



## How health navigators legitimize the Affordable Care Act to the uninsured poor



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### ABSTRACT

Health navigators are a new health care workforce created by the Affordable Care Act (ACA) to assist low-income minority populations with acquiring health insurance. Given the high levels of distrust among the poor toward government and the medical profession, this article asks: How do health navigators build the legitimacy necessary to persuade low-income uninsured clients to enroll in health insurance? Through ethnography of face-to-face interaction between navigators and the uninsured poor in Chicago, this study shows that successful navigators deployed a combination of cultural repertoires for building trust and legitimacy. These repertoires included ceding control of the conversation, creating ethnic solidarity, and disassociating themselves from government bureaucrats or self-serving insurance employees. These findings demonstrate the usefulness of cultural sociology for understanding health insurance provision to the poor, ACA outreach efforts, and the more general study of how occupations legitimize themselves to clients.

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From website glitches to misleading media coverage, millions of uninsured Americans did not know who or what to trust when the Affordable Care Act rolled out in 2013. In anticipation of such chaos, policymakers created a new health care work force called “health navigators,” who provide free “help to consumers, small businesses, and their employees as they look for health coverage options and complete enrollment forms” ([Healthcare.gov](http://www.healthcare.gov) 2015). The U.S. Center for Medicare and Medicaid Services (CMS) allocated \$67 million to fund navigator programs in 34 states that, in total, employ 28,000 health navigators nationwide ([Pollitz et al., 2014](#)). This new bureaucracy faces a classic problem of building legitimacy in the eyes of a clientele newly eligible for health insurance ([Lipsky, 1980](#)). This work is especially challenging in low-income minority communities which have high levels of distrust toward both government bureaucrats ([Levine, 2013](#); [Soss, 1999](#)) and the medical profession ([Gamble, 1997](#); [LaVeist et al., 2000](#)). Using the case of health navigators, this article asks: how do bureaucrats build legitimacy with distrustful low-income clients?

The study of health navigators is a new and growing area of social science. To date, studies of health navigators have used interview or survey data to show they are helping boost enrollment rates in some states but not others ([Tummers and Rocco, 2015](#);

[Sommers et al., 2015](#)). These studies, however, provide little insight on which face-to-face strategies succeed and fail at convincing clients to enroll. To get a deeper understanding of navigator action, this study used an ethnographic approach. For five months, I trained and worked with 15 health navigators in Chicago as the ACA rolled out in late 2013, observing them in action as they interacted face-to-face with low-income uninsured adults in churches, community organizations, and health fairs. Findings show that health navigators can overcome client distrust and build legitimacy by deploying combinations of cultural repertoires. Repertoires are strategies of action for problem solving or achieving goals ([Hannerz, 1969](#); [Swidler, 1986](#)), they are like a tool-kit navigators draw upon when interacting with clients. Navigators built legitimacy by deploying repertoires that constructed a shared interest or identity with clients, responded to challenging questions, and distinguished their work from occupations clients distrusted.

These findings have implications for the study of frontline health workers serving low-income minority populations. Studying health worker repertoires at the micro level can illuminate concrete structural factors constraining health outreach work. In the case of ACA outreach, observing health navigator repertoires revealed the damage inflicted by decades of poor people’s experiences with a heavy handed and retrenched welfare state ([Levine, 2013](#); [Soss et al., 2011](#)). Many clients initially viewed health navigators no differently than the untrustworthy and impersonal welfare

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bureaucrats they had been accustomed to facing when applying for Medicaid. Clients' negative perceptions of government, distrust of health insurance bureaucrats, and previous negative experiences with Medicaid enrollment constrained navigators' ability to build legitimacy. By observing health worker repertoires, scholars can identify concrete ways that 1) social structures impede enrollment in health programs and 2) how health care workers overcome structural barriers through deploying combinations of cultural repertoires.

### 1. The challenges of building legitimacy in ACA outreach

One of the central tenets in the sociological study of occupations is that professionals need legitimacy to compel trust and obedience from clients (Abbott, 1988; Starr 1982). Suchman (1995, 574) defined legitimacy as “a generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions.” In the medical world, legitimacy is rooted in communities that have objectively validated competence. Doctors and hospitals, for example, go through extensive training and certification processes by professional associations or government bodies (Ruef and Scott, 1998; Starr 1982).

As an occupation in its infancy, health navigators do not have the same legitimacy in their interactions with the population. Although navigators undergo extensive training and certification by the state, many uninsured people have never applied for health insurance nor been made aware of what health navigators do. In low-income communities, people are most likely to first learn about health navigators when they encounter a navigator face-to-face at a health event or neighborhood organization. In these situations, clients do not take navigators' legitimacy for granted; rather, legitimacy is something navigators must achieve through interaction. Sociologists have described this as “relational work” (Zelizer, 2012), or work that professionals must do to build legitimacy with clients and conduct tasks such as diagnosing autism (Eyal, 2013) or inducing compliance with regulations (Huisig 2014).

For health navigators, building legitimacy is especially challenging because low-income and minority uninsured populations have high levels of distrust toward government bureaucracy and health professionals. Prior to the ACA, many low-income uninsured people enrolled in Medicaid at public aid offices where welfare bureaucrats worked more as gatekeepers than benefit providers. For example, the low-income women in Levine's (2013, 55) study described welfare bureaucrats as “making you feel stupid” and making promises to deliver benefits only to be later told “you don't qualify for that.” Similarly, Hays's (2003, 35) study found welfare case managers to be “cold and impersonal.” Even worse, the public aid offices where low-income people apply for Medicaid often share client names with law enforcement agencies searching for individuals with outstanding warrants (Gustafson, 2009). In the pursuit of various public benefits, the poor have been subjected to deception, long waits, and intrusion into their private lives (Lara-Millan, 2014; Soss et al., 2011).

To complicate matters further, the African–American population still harbors mistrust toward the medical profession in the aftermath of the infamous Tuskegee syphilis study where individuals were experimented upon without their consent (Gamble, 1997; LaVeist et al., 2000). Mistrust of legitimate health professionals and medical institutions remains associated with African–Americans' unwillingness to consent to invasive medical procedures and body donation (Anteby and Hyman, 2008. Harris et al., 1996). It is in this context of pervasive distrust that navigators are attempting to build legitimacy with the uninsured poor.

This article describes cultural repertoires as a key component of the relational work health navigators must employ to build legitimacy and enroll clients in health insurance through the ACA. The concept of repertoires in cultural sociology provides a useful heuristic for identifying structural factors impeding outreach work, as well as face-to-face strategies navigators use to overcome challenges during interactions with clients. For example, navigators faced questions from clients about whether they earned commission, or whether the government was really protecting the uninsured from being denied coverage on the basis of pre-existing conditions. In response, navigators deployed a combination of repertoires such as mirroring clients' perceptions of government or distancing themselves from bureaucrats with whom clients expected to interact. Successful health navigators transformed low-income clients' perceived illegitimacy of government and health care bureaucrats into a tool from which to build legitimacy. Studying such relational work provides a clearer picture of the cultural and structural forces shaping ACA outreach and, more generally, the processes whereby members of occupations build legitimacy with clients.

### 2. Fieldwork methodology

From September 2013 to January of 2014, I observed 25 interactions between low-income uninsured individuals between the ages of 21–35 and health navigators in four neighborhoods of Chicago (Humboldt Park, North Lawndale, Little Village, and Logan Square). While I use real neighborhood names, I use pseudonyms to hide the identities of the individuals and organizations in this study. Informed consent was obtained verbally and with the approval of the institutional review board at Harvard University. I observed face-to-face interactions through two data collection strategies: shadowing navigators and shadowing uninsured respondents.

First, in the process of shadowing and observing 10 health navigators, I observed and audio-recorded 10 face-to-face interactions with clients. To recruit navigators, I volunteered and underwent training to become a certified health navigator in Illinois. Through attending the multiple training sessions, I built relationships with 10 health navigators working in these four west side Chicago neighborhoods. This provided me access to outreach events at churches, parks, community organizations, and clinics. Second, as part of a larger study of the ACA, I recruited and interviewed 45 individual low-income uninsured people. Recruitment occurred at fast food restaurants, church services, art galleries, and coffee shops, where I introduced myself as a researcher and offered \$25 to respondents to participate in an interview about their thoughts on the ACA. By shadowing 15 uninsured interviewees who sought to enroll, I observed and audio recorded an additional 15 face-to-face interactions with health navigators. For this article, I only use data from ethnographic observations because interviews with uninsured respondents were conducted prior to enrollment efforts and, thus, provided little insight on the ethnographic observations. To conduct the ethnography, I carried a digital recorder to fully capture the audio of the interactions observed. At all times, I carried a notepad to write down observations and important body language cues during interactions.

The sample of uninsured clients consisted of 8 whites, 10 Hispanics, and 7 African Americans. I included racial variation to collect a sample resembling the more general uninsured population. In both Cook County and the nation, blacks and Hispanics make up nearly 40% of the population, but account for over half of the total uninsured population (Kaiser Family Foundation, 2014). My sample of health navigators consisted of 4 whites, 13 Hispanics, and 8 African Americans. All navigators were employees of

nonprofit social service organizations.

Navigators had no enrollment quotas but were evaluated based on the number of contacts made with potential clients. To track the number of contacts made by navigators, organizations required navigators to have clients write their name, address, and phone number on a three by five inch card. Navigators ranged from young adults straight out of college to senior citizens. Some had college degrees, others just high school. In addition to a 20 h training program to learn about the ACA, navigators were required to pass a Federal background check and score at least 80% or higher on a state exam before entering the field. On average, health navigators earned \$27,000 per year. At the time of data collection, navigators on average had six months of experience on the job.

Findings with respect to repertoires emerged from analysis of ethnographic recordings and field notes. I did not enter the field with these concepts already developed or with the intention of testing them. Rather, I used a grounded theory approach of entering the field interested in the interactions between the uninsured and health navigators (Glaser and Strauss, 2009). To discern patterns in the data, I used an open coding scheme in Atlas-Ti software. After listening to the recorded interactions from the field, and reading recording transcripts, I recognized patterns in how navigators sought to build legitimacy and trust with clients.

### 3. Findings

Navigators underwent three days of extensive training, two in person with an instructor, and one online in front of a computer. The training consisted of lectures on health care terminology and ACA policies. While organizations hired many with previous work experience in health care, nearly half of navigator trainees had no prior experience. Thus, the training taught basic health insurance terms such as premium, deductible, subsidy, and Medicaid. The training also covered key components of the ACA such as protection from being denied coverage for pre-existing conditions, the Medicaid expansion, and how subsidies work for purchasing private insurance. In addition, the training taught navigators to keep client information confidential and provided a demographic overview of the uninsured population in Cook County. Hosted in school auditoriums, the trainings functioned like large lectures as the instructors (professors of health policy at a local research university) gave power-point presentations for the duration of the training sessions.

Over the course of the three day training, only 5 min were spent discussing how navigators should interact face-to-face with clients from disadvantaged populations. It was 4.30 pm on day two of the 9am–5 pm training session and both the instructor and navigators in the audience were tired from two days of constant lecture. Wrapping up her presentation, the instructor turned to the next power-point slide titled “cultural competency” and addressed the navigators saying:

“People have a lot of barriers. There’s a million things you need to overcome because this is a population that has never had health insurance. Consumer surveys suggest people want more information, so you’re best strategy is to tell people they can get financial help. Like, “come over here and let’s see what you’re eligible for.” Just put all their information in, and the computer will tell you what they should get.”

The instructor re-emphasized the importance of informing clients they can’t be denied coverage based on pre-existing conditions then moved on to the next topic. The exam also did not ask questions about how to interact with clients. Overall, the training had more to do with teaching basic health care terminology and ACA

facts than face-to-face relational work.

In light of this training, navigators had to improvise and come up with their own repertoires for building legitimacy with clients. Of the 25 interactions I observed, 15 ended with clients enrolling while the other 10 did not. The following five in-depth cases best exemplify the broader trend in the data that navigators who used a combination of repertoires enrolled clients whereas navigators who relied on just one repertoire did not. These interactions also revealed a number of structural factors constraining navigators’ outreach work.

#### 3.1. *Mirroring, validating, and distancing*

Amanda, a 34 year old Hispanic navigator with a college degree in social work, accidentally arrived 2 h early to a health fair at St. Matthew’s church in Humboldt Park. To pass time, Amanda and I went to the basement where we met Shavon, Betty, and Tina, volunteers for the event who were sitting behind computers checking email and surfing the web while venting frustrations about the high fees for county government services.

“The government will go after every little thing,” said Tina.

Betty added, “Yeah, the government pockets money for themselves.” These women’s comments reflected a cynical attitude toward government.

Without introducing herself, Amanda inserted herself into the conversation by mirroring the women’s sentiments. “Yeah!” Amanda agreed, “and those speed cameras they setup all over the city, that’s the city just trying to get more money.”

“Damn straight,” Betty replied, “who are you?”

“I’m Amanda Ortiz, a health navigator with the CASA organization. I’m doing outreach for the Affordable Care Act.”

“You’re just the kind of person I need to talk to!” exclaimed Betty. By mirroring the women’s sentiments about government, Amanda inserted herself into the conversation.

Betty continued, “I have good health insurance, but I can’t afford the premium. With Obamacare, how do they figure out what is affordable?”

“That’s a great question, but there’s not a simple answer because everything depends on your age, your income level, and all these things. But tell me, what has your experience been like trying to get health insurance?”

“Crazy!” Tina interjected, “The website is awful. Like, to see anything you need to register, and then to register you need an email, then you need confirmation for the confirmation ...”

“Yeah, if you’re not experienced with this type of system, I understand,” Amanda replied, “But, if you have accounts online, verifying your email is a common thing you need to do.”

“Ok,” said Tina as she leaned back and crossed her arms. Sensing that Tina was disengaging from the conversation, Amanda deployed another repertoire by validating Tina’s struggles with technology saying “what you’re expressing right now, I feel you, because there’s a lot of folks who are not tech savvy, and that’s a hard thing for people.”

“Yeah,” Tina responded, “it gets me so frustrated!”

“Well I have a laptop and my office is [nearby], so you can stop by and I can help you through this” said Amanda, “I’ll give you my card and we can setup an appointment.” Amanda responded to Tina’s complaints by deploying a repertoire of validating her concern. When Amanda felt Tina receding from the conversation, Amanda reengaged Tina by talking about people’s struggles with technology. Amanda’s work, however, wasn’t over.

“Wait, hold up!” Shavon interrupted, “What about commission? Do you get bonus points or something for signing people up?” By asking this question, Shavon was directly questioning Amanda’s motivations for enrolling people.

“No”, said Amanda, “other states do compensation based payment for their navigators, but we don't. I don't get paid extra for signing up more people. The focus is to do outreach and education, to make sure people are aware of what's coming and making the right choices.” In this answer, Amanda employed another repertoire of distancing herself from a self-serving bureaucrat by saying she doesn't earn a commission. The repertoire worked as Shavon replied asking, “Ok, well, my job does not provide health insurance for my children, what am I eligible for?”

In this interaction, Amanda's response to Shavon's challenge helped build trust and legitimacy that made the women more comfortable with asking questions about their health insurance options.

Amanda continued to engage in distancing except, this time, from government.

“It depends on whether your income is below the Federal poverty level,” said Amanda about Shavon's eligibility for assistance.

“What is the federal poverty level?” Shavon asked. Amanda replied:

“The federal poverty line is this *arbitrary* number that has been given as a threshold. If you fall under it, then you qualify for Medicaid. But if you are over then you have to buy your own insurance in the marketplace. I don't make up these numbers, and I say it's arbitrary because I have seen people who make just a little bit more than the federal poverty line that still need Medicaid. Just know that my first concern is that you know what the ACA is and that you have all the information you need. If you're interested in enrolling in an insurance plan, I can get you started on that and help you through it. If [pauses and elongates her pronunciation], *if you want that assistance.*”

As the women expressed cynical views of government, describing the Federal poverty line as “arbitrary” helped distance Amanda from government. Amanda conveyed that she shared these women's attitudes toward government and could, therefore, be trusted. In addition, Amanda combined distancing with the repertoire of ceding control of the conversation to the women. By emphasizing she is only there to help “if you want that assistance,” Amanda expressed to these women that they had the power to exit the interaction or application process whenever they pleased and with no consequences.

Through a combination of repertoires, Amanda built trust and legitimacy with these uninsured women. I asked Amanda “how do you build trust to explain such a complex thing to people?” She replied,

“You gauge where the person is. I am not going to run my mouth off about marketplace or Medicaid if I don't know what you qualify for. I can stand and talk until my face turns blue saying you need help because you are going to get a penalty if you do not get health insurance, but who is going to want to come and talk to me after saying that?”

Amanda did not believe in scaring her potential clients into enrolling, rather she deployed a combination of repertoires to build trust and meet her clients' health needs.

### 3.2. Building ethnic solidarity

Janet, a 25 year-old Mexican American health navigator who had recently graduated college with a degree in public policy, greeted Steve and led him to a windowless meeting room. Steve

was an uninsured 28 year-old Mexican–American working in retail part-time. With little knowledge of the ACA, Steve visited a nonprofit community organization in his neighborhood to learn more and decide whether to enroll. After introductions, Janet tried explaining some basic features of the ACA, but Steve cut to the chase.

“What about all those plans that they've been saying in the news that have been canceled?”

At the time of this interaction, the media was reporting on people having health insurance plans canceled by companies because they no longer met the ACA's minimum requirements. Steve, however, did not understand this and was worried that his plan might get canceled.

“Those plans were canceled because they didn't meet criteria of minimum essential coverage,” said Janet.

“Ok” Steve answered.

Sensing Steve did not understand nor trust her, Janet responded by building ethnic solidarity and using analogies. “I remember learning about this because I wrote a paper about it in college. I wanted to know how the ACA was going to help Latino people. I wanted to see how it was going to allow for more opportunity and how it was going to be culturally competent. I learned, since 2010, health insurance plans had to meet a minimum essential coverage otherwise it would have to be canceled.”

Janet's concern for the Latino population resonated with Steve who, in response, asked, “So none of the stuff being canceled is any of the new [health insurance plans]?”

“No,” Janet answered, “It's like car insurance. There's really shitty car insurance. There's also really shitty health insurance, and the ACA is making companies cancel their shitty plans and get better ones through the ACA.” In this interaction, Janet used a combination of building ethnic solidarity and using analogies to not simply inform but also build legitimacy with Steve.

Janet returned to her ethnic solidarity repertoire saying “I'm glad you're asking these questions because the Latino population, we are the least likely to complain. We are complacent. But, it's not really complaining, it's about getting what you are entitled to.” By expressing her concern for the Latino population, and using the pronoun “we” (as in Steve and herself) when describing the challenges of the Latino population, Janet built trust with Steve by creating a sense of shared identity. After establishing this trust, Janet used the car insurance analogy to persuade Steve not to worry about canceled plans. These repertoires helped build trust and legitimacy to persuade Steve to enroll in Medicaid.

### 3.3. Ceding control and distancing

Abe, a 28 year old college educated Hispanic health navigator, approached Joyce (an uninsured 32 year-old African American woman) as she sat at a table eating a sandwich with her niece during “family fun night” at a Boys and Girls Club in Little Village. Dressed in slacks and a button down shirt, Abe introduced himself.

“Hi, I'm Abe.”

“Nice to meet you, I'm Joyce.”

“I'm here working for an organization and we're trying to sign people up for the ACA.”

“Really?” asked Joyce.

“Yes, do you have health insurance now?”

“No.”

Abe pulled out a bright yellow pamphlet and said to Joyce:

“That's ok. I can assist you with enrolling. In the end, it is completely up to you to make that final decision if you want to enroll in anything at all. I can start you off to see what's out there. There's Medicaid, which is completely free public

assistance. Let's say you're income is above what they accept. Then you could qualify for marketplace insurance. That's actually private insurance.”

By saying “it is completely up to you to make that final decision”, Abe was ceding control of the interaction to Joyce. Unlike Janet and Steve, Abe (a Latino) was not of the same ethnicity as Joyce (African–American). Thus, Abe made sure to convey to Joyce that she had the power in this interaction and that his role was to serve her. This repertoire kept the conversation going as Joyce responded saying she didn't make much money, and that she probably could not afford private insurance. Abe replied, “Ok, we can see what you're eligible for, show you your options and then you can make a decision on whatever you feel is best for your budget and needs.”

Abe continued “So, with the new Medicaid, insurance companies can no longer deny you for pre-existing conditions.” Joyce raised her eyebrow asking “Really?” In response, Abe raised both hands in the air to gesture he meant no harm stuttering “I, I, I, don't want to make any promises because, obviously, we have to see what plan you are eligible for ...” Joyce interrupted, “But that really means a lot to me because I have a hearing problem and I've been denied lots of things in the past.” Abe continued to cede control in order to persuade Joyce to schedule an appointment with him:

“I'm going to leave you with my information [hands her his business card]. [Abe pulls out another sheet of paper] This is a list of documents that we are going to need in order to fill out your application, and I can actually sit down with you, with your permission, to go through the entire application. That is something you could do by yourself if you wanted to, or I could sit down with you and assist you.”

By saying “I can sit down with you *with your permission*,” Abe was, again, ceding control to Joyce. Abe never disagreed with Joyce or told her not to worry. Like the low-income women in [Levine \(2013\)](#) and [Hays' \(2003\)](#) studies, Joyce had painful experiences of being denied health benefits in the past by welfare bureaucrats, but Abe engaged in distancing by saying he was not making any promises, but that he was committed to helping her determine which ACA benefits she could acquire. By ceding control, Abe built legitimacy to persuade Joyce to schedule an appointment. Abe made Joyce feel like she had a trustworthy partner to navigate the ACA, and one week later he guided her through her Medicaid application and she became insured.

In a follow up interview, Joyce described how Abe's ceding of control was effective at building trust.

“Abe was friendly and he didn't lie to me, he didn't try to sell me. He just say “once we do this it's strictly up to you, just because you talk with us and give us your information doesn't mean you have to sign up, the ultimate decision is up to you.” Most people, when you try these HMO's, you give them your information that mean you signed up and you don't get a chance to think about it reading material or nothing.”

Abe's repertoire of ceding control helped Joyce feel like she had an ally who would listen to her concerns, help address them, and, most importantly, not cause harm. This relational work resonated with Joyce who was accustomed to welfare bureaucrats who she perceived as impersonal and untrustworthy. After asking Joyce if Abe was like any bureaucrat she had interacted with before, she answered “No! Nobody treats you like that.” In this example, Abe relied on a combination of distancing and ceding control to respond to Joyce's challenges and establish enough legitimacy to convince

her to accept his assistance.

[Table 1](#) provides counts of the number of times navigators used each repertoire during interactions that did and did not lead to clients enrolling. In 13 of 15 interactions resulting in client enrollment, navigators used a combination of ceding control and distancing. The other most commonly used repertoires during successful interactions were mirroring (7), validating (4), and building ethnic solidarity (3). During interactions where clients did not enroll, navigators overwhelmingly did not use these effective repertoires as often. Instead, they relied mostly on insistence (4) and informing (6), which, in the next section, I show were ineffective at building legitimacy with clients.

### 3.4. Ineffective repertoires

Ray was a 45 year old white health navigator with no college education who hosted an open enrollment session at a library in Logan Square. Matt, a 36 year old white uninsured construction worker walked in to ask some questions about the online marketplace.

“Is there a guide to figuring out what plan to get? Is a platinum plan better than a gold plan? I don't know how to think through these different color options.”

“I myself can't tell you that,” Ray answered, “Like legally, I can't tell you which plan to pick. I can tell you the most commonly used is the silver.” From the beginning of the interaction, Ray's lone repertoire was to inform Matt through pamphlets and videos while refusing to share his opinion.

“So you can't be a salesman?” Matt asked.

“Yeah, I don't get commission. It's like we pretty much can't be sharks. Here, watch this 6 min video. It sums up so much information. It's accurate.” While Ray distanced himself from a sales employee, he did nothing else to build trust or legitimacy with Matt.

Matt continued, “I ask because there's so much bad information out there, I don't know who or what to trust.”

“Yeah”, Ray agreed, “here's a pamphlet. Fill out this card too, put your information down and I can get back to you with more information.” Matt was also concerned about stories of people's health insurance plans being canceled and asked, “Why are these plans being canceled in the news?”

“That has to do with how health insurance is broken down and how companies are coping with the ACA,” Ray answered, “but I can't give you a definitive answer. I can only give you my opinion.”

“Ok,” Matt answered sarcastically, “in your opinion, where is the best place to get information on all this?” Ray replied while pointing to the website link on the flyer “this is an accurate source.”

“Alright, well, I earn around \$25,000, so I know I'm not poor enough to get Medicaid, what color plan should I consider choosing?”

“Maybe when you fill out your application it will tell you what to get,” Ray responded, “when you apply online it asks you a bunch of questions and at the end it tells you what you should get.”

Frustrated with Ray's inability to help, Matt asked “If you are not legally allowed to steer people to certain plans, then who is legally allowed to do that?”

“I would say yourself,” Ray answered.

Confused, Matt asked “Is this like buying a car? Like instead of going to a shady car dealer you have to go to a healthcare company to hear what they have to offer you?”

“I don't know. I can't really say,” Ray replied.

“Look, I feel more comfortable with you because you don't get paid for whether or not I sign up, but you're not legally allowed to share anything. I wouldn't trust an insurance salesman because to me they'd be like a car salesman.” In this quote, Matt conveyed to

**Table 1**  
Count of navigators' repertoire usage by client enrollment outcome.

Repertoire	Interactions where client enrolled (N = 15)	Interaction where client did not enroll (N = 10)
Mirroring	7	0
Validating	4	0
Ceding Control	13	0
Distancing	13	1
Building Ethnic Solidarity	3	1
Insistence	0	4
Informing	0	6

Ray that he wants to trust him and learn more, but Ray responded by going back to his lone repertoire of informing. “Well I can't directly tell you what to get,” said Ray, “but I can say what is common.”

Matt paused for a few seconds, thanked Ray for his time and walked out. In this interaction, Ray distanced himself and attempted to inform Matt, but did not go any further to understand Matt's needs or build trust. Instead, Ray kept referring to information sources like the website, pamphlets, or videos to answer all of Matt's questions when, at the root of it all, Matt was trying to build trust but Ray could not adequately respond, and consequently Matt walked away from the interaction still uninsured.

Many ineffective navigators like Ray seemed to repeat the same lone repertoire of informing clients during interactions. This mode of interacting with clients actually followed the instructor's advice of simply informing clients that “they might be eligible for something.” If the ACA and health navigator occupation had legitimacy similar to that of doctors or nurses, the lone repertoire of informing clients may have worked. For example, when a nurse draws blood from a patient in a hospital bed, patients often assume the nurse knows what she or he is doing. Health navigators, however, do not have such legitimacy in their work. Without employing the relational work to build trust and legitimacy, the seven navigators who exclusively relied on informing clients were unsuccessful at convincing clients to accept their assistance and enroll.

### 3.5. Insistence

Besides informing, other unsuccessful navigators tried to enroll clients by being insistent, an aggressive repertoire that sought to push clients into enrolling. Tiffany, a 37 year old African–American health navigator with an associate's degree and previous work experience as a cell phone sales employee explained her rationale for being insistent.

“It's difficult to get some people to buy into the idea of health insurance. To change the way they think about it. With the communities that some of us work in, they think it's like an extra bill. They'd rather have a cell phone versus health insurance!” She continued, “I just try to get them to understand the importance of being covered, and I think once they hear it 3 or more times, then they're convinced. You just have to keep repeating the message.” Rather than building trust, Tiffany believed she needed to push her clients to enroll.

I observed Tiffany deploy this repertoire in her exchange with Alan, a 25 year old uninsured African–American graduate student. Alan made an appointment at Tiffany's clinic to learn more about the ACA before deciding to enroll.

“I want to ask you some questions,” said Alan.

“Ok, so you don't want to apply?” Tiffany asked.

“Not today, I want to know what I am applying for. So I wanted to speak to someone.”

Tiffany stood up, folded her arms, and leaned forward as she said

to Alan “If you are not insured, you need to be.”

“I know,” Alan said.

“I mean that is what we do.”

“I agree,” Alan replied, “but I wanted to know as much as I can before I sign up for it.”

Tiffany raised her eyebrow and asked, “Ok, are you employed?”

“I don't even know how to answer that question,” Alan replied sounding embarrassed, “Kind of ... I work at a place that I don't get paid for.”

“Then you are not employed.” Tiffany's speech accelerated as she continued:

“If you are not employed you are going to qualify for Medicaid. With Medicaid you can go anywhere and do anything. Medicaid can be compared to BlueCross BlueShield because you can do anything and everything with it.”

This exchange startled Alan. Tiffany continued, “Before we even start. Can I get you to sign this card? We are not going to call you. I just need your name and your address to say I talked to you, Ok?”

“Why do you need us to sign a card?” Alan asked.

Tiffany sighed, rolled her eyes, and condescendingly answered very slowly, “To ... say ... that ... I ... talked ... to ... you ... about ... health insurance.” Tiffany sped up her voice again and continued, “I mean it's not signing anything. You are just putting your name, your address, and your phone number. That is it. I mean, we are not going to do anything with it.”

After filling out the card, Alan asked “Is there information that you know about the [health insurance] plans that I obviously cannot get on the website. That is part of the reason that I wanted to talk to somebody. If I sign up, what do I get?”

“Health insurance which is medical and vision.”

“But that health insurance is it ... I mean, there is good health insurance and I have heard people say there is bad insurance ...” said Alan.

“Ok. You are going to get Medicaid,” Tiffany interrupted, “Medicaid is a good insurance. That is why I compared it with BlueCross BlueShield the good insurance.”

Visibly frustrated, Alan raised his voice and said “Yeah, I've never had health insurance, so I don't even know what that means!”

“It is going to cover everything,” Tiffany answered, “Medically, it is going to cover everything that you need to do. And visually, you can get glasses.”

Alan paused, looked down at the ground, and replied, “Ok. Anything else that I should be knowing in terms of the Medicaid because, to be honest, when I was coming in I was not anticipating Medicaid being the only option that you said that I would have. I do work. I actually work at [the University], but they just pay for me to go to school.” Tiffany cut off Alan, “Exactly, so you are unemployed.” Alan's facial expression conveyed embarrassment and a sense of pain. Alan replied in a lowered voice, “Ok. Cool.”

Tiffany's insistence did nothing to build legitimacy with Alan who walked away less certain that the ACA would provide him adequate benefits. In contrast to other navigators who relied on a

combination of repertoires to persuade clients to accept their assistance and enroll, Tiffany relied exclusively on insistence. As the bulk of Tiffany's uninsured clients in North Lawndale were highly impoverished people who she believed did not want health insurance, she treated Alan like he needed to be taught the value of health insurance. Alan, however, needed someone he could trust to answer his questions and concerns. Like the other uninsured clients in this study, Alan needed a trusted partner to help him take on the complexity of the ACA. Informing him of the benefits and being insistent was not helpful.

In contrast to Janet, who strategically relied on her shared ethnicity to build trust with her client, Tiffany missed out on several opportunities to build legitimacy with Alan. In interviews with Alan and Tiffany, they shared much in common. They had attended the same high school, they lived in the same neighborhood, and they were of the same race, but Tiffany made no effort to make such a connection. Both Tiffany and Ray's examples demonstrate how, in the absence of any shared interest, identity, or connection with clients, navigators have a much more difficult time building legitimacy with clients.

#### 4. Conclusion

The provision of health insurance benefits to disadvantaged minority populations requires navigators to have an assortment of repertoires for establishing legitimacy and trust. Navigators must build rapport, respond to challenges to their integrity, and thoughtfully describe their purpose to clients. Successful navigators accomplished this by deploying a combination of repertoires such as ceding control, distancing, and building ethnic solidarity. Effective navigators validated clients' concerns and directly responded to skepticism. In contrast, ineffective navigators took their legitimacy for granted. These navigators either informed or insisted that clients enroll without building legitimacy during the interaction.

This article demonstrates that the study of health navigators (Tummers and Rocco, 2015; Sommers et al., 2015) can benefit from incorporating insight from the sociology of occupations, particularly the study of face-to-face relational work necessary for building professional legitimacy and authority with clients (Eyal, 2013; Huising 2014). While patients might depend on legitimized occupations like nurses and doctors for medical care, many of the uninsured navigating the ACA will not actively seek out or automatically trust health navigators' guidance. In this study, legitimacy and trust between navigators and clients was something to be achieved. Clients accepted help only after navigators created conditions where the client felt under control and capable of exiting the interaction at any time.

Research on health navigators needs to focus on navigators' ability to respond to uninsured clients' distrust in government and the health care industry (Levine, 2013; Mechanic, 1998; LaVeist et al., 2000). For low-income uninsured individuals like Joyce or Shavon, their perception of government provided or subsidized health insurance was filtered through their past experiences with government and health care in general. Navigators' ability to distance themselves from government or self-serving bureaucrats may be a critical component of successful ACA outreach. To better inform researchers and practitioners involved with ACA outreach, future studies of health navigators needs to engage the sociological literature on poverty and the welfare state. Urban poverty scholars have examined similar processes in the study of other welfare bureaucracies interacting face-to-face with the poor (Soss et al. 2011; Watkins-Hayes, 2009). ACA outreach efforts, however, present a rare opportunity to study how cultural repertoires matter in the implementation of a public benefit *expansion* to the poor.

A research agenda on health navigators can fit within the

broader study of how policymakers and frontline health workers use culture to deliver messages about public benefits that boost enrollment among the urban poor. This article shed some light on this process from a study based in Chicago, but these face-to-face interactions will likely vary by region of the US or urban versus rural setting. Because the uninsured population is more heterogeneous than the sample in this study, additional research is needed to identify other cultural repertoires that build legitimacy and trust in different locations.

Despite limits to generalizability, this study highlights an important and understudied repertoire that occupations can use to build legitimacy: distancing from occupations clients perceive as illegitimate. Frontline health workers like nursing assistants (Zinn et al., 2009), HIV/aids outreach staff (Coyle et al., 1998), and community health workers (Perry et al., 2014) face similar challenges in building the legitimacy necessary to convince clients to adhere to prescribed medications, engage in safe sex practices, or enroll in health programs. Health outreach efforts typically attempt to build legitimacy by hiring health workers directly from the disadvantaged communities being served (Shaya and Gbarayor, 2006). But the findings from this case study indicate that health workers can also build legitimacy by validating clients' negative perceptions of occupations and distinguishing themselves from those occupations perceived as illegitimate. Through face-to-face relational work, frontline health care workers can view distrust and negative perceptions among clients as not just a barrier to be overcome, but also as a possible foundation from which to build legitimacy on unconventional grounds. Such a foundation would be grounded in a mutual disdain or negative perception of a particular occupation that simultaneously grants the health worker legitimacy with assisting the client on a given task.

Finally, with respect to policy implications, this article shows that it is a huge mistake for navigator training to neglect low-income minority populations' distrust in government and the medical profession. It is not too late, however, to improve ACA outreach efforts. Navigator training on health insurance and ACA terminology can be supplemented with training on how to interact with clients, build trust, and respond to challenging questions. Uninsured clients' lack of familiarity with navigators was not always a barrier as some navigators used it as an opportunity to dispel clients' preconceived notions. Whereas welfare case managers established legitimacy through their formal power to cut clients off from benefits, successful navigators established legitimacy through face-to-face relational work that built shared interests, addressed clients' questions, and ceded control to the client. In addition to hiring a diverse navigator work force on the basis of race, class, and gender, ACA outreach efforts can improve by instilling navigators with a variety of repertoires for building legitimacy and trust.

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