# ADVANCING HEALTH EQUITY IN THE HEALTH INSURANCE MARKETPLACE:

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

## EXECUTIVE SUMMARY

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**Developed by:**
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## ABOUT TEXAS HEALTH INSTITUTE

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

Texas Health Institute
8501 North Mopac Expressway, Suite 170
Austin, TX 78759
512-279-3910

## THI PROJECT TEAM

Nadia Siddiqui, MPH, Director of Health Equity Programs
Dennis Andrulis, PhD, MPH, Senior Research Scientist
Matthew Turner, PhD, MPH, Senior Health Policy Analyst
Anna Stelter, LMSW, MPH, Health Policy Analyst
Lauren Jahnke, MPAff, Health Policy Consultant

# INTRODUCTION

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

In this report, we feature findings from the pilot administration of the M-HEAT in Connecticut. It integrates public and self-reported data from Connecticut's health insurance marketplace with experience and perceptions of progress from community stakeholders and advocates. Results identify leading AHCT programs and policies as well as opportunities to build on significant initial progress and promise to reach, enroll, and retain all in coverage, regardless of race, ethnicity, spoken language, and gender identity.

The primary resource for this review, the M-HEAT, was created by THI to offer Connecticut and other states a protocol for evaluating progress in reaching and enrolling diverse populations in their respective marketplaces. The marketplace component of the M-HEAT compiles self-reported and publicly available data on health equity programs, progress, and performance. A parallel version, administered to community advocates and representatives within a state, was developed to offer an external "reference point" for the marketplace to measure how well it has worked to reach communities and advance equity. A common set of M-HEAT questions on both components are designed to determine areas of agreement and disagreement between the marketplace and its community stakeholders about progress and performance toward health equity across six key marketplace priorities.

# METHODS

The M-HEAT was developed and administered through a multi-stage process that significantly benefited from the ongoing engagement of representatives from AHCT and diverse communities in Connecticut. Following is a summary of key methods involved with developing, administering, and analyzing results of the M-HEAT:

### The Marketplace Health Equity Assessment Tool (M-HEAT)

**What is the M-HEAT?**

The M-HEAT is a tool to help measure health insurance marketplace progress and performance toward health equity. It uses the following two components to compile data from both the marketplace *and* community stakeholders:

- An 87-item health insurance marketplace assessment administered electronically; and
- A 46-item community stakeholder survey administered online.

**What are the M-HEAT's Objectives?**

- To take stock of the marketplace's ***actual health equity initiatives***;
- To understand the marketplace's ***perceived progress and performance*** toward equity; and
- To provide ***external, community-based validation*** of the marketplace's progress and performance toward health equity.

**What Does the M-HEAT Tell Us?**

- Level of ***commitment*** to health equity across marketplace functions;
- Point-in-time and over-time ***progress*** toward health equity;
- Program ***strengths and gaps*** toward health equity; and
- Marketplace and community-based ***opportunities*** for improving efforts to advance health equity.

- **Community Stakeholder Advisory Group.** THI assembled and consulted an advisory group of community advocates and stakeholders throughout the project, starting with an inaugural meeting on April 7, 2015 to inform and tailor the M-HEAT's content, followed by e-mail follow-up to review early drafts of the M-HEAT. A final in-person meeting took place on May 19, 2016 to discuss results.

- **M-HEAT Development.** THI developed two versions of the M-HEAT including a marketplace self-assessment tool and a community stakeholder survey, building on an extensive review of the literature on state-based marketplaces and existing health equity assessments.

- **Marketplace Self-Assessment**. Data on the marketplace version of the M-HEAT were collected between October 2015 and May 2016. Responses to questions on perceived health equity progress and performance were provided by designated AHCT staff. Objective data and information (e.g., enrollment and retention estimates) were provided by AHCT as well as compiled through publicly available reports and documents.

- **Community Stakeholder Survey.** The community version of the M-HEAT was administered online via Survey Monkey between October and December 2015. The survey was sent to 143 organizations of which 64 responded (45% response rate). Twenty-seven percent of respondents indicated an affiliation with community-based organizations, 23% with health centers or clinics, and 22% with advocacy groups. Nearly 70% of organizations reported working in some capacity with AHCT on outreach or enrollment. Over 75% said they served a racially and ethnically diverse population (e.g., 94% targeting Blacks and 89% targeting Hispanics).

### M-HEAT's Six Content Areas

**Part 1: Organizational Commitment to Advancing Health Equity** which assesses the extent to which the marketplace has made a commitment to health equity in organizational policies, financial resources, and human resources.

**Part 2: Plan Management and Health Equity** which asks about active purchasing, disparities data collection, and network adequacy.

**Part 3: Community Engagement and Collaboration** which focuses on the process and progress of diverse community and stakeholder engagement.

**Part 4: Navigator and In-Person Assistance Programs** which asks about the scope and reach of programs, training, and language services.

**Part 5: Marketing and Communication** which asks about the ways in which marketing and outreach explicitly targets diverse populations.

**Part 6: Marketplace Outcomes** which includes questions on number enrolled, renewed, and churned, as well as health care access measures.

# RESULTS

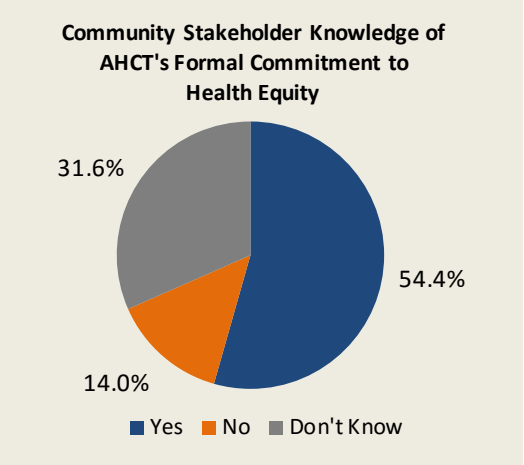
Results were organized into six sections corresponding to the six content areas of the M-HEAT. The following narrative summarizes key highlights from each section.

## Organizational Commitment to Health Equity

The M-HEAT sought to understand the extent to which the marketplace made an explicit strategic, organizational, and financial commitment to health equity.

***Strategic Commitment.*** Since establishment in 2011, AHCT has reflected health equity tenets in its mission and values. However, only 54% of community stakeholders were aware of this strategic commitment.

When asked to report how well they felt AHCT had communicated its commitment to health equity, just under half (49%) said this was communicated well.




***Leadership and Staff Diversity***. AHCT reported that it works to assure that its staff reflects the population it serves, and stakeholders generally agreed with this perception. However, stakeholders also perceived that those on the frontlines were more reflective of diversity than those in leadership roles. Whereas 51% and 38% of stakeholders felt that service center and other staff, respectively, were very or mostly reflective of racial/ethnic composition of target populations, only 20% felt this was the case for board and executive leadership.

***Financial Commitment***. AHCT reported that accounting procedures made it difficult to assess how much of its annual spending was dedicated specifically to advance health equity or for specific diverse population groups. When stakeholders were asked to share their perceptions on the importance of allocation of financial resources by diverse population groups, an overwhelming majority (over 90%) said this was important to track for racially, ethnically, and linguistically diverse and LGBTQ populations.

## Plan Management and Health Equity

The M-HEAT sought to understand the marketplace's efforts and progress to address health equity objectives in plan management—such as network adequacy, plan affordability, and data analytics.

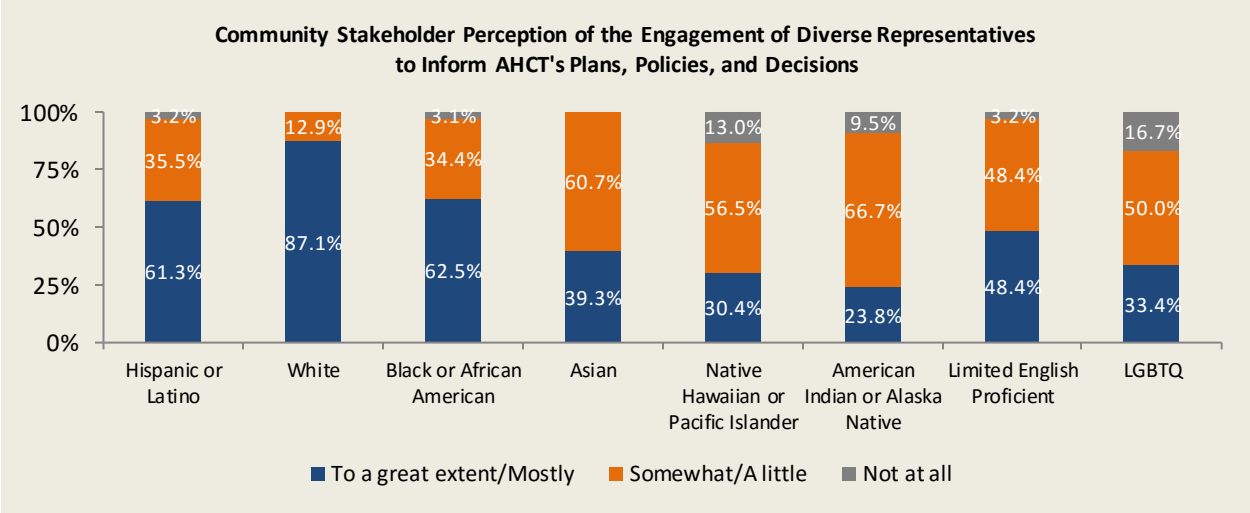
***Plan affordability and network adequacy.*** AHCT reported that it is committed to offering affordable, accessible plans, especially as Connecticut is one of just six states with statutes that set related standards and definitions. When stakeholders were asked about plan management, about half felt that AHCT assured that plans were affordable and included a range of care settings, including FQHCs and other essential community providers. Just under 50% of respondents felt that qualified health plans assured timely access to care and provided an adequate number and geographic distribution of providers. Less certainty was voiced about plans providing adequate culturally and linguistically appropriate services—only 39% felt this was mostly or to a great extent assured.

***Disparities data analytics***. AHCT reported providing enrollees the option to self-report their race, ethnicity, and primary language. However, over the past three years, this question has yielded a non-response rate of approximately 35%. In efforts to improve demographic data collection and address health disparities, Connecticut has established an All-Payer Claims Database (APCD).

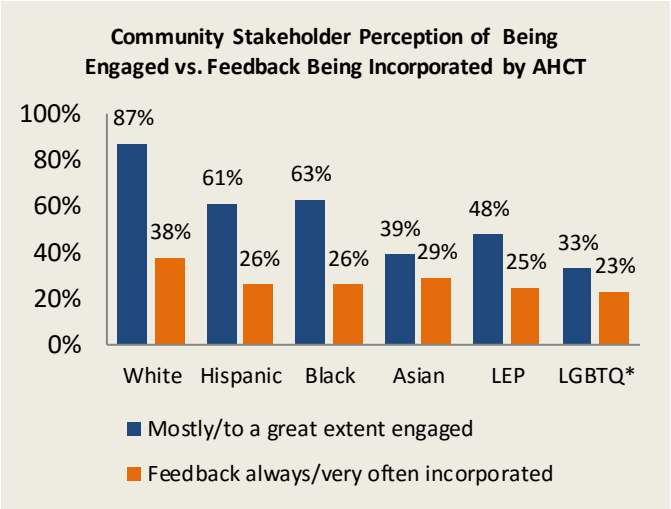
## Community Engagement and Collaboration

The M-HEAT asked a set of questions to understand AHCT's process and progress to engaging diverse community stakeholders and partners in other sectors.

***Overall engagement to inform policies and decisions***. AHCT reported that it mostly or to a great extent engages representatives from diverse population groups including White, Hispanic, Black, Asian, multi-racial and LGBTQ. They acknowledged only somewhat engaging Native Hawaiian/Pacific Islander and American Indian/Alaska Native communities. A majority of surveyed stakeholders felt that Whites were more often engaged to inform AHCT's policies and decisions than other non-White groups.




***Incorporation of stakeholder feedback.*** Community stakeholders indicated that while AHCT is successfully bringing the community to the table, feedback is integrated far less often, with variation by race/ethnicity. In general, Whites were perceived to have been engaged and their feedback incorporated most often, with less engagement and incorporation of feedback for non-White groups. While only a few respondents shared their perceptions about LGBTQ populations, those few responses suggest that this group is likely less engaged and heard by the marketplace.




***Cross-sector collaboration.*** AHCT shared that its most effective partnerships have been with community-based organizations, faith groups, ethnic media, universities, and philanthropies. More than half (54%) of responding stakeholders perceived that the AHCT's strongest and most effective partnership was with philanthropies. While 43% of stakeholders felt that partnerships with community-based organizations were effective, 23% felt they were not effective.

## Navigator and In-Person Assisters

Over the last three years, AHCT's outreach and enrollment initiatives shifted from an in-person focus to a primary presence in brick-and-mortar enrollment centers. The M-HEAT asked a series of questions on the scope, process, and reach of these programs.

***Diversity of navigators and assisters***. When asked the extent that outreach and enrollment assister organizations represented culturally and linguistically diverse populations, AHCT reported they were very representative across all three years. A large majority of community stakeholders generally agreed with this statement, but less so by language and for LGBTQ communities.

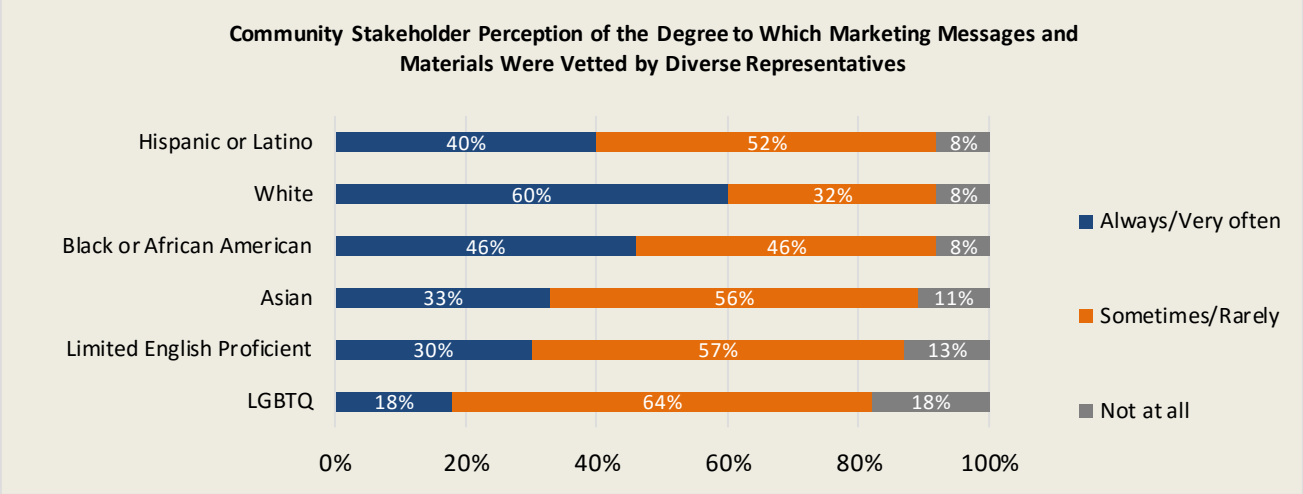
***Culturally and linguistically appropriate assistance***. AHCT reported it has been providing culturally and linguistically appropriate assistance since the inception of the marketplace; half of community stakeholders reported being aware of these programs. When asked specific questions about availability of interpreter

services, 61% of community stakeholders felt that interpreter services in a consumer's requested language were very often or always available.

## Marketing and Communication

The M-HEAT included questions on the ways in which marketing and outreach explicitly engages and targets diverse populations.

***Stakeholder engagement to inform marketing***. Both AHCT and stakeholders acknowledged that engagement of stakeholders to inform marketing varied by race/ethnicity. Asked to report how often AHCT incorporated community stakeholders' feedback on marketing messages, AHCT felt they did so very often. In contrast, the majority of stakeholders (68%) felt that marketing-related feedback to improve cultural and linguistic appropriateness was rarely or only sometimes incorporated.



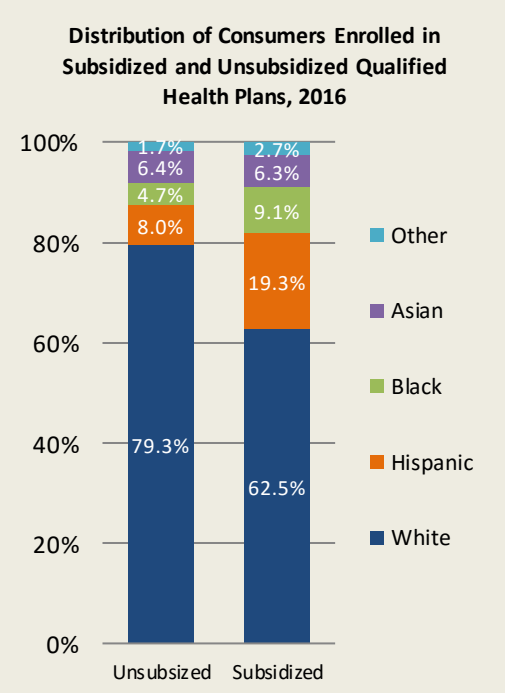

## Marketplace Outcomes

The M-HEAT collected data on marketplace outcomes, including enrollment, retention, and churn. These data were complemented by community perceptions on the effectiveness of the marketplace's efforts to enroll diverse populations.

***Enrollment, Retention, and Churn***. A total of 116,019 people enrolled in qualified health plans offered through AHCT by the end of the third open enrollment. However, as of April 2016, enrollment had dropped by nearly 11,000 to 105,437, including roughly 8,000 customers who failed to effectuate their coverage by making their first payment.

As of the third open enrollment, a greater proportion of Whites were enrolled in unsubsidized (79%) plans than subsidized (63%) when compared to their non-White counterparts. Over twice as many Hispanics and Blacks were enrolled in subsidized coverage than unsubsidized.

In addition, Spanish-speaking individuals (96%) were far more likely to be enrolled in a subsidized plan as compared to English-

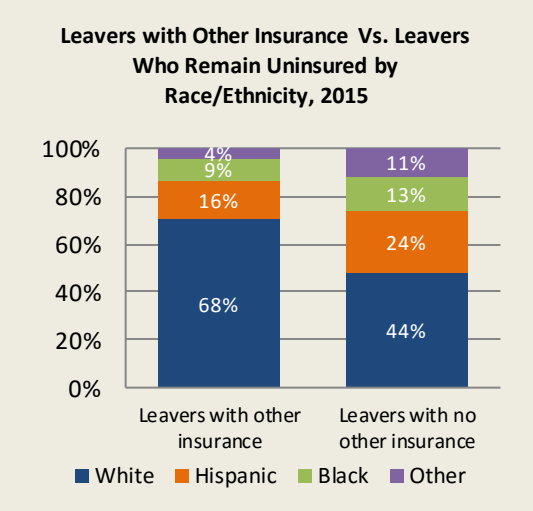


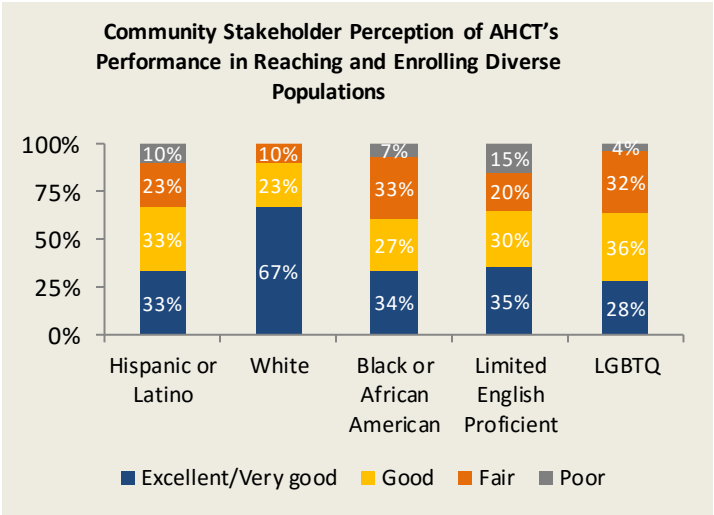

*Data source: AHCT, 2016 Note: Respondents with missing race/ethnic data are not included in the denominator.*

speaking (80%). AHCT's 2015 consumer survey found that Whites who left AHCT were more likely to have other insurance rather than remaining uninsured (68% vs. 44%, respectively). In contrast, a larger proportion of Hispanics (24% vs. 16%), Blacks (13% vs. 9%), and others (11% vs. 4%) remained uninsured than covered by other health insurance once they left AHCT.

***Community stakeholder perception of enrollment.*** Stakeholder responses varied by race and ethnicity, with two-thirds indicated that performance was at least very good for Whites as compared to only one-third for Hispanics, Blacks, and limited English proficient. Rating of performance was lowest for LGBTQ.

***Coverage to Care.*** AHCT's 2015 consumer survey found that non-White individuals were less engaged customers than their White counterparts. Fewer Blacks, Hispanics, and others (30%) reported both having used health insurance and having a primary care provider as compared to nearly double (54%) saying they have not used health insurance and do not have a provider




*Data source: The PERT Group. Access Health CT: Enrollee/Leaver Satisfaction and Understanding Study.* July 2015. See page 78.

# DISCUSSION

The pilot administration of the M-HEAT in Connecticut revealed a plethora of mutually identified strengths that suggest that AHCT is well on its way to working to advance health equity. At the same time, opportunities remain to fill gaps and improve coverage and access.

***Mutually identified strengths and successes.*** AHCT together with community stakeholders cited three key strengths of AHCT in working to advance health equity: (1) a strong, strategic commitment to health equity as defined in their mission and values, and more recently built into their new three-year strategic plan; (2) workforce diversity, especially among frontline staff and assisters working to reach and enroll diverse populations; and (3) cutting-edge technology, education, and resources.

***Differing health equity perceptions and realities***. AHCT and community stakeholders differed in their perceptions of progress toward health equity in three key areas: (1) engagement and incorporation of feedback from diverse community stakeholders; (2) marketing and communication tailored to diverse communities; and (3) financial commitment and accountability to health equity.

# AREAS OF OPPORTUNITY

This initiative has uniquely revealed a number of opportunities for the marketplace and community stakeholders to address in collaboration to improve outreach, enrollment, and retention of particularly hard-to-reach and diverse populations. We identified five areas of opportunity that build on both the gaps identified through the M-HEAT as well as our discussions with AHCT's Board of Directors and community stakeholders during the May 19, 2016, in-person briefings.

**Embracing health equity as an organizational priority.** While a codified commitment is a key first step, as AHCT has done, assuring that health equity is embraced by the organization—in personnel and resources—is central to advancing progress and accountability. As experience from the health care arena suggests, organizations successful in advancing health equity not only work to understand and engage local communities, but provide education and training on health equity to leadership and staff, build health equity measures into data analytics, and align resources to health equity objectives.

**Bridging the communication divide between AHCT and community stakeholders.** As continuing to build and sustain trust and understanding are fundamental to effective outreach, enrollment and retention, our data and stakeholders pointed to short-term and sustaning actions: (1) A stakeholder and marketplace retreat, mediated and facilitated by a neutral party, that allows for an candid dialogue to reinforce strengths and assets that each group brings to the joint effort to achieve health equity, and (2) an ongoing feedback loop established by the marketplace to provide regular, in-person opportunities for stakeholders to interact with marketplace staff, leaders, and board members.

**Restoring a focus on in-person assistance and meeting people where they are.** The remaining uninsured are in many cases less informed, more isolated, and may need additional assistance to enroll. Hesitant consumers may not be inclined to seek out help at storefronts, health fairs, and other events. These individuals are more likely to be receptive to education from trusted, culturally and linguistically representative messengers. The marketplace may consider enhancing initiatives currently embedded in enrollment centers by working with other community partners to meet hard-to-reach people where they are in their communities and provide in-person assistance.

**Improving data collection by race and ethnicity.** While AHCT plans to monitor disparities through its All Payer Claims Database, there may be opportunities to further encourage or support better data collection by health plans. For example, Covered California incentivizes health plans to increase the percentage of self-reported demographic data annually, with a goal of 80% by the end of 2019.

**Monitoring health equity progress over time**. The M-HEAT provided a unique platform for mutual discussion of common concerns between the marketplace and its community stakeholders. As such, AHCT and its partners may consider utilizing the tool in part or whole to continue monitoring progress toward health equity.

# CONCLUSION

AHCT has pursued extensive efforts to advance health equity, a commitment first reflected in its original mission and values and sustained through the continued pursuit of equity initiatives across numerous marketplace functions. This report offers insights on how AHCT's efforts have been received in the community, highlighting achievements to date as well as remaining opportunities for AHCT to build upon its initial years' work to advance health equity.