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ORIGINAL PAPER

Health Insurance Status and Eligibility Among Patients who Seek Healthcare at a Free Clinic in the Affordable Care Act Era

Kristen Sessions[1] · **Amal Hassan**[1] · **Thomas G. McLeod**[2] · **Mark L. Wieland**[3]

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Abstract Free clinics provide care to over 1.8 million people in the United States every year and are a valuable safety net for uninsured and underinsured patients. The Affordable Care Act has resulted in millions of newly insured Americans, yet there is continued demand for healthcare at free clinics. In this study, we assessed health insurance status and eligibility among 489 patients who visited a free clinic in 2016. Eighty-seven percent of patients seen were uninsured, 53.1% of whom were eligible for health insurance (Medicaid or subsidized insurance premiums). The majority of these patients completed health insurance applications at their visit with the help of a navigator. A majority of patients who were not eligible for health insurance lacked citizenship status. This study highlights that a significant number of patients who visit free clinics are eligible for health insurance, and that free clinics are important sites for health insurance navigation programs.

Keywords Free clinics · Affordable Care Act · Uninsured · Medically underserved

✉ Kristen Sessions
Sessions.kristen@mayo.edu

[1] Mayo Clinic School of Medicine, 200 1st Street SW, Rochester, MN 55905, USA

[2] Department of Internal Medicine, Mayo Clinic, 221 4th Ave SW, Rochester, MN 55902, USA

[3] Department of Family Medicine, Mayo Clinic, 221 4th Ave SW, Rochester, MN 55902, USA

Introduction

Free clinics are part of a larger "safety net" that provides medical, dental, and pharmaceutical services to uninsured and underinsured patients nationwide. Free clinics serve 1.8 million people annually and provide a valuable access point for many people to enter the healthcare system [1, 2]. These clinics are often not a sufficient replacement for primary care but they have been shown to reduce emergency room visits and continue to be an important source of care for many patients [2, 3].

In 2010, the Affordable Care Act (ACA) and Patient Protection Act increased the opportunity to obtain health insurance by expanding Medicaid eligibility, creating health insurance exchanges, subsidizing premiums for health insurance, and requiring minimum insurance coverage [4]. Under the ACA, more than 20 million previously uninsured people gained coverage [5]. The impact was even more significant in states that implemented Medicaid expansion. One study documented a 40% decrease in uninsured visits to free clinics in states that expanded Medicaid eligibility compared to a 16% decrease in states that did not [6].

Despite expanded coverage, barriers to obtaining health insurance still exist for some patients. Two studies have examined perceived barriers to health insurance enrollment among potentially eligible patients at free clinics. Interviews with 80 patients at a free clinic in a Medicaid expansion state under the ACA demonstrated that the most significant barriers to enrollment were perceived ineligibility and cost [7]. In a survey of 551 patients at a free clinic in a non-Medicaid expansion state, the most common reported barriers were difficulty obtaining application information and perceived high cost [8].

In the current study, we address a gap in the literature relative to understanding the health insurance status and

eligibility among all patients who seek care at a free clinic in the ACA era. In particular, our investigation sought to more precisely characterize social and demographic features at play as patients consider and progress through the enrollment process. We analyzed the patient population utilizing the services of a free clinic in a Medicaid expansion state (Minnesota) to elucidate the granular nature of health insurance status and eligibility among these patients. Free clinics are uniquely important settings to pursue these questions because they serve as barometers of policy implementation more broadly. Patients seeking care at free clinics are expressing a demand for healthcare, but their choice of visiting a free clinic generally reflects lack of insurance, underinsurance, or other barriers to healthcare access.

Methods

Study Site

The Rochester Area Salvation Army's Good Samaritan Health Clinic is a free clinic in Rochester, Minnesota that provides health care and prescription medications to person's in Olmsted County who are uninsured or underinsured. Rochester is a medium-sized city in Southeast Minnesota; 77% of the population is white, 16.5% speak a language other than English, and 10.3% of residents live below the federal poverty level. The clinic offers adult and pediatric general medical care, psychiatry services, a diabetes clinic, eye care, smoking cessation services, and general dental care. The office is centrally located in a downtown area and it is supported by three full-time employees and a roster of volunteer physicians and dentists, nurses, diabetes educators, dieticians, social workers, and lay personnel [9].

Data Collection

Data were abstracted for all patient visits to the study site from March through September 2016 from an existing database. During each patient visit to the clinic, patient data including patient age, sex, race/ethnicity, and income level are collected entered into the database. During appointment registration, insurance status is also recorded in the database. For patients without insurance, the database also includes health insurance eligibility and free text to indicate the reason for lack of insurance. These granular health insurance data are entered by a certified patient health insurance navigator who meets with every patient during their visit. The purpose of this meeting is to assess existing health insurance status. If the patient is uninsured, the navigator provides patients with the opportunity to complete an application for health insurance through the state-run exchange. Members of the study team reviewed free text comments and collapsed the reasons for lack of insurance into nine categories through a consensus process. This study was deemed exempt for quality improvement purposes by the Mayo Clinic Institutional Review Board.

Data Analysis

Results were reported with descriptive statistics, including frequencies and percentages.

Results

There were 489 distinct patients who accounted for 1145 free clinic visits during the study interval. Forty-six percent of patients were male and 85.7% were between the ages of 18 and 64 years. Sixty percent of the patients were racial/ethnic minorities in a community that is 86% white. Eighty-five percent of the patients lived under 200% of the national poverty level with 69% of these patients falling below 133% of the national poverty level (Table 1).

The majority of patients (87%) were uninsured. Of the uninsured patients, 53.1% (46.6% of all patients visiting the clinic) were eligible for some form of insurance assistance including Medicaid, Medicare, or premium subsidies. The remaining 46.9% of uninsured patients were ineligible for

Table 1 Demographic characteristics of 489 patients vising a free clinic from March to September 2016

	n	%
Gender		
Male	223	45.6
Age		
0–17	38	7.8
18–24	28	5.7
25–34	89	18.2
35–54	218	44.6
55–64	84	17.2
65 and older	32	6.5
Race/ethnicity		
Black or African American	70	14.3
Asian	75	15.3
White	195	39.9
Hispanic or Latino	148	30.3
Other or unknown	1	0.2
Income		
<133% federal poverty level	339	69.3
133–200% federal poverty level	77	15.8
200–400% federal poverty level	58	11.9
Over 400% federal poverty level	15	3.1

health insurance assistance; the majority of these patients lacked citizenship status (Table 2).

Discussion

An important finding of this study was that the majority of patients seeking care in a free clinic more than 6 years after ACA implementation were eligible for health insurance. This finding emphasizes the challenges of implementing large scale legislation of this nature.

Initial health insurance application and subsequent renewal process could serve as a barrier to obtaining and retaining health insurance. Furthermore, for household members that are eligible for different assistance programs (e.g. Medicaid versus state funded programs), there are different renewal criteria and points of contact. Consequently, a significant degree of health literacy, as well as consistent and longitudinal involvement in the process is often required in order to remain insured. Previous studies have demonstrated barriers to health insurance enrollment among eligible individuals, including perceived high cost of insurance, low knowledge of eligibility criteria, difficulty navigating enrollment logistics, and language barriers [7, 8, 10–13].

To address some of the barriers to health insurance enrollment, many states, including Minnesota, have developed Patient Navigator Programs to bridge the gap between policy and implementation. Navigators help guide patients through Marketplace enrollment, answer questions about eligibility and enrollment, and assist with applications. Navigators facilitate selection of the health insurance plan that is best-suited for a potential enrollee's needs in order to optimize access and utilization of health services [14]. They also implicitly work to establish trust and legitimize their roles as being distinct from any agencies that would directly benefit from increased enrollment. This is particularly relevant in traditionally disenfranchised communities where navigators can serve as an important link in engendering trust for successful enrollment [15].

Given that the highest burden for obtaining health insurance has been placed on some of the most vulnerable subsets of the population, patient navigators serve a critical role in identifying and assisting patients who qualify for assistance. This is demonstrated by the 23.5% of patients who completed applications at our clinic during their visit. As health policy implementation moves forward, there will be an increasing push beyond simply enrolling new persons to assisting persons in maintaining insurance coverage, navigating health systems, and accessing appropriate health care. Indeed, the scope of the navigator role in many program areas has expanded to include assistance with post-enrollment questions to help consumers maintain coverage [16]. Given that a large proportion of the patient population seeking services in free clinics are uninsured, free clinics will be vital sites for employing patient navigator programs.

Under the ACA, there is still a part of the population that does not qualify for insurance coverage and therefore remain "uninsurable", including 44.3% of our study population. For example, undocumented immigrants made up 21.3% of the patients in our study group. Other, less widely recognized "uninsurable" patients included permanent residents who have lived in the U.S. less than 5 years and persons in the

Table 2 Insurance status for 489 patients visiting a free clinic from March to September 2016

	n	%
Insured		
Privately insured	7	1.4
Enrolled in Medicaid or Medicare	53	10.8
Uninsured		
Eligible for health insurance		
Completed insurance application at the free clinic	115	23.5
Application information given to patient to complete on their own	60	12.3
Access to employer-based insurance, but unacceptably high premium or deductible	11	2.3
Over income for Medicaid, eligible for open market	36	7.36
Not eligible for health insurance		
Not a state resident (recent relocation)	10	2.0
Visitor Visa or sponsor	52	10.6
Permanent resident <5 years in the country	20	4.1
Undocumented immigrant	104	21.3
Other[a]	21	4.3

[a]Other reasons included religious beliefs, waiting for open enrollment, applying for asylum or legal permanent resident status, and waiting on paperwork for employer-based insurance

U.S. with a Visitor Visa. Permanent residents must live full time in the U.S. for 5 years to be eligible for federal assistance with health insurance. Despite legal means of entry, these individuals are often unable to access health insurance and therefore utilize free clinics.

This study also highlights the group of patients who were eligible for health insurance but, despite interacting with a navigator, chose not to complete an application. This group included those who were in-between jobs and those for whom employer-based health insurance premiums or deductibles were unacceptably expensive. This group also included those patients with incomes between 133 and 400% of the federal poverty level who were eligible for federally subsidized premiums, but still experienced unacceptably high costs for plans that were available to them.

Twelve percent of the patients seen at our clinic had some form of insurance and their presentation to a free clinic demonstrates gaps in coverage and strain on existing insurance markets. Whether private or government insurance, patients were often seen at the free clinic citing gaps in prescription drug coverage or limitations to conventional healthcare access due to outstanding balances. Nationally, these "underinsured" patients often forgo necessary healthcare due to cost concerns [17].

At the time of article submission, the United States Congress was deliberating ACA repeal with or without alternative healthcare legislation. Any resultant bill is likely to significantly impact the number of uninsured people, which will play out as shifts in patient volumes at free clinics across the country. Regardless of legislative outcomes, this study reflects the importance of dedicated health insurance navigation programs at free clinics in order to maximize policy implementation.

Limitations

The patient demographics and the experiences of a single clinic in this study are not generalizable to free clinic populations more broadly. However, the categories of insurance status, eligibility and circumstance described in this study are likely the same across the country, albeit in varying proportions. Further research is needed to assess these free clinic demographics at a national level and to explore means of addressing the most common issues that arise in pursing and maintain enrollment for those eligible for coverage.

Conclusions

Despite expansion of health insurance eligibility under the ACA, free clinics continue to serve an important role in the healthcare safety net for working-age adults. The majority of patients in this study were eligible for health insurance, highlighting the fact that free clinics are efficient and effective sites for health insurance navigation programs.

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Compliance with Ethical Standards

Conflict of interest The authors declare they have no conflicts of interest.

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