In Person Assisters:

Lessons Learned from Enrolling the Uninsured in North Carolina

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I. INTRODUCTION

Enactment of the Affordable Care Act (ACA) in 2010 marked a new era in the American health care system. The ACA seeks to make health insurance more accessible and affordable, in part by establishing new purchasing pools that the uninsured and small businesses can join. As of October 1, 2013, millions of uninsured individuals are able to buy health coverage through these new “marketplaces.” The Congressional Budget Office estimates that 22 million individuals will enroll through the marketplaces, and altogether, including expanded access to Medicaid, 25 million currently uninsured individuals could gain health insurance coverage by 2016. This potential influx of individuals seeking coverage has large implications for the American health care system and will require well-coordinated efforts by many different stakeholders across the country.

Although the ACA aims to reduce barriers to purchasing insurance, millions of the newly insured will come from difficult experiences of struggling to access health care and facing the associated challenges of being uninsured. Without health insurance, uninsured individuals, especially low-income individuals, may forego necessary medical care in lieu of other important expenses, such as food, transportation, housing, utilities, and child-care. These persons are more likely than their insured counterparts to delay needed care, end up in the hospital with preventable conditions, and ultimately die from avoidable conditions. Through expanded access to subsidized private insurance, the ACA could potentially reduce the number of uninsured by 997,770 income-eligible individuals in North Carolina alone—although the Kaiser Family

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1 Note that the words “marketplace” and “exchange” are used interchangeably throughout this paper. The ACA called these purchasing pools exchanges, but amidst the controversy surrounding their establishment, the Obama Administration subsequently relabeled them as marketplaces.

2 Also referred to in the literature as consumer assistance and enrollment assistance.

3 Although there is a third type of consumer assister called Non-Navigator Assistance Personnel, North Carolina will not employ...
Foundation predicts that only 398,000 of those who are eligible will actually gain coverage. Since 1,549,918 uninsured adults lived in North Carolina in 2010 – representing nearly one-fifth of adults, and almost one-half of low-income adults – the new coverage options through the ACA represent a large opportunity to improve the health of the state.

In spite of these potential gains, the uninsured have many misconceptions about the ACA. Although nearly 75% of adults know that the ACA requires that they have health insurance, only two in five were aware of the new health insurance marketplaces between July and September of 2013. Those most likely to benefit from these marketplaces are even less likely to know about them, with 32% of the uninsured knowing about the marketplaces as compared to 43% of their insured counterparts.

Confusion about the ACA’s coverage provisions underscores the importance of outreach and enrollment. Successful efforts are crucial if the ACA is to meet its projected target for covering the uninsured. Due to their widespread unfamiliarity with the health insurance marketplaces, more than half of (60%) uninsured individuals report that they want personalized help navigating the new online system. The federal government has established in person assistance programs to identify, educate, and assist consumers with enrollment into the new health insurance marketplaces. These in person assistors (IPAs) include Navigators, Certified Application Counselors, and Non-Navigator Assistance Personnel. They receive training by the state and/or federal government to help the uninsured enroll through the marketplace and will need to implement a variety of strategies in order to help enroll the uninsured.

Although IPAs will play a central role in new enrollment efforts, not much is known on best enrollment practices for the marketplaces. While policy makers and IPAs can learn key

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2 Also referred to in the literature as consumer assistance and enrollment assistance.
lessons from previous enrollment efforts conducted in Massachusetts in 2006, and nationwide for Children’s Health Insurance Program (CHIP) and Medicaid, it is unclear which practices will prove most effective for enrolling the uninsured through the ACA. As ACA enrollment efforts move forward, it will be important to both document and analyze the enrollment experience of IPAs.

Given the importance of IPAs to ACA implementation, this study aims to explore the role that IPAs play in enrolling the uninsured across the state. This research will use semi-structured interviews with IPAs to address the following two research questions:

(1) What barriers have the IPAs faced in enrolling the uninsured in North Carolina?

(2) What strategies and conditions have, according to IPAs, helped facilitate enrollment among the uninsured?
II. BACKGROUND: THE ACA IN NORTH CAROLINA

The June 2012 Supreme Court ruling has had a major impact on ACA implementation. The Supreme Court upheld the constitutionality of the “individual mandate” (a required that all individuals obtain health insurance or else pay a tax penalty) as a valid exercise of the constitutional power to impose taxes. But the court struck down the constitutionality of the federal government defunding a state’s existing Medicaid program if the state chose to opt out of Medicaid expansion (to 138% of the Federal Poverty Line, or FPL).11 The Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) estimate that the Supreme Court decision will result in fewer individuals receiving Medicaid coverage, more individuals buying health insurance through the health insurance marketplaces, and more individuals being uninsured.12

The CBO and JCT estimate that roughly 6 million people who would have been eligible for Medicaid before the Supreme Court ruling will have incomes too low to qualify for subsidies in the health insurance marketplace.13 The marketplace will automatically apply these subsidies for insurance enrollees with incomes between 100-400% of the FPL. Another 3 million individuals who were previously eligible for Medicaid (with incomes between 100-138% of FPL) will have incomes high enough to qualify for government subsidies. However, these individuals will also be in a different position than they would have been had they received Medicaid coverage, for they will have to pay a portion of the marketplace premiums – a fact that may prevent some low-income individuals from enrolling into a health plan.14 Consequently, 4 million individuals who would have originally received coverage through the ACA will likely remain uninsured due to the Supreme Court ruling.15
States with high rates of uninsured individuals, like North Carolina, will be greatly impacted by the Supreme Court decision. Nearly one-fifth of adults, and almost one-half of low-income adults, are currently uninsured in North Carolina. Among the uninsured, 61.1% reported the main reason that they do not have health insurance is that they could not afford premiums. Thirteen hundred and seventy-seven thousand of these individuals would have enrolled in Medicaid if North Carolina had expanded the program, but will now remain uninsured.

These uninsured individuals may not receive needed health care, for nearly one-third of low-income adults in North Carolina in 2012 reported forgoing care in the last year due to it being unaffordable. Furthermore, the uninsured are less likely to receive important preventive care, primary care, and assistance with chronic care management. With more than 70% of the uninsured nationwide having gone without insurance coverage for at least a year, the health effects of uninsurance can accumulate with time.

Although the North Carolina General Assembly under former Governor Beverly Purdue (D) declared it would establish a state-run health insurance marketplace, under Governor Pat McCrory (R), it shifted to a federally facilitated marketplace. As a result, the federal government is operating the health insurance marketplace in NC and it has selected four Navigator entities to provide one-on-one assistance to consumers across the state. In fact, the ACA requires that every health insurance marketplace award grants to IPAs called navigators, who will help enroll uninsured individuals, self-employed individuals, and small businesses into health plans. These navigator entities must demonstrate that they have a well-established relationship, or could establish a relationship, with consumers who will likely enroll into the exchanges. In North Carolina, the four entities that received Navigator funding are: Mountain Projects Inc., Randolph Hospital Inc., Alcohol and Drug Council of NC, and North Carolina
Community Care Networks. Together with the additional 62 entities identified as “Certified Application Counselors” on the https://localhelp.healthcare.gov/ database for North Carolina, Navigators will work throughout the state to enroll individuals into the federally facilitated marketplace.

Table 1: Definitions of Three Types of IPAs in North Carolina

<table>
<thead>
<tr>
<th>In Person Assister:</th>
<th>Required Training:</th>
<th>Funding source:</th>
<th>Functions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Navigators</td>
<td>State-specific training, and 20-30 hour federal online course</td>
<td>Center for Consumer Information and Insurance Oversight</td>
<td>“Providing public outreach and education about the new health insurance marketplace, distributing fair and impartial information, facilitating enrollment in a qualified health plan, providing information in a manner that is culturally and linguistically appropriate for the population being served, and providing referrals to any applicable office of health insurance consumer assistance”</td>
</tr>
<tr>
<td>Volunteer Certified Application Counselors (CACs)</td>
<td>State-specific training, and 5-hour federal online course</td>
<td>n/a</td>
<td>Same as above</td>
</tr>
<tr>
<td>Certified Application Counselors (CACs)</td>
<td>State-specific training, and 5-hour federal online course</td>
<td>Bureau of Primary Health Care</td>
<td>Same as above, and maintain consumers’ contact information, receive ongoing training from BPHC, submit quarterly reports on efforts</td>
</tr>
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IPAs in North Carolina face significant challenges in facilitating enrolling into the health insurance marketplace. With 51.8% of the state’s uninsured having gone at least five years without insurance, some may be unfamiliar with key ACA provisions. In fact, 78% of the uninsured, and 72% of all individuals, reported no awareness of the new health insurance options available through the health insurance exchanges between September and October of 2012. For

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3 Although there is a third type of consumer assister called Non-Navigator Assistance Personnel, North Carolina will not employ these personnel as they are only available through state-run exchanges.
those who are aware, many report feeling “confused,” “overwhelmed,” “worried,” and “helpless” due to the ACA’s complexities. In order to meet enrollment goals, it is therefore critical that IPAs promote awareness of, and information about, the marketplace, including details about the insurance affordability programs offered through the website. According to one study by the Kaiser Commission on Medicaid and the Uninsured, the uninsured are less likely than their insured counterparts to understand the availability of financial assistance for health insurance through the online marketplaces: 31% of the uninsured said that they were aware of financial assistance as compared to 43% of the insured. Since the uninsured typically lack coverage because of the cost and not because of a lack of desire for coverage, it is important that consumer assistance efforts in North Carolina highlight the various affordability components of the health insurance exchanges when working with the uninsured.

IPAs will thus be a vital component of statewide efforts to enroll the 997,770 uninsured in North Carolina who are now eligible for coverage. All IPAs will work to provide public outreach and education about the exchanges, distribute fair and unbiased information to consumers, facilitate enrollment into Qualified Health Plans (QHPs), provide information in a culturally and linguistically appropriate way, and address all unmet concerns by providing referrals to any relevant office of health insurance consumer assistance. Regulations issued by the US Department of Health and Human Services also require navigators to complete an online training by the federal government and to be free of any conflict of interest – for example, navigators cannot receive any form of benefit from health insurance issuers by enrolling individuals into a health plan. Consumer information, collected by county through a central call center, will help inform the outreach and enrollment efforts to be conducted by the IPAs in North
Consequently, dozens of IPAs will be making a concerted effort in the upcoming months to find and enroll the uninsured across the state.
III. LITERATURE REVIEW: A HISTORICAL LENS

Learning from the Experiences of Medicaid, CHIP, and SHIP

Although IPAs have just recently begun their outreach and enrollment efforts through the ACA, previous efforts to promote enrollment in Medicaid, Children’s Health Insurance Program (CHIP), and Medicare, and state programs such as the 2006 health reform in Massachusetts offer potential lessons.

Medicaid is the nation’s premier health insurance program for low-income children, parents, pregnant women, elderly, and disabled individuals. However, Medicaid’s eligibility guidelines leave millions of low-income individuals ineligible for Medicaid every year. To fill this hole, CHIP was enacted in 1997 as an extension of the Medicaid eligibility guidelines for children. While enrollment into CHIP was modest in the first year, it increased quickly by the third year due to heavy marketing efforts. CHIP’s history is therefore especially relevant to current outreach and enrollment efforts through ACA because, prior to the enactment of CHIP, states did little to actively market public programs. Through Medicaid and CHIP, stakeholders can examine the success of outreach efforts, the take-up rates for enrollment into health insurance programs, as well as the assistance needed by consumers to overcome barriers to enrollment.

One fundamental barrier to enrolling eligible individuals into Medicaid and CHIP is the lack of awareness among the uninsured about their eligibility for the programs. In fact, Kenny et al. (2009) found that over 90% of low-income parents would enroll their uninsured children in Medicaid and CHIP if they were eligible, but half did not know that their children were eligible. Medicaid and CHIP have implemented a combination of broad and targeted outreach
efforts to promote enrollment, including creating marketing materials in languages beyond English and using images of families from different racial/ethnic backgrounds.\textsuperscript{41} Along with these broad messaging techniques meant to build brand recognition, state CHIP programs also utilized more fine-tuned messages that highlighted the specific eligibility criteria and the value of having one’s kids covered in CHIP.\textsuperscript{42} Many states found it helpful to keep outreach messages simple and utilize a “less is more” approach in order to not overload the public with potentially confusing details.\textsuperscript{43} These ads did, however, often included information for a website or toll-free hotline that parents could contact for further details.\textsuperscript{44} Some states, such as Oregon, worked directly with members of racial/ethnic minority communities to create CHIP materials, in order to ensure that they were linguistically, as well as culturally, appropriate for certain uninsured communities.\textsuperscript{45}

Despite the importance of outreach, Medicaid and CHIP’s experiences demonstrate that enrollment efforts must take additional steps to address stigma and poor perceptions of public programs that may hinder enrollment.\textsuperscript{46} IPAs must therefore address the barriers of stigma associated with public programs in order to enroll the uninsured. Medicaid and CHIP enrollment efforts have utilized one-on-one enrollment assistance by trusted individuals in the community as a successful method to address negative perceptions. Both the Medicaid and CHIP programs have seen positive responses from their efforts to leverage partnerships with community-based organizations, such as schools, faith-based organizations, child care centers, and human service organizations, to enroll the uninsured.\textsuperscript{47} While the estimated Medicaid take-up rate, or rate of Medicaid enrollment among Medicaid-eligible individuals, was 54% for adults nationwide in 1999, it has since increased to 68.2% in 2009.\textsuperscript{48} Meanwhile, take up rates into Medicaid and CHIP are even higher in children, with 85.8% of eligible children participating in Medicaid or
CHIP in 2010.\textsuperscript{49} A 2011 evaluation found that many states reported partnerships with community-based organizations (CBOs) as the most effective partnerships for enrollment, due to the “prominence and trust” that these organizations had within their communities.\textsuperscript{50} Three specific noteworthy examples of successful CHIP efforts to enroll children with CBOs include: back-to-school campaigns Kentucky in which children and their families were encouraged to enroll through their schools; another effort in southwest Georgia that had leadership from African American ministers who led a community-wide faith-based initiative; and another program in Georgia that gave a mini-grant to a local Goodwill agency which targeted enrollment efforts through Goodwill stores, job placement agencies, and job fairs.\textsuperscript{51} These community-based efforts capitalized on the important role that trusted community-based organizations often have with hard-to-reach populations who might otherwise not enroll into public programs.

Another challenge faced by families with children eligible for CHIP is the difficulty of completing the enrollment process, and confusion surrounding the administrative complexities of renewing one’s enrollment.\textsuperscript{52} In a study by Kenney et al. (2009), 55\% of low-income parents found the CHIP application process difficult, and 51\% did not know where to get more information or help.\textsuperscript{53} Consequently, 64\% of uninsured children in the study were eligible for Medicaid/CHIP but not enrolled.\textsuperscript{54} Because so many individuals were eligible for Medicaid and CHIP but not covered, states started to take new and innovative approaches to simplify enrollment. Some of the efforts undertaken for CHIP included the use of one-on-one assistance, offering multiple enrollment avenues by developing the capacity for enrollees to submit their application by mail or online, eliminating the need for a face-to-face interview, implementing continuous coverage for the child despite small changes in the family income, and extending grace periods to families who are unable to pay their premiums on time.\textsuperscript{55} Many states also
utilized web-based tools for CHIP enrollment that could be accessed through mobile devices, which worked well with low-income communities; in fact, research demonstrates that low-income populations are faster adopters of the Mobile web than their higher-income counterparts. States also placed an increased focus on “in-reach” by conducting education efforts to keep kids enrolled in CHIP and reduce “churning”. These statewide “in-reach” campaigns often promoted two main messages: families experience significant value from CHIP coverage for their children, and families should appropriately use health insurance in order to access care for their kids. Other states utilized data collected from other state programs – such as food stamps or the Women, Infant and Children program (WIC) – to simplify enrollment and decided to simplify their renewal process. Further simplification efforts, such as reducing paperwork requirements and ensuring that application forms are offered in plain language, as well as multiple languages, helped consumers who had low literacy and/or for whom English was not a primary language. As a result of these efforts, low-income families with children enrolled in CHIP faced less of an administrative burden when aiming to enroll or keep their children in CHIP.

Whereas CHIP and Medicaid efforts provide valuable information about take-up among low-income children and adults, Medicare Part D enrollment efforts provide valuable information related to take-up among the elderly in a program that resembles the ACA’s marketplaces since it offers numerous private insurance options. Medicare consumers feel that the program is “confusing” and that the decision process is “overwhelming” because of the wide array of plan choices associated with Medicare Part D. As a result of the difficulty comparing available plans, many potential enrollees into Medicare Part D ended up making choices that

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4 Churning is the phenomenon when eligible children drop out of coverage and then reenroll within a short time frame such as three to six months.
were not ideal for their personal circumstance.\textsuperscript{64} Consumer assistance programs are vital for the elderly, who may need help reading the forms, understanding the options, and applying for coverage.

The federal government has implemented in-person consumer assistance efforts in every state to help seniors with their Medicare options. Specifically, the federal government funds State Health Insurance Assistance Programs (SHIP) across the country to provide one-on-one assistance to Medicare beneficiaries;\textsuperscript{65} these programs are in fact the foundation on which the Navigator efforts were modeled.\textsuperscript{66} SHIP programs in different states have included in-person assistance efforts by local partners, such as senior centers, civic and social organizations, and local government agencies.\textsuperscript{67} In North Carolina, this program is run through the North Carolina Department of Insurance, and is called the Seniors Health Insurance Information Program (SHIIP). SHIIP trains volunteers to provide in-person counseling to Medicare beneficiaries across the state. SHIIP volunteers counsel Medicare beneficiaries on a wide range of issues, including: Medicare Part B premiums, Medicare supplement plans, Medicare Advantage/Medicare Healthplans (Part C), Medicare Prescription Drug Plan (Part D), employer health insurance, and long-term care information.\textsuperscript{68} There is no systematic study on SHIIP’s impact, however the program prides itself on the full range of services provided, as well as the uniformity and quality of services provided across North Carolina. According to Carla Obiol from the North Carolina Department of Insurance (NCDOI), “What has served SHIIP so well through the years is the ability to provide uniform messaging and training across the state as well as continuous training and updates to the volunteer counselors.”\textsuperscript{69} The NCDOI provides ongoing training and education to volunteers through e-mail updates, news bulletins, and monthly in-person trainings. Furthermore, the NCDOI has a statewide toll-free line to which counselors can
all and receive consumer-oriented assistance. Obiol said that they “take pride in [the counselors’] contributions and strive to honor their commitment by keeping them informed at all times.” Statewide efforts to enroll the elderly into Medicare Part D, such as SHIIP, therefore provide valuable insight moving forward on the value of in-person assistance for groups that may be confused about health insurance options.

The Massachusetts Experience with Health Reform

Massachusetts provides another example of government efforts to enroll consumers into health insurance. In 2006, Massachusetts enacted a statewide health reform to expand health insurance coverage that would later become the model for the ACA. Along with expanded eligibility for Medicaid, new coverage provisions, and increased outreach efforts, Massachusetts health reform allocated funding for IPAs to enroll uninsured communities. The 2006 law also created the Connector, a statewide online website on which to purchase health insurance in Massachusetts. This website offered private and subsidized health plan options for individuals, families, and small employers in an easily comparable side-by-side format, and utilized government data to check eligibility. The Connector became the model for the ACA’s health insurance exchanges. With the aid of IPAs, tens of thousands of individuals in Massachusetts navigated through the Connector to buy health insurance.

One main challenge that IPAs observed was that consumers had a difficult time determining their eligibility for, and understanding the various components of, health insurance plans. Low-income communities, in particular, were confused about their eligibility because of their unstable income and residential living situations. Although low-income communities in Massachusetts are likely to experience monthly fluctuations in income, eligibility criteria for
subsidy programs remain constant.\textsuperscript{72} Some low-income consumers consequently faced the risk of getting rejected for subsidies, because their information no longer met the eligibility criteria. Others were confused about how to document their living situation, as it changed often. Further misunderstanding of concepts like premiums, deductibles, provider networks, formularies, or coverage exclusions and limitations, made the selection of a health choice very difficult for communities with low health insurance literacy rates, especially for those who had little or no experience with health insurance.\textsuperscript{73} In fact 42\% of Massachusetts citizens in one study found that the plan information offered in the Connector was difficult to understand.\textsuperscript{74} When faced with these complex decisions, consumers were more likely to make choices based upon shortcuts – such as comparing their options with the sole consideration of brand, rather than formularies or provider networks.\textsuperscript{75} This can lead to suboptimal plan selection, and in fact nearly one in two (45\%) who were confused said that out-of-pocket costs were higher than they anticipated\textsuperscript{76} – a consequence that could also be associated with a lack of comprehensive coverage options offered on the Connector. The lack of full understanding of eligibility for, and the various components of, health insurance posed a major challenge for consumers shopping in the Massachusetts Connector.

In order to help consumers, Massachusetts employed in-person assistance to answer general questions, determine eligibility, and guide consumers with enrollment. Staff at community health centers was central to enrollment efforts, because they were familiar with the challenges of, and well trusted by, medically underserved communities.\textsuperscript{77} Other IPAs found that having direct access to important documents, such as wage information, was important for screening consumers for eligibility in various subsidies and for helping with enrollment, but also required privacy and confidentiality trainings.\textsuperscript{78} Sinaiko et al. found that one-third of
respondents reported incomes that would have made them eligible for subsidies had they known, so it is clear that there was further need for in-person assistance. They also found that there was need for assistance at all points in the enrollment process, for “assistance is not a one-time matter”.

Another challenge in Massachusetts was the limited capacity of the staff working to enroll the uninsured. Massachusetts underestimated the number of people who would be eligible, and who would enroll, for free and subsidized coverage. Although the 2006 estimate was 140,000, enrollment reached a height in 2009 at 177,000. In total, there were 367,000 newly insured individuals in the first year alone of health reform. The statewide workforce of IPAs was thus inadequate for the high demand. Nearly one in three consumers (28%) thought that selection would have been easier if there had been fewer options. Furthermore, health center staff noted that many of the individuals they worked with had no experience with health insurance, and thus did not understand concepts such as provider networks, formularies, premiums or deductibles. IPAs spent substantial time educating consumers about how to compare plans, on top of the time-intensive process of going through documentation for the eligibility requirements of such plans. Consequently, there were backlogs of consumers seeking help, and many individuals expressed frustration from the long wait times to speak with an assistor over the phone. One-fifth of all respondents in one study wished they had help in narrowing their plan choices, indicating unmet demand for assistance.

The 2006 MA health reform included various online tools that mitigated some of the unmet demand for staff support. With 82% of survey participants responding that they learned about the different Connector health plans through the internet, it is clear that online platforms can provide valuable information to answer some questions. However, internet usage was not
uniform across all age groups, with younger respondents between 18-34 reporting higher rates than respondents over 50 at 87% and 70% respectively. In-person enrollment assistance may be less necessary for younger groups, who might feel more comfortable relying on online resources. Other enrollment efforts demonstrated that some consumers simply lacked access to computers with Internet, and therefore needed access to mobile technology more than a consumer assister. Consequently, some parts of the state set up “self-serve kiosks” in community locations – such as health fairs, clinics, homeless shelters, unemployment offices, etc. – for use by uninsured individuals. Lastly, for those individuals who simply needed to renew their existing coverage, experience from Massachusetts showed that passive renewal efforts that automatically renewed coverage if no household circumstances had changed freed up IPAs to work with individuals needed more personalized assistance.

While the Massachusetts health reform experience offers potential lessons about the challenges that IPAs may face in enrolling the uninsured in North Carolina, there are significant differences between the situation in Massachusetts and that of North Carolina. First of all, there were six commercial insurance carriers offering private health plans in the Connector, while there are only two in North Carolina – Blue Cross Blue Shield of North Carolina in all 100 counties and CoventryOne in 39 counties. Since nearly one-third of consumers in the Connector reported that enrollment would have been easier had there been fewer plan options, it is possible that the fewer commercial insurance carriers in North Carolina will ease some enrollment-related confusion for consumers. However, given that Massachusetts citizens have a higher average level of educational attainment than North Carolina citizens, North Carolina has opted out of Medicaid expansion, and the political environment in North Carolina is inhospitable
towards the ACA, the challenges that IPAs face in North Carolina could be different than those faced by IPAs in Massachusetts.
IV. METHODS

Design

This research uses a multiple case study design involving enrollment-related organizations. The methodology comes from Robert Yin’s *Case Study Research: Design and Methods* (2009) as well as Huberman and Miles’ *Drawing Valid Meaning from Qualitative Data* (1983). As stated in the Introduction section, this study will address the following two research questions:

1. What barriers have the IPAs faced in enrolling the uninsured in North Carolina?
2. What strategies and conditions have, according to IPAs, facilitated enrollment among the uninsured?

Implementing the ACA in North Carolina

Due to the North Carolina General Assembly’s decision for North Carolina to utilize a Federally-Facilitated marketplace, there are only two types of consumer assistance entities in North Carolina: Navigators and CACs. These entities differ in the level of training; although both have to complete the state-specific training, Navigators are required to complete a 20-30 hour federal online training course, while CACs must only complete a 5-hour federal online training course. In North Carolina, four Navigator entities received federal grants, including: Randolph Hospital Inc., Mountain Projects Inc., NC Community Care Networks, and the Alcohol and Drug Council of NC. Two distinct types of CACs also exist, based upon whether they receive grant money. While all Navigators in North Carolina receive grant money funded through the Center for Consumer Information and Insurance Oversight (CCIIO), some CACs are
volunteers who receive no grant funding. Meanwhile, the grant-funded CACs operate through Federally Qualified Health Centers (FQHCs), and are funded through the Bureau of Primary Health Care (BPHC). Consequently, these grant-funded CACs must fulfill additional requirements, such as: conducting outreach, maintaining consumers’ contact information for follow-up and ongoing consumer education, receiving ongoing training from BPHC, and submitting quarterly reports on outreach and enrollment efforts – these reports include: the number of CACs trained, the number of individuals getting in-person enrollment assistance, the number of applications submitted in the marketplace with assistance from a grant-funded CAC, and the estimated number of individuals who will enroll in assistance.

In North Carolina there are also enrollment facilitation groups working across the state, such as Enroll America, the “Big Tent” collaboration, Legal Aid, and the North Carolina Justice Center. While Enroll America is a nationwide organization that works to facilitate enrollment efforts in every state, the “Big Tent” group is a statewide collaboration of different individuals involved in enrolling the uninsured. Legal Aid employs Navigators to work in 93 counties (and partners with other groups to cover the remaining seven counties in NC), and the North Carolina Justice Center works on policy and advocacy work surrounding issues affecting low-income populations in North Carolina.

Research Methods

It is important for policy makers and future enrollment-related individuals to understand IPAs’ experiences and perceptions. This study utilizes qualitative methods to obtain first-hand perspectives by speaking with individuals who are best equipped to provide that information.
Because the perspectives of the interviewees will likely vary, qualitative methods will prove important for the sake of portraying the richness and diversity of the findings.

Specifically, this study will utilize semi-structured in-person interviews with enrollment-related individuals to collect qualitative data on the perceived challenges and barriers, as well as perceived successful strategies, for enrolling the uninsured. This method is especially useful when the researcher has limited opportunities to interview someone. According to Bernard, the semi-structured format allows the researcher to follow a general script and cover important topics, while still remaining open-ended for the key informant to provide the information that he or she thinks is the most important. Or as Bernard writes, “The rule is: Get people onto a topic of interest and get out of the way.” The structure also helps to ensure comparable data between key informants. I used an interview guide to guide the interviews, which included a general script of important topics. I probed for additional information as needed throughout the interview.

Refer to section titled “Instruments” below to view the topics addressed in the interview guides, and “Appendix A” and “Appendix B” to view the instruments.

Selecting the Case Counties

The sources of data were (1) interviews with Navigators, (2) interviews with Certified Application Counselors (CACs), and (3) interviews with state enrollment personnel. All interviews were conducted in person. The study examined enrollment work through three cases: counties identified as “Metropolitan,” others as “Micropolitan,” and others as “Noncore.”

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5 Throughout the paper, the researcher will interchangeably refer to these individuals who were interviewed as “informants” and “interviewees.”
Cases were selected using convenience sampling, a method through which samples are selected based upon how convenient it was for the study to access them. First, all counties in North Carolina were stratified into three Core Based Statistical Area classifications: Metropolitan Statistical Area (urbanized areas of 50,000 population or more), Micropolitan Statistical Area (10,000-50,000 population), and Noncore (less than 10,000 population). As of 2013 distinctions from the United States Office of Management and Budget, North Carolina contains 46 Metropolitan Statistical Areas, 28 Micropolitan Statistical Areas, and 26 Noncore Statistical Areas.

The study then used a combination of purposeful and convenience sampling to select the case counties. First, the study selected several possible counties to include in each of the three classifications based on proximity to central North Carolina. Then, potential key informants were contacted from each type of case county, using the “North Carolina ACA Outreach and Enrollment: In Person Assister County Resource Directory.” This directory, compiled by the Big Tent on January 17, 2014, lists in person assisters by type of organization (Navigator, FQHC, or independent CAC) and by county.

For the state enrollment key informants, I worked closely with the CEO of the North Carolina Institute of Medicine to identify stakeholders that would be most knowledgeable about various forms of statewide enrollment facilitation work. I then contacted these four individuals, and all four agreed to participate in the study.

This study then moved forward using convenience sampling, based upon which IPAs responded with an availability and willingness to participate. As a result of time limitations, I did not only select from three case counties, but instead from multiple counties that fell into each Core Based Statistical Area classification.
Selecting Respondents within Each Case

Subjects for interviews acted as key informants into the perspectives and experiences of IPAs, and were primarily defined by one of the four following types of enrollment-related organizations: Navigators, Certified Application Counselors (CACs), FQHC CACs, and enrollment facilitation groups. The individuals in each group provided a helpful overview of enrollment efforts, as well as a different perspective from the CACs and Navigators who worked directly with consumers.

At least one individual in each type of enrollment-related organization was contacted to participate in interviews for each case county, and only one was interviewed when more than one replied with interest. I initiated primary contact via e-mail, and then contacted the potential participant by phone if there was no response to the e-mail within one week. If there was still no contact after the initial e-mail and phone call, I sent a follow-up e-mail and phone call. If there was no response after these two rounds of contact, I moved on to a new potential participant. This study included interviews with thirteen enrollment-related individuals – three from each of the three types of case counties, and four from statewide enrollment organizations (Figure 1).
Data analysis methods

Qualitative data collected from in-person interviews was recorded using a handheld digital voice recorder and transcribed on Microsoft Word. All data were then analyzed for common themes and trends using Atlas.ti data analysis software. I participated in a two-part training, titled “Introductory Hands-on Workshop” on the Atlas.ti software through the Odum Institute at the University of North Carolina at Chapel Hill on January 21, 2014 from 2:00-4:00pm and on January 30, 2014 from 2:00-4:00pm. I then analyzed interview data by examining trends between all thirteen interviews, with a focus on trends between all interviewees and trends exclusively between IPAs. This approach allowed the study to identify perceived successes and challenges that various stakeholders faced in different settings.

Figure 1: Research Design
Ethnical considerations

As MQ Patton states, “Interviews are interventions. They affect people.” Due to this, Bernard states, “there is no ethical imperative in social research more important than seeing to it that you do not harm innocent people who have provided you with information in good faith.” Maintaining confidentiality about sensitive information given the controversy surrounding health care form was particularly important.

This study aimed to structure the interview tools, conduct the interviews, and analyze the data as responsibly as possible to minimize potential ethical risks. However, I could not fully predict what information the interviewee chose to offer. I therefore took into consideration how to respond if the interviewees revealed information that put their position at risk – for example, if they revealed personally-identifiable health information or experiential accounts of incorrect assistance to consumers. In this study, the ethical considerations were especially important to consider, because the interviewees explained their experiences working with other individuals who were not in the room. This study therefore ensured the anonymity of its findings through a variety of ways. First, any data related to personally identifiable information about the key informants or their clients was anonymized. Furthermore, when analyzing the data, any data that could potentially hinder the position of any of the key informants was omitted. These measures also, in effect, minimized the risk of the key informants experiencing a loss of professional standing or reputation, since the findings were not traceable back to any one key informant.

Instruments

This study utilized interview guides to prompt responses by the study participants. The interviews were designed to prompt enrollment-related individuals to describe the strategies that
they utilize to enroll the uninsured, especially regarding the perceived effectiveness and challenges associated with each strategy. MQ Patton’s *Qualitative Evaluation and Research Methods* (1990), Bernard’s *Interviewing: Unstructured and Semi-structured* (1988), and Yow’s *A Practical Guide for Social Scientists: Interviewing Techniques* (1994) informed the development of these interview guides.

The interview guide for IPAs (Appendix A) addressed the following topics:

- Background
- Challenges
- Current Political/Demographic Environment
- Successful Strategies
- Training/Preparedness
- Future Efforts

The interview guide for statewide enrollment personnel (Appendix B) addressed the following topics:

- Background
- Challenges
- Current Political/Demographic Environment
- Successful Strategies
- Future Efforts
V. RESULTS

Qualitative Analysis:

Qualitative data were categorized into three primary themes related to enrollment into the marketplace: a) strategies and conditions that facilitated enrollment, b) barriers to enrollment, and c) other themes. Interviewees identified several different facilitators, barriers, and other themes. Strategies and conditions identified that facilitated enrollment include: 1) the importance of partnerships; 2) the importance of the Scheduler; 3) the importance of Enroll America; 4) the persistence of consumers; 5) the use of phone call reminders to consumers; 6) the affordability of insurance options; and 7) the use of printed or written information for consumers to review at home. The frequency of these themes can be found represented in green in Figure 2 and Figure 3 below.

Meanwhile, factors identified as barriers to enrollment include: 1) the exchange glitches; 2) the existence of the “Medicaid gap”; 3) misconceptions about the ACA; 4) the challenges of a demanding workload for IPAs; 5) low health insurance literacy among consumers; 6) the absence of a state-run exchange; 7) an inadequate or cumbersome IPA training; 8) challenges of outreach; 9) the unaffordability of insurance options; and 10) IPA misunderstanding of Medicaid eligibility. The frequency of these themes can be found represented in red in Figure 2 and Figure 3 below.

Finally, two themes emerged that were not necessarily facilitators or barriers, and were therefore categorized as “other themes.” These factors include: 1) the absence of a formal or standardized evaluation plan to monitor the impact of efforts; and 2) the effect of county politics
on enrollment. The frequency of these other themes can be found represented in grey in Figure 2 and Figure 3 below.

Meanwhile, Table 4 in the Appendix has a full list of all codes, as well as their frequency from the interviews. Key findings are discussed in more detail below.

### Strategies and Conditions that Facilitated Enrollment

<table>
<thead>
<tr>
<th>Theme</th>
<th>Percentage of Interviewees that Mentioned Each Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Importance of partnerships</td>
<td>100</td>
</tr>
<tr>
<td>B. Importance of the Scheduler</td>
<td>62</td>
</tr>
<tr>
<td>C. Importance of Enroll America</td>
<td>54</td>
</tr>
<tr>
<td>D. Persistence of consumers</td>
<td>46</td>
</tr>
<tr>
<td>E. Use of phone call reminders to consumers</td>
<td>38</td>
</tr>
<tr>
<td>F. Affordability of insurance options</td>
<td>31</td>
</tr>
<tr>
<td>G. Use of printed or written information for consumers to review at home</td>
<td>23</td>
</tr>
</tbody>
</table>

Note: Percentages add up to more than 100, because some informants mentioned more than one major theme during their interview.

**The Importance of Partnerships**

Partnerships were unanimously identified as a crucial contributor to North Carolina’s enrollment success (N=13). Informants spoke about a wide variety of organizations that participated in outreach and enrollment work. Almost all informants mentioned that libraries and churches were their core partners. In fact, one interviewee explained that most libraries have gone above and beyond with their willingness and initiative in hosting outreach and enrollment events. Furthermore, this interviewee explained that libraries have been useful places for enrollment appointments because they tend to be quiet and have computers readily available with Internet access. Another informant explained that churches have been particularly useful places for outreach and enrollment, because “a lot of people feel more comfortable putting foot in a
fellowship hall or Sunday school or a church, than they might at, say, DSS.” Informants also spoke about other important partners, such as Departments of Social Services, hospitals (especially large hospitals with big charity care programs), Smart Start programs, YWCAs, Food Lions, K-Marts, League of Women Voters, local newspapers and radio stations, local electric and water companies, local community colleges, universities, pharmacies, and laundry mats. While some of these partners were used exclusively for outreach purposes (such as the electric and water companies), other helped with both outreach and enrollment. Due to this wide variety of partners, one informant explained that she approached the outreach portion of her job like a “grassroots campaign” for a new and unknown political candidate.

As mentioned above, universities and community colleges were recognized as key partners for enrollment purposes. Some IPAs mentioned that they targeted schools of law, social work, and public health to recruit student volunteers for either outreach and/or enrollment work. One informant explained that her organization has had more willingness from graduate rather than undergraduate students to volunteer, perhaps because of more “maturity and [disposable] time.” Another interviewee explained that her organization contacted schools with whom her organization already had a relationship, in order to maximize on convenience given the limited time for enrollment.

Additionally, collaborative partnerships existed between various IPA organizations. One informant identified that the NC Navigator Consortium, a group described as “a little bit of apples, oranges, pomegranates, [and] elephants,” has worked with “tremendous commitment to really mak[e] sure that NC does the best it can in enrolling the uninsured in the state.” Another important statewide coalition identified was the Big Tent, which comprises over 100 organizations that share information with one another in order to most successfully conduct
outreach and enrollment in NC. Other informants identified similar models to the Big Tent, but carried out at a local or regional level rather than statewide level.

Overall, partnerships were identified as a crucial ingredient for North Carolina’s enrollment success. One interviewee explained, “Funds are limited and resources are limited and so strength is in numbers,” and therefore, that community groups recognized the benefit of working together. However, one informant explained that local groups need additional regional collaboration in the future, so that they can sit down and brainstorm specific challenges and solutions faced regionally. Finally, it was clear that these partnerships were most effective when IPAs made sure to enlist the help of partners who were already trusted by the community, such as well-visited churches, libraries, or public health departments.

TheScheduler

The majority of interviews (N=8) spoke about the importance of the Scheduler, which is the online appointment scheduling system created by the North Carolina Navigator Consortium and the North Carolina Community Health Center Association (NCCHCA), with leadership and initiative by staff at Legal Aid of NC. Individuals from across the state can use the Scheduler to schedule an appointment near them by calling one toll-free statewide phone number, often referred to as the “(855) number.” One informant therefore said that the Scheduler acts as “the gate to everything.” The statewide and centralized aspects of this system were highly acclaimed by many informants. One interviewee explained, “Having the centralized Scheduler is something that is...almost non-existent in other places. [It] is a tremendous asset to be able to give people one number.” This interviewee went on to explain that in other states, for example, although outreach and enrollment workers have identified thousands of uninsured individuals
who need help, there is no way to directly schedule an appointment for them. The Scheduler is important because it creates a de facto statewide system for appointments, despite the lack of a state agency to coordinate efforts.

Furthermore, the Scheduler was identified as an important tool for consumers who do not feel comfortable navigating the Internet or computers in general. Based on anecdotal evidence from informants, these consumers ranged from elderly individuals who did not understand how to turn on a computer, to individuals who did not know how to read or write. For these consumers, it would have been difficult to go find local help using the www.healthcare.gov website. It was especially helpful to have a number that they could call so that they could speak with someone in order to schedule an enrollment appointment.

However, the Scheduler is not accessible to all IPAs; only Navigator and FQHC CAC organizations in the North Carolina Navigator Consortium and the North Carolina Community Health Center Association can enter in their appointments to the Scheduler, respectively. Although many interviewees said that they would like the Scheduler to be a “one stop [tool] for all the appointments in the state,” one interviewee explained:

*There’s been a big hesitation to expand it beyond those groups [in the NC Navigator Consortium and NCCHCA], because of uncertainty about ... the quality that those additional organizations would bring to the table, and how they would be approaching the appointments.*

Consequently, independent CACs each used their own personalized scheduling system for appointments, such as their work agenda or another individualized work calendar. As a result, some independent CACs struggled to conduct sufficient outreach to fill their available appointments, and were left “sitting around twiddling their thumbs…because they didn’t have
any consumers coming in the door to see them.” IPAs without access to the Scheduler also lacked access to a valuable source of data, in regards to the location and quantity of appointments held in various places.

One unexpected insight into the Scheduler was that, in some parts of the state, IPAs found it more effective to distribute the local number for their IPA organization, rather than the statewide (855) number. One IPA explained that her colleague in a micropolitan county asked to advertise her local office number as well as the (855) number, because people in that area felt more comfortable calling a local number than a statewide number.

**Enroll America**

Enroll America, a national nonprofit that seeks to maximize the number of individuals who obtain health insurance coverage, was often identified as an integral group for outreach efforts related to the Affordable Care Act (N=7). It was clear that this organization serves a unique role, especially for IPAs that were struggling with the outreach component of enrollment. One informant explained that working with Enroll America “is great, because they’re doing more of the motivating and directing and then we’re there to serve once they can do the handoff from the outreach to the enrollment.” Several other interviewees also mentioned the importance of this handoff between Enroll America and the IPA, and one interviewee even called the process the “one-two enrollment punch.” When asked to explain further, the informant described how Enroll America first conducts outreach in a community, and then uses Scheduler to directly schedule appointments with interested consumers. The IPAs then return to that same location in a few days to a week, and host a series of appointments with the interested consumers. By that point, one informant explained, the consumers have “learned how they fit [into the enrollment
eligibility criteria], they’ve learned what they need, and then you basically just roll through the enrollment process with them.”

Interviewees noted that another facilitator to successful enrollment was Enroll America’s use of Commit Cards. These cards collect the names, contact information, and insurance status of individuals who are interested in receiving more information about the Affordable Care Act, and/or who would like to schedule an appointment with an IPA. Enroll America then puts this information into the Get Covered Database, which is the comprehensive database kept by Enroll America for their “Get Covered” campaign to enroll individuals into the ACA. Enroll America then follows up with the individuals via telephone to provide more information and/or to schedule an appointment for the consumer in the Scheduler. Navigators identified this strategy as particularly helpful, because Navigators, unlike CACs or Enroll America staff, are legally prohibited by federal rules from keeping consumers’ personal information. Without personal information of consumers, Navigators could not make phone calls. One limitation of the Commit Cards is that they were printed while the www.healthcare.gov exchange was still experiencing major glitches; as a result, the Commit Cards do not have the www.healthcare.gov website on them, nor do they have state-specific information printed directly on them.

Overall, many IPAs viewed their ability to rely on Enroll America for successful outreach as a key component of successful enrollment work, which they might not have been able to do otherwise. One IPA felt as though Enroll America was available to help her whenever she expressed the need. Another informant explained that Enroll America “will work with anybody. You know, if you’re willing to spread the word, [Enroll America is] willing to help you do it.” This personal connection to Enroll America is better understood within the context of the initial challenges faced by IPAs when trying to fill enrollment appointments. While FQHC CACs
could fill their appointments with individuals in their existing FQHC patient population (a process referred to as “in-reach”), some Navigators and independent CACs experienced outreach challenges before they partnered with Enroll America. One interviewee explained that some Navigators are “used to just advertising their phone number and having more appointments than they can take, and that’s just not how this works. People are scared to sign up.” As a result, this informant explained that some Navigators had appointments that went unfilled until Enroll America came to conduct outreach, be it in the form of community education forums, information tables set out in front of grocery stores, or other methods.

**Consumer Persistence**

About half of all interviewees (N=6), and the majority of IPAs (N=5), spoke about the persistence of consumers with regards to enrollment. One informant remembered that her organization saw individuals who came in as many as eight times to complete their application, but still could not finish because of the glitches with www.healthcare.gov. However, the slow pace of the enrollment process did not stop some consumers. It was especially interesting to hear one informant explain:

*The medically needy are the people who are [most] persistent about [enrolling] because they have a need for insurance… it impacts the proportion of medically needy versus non-medically needy people that are going to end up in the [health insurance] pool.*
The Use of Phone Call Reminders to Consumers

Several interviewees (N=5) mentioned that using reminder telephone calls to consumers was a successfully strategy for reducing missed appointments and reducing the number of times that a consumer had to return to complete their application. One CAC explained that she told consumers about the necessary documents when they first scheduled their appointment, and then also reminded them about these documents over the phone the day before their appointment. Another CAC did not use phone calls to remind her consumers, but said that it was something she would consider doing in the future as a strategy to decrease the number of missed appointments that her organization experiences. Finally, all consumers who scheduled their appointment through the Scheduler receive a phone call from the North Carolina Call Center regarding which documents they need to bring to their appointment. These consumers then also receive a follow up e-mail to confirm the date and time of their appointment. Strategies such as these were seen as helpful to best utilize the limited time of IPAs.

Affordable Insurance Options

A few informants (N=4), and around one-third of all IPAs interviewed (N=3) spoke about the importance of having affordable insurance options on the exchange. One informant said that a family of four was able to buy a silver plan for just $45 a month. This informant explained that one woman was able to buy a silver plan for just $12 a month, and another woman was able to pay just $7.84 for a silver plan.\(^6\) The latter woman was noticeably happy, and “[she] danced [with the IPA] when they enroll[ed].” Another interviewee explained that she enjoyed turning the

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\(^6\) These monthly premiums are in comparison to the North Carolina state average of $145, after tax credits, for a 27-year-old with an annual income of $25,000 to purchase a silver plan. The state average for a silver plan for a family of four with an annual income of $50,000 is $282 after tax credits. Source: U.S. Department of Health & Human Services, Sept. 2013.
computer screen away from the consumer throughout the length of the enrollment appointment, until the very end when the consumer’s premium was determined. At that point, if the premium was inexpensive, she would look at the consumer and ask, “Well do you think... you might be able to pay $2.41 for insurance?” This interviewee laughed while explaining her strategy, and said “it’s just so much fun. There are some bad days, but the good days outweigh them.”

Another IPA explained that the presence of affordable options helped to overcome negative perceptions that consumers have of the ACA. According to this interviewee, once the consumers see the low price of their premium – some as low as 14 cents – they are immediately excited no matter how they felt coming into the session. However, this informant explained that some of these elated consumers cannot understand that this affordable insurance “has anything to do with Obamacare. They think it’s something different.” She said that these consumers “can’t bring the ideological hatred together in the room with the other piece,” but that ultimately the most important thing is for people to get enrolled into health insurance, no matter how they perceive the ACA.

The Use of Printed and Written Information for Consumers to Review at Home

One-third of the IPAs interviewed (N=3) spoke about printing or writing down insurance plan options as a useful strategy for helping consumers decide on an insurance plan. A few informants explained that navigating through the different options can be confusing for consumers, and that most of their consumers wanted to go home and think about their options before making a decision. As a result, another informant explained that she gave everyone “homework” to go home and add up predicted health costs for the family in order to help make their decision. In order to further help her consumers make their decision, this informant said her
organization would “print everything for them…we print their eligibility letter, we print the plans for their families. We want them to understand.” The use of printing was especially important for consumers who did not have access to a computer, Internet, nor printer at home. Another interviewee explained that her organization photocopied consumers’ paper applications and sent the photocopy back home with the consumer. All of these strategies seemed to help consumers become more familiar with the process and with their options, and ultimately seemed to help facilitate the selection and enrollment into a plan.

**Table 3**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Percentage of Interviewees that Mentioned Each Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Exchange glitches</td>
<td>100</td>
</tr>
<tr>
<td>B. Existence of the “Medicaid gap”</td>
<td>100</td>
</tr>
<tr>
<td>C. Misconceptions of the ACA</td>
<td>92</td>
</tr>
<tr>
<td>D. Challenges of a demanding workload for IPAs</td>
<td>77</td>
</tr>
<tr>
<td>E. Low health insurance literacy among consumers</td>
<td>69</td>
</tr>
<tr>
<td>F. Absence of a state-run exchange</td>
<td>69</td>
</tr>
<tr>
<td>G. Inadequate or cumbersome IPA training</td>
<td>54</td>
</tr>
<tr>
<td>H. Challenges of outreach</td>
<td>31</td>
</tr>
<tr>
<td>I. Unaffordability of insurance options</td>
<td>31</td>
</tr>
<tr>
<td>J. IPA misunderstanding of Medicaid Eligibility</td>
<td>23</td>
</tr>
</tbody>
</table>

Note: Percentages add up to more than 100, because some informants mentioned more than one major theme during their interview.

**The Exchange Glitches**

Every single informant spoke about the federal exchange glitches as a large barrier to enrollment in North Carolina (N=13). Put simply, one IPA explained that, “It was just a mess.” Another stated, “[The website] was probably working at 1%...[so] it was a major major stumbling block in the beginning.” Interviewees identified the glitches as multifaceted and persistent for the first two months, on both the English and Spanish websites. One frustration
was that the website was intended to be a one-stop place, and yet it actually required many
different steps since there were various organizations that needed to communicate to determine
eligibility and identification. Another informant explained, “When healthcare.gov is designed to
be the solution to everything and it doesn’t work, that absolutely impacts and derails the
process.” Unfortunately, some consumers chose to forgo tax credits because they didn’t “want to
have to deal with the hassle” of the website. In fact, some IPAs said that their consumers were
getting so upset by the exchange glitches, that the IPAs stopped their enrollment efforts during
the first two months of the Open Enrollment Period, and focused on outreach instead until
December 2\textsuperscript{nd}. Furthermore, a few of the informants explained that the effects of the website
glitches were only further compounded by negative press.

As a result of all of the exchange glitches, IPAs and consumers alike felt very upset. One
interviewee identified that it was particularly frustrating for IPAs and consumers when the
consumer had to delete their application and start from the beginning, especially after having
spent a lot of time on the initial application. Other informants expressed feelings of guilt,
because consumers were misdirecting their blame and frustration about the glitches onto the
IPAs. Overall, it appears as though the exchange glitches contributed to poor morale among
some IPAs.

Although the majority of the problems with healthcare.gov have since been fixed, one
major glitch still remains. Many of the IPAs who work with immigrants spoke about the legal
verification issues with lawfully present immigrants. One person explained, “The pull down
websites…don’t accommodate the special circumstances of lawfully present immigrants.”
Another explained that this problem occurs for any non-US born citizen, whether they are a
naturalized citizen, a visa holder, or a legal permanent resident. According to this informant,
“Our best understanding of what’s going on is that the hub is not verifying their statuses correctly, or at all. And so almost 100% of the time we’re seeing an error message.” As a result, IPAs working with non-US born citizens have had to find a work-around. According to one interviewee, the solution is to not submit any of the document numbers online, in order to not allow the system to verify the applicant electronically. Instead, these IPAs would submit the required paperwork via mail. Another informant explained that, after submitting the documents by mail “to somewhere in Kentucky,” it may take another two or three weeks for these documented to get verified. As a result, “It’s a very long process.”

When faced with these glitches, some IPAs and consumers opted to submit appeals. However, a few IPAs explained that, despite advice from the federal government for IPAs to submit appeals if the website was not working, nearly 22,000 appeals are now pending that the government cannot process. Consequently, IPAs who encouraged consumers to submit appeals are concerned about the lack of progress for their clients.

Another strategy used by IPAs facing exchange glitches, was to seek federal guidance either though the live chat or the federal call center. However it is clear that federal guidance varied widely in quality. One interviewee explained that IPAs often felt as though they knew more than the live chat people with whom they were speaking. Another informant explained that she:

*Never found the chat function particularly helpful except to answer discrete questions. The quality of customer service representative training at the call center... the quality of skill and knowledge varies widely between staff members.*

*So we’ve had very competent, knowledgeable, helpful people, and we’ve had*
people who were utterly unhelpful and did not appear to know what they were doing.

This sentiment was repeated by several interviewees. Consequently, one IPA suggested that the federal government “give [IPAs] federal call people who know our state specifically, [not] just whoever answer the phone. That would’ve been so much more helpful. Because then we would’ve at least been speaking the same language.” Otherwise, this informant explained, she sometimes had to give the federal call center person “a primer” on North Carolina insurance law – and this only further slowed down and complicated the process.

The “Medicaid Gap”

The North Carolina General Assembly’s decision to turn down the federal money to expand Medicaid Eligibility, and the resulting “Medicaid gap,” was identified by all informants as a major barrier to enrollment (N=13). One theme brought up was how political the topic of Medicaid Expansion has become in North Carolina. Some informants expressed fear or anxiety about getting involved in these politics, because it had become such a charged issue. One interviewee put it well, when she explained:

[They] have worked really hard to stay out of the political conversation around the Medicaid Expansion, just because [they] feel like the work that [they’re] doing is so important, [they] don’t want to taint it with any glimmer of politics.

Another informant expressed a similar sentiment that her organization preferred to avoid politics, despite the fact that many of their poorest clients could not get Medicaid coverage. She explained:
[Consumers] may really want to get insured, and realize they fit in the gap, and they’re not going to get anything. So those are the really hard ones, and [it’s] very painful, [but] we also cannot get into that debate! Because when you get into that, again, you are no longer telling a person how to go sign up for insurance, right? You’re having a different discussion, and it sucks all of the air out of the room. Because it is horrendous. That the poorest people are going to get zero help. I mean, it’s horrible.

Meanwhile, despite an organization’s comfort level around speaking about Medicaid Expansion and the Medicaid gap, it was clear that all IPAs had to navigate this issue with their clients. IPA organizations responded in different ways. Some informants decided to finish and submit the application, even when they realized a client would not qualify for Medicaid nor for insurance subsidies – because, if for nothing else, consumer education about the experience was important. Two other interviewees said they always explained to their client that the North Carolina Generally Assembly could still expand Medicaid in the future if so desired. Others, who recognized the need for care for their Medicaid gap population, created handouts with contact information for local safety-net resources listed on them, and encouraged any client who fell in the Medicaid gap to seek care at a safety-net organization. This response seemed to be the most soothing for the IPAs, although it was also evident that there were not enough safety-net resources in some counties to accommodate all of the need of individuals who fell within the Medicaid gap.

One surprising insight was that no IPA spoke about screening consumers out based upon their income – instead, one IPA said that, despite the fact that one-third of their appointments fell in the Medicaid gap, her organization made the affirmative decision to not screen anyone out.
Another informant explained that her choice not to screen out anyone came from a hope that consumers might not actually know their whole income, and so speaking with an IPA might help them realize they earn more than they previously thought. Another interviewee explained:

*People who have lived in or near poverty for a very long time are often trained to underestimate their income to maximize benefits…People are incredibly resourceful and they are not accustomed often to placing a value on their resourcefulness.*

Consequently, it was important to offer enrollment appointments to everyone, regardless of how much money they thought they earned.

Most consumers felt upset and confused when they learned that they fell within the Medicaid gap. One informant said she sometimes had to explain 10 or 15 times to some persons, because they simply did not understand how someone could be too poor to qualify for financial assistance. Other interviewees recounted stories of consumers crying, feeling blamed by the system, and walking away without hope. Another informant explained that consumers who were most accepting of the fact that they fell into the Medicaid gap, were individuals who had been low-income yet previously uninsured for years.

The effect on IPAs was also generally described as a negative one. One informant explained that each IPA in her organization “has actually broken down in tears throughout the process of letting [consumers] know they’re not eligible.” Along with a damper on IPA morale, some informants expressed feelings of frustration. One interviewee said that he often asked himself the question, “Why would you turn down 90% money? …But the arguments aren’t rational, the arguments are political.” Other informants described this political decision by the North Carolina General Assembly as immoral, and especially burdensome on low-income
counties where a majority of their population falls into the Medicaid gap. However, one IPA explained that “numbers speak volumes,” so she continued to keep count of how many of her clients fell into the Medicaid gap in the hopes that those numbers might be helpful to encourage the state to change its decision in the future.

Finally, some informants explained local responses to the North Carolina General Assembly’s decision not to expand Medicaid. One interviewee explained that some city councils, board of health, and county commissioners were working to pass county resolutions supporting Medicaid expansion. Meanwhile, other organizations, such as hospitals, businesses, and religious communities, have become involved in the issue as well. Lay individuals in some areas of the state have also become involved in the issue. One informant explained that citizens in some counties are lobbying for the decision to expand Medicaid, while others participate in marches such as Historic Thousands on Jones Street as a way to express their opinion.

**Misconceptions about the ACA**

Almost all informants (N=12) and every IPA (N=9) spoke about consumer misconceptions regarding the Affordable Care Act. One interviewee explained:

*There’s four main things. One, that there’s too much fine print and I’ll never understand it. It’s not going to cover what I need. I can’t afford it. And there’re going to deny me anyways because I have these problems and they’re insurance companies and they’re going to rip me off...And then fifth thing, which is basically, what is the marketplace?... And that’s true when you’re talking to a doctor, when you’re talking to a guy off the street, you know, anybody.*
The most frequently mentioned misconception was that consumers will not be able to afford health insurance. Some informants explained that their clients did not know about the financial assistance options, while others understood but still did not believe that they would be able to afford the monthly premium. Other persons felt that coverage would be too expensive, simply because they associated the word “insurance” with “unaffordable.” Another informant explained that her clients were concerned that they would have to pay for their coverage the same day that they applied, and that this caused them anxiety over financial affordability. Many interviewees said that these fears were further compounded by the fact their low-income clients focused heavily on the immediate price of the premium, rather than the long-term benefits of having insurance coverage. This short-term focus of clients also conflicted with the fact that the marketplace could not always immediately determine Medicaid eligibility, but instead would require extra time.

In addition to the five major misconceptions identified above, informants identified additional misconceptions that were extremely diverse and frequently unfounded. One interviewee said that someone at a public forum seemed to have a conservative talking point when he asked, “Doesn’t this give Obama access to your personal bank account?” Another informant said that they spoke with individuals who were convinced they were signing up for a “government takeover of healthcare,” and that they were concerned that they wouldn’t be able to get off the insurance even if they wanted to. Other interviewees explained that some clients have thought that the ACA was free for everyone, regardless of their working status, income, tax history, or existing employer-provided coverage. Another informant said that her clients thought that, if they enrolled online, the IRS would come after them for not having paid their taxes in previous years.
All of these misconceptions were based in emotion, even if they were not based in fact. One informant explained, “People don’t know much about [the ACA]….but everyone has a strong feeling about it. Sort of, a gut reaction to it.” Another interviewee brought up the phrase by Sarah Kliff, a Washington Post writer, that most Americans don’t understand the ACA, but they know that they’re against it. Other informants explained that these negative, and uneducated, feelings by consumers about the ACA were only worsened by negative media coverage, and a general lack of trust between consumers and “Obamacare.”

**The Challenges of a Demanding Workload for IPAs**

Most of the informants (N=10) spoke about the challenges associated with having a demanding workload. One key challenge identified was the lack of sufficient funding for outreach and enrollment work in North Carolina. One interviewee explained that, after the ACA’s passage, various nationwide and state level foundations pulled funding out of healthcare because they believed it was no longer an issue of financial need. Furthermore, this interviewee explained that the South, in general, is not a resource rich area for foundations. Many of the informants also identified the need for more federal funding. One informant explained their hope that the federal government “will put more resources behind [enrollment in NC], because at two million dollars, we’ve got this put together with scotch tape, string, and bailing wire.”

Another interviewee noted that, when North Carolina turned down the outreach and enrollment money associated with a state-run exchange through Senate Bill 4, there simply was not enough money for sufficient numbers of IPAs; instead of having $20,000,000, North Carolina was left with just $2,000,000. As a result, some counties had more demand for appointments than they could feasibly handle before the end of Open Enrollment, especially the areas in which there was
only one Navigator for the whole county. Overall, it came out as no surprise that one informant identified “human resources [as] the biggest challenge, and that really just comes down to money. I know that I could have easily three people doing my job.”

Another problem identified by informants was the limited time available during the Open Enrollment period. Some informants said they ran out of time to conduct sufficient outreach, while others reported that they did not have enough time to do enough enrollment appointments. Overall, the six months were portrayed as incredibly busy – and one interviewee joked that she could barely remember her life before enrollment because of how densely packed all of her work has been. Another informant explained that his organization increased their enrollment hours, so that they were working 12-hour days from Monday through Friday, and were also going to work four-hour days over the weekend. Consequently, a few of the interviewees felt like there were so many people “bombarding [them] from left and right,” that they didn’t even have time to think about anything except their enrollment work. It seemed understandable that one informant, when asked what she hoped to do different next Open Enrollment Period, responded that she would “sleep” next time around. Another IPA responded that she did not plan to return as an IPA at all.

Furthermore, IPAs needed to have a wide variety of skills for their work. One informant explained that, as an IPA, you could never know what sort of consumer response you would have to face, “so you just have to kind of gear up for whatever’s out there.” Another said that this job requires that the IPAs be knowledgeable not only on health insurance terminology, but additional on immigration, taxes, disability issues, and safety-net resources in the community. Furthermore, some IPAs worked with consumers who had never owned or work with a
computer, and who therefore did not understand how to operate an e-mail account or the Internet at all.

Consequently, many of the IPAs reported that it was hard for them to find the time to keep up with changes in the law or news from other states’ efforts. One interviewee explained that, since they “do have to work boots on the ground…[he had] to make sure that [his team and he were] completely focused on the patient.” This interviewee felt like the members of his IPA team were “like dears, staring at headlights” when CMS and HHS sent information, because they could not keep up with it. Some Navigators tried to keep up with changes in legislation through the Big Tent, but others believed it was not the best use of their time to read all of the update-related e-mails from the Big Tent and other similar groups. One IPA suggested that it would be helpful if there were an open online forum on which all IPAs could ask questions and get answers specifically related to the plans in North Carolina, rather than having to sort through all of the information on the federally-managed newsletter called In the Loop.

Overall, many of the IPAs appeared to find a way to make the best out of the hand they were dealt. While some IPAs created systems of delegation to streamline work and ease the burden on the supervisor, other IPAs focused on fostering passion and interpersonal support between IPA team members. Ultimately, they showed great resilience, as exemplified by the comments of one IPA: “You know, give me lemons, I’ll do a great lemonade, I promise you that.”
**Low Health Insurance Literacy among Consumers**

The majority of informants (N=9) and almost all IPAs (N=8) spoke about the difficulties they faced while addressing low health insurance literacy among consumers. As one informant explained:

*It’s one thing to be hit with a bunch of plans, and have to choose between silver and gold and bronze, but it’s another thing to have to reconcile premiums and deductibles and co-pays and co-sharing, and what that means.*

Many interviewees noted that these terms are especially confusing for patients who have been uninsured, insured in public insurance, or who come from another country. One informant explained that a large percentage of their population had been uninsured for 10 or 20 years, which means, “They absolutely are starting from ground zero to learn this information.” Another interviewee explained that those who have been enrolled in publically provided insurance have had less exposure to insurance concepts, so they often need more education before choosing a plan. Another noted that immigrants who come from a different health system, they sometimes struggled when trying to understand how health insurance works in the United States. These immigrant families tend to bring more documentation that they need, but do not understand the process for determining eligibility for insurance. Due to the confusion faced by consumers with low health insurance literacy, IPAs explained that this population tended to focus exclusively on the monthly premium when selecting a plan.

Consequently, IPAs highly emphasized the need for future consumer education related to health insurance.

*We’re going to run into issues beyond the fact that people are now insured… You know, if the ER is still your point of reference where you go when you get sick,*
you gotta change the culture and we all know about changing culture and
changing behaviors – it takes time!

Therefore, when working with consumers with low health literacy, this informant always tried to “break the information down to their understanding, without judgment, with compassion, [and] with sincere personality.” According to the informant, is the only way to “make sure that they understand exactly what you’re saying, because too often … so many are doing so poorly, because of the embarrassment of saying ‘I don’t understand.’” However, it is unclear who will fill this consumer education role in the future. Some IPAs hope that the health insurance companies will provide the educational component to the newly insured, while others believe that outside care management groups would be most effective. This is especially a need for certain communities in which the IPAs said that around 90% of consumers did not understand the basics of health insurance literacy.

The Absence of a State-Run Exchange

The majority of the interviews identified the absence of a state-run exchange as a large barrier for enrollment work (N=9). Many IPAs thought that they would not have experienced exchange glitches, or at least fewer glitches, had there been a state-run exchange rather than the federal healthcare.gov website. Others believed that it was not the healthcare.gov glitches, but rather, the lack of financial resources associated with a state-run exchange, which were the most hurtful to enrollment efforts. Specifically, quite a few informants mentioned how the rejection of a state-run exchange led to decreased outreach funds. As one person explained, “As opposed to like $4 million in outreach funds, which is what we have I think, it would’ve been more like $24 million. So an extra $20 million would’ve been nice!” While these resources would have been
helpful to pay for additional IPAs, another informant explained that they would also have been useful for improving the Call Center and the Scheduler.

Furthermore, the presence of a state-run exchange would have meant the presence of a statewide agency to implement, coordinate, and track enrollment efforts. One interviewee explained that she thought IPAs would have received more cooperation from local county governments and other groups if the enrollment announcements came from a recognized state agency. Another informant explained that a state-run exchange would have guaranteed that outreach and enrollment efforts were more coordinated and standardized. However, without a state agency coordinating efforts, “it’s just a group of people trying to do the best they can.” Another contended that, having a state agency to coordinate efforts would not guarantee complete equality in the amount of efforts in each county, but it would at least prevent the current situation in which entire counties with very little activity. Furthermore, various informants argued that having a statewide agency running the implementation of the ACA in North Carolina would have allowed for more quality control, which they said the federal government cannot as thoroughly implement nor enforce.

Having a state-run exchange would also help to standardize the track of enrollment efforts. One interviewee mentioned that a statewide agency could have conducted polling to better understand outreach and enrollment challenges in different part of the state. Another noted that a statewide agency, such as the Department of Insurance, could have conducted follow up calls in order to better understand why certain appointments were “no shows” – whereas IPAs “just have to move on to the next person that’s in front of [them].”

Consequently, local players in North Carolina took a more active role in leading and coordinate statewide efforts. One individual mentioned the Big Tent collaborative in Raleigh is
the main mechanism for statewide organization because it serves as a “central communications network.” Some informants spoke similarly about Enroll America’s work across the state, as a method for statewide outreach. Other informants identified partnerships as the solution for how to move forward without a centralized agency. However, one important interviewee noted that while these organizations and efforts do very important work, they “don’t replace a statewide system.”

**Inadequate and/or Cumbersome IPA training**

Over half of all informants (N=7), and three-fourths of IPAs (N=6), spoke about their frustrations with the current IPA online training. One frustration expressed was that the CAC training was not thorough enough. For example, one interviewee explained that the CAC trainings were very helpful in terms of describing confidentiality protocol, but did not explain other related topics such as taxes. This interviewee said, “They could have done a little more in depth with [the IPAs] so that [the IPAs] could really be on top of [their] game.” Other CAC informants explained the need to be versed in immigration law, disability rights, and Medicaid eligibility in NC – none of which they felt like the CAC training prepared them for. Still another informant explained that they did not learn enough from the CAC training regarding how to handle casework when problems arose with the online applications. Given that some of the Navigators felt as though their own 20-hour training was not adequate, many Navigators believed the 6-hour CAC training was certainly inadequate.

Another frustration expressed was that the federal online training for Navigators and CACs alike did not cover enough state-specific information. However, all Navigators had access to, and were required to complete, two additional state-specific hours of training. These
Navigators often expressed that they felt like these state-specific hours were the most relevant hours of their entire online training experience. The state-specific hours, organized by Legal Aid of North Carolina, offer more practical tips as to how to sit down and work with a consumer, and also offered information about the insurance plans offered in NC. Consequently, many interviewees believed that all IPAs should have access to these state-specific trainings. Furthermore, interviewees identified the need for more hands-on or practice-based scenarios as a way to strengthen the trainings. According to one informant, “If it were actually state specific, it’d be more meaningful. But when you have national general information, and you have these really specific consumer issues, it makes the training hard to apply.”

Consequently, many informants said that they felt unprepared after the training to go do their work. One informant explained:

*You can be a teacher and go to school for four years but until you get into that classroom the first day, it means absolutely nothing. We got out, we didn’t let the public know – that’s the thing, you don’t let the public know – that you’re just as dumb as [they are].*

This sentiment was further emphasized by another interviewee who finished the CAC training without understanding how to even get onto the marketplace. Perhaps one explanation for these feelings of unpreparedness was that some interviewees felt as though the training gave too much information at one time, without sufficient review. As a result, some IPAs felt as though they had forgotten the information by the end of the training. Furthermore, both training sessions were multiple hours, and many IPAs found themselves interrupted frequently while trying to complete the trainings.
Another downside to the long training sessions was that they may have deterred potential volunteers from getting trained. One interviewee recounted his experience with a potential volunteer, who left the building after hearing that he would have to read a 250 page Standard Operating Procedures model and complete a 6-hour training before becoming a CAC. Another interviewee said that volunteers sometimes “found the training too daunting to follow through with.”

The informants identified two main aspects of the online trainings that they thought should improved upon before next year. One informant said that the Navigator certification process experienced a lot of technical glitches during this first Open Enrollment period, and that it sometimes took weeks or even months before a Navigator would receive their certification e-mail. This process, she explained, was very frustrating because it prevented trained Navigators from being able to begin their enrollment work. Furthermore, due to the large volume of information that IPAs are expected to know, another informant suggested that all relevant information be stored in one online database that could be easily searched through for enrollment-related material.

**Challenges of Outreach**

A few of the interviewees mentioned challenges they faced while conducting, or attempting to conduct, outreach related to the Affordable Care Act (N=4). One interviewee said that, given the 1.3 million uninsured individuals in North Carolina, they “really thought that [they’d] have people knocking down [their] door and that [their] problem would be serving everybody, not finding consumers to serve.” Many organizations were surprised when they
experienced a lull in demand, especially towards the beginning while the press regarding the Affordable Care Act was so negative.

Some speculated that it was difficult to bring consumers in who lived in rural areas because of transportation barriers. One informant explained that, when consumers in rural areas couldn’t reach the IPAs, the IPAs would try to send out paper applications by mail – but that there’s a lack of accountability in the paper applications, and people only periodically came back in to work on the applications. Another informant said that some people tend to put aside any unrecognized letter that might be a bill – and therefore that mail applications were ineffective. Several additional interviewees noted that some rural areas of the state lack access to public transportation, such as buses, in order to get to the enrollment appointments. Consequently, IPAs had to be creative in their outreach and enrollment work. One organization gave out bus passes to consumers who couldn’t afford to take the bus, while another few organizations tried to “be creative” about where they went to conduct outreach. As one informant noted, IPAs needed to “go to them…wherever they need be” in order to reach individuals with limited access to transportation. These universally visited spots were often mentioned as churches, grocery stores, and schools. Finally, one interviewee explained that individuals in rural areas who have cell phones are not going to want to spend their free minutes on the phone talking about enrollment. Overall, access and availability for individuals in rural areas was emphasized as an important issue.

These outreach challenges were compounded by the abundance of bad press related to the Affordable Care Act. As one informant explained, it was very difficult to reach out to people who had only heard bad news about the ACA. Furthermore, another interviewee explained that people in rural counties may “feel disconnected from both Raleigh and Washington policy” and
that it’s therefore hard to “get some of the rural communities to see how these policy decisions impact them every day.”

However, some organizations found successful outreach strategies. One organization used fans with promotional message on the front for church congregations, and another became a buyer at a store/restaurant before asking to publicize there. Other organizations made sure to speak to stakeholders with a vested interested in covering the uninsured, such as big safety-net hospitals whose “financial advisors are begging for [IPAs] to sit right there, because they don’t want these people coming back again with no insurance.” In these situations, mutually beneficial partnerships are, once again, a critical aspect to enrollment success. A few of these organizations also reported that this work offers an exciting opportunity to extend awareness of their organization beyond their traditional client base.

Recognition was another theme mentioned as an outreach challenge. This trend referred to the recognition of the IPA organization, as well as the recognition of the law. Some informants noted that word of mouth is such a powerful and important tool for spreading recognition of any new program or law, but that people are not very willing to spread word about an organization or program in which they do not have trust. Newer organizations therefore seemed to have a harder time establishing relationships with their community in order to encourage this natural outreach. Furthermore, outreach can be challenging because, as one informant explained:

*The estimate when [open enrollment] began was that people were going to need to be touched 14-21 times before they were going to actually enroll. And those touches are like a million different things. You know, it could be a neighbor*
going ‘what is this healthcare thing?’ To [IPAs] talking to [consumers] directly, to an ad on TV, to a little news blurb, or whatever.

In light of all of these challenges, some interviewees spoke about what they hope to do differently next year. One interviewee said that some counties need teams of traveling IPAs, who can travel to complete enrollment events in specific under-resourced counties. Another informant explained that they now know outreach is most difficult during the holiday months, especially during December. However, since next year’s Open Enrollment period will only be November 15 to January 15, they know that they will need to invest extra effort in order to reach people during these holiday months.

Unaffordability of Insurance Options

While the Affordable Care Act has promoted the use of federal subsidies and cost-sharing reductions as methods by which to ensure low cost health insurance, some consumers still found that the plans offered were unaffordable. Some informants identified a salient question that has arisen in the news in recent months: How affordable is the Affordable Care Act? One interviewee explained that he had a consumer who could not afford the insurance options because of the high price of his prescription medicine – and that it was only after changing to generic medicine that the consumer could afford the plan. Another informant explained that they have run into consumers for whom the cost is prohibitive, even if they qualify for a subsidy. Consequently, another interviewee explained that consumers will sometimes opt to pay the penalty rather than the premium, if they view the premium as unaffordable. The insurance options were viewed as especially unaffordable for individuals who fall into the Medicaid gap, but who would have qualified for Medicaid had NC chosen to expand eligibility.
IPA Misunderstanding of Medicaid eligibility

One unexpected, yet important, finding was that one-third of IPAs interviewed did not fully understand Medicaid eligibility, especially as it relates to Medicaid expansion (N=3). These informants misunderstood the categorical aspect of Medicaid eligibility, and how Medicaid expansion would effect Medicaid eligibility. One informant explained that she had experienced “cases where [consumers] should have qualified for Medicaid because of their income, but they didn’t.” Another interviewee felt like the estimated 500,000 North Carolinians who could have gained access to Medicaid with Medicaid expansion was actually “not a lot.” According to this interviewee, if only “the qualifications to get Medicaid were a little broader, the Affordable Care Act would have not only covered half a million individuals, [but] it would have covered a lot more.” Meanwhile, another informant explained that expanding Medicaid eligibility to “133% [of FPL] would help…but the problem is…there’s too many out there who need Medicaid that are not blind, aged, or disabled.” Therefore, she thought that “changing the rules, or the requirements,” as they related to categorical eligibility, beyond the changes in the ACA regarding Medicaid expansion, were important in order to help more people. These statements suggest a misunderstanding of how Medicaid expansion would have rid categorical eligibility from Medicaid eligibility requirements.

Furthermore, an additional part of the Medicaid program in North Carolina exists, called the Health Coverage for Workers with Disabilities program, that is not exclusively subject to income eligibility requirements. However, one interviewee explained that eligibility for this program is not tested on ePASS (North Carolina’s Medicaid application system), nor on the
marketplace. As a result, IPAs who are unsure about Medicaid eligibility might not know to take the extra steps to screen for eligibility into this program.

One informant explained:

_It’s interesting [that] even folks who work all the time in DSS offices, or Division of Vocational Rehabilitation, who work with low income folks all the time – didn’t understand Medicaid expansion...[I was] shocked at what inadequate information folks have who work in public benefits._

She further explained that all public benefits workers, from food stamp case workers to unemployment benefits workers, need to understand marketplace eligibility. This is especially problematic because some consumers “are getting bounced around because there’s bad information.”

### Other Themes

**Table 4**

<table>
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<th>Other Issues: Major Themes (N = 13)</th>
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<tbody>
<tr>
<td><strong>Theme</strong></td>
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<tr>
<td>A. Absence of Formal or Standardized Evaluations Plan</td>
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<tr>
<td>B. Effect of County Politics on Enrollment</td>
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Note: Percentages add up to more than 100, because some informants mentioned more than one major theme during their interview.

**Absence of a Formal or Standardized Evaluation Plan to Monitor Impact of Efforts**

It was interesting to note that all interviewees (N=13) mentioned the absence of formal or standardized evaluation plans to monitor the impact their efforts. One person contended that it is hard to measure impact for any outreach or advocacy-related work. However, other IPAs
mentioned that it will be important to do “some evaluation and some self-evaluation after the enrollment period is over and before the next enrollment period” in order to find out “what worked and what really didn’t.” One interviewee suggested that the first thing IPAs do after Open Enrollment, is to get together and list things about their experience that they would otherwise forget. Another suggested that this information exchange could take place in the form of a retreat for IPAs to share ideas and create a work plan moving forward.

However, the above comments allude to the fact that there was little energy spent on a formal or standardized evaluation during the first Open Enrollment period. In fact, one IPA explained that their plan was “just to survive to March 31st for right now.” Comments such as these were not surprising, given the demanding workload that many of the IPAs mentioned.

Some IPAs did manage to create an informal method of tracking data, such as an excel sheet used to track the number of individuals reached through phone calls or in-person appointments, and to determine how many people successfully enrolled into a plan. Others tried to keep track of the number of individuals who fell into the Medicaid gap, because “it speaks volumes” and is “powerful” to keep track of, and share, this data. Moreover, some interviewees explained that they kept certain data for grant purposes. However, these data collection methods varied across enrollment organizations, and sometimes even between IPAs in the same organization.

The one formal and standardized evaluation method established for IPAs was the quarterly reporting system required for all Navigators to complete as a part of their participation in the NC Navigator Consortium and the Scheduler. However, there seemed to be no standardized formal data collection tool that could be used to evaluate the impact of all IPA efforts across the state.
The Effect of County Politics on Enrollment

The majority of informants (N=10) spoke about the effect of county politics on their work. Some informants explained that the politics in their county acted as a barrier to enrollment, others felt it was a facilitator, and others said that it had very little effect.

County politics affected where some IPAs could go work, and what sort of reception they faced by consumers out in the community. One interviewee explained that, “Politically, the tone of the area that you’re in definitely impacts your ability to go to public buildings, private buildings.” This interviewee identified the “low-hanging group” as the Departments of Social Services and Departments of Public Health, both of which had to find a way to address the people coming in their doors asking for help with the ACA. However, even in receptive buildings, IPAs sometimes faced negative comments from consumers. One informant reported that IPAs “get hit with people who are heckling… so it is sometimes discouraging.” Many interviewees also recounted similar stories of hecklers, some of whom became aggressive. Another informant identified instances in which “conservative groups have gone in with hidden cameras to [outreach and enrollment] events and taped them, and in some cases they’ve spliced together tape to say that we were doing [inappropriate] activity.” Consequently, some IPAs admitted that they feared partnering with certain other groups that were perceived negatively by conservative groups. In other interviews, interviewees felt like negative county politics prevented consumers from knowing who the available IPAs were in their county.

In some counties there appeared to be a delicate line between county and state politics. Several counties experienced feelings of hopelessness and defeat when their county was the political base of an anti-ACA representative in the NC General Assembly. Others believed that the political pressure from the NCGA made IPAs “scared to do public outreach because of the political
ramifications.” Conversely, some informants explained that their state representatives were politically engaged in a positive way at a local level, and that they provided “phenomenal support.” Another interviewee explained that he was glad that the NCGA did not pass restrictive Navigator laws, because those could have had an even greater, widespread negative effect on local enrollment work.

Finally, there were counties in which the local politics helped to facilitate enrollment work. One informant said that his county felt politically united in their work together, and that the various entities across the county had all been very supportive. Other interviewees believed that the mayors in their counties have been very positive about the ACA, even to the extent of personally going out and conducting public education. Others spoke about how their counties held local meetings in which individuals from across the county came together to support one another in their enrollment work.
Figure 2: Themes Mentioned Throughout all Interviews (N=13)

Key:
- **Bars in green**: represent facilitating factors
- **Bars in red**: represent barriers
- **Bars in grey**: represent other factors
Figure 3: Themes Mentioned Throughout IPA Interviews (N=9)

**Key:**
- **Bars in green:** represent facilitating factors
- **Bars in red:** represent barriers
- **Bars in grey:** represent other factors
VI. DISCUSSION

A Department of Health and Human Services report on March 11 demonstrated that North Carolina had the 5th highest number of individuals who selected a marketplace plan, at a total of 200,546 individuals as of March 1, 2014. IPAs throughout North Carolina faced a number of barriers to enrolling uninsured persons into health insurance coverage, yet there were also strategies and conditions that facilitated enrollment. These findings have important implications for policy makers designing programs for uninsured and newly insured individuals, for practitioners working with uninsured and newly insured individuals, and for future research related to the implementation of the Affordable Care Act and access to health insurance.

Implications for Policy

The study has identified several important policy issues that could be addressed to better facilitate enrollment around the state. These issues are relevant to policy makers at a local, statewide, and federal level. First, this research highlights the importance of Medicaid expansion for individuals and organizations throughout the state. IPAs repeatedly expressed how the current “Medicaid gap” prevents them from finding affordable insurance options for their low-income clients. Furthermore, IPAs spoke often about their fear of addressing Medicaid expansion in North Carolina because it has become a highly politicized and charged topic. If North Carolina policy makers were to expand Medicaid, IPAs could divert energy currently spent on navigating this tense political environment into conducting more effective enrollment work.
The findings also highlight the importance of establishing a state-run exchange and appointing a statewide agency to coordinate and standardize enrollment efforts. Many IPAs believe that enrollment efforts would be more effective if policy makers were to adopt a state-run exchange, and appoint responsibility to a statewide agency such as the Department of Insurance. With a statewide agency coordinating efforts, there would be standardized information sent to all counties, regardless of county politics. The existence of standardized information related to the ACA was seen by IPAs as very important for enrollment, especially given that some counties in North Carolina currently have very little outreach or enrollment activity happening. The implementation of a state-run exchange might also mitigate the need for IPAs to find workarounds to any further glitches on the federal exchange.

However, in states where state policy makers do not implement a state-run exchange, federal policy makers must work diligently to ensure that the federal website, Call Center, and IPA training run as smoothly as possible. First, federal policy makers should prioritize fixing all glitches in the federal website. As long as glitches exist, consumers in North Carolina will face significant barriers to enrollment. Second, federal policymakers should ensure that the staff at the federal Call Center are adequately trained and prepared to provide state-specific guidance to IPAs who call. Third, federal policy makers should strengthen the federal training for Navigators and Certified Application Counselors, so that it includes more practical scenarios, more time for IPAs to review what they have learned, and more state-specific information regarding insurance plans in North Carolina.

Additionally, state policy makers in North Carolina should put together a formal, standardized evaluation plan to monitor the impact of outreach and enrollment efforts across the state. In order to shape well-informed state health policy that addresses the needs of individuals
across the state, key stakeholders must better understand the impact of efforts in the first Open Enrollment Period.

Finally, it is critical that state and federal policy makers focus on the financial sustainability of insurance options and enrollment work across the state. State policy makers should try to ensure that insurance options on the federal marketplace are affordable for North Carolina consumers. Despite the availability of financial assistance programs, such as insurance subsidies and cost-sharing reductions, some consumers in North Carolina are still concerned about their ability to pay for premiums. Consequently, state policy makers should encourage the Department of Insurance to continue its work with Blue Cross Blue Shield of North Carolina and Coventry, in order to further examine actuarial estimates regarding what options are unaffordable to consumers. This examination will require a balance between consumer affordability and the financial sustainability of the insurance companies. Moreover, federal policy makers should more critically analyze whether the financial assistance currently provided to consumers is sufficient to cover the vast financial need across the state. Policy makers at all levels must provide further financial support to ensure the sustainability of outreach and enrollment efforts. Supplementary financial appropriations from local, state, and federal governments would not only help reduce the demanding workload that many IPAs face, but would also help ensure that organizations in under-resourced parts of the state could hire enough IPAs to meet the consumer demand.

**Implications for Practice**

This research study also provides insight into how IPAs might better facilitate enrollment across the state. Most research on outreach and enrollment efforts emphasizes the importance of
partnerships, and this study yielded similar findings. It will be important for IPAs to further develop and strengthen their relationships with other IPAs. These partnerships may be in the form of collaboration on community education forums, or weekly meetings for IPAs in a specific region. Partnerships could also exist through the “one-two punch,” a method in which an outreach group and an enrollment group work together to move consumers from outreach to enrollment. These partnerships are critical, especially given the interconnected aspect of outreach and enrollment; many informants found that they could not conduct successful enrollment work without sufficient outreach. Furthermore, partnerships will be increasingly informative in the future as individual organizations reflect upon, and can share, the lessons they learned during the first Open Enrollment period.

Another important and useful strategy for IPAs is to use phone calls and printed or written materials to facilitate enrollment. The use of phone calls to remind consumers about the documents they need, and subsequent follow up phone calls to remind consumers about their appointment, is an important way that IPAs can reduce numbers of individuals who do not come to their appointment prepared, or at all. Furthermore, if a consumer needs more time to think through their options, IPAs should print or write the insurance options and allow consumers to take them home and think them through with their family.

Given that many consumers have low health insurance literacy, IPAs should allot more time for enrollment sessions. This need is especially relevant for consumers who are immigrants, have a disability, were previously publicly insured, or were previously uninsured. When working with any of these consumers, it is important that the IPA have sufficient time to address the questions and concerns of the consumer so that they can make the best-informed choice.
IPAs must also know how to assist consumers who come in for an enrollment appointment, but fall within the Medicaid gap. IPAs should work together to create a comprehensive and up-to-date list of local safety-net organizations that they can share with individuals who fall within the Medicaid gap. Furthermore, outreach and enrollment organizations should be responsible for adequately preparing their staff and volunteers to have these difficult conversations.

Finally, IPAs across the state should maintain and strengthen their focus on public education regarding the ACA. Many misconceptions exist regarding eligibility for, services offered within, enrollment into, and implications of having health insurance coverage through the marketplace. Furthermore, the public and some IPAs alike misunderstand Medicaid eligibility in North Carolina. As such, it is vital that IPAs dedicate consistent resources to community and IPA education.

**Implications for Research**

The findings of this study highlight a need for further research related to the ACA’s implementation in North Carolina. At a basic level, there is a need for researchers to identify the demographics of individuals who successfully enrolled into the marketplace, including their age, sex, race/ethnicity, income, geographic location, education level, health insurance literacy, and former insurance status. With a better understanding of these demographics, IPAs can more effectively target their efforts to underrepresented consumers and locations. Furthermore, IPAs’ future consumer education efforts could be better informed by a deeper understanding of consumers’ health insurance literacy.
Furthermore, various stakeholders across the state would benefit from having more formalized research regarding the effects of county politics on enrollment efforts. While IPAs offer a rich source of anecdotal evidence about their experiences, their willingness and availability to offer these anecdotes varies. Researchers therefore need to conduct a statewide study on the effects of county politics, in which they survey individuals from a representative group of organizations and areas. This valuable data could inform future policies on a statewide level, as well as inter-organizational decisions made at a regional level.

**Limitations**

This study has multiple limitations. It is based on a small sample size of only 13 informants. Although time limitations required that the sample size remain small, the sample may not be large enough to protect against random bias. In addition, the convenience case sampling method used may have introduced bias or other confounding variables. Therefore, the findings from the interviewees who responded to the researcher’s contact may not fully represent the experiences of all IPAs across the state.

Additionally, the interviews reflected the timing in which they were conducted; informants’ responses may have been affected by the fact that the interviews were conducted at a time the website glitches were recently fixed, and enrollment numbers increasing.

Finally, self-reported, in-person data may not be accurate. This is true for multiple reasons. Bernard notes that researchers cannot assume that data from informants are entirely accurate, because informants might not have truly understood the question, might have forgotten the full extent of their experiences, might have responded in a socially favorable way, and might have reported what they assume happened rather than what actually happened.107 This last point
is of particular consequence for questions in which the interviewees were asked to explain an experience with a client; although interviewees sometimes spoke about the client’s experience, they may have in fact not fully represented that experience. Furthermore, the highly politicized nature of the Affordable Care Act in North Carolina may have impacted the data gathered. Although each informant was assured that his or her answers would be anonymized as to ensure confidentiality, informants may still have felt uncertain about speaking openly and candidly during the interview.
Appendix A. Interview Guide for IPAs

**Intro:** I would like to remind you that this will be a confidential process, and that all findings will be reported anonymously. I am trying to learn about what you’ve experienced, and how you feel about those experiences. You were chosen after I contacted a variety of enrollment-related individuals in the state – I thought that it was important to talk with you in order to represent some of the experiences and perceptions of (select: Navigators/CACs/FQHC CACs) in North Carolina.

It’s really important for me to learn from you. If at any point during the interview you think there is something important to say, or you have any questions, please feel free to interrupt me. This will help us have the most thorough and accurate interview possible.

Finally, I would like to check and make sure that it’s ok with you for me to record this interview. I plan to go back through the recording over the next few weeks, and to have my findings by late March. At that point, if you’re interested, I’d love to share my findings with you.

I’m going to start by asking a little about you and your background. After that, we’ll delve into more of the challenges and successes you’ve experienced.

**Background:**

1. What were your work experiences before you starting working/volunteering as a consumer assister?
2. How many individuals have you met with so far to enroll into the healthcare.gov marketplace? *(What has it been like, in general, these past three months?)*
   a. **Probe:** How do they break down in terms of race/ethnicity, socio-economic status, and their former insurance status?

**Challenges:**

3. When individuals arrive to speak with you about enrolling into insurance, what common attitudes do they hold towards enrollment that influence the process?
   a. **Probe:** Where do you think these come from?
   b. **Potential probes:** unhelpful/helpful?
4. To what degree have consumers understood what documents they need to bring to the enrollment meeting? Could you tell me more about that?
   c. **Probe:** Have you tried explaining? Can you tell me a little more about that?
5. How have people who you’ve worked with understood the insurance plans?
   d. **Probe:** What about premiums, out-of-pocket costs, deductibles, or limitations on the networks of providers that they can choose within the health insurance plan?
   e. **Probe:** How do you think they felt about these plans?
6. Did you encounter consumers who were eligible for subsidized plans, but preferred unsubsidized plans?
   f. **Probe:** Why do you think that was the case?
7. How has the healthcare.gov website affected your enrollment efforts (if at all)?
   g. **Probe:** Did you try using other enrollment methods, like paper applications?

**Current Political/Demographic Environment:**
8. How does the political environment in North Carolina surrounding implementation, affect your enrollment efforts (if at all)?
   a. **Probe**: Has it, for example, affected people's receptivity to your efforts?
9. Do you think that consumer assisters play a special role in states like North Carolina that chose not to expand Medicaid?
   a. **Probe**: (if yes) Can you talk more about that?
   b. **Probe**: For people who came in, not eligible for coverage, how have you responded?
   c. **Probe**: Who have you seen that was not eligible for coverage? What was that like?
10. What (if anything) do you think would be different if we had a state-run exchange?

**Successful Strategies:**
11. What do you believe have been some of the most effective strategies that you personally have used to enroll the uninsured in your county? Can you tell me a little more about that?
12. How, if at all, has your approach shifted from when you first began?

**Training/Preparedness:**
13. Before ACA enrollment started, how prepared did you feel to enroll consumers?
14. Looking back, how did the trainings prepare or not prepare you for your work?
   a. **Probe**: Could you give some examples of things that the training did/did not prepare you well for? How prepared do you feel now?
15. Knowing what you know now, what do you hope to do differently next year?
16. Overall, how do you feel about your experiences as a Navigator/CAC so far?
   b. **Probe**: Could you explain any specific situations that made you feel that way?
17. Do you plan to return to work as a (Navigator/CAC) next year?

**Future Efforts:**
18. Has anyone who came in gotten back in contact with you to discuss further questions?
19. What do you think will be necessary to ensure the long-term sustainability of consumer assistance programs in North Carolina?

**Ending:**
20. Is there something that I didn’t ask you that you want to add?
21. Can I contact you again if I have any additional questions to follow-up with?
22. Would you be interested in hearing about the findings of my research?

Thank you so much for your time, and your willingness to help contribute towards this study!
Appendix B: Interview Guide for Statewide Enrollment Personnel

Intro: Thanks again for taking the time to talk with me. In this interview, I am hoping to learn about your experience with statewide enrollment efforts, especially regarding any challenges you’ve seen and strategies used to overcome them. I would like to remind you that this will be a confidential process, and that all findings will be reported anonymously.

It’s really important that I learn from you, so if at any point during the interview you think there is something important to say, or if you have any questions, please feel free to interrupt me. This will help us have the most thorough and accurate interview possible.

Finally, I want to check and make sure that it’s ok with you for me to record this interview. I plan to go back through the recording over the next few weeks, and to have my findings by late March. At that point, if you’re interested, I’d love to share my findings with you.

I’m going to start by asking a little about you and your background. After that, we’ll delve into more of the challenges and successes you’ve seen with statewide enrollment efforts.

Background:
23. What were your work experiences before you starting working to coordinate enrollment efforts for the ACA?
24. What do you currently do in your work?
   a. **Probe**: What does an “average” day look for you?
25. Have you all been working with other organizations that are also involved in statewide enrollment? If so, which?

Challenges:
1. **General challenges**: What challenges have you seen with statewide enrollment efforts?
2. **Attitudes**: What common attitudes do consumers hold towards the Affordable Care Act that influence enrollment efforts?
3. **Website**: How has the healthcare.gov website affected statewide enrollment efforts (if at all)?

Current Political/Demographic Environment:
4. **NC politics**: How does the political environment in North Carolina surrounding implementation, affect statewide enrollment efforts (if at all)?
   a. **Probe**: Has it, for example, affected people's receptivity to statewide efforts?
   b. **Probe**: Has it affected where your staff can work? Where do your staff currently work?
5. **Medicaid gap**: Do you think that consumer assisters play a special role in states like North Carolina that chose not to expand Medicaid?
   a. **Probe**: (if yes) Can you talk more about that?
   b. **Probe**: For people who come in, not eligible for coverage, how do you think In-Person Assisters should respond? Have you all been documenting these cases?
6. **Exchange**: What (if anything) do you think would be different if we had a state-run exchange?

Successful Strategies:
7. What do you believe have been some of the most effective strategies used around the state to enroll folks into insurance?
8. What strategies have been helpful for coordinating enrollment efforts across the state?

**Training/Preparedness:**
9. Knowing what you know now, what do you hope to do differently next year?
10. Overall, how do you feel about your experiences working to facilitate enrollment efforts?
   c. **Probe:** Could you explain any specific situations that made you feel that way?
11. Do you plan to return to work on enrollment efforts after March 31?

**Future Efforts:**
12. What do you think will be necessary to ensure the long-term sustainability of consumer assistance programs in North Carolina?

**Ending:**
13. Is there something that I didn’t ask you that you want to add?
14. Can I contact you again if I have any additional questions to follow-up with?
15. Would you be interested in hearing about the findings of my research?

Thank you so much for your time, and your willingness to help contribute towards this study!
## Appendix C: Frequency of Themes Mentioned Throughout all Interviews

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This project was supported by the Dunlevie Honors Undergraduate Research Fund, administered by Honors Carolina.


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Rachel Holtzman


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Source: 2013 Metropolitan Statistical Areas. OMB.


