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The Association between Demographic Factors and Use of California's Health Insurance

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
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Walden University
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Abstract

The Association between Demographic Factors and Use of California's Health Insurance Exchange

by

Chiquita T. Tuttle

MBA, Golden Gate University, 1990

BS, Golden Gate University, 1986

Dissertation Submitted in Partial Fulfillment

Of the Requirements for the Degree of

Doctor of Philosophy

Health Services Administration/Public Health Policy

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Abstract

The Patient Protection and Affordability Act of 2010 (PPACA) addressed the access to healthcare in the United States. One of the problems of this healthcare access was rooted in disproportionally lower access among minority populations. The purpose of this quantitative study, guided by the consumer behavior theory, was to examine the association between race/ethnicity and enrollment within the Covered California™ (CoveredCA) Insurance Exchange. A cross-sectional study design was used to investigate the association between race/ethnicity and the use of Covered CA health benefit exchange. Logistic regression analysis was used to examine the relationship between enrollment and race/ethnicity, having adjusted for covariates of age, gender, and literacy. The results revealed that, while all other race/ethnicity groups were less likely to purchase Bronze level versus Silver and above coverage compared to the Hispanic race/ethnicity, Asians (*OR* =1.16, 95% CI: 1.11, 1.20) and Whites (*OR* = 1.12, 95% CI: 1.02, 1.14) were more likely to purchase Bronze level versus Silver and above coverage compared to the Hispanic group. Chi- square test results indicated a statistically significant difference in the proportion of individuals selecting the Bronze level coverage compared to the Silver and above among the various race/ethnicity groups χ^2 (13, N= 763,531), 1922.083, $p < 0.0001$. The Hispanic race/ethnicity was more likely to enroll in the Bronze versus Silver and above compared to other race/ethnicities. The results of this study may contribute to positive social change by informing policy that besides income and age, race/ethnicity is an important determinant of the likelihood of enrollment in the Covered CA health exchange.

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Dedication

This proposal is dedicated to my husband John I. Tuttle for his support, love, dedication and continuous encouragement to attain my goal for this important work in public health policy. He unselfishly provided me the space to study and move forward to accomplish this lifetime journey. Thank you to each of my children, Jon, Chiquita, Carmella, Cassondra and Jared Tuttle for their unwavering love, support, encouragement and incredible technical assistance. This accomplishment is important for each of them to know that it is never too late to learn, dream and achieve their goals. To my grandchildren, Jordan, Courtland, Amara, Akayla, Londyn, Milan, Brooklyn, and Cameren, know that you should always pursue your education and dreams early in life and never get discouraged. To my transitioned parents, William B. and Anna M. Severin Drake who always taught me that no one could take my education away from me and to always strive to continuously learn, be patient, strive for excellence and dignity. I am grateful for their love and for bringing me into this life. I am certain that they would be very proud of my accomplishment and wish that they could be physically present to see me graduate with this honor. I know that they are extremely proud and smiling down on me.

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Chapter 1: Introduction to the Study

Background

The Patient Protection and Affordable Care Act (ACA) of 2010 provided for health care coverage for previously uninsured persons in the United States who met the eligibility parameters (ACA, March 23, 2010). In the U.S. and particularly in the State of California, the targeted uninsured population for this study identified as communities of color, are specifically Hispanics, African Americans, Asian/Pacific Islanders, and American Indian/Alaskan Native (National Institutes of Health, 2010). This study will examine the buying behaviors of African American, Hispanics, Asian/Pacific Islanders, and American Indian/Alaskan Natives selecting health insurance in Covered California's Health Benefit Exchange Marketplace. The relationship between ethnicity and buying behaviors may shed some insight for marketing professionals as they develop their communication strategies for health care offerings during future Health Benefit Exchange annual open enrollment periods whereby ethnic consumers are selecting the best health care options at the most affordable costs based on concrete information such as beliefs, communications, personal preferences social media, other influences, and perceptions.

The current Hispanic population in the U.S. is approximately 50 million (The Henry J. Kaiser Family Foundation, April 2013). Of particular interest and importance, however, is that illegal immigrants residing in the US for less than five years are not eligible to participate in ACA (KFF.org). Undocumented immigrants will remain ineligible for Medicaid and will be ineligible for the premium tax credits; they also will be prohibited from purchasing exchange coverage at full cost. As of 2011, there were 40

million immigrants residing in the United States, accounting for 13 percent of the total population (Kaiser Commission on Medicaid and the Uninsured, March 2014). There are, however, community and nonprofit organizations that do provide health care for this population as safety net providers (www.achealthcare.org/about).

One goal of the ACA was to reduce disparities in health care coverage by providing access to enrollment for the uninsured in the Health Benefit Exchanges (HBE) and with the expansion of Medicaid in the states. Additionally, the law's overarching goals are to improve health care for all citizens as well as slowing the growth of medical care costs (ACA, March 23, 2010). The literature on health coverage disparities is plentiful and the subject of reducing disparities has become more prevalent given the goals of the ACA legislation and as the open enrollment period for the Affordable Care Act, 2010 for this initial calendar year came to a close as of April 30, 2014.

This study will add to the literature regarding the impact of marketing/media strategies among communities of color as it pertains to buying behaviors and health care decisions for enrollment as noted in the publication The Minority Health & Health Equity Archive, March 21, 2012.

In the publication related to the Affordable Care Act (2010), health care legislation, Facts on Health Reform, The Henry Kaiser Family Foundation, (2009) stated that the goal is to assure that health care is available to every eligible person. Reports from the Kaiser Family Foundation, Gallup, Covered California, the Office of the President and other state and federal agencies have been vital in reporting the results of the membership, including demographics such as the economic and socio-economic

status of the eligible uninsured throughout this initial offering period (KFF.org). The success of the effectiveness of the overall enrollment will clearly be, from the actuarial lens, an appropriate balance of health risks within the various ethnic groups (CoveredCa.com).

The literature also validates that access to preventive services results in fewer people suffering from chronic diseases and reduces the utilization of emergency room visits for non-emergency services (The World Health Organization [WTO], n.d.). In addition, preventive services are less costly than emergency room services for non-emergency health incidents (The Henry J. Kaiser Family Foundation, 2012). This is important as the premise behind the Affordable Health Care Act, 2010 is that preventive care can impact chronic health conditions due to early detection. An important outcome of the ACA on enrollment considers the impact of ultimately reducing health disparities (Covered California, March 21, 2013). Although there are many studies on disparities and inequality of health care delivery services that affect communities of color, there has been no study that has examined the impact of a marketing/media strategy for communities of color enrolling in a Health Exchange or federally subsidized program of mandated health coverage such as Covered California, according to a report published by The Henry Kaiser Family Foundation (March 21, 2013) entitled "Facts on Health Reform. “.

Articles researched for this study included The Henry J. Kaiser Family Foundation (November, 2009), Kaiser Commission on Medicaid and the Uninsured (July, 2013), and The ACA (2010), and (Newhouse, 2010). The ACA is relatively new legislation and the creation of the Health Benefit Exchanges presented challenges both statewide and federally in terms of the implementation, the enrollment process including the demands on technological systems (CoveredCa.com). The literature review in Chapter 2 provides more detail on the subject and the implications of this legislation.

Problem Statement

Health care for the uninsured, specifically communities of color and the marginalized, has reached over 47 million individuals nationally and approximately 7 million individuals within the state of California (Covered California, 2013). The cost of providing health care to those who are uninsured has had an enormous financial impact on the economy and the health care delivery system. The number of uninsured nonelderly Americans in 2014 was 32 million, a decrease of nearly 9 million since 2013. People of color make up *40%* of the overall U.S. population but account for over half of the total uninsured population (www.KFF.org).

The passage of The Patient Protection and Affordable Care Act of 2010, signed by President Barack Obama, has changed the landscape for the uninsured by offering health care insurance options that are subsidized and priced affordably. Individuals and small businesses who could not afford health coverage in the past are offered several levels of coverage through the creation of the healthcare marketplace.

Eligibility is based on their income and health care needs (Patient Protection and Affordable Care Act, 2010). The state of California was among the first to implement an Insurance Health Exchange offering health care options to the nonelderly uninsured through the marketplace with the assistance of financial subsidies. (CoveredCa.com). The expansion of Medi-Cal (identified as Medicaid in states other than California) has also increased the number of eligible participants for health care coverage and is inherent in the health care legislation (CoveredCa.com). The importance and relevance of this are that prior to the ACA legislation, huge gaps in health care coverage and access to care existed for those not able to qualify for state Medicaid/Medi-Cal benefits). In California, that applies to income levels at or below *138%* of the federal poverty level (FPL), which translates to $32,500 for a family of four (The Henry J. Kaiser Family Foundation, 2012).

Nature of the Study

This study examined the decision making process of ethnic consumers used to purchase health care benefits while understanding the complexities that include both internal and external factors. Greater detail regarding these buying and decision complexities such as rational choice, purchasing motivators, messaging and communications based on marketing theories is provided in Chapter 3, Methodology.

Research Questions and Hypotheses

The researcher for this study utilized secondary enrollment data available from Covered California's Health Benefit Exchange 2014 Enrollment Data Book. The data represented the final enrollment figures as a result of the initial open enrollment period that began on November, 2013and concluded in April, 2014.

The 2014 Enrollment Data Book provided de-identified summary data figures for the initial enrollment which included age, gender, metal level, federal poverty level, language spoken and race/ethnicity.

Research Questions

Q1: What is the marketing and media strategy association between the enrollment in the Covered California Health Benefits Exchange and the race/ethnicity of the potential enrollees, specifically that of African Americans, Hispanics, Asian/Pacific Islanders, and American Indian/Alaskan Natives during the initial open enrollment period occurring between October, 2013 and April, 2014?

Q2: Does age influence the relationship between Hispanic identity and enrollment in Covered California Health Benefits Exchange?

This study used a quasi-experimental method examining the specified ethnic enrollment groups (African Americans, Hispanics, Asian/Pacific Islanders, and American Indian/Alaskan Natives) and their respective relationship to the Health Benefit Exchange enrollment. The ethnic enrollment groups are the independent variables (IV), and the Health Benefit Exchange enrollment is the dependent variable (DV). The study examined

how different populations responded to the marketing and media communications strategies during the open enrollment period between October 2013 and April 2014.

Hypotheses

Research Question 1

Null Hypothesis (H_o): There is no significant statistical association between ethnicity and enrollment statewide from November 2013 through April 2014 based on the marketing and media strategies employed by Covered California's Health Benefit Exchange.

Alternative Hypothesis (H_1): There is a significant statistical association between ethnicity and enrollment statewide from November 2013 through April 2014 based on the marketing and media strategies employed by Covered California's Health Benefit Exchange.

Research Objectives

This study will inform policy makers on enhanced, effective marketing and media methods of communication when conducting open enrollment for Covered California's Health Benefit Exchanges (HBE) in subsequent years based on buying behaviors and ethnicity. Policy makers will become more cognizant of the need to target their marketing and communication efforts to consumers based on beliefs cultures, literacy challenges, and other external and internal influences.

Purpose of the Study

The purpose of this quantitative study is to understand and describe the actions and motivators affecting the behaviors of participants electing to enroll in Covered California's (HBE) and the level of influence of the marketing and media strategies in communities of color. This project focuses specifically on, African American, Hispanic, Asian/Pacific Islander, and American Indian populations. The core research for this study is predicated on the Covered California's (HBE) final open enrollment statistics as of April 2014.

Theoretical Foundation

Marketing theories of consumer behavior and buyer behavior are used in this study to analyze marketing strategies directed at consumers. Marketing and buying behavior theories of Ajzen and Fishbein (2007, 2010, 2014), Bray (2008.), Cohen (2013), Foxall (1990, 2003, 2004) Heller (2000), Kotler, (2003, 2010) Loudin and Della Bitta (1993), Peters (1960), examine consumer behaviors, values, cultures, needs, education, intention, economic, and socioeconomic factors.

Buying behaviors are influenced by information provided through strategic marketing communications regarding a service or product (Evans, Jamal and Evans (2009). Knowledge, attitudes, personality, values, and lifestyles also influence buying decisions according to Blackwell, Miniard et al, (2001). These elements influenced the demographic factors of each ethnic group in terms of their buying behaviors.

The factors that contributed to why and how they purchase health care were based on personal beliefs, marketing, persuasion, personal experience and overall comprehension of services, benefits and needed health care coverage. A key theoretical contribution validating this concept is that of Weber reflected in his teachings relative to social action.

Freund informed us that Weber's concept of social action focused on achieving the most objective understanding possible of how men evaluate and appraise, use, create and destroy their various social relationships. Weber thus sought to understand actual man living in society. He goes on further to describe how man behaves in his community and society he forms and transforms these relationships (Freund, 1968. p.88).

Operational Definitions

Communities of color: Refers to racial and ethnic communities such as African American, Hispanic, Asian/Pacific Islander, and American Indian/Alaskan natives. These are terms used in the industry and other research studies.

Health Benefit Exchange (HBE): The plan created by the State of California identified as Covered California as a result of The Patient Protection and Affordable Care Act of 2010 (ACA). Medicaid and Medi-Cal refers to the state funded health coverage for low income families based on federal poverty levels.

The Patient Protection and Affordable Care Act of 2010 (ACA): The landmark legislation passed by President Barack Obama that provides for health care benefits afforded to all eligible citizens focused on reducing the number of uninsured Americans and the overall costs of health care. The health care reform act includes the expansion of

health care centers in rural areas and Medicaid in states nationally. States have the option to expand Medicaid (identified as Medi-Cal in the state of California) coverage for their respective communities providing for primary care services that would reach the uninsured vulnerable adult population with incomes below the 138% (FPL) federal poverty level (KFF.org.). Federal Poverty levels are determine annually by the Federal government and are used to determine subsidy levels for the ACA legislation and Medicaid coverage.

Health disparity refers to a particular health difference that is closely linked with social or economic disadvantage as noted by the National Partnership for Action to End Disparities (www.minorityhealth.hhs.gov). Those impacted by health disparities have traditionally been communities of color experiencing economic, environmental factors and other social obstacles (Covered Ca.com).

Health Benefit Exchange (HBE) was created through the ACA legislation, 2010 which provides for individuals and businesses to purchase health insurance.

The Small Business Option Program (SHOP) is the designated employer option.

Specific Essential Health Benefits Coverage (EHB's) are detailed and spelled out in the legislation as health coverage options for individuals and employers.

Covered California is the state of California's Health Benefit Exchange designed as a result of The Patient Protection an Affordable Care Act (PPACA), 2010.

Assumptions

This study conducted test for normal distribution, homoscedasticity, multicollinearity and linearity. The assumption was that the selected populations have similar circumstances (e.g. they have low income, are uninsured, have low education levels, and have literacy challenges), and are representative of the identified communities of color in this study. Specifically, ethnic and racial communities included African Americans, Hispanics/Latinos, Asian/Pacific Islanders, and Native American Indians/Alaskan Natives. An additional assumption is that demographic variables can be used as surrogates to predict the utilization of Covered California's Health Benefit Exchange. These demographic variables include age, income, gender, sex, education levels, marital status, occupation, family size and death and birth rates.

Limitations

Among the challenges in using secondary data are limited or no access to the data, no means to validate the data, and no access to the primary sources in terms of the enrollment applications collected during the enrollment process. There is also the limitation of the inability to determine missing data, if any, and how missing data are accounted for. Another limitation is the inability to measure all factors involved in the enrollment decision making process by potential eligible enrollees. There are always unmeasured variables that may impact the dependent variable in unobservable ways.

Scope and Delimitations

The research study only examined the enrollment process and results in the state of California The study will only focus on the enrollment outcomes as it relates to buying behaviors of the ethnic groups identified in the study: African Americans, Asian/Pacific Islanders, American Indian/Alaskan Natives, and Hispanics. Racial and ethnic minority communities have significantly different beliefs, behaviors, cultural attitudes, literacy and educational levels that influence their purchasing decisions. These beliefs include religious beliefs, trust, communication, and the need for one on one consultation. Internal and external factors impact buying decisions as noted in the literature theories of Weber, Loudin and Evans (1993), Jamal and Foxall (2009) among others researched for this study.

Significance of the Study

This project is unique because the Health Benefit Exchange (HBE) program was created recently (Covered California, 2013). This study will provide insights into new methods of marketing and communicating in communities of color. This is important because of the challenges related to health literacy limitation, linguistic challenges, and clear communication surrounding ethnic community participants relative to their health care options.

In Chapter 1, the importance of marketing strategies that include cultural competency and cultural sensitivity while remaining cognizant of the need to deal with determinants of health, limited literacy, communication, and appropriate media messaging for communities of color were discussed. Evans, Jamal and Foxall, (2009)

informed us that a great deal of marketing effort is aimed at persuasion in order to change attitudes and behaviors. It was emphasized that participants must understand the marketing and medical language related to their medical conditions. Outreach efforts are important in terms of successful consumer experiences. Statement of the problem, significance, and purpose of the study were described and the research questions to be answered and the specific hypotheses to be tested were stated.

The chapters that follow provide more in depth descriptions of the literature reviews and methodology utilized to address the research questions. Included in the chapter is an introduction of the study providing background as the basis of the study. The problem statement discusses the state of the uninsured and the means by which the Affordable Care Act, 2010 has changed the insurance landscape. A description of the nature of the study research questions posed and hypotheses are focused on association of demographics and enrollment within the California health exchange. How the study will inform health benefit exchanges is addressed in the research objectives. Additional information includes the purpose of the study, theoretical basis for the research, operational definitions and assumptions made for the study.

Chapter 2: Literature Review

Introduction

The mission of Covered California is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value (Covered California, 2013). This study will examine if consumer buying behaviors and health care choices are influenced based on ethnicity.

Over the years, the function of marketing has evolved into a science that is more strategic and incorporates marketing concepts and motivation theories (Evans, Jamal and Foxall (2009). Access to information about a product or service is instantaneous give the inroads to social media and the technological revolution. Marketing strategies and communication provide consumers with a number of avenues to become knowledgeable about products and services. Information is available on television, radio, in print, electronically, and hard copy to help consumer make buying decisions.

The process of selling involves offering a product or services in exchange for some form of payment, usually in a monetary form. The consumer determines their need and desire for a product or service, based on certain attitudes, stimuli, information, beliefs, education, and is willing to pay an amount to obtain the product or service (Evans, Jamal and Foxall, 2009). The role of the salesperson is to persuade and inform the buyer that the product or service is reliable, and will meet the needs of the prospective customer.

Theoretical Framework

This study was analyzed from a marketing theoretical lens taken from Foxall, (1990), Loudon and Della Bitta, (1993), Kotler, (2003, 2010), Weber (1993, 1969, 1963), Engle et al, (1995), Kotler (2003), Foxall, Goldsmith and Brown (1998), and Cohen, (2013). The research study will demonstrate in terms of conclusion validity that there is a statistically significant association between the variables of ethnicity and health plan enrollment in the Covered California's Health Exchange. Assuming that there is a statistically significant association in the study, this will validate that the marketing and media strategies, such as one on one assistance with the application process strongly related to the theories of consumer buying behavior and rational choice. From an external validity perspective, the outcomes can generalize that the cause and effect of ethnicity and health plan enrollment to other areas of the country during similar Affordable Care Act Health Benefit Exchange open enrollment periods in subsequent years given similar demographics are generalizable. In addition, Weber's rational choice theory is a significant contributing factor based on his concept of rational choice behavior and social action. Weber's work on social action and rational behavior links goal oriented conduct and value oriented conduct by individuals. These concepts directly relate to buying behaviors and motivation in this study.

This study was based on the quantitative research methodology and was quasi experimental in nature. The researcher for this study utilized secondary public enrollment data available from Covered California's Health Benefit Exchange (2014) data book representing the final statewide enrollment figures resulting from the initial open enrollment period that occurred between November 2013 and April 2014.

Marketing and buying behavior theories of Foxall (1990, 2003, 2004), (Bray,2008.), Loudin and Della Bella (1993), Heller (2000), Cohen (2013), Peters (1960), Bray (2008), Ajzen and Fishbein (2007, 2010, 2014), and Cohen (2013) examine consumer behaviors, values, cultures, needs, education, intention, economic and socioeconomic factors. According to Evans, Jamal and Foxall, (2009), buying behaviors are influenced by information provided through strategic marketing communications regarding a service or product. That information can be relayed in various media forms such as, radio, one on one counseling, television or print ads (Evans, Jamal and Foxall, 2009).

Research theories on the variations of consumer buying behavior and choice have produced a range of decision models including reasoned action, trying, planned behavior and goal-directed behavior to note a few. Ajzen and Fishbein (2007, 2010) and Foxall, (2003, 2004) are proponents of these theories.

These theories examine the thought process that consumers undergo when making a buying decision. Influences, both internal and external are factors which aid in the determination of the buying decisions. (Loudin & Della Bitta, 1993). Factors such as prior experience, recommendations from family and friends, available literature, internet

resources, social networking, and one- on- one assistance influence buying behavior in addition to an individual's beliefs and attitudes (Ajzen, 1975, 2012, 2013).

In order to make informed decisions, the consumer requires knowledge. Peter Drucker affirms the value of knowledge, noting that our existing society today, is one that is built around the exchange of knowledge (Cohen, 2013, p 161, Heller, 2000, p.98). Health care decisions require knowledge of the services, providers, and the level of benefits and out of pocket cost (Cohen, 2013). Consumers make health care decisions based on their health care needs and the cost (Rudd and Glanz, 1989). The Kaiser Family Foundation validates this in their July 2014 report of the National Survey findings that 10.6 million people were helped by navigators and assisters during the Affordable Act's first open enrollment period (KFF, July 15, 2014, p1).

In health care, the need for insurance coverage is a given and mandated by law, however, the cost and benefits are weighed by the consumer in terms of their specific health care needs and available financial resources (ACA, 2010). Weber theorized that behavior is a result of motivation, emotion and rationalism. He further discusses the importance of understanding on the part of the consumer in terms of their behavior patterns (Secher, 1962). The decision to purchase health care is motivated by health care status and the rationalization that unforeseen health care issues can have devastating financial implications without health insurance (Kaiser Health News, 2015). Therefore, prospective health care purchasers buying behavior during the open enrollment periods for Covered California's Health Benefit Exchange are the results of understanding, based

on Weber's theoretical interpretation of the state of mind of individuals when makings decisions (Secher, 1962).

Buying behavior and rational choice theories put forth by Weber inform this study on health care decision and purchases in various ethnic groups. The customer is motivated to be offered options for health insurance and becomes emotional about the decision. Because of existing medical needs the consumer, therefore, rationalizes the purchasing decision based on anticipated improved health status coupled with an affordable premium. This interpretation aligns with Weber's theory on the state of mind of individuals when making decisions (Secher, 1962). These theories explain consumer values by examining ethnicity, personal goals, attitudes, beliefs, objectives, as well as individual preferences and priorities relative to health care needs and choice.

According to Weber, human conduct, in order to qualify as a social behavior, must be clearly *intentional.* It must have meaning attached to it by the individuals engaged in it, who in turn orient themselves toward the similar behavior of others (Weber, 1993). In the case of this study, the consumer's decision to secure and purchase health care coverage is intentional and highly motivational.

Among the theories explored for this study will be the planned behavior model to identify each ethnic group's respective motives and rationale for their purchasing selection suggested by Professor Icek Ajzen (2013, p.179-211). The theory of planned behavior (TPB) started as the Theory of Reasoned Action (TRA) in 1980 to predict an individual's intention to engage in a behavior at a specific time and place (Ajzen, 2013). This theory was intended to explain all behaviors over which people have the ability to

exert self-control (People.umass.edu/Ajzen/tpb.html) n.d.). The key component to this model is behavioral intent. Behavioral intentions are influenced by the attitude about the likelihood that the behavior will have the expected outcome and the subjective evaluation of the risks and benefits of that outcome (Ajzen, 2013). The Theory of Planned Behavior links beliefs to behavior and is related to the theory of reasoned action, which predicts behavior and attitudes (Ajzen, 2013). This separation of attitudes and intention was further developed by Ajzen in 1980. Ajzen and Fishbein jointly developed the Theory of Reasoned Action (TRA), which explores the theory of attitude in behavior (Ajzen & Fishbein, 1975).

TPB has been used successfully to predict and explain a wide range of health behaviors and intentions including smoking, drinking, health services, utilization, breastfeeding, and substance use (Ajzen, 2013). The TPB theory states that behavioral achievement depends on both motivation (intention) and ability (behavioral control). It distinguishes between three types of beliefs - behavioral, normative, and control. The TPB is comprised of six constructs that collectively represent a person's actual control over the behavior (Ajzen, 2013).

According to the Theory of Planned Behavior (TPB), a relationship exists between beliefs and attitudes. An individual’s beliefs contribute to their attitude towards buying decisions. Behavioral belief is predicated on the probability that a specific outcome will be the result of the behavior. An attitude behavior, on the other hand, is a result of how positively or negatively an individual perceives during a buying decision (Ajzen, 2013).

Ajzen informs us that according to the theory, human behavior is guided by three kinds of considerations: beliefs about the likely consequences of the behavior (behavioral beliefs), beliefs about the normative expectations of others (normative beliefs), and beliefs about the presence of factors that may facilitate or impede performance of the behavior (control beliefs), (Fishbein, M., & Ajzen, I. (2010). Normative beliefs, on the other hand are biased by those perceptions of other persons from a social environment (Ajzen, 2013). In line with this belief is the subjective norm in which the decision that an individual makes is highly influenced by individual's within the social and familial circle of the decision maker. This may include family, friends, colleagues, and professional associates. In the case of Covered California and health care decisions, health care recommendations often come from individuals who are current members and who have had a positive customer experience. In addition, the use of Assisters and Enrollment Advocates were designed to facilitate a positive enrollment outcome (CoveredCa.com).

Ajzen and Fischbein's (1972) study on attitudes and normative beliefs as factors influencing behavioral intentions illustrated that individuals can be influenced by attitudes and beliefs when making buying decisions. Their study examines the prediction theory of behavioral intentions (BI) which individuals assumed to mediate overt behavior (Ajzen & Fishbein, 1972, p. 1). The study further describes the relevance of a person's attitude toward a decision and the perceived value of the decision making consequences. The findings in the study found that behavioral intentions can be controlled by attitudinal considerations (Ajzen & Fishbein, 1972, p. 7). An additional finding of the study illustrated the possibility to influence a person's normative behavior by manipulating his

perception of the beliefs of others about the consequence of performing a given behavior (Ajzen & Fishbein, 1972, p. 8). This is relevant in terms of Covered California's open enrollment decision making process for individuals. Health care options were made available to individuals who may or may not be informed about the various health plans and how they provide health care or the level of health care services. Potential enrollees may rely on the marketing strategy communicated via Covered California's ad campaigns or they may inquire about these options with family or friends which may influence their ultimate enrollment decision. The influence of family and friends may, in fact, change the potential enrollee's perception of the health plan offerings as noted in an earlier study (Ajzen, 1971).

More recent studies on the Health Benefit Exchange (HBE) enrollment process and decisions are described in Academy Health Research Insights where academic researchers were convened with policy experts to discuss choice and decision making in a health insurance exchange. The article explores the practices of successful enrollment strategies and compares them to the Children's Health Insurance Program (CHIP) and its long-term success using pre-filled applications forms that facilitate auto enrollment. The article discusses the complexity and confusion of the enrollment process as well as the administrative costs. It is interesting to note, however, the article mentioned that "most people, with the exception of the chronically ill, do not have an immediate need for health insurance (Academy Health, n.d.). This appears to be unfounded, based on the total number of individual that enrolled during the open enrollment period, particularly in California.

In addition, the tax penalties attached to non-enrollees would be compounded in year two of the open enrollment season. Therefore, there was a clear incentive to enroll. The offering of financial subsidies also made enrollment attractive for many who would otherwise not obtain or seek coverage.

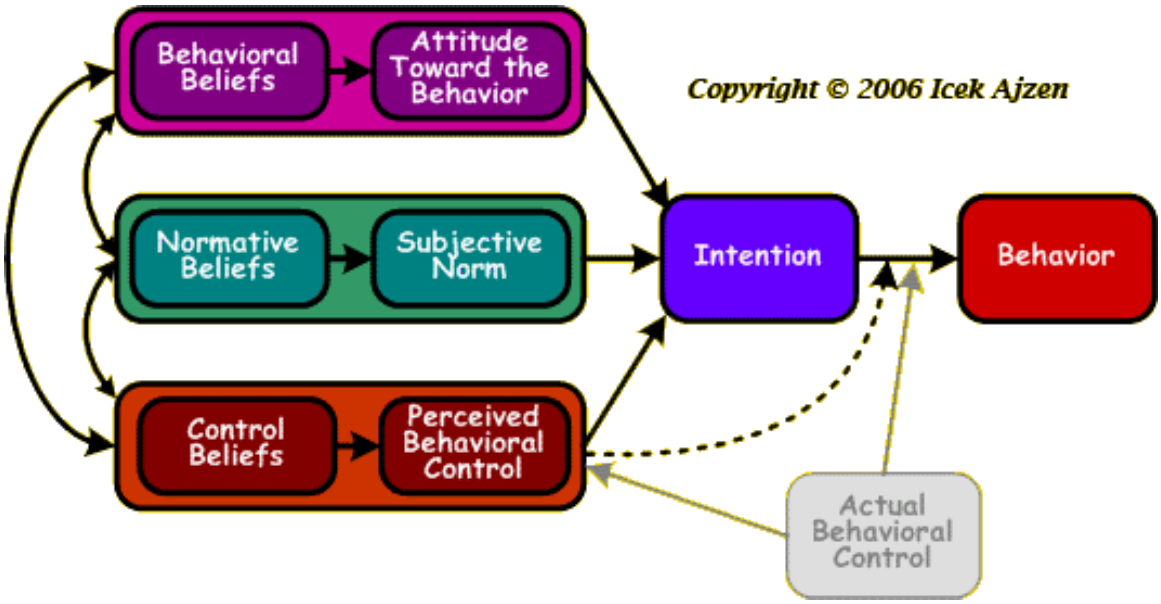

Figure 1.Theory of Consumer Behavior Illustration.

Theory and Theorist

Peter Drucker discussed customer focus as a "valid definition for business purpose…therefore customer values and decisions are the starting points for policy and strategy" (Heller, 2000, p. 38, Drucker, 2000). From a marketing perspective, knowledge regarding customer values is important when developing marketing, media or a communication strategic plan. (Drucker, 2000).

Understanding the buying behaviors should determine the messaging. Drucker, according to Cohen (2013), informs us that marketers are on the right track when they seek to learn who their customers and potential customers are, what they buy, where they are, what they read or what is on television and so on (Cohen, 2013, p. 161).

Tom Peter's theory focuses on processes and performance within an organization that affect profit margins. Market orientation to improve performance is the basis from which Peters provides his theory.

The relationship to this research study is that the health care organizations in the Covered California's Health Benefit Exchange (HBE), chosen by the new customer are required to perform effectively and efficiently in terms of service levels and cost efficiencies.

Evans, Jamal and Foxall (2009) on the other hand, emphasize the importance of Maslow's hierarchy of needs theory which references motivation as the driver of the individual's needs. Maslow's needs are categorized in seven levels: Physiological, Safety, Social Esteem, Cognitive, Aesthetic, and Self Actualization. An explanation of each of these needs can be found at http://www.businessballs.com/maslow.htm (Evans, Jamal, & Foxall, 2009, p.12). Individuals move on the need ladder in terms of their specific situation. In terms of health care, the rise on the various levels is most likely high. The field of consumer behavior analysis was introduced by Professor Gordon Foxall (2013) evaluates marketing theory and consumer behavior analysis.

Jeff Bray, (2009) explores various consumer behavior models and concurs with Foxall, et al (2009) regarding the variables impacting buying behavior, specifically, the theory that marketing influences affect consumer choice. Bray, (2009) references Loudin and Della Bitta, (1993) discussing the various environmental stimuli; significative, social and symbolic. Variables such as stimulus variables include advertising and products. Response variables, on the other hand include mental and physical response reactions which are influenced by stimulus variables. A third variable, intervening actually intervenes between the response and stimulus variables by magnifying, reducing, or modifying their effects.

Loudin and Della Bitta, (1993) emphasized that culture is everything that is socially learned and shared by the members of society (Loudon & Della Bitta, 1993, p.84) validating other studies that indicate the impact of culture in buying behavior and choice. Bray, (2009) helps us to understand the various consumer behavior theories by

providing models that describe the process. A common theme in the models includes motivation, culture, social class, buyer control, need recognition, and search for information.

Louden and Della Bitta, (1993/8) frame their discussion around the value of segmentation and positioning in marketing. Selecting homogeneous consumers to conduct target marketing for specific products and services is a practice frequently used by marketing experts. This can result in large targets and market share, but also provides for measuring results from such activities. Elaborating on the consumer decision making process, the authors inform us that consumer behavior is seen to involve a mental decision process as well as a physical activity. These activities occur at a specified period of time. In the case of enrolling in the California Health Benefit Exchange, consumers were apprised of the open enrollment period and the deadlines for enrollment. Initially enrollment activity in Covered California during the first quarter was moderately slow. However, during March and April of 2014, the enrollment increased significantly resulting in a surge of enrollment prior to April 15, the designated closure deadline date. Loudin and Della Bitta stress that enrollment decisions often take time when consumers are pressed with both the mental and physical process (Loudon & Della Bitta, 1993, p.7). Their theories are complimentary to Fishbein & Ajzen (2010), Evans, Jamal & Foxall (2009) noting that consumer behavior is influenced by internal and external factors, social expectations, constraints, and most importantly the needs of the consumer.

Hibbard, Slovic, & Jewett, (1997) present the result of a study that focuses on informed consumers and their decisions. In their report, they note that when consumers are informed about the relative cost and quality of health plans, it is assumed that, faced with the collective effect of their educated choices, plans and providers will compete on both cost and quality (Hibbard et al., 1997, p.395). Certainly with the options available through the Health Benefit Exchange, consumers made choices based on their out of pocket (OOP) costs, level of benefits, location, and their understanding of what options were available to them.

Philip Kotler, (2010) a leading authority on marketing informs us that marketing practices evolved over the years and embraced consumer behavior and attitudes. The industry moved in three stages; product management, customer management, and finally brand management. Relationship management is a critical component of the marketing process. Building trust and confidence generates return customers and sales. Segmentation is also important as customers have different want and needs. The communication strategy is important when marketing to various ethnic communities. The level of literacy, trust, and language requirements are important in order to gain customer loyalty for a product or service.

Kotler, (2010) also tells us that marketing must include integrity, identity and image. These facets of the marketing process are persuading aspects that will influence the potential customer. Poor people have been longing for some products previously not available to them not only because of income limitation but also because of access problems (Kotler, 2010). This statement is very applicable to the Affordable Care Act, (2010) and the Health Benefit Exchanges being offered nationally. The number of uninsured persons electing to enroll in the California Marketplaces totaled, 1,395,929 enrollees at the closure of the initial open enrollment period is valid and indicative of Kotler's observation noted above (Covered California, April 17, 2014).

Consumers have become more sophisticated in their buying decisions and are demanding more information on products and services and are approaching buying more holistically. This approach to buying also includes cultural and spiritual components in the decision process. The Affordable Care Act, (2010) provided a historical social change for the country by making health care accessible and affordable as well as expanding the statewide Medicaid or Medi-Cal as it is noted in California. All states, however, did not elect to expand their Medicaid coverage, thereby leaving thousands of persons remaining without health coverage.

The offering of Covered California and other Health Benefit Exchanges represents a major social change for society in terms of meeting the goals of creating a healthy society. Healthy People 2020 set goals that addresses a healthy community and healthy workforce (Healthy People 2010, n.d.).

The majority of the population, regardless of race, religion or ethnicity, is supportive of the ACA's, (2010) social initiatives particularly if it avails people of access to health care services resulting in the reduction of the number of uninsured persons nationally. A major theme for all marketing is based on education. Providing relevant product, pricing, features, and benefit information assists the consumer in making informed decisions.

This literature research presents marketing, communication, and behavioral theories that have a consistent theme relative to consumer health care purchasing. The emphasis has been on behaviors based on education, as well as internal and external influences. The theories describe the importance of culture in buying decisions and why marketers must pay attention to this as they develop their marketing strategies. In addition to culture, the value of segmentation is addressed in making an impact on consumer decisions. Segmentation is relevant to the various cultural groups and concentrates on market share based on geography and price. The literature is also clear that the role of intermediaries such as assisters and navigators who assist consumers in their buying behaviors is critical to making informed decisions.

According to U.S. Department of Health & Human Services, the ACA (2010) is working to make health care more affordable, accessible, and of a higher quality, for families, seniors, businesses, and taxpayers alike. This includes previously uninsured American and Americans who had insurance that didn't provide them adequate coverage and security (www.HHS.gov). The map below indicates, by state, which states have expanded Medicaid making health care available to previously uninsured persons. The map does not reflect Health Benefit Exchanges implemented as a result of the ACA

however, the post enrollment data indicate that previously uninsured persons did take advantage of the initial health insurance offerings.

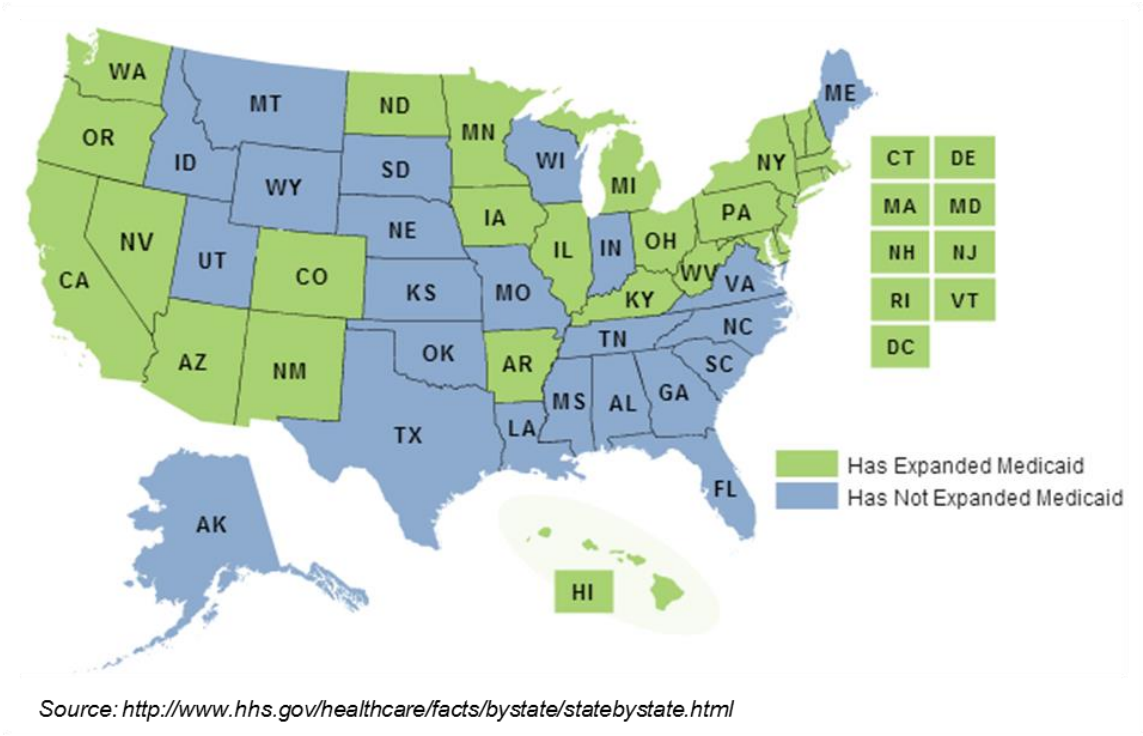

Figure 2. Medicaid Expansion by State.

In the State of California, 1,405,102.00 persons opted to enroll in a health plan during the open enrollment period. Nearly 3.4 million previously uninsured persons gained covered through Covered California or Medi-Cal (http://hbex.coveredca.com/data-research/library/2015_leg_report.pdf). Nationally, 6.8 million uninsured African Americans, 2 million Asian Americans and Pacific Islander, 10.2 million Latinos, and 579,000 American Indian/ Alaskan Natives were provided new health care options due to the Affordable Health Care Act, 2010.

Racial and Ethnic Differences

The National Research Council of the National Academies focuses its work on the reduction of health disparities. In its publication Understanding Racial and Ethnic Differences in Health in Late Life, A Research Agenda discusses the importance of health and income as it relates to the well-being and economics of low income communities (Bulatao & Anderson, 2004, p.28). An additional discussion explores why health matters provides the following: the main reasons for concern about health differences are their relationships to the well-being and individuals and to society as a whole (Bulatao & Anderson, 2004). This is important and relevant to social change as health care is made available to all eligible citizens such that they can become, in some instances, gainfully employed and improve their health status due new and improved access to care. For consumers who are employed, but had no access to health care, the Health Exchanges provides an opportunity for affordable care.

Hunt, Gaba and Laviazzo-Mourey (2005) telephone survey on racial and ethnic disparities and perceptions of health care conclude that racial disparities and trust are clearly factors in the health plan selection process. This study's primary purpose was to examine differences in levels of health care based on ethnic groups. They conclude that their study both confirm and add to earlier findings by Doescher et al, (2000) on racial and ethnic disparities in trust and satisfaction (Hunt, Gaba, & Lavizzo-Mourey, 2005, p. 9/13).

Zmud & Arce inform us in their study The Ethnicity and Consumption Relationship suggests that behavior is a function of ethnicity, social surroundings, and product type (Zmud & Arce, 1992). The focus of this study was to investigate the relationship between ethnicity and consumer behavior. The findings in this study are relevant to the Covered California Health Benefit Exchange as the research question investigates the relationship and influence of ethnicity on enrollment among the ethnic communities. Zmud & Arce, (1992) define ethnicity as the state that ethnicity as country of origin, surname, ancestry, self-identification, and language spoken at home.

In this research study, Weber's, (1993) social action theory and rational choice are referenced. Zmud & Arc cite Weber's (1986) definition of ethnicity as a common inherited and inheritable trait that actually derives from a common descent. Ethnicity is important in consumer decision making based on a variety of variables and influences. Those variables are culture and social identification.

The Nielson Company provides support of the importance and relevance of ethnicity and culture in their report Dissecting Diversity Understanding the Ethnic Consumer, (2011). In this report findings conclude that consumers utilize the same resources differently (McNeil & Hale, May 19, 2011). In evaluating the final enrollment numbers for Covered California, it is apparent that the various ethnic groups took advantage of the enrollment tools differently. Enrollment tools included self-serve (online) certified insurance agent, certified enrollment counselors, county eligibility workers, plan-based enrollers, and service center representatives. Final enrollment

numbers in Covered California indicate that the Hispanic population had a higher enrollment gain than all other ethnic communities.

The purpose and test of the research under study is to determine what role ethnicity played in the Covered California enrollment. The Nielson report identifies different buying behaviors among African Americans, Hispanics, and Asian/Pacific Islanders. The findings were African Americans clearly watched more TV than Hispanics and Asians, Hispanics utilize smart phones more while Asian /Pacific Islanders watched far less TV and used the internet more. These findings may have been valuable in assessing the final enrollment outcomes for Covered California statewide.

Marketing Theories

Marketing theories and concepts are important in understanding consumer buying behavior. Factors that influence buying behaviors are culture, ethnicity, external and internal factors, education, language, and cognitive discernment. Segmentation provides marketers an opportunity to develop marketing strategies that increases market share, communicates effectively with potential consumers and develops marketing collateral that aids in consumers making an informed choice.

Marketing according to the American Marketing Association is newly defined as:

"Marketing is the activity, set of institutions, and processes for creating, communicating, delivering, and exchanging offerings that have value for consumers, clients, partners, and society at large ("Press Release, American Marketing Association," 2008). A key function of marketing is to generate demand for products (Kotler et al, 2010).

The Affordable Health Care Act, 2010 generated a demand for health care coverage for millions of individuals who were uninsured and were utilizing community and public services without a means to pay for services received. The Health Benefit Exchanges (HBE's) created nationally, were designed to communicate, deliver and exchange a premium for a level of covered health services providing access to care previously unavailable for this population. The marketing strategies selected by the various states differed resulting in different levels of enrollment. Covered California, however, took a strategic step to market heavily to the Hispanic community given the population percentage statewide.

In California, the Hispanic population is over 14 million and they make up approximately 17% of the total United States population. African Americans represent *13.2%* of the U.S. population yet only *6.6%* in the state of California. In comparison Asians alone represent *14%* of the population in the state of California while representing *5.3%* in the United States. Native Hawaiian and Pacific Islander have the lowest representation with 0.5% in the state of California and *0.2%* nationally. American Indian/Alaskan Natives represent *1.7%* in the state and in the United States by 1.*2%*. Each of these ethnic groups has different and complex buying behaviors that are impacted by culture and other variables.

Ethnic marketing is increasingly used by marketing firms looking to gain market share and product or service approval and utilization. The key to ethnic advertising is to understand the needs of that particular ethnic group. Due to the huge demographic shifts across the nation, marketers are spending more time on specific cultural messaging. An

article in the Journal of Advertising, (Spring, 1999) states that marketers are increasingly recognizing the growing power of ethnic groups, and are responding with targeted marketing efforts (Holland & Gentry, Spring 1999).

Velioglu, Karsu and Umit, (n.d.) provide insight into ethnic marketing strategies. The study informs us that two main questions are required when marketing to ethnic communities: “Is there similar product needs and preferences of ethnic minorities?” and are the reactions to the media and advertising to ethnic groups having any differences? (Velioglu, et al., n.d., p.2).

The authors note that ethnic marketing, is not only the development of products that are special to a certain ethnic sub group, but it is also the product of a unifying understanding the meaning of accepting and favoring of the products that are belonging to all consumers of the ethnic groups (Velioglu, et al., n.d., p.4). This particular study involved 11 different ethnic groups in Turkey using an interview model that was based on economic equality. Ethnic marketing, according to the authors, cite Guion, Kent et al. (2010:2), is related with marketing actions which are served to discern subculture needs and demands and requires adjusting marketing strategies to the values, beliefs, attitudes, and practice of your target ethnic groups (Velioglu et al., n.d., p.2). This study focused on the African American community and concluded that personal marketing techniques are much more effective in reaching diverse or underserved audiences, but you must take into account the level of ethnic diversity of the audience you are trying to reach (Guion, Kent, & Diehl, 2010, p. 4).

Studies on ethnic purchasing buying behavior (Cui, 1997, Lamont and Molnar, 2001, Stayman and Deshpande, 1989) all conclude that marketing to ethnic groups requires specific strategies directed to ethnic group based on needs and attitudes. Additionally, the studies conclude that there are differences in purchasing decisions and behaviors by individuals of various and differing ethic identities and that the marketing strategies must ask the question "whether the needs and the products preferences are similar or not.

Research on the Euromed Info website state that cultural differences affect patient's attitudes about medical care and their ability to understand, manage, and cope with the course of an illness, the meaning of a diagnosis, and the consequences of medical treatment (Euromed, n.d.) .

Consumer Choice and Health Benefit Exchange Learnings

A study conducted by the Pacific Business Group on Health (PGBGH) emphasized the importance of minimizing the complexity of selecting health plans during the decision process. The study states that consumers can be overwhelmed by a large number of complex choice options and references further discussion to Quincy & Silas, 2012 ("Pacific Business Group on Health ," 2013). The report further indicates that consumers prefer presorted information on providers, cost, and health facilities which aids in their selection of health plans. When too much information is presented to consumers on health plans who often are not well versed in health care issues, have difficulty making decisions that include cost and benefit designs.

The California Health Care Foundation in its report Consumers in Health Care: The Burden of Choice provides the components of the nature of a consumer's health care decision process (The California Health Care Foundation, October 2006, p. 27). Three components are noted in terms of the decision process: the frequency of the decision, the degree of choice and the key factors influencing choice. In terms of health care decisions, individuals are provided an annual choice opt out or opt in for health coverage. The number of health care plans may include managed care plans, indemnity or Preferred Provider organizations representing a variety of options for consideration. Determining factors in health care decisions are the out of pocket cost, level of covered benefits and the provider network. The report validates and confirms that providing support to consumers who are making health care decisions will result in positive outcomes for the consumer and the selected health plan and providers (The California Health Care Foundation, October 2006, p.6). The use of the Assisters and Navigators in Covered California proved to be instrumental in the enrollment process.

Guest and Quincy (2013) suggest in their article that for the first time, consumers have a chance to meaningfully shop for coverage. This not only is fairer to consumers according to the authors, but is essential for a fully functioning marketplace (Guest & Quincy, November 13, 2013). The article further discusses the necessity to standardize, as much as possible, the way coverage is described no matter which company or organization is offering it. This becomes paramount for limited English speaking and low literacy levels of potential participants who need to understand their benefit levels and out of pocket costs.

How health information is marketed and communicated to facilitate an informed choice is validated in a report by the AcademyHealth. In it the discussion on how much choice is desirable the article states that with many choices, especially when each option has multiple factors to consider, people may have a harder time choosing than if fewer choices were available. Further discussions by the author informs us that the literature suggests that as a result of "choice overload", people may have "decision fatigue", have a harder time choosing, perform worse if they choose, and be less satisfied with the choice they make.(Summer, 2014, p. 5). In terms of identifying the variations in buying and consumer choice, the article notes the following:

Past research suggests that consumers value certain features of health insurance. For example, they have a strong preference and willingness to pay for an open network that will allow them to choose the providers they want to see. But other factors are important also. Research that examined Medicare beneficiaries' priorities in choosing plans shows that the most important priority is whether they can get the care they need when they are sick. Other factors are the costs and benefits associated with the plans and whether they can choose their personal doctor or self-refer to a specialist. The ability to get care away from home and limited paperwork are also attractive. (Summer, 2014, p.3).

The Consumers' Checkbook center for the study of services emphasizes the importance of providing information on health plan options that compare plans in terms of cost and benefits (www.checkbook.org). The report highly recommends the Federal Employee explanation of benefits as a model for health exchanges to consider. Federal employees have traditionally had several options to select from for their health benefits

and various costs (Consumer's Checkbook Center for the Study of Services, n.d., p. 3). The Consumers' Checkbook study refers to the Federal health options as a best practice model to consider (Krughoff, Francis, & Ellis, February 29, 2012).

The review of all of the literature in this chapter has consistently emphasized the importance of communicating with potential consumers when health care is the option. Cost, plan design, location of health centers, and language are important factors. During open enrollment periods, various ethnic groups relate and translate information differently. Marketing and strategic planning staff needs to be cognizant of addressing the needs of the consumer from their perspective. The utilization of staff during the open enrollment periods is very critical assuring that potential consumers understand the enrollment process and plan designs. As noted in a number of the studies, language and literacy comprehension varies with the various ethnic groups and having literature and staff available to appropriately communicate with the consumer is highly desirable.

Health Exchanges have access to a huge potential market segment due to the Affordable Health Care legislation. The enrollment tools that are developed need to clearly indicate the cost, coverage, and benefits to the potential consumer.
The explanation of benefits will become the critical communication collateral that will persuade or dissuade potential consumers to join the Health Benefit Exchange. Studies have clearly shown that ethnicity and culture are clearly important factors in the consumer's choice of health plans.

Findings in decision research indicate that information in important. The research also notes that choices are made by individuals based on attitude, culture, familiarity,

content, and perceptions. The research validates that design and presentation of information aids decision making. Therefore, marketing and communications strategies need to consider language, literacy, and brand imagery. This study concludes that "providing effective information and decision support to consumers is critical for driving the health care system to higher levels of performance and accountability (Shaller, October 2005, p. 7).

Based on the research, marketing and media strategies relative to communities of color are broadly based on a number of factors. Culture, ethnicity, education, language proficiency, and knowledge are critical in communicating with these populations. Research also validates that buying behaviors are critical in understanding marketing strategies relative to health care purchases and consumption. Ethnic marketing and media strategies are important and must include culturally sensitive and competent messaging. Communication of health care information must be relevant and meet the needs of each of the respective communities e.g., African Americans, Hispanics, Asian/Pacific Islander, and American Indian/Alaskan Natives. Each of these communities has cultural nuisances that affect their buying behaviors and cultural beliefs that need to be addressed in all health plan marketing and communications strategies. A major theme for all marketing is based on education. Each of the theorists noted in this study validate that attitudes, beliefs, medical needs, affordability, consumer values and internal and external influences must be considered when embarking on marketing and media strategies for historically low income and disenfranchised communities.

Chapter 3: Research Method

Research Design and Approach

This chapter describes the research methods used in this study to investigate and explore whether there is a relationship between ethnicity and consumer buying behavior in relation to Covered California's Health Benefit Exchange (HBE). This chapter will discuss the research design, population demographics, sample size, data collection, and give a description of study variables, instrumentation, and data analysis.

This project determined to what extent marketing and media strategies influenced the health care buying behaviors and decisions of ethnic communities (African Americans, Asia/Pacific Islanders, Hispanics, and American Indian/Alaskan Natives). The study examined what specific marketing strategy influences resulted in the eligible participants deciding to enroll in the Health Benefit Exchange (HBE). The study also examined if the independent variable (IV), ethnicity, had an association to disparities such as health, racism, poor income, lack of education, health literacy, and language barriers. The dependent variable (DV) for this study is the final enrollment of participants in Covered California's Exchange. The independent variable (IV) is ethnicity. Covariates (CV) include literacy, gender, age, income, education, and language spoken. Outreach, social media, and marketing collateral, had a direct effect on the buying behavior of the participants' and their decision to enroll in the Covered CA's Health Benefit Exchange.

Data collection and Analysis

The study will be cross sectional, examining the initial enrollment of eligible participants during the time period October, 2013 through April, 2014 in the Exchange. The study utilized secondary data secured from Covered California collected from enrollment applications. Additionally, a one way Anova was performed to analyze group comparisons among ethnic populations, specifically African Americans, Hispanics/Latinos, Asian/Pacific Islanders, and Native American Indians/Native Alaskans that are noted in this study as the independent variable (IV), using a non-randomized sampling.

This study will employ regression analysis, chi square for categorical variables association, t-test, and correlation applications utilizing the SPSS software. The validity instrument is the basis of predictability and this study will determine if the findings are generalizable to the general population in terms of health care buying decisions. Sample size, using G*Power software, for this study will be the determining factor. Bivariate analysis will be used to determine if there is any significant relationship between the predictor variables. Tests to examine these relationships are the independent t-test, chi square, one way ANOVA, and the Pearson's r correlation.

Secondary public data utilized for this study was provided by Covered California's Health Benefit Exchange's June 2014 Open Enrollment Data book. Additional sources of data were also utilized for comparison purposes only including a report from the CalSIM 1.91 produced by the UCLA Fielding School of Public Health

and UCLA's Center for Health Policy Research as well as NORC at the University of Chicago Consumer Tracking Report (www.hbex.coveredca.com/data-research).

This study was important from a social change perspective, as it provided insights on ethnic buying behaviors relative to communities of color and their health care purchasing motivators and decisions. It also correlated rational choice and motivation theories attributed to the purchase of health care in markets that are predominately ethnic and low income in composition. The study reaffirmed the importance of marketing strategies that included cultural competency and cultural sensitivity while remaining cognizant of the need to deal with determinants of health, limited literacy, communication, and appropriate media messaging for marginalized communities .

Assuring that participants understand the marketing and medical language related to their medical conditions becomes important in their decision making process. Outreach efforts are important in terms of a successful consumer experience. Additionally, future enrollment strategies will require that the variables identified in this study become pertinent to the health exchanges full marketing and communication strategy.

Research Questions and Hypotheses

This study sought to answer two questions and associated hypotheses:

Research Q1: What is the association between the enrollment in the Covered California Health Benefits Exchange and the race/ethnicity of the potential enrollees, specifically that of African Americans, Hispanics, Asian/Pacific Islanders, and American Indian/Alaskan Natives during the initial open enrollment period occurring October 2013- April 2014?

Alternative Hypothesis

There is a significant relationship between the enrollment and race/ethnicity in Covered California's Health Benefit Exchange among African Americans, Asian/Pacific Islanders, and American Indian/Alaskan Natives during the initial enrollment period occurring during October 2013 and April 2014.

Null Hypothesis

There is no significant relationship between the enrollment and race/ethnicity in Covered California's Health Benefit Exchange among African Americans, Asian/Pacific Islanders, and American Indian/Alaskan Natives during the initial enrollment period occurring during October 2013 and April 2014.

Research Q2: Does age moderate the relationship between Hispanic identity and enrollment in covered California Health Benefits Exchange?

Alternative Hypothesis

Age does moderate the relationship between Hispanic identity and enrollment in Covered California's Health Benefit Exchange.

Null Hypothesis

Age does not moderate the relationship between Hispanic identity and enrollment in Covered California's Health Benefit Exchange.

An additional outcome worth noting as a result of the Affordable Care Act, 2010 is the reduction of health disparities (Covered California, 2013). Health care reform will make available health coverage for millions who are currently uninsured and provide access to preventive health care services that will undoubtedly reduce health disparities and unnecessary emergency room visits as a source of primary care ("The Henry J. Kaiser Family Foundation," 2013). Therefore, the goal from a marketing perspective is to enroll as many eligible persons as possible balancing actuarial health risk meeting this overarching reduction in disparities objective. The marketing strategies employed by the Health Benefit Exchange can greatly affect this goal through effective communication and education.

Statistical Analysis Plan

The statistical analysis plan included parametric test making certain assumptions relative to the normal distribution of scores. The variables for this study were: dependent variable: (DV) enrollment, independent variable (IV) ethnicity and the covariates (CV) were income, age, gender, language spoken, federal poverty level, and race/ethnicity. To examine the relationship between the enrollment and ethnicity having adjusted for relevant covariates multiple logistic regressions was used. The chi square was used to examine the association between enrollment and ethnicity.

Enrollment Data

Enrollment data was analyzed from the period October 2013–April 2014. Specific ethnic analysis factoring in age, gender, education, income, health literacy, and language are included in the analysis. Major marketing change implementation occurred during January-March, 2014, introduced by a national marketing firm that is based on targeted baseline benchmarks initially established by Covered California by geography, ethnicity and age. (CoveredCa.com). Changes in the marketing strategy included high tech, high touch outreach, 250 additional staff, and resources for the call centers located in Fresno, Contra Costa County, and Rancho Cordova (CoveredCA.com). Improvements in Covered California's exchange website functionality, improved tools for service channels that included brokers and insurance agents, accurate notifications to enrollees via e-mail, and improved tools for certified assisters were implemented by the CoveredCA to meet marketing and enrollment targets. Improved and enhanced media

messaging through TV, radio, social media, and print were also launched throughout the second half of the open enrollment by the HBE.

Justification

Limitations

Use of secondary data presents a number of challenges. Among the challenges are limited to no access to the data, no means to validate the data and no access to the primary sources in terms of the enrollment applications collected during the enrollment process. There is also the limitation of the inability to determine missing data, if any, and how missing data is accounted for. Other limitations include the fact that one cannot get everything measured (e.g. knowledge on health care may be a large predictor, and not having the data to support that poses limitations). There are always variables that are not measured that impact the dependent variable because of the nature of the study, the data is may not be available.

Delimitations

The research study will only examine the enrollment process and results in the State of California and no other Health Benefit Exchanges established nationwide. The rational for this is the lack of access to the data by state, limited public data availability and lack of access to staff within those states that are privy to the data as a whole. The study will only focus on the enrollment outcomes as it relates to buying behaviors of the ethnic groups identified in the study; African Americans, Asian/Pacific Islanders, American Indian/Alaskan Natives, and Hispanics. These populations have significantly

different beliefs, cultural, literacy, and educational levels that influence their purchasing decisions.

Threats to Validity

External Validity

External validity refers to the degree to which the results of an empirical investigation can be generalized to and across individuals, settings, and times. The populations determined for this study can be generalized nationally as each of the ethnic communities are representative of the eligible population nationally. For example, the Hispanic population provides a confidence level that will allow the research to be generalized from that population. There exists no bias in the selection of the ethnic communities selected for this study.

Internal Validity

Internal validity refers specifically to whether an experimental treatment/condition makes a difference or not, and whether there is sufficient evidence to support the claim. History is normally a threat to validity; however in the case of Covered California's Health Benefit Exchange there are no prior historical unanticipated events that would affect the dependent variable (DV), enrollment. No pre and posttest were in effect. No maturation issues are related to the dependent variable. Statistical regression and selection threats are not anticipated at the ethnic groups selected are the relative based on actual enrollment outcomes. There is no threat within the selection process. In terms of instrumentation and design, no change occurred during the study nor is there any

awareness of any group known among the participants. There is no contact with enrollees at any point in this study. This is purely a numerical analysis.

Process for Assessment of Reliability and Validity

In order for a study to have integrity, reliability and validity must be assessed. This study test for reliability and validity to measure the quality of the measurement to determine if the construct measured has face validity. Since enrollment (DV) is the question being asked, on face value, it seems to appear that this is a reasonable measurement

Assumptions

Quantitative analysis includes a number of assumptions that must be tested before any analysis. This study will conduct test for normal distribution, homoscedasticity, multicollinearity and linearity.

Setting and Sample

The populations studied in this proposal are drawn from the enrollees during the initial open enrollment for the Health Benefit Exchange in California known as Covered California. The data is secondary and has been made public for review and information in an excel format published by Covered California's 2014 Databook. The population data, for the purpose of this study, includes all ethnic communities who were eligible to participate in the open enrollment from the period October 2013 through April 2014 residing in the State of California's 19 counties. Those ethnic communities include African American, Hispanic, Asian and Pacific Islanders, as well as American Indian/Alaskan Natives.

The sample size includes all eligible enrollees within the state of California who enrolled in Covered California for a 2014 effective date. Effectuation is defined as premium payment made prior to effective date of enrollment according to Covered California.

Covered California, available to all eligible residents within the State of California, reported a population of 38,332,521 million in 2013. The ethnic breakdown for the specific population of interest for this study is *12.8%* African American, *1.2%* American Indian, *27.6%* Asian, *1.0%* Native Hawaiian and Pacific Islander, *22.7%* Hispanic (U.S. Department of Commerce, United States Census Bureau. State and County QuickFacts, Last Revised: March 27, 2014).

Defends Sample Size

The sample size consists of the entire state of California. The following areas represent the State of California: Northern, Central Coast, Central Valley, North Bay, Los Angeles, Inland Empire, Orange County, San Francisco Sacramento, and San Diego. The dynamics of the cultural diversity within the State warrants utilizing the entire state data to determine if ethnicity impacts enrollment differently by county or geographic area. A "G" Power analysis conducted determined effect sample size of 305 given the size of the state's population.

Eligibility Criteria and Characteristics

Legal California residents, except for currently incarcerated individuals and legal minors, are eligible to buy insurance through Covered California. However, if an enrollee has access to affordable health insurance through another source such as an employer or government program, the enrollee may not qualify for financial assistance through Covered California (Covered California, 2013). Different eligibility rules apply for pregnant women. Eligibility for enrollment is based on the criteria established in The Patient Protection and Affordable Care Act, 2010 also known as ACA (Covered California, 2013).

Enrollee personal date information is protected by privacy laws described in the Health Insurance Portability and Accountability Act of 1996 (HIPPA) which provides for among other things, measures to protect the security and privacy of personally identifiable health care.(www.healthinsurance.org). Enrollment applications are coordinated through the Covered California database and the Health Department of Social Services. The secondary data used for this research is provided in excel format with no personal identifiers noted in the public files.

Health insurance premium costs through Covered California are based on age, where the participant lives (ZIP code), household size, income, selected health plan, and benefit level.

Income includes wages, salaries, tips, business or self-employment income, rental income, interest received or accrued, lottery and gambling income, capital gains, pensions, Social Security retirement benefits, foreign-earned income, alimony income, and bartering income (i.e., exchange of goods or services without exchanging money). For the purposes of determining eligibility for premium assistance and cost-sharing assistance, Covered California will use the modified adjusted gross income (MAGI). For most taxpayers, MAGI is the same as adjusted gross income (AGI), which can be found on Line 4 of a Form 1040EZ, or Line 21 of a Form 1040A, or Line 37 of a Form 1040 (Covered California, 2013). Information regarding eligibility and income are provided on the Covered California website, specifically under the frequently asked questions page (https://www.affordableca.com/frequently-asked-questions/). Prospective enrollees are directed to this page for quick responses to their immediate enrollment concerns.

Covered California benefit levels for all available health plans provide for a comprehensive set of benefits known as "essential health benefits" (EHB). They include the following 10 categories:

- ambulatory patient services
- emergency services
- hospitalization
- maternity and newborn care

- mental health and substance use disorder services, including behavioral health
- treatment
- prescription drugs
- rehabilitative and habilitative services and devices
- laboratory services
- preventive and wellness services and chronic disease management
- pediatric services, including oral and vision care

All health plans are mandated to offer these standardized essential health benefits aiding participants in making comparisons among plans (Covered California, 2013).

Instrumentation and Materials

This quantitative research study will be conducted using multiple logistic regressions to examine the relationship between the dependent variable (DV) enrollment and ethnic buying behaviors. This numeric description of buying behaviors and the relationship to enrollment may provide a gap in the literature relative to health care decision making by ethnicity. The purpose of this research is to generalize from the sample populations in California so that inferences may be made about their buying decisions and behaviors. The secondary data has been collected over a specific open enrollment period, specifically October 2013 through April 2014 based on health care enrollment application forms. Covariant variables identified for this study include literacy, language, age, gender, income, marketing, one-on-one assisters, and the internet.

Detail Description of Variables

The maps below provides a description of the variables for this study as it related to the research Question #1 and Question #2.

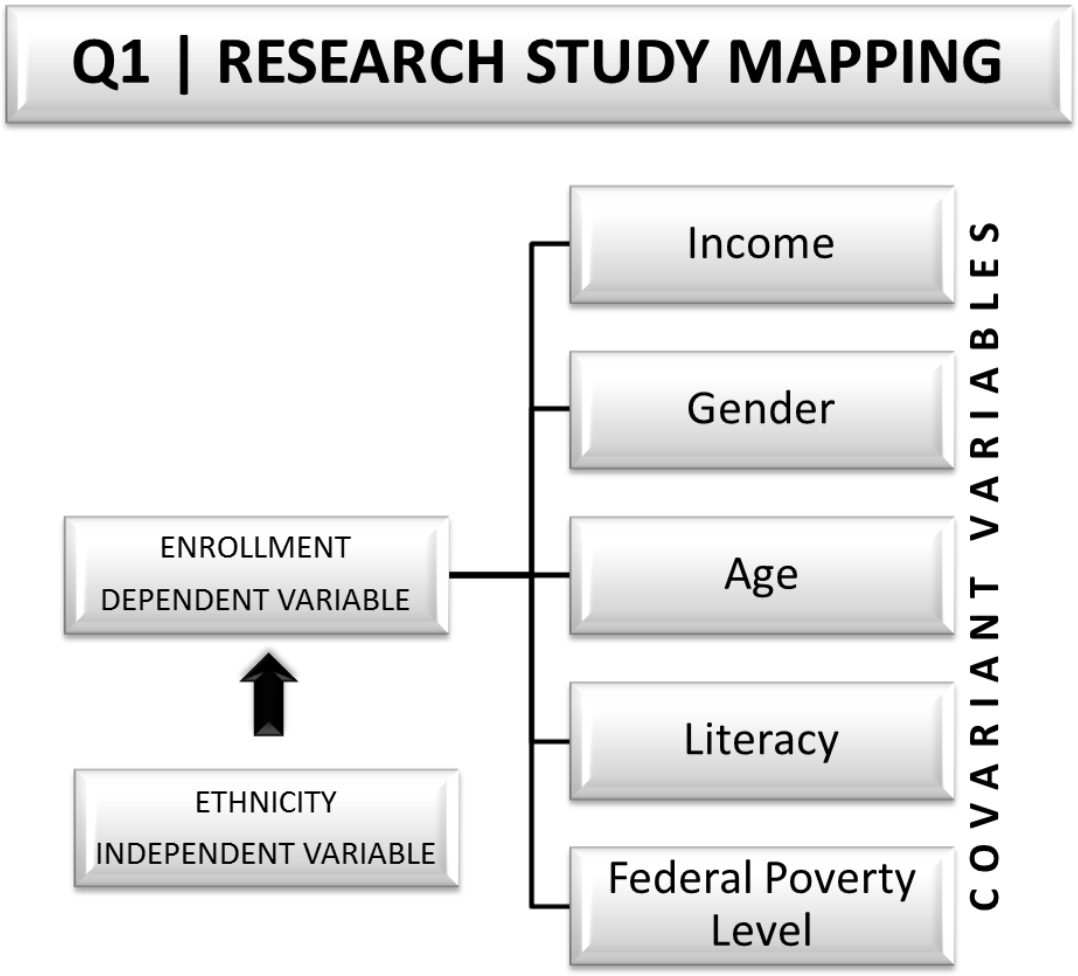

*Figure 3.*Covariant Research Study Mapping for research question Q1 identifying variables.

Q1: What is the association between the enrollment in the Covered California Health Benefits Exchange and the race/ethnicity of the potential enrollees, specifically of African Americans, Hispanics, Asian/Pacific Islanders, and American Indian/Alaskan Natives during the initial open enrollment period occurring October 2013-April 2014?

$H_0$1: There is no association between the association between the enrollment in the Covered California Health Benefits Exchange and the race/ethnicity.

$H_1$1: There is association between the association between the enrollment in the Covered California Health Benefits Exchange and the race/ethnicity.

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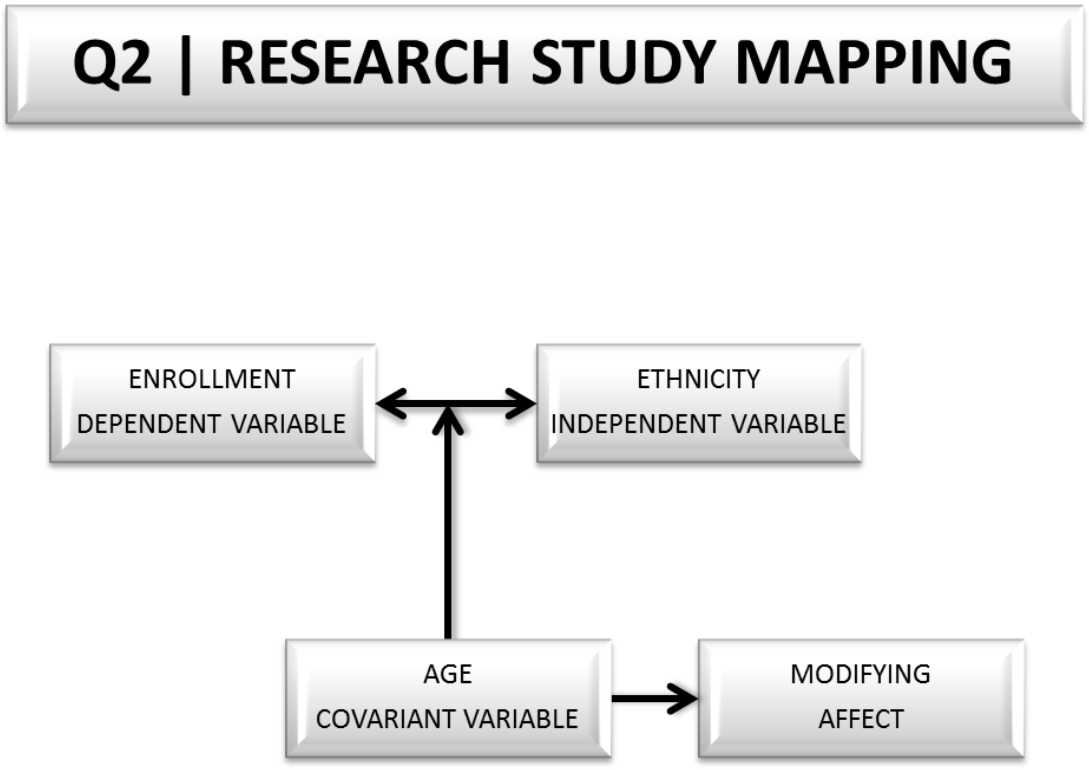

Figure 4. Research Study Mapping for research question Q2 identifying dependent and independent variables.

Research Question

Q2: Does age moderate the relationship between Hispanic identity and enrollment in covered California health benefits exchange?

Null Hypothesis

(H_o) Q2: Age does not have a moderating effect on the relationship between Hispanic identity and enrollment in covered California health benefits exchange

Alternative Hypothesis

(H_1) Q2: Age does have a moderating effect on the relationship between Hispanic identity and enrollment in covered California health benefits exchange

Description of Data Collection Processes

The data collected for this study was conducted solely by Covered California from enrollment applications during the open enrollment period October 2013 through April 2014. This secondary data is the primary source to be used in the analysis for this research study.

Multiple logistic regressions were used given that there are several covariates identified in this study that may impact buying behaviors and enrollment. This test aided in determining which predictors, as well as the independent variable, was related to the dependent variable (DV) enrollment. The analysis also determined, at what significant levels, and identified which predictor had the strongest relationship. For example, race / ethnicity may be predictors to enrollment beyond age, income and language spoken.

Data Analysis Plan

Data analysis for this study was conducted in three phases. Using the univariate analysis, the data was analyzed from a descriptive view. While the chi-square test was used to test the first hypothesis, multiple logistic regressions were used to test the second hypothesis. The dependent variable, enrollment and its relationship to the independent variable, ethnicity and the covariates (age, income, gender, literacy, etc. was be examined using the bivariate analysis, and t-test).

A statistically significant result was declared in each case when the p-value was less than 0.05. The dependent variable (DV), enrollment was used as the predictor in the multivariate model. As noted, testing for assumptions included homoscedasticity, linearity, and normality.

A power level was completed, however, given the size of these enrolled participants, sufficient statistical power is not presented as an issue for effect size. Utilizing the G*Power software, a power analysis with a power value of .80 (80%) is used and is recognized as an acceptable in statistical analysis. G*Power is a statistical power analysis program. It covers many different statistical tests including, t-test, chi-square, and z test families as well as some exact tests. G*Power 3 provides improved effect size calculators and graphic options, it supports both a distribution-based and a design-based input mode, and it offers five different types of power. Alpha is set at .05 ($p<.05$) and an effect size of (.25) medium , number of groups is set at 5 and the probability set as 0.95, all generally used settings in the research industry. The results of the G-Power analysis based on these settings produced a total sample size for this

research study at 305. The file from Covered California contained 1,048,575 de identified participant enrollment data.

Summary

This study will be important from a social change perspective, as it will provide insights on ethnic buying behaviors relative to communities of color and their health care purchasing motivators and decisions in Health Exchanges. It will also correlate rational choice and motivation theories attributed to the purchase of health care in markets that are predominately ethnic and low income in composition. The study will reaffirm the importance of marketing strategies that include cultural competency and cultural sensitivity while remaining cognizant of the need to deal with determinants of health, limited literacy, communication, and appropriate media messaging for communities of color. Assuring that participants understand the marketing and medical language related to their medical conditions becomes important in their decision making process. Outreach efforts are important in terms of a successful consumer experiences. Additionally, future enrollment strategies will require that the variables identified in this study become pertinent to the health exchanges full marketing and communication strategy.

Chapter 4: Results

This chapter describes the data and the analysis conducted addressing the research questions related to the marketing and media strategies used for enrollment and whether age moderates enrollment in the Hispanic community.

Descriptive Analysis

This chapter provides details of the variables used for this study. The variables include gender, age, language spoken, federal poverty level, and race/ethnicity. The independent variable is ethnicity and the dependent variable is enrollment.

Table 1 presents a description of the study variables is there an association between demographic factors (ethnicity) and use of California's health insurance exchange (enrollment). Data indicate that half of the participants were female (*75.9%: n*=305,725) Male 73.4%: *N*=264,854). Among the various race and ethnic groups studied, White* and Hispanic were the largest represented 221,748 participants *(39.1%)* and Hispanics were *150,226 (26%)* respectively. The age group *55-64, 23.8%)* represented the largest segment while the *65>, 593 (0.1%) were* the lowest represented in the study. English *(n=454,475; 81.8%)* was the most prevalent language spoken among the participants. However, Spanish represented the second largest language spoken *(n=60,707, 9.7%).* The highest federal poverty level represented in the study was in the range *150-200 (n=204,063; 32%* and the lowest number of participants were in the*>400 level (n=28,439; 5.8 %).*

Table 1.

Descriptive Analysis of Categories Variables (N=763,531)

Variable		n	(%)
Gender			
	Male	264,854	47.3
	Female	305,725	52.7
Race Ethnicity			
	American Indian/Alaska Native	745	0.2
	Asian Indian	15,254	2.6
	Black/African American	14,684	2.7
	Chinese	45,683	7.8
	Filipino	12,651	2.5
	Guamanian/Chamorro	114	0
	Japanese	3,890	0.8
	Korean	22,335	3.8
	Mixed Race	33,002	6.1
	Native Hawaiian	115	0
	Other	16,803	2.8
	Other Asian	8,444	1.5
	Other Pacific Islander	866	0.2
	Samoan	128	0
	Vietnamese	23,892	3.9
	White	221,748	39.1
	Hispanic	150,226	26

Table 1.

Descriptive Analysis of Categories Variables (N=763,531)

Variable	n	(%)
Age Bracket		
under 18	26,681	5.3
18-25	61,922	10.6
26-34	98,395	17.8
35-44	95,241	16.9
45-54	137,781	23.8
55-64	149,966	25.5
65 and greater	593	0.1
Metal Level		
Bronze	193,431	25.3
Gold	465,472	60.7
Silver	50,128	6.5
Platinum	46,807	6.1
Catastrophic	10,560	1.4
Language Spoken		
Arabic	508	0.1
Armenian	424	0.1
Cambodian	404	0.1
Cantonese	11,675	1.8
English	454,478	81.8
Farsi	871	0.1
Hmong	71	0
Korean	13,979	2
Mandarin	13,995	2.2
Russian	580	0.1
Spanish	60,707	9.7
Tagalog	924	0.2
Chinese Traditional Character	118	0
Vietnamese	11,885	1.8

Table 1.

Descriptive Analysis of Categories Variables (N=763,531)

Variable	n	(%)
Federal Poverty Level		
< 150	106,618	15.2
150-200	204,063	32
200-250	90,364	17.3
250-400	105,816	22.6
> $400	28,439	5.8
Unsubsidized	35,279	7

Table 1 presents a description of the study variables. Data indicate that half of the participants were female (75.9%: *n*=305,725) Male 73.4%: *N*=264,854). Among the various race and ethnic groups studied, White* and Hispanic were the largest represented 221,748 participants (39.1%) and Hispanics were *150,226 (26%)* respectively. The age group *55-64, 23.8%)* represented the largest segment while the *65>, 593 (0.1%) were* the lowest represented in the study. English *(n=454,475; 81.8%)* was the most prevalent language spoken among the participants. However, Spanish represented the second largest language spoken *(n=60,707, 9.7%).* The highest federal poverty level represented in the study was in the range *150-200 (n=204,063; 32%* and the lowest number of participants were in *the>400 level (n=28,439; 5.8 %).*

Table 2.

Bivariate Analysis of Study Participants Selecting Metal Level Bronze Versus Silver and Above (N=763,531)

	Yes		No		
Variable	n	(%)	n	(%)	X^2 (df)
Gender					650.573 (1)
Male	264,854	73.4	96,036	26.6	
Female	305,725	75.9	96,916	24.1	
Age Bracket					2841.026 (6)
under 18	26,681	65.9	13,792	34.1	
18-25	61,922	76.3	19,215	23.7	
26-34	98,395	72.5	37,285	27.5	
35-44	95,241	73.9	33,609	26.1	
45-54	137,781	78.5	43,639	24.1	
55-64	149,966	76.9	45,084	23.1	
65 and greater	593	64.4	328	35.6	
Race Ethnicity					3165.414(16)
American Indian/Alaska Native	745	50.9	719	49.1	
Asian Indian	15,253	76.7	4,636	23.3	
Black/African American	14,684	71.8	5,781	28.2	
Chinese	45,683	77	13,648	23	
Filipino	12,651	65.8	6,564	34.2	
Guamanian/Chamorro	114	67.5	55	32.5	
Japanese	3,890	66.9	1,923	33.1	
Korean	22,335	76.3	6,930	23.7	
Mixed Race	33,002	70.7	13,701	29.3	
Native Hawaiian	115	72.8	43	27.2	
Other	16,803	78.6	4,583	21.4	
Other Asian	8,444	72.5	3210	27.5	
Other Pacific Islander	866	70	372	30	
Samoan	128	71.9	50	28.1	
Vietnamese	23,892	80.9	5631	129.1	
White	221,748	74.2	77146	25.8	
Hispanic	150,226	75.8	47960	24.2	

Table 2.

Bivariate Analysis of Study Participants Selecting Metal Level Bronze Versus Silver and Above (N=763,531)

	Yes		No		
Variable	n	(%)	n	(%)	X^2 (df)
Language Spoken					1922.083(13)
Arabic	508	82.1	111	17.9	
Armenian	424	83.1	86	16.9	
Cambodian	404	81	95	19	
Cantonese	11,675	78.8	3,142	21.2	
English	454,478	73.8	161,476	26	
Farsi	871	78.1	244	21.9	
Hmong	71	65.1	38	34.9	
Korean	13,979	78.7	3,783	21.3	
Mandarin	13,955	80.1	3,474	19.9	
Russian	580	73	215	27	
Spanish	60,707	77.6	17,553	22.4	
Tagalog	924	67.2	452	32.8	
Chinese Traditional Character	118	84.3	22	15.7	
Vietnamese	11,885	84	2,261	16	
Federal Poverty Level					52100.773(5)
< 150	106,618	91.7	10	8.3	
150-200	204,063	83.5	40	16.5	
200-250	90,364	68.3	41,960	31.7	
250-400	105,816	64.1	66,545	38.6	
> 400	28,439	63.9	16,054	36.1	
Unsubsidized	35,279	65.6	18,539	34.4	

Note: for Model: X=41=61286.323, p<.001, **p<.01,***p<.001

Multivariate Analysis

Table 3 presents a binary logistic regression analysis. The Binary logistic regression analysis examined study participants selecting metal level bronze vs. silver and above. Data overall was statistically significantly. *(X41, = 61286,323, p<.001).* The reference groups for this segment of the study are participants identified as *65>.* This analysis indicated a positive relationship in all age groups. The lowest range was among the age group *26-34 (OR=1.217, 95% CI = 1.057-1.40).* The highest range was among the age group *45-64 (OR= 1.535, 95% CI = 1.334-1766).*

Age

In comparison to the reference group (individuals 65>) all other age groups were significantly more likely to enroll in silver and above. However, the odds ratio reflected a relatively weak effect size *(1.06-1.51)* between these variables.

Race and Ethnicity

A negative (-) indication in the B(SE) indicated that study participants are less likely to sign up for silver and above health plan options relative to the reference group Hispanic/Latino. There are several racial/ethnic categories that were significantly less likely to enroll in silver or above relative to the reference group. Specifically American Indian/Alaska Natives groups were less like to sign up *(OR = .197, 95% CI=.176-.221), Black/African America (OR=.848, 95% CI =.819-.877), Chinese (OR=.995, 95% CI=.65-1.026), Filipino (OR=.686, CI=.663-.711), Guamanian or Chamorro (OR=.687, 95% CI=.491-.961), Japanese (OR=.782 95% CI .738-.830),Korean (OR=.925, 95%*

CI= .0885-0967), Mixed Race (OR = .914 95% CI.891-.937), Native Hawaiian(OR=.899, 95% CI= .0624-1.295, Other (OR=.1.302, 95% CI .1.255-1.350, Other Asian (OR= .848, 95% CI, .810-.887, Other Pacific Islander (OR =.773, 95% CI= .680-.878, Samoan (OR= .815, 95% CI= .579-1.148), White (OR=1.120, 95% CI= 1.102-1.138.* There were fewer racial /ethnic groups that were more like to sign up for silver and above relative to the reference group. Those specific groups were *Asian (OR = 1.16, 95%CI=1.11-1.20), Other (OR = 1.30, 95% CI= 1.26-1.35), .Vietnamese (OR 1.16, 95% CI = 1.11-1.21), and White* (OR 1.12, 95% CI=1.10-1.14).*

Language Spoken

Of the thirteen (13) languages identified for this study, only four (4) had a positive relationship to the reference group Hispanic/Latino. They were *Arabic (OR=1.120, 95% CI= .89990-1.3970) Armenian (OR =1.031, 95% CI = .805-1.320, Cambodian (OR = 1.167, 95% CI = .917-1.486), and Chinese Traditional (OR=1.433, 95% CI= .893-2.300).* All other languages indicated a negative relationship in terms of the magnitude of change in the variable. Among the 13 languages spoken, nearly half (6) of the study participants resulted in a negative relationship.

Federal Poverty Level

Two of the five federal poverty level (FPL) brackets indicated a negative relationship to the moderator age. Those were *FPL 250-400 (O R.82, 95% CI = .80-.84), and FPL bracket >400 (OR = .92, 95% CI = .90-.95). The other categories, <150, 150-200, and 200-250 had a statistically significant moderating factor. The results were statistically significant, p< (.000).*

Table 3.

Binary Logistic Regression Analysis Examining Study Participants Selecting Metal Level Bronze Versus Silver and Above (N=763,531)

Variable	B	(SE)	Wald (X^2)	Sig.	Exp (B)	OR (95% CI)	
Gender	.121	.005	485.434	.000	1.129	1.116	1.141
Male							
Female							
Age Bracket							
Reference Group: Over 65							
less than 18	.546	.072	57.105	.000	1.726	1.498	1.989
18 - 25	.352	.072	23.974	.000	1.423	1.235	1.638
26-34	.196	.072	7.473	.006	1.217	1.057	1.400
35-44	.300	.072	17.493	.000	1.350	1.173	1.554
45-64	.428	.072	35.722	.000	1.535	1.334	1.766
over 65	.551	.072	59.160	.000	1.735	1.508	1.997
Race Ethnicity							
Reference Group: Hispanic/Latino							
Race Ethnicity							
American Indian/Alaskan Native	-1.623	.058	788.684	.000	.197	.176	.221
Asian	.145	.019	59.498	.000	1.156	1.114	1.199
Black/African American	-.165	.018	88.149	.000	.848	.819	.877
Chinese	-.005	.016	0.095	.758	.995	.965	1.026
Filipino	-.377	.018	444.537	.000	.686	.663	.711
Guamanian or Chamorro	-.376	.171	4.807	.028	.687	.491	.961
Japanese	-.245	.003	67.614	.000	.782	.738	.830
Korean	-.078	.023	11.832	.001	.925	.885	.967
Mixed Race	-.090	.013	50.878	.568	.914	.891	.937
Native Hawaiian	-.106	.186	0.326	.000	.899	.624	1.295
Other	.264	.019	201.154	.000	1.302	1.255	1.350
Other Asian	-.165	.023	51.629	.000	.848	.810	.887
Other Pacific Islander	-.258	.065	15.626	.242	.773	.680	.878
Samoan	-.204	.174	1.370	.000	.815	.579	1.148
Vietnamese	.146	.021	49.977	.000	1.158	1.112	1.206
White	.113	.008	186.187	.000	1.120	1.102	1.138

Table 3.

Binary Logistic Regression Analysis Examining Study Participants Selecting Metal Level Bronze Versus Silver and Above (N=763,531)

Variable	B (SE)		Wald (X^2)	Sig.	Exp (B)	OR (95% CI)	
Language Spoken							
Reference Group: English Speaking							
Arabic	.114	.113	1.021	.312	1.120	.899	1.397
Armenian	.030	.126	0.057	.811	1.031	.805	1.320
Cambodian	.155	.123	1.579	.209	1.167	.917	1.486
Cantonese	-.157	.039	16.355	.000	0.855	.792	.922
English	-.168	.082	31.162	.000	0.845	.797	.897
Farsi	-.217	.082	7.069	.008	0.805	.686	.945
Hmong	-.907	.213	18.105	.000	0.404	.266	.613
Korean	-.074	.042	3.135	.077	0.929	.857	1.008
Mandarin	-.153	.038	15.862	.000	0.585	.796	.925
Russian	-.542	.089	37.034	.000	0.582	.488	.693
Spanish	-.279	0.32	75.321	.000	0.757	.711	.806
Tagalog	-.337	.069	23.686	.000	0.714	.624	.818
Chinese Trad. Character	.360	.241	2.227	.136	1.433	.893	2.300
Vietnamese							
Federal Poverty Level							
< 150	1.826	.014	16030.613	.000	6.207	6.034	6.385
150-200	1.019	.011	8596.979	.000	2.771	2.712	2.832
200-250	.143	.011	163.112	.000	1.153	1.128	1.179
250-400	-.217	.010	428.051	.000	0.805	.789	.822
>400	-.047	.014	12.015	.001	0.954	.929	.980

Note: For Model: X41 = 61286.323, p<.001, **p<.01, ***p<.001.

Test for Moderating Effects

Figure 5 presents the test of moderation examining if ethnicity moderates the relationship between age and enrollment. Gender and age were controlled for and the interaction was found to be statistically significant. The regression analysis data indicates a statistical significance. Data also indicates an interaction between age and ethnicity was statistically significant within the Hispanic population.

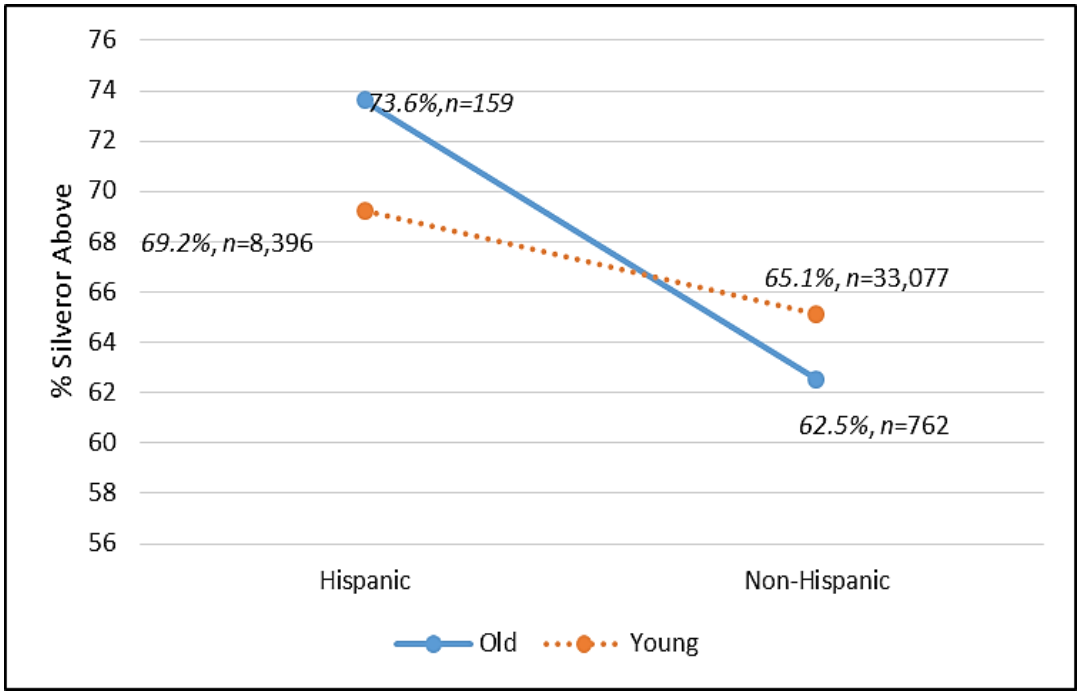

Figure 5. Moderating Age among Hispanics.

Table 4.

Binary Logistic Regression Analysis Moderating Age Among Hispanics Identity and Enrollment (N=763,531)

Variable	B (SE)		Wald (X^2)	Sig.	Exp (B)	OR (95% CI)	
Age							
Age_Bracketnum	.036	.002	309.484	.000	1.036	1.032	1.040
Hispanicyn	-.193	.018	117.675	.000	.824	.796	.854
Age Bracket by Hispanicyn	.039	.014	81.927	.000	1.040	1.031	1.049

Note: For Model: X (22) = 57209.016, p<.001, **p<.01, ***p<.001.

Table 5.

Chi-Square Tests - Gender

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	650.573[a]	1	0.000		
Continuity Correction[b]	650.438	1	0.000		
Likelihood Ratio	649.997	1	0.000		
Fisher's Exact Test				0.000	0.000
Linear-by-Linear Association	650.572	1	0.000		
N of Valid Cases	763531				

a. 0 cells (0.0% have expected count less than 5. The minimum expected count is 91200.55.

b. Computer only for a 2x2 table.

Table 6.

Chi-Square Tests - Federal Poverty Level

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	52100.773[a]	5	0.000
Likelihood Ratio	55574.019	5	0.000
Linear-by-Linear Association	40433.98	1	0.000
N of Valid Cases	763531		

a. 0 cells (0.0% have expected count less than 5. The minimum expected count is a 11243.83.

Table 7.

Crosstab Metal Silver or Above - Gender

			metalsilverorabove		Total
			0	1	
Gender	male	Count	96036	264854	360890
		% within Gender	26.60%	73.40%	100.00%
	female	Count	96916	305725	402641
		% within Gender	24.10%	75.90%	100.00%
Total		Count	192952	570579	763531
		% within Gender	25.30%	74.70%	100.00%

Tables 5, 6 and 7 are reflective of the chi square and cross tabs analyses conducted for the study. Table 5 reflects the chi square for gender. Table 6 reflects the chi square for poverty level (df5). Table 7 is a crosstab related to the selection of metal level Silver or Above by gender. Results indicate that females selected this level over males.

Chapter 5: Conclusions, Recommendations and Impact for Social Change

This chapter is a summary of the sections discussed in this study of the association of demographic factors and use of California's Health Insurance Exchange and a perspective on the relevance of the analyses and its implications and impact to social change. This study supported both hypotheses and research questions.

Research Question 1 Findings

Q1 asked: What is the marketing and media strategy association between enrollment in the Covered California health benefit exchange and the race/ethnicity of the potential enrollees specifically that of African Americans, Hispanics, Asian/Pacific Islanders, and Native American Indians during the initial open enrollment period occurring October 2013 – April 2014.

The alternative hypotheses (H_1) stated that there is a significant statistically association between ethnicity and enrollment based on the marketing and media strategies employed by Covered California's health Benefit Exchange and the buying behavior of ethnic communities resulting in an increase enrollment statewide from November 2013 through April 15, 2014.

The null hypotheses (H_o) stated there is no significant statistically association between ethnicity and enrollment based on the marketing and media strategies employed by Covered California's Health Benefit Exchange and the buying behavior of ethnic communities resulting in an increase enrollment statewide from November 2013 through April 15, 2014.

Specifically, the analysis examined the racial groups which were more likely to enroll in the silver or above health benefit option. The reference group, Hispanic/Latino was more likely to enroll in Bronze vs Silver plans. Other ethnic/racial communities likely to enroll in silver or above health plan option categories included: African Americans, American Indian/Alaskan Natives, Asian Pacific Islanders, and Hispanics.

Research Question 2 Findings

The data supported the second research question:

Q2 asked: Does age moderate the relationship between Hispanic identity and enrollment in Covered California's health benefit exchange. Hispanic ethnicity did moderate the relationship between age and enrollment in the silver or above category. Specifically, the older Hispanic group was the most likely to enroll in silver or above plans. Older Hispanics were more likely to enroll relative to the older Non-Hispanics

A report published by The Henry J. Kaiser Family Foundation supports the notion that, communities of color are more likely in one group and less likely in the other to enroll in silver and above (KFF.org, April 2014).

Buying behavior theories described in the literature segment of this report indicate that ethnic/racial communities make buying decisions based on values, culture, needs, education, trust, intention, information ,economics and socioeconomic factors and knowledge. Theories such as reasoned action, social action, and rational choice all demonstrate the need for better communication and education when consumers are purchasing services or products. Informed decisions are key factors for these communities and are validated in this study.

The impetus for this study was the enactment of the Patient Protection and Affordability Act of 2010 signed by President Barack Obama. The goal of that legislation was to provide health coverage for the millions of uninsured persons in the nation who would be provided some financial subsidy based on their income according to the Federal Poverty Level statutes (FPL). This study examined the association between demographics and use of California's Health Insurance Exchange known as Covered California. The theoretical basis was predicated on marketing strategies and consumer buying behaviors posited by Ajzen (1971,1972,1975,2010,2013), Weber (1993, 1969, 1963), Loudin and Della Bella (1993), Cohen (2013), Bray (2008) Foxall (1990,2003, 2004) and Drucker(.2000). These marketing and buying theories examine consumer behaviors in terms of their decision making. Cultural norms and communication are major components of a successful marketing campaign as they provide knowledge for the consumer who ultimately makes buying decisions based on attitudes, personality, values, and lifestyles. The communities of color identified for this study included African American, Hispanics, Asian/Pacific Islanders, and American Indian/Alaskan Natives.

This study findings supports the hypotheses postulated that the participants who elected to enroll in Covered California's Health Benefit Exchange were more likely to choose a health plan based on the marketing and media strategies conducted by that agency.

Secondary data was obtained from Covered California's 2014 Databook for the initial open enrollment period October 2013 thru April 2014. Statistical analysis conducted for this study was the chi-square, and multiple logistic regressions. Enrollment was the dependent variable and race/ethnicity was the independent variable. The predictors or covariates included age, federal poverty level, language spoken, and gender.

Study Limitations

Social Change

The social change implications of this study contributes and impacts future Health Benefit Exchanges health plan strategies, relative to communications and marketing when conducting future open enrollment periods. Specifically, targeting the marketing and outreach to communities of color placing more emphasis on culture, language, income, and age may increase health benefit exchanges and health plan enrollment activities in the future. After several years of the implementation of the ACA, many more individuals and families have acquired health care benefits that will result in improved health and quality of life.

This study can contribute to increased enrollment in Covered California's Health Benefit Exchange if marketing strategist and health plans focus on the culture, language, and income needs of communities of color who have traditionally been impacted by poor

health outcomes and lack of health care coverage. Studies will continue to be conducted to determine if the ACA will meet its target goal of providing health care coverage for the nation and the projections by The Congressional Budget Office informs us that 32 million people who elected to enroll in the Health Benefit Exchanges nationally and have gained new health coverage. (http://www.nytimes.com/).

The expansion of Medicaid has had it challenges as many states continue not to offer an expanded coverage for its adult population. There is no question that the Affordable Care Act (ACA) has had a significant impact on the nation as health care options have been made to the general population. In an issue brief published by The Henry J. Kaiser Family Foundation it noted that one of the major vehicles in the ACA to increase coverage is an expansion of Medicaid to adults with income at or below *138%* of the federal poverty level (FPL). It goes on to state that while the expansion was intended to occur nationwide, it was effectively made a state option by the Supreme Court decision on the ACA. In states that do not expand Medicaid, many poor uninsured adults will not gain a new coverage option and will likely remain uninsured. With reference to communities of color and the uninsured, there continued to be significant racial and ethnic disparities in health coverage for adults. According to the Kaiser Family Foundation issue brief people of color are more likely to be uninsured that White*s *(27% vs. 15%)* with Hispanics *(33%)* at the highest risk of lacking coverage (The Henry J. Kaiser Family Foundation, Dec. 17, 2013).

Recommendations

Health care decision making is an important process that requires knowledge, literacy, and communication. As health exchanges are being implemented across the country, marketing and communication strategist and policy makers must consider all aspects of the potential consumer needs to be effective. For communities of color this includes extensive outreach, language and literacy considerations, education levels, and income assessments. The ultimate goal of the Patient Protection and Affordability Act, (2010) is to make health care available to the uninsured through appropriate state and federal channels. The Marketplaces were established to accomplish that. California, in particular was the first State to create and offer a Health Benefit Exchange to its uninsured population.

Further study by organizations such as The Office of Health Equity, Department of Health & Human Services Office of the Assistant Secretary for Planning and Evaluation, The Kaiser Family Foundation, and UCLA Fielding School of Public Health would provide more insight into the impact of ethnicity for the future open enrollment outcomes. The Commonwealth Fund and others are likely to examine what marketing approaches applied during year 1 and their impact such that in subsequent years, more focus and detail are applied in the marketing and communications strategies to increase enrollment in ethnic communities ensuring growth for the uninsured in these populations and the reduction of cost for uncompensated care nationally.

Conclusion

In conclusion, the analysis showed that ethnicity does have a statistically significant effect on enrollment based on the communities of color identified for this study and those participants who enrolled (1,395,929) in Covered California's Health Benefit Exchange during the initial 2014 open enrollment period (CoveredCA.com). A large segment of the Hispanic population *28%,* elected to enroll during this initial period compared to the other ethnic groups: Asians *(21%),* White* *(35%),* African American *(3%),* American Indian and Alaska Native *(1%),* Native Hawaiian and other Pacific Islander *(1%),* Other *(3%),* Mixed Race *(6%),* according the enrollment statistics provided by Covered California as of April 14, 2014. These enrollment results may be attributed to the aggressive outreach conducted within these communities which validates this study in terms of the theoretical framework of consumer knowledge, rational choice, culture, attitudes, and education. Marketing, communication and collateral literature are critical to consumers who need to understand product and services.

Access to health are at an affordable cost has been the foundation of the ACA. Reducing the number of uninsured as well as health disparities among communities of color are potential positive outcomes of having access to affordable health care. Strategic marketing communications and education are critical factors that can strongly influence the decision making and purchasing of health care for communities of color.

By doing so will result in the likely hood that enrollees will select a personal physician and seek regular physical checkups. The reduction in uncompensated care that reached $4.5 billion according a report published by the Council of Economic Advisers, (June 04, 2015) will greatly impact the national economy and health care system.

Expanding Medicaid for those adults who do not qualify for the Health Benefit Exchange or private insurance will also have an impact on the uninsured population as well as an economic impact as noted by the Council of Economic Advisers. A White House report also noted that the expansion of Medicaid provides improved access to care, better health outcomes and longer life expectancy, grater financial security, a higher standard of living, better state economies, and healthier and productive workers (Insure the Uninsured Project, June 08, 2015). Immigration remains an issue for the nation and legislation and policy decision makers will need to develop policies that will reduce the million plus uninsured immigrants.

Future and continued studies to expand on reducing the uninsured, who are typically communities of color, are needed. Specific marketing strategies that include cultural sensitivity and competence are necessary to engage and influence buying behaviors. Future open enrollment activities and collateral should reflect the clients' attitudes, beliefs, culture and linguistic abilities and needs. This study addressed factors supporting consumer attitudes, social action, and buying behaviors that impact decisions related to health care purchases and services. Future research on open enrollment marketing approaches is warranted to increase ethnic community participation.

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