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The Impact Of State Policies On ACA Applications And Enrollment Among Low-Income Adults In Arkansas, Kentucky, And Texas

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ABSTRACT **States are taking variable approaches to the Affordable Care Act (ACA) Medicaid expansion, Marketplace design, enrollment outreach, and application assistance. We surveyed nearly 3,000 low-income adults in late 2014 to compare experiences in three states with markedly different policies: Kentucky, which expanded Medicaid, created a successful state Marketplace, and supported outreach efforts; Arkansas, which enacted the private option and a federal-state partnership Marketplace, but with legislative limitations on outreach; and Texas, which did not expand Medicaid and passed restrictions on navigators. We found that application rates, successful enrollment, and positive experiences with the ACA were highest in Kentucky, followed by Arkansas, with Texas performing worst. Limited awareness remains a critical barrier: Fewer than half of adults had heard some or a lot about the coverage expansions. Application assistance from navigators and others was the strongest predictor of enrollment, while Latino applicants were less likely than others to successfully enroll. Twice as many respondents felt that the ACA had helped them as hurt them (although the majority reported no direct impact), and advertising was strongly associated with perceptions of the law. State policy choices appeared to have had major impacts on enrollment experiences among low-income adults and their perceptions of the ACA.**

Expansion of Medicaid has the potential to dramatically improve access to health care for low-income Americans.[1–3] In 2014 the Affordable Care Act (ACA) expanded Medicaid eligibility to 138 percent of the federal poverty level in participating states. However, a US Supreme Court ruling in 2012 made this expansion optional. More than half of states have expanded, some have decided not to expand, and others are still debating the issue.[4] Among expansion states, several have opted to expand by using federal dollars to purchase private insurance for low-income adults, instead of traditional Medicaid. This so-called private option, first introduced by Arkansas, has been approved in some form by at least four other states thus far.[5]

Beyond the decision of whether to expand Medicaid, the ACA provides states with substantial discretion in other areas. Sixteen states and the District of Columbia have launched state-based Marketplaces, while the remaining states chose to partner with the federal government or defaulted to the federal Marketplace.[6] States also have flexibility to determine how they want to regulate or employ navigators and other enrollment assisters. Navigators are people tasked with providing consumers with unbiased information about health insurance plans to best meet their needs and assisting them with the

application process.[7] The navigators are trained, certified, and funded by the Marketplaces in which they operate. Navigators and enrollment assisters also work to increase awareness about their state's Marketplace by conducting outreach campaigns and information sessions to highlight health plan offerings. However, a number of states have imposed restrictions that may impede the work of navigators and other enrollment assisters by requiring additional training beyond the federal requirements and more extensive background checks, including fingerprinting—which critics have called burdensome and unnecessary.[8]

It is unclear how these different approaches to Medicaid expansion, Marketplace design, and application assistance programs will affect overall insurance enrollment and experiences with the ACA among low-income Americans. Medicaid historically has struggled to achieve high enrollment rates among eligible individuals, and the ACA sought, in part, to address this with enrollment assistance and a streamlined application process.[9,10]

In this article we report our findings from a survey of nearly 3,000 low-income adults in three states that have taken different approaches to the ACA: Kentucky implemented a traditional Medicaid expansion and a successful state Marketplace, combined with aggressive outreach by the governor's office, navigators, and in-person assisters.[11–16] Arkansas employed the private option and a federal-state partnership Marketplace (using a series of federal grants to support state-operated plan management and consumer assistance functions),[17] along with an in-person assistance program,[14] but passed legislative prohibitions against the state's spending any money to promote the ACA or the private option.[18] Texas neither expanded Medicaid nor established a state Marketplace, enacted restrictive regulations on navigators,[8] and did not create an in-person assistance program.[14] However, even in a nonexpansion state such as Texas, there were opportunities for many low-income adults to apply for coverage in 2014: Nearly half of adults in Texas eligible for Medicaid under pre-ACA criteria were uninsured as of 2010,[19] and those with incomes above 100 percent of poverty were newly eligible for subsidized Marketplace coverage.

Our objective was to assess ACA-related experiences among low-income adults in these three states and to explore predictors of applying for Medicaid or Marketplace coverage, successful enrollment, and perceived harms or benefits of the ACA.

Study Data And Methods

SURVEY DESIGN We conducted a random-digit-dialed telephone survey of low-income adults in Arkansas, Kentucky, and Texas. Adults eligible for the study had to be US citizens ages 19–64, with family incomes below 138 percent of poverty. The sampling frame included both mobile phones and landlines. Interviews were available in English or Spanish.

The survey explored several issues related to health care and the ACA, as well as basic demographic information. In the survey, the ACA was described as "the national health reform law, sometimes referred to as Obamacare or the Affordable Care Act." Prior research has shown that survey questions using only one term or the other can produce bias.[20] Respondents were asked a series of questions about their experiences with and perceptions of the ACA. When possible, questions were drawn from past surveys,[21–23] and all questions were pilot-tested before the survey instrument was finalized. (See the online Appendix for survey questions and approach to missing values.)[24]

Surveys were completed in November and December 2014—nearly a full year after the expansion of Medicaid eligibility in Kentucky and Arkansas and the beginning of Marketplace subsidies under the ACA. The overall response rate was 23 percent, using the American Association for Public Opinion Research's RR3 definition. Data were weighted to demographic estimates in each state for the low-income citizen population ages 19–64, based on the 2012 American Community Survey and National Health Interview Survey. Further details on the survey methodology have been published previously.[25]

ANALYSIS We conducted two sets of analyses. First, we compared several measures related to low-income adults' experiences with the ACA across the three study states. These measures were awareness of the ACA coverage expansions; application for Medicaid or Marketplace coverage in 2014; receipt of application assistance "from a navigator or social worker"; successful enrollment in coverage; overall quality of the application experience; exposure to advertisements in favor or opposed to the ACA; and whether the ACA had "helped you, hurt you, or had no direct impact." Unadjusted comparisons of these outcomes across the states were conducted using chi-square tests.

Next, we used multivariate logistic regression to examine demographic and policy predictors for three key outcomes. We asked all respondents ($N = 2,801$) whether they had applied for Medicaid or Marketplace coverage (received 2,772 responses) and whether the ACA had helped or hurt them (received 2,771 responses). Then, we

asked only those who had applied ($n = 1,070$) whether they had successfully enrolled in coverage. Given the law's ongoing political controversy and potential spillover effects on preexisting insurance coverage and safety-net options, we were interested in perceptions of the law among both applicants and nonapplicants.

Regression covariates were the state of residence, awareness of the ACA expansions, exposure to positive or negative advertisements, demographic variables, political affiliation, and two measures of health—"fair or poor" self-reported health and the presence of one or more chronic conditions assessed in the survey.[24]

For the analysis of whether a person who applied had successfully enrolled in coverage, we included two additional questions asked only of this subsample ($n = 1,070$). First, we asked whether they had received assistance from "a navigator or social worker" (which we used to encompass roles such as non-navigator assisters and certified application counselors,[7] descriptions likely unfamiliar to most respondents). Second, we asked at which location(s) they had applied for coverage—Marketplace website, Medicaid or public assistance office, doctor's office or hospital, or somewhere else; respondents were allowed to select one or more options.

Results were reported as adjusted odds ratios, which we then converted into predicted probabilities for ease of interpretation. All analyses were conducted using Stata software, version 12.1.

LIMITATIONS Several limitations should be noted. Our survey had a lower response rate than those obtained by in-person government interview surveys. However, our response rate of 23 percent is significantly higher than that of many political polls and health care surveys,[21,26] and research suggests that the bias from low response rates in polls can be largely mitigated by appropriate demographic weighting, as we did here.[27,28]

Another limitation is that our analysis uses self-reported outcomes, subject to bias depending on respondents' perspectives. This may have led those who already favored the ACA to describe it more positively and vice versa among the law's opponents. Our multivariate analysis was designed to tease apart these factors by considering both behavior (whether someone applied) and attitude (whether they thought the ACA helped or hurt them) and by adjusting for political ideology. However, unmeasured influences may have produced additional bias. Overall, our data can only show associations, not causal relationships. In addition, some of our findings—such as the association between awareness of the law and having applied for coverage—may be subject to reverse causation, with awareness increasing only after someone had applied.

Some respondents may have interpreted the question, "Did you successfully complete the application process to obtain coverage?", to mean that they had completed their application, even if it did not result in coverage. Fortunately, nearly 90 percent of people who said "yes" to this question reported having insurance at the time of the survey (overwhelmingly Medicaid or Marketplace coverage), which suggests that this item accurately captured "enrollment in coverage" for most respondents.

Finally, our sample was drawn from just three states. However, these states represent three distinct approaches to implementation, thus providing a useful set of case studies for evaluating the experiences of low-income adults under health reform.

A key demographic predictor of failure to enroll among applicants was Latino ethnicity.

Study Results

Our sample consisted of 2,801 low-income adults, evenly divided among the three states. Key demographic features of the sample are in Appendix Table 1.[24]

Awareness about ACA coverage options was highest in Kentucky, but even there, only 50 percent of respondents had read or heard "some" or "a lot" about the ACA coverage options (Exhibit 1). Application rates for Medicaid or Marketplace coverage were higher in Arkansas (42.8 percent) and Kentucky (44.1 percent) than Texas (32.8 percent). Among those who applied, application assistance was most common in Kentucky (46.2 percent) and least common in Texas (31.9 percent). At least half of applicants in all three states (49.7–64.5 percent) said that their overall application experience was "good" or "excellent," with rates highest in Kentucky. In all three states, most applicants (80.0–94.4 percent) said that they were able to complete the process and enroll in coverage.

Of those who said they successfully completed

40–50%

Read or heard about ACA

At the end of 2014, just 40–50 percent of respondents said that they had read or heard "a lot" or "some" about the Affordable Care Act.

EXHIBIT 1

Experiences Of Low-Income Adults In Three States During The 2014 Affordable Care Act (ACA) Open Enrollment Period

Variable	Arkansas	Kentucky	Texas	*p* value
ALL RESPONDENTS				
How much have you heard or read about the ACA's coverage expansions? ($n = 2,794$)				
A lot	25.0%	24.7%	22.3%	0.04
Some	18.4	25.7	22.7	
Little or none	56.6	49.5	55.0	
Advertisements about ACA ($n = 2,782$)				
More in support	8.9	13.1	13.1	<0.001
More opposed	26.5	16.5	18.2	
Equal numbers	64.6	70.4	68.7	
Applied for Medicaid or Marketplace coverage ($n = 2,797$)	42.8	44.1	32.8	<0.001
AMONG THOSE WHO APPLIED				
Received application assistance from a navigator or a social worker ($n = 1,107$)	36.4	46.2	31.9	0.01
Successfully completed enrollment process ($n = 1,088$)	87.5	94.4	80.0	<0.001
Quality of application experience ($n = 1,095$)				
Excellent/good	52.0	64.5	49.7	0.02
Fair	22.7	18.9	24.2	
Poor	25.3	16.7	26.1	
Impact of ACA on you ($n = 2,797$)				
Helped you	29.6	40.1	20.5	<0.001
Hurt you	16.8	12.3	13.7	
Not impacted directly	53.6	47.6	65.8	

SOURCE Authors' analysis of data from a three-state survey of low-income adults, conducted in November–December 2014. **NOTES** $N = 2,801$. Sample sizes are listed for each question and exclude item nonresponse. *p* values represent chi-square tests for significant differences in each variable across the three states.

the application for coverage during the prior twelve months, 83.4 percent reported having Medicaid or Marketplace coverage at the time of the survey (including 27.3 percent who said both), 6.0 percent reported another coverage type, and 10.7 percent were uninsured (data not shown). The majority (67.9 percent) of those who failed to complete the application process were uninsured at the time of the survey, while some had acquired other insurance—most commonly employer coverage (14.4 percent).

On average for all three states, roughly 20 percent of respondents had read or heard more advertising against the law than in support of it, while approximately 12 percent recalled more positive ads. Approximately two-thirds said that they had read or heard equal numbers of both. Negative ads were most frequently reported in Arkansas.

The strongest predictor associated with applying for Medicaid or Marketplace coverage was greater awareness of the ACA, which was associated with an increase in the application rate from 34.6 percent to 46.2 percent, after multivariate adjustment (Exhibit 2). Other positive predictors were living in Kentucky or Arkansas, being female, and having an income below 50 percent of poverty.

Application assistance was the strongest predictor of successful enrollment in coverage, increasing enrollment from 84.9 percent to 93.1 percent (Exhibit 3). Applying through the Medicaid office, higher levels of education, and being female were also positively associated with enrollment. Conversely, Latino applicants had much lower adjusted enrollment rates (75.2 percent versus 90.7 percent for non-Latino whites). Kentucky had a significantly higher enrollment rate among applicants (92.4 percent) than Arkansas (87.0 percent) and Texas (84.8 percent), even after adjustment. In a sensitivity analysis limited to adults with incomes above 100 percent of poverty (who are eligible for subsidized coverage in all three states), Kentucky still had significantly higher enrollment rates than the other two states, and inclusion of a variable adjusting for eligibility for subsidized coverage produced similar findings (see the Appendix).[24]

A large plurality in all three states (48–66 percent) said that the ACA had not impacted them personally. Of those directly impacted, roughly twice as many said that the law had helped rather than hurt them. Older adults and people who recalled mostly negative advertisements were more likely to say that the ACA had hurt them, compared to younger adults and those who recalled neutral or pro-ACA ads (Exhibit 4). Mean-

EXHIBIT 2

Predictors Of Applying For Medicaid Or Marketplace Coverage In Three States, 2014

Variable	Odds ratio	*p* value	Predicted probability
AWARENESS OF AFFORDABLE CARE ACT COVERAGE EXPANSION			
Read/heard "a lot" or "some"	1.66	<0.001	46.2%
Read/heard "a little" or "none"	1.00	Ref	34.6
ADVERTISEMENTS ABOUT AFFORDABLE CARE ACT			
Read/heard more in support	1.03	0.86	40.9
Read/heard more opposed	0.94	0.64	38.8
Read/heard equal numbers in support and opposed	1.00	Ref	40.2
DEMOGRAPHICS			
Female	1.66	<0.001	44.9
Married/partnered	1.04	0.70	40.5
Rural	1.12	0.32	41.5
Mobile phone survey	1.11	0.37	40.8
Fair/poor health	1.09	0.46	41.3
Any chronic medical condition	1.13	0.36	41.0
AGE (YEARS)			
19–34	1.14	0.39	39.9
35–44	1.31	0.09	43.2
45–54	1.15	0.36	40.1
55–64	1.00	Ref	37.0
RACE/ETHNICITY			
Latino	1.17	0.38	42.3
Black non-Latino	1.17	0.45	38.6
Other	1.39	0.17	41.3
White non-Latino	1.00	Ref	38.6
EDUCATION			
Less than high school degree	1.03	0.84	39.4
High school graduate	1.11	0.40	41.2
Some college	1.00	Ref	38.7
INCOME (AS PERCENT OF FEDERAL POVERTY LEVEL)			
Not reported	1.11	0.69	38.5
Less than 50% of poverty	1.41	0.02	44.1
50–100% of poverty	1.13	0.36	39.1
101–138% of poverty	1.00	Ref	36.3
POLITICAL AFFILIATION			
Democrat	1.26	0.17	43.4
Independent or don't know/other	1.01	0.95	38.4
Republican	1.00	Ref	38.1
STATE			
Arkansas	1.53	0.005	43.0
Kentucky	1.56	0.006	43.4
Texas	1.00	Ref	33.4

SOURCE Authors' analysis of data from a three-state survey of low-income adults, conducted in November–December 2014. **NOTES** $N = 2,772$. Odds ratios are from multivariate logistic regression controlling for all the variables listed in the table. Predicted probabilities were obtained using the "margins" command in Stata.

while Democrats, blacks, those recalling mostly positive ads, and people in expansion states were more likely than others to say that the law had helped them (38 percent and 29 percent in Kentucky and Arkansas, respectively, versus 22 percent in Texas). In a sensitivity analysis, we found that successful applicants were significantly more likely to say the law had helped them (47 percent versus 20 percent otherwise), while those whose applications did not result in enrollment disproportionately said the law had hurt them (27 percent versus 13 percent otherwise).

Among those who did not apply despite having no other insurance (Appendix Table 2), the most common explanation was that they thought coverage would cost too much (21 percent) or they did not know enough about the coverage options (19 percent).[24]

Discussion

The ACA was enacted as a national health reform law, but states have substantial discretion in its implementation. Among low-income adults in three Southern states, ACA-related experiences varied widely and demonstrated strong associations with key state policy decisions. Application rates, successful enrollment, and positive experiences with the ACA's 2014 expansions were highest in Kentucky, followed by Arkansas, with Texas performing the most poorly. This corresponds to the general pattern of state-level engagement and support for the ACA coverage expansions in these three states.

Kentucky established a well-functioning Marketplace run by the state, created an integrated system that assessed Medicaid and Marketplace eligibility simultaneously,[29] and conducted aggressive outreach that branded itself distinctly from the national law, which remains controversial in the state.[11–13,15] Meanwhile, Arkansas adopted the innovative private option and a partnership-style Marketplace, as well as "fast-track enrollment" under a federal waiver that allowed the use of Supplemental Nutrition Assistance Program (SNAP) enrollment data to target Medicaid-eligible SNAP recipients.[30]

Both expansion states also enabled their Marketplace websites to link consumers directly to information on navigator programs.[14] However, in contrast to Kentucky's ongoing outreach for Marketplace and Medicaid coverage, in early 2014 Arkansas enacted a legislative prohibition against state-funded efforts to support enrollment.[18] Recent survey data suggest that these two states, even with Arkansas's limitations on state-supported outreach, experienced the largest declines in their uninsurance rates in 2014 in the country.[31]

At the other extreme, Texas did not expand Medicaid; did not participate in Marketplace planning; ranked forty-ninth out of fifty-one in the country in per capita rates of grant funding for application assistance;[32] and enacted restrictive regulations for navigators, such as additional training beyond federal requirements, more extensive background checks, and finger-

printing[8,14]—although federal regulators have recently struck down several restrictions.[33] The fruits of these different policy efforts are evident in our findings.

Beyond these state-level differences, our findings also shed light on who applied for ACA coverage, who successfully enrolled, and how low-income adults perceive the law's impact.

WHO APPLIED? Overall, fewer than half of our respondents applied for Medicaid or Marketplace coverage. Lack of information was a key barrier. Awareness of the ACA expansions remained low even at the end of 2014, with just 40–50 percent saying they had read or heard "a lot" or "some" about the new ACA coverage options. This adds to previous evidence that information gaps about the law remain a major challenge, particularly among low-income populations who likely have the most to gain from the coverage expansions.[25]

Another barrier to applying was the perception that coverage would cost too much, consistent with a recent report from the Henry J. Kaiser Family Foundation.[34] However, for people with incomes below 138 percent of poverty in these expansion states, coverage is available without having to pay a premium, again pointing to challenges related to lack of knowledge about the law.

WHO ENROLLED? Among those adults who applied for coverage, enrollment rates were more than 80 percent in all three states. Some applicants reported acquiring both Medicaid and Marketplace insurance simultaneously, which is not permitted by the ACA. This could indicate confusion about the new coverage options or people applying for one type of coverage (for example, Marketplace) before ultimately enrolling in another type (for example, Medicaid). Kentucky had the highest enrollment rates among applicants, followed by Arkansas, with Texas lowest. While it is to be expected that expansion states should have more success getting applicants into coverage than nonexpanding states, we found that enrollment success in Kentucky remained significantly higher even among applicants with incomes between 100 percent and 138 percent of poverty, who were eligible for subsidized coverage in all three states.

The strongest predictor of completing the application process was receiving help with enrollment from a navigator or application assister, which increased the probability of obtaining coverage by nearly 10 percentage points. To our knowledge, our study is the first to quantify the potential impact of application assistance on enrollment rates. We found that such assistance was least common in Texas, which has enacted various restrictions on their activities.

EXHIBIT 3

Predictors Of Successful Enrollment In Medicaid Or Marketplace Coverage Among Applicants In Three States, 2014

Variable	Odds ratio	*p* value	Predicted probability
AWARENESS OF AFFORDABLE CARE ACT COVERAGE EXPANSION			
Read/heard "a lot" or "some"	0.86	0.58	87.1%
Read/heard "a little" or "none"	1.00	Ref	88.5
ADVERTISEMENTS ABOUT AFFORDABLE CARE ACT			
Read/heard more in support	1.16	0.71	88.9
Read/heard more opposed	1.08	0.83	88.2
Read/heard equal numbers in support and opposed	1.00	Ref	87.5
NAVIGATOR/SOCIAL WORK ASSISTANCE			
Yes	2.67	0.001	93.1
No	1.00	Ref	84.9
LOCATION/METHOD OF APPLICATION[a]			
Applied via Marketplace	0.96	0.89	87.6
Applied via Medicaid or public assistance office	2.24	0.01	91.8
Applied via physician office or hospital	0.63	0.20	84.2
Other	1.18	0.64	88.9
DEMOGRAPHICS			
Female	1.80	0.03	89.8
Married/partnered	1.86	0.03	91.1
Rural	0.70	0.25	85.7
Mobile phone survey	0.79	0.45	87.2
Fair/poor health	1.05	0.85	88.1
Any chronic medical condition	0.80	0.47	87.1
AGE (YEARS)			
19–34	1.00	0.99	87.0
35–44	1.85	0.15	92.0
45–54	0.82	0.60	85.0
55–64	1.00	Ref	87.0
RACE			
Latino	0.26	0.002	75.2
Black non-Latino	0.77	0.51	88.5
Other	0.66	0.51	87.1
White non-Latino	1.00	Ref	90.7
EDUCATION			
Less than high school diploma	0.75	0.47	87.7
High school graduate	0.63	0.15	86.0
Some college	1.00	Ref	90.1
INCOME (AS PERCENT OF FEDERAL POVERTY LEVEL)			
Not reported	1.97	0.21	91.2
Less than 50% of poverty	1.24	0.56	87.4
50–100% of poverty	1.51	0.25	89.2
101–138% of poverty	1.00	Ref	85.3
POLITICAL AFFILIATION			
Democrat	1.16	0.76	92.1
Independent or don't know/other	0.48	0.08	84.3
Republican	1.00	Ref	91.1
STATE			
Arkansas	1.23	0.56	87.0
Kentucky	2.40	0.05	92.4
Texas	1.00	Ref	84.8

SOURCE Authors' analysis of data from a three-state survey of low-income adults, conducted in November–December 2014. **NOTES** $N = 1,070$. Odds ratios are from multivariate logistic regression controlling for all the variables listed in the table. Predicted probabilities were obtained using the "margins" command in Stata. [a]Options for this variable were not mutually exclusive; respondents could indicate one or more.

EXHIBIT 4

Predictors Of Perceived Benefit Or Harm From The Affordable Care Act (ACA) Among Respondents In Three States, 2014

	"ACA helped me"		"ACA hurt me"	
Variable	Odds ratio	Predicted probability	Odds ratio	Predicted probability
AWARENESS OF AFFORDABLE CARE ACT COVERAGE EXPANSION				
Read/heard "a lot" or "some"	1.74****	35.7%	1.05	14.5%
Read/heard "a little" or "none"	1.00	25.2	1.00	14.0
ADVERTISEMENTS ABOUT AFFORDABLE CARE ACT				
Read/heard more in support	1.78***	40.3	0.76	9.9
Read/heard more opposed	0.98	28.8	1.96****	21.5
Read/heard equal numbers in support and opposed	1.00	28.8	1.00	12.5
DEMOGRAPHICS				
Female	1.31**	32.2	0.95	14.0
Married/partnered	1.21	32.3	1.00	14.2
Rural	1.26*	32.5	0.83	13.1
Mobile phone survey	0.92	29.5	1.19	14.9
Fair/poor health	0.80*	27.5	1.18	15.5
Any chronic medical condition	1.30*	31.8	1.10	14.6
AGE (YEARS)				
19–34	0.92	29.1	0.65**	10.9
35–44	1.04	31.6	1.20	17.9
45–54	0.96	29.0	1.18	17.8
55–64	1.00	30.8	1.00	15.6
RACE				
Latino	0.79	24.8	0.96	15.1
Black non-Latino	1.56***	37.8	0.44***	7.8
Other	0.97	28.4	1.13	17.2
White non-Latino	1.00	28.9	1.00	15.6
EDUCATION				
Less than high school diploma	1.30	34.4	0.79	12.2
High school graduate	0.94	28.3	1.01	14.9
Some college	1.00	29.5	1.00	14.8
INCOME (AS PERCENT OF FEDERAL POVERTY LEVEL)				
Not reported	2.29***	35.4	0.81	14.8
Less than 50% of poverty	2.21****	34.7	0.67**	12.5
50–100% of poverty	1.85****	31.2	0.71*	13.2
101–138% of poverty	1.00	20.5	1.00	17.4
POLITICAL AFFILIATION				
Democrat	1.79***	36.7	0.57***	11.2
Independent or don't know/ other	1.10	27.1	0.79	14.8
Republican	1.00	25.5	1.00	17.8
STATE				
Arkansas	1.47**	29.1	1.24	16.5
Kentucky	2.26****	37.9	0.87	12.3
Texas	1.00	22.4	1.00	13.9

SOURCE Authors' analysis of data from a three-state survey of low-income adults, conducted in November–December 2014. **NOTES** $N = 2,771$. Odds ratios are from multivariate logistic regression controlling for all the variables listed in the table. Predicted probabilities were obtained using the "margins" command in Stata. *$p < 0.10$ **$p < 0.05$ ***$p < 0.01$ ****$p < 0.001$

Applicants who applied at state Medicaid offices were more likely to successfully enroll than those who applied via the Marketplace or in a medical facility. One possible explanation is that Medicaid offices provide in-person social services assistance, in contrast to the Marketplace, where difficulties understanding or navigating a website may be particularly challenging for lower-income and less educated populations. Another consideration is that some Marketplaces (including HealthCare.gov) had trouble transferring information from website applications to Medicaid offices, which may have delayed or prevented some applicants from obtaining coverage.[35]

A key demographic predictor of failure to enroll among applicants was Latino ethnicity. Federal statistics suggest that Latino enrollment has been slow,[36] and our study suggests that the application process (as opposed to never applying in the first place) may be a key obstacle. While this might be attributable to language barriers,[29] in a sensitivity analysis Latino ethnicity remained a strong predictor even after adjustment for completing the survey in Spanish. Another possibility is that concerns about immigration enforcement kept some from finishing their applications. Even though all members of our sample were self-reported US citizens, prior research has documented a "chilling effect" for Medicaid enrollment among households with mixed citizenship status.[37] Furthermore, challenges with verification of immigration status appear to have caused difficulties for some legal immigrants attempting to enroll in coverage.[38]

PERCEIVED IMPACT OF THE AFFORDABLE CARE ACT ACA-related advertisements had little correlation with whether people applied or successfully enrolled in coverage. However, advertisement tone was strongly associated with people's perceptions of whether the law had helped or hurt them. This may reflect that the ads were effectively persuasive or, alternatively, that people with preexisting views of the law were more likely to recall ads consistent with those views. Negative ads were most common in Arkansas, consistent with a recent analysis that found high levels of anti-ACA ads during that state's 2014 US Senate election.[39]

Personal assessments of the law's impact were shaped by race, income, and political affiliation, as well as by application experience. Blacks, lower-income people, Democrats, and successful applicants were significantly more likely to say that the ACA had helped them, while Republicans, older adults, and those whose applications did not result in enrollment were more likely to say that the law had hurt them. Finally, low-income adults in the two expansion states were much more likely than adults in Texas were to say that the law had helped them.

Nonetheless, 48–66 percent of low-income adults in all three states felt the law had not directly impacted them in 2014, which suggests

that the ACA has not yet reached many who might benefit from it.

Conclusion

The first year of the ACA's major coverage expansions is now complete. Although the legislation was national in scope, our study suggests that state policy decisions are likely having a critical impact not only on eligibility but also on who chooses to apply for coverage and whether they successfully enroll. Low awareness of the law remains a critical obstacle. Meanwhile, navigators and application assistance programs appear to be a valuable approach to improving the effectiveness of the coverage expansion, and states enacting restrictions on these programs are likely harming their low-income residents' ability to obtain coverage. Finally, our findings suggest that effective implementation—as in Kentucky and Arkansas—and positive outreach efforts—most evident in Kentucky—may have major effects on the experiences and perceptions of low-income adults under the ACA. ■

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NOTES

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