

# REPORT

## The Seedco Health Insurance Navigator Enrollment Process in Georgia, Maryland, New York, and Tennessee

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### Policy Implications and Opportunities for Quality Improvement

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## **EXECUTIVE SUMMARY**

### **BACKGROUND**

The Patient Protection and Affordable Care Act (ACA) put in place reforms that improve access to quality, affordable health coverage. One of the provisions of the ACA was the creation of new Health Insurance Exchanges, or Marketplaces, to provide a one-stop-shop for Consumers to compare plans, apply for subsidies or public insurance, and enroll in health coverage. The ACA also required each Marketplace to fund a Navigator function to provide in-person outreach, education and enrollment assistance. In 2013, Seedco was awarded funding to lead Navigator consortia in 4 states, Georgia, Maryland, New York, and Tennessee, overseeing Navigator training and program implementation. Seedco is a national nonprofit organization, founded in 1987, with a mission to advance economic opportunity for people, communities and businesses in need. Seedco operates programs in workforce development and benefits outreach and enrollment; and provides technical assistance services for small businesses and nonprofits.

Seedco Navigators operate in two states that opted to create their own insurance Marketplaces and that expanded Medicaid eligibility: New York and Maryland. Seedco Navigators also operate in two states that utilize the federally facilitated Marketplace and that opted out of Medicaid eligibility expansion: Georgia and Tennessee. In light of the diverse environments in which it operated during the first ACA open enrollment period in 2013-2014, Seedco leadership commissioned an evaluation study to learn about barriers and facilitators to health insurance navigation. The study was conducted by researchers in the Department of Health Policy and Management in the College of Public Health at the University of Georgia.

The primary purpose of this evaluation report is to identify factors associated with successful facilitated enrollment of Consumers in health coverage by consortium-contracted health insurance Navigators in four states, Georgia, Maryland, New York, and Tennessee, during the October 1, 2013 – March 31, 2014 Patient Protection and Affordable Care Act (ACA) open enrollment period. This evaluation was carried out so that findings can be used by Seedco and other Navigator entities as well as policy makers to inform program design and Navigator training protocols, and to ultimately increase successful enrollment of Consumers.

Seedco's role in the implementation of the 2010 ACA began when the Centers for Medicaid & Medicare Services (CMS; a branch of the US Department of Health and Human Services) awarded it a contract in 2013 to oversee health insurance Navigator programs in Georgia and Tennessee (federally facilitated exchange states). Seedco obtained similar contracts from the states of Maryland and New York (states that established their own exchanges).

Seedco leadership recognized these Navigator programs as an opportunity to identify barriers to enrollment, factors that are facilitators to successful health insurance enrollment, training needs for Navigators, and best practices for in-person education and assistance. Seedco contracted with a research team from the Department of Health Policy and Management in the College of Public Health at the University of Georgia to collaborate in carrying out a rapid-response evaluation of the Seedco Navigator programs in four states. The evaluation collected and analyzed data from several sources that reflected on Consumer experiences and Navigator effectiveness during the first ACA open-enrollment period. Results of this evaluation can inform quality improvement activities, subsequent Seedco participation in ACA marketplace activities, and can also contribute to evidence-based health benefits system reform.

## **CONTEXT OF THE EVALUATION**

The ACA encourages state-run insurance exchanges, or Marketplaces, but residents of states that do not establish their own exchanges may use a federally facilitated Marketplace to shop for insurance plans and to apply for subsidies. Of the Seedco Navigator program states, Maryland and New York created their own Marketplaces, while Georgia and Tennessee defaulted to the federally facilitated Marketplace.

Similarly, Maryland and New York expanded Medicaid eligibility while Georgia and Tennessee declined Medicaid eligibility expansion despite federal incentives. By not expanding Medicaid eligibility, Georgia and Tennessee each created a Medicaid “gap;” in other words, a significant number of people have incomes too low to qualify for subsidies/tax credits on plans purchased through the federally facilitated Marketplace, but too high to qualify for public coverage through Medicaid. In Georgia, an estimated 410,000 people—nearly 1 in 3 of all uninsured adults—fell into that gap. In Tennessee, about 161,000—1 in 4 uninsured adults—were ineligible for either Marketplace or public coverage (Kaiser 2014). Because Seedco operated in these diverse environments, the study was well positioned to identify relative benefits and consequences of different state policy decisions.

Seedco provides oversight for a network of local community-based partner organizations: seven partners in New York City to cover the five boroughs; six partners on Maryland’s Upper Eastern Shore region, one of the six regions in the state; 14 partners serving the entire state of Georgia; and eight partners serving the entire state of Tennessee. Navigators employed by these agencies have to meet state and federal screening, training, and licensing requirements. Georgia and Tennessee enacted additional licensing requirements through the offices of their state Insurance Commissioners.

Online federal and state Marketplaces are meant to enable Consumers to self-enroll. Navigators supplement those resources by providing in-person public outreach, education, and enrollment assistance for Consumers. As extensively reported in various

sources technical problems associated with the federal Marketplace website resulted in high rates of self-enrollment failure for Consumers during much of the early open-enrollment period. Both the New York and Maryland Marketplaces experienced technical issues, but Maryland experienced much more serious issues throughout all of open enrollment. Since Navigators depend on many of those same online resources, their activity was likewise severely curtailed by technological factors beyond their control. Consumer experience with Navigators was dramatically affected by these technological factors.

## **GOALS AND METHODS OF EVALUATION**

The primary purpose of the study was to identify factors associated with successful enrollment by Seedco of Consumers in private Qualified Health Plans (QHPs) or in public insurance. The overall goals—operationalized in terms of more specific objectives—include the following:

- Identifying disparities in health insurance enrollment and experience for Consumers who came in contact with Seedco Navigators
- Understanding how Consumer health literacy and health needs and Navigator communication practices influence health insurance enrollment
- Identifying areas for structural and operational improvement (including Navigator training) for next round of open enrollment

The study utilized mixed quantitative and qualitative methods. While quantitative survey results can be used to paint a generalizable “big picture” around Consumer characteristics and outcomes, analyses of qualitative data can be used to provide more in-depth understanding of phenomena and processes.

### ***Survey data***

In the process of meeting with Consumers, Navigators entered quantitative data from Consumer contacts into a Seedco-designed Salesforce database. Salesforce is a proprietary, customizable, web-based, HIPPA-compliant, secure database application. In addition to demographic information, Salesforce data documented Consumers’ progress through the enrollment process (e.g., just opening an online marketplace account versus submitting an application or selecting a plan). Additional survey items captured data about Consumers’ health literacy, health status, unmet medical needs, and financial security. Information was only recorded for Consumers who consented, and all consumer data were recorded, stored, and transferred in compliance with the relevant privacy laws and regulations.

The Salesforce database (n=14,584) is a unique and illuminating data source. However, consistency in data collection was confounded during this first open enrollment period by a number of factors including divergent data fields and definitions employed in

surveys across the four states, inconsistent guidelines for data collection among the individual states and the federal government, and lack of consistent recordkeeping practices by Navigators who were under a great deal of pressure to assist Consumers and did not always prioritize documentation among their many tasks.

### ***Semi-structured telephone interviews with Navigators and Consumers***

Qualitative data were collected via semi-structured telephone interviews conducted by medical anthropologists with extensive training and experience in mixed-methods research design and qualitative data collection. For each of the four states included in the project, ten Consumers (n=40) who had experienced in-person assistance from Seedco Navigators were randomly selected from a list of consent forms supplied by Seedco partner agencies. Five Navigators in each state (n=20) were similarly sampled from a list of Navigators supplied by Seedco administrative staff based in New York. The interview responses were subjected to qualitative content analysis to identify recurrent themes articulated by the interviewees that were relevant to the initial goals of the evaluation, as well as to emergent themes that arose during interviews but were not anticipated prior to the conversations between the researchers, Consumers, and Navigators.

## **SELECTED RESULTS AND CONCLUSIONS**

Results summarized below represent just a select snapshot of the study findings. The full report includes a detailed presentation of results. The full report also provides a more complete description of the methodological limitations of the study.

***Seedco Navigators Touched a Diverse Population of Consumers.*** Demographic analyses of the full four-state Salesforce dataset indicate that among Consumers whose race and ethnicity were recorded, over half (64.5%) are persons of color. African Americans were especially prevalent among Georgia Consumers. About 10% of Consumers preferred to speak a language other than English. About 7% of the sample (17% in New York) identified as Hispanic. Of particular importance for the financial viability of ACA health insurance is enrollment for people under the age of 35, who presumably contribute more in premiums than they draw down in benefits. In the full four-state sample, about 24% of Consumers who received in-person assistance were between the ages of 18-34.

***Seedco Navigators touched Consumers in need of affordable health insurance.*** In the full four-state sample, Consumers who received in-person assistance were not, in general, financially secure. Only about 11% indicated that they typically had discretionary funds left at the end of each month for spending or saving. Unmet health care needs due to financial problems were common. Over half the Consumers said they had put off at least one health care visit during the past year because they could not afford the expense; one-third had deferred three or more health visits. About 30% of all Consumers who interacted with Navigators were able to enroll in public insurance coverage (despite the fact that Georgia and Tennessee declined Medicaid expansion).

About three fourths of those who qualified for private Qualified Health Plans (as opposed to Medicaid) qualified to receive income-based subsidies.

***Enrollment in private marketplace insurance or in public insurance varied by state and by Consumer demographics. Even where Medicaid was not expanded, a reservoir of Medicaid-eligible Consumers was assisted.***

Not surprisingly, Medicaid enrollment was much higher in states with Medicaid eligibility expansion than in those without. Among those whose data were recorded in the Salesforce database, about 70% of newly insured Consumers in New York and 56% of those in Maryland qualified for Medicaid. The comparable figures for Georgia and Tennessee, both states that did not expand eligibility in Medicaid, were about 24% and 38%, respectively—suggesting that even without Medicaid expansion, Navigator assistance helped secure benefits for many Consumers who had previously not applied or realized that they were eligible.

***Rates of “success” in progressing through the enrollment process were highest, for minority Consumers, for Consumers with a history of unmet medical need and in Maryland.*** In the Salesforce data, “success” in enrollment means that a Consumer was documented as having selected, applied for, or enrolled in a plan by April 15, 2014. Many Consumers may have completed enrollment on their own after departing from an in-person assistance session, or even after April 15, but those data were not included in the Salesforce dataset and Consumers who deferred enrollment for any reason are not counted as “successes” in this analysis.

African American and Hispanic Consumers were up to 50% more likely to have attained enrollment, compared with White Consumers. Similarly, non-English speakers were 50% more likely to have attained enrollment, relative to English speakers. Non-English speakers were also 50% more likely to apply for subsidies. In addition, Consumers who reported that they had deferred medical treatment due to cost were more likely to ultimately enroll in coverage.

Logistic regression analyses also showed that Consumers in Maryland were more likely to have attained enrollment (in any type of plan) when compared with those in all the other Seedco states. The data precluded determination of precisely why Maryland fared better than the other three states. It may be noted, however, that unlike in the other three states, Navigators in Maryland were able to monitor and access applications after submission as they progressed toward approval within the State’s IT system. Maryland Navigators therefore served as an adjunct troubleshooting team to address technical problems that otherwise might have prevented enrollment.

Taken as a whole, these findings suggest that Navigators were responsive to special needs and motivations of Consumers.



**Consumers encountered problems with the online Marketplaces, but technology problems were just one of several drivers for seeking out Navigators. In-person assistance was appealing to Consumers.** About half of the Consumers who were interviewed had experienced frustrations using the online federally facilitated and state-based Marketplaces prior to obtaining in-person assistance and many sought out Navigators for that reason. Others sought out Navigators for additional expertise, hoping for example that a Navigator could find a better deal for them or because they had special problems like a recently canceled policy. About half the Consumers interviewed sought out Navigators before they even attempted to use the Marketplaces, or after a self-reported trouble-free experience with the online Marketplaces.

**Consumer experience with Navigators was generally very positive. Consumers especially appreciated post-assistance follow-up from Navigators.** Evaluation of the navigation experience was carried out by means of Consumer interviews. Nearly three-quarters of the interviewees expressed enthusiastic satisfaction or used positive language to describe the Navigator interaction. Consumers remarked particularly on Navigator professionalism and ability to explain and clarify complex concepts and processes. Where Consumer experiences were less positive, some entered the process with negative attitudes toward “Obamacare,” while a very few others felt that the Navigator was inattentive to their needs. Because enrollment success was rarely accomplished in one meeting with a Navigator and further action was frequently required on the part of Consumers, Navigators who took the initiative to follow up with Consumers following assistance sessions were especially appreciated, and increasing Navigator follow-up across states and agencies is identified as one way to improve the enrollment process and increase likelihood of enrollment success for Consumers undergoing navigation. This may require a policy revision for states using the federally facilitated Marketplace, as federally funded Navigators were not permitted to follow-up with Consumers in as comprehensive a manner as were Navigators in state-based Marketplaces.

**Consumers were not sufficiently aware of Navigator availability. Even those who were aware of Navigators were often unclear about their function.** While Consumers were overwhelmingly positive in their regard for Navigators once they had gone through in-person assistance, several Consumers mentioned that they were frustrated that it took them so long to learn that Navigators were available to them free of charge. Some had heard of Navigators but did not know where to locate them and were unsure if they would be charged for their services. During interviews, these Consumers strongly suggested that the Navigator program be more widely publicized with clear instructions about how to receive Navigator services.

**Navigators come from diverse backgrounds, and their experiences contribute to their motivation to become Navigators and their navigation style.** Understanding people’s motivation to become Navigators and to succeed in helping Consumers can inform

future recruitment of new cohorts of Navigators. In interviews, Navigators discussed many factors, both practical and ideological, at play in their decisions to become Navigators. In addition to needing employment, these included:

- Feeling that the work is relevant to their studies or to gaining valuable experience for future careers
- Feeling that serving people in need is in line with ethical and religious values that are important to them
- Strong desire to be a part of history/participate in “an historical moment”
- Desire to make a difference or change society for the better
- Motivation to help people and save lives
- Preference for and experience working directly with people in need of help
- Sense of solidarity with underserved people due to shared experiences in Navigator’s own past
- Background working in the insurance industry; thought their experience and working knowledge were appropriate to the job
- Background as a grassroots/community organizer, activist, or advocate; thought their experience and working knowledge were appropriate to the job

***The Navigator role is complex, and involves much more than providing in-person assistance.*** When Navigators were asked about their job responsibilities and how to improve the navigation process, several mentioned that community outreach and coalition building consumed more of their attention than many people recognized. This part of their jobs was highly gratifying to them, and also considered essential. However, community outreach and coalition building is not as easily tabulated as number of Consumers provided with in-person enrollment assistance even though it is necessary to recruiting Consumers for navigation.

***Navigators attribute success to communication practices, interpersonal sensitivity, and access to specific types of resources. Logistical factors also contribute, especially better Navigator networking and mentoring.*** Aspects of communication are among the traits that Navigators described as essential to their job performance. These valuable traits included cultural sensitivity, patience, listening skills, and problem solving. Among the logistical factors that would facilitate their jobs, Navigators suggested use of pre-assistance tools to screen Consumer eligibility, fixed locations and schedules for Consumer appointments, and mobile Internet hot spots. Several Navigators noted that the best in-service assistance comes from other Navigators who are grappling with the same challenges. They urged that means for regular meetings or sharing among Navigators be made available. Another suggestion expressed by several called for veteran Navigators to serve as mentors for members of newly recruited Navigator cohorts.

Navigators articulated a number of facilitators and barriers to effective navigation. It should be stressed that the presentation of the issues below does not indicate or imply

that Seedco is responsible for any of the barriers and facilitators. We are simply presenting what the Navigators articulated in the semi-structured interviews. Listed below and in no specific order are key facilitating factors and circumstances of successful and effective navigation described by individual Navigators:

- Cultural sensitivity training in previous work
- Communication opportunities, regular meetings, or frequent casual interaction among Navigators during open enrollment (brainstorm problems, “compare notes,” discuss shared concerns and strategies for outreach and engagement)
- Having Consumers who come to Navigation without fixed, politically-influenced, preconceptions and expectations
- Consumers who are well-informed about health insurance reform
- Having a fixed location and regular schedule for meeting with Consumers
- Having adequate technology equipment (e.g., mobile hotspot, laptop, etc.)
- Patience, empathy, and listening skills
- Ability to “think on (one’s) feet,” to solve or work around problems that arise unexpectedly

Listed below (in no specific order of priority) are salient barriers to effective navigation that were described by Navigators:

- Technological factors related to online Marketplaces or a lack of access to other useful and functional technology
- Individual cultural, linguistic, or political factors
- Systemic/bureaucratic complexities and dysfunctions
- Wait times for processing applications, for speaking to call center representatives, and the time it takes to meet with Consumers due to a number of systemic inefficiencies
- Local political animosity towards health insurance reforms
- Poor health insurance literacy and computer literacy among Consumers
- Insufficiencies in marketing around health insurance and Marketplaces resulting in Consumers having low accessibility of information about reforms, plans, and health care prior to Navigation

Overall, Navigators believed that they improved in their mission of enrolling Consumers as time went on in the open enrollment process. Overall, the barriers identified above can serve as topics for increased scrutiny by program planners and teachable moments for informing the training of future Navigator cohorts.

## **SELECTED RECOMMENDATIONS BY THEME**

### ***Capacity building, community education, and engagement***

- Continue partnering with culturally diverse community agencies and organizations.

- Create public awareness campaigns that emphasize positive Consumer response to Navigators. Create a narrative of Navigator success in real communities.
- Create advertisements and outreach materials specifically to reach people with histories of deferring healthcare.
- Help the public understand that Navigators are unbiased professionals, and that the Navigator's role is unique from other types of assisters.
- Advertisements and outreach should highlight very concrete ways to access in-person assistance.

### ***Consumer education, accessibility, and outreach***

- Facilitate increased accessibility of in-person assistance and information sessions for non-English speaking Consumers.
- Give extra help, including graphic materials, to help explain insurance basics to Consumers of low health literacy.

### ***Resources for Navigators***

- Provide Navigators with resources to facilitate networking and mentoring with their colleagues.
- Ensure access to technology that Navigators need to be most effective (e.g. hotspots, laptops, etc.)
- Ensure accuracy of materials and guides provided to Navigators.
- Increase access to supplemental training for Navigators to accommodate changes in technology and policy.
- Continue efforts to incorporate health and financial literacy into Navigator training

### ***Navigator practice and Navigator program administration***

- Create a culture of documentation among Navigators; accurately capturing information about Consumer progress and work performance is part of their jobs.
- Navigator organizations, funders, and partners should work together to establish uniform and informative data collection procedures across the various state and federal Marketplaces.
- Promote linkage to Medicaid when possible.
- Facilitate follow-up with Consumers to update on/ascertain their progress to enrollment as possible
- Facilitate follow-up with newly insured Consumers, consistent with applicable regulations, to assist them in maintaining and using their access to health services.
- Increase Navigator ability to assist consumers experiencing enrollment problems by increasing call center access and/or special privileges within the online marketplace

# 1. Introduction

## 1.1—OVERVIEW

The primary purpose of this report is to identify factors associated with successful enrollment of Consumers in Qualified Health Plans (QHPs) by Seedco consortium-contracted health insurance Navigators in four states, Georgia, Maryland, New York, and Tennessee, during the October 1, 2013 – March 31, 2014 ACA open enrollment period. This evaluation was carried out so that findings can be used by Seedco, other navigator entities and policy makers to inform Navigator program design and training protocols and to increase successful enrollment of Consumers. These outcomes will directly and indirectly benefit a number of stakeholder groups, including members of the Seedco consortium, health insurance Navigators, and people seeking health insurance coverage.

Seedco, the Structured Employment Economic Development Corporation, is a nonprofit community development organization that “designs and implements innovative programs and services for workers, families, and businesses” in order to forward their organizational mission “to advance economic opportunity for people, businesses, and communities in need” (Seedco.org). During the 2013-2014 open enrollment period, with funding through the Centers for Medicare & Medicaid Services (CMS), the Maryland Health Benefit Exchange (MHBE), and the New York State Department of Health (NYS DOH), Seedco led a consortium of community partner agencies in Georgia, Maryland, New York, and Tennessee to employ, train, and certify health insurance Navigators. In leading this multistate consortium, Seedco administration had to work with agencies to help consumers simultaneously in different state policy environments, using different health insurance Marketplaces, and working to accommodate different and sometimes conflicting sets of state and federal guidelines.

Across the US, health insurance Navigators are a type of Consumer “assister” funded through special federal and state grant programs. Navigators are trained by states, the federal government, and designated community organizations to provide free and in-person assistance in understanding the rules of state and federal health insurance marketplaces, in applying for premium tax credits and subsidies, and in enrolling in health insurance in states with federal- or state-run health insurance marketplaces. Navigators also play an important role in providing Marketplace outreach and educational services in the communities in which they work, and in making referrals to ombudsmen and other assistance programs when necessary (CMS 2014).

A research team in the Department of Health Policy and Management in the College of Public Health at the University of Georgia conducted out mixed-methods research activities for this evaluation, working in collaboration with Seedco administrators. Co-Investigators of this project are Neale Chumbler, PhD, Department Head of Health Policy and Management, Don Rubin, PhD, Center for Health and Risk Communication, and

Mauricio Garcia, the New York Navigator Program Director at Seedco. Amber Huff, PhD, is the research manager for the project. The research protocol was approved and is overseen by UGA's Institutional Review Board (UGA IRB ID STUDY00000705).

## **1.2—STUDY GOALS & OBJECTIVES**

The study is oriented around assessing the effectiveness of Navigators in providing education and outreach to Consumers, assisting Consumers in applying for premium tax credits and subsidies, and linking Consumers to QHPs. As such, and to further the goals of the Seedco Navigator program, we identified broadly relevant policy and practice themes addressed by the investigation which include the following points, which are presented as questions below and discussed in more depth in Section 2:

- What are major disparities in the navigated health insurance experience?
- How do Marketplace characteristics and characteristics of insurance policies affect Consumers' choices about health insurance enrollment?
- How do Consumer health literacy and Navigator communication practices influence health insurance enrollment?
- What are logistic and technological barriers and facilitators to navigated health insurance enrollment from the perspectives of Consumers and Navigators?
- How does Navigator-facilitated enrollment impact Medicaid enrollment?
- How do differences among state and federal Marketplaces affect facilitated enrollment?

## **1.3—OVERVIEW OF STUDY DESIGN**

In order to satisfy the goals of the study and obtain in-depth insight on the policy and practice themes and questions described above, the research team decided on a multi-method approach to research design that involved quantitative analysis of survey data, and qualitative analysis of telephone interview data collected with both Consumers and Navigators in Georgia, Maryland, New York, and Tennessee.

### ***Quantitative data collection and analysis***

The UGA project team analyzed survey data that was collected by Navigators between January 1 and April 15, 2014. After data cleaning, which involved the removal of duplicate, blank, or otherwise unusable Consumer records, these included 14,854 records of Consumers who signed consent forms and participated in Navigation in Georgia, Maryland, New York, and Tennessee.

Navigators were responsible for survey data collection during each navigation encounter with individual Consumers using Salesforce, a web-based, HIPPA-compliant, secure database application. The survey data were then de-identified (all individual identifying information was removed) by Seedco, and were sent to members of the UGA project team via secure (encrypted) data transfer using Hightail, a secured online file sharing application. The UGA project team then cleaned, error-checked, standardized, and combined the data from each state before subjecting it to analysis in SPSS statistical analysis software. Because Seedco Navigators collected these data using different Salesforce surveys (see Tables 1.1 through 1.3<sup>1</sup>) in the different states, some variables are not available or were not assessed in commensurate ways across all four states. When possible (indicated in the results section), indirect or proxy measures are used to make comparisons across states in which non-commensurate data were collected. This particularly affects demographic results, and cross-state comparisons pertaining to enrollment status and qualification for Advance Premium Tax Credits (APTCs) and Cost Sharing Reductions (CSRs).

#### ***Qualitative data collection and analysis***

The UGA project team included the qualitative component in the evaluation in order to produce in-depth and fine-grained information to help explain how characteristics of the Navigator-Consumer interaction contribute to relative success or failure of attempts at enrollment, and what adjustments to practice may be needed to improve training and enrollment success during future open enrollment periods. Telephone interviews were conducted with Consumers (n=40) between late February and early April 2014, and with health insurance Navigators (n=20) in April and May 2014. Resulting interview data was transcribed and analyzed by members of the UGA project team to identify specific information relating to pre-identified themes, as well as to identify unanticipated themes that emerged during interviews and analysis.

### **1.4—NOTES ON STUDY DESIGN AND THE VALUE OF MULTI-METHOD EVALUATIONS**

Because of the timing of this study during the first Marketplace open enrollment period, our approach to cross-site analysis, and our multi-method research design, the results presented in this report give critical insight into key emerging policy and practice issues related to insurance expansion, including disparities in Navigated enrollment and barriers and facilitators to navigated health insurance enrollment. When possible, cross-site comparison has been an important part of this investigation in order to determine whether local characteristics or the use of federal versus state-run Marketplaces contribute to relative success or failure of attempt at enrollment of consumers. Because of the comparative and extremely timely nature of this investigation, the findings have national-scale implications. The data can be useful to inform policy solutions and quality

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<sup>1</sup> All tables appear in Appendix A.

improvement strategies and strategic planning on federal, state, local, and organizational levels far beyond the four states included in the project.



## **2. STUDY DESIGN: OBJECTIVES, SITES, AND METHODS**

### **2.1—STUDY OBJECTIVES, POLICY AND PRACTICE-RELEVANT THEMES, AND QUESTIONS ABOUT NAVIGATED ENROLLMENT**

The study was designed to determine Navigator training needs and to assess the effectiveness of Seedco health insurance Navigators in providing education and outreach to consumers, assisting consumers in applying for premium tax credits and subsidies, and linking consumers to QHPs. More specifically, the study’s objectives centered on gaining a greater understanding around several relevant policy-practice themes conceived as questions.

These included:

- What factors are associated with successes and disparities in the navigated health insurance enrollment experience? Which populations experienced the most successful rates of enrollment?
- What factors are associated with enrollment in private plans?
- What is the impact of facilitated enrollment on enrollment in Medicaid and other forms public coverage?
- To what extent are Consumers aged 18 to 34 years, known as “young invincibles”, represented among enrollees?
- What specific barriers and frustrations do Consumers experience in the navigated enrollment process?
- What Navigator practices and resources effectively mitigate barriers and problems in the context of facilitated enrollment?
- Navigating “the gap”: how do Navigators assist Consumers who are found to be ineligible for both the Marketplace subsidies and for Medicaid?
- What do Consumers and Navigators consider the characteristics of effective communication in the context of navigation?
- How is Consumer health literacy (and health insurance literacy) associated with outcomes of facilitated enrollment?
- What are the relationships among Marketplace characteristics, insurance policy options, and Consumers’ choices about health insurance enrollment?

### **2.2—THE SEEDCO-UGA COLLABORATION**

This evaluation was carried out through collaboration between Seedco administrators based in New York and a project team affiliated with the University of Georgia’s College of Public Health. A research team based in the Department of Health Policy and Management in the College of Public Health at the University of Georgia carried out mixed-methods research and writing activities for this evaluation.

### **2.3—RESEARCH SITES: POLICY CONTEXTS, MARKETPLACE CHARACTERISTICS, AND NAVIGATOR TRAINING REQUIREMENTS**

This evaluation specifically pertains to Navigated health insurance enrollment by Seedco-contracted Navigators in Georgia, Maryland, New York, and Tennessee during the October 1, 2013 – March 31, 2014 ACA Health Insurance Marketplace open enrollment period. In addition to analytic interest in broad patterns and disparities across the full sample, the project team opted to treat each state as a unique research “site” for the purposes of cross-site comparison and due to significant differences in the current policy environments in each state.

#### ***Marketplace Characteristics***

Seedco-contracted Navigators worked within three different Marketplace contexts, the federal Marketplace, Maryland Health Connection, and New York State of Health. Whether federal or state-run, the purpose of a health benefits Marketplace is to provide a one-stop shop for individuals and businesses to apply for subsidies and compare and purchase health insurance coverage. Both Maryland and New York operate state-run Marketplaces, while both Georgia and Tennessee use the federally facilitated Marketplace

The Maryland Marketplace, Maryland Health Connection, is a quasi-governmental organization in that it is an independent public corporation. It is governed by a nine-member board that consists of the Secretary of Health and Mental Hygiene, the Maryland Insurance Commissioner, and the Executive Director of the Maryland Health Care Commission in addition to six gubernatorial appointees who represent different stakeholder groups (NCSL 2014). Seedco’s contract is to serve a seven county region on the Eastern Shore (of Chesapeake Bay) region of Maryland.

New York State of Health, the New York Marketplace, is a public organization that is housed in the New York Department of Health. New York Governor Andrew Cuomo established the Marketplace in 2012 through executive order. It is governed through regional advisory committees made up of diverse stakeholders including consumer advocates, small business representatives, health care providers, agents, brokers, insurers, and labor organizations. Seedco partners were clustered in New York City’s five boroughs with a focus on Brooklyn.

Even though Georgia Governor Nathan Deal created an executive order to establish the Georgia Health Insurance Exchange Advisory Committee and the Tennessee Department of Finance and Administration established the Insurance Exchange Planning Initiative in 2011, both Georgia and Tennessee ultimately defaulted to the federally facilitated Marketplace in 2012. The federally facilitated Marketplace used in both states is operated by the Centers for Medicare and Medicaid Services (CMS) (CMS.gov). The scope of the Georgia and the Tennessee Seedco partners encompassed the entirety of their respective states.

### ***Navigator training requirements by state***

Navigator training requirements vary by state in the case of state-run Marketplaces, and are dictated by CMS and state legal bodies for states using the federally facilitated Marketplace.

In both Maryland and New York, Navigators must be employed through an approved agency and complete a state-approved training program and be certified annually. Under Maryland regulations, health insurance Navigators are required to complete 120 hours of training and are required to be re-certified on an annual basis (NCSL 2014). The New York Department of Health (DOH) is responsible for overseeing Navigator training in the state; all New York-based Navigators must complete DOH-approved training programs and be certified annually (NCSL 2014).

Navigators in Georgia and Tennessee must meet CMS training requirements, which include 30 hours of online training and web certification, in addition to licensing/certification by the state insurance commissioner. In Tennessee, the state legislature passed additional legislation requiring that the state insurance commissioner establish statewide standards for Navigator training, certification, and behavior (NCSL 2014). The state-mandated training in Georgia is similar to—though not identical with—training required for licensure as an insurance broker.

Seedco also provided Navigators with special media training, training in health literacy and Consumer engagement, and training around the use of the Salesforce web application to collect Consumer data.

### ***Medicaid eligibility expansion by state***

The nationwide expansion of Medicaid programs was an original provision of the 2010 Patient Protection and Affordable Care Act (ACA). The expansion of Medicaid eligibility for adults was meant to serve as the means of improving access to insurance coverage low-income individuals, and subsidies toward the purchase of QHPs was to serve as the means of improving access to insurance coverage for people with moderate incomes. However, following the US Supreme Court ruling on *National Federation of Independent Business (NFIB) v. Sebelius* (2012), Medicaid eligibility expansion became optional for individual states. During the 2013-2014 open enrollment period, 14 states plus the District of Columbia had opted for state-based Marketplaces with Medicaid expansion. Thirty-six states used the federally facilitated Marketplace and declined to expand Medicaid (See <http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/pdf/workbook.pdf>).

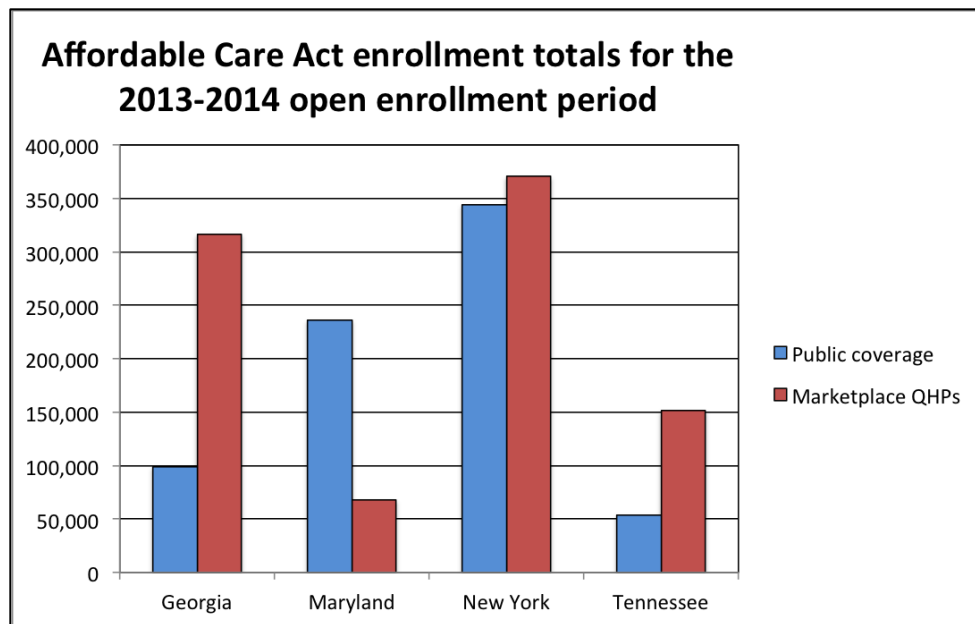
Following the *NFIB v. Sebelius* ruling, whether a state is opted in or opted out of the Medicaid expansion has important implications for its residents' ability to access health insurance under the new rules, especially people that earn relatively low or low-moderate incomes. The drafters of the ACA envisioned low-income people receiving

coverage through a universal Medicaid expansion, and people who fall below the poverty threshold are therefore not eligible for Marketplace subsidies to help cover the cost of QHPs (Kaiser 2014b). Thus, some adults in Georgia and Tennessee (and other “opt-out” states) fall into what has been termed a “coverage gap”: a situation in which an adult or household earns too much income to qualify for Medicaid, but not enough to qualify for tax credits/subsidies. While people who fall into the “gap” are ineligible for financial assistance, people with higher incomes are eligible for tax credits to assist them in purchasing private coverage (Kaiser 2013b). Theoretically, people with incomes that place them in the Medicaid gap *could* purchase insurance through the Marketplace at full cost, but this situation is unlikely due to lack of sufficient income to afford these policies without subsidies.

Both New York and Maryland are part of the Medicaid eligibility expansion option under the ACA. Almost all uninsured persons in Maryland are eligible for some type of coverage under the ACA. Medicaid eligibility in Maryland and New York covers almost all nonelderly adults up to 138% of the federal poverty level. People with incomes between 100% and 400% of the federal poverty level may be eligible for subsidies when purchasing private coverage through the Maryland Health Connection state Marketplace (Kaiser 2014). People with incomes between 138% and 400% of the federal poverty level may be eligible for subsidies when purchasing private coverage through the New York State of Health Marketplace (Kaiser 2014b).

Both Georgia and Tennessee opted out of the Medicaid eligibility expansion. In Georgia, healthy adults with children may access Medicaid if their income is below 35% of the federal poverty level. Adults without dependent children are ineligible for Medicaid regardless of their income, unless they are disabled (Kaiser 2014). In Tennessee, healthy adults with children may access Medicaid if their income is below 111% of the federal poverty level. Adults without dependent children are ineligible for Medicaid regardless of their income, unless they are disabled (Kaiser 2013a). In both Georgia and Tennessee, people with incomes between 100% and 400% of the federal poverty level may be eligible for subsidies when purchasing private coverage through the federally facilitated Marketplace.

About half of the uninsured non-elderly populations of Georgia and Tennessee were eligible for some sort of assistance in obtaining coverage through the federally facilitated Marketplace. In both states, a sizable portion of uninsured non-elderly persons falls into the coverage gap; they would have been eligible for coverage under the Medicaid eligibility expansion but currently have incomes that are too high for Medicaid eligibility but too low to qualify for premium reductions. This includes 31% of all uninsured non-elderly Georgians and 24% of all uninsured non-elderly Tennesseans (Kaiser 2014a, Kaiser 2013a).



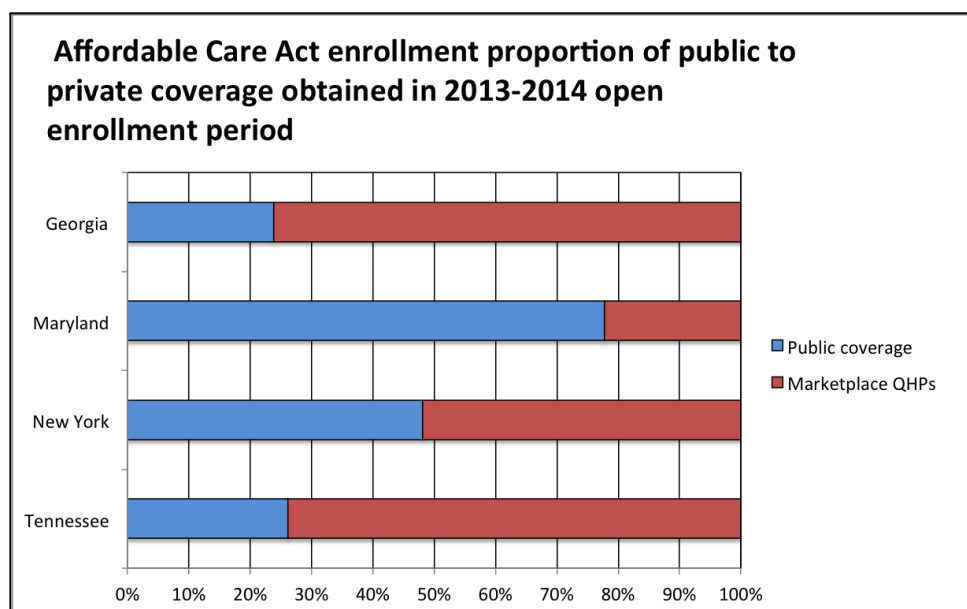
**Figure 2.1—Affordable Care Act enrollment totals for the 2013-2014 open enrollment period, public and private coverage, in Georgia, Maryland, New York, and Tennessee.** Source: ASPE Marketplace Summary Enrollment Report (2014) and the CMS March Medicaid/CHIP Enrollment Report (2014).

### ***ACA open enrollment 2013-2014: the “big picture” in four states***

The different social and policy environments in each of Seedco’s Navigator states interact with Consumer characteristics, barriers to enrollment, and facilitators to enrollment, resulting in different rates of enrollment in public and private coverage over the course of open enrollment. These overall enrollment rates for Georgia, Maryland, New York, and Tennessee are presented in Table 2.1<sup>2</sup>, and in Figures 2.1 and 2.2, and are based on information presented in the ASPE Marketplace Summary Enrollment Report (2014) and the CMS March Medicaid/CHIP Enrollment Report (2014). Of the total number of enrollees in those states, only a fraction utilized in-person assistance (others enrolled entirely online or with assistance only of CMS telephone counselors), and of those who enrolled with in-person assistance, only a fraction received those services from Seedco Navigators (in fact, the majority of in-person assistance was provided by clinic-based assisters). Furthermore, many people received some in-person assistance and later completed the application process independently leading to some complexity in understanding the roll that assistance played in their enrollment.

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<sup>2</sup> Note, the extensive tables supporting these findings appear in the attached Appendix.



**Figure 2.2—Proportion of Affordable Care Act enrollment totals for public versus private coverage during the 2013-2014 open enrollment period, in Georgia, Maryland, New York, and Tennessee. Source: ASPE Marketplace Summary Enrollment Report (2014) and the CMS March Medicaid/CHIP Enrollment Report (2014).**

## 2.4—DATA TRANSFER & DATA MANAGEMENT

All data transfer and management for this study protected informed consent and privacy for participants. Information was only recorded for Consumers and Navigators who consented, and all consumer data were recorded, stored, and transferred in compliance with HIPAA and other relevant privacy laws and regulations. Between late February and late March 2014, Seedco-contracted Navigator partners operating in Georgia, Maryland, New York, and Tennessee scanned and uploaded consent forms to a secure online file sharing application on a weekly basis. Consent forms received by the UGA research team included only those on which enrollees indicated consent to be contacted by the UGA research team. During enrollee data collection, UGA compiled a spreadsheet (referred to henceforth as the enrollee contact spreadsheet) from the consent forms that the UGA team had received in the previous week. The spreadsheet, which was password-protected and stored in a separate folder, included the name of the uploading agency, date of receipt, enrollee name, enrollee telephone number, and any important notes (preferred language if other than English, hearing disability, etc.). Upon completion of enrollee data collection, the UGA team deleted all spreadsheets that included personal identifying information.

In late April, names and contact information for Navigators in each state were transferred between Seedco offices in New York and the UGA project team using a secure online transfer. In late April as well, raw de-identified survey data were received from Seedco offices in New York by the UGA project team.

Throughout the course of the study, all survey data, contact information, and interview data were kept in dedicated folders on a secure password-protected computer located in a locked office in the Department of Health Policy and Management at UGA. Only members of the UGA project team had access to the research materials.

## **2.5—PARTICIPANT SAMPLING & DATA COLLECTION**

### ***Seedco Salesforce data: Documenting the Navigation encounter***

Salesforce data were collected during Navigated health insurance enrollment encounters over the course of the 2013-2014 open enrollment period. The data consisted of socio-demographic items, items documenting progress through the enrollment process, and four questions related to health insurance literacy, use of health services, household finances, and budgeting for health insurance. The data were entered on computers by Navigators on behalf of enrollees. Due (in part) to different state privacy rules, certain items and response options differed across the jurisdictions.

### ***Consumer Interviews***

Three members of the UGA project team who were experienced in qualitative data collection and analysis interviewed Consumers who participated in Navigation in Georgia, Maryland, New York, and Tennessee via telephone between February 24 and April 3, 2014. The UGA project team interviewed 40 Consumers in total, 10 from each of the four states included in the project. The goal of qualitative research is not generalizability. Rather, it is to produce information-rich data from a sample chosen for its ability to speak to the issue of concern (Patton 2001). Qualitative research emphasizes depth rather than breadth, insight rather than generalization, and is interested in unmasking processes and determining the meaning of particular behaviors, processes, or outcomes (Ulin et al. 2005). Interviewees were selected from Consumer contact information that was received weekly. Enrollee contact spreadsheets were sorted by state in Microsoft Excel, and a random number generator was used to select enrollees to contact for an interview.

An Interview Guide (Appendix B) was used to elicit detailed information on particular topics of interest. The interview guide included a series of questions and prompts that interviewers used to guide conversations with Consumers around particular themes of interest. Each interview was audio-recorded and interviewers took detailed notes as the interview was conducted. At the end of each telephone interview, Consumers were asked questions on a brief socio-demographic questionnaire (Appendix B). The Consumer selection and interview procedure were repeated until the pre-established quota of 10 interviews per state was reached. Following preliminary analysis of interviews, all audio-recordings of Consumer interviews were deleted as set forth in the IRB protocol.

### ***Navigator Interviews***

As with Consumer interviews, three experienced qualitative data collectors on the UGA project team interviewed Navigators working in Georgia, Maryland, New York, and Tennessee via telephone between April 21 and May 9, 2014. The UGA project team interviewed 20 Navigators in total, five who worked in each of the four states included in the project.

Interviewers selected interviewees from a Navigator contact list compiled and provided by Seedco administrators. For personnel reasons, Seedco withheld three Navigators from the pool from which interviewees were drawn. The resulting contact list included the names and contact information for seventy-two Navigators, which are detailed by state and by agency of affiliation in Table 2.2.

As with Consumer sampling, a random number generator was used to select Navigators from a numbered spreadsheet to contact for an interview, and an Interview Guide (Appendix C), which included a series of questions and prompts, guided conversations with Navigators around particular themes of interest, and was used to elicit detailed information on particular topics of interest. At the end of each telephone interview, Navigators were asked questions from a brief socio-demographic questionnaire. Each interview was audio-recorded and interviewers took detailed notes as the interview was conducted. This process was repeated until the pre-established quota of five Navigator interviews per state was reached. Following preliminary analysis of the interviews, all audio-recordings of Consumer interviews were deleted as set forth in the IRB protocol.

## **2.6—DATA ANALYSIS**

### ***Survey Analysis***

Following the end of the 2013-2014 open enrollment period, surveys completed from January 1 through March 31, 2014 were sent by Seedco to the UGA project team via a secure online transfer. The UGA project team received the raw survey data in the form of five Microsoft Excel spreadsheets: two spreadsheets each for New York and Maryland (one capturing data for heads of household and one capturing data for household members), and one spreadsheet containing combined data for Georgia and Tennessee enrollees.

Members of the UGA project team developed a codebook to guide data cleaning and analysis. After standardizing the survey data from each state, the data were error-checked and combined into a single database using Microsoft Excel. Descriptive, bivariate (Pearson's Chi-Square), and multivariate (logistic and linear regression) analyses were completed using SPSS statistical analysis software.

In Section 3 of this report, we present results of three types of quantitative analysis that include a basic but extensive quantitative description of the sample (both in full and by state), bivariate data analyses using Pearson's Chi-squared test, and multivariate



analyses using linear and logistic regression modeling. The bivariate analyses test the assumption that observations being compared are independent of one another, while regression analysis allows us to model relationships among several independent and dependent variables. In Section 3, before each type of results is presented, we briefly explain the logic of the test to aid the reader in interpreting the results and understanding the associations.

The quantitative results are based on a sample size of 14,854 Salesforce survey records of participants living in Georgia, Maryland, New York, and Tennessee, and analyses were carried out using SPSS statistical analysis software. Because the surveys collected Consumer information on important variables in different ways using different measures in different states, several variables are not available or are not comparable across all states. When possible (indicated in the results section), indirect or proxy measures are used to make comparisons across states in which non-commensurate data were collected.

Inconsistencies in data definitions particularly affected demographic variables, and cross-state comparisons pertaining to Enrollment Status and qualification for Advance Premium Tax Credits and Cost Sharing Reductions. As analyses were processed, a practice called “listwise deletion” was applied in order to accommodate the fact that there were substantial missing survey data throughout the full sample. In other words, for any particular analysis, if a pertinent variable was missing from a particular record, that entire record was excluded from the particular analysis. The result of this practice is that, for particular queries and tests, the sample size is reduced. Even though the full sample is 14,854, the number of records included the analyses presented in Section 3 are smaller than the full sample and are variable across analyses.

In addition, a set of 1,418 records could not be definitively assigned to a state of origin. Some of these Consumers were from Georgia, and some were from Tennessee. Where referenced, this group is identified as Consumers from either Georgia or Tennessee. Data for these Consumers do appear in analyses, which do not require identification by state. However where state-specific analyses are discussed, these cases are treated as “missing” (although they are broken out as a group in pertinent tables and figures).

In analyses presented in this report, the demographic category of “Hispanic” is presented as follows. In data tables, “Hispanic” is listed as one of several groups under the heading “Race/ethnicity.” “Hispanic ethnicity” also appears as a stand-alone category in these tables. This is an artifact of Seedco design of Salesforce surveys for each state: “Hispanic/Latino” was doubly assessed as a “race” and as an “ethnicity” (separate survey items) in Maryland, and counts for both items are included in descriptive data tables when Maryland data are reported. It was assessed as a national identity in a stand-alone item Georgia and Tennessee (e.g. “Mexican,” “Puerto Rican,” etc.). It was assessed with stand-alone yes-or-no “ethnicity” item in New York. For statistical analyses, as with other racial/ethnic categories, we created a single dummy

variable to represent “Hispanic” across the data set. Because of the particular ways in which Hispanic ethnicity was indexed, we are unable to report a category that corresponds to “non-Hispanic white.”

### ***Interview Analysis***

Because of time constraints that prohibited full professional transcription of audio-recorded interviews for analysis in NVivo software, the UGA project team opted for the more expedient but equally reliable method of thematic transcription and content analysis. Analysis of Consumer and Navigator interviews involved the transcription of qualitative data from participant questionnaires, hand-written interview notes, and audio-recordings into an Excel spreadsheet. Each interview was assigned a code that included components indicating whether the interviewee was a Navigator or Consumer, the date and time of the interview, and the identity of the interviewer. This code, along with time, date, and duration of the interview, and Consumer demographic information was also entered into the spreadsheet. With the project goals and objectives as a guide, special columns were created in the spreadsheet for specific thematic content, and relevant information from notes and recordings were transcribed into these columns based on theme. The complete spreadsheets were color-coded by state and used to identify general patterns among respondents relative to pertinent themes, as well as to identify patterns that were unique to particular states. Socio-demographic characteristics and pertinent themes identified in analyses of telephone interviews with Consumers and Navigators are presented in Table 2.3. Results of analyses are presented in Section 3.

### 3. RESULTS: ANALYSES OF SURVEYS AND INTERVIEWS

The statistical analyses of Salesforce survey data that are presented below are based on a sample of 14,854 records of participants living in Georgia, Maryland, New York, and Tennessee. Analyses of qualitative data are based on interviews with forty Consumers, ten each from Georgia, Maryland, New York, and Tennessee, and twenty interviews with Navigators, five each from Georgia, Maryland, New York, and Tennessee.

#### 3.1—ANALYSES OF SALESFORCE SURVEYS

##### *Descriptive analysis*

##### **Description of the sample, all enrollment statuses, of Seedco consortium Consumers**

This report includes detailed documentation of the demographics of Salesforce Survey participants in terms of the full sample and the samples from individual states. For variables of particular interest, demographic profiles are reported as well. While summaries are presented here, full descriptive data tables are presented in Section 6 of this report.

The demographic profile of Salesforce survey participants, segmented by state, is presented in Table 3.1. The largest proportion of records, 41.3% of the full sample, was collected in Maryland (n=6,130) followed by New York with 22% (n=3,279), Georgia with 19.2% (n=2,840), and Tennessee with 8% (n=1,187). A total of 1,418 records, or 9.5% of the total sample, may have been collected in either Georgia or Tennessee. Because a more precise state attribution is not possible for these records, they are excluded from subsequent state-level analyses.

The sub-sample from New York is biased towards individuals who live in single-person households or very racially and gender-homogenous households because during the data collection process, individual demographic data for heads of household were not reported; rather, demographic data associated with heads of household were aggregated on the level of household and were excluded from individual-level analyses because individual characteristics could not be identified or disaggregated for many Consumers.

Records of 6,855 women, 5,485 men, and 16 transgender individuals were included in the full sample. Sex/gender identity was missing from the records of 2,499 participants.

For purposes of comparability, age distribution was assessed in terms of age group (<18 years; 18-25 years; 26-34 years; 35-45 years; 46-55 years; 56-65 years, and >65 years). This standardization was performed across the sample because age was recorded in different ways in different states. The majority of participants fall into 35-45 years and

46-55 years groups, comprising 27.4% and 23.5% of the sample, respectively. These groups are followed by 56-65 year-olds, who make up 14.8% of the sample, 26-34 year-olds who make up 13.4% of the sample, 18-25 year-olds who make up 10.2% of the sample, and persons under 17 years of age, who make up 9.8% of the sample. While we realize that Navigators were not permitted to directly counsel and submit applications for minors, we retained and report on data received for persons under the age of 18. Persons over age 65 only make up 1% of the sample.

In terms of race/ethnicity, 36.7% of the sample (n=5,444) identified as white. The second largest racial/ethnic group is Black/African American (n=4,015) at 27% (there were more respondents who identified as Black/African American in Georgia than any other racial/ethnic group), followed by Asian (n=1,263) at 8.5% and Hispanic at 7%. People identifying as American Indians/Alaskan Natives (n=22) made up 0.1% of the sample. 22.7% of the sample (n=3,366) identified with a different racial/ethnic group, or was not recorded. Nine percent of respondents (n=1,018) identified as Hispanic (17% of respondents in New York identified as Hispanic).

English is the preferred language among 69.6% of respondents, followed distantly by Spanish at 4.3% (n=641), a Chinese language at 2% (n=293), and Vietnamese (n=6) at <0.1%. The proportion of respondents (n=541) who were recorded as preferring a language other than those mentioned is 3.6%. This tendency is the same for individual states, too.

**Description of the sub-sample of Seedco consortium Consumers who applied for public health coverage, selected a Qualified Health Plan (QHP) or successfully enrolled in either a public plan or a QHP**

Table 3.2 presents the demographic profile of Consumers who applied for public health coverage, selected a QHP or successfully enrolled in either a public plan or a QHP, segmented by state, based on available data. The distinction between application/selection versus enrollment was necessitated by the fact that data on enrollment progress were collected in different ways in New York and Maryland, compared with Georgia and Tennessee (as a result of New York and Maryland operating their own Marketplaces and Georgia and Tennessee using the federal Marketplace). In New York and Maryland, detailed data on enrollment status and data indicating whether or not a Consumer successfully enrolled in a plan were collected, while in Georgia and Tennessee the most commensurate variables (though distinct) indicated whether a consumer had applied for a public plan or had selected a QHP. Following the style of a report published by the Robert Wood Johnson Foundation (2014), we treat the latter as “pre-effectuated enrollment” “because it includes those who have selected a plan with or without the first premium payment having been received directly by the marketplace or the issuer” (1). For the sake of brevity, despite these differences, successful application/selection/enrollment will be discussed in this document in terms of

enrollment process completion. In short, the criteria for “successful enrollment” as used in this report vary, depending on whether a Consumer uses a federally facilitated marketplace or a state-based marketplace.

Successful enrollment, thus defined, was recorded for 3,381 women, 2,281 men, and 2 transgender individuals in the full sample. Women comprised 57% of completed enrollments, while men comprised 42%. Transgender individuals comprised <1% of completed enrollments. In Georgia, 610 Consumers applied for/selected coverage. In Maryland, 4,235 Consumers enrolled. In New York, 1,356 Consumers enrolled in coverage. In Tennessee, 510 individual Consumers applied for/selected coverage.

The majority of participants who completed enrollment fell into 35-45 years and 46-55 years age groups, comprising 30% and 23% of completed enrollments, respectively. These groups are followed by 26-34 year-olds who make up 12% of completed enrollments, 18-25 year-olds who make up 10% of completed enrollments, 56-65 year-olds, who make up 9% of completed enrollments, and persons under 17 years of age, who make up 7% of completed enrollments.

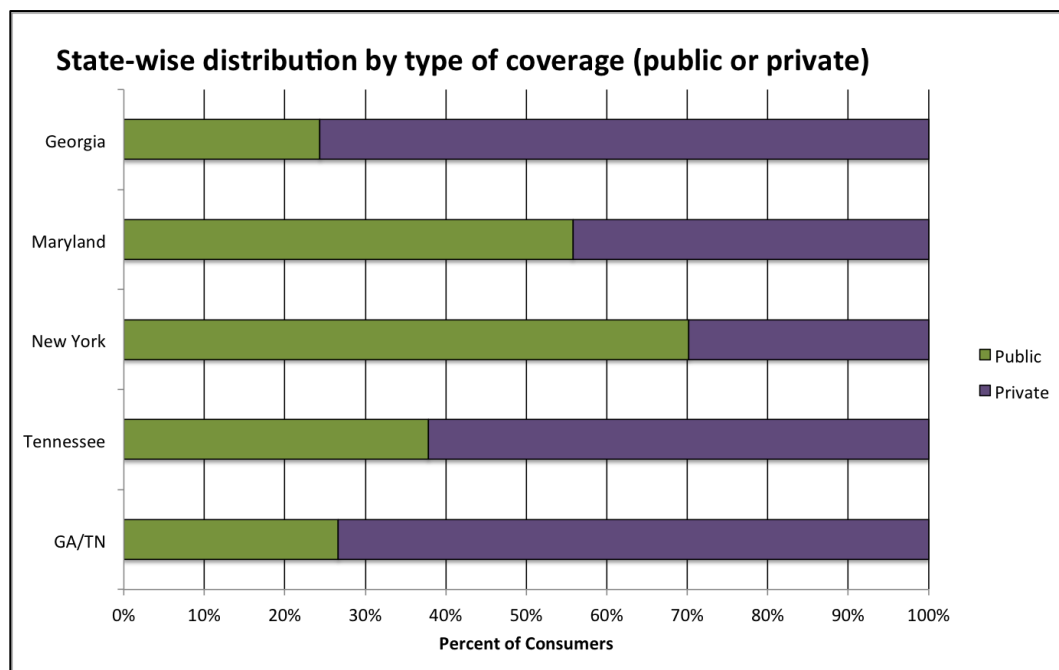
In terms of race/ethnicity, 47% of completed enrollments (n=3,148) identified as white. The second largest racial/ethnic group to complete enrollment is Black/African American (n=1,939) at 29%, followed by Asian (n=408) at ~6% and Hispanic (n=414) at ~6%. People identifying as American Indians/Alaskan Natives (n=6) made up <1% of completed enrollments. Fourteen percent of the sub-sample (n=926) identified with a different racial/ethnic group, or their racial/ethnic group was not recorded. Regardless of racial/ethnic self-identification, 9% of respondents who completed enrollment (n=574) identified as ethnically Hispanic in a separate survey item. In New York, 26% of respondents who completed enrollment identified as ethnically Hispanic (n=346).

English was the preferred language among 87% of respondents who completed enrollment (n=5,766), followed distantly by Spanish at 4% (n=299). Chinese languages and Vietnamese represent <1% each of respondents who completed enrollment. The proportion of respondents (n=187) who were recorded as preferring a language other than those mentioned is 3%.

Tables 3.3 through 3.7 present enrollment demographics in each individual state. Tables 3.3 and 3.4 present a demographic breakdown of enrollment status for individual states of Maryland and New York. Tables 3.5 and 3.6 present a demographic breakdown of Consumers who either applied for public coverage or selected QHP in Georgia and Tennessee. In the tables for Georgia and Tennessee, “Applied/selected” indicates that Consumers were documented as having either applied for public coverage or as having selected a private plan. “Not applied/selected” indicates Consumers who are recorded as having completed neither.

## Demographic description of coverage type (application/selection/enrollment in public vs. private coverage) among Seedco consortium Consumers

Table 3.8 summarizes coverage type for all states and indicates whether Seedco consortium Consumers who applied for/selected (Georgia and Tennessee) or enrolled (Maryland and New York) in coverage under a public (Medicaid, CHIP, etc.) or private health plan. Tables 3.9 through 3.13 present the full descriptive demographic profiles of public versus private coverage for Consumers who applied/selected/enrolled in plans in individual states and in the subset of the sample that was collected in Georgia or Tennessee yet includes no geographic identifiers.



**Figure 3.1.** The distribution of public to private coverage among Seedco consortium Consumers in each state based on Salesforce data from January through April 2014.

This distribution of public to private in each state is represented graphically as proportions of the whole in Figure 3.1. More participants enrolled in public plans than private plans in both Maryland and New York, which is likely highly influenced by the expansion of Medicaid in both states. Across states, Georgia and Tennessee saw the highest rates of respondents who selected private QHPs. In Georgia, 76% of respondents selected private QHPs, and 62% of Tennessee respondents selected private QHPs. Maryland and New York saw rates of enrollment in QHPs at 44.5% and 42.5%, respectively. It warrants note that the proportions of Seedco consortium consumers enrolling in public versus private coverage in each state between January and April follow the same pattern as is observed in the full state-level data for the full 2013-2014 open enrollment period published by ASPE (2014)(reported previously in Table 2.1 and represented graphically in Figures 2.1 and 2.2).

### Demographic description of application or qualification for Advance Premium Tax Credits and Cost Sharing Reductions among Seedco consortium Consumers

Table 3.14 presents an overview of the number of Consumers who applied for (Georgia and Tennessee) or qualified for (Maryland and New York) Advance Premium Tax Credits (APTCs) and Cost Sharing Reductions (CSRs), segmented by state.

Based on available data, 75% of all Consumer respondents either applied for or received APTCs or CSRs. Across states, rates of application and receipt of subsidies were very similar. Georgia had the lowest rate of application for subsidies with 70%, and Tennessee had the highest rate with 79%. The rate of receiving APTCs or CSRs in Maryland and New York was identical, with both at 77% (Figure 3.2).

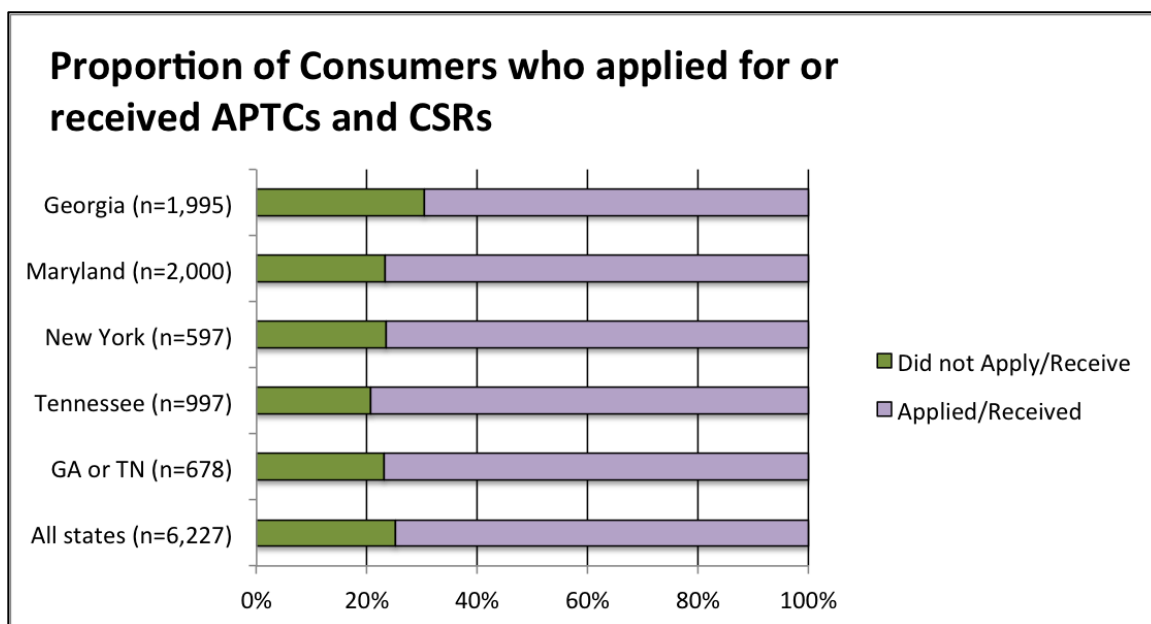


Figure 3.2. The distribution of Consumers who applied for/received APTCs and CSRs among Seedco consortium Consumers in each state based on Salesforce data from January through April 2014.

Demographic breakdowns of application or qualification for APTCs and CSRs among Seedco consortium Consumers in each individual state grouping, segmented by sex/gender, age group, race/ethnicity, Hispanic ethnicity, and preferred language, are presented in Tables 3.15 through 3.19. Data were relatively sparse for New York due to missing values in the data set.

## Demographics of health literacy, health visits in the past year, delay of health care due to cost, and monthly financial situation, by state

Tables 3.20 through 3.24 present full demographics of health literacy, based on the health literacy screening item that asked Consumers, “How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?” Across the sample, the most frequent response to the screening question was “Never,” with a frequency of 57% (n=1,870), followed distantly by “Rarely” with 15% (n=501), “Sometimes” with 14% (n=463), “Often” with ~7% (n=239), and “Always” with ~7% as well (n=230).

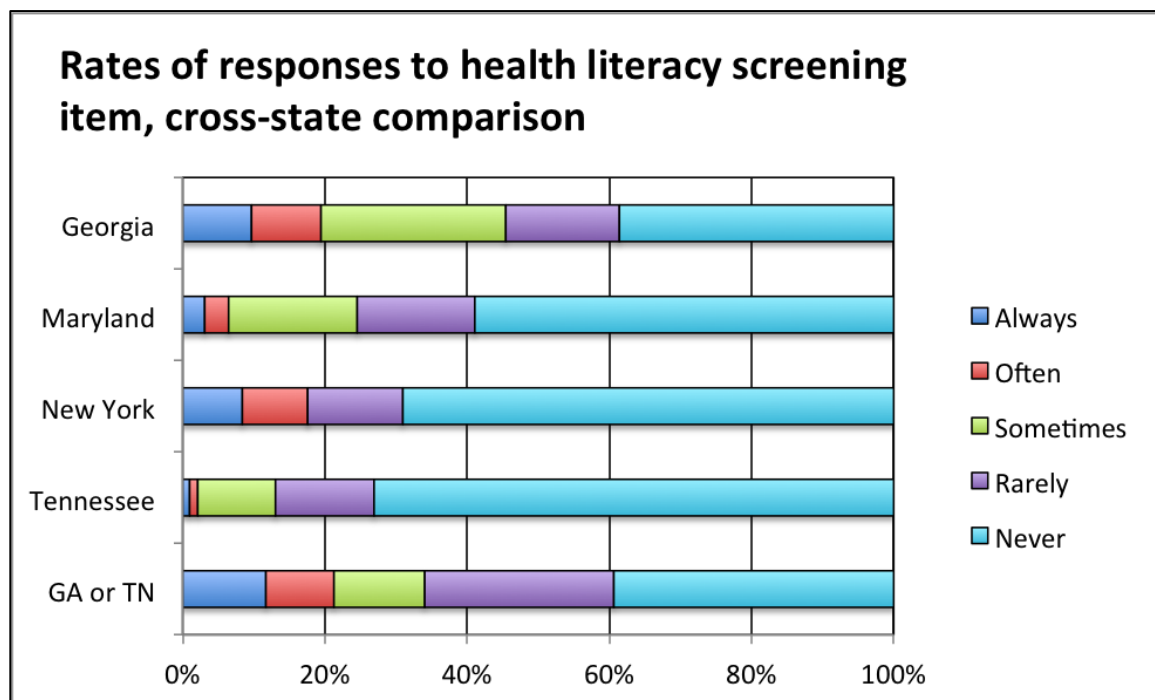


Figure 3.3. The distribution of responses to the question, “How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?” by state among Seedco consortium Consumers in each state based on Salesforce data from January through late March, 2014.

While it would be erroneous to claim a standard for using this sort of item, some authorities use responses of “sometimes,” “often,” and “always” to indicate limited health literacy. In that case, 28% of this sample might qualify as having limited health literacy, a figure that is consistent with some national-level findings. Patterns of response to the health literacy screening item were quite variable across individual states included in the Salesforce sample (Figure 3.3).

Tables 3.25 through 3.29 present demographics of response to the item that asked Consumers about the number of health visits that they have had in the previous 12 months.



Tables 3.30 through 3.34 present demographics of responses in each state to an item that asked how many times Consumers delayed a health care visit because of cost in the previous 12 months.

Tables 3.35 through 3.39 present state-wise demographics of responses to an item that asked Consumers about their monthly financial situation.

### ***Results of bivariate analyses***

#### **Technical note on bivariate analyses**

The UGA project team conducted bivariate analyses on the data set using the Pearson's chi-squared test in SPSS statistical analysis software. The Pearson's chi-squared ( $\chi^2$ ) test is useful for determining associations between two variables. Another way to think about  $\chi^2$  analyses is that they tell you whether the proportion of Consumers who fall into a particular category (e.g., females who qualified for health insurance subsidies) could have come about by chance (e.g., given the total number of females and the total number of Consumers who qualified for subsidies).

In a later section, this report gives results using a different kind of statistical analysis, logistic regression. Logistic regression answers a different kind of question: how much more likely is a Consumer who falls into a particular category (e.g., female) to experience a particular outcome (e.g., obtaining a subsidy) relative to a person from another category (male)? Both kinds of analyses are useful. The  $\chi^2$  analysis yields percentages that help you estimate how many Consumers will fall into each subcategory. However the  $\chi^2$  can only look at two variables at a time. Regression can look at the conjoint effects of many variables at the same time (e.g., gender, state of residence, level of health literacy). Regression is used for building predictive models, especially powerful for policy development. However regression does not directly yield the same kind of descriptive picture that a  $\chi^2$  does. These two statistical approaches are complementary to each other. But because they ask different questions, they can sometimes yield results that appear to be contradictory at first glance. For example, it is possible that regressions might show that women are *more likely* than men to receive subsidies, and at the same time  $\chi^2$  could show that the *proportion* of women who receive subsidies is no greater than chance.

To determine statistical significance, we used a standard probability level of 0.05, which means that for each test, a p-value of <0.05 indicates that observed patterns are not likely to have arisen by chance, and is therefore statistically significant. In the results presented below, we explore how social, demographic, and economic factors are associated with a number of outcomes in individual states—successful enrollment in different types of health plans, rates of application for APTCs and CSRs, and health literacy. In terms of sampling, for the results presented below there were sufficient Consumer records in each reported category to meet or exceed the assumptions of the

$\chi^2$  test. Only significant results are presented below. For some associations, we present the full four-state sample followed by combined results for Maryland and New York cases and combined results for Georgia and Tennessee cases before presenting results for individual states. These combined tests were run in order to examine patterns within and between different state policy environments created by type of Marketplace and whether the state expanded Medicaid eligibility.

### **Language preference and enrollment success in four states**

In the analyses presented below (Tables 3.40 through 3.47) involving associations between language preference and enrollment success, the responses for Consumers who preferred to speak a language other than Chinese, English, Spanish, or Vietnamese were excluded for the sake of clarity.

According to bivariate analyses of the **full four-state sample** (n = 9,838) English speakers comprised the largest population of Consumers (n = 9,032) and they enrolled successfully in coverage at a rate of 62.9%. English speakers were followed in frequency in the sample by Consumers who preferred to speak Spanish (n = 516), who enrolled successfully at a rate of 55.6%. Consumers who preferred to speak a Chinese language (n = 293) enrolled successfully at a proportionally much lower rate of 1.7% ( $\chi^2 = 450.973$ , p = .000).

In **Georgia** (n = 911), although people who preferred English (n = 273) were the largest linguistic group to undergo Navigation. They achieved enrollment success (as defined previously for federal Marketplace states) at a rate of 33.3%, which was proportionally lower than that of Consumers who preferred Spanish (n = 47), who applied for public coverage or chose a private plan at a rate of 52.2% ( $\chi^2 = 295.695$ , p = .000).

Likewise, in **New York** (n = 1,943), Consumers who preferred English (n = 743) enrolled in public or private coverage at a slightly lower proportional rate (54.5%) than that of Consumers who preferred Spanish (n = 179), who enrolled at a rate of 59.5% ( $\chi^2 = 295.695$ , p = .000).

Only in **Maryland**, in which English speakers (n = 5,872) had a 70.8% chance of being enrolled, was the trend different. In Maryland, English speakers were followed by Spanish speakers (n = 104), who had a 51.9% chance of being enrolled in a health plan ( $\chi^2 = 17.411$ , p = .000).

Linguistic preference is not significantly associated with rates of application for public coverage or choice of private plan in **Tennessee**.

### Race/ethnic identity and enrollment success in four states

Associations between race/ethnic identity and enrollment success are summarized in Tables 3.48 through 3.55. Among Consumers for whom both racial/ethnic data and enrollment status were documented in the **full four-state sample** (n = 9,618), Black/African American (n = 3,222), Hispanic (n = 671), and White (n = 4,723) Consumers experienced comparable rates of enrollment success. Black/African American Consumers undergoing Navigation enrolled at a proportional rate of 58.4%, while Hispanic and White Consumers enrolled at rates of 60.2% and 66.1%, respectively. Native American (n = 16) and Asian (n = 949) Consumers experienced much lower rates of enrollment, at 37.5% and 37.8%, respectively ( $\chi^2 = 274.096$ , p = .000).

According to bivariate analyses, race/ethnic identity is not significantly associated with enrollment success in **Maryland**, but it is associated with enrollment success in other states.

In **New York** (n = 1,517) Asian Consumers (n = 514) were least likely among all racial/ethnic groups to successfully enroll in coverage. Only 15.6% of Asian Consumers enrolled in coverage, compared to Hispanic Consumers (n = 348) who had a 47.7% likelihood of enrolling, White Consumers (n = 181) who had a 37.7% chance of enrolling, and Black/African American Consumers (n = 474) who had a 35.6% chance of enrolling ( $\chi^2 = 521.695$ , p = .000).

In **Georgia** (n = 1,405) by contrast, Asian Consumers (n = 111) had the highest likelihood of enrollment success at 50.5%. Hispanic Consumers (n = 44) followed, with a 47.7% likelihood of applying for public coverage or choosing a private plan. White (n = 461) and Black/African American (n = 789) Consumers followed with 37.7% and 35.6%, respectively ( $\chi^2 = 10.993$ , p = .012).

In **Tennessee** (n = 742), Black/African Americans (n = 341) had the highest likelihood of enrollment success, at a rate of 58.7%. White Consumers (n = 360) were the least likely to successfully enroll in coverage at 49.3% ( $\chi^2 = 15.992$ , p = .001).

### Monthly financial situation and enrollment success in four states

Tables 3.56 through 3.62 summarize association between monthly financial situation and enrollment success in the Salesforce dataset. Consumers who completed Salesforce surveys had five categorical options from which to choose in response to the survey item that asked, “What is your monthly financial situation?” Possible responses included the following:

1. I don’t know
2. I come up short and I sometimes have to borrow money from friends or relatives to make ends meet.

3. I come up short and sometimes use my credit card or take on other debt to make ends meet.
4. I have money left over that I can either save or spend on things I want.
5. I just break even after paying my expenses and buying what I need.
6. (Participant declined to respond to the item)

Among Consumers for whom monthly financial situation and enrollment status were documented in the **full four-state sample** (n = 3,406), Consumers in four response categories experienced enrollment success at similar rates: those who responded that they come up short and sometimes have to borrow money from friends or relatives to make ends meet (n = 840) enrolled at a rate of 55.5%. Those who responded that they come up short and sometimes use a credit card or take on other debt to make ends meet (n = 118) enrolled at a rate of 55.7%. Those who recall that they have money left over that they can either save or spend on things they want (n = 311) enrolled at a rate of 54.3%, and those that respond that they just break even after paying expenses and buying what they need (n = 1,018) enrolled at a rate of 56.0%. Consumers who responded that they did not know their monthly financial situation (n = 510) and those who declined to answer (n = 155) enrolled at the much lower proportional rates of 35.5% and 41.9%, respectively ( $\chi^2 = 75.314$ ,  $p = .000$ ).

In **Georgia** (n = 984), Consumers who chose to describe their monthly financial situation as “I just break even after paying my expenses and buying what I need” (n = 341) had 51% likelihood of applying for public coverage or choosing a private plan, which was a higher likelihood than is associated with any of the other options ( $\chi^2 = 31.190$ ,  $p = .000$ ).

Monthly financial situation was not significantly associated with enrollment success in **Tennessee**.

Among **New York** Consumers (n = 1,027), 63.5% of those who responded, “I come up short and I sometimes have to borrow money from friends or relatives to make ends meet” (n = 359) and 68.7% of those who responded, “I come up and I short sometimes use my credit card or take on other debt to make ends meet” (n = 67) successfully enrolled in coverage, whereas those who did not know their monthly financial situation (n = 102) saw enrollment success at the very low rate of 19.6% ( $\chi^2 = 189.532$ ,  $p = .000$ ).

In **Maryland** (n = 409), Consumers reporting all monthly financial situations experienced relatively high rates of successful enrollment in coverage, but differences are still significant, with Consumers reporting that they do not know their monthly financial status (n = 39) experiencing lower rates of enrollment than respondents in all other groups (69.2%). Consumers who report that they come up short and sometimes have to borrow money from friends or relatives to make ends meet (n = 100) enrolled at a 90.0% rate; people who sometimes have to take on other forms of debt to make ends meet (n = 51) enrolled in coverage at a rate of 74.5%; those who have money left over that they can either save or spend on things they want (n = 47) enrolled at a rate of

83.0%, and those who just break even ( $n = 154$ ) enrolled at a rate of 81.2% ( $\chi^2 = 27.540$ ,  $p = .000$ ).

### **Race/ethnic identity and private QHP enrollment in four states**

In the **full four-state sample of people who succeeded in enrolling**, the proportion of White Consumers who enrolled in private plans (rather than in public plans) was 49.5%, and Asian Consumers enrolled in private plans at a slightly lower rate of 48.5%. Black/African American and Hispanic Consumers enrolled in or selected private plans at significantly lower (but not dramatically so) rates of 45.4% and 45.7%, respectively ( $\chi^2 = 9.579$ ,  $p = .023$ ).

Among Consumers who successfully enrolled (as previously defined for federal Marketplaces) in **Georgia ( $n=685$ )**, there were no significant associations between racial/ethnic groups and enrollment in public versus private coverage.

Among **Maryland** Consumers who succeeded in enrolling ( $n = 4596$ ), people identifying as Hispanic and Asian experienced highest rates of enrollment in private plans as compared to public, with 59% ( $n=99$ ) and 52%, ( $n=99$ ) of those who enrolled going with QHPs respectively. Of White Consumers who enrolled in Maryland, 48% ( $n=1367$ ) enrolled in private plans, while Black/African American consumers experienced the relatively lowest rates of private plan enrollment at 34.2% ( $n=356$ ) of those who succeeded in enrolling ( $\chi^2 = 75.088$ ,  $p = .000$ ).

In **New York** ( $n = 1,953$ ), members of all racial/ethnic groups who experienced enrollment success enrolled in public coverage at higher rates than private coverage. Among New Yorker Consumers who enrolled in coverage, white Consumers experienced the highest rate of enrollment in private plans at 42.4% ( $n=61$ ) and Black/African American Consumers enrolled in private plans at the lowest rate with 24.5%. ( $n=89$ ) Asian and Hispanic Consumers fell in between with 37.1% ( $n=170$ ) and 34% ( $n=137$ ) enrollment in private plans, respectively ( $\chi^2 = 21.089$ ,  $p = .000$ ).

In **Tennessee** ( $n = 510$ ), Black/African American Consumers who succeeded in applying applied in private plans at a rate of 75.1% ( $n=1577$ ) and Asian Consumers enrolled at a rate of 58 % ( $n=11$ ). Very few Hispanic Consumers ( $n=8$ ) were included among those who succeeded in applying in Tennessee. White Consumers who succeeded in applying applied to private plans at a rate of 53.3% ( $n=89$ ) ( $\chi^2 = 25.035$ ,  $p = .000$ ).

### **Age and private QHP enrollment in four states**

In the analyses presented below, which deal specifically with the proportion of Consumers in different age groups who succeeded in enrolling and selected private QHPs (as opposed to public insurance coverage), individuals who were recorded as aged

less than 18 years were omitted from analyses. Summaries of these analyses appear in Tables 3.63 through 3.69.

Among Consumers who experienced enrollment success in the **full four-state sample** (n = 6,312), more than half who enrolled in private coverage were between the ages of 35-45 (n = 2,180) and 46-55 (n = 1,760). Consumers aged 18-25 years who succeeded in enrolling were proportionately less likely to enroll in or apply for private coverage and did so at a proportional rate of 26.7% while Consumers aged 45-55 and 56-65 who succeeded in enrolling were most likely to enroll in or select private plans, and did so at rates of 56.5% and 61.0%, respectively ( $\chi^2 = 237.626$ , p = .000).

In **Georgia**, members of all age groups who experienced enrollment success (n = 685) enrolled in private coverage at higher rates than public coverage. Consumers aged 56-65 years led rates of private enrollment with 84.3% (n = 118), followed by Consumers aged 18-25 years at 79.3% (n = 23;), aged 26-34 years at 72.7% (n = 48), aged 46-55 years at 71.2% (n = 121), and aged 35-45 years at 65.4% (n = 1106) ( $\chi^2 = 14.718$ , p = .005).

In **Maryland**, as in the full four-state sample, the majority of successful enrollees (n=4596) who enrolled in private coverage for whom age was documented were between the ages of 35-45 (n = 820) and 46-55 (n = 610), who enrolled in private plans at rates of 50.8% and 56.9%, respectively. Also among Consumers who succeeded in enrolling in Maryland, rates of enrollment in private coverage increased with age. Consumers aged 56-65 years who enrolled in private QHPs (n = 14) lead with a rate of 66.7% and Consumers aged 18-25 years enrolled in private coverage at a rate of 27.2% (n = 133) ( $\chi^2 = 129.596$ , p = .000).

In **New York**, members of all age groups who experienced enrollment success (n = 1,953) enrolled in public coverage at higher rates than private coverage. Consumers aged 56-65 years who enrolled in private QHPs (n = 149) and aged 46-55 years (n = 120) led the rates of private enrollment with rates of 40.7% and 39.6% of those who succeeded in enrolling, respectively. Consumers aged 26-35 years who enrolled in private QHPs (n = 86) and 35-45 years (n = 80) fell in the middle, with 32.3% and 31.3% of those who succeeded in enrolling, respectively, and those aged 18-25 years experienced the lowest rates of enrollment in QHPs relative to those who succeeded in any enrollment, at 14.3% (n = 27) ( $\chi^2 = 45.690$ , p = .000).

Among Consumers who succeeded in enrolling in **Tennessee** (n = 464), the highest rates of private enrollment were observed among persons aged 56-65 years (n = 60; 75.3%) and 46-55 years (n=81; 71.2%). Lowest rates were observed among Consumers aged 18-25 years (n = 20; 25.0%) ( $\chi^2 = 42.776$ , p = .000).

## Health literacy and private QHP enrollment in four states

In the **full four-state sample**, among consumers who enrolled in any type of coverage (n = 1,939), Consumers who responded that they “sometimes” need help reading documents (n = 232) enrolled in or selected private coverage at a significantly high rate of 72.4% ( $\chi^2 = 56.224$ , p = .000) compared to Consumers who provided other responses.

Regarding state-by-state results, health literacy was not significantly associated with enrollment in public versus private coverage in any state except for **Tennessee** (n = 337), where people who responded that they “Rarely” need help reading documents (n = 38) selected private coverage at the relatively high rate of 84.2% ( $\chi^2 = 10.486$ , p = .033). These results are summarized in Tables 3.70 and 3.71.

## Monthly financial situation and private QHP enrollment in four states

The following analyses look only at Consumers who succeeded in enrolling (as that is defined previously) and ask whether enrollment into a private QHP (as opposed to public insurance) is contingent on monthly financial status (i.e., financial frailty). These findings are summarized in Tables 3.72 through 3.77. In the **full four-state sample of Consumers who succeeded in enrolling** (n = 1,887), Consumers who were more financially secure in that they reported having money left over (n = 202) or just breaking even (n = 646) enrolled in or selected private coverage at much proportionally higher rates (81.2% and 63.9%) than Consumers who reported other monthly financial situations. Consumers who were less financially secure in that they reported needing to borrow money from friends or family members (n = 528) enrolled in or applied for public coverage at a significantly high rate of (70.8%). People who reported not knowing their financial situation (n = 258) or who reported that they need to use credit cards or otherwise go in to debt (n = 128) were about equally likely to enroll in private and public insurance ( $\chi^2 = 235.268$ , p = .000).

In **Georgia**, among Consumers who succeeded in enrolling (n = 404), 100.0% of those who reported that they have money left over at the end of each month (n = 33) enrolled in private plans; 81.5% of those who reported that they just break even (n = 178), and 80.0% who reported that they fall short and use credit cards or go into other debt (n = 25) enrolled in private plans. In comparison, only 48.8% of Consumers who reported shortfalls and needing to borrow money from friends or relatives (n = 86) enrolled in private plans ( $\chi^2 = 47.114$ , p = .000).

Among **Tennessee** Consumers who succeeded in enrolling (n = 279), those who had money left over at the end of the month (n = 43) enrolled in private plans at a rate of 86.0%. Consumers who just break even (n = 123) or need to borrow from friends or relatives (n = 63) enrolled in private plans at rates of 65.9% and 69.0%, respectively. Consumers who reported that they fall short and use credit cards or go into other debt (n = 6) enrolled in private plans at a rate of 50.0% ( $\chi^2 = 18.996$ , p = .001).

In **New York** the only financial category of those who succeeded in enrolling (n = 785) that was associated with eligibility for private plans was “I have money left over that I can either save or spend on things I want” (66.7%; n = 78). The lowest rates of private enrollment were among Consumers who reported that they use credit cards or go into other debt (n = 48; 22.9%) or reported the need to borrow from friends or relatives (n = 281; 8.5%) ( $\chi^2 = 121.700$ , p = .000).

Among **Maryland** Consumers who succeeded in enrolling (n = 385), 85.4% of Consumers with money left over at the end of the month (n = 41) and 69.2% of Consumers who just break even (n = 130) purchased private plans. Rates among Consumers who use credit cards or go into other debt (n = 45; 57.8%) or who must borrow from family or friends (n = 92; 42.4%) were notably lower ( $\chi^2 = 36.294$ , p = .000).

#### **Application/qualification for APTCs/CSRs and language preference in four states**

Summaries of relationships between application/qualification for APTCs and CSRs and health literacy are presented in Tables 3.78 through 3.81. In the analyses presented below involving associations between language preference and enrollment success, the responses for Consumers who preferred to speak a language other than Chinese, English, Spanish, or Vietnamese was excluded for the sake of clarity.

In the **full four-state sample**, among consumers for whom information on both language preference and subsidies were documented (n = 4,632), English speakers were most plentiful (n = 4,282), but Consumers who preferred to speak a Chinese language (n = 96) experienced the highest proportional rate of application for or receipt of Advance Premium Tax Credits (APTCs) and Cost Sharing Reductions (CSRs) with a rate of 92.7%. They were followed by Consumers who preferred Spanish (n = 254), who applied for/received subsidies at a rate of 84.3%, and Consumers who preferred English who applied for/received subsidies at a rate of 72.9% ( $\chi^2 = 33.927$ , p = .000).

There was no significant association between application /qualification for APTCs/CSRs and language preference in individual states of **New York, Maryland, or Tennessee**, or among Consumers who may have been from **Georgia or Tennessee**. In **Georgia** (n = 1,055;  $\chi^2 = 33.609$ , p = .000), Consumers who preferred Spanish (n = 133) experienced the highest rates of application for APTCs/CSRs with 81.2%, followed by those who preferred English (n = 922) with 54.7%.

#### **Application/qualification for APTCs/CSRs and health literacy in four states**

Health literacy was assessed based on Consumers' responses to a screening item that asked “How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?” Consumers could choose from “Always,” “Often,” “Sometimes,” “Rarely,” and “Never.” Summaries of



relationships between application/qualification for APTCs and CSRs and health literacy are presented in Tables 3.82 through 3.84.

In the **full four-state sample** (n = 2,111), Consumers who reported that they “always” needed help reading documents (n = 131) qualified for APTCs/CSRs at a rate of 87.8%, which is notably higher than the rates of qualification associated with all other responses, which fell in the range of 73%-79.9% ( $\chi^2 = 14.104$ , p = .007).

In **Georgia** (n = 1,049), Consumers who responded “Always” to the item that asked, “How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?” (n = 103) experienced highest rates of application for APTCs/CSRs (87.4%), followed by those who responded, “Often” (n = 99; 72.7%). Consumers who responded “Sometimes” (n = 276; 66.3%), “Rarely” (n = 178; 69.7%), and “Never” (n = 393; 67.9%) experienced the lowest rate ( $\chi^2 = 17.806$ , p = .001).

There was no significant association between application/qualification for APTCs/CSRs and health literacy in **New York, Maryland, Tennessee**, or among Consumers who may have been from **Georgia or Tennessee**.

#### **Application/qualification for APTCs/CSRs and age group Among Consumers who Enrolled in QHPs in four states**

Summaries of Chi-squared analyses of relations between application/qualification for APTCs/CSRs and Consumer age group among Consumers who enrolled in private QHPs are presented in tables 3.85 through 3.91. Consumers recorded as under age 18 were excluded from the following analyses.

Among Consumers who enrolled in private insurance in the **full four-state sample** (n = 5,128), Consumers aged 18-25 years (n = 318) qualified for APTCs/CSRs at the lowest rate (68.6%). All other age groups qualified at rates between about 74% and 79.7% ( $\chi^2 = 24.756$ , p = .000).

Among Consumers who enrolled in private insurance in **Georgia**, the youngest Consumers, aged 18-25 years (n = 86), were least likely to qualify for APTCs/CSRs (54.7%), while those aged 26-34 years (n = 235) and 35-45 years (n = 459) were most likely (71.5% and 73.9% respectively) ( $\chi^2 = 20.545$ , p = .000).

Among Consumers who enrolled in private insurance in **Maryland**, Consumers aged 35-45 years (n = 749) and 46-55 years (n = 558) experienced highest rates of qualification in APTCs and/or CSRs (83.4% and 83.3%, respectively). Consumers aged 18-25 years (n = 139) and 26-34 years (n = 211) experienced somewhat lower rates (75.5% and 74.4%), while the eldest consumers, those aged 56-65 years (n = 26), experienced the lowest rates of qualification with just 34.6% ( $\chi^2 = 49.599$ , p = .000).

Among Consumers who enrolled in private insurance in **New York** Consumers, there were no significant associations among qualification for subsidies and age group.

Among **Tennessee** Consumers who enrolled in private insurance, those aged 18-25 years (n = 36), were least likely to qualify for APTCs/CSRs (50.0%). Those aged 26-34 years (n = 79), 35-45 years (n = 97), and 46-55 years (n = 104) experienced similar rates and were most likely (78.5%, 80.0%, and 78.8% respectively) ( $\chi^2 = 22.992$ ,  $p = .000$ ).

### **Application/qualification for APTCs/CSRs and monthly financial situation Among Consumers who Enrolled in QHPs in four states**

Bivariate associations between application/qualification for APTCs and CSRs and monthly financial situation are summarized in Tables 3.92 through 3.96. Consumers who completed Salesforce surveys had five categorical options from which to choose in response to the survey item that asked, “What is your monthly financial situation?” Possible responses included the following:

1. I don’t know
2. I come up short and I sometimes have to borrow money from friends or relatives to make ends meet.
3. I come up short and sometimes use my credit card or take on other debt to make ends meet.
4. I have money left over that I can either save or spend on things I want.
5. I just break even after paying my expenses and buying what I need.
6. (Participant declined to respond to the item)

Among Consumers who enrolled in private insurance in the **full four-state sample** (n = 2,151), Consumers who reported that they just break even every month (n = 794) experienced highest rates of application/qualification for subsidies at 80.7%. They were followed in proportion of qualification for subsidies by Consumers who reported not knowing their financial situation (n = 466; 73.2%), and those who reported having money left over (n = 237; 74.7%). Lowest rates for obtaining subsidies were observed among those who reported that they come up short and need to either borrow from friends or relatives (n = 482; 63.5%) or use a credit card or other form of debt (n = 135; 68.9%) ( $\chi^2 = 50.109$ ,  $p = .000$ ).

Among Consumers in **Maryland** who enrolled in private insurance there were no significant associations between monthly financial situation and qualification for APTCs and CSRs.

Among **New York** Consumers who enrolled in private insurance (n = 165), those who reported needing to use a credit card or to take on other debt (n = 6) and those who reported that they just break even (n = 54) qualified for APTCs/CSRs at respective rates

of 100% and 98.1%. People who reported having money left over (n = 38) qualified for APTCs/CSRs at the lower rate of 68.4% ( $\chi^2 = 21.896$ , p = .001).

People who just break even (71.2%) or have money left over (65.9%) experienced the highest rates of application for APTCs/CSRs among Consumers who enrolled in private insurance in **Georgia** (n = 1,098). Those who use a credit card or take on other debt to get through the month (n = 74; 73.7%) and those who borrow from friends or relatives (n = 257; 69.3%) experienced the lowest rates of application for subsidies ( $\chi^2 = 23.177$ , p = .000).

Similarly, among Consumers who enrolled in private insurance in **Tennessee** (n = 539), Consumers who just break even (n = 233; 86.3%) or have money left over (n = 71; 80.3%) experienced the highest rates of application for APTCs/CSRs and those who use a credit card or take on other debt (n = 19; 73.7%) and those who borrow from friends or relatives (n = 140; 69.3%) experienced the lowest rates of application for subsidies ( $\chi^2 = 16.034$ , p = .003).

### **Language preference and health literacy in four states**

Health literacy was assessed based on Consumers' responses to a screening item that asked "How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?" Consumers could choose from "Always," "Often," "Sometimes," "Rarely," and "Never;" the less frequent the need of assistance, the higher relative health literacy is assumed. We were interested in understanding whether the health literacy screening item was meaningful to intent, or whether it might be reflecting other characteristics like native language. Therefore, we use this section to ask whether (and to what extent) responses to the health literacy screening item included in the Salesforce survey instruments were contingent on preference for English. Statistically significant bivariate associations between language preference and health literacy are summarized in Tables 3.97 through 3.99. We observed significant associations between language preference and health literacy in the **full four-state sample** and in **New York** and **Georgia only**. These are explained below.

In the **full four-state sample**, Consumers who expressed a preference for English (n = 2,490) responded that they "Never" need help reading documents at a high rate of 64.7%, and only reported "Always" needing assistance at a notably low rate of 2.5%. People who preferred to speak Spanish (n = 219) and those who preferred a Chinese language (n = 99) reported that they "Never" need help at rates of 40.2% and 41.4%, respectively, and that they "Always" need help at rates of 13.2% and 25.3%, respectively ( $\chi^2 = 336.071$ , p = .000).

In **New York**, of Consumers who reported a preference for speaking English (n = 914), 2.2% reported that they "Always" need help and 3.2% reported that they "Often" need

help, as opposed to 80.6% who reported that they “Never” need help reading documents. This is a much higher rate of “health literacy” than observed among people who preferred other languages included in the analysis. 25.3% of Consumers who preferred to speak a Chinese language (n = 99) reported that they “Always” need help, 28.3% reported that they “Often” need help, and 41.4% reported that they “Never” need help reading documents. Among people with a preference for Spanish (n = 120), 15.0% reported that they “Always” need help, 15.0% reported that they “Often” need help, and 53.3% reported that they “Never” need help reading documents ( $\chi^2 = 204.992$ ,  $p = .000$ ).

In **Georgia**, of Consumers who reported a preference for speaking English (n = 592), 4.1% reported that they “Always” need help and 7.6% reported that they “Often” need help, as opposed to 43.4% who reported that they “Never” need help reading documents. This is a much lower rate of “health literacy” than was observed among English speakers in New York above, but a higher rate of “health literacy” than observed among people who preferred to Speak Spanish (n = 76). Among people in Georgia with a preference for Spanish, 11.8% reported that they “Always” need help, 34.2% reported that they “Sometimes” need help, and 28.9% report that they “Never” need help reading documents. Other language preferences were not included in this test due to low number of cases and high rates of missing data ( $\chi^2 = 13.585$ ,  $p = .009$ ).

No association between health literacy and language preference in Maryland or Tennessee.

### **Age and health literacy in four states**

Records that indicated that Consumers were under age 18 were excluded from the following analyses. Statistically significant bivariate associations between age and health literacy are summarized in Tables 3.100 through 3.102.

Results for the **full four-state sample** (n = 2,848), suggested a slight trend of decreasing health literacy with age. The likelihood of needing help reading documents “Sometimes,” “Often,” or “Always” increased with age. Among persons aged 18-25 years (n = 211), 66.4% responded that they “Never” need help reading documents while 55.4% of persons aged 56-65 years (n = 704) gave the same response. In addition, 4.3% of those aged 18-25 years reported that they “Always” need help, while 7.1% of 56-65 year-olds gave the same response ( $\chi^2 = 30.341$ ,  $p = .016$ ).

In **New York** (n = 781), as in the full four-state sample, there is an observed trend by age group; responses of Consumers belonging to increasingly aged groups indicated decreasing health literacy. The likelihood of needing help reading documents “Sometimes,” “Often,” or “Always” increased with age. Among persons aged 18-25 years (n = 96), 82.3% responded that they “Never” need help reading documents while 63.8% of persons aged 56-65 years (n = 174) gave the same response. In addition, 3.1%

of those aged 18-25 years reported that they “Always” need help, while 12.6% of 56-65 year-olds gave the same response ( $\chi^2 = 32.007$ ,  $p = .001$ ).

Similarly, among **Georgia** Consumers ( $n = 1,015$ ), health literacy decreased with age; 48.2% of 18-25 year-olds ( $n = 56$ ) reported that they “Never” need help reading documents, while only 39.7% of 56-65 year-olds ( $n = 290$ ) gave the same response ( $\chi^2 = 28.271$ ,  $p = .029$ ).

There were no significant bivariate associations between age group and health literacy among Consumers from **Maryland** or from **Tennessee**.

### ***Results of multivariate analyses***

Following the bivariate analyses, we performed multivariate analyses of Salesforce survey data. In the multivariate analyses, we were interested in understanding the conjoint and simultaneous effects of several social, demographic, geographic, and economic characteristics of Consumers on enrollment outcomes. These outcomes included (a) successful enrollment in coverage; (b) enrollment in private insurance plans, and (c) qualification for APTCs and CSRs. Furthermore, we were interested in understanding these impacts in the **full four-state sample** and, separately, in **sub-samples from individual states**. The first results reported for each question pertain to the **full four-state sample**, and these are followed by reports of associations observed **within individual states**. Results are omitted in instances where no statistically significant effects were observed, and in instances in which assumptions of the statistical test were not met due to low sample size ( $n < \sim 100$ ). As mentioned previously, it is possible for results of the multivariate analyses to differ from those in the bivariate analyses, because they are asking different questions. Results below are organized around answering the following eight basic questions:

1. How are social, demographic, geographic, and economic factors associated with successful enrollment in health plans?
2. How are social, demographic, geographic, and economic factors associated with progress in enrollment status in New York and Maryland specifically?
3. How are social, demographic, geographic, and economic factors associated with enrollment in private QHPs?
4. How are social, demographic, geographic, and economic factors associated with enrollment in public coverage?
5. How are social, demographic, geographic, and economic characteristics associated with application for or qualification for Advance Premium Tax Credits/Cost Sharing Reductions (APTCs/CSRs)?

6. How are social, demographic, geographic, and economic factors associated with Health Literacy?
7. How are social, demographic, geographic, and economic factors associated with frequency of health care visits in the past year?
8. How are social, demographic, geographic, and economic factors associated with associated with delay of health due to cost (i.e., number of times health care visits were delayed because of cost)?

### **Technical notes on regression analyses and interpreting results**

In all analyses, we controlled for a series of (independent) variables: sex/gender; race/ethnicity; age group; monthly financial situation; health literacy<sup>3</sup>; preferred language; and state versus federal marketplace<sup>4</sup>. Note that the variable indicating state versus federal Marketplace encoded virtually the same information as state (i.e. federal Marketplace was always equivalent to Georgia and Tennessee; state Marketplace was always equivalent to Maryland and New York). Because of this, and because we were also interested in the predictive value of residence in individual states, we ran separate regression analyses for each state of residence in which Marketplace type was not a predictor.

For outcome (dependent) variables with dichotomous coding schemes (i.e., whether Consumers enrolled in any type of overage; whether Consumers were enrolled in private insurance or public coverage; and whether Consumers applied or qualified for APTCs or CSRs), we ran multivariate logistic regressions to model associations. In these results, adjusted odds ratios (AORs) indicate the net change in the likelihood of a particular outcome per unit increase in the independent variable. For a binary independent variable, such as gender, the AOR indicates the difference in odds for

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<sup>3</sup> Health literacy was used as a dependent or outcome variable in the linear model constructed to answer Question 4.

<sup>4</sup> Sex/gender was coded as a dichotomous variable. Race was entered in the model in four categories: Asian; Black/African American; Hispanic; and White, Non-Hispanic (referent category). Likewise, age was entered in the models as an ordinal variable that included the following categories: 18-25 years of age; ages 26-34; ages 35 to 45; ages 46 to 55; and greater than age 55. We controlled for the Consumers' monthly financial situation using responses to a single survey item, the responses to which included "I come up short and I sometimes have to borrow money from friends or relatives to make ends meet," "I come up short and I sometimes use my credit card or take on other debt to make ends meet," "I have money left over that I can either save or spend on things I want," and "I just break even after paying my expenses and buying what I need" (referent category in the multivariate models). We also controlled for state (New York, Georgia, Tennessee and Maryland) and health literacy. Maryland served as the referent category with respect to the site variable. Health Literacy was measured by a single screening item that asked, "How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?" The response options ranged where 1 = "always", 2 = "often", 3 = "sometimes"; 4 = "rarely", and 5 = "never." Higher scores indicate greater health literacy. We also controlled for respondents preferred language (Chinese, English, Spanish, Vietnamese, and Other).

females versus males. In both of the types of multivariate modeling, we simultaneously entered all of the independent variables.

For continuous outcome (dependent) variables, multiple linear regression models were fitted to test the independent association of the aforementioned demographic variables with health service use indicators (i.e., health literacy; number of health visits in the past year; number of times a health visit was delayed because of cost). In these results,  $\beta$  (beta)-coefficients indicate the net change in the likelihood of a particular outcome per unit increase in the independent variable.

### **How are social, demographic, geographic, and economic factors associated with successful enrollment in health plans?**

We used logistic regression modeling to “ask” how social, demographic, geographic, and economic factors are associated with enrollment success as previously defined in this document, (that is, enrolling in either private or public insurance in a state Marketplace or applying for or selecting either private or public insurance in a federal Marketplace.) in Georgia, Maryland, New York, and Tennessee. We only report statistically significant associations below. In order to dig more deeply and understand how the enrollment varies among states, we examined the full four-state sample as well as samples comprised of individual states.

**In the full four-state sample** ( $n = 1,723$ ), racial/ethnic identity, Marketplace type, and monthly financial situation all significantly predicted application for or enrollment in coverage. In the full sample, identification as Asian ( $AOR = .41$ ,  $p = .03$ ) was associated with a relatively lower likelihood of enrollment success than identification as White. As compared to Consumers using federally facilitated Marketplaces (in Georgia and Tennessee), Consumers using state-based Marketplaces (in Maryland and New York) had a higher likelihood of application for or enrollment in coverage ( $AOR = 2.97$ ,  $p < .001$ ). Preferred language was also associated with enrollment status, with English predicting enrollment. In terms of monthly financial situation, those who reported having money left over that can be spent or saved had a higher likelihood of successful enrollment as compared to those who indicated that they just break even after paying expenses and buying what is needed ( $AOR = 1.56$ ,  $p = .03$ ).

In a separate model, Consumers in Georgia ( $AOR = .12$ ,  $p < .001$ ), Tennessee ( $AOR = .21$ ,  $p < .001$ ) and New York ( $AOR = .23$ ,  $p < .001$ ) were less likely to succeed in enrolling than consumers in Maryland.

**Among Consumers from New York only** ( $n = 503$ ), racial/ethnic identity and monthly financial situation were significantly associated with enrollment in coverage. Asian Consumers had a lower likelihood of successful enrollment in coverage ( $AOR = .21$ ,  $p = .001$ ) compared to their White counterparts. Those who have to borrow money ( $AOR = 1.98$ ,  $p = .02$ ), who use their credit card or take on other debt ( $AOR = 2.85$ ,  $p < .05$ ), and

who have money left over that can either be saved or spent ( $AOR = 2.65, p < .05$ ) have a greater likelihood of successful enrollment as compared to those who indicated that they just break even after paying expenses and buying what is needed. Note that since successful enrollment includes enrollment in public insurance, and most Consumers in state exchanges did enroll in public insurance, this finding very likely reflects the fact that Medicaid expansion accommodated financially distressed Consumers in particular.

**Among Consumers from Maryland** ( $n = 363$ ), only one indicator was associated with successful enrollment: those who have to borrow money from friends or relatives to make ends meet had a greater likelihood of successful enrollment ( $AOR = 2.95, p = .02$ ) as compared to those who indicated that they just break even after paying expenses and buying what is needed. Note that, as in the similar finding for New York reported above, this finding likely reflects the impact of Medicaid expansion in promoting enrollment for financially distressed Consumers.

**Among Tennessee Consumers** ( $n = 394$ ), racial/ethnic identity and monthly financial situation were significantly associated with application for or enrollment in coverage. Black/African American Consumers ( $AOR = 2.12, p = .001$ ) had a higher likelihood of successful enrollment than their White counterparts. Those who have to use their credit card or take on other debt ( $AOR = .29, p = .04$ ) had a lower likelihood of successful enrollment than those who indicated that they just break even after paying expenses and buying what is needed.

### **Which factors predicted progress in enrollment status in New York and Maryland?**

In New York and Maryland, enrollment status was recorded as one of five options: “Enrolled,” “Applied,” “Active,” “Inactive,” and “Lead.” Thus for these two states only, it was possible to conduct a different kind of regression that treated enrollment status as a continuous dependent variable in a linear regression model. Although the question may sound similar to Question 1, the results around Question 2 are based on a different type of regression and the focus is on progress through the enrollment process rather than on the final outcome of that process (i.e., enrollment success). Incidentally, Consumers in Maryland and New York both use state Marketplaces and live in states that opted in to Medicaid eligibility expansion.

In this model, we found two unique predictors of Maryland-New York Consumers’ data. As compared with residents of Maryland, New York residents were less likely to reach more advanced enrollment status ( $\beta = .23, p < .001$ ). Preferred language was also significantly associated with more advanced enrollment status. As compared to English speaking individuals, those who preferred to speak a Chinese language were more likely to reach more advanced enrollment status ( $\beta = .11, p = .014$ ). The financial situation of the respondents was also associated with enrollment status. As compared to those who indicated that they just break even after paying expenses and buying what is needed, those who come up short with their finances and have to borrow money were *less* likely



to advance in enrollment status ( $\beta = -.15$ ,  $p = .001$ ). The result regarding Chinese speakers is counter-intuitive, and therefore a word about interpretation is in order. As explained above, unlike the logistic regressions that treat enrollment success as a dichotomous (yes/no) outcomes, this analysis does not tell us whether a Consumer surmounted the final step to actually succeed in enrolling. Therefore it is possible that, for example, Chinese speakers progressed well through preliminary steps toward enrollment without actually enrolling with a Navigator.

### **How are social, demographic, geographic, and economic factors associated with enrollment in private QHPs?**

Among those Consumers in the **full, four-state sample** who succeeded in enrolling (as previously defined;  $n = 1,605$ ), race/ethnicity, age group, Marketplace type, sex/gender, and monthly financial situation were all significant predictors of enrollment in private coverage. Consumers identifying as Asian were significantly less likely ( $AOR = .609$ ,  $p = .039$ ) to enroll in a private plan than those identifying as white. Consumers aged 35 to 45 years ( $AOR = 2.307$ ,  $p = .001$ ), aged 46 to 55 years ( $AOR = 2.009$ ,  $p = .006$ ), and aged 56 to 65 years ( $AOR = 1.938$ ,  $p = .013$ ) were each significantly more likely to enroll in a private QHP than Consumers aged 18 to 25 years. Consumers using state-based Marketplaces (that is, Consumers in Maryland and New York) were more likely to enroll in private plans ( $AOR = 2.402$ ,  $p = .000$ ) than Consumers using federally facilitated Marketplaces (i.e., Consumers in Georgia and Tennessee), and women ( $AOR = .769$ ,  $p = .021$ ) were less likely than men to enroll in private coverage. Consumers who sometimes come up short financially and have to borrow from friends and family ( $AOR = .33$ ,  $p = .000$ ) and those who have to use a credit card or take on other debt ( $AOR = .563$ ,  $p = .009$ ) were less likely than those who just break even each month enroll in a private plan. Conversely, those who said that they have money left over at the end of the month ( $AOR = 2.399$ ,  $p = .000$ ) were more likely than those who just break even to enroll in a private plan.

In the sample of Consumers who successfully enrolled from **New York** ( $n = 424$ ), only sex/gender and monthly financial situation were significantly associated with enrollment in a private QHP. Women ( $AOR = .499$ ,  $p = .006$ ) were less likely than men to select or enroll in private coverage. Consumers who sometimes come up short financially and have to borrow from friends and family ( $AOR = .110$ ,  $p = .000$ ) were less likely than those who just break even each month to select or enroll in a private plan. Conversely, those who said that they have money left over at the end of the month ( $AOR = 3.222$ ,  $p = .006$ ) were more likely than those who just break even to select or enroll in a private plan.

Among **Maryland Consumers who successfully enrolled** ( $n = 316$ ), only monthly financial situation predicted private QHP enrollment. Consumers who sometimes come up short financially and have to borrow from friends and family ( $AOR = .239$ ,  $p = .000$ ) were less likely than those who just break even each month to enroll in a private plan.

Among Consumers who successfully enrolled in **Georgia** (n = 475), as in Maryland, only monthly financial situation was significantly associated with private QHP selection. Consumers who sometimes come up short financially and have to borrow from friends and family (AOR = .476, p = .010) were less likely than those who just break even each month to enroll in a private plan.

Among **Tennessee Consumers** who successfully enrolled (n = 397), race/ethnicity, age group, and monthly financial situation are all predicted selection of a private plan. Consumers who identified as Black/African American (AOR = 3.561, p = .000) were more likely to select a private plan than White consumers. Those aged 46 to 55 years (AOR = 11.333, p = .024) and aged 56 to 65 years (AOR = 12.617, p = .018) were also significantly more likely to select private plans than were Consumers aged 18 to 25 years. Consumers who said that they have money left over at the end of the month (AOR = 2.711, p = .002) were more likely than those who just break even to select or enroll in a private plan.

#### **How are social, demographic, geographic, and economic factors associated with successful enrollment in public coverage (Medicaid, CHIP, etc.)?**

In the model constructed using **the full four-state sample of Consumers who succeeded in enrolling** (n = 1,650), Marketplace type, race/ethnicity, age, sex, language preference, health literacy, and monthly financial situation were all significantly associated with application for or enrollment in public coverage. Consumers using state-based Marketplaces were significantly more likely to apply for or enroll in public coverage than those using the federal Marketplace (AOR = 3.845, p = .000). Asian (AOR = 1.96, p = .004) and Black/African American (AOR = 1.36, p = .03) Consumers (AOR = 2.050, p = .009) were more likely than White Consumers to apply for or enroll in public coverage. Age was also associated with successful enrollment in public coverage. Compared to Consumers aged 18 to 25 years, those aged 46 to 55 (AOR = .62, p = .04) and those aged 56 to 65 (AOR = .45, p = .002) had a lower likelihood of application for or enrollment in public coverage. Compared to Consumers who preferred to speak English, those who preferred to speak Spanish had a greater likelihood of application for or enrollment in public coverage (AOR = 2.17, p = .013). Women were more likely than men to enroll in public coverage (AOR = 1.44, p = .002). Consumers with greater health literacy were more likely to have enrolled in public coverage (AOR = 1.15, p = .01), compared to those with low health literacy. Compared to consumers who reported that they just break even every month, Consumers who reported that they come up short and sometimes have to borrow money from friends or relatives to make ends meet were more likely to have enrolled in public coverage (AOR = 2.19, p < .001). Conversely, consumers who reported that they have discretionary money left over were less likely to apply for or enroll in public coverage (AOR = .459, p = .001).

**Among New York Consumers who successfully enrolled** (n = 424), sex/gender and monthly financial situation were significantly associated with enrollment in public

coverage. Women were more likely than men to enroll in public coverage (AOR = 2.00,  $p = .01$ ). Compared to Consumers who reported that they just break even each month, Consumers who reported that they come up short and sometimes have to borrow money from friends or relatives to make ends meet (AOR = 9.113,  $p = .000$ ) were more likely to enroll in public coverage, but those who reported that they have discretionary money left over each month were less likely to enroll in public coverage (AOR = .310,  $p = .006$ ).

**Among Consumers who successfully enrolled in Maryland** ( $n = 316$ ), only one variable predicted enrollment in public plans. Compared with Consumers who reported that they just break even each month, Consumers who reported that they come up short and sometimes have to borrow money from friends or relatives to make ends meet (AOR = 4.19,  $p = .000$ ) are more likely to enroll in a public plan.

**Among Georgia respondents who succeeded in enrolling** ( $n = 512$ ), compared to Consumers who preferred to speak English, those who preferred Spanish had a greater likelihood of applying for public coverage (AOR = 2.93,  $p = .02$ ).

**Among Tennessee Consumers who succeeded in enrolling** ( $n = 405$ ), Consumers age 46 to 55 years (AOR = .32,  $p = .04$ ) and those age 56 to 65 years (AOR = .22,  $p = .01$ ) were less likely than Consumers age 18 to 25 years to apply for a public plan.

**Which social, demographic, geographic, and economic characteristics are associated with application for or qualification for Advance Premium Tax Credits/Cost Sharing Reductions (APTCs/CSRs)?**

**Among Consumers who enrolled in private insurance in the full four-state sample** ( $n = 1,234$ ), age, exchange type, language preference, health literacy, and monthly financial situation all predicted application or qualification for APTCs/CSRs. Consumers aged 35 to 45 years (AOR = 2.066,  $p = .024$ ) were significantly more likely to apply or qualify for APTCs/CSRs than Consumers aged 18 to 25 years. Consumers living in states with state-based exchanges (AOR = 2.11,  $p = .000$ ) were more likely than those living in states with federally facilitated exchanges to apply or qualify for APTCs/CSRs. Consumers who expressed a preference for speaking Spanish (AOR = 2.758,  $p = .045$ ) were slightly but significantly more likely to apply or qualify for subsidies than speakers of English. Higher health literacy rankings (AOR = 1.203,  $p = .005$ ) were also associated with likelihood of applying or qualifying for subsidies, compare with lower health literacy rankings. Consumers who reported that they have discretionary money left over each month (AOR = .566  $p = .001$ ) had a significantly lower likelihood of applying or qualifying for APTCs and CSRs compared to those who indicated that they just break even each month.

In a separate model in which state of residence was substituted for type of exchange, we observed that Consumers in Georgia who enrolled in private insurance had a

significantly lower likelihood of applying for APTCs/CSRs (AOR = .27,  $p < .001$ ) relative to Consumers in Maryland.

There were no statistically significant predictors of subsidies when the model was run for **New York** respondents only.

**Among Maryland Consumers** who enrolled in private insurance ( $n = 206$ ), respondents with greater health literacy had a lower likelihood of receipt of subsidies (AOR = .514,  $p = .022$ ).

**Among Georgia Consumers who enrolled in private insurance** ( $n = 517$ ), being Black/African American (AOR = .612,  $p = .033$ ) predicted lower odds of submitting an application for APTCs/CSRs compared with White counterparts. As compared to Consumers who preferred English, those who preferred Spanish (AOR = 3.735,  $p = .023$ ) had a greater likelihood of applying for APTCs/CSRs.

**Among Tennessee Consumers who enrolled in private insurance** ( $n = 405$ ), likelihood of applying for subsidies was predicted by age. In fact, Consumers aged 26 to 34 years (AOR = 4.1,  $p = .03$ ), aged 35 to 45 years (AOR = 6.69,  $p = .002$ ), aged 46 to 55 years (AOR = 5.895,  $p = .002$ ), and aged 56 to 65 years (AOR = 5.889,  $p = .002$ ) each had a significantly higher likelihood of applying for subsidies than 18 to 25 year olds. Consumers who reported that they have discretionary money left over each month (AOR = .384  $p = .006$ ) had lower likelihood of applying or qualifying for APTCs and CSRs compared to those who indicated that they just break even each month.

### **How are social, demographic, geographic, and economic factors associated with Health Literacy?**

Several variables predicted health literacy in the **full four-state sample** ( $n = 1,858$ ). Living in a federal Marketplace was associated with higher health literacy ( $\beta = .17$ ,  $p < .001$ ) compared with state-based Marketplace Consumers. Relative to White Consumers, Asian ethnicity was negatively associated with health literacy ( $\beta = -.23$ ,  $p < .001$ ). Age predicted health literacy. As compared to those aged 18 to 25 years, Consumers in each of the following age groups had significantly lower health literacy: 35 to 45 years ( $\beta = -.14$ ,  $p < .001$ ), 46 to 55 years ( $\beta = -.13$ ,  $p = .001$ ), and 56 to 65 years ( $\beta = -.13$ ,  $p = .001$ )—. Compared to those who preferred English, preference for Chinese ( $\beta = -.09$ ,  $p = .001$ ), and Spanish ( $\beta = -.08$ ,  $p = .001$ ) were associated with lower health literacy in the full sample. Compared to those who indicated that they just break even each month, respondents who have discretionary money left at the end of the month had significantly higher health literacy ( $\beta = .05$ ,  $p = .02$ ). However those who have to borrow money ( $\beta = -.14$ ,  $p < .001$ ) and who use their credit card or take on other debt ( $\beta = -.07$ ,  $p = .001$ ) had lower health literacy than those who indicated that they just break even each month.

**Among New York Consumers** (n = 503), Asian ethnicity predicted lower health literacy ( $\beta = -.35, p < .001$ ) compared to Consumers who identified as White. As in the full four-state sample, age predicted health literacy in an inverse relation. That is, as compared to Consumers 25 years of age and younger, individuals in the age categories of 35 to 45 ( $\beta = -.13, p = .014$ ), and 56 to 65 ( $\beta = -.15, p = .01$ ) had lower health literacy. Compared to those who preferred English, Consumer preference for Chinese language ( $\beta = -.14, p = .01$ ) and for Spanish ( $\beta = -.11, p = .01$ ) were associated with lower health literacy.

**Among Maryland Consumers** (n = 363), only the monthly financial situation variables predicted health literacy. Those who have to borrow money ( $\beta = -.20, p < .001$ ) and who use their credit card or take on other debt ( $\beta = -.15, p = .01$ ) had lower health literacy, relative to those who indicated that they just break even each month. Conversely, consumers who had discretionary money left over each month had higher health literacy ( $\beta = .12, p = .03$ ).

**Among Georgia Consumers** (n = 587), Asian s ( $\beta = -.24, p < .001$ ) and Hispanic ( $\beta = -.10, p = .01$ ) identities were associated with lower health literacy, relative to White Consumers. Male identity predicted lower health literacy ( $\beta = -.09, p = .01$ ) relative to women. Having to borrow money to makes ends meet ( $\beta = -.22, p < .001$ ) predicted lower health literacy relative to those who indicated that they just break even each month.

**Among Tennessee respondents** (n = 412), as compared to White Consumers, Asian ethnicity predicted lower health literacy ( $\beta = -.20, p = .001$ ). Compared to preference for English, Consumer preference for Spanish ( $\beta = -.16, p = .003$ ) was associated with lower health literacy. Having to borrow money to make ends meet ( $\beta = -.22, p < .001$ ) was associated with lower health literacy, relative to those who indicated that they just break even each month.

#### **How are social, demographic, geographic, and economic factors associated with frequency of health care visits in the past year?**

**In the full four-state sample** (n = 1,627), being male was associated with fewer reported health care visits in the previous 12 months ( $\beta = -.06, p = .02$ ). Asian ethnicity ( $\beta = -.08, p < .03$ ) and Black/African American identity ( $\beta = -.11, p < .001$ ) predicted fewer health care visits in the previous year compared to White Consumers. Age predicted frequency of medical visits. As compared to individuals aged 18 to 25 years, being 46 to 55 ( $\beta = .13, p = .01$ ) and being 56 to 65 ( $\beta = .15, < .001$ ) predicted greater frequency of health care visits in the past year. Living in states with the federal Marketplace predicted fewer health care visits in the past year ( $\beta = -.16, p < .001$ ) when compared to Consumers living in states with state-based Marketplaces. Health literacy predicted health visits in the past year. Higher health literacy was associated with fewer health care visits in the previous year ( $\beta = -.06, p < .03$ ). Compared to those who preferred to speak English, a preference for speaking Chinese was associated with a fewer number of health care

visits ( $\beta = -.10$ ,  $p = .001$ ). Having to borrow money each month ( $\beta = .14$ ,  $p < .001$ ) and using one's credit card or taking on other debt ( $\beta = .08$ ,  $p = .001$ ) were associated with a greater number of health visits in the past year relative to those who indicated that they just break even each month.

With reference to **New York Consumers** only ( $n = 450$ ), a preference for speaking Chinese ( $\beta = -.17$ ,  $p = .01$ ) was associated with a fewer number of health care visits compared to Consumers who preferred to speak English. Having to borrow money from friends or relatives ( $\beta = .20$ ,  $p = .001$ ) and using their credit card or taking on other debt each month ( $\beta = .11$ ,  $p = .02$ ) both predicted a greater number of health care visits in the past year compared to those who indicated that they just break even each month.

With reference to **Consumers in Maryland** ( $n = 354$ ), only one indicator was significantly associated with the frequency of health care visits. Using one's credit card or taking on other debt each month ( $\beta = .12$ ,  $p = .04$ ) predicted a greater frequency of health care visits in the past year relative to those who indicated that they just break even each month.

**Among Georgia Consumers** ( $n = 490$ ), being male was associated with fewer health care visits ( $\beta = -.17$ ,  $p < .001$ ) relative to females, and Hispanic ethnicity ( $\beta = -.09$ ,  $p < .05$ ) predicted fewer health visits in the past year than White Consumers. Age predicted frequency of medical visits in a directly proportional manner. More specifically, as compared to 18 to 25 year old Consumers, being 35 to 45 years ( $\beta = .19$ ,  $p = .04$ ), being 46 to 55 years ( $\beta = .28$ ,  $p = .01$ ), and being 56 to 65 years ( $\beta = .36$ ,  $p < .001$ ) each predicted a greater number of health care visits. Consumers who had higher health literacy had fewer number of health visits in the past year ( $\beta = -.16$ ,  $p = .002$ ), and those who had to borrow money ( $\beta = .12$ ,  $p = .02$ ) had more health care visits relative to those who indicated that they just break even every month.

**Among respondents in Tennessee** ( $n = 337$ ), being Black/African American ( $\beta = -.33$ ,  $p < .001$ ) and Asian ( $\beta = -.16$ ,  $p = .01$ ) was associated with a fewer number of health visits in the past year compared to White Consumers. Age predicted frequency of medical visits. As compared to Consumers age 18-25 years, being 35 to 45 ( $\beta = .27$ ,  $p = .01$ ), 46 to 55 ( $\beta = .37$ ,  $p = .01$ ), and 56 to 65 ( $\beta = .37$ ,  $p = .01$ ), each was associated with a greater frequency of health care visits in the past year. Consumers health literacy predicted fewer number of health visits in the past year ( $\beta = -.12$ ,  $p = .04$ ). Using one's credit card or taking on other debt ( $\beta = .13$ ,  $p = .02$ ) were both associated with greater frequency of health care visits as compared to those who indicated that they just break even each month.

**How are Consumer and state characteristics associated with deferring healthcare due to cost (i.e., number of times health care visits were deferred because of cost)?**

**In the full four-state sample** ( $n = 1,584$ ), being male was associated with fewer delays of health care visits due to cost ( $\beta = -.05$ ,  $p = .03$ ). Black/African identity ( $\beta = -.12$ ,  $p < .001$ ) predicted fewer delays of health care visits due to cost, relative to White Consumers. Relative to living in a state-run Marketplace, living in a federal Marketplace state predicted fewer delays of health care visits due to cost ( $\beta = -.14$ ,  $p < .001$ ). Compared to those who preferred English, preferring Chinese predicted fewer delays of health care visits due to cost ( $\beta = -.10$ ,  $p = .001$ ). Relative to those who indicated that they just break even every month, having disposable money left over predicted fewer delays of health care visits due to cost ( $\beta = -.13$ ,  $p = .002$ ). However having to borrow money ( $\beta = .28$ ,  $p < .001$ ) and using one's credit card or taking on other debt ( $\beta = .08$ ,  $p = .01$ ) predicted greater frequency of delays of health care visits due to cost relative to those who indicated that they just break even every month.

**Among New York respondents** ( $n = 450$ ), Hispanic identity was associated with more frequent delays of health care visits due to cost, relative to White Consumers ( $\beta = .14$ ,  $p = .03$ ). As compared to those who prefer English, Consumers who preferring Chinese predicted fewer delays of health care visits due to cost ( $\beta = -.14$ ,  $p = .023$ ). Having to borrow money ( $\beta = .32$ ,  $p < .001$ ) and using one's credit card or taking on other debt ( $\beta = .09$ ,  $p = .04$ ) more common deferrals of health care visits due to cost-- relative to those who indicated that they just break even after paying expenses and buying what is needed.

With reference to **Maryland respondents** ( $n = 338$ ), only financial indicators were associated with number of times health care visits were deferred due to cost. Having to borrow money ( $\beta = .38$ ,  $p < .001$ ) and using one's credit card or taking on other debt ( $\beta = .14$ ,  $p = .01$ ) predicted more delays of health care visits due to cost relative to Consumers who indicated that they just break even every month. Conversely, having disposable money left over predicted fewer delays of health care visits due to cost, relative to those who indicated that they just break even every month ( $\beta = -.15$ ,  $p = .01$ ).

**Among Georgia Consumers** ( $n = 468$ ), being male was associated with fewer delays of health care visits due to cost ( $\beta = -.16$ ,  $p < .001$ ). Enrollees with higher health literacy reported significantly less delays of health care visits due to cost ( $\beta = -.20$ ,  $p < .001$ ). Those who have to borrow money ( $\beta = .18$ ,  $p < .001$ ) reported greater frequency of delays of health care visits due to cost as compared to those who indicated that they just break even after paying expenses and buying what is needed.

**Among Tennessee respondents** ( $n = 331$ ), identifying as Black/African American ( $\beta = -.33$ ,  $p < .001$ ) and Asian ( $\beta = -.14$ ,  $p = .02$ ) was associated with lower frequency of delays of health care visits due to cost than being White. As compared to Consumers aged 18 to 25 years, those who were aged 26 to 34 years ( $\beta = .20$ ,  $p = .02$ ), aged 35 to 45 years ( $\beta$

= .27,  $p = .01$ ) and those aged 46 to 55 years ( $\beta = .25$ ,  $p = .03$ ) had a greater number of delays of health care visits due to cost. Those who have to borrow money ( $\beta = .18$ ,  $p = .001$ ) reported a greater number of delays of health care visits due to cost compared to those who indicated that they just break even after paying expenses and buying what is needed. Conversely, those who have money left over that can be spent or saved reported fewer delays of health care visits due to cost compared to those who indicated that they just break even after paying expenses and buying what is needed ( $\beta = -.29$ ,  $p < .001$ ).



### **3.2—ANALYSIS OF CONSUMER INTERVIEWS**

#### ***Qualitative analysis of Consumer interview data***

The UGA project team interviewed 40 Consumers in total, 10 from each of the four states included in the project. The UGA project team only contacted Consumers who, during a session with a Navigator, gave consent to be contacted for research purposes. Contact information for these Consumers was compiled in spreadsheets weekly, and potential interviewees were selected from these weekly enrollee contact spreadsheets. Enrollee contact spreadsheets were sorted by state in Microsoft Excel. Then, a random number generator was used to select a Consumer to contact for each interview. Next, the selected Consumer was then contacted by the interviewer and, if they gave consent, they were interviewed using a standard interview guide which included several questions and prompts that were used by the interviewer to generate discussion and commentary on topics related to health insurance navigation. This process was repeated until the quota of 10 interviews per state was reached. Demographic characteristics and socio-economic characteristics of Consumers who were interviewed are presented in tables 3.103 and 3.104. The health status, enrollment status, and navigation experience profile of Consumers who were interviewed is presented in table 3.105.

#### **Reasons for seeking out Navigator assistance**

Analyses of interviews with Consumers reveal that Consumers sought Navigator assistance for a number of reasons, summarized in Table 3.106. These include the following: (1) frustration with technical problems when attempting to self-submit materials to state or federal Marketplaces; (2) desiring insurance; (3) being inspired by Navigator outreach, word of mouth, or media coverage of navigation; (4) desire to find better insurance coverage; (5) perceived need for coverage due to health problems; (5) problems with or cancellation of prior coverage, and (6) desire to avoid paying a penalty for being uninsured.

Problems using state or federal Marketplace web sites were very common among Consumers (nearly half of the Consumers encountered technical difficulties during internet sessions), even when technical problems were not Consumers' primary reason for seeking out a Navigator (see Table 3.107). Problems that were encountered when attempting to self-apply and self-enroll included inoperable web sites (site would freeze; site would not load; application information was deleted; Consumer was unable to log on to site), problems with verifying identity or household income, and problems understanding the information and instructions on the web sites.

Among Consumers who came to Navigators after beginning the process of submitting a Marketplace application on their own and experiencing difficulties, most had never heard of the Navigator role or were not aware that Navigators serve a unique purpose

compared to other types of assisters. Informal mechanisms such as word of mouth and referral by another assister or a social services agency were the most frequent way that Consumers who began the process on their own learned of Navigators. Conversely, Consumers who saw Navigators early in the process either had prior knowledge of them through outreach materials or media or learned of them at a special event at a church, community center, health center, or library. One uninsured woman appreciated the fact that she was put in touch with a Navigator by hospital staff when she was hospitalized.

### **Consumer experiences with and assessment of the quality of Navigation**

In analyzing interviews with Consumers, several elements were considered in evaluating each Consumer's overall experience of Navigation. These included:

1. The Consumer's self-professed satisfaction with their Navigator encounter(s)
2. The Consumers' use of praiseful adjectives (ex: excellent, wonderful, helpful, thorough, incredible, etc.) to describe the quality of the Navigator or the Navigation experience
3. Whether the Consumer discussed negative aspects of Navigation
4. Whether the Consumer experienced a subjectively undesirable outcome (related to subsidies, Medicaid, or other aspect of applying or enrolling), which may have been outside of the Navigator's control
5. Whether the Consumer perceived any insufficiencies in the quality of information or support offered by the Navigator
6. Whether the Consumer felt that the Navigator provided sufficient follow-up during the process
7. Whether the Consumer could reach the Navigator for follow-up questions or status inquiries
8. Whether the Consumer expressed explicit dissatisfaction with their Navigator interaction (and gave specific examples and explanations)

Based on analyses of interviews, we found that Consumer experiences with Navigators were quite varied depending on the Consumer's particular circumstances and their expectations prior to navigation, yet we also found that overall experiences of Consumers could be characterized in four general ways. These descriptive categories include: (1) the Consumer was enthusiastically happy with Navigator encounter(s), used praiseful adjectives to describe encounter(s) or specific Navigator, and discussed no negative aspects of their Navigator experience; (2) the Consumer was happy with the Navigator encounter(s), but experienced an undesirable outcome (related to subsidies, Medicaid, or other aspect of applying or enrolling) which was outside of the Navigator's control; (3) the Consumer thought that the Navigator was somewhat helpful, but did not provide enough information about how the Marketplace works, how health insurance works, or did not follow up promptly, and (4) the Consumer felt that the Navigator was not helpful at all, did not sufficiently explain how the Marketplace works, how health insurance works, or did not follow up with needed information or application status. A

summary of Consumers' overall Navigation experience, by state, is presented in table 3.108.

There is cross-site variation in Consumer experience by state, with the experience of Consumers from Georgia particularly deviating from the experience of Consumers from other states. This may be the result of different policy environments, different levels of Consumer choice, the existence in Georgia of a significant Medicaid-Subsidy gap, different levels of information delivered to consumers via media and outreach prior to Navigation, and/or different levels of politicization of health insurance reform-related issues within each state.

The majority of Consumers interviewed expressed that they greatly appreciated their experience with a health insurance Navigator, and praised their Navigators' professionalism and effort to clarify the complex process. Furthermore, Navigators were able to help Consumers in many different ways and were able to accommodate a variety of different problems and circumstances among Consumers, particularly after Consumers had experienced frustrating and persistent technical problems when trying to submit Marketplace applications on their own.

One Georgia Consumer discussed needing health insurance badly because he suffers from hypertension and takes expensive medication. Despite this serious chronic health condition, he had previously resolved not to submit an application on the federal Marketplace after repeatedly experiencing technical problems with the website, and because he believed that health insurance would be too expensive, even if he qualified for a tax credit. On a whim, the Consumer decided to attend a workshop hosted by a Navigator at a local community center, and afterward was able to meet with the Navigator one-on-one. The Consumer found the Navigator to be extremely helpful, and said that she "made me feel so much more comfortable with the process." She helped him submit his application on the federal Marketplace, and ultimately helped him discover mechanisms to easily afford a health plan after all.

Navigators are not limited to assisting Consumers who wish to apply for subsidies and enroll in health insurance plans through state and federal Marketplaces. For example, a Maryland Consumer who is a woman of advanced age living on a fixed income had recently received correspondence that her health coverage had been cancelled. A social worker put her in touch with a health insurance Navigator who was able to quickly pinpoint the cause of the cancellation, communicate between two government agencies, resolve the problem (a missing piece of paperwork), and have her health coverage reinstated. As a result of her experience, the Consumer described her encounter with the Navigator as "excellent and efficient" and the Navigator program overall as "extremely helpful." As the Affordable Care Act continues to be implemented, this scenario underscores the importance of careful coordination between Navigators and health/social service departments.

Several Consumers praised their experience with Navigators even when outcomes of Navigation were disappointing or significantly different than they had expected. For example, one young Consumer in New York was a full-time student who is in the US on a student visa and needed affordable basic health insurance “in case there is an accident or emergency.” However, as an international student, she is limited in the amount of work she can perform and therefore limited in the amount of income she can legally make. The Consumer’s university health center put her in touch with a Navigator. She was very pleased with the interaction, and explained that the Navigator was very nice, very knowledgeable, and tried to be helpful. Unfortunately, the Navigator was not able to access information on available insurance options for low-income international students.

A Consumer from Tennessee was similarly very pleased with their Navigation experience even though the outcome of the process was not all she had hoped. This particular Consumer had experienced technical problems when she tried to submit a Marketplace application on her own. According to the Consumer, the Navigator was extremely patient and persistent, and tried three times to reset the Consumer’s account. The Navigator was eventually able to re-establish the Consumer’s account and submit an application. The Navigator was professional and effective, and provided all of the information that the Consumer needed, regardless of the fact that she is not satisfied with some of her options: her preferred doctors are excluded from her coverage options, and she was upset that she could not keep her grown sons on her policy even though they still live in her home. While this Consumer does not think that she will need any more help from a Navigator, she would contact them “in a heartbeat” if she had any lingering questions or problems. She also vowed to recommend Navigators to friends who need information or support in finding insurance.

### **Communication between Navigator and Consumer from Consumers’ perspectives**

Communication between the Navigator and Consumer seems to be the key to Consumer satisfaction with the navigation process, regardless of outcome. From Consumers’ point of view, good communication involves both the delivery of pertinent information, as well as a supportive and understanding attitude. Several Consumers who had previously heard anti-ACA messages also felt relieved by the fact that the Navigator seemed unbiased and interested in the Consumers’ wellbeing and did not, in the words of one Georgia woman, “come off like they were trying to give me propaganda to sell me something.” Important aspects of communication during navigation encounters that were stated by consumers included:

1. Willingness and patience to listen to the Consumer about their experiences and needs
2. The Navigator should ask questions about the Consumer’s individual circumstances
3. A clear explanation of how the Marketplace works

4. A clear explanation of how health insurance works
5. An explanation of industry-specific terms
6. An explanation of the expected timeline for application and enrollment
7. Explaining how the information that the Consumer gives the Navigator is being input into the Marketplace website (showing the screen and explaining)
8. Frequent follow-up with Consumers regarding the status of their applications; promptly return calls from Consumers
9. Ability to articulate the key differences among policy options

### **Program improvement and Navigator training from Consumers' perspectives**

Most Consumers had suggestions for improving the process of health insurance enrollment. Predictably, most of these suggestions either pertain to improving the functionality of state and federal Marketplace web sites, or to suggesting policy solutions to rectify the Medicaid/subsidy gap (particularly in Georgia) to make health insurance reform more equitable for people with very low income or no income. These suggestions, while important, will not be summarized in this preliminary report.

Many Consumers also had important suggestions for specifically improving the Navigator program. A common critique of the Navigator program is that, as mentioned previously, several Consumers who were interviewed had no knowledge of Navigators or did not understand their role until relatively late in the process, often after experiencing many frustrations with the exchanges or other assisters. This experience suggests that increased public relations training may be a useful element in Navigator orientation/training. Such training is especially applicable to the Navigator partners (subcontractors and advocacy groups), Navigator agencies (e.g., Seedco), and state/federal entities.

One Maryland Consumer explained that more outreach and publicity for the Navigator program is needed in order to demonstrate to people who Navigators are (including their roles and responsibilities) and how smooth and simple the process can be with a Navigator's assistance. This Consumer, based on previous experience with a broker, was concerned that brokers and other assisters who are not specifically trained to submit applications will enter incorrect information for people and cause them to get in trouble legally or financially. The Consumer also explained that the plan choice is confusing or overwhelming to many people. Because of this, the Consumer felt that there should be resources available for Consumers to prepare ahead of time so that they can be better informed about how to evaluate and choose among the policies.

Another Maryland Consumer explained that more publicity is needed to promote the Navigator program, because it is a valuable resource that he thinks people are not informed of. In addition, this same respondent stated that people need more information on "who's who" as well: "Navigators, Facilitators, Assisters, Brokers, and so on... It's difficult to keep track, and I think that the titles obscure the roles."

A New York Consumer explained that he had no knowledge of Navigators prior to meeting one of the Seedco Navigators. He further explained that Navigators and agencies really need to get the word out because it is such a good service. “Navigators are empowering to people who need guidance,” he stated, and then explained that more marketing is needed because people, especially those who are less comfortable with computers, need their assistance.

Similarly, a retired Consumer in Tennessee stated that her acquaintances have asked her advice on health insurance enrollment and she recommended Navigators. She thinks something should be done to better educate people on where the Navigators can be located and what they can do to help individuals. She believes that there needs to be more outreach, but not all through the Internet because not everyone is computer/internet literate.

Other suggestions for improvement came from Consumers who were not as enthusiastic about their navigation experience. One New York Consumer who had not experienced satisfactory follow-up with a Navigator suggested that Navigators be trained to have “more professional behavior, like to return calls promptly and be willing to find out pertinent information for Consumers.”

A different Tennessee Consumer explained that this might be accomplished by making sure that Navigators have training on “grassroots communication efforts.” These Consumer experiences suggest that as the ACA is further implemented, more resources should be devoted for concerted follow-up and efficient communication methods for Navigators.

### ***Qualitative analysis of Navigator interview data***

The UGA project team completed 20 interviews with Navigators who were active in Georgia, Maryland, New York, and Tennessee during the 2013-2014 open enrollment period, with the goal of interviewing five Navigators from each state. Contact information for Navigators was transferred from Seedco administrators to the UGA project team via secure data transfer, and was compiled in an Excel spreadsheet. Potential interviewees were selected from these contact spreadsheets. As with Consumer contact information, Navigator contact spreadsheets were sorted by state in Microsoft Excel, and a random number generator was used to select a Navigator to contact for each interview. The selected Navigator was then contacted by the interviewer and, if they gave consent, they were interviewed using a standard interview guide which included several questions and prompts that were used by the researcher to generate discussion and commentary on topics related to health insurance navigation. This process was repeated until the quota of five interviews per state was reached. Demographic and socio-economic characteristics, and select job-related characteristics of Navigators who completed interviews (n=20) are summarized in tables 3.109 and 3.110. Emerging themes are grouped by topic (Navigator experiences, quality of interaction, training, etc.) and described in bulleted points.

#### **Navigator experiences: what Navigators do, reasons for becoming a Navigator, and populations served by Navigators**

**What is a Navigator's role from Navigators' perspectives?** Based on information shared by Navigators participating in telephone interviews, we learned that the role of Navigator is both challenging and dynamic. Navigators represent a tangible human connection between Consumers and the complex US health care and financing system. The Navigators also serve as important conduits between Consumers and, the federal or state Marketplaces, which are widely considered by Consumers to be overwhelming and inoperative.

Working as a Navigator involves accommodating Consumers' needs and schedules, as well as balancing many types of tasks that contribute to the ultimate goals of assisting Consumers in submitting Marketplace applications and enrolling in QHPs. These tasks include training; coalition building; developing and performing outreach activities at diverse locations in their areas (leading classes, hosting workshops, making presentations, public speaking, setting up information tables); teaching people about health care, health care financing, and the particularities of health insurance plans; developing informational materials for Consumers; having one-on-one meetings with Consumers to help complete applications and choose health plans; making sure to conduct follow-up communication with Consumers; and troubleshooting problems with online systems and errors in Marketplace applications and CMS call center misinformation.

A Navigator's work also includes outreach and recruitment of Consumers. Navigators described various methods of recruiting Consumers including: flyers, news and media broadcasts, community events, site visits, the Internet, and word of mouth. In some cases, Navigators used their unique skill sets to raise awareness about the Navigator program. For example, one Tennessee Navigator said, "I love going out into the community and I love going to colleges and speaking to nurses. The biggest crowd I ever spoke to was a crowd of 300 nursing students. I was really nervous...but it doesn't scare me any more to talk". Another New York Navigator used a word of mouth approach. She stated, "I give out my business cards to everybody I see that may need health insurance, in the street as I'm walking home or walking to work or if I took a cab I'd ask 'Do you have health insurance? Are you interested? Here's my card'".

Working as a Navigator is stressful, but also rewarding according to many who do it. One Tennessee Navigator expressed enthusiasm for her work, "I love it! Helping people. By the time they get to me, [people] are so upset, confused, and discouraged. But, by the time we finish talking it makes sense to them...being able to help people understand the entire process better."

Many Navigators feel that because they work "on the front lines" of health insurance reform during the first open enrollment period, they have gained valuable insights from their experience. From analytic and evaluative standpoints, Navigators' insights can be dialogued with those of Consumers in order to inform best practice guidelines, informational resources, and training protocols.

**Why become a Navigator?** An understanding of motivations for becoming a Navigator can provide informative details for recruitment and retention. Personal motivation may be associated with better performance in the role of Navigator, so understanding why people choose to become Navigators is relevant to future recruitment efforts. When asked why someone would become a health insurance Navigator, Navigators discuss many factors, both practical and ideological, at play in their decision. All but one Navigator listed more than one reason for the personal choice to become a Navigator.

Reasons discussed include:

- Has background as a grassroots/community organizer, activist or advocate; thought experience was appropriate (n=7)
- A desire to make a difference or change society for the better (n=6)
- Motivation to help people and save lives (n=5)
- Needing employment (n=4)
- Preference for working directly with people in need of help (n=4)
- Feeling that it is relevant to their studies or to gaining valuable experience for future careers (n=3)



- Feeling that serving people in need is in line with ethical and religious values that are important to them (n=3)
- Has a background working in the insurance industry; thought their experience was appropriate (n=3)
- A sense of solidarity with underserved and underprivileged people due to shared experiences in Navigator's own past (n=2)
- A strong desire to be a part of history/participate in "an historical moment" (n=2)
- Supervisor requested their training (n=1)

**What populations do Navigators serve?** All Navigators interviewed explained that they offer assistance to anyone in their designated geographical area who needs help with the Marketplace or health insurance enrollment. In addition to serving the general population, several Navigators also work with social groups that may be in particular need of assistance due to social exclusions, rates of underinsurance, or a lack of access to information and resources related to health insurance reform. These groups include refugee populations, people recently released from incarceration, people who speak languages other than English, people who identify as LGBTQ, and college students.

**Navigator-reported facilitators and barriers to navigation.** We define facilitators to navigation as the key factors, characteristics, or resources that Navigators feel are exceptionally conducive to successful enrollment of Consumers in public or private health insurance plans. Barriers are defined as the key factors and circumstances that prevent Navigators from being effective in their roles. Key facilitating factors and circumstances described by individual Navigators include:

- Cultural sensitivity training in previous work
- Communication fora, regular meetings, or frequent casual interaction among Navigators during open enrollment (brainstorm problems, "compare notes," discuss shared concerns and strategies for outreach and engagement)
- Consumers who come to navigation without fixed, politically-influenced, preconceptions and expectations; Consumers who are well-informed about health insurance reform
- A fixed location and regular schedule for meeting with Consumers
- Adequate technology and equipment (e.g., mobile hotspot and laptop)
- Patience, empathy, and listening skills
- Ability to solve problems that arise unexpectedly
- The establishment of a screening tool used for first contact with consumers in order to determine eligibility and direct them on necessary documents needed for eligibility

Barriers to effective Navigation include a number of factors, and some of these factors are interrelated. Barriers to effective navigation that were described by Navigators included:

- Technical factors related to the Marketplaces or a lack of access to other useful and functional technology
- Individual cultural, linguistic, or political factors
- Systemic/bureaucratic complexities and dysfunctions
- Wait times for processing applications, for speaking to call center representatives, and the time it takes to meet with Consumers due to a number of systemic inefficiencies
- Local political animosity towards health insurance reforms
- Poor health insurance literacy and computer literacy among Consumers
- Insufficiencies in marketing around health insurance and exchanges resulting in Consumers having low accessibility of information about reforms, plans, and health care prior to navigation

One of the barriers that Navigators frequently discussed included language barriers that they experienced with immigrant populations, and periodic shortages of translators to facilitate communication with these persons during navigation. For example, in Tennessee and New York there were Consumers who did not speak fluent English so it was hard to communicate with them and to explain insurance terms in particular. According to Navigators, Spanish and Arabic were two of the languages that were in most need of translated materials. In some cases, Navigators were bilingual which greatly facilitated the application process and reduced the need for translators, because in such cases Navigators were able to translate or explain some unclear questions and items.

Another barrier that was often cited by Navigators is low health insurance literacy of Consumers. Many of the Consumers had never been insured and therefore did not understand some of the general terminology such as “co-pays,” “deductibles,” or “coinsurance”. One Tennessee Navigator described the need to explain why it is important to have insurance, not just for emergencies but also for health and wellness. Navigators reported spending significant time on educating the Consumers on the basics of health insurance. In New York, one Navigator explained that many of the Consumers were overwhelmed by how much there is to know about health insurance. She said, “That’s why it is so important for us as Navigators to go through this with them and explain it in basic terms”.

The political environment in different areas also erected barriers to Navigator outreach and assistance of Consumers. Navigators in Georgia, Maryland, and Tennessee all discussed the contentious politics around the ACA as creating tensions in some navigation encounters and erecting barriers to Consumers receiving accurate

information about health insurance reform, their rights, their obligations, and about who would qualify for subsidies and Medicaid. Some of these Navigators experienced resistance from staff when attempting to post information on public bulletin boards. For example, one Navigator working in south Georgia described how repeated attempts to post information on the community bulletin board and leave pamphlets for potential Consumers in the local public library were actively discouraged by a librarian. Rather than allowing the Navigator to leave the materials in visible public areas where it was customary to post information of community interest, the librarian insisted that pamphlets and other information about navigation be kept “behind the counter.” Other Navigators discussed problems resulting from Consumers coming into navigation with erroneous information about health insurance reform, which led them to have unrealistic expectations about Navigators or outcomes.

Navigators also experienced frustration with the process of identity verification. Navigators cited frustrations with this process on two levels. The first level included the need for Consumers to have the proper documentation. A second level of frustration reported related to the dilatory process of uploading the documents and waiting for them to be managed in the system. For example, Consumers would not have their birth certificate or green card at the first meeting, so they would have to reschedule to complete their Marketplace application. Then once the Consumers did have the proper documentation, all of the information was required to be uploaded simultaneously into the system, which presented additional problems. This problem was articulated by a Tennessee Navigator who explained that, “We were told by CMS to upload the documents to the application by using the upload button. Then I was speaking with a Marketplace representative six weeks after they told me to use the upload button and they said do not use the upload button, but send it in because nobody checks the uploads on the applications. You need to mail it in.” This experience was further wearisome for the Consumer because then when Consumers did mail in their documentation, there was no confirmation of receipt for them. In fact, there was no tracking of where their application was in the system. Similarly, a New York Navigator said that the identity verification process took months for some Consumers whose records were “lost” in the system or could not otherwise be tracked.

#### **Communication between Navigator and Consumer from Navigators’ perspectives.**

Navigators in all four states stated that cultural, linguistic, and class-based differences sometimes erected barriers to effective communication and enrollment in the navigation encounter. While some Navigators have developed unique communication strategies, most agree that some key principles of communication are crucial to effective navigation. These principles and practices include professionalism; patience with the system and with Consumers who often have complicated problems; the ability to listen first, then ask *the right* questions once you have a grasp of the individual’s situation; being overtly attentive to the Consumer’s needs for information, coverage, and follow-up; having the ability to empathize and assure the Consumer that you are there to help, and having the ability to clearly explain the “inner working” and the “inner

logic” of the health care and health insurance system to Consumers. One Navigator described her role as a “hub” of information that she translated and passed on to the Consumers.

“Navigators must be professional, take control, be patient, and calm because it helps clients to be calm... You must also be able to ‘dig deep’ verbally with questions about clients' particular situations,” one Georgia Navigator stated in the context of discussing her communication strategy in great detail. She went on to describe steps that she uses in the navigation process in terms of communication:

*LISTEN → CALM AND REASSURE → QUESTION → INFORM → CHECK FOR  
UNDERSTANDING → ASSIST WITH INFORMED DECISION-MAKING*

One New York Navigator explained the importance of calming and reassuring Consumers about the process. She described the process of applying as “very psychological; it’s very scary for some people...it’s a completely new world for them.”

Another Navigator from Maryland brings his experience as a former long-time insurance broker into his navigation strategy. He treats the navigation encounter as an opportunity to educate people and shine light on a very complex set of policies and industry practices, what he calls “Health Policy 101” and “Health Insurance 101.” One Tennessee Navigator explained the importance of being as “transparent” as possible. They would first sit down with the Consumer and explain the Navigator role and the consumer rights. A New York Navigator stressed the importance of giving “concrete example” to the Consumers, explaining how much they would be expected to pay if they got sick and had to go to the doctor. This was helpful for Consumers to know the true costs of choosing certain plans.

Effective navigation is clearly linked to effective communication with Consumers. In addition to communication during the encounter with Consumers, Navigators interviewed feel that there should be broader public relations strategies in place to deliver information about health reform and specifically about navigation and Navigators. In addition to delivering accurate information about health insurance reforms and requirements, publicity campaigns should articulate specific messages about what the Navigator program is and who Navigators are. Such messages may include:

- A Navigator is someone to turn to when you have problems in the application or enrollment process
- A Navigator understands that you may be frustrated and wants to know about your needs
- A Navigator’s job is to inform you and assist you through a complex process
- A Navigator has specialized knowledge about new rules, the Marketplace, and health insurance options

- A Navigator is someone that you can trust with your personal information
- A Navigator's responsibility is to the Consumer
- A Navigator knows about resources that can help you be informed and healthy
- A Navigator is someone who can talk with you face to face

**Navigator training and training needs from Navigators' perspectives—** Across the four states, there is variability in the methods and processes of training for the Navigators. According to Navigators participating in interviews, Navigator training prior to certification involved two basic components: in-person training lasting from between two days (Georgia) to one week (Maryland), and Centers for Medicare & Medicaid Services (CMS) online Navigator training modules (implemented only in Georgia and Tennessee).

The CMS online training modules were 30 hours of training and were described by several Navigators in Georgia and Tennessee as “intense”. While the content of the online CMS training was the same between Georgia and Tennessee, the Navigators' perceptions of the utility and usability of the training were somewhat different. One Tennessee Navigator said, “It took a lot of discipline because we didn't have a sit down class or anyone to walk us through it or explain it to us.” Another Tennessee Navigator described the initial CMS training as “lacking as far as how the web site was going to work. There were no screen shots of what the pages would look like...the training was focused on the ACA policy and not on how to actually process the applications on Healthcare.gov.”

While the content of the online CMS course was the same for all Navigators in states using the federal Marketplace, the characteristics and depth of in-person group training varied from Navigator to Navigator. One Navigator from Georgia described their in-person training as involving, “...hands-on practice, basically ‘Health Insurance 101.’ Understanding how to be a Navigator, understanding the health law, using Salesforce, learning as a group.”

Georgia Navigators also had to pass a licensing examination similar to the one required of all insurance sales professionals. Seedco provided a vendor to handle in-person training for that exam. A Georgia Navigator described this training as very basic, “[T]raining was two days of in-person training and studying for the state licensure test.” Yet another Georgia Navigator described their training experience as, “...a twenty-hour pre-licensing course with a great instructor who had a history working in consulting for the insurance industry.” One New York Navigator praised the three-day training, provided in that case by a state-mandated vendor, as involving, “active learning” with a manual that included a lot of thorough exercises and information which she printed and used often when meeting with Consumers.

One Maryland Navigator, in contrast, described her training as brief and basic, involving basic instructions for assisting Consumers, selecting a health insurance plan, offering

good customer services, and learning about how to handle frustrated or upset Consumers. Another Maryland Navigator said that she was “hired in a rush” and the state was not quite ready for organized Navigator training. Her experience involved sitting in a room with other recruits, and their first task was to choose their own health insurance policy. She said that this initial task was helpful because it built up a sense of teamwork. In her cohort, training for Navigators was done separately from other assisters, which was justified on the claim that Navigators should be more focused on enrolling people in private health plans, while phone assisters were supposed to be Medicaid specialists. The third Navigator from Maryland included in the sample, like the Georgia Navigator described previously, described his training as “...a one-week class that was basically ‘Health Insurance 101’”, and that aside from the online CMS training component, “...everything else we had to learn on the fly.”

Navigators also carried out training and continuing education activities during the open enrollment period, subsequent to their initial training. One Georgia Navigator described useful subsequent training that included webinars, conferences, and meetings as open enrollment “unfolded” This same Navigator also discussed the importance of “a lot of self-training on the ground.”

Comparing the variations in training experiences within different states and between states is useful because it can give insight into what the most effective training strategies experienced by the Navigators. The identification of effective strategies can be spread and disseminated in future training sessions and modules for Navigators. Asking Navigators specifically about how their training translated into functionality when they were on-the-ground working as Navigators is helpful because one can then identify specific needs and apply this knowledge to designing training protocols for future Navigator cohorts. While few Navigators feel that their training was completely adequate for the tasks and challenges that they encountered during the first open enrollment period, many point out that because this is the “roll-out” and the “first time around the block” it should be considered a valuable learning experience.

Navigators suggest four changes that could greatly improve the effectiveness of Navigator training for future cohorts. It is beyond the scope of this evaluation to determine which of the following suggested changes should be performed by Seedco versus CMS, or other entities. As independent evaluators, we are putting forward suggestions that have emerged from a comprehensive analysis of the data. These are listed (in no particular order) and then discussed below.

1. In-person Navigator training could benefit from more structure and standardization
2. Establish mentoring relationships between “veteran” Navigators and newly recruited trainees
3. Open more opportunities for Navigator-to-Navigator communication, introduced during training. Navigators want more opportunities to exchange ideas and

strategies with each other and to learn best practices that had worked for others. These opportunities could be face-to-face or they could be facilitated by technology like wikis and chat rooms.

4. Hands-on training with computer systems/Marketplaces. That is, perform additional work to incorporate more use of online marketplaces into training prior to the next enrollment period.

Structured in-person Navigator training should be designed to prepare Navigators for the different aspects of the dynamic roles they play in the new policy environment. A more structured training might involve the development of standardized nuts-and-bolts modules on topics like 'health insurance 101,' navigating the Marketplace, and protecting Consumer privacy, as well as topics (suggested by different interviewees) such as and troubleshooting; consistent Consumer record-keeping; strategies for public relations and capacity building; developing informational and promotional materials for navigation; communication strategies; income calculation; and navigating "the gap." Another suggestion is to include an in-person training component (in instances in which such a component does not already exist) involving health insurance industry and CMS representatives so that Navigators could be more familiar with insurance products available in their service areas and with public policy issues. We realize that Seedco could employ more standardization in their in-person training for Navigators, but personnel from Seedco cannot command other states to do so.

In addition to helping Navigators be better prepared, a tangible benefit of standardized and structured training on a variety of topics would be, in the words of a Navigator based in Maryland, to establish "standard operating procedures" across agencies, which could reduce the significant challenges associated with inconsistent record-keeping practices and miscommunication/misunderstandings between Navigators. Navigators, who have diverse backgrounds and different training experiences, sometimes had problems communicating with one another about technical problems or paperwork because they would be using different terminology that was not mutually understood. When this occurred, finding solutions to technical problems and answering questions about procedures could be delayed due to misunderstandings. This could also result in entry of incorrect information about Consumers that could further delay the processing of their Marketplace applications.

Establishing a vehicle by which Navigators who have been through the process mentor new Navigators will present opportunities for valuable exchange of information and on-the-job training that could help prepare new trainees. Navigator mentoring could involve shadowing, real-time observation of Salesforce, the Marketplaces in action, and could familiarize trainees with Consumer interactions before they must navigate independently. Establishing mentoring would also provide new trainees with an experienced go-to person for challenges that they encounter early on in their work.

Establishing secure online communities—similar to what is already in place in Georgia and New York— for Navigators to share information, compare strategies, and discuss challenges would be beneficial to Navigators at all stages. Requiring that new recruits explore discussion topics and become comfortable posting their own questions and issues would be a means to build community among Navigators and help orient trainees.



## 4. DISCUSSION AND CONCLUSIONS

### 4.1— WHAT FACTORS ARE ASSOCIATED WITH SUCCESSES AND DISPARITIES IN THE NAVIGATED HEALTH INSURANCE ENROLLMENT EXPERIENCE? WHICH POPULATIONS EXPERIENCED THE MOST SUCCESSFUL RATES OF ENROLLMENT?

***Successful enrollment in any type of coverage in the full, four-state sample.*** Analyses of Salesforce data reveal socio-demographic patterns of enrollment in coverage, and also reveal state-specific patterns that differ to various degrees from the patterns observed for the full four-state sample.

Seedco's community partner agencies included several that primarily served Asian populations, several based in predominantly African American neighborhoods, and several based in predominantly Hispanic/Latino neighborhoods. Those coalitions no doubt ensured that the racial/ethnic profile of Consumers who received in-person assistance from Seedco Navigators was highly diverse. In the full four-state Salesforce survey sample, Black/African American Consumers were represented well above their proportion in the general population<sup>5</sup>. Asian and Hispanic consumers followed White and Black/African American Consumers in frequency of assistance and enrollment. While Navigators met with more Asian Consumers than Hispanic Consumers, the two groups attained success in applying for or enrolling in coverage in similar numbers. Although this general pattern characterizes the full four-state data set, each state's assistance and enrollment demographics were unique (see descriptive analyses for full details). The data do not allow a conclusion about the degree to which the high rate of participation was due to especially intense outreach to Black/African American communities, or especially high receptivity to the ACA message among Black/African Americans. What is clear is that Seedco partners included organizations with strong roots in Black/African American communities.

Consumers who received in-person assistance from Navigators tended toward financial insecurity. Only about 11% indicated that they typically had discretionary funds at the end of each month for spending or saving. Unmet health care needs due to financial hardship were common. Over one-half of Consumers said they had put off at least one visit during the past year because they couldn't afford it; one-third had deferred three or more health visits due to cost. (These data do not reveal the health services that were eventually obtained.) In the end, over 75% of the Consumers in this who qualified for private insurance either qualified for or received health insurance subsidies to help with the cost of premiums (Advance Premium Tax Credits and/or Cost Sharing Reductions).

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<sup>5</sup> Consumers who identified as Black/African American comprised just fewer than 28% of the full Salesforce sample. Black/African American persons make up about 13% of the US population (census.gov).

In addition to these descriptive statistics about the demographics of Consumers counseled by Seedco Navigators, bivariate (Chi-square) and multivariate modeling (regression) give insight into relative proportional enrollment success and tell us which factors significantly predicted navigated enrollment successes. Bivariate analyses give insight into the strength of association between two variables, and multivariate analyses tell us, when controlling for other factors, which characteristics predict particular outcomes.

In the full four-state sample, general enrollment success (whether a Consumer selected or applied for coverage in Georgia and Tennessee, and whether a Consumer enrolled in a plan in Maryland and New York) in any type of coverage while meeting with a Navigator was significantly associated with several characteristics: race/ethnicity, type of Marketplace (state-based versus federal) used, state of residence, financial characteristics of Consumers, and language preference. Identifying as white, using a state-based Marketplace, undergoing navigation in Maryland, and being financially secure (having money left over at the end of the month after taking care of expenses) are all factors that predict successful enrollment in private QHPs or public plans. Conversely, identifying as Asian, using the federal Marketplace, and mid-level financial security (just breaking even at the end of the month) predict lower likelihood of enrollment success.

While over one-half of counseled Consumers who preferred English or Spanish, as well as those identifying as Black/African American, White, and Hispanic, experienced enrollment success, rates of success were much lower for Asian consumers. Because many Asian Consumers were served by Navigators with three particular Seedco partner agencies in Georgia and New York, these results may or may not be specific to those populations, and this conclusion may or may not have broader implications. Recommended issues for further study include a broader review of enrollment outcomes for Asian populations, and comparison of navigation outcomes when Navigators speak the consumers' language and when they rely on third party translation services.

Navigators were clearly responsive to financial hardship and diverse financial situations among Consumers. Over half of those who reported problems meeting financial obligations at the end of each month enrolled successfully (as was the case for those who had surplus funds at the end of each month). But Consumers who reported uncertainty regarding their monthly financial situation experienced proportionally low rates of enrollment success, with less than one-third of Consumers who belong to each of these groups experiencing enrollment success.

***Successful enrollment, state-by-state comparisons.*** In state-specific findings, significant predictors of general enrollment success pertain primarily to racial/ethnic, linguistic, and financial characteristics of Consumers. Although not observed in all states, there are observed tendencies for Consumers who are less financially secure (people who report

that they experience financial shortfalls and must either borrow from friends/relatives or use a credit card/ take on other debt to make ends meet) to have notably high rates of enrollment success. This tendency is particularly strong in states using state-based Marketplaces where Medicaid eligibility was expanded, but was also observed to a lesser degree in Tennessee. We would recommend further analysis to test the hypothesis that Medicaid expansion and very robust tax credits available to consumers at the lower end of the income scale is the primary reason for enrollment success among economically fragile Consumers. There is also a tendency for Consumers who report that they do not know their financial status to experience low likelihood of enrollment success compared to Consumers who reported any of the other financial statuses—whether fragile or robust. The data cannot explain why economic fragility leads to enrollment success and why low financial awareness leads to the enrollment failure, but these findings do lead to interesting hypotheses.

Comparing across the four states, Maryland Consumers experienced the overall highest rates of general enrollment success, and these were significantly higher than in other states. There were no observations of significant gendered disparities in general benefits enrollment, nor observed disparities on the basis of health literacy or health status (number medical visits in the past year) in any state. In sum, especially in states with Medicaid expansion, Consumers with low levels of economic security enjoyed high levels of enrollment success. Several factors might account for the success of those Consumers. However, this result can be seen as evidence that Medicaid expansion was helping meet the goal of affordable access to care for those who most needed it.

In Georgia, no statistically significant linguistic disparities in application success were observed. Consumers who reported relative financial insecurity, in that they experienced shortfalls and must either borrow or go in to debt to make ends meet, as well as Consumers who reported that they did not know their monthly financial status, had a low likelihood of experiencing enrollment success. This finding about financial insecurity is the opposite of what was found in state-based Marketplaces, where Medicaid was expanded. In fact, this contrary finding in Georgia—a state that declined to expand Medicaid eligibility—bolsters the hypothesis that Medicaid expansion in state Marketplaces facilitated enrollment especially for financially fragile Consumers. Future research could also address whether group differences in financial security (if any exist) might help explain ethnic group differences in type of policy selected.

In Maryland, significant financial, linguistic, and age-wise differences in enrollment status were observed. Although people in nearly all financial situations experienced high rates of enrollment success in Maryland, being in a less secure financial situation (reporting that they experience shortfalls and must borrow from friends or relatives to make ends meet) was positively associated with successful enrollment in coverage. The primary exception to the pattern of high rates of enrollment across financial statuses is that people who reported that they did not know their monthly financial status experienced significantly lower rates of enrollment than respondents in all other

financial groups. Maryland was the only state in which English speakers had higher odds of successful enrollment than speakers of other languages (>70% of English speakers in the sample experienced enrollment success), and Spanish speakers had the lowest chance of becoming enrolled. Yet, both English and Spanish speakers experienced enrollment success at rates of over 50%. Race/ethnic identity was not significantly associated with enrollment success in Maryland.

In New York, race/ethnicity, and (as in Maryland) being less financially secure were all significantly associated with successful enrollment in coverage. Speakers of Spanish and English both enrolled at rates of over 50%, and Consumers identifying as Black/African American, Hispanic, and White all enrolled at rates falling between 30% and 50%. Consumers identifying as Asian experienced enrollment success at the much lower proportional rate of about 16%. Experiencing shortfalls and needing to borrow from friends or relatives or go into debt to make ends meet were both positively associated with successful enrollment in coverage—over 60% of individuals in these two groups successfully enrolled in coverage. Similarly, being relatively financially secure (having money left over) was significantly associated with successful enrollment. The primary difference between less and more financially secure enrollees was that less financially secure Consumers were eligible for Medicaid, while more financially secure Consumers tended to receive subsidies and purchase private coverage. As in Maryland, those who did not know their monthly financial situation saw significantly lower odds of enrollment success than respondents in all other financial groups. Asian consumers were less likely than consumers of other racial/ethnic backgrounds to experience enrollment success, which may be a result of linguistic barriers.

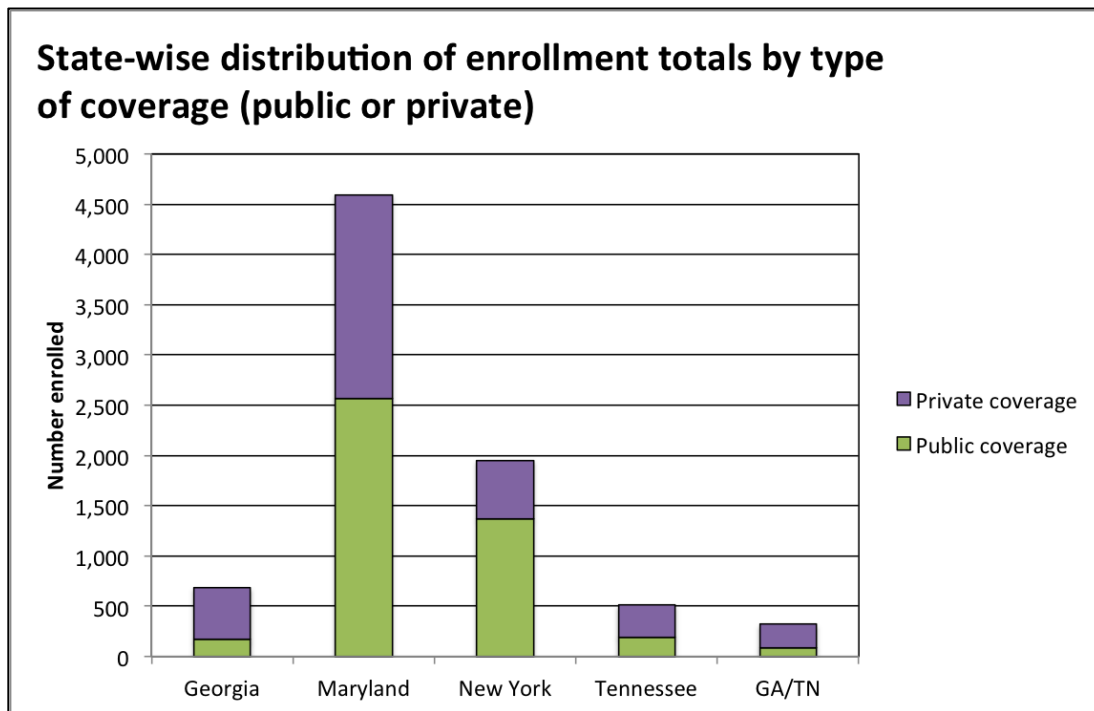
In Tennessee, statistically significant disparities in successfully applying pertain to both racial/ethnic identity and to financial situation. Identifying as Black/African American and being in a less secure financial situation both predicted successful enrollment in coverage. There were no other statistically significant findings specific to Tennessee with respect to successfully applying for coverage.

Future research should aim to understand the dynamics that produce statewide variation in relationships among race/ethnicity, linguistic preference, financial security, and enrollment success.

#### **4.2— WHAT FACTORS ARE ASSOCIATED WITH PRIVATE QHP ENROLLMENT SUCCESSES AND DISPARITIES?**

In addition to understanding factors associated with successes and disparities in general facilitated enrollment, we were also interested in understanding factors that were associated specifically with successful enrollment in a private versus public health plan. Figure 4.1 presents a breakdown of the Consumers who were documented as having successfully enrolled in each state, in terms of absolute numbers. Figure 4.2 presents

these same Salesforce data as a ratio of public to private coverage enrollment in each state.



**Figure 4.1.** A breakdown of the Consumers included in the Salesforce dataset who were documented as having successfully enrolled in each state. The category labeled “GA/TN” captures the subsample of Consumers who underwent assistance in either Georgia or Tennessee, but for whom more specific geographic indicators were not recorded.

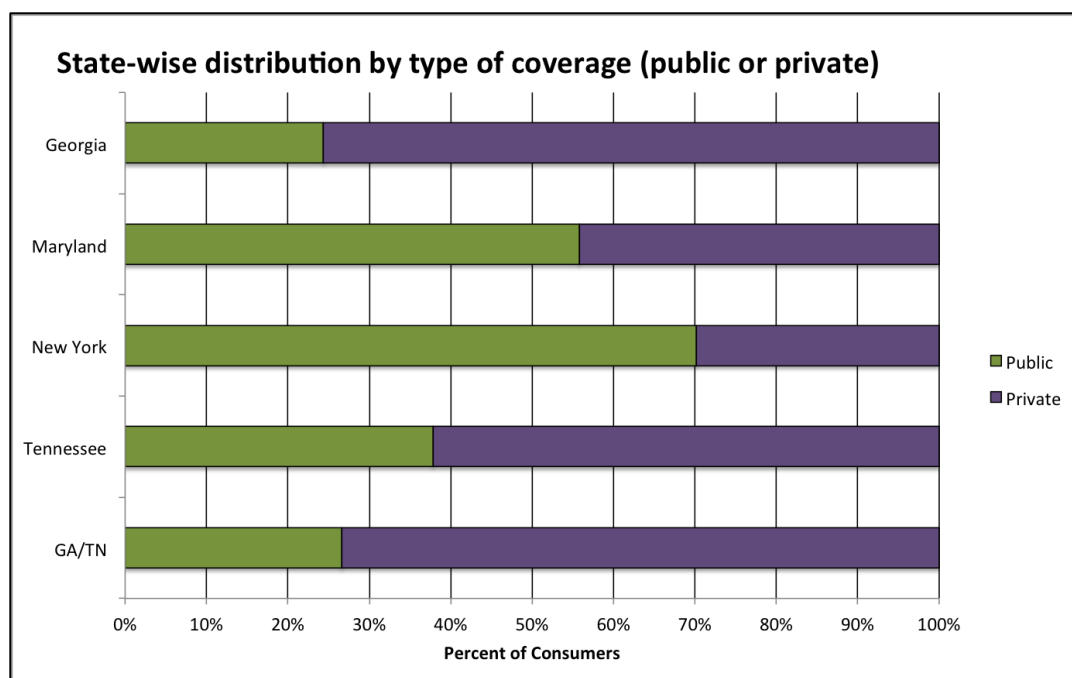


Figure 4.2. Consumer enrollment in the Salesforce dataset, represented as a ratio of public to private coverage. The category labeled “GA/TN” captures the subsample of Consumers who underwent assistance in either Georgia or Tennessee, but for whom more specific geographic indicators were not recorded.

**Enrollment in private coverage in the full, four-state sample.** Among Consumers across the four state sample who succeeded in enrolling, enrollment specifically in private Qualified Health Plans (QHPs) was associated with state of residence, race/ethnicity, gender, age, and financial situation. Residence in Georgia, New York, or Tennessee was statistically associated with higher enrollment in private health plans compared with Maryland (even though the raw numbers were higher in Maryland for all categories of insurance). Although proportional rates of enrollment were similar across racial/ethnic groups (between 45% and 50%), when controlling for all other factors in our regression model (like health literacy and unmet medical need), white Consumers were significantly more likely than Asian Consumers to enroll in private QHPs.

Being a woman was significantly associated with private plan enrollment, and likelihood of enrolling in a private plan increased with age. Private enrollment was most prevalent among Consumers in the age range of 35 to 55 years. Consumers who reported being financially insecure were significantly less likely to enroll in private health plans than those reporting more financial security. Consumers who reported being the most financially secure (they have money left over that they can either save or spend on things they want) were more likely to enroll in a private health plan than Consumers reporting other financial situations.

Lower likelihood of enrollment in a private plan is predicted by being young, particularly between the ages of 18 to 25 years, using the federal Marketplace, and being less financially secure (experiencing shortfalls and needing to borrow money or use credit

cards/go into debt). Identifying as Black/African American or Hispanic were also associated with lower likelihood of enrolling in a private plan.

***Enrollment in private coverage, state-specific analyses.*** In Georgia, applications to private plans surpassed applications to public coverage by a magnitude of three to one. Members of all racial/ethnic groups and all age groups who experienced application success applied to private coverage at higher rates than to public coverage. Likelihood of applying to a private plan increased significantly with age, with Consumers aged 56 to 65 years having the highest proportional rates of applying to QHPs. Consumers who reported having money left over at the end of the month, those who break even, and those who reported needing to use credit cards or go into debt applied to private coverage at rates of over 80% in Georgia, while those who reported shortfalls resulting in the need to borrow money from friends or family members enrolled in private coverage at a significantly lower rate of less than 50%. Future research could address other dynamics that may explain these findings. For instance, future evaluations can examine whether Consumers are more willing to take on credit card debt than ask their family members and/or friends for money.

In Maryland, identification as Hispanic or Asian was positively associated with enrollment in private plans, compared to White Consumers; Hispanic and Asian Consumers enrolled in private plans at rates of over 50%. Black/African American Consumers were significantly less likely than White Consumers to enroll in private coverage. Likelihood of enrolling in a private plan increased significantly with age. Consumers aged 18 to 25 years enrolled in private coverage at a rate of under 30%, while Consumers aged 35 to 65 years enrolled at rates of over 60%. Consumers who reported that they come up short and sometimes have to borrow money from friends or relatives to make ends meet or who have to use credit cards or otherwise go into debt were significantly less likely to enroll in a private plan than Consumers who just break even, while Consumers who reported that they have money left over were significantly more likely to enroll in private coverage.

In New York, Consumers who enrolled in coverage enrolled in public coverage at higher rates than private coverage. Consumers who are women, and those who are relatively more financially secure in that they have money left over were significantly more likely to enroll in private plans than men or people who just break even. Likelihood of enrollment in private plans increased with age and was prevalent among Consumers aged 46 to 65 years. Conversely, Consumers who identified as Black/African American, are aged 18 to 25 years, or who experience financial shortfalls and need to borrow from friends or relatives had relatively low likelihood of private enrollment in New York.

In Tennessee, successful enrollment in a private plan was associated with Black/African American racial/ethnic identity and with relative financial security. Black/African American Consumers enrolled in private plans at a rate of over 70%. Likelihood of enrollment in private plans increased with age. Consumers aged 45 to 65 years were

being especially likely to enroll in private coverage. Consumers who reported having money left over at the end of the month enrolled in private plans at a rate of over 80%, and high health literacy was also associated with private enrollment. Consumers aged 18 to 25 years were significantly less likely than members of other age groups to enroll in private plans.

#### **4.3—WHAT IS THE IMPACT OF FACILITATED ENROLLMENT ON ENROLLMENT IN MEDICAID AND OTHER FORMS PUBLIC COVERAGE?**

***Navigated enrollment and Medicaid eligibility expansion.*** The primary determining factor in relative rates of enrollment in public versus private plans was whether Consumers underwent navigation in states that expanded eligibility for Medicaid and other forms of public coverage. In New York and Maryland, both states that “opted in” to eligibility expansion, more Consumers were enrolled in public coverage than private. Furthermore, in these states, Navigators and Consumers participating in interviews discussed helpful assistance provided by Navigators to link Medicaid-eligible Consumers to social services organizations that could offer further assistance in the process of enrolling in public coverage. In Georgia and Tennessee, both states that “opted out” of eligibility expansion, enrollment in private plans exceeded enrollment in public plans dramatically. That being said, Navigators in these two states did assist many Consumers who were eligible for Medicaid under the more restrictive state eligibility rules.

***Enrollment in public coverage in the full four-state sample.*** In the full, four-state sample, using a state-based Marketplace was significantly associated with enrollment in a public plan. In our sample, living in a state with a state-based Marketplace is the same as living in a state that expanded Medicaid eligibility. Within the full sample, residence in Maryland was significantly associated with enrollment in public coverage, as is having relatively high health literacy. Three-fourths of Consumers aged 18 to 25 years enrolled in public coverage, while persons aged 45 to 65 were significantly less likely to enroll in public plans. Men were more likely to enroll in public plans than women, and this observation is highly influenced by enrollment dynamics in New York (see state-by-state discussion below). Consumers identifying as Asian and Black/African American, and those who expressed a preference for speaking Spanish were statistically more likely to enroll in public coverage than private. In terms of financial situation, Consumers who reported shortfalls and needing to borrow money from friends or relatives were significantly more likely to enroll in public coverage than those who reported just breaking even. Those reporting that they have money left over were significantly less likely than those who just break even to enroll in public plans.

***Enrollment in public coverage, state-specific analyses.*** When looking at each individual state of residence and use of state versus federal Marketplace, very few additional factors were statistically associated with enrollment in public plans.

In Georgia, preference for speaking Spanish predicted application for public coverage.



In Maryland, Consumers who reported shortfalls and needing to borrow money from friends or relatives were significantly more likely to enroll in public coverage than those who reported just breaking even.

In New York, men and Consumers who reported shortfalls and needing to borrow money from friends or relatives were significantly more likely to enroll in public coverage than those who reported just breaking even. Consumers who reported having money left over were significantly less likely to enroll in public insurance than those who reported just breaking even.

In Tennessee, age group is the only significant predictor of application for public coverage. Consumers aged 18 to 25 years were significantly more likely than those aged 46 to 65 years to enroll in public plans. No other variables were statistically significant.

#### **4.4—TO WHAT EXTENT ARE SO-CALLED “YOUNG INVINCIBLES” (CONSUMERS AGED 18 TO 34 YEARS) REPRESENTED AMONG ENROLLEES?**

The success of health insurance reform requires robust numbers of young, healthy people—so-called “young invincibles” (persons aged 18 to 34 years)—to enroll in Marketplace plans, compared to the number of older individuals who enroll. According to Levitt and colleagues (2013), “for this system to work, young people need to enroll in sufficient numbers to produce a surplus in premium revenues that can be used to cross-subsidize the deficit created by the enrollment of older people.” In other words, a sufficient number of younger, typically healthier people must purchase plans on the Marketplace to offset the cost of insuring older people who are likely to use more medical services, allowing insurers to maintain profit margins, and keeping premiums at a stable price. A rule of thumb among planners has been that young adults must enroll in private coverage at approximately the same proportion that they constitute in the pool of potential enrollees—approximately 40% (Levitt et al. 2013).

In terms of national enrollment numbers, according to a report by the Department for Health and Human Services office of the Assistant Secretary for Planning and Evaluation (ASPE) (2014), during the 2013-2014 open enrollment period, approximately 28% of enrollees in state and federally facilitated Marketplace plans fell into the 18-34 year-old age range. Official reports by the ASPE for individual states indicate that in Georgia about 23% of Marketplace plans went to 18-34 year-olds; in Maryland 30% of Marketplace plans went to 18-34 year-olds; in New York 31% of Marketplace plans went to 18-34 year-olds, and in Tennessee 28% of Marketplace plans went to 18-34 year-olds.

According to descriptive analyses of Salesforce survey data, about 24% of all consultations by Seedco-contracted Navigators in Georgia, Maryland, New York, and Tennessee were carried out with 18-34 year-olds. Of those who did successfully apply for or enroll in private insurance, 16.5% were 18-34 year-olds. The discrepancy between

Seedco Navigator-assisted enrollment figures for younger Consumers and the figures reported by ASPE would be explained if a larger proportion of this population were found to have self-enrolled online and if young consumers who consulted with Navigators were more likely to complete the enrollment process independently. Future research could examine if younger Consumers are more adept with technology and due to this potential adroitness may have been less inclined to seek in-person assistance than older Consumers (or more likely to complete their enrollment on their own, after taking leave of a Navigator).

Analyses of Seedco-contracted Navigator consultation rates by age group in individual states indicate that in Georgia about 25% of consultations were with 18-34 year-olds; in Maryland 22% of consultations were with 18-34 year-olds; in New York 28% of consultations were with 18-34 year-olds, and in Tennessee 15% of consultations were with 18-34 year-olds.

Analyses of Seedco-contracted Navigator enrollment rates by age group in individual states indicate that in Georgia about 14% of private Marketplace plans went to 18-34 year-olds; in Maryland 17% of Marketplace plans went to 18-34 year-olds; in New York 19% of Marketplace plans went to 18-34 year-olds, and in Tennessee 9% of Marketplace plans went to 18-34 year-olds.

Navigators faced predictable challenges when attempting to enroll these “young invincibles” in private plans. Younger people tend to report being in excellent health and may not be cognizant of future health risk and healthcare needs due to a lack of personal experience with health problems and medical bills. In these evaluation data, younger people tended toward financial insecurity and 52% of newly Medicaid-eligible uninsured persons were between the ages of 18 and 34. Persons on the younger end of that spectrum seem to be particularly difficult to reach with private coverage. Fully three-quarters of 18 to 25 year-olds in the four-state sample who experienced enrollment success enrolled in public plans. In states where Medicaid eligibility was not expanded, relatively few Consumers aged 18 to 34 years were enrolled in any sort of plan.

#### **4.5—WHAT SPECIFIC BARRIERS AND FRUSTRATIONS DO PEOPLE EXPERIENCE IN THE NAVIGATED ENROLLMENT PROCESS?**

We define “barriers” as phenomena that cause significant distress or otherwise obstruct or delay Consumers’ progress at some point in the facilitated enrollment process. Consumers and Navigators may encounter barriers to enrollment related to Navigator skills. But other barriers are systemic, relating, for example, to Consumer socioeconomic characteristics, language skills, computer literacy or health insurance literacy, or based on the policy environment or political climate in a particular geographic location. Encountering barriers without removing them results in enrollment failures. The following findings are derived from in-depth interviews with 40 Consumers who worked with Navigators across the four states.

***Important barriers to facilitated enrollment from Consumers' perspectives—***

Thirty-seven out of 40 Consumers interviewed were uninsured when they first met with Seedco Navigators. Fourteen of those 40 never did submit applications, either because they fell into the Medicaid eligibility gap or because Navigators informed them that they would not qualify for subsidies.

By the time these Consumers were interviewed—mostly March and April of 2014--eleven of them were successfully enrolled in QHPs, and twelve had enrolled in Medicaid—noteworthy successes for Navigators and potentially life-changing events for these Consumers. At the same time, however, seventeen interviewees remained uninsured for various reasons, and one was still uncertain of insurance status. Based on analyses of Consumer telephone interviews, many Consumers with whom we spoke encountered barriers at some point in their attempts to procure health insurance. For the many interviewees who eventually were able to enroll in a private QHP or Medicaid, these barriers were overcome with Navigator assistance.

When Consumers were unable to overcome barriers and enroll in coverage, it was often due to factors outside of Navigators' immediate control. For example, eight of the Consumers who participated in telephone interviews (six in Georgia and two from Tennessee) learned from Navigators that they fell into the Medicaid/subsidy gap. Navigators informed them about what financial characteristics would have to change to make them eligible for financial assistance obtaining coverage.

Barriers frequently mentioned by Consumers included technological problems with the online portal, lack of prior knowledge about the Navigator program, lack of prior knowledge about how health insurance works or what sorts of plans would be available to them, delay in receiving a Marketplace decision or communication regarding policy enrollment, falling into the Medicaid-subsidy gap, or otherwise being unable to afford to purchase a policy.

For 17 of the Consumers interviewed, the first frustrations encountered were related to the online benefits exchanges themselves. These problems included periodically inoperable web sites (site would freeze; site would not load; application information was deleted; Consumer was unable to log on to site), problems with verifying identity or household income once signed on the website, and problems understanding the information and instructions on the websites. Twenty-three Consumers either did not attempt to self-enroll or did not encounter technical difficulties using state or federal exchanges. Six Consumers stated that problems that they encountered when attempting to self-apply or self-enroll were the *primary* reason for seeking out Navigator assistance.

A lack of prior knowledge about the Navigator program was a common barrier to enrollment as well. Among Consumers who consulted Navigators after beginning the

process on their own and experiencing difficulties, most had never previously heard of the Navigator program or were not aware that Navigators serve a unique purpose compared to other types of assisters. Among a majority of interviewees, word-of-mouth from friends, medical staff, or social workers was an important means by which these individuals learned about Navigators and how to find them. Related frustrations discussed by Consumers included delay in locating a Navigator, lack of easy-to-access information online about available policies and how to complete applications, and delay in receiving decisions about submitted Marketplace applications, Medicaid applications, and new QHPs.

The most significant barriers to enrollment, those that could not be overcome by Consumers or by Navigators, were erected by policy decisions and particularly the mismatch between federal and state-level policies related to health insurance reform that resulted in the Medicaid gap in Tennessee and, more dramatically, in Georgia. Two Consumers in Tennessee fell in to “the gap” as did five from Georgia.

***Important barriers to facilitated enrollment from Navigators’ perspectives***—Navigators who participated in interviews shared their perspectives on barriers to enrollment as well, and in fact discussed many of the same barriers as Consumers. Navigators working in all four states discussed technological problems (related to state or federally-facilitated Marketplace online portals) and bureaucratic complexities and inconsistencies (pertaining to redundant paperwork or forms, contradictory information provided by different offices or agencies, inconsistent information provided by single offices or agencies, etc.) as important barriers to enrolling Consumers in an efficient way. Navigators in Georgia, New York, and Tennessee specifically mentioned identity verification procedures as particularly onerous for both Navigators and Consumers.

Navigators in all four states also stated that cultural, linguistic, and class-based differences erected barriers to effective communication and enrollment in the navigation encounter, in encounters between Consumers and online systems, and within the Navigator community. Among Navigators interviewed, there was a perceived discordance in socioeconomic status and life experience between Navigators and Consumer populations. Communication barriers between Navigators and Consumers were associated with differences in language competency (especially due to a shortage of translators in some areas at some times), basic literacy, trust of technology and computer skills, or health insurance literacy. While Navigators could explain terms and how health insurance works, this took a significant amount of time with each Consumer. Consumers who had little experience using computers and the Internet and who were unfamiliar with language and terms specific to the health insurance industry had extra difficulty explaining their problems to Navigators, which could result in delays or errors entering information or submitting applications. Navigators, who have diverse backgrounds and different training experiences, sometimes had problems communicating with one another about technical problems or paperwork because they would be using different terminology that was not mutually understood. When this

occurred, finding solutions to technical problems and answering questions about procedures could be delayed due to misunderstandings. This could also result in entry of incorrect information about Consumers that could further delay the processing of their Marketplace applications.

The political environment in different areas also influenced these barriers. Navigators in Georgia, Maryland, and Tennessee all discussed the contentious politics around the ACA as creating barriers to Consumers receiving accurate information about health insurance reform, their rights, their obligations, and about who would qualify for subsidies and Medicaid. Some Navigators experienced resistance from staff when attempting to post information on bulletin boards in community settings. Others discussed problems resulting from Consumers coming into Navigation with erroneous information about health insurance reform, which led them to have unrealistic expectations about Navigators or outcomes.

Marketplace call centers were a third source of barriers to enrollment listed by Navigators in all states. According to Georgia, Maryland, and New York Navigators, they often met with Consumers after the Consumer had been given instructions by individuals working at Marketplace call centers. Often call center assisters had given Consumers incorrect information about how to complete online applications, anticipated wait times, and other procedures. Navigators often had to call the Marketplace call centers themselves. Navigators complained about wait times of several hours to speak with operators, and of receiving a ticket number and a promise of a return call that was never returned.

Other barriers discussed by Navigators resulted from a shortage of Navigators or translators in high demand areas (Georgia and New York); a lack of technological resources like Wi-Fi hotspots and a lack of fixed-location Navigators (so the Consumer could always know where to find them) (Georgia); insufficient Navigator training prior to open enrollment (Maryland and Tennessee), and a lack of prior information among Consumers regarding Navigators, plans, health insurance in general, etc. (Georgia and Maryland), and an inability to offer solutions to people who fall into the Medicaid/subsidy gap (Georgia).

***Additional barriers affecting specific groups of Consumers.*** Analyses of Salesforce data demonstrate that Navigators in each state reached an ethnically, linguistically, and socio-economically diverse Consumer base. Yet, at the same time, as revealed in interviews, members of some social and demographic groups experienced less desirable outcomes or rates of enrollment success than others. Consumers in less well-represented groups (e. g., college students, recent immigrants, self-employed persons, and chronically ill persons) face the same barriers as other Consumers, but they may also face additional or unique barriers or disincentives to insurance enrollment.

Enrolling young adults (so-called “young invincibles” aged 18-34 years) in private QHPs is a priority under new ACA rules. Yet it is also a challenge to Navigators because uninsured young adults face a unique combination of both cognitive and socioeconomic barriers and disincentives to enrolling compared to people in other age groups. In terms of cognitive barriers, while young adults to whom we spoke view health insurance as beneficial, they perceived that (barring accidents) they and their peers face relatively low health risks, and they also have a relatively lower incidence/experience of chronic or recurring health problems than older adults. In terms of socioeconomic barriers, they are more likely to be in unskilled work, to be students or recent college graduates with student loan debt, tend to have lower or highly fluctuating income, have relatively fewer assets than older adults, and often have shorter histories of employment, which contributes to financial insecurity for some. When deciding whether to take on the expense of a health insurance policy, relatively low perception of health risk, combined with a lack of financial resources and income insecurity can influence the choice not to purchase coverage.

#### **4.6—WHAT NAVIGATOR PRACTICES AND RESOURCES EFFECTIVELY MITIGATE BARRIERS AND PROBLEMS IN THE CONTEXT OF FACILITATED ENROLLMENT?**

Navigators are key facilitators in the enrollment process, and may be the only “human face” that Consumers encounter on the pathway to health insurance enrollment. The majority of Consumers interviewed expressed appreciation for their experience with a health insurance Navigator, and often praised their Navigators’ professionalism and efforts to clarify the complex and often frustrating process. Several Consumers praised their experience with Navigators even when outcomes of Navigation were disappointing or significantly different than they expected. The professionalism, competency, and skilled communication strategies demonstrated by Navigators were key facilitators to enrollment for many Consumers who met with them.

Navigators’ work is not limited to assisting Consumers apply for subsidies and enroll in health insurance plans through state and federal Marketplaces. A Navigator’s work involves many tasks and responsibilities, including training; coalition building; developing and performing outreach activities at diverse locations in their areas (leading classes/info sessions, hosting workshops, making presentations, public speaking, setting up information tables); teaching people about the health care system, the health insurance industry, health care financing, and the particularities of health insurance plans; developing useful informational materials for Consumers; conducting one-on-one meetings with Consumers to help complete applications and choose health plans; making sure to conduct follow-up communication with Consumers who need updates on their application and enrollment status; and troubleshooting problems with online systems and errors in Marketplace applications and call center misinformation.

Of the skills that Navigators bring to their work, effective communication strategies--including the ability to educate and inform Consumers--ability to troubleshoot or bypass

technological problems, and patience seem to have been most crucial in mitigating barriers to enrollment for Consumers during the first ACA open enrollment period. Navigators used educational materials like information sheets, web sites, and pamphlets to de-mystify the process and educate consumers.

#### **4.7—NAVIGATING “THE GAP”: HOW DO NAVIGATORS ASSIST CONSUMERS WHO ARE FOUND TO BE INELIGIBLE FOR BOTH THE MARKETPLACE AND FOR MEDICAID?**

As stated above, one of the most significant barriers to enrollment was constructed through policy decisions that resulted in the Medicaid-subsidy gap in Tennessee and in Georgia. Two Consumers interviewed in Tennessee fell in to “the gap” as did five from Georgia. That is, those Consumers made too little income to qualify for subsidies or to afford a full-priced plan, yet earned too much income to qualify for Medicaid. Although Navigators living in Georgia and Tennessee were unable to assist these Consumers in applying for private or public coverage, they often did provide education and resources. Strategies for assisting Consumers in this situation included sharing detailed information on why the gap exists and how the particular Consumer fell within it, explaining which Consumer characteristics would have to change for them to qualify for subsidies under current guidelines, and by providing information on sliding scale health services for which the Consumer might qualify. The data do not allow a conclusion about the degree to which any of these services yielded satisfactory health care for the Medicaid-subsidy gap Consumers.

#### **4.8—WHAT DO CONSUMERS AND NAVIGATORS CONSIDER THE CHARACTERISTICS OF EFFECTIVE COMMUNICATION IN THE CONTEXT OF NAVIGATION?**

Communication between the Navigator and Consumer seemed to be the key to Consumer satisfaction with the Navigation process, regardless of enrollment success. From Consumers’ point of view, good communication involves both delivering pertinent information, and displaying a supportive and understanding attitude. Consumers value an individualized, Consumer-centered approach by Navigators. The unbiased, professional attitude and personal approach that they experienced during Navigation caused some Consumers to question negative rumors that they had heard about “Obamacare” through various media and networks. In interviews, Consumers remarked on several particularly helpful aspects of communication during Navigation encounters. These included Navigators’:

- Willingness and patience to listen to the Consumer about their experiences and needs
- Inquiries about the Consumer’s individual circumstances
- Clear explanation of how the Marketplace works
- Clear explanation of how health insurance works
- Accessible explanation of industry-specific terms

- Explanation of the expected timeline for application and enrollment
- Explanation of how the information that the Consumer gives the Navigator is being input into the Marketplace portal (showing the screen and explaining)
- Prompt follow-up with Consumers regarding the status of their applications; promptly returning calls from Consumers
- Ability to articulate the key differences among policy options

Some Navigators have developed unique communication strategies that grow from their personalities and particular competencies and experiences, but most agree that some key characteristics and principles of communication are crucial to effective Navigation. These include:

- A professional and calm attitude
- Availability, both in person and for follow-up questions and updates
- Listening first, then ask the right questions once one has grasped the particularities of the individual Consumer's situation
- Paying overt attention to the Consumer's needs for information, coverage, and follow-up
- Empathizing and assuring the Consumer that Navigators are there to help, regardless of the problems the Consumer has encountered
- Clearly explaining the "inner workings" and the "inner logic" of the health care and health insurance system to Consumers
- Simultaneously working as an information "translator" and "hub," and an enrollment facilitator

#### **4.9—IS CONSUMER HEALTH (AND HEALTH INSURANCE) LITERACY ASSOCIATED WITH OUTCOMES OF FACILITATED ENROLLMENT?**

In Salesforce surveys, health literacy was assessed using a single screening item that asked, "How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?" The response options ranged where 1 = "always", 2 = "often", 3 = "sometimes"; 4 = "rarely", and 5 = "never." Higher scores indicate greater health literacy. This screening item was intended to capture the degree of competency that each Consumer possesses for evaluating health-related information.

In the full, four-state sample, we observed that Consumers with greater health literacy scores were significantly more likely to have enrolled in public coverage. For those who enrolled in private coverage, health literacy was associated with applying for or qualifying for insurance subsidies. However, health literacy was not significantly associated with likelihood of successful enrollment in a private QHP. It is possible that consumers with higher health literacy were more likely to complete the enrollment process independently, after consulting with a Navigator. Thus the highest percentiles



of health literates would not register in these results as “succeeding in enrollment.” We recommend further study to test this hypothesis. Within-state analyses of the relationships among health literacy and enrollment success did not yield significant findings.

Health literacy scores reflect the degree of competency Consumers possesses for absorbing and applying health-related information. Socioeconomic, linguistic, and demographic characteristics of Consumers, and particularly whether one prefers to speak English, are correlated with health literacy scores.

From interviews with Consumers and Navigators, we learned that health insurance literacy, or prior knowledge of and comfort with the terminology and structure of the health insurance industry, is important to almost every aspect of the enrollment. For most people—even those who have been insured in the past—many aspects of selecting and using health insurance are complicated and non-intuitive, and therefore intimidating. In the face of low health insurance literacy, Navigators’ ability to educate and inform Consumers is of paramount importance.

#### **4.10—RELATIONSHIPS AMONG MARKETPLACE CHARACTERISTICS, INSURANCE POLICY OPTIONS, AND CONSUMERS’ CHOICES ABOUT HEALTH INSURANCE ENROLLMENT**

According to a report issued by the Robert Wood Johnson Foundation in June of 2014, state-based Marketplaces achieved higher average enrollment rates (32.5% of eligible people) than the federally facilitated Marketplace (26.3% of eligible people). However, presenting averages masks significant variability in performances among Marketplaces of both types, and particularly those with state-run Marketplaces (Polisky et al. 2014). Enrollment rates in the federal Marketplace varied from 11% (South Dakota) to 39% (Florida), while enrollment rates in the state based Marketplaces vary from 12% (Massachusetts, which may have been saturated due to early adoption of more inclusive insurance coverage) to 85% (Vermont).

Some of this variation in enrollment success across states is tied to difficulties during the “roll-out” of the Marketplace web sites. Enrollment suffered in states using Marketplaces with well-documented problems, including those using the federal web site Healthcare.gov (Georgia and Tennessee) and Maryland Health Connection site. Notwithstanding problems with online Marketplaces, and particularly the one in Maryland, it is important to include a counter-note regarding facilitated enrollment success achieved by Maryland Seedco Navigators despite technological difficulties. The Maryland example demonstrates the value of Navigators who can, in their own words, “think on your feet” to solve problems that arise in the context of navigation.

Another Marketplace factor that presumably affected enrollment success pertained to the number and types of insurance products from which Consumers could choose. In this evaluation, a quantitative analysis of the relationship between number of available

policies and consumer plan choice was not feasible due to unavailability of necessary data. However, information from interviews gives insight into how Consumers made decisions about plans, and the role of the number and characteristics of available policies in Consumer decision-making.

Interviews with both Consumers and Navigators indicated that plan choice is confusing or overwhelming to many people. This confusion results because understanding the differences between policies available depends on people's ability to understand insurance industry-specific concepts and terminology and to make complex decisions about unknown future benefits. These factors directly affect the complexity of the cost-benefit analysis that people must make when choosing a policy, and complexity increases with the variety of available plans and variability among plans. Even among highly educated Consumers, prior knowledge about industry-specific terms and practices was low, and this can present barriers to making an informed decision, especially when there are several different options from which to choose.

Navigators noticed a tendency among Consumers to gravitate toward the policy with the lowest monthly premium in a given Metal level (categories of plans based on actuarial value of benefits and classed as "Bronze," "Silver," "Gold," or "Platinum"), regardless of benefits. This impression is substantiated by recent policy research. According to a 2014 report released by the Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, analyses of available data on plan selections in federally facilitated Marketplace states indicates that within each metal level, Consumers tended to select the plan with the lowest premium (ASPE 2014). Lowest premium plans are not always the least expensive insurance options however, especially as low premiums are generally linked to high deductibles.

A study by Ericson and Stark (2012) based on data from the Massachusetts Connector benefits exchange indicates that Consumers have difficulty making optimal choices in a complex environment, which may result in extreme price sensitivity when choosing a benefits plan. Based on information shared by Consumers and Navigators, it seems as though, in the face of a very complex and unfamiliar comparison, as well as uncertainty about their future health care needs (and thus uncertainty about the future "value" or "utility" that will be derived from any particular plan), Consumers resort to a heuristic (a cognitive "rule" that guides decision-making in the face of complexity) (Tversky and Kahneman 1974) that they use regularly when shopping for other goods and services: an immediate cost comparison. This rationale may be particularly pertinent to Consumers who seek enrollment due to a desire to avoid "punishment" (fines) for being uninsured, rather than out of a desire to reduce future financial and health risk or lower current health care costs. Consumers seem to look beyond monthly premiums in just a few circumstances: (1) when Consumers have a strong preference for coverage of particular physicians' services and (2) when Consumers have pre-existing health conditions and have a preference for generous coverage regarding known future healthcare needs. The

data do not allow a conclusion regarding the extent to which Consumers will migrate to other insurance plans.

Even though Navigators do not recommend specific choices to Consumers, the navigation process can ease the burden of decision-making in the face of complex choices. Navigators provide Consumers with the knowledge that they need to make informed decisions about packages of coverage offered in different health plans. In outreach and education sessions, Navigators distribute preparatory information or direct consumers to useful resources related to “Health Insurance 101.” In one-on-one interactions, Navigators learn of Consumers’ individual needs and can assist in plan-by-plan comparisons and explain relative costs and benefits of different plans.

## 5. RECOMMENDATIONS

Based on our analyses, we make the following recommendations around concerns of addressing disparities in Navigated enrollment, improving overall effectiveness of the Navigator program, and addressing training needs of future cohorts of Navigators.

***Continue partnering with community agencies that serve diverse populations.*** Results of this evaluation document that Seedco Navigators reached a very diverse group of Consumers in terms of age, race/ethnicity, and linguistic background. This was achieved by virtue of the wide range of community agencies that partnered with Seedco and hosted Navigators, as well as due to Navigators' high level of competence in working with a diverse Consumer base.

***Continue to facilitate in-person assistance for non-English speaking Consumers.*** Several Seedco Navigators display multilingual competence, and they were often deployed to meet needs of Consumers who preferred to speak a language other than English. Seedco also made a telephonic translation service and other resources available to Navigators to assist Consumers who preferred languages other than English. Yet Navigators need additional training and coordination to consistently meet the needs of linguistically diverse Consumers. In addition, outreach activities and informational materials should continue be available in languages other than English and in graphic form for people who may have trouble reading documents in English or who may have trouble with the complexity of information about health insurance.

***Give extra assistance, including graphic materials, to help explain insurance basics to Consumers of low health literacy.*** While many excellent print materials are available for Consumers, many still fall short in incorporating health literacy best practices. Seedco could invest in creating its own graphics-rich "pre-enrollment workbook" that might take the form of a comic book or Photonovella. In addition to handing out the workbook at education events, Navigators could use its graphics in their interactions with consumers. The pre-enrollment workbook would facilitate the assistance process because it would ask the Consumer to record her email address and password, to think about who is in her household, to gather the necessary documentation, and to reflect on her health care needs (e.g., chronic conditions that need frequent visits to a primary care provider or specialists and medications that she takes regularly).

***Continue to promote linkage to Medicaid.*** Experience in the first open enrollment period revealed the depth of the reservoir of Medicaid-eligible Consumers. Even in Seedco states that did not expand Medicaid, about one in four Consumers applied for public insurance rather than private. In Tennessee, Navigators endured several weeks in which the federal Marketplace was the primary portal to Medicaid in that state. Therefore Navigators need continuing training about Medicaid eligibility and services, and seamless connections for Medicaid enrollment need to be maintained.

**Create public awareness campaigns that build on positive Consumer response to Navigators. Create a narrative of Navigator success in the communities.** Where facilitated enrollment generated negative responses in the general population, it was often a result negative press, disproportionate media attention to problems with Marketplaces, and contentious political climates. Nearly all consumers who came to navigation with negative expectations left pleasantly surprised and feeling more educated on health insurance and ACA reforms. To become proactive in countering negative sentiments, Seedco and the government agencies operating the Marketplaces can take the lead in creating media to make sure that communities are exposed to “good news” about enrollment. One way to accomplish this may be to create events in which satisfied Consumers tell their stories at community fora. Other ways may be to create web or television advertisements or pamphlets with testimonials about positive experiences with Navigators. Also, Consumers could be encouraged to talk up their experiences with their social network (i.e., friends and family members).

**Create publicity to reach and educate people who are deferring health care.** This study determined that it was not unusual for Consumers to defer health treatments because of affordability issues. Some Consumers skipped healthcare visits with alarming frequency. These are the individuals who constitute the highest priority for outreach. Possible ways to reach them include continuing and increasing outreach at or near pharmacies, community health centers, hospitals, at recreation centers, and at technical schools.

**Help the public understand that Navigators are unbiased professionals who will protect their personal health information.** Prior to navigation encounters, some Consumers were confused about the role of Navigators and did not always differentiate them from other individuals who might be providing enrollment assistance, such as insurance agents and telephone assisters. Materials introducing Navigators should stress the uniqueness of the Navigator role, that the service is free and professional, and that Navigators’ only concern is that Consumers make the best possible insurance decisions to meet their needs. Furthermore, materials should highlight that Consumers’ personal information will be kept private and will not be shared with third parties without Consumers’ consent.

**Publicity and outreach should highlight concrete ways to access in-person assistance.** Despite much effort expended at outreach and education, many Consumers indicated that they were not aware that Navigators were available in their communities to offer in-person assistance, or that they had trouble locating a Navigator. This finding demonstrates that Navigators and their agencies need to describe in very concrete terms who Navigators are, what services they offer, how they can be reached, and that they will accommodate Consumers’ schedules. The finding that people who had trouble with independent online enrollment were not aware of Navigators indicates that the Marketplace web sites should more prominently feature messages that free and professional in-person assistance is available.

***Provide Navigators with resources to facilitate networking and mentoring with their colleagues.*** Navigators clearly voiced their desire for a way to network with their colleagues and to receive mentoring from more experienced Navigators. Seedco did create several opportunities for Navigators to meet face-to-face. And Navigators could exchange information via e-mail lists and webinars. However, Navigators were interested in more frequent interaction with their colleagues through dedicated channels. Such interaction will be especially important during future years of service, as there will be a growing cadre of veteran Navigators who have years of direct experience with the Marketplaces, and presumably a steady stream of brand new Navigators as well.

***Create a culture of documentation among Navigators. Accurately capturing information about Consumer contact and outcomes is part of their jobs.*** Seedco's efforts to create a data collection system via Salesforce are commendable. Regrettably, the early challenges of the Marketplace rollout were not conducive to detecting and eliminating systemic bugs and individual work routines that resulted in missing and inconsistent data collection. Navigators are of course focused first and foremost on providing assistance to Consumers. Therefore data collection often takes a second or even third seat in terms of allocating time and energy. Nonetheless accurate and complete data entry needs to be enforced as an expectation of their professional positions.

***Improve data collection design across Marketplaces.*** Funders, Navigator organizations and consortia, and social scientists must join together to optimize procedures to assess ACA Marketplaces and the role of assisters within them. The pages of this document attest to the deficiencies of “retrofitting” data analysis to inconsistent variable definitions and data fields that sometimes fail to capture key information. In many instances the suboptimal data design was a function of systemic factors, rather than a lack of expertise or good intent. “Enrollment success” is just one illustrative case. In the federal Marketplace, it was only possible to ascertain whether a Consumer had selected a policy or applied for coverage. The two state Marketplaces in this study, —in contrast, yielded information about whether an application had been accepted by a carrier. No centralized information has yet been provided about “effectuated enrollment,” that is, whether a Consumer had actually consummated enrollment by paying the first premium. Similarly, privacy strictures have prevented Navigator organizations from following up on Consumers who received in-person assistance. Thus it is only through the surveying of external organizations such as the Kaiser Family Foundation or Enroll America that we can even glimpse at the efficacy of Navigators in promoting success among the many Consumers who receive navigation services but then depart and complete their enrollment on their own.

***Capture data about Consumers whom Navigators touch, but who never engage in conventional in-person assistance.*** Available data sources sorely underestimate the true reach of Navigators. In the field, Navigators provide individual enrollment

counseling to many Consumers whose interactions are never documented. For example, a Consumer will sit down with a Navigator who first conducts a rapid assessment of the Consumer's eligibility. If the Consumer falls in the Medicaid gap, she will likely be referred to a list of low-cost health clinics in lieu of enrollment assistance from a Navigator. But that Consumer interaction will never be documented in the database. Likewise a Consumer who approaches a Navigator after an education or enrollment event with "just one quick question" does not get entered into the database, notwithstanding the thirty minute counseling session that ensues "on the fly." A recent Kaiser Family study estimated that during the first open enrollment period, in-person assisters spoke with 10.6 Americans. But only a fraction of those are credited on Navigator databases.

***Follow-up with Consumers to ascertain their progress to enrollment.*** Consumers spoke clearly about their need and appreciation for follow-up after receiving in-person assistance. Resolution of Consumers' issues was rarely accomplished during one navigation encounter, and follow-up is needed to determine if a Consumer who does not "succeed" in enrolling during an in-person assistance session later self-enrolls online or completes enrollment with a different assister. If it is determined that it does not violate CMS guidelines, Navigators should retain Consumer contact information and conduct periodic follow-up until they ascertain that the Consumer has received an insurance card and paid a first premium—thus completing enrollment. If the Consumer does not complete enrollment, Navigators should be authorized to provide additional assistance, including guidance about contacting the carrier or filing appeals.

***Follow-up with newly insured Consumers to assist them in maintaining and using their access to health services.*** Current regulations authorize Navigators only to conduct outreach, education, and assistance bearing on enrolling in Marketplace insurance. However, Navigators are especially well positioned to provide post-enrollment assistance to the newly insured to make sure that they are able to take advantage of their coverage. Newly insured consumers need to know about how to budget for health expenses (an estimated 15% never made their first premium payment, much less saved for co-insurance costs), how to choose a primary care provider, how to access preventive and well patient care that the ACA offers without out-of-pocket expense, how to schedule and optimize a medical visit, how to file a health insurance claim and how to appeal a denied claim. Future research should examine the extent to which Consumers who make the first premium payment drop out or not. CMS has an initiative called "Coverage to Care" (C2C) to serve some of these purposes, but at present the Navigator role excludes extensive involvement in C2C. Seedco Navigators can integrate some C2C counseling in their enrollment assistance, such as realistic discussions about how budgeting for Silver Plan expenses differs from budgeting for Gold Plan expenses. Seedco Navigators can, at minimum, make sure that Consumers depart in-person assistance with a copy of the CMS C2C "Roadmap." Coverage to Care (and related) videos can play while Consumers are waiting for in-person assistance.

## References

- Center for Medicare and Medicaid Services (CMS), 2014. Medicaid & CHIP: March 2014 Monthly Applications, Eligibility Determinations, and Enrollment Report, Baltimore, MD. <http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/March-2014-Enrollment-Report.pdf>
- Ericson, K.M. & Starc, A. 2012. Heuristics and heterogeneity in health insurance exchanges: evidence from the Massachusetts Connector. *American Economic Review*, 102, 493-497.
- The Henry J. Kaiser Family Foundation, 2013a. State Health Insurance Marketplace Profiles. The Henry J. Kaiser Family Foundation, Menlo Park, CA. <http://kff.org/state-health-marketplace-profiles/>
- The Henry J. Kaiser Family Foundation (Kaiser), 2013b. Medicaid eligibility for adults as of January 1, 2014. The Kaiser Commission on Medicaid and the Uninsured, Menlo Park, CA. <http://kff.org/medicaid/fact-sheet/medicaid-eligibility-for-adults-as-of-january-1-2014/>
- The Henry J. Kaiser Family Foundation (Kaiser), 2013c. Characteristics of poor uninsured adults who fall into the coverage gap. The Henry J. Kaiser Family Foundation, Menlo Park, CA. <http://kff.org/health-reform/issue-brief/characteristics-of-poor-uninsured-adults-who-fall-into-the-coverage-gap/>
- The Henry J. Kaiser Family Foundation (Kaiser), 2014. How will the uninsured in Georgia fare under the Affordable Care Act? The Henry J. Kaiser Family Foundation, Menlo Park, CA. <http://kff.org/health-reform/fact-sheet/state-profiles-uninsured-under-aca-georgia/>
- Levitt, L. & Damico, A., 2013. The numbers behind "Young Invincibles" and the Affordable Care Act. The Henry J. Kaiser Family Foundation. Menlo Park, CA. <http://kff.org/health-reform/perspective/the-numbers-behind-young-invincibles-and-the-affordable-care-act/>
- MHBE, 2014. The Maryland Health Benefits Exchange, <http://www.marylandhbe.com>.
- National Federation of Independent Business, et al. v. Kathleen Sebelius, Secretary of Health and Human Services, et al., 2012. United States Reports.
- National Conference of State Legislatures (NCSL), 2014. Health insurance exchanges or marketplaces: state profiles and actions, Washington D.C., pp. 59. [http://www.ncsl.org/Portals/1/Documents/Health/Health\\_Insurance\\_Exchanges\\_State\\_Profiles.pdf](http://www.ncsl.org/Portals/1/Documents/Health/Health_Insurance_Exchanges_State_Profiles.pdf)



- Office of the Assistant Secretary for Planning and Evaluation (ASPE), 2014. Health Insurance Marketplace: summary enrollment report for the initial annual open enrollment period, Washington D.C.  
[http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib\\_2014apr\\_enrollment.pdf](http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014apr_enrollment.pdf)
- Patton, M. Q. (2001). *Qualitative evaluation and research methods* (3rd ed.). Newbury Park, CA: Sage Publications.
- Polisky, D.E., Weiner, J., Colameco, C., & Becker, N., 2014. Deciphering the data: final enrollment rates show that federally run marketplaces make up lost ground at end of open enrollment. The Robert Wood Johnson Foundation, Philadelphia, PA.  
[http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2014/rwjf411792](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf411792)
- Seedco, 2014. About us, <http://www.seedco.org>.
- Tversky, A. & Kahneman, D. 1974. Judgement under uncertainty" heuristics and biases. *Science*, 185, 1124-1131.
- Ulin, Priscilla R., Robinson, Elizabeth T., & Tolley, Elizabeth E. (2005). *Qualitative methods in public health: a field guide for applied research*. New York: Jossey-Bass.

## **APPENDICES TO THE REPORT**

## Appendix A: Tables referenced in text

Table 1.1—Variables collected with Maryland Consumers using Salesforce survey application	
<u>“Household members” datasheet</u>	<u>“Head of household” datasheet</u>
Household identification number	Household identification number
Enrollment status	Enrollment status
Date of Birth	Head of Household Annual Income
Individual's Total Annual Income	Total Annual Household Income
Zip code	Zip code
Hispanic/Latino Ethnicity	Health literacy screener <sup>a</sup>
Race (includes “Hispanic”)	Health visits in past year <sup>b</sup>
Preferred language	Care deferred due to cost <sup>c</sup>
American Indian/Alaskan Native Ethnicity	Monthly Financial Situation <sup>d</sup>
Sex	
Citizenship Status	
Disability Status	
Enrollment Type	
Eligible for premium tax credit?	
Eligible for cost sharing reduction?	
<sup>a</sup> Health literacy was assessed based on Consumers’ responses to a screening item that asked “How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?” Consumers could choose from “Always,” “Often,” “Sometimes,” “Rarely,” and “Never.”	
<sup>b</sup> Consumers were asked to recall the number of healthcare visits they had made in the past year.	
<sup>c</sup> Consumers were asked how frequently in the past year they delayed healthcare visits due to cost.	
<sup>d</sup> Consumers who completed Salesforce Surveys had five categorical options from which to choose in response to the survey item that asked, “What is your monthly financial situation?” Possible responses included the following: I don’t know; I come up short and I sometimes have to borrow money from friends or relatives to make ends meet; I come up short and sometimes use my credit card or take on other debt to make ends meet; I have money left over that I can either save or spend on things I want; I just break even after paying my expenses and buying what I need. Participants were also free to decline response.	

**Table 1.2—Variables collected from Maryland Consumers using Salesforce survey application**

<b><u>“Household members” datasheet</u></b>	<b><u>“Head of household” datasheet</u></b>
Household identification number	Household identification number
Status	Total Household Count
Date of birth	Total Household Income
Household member income	Date of Birth
Citizenship status	Head of Household Status
Zip code	Head of Household Income
Type of Coverage	Citizenship Status
Carrier/insurer	Preferred Language
Metal level	Zip code
Dental coverage	Health literacy screener
Cost Sharing Reduction	Health visits in past year
Advanced Premium Tax Credit	Care deferred due to cost
	Monthly Financial Situation
	Carrier
	Type of Coverage
	Metal Level
	Advanced Premium Tax Credit
	Cost Sharing Reduction
	Dental Coverage
	American Indian or an Alaskan Native # *
	Asian # *
	Black or African American # *
	Native Hawaiian # *
	Other Pacific Islander # *
	White # *
	Other/No Response # *
	Ethnicity: Hispanic/Latino # *
	Ethnicity: Not Hispanic or Latino # *
	Male # *
	Female # *
	Transgender # *
	Other Sex/No Response # *
<p><i>* Variables marked with an asterisk were collected on the level of number per household, making it impossible for analysts to attribute characteristics to the individual Consumer unless the household was homogenous in terms of race/ethnicity/sex.</i></p>	

**Table 1.3—Variables collected with Georgia and Tennessee Consumers using Salesforce survey application**

Zip code (first three digits only)
Gender
Age group
Household size
Disability in Household?
Race (not incl. Hispanic)
Hispanic/Latino Ethnicity
Preferred language
Agree to provide info/consent
Health literacy screener
Health visits in past year
Care deferred due to cost
Monthly Financial Situation
Was enrollment assistance provided?
Applying for APTCs and CSRs
Applying for Medicaid/CHIP enrollment?
Complete an application?
QHP selection (Y/N)
QHP selected
Metal Level
Submit an application?
Decline to submit an application?
Initial Navigator assistance?
Number of assistance requests
Number of telephone or internet sessions
Need assistance after enrollment?
Referred to other programs?
Consumer too high income for Medicaid and too low income for APTC' or CSR's? (Y/N)

**Table 2.1—Affordable Care Act enrollment totals for the 2013-2014 open enrollment period\***

	<b>Marketplace QHPs</b>	<b>Public coverage</b>
Georgia	316,543	98,843
Maryland	67,757	236,112
New York	370,451	343,835
Tennessee	151,352	53,665

\*Source: ASPE Marketplace Summary Enrollment Report (2014) and the CMS March Medicaid/CHIP Enrollment Report (2014).

**Table 2.2—Contact information for Navigators received by the UGA project team and Seedco-affiliated agencies in each state**

<b>Georgia (n=19)</b>	<b>Maryland (n=22)</b>	<b>New York (n=15)</b>	<b>Tennessee (n=17)</b>
Parent to Parent (n=3)	Eastern Shore Area Health Education Center (n=6)	Food Bank of New York (n=5)	Knoxville Project Access (n=4)
Quality Med-Care (n=3)	Harford County Health Department (n=5)	Chinese-American Planning Council (n=2)	Family and Children's Services – Middle Tennessee (n=3)
The Health Initiative (n=3)	Choptank Community Health System (n=3)	Gay Men's Health Crisis (GMHC) (n=2)	Jefferson Street Missionary Baptist Church (n=3)
Emory-Grady Urban Health Initiative (n=2)	Harford Community Action Agency (n=3)	Seedco (n=2)	Medical Foundation of Chattanooga (n=3)
Boat People SOS (n=1)	Triangle Health Alliance (n=3)	Council of Peoples Organization (n=1)	Appalachian Mountain Project Access (n=2)
Center for Black Women's Wellness (n=1)	Carroll County Health Department (n=2)	Cypress Hills Local Development Corporation (n=1)	Easter Seals of Tennessee (n=2)
Georgia Refugee Health and Mental Health (n=1)		St. Nicks Alliance (n=1)	BRIDGES (n=1)
Georgians for a Healthy Future (n=1)		Urban Upbound (n=1)	Community Development Council (n=1)
Healthy Mothers Healthy Babies (n=1)			Porter Leath (n=1)
Latin American Association (n=1)			
Mental Health America of Georgia (n=1)			
Spring Creek (n=1)			

**Table 2.3—Socio-demographic characteristics and pertinent themes addressed in telephone interviews**

<b>Consumers</b>	<b>Navigators</b>
State of residence and zip code	State of residence and zip code
Year of birth	Year of birth
Sex/gender	Sex/gender
Race/ethnicity	Race/ethnicity
Household size (adults and children)	Household size (adults and children)
Current employment and duration; ever insured through employer?	Employment history in insurance industry or healthcare?
Estimated annual income	Estimated annual income
Navigation status & outcome/ Follow-up with Navigator	Average number of Consumers assisted per week during open enrollment
Health history and insurance history/ chronic health problems/medication?	Description of the work of a Navigator & specific work of interviewee
Experience being uninsured	Reasons for becoming a Navigator
Knowledge prior to Navigation	Particular populations served & needs
Actions taken prior to Navigation	Experience of training
Experience of Navigation	Training needs/gaps for Navigators
Comments on Navigator practice	Outreach activities
Characteristics of communication with the Navigator	Factors of good communication; Communication and best practice strategies
Actions and progress post-Navigation	Barriers and facilitators to enrolling Consumers/ working as Navigator
Barriers and facilitators to Navigation and enrollment	Barriers and facilitators experienced by Consumers
Recommendations for program improvement	Useful resources for Navigators & needed resources (materials, support, etc.)
Continuing concerns regarding enrollment	Concerns for Navigator program going forward
Concerns regarding broader issues	Concerns for broader issues going forward

Table 3.1—Demographic profile of all Consumers captured in Salesforce surveys						
	Georgia (n=2,840)	Maryland (n=6,130)	New York (n=3,279)	Tennessee (n=1,187)	GA or TN* (n=1,418)	Total (n=14,584)
<b>Sex/gender</b>						
Women	1656	3016	651	713	819	6855
Men	1084	2692	737	438	534	5485
Transgender	11	0	1	0	4	16
<b>Age group</b>						
0-17 years	8	800	361	2	1	1172
18-25 years	200	583	338	48	48	1217
26-34 years	399	611	393	98	100	1601
35-45 years	652	1907	405	195	130	3289
46-55 years	631	1297	488	261	139	2816
56-65 years	535	119	555	376	191	1776
65+ years	11	0	89	6	8	114
<b>Race/ethnicity</b>						
Amer. Indian	7	2	0	10	3	22
Asian	367	291	514	46	45	1263
Black/African American	1268	1350	474	408	515	4015
Hispanic	NA	265	NA	NA	NA	265
White	851	3622	181	458	332	5444
Other/unknown	256	600	1762	258	490	3366
<b>Hispanic ethnicity</b>	139	269	557	17	36	1018
<b>Language</b>						
Chinese	--	2	291	--	--	293
English	1219	5874	1363	770	1107	10333
Other	392	7	93	18	31	541
Spanish	192	104	289	8	48	641
Vietnamese	0	6	0	0	0	6



Table 3.2—Demographic profile of Consumers who applied for/selected coverage* or enrolled in coverage, by state						
	Georgia (n=610*)	Maryland (n=4,235)	New York (n=1,356)	Tennessee (n=510*)	GA or TN (n=319*)	Total (n=6,660)
<b>Sex/gender</b>						
Women	388*	2164	333	311*	185*	3381
Men	263*	1869	392	189*	108*	2821
Transgender	1*	0-	0	0*	1*	2
<b>Age group</b>						
0-17 years	0*	386	107	0*	0*	493
18-25 years	29*	456	141	20*	12*	658
26-34 years	66*	463	181	47*	40*	797
35-45 years	162*	1491	174	99*	50*	1976
46-55 years	170*	1021	191	120*	41*	1543
56-65 years	140*	15	186	178*	60*	579
65+ years	3*	0	13	2*	1*	19
<b>Race/ethnicity</b>						
American Indian	2*	2	0	1*	1*	6
Asian	84*	202	80	19*	23*	408
Black/African American	312*	962	306	209*	150*	1939
Hispanic	NA*	158	NA	NA*	NA*	158
White	179*	2626	111	167*	65*	3148
Other/unknown	0*	285	639	2*	0*	926
<b>Hispanic ethnicity</b>						
	49*	161	346	8*	10*	574
<b>Language</b>						
Chinese	0*	2	3	0*	0*	5
English	289*	4155	743	363*	216*	5766
Other	92*	4	60	11*	20*	187
Spanish	55*	54	172	5*	13*	299
Vietnamese	0*	6	0	0*	0*	6
*Marked records indicate that the Consumers either applied for public coverage or selected a QHP. Unmarked records indicate that Consumers successfully enrolled in health coverage (public or private).						

**Table 3.3—Demographic profile of enrollment status in Maryland**

	<b>Enrolled</b> (n=4235)	<b>Applied</b> (n=233)	<b>Active</b> (n=75)	<b>Inactive</b> (n=1107)	<b>Lead</b> (n=477)	<b>Total</b> (n=6127)
<b>Sex/gender</b>						
<i>Women</i>	2164	122	33	508	189	3016
<i>Men</i>	1869	99	26	536	159	2689
<i>Transgender</i>	0	0	0	0	0	0
<b>Age group</b>						
<i>0-17 years</i>	386	15	7	349	41	798
<i>18-25 years</i>	456	18	6	74	29	583
<i>26-34 years</i>	463	28	3	74	42	610
<i>35-45 years</i>	1491	79	15	223	99	1907
<i>46-55 years</i>	1021	53	16	129	78	1297
<i>56-65 years</i>	15	5	2	88	9	119
<i>65+ years</i>	0	0	0	0	0	0
<b>Race/ethnicity</b>						
<i>American Indian</i>	2	0	0	0	0	2
<i>Asian</i>	185	13	2	51	16	267
<i>Black/African American</i>	962	34	9	250	93	1348
<i>Hispanic</i>	154	6	0	90	6	256
<i>White</i>	2626	166	45	609	175	3621
<i>Other/unknown</i>	21	1	0	7	4	33
<b>Hispanic ethnicity</b>	161	6	0	92	10	269
<b>Language</b>						
<i>Chinese</i>	2	0	0	0	0	2
<i>English</i>	4155	230	54	1060	373	5872
<i>Other</i>	4	0	1	1	1	7
<i>Spanish</i>	54	2	0	29	19	104
<i>Vietnamese</i>	6	0	0	0	0	6

**Table 3.4—Demographic profile of enrollment status in New York**

	<b>Enrolled</b> (n=1356)	<b>Applied</b> (n=375)	<b>Active</b> (n=512)	<b>Inactive</b> (n=365)	<b>Lead</b> (n=671)	<b>Total</b> (n=3279)
<b>Sex/gender</b>						
<i>Women</i>	333	65	150	34	69	651
<i>Men</i>	392	68	159	29	89	737
<i>Transgender</i>	0	1	0	0	0	1
<b>Age group</b>						
<i>0-17 years</i>	107	58	30	93	73	361
<i>18-25 years</i>	141	31	43	51	72	338
<i>26-34 years</i>	181	47	49	29	87	393
<i>35-45 years</i>	174	64	69	27	71	405
<i>46-55 years</i>	191	41	98	40	118	488
<i>56-65 years</i>	186	23	156	34	156	555
<i>65+ years</i>	13	6	26	21	23	89
<b>Race/ethnicity</b>						
<i>American Indian</i>	0	0	0	0	0	0
<i>Asian</i>	79	25	244	20	144	512
<i>Black/African American</i>	306	54	29	26	59	474
<i>Hispanic</i>	NA	NA	NA	NA	NA	NA
<i>White</i>	111	27	24	4	15	181
<i>Other/unknown</i>	1	1	0	0	0	2
<b>Hispanic ethnicity</b>	346	78	31	32	70	557
<b>Language</b>						
<i>Chinese</i>	3	0	171	17	100	291
<i>English</i>	743	175	167	60	218	1363
<i>Other</i>	60	20	3	2	8	93
<i>Spanish</i>	172	39	16	18	44	289
<i>Vietnamese</i>	0	0	0	0	0	0

**Table 3.5—Demographic profile of Consumers who either applied for public coverage or selected QHP in Georgia**

	<b>Applied/selected</b> (n=610)	<b>Not applied/selected</b> (n=934)	<b>Total</b> (n=1544)
<b>Sex/gender</b>			
<i>Women</i>	354	559	913
<i>Men</i>	224	345	569
<i>Transgender</i>	1	3	4
<b>Age group</b>			
<i>0-17 years</i>	0	2	2
<i>18-25 years</i>	27	49	76
<i>26-34 years</i>	61	129	190
<i>35-45 years</i>	147	208	355
<i>46-55 years</i>	164	240	404
<i>56-65 years</i>	134	240	374
<i>65+ years</i>	3	4	7
<b>Race/ethnicity</b>			
<i>American Indian</i>	2	2	4
<i>Asian</i>	56	55	111
<i>Black/African American</i>	281	508	789
<i>Hispanic</i>	NA	NA	NA
<i>White</i>	174	287	461
<i>Other/unknown</i>	0	0	0
<b>Hispanic ethnicity</b>	45	37	82
<b>Language</b>			
<i>Chinese</i>	0	0	0
<i>English</i>	273	548	821
<i>Other</i>	51	28	79
<i>Spanish</i>	47	43	90
<i>Vietnamese</i>	0	0	0

**Table 3.6—Demographic profile of Consumers who either applied for public coverage or selected QHP in Tennessee**

	<b>Applied/selected</b> (n=478)	<b>Not applied/selected</b> (n=433)	<b>Total</b> (n=911)
<b>Sex/gender</b>			
<i>Women</i>	290	267	557
<i>Men</i>	180	161	341
<i>Transgender</i>	0	0	0
<b>Age group</b>			
<i>0-17 years</i>	0	2	2
<i>18-25 years</i>	18	16	34
<i>26-34 years</i>	43	30	73
<i>35-45 years</i>	95	62	157
<i>46-55 years</i>	115	113	228
<i>56-65 years</i>	168	152	320
<i>65+ years</i>	2	4	6
<b>Race/ethnicity</b>			
<i>American Indian</i>	1	7	8
<i>Asian</i>	18	17	35
<i>Black/African American</i>	200	141	341
<i>Hispanic</i>	NA	NA	NA
<i>White</i>	157	203	360
<i>Other/unknown</i>	2	0	2
<b>Hispanic ethnicity</b>	7	6	13
<b>Language</b>			
<i>Chinese</i>	0	0	0
<i>English</i>	345	308	653
<i>Other</i>	10	3	13
<i>Spanish</i>	4	2	6
<i>Vietnamese</i>	0	0	0

**Table 3.7—Demographic profile of Consumers who either applied for public coverage or selected QHP in Georgia or Tennessee combined**

	<b>Applied/selected</b> (n=253)	<b>Not applied/selected</b> (n=237)	<b>Total</b> (n=490)
<b>Sex/gender</b>			
<i>Women</i>	149	141	290
<i>Men</i>	79	89	168
<i>Transgender</i>	1	0	1
<b>Age group</b>			
<i>0-17 years</i>	0	0	0
<i>18-25 years</i>	10	13	23
<i>26-34 years</i>	36	27	63
<i>35-45 years</i>	48	36	84
<i>46-55 years</i>	38	42	80
<i>56-65 years</i>	49	56	105
<i>65+ years</i>	0	2	2
<b>Race/ethnicity</b>			
<i>American Indian</i>	1	1	2
<i>Asian</i>	21	3	24
<i>Black/African American</i>	133	137	270
<i>Hispanic</i>	NA	NA	NA
<i>White</i>	52	48	100
<i>Other/unknown</i>	0	0	0
<b>Hispanic ethnicity</b>	9	12	21
<b>Language</b>			
<i>Chinese</i>	0	0	0
<i>English</i>	163	160	323
<i>Other</i>	19	1	20
<i>Spanish</i>	8	16	24
<i>Vietnamese</i>	0	0	0

**Table 3.8—Type of coverage (public or private) which Consumers applied for/selected\* or enrolled, all states**

	<b>Georgia*</b>	<b>Maryland</b>	<b>New York</b>	<b>Tennessee*</b>	<b>GA or TN*</b>	<b>All states</b>
	(n=685)	(n=4,596)	(n=1,953)	(n=510)	(n=319)	(n=8,063)
Public	167	2,564	1,371	193	85	4380
Private	518	2,032	582	317	234	3683

**Table 3.9—Demographic profile of enrollment type in Georgia**

	<b>Public</b>	<b>Private</b>	<b>Total</b>
	(n=167)	(n=518)	(n=685)
<b>Sex/gender</b>			
<i>Women</i>	103	285	388
<i>Men</i>	60	203	263
<i>Transgender</i>	0	1	1
<b>Age group</b>			
<i>0-17 years</i>	0	0	0
<i>18-25 years</i>	6	23	29
<i>26-34 years</i>	18	48	66
<i>35-45 years</i>	56	106	162
<i>46-55 years</i>	49	121	170
<i>56-65 years</i>	22	118	140
<i>65+ years</i>	1	2	3
<b>Race/ethnicity</b>			
<i>American Indian</i>	0	2	2
<i>Asian</i>	14	70	84
<i>Black/African American</i>	82	230	312
<i>Hispanic</i>	NA	NA	NA
<i>White</i>	49	130	179
<i>Other/unknown</i>	0	0	00
<b>Hispanic</b>	17	32	49
<b>Language</b>			
<i>Chinese</i>	0	0	0
<i>English</i>	108	181	289
<i>Other</i>	8	84	92
<i>Spanish</i>	18	37	55
<i>Vietnamese</i>	0	0	0

**Table 3.10—Demographic profile of enrollment type in Maryland**

	<b>Public</b> (n=2564)	<b>Private</b> (n=2032)	<b>Total</b> (n=4596)
<b>Sex/gender</b>			
<i>Women</i>	1242	1124	2366
<i>Men</i>	1184	835	2019
<i>Transgender</i>	0	0	0
<b>Age group</b>			
<i>0-17 years</i>	422	52	474
<i>18-25 years</i>	356	133	489
<i>26-34 years</i>	282	221	503
<i>35-45 years</i>	793	820	1613
<i>46-55 years</i>	462	610	1072
<i>56-65 years</i>	7	14	21
<i>65+ years</i>	0	0	0
<b>Race/ethnicity</b>			
<i>American Indian</i>	2	0	2
<i>Asian</i>	92	99	191
<i>Black/African American</i>	684	356	1040
<i>Hispanic</i>	68	99	167
<i>White</i>	1507	1367	2874
<i>Other/unknown</i>	9	15	24
<b>Hispanic ethnicity</b>	74	101	175
<b>Language</b>			
<i>Chinese</i>	2	0	2
<i>English</i>	2526	1990	4516
<i>Other</i>	4	0	4
<i>Spanish</i>	25	34	59
<i>Vietnamese</i>	3	3	6



**Table 3.11—Demographic profile of coverage type in New York**

	<b>Public</b> (n=1371)	<b>Private</b> (n=582)	<b>Total</b> (n=1953)
<b>Sex/gender</b>			
<i>Women</i>	349	171	520
<i>Men</i>	402	192	594
<i>Transgender</i>	0	0	0
<b>Age group</b>			
<i>0-17 years</i>	147	2	149
<i>18-25 years</i>	162	27	189
<i>26-34 years</i>	180	86	266
<i>35-45 years</i>	176	80	256
<i>46-55 years</i>	183	120	303
<i>56-65 years</i>	217	149	366
<i>65+ years</i>	31	5	36
<b>Race/ethnicity</b>			
<i>American Indian</i>	0	0	0
<i>Asian</i>	290	170	460
<i>Black/African American</i>	274	89	363
<i>Hispanic</i>	NA	NA	NA
<i>White</i>	83	61	144
<i>Other/unknown</i>	0	1	1
<b>Hispanic ethnicity</b>	263	137	400
<b>Language</b>			
<i>Chinese</i>	144	113	257
<i>English</i>	671	302	973
<i>Other</i>	67	15	82
<i>Spanish</i>	123	68	191
<i>Vietnamese</i>	0	0	0

**Table 3.12—Demographic profile of enrollment type in Tennessee**

	<b>Public</b> (n=193)	<b>Private</b> (n=317)	<b>Total</b> (n=510)
<b>Sex/gender</b>			
<i>Women</i>	111	200	311
<i>Men</i>	77	112	189
<i>Transgender</i>			
<b>Age group</b>			
<i>0-17 years</i>	0	0	0
<i>18-25 years</i>	15	5	20
<i>26-34 years</i>	24	23	47
<i>35-45 years</i>	55	44	99
<i>46-55 years</i>	39	81	120
<i>56-65 years</i>	44	134	178
<i>65+ years</i>	2	0	2
<b>Race/ethnicity</b>			
<i>American Indian</i>	0	1	1
<i>Asian</i>	8	11	19
<i>Black/African American</i>	52	157	209
<i>Hispanic</i>	NA	NA	NA
<i>White</i>	78	89	167
<i>Other/unknown</i>	0	2	2
<b>Hispanic ethnicity</b>	6	2	8
<b>Language</b>			
<i>Chinese</i>	0	0	0
<i>English</i>	123	240	363
<i>Other</i>	8	3	11
<i>Spanish</i>	5	0	5
<i>Vietnamese</i>	0	0	0

**Table 3.13—Demographic profile of enrollment type in Georgia or Tennessee (indeterminate)**

	<b>Public</b> (n=85)	<b>Private</b> (n=234)	<b>Total</b> (n=319)
<b>Sex/gender</b>			
<i>Women</i>	81	228	309
<i>Men</i>	4	6	10
<i>Transgender</i>	0	0	0
<b>Age group</b>			
<i>0-17 years</i>	0	0	0
<i>18-25 years</i>	3	9	12
<i>26-34 years</i>	7	33	40
<i>35-45 years</i>	12	38	50
<i>46-55 years</i>	9	32	41
<i>56-65 years</i>	8	52	60
<i>65+ years</i>	1	0	1
<b>Race/ethnicity</b>			
<i>American Indian</i>	0	1	1
<i>Asian</i>	2	21	23
<i>Black/African American</i>	40	110	150
<i>Hispanic</i>	NA	NA	NA
<i>White</i>	15	50	65
<i>Other/unknown</i>	0	0	0
<b>Hispanic ethnicity</b>	4	6	10
<b>Language</b>			
<i>Chinese</i>	0	0	0
<i>English</i>	61	155	216
<i>Other</i>	2	18	20
<i>Spanish</i>	5	8	13
<i>Vietnamese</i>	0	0	0

**Table 3.14—Participants (for whom data were recorded) who applied for\* or qualified for Advanced Premium Tax Credits/Cost Sharing Reductions, all states**

	<b>Georgia*</b>	<b>Maryland</b>	<b>New York</b>	<b>Tennessee*</b>	<b>GA or TN*</b>	<b>All states</b>
	(n=1,955)	(n=2,000)	(n=597)	(n=997)	(n=678)	(n=6,227)
No	595	467	140	207	157	1,566
Yes	1,360	1,533	457	790	521	4,661

**Table 3.15—Demographic profile of qualification for APTCs and CSRs in Georgia**

<b>Qualified?</b>	<b>Yes</b>	<b>No</b>	<b>Total</b>
	(n=1360)	(n=595)	(n=1955)
<b>Sex/gender</b>			
<i>Women</i>	736	390	1126
<i>Men</i>	563	192	755
<i>Transgender</i>	3	1	4
<b>Age group</b>			
<i>0-17 years</i>	0	2	2
<i>18-25 years</i>	47	39	86
<i>26-34 years</i>	168	67	235
<i>35-45 years</i>	339	120	459
<i>46-55 years</i>	295	166	461
<i>56-65 years</i>	287	155	442
<i>65+ years</i>	2	5	7
<b>Race/ethnicity</b>			
<i>American Indian</i>	5	0	5
<i>Asian</i>	258	17	275
<i>Black/African American</i>	586	344	930
<i>Hispanic</i>	NA	NA	NA
<i>White</i>	343	172	515
<i>Other/unknown</i>	0	0	0
<b>Hispanic ethnicity</b>	72	25	97
<b>Language</b>			
<i>Chinese</i>	0	0	0
<i>English</i>	504	418	922
<i>Other</i>	278	4	282
<i>Spanish</i>	108	25	133
<i>Vietnamese</i>	0	0	0

**Table 3.16—Demographic profile of qualification for APTCs and CSRs in Maryland**

<b>Qualified?</b>	<b>Yes</b>	<b>No</b>	<b>Total</b>
	(n=1533)	(n=467)	(n=2000)
<b>Sex/gender</b>			
<i>Women</i>	863	229	1092
<i>Men</i>	623	224	847
<i>Transgender</i>	0	0	0
<b>Age group</b>			
<i>0-17 years</i>	36	131	167
<i>18-25 years</i>	105	34	139
<i>26-34 years</i>	157	54	211
<i>35-45 years</i>	625	124	749
<i>46-55 years</i>	465	93	558
<i>56-65 years</i>	9	17	26
<i>65+ years</i>	0	0	0
<b>Race/ethnicity</b>			
<i>American Indian</i>	0	0	0
<i>Asian</i>	82	38	120
<i>Black/African American</i>	237	76	313
<i>Hispanic</i>	76	21	97
<i>White</i>	1078	325	1403
<i>Other/unknown</i>	11	1	12
<b>Hispanic ethnicity</b>	77	22	99
<b>Language</b>			
<i>Chinese</i>	0	0	0
<i>English</i>	1503	465	1968
<i>Other</i>	0	0	0
<i>Spanish</i>	24	2	26
<i>Vietnamese</i>	3	0	3

**Table 3.17—Demographic profile of qualification for APTCs and CSRs in New York**

<b>Qualified?</b>	<b>Yes</b>	<b>No</b>	<b>Total</b>
	(n=457)	(n=140)	(n=597)
<b>Sex/gender</b>			
<i>Women</i>	123	10	133
<i>Men</i>	124	20	144
<i>Transgender</i>	0	0	0
<b>Age group</b>			
<i>0-17 years</i>	1	14	15
<i>18-25 years</i>	20	6	26
<i>26-34 years</i>	58	9	67
<i>35-45 years</i>	67	14	81
<i>46-55 years</i>	97	19	116
<i>56-65 years</i>	132	26	158
<i>65+ years</i>	5	4	9
<b>Race/ethnicity</b>			
<i>American Indian</i>	0	0	0
<i>Asian</i>	124	13	137
<i>Black/African American</i>	69	4	73
<i>Hispanic</i>	NA	NA	NA
<i>White</i>	37	12	49
<i>Other/unknown</i>	1	0	1
<b>Hispanic ethnicity</b>	91	8	99
<b>Language</b>			
<i>Chinese</i>	89	7	96
<i>English</i>	195	28	223
<i>Other</i>	10	3	13
<i>Spanish</i>	46	8	54
<i>Vietnamese</i>	0	0	0

**Table 3.18—Demographic profile of qualification for APTCs and CSRs in Tennessee**

<b>Qualified?</b>	<b>Yes</b>	<b>No</b>	<b>Total</b>
	(n=790)	(n=207)	(n=997)
<b>Sex/gender</b>			
<i>Women</i>	473	127	600
<i>Men</i>	298	77	375
<i>Transgender</i>	0	0	0
<b>Age group</b>			
<i>0-17 years</i>	1	1	2
<i>18-25 years</i>	18	18	36
<i>26-34 years</i>	62	17	79
<i>35-45 years</i>	136	34	170
<i>46-55 years</i>	189	51	240
<i>56-65 years</i>	285	56	341
<i>65+ years</i>	6	0	6
<b>Race/ethnicity</b>			
<i>American Indian</i>	6	3	9
<i>Asian</i>	23	13	36
<i>Black/African American</i>	310	54	364
<i>Hispanic</i>	NA	NA	NA
<i>White</i>	292	93	385
<i>Other/unknown</i>	2	0	2
<b>Hispanic ethnicity</b>	10	6	16
<b>Language</b>			
<i>Chinese</i>	0	0	0
<i>English</i>	564	130	694
<i>Other</i>	12	2	14
<i>Spanish</i>	7	1	8
<i>Vietnamese</i>	0	0	0

**Table 3.19—Demographic profile of qualification for APTCs and CSRs in Georgia or Tennessee (indeterminate)**

<b>Qualified?</b>	<b>Yes</b>	<b>No</b>	<b>Total</b>
	(n=521)	(n=157)	(n=678)
<b>Sex/gender</b>			
<i>Women</i>	309	95	404
<i>Men</i>	183	55	238
<i>Transgender</i>	1	1	2
<b>Age group</b>			
<i>0-17 years</i>	1	0	1
<i>18-25 years</i>	28	3	31
<i>26-34 years</i>	68	11	79
<i>35-45 years</i>	73	24	97
<i>46-55 years</i>	81	23	104
<i>56-65 years</i>	100	37	137
<i>65+ years</i>	2	0	2
<b>Race/ethnicity</b>			
<i>American Indian</i>	1	1	2
<i>Asian</i>	30	3	33
<i>Black/African American</i>	246	81	327
<i>Hispanic</i>	NA	NA	NA
<i>White</i>	113	50	163
<i>Other/unknown</i>	0	0	0
<b>Hispanic ethnicity</b>	27	2	29
<b>Language</b>			
<i>Chinese</i>	0	0	0
<i>English</i>	356	119	475
<i>Other</i>	26	0	26
<i>Spanish</i>	29	4	33
<i>Vietnamese</i>	0	0	0



**Table 3.20—Demographics of health literacy (How often do you need help reading documents?), in Georgia**

		<b>Always</b>	<b>Often</b>	<b>Sometimes</b>	<b>Rarely</b>	<b>Never</b>	<b>Total</b>
		(n=117)	(n=118)	(n=314)	(n=193)	(n=466)	(n=1208)
<b>Sex/gender</b>							
	<i>Women</i>	48	52	182	115	300	697
	<i>Men</i>	67	65	126	73	143	474
	<i>Transgender</i>	0	0	0	0	2	2
<b>Age group</b>							
	<i>0-17 years</i>	0	0	0	2	0	2
	<i>18-25 years</i>	3	0	20	6	27	56
	<i>26-34 years</i>	9	2	32	34	58	135
	<i>35-45 years</i>	24	20	62	35	114	255
	<i>46-55 years</i>	16	21	70	57	115	279
	<i>56-65 years</i>	26	22	80	47	115	290
	<i>65+ years</i>	0	0	3	0	3	6
<b>Race/ethnicity</b>							
	<i>American Indian</i>	0	0	0	0	2	2
	<i>Asian</i>	62	23	29	11	11	136
	<i>Black/African American</i>	30	73	160	104	272	639
	<i>Hispanic</i>	NA	NA	NA	NA	NA	NA
	<i>White</i>	17	14	74	67	139	311
	<i>Other/unknown</i>	0	0	0	0	0	0
<b>Hispanic ethnicity</b>		3	8	27	13	21	72
<b>Language</b>							
	<i>Chinese</i>	0	0	0	0	0	0
	<i>English</i>	24	45	165	101	257	592
	<i>Other</i>	64	51	30	8	2	155
	<i>Spanish</i>	9	8	26	11	22	76
	<i>Vietnamese</i>	0	0	0	0	0	0

**Table 3.21—Demographics of health literacy (How often do you need help reading documents?), in Maryland**

		<b>Always</b>	<b>Often</b>	<b>Sometimes</b>	<b>Rarely</b>	<b>Never</b>	<b>Total</b>
		(n=12)	(n=13)	(n=70)	(n=64)	(n=228)	(n=387)
<b>Sex/gender</b>							
	<i>Women</i>	5	4	40	38	124	211
	<i>Men</i>	7	9	29	26	98	169
	<i>Transgender</i>	0	0	0	0	0	0
<b>Age group</b>							
	<i>0-17 years</i>	0	0	2	1	4	7
	<i>18-25 years</i>	1	1	5	6	15	28
	<i>26-34 years</i>	2	3	10	8	33	56
	<i>35-45 years</i>	7	5	27	30	91	160
	<i>46-55 years</i>	2	3	25	17	79	126
	<i>56-65 years</i>	0	1	0	2	2	5
	<i>65+ years</i>	0	0	0	0	0	0
<b>Race/ethnicity</b>							
	<i>American Indian</i>	0	0	0	0	0	0
	<i>Asian</i>	1	2	8	2	14	27
	<i>Black/African American</i>	2	3	15	16	54	90
	<i>Hispanic</i>	1	1	4	1	5	12
	<i>White</i>	8	7	42	43	154	254
	<i>Other/unknown</i>	0	0	0	0	0	0
<b>Hispanic ethnicity</b>		1	1	4	1	6	13
<b>Language</b>							
	<i>Chinese</i>	0	0	0	0	0	0
	<i>English</i>	11	13	68	63	226	381
	<i>Other</i>	0	0	1	0	0	1
	<i>Spanish</i>	1	0	1	1	2	5
	<i>Vietnamese</i>	0	0	0	0	0	0

**Table 3.22—Demographics of health literacy (How often do you need help reading documents?), New York**

	<b>Always</b> (n=84)	<b>Often</b> (n=92)	<b>Sometimes</b> (n=0)	<b>Rarely</b> (n=134)	<b>Never</b> (n=691)	<b>Total</b> (n=1001)
<b>Sex/gender</b>						
<i>Women</i>	22	31	0	44	241	338
<i>Men</i>	32	30	0	42	287	391
<i>Transgender</i>	0	0	0	0	1	1
<b>Age group</b>						
<i>0-17 years</i>	0	0	0	0	1	1
<i>18-25 years</i>	3	4	0	10	79	96
<i>26-34 years</i>	10	7	0	22	131	170
<i>35-45 years</i>	17	20	0	28	106	171
<i>46-55 years</i>	10	20	0	28	112	170
<i>56-65 years</i>	22	22	0	19	111	174
<i>65+ years</i>	12	7	0	1	10	30
<b>Race/ethnicity</b>						
<i>American Indian</i>	0	0	0	0	0	0
<i>Asian</i>	57	64	0	33	99	253
<i>Black/African American</i>	5	5	0	23	234	267
<i>Hispanic</i>	NA	NA	NA	NA	NA	NA
<i>White</i>	5	0	0	13	66	84
<i>Other/unknown</i>	0	0	0	1	1	2
<b>Hispanic ethnicity</b>	18	18	0	40	191	267
<b>Language</b>						
<i>Chinese</i>	25	28	0	5	41	99
<i>English</i>	15	22	0	98	560	695
<i>Other</i>	26	24	0	11	25	86
<i>Spanish</i>	18	18	0	20	64	120
<i>Vietnamese</i>	0	0	0	0	0	0

**Table 3.23—Demographics of health literacy (How often do you need help reading documents?), in Tennessee**

	<b>Always</b>	<b>Often</b>	<b>Sometimes</b>	<b>Rarely</b>	<b>Never</b>	<b>Total</b>
	(n=6)	(n=7)	(n=67)	(n=85)	(n=448)	(n=613)
<b>Sex/gender</b>						
<i>Women</i>	2	4	37	52	278	373
<i>Men</i>	4	2	30	31	162	229
<i>Transgender</i>	0	0	0	0	0	0
<b>Age group</b>						
<i>0-17 years</i>	0	0	0	0	0	0
<i>18-25 years</i>	0	1	2	2	19	24
<i>26-34 years</i>	0	2	7	9	39	57
<i>35-45 years</i>	0	0	13	10	87	110
<i>46-55 years</i>	3	0	20	23	136	182
<i>56-65 years</i>	1	4	20	39	155	219
<i>65+ years</i>	1	0	0	0	1	2
<b>Race/ethnicity</b>						
<i>American Indian</i>	1	0	0	1	3	5
<i>Asian</i>	0	1	10	2	11	24
<i>Black/African American</i>	3	2	23	41	156	225
<i>Hispanic</i>	NA	NA	NA	NA	NA	NA
<i>White</i>	1	4	26	36	198	265
<i>Other/unknown</i>	0	0	1	1	0	2
<b>Hispanic ethnicity</b>	0	0	3	1	7	11
<b>Language</b>						
<i>Chinese</i>	0	0	0	0	0	0
<i>English</i>	5	2	46	70	352	5
<i>Other</i>	0	2	5	0	2	0
<i>Spanish</i>	0	0	4	0	0	0
<i>Vietnamese</i>	0	0	0	0	0	0

**Table 3.24—Demographics of health literacy (How often do you need help reading documents?), in Georgia or Tennessee (indeterminate)**

		<b>Always</b>	<b>Often</b>	<b>Sometimes</b>	<b>Rarely</b>	<b>Never</b>	<b>Total</b>
		(n=11)	(n=9)	(n=12)	(n=25)	(n=37)	(n=94)
<b>Sex/gender</b>							
	<i>Women</i>	7	4	7	15	21	54
	<i>Men</i>	4	4	4	10	15	37
	<i>Transgender</i>	0	0	0	0	0	0
<b>Age group</b>							
	<i>0-17 years</i>	0	0	0	0	0	0
	<i>18-25 years</i>	2	0	0	5	0	7
	<i>26-34 years</i>	3	0	4	6	14	27
	<i>35-45 years</i>	2	0	5	2	14	23
	<i>46-55 years</i>	2	2	1	6	1	12
	<i>56-65 years</i>	1	4	1	3	7	16
	<i>65+ years</i>	0	0	0	0	0	0
<b>Race/ethnicity</b>							
	<i>American Indian</i>	0	0	0	0	0	0
	<i>Asian</i>	10	2	1	7	2	22
	<i>Black/African American</i>	0	0	5	12	11	28
	<i>Hispanic</i>	NA	NA	NA	NA	NA	NA
	<i>White</i>	0	1	2	2	20	25
	<i>Other/unknown</i>	0	0	0	0	0	0
<b>Hispanic ethnicity</b>		1	2	3	3	4	13
<b>Language</b>							
	<i>Chinese</i>	0	0	0	0	0	0
	<i>English</i>	0	0	2	16	11	29
	<i>Other</i>	10	2	1	4	1	18
	<i>Spanish</i>	1	6	4	3	0	14
	<i>Vietnamese</i>	0	0	0	0	0	0

**Table 3.25—Health visits in the past year, by demographic characteristic, Georgia**

	<b>None</b> (n=144)	<b>1 visit</b> (n=132)	<b>2 visits</b> (n=154)	<b>3 visits</b> (n=132)	<b>4 visits</b> (n=125)	<b>5-9 visits</b> (n=110)	<b>10+ visits</b> (n=83)	<b>Total</b> (n=880)
<b>Sex/gender</b>								
<i>Women</i>	72	81	101	92	81	79	63	569
<i>Men</i>	70	48	50	38	42	31	19	298
<i>Transgender</i>	0	0	1	0	0	0	0	1
<b>Age group</b>								
<i>0-17 years</i>	1	0	0	0	0	0	0	1
<i>18-25 years</i>	20	11	14	12	3	5	11	76
<i>26-34 years</i>	65	16	22	9	10	12	15	149
<i>35-45 years</i>	61	11	14	15	10	16	15	142
<i>46-55 years</i>	60	18	16	14	7	14	24	153
<i>56-65 years</i>	58	21	22	11	11	18	20	161
<i>65+ years</i>	22	2	1	2	1	0	2	30
<b>Race/ethnicity</b>								
<i>American Indian</i>	0	0	0	0	0	0	0	0
<i>Asian</i>	100	14	17	11	8	25	49	224
<i>Black/African American</i>	77	48	39	32	9	19	17	241
<i>Hispanic</i>	NA	NA	NA	NA	NA	NA	NA	NA
<i>White</i>	39	6	8	2	4	10	5	74
<i>Other/unknown</i>	1	0	0	0	0	0	0	1
<b>Hispanic ethnicity</b>	91	25	32	32	23	20	15	238
<b>Language</b>								
<i>Chinese</i>	60	12	10	5	2	1	1	91
<i>English</i>	226	85	89	68	47	65	49	629
<i>Other</i>	7	1	1	3	5	19	39	75
<i>Spanish</i>	42	7	10	10	14	12	7	102
<i>Vietnamese</i>	0	0	0	0	0	0	0	0

**Table 3.26—Health visits in the past year, by demographic characteristic, Maryland**

	<b>None</b> (n=93)	<b>1 visit</b> (n=61)	<b>2 visits</b> (n=78)	<b>3 visits</b> (n=51)	<b>4 visits</b> (n=29)	<b>5-9 visits</b> (n=41)	<b>10+ visits</b> (n=22)	<b>Total</b> (n=375)
<b>Sex/gender</b>								
<i>Women</i>	44	34	41	28	24	22	12	205
<i>Men</i>	46	25	36	23	5	19	10	164
<i>Transgender</i>	0	0	0	0	0	0	0	0
<b>Age group</b>								
<i>0-17 years</i>	1	2	3	0	1	0	0	7
<i>18-25 years</i>	7	6	7	2	4	0	1	27
<i>26-34 years</i>	9	11	15	7	3	5	3	53
<i>35-45 years</i>	40	25	30	22	7	17	14	155
<i>46-55 years</i>	34	17	20	19	13	16	4	123
<i>56-65 years</i>	1	0	1	1	1	1	0	5
<i>65+ years</i>	0	0	0	0	0	0	0	0
<b>Race/ethnicity</b>								
<i>American Indian</i>	0	0	0	0	0	0	0	0
<i>Asian</i>	7	8	5	1	1	3	1	26
<i>Black/African American</i>	21	14	22	13	9	5	2	86
<i>Hispanic</i>	2	1	5	0	1	3	0	12
<i>White</i>	62	37	45	36	18	30	19	247
<i>Other/unknown</i>	0	0	0	0	0	0	0	0
<b>Hispanic ethnicity</b>	2	2	5	0	1	3	0	13
<b>Language</b>								
<i>Chinese</i>	0	0	0	0	0	0	0	0
<i>English</i>	93	59	76	51	28	40	22	369
<i>Other</i>	0	0	1	0	0	0	0	1
<i>Spanish</i>	0	2	1	0	1	1	0	5
<i>Vietnamese</i>	0	0	0	0	0	0	0	0

**Table 3.27—Health visits in the past year, by demographic characteristic, New York**

	<b>None</b> (n=336)	<b>1 visit</b> (n=105)	<b>2 visits</b> (n=110)	<b>3 visits</b> (n=86)	<b>4 visits</b> (n=68)	<b>5-9 visits</b> (n=97)	<b>10+ visits</b> (n=96)	<b>Total</b> (n=898)
<b>Sex/gender</b>								
<i>Women</i>	117	46	37	35	20	26	26	307
<i>Men</i>	154	41	51	34	16	29	19	344
<i>Transgender</i>	1	0	0	0	0	0	0	1
<b>Age group</b>								
<i>0-17 years</i>	1	0	0	0	0	0	0	1
<i>18-25 years</i>	20	11	14	12	3	5	11	76
<i>26-34 years</i>	65	16	22	9	10	12	15	149
<i>35-45 years</i>	61	11	14	15	10	16	15	142
<i>46-55 years</i>	60	18	16	14	7	14	24	153
<i>56-65 years</i>	58	21	22	11	11	18	20	161
<i>65+ years</i>	22	2	1	2	1	0	2	30
<b>Race/ethnicity</b>								
<i>American Indian</i>	0	0	0	0	0	0	0	0
<i>Asian</i>	100	14	17	11	8	25	49	224
<i>Black/African</i>	77	48	39	32	9	19	17	241
<i>American</i>								
<i>Hispanic</i>	NA	NA	NA	NA	NA	NA	NA	NA
<i>White</i>	39	6	8	2	4	10	5	74
<i>Other/unknown</i>	1	0	0	0	0	0	0	1
<b>Hispanic ethnicity</b>	91	25	32	32	23	20	15	238
<b>Language</b>								
<i>Chinese</i>	60	12	10	5	2	1	1	91
<i>English</i>	226	85	89	68	47	65	49	629
<i>Other</i>	7	1	1	3	5	19	39	75
<i>Spanish</i>	42	7	10	10	14	12	7	102
<i>Vietnamese</i>	0	0	0	0	0	0	0	0



**Table 3.28—Health visits in the past year, by demographic characteristic, Tennessee**

	<b>None</b> (n=106)	<b>1 visit</b> (n=30)	<b>2 visits</b> (n=64)	<b>3 visits</b> (n=78)	<b>4 visits</b> (n=61)	<b>5-9 visits</b> (n=67)	<b>10+ visits</b> (n=65)	<b>Total</b> (n=471)
<b>Sex/gender</b>								
<i>Women</i>	65	20	41	49	36	44	41	296
<i>Men</i>	40	9	23	26	22	21	24	165
<i>Transgender</i>	0	0	0	0	0	0	0	0
<b>Age group</b>								
<i>0-17 years</i>	0	0	0	0	0	0	0	0
<i>18-25 years</i>	7	4	1	3	2	1	1	19
<i>26-34 years</i>	15	2	4	5	3	6	6	41
<i>35-45 years</i>	23	3	10	17	8	7	6	74
<i>46-55 years</i>	26	9	18	21	22	26	26	148
<i>56-65 years</i>	30	11	29	30	25	27	24	176
<i>65+ years</i>	2	0	0	0	0	0	0	2
<b>Race/ethnicity</b>								
<i>American Indian</i>	2	0	1	0	0	2	0	5
<i>Asian</i>	8	0	0	3	1	2	0	14
<i>Black/African American</i>	52	17	30	28	14	20	13	174
<i>Hispanic</i>	NA	NA	NA	NA	NA	NA	NA	NA
<i>White</i>	34	9	23	41	37	37	45	226
<i>Other/unknown</i>	2	0	0	0	0	0	0	2
<b>Hispanic ethnicity</b>	4	0	1	1	3	1	0	10
<b>Language</b>								
<i>Chinese</i>	0	0	0	0	0	0	0	0
<i>English</i>	91	29	51	58	43	59	56	387
<i>Other</i>	4	0	0	2	2	0	0	8
<i>Spanish</i>	0	0	0	0	1	0	1	2
<i>Vietnamese</i>	0	0	0	0	0	0	0	0

**Table 3.29—Health visits in the past year, by demographic characteristic, Georgia or Tennessee**

	<b>None</b>	<b>1 visit</b>	<b>2 visits</b>	<b>3 visits</b>	<b>4 visits</b>	<b>5-9 visits</b>	<b>10+ visits</b>	<b>Total</b>
	(n=12)	(n=17)	(n=18)	(n=20)	(n=14)	(n=3)	(n=1)	(n=85)
<b>Sex/gender</b>								
<i>Women</i>	5	7	12	13	9	2	0	48
<i>Men</i>	7	10	5	5	5	1	1	34
<b>Age group</b>								
<i>0-17 years</i>	0	0	0	0	0	0	0	0
<i>18-25 years</i>	2	2	0	2	0	0	0	6
<i>26-34 years</i>	5	6	4	7	1	2	1	26
<i>35-45 years</i>	1	6	7	3	5	0	0	22
<i>46-55 years</i>	3	0	2	4	1	0	0	10
<i>56-65 years</i>	0	2	4	2	4	1	0	13
<i>65+ years</i>	0	0	0	0	0	0	0	0
<b>Race/ethnicity</b>								
<i>American Indian</i>	0	0	0	0	0	0	0	0
<i>Asian</i>	3	7	7	2	0	0	0	19
<i>Black/African American</i>	0	6	5	8	8	0	0	27
<i>Hispanic</i>	NA	NA	NA	NA	NA	NA	NA	NA
<i>White</i>	7	3	4	2	4	2	1	23
<i>Other/unknown</i>	0	0	0	0	0	0	0	0
<b>Hispanic ethnicity</b>	0	1	2	7	1	0	0	11
<b>Language</b>								
<i>Chinese</i>	0	0	0	0	0	0	0	0
<i>English</i>	3	6	5	7	4	1	26	3
<i>Other</i>	2	6	6	2	0	0	16	2
<i>Spanish</i>	1	0	1	7	2	0	11	1
<i>Vietnamese</i>	0	0	0	0	0	0	0	0

**Table 3.30—How many times have you delayed a health care visit because of cost, by demographic characteristic, Georgia**

	Never	1 time	2 times	3 times	4 times	5-9 times	10+ times	Total
	(n=289)	(n=107)	(n=135)	(n=80)	(n=61)	(n=96)	(n=62)	(n=830)
<b>Sex/gender</b>								
<i>Women</i>	161	70	95	55	40	64	46	531
<i>Men</i>	125	35	37	23	21	31	13	285
<i>Transgender</i>	0	0	0	0	0	1	0	1
<b>Age group</b>								
<i>0-17 years</i>	0	0	0	0	0	0	0	0
<i>18-25 years</i>	12	9	6	7	1	5	0	40
<i>26-34 years</i>	42	13	10	7	6	7	8	93
<i>35-45 years</i>	61	29	30	12	7	21	22	182
<i>46-55 years</i>	71	20	43	26	25	29	9	223
<i>56-65 years</i>	85	28	41	25	20	29	21	249
<i>65+ years</i>	3	0	0	0	0	0	1	4
<b>Race/ethnicity</b>								
<i>American Indian</i>	1	0	0	0	0	0	0	1
<i>Asian</i>	19	11	12	4	7	3	4	60
<i>Black/African American</i>	151	60	77	50	34	61	31	464
<i>Hispanic White</i>	NA	NA	NA	NA	NA	NA	NA	NA
<i>Other/unknown</i>	92	25	33	20	14	24	27	235
<b>Hispanic ethnicity</b>	0	0	0	0	0	0	0	0
<b>Language</b>	19	8	10	5	3	3	5	53
<i>Chinese</i>	0	0	0	0	0	0	0	0
<i>English</i>	158	69	68	47	36	60	42	480
<i>Other</i>	10	7	10	4	3	1	0	35
<i>Spanish</i>	16	10	5	2	0	3	6	42
<i>Vietnamese</i>	0	0	0	0	0	0	0	0

**Table 3.31—How many times have you delayed a health care visit because of cost, by demographic characteristic, Maryland**

	Never	1 time	2 times	3 times	4 times	5-9 times	10+ times	Total
	(n=180)	(n=42)	(n=42)	(n=28)	(n=21)	(n=27)	(n=24)	(n=364)
<b>Sex/gender</b>								
<i>Women</i>	83	26	25	16	12	20	13	195
<i>Men</i>	93	16	16	11	8	7	11	162
<i>Transgender</i>	0	0	0	0	0	0	0	0
<b>Age group</b>								
<i>0-17 years</i>	3	1	1	1	0	1	0	7
<i>18-25 years</i>	9	4	3	4	2	3	2	27
<i>26-34 years</i>	29	4	7	3	4	4	3	54
<i>35-45 years</i>	75	18	15	10	9	8	13	148
<i>46-55 years</i>	60	15	13	10	5	11	6	120
<i>56-65 years</i>	1	0	2	0	1	0	0	4
<i>65+ years</i>	0	0	0	0	0	0	0	0
<b>Race/ethnicity</b>								
<i>American Indian</i>	0	0	0	0	0	0	0	0
<i>Asian</i>	10	2	2	3	1	2	2	22
<i>Black/African American</i>	46	4	12	8	4	6	8	88
<i>Hispanic</i>	6	1	1	1	0	1	1	11
<i>White</i>	117	34	27	15	15	18	13	239
<i>Other/unknown</i>	0	0	0	0	0	0	0	0
<b>Hispanic ethnicity</b>	7	1	1	1	0	1	1	12
<b>Language</b>								
<i>Chinese</i>	0	0	0	0	0	0	0	0
<i>English</i>	178	41	41	27	21	27	23	358
<i>Other</i>	0	0	1	0	0	0	0	1
<i>Spanish</i>	2	1	0	1	0	0	1	5
<i>Vietnamese</i>	0	0	0	0	0	0	0	0

**Table 3.32—How many times have you delayed a health care visit because of cost, by demographic characteristic, New York**

	Never	1 time	2 times	3 times	4 times	5-9 times	10+ times	Total
	(n=477)	(n=85)	(n=78)	(n=50)	(n=36)	(n=61)	(n=85)	(n=872)
<b>Sex/gender</b>								
<i>Women</i>	171	40	24	21	9	16	23	304
<i>Men</i>	209	26	30	20	18	20	21	344
<i>Transgender</i>	1	0	0	0	0	0	0	1
<b>Age group</b>								
<i>0-17 years</i>	0	0	0	1	0	0	0	1
<i>18-25 years</i>	35	8	9	7	3	4	14	80
<i>26-34 years</i>	79	12	14	9	6	10	15	145
<i>35-45 years</i>	87	10	8	4	5	10	17	141
<i>46-55 years</i>	88	14	12	6	4	10	14	148
<i>56-65 years</i>	85	13	13	9	6	13	16	155
<i>65+ years</i>	22	1	1	1	0	1	1	27
<b>Race/ethnicity</b>								
<i>American Indian</i>	0	0	0	0	0	0	0	0
<i>Asian</i>	136	1	2	5	3	23	40	210
<i>Black/African American</i>	122	37	29	12	12	16	14	242
<i>Hispanic</i>	NA	NA	NA	NA	NA	NA	NA	NA
<i>White</i>	47	4	7	5	3	5	1	72
<i>Other/unknown</i>	2	0	0	0	0	0	0	2
<b>Hispanic ethnicity</b>	119	19	25	22	13	8	24	230
<b>Language</b>								
<i>Chinese</i>	86	0	0	1	0	1	0	88
<i>English</i>	334	77	67	39	26	37	43	623
<i>Other</i>	7	1	1	2	4	17	32	64
<i>Spanish</i>	50	7	10	8	6	6	9	96
<i>Vietnamese</i>	0	0	0	0	0	0	0	0

**Table 3.33—How many times have you delayed a health care visit because of cost, by demographic characteristic, Tennessee**

	Never	1 time	2 times	3 times	4 times	5-9 times	10+ times	Total
	(n=167)	(n=29)	(n=41)	(n=54)	(n=46)	(n=47)	(n=57)	(n=441)
<b>Sex/gender</b>								
<i>Women</i>	113	13	23	36	27	26	35	273
<i>Men</i>	54	16	18	15	18	18	22	161
<i>Transgender</i>	0	0	0	0	0	0	0	0
<b>Age group</b>								
<i>0-17 years</i>	0	0	0	0	0	0	0	0
<i>18-25 years</i>	8	2	1	3	1	1	1	17
<i>26-34 years</i>	17	1	4	6	2	1	9	40
<i>35-45 years</i>	28	6	6	10	7	8	5	70
<i>46-55 years</i>	44	13	13	13	17	18	20	138
<i>56-65 years</i>	65	7	15	21	17	19	19	163
<i>65+ years</i>	0	0	0	0	0	0	0	0
<b>Race/ethnicity</b>								
<i>American Indian</i>	0	0	1	1	1	2	0	5
<i>Asian</i>	9	0	0	1	0	1	0	11
<i>Black/African American</i>	90	14	18	16	10	9	12	169
<i>Hispanic White</i>	NA	NA	NA	NA	NA	NA	NA	NA
<i>Other/unknown</i>	1	0	0	0	0	0	0	1
<b>Hispanic ethnicity</b>	6	1	1	0	1	0	0	9
<b>Language</b>								
<i>Chinese</i>	0	0	0	0	0	0	0	0
<i>English</i>	152	26	32	40	29	39	48	366
<i>Other</i>	6	0	1	0	0	0	0	7
<i>Spanish</i>	0	1	0	0	1	0	0	2
<i>Vietnamese</i>	0	0	0	0	0	0	0	0

**Table 3.34—How many times have you delayed a health care visit because of cost, by demographic characteristic, Georgia and Tennessee combined**

	Never	1 time	2 times	3 times	4 times	5-9 times	10+ times	Total
	(n=28)	(n=17)	(n=17)	(n=9)	(n=6)	(n=4)	(n=3)	(n=84)
<b>Sex/gender</b>								
<i>Women</i>	14	6	10	8	4	3	3	48
<i>Men</i>	13	10	6	1	2	1	0	33
<i>Transgender</i>	0	0	0	0	0	0	0	0
<b>Age group</b>								
<i>0-17 years</i>	0	0	0	0	0	0	0	0
<i>18-25 years</i>	2	2	0	2	0	0	0	6
<i>26-34 years</i>	13	4	5	2	0	1	0	25
<i>35-45 years</i>	5	5	5	2	2	2	2	23
<i>46-55 years</i>	4	1	3	3	1	0	0	12
<i>56-65 years</i>	3	2	3	0	1	1	1	11
<i>65+ years</i>	0	0	0	0	0	0	0	0
<b>Race/ethnicity</b>								
<i>American Indian</i>	0	0	0	0	0	0	0	0
<i>Asian</i>	6	8	5	1	0	0	0	20
<i>Black/African American</i>	6	4	3	6	5	1	3	28
<i>Hispanic White</i>	NA	NA	NA	NA	NA	NA	NA	NA
<i>Other/unknown</i>	12	3	2	0	1	3	0	21
<b>Hispanic ethnicity</b>	0	0	0	0	0	0	0	0
<b>Language</b>	2	2	5	2	0	0	0	11
<i>Chinese</i>	0	0	0	0	0	0	0	0
<i>English</i>	10	3	5	5	3	1	27	10
<i>Other</i>	4	7	5	1	0	0	17	4
<i>Spanish</i>	0	2	6	2	0	0	10	0
<i>Vietnamese</i>	0	0	0	0	0	0	0	0

**Table 3.35—What is your monthly financial situation, by demographic characteristics, Georgia**

	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>	<b>F</b>	<b>Total</b>
	(n=338)	(n=285)	(n=83)	(n=92)	(n=418)	(n=0)	(n=1216)
<b>Sex/gender</b>							
<i>Women</i>	146	190	49	55	275	0	715
<i>Men</i>	170	92	31	34	140	0	467
<i>Transgender</i>	2	0	1	0	0	0	3
<b>Age group</b>							
<i>0-17 years</i>	2	0	0	0	0	0	2
<i>18-25 years</i>	29	23	4	5	13	0	74
<i>26-34 years</i>	55	31	9	19	39	0	153
<i>35-45 years</i>	82	76	17	20	94	0	289
<i>46-55 years</i>	92	73	21	17	111	0	314
<i>56-65 years</i>	58	75	28	21	136	00	318
<i>65+ years</i>	3	0	0	0	3	0	6
<b>Race/ethnicity</b>							
<i>American Indian</i>	1	0	1	0	1	0	3
<i>Asian</i>	12	21	4	13	30	0	80
<i>Black/African American</i>	208	180	46	52	217	0	703
<i>Hispanic</i>	NA	NA	NA	NA	NA	NA	NA
<i>White</i>	100	64	26	21	132	0	343
<i>Other/unknown</i>	0	0	0	0	0	0	0
<b>Hispanic ethnicity</b>	8	7	3	3	43	0	64
<b>Language</b>							
<i>Chinese</i>							
<i>English</i>	146	199	59	44	212	0	660
<i>Other</i>	2	14	1	10	20	0	47
<i>Spanish</i>	5	8	1	0	31	0	45
<i>Vietnamese</i>	0	0	0	0	0	0	0



**Table 3.36—What is your monthly financial situation, by demographic characteristics, Maryland**

	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>	<b>F</b>	<b>Total</b>
	(n=39)	(n=100)	(n=51)	(n=47)	(n=154)	(n=18)	(n=409)
<b>Sex/gender</b>							
<i>Women</i>	22	62	30	22	81	7	224
<i>Men</i>	16	36	21	24	70	11	178
<i>Transgender</i>	0	0	0	0	0	0	0
<b>Age group</b>							
<i>0-17 years</i>	1	0	2	2	2	1	8
<i>18-25 years</i>	2	8	3	1	13	0	27
<i>26-34 years</i>	2	15	8	8	19	4	56
<i>35-45 years</i>	15	43	18	23	61	5	165
<i>46-55 years</i>	14	31	20	12	55	8	140
<i>56-65 years</i>	2	2	0	0	2	0	6
<i>65+ years</i>							
<b>Race/ethnicity</b>							
<i>American Indian</i>							
<i>Asian</i>	3	3	8	2	9	2	27
<i>Black/African American</i>	7	22	14	10	35	6	94
<i>Hispanic</i>	0	3	1	2	4	2	12
<i>White</i>	27	70	28	32	105	8	270
<i>Other/unknown</i>							
<b>Hispanic ethnicity</b>	0	3	1	2	5	2	13
<b>Language</b>							
<i>Chinese</i>							
<i>English</i>	39	98	51	47	150	18	403
<i>Other</i>	0	0	0	0	1	0	1
<i>Spanish</i>	0	2	0	0	3	0	5
<i>Vietnamese</i>							

**Table 3.37—What is your monthly financial situation, by demographic characteristics, New York**

	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>	<b>F</b>	<b>Total</b>
	(n=102)	(n=359)	(n=67)	(n=109)	(n=253)	(n=137)	(n=1027)
<b>Sex/gender</b>							
<i>Women</i>	41	119	27	32	84	55	358
<i>Men</i>	50	140	17	32	94	66	399
<i>Transgender</i>	0	0	0	0	1	0	1
<b>Age group</b>							
<i>0-17 years</i>	0	0	0	0	1	0	1
<i>18-25 years</i>	9	53	8	3	13	7	93
<i>26-34 years</i>	12	62	13	18	38	24	167
<i>35-45 years</i>	22	58	13	16	37	31	177
<i>46-55 years</i>	17	53	14	19	47	27	177
<i>56-65 years</i>	27	58	6	23	43	34	191
<i>65+ years</i>	8	9	0	3	2	9	31
<b>Race/ethnicity</b>							
<i>American Indian</i>							
<i>Asian</i>	59	69	7	34	47	46	262
<i>Black/African American</i>	21	119	18	19	63	40	280
<i>Hispanic</i>	NA	NA	NA	NA	NA	NA	NA
<i>White</i>	8	12	8	19	17	24	88
<i>Other/unknown</i>	0	1	0	0	0	0	1
<b>Hispanic ethnicity</b>	10	105	19	23	84	32	273
<b>Language</b>							
<i>Chinese</i>	40	3	0	15	23	28	109
<i>English</i>	55	253	53	79	182	87	709
<i>Other</i>	3	54	7	9	9	6	88
<i>Spanish</i>	4	48	7	6	39	16	120
<i>Vietnamese</i>	0	0	0	0	0	0	0

**Table 3.38—What is your monthly financial situation, by demographic characteristics, Tennessee**

	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>	<b>F</b>	<b>Total</b>
	(n=80)	(n=147)	(n=19)	(n=75)	(n=237)	(n=0)	(n=558)
<b>Sex/gender</b>							
<i>Women</i>	45	83	10	39	159	0	336
<i>Men</i>	34	60	9	35	75	0	213
<i>Transgender</i>	0	0	0	0	0	0	0
<b>Age group</b>							
<i>0-17 years</i>	0	0	0	0	0	0	0
<i>18-25 years</i>	5	5	1	1	12	0	24
<i>26-34 years</i>	8	10	2	10	18	0	48
<i>35-45 years</i>	17	21	3	19	45	0	105
<i>46-55 years</i>	25	49	7	14	72	0	167
<i>56-65 years</i>	21	58	6	29	83	0	197
<i>65+ years</i>	0	0	0	0	0	0	0
<b>Race/ethnicity</b>							
<i>American Indian</i>	0	3	0	1	1	0	5
<i>Asian</i>	2	1	0	8	7	0	18
<i>Black/African American</i>	46	54	8	28	99	0	235
<i>Hispanic</i>	NA	NA	NA	NA	NA	NA	NA
<i>White</i>	20	72	9	35	110	0	246
<i>Other/unknown</i>	2	0	0	0	0	0	2
<b>Hispanic ethnicity</b>	2	0	0	2	7	0	11
<b>Language</b>							
<i>Chinese</i>	0	0	0	0	0	0	0
<i>English</i>	68	113	19	68	200	0	468
<i>Other</i>	3	0	0	3	3	0	9
<i>Spanish</i>	1	0	0	0	3	0	4
<i>Vietnamese</i>	0	0	0	0	0	0	0

**Table 3.39—What is your monthly financial situation, by demographic characteristics, Georgia and Tennessee combined**

	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>	<b>F</b>	<b>Total</b>
	(n=36)	(n=20)	(n=5)	(n=10)	(n=517)	(n=0)	(n=122)
<b>Sex/gender</b>							
<i>Women</i>	19	10	4	5	31	0	69
<i>Men</i>	16	10	1	3	19	0	49
<i>Transgender</i>	1	0	0	0	0	0	1
<b>Age group</b>							
<i>0-17 years</i>	0	0	0	0	0	0	0
<i>18-25 years</i>	2	2	0	0	4	0	8
<i>26-34 years</i>	6	3	2	8	13	0	32
<i>35-45 years</i>	11	9	0	1	11	0	32
<i>46-55 years</i>	8	3	0	1	8	0	20
<i>56-65 years</i>	8	3	1	0	8	0	20
<i>65+ years</i>	0	0	0	0	0	0	0
<b>Race/ethnicity</b>							
<i>American Indian</i>	0	0	0	0	0	0	0
<i>Asian</i>	1	2	0	2	16	0	21
<i>Black/African American</i>	32	9	3	3	11	0	58
<i>Hispanic</i>	NA	NA	NA	NA	NA	NA	NA
<i>White</i>	2	4	2	4	12	0	24
<i>Other/unknown</i>	0	0	0	0	0	0	0
<b>Hispanic ethnicity</b>	0	4	0	1	7	0	12
<b>Language</b>							
<i>Chinese</i>	0	0	0	0	0	0	0
<i>English</i>	34	7	3	3	12	0	59
<i>Other</i>	0	2	0	2	13	0	17
<i>Spanish</i>	0	3	0	1	9	0	13
<i>Vietnamese</i>	0	0	0	0	0	0	0

**Table 3.40—Language preference and enrollment success, all states\***

	<b>Not enrolled</b>	<b>Enrolled</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
Chinese	288 (98.3%)	5 (1.7%)	293
English	3353 (37.1%)	5679 (62.9%)	9032
Spanish	228 (44.4%)	285 (55.6%)	513
Total	3869	5969	9838

\*  $\chi^2 = 450.973$ ; DF: 2;  $p=0.000$

**Table 3.41—Language preference and enrollment success, in New York and Maryland combined\***

	<b>Not enrolled</b>	<b>Enrolled</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
Chinese	288 (98.3%)	5 (1.7%)	293
English	2337 (32.3%)	4898 (67.7%)	7235
Spanish	167 (42.5%)	226 (57.5%)	393
Total	2792	5129	7921

\*  $\chi^2 = 546.820$ ; DF: 2;  $p=0.000$

**Table 3.42—Language preference and enrollment success, in Georgia and Tennessee combined\***

	<b>Not enrolled</b>	<b>Enrolled</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
English	1016 (56.5%)	781 (43.5%)	1797
Spanish	61 (50.8%)	59 (49.2%)	120
Total	1077	840	1917

\*  $\chi^2 = 1.487$ ; DF: 1;  $p=0.223$

**Table 3.43—Language preference and Enrollment success, in Georgia\***

	<b>Not enrolled</b>	<b>Enrolled</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
English	548 (66.7%)	273 (33.3%)	821
Spanish	43 (47.8%)	47 (52.2%)	90
Total	591	320	911

\*  $\chi^2 = 12.809$ ; DF: 1;  $p=0.000$

**Table 3.44—Language preference and Enrollment success, in Maryland\***

	<b>Not enrolled</b>	<b>Enrolled</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
English	1717 (29.2%)	4155 (70.8%)	5872
Spanish	50 (48.1%)	54 (51.9%)	104
Total	1767	4209	5976

\*  $\chi^2 = 17.411$ ; DF: 1;  $p=0.000$

**Table 3.45—Language preference and enrollment success, in New York\***

	<b>Not enrolled</b>	<b>Enrolled</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
Chinese	288 (99.0%)	3 (1.0%)	291
English	620 (45.5%)	743 (54.5%)	1363
Spanish	117 (40.5%)	172 (59.5%)	289
Total	1025	918	1934

\*  $\chi^2 = 295.695$ ; DF: 2;  $p=0.000$

**Table 3.46—Language preference and Enrollment success, in Tennessee\***

	<b>Not enrolled</b>	<b>Enrolled</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
English	308 (47.2%)	345 (52.8%)	653
Spanish	2 (33.3%)	4 (66.7%)	6
Total	310	349	659

\*  $\chi^2 = .457$ ; DF: 1;  $p=0.499$

**Table 3.47—Language preference and Enrollment success, in Georgia or Tennessee (indeterminate)\***

	<b>Not enrolled</b>	<b>Enrolled</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
English	160 (49.5%)	163 (50.5%)	323
Spanish	16 (66.7%)	8 (33.3%)	24
Total	176	171	347

\*  $\chi^2 = 2.623$ ; DF: 1;  $p=0.105$

**Table 3.48—Race/ethnic identity and enrollment success for the full sample**

	Not applied/ selected/ enrolled	Applied/ selected/ enrolled	Total
	N (%)	N (%)	N
Am Indian/Alaskan	10 (62.5%)	6 (37.5%)	16
Asian	590 (62.2%)	359 (37.8%)	949
Black	1340 (41.6%)	1882 (58.4%)	3222
Hispanic	267 (39.8%)	404 (60.2%)	671
White	1603 (33.9%)	3120 (66.1%)	4723
Other	13 (35.1%)	24 (64.9%)	37
Total	3823	5795	9618

\*  $\chi^2 = 274.096$ ; DF: 5;  $p=0.000$

**Table 3.49—Race/ethnic identity and enrollment success in Maryland and New York\***

	Enrolled	Applied	Active	Inactive	Lead	Total
	N (%)	N (%)	N (%)	N (%)	N (%)	N
Asian	282 (35.0%)	40 (5.0%)	246 (30.6%)	74 (9.2%)	163 (20.2%)	805
Black/Af. Amer.	1268 (69.6%)	88 (4.8%)	38 (2.1%)	276 (15.1%)	152 (8.3%)	1822
Hispanic	378 (61.7%)	47 (7.7%)	14 (2.3%)	117 (19.1%)	57 (9.3%)	613
White	2737 (72.0%)	193 (5.1%)	69 (1.8%)	613 (16.1%)	190 (5.0%)	3802
Total	4665	368	367	1080	562	7042

\*  $\chi^2 = 1493.838$ ; DF: 12;  $p=0.000$

**Table 3.50— Race/ethnic identity and enrollment success in Georgia and Tennessee combined\***

	Did not apply/select	Applied/selected plan	Total
	N (%)	N (%)	N
Asian	75 (43.6%)	97 (56.4%)	172
Black/Af. Amer.	786 (56.1%)	614 (43.9%)	1400
Hispanic	37 (55.2%)	30 (44.8%)	67
White	538 (58.4%)	383 (41.6%)	921
Total	1436	1124	2560

\*  $\chi^2 = 12.930$ ; DF: 3;  $p=0.005$

**Table 3.51—Race/ethnic identity and enrollment success in Maryland\***

	<b>Enrolled</b>	<b>Applied</b>	<b>Active</b>	<b>Inactive</b>	<b>Lead</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N (%)</b>	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
Asian	185 (69.3%)	13 (4.9%)	2 (0.7%)	51 (19.1%)	16 (6.0%)	267
Black/Af. Amer.	962 (71.4%)	34 (2.5%)	9 (0.7%)	250 (18.5%)	93 (6.9%)	1348
Hispanic	154 (60.2%)	6 (2.3%)	0 (0.0%)	90 (35.2%)	6 (2.3%)	256
White	2626 (72.5%)	166 (4.6%)	45 (1.2%)	609 (16.8%)	175 (4.8%)	3621
Other	21 (63.6%)	1 (3.0%)	0 (0.0%)	7 (21.2%)	4 (12.1%)	33
Total	3948	220	56	1007	294	5525

\*  $\chi^2 = 84.864$ ; DF: 16;  $p=0.000$

**Table 3.52—Race/ethnic identity and enrollment success in New York\***

	<b>Enrolled</b>	<b>Applied</b>	<b>Active</b>	<b>Inactive</b>	<b>Lead</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N (%)</b>	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
Asian	80 (15.6%)	26 (5.1%)	244 (47.5%)	20 (3.9%)	144 (28.0%)	514
Black/Af. Amer.	306 (64.6%)	54 (11.4%)	29 (6.1%)	26 (5.5%)	59 (12.4%)	474
Hispanic	220 (63.2%)	41 (11.8%)	14 (4.0%)	23 (6.6%)	50 (14.4%)	348
White	111 (61.3%)	27 (14.9%)	24 (13.3%)	4 (2.2%)	15 (8.3%)	181
Total	717	148	311	73	268	1517

\*  $\chi^2 = 521.695$ ; DF: 12;  $p=0.000$

**Table 3.53—Race/ethnic identity and enrollment success in Georgia\***

	<b>Did not apply/select</b>	<b>Applied/selected plan</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
Asian	55 (49.5%)	56 (50.5%)	111
Black/Af. Amer.	508 (64.4%)	281 (35.6%)	789
Hispanic	23 (52.3%)	21 (47.7%)	44
White	287 (62.3%)	174 (37.7%)	461
Total	873	532	1405

\*  $\chi^2 = 10.993$ ; DF: 3;  $p=0.012$



**Table 3.54—Race/ethnic identity and enrollment success in Georgia or Tennessee (indeterminate)\***

	<b>Did not apply/select</b>	<b>Applied/selected plan</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
Asian	3 (12.5%)	21 (87.5%)	24
Black/Af. Amer.	137 (50.7%)	133 (49.3%)	270
Hispanic	12 (63.2%)	7 (36.8%)	19
White	48 (48.0%)	52 (52.0%)	100
Total	200	213	413

\*  $\chi^2 = 14.640$ ; DF: 3;  $p=0.002$

**Table 3.55—Race/ethnic identity and enrollment success in Tennessee\***

	<b>Did not apply/select</b>	<b>Applied/selected plan</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
Asian	17 (45.9%)	20 (54.1%)	37
Black/Af. Amer.	141 (41.3%)	200 (58.7%)	341
Hispanic	2 (50.0%)	2 (50.0%)	4
White	203 (56.4%)	157 (43.6%)	360
Total	363	379	742

\*  $\chi^2 = 15.992$ ; DF: 3;  $p=0.001$

**Table 3.56—Monthly financial situation and enrollment success for the full sample\***

	Not applied/ selected/ enrolled	Applied/ selected/ enrolled	Total
	N (%)	N (%)	N
I don't know	330 (64.7%)	180 (35.3%)	510
Borrow from friends/relatives	374 (44.5%)	466 (55.5%)	840
Use my credit card/ take on other debt	94 (44.3%)	118 (55.7%)	212
Money left over	142 (45.7%)	169 (54.3%)	311
Just break even	448 (44.0%)	570 (56.0%)	1018
Declined to respond	90 (58.1%)	65 (41.9%)	155
Total	1478	1568	3046

\*  $\chi^2 = 75.314$ ; DF: 5;  $p=0.000$

**Table 3.57— Monthly financial situation and enrollment success in Maryland and New York\***

	Enrolled	Applied	Active	Inactive	Lead	Total
	N (%)	N (%)	N (%)	N (%)	N (%)	N
I don't know	47 (33.3%)	6 (4.3%)	52 (36.9%)	16 (11.3%)	20 (14.2%)	141
Borrow from friends/relatives	318 (69.4%)	47 (10.3%)	25 (5.5%)	22 (4.8%)	46 (10.0%)	458
Use my credit card/ take on other debt	84 (71.2%)	14 (11.9%)	2 (1.7%)	10 (8.5%)	8 (6.8%)	118
Money left over	88 (56.4%)	12 (7.7%)	23 (14.7%)	7 (4.5%)	26 (16.7%)	156
Just break even	243 (59.7%)	27 (6.6%)	54 (13.3%)	28 (6.9%)	55 (13.5%)	407
Declined to respond	845	124	212	92	162	1435

\*  $\chi^2 = 205.355$ ; DF: 20;  $p=0.000$

**Table 3.58— Monthly financial situation and enrollment success in Georgia and Tennessee combined\***

	Did not enroll/ apply/ select	Enrolled/ applied/ selected	Total
	N (%)	N (%)	N
I don't know	236 (64.0%)	133 (36.0%)	369
Borrow from friends/relatives	233 (61.2%)	148 (38.8%)	381
Use my credit card/ take on other debt	60 (63.8%)	34 (36.2%)	94
Money left over	74 (47.7%)	81 (52.3%)	155
Just break even	284 (46.5%)	327 (53.5%)	611
Declined to respond	N/A	N/A	N/A
Total	887	723	1610

\*  $\chi^2 = 41.978$ ; DF: 4;  $p=0.000$

**Table 3.59— Monthly financial situation and enrollment success in Georgia\***

	Did not apply/ select	Applied/ selected	Total
	N (%)	N (%)	N
I don't know	184 (69.7%)	80 (30.3%)	264
Borrow from friends/relatives	151 (65.1%)	81 (34.9%)	232
Use my credit card/ take on other debt	46 (65.7%)	24 (34.3%)	70
Money left over	45 (58.4%)	32 (41.6%)	77
Just break even	167 (49.0%)	174 (51.0%)	341
Declined to respond	NA	NA	NA
Total	593	391	984

\*  $\chi^2 = 31.190$ ; DF: 4;  $p=0.000$

**Table 3.60— Monthly financial situation and enrollment success in Georgia or Tennessee (indeterminate)\***

	Did not apply/ select	Applied/ selected	Total
	N (%)	N (%)	N
I don't know	23 (65.7%)	12 (34.3%)	35
Borrow from friends/relatives	11 (68.8%)	5 (31.3%)	16
Use my credit card/ take on other debt	1 (20.0%)	4 (80.0%)	5
Money left over	2 (22.2%)	7 (77.8%)	9
Just break even	10 (23.8%)	32 (76.2%)	42
Declined to respond	NA	NA	NA
Total	47	60	107

\*  $\chi^2 = 20.532$ ; DF: 4;  $p=0.000$

**Table 3.61—Monthly financial situation and enrollment success in New York\***

	Enrolled	Applied	Active	Inactive	Lead	Total
	N (%)	N (%)	N (%)	N (%)	N (%)	N
I don't know	20 (19.6%)	5 (4.9%)	52 (51.0%)	5 (4.9%)	20 (19.6%)	102
Borrow from friends/relatives	228 (63.5%)	44 (12.3%)	25 (7.0%)	17 (4.7%)	45 (12.5%)	359
Use my credit card/ take on other debt	46 (68.7%)	8 (11.9%)	2 (3.0%)	3 (4.5%)	8 (11.9%)	67
Money left over	49 (45.0%)	9 (8.3%)	23 (21.1%)	3 (2.8%)	25 (22.9%)	109
Just break even	118 (46.6%)	22 (8.7%)	54 (21.3%)	8 (3.2%)	51 (20.2%)	253
Declined to respond	48 (35.0%)	18 (13.1%)	56 (40.9%)	8 (5.8%)	7 (5.1%)	137
Total	509	106	212	44	156	1027

\*  $\chi^2 = 189.532$ ; DF: 20;  $p=0.000$

**Table 3.62—Monthly financial situation and enrollment success in Maryland\***

	Enrolled	Applied	Active	Inactive	Lead	Total
	N (%)	N (%)	N (%)	N (%)	N (%)	N
I don't know	27 (69.2%)	1 (2.6%)	N/A	11 (28.2%)	0 (0.0%)	39
Borrow from friends/relatives	90 (90.0%)	4 (4.0%)	N/A	5 (5.0%)	1 (1.0%)	100
Use my credit card/ take on other debt	38 (74.5%)	6 (11.8%)	N/A	7 (13.7%)	0 (0.0%)	51
Money left over	39 (83.0%)	3 (6.4%)	N/A	4 (8.5%)	1 (2.1%)	47
Just break even	125 (81.2%)	5 (3.2%)	N/A	20 (13.0%)	4 (2.6%)	154
Declined to respond	17 (94.4%)	0 (0.0%)	N/A	1 (5.6%)	0 (0.0%)	18
Total	336	19	N/A	48	6	409

\*  $\chi^2 = 27.540$ ; DF: 15;  $p=0.025$

**Table 3.63—Age and public vs. private enrollment for the full sample\***

	No	Private	Total
	N (%)	N (%)	N
18-25 years	542 (73.3%)	197 (26.7%)	739
26-34 years	511 (55.4%)	411 (44.6%)	922
35-45 years	1092 (50.1%)	1088 (49.9%)	2180
46-55 years	742 (43.5%)	964 (56.5%)	1706
56-65 years	298 (39.0%)	467 (61.0%)	765
Total	3185	3127	6312

\*  $\chi^2 = 237.626$ ; DF: 4;  $p=0.000$

**Table 3.64—Age and public vs. private enrollment in New York and Maryland combined\***

	No	Private	Total
	N (%)	N (%)	N
18-25 years	518 (76.4%)	160 (23.6%)	678
26-34 years	462 (60.1%)	307 (39.9%)	769
35-45 years	969 (51.8%)	900 (48.2%)	1869
46-55 years	645 (46.9%)	730 (53.1%)	1375
56-65 years	224 (57.9%)	163 (42.1%)	387
Total	2818	2260	5078

\*  $\chi^2 = 178.531$ ; DF: 4;  $p=0.000$

**Table 3.65—Age and public vs. private enrollment for Georgia and Tennessee combined\***

	<b>No</b>	<b>Private</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
18-25 years	24 (39.3%)	37 (60.7%)	61
26-34 years	49 (32.0%)	104 (68.0%)	153
35-45 years	123 (39.5%)	188 (60.5%)	311
46-55 years	97 (29.3%)	234 (70.7%)	331
56-65 years	74 (19.6%)	304 (80.4%)	378
Total	367	867	1234

\*  $\chi^2 = 36.114$ : DF: 4;  $p=0.000$

**Table 3.66—Age and public vs. private enrollment in Georgia\***

	<b>No</b>	<b>Private</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
18-25 years	6 (20.7%)	23 (79.3%)	29
26-34 years	18 (27.3%)	48 (72.7%)	66
35-45 years	56 (34.6%)	106 (65.4%)	162
46-55 years	49 (28.8%)	121 (71.2%)	170
56-65 years	22 (15.7%)	118 (84.3%)	140
Total	151	416	567

\*  $\chi^2 = 14.718$ : DF: 4;  $p=0.005$

**Table 3.67— Age and public vs. private enrollment for Maryland\***

	<b>No</b>	<b>Private</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
18-25 years	356 (72.8%)	133 (27.2%)	489
26-34 years	282 (56.1%)	221 (43.9%)	503
35-45 years	793 (49.2%)	820 (50.8%)	1613
46-55 years	462 (43.1%)	610 (56.9%)	1072
56-65 years	7 (33.3%)	14 (66.7%)	21
Total	1900	1798	3698

\*  $\chi^2 = 129.596$ : DF: 4;  $p=0.000$

**Table 3.68—Age and public vs. private enrollment for New York\***

	<b>No</b>	<b>Private</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
18-25 years	162 (85.7%)	27 (14.3%)	189
26-34 years	180 (67.7%)	86 (32.3%)	266
35-45 years	176 (68.8%)	80 (31.3%)	256
46-55 years	183 (60.4%)	120 (39.6%)	303
56-65 years	217 (59.3%)	149 (40.7%)	366
Total	918	462	1380

\*  $\chi^2 = 45.690$ ; DF: 4;  $p=0.000$

**Table 3.69—Age and public vs. private enrollment in Tennessee\***

	<b>No</b>	<b>Private</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
18-25 years	15 (75.0%)	5 (25.0%)	20
26-34 years	24 (51.1%)	23 (48.9%)	47
35-45 years	55 (55.6%)	44 (44.4%)	99
46-55 years	39 (32.5%)	81 (67.5%)	120
56-65 years	44 (24.7%)	134 (75.3%)	178
Total	177	287	464

\*  $\chi^2 = 42.776$ ; DF: 4;  $p=0.000$

**Table 3.70—Public vs. private enrollment and health literacy (How often do you need help reading documents?), all states\***

	<b>Public</b>	<b>Private</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
Always	78 (53.8%)	67 (46.2%)	145
Often	74 (56.1%)	58 (43.9%)	132
Sometimes	64 (27.6%)	168 (72.4%)	232
Rarely	117 (40.5%)	172 (59.5%)	289
Never	588 (51.5%)	553 (48.5%)	1141
Total	921	1018	1939

\*  $\chi^2 = 56.224$ ; DF: 4;  $p=0.000$

**Table 3.71—Public vs. private enrollment and health literacy (How often do you need help reading documents?) in Tennessee\***

	<b>Public</b>	<b>Private</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
Always	3 (60.0%)	2 (40.0%)	5
Often	1 (50.0%)	1 (50.0%)	2
Sometimes	18 (45.0%)	22 (55.0%)	40
Rarely	6 (15.8%)	32 (84.2%)	38
Never	102 (40.5%)	150 (59.5%)	252
Total	130	207	337

\*  $\chi^2 = 10.486$ ; DF: 4;  $p=0.033$

**Table 3.72—Public vs. private enrollment and monthly financial situation, all states\***

	<b>Public</b>	<b>Private</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
I don't know	119 (46.1%)	139 (53.9%)	258
Borrow from friends/relatives	374 (70.8%)	154 (29.2%)	528
Use my credit card/ take on other debt	66 (51.6%)	62 (48.4%)	128
Money left over	38 (18.8%)	164 (81.2%)	202
Just break even	233 (36.1%)	413 (63.9%)	646
Declined to respond	84 (67.2%)	41 (32.8%)	125
Total	914	973	1887

\*  $\chi^2 = 235.268$ ; DF: 5;  $p=0.000$



**Table 3.73—Public vs. private enrollment and monthly financial situation, in Georgia\***

	<b>Public</b>	<b>Private</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
I don't know	29 (35.4%)	53 (64.6%)	82
Borrow from friends/relatives	44 (51.2%)	42 (48.8%)	86
Use my credit card/ take on other debt	5 (20.0%)	20 (80.0%)	25
Money left over	0 (0.0%)	33 (100.0%)	33
Just break even	33 (18.5%)	145 (81.5%)	178
Declined to respond	N/A	N/A	N/A
<b>Total</b>	<b>111</b>	<b>293</b>	<b>404</b>

\*  $\chi^2 = 47.114$ ; DF: 4;  $p=0.000$

**Table 3.74—Public vs. private enrollment and monthly financial situation in Tennessee\***

	<b>Public</b>	<b>Private</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
I don't know	25 (56.8%)	19 (43.2%)	44
Borrow from friends/relatives	19 (30.2%)	44 (69.8%)	63
Use my credit card/ take on other debt	3 (50.0%)	3 (50.0%)	6
Money left over	6 (14.0%)	37 (86.0%)	43
Just break even	42 (34.1%)	81 (65.9%)	123
Declined to respond	N/A	N/A	N/A
<b>Total</b>	<b>95</b>	<b>184</b>	<b>279</b>

\*  $\chi^2 = 18.996$ ; DF: 4;  $p=0.001$

**Table 3.75—Public vs. private enrollment and monthly financial situation in Georgia or Tennessee\***

	<b>Public</b>	<b>Private</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
I don't know	2 (16.7%)	10 (83.3%)	12
Borrow from friends/relatives	1 (16.7%)	5 (83.3%)	6
Use my credit card/ take on other debt	2 (50.0%)	2 (50.0%)	4
Money left over	0	7 (100.0%)	7
Just break even	0	32 (100.0%)	32
Declined to respond	N/A	N/A	N/A
<b>Total</b>	<b>5</b>	<b>56</b>	<b>61</b>

\*  $\chi^2 = 14.487$ ; DF: 4; p=0.006

**Table 3.76—Public vs. private enrollment and monthly financial situation in New York\***

	<b>Public</b>	<b>Private</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
I don't know	57 (65.5%)	30 (34.5%)	87
Borrow from friends/relatives	257 (91.5%)	24 (8.5%)	281
Use my credit card/ take on other debt	37 (77.1%)	11 (22.9%)	48
Money left over	26 (33.3%)	52 (66.7%)	78
Just break even	118 (64.5%)	65 (35.5%)	183
Declined to respond	81 (75.0%)	27 (25.0%)	108
<b>Total</b>	<b>576</b>	<b>209</b>	<b>785</b>

\*  $\chi^2 = 121.700$ ; DF: 5; p=0.000

**Table 3.77—Public vs. private enrollment and monthly financial situation in Maryland\***

	<b>Public</b>	<b>Private</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
I don't know	6 (18.2%)	27 (81.8%)	33
Borrow from friends/relatives	53 (57.6%)	39 (42.4%)	92
Use my credit card/ take on other debt	19 (42.2%)	26 (57.8%)	45
Money left over	6 (14.6%)	35 (85.4%)	41
Just break even	40 (30.8%)	90 (69.2%)	130
Declined to respond	3 (17.6%)	14 (82.4%)	17
<b>Total</b>	<b>127</b>	<b>231</b>	<b>358</b>

\*  $\chi^2 = 36.294$ ; DF: 5;  $p=0.000$

**Table 3.78—Application/qualification for APTCs/CSRs and language preference in the full sample\***

	<b>Did not apply/ qualify</b>	<b>Applied/ qualified</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
Chinese	7 (7.3%)	89 (92.7%)	96
English	1160 (27.1%)	3122 (72.9%)	4282
Spanish	40 (15.7%)	214 (84.3%)	254
<b>Total</b>	<b>1207</b>	<b>3425</b>	<b>4632</b>

\*  $\chi^2 = 33.927$ ; DF: 2;  $p=0.000$

**Table 3.79—Application/qualification for APTCs/CSRs and language preference in New York and Maryland, combined\***

	<b>Did not qualify</b>	<b>Qualified</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
Chinese	7 (7.3%)	89 (92.7%)	96
English	493 (22.5%)	1698 (77.5%)	2191
Spanish	10 (12.5%)	70 (87.5%)	80
<b>Total</b>	<b>510</b>	<b>1857</b>	<b>2367</b>

\*  $\chi^2 = 16.595$ ; DF: 2;  $p=0.000$

**Table 3.80—Application/qualification for APTCs/CSRs and language preference in Georgia and Tennessee, combined\***

	<b>Did not apply</b>	<b>Applied</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
English	667 (31.9%)	1424 (68.1%)	2091
Spanish	30 (17.2%)	144 (82.8%)	174
Total	697	1568	2265

\*  $\chi^2 = 16.199$ : DF: 1;  $p=0.000$

**Table 3.81—Application/qualification for APTCs/CSRs and language preference in Georgia\***

	<b>Did not apply</b>	<b>Applied</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
English	418 (45.3%)	504 (54.7%)	922
Spanish	25 (18.8%)	108 (81.2%)	133
Total	443	612	1055

\*  $\chi^2 = 33.609$ : DF: 1;  $p=0.000$

**Table 3.82—Application/qualification for APTCs/CSRs and health literacy (How often do you need help reading documents?) in the full sample\***

	<b>Did not apply/ qualify</b>	<b>Applied/ qualified</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
Always	16 (12.2%)	115 (87.8%)	131
Often	28 (20.1%)	111 (79.9%)	139
Sometimes	106 (27.0%)	287 (73.0%)	393
Rarely	86 (25.6%)	250 (74.4%)	336
Never	251 (22.6%)	861 (77.4%)	1112
Total	487	1624	2111

\*  $\chi^2 = 14.104$ : DF: 4;  $p=0.007$

**Table 3.83—Application/qualification for APTCs/CSRs and health literacy, in Georgia and Tennessee combined\***

	<b>Did not apply</b>	<b>Applied</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
Always	14 (11.7%)	106 (88.3%)	120
Often	27 (24.3%)	84 (75.7%)	111
Sometimes	103 (29.3%)	248 (70.7%)	351
Rarely	75 (26.6%)	207 (73.4%)	282
Never	215 (24.8%)	651 (75.2%)	866
Total	434	1296	1730

\*  $\chi^2 = 15.293$ ; DF:4; p=0.004

**Table 3.84—Application/qualification for APTCs/CSRs and health literacy in Georgia\***

	<b>Did not apply</b>	<b>Applied</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
Always	13 (12.6%)	90 (87.4%)	103
Often	27 (27.3%)	72 (72.7%)	99
Sometimes	93 (33.7%)	183 (66.3%)	276
Rarely	54 (30.3%)	124 (69.7%)	178
Never	126 (32.1%)	267 (67.9%)	393
Total	313	736	1049

\*  $\chi^2 = 17.806$ ; DF:4; p=0.001

**Table 3.85—Application/qualification for APTCs/CSRs and age group in the full sample\***

	<b>Did not apply/ qualify</b>	<b>Applied/ qualified</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
18-25 years	100 (31.4%)	218 (68.6%)	318
26-34 years	158 (23.5%)	513 (76.5%)	671
35-45 years	316 (20.3%)	1240 (79.7%)	1556
46-55 years	352 (23.8%)	1127 (76.2%)	1479
56-65 years	291 (26.4%)	813 (73.6%)	1104
Total	1217	3911	5128

\*  $\chi^2 = 24.756$ ; DF: 4; p=0.000

**Table 3.86—Application/qualification for APTCs/CSRs and age group in New York and Maryland, combined\***

	<b>Did not qualify</b>	<b>Qualified</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
18-25 years	40 (24.2%)	125 (75.8%)	165
26-34 years	63 (22.7%)	215 (77.3%)	278
35-45 years	138 (16.6%)	692 (83.4%)	830
46-55 years	112 (16.6%)	562 (83.4%)	674
56-65 years	43 (23.4%)	141 (76.6%)	184
Total	396	1735	2131

\*  $\chi^2 = 13.158$ ; DF: 4;  $p=0.011$

**Table 3.87—Application/qualification for APTCs/CSRs and age group in Georgia and Tennessee, combined**

	<b>Did not apply</b>	<b>Applied</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
18-25 years	60 (39.2%)	93 (60.8%)	153
26-34 years	95 (24.2%)	298 (75.8%)	393
35-45 years	178 (24.5%)	548 (75.5%)	726
46-55 years	240 (29.8%)	565 (70.2%)	805
56-65 years	248 (27.0%)	672 (73.0%)	920
Total	821	2176	2997

\*  $\chi^2 = 18.278$ ; DF: 4;  $p=0.001$

**Table 3.88—Application/qualification for APTCs/CSRs and age group in Georgia\***

	<b>Did not apply</b>	<b>Applied</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
18-25 years	39 (45.3%)	47 (54.7%)	86
26-34 years	67 (28.5%)	168 (71.5%)	235
35-45 years	120 (26.1%)	339 (73.9%)	459
46-55 years	166 (36.0%)	295 (64.0%)	461
56-65 years	155 (35.1%)	287 (64.9%)	442
Total	547	1136	1683

\*  $\chi^2 = 20.545$ ; DF: 4;  $p=0.000$

**Table 3.89—Application/qualification for APTCs/CSRs and age group in Maryland\***

	<b>Did not qualify</b>	<b>Qualified</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
18-25 years	34 (24.5%)	105 (75.5%)	139
26-34 years	54 (25.6%)	157 (74.4%)	211
35-45 years	124 (16.6%)	625 (83.4%)	749
46-55 years	93 (16.7%)	465 (83.3%)	558
56-65 years	17 (65.4%)	9 (34.6%)	26
Total	322	1361	1683

\*  $\chi^2 = 49.599$ : DF: 4;  $p=0.000$

**Table 3.90—Application/qualification for APTCs/CSRs and age group in New York\***

	<b>Did not qualify</b>	<b>Qualified</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
18-25 years	6 (23.1%)	20 (76.9%)	26
26-34 years	9 (13.4%)	58 (86.6%)	67
35-45 years	14 (17.3%)	67 (82.7%)	81
46-55 years	19 (16.4%)	97 (83.6%)	116
56-65 years	26 (16.5%)	132 (83.5%)	158
Total	74	374	448

\*  $\chi^2 = 1.310$ : DF: 4;  $p=0.860$

**Table 3.91—Application/qualification for APTCs/CSRs and age group in Tennessee\***

	<b>Did not apply</b>	<b>Applied</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
18-25 years	18 (50.0%)	18 (50.0%)	36
26-34 years	17 (21.5%)	62 (78.5%)	79
35-45 years	34 (20.0%)	136 (80.0%)	170
46-55 years	51 (21.3%)	189 (78.8%)	240
56-65 years	56 (16.4%)	285 (83.6%)	341
Total	176	690	866

\*  $\chi^2 = 22.992$ : DF: 4;  $p=0.000$

**Table 3.92—Application/qualification for APTCs/CSRs and monthly financial situation for the full sample\***

	<b>Did not apply/ qualify</b>	<b>Applied/ qualified</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
I don't know	125 (26.8%)	341 (73.2%)	466
Borrow from friends/relatives	176 (36.5%)	306 (63.5%)	482
Use my credit card/ take on other debt	42 (31.1%)	93 (68.9%)	135
Money left over	60 (25.3%)	177 (74.7%)	237
Just break even	153 (19.3%)	641 (80.7%)	794
Declined to respond	6 (16.2%)	31 (83.8%)	37
<b>Total</b>	<b>562</b>	<b>1589</b>	<b>2151</b>

\*  $\chi^2 = 50.109$ ; DF: 5;  $p=0.000$

**Table 3.93—Application/qualification for APTCs/CSRs and monthly financial situation in Georgia and Tennessee, combined\***

	<b>Did not apply/ qualify</b>	<b>Applied/ qualified</b>	<b>Total</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N</b>
I don't know	115 (27.6%)	302 (72.4%)	417
Borrow from friends/relatives	164 (39.5%)	251 (60.5%)	415
Use my credit card/ take on other debt	37 (37.8%)	61 (62.2%)	98
Money left over	45 (26.8%)	123 (73.2%)	168
Just break even	140 (21.6%)	508 (78.4%)	648
Declined to respond	NA	NA	NA
<b>Total</b>	<b>501</b>	<b>1245</b>	<b>1746</b>

\*Chi-square: 44.165; DF:4;  $p=0.000$



**Table 3.94—Application/qualification for APTCs/CSRs and monthly financial situation in New York\***

	Did not apply/ qualify	Applied/ qualified	Total
	N (%)	N (%)	N
I don't know	1 (4.5%)	21 (95.5%)	22
Borrow from friends/relatives	3 (12.5%)	21 (87.5%)	24
Use my credit card/ take on other debt	0 (0.0%)	6 (100.0%)	6
Money left over	12 (31.6%)	26 (68.4%)	38
Just break even	1 (1.9%)	53 (98.1%)	54
Declined to respond	2 (9.5%)	19 (90.5%)	21
Total	19	146	165

\*Chi-square: 21.896; DF: 5; p=0.001

**Table 3.95—Application/qualification for APTCs/CSRs and monthly financial situation in Georgia\***

	Did not apply/ qualify	Applied/ qualified	Total
	N (%)	N (%)	N
I don't know	90 (29.5%)	215 (70.5%)	305
Borrow from friends/relatives	115 (44.7%)	142 (55.3%)	257
Use my credit card/ take on other debt	32 (43.2%)	42 (56.8%)	74
Money left over	30 (34.1%)	58 (65.9%)	88
Just break even	105 (28.8%)	260 (71.2%)	365
Declined to respond	N/A	N/A	N/A
Total	372 (34.2%)	717 (65.8%)	1089

\*Chi-square: 23.177; DF:4; p=0.000

**Table 3.96—Application/qualification for APTCs/CSRs and monthly financial situation in Tennessee\***

	Did not apply/ qualify	Applied/ qualified	Total
	N (%)	N (%)	N
I don't know	17 (22.4%)	59 (77.6%)	76
Borrow from friends/relatives	43 (30.7%)	97 (69.3%)	140
Use my credit card/ take on other debt	5 (26.3%)	14 (73.7%)	19
Money left over	14 (19.7%)	57 (80.3%)	71
Just break even	32 (13.7%)	201 (86.3%)	233
Declined to respond	N/A	N/A	N/A
Total	111	428	539

\*Chi-square: 16.034; DF:4; p=0.003

**Table 3.97—Language preference and health literacy for the full sample\***

	Always	Often	Sometimes	Rarely	Never	Total
	N (%)	N (%)	N (%)	N (%)	N (%)	N
Chinese	25 (25.3%)	28 (28.3%)	0 (0.0%)	5 (5.1%)	41 (41.4%)	99
English	55 (2.5%)	82 (3.8%)	281 (12.9%)	348 (16.0%)	1406 (64.7%)	2172
Spanish	29 (13.2%)	32 (14.6%)	35 (16.0%)	35 (16.0%)	88 (40.2%)	219
Total	109	142	316	388	1535	2490

\*  $\chi^2 = 336.071$ ; DF: 8; p=0.000

**Table 3.98—Language preference and health literacy in New York \***

	Always	Often	Sometimes	Rarely	Never	Total
	N (%)	N (%)	N (%)	N (%)	N (%)	N
Chinese	25 (25.3%)	28 (28.3%)	N/A	5 (5.1%)	41 (41.4%)	99
English	15 (2.2%)	22 (3.2%)	N/A	98 (14.1%)	560 (80.6%)	695
Spanish	18 (15.0%)	18 (15.0%)	N/A	20 (16.7%)	64 (53.3%)	120
Total	58	68	N/A	123	665	914

\*  $\chi^2 = 204.992$ ; DF: 6; p=0.000

Table 3.99—Language preference and health literacy in Georgia*						
	Always	Often	Sometimes	Rarely	Never	Total
	N (%)	N (%)	N (%)	N (%)	N (%)	N
English	24 (4.1%)	45 (7.6%)	165 (27.9%)	101 (17.1%)	257 (43.4%)	592
Spanish	9 (11.8%)	8 (10.5%)	26 (34.2%)	11 (14.5%)	22 (28.9%)	76
Total	33	53	191	112	279	668

\*  $\chi^2 = 13.585$ : DF: 4; p=0.009

Table 3.100—Age group and health literacy for the full sample *						
	Always	Often	Sometimes	Rarely	Never	Total
	N (%)	N (%)	N (%)	N (%)	N (%)	N
18-25 years	9 (4.3%)	6 (2.8%)	27 (12.8%)	29 (13.7%)	140 (66.4%)	211
26-34 years	24 (5.4%)	14 (3.1%)	53 (11.9%)	79 (17.8%)	275 (61.8%)	445
35-45 years	50 (7.0%)	45 (6.3%)	107 (14.9%)	105 (14.6%)	412 (57.3%)	719
46-55 years	33 (4.3%)	46 (6.0%)	116 (15.1%)	131 (17.0%)	443 (57.6%)	769
56-65 years	50 (7.1%)	53 (7.5%)	101 (14.3%)	110 (15.6%)	390 (55.4%)	704
Total	166	164	404	454	1660	2848

\*  $\chi^2 = 30.341$ : DF: 16; p=0.016

Table 3.101—Age group and health literacy in New York*						
	Always	Often	Sometimes	Rarely	Never	Total
	N (%)	N (%)	N (%)	N (%)	N (%)	N
18-25 years	3 (3.1%)	4 (4.2%)	N/A	10 (10.4%)	79 (82.3%)	96
26-34 years	10 (5.9%)	7 (4.1%)	N/A	22 (12.9%)	131 (77.1%)	170
35-45 years	17 (9.9%)	20 (11.7%)	N/A	28 (16.4%)	106 (62.0%)	171
46-55 years	10 (5.9%)	20 (11.8%)	N/A	28 (16.5%)	112 (65.9%)	170
56-65 years	22 (12.6%)	22 (12.6%)	N/A	19 (10.9%)	111 (63.8%)	174
Total	62	73	N/A	107	539	781

\*  $\chi^2 = 32.007$ : DF: 12; p=0.001

Table 3.102—Age group and health literacy in Georgia\*

	Always	Often	Sometimes	Rarely	Never	Total
	N (%)	N (%)	N (%)	N (%)	N (%)	N
18-25 years	3 (5.4%)	0 (0.0%)	20 (35.7%)	6 (10.7%)	27 (48.2%)	56
26-34 years	9 (6.7%)	2 (1.5%)	32 (23.7%)	34 (25.2%)	58 (43.0%)	135
35-45 years	24 (9.4%)	20 (7.8%)	62 (24.3%)	35 (13.7%)	114 (44.7%)	255
46-55 years	16 (5.7%)	21 (7.5%)	70 (25.1%)	57 (20.4%)	115 (41.2%)	279
56-65 years	26 (9.0%)	22 (7.6%)	80 (27.6%)	47 (16.2%)	115 (39.7%)	290
Total	78	65	264	179	429	1015

\*  $\chi^2 = 28.271$ ; DF: 16;  $p=0.029$ 

Table 3.103—Demographic profile of Consumers participating in telephone interviews, by state

	Georgia	Maryland	New York	Tennessee	All states
Sample size	10	10	10	10	40
Sex					
<i>Women</i>	6	8	3	9	26
<i>Men</i>	4	2	7	1	14
Age group (years)					
18-24	--	1	2	--	2
26-34	1	1	3	--	5
35-45	2	--	1	1	4
46-55	4	1	1	2	7
56-65	3	7	3	7	20
65+	--	--	--	--	--
Race/ethnicity					
<i>Asian, East</i>	1	--	--	--	1
<i>Asian, South</i>	--	1	1	--	2
<i>Asian, West</i>	--	--	1	--	1
<i>Black/African American</i>	5	3	4	6	18
<i>Hispanic/Latino</i>	1	--	1	--	2
<i>Multiracial</i>	1	--	1	--	2
<i>White</i>	1	6	2	4	13
<i>Black African</i>	1	--	--	--	1
Average household size	3.1	2.1	2	1.8	2.1
<i>Average adults</i>	2.1	1.6	2	1.6	1.8
<i>Average children</i>	1	0.5	0	0.2	0.3

**Table 3.104—Socio-economic profile of Consumers participating in telephone interviews, by state**

	<b>Georgia</b>	<b>Maryland</b>	<b>New York</b>	<b>Tennessee</b>	<b>All states</b>
Employment status					
<i>Employed, Full-time</i>	3	1	1	2	7
<i>Employed, Part-time</i>	2	--	--	1	3
<i>Employed, self-</i>	1	1	5	--	7
<i>Unemployed, disabled</i>	1	1	--	--	2
<i>Unemployed, laid off</i>	2	1	1	1	5
<i>Unemployed, retired</i>	--	1	--	3	4
<i>Unemployed, student</i>	--	1	1	--	1
<i>Unemployed, other</i>	1	4	2	3	10
Annual income (estimate)					
<i>Range (yearly)</i>	\$8-68,000	\$10-40,000	\$0-80,000	\$10-76,000	\$0-80,000
<i>Median</i>	24,000	14,000	18,500	20,000	19,000
<i>Mean</i>	28,800	18,875	27,045	24,636	25,167
Educational attainment					
<i>Some high school</i>	--	--	--	1	1
<i>High school/GED</i>	1	4	1	--	6
<i>Some College/Associates</i>	3	5	4	4	17
<i>BA or BS degree</i>	6	--	5	2	13
<i>Graduate school</i>	--	--	--	3	3
<i>Other</i>	--	1	--	--	1

**Table 3.105—Summary health, enrollment, and Navigation experience profile of Consumers participating in telephone interviews, by state**

	Georgia	Maryland	New York	Tennessee	All states
Current self-assessed health status					
<i>Excellent</i>	--	1	2	--	3
<i>Good</i>	7	3	5	3	18
<i>Fair</i>	2	3	1	3	9
<i>Poor</i>	--	3	2	4	9
<i>NA/Don't know</i>	1	--	--	--	1
Has a health condition requiring regular medication or management	3	10	3	8	24
Coverage status (at time of interview)					
<i>Insured in QHP</i>	2	2	--	7	11
<i>Uninsured</i>	3	1	5	--	9
<i>Uninsured due to falling in Medicaid/Subsidy Gap</i>	5	--	--	2	7
<i>Medicaid or other state program</i>	--	7	4	1	12
<i>Uncertain</i>	--	--	1	--	1
Time uninsured prior to Navigation					
Already insured	1	1	--	1	3
<1 year	3	2	3	1	9
1-4 years	3	4	3	3	13
5-20 years	1	--	2	5	8
Never had	2	3	2	--	7
Was assistance provided by Navigator (from POV of enrollee)?					
<i>Yes</i>	7	9	5	8	29
<i>No</i>	2	--	3	2	7
<i>Uncertain</i>	1	1	2	--	4
Successful in submitting application to federal or state marketplace?					
<i>Yes</i>	4	8	6	8	26
<i>No</i>	6	2	4	2	14

Table 3.106—Primary reasons for seeking Navigator assistance, by state					
<i>Reason for seeking Navigator assistance</i>	<i>GA n=10</i>	<i>MD n=10</i>	<i>NY n=10</i>	<i>TN n=10</i>	<i>All n=40</i>
Technical problems with federal or state marketplace web site were primary reason for seeking out Navigator	2	1	0	3	6
Was uninsured and thought a Navigator would help them find coverage	4	2	4	4	14
Learned about Navigation from media, presentations, or other outreach activities and was interested	2	1	1	0	4
Was already insured but interested in applying for subsidies or finding a better policy	1	1	0	2	4
Uninsured, but needed coverage due to health condition	1	3	1	1	6
Was already insured, but had a problem with plan/coverage recently cancelled	0	1	3	0	4
Wanted to avoid penalty for not having coverage	0	1	1	0	2

Table 3.107—Experience of technical problems with state or federal Marketplace web sites, by state					
	<i>GA n=10</i>	<i>MD n=10</i>	<i>NY n=10</i>	<i>TN n=10</i>	<i>All N=40</i>
Experienced technical problems during online registration, attempts to submit Marketplace application, or when attempting to select a health insurance policy	6	5	3	3	17
Did not attempt to use Marketplace prior to Navigation, or experienced no difficulties	4	5	7	7	23

**Table 3.108—Summary of Consumers’ overall experience with Navigator, by state**

<i>Summary of Navigator encounter</i>	<i>GA n=10</i>	<i>MD n=10</i>	<i>NY n=10</i>	<i>TN n=10</i>	<i>All n=40</i>
Consumer was enthusiastically happy with Navigator encounter(s), used praiseful adjectives to describe encounter(s) or specific Navigator, and discussed no negative aspects of their Navigator experience	2	8	7	7	24
Consumer was happy with the Navigator encounter(s), but experienced an undesirable outcome (related to subsidies, Medicaid, or other aspect of applying or enrolling) which was outside of the Navigator’s control	3	1	1	1	6
Consumer thought that the Navigator was somewhat helpful, but did not provide enough information about how the Marketplace works, how health insurance works, or did not follow up promptly	2	1	1	1	5
Consumer felt that the Navigator was not helpful, did not sufficiently explain how the Marketplace works, how health insurance works, or did not follow up with needed information or application status	3	0	1	1	5



**Table 3.109—Demographic profile of Navigators participating in telephone interviews, by state**

		Georgia	Maryland	New York	Tennessee	All states
Completed interviews		5	5	5	5	20
Sex						
	<i>Women</i>	3	3	4	5	8
	<i>Men</i>	2	2	1	--	3
Age group (years)						
	<i>18-24</i>	--	--	--	--	--
	<i>26-34</i>	1	3	1	3	4
	<i>35-45</i>	--	2	2	1	3
	<i>46-55</i>	3	--	1	--	3
	<i>56-65</i>	--	--	--	1	--
	<i>65+</i>	--	--	--	--	--
	<i>Refused</i>	1	--	1	--	1
Race/ethnicity						
	<i>Asian, East</i>	--	--	1	--	1
	<i>Asian, South</i>	1	--	--	--	1
	<i>Asian, West</i>	--	--	--	--	--
	<i>Black/African American</i>	4	1	--	1	6
	<i>Hispanic/Latino</i>	--	1	2	--	2
	<i>Multiracial</i>	--	--	--	--	--
	<i>White</i>	--	3	1	4	7
	<i>Other</i>	--	--	--	--	--
	<i>Refused</i>			1		

**Table 3.110—Socio-economic and Navigator experience profile of Navigators participating in telephone interviews, by state**

	<b>Georgia</b>	<b>Maryland</b>	<b>New York</b>	<b>Tennessee</b>
Completed interviews	5	3	5	5
Annual income (self-estimate)				
<i>Range</i>	\$15-80,000	\$20-150,000	\$9-40,000	\$15-90,000
<i>Median</i>	45,000	27,000	21,000	40,000
<i>Mean</i>	46,250	65,666	22,750	43,200
Educational attainment				
<i>Some College/Associates</i>	1	--	--	--
<i>BA or BS degree</i>	--	2	3	2
<i>Masters Degree</i>	2	3	1	3
<i>MBA</i>	1	--	--	--
<i>Other</i>	--	--	1	--
<i>Refused</i>	1	--	--	--
Began as Navigator				
<i>Pre-open enrollment</i>	1	1	--	1
<i>Since Oct/Nov 2013</i>	2	2	5	3
<i>Since Jan 2014</i>	2	--	--	1
Average number of consumers assisted per week during open enrollment (self-report)				
<i>&lt;10</i>	--	--	--	1
<i>10-20</i>	2	--	2	1
<i>20-50</i>	1	4	2	2
<i>50-100</i>	1	--	--	--
<i>&gt;100</i>	--	--	--	1
<i>Refused or unknown</i>	1	1	1	--
Prior experience in health insurance or health care industries?				
<i>None</i>	2	2	--	3
<i>&lt;1 year</i>	2	--	1	--
<i>1-3 years</i>	--	2	1	1
<i>3-5 years</i>	1	1	1	1
<i>&gt;5 years</i>	--	--	1	--
<i>Refused</i>	--	--	1	--

**Table 3.111—Barriers to effective and efficient Navigation, by state (\* indicates responses only occurred in one state)**

<b>Georgia</b> (n=5)	<ul style="list-style-type: none"> <li>• Low health insurance literacy among Consumers (n=3)</li> <li>• Financial hardship among Consumers or the Medicaid-Subsidy gap (n=3)</li> <li>• Cultural, linguistic, and class-based barriers that effect communication (n=3)</li> <li>• Politics around the ACA (n=3)</li> <li>• Technical problems, dysfunctional web sites, and bureaucratic challenges/inconsistencies (n=2)</li> <li>• Lack of prior information about Navigators, plans, etc. among Consumers (n=2)</li> <li>• Low computer literacy among Consumers/too much reliance on computer/web sites in system (n=2)</li> <li>• Shortage of Navigators/high volume of Consumers (n=1)</li> <li>• Identity verification procedures (n=1)</li> <li>• Call center wait times and call center representatives giving inaccurate information to Consumers (n=1)</li> <li>• Time necessary to help Consumers one-on-one and with follow-up ((n=1)</li> <li>• Lack of technical resources (ex: Hotspot) (n=1)*</li> <li>• Unreasonable or misinformed expectations among consumers (n=1)*</li> </ul>
<b>Maryland</b> (n=5)	<ul style="list-style-type: none"> <li>• Cultural, linguistic, and class-based barriers that effect communication (n=3)</li> <li>• Technical problems, dysfunctional web sites, and bureaucratic challenges/inconsistencies (n=3)</li> <li>• Lack of prior information about Navigators, plans, etc. among Consumers (n=2)</li> <li>• Financial hardship among Consumers <del>or the Medicaid-Subsidy gap</del> (n=2)</li> <li>• Insufficient Navigator training to prepare for open enrollment (n=2)*</li> <li>• Politics around the ACA (n=1)</li> <li>• Call center wait times and call center representatives giving inaccurate information to Consumers (n=1)</li> <li>• Low health insurance literacy among Consumers (n=1)</li> </ul>
<b>New York</b> (n=5)	<ul style="list-style-type: none"> <li>• Identity verification procedures (n=3)</li> <li>• Low health insurance literacy (n=3)</li> <li>• Income verification wait times (n=3)</li> <li>• Technical problems, dysfunctional web sites, and bureaucratic challenges/inconsistencies (n=2)</li> <li>• Call center wait times and call center representatives giving inaccurate information to Consumers (n=2)</li> <li>• Confusing questions on application involving predicting income (n=1)</li> <li>• Shortage of Navigators/high volume of Consumers (n=1)</li> <li>• Need more forms available on the website (n=1)</li> </ul>
<b>Tennessee</b> (n=5)	<ul style="list-style-type: none"> <li>• Technical problems, dysfunctional web sites, and bureaucratic challenges/inconsistencies (n=4)</li> <li>• Communication problems (language or illiteracy) (n=3)</li> <li>• Identity verification procedures (n=3)</li> </ul>

- Low health insurance literacy among Consumers (n=2)
- Low computer literacy among Consumers/too much reliance on computer/web sites in system (n=2)
- Due to insufficient training, had to learn on the job (n=2)
- Politics around the ACA (n=1)
- Call center never verified receipt of information (n=1)

## Appendix B: Data collection instruments used with Consumers

### 1. DEMOGRAPHIC QUESTIONNAIRE FOR USE WITH CONSUMERS PARTICIPATING IN TELEPHONE INTERVIEWS

#### INSTRUCTIONS:

For each question, please check the box next to the answer that best describes the participant and, if appropriate, fill in the blank with the requested information. If you choose "other" for any of the following items, please write a specific answer in the space provided.

(1) What year were you born? \_\_\_\_\_

(2) What is your gender? \_\_\_\_\_

(3) What is your zip code? \_\_\_\_\_

(4) How many people live in your household? (a) Number of adults \_\_\_\_\_ (b) Number of children \_\_\_\_\_

(5) Are you employed? Y / N

(a) If the answer to (5) above is yes, in what field(s)?  
\_\_\_\_\_

(b) If the answer to (5) above is yes, how long have you worked at your current job(s)?  
\_\_\_\_\_

(c) If the answer to (5) above is yes, do you currently or have you ever received insurance from this employer? Y / N

(6) What is your best estimate of how much money came into your household last year?

(7) What is the highest level of education that you completed?

(8) What do you consider your ethnic background or ethnic self-identity?

<input type="checkbox"/>	African American/Black
<input type="checkbox"/>	Asian Pacific Islander
<input type="checkbox"/>	Asian
<input type="checkbox"/>	Native American
<input type="checkbox"/>	Hispanic/Latino/Latina
<input type="checkbox"/>	Multi-racial
<input type="checkbox"/>	White, non-Hispanic
<input type="checkbox"/>	Other ethnic self-identity _____

(9) When you recently met with or spoke to a health insurance navigator, was enrollment assistance provided?

(9a) If so, did you submit an application of healthcare.gov? Y / N

(9b) If so, have you successfully enrolled in a health plan? Y / N

(9c) If so, have you paid the first month's premium for health insurance? Y / N

## 2. INTERVIEW GUIDE FOR USE WITH CONSUMERS PARTICIPATING IN TELEPHONE INTERVIEWS

### INSTRUCTIONS

After obtaining oral consent from the participant, use this guide to complete the semi-structured telephone interview. Following the interview, collect any additional demographic information needed to complete the Demographic questionnaire for Navigator participants in telephone interviews.

#### Non-ordered interview questions and follow-up prompts (lettered items)

Can you tell me about your history of health insurance?

- a) Are you currently insured or uninsured? For how long have you been insured/uninsured?
- b) Have you gone for a long period of time without health coverage?
- c) If you are uninsured, can you tell me why? (For example, is insurance cost prohibitive? Are you generally very healthy? Do you think you do not need it?)
- d) Have you been insured in the past? If so, what type of insurance did you have (ex: Medicaid, employer-sponsored, individual plan, etc.) and were you satisfied with your coverage?
- e) Has the cost of health care ever caused you to decide not to seek treatment for a health problem?

Can you tell me about your health status?

- a) For example, would you say that you are in good health or do you have health conditions that give you problems?
- b) How often do you use medical services (general practice, nurse practitioner, specialist, ER)?
- c) Do you take prescription medication regularly?

Can you tell me about your experiences during health insurance navigation?

- a) What made you decide to seek out a health insurance navigator?
- b) How did you come into contact with the health insurance Navigator who helped you?
- c) Did you attempt to go through the process without assistance before seeking out a Navigator to guide you through the process?
- d) Can you describe the basic elements of your health insurance enrollment navigation encounter?
- e) Do you consider your navigation experience to have been successful or unsuccessful? Why?
- f) Prompt for details about quality of communication between the participant and the client.

Did a health insurance Navigator help you submit an application to the federal/state Marketplace web site?

- a) How would you evaluate the experience of using the exchange web site?
- b) Did you find it easy or difficult to fill out the application? (Please ask for specifics either way)

- c) Was anything about the experience particularly frustrating or confusing? If so, what (if anything) did the Navigator do to mediate your frustration and help you along?
- d) Was anything about the experience particularly satisfying, empowering, or surprising in a positive way?

(If relevant to participant) Did a health insurance Navigator help you choose a health insurance policy? Was this process successful for you?

- a) Was anything about the experience particularly frustrating or confusing? If so, what (if anything) did the Navigator do to mediate your frustration and help you along?
- b) Was anything about the experience particularly satisfying, empowering, or surprising in a positive way?
- c) Did you find it easy or difficult to choose between plans? (Please ask for specifics either way)
- d) What do you recall about the number and variety of plans available to you? How did this affect your decisions about purchasing coverage?
- e) Did you have problems understanding the policy descriptions because of technical wording, or was it easy to understand them? Did your Navigator explain unfamiliar terms?
- f) What were you looking for in a health plan (examples: types of coverage, low copay, low deductibles, low-cost plan, etc.)?

(If relevant to participant) Do you have any concerns about your new health insurance policy?

- a) Budgeting for premiums?
- b) Meeting copay and deductibles?
- c) Choice among providers?
- d) Knowing which providers accept your plan?
- e) Accessing information and resources about your coverage?

As a consumer, what factors do you think are most important to being able to successfully submit a marketplace application and enroll in an insurance plan?

- a) What factors make someone less likely to successfully submit a marketplace application and enroll in an insurance plan?
- b) What sorts of technology are important? What sorts of information do people need access to?
- c) Have you been able access the information that you need or find good and helpful information sources?

(If applicable to participant) Was your Navigator able to assist you when you were found to be eligible for Medicaid? What resources, if any, did the Navigators provide you with? Did they help you enroll?

(If applicable to participant) Was your Navigator able to assist you when you were found to be ineligible for both Marketplace and Medicaid? How?

What do you think would be most helpful for consumers like you who are going through the navigation and enrollment process?

- a) Technology/technical support?
- b) Information?
- c) Financial planning and health insurance literacy resources?

## Appendix C: Data collection instruments used with Navigators

### 1. DEMOGRAPHIC QUESTIONNAIRE FOR USE WITH NAVIGATORS PARTICIPATING IN TELEPHONE INTERVIEWS

#### INSTRUCTIONS:

For each question, please check the box next to the answer that best describes the participant and, if appropriate, fill in the blank with the requested information. If you choose “other” for any of the following items, please write a specific answer in the space provided.

- (1) What year were you born? \_\_\_\_\_
- (2) What is your gender? \_\_\_\_\_
- (3) What is your zip code? \_\_\_\_\_
- (4) In which zip code do you work? \_\_\_\_\_
- (5a) How long have you worked as a health insurance navigator? \_\_\_\_\_
- (5b) How long have you worked in the health insurance industry? \_\_\_\_\_
- (6) What is your best estimate of how much money came into your household last year?

\_\_\_\_\_

(7) What is the highest level of education that you completed? \_\_\_\_\_

(8) What do you consider your ethnic background or ethnic self-identity?

<input type="checkbox"/>	African American/Black
<input type="checkbox"/>	Asian Pacific Islander
<input type="checkbox"/>	Asian
<input type="checkbox"/>	Native American
<input type="checkbox"/>	Hispanic/Latino/Latina
<input type="checkbox"/>	Multi-racial
<input type="checkbox"/>	White, non-Hispanic
<input type="checkbox"/>	Other ethnic self-identity_____

(9a) Can you estimate how many clients you assisted with insurance enrollment per week on average?

\_\_\_\_\_

(9b) Can you estimate on average the proportion of clients who you have successfully assisted in submitting an application on healthcare.gov? \_\_\_\_\_

(9c) Can you estimate on average the proportion of clients who you have successfully assisted in choosing a health insurance policy? \_\_\_\_\_



## 2. INTERVIEW GUIDE FOR USE WITH NAVIGATORS PARTICIPATING IN TELEPHONE INTERVIEWS

### INSTRUCTIONS

After obtaining oral consent from the participant, use this guide to complete the semi-structured telephone interview. Following the interview, collect any additional demographic information needed to complete the Demographic questionnaire for Navigator participants in telephone interviews.

Can you tell me about your work as a health insurance Navigator?

- a) How long have you worked as a Navigator?
- b) Can you describe the training you received?
- c) What made you decide to become a health insurance Navigator?
- d) How are you put in contact with clients?
- e) Can you describe the basic elements of a health insurance enrollment navigation encounter?
- f) Have you developed any strategies or practices to make navigation go smoothly or improve success for clients?
- g) What are frustrations that Navigators encounter in their work?
- h) How do Navigators mitigate frustrating situations?

Based on your experiences as a Navigator, what factors make a client likely to successfully submit a marketplace application and enroll in an insurance plan?

- a) What factors make a client less likely to successfully submit a marketplace application and enroll in an insurance plan?
- b) What sorts of information do clients need?
- c) Have you been able to provide clients with the information they need or direct them to good information sources?

What are the greatest barriers to successful navigation that you have encountered? How did this affect your ability to help clients?

- a) Are there specific barriers associated with submitting a state/federal marketplace application?
- b) Are there specific barriers associated with choosing a health insurance plan?
- c) Does the number of plans available to clients through exchanges seem to affect their likelihood of choosing and enrolling in a plan? If so, how?
- d) What are the most effective elements of the state/federal exchanges in terms of facilitating the enrollment process?

As a Navigator, what do you think are the characteristics of effective communication in the Navigation encounter?

When you and a client experience communication problems or barriers associated with health insurance literacy or technological literacy, what can you do to improve the situation?

Which resources are most useful for you as a health insurance Navigator?

- a) What resources are least useful for you as a Navigator?
- b) Are there any resources that would be useful to you or your clients but do not exist?
- c) Are there resources that could be improved? How should they be improved?

What resources do Navigators have to help clients who are found to be eligible for Medicaid?

- a) What resources do Navigators have to help clients who are found to be ineligible for both Marketplace and Medicaid?
- b) How do you proceed when clients fall into the "Medicaid Gap"?