Identifying Barriers to Enrollment of Diverse Populations in Arizona Following the Initial Open-Enrollment Period of the Affordable Care Act

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Abstract

While it is known that over 266,000 Arizonans enrolled in health coverage through the federal Marketplace and Medicaid from October 2013 through May 2014, little analysis has been performed to examine whether enrollment by diverse racial and ethnic groups sufficiently reduced disparities in coverage. We obtained publicly available data from the Census Bureau comparing rates of uninsured by race/ethnicity from 2013 to 2014 in Arizona from the American Community Survey. The uninsured rate in Arizona for the total civilian non-institutionalized population dropped from 17% in 2013 to 13.6% in 2014. The uninsured rate in Arizona for whites declined from 15.7% to 12.2%, for African Americans declined from 17.4% to 11.1%, for American Indian/Alaskan Natives declined from 26.9% to 24.1%, for Asian Americans declined from 15.1% to 11.0% and for Hispanic/Latino declined from 27.5% to 22.2%. We conducted interviews with nine community organizations in order to identify barriers that must be addressed moving forward to lessen insurance coverage disparities among various minority groups. Technological literacy and functionality, lack of funding, lack of personnel, physical vastness of many populations, language, and cultural differences were commonly identified as barriers to enrollment. Mistrust of government and confusion regarding the specific provisions within the ACA pertaining to Native individuals were also cited.

Introduction

The Affordable Care Act (ACA) is one of the most substantial and most politically controversial bills regarding healthcare reform since the enacting of Medicare in 1965. Passed in 2010, the rollout of the new healthcare bill was fraught with difficulties regarding implementation. Despite these difficulties, the U.S. Department of Health and Human Services estimates that some 20 million Americans have gained health insurance coverage under the ACA since its inception. This represents a drop in the total uninsured rate for nonelderly adults from 20.4% just prior to the initial open-enrollment to 11.5% the following year. Many entities are providing analysis to see if the law is working equally and efficiently for all demographics of the population and further analysis of these 20 million enrollees is required to identify who exactly is making the biggest gains as a result of healthcare reform. Historically, there has been a large disparity between the rate of uninsured whites compared with various other minority populations, and this has held true in the state of Arizona. This study seeks to highlight best practices for enrollment organizations and to identify barriers to enrollment for minority populations.

Materials and Methods

Data for this project was obtained using Census Bureau Data from the American Community Survey. The data provided shows rates of uninsured racial and ethnic groups throughout Arizona before and after the initial open enrollment period of the ACA from November 1st 2013 through March 31st of 2014. We spoke with nine different representatives with organizations directly involved in enrollment, outreach and education efforts to decrease the number of uninsured residents of some of the most diverse and disadvantaged communities. Five questions were utilized to guide discussion regarding what went well, along with difficulties in getting people enrolled in the health insurance marketplace or through Medicaid expansion. Following the completion of all nine interviews, the information from the interviews was summarized and organized by barriers identified pertaining to specific racial and ethnic minority populations.

1. What is your background/organizational affiliation and what was your roll in promoting enrollment under healthcare reform?
2. What populations did you predominantly work with in this endeavor and what sort of health and insurance disparities are present in these populations?
3. What sort of difficulties did you encounter when working to enroll these populations?
4. What could have been done differently to eliminate these barriers to enrollment?
5. What more can be done to encourage enrollment for racial/ethnic minorities?

Five questions were used to guide the interviews with community leaders at organizations responsible for enrolling diverse groups around the state.

Results

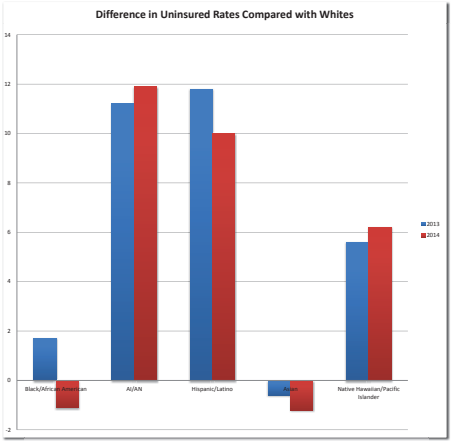

Figure 1: Absolute difference in percentage points between racial groups and whites before and after the initial open-enrollment period. Negative values signify groups with lower rates of uninsured compared to whites in Arizona.

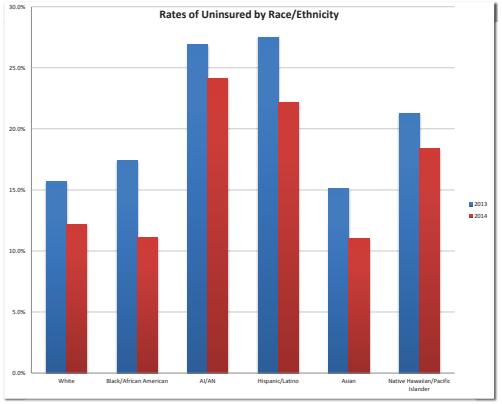

Figure 2: Rates of uninsured by race for the state of Arizona for both 2013 and 2014 following the initial open enrollment period. (AI/AN: American Indian/Alaskan Native)

Table 1: Rates of uninsured by race/ethnicity for 2013 and 2014 (before and after the initial open-enrollment period), along with absolute percentage point change, relative percent reduction in uninsured rate and absolute percentage point differential with the white uninsured rate.

Group	2013	2014	Percentage Point Change	Percentage Reduction in Rate	Differential with Whites
White Alone	15.7%	12.2%	-3.5	22.3%	2013/2014
Black	17.4%	11.1%	-6.3	36.2%	1.7/-1.1
AI/AN	26.9%	24.1%	-2.8	10.4%	11.2/11.9
Asian	15.1%	11.0%	-4.1	27.2%	-0.6/-1.2
Native Hawaiian/Other Pacific Islander	21.3%	18.4%	-2.9	13.6%	5.6/6.2
Hispanic/Latino	27.5%	22.2%	-5.3	19.3%	11.8/10.0
Other	30.1%	27.2%	-2.9	9.6%	14.4/15.0

Discussion and Conclusions

Multiple community groups allocated resources to target the uninsured African-American population in Arizona. Targeting predominantly black churches as a way to utilize community connections to identify the uninsured proved effective. Asian American groups showed particular cultural and linguistic barriers, described as both culturally suspicious and culturally self-reliant, creating a closed-community population that was difficult to break into. Although each of these racial groups experienced barriers, both surpassed whites in the rates of uninsured.

The Native American population has special regulations within the ACA, and many qualify for AHCCCS or subsidies but do not understand the need for obtaining coverage. Sentiment among some tribal members is that the federal government is obligated to provide healthcare services to Native peoples, and thus there is confusion about members' responsibilities in obtaining insurance. The organization operating out of Arizona was tasked with outreach to all Arizona tribes, along with tribes in Southern Utah and Nevada. The traditionally effective outreach and education efforts used in urban areas were ineffective in reaching a sufficient number of people. Another barrier were the differences in languages among tribes, and interpreters and translated outreach and educational materials were in short supply.

Regarding the Hispanic/Latino populations, a of mistrust of the government was often cited. Some enrollees were reluctant to submit personal information due to fear that this would be used against them politically or financially. For migrant populations, preventive care is not common practice, so promoting the need for health insurance was difficult. Technology proved to be a barrier as many Hispanics are uncomfortable or mistrusting of technology. Many rural or poor Hispanics may not utilize email due to lack of need or lack computer access. Initially, translated educational materials were only available electronically, when print sources were most effective. The ACA provision requiring legal residence likely contributed to the persistent rates of uninsured among Hispanics, as Arizona is estimated to have a significant undocumented Hispanic population ineligible for Medicaid or the exchange. Mixed immigration status families created unique difficulties for Navigators and Enrollment specialists who may have not had sufficient training in helping these special groups.

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