

# Barriers to Health Insurance Pre- and Post-Affordable Care Act Implementation in Providence, RI

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## ABSTRACT

The impact of healthcare reform under the Affordable Care Act (ACA) on individuals living in cities has not yet been quantified by local Departments of Health. This makes it difficult for safety net sources of healthcare, such as free clinics, to plan for the future. Therefore, members of Clinica Esperanza/Hope Clinic conducted a survey in predominantly Latino communities of South and West Providence, RI, using a convenience sample method (N = 206). Survey results were compared to a prior survey conducted in the same communities prior to ACA implementation. Despite gains due to Obamacare, a much higher level of uninsurance was reported in this survey than has been reported statewide. In 2014, as compared to 2010, 48% vs. 95% of respondents reported being uninsured, and more held private (20% vs. 5%) or government-subsidized health insurance (32% vs. 1%). Undocumented immigration status and cost were the two most commonly reported reasons for remaining uninsured under the ACA. First-generation immigrants living in urban centers are still reporting significantly higher rates of uninsurance (48%) than the general population in RI (7.4%).

**KEYWORDS:** Affordable Care Act, health disparities, uninsured, immigrant, free clinic

## INTRODUCTION

The 2010 Patient Protection and Affordable Care Act (ACA) improved health insurance coverage for some previously uninsured populations, such as young adults.<sup>1-4</sup> The impact of the ACA on millions of immigrants, both legal and undocumented, and low-income populations in the “coverage gap” deserves additional scrutiny.<sup>4-6</sup> Lack of health insurance is prevalent in Rhode Island (RI) due to the confluence of two major factors: unemployment and increasing numbers of foreign-born residents. At the height of the economic recession in 2008, RI had the second-highest unemployment rate of any state at 7.7%.<sup>7</sup> Largely due to the subsequent loss of employer-based coverage, 1 in 5 RI residents under 65 were uninsured in 2010.<sup>8</sup> The foreign-born population also increased 5% by more than 40,000 people in the last two decades. These official census figures omit an equally large number of undocumented immigrants.

Low-income populations such as recent immigrants benefit most from insurance expansion, as demonstrated by results from nearby Massachusetts, which has provided universal coverage to all state residents since 2006.<sup>9</sup> Low levels of uninsurance were maintained, in Massachusetts, even in the face of nationwide economic recession.<sup>10,11</sup> Improvements in the health status of low-income populations after state-wide reform in Massachusetts suggests that similar changes may occur after ACA implementation in neighboring RI.

“Safety net” healthcare, which is provided by community health centers, emergency departments, and free clinics, makes healthcare accessible to patients regardless of ability to pay,<sup>12</sup> and continues to be a critically important source of care in the post-ACA era.<sup>13</sup> Free clinics help expand options available to patients for primary care services and can reduce out-of-pocket costs for non-urgent visits that may have otherwise been handled in costly emergency rooms.<sup>14-16</sup> The present investigation evaluated the extent to which the ACA has had an impact on healthcare access and insurance enrollment in a low-income, predominantly Spanish-speaking, largely foreign-born urban community within proximity to a free clinic serving the same population (Clinica Esperanza/Hope Clinic, CEHC). In this study, we used street-level surveying by community health workers (CHW) to assess the population’s barriers to insurance coverage and continued need, if any, for safety net healthcare services. The study expands on a 2011 RI Department of Health report<sup>17</sup> and is compared to a 2010 survey performed using the same method, in the same neighborhoods.<sup>18</sup>

## METHODS

Convenience sample surveys similar to a previous assessment were conducted in public areas of West and South Providence in July-September 2014.<sup>18</sup> CEHC’s bilingual (Spanish/English) CHW facilitated survey completion with participants in their preferred language. The communities are 36–56% Hispanic/Latino, approximately 17% Non-Hispanic Black, with a median age of approximately 29 years. One-quarter of families in the survey neighborhoods live below the federal poverty line (FPL). The area is a designated Primary Care Health Professional Shortage Area.<sup>19</sup>

Participants were over age 18, spoke Spanish and/or English, and were not compensated for their participation. Oral consent was obtained at the time of the interview and

documented on the paper survey form. No personal identifiers were collected. Survey data related to immigration status, income, and insurance status were collected. If uninsured, participants were asked to provide at least one reason for not having coverage under the ACA. Questions assessing basic past medical history and health services utilization of the sample were also asked. Responses were assessed for quality, and entered and analyzed using Microsoft Excel and SPSS.

Based on responses to certain questions, participants were offered informational pamphlets with clinic offerings and other local assistance programs. Individuals who appeared to be eligible for insurance under the ACA were given information on how to arrange follow-up with a trained ACA navigator at CEHC.

## RESULTS

### Demographics

A total of 206 participants were surveyed; data was compared to a survey conducted in the same community in 2010. The majority of respondents identified as Hispanic/Latino in both surveys and reported Spanish as their primary language. Mean age of respondents was 40.2 years (SD = 15.2 years), a slightly wider age range than the 2010 study (37.9 ± 11.7 years). Compared to the 2010 study, more women and more US citizens were surveyed. There was a decrease in the proportion of foreign-born respondents and an increase in the number of white respondents, which may have increased the number of participants reporting having insurance. After adjusting for household size, 55% of respondents had an annual income less than the 2014 FPL. Ninety percent of respondents had an annual income less than 250% FPL, the cut-off for ACA Cost Sharing Reduction eligibility. See **Table 1** for full demographic details.

### Insurance and Healthcare Utilization

The overall number of participants reporting having health insurance (52%) was significantly higher in 2014, post-ACA, than in 2010 (5%,  $p < 0.001$ ) (**Table 2**). In 2014, a significantly larger proportion of survey participants utilized a subsidized healthcare program such as Medicaid, Medicare, or RItCare ( $p < 0.01$ ). 38 participants reported having access to insurance under an ACA/marketplace/Obamacare health plan, an option that did not exist in 2010. **Figure 2** depicts the distribution of healthcare coverage during both years. The proportion of patients receiving healthcare at a community health center increased nearly ten-fold in the four years between surveys, from 5% to 49%. The use of emergency rooms was reported to be lower, as compared to 2014, the use of free clinics remained the same, and the use of all other sources of healthcare increased. Additionally, the percentage of respondents receiving primary care in the past year increased from 29% in 2010 to 69% in 2014.

**Table 1.** Participant Demographics

	2010 (N = 138)		2014 (N = 206)	
	n	%	n	%
<b>Sex</b>				
Male	74	56%	93	45%
Female	57	44%	113	55%
<b>Race/Ethnicity and Nativity Status</b>				
Hispanic/Latino	119	86%	159	78%
Non-Hispanic/Latino	19	14%	45	22%
White	5	4%	23	11%
Black	10	7%	12	6%
Mixed/Other	2	1%	7	3%
<b>Nativity Status</b>				
US-Born	19	15%	44	22%
RI-Born	12	9%	31	15%
Foreign-Born	97	76%	128	63%
<b>Primary Language</b>				
English	19	14%	62	31%
Spanish	92	67%	130	65%
English and Spanish	21	15%	3	2%
Other	5	4%	5	3%
<b>Immigration Status</b>				
US Citizen	59	44%	99	50%
Documented Immigrant ≥5 Years	27	20%	49	25%
Immigrant <5 Years	7	5%	17	9%
Undocumented Immigrant	42	31%	32	16%

**Table 2.** Healthcare-Related Variables

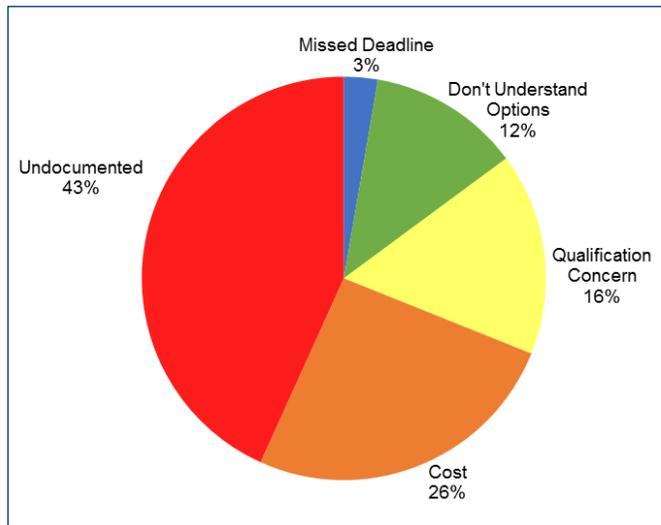
	2010 (N = 138)		2014 (N = 206)	
	n	%	n	%
<b>Insurance Status</b>				
Uninsured	122	95%	75	48%
Insured	7	5%	81	52%
Subsidized Program (Medicaid, Medicare, VA, etc.)	1	1%	50	32%
Private or Employer-Based	6	5%	31	20%
Marketplace Plan/ACA/Obamacare <sup>a</sup>	NA	NA	38	24%
<b>Healthcare Utilization</b>				
Emergency Department	74	57%	15	8%
Health Center	6	5%	93	49%
Free Clinic	12	9%	16	9%
Hospital Clinic	7	5%	25	13%
Private Physician	13	10%	31	16%
Other	18	14%	8	4%
<b>Most Recent Physical Exam</b>				
<1 Year Ago	40	29%	139	69%
1-5 Years Ago	39	28%	35	17%
>5 Years Ago	58	42%	27	13%

### Characteristics of the Uninsured

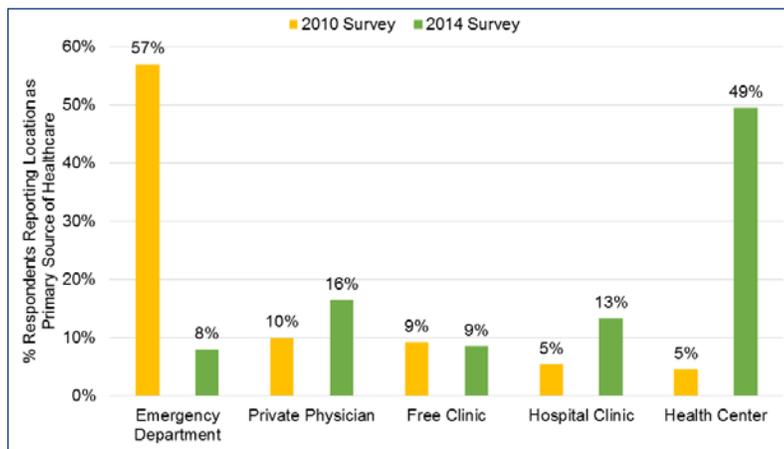
In the 2014 survey, more males than females ( $p = 0.025$ ) reported being uninsured, compared to those with all other sources of health insurance. Uninsured individuals were also more likely than insured participants to use the emergency room when they need healthcare compared to all other locations ( $p = 0.019$ ). Uninsured participants were equally likely to be Hispanic versus all other races ( $p = 0.080$ ), and approximately the same age ( $p = 0.181$ ) as compared to insured patients, for this survey conducted in predominantly Latino neighborhoods.

The 2014 survey asked for explanations as to why participants lacked insurance coverage in the advent of the ACA. Lack of citizenship documentation was identified as the greatest barrier, with 43% of uninsured respondents citing this as rationale for their uninsurance (**Figure 1**). The next greatest barriers to healthcare access were cost (26%) and

**Figure 1.** Primary barriers to ACA coverage among a sample of the uninsured in Providence, RI (N = 74). A majority reported undocumented immigrant status as their primary barrier, followed by high cost of ACA plans.



**Figure 2.** Primary sources of healthcare received, pre- and post-ACA implementation. Most notably, use of emergency rooms greatly decreased, while use of health centers greatly increased.



concerns about qualifications (16%). Missing the deadlines for online application was of little concern, with only 3% claiming this issue. Additionally, 32% of patients lacked computer/internet access and 27% lacked the skills to utilize the technology. Significant financial and technical barriers to accessing insured care following the implementation of the ACA remain, for members of this predominantly Spanish-speaking, low-income population, in 2014.

## DISCUSSION

Since the expansion of Medicaid under the ACA, RI and many other states in the nation remain in a period of transition. Evaluating the impact of ACA reform on populations affected by health disparities enables safety net providers,

such as free clinics, to determine how to address the gap in coverage. This survey uncovered legal, technical and financial impediments to enrollment that could reduce the number of individuals who are able to access subsidized healthcare under the ACA for low-income, Spanish speaking residents of RI.

As expected, more survey participants reported having insurance in 2014 than in 2010, predominantly through government-subsidized programs such as Medicaid and Medicare. In RI, 65% of those eligible had obtained health insurance through the marketplace in 2014<sup>20</sup> and more recently, the uninsurance rate was reported to drop to 5% (50,000 individuals remained uninsured according to figures released on September 10, 2015<sup>21</sup>). Nationally, more than 10 million previously uninsured individuals gained coverage. By the second quarter of 2014, the likelihood of having a personal doctor increased by 2.2 percentage points ( $p < 0.001$ ) and the proportion of adults unable to afford medical care at the national level decreased by 2.7 percentage points ( $p < 0.001$ ).<sup>4</sup> Unfortunately, as documented by this street-level survey,

there is a gap in coverage for populations that may have been overlooked in statewide surveys. 48% of individuals who were approached by CHW in West and South Providence reported being uninsured.

Still, there has been progress. The rate of insurance coverage through government-subsidized programs increased in our sample population, as compared to the results of our previous survey from 2010. This can be attributed to Medicaid expansion following implementation of the ACA. Members of the still-uninsured sample population in this survey stated that their lack of insurance could be attributed to a lack of legal documentation, although a significant proportion stated that subsidies were not sufficient to cover the cost of insurance, and they had therefore declined to be enrolled (despite the penalties that would be applied).

Participants in this survey were predominantly Spanish-speaking, a population that has reported higher uninsurance rates. Nationally, Hispanic uninsurance rates remain high, although they dropped from 36% to 23% post ACA. States without expanded Medicaid did not see this change, with the uninsurance rate among Hispanics remaining at 33% in those areas.<sup>22</sup>

Decreased uninsurance rates were also accompanied by a major shift in the location of care, indicating potential savings for low-income families in Providence. In 2010, a majority of our survey respondents identified the emergency room as their main source of (fairly expensive) healthcare. Based on participant reports for the 2014 survey, reported emergency room usage appears to have decreased, whilst community health clinic (less expensive) usage increased.

In addition, access to primary care appears to have

increased by more than two-fold compared to 2010, post-ACA. Increased access to primary care and reduced emergency room usage is likely to translate into health-related and economic gains for the low-income population represented by our survey participants. Detailed evaluation of the economic and health benefits of becoming insured under the ACA, for members of low-income populations would be worth further evaluation.

Prior to ACA implementation, almost two-thirds of the uninsured were members of working families.<sup>23</sup> This street-level survey provides additional evidence that uninsured residents of RI are working, low-income immigrants. Despite the fact that these individuals make important contributions to their local and national economies,<sup>24</sup> they continue to experience significant barriers to improved health and increased rates of chronic disease,<sup>25</sup> a situation referred to as a “health disparity.” Free clinics and safety net primary care at community clinics provide a low barrier of entry to chronic disease diagnosis for the uninsured and a point of referral into the system for those who are eligible. Based on a recent report that 50,000 individuals remain uninsured in RI,<sup>21</sup> “safety net” clinics that link uninsured populations to primary care deserve continued support.

Many survey respondents who were eligible for insurance under the ACA stated that they remained uninsured due to confusion about their options, concern about qualifications, and cost. Of the 48% reporting that they remained uninsured, nearly half (33 of the 75 uninsured participants) were found to be eligible to apply for insurance, underscoring the need for outreach to members of this low-income, limited English proficiency population. A street-level approach similar to the effort described here might be effective at reaching these individuals. Assistance with applications to insurance under the ACA was offered to every individual who was found to be eligible, and expert assistance was provided at no cost, at CEHC. More than 100 individuals were successfully enrolled in insurance by CHW at CEHC during the survey period.

### Limitations

Survey limitations include the small sample size and use of convenience sampling by healthcare outreach workers, both of which may contribute to the noted variance in some key demographic variables between 2010 and 2014. For example, differences in the gender and ethnicity of the participants may have been due to parallel changes in the ethnicity and gender of the surveyors. This limitation does not appear to have diminished the key finding in this survey; many more low-income individuals are able to access healthcare than before.

### Future Directions

Although the number of persons who have access to health insurance has increased under the ACA in RI largely due to Medicaid expansion, significant gaps remain that put low-income RI residents at risk for economic instability in

the case of health-related events. For example, legally resident Rhode Islanders have to wait as long as five years before becoming eligible for health insurance. Free clinics provide a point of access to healthcare and provide important linkages to insured care for individuals who may be eligible for insurance under the ACA, but unaware of their eligibility status. Results of this survey clearly demonstrate that extended community outreach and safety net entry points are needed for individuals belonging to these difficult-to-reach populations who remain outside the usual sources of healthcare.

Lastly, it is worth noting that the number of uninsured individuals living in low-income neighborhoods in RI still vastly exceeds the number that can be accommodated during available patient visit hours in local free clinics (the two clinics serve approximately 5,000 patients; while more than 50,000 legally present Rhode Islanders remain uninsured in 2015). Rather than close safety net clinics in the post-ACA era, the role of free and safety net clinics as providers of healthcare to those who are not yet eligible for insurance under the ACA, and as critically important portals of entry into the healthcare system, should be recognized and reinforced.

### References

1. Shaw FE, Asomugha CN, Conway PH, Rein AS. The Patient Protection and Affordable Care Act: opportunities for prevention and public health. *Lancet*. 2014 Jul 5;384(9937):75-82. Review.
2. Cogan JA Jr. The Affordable Care Act's preventive services mandate: breaking down the barriers to nationwide access to preventive services. *J Law Med Ethics*. 2011;39(3):355-365.
3. Lau JS, Adams SH, Park MJ, Boscardin WJ, Irwin CE Jr. Improvement in preventive care of young adults after the Affordable Care Act: the Affordable Care Act is helping. *JAMA Pediatr*. 2014;168(12):1101-1106.
4. Sommers BD, Musco T, Finegold K, Gunja MZ, Burke A, McDowell AM. Health reform and changes in health insurance coverage in 2014. *N Engl J Med*. 2014;28;371(9):867-874.
5. Fried B, Pintor JK, Graven P, Blewett LA. Implementing federal health reform in the States: who is included and excluded and what are their characteristics? *Health Serv Res*. 2014;49 Suppl 2:2062-2085.
6. Ortega AN, Rodriguez HP, Vargas Bustamante A. Policy dilemmas in Latino health care and implementation of the Affordable Care Act. *Annu Rev Public Health*. 2015 Jan 7.
7. Bureau of Labor Statistics. Unemployment rates for states. Available at: <http://www.bls.gov/lau/lastrk08.htm>
8. Chollet D, Ballou J, Barrett A, Bell T. Study of Rhode Island's uninsured: Current costs and future options. Mathematica Policy Research, Inc. March 2010. Available at: [http://www.mathematica-mpr.com/~media/publications/pdfs/health/ri\\_uninsured.pdf](http://www.mathematica-mpr.com/~media/publications/pdfs/health/ri_uninsured.pdf)
9. Van Der Wees PJ, Zaslavsky AM, Ayanian JZ. Improvements in health status after Massachusetts health care reform. *Milbank Q*. 2013;91(4):663-689.
10. Holahan J, Chen V. Changes in health insurance coverage in the Great Recession, 2007-2010. 2011 Dec. Available at: <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8264.pdf>
11. Massachusetts health care reform: Six years later. 2012 May. Available at: <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8311.pdf>
12. Wynn B, Coughlin T, Bondarenko S, Bruen B. Analysis of the joint distribution of disproportionate share hospital payments.

2002. Available at: <http://aspe.hhs.gov/health/reports/02/dsh/report.pdf>
13. Angier H, Hoopes M, Gold R, Bailey SR, Cottrell EK, Heintzman J, Marino M, DeVoe JE. An early look at rates of uninsured safety net clinic visits after the Affordable Care Act. *Ann Fam Med*. 2015;13(1):10-16.
  14. Fertig AR, Corso PS, Balasubramaniam D. Benefits and costs of a free community-based primary care clinic. *J Health Hum Serv Adm*. 2012;34(4):456-470.
  15. Hwang W, Liao K, Griffin L, Foley KL. Do free clinics reduce unnecessary emergency department visits? The Virginian experience. *J Health Care Poor Underserved*. 2012;23(3):1189-1204.
  16. Bicki A, Silva A, Joseph V, Handoko R, Rico SV, Burns J, Simonelli A, Harrop J, Nedow J, De Groot AS. A nurse-run walk-in clinic: cost-effective alternative to non-urgent emergency department use by the uninsured. *J Community Health*. 2013;38(6):1042-1049.
  17. Olneyville: Action for a healthier community. Rhode Island Department of Health and Olneyville Housing Corporation. 2011. Available at: <http://www.health.ri.gov/publications/datareports/2011Olneyville.pdf>
  18. Khan S, Velazquez V, O'Connor C, Simon RE, De Groot AS. Health care access, utilization, and needs in a predominantly Latino immigrant community in Providence, Rhode Island. *Med Health R I*. 2011;94(10):284-287.
  19. Health professional shortage areas. US Department of Health and Human Services. Available at: <http://www.hrsa.gov/shortage/find.html>
  20. State Marketplace Statistics. Kaiser Family Foundation. Sept. 2014. Available at: <http://kff.org/health-reform/state-indicator/state-marketplace-statistics/>
  21. Richard Asinof, Delivery of Care; Number of uninsured drops to 5 percent, below unemployment rate. Data from the 2015 Health Information Survey reported by HealthSourceRI. <http://newsletter.convergenceri.com/stories/Number-of-uninsured-drops-to-5-percent-below-unemployment-rate,1789>. Convergence RI, accessed 06 October 2015.
  22. Doty MM, Rasmussen PW, Collins SR. Catching up: Latino health coverage gains and challenges under the Affordable Care Act: results from the Commonwealth Fund Affordable Care Act Tracking Survey. *Issue Brief (Commonw Fund)*. 2014 Sep;26:1-15. PubMed PMID: 25276871.
  23. The uninsured and the difference health insurance makes. Kaiser Family Foundation. 2012 Sept. Available at: <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/1420-14>
  24. NIIC. Paying Their Way and Then Some: Facts about the Contributions of Immigrants to Economic Growth and Public Investment. *Immigrants' Rights Update*, Vol. 20, Issue 5, September 29, 2006. Available at: <https://nilc.org/research003.html>
  25. Cohen RA, Martinez ME. Health insurance coverage: Early release of estimates from the National Health Interview Survey, January–March 2012. National Center for Health Statistics. September 2012. Available at: <http://www.cdc.gov/nchs/nhis/releases.htm>

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