



Health Insurance Enrollment of Children and Young Adults in Wayne County, Michigan: A Qualitative Evaluation

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Health Insurance Enrollment of Children and Young Adults in Wayne County, Michigan: A Qualitative Evaluation

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Abstract

Since the Affordable Care Act went into effect, community outreach to increase health insurance enrollment of young adults and children in low-income families of color has been a priority in Wayne County, Michigan. Our objective was to inform community efforts for improved outreach, we explored perceptions around the importance of health insurance and barriers to enrollment for children and young adults through a qualitative research study. We conducted a focus group with enrollment assisters and nine focus groups with Arab American, Latino/Hispanic, and African American community members. Several themes emerged about community members' perceptions and experiences: they believe that children have time sensitive and specific health needs; they appreciate the generous, public health insurance options available for children; they experience frustration with the affordability of enrolling dependents in private insurance; young adults experience frequent denials and failures with insurance enrollment; and they experience confusion about how insurance eligibility changes during the young adulthood. There is a need for community outreach in Wayne County to focus on connecting low-income, working families to affordable health insurance options and tailoring help to young adults to overcome barriers to enrollment in public insurance.

Keywords

Affordable Care Act; uninsured; child; young adult

Cover Page Footnote

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ABSTRACT

Since the Affordable Care Act went into effect, community outreach to increase health insurance enrollment of young adults and children in low-income families of color has been a priority in Wayne County, Michigan. Our objective was to inform community efforts for improved outreach, we explored perceptions around the importance of health insurance and barriers to enrollment for children and young adults through a qualitative research study. We conducted a focus group with enrollment assisters and nine focus groups with Arab American, Latino/Hispanic, and African American community members. Several themes emerged about community members' perceptions and experiences: they believe that children have time sensitive and specific health needs; they appreciate the generous, public health insurance options available for children; they experience frustration with the affordability of enrolling dependents in private insurance; young adults experience frequent denials and failures with insurance enrollment; and they experience confusion about how insurance eligibility changes during the young adulthood. There is a need for community outreach in Wayne County to focus on connecting low-income, working families to affordable health insurance options and tailoring help to young adults to overcome barriers to enrollment in public insurance.

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INTRODUCTION

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Wayne County, Michigan, where Detroit is located, is a medically underserved area and faces significant health disparities. Infant mortality rates in the city remain twice that of the county and state and disproportionately affect African-American populations.(Data Driven Detroit, 2012) Wayne County also ranks among the lowest in the nation for average life expectancy (Chetty et al., 2016) and among the lowest in the state for adult obesity and sexually transmitted infections.(University of Wisconsin Population Health Institute & Robert Wood Johnson Foundation, 2017) Health insurance coverage is an important determinant of timely access to care, unmet medical need, and health disparities;(Hargraves & Hadley, 2003) and as of 2016, over one-quarter of those who remain uninsured in Michigan live in Wayne County.

The disparities in insurance coverage among the county's population of color are a significant concern.(Enroll America, 2015; Schulz, Williams, Israel, & Lempert, 2002) With the passage of the Patient Protection and Affordable Care Act (ACA) in 2010, expanded opportunities emerged for Wayne County residents to enroll. As a result, uninsured rates dropped from 22% to 12% between 2013 and 2015 among young adults in Michigan most likely from Medicaid expansion and some enrollment in the Marketplace.(Fangmeier & Udow-Phillips, July 2016) However, certain population subgroups did not experience the same reduction. African American young men still had the highest uninsured rates at 19%, followed by Hispanic young men at 17% and African American young women at 16%.(Enroll America, 2015) There is also a large Arab-American population in Wayne County, who are not adequately captured in census data. Local data sources report that in 2013 the uninsured rate was as high as 23% in this group.(Perlstadt, McNall, Hembroff, & Lee, 2015) Among children in Michigan, the uninsured rate was only 3.8%, but children of color continued to have higher uninsured rates at 4.5%.(The State Health Access Data Assistance Center (SHADAC), February 2016)

Data also shows that low-income families with children and young adults still have high uninsured rates after ACA implementation.(Long, 2015) The Institute of Medicine has highlighted mounting evidence showing that the health of an entire family can be negatively affected if even one member lacks health insurance.(Institute of Medicine, 2002) When any member of a family fails to obtain insurance coverage, the consequences of diminished health status not only affect them but also put their families at risk for poor health outcomes.(Institute of Medicine, 2002) Children and young adults are on a spectrum of dependence on their families for health care access; and although young adults are legally viewed as independent from their parents, nearly half of young adults, aged 18-24 years old, reported living in their parent's homes in 2015. (Canon, October 2015) While the ACA aimed to bolster individual insurance enrollment, understanding how to promote the enrollment of entire households became a commitment of community-based organizations (CBOs) in Wayne County.

Community-based models of outreach and assistance can be effective at enrolling ethnic, minority families in health insurance. In a study of children in immigrant families with and without public insurance, parents reported that having personal assistance throughout the application process was crucial for understanding how to successfully enroll their eligible child.(Rhee, Belmonte, & Weiner, 2009) Additionally, Latino families identified neighborhood organizations as a useful source of enrollment assistance.(Manos et al., 2001) A recent randomized control trial using a community-based intervention demonstrated that Latino and

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African-American families were more likely to obtain and sustain insurance coverage with personal assistance from parent mentors.(Glenn Flores et al., 2016)

Recently, Wayne County CBOs united with academic partners to explore ways to improve health insurance coverage rates and address the navigation needs among communities of color in Wayne County. The objective is to inform these efforts through qualitative study that investigates community members' perceptions of barriers and facilitators to health insurance enrollment for children and young adults. The collected data, which highlight gaps in knowledge, health beliefs, and experiences with insurance enrollment, will be used to direct the design and implementation of future community-based interventions to enroll underserved, ethnically diverse families in new health insurance coverage.

METHODS

Setting and Participants

This qualitative study was a part of a broader, initial, exploratory assessment of perspectives on health insurance among African American, Latino/Hispanic, and Arab American communities in Wayne County.(Patel et al.) All aspects of the study were approved by the Institutional Review Boards of the University of Michigan and the Saint Joseph Mercy Health System, the parent organization of one of our community-based sites.

Ten focus groups were conducted between March and June 2015. The first focus group (n=8) was comprised of a convenience sample of health enrollment assisters (e.g., Enrollment Navigators, Certified Application Counselors, and non-navigator assisters), to inform the development of the moderator guide to be used with community participants and to enhance our understanding of health insurance issues by providing their experiences with enrolling community members. The other nine focus groups (n=87) were comprised of community members from Wayne County with each group ranging from 7-9 participants.

Focus group participants were recruited through a purposive sampling approach at two Federally Qualified Health Centers (FQHCs) in Detroit, MI, that predominantly serve African-American patients, one FQHC with mostly Latino/Hispanic patients in Detroit, and a human services non-profit in Dearborn, MI that served the Arab-American community, defined as immigrants from any country comprising the Arab World or Arabian Peninsula and their neighboring countries. These CBOs serve a large proportion of uninsured, low-income families in the Wayne County community. The study focused on these sites since they had strong ties to communities of color in Wayne County.

Inclusion criteria included: 1) being 18 years of age or older, 2) self-identified as African American, Arab American, or Latino/Hispanic, and 3) seeking care or services at one of the four CBOs. Recruitment was performed in-person and over the telephone. All focus group participants gave informed consent and were given a modest monetary incentive for their participation.

Data Collection

Community participants were organized into focus groups based on language and self-identification by their racial/ethnic background: 1) two Arabic language groups, 2) two Spanish language groups, and 3) five English language groups. Two to three focus groups were hosted at each of the four CBO sites. The main moderator at each site was an enrollment assister, who

worked directly with the population of interest at that site, and who spoke either Spanish or Arabic for the language-specific sessions. An academic research staff member assisted the moderator by taking notes on focus group observations. All focus groups used a standardized protocol of questions and probes to insure consistency across all groups.(Stewart DW, 1990) Focus group sessions lasted 90 minutes. Data saturation was met after conducting nine focus groups with community members.

The moderator's guide included questions to elicit participants' experiences with health insurance enrollment and coverage and their views on challenges and successes with health insurance enrollment and use. The moderator guide was created through an iterative process. First, questions and prompts were developed by the research team to elicit conversation about experiences with ACA-related enrollment, maintaining insurance coverage, and navigation needs. The research team used the qualitative focus group information with health enrollment assisters to direct the initial guide development. A content review of the questions was then performed by the project steering committee and enrollment experts from our partner organizations. They refined questions and prompts to derive the final version of the moderator guide. A self-administered questionnaire was also used to collect participants' sociodemographic information and health insurance coverage characteristics. The questionnaire was written at an 8th grade literacy level and was administered in English, Spanish, and Arabic.

Analysis

Data from the focus groups were analyzed for perceptions around the importance of health insurance and the barriers to enrollment for children and young adults specifically, although discussion questions probed participants broadly on insurance coverage and access. Each focus group discussion was recorded, professionally transcribed verbatim and translated, if necessary. Two coders reviewed the enrollment assister focus group transcript to generate initial codes using inductive analysis. The enrollment assister focus group provided guidance on what community participants might identify as facilitators and barriers to insurance enrollment for children and young adults. The community participant focus groups were then analyzed independently with a deductive approach using the initial codes. Both coders used a final codebook to code all transcripts, separately, and resolved discrepancies by consensus. The coders frequently reviewed all code reports and met to discuss and finalize themes, revisiting the original data as needed to confirm their findings.(Creswell, 2013) Interrater reliability for the categories was assessed by Cohen's Kappa ($k=0.79$) and found to be acceptable for explanatory work. The NVivo (Version 9; Doncaster, Australia) software was used for qualitative data management and analysis. Sociodemographic data were analyzed using SAS 9.4. Themes were presented back to the CBO partners at the project steering committee meetings for member checking.

RESULTS

The demographic characteristics, other than race and ethnicity, of the African American, Arab American, and Latino community members, who participated in the nine focus groups were similar (Table 1). The focus group participants were predominantly female, and nearly 38% were married. Over half of the study participants had children; the household size varied from 1 to 8 persons, with the mean household size between 3 and 4 persons. Among the 73% of participants

who had health insurance during the study period, over half were enrolled in Medicaid. Most participants in the enrollment assister focus group had a college degree and worked more than 40 hours per week helping community members with health insurance enrollment and coverage issues (Table 2).

Table 1. Demographic characteristics of the community sample (n=87)

Characteristic	N	%
Race		
Black African American	23	27.1
Arab American or Middle Eastern	25	29.4
Hispanic/Latino	27	31.8
Other	10	12.0
Sex (% male)	22	25.6
Age (mean, SD)	39.6	14.7
Marital status (% married)	33	37.9
Child <18 years old in household	43	54.0
Household income <\$30,000	50	71.4
Household size (mean, SD)	3.6	2.1
Education		
High school or less	38	44.7
Some college	33	38.8
College or above	14	16.5
Employed		
Full time	18	20.7
Part time	16	18.4
Unemployed	53	60.9
Health insurance (% yes)	54	73.0
Private	12	21.8
Medicare	9	16.4
Medicaid	28	51.0
Medicare and Medicaid	2	3.6
Medicare and Private	0	0.0
Other	4	7.3

Across the focus groups, there were no meaningful between-group differences observed in the themes on insurance enrollment of children and young adults among participants in the African-American, Latino/Hispanic, and Arab American focus groups (Table 3). The findings below expand on the themes that emerged from the focus group discussions on insurance enrollment for children and young adults.

Belief that children have time sensitive and specific health needs

Most participants conveyed a belief that children required health insurance because they were more fragile than adults and required care from a health professional. One participant

emphasized that their perceived need for insurance was somewhat age-dependent:

I think that many times it depends on your age as to when someone doesn't have insurance...If you have children, yes, because for children it is important.

When probing as to what it was about a child's health status that made insurance a necessity, community members gave varied answers about their use and access of health providers and services and the urgency of children's conditions compared with adults. One parent elaborated that he felt comfortable self-diagnosing and treating himself but did not feel similarly for his children:

I guess it depends on whether they're your children or whether it's yourself because I tend to self-medicate...faster. And with them it's like they need to be seen by somebody.

Table 2. Demographic characteristics of enrollment assisters (n=8)

Characteristics	N	%
Age (mean, SD)	32	7.91
Sex (% female)	7	88.
	0	
Race		
White	5	62.
	5	
Latino	2	25.
	0	
Black/African American	1	12.
	5	
Education		
Associate degree	1	12.
	5	
Some college	1	12.
	5	
College degree	5	62.
	5	
Graduate degree	1	12.
	5	
Time devoted to assisting community with health insurance		
Under 30 hours per week	1	12.
	5	
30-39 hours per week	2	25.
	0	
40 or more hours per week	5	62.
	5	

Table 3. Theme Endorsement by Focus Group Types (N = 9 focus groups, 87 participants)

<u>Focus Groups Types</u>	<u>Children and health needs</u>	<u>Appreciation of child insurance</u>	<u>Affordability in private insurance</u>	<u>Denials among young adults</u>	<u>Young adult eligibility confusion</u>
African-American/ English language (3 groups)	Yes	Yes	Yes	Yes	Yes
Latino-Hispanic/ Spanish & English language (3 groups)	Yes	Yes	Yes	No	Yes
Arab-American/ Arabic & English language (3 groups)	Yes	Yes	Yes	Yes	No

One parent described how important it was to preserve the continuity of care with their child's pediatrician, and because of this she selected the insurance plan that covered her child's specific physician:

"The same thing goes for the pediatrician for my son. I've been going there for 14 years or whatever. That's pretty much what I do. I pick the health insurance that our doctors take."

Another parent elaborated that her physician aided her in selecting the public insurance plan that would most optimally help cover the medicines that her child needs:

[Moderator: So the doctor told you?] He told me to get Molina. Not all forms of Medicaid cover what I need...nor for [the] children...And there is a certain medicine...that may be for the children that [I] may have to pay for...[so] it depends on the plan that one has.

One father described how being on Medicaid meant that he could access needed health services for his child:

And so...sometimes people say that your wife controls everything, but when it comes to the health care, you going to the doctor today, my son, you going to the dentist. It's no questions asked. We going to the doctor.

Appreciation for the generous, public health insurance options for children

For many community members, the availability of a no to low cost insurance program through the Children's Health Insurance Program (CHIP) or Medicaid was also a major facilitator for enrolling their child in health insurance coverage. They recognized the accessibility of these public programs for children and enrolled in them. One parent highlighted the benefits of Medicaid for parents and children, succinctly stating:

So now that [the insurance is] free I'm--my wife, my son, we [are] all on the same plan.

However, some participants described how their children had much easier access to publicly available insurance than the rest of the household. Given the age and income eligibility criteria for enrolling in Medicaid, a common scenario is that multiple family members do not have health insurance, except for the children, due to expanded child health public insurance options. A mother reported:

And they refuse[d] us...I have six kids. [For] three of them, the Department of Michigan...[gave] them health insurance because it was a special case...But in my case and my husband['s] case and the rest of the kids, the one in college, they never [accepted] us.

One community member emphasized that while she and her child had benefited from Medicaid coverage during her pregnancy, her own eligibility was more limited post-partum than was her child's:

The government, they [gave] me Medicaid for my kids for one year and through [out] all the pregnancy. But me, after 40 days, that's it.

Here, she had qualified for Medicaid only for the first 40 days after delivery, but her child continued to receive Medicaid benefits for the full year. She may not have been aware that her

child could potentially receive coverage under Medicaid beyond one year as income eligibility cut-offs are more generous for children less than 5 years old than most other groups.

Many participants focused on the high costs of monthly premiums for themselves versus the less expensive options through CHIP, which often was a sliding scale premium based on the family's income. These families likely had private insurance but still relied on the CHIP program to affordably cover their child. This participant explained that the premiums for purchasing coverage for them as parents were expensive, but that their child could access CHIP without a similar financial burden:

For my husband and me [it is] like \$400 a month,...[but] for my daughters...I had MiChild [Michigan Children's Health Insurance Program].

Frustration with the affordability of enrolling dependents in private insurance

Over one-fifth of our focus group members had private insurance. These participants struggled with the perceived affordability of insurance coverage for the whole family through employer-sponsored insurance (ESI). One community member highlighted her struggle with premiums:

Maybe for like a family plan you'll probably be out almost a grand every...pay period. So that was quite expensive.

Another participant expressed general frustration with the affordability of a family plan through her ESI and indicated that the insurance premiums would consume a large portion of her paycheck. She had sought other forms of coverage but was unsuccessful:

What I found was [that] I was working to pay my insurance. There was no coverage after I was working to pay the insurance for my family, and it was just impossible to maintain. So when I researched the alternative I obviously didn't qualify for Medicaid and it was like I was between a hard place and a rock. That was definitely a challenge. I want to be insured, I can't afford it, or I'm working just for that reason, but I'm not eligible for anything else.

In some cases, participants reported that they felt that employer plans prohibited additional beneficiaries:

And at the time it was--one insurance that they were covered under [that] did not allow you to put your other family members on.

Experience with frequent denials and failures during insurance enrollment for young adults

Some young adult participants described the ease in transitioning to their own coverage, but most faced numerous challenges. Young adults described a lack of knowledge about insurance options and eligibility criteria that led to frequent failures to obtain coverage. They reported persistently applying for insurance options in spite of frequent denials, especially with Medicaid, until they were successful. One participant reported:

I was under my father's insurance until I was 18 and then I was taken out. And [I have] been applying for insurance for many years. Never got approved until recently when I applied through the Obamacare

Another participant echoed the experience of trying but failing to obtain coverage:

I used to have Medicaid until I was 21. And then from 21 to 24 I didn't have anything and I started applying for Medicaid, getting declined, declined, declining. And then just this year I finally got approved.

Confusion on how insurance eligibility changes during the young adult period

The experience of frequent disappointments with insurance enrollment was closely tied with the discovery that they had aged out of previous insurance coverage; and most were uninformed about how to re-enroll. Participants felt that young adults overall lacked awareness of health insurance and its use.

For some young adults, they knew they had coverage under their parents' plans so otherwise felt it was not necessary to learn more about their coverage. One participant reported:

Well, like, I already have private insurance through my dad's thing so I didn't really pay much attention to that. I figured I was—I'm good.

The moderator then shared with the participant that private insurance coverage through his parents was only possible until he was age 26.

Some young adults were unaware that they had aged out of their previous coverage until they were denied care or had trouble obtaining care. Programs, such as CHIP and Medicaid, have varying combinations of age and income cutoffs that can be confusing for individuals. One participant described seeing the same health provider for many years but not knowing that his Medicaid coverage had ended until he returned for a clinic visit:

I had been on state Medicaid pretty much all my life. I started through my mom. I was on her benefits for state Medicaid, and I was [at] the doctor's [for] heart appointments and checkups, and then once I turned 18 I went to the doctor on my own to get a checkup and the...family doctor, we have been seeing her all our life, registration...told me I couldn't get seen because I was no longer [on] the one insurance. And so at the time I was having asthma issues, trying new inhalers and stuff like that, and so I was without insurance from 18, up until I turned 26.

This participant, who had active chronic health issues during his young adulthood, had his access to care restricted because of aging out of Medicaid eligibility. He also misunderstood that his Medicaid eligibility was determined at the individual level and was not based on his mother's insurance coverage status.

Some participants were proactive in seeking options for coverage as young adults, independent from their families, but with mixed success. They reported that living with their parents or having close financial ties to their family unit was a source of confusion in relation to whether they qualified for certain health insurance plans. One participant described how when she lived away from her family for school she was particularly puzzled by how to enroll in insurance appropriately. She reported:

Like me, when I turned 19 years old, I saw that they took me off of MiChild and then I had to pay for my insurance...I worked but I only earned like 300 dollars a month. They charged me like 100 - 130, and ...I lived at the school, but still my permanent address was with [my parents] and so, I saw how they charged me as if I was living with them, and I wasn't. I was by myself. It's not fair. They didn't

educate me and didn't say anything about this and they didn't have any instructions... And me, what do I have to do?

When she was asked about how outreach workers could help her with this transition, this participant suggested that an opportunity for addressing the lack of awareness among young adults could occur in the college setting:

I think that they need to say more and give more education to students who are going to college because they don't say anything to them.

DISCUSSION

This exploratory study aimed to understand how to improve community outreach to families in Wayne County to increase the health insurance enrollment of children and young adults. We elicited the perceptions of community members to identify specific facilitators and barriers to insurance enrollment to inform us about how outreach efforts can be improved for this population. Our findings underscored the perspectives that must be considered in the development of outreach messages, the gaps in knowledge that outreach information should fill, and the personal experiences with insurance enrollment that could inform the settings that might be optimal for reaching community members.

An affirmative belief in the need to insure children was shared across all focus groups and is consistent with previous research related to enrollment in CHIP.(DeVoe, Tillotson, Angier, & Wallace, 2014; Hill, Stockdale, Evert, & Gifford, 2006; Kenney, 2007) Participants' unanimous support for insuring children might also reflect the success of child health policy and promotion over the years. Although the uninsured rates of American children are at a historic low,(Alker, October 2015.; Choi, Sommers, & McWilliams, 2011) gaps in children's coverage persist among historically difficult-to-reach communities—a key focus of our work.(Blumberg, Karpman, Buettgens, & Solleveld, March 2016; The Kaiser Commission on Medicaid and the Uninsured, October 2015) The use of community-based models has shown promise in reaching these ethnic, minority populations to increase the insurance enrollment of children.(G. Flores et al., 2005; Glenn Flores et al., 2016) Tailoring outreach efforts to low-income, ethnically diverse families is crucial, but our data also showed the potential of using messages that capitalize on the collective belief in the importance of insurance for children as a way to further address the disparities in children's coverage.

The perception that insurance is unaffordable was prevalent among our focus groups, as it previously has been among studies of low-income individuals.(Desmond, Laux, Levin, Huang, & Williams, 2016; Kamimura et al., 2016) While most insurance enrollment outreach post-ACA has concentrated on uninsured populations, our findings highlighted that connecting with families that have private insurance was also important in our community. Participants emphasized that purchasing family plans on ESI was untenable and described that while their incomes were high enough to prohibit them from qualifying for safety net insurance programs, they still experienced significant financial and material hardship. Difficulties with paying for basic needs and insurance coverage jointly by low-income families has been previously described.(Saloner, 2013) The ACA provided some low-income families an option to access insurance through the Marketplace for their children and dependents; however, subsidies are not available to these families if their employer-offered insurance is deemed affordable. The

standard of affordability is based on the individual and does not take into account the number of other household members potentially dependent on the income. This problem is called the “family glitch” and might perpetuate mixed coverage families (i.e., multiple insurance types among one household).(Buettgens, Dubay, & Kenney, 2016) Thus, continued dependence of families with ESI on CHIP for their children’s coverage will be likely even post-ACA.(Strane et al., 2016) Enrollment assistance among our ethnic minority communities should communicate that CHIP might be still available to families with ESI.

For low-income young adults, our findings highlighted that different approaches are necessary. Although young adults are typically characterized as “young invincibles,” who lack awareness or concern about the need for insurance,(Collins, June 2012; Cunningham & Bond, 2013; Holahan, 2008) our participants focused on their experiences of repeated failures to enroll in insurance as young adults and their confusion about how their eligibility was determined in the various programs. Their feedback highlight the need for information and education about insurance enrollment to occur early, before they apply or need to use it. Young adults, who are age 18 and 25 years old, and their families might benefit from early notification through clinics about upcoming changes in eligibility depending on their type of insurance. They might also consider bringing these young adults in early to discuss what kinds of documentation and verification might be needed, especially in applying for Medicaid. Furthermore, outreach into the community might also include post-secondary education settings, such as community colleges. Young adulthood is a susceptible period for unintended pregnancy, trauma, substance abuse, and even development of chronic diseases,(Harris, Gordon-Larsen, Chantala, & Udry, 2006; Park, Brindis, Chang, & Irwin, 2008) and waiting until urgent health matters arise could be potentially harmful. Some of these outreach strategies might work to counteract the known poor health insurance literacy among young adults.(Dauner, 2014; Wong et al., 2015)

An extra challenge for some young adults was confusion about appropriate insurance options when living as a dependent in and with their family. To date, existing outreach to young adults has mostly emphasized independent insurance enrollment and built awareness through media and online venues,(Dauner, 2014) but some young adults and adolescents valued shared responsibility for their health decisions with the adults in their lives.(Ott, Rosenberger, McBride, & Woodcox, 2011) In fact, nationally nearly half of 18-24 year-olds lived with their parents in 2015.(Canon, October 2015) Metropolitan areas with more low-income, unmarried, and racial/ethnic minority young adults had higher levels of co-residence with parents than other cities.(Qian, 2012) Thus, enrollment assistance might be directed to parents in addition to young adults who are in the process of insurance transition and enrollment. Evaluating how best to implement parental support for low-income young adults is a ripe area for further investigation.

We identified that focus group participants also actively sought care for their children, and directly as young adults, in community clinic settings. Health information in these clinics could be delivered as low burden interventions, such as short videos.(Petranj & Christiansen, 2014) The intervention could begin to address commonly recognized information gaps, tailoring to young adults or families with children. The intervention could complement the in-person work already provided by enrollment assisters and potentially be portable to other community settings. Limitations to our study should be noted. Recruitment was conducted through community-based agencies; thus, the sample may be largely representative of individuals who use FQHCs and

social service agencies, and therefore may not be representative of those who are not connected to these services. Qualitative inquiry was intended to elicit a rich in-depth understanding of community members' experiences with health insurance, whose experiences may not be representative of the experiences of those from other urban communities in the United States. Because the focus groups were not limited to participants with children, focus group discussion dynamics may be partly shaped by individuals living without other family members in the household. Possible nuanced problems that families with children might face may not have been presented by participants, if they felt it was not relevant to other members of the focus group who did not have children. Furthermore, perspectives contrary to the ones discussed in our paper may not have been elicited as focus group recruitment was not targeted to recruit a breadth of participants in families with children and young adults. We described perceptions around barriers to enrolling in health insurance for children and young adults. Nevertheless, a more in-depth investigation into the perspectives and experiences of each of these groups is needed to improve implementation of community-based solutions for low-income families.

CONCLUSION

As the health policy landscape changes and uncertainty remains about the future of the ACA, continued work is essential in communities of color and low-income populations to close the gaps in health insurance coverage. As our findings show, there is an ongoing need for CBOs and enrollment assistors to serve as sources of information and expertise for local communities to not only help people enroll but help keep them enrolled as they age and their eligibility changes. These findings provide some understanding of community members' beliefs and experiences that can be used to target key areas for insurance enrollment assistance in Wayne County, MI.

Both policy and community approaches are needed to promote health insurance coverage of children and young adults in economically challenged and hard-to-reach communities. Future policy changes should keep in view the experiences of low-income working families who still struggle to attain coverage of the entire household. Policy options include fixing the "family glitch" in the ACA Marketplace insurance design or considering provision of subsidies to offset costs directly in ESI family coverage premiums. Programs and policies designed to help low-income families obtain health insurance coverage for their children throughout their childhood and young adult years should be a crucial part of the discussions that guide health policy moving forward.

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