Implementing Health Care Reform in North Carolina:

Reaching and Enrolling Immigrants and Refugees

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IMPLEMENTING HEALTH CARE REFORM IN NORTH CAROLINA:

Reaching and Enrolling Immigrants and Refugees

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For the Robert Wood Johnson Foundation

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About the Authors

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Executive Summary

The Affordable Care Act (ACA) passed in 2010, creating new opportunities for the uninsured to obtain health insurance coverage. This study was designed to understand outreach and enrollment efforts to immigrants legally present in the United States and required to obtain health insurance coverage while living in the U.S. In 2013-14, we conducted site visits in 4 regions of North Carolina: (1) the Charlotte Metropolitan Area, (2) the Piedmont Triad, (3) the Research Triangle, and (4) the Eastern Region. During these site visits, we completed just over 100 interviews with key state and county community leaders as well as 11 focus groups with nearly 100 immigrants from various countries of origin. We also analyzed data on immigrants and health insurance from the American Community Survey. We found the following:

- As of 2012, 748,072 immigrants live in North Carolina, including many persons from Latin America and the Caribbean (56%), Asia (24%), Europe (11%), Africa (6%), and other origins (3%). Most (55%) have entered the U.S. legally and become eligible for naturalized citizenship after 5 years of residency; one-third have naturalized.
- Among foreign-born citizens who have not naturalized (i.e. noncitizens), 61% have no health insurance coverage. Nearly half of these noncitizen immigrants live in just 5 counties: Durham, Forsyth, Guilford, Mecklenburg, and Wake.
- Having been unable to afford necessary medical care in the past, the majority of our focus group participants (81%) believed that health insurance was a necessity that they would not give up if they could obtain it.
- Many of the lawfully present immigrants, refugees, asylees, and temporary workers we spoke with were eligible for either Medicaid or subsidized health insurance but were not aware of their eligibility. Ninety-four percent of participants in our focus groups said that they knew little if anything about the ACA or "Obamacare."
- Complex eligibility rules lead some immigrants to believe that they could not qualify for Medicaid or subsidized health insurance. Confusion about health insurance systems in the U.S. and how to evaluate health insurance plans deterred others from enrollment.
- When asked whom they trusted most to provide them with information about health care reform, 25% of immigrants indicated that they trusted their local Medicaid office. Another 26% indicated that they trusted a local Community-Based Organization (CBO) that provided services to immigrant or refugee populations.
- Community leaders were aware of the challenges faced by immigrant populations and were eager to engage in outreach and the development of culturally and linguistically appropriate materials. Immigrants were eager to attend community-based information sessions about the ACA and receive personalized assistance to help them enroll.

About the Study

The 2010 Patient Protection and Affordable Care Act (ACA) aims to expand and enhance health insurance coverage for U.S. residents, including legal immigrants and refugees. However, 59% of Americans do not understand the law or how it will affect them (KFF 2012). Due to eligibility requirements which vary by citizenship status, length of U.S. residency, state, and a variety of other factors, immigrants face additional complexity and confusion about the law. Even if they or their children are eligible for health insurance expansions, immigrants may be at high risk of forgoing coverage due to costs and other factors which dissuade them from taking up benefits (Perreira et al. 2012; Oberlander & Perreira 2013).

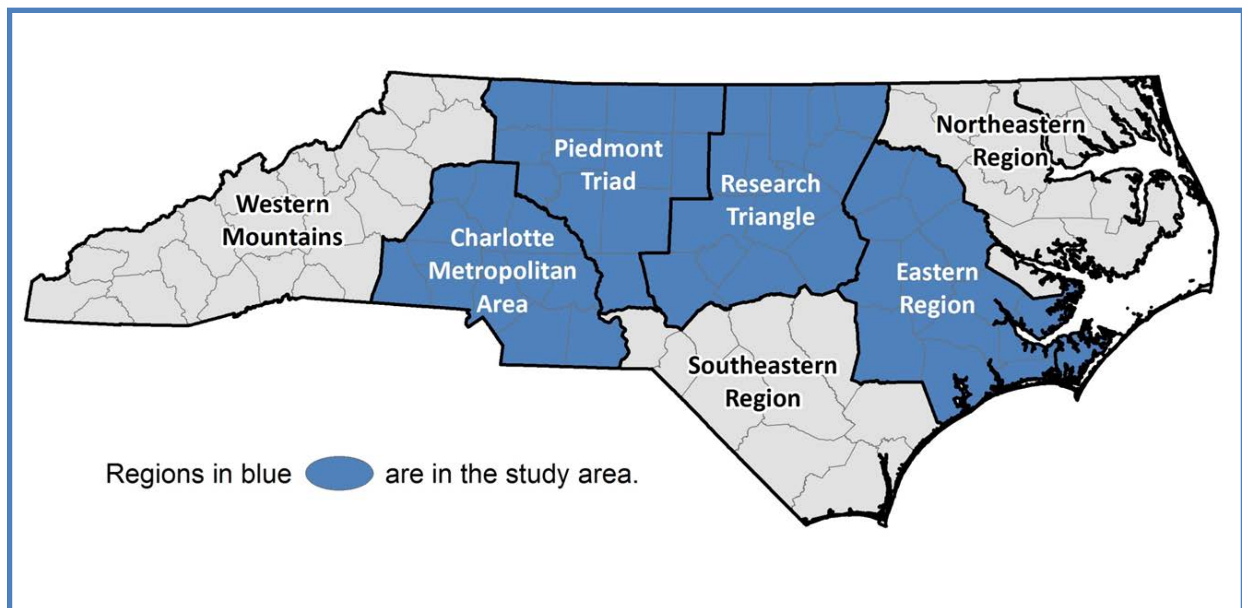
In 2012, RWJF began a project to monitor and track the implementation of the ACA across 10 states (Courtot & Coughlin). This study extends that project by focusing on a critical state in the Southeast, North Carolina, and by focusing on the implications of health care reform for immigrants. North Carolina offers a compelling case study because it is one of thirty-four states that have chosen not to implement a state-run health insurance marketplace (KFF 2014c). The state has also chosen not to expand Medicaid (KFF 2014b). Furthermore, the state has had one of the fastest growing immigrant populations in the U.S. since 1990. Between 1990 and 2012, the foreign-born population in North Carolina increased 550% from 115,077 to 748,072 (MPI 2014).

To assist community-based organizations (CBOs), state, and federal officials with the ACA's implementation, this study aims to: (1) provide a review of immigrants' and their children's eligibility and enrollment in privately and publicly funded health insurance programs in North Carolina, (2) identify and describe the challenges faced by state and local providers in enrolling immigrant families and their children into health insurance options available through the ACA, and (3) discover and evaluate promising practices that CBOs, private employers, and public agencies have utilized or can develop to increase enrollment into health insurance programs, especially among immigrants and their children.

Study Sites And Methods

The North Carolina Department of Commerce divides the state into seven economic development regions: (1) the Western Mountains, (2) the Charlotte Metropolitan Area, (3) the Piedmont Triad, (4) the Research Triangle, (5) the Southeastern Region, (6) the Eastern Region, and (7) the Northeastern Region. To reflect the diversity of immigrant experiences, and local economic and political conditions in the state, this study focused on counties within four of these regions – the Charlotte Metro Area, the Piedmont, the Research Triangle, and Eastern North Carolina – shaded in the map below (Figure 1). All data for this study were collected between June 2013 and June 2014.

Figure 1. Map of Our Study Area



In each region we visited, we conducted in-depth, qualitative interviews with state- and county-level policymakers, leaders of health care facilities and immigrant-serving CBOs, and public officials responsible for health reform implementation in North Carolina. These interviews provided us with insight into their awareness of barriers that immigrants face enrolling in health insurance programs and the strategies key leaders were implementing as part of health care reform. We interviewed a total of 93 local community leaders and 8 state-level leaders from government agencies, non-profit providers, and non-profit advocacy groups (Table 1).

Table 1. Site Visit Consultations, by Organization Type and Service Area

Service Area	Government Agency	Non-profit Providers	Non-profit Advocacy Group
State	3	1	4
Local	47	32	14
Total	50	33	18

We also conducted focus groups with immigrants in each regional area. Focus groups were organized by community-based organizations (CBOs), including churches, which served specific immigrant and refugee populations in their communities. They were conducted in English and Spanish by the research team. Focus groups in Arabic, Chinese, Dzongku, Korean, and Sgaw Karen were conducted with the assistance of translators from within these communities. These focus groups allowed us to learn about access to health insurance and health care reform from the perspectives of immigrants themselves. At the start of the focus group, all participants were asked to complete a brief 15-item survey which included basic demographic questions and questions on health insurance and health reform. Questions on insurance and reform were derived from the 2005 Kaiser Family Foundation (KFF) Health Care Costs Survey and the 2013 Latino Decisions National Health Care Survey (KFF 2005; Latino Decisions 2013).

We spoke with a total of 99 immigrants and refugees as part of 11 focus groups. The immigrants and refugees in these group conversations came from 20 different countries including: Afghanistan, Bhutan, Burma, Colombia, Congo, Costa Rica, Dominican Republic, Ecuador, Egypt, El Salvador, Eritrea, Ethiopia, Honduras, Mexico, Myanmar, Pakistan, Panama, Philippines, South Korea, and Thailand. A handful (N=6) of U.S.-born individuals married to immigrants also participated in these conversations. About half (48%) of the immigrants we spoke with came from a Latin American country. Most (54%) had also lived in the U.S. over 5 years. The mean age of focus group participants was 39. Most participants were female (62%), had a high school education or less (60%), and worked full- or part-time (57%). All the immigrants in our focus groups lived near poverty and many had qualified for Medicaid or had a child who qualified for Medicaid at some point in the past few years.

In addition to conducting site visits across the state, we analyzed data on the foreign-born population and health insurance from the U.S. Census Bureau, American Community Survey (ACS), 5 year estimates for 2008-2012. These are the most recently available data at the time of this publication. Estimates based on the 5-year ACS data may differ from estimates based on 1-year and 3-year ACS data. We chose to focus on the 5-year data because it allows for the most reliable estimations at the county level (U.S. Census Bureau 2008).

Background

The Immigrant Population in North Carolina

As of 2012, 7.7% (N=748,072) of North Carolina's residents were foreign-born and nearly 17% (N=377,843) of children (ages 0-18) in North Carolina had at least one immigrant parent (MPI 2014). In North Carolina, 86% of these children with foreign-born parents are citizens by birth (MPI 2014).

These immigrant populations are diverse, including many persons from Latin America and the Caribbean (56%), Asia (24%), Europe (11%), and Africa (6%) (MPI 2014). Immigrants living in North Carolina typically come to work and join family members already living in the state. Additionally, the Office of Refugee Resettlement (ORR) settles several thousand refugees and asylees in North Carolina each year. In 2012, 2,272 refugees and asylees settled in North Carolina. The majority came from Bhutan (N=639), Burma (N=785), and Iraq (N=148) (ORR 2013).

Table 2. Foreign born by Period of Entry and Naturalization (N=748,072)

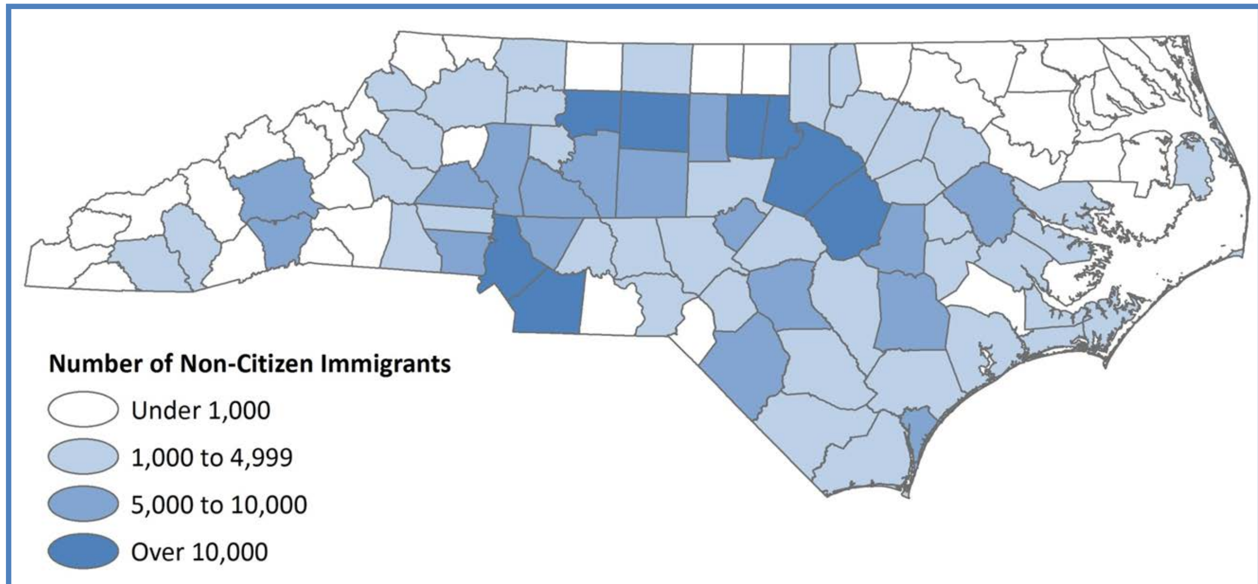
Period of Entry into U.S.		
Before 1990	169,346	22.60%
1990-1999	215,296	28.80%
2000-2009	301,718	40.30%
Since 2010	61,712	8.20%
Naturalization		
Naturalized citizens	239,280	32.00%
Noncitizens	508,792	68.00%

Source: MPI 2014

Most (55%) immigrants to North Carolina enter the U.S. legally and become eligible for naturalized citizenship after 5 years of residency (Passel & Cohn, 2011). Spouses of U.S. citizens and immigrants who have served in the U.S. military can naturalize within 3 years and 1 year, respectively (U.S. CIS 2012). In North Carolina, 92% of foreign-born residents came to the U.S. before 2010 and have lived in the country for over 5 years (Table 2). Nearly one-third (32%) have become naturalized citizens. Naturalized U.S. citizens receive all the same rights and protections as U.S. born citizens. We refer to the remaining foreign-born residents as noncitizens and focus this analysis on access to health insurance for the noncitizen population.

Half of all noncitizen immigrants to North Carolina live along the I-85 or I-95 corridors in just 5 counties: Mecklenburg (18%), Wake (15%), Guilford (6%), Durham (6%), and Forsyth (5%) (Figure 2). Their concentration in these counties can facilitate outreach and enrollment efforts.

Figure 2. Map of Noncitizen Immigrants, by County of Residence



Source: U.S. Census Bureau 2014b

The Uninsured Population in North Carolina

Based on 5-year estimates from the ACS, 1.5 million North Carolinians had no insurance coverage as of 2012. Given that noncitizens comprise a relatively small percent (<6%) of North Carolina's population, most (80%) uninsured North Carolinians are citizens. However, both naturalized citizens and noncitizens are at higher risk of being uninsured than U.S.-born citizens. Sixty-one percent of noncitizens have no health insurance coverage, whereas only 14% of U.S.-born citizens have no health insurance coverage (Table 3).

Compared to those with health insurance, uninsured North Carolinians are more likely to be male (18% vs. 15%), adults ages 18-64 (23% vs. 5%), non-white (22% vs. 16%), and Latino (44% vs. 12%). They tend to have a high school education or less (25% vs. 12%), be unemployed (51% vs. 19%), and work less than full-time (30% vs. 14%). Thus, among those without insurance, 68% lived in households with under $50,000 in income per year and 64% live in households with incomes below 200% of the Federal Poverty Level (see Appendix 2 for more details). The Federal Poverty Level (FPL) is an income level set by the federal government to determine eligibility for public assistance programs such as Medicaid. It varies by year and family size. In 2014, the FPL for a single-person family living in North Carolina was $11,670 (ASPE 2014). For each additional person in the family, the poverty rate increases by $4,060 (ASPE 2014).

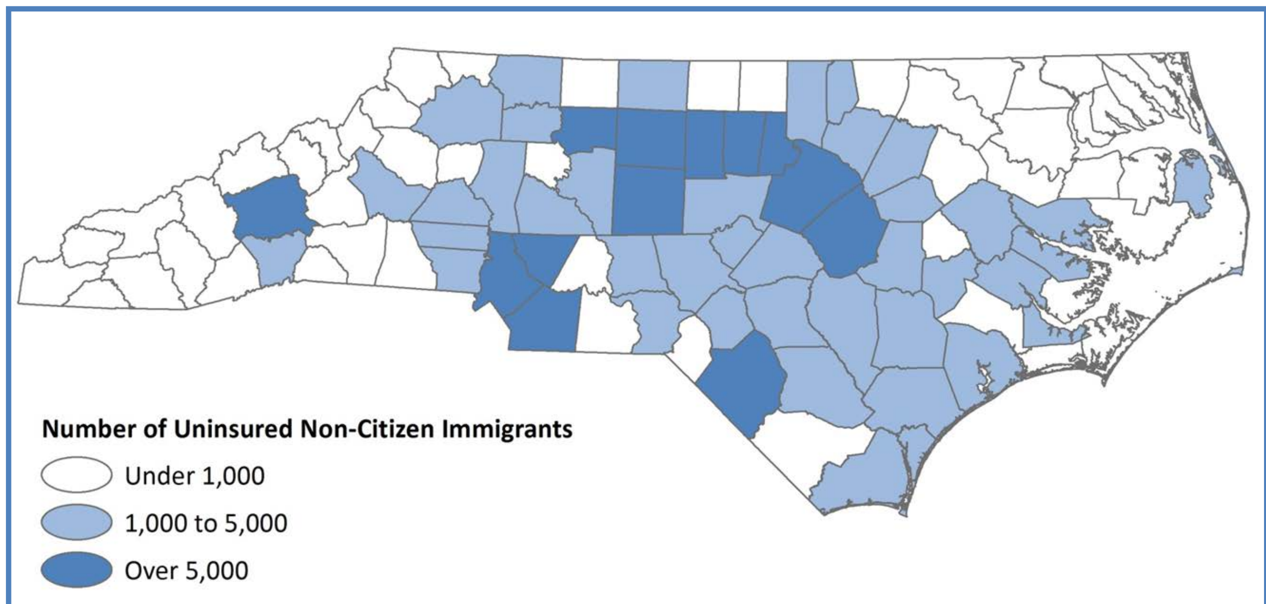
Table 3. Health Insurance Coverage in North Carolina, by Nativity and Citizenship

	U.S. Born		Foreign Born			
	Citizen		Naturalized Citizen		Non-Citizen	
	N	%	N	%	N	%
With health insurance coverage	7,462,763	86%	175,086	81%	191,818	39%
With private health insurance	5,745,152	67%	154,612	71%	165,353	33%
With public insurance	2,750,084	32%	45,140	21%	33,291	7%
No health insurance coverage	1,168,180	14%	41,708	19%	301,812	61%
Total Population Size	8,630,943		216,794		493,630	

Source: U.S. Census Bureau 2014b

Note: Public coverage includes Medicare, Medicaid, and VA coverage. Private coverage includes employer- or union-sponsored coverage, directly-purchased coverage, and coverage offered to members of the armed forces (e.g., CHAMPUS and TRICARE). Because individuals, especially those on Medicare, may have coverage from both public and private insurers, the percentage of those with private insurance, public insurance, and no insurance is greater than 100%.

Figure 3. Map of Number of Uninsured who are Foreign-Born Noncitizens, by County.



Source: U.S. Census Bureau 2014b

Because insurance coverage in the United States depends largely on the availability of coverage through work, the percentage of the population without insurance coverage varies substantially by county. Counties with higher unemployment rates and counties with a concentration of industries which historically have not insured their workers (e.g., agriculture and construction)

have relatively high rates of uninsured North Carolinians. These include counties such as Swain, Tyrell, Duplin, Robeson, and Hyde which have rates of uninsured that are 8-12 percentage points higher than the average rate (16%) in North Carolina (see Appendix 3 for more details).

Because foreign-born noncitizens are at higher risk of being uninsured than either U.S.-born or naturalized citizens, counties with a high concentration of foreign-born noncitizens also tend to have higher concentrations of uninsured persons. The counties with the largest percent of uninsured who are foreign-born noncitizens include: Lee (38%), Durham (37%), Chatham (35%), Orange (34%), Duplin (34%), Wake (34%), and Mecklenburg (32%). In these counties, the number of uninsured noncitizens ranges from 3,328 in Chatham to 49,324 in Mecklenburg (Figure 3).

Health Insurance Coverage for Immigrants before the Implementation of the ACA

Two factors explain most of the difference in health insurance coverage between citizens and noncitizen immigrants: (1) access to employer-sponsored coverage and (2) access to Medicaid or the Children's Health Insurance Program (CHIP) for low-income families (Alker & Ng'andu 2006; Buchmueller et al. 2007; Ku 2007).

Noncitizens' access to employer-provided coverage depends on the types of jobs they have. Noncitizens often work in low-wage jobs where employers do not offer health insurance coverage (Alker & Ng'andu 2006; Buchmueller et al. 2007). Compared to citizens in North Carolina, noncitizens are more likely to be employed in service occupations (29% vs. 17%) or to work as laborers in natural resource, construction, or maintenance occupations (26% vs. 5%); they are less likely to be employed by government (4% vs. 16%) or to work in managerial occupations (17% vs. 37%). Seventy-one percent of noncitizens earn under $35,000 per year; only 42% of citizens earn under $35,000 per year. Similarly, 63% of noncitizens live below 200% of the FPL but only 38% of citizens live below 200% of FPL. Though data specific to noncitizens are unavailable, analyses of trends in employer-sponsored insurance coverage in North Carolina show that this coverage has declined by 13 percentage points (from 69% to 56%) over the past decade (SHADAC 2013). Moreover, these declines in coverage were concentrated among individuals with incomes below 400% of FPL (SHADAC 2013).

Noncitizens access to insurance coverage through Medicaid and CHIP depends on immigration background as well as income. On August 22, 1996,

Immigrant Populations Eligible for Medicaid/CHIP in NC

- Lawful Permanent Residents Arriving to U.S. Prior to August 22, 1996
- Lawful Permanent Residents with over 5 years of U.S. residency
- Refugees and Asylees regardless of date of entry or years of U.S. residency
- Pregnant women and children regardless of date of entry or years of residency

Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). This act established two categories of immigrants (qualified and non-qualified). As summarized by Fortuny and Chaundry (2011), "Qualified immigrants include lawful permanent residents (LPRs), refugees, asylees, and persons in various other immigration statuses, such as battered spouses and children. The nonqualified category captures all other foreign-born persons and includes some lawfully present foreign-born residents, such as students and tourists, along with unauthorized immigrants."

PWRORA also restricted eligibility for Medicaid/CHIP based on time of arrival into the United States (pre-enactment vs. post-enactment immigrants), and length of U.S. residency (over 5 year vs. 5 years or less) (Fortuny & Chaundry 2011; Perreira et al. 2012). Naturalized immigrants face no restrictions in their eligibility for Medicaid/CHIP. In addition, all refugees receive 8 months of Medicaid coverage upon their arrival to the United States. If they meet the income eligibility and family eligibility requirements, they can also continue to receive Medicaid/CHIP after these initial 8 months (ASPE 2009). Refugees face no 5-year residency requirement. Exceptions to the 5-year ban are also available for others on humanitarian grounds and to military veterans, service members, their spouses, and their dependents. Lastly, with some exceptions, unauthorized immigrants continue to remain ineligible for all public insurance *except* emergency Medicaid.

After PWRORA's enactment, subsequent changes in federal legislation have restored eligibility for some benefits to some categories of legal immigrants (Fortuny & Chaundry 2011). In particular, passage of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) gave states the option to provide Medicaid and CHIP coverage to lawfully residing children and pregnant women, regardless of their date of entry into the United States. CHIPRA also allowed states to provide prenatal care to pregnant women regardless of their immigration status. Lastly, states have the option of covering non-qualified immigrant populations using state-only funds. As of 2014, North Carolina provided Medicaid/CHIP coverage to all lawfully residing pregnant women and children, regardless of their date of entry (NILC 2014). However, North Carolina does not provide coverage to non-qualified pregnant women or any other non-qualified immigrants, including unauthorized immigrants.

Maximum Monthly Income for a Family of Three to Qualify for Medicaid/CHIP, 2014

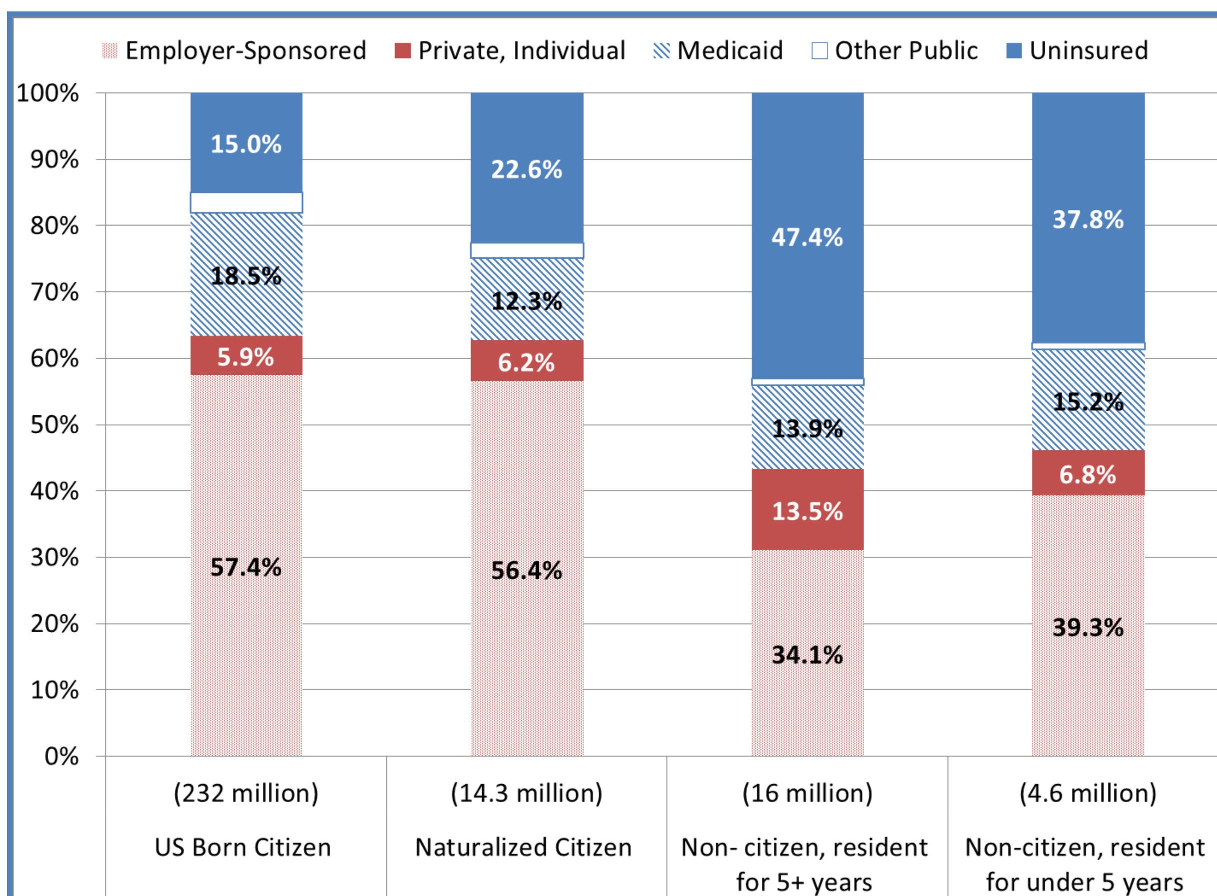
- Children (0-18): $3, 480
- Pregnant Women: $3,232
- Adult Parents: $742

Source: CMS 2014b

Finally, Medicaid/CHIP coverage to both citizens and noncitizens in North Carolina is limited to low-income families. Children must be living in families with incomes below 210% FPL; pregnant women must be living in families with incomes below 196% FPL; and adults are only eligible if they have children and family incomes below 45% of FPL (CMS 2014a). For a family of three living in North Carolina in 2014, FPL is $19,790. The focus of Medicaid coverage on families with children leaves low-income and single, childless adults (e.g., many male refugees) most at risk of being uninsured (Dubay, Cook & Garret 2009; NC IOM 2009).

The consequences of differential access to employer-provided insurance coverage and Medicaid/CHIP for noncitizens can be most easily seen at the national level (Figure 4). Rates of employer-sponsored insurance coverage among noncitizens are 18-23 percentage points lower than rates of employer-sponsored insurance coverage among U.S.-born citizens. Similarly, rates of Medicaid coverage for noncitizens are 3-5 percentage points lower than for U.S.-born citizens.

Figure 4. Health Insurance Coverage in the US among the Nonelderly, by Type of Coverage and Citizenship



Source: KCMU/Urban Institute analysis of the 2013 ASEC supplement to the CPS (KFF 2013a).
Note: Nonelderly include all persons under age 65.

Health Insurance Coverage for Immigrants after the Implementation of the ACA

The 2010 Affordable Care Act (ACA) included a number of provisions that will expand health coverage for nonelderly populations, including immigrants. First, the ACA reformed health insurance markets and established a variety of regulations to expand access to individual and

employer-sponsored private coverage. Second, the ACA allowed state governments to extend eligibility for Medicaid coverage to more low-income families and single adults with no children. Third, the ACA created insurance markets operated through state- or federal exchanges where individuals could purchase both government-subsidized and unsubsidized insurance. To encourage all U.S. residents to purchase health insurance, the ACA established an individual mandate to purchase insurance and annual penalties to be paid by those who choose to forgo health insurance coverage for themselves or their dependents.

Private Insurance Market Regulations. Implementation of the ACA's reforms and regulations of private health insurance markets began in 2010 (Kenney & Huntress 2012; KFF 2014a). As of 2014, insurers are required to allow parents to cover their adult children up to age 26. This requirement extends to all adult children under age 26 including those who are married, not living with their parents or dependent on them, or attending school. Before the ACA, most private insurers ended dependent coverage when children turned 19 years old or graduated college. As of 2014, insurers must also provide coverage to both adults and children with pre-existing health conditions (e.g., asthma, back pain, cancer, diabetes, or depression). Before the law went into effect, insurers in most states could choose not to provide coverage or could charge higher premiums to persons who wanted to purchase insurance through the individual non-group market and had a history of mental or physical health problems. Finally, for insurers in the individual non-group and small group markets, the law established a set of 10 Essential Health Benefits (e.g., preventive services, hospitalizations, prescription drugs) that all health insurers must provide at a minimum. As of 2014, insurers cannot impose a yearly or lifetime limit on what they spend on these essential health benefits for a person. These regulations and others help to ensure that all U.S. residents, including noncitizen immigrants, have greater access to high-quality health care coverage.

Medicaid Expansions. Unlike the implementation of private health insurance market reforms which were applied universally throughout the country, the ACA's implementation of Medicaid expansion has varied by state. North Carolina is one of 24 states that have chosen ***not*** to expand Medicaid to all individuals with incomes below 138% of FPL (KFF 2014b). Medicaid/CHIP coverage in North Carolina will continue to be restricted to children with incomes below 210% of FPL, pregnant women with incomes below 196% of FPL, and parents with incomes below 45% of FPL (CMS 2014a). Parents with incomes between 45% and 138% of FPL and single adults with incomes below 138% of FPL who are not disabled or elderly ***cannot*** receive Medicaid benefits in North Carolina. In addition, the 5-year ban on Medicaid eligibility for most legal immigrants who arrived to the U.S. after August 22, 1996 still applies.

North Carolina's decision not to expand Medicaid has enormous implications. An estimated 319,000 uninsured North Carolinians with annual incomes below the Federal Poverty Level (FPL) are ineligible for Medicaid because the state rejected program expansion (Oberlander & Perreira 2013). In North Carolina, about 29% of foreign-born noncitizens lived below 100% of FPL in 2012, compared with about 18% of U.S.-born citizens (U.S. Census 2014a).

The Health Insurance Marketplace. In North Carolina, the ACA's Health Insurance Marketplace—also known as the exchange-- is run by the federal government (www.healthcare.gov). The ACA allowed states to decide whether to implement a federally-facilitated exchange, a state-based exchange, or a partnership with some aspects of the exchange administered by the federal government and other aspects administered by the state government. Twenty-seven states, including North Carolina, chose the federally-facilitated marketplace option (KFF 2014c).

The decision by the state to accept the federally-facilitated exchange option reflects, in large part, the opposition of a Republican governor and legislative majority to the ACA (Oberlander & Perreira 2013). This decision also has had significant implications for outreach and enrollment efforts in the state "There was no state-organized outreach and enrollment effort, no state campaign to raise awareness about the new coverage options, and no state-led drive to cover hard-to-reach populations such as immigrants" (Oberlander & Perreira 2013: 2470). Instead, outreach and enrollment were dependent on the efforts of local Community-Based Organizations (CBOs) as well as a network (known as the "big tent" group) of community groups, social service providers, insurers, and health care providers that formed to promote ACA enrollment in the state. Enroll America, a nonprofit group working to promote the ACA in eleven states that did not establish their own insurance exchange, also has played a key role in North Carolina.

All noncitizens who are lawfully present in the U.S. are eligible to purchase both subsidized and unsubsidized insurance through the Health Insurance Marketplace. There are *no* years-of-residency restrictions on eligibility for subsidized or unsubsidized insurance purchased through the Marketplace. Lawfully present noncitizens include lawful permanent residents (LPRs) and those who have approved visa petitions to adjust their status; refugees, asylees and other persons fleeing persecution; persons with Temporary Protected Status and other categories of humanitarian immigrants; survivors of domestic violence, trafficking and other serious crimes (e.g. U-visa holders); persons with valid nonimmigrant status such as those with student visas and temporary work visas (e.g., H-1B, H-2A, and H-2B); and other longtime residents awaiting legalization (e.g., IRCA applicants) (NILC 2012). Only unauthorized immigrant children and adults are barred from purchasing insurance through the Marketplace. This includes children and adults who have received "Deferred Action for Childhood Arrivals"(DACA). Unauthorized immigrants, including DACA recipients, are eligible for an

Selected Immigrant Populations Eligible for Subsidized Health Insurance

- Persons, not eligible for Medicaid, with family incomes below 400% of the Federal Poverty Level

----- and who are ----

- Lawful Permanent Residents, refugees, or asylees
- Persons with Temporary Protected Status (TPS)
- Victims of domestic violence and serious crimes (e.g., U-visas)
- Nonimmigrants with student or temporary work visas (e.g., H-2a)

exemption to the individual mandate to purchase insurance (Woomer-Deters 2014; U.S. DHHS 2014).

Those who purchase insurance through the Health Insurance Marketplace have the option to purchase four types of plans that reflect different levels of coverage: (1) a bronze plan, (2) a silver plan, (3) a gold plan, and (4) a platinum plan. Bronze plans cover the least amount of health care services and platinum plans provide the most comprehensive coverage. Young adults between the ages of 18-30 may also choose to purchase a catastrophic health plan that offers more limited coverage.

Health Insurance Subsidies. Eligibility for subsidized insurance purchased through the Marketplace depends on the availability of employer-sponsored insurance, and varies by income and family size. Only persons without access to employer-sponsored insurance or unable to afford the insurance offered by their employers are eligible to receive subsidies. Employer-sponsored insurance is considered unaffordable if the employee's annual premiums for individual coverage cost more than 9.5% of his/her family's income (KFF 2013b). Thus, an employee in a family earning $40,881 (the median family income among noncitizens) with an annual premium of over $3,884 for their employer-sponsored, individual insurance plan could choose to purchase subsidized insurance through www.healthcare.gov (U.S. Census Bureau 2012).

Two forms of subsidies are available to both U.S. citizens and lawfully residing noncitizens who do not qualify for Medicaid: (1) premium subsidies, and (2) cost-sharing subsidies (Kenney & Huntress 2012; KFF 2013b). Premium subsidies help individuals pay for the monthly cost of insurance and can be paid directly by the government to the insurer. In North Carolina, premium subsidies are available to lawfully residing noncitizens with 5 years of residency or less and live in families with incomes below 400% of FPL (or $46,680 for a single adult) (ASPE 2014; Kenney & Huntress 2012). In North Carolina, premium subsidies are available to U.S. citizens and lawfully residing noncitizens with more than 5 years of residency if they have family incomes between 100-400% of the FPL. Persons living in states such as North Carolina that have chosen not to expand Medicaid and who have incomes below 100% of FPL may apply for an exemption to the individual mandate if they are not eligible for Medicaid (U.S. DHHS 2014).

The premium subsidy is calculated as a percentage of family income. For a single person living at 100% of FPL, with the subsidy their premium would be capped at 2% of income (or $233/year). For a single person living at 400% of FPL, their premium would be a maximum of 9.5% of their income (or

Definition of a family for Medicaid, the ACA, and other Public Assistance Programs in the United States

A family is defined by the group of individuals for whom an adult taxpayer claims a deduction.

Immigrant families sometimes share a home but pay their taxes separately. Thus, multiple families may live in the same household.

$4,435/year). The premium cap is based on the cost for the second lowest priced silver plan in a participant's area.

Cost-sharing subsidies help individuals pay for the cost of deductibles, co-payments and co-insurance for doctors' visits, hospital stays, labs, prescriptions drugs and other types of medical care. These subsidies are available to both U.S. citizens and lawfully residing noncitizens who have incomes below 250% of FPL (or $29, 175 for a single adult). These cost-sharing subsidies are only available to individuals who purchase a silver plan (Andrews 2013). Like premium subsidies, cost-sharing subsidies also vary by family income. In this case, families with higher incomes have to pay a higher share of their costs. The cost-sharing subsidies are set so that the maximum out-of-pocket costs for deductibles, co-payments, and co-insurance for a standard silver plan are: (1) 6% for a family at 100-150% of FPL, (2) 13% for a family at 150-200% of FPL, and (3) 27% for a family at 200-250% of FPL. Once a family's income reaches 250% or more, they are no longer eligible for cost sharing subsidies and they are responsible, on average, for 30% of their health care costs. For example, if a silver plan advertises a co-payment rate of $45 for a doctor's visit, an individual with a family income at 100-150% of FPL would only have to pay 6% of this co-payment (or $2.70). For low-income families, the savings from cost-sharing subsidies can be quite large.

Penalties. Under the ACA, most individuals are required to obtain insurance. Individuals who choose not to purchase insurance must pay a fine or penalty at the end of the year. In 2014, the penalty is 1% of a family's income or a minimum of $95 per adult, $47.50 per child, or $285 per family (KFF 2014d). In 2015, the penalties will increase to 2.0% of family income or a minimum of $325 per adult, $162.50 per child, or $975 per family (KFF 2014d). These penalties will increase again in 2016. The penalties, if any, are calculated and paid when individuals file their income taxes.

Some individuals and their families are exempt from these penalties (U.S. DHHS 2014). Some exemptions may be particularly helpful to immigrants and refugees with low incomes. For example, individuals who do not have to file a tax return because their incomes are too low are exempt from paying penalties. In addition, if the premium for the lowest-priced health insurance plan available through the Health Insurance Marketplace is more than 8% of a family's income, then a penalty will not be owed. If an individual with lawful presence in the U.S. is uninsured for less than 3 months in a year, a penalty will not be owed. Additional exemptions are available to family's experiencing hardships such as homelessness, evictions or foreclosures, bankruptcy, natural disasters, or death of a close family member. Exemptions are also available to individuals who are ineligible for Medicaid because the state in which they live did not implement Medicaid Expansions. Finally, unauthorized immigrants are exempt from penalties and U.S. Immigration Reform and Control (ICE) has indicated that it will not use information provided during the health insurance enrollment process as a basis for immigration enforcement actions (U.S. ICE 2013).

Findings

Immigrants Want Affordable Health Insurance Coverage and Information about the ACA

The immigrants and refugees that participated in our focus groups (N=99) uniformly voiced their desire to have affordable health insurance coverage and to learn more about the Affordable Care Act (ACA). Seventy-two percent were without health insurance at the time that the focus groups were conducted between June 2013 and June 2014. Nearly all (86%) of the focus group participants had been uninsured at some point during the past 12 months. Sixty-percent reported not having enough money to pay for health care that they needed during the past 12 months. Nationally, only about 2 in 10 (20%-22%) adults reported a time in the past year when they did not have enough money to pay for medical care or had problems paying for medical bills (Szabo & Appleby 2009; Holohan et al. 2014).

As a result of the lack of affordable health insurance, several immigrants and refugees shared stories about the difficulties they or others in their communities experienced either obtaining critical medical care or paying for care they had received. For example, a Bhutanese refugee told of knowing two fellow refugees requiring hernia operations. One was able to obtain the operation during their first 8 months in the U.S. and while receiving Refugee Medicaid Assistance through Medicaid. It cost nothing. The other had lost his Medicaid coverage by the time he needed surgery and it cost $24,000. Several Latino immigrants we interviewed told of forgoing medical care and not filling prescription for diabetes, cardiovascular problems, and asthma because they or others in their family had no insurance.

Several immigrants had experience with medical debts being sent to collection agencies and being refused care at local hospitals until their debts were paid. Though hospitals are required to provide emergency care to all persons regardless of insurance status, care for many serious conditions (e.g., cancer) does not qualify as emergent (Gusmano 2012). Under North Carolina law, emergencies include: "(1) labor and delivery, including delivery by Caesarean section, or (2) treatment after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part."

Based on their experiences being unable to afford necessary medical care, the majority of our focus group participants (81%) believed that health insurance was a necessity that they would not give up if they could obtain it. Only a handful (9%) indicated that health insurance was not very important. On average these immigrants were 7 years younger than those who believed

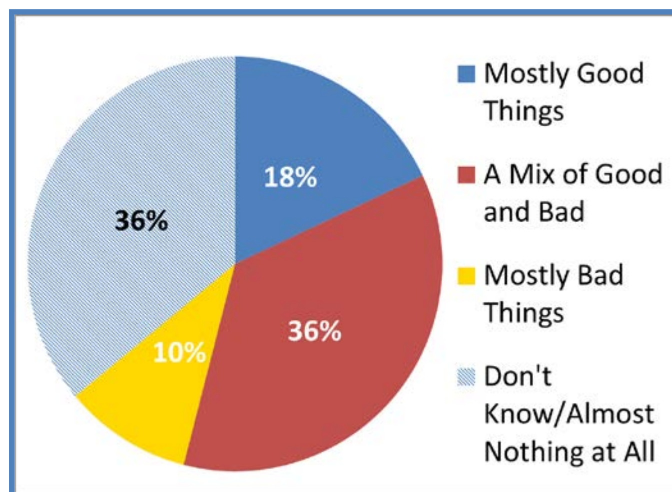
insurance was a necessity. In further discussions, they also emphasized that paying for health insurance simply could not take precedence over paying for food, housing, or utility bills.

Discussing the importance of health insurance for themselves and their families, immigrants and refugees consistently stated that having health insurance makes them feel "secure and safe." The lack of insurance made some immigrants feel that they had no "peace of mind." Without insurance, they worried about being able to afford to see a doctor for basic preventive health services and they worried about having an accident or serious medical need. Several of the Latino immigrant women that we spoke with also emphasized health insurance as a family responsibility. They commented that insurance is needed to help protect the growth and development of their children, help protect their older parents from financial difficulties, and help protect themselves from illnesses that could keep them from caring for their family members. Some of the male refugees that we spoke with shared this sentiment. But, also emphasized the importance of health for work.

Limited Availability of Information in Languages Other than English Results in Misinformation

To obtain insurance through the Marketplace, immigrants must first know about their options. Yet 94% of participants in our focus groups said that they knew little if anything about the Affordable Care Act (ACA) or "Obamacare." Even among those we spoke with in June 2014, after the first-year of ACA's implementation, 89% still reported knowing little if anything about the ACA. Nationally, during this same time period, approximately 30% of all U.S. residents and 52% of Latinos reported being relatively unfamiliar with the ACA (Latino Decisions 2013; Dugan 2014).

Figure 5. What Immigrants have Heard about the ACA or "Obamacare"



Most (78%) of the immigrants and refugees we spoke with were "very interested" in learning more about the new health care law; an additional 19% were "somewhat interested". Those who reported not being interested in learning more about the new law (2%) indicated, in our conversations, that this was because they knew that the law did not apply to them. Though they had family members' eligible for health insurance through Medicaid or the Marketplace, they were among those immigrants not eligible to participate in these programs.

When asked about what they had heard about health reform, 36% indicated that they had heard a mix of good and bad things; 18% had

heard mostly good things; and 10% had heard mostly bad things. The remaining 36% had heard almost nothing at all. Thus, it is not surprising that only 30% of the immigrants and refugees we spoke with knew for sure that the ACA had become the law of the land and was in the process of being implemented. This was true even among those that we spoke with in June 2014, after the first year of ACA's implementation.

As a result of limited outreach efforts by the state, conflicting news reports about the legality of health care reform, and the absence of information available in languages other the English, immigrants who participated in our focus groups had some misperceptions about their eligibility for benefits and many had questions about the law. In one of the first focus groups that we completed in rural North Carolina with Latino immigrants, participants reported hearing that only citizens were eligible to participate in the Health Insurance Marketplace and that resources for community-based healthcare clinics and federally-qualified healthcare clinics were being cut. Consequently, they worried about having reduced access to health providers serving lower income communities and longer wait times for care. Others had heard that their employers would be cutting their hours and would stop providing health insurance to their employees. They had heard they would pay higher taxes as a result of the ACA and they would be "punished" for not buying health insurance. Most importantly, they believed that health insurance purchased through the Marketplace would be too expensive for them to afford and would not cover pre-existing conditions. They had not heard about the premium or cost-sharing subsidies available to them and they did not know where to find accurate information about the ACA and their eligibility for benefits. This was still true among focus group participants we spoke with in June 2014.

Available Languages for Information on the Health Insurance Marketplace	
• Arabic	• Khmer
• Amharic	• Kinyarwanda
• Bosnian	• Korean
• Burmese	• Nepali
• Chin	• Polish
• Chinese	• Portuguese
• Farsi	• Spanish
• French	• Sgaw Karen
• French Creole	• Somali
• German	• Swahili
• Gujarati	• Tagalog
• Hindi	• Tibetan
• Karenni or Kayah	• Tigrinya
	• Vietnamese

The availability of information on the ACA has improved substantially since June 2013 and information at a national-level is now available in multiple languages (See Appendix 5 for links). Healthcare.gov provides links to language resources in Chinese, French Creole, French, German, Gujarati, Hindi, Korean, Polish, Portuguese, Russian, Spanish, Tagalog, and Vietnamese. In collaboration with the Centers for Medicaid and Medicare Services, Office of Refugee Resettlement (ORR) has produced applications for healthcare.gov in Arabic, Amharic, Bosnian, Burmese, Chin, Farsi, French, Karenni (also known as Kayah), Khmer, Kinyarwanda, Nepali, Sgaw Karen, Somali, Swahili, Tibetan, and Tigrinya. The federal government has also provided a fully-operational web-based enrollment option in Spanish, called www.CuidadoDeSalud.gov. Brochures and webinars in several Asian languages about the value of health insurance and the

Marketplace are also available from the White House. In addition, the ORR has produced a video to communicate with refuges about the ACA in several languages including Arabic, Kinyarwqanda, Nepali, Sgaw Karen, and Somali.

Not only have federal government agencies been working to develop outreach and enrollment information in multiple languages, a variety of national non-profit foundations have been developing and distributing this information. The Kaiser Family Foundation has developed detailed information about the ACA in Spanish. In addition, the AARP has provided basic information about the ACA in Chinese, Korean, Spanish, Tagalog, and Vietnamese. Lastly, EnrollAmerica has recently released a Spanish version of its website. But, the site does not yet include state-specific information on eligibility. In those states that have not adopted the Medicaid Expansions, this state-specific information can be particularly important.

In North Carolina, the challenge is now getting this information to the non-English speakers and refugee and immigrant communities that need it. Some counties (such as Orange County, NC) have created links on their websites to information about the ACA in other languages. But, most have not. Moreover, even with information available in multiple languages, the basic platforms of most web sites are in English. Therefore, immigrants who do not speak English, may have limited internet access, or lack experience navigating the web will need personal assistance to help them find information in their languages.

Complex Eligibility Rules Lead Immigrants to Believe They Cannot Qualify for Medicaid or Subsidized Insurance

Personal assistance for immigrants is often necessary due to the complexity of eligibility rules that apply to immigrants. During our focus group, we discussed eligibility for Medicaid and subsidized health insurance through the Healthcare Marketplace. These conversations helped us to identify topics and aspects of health reform that confused immigrants and refugees. Key informants experienced with serving immigrant and refugee communities also reflected on the types of questions that immigrants would have and aspects of eligibility for Medicaid and subsidized insurance that would need clarification.

Eligibility in Mixed-Status Families. Some of the immigrants that we spoke with had heard that health care reform was “not for them.” They lived in mixed-status families where at least one member of the family was U.S.-born even if others were unauthorized immigrants. These mixed-status families did not realize that unauthorized immigrants were the only immigrant group ineligible to apply for either Medicaid or subsidized health insurance benefits. This was especially important for immigrant families with children to understand. In North Carolina, 86% of children with a foreign-born parent are U.S.-born citizens (MPI 2014). These U.S.-born children are potentially eligible for either Medicaid or subsidized health insurance benefits even if one or both of their parents are not eligible.

Eligibility of Temporary Workers. Additionally, many immigrants that we spoke with did not realize that individuals with temporary work visas (e.g., H-1B, H-2A, and H-2B) or Temporary Protected Status (TPS) would qualify for subsidized health insurances if they were unable to obtain insurance through their employers. In North Carolina, 34,883 persons were certified to work under an H-1B, H-2A, or H-2B visa in 2012 (U.S. DOL 2013). While those with H-1B visas work in high-skill jobs with salaries over $60,000 and benefits, those with H-2A and H-2B visas earn an average wage of $9.44 and do not receive benefits from their employers (U.S. DOL 2013). These workers will now be able to obtain health insurance.

5-year Medicaid ban. The 5-year ban on eligibility for Medicaid benefits was also a source of confusion. Refugee women with children needed assurance that they and their children would continue to be eligible for Medicaid during the 5-year ban. In addition, male and female refugees without children needed to know that they would qualify for subsidized health insurance if their incomes were below 400% of the Federal Poverty Level (FPL). Non-refugee immigrants with legal presence in the U.S. were also eager to hear that they could apply for subsidized health insurance through the Health Insurance Marketplace. The 5-year ban on eligibility for public assistance does not apply to insurance purchased through the Marketplace.

Income Eligibility Rules. Immigrants we spoke with also wanted additional clarity on the income-eligibility rules for both Medicaid and subsidized insurance coverage. In these small communities, individuals would often hear of a person in their community that did not qualify for benefits and then assume that they also would not qualify. A simple message that legal immigrants in families living below 400% of the FPL are potentially eligible for either Medicaid or subsidized health insurance provided the clarity needed. It then opened up a conversation about what the FPL was and how it varied by family size. It also led to discussions about how a family was defined.

Availability of Subsidies and Penalty Exemptions. With a clearer understanding of their eligibility, the immigrants that we spoke with were then interested in learning more about the cost of benefits. Knowing the average premium cost for plans in their areas among those who received premium tax credits helped to assuage concerns about affordability. In North Carolina, 71% of individuals purchasing a silver plan paid less than $100 per month after tax credits were applied; 48% paid $50 or less per month (Burke, Misra, & Sheingold 2014). For those who still could not afford these monthly premium costs, the knowledge that they might qualify for an exemption from penalties helped to ease their concerns.

Covered Benefits. Lastly, immigrants wanted to understand how paying monthly for health insurance benefited them. It was important to them to know that their pre-existing conditions would be covered. It was also important for them to know that preventive health services would be covered without first having to pay a copayment, co-insurance, or a deductible. This type of first-dollar coverage was essential to making immigrants and refugees feel like insurance might be a worthwhile purchase for them or their families.

Limited Understanding of U.S. Health Insurance Systems Causes Confusion and Deters Immigrants from Enrolling

As immigrants discussed their experiences with health insurance in the U.S. and their questions about insurance available in the Marketplace, it became apparent that many also did not understand how insurance spreads financial risk; the differences between premiums, copays, co-insurance, and deductibles; or the billing practices of hospitals and other providers. Others with insurance were confused about their inability to go to any doctor that they wished and restrictions on covered services (e.g., eye care, dental care, or mental health). For a few, the western conceptualization of health and the need for medical care to maintain health did not resonate with them or others in their communities. Instead, they preferred to seek care from traditional healers or spiritual leaders in their communities and health insurance was not needed for this care.

These findings are consistent with results from Urban Institute's Health Reform Monitoring Survey, a national survey administered over the telephone each quarter between 2013-2014 (Blumberg et al. 2013). Sixty-six percent of individuals with incomes between 138%-400% of FPL felt that they did not understand health insurance terms such as premiums, deductibles, co-payments, and co-insurance. Similarly, 50% of these low-income persons did not understand aspects of insurance related to access and benefit structures such as provider networks and covered services. The Health Reform Monitoring Survey did not ask participants about their use of traditional healers. However, previous studies have reported that approximately 43% of the U.S. population utilizes complementary and alternative medicine including herbal medicine, acupuncture, chiropractic care, and traditional healers (Mackenzie et al. 2003).

Immigrants' frustrations with the American health care and payment systems were exacerbated by their experiences with very different medical systems in their home countries. In trying to explain their frustrations and confusion with U.S. health care, immigrants and refugees that we spoke with first told us about the health systems in their own countries and in the refugee camps in which many had lived for several years. Most were accustomed to government provision of health care, including hospital care, which did not require the payment of premiums, deductibles, or copays. At most, small "registration fees" were required when they first entered a medical clinic or hospital. Thus, when they first learned that the federal government was developing "Obamacare", they expected the care to be free. Refugees were particularly perplexed by the lack of free or affordable health care in the U.S. when their home countries which were much poorer were able to provide free care to residents. Others had grown up with little or no access to health care or insurance. Thus, they said that people in their communities don't worry about the presence or absence of insurance or health care. Instead, they are accustomed to tolerating any medical problems.

Unable to understand how health insurance worked in the U.S., immigrants felt that it was, in some sense, too risky to purchase. They did not want to buy a product that they did not understand and were concerned about being taken advantage of by insurers and providers. In

the words of one Bhutanese man, "We're scared to buy insurance." Moreover, they felt that paying monthly premiums for insurance served no purpose especially when they were young and healthy and did not need medical care on a regular basis. In the words of one Latina immigrant, "It was money thrown away." The payment of monthly insurance premiums also made little sense to our focus group participants since they would still be charged large amounts at the time that they received services. They believed that it was better to save the money that they would have to apply to premiums to pay for the cost of an actual doctor's visit. Several focus group participants reported trying to obtain information on the costs of services they needed so that they could save money and plan accordingly. But, the costs relayed to them by insurers or providers would turn out to be incorrect. In one case, a man told of needing a stress test to evaluate chest pain that he had been having. He contacted a hospital which told him the stress test would cost $1,200. However, when he got there, the medical specialist chose not to run the stress test, did nothing, and referred him to a radiologist. The radiologist then conducted several tests, he was told he was fine, and days later a bill arrived from the hospital for over $10,000.

Immigrants we spoke with thought they could afford health insurance premiums of $50-$70 per month.

In 2013-14, the average monthly premium for individuals receiving premium tax credits was $69.

As they tried to envision a health insurance system that would make sense to them and be affordable, all the refugee and immigrant groups that we spoke with imagined a system in which they could pay a flat, predictable, and affordable monthly fee for health insurance. Though the amount considered affordable varied somewhat across groups, most groups settled on an amount of approximately $50-$70 per month per adult, a cost similar to the cost of cell phone service. A cost of $100 per month was not affordable for many. Coincidently, a national analyses of the premiums paid by individuals who selected silver plans in 2013-14 and received tax credits showed that they paid an average monthly premium of $69 (Burke, Misra & Sheingold 2014), a monthly cost considered affordable among the immigrants participating in our focus groups. However, any added costs for prescription medicines, hospitalizations, and doctor's visits would force many to choose between covering basic food and housing costs or covering medical costs.

Immigrants Trust Their Local Medicaid Offices to Provide Them with Accurate Information about the ACA

When asked whom they trusted most to provide them with information about health care reform, 25% of immigrants indicated that they trusted their local Medicaid office. Another 26% indicated that they trusted a local Community-Based Organization (CBO) that provided services to immigrant or refugee populations. Other immigrants (20%) turned to health professionals or outreach workers, especially those based at local non-profit health care clinics or Federally-Qualified Health Clinics (FQHCs). Few (7%) trusted news media sources such as the newspaper, TV news, or internet-based news. Moreover, few (14%) trusted friends or family to be able to

provide them with accurate information about the ACA. While many immigrants trust family and friends to provide them with information generally, they realized that these family and friends could not adequately help them with understanding health reform.

In North Carolina, county Departments of Social Services (DSS) have primary responsibility for administrating the Medicaid program within state- and federal guidelines (Perreira et al., 2012). Because many uninsured immigrants or their family members have received Medicaid benefits at some point, they are comfortable visiting these offices and trust eligibility workers to be able to assist them with their questions regarding health insurance. However, in North Carolina and other states that chose not to adopt the Medicaid expansion or develop a state-administered exchange, initial reports from key informants indicated that DSS employees and state-level outreach workers had received little information about the ACA and were barred from engaging in outreach activities. It was not until November 22, 2013 (one month after enrollment began) that the NC Division of Medical Assistance (DMA) sent a letter to county DSS offices instructing them that "there is no wrong door when applying for benefits" and advising them to assist individuals in North Carolina with their applications for Medicaid, NC Health Choice, premium tax credits available through the ACA, and cost-sharing subsidies available through the ACA (NC DMA 2013). DSS offices were further instructed to "ensure that the individual wants only to purchase insurance at full price" through the Federally-Facilitated Marketplace (i.e. www.healthcare.gov) before referring him to www.healthcare.gov or a navigator, an individual or organization trained to help consumers look for health coverage options through the Marketplace (NC DMA 2013).

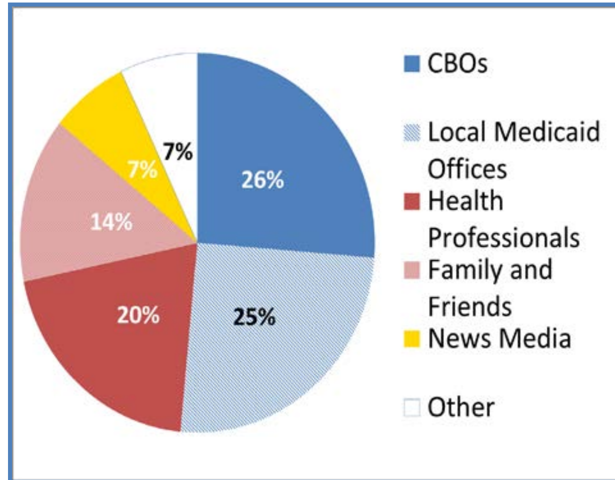
Despite the fact that the immigrants we spoke with trusted their local DSS offices to provide them with accurate information about the ACA, they also expressed concern about the ability of DSS eligibility workers to provide them with high-quality assistance. Some Latino immigrant participants reported negative experiences applying for Medicaid at their local DSS offices. They felt that DSS workers were always "in a hurry" and did not want to provide services to them. They felt treated poorly even when they spoke English and were offended by eligibility workers who presumed that they could not speak English. On the other hand, most refugee populations reported having a positive experience with their local DSS offices and applications for Medicaid. This was in large part because they received personalized attention with the support of refugee resettlement agencies. Other immigrant groups, including Latino immigrants, who had personalized assistance from an outreach worker at either a community-based health clinic or immigrant-serving CBOs reported similarly positive experiences applying for Medicaid and other social services.

Community Leaders are Eager to Engage in Outreach and Develop Culturally and Linguistically Appropriate Materials

Leaders in county governments, community-based health care and immigrant serving organizations provide a critical link to immigrant communities and ensuring that they have accurate information about the ACA. Nevertheless, key informant interviews suggested that

few local community leaders had been provided with information about the ACA, knew where to find that information, or had begun to develop outreach efforts for immigrant and refugee communities in the summer of 2013. Many state-level and local CBOs were caught off guard when the North Carolina legislature passed Senate Bill 4 (signed by the governor into law on March 6, 2013) and decided not to expand Medicaid or to develop a statewide outreach strategy (Oberlander & Perreira 2013; Ross 2013). As a result, North Carolina had to return more than $20 million dollars in support for outreach and enrollment efforts to the federal government. This left staff in local Departments of Social Services, County Health Departments, Federally-Qualified Health Centers, and other CBOs feeling overwhelmed and without the resources they wanted to give outreach and enrollment under the ACA sufficient attention.

Figure 6. Trusted Sources of Information



To add to the frustrations of many directors of county Departments of Social Services (DSS) and Health Departments, multiple new computer systems were also being implemented in the summer of 2013. These included: (1) NC FAST, a new computer system used to enroll individuals in public assistance programs such as Medicaid, (2) NC Tracks, a new Medicaid billing system, and (3) electronic medical record systems. As explained to us by DSS and county health department officials, the implementation of any one of these systems requires significant staff time as personnel convert paper files to electronic files and learn to navigate new on-line systems. The implementation of all three types of computer systems at one time was a perfect storm.

Multiple problems with the computer software associated with NC Tracks prevented staff from processing applications and renewals for Medicaid efficiently. Consequently, counties have developed extensive backlogs. A recent report from one of the most populated counties in North Carolina, Wake County, indicates that the county has 14,989 applications pending, with 5,797 coming from the Health Insurance Marketplace (Hankerson 2014). Similarly, programming bugs in the NC Tracks system, have prevented providers from filing their claims and getting paid, and Medicaid patients from getting medically necessary services (Bonner 2014). To deal with the numerous problems they have encountered with these systems, DSS offices and health care providers have routinely asked their staff to work overtime and have sought to hire additional staff.

Despite these setbacks and the limited resources available, officials in Departments of Social Services, County Health Departments, and state-government outreach offices of Medicaid

programs were eager to provide whatever assistance they could within the scope of state law. Thus, many were relieved when the North Carolina Division of Medical Assistance (DMA) sent a letter out on November 22, 2013 letting Medicaid eligibility staff know that they could evaluate individuals for their eligibility for subsidized health insurance through the Healthcare Marketplace and could refer those who did not qualify for or did not want subsidized insurance to www.healthcare.gov for further assistance (DMA 2013).

Moreover, through the leadership of Community Care of North Carolina (CCNC), an organization providing care management to mostly Medicaid patients, community-based organizations came together to apply for federal funding for the development of navigator programs to reach out to, support and enroll North Carolina's uninsured population into qualified health plans within the Federally Facilitated Marketplace. In August 2013, the Department of Health and Human Services (HHS) announced the awards and CCNC received just under $2 million to assist with outreach and enrollment throughout the state (Sisk 2013). Two other organizations received navigator grants in the state -- Mountain Projects of Sylvia, NC and Randolph Hospital of Asheboro, NC. In addition, HHS awarded 31 health centers in North Carolina $6 million to provide outreach and enrollment services throughout the state (HRSA 2013). Health centers receiving these awards included hospitals, community-based health clinics, and Federally-Qualified Health Centers (FQHCs).

As part of this project, we spoke with many of the leaders of these health centers. The key informants that we interviewed were sensitive to the need to develop linguistically and culturally appropriate outreach materials for immigrant and refugee populations in North Carolina. However, few had had the time or resources to begin developing these materials.

Immigrants Would Benefit from Community-Based Information Sessions and Personalized Conversations with Experienced Navigators

At the end of our focus groups, immigrants also discussed outreach and enrollment strategies that would be most effective for themselves and others in their communities. The immigrants we spoke with in June/July 2013 had only heard about health care reform through word of mouth.

To obtain assistance in English or their native language, immigrants can call: 1-800-318-2596

In North Carolina, assistance in English or Spanish is available at: 1-855-733-3711

Immigrants unanimously concluded that the most effect outreach efforts in their communities would involve a community-based information session held by a local trusted organization such as a church or immigrant and refugee-serving CBO. Because several immigrant population groups had low literacy, these information sessions would be essential to ensuring their communities could hear about and understand the new law. Immigrants we spoke with very much wanted the opportunity to engage in a discussion and ask questions about the new law. Even if a speaker was unavailable in their native languages, they recommended that these

information sessions could be organized with the help of leaders in their communities and these leaders would provide translation. As several individuals commented in different groups, "We stick together," "We work as a community." They explained that when one person has a need, they share information and use their personal networks to help each other. Thus, outreach strategies should take advantage of these personal networks for disseminating information throughout the community. Information sessions located within these immigrant communities would help start the flow of information.

Few immigrants had actually heard of healthcare navigators, certified application counselors, or in-person assisters. But after hearing about them, they agreed that navigators with experience working with immigrant communities would be essential to successful enrollment. Thus, they recommended that following the information sessions, individuals be allowed to set up face-to-face, personal meetings with navigators in their communities. Because of the complexity of their cases and the difficulty many experienced completing applications on-line, they believed that personalized enrollment assistance would be necessary. They also indicated that it would be helpful if navigators from within their communities were identified and trained. These individuals would have the language skills and cultural background necessary to build trust and understand the needs of immigrants.

The immigrants and refugees that we spoke with did not uniformly support outreach strategies that focused on internet-based campaigns. Younger immigrants from Africa and Asia typically had smartphones and felt comfortable surfing the internet for information. Several also had computers and access to the internet in their homes. However, older immigrants typically relied on younger relatives to get information from the internet and did not feel comfortable using the internet on their own. Immigrants from Latin America also had smartphones that could access the internet. But those living in rural areas were less likely to have computers and stable internet service in their homes. Instead, they visited their local libraries or McDonalds for internet service. Instead of focusing on internet-based outreach campaigns, several immigrant groups recommended text-based campaigns. Many preferred text messages to e-mails or voice messages and believed that simply texts with brief messages about requirements to purchase health insurance and numbers to call for assistance would be useful.

Due to limited TV news and radio media in their native languages, they believed that public service announcements through these venues would have little utility. Due to limited literacy, they also suggested that the dissemination of posters, trifolds, and other written materials would be helpful for some but not for everyone. Any written materials needed to be in their native languages, written as simply as possible, and utilize helpful graphics. To overcome the limits of written communication, TV news, and radio media, they recommended the development of videos describing the new health care law and the application process. These videos could be made in their native languages and distributed to key community leaders and to community-based organizations where immigrants gather. Recently, the Office of Refugee Resettlement (ORR) has developed several 6-minute videos to introduce the Marketplace to refugees (see link in Appendix 5).

Recommendations

Nationally, the number of uninsured adults has fallen nearly 4 percentage points since September 2013, the month before the Health Insurance Marketplace's initial open enrollment began (Long et al. 2014). The percentage of the U.S. population without health insurance is now approximately 14%. However, in states like North Carolina that chose not to expand Medicaid, individuals are more likely to be uninsured than in states that adopted the Medicaid expansions (18% vs. 10%) (Long et al. 2014). Approximately, 8 million persons obtained their new coverage through a state- or federally-facilitated Health Insurance Marketplace (ASPE 2014). In North Carolina, 357,584 individuals selected a plan through the Marketplace (ASPE 2014).

Immigrants are typically a young, working-age population. While some have few health needs, others have experienced significant hardships and forgone medical care for years. Most immigrants are legal and eligible to participate in the Health Insurance Marketplace. Yet, immigrant populations remain one of the most hard-to-reach population groups. To further reduce the number of uninsured in the U.S. and North Carolina, outreach to this population is critical. Based on our discussions with community-leaders and immigrants themselves, we recommend several strategies to connect with them and increase their enrollment in health insurance.

- First, with limited resources, statewide organizations such as Community Care of North Carolina (CCNC) and EnrollAmerica should concentrate their immigrant outreach and enrollment efforts on the five counties (Durham, Forsyth, Guilford, Mecklenburg, and Wake) where nearly 50% of uninsured noncitizens live.
- Second, statewide organizations should partner with local community leaders to develop information sessions and translations of materials. Any written materials should be succinct and straightforward with colorful graphics.
- Third, short text messages indicating that health reform is for everyone and providing a number to call for more information should be developed to help inform immigrants and their family about their eligibility for subsidized health insurance benefits.
- Fourth, public awareness campaigns should be directed at immigrants and emphasize the themes of financial security, protecting health for work, and family responsibility that resonated with the immigrants in our focus groups.
- Fifth, public awareness campaigns should also emphasize that lawfully present immigrants, refugees, and temporary workers are eligible for benefits. Moreover, premiums are affordable with an average cost of $69 per month after subsidies are applied.
- Finally, health providers and community-based organizations serving immigrants should continue to work together to promote Medicaid expansion in North Carolina.

Appendices

Appendix 1. Nativity and Citizenship, by County of Residence

County	U.S.-Born Citizen		Foreign-born Naturalized Citizen		Foreign-born Non-Citizen	
	N	% of County	N	% of County	N	% of County
Alamance	139,007	93%	3,057	2%	7,951	5%
Alexander	35,503	98%	248	1%	646	2%
Alleghany	10,301	95%	99	1%	484	4%
Anson	23,904	98%	125	1%	412	2%
Ashe	25,731	96%	171	1%	940	4%
Avery	15,340	96%	86	1%	532	3%
Beaufort	44,864	95%	357	1%	1,902	4%
Bertie	19,764	99%	25	0%	94	<1%
Bladen	32,612	95%	136	0%	1,582	5%
Brunswick	102,765	96%	1,838	2%	2,527	2%
Buncombe	221,872	94%	4,226	2%	8,978	4%
Burke	83,561	95%	1,558	2%	3,081	3%
Cabarrus	163,899	93%	3,741	2%	9,392	5%
Caldwell	79,141	97%	634	1%	1,543	2%
Camden	9,545	97%	59	1%	192	2%
Carteret	62,313	97%	767	1%	1,423	2%
Caswell	21,997	99%	73	0%	195	1%
Catawba	142,075	93%	3,452	2%	7,355	5%
Chatham	56,563	89%	1,771	3%	4,957	8%
Cherokee	26,374	98%	269	1%	397	1%
Chowan	14,051	97%	238	2%	262	2%
Clay	10,144	97%	158	2%	175	2%
Cleveland	95,037	98%	589	1%	1,436	1%
Columbus	53,731	97%	206	0%	1,329	2%
Craven	90,631	95%	1,653	2%	2,879	3%
Cumberland	271,728	94%	8,450	3%	8,510	3%
Currituck	22,478	97%	265	1%	442	2%
Dare	31,889	94%	512	2%	1,351	4%
Davidson	153,637	95%	1,741	1%	5,583	3%
Davie	39,129	96%	587	1%	1,120	3%
Duplin	50,579	87%	975	2%	6,291	11%
Durham	226,447	86%	9,798	4%	27,239	10%
Edgecombe	53,663	98%	261	0%	1,071	2%
Forsyth	315,960	91%	8,187	2%	23,839	7%
Franklin	56,670	95%	621	1%	2,161	4%

County	U.S.-Born Citizen		Foreign-born Naturalized Citizen		Foreign-born Non-Citizen	
	N	% of County	N	% of County	N	% of County
Gaston	194,004	95%	3,083	2%	7,037	3%
Gates	11,818	99%	72	1%	49	<1%
Graham	8,510	98%	94	1%	50	1%
Granville	53,513	96%	513	1%	2,006	4%
Greene	17,744	92%	215	1%	1,247	6%
Guilford	439,564	90%	16,479	3%	29,980	6%
Halifax	52,207	98%	375	1%	556	1%
Harnett	103,474	94%	1,645	1%	4,872	4%
Haywood	56,620	97%	704	1%	885	2%
Henderson	96,841	92%	3,219	3%	5,283	5%
Hertford	22,486	98%	179	1%	292	1%
Hoke	41,140	94%	629	1%	1,819	4%
Hyde	4,686	95%	-	0%	272	5%
Iredell	149,695	95%	2,737	2%	5,841	4%
Jackson	37,935	96%	495	1%	1,235	3%
Johnston	153,945	92%	2,580	2%	10,818	6%
Jones	9,596	96%	134	1%	279	3%
Lee	50,058	88%	1,004	2%	5,764	10%
Lenoir	56,275	96%	366	1%	1,708	3%
Lincoln	73,461	95%	1,161	1%	2,794	4%
McDowell	42,647	97%	417	1%	950	2%
Macon	31,631	94%	496	1%	1,374	4%
Madison	20,073	98%	195	1%	235	1%
Martin	23,700	98%	44	0%	433	2%
Mecklenburg	792,650	86%	40,568	4%	87,800	10%
Mitchell	15,087	98%	67	0%	228	1%
Montgomery	24,398	91%	431	2%	1,930	7%
Moore	81,624	94%	1,836	2%	2,988	3%
Nash	89,528	95%	969	1%	3,480	4%
New Hanover	189,875	94%	3,936	2%	7,292	4%
Northampton	20,978	99%	66	0%	182	1%
Onslow	138,072	95%	2,750	2%	3,835	3%
Orange	115,420	87%	5,966	4%	11,609	9%
Pamlico	12,071	96%	147	1%	299	2%
Pasquotank	37,345	97%	420	1%	916	2%
Pender	48,952	96%	447	1%	1,426	3%
Perquimans	13,044	98%	139	1%	93	1%
Person	37,900	97%	175	0%	860	2%
Pitt	158,303	95%	2,667	2%	5,540	3%
Polk	19,245	96%	233	1%	612	3%
Randolph	131,078	93%	1,883	1%	7,497	5%
Richmond	43,525	96%	333	1%	1,579	3%
Robeson	123,889	94%	1,017	1%	6,348	5%

County	U.S.-Born Citizen		Foreign-born Naturalized Citizen		Foreign-born Non-Citizen	
	N	% of County	N	% of County	N	% of County
Rockingham	88,881	96%	612	1%	2,876	3%
Rowan	127,412	95%	1,979	1%	5,400	4%
Rutherford	64,469	97%	820	1%	906	1%
Sampson	57,101	91%	1,011	2%	4,702	7%
Scotland	34,523	98%	229	1%	465	1%
Stanly	57,376	97%	306	1%	1,340	2%
Stokes	46,170	99%	84	0%	562	1%
Surry	68,729	94%	696	1%	3,327	5%
Swain	13,510	98%	64	0%	213	2%
Transylvania	31,586	97%	376	1%	476	1%
Tyrrell	3,454	92%	59	2%	231	6%
Union	182,561	91%	6,262	3%	11,826	6%
Vance	42,944	96%	450	1%	1,340	3%
Wake	781,629	87%	41,670	5%	74,442	8%
Warren	19,823	98%	158	1%	248	1%
Washington	12,591	97%	46	0%	305	2%
Watauga	49,040	97%	688	1%	1,064	2%
Wayne	108,385	93%	1,478	1%	6,542	6%
Wilkes	66,013	97%	481	1%	1,800	3%
Wilson	74,262	93%	991	1%	4,690	6%
Yadkin	35,615	94%	422	1%	1,887	5%
Yancey	17,131	97%	93	1%	425	2%

Source: U.S. Census Bureau 2014b

Appendix 2. Characteristics of Uninsured North Carolinians

	Total N	Uninsured N	% of Total	% of Uninsured
STATE	9,341,367	1,511,700	16%	100%
AGE				
Under 18 years	2,271,929	182,011	8%	12%
18 to 64 years	5,862,832	1,323,233	23%	88%
65 years and older	1,206,606	6,456	1%	<1%
19 to 25 years	874,518	283,901	33%	19%
SEX				
Male	4,494,124	801,330	18%	53%
Female	4,847,243	710,370	15%	47%
RACE AND HISPANIC/LATINO				
One Race	9,142,744	1,479,671	16%	98%
White	6,535,003	902,318	14%	60%
Black or African American	1,986,039	359,742	18%	24%
American Indian/Alaska Native	107,242	27,676	26%	2%
Asian	209,770	38,096	18%	3%
Native Hawaiian/Pacific Islander	3,987	969	24%	<1%
Some other race	300,703	150,870	50%	10%
Two or more races	198,623	32,029	16%	2%
White alone, not Hispanic or Latino	6,110,957	724,476	12%	48%
Hispanic or Latino (of any race)	779,729	343,310	44%	23%
NATIVITY AND CITIZENSHIP STATUS				
Native born	8,630,943	1,168,180	14%	77%
Foreign born	710,424	343,520	48%	23%
Naturalized	216,794	41,708	19%	3%
Not a citizen	493,630	301,812	61%	20%
EDUCATIONAL ATTAINMENT				
Population 25+	6,174,034	1,067,137	17%	100%
Less than high school graduate	942,082	300,956	32%	28%
High school graduate/ GED	1,680,529	357,038	21%	33%
Some college or associate's degree	1,874,552	304,422	16%	29%
Bachelor's degree or higher	1,676,871	104,721	6%	10%

	Total N	Uninsured N	% of Total	% of Uninsured
EMPLOYMENT STATUS				
Population 18+	7,069,438	1,329,689	19%	100%
In labor force	4,676,003	1,018,728	22%	77%
Employed	4,200,922	776,249	19%	58%
Unemployed	475,081	242,479	51%	18%
Not in labor force	2,393,435	310,961	13%	23%
WORK EXPERIENCE PAST 12 MONTHS				
Population 18+	7,069,438	1,329,689	19%	100%
Worked full-time	2,941,311	421,740	14%	32%
Worked less than full-time	1,800,838	540,887	30%	41%
Did not work	2,327,289	367,062	16%	28%
HOUSEHOLD INCOME				
Total Households	9,223,562	1,496,999	16%	100%
Under $25,000	1,959,653	500,393	26%	33%
$25,000 to $49,999	2,347,377	529,619	23%	35%
$50,000 to $74,999	1,795,848	260,663	15%	17%
$75,000 to $99,999	1,215,084	112,039	9%	7%
$100,000 and over	1,905,600	94,285	5%	6%
POVERTY LEVEL PAST 12 MONTHS				
Total Households	9,226,233	1,504,154	16%	100%
Under 138% of poverty threshold	2,316,942	678,898	29%	45%
138% to 199% of poverty threshold	1,155,298	286,519	25%	19%
200% of poverty threshold and over	5,753,993	538,737	9%	36%

Source: U.S. Census Bureau 2014b

Appendix 3. Uninsured by Citizenship and County of Residence

County	Uninsured Total		Uninsured Non-Citizen		
	N	% of County Population	N	% of County Uninsured	% of Non-Citizen Population
STATEWIDE	1511700	16%	301812	20%	61%
Alamance	24541	16%	5223	21%	66%
Alexander	6006	17%	354	6%	55%
Alleghany	2180	20%	456	21%	94%
Anson	4632	19%	332	7%	81%
Ashe	4854	18%	800	16%	85%
Avery	3229	20%	380	12%	71%
Beaufort	8485	18%	1494	18%	79%
Bertie	2764	14%	51	2%	54%
Bladen	6952	20%	1258	18%	80%
Brunswick	17960	17%	2072	12%	82%
Buncombe	38764	17%	5383	14%	60%
Burke	14841	17%	1938	13%	63%
Cabarrus	28305	16%	6124	22%	65%
Caldwell	13935	17%	924	7%	60%
Camden	881	9%	24	3%	13%
Carteret	10724	17%	944	9%	66%
Caswell	3357	15%	113	3%	58%
Catawba	24088	16%	4074	17%	55%
Chatham	9498	15%	3328	35%	67%
Cherokee	5084	19%	200	4%	50%
Chowan	2486	17%	172	7%	66%
Clay	2283	22%	130	6%	74%
Cleveland	15700	16%	707	5%	49%
Columbus	11398	21%	900	8%	68%
Craven	13290	14%	1465	11%	51%
Cumberland	41061	14%	3486	8%	41%
Currituck	4108	18%	143	3%	32%
Dare	6497	19%	1004	15%	74%
Davidson	24649	15%	3368	14%	60%
Davie	4817	12%	634	13%	57%
Duplin	13993	24%	4737	34%	75%
Durham	43093	16%	15727	36%	58%
Edgecombe	10275	19%	648	6%	61%
Forsyth	55346	16%	16035	29%	67%
Franklin	10487	18%	1406	13%	65%
Gaston	35676	18%	4396	12%	63%
Gates	1281	11%	32	2%	65%
Graham	2020	23%	29	1%	58%
Granville	8029	14%	1390	17%	69%

County	Uninsured Total		Uninsured Non-Citizen		
	N	% of County Population	N	% of County Uninsured	% of Non-Citizen Population
Greene	3484	18%	982	28%	79%
Guilford	79688	16%	16215	20%	54%
Halifax	7946	15%	415	5%	75%
Harnett	17954	16%	3212	18%	66%
Haywood	9920	17%	580	6%	66%
Henderson	18331	17%	3978	22%	75%
Hertford	3251	14%	160	5%	55%
Hoke	7173	17%	1227	17%	68%
Hyde	1174	24%	272	23%	100%
Iredell	23663	15%	3035	13%	52%
Jackson	7340	19%	601	8%	49%
Johnston	28015	17%	8214	29%	76%
Jones	1955	20%	194	10%	70%
Lee	10970	19%	4164	38%	72%
Lenoir	11314	19%	1444	13%	85%
Lincoln	12659	16%	1894	15%	68%
McDowell	6541	15%	722	11%	76%
Macon	6809	20%	901	13%	66%
Madison	3051	15%	129	4%	55%
Martin	4692	19%	382	8%	88%
Mecklenburg	154535	17%	49324	32%	56%
Mitchell	2658	17%	197	7%	86%
Montgomery	5417	20%	1354	25%	70%
Moore	11662	14%	1833	16%	61%
Nash	14941	16%	2585	17%	74%
New Hanover	31718	16%	4745	15%	65%
Northampton	3502	17%	88	3%	48%
Onslow	20468	14%	1838	9%	48%
Orange	15199	11%	5167	34%	45%
Pamlico	1836	15%	252	14%	84%
Pasquotank	6764	18%	818	12%	89%
Pender	9621	19%	1116	12%	78%
Perquimans	2145	16%	43	2%	46%
Person	5919	15%	634	11%	74%
Pitt	27067	16%	3481	13%	63%
Polk	3070	15%	441	14%	72%
Randolph	24638	18%	5004	20%	67%
Richmond	9035	20%	1349	15%	85%
Robeson	31214	24%	5067	16%	80%
Rockingham	13459	15%	1864	14%	65%
Rowan	23878	18%	3855	16%	71%
Rutherford	11690	18%	599	5%	66%
Sampson	12175	19%	3465	28%	74%

County	Uninsured Total		Uninsured Non-Citizen		
	N	% of County Population	N	% of County Uninsured	% of Non-Citizen Population
Scotland	5691	16%	276	5%	59%
Stanly	8570	15%	901	11%	67%
Stokes	5804	12%	330	6%	59%
Surry	13367	18%	2113	16%	64%
Swain	3894	28%	113	3%	53%
Transylvania	5470	17%	330	6%	69%
Tyrrell	906	24%	201	22%	87%
Union	26908	13%	7978	30%	68%
Vance	7392	17%	1005	14%	75%
Wake	120267	13%	40555	34%	55%
Warren	3583	18%	171	5%	69%
Washington	2214	17%	235	11%	77%
Watauga	6833	14%	533	8%	50%
Wayne	19425	17%	4580	24%	70%
Wilkes	11345	17%	1329	12%	74%
Wilson	14947	19%	3831	26%	82%
Yadkin	5573	15%	1283	23%	68%
Yancey	3406	19%	327	10%	77%

Source: U.S. Census Bureau 2014b

Appendix 4. Helpful Fact Sheets on the ACA

Organization	Web Address
Enroll America	http://www.enrollamerica.org/resources/toolkits/
Farm Information Resource Management (FIRM) Program	http://firm.msue.msu.edu/uploads/files/FIRM_Archive/FIRM_13-04_Health_Care_QA_Individuals_and_Families.Final_Release.pdf
Kaiser Family Foundation	http://kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/
Kaiser Family Foundation	http://kff.org/health-reform/faq/health-reform-frequently-asked-questions/
National Immigration Law Center (NILC)	http://www.nilc.org/immigrantshcr.html
North Carolina Justice Center	http://www.ncjustice.org/?q=immigrants-and-refugees/factsheet-immigrants-north-carolina-and-affordable-care-act

Appendix 5. Resources in Languages other than English

Organization	Web Address
AARP	http://www.aarp.org/health/health-insurance/health-care-law-fact-sheets-translations/
EnrollAmerica	https://www.getcoveredamerica.org/es/
Office of Refugee Resettlement	http://www.acf.hhs.gov/programs/orr/health
U.S. Centers for Medicare and Medicaid Services	https://www.healthcare.gov/language-resource/
U.S. Centers for Medicare and Medicaid Services	https://www.cuidadodesalud.gov/es/
U.S. Department of Health and Human Services	http://www.hhs.gov/iea/acaresources/,
White House Initiative on Asian and Pacific Islanders	http://www.ed.gov/edblogs/aapi/issue-areas/the-affordable-care-act/

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