

# Insuring the Uninsured: A Student-Run Initiative to Improve Access to Care in an Urban Community

Michelle L. Niescierenko, BA; Renee B. Cadzow, MA; and Chester H. Fox, MD  
Buffalo, New York

*Context:* There are 44 million uninsured Americans. Lack of insurance creates a major barrier for the poor and near poor to get adequate medical attention. A portion of these are eligible for insurance and either do not know they are eligible or have difficulty navigating the application process.

*Objective:* To evaluate the success of University at Buffalo medical students at a free clinic in helping patients enroll in government-sponsored insurance plans.

*Design:* Observational study

*Setting:* The Lighthouse Free Medical Clinic—a student-run free clinic operating in an urban minority Buffalo, NY neighborhood.

*Patients:* Five-hundred-seventy-nine inner-city, low-socioeconomic-status patients age <65.

*Intervention:* All patients are screened, and those eligible are encouraged and assisted in completing insurance applications.

*Outcome Measures:* Primary outcome is the percentage of patients who completed the application process.

*Results:* Five-hundred-seventy-nine patients were seen from October 2003 through October 2004; 319 (55%) were uninsured. Fifty-nine (26%) of those uninsured were found to be eligible for insurance. Fifty-seven applications were initiated, and 23 (40%) were completed and accepted.

*Conclusions:* There are a significant number of people using the free clinic who are eligible for insurance. The number-one reason adults were ineligible was household income exceeding the state limit. Success of this project provides support for the use of medical student volunteers to assist in insurance application completion in community settings.

**Key words:** uninsured ■ free clinic ■ medical education

© 2006. From University of Buffalo School of Medicine and Biomedical Sciences (Niescierenko, medical student); Family Medicine Research Institute, Family Medicine Research Center, University at Buffalo Graduate Student Department of Anthropology (Cadzow); and University at Buffalo School of Medicine and Biomedical Sciences, Deaconess Family Medicine Center (Fox, associate professor of family medicine), Buffalo, NY. Send correspondence and reprint requests for *J Natl Med Assoc.* 2006;98:906–911 to: Dr. Michelle L. Niescierenko, University of Buffalo School of Medicine and Biomedical Sciences, 703 W. Delavan Ave., Buffalo, NY 14222; phone: (716) 863-0757; fax: (716) 829-2798; e-mail: michelleln@gmail.com

## INTRODUCTION

According to the 2004 U.S. Census Bureau, the number of people without insurance has reached 45 million, which is equal to one in every seven U.S. residents.<sup>1</sup> This number rose again despite a modest increase in access to publicly funded insurance programs, such as Medicaid and Child Health Insurance Program (CHIP).

The National Coalition on Health Care identified 10 systematic forces eroding health insurance coverage in the United States. All of these forces have to do with employment status, as it is intimately intertwined with insurance status. There has been a: 1) decline in employer-based coverage due to the: 2) rise in healthcare costs, 3) insurance becoming unaffordable for small businesses and 4) an increase in the required number of contingent workers. Related to this, there has been: 5) an increase in the number of service sector jobs, which are unlikely to offer insurance to employees as: 6) low-wage jobs do not usually do so. When insurance is offered, there are often: 7) increased premiums for the employees. When income is low and insurance is not provided by the employer: 8) individual insurance is prohibitively expensive. This is magnified when: 9) a person lacks employment entirely (rates of which are also increasing). Finally, there has been a: 10) scaling back of retiree coverage.<sup>2</sup>

Publicly funded insurance programs have gone through a number of changes in the last decade in an effort to make the process more efficient and, in some cases, offer more extensive coverage. In 1996, legislation was passed that separated Medicaid from Aid to Families with Dependent Children (AFDC) and Temporary Assistance to Needy Families (TANF). This was accomplished by the Personal Responsibility and Work Opportunity Reconciliation Act (PROWA) or Welfare Reform Act. PROWA allowed for individual states to have control over eligibility requirements, such as income, for all Medicaid applicants. In many states, including New York, eligibility was expanded through an increase in

qualifying income levels and the creation of supplementary programs. To insure children, Congress legalized the Children's Health Insurance Program (CHIP) as part of the Social Security Act of 1997.<sup>2</sup>

Despite the expansion in eligibility, 24% of low-income children and 30% of low-income adults still remain uninsured.<sup>3</sup> Nonparticipation in these public insurance programs and subsequently being uninsured has been shown to adversely affect access to healthcare through numerous pathways, including: decreases in immunization rates, preventative screening and routine check-ups, an increased frequency of emergency room visits, and increased rates of undiagnosed chronic disease.<sup>2,4-7</sup>

A lack of knowledge about the eligibility status may be understandable in light of the past decade's legislative events. The issue of individual/family insurance eligibility has become more complex since PROWA's separation of Medicaid from AFDC/TANF, the inception of state-level control of supplementary programs and the establishment of CHIP. Those not currently receiving public assistance may still be eligible, but income requirements vary by state and change on a yearly basis.<sup>2</sup> The changing income requirements are especially pertinent, as 85% of the uninsured are considered "working poor", meaning they are either employed full time (63.1%) or part time (21.7%) and are not accessing public assistance.<sup>7,8</sup> Often, the "working poor" work in the service sector where insurance is rarely offered, and 74% of them cannot afford to purchase insurance as it would consume too significant a portion of their annual income.<sup>8</sup> According to a number of studies, these systematic forces are partially reflected in uninsured patients' situations and explanations of their insurance status.<sup>8,9</sup> When surveyed in 2000, 80% of parents of uninsured children reported that they were unaware of their eligibility status. In a 2004 follow-up study by McAlearney, 50% of parents perceived their children to be ineligible.<sup>2,10</sup> In fact, the number-one identified barrier to enrollment of children and adults is a lack of knowledge of eligibility status (enrollment pathways and barriers to enrollment of children in publicly funded health insurance programs: lessons from a state initiative. Unpublished doctoral dissertation. Boston: Harvard School of Public Health, 2000. The Health Status of the Near East Side Black Community. Wellness and Neighborhood Coalition. Unpublished Data 2001, State University at Buffalo Black Leadership Forum of Buffalo, Buffalo, NY).<sup>11,12</sup> Major reasons cited by uninsured individuals for not having health insurance include expense, it's not offered by employer, they're unemployed, they don't think they need it, they don't know how to apply for coverage, they don't think they are eligible, the enroll-

ment process is too complicated and they have a negative perception of publicly funded programs (The Health Status of the Near East Side Black Community. Wellness and Neighborhood Coalition. Unpublished Data 2001, State University at Buffalo Black Leadership Forum of Buffalo, Buffalo, NY)<sup>2</sup>

Among all the systematic and individual barriers to obtaining health insurance, people's awareness of their eligibility can most easily be addressed. It has been shown that areas with higher expenditures on insurance outreach programs are associated with greater Medicaid/CHIP participation. The availability of outreach programs depend on geographical location and availability of program funding as cost per enrollment has been estimated at \$20 per uninsured child.<sup>2</sup> The effectiveness of outreach programs has not been objectively evaluated and may coincidentally promote enrollment by inadvertently providing an enrollment-friendly environment. Despite this, there is clearly a need for outreach as a means toward expanding participation in publicly funded insurance programs.

In response to this need for outreach programs, University at Buffalo School of Medicine and Biomedical Science (SMBS) students formed the Lighthouse Insurance Initiative (LII) in 2003. The objectives of the LII are: 1) to implement an insurance outreach program at a student-run free medical clinic and 2) to evaluate the success of this outreach program through the total number of completed applications.

## METHODS

### Lighthouse Insurance Initiative

A volunteer facilitated enroller (FE) from one of the local HMOs trained a medical student project coordinator in the eligibility criteria and application process for Medicaid, and New York State's Child Health Plus (CHP) and Family Health Plus (FHP) insurance programs. The project coordinator then trained students at all levels of medical education, including premedical students, in the application process. In addition to training, the project coordinator directs the screening process at the clinic, answers volunteers' questions, maintains the patient tracking forms and makes follow-up phone calls. Student volunteers then become responsible for screening all uninsured patients and completing insurance applications for those patients who qualify.

### Target Population

The LII is part of The Lighthouse Free Medical Clinic (LFMC). The LFMC operates for a few hours each week during which medical students see on average 20 patients under the guidance of an attending physician. Since inception in October of 2001,

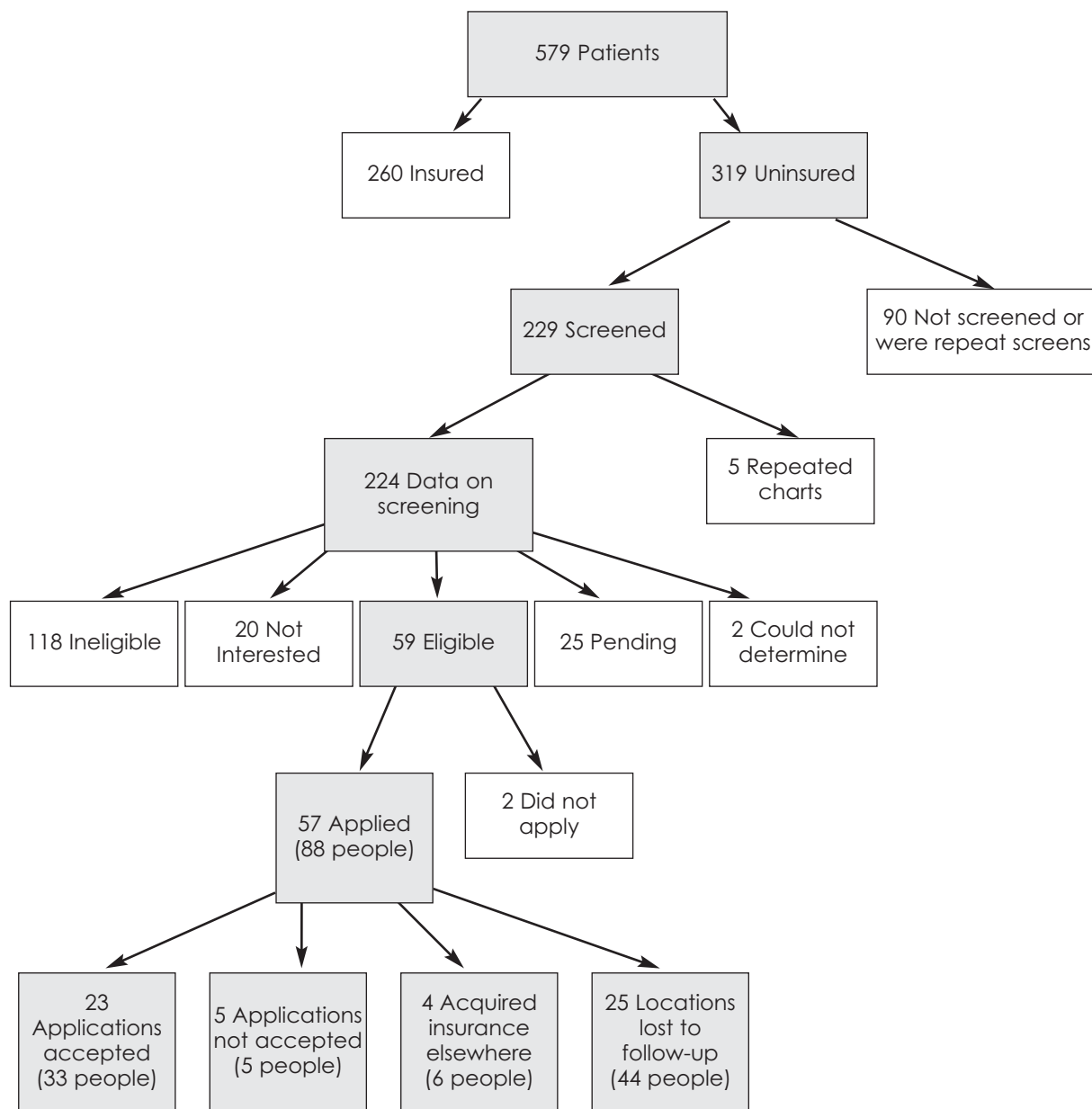
the LFMC staff has cared for >1,500 patients and thus provides the LII access to a large population of urban working poor. Of patients surveyed at the clinic, 89% were African-American, 68.5% had <\$10,000 annual income, two-thirds had the equivalent of a high-school education or less and 41% had ≥1 previously diagnosed chronic disease. (Unpublished survey results collected from patients at the Lighthouse Free Medical Clinic, Buffalo, NY; June 2004). Similarly, in a survey of Buffalo's medically underserved east side, The Black Leadership Forum of Buffalo found that 40% of Near East Side resi-

dents used the emergency department as their primary source of care, 16% of residents had difficulty paying for their healthcare and >20% had difficulty paying for prescriptions (unpublished survey results—The Health Status of the Near East Side Black Community, The Black Leadership Forum, Buffalo, NY; January 2001).

### Application Process

The application process has four steps: screening, application, documentation and follow-up. When patients check in for medical services, a clinic manag-

**Figure 1. "Sample of Insurance Applicants" Tree diagram depicting the flow of patients through the screening, application and follow up stages of the insurance application process. The diagram also contains both the number and percentages of patients reaching each point in the process.**



er inquires about their insurance status. All uninsured patients are then screened by an LII volunteer. Medicaid, FHP and CHP provide insurance based on income in relation to the federal poverty level (FPL) and number of family members in the household. Medicaid insures those  $\leq 133\%$  of the FPL; FHP and CHP insure those  $\leq 185\%$  and  $200\%$ , respectively, of the FPL at no cost. CHP is also available to those whose income is  $>200\%$  of the FPL on a sliding-scale monthly premium. The screening questions used by the LII to determine eligibility before starting the enrollment process reflect income criteria set by each program. Factors evaluated by screening include employment status, monthly income, composition of household and who in the household desires insurance.

Once eligibility is determined, the LII volunteer completes the application and supplemental paperwork individually with the applicant. The applicant is then instructed on the supporting documentation required. Documentation includes but is not limited to birth certificate, rent receipt, utility bills, social security card and pay stubs. Each applicant is given a reminder slip with the list of documentation necessary and the date of their documentation and completion appointment with the FE. During this first encounter with the applicant, the LII volunteer completes a patient tracking form, which includes patient demographics, contact information, documentation required and date of initial encounter. Each subsequent applicant encounter and its date are recorded on this tracking form.

All applicants must meet with the FE when returning to provide their documentation and complete their application. The purpose of this meeting is to review the application and check the accuracy

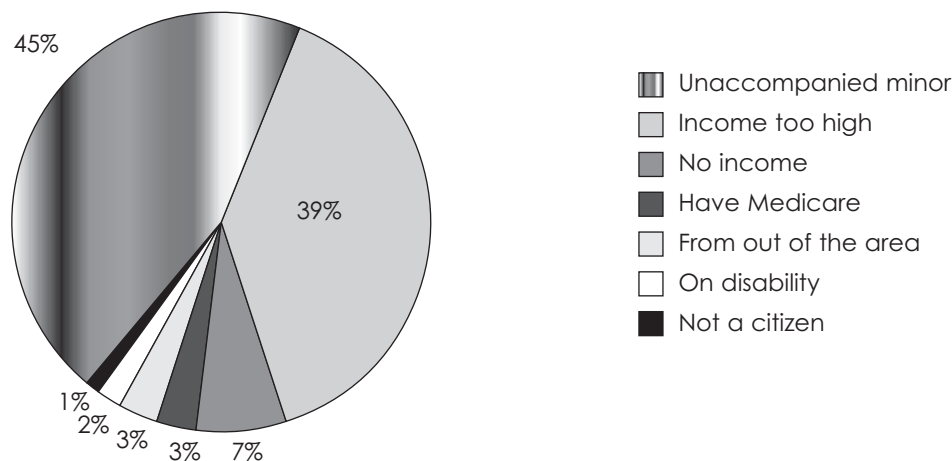
with which it was completed by the volunteer. At this time, the applicant can ask questions regarding the plan in which they will be enrolled. The FE is only available to the LII on a volunteer basis once per month. To help increase the number of applicants returning with their documentation and completing the application process, all applicants are phoned two days prior to their scheduled meeting with the FE. During the phone call, they are reminded of the upcoming meeting and what documents they should bring with them, which are recorded on the patient tracking form. Applicants are phoned up to three months after initiation of the application process. After this, they are considered lost to follow-up if they do not return to provide documentation. The date and the reason for loss to follow-up are documented on the patient tracking forms.

Once an application has been completed and submitted, it can take up to three months to be processed and for the applicant to be notified of acceptance. The date of completion is recorded and the tracking form is then flagged for a follow-up phone call in three months. At three months, the applicant is then contacted by phone by the LII project coordinator to inquire whether or not their application was accepted or denied. Outcome of the application was documented on the tracking form.

## Statistical Analysis

Approval was obtained from the State University of Buffalo Institutional Review Board. The patient tracking forms were then deidentified and logged into a spreadsheet for tracking. At the end of one year, descriptive statistics were completed to determine the total number of patients evaluated at the

**Figure 2. "Reasons for insurance ineligibility" pie chart depicting the different reasons patients did not qualify for free government-sponsored health insurance programs, including unaccompanied minors visiting the clinic, patients whose incomes were above the qualifying level, those with Medicare and those without any income**



clinic, the number of uninsured, the number screened and the number of qualifying patients. Those patients that qualified were then tracked through the application process, and the number of completed and accepted applications were determined. This database was then used to evaluate the success of the program at the end of one year.

## RESULTS

The results for one year's worth of potential applicants are summarized in Figure 1. Between October 22, 2003 and October 6, 2004, a total of 579 patients presented at the Lighthouse Free Medical Clinic. Two-hundred-sixty (45%) of these patients were insured, while 319 (55%) were uninsured. Of the 319 uninsured patients, 281 were screened for insurance eligibility (88%). Fifty-two (16%) of the screened patients were repeat screenings where the LII volunteer inquired if anything had changed in a returning patient's insurance or employment status. Thirty-eight (12%) patients were not screened due to understaffing and/or a particularly busy night on the date that they attended the clinic. Of the 229 for which there is screening data, five of them are repeat chart numbers. Screening and document tracking data exists for a total of 224 patients (70% of the uninsured patients).

Of the 224 that were screened, 59 people (26%) were found to be eligible for insurance and 57 (97%) applied. Two did not apply for the reasons: "no time" or unknown. Twenty-five (11%) had insurance pending elsewhere. One-hundred-eighteen (53%) were ineligible for insurance. The most common reasons for ineligibility were that the patient was an unaccompanied minor (52 applications, 45%) and that the patient's income was too high (45 applications, 39%). Eight applicants (7%) had no income and four (3%) had Medicare. See Figure 2 for a full listing of ineligibility reasons.

Of 57 applications initiated, 23 (40%) were accepted. Since one person would often apply for the entire family, this amounted to 33 total applicants from 23 applications. Six applicants (7%) acquired insurance from another source. Five (6%) were not accepted due to having too high of an income. Finally, 25 of the insurance applications, which included 44 applicants (or 50% of the applicants), were lost to follow-up. The most common reason that patients were lost to follow-up was reaching the three-month deadline without completing the final steps of the application (16 applications, including 29 people, or 66%) Eight of the applications (including 14 people or 32%) were associated with disconnected phone numbers—making it difficult for follow-up to occur. One patient (2%), when contacted, was no longer interested in insurance. There are also other psychosocial

factors including but not limited to drug/alcohol abuse and mental illness that could be influencing our patient population's judgment and ability to initiate or complete insurance applications.

## DISCUSSION

At the end of the study year, 45% of the 88 applicants became insured either with the help of the LII or through another source. Only 5% of those that completed the application process were deemed ineligible. Fifty percent (50%) of the applicants were lost to follow-up and, thus, their insurance status is unknown. Most everyone who was eligible for insurance was unaware that they were eligible at the initiation of the application. Few were able to navigate the system on their own without the help of the volunteers working as "financial case managers" for them. Thirty-three people who would not have medical insurance without this program are now fully covered, and an additional 25 applications are pending. These results support the expansion of public outreach programs to increase the awareness of eligibility since PROWA's uncoupling of Medicaid and Aid to Needy Families as well as individual state's expansion of income criteria.

This program is a unique medical-student-led initiative that was an outgrowth of another medical student initiative. Medical students started operating a free clinic in an underserved, urban African-American community in Buffalo under the supervision of faculty from the Department of Family Medicine at the University at Buffalo. Because the volunteer clinic was only open one night a week, it did mainly medical screening, triage and linkage to primary care services, such as federally funded community health centers. With addition of the LII, patients are assisted in navigating the health insurance application process and are linked with a primary care provider through a means that will be affordable to them, allowing for continuity of care in the future and decreased emergency room visits. This program has been in existence for 18 months and is readily sustainable, with six new medical student coordinators trained in directing the operations of the LII over that time. Volunteers find this activity to be worthwhile both personally and professionally, and there has been no difficulty recruiting an adequate number of volunteers.

The LII has been a clear benefit to the community and an important educational experience for the volunteers on the difficulties that the working poor have in obtaining health benefits. The success of this program and ongoing interest support the potential for it to be reproduced in other cities that have student-run free medical centers and have the potential to be adapted to other situations.

## ACKNOWLEDGEMENTS

My sincere thanks to all the Lighthouse free medical clinic managers past and present who helped to make possible integrating this program into the clinic's operation. The work of the new medical student insurance coordinators—Emily McCourt, Rebecca Taxier, Anna Buchsbaum, Sheerene Brown, Kelly Sayles and Jing Wang—is irreplaceable in maintaining the day-to-day operations and ensuring continuation of the program. Thanks to Lisa Stabel for assisting with data entry. Special thanks to Gareth Lema for his support of the idea of the program from its inception, encouragement throughout its growth, and his reassurance and editing during the writing of this manuscript. No funding or financial support was required for the implementation or continuation of this program. Michelle L. Niescierenko, corresponding author, had full access to all data in the study and takes responsibility for the integrity of the data and the accuracy of data analysis.

## REFERENCES

1. U.S. Department of Commerce Economics and Statistics Administration's Income, Poverty and Health Insurance Coverage in the States for 2003; a Current Population Report on Consumer Income. Washington, DC: The U.S. Census Bureau; August 26, 2004;60-226.

2. McAlearney, JS. Opportunities for outreach: Medicaid Participation Among Children in Ohio. *J Health Care Poor Underserved*. 2004;15:357-374.
3. Salsberry, PJ. Why are some children still uninsured?. *J Pediatr Health Care*. 2003;17:11,32-38.
4. Cunningham P, May J. Uninsured Americans drive surge in Emergency Department Visits. *Issue Brief Cent Stud Health Syst Change*. 2003;70:1-6.
5. Ayanian JZ, Zaslavsky AM, Weissman JS, et al. Undiagnosed Hypertension and Hypercholesterolemia Among Uninsured and Insured Adults in the Third National Health and Nutrition Examination Survey. *Am J Public Health*. 2003;93(12):2051-2054.
6. Ayanian J, Weissman JS, Schneider EC, Et al. Unmet needs of uninsured adults in the United States. *JAMA*. 2000;284:2061-2069.
7. Nadkarni MM, Philbrick JT. Uninsured free clinic patients: what would happen if there were no free clinic?. *J Gen Intern Med*. V 13 n 1. 1998;13(1):112.
8. Thrall TH, Scalise D. America's Uninsured: Rethinking the problem that won't go away. *Hosp Health Netw*. 2002;76(11):30-32,34,36,38,40.
9. Report of the National Coalition on Health Care, Charting the Cost of Inaction. Washington, DC: Government Printing Office; 2003. National Coalition on Health Care.
10. The 1998 report of the U.S General Accounting Office, Medicaid: Demographics of non-enrolled children suggest state outreach strategies. Washington, DC: U.S. Government Printing Office; 1998. GAO Pub. No. GAO/HEHS-98-93.
11. Perry MJ, Stark E, Valdez RB. Barriers to Medi-Cal enrollment and ideas for improving enrollment: findings for eight focus groups in California with parents of potentially eligible children. Menlo Park, CA: The Henry J. Kaiser Family Foundation publication; 1998.
12. Dubay LC, Kenney GM. The effects of Medicaid expansions on insurance coverage of children. *Future Child*. 1996;6(1):152-161. ■



# FIFTEEN YEARS

PARISH GALLERY 1991 to 2006

## Living Embodiments: Artistic Expressions of Being

**April 21th thru May 16th**

Antonio Carreno, Helen Elliott, Alemayehou Gebremedhin, Cynthia Farrell Johnson, Harriet Lesser, Michael Piechocinski, Wendy Plotkin-Mates, Sandi Ritchie Miller, Floyd Roberts, Daniel Stuelpnagel, Patricia Underwood, Miguel Van Esso, Shirley Woodson, Kenneth Young, Michael Platt.

**June 16th**

**Parish Gallery 15th year anniversary celebration exhibition**

reception 6-8 PM, showing thru July 18th

Artists include Ed Clark, Richard Mayhew, Herbert Gentry, Lois Mailou Jones, Joyce Scott, John Scott, Evangeline Montgomery, Wadsworth A. Jarrell, Frank Smith, William Henry Smith, James Phillips, Norman Parish, Sylvia Snowden, Kosrof Wosene, and Glover. Come celebrate with us.





Parish Gallery-Georgetown  
1054 31st Street, NW  
Canal Square  
Washington, DC 20007

(202) 944-2310  
[www.parishgallery.com](http://www.parishgallery.com)