

Date: APRIL 01, 2015

TO: Senator Ellen Roberts, Chair, Legislative Health Benefit Exchange Implementation Review Committee

CC: Amanda King, Colorado Legislative Council, Research and Committee Staff

From: Gary Drews, Interim CEO, Connect for Health Colorado

RE: Responses to Committee Members Questions from 3/18

The Legislative Health Benefit Exchange Implementation Review Committee asked Connect for Health Colorado the following questions during the March 18 meeting. Below are Connect for Health Colorado's responses.

1. What is status of interoperability between CBMS (Medicaid) and Connect for Health computer system (private insurance)? How is functionality being measured? How close are we to real-time Medicaid eligibility denial so that customers can quickly apply for private insurance plan? (Asked by Kefalas-D)

In the fall of 2013, the Centers for Medicare and Medicaid Services (CMS) mandated Connect for Health Colorado (The Marketplace) and the Department of Healthcare Policy and Financing (HCPF) implement a single eligibility application and rules engine for determinations of Medicaid, CHP+, Advance Premium Tax Credits, and Cost Sharing Reductions. The Marketplace and HCPF jointly built a Shared Application and Shared Eligibility System that was made available to applicants on November 10, 2014. Applicants can access the Shared Application from either their Marketplace account or their PEAK account. Regardless of how one enters, an applicant will complete and submit one application. Once their application is submitted, the Shared Eligibility System, which is part of CBMS, provides the applicant with an eligibility determination for all programs (Medicaid, CHP+, APTC, CSR). This determination is either provided in real-time (i.e. appears on the user screen directly after submission) or in a letter that is mailed to the applicant. An eligibility determination letter is mailed after a caseworker has manually made a determination.

During the 2015 Open Enrollment Period, a total of 224,171 applications for financial assistance were submitted through the new System. Applications submitted from Connect for Health Colorado totaled 76,783. Of the Marketplace customers who went through the Single Application and Shared Eligibility System, 78% received a real-time eligibility determination. It is important to note that the 78% does not take into account an applicant that accessed the application through PEAK or through a caseworker entering directly into CBMS.

In our first year of interoperability with HCPF, the Marketplace has identified areas where the Shared System has negatively impacted our customers. These include:

- *The Shared System doesn't work well where Medicaid and APTC / CSR federal policies do not align (for example, Medicaid counts income on a current monthly basis and the Marketplace counts income on a projected annual basis),*
- *The Shared System does not work well for populations of returning customers or people with complex income or family situations.*
- *The Shared System does not work for APTC/CSR customers who wish to report a change*
- *The Shared System is resulting in a large number of Medicaid calls to the Marketplace customer sales and support channels; and unanticipated numbers of Marketplace calls to Medicaid – potentially reflecting confusion among Coloradans over roles of the two organizations.*
- *Marketplace customer service representatives, Brokers and Health Coverage Guides don't have visibility into the eligibility portion of the application and can't assist customers with questions about how their eligibility was determined, why their application may be "stuck", and they also cannot modify data in CBMS to correct eligibility determination errors caused by incorrect income entries, technical glitches or incomplete relationship definitions*

Due to the feedback received from customers, our sales-channels and key stakeholders, the Marketplace and HCPF have committed to improving the user experience. The Marketplace and HCPF have proposed a joint recommendation to the Marketplace Board of Directors.

2. Has Connect for Health done a SWOT analysis - strengths, weaknesses, opportunities and threats? (Asked by Kefalas-D)

The Marketplace has not conducted a recent SWOT analysis for the current planning cycle, as this information is largely understood. However, the staff and Board are currently conducting a strategic planning process that has included a variety of 'inputs' including identifying the Marketplace's value propositions, SWOT-like feedback from its several Advisory Groups, surveys from sales channels (brokers, health coverage guides, service center), informal environmental scans, and internal analyses. Staff is currently in the process of drafting analyses/business cases for initiatives for 2015/2016, building a financial forecast/budget, and collecting additional data to support strategic directions anticipated.

3. What has been done to address the deficiencies found in the sample audit? What new policies are in place? (Asked by Landgraf-R)

*Connect for Health Colorado hired full-time General Counsel on September 2, 2014; the same day the OSA held its exit meeting at Connect for Health Colorado's offices. General Counsel fulfills the role of Compliance Officer for the organization and has implemented a comprehensive **Management & Oversight Plan** reviewed and approved by our federal regulators, CMS/CCIIO. Moreover, General Counsel has established a comprehensive **Procurement Policy** and associated procedures to address the procedural and documentary issues identified in the OSA Audit Report.*

*Each audit and review to which Connect for Health Colorado is subject is used to identify areas that need to be addressed. Connect for Health Colorado's **Implementation Plan** (attached) provides a status report on what has been completed and what is underway to address OSA's findings and recommendations.*

It is important to note the OSA launched its audit in January 2014 –three months after the Marketplace launched and halfway into its inaugural Open Enrollment Period. A comprehensive reading of the OSA's report and its findings in context of the input and responses provided by Connect for Health Colorado reflects that the greatest shortcoming in the early operation of the organization concern adequate documentation surrounding procurement, contracting, and Board/Senior Leadership decision-making processes. In OSA's report, costs are "questioned" if the underlying documentation is inadequate or not sufficient. Contracts were found to be non-compliant with law if they were missing certain clauses (e.g. – failure to require a vendor to adhere to "Executive Order 11246 'Equal Employment Opportunity' as amended by E.O. 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulations at 41 CFR part 60, 'Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor.'")

The absence of adequate documentation with respect to a given contract resulting in "questioned costs" should not lead anyone to conclude that a vendor did not provide the service, or that funds were wasted or lost. In each case, the service was necessary and provided. The fault lay in the adequacy and availability of documentation to substantiate (from an audit perspective) the expenditures.

Connect for Health Colorado leadership, Board and staff takes our stewardship of public dollars very seriously. As recipients of federal grants, we are held accountable to operate with responsible and compliant financial systems, and performance practices and policies. The US Department of Health and Human Services, the Centers for Medicare and Medicaid Services, the Office of the Inspector General, the Internal Revenue Service, and others have closely and continuously monitored us since 2012 and approved our operations, policies and procedures.

This was in a very complex environment; while creating a brand new enterprise; within an ambitious timeframe set by Congress; and under federal regulations that changed sometimes weekly.

It should be noted that Connect for Health Colorado has undergone approximately 27 audits, reviews and reports by federal, state and external agencies and auditors during the past 30 months; currently five are in various stages of progress. Each of the independent audits and reviews has brought tremendous value to us as a start-up, and we have implemented their recommendations to improve the organization. The Marketplace is currently conducting its own reviews internally as well to reduce future findings incidents and strengthen policy adherence. Additionally, the organization is hiring internal audit staff to manage the volume of audits and oversight anticipated to continue indefinitely.

4. What reason is there for the overpayment on contracts? Has that money been refunded? Or earned? (Asked by Landgraf-R)

Connect for Health Colorado entered into contractual arrangements with various vendors to supply services. As needs dictated that additional services were required to launch the Marketplace, vendors provided these services and Connect for Health Colorado paid for them. However, the documentation associated with the additional services in the form of additional “statements of work” was not adequate. Absent this context, the OSA report makes it appear that there were overpayments on contracts resulting in “questioned costs.” In fact, Connect for Health Colorado received all services paid for on its contracts, but did not present adequate documentation (from an audit perspective) to reflect that the payments were related to services provided. In that the services were provided, no requests for “refunds” is appropriate; rather Connect for Health Colorado’s vendor and procurement documentation policies and procedures have been materially revised to avoid future documentation inadequacies.

5. Has Connect for Health conducted customer service surveys? If so, what have been the results and have responses been more favorable over time? If surveys have not been conducted, why not? (Asked by Kefalas-D)

Connect for Health Colorado developed and sent out initial Customer Satisfaction surveys from January 2014 through May 2014. We suspended survey efforts to better develop a methodology for garnering customer survey feedback each month, rather than at one point and time per year. We also decided to wait until Spring/Summer of 2015, to be able to obtain feedback on the whole annual lifecycle of the customer experience, i.e.: renewal, account changes and support mid-year, etc. To be highly successful in taking feedback and developing initiatives, changes, etc. organizations need to also develop an infrastructure to identify and prioritize this feedback. This operationalization is now possible since the Marketplace has experienced a first full cycle of operations. That said, Connect for Health Colorado does conduct the following forums to receive ongoing customer and key stakeholder feedback:

- *Spark Policy Institute- Conducted an annual review of the efficacy of Marketplace efforts in a number of areas (attached)*
- *Kaiser Family Foundation via PerryUndem Research and Communications –Conducts annual studies with stakeholders in the following areas: outreach, implementation, securing provider and plan participation, enrollment, and affordability issues*
- *American Institute of Research – Conducted a study in winter 2014 to assess the user experience and navigation ease for customers (attached)*
- *JVA Consulting – Conducted pre-launch random surveys of the Shared Eligibility System on behalf of the Marketplace and HCPF*
- *Connect for Health Colorado- Conducts:*
 - *Weekly one hour calls with each Carrier (15) on feedback pertaining to technology, process, interfaces, problem resolution, and continuous improvement at all levels*
 - *Daily calls with the Assistance Network to garner feedback, identify themes, and share trends among customers, etc.*

- *Monthly Broker Focus Group meetings to garner feedback, identify customer concerns and themes, develop resolution pathways, etc.*
- *Daily huddle meetings with Service Center staff to identify customer feedback themes, identify problems/solutions, share consistent messaging on critical caller issues, etc.*
- *An Executive Director email address for stakeholders to address concerns, compliments, etc. directly to the CEO*
- *Public comment periods at each Board/Committee meeting*
- *Post contact caller surveys – Service Center interactions*

Customer satisfaction surveys for 2014/2015 will be developed and deployed in summer 2015. For future Open Enrollment Periods, the federal government will provide a standard survey that Marketplaces must send to enrollees.

6. What is relationship between plans offered within health benefit exchange and plans outside of exchange? How are insurance brokers operating in this new health insurance landscape? (Asked by Kefalas-D)

Health insurance carriers who file plans on the Marketplace are required to offer the same plans at the same premium rates outside of the Marketplace. Colorado is a leader in ensuring market stability in this regard. Carriers can offer additional plans beyond Marketplace parity plans in their non-exchange product portfolio.

Insurance brokers are an integral part of our sales channel. For the 2015 Open Enrollment Period we trained and certified over 1,300 brokers and agents to sell health and dental policies offered in the individual and small group Marketplace. Our brokers produced in 40% of our covered lives for this past Open Enrollment Period. Our top producer has over 400 customers on the Marketplace.

7. Does Connect for Health CO have a role in addressing problems with carriers such as Health Care Cooperative regarding their customer service and computer glitches? If so, how does it help to address problems? If not, why not? (Asked by Kefalas-D)

The Marketplace does have a role in “certifying” a Carrier as a Qualified Health Plan offering products on the Marketplace. We work closely with the Division of Insurance, as the regulatory authority over licensed issuers in Colorado. The Marketplace has a Carrier Business Team that works regularly with each Carrier on customer, strategic and operational issues. The Marketplace has a weekly meeting with a subset of the 15 represented Carriers, as a Tactical Issues Team, to identify systemic issues impacting customers and develop resolutions. That said, the DOI is the consumer protection agency and we do work very closely with this partner. The Marketplace does have the ability to remove a Carrier from the Marketplace.

In addition, the Marketplace and its carriers are partners in helping resolve our customers' issues. The Marketplace has a dedicated team within its Customer Service Center that works directly with each carrier.

ATT:

State Audit Implementation Dashboard

Spark Policy Assistance Network Evaluation

American Institute of Research (AIR) Colorado Usability Testing Report

C4HCO Stakeholder Feedback 2OEP



State Audit Implementation Plan

RECOMMENDATIONS & RESPONSES

Karen Phillips
CONNECT FOR HEALTH COLORADO

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Implementation Dashboard

Section	Date to Implement	Date Completed	%	Notes
1-A	2/15	2/15	100%	Policies and procedures have been written and will continue to evolve and improve as needed.
1-B	3/15	3/15	100%	Policies and procedures have been written and will continue to evolve and improve as needed.
1-C	6/15		30%	Interim CFO retained. CEO search continues. Re-evaluating internal audit position.
1-D	12/14	1/15	100%	Board and CEO approved \$3,000 corporate credit card which is controlled by Controller.
1-E	3/15	3/15	100%	General Counsel, Interim CFO and Controller continue to work with Board and management.
1-F	6/15		75%	Training will continue to be provided as needed to management, staff and Board.
1-G	3/15	12/14	100%	Identified costs have been reclassified to HRPRPF funding, and grant funding adjusted.
2-A	1/15		95%	Revised draft policy presented to Board 1/13/15. Final to Finance Committee/Board pending.
2-B	3/15	3/15	100%	Report is in final stages of completion. When finished, policy/procedure will be written.
2-C	1/15	12/14	100%	Template for new contracts in place, and General Counsel reviewing all contracts.
2-D	3/15		90%	Spreadsheet for tracking all Board decisions in development and historical data added.
2-E	6/15		75%	As new policies/procedures are approved, training will proceed as appropriate.
3-A	3/15	3/15	100%	Policies and procedures have been written and will continue to evolve and improve as needed.
3-B	12/14	12/14	100%	New process/procedures were put in place and refined during 3 rd Quarter 2014.
3-C	3/15	12/14	100%	Advance policy completely revised and strictly enforced.
3-D	3/15	12/14	100%	Review completed and adjustments made, ongoing review on a monthly basis.
4-A	3/15	3/15	100%	Policies and procedures have been written and will continue to evolve and improve as needed.
4-B	6/15		30%	Interim CFO retained. CEO search continues. Re-evaluating internal audit position.
4-C	4/15		80%	General Counsel is expanding initial program with input from CCIIO. Retained consulting firm.
4-D	6/15		75%	As new policies/procedures are approved, training will proceed as appropriate.

SECTION 1 – PAYMENT TO VENDORS

1 – A: Establishing and implementing written policies and procedures that: (1) require documentation of all goods and services that supports the payment amount and business purpose prior to paying vendors, (2) specify the types of documentation required to verify the receipt of goods and services prior to payment, and (3) require all payments to be allowable, compliant, reasonable, and accurate.

- ◆ Connect for Health Colorado will establish and implement additional written policies and procedures that:
 - i) Require documentation of all goods and services that supports the payment amount and business purpose prior to paying vendors
 - ii) Specify the types of documentation required to verify the receipt of goods and services prior to payment
 - iii) Require all payments to be allowable, compliant, reasonable, and accurate. COHBE will continue to update on an ongoing basis, written financial and personnel policies and procedures reflective of the evolving nature of the organization and its staff moving from a start-up toward a stable, established entity
- ◆ COHBE will continue to improve and add to these policies to specify the documentation required to verify the receipt of goods and services prior to payment and require all payments to be allowable, compliant, reasonable, and accurate
- ◆ New staff members with accounting responsibilities will be instructed on use and management of the goods and services payment systems and documentation requirements.

Implementation Date	2/15	Completion Date	2/15
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1 – B: Establishing and implementing written processes and guidance that ensures staff and supervisors understand federal compliance requirements and consistently review all pending payments for compliance, reasonableness, and accuracy before they are paid. Each review should be performed and documented by an individual who is independent of the preparer and possesses sufficient knowledge of compliance and accounting requirements.

- ◆ COHBE will establish and implement additional written processes and guidance that ensure staff and supervisors understand federal compliance requirements and consistently review all pending payments for compliance, reasonableness, and accuracy before they are paid
- ◆ Each review will be performed and documented by an individual who is independent of the preparer and possesses sufficient knowledge of compliance and accounting requirements
- ◆ COHBE will update its written financial and personnel policies and procedures with respect to federal compliance requirements
- ◆ COHBE will ensure that it complies with federal oversight as the organization’s structure and staffing evolves
- ◆ COHBE is working with General Counsel and finance staff to update and improve the system for approving vendors and contracts prior to full execution to ensure compliance, reasonableness, and accuracy before engagement with vendor. This review shall be performed

and documented by several individuals, including General Counsel, managerial and/or executive staff, and the controller before final entry into COHBE’s accounting system for payment submission, and ultimately must be approved with the signature of COHBE’s CEO/ED

- ◆ As new staff are hired, consideration will be given to those individuals with federal compliance experience
- ◆ Current staff will be trained as needed on federal guidelines as well
- ◆ COHBE will continue to improve and add to these policies as organizational growth and sophistication warrant, ensuring that staff and supervisors understand federal compliance requirements and consistently review all pending payments for compliance, reasonableness, and accuracy before they are paid

Implementation Date	3/15	Completion Date	3/15
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1 – C: Ensuring that there is an adequate number of supervisors and staff available to review financial documentation, verify the basis for the billed amounts, and ensure goods and services are received prior to paying vendors.

- ◆ COHBE agrees with the audit findings regarding adequate number of supervisors and staff needed to review financial documentation
- ◆ Currently COHBE is seeking a new CFO and after this individual is hired, staff requirements will be reviewed again and new staff hired as needed
 - i) The goal will be to ensure that there is an adequate number of supervisors and staff available to review financial documentation, verify the basis for the billed amounts, and ensure goods and services are received prior to paying vendors
 - ii) On September 2, 2014, COHBE transitioned from a staff legal counsel to retaining general counsel with over 25 years of experience to assist in the implementation of an organization-wide governance and compliance program addressing the breadth and scope of the each Recommendation provided by the Office of the State Auditor

Implementation Date	6/15	Completion Date	
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1 – D: Establishing and implementing a risk-based process for expediting low-risk purchases, such as low-dollar recurring administrative expenses to expedite the procurement process, as appropriate, during times of high workload within the organization.

- ◆ COHBE agrees with audit findings and will have a corporate credit card for expediting low-risk purchase process by the end of November 2014
- ◆ A policy is currently being drafted detailing the use of this card and staff will be informed and trained as needed in December

Implementation Date	12/14	Completion Date	1/15
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1 – E: Implementing an ongoing periodic monitoring process that involves members of the Board of Directors (Board), management, and supervisors, as appropriate, to ensure financial policies, procedures, processes, guidance, and training are implemented and operating as intended.

- ◆ COHBE will implement an ongoing periodic monitoring process that involves members of the Board of Directors (Board), management, and supervisors, as appropriate, to ensure financial policies, procedures, processes, guidance, and training are implemented and operating as intended
- ◆ Executive management will review and approve financial policies and implementation of new policies and procedures
- ◆ The Board and its finance committee will be advised on improvements in financial reporting and budget reporting
- ◆ COHBE accounting staff will use multiple reporting tools to provide information to the Board, management and supervisors with respect to new developments/processes/procedures; and to provide overall transparency and facilitate appropriate control and oversight
- ◆ Periodic review and spot checks of implemented policies and procedures will occur as a function of the use of COHBE’s accounting systems and record-keeping and record-retention requirements

Implementation Date	3/15	Completion Date	3/15
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1 – F: Training management, supervisors, staff, and Board members, as appropriate, on the policies, procedures, processes, and guidance developed in recommendation parts A through E.

- ◆ COHBE will provide training as needed to management, supervisors, staff and Board members as appropriate, on the policies, procedures, processes, and guidance developed in Recommendation parts A through E
- ◆ Training and information will be communicated in person at all-staff meetings twice per month, and through the use of required on-line training modules each employee must pass upon hire (and annually re-certify), and through the internal publication of a common repository of established policies and procedures
- ◆ With the hire of a general counsel, COHBE is implementing an organizational-wide oversight, monitoring, and compliance program – a description of which was submitted to the Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, on October 17, 2014

Implementation Date	6/1/15	Completion Date	
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1 – G: *Recovering payments for the unallowable costs and payment errors identified in this audit, including identifying and recovering payments to vendors made using the cost plus a percentage method and reporting the results of these efforts to the Board. This should include reviewing current vendor contracts to identify those allowing the cost plus a percentage payment, revising the contracts, and prohibiting future contracts from allowing this payment method.*

- ◆ COHBE will conduct an internal audit by the end of this year to identify unallowable costs, and an adjustment will be made in the Intacct accounting software to reclassify the funding source to non-federal grant funds
- ◆ An internal tracking process will be used to ensure that the next request for payment from the payment management system is reduced by that amount
- ◆ With ongoing internal auditing, unallowable costs will be identified and adjusted accordingly
- ◆ The Board’s Finance Committee will be advised on all identified costs, payments, and corrective actions with respect to material agreements
- ◆ General Counsel (or other appropriate legal staff) will review each material agreement for compliance with applicable regulatory requirements and other transactional best practices
- ◆ For vendors with a continuing relationship with COHBE, oversight processes on vendor payment will be used to recover or net out vendor payments to eliminate overpayments or other identified accounting errors

Implementation Date	3/15	Completion Date	12/14
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SECTION 2 – ADMINISTRATION OF FEDERALLY FUNDED CONTRACTS

2 – A: Establishing a comprehensive written procurement policy or procedure that specifies the Board of Directors’ (Board’s) responsibilities for contract approval. This should include establishing an appropriate minimum threshold for executing contracts, implementing a consistent Board-approval procedure for all contracts of \$150,000 or more, and establishing reporting and approval procedures for payments that exceed the amount that was approved by the Board.

- ◆ To obtain federal grants in 2012, COHBE was required to have in place federally approved procurement policies and procedures
- ◆ COHBE agrees with audit findings and will establish a more comprehensive written procurement policy and applicable procedures that specifies the Board of Directors’ (Board’s) responsibilities for contract approval
- ◆ This will include establishing an appropriate minimum threshold for executing contracts, implementing a consistent Board-approval procedure for all contracts of \$150,000 or more, and establishing reporting and approval procedures for payments that exceed the amount approved by the Board
- ◆ In October 2014, COHBE began updating current procurement policies to include a more robust process in conjunction with the executive management team, members of the Board’s Finance Committee, and the Board with respect to procurement and independent contractor management, including:
 - i) An appropriate minimum threshold for executing contracts
 - ii) Consistent Board-approval procedure for all contracts with a specified threshold
 - iii) Reporting and approval procedures for payments that exceed thresholds approved by the Board
- ◆ The procedure will address multiple individual “statements of work” from a single vendor below any applicable approval threshold that may cumulatively exceed the threshold over time so as to clarify the circumstances when additional Board approval will be required
- ◆ These updated policies will be presented to the Finance Committee and Board of Directors in January, 2015 for approval before final implementation

Implementation Date	1/15	Completion Date	
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2 – B: Establishing and implementing procedures and processes to accurately track each contract and monitor payments to vendors to ensure that payments do not begin before the contract is fully executed and do not exceed contract amounts without appropriate Board and management approval, an executed addendum to the contract statement of work, and documentation of the services provided.

- ◆ COHBE agrees with the audit findings regarding the accurate tracking of contract amounts, terms and payments

- ◆ The Controller, Assistant Controller, and Accounts Payable Specialist were trained in October on Intacct’s tools and workflow processes to track vendor contracts through the Purchase Order and Project Modules
- ◆ A customized report will be finalized by the end of December that will show contract amount, term, spend to date, and balance
- ◆ Work on this report began in November and will be tested and audited to ensure accuracy
- ◆ This report will be monitored monthly by the Controller and Accounts Payable Specialist. With the implementation of these accounting tools, COHBE will establish and implement procedures and processes to document this
- ◆ These procedures will include how to accurately track each contract, monitor payments to vendors to ensure appropriate timing of payments, and that payments do not exceed contract amounts without appropriate Board and management approval, an executed addendum to the contract statement of work, and documentation of the services provided
- ◆ Oversight and management of vendor relationships by General Counsel and legal staff will ensure that each contract contains all the appropriate language, that appropriate Board and executive level approval exists and that the terms and conditions lay out all appropriate, required and prudent contract terms

Implementation Date	3/15	Completion Date	3/15
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2 – C: Consistently utilizing contract templates that include federally required provisions and developing and implementing written procedures to review all contracts for completeness before they are executed. This should include ensuring contracts contain all required provisions, are signed by authorized management, and specify statements of work, periods of performance, and payment terms.

- ◆ COHBE will consistently utilize contract templates that include federally required provisions and develop and implement written procedures to review all contracts for completeness before they are executed
- ◆ This will include ensuring contracts contain all required provisions, are signed by authorized management, and specify statements of work, periods of performance, and payment terms
- ◆ As noted in Recommendation 2, Part B, COHBE’s General Counsel will oversee and monitor all contractual procedures
- ◆ The addition of COHBE’s General Counsel will help ensure that this template is used for all contracts, and that written procedures are updated as needed
- ◆ This will include ensuring contracts contain all required provisions, are executed by an individual clothed with the authority to bind the organization, and contain all appropriate, required, and prudent terms and conditions

Implementation Date	1/15	Completion Date	12/14
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2 – D: Establishing and implementing written procedures to ensure that complete information about contracts exceeding the approval thresholds is provided to the Board and documented in the Board minutes. This should include a process to ensure Board approvals are documented.

- ◆ COHBE agrees with the state audit findings regarding the need for documentation of Board decisions
- ◆ In combination with the revision of the procurement policies detailed in Recommendation 2, Part A, and the implementation of the finance tools and reports detailed in Recommendation 2, Part B, COHBE will take steps to document all Board decisions as well
- ◆ The steps that are being taken to accomplish this documentation are:
 - i) Improving an existing spreadsheet document that memorializes action items from previous Board Meetings and policy decisions to include
 - Vendor name and contract amount and terms
 - Board votes, including unanimous votes, and counts on Yes/No votes
 - ii) Enlisting staff to capture historical decisions in this spreadsheet by researching Board meeting documentation on file
- ◆ COHBE will establish and implement written procedures to ensure that complete information about contracts exceeding the approval thresholds is provided to the Board and documented in Board minutes. This will include a procedure detailing the Board documentation process detailed above.

Implementation Date	3/15	Completion Date	
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2 – E: Training management, staff, and Board members, as appropriate, on the policies, procedures, and processes developed in recommendation parts A through D.

- ◆ COHBE will train management, staff, and Board members, on the new or improved policies, procedures, and processes developed in recommendation parts A through D

Implementation Date	6/15	Completion Date	
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SECTION 3 – GRANTEE PAYMENTS AND REIMBURSEMENTS

3 – A: *Establishing and implementing comprehensive written policies and procedures to administer its grant program. This should include policies and/or procedures that prohibit the organization from obtaining or using federal funds for grantees that are prohibited from receiving federal funds; ensure grantees are paid in compliance with their contract terms and the documentation supporting grantees' actual costs; and ensure timely payment processing.*

- ◆ COHBE will establish and implement additional written policies and procedures to administer its grant program
- ◆ This will include policies and/or procedures that control the use of federal funds for grantees; ensure grantees are paid in compliance with their contract terms and the documentation supporting grantees' actual costs; and ensure timely payment processing
- ◆ COHBE will implement written policies and procedures regarding the administration of COHBE's grant program

Implementation Date	3/15	Completion Date	3/15
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3 – B: *Establishing and implementing processes to oversee the grant program, including ensuring that there are adequate staff to review and process payment requests in a timely manner; ensuring staff review documentation supporting grantee payment requests and correct errors prior to payment; implementing consistent supervisory reviews of transactions before grantees are paid; and accurately recording all transactions in the general ledger.*

- ◆ COHBE will review and update written policies and procedures regarding the administration of COHBE's grant program, which was approved and monitored by the federal government under its grant award
- ◆ In May of this year, COHBE hired new staff and began implementation of additional procedures to ensure:
 - i) That there is adequate staff to review and process payment requests in a timely manner
 - ii) Ensure staff review documentation supporting grantee payment requests and correct errors prior to payment
 - iii) Implement consistent supervisory review of transactions before grantees are paid; and accurately record all transactions in the general ledger
- ◆ This procedure, which includes review by COHBE's Controller prior to the disbursement of funds, has helped to ensure that grantees are paid in compliance with their contract terms and the documentation supporting costs has been received
- ◆ The procedure further ensures timely payment processing

- ◆ Grantees have not experienced delays in reimbursement payment since July, 2014
- ◆ Requests for reimbursement contain appropriate and adequate documentation, and reimbursement is being made from appropriate funding sources

Implementation Date	12/14	Completion Date	12/14
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3 – C: Evaluating the practice of making advance payments to grantees before services are provided. If this practice continues, Connect for Health should develop a written policy and/or procedure requiring grantees to submit documentation demonstrating an immediate need before making advance payments grantees; an appropriate supervisory review of all advance payments for reasonableness, appropriateness, and federal compliance; and a reconciliation to ensure grantees spend all advances before receiving subsequent advances.

- ◆ Over the past three months, COHBE has been able to improve internal processes to ensure timely payment of grantees reimbursement requests
- ◆ COHBE’s management and staff have worked with grantees who were not consistent in providing the appropriate documentation after being awarded an advance payment
- ◆ Internally, COHBE now has tracking tools to ensure that grantees who are being awarded advances have submitted their previous month’s reimbursement documentation, and that the outstanding advanced monies are not more than they have historically shown a need for on a monthly basis. If the balance in a grantee’s advance account is greater than historical monthly need, the advance has been denied and the organization was notified to determine how to proceed.
- ◆ Additionally, COHBE’s improved internal processes and the hiring of staff has reduced the repayment time for reimbursement requests, thus allowing those grantees requesting advances to be reduced as well, as follows:
 - i) February 2014 – 11 grantees requested advances of \$379,487
 - ii) September 2014 – 3 grantees requested advances of \$59,480
- ◆ The three grantees who are still requesting advances have been notified of the controls implemented by COHBE in late July, and were queried as to whether they would be capable to continue exchange activity without advances in the future. Two of the three have indicated that this amount is still necessary. The third grantee has been converted to a reimbursement-only payment type.

Implementation Date	3/15	Completion Date	12/14
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3 – D: *Investigating each instance of overpayment, noncompliance, and error we identified in the audit and recover funds from grantees, as appropriate.*

- ◆ COHBE’s internal review processes were strengthened in February, when COHBE hired a Controller (filling a vacancy), and continued in full force in May, when new grant accounting staff was hired
- ◆ Moving forward, for any organization or vendor where an overpayment, noncompliance indicating an overpayment, or where errors have been identified which result in under or overpayments, the amounts and instances will be reviewed and addressed by the Controller
- ◆ Meetings will be scheduled with organizations to discuss the results of any review or investigation. As appropriate, reimbursement payment requested by an organization will be reduced or increased.
- ◆ This review and adjustment process will be ongoing and will continue through the grantee award cycle as appropriate. This process is intended to ensure that federal funds are tracked and maintained pursuant to all applicable regulatory authority

Implementation Date	3/15	Completion Date	12/14
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SECTION 4 – FINANCIAL ADMINISTRATION AND MANAGEMENT

4 – A: Establishing and implementing appropriate written financial policies, procedures, and internal controls that ensure proper accounting, recording of all checks and financial transactions, and compliance with applicable laws, regulations, and internal requirements. This should include developing procedures for identifying, reporting, investigating, and correcting transactions that appear noncompliant with laws, regulations, and requirements; developing policies and procedures over reimbursing staff for purchases, such as supplies, equipment and overtime meals; and considering centralizing procurement for office items such as supplies and equipment.

- ◆ COHBE will establish and implement additional appropriate written financial policies, procedures, and internal controls that ensure proper accounting, recording of all checks and financial transactions, and compliance with applicable laws, regulations, and internal requirements
- ◆ This will include developing more robust procedures for identifying, reporting, investigating, and correcting transactions that appear noncompliant with laws, regulations, and requirements; developing policies and procedures over reimbursing staff for purchases, such as supplies, equipment and overtime meals; and considering centralizing procurement for office items such as supplies and equipment
- ◆ Additional improvements will include financial policies, procedures and internal controls regarding all revenue transactions
- ◆ Employee requests for reimbursement are formalized in an on-line accounting process requiring documentation and approval
- ◆ With the continuing maturation of COHBE from its initial start-up as a new state-based marketplace, accounting and oversight processes for low-dollar recurring expenses will be established through appropriate accounting protocols
- ◆ COHBE will use a corporate credit card to expedite and control the recurring low-dollar administrative costs with appropriate use restrictions and oversight

Implementation Date	3/15	Completion Date	3/15
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4 – B: Ensuring that an appropriate number of staff and supervisors are assigned to accounting functions, with the appropriate levels of system access and segregation of duties controls in place.

- ◆ COHBE agrees with the state audit findings and will review current staffing and make changes as needed to ensure that an appropriate number of staff and supervisors are assigned to accounting functions, with appropriate levels of system access and segregation of duty controls
- ◆ From the first full operations as a new non-profit in 2012, COHBE has focused on identifying staffing needs and the stabilization within all functional areas of operation

- ◆ Vendor billing and payment processes continue to evolve to meet identified needs as COHBE continues to establish itself as a sustainable organization
- ◆ COHBE is currently searching for a new CFO with the assistance of a professional search firm – COHBE’s first hiring priority is a new CEO/Executive Director
- ◆ An internal audit position is under consideration given the volume and burden associated with approximately 30 audits and reviews of COHBE in its first 30 months of operation
- ◆ COHBE retained general counsel with over 25 years of experience on September 2nd, 2014 to assist in the implementation of an organization-wide governance and compliance program addressing the breadth and scope of the each Recommendation provided by the Office of the State Auditor

Implementation Date	6/15	Completion Date	
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4 – C: Establishing and implementing periodic risk-based quality control reviews to ensure organizational compliance with laws, regulations, and internal policies and procedures. This should include reporting the results of the reviews to the Board, and revising policies and procedures, as appropriate, based on the results of the reviews.

- ◆ COHBE has submitted an Oversight and Monitoring Program description to CMS/CCIIO as part of a comprehensive process to implement an over-arching and holistic monitoring, compliance and quality control program for the functional and operational components of a state-based marketplace
- ◆ The comprehensive program description was submitted for review and feedback on October 17th, 2014
- ◆ As COHBE moves from a start-up organization in the implementation phase into sustainability and operation as a more mature entity, oversight, monitoring, compliance and quality control processes will be continually reviewed and amended as the regulatory environment evolves at both a state and a federal level
- ◆ COHBE recognizes its obligation to ensure on-going compliance and appropriate market conduct in keeping with its statutory mission

Implementation Date	4/15	Completion Date	
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4 – D: Training Board members, management, and appropriate staff on the policies and procedures established in recommendation parts A, B, and C above.

- ◆ COHBE will train Board members, management, and appropriate staff on the policies and procedures established in recommendation parts A, B, and C above, as detailed through-out the various responses contained herein
- ◆ COHBE will work with Board members, management and staff to determine the most effective way of conducting this training including staff meetings, on-line training, new staff training, and any other methods identified

Implementation Date	6/15	Completion Date	
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SPARK POLICY INSTITUTE
igniting public policy and community change

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 through 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, there 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 through 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.

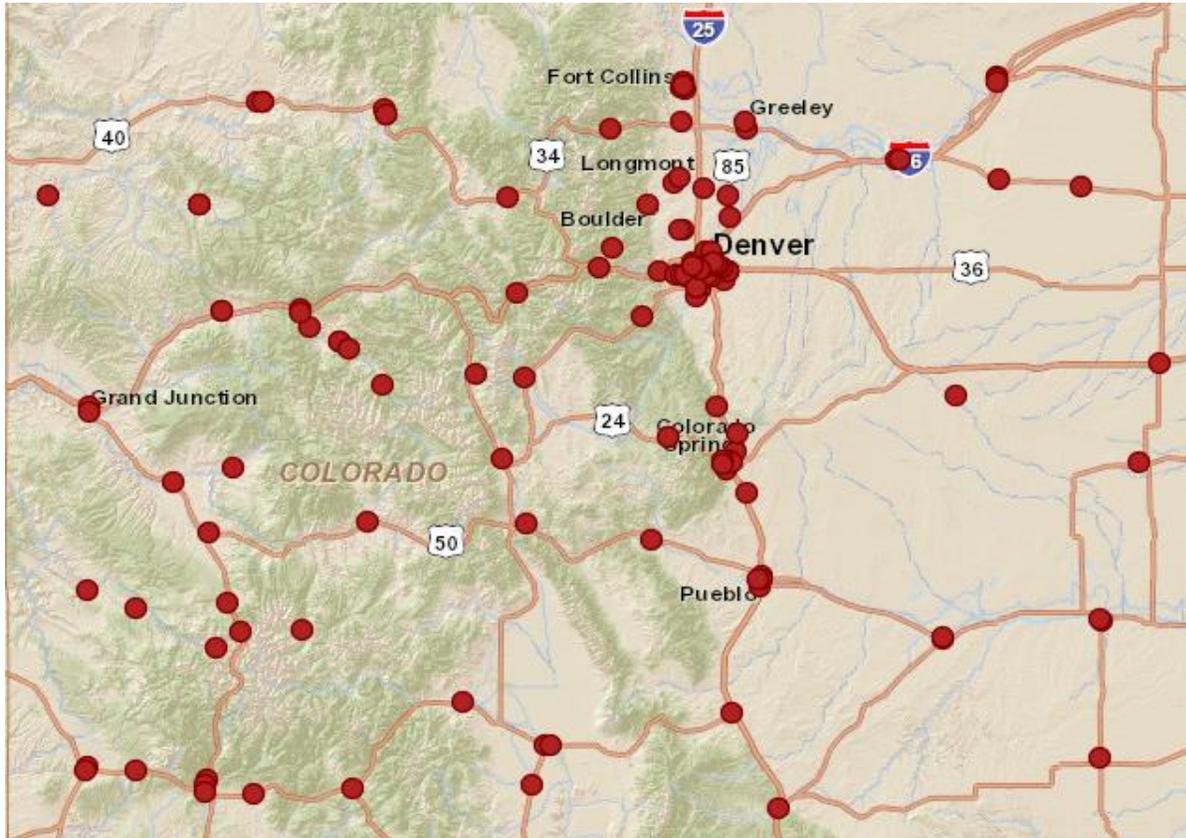
THE ASSISTANCE NETWORK

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 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.

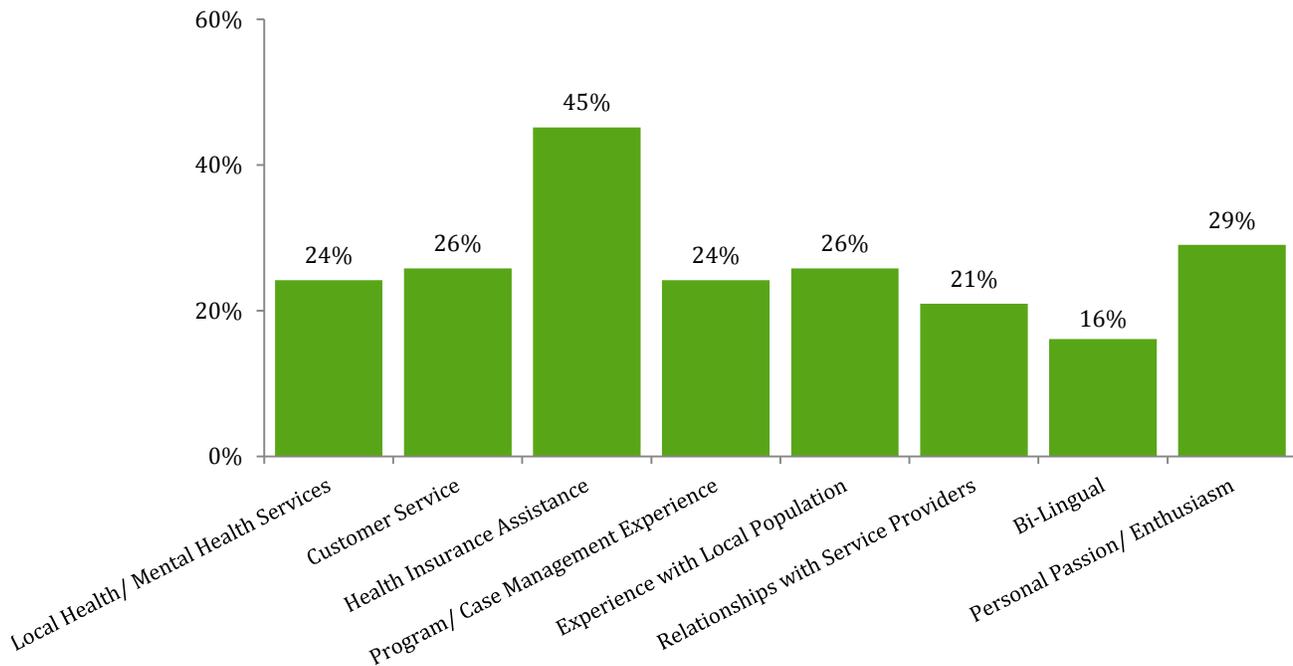
HEALTH COVERAGE GUIDES

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*

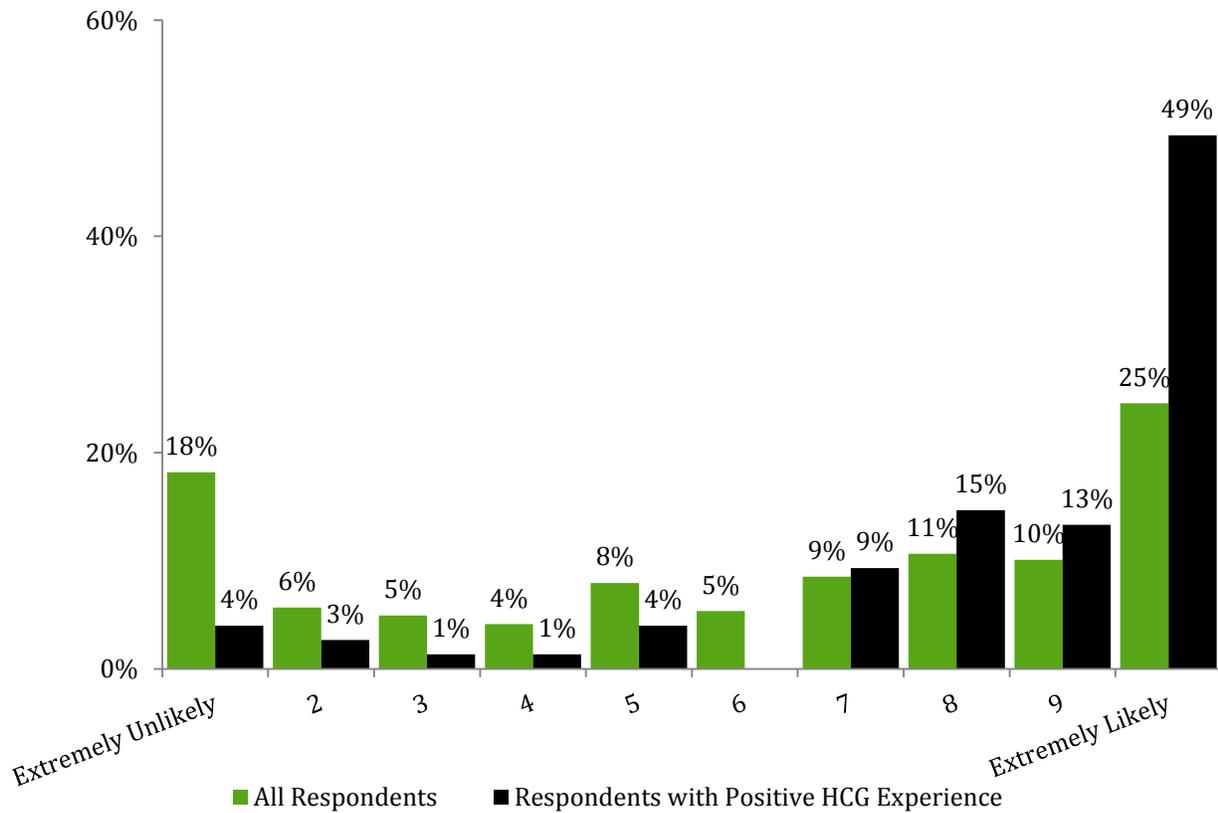
Overall, the data suggests health coverage guides had a significant impact on every aspect of the client experience. From open-ended customer satisfaction survey data, it is evident that the support of a health coverage guide was critical to getting many clients enrolled in a health plan. Indeed, some 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 C4HCO¹. 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 assistance². 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 measurements³. 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

¹Note: 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.

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

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*

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 difference 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 were 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, there 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

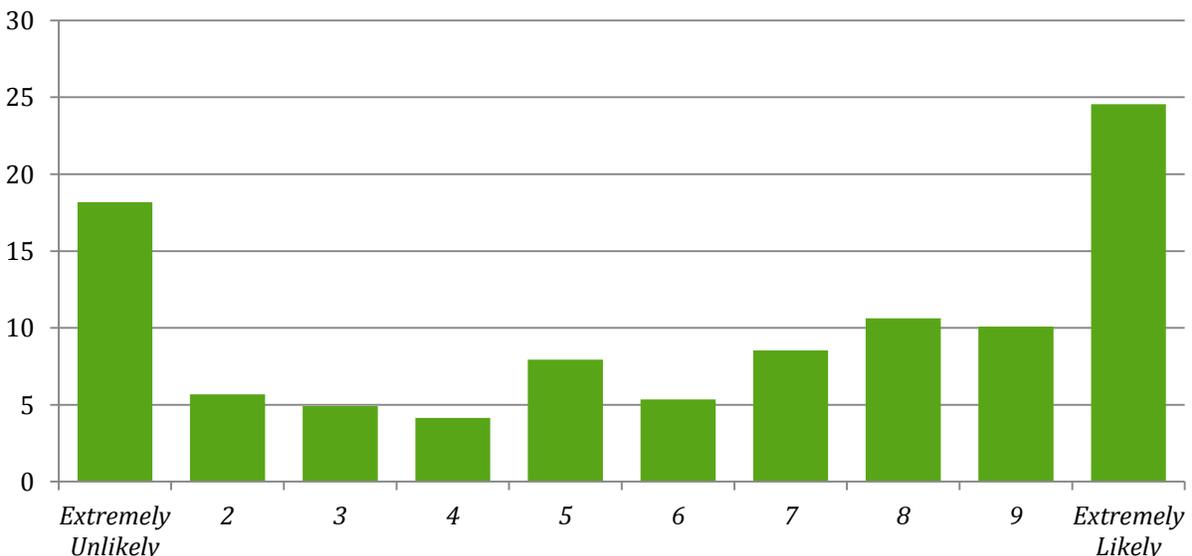
Ethnic Group	In-Person Presentations	Fairs/ Enrollment Events	Conversations	Trained Spokespeople
Under 18 years old	28%	25%	35%	9%
Age 19-25	51%	46%	58%	14%
Age 26-35	63%	48%	61%	14%
Age 36-45	64%	45%	62%	14%
Age 46-55	61%	44%	64%	16%
Age 56-65	57%	45%	61%	16%
Over 65 years old	18%	20%	23%	7%

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

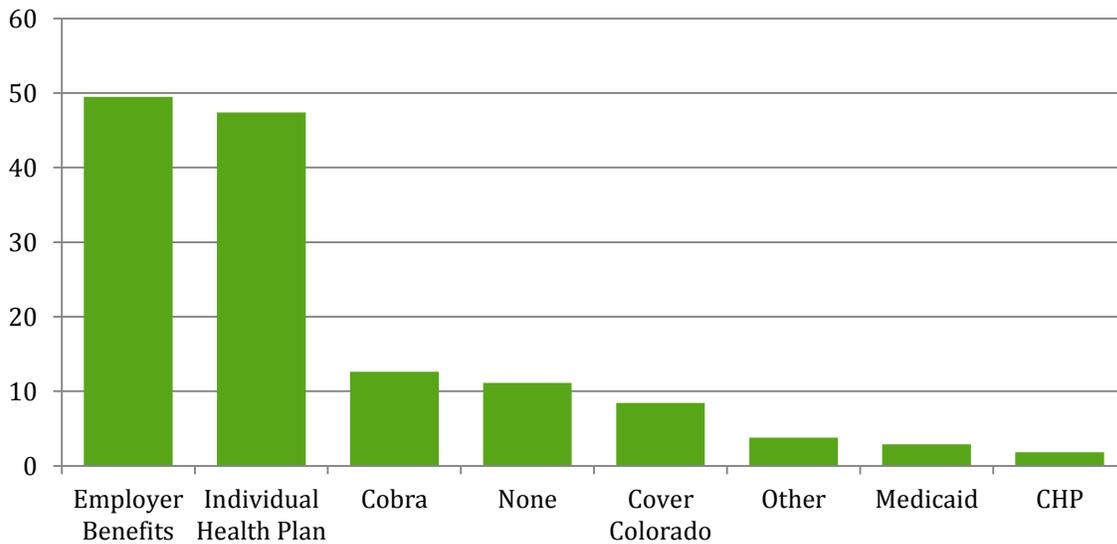


From whom did the client receive assistance?

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			

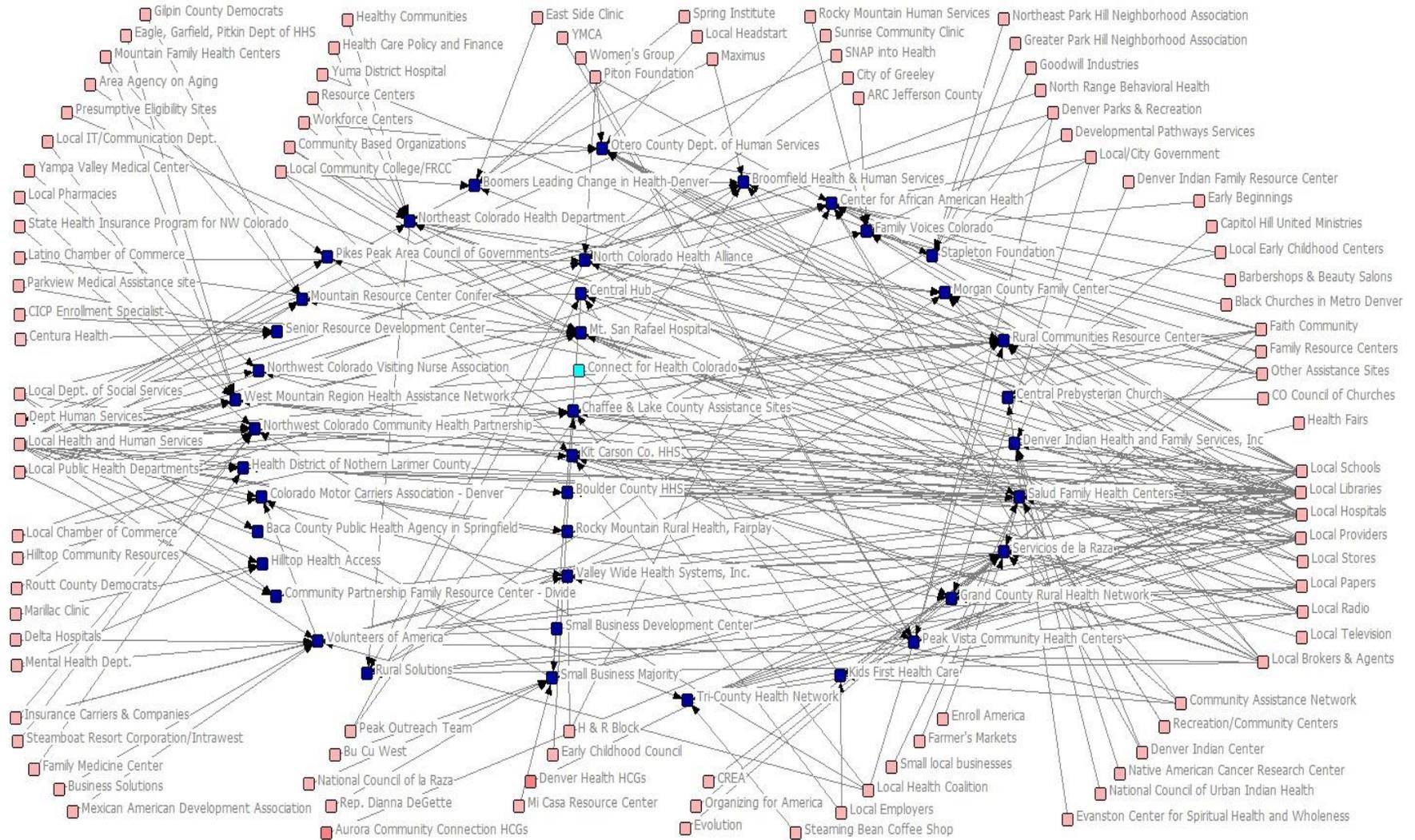
Note: All factors are significant $p>0.05$ except the Connect for Health Online Index

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 χ^2 (Prob > χ^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.



Connect for Health Colorado: Results and Recommendations From Website Usability Testing with Consumers

Deliverable 20.1.f.3: Consumer Website Usability Report, Connect for Health Colorado (Draft Work Product Version 2)

March 13, 2015

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I. Executive Summary

Introduction and Methods

This report summarizes the results of consumer usability testing of Connect for Health Colorado's website, developed and maintained by the Health Insurance Marketplace in Colorado. Usability testing focused on the key functions of the Marketplace website, including helping consumers assess their eligibility for Qualified Health Plans (QHPs) offered through the Marketplace and public and private subsidies; comparing and choosing a QHP; and enrolling in a plan.

American Institutes for Research[®] (AIR[®]), contracted by the Centers for Medicare & Medicaid Services (CMS), conducted the assessment in December 2014. During the testing, AIR facilitators guided 10 participants through 11 tasks on the website.¹

Findings and Recommendations

Overall, participants were able to complete most tasks. Some tasks were relatively easy for participants to complete, such as the Get Started (Tasks 1–2) and Get Help (Tasks 9–10) tasks.

However, the Assess Eligibility (Tasks 3–5) and Compare, Select, and Enroll in a Health Plan (Tasks 6–8) tasks were more challenging for participants. They struggled with the length of the shared eligibility application as well as understanding some of the questions in the application. Participants also had difficulty comparing health plans and understanding health insurance terms (e.g., coinsurance). However, difficulty understanding health insurance is not a challenge that is unique to the Marketplace; problems with health insurance literacy are widespread.^{2,3}

Connect for Health Colorado can begin to address some of these challenges with small immediate changes, but other challenges will require longer term efforts. For example, adding in-text definitions of complex terms is one immediate step to help consumers better understand health insurance. Ultimately, improving health insurance literacy is a long-term effort.

Strengths

Participants were able to complete several tasks with ease and had a positive experience while completing them:

- Participants were able to **identify the website purpose** as helping people in Colorado get health insurance. (*Task 1: Find website purpose*)
- Participants were able to easily **navigate to the account creation page**. (*Task 2: Create account*)
- Participants were able to **find a checklist of documents** for the shared eligibility application. (*Task 3: Find list of information needed to apply*)

¹ Because of time constraints, the facilitator asked participants to complete a subset of the 11 tasks.

² Paez, K., & Mallery, C. (2014, October). *A little knowledge is a risky thing: Wide gap in what people think they know about health insurance and what they actually know*. Retrieved from, http://aircpce.org/wp-content/uploads/2014/10/11801-451-05_Issue_Brief_102014.pdf

³ Parragh, Z. A., & Okrent, D. (2015). *Health literacy and health insurance literacy: Do consumers know what they are buying?* Retrieved from http://www.allhealth.org/publications/Private_health_insurance/Health-Literacy-Toolkit_163.pdf

- Most **found information on how to appeal** an eligibility decision without any major problems. *(Task 4: Find appeals information)*
- Participants easily **found information on how to get assistance** by phone or in-person. Many said they would prefer to find help online or over the phone. However, no one found the online chat feature. *(Task 9: Find where to get help)*

Areas for Improvement

Participants also experienced challenges completing several tasks; however, Connect for Health Colorado can implement several things to help improve the consumer experience:

- Participants struggled with the **number of questions in the shared eligibility application** and the amount of time it took to complete. *(Task 5: Determine eligibility)*
 - *Recommendation:* Review the questions to determine whether all are critical for Connect for Health Colorado to collect. In addition, consider whether some of the information can automatically populate from the account creation page or other sources.
- Participants had difficulty **understanding some of the shared eligibility application questions**, such as: “Who is Helping You?”, “Program Selection: Medical assistance or none,” and “individual shared responsibility exemption.”
 - *Recommendation:* Revise the wording of some of the questions and add in-text plain language definitions for complex or confusing terms.
- Participants had difficulty **using some of the plan shopping features**, such as the “apply filters” button, two-sided filters, and “compare X plans” button.
 - *Recommendation:* Implement improvements to these features so plan lists update automatically when filters are adjusted, make the slider ends more noticeable, and place “compare X plans” buttons on the right side above and below the plan list.
- Participants had **difficulty comparing health plans and understanding health insurance terms**. But difficulty understanding health insurance is not a challenge that is unique to the Marketplace; problems with health insurance literacy are widespread.^{2,3} *(Task 6: Compare health plans)*
 - *Recommendation:* Provide brief in-text definitions of health insurance terms. Consumers could benefit from having definitions and examples of insurance terms easily accessible while they compare plans.
- Participants were confused by the **results received when using the search box on the homepage** because results from the Connect for Health Colorado website were not prominently featured. *(Task 9: Find where to get help)*
 - *Recommendation:* Modify the search box on the homepage to feature primarily results from the Connect for Health Colorado site.

II. Introduction

Purpose

This report summarizes the results of consumer usability testing of Connect for Health Colorado's website, developed and maintained by the Health Insurance Marketplace in Colorado. Consumer website usability testing gathers information about whether—⁴

- Consumers are able to readily find the information they want (navigation)
- Consumers can interpret the language used and information as intended (comprehension)
- The website provides information about what consumers want to know (relevance)

To do this, the Centers for Medicare & Medicaid Services (CMS) contracted with American Institutes for Research[®] (AIR[®]) to conduct website usability assessments with consumers. This work is part of CMS' contract with AIR to provide technical assistance (TA) to the Marketplaces. The contract with AIR also funds the development, testing, and implementation of two consumer experience surveys, which will provide standardized information on consumers' experiences with the Marketplaces and the Qualified Health Plans (QHPs) offered through the Marketplaces.⁵ Health Insurance Marketplace Survey (Marketplace Survey) scores provide general feedback about how consumers view the Marketplace website experience and other aspects of Marketplace performance.

To support Marketplaces in using the results of the Marketplace Survey and improving the consumer experience, in 2015, CMS will be publishing the Marketplace Survey Improvement Guide. The Guide will also include suggestions for improving website usability (see exhibit 1).

The purpose of the usability testing was to provide the Marketplaces with feedback that—

- Improves the consumer's experience
- Informs the interpretation of the Marketplace Survey scores

Exhibit 1. Helping the Marketplace Improve the Consumer Experience

In 2015, CMS will publish the Marketplace Survey Improvement Guide. Some of the topics addressed in the Guide will include:

- Applying website usability principles to help consumers easily find information they need on your Marketplace's website
- Using plain language to help consumers find, understand, and use information to make informed decisions
- Providing consumer decision-support tools that help consumers manage the amount of information they see and make informed choices

The Guide will be available at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html>

⁴ Nielsen, J., & Loranger, H. (2006). *Prioritizing Web usability*. Berkeley, CA: Nielsen Norman Group.

⁵ For further information about the survey, see: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html>

The usability testing focused on the key functions of the Marketplace websites, including helping consumers determine their eligibility for Marketplace QHPs offered through the Marketplace and public and private subsidies; comparing and choosing a QHP; and enrolling in a plan.

This report describes results and recommendations from the usability testing. Each Marketplace will choose to follow through on some recommendations but not others, taking into consideration their circumstances and overall priorities. Some of the recommendations, such as small changes to Web content, may be relatively easy to implement. Other recommendations may require more extensive resources and time, such as extensive programming or additional Marketplace infrastructure. Marketplaces may choose to address resource-intensive recommendations at a future point or over multiple years.

Most of the recommendations focus on the immediate goal of providing consumers with a positive enrollment experience. However, longer-term goals include improving health insurance literacy among consumers. For example, adding in-text definitions of complex terms is one immediate step to help consumers better understand health insurance. Ultimately improving health insurance literacy is a long-term effort.

Methods and Population

To assess the usability of the websites, AIR experts in measure development, public reporting, plain language, consumer engagement, and website usability developed a semi-structured interview protocol to guide consumers through 11 tasks on the website (exhibit 2). AIR worked with Connect for Health Colorado to tailor the protocol to focus on the testing tasks and participant characteristics that were of greatest interest to them. See appendix B for the testing guide.

Population. AIR recruited consumers with demographic characteristics of people eligible to shop for and purchase insurance through the Marketplace website. Ten people participated in the testing. See appendix C for more details on the population and methods used to conduct and analyze the findings from the assessment.

Limitations. There are several limitations to this testing:

- **Participants and testing.** The participants fit the demographic criteria of those who were eligible to purchase health insurance through the Marketplace; however, they were not required to be shopping for insurance through the Marketplace. Therefore, they were less invested in completing the tasks than a consumer actively looking to get health insurance through the Marketplace. In addition, participants knew this was a test; therefore, they may have spent less time completing some tasks (e.g., comparing health plans) than they would in a real-life situation. AIR encouraged participants to make decisions that were as realistic as possible.
- **User Acceptance Testing (UAT) environment.** The testing to determine eligibility, compare plans, and enroll was conducted in the UAT environment, which may not be identical to the production website in terms of content and traffic volume.
- **Time and travel.** Testing sessions were conducted at the Connect for Health Colorado office between the hours of 8:30 a.m. and 5:30 p.m. Therefore, participants who were not able to travel or complete the testing during these hours are not represented.
- **Language.** Individuals who were not comfortable reviewing a website in English and answering questions in English were not included. This is a subset of the population that the Marketplace serves. Future testing should consider including people whose primary language is not English and should also explore testing the accessibility of the website for visually impaired consumers.

- **Task duration.** Participants were asked to “think aloud” while performing tasks, which likely affected task duration.

Exhibit 2. Usability Testing Tasks⁶

Tasks 1–2: Get Started

- **Task 1:** Find and tell me the purpose of this website.
- **Task 2:** Create an account for this website.

Tasks 3–5: Assess Eligibility

- **Task 3:** Find a list of the types of information or documents you would need to apply for health insurance.
- **Task 4:** Find information about how to appeal a decision from the Marketplace.
- **Task 5:** Assess your eligibility to receive financial assistance to purchase the health insurance.

Tasks 6–8: Compare, Select, and Enroll in a Health Plan

- **Task 6:** Find and compare the features of at least two of the health insurance plans that you think might be a good fit for you.
- **Task 7:** Select the health plan that would be best for you.
- **Task 8:** Complete the enrollment process.

Tasks 9–10: Get Help

- **Task 9:** Find out where you could get help if you were using this website and had questions.
- **Task 10:** Find a list of frequently asked questions (FAQs).

Task 11: Word Activity

- **Task 11:** Select five words that describe your experience using the website.

⁶ AIR did not test two originally planned tasks: (1) “Identify the steps (or process) to apply for a health insurance plan through the Marketplace website,” and (2) “In your own words, tell me what this notice tells you [show eligibility notice].” The first task was not included because this information was not available on the website; the second, because AIR did not receive real-time eligibility notices during testing.

III. Summary Results

Overall, participants were able to complete most of the tasks. Some of the tasks were relatively easy for participants to complete, such as the Get Started (Tasks 1–2) and Get Help (Tasks 9–10) tasks. However, the Assess Eligibility (Tasks 3–5) and Compare, Select, and Enroll in a Health Plan (Tasks 6–8) tasks were more challenging for participants. They struggled with the length of the application to assess their eligibility for financial assistance, as well as understanding some of the questions in the application. Participants also had difficulty comparing health plans and understanding health insurance terms. But difficulty understanding health insurance is not a challenge that is unique to the Marketplace; problems with health insurance literacy are widespread.^{2, 3}

Connect for Health Colorado can begin to address some of these challenges with relatively small immediate changes, whereas others will need more long-term efforts. For example, adding in-text definitions of complex terms is one immediate step to help consumers better understand health insurance. But, ultimately improving health insurance literacy is a long-term effort (see exhibit 3 for resources).

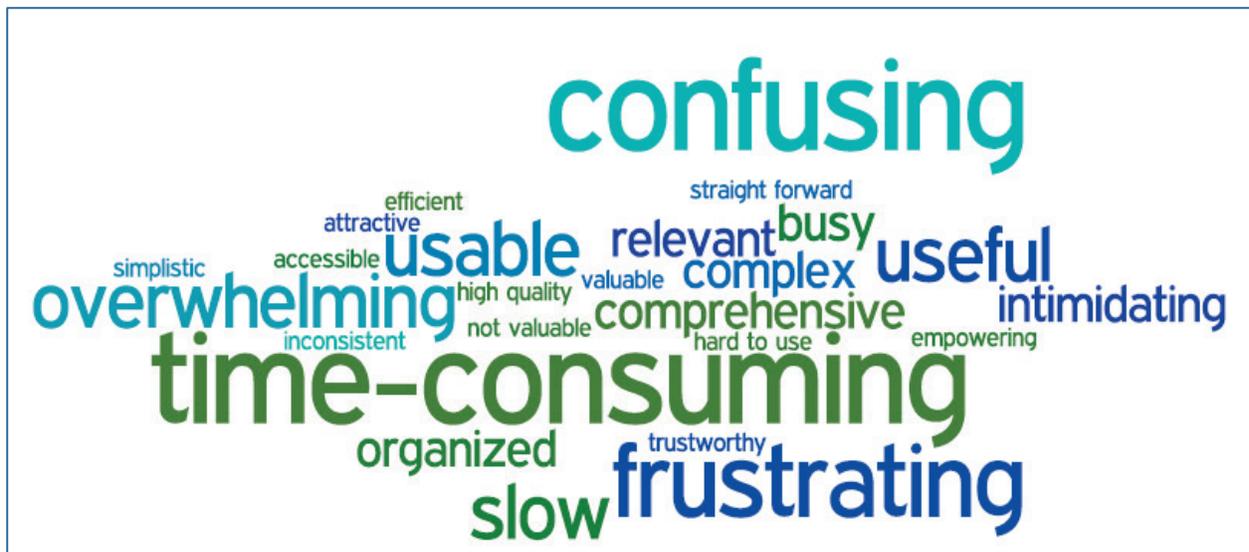
Exhibit 3. Resources for Long-Term Efforts to Improve Health Insurance Literacy

- National Academy for State Health Policy, Around the Network Promising Practices: Health Insurance Literacy, https://www.statereforum.org/sites/default/files/promising_practices_health_insurance_literacy_january_2015.pdf
- Enroll America, Health Insurance Literacy Resource Hub, <http://www.enrollamerica.org/hil/>
- Alliance for Health Reform, Health Literacy and Health Insurance Literacy: Do Consumers Know What They Are Buying? http://www.allhealth.org/publications/Private_health_insurance/Health-Literacy-Toolkit_163.pdf
- Pacific Business Group on Health, Supporting Consumers' Decisions in the Exchange, <http://www.pbgh.org/key-strategies/engaging-consumers/216-supporting-consumers-decisions-in-the-exchange>
- Marketplace Survey Improvement Guide, available in 2015 at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html>

Words That Describe Participant’s Overall Experience

At the end of each test session, participants selected five words that best described their experience using the website (Task 11).⁷ The results are shown in the word cloud in figure 1. The most popular words (chosen by five participants) were “confusing” and “time-consuming.” Some also said that their experience was “overwhelming” or “frustrating.” When participants used the words “frustrating,” “overwhelming,” or “time-consuming” to describe their experience using the website, it was in reference to the time it took to go through the financial eligibility application (Task 5) and/or the comparing and selecting a health plan page (Tasks 6-8). While most participants saw the value in using the Connect for Health Colorado website to apply for financial assistance and purchase health insurance, they were generally dissatisfied with their experience on the site. But some called the site “useful” and “usable” and “organized.” Those who described it as organized liked the FAQs page and thought the information was well-organized and useful. Others said it was “relevant” because everyone needs health insurance.

Figure 1. Words Chosen by Participants to Describe Their Experience Using the Website (Task 11 Results)



Summary Results and Recommendations

Table 1 summarizes the results and recommendations to improve the usability of the Connect for Health Colorado website. The last column of the table also suggests the order in which Connect for Health Colorado may want to prioritize the recommendations. The priority categories are as follows:

- **Priority 1** – changes that may be relatively easy to implement or are critical to core website functions (short-term changes)
- **Priority 2** – changes that may require a moderate amount of effort (mid-term changes)
- **Priority 3** – changes that may require more significant time and resources (long-term changes).

⁷ Benedek, J., & Miner, T. *Measuring desirability: New methods for evaluating desirability in a usability lab setting*. Microsoft Corporation, Retrieved from: <http://www.uxmatters.com/mt/archives/2010/02/rapid-desirability-testing-a-case-study.php>

Each Marketplace’s circumstances and priorities are unique; therefore, it will be important for each Marketplace to review the recommendations and suggested priorities to determine what changes are the most feasible to start with and what changes should be addressed at a future point or over multiple years.

Table 1. Results and Recommendations

Task	Results and Reactions	Recommendations	Priority ⁸
Tasks 1–2: Get Started			
Task 1: Find and tell me the purpose of this website.	Most participants were able to identify the website purpose as a place to help people in Colorado get health insurance.	No changes needed.	NA
	Some commented that the photo banner on the homepage was too large or busy, which made it more difficult for some to find information on the website’s purpose.	Reduce the size of the photo banner on the homepage so people can more easily see the main website buttons such as “Individuals and Families – Current Customers.”	1
Task 2: Create an account for this website.	Participants were able to easily navigate to the account creation page.	No changes needed.	NA
	Since the “username” field autopopulated with the participant’s email address, some participants were confused about whether they could create their own username or they had to use their email address.	Add a note above the username field to explain that consumers can use their email address or create their own username. For example, “You may use your email address as your username, or you can choose your own.” The note should be in a different font or italicized to help distinguish it from the field name.	1
	Some participants wanted to see a confirmation screen after they finished creating their account.	Create a confirmation page after the user has created his/her account that says something such as: “Congratulations, you have created an account with Connect for Health Colorado.” The message should then provide instructions on how to log in.	1
Tasks 3–5: Assess Eligibility			
Task 3: Find a list of the types of information or documents you would need to apply for health insurance.	Most were able to find a checklist of documents for the financial assistance application.	No changes needed.	NA

⁸ Priority 1 = changes that may be relatively easy to implement or are critical to core website functions; priority 2 = changes that may require a moderate amount of effort; priority 3 = changes that may require more significant time and resources.

Task	Results and Reactions	Recommendations	Priority ⁸
	Some participants were confused by the list of documents because they were not sure if the same documents were needed by those who were not applying for tax credits. Also at this point, they were not sure if they would apply for tax credits, primarily because they did not understand what they were.	<ul style="list-style-type: none"> ■ Revise the checklist to differentiate between the information that is needed to assess eligibility for tax credits and the information needed to apply for health insurance. ■ Provide a concise and clear explanation of tax credits and how the financial application relates to getting health insurance. ■ Provide information on what consumers should consider when making the decision to apply for financial assistance. 	1
Task 4: Find information about how to appeal a decision from the Marketplace.	Most found information on how to appeal a decision without any major problems.	No changes needed.	NA
	Many participants were disappointed that more information on appeals was not provided on the page. Some participants did not notice the hyperlink to the appeal form.	Add information to educate consumers about the appeals process and include a hyperlink directly to the appeal form instead of the page on which the form can be found.	1
Task 5: Determine your eligibility to receive financial assistance to purchase the health insurance.	Participants struggled with the number of questions in the shared eligibility application and the amount of time it took to complete.	Review the questions to determine if all are critical for Connect for Health Colorado to collect and can be removed. In addition, consider whether some of the information can automatically populate from the account creation page or other sources.	2–3 ⁹
	Participants did not see the options they expected in the “About Your Application: Application Location” question. They were also unsure of why this information was needed.	Remove this question from the application if it is not critical.	1
	Participants were confused when they were asked to identify the “Reasons for Enrolling Outside of Open Enrollment” because it was during the open enrollment period.	Remove this question from the application, except when it is outside of the open enrollment period. Alternatively, add an option for “none” or “not applicable” when it is open enrollment.	1
	Participants were confused by the “Who is Helping You?” page because they did not understand how to respond if no one was helping them.	Add a question that first asks “Is anyone helping you (e.g., agent, broker, guide, counselor)?” Then, if applicable, ask the follow-up questions to determine the source of assistance.	1

⁹ Identifying questions to remove may require moderate changes (priority 2), but autopopulating from other sources may be a more long-term effort (priority 3).

Task	Results and Reactions	Recommendations	Priority ⁸
	Participants were confused by the “Program Selection: Medical assistance or none” question because they did not understand the terminology and that these were options in response to a single question.	Include in-text definitions in plain language for “medical assistance” and “none.” In addition, change the check box to a radio button, so only one choice can be selected.	1
	When receiving an error message, participants had some difficulties identifying which question was the source of their application errors.	Highlight the exact location of each error (e.g., highlight the field with the error in red or yellow) using inline error messages to draw attention to the location of errors. ¹⁰	2
	Participants did not understand what was meant by “individual shared responsibility exemption” in the Exemption to the Requirement to Purchase Health Insurance question.	Include a brief in-text definition in plain language of this phrase after the question.	1
	Participants tried to type their street number and street name in the same field rather than as two separate fields.	Have a single field for both street number and street name.	1
	Participants were not able to select a “county” from the drop-down list after entering their ZIP code.	Investigate why this drop-down option would not work and update the site accordingly.	1
Tasks 6–8: Compare, Select, and Enroll in a Health Plan			
Task 6: Find and compare the features of at least two of the health insurance plans that you think might be a good fit for you.	Most participants easily accessed the list of insurance plans available to them.	No changes needed.	NA
	Some participants felt that the list of plan results loaded very slowly.	Optimize the speed at which plan results load, possibly by rendering results in smaller groups as they are found, to reduce user frustration.	1
	Some users did not realize the “apply filters” button needed to be selected in order to narrow the plan list.	Have the plan list update as filters are adjusted so users can see immediate updates to the plan options.	1
	Some did not realize the sliding filters were two-sided and excluded dollar amounts they desired.	Make the movable ends of the sliders more noticeable by increasing their size or altering their color.	1

¹⁰ Enroll UX2014. (2012). *A new standard for public and private health insurance enrollment: Design specifications manual*. Retrieved from: <http://www.ux2014.org/deliverables>

Task	Results and Reactions	Recommendations	Priority ⁸
	Some participants had difficulty adjusting cost filters to the dollar amount they desired because the range was large (e.g., \$0 to \$20,000).	Lessen the range of prices displayed in the monthly premium cost filter by customizing it to the range in the user’s search results.	2
	Most participants attempted to use the side-by-side plan comparison feature, but some had difficulty locating the “compare X plans” button.	Place “compare X plans” buttons on the right side above and below the plan list, where users are more likely to look for it.	1
	Some participants were unfamiliar with some health insurance terms, especially terms on the plan details pages and the metal levels.	Add brief definitions of health insurance terms (e.g., metal levels) on the pages where these terms appear in the text. When possible, replace confusing terms with plain language terms. In addition, include a link to the “Glossary of Terms” from within the plan compare pages. Provide an example scenario to help consumers understand how the metal levels translate into costs to the consumer.	2–3 ¹¹
	For plans that had coinsurance rather than copays for a particular service, some participants only noticed the “no charge” that appeared in copay rows while ignoring the costs listed in the coinsurance rows.	Revise the plan details table to use “does not apply for this plan” when the feature is not applicable to the health plan and “no charge” when the feature is part of the plan but there is no charge associated with the service.	1
	Some participants expected the “facilities” category of the plan details to contain information about which doctors, hospitals, or urgent care centers were in-network. However, the “facilities” category provides the cost of services in hospitals and other facilities.	Add the “provider look up” button to the plan details page. This will help users determine if their preferred care providers, hospitals, and facilities participate in a plan when they are reviewing plan details.	2
Task 7: Select the health plan that would be best for you.	Participants completed this task relatively quickly, but some mentioned they would have needed assistance or additional time if they were actually selecting a health plan. ¹²	No changes needed.	NA

¹¹ Adding in-text definitions would require moderate changes (priority 2); however, adding features that help consumers understand health insurance terms and metal levels would require more ongoing and long-term efforts (priority 3).

¹² AIR encouraged participants to make decisions that were as realistic as possible on their own. However, participants knew this was a test and they were not actually enrolling in insurance during the session.

Task	Results and Reactions	Recommendations	Priority ⁸
	The final deciding factor for all participants was some element of cost. Monthly premium and annual deductible were mentioned most often, but some consumers had difficulty understanding the different types of costs.	Add in a measure of cost at time of care that accounts for the plans' covered benefits (e.g., premiums) and anticipated health care service use for the year. If such a measure is not available, consider adding plan averages for low or high service use in addition to premiums. ¹³ This would help consumers get a better sense of the total costs for each insurance plan, which will help them make a more informed decision when selecting a health plan.	3
	Participants were familiar with the concept of adding the plan to their shopping cart, but one person did not realize that the plan was already in her cart.	Change the color and/or shape of the "Remove from cart" button to visually distinguish it from the "Add to cart" button.	1
Task 8: Complete the enrollment process.	Participant wanted to see a clearer "thank you for enrolling" page to confirm that her enrollment application was received. Participant also wanted to see options for paying online.	Add additional text to the "thank you for enrolling page" that states something such as "We have received your application. Your health plan carrier will notify you by email/postal mail and provide you with information on how to pay your monthly premium. You will not be enrolled in the plan you selected until your insurer receives your first payment."	1
	Participant looked for a shopping cart icon (similar to an online shopping website) that would direct him to the checkout page, but did not notice the one in the top banner.	Make the shopping cart icon more visible, so users can easily see and click on it to navigate to the checkout page.	1
Tasks 9–10: Help Function			
Task 9: Find out where you could get help if you were using this website and had questions.	Participants easily found how to get assistance by phone or in-person. Many said they would prefer to find help online or over the phone. No one found the online chat feature.	Add a link to online chat in the button in the middle of the homepage that currently says, "Find free in-person help." Rename this button to something such as "Get help" and include information on online, phone, and in-person help. This will help users find the online chat function, and all forms of assistance, much easier.	1
	Many participants stated they were not likely to use the Avatar, Kyla, for assistance. Some thought Kyla would direct them to an online chat feature.	Allow the Avatar, Kyla, to direct users to the online chat feature or the FAQs page.	2

¹³ Pacific Business Group on Health. (2013). *Consumer choice of health plan decision support rules for health exchanges: Top 5 rules for decision support, and strategies to bridge the gaps* [Issue Brief]. Retrieved from: <http://www.pbgh.org/key-strategies/engaging-consumers/216-supporting-consumers-decisions-in-the-exchange>

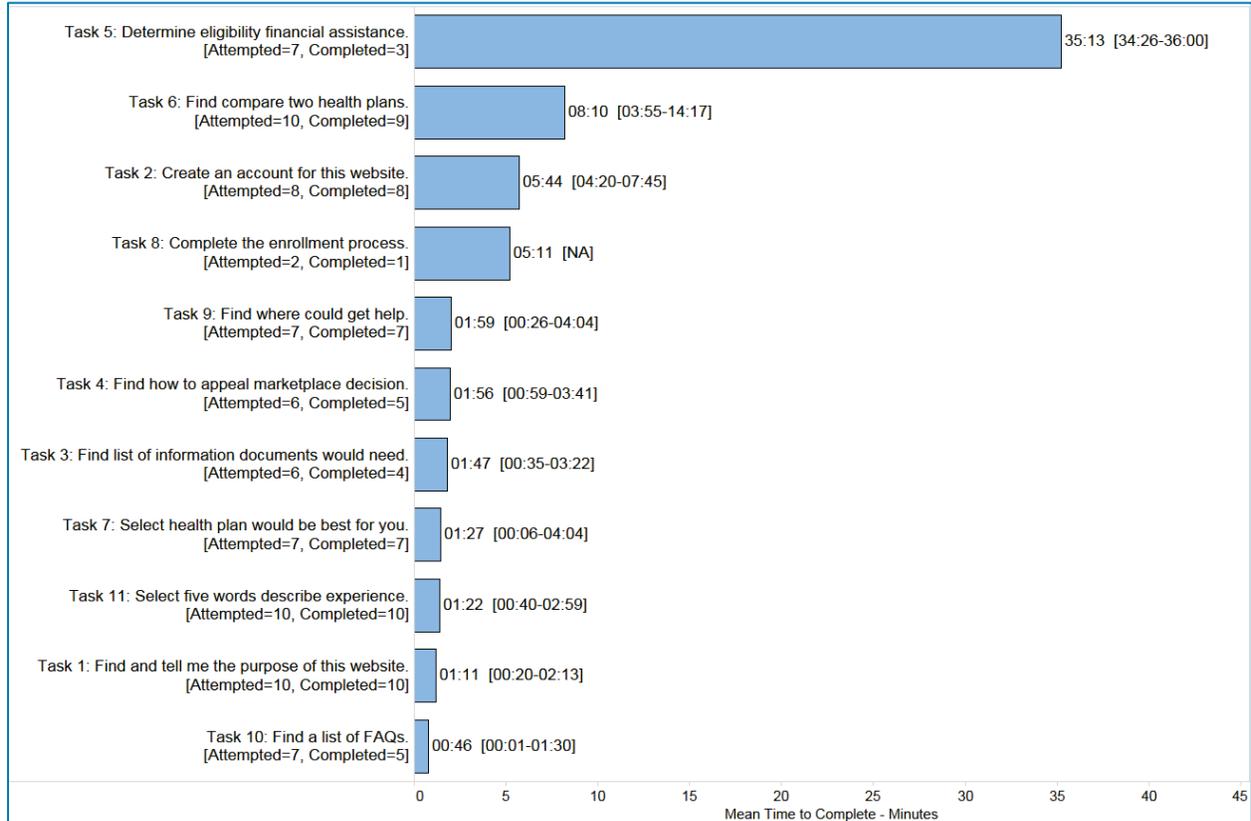
Task	Results and Reactions	Recommendations	Priority ⁸
	Participants were confused by the results received when using the search box on the homepage because results from the Connect for Health Colorado website were not prominently featured. Instead, some of the results were for links outside of Connect for Health Colorado, and were not necessarily relevant to information on the Marketplace website.	Modify the search box on the homepage to primarily feature results from the Connect for Health Colorado site as opposed to other websites outside of the Marketplace, and also move the search bar to the top of the page on every page of the site. This will allow users to find results that are applicable to the Connect for Health Colorado site, and by moving the search bar to the top of every page users will not have to scroll down the page to find it.	2
	When reviewing the “In-person Assistance” page, participants were not sure what differences existed between the three types of help (enrollment centers, brokers, health coverage guides).	Add a short, bulleted summary on the “In-person Assistance” page to summarize and define the three types of help available.	1
Task 10: Find a list of frequently asked questions (FAQs).	Most participants were able to find the list of FAQs; however, some had difficulty finding it.	<ul style="list-style-type: none"> ■ Include a “help drawer” on the top-right side of all webpages that includes access to the FAQs, as well as the glossary and online chat.¹⁴ ■ Rename the “Questions” under the “Brokers” heading on the bottom of the homepage to something such as “Questions for Brokers” to clarify that this is not the general FAQ link for consumers. ■ List the FAQs webpage as the first returned result when consumers type “FAQs” in the search box on the homepage. ■ Have the Avatar Kyla direct users to the FAQs page. 	2
	Some participants who found the FAQs page quickly and easily felt there were too many topics on the page, preferring a narrower list of categories. However, not all of the participants thought there was too much information on the page, as one participant liked that a lot of information was provided at once.	List “General Information” and other most popular consumer topics at the top of the FAQs page (rather than “Carrier Support and Carrier Team Questions”) at the top of the page.	1
	Some participants were looking for the words “Frequently Asked Questions” instead of its abbreviation, “FAQs.” Even when reviewing the topics under “Resources” on the homepage, they did not notice FAQs listed there.	Spell out “FAQs” as “Frequently Asked Questions” where it is listed on the homepage.	1

¹⁴ Enroll UX2014. (2012). *A new standard for public and private health insurance enrollment: Design specifications manual*. Retrieved from: <http://www.ux2014.org/deliverables>

Average Time to Completion for Each Task

For each task, figure 2 shows the number of participants who attempted the task and completed it. Among those who completed the task, the average time to complete and the range are calculated. Some participants attempting a task did not complete the task because of reasons such as insufficient time and inability to complete (e.g., could not locate the information).

Figure 2. Mean Time [and Low–High Range] to Complete Each Task [Minutes: Seconds]



IV. Findings and Recommendations by Task

This section describes the findings and recommendations by task. Participants were asked to perform tasks related to—

- Get Started (Tasks 1–2)
- Assess Eligibility (Tasks 3–5)
- Compare, Select, and Enroll in a Health Plan (Tasks 6–8)
- Get Help (Tasks 9–10).

See exhibit 4 for resources on improving webpage layout and readability that can be used to improve consumer’s experiences across the tasks.

Exhibit 4. Resources for Improving Webpage Layout and Readability

- Enroll UX2014. A new standard for public and private health insurance enrollment: Design specifications manual, <http://www.ux2014.org/deliverables>
- PlainLanguage.Gov. Writing for the web, <http://www.plainlanguage.gov/howto/guidelines/FederalPLGuidelines/webWrite.cfm>

Task 1: Find and tell me the purpose of this website.

Results and Reactions

Participants were able to complete this task relatively quickly. Most reviewed the homepage to identify the website’s purpose and indicated that this was a website where people in Colorado could get health insurance. Some participants noted it was for people in Colorado without an employer-sponsored health plan.

Some participants noted that they had to scroll down below the fold of the first screen on the homepage in order to find the content that told them the purpose of the webpage (see figure 3 for a screenshot of the homepage). Some described the homepage as “busy” because of the rotating photos. Buttons for more information about issues such as “Individuals and Families-Current Customers” were below the photos. The size of the monitor used during the testing did not allow participants to see these buttons without scrolling. Some participants liked the photos and indicated they were reflective of people in Colorado; however, some noted that they did not identify with the people in the photos.

Figure 3. Connect for Health Colorado Homepage



Recommendations

No major changes are needed to the homepage in order for consumers to identify the website’s purpose. However, Connect for Health Colorado may want to consider—

- **Reducing the size of the photo banner on the homepage.** This will make it easier for consumers using smaller monitors to see the buttons below the photos, such as “Individuals and Families–Current Customers.”

Task 2: Create an account for this website.

Results and Reactions

Of those who attempted this task, all completed it. Participants understood where to go to create an account.

On the account creation page, some of the participants were confused about whether they could create a username or had to use their email address as the username because the username field was autopopulated with their email address. Some liked that their email address was autopopulated as the username because it would be easier to remember; others did not like this feature and wanted to create their own username.

After participants created an account, they were taken to the account log-in screen. One participant was surprised that she did not see a confirmation screen after she finished creating her account.

I would assume when the page refreshed after I created the account that it would say, “Congratulations, you’ve created an account.” Or I assumed it would say I would be receiving an email that my account had been created. When it takes you back to the log-in page, it makes me think I did something wrong.

(CO15, 31-year-old white female, new enrollee)

Recommendations

Connect for Health Colorado may want to consider the following types of changes:

- **Add a note above the username field to explain that consumers can use their email address or create their own username.** For example, “You may use your email address as your

username, or you can choose your own.” The note should be in a different font or italicized to help distinguish it from the field name. This should help to eliminate any confusion as to whether they should enter their own username or use their email address as their username.

- **Create an account confirmation page.** After the user creates his/her account, the page could say, “Congratulations, you have created an account with Connect for Health Colorado” and provide the consumer with instructions on how to log in. This will reduce confusion about whether the user’s account information was received.

Task 3: Find a list of the types of information or documents you would need to apply for health insurance.

Results and Reactions

Most participants who attempted this task completed it. Some found the list of documents in the “Individuals and Families–New Customers” section, while others found it on the FAQs page.

Some participants indicated that they would not look for a list like this one on their own. Instead, they would prefer to just begin the application or they assumed that they would not need that much information to complete the application.

Some participants, upon finding the list of documents, noted that the list said it was for those seeking tax credits. They wondered what documents were needed by people who were not seeking tax credits. One participant was not sure if he would apply for financial assistance, primarily because he did not understand what it was..

This still doesn’t seem like I would be [completing the task] because this is about financial information, and I don’t know if I would apply for financial aid. [Reads the top of the sheet] This might apply to me. I’m not familiar with these tax credits.

(CO14, 42-year-old white male, new enrollee)

Recommendations

Connect for Health Colorado may want to consider the following types of changes to help consumers better understand the tax credits/financial assistance and how financial assistance relates to enrolling in a health insurance plan:

- Revise the lists to differentiate between the information needed to apply for financial assistance and the information needed to enroll in health insurance.
- Provide a concise explanation of tax credits and how the financial application relates to enrollment.
- Provide information on what consumers should consider when making the decision to apply for financial assistance.

Task 4: Find information about how to appeal a decision from the Marketplace.

Results and Reactions

Most of the participants attempting this task completed it and most found the information by looking on the FAQs page and locating the Q&A page titled, “I don’t agree with my eligibility results. How do I

appeal?” Most were dissatisfied that more information on appeals was not provided. The first thing that some participants noticed was a phone number, and they did not want to call someone. Others said they expected to find more information on the appeals process or what information they needed to gather to make an appeal. One participant noticed that an appeal form was mentioned and clicked on the link provided, but he was surprised that it did not take him directly to the form. Instead, it took him to a page with a list of documents on which the form could be found.

There’s a form you would download and complete [clicks on the link].... I don’t think is the right form either. Oh, the appeal form is at the bottom. If you’re going to appeal, I would think this is the first form you should see, not at the bottom.

(CO22, 44-year-old Hispanic male, new enrollee)

Recommendations

Connect for Health Colorado may want to consider the following types of changes:

- **Add information to educate consumers about the appeals process, such as what steps they should take to get started, how long it will take, and what information they need to provide.** Also, consider adding a hyperlink to the appeals form instead of the page on which the form can be found. This will provide consumers with the information they expect to find.

Task 5: Determine your eligibility to receive financial assistance to purchase the health insurance.

Results and Reactions

Although seven participants attempted this task, only three were able to complete it during the testing.¹⁵ The shared eligibility application for financial assistance has approximately 31 screen pages for a single person, and more for households with multiple people.

Participants struggled with the number of questions in the shared eligibility application and the amount of time it took to complete. Several participants indicated they would not have enough time to complete the application in a single sitting, and some were not sure they would return to complete it. Some participants said the application asked for the same information they provide through their taxes, and they would have liked for information to automatically populate from their taxes. Some also said they wished that the application pulled more information from their account creation (e.g., address), so they did not have to enter it again.

It’s at 0 percent and I’m still at start...this is going to be a process. I would make sure I had at least an hour to sit down. I have a one-year old and three-year old. If it wasn’t a time when my daughter or son was at school or at a nap, I would make sure I had the time to concentrate on this....

(CO11, 28-year-old African American female, new enrollee)

¹⁵ On the second and third days of testing, AIR prioritized this task to allow respondents to have more time during the session to attempt to complete it. Two of the three participants completed the task on the second and third days of testing.

Participants were able to easily navigate the website to start the application. However, participants had difficulty understanding some of the questions and using some of the functions in the application. Some of the issues included:

Content Issues

- **Who is helping you?** This page asked participants whether an agent or broker was helping them with the application. Most participants were confused by this. Some thought they had to identify an agent or broker in order to proceed. Most did not see the instructions on the top of the page that said, “If no one is helping you, click ‘Save and Continue.’”
- **About your application: Application location.** This question asked the participant to identify where he/she is applying from. Options included childcare provider, county offices, home, etc. Most participants were confused by this question. Some said they thought they would see drop-down options to indicate their county of residence. Some did not understand why this information was needed.
- **Reasons for enrolling outside of open enrollment.** This question asks the participant to select the reason(s) for shopping for health insurance outside of open enrollment. There is no option to indicate “does not apply” or “not applicable.” Most did not understand why they were being asked this question during open enrollment or what they should do if they didn’t have one of these events. Participants thought they had to select an answer to this question.
- **Program selection: medical assistance or none.** The question asks the participant to select the box for each program they would like to apply to: medical assistance or none. Most participants did not understand what this question was asking for and were unfamiliar with the term “medical assistance” (see figure 4). Some were unclear about whether this was one question or two separate questions. Some received an error message after selecting both boxes, since only one option can be selected.
- **Error messages.** Error messages were displayed with a “warning” box at the top of the page. Some participants did not easily see the error message. Some suggested that it would be helpful if the exact location of the error were highlighted in the webpage, rather than describing the location of the error at the top of the page.
- **Exemption to the requirement to purchase health insurance.** The question asks, “Does this person have an individual shared responsibility exemption?” Some participants said they did not understand this question and did not know what such an exemption was. One person read the information available by clicking on the question mark button, but was not helped by the explanation. Some said they would have to Google the terms to understand the question.

Figure 4. Participants Did Not Understand the Program Selection Question

Program Selection

*Please check the box for each program this person would like to apply for. If you don't check a box, this person will not be applying for that program.

Medical Assistance [Show Details](#)

If you want help paying medical bills from the last three months please check each month in which you have medical expenses and were a Colorado resident. [?](#)

September October November

None

*Is this application for the current coverage year or the next coverage year? [?](#)

2014 2015

Website Function Issues

- **Where you live: Separate street # and street name.** The application asks the participant to indicate where he/she lives. There are two separate fields for the street number and the street name. Most participants did not notice this and would try to type their street number and street name in the same field. Some did not understand this was a problem until they received an error message.
- **County button.** The drop-down menu for the question “in what county do you live?” did not activate after the participant typed in their ZIP code. Participants were not able to select a county until they tried to proceed to the next page and received an error message for not completing that field.

Recommendations

To address the issues that participants experienced, Connect for Health Colorado may want to consider the following types of changes:

- **Review the shared eligibility application questions to determine which, if any, are not critical for Connect for Health Colorado to collect and can be removed.** For example,
 - Could “Application Location” be removed?
 - Could the number of questions about “Who is Helping You?” be reduced?
 - Could “Reasons for Enrolling Outside of Open Enrollment” only be included when it is outside of the open-enrollment period?
 - Could some fields pre-populate with information from account creation or other sources (e.g., address)?

These changes will help reduce the number of questions in the shared eligibility application and the amount of time it takes consumers to complete it.

- **Add screener questions, when applicable, so that only consumers who respond with an affirmative receive more detailed follow-up questions.** In the “Who is Helping You?” section, have a screener question such as “Is anyone (e.g., agent/broker, guide, counselor) helping you with your application?” If the person selects “yes,” then he/she would see follow-up questions about the person’s name and license number.

- **Clarify some of the terms within the application**, including: “individual shared responsibility exemption” in the Exemption to the Requirement to Purchase Health Insurance question, and “medical assistance or none” in the Program Selection question. Provide a brief in-text definition of these terms using a different font or italics to help the consumer understand the question.
- **Add radio buttons instead of check boxes** when people should only select one response option. For example, this change would help people select only one choice in the Program Selection question.
- **Highlight the exact location of each error** (e.g., highlight the field with the error in red or yellow) using inline error messages to draw attention to the location of errors.¹⁶
- **Resolve the malfunctioning “county” drop-down list that did not function properly.**
- **Collapse the “Where You Live: Street # and Street Name” into a single field.** This may reduce the number of errors consumers receive while completing the application.

Task 6: Find and compare the features of at least two of the health insurance plans that you think might be a good fit for you.

Results and Reactions

All participants attempting this task were able to access the list of health plans, and most were able to compare the features of two plans in order to complete the task.

The health plan result lists tended to load slowly on both the UAT and the public site, but the UAT was particularly slow. Most participants commented on this slow speed, and some expressed frustration. All participants looked at the list of plans and said that cost was important to them. Most began by reviewing premium costs, and some also considered deductible costs. Some of those reviewing deductible costs expressed concern about selecting a plan with a high deductible because if they had a medical emergency they would owe a large amount at once.

I don't mind paying out of pocket to go to the doctor. I would worry about things that would be extremely expensive, like hospital stays.

(CO16, 39-year-old white female, returning enrollee)

Some noticed the plan metal levels, commenting that they did not understand what they signified; some decided it was best not to pick bronze plans. One participant decided to review silver plans because she did not want “the best or the worst.” Participants did not seem to connect the metal levels with how much they would have to pay for their monthly premiums and out-of-pocket expenses for services. But some said they would like to know how much they would pay out of pocket during the year and were not sure if there was a type of plan that might be best for them. One participant said that she would call a service representative for assistance.

I'm math challenged, so I'd need someone on the phone to help me figure out which of these three is better for me. This one is \$400 a month with no deductible but this one is \$200 a month with a \$6250 deductible.

(CO17, 48-year-old African American female, new enrollee)

¹⁶ Enroll UX2014. (2012). *A new standard for public and private health insurance enrollment: Design specifications manual*. Retrieved from: <http://www.ux2014.org/deliverables>

Filtering the list of plans was problematic. Some participants used filters to narrow the list of plans, but many people had difficulty using them. Participants experienced a variety of problems, including:

- Not being able to adjust the sliders to the desired dollar amount because the range of values was large (e.g., \$0 to \$20,000 for monthly premium)
- Not realizing that the sliders were two-sided. Many assumed that the left side of the slider was setting a maximum filter value, but it was set a minimum value. For example, a participant might desire a maximum monthly premium of \$350, but moving the left side slider to \$350 limits the results to plans with premiums that are \$350 or more.
- Not realizing that the user needs to press the “apply filter” button to update results
- Having difficulty locating the “apply filter” button
- Choosing desired criteria and then applying filters, only to learn that no plans fit the desired combination of criteria

Some users commented that they would like the list of plans to update as they selected filter options.

I have to go back to the top to apply the filter. I like that Kayak just does it automatically. I wish it would change the [list of plan] options immediately as I make filter changes.

(CO15, 31-year-old white female, new enrollee)

The “compare X plans” button was difficult for some to locate. When reviewing plan options, most participants attempted to use the “compare plans” feature for a side-by-side comparison of plan details. However, some had difficulty locating the “compare X plans” button, located at the top-left side of the plan list, and one person was not able to find the button. One participant repeatedly hit the “save and continue” button prominently displayed at the bottom-right side of the page during his attempt to view a side-by-side comparison. When asked about the button’s location, participants suggested that it be moved to the right side of the page, either at the top or bottom of the list of results.

Some participants were unfamiliar with terms used to describe plans. While some said they were familiar with the terms used to compare plans, others admitted that they were not familiar with all of them. The unfamiliar terms varied by person, but some of the terms were *essential health benefits (EHB)*, *exclusive provider organization (EPO)*, *tier*, *combined deductible*, *monthly cost value*, *annual maximum cost*, *level of coverage (platinum, gold, silver, bronze)*, and *coinsurance*. Some said that they would like an explanation of the terms on the page, and that if they were comparing plans in real life (not part of usability testing), they would seek help from a variety of sources (e.g., family members, online searches, customer service representatives) to confirm they understood the information before they selected a plan.

I don’t want to agree with something that I don’t know what it means. . . . I want them to define these terms. . . . There should be a study guide that would tell you what an EPO, HMO is.

(CO11, 28-year-old African American female, new enrollee)

Not knowing the meaning of the term “coinsurance” led some participants to believe that out-of-pocket costs for a plan were lower than they were. The facilitator asked some participants about the meaning of “coinsurance.” Rather than understanding it to be an out-of-pocket cost to the consumer, they thought it was a cost to the insurer that only applied in situations where the insured person was covered by more

than one plan, such as a spouse’s plan. When these participants reviewed details for plans that required coinsurance, as in figure 5, they looked at the copay for a service, saw “no charge,” and ignored coinsurance costs. This misunderstanding could have led participants to pick plans with higher than anticipated out-of-pocket costs.

Figure 5. Participants Unfamiliar With the Term “Coinsurance” Ignored Those Costs

<p>Plan Details</p>	<p>Colorado HealthOP Bison HSA Qualified High Deductible Health Plan EPO EPO</p>  <p>Monthly Premium \$195²²</p>	
<p>General Details</p>		
<p>Provider Office Visits</p>		
	<p>In Network (Tier 1)</p>	<p>Out Network</p>
<p>Primary Care Visit to Treat an Injury or Illness</p>		
<p>Copay</p>	<p>No Charge</p>	<p>Not Covered</p>
<p>Coinsurance</p>	<p>40% Coinsurance after deductible</p>	<p>Not Covered</p>

Some participants were confused by the “facilities” category on the plan details page. Most participants mentioned they were interested in learning which providers were participating in plans. When some looked at the “facilities” category under plan details (figure 6), they were surprised to see the costs of care at hospitals, outpatient centers, and skilled nursing facilities. One person expected emergency department and urgent care visits to be listed, and others expected to find a list of in-network doctors or facilities.

Figure 6. Plan Details for the Facilities Category

General Details		
Provider Office Visits		
Prescription Medication		
Facilities		
	In Network (Tier 1)	Out Network
Outpatient Surgery Physician/Surgical Services		
Copay	No Charge	Not Covered
Coinsurance	No Charge after deductible	Not Covered
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		
Copay	No Charge	Not Covered
Coinsurance	No Charge after deductible	Not Covered

Recommendations

To address the issues that participants experienced during testing, Connect for Health Colorado may consider making the following changes to the site:

For the Health Plan List

- Optimize the speed at which health plan results load.** One possible way to do this is to render results in smaller batches as they are found. This may decrease the likelihood of consumers becoming frustrated while shopping.
- Make the filtering features easier to use.** Consider making the plan list update as users select filter criteria, since some users expect this to happen. If this is not changed, consider moving the “apply filter” button to the bottom of the filter options, where users are more likely to see it after they finish reviewing options. For filter sliders, users would benefit from having a price range customized to their results. This would give them a snapshot of the range of costs available to them and would allow improved accuracy in setting the desired dollar amount.
- Reposition the “compare X plans” button.** The “save and continue” button was prominently displayed on the right side above and below the plan list. This overshadowed the “compare X plans” button on the left side above the plan list. In testing, most participants wanted to use the “compare plans” feature after reviewing the list, so it may be easier for them to locate on the top and bottom of the right side of the page, since the right side is a location that they seem to associate with the next step.

For the Plan Details

- Connect users with insurance term definitions and examples.** Many users could benefit from having definitions and examples of insurance terms easily accessible while they compare plans. This could be implemented in a variety of ways, but it would be ideal to add them directly on the page. The Connect for Health Colorado Glossary of Terms and Healthcare.gov Glossary include definitions to many of these terms. When possible, replace confusing terms with plain-language

terms. In addition, include a link to the “Glossary of Terms” from within the “plan compare” pages.

- **Explain the meaning of the metal levels.** Participants did not understand the meaning of the metal levels. To help consumers understand the total costs of plans, it would be helpful to explain on the “plan compare” pages the meaning of the metal levels. It may also be beneficial to provide an example scenario for how a consumer’s total costs would compare between bronze, silver, gold, and platinum plans. Explaining numbers and calculations clearly through examples that break down calculations into simple steps can be helpful for consumers.¹⁷
- **Revise the “plan details” table to indicate when cost-sharing charges “do not apply” as opposed to have “no charge.”** Most plans have either copays or coinsurance for a particular type of service. For plans that had coinsurance rather than copays, some participants only noticed the “no charge” that appeared in copay rows while ignoring the costs listed in the coinsurance rows. To help consumers understand the cost-sharing structure of each health plan, use “does not apply for this plan” when the feature is not applicable to the health plan and “no charge” when the feature is part of the plan but there is no charge associated with the service.
- **Add the “provider look up” button to the “plan details” page.** Participants were interested to know which hospitals and doctors participated in plans. While the plan list can be filtered by providers, some users were also seeking provider information on the “plan details” pages.

Task 7: Select the health plan that would be best for you.

Results and Reactions

All seven of the participants attempting this task completed it. Three did not attempt due to time constraints. Most participants selected from the two plans they had compared in the previous task and made a choice relatively quickly. Some participants said that, in real life, they would have sought advice or done more research before making a decision. It seemed that most decided more quickly because during the testing there were no consequences to their selection.

When explaining their selection, all participants named some element of cost as the deciding factor in choosing that plan. Participants discussed cost in a variety of ways, and most took their current health and history of health care services utilization into account when considering the total cost of the plan. Some weighed the tradeoffs of choosing a higher monthly premium versus a higher deductible. One participant said she would prefer a plan with a lower deductible because it would be difficult for her to pay the full cost of a high deductible at one time, which could occur with a medical emergency. Another participant said he considered the prescription costs shown under plan details when deciding.

I would pick the Kaiser plan. . . . The monthly premium is less. I would pay 30 percent coinsurance after the deductible. So, overall, it’s cheaper. I noticed that Kaiser had generic drugs for \$20 when they were free with Access, but I think I don’t use many prescriptions, so I would still save in the long run.

(CO20,38-year-old white Hispanic male, returning enrollee)

¹⁷ McGee, J. (2010, September). *Understanding and using the “Toolkit Guidelines for Graphic Design” toolkit for making written material clear and effective* (CMS Product No. 11476). Washington, DC: U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, <https://www.cms.gov/Outreach-and-Education/Outreach/WrittenMaterialsToolkit/index.html?redirect=/writtenmaterialstoolkit/>

Some participants also considered physician choice when selecting a plan. Some wanted an insurer that offered its own doctors in-house. Others said they would like a plan that allowed them to continue to see their current doctors. One participant said that it was important that she could see her doctors with the new plan because they knew her health.

For those using the UAT site, the task was complete once the participant added the plan to their shopping cart; for those using the public site, the task was complete once the participant verbally selected the plan. The concept of putting a plan in a shopping cart seemed to be familiar to participants. However, one participant had difficulty, because she did not easily see confirmation that the plan had been successfully added to her cart. When on the compare plans page, she attempted to add the plan to her cart several times before returning to the plan list and seeing an icon that said “remove from cart” which helped her realize it was already in her cart.

Recommendations

Participants did not encounter any major problems that would require changes to the site. However, based on the lessons learned from this task, Connect for Health Colorado may consider taking the following actions:

- **Add in a measure of cost at time of care** that accounts for the plans’ covered benefits and anticipated health care service use. If such a measure is not available, consider adding plan averages for low or high service use in addition to premiums.¹⁸ This would help consumers get a better sense of the total costs for each insurance plan, which would help them make a more informed decision when selecting a health plan.
- **Clarify when consumers have a plan in their shopping cart.** Change the color and/or shape of the “Remove from cart” button to visually distinguish it from the “Add to cart” button. Another option is to add an icon to indicate that this “Plan is in cart.”

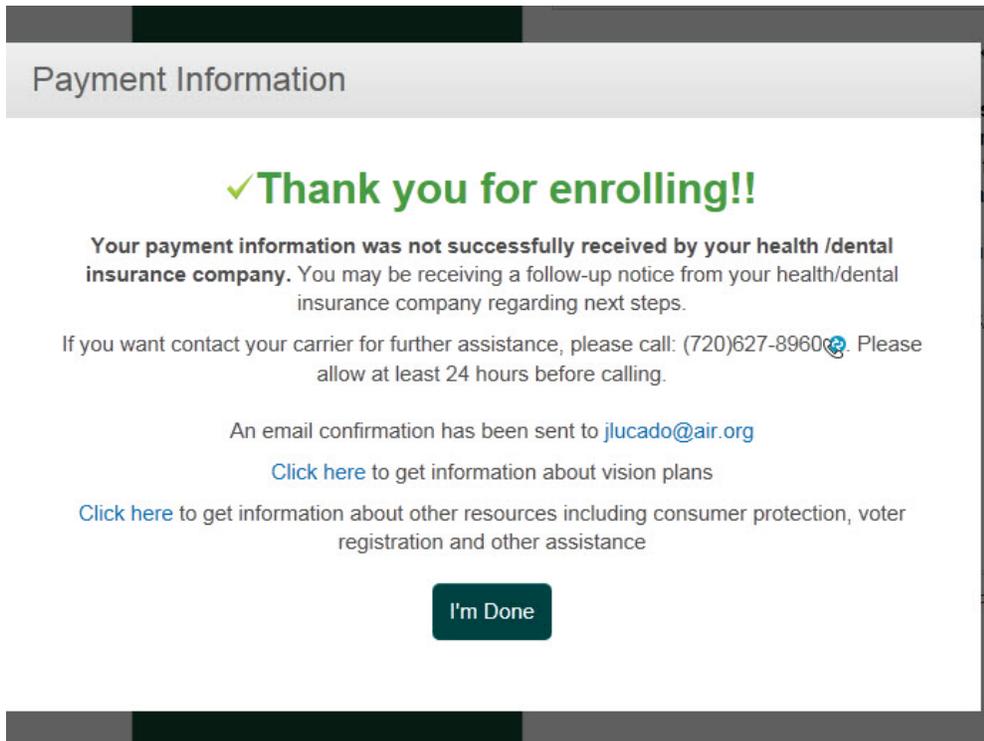
Task 8: Complete the enrollment process.

Results and Reactions

Two participants attempted this task and one participant completed it. The others didn’t attempt mostly due to time constraints but one participant was logged out of the site and was not able to get back to the enrollment page. The one participant who completed this task, a 48-year-old female and new enrollee, was frustrated primarily because the only payment options were sending in a check or money order. She hoped to see an online payment option. Furthermore, the “Thank you for enrolling” page that popped up upon completing enrollment stated that her payment information was not received, and she was uncertain about whether this meant Connect for Health Colorado did not receive her enrollment information (figure 7). The current message states, “Your payment information was not successfully received by your health/dental insurance company. You may be receiving a follow-up notice from your health/dental insurance company regarding next steps.”

¹⁸ Pacific Business Group on Health. (2013). *Consumer choice of health plan decision support rules for health exchanges: Top 5 rules for decision support, and strategies to bridge the gaps* [Issue Brief]. Retrieved from: <http://www.pbgh.org/key-strategies/engaging-consumers/216-supporting-consumers-decisions-in-the-exchange>

Figure 7. Confirmation of Enrollment Screen



The other participant was not able to complete this task because he was logged out of the system when he tried to check out. This participant did not notice the shopping cart button that is located in the top banner and suggested one should be placed in the top-right corner of the page, similar to an online shopping website.

I wanted to see a cart in top-right corner...would have thought when you click on it, it would bring you to checkout page.
(CO20, 38-year-old white Hispanic male, returning enrollee)

The participant also had difficulty finding the checkout button, which was on the left-hand side of the page. It was not intuitive to him that it would be located there.

Recommendations

Connect for Health Colorado may consider taking the following actions to help users to complete the enrollment process smoothly and easily:

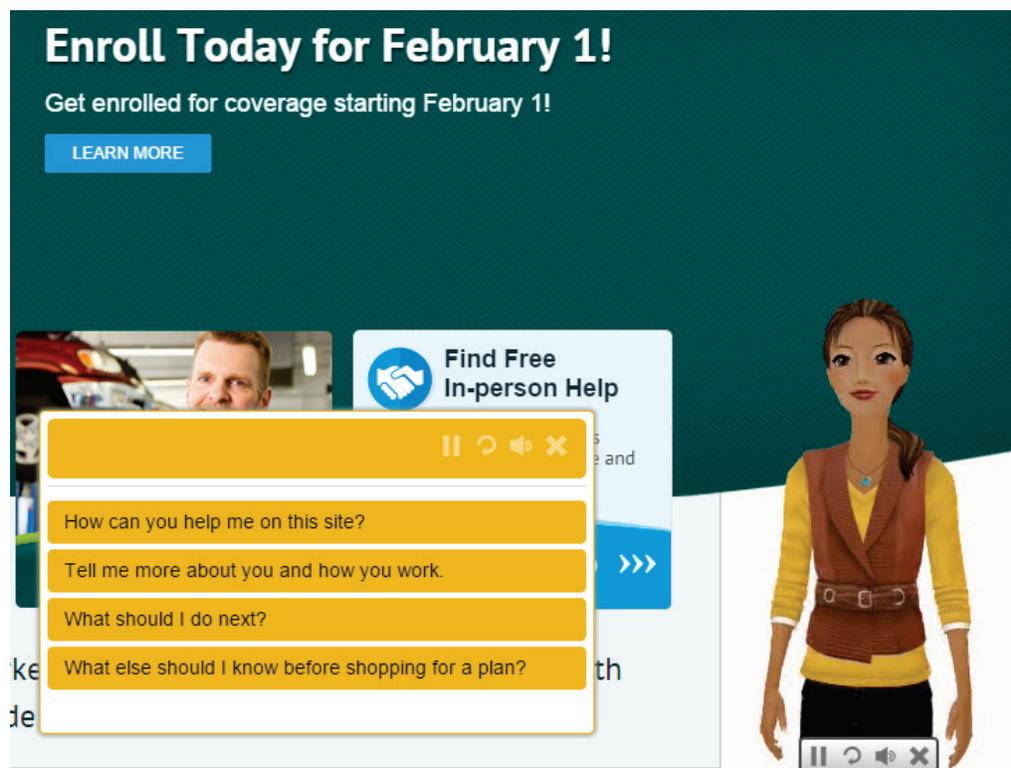
- **Add additional text to the “thank you for enrolling” screen** that acknowledges that their application was submitted and explains the next steps of enrollment. For example, this screen could state: “We have received your application. Your health plan carrier will notify you by email/postal mail and provide you with information on how to pay your monthly premium. You will not be enrolled in the plan you selected until your insurer receives your first payment.”
- **Make the shopping cart in the top banner easier for users to notice.** This will help consumers more easily navigate to the checkout page and complete enrollment.

Task 9: Find out where you could get help if you were using this website and had questions.

Results and Reactions

Participants were easily able to learn how to get assistance by phone or in-person from the homepage. Most said they were likely to seek help via phone or online (i.e., chat feature or information on the site) before seeking in-person help. However, no one found the site's chat feature. Of those participants interested in online help, one said they would attempt to use the Avatar Kyla, but a few participants did not think Kyla would be useful or did not want that level of “hand-holding.” One participant thought she would be able to type a question to Kyla that would connect her with an online chat feature, since only a few options pop-up when you click on her (see yellow box in figure 8).

Figure 8. Kyla Offers Assistance on the Connect for Health Colorado Homepage



When reviewing the “In-person Assistance” page, participants were not sure what differences existed between the three types of help (enrollment centers, brokers, health coverage guides). Some worried that brokers might try to steer them to a plan that was not the best fit because the broker might have some financial incentive. However, participants seemed to perceive brokers as knowledgeable and able to help. One participant believed a broker would be a more knowledgeable source of help than a customer service representative.

If you are calling yourself a broker, I hope you are experienced enough to tell me right away what I need. Instead of me taking like 8 hours, they would take 10 minutes. It seems like they would know. But then I wonder if they are getting a commission for what they're signing people up for, so maybe I would call the help line and the broker and compare [their recommendations].

(CO17, 48-year-old African American female, new enrollee)

A few participants used the search bar at the bottom of the homepage when seeking information for other tasks. They were confused by the results that popped up. During Task 4, several attempted to search for “appeal” and were disappointed that they did not see more relevant results from the site.

I would go to the search bar now and type “appeal.” When I went there, I noticed there is a U.S. Court of Appeals Ruling on Subsidies. That’s not helpful. It looks like it’s a Google response. I see on the right-hand side there’s a link on how to appeal. This isn’t the way I would want to encounter the information.

(CO15, 31-year-old white female, new enrollee)

Recommendations

Connect for Health Colorado may consider taking the following actions:

- **Add a link to online chat in the button in the middle of the homepage that currently says, “Find free in-person help.”** Rename this button to something such as “Get Help” and include information on online, phone, and in-person help. This will help users find the online chat function much easier.
- **Consider allowing Kyla to direct users to the online chat feature or the FAQs page.** This would allow users to receive instant results on their questions. Many participants mentioned online assistance was easier and quicker than phone or in-person assistance. Though many of the participants did not find Kyla to be a helpful method of seeking assistance, it is possible that users would consider using her if she quickly routed them to online chat or FAQs.
- **Modify the search feature on the homepage to feature relevant results from the Connect for Health Colorado site and consider moving the search bar to the top of the page.** This will help users to easily find the answers they are searching for, instead of being confused by results that direct them to information on other websites. By moving the search bar to the top of every page, users will not have to scroll down on the page to find it.
- **Consider adding a short, bulleted summary on the “In-person Assistance” page to define the three types of in-person help available (i.e., enrollment centers, brokers, and health coverage guides).** This will help inform users on their different help options.

Task 10: Find a list of frequently asked questions (FAQs).

Results and Reactions

Most participants were able to find the list of FAQs; however, some found it with ease and others found it with some with difficulty. Participants who found the list of FAQs quickly and easily mentioned there were too many topics listed on the page. They preferred a narrower list of categories. They also thought the font size of the categories was too small and suggested using a larger font. However, not all participants thought the FAQs page had too much information; one participant liked that a lot of information was provided on one page.

Among those who had difficulty finding or did not find the FAQs page, participants tended to click on the “Questions” link under the Brokers heading at the bottom of the homepage (figure 9). This page is to assist brokers with questions they have, however. Two participants described why they had trouble finding the FAQs page:

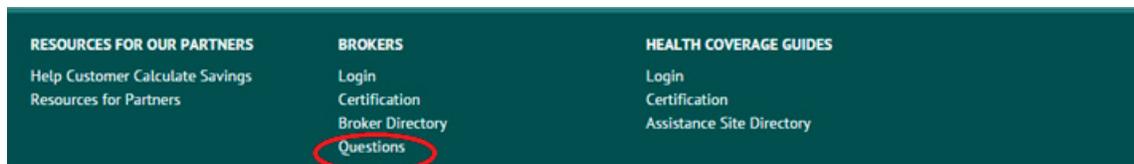
On other websites, I go to the bottom. I go to the bottom and see the “questions” here.

(CO20, 38-year-old white male, returning enrollee)

I’m under “Broker,” and I’m going to “Questions.” That’s not what I need. I’ll click on “Get Help” again. “At Enrollment Center,” OK. So this gives me phone numbers for some people. I could call and see if they could answer on the phone. I would ask Avatar [Kyla]. She pointed up here on the scrolling banner. I’ll click on this picture which takes me back to this same page. I’ll click on Kyla again. [After Kyla finishes talking] “Ok, look, connect me with an in-person assister. [clicks] Now I’m back at this page again! I thought I had landed somewhere.”

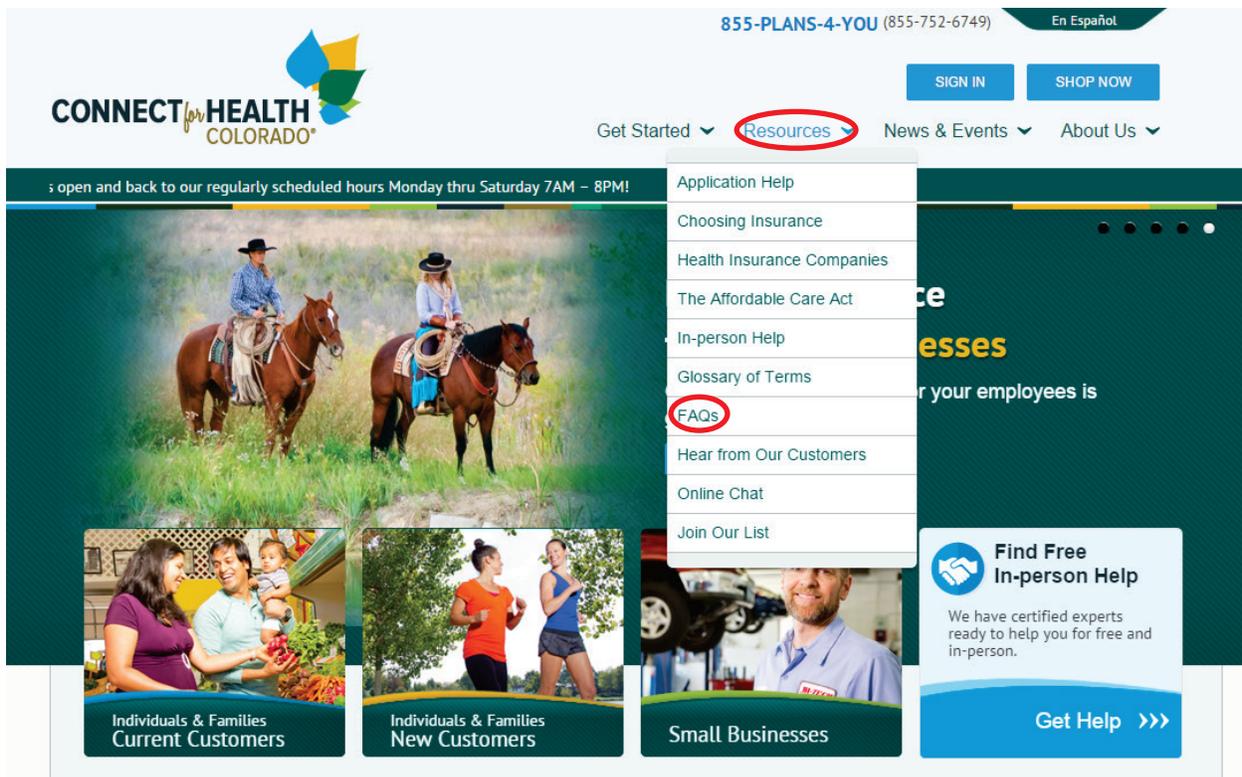
(CO17, 48-year-old African American female, new enrollee)

Figure 9. The Bottom Banner of the Connect for Colorado Homepage



A few participants were looking for the words “Frequently Asked Questions” instead of the abbreviated “FAQs,” so even when they went to the “Resources” header at the top of the homepage, they did not see the FAQs listed there (figure 10).

Figure 10. Resources Listed on the Connect for Health Colorado Homepage



Recommendations

Connect for Health Colorado may consider taking the following actions to help users locate the FAQs page more easily:

- **Include a “help drawer” on the top-right side of all webpages that includes access to the Frequently Asked Questions, as well as the glossary and online chat.**¹⁹ In addition, spell out the term “Frequently Asked Questions (FAQs)” rather than using only “FAQs.”
- **Rename the “Questions” under the “Brokers” heading on the bottom of the homepage to something such as “Questions for Brokers” to clarify that this is not the general FAQs link for consumers.**
- **List the FAQs webpage as the first returned result when consumers type “FAQs” in the search box on the homepage.**
- **Have the Avatar Kyla direct users to the FAQs page.**
- **List “General Information” and other most popular consumer topics to the top of the FAQs page** (rather than “Carrier Support” and “Carrier Team Questions” at the top of the page). This could help consumers find their topics of interest more quickly.

¹⁹ Enroll UX2014. (2012). *A new standard for public and private health insurance enrollment: Design specifications manual*. Retrieved from: <http://www.ux2014.org/deliverables>

Appendices

Appendix A. Colorado Comments

Staff from Connect for Health Colorado provided verbal feedback to AIR during a debrief session held on February 2, 2015. The feedback is summarized below.

Requests for clarification:

- We noticed the term “some” was used to describe the number of people who did or said something. How do we interpret that term?
 - *AIR Response:* AIR explained the qualitative analytical methods used and referred to the methods described in appendix C.
- Will there be a best practices report? We would like to know if a state is doing something well and it would be helpful if we could talk with them.
 - *AIR Response:* AIR explained that there will be a global summary report once all testing is complete. AIR is also now working with the states to schedule an informal conference call where states can share their best practices.
- For the word cloud, is it possible to differentiate which words were used to describe which parts of the website? We have different vendors. One is responsible for the shared eligibility application and shopping experience and the other is responsible for the other parts of the site. It would be helpful to know which parts the comments pertain to so that we can share this feedback with the vendors.
 - *AIR Response:* AIR added more details to the “Words That Describe Participant’s Overall Experience” section in Draft Work Product Version 2.
- For Task 5, when you write about the “eligibility application,” do you mean the “shared eligibility application”?
 - *AIR Response:* AIR revised the text to use the term “shared eligibility application” in Draft Work Product Version 2.

Responses to report findings for Task 6:

- It was noted that plan options loaded at a slow speed. We believe this to be an effect of the UAT environment. We have not seen that problem in the production environment.
- The price ranges shown on the sliding filters have been adjusted to correspond with the highest and lowest values for the plan options available in the search results.
- With regard to the recommendation to incorporate more definitions of terms, there had been more included last year. We are not sure where those definitions went.
- In response to the recommendation to clarify the term “no charge” that appeared on plan details pages during testing, a database change has occurred and this term is clarified on the production site.

Appendix B. Testing Guide

Colorado Website Usability Testing Guide

Testing Materials

- Laptop for testing
- Laptop for note-taking
- Audio recorder and extra batteries
- Interviewer clock
- Pens and notepads in each testing room
- Information sheet
- Interview guide
- Incentive payments

Procedures for Obtaining Informed Consent

As interviewees arrive, greeter should have them read the information sheet (if not enough time, interviewer should do this prior to starting). Give each person a copy of the form to keep.

Testing Goals

1. **Trust of website** – Who do respondents think is providing the information on the website? Do respondents trust the source of the information? Do they trust the information? Do they trust the processes? What would improve their trust of the web site? What would improve their trust of the processes (e.g., applying for a subsidy, enrolling in a plan, comparing plans)?
2. **Navigation of site** - Is it easy for respondents to find the information they need? What changes would improve their ability to navigate the site?
3. **Understanding and application of content** – How well can respondents understand and use the information as it is presented? How well do they understand and interpret the information? How well can they apply the information to their personal situation and help them achieve their purpose or goal (e.g., applying for a subsidy, comparing and choosing a plan)? What changes to display or text would improve their understanding?
4. **Ability to act** – What do respondents plan to do with the information? What influences their ability to act on the information presented in the website? What other information or supports do they need to take action?
5. **General response to the site** – What information on the site is of greatest interest to respondents? What do they like about the site? What don't they like? What would they want to know or do on the site?

Timing: 90 minutes total

Approximate time	Topic	Tasks	Elapsed time
5	A. Background	NA	5
5	B. Opening	NA	10
3	C. Public home page	Task 1: Purpose of the website.	13
7	D. Individual UAT Site	Task 2: Account creation.	20
20	E. Eligibility	Task 3: List of information or documents needed to apply for health insurance. Task 4: Does not apply. Task 5: Appeals. Task 6: Eligible for financial subsidy. Task 7: Eligibility notice.	40
20	F. Compare and Choose a Health Plan	Task 8: Find health plans. Task 9: Select health plan.	60
20	G. Enroll in a Health Plan	Task 10: Apply for health insurance.	80
5	H. Help Function	Task 11: Get help. Task 12: Find FAQs.	85
5	Closing	Task 13: Word search	90

Key Interview Questions and Probes

Think aloud reminders:

- Remember to tell me your thoughts and reactions as you're looking at the webpages.
- Can you tell me what you're thinking as you are working on the task?

Track where and what participants are looking at:

- What do you see first?
- Can you show me which part you were looking at when you got that reaction?
- Where are your eyes going? What are you looking at?
- What are you looking at now? What are your thoughts?

To elicit further information:

- And you say that because...
- How so?
- In what way?
- Tell me more about that
- Remember, there isn't any right or wrong answer. I just want to know your honest opinion. That's what will help in making improvements to this website.

{Probe on significant non-verbal communication, smiles, eye-rolling, etc. Don't over-probe non-verbal communication—i.e., don't probe to the point that it makes participant self-conscious}

[Interviewer begins reading intro here]

Background

5 minutes

- Thank you for agreeing to do this interview. My name is [NAME] and I'll be talking with you today. [INTRODUCE NOTE-TAKER]
- I work for a non-profit research organization, [American Institutes for Research].
- We'll be here about 90 minutes today. We won't be taking any formal breaks, but feel free to let me know if you need a break to go to the restroom [DESCRIBE LOCATION] or to get something to drink.
- Our discussion today is part of a project sponsored by the Centers for Medicare & Medicaid Services, a federal government agency that coordinates with States to set up Health Insurance Marketplaces, expand Medicaid, and regulate private health insurance plans.
- Because of the Affordable Care Act, which you may know as Obamacare, people can purchase health insurance plans through what's called a Health Insurance Marketplace. Today we'll be talking about a website developed by Connect for Health Colorado. The website is designed to help some individuals purchase health insurance.
- We would like to learn from you how the website design can be improved.
- We will ask you to perform a series of tasks. We will observe you as you are doing the tasks on the website to get a sense of how well the website is working. I'll ask you to tell me what you are thinking as you work on each task.
- I will try to keep silent when you are doing the task, to avoid influencing what you do. So if you ask me questions, I may not be able to answer, though I will try to help if you get really stuck.
- Once you are finished with the task, we will ask you questions so we can understand how to make the website better.
 - We will ask you questions to better understand your motivation behind making selections on the website. We are **not** interested in your (or your family's) personal health information. We just want to understand your thought process when viewing information on the website.
- Remember that **we are not testing you—we are testing the website**. My job is just to collect comments about the website. If something is unclear or confusing to you, it's bound to be confusing to other people too. If tasks are confusing, it shows problems with the design of the website (not you).
- I would like to **record our discussion** today so that I can make sure I capture all of your feedback. As I mentioned before, your full name or identity will not be associated with your comments.
- Everything you tell me will be **confidential**. We won't connect your personal contact information with anything that you say. While you will see us taking notes to record our discussion, within our notes and our final report, you will be known as "**Participant n.**"

Any questions?

- Before we begin I need to obtain verbal consent.
- Did you have the opportunity to look over the information sheet? (If no, review the information sheet with the participant).

Please answer yes or no to each of the following questions.	Yes	No
Do you understand the described project and agree to be interviewed as I guide you through Colorado's health insurance Marketplace website?		
Do you agree to have the interview recorded?		
Do you understand that your name will not be associated with reports or documents related to this project?		
Do you understand that you can withdraw your consent at any time and stop participating in the interview without any penalty to you?		

Ground Rules

- Please give us your honest feedback. Our goal is to make recommendations on how make the website more easy to use, so the more feedback you offer; the more you are helping us with improve the website.
- We have a lot to talk about today, so there may be times when I need to move the discussion along. Please understand that when I ask that we move to a new task, I don't mean to hurry you. If there is time later we can go back to pages you would like to explore more.
- Because we're recording, please try to speak in a voice at least as loud as the one I'm using now so that we can make sure the tape is picking up our voices.
- Before we begin, do you have any questions?

Opening 5 minutes

1. Where, if anywhere, have you ever looked for information about health insurance?
 - a. Where did you go or who did you talk with to get that information?
 - b. What kind of information did you look at?
 - c. What was most important to you?
2. Before today, what did you know about state health insurance Marketplaces?
 - a. Have you ever gone to the Connect for Health Colorado website before?
 - b. If so, what did you use it for?

Homepage **5 minutes**

As I mentioned, today we'll be talking about a website that provides information to help people compare and make decisions when selecting health insurance. One way that we figure out how to improve websites is to have a small group of people look at them first so we can find out about any potential problems and fix them.

The way we do this is by having you look at the website and tell us what you are thinking as you look at it. In other words, we want you to talk out loud about any thoughts, feelings, reactions or questions you have.

For example, if I asked you how many windows are in your living room you might think: "Well, my living room and dining room are connected, so there are 6, but I guess the question is just about my living room, so I will say 4." Today, we'd like to hear the thoughts going through your mind. As you do each task, go ahead and talk out loud and tell me what you're looking at, thinking, and what you are reading so we can understand your thought process.

Now, let's begin with the first task.

Task 1: Find and tell me the purpose of this website.

(ALT Description: What is the website designed to do? What can this website help you with?)



[GO TO SBM HOME PAGE AND OBSERVE]

1. What do you think are the main things you do or can learn about on this website?
2. Who do you think this site is for? (e.g., someone like you? Older persons? Younger persons? Someone with a health problem?)
 - a. What made you think that?
3. What were your general thoughts on the homepage?
4. What are some words that describe the webpage to you? E.g., clean, simple, confusing. *[note: we will give them the word card near the end of the session]*
5. Where would you want to go to next from this webpage?
6. What, if anything, on this page (the homepage) did you find to be confusing or unclear?
 - a. What could improve it?
7. Who do you think is running this webpage?
 - a. How did you figure that out?

Task 2: Create an account for this website.

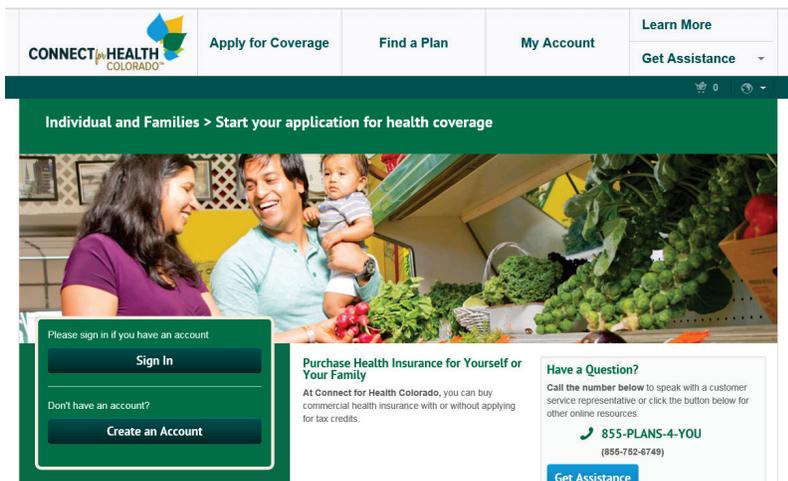
(ALT Description: If you wanted to create an account on this website, how would you do that? Please show me.)

Don't worry, the State has given us a fake information so you do not need to provide your real personal information.

CORRECT PATHS TO CREATING AN ACCOUNT:

Create an account:

- Create an Account



[GO TO SBM HOME PAGE AND OBSERVE]

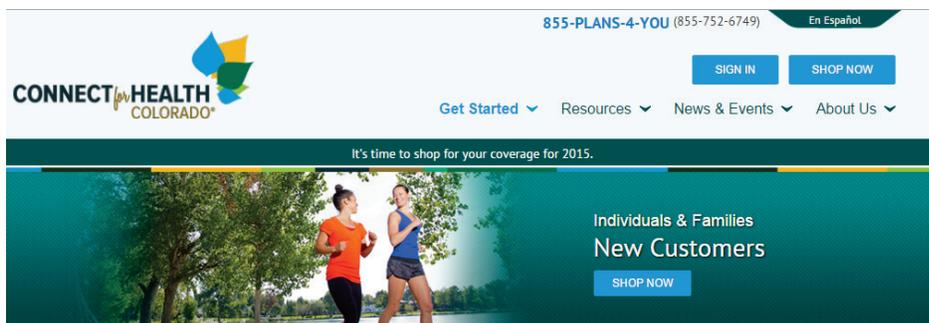
1. To what extent was the information located where you expected?
2. What, if anything, was confusing or unclear?
 - a. What could improve it?

Eligibility**20 minutes****Task 3: Find a list of the types of information or documents you would need to apply for health insurance for you (and/or your family) through the website.**

(Alt. Description: Before sitting down at the computer to apply for health insurance, let's say you wanted to know what type of information you would need to apply. See if you can find a list of the type of information or documents you would need in order to apply.)

CORRECT PATHS TO FIND A LIST OF INFORMATION YOU NEED TO APPLY:

1. Click on “Get Started” at top of homepage, then click “New Customers.” Click on “Use our quick checklist” under the first bullet on the page.



Welcome to Connect for Health Colorado®, the only place to apply for financial assistance to help reduce your costs and get access to a statewide network of free, in-person assistance. With the Affordable Care Act, more people now have access to more health insurance options. Now you can:

- ✓ [Get financial assistance](#) (if you qualify). [Use our quick checklist](#) to make sure you have all the information ready before applying!
- ✓ [View and compare](#) all plans available in your area
- ✓ Buy a health insurance plan regardless of a pre-existing condition
- ✓ [Access free, expert, in-person help](#) from our network of certified Brokers and Health Coverage Guides

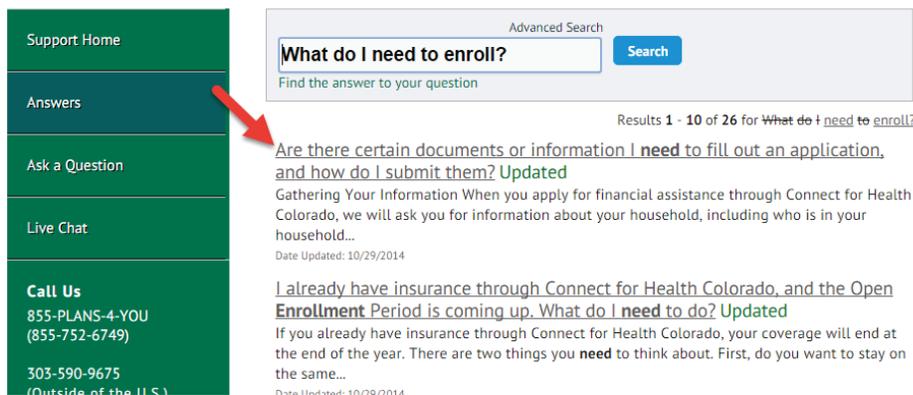
Calculate Your Savings

Use our savings calculators to see if you will be able to lower the cost of your health insurance.

**Individuals & Families
CALCULATOR**

**Small Businesses
CALCULATOR**

2. Click on “Learn More” under Individuals & Families – New Customers” on the homepage. Then click, “Use our quick checklist” under the first bullet on the page.3) Click the “Shop Now” button at the top of the homepage. Then click on “Learn More” at the top of the following page. After clicking “Learn More,” type “What do I need to enroll?” in the search box. The answer is the first option listed.



[OBSERVE]

1. To what extent was the information located where you expected?
2. What, if anything, was confusing or unclear?
 - a. What could improve it?

Task 5: Find information about how to appeal a decision from the Marketplace.

(Alt. Description: Let’s say that you have applied for health insurance through the website, and the Marketplace tells you that you are not eligible for financial assistance. However, you believe this is incorrect and that you really are eligible. You want to know how to appeal (or challenge) the Marketplace’s decision and let them know you don’t agree. Now try to find information on how you would go about this appeal.

To appeal means to tell someone at the Marketplace that you think the decision is wrong, and ask for a fair review of the decision about how much you would have to pay for your health insurance.)

CORRECT PATH TO FIND INFORMATION ABOUT HOW TO APPEAL:

1. Click “Learn More” on the homepage Scroll down to “Complaint/Appeal” and click on “Appeal – Why am I not eligible?”

The screenshot shows a support website interface. On the left is a dark green navigation sidebar with the following links: Support Home, Answers, Ask a Question, Live Chat, and Call Us (with phone numbers: 855-PLANS-4-YOU (855-752-6749), 303-590-9675 (Outside of the U.S.), and 855-346-3432 (TTY Line for the hearing impaired)).

At the top right is an 'Advanced Search' box with a search input field and a 'Search' button. Below the search box is the text 'Find the answer to your question'.

The main content area is titled 'Featured Support Categories' and is divided into four columns:

- Carrier Support:** SHOP Payment Questions, Enrollment Confirmation, Other.
- Carrier Team Questions:** Colorado Health Insurance Cooperative, I, Colorado Choice Health Plans, Cigna Health and Life Insurance Company, Elevate by Denver Health Medical Plan, Dentegra, Humana Health Plan Inc, Kaiser Foundation Health Plan of Colorad, Metropolitan Life Insurance Company, New Health Ventures, Inc, Premier Access Insurance Co, Rocky Mountain Health Plans, The Guardian Life Insurance Company of A, United Health Care, Anthem, Delta dental.
- General Information:** Healthcare Reform Questions, Affordable Care Act Questions, Status of a Complaint or Appeal, Customer Assistance Questions, Medicaid/CHP+/CICP, Medicare, Veterans Affairs, Employer Sponsored/Retiree Coverage, TRICARE, American Indian/Native American rules, Marketplace Questions.
- Enrolling:** Full Enrollment, Enrollment Process Question, Problem/error during web enrollment pr, Plan Choice Advice.
- Employer/SHOP Support:** Invoice/Billing, Drop/Terminate, LCE, Other, Eligibility.
- Complaint/Appeal:** Complaints about the Marketplace, Complaints about the plan or carrier, Complaints about access to benefits or p, Complaint about a Broker, Complaint about a Health Coverage Guide, Complaint about Service Center, Appeal-Why am I not eligible?, Appeal-Filing a formal appeal.

A red arrow points to the 'Appeal-Why am I not eligible?' link in the 'Complaint/Appeal' section.

CONNECT for HEALTH COLORADO

Apply for Coverage Find a Plan My Account Learn More Get Assistance

Support Home

Answers

Ask a Question

Live Chat

Call Us
855-PLANS-4-YOU (855-752-6749)
303-590-9675 (Outside of the U.S.)
855-346-3432 (TTY Line for the hearing impaired)

Advanced Search

Find the answer to your question

Search filters applied

Category

Complaint/Appeal Appeal-Why am I not eligible?

Results 1 - 2 of 2

[How can I submit a complaint? Updated](#)
If you have a complaint about Connect for Health Colorado, please visit our Customer Feedback page to determine the best course of action. It may be appropriate that you submit a formal appeal...
Date Updated: 11/12/2014

[I don't agree with my eligibility results. How do I appeal? Updated](#)
To appeal your eligibility determination for an exemption to the requirement to have health insurance, please follow the instructions provided to you in your determination notice. This determination...
Date Updated: 11/12/2014

[OBSERVE]

1. To what extent was this information located where you thought it would be?
2. What, if anything, was confusing or unclear?
 - a. What could improve it?

Task 6: Determine your eligibility to receive financial assistance to purchase the health insurance (get help paying for your health insurance).

(Alt. Description: let’s say that you want to get health insurance through this website. How would you find out if you could purchase it through the website? How would you find out if you could get financial help paying for your insurance through the website?)

CORRECT PATHWAYS FOR ELIGIBILITY TO RECEIVE FINANCIAL ASSISTANCE:

1. Apply for Coverage→My eligibility
2. My Account→My eligibility

Bobby Manriquez		View Account	Logout	Español	Print	
Apply For Benefits		This is a TEST environment. To file a real application, visit http://coloradopeak.force.com				
0%		What coverage you may qualify for:				
1 Start		<ul style="list-style-type: none"> Free or low-cost insurance from Medicaid or the Child Health Plan <i>Plus</i> Program(CHP+). A tax credit that can immediately help pay your premiums for health coverage even if you earn as much as \$94,000 a year (for a family of 4) Reduced out-of-pocket costs Affordable private health insurance plans that offer comprehensive coverage to help you stay well 				
2 People		Who should apply:				
3 Liquid Assets		<ul style="list-style-type: none"> Use this application to apply for yourself and anyone in your household. Apply even if you or your child already have health coverage. You could be eligible for lower-cost or free coverage. Single adults who aren't offered health coverage from their employer, don't have any dependents, and can't be claimed as a dependent on someone else's tax return may be able to receive benefits too. 				
4 Other Assets						
5 Job Income						
6 Other Income		<div style="display: flex; justify-content: flex-end; gap: 10px;"> Back Next </div>				

[OBSERVE]

1. To what extent was this information located where you thought it would be?
2. What, if anything, was confusing or unclear?
 - a. What could improve it?
3. Do you feel like the information on this page can be trusted? Tell me more about that.

Task 7: In your own words, tell me what this notice tells you [show eligibility notice].

(Alt. Description: You completed the eligibility application on this website. After the application is reviewed, you receive this notice. What is it telling you?)

1. What would you use this notice for?
2. What, if anything, is unclear or confusing?
 - a. What could improve it?

Compare and Choose a Health Plan **20 minutes**

Now, we want to think about comparing the health plans available on the website. You want to be sure that there are health plans that fit your needs.

Task 8: Find out what health insurance plans are available to you through this website and compare the features of at least two of the health insurance plans that you think might be a good fit for you.

(Alt. Description: Let’s say you want to review the health plan options and compare at least two of the plans to see which one you may prefer to purchase. Show me at least two health plans that you think may be a good fit for you.)

CORRECT PATH TO REVIEW PLANS:

1. Homepage → Find a plan → Plan finder tool

Participant may use “compare plans” feature or look at “plan details” to compare features

The screenshot shows the 'Plan Finder Tool' interface. On the left is a sidebar with 'Plan Quick Filters' including 'Search by Providers', 'Search by Medication', 'Adjust Monthly Premium' (with a slider from \$154⁹⁷ to \$432¹⁷), and 'Carriers'. The main area displays a table of health plans with columns for Monthly Premium, Carrier Details, Plan Details, Annual Deductibles, and Estimated Out of Pocket Costs. Three plans are visible, including Colorado HealthOP Bear HSA Qualified High Deductible Health Plan EPO and Colorado HealthOP Bear EPO.

MONTHLY PREMIUM	CARRIER DETAILS	PLAN DETAILS	ANNUAL DEDUCTIBLES	EST. OUT OF POCKET COSTS
\$154 ⁹⁷	Colorado HealthOP	Colorado HealthOP Bear HSA Qualified High Deductible Health Plan EPO Preferred Medication List EPO/Bronze	\$8,250 ⁰⁰ / Person \$12,500 ⁰⁰ / Family	Annual Max. Costs \$6,250 ⁰⁰ / Person \$12,500 ⁰⁰ / Family N/A
\$159 ⁸⁷	Colorado HealthOP	Colorado HealthOP Bear EPO Preferred Medication List EPO/Bronze	\$6,500 ⁰⁰ / Person \$13,000 ⁰⁰ / Family	Annual Max. Costs \$6,500 ⁰⁰ / Person \$13,000 ⁰⁰ / Family N/A
\$187 ²³	WASER FARMANETC.	KP CO Bronze 5000/30%HSA	\$5,000 ⁰⁰ / Person	Annual Max. Costs

[OBSERVE]

We are now going to ask you some questions to better understand your motivation behind comparing and choosing a health plan. We are **not** interested in your (or your family’s) personal health information. We just want to understand your thought process when viewing these plans on the website.

1. To what extent was this information located where you thought it would be?
2. What, if anything, was confusing or unclear?
3. When you went to shop for and compare plans, did you notice any changes in the look or feel of the website?
 - a. What URL would you type in to log into your account?

4. What were some of the main differences between the health insurance plans?
5. *What features were the most important to you? What makes them important to you?
6. *What types of information about the health insurance plans was missing or not included?
7. What terms or words about the health insurance plans were unclear?
8. *What could make it easier for you to compare at least two health plans?
9. At what points did you feel like you needed assistance?
 - a. How would you prefer to receive this assistance (phone, Web, in-person)?
 - b. What would you ask?
 - c. What makes you prefer to get the information in this way?

Task 9: Now that you have reviewed the different health plans, let’s say that you are ready to make a decision and select a health plan. Select the health plan that would be best for you [and your family].

(Alt. Description: think about the health plans that you just looked at and consider which one of them you would select for your insurance. Show me which plan you would pick.)

PATHWAY TO SELECTING A HEALTH PLAN:

1. While already in the plan finder, click on “Plan Details View”

MONTHLY PREMIUM	CARRIER DETAILS	PLAN DETAILS	ANNUAL DEDUCTIBLES	ANNUAL MAX. COSTS	
\$148 ⁶⁸	 <p>Rating in progress</p>	<p>Colorado HealthOP Bear HSA Qualified High Deductible Health Plan EPO Preferred Drug List EPO/Bronze</p>	<p>\$6,250⁰⁰ / Person \$12,500⁰⁰ / Family</p>	<p>\$6,250⁰⁰ / Person \$12,500⁰⁰ / Family</p>	<input type="button" value="Add to Cart"/>

Please review attachments in the Plan Documents section below for additional plan details to inform your decision. Each plan may have specific features, requirements, and age restrictions.

▼ General Plan Details			
	In Network	Out of Network	Out of Network
Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) - Individual	\$6250		Not Applicable
Combined Medical and Drug EHB Deductible - Individual	\$6250		Not Applicable
Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) - Family	\$12500		Not Applicable
Combined Medical and Drug EHB Deductible - Family	\$12500		Not Applicable
▶ Provider Office Visits			

* Note: These questions are priority and should not be skipped if time is short.

2. Or while the plan finder, click on “Plan List View”

MONTHLY PREMIUM	CARRIER DETAILS	PLAN DETAILS	ANNUAL DEDUCTIBLES	Annual Max. Costs	1-10 of 79	<	>
\$148 ⁶⁸	 Rating in progress <input type="checkbox"/> Select to compare	Colorado HealthOP Bear HSA Qualified High Deductible Health Plan EPO Preferred Drug List EPO/BRONZE	\$6,250 ⁰⁰ / Person \$12,500 ⁰⁰ / Family	\$6,250 ⁰⁰ / Person \$12,500 ⁰⁰ / Family	   		
							<input type="button" value="Add To Cart"/>

[OBSERVE]

1. Help me understand why you chose that plan?
2. What health plan features were most important to you (and/or your family) and why?
 - a. Doctors or hospitals
 - b. Costs (probe on what types of costs)
 - c. Benefits, such as:
 - i. Prescription medicines
 - ii. Physical, occupational, or speech therapy
 - iii. Home health care or assistance
3. What, if anything, was confusing or unclear?
4. Do you feel like the information on this page can be trusted? Tell me more about that.

Enroll in a Health Plan

20 minutes

[NOTE: Some sites require user name and passwords to enroll in a plan. If this is the case, we will ask the states for dummy test accounts for the purpose of testing. If we have dummy test accounts, please complete this section with the participant. If not, please proceed to the next section (Help Function).]

Now that you determined whether you are eligible for health insurance, you have selected a health plan, go ahead and ...

Task 10: Complete the enrollment process.

(Alt. Description: Go ahead and get (or sign up for) health insurance.)

Don't worry, the State has given us a fake username and password and you do not need to provide your real personal information.

CORRECT PATHWAY TO APPLYING FOR HEALTH INSURANCE:

1. From the plan finder, Add to cart→Check out→Apply

[OBSERVE]

2. To what extent was this information located where you thought it would be?
3. What, if anything, was confusing or unclear?
 - a. What could improve it?
4. What do you think happens next?
 - a. When do you expect this next step will happen?
5. How can you make the first premium payment for your health insurance?
 - a. Who are you paying for your health insurance (who is your insurance company)?
6. How did you feel going through this process?
7. What, if anything, did you feel like you needed assistance with?
 - a. How would you prefer to receive this assistance (phone, Web, in-person)?
 - b. What would you ask?
 - c. What makes you prefer to get the information in this way?
8. Do you feel like the information on this page can be trusted? Tell me more about that.

Help Function**5 minutes**

Now we want to focus on the help that is available on the website. (Need to go to public site at this point)

Task 11: Find out where you could get help if you were using this website and had questions.

(Alt. Description: Let's say you are using the website and you run into any type of question, where or how would you get help.)

CORRECT PATHS TO FINDING HELP:

1. Homepage → Resources, In-person help



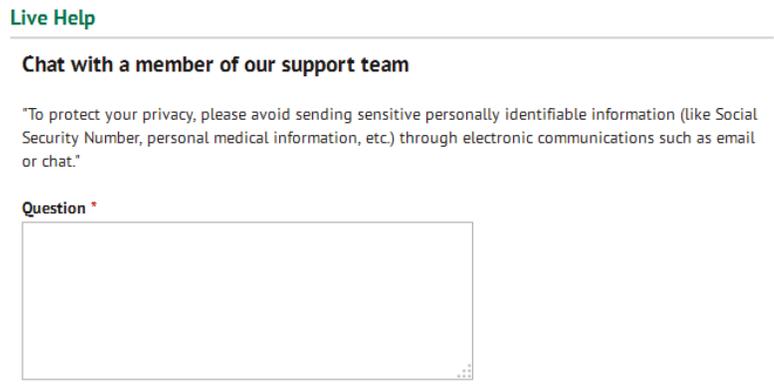
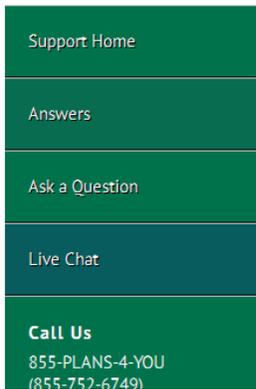
Free In-person Help

Insurance is complicated. That's why we offer a state-wide network of experts who can help you complete your application in person, at no charge. Our certified Brokers and Health Coverage Guides can help answer your questions and find a health insurance plan that meets your health and financial needs.

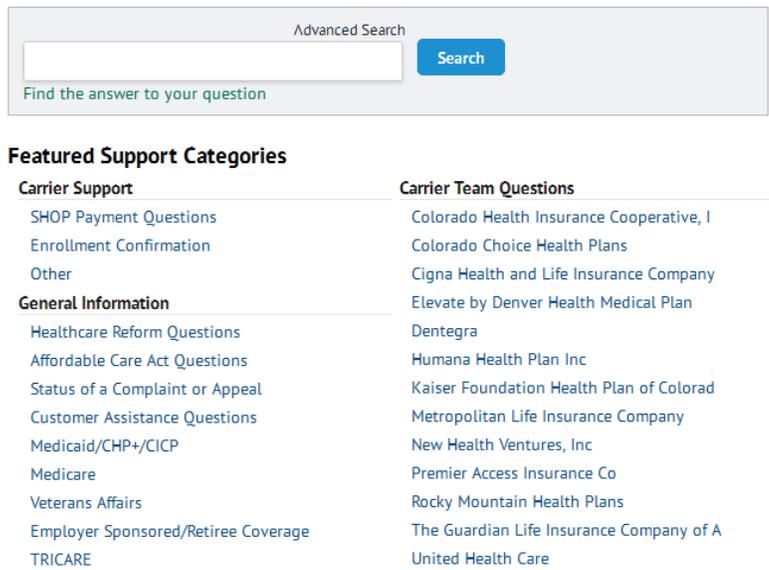
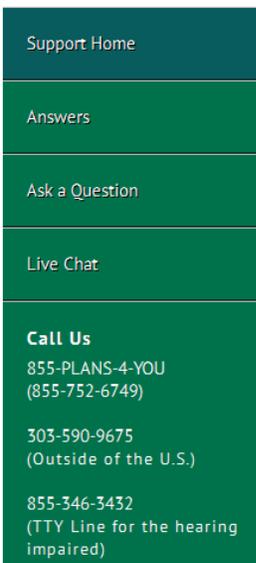


Use our savings calculator to see if you will be the cost of your plan.

2. Homepage → Resources, Online help



3. Homepage → Resources, FAQs



[OBSERVE]

1. To what extent was this information located where you thought it would be?
2. What, if anything, was confusing or unclear?
3. How else would you have liked to have been able to get help?
4. How would you prefer to get help? (website, phone, in-person). Please explain.
 - a. What would you ask?
 - b. What makes you prefer to get the information in this way?
 - c. 48. What are your thoughts on using the search bar?
5. *How likely are you to use the avatar (Kyla)?
 - a. How would you find her to be useful?
 - b. If she is useful, where else would you like to see her? OR If not, why?

Now, please think back to a specific topic that you would have liked to get more information about. This may have been a term that you saw that was unfamiliar or one of the questions that you asked me while you were performing the tasks.

Task 12: Find a list of frequently asked questions (FAQs).

(Alt. Description: You have a question but are not sure where to look to find information about it. You decide to look for a page that shares frequently asked questions so you can look through them.)

CORRECT PATHWAY TO FINDING FAQs:

1. Homepage → Resources, FAQs

The screenshot shows a website interface with a dark green sidebar on the left and a light grey main content area on the right. The sidebar contains links for 'Support Home', 'Answers', 'Ask a Question', 'Live Chat', and 'Call Us' with phone numbers. The main content area features an 'Advanced Search' bar with a search button and a 'Find the answer to your question' prompt. Below the search bar is a section titled 'Featured Support Categories' with two columns: 'Carrier Support' and 'Carrier Team Questions'. The 'Carrier Support' column lists categories like 'SHOP Payment Questions', 'Enrollment Confirmation', and 'Other'. The 'Carrier Team Questions' column lists various insurance providers such as 'Colorado Health Insurance Cooperative, I', 'Colorado Choice Health Plans', and 'Cigna Health and Life Insurance Company'.

[OBSERVE]

1. What do you think of what you’re seeing?
2. What, if anything, is confusing or unclear?
3. What else, if anything, could help you find these FAQs more easily?
4. What would you use this information for?

Closing	5 minutes
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Task 13: Now that you have used the website, can you circle [or select] 5 words that describe your experience using the website [hand word card sheet or cards]?

Before we end, I’d like to give you a chance to share any additional thoughts or comments about the items we talked about today. Was there anything that you didn’t have a chance to say during our discussion today or something that we didn’t talk about that you wish we had?

Thank you very much for participating in this discussion today. We appreciate your time.

Please circle the 5 words that best describe your experience using the website²⁰. Thank you!

Accessible	Desirable	Gets in the way	Patronizing	Stressful
Appealing	Easy to use	Hard to use	Personal	Time-consuming
Attractive	Efficient	High quality	Predictable	Time-saving
Busy	Empowering	Inconsistent	Relevant	Too technical
Collaborative	Exciting	Intimidating	Reliable	Trustworthy
Complex	Familiar	Inviting	Rigid	Uncontrollable
Comprehensive	Fast	Motivating	Simplistic	Unconventional
Confusing	Flexible	Not valuable	Slow	Unpredictable
Connected	Fresh	Organized	Sophisticated	Usable
Consistent	Frustrating	Overbearing	Stimulating	Useful
Customizable	Fun	Overwhelming	Straight Forward	Valuable

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²⁰ An alternative approach we may use is to instruct the respondent to do the following: Please select five cards from this pile that best describe your experience using the website.

Appendix C. Methods

Participant Characteristics.

AIR recruited consumers with demographic characteristics of people eligible to shop for and purchase insurance through the Marketplace website. To be eligible for the testing, consumers had to meet the following criteria:

1. U.S. citizen or national
2. Age of 18 to 64
3. Comfortable reviewing a website in English and answering questions in English
4. Used the internet in the past three months and have access to the internet either at home or through a public venue such as the library
5. Responsible for selecting health insurance for themselves and family, if applicable
6. Have not applied or enrolled via the Connect for Health Colorado Website during the fall 2014/winter 2015 open enrollment period for 2015 coverage

AIR recruited 12 consumers for this testing and 10 participated. Two participants did not appear at the scheduled time. Table C1 displays the demographic characteristics of the participating participants.

Table C1. Sample Characteristics (n=10)

Characteristic	Sample
Enrollee type	<ul style="list-style-type: none"> ■ 6 New ■ 4 Renewal
Eligibility	<ul style="list-style-type: none"> ■ 2 Medicaid ■ 7 QHP subsidy ■ 1 no subsidy
Health status	<ul style="list-style-type: none"> ■ 5 Chronic conditions ■ 5 No chronic conditions
Geographic	<ul style="list-style-type: none"> ■ 6 Suburban ■ 4 Urban ■ 0 Rural
Gender	<ul style="list-style-type: none"> ■ 3 Male ■ 7 Female
Average Age	<ul style="list-style-type: none"> ■ 37.9 years
Race	<ul style="list-style-type: none"> ■ 7 White/Caucasian ■ 2 Black/African-American ■ 1 Other
Ethnicity	<ul style="list-style-type: none"> ■ 3 Hispanic/Latino ■ 7 Not Hispanic/Latino
Education	<ul style="list-style-type: none"> ■ 1 High School Diploma or GED ■ 3 Vocational/Associate's/Some College ■ 5 Bachelor's Degree

Characteristic	Sample
Education (continued)	<ul style="list-style-type: none"> ■ Graduate Degree
Household size	<ul style="list-style-type: none"> ■ 7 Families ■ 3 Single

Conducting the Testing.

AIR conducted testing December 2-4, 2014, in Denver, Colorado. The participants used the Connect for Health Colorado User Acceptance Testing (UAT) website for Tasks 2-Create an account, 5-Determine eligibility, 6-Compare health plans, 7-Select a health plan, and 8-Enroll²¹; the remaining tasks were conducted on the public website.²² Participants completed the tasks using either Firefox or Chrome browsers on a PC.

An AIR facilitator, note taker, and observer participated in each 90 minute individual session. Due to time constraints, the facilitator asked the participant to complete a subset of the 11 tasks. The facilitator asked the participant to perform each task and “think aloud” as he/she performed the task. Upon completion of the task, the facilitator asked the participant follow-up questions. The note taker recorded what the participant said and the observer recorded the participant’s navigation on the website, non-verbal information, and the time to complete each task. The sessions were audio recorded. The AIR team used standardized templates for the notes, observations, and debriefs after each session. Each participant received a \$75 incentive as a thank you for their involvement.

Analysis.

Following the testing, the AIR team uploaded notes, observation forms, and debrief forms into a qualitative data analysis software (NVivo 10). AIR reviewed this information by task to identify the key issues, which are summarized in this report.

The issues highlighted in this report were selected based on the (a) proportion of participants who attempted the task who had the issue and (b) the potential negative impact on participants’ ability to complete the task. To describe the frequency that issues arose, we used terms such as:

- Most: experienced by more than half of those who attempted the task
- Some: experienced by less than half of those who attempted the task

²¹ Due to time constraints, some participants also compared and selected health plans on the public website.

²² The public website was used for the remaining tasks because the information needed for these tasks was located on the public website and not the UAT.

Customer and Stakeholder Feedback on Second Open Enrollment Period

Connect for Health Colorado regularly seeks input from customers, assistance channels and stakeholders to inform our policies and identify areas for improvement in our technology, processes and operations.

Within a year of opening the Marketplace, the organization had to plan and initiate a number of first-ever programs for 2014, including launch of the Shared Eligibility System and single financial application in collaboration with the state Department of Health Care Policy and Financing; the first Marketplace plan renewals program; and the inaugural 1095-A tax form implementation.

Given the short window between enrollment periods and complexity of these programs, obtaining ample and honest feedback is essential to identifying and prioritizing the most critical improvements to better our customer experience and establish long-term stability. Connect for Health Colorado has implemented a number of efforts to ensure constructive feedback before, during and after enrollment periods from key audiences.

Audiences

- *Staff* – bi-monthly meetings; strategic planning exercises; team meetings
- *Advisory Groups* – Rural AG, Individual Experience AG, Outreach & Communications AG – feedback meetings conducted in summer 2014, winter 2014 and March 2015
- *Brokers* – Monthly focus groups; state/regional meetings; emails; one-on-ones; special projects
- *Assistance Network* – daily HCG support calls; twice-monthly HUB meetings; feedback surveys; regional gatherings; site visits; emails; one-on-ones
- *Service Center* – Daily director meetings; daily report feedback; staff huddles; surveys
- *Carriers* – Monthly meetings; survey; focus groups
- *Community organizations and thought-leaders* – One-on-one meetings; participation in Advisory Groups
- *Customers* – Service Center comments; customer satisfaction surveys; social media; emails

Summary:

Our customers, sales channels, stakeholders and staff want a Marketplace that works and can succeed – but the experience of the most recent open enrollment period fell far short of meeting expectations for all. A difficult and complicated financial application process; technology glitches; an inability to fix problems quickly and inadequate communications have hindered our customers.

However, the numbers of individuals who have taken time to provide feedback and made recommendations suggest there is continued support of the Marketplace and confidence that efforts will be made to improve it.

Key learnings include the need to simplify the technology and ensure it works before the next enrollment period; make the entire process more consumer-friendly; improve training and communications; and give our Brokers, Health Coverage Guides, Certified Application Counselors and Service Center Representatives the tools they need to more effectively help Coloradans obtain coverage. Following is a summary of feedback related to the second enrollment period, which is helping staff prioritize and plan for the November 1 start of the next Open Enrollment.

Sales Channels: 287 Confidential comments were collected during two weeks in February - 65.2% brokers; 19.5% Health Coverage Guides; 13.6% Customer Service Representatives; 1.7% Certified Application Counselors.
Results:

Consistent Themes:

1. 2nd OEP experience was worse than 1st OEP
2. **More than 90% reported negative experiences with the financial application and determination process in the new SES**
 - a. Most common suggestion was to separate APTC and Medicaid determination processes
 - b. Application is too long and hard to understand
 - c. Technical interplay/data transfer between SES and Marketplace systems is poor
 - d. Fixing eligibility issues took too long – and communications with customers poor
 - e. Wide perception that testing of SES and interface with Marketplace was inadequate prior to launch
 - f. Training on new SES was too late/inadequate
 - g. Assistors (brokers, HCGs) need to be able to see applications from end-to-end so they can identify and correct problems within an application and update them
 - h. Rental income and self-employed income caused many barriers to quick eligibility completion
 - i. Legal Permanent Residents conflicts must be fixed so they can get coverage
3. Wait/hold/response times for Customer Service (both Marketplace and Medicaid) were too long
4. Follow-up on reported issues is not happening well or in acceptable time-frame
5. Inability to make changes to accounts and within financial applications is big problem
6. Customer Service Representatives are providing inconsistent answers
7. Small Business Marketplace needs significant improvements to ease small group enrollments
8. The technology and process worked best for those without financial assistance
9. Marketplace enrollment data is not going to carriers accurately or in adequate time period and customers are not getting enrollment packets/bills/cards timely
10. Assistors should be able to track their customer enrollments –specifically status of application; incident resolution; when confirmation is sent to carriers.
11. Improvements are needed to the renewal processes and communications to customers to avoid confusion (Split opinion on auto-renew program)
12. Marketplace site experienced multiple ‘slowness’ and ‘freezing up’ events
13. Broker portal did not work as expected
14. Brokers want more ability to make changes to applications
15. It is too difficult to cancel plans
16. Data transfer to carriers to ensure broker payments must be improved

Carrier Survey – February/March Sent to about 80 carrier contacts with 24% response. **Results:**

- 16% said enrollments with Marketplace met expectations “extremely” or “quite” well; 26% said “moderately” well
- 89% said their product portfolio has met customer needs
- Enhance renewal processes: move up timing; do not cancel passive renewals; better communication to customers; improve service center training on products
- Manage simultaneous enrollment process
- Prioritize enrollment data process improvement
- Automate reconciliation
- Separate/expedite SES financial assistance determination process
- Allow direct links from Marketplace site to carrier products

Assistance Network – March Survey to all Health Coverage Guides and Certified Application Counselors

What element of the Assistance Network do you think is most important to your customer:

1. Assistance available to meet needs of vulnerable populations (e.g. limited English, limited literacy, limited technical skills)
2. Organizations located in geographically convenient locations
3. Assistance available outside traditional hours
4. Assistance available on a walk-in basis
5. Organizations traveling to out stationed locations to meet customers

Which supports for your job are crucial?

1. Being provided resources for enrollment (65%)
2. Forums to provide user experience feedback and getting updates on Issues (54%)
3. Meetings with peers to share best practices and strategies (41%)
4. Being provided resources for outreach (41%)

What types of scheduling ended up being most successful?

- Regular business hours, scheduled appointments (71%)

In your opinion, what made the difference between customers who chose to buy insurance and those who did not?

Affordability/premium price

Value/total cost

Available budget

What 3 things would improve the customer experience with AN?

Don't go live with eligibility problems

Better trained SR on eligibility/IRS rules (not system results) and plan distinction

Less wait time for SR

More realistic messaging/transparency about errors/issues/work arounds

What 3 things would improve the HCG/CAC experience?

Don't go live with eligibility/tech problems

Visibility into application answers/determination results

Real Time SR triage teams with highly skilled eligibility and tech SMEs

More realistic messaging/transparency about errors/issues/work arounds

Advisory Group Meetings - March

Individual Experience and Outreach & Communications advisory groups

What worked well this Open Enrollment?

- Release of new technology and processes occurred too close to start of Open Enrollment
- Spanish outreach and media were improved
- There was better cooperation between Health Coverage Guides and Brokers
- The process of applying for coverage without financial assistance was smooth
- The knowledge base of assistors is stronger

What can be improved for future Open Enrollment Periods?

- Training must be improved
- We should analyze data of who did and did not enroll to better understand how to increase enrollments
- Must ensure correct determinations and subsidy calculations
- Must correct enrollment process for legal permanent residents of our state
- There is ineffective and untimely response to reports of issues/tickets
- Must make financial application easier to understand (more consumer-friendly)
- The Marketplace and HCPF need to understand that policy differences impact customers
- The renewal process was confusing and auto-renewals not handled well
- Assistors need to understand the timelines for system/program enhancements

Rural Regions Advisory Group

What worked well this Open Enrollment?

- Having in person enrollment events in local communities
- Advertising in local newspapers
- Local community organizations and agencies were a great referral base
- In person assistors had more experience and knowledge
- More people were spreading word of mouth to get covered
- Brokers and Health Coverage Guides were able to partner to help customers apply and enroll
- The application process for those not seeking financial assistance

What can be improved for future Open Enrollment Periods?

- More in person enrollment events
- More frequent and robust training, especially on how to calculate income
- The eligibility application for customers only seeking APTC/CSR
- Simplify language in eligibility notices
- Education to customers on health insurance basics
- Improve side by side comparison screens
- Easier access to the Summary of Benefits and Coverage on the shopping site