IDENTIFYING BARRIERS TO ENROLLMENT FOR DIVERSE POPULATIONS THROUGHOUT ARIZONA DURING 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.

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Introduction

The Affordable Care Act is one of the most substantial and most politically controversial bills regarding healthcare reform since the enacting of Medicare in 1965. Passed in 2010 by Congress and signed by President Obama, the rollout of the new healthcare bill has been fraught with difficulties regarding implementation, most notably the deficiencies in the Federally Facilitated Marketplace exchange website which functions in 37 states throughout the country. Despite the difficulties with the rollout, 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.[1] 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% today.[1] 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 to uninsured rates of various racial and ethnic minority populations, and this has held true in the state of Arizona. This paper looks at how rates of the uninsured have changed in the state of Arizona among various racial and ethnic groups following the initial open-enrollment period, while seeking to identify the potential barriers to enrollment that various minority groups face when seeking insurance coverage.

In 2008, over 46 million Americans were without health insurance coverage accounting for over 16% of the US population.[2] From 2001 to 2010, the uninsured rate increased from 16.1% to 18.2% and the Affordable Care Act (ACA) was implemented to combat this trend and to stem increasing healthcare costs and disparities.[3] The ACA was modeled on the Massachusetts healthcare reform implemented in 2006 that extended coverage to thousands of Massachusetts residents by mandating health insurance for all citizens, implementing Medicaid expansion and providing subsidies for low-income residents, among other provisions. The program was a success in terms of increasing insurance coverage, as uninsured rates for Massachusetts dropped from 10.4% in 2006 to somewhere between 2.7% and 4.8% by 2009, three years after the new reforms.[4] However, it remains unclear whether this has reduced

health disparities or improved the health of the general population. Van der Wees, Zaslavsky and Ayanian found that residents reported gains in general health, mental health and physical health, as well as increased use of preventive health services.[5] Conversely, Zhu et. al. found no improvements in access to a personal doctor or in health status.[6] Other studies have sought to evaluate the costs and benefits of expanding healthcare coverage to the 46 million uninsured Americans. Thornton and Rice estimated that a simple 10% increase in the insured population would result in a 1.69-1.92% reduction in mortality, and if insurance were extended to all uninsured in the US, 75,000 deaths would be prevented annually with a $400 billion annual economic benefit.[2]

Historically, non-Hispanic whites have been much more likely to have health insurance compared to various other racial and ethnic minority groups. According to US Census data for 2012, only 11.1% of non-Hispanic whites were uninsured compared to 19.0% of non-Hispanic blacks and 29.1% of Hispanics, illustrating high disparities in health insurance coverage among racial groups.[7] The Urban Institute estimated that full implementation of the ACA over one year could potentially reduce the white uninsured rate by 7.4 percentage points, the black uninsured rate by 11.8 percentage points, the Hispanic rate by 12.2 percentage points, and the Asian/Other rate by 8.2 percentage points.[8] However, due to the higher baseline uninsured rates for minority groups, the percent reduction in uninsured rates for whites and blacks would be 53.1% and 54.6% respectively, while Hispanics and Asian/other would see 36.6% and 44.1% respective reductions.[8] These predictions illustrate that although uninsured rates would lessen across the population, these reductions may not be experienced equally among racial groups. These disparities in insurance coverage can have adverse effects on health outcomes, and addressing these disparities in insurance status has been a driving force for healthcare reform.

Enrollment figures throughout the country as a result of ACA implementation are beginning to take shape and there are a number of interesting findings. Following the initial open enrollment period, the US Department of Health and Human Services released a briefing from the Assistant Secretary for Planning and Evaluation (ASPE) Office of Health Policy released data pertaining to enrollment statistics on the federally facilitated exchange for the initial open-enrollment period. According to the brief, 5,446,178 individuals selected a marketplace plan on

the FFM during the initial open-enrollment period. The state of Arizona accounted for 120,071 of these individuals.[9] Because Medicaid enrollment is not confined by an open-enrollment period, it is difficult to compare changes in Medicaid enrollment to those seen in the FFM. However, the Center for Medicare and Medicaid Services released a report following the initial open-enrollment period that revealed statistics for Medicaid and CHIP enrollment in the months prior to, and following the initial open-enrollment period of the FFM. From July to September 2013, the average Medicaid and CHIP enrollment across the country stood at 58,855,645 enrollees. For the month of March 2014, which signifies the final month of the open-enrollment period for FFM plans, this figure stood at 64,617,862 enrollees, representing 5,762,217 additional enrollees, an 8.2% increase in enrollment during this period.[10] The state of Arizona saw an increase from 1,201,770 to 1,301,010 enrollees over this same time period, representing a total increase of 99,240 enrollees and an 8.3% increase.[10]

The 2014 ASPE brief identified the total number of people by race who would qualify to obtain insurance through the FFM and compared this to the actual enrollment figures by race in the marketplace. Black and Asian enrollees accounted for 16.7% and 7.9% of marketplace selections respectively during the initial enrollment period despite accounting for only 13.3% and 3.3% respectively of the eligible population. Conversely, Latino and white enrollment accounted for 10.7% and 62.9% of FFM selections respectively, compared to being 14.5% and 66.5% of the eligible marketplace population.[9] These numbers include only enrollees who reported race on their application and only apply to enrollments in the marketplace, not for Medicaid/CHIP enrollments. In the most recent brief released by ASPE, data from the Gallup-Healthways Well-Being Index was used to trend uninsured rates by race and ethnicity from 2012 to 2016. From the last quarter of 2013 to the first quarter of 2014 (roughly the time period of the initial open-enrollment period), estimates of uninsured rates down-trended for all racial groups, including 12.8% from 14.3% for whites, 18.5% from 23.2% for blacks, and 38.4% from 41.2% for Hispanics.[1]

Methods and Materials

All data obtained for this project is publicly available data from the Maricopa County Department of Public Health. A request for data was placed with the Office of Epidemiology and Data Services and provided by epidemiologists at the county health department and we are grateful for their work in identifying the data pertinent to this quality improvement project. The data provided was in the form of 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. Simple calculations were performed to identify the percentage point change in insurance rates, percentage change in insurance rates, as well as the differential between whites and different minority groups.

This project also sought to identify barriers to enrollment, as well as best practices utilized by a number of community organizations that set forth to identify various populations throughout the state. We spoke with nine different representatives with organizations directly involved in enrollment, outreach and education efforts to increase the 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. The sample discussion questions can be found under the Table 5 of this document. Following the completion of all nine interviews, the information from the interviews were summarized and organized by barriers identified pertaining to specific racial and ethnic minority populations. Different topics identified by these interviews can be found in the Discussion section of this document.

Results

According to publicly available data requested through the Maricopa County Department of Public Health, we were able to compare the rates of uninsured of both the entire population of Arizona as well as specific racial and ethnic groups from 2013 to 2014 covering the initial open enrollment period of the ACA. The results are displayed in the Table 1. The percent of uninsured Arizona residents declined from 17.1% in 2013 to 13.6% in 2014. Additionally, the uninsured rates for whites declined from 15.7% to 12.2%, while African Americans declined from 17.4% to 11.1%, Hispanics from 27.5% to 22.2%, and Asians from 15.1% to 11.0%. In this same time period, uninsured rates for those potentially eligible for Medicaid making under 138% of the federal poverty level under the new expansion program decreased from 28% to 22%.[11]

Table 1: The rates of uninsured for specific racial/ethnic groups in Arizona before and after the open enrollment period of the ACA. Also shows the absolute percentage point change in uninsured rate, the percent reduction and the differential in uninsured rate compared with whites.

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

Table 2: Rates and numbers of uninsured by racial/ethnic group in Arizona before and after the initial open enrollment period, including confidence intervals (CI) and p-values for each racial group.

	Year	Uninsured	% Uninsured	Lower CI	Upper CI	Year	Uninsured	% Uninsured	Lower CI	Upper CI	p-value
Overall	2013	1118186	17.10%	17.03%	17.17%	2014	903328	13.60%	13.53%	13.67%	
White alone	2013	812188	15.70%	15.62%	15.78%	2014	633034	12.20%	12.12%	12.28%	<0.0001
Black or African American alone	2013	45960	17.40%	%	17.75%	2014	29851	11.10%	10.74%	11.46%	<0.0001
American Indian and Alaska Native alone	2013	76018	26.90%	26.58%	27.22%	2014	69745	24.10%	23.78%	24.42%	<0.0001
Asian alone	2013	28807	15.10%	14.69%	15.51%	2014	23015	11.00%	10.60%	11.40%	0.2
Native Hawaiian and Other Pacific Islander alone	2013	2542	21.30%	19.71%	22.89%	2014	2122	18.40%	16.75%	20.05%	0.26
Some other race alone	2013	121059	30.10%	29.84%	30.36%	2014	116380	27.20%	26.94%	27.46%	<0.0001
Two or more races	2013	31612	15.20%	14.80%	15.60%	2014	29181	13.20%	12.81%	13.59%	<0.0001
White alone, not Hispanic or Latino	2013	413735	11.20%	11.10%	11.30%	2014	320157	8.60%	8.50%	8.70%	<0.0001
Hispanic or Latino (of any race)	2013	541619	27.50%	27.38%	27.62%	2014	447970	22.20%	22.08%	22.32%	<0.0001

Table 3: Rates and numbers of uninsured by poverty status in Arizona, including confidence intervals (CI) and p-values.

	Year	Uninsured	% Uninsured	Lower CI	Upper CI	Year	Uninsured	% Uninsured	Lower CI	Upper CI	p-value
Civilian non-institutionalized population for whom poverty status is determined	2013	1109267	17.00%	16.93%	17.07%	2014	898956	14.00%	13.93%	14.07%	
Under 1.38 of poverty threshold	2013	487900	28.00%	27.87%	28.13%	2014	386168	22.00%	21.87%	22.13%	<0.0001
1.38 to 1.99 of poverty threshold	2013	221596	27.00%	26.82%	27.18%	2014	173155	21.00%	20.81%	21.19%	<0.0001
2.00 of poverty threshold and over	2013	399771	10.00%	9.91%	10.09%	2014	339633	9.00%	8.90%	9.10%	<0.0001

Table 4: Rates and numbers of uninsured by household income in Arizona, including confidence intervals (CI) and p-values.

	Year	Uninsured	% Uninsured	Lower CI	Upper CI	Year	Uninsured	% Uninsured	Lower CI	Upper CI	p-value
Civilian household population	2013	1105526	17.10%	17.03%	17.17%	2014	895082	13.60%	13.53%	13.67%	
Under $25,000	2013	330074	25.20%	25.05%	25.35%	2014	252183	20.00%	19.84%	20.16%	<0.0001
$25,000 to $49,999	2013	375412	23.50%	23.36%	23.64%	2014	298160	18.90%	18.76%	19.04%	<0.0001
$50,000 to $74,999	2013	214038	16.80%	16.64%	16.96%	2014	168530	13.10%	12.94%	13.26%	<0.0001
$75,000 to $99,999	2013	92785	11.00%	10.80%	11.20%	2014	83965	9.80%	9.60%	10.00%	<0.0001
$100,000 and over	2013	93217	6.40%	6.24%	6.56%	2014	92244	5.80%	5.65%	5.95%	<0.0001

Figure 1: Absolute percentage point differential for various racial/ethnic groups compared with Whites in Arizona before and after the initial open-enrollment period.

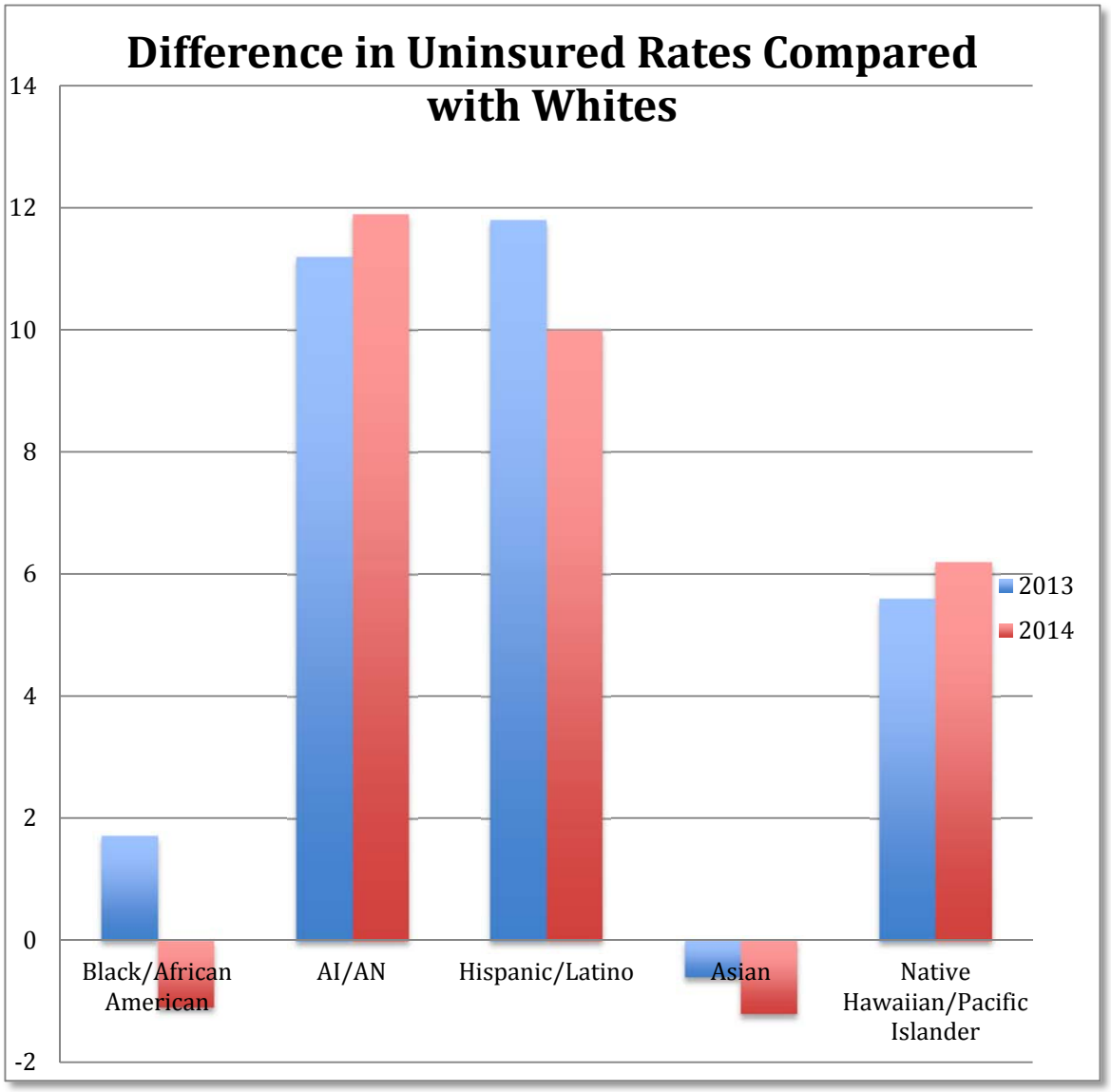
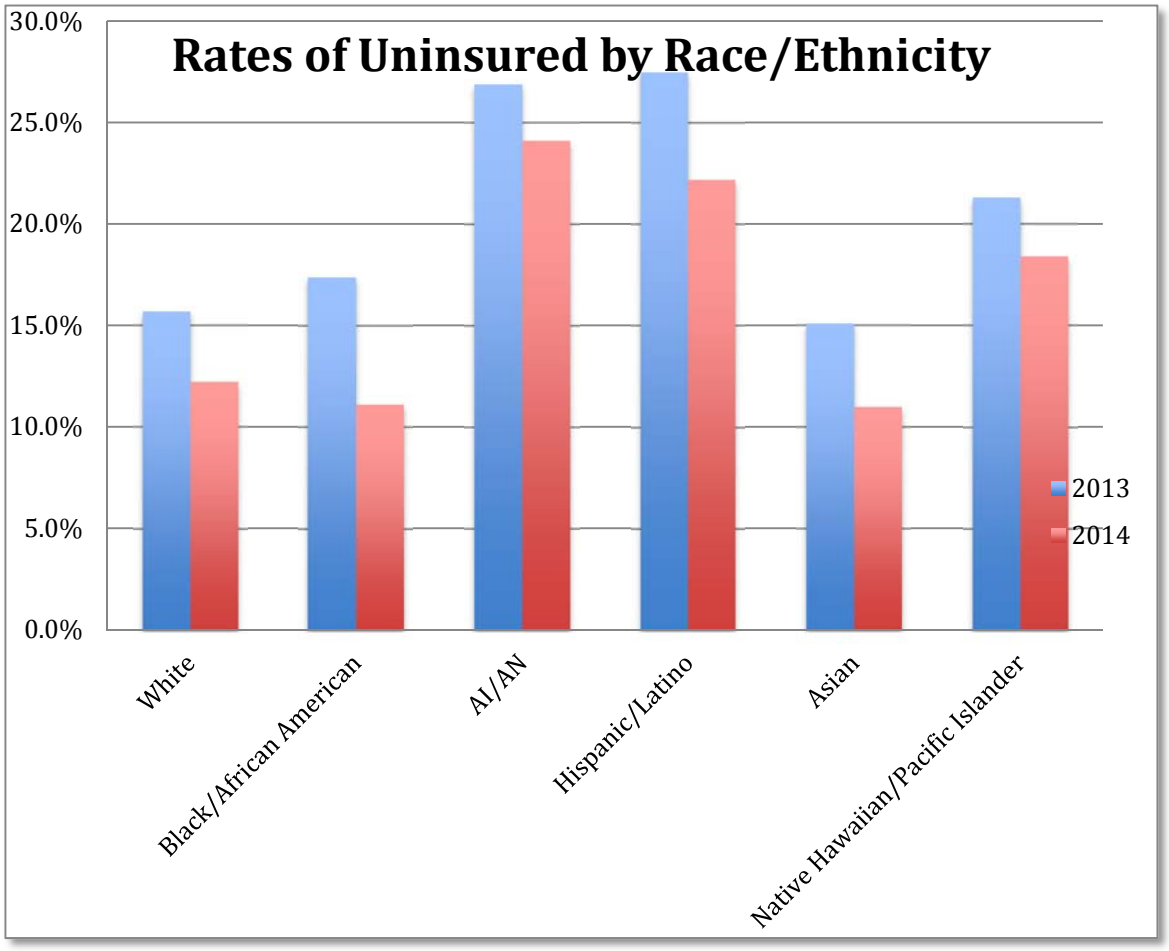


Figure 2: Rates of uninsured in Arizona for 2013 and 2014 by race/ethnicity in Arizona



Discussion

There are many things to be gleaned from the available data, and although all racial groups improved their respective rates of uninsured, these gains were not shared equally among each group. The Affordable Care Act was touted by many as a way to narrow the disparities in insurance rates between whites and non-white minorities. When analyzing the data, some important trends arise that should be taken note of. The three groups with the lowest initial rates of uninsured saw the largest percentage gains in insurance. Asians had the lowest initial rates of uninsured at 15.1% but showed a 27.2% reduction in the uninsured population. Whites had the second lowest baseline rates of uninsured and still achieved a robust decline of 22.3% in the uninsured. African Americans in Arizona showed the largest decline in uninsured rates by absolute percentage points with a 6.3 percentage point decline in uninsured rates, equating to a 36.2% reduction in the number of uninsured blacks. Conversely, those with the highest rates of baseline uninsured showed improvement, but not to the same extent as those with lower baseline rates. Although Hispanic/Latino residents saw a decline of 5.3 percentage points in their uninsured rate, they only saw a 19.3% reduction in uninsured individuals, because of this group's high baseline rates of uninsured. American Indian/Alaska Native groups in Arizona showed the smallest decline in the uninsured population with a mere 10.6% reduction. A number of potential factors play into these numbers and it is important to understand these unique trends. Hispanics and Native Americans have high baseline rates of being uninsured because of the unique social, political and economic forces at play in the state of Arizona and the ACA has not addressed these factors specifically to improve rates equally among groups.

Although gains in the number of insured individuals were observed across diverse populations, barriers remain to enrollment and must be addressed for future outreach and enrollment efforts. In order to identify these barriers, we first identified nine different community organizations across the state, which were involved in outreach and enrollment, with specific focus on groups who were responsible for targeting unique and diverse populations. We then conducted interviews with designated staff working within these organizations regarding their experiences during the initial open-enrollment period and the

issues they faced in successfully enrolling their targeted populations. A list of the various community organizations and interviewees can be found in the appendix of this document. Based on these responses, a number of barriers unique to Arizona populations were identified and will be covered in the following text.

Table 5: Five questions used to guide interviews and identify barriers and best practices from community organizations who were responsible for enrolling diverse populations across the state.

1. What is your background/organizational affiliation and what was your role 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?

Although the population is small in Arizona compared to other states, African Americans in Arizona experienced the greatest gains in insurance coverage following the initial open-enrollment period of the ACA. They showed a robust absolute percentage point decline of 6.3 percentage points, equaling a 36.2% reduction in the uninsured African American population. Also, they were one of two racial groups that surpassed the insured rates of whites, having a differential with whites of 1.7 percentage points lower before the open-enrollment period and ending with a better percentage of uninsured, beating whites by 1.1 percentage points. Multiple community and Navigator groups allocated resources to target the uninsured African-American population in Arizona. One group in particular had the best success targeting predominantly black churches in the area as a way to utilize community connections to identify the uninsured. Additionally, the uninsured African American community may have been most helped by the expansion of Medicaid in the state, as this group has traditionally been in lower income brackets.

Asian Americans were another group that saw great improvements in the rates of uninsured, with a reduction of 27.2% of the uninsured Asian Americans population in Arizona. Although this group had better insurance rates compared to whites before the enrollment period, their uninsured differential continued to widen from 0.6 percentage points to 1.2 percentage points less than the white group. One group in the Tucson area focused most of their resources in targeting the Asian American uninsured, with particular focus on refugee groups and others most likely to lack health insurance. These groups showed particular cultural and linguistic barriers that had to be overcome over many weeks and even months. According to community leaders, getting access to the people of these communities was difficult. Navigator organizations first had to approach the prominent leaders of these unique cultural communities in order to determine if the community members would be open to having a presentation about health insurance and the new health insurance law. Once approved and with the help of the community leaders and interpreters, the navigator organization was able to give presentations on the benefits of health insurance, tax implications and how to enroll in either AHCCCS or the Marketplace.

Multiple barriers were identified by this Navigator organization in regards to these unique communities. Eight different culturally distinct groups were identified by the Navigator organization and each had to be courted in culturally specific ways. Initially, there was no infrastructure set up to reach the various Asian-American groups, and a network of outreach and education had to be developed from scratch. Cultural barriers were the largest source of difficulty when attempting to reach these communities. These groups were described as both culturally suspicious and culturally self-reliant, creating a closed-community population that was difficult to break into if not part of the community oneself. Thus, all events had to be coordinated with leaders of these particular ethnic and cultural groups in order to break into this tight-knit community and share information about the Affordable Care Act. Additionally, because these communities had suspicions of the government and the program in general, first impressions were crucial to the success of educating these groups and the Navigators felt that they had only one chance to get it right. On further discussion with the Navigators, funding for interpreters and translated materials were lacking, and many of the materials available for English-speakers were not available for the 8 different subgroups of Asian-Americans identified. Additionally, interpreters and ambassadors within the community had to be trained on health-insurance literacy in order to educate and communicate with the various Asian-American groups. Health insurance literacy, as well as technologic literacy were identified as barriers to these groups. Because many are immigrants or refugees, health insurance is a uniquely American concept and educational efforts to improve understanding of the complex system were a constant challenge. Additionally, most resources offered for enrollees were virtual, including both informational materials and applications for enrollment. Those without email addresses or computers in the home were particularly disadvantaged in this process.

Arizona has a significant Native American population with multiple tribes spread out across the state, each with unique cultures, customs and resources but connected by their Native heritage and designations under the federal government. The Indian Health Service generally provides various primary care services to members of the numerous tribes, creating a unique population under the regulations of the ACA. IHS is a free service for members of the Native Community, but does have a limited budget and accepts insurance from any member

who has it in a fee-for-service model of care. Although services are free of charge to tribal members, specialty and more advanced ancillary services are not covered and insurance or self-pay is required to obtain such services. This creates issues with insurance and healthcare literacy among the Native populations, and many still qualify for AHCCCS or benefit from having insurance but do not understand the need. There is certain sentiment among some tribal members that according to various treaty rights, the federal government is obligated to provide healthcare services to Native peoples, and thus there is confusion about members' responsibilities in obtaining insurance. Additionally, there is also confusion on the side of the insurers. A local tribal organization held a conference with various insurance executives who admitted that they were not entirely familiar with the IHS system and how insurance operates within this federally funded organization, making it difficult for them to tailor marketplace plans to Native individuals operating differently than others seeking insurance. This could explain why the Native American group saw the smallest gains in decreasing rates of uninsured, with only a 10.4% reduction in the uninsured population.

A number of specific barriers were identified by the Navigator organization tasked with increasing enrollment and education among Native Americans. The organization operating out of Arizona under guidance of IHS was tasked with outreach to all Arizona tribes, along with tribes in Southern Utah and Nevada. This created the very difficult tasks of outreach and education as each tribe is culturally, geographically and linguistically unique. These Native populations cover vast stretches of land with individuals spread out over large distances, some with little resources for travel. Thus, the traditionally effective outreach and education efforts used in urban areas (health fairs, school gatherings, etc.) were ineffective in reaching a sufficient number of people. The physical constraints of this population required additional personnel that were simply not funded by the initial grants dispensed to the organization. Navigators also looked to use tribal media and advertising to disseminate their message about health insurance options available to Native populations. However, this form of advertising was found to be prohibitively expensive and funding for such methods was insufficient to truly reach the number of people necessary to substantially reduce the number of Native uninsured. Another barrier identified was the differences in language among various tribes. Interpreter

services and translated outreach and educational materials were in short supply, illustrating the need for additional grants to organizations targeting linguistically unique populations.

The Hispanic/Latino population in Arizona saw the second-largest drop in absolute percentage points, dropping 5.3 percentage points in the rate of uninsured. However, because the baseline rates for uninsured are so high in this population, this group remains the largest uninsured population at 22.2% behind Native Americans and the Other racial group. Although rates remain high, the uninsured differential with whites did drop slightly from 11.8 percentage points to 10 percentage points. This illustrates that the ACA did help to close racial disparities in insurance coverage, but much more work needs to be done.

Barriers specific to the Hispanic/Latino population were identified through interviews with numerous community organizations, each of whom worked predominantly with uninsured Hispanics. A reoccurring theme among these interviews illustrated a significant barrier to enrollment: mistrust of the government. In 2010, Arizona passed the controversial State Bill 1070, better known as the "Show Me Your Papers" law. Proponents of the law touted it as the state's solution to illegal immigration, while opponents saw it as a biased and racially-motivated attempt to disenfranchise Hispanics. Although the most controversial parts of the bill were struck down by the courts, the resulting mistrust of the government by the Hispanic community became reinforced and continues to influence social and cultural interaction. Multiple organizations found it difficult to convince enrollees to give their personal information because enrollees feared this information would be used against them politically, financially or regarding immigration for themselves or their families. One organization began changing information from reading "Government mandated" to "Resources available to you" and seemed to improve their outreach and educational efforts.

Another barrier cited by Navigators and enrollment organizations were issues with literacy regarding the American health insurance system. This was prevalent in various communities, but notable in the migrant agricultural communities closer to the US-Mexico border. Many of these migrants travel to Mexico to receive care at much more affordable rates. The general sentiment among many in this population is to seek care when sick. The idea of preventive care, a cornerstone of the ACA, is not generally common practice among this

population, so convincing them of the need for health insurance was a tall order. The migrant worker population is also located in rural areas of the state, making it difficult to physically reach individuals and work with them on a face-to-face basis. Funding for enrollment and outreach training for personnel could have been improved in order to have more physical presence in the rural areas where many of the uninsured live. Technology also became a regularly cited barrier by community workers. Many Hispanics are technologically illiterate, or mistrusting of technology. An email address was required to fill out the initial application, something that rural or poor Hispanics may not have due to lack of need or lack of access to a computer. Many educational materials were created in both English and Spanish, however only English print sources were circulated initially. Spanish versions were available, but only virtual versions were created initially, making them much less effective due to the lack of technology use by the Spanish-speaking population.

Finally, the most prominent barrier to the Hispanic population is written within the law itself. Currently, all individuals who wish to qualify for Medicaid or subsidies on the marketplace must be legal citizens and reside within the US for five years. This provision could explain the significant number of remaining uninsured, as it is estimated that Arizona has a significant undocumented Hispanic population that is not eligible for any sort of help under the ACA. Because many families have mixed immigration status, some were reluctant to even seek enrollment for those who were eligible. Additionally, mixed immigration status families created unique difficulties for Navigators and Enrollment specialists who may have not had sufficient training in helping these special groups.

Future Directions

As the ACA continues to evolve, a number of opportunities arise for the nation to reduce the number of uninsured across all racial and ethnic groups. Funding continues to be a significant barrier and needs to be strengthened for future efforts on outreach, education and enrollment. Many uninsured minorities continue to be hindered by physical constraints, living in rural locations or under constant migration for work, family, etc. Increasing the number of committed enrollment specialists and navigators could significantly help with reaching these vulnerable populations and planting the seeds that lead to enrollment. The law itself places specific barriers to immigrants and refugees, particularly Hispanics and other minority populations. Until all residents are incorporated into the regulations of the law, a significant population will continue to go without insurance.

Conclusions

Following the initial open enrollment period of the ACA, the rates of uninsured among various ethnic and racial minorities improved across all groups, though some experienced greater gains than others. The gap in rates of uninsured for the largest minority groups compared to whites narrowed for every group except Native Americans/Alaskan Natives where the differential widened. Both African Americans and Asian populations in Arizona surpassed their white counterparts, finishing the open enrollment period with lower rates of uninsured than whites. More resources must be committed and best practices must be adopted in order to continue to lower the rates of uninsured minorities within the state of Arizona.

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