies after having worked with a health coverage guide as compared to individuals who did not receive assistance. In some instances, however, the level of objectivity required of health coverage guides made assistance challenging, particularly for those individuals lacking with health coverage or computer skills, or who faced language barriers during the process. Strong relationships with local brokers helped some sites overcome these issues, offering clients multiple avenues for accessing care. Overall, a benefit to the network model is that there is ample room for health coverage guides, brokers and Medicaid techs at the table in order to meet customer needs. The model thrives when partnerships are cultivated and maintained, meaning that clients truly find a "no wrong door" entry into the health insurance system.

Key weaknesses of the assistance network model included the varied levels of organizational capacities across the state. Some sites were simply less equipped to handle outreach and enrollment activities, whereas others were well situated to be effective. Instead of providing a standardized set of procedures, such as enrollment tracking databases or client in-take forms, each site was left to create their own set of materials. As noted above, some sites already had working computer-based tracking systems with a common scheduling portal and access for their local partners. Others were still creating spreadsheets and paper forms and checklists months into the open enrollment process. While each site was uniquely situated to answer the specific needs of their community, the lack of common capacity across the state produced varying outcomes. For future, these is a need to either create a standardized system for all or to support lower capacity organizations in development and achievement of equivocal operating systems as compared to higher capacity sites.

Evaluation Question 5: Moving forward, what are the opportunities to improve the Assistance Network's activities and outcomes during the 2014-2015 open enrollment period?

The 2014-2015 open enrollment period will present new and different challenges compared to the first open enrollment period. Unreached audiences in the first year will continue to be difficult to access while, simultaneously, existing marketplace customers will have changes to their existing plans. The recommendations below outline in detail the opportunities available for improving the work of the health coverage guides and the overall assistance network.

RECOMMENDATIONS FOR 2014-2015 OPEN ENROLLMENT

Via quarterly reports, in-depth interviews and health coverage guide surveys, a variety of suggestions and requests emerged for improving the 2014-2015 open enrollment process.

- As the C4HCO application process becomes more streamlined with the Medicaid/Peak application, health coverage guides have asked for opportunities to become familiar with and test the new application protocols before they go live to customers.
- Moving into the next enrollment period, shared marketing materials, tips sheets and checklists, sample forms and tracking sheets for clients should be made widely available to assistance sites.
- A common database platform should be launched in order to provide more effective monitoring systems and promote efficiency in client management.
- Additional support for developing outreach and enrollment strategies for the hardest to reach populations across the state, including a word of mouth strategy for outreach that assists with access to communities of color, young 'invincibles' or other target populations should be developed and scaled to all assistance sites.
- Assistance sites that were well connected to, or even embedded within, local health and human services departments were better able to troubleshoot client applications during the enrollment process. Many of these sites also had direct information about Medicaid denials that could be used to inform targeted outreach strategies. C4HCO should assist in facilitating these relationships where they don't currently exist, encouraging more information sharing to assistance sites in identifying outreach audiences.
- Another critical area for exploration is the development of performance measures and tracking/reporting mechanisms for the upcoming grant year, particularly measures that take into account support offered by health coverage guides for Medicaid eligible clients prior to that status being known. A suggested list of performance metrics is listed in Appendix B, followed by a list of recommendations for implementing tracking and reporting guidelines for all grantees.

Overall, the evaluation of the assistance network and its health coverage guides demonstrates the unique role that this program has playing in launching Connect for Health Colorado. The analysis of marketplace data reveals a significant relationship exists between consumers and health coverage guides when it comes to helping the public navigate their health coverage choices. Particularly as the next open enrollment period gets underway with the expectation that carriers will alter plans and offer new avenues for coverage, the importance of the health coverage guide in assisting individuals with enrollment is in no way diminished. While not always able to seize every opportunity or capture every population in need, the assistance network demonstrated great potential in its first year. While there are many options for improvement in the years to come, this evaluation concludes that across a number of levels, the assistance network was able to begin to articulate effective strategies for utilization in the future. The strength of the assistance network model should be capitalized upon in order to ensure long-term financial sustainability and that cost-effective service delivery by Connect for Health Colorado can continue while serving those most in need across our state.

INTRODUCTION

CONNECT FOR HEALTH COLORADO

Connect for Health Colorado (C4HCO) is the Colorado-specific health insurance marketplace that opened in October 2013 to help individuals, families and small employers purchase health insurance and apply for new cost reductions and subsidies though federal financial assistance. C4HCO offers a website for shopping and purchasing insurance plans as well as a statewide network of support via customer services representatives, health coverage guides and licensed brokers and agents. C4HCO is a non-profit entity and its mission is to increase access, affordability and choice for individuals and small businesses when purchasing health insurance coverage.

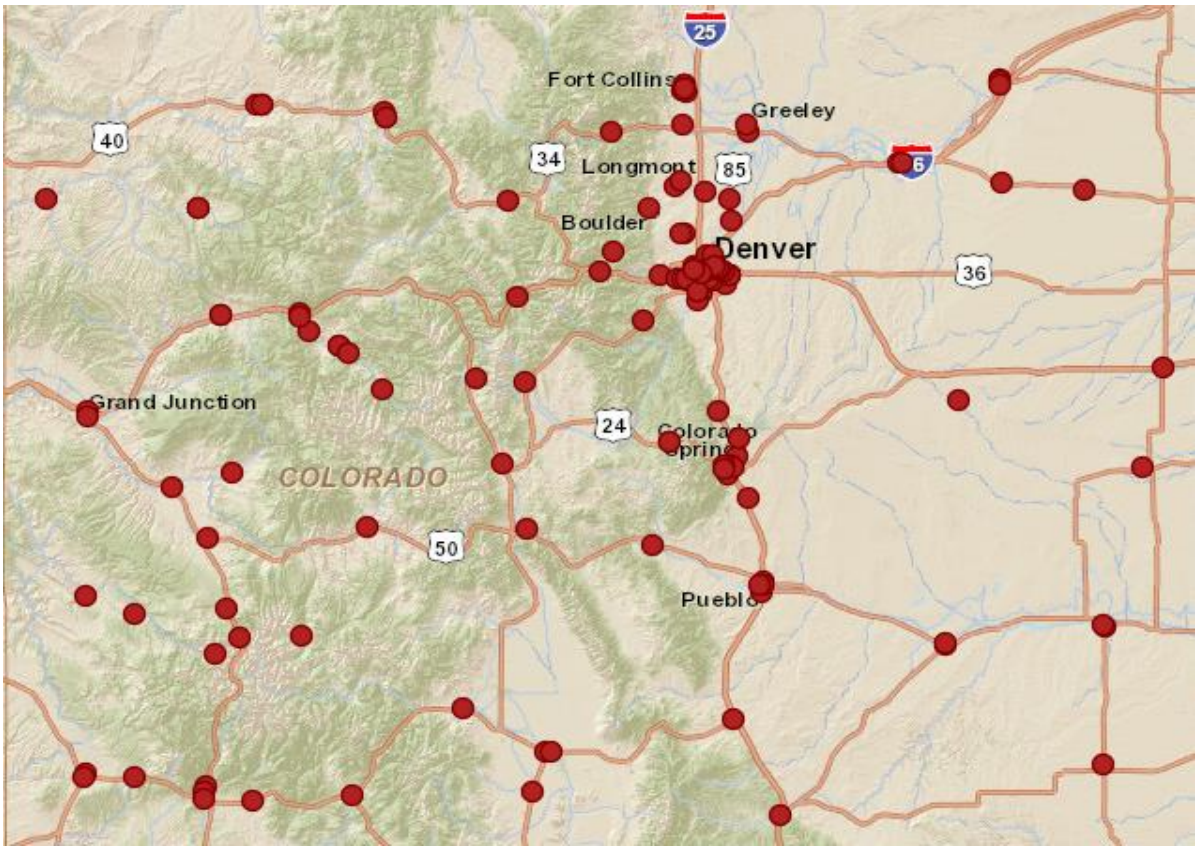
THE ASSISTANCE NETWORK

The Assistance Network, a collection of more than seventy organizations across the state, was created to provide free, locally based, in-person education and help with enrollment for individuals and small businesses. See Appendix A for a list of all Assistance sites across the state. Assistance sites were tasked with hiring and managing health coverage guides, as well as managing the day to day operations of a site, including the physical space and infrastructure. Health coverage guides were expected, per federal guidelines, to assist individuals and small businesses with education and application for health insurance coverage. Regional Hubs were also selected, and awarded enhanced grant funding, to support assistance sites via information sharing, collaboration, training on outreach and education and technical assistance services.

These sites were chosen on a competitive basis, with $17 million awarded in grant funding over an 18-month period. Each site had to meet the following criteria, among other infrastructure requirements and organization (hiring, background checks, managing staff, etc.):

- Organizational commitment to providing accurate, fair and impartial information;
- Organizational commitment to providing culturally and linguistically appropriate services that meet the needs of their population;
- Demonstrated organizational proficiency and capacity to provide services to specific target populations, including low-income, LGBT, limited literacy or English proficiency, or disabled individuals, across a range of language, faith, ethnic and racial groups; and
- Demonstrated organizational recognition within community partnerships as a trusted community resource.

Figure 1: Colorado Assistance Network Map



CONTEXT AND STRATEGY

The Assistance Network, along with similar efforts in other states, sought to identify and engage key populations for the purposes of enrolling them in private health insurance. As is true with the implementation of many components of the Affordable Care Act, the concept of an outreach and enrollment strategy was not new, but the context of this particular strategy was. Much was learned from other outreach and enrollment strategies, such as those that sought to enroll children and adults in programs like CHP+ and Medicaid. Ultimately, however, the Assistance Network represented a distinct departure from the strategies most similar to it and cannot be assumed to have had the same challenges and opportunities.

Some of the elements of the Assistance Network strategy that made it different from previous efforts include:

- The Assistance Network was not designed to increase the number of people enrolling in a free or low cost service already available to them (as is typical with a CHP+ or Medicaid enrollment strategy). Rather, it enrolls everyone who is eligible into new plans they will have to at least partially pay for through a new mechanism. However, during the first open enrollment period, a large number of individuals seeking coverage were eligible for Medicaid or CHP+ rather than private coverage, so the Assistance Network played a dual role in this capacity.

- The Assistance Network was not designed to funnel everyone into one or two specific options, but rather to allow individuals to select from among a group of options to ensure the best fit with their needs, financial and otherwise. In this way, it has more in common with Medicare Part D Prescription Drug enrollment efforts than Medicaid and CHP+ enrollment.
- The Assistance Network is not specific to low-income individuals, older adults, or individuals with health needs; rather it sought to engage all individuals and small businesses, representing many different ages, incomes and health needs along with speaking a variety of languages.
- The Assistance Network is interconnected with existing infrastructure, such as the Department of Health Care Policy and Financing (HCPF) Medicaid eligibility and enrollment systems, making it heavily dependent on the success of the connections and actions of outside entities for the success of individual enrollments.
- The Assistance Network is reliant on a technological infrastructure that is new, meaning it had never been implemented before and includes components uniquely designed for this setting. This was both an opportunity – the technology is being designed to meet the specific needs of the Network – and a challenge as the technology had unexpected issues during implementation. New technology can be intimidating and often involves a steep learning curve.
- While some other states were also implementing strategies similar to the Assistance Network, with common mandated outcomes, there is little evidence they are including comprehensive evaluation in their approaches. Consequently, this evaluation could not build on an existing approach to evaluation any more than the Assistance Network itself could be based on an existing model for such networks.
- Because the Assistance Network was both new and unprecedented, there is neither a baseline (previous trends for the program) nor a standard (how many people have been enrolled in a similar effort with similar resources). This means the evaluation had no established yardstick against which success could be measured. However, measures identified through other programs provided a starting point. For example, Colorado's CHP+ grants resulted in 7,000 encounters and 3,500 enrollments for every million dollars of investment (information received through C4HCO staff).

In short, the Assistance Network represents an emergent strategy, in its first year of implementation, based loosely on outreach and enrollment efforts that have worked in other settings, but with recognition that this setting was meaningfully different. As is regularly stated in dialogues about the Assistance Network, "We are all learning together as this has never been done before."

EVALUATION PURPOSE AND METHODS

For the reasons listed above, the evaluation had the dual purpose of comprehensively assessing what happened over the past ten months and providing concrete action items for improving the process for the coming year.

This evaluation did not attempt to collect in-depth data on how all Assistance Sites implemented their work. Rather, the overall approach was to collect data that outlines the basic elements of sites' outreach and enrollment strategies, while digging deeper into a subset of sites' activities for a more thorough data collection and analysis. For this reason, only those sites identified as critical for better understanding in order to improve the program were investigated in more detail.

These sites were chosen based on a variety of criteria. When designing the matrix for site selection, sites only assisting individuals were separated from those also offering Small Business Health Options Program (SHOP) services. Then, sites were sub-divided based on the number of health coverage guides (by full-time employee (FTE)) and the size of the organization. Finally, consideration was given to those sites focusing on particular target populations, those located in urban, mixed, rural and frontier counties, and according to organization type (non-profit, health care provider or local government). Using these criteria as the frame, sites were considered according to a variety of measures including self-report data from quarterly reports, tracking data submitted to C4HCO, available marketplace data, and feedback from C4HCO about their work with individual sites throughout the open enrollment period. Given the lack of comprehensive marketplace data (significant limitations were presented due to technical problems with health coverage IDs being entered into the enrollment system); these measures triangulated all available data to sites that may have useful approaches to learn from. There were additional sites that had either promising outreach strategies or successful enrollments; however, the selection matrix was specifically designed to identify sites across a number of categories and within their specific contextual environment. It is important to note that these sites neither enrolled the highest number of individuals, nor were they necessarily the 'best' examples overall, but they do provide insights into particular aspects of the assistance network.

This evaluation was somewhat limited by the types of data available through C4HCO's Marketplace database, and there were significant and unplanned barriers to accessing data through the enrollment database due to technical difficulties. In the original plan for analysis, comprehensive marketplace data including health coverage guide IDs and other identifying features were to be available. Moreover, the expectation was that use of tracking tools at the site level would be widespread and timely. C4HCO allowed Spark to collect additional data to supplement the self-report database, including Health Coverage Guide surveys, an organizational network survey and in-depth site interviews. Some information, e.g., the source of referrals and the time spent with individual clients on issues such as health care literacy services needed before proceeding to enrollment, was not collected at the individual level. Rather, aggregate information was collected at the site level and supplemental survey and interview data was collected to complete the analysis of client engagement. Finally, the quarterly report data was self-report submitted by each of the Assistance Sites, meaning that there were data quality issues, including over- and under-reporting, as well as misinterpretation of questions and measures. This is not uncommon in evaluations and

the evaluation team worked to mediate the issues by triangulating findings across multiple sources of data.

EVALUATION QUESTIONS AND METHODS

The evaluation sought to answer the following five questions:

1. In what ways were people were reached, assisted and enrolled via the Assistance Network? How did the experience and expertise of health coverage guides contribute to the process, including outreach and enrollment outcomes and customer satisfaction?
2. What effective practices (including outreach to specific target populations, enrollment strategies, quality assurance and internal program management) were reported by Assistance Sites that should be integrated or scaled up for broader use?
3. How did partnerships, both within and outside the Assistance Network, contribute to the effectiveness and efficiency of the enrollment process at the site level?
4. Overall, what were the strengths and weaknesses of the Assistance Network model?
5. Moving forward, what are the opportunities to improve the Assistance Network's activities and outcomes during the 2014-2015 open enrollment period?

To answer the evaluation questions, the evaluation design used multiple data collection strategies, increasing the quality of cross-tool analysis and creating opportunities to leverage insights from a variety of sources. Data collection tools included:

- Quarterly reports submitted by assistance sites including outreach and enrollment strategies, partnership activities and program management/quality assurance strategies;
- Additional quarterly reporting from regional Hubs about support provided to Assistance Sites;
- Feedback and data collected during weekly calls, advisory committee meetings and other engagements;
- Tracking and timesheet data submitted by assistance sites;
- Tracking data submitted via Survey Monkey by assistance sites to C4HCO;
- Health coverage guide surveys following autumn training and spring wrap-up convening;
- Health coverage and program manager organizational network survey;
- In-person and phone interviews with a sub set of assistance sites, including program managers and health coverage guides;
- Customer Satisfaction survey data for individuals enrolled through C4HCO;
- C4HCO Marketplace data from the website pertaining to enrollments; and
- Colorado Health Institute data on uninsured/underinsured populations in Colorado.

The statistical analysis methods used are outlined in the endnotes in more detail. In brief summary:

- *Quantitative analysis methods* were used for data collected in quarterly reports to produce counts, means and percentages of grantees engaged in a variety of outreach and enrollment

strategies. Methods such as bivariate correlation and multivariate regression analysis were also used for evaluation of all tracking data and close-ended customer satisfaction data.

- *Qualitative analysis*, including *in vivo* coding using Dedoose software, was used to evaluate open-ended responses from quarterly reports and customer satisfaction data, interview data and health coverage guide survey responses.
- *Network analysis methods* were used to analyze the position and centrality of assistance sites and organizations within the grantees' broader network.

THE EVALUATION FINDINGS

In order to address the questions outlined above, the C4HCO evaluation was framed through four major, overlapping levels of analysis:

1. Evaluating the role, experience and expertise of health coverage guides;
2. Consideration of the specific strategies used for outreach and enrollments across health coverage guides and assistance sites;
3. Analyzing the structure and operations of Assistance Sites, including quality assurance, team building and client management protocols; and
4. Examining the broader network of Assistance Sites and their external partners.

The findings in this section begin with a discussion of the core competencies of health coverage guides, followed by: findings related to outreach and enrollment strategies; internal site dynamics; and the overall Assistance Network. The report then addresses these major findings relevant to the evaluation questions and concludes with an analysis of implications and recommendations for the future.

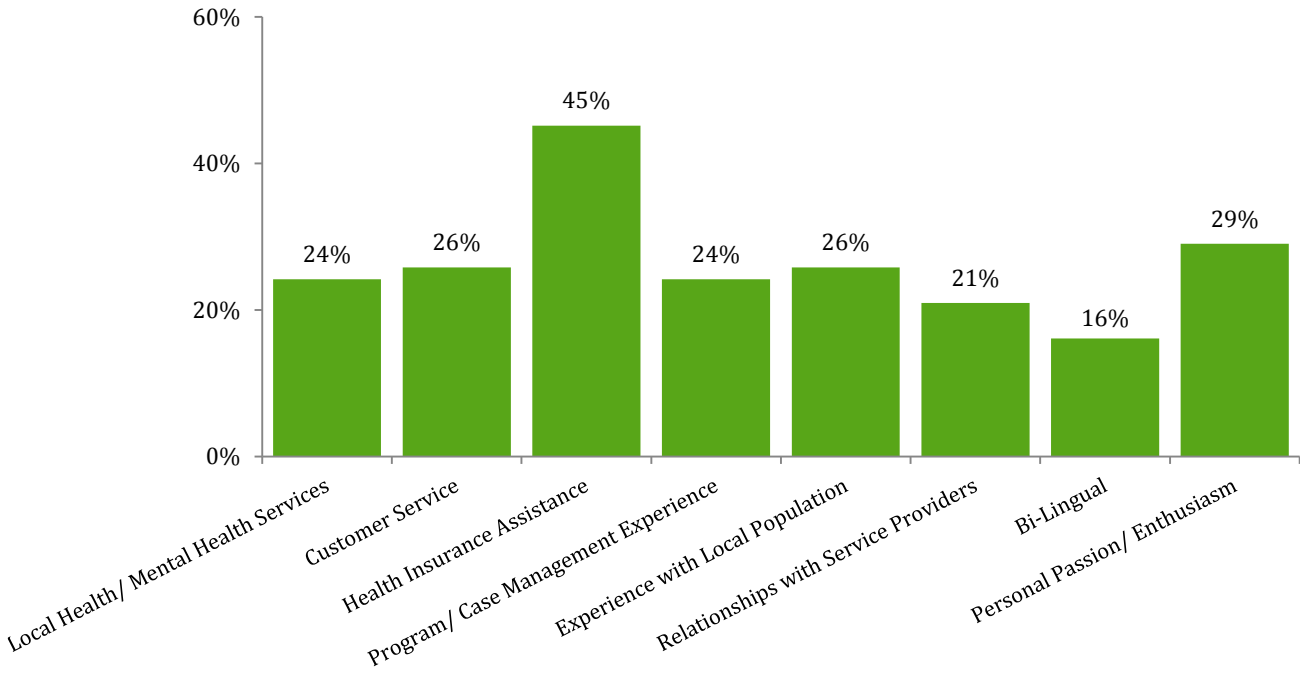
HEALTH COVERAGE GUIDES

As part of the statewide network for customer support, C4HCO supported Assistance Sites in the hiring, funding and training of community-based health coverage guides throughout Colorado. By definition, health coverage guides are available to provide unbiased assistance with enrollment, free of charge and they receive no commission based on the applicant's plan selection. Moreover, health coverage guides are active in their community via outreach and public education on health insurance and access to care. Early estimates suggest that between 7,000 and 14,000 individuals were assisted by health coverage guides during the enrollment process.

The total number of health coverage guides at an assistance site ranged from one to sixty, with an average of six health coverage guides per site and a median of three. The highest numbers of health coverage guides were located in urban settings as compared to rural or frontier locations, reflecting higher levels of demand from larger population centers, however rural health coverage guides were often covering a much broader geographic distribution of clients. Health coverage guides were most likely to be housed by local government agencies, followed by non-profits and healthcare providers.

In addition to being objective and customer service focused individuals, health coverage guides brought a range of prior work experiences to their role. The table below outlines in more detail the variety of assets, including: local knowledge and experience working with local populations; experience working in health insurance coverage, including private and public services like Medicaid and CHP+; having worked in local health or mental health services, non-profits or community-based organizations; and having backgrounds in customer service. Other personal characteristics included the ability to speak more than one language, and an individual passion, enthusiasm and deep, personal commitment to helping their clients.

Figure 1: Health Coverage Guide Previous Work Experience or Special Skills



As the first open enrollment period began, the job of the health coverage guide in communities around Colorado was multi-faceted, including management of many technical aspects such as troubleshooting the Medicaid/PEAK and C4HCO application processes, website and call center challenges; negotiating interpersonal relationships with clients; and meeting extensive computer and health literacy needs. In a number of cases, individual applicants had tried to begin the enrollment process online at home, often with support from the Connect for Health customer service representatives, only to seek assistance from a health coverage guide after hours of confusion and frustration. In customer satisfaction survey comments and reports from health coverage guides, many enrollees suggested they would have never been able to navigate the process without the help of a health coverage guide. Moreover, there are specific examples of individuals who started the enrollment process and chose not to apply for financial assistance who later discovered, because of the support of a health coverage guide, that they were eligible for beneficial subsidies.

Health coverage guides were sometimes faced with unexpectedly complicated cases, including families with multiple levels of eligibility due to age and/or immigration status, and self-employed individuals for whom estimating monthly income presented particular challenges. Additionally, language barriers were often significant in many communities. During the first open enrollment period, over twenty-five languages were used during enrollment assistance. Finally, lack of public

> *The in-person service we received was critical to being able to complete the application. The website alone was not adequate; I navigated the website prior to the appointment (with a health coverage guide) and it was not as informative as having a live person there. While some of this may be a no brainer for some, this has never been my field or work or interest.*
> - *Customer Satisfaction Survey Respondent*

awareness, low value placed on health insurance by the public, political opposition and negative media coverage contributed to the challenges faced by health coverage guides. In some cases, community members simply lacked education about the Affordable Care Act (ACA) or the benefits of health coverage and guides were able to provide comprehensive information. In other cases, strong political opposition was present, challenging guides to compete with anti-"Obamacare", anti-government and anti-health reform messages. In assistance site interviews and health coverage guide surveys, respondents consistently reiterated their aim as guides to remain entirely unbiased, offering non-political information and support, ensuring they delivered objective, quality customer service. However, some sites reported that they continued to face opposition and negative public opinion throughout the open enrollment period.

> *I retired two years ago to go in to full time ministry. I wasn't able to retire with COBRA because it was too expensive! I tried looking at the website and navigating my way through so many plans and options and found myself totally lost! The Health Coverage Guide took the time to walk me through and show me the absolute best options for me and my family. The experience is one that I shared with my congregation as well as friends and family! I will forever be thankful.*
>
> - *Customer Satisfaction Survey Respondent*

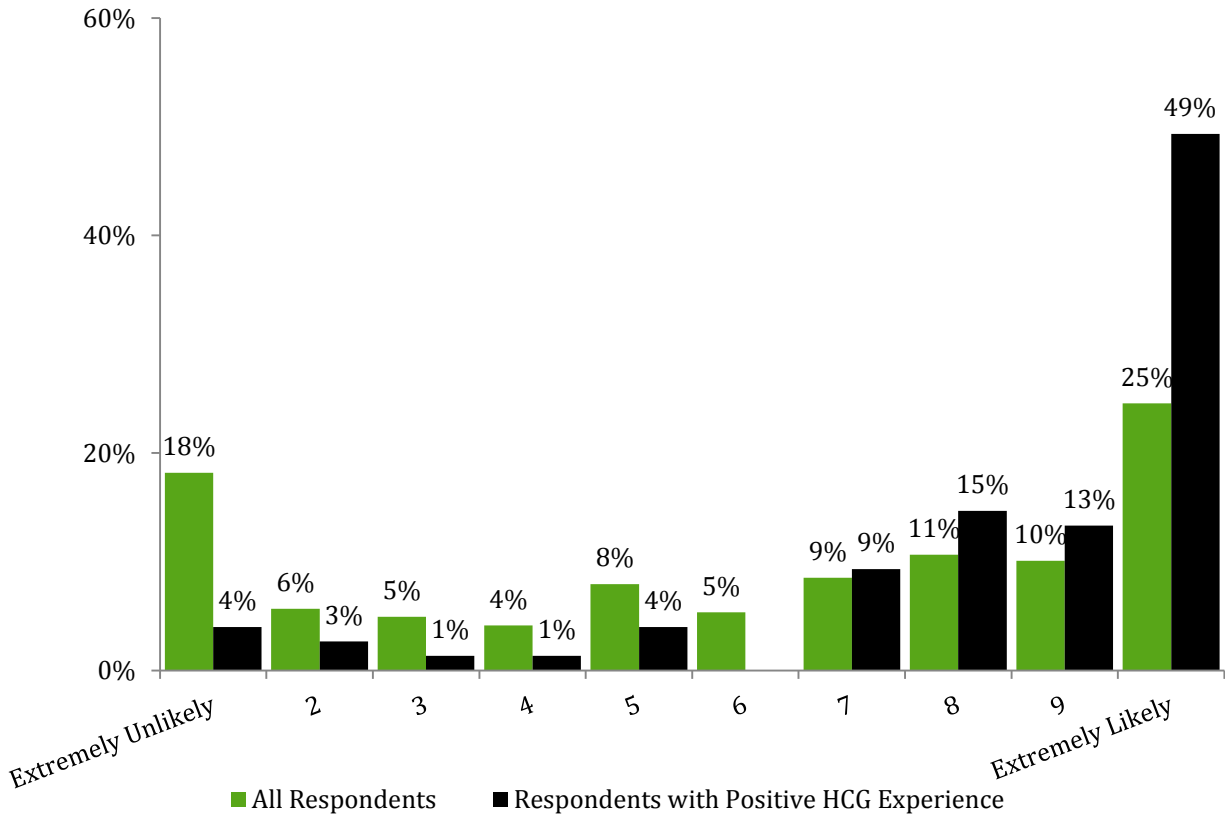
Overall, the data suggests health coverage guides had a significant impact on every aspect of the client experience. From open-ended customer satisfaction survey data, it is evident that the support of a health coverage guide was critical to getting many clients enrolled in a health plan. Indeed, some individuals report having had a difficult or frustrating experience *except* for their relationship with their health coverage guide. Moreover, many health coverage guides also reported in our survey and during convening discussions that their role as a community resource went well beyond simply completing enrollments. Health coverage guides report assisting clients with getting email addresses, finding and contacting health care providers, and directing clients to other benefits, such as SNAP or other community resources including food banks and housing assistance.

Evidence from the Customer Satisfaction Survey and Marketplace Data

Beyond anecdotal reports, however, there is strong statistical evidence supporting the significant effect health coverage guides had on the enrollment process. Clients who had a positive experience with a health coverage guide were statistically significantly (Figure 2):

- Much more likely to be satisfied with their overall experience;
- More likely to be satisfied with their plan selection, and
- Much more likely to recommend C4HCO to family, friends, neighbors and colleagues.

Figure 2: Likelihood the Client Will Recommend C4HCO to a Friend or Family Member



Conversely, 68% of individuals who had a bad experience with a health coverage guide said they were *extremely unlikely* to recommend C4HCO[1]. However, only eleven respondents fell into that category, compared to 75 respondents in the highest category. Moreover, an analysis of the marketplace data found that individuals who worked with a health coverage guide were more likely to enroll in a silver tier plan and were more likely to be enrolled in a plan with cost sharing benefits and higher subsidies as compared to individuals who enrolled without any assistance[2]. The data suggests that health coverage guides were often working with populations closer to the federal poverty line, a finding that correlates with the higher subsidy rates; however, their clients were also enrolling more often in silver-tier plans as compared to those going through the enrollment process without assistance (See full marketplace analysis for more detail).

*Individuals that worked with a health coverage guide were **more likely to enroll in a silver metal plan** and were more likely to be enrolled in a plan with cost sharing benefits and with higher subsidies.*

STRATEGIES FOR OUTREACH

Unlike the promotion of more familiar programs like Medicaid or CHP+, effectively raising public awareness and interest in Connect for Health Colorado presented unique challenges. Although

individuals are required by federal law to have health coverage, reaching out to the general population on the topic of private health insurance was not necessarily an easy task. In some cases, people had been following the passage of health reform laws and were eager to sign up. At other times, however, individuals were either unaware or politically opposed to the new legislation, making the job of health coverage guides difficult at times.

As documented above, one key factor in overcoming these challenges was cultivating the perspective that health coverage guides are trusted, unbiased, community resources. Outreach strategies that sought to inform consumers and empower them with the knowledge necessary to make appropriate choices for themselves and their families were also critical to overcoming barriers. As sites reported, sometimes achieving this goal of informing consumers required providing extensive health literacy education. Early on in the process, health coverage guides at many sites shifted their outreach strategies away from purely technical information and jargon to better reflect health literacy needs and to help individuals make informed choices. Additionally, health coverage guides learned that outreach strategies focused on available subsidies and cost sharing opportunities were critical to reaching individuals who assumed coverage was beyond their means.

Grantees reported using a variety of outreach strategies in their communities during the first year of open enrollment, including e-communication, media, flyers and brochures, community events, presentations and enrollment events. Over time, grantees honed their outreach activities, identifying ways to be more effective with particular strategies. For example, several grantees hosted information sessions, either at their offices or at partner locations, simply to answer questions and help people find assistance rather than trying to get individuals enrolled on the same day. For other sites, getting people through the entire process in one event was the stated goal of enrollment fairs. Interviews with sites revealed the importance of having health coverage guides, brokers and Medicaid techs available at outreach and enrollment events, providing a one-stop-shop for any individuals' coverage needs. Some grantees found providing flyers that serve as a worksheet or checklist for clients to write notes, document questions and gather materials before meeting with a health coverage guide supported efficient enrollment.

Grantees also developed strategies to reach target populations within the community at places where these groups typically gather. For example, some of the sites focused on younger populations set up information booths on college campuses and at ski resorts, raising awareness among a highly sought-after population. For outreach to LGBT clients, health coverage guides visited bars and restaurants wearing bright t-shirts and carrying informational flyers and business cards. To reach refugee and immigrant groups, one assistance site hosted house parties at community leaders' homes, creating an informal introduction to the health coverage marketplace. Some grantees highlighted the need for cultivating community champions: individuals recognized by their communities as a trusted resource or individuals who had a positive experience working with a health coverage guide. An important outreach strategy, particularly for hard to reach populations where word-of-mouth may be the primary form of access, was encouraging individuals to share their success stories and support other community members to seek assistance.

It is important to note that several of the more than seventy organizations involved in outreach activities were unable to fully capture their potential during this open enrollment period. Some

sites reported very few, if any, events or other active outreach strategies. While reporting during this period was problematic at times, there is also strong evidence to suggest that particular sites were unable to develop truly effective outreach strategies. Looking forward toward 2014-2015, Connect for Health Colorado could support dissemination of effective strategies and promote co-branded events in order to assist those sites that were unable to take advantage of outreach opportunities this past year.

OUTREACH BY THE NUMBERS

Grantees used a variety of outreach strategies in their communities, including e-communication, media, flyers and brochures, community events, presentations and enrollment events. The tables below outline light touch and in-depth outreach strategies, including the percentage of grantees reporting each type of outreach, the potential audience size and the primary populations reached by each strategy. Data reported in Table 1 are based on cumulative totals from the December 2013 and March 2014 quarterly reports.

The numbers for grantees' engaged in each strategy were relatively steady over the open enrollment period. It is notable that the number of flyers or brochures was higher in December and the number of community meetings, enrollment events and presentations were higher for March 2014; as grantees were more deeply engaged with the community and with their partners, the number of in-person activities began to increase. However, there were some data collection irregularities that pose validity problems for the size of audience measurements[3]. It was also unclear from quarterly reporting whether individual grantees were totaling their audience reach over the entire open enrollment period or just for that quarter. Best estimates are provided below to give an indication of the grantees' level of activity in each strategy, their potential audience reach and the populations most often engaged.

Table 1: Summary of Light Touch Outreach Strategies from 2013- 2014 Open Enrollment Quarterly Reports

Outreach Activity	Percentage of Grantees Engaged	Potential Audience Size[1]	Primary Populations Reached
E-Newsletter	43%	~16,500 people	
Social Media	50%	~20,000 people	
All E-Communication*	70%	~25,000 people	White, Black, Latino, ages 19-45 years old
Internet	11%	~60,000 people	
Television	6%	estimate not available	
Radio	19%	~800 people	
Newspaper	26%	~40,000 people	
Community Newsletter	17%	~130 people	

Outreach Activity	Percentage of Grantees Engaged	Potential Audience Size[1]	Primary Populations Reached
All Traditional Media**	41%	~80,000 people	Latino, White, Black, Asian, ages 26-55 years old
All Flyers***	85%	~300,000 people	Latino, Black, White, ages 19-65 years old
Editorials	54%	~800 people	Latino, White, ages 26-55 years old

[1]Note: potential audience size is an estimate based on self-reported data from the grantees. At times, grantees reported the number of ads or posts on media or social media; at other times, grantees reported the total number of people reached via these ads or posts. Unfortunately, this data was conflated in the reporting, meaning the potential audience size is a best estimate for the number of individuals that might have been reached through this outreach activity.
*E-communication includes e-newsletter, social media, website, blog and SMS activities
**All traditional media includes internet, television, radio, newspaper, community newsletter, ethnic newspapers, and other ethnic media
***All Flyers includes all locations reported, including: health care settings, pharmacies, childcare settings, primary and secondary schools, university and college campuses, human or social services department, libraries and rec centers, small businesses, faith based settings, and other community settings.

Table 2: Summary of In-Person Outreach Strategies from March 2014 Quarterly Reports

Outreach Activity	Percentage of Grantees Engaged	Range of Number Activities/ Events	Range of Number of People Reached	Primary Populations Reached
Community Meetings	65%	1 to 35	2 to 1,000	
Faith-Based Meetings	23%	1 to 100	1 to 2,000	
College Campuses	25%	1 to 8	2 to 500	
Primary/Secondary Schools	21%	1 to 20	10 to 750	
Government Agencies	21%	1 to 21	1 to 4,100	
Total In-Person	77%	1 to 150	1 to 4,100	Latino, White, Black, ages 26-55 years old
Health Fairs	39%	1 to 14	2 to 8,000	
Enrollment Events hosted by other organizations	36%	1 to 20	5 to 2,000	
Other Community Events	42%	1 to 98	22 to ~3,700	
Enrollment Events hosted by our organization	41%	1 to 30	1 to 650	Latino, White, Black, ages 26-45 years old
Total Community Events/ Fairs	67%	1 to 102	7 to ~8,700	White, Latino, Black, ages 19-35 years old
Total Conversations*	85%	1 to ~6,700	1 to ~6,700	White, Black, Latino, Asian, ages 36-55 years old

Outreach Activity	Percentage of Grantees Engaged	Range of Number Activities/ Events	Range of Number of People Reached	Primary Populations Reached
Training Spokespeople	22%	1 to 47	1 to 3,200	Black, Latino, ages 46-65 years old

* Total conversations include conversations at grantees' offices, in health care settings, at homes, in childcare or school settings, on university or college campuses, and in faith-based settings. The primary location for conversations was within the grantees' offices which accounts, to some degree, for the higher number of total conversations reported versus the total number of individuals reached, as many of these conversations may have taken place with the same person on more than one occasion.

Grantees report that "difficult to reach" populations include a variety of demographic groups, not only Hispanics, African Americans, Asians and Native Americans, but also younger populations, the self-employed, immigrant populations, seasonal workers, LGBT individuals, the previously uninsured and those that are politically opposed to health reform. As noted above, word-of-mouth has been the most valuable outreach strategy for many of these communities and having a local champion or a satisfied customer share their experience with the community was a particularly important form of outreach.

Assistance sites also reported that traditional strategies were effective in reaching specific target populations. For example, grantees reported that outreach to communities of color via electronic communication, flyers or a brochure was a more successful strategy compared to outreach via editorials or television. Among those grantees who specifically reached out to Latino, African American, Asian and younger audiences, more than 70% used social media and 72% used websites. One site reported creating YouTube videos in several different languages to provide basic information about health coverage.

> *The hard work and success of reaching clients has paid off through word-of-mouth from clients to their friends, relatives and employers*
>
> - *Pinon Project FRCA Respondent*

While most outreach strategies focused on the potential for tax credits and emphasized the availability of free assistance from the health coverage guides throughout the enrollment process, some approaches used by grantees were highly targeted to specific communities. For example, the Aurora Coverage Assistance Network's outreach strategy included well-respected Latino radio personalities. The Denver Indian Family Resource Center used flyers with language specific to the federal exemption for Native Americans and the importance of getting health coverage. Grantees in Western Slope communities emphasized the legal requirement for health coverage based on their recognition that many people in their areas might be politically opposed to health reform, but are also law-abiding citizens.

While traditional media was a smaller portion of grantees' overall outreach strategy, often due to budget limitations and larger media efforts by C4HCO, many grantees still reported using local media for outreach. Nearly a quarter of all grantees reported placing ads in the local newspaper and nearly 20% placed radio ads. Many grantees also reported an increasing use of ads in local community newsletters (17%) and ethnic newspapers (10%) as the open enrollment deadline approached, taking advantage of free broadsheets and radio interviews as a way to reach last-minute clients. Of those grantees focused on reaching audiences over 55 year old, 57% used

traditional media ads in newspapers. Similarly, more than 20% of grantees reaching out to African American, Asian and Latino audiences used advertising in ethnic newspapers.

STRATEGIES FOR ENROLLMENT

Although enrollment strategies were not entirely separate from grantee outreach activities, there were specific elements of support that moved individuals through the application process. Over the course of the first open enrollment period, grantees learned that improving health care literacy was often required before an application could begin. Many individuals seeking the support of health coverage guides needed an introduction to the basics of health coverage, including deductibles, premiums and finding providers, as well as education on the ACA, Medicaid expansion and how consumers can self-advocate for quality health care. In some cases, individuals also required assistance with computer technology, such as obtaining an email address, creating a user name and password and learning how to navigate a webpage. Sites developed a number of tailored strategies to address client needs. For example, sites highlighted the benefit of having clients participate fully in the application process, often side by side with the health coverage guide or on a parallel computer screen. In many cases, guides supported clients in completing online forms rather than having the guide complete the application. Sites also tailored the enrollment process to the needs of the client, taking into account the need for language interpretation, religious considerations, needs of the family, comfort level, etc. by matching the skills of the health coverage guide, such as language, cultural knowledge and professional experience.

> *I had a lot of questions about things my guide had the answers for. I think it would be difficult to sign up without help. Many people don't have a lot of experience with computers. My guides were excellent!*
>
> *Customer Satisfaction Survey Respondent*

While grantees typically offered traditional 8am – 5pm, Monday through Friday enrollment assistance, more than half of all grantees offered flexible scheduling, including assistance after 5pm and on weekends. In many rural communities, health coverage guides were available for significantly extended hours. As one site outlined, their health coverage guides responded to client requests at all hours of the day or night, even if only to confirm that they would be in touch to schedule an appointment within twenty-four hours. Many of the sites interviewed, particularly in rural communities, provided health coverage guides' cell phone numbers on their marketing materials so they could be reached after office hours. More than 80% of appointments took place within grantee offices. However, 63% of grantees also co-located health coverage guides at partner sites or had guides keep multiple office locations. Anecdotally, grantees reported having regular "office hours" at local libraries, in coffee shops and in health clinics in order to reach a broader audience for enrollment assistance. SHOP sites also routinely co-located health coverage guides at partner offices and offered services at small business locations.

Many of the interviewed grantee sites reported the enrollment process became more streamlined and efficient over time. As compared to the beginning of the open enrollment period, some grantees reported their appointment times and time spent processing enrollments decreased by more than 50% by March/April of 2014. For some sites, the key to success was providing every opportunity to

meet client needs. As one health coverage guide noted, "even if we didn't have time, we would have time for them."

Effective strategies for enrollment also involved overcoming a number of barriers beyond those presented by client needs. The largest barriers to enrollment have been well documented:

- The Medicaid/Peak application process;
- Working with the C4HCO call center and website;
- Working with the Maximus system;
- Handling demands on staff time; and
- Staying current with changing information.

Both the Medicaid application process and the C4HCO website have improved over time, easing the process of obtaining real-time denials and pushing forward with enrollment. With regard to staff time, barriers were identified related to handling complicated family cases. During interviews, grantees reported "mixed" families – those with differing insurance qualifications, such as Medicaid, CHP+ for children, Medicare, employer insurance, etc. – were the most time-consuming and problematic for the enrollment process. Additionally, immigrant families, sometimes with differing legal status, often faced challenges addressing the five-year requirement. Enrollments for self-employed individuals presented unique obstacles when establishing income level and meeting eligibility requirements. Some sites, particularly those within local government, used relationships with local health and human services departments to expedite difficult cases and trouble-shoot applications. Having the facility to connect with a Medicaid tech or an individual in the local department provided opportunities to troubleshoot the enrollment process in real-time, lowering client waiting times and frustration levels. Another effective strategy highlighted by sites include having a common scheduling system, allowing health coverage guides to populate each other's calendars with appointments while also providing background information on a new client. Finally, health coverage guides highlighted using each other's experience and expertise as a support network for overcoming enrollment barriers. Weekly learning calls, inter-site meetings and coaching, sharing information at convenings and trainings: these opportunities provided valuable insight into strategies being used at other sites to support enrollment completion.

ASSISTANCE SITES

The next section of the evaluation moves outward from the role of individual health coverage guides and strategy-level activities for outreach and enrollment to the actions taken at the assistance site level for ensuring success. While health coverage guides and their strategies are intimately bound with the assistance site, there was some specific learning around aspects of site management, team interaction and internal tracking strategies that should be highlighted when evaluating progress to date and planning for the future.

First, analysis of self-reported quarterly data and in-depth interviews with assistance sites revealed a variety of quality assurance measures were in use across the state. Most sites had taken measures to ensure all of their health coverage guides and/or staff members had completed training, and that on-going professional development and training for health coverage guides and/or staff members was available. During the early months of open enrollment, most sites reported that they held

regular team meetings to make sure everyone had up-to-date information and to share troubleshooting ideas. From interviewed sites, we learned that on-going weekly or bi-weekly team meetings, in-person or on the phone depending on location, were very common. The content of these team meetings varied, often depending on developments within the marketplace place, but two notable effective outcomes emerged across multiple sites. First, teams that documented learning and redistributed notes and information, particularly to team members who could not attend meetings, stayed in sync with changes in the marketplace and supported internal troubleshooting. There was evidence of Hub sites also acting as a clearing house for information, distilling updates and providing consistent streams of information in manageable doses. The majority of interviewees reported that there was a steep learning curve with the enrollment process and regular team interaction helped health coverage guides be more confident and efficient as time progressed. Second, sites remarked that the work of a health coverage guide can be emotionally draining; having a solid team with strong leadership helped overcome the exhaustion. Feeling connected to and encouraged by team members was critical to health coverage guides staying motivated and feeling empowered, particularly in rural areas of the state where guides were often alone in their communities.

Nearly two-thirds of all sites reported using some form of tracking tools for both outreach and enrollment numbers in their quarterly reports. These forms, and the consistency of their use, varied widely across sites. Most sites kept record of the dates and locations of outreach events or community meetings, and most sites had a system for tracking appointments and applications. In some cases, however, the tracking system was housed with a single health coverage guide's files and their personal organizational style. However, a smaller selection of sites were able to more formally document the number of attendees and their demographic profiles, and to even track which outreach activities lead to applications for enrollment. For example, some sites had a central records database to which all of the organization's health coverage guides had access. From this central point, health coverage guides could track an application's progress, view notes from other health coverage guides and document important dates and upcoming appointments. Additionally, health coverage guides could schedule appointments for each other and include any relevant information gathered about a client prior to the meeting. Other sites, particularly smaller organizations, maintained an Excel spreadsheet or used paper in-take forms and manila folders as a way of tracking clients throughout the process.

Very few sites reported having set specific targets or goals when it comes to outreach and enrollment. In interviews with assistance sites, the lack of targets was often linked with the unpredictability of the enrollment process. As one interviewee put it "we came to understand the process wasn't able to be controlled, but we just made a commitment to see the process all the way through." Other sites explained that they had set high goals at the start of open enrollment, but had had to scale back when they became more familiar with the process, learning that the complexities of application assistance made their expected enrollment time frames unrealistic.

Very few sites used a well-articulated system to track quality customer service. Several sites noted that they developed in-house customer satisfaction feedback materials, such as comment cards, but few had highly-developed surveys. For example, the Health District of Northern Larimer County used "Caught You Caring" cards for clients to leave feedback when they have had a particularly

positive experience with a health coverage guide. While they captured some excellent examples of health coverage guides making a significant different for a client, they rarely captured negative feedback or even constructive criticism. Even sites that were collecting data were often not systematically using the information to improve their strategy. While there is clear evidence of some effective team building practices and information sharing strategies to maintain consistency and support among health coverage guides, there is a great deal of development that could be done to promote more effective tracking strategies, including regular use of customer feedback to improve organizational practices.

ASSISTANCE NETWORK

Over the course of the open enrollment period, grantees repeatedly highlighted partnerships, both within and outside of the Assistance Network, as critical to their successful engagement and enrollment of clients. Many sites reported referrals from partner organizations as one key driver of clients. Referrals were gained in a variety of ways through partnerships:

- From quarterly report data, nearly half of the grantees indicated they provided a training or information session at a partner location, such as a school, restaurant, rotary club, etc. allowing for question and answer periods with partners' employees, volunteers, or members.
- Three-quarters of grantees also linked up with service providers, e.g., food banks, social welfare offices, clinics, hospitals and providers offices, to ensure that they had the necessary flyers or brochures to refer clients or patients with health insurance needs directly to a health coverage guide.
- Some grantees either hosted or co-sponsored events with partners, such as enrollment fairs with local brokers and local Medicaid techs, to offer a one-stop-shop for individuals needing health insurance.
- Many grantees linked up with the faith-based communities in their area, providing information through churches and through religious leaders, particularly for immigrant populations.
- Finally, grantees co-located their health coverage guides with partners, such as the public library system, to offer 'office hours' for individuals seeking coverage at regular times and locations.

Using network analysis generated from health coverage guide surveys collected from representatives of thirty-five assistance sites, it is evident that locally-based connections are the most widely utilized among the grantee sites (see Appendix C for the full map of organizations). The analysis allowed individual sites to identify critical partners, many of which also overlapped with other assistance sites across the state. For example, more than half of the respondents indicated they had a partnership with the local library system; nearly half identified local schools; and a similar share mentioned local hospitals, providers or clinics. The most important connection identified for more than 70% of grantee sites was the local health and human services, social services or public health department. With the exception of those sites already housed within a

health and human services department, like Boulder County, this relationship was the key for overcoming enrollment barriers and expediting applications during the open enrollment period.

Within the Assistance Network, 71% of grantees reported receiving a referral from another assistance site and 70% reported referring a client to other network sites. In open comments in quarterly reports, grantees highlighted co-hosting tables at events, like the National Western Stock Show; scheduling clients for other grantee sites; sharing advertising funds; and partnering with sites to share translation services as some of the other ways collaboration took place during the last quarter. At the final convening, a number of health coverage guides reported that increased opportunities for assistance sites to work together were critical to reaching future clients. Moreover, health coverage guides and assistance sites highlighted that relationships with local brokers became increasingly important during the last quarter of open enrollment. Compared to health coverage guides, brokers have the ability to encourage clients to consider particular health plans. In-depth interviews revealed that, in some instances, having a broker provide advice to a client was a benefit, even if the customer returned to the health coverage guide to finalize enrollment.

It also emerged in site interviews that good relationships between sites and Hubs helped to promote the team environment. For example, the Hilltop Hub manager on the Western Slope held regular conference calls, conducted site visits, summarized and redistributed vital information to assistance sites throughout their area, and generally promoted open lines of communication. Most sites in that area reported feeling engaged by the hub leadership in a way that was meaningful to the work of their site. Similar trends were apparent in the Central Hub's relationships with assistance sites in their region. In other areas around the state, however, sites and hubs failed to connect as a team. For example, one site in Eagle County with a wide variety of tracking tools and a common database for health coverage guides to monitor clients was not well connected with their Regional Hub. In this instance, the effective, well-organized system at the site level somewhat discouraged collaboration with the hub since effective practices were already fairly well entrenched at the site level and the perception was that the hub had little additional insight to offer. The research findings indicate that the hub structure was most effective when hubs where highly proactive, taking a strong leadership role and offering a real service to sites as well as when sites were open and willing to engage with hubs, making the relationship mutually beneficial. Moreover, the hub model seemed particularly useful for organizing smaller or less experienced sites, particularly in rural areas, rather than competing with larger or more established assistance sites.

CONCLUSIONS AND RECOMMENDATIONS

Evaluation Question 1: In what ways were people were reached, assisted and enrolled via the Assistance Network? How did the experience and expertise of health coverage guides contribute to the process, including outreach and enrollment outcomes and customer satisfaction?

Across the state of Colorado, nearly 140,000 people signed up for health care in the first open enrollment period of the Colorado Health Exchange. Our research estimates more than 400,000 people were made aware of Connect for Health Colorado via myriad outreach efforts and between

7,000 – 14,000 people were assisted during the enrollment process by a health coverage guide. Overall, two critical themes emerged from the analysis of outreach strategies:

- Grantees were creative and sought to find new ways to present information, capture audiences and reach new populations; and
- Grantees tailored their efforts to the needs of their communities.

Our findings also suggest there are additional audiences that have not been reached. Despite best efforts by many sites, reports indicate Latinos, younger people and the politically opposed remain under-enrolled. In some cases, more fully developed outreach strategies, including word of mouth campaigns, will be necessary to reach these populations. In others, the upcoming increase in penalties will drive new clients into the marketplace. Strategies honed over the past year will support efficient enrollment of these new individuals, but grantees will need to continue to be dynamic and nimble in their work. Research findings suggest a large portion of the current health coverage guides are well-equipped, with a background in health insurance and customer service, and experience with the local population and a personal passion and enthusiasm for getting clients access to quality health coverage. Moreover, findings confirm that a positive experience with a health coverage guide had a significant impact on an individual's overall satisfaction with Connect for Health Colorado.

Evaluation Question 2: What effective practices (including outreach to specific target populations, enrollment strategies, quality assurance and internal program management) were reported by Assistance Sites that should be integrated or scaled up for broader use?

Interviews with the assistance sites highlighted two important areas of effective practices, both internal and external. First, effective sites had efficient, team-oriented work practices, including a common scheduling system, weekly check-ins, trouble-shooting opportunities with leadership and quality assurance strategies built in to monitor their work. Externally, more effective sites were also highly connected to partners, capitalizing on those relationships to bring clients into the marketplace. Specific practices that could be scaled to all assistance sites include:

- Consistent use of tracking tools, common forms and internal monitoring processes by all team members;
- Community enrollment events that include local brokers, Medicaid techs and local assistance sites for one-stop-shopping for clients;
- Creative outreach strategies that build on word of mouth, cultivating community champions and gaining access to populations not typically connected with traditional media or social media outreach;
- Enrollment systems that offer space for health care literacy or language interpretation needs, starting clients in the application process where they are most comfortable;
- Internal and external customer satisfaction data collection for use in updating and adapting strategies based on community feedback; and
- Development and maintenance of partnerships with local health and human services departments, other local government bodies, and critical community partners.

Evaluation Question 3: How did partnerships, both within and outside the Assistance Network, contribute to the effectiveness and efficiency of the enrollment process at the site level?

Partnerships offered a great deal to assistance sites, including avenues for sharing information about the health exchange; locations from which to build a client base; opportunities to advertise, co-host, co-sponsor outreach and enrollment events; and referrals to and from partners for clients and services. In addition, partners were able to provide support for troubleshooting enrollment, moving applications through the process, assisting with finding an individual the right coverage, providing language assistance, etc. Partners, as seen in the network map in Appendix C, included a variety of organizations such as local schools, churches, and recreation centers to local health departments and community-based organizations. Evidence suggests that sites that were able to capitalize on their relationship with the local health organization were better equipped to handle complicated or problematic applications. Fostering those relationships for the future will be critical to on-going support for the enrollment process. The evaluation also revealed that organizations that were strategic about their partnerships were often able to reach an audience or target population that might have been otherwise out of their reach. These strategic linkages provided avenues into communities and populations that would not have existed in any other form. Finally, many of the partners highlighted by assistance sites were a key driver of clients, either from within the membership of the partner organization or from the partners' network. During the next round of open enrollment, it is vitally important that assistance sites continue to cultivate deep partnerships as well as develop new ones in order to reach new populations and to continue to capture clients from within existing channels.

Evaluation Question 4: Overall, what were the strengths and weaknesses of the Assistance Network model?

A key strength that emerged from the evaluation was the unbiased nature of the assistance offered by health coverage guides. Rather than sell particular plans, or funnel individuals into one or two specific options, health coverage guides were able to listen to and support individuals making health coverage choices that best met their family's needs. Moreover, health coverage guides are able to provide extensive information and answer client questions. As the evidence from the marketplace data suggests, clients have a better understanding of cost sharing reductions and subsidies after having worked with a health coverage guide as compared to individuals who did not receive assistance. In some instances, however, the level of objectivity required of health coverage guides made assistance challenging, particularly for those individuals lacking with health coverage or computer skills, or who faced language barriers during the process. Strong relationships with local brokers helped some sites overcome these issues, offering clients multiple avenues for accessing care. Overall, a benefit to the network model is that there is ample room for health coverage guides, brokers and Medicaid techs at the table in order to meet customer needs. The model thrives when partnerships are cultivated and maintained, meaning that clients truly find a "no wrong door" entry into the health insurance system.

Key weaknesses of the assistance network model included the variety of organizational capacities across the state. Some sites were simply less equipped to handle outreach and enrollment activities, whereas others were well situated to be effective. Instead of providing a standardized set of procedures, such as enrollment tracking databases or client in-take forms, each site was left to

create their own set of materials. As noted above, some sites already had working computer-based tracking systems with a common scheduling portal and access for their local partners. Others were still creating spreadsheets and paper forms and checklists months into the open enrollment process. While each site was uniquely situated to answer the specific needs of their community, the lack of common capacity across the state produced varying outcomes. For future, these is a need to either create a standardized system for all or to support lower capacity organizations in development and achievement of equivocal operating systems as compared to higher capacity sites.

Evaluation Question 5: Moving forward, what are the opportunities to improve the Assistance Network's activities and outcomes during the 2014-2015 open enrollment period?

The 2014-2015 open enrollment period will present new and different challenges compared to the first open enrollment period. Unreached audiences in the first year will continue to be difficult to access while, simultaneously, existing marketplace customers will have changes to their existing plans. The recommendations below outline in detail the opportunities available for improving the work of the health coverage guides and the overall assistance network.

RECOMMENDATIONS FOR 2014-2015 OPEN ENROLLMENT

Via quarterly reports, in-depth interviews and health coverage guide surveys, a variety of suggestions emerged for improving the 2014-2015 open enrollment process. During the past nine months, C4HCO has addressed a number of these items, such as offering requested training to assistance sites on Medicaid/Peak applications, SHOP outreach and enrollment and other special coverage challenges such as life changing events. Also, as the C4HCO application process becomes more streamlined with the Medicaid/Peak application, health coverage guides have asked for opportunities to become familiar with and test the new application protocols before they go live to customers. C4HCO has been responsive to this request to date and aims to have testing available in mid-October of 2015. Finally, moving into the next enrollment period, shared marketing materials, tips sheets and checklists, sample forms and tracking sheets for clients should be made widely available to assistance sites. A common database platform should be launched in order to provide more effective monitoring systems and promote efficiency in client management.

Additional support for developing outreach and enrollment strategies for the hardest to reach populations across the state will be required this coming year. A word of mouth strategy for outreach that assists with access to communities of color, young 'invincibles' or other target populations should be developed and scaled to all assistance sites. Additionally, the research findings indicate assistance sites that were well connected to, or even embedded within, local health and human services departments were better able to troubleshoot client applications during the enrollment process. Many of these sites also had direct information about Medicaid denials that could be used to inform targeted outreach strategies. C4HCO could assist in facilitating these relationships where they don't currently exist, encouraging more information sharing to assistance sites in identifying outreach audiences.

Another critical area for exploration is the development of performance measures and tracking/reporting mechanisms for the upcoming grant year. The Assistance Network model is, by design, an inclusive, "no wrong door" entry into health coverage. Health coverage guides often

reach populations that were previously uninsured, have lower incomes or have health literacy needs. Many of these clients are Medicaid eligible, a status often not discernable until after the application process has begun. Therefore, while the model captures a number of individuals in need of health coverage, not all of these customers will enroll in a C4HCO plan. The strength of the assistance network model should be capitalized upon in order to ensure long-term financial sustainability and that cost-effective service delivery by Connect for Health Colorado can continue while serving those most in need across our state. A suggested list of performance metrics is listed in Appendix B, followed by a list of recommendations for implementing tracking and reporting guidelines for all grantees. The draft measures below build on the triple aims of C4HCO and healthcare reform more broadly:

- Improving the patient experience (customer satisfaction);
- Improving the health of populations (clients enroll in and remain enrolled in a health plan); and
- Reducing the per capita cost of health care (in this case, the cost of outreach and enrollment services).

Finally, the evaluation of the assistance network and its health coverage guides demonstrates the unique role that this program has playing in launching Connect for Health Colorado. The analysis of marketplace data reveals a significant relationship exists between consumers and health coverage guides when it comes to helping the public navigate their health coverage choices. Particularly as the next open enrollment period gets underway, with the expectation that carriers will alter plans and offer new avenues for coverage, the importance of the health coverage guide in assisting individuals with enrollment is in no way diminished. While not always able to seize every opportunity or capture every population in need, the assistance network demonstrated great potential in its first year. While there are many options for improvement in the years to come, this evaluation concludes that across a number of levels, the assistance network was able to begin to articulate effective strategies for utilization in the future.

APPENDIX A: ASSISTANCE SITES

Assistance Sites Across Colorado		
Advanced Patient Advocacy	Denver Human Services	Rural Solutions - NCHA
Aurora Coverage Assistance Network	Denver Indian Health and Family Services	North Colorado Health Alliance
Colorado African Organization – ACAN	Doctors Care	Northeast Colorado Health Department
Metro Community Provider Network - ACAN	Eagle County Health Human Services	Northwest Colorado Community Health Partnership
Aurora Mental Health Center - ACAN	Family Resource Center Association	Grand County Rural Health Network - NwCCHP
Asian Pacific Development Center - ACAN	Washington County Connections - FRCA	NW Colorado Council of Governments
Aurora NAACP - ACAN	Fire for the Nations - FRCA	Otero County Department Human Services
Baca County Public Health Agency	Morgan Family Resource Center - FRCA	Pikes Peak Area Council of Governments
Boomers Leading Change in Healthcare	La Plata Family Centers Coalition - FRCA	Peak Vista Community Health Centers
Boulder County Housing and Human Services	Family Intercultural Resource Center - FRCA	Pueblo Senior Resource Development Agency
Broomfield Health and Human Services	Pinon Project - FRCA	Rio Grande Hospital
Center for African American Health	Rural Communities Resource - FRCA	Salud Family Health Centers
Central Presbyterian Church	Aurora Community Connections - FRCA	San Juan Basin Health
Centura	Denver Indian Family Resource Center - FRCA	San Luis Valley Regional Medical Center
Lake County - CCPH	Family Voices Colorado	Servicios de La Raza
Chaffee County Public Health	Health District Northern Larimer County	Small Business Majority Foundation
Colorado AIDS Drug Assistance Program	Healthy Communities El Paso County Memorial Hospital	Southwest Health Systems
Colorado Alliance for Health Equity and Practice	High Plains Community Health Center	Stapleton Foundation
Colorado Health Care Association	Hilltop Community Resources	The GLBT Community Center of Colorado
Colorado Motor Carriers Association	Jefferson County Human Services	Tri - County Health Network
Small Business Development Center	Kit Carson County Health Human Services	Tri - Lakes Cares
Commerce City Community Health Services	Mountain Resource Center	ValleyWide Health Systems
Community Partnership Family Resource Center	Rocky Mountain Rural Health - MRC	Volunteers of America
Denver Health and Hospital Authority	Mt San Rafael Hospital	Women's Resource Center

APPENDIX B: PERFORMANCE MEASURES

Purpose

To identify possible performance measures and models for calculating final scores for the Connect for Health Assistance Sites. Measures can be tied to performance incentive for 2014-2015 open enrollment period.

Model for Calculating Scores

Multiple models have been discussed for calculating final scores, each with pros and cons:

1. *Minimum standards across all measures collectively.* An index is created across all performance measures with each measure feeding into the index. A total score is used to assess whether the minimum standard is met by a grantee site.
    a. Pros: Allows assistance sites to balance areas of weakness with areas of strength. Eliminates competition between assistance sites for incentives, as all sites can receive incentives.
    b. Cons: Potential for an assistance site to do very poorly on one measure and still receive incentive payments provided all other measures are met. Requires establishing a cut-off point for the minimum standard index, which may be difficult to establish in advance. May result in very low incentives if most or all sites meet the minimum standards.
2. *Minimum standards across each measure separately.* Each measure would have an independent minimum standard; only those sites meeting the minimum across all standards would be eligible for incentive payments.
    a. Pros: Ensures incentive payments only go to site performing well across all aspects of their grant strategy. Eliminates risk that a site might do quite well in many areas, but be unusually ineffective on a critical measure (e.g. rate of disenrollment). Eliminates competition between assistance sites for incentives, as all sites can receive incentives.
    b. Cons: Requires establishing multiple cut-off points, one for each measure, which may be difficult to identify in advance. May overly penalize a high performing organization that has one area that is less effective. May result in very low incentives if most or all sites meet the minimum standards.
3. *High performance standard, either across all measures collectively or across each measure separately.* This could match either model 1 or 2, but have a higher standard that only rewards exceptional performance, rather than meeting a minimum standard. The minimum standard could remain and be used to identify corrective action needs.
    a. Pros: Ensures sufficient funding in the incentive pool for the incentives received to be meaningful. Eliminates competition between assistance sites for incentives, as all sites can receive incentives.

   b. Cons: May overly limit the number of sites receiving incentives or be difficult to achieve, resulting in little motivation by grantees to seek to meet the standard.

4. *Top performers across all measures collectively.* An index is created across all performance measures and the top performers on the measures are awarded incentives (e.g. top 20% of assistance sites).
   a. Pros: Ensures sufficient funding in the incentive pool for the incentives received to be meaningful. Eliminates need to establish cut-off scores in advance.
   b. Cons: Creates competition between assistance sites for incentives as not all sites can receive incentives. Would need to identify what percent of sites will be included in the top performers.

Possible Measures

- *Number of individuals completing applications per… Health Coverage Guide FTE, Health Coverage Guide reported time on direct application assistance, total FTE, or total funding:* This measure could be mediated using a complexity index assigned to each person served. The complexity index could be based on demographic factors such as geographic location, eligibility for subsidies, language, number of family members being enrolled, complexity of application/enrollment, etc.
  - Pros: Measure is aligned with a primary focus of Connect for Health Colorado – decreasing the rate of uninsured in Colorado. It also balances need for high numbers with reality that some grantees have target populations who need more assistance.
  - Cons: It is not clear which measure makes the most sense – applications compared to Health Coverage Guide time on direct application assistance is the most direct measure of the efficiency of enrollment processes, however it does not account for the differences in levels of support for some HCGs (e.g. other staff supported through the grant to provide administrative support). Also, all data collected on time spent with a given client will be self-report data from HCGs, requiring careful tracking to maintain accuracy.
  - Challenges to date: It has not been possible to consistently link marketplace data, including enrollments, with a given HCG due to website problems with HCG ID numbers getting entered into the system. To date, there have also been challenges with accurately capturing FTE rates for all HCGs. Finally, tracking of appointment times and services provided has been done differently at each site; common tools have not met the needs of many sites.
- *Cost per enrollment: Numbers of individuals completing applications as compared to funding per HCG FTE, total FTE, or total funding.* This measure could also be mediated using a complexity index assigned to each person served. The complexity index will be based on demographic factors such as geographic location, eligibility for subsidies, language, number of family members being enrolled, complexity of application/enrollment, etc.

  - Pros: Measure is aligned with a primary focus of Connect for Health Colorado – decreasing the rate of uninsured in Colorado. It also balances need for high numbers with reality that some grantees target populations who need more assistance.
  - Cons: Cost per enrollment measure can be challenging as HCGs hourly rates vary greatly across sites. Also, does not account for the differences in levels of support for some HCGs (such as other administrative support) or the costs incurred at the site level that are not reflected in HCG hourly rates alone.
  - Challenges to date: It has not been possible to consistently link marketplace data, including enrollments, with a given HCG due to website problems with HCG ID numbers getting entered into the system. To date, there have also been challenges with accurately capturing FTE rates for all HCGs. Finally, tracking of appointment times and services provided has been done differently at each site; common tools have not met the needs of many sites.

- *Application to enrollment rate.*
  - Pros: This is a critical measure of success. If applications are not resulting in enrollments, the outcomes of Connect for Health Colorado will not be met. The minimum standard could be developed using data from CHP+.
  - Cons: There are critical steps along the way that cannot be well captured when it comes to conversion rates, including aspects that are outside of HCGs control (technical issues, plan shopping, employer benefit offers); individuals might have reasons for not completing the application process that are beyond the scope or capacity of HCGs.
  - Challenges to Date: In the first round of open enrollment, many individuals either initiated applications and then did not proceed or initiated applications that were later cancelled when they became stuck in the system. In some cases, new applications were filed to replace stuck application, meaning that there is a risk of double counting (thus making conversion rates look worse). Also, some of those that began an application and then did not proceed enrolled with another family member, meaning that measures are also over counting.
- *Enrollment to disenrollment rates*, focusing on identifying outliers.
  - Pros: This is a critical measure of success. If individuals are enrolling in plans that they cannot sustain, it will not decrease the rate of uninsured in Colorado.
  - Cons: Much of what can lead to disenrollment is outside of the control of HCGs. The minimum standard would need to be set to allow for a reasonable disenrollment rate, but still flag those sites with unusually high rates. An outlier rate – much higher than other sites - would be an indicator of problems with the application process, such as enrolling individuals in plans they cannot financially sustain. Disenrollment is also not within a set time-limit; therefore this measure would have to include an appropriate cut-off date.
  - Challenges to date: It has not been possible to consistently link marketplace data, including enrollments, with a given HCG due to website problems with HCG ID

numbers getting entered into the system. Also, disenrollment data has not been consistently and accurately reported in the marketplace data.

- *Customer satisfaction level.* A minimum level of satisfaction can be identified across a set of measures.
    - Pros: In the context of Connect for Health Colorado, HCGs are not just application assisters; they are representatives of Connect for Health Colorado. Customer satisfaction with the process is critical. Much information exists on how to measure customer satisfaction and set appropriate baselines.
    - Cons: There are multiple indicators that could be included and selection of the indicators will affect the scores for sites. For example, should satisfaction be with the HCG interactions only or also satisfaction with the plan selected? While satisfaction with the plan selected may be influenced by whether the plans available meet the needs of different types of clients, it could also be suggestive of the HCGs ability to provide information to the client that helps them select the best plan for their household needs. Also, there is a potential for reporting bias such that only those that were extremely satisfied or extremely unsatisfied are likely to report; Non-English speakers may be less likely to report, etc.
    - Challenges to date: Of the 138,978 enrollments in Connect for Health, 6,068 people have responded and only 34 Spanish speakers (approx. 4%). Data does not include SHOP enrollees. There are needed revisions to the survey, which are underway, that will make the comparison of some survey data with future surveys less reliable. No HCG ID or assistance site ID currently associated with customer satisfaction survey data.
- *Number of individuals reached through targeted in-reach and outreach strategies.* Targeted refers to direct reach in a documentable way. It would exclude reach that occurs primarily through "impressions" of paid media, flyers distributed, email blasts, etc. Instead, in-person events, presentations, information shared with existing clients, etc. would be tracked.
    - Pros: Outreach and in-reach strategies are necessary in order to access individuals to assist with applications. Recognizing the importance of outreach strategies will also help avoid disproportionately awarding incentive payments to sites with fairly easy in-reach strategies available (e.g. hospitals with existing clients who need health insurance), which is likely to result in a higher application rate.
    - Cons: While all of the information on previous measures can be collected from the Connect for Health Colorado online database or directly from clients, outreach would be entirely self-report. Further, it will require steady tracking by grantees that may be difficult to maintain accurately.
    - Challenges to date: Tracking in-person events, presentations and information sessions has been inconsistent. It has been difficult to capture the qualitative difference between these events and activities. The level and type of information shared with clients has not been systematically recorded through any common set of indicators to date. Reporting measures have been focused on intended audiences

for specific target population groups rather than *actual* audiences, but it has been unclear whether grantees are consistently reporting intent or actual.

- *Number of individuals reached through un-targeted outreach strategies.* Unlike targeted reach, this measure would include 'impressions', flyers, email blasts, and other forms of documentable communication to potential clients.
    - Pros: Outreach strategies are necessary to access a wide variety of individuals to assist with applications and also to raise public awareness about Connect for Health Colorado. Recognizing the broader outreach strategies allows for identification of areas within the State that are being overlooked and those that maybe saturated.
    - Cons: Outreach strategies would be entirely self-report and require steady tracking to maintain accurate data. It has been challenging to track the impact of these outreach strategies to client's engaging in the enrollment process without additional tracking tools.
    - Challenges to date: Tracking broader outreach strategies has been challenging given conceptual differences in the reporting requirements (Does # of flyers mean total distributed or total of different types of flyers created and distributed – so.. 30,000 vs. 8?, how do you record 10 email blasts to the same 1,000 people on a listserv – as 10, 1,000 or 10,000?) Reporting has been inconsistent across grantees as a result. Reporting measures have been focused on intended audiences for specific target population groups rather than *actual* audiences, but it has been unclear whether grantees are consistently reporting intent or actual, or if they are unable to measure given the broader nature of the outreach strategy.
- *Timely and complete reporting.* This refers to the quarterly reports & monthly financial reporting.
    - Pros: Federal funding has specific reporting requirements and failure to meet these will put Connect for Health Colorado funding in jeopardy and increase administrative burden for Connect for Health Colorado. Including timely and complete reporting as a measure will emphasize this issue and encourage full participation in the reporting processes.
    - Cons: No cons identified.
    - Challenges to date: Quarterly reporting has been cumbersome. Questions have evolved over time, making tracking and comparison challenging. There has been very little consistency for financial reporting, making monitoring the first two performance measures impossible.

Recommendations for Implementation

1. *Keep it simple.* Ask only the questions for which information is required in self-reported data collection efforts. Make reporting monthly, using an easy mechanism. As the marketplace data issues are addressed, eliminate any tracking that grantees need to do that is duplicated by what is available in the marketplace.

2. *Standardize the forms.* Provide a template, a tracking sheet, a form; whatever is needed for accurate recordkeeping. Ensure template contains the exact reporting questions. Inform grantees of any changes a month in *advance* of the reporting period. Provide a template for tracking that can be used easily to enter data into the reporting system.
3. *Summarize Grantee Reporting.* Return summaries of sites' tracking data back to the sites as quickly as possible so that grantees can update their outreach strategies and integrate real time data into enrollments.
4. *Combine Grantee and Marketplace Data.* Couple self-reported site data with marketplace data, tracking enrollments in real time in across Colorado so grantees are aware of how things are going in their communities outside of those that they have personally enrolled.
5. *Customer Satisfaction Data.* Distribute a much broader range of customer feedback surveys to all sites, including paper surveys for individual and SHOP enrollments. Provide feedback to the assistance sites about their progress from these customer surveys.
6. *Tell the stories.* Offer a way to have an internal blog or wiki or some mechanism for HCGs to share stories with other HCGs.
7. *Track the level of network activity, capitalize on partnership.* Track grantees' collaborative work with other assistance sites and external partners, including client referrals to and from sites, thus crediting both organizations with supporting clients. Sites could be matched according to strengths and weaknesses.
8. *Marketing Support.* Coordinate co-branded outreach efforts to support marketing and to drive additional clients to their local assistance sites.
9. *Assistance Network Input into Hub selection.* Allow for grantees input into the Hub selection. Fully utilize the Hub structure, supporting a community feeling among assistance sites, while having Hub support for sites tracking performance measures, for outreach activities, for troubleshooting, etc.
10. *Improve Marketplace Metrics:* Examples include providing data that tracks interaction with a Connect for Health customer service representative on the phone or via email. Also, tracking employment status alongside insurance status for the last six months to know if someone didn't take employer insurance, was unemployed, lost job, never had insurance, etc. Allow for a more nuanced picture of what motivates clients as well as outcomes achieved across different groups within society.

APPENDIX C: ADDITIONAL TABLES

Quarterly report analysis of outreach to target populations

Grantees (%) Reporting Targeting Ethnic/Racial Population by Light Touch Outreach strategy

Ethnic Group	Electronic	Media	Flyers/ Brochures	Editorials
African American/ Black	44%	32%	44%	26%
Native American	33%	25%	39%	21%
Asian	39%	29%	42%	19%
Latino	57%	38%	67%	33%
White	63%	36%	65%	33%

Grantees (%) Reporting Targeting Ethnic/Racial Population by In-Person Outreach strategy

Ethnic Group	In-Person Presentations	Fairs/ Enrollment Events	Conversations	Trained Spokespeople
African American/ Black	38%	38%	41%	13%
Native American	28%	26%	33%	6%
Asian	31%	29%	41%	10%
Latino	51%	48%	58%	12%
White	58%	52%	62%	12%

Grantees (%) Reporting Targeting Age Groups by Light Touch Outreach strategy

Ethnic Group	Electronic	Traditional Media	Flyers/ Brochures	Editorials
Under 18 years old	28%	21%	42%	18%
Age 19-25	65%	39%	69%	38%
Age 26-35	67%	39%	71%	39%
Age 36-45	67%	40%	71%	40%
Age 46-55	64%	40%	69%	39%
Age 56-65	63%	39%	65%	36%
Over 65 years old	19%	19%	25%	14%

Grantees (%) Reporting Targeting Age Groups by In-Person Outreach strategy

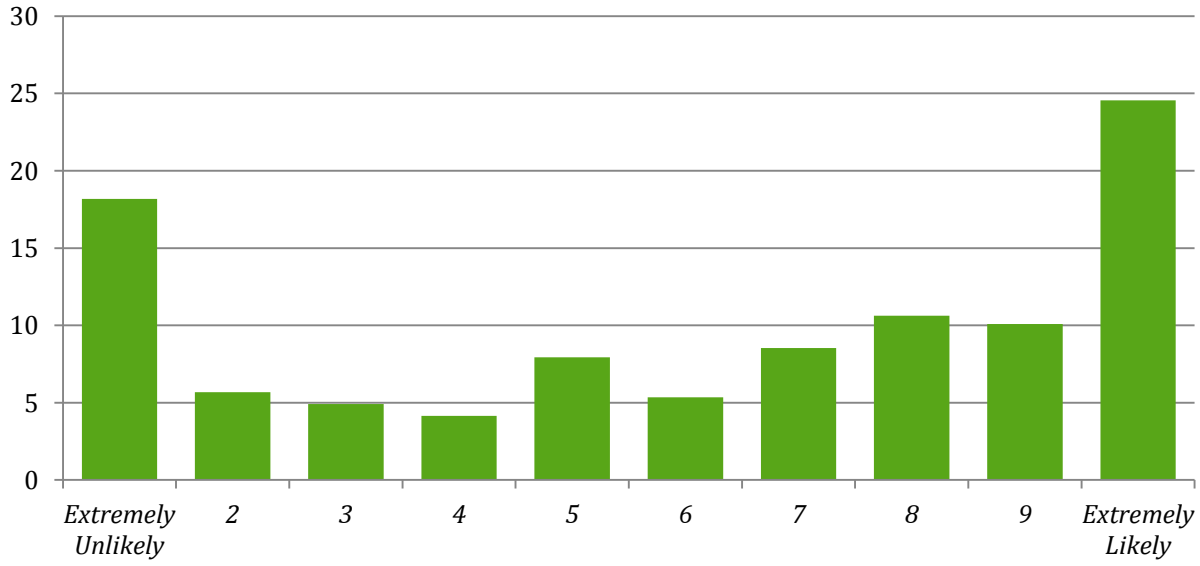
Ethnic Group	In-Person Presentations	Fairs/ Enrollment Events	Conversations	Trained Spokespeople
Under 18 years old	28%	25%	35%	9%
Age 19-25	51%	46%	58%	14%
Age 26-35	63%	48%	61%	14%
Age 36-45	64%	45%	62%	14%
Age 46-55	61%	44%	64%	16%
Age 56-65	57%	45%	61%	16%
Over 65 years old	18%	20%	23%	7%

Customer Satisfaction Data

The customer satisfaction survey tool was designed in conjunction with Spark Policy Institute as a way to engage consumers post-enrollment to provide feedback on their experience. Over the course of the period between February to May 2014, a total of 6,068 respondents completed the customer satisfaction survey. During the initial planning stages, the survey was also intended to be distributed to SHOP customers and a paper survey was to be provided to customers upon completion of enrollment with health coverage guides. These two secondary surveys were not distributed during the first year of open enrollment.

Findings from the customer satisfaction surveys indicate that having the assistance of a health coverage guide is a significant predictor of overall client happiness with C4HCO and the likelihood that they will recommend C4HCO to others. In the final evaluation report, these findings will be integrated into the health coverage guide analysis, supporting the principle results in that section that suggest health coverage guides were critical to enrolling specific populations.

Likelihood that the Client will recommend C4HCO to a Friend or Family Member

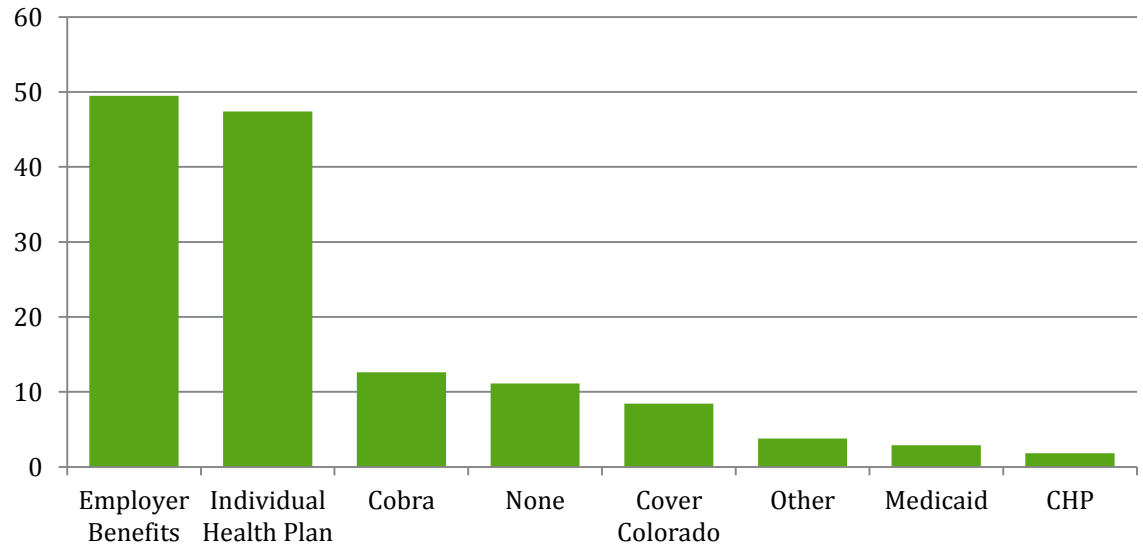


From whom did the client receive assistance?

Method	Percent
Connect for Health on the Phone	70% (1,566)
Broker	25% (560)
Connect for Health Online	17% (392)
Certified Application Counselor	13% (289)
Peak Representative	13% (284)
HCG	10% (228)
Sales Rep*	5% (122)
Total Respondents that Completed the Application with Assistance	2,245

*Please note that future revisions to the customer satisfaction survey are suggested to eliminate the overlap between the category of 'brokers' and 'sales representatives' since it has been impossible to accurately discern individual responses to the 'sales rep' category.

Client's Previous Form of Insurance



Multi-Variate Regression Analysis: Factors predicting the likelihood client will recommend C4HCO

How likely are you to recommend C4HCO?	Coefficient	Std. Err.	t	P>t
Found a plan that meets my needs	0.58	0.02	**29.79**	0
It was easy to enroll on the website	0.51	0.02	**25.62**	0
It was easy to find out about eligibility for premium assistance	0.18	0.02	**9.68**	0
Health Coverage Guide Index	0.07	0.03	**2.37**	0.018
Broker Index	0.04	0.02	**2.14**	0.032
Connect for Health Online Index	0.02	0.03	0.7	0.485
Connect for Health Phone Index	0.20	0.01	**14.34**	0
Prior Insurance: None	0.53	0.11	**4.9**	0
Constant	0.25	0.09	**2.88**	0.004
Adj R-squared	0.5321			
Observations	4807			

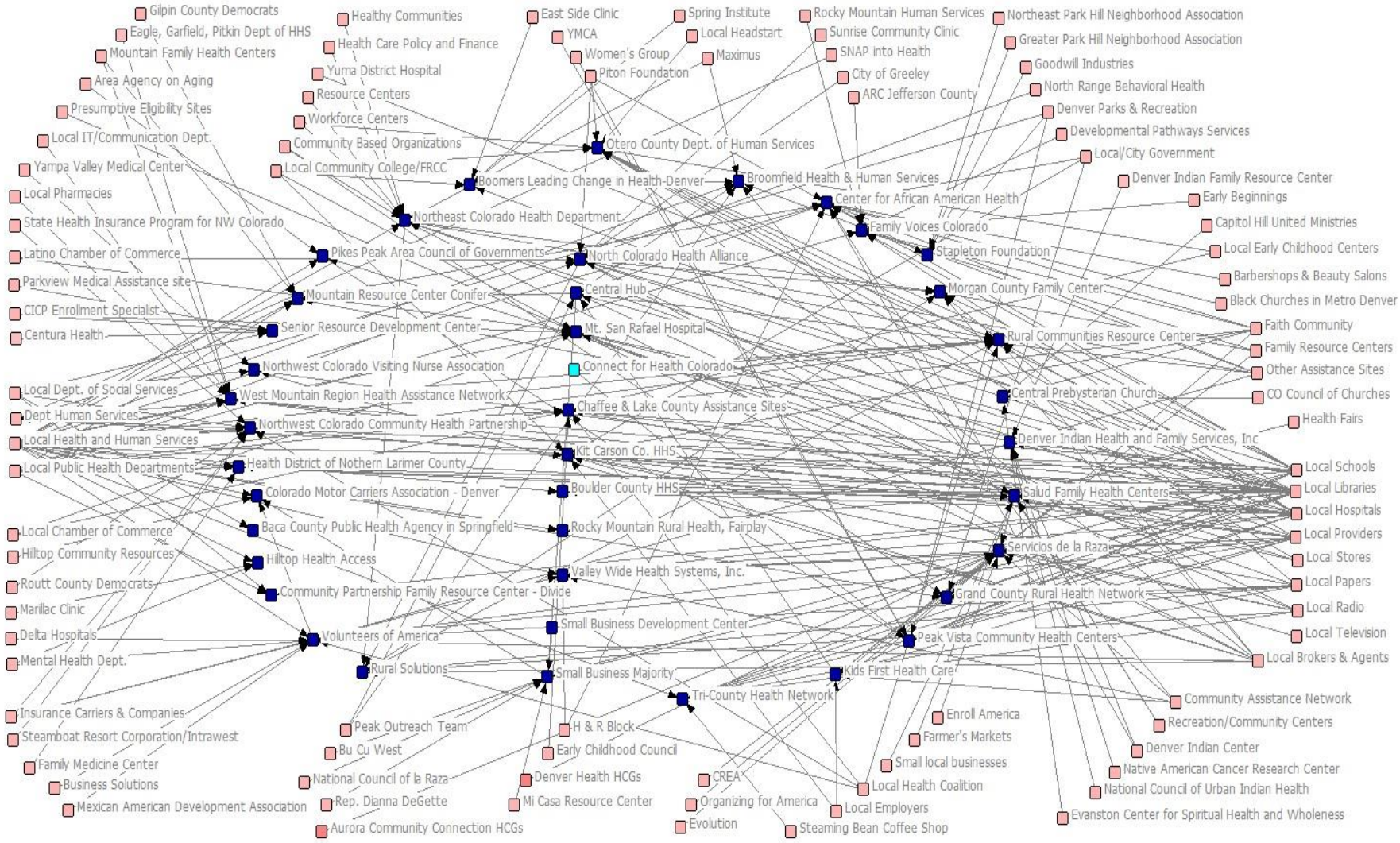
Note: All factors are significant p>0.05 except the Connect for Health Online Index

Multi-Variate Regression Analysis: Factors predicting Overall Satisfaction with C4HCO

Overall, How satisfied are you with C4HCO?	Coefficient	Std. Err.	t	P>t
Found a plan that meets my needs	0.32	0.01	**26.5**	0
It was easy to enroll on the website	0.40	0.01	**31.86**	0
It was easy to find out about eligibility for premium assistance	0.14	0.01	**11.99**	0
Health Coverage Guide Index	0.06	0.02	**2.88**	0.004
Broker Index	0.04	0.01	**3.26**	0.001
Connect for Health Online Index	-0.02	0.02	-1.07	0.285
Connect for Health Phone Index	0.15	0.01	**16.8**	0
Prior Insurance: None	0.29	0.07	**4.3**	0
Constant	0.32	0.05	**5.89**	0
Adj R-squared	0.5693			
Observations	4890			

Note: All factors are significant p>0.05 except the Connect for Health Online Index

Health Coverage Guide Network Map



The above map of the assistance network's identified critical partners was generated from survey data collected during the final health coverage guide convening in June of 2013. Each health coverage guide was encourage to name up to ten critical partners in their community that helped them with their work, either by offering referrals to clients, space for meetings or presentations, information or resources, or some other specific form of support. For example, the local health or human services department was frequently noted as a critical partner for expediting Medicaid denials and troubleshooting difficult applications. In the map above, survey respondents are indicated by the dark blue symbols, identified critical partners are in light pink. Although there are some assistance sites within the light pink symbols, this is only an indication that they did not submit a survey at that time, not that they did not have any critical partners. Connect for Health Colorado is identified by the light teal symbol in the center of the map.

Endnotes

[1] In the customer satisfaction survey data, of the 6,068 respondents, there were 228 individuals who had worked with a health coverage guide during their enrollment process. There were three measures of satisfaction with a health coverage guide: Whether the respondent felt the HCG had their best interests at heart, whether the HCG was available to provide help when needed; and whether the health coverage guide provided accurate information. An index was created using these three measures in order to provide a scale variable that incorporates the range of customer satisfaction levels working with health coverage guides.

[2] To investigate differences in metal plans based on assistance group, a chi-square analysis was used. Results indicated that there were differences in proportion of metal plan chosen depending on whether enrollees received help from a health coverage guide, broker, or received no assistance, $\chi 2$ (8) = 17003, p<.000, Cramer's V= 0.093). Individuals that had no assistance were also statistically significantly more likely to enroll in Catastrophic or Bronze plans as compared to those that had assistance (either broker or health coverage guide): ($\chi 2$ (4) = 14000, p<.000 Cramer's V= 0.1195).The strongest statistical relationship exists for individuals enrolling in silver plans. Those that worked with a health coverage guide were nearly twice as likely to enroll in a silver plan as compared to those that worked with a broker or received no assistance: $\chi 2$ (2) = 12000, p<.000, Cramer's V= 0.1114. Logistic regression models further confirm these findings. Controlling for other factors that might have included plan selection (whether an individual was uninsured during the past six months, their CSR eligibility level, the individual premium amount, working with a broker, age, and ethnicity), working with a health coverage guide is statistically significantly more likely to lead to enrollment in a silver plan (Coefficient 0.4435, std. error 0.03601, z score – 12.32, P>z 0). Overall, the logistic regression model predicting factors that affect enrollment in a silver plan had a LR Chi^2 (Prob > Chi^2) of 10266.19 (0.000) and Pseudo R^2 of 0.1190.

[3] For example, when grantees were asked how many flyers or brochures they distributed, some respondents captured the number of different flyers (perhaps only four or five different documents) while others captured the distribution (perhaps as many as 30,000 in a given county). Therefore the comparison between sites was not equivocal.