New Mexico Health Insurance Exchange: Consumer Behavior and Stakeholder Engagement Market Assessment Report

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Executive Summary

The Patient Protection and Affordable Care Act (ACA) provides roughly 15 million Americans who would have been uninsured access to comprehensive health insurance.[1] Acting on the new choices made possible by the ACA, New Mexico is one of 17 states with its own health insurance Marketplace and one of 27 states that chose to expand Medicaid to low-income adults.[2] Fulfilling the potential of this significant legislation has partially hinged upon making consumers aware of beWellnm—New Mexico's public-facing Marketplace—and the opportunities it provides for purchasing health insurance at an affordable price. Equally critical has been providing interested consumers with accessible information to make an informed plan selection and sufficient assistance to help them through the enrollment process.

According to 2014 census data, approximately 268,000 New Mexicans under the age of 65 continued to lack coverage.[3] Building awareness among New Mexicans who are eligible for subsidized individual policies through beWellnm and providing enrollment support have proven challenging. New Mexico is a rural and expansive state with a culturally diverse population, many of whom have low literacy and live in poverty. These factors shape how well people receive, understand, and interpret information; their expectations and attitudes about health and health insurance; and their tolerance for risk. Investigating the interplay between these factors is a critical component for understanding how to address the barriers to successfully reach out to the remaining marketplace-eligible New Mexicans who lack coverage.[3]

In October 2015, beWellnm commissioned the American Institutes for Research in collaboration with its research partners—Lovelace Scientific Resources and New Mexico consultants, representing the Native American and Hispanic communities—to conduct an assessment to (1) better understand why subpopulations of New Mexicans who are eligible to receive financial subsidies have not enrolled in health insurance and (2) develop actionable recommendations that beWellnm can use to tailor outreach communications and support to each subpopulation to improve its rate of enrollment. This report presents results from our assessment focusing on subsidy-eligible Native Americans and Hispanics living in rural areas. We began by gathering information from the literature on outreach and enrollment strategies that others have found to be effective; we then interviewed enrollment counselors and other professionals who work closely with uninsured subsidy-eligible New Mexicans. In the next phase of data collection, we held consumer focus groups in nine communities across New Mexico and surveyed focus group participants and other subsidy-eligible consumers living in the targeted communities beginning in January 2015 and ending in March 2016..

Through this work, we identified key challenges rural New Mexicans face in learning about beWellnm and their health plan choices and enrolling in a plan and make recommendations for addressing these challenges drawing from effective strategies implemented in other states. Our recommendations consider outreach and enrollment strategies, and the processes and structures that enable people to become enrolled. We divided our recommendations and supporting data into two main themes; *tailor outreach communications to each subpopulation*

and *improve outreach and enrollment structures and support*. We present the main recommendations and then supporting results under the two themes below.

Tailor Outreach Communications to Each Subpopulation

- Focus outreach on positive messaging of interest to uninsured New Mexicans with less emphasis on the tax penalties for being uninsured.
- Provide easily accessible and detailed information about what a tax credit and cost-sharing subsidy means, the process for applying to receive a subsidy, and where people can go to find out if they qualify.
- Develop innovative approaches to reach out to the subsidy-eligible uninsured through local news broadcasts, ethnic media (local and internet radio stations and newspaper), the Internet, text messaging, email, and the phone.
- Engage people whom the uninsured trust or access for medical care as advocates for becoming insured.

Key results

Our results point to the need for a communication approach that imparts sufficient detail about what the uninsured want to know while appealing to their values and culture and addressing their concerns. Paying for health care was a major concern for both the insured and uninsured, and many of the uninsured valued highly the security associated with being insured. Messaging that emphasizes the financial and health benefits of having insurance may resonate effectively with a broader population compared with a campaign that highlights the tax penalty for being uninsured. The uninsured had little knowledge about beWellnm or the tax subsidies available to them, but they were aware of the tax penalty. Messages highlighting the penalty generated feelings of anger and were seen as threatening by study participants rather than as a motivator to purchase insurance.

For Native Americans, increased choice of providers and full access to services was an appealing message. Native Americans participating in the focus groups were dissatisfied with the quality of services provided by the Indian Health Services and the lack of access it afforded to a full range of services. Monolingual Spanish speakers saw health insurance as access to local health care without the worry of traveling to Mexico for care. Although they were content with the quality and price of the care they received in Mexico, they described the journey as burdensome, expensive, and an extreme measure; it was not a viable option in an emergency.

Across our data collection, we heard individuals discuss the importance of family members as both a motivator to purchase insurance and a trusted information resource. Research shows this is especially true among uninsured Hispanics, who place considerable weight on family input when shaping their own opinions and actions.[4] Key informants indicated that in the Native American community, major decisions are made as a family unit; this finding shows that

outreach should be family focused. They added that matriarchs in both these populations often assume responsibility for the well-being of the family and can reinforce messaging to younger audiences about the importance of purchasing insurance and timelines for enrollment.

Focus group participants expressed receptiveness to outreach efforts at places they trust and frequent regularly. Focus group participants listed their doctor's office as a preferred source of health insurance information. However, many of the uninsured visit a physician's office rarely, if at all, and instead opt for self-care or an urgent care or walk-in clinic as their usual source of care. In some cases, the insured participants did see a regular office-based physician, but their preferred provider was not in-network for plans offered through beWellnm. Going forward, it will be important to engage urgent care, walk-in clinics, and out-of-network providers—particularly those who speak Spanish—in referring the uninsured to enrollment counselors and enrollment events. Given that the uninsured may not seek healthcare services during open enrollment, these providers will need to share information with the uninsured patients about beWellnm throughout the year and a system to follow-up with this group during open enrollment is needed.

Improve Outreach and Enrollment Structures and Support

- Assess consumer-facing informational and enrollment resources and assistance to identify and correct interfaces that stop the uninsured from moving forward to enrollment.
- Adopt the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.[5]

Key results

The assessment revealed a need to improve the enrollment experience by removing the roadblocks all groups encountered as they looked into beWellnm, the subsidies, and their plan choices and then tried to enroll in a plan. Consumers wanted easy access to accurate information relevant to them. Many preferred to review Marketplace information on their own, then reach out for one-on-one assistance. Even consumers who were able to select a plan without help wanted access to an enrollment counselor who could verify that their plan choice was in fact the best option for them.

Key informants and consumers described the need for in-depth assessment and improvement of web-based and printed information resources and counseling and enrollment-support processes. Consumer testing of the beWellnm public-facing website and materials in English and Spanish can suggest simple changes that can ensure consumers are able to locate and accurately understand critical information.

Consumers, key informants, and stakeholder advisory members all noted the importance and effectiveness of localized outreach and individualized enrollment assistance provided by New Mexicans. Because counseling is a cornerstone to enrollment and requires considerable expertise, routine monitoring of counselors' performance and feedback to develop enrollment

counselors' skills can reinforce performance expectations. Many of the remaining uninsured are unable to travel for enrollment assistance meaning people living in the less populated areas of the state will need help from counselors who are mobile and come to them. The development of a cadre of well-trained, volunteer enrollment counselors to meet the high demand during open enrollment needs to be secured before Federal funding for outreach is reduced further.

BeWellnm should consider developing a case management system enabling enrollment counselors to follow-up on problems consumers experience with enrollment and offer a personalized, responsive consumer experience. However, some of the difficulties consumers reported—long wait times for phone assistance, poorly informed call center staff, and glitches with the transfer of enrollment information to insurers—are not within the control of beWellnm. beWellnm will need to be persistent in conveying consumers' frustrations to the Centers for Medicare & Medicaid Services (CMS) and closely collaborate with CMS until resolutions to these systematic problems are reached.

We heard from monolingual Spanish speakers and Native American focus group participants that they are not always treated fairly and equally by individuals whose job is to assist them. *Trust, respect,* and *understanding* were three words that frequently came up in the data collection. Historical and personal experiences of mistreatment from being outside the dominant culture affected focus group participants' perceptions of beWellnm, health insurance, health care, and the struggles they experience with shopping for and purchasing health insurance through beWellnm. We recommend that beWellnm adopt the National Standards for CLAS in Health and Health Care.[6] By doing so, beWellnm will develop an organizational culture and an infrastructure to provide effective, equitable, understandable, and respectful services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

I. Background and Objectives

The Patient Protection and Affordable Care Act (ACA) provides roughly 15 million Americans who would have been uninsured access to comprehensive health insurance.[7] Acting on the new choices made possible by the ACA, New Mexico is one of 17 states with its own health insurance Marketplace and one of 27 states that chose to expand Medicaid to low-income adults.[8] Fulfilling the potential of this significant legislation has partially hinged upon making consumers aware of the Marketplace and the opportunities it provides for purchasing health insurance at an affordable price. Equally critical has been providing consumers with accessible information to make an informed plan selection and sufficient assistance to help them through the enrollment process.

Building awareness among New Mexicans who are eligible for subsidized individual policies through beWellnm—New Mexico's public-facing Marketplace—and providing enrollment support has proven challenging. New Mexico is the fifth largest state in the country in geographic size, but ranks 36 for population size. Over 21 percent of New Mexicans live in poverty in a state where Hispanics and Native Americans combined make up the majority of the population.[9] Cultural issues, low literacy, and poverty are all interrelated and closely connected with being uninsured. These factors shape how well people receive, understand, and interpret information; their expectations and attitudes about health and health insurance; and their tolerance for risk. Investigating the interplay between these factors is a critical component for understanding how to address the barriers to successfully reach out to the remaining 268,000 New Mexicans under the age of 65 who lack coverage.[10]

New Mexico first opened its Marketplace in 2012–2013 with approximately 422,000 New Mexicans in need of health insurance coverage.[11] More than one in five of them were estimated to be eligible for Marketplace subsidies, and nearly one-half were expected to be Medicaid or Children's Health Insurance Program eligible. In the most recent and third open enrollment period, 54,865 people selected individual polices, which is a substantial increase from 2 years earlier but a sign of leveling off from year 2, when 52,358 people enrolled.[12,13] This slowed momentum can be attributed to the loss of Blue Cross and Blue Shield participation in 2016, an insurer that covered half of beWellnm private plan enrollees in the previous year, and to the reduced pool of people who remain uninsured. Of the people who selected a plan through beWellnm for 2016 coverage, approximately 59% percent of those consumers had the option to purchase insurance with premiums of $100 or less after tax credits.[14] Special attention is needed to better understand the barriers to enrollment that exist for consumers who remain uninsured despite the availability of low-cost and high-quality coverage.

NMHX commissioned the American Institutes for Research in collaboration with its research partners, Lovelace Scientific Resources and New Mexico consultants representing the Native American and Hispanic communities to conduct an assessment to (1) better understand why subpopulations of New Mexicans who are eligible to receive financial subsidies have not enrolled in health insurance and (2) develop actionable recommendations that beWellnm can use to tailor outreach communications and support to each subpopulation to improve its rate of enrollment.

II. Assessment Approach

The assessment had a multipronged data collection strategy. We began by reviewing literature on outreach and enrollment strategies that others had found to be effective. We then conducted telephone interviews with 30 key informants who serve uninsured subsidy-eligible consumers who live across the state. In the next phase of data collection, we held 21 consumer focus groups in 9 communities. A consumer survey was completed by the focus group participants and other subsidy-eligible consumers who contacted our recruitment line or were screened by the research team in the community. We collected the data December 2015 through March 2016. A detailed description of the data collection methods can be found in appendix A. In appendix B, table B–2, we provide detailed information about the survey respondents' characteristics with comparisons made by insurance status (insured and uninsured), race and ethnicity (Native Americans, Hispanic English speaker, Hispanic Spanish speakers, and all other), age (millennial and nonmillennial), and degree of rurality (more rural and less rural).

Exhibit 1. Criteria for Consumers to Participate in the Assessment

- Family income 138 percent to 400 percent of Federal poverty level
- 18 to 64 years old
- U.S. citizen or documented immigrant
- Live a reasonable driving distance from Clovis, Farmington, Gallup, Las Cruces, Los Lunas, Santa Fe, South Valley (Albuquerque), Silver City, or Taos

Enrollment targeted Hispanics, Native Americans, and uninsured, but a limited number of consumers from other racial and ethnic groups and insured consumers were included.

The primary focus of the assessment was on subsidy-eligible Native Americans and Hispanics living in rural areas. We included a limited number of rural participants identifying as Caucasian and other races and insured New Mexicans. The addition of insured New Mexicans enabled us to isolate factors leading the insured to enroll that could be applied to the uninsured group. The participant selection criteria are listed in exhibit 1.

The core areas of inquiry were organized into the phases consumers move through as they first become aware of beWellnm and progress to actual enrollment. The three phases—exploration, decisionmaking and enrollment—are described below.

Exploration

- **Experience with health care/care seeking:** Consumers' experiences getting health care, where they go for health care, how they pay for services, and why they may not get timely care
- **Attitudes toward and experiences with health insurance:** Why consumers choose to buy (or not buy) health insurance; why consumers who are eligible for low-cost health insurance do not sign up or drop coverage; what consumers think health insurance is for; why consumers trust or do not trust health insurance companies
- **Awareness of beWellnm:** Consumer awareness; attitudes, and perceptions about beWellnm; trust in beWellnm; where they go for information

Decisionmaking

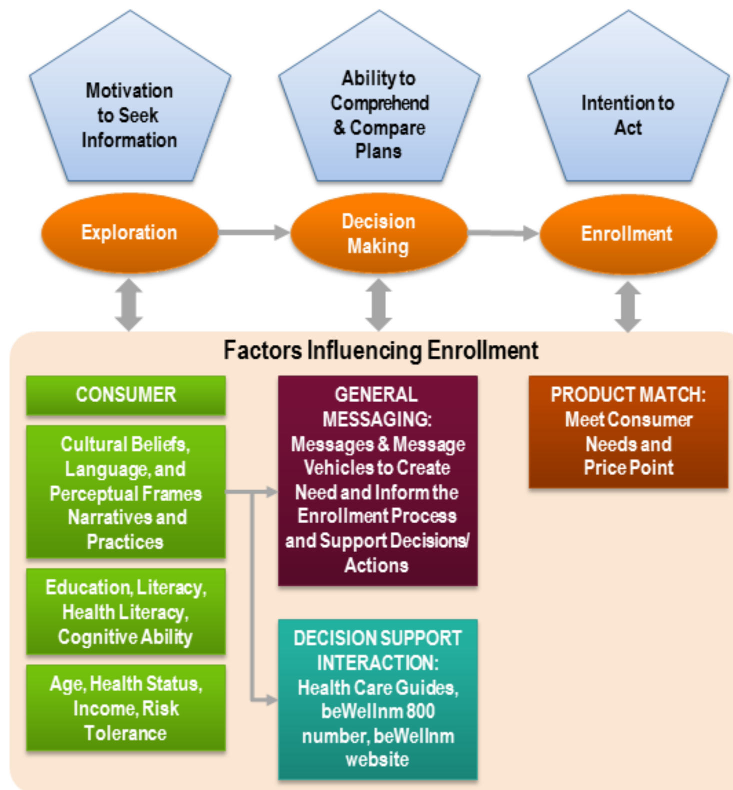
- **Health plan selection:** Factors consumers consider when choosing a health plan; the assistance consumers want and need when selecting a health plan; where they prefer to go for information; the types of information they consider in making a selection

Enrollment

- **Recommendations for increasing enrollment:** Barriers and facilitators to enrolling in a qualified health plan

Organizing Framework. The conceptual framework, pictured in exhibit 2, provides an organizing structure for the assessment questions. The model identifies consumer characteristics that may influence receptivity to beWellnm and willingness to enroll. The focus of the assessment was to understand how to match outreach, messaging, and decision support with rural New Mexicans' needs and expectations—in particular Hispanics' and Native Americans' understanding of health insurance, their cultural attitudes and expectations for health insurance, and the shopping experience.

Exhibit 2: The Influence of Consumer- and Market-Based Factors on Consumer Progress Along the Enrollment Pathway



We engaged a diverse stakeholder advisory panel of New Mexico advocacy, provider, and public health leadership to ensure that important issues were not missed and to overcome the

challenges of research with socially disadvantaged groups who can be hard to engage. The stakeholder advisory panel helped to tailor the study design to the population of interest, and provided entrée to the rural communities and trusted individuals who could assist with recruitment. The Panel was instrumental in helping the project team to understand how the data related to issues of broad concern in the state and providing input into the recommendations.

III. Recommendations and Supporting Evidence

This section of the report presents our results and recommendations. Because what we learned from key informants and consumers indicates that implementing tailored communication strategies alone is unlikely to move Native Americans and Hispanics to enroll, our recommendations also consider the overall outreach and enrollment strategies, structures, and support. We divided the recommendations with supporting data into two main themes: *Tailor outreach communications to each subpopulation* and *Improve outreach and enrollment structures and support*. A summary of our recommendations is presented below followed by a detailed description of our assessment results.

1. Tailor Outreach Communications to Each Subpopulation

- ► Focus outreach on positive messaging of interest to uninsured New Mexicans with less emphasis on the tax penalties for being uninsured.
- ► Provide easily accessible and detailed information about what a tax credit and cost-sharing subsidy means, the process for applying to receive a subsidy, and where people can go to find out whether they qualify.
- ► Develop innovative approaches to reach out to the subsidy-eligible uninsured through local news broadcasts, ethnic media (local and internet radio stations and newspaper), the Internet, text messaging, email, and the phone.
- ► Engage people whom the uninsured trust or access for medical care as advocates for becoming insured.

2. Improve Outreach and Enrollment Structures and Support

- ► Assess consumer-facing informational and enrollment resources and assistance to identify and correct interfaces that stop the uninsured from moving forward to enrollment.
- ► Adopt the National Standards for CLAS in Health and Health Care.[15]

1. Tailor Outreach Communications to Each Subpopulation

This set of recommendations and supporting evidence identifies messages that will be compelling to rural residents and meaningful to Native Americans and Hispanic audiences. We

describe trusted sources of information and how our various race and ethnic groups access information.

Recommendation: Emphasize positive messages

- Focus outreach on positive messaging of interest to uninsured New Mexicans with less emphasis on the tax penalties for being uninsured.

Suggested Messaging

For All Groups

- Health insurance protects your health, your family, and your wallet.
- Access to high-quality and lower cost health insurance.

Specific to Monolingual Spanish Speakers

- Access to health care near home

Specific to Native Americans

- A choice of doctors and timely access to quality care
- Access to health care where and when you need it

Supporting Evidence

Overall. Across all focus groups, participants understood they would incur tax penalties if they were uninsured. Many recalled this message from previous advertising campaigns or remembered their experience filing tax returns in recent years, and viewed additional reminders about the penalty as unnecessary. In fact, messaging that emphasized the penalty generated feelings of anger and was seen as threatening by respondents rather than as a motivator to purchase insurance. For these individuals, the main barrier to purchasing insurance did not relate to a lack of understanding about the penalty. Additionally, most uninsured focus group participants did not see avoiding the penalty as the main benefit of being insured.

Paying for health care was a major concern for both the insured and uninsured. The vast majority of insured and uninsured survey respondents worried about paying for health care if sick (86.6% and 83.2%, respectively; see appendix C, table C–2). However, insured focus group participants felt protected from the stress associated with uncertainty about major health care costs. To them, insurance offered protection from costly medical bills resulting from emergency or long-term medical care. They were relieved to not worry about the risk of property loss or bankruptcy as a result of medical debt, or transferring debt to their children. In particular, the Spanish-

Health insurance as financial security

"I was playing basketball and tore my ACL … I would have been about $125,000 in debt if I hadn't had the insurance at that time."
—Uninsured Caucasian man, 47 years old

"[Insurance offers] asset protection. … I own property and I don't want to have to sell that property to be able to pay if I have a heart attack or a broken leg or 9 days in the hospital."
—Insured Caucasian woman, 50 years old

"Working in an attorney's office, I've seen that the hospitals are putting liens on properties. I've worked too hard for what I have. I want to leave it to my kids, not to the hospital."
—Uninsured Hispanic woman, 54 years old

To some Hispanics, health insurance means access to health care without the worry

Insurance allows you to schedule doctor appointments without stressing. Can get a regular checkup or physical. If you're not feeling well, maybe you should see the doctor. Having the luxury of being able to see the doctor limits your stress."
—Uninsured English Speaker, 40 years old

"I feel more confident to go to the doctor in case of an emergency with health insurance. I used to go to Mexico for toothaches and I use to take different medications. … Now I don't worry about the extreme measures. I have the option to go to doctor here now."
—Insured Spanish speaker, 46 years old

"You are seen differently [by health care providers] based on the insurance that you have."
—Uninsured Spanish speaker, 18 years old

speaking insured attributed their decision to get coverage to a desire to protect their families' security and well-being. They also saw purchasing insurance as a responsibility of citizenship.

Uninsured participants worried about the prospect of needing expensive care; they also expressed frustration about the inability to schedule timely appointments at community clinics, afford medications they needed, or access laboratory services and specialty care as a result of being uninsured. Participants across all focus groups wanted access to comprehensive health care services—not just primary care—at prices they could pay. Messaging that emphasizes the financial and health benefits of having insurance may resonate with a broader population compared with a campaign that highlights the tax penalty for being uninsured. However, messaging about the financial benefits must be carefully worded. Participants that looked into buying insurance through beWellnm, some of whom enrolled and dropped out and others who decided not to enroll, believed the plans were not affordable. They strongly felt beWellnm messages promising affordability were false and felt tricked into shopping with the Exchange.

Monolingual Spanish speakers. Monolingual Spanish-speaking Hispanic participants frequently traveled to Mexico to access routine medical care, dental care, and prescription medications. Although they were content with the quality and price of the care they received, they described the journey as burdensome, expensive, and an extreme measure. It required a car, leave from work, and hotel expenses if they could not stay with a relative or friend. Individuals who chose this option also described

challenges accessing follow up care or medicine easily. They worried also about the prospect of needing care for an emergency or prolonged illness for which traveling to Mexico was not an option.

To Native Americans, health insurance means provider choice and dependable access to health care

"I have waited the whole day [at IHS]."
—Uninsured woman, 26 years old

"The [IHS] don't fully examine your injury. They bandage you and send you home. Sometimes it's not even worth going there. I could have just stayed home and done this myself."
—Uninsured man, 22 years old

Native Americans. Across the focus groups, we consistently heard Native Americans express dissatisfaction with the timeliness and quality of care they receive from the Indian Health Service (IHS). Less than a third (30.4%) of uninsured Native American survey respondents identified the IHS as their usual source of care (appendix C, table C–2). Native Americans who accessed the IHS expressed frustration about long wait times at IHS clinics, unprofessional and disrespectful interactions with IHS staff and providers, and inadequate treatment that didn't address their medical needs fully. They believed that non-IHS providers offered timely, respectful, and better quality care. Some also noted that relying on the IHS meant being limited to seeking care within specific geographic areas where clinics were located and left them vulnerable while traveling.

Recommendation: Emphasize tax credits in messaging

- Provide easily accessible and detailed information about what tax credits and cost-sharing subsidies mean, the process for applying to receive a subsidy, and where people can go to find out whether they qualify.

Messaging

- "If you make less, you pay less. Basic plans can cost as little as $XX–$XXX a month."

Supporting Evidence

The uninsured had little knowledge about beWellnm. We heard many focus group participants voice confusion about whether beWellnm was an insurance carrier or health plan, how beWellnm was related to ACA or "Obamacare," or whether beWellnm offered only state-run plans. Understandably, they were unsure how to get information about insurance options and knew little about financial assistance available to them. Only half the uninsured survey respondents (52.3%) had heard of beWellnm, and only 34.6 percent of these individuals were aware of the tax subsidies (appendix E, table E–1).

Overall, 70 percent of uninsured survey respondents were unaware of the financial subsidies (appendix E, table E–1). Even 34.6 percent of insured respondents did not know financial assistance was available, despite presumably having purchased a subsidized plan. Focus group participants voiced questions or misconceptions about what the subsidy is, how it is applied, and

who qualifies for it. Some thought they would receive the subsidy only once they filed their taxes or wondered whether they would have to pay back part of the credit if their income was higher than they anticipated. Others assumed that subsidies were limited to very low income individuals and didn't realize they were applied on a sliding scale. Multiple participants said they were told that they did not qualify for financial assistance but appeared to know little about how this was determined. Participants expressed strong interest in being able to easily access accurate information themselves about whether they qualified for a subsidy and how much financial assistance they could receive.

Some focus group participants were upset about previous messaging that highlighted people who received very large subsidies. These individuals found they qualified for much lower subsidies that did not sufficiently offset the financial burden of purchasing insurance to make health insurance affordable to them. It is important that beWellnm delivers messaging that encourages individuals to seek information but does not accidentally promote false expectations.

Recommendation: Deliver messages through local and Internet ethnic radio, ethnic print media, email and text messaging

Develop innovative approaches to reach out to the subsidy-eligible uninsured through local news broadcasts, ethnic media (local and internet radio stations and newspaper), the Internet, text messaging, email, and the phone.

- Incorporate communications strategies into every campaign event, framing it as a local media opportunity. Establish strong relationships with TV, radio, and ethnic newspaper reporters and think creatively when pitching stories. Connect local media with an in-person assister in each region.
- Market beWellnm through Native American newspapers such as the *Navajo Times* and the *Shiwi Messenger* and Native American radio stations and stations that offer popular Native American programing targeting listeners in the Marketplace-eligible age groups.
- Market beWellnm to Spanish-speaking Hispanics through local and internet radio stations that offer popular Latino music programming targeting listeners in the Marketplace-eligible age groups.
- Drive enrollment with email by emphasizing email acquisition in the field and developing a series of email messages that are short, simple, and action oriented, directing consumers down the path to enrollment.[16]
    - Send text messages and email to alert consumers to enrollment events, where to access enrollment counselors, and deadlines.
    - Offer a listserv on the beWellnm website where consumers and groups supporting enrollment can get updates about enrollment events, how to get help, tip sheets, and reminders of enrollment deadlines.

Supporting Evidence

Use of the Internet and local media is an effective way to spread information about beWellnm, particularly to those who remain uninsured. When our survey respondents were asked to identify where they go for news or to find information, the top choices of insured and uninsured groups were the Internet (79.4%) followed by local TV stations (58.4%) (appendix F, table F–1). For some respondents, ethnic internet radio may be their preferred media. Approximately one-quarter to one-third of insured and uninsured groups access national TV, newspaper, or radio for news or information. When we looked at the uninsured, we found this group was significantly less likely than the insured to watch national TV news (20.3% vs. 36.9%, $p \leq .01$). A nationwide survey found that over 60 percent of uninsured Latinos viewed local TV news as their main source of information about health insurance.[17]

Local newspapers tend to be favored in rural communities, and ethnic media outlets are popular and trusted information sources among minority groups. Our survey found that uninsured Native Americans were more likely to read the newspaper compared with the insured (49.3% vs. 32.1%, $p \leq .05$), whereas uninsured Spanish–speaking Hispanics were less likely to read the newspaper (6.1% vs. 32.1%, $p \leq .01$). A stakeholder advisory group identified Latino music radio broadcasts as an effective venue to reach uninsured Hispanic individuals.

Using tested approaches to develop appealing human interest stories and build strong relationships with reporters are essential components of establishing a local media presence. Reporters may find it helpful to have key statistics on hand to feature within their stories. Examples include the number of uninsured in a particular area, how many qualify for subsidies above $100, and the average cost of a subsidized plan. Television and print media appreciate unique and attractive visuals because these are an essential component of their work. Encouraging or sharing photography and filming at an event—while establishing boundaries to respect consumers' privacy—and offering attractive imagery, makes their job easier.

Adding email acquisition and followup to outreach efforts is an effective way to drive enrollment. Approximately 52 percent of the uninsured survey respondents indicated that they used email (appendix F, table F–2). National data show that consumers were significantly more likely to enroll if they received phone calls and email than phone calls alone.[18] Encourage assistors to obtain email addresses and phone numbers when speaking with consumers, and develop a series of email and text messages to follow up within 1 week of initial contact. To examine whether consumers are responsive to the messaging, consider using free software to monitor open, click-through, and unsubscribe rates. The beWellnm website can be a way to reach and collect email addresses from individuals who may not have encountered an in-person assistor but who may be still looking for information about their insurance options. Allow individuals to sign up for a listserv on the website and use this as a communication tool to remind them about important dates and share educational information and materials.

Recommendation: Engage people whom the uninsured trust or approach for medical care as advocates for becoming insured.

All

- Develop an outreach campaign that appeals to the role of family members—women in particular—who are seen as the advisors to their adult children, spouses, and other family members.
- Engage urgent care and walk-in clinics in referring the uninsured to enrollment counselors and enrollment events in addition to placing enrollment counselors with hospitals and community health centers.
- Work with state professional associations to engage rural primary care providers who are not accepting Marketplace plans to educate patients about beWellnm. Encourage providers to refer them to an enrollment counselor so that their patients will be covered for diagnostic services, specialty care, and hospital services. Develop an outreach campaign that guides health care professionals on how to talk about beWellnm with patients.
- Emphasize the use of local people within the communities where the uninsured live to conduct outreach and one-on-one enrollment assistance while recognizing the need to offer choice to people who may be sensitive about seeking help from someone they know. (The need for one-on-one enrollment counseling was consistently heard in the focus groups, at key informant interviews, and at the April stakeholder advisory meeting.)
- Market face-to-face enrollment assistance as a service by New Mexicans for New Mexicans.

Monolingual Spanish Speakers

- Continue to engage and develop the skills of promotoras as enrollment counselors and advisors once insured.
- Educate and engage private, Spanish-speaking providers within rural communities to refer uninsured patients to enrollment counselors.

Native Americans

- Approach Native American enrollment as a family decision.
- Consider a home-visiting program where family members can be present and the application can be completed in one session.
- Work with the chapter houses where most of the elders are present and discussion about important matters to the people take place.

Supporting Evidence

Target family members. When asked about their main reason for having purchased insurance, numerous Spanish-speaking focus group participants cited love for their family and a desire to protect their children. Across our data collection, we heard individuals discuss the importance of family members as both a motivator to purchase insurance and a trusted information resource. Research shows this is especially true among uninsured Hispanics, who place considerable weight on family input when shaping their own opinions and actions.[19] This was true in the Native American community, as well, according to our key informants who indicated major decisions are made as a family unit. Informants added that matriarchs in both these populations often assume responsibility for the well-being of the family and can reinforce messaging to younger audiences about the importance of purchasing insurance and timelines for enrollment.

Uninsured and insured survey respondents most frequently identified female family members as a trusted source of information about buying health insurance in the survey. Approximately one-third of respondents identified women, while male family members were identified by 20.2 percent of the insured and 23.4 percent of the uninsured (appendix F, table F–1). A greater percentage of Native Americans identified female and male family members (41.8% and 32.8%) than all other groups.

Engage and inform health care providers. Other trusted sources of information about health insurance were doctors, nurses, and office staff. Focus group participants listed their doctor's office as a preferred source of health insurance information. Individuals who had long-term relationships with their primary care providers trusted input from a doctor who was familiar with their medical history. Others wanted to be able to read information materials in waiting rooms and have time during the appointment to discuss their questions with a provider.

Slightly more Native Americans who were surveyed chose doctors and nurses compared with the overall uninsured group (34.3% vs. 28.4%), but they were less likely to identify office staff as a trusted source of health insurance information compared to the overall uninsured group (17.9% vs. 23.9%) (appendix F, table F–1). This difference was not statistically significant but may be of practical importance.

Some of the uninsured respondents may not have selected health providers or their staff as an information source because they seldom access health care; 31.6 percent of the uninsured did not see a doctor in the previous year (appendix C, table C–1). Key informants indicated that the uninsured may be uncomfortable going to their community health center for enrollment assistance because they have unpaid bills there.

The recommendation to engage urgent care centers, walk-in clinics, and out-of-network providers in supporting enrollment came from studying data on the utilization patterns of the uninsured. Uninsured Hispanic and Native American groups accessed a usual source of care less frequently than the insured group. Approximately 56 percent of the uninsured identified a doctor's office, a clinic, or a community health center as a usual source of care, and an equal number indicated

that they visited the doctor one to three times in the previous year (appendix C, table C–1). Some focus group participants indicated that their usual source of care was a provider who did not participate in the beWellnm health plan networks. A little more than a quarter of uninsured Native Americans and English-speaking Hispanics identified urgent care or walk-in clinic as their usual source of care.

Some of the uninsured look to their doctor's office for health insurance information

"The doctor's office because I would [learn] what insurance [they take]. I'm comfortable with them. … I've been with them for … maybe 30, 40 years. And so they know my history.

—Insured Hispanic woman, 54 years old

Others rarely go for care

"I got hurt on the job. I took care of myself, just wrapped my arm up, took different teas. … My elbow, it still hurts. I took care of it myself. If I have a cold or anything, I do like natural remedies."

—Uninsured Hispanic woman, 37 years old

Insured and uninsured focus group participants described positive experiences receiving detailed one-on-one counseling from enrollment counselors at walk-in clinics affiliated with La Clinica de Familia and Ben Archer Health Centers. An enrollment counselor with a consistent presence at high-volume clinics could reach uninsured who do not have regular sources of care, at a time and location where they are receptive to learning about how to defray their health care costs by becoming insured.

Health care organizations that are unable to host a full-time enrollment counselor onsite may be involved in promoting enrollment through a concentrated initiative sponsored by beWellnm. Each year, the United States Department of Health and Human Services partners with hospital and provider associations, community health centers, and other community organizations to carry out "Provider and Hospital Week of Action," which engages providers to encourage patients to seek enrollment assistance and get insured.[20,21] Existing tools such as the "ACA Pocket Guide for Providers"[22] and Prescription for Coverage card[23] can be tailored to New Mexico by beWellnm for use across the state in a similar campaign. Primary care providers in particular are well positioned to have these conversations, since their uninsured patients are often unable to afford diagnostic and specialty services to which they are referred.

Prioritize localized outreach. Across conversations with consumers, key informants, and stakeholder advisory members, we heard about the importance and effectiveness of localized outreach and individualized enrollment assistance. Along with a preference for receiving information from their health care providers, focus group participants expressed receptiveness to outreach efforts at places they trust and frequent regularly—where they are receptive to learning about resources that can help them access health care. Examples included employers, schools and colleges, community centers, places of business (e.g., banks, post offices, barbershops, and beauty salons), libraries, chapter houses, and offices of government assistance programs (e.g., Temporary Assistance for Needy Families, unemployment). Also suggested were places where people expect to experience wait times, such as bus terminals and laundromats. beWellnm may consider hosting targeted efforts (e.g., daily for a week) at some of these locations and

establishing an ongoing presence (e.g., weekly or monthly) at others. An enrollment counselor spoke of how a consistent, ongoing presence in a visible location frequented by hard-to-enroll individuals is a way to build trust and increase their receptivity to talking about becoming enrolled.

Consumers felt it was important that outreach staff be knowledgeable and able to answer questions in real time without directing them elsewhere or offering to get back to them. They also wanted to know that the person helping them reflects their cultural background, is respectful of their financial situation, and is familiar with the social and economic hardships that many New Mexicans face. For some participants, this translated into a preference for assistance from New Mexicans. Overall, 78.9 percent of survey respondents said it was important that the person providing them with phone assistance was from New Mexico, and this was significantly higher for uninsured compared to insured respondents (83.4% vs. 68.3% respectively). Others prefer to speak with people from their local communities or those who had purchased insurance through beWellnm. However, some focus group participants and key informants noted that people living in small communities may be hesitant to provide personal health and financial information to someone they know out of concern about confidentiality.

Offer individualized assistance. Assistors are able to provide detailed explanations of insurance terms, coverage options, plan differences, and eligibility criteria that are difficult for many consumers to navigate themselves. The support they provide is crucial for individuals who know little about health insurance and are worried about the financial consequences of making poor decisions about their coverage. The need for one-on-one enrollment counseling was consistently heard in the focus groups, at key informant interviews, and at the April stakeholder advisory meeting. For consumers with limited prior exposure to purchasing insurance, assistors can be valuable at clarifying misinformation or offering protection from insurance scams. For example, we met focus group participants who thought that plans could turn away people with preexisting conditions or that they would receive the subsidy upon filing their taxes.

Research elsewhere shows that enrollment rates are significantly higher for consumers who received face-to-face assistance compared with people who tried to enroll online (51% vs. 32% respectively).[24] In particular, in-person assistance is critical for Hispanics, immigrants, individuals who are less familiar with health insurance, and people less comfortable with using a computer.[25] These results are consistent with what we heard from focus group participants. Even individuals who said they would use the Internet first to gather information about plan options were hesitant to purchase insurance without meeting with an enrollment counselor first to verify their choice. Although focus group participants said repeatedly that they would most value, trust, need, and use in-person enrollment assistance, phone-based support is an important resource as well. Among survey respondents, the insured were significantly more likely to have obtained information about beWellnm over the phone compared with the uninsured (48.4% vs. 27.6%). Overall, they were also more likely to get information from face-to-face interactions or events and less likely to look for information about beWellnm online than uninsured respondents, although these differences were not statistically significant.

2. Approaches to Supporting Enrollment and Access to Assistance

The recommendations and supporting evidence in this section identifies the challenges consumers have with accessing information and support for enrollment through the various channels available to them: web, phone, and face-to-face counseling. Approaches are offered for addressing these challenges with attention to the importance of cultural and linguistic competence when serving populations that have been disenfranchised.

Recommendation: Correct enrollment interfaces

Assess consumer-facing informational and enrollment resources and assistance to identify and correct interfaces that stop the uninsured from moving forward to enrollment.

Shorter Term Recommendations

Assessment and Improvement

- Conduct consumer usability testing of the beWellnm website and outreach materials to identify ways to improve consumers' success in finding and understanding eligibility and enrollment information and their purchasing options.[26]
- Assess consumer support processes by shadowing consumers or using mystery shoppers to identify and correct specific points of frustration and bottlenecks that derail enrollment through the call center and online.
- Assess beWellnm.com's search engine optimization and branding strategy to determine whether it is effective in clearly distinguishing the state's exchange website from private exchanges and fraudulent sites.

Training and Quality Control

- Train enrollment counselors and call center staff to apply plain language techniques in written and oral interpersonal communication.[27]
- Establish a quality management system to observe enrollment counselors and call center staff and provide feedback on how to improve performance. Require a written summary of what was learned to identify training needs and what enrollment processes and systems that need improvement.

Outreach and Enrollment Systems

- Continue to staff rural areas with enrollment counselors who reflect the characteristics of the local communities and are known to the subsidy-eligible, uninsured Hispanics and Native Americans.
- Offer enrollment counseling services close to where people work and live and at times that are convenient for adults working in lower paying jobs.
- Work with employers to offer enrollment counseling sessions at businesses where the uninsured work.
- Consider use of a roving enrollment van in less populated areas, particularly on the Navajo reservation.

Longer Term Recommendations

Outreach and Enrollment Systems

- In consideration of reduced Federal funds to support outreach activities, continue to fund local enrollment counselors while prioritizing establishing statewide structure to recruit, train, and monitor volunteer enrollment counselors.[28] Consider modeling after the State Health Insurance Assistance Program, which recruits and trains retired professionals who bring relevant career knowledge to counsel seniors in making informed Medicare decisions.
- Use commit cards[29] and an electronic system with retrievable records so enrollment counselors can track their efforts, send appointment reminders, and follow up with consumers until they have enrolled or declined enrollment.
- Work with CMS to improve their enrollment phone support.
- Work with CMS and insurers to improve systems for notifying insurers of newly enrolled members, sending out a new enrollee packet, and accurately billing premiums.

Knowledge Management

- Develop systematic approaches to identify and solve difficult customer problems. One method to do this is referred to as knowledge management (also known as “knowledge sharing” and “knowledge base”). It involves collecting and processing information about challenges faced by enrollment and customer service staff and then developing and disseminating solutions so that enrollment counselors have ready access to accurate information to assist consumers with problems.[30]

Supporting Evidence

In all the focus group locations, we heard about the struggle insured and uninsured focus group participants had in using the beWellnm and healthcare.gov websites to enroll and accessing information and assistance on the phone. The problems they encountered can be attributed to lack of familiarity with health insurance, difficulties encountered when using the beWellnm and healthcare.gov websites, and inadequate customer service on the phone and sometimes through enrollment counselors.

Sixty percent of the uninsured who knew about beWellnm accessed information about beWellnm through the Internet compared with 50 percent of the insured. The insured were more likely to get help on the phone (50%) or in person (44%) compared with the uninsured who accessed these resources in only about a quarter of cases. Uninsured participants of all types found enrolling in a health plan confusing and encountered poor support in explaining their coverage and plan options in a way they could understand. They were perplexed by the process of enrolling and did not understand enrollment deadlines. Participants were often unsure whether they qualified for subsidies or where to submit their application.

Website set up under the KISS method

"If it's on the Internet, the websites need to be set up like, set up under the KISS method. Keep It Simple, Stupid. ... Not everybody can sit down and do this. ... I'm not computer literate. When I sit down to a computer, it starts smoking."

—Uninsured Caucasian woman, 56 years old

"I just bought a new car and before I decided on what car I wanted, I narrowed it down to my top three. ... I went online real quick and requested a quote from my insurance company and it just asked some basic questions and then it gave you a number. And if beWellnm could be like that where you enter a little bit of information and it gives you a quote and then possible agencies where you can attain that from, that would be great rather than just giving you the runaround and sending you to Kingdom Come and still not resolving anything."

—Uninsured Hispanic woman, 23 years old

Survey data showed many insured and uninsured respondents struggled with comparing health plans. Eighty percent of Native Americans and 67.1 percent of English-speaking Hispanics were not at all likely or only somewhat likely to understand how health plans differ (appendix C, table C–3). A provider representative on the stakeholder advisory panel spoke of the fallout when consumers expect their beWellnm plan to more completely cover the cost of services than it does. Consumers "tell everyone" about these problems, which can have lasting negative effects.

Insured and uninsured participants tried enrolling in a plan online but encountered error messages or were confused by being redirected to healthcare.gov. Some uninsured individuals spoke of being unsure where to go to purchase health insurance; they accessed enrollment sites that appear to have been fraudulent or sponsored by private health insurance exchanges. Those attempting to enroll online through beWellnm and healthcare.gov started an application only to get stuck or have to call for assistance. In some cases, they tried to overcome the problems they were having by starting a new application but then ended up with more than one application that they could not finish. Participants found enrollment took many hours and often days—much more time than they anticipated. Usually they tried for several days to apply on their own before seeking assistance. Some of the uninsured gave up, missed the enrollment deadline, or thought they had enrolled but later found out that their application was not complete.

Almost all of the person-to-person negative experiences insured and uninsured participants spoke of concerned getting help on the phone. There were long hold times, and they felt the customer service was poor. A number of people spoke of the numerous attempts to get accurate answers to questions and help with enrollment problems. Some call center staff members were not knowledgeable, or callers received different answers to their questions when they spoke with different individuals. Focus

Exhibit 3. The Ideal Phone Assistance

- Call answered quickly without spending a long time on hold
- Call answered by a person rather than automated prompts
- Concerns are addressed by one person rather than being transferred around to multiple people
- Accountability where the counselor states their name and works with you each time
- The counselor lives in New Mexico and knows about New Mexico providers, plans, and the local languages

group participants provided clear direction on how phone assistance can be improved (exhibit 3). Sometimes calls were not answered at all. One person spoke of sending emails that were not answered. A few Native American participants noted the people they sought help from on the phone and in person were sometimes disrespectful.

Participants preferred in-person assistance for a number of reasons: The financial consequences of their purchasing decision, better support and accountability from counselors, less confusion, their tendency to focus better than when on the phone, and fewer sources of frustration. They ideally wanted to have a designated person who would know their history and with whom they could build a relationship over time as they might with a broker. Characteristics that participants expect of an enrollment counselor are listed in exhibit 4. Working with an enrollment counselor became burdensome when they had to make multiple trips, take time off of work and travel distances. Taking time away from jobs where absences were not acceptable caused stress as well as extra fuel costs when living with tight budgets.

Exhibit 4. Desired Qualities of an Enrollment Counselor

- Knowledgeable: Well trained and able to provide accurate and timely information
- Conveys complex information in a manner that is easy to understand and without judgement
- Honest and unbiased
- Caring and compassionate
- Professional and respectful: Treats all people equally without regard to socioeconomic status, race, and ethnicity
- Culturally competent: Deep understanding of the different cultures in the state and fluent in Spanish and Native American languages

After going through the enrollment process, some participants were not entirely certain they were actually insured. They were told their application was approved but received neither an insurance card in the mail nor a packet they were told to expect. Others spoke about problems such as premiums not being billed, automatic premium withdrawals stopping suddenly, and times when they had difficulty obtaining their Form 1085 for tax reporting purposes. The confusion added to their frustration with beWellnm and their insurer.

Recommendation: Adopt the National Standards for CLAS in Health and Health Care

The underlying principle of the CLAS standards is to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs[31]

This is achieved by implementing standards in the following content areas:

- Governance, leadership, and workforce
- Communication and language assistance
- Engagement, continuous improvement, and accountability

Supporting Evidence

> ***Quote From a Spanish Speaker and Focus Group Participant***
>
> *"I cannot defend myself, I do not speak English. There are interpreters. Everywhere we go there will be racist people—even our own people. We have to take steps to make it stop. I ask for an interpreter. I am embarrassed to do so because I've been here so long."*

Trust, respect, and *understanding* were three words that frequently came up in the focus group, key informant interviews, and stakeholder advisory group discussions. An underlying theme in Native American and Spanish-speaking Hispanic focus groups was the desire to be understood within the cultural values that were important to them and the social inequities impacting their daily lives. Participants' experiences as part of the nondominant culture affected their perceptions of beWellnm, health insurance and health care, and the struggles they experienced interfacing with beWellnm, and learning how to pay for and use private health insurance, often for the first time. Native Americans and Spanish speakers shared experiences of how people of their culture did not always treat them respectfully. Negative experiences led some of the focus group participants to automatically view beWellnm with distrust. The need for one-on-one education from someone who is patient and knowledgeable and whom Native Americans and Hispanics trust came up repeatedly in the focus groups and was voiced by the stakeholder advisory panel. It is critical that there be respect and not prejudice in the educational process as people learn about beWellnm, their options, the subsidies, and costs; this respect must continue as applicants complete the subsidy and enrollment applications and transition to being insured

By adopting the National Standards for CLAS in Health and Health Care,[32] beWellnm will have established an organizational culture and infrastructure to provide effective, equitable, understandable, and respectful services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

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Appendix A. Data Collection Methods

Key Informants

To ensure that we captured the full range of concerns, we interviewed key informants who are involved in meeting the health needs of rural populations. We initiated recruitment by asking stakeholder advisory panel members to identify people on the ground who work with the target population and have in-depth knowledge of the barriers and issues experienced by the uninsured in accessing health insurance and health care. In some cases, advisory members were interviewed because they had extensive knowledge of the target population.

We recruited 30 key informants with an emphasis on identifying people throughout the state who have direct contact with low-income insured and uninsured Hispanics and Native Americans (exhibit A-1). Following a semi-structured interview guide, five researchers conducted phone interviews to collect their insights about the challenges uninsured and newly insured consumers experience in accessing and paying for health care and exploring and enrolling in health insurance through beWellnm. Most of the key informants represented provider organizations, community organizations, or public health agencies (exhibit A–1). Over two-thirds of the interviewees had experience as enrollment counselors or served as community-based outreach managers overseeing beWellnm enrollment activities within a portion of the state.

Exhibit A–1. Affiliations of Key Informants

Affiliations	# Participants	Affiliations	# Participants
Institution*		**Region served***	
Provider	11	Central	10
Community organization	8	West	6
Public health agency	7	North	5
Health plan	1	South	3
Other*	2	East	3
		All	2
Job role		**Population expertise**	
Enrollment counselor	15	All	10
Outreach manager	7	Hispanic	15
Administrator	7	Native American	6
Religious leader	1	Millennial	4

*The number of participants totals 29 because we conducted one interview with two key informants who were from the same institution and region.

Focus Groups

We held 21 focus groups with 177 participants in nine communities (exhibit A–2). The communities were chosen in order to obtain a sufficient proportion of uninsured people who represent the literacy levels and race and ethnicity of their respective regions. We identified the most populous rural communities in each of the four Public Health regions (Los Lunas, Santa Fe, Taos, Las Cruces, Silver City, and Clovis) and the communities with a concentrated population of Native Americans (Gallup, Farmington). The South Valley of Albuquerque was added in order to increase our sample of monolingual Spanish speakers.

Exhibit A–2. Focus Group Recruitment Methods

First Wave: Media

- Television
- Radio, including ethnic radio stations
- Local community newspapers
- Social media (Craigslist, Facebook, Twitter)
- Flyers (electronic and onsite distribution)
- Direct mail

Second Wave: Personal Outreach

- FQHCs and insurance enrollment counselors
- Promotoras
- Social workers
- Community leaders
- Professional recruitment firms

In order to participate in the assessment, consumers had to meet the Marketplace criteria for receiving a premium subsidy. This meant their family income had to be within 139 percent and 400 percent of the Federal poverty level. Participants needed to be between 18 and 64 years of age and a U.S. citizen or documented resident; they also needed to reside within a reasonable driving distance of the nine communities where focus groups were to be held.

Consumer Recruitment

Potential participants were screened by phone or in person to determine whether they met the criteria for the study. We purposefully sought out uninsured Native Americans and Hispanics who were monolingual Spanish-speaking or English-speaking but also recruited a limited sample of uninsured New Mexicans of all race and ethnicities and New Mexicans insured with subsides through beWellnm. We made an effort to recruit a sample that included representation from millennials (age 18 to 34 years). The focus group recruitment process was extremely challenging. This was not surprising, given the narrow participation criteria and that the target group was the "hard-to-reach uninsured" living in relatively rural communities/regions throughout the state. The recruitment took place in two waves (exhibit A–2).

In the first weeks of recruitment, we relied on radio, local community newspapers, social media (Craigslist, Facebook, Twitter), direct mail, and the Lovelace Scientific Resources clinical trials database. After a slow response, we expanded the recruitment approach to include TV ads. Many people, including Native Americans, called the 800 recruitment line number, but few met the inclusion criteria, most often because their incomes qualified them for Medicaid. Some were excluded because they lived in parts of the state not included in the eight targeted communities.

After the first 2 weeks, we shifted our focus to on-the-ground recruitment by identifying trusted local individuals and consultants who had deep knowledge of the local culture and were professionally or personally known to the hard-to-reach population or had relationships with groups that served them (exhibit A–1). In the southern part of the state, we relied on recruitment firms. A former Navajo hospital executive and a Navajo enrollment counselor were instrumental to recruiting Native Americans. We found that prescreening Native American and Hispanic focus group participants living in Farmington, Gallup, and the South Valley was not realistic, so we screened them onsite. We also pursued people by phone who were listed on contact cards completed by beWellnm enrollment counselors from previous outreach efforts. We found that many of the people identified on the cards had aged into Medicare or were now enrolled in Medicaid.

In the end, our success was due to tenacity and persistence, to using a variety of recruitment methods tailored to specific regions/communities, and to seeking creative methods of recruitment that depended on personal connections and outreach in the community and to its racial and ethnic groups.

Conduct of Groups

Focus groups were moderated by trained facilitators, many of whom were licensed health care professionals, New Mexicans and had close cultural and professional ties with the Hispanic and Native American communities. Moderators followed a semi-structured protocol to inquire about challenges participants faced in accessing healthcare, their attitudes toward health insurance, and their experiences seeking enrollment support and purchasing coverage from beWellnm. Each moderator was assisted by a note taker and, in the case of the Native American groups, by a Navajo enrollment counselor and former hospital administrator who are respected figures within the local community.

Locations and Composition

We stratified the focus groups by insurance status, race, ethnicity, and language spoken at home (see table A–1). In total, we held 3 Native American groups, 6 Spanish-speaking Hispanic groups, and 13 groups that were largely English-speaking Hispanic but also included Caucasians and a small number of Asians and African Americans.

The “all other” category included English speaking individuals who self-identified as Hispanic or Caucasian. There were a small number of Asians and African Americans in these groups.

Table A–1. Location and Composition of Focus Groups

Location	Native American		Spanish-speaking Hispanic		All other		Total
	Insured # groups	Uninsured # groups	Insured # groups	Uninsured # groups	Insured # groups	Uninsured # groups	# groups
Clovis				1	1		2
Farmington		1					1
Gallup		2					2
Las Cruces				2	1	1	4
Los Lunas					1	1	2
Santa Fe					1	1	2
Silver City					1	1	2
South Valley			1	2	2		5
Taos						1	1
Total	0	3	1	5	7	5	21

Survey

In order to capture as large a sample as possible within the project budget, the research team administered the survey in the focus groups (177 participants), by phone (20 people), and in the community (84 people) using intercept techniques. A total of 281 people completed the survey. The survey inquired about usual sources of care, how consumers pay for health care, and their attitudes about health insurance. The survey assessed trusted sources of information and habits related to accessing information. The insured were asked about their experiences purchasing insurance through beWellnm, whereas the uninsured were questioned about their willingness to pay for health insurance. Sociodemographic characteristics were collected as part of the screening process and from the survey. Many survey questions were drawn from validated and commonly used surveys including: Consumer Assessment of Health Plans Survey HP 5.0, Health Insurance Literacy Measure (HLM), National Health Interview Survey, and the New Mexico Hispanic ACA and Health Survey. We drew questions on sources of news and information from a survey conducted by American Press Institute and the Associated Press-NORC Center for Public Affairs Research in the Personal News Cycle. The remaining questions were created by the project team using best practices from Consumer Assessment of Health Plans Surveys.

Focus group participants completed the survey at the beginning of the session. People who called in to be screened for the focus groups and met the screening criteria but were unable to attend the groups were given the option of completing the survey by phone.

We went out into the communities and intercepted people as an added data collection strategy to compensate for the focus group recruitment challenges we experienced. Researchers set up tables with signs at libraries, stores, and other public places in Taos, Farmington, Santa Fe, Silver City, and Los Lunas, then approached people who appeared to meet the age criteria. Of the participants who were screened, 89 people met the inclusion criteria and consented and completed the survey onsite. The intercept surveys were a slightly shortened version of the tool that was administered to focus group participants.

Appendix B. Survey Respondent Characteristics

Table B–1 shows the number of survey respondents by location. In table B–2, we provide detailed information about the survey respondents' characteristics with comparisons made by insurance status (insured and uninsured), race and ethnicity (Native Americans, Hispanic English speakers, Hispanic Spanish speakers, and all other), age (millennial and nonmillennial), and degree of rurality (more rural and less rural).

Table B–1 Survey Respondent Characteristics[1]

Demographic characteristics	Overall results % (n)	By insurance status		Uninsured, by demographic subgroups				Uninsured, by age group		Uninsured, by location	
		All insured % (n)	All uninsured % (n)	Uninsured English-speaking Hispanics % (n)	Uninsured Spanish-speaking Hispanics % (n)	Uninsured Native Americans % (n)	All other uninsured % (n)	Millennials % (n)	Non-millennials % (n)	More rural % (n)	Less rural % (n)
Total number	273	84	189	57	33	67	32	73	112	93	96
Age, mean (SD)	42.5 (13.3)	47.4 (13.1)	40.3 (12.8)**	40.2 (13.3)**	38.9 (11.4)**	37.9 (12.6)**	47.8 (12.3)	26.8 (4.4)	49.0 (8.0)**	40.3 (12.9)	40.2 (12.8)
18–34 years	33.4 (90)	20.2 (17)	39.5 (73)**	40.4 (23)**	34.4 (11)**	44.6 (29)**	32.3 (10)	100.0 (73)		39.6 (36)	30.4 (37)
35–45 years	20.1 (54)	15.5 (13)	22.2 (41)	19.3 (11)	37.5 (12)	26.2 (17)	3.2 (1)		36.6 (41)	22.0 (20)	22.3 (21)
46–55 years	26.0 (70)	31.0 (26)	23.8 (44)	28.1 (16)	25.0 (8)	15.4 (10)	32.3 (10)		39.3 (44)	23.1 (21)	24.5 (23)
56–64 years	20.4 (55)	33.3 (28)	14.6 (27)	12.3 (7)	3.1 (1)	13.8 (9)	32.3 (10)		24.1 (27)	15.4 (14)	13.8 (13)
Gender, female	58.5 (158)	66.7 (56)	54.8 (102)	60.7 (34)	57.6 (19)	53.7 (36)	40.6 (13)*	43.7 (31)	62.2 (69)**	53.8 (49)	55.8 (53)

[1] Survey respondent were insured and uninsured New Mexicans who were eligible for ACA subsidies. Respondents included people attending the focus groups, people who completed intercept surveys in the nine focus group locations, and people who called in to be screened for the focus groups but were unable to attend the focus groups because of scheduling problems or their characteristics did not match the criteria for the group that was scheduled.

Demographic characteristics	Overall results % (n)	By insurance status		Uninsured, by demographic subgroups				Uninsured, by age group		Uninsured, by location	
		All insured % (n)	All uninsured % (n)	Uninsured English-speaking Hispanics % (n)	Uninsured Spanish-speaking Hispanics % (n)	Uninsured Native Americans % (n)	All other uninsured % (n)	Millennials % (n)	Non-millennials % (n)	More rural % (n)	Less rural % (n)
Race/ethnicity											
Hispanic											
English-speaking Hispanic	27.1 (74)	20.2 (17)	30.2 (57)					31.5 (23)	30.4 (34)	19.4 (18)	40.6 (39)**
Monolingual Spanish-speaking Hispanic	17.9 (49)	19.0 (16)	17.5 (33)					15.1 (11)	18.8 (21)	0.0 (0)	34.4 (33)**
Native American	30.8 (84)	20.2 (17)	35.4 (67)**					39.7 (29)	32.1 (36)	68.8 (64)	3.1 (3)**
Other (not Hispanic, not Native American)	24.2 (66)	40.5 (34)	16.9 (32)**					13.7 (10)	18.8 (21)	11.8 (11)	21.9 (21)
Highest level of education completed											
High school diploma or less	31.9 (87)	17.8 (15)	38.1 (72)**	47.4 (27)**	36.4 (12)**	31.3 (21)**	37.5 (12)*	37.0 (27)	36.6 (41)	32.3 (30)	43.8 (42)
More than high school	46.5 (127)	66.7 (56)	37.6 (71)	38.6 (22)	15.2 (5)	38.8 (26)	56.2 (18)	37.0 (27)	39.3 (44)	39.8 (37)	35.2 (34)
Unknown	21.6 (59)	15.5 (13)	24.3 (46)	14.0 (8)	48.5 (16)	29.9 (20)	6.3 (2)	26.0 (19)	24.1 (27)	28.0 (26)	20.8 (20)

Notes: Statistical comparisons using chi square tests were made between: (a) all uninsured participants vs. all insured participants; (b) individual subgroups of uninsured participants vs. all insured; (3) uninsured millennials vs. uninsured people of all other ages; (4) uninsured residents of more rural areas vs. uninsured residents of less rural areas. Observations with missing values were omitted from statistical tests. “More rural areas” included Clovis, Farmington, Gallup, Silver City, and Taos. “Less rural areas” included Las Cruces, Los Lunas, Santa Fe, and the South Valley.
* p≤.05
** p≤.01

Table B–2. Survey Responses by Location

Location	Overall results, % (n)	All insured, % (n)	All uninsured, % (n)
Total	273	84	189
Clovis Portales	4.8 (13)	8.3 (7)	3.2 (6)
Farmington	19.4 (53)	16.7 (14)	20.6 (39)
Gallup	11.4 (31)	7.1 (6)	13.3 (25)
Las Cruces	10.6 (29)	10.7 (9)	10.6 (20)
Los Lunas	11.0 (30)	13.1 (11)	10.0 (19)
Silver City	5.9 (16)	6.0 (5)	5.8 (11)
Santa Fe	16.5 (45)	25.0 (21)	12.7 (24)
South Valley	14.6 (40)	8.3 (7)	17.5 (33)
Taos	5.9 (16)	4.8 (4)	6.4 (12)

Appendix C. Survey Results: Medical Care Seeking Behaviors of Subsidy-Eligible New Mexicans

Table C–1. Medical Care Seeking Behaviors Reported by Survey Respondents

Medical care seeking behaviors	Overall results % (n)	By insurance status		Uninsured, by demographic subgroups				Uninsured, by age group		Uninsured, by location	
		All insured % (n)	All uninsured % (n)	Uninsured English-speaking Hispanics % (n)	Uninsured Spanish-speaking Hispanics % (n)	Uninsured Native Americans % (n)	All other uninsured % (n)	Millennials % (n)	Non-millennials % (n)	More rural % (n)	Less rural % (n)
Total number	273	84	189	57	33	67	32	73	112	93	96
Health											
Self-rated health status (collapsed)											
Excellent or very good	42.4 (115)	41.5 (34)	42.9 (81)	54.4 (31)	30.3 (10)	40.3 (27)	40.6 (13)	54.8 (40)	35.7 (40)*	38.7 (36)	46.9 (45)
Good	37.6 (102)	35.4 (29)	38.6 (73)	24.6 (14)	42.4 (14)	46.3 (31)	43.8 (14)	32.9 (24)	42.0 (47)	45.2 (42)	32.3 (31)
Fair or poor	19.9 (54)	23.2 (19)	18.5 (35)	21.0 (12)	27.3 (9)	13.4 (9)	15.6 (5)	12.3 (9)	22.3 (25)	16.2 (15)	20.8 (20)
Medical care seeking behaviors											
Doctor visits, previous year§											
0	27.7 (75)	19.3 (16)	31.6 (59)	28.6 (16)	34.4 (11)	29.9 (20)	37.5 (12)	43.8 (32)	22.7 (25)	31.5 (29)	31.6 (30)
1–3	54.8 (148)	53.0 (44)	55.6 (104)	64.3 (36)	50.0 (16)	55.2 (37)	46.9 (15)	43.8 (32)	64.6 (71)	58.7 (54)	52.6 (50)
4–9	13.3 (36)	20.5 (17)	10.2 (19)	5.4 (3)	12.5 (4)	11.9 (8)	12.5 (4)	11.0 (8)	10.0 (11)	7.6 (7)	12.6 (12)
10 or more	4.1 (11)	7.2 (6)	2.7 (5)	1.8 (1)	3.1 (1)	3.0 (2)	3.1 (1)	1.4 (1)	2.7 (3)	2.2 (2)	3.2 (3)
Access a usual source of care	72.1 (191)	81.7 (67)	67.8 (124)*	62.5 (35)**	76.7 (23)	68.2 (45)	67.7 (21)	56.9 (41)	73.8 (79)*	64.8 (59)	70.6 (65)

Medical care seeking	Overall results	By insurance status		Uninsured, by demographic subgroups				Uninsured, by age group		Uninsured, by location	
Usual source of care											
Doctor's office or clinic	40.2 (80)	66.7 (46)	26.2 (34)**	19.4 (7)**	46.2 (12)	4.4 (2)**	59.1 (13)	16.7 (7)	31.0 (26)	11.5 (7)	39.1 (27)**
Community health center	24.1 (48)	13.0 (9)	30.0 (39)**	36.1 (13)**	30.8 (8)*	30.4 (14)*	18.2 (4)	23.8 (10)	32.4 (27)	34.4 (21)	26.1 (18)
Emergency room	9.0 (18)	5.8 (4)	10.8 (14)	8.3 (3)	15.4 (4)	15.2 (7)	0.0 (0)	9.5 (4)	11.9 (10)	14.8 (9)	7.2 (5)
Urgent care/walk in clinic	15.6 (31)	10.1 (7)	18.5 (24)	30.6 (11)**	3.9 (1)	26.1 (12)*	0.0 (0)	28.6 (12)	14.3 (12)*	21.3 (13)	15.9 (11)
Traditional healer	3.0 (6)	1.5 (1)	3.8 (5)	2.8 (1)	0.0 (0)	2.2 (1)	13.6 (3)*	2.4 (1)	4.8 (4)	4.9 (3)	2.9 (2)
Indian Health Service	8.0 (16)	2.9 (2)	10.8 (14)*	0.0 (0)	0.0 (0)	30.4 (14)**	0.0 (0)	14.3 (6)	9.5 (8)	23.0 (14)	0.0 (0)**
Other	6.0 (12)	7.3 (5)	5.4 (7)	8.3 (3)	7.7 (2)	4.4 (2)	0.0 (0)	7.1 (3)	4.8 (4)	3.3 (2)	7.2 (5)
Satisfaction with health care†											
Very satisfied	16.0 (26)	20.0 (11)	14.0 (15)	16.7 (6)	4.8 (1)	10.0 (3)	25.0 (5)	13.3 (6)	14.5 (9)	11.9 (5)	15.4 (10)
Satisfied	51.2 (83)	54.6 (30)	49.5 (53)	50.0 (18)	57.1 (12)	53.3 (16)	35.0 (7)	51.1 (23)	48.4 (30)	57.1 (24)	44.6 (29)
Dissatisfied	14.2 (23)	10.9 (6)	15.9 (17)	11.1 (4)	23.8 (5)	16.7 (5)	15.0 (3)	8.9 (4)	21.0 (13)	16.7 (7)	15.4 (10)
Very dissatisfied	6.8 (11)	5.4 (3)	7.5 (8)	5.6 (2)	9.5 (2)	6.7 (2)	10.0 (2)	8.9 (4)	6.4 (4)	7.1 (3)	7.7 (5)
Do not go anywhere for care	11.7 (19)	9.1 (5)	13.1 (14)	16.7 (6)	4.8 (1)	13.3 (4)	15.0 (3)	17.8 (8)	9.7 (6)	7.1 (3)	16.9 (11)

Note: Statistical comparisons using chi square tests were made between all uninsured participants vs. insured participants; subgroups of uninsured participants were compared individually to the insured. Observations with missing values were omitted from statistical tests.

§ Statistical testing using ordinal logistic regression was performed, and results are summarized in table C–2.

† The total number of respondents for this question is lower because the question was not asked during in-person intercept interviews.

* p≤.05

** p≤.01

Table C–2. Insurance Status and Race and Ethnicity as a Predictor of Provider Visit Frequency and Health Insurance Literacy

	All Uninsured,	By Uninsured subgroup, compared to all insured	Uninsured,	Uninsured,

Characteristic	compared to all insured		Uninsured English-speaking Hispanics		Uninsured Spanish-speaking Hispanics		Uninsured Native Americans		All other uninsured		millennials compared to non-millennials		more rural compared to less rural	
	OR	*p*-value	OR	*p*-value	OR	*p*-value	OR	*p*-value	OR	*p*-value	OR	*p*-value	OR	*p*-value
Number of doctor visits, previous year [a]	2.25	<.01	2.46	.01	2.15	.06	1.96	.04	2.35	.03	2.09	.01	1.16	.59

Note: An ordinal logistic regression was performed to test for differences between all uninsured participants compared with insured participants as a whole and by racial and ethnic subgroup. One of the assumptions underlying ordinal logistic regression is that the relationship between each pair of outcome groups is the same. In other words, ordinal logistic regression assumes that the coefficients that describe the relationship between, for example, the lowest vs. all higher categories of the response variable are the same as those that describe the relationship between the next lowest category and all higher categories, etc. This is called the proportional odds assumption or the parallel regression assumption. Because the relationship between all pairs of groups is the same, there is only one set of coefficients (only one model).

OR = Odds ratio estimate

[a] Reference group is 0 visits.

Appendix D: Survey Results: Subsidy-Eligible New Mexicans Opinions About Health Insurance

Table D–1. Survey Respondents Opinions About Health Insurance

Opinions about health insurance	Overall results % (n)	By insurance status		Uninsured, by demographic subgroups				Uninsured, by age group		Uninsured, by location	
		All insured % (n)	All uninsured % (n)	Uninsured English-speaking Hispanics % (n)	Uninsured Spanish-speaking Hispanics % (n)	Uninsured Native Americans % (n)	All other uninsured % (n)	Millennials % (n)	Non-millennials % (n)	More rural % (n)	Less rural % (n)
Total number	273	84	189	57	33	67	32	73	112	93	96
Motivation to get health insurance											
What is the main reason you would get/ have gotten health insurance? †											
Get treatment	15.0 (23)	29.4 (15)	7.8 (8)**	9.1 (3)	10.0 (2)	3.5 (1)**	10.0 (2)**	4.8 (2)	10.0 (6)	7.5 (3)	8.1 (5)
Stay healthy	26.8 (41)	17.7 (9)	31.4 (32)	21.2 (7)	40.0 (8)	37.9 (11)	30.0 (6)	33.3 (14)	30.0 (18)	30.0 (12)	32.3 (20)
Afford care if sick or hurt	39.9 (61)	33.3 (17)	43.1 (61)	42.4 (14)	45.0 (9)	44.8 (13)	40.0 (8)	42.9 (18)	43.3 (26)	45.0 (18)	41.9 (26)
Not pay penalty	14.4 (22)	19.6 (10)	11.8 (12)	24.2 (8)	5.0 (1)	6.9 (2)	5.0 (1)	7.1 (3)	15.0 (9)	12.5 (5)	11.3 (7)
Other	3.9 (6)	0.0 (0)	5.9 (6)	3.0 (1)	0.0 (0)	6.9 (2)	15.0 (3)	11.9 (5)	1.7 (1)	5.0 (2)	6.5 (4)
Opinions about health insurance											
I don't need health insurance because I am healthy.											
Agree or strongly agree	21.3 (58)	14.5 (12)	24.3 (46)	29.8 (17)*	9.1 (3)	25.4 (17)	28.1 (9)	27.4 (20)	22.3 (25)	25.8 (24)	22.9 (22)
Health insurance costs too much.											
Agree or strongly	85.6 (231)	81.9 (68)	87.2 (163)	86.0 (49)	80.6 (25)	89.6 (60)	90.6 (29)	83.6 (61)	90.0 (99)	91.4 (85)	83.0 (78)

Opinions about health insurance	Overall results % (n)	By insurance status		Uninsured, by demographic subgroups				Uninsured, by age group		Uninsured, by location	
agree											
I do not need health insurance to get good health care. †											
Agree or strongly agree	23.3 (37)	13.2 (7)	28.3 (30)*	31.4 (11)*	23.8 (5)	30.0 (9)	25.0 (5)	29.6 (13)	27.4 (17)	23.8 (10)	31.25 (20)
I would not buy health insurance from the New Mexico Health Insurance Marketplace, also known as beWellnm, because I disagree with Obamacare.											
Agree or strongly agree	36.9 (90)	19.7 (14)	43.9 (76)**	44.4 (24)**	44.8 (13)**	40.0 (24)**	50.0 (15)**	38.9 (28)	48.4 (47)	40.5 (34)	47.2 (42)
I am worried about paying for health care if I get sick. †											
Agree or strongly agree	84.4 (135)	86.8 (46)	83.2 (89)	77.8 (28)	95.2 (20)	83.3 (25)	80.0 (16)	80.0 (36)	85.5 (53)	81.5 (53)	85.7 (36)
Health insurance literacy											
How confident are you that you understand health insurance terms? §											
Not at all confident	23.3 (61)	13.8 (11)	27.6 (50)	26.8 (15)	58.1 (18)	11.3 (7)	31.2 (10)	28.2 (20)	26.4 (28)	21.4 (19)	33.7 (31)
Somewhat confident	37.5 (98)	40.0 (32)	36.5 (66)	41.1 (23)	32.3 (10)	37.1 (23)	31.2 (10)	45.1 (32)	31.2 (33)	38.1 (33)	35.9 (33)
Moderately confident	25.3 (66)	28.8 (23)	23.8 (43)	19.6 (11)	9.7 (3)	37.1 (23)	18.8 (6)	24.0 (17)	24.5 (26)	28.1 (25)	19.6 (18)
Very confident	13.8 (36)	17.5 (14)	12.2 (22)	12.5 (7)	0.0 (0)	14.5 (9)	18.8 (6)	2.8 (2)	17.9 (19)	13.5 (12)	10.9 (10)
If you were to compare health plans, how likely are											

Opinions about health insurance	Overall results % (n)	By insurance status		Uninsured, by demographic subgroups				Uninsured, by age group		Uninsured, by location	
you to understand how the plans are different? § †											
Not at all likely	15.8 (25)	9.6 (5)	18.9 (20)	17.1 (6)	33.3 (7)	20.0 (6)	5.0 (1)	18.2 (8)	19.4 (12)	19.1 (8)	18.8 (12)
Somewhat likely	44.3 (70)	42.3 (22)	45.3 (48)	40.0 (14)	47.6 (10)	60.0 (18)	30.0 (6)	61.4 (27)	33.9 (21)	52.4 (22)	40.6 (26)
Moderately likely	24.7 (39)	34.6 (18)	19.8 (21)	22.9 (8)	9.5 (2)	16.7 (5)	30.0 (6)	18.2 (8)	21.0 (13)	19.1 (8)	20.3 (13)
Very likely	15.2 (24)	13.5 (7)	16.0 (17)	20.0 (7)	9.5 (2)	3.3 (1)	35.0 (7)	2.3 (1)	25.8 (16)	9.5 (4)	20.3 (13)

Note: Statistical comparisons using chi square tests were made between all uninsured participants vs. insured participants; subgroups of uninsured participants were compared individually to the insured. Observations with missing values were omitted from statistical tests.

§ Statistical testing using ordinal logistic regression was performed and results are summarized in table D–2.

† The total number of respondents for these questions are lower because the questions were not asked during in-person intercept interviews.

* p≤.05

** p≤.01

Table D–2. Insurance Status and Race and Ethnicity as a Predictor of Health Insurance Literacy

Characteristic	All Uninsured, compared to all insured		By Uninsured Subgroup, Compared to All Insured								Uninsured, millennials compared to non-millennials		Uninsured, more rural compared to less rural	
			Uninsured English-speaking Hispanics		Uninsured Spanish-speaking Hispanics		Uninsured Native Americans		All other uninsured					
	OR	*p*-value	OR	*p*-value	OR	*p*-value	OR	*p*-value	OR	*p*-value	OR	*p*-value	OR	*p*-value
If you were to compare health plans, how likely are you to understand how the plans are different? † [a]	1.53	.17	1.18	.68	3.98	<.01	3.21	.01	0.40	.06	2.32	.02	1.49	.28
How confident are you that you understand health insurance terms? [b]	1.74	.02	1.91	.04	8.70	<.01	0.89	.70	1.69	.17	1.69	.06	0.60	.06

Note: An ordinal logistic regression was performed to test for differences between all uninsured participants compared with insured participants as a whole and by racial and ethnic subgroup. One of the assumptions underlying ordinal logistic regression is that the relationship between each pair of outcome groups is the same. In other words, ordinal logistic regression assumes that the coefficients that describe the relationship between, for example, the lowest vs. all higher categories of the response variable are the same as those that describe the relationship between the next lowest category and all higher categories, etc. This is called the proportional odds assumption or the parallel regression assumption. Because the relationship between all pairs of groups is the same, there is only one set of coefficients (only one model).

OR= Odds ratio estimate

† The total number of respondents for these questions is lower because the questions were not asked during in-person intercept interviews.

[a] Reference group is not at all likely.

[b] Reference group is not at all confident.

Appendix E. Survey Results: Subsidy-Eligible New Mexicans Knowledge of beWellnm and Willingness to Purchase Insurance Through beWellnm

Table E–1. Survey Respondents Knowledge of beWellnm and Willingness to Purchase Insurance Through beWellnm

Interactions with beWellnm	Overall results % (n)	By insurance status		Uninsured, by demographic subgroups				Uninsured, by age group		Uninsured, by location	
		All insured % (n)	All uninsured % (n)	Uninsured English-speaking Hispanics % (n)	Uninsured Spanish-speaking Hispanics % (n)	Uninsured Native Americans % (n)	All other uninsured % (n)	Millennials % (n)	Non-millennials % (n)	More rural % (n)	Less rural % (n)
Total number	273	84	189	57	33	67	32	73	112	93	96
Familiarity of beWellnm, among uninsured											
Had heard of beWellnm before taking survey §			52.3 (93)	56.1 (32)	43.8 (14)	41.0 (25)	78.6 (22)	52.8 (38)	51.0 (52)	45.4 (39)	58.7 (54)
Tried to get more information about beWellnm	59.9 (109)	73.8 (59)	49.0 (50)**	71.9 (22)	46.7 (7)*	12.9 (4)**	66.7 (16)	42.1 (16)	54.1 (33)	26.7 (12)	68.7 (38)**
Considered getting health insurance through beWellnm§†			59.6 (56)	68.8 (22)	60.0 (9)	36.0 (9)	72.7 (16)	52.6 (20)	66.0 (35)	48.7 (19)	67.3 (37)
Have gotten health insurance through beWellnm in past § †			12.5 (7)	18.2 (4)	0.0 (0)	0.0 (0)	18.8 (3)	10.0 (2)	14.3 (5)	10.5 (2)	13.5 (5)
Willingness to pay for health insurance for self, among uninsured											
Would pay $50/month § †			72.8 (118)	76.9 (40)	82.1 (23)	69.2 (36)	63.3 (19)	66.7 (42)	76.8 (73)	67.5 (52)	77.6 (66)
Would pay $100/month § †			26.4 (41)	33.3 (17)	7.7 (2)	26.5 (13)	31.0 (9)	19.0 (12)	32.6 (29)	28.4 (21)	24.7 (20)

Interactions with beWellnm	Overall results	By insurance status		Uninsured, by demographic subgroups				Uninsured, by age group		Uninsured, by location	
Awareness of subsidy											
Not aware health insurance can be financially subsidized	60.8 (149)	34.6 (28)	75.0 (117)**	64.7 (33)**	92.6 (25)**	88.0 (44)**	53.6 (15)	84.4 (54)	69.7 (62)*	77.5 (55)	72.9 (62)
Getting information about beWellnm											
Sources of information about beWellnm, among those who looked for information											
beWellnm website	55.3 (63)	50.0 (31)	61.5 (32)	60.9 (14)	71.4 (5)	25.0 (1)	66.7 (12)	76.5 (13)	52.9 (18)	46.2 (6)	66.7 (26)
On the phone	38.6 (44)	48.4 (30)	26.9 (14)*	21.7 (5)*	14.1 (1)	25.0 (1)	38.9 (7)	11.8 (2)	35.3 (12)	30.8 (4)	25.6 (10)
Met face-to-face	28.9 (33)	33.9 (21)	23.1 (12)	30.4 (7)	28.6 (2)	25.0 (1)	11.1 (2)	17.6 (3)	26.5 (9)	30.8 (4)	20.5 (8)
Attended event	14.9 (17)	21.0 (13)	7.7 (4)*	13.8 (4)	14.3 (1)	0.0 (0)	0.0 (0)*	5.9 (1)	8.8 (3)	0.0 (0)	10.2 (4)
Talked to friend	14.0 (16)	11.3 (7)	17.3 (9)	26.1 (6)	28.6 (2)	25.0 (1)	0.0 (0)	29.4 (5)	11.8 (4)	7.7 (1)	20.5 (8)
Talked to family	10.5 (12)	12.9 (8)	7.7 (4)	4.4 (1)	14.3 (1)	50.0 (2)*	0.0 (0)	17.6 (3)	2.9 (1)	7.7 (1)	7.7 (3)
Asked doctor, nurse, or other health care staff	7.0 (8)	4.8 (3)	9.6 (5)	4.4 (1)	0.0 (0)	0.0 (0)	22.2 (4)*	0.0 (0)	14.7 (5)	7.7 (1)	10.3 (4)
Some other source	11.2 (13)	14.5 (9)	7.7 (4)	8.7 (2)	0.0 (0)	25.0 (1)	5.6 (1)	5.9 (1)	8.8 (3)	23.1 (3)	2.6 (1)*
Believe it is important that person helping on phone is from New Mexico	79.0 (211)	68.3 (56)	83.8 (155)**	82.1 (46)	80.6 (25)	93.9 (62)**	68.8 (22)	83.3 (60)	83.5 (91)	91.3 (84)	76.3 (71)**
Reasons for not getting health insurance through beWellnm											
Plans cost too much§ †			52.1 (25)	66.7 (12)	77.8 (7)	11.1 (1)	41.7 (5)	26.3 (5)	69.0 (20)**	17.6 (3)	71.0 (22)**
I did not see a			16.7 (8)	16.7 (3)	55.6 (5)	0.0 (0)	0.0 (0)	21.0 (4)	13.8 (4)	0.0 (0)	25.8 (8)*

Interactions with beWellnm	Overall results	By insurance status		Uninsured, by demographic subgroups				Uninsured, by age group		Uninsured, by location	
plan I liked § †											
Choosing a plan was too confusing§ †			20.8 (10)	11.1 (2)	44.4 (4)	22.2 (2)	16.7 (2)	36.8 (7)	10.3 (3)*	23.5 (4)	19.4 (6)
Healthcare.gov was too hard to use § †			22.9 (11)	38.9 (7)	11.1 (1)	11.1 (1)	16.7 (2)	21.0 (4)	24.1 (7)	17.6 (3)	25.8 (8)
Healthcare.gov did not work § †			10.4 (5)	11.1 (2)	11.1 (1)	0.0 (0)	16.7 (2)	5.3 (1)	13.8 (4)	11.8 (2)	9.7 (3)
I could not get the help I needed § †			22.9 (11)	11.1 (2)	33.3 (3)	22.2 (2)	33.3 (4)	31.6 (6)	17.2 (5)	23.5 (4)	22.6 (7)
Some other reason§†			25.0 (12)	27.8 (5)	0.0 (0)	44.4 (4)	25.0 (3)	47.4 (9)	10.3 (3)**	29.4 (5)	22.6 (7)

Note: Statistical comparisons using chi square tests were made between all uninsured participants vs. insured participants; subgroups of uninsured participants were compared individually to the insured. Observations with missing values were omitted from statistical tests.

§ People with insurance were not asked these questions. Therefore, statistic comparisons are not available for the uninsured by demographic groups for these questions.

† The total number of respondents for these questions are lower because the questions were not asked during in-person intercept interviews.

* p≤.05

** p≤.01

Appendix F. Survey Results: Subsidy-Eligible New Mexicans Information Seeking Habits

Table F–1. Information Seeking Habits of Survey Respondents

Information seeking habits	Overall results % (n)	By insurance status		Uninsured, by demographic subgroups				Uninsured, by age group		Uninsured, by location	
		All insured % (n)	All uninsured % (n)	Uninsured English-speaking Hispanics % (n)	Uninsured Spanish-speaking Hispanics % (n)	Uninsured Native Americans % (n)	All other uninsured % (n)	Uninsured millennials % (n)	Uninsured non-millennials % (n)	Uninsured more rural % (n)	Uninsured less rural % (n)
Total number	273	84	189	57	33	67	32	73	112	93	96
Where go for news or to find information											
Local TV news	57.9 (158)	52.4 (44)	60.3 (114)	63.2 (36)	66.7 (22)	64.2 (43)	40.6 (13)	52.0 (38)	67.9 (76)*	61.3 (57)	59.4 (57)
National TV news	25.3 (69)	36.9 (31)	20.1 (38)**	22.8 (13)	27.3 (9)	17.9 (12)**	12.5 (4)**	16.4 (12)	23.2 (26)	16.1 (15)	24.0 (23)
Radio news	25.3 (69)	27.4 (23)	24.3 (46)	21.0 (12)	12.1 (4)	32.8 (22)	25.0 (8)	19.2 (14)	28.6 (32)	29.0 (27)	19.8 (19)
Newspaper (paper format)	30.0 (82)	32.1 (27)	29.1 (55)	22.8 (13)	6.1 (2)**	49.3 (33)*	21.9 (7)	24.7 (18)	32.1 (36)	39.8 (37)	18.8 (18)**
Internet	80.6 (220)	84.5 (71)	78.8 (149)	79.0 (45)	72.7 (24)	73.1 (49)	90.6 (29)	86.3 (63)	73.2 (82)*	76.3 (71)	81.2 (78)
Other	8.4 (23)	13.1 (11)	6.4 (12)	3.5 (2)*	9.1 (3)	7.5 (5)	6.3 (2)	8.2 (6)	5.4 (6)	7.5 (7)	5.2 (5)
Trusted source of information about buying health insurance											
Female family members	35.5 (97)	34.5 (29)	36.0 (68)	35.1 (20)	42.4 (14)	41.8 (28)	18.8 (6)	48.0 (35)	29.5 (33)**	37.6 (35)	34.4 (33)
Male family members	22.3 (61)	20.2 (17)	23.3 (44)	19.3 (11)	24.2 (8)	32.8 (22)	9.4 (3)	32.9 (24)	17.9 (20)*	24.7 (23)	21.9 (21)
A doctor or nurse	27.1 (74)	22.6 (19)	29.1 (55)	26.3 (15)	30.3 (10)	34.3 (23)	21.9 (7)	28.8 (21)	28.6 (32)	32.3 (30)	26.0 (25)

Information seeking habits	Overall results % (n)	By insurance status		Uninsured, by demographic subgroups				Uninsured, by age group		Uninsured, by location	
Doctor's office staff	22.0 (60)	19.0 (16)	23.3 (44)	28.1 (16)	24.2 (8)	17.9 (12)	25.0 (8)	23.3 (17)	23.2 (26)	19.4 (18)	27.1 (26)
An insurance agent	28.2 (77)	33.3 (28)	25.9 (49)	28.1 (16)	27.3 (9)	25.4 (17)	21.9 (7)	24.7 (18)	27.7 (31)	24.7 (23)	27.1 (26)
State government agencies	20.5 (56)	21.4 (18)	20.1 (38)	29.8 (17)	15.2 (5)	17.9 (12)	12.5 (4)	16.4 (12)	23.2 (26)	20.4 (19)	19.8 (19)
Federal government agencies	14.3 (39)	21.4 (18)	11.1 (21)*	12.3 (7)	6.1 (2)*	14.9 (10)	6.3 (2)	6.8 (5)	14.3 (16)	12.9 (12)	9.4 (9)
Other	22.2 (58)	28.6 (24)	18.0 (34)*	14.0 (8)*	18.2 (6)	13.4 (9)*	34.4 (11)	13.7 (10)	20.5 (23)	16.1 (15)	19.8 (19)
Places visited in typical week											
Work	65.6 (179)	69.0 (58)	64.0 (121)	66.7 (38)	72.7 (24)	56.7 (38)	65.6 (21)	63.0 (46)	65.2 (73)	60.2 (56)	67.7 (56)
School	24.2 (66)	25.0 (21)	23.8 (45)	10.5 (6)*	45.4 (15)*	32.8 (22)	6.2 (32)*	28.8 (21)	21.4 (24)	23.7 (22)	24.0 (23)

Note: Statistical comparisons using chi square tests were made between all uninsured participants vs. insured participants; subgroups of uninsured participants were compared individually to the insured. Observations with missing values were omitted from statistical tests.
* p≤.05
** p≤.01

Table F–2. Survey Respondents Internet Use Habits

Internet use habits	Overall results % (n)	By insurance status		Uninsured, by demographic subgroups				Uninsured, by age group		Uninsured, by location	
		All insured % (n)	All uninsured % (n)	Uninsured English-speaking Hispanics % (n)	Uninsured Spanish-speaking Hispanics % (n)	Uninsured Native Americans % (n)	All other uninsured % (n)	Uninsured millennials % (n)	Uninsured non-millennials % (n)	Uninsured more rural % (n)	Uninsured less rural % (n)
Total number	273	84	189	57	33	67	32	73	112	93	96
Internet use											
Uses the Internet to find news	80.6 (220)	84.5 (71)	78.8 (194)	79.0 (45)	72.7 (24)	76.1 (51)	90.6 (29)	86.3 (63)	73.2 (82)*	76.3 (71)	81.2 (78)
Use Internet at least once a week†	81.8 (130)	88.5 (46)	78.5 (84)	75.0 (27)	71.4 (15)**	76.7 (23)	95.0 (19)	95.6 (43)	66.1 (41)**	73.8 (31)	81.5 (53)
Means to access Internet											
Cell phone†	60.5 (92)	51.9 (27)	65.0 (65)	59.4 (19)	70.0 (14)	69.0 (20)	63.2 (12)	73.3 (33)	58.2 (32)	59.0 (23)	68.8 (42)
Computer†	65.8 (100)	82.7 (43)	57.0 (57)**	46.9 (15)**	65.0 (13)	41.4 (12)**	89.5 (17)	51.1 (23)	61.8 (34)	48.7 (19)	62.3 (38)
Tablet/iPad†	21.7 (33)	25.0 (13)	20.0 (20)	18.8 (6)	20.0 (4)	24.2 (7)	15.8 (3)	26.7 (12)	14.6 (8)	23.1 (9)	18.0 (11)
Internet resources accessed											
Search engines	85.7 (198)	86.5 (64)	85.4 (134)	84.8 (39)	91.3 (21)	79.3 (46)	93.3 (28)	84.5 (60)	86.6 (71)	81.8 (63)	88.8 (71)
Social media	54.5 (126)	63.5 (47)	50.3 (79)	54.4 (25)	60.9 (14)	44.8 (26)*	46.7 (14)	64.8 (46)	40.2 (33)**	46.8 (36)	50.0 (43)
Email	55.8 (129)	64.9 (48)	51.6 (81)	50.0 (23)	56.5 (13)	51.7 (30)	50.0 (15)	49.3 (35)	56.1 (46)	50.6 (39)	52.5 (42)
Other	7.4 (17)	12.2 (9)	5.1 (8)*	6.5 (12)	0.0 (0)	5.2 (3)	6.7 (2)	4.2 (3)	4.9 (4)	2.6 (2)	7.5 (6)

Note: Statistical comparisons using chi square tests were made between all uninsured participants vs. insured participants; subgroups of uninsured participants were compared individually to the insured. Observations with missing values were omitted from statistical tests.
† The total number of respondents for these questions are lower because the questions were not asked during in-person intercept interviews.
* p≤.05
** p≤.01

Appendix G: Acknowledgments

We would like to thank the many consumers and stakeholders across New Mexico who made this assessment possible by sharing their knowledge and experiences with the project team. We are grateful to the stakeholder advisory group, many of whom provided entrée into the communities where the data collection took place, in addition to providing advice and guidance.

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