OBAMACARE IN NEW MEXICO: THE NEW MEXICO HEALTH INSURANCE EXCHANGE: WHO OR WHAT INFLUENCES AND MOTIVATES HISPANIC INDIVIDUALS TO ENROLL?

Joseph Sanchez

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Approved by the Dissertation Committee:

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Sylvia Celedón-Pattichis
Judy Liesveld
OBAMACARE IN NEW MEXICO – THE NEW MEXICO HEALTH INSURANCE EXCHANGE: WHO OR WHAT INFLUENCES AND MOTIVATES HISPANIC INDIVIDUALS TO ENROLL?

By

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DISSEPTION

Submitted in Partial Fulfillment of the Requirements of the Degree of

Doctor of Philosophy
Family Studies

The University of New Mexico
Albuquerque, New Mexico

May, 2016
Dedication

I dedicate my dissertation work to my parents, Lila and Alfredo Sánchez, who supported me throughout the process and gave me the love and strength to reach for the stars and chase my dreams. I also dedicate this work to the memory of my grandmother, Gabriela Pino, who passed on a love of my norteño values and beliefs and admiration for my cultural wisdom.
Acknowledgements

I would like to express my sincere gratitude and appreciation to my committee chairman, Dr. Ziarat Hossain, for the continuous support of my Ph.D. work in Family Studies. His knowledge, encouragement and guidance helped me successfully research, write and defend this dissertation. I could not have imagined having a better advisor and mentor for my research study. Also, I would like to thank the rest of my dissertation committee members, Dr. Ryan Kelly, Dr. Sylvia Celedón-Pattichis and Dr. Judy Liesveld, for their insightful comments and consistent encouragement. Their support strengthened my scholarship to include multiple perspectives on my research topic and the process.

I would like to acknowledge and thank Dr. Nancy Ridenour and the late Ed Mason for their friendship and encouragement throughout my dissertation. Special thanks to the endless support provided by Ms. Margaret Gonzales and Mr. Doug Weintraub at the University of New Mexico Graduate Studies office. I duly recognize the active contributions of the Collaborative for Hispano/Latino Health Equity, Project for New Mexico Graduates of Color, Graduate Resource Center and El Centro de la Raza organizations that provide steady and relentless support of underrepresented minorities at the University of New Mexico.

Finally I would like to thank the participants from San Miguel County that participated in my study. Their selfless participation in my study made the completion of this research an enjoyable experience and a productive endeavor.

Always and forever with deepest gratitude thank you, Lord, for always being there for me.
The primary purpose of this study is to explore factors and contexts that influenced and motivated individuals to enroll in the Affordable Care Act (ACA). The ACA, commonly called Obamacare, is also known as the New Mexico Health Insurance Exchange (NMHIX). The study is specifically designed to examine the participants’ lived experiences and opinions regarding the acquisition, or opposition to health care insurance coverage.

Nine self-identified Hispanic residents of the San Miguel County (SMC) participated in semi-structured in-depth interviews. The research site for the current study was the SMC located in northern New Mexico (NM). The population of northern NM is approximately 80% “Hispanic or Norteña/o”\(^1\). Whereas about 19% of SMC population is uninsured, a disproportionate 17% of Hispanics in SMC are uninsured. The rates of the uninsured in SMC are noticeably higher than the state average of 15% (U.S. Census Bureau American Community Survey, 2010-2012; Stern, 2015). In other words, a high percentage of the SMC

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\(^1\) Hernández and Rodriguez y Gibson (2014) use the term Latina/o frequently to identify a Hispanic or Latino population. Also see Gutierrez (2011) and González & Ballysingh (2012). For the purpose of this manuscript, I am going to use the terms Hispanic or Norteña/o interchangeably. These terms are what my research participants from SMC identify as an ethnic classification.
population has health insurance. However, very little is known about the factors that influenced them to enroll or not enroll in the NMHIX.

I have employed the hermeneutic phenomenological research methodology to conduct this study. In line with the prescribed techniques of this methodology (Creswell, 2014), I exercised the following steps to collect and analyze my data: (a) Organized and prepared the data for analysis, (b) Read or reviewed all data, (c) Began coding all of the data, (d) Used the coding process to generate a description of the setting or people as well as categorize or themes for analysis, (e) Advanced how the description and the themes were represented in the narrative, and (f) Interpreted the findings.

Based on my research objectives, I transcribed and analyzed interview data to generate themes. The themes that emerged are: (a) Chronicles of Health Care and Home Remedies Used to Cure Ailments, (b) Messaging – Information Source Gained Through Trusted Sources, (c) Motivation and Influential Factors on Health Care Insurance Enrollment, (d) Enrollment Process Experience in Health Care Insurance, (e) Health Care Insurance Implications, and (f) Conceptual Thoughts. These themes were analyzed and the results discussed, along with the application achievement of the theoretical framework, recommendation for practice and research, limitations of the study, and concluding thoughts.

The major findings in this study, congruent with the themes, revealed the following response patterns: (a) participant’s memory of having health care insurance while growing up was divided among those that had health care insurance and those who did not have health care insurance or those who had state supported health care insurance such as Medicaid; (b) Trusted sources such as family and friends are methods that were used to obtain and learn about the NMHIX; (c) Mandate and penalty assessments for not having the health care
insurance coverage was the number one motivational factor to enrolling in the NMHIX; (d) Participants had more negative experiences than positive in the enrollment process; (e) Nearly 90% of the respondents felt they have benefited from having health care insurance coverage, and; (f) The findings revealed that if participants had the authority to change something with health care insurance coverage, participants would like co-payments and deductibles reduced or eliminated.

The results of this research provide a venue to strengthen the implementation of the ACA. In addition, there may be the notion to rethink and systematize ideas that enable and support local communities to operate as health communication channels aiding citizens navigate the optimal use of health care insurance. Although NMHIX enrollment counselors and agents/brokers are available, the evidence in this study implies that enrollees in the NMHIX do not recognize the full benefit of their health care insurance coverage. Moreover, insurance owners of the NMHIX do not realize the value of preventive health care. Finally, with reference to growing diversity in New Mexico and in the country, it is also imperative to address the health care system’s organizational and structural barriers. For instance, lack of culturally and literacy sensitive support in health care settings complicates and impairs the ability of a consumer to receive accurate health care information and obtain appropriate care.
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Chapter I

Introduction

*Having health care insurance is important to me because the insurance provides a giant financial relief.*
- Carlos, interview, September 2015

*Having health care insurance is important to me because I have a grandchild and a daughter and I want to live a long and healthy life for them and for myself.*
- Maria, interview, October 2015

*Having health care insurance is very important to me because of my health issues. I don’t know that I could afford my medications on a monthly basis without my insurance.*
- Luisa, interview, October 2015

Like Carlos, Maria, and Luisa, who were participants in my dissertation research, many citizens in the United States expect and receive health care services when needed. However, this is not reality for approximately 32 million citizens who have no health insurance (Hornik, 2001; Kaiser Family Foundation, 20152). Now that the Patient Protection and Affordable Care Act (PPACA) commonly called the Affordable Care Act (ACA) or Obamacare has been instituted many of the uninsured now have access to health insurance. There are several challenges to successfully implementing a health care insurance system. Access to insurance is varied and limited and, irrespective of socio-economics and population, individuals do not take advantage of available health care coverage.

The bases for choosing appropriate health care coverage are diverse and variable. Individuals with preexisting conditions or a family history of certain health issues, or a family with children may appreciate the importance of having health care coverage. A single healthy person may not understand the value of it. However, individuals who have never had

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2 Kaiser Family Foundation is a non-profit organization focusing on national health issues, as well as the U.S. role in global health policy. Kaiser Family Foundation serves as a non-partisan source of facts, analysis and journalism for policymakers, the media, the health policy community and the public.
the opportunity to obtain health care insurance because of access or affordability are now required to have that coverage under the ACA.

The ACA health care insurance options provide an opportunity for many persons to have coverage. Health care insurance covers the costs of illness or injury and offsets unexpected, often exorbitant, medical costs. According to the U.S. Centers for Medicare and Medicaid Services (2015), people without health care coverage are subjected to excessive medical costs that can result in substantial financial strain including bankruptcy. Medical care cost can easily be underestimated for people who have never had health care insurance. For example, medical costs for a broken leg can cost up to $7,500 and the average cost of a 3-day hospital stay is approximately $30,000 (U.S. Department of Health and Human Services, 2012).

Requiring health care insurance may pose an unintended adverse consequence on the single ‘people living in poverty’3 and low-income individuals who are required to have the coverage. The New Mexico Health Insurance Exchange (NMHIX) offers cost-sharing subsidies for enrollees who qualify under certain income guidelines (NMHIX, 2014). Cost-share subsidies minimize enrollees’ out-of-pocket costs when they go to the doctor or have a hospital stay (Kaiser Family Foundation, 2014b). An unintended consequence may come from having to pay a co-payments or meet certain thresholds on premiums before insurance benefits take effect or having to decide between going to the doctor for an ailment or buying groceries. An additional unintended consequence for these people may be the concept of

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3 In 2014, 47 million people lived in Poverty USA. That means the poverty rate for 2014 was 15%. The 2014 poverty rate was 2.3 percentage points higher than in 2007, the year before the 2008 recession. According to 2014 U.S. Census Data, the highest poverty rate by race is found among Blacks (26%), with Hispanics (of any race) having the second highest poverty rate (24%). Whites had a poverty rate of 10%, while Asians had a poverty rate at 12% (Income, Poverty, and Health Insurance Coverage in the United States, U.S. Census Bureau, 2014).
accessing and knowing how to use the coverage for preventative care. For the aforementioned reasons, I have selected to investigate the use of the NMHIX.

**Research Context and Background**

New Mexico is called the “Land of Enchantment” for its breathtakingly beautiful high desert mountains and multicultural influences in food and the arts. The state is racially and ethnically diverse, making it a minority-majority state. It ranks first in the nation for the percent of Hispanic population and second for the percent of Native American population (U.S. Census Bureau Statistical Abstract, 2012).

New Mexico is underserved in terms of access to primary care providers, which correlates to a deficit of adequate health care. Thirty-two of the thirty-three counties in New Mexico are designated as all or part Health Professions Shortage Areas (HPSAs). In 2011, the estimated underserved population living in primary care HPSAs was 30% in New Mexico, compared to 11% in the United States. The geography of New Mexico is stunning and beautiful but presents great challenges for maintaining optimal health and health care delivery. New Mexico is the nation’s fifth largest state, with a landmass of more than 121,000 square miles. According to the 2014 U.S. Census Bureau, the population of New Mexico was 2,085,572 (ranking 36th in the nation for population), with an average of only 17 people per square mile (compared with a national average of 87.4 people per square mile). This distribution illustrates the rural character of the state and the need for attention to a widely dispersed population.

**Study site – San Miguel County context.** SMC has a population of 28,239 and is the seventeenth largest county with population in the state (U.S. Census Bureau, 2015). SMC has a population of 20% (5,919) persons under 18 years old and a population of 18% (5,187)
persons 65 years old and over; therefore, the differences of 62% (18,197) of persons in SMC are between the ages of 18 and 64 years. My research is proposing to target this 18 to 64 year old population. The SMC is predominantly Hispanic, 77% compared to 47% statewide. Nearly 60% of this population speaks a language other than English at home compared to 36% statewide (U.S. Census Bureau, 2015).

The U.S. Census Bureau (2010-2012) revealed significant socioeconomic data from SMC. The SMC high school graduation rate is a mere 38% which is numbing in comparison to the state’s 84%. The state average is slightly lower than the national percentage of 86%. The SMC educational attainment for the Hispanic population 25 years and older that has a bachelor’s degree or higher is 12%, which is also disconcerting in comparison to the state’s 26% and the national percentage of 29%. Similarly, the percentage of SMC Hispanics that possess a high school diploma, GED or alternative is 38% and nearly 20% of Hispanics in SMC have less than a high school diploma (U.S. Census Bureau American Community Survey 2010-2012).

The U.S Census Bureau American Community Survey (2010-2012) reported that in a 12-month period nearly 30% of Hispanics ages 18 to 64 and 25% of Hispanics ages 65 and older are living with incomes below poverty level. The survey also reported household annual income earnings in 2011-2012 was less than $10,000, which equates to nearly 20% of SMC Hispanics; 10% had an income of $10,000 to $14,999; 20% had an income of $15,000 to $49,999; 15% an income of $25,000 to $34,999; 15% an income of $35,000 to $49,999; 10% income of $50,000 to $74,999; The remaining 10% had an income over $75,000. The survey reported a disproportionate median household income between SMC Hispanics and non-Hispanic Whites, $28,671 and $40,080, respectively. Additionally, the survey reported
that nearly 25% of SMC Hispanics received food stamps/supplemental nutrition assistance program during 2011-2012 compared to 6% of SMC non-Hispanic Whites.

The socioeconomic status (SES) factors affect individuals and families of all ethnic and religious backgrounds in New Mexico. More specifically, SMC’s SES factors for its Hispanic population are disproportionate and lag in all areas when compared to non-Hispanic Whites. The many complex factors that influence lack of health care coverage or the wherewithal for access to health care coverage for many of the SMC population.

**New Mexico health care status.** New Mexicans are grossly underinsured. The Kaiser Family Foundation (2014a) reports that 28% of New Mexicans are covered under Medicaid, 15% receive health care benefits from Medicare; and 12% are uninsured. Similarly, 13% of the U.S. population is covered under Medicare, 19% is covered under Medicaid, and only 10% is uninsured. The Robert Wood Johnson Foundation County Health Ranking and Roadmaps (2015) reports that nearly 20% of New Mexicans are uninsured. Although these percentages are not egregiously disparate, and average 14% of this population has no health care coverage. The Pew Center (2011) demographics profile of Hispanics in New Mexico illustrates that 47% of the state’s total population is Hispanic. The native Hispanic population is 83% compared to 17% that are foreign-born Hispanics and the median age of all Hispanics is 30 years old. Demographic statistics based on age groups demonstrate that many Hispanics face impoverished living conditions. 37% of 17 year-olds and younger and 25% of 18 to 64 year-olds live in poverty. Correspondingly, 40% of Hispanics age 17 and younger and every 3 in 10 Hispanic individuals ages 18 to 64 years live in poverty compared to 1 in 10 non-Hispanic White individuals ages 17 and younger and every 1 in 10 non-Hispanic White individuals ages 18-64 that live in poverty. According to
data from the U.S. Department of Education, National Center for Education Statistics (2015) in 2012-2013 New Mexico reported the third worst graduation rates at 70%, followed by Oregon and District of Columbia reporting 69% and 62%, respectively. In addition, the New Mexico Association of Food Banks (2014) report revealed that 1 in 3 children and 1 in 5 adults experience hunger weekly and nearly 70,000 New Mexicans seek food assistance weekly. Household spending tradeoffs regularly occur in American households. Many of these households are challenged with the hard balance of providing food against paying for utilities, transportation, medical care, housing and education (see Figure 1) (New Mexico Association of Food Banks, 2014).

Figure 1. Household Spending Tradeoffs. Factors affecting client households include difficult decisions about household resource management in an effort to ensure they have sufficient food. A majority of client households report having to choose between paying for food and paying for utilities, transportation, medical care, or housing at some point during the year (New Mexico Association of Food Banks, 2014).

Poverty, lack of health care, low graduation rates, and food insecurity are several of the social determinants guiding life style decisions. The World Health Organization (2013) defines social determinants of health as conditions in which people are born, grow, live, work and age. Moreover, these conditions are shaped by the distribution of money, power, and resources at global, national and local levels. These social determinants contribute to the high rate of New Mexico’s uninsured population.
A 2012 article published on health care in Forbes magazine revealed that the number of Americans without health care insurance has increased over the last two decades. Chideya (2012) reported that 14%, 13% and 16% of Americans were uninsured in 1990, 2000, and 2012, respectively. Over time the percentage of uninsured New Mexicans has remained constant at 20%. New Mexico’s uninsured rates from 2009 to 2012 are 20%, 20%, 20%, and 21% respectively. The percentages of those uninsured were even greater when discussing parents and children. A state-by-state analysis published in 2001 indicated that New Mexico has one of the highest rates of low income and uninsured parents (Lambrew, 2001). The analysis also revealed that the percent of uninsured parents in New Mexico is 47%, compared to the nation’s average of 33%. According to the analysis 52% of low-income families and 62% of uninsured parents are Hispanic, African American, and American Indian/Native American.

In general, someone who has health care coverage is likely to include preventative health checkups. The analysis revealed children are much more likely to receive essential health care services such as immunizations and well child exams when their parents have health care coverage.

New Mexico offers the Children’s Health Insurance Program (CHIP). The CHIP operates under the name of New MexiKids and New MexiTeens. This program was created in 1997 to provide quality health coverage for children in families that earn too much to qualify for Medicaid but are unable to afford coverage in the private market. The ACA was signed into law on March 23, 2010, with the goals of increasing the quality and affordability of health care insurance, lowering the uninsured rate by expanding public and private insurance coverage, reducing costs of health care and expanding Medicaid. The ACA
included a provision that extended CHIP funding through federal fiscal year 2015 and requires states to maintain eligibility levels through 2019. The CHIP program in New Mexico covered 90% of eligible children in 2011 (Kenney, Anderson, & Lynch, 2013). However, there are still an estimated 41,000 uninsured children eligible but not enrolled in Medicaid or CHIP (Kenney, Lynch, Huntress, Haley, & Anderson, 2012). Uncertainty over the future of CHIP, which ACA extended through 2015, raises the possibility that the coverage gains that children have experienced will erode.

An increase of individuals with health care coverage correlates with a greater need for more primary care providers. The New Mexico Center on Law and Poverty (2015) implies that New Mexico suffers from a classic supply and demand problem. For instance, New Mexico’s uninsured health care population requires medical services that are free and few providers are willing to provide those services. The New Mexico Center on Law and Poverty has proposed that an increase in primary care physicians will occur when people who have health care coverage demand the services. ACA presents an opportunity to provide health care coverage to many of the uninsured population. Realizing the impending shortage of primary care access, the 2014 NM State Legislature appropriated $1.6 million to the University of New Mexico in an effort to double the Advanced Nurse Practice Registered Nurse program from (APRNs) 24 to 48 graduates every two-years. Presently, APRNs provide primary care services in many rural and frontier settings across New Mexico.

New Mexico’s independent practice law allows for APRNs to administer appropriate health care serving patients for the duration of their lives; this care includes certified nurse midwives, pediatric nurse practitioners and family nurse practitioners. These services are available in a variety of settings including fully staffed clinics and small, community urgent
care facilities (University of New Mexico, College of Nursing, 2015). The New Mexico State legislature has recognized that efficiency in the scope of practice provided by APRNs and is hopeful it will reduce the deficit of primary care providers. The lack of primary care services is expected to become dire with the implementation of the ACA and the expansion of the state Medicaid program.

**Medicaid and Medicare in New Mexico.** The percentage of the population in New Mexico enrolled in Medicaid and Medicare is 28% and 15%, respectively (Kaiser Family Foundation, 2014a). Medicaid is a health insurance program for low-income individuals and families who cannot afford health care costs. Medicaid serves low-income parents, children, seniors, and people with disabilities. Medicare is the federal health insurance program for people who are 65 or older and for younger people with disabilities. Kaiser Family Foundation (2014a) reported that Medicaid spending in New Mexico was nearly $4.2 billion in fiscal year 2014, and in fiscal year 2009 $2.5 million was spent on Medicare.

**Patient protection and Affordable Care Act.** The ACA presented states with two decisions. Decision one: develop their own health insurance marketplace (exchange) qualified health plans, have the federal government manage the exchange, or partner with the federal government to manage the exchange. Decision two: participate in Medicaid expansion providing coverage for an expanded portion of the population. The first decision is a requirement and the second decision is an option under the ACA. The exchange is a way to select health care insurance. These health care insurance options are comprehensive and offer a wide range of services including physician appointments, hospital stays, and medical prescriptions. The exchange was developed particularly to help individuals who do not receive insurance through their employment, and for small business owners who wish to
offer health care insurance for their staff. Furthermore, the exchange was designed for people who make too much money to qualify for Medicaid, but not enough money to afford private insurance. There are four reasons why the exchange may be good options for consumers: (a) you do not qualify for Medicaid, (b) you are self-employed, (c) you are a small business that wants to offer health insurance to your employees, or (d) or you do not have health care insurance for another reason.

The ACA provisions required changes to the Medicaid program, which opened new opportunities for coverage eligibilities based on Federal Poverty Levels. Since 2015, 28 states have covered families with incomes at or above 250% Federal Poverty Level; 19 of the 28, including New Mexico, extending coverage, to 300% Federal Poverty Level or higher. For example, 250% of Federal Poverty Level for a family of four would include a family income of $60,625 or less (U.S. Department of Health and Human Services, 2015c). Medicaid primarily serves children, pregnant women, single mothers living below the poverty line, and people with disabilities. This Medicaid expansion now affords the opportunity to many other adults. Below certain income levels a single childless adult is now eligible to qualify for Medicaid; this has never been the case until the ACA was enacted into law.

New Mexico is 1 of 17 states that declared a state-based exchange as well as 1 of 27 states that expanded access to Medicaid. As of April 2014, nearly 34,966 New Mexicans had enrolled in health insurance exchange qualified health plan and 112,000 have enrolled in the Medicaid expansion. In 2012 approximately 425,900 uninsured New Mexicans became eligible for health care coverage. Nearly 170,000 (40%) qualify for Medicaid expansion and
nearly 255,900 (60%) were eligible for the qualified health plan (NMHIX, 2014). In spite of this increase of coverage, Hispanics in New Mexico have the highest rate of being uninsured.

In 2015 the data from the State Health Access Data Assistance Center of the Robert Wood Johnson Foundation showed that an average of 18% of New Mexico’s overall population and 22% of New Mexico’s Hispanic population was uninsured from 2011 to 2014 (see Table 1). During that same time period, an average of 14% of the U.S. population and 28% of the U.S. Hispanic population was uninsured. A more detailed comparison of New Mexico and the U.S. uninsured and insured population can be found in Table D-1 (see Appendix D) of this manuscript. Health reform through the ACA offers solutions in reducing the uninsured population in New Mexico. The Gallup analytics illustrated that uninsured population for the nation between 2009 through 2014 is 16%, 16%, 17%, 18%, 16% and 17% respectively for that timeframe (Levy, 2014).
Table 1:

*Health Care Insurance Coverage of Total Population*

<table>
<thead>
<tr>
<th>Location: New Mexico and United States</th>
<th>4-Year Observation by %</th>
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<tbody>
<tr>
<td></td>
<td>2011</td>
</tr>
<tr>
<td>Employer N.M. (All)</td>
<td>46.7</td>
</tr>
<tr>
<td>Medicaid &amp; CHIP N.M. (All)</td>
<td>23.8</td>
</tr>
<tr>
<td>Medicare N.M. (All)</td>
<td>15.6</td>
</tr>
</tbody>
</table>

Uninsured

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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>19.9</td>
<td>18.7</td>
<td>19.1</td>
<td>14.8</td>
</tr>
<tr>
<td>Hispanic</td>
<td>24.2</td>
<td>22.0</td>
<td>23.2</td>
<td>17.6</td>
</tr>
<tr>
<td>White</td>
<td>11.3</td>
<td>11.5</td>
<td>10.4</td>
<td>8.4</td>
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</table>

<table>
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<th>U.S.</th>
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<tr>
<td>All</td>
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<td>14.7</td>
<td>14.4</td>
<td>11.6</td>
</tr>
<tr>
<td>Hispanic</td>
<td>29.7</td>
<td>28.8</td>
<td>28.2</td>
<td>23.3</td>
</tr>
<tr>
<td>White</td>
<td>10.6</td>
<td>10.3</td>
<td>10.1</td>
<td>8.0</td>
</tr>
</tbody>
</table>

Source: State Health Access Data Assistance Center program of the Robert Wood Johnson Foundation (2015)

Note: Data in Table 1 suggests that N.M. overall population and N.M. Hispanic population is consistently uninsured, on an average of 18% and 22%, respectively.

Similar data presented by the Kaiser Family Foundation (see Table 2) indicates a slightly lower rate of uninsured individuals in New Mexico. However, these data do not break down the uninsured population by ethnicity.
Table 2:

*Health Care Insurance Coverage of Total Population*

<table>
<thead>
<tr>
<th>Years Observed by Type of Coverage</th>
<th>Location (by %)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N.M.</td>
</tr>
<tr>
<td>2012</td>
<td></td>
</tr>
<tr>
<td>Employer</td>
<td>38</td>
</tr>
<tr>
<td>Medicaid</td>
<td>21</td>
</tr>
<tr>
<td>Medicare</td>
<td>15</td>
</tr>
<tr>
<td>Uninsured</td>
<td>21</td>
</tr>
<tr>
<td>2013</td>
<td></td>
</tr>
<tr>
<td>Employer</td>
<td>38</td>
</tr>
<tr>
<td>Medicaid</td>
<td>23</td>
</tr>
<tr>
<td>Medicare</td>
<td>16</td>
</tr>
<tr>
<td>Uninsured</td>
<td>16</td>
</tr>
<tr>
<td>2014</td>
<td></td>
</tr>
<tr>
<td>Employer</td>
<td>37</td>
</tr>
<tr>
<td>Medicaid</td>
<td>28</td>
</tr>
<tr>
<td>Medicare</td>
<td>15</td>
</tr>
<tr>
<td>Uninsured</td>
<td>12</td>
</tr>
</tbody>
</table>

Source: Kaiser Family Foundation

Note: Data in Table 2 suggests that N.M. overall population is consistently uninsured, on an average of 16%.

On May 1, 2014, a Cable News Network article reported percentages of Americans who had signed up for ACA based on ethnicity (Luhby, 2014). Specifically, 11% of
Hispanics had enrolled in the ACA compared to 63% of Whites and 17% of Blacks. The percent of participating Hispanics was discouraging. The Cable News Network article also suggested that a main challenge for enrolling individuals is working with large numbers of Hispanics in border states like New Mexico, Texas, Arizona, and California. The U.S. Department of Health and Human Services, Office of Minority Health (2014) revealed that Hispanics have the highest uninsured rates of any ethnic group within the United States. The Office of Minority Health also suggested that Hispanics poor health could be attributed not only to lack of access to preventive care and the lack of health insurance but also language and cultural barriers.

The U.S. Department of Health and Human Services, Office of Minority Health (2014) suggested that “racial, ethnic minority, and minorities” groups represent about one-third of the nation’s population, but make up over half of the estimated 50 million Americans with no health care insurance coverage. In addition, when compared to other groups, Hispanics have the highest health disparities in areas such as pregnancy and birth outcomes (e.g., infant mortality and low birth rates), children’s health and development (e.g., obesity, oral health, suicidal ideation), and adult functioning (e.g., life expectancy, obesity, and diabetes mortality). For these reasons, underscored by the U.S. Department of Health & Human Services, health care insurance does matter for populations, particularly for Hispanics.

Those who are uninsured are less likely to have a usual source of care outside an emergency room visit; they often do not receive preventive care and often delay or forgo needed medical attention, their illnesses or injuries are more grievous resulting in a higher mortality rate than their counterparts who have insurance, and pay more for medical care.
(Bailey, 2012). ACA plays a vital role in diverse communities to abrogate preventable disease and injuries by providing an opportunity to obtain health care coverage. However Norteños must find effective ways of accessing these services to combat the overwhelming health disparities and inequities and achieve optimal health.

I specifically selected SMC because I have strong ties to this community. As a Hispanic from a reticent, rural community in northern New Mexico and a scholar in family studies, I have a keen interest in the topic of health care insurance and, more specifically, what has influenced and motivated Hispanics from SMC to enroll in the NMHIX. According to the NMHIX Outreach Director, SMC has been one of the areas with individuals who are the most averse to engage and enroll (personal communication, August 12, 2014). For this reason, the NMHIX is supportive of my study and believes that it will inform the NMHIX operations about developing strategies that will facilitate and increase the enlisting of individuals in the SMC and in similar communities across New Mexico.

**Importance of having health care insurance.** People who cannot afford to pay medical bills are often uninsured, miss more work and often die young (Kaiser Family Foundation, 2013b). Poor health is often endemic for people living in poverty. Without appropriate comprehensive health care the health status of “groups of color or persons of color” will continue to deteriorate (Kaiser Family Foundation, 2013b). Poverty exacerbates the extent of ability to be insured; (a) poverty results in fewer insured persons; (b) uninsured people get care that is uncompensated, and; (c) insured individuals pick up the cost of uncompensated medical care in the form of increased premiums and co-payments (Kaiser Family Foundation, 2013b). The view is that uninsured people increase uncompensated care cost (Coughlin, Holahm, Caswell, & McGrath, 2014). Uncompensated care cost can be
defined as cost shifting. Cost shifting is a method used by health care providers to make up for losses incurred in treating uninsured patients by charging higher prices to privately insured patients. Uncompensated expenditures are perceived as one of the reasons for the exorbitant cost of health care in the United States and the reason private insurances deny certain medical testing, premium medication and medical devices for patients (Coughlin et al., 2014). Nearly 375 New Mexicans die of treatable illnesses or injuries due to lack of access to adequate medical care (Wilper et al., 2009). Even when the uninsured have access to health care, they tend to have more severe health issues than those with health insurance (Hadley, 2003). This leads to high cost medical care and overcrowding of emergency rooms in hospitals. County indigent funds are limited and local taxpayers cannot keep up with the need to help pay medical bills for the uninsured. County indigent funds are used to offset health care costs for low-income or uninsured persons (New Mexico Center on Law and Poverty, 2015). The health care reform movement under the ACA may serve as a mechanism for counties having to carry the burden of health care costs for low-income and uninsured once everyone is covered under the ACA.

Rising health care costs are disabling to our nation on multiple fronts. For families and seniors, the soaring cost of medical care means less money in their pockets and forces hard choices about balancing food, housing, and health care. Those who are uninsured often face excessive medical bills after receiving care and are expected to pay out of pocket. Medical bills for the uninsured can quickly translate into staggering debt since most of the uninsured have low to moderate incomes and reduced savings. In addition, among those who are uninsured, as debt accumulates credit ratings drop. Compromised credit rating prohibits individuals from qualifying for many needs such as approval for housing or receiving a
reasonable interest rate for financing the purchase of a vehicle (Kaiser Family Foundation, 2013b). The ACA presents an opportunity to reduce the need for indigent funds, reduce health care costs for families and seniors, and provide affordable or free health care insurance for the uninsured. The proposed research will focus on identifying what has influenced and motivated Hispanics in SMC to enroll in the NMHIX.

Definition of Terms and Concepts

This section includes a discussion of the key concepts used in this study. These concepts serve to provide a context for the current research project and are defined according to their application to this study.

San Miguel County – San Miguel County will be used to reference SMC. SMC is located in the U.S. state of New Mexico. SMC was founded on January 9, 1852, and has an estimated population of 28,541 as of 2013. The county is 77% Hispanic or Latina/o and 56% of the households in this county speak a language other than English at home (U.S. Census Bureau, 2015).

Hispanic vs. Latina/o vs. Norteña/o – Hernández and Rodriguez y Gibson (2014) use the term Latina/o frequently to identify a Hispanic or Latina/o population (also see Gutiérrez (2011); González & Ballysingh, (2012). However, for the purpose of this research I am going to use the terms Hispanic or Norteña/o interchangeably. These are the terms with which my research participants from SMC identify.

Racial, Ethnic Minority and Minorities – The U.S. Government, U.S. Department of Health & Human Services, and affiliates describe racial and ethnic minority as Asian American, Black or African American, Hispanic or Latina/o, Native Hawaiian and Other Pacific Islander, and American Indian and Alaska Native.
Groups of Color or Persons of Color – These terms racially identify national origin group or national origin-based groups of color, and are used to include all persons of color who have immigrated to the United States. This would include Latinas/os who have not immigrated to the United States but who have been made part of this country through territorial expansion and conquest (Mexico), and colonization (Puerto Rico). See Michael A. Olivas, The Chronicles, My Grandfather's Stories, and Immigration Law: The Slave Traders As Racial History (1990). Also see Delgado Bernal (2002); Solórzano and Yosso (2002); López (2003); Valdes, McCristal Culp, and Harris (2002).

People Living in Poverty – In 2014, approximately 47 million people lived in poverty in the United States (U.S. Census Bureau, 2014b). The 2014 poverty rate was 2.3 percentage points higher than in 2007, the year before the 2008 recession. According to U.S. Census Data (2014b), the highest poverty rate by race is found among Blacks (26%), with Hispanics (of any race) having the second highest poverty rate (24%). Whites had a poverty rate of 10%, and while Asians had a poverty rate of 12%.

Federal Poverty Level – The phrases Federal Poverty Level or below poverty level refer to the Census Bureau poverty thresholds. Poverty thresholds are used for calculating all official poverty population statistics. These thresholds for poverty are located in Table 3 (U.S. Department of Health and Human Services, 2015c).
Table 3.

_U.S. Department of Health & Human Services – Poverty Guidelines_

<table>
<thead>
<tr>
<th>Persons in a Family Household</th>
<th>Income Guidelines</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>$11,770</td>
</tr>
<tr>
<td>2</td>
<td>$15,930</td>
</tr>
<tr>
<td>3</td>
<td>$20,090</td>
</tr>
<tr>
<td>4</td>
<td>$24,250</td>
</tr>
<tr>
<td>5</td>
<td>$28,410</td>
</tr>
<tr>
<td>6</td>
<td>$32,570</td>
</tr>
<tr>
<td>7</td>
<td>$36,730</td>
</tr>
<tr>
<td>8</td>
<td>$40,890</td>
</tr>
</tbody>
</table>

**Statement of the Problem**

Compared to national rates, New Mexico’s population is poorly educated. For instance, the percentage of New Mexico’s population with a high school diploma is 83% compared to 86% for the United States (U.S. Census Bureau, 2015). The rates for bachelor degree or higher are 26% for New Mexico compared to 29% for the United States (U.S. Census Bureau, 2015). New Mexico has a low median household income level compared to the national average, $44,927 and $53,046 respectively (U.S. Census Bureau, 2015). New Mexico has a higher proportion of persons below poverty level\(^4\) when compared to the national average, 20% and 15 % respectively (U.S. Census Bureau, 2015). New Mexico has a

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\(^4\) The Federal Poverty Level or below poverty level phrases refer to the Census Bureau poverty thresholds. Poverty thresholds are used for calculating all official poverty population statistics — for instance, figures on the number of Americans in poverty each year (U.S. Department of Health and Human Services, 2015).
higher proportion lacking health care insurance. New Mexico’s rate of population without health insurance coverage is 15% compared to 12% for the United States (Smith and Medalia, 2015). Inferior education attainment, poverty and lack of adequate health care are all factors related to New Mexico’s overall declining health status.

In New Mexico persons younger than 18 comprise 24% (506,725) of the population; those 65 and older make up 15% (306,537). The predominating group is between 18 and 64 years old and makes up 61%, and totals 1,272,025 individuals. New Mexico Norteño population is 47% compared to 17% in the United States; 36% of this population speaks a language other than English at home compared to the 20% nationwide (U.S. Census Bureau, 2015).

Historically, lack of health care insurance coverage has been a major problem for Hispanics who are substantially more likely to be uninsured than non-Hispanic Whites. Hispanics face a variety of financial and nonfinancial barriers to acquiring appropriate health insurance coverage, accessing care, and receiving timely care (Escarce & Kapur, 2006). Kaiser Family Foundation (2013c) data illustrates the disparity of coverage based on race and ethnicity. Fifty-seven percent of nonelderly Hispanics (age 0-64) is uninsured compared to only 18% non-Hispanic Whites in the same age group. ACA is a mean to reduce the inequity. Hispanic working adults are far more likely than whites to be uninsured, lack a primary care provider, and go without needed care because of cost (Hayes Riley, Radley, & McCarthy, 2015). I believe that more needs to be done to properly educate and enroll the Hispanic population on health care insurance responsibilities and benefits. In addition, an assessment on the efficacy of the information received by Hispanics should be initiated. It is critical that they understand the provisions in the NMHIX plan options. In view of the issue of
affordability and lack of access to health care insurance, the primary purpose of this qualitative study was to investigate the experiences and factors that have influenced and motivated Hispanics to enroll in the NMHIX program in SMC. Furthermore, this study served as an investigation of how Hispanics in SMC have benefited or not from having the NMHIX insurance. The results of this study lends an empirical body of knowledge to policy makers and the NMHIX Board of Directors on the approaches that influence, motivate, and engage a Hispanic population to enroll in the NMHIX.

**Objective of the Study**

This study (a) explored the chronicles of each participant relative to the topic of health insurance coverage, (b) investigated what methods of marketing and messaging had been most influential in motivating each participant to enroll in the NMHIX, (c) investigated the experiences of Hispanic individuals who had recently enrolled in the NMHIX, (d) explored what have been the implications, if any, of having the NMHIX health insurance coverage, and (e) conceptually explored what change(s) each participant would make to the NMHIX and to their personal life. In order to investigate how Hispanics experienced their enrollment in the NMHIX, I relied on the research questions that are stated explicitly in the following section.

**Research Questions**

The overriding question and aim of my research study was to identify what influenced and motivated Hispanics from SMC in Northern NM who have recently enrolled in the NMHIX. This research study also explored the following sub questions:

1. What experiences have Hispanics in SMC had in awareness of the NMHIX?
2. What messaging methods have been most relevant for Hispanics in SMC?
3. What are the experiences Hispanics in SMC had with the NMHIX?

4. How have Hispanics in SMC experienced the benefits of the NMHIX?

5. What motivates Hispanics in SMC to construct meaning and understanding of being required to have health insurance coverage?

6. Who or what influenced and motivated Hispanics in SMC to become aware of the NMHIX?

**Significance of the Study**

The innovation of universal health care coverage in America is relatively new. Therefore, there is limited research on consumers’ experiences, perceptions, and implications of the ACA. Nevertheless, a significant body of research exists on the benefits of having health care insurance (Bovbjerg & Hadley, 2007; Hadley, 2007; Hadley & Cunningham, 2004; Holahan & Spillman, 2002; McGinnis, Williams-Russo, & Knickman, 2002; Politzer et al., 2001). The current study explored the experiences of SMC Hispanics who have recently enrolled in the NMHIX in an effort to expand the understanding of what influences or motivates these individuals to enroll. The outcome of the study could clarify the reasons for enrolling and encourage the uninsured Hispanics to participate. Messaging of health care insurance enrollment and implications of having health insurance coverage were also examined to gain insight into how marketing strategies influence and motivate individuals to enroll. Utilization of insurance benefits was also examined.

Conclusions drawn from this study may increase the understanding of what newly enrolled health insurance owners want and need, and what educational support can be initiated in order to better serve them. These findings may also be utilized to explore outreach practices that encourage and assist enrollment and educate a new populace with health
insurance coverage. Additionally, the results of the study may facilitate ethnically and culturally sensitive changes when implementing plans for enrollment in health care insurance.

**Summary**

Chapter 1 provided a basic introduction to the research study, research context and background, definition of terms and concepts, statement of the problem, objective of the study, research questions, and significance of the research study.
Chapter II

Literature Review

This chapter reviews relevant literature for the proposed research study. Related areas of research were explored to provide a background and present the array of research that pertains to the proposed study. The literature review in this research study follows four major themes that are consistent with my research objectives. The first is a review of the literature on messaging and health messaging targeted at Norteños. The second is a review of the importance of the ACA and the NMHIX for Hispanics. The third is a review of access to health care for Norteños. The fourth is a review of the literature on having or not having health care insurance. This chapter concludes with an explanation of the chosen theoretical framework for this study.

Health Messaging

Elaborative processing is a practice that can be used to draw attention when targeting a health message. Elaborative processing involves conscious cognitive activities that include receiving information such as reading an insightful book, having a compelling conversation, seeing the unarguable results of scientific research, and visualizing (Chang, 2011). Self-referencing product advertising enhances persuasion for the receiver (Chang, 2011). Self-referencing advertisement or messaging products should personify the population and environment that advertisement or messaging is targeting.

The elaborative processing suggested by Chang is consistent with the high and low elaboration processes of the central and peripheral routes of the Elaboration Likelihood Model theory. Attitude change occurs in the central route when motivation and ability to think is high, whereas attitude change occurs in the peripheral route when motivation is low
or ability to process is hindered (Petty, Rucker, Bizer, & Cacioppo, 2004). Chang stated that health messaging fails because the messages draw boring responses from the audiences; this further suggests the importance of motivating people to apply mental effort to processing messages. People exposed to health messaging commonly ignore them, believing they are not vulnerable to risky behavior therefore the message is irrelevant (Leventhal, 1970). People are bombarded with prevention information such as methods to prevent human immunodeficiency virus and acquired immune deficiency syndrome and health hazards about drunk driving and cigarette smoking (Chang, 2011). Prevention information messaging should contemplate the intended target population (Chang, 2011). For example, messaging should include language and images that are representative of the community or the targeted population. Message receivers aim for an equilibrium between the time and effort that they devote and what they get in return when they process persuasive messages (Campbell, 1995). Therefore, health messaging and communication may be linked to race and ethnic inequities in health care.

Health disparities in health care outcomes are often related to miscommunication (Kreps, 2006). Sensitive, adaptive and strategic health communication programs and policies can help reduce the barriers that contribute to disparities and inequities in health care outcomes (Kreps, 2006). Messaging needs to incorporate careful and relevant communication channels for specific audiences (Kreps, 2006). Relevant health communication channels may include the use of trusted sources such as schools and churches (Hornik, 2001).
A 2013 brief from Latino Decisions\(^5\) revealed survey results from the National Latino Health Care Survey (Lilley, 2013) that are congruent with Hornik’s suggestions of trusted sources. The survey results suggest that 76% of Hispanics would be more likely to enroll in ACA coverage if a family member or friend encouraged them, followed by being advised by a Norteña/o doctors and mentored by Norteña/o teachers. Therefore, the ACA and Health Care exchange programs have to rethink their strategies to engage and educate the uninsured population of Norteños. The communication/messaging has to be congruent to the population in order to increase enrollment and reduce health disparities among the emerging Hispanic population (Clayman, Manganello, Viswanath, Hesse, & Arora, 2010).

Appropriate messaging is paramount for the success of getting the uninsured enrolled. Communities must explore methods to empower the uninsured with the proper tools and well-timed information to help them shop for and enroll in coverage that meets their needs (Stern, 2015). The ACA messaging should adequate delineate the penalty for not having health care coverage (Hope, 2014). Furthermore, Hope (2014) expresses that informing the uninsured about the penalty could serve as an impetus for many to enroll.

**ACA and the NMHIX**

The Affordable Care Act has indicated that one of the provisions of the Act was created to make health insurance coverage more affordable and accessible for millions of Americans (U.S. Center for Medicare and Medicaid Services, 2015). The ACA addresses inequities Hispanics often confront when accessing quality care and affordable health care coverage. Hispanics have one of the most disproportionately uninsured minority populations

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\(^5\) Latino Decisions is a Latino political opinion research organization. Latino Decisions is comprised of credentialed research scientists with established publication records, rigorous methodological training, and experience with large-scale collaborative research projects (Latino Decisions, 2015).
per capita (Majerol, Newkirk, & Garfield, 2015). These authors report that nearly 25% of the uninsured populations who are eligible for coverage through the ACA are Hispanic and in New Mexico, 15% of the Hispanic population is uninsured which represents one of the largest uninsured populations (Smith & Medalia, 2015). ACA makes private insurance more affordable, which expands coverage to millions that are currently uninsured.

The ACA was challenged at the highest court within the hierarchy of legal jurisdiction in the United States. The National Federation of Independent Business and the conservatives across the country challenged the constitutionality of the ACA in federal courts. On June 28, 2012, the Supreme Court handed down a 5 to 4 decision finding the ACA constitutional (Jost, 2012). Shortly after the ruling, New Mexico formed a task force to develop a proposal for creating a state-based health insurance exchange, now called the NMHIX. In a letter dated December 13, 2012, Governor Susana Martinez submitted a letter to Secretary of the U.S. Department of Health and Human Services, Kathleen Sebelius, advising the Secretary that New Mexico intended to operate a state-based exchange option to expand health insurance access to small businesses and individuals (Valdez & Sanchez, 2014). Following the letter to Secretary Sebelius, Governor Martinez signed into law Senate Bill 221 during the 2013 legislative session on March 28, 2013. Senate Bill 221 authorized the establishment of a state-run NMHIX (Valdez & Sanchez, 2014). NM’s uninsured population is approximately 425,900 (Kaiser Family Foundation, 2012). As of April 15, 2014, nearly 35,000 New Mexicans had enrolled into a qualified health plan offered through the NMHIX (NMHIX Press Release, 2014). The ACA provided the groundwork for the NMHIX option and now the state is challenged with informing and enrolling the uninsured into a qualified health plan.
Access to Health Care for Minority Populations

Socioeconomic factors play a large part for Hispanic populations in regard to accessing health care. A 2007 National Health Disparities report revealed that poverty, lack of insurance coverage, and ethnic minority status are predominant factors for creating inequity with access to and quality of health care. Racial/ethnic groups fall behind on employment, income, education, and possession of health care insurance when compared to Whites (Durden & Hummer, 2006). In addition, Spanish-speaking Hispanics who are at beginning stages of English language development lack the aptitude to communicate clearly with the staff at a physician’s office including the physician or nurse, which mitigates the comprehension of information and subsequent appropriate care (Askim-Lovseth & Aldana, 2010).

Hispanics are confronted with different health care barriers such as regular access to care, inability to pay, and cultural and institutional barriers (Giachello & Arrom, 1997). The researchers disclosed that children living in poverty, uninsured minority children and adolescents access public health care facilities or hospital outpatient clinics more frequently than children whose families are insured. Moreover, they are less likely to have the advantage of preventative care. It was also suggested that financial barriers include inadequate education coupled with low paying jobs or jobs that do not offer health care insurance. Health care institutions have cultural and institutional barriers that have created a lack of flexibility in meeting the needs of ethnic minority populations or people living in poverty (Giachello & Arrom, 1997). For example, staff, physicians and nurses in a health care facility may lack the knowledge of cultural practices, diets, languages, or age groups in order to be didactically sensitive. In a similar study regarding access to care and utilization of
services, Andersen, Lewis, Giachello, Aday, and Chiu (1981) revealed that the Hispanic population in Colorado, Texas, New Mexico, and California had lower levels of health care insurance and utilization of services when compared to the general population.

Patient satisfaction and quality of care can be improved by providing culturally and linguistically appropriate care (Torres, Parra-Medina, Bellinger, Johnson, & Probst, 2008). Hispanic communities develop social networks and share information regarding physicians who are bilingual and physicians who offer low-cost or charity care (Gresenz, Rogowski, & Escarce, 2009). These authors also discovered that portions of the Hispanic population that possess health care coverage are challenged by the inability to connect with hospitals, clinics, or physicians. For example, the ability of Hispanic women to obtain care depends largely on the connections that they establish with bilingual friends, who help them navigate the pathways to care, as well as with bilingual physicians, pharmacy clerks, and medical office administrative staff (Derose, 2000). Hispanics aim to build relationships and connections with their health care physician because they believe it will build culturally competent health care (Castro & Ruiz, 2009).

**Why People Have or Do Not Have Health Care Insurance**

A growing body of literature has clarified why individuals do not have health care coverage (Durdan & Hummer, 2006; Falen, 2004; Fronstin, 2007; Gabel, Hunt, & Kim 1998; Pauly & Percy 2000). One of the main reasons is that employers do not offer or the employee cannot afford to pay for coverage (Falen, 2004). Limited education hampers the ability of individuals to understand the importance of medical intervention and the nature of the medical-care system (Durden & Hummer, 2006). Higher incomes improve access to, and use of, the medical system because it allows individuals and families to pay for coverage or care.
Further, employment status not only influences income, but also increases the likelihood of having health care insurance through employment-sponsored benefits or private health care insurance (U.S. Department of Health and Human Services, 2011).

Insurance coverage greatly increases regular access to care (Starfield & Shi, 2004). Health care coverage status is a key variable in accessing routine and acute health care needs in the United States (Baldwin, 2003). The literature also supports that although many Americans have access to health care insurance, very few use the coverage for preventative care, often due to an inability to pay the copayment (Centers for Disease Control and Prevention, 2015). Healthy People 2020 report revealed that health care insurance coverage is important for health equity and for increasing the quality of a healthy life. Sufficient access to health care impacts overall physical, social, and mental health functioning. Individuals with health care coverage are able to more effectively prevent disease, detect and treat health conditions, have a better quality of life, and live longer (U.S. Department of Health and Human Services, 2015b).

The literature review suggests that there are challenges with access to health care for minority populations and for people who do not have health care insurance (Durden & Hummer, 2006; Starfield & Shi, 2004). In view of the current context of health care in the nation and New Mexico, the focus of my research is to address the following question: What or who has influenced and motivated Hispanics from SMC in northern New Mexico who have enrolled in the NMHIX? This overarching research question encapsulates the six sub-questions that were introduced in Chapter 1. In the next sections I discuss the theoretical framework I used for my study. I have selected a communication theory, Elaboration Likelihood Model (ELM), which fits in the broad scheme of social inquiry.
Theoretical Framework

This research study was achieved by using the hermeneutic phenomenological research methodology. Hermeneutic is a philosophy of interpretation where the interpretation of the text informs the meaning of the parts (Rennie, 2012). Hermeneutic is the interpretation of text or language by an observer (Sloan & Bowe, 2014). For example, a researcher who uses this approach is continually reflecting on his or her experience and how the position or experience relates to the issue being researched. Phenomenology is a method concerned with the description of the experiences of the participants (Creswell, 2013). Furthermore, the researcher suggests that the method aims to uncover the meaning of an individual’s experience based on a specific phenomenon that is grounded in everyday life.

Phenomenology is an approach to understand collectively the indefinable significance and essence of an experience (Grbich, 2007). Phenomenology is also described as the study of phenomena (Finlay, 2009). This methodology practices an unstructured interview approach. However, my research interviews will be semi-structured. Semi-structured interviews allow the interviewer and respondents to engage in a formal interview. The interviewer develops and uses an interview guide. The interviewer follows the guide, but is able to follow topical trajectories in the conversation that may stray from the guide when the researcher feels this is appropriate (Warren & Karner, 2005).

This study aims to understand people’s perception of health care insurance and the process of selecting, enrolling, and paying for health care coverage. The aim is to reveal the indefinable significance and the essence of what encourages and moves Hispanic individuals in SMC to enroll in the NMHIX. For these reasons, phenomenology will allow me to reveal
individual experience and how participants select health care coverage. In addition, this process will help uncover commonalities among participants.

   This hermeneutic phenomenology study was examined through the theoretical lens of the ELM. To shed light on the topic, the following overarching research question will be addressed: What influenced and motivated Hispanics from SMC in northern New Mexico who have recently enrolled in the NMHIX?

   Petty and Cacioppo (1986) developed the ELM theory in the mid-1970s. One of the basic tenets of the ELM is processing information. These processes are defined as the fundamental changes in attitudes, those variables that convince these processes, and the outcome of the decisions resulting from these processes (Petty et al., 2004). Furthermore, the ELM suggests that any one variable can influence persuasion by only one process. The one variable that influences persuasion can work to either increase or decrease persuasion. Another tenet of the ELM is defined as the elaboration continuum. An elaboration continuum can involve different degrees of thinking and processing for the receiver of the message. For example, every person is unique and has different motivational and ability factors. The continuum also has many variables such as high and low participation and external distraction for the individual receiving the message (Petty & Brinol, 2012).

   Researchers in the areas of health messaging, smoking, substance abuse, sexually transmitted diseases, acquired immune deficiency syndrome, condom use, and many more capacities regarding health promotion messaging have heavily applied the ELM framework. For example, Salovey, Bibace, Laird, Noller, and Valsiner (2005) applied the ELM framework to explore the topic of psychologically tailoring and framing messages about health care. This framework has been used to investigate increased attention for computer-
tailed health care communications and has been applied to explore the effect of message
quality and congruency on perception of tailored health care communication (Ruiter, Kessels,
Jansma, & Brug, 2006; Updegraff, Sherman, Luyster, & Mann, 2007). In line with these
studies, the ELM theoretical framework will be appropriate to explore my research interest
regarding who or what influenced and motivated individuals to enroll in the NMHIX.

The elaboration continuum is a person’s motivation and ability to think, assess, and
extract value from issue-relevant information being presented in the persuasion context
(Petty et al., 2004). The ELM theory submits that persuasion can be examined through two
routes. These routes are termed the central and peripheral. More specifically, these two routes
thrive at the core of the elaboration continuum where there is change in attitude. The attitude
change at the central route occurs when an individual scrutinizes all the information made
available on an issue (Petty et al., 2004). This route, known as high-elaboration processes,
requires considerable effort and thought to reach a decision. The attitude change at the
peripheral route occurs when an individual has low involvement. For example, an individual
may receive information on a given issue that has little importance to the person. Another
example includes an individual who is receiving information and the ability to process the
information is hindered by interruption (e.g., cell phone rings, crying child, and multiple
people talking at once). The central route has two spectrums, a central favorable attitude
change and a central unfavorable attitude change (Petty, Kasmer, Haugtvedt, & Cacioppo,
1987). Both of these spectrums involve high-elaboration processes. For example, where your
grandfather discovered an idea or product and 40 years later you’re a beneficiary of his
invention and operating the family business, and you are required to pay state and federal
business taxes. You understand the reason of having to pay taxes but you may not agree. This represents the central unfavorable attitude.

Unlike the central route where the individual scrutinizes all the information made available on an issue, at the peripheral route the individual will scrutinize only one or two pieces of information instead of all the information made available. This route is known as \textit{low-elaboration processes} (Petty et al., 2004)

When attitude changes as a result of a high amount of information processing on an issue, individuals are said to follow the central route. Whereas, when attitude changes as a result of low amounts of information processing on an issue, individuals are said to follow the peripheral route. The implication of this theoretical framework will help demonstrate the impactful approaches that influenced and motivated individuals to enroll in the NMHIX. This framework can help shape suggestions on how to improve health care insurance messages. There is a narrow body of literature that exists on the ACA messaging regarding what influences and motivates Hispanics to enroll in health insurance.

There are two major tenets of the ELM theory that are relevant to my research objectives. The first is persuasion and how persuasion differs across individuals and situations (Petty et al., 2004). The concept of persuasion is relevant for my research objective in understanding what or who influenced and motivated (persuaded) Hispanics in SMC to enroll in the NMHIX. The second is that not all attitude changes of the same degree are equal. For example, when two individuals are hesitant to enroll in the NMHIX, both are listening to a guest speaker on the topic of “benefits of enrolling in the NMHIX”, the two individuals may enroll (attitude change) but the point of getting to the enrollment stage may vary between both persons (Petty et al., 2004).
The ELM model defines two routes that lead to attitude change (Petty et al., 2004). One route is the central route. This route involves high elaboration and forms long-term attitude changes. The second is the peripheral route, which involves low elaboration and forms short-term attitude changes. A visual representation of the ELM model is presented in Appendix A. The dissimilarity is that one is long-term and the other is a short-term attitude change. The concepts of central and peripheral routes are relevant for my research objectives in order to construct meaning and understanding of the requirement for health care insurance. Hispanics in SMC who have had an attitude change and constructed meaning of the NMHIX via the peripheral route may not have all the necessary information to fully benefit from the insurance. For example, a user of the NMHIX may not fully understand the payment of a monthly premium, the required co-payment when visiting a physician’s office, co-payment for prescription drugs or meeting a deductible. Additionally, if the monthly premiums are not paid, a penalty will be assessed at the end of the year on the federal income tax return.

Making an attitude change by the peripheral route may have some unintended consequences for those persons.

Summary

This chapter presented an exhaustive appraisal of the literature and provided the grounding for my research study. A summary of information pertaining to health messaging, ACA and the NMHIX, access to health care for minority population, and why people have or do not have health care insurance are topics addressed in an effort to shed light on health care coverage enrollment for a Hispanic/Latina/o population. Based on the limited available research inquiry on the topic of the uses of the ACA and the NMHIX, the study sought to contribute knowledge in this area. In addition, this chapter described the theoretical
framework that provided a parallel to the framework of my research study. The ELM model I selected for my research study, as described above, played an important role in guiding the entire process of my study. The next chapter presents a detailed description of the research methodology used in my research study.
Chapter III
Research Design Methodology

Qualitative Research Design

This chapter includes a detailed description of the research methodology that was applied in my research. This chapter is organized in seven sections that provides context in unfolding the research design. The sections contained in this chapter are: (a) the paradigm and research approach, (b) my role as the researcher, (c) bracketing, (d) unique contribution, (e) research method, (f) data analysis procedures, (g) trustworthiness of the research, and (h) summary. I am emphasizing my role as the researcher and my unique contributions to my research. This chapter will elaborate the main sections and provide the connections to the research design methodology for this study.

Qualitative research has been defined in a variety of ways. In one definition, Rossman and Rallis (2012) it as:

Qualitative research refers to any type of research that seeks to answer questions in the real world. Qualitative research can refer to research about persons’ lives, lived experiences, behavior emotions, and feelings as well as seeks to understand the culture of people or settings. (p. 92)

There are four major genres in this inquiry: (a) ethnographies, (b) phenomenological studies, (c) sociocommunication studies, and (d) case studies (Rossman & Rallis, 2012). Qualitative inquiry also involves various designs such as narrative approach, case study, grounded theory, phenomenology, and participatory action research (Creswell, Hanson, Clark, & Morales, 2007). Several of the best “how to guides” on formulating qualitative research comes from a body of scholars and these scholars provide methodology guides that
place emphasis on gaining greater understanding of how to carry out research enabling informed judgments on quality (Corbin & Strauss, 2008; Denzin & Lincoln, 2011; Guba & Lincoln, 1994; Lincoln & Guba, 1985). The interview is the most common method of data gathering in qualitative research and a flexible data collection methodology that allows participants to express their views more openly than would be possible in a questionnaire or survey (Flick, 2009; Kvale & Brinkmann, 2009). These researchers add that there is a range of approaches to interviewing such as in-depth, exploratory, semistructured, or unstructured. Consistent with these authors this research study adopted the in-depth interview methodology.

**Paradigm and Research Approach**

A paradigm can be defined as a belief system or worldview that guides the researcher (Guba & Lincoln, 1994). Paradigms include positivism, postpositivism, constructivism interpretivism, critical theory, participatory, and pragmatism. For this study, the interpretivist paradigm was adopted. This paradigm supports a hermeneutical approach, which argues that meaning is covert and must be brought to the surface through reflection (Ponterotto, 2005). Interviewing through a semi-structured approach can initiate reflection by interactive researcher and participant dialogue.

Qualitative inquiry encompasses emic and etic perspectives. Etic perspective examines behavior from outside a specific system and emic perspective is a study that examines behavior from inside a specific system (Olive, 2014). For the purposes of my research study the emic perspective was assumed. The emic is a perspective that represents the inside of a system or institution (Merriam, 2009). For example, a researcher may study the adoption of a policy in an entire institution or a unit of the institution or one particular
program of the institution or a small group of individuals within the institution who share common characteristics. Consistent with Merriam (2009), the interpretivist and emic approach was the appropriate combination adopted for my research study.

**My Role as the Researcher**

As a researcher, my role was multifaceted. Beginning with recognizing a topic that would be equally meaningful and invigorating, formulating appropriate research questions, and developing a comprehensive research strategy was thought provoking. In addition, as I entered the data collection stage I needed to reduce potential personal biases. Objectivity with room for reflective interpretation was at the forefront of my conscious mind as I entered each stage of interviews. I had to be mindful of not allowing my personal biases to influence participant responses. In an effort to clarify my preferences and ideas, I included a reflection and discussion of my personal beliefs as they relate to my research topic. The following section includes a presentation of my personal belief, feeling, and expectation.

**My Personal Belief, Feeling and Expectation – Bracketing**

The phenomenological design contains the tenant of bracketing. Bracketing is a process the researcher incorporates by taking into consideration his or her own beliefs and feelings; identifying what he or she expects to discover; then deliberately putting those ideas aside (Tufford & Newman, 2010). In order for the research design to be effective the researcher must acknowledge this bracketing.

This notion of bracketing was challenging. My attempt to study this particular subject matter was grounded on what I have experienced, heard, and seen amid my community. My personal belief and feeling is that everyone should be provided health care insurance coverage that is affordable, accessible, and deliberate. I expected to discover that by
examining a population that never had health care insurance coverage and is now mandated
to have coverage, I expected to discover a communal lack of understanding of the benefits of
the insurance. The following section includes a presentation of my unique contribution.

**Unique Contribution**

My research interest stems from personal experience growing up and not having
health care insurance coverage regularly. I witnessed at a young age that well-child health
exams and preventive health care were not routine in my life. My family experienced hard
times (*tiempos duros*) and many challenges due to my parents’ minimal education,
unemployment or underemployment, and meager income, which fueled our family poverty.
Instead of resigning myself to poverty I identified with “*mi abuelita*” (my grandma) who was
a *curandera* (midwife), *hierbera* (herbalist), and *sobadora* (folk chiropractor). I respectfully
considered *mi abuelita* my pediatric nurse and physician from infancy through school age
and into my adolescent years. Oddly, even when I had those rare moments of access to health
care, via health care insurance coverage, the care was never like the incredible care *mi
abuelita* provided me. Similarly, many times preventative oral care was delayed until an
emergency surfaced that was often more costly for my parents. I am particularly passionate
about gaining an understanding of how a Norteña/o has accessed health care insurance
coverage. Thus, understanding what or who has influenced and motivated Hispanics to enroll
in the ACA is imperative as New Mexico and the rest of the country advances health care
coverage for more of the uninsured.

I am aware of the struggles that Norteñas/os have had with an inability to afford,
access, and understand the importance of preventive health care. As a Norteño, I feel strongly
about the role of having health care insurance coverage in my life and I believe that having
health care insurance coverage allows for a sense of safety and security. Maslow’s (1943) hierarchy of needs outlines five motivational needs, often depicted as the hierarchical levels within a pyramid. The five needs are psychological, safety, social, esteem and self-actualization. Maslow believed that people are motivated to achieve certain needs and when one need is fulfilled they seek to fulfill the next higher level of needs. I know that the Norteña/o population faces a variety of challenges when having to decide whether to purchase health care insurance coverage or provide basic needs for the household. These challenges become even more notable to people living in poverty and low-income individuals. The safety and security needs illustrated in Maslow’s hierarchy are overshadowed by the fundamental physiological needs of food and shelter.

Early in my life, experiences taught me the importance of health care and that it would be a motivating dynamic in my life. I realized that having a healthy lifestyle coupled with health care access would allow me to advance my life in a healthy and productive manner. I am a strong believer that with a strong mind (e.g., continually advancing in academics), body (e.g., living a healthy lifestyle, exercising, eating healthy, and having preventative health care), and soul (e.g., nourishing my soul with the word of the Lord and practicing my religion) anything is possible to achieve in life when you have a poised mind, body, and soul.

My investment as a researcher and working in the field of health sciences is to advocate for an increase in health care providers that are representative of communities. My aim is to decrease health disparities among the Hispanic population in New Mexico. I am currently a member of the New Mexico Health Workforce Committee at the University of New Mexico Health Sciences Center (UNM HSC). This committee continuously analyzes
the needs for the current and future health care workforce of New Mexico. I have been instrumental in helping to secure $1.6 million dollars in legislative funding for UNM HSC to address the lack of primary care providers for New Mexico. Additionally, I am part of a team that organizes pipeline program opportunities for New Mexico mid-school and high school students. These pipeline programs are targeted at Hispanic, Mexican, African American, and American Indian/Alaskan Native high school students with the intent of engaging these students in a health care profession career path. The aim of the pipeline program is to increase a more diverse medical workforce that is reflective of New Mexico communities. Through my efforts I am hoping to reduce health disparities among the Hispanic population and increase health equity for New Mexicans.

In light of the philosophy of hermeneutic phenomenology, my research design required me to conduct in-depth individual interviews. Hermeneutic phenomenology studies seek to go beyond description in order to discover meanings that are not immediately apparent (Merleau-Ponty, 2006). Hermeneutics can be described as an individual expressed engagement with the world (Packer, 2011). More specifically, the focus is on the lived experiences of the research participants’ understanding of a concept or phenomenon (e.g., the participants’ experiences that influenced and motivated individuals to enroll in the NMHIX). A key characteristic of hermeneutics is the art of interpretation (Kakkori, 2009).

Phenomenology is unequivocally the study of lived experience and the emphasis is on the world as lived by a person (Sloan & Bowe, 2014). My research stimulated a need to understand what influenced and motivated individuals in SMC to enroll in the NMHIX. I was captivated and inspired by Martin Heidegger’s existential school of phenomenology with its ontological focus (Heidegger, 2000). Ontology is the belief about the nurture of reality and
humanity – what real world truth is (Tuli, 2010). The research method that I employed included iterative interview (semi-structured and open-ended interviews), field notes, personal periodic spot transcription of data, and member check-ins. Triangulation of these methods provided a fuller understanding of how Hispanic individuals in SMC reached the point of enrolling in the NMHIX. Furthermore, these methods were useful in gathering data to determine current attitudes of having health care insurance coverage, particularly influences and motivation.

**Methods**

**Sample.** The targeted sample was those SMC participants who met the following stated criteria:

a) Between the ages of 18 and 64,

b) Hispanic/Latina/o,

c) Resident of San Miguel County,

d) Recently enrolled, within the past 2-years, in the New Mexico Health Insurance Exchange.

**Participants.** My study population was comprised of nine participants. The nine participants’ household characteristics included: four single workers, four dual-workers, and one post retiree, all lower income families with no children in the home. I was particularly interested in examining the influence and motivation of Hispanics as some recent literature suggests that Hispanic families are more influenced and motivated through established and trusted organizations and people (Kaiser Family Foundation, 2013a; Maurana & Rodney, 2000; Ortega, Rodriguez, & Vargas Bustamante, 2015; Valdez & de Posada, 2006). Since I was intrigued by the possibility that trusted sources could be a key variable in providing the
necessary impetus for a Hispanic audience to enroll in the NMHIX, and because trusted sources also crosscut socioeconomics, race/ethnicity, and similar lived experiences, I decided to select a sample that was only Hispanic. This would allow me to determine if there were important consistencies among my participants. I selected my participants to establish a diverse age group and gender representation. Although I accomplished a diverse age group, I found that the Hispanic male population in northern New Mexico was extremely difficult to recruit. Scholars have revealed that Hispanic men are less likely to participate in health related research studies (Gonzalez-Guara, Ortega, Vasquez, & De Santos, 2010; Wells, Klap, Koike, & Sherbourne, 2001).

My participant analysis included the following: two females in their 40’s, three female and one male, in their 50’s, and three females and one male, in their early 60’s (see Table 3). The table illustrates a participant pool from low-income family backgrounds. It is a mixture of single, married, and single with adult children and grandchild in household. The education levels of these participants are consistent with the 2010-2012 U.S. Census Bureau American Community Survey results. Nearly 20% of the participants have Bachelor’s degrees compared to the state’s 26% and the overall SMC 12%. In addition, four other participants from the study have a high school diploma with some college credit. All participants’ names in Table 4 are pseudonyms.
Table 4:

*Participant Demographic Summary*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Marital Status</th>
<th>Age</th>
<th>Income Per Year</th>
<th>Family Size</th>
<th>Highest Level of Education</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carlos</td>
<td>M</td>
<td>63</td>
<td>$30,000+</td>
<td>2</td>
<td>High School Diploma + College courses</td>
<td>Retired</td>
</tr>
<tr>
<td>Elena</td>
<td>S</td>
<td>60</td>
<td>$24,000 or less</td>
<td>1</td>
<td>High School Grade 11</td>
<td>Home Health Aide</td>
</tr>
<tr>
<td>Carmela</td>
<td>S</td>
<td>44</td>
<td>$20,001-$29,999</td>
<td>1 + two adult daughters</td>
<td>High School Diploma + College courses</td>
<td>Certified Nursing Assistant</td>
</tr>
<tr>
<td>Jesus</td>
<td>M</td>
<td>59</td>
<td>$30,000+</td>
<td>2 + one adult daughter part-time</td>
<td>High School Diploma + College courses</td>
<td>Delivery Driver</td>
</tr>
<tr>
<td>Isabel</td>
<td>M</td>
<td>61</td>
<td>$20,001-$29,999</td>
<td>2 + one adult son with a daughter</td>
<td>High School Grade 11</td>
<td>Patient Care Assistant</td>
</tr>
<tr>
<td>Maria</td>
<td>S</td>
<td>57</td>
<td>$24,000 or less</td>
<td>1 + one granddaughter part-time</td>
<td>Bachelor &amp; Associates Degree</td>
<td>Certified Nursing Assistant</td>
</tr>
<tr>
<td>Sara</td>
<td>S</td>
<td>62</td>
<td>$20,001-$29,999</td>
<td>1</td>
<td>Bachelor Degree</td>
<td>Medical Technologist</td>
</tr>
<tr>
<td>Luisa</td>
<td>S</td>
<td>48</td>
<td>$20,001-$29,999</td>
<td>1 + one adult son</td>
<td>High School Diploma</td>
<td>Home Health Aide</td>
</tr>
<tr>
<td>Teresa</td>
<td>S</td>
<td>53</td>
<td>$20,001-$29,999</td>
<td>1 + one adult son</td>
<td>High School Diploma + College courses</td>
<td>County Scale Operator</td>
</tr>
</tbody>
</table>

Typically small sample sizes are used in qualitative research (Boyd, 2001; Creswell, 2014; Green & Thorogood, 2009; Groenewald, 2004). In view of this qualitative study nine
participants were adequate. However, the guiding principal for qualitative research is the concept of saturation. Saturation is a form of reaching a point of no new data (Fusch & Ness, 2015). Saturation can also be described as a concept that transpires when the collection of new data does not shed further light on the issue under investigation (Given, 2008). The number of participants needed for a study depends on the nature of the research and how many are needed to answer the research questions (Bowen, 2008).

The nine participants were all residents of SMC. Participants included both men and women between the ages of 40’s to 60’s. All but one participant in my study were employed halftime (20 hours per week or greater) or fulltime (40 hours per week or greater) and their employers did not offer health care insurance or was offering health care insurance under the NMHIX options. I also had one retiree participate in my study who had obtained health care insurance coverage under the NMHIX options.

In my estimation the participants were representative of a cross-section of SMC. This representation was achieved through multiple recruitment strategies. The participants came from a variety of household makeups such as married and unmarried, and single income and dual income households. Although the aim was not to exclude households with children, my participant pool only included households with adult children living full-time and part-time in the home. In view of the socioeconomic context of SMC, a majority of the population is low income. However, in order to get to the basis of my question, I did not recruit participants from households that were below the federal poverty low-income levels. Individuals from households below the federal poverty/low-income levels qualify under regular Medicaid or the expansion of Medicaid making them eligible for free health care insurance coverage. The nine participants in my study came from households with low-to-
median or higher income levels. Individuals with incomes above the federal poverty low-income guidelines are not eligible for Medicaid and are required to have health care insurance coverage under the ACA. For example, a family household of 4-persons earning more than $23,850, or a family household of 2-persons earning more than $15,730 are required to purchase their own health care insurance (U.S. Department of Health and Human Services, 2015a). In essence, these populations that fall above the poverty guideline thresholds are required under the ACA to enroll in a health care insurance option.

**Recruitment and procedures.** The participant sample was by means of convenience sampling process. This selection process was based on accessibility, ease, speed, and low cost (Koerber & McMichael, 2008). I enlisted participants from four settings. The settings included churches and worship homes, City of Las Vegas Abe Montoya Recreation Center, Luna Community College and New Mexico Highlands University. The final site included El Centro Family Health Clinic and Alta Vista Regional Hospital, two local health care facilities. In order to obtain access into these spaces and places, I contacted and/or visited these locations and received an in-person verbal or electronic mail permission to recruit from each of the above-mentioned locations. The recruitment effort at these locations consisted of posting my research study recruitment flier. This effort occurred once per week for three consecutive weeks. In addition, I purchased two separate recruitment advertisement announcements in the Las Vegas Daily Optic which is a small newspaper circulated three-times per week in the SMC.

Recruitment from churches was of particular interest because of my personal attachment to my spiritual side. Information from the Gallup Poll indicates that 43% of the American population attends church 46% of the Hispanic subgroup attends church frequently
(Newport, 2013). The SMC churches and worship homes are diversified in religious
denomination, including two Roman Catholic Churches, one Baptist Church, one
Presbyterian Church, one Mennonite Church, one non-denominational Cornerstone Church,
and one Church of Christ. By attending the masses or worship sessions at different times over
the course of three weekends I was able to enlist interest from three potential participants. I
requested permission from church leaders to allow me to either stand at the pulpit to
introduce myself or to provide a short written announcement in their weekly bulletins. Two
of the local churches allowed me to submit a short announcement in their weekly bulletins,
which was for a full-weekend at all of their masses.

The other areas of recruitment attracted a variety of individuals, for example. The
City of Las Vegas Abe Montoya Recreation Center provides families in the SMC an outlet
for wellness/fitness, leisure swimming, skateboarding park, and senior/adult and youth
programs. Luna Community College and New Mexico Highlands University and the medical
and dental practices attract all demographic of individuals.

Recruitment often became a time consuming effort. Employing my network of
colleagues, I was able to create a contact with the Chief Executive Officer at El Centro
Family Health in Española, New Mexico. The Chief Executive Officer connected me with
the local Office Manager at El Centro Family Health in the SMC. The Office Manager
worked with a network of individuals from the SMC telephoning several individuals and
telling them about my research study; in addition the Office Manager provided them my
contact information so they could call me if they would be interested in participating. The
effort from the Office Manager established four qualified participants. Two participants were
established by instituting the snowball recruitment effort, while the remaining three
participants came from my multiple efforts of outreach in the community. Snowballing is a referral process where a study participant suggests other potential eligible individuals for the study (Patton, 2015). This process is typically utilized with hard to reach individuals.

Participants were given a $25 gift card for each interview they provided in an effort to thank them for their participation and offset any out-of-pocket costs they incurred such as gas, parking, senior care, pet care, etc. These incentives were in the form of a Visa card valued at $25 for each interview meeting scheduled per participant.

**Participant selection and establishing contact.** The selection process would begin at the moment of receiving a phone call from a potential participant. This initial step would involve a brief phone interview to qualify the participant based on the four criteria (age, ethnicity, county of residency, and enrollment in the NMHIX). Once a participant was qualified, I ascertained the participant’s willingness to meet in person, commit to meet with me multiple times and to be interviewed and audio-recorded.

Once a commitment to meet was established, I would request the participant provide me with a preference of days and times to meet. To assure participant accessibility, transportation would be offered or the meeting would be set in a place that was the participant’s preference. An initial meeting place, time and date would be established for the convenience of the participant. With sensitivity for minimizing distractions, rooms would be reserved at the SMC El Centro Family Health facility and New Mexico Highlands University, Dean of Students Office or Thomas C. Donnelly Library.

In preparation for interviews, I developed a checklist in my reflexive journal to ensure ease of initial contact for both the participant and myself. The day prior to the interview I would confirm the following: consent forms, interview protocols, reflexive journal for note
taking, and audio-recorder with back up batteries, and secured interview space. All the participants selected to meet at a coffee shop or at their homes. Nevertheless, a back-up location was always secured in the event a participant decided not to meet at a coffee shop or at their home. In addition, I would call the participant the day before meeting to confirm location and time and would also ask participant if he or she would prefer a reminder phone call one-hour before the interview was to take place.

Initiating the first in-person contact began by introducing myself. The procedures continued as follows:

1. Orally reviewed the purpose of the study.
2. Provide the consent form to the participant and allow enough time to read it.
3. Read the consent for aloud to the participant, allow time for questions or concerns.
4. Verify the participant’s commitment to participate by signing the consent form.
5. The initial interview with protocol #1 would then commence.

**Data collection and in-depth semi-structured interviews.** For the purposes of my research, I adopted in-depth individual interviews as the primary method of qualitative data collection. To gain a detailed description of participants’ influence and motivation to enroll in the NMHIX, I conducted two individual interviews, each lasting between 20 minutes and 55 minutes. The specific protocols that consist of the questions explored are included in Appendix C. I created four different semi-structured interview protocols for this research study. Because Spanish is the less spoken language in SMC, interviews were conducted in the predominant language, English.

Following the hermeneutic phenomenological research methodology approach, I used semi-structured iterative interviews. This semi-structure interview design was used to
uncover an emic view (inductive or insider view) to collect data. This approach helped me construct accounts and descriptions expressed in terms of the individual member of the culture whose beliefs and behaviors were being studied (Olive, 2014). The emic approach allowed me to ignore prior theories and assumption and more fully allow the participant and data to evolve into themes and patterns (Olive, 2014).

Qualitative inquiry suggests a three-prong approach in reviewing interviews (Seidman, 2006). The participant and researcher have the opportunity to elaborate and/or clarify questions from the first interview during the iterative process (Knox & Burkard, 2009). The first interview is focused on a participant’s life history regarding the subject matter. The second meeting allows participants to share their experience in regard to the subject and the final meeting allows participants to consider the meaning of their experience in the area of the subject (Seidman, 2006). Following Seidman, I adopted a two-prong approach to review my results.

The initial interview included questions from protocol #1 (Appendix C) that intended to uncover socioeconomic and demographic information and reveal participants’ personal life history, relative to health care insurance coverage, past to present. This discussion also involved questions from protocol #2 (Appendix C) that proposed to discover what messaging and marketing participants have received that may have led them to enroll in the NMHIX.

The second interview would begin with a participant check-in. This check-in process was used to follow up with my participant and clarify any incomplete information or answer any questions from the first conversation. This second discussion included questions from protocol #3 (Appendix C) that proposed to allow participants to consider the meaning of their experience regarding the enrollment in the NMHIX. The final interview protocol #4
(Appendix C) intended to allow participants to use their conceptual opinion. For example, if you had the authority or power to change anything, what would that change be, and why? Also, if you had the power to change anything in your life, what would that be, and why? Similar to the first discussion, I exited the meeting space and would find a café to reflect, review my field notes, and jot down additional impressions or thoughts into my reflexive journal. Then, audio recording would be submitted to a transcription service for transcribing.

**Data Analysis Procedures**

Qualitative studies offer techniques for data analysis. In line with data analysis techniques in qualitative research, I used processes as coding, categorizing, and making sense of the essential meaning of the topic of study (Creswell, 2014). In particular, I adopted the following data analysis steps for my research study. These steps come from a blend of techniques adapted from Denzin and Lincoln (2011), Ellingson (2009), Hesse-Biber and Leavy (2008), Packer (2011), Pascale (2011), Miles, Huberman, and Saldana (2014), and Moustakas (1994). The first step I used was *horizontalization*, also known as *horizontalization* or *horizon*. A horizon can be thought of as a perspective, or way of seeing the world (Moustakas, 1994). An in-depth review of interview transcriptions took place to better understand how the participants experienced the phenomenon of enrolling in health care coverage for the first time. Next, I developed *clusters of meaning* from the significant statements, sentences, or quotes into themes. The significant portions are then used to narrate a description of what the participants experienced and how it induced the phenomenon (Moustakas, 1994). Finally, I wrote about my own experiences and the contexts and situations that have influenced them (Moustakas, 1994). This final step was articulated in the unique contribution section of this manuscript.
Overall, the data analysis techniques followed Creswell’s (2014) six-step data analysis techniques in conjunction with an organizational model created by Miles et al. (2014). The model includes collecting data, data reduction, data display, and conclusion drawing and verification.

**Data collection.** Data was collected through the interview process. The data collections tools used to record data included note jotting on the protocol hard copy, audio recorder, and reflexive journal.

**Data reduction.** Two parameters were used in data reduction: (a) organization and preparation for analysis, and (b) reviewing the data. The process of data reduction involves selecting, focusing, simplifying, abstracting and transforming data from resources that synthesize post interview evidence (Creswell, 2014; Miles et al., 2014). To accomplish this phase of data reduction, I read and re-read the interview transcriptions and my entire note taking techniques while searching for evolving themes and patterns among participants.

For the purposes of my research study I adopted NVivo 11 to streamline the data analysis. NVivo 11 is a qualitative data analysis computer software package. This program has been designed for qualitative researchers working with very rich text-based and multimedia information, where deep levels of analysis on small or large volumes of data are required. Nine interviews were imported into NVivo 11. Each line was read and coded to five parent nodes (nodes refer to categories). The five parent nodes are: socioeconomic-personal history, messaging-marketing, reflection on experience, conceptual, and current health care plan. In addition 289 subcategories were created as content from the five parent nodes. The complete node listing is in Appendix F of this manuscript.
**Data display.** The data display level is described as the second element of Miles et al. (2014) model of qualitative data analysis. In this level I organized data and discerned patterns and similarities from the text and graphics. In step three I coded my data. I categorized the participants and themes from the codes. Following Miles et al. (2014), I organized my data by implementing matrices and networks. These are defined as follows:

1. **Matrices**, display defined rows and columns of coded data that are organized according to themes (Miles et al., 2014).

2. **Networks**, display a series of nodes (categories) with links (lines and arrows) between them. Networks are charts representing data in a symbolic method (Miles et al., 2014).

Procedures used to present the data innately emerged from the research questions and concepts.

**Conclusion drawing and verification.** The final level of qualitative data analysis involved drawing conclusions and validation of my data (Miles et al., 2014). During this level I revisited the data and crosschecked to verify the emergent concepts. Next, I tested for credibility and confirmability of my emergent concept to establish validity (Miles et al. 2014). Conclusion drawing and verification is similar to Creswell’s (2014) data analysis techniques steps five and six. In step five I presented the themes in narrative form. I proposed an interpretation of the findings in step six.

**Trustworthiness of Results**

Trustworthiness is a necessity for establishing rigor in qualitative research. Equally, validity is a process that is necessary for establishing appropriateness, meaningfulness and usefulness of a quantitative research. Strategies to achieve trustworthiness include peer
debriefing, prolonged engagement and persistent observation, audit trails and member check-ins (Schwandt, Lincoln, & Guba, 2007). These authors suggest that evaluating the research results is necessary to accomplish trustworthiness. In order to demonstrate trustworthiness, I adopted the following four foundations: credibility, transferability, dependability, and confirmability (Schwandt et al., 2007).

**Credibility.** Credibility is as necessary for establishing trustworthiness in qualitative research as internal validity is to quantitative research. Having a familiarity with the culture of participants is a component of credibility. Prolonged engagement or a broad understanding of the community is an important component when constructing credibility (Schwandt et al., 2007; Erlandson, Harris, Skipper, & Allen, 1993). Being a native from northern New Mexican, I embrace a broad understanding of the population and the community at large in SMC. Research results were examined by the basis of three questions: (a) Do the conclusions make sense? (b) Do the conclusions adequately describe the research participant perspectives? (c) Do conclusions accurately represent the phenomena being studied? (Schwandt et al., 2007). I relied on triangulation among different sources of data to attain credibility. Triangulation of data included referencing field notes, reflexive journal, personal periodic spot transcription of data, peer debriefing and participant check-in. In addition, I consulted with an expert in the field of the NMHIX from northern New Mexico as an alternate source of data.

The field notes and reflexive journal were used throughout my research and were filled with rich data. The purpose of the field notes was to allow me to jot down impressions, quick thoughts, phrases, and jargon used during the interview. The field notes were written on the hard copies of the protocols. The reflexive journal was used during the recruitment
phase of my research, as I met with organizations and business. In addition, the reflexive journal was used most frequently during post-interviews to jot down new ideas regarding different approaches to rephrasing questions, and highlighting cogent phrases, themes and significant responses from the interview.

**Transferability.** Transferability is as necessary for establishing trustworthiness in qualitative research as external validity is to quantitative research. Thick description is a technique used to attain transferability. Thick description is a method of unfolding a phenomenon in sufficient detail that one can begin to assess the degree to which the inferences drawn are transferable to other times, settings, situations, and people (Schwandt et al., 2007). By providing sufficient detail and content, readers may draw their own conclusion whether or not the information provided in this research study is transferable to other settings. I was able to construct thick description to support transferability of findings by examining my field notes, reflexive journal, and my detailed log that included activities and contacts acquired during my fieldwork in SMC.

**Dependability.** Dependability is as necessary for establishing trustworthiness in qualitative research as reliability is to quantitative research. Dependability was accomplished by adopting the concept of an external auditor. An external auditor, distinct from a peer debriefer, is a new person to the researcher and the research study (Creswell, 2014). In establishing dependability, I recruited four external auditors to provide an assessment at the conclusion of my research study. An external auditor can be viewed as an auditor. His objective may include specific questions about the methodology, approach to the research, and subsequent findings (Creswell, 2014). The four external auditors I used for my study commented on all aspects of my study, particularly on the clarity of the research plan and the
potential for a future investigator to repeat the study. The four external auditors included an associate research scientist from New Mexico State University, a retired geochemist and materials scientist from Sandia National Laboratories, a doctor of physical therapy in the health care field, and a graduate student from the University of New Mexico Graduate Resource Center.

**Confirmability.** Confirmability is as necessary for establishing trustworthiness in qualitative research as objectivity is to quantitative research. Reflexivity is a concept of neutrality or the extent that the findings of a study are derived from participants’ responses and not research bias (Schwandt et al., 2007). To address confirmability in my study I openly stated my assumptions about the topic of interest in relationship to my own unique contribution.

**Summary**

This chapter presented the qualitative methodology research design that explored the research questions regarding participants’ enrollment in the NMHIX. A comprehensive research plan was presented, including qualitative research design, methods, data analysis and procedures, and trustworthiness of results. This plan provided the necessary structure to examine the research question; The methods included in the plan that provided the researcher the processes to deliver a comprehensive investigation on what influenced and motivated participants to enroll in the NMHIX.
Chapter IV

Findings

Chronicles of Health Care and Home Remedies Used to Cure Ailments

Participants chronicled reflections on health care insurance coverage. Nearly 80% of the participants reported having health care insurance coverage while growing up. Approximately 20% reported not having health care insurance coverage and another 20% reported having state supported health care insurance coverage through Medicaid. Figure 2 illustrates types of health care insurance coverage by percentage. Although 56% of the participants in my study reported they had health care insurance coverage, none of these respondents recount ever visiting a physician’s office for an annual well child exam or an annual physical. However, Teresa and Carmela recall going for immunizations at a county health office when they were adolescents..

Figure 2. Health Care Insurance Coverage while Growing-up.

The findings also revealed that 56% of the participants relied on home remedies, 22% used their Medicaid coverage for health care, and 22% who had no health care coverage
either did nothing or used emergency room or urgent care to access health care (see Figure
3). I argue that participants who have ‘no coverage’ or ‘Medicaid coverage’ can essentially
be correlated – because Medicaid recipients have paid health care coverage through Federal
or State Government subsidies and individuals with no coverage access emergency room and
urgent care for health care. Consequently, hospitals and clinics use indigent funds that are
gained through city or county subsidies. The indigent fund is what a non-covered patient
accesses to help cover the payment for a hospital or clinic visit. In review of my field notes
and reflexive journal, this argument is supported based on what participants shared with me.
For those participants with ‘Medicaid coverage’ their experience with accessing health care
was no different than the participants with ‘no coverage.’ The care that the Medicaid covered
and the non-covered participants acquired was an emergency room or urgent care visit.

Teresa, Elena, Carmela, Luisa, and Isabel shared stories of growing up and being
cured with home remedies. Teresa provided a rich memory regarding her experience of going
to her grandma’s house for medical care. Similarly, Teresa had an abuelita who was a
curandera like my abuelita. A curandera is a folk healer that provides healing for different
illnesses using remedios (natural herbs). This particular trend of curandera and remedios,
after review of my field notes, was evident in discussions with my participants. According to
my field notes, the majority of my participants had similar experiences with home remedies.
The term *curandera/o or curanderismo* is a term used to describe a folk healers practice. *Curanderismo* is a healing practice founded upon faith, experience, and knowledge of plants accumulated over the course of four centuries (Arellano, 1997; Carrasco, 1984; Torres, 1983; & Trotter, 1981). Teresa, Elena, Carmela, Luisa, and Isabel attributed many of their childhood, young adult life, and adult life cures the remedies administered by their mothers and grandmothers for miscellaneous ailments. Teresa also shared that presently her mother, at the age of 79, still provides her with remedies that she uses at home to cure different illnesses. For example, remedies that Teresa recalls using, and still uses, are *oshá* (osha) to help alleviate stomach cramps, *altamisa* (mountain mugwort) used for colds and fever, and *malvas* (mallow) used for sore throats.

The findings further revealed that the importance of health care was very rarely discussed at home (see Figure 4). The figure illustrates that approximately 80% of the participants reported that the topic of health care was never discussed at home. According to
my field notes health care was not discussed or rarely discussed at home is accurate. Furthermore, my own personal reflection resonated with this response because I don’t ever recall discussing health care while I was growing up. Establishing healthy behaviors during childhood is easier and more effective than trying to change unhealthy behaviors during adulthood (Centers for Disease Control and Prevention, 2016). However, Sara and Maria reported that the importance of health care was often spoken about at home. Maria recalls growing up and always having health care insurance, Maria stated:

   My mom was happy that we had health care insurance because if my sister or me needed to go to the doctor we always had health care insurance. My mom would always mention that she was grateful for having insurance and felt safe that we had coverage because she knew some people that didn’t have health care insurance.

Sara and Maria were also the only two participants who have achieved a college degree. This observation helps me argue that there is a relationship between education and optimal health. Findings from prior research also support my argument. Education adds to a higher investment in personal health (Grossman, 1972). Whereas, having poor health leads to lower levels of education (Fletcher & Frisvold, 2009). Individuals with higher levels of education are more likely to access preventative health care services such as an annual physical exam or mammogram (Cutler & Lleras-Muney, 2008; Kenkel, 2000). Other findings suggest that having higher levels of education are associated with visiting a dentist (Manksi, 1998). My field notes and reflexive journal review illustrate that Sara and Maria were very confident and aware of having had health care insurance coverage growing up and remembering visiting doctors’ offices while growing up for preventative care.
Figure 4. Health Care Discussed or Not Discussed at Home.

**Messaging – Information Source Gained Through Trusted Sources**

This objective was to disclose how participants first became aware of the NMHIX. To reveal the responses from participants, I have merged multiple responses into a category termed ‘trusted sources.’ The category of trusted sources includes the following: family and friends, doctor, health care facility, co-workers, and neighbors. The responses overwhelming reveal that trusted sources were a method of obtaining and learning about the NMHIX (see Figure 5). As mentioned in Chapter 2, Hispanics are more likely to enroll in health care insurance coverage if they are educated about the importance and benefits of health care insurance by a trusted sources (Hornik, 2001; Kaiser Family Foundation, 2013; Lilley, 2013). Teresa recalls going to her doctor’s office and learning about the mandate to have health care insurance. She stated:
When I went to a doctor’s appointment, my doctor told me that I was going to have to enroll in a health care plan. That very same day that my doctor told me about this I enrolled for coverage.

Figure 5. First Became Aware of the NMHIX.

Responses to other participants’ inquiries included: *What was their daily format of obtaining daily news?* The findings indicate an overwhelming response was newspaper and TV, 100% and 89% respectively. In addition, when asked: *What would be the most meaningful format to get information regarding changes to their health care insurance coverage?* The findings indicate by mail or phone call, 100% and 89% respectively. In review of my field notes and my reflection of the interviews, the resounding responses were that participants would like to be notified by mail or a phone call regarding changes to their health care insurance coverage. This particular trend of trusted sources became evident in listening to the stories of my participants on how they gain information about health care
related matters. To this end, these findings are congruent with my review of my field notes and reflexive journal.

**Enroll in the NMHIX – Motivation and Influential Factors**

This next objective focused on the motivation and influencing factor(s) for enrolling in the NMHIX. The findings showed that nearly 70% of the respondents reported that the mandate and penalty assessment for not having the health care insurance coverage was the motivational factor to enroll (see Figure 6). The theme of participant concern of being penalized for not enrolling was definitive in my field notes and reflexive journal. The finding revealed that participants’ current health issues and the financial risk of paying a large fee for a doctor’s office visit versus the reward of having health care insurance that reduces the financial responsibility were equally important 56% and 56%, respectively. The findings revealed that a participant’s age was somewhat important, 44%, in the motivation to enroll in the NMHIX. The participants in my research study ranged in age from 44 to 63, and the older participants admitted that their age and current health status was a deciding motivation. Alas, preventative health care, 33%, was the least important factor for enrolling, which is consistent with my field notes. The mandate and income tax penalty for not having health care insurance coverage, coupled with preexisting health issues and the financial risk of having to pay overwhelming medical bills, have served as evidential factors to having participants in my study enroll for health care insurance coverage.
The topic of why having health care insurance coverage is important was also investigated. Participants’ responses revealed that they were extremely focused on the belief of having access to care (see Figure 7). 100% of the respondents felt that having health care insurance coverage was important to take care of current health issues; the participants also gained an appreciation for the health care insurance as a means towards a healthier life. Additionally, my filed notes reflect that participants’ motivation to enroll was due largely to the penalty assessment they would incur if they did not have health care insurance. Findings show that nearly 60% of the participants believe that having health care insurance coverage is important for good health. Approximately 35% of participants responded that health care insurance coverage was important in order to alleviate a financial burden for their families in case of an emergency, protracted medical care or death.

*Figure 6. Motivation to Enroll in the NMHIX.*
This next objective focused on the participants’ experience in the enrollment process of the NMHIX. Seven participants responded negatively about their enrollment experience and five responded with positive thoughts about their experience. Jesus experienced positive and negative events during the process; Maria had a few negative issues. Over 50% of the participants indicated that the NMHIX customer service staff was helpful and the process to enroll was seamless. However, positive response to the enrollment process is deceiving. Nearly 70% of the respondents enrolled with the assistance from a NMHIX navigator. A navigator is described as a health care guide service that delivers education, outreach, and in person assistance for those seeking NMHIX coverage (see Figures 8 & 9). The positive responses to enrollment were confirmed in my field notes. My observation verified that the majority of my participants spoke highly about the great support the NMHIX navigator provided in the enrollment process.
Participants were asked to reflect on their experience and describe what they would have done differently or would have liked to see differently. The findings indicated that approximately 20% of the respondents would have asked more questions to the navigator assistant and 20% would have explored other health care insurance options that may have been less expensive. The remaining 60% would have liked the navigator assistants’ to be better trained and the billing system easier to understand. Overall, the participants were very aloof when asked this question.

Additionally, participants were asked how their experience in the NMHIX enrollment process has changed them. Although their answers varied three overall themes resonated. On one end, Carlos, Maria, Sara, Jesus, and Teresa felt they had gained an appreciation for the health care insurance coverage that they had when their employer provided the health care coverage. Now they find it difficult to navigate and find insurance on their own. Elena and Luisa felt confident about the process of health care insurance enrollment. Isabel and Carmela felt this experience had extreme worry about meeting the monthly premium payment and the deductibles. For example, Carmela stated:

I have to work extra hours just to come up with the monthly premium payment. I’m afraid to use the insurance because I’m afraid my insurance rates will keep getting higher and higher. I feel that I will get punished for using my insurance. In order for me to go to my doctor or the emergency room and use my insurance I have to be in extreme pain where I can’t stand the pain.
I scheduled the second interview with Carmela on a Friday but she cancelled because she had a severe cold. After rescheduling for the following week on Saturday, she was still sick with a cold but was determined to talk to me. I asked Carmela if she had been to the doctor or the emergency room. She had not been to either but she had finally decided to schedule an
appointment with her physician for that upcoming Monday. I asked her to consider going to the emergency room for care, she responded, “I can’t afford to pay the $50 co-pay for an emergency room visit so I will wait to see my physician in his office and pay a $25 co-pay instead”.

**Health Care Insurance Implications**

The next objective focused on implications of having health care insurance coverage. The findings were resoundingly positive. Nearly 90% of the respondents believed they have benefited from having health care insurance coverage (see Figure 10). However, Isabel and Carmela felt stressed by having the mandated health care insurance. Isabel, who makes a modest income and is paid bimonthly, uses nearly 100% of a paycheck to pay her monthly premium on her health care insurance coverage. Isabel stated:

I appreciate the health care insurance because I have benefited from having the insurance. The only thing I find really hard is to pay the premiums – nearly an entire paycheck goes to paying the monthly insurance premium, and on top of that I have to pay the co-pays for every appointment I go to and for my prescription medication.

However, she expressed that she understands the importance of having health care insurance coverage and feels secure with the insurance in case of an emergency. A second participant, Carmela, also makes a modest income, has health care insurance coverage, and finds herself financially strained. While having health care insurance in Carmela’s case does not translate to her ability to access health care services because of the deductible; the deductible creates a significant burden on her already constrained income.
Participants were also asked how the experience of enrolling in the NMHIX and having the health care insurance coverage has helped them. The findings reveled that nearly 70% of the respondents have become more self-reliant, aware, and responsible (see Figure 11). The confidant responses on how the participants’ experience of enrolling has helped them were confirmed in reviewing my field notes. For example, Teresa stated:

I understand my health care benefits more now, I feel a lot more confident in the enrollment process, and I was able to enroll this year for my health care benefits on my own over the phone.

Jesus stated:

I don’t have to worry about my medical health care. I can go to see the doctors whenever I feel like it. Today, I can honestly say I understand my health care insurance coverage much better and I’m very happy with my choice of insurance.
Elena stated:

The insurance itself is a lot of help. If I have problems whatsoever, I feel that now I call and I am not nervous to ask for help.

Moreover, at the time of this interview Sara revealed that she no longer had health care insurance coverage. Sara disclosed that she had to drop her health care insurance coverage because she could not afford to pay the monthly premium. Nevertheless, she understands the importance, as well as the need, for health care coverage. Sara stated the following:

It makes me panicked because I know I need it, especially now that I’m the age that I am and I am having to pay for everything out of my pocket. Going to see my doctor, since he is a specialist, costs me $180.00 for an office visit. My prescriptions—today I had to get a couple of prescriptions and it was $89.00.

![Figure 11](chart.png)

*Figure 11. How has this experience and having Health Care Coverage helped you?*
Isabel and Carlos indicated that having health care insurance coverage is necessary because without insurance some physician offices will not provide them with health care. In addition, the findings showed that having the insurance and paying nominal co-pay is better than having no insurance and having to pay the high price of medical care.

**Conceptual Thought**

The last objective concentrated on the participants’ conceptual thoughts. To this end, I wanted the participants to be innovative and ambitious with their responses. Participants were asked: *if you had the authority to change or eliminate anything associated with health care insurance what would that be and why.* The findings revealed that reducing or eliminating co-payments and deductibles from health care insurance, 56% and 67%, respectively, would be the desired change (see Figure 12).

![Figure 12](image)

*Figure 12. If you had the power to change something with Health Care Insurance what would that be?*
Findings also suggested that the reduction or elimination of the copayments and deductibles would be enacted to lessen the burden on those that can’t afford them. In addition, the majority of the respondents stated that since they pay a monthly premium they should not need to pay additional copayments and meet deductibles.

Participants were then asked: *If you had the power to change anything in your life, what would that be and why.* Maria, Isabel, Carmela, Elena, and Sara would have focused on their education and would have achieved a high school diploma, graduated college, or would have attended community college or the university (see Figure 13). Luisa, Carmela, Teresa, and Elena would change their lifestyle by making better food choices and exercising regularly.

![Figure 13. If you had the power to change something in your life what would that be?](image)

**Summary**

This chapter included a presentation of findings that were drawn from the data analysis as previously discussed. Descriptive analysis using pie, bar, and line graphs were
developed to display the findings related to the objectives. The data analysis procedures were discussed and the emergence of themes was illustrated in narrative as well as visual displays. The next part of this manuscript, Chapter 5, will illustrate a discussion, recommendations, and conclusion.
Chapter V

Discussion and Conclusion

Using the ELM qualitative methodology as the conceptual framework, this study examined the chronicles of Hispanic individuals in relation to health care insurance and investigated their experiences in the enrollment process of the NMHIX, and explored the implications of having health care insurance. Nine participants were recruited from one county located in the northern corridor of New Mexico. Semi-structured in-depth interviews were conducted with participants who had recently enrolled in the NMHIX. Specifically, the participants shared their personal histories of growing up with or without health care insurance, expressed their experiences in the enrollment of the NMHIX, and explained the motivation and influence that led them to enroll in the NMHIX. In doing so, themes emerged in the following areas: (a) health care was rarely discussed at home and home remedies were commonly used; (b) learning about the NMHIX was primarily through trusted sources; (c) impending penalties for not enrolling were often the motivation for enrolling in NMHIX; (d) the enrollment process was essentially positive; (e) respondents agreed on the importance of having health care insurance coverage; and (f) the experience has led participants to become more self-reliant, responsible, and aware of various matters related to their health and health care insurance.

With reference to chronicles of health care and home remedies to cure ailments, the findings revealed that participants’ memories of having health care insurance while growing up varied between those who had health care insurance (56%), those who did not (22%), and those who had state supported health care insurance such as Medicaid (22%). The findings are corroborated by various sources indicating individuals lack health insurance because their
employers do not offer or the employee cannot afford to pay for coverage (Durden & Hummer, 2006; Falen, 2004). Low-income workers, those at greatest risk of being uninsured, are less likely to be offered job-based coverage and less able to afford their share of the premiums than workers with higher incomes (Kaiser Family Foundation, 2012). Although many Americans have access to health care insurance very few use the coverage for preventative care because an inability to pay the copayment (Center for Disease Control and Prevention, 2015a). In addition, limited education undermines the importance of medical intervention and the complex nature of the medical-care system at work in this country. The participants who recalled having health care insurance while growing up very seldom used health insurance for preventative health care. This particular finding perhaps underscores the fact that Spanish-speaking Hispanics often struggle to communicate clearly when pursuing health information and appropriate care (Askim-Lovseth & Aldana, 2010; Giachello & Arrom, 1997). My participants are fluent in English therefore the language argument perhaps is not the best approach to explain lack of use of health care insurance for preventative health care. Based on my field experience and reflections, I would argue that we need to look at factors such as the remoteness of the study site, lack of adequate health care providers, and cultural and institutional barriers to access health care to understand limited use of preventative health care among this population. For example Carmela stated:

Now that I’m sick, I can’t even go to the doctors, because we don’t have an urgent care in our community and going to the emergency room takes to long to be seen.

Carmela added:

It is challenging to understand the benefits that I have with my health care insurance.

A few weeks ago I went for my prescription medication at Walgreens and they
wanted to charge me $190 and it took me forty-five minutes to get a person from my insurance on the phone to fix the error. After all the waiting I ended up paying $25 for my prescription.

Maria states:

I don’t typically go to the doctor, I only go in case of an emergency or if I am not feeling well. Having the insurance is nice to have in case I ever end up in the hospital. Traditional practices and beliefs about illness and health care may explain the lack of preventative health care among the study participants. The findings exposed a nearly four-century-old practice called curanderismo. It is a widely used practice of using shrubs and other natural products to treat ailments. The knowledge of the healing power of shrubs has been handed down from generation to generation. About 60% of the participants in the study reported using this traditional method of healing illnesses such as stomach cramps, colds and fever, and sore throats. This particular finding revealed that some levels of cultural practices and personal beliefs toward illness and health care are important parameters that are still valued in this community. Therefore, there are reasons to believe that individuals who did not have health care insurance or had state supported health care insurance would utilize remedios (home remedies) to cure illnesses. Remedios are remedies that are produced from indigenous plants by curanderos/as. They are affordable and can easily be procured from a community member (Arellano, 1997; Carrasco, 1984; Harris, 1998; Torres, 1983; Trotter, 1981). Curanderos/as primarily provide remedios for known ailments. Individuals within the community learn about Curanderos/as through trusted sources. Whereas it is important to recognize people’s willingness to use curanderismo, it is crucial that people seriously explore the benefits of modern medicine and the bio-medical model for treating illnesses. The notion
of modern medicine and bio-medical model can provide early detection of illnesses that may need to be treated with chemotherapy, radiation, or require prescription medication such as antiretroviral therapy for HIV/AIDS patients. This understanding should encourage people to see the benefit of having health care insurance.

Participants’ responses indicated that they primarily depended on both family and professional sources to obtain information about NMHIX. In particular, family members and friends, family doctors, health care facility staff, co-workers, and neighbors played a significant role for the research participants to gain and learn about the NMHIX. These resources are categorized as ‘trusted sources’ for gaining information that is important for personal growth and development (Hornik, 2001). It is important to highlight that most people demonstrate a natural tendency to use trusted sources such as schools, churches, and community members as relevant communication channels. This particular line of thought and practice is perhaps more relevant to ethnic minority families in the United States (Derose, 2000; Gresenz et al., 2009). Hispanic communities develop social networks of trusted sources and share information regarding health care access and pathways to care. They respect kinship bonds and professional authority for deciding on health care needs and services. The cultural lens of how Hispanics view the importance of health differs from what many Americans would consider health issues. Most Hispanics believe that not having a disease either mental or physical problems is considered good health (Luquis, Garcia, & Asford, 2003). Hispanics also tend to infer a solution to a health situation rather than to analyze the reasons for it (Vivano, 2013). The impetus of my growing up in a rural Hispanic community, and my observations and reflections of my field experience lead me to believe that currently many Hispanics hesitate to take medication prescribed by a physician without
first asking family for traditional alternatives. Many Hispanic communities have created a network of alternative health practitioners that are often trusted more than physicians. White or another ethnic background physicians that serve Hispanic communities need to build trust relationships with patients in order for Hispanic community members to access primary care more readily. In the Hispanic community there is a greater trust for what has worked for a family or what has reputedly worked for others in your community.

Hispanics display collectivist behaviors that underscore the fact that relationships and family networks are far more important than individualism (Korzenny & Korzenny, 2005). Hispanics trust their family and other members of their social groups. Hispanic cultural values are built on four standards that emphasize their collective tendencies (American Cancer Society, 2005). These four standards are: (a) familialismo, (b) respeto, (c) confianza, and (d) personalismo. Familialismo – reflects the Hispanic notion of family that includes extended family and friends; respeto – refers to mutual respect that is required for a successful relationship; confianza – refers to mutual trust that is gained over a period of time between individuals during the relationship-building process; personalismo – refers to a relationship-building on a personal, warm, and friendly level and demonstrating interest in a person’s personal life, family, or other interests. Hispanics tend to view illnesses as caused by various factors such as psychological causes that occur from envy, anger, fear, turmoil, worry, family stress, bad behavior and supernatural factors such as spirits, sins, or witchcraft (Korzenny & Korzenny, 2005). Therefore, emotional and social support must be a factor in using modern medicine and bio-medical models to treat illnesses.

The current findings suggested that the mandate to have health insurance and the penalty for not having the health care insurance coverage were the major factors to enrolling
in the NMHIX. The fear of having to pay a penalty at the end of the year when filing tax returns is reason enough for most Americans to comply with the ACA mandate. Sara feared the potential penalty but was forced to forgo her health care insurance because she could not afford to pay her monthly premium. During one of my interviews with Sara I provided information about the ACA alternative to qualify for a health care coverage exception. My interpretation of this finding is that the general public by and large follows the rules and complies with the laws. Although Isabel and Carmela are challenged at times in meeting their monthly health care insurance premium payment they have never neglected to pay. Furthermore, preexisting health issues and age have served as motivational and influential factors to enroll for health care insurance coverage. My findings resonate with findings from other studies that reveal that understanding the ACA and the penalties motivates individuals to enroll in health care insurance (Hope, 2014). Being able to see a doctor for illnesses and avoid big medical bills are also important motivators (Hope, 2014). It is important that communities find creative methods of educating the uninsured with well-timed information to help them shop for and enroll in health care coverage that meets their needs (Stern, 2015). Individuals that have preexisting conditions may require a more elaborate, higher cost health care insurance option to help reduce out-of-pocket expenses. For example, Sara has a rare diagnosis called acromegaly, also known as gigantism, which may require a surgery in the near future. This surgery is projected to cost between $50,000 and $70,000. A more elaborate higher cost health care insurance option is necessary for someone like Sara in order to reduce her out-of-pocket costs. Similarly, individuals that may have certain types of cancer, transplant, stroke, heart disease, HIV/Aids or other long-term illness may also require a more expensive option.
In relation to enrollment process experience in health care insurance, the findings revealed that the participants had more negative experiences than positive. The negative responses ranged from being confused to misunderstanding coverage options to dealing with uninformed staff at the NMHIX. For example, Teresa acknowledged that her experience was not good and categorized her experience as a nightmare. Maria felt that the NMHIX agent provided her incorrect information when she selected her health care option. Maria went to her dentist for a dental cleaning and when she presented her insurance information she was informed that her coverage did not include dental care. Carmela’s experience was frustrating. When she applied for the NMHIX the staff seemed uninformed about the health care insurance options and unable to help her navigate an appropriate health care insurance option plan to meet her specific needs. This is consistent with findings from other researchers who suggest that Hispanics are faced with language barriers to obtaining information about health insurance options and obtaining appropriate and timely care (Giachello & Arrom, 1997; Perry, Kannel & Castillo, 2000).

Other responses clearly suggest a mixed paradigm of experiences during the enrollment process. Over 50% of the participants indicated that the NMHIX customer service staff was helpful and that the process to enroll was seamless. Health care consumers should have positive experiences when programs are built to be culturally and literacy sensitive and barriers to access are removed. My study signifies that the majority of my participants have low health literacy. The majority of the participants in my study revealed that health care insurance is importance to have in case of a medical emergency but don’t understand the importance of preventative health care. This phenomenon of health care insurance coverage and health literacy is new to many NMHIX enrollees. Education on health literacy needs to
be provided to new enrollees so they understand the importance of preventative health care such as setting up an appointment for annual physical, yearly immunizations, mammogram, and other preventative examinations. However, the NMHIX has navigator sites where consumers can receive assistance in the selection and enrolling of health care insurance. The World Health Organization has defined health literacy as “the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand, and use information in ways that promote and maintain good health” (World Health Organization, 1998, p.10). Elena, Luisa, and Carmela emphasized that the navigator site at El Centro Family Health was extremely helpful and made the enrollment process easy. Extant research suggests that health care facilities that do not offer bilingual assistance further impairs the ability of a consumer to receive accurate health care information and obtain appropriate care (Askim-Lovseth & Aldana, 2010). Similar to having bilingual services, health literacy professionals are needed in the complex medical-care and health care insurance systems to reduce any obstacles to understanding options and benefits for adequate healthcare.

Responding to inquiries regarding implications for having health insurance, nearly 90% of the respondents felt they have benefited from having health care insurance coverage. Such a resounding positive voice toward having health insurance is remarkable. My assessment of this finding lends to the notion of Maslow’s hierarchy level of safety and security. This high positive response to having health care insurance coverage augments the ‘safety’ motivational need of Maslow’s hierarchy. This is consistent with other findings that affirmed health care coverage is a key indicator that influences regular access for routine and acute health care needs (Baldwin, 2003). Furthermore, a Healthy People 2000 report released
by U.S. Department of Health and Human Services suggested that health care insurance coverage is important for health equity and for increasing the quality of a healthy life. The current findings indicate that the experience of enrolling and selecting health care insurance has improved participants’ understanding of health care, including improved personal self-reliance and responsibility. My deduction from talking to my participants and reviewing my field notes support these findings. Specifically, in review of the SES and their education attainment I was surprised to learn that the majority of my participants have become more resourceful and are now better able to navigate the health care insurance system with ease.

My inquiry to understand participants’ sense of “looking ahead” yielded much speculated and talked about trends and issues in health care services and practices in the U.S. The findings revealed that if participants had the authority to change something with health care insurance coverage, participants would like co-payments and deductibles reduced or eliminated. The findings also showed that if participants could change something in their lives, they would change their lifestyle habits by making better food choices and exercising regularly. Furthermore, they would increase their education level to include completion of high school or college.

The responses guide me to discuss three major aspects of health and resources: current healthcare and insurance practices, personal well-being and health lifestyles, and education as a resource to navigate and access health care.

1. **Healthcare and insurance practices:** Relating to healthcare consumers are demanding that medical-systems improve care delivery. The ACA is rewarding doctors who keep their patients well and manage chronic disease results in healthier patients with less healthcare spending. Consumers want to be
Consumers who are provided the tools to make smart choices about their health are empowered become more health conscious. Consumers want options that are tailored—offer better value. Consumers want products and services that are tailored to their specific needs and extended provider networks. Expand medical innovation to provide high quality and underrepresented medical disciplines in rural areas of New Mexico. Build on the successful UNM School of Medicine Extension for Community Healthcare Outcomes (ECHO) project to expand culturally and sensitive healthcare to Hispanics. A fix to help improve the healthcare system in the U.S. would be to adopt a single-payer/universal complete government-run health insurance system under which everyone is covered (e.g., Canada’s system). Canada’s single-payer system is more efficient, has greater power negotiating payments and will be accepted by more health care providers (than private insurance). A single-payer system would provide an economic benefit. A federally run financing system would have lower administrative costs than private insurance, as the Medicare program consistently demonstrates. Unfortunately, in the U.S., lobbyists from the insurance industry and Conservative political leaders opposed to Government expansion made the single-payer system a non-option. A single-payer system would benefit all individuals especially the poor, working class, and the sick. Furthermore, a single-payer system would have a positive implication on the participants in my research study and minority groups.
Pertaining to insurance practices, the ACA now protects consumers from being denied health insurance because they have or had an illness; insurers can only change premiums based on age, tobacco use, family size, and geography; insurers can’t determine premiums based on health status, past insurance claims, gender, or occupation; insurers can’t refuse to renew coverage because an individual or an employee has become sick; and insurers can’t charge higher premiums to higher cost enrollees by moving users into separate risk pools (U.S. Department of Health and Human Services, 2013). Healthcare systems should function in a free market economy. While most people believe that our healthcare systems are comprised of free markets, it is anything but that. The industry appears to be completely distorted by institutional manipulation. To start with, the American Medical Association (AMA) has a government-granted monopoly on the healthcare system. The AMA has the authority to restrict the number of doctors allowed to practice medicine. This may be seen as a correlation to raise physician incomes artificially. The AMA has the power to restrict the number of approved medical schools in operation (Kelly, 2010). However, I do believe that with the implementation of the ACA and the raise in accountability measures in the ACA the country is moving towards a more free market healthcare economy. The ACA was designed to provide benefits that will provide health insurance coverage to some 32 million uninsured people, many from low and moderate-income households, over the next 10 years. The ACA established state health insurance exchanges, such as the NMHIX, for small employers and individuals without employer or public coverage. For the first time, people buying coverage on their
own will have access to a premium subsidy. People with low and moderate incomes will also benefit from cost-sharing credits that effectively reduce out-of-pocket costs.

2. **Personal well-being and health lifestyles:** Relating to **personal well-being** and **health lifestyles** preventative health care services and making lifestyle choices are key steps to good health and well-being. Preventative health care may begin with participating in an annual physical, routine immunization, well-woman visits, colon cancer screening, and more. A healthy lifestyle may begin with regularly exercise, maintain healthy weight, eat a healthy diet, eliminate tobacco use, reduce or eliminate alcohol intake, and more. All these preventive measures and healthy lifestyle options together will reduce healthcare costs for individuals. The NMHIX provides preventative health care options in their health plans. However, the NMHIX fails to provide health education for enrollees. My assessment of the personal well-being and health lifestyles would suggest that the NMHIX health care insurance options be required to provide health education regarding proper use of the health care coverage to support preventative care and educational resources on healthy lifestyles can be significant for new health care insurance users. Providing education about preventative health care and healthy living may help reduce health disparities with Hispanics, such as diabetes and obesity, and decrease health care costs for Hispanic participants in my research study. Health care insurance providers should establish incentives for health care insurance users; this may lead to a decrease in health care costs. For example, incentives can
include providing a discount on monthly premiums for individuals that sign up and successfully complete a smoking cessation program. Similar options can be afforded for obesity and alcohol or drug programming.

3. **Education as a resource to navigate and health care**: Relating to education and health care, research indicates that higher education is correlated to better health (Agency for Healthcare Research and Quality, 2007; Cutler & Lleras-Muney, 2007). People with less than a high school education and with a high school diploma are more likely to be uninsured than people with at least some college education (Agency for Healthcare Research and Quality, 2004). Individuals with a college education reduce their chances of heart disease and diabetes, reduce lost days of work for sickness, have more positive behaviors, are less likely to smoke and abuse alcohol, are less likely to be overweight or obese, and are less likely to use illegal drugs (Cutler & Lleras-Muney, 2007). My observation of the participants that I interviewed that had less education and poor health are not necessarily making poor choices but simply surviving. Many of the participants revealed that they would have liked to have finished high school or continue on to higher education. Some participants did not have modeling of promoting higher education. Others didn’t have the means to pay for higher education or had to drop out of school to help support or care for family. My concern based on my observation of this community is lack of opportunity for better paying jobs and access to quality food options. I often reflect on the Supplemental Nutritional Assistance Program (SNAP) that provides eligible
individuals and families’ support with assistance to purchase food. For example, a family of four must first meet the income eligibility of $2,628 per month to qualify for a maximum of $649 per month of SNAP benefits (U.S. Department of Agriculture, 2015). This $649 calculates to approximately $21 per day for a family of four, $7 per day per family member, and $2.30 per meal per family member. Undoubtedly, a burger and French fries off the dollar menu at McDonalds or a bag of chips is affordable and more accessible than preparing a nutritional home cooked meal that is more costly and time consuming. My interpretation is that our safety net programs in the U.S. are not funded appropriately. Relating to health care insurance the cost has to be reasonable in order for families to benefit and to be able to sustain the premium costs over time. Most policymakers in this country do not think of passing a law without considering its economic impact, yet family considerations is seldom taken into account in the normal routine of policymaking. My observation of my participants implies that those participants that indicated poor health had lower levels of schooling and for the few, Sara and Maria, with higher levels of education and family backgrounds that talked about the importance of health care growing and having health care coverage indicate that they have better health.

**Theoretical Implication of the Findings**

As indicated earlier, the current study used the theoretical lens of the ELM as a framework for understanding attitude formation and change with regard to health care products and services. The ELM incorporates the tenets of processing information and the elaboration continuum (Petty & Cacioppo, 1986). The elaboration continuum involves
different degrees of thinking and processing information as the ELM theory submits that persuasion can be examined through two routes – central route (high-involvement processing) and peripheral route (low-involvement processing). Theoretically, when making a decision, all individuals fall somewhere on the elaboration continuum. The involvement and experiences of the participants in the current study are congruent with this theoretical framework. The participants in my study are closely split on the central and peripheral route continuum 44% and 56%, respectively. Jesus, Maria, Teresa, and Sara demonstrated high-involvement processing and Carlos, Isabel, Carmela, Luisa, and Elena demonstrated low-involvement processing. I have provided two case studies from my participant pool to explain the participants’ views toward the achievement of this theoretical framework. A summary of the participants is provided on an elaboration continuum dimension (see Appendix E).

Carlos: Peripheral Route – low involvement process. A large influence from the peripheral route is representative of this participant. After retiring at age 63, he felt he could hold-off having health care insurance until he would become eligible at age 65 for Medicare benefits. However, he learned that having health care insurance was a mandate and if he did not enroll he would be penalized; he then immediately enrolled. The variable of requiring health care insurance coverage increased his resolve to enroll in the NMHIX. Although he recognizes the importance of health care insurance coverage, he does not examine all the information made available to him on the issue of health care insurance. It means that he lacks high-involvement processing. Furthermore, he has not moved in the continuum to the stage of ‘belief and attitude change’ due to the inattention and lack of comprehension in the high-involvement processing stage. He represents an attitude change and not a behavior
change. Furthermore, this participant is unique in that he worked for over 30+ years as a law enforcement officer and always had health care insurance coverage through his employment. During his employment tenure he represented the central route. Although he may have never fully understood his health care insurance benefits while working, he participated in the cognitive response – of the central route continuum because he was left to ponder annually about the different health care insurance options for enrollment – that theoretically forms belief and attitude, and behavior change.

Maria: Central Route – high involvement process. Maria has experience of navigating many health care insurance options while working for the New Mexico Children Youth and Families Department and New Mexico Highlands University. The central route is representative of this participant. She has been able to enroll in the NMHIX on her own without any significant issue. She worked as a social worker and during her employment she would provide advice and resources regarding access to health care insurance coverage to her clients. In addition, she represents the belief change in the peripheral route continuum. This route relies on environment factors and six cues: reciprocation, liking, social proofing, consistency, authority and scarcity (Petty & Cacioppo, 1986), she represented two cues: social proofing and authority. Social proofing is a form of social influence, which is a psychological phenomenon whereby people assume the actions of others in an attempt to reflect correct behavior for a given situation (MacCoun, 2012). In my observation and review of field notes Maria actuates this action based on her sister’s encouragement to enroll in the NMHIX.

Carlos and Maria differ in three very distinct ways. Maria has a higher level of education, Carlos is married and Maria is single. Maria grew up in a household where the
importance of health care was often discussed and Carlos did not. These two participants also have three unique similarities. Carlos and Maria have both worked for the state of New Mexico serving people; Carlos worked as a law enforcement officer and Maria as a social worker. Another similarity is that they both recall growing up and having health care insurance coverage. Finally, they both own their childhood homes.

The theoretical implication of the findings demonstrates that an attitude change is easier to achieve than behavior change. An intellectual acumen is necessary to achieve behavior change on the central route continuum of the ELM. Jesus, Maria, Teresa, and Sara all have achieved a level of higher education or training that has led them to achieve behavioral change. Carlos, Isabel, Carmela, Luisa, and Elena have not had the experience of intellectual processing like the participants on the central route. The lack of intellectual processing may come from having a low level of education, language barrier or inability to examine the NMHIX system. The participants on the peripheral route are quick to experience a belief change based on peripheral information such as gossip or fear mongering. My observation of this entire participant pool left me believing that each participant is extraordinary and their individual chronicles are different but similar in many ways.

**Recommendations for Practice**

The contribution and results of this research study provide needed background information about the NMHIX, professional organizations that administer ACA, and local governments. This type of qualitative investigation lends a body of knowledge and serves many different purposes including strengthening responsibility for the overall implementation of the ACA, informing subsequent outreach, increasing education, and enrolment efforts in rural communities, and providing a framework for program
improvement targeted at Hispanics. Results gleaned from this study indicate several important recommendations by which the ACA can be redesigned to better meet the needs of Hispanic populations. As a researcher, I recognize that outcomes of primary interest for the ACA are affected by the number of individuals enrolled and utilizing the ACA for preventative health care purposes will eventually lead to a reduced health care costs and build a healthier society. Consistent with some of the recommendations made by U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (2014), and findings drawn from this study and relevant literature, the following recommendations can be made.

**Leverage existing community infrastructure to reach Hispanic populations.** Strategies need to be developed to efficiently use family and other respected members of the community as a resource for people who need to access health care. It is essential that families that have enrolled in health care insurance be empowered to assist and educate extended family members and other members of the community. My experiences vouch to establish working relationships with organizations such as the USDA Rural Development offices that are focused on helping to improve the economy and quality of life in rural America, public schools that are focused on providing a world-class education for students and preparing them to succeed in a diverse increasingly complex world, and faith based communities that are focused on fostering family spirit of peace, communication, cooperation, and services.

**Advance on a personal approach.** Hispanic and Latina/o communities are diverse. A one-size-fits-all approach to educating and enrolling individuals in the ACA is not likely to work. We need to recruit and hire bilingual persons from the community to help build
understanding and trust into outreach and enrollment activities. Organizations such as Promotores de Salud or Community Health Workers (CHWs) are bilingual and are able to connect with people’s needs and values about health practices. Nearly 70% of the respondents enrolled with the assistance from a NMHIX navigator. A navigator is described as a health care guide service that delivers education. For example, Elena shared that she became aware of the NMHIX because her daughter told her about it and connected her with a Hispanic Las Vegas resident that worked at El Centro Family Health that helped her enroll in the NMHIX. Luisa shared that she became aware of the NMHIX because a cousin told her about a Hispanic Las Vegas resident that worked at New Mexico Highlands University and helps helped her enroll in the NMHIX. The Center for Disease Control and Prevention (2015) describes Promotors de Salud and CHWs as patient navigators, peer counselors, lay health and peer health advisors. A promoters/a or CHWs would be a useful link for Hispanics as CHW workers generally share the ethnicity, language, and socioeconomic status of the community members they serve. These social attributes and trusting relationships enable a promoters/a or CHWs to serve as a liaison or intermediary between health and social services and the community.

**Build awareness and an outlet for healthy living.** This study uncovered that there is a tremendous lack of knowledge in the Hispanic community concerning preventative health care. Consumers, particularly a population that has never had health care insurance, need to be provided educational opportunities to understand the importance of using the benefits and having routine health care. The findings also uncovered that participants would like to be able to live a longer and healthier life. It will be beneficial to build a community center that allows individuals to learn about exercising and about healthy cooking and eating options.
**Address barriers.** It is of utmost importance to identify the barriers that keep Hispanics from receiving services and understanding their health care options. Barriers may include traditional personal belief structures, childcare challenges, inflexible work schedules, lack of transportation, low levels of reading comprehension, and need for English translation. With the combined presence of Hispanics and American Indians, New Mexico is a minority-majority state; therefore we need to boldly address sociolinguistic, cultural, and economic factors that may prevent accessing health care insurance.

- **Reallocate marketing dollars to communities.** It is apparent that Hispanic communities, mainly due to lack of access, are less likely to use electronic media for health care insurance information. We need to create opportunities for communities to organically address the ACA by creating their own marketing outreach activities. The ACA can be addressed by local people from within the communities that look like the population and talk like the population. Disseminating information and educating communities regarding the ACA can take place anywhere community members assemble such as churches and worship homes, schools and community centers, grocery stores and farmers markets, and at the Tuesday night bingo and Saturday morning farmers market.

**Future Research Directions**

The current study is exploratory in nature. However, based on my personal experiences and participants’ responses, I offer several important recommendations for additional research in the areas of Hispanic enrollment in health care insurance coverage and
the education efforts on preventative health care for newly insured persons. Future studies can be conducted in the following areas:

1. The role the NMHIX enrollment counselors and agents/brokers play in the process of empowering first time consumers to select a health care insurance option that is most suitable for their health care needs. Currently, there are no studies that directly link the NMHIX or ACA enrollment counselors, agents/brokers with participants’ enrollment experience. This focus could be part of a larger study about navigating practices and the ways these navigating processes yield results for health care insurance clients.

2. The role Hispanic social networks play in educating, influencing, and motivating other Hispanics’ about enrolling for health care insurance coverage. There are suggestions that directly link Hispanic social networks with providing information about bilingual physicians and helping navigate pathways to care to other Hispanics. Such a comparison will seek to uncover the effectiveness of the social network structure applied in a health care insurance environment and professional with cultural sensitivity.

3. The role health communication from the NMHIX or ACA plays in the process of offering sensitive and adaptive health communication that lends itself to preventative health care. It is important that health communication be practiced as the dissemination of understandable and usable information that refers to health (Calderón & Beltran, 2004). There are studies that directly link health communication with healthcare delivery systems. However, research in the area
of health communication linked to health care insurers, especially with reference to ethnic minority families is limited.

4. The present study should be replicated with a larger and more diverse sample, including other ethnic families in the United States. Replication studies with other diverse groups would aid in our ability to understand the general patterns of use of and access to health insurance across cultural communities.

5. The present study should be replicated in other states to bring a greater understanding to how Hispanics with limited English enroll in health care insurance coverage. Replication studies in other states with large Hispanic communities would aid in our ability to fathom the national picture of health need and use of health care insurance among Hispanic families. It is also important to conduct additional in-depth and longitudinal qualitative research to articulate a comprehensive picture of health care practices among Hispanics in the state of New Mexico.

**Limitations of the Study**

This study is limited to the chosen participants who may not represent the entire population in the San Miguel County. For example, I was unable to recruit any participant with young children. I have used a convenient sampling technique that is based on the precepts of voluntary participation and self-selection. The self-selection bias could limit the authenticity of participants’ responses. Although in line with the qualitative research practice I have adequate participants, nine participants may not represent the health care ethos of the entire community. Other health care stakeholders such as NMHIX staff, policy makers, and health care providers were not included. A study that would include these individuals may
yield a different result in the influence and motivation to enroll in health care insurance coverage.

Although I have used semi-structured interviews with open-ended questions, field notes, reflective journal, and participant check-in, the instruments are new and could include additional questions to grasp the real world situation of health care practices in the study site. In addition, all interview data were self-reported and assumed to be valid responses. This study was limited by interview design only. This situation precluded the assessment of potential artifacts and participant observation on how individuals observe written or communicated information and how individuals approach the enrollment process. Therefore, my data and study scheme are not grounded within the vigorous finesse of participant observation design that is often used by qualitative researchers.

**Summary and Concluding Thoughts**

The findings in this study indicate that both the ACA’s health care mandate and participant health issues have operated as routes to influence and motivate enrollment in the NMHIX. Although these two routes have encouraged participants to enroll, participants have a largely positive perception of the implication of having health care insurance coverage. Amid millions of dollars being spent in marketing by the NMHIX, participants revealed that they learn about the NMHIX or ACA mostly through trusted sources such as family members and health professionals. Participants see themselves as more self-reliant, aware, and responsible after experiencing the enrollment process for health care insurance coverage. Whereas some participants described their overall experience in the enrollment process as positive, others pointed out some unsatisfactory experiences. The rich stories of participants produced an increased awareness of what the driving factors for enrollment in health care
insurance are, how home remedies (remedios) were and are still used for curing ailments, and how trusted sources are a means for gaining information on the NMHIX or ACA. Participants in this study would select to be healthier and have a higher education.

Although insuring Americans with health care coverage remains a dream for many people, significant progress can be made by continuing to provide coverage through ACA to the uninsured and helping the newly insured to recognize the comfort of the benefits that support their immediate and future health. Certainly there are many plausible approaches to health communication. Whereas no cookie-cutter or one-size-fits-all health communication approach will work in the pursuit of health care coverage for all Americans, communication styles need to be organically created with communities – from urban to rural to frontier regions of the state and country.

The Social Security Act (SSA) of 1935 established a program that provides benefits for workers after age 62, benefits for victims of industrial accidents, unemployment insurance, aid for dependent mother and children, the blind, and the physically handicapped (U.S. National Archives & Records Administration, 2016). Eighty-one years later the SSA covers approximately 95% of the U.S. retired workforce including the unemployed and the disabled. The SSA endeavor took decades to get the American workforce covered. The SSA program has been respected by many as one of the most successful domestic benefit programs in our history. Policymakers and scholars point out that the elderly poverty rate in the country has been consistently declining as a function of the SSA. Likewise, the ACA program may take decades to cover the populace with affordable insurance and reform a health care delivery system to reduce health care delivery costs and improve quality care. However, in order to make gains in the ACA program, new enrollees need to understand
their coverage and, more significantly, they need to understand the benefits of preventative health care to decrease preventable urgent care and emergency room visits which will help reduce health care costs. Will the time come soon when we as the wealthiest nation, be able to exercise the notion that access to health care must not be based on privileges?
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Appendix A: Elaboration Likelihood Model

Appendix B: Interview (Data Collection) Timeline

INTERVIEW 1 (PROTOCOL 1 & 2)
TRANScribing
INTERVIEW 2 (PROTOCOL 3 & 4)
TRANScribing
FOLLOW-UP & FINAL MEMBER CHECK-IN
TRANScribing

Week 1  Week 2  Week 3  Week 4  Week 5  Week 6  Week 7
TRANScribing REVIEW  TRANScribing REVIEW
Appendix C: Research Instrument

#1
Interview Protocol – Socioeconomic Status

<table>
<thead>
<tr>
<th>Date:</th>
<th>Participant ID:</th>
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Pseudonyms:

Introduction:
- Introduce yourself.
- Discuss the purpose of the study.
- Provide informed consent.
- Provide structure of the interview (audio recording, field notes, and use of pseudonym).
- Ask if he/she has any questions.
- Test audio recording equipment.
- SMILE—make the participant feel comfortable.

This set of questions is focused on SES of the participants. This set of questions is called “SES.”

<table>
<thead>
<tr>
<th>SES objectives:</th>
<th>Guide questions on SES:</th>
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</table>

1. What is the economic and sociological combined total measure of a person’s work experience and of an individual’s or family’s economic and social position in relation to others, based on income, education, and occupation?

1. Are you married or single?
2. Do you identify as Hispanic or Latino, American Indian or Alaskan Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White, nonresident alien, Resident alien (and other eligible non-citizens)?
3. How old are you?
4. Can you give an estimate of your household income?
5. How many people are working in your household?
6. Family size (household composition)?
7. What is the highest level of schooling you completed?
8. What is your occupation?

This set of questions focuses on a participant’s description of his/her personal life history relative to the topic of health care. This set of questions is called “personal life history.”
### Personal life history objectives:

<table>
<thead>
<tr>
<th>Guide questions on personal life history:</th>
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</thead>
<tbody>
<tr>
<td>1. What are the chronicles about health care insurance for you?</td>
</tr>
<tr>
<td>1. Describe your experience growing up in relation to having or not having health care coverage.</td>
</tr>
<tr>
<td>2. Describe a time in your life (childhood, adolescents, young adult, or as an adult) when you did not have access to health care coverage.</td>
</tr>
<tr>
<td>3. Describe how the topic of health care was addressed at home when you were growing up.</td>
</tr>
<tr>
<td>4. Describe how you recall your relatives getting health care.</td>
</tr>
<tr>
<td>5. Describe how your friends and neighbors attained health care.</td>
</tr>
<tr>
<td>6. Describe how important health care was in your household growing up.</td>
</tr>
<tr>
<td>7. Did you have a family doctor growing up that you would visit at least one time per year?</td>
</tr>
<tr>
<td>8. Did other family members in your household have a family doctor that they would visit one time per year?</td>
</tr>
</tbody>
</table>

### Concluding Question and Statements

Is there anything else you would like to add or share about this topic that you feel is important for me to know?

* Besides what we talked about?

☐ Thank participant for his/her participation.
☐ Ask if he/she would like to see a copy of the results.
☐ Record any observations, feelings, thoughts and/or reactions about the interview.
#2

## Interview Protocol – Messaging and Marketing

<table>
<thead>
<tr>
<th>Date:</th>
<th>Participant ID:</th>
</tr>
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<tbody>
<tr>
<td>Pseudonyms:</td>
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</table>

### Introduction:
- Introduce yourself.
- Discuss the purpose of the study.
- Provide informed consent.
- Provide structure of the interview (audio recording, field notes, and use of pseudonym).
- Ask if he/she has any questions.
- Test audio recording equipment.
- SMILE: make the participant feel comfortable.

This set of questions focuses on messaging and marketing that Hispanics have been faced with leading up to their experience and motivation of enrolling in the NMHIX. This set of questions is called “messaging.”

### Messaging objectives:

<table>
<thead>
<tr>
<th>Guide questions on messaging:</th>
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<tbody>
<tr>
<td>1. Describe how you first became aware of the NMHIX.</td>
</tr>
<tr>
<td>2. Tell me how you obtain your daily news. For example, in what format do you receive your local, state, or national news?</td>
</tr>
<tr>
<td>3. Tell me what would be the most meaningful way to get news to you? For example, in what format would you prefer to receive information about changes to your health care benefits?</td>
</tr>
</tbody>
</table>

### Motivation objectives:

<table>
<thead>
<tr>
<th>Guide questions on motivation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tell me what motivated you to get health care insurance.</td>
</tr>
<tr>
<td>2. Tell me why having health care insurance is important to you.</td>
</tr>
<tr>
<td>3. What has motivated you to understand the importance of health care insurance?</td>
</tr>
<tr>
<td>4. What motivates you to pay your monthly premium on your health care insurance?</td>
</tr>
</tbody>
</table>

### Concluding Question and Statements
Is there anything else you would like to add or share about this topic that you feel is important for me to know?
   * Besides what we talked about?

- Thank participant for his/her participation.
- Ask if he/she would like to see a copy of the results.
- Record any observations, feelings, thoughts and/or reactions about the interview.
#3  Interview Protocol – Reflection on experience

<table>
<thead>
<tr>
<th>Date:</th>
<th>Participant ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pseudonyms:</td>
<td></td>
</tr>
</tbody>
</table>

**Introduction:**
- [ ] Introduce yourself.
- [ ] Discuss the purpose of the study.
- [ ] Provide informed consent.
- [ ] Provide structure of the interview (audio recording, field notes, and use of pseudonym).
- [ ] Ask if he/she has any questions.
- [ ] Test audio recording equipment.
- [ ] SMILE - make the participant feel comfortable.

This set of questions focuses on reflection on the meaning of the experiences Hispanics have had with the NMHIX. This set of questions is called “experience.”

**Experience objectives:**

<table>
<thead>
<tr>
<th>Experience objectives:</th>
<th>Guide questions on experiences:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reflecting on the path that led you to enrolling in the NMHIX, what did you learn from your experience?</td>
<td>1. Describe your experience (good or bad) in the enrollment process for the NMHIX?</td>
</tr>
<tr>
<td>2. How have Hispanics in SMC experienced the benefits of the NMHIX?</td>
<td>2. From what you learned through your experience, what would you have done differently?</td>
</tr>
<tr>
<td></td>
<td>3. From what you learned, what would have helped you enroll with more comfort?</td>
</tr>
<tr>
<td></td>
<td>4. How has this experience changed you?</td>
</tr>
<tr>
<td></td>
<td>5. How has this experience helped you (and your family)?</td>
</tr>
<tr>
<td></td>
<td>6. How have you (and your family) benefited (or not) from having health care insurance?</td>
</tr>
<tr>
<td></td>
<td>7. How often have you used your health care insurance?</td>
</tr>
</tbody>
</table>

**Concluding Question and Statements**

Is there anything else you would like to add or share about this topic that you feel is important for me to know?
- * Besides what we talked about?

- [ ] Thank participant for his/her participation.
- [ ] Ask if he/she would like to see a copy of the results.
- [ ] Record any observations, feelings, thoughts and/or reactions about the interview.
#4  
## Interview Protocol – Conceptual

<table>
<thead>
<tr>
<th>Date:</th>
<th>Participant ID:</th>
</tr>
</thead>
</table>

### Pseudonyms:

### Introduction:
- [ ] Introduce yourself.
- [ ] Discuss the purpose of the study.
- [ ] Provide informed consent.
- [ ] Provide structure of the interview (audio recording, field notes, and use of pseudonym).
- [ ] Ask if he/she has any questions.
- [ ] Test audio recording equipment.
- [ ] SMILE: make the participant feel comfortable.

This set of questions is conceptual on what you would do if you had the authority to make changes to the NMHIX. This set of questions is called “conceptual.”

<table>
<thead>
<tr>
<th>Conceptual objective:</th>
<th>Guide question on conceptual:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If you had the authority or power to change anything, what would that change be?</td>
<td>1. If you were the Executive Director for the NMHIX, tell me what changes you would have made in the enrollment process to make it easier for you.</td>
</tr>
<tr>
<td></td>
<td>2. If you had the authority to change or eliminate anything associated with health care insurance, what would that be, and why?</td>
</tr>
<tr>
<td></td>
<td>3. If you had the power to change anything in your life, what would that be, and why?</td>
</tr>
</tbody>
</table>

### Concluding Question and Statements

Is there anything else you would like to add or share about this topic that you feel is important for me to know?

* Besides what we talked about?

- [ ] Thank participant for his/her participation.
- [ ] Ask if he/she would like to see a copy of the results.
- [ ] Record any observations, feelings, thoughts and/or reactions about the interview.
Appendix D: Robert Wood Johnson Foundation Uninsured and Insured

Table D-1. Health Care Insurance Coverage of Total Population

<table>
<thead>
<tr>
<th>Location: New Mexico and United States</th>
<th>4-Year Observation by %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2011</td>
</tr>
<tr>
<td><strong>Employer</strong></td>
<td></td>
</tr>
<tr>
<td>N.M. (All)</td>
<td>46.7</td>
</tr>
<tr>
<td>U.S. (All)</td>
<td>56.7</td>
</tr>
<tr>
<td><strong>Medicaid &amp; CHIP</strong></td>
<td></td>
</tr>
<tr>
<td>N.M. (All)</td>
<td>23.8</td>
</tr>
<tr>
<td>U.S. (All)</td>
<td>17.5</td>
</tr>
<tr>
<td><strong>Medicare</strong></td>
<td></td>
</tr>
<tr>
<td>N.M. (All)</td>
<td>15.6</td>
</tr>
<tr>
<td>U.S. (All)</td>
<td>15.0</td>
</tr>
<tr>
<td><strong>Uninsured</strong></td>
<td></td>
</tr>
<tr>
<td>N.M.</td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>19.9</td>
</tr>
<tr>
<td>Hispanic</td>
<td>24.2</td>
</tr>
<tr>
<td>White</td>
<td>11.3</td>
</tr>
<tr>
<td>U.S.</td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>15.1</td>
</tr>
<tr>
<td>Hispanic</td>
<td>29.7</td>
</tr>
<tr>
<td>White</td>
<td>10.6</td>
</tr>
</tbody>
</table>

Appendix E: Elaboration Likelihood Model: Continuum Scale by Participant

Central Route
High-Involvement Processing
 Behaviour Change
• Jesus
• Maria
• Teresa
• Sara

Peripheral Route
Low-Involvement Processing
 Attitude Change
• Carlos
• Isabel
• Carmela
• Luisa
• Elena
Appendix F: Node Listing of Coding Reports

NODE LISTING OF CODING REPORTS
Total: 5 coding reports with 289 subcategories
Titles sorted alphabetically

1. 1_Socioeconomic - Life History (17 subcategories)
   • Q01_Marital status (2 subcategories)
     - Married
     - Single
   • Q02_Identify as Hispanic
   • Q03_Age (3 subcategories)
     - 40s
     - 50s
     - 60s
   • Q04_Estimate annual household income (3 subcategories)
     - 20000 or less
     - 20001-29999
     - 30000+
   • Q05_People working in household (3 subcategories)
     - 0
     - 1
     - 2
   • Q06_Family size (household) (6 subcategories)
     - 1
     - 1 + 1 part-time
     - 2
     - 2 + 1 part-time
     - 3
     - 3 + 1 part-time
   • Q07_Highest level of schooling (4 subcategories)
     - Bachelors
     - HS-Grade 11
     - HS-Grade 12
     - HS-Grade 12 + college courses
   • Q08_Occupation (current) (2 subcategories)
     - Healthcare
• Non-healthcare

Continue 1_Socioeconomic - Life History

• Q09_HC coverage growing up (3 subcategories)
  – Do not remember
  – Home remedies
  – Insurance coverage (3 subcategories)
    o Lacking dental care
    o Medicaid
    o Private medical

• Q10_Time in life without HC coverage (4 subcategories)
  – No coverage (adult)
    o Length of time (3 subcategories)
      ▪ 0-1 yr
      ▪ 2-5 yr
      ▪ Entire adult life
    o Why no coverage (2 subcategories)
      ▪ Post-retirement
      ▪ Pre-retirement
  – No coverage (child)
  – Not applicable (always had coverage)

• Q11_How topic HC addressed at home (3 subcategories)
  – Discussed
  – Not discussed
  – Other

• Q12_Relatives getting HC (3 subcategories)
  – Discussed (2 subcategories)
    o No
    o Yes
  – Insurance coverage (3 subcategories)
    o Medicare - Medicaid
    o None
    o Private coverage
  – Types of healthcare (3 subcategories)
    o Home remedies
    o Primary care physician
    o Urgent care - ER

• Q13_Friends neighbors getting HC (3 subcategories)
  – Discussed (3 subcategories)
    o Do not remember
    o No
Insurance coverage (3 subcategories)
- Medicaid
- None
- Private coverage

Types of healthcare (4 subcategories)
- Dental
- Home remedies
- Primary care physician
- Urgent care – ER

Continue 1_Socioeconomic - Life History
- Q14_Importance HC in household (3 subcategories)
  - Important (5 subcategories)
    - Appointments
    - Elderly father healthcare
    - Home remedies
    - Insurance coverage
    - Nutrition
  - Limited budget
  - Not discussed

- Q15_Family doctor – you visit 1+ yr (3 subcategories)
  - Name of doctor (8 subcategories)
    - Does not remember
    - Dr. Bunch
    - Dr. Madrid
    - Dr. Millican
    - Dr. Osgood
    - Dr. Tare
    - Dr. Valdevia
    - Dr. Zold
  - No (4 subcategories)
    - Did not use fee-based services
    - Do not remember
    - No preventative care
    - Not annual
  - Yes (6 subcategories)
    - Dental
    - General care
    - Immunizations
    - Physical (2 subcategories)
      - Basic
      - Sports
    - Surgery
• Q16_Family doctor – others visit 1+ yr (2 subcategories)
  – Name of doctor (8 subcategories)
    o Dr. Bunch
    o Dr. Kanode
    o Dr. Millican
    o Dr. Osgood
    o Dr. Tare
    o Dr. Valdevia
    o Dr. Zold
  – Yes (8 subcategories)
    o Cancer
    o Childbirth
    o Dental
    o Emergency care
    o General care
    o Immunizations
    o Physical (2 subcategories)
      ▪ Basic
      ▪ Sports
    o Vision

Continue 1_Socioeconomic - Life History
• Q17_Anything else (5 subcategories)
  – Changing times
  – Home remedies
  – Insurance coverage and healthcare (2 subcategories)
    o Barriers
    o Benefits
  – Other
  – Prioritizing in budget

2. 2_Messaging – Marketing (3 subcategories)
• Q1_First aware NMHIX
  – Learned about program (12 subcategories)
    o Co-workers
    o Doctor
    o El Centro Family Health
    o Family member
    o Friends
    o Insurance agent
    o Internet
    o Newspaper
    o Talk
• TV
  o Unspecified news media
  o Welfare office
  - Premiums and benefits
  - Thoughts about program

• Q2_Format obtain daily news (7 subcategories)
  – Billboards
  – Internet - Smartphone
  – Newspaper
  – Radio
  – Text messages
  – TV
  – Word-of-mouth

• Q3_Most meaningful to get news (3 subcategories)
  – Format (8 subcategories)
    o Email
    o Home visit
    o Internet - Smartphone
    o Mail
    o Newspaper
    o Phone call
    o Text message
    o TV
  – Notification received
  – Point of contact (4 subcategories)
    o Community contact
    o Doctor
    o Family member
    o Insurance provider or agent

Continue 2_Messaging – Marketing
• Q4_Motivation to get HC insurance (6 subcategories)
  – Age as factor
  – Financial risk-reward
  – Health issues
  – Mandated or penalty
  – Preventative healthcare
  – Thoughts about program

• Q5_Why having insurance important (3 subcategories)
  – Access to care
- Family and friends
- Good health

- Q6_What motivated understanding (6 subcategories)
  - Access to care
  - Aging increased health issues
  - Financial concerns
  - Maintain health
  - Obamacare after Obama
  - Security - Comfort

- Q7_Why pay monthly premiums (5 subcategories)
  - Avoid cancellation
  - Avoid penalty - obey law
  - Care about my health
  - Premiums
  - Thoughts about program

- Q8_Anything else (6 subcategories)
  - No
  - Other
  - Plans and premiums
  - Recap
  - Security having insurance
  - Work issues

3. 3_Reflection on Experience (8 subcategories)
- Q1_Enrollment experience NMHIX (2 subcategories)
  - Negative (8 subcategories)
    o Confusing
    o Income qualification criteria
    o Misunderstood coverage
    o No option to enroll after deadline
    o Plans - premiums - deductibles
    o Process
    o Unfair penalties
    o Uninformed staff
  - Positive (5 subcategories)
    o Corrected errors in premium
    o Cost
    o Customer service - staff
    o Helpful information
    o Process
• Q2_What do differently (6 subcategories)
  – Ask more questions
  – Billing system
  – Find cheaper alternative
  – Navigator training
  – Nothing
  – Qualified better for help

• Q3_What enroll more comfort (5 subcategories)
  – Better informed staff
  – Change waiting period
  – More information about options
  – Nothing - satisfied with process
  – Sign up earlier

• Q4_How changed you (3 subcategories)
  – Appreciation
  – Confidence
  – Stress - worry

• Q5_How helped you and family (3 subcategories)
  – Helps in general
  – Panicked - dropped coverage
  – Self-reliant - aware - responsible

• Q6_Benefit or not having HC insurance (2 subcategories)
  – Negative
  – Positive

Continue 3_Reflection on Experience
• Q7_How often used HC insurance (4 subcategories)
  – Doctor - tests
  – ER
  – Physical therapy
  – Prescription drugs

• Q8_Anything else (5 subcategories)
  – Affordability
  – Preventative care
  – Recap
  – Self-motivation
  – Teach clients
4. 4_Conceptual (4 subcategories)
   • Q1 Changes enrollment process (11 subcategories)
     – All doctors accept coverage
     – Billing system
     – Consumer-friendly messaging
     – Customer service
     – Educate consumers
     – Employee training
     – Enrollment date
     – Free insurance for unemployed
     – Hardship premium extension
     – Income criteria
     – None

   • Q2 Changes HC insurance (6 subcategories)
     – Co-payments
     – Cost of living, in general
     – Customer service
     – Deductibles
     – Income criteria
     – Premiums

   • Q3 Changes your life (2 subcategories)
     – Personal life (6 subcategories)
       o Bucolic lifestyle
       o Education
       o Family
       o Health
       o Job - career
       o Regrets - unspecified
     – Systems (3 subcategories)
       o Age discrimination hiring practices
       o Consumer support
       o SS benefits age eligibility

Continue 4_Conceptual
• Q4 Anything else (3 subcategories)
  – No
  – Thoughts about healthcare
  – Thoughts about study

5. Current healthcare plans