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Assessing Changes in Insurance Status and Access to Care Among Patients Attending Chicago Sexually Transmitted Infection Specialty Clinics From 2013 to 2019

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Abstract

Background: Public sexually transmitted infection (STI) clinics are safety net providers for uninsured and underinsured individuals but are at risk for closure due to declining budgets and shifting priorities. This study sought to assess changes in insurance status and access to preventive care among public STI clinic patients after immediate and long-term implementation of the Affordable Care Act (ACA).

Methods: Patients receiving care in STI clinics administered by Chicago Department of Public Health were asked to complete an anonymous survey in 2013, 2014, and 2019. We estimated the prevalence rate ratio (PRR) of (1) being insured and (2) having access to preventive care over time, adjusted for age, race, and gender/sexual orientation, and employment status.

Results: Among 1711 respondents, compared with 2013 patients, patients were 1.41 (adjusted PRR [aPRR]) times more likely to report being insured in 2014 (95% confidence interval, 1.11–1.77) and 1.24 (aPRR) times more likely to report being insured in 2019 (95% confidence interval, 0.99–1.55). After adjusting for other significant variables (age, sex and orientation, and insurance status), reported access to preventive care increased by 34% among respondents in 2019 as compared with 2013 (aPRR, 1.34). Unsurprisingly, being insured was associated with increased preventive care access (aPRR, 1.78).

Conclusions: Even after the implementation of the Affordable Care Act, a survey of public STI clinic patients in Chicago found a sizeable proportion of individuals without insurance, and many lacked access to preventive care, highlighting the continued need for these safety net clinics to provide STI care.

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The American health care system notably faces challenges with its decentralized nature and its high cost of care, creating barriers for patients without sufficient insurance coverage. The Affordable Care Act[1] (ACA) is the most significant attempt in recent times to improve some of the myriad of challenges this system faces. Implemented in 2014, the ACA created a public market for health insurance, mandated that US citizens have health insurance, allowed dependents to remain on their parents' insurance until they turn 26, and implemented various restrictions on the private health care market to prevent patient discrimination for chronic conditions and other unavoidable health events. In the context of the ACA's implementation, it is important to assess the insurance status and access to care of different patient populations, especially those who use safety net services, which may be at risk of defunding, despite continuing need.[2]

Publicly funded sexually transmitted infection (STI) clinics may serve populations that have difficulty with obtaining or using insurance and accessing care. Individuals may seek out these clinics despite having insurance because of desiring care that is mindful of the sensitive nature of STIs, as well as providing anonymity by not going through normal insurance billing processes. Studies have found that after ACA implementation, up to 40% of clinic users remain without insurance, and 50% of users with insurance will not use it to obtain care, with anonymity and confidentiality concerns being most frequently cited for not using insurance.[3,4] As such, these patients represent a population whose insurance status, usage, and needs might not reflect what is seen by non-STI specialty providers, and who might not seek care in those settings, even with insurance.

Up until 2014, the Chicago Department of Public Health (CDPH) administered 5 specialty clinics that offered services for persons seeking prevention and care for STIs, regardless of ability to pay. Since 2014, all but 2 of these clinics have been closed or operate at severely reduced hours, still serving the city of Chicago with a population of 2,695,598 as of 2018,[5] although nationally Chicago ranks second among large US cities in magnitude of reported STI cases.[6] Most recently, the clinic in Englewood, an underserved area on the south side of Chicago, was closed in favor of securing no-cost service commitments from local health care centers. Englewood is an area that is predominantly African American, a racial group disproportionately affected by STIs and HIV in Chicago, and nationally. The 2018 CDC STD surveillance report notes that women, young people, and men who have sex with men (MSM) all face a greater burden of infections.[7] Safety net clinics serve populations more vulnerable to STIs—such as women, MSM, young adults, racial minorities, and any intersection of these groups—because of structural inequities and economic disadvantages. These clinics provide services to those who cannot or might not otherwise seek them out.[8]

The notion that safety net providers are no longer needed, potentially because of the ACA or other, privatized avenues of obtaining care, is a policy direction that should be evaluated with thorough research and considerations. In 2013 and 2014, the CDPH performed a survey to assess patient characteristics, insurance status, and access to primary care, at STI free clinics around the city.[9] In the current study, we administered the same survey in 2019, seeking to assess whether the increase in insured patients has sustained or increased with a longer-term effect, 5 years after ACA implementation.

MATERIALS AND METHODS

This survey was classified exempt from human subjects review by the CDPH.

Data Collected

Patients were surveyed at CDPH STI specialty clinics in the Lakeview and Austin neighborhoods from June 2019 to September 2019 (a third clinic was not operating full time and was not included in this data collection). Surveys were provided in English and collected information about insurance status and type, and demographic characteristics including age, race/ethnicity, sexual orientation, gender identity, employment, and access to care. Because sexual orientation and gender were highly correlated for men, the 2 variables were combined. Patients were provided surveys when checking into the clinic and asked to complete and return them either to the front desk or a drop-off box before leaving. Assistants were available on site to provide help with understanding and answering specific questions when requested. Data obtained from surveys were entered into an Excel spreadsheet.

Data Analysis

In addition to the data collected in 2019, the analysis included the previous rounds of this survey, administered from August to October in both 2013 and 2014. The 2013 and 2014 surveys included the same demographic and insurance variables used for the 2019 round except for country of birth, which was not included on the 2013 survey. For direct comparability to 2019 data, data were only used from the 2013 and 2014 surveys that came from Lakeview or Austin clinics.

There were 2 outcomes for this analysis: (1) insurance status, dichotomized as yes (private insurance, government insurance, parental insurance) versus no, and (2) access to preventive care ("Is there a place that you usually go to when you need routine or preventive care, such as a physical exam or check-up?"), dichotomized as yes versus no. Those who listed "Urgent Care" or "Emergency Room" as their source of usual care were categorized as "no" for analysis of access to preventive care. χ^2 Tests were used to assess the relationship between sociodemographic factors and outcomes. Crude prevalence rate ratios (PRRs) were generated using Poisson regression with robust variance estimate. Backward variable selection was used to determine variables to include in an adjusted model for insurance status by year. We retained variables with $P < 0.05$ in the final model for insurance (age, race/ethnicity, gender/orientation, employment) and access to preventative care (insurance, gender/orientation, employment). Statistical analyses were conducted using Stata/SE v15 (College Station, TX).

RESULTS

The analysis included 1711 surveys (Table 1). Respondents were predominantly uninsured (range, 55%–68%), non-White (range, 78%–84%), aged 26 to 45 years (range, 50%–56%), US born (range, 85%–88%), and heterosexual men (range, 42%–51%). Overall, the distribution of age, race, and location of birth remained similar over time, although the proportion of White patients declined in 2019. Full-time employment status, access to

preventative care, and proportion of heterosexual males increased, whereas men who have sex with men decreased.

Insurance status did not differ significantly by clinic location (Table 2), but differed by survey year, age group, race ethnicity, gender/orientation, and employment (Fig. 1). After adjustment, compared with 2013 patients, patients were 1.41 (adjusted PRR [aPRR]) times more likely to report being insured in 2014 (95% confidence interval [CI], 1.11–1.77) and 1.24 (aPRR) times more likely to report being insured in 2019 (95% CI, 0.99–1.55). Being insured was less likely for patients aged 13 to 25 years (aPRR, 0.83) and 26 to 44 years (aPRR, 0.65) compared with those older than 45 years. When compared with Whites, Black non-Hispanics were 0.81 times as likely to report being insured (95% CI, 0.66–1.01), Hispanics were 0.65 times as likely to report being insured (95% CI, 0.51–0.83), and those of other/mixed race were 0.88 times as likely to report being insured (95% CI, 0.62–1.26). Compared with women, heterosexual men were 0.77 times as likely to report being insured (95% CI, 0.64–0.92). Employment had the strongest association with insurance status; unemployed patients were 0.55 times as likely to report being insured compared with those employed full-time (95% CI, 0.43–0.70).

Adjusting for other significant variables (age, sex and orientation, and insurance status), reported access to preventive care was statistically significantly increased by 34% among respondents in 2019 as compared with 2013 (aPRR, 1.34) and was not associated with age, race/ethnicity, or clinic site. Unsurprisingly, being insured was associated with increased preventive care access (aPRR, 1.78), whereas heterosexual men (aPRR, 0.65) and those were unemployed (aPRR, 0.85) or disabled/other (aPRR, 0.73) were less likely to have access to preventive care (Table 3).

DISCUSSION

After the ACA implementation, among public STI clinic survey respondents, insured patients increased significantly from 2013 to 2014 by 41%, but this increase did not expand into 2019, although access to preventive care continued to increase in 2014 and 2019.

Although the overall increase in insured patients is promising evidence of the ACA decreasing the insurance gap, caution must be taken to avoid overinterpreting this as declining need for public STI clinics. In 2019, around 60% of respondents were uninsured and thus unlikely to be able to obtain private care, as nearly 68% of uninsured patients reported not having access to preventive care. The relative decrease in insured patients from 2014 to 2019 could be due to many factors surrounding the ACA. It is possible that patients who were seeking care at the clinics had obtained insurance after the ACA implementation in 2014 but were reluctant to make use of or disclose it at the STI clinics. It is also possible that the 2019 drop in insured patients is a result of the decreasing number of CDPH STI Specialty clinics, driving more uninsured patients to make use of those clinics remaining operational full time. The south side of Chicago is a broad geographic area that is underserved and disproportionately faces a broad range of negative health outcomes[10]; however, as of 2019, the only CDPH STI clinic in that area is in Roseland,

which operates just 2 days per week in a location that can be time-consuming to access on public transportation.

Employed persons were more likely to report being insured, and this is in keeping with the majority of insured persons having employment-based insurance.[11] However, income could be impacting insurance status independently of employment[12]; we are unable to assess this because we did not assess income. Those aged 26 to 45 years were less likely to be insured, potentially because this age group includes young adults who are no longer able to be on their parent's insurance. This aligns with the 2018 US census data, with those aged 26 to 34 years and those 35 to 44 years being the most commonly uninsured.[5] Black and Hispanic patients were also less likely to be insured. A national evaluation examining the racial disparities in health insurance before and after the ACA implementation found that when controlling for income, the insurance gap between Whites and Blacks declined from 11% pre-ACA to 9% post-ACA, and from 26.5% to 22.2% for the White-Hispanic insurance gap.[13] Hispanic patients might also face the challenge of health insurance literacy when enrolling, compounded by potentially not having English as their primary language.[14] Undocumented and certain other immigrants might not qualify for obtaining coverage and specifically do not qualify for coverage under the ACA.[1] The proportion of Hispanic survey respondents increased from 21.8% in 2013 to 26.4% in 2019. Although we do not know whether this is an increase in the underlying patient population or those responding to survey, this is in keeping with citywide statistics of 28.8% Hispanic Chicago residents in the 2016–2020 Census.[15] These persistent racial disparities show how the ACA alone is not enough to close these gaps and that public STI clinics will continue to serve as a safety net for minorities.

Individuals with access to health care are likely underrepresented in our survey, as they may be less likely to access public STI clinics. However, it is important to note that patients make use of public STI clinics even if they are insured and have access to other health care, as found in our survey. Patients visit these specialty clinics because they specifically deal with STIs and sexual health, so patients feel more comfortable visiting these clinics with these types of health concerns.[16] In addition, patients may visit these clinics because they do not have to use their insurance. This has been seen with high usage of free clinics in adolescent and young adults.[17] Free clinics are an important avenue to maintain confidentiality for youth on their parent or caregiver's insurance, to avoid disclosure of care for STI testing or other sexual health concerns. This serves a vulnerable population that might not seek out health care without the assurance of the privacy these clinics provide. As our 2013–2014 surveys found, the main reasons for choosing the STI clinics were the ability to walk-in (61%) and cost (25%).[9] Notably, when all 5 of the CDPH STI clinics were operating, in 2012, there were 21,706 clinic visits, and in 2013, there were 20,521 clinic visits; whereas in 2019, when 3 of the clinics were operating (1 part-time), there were a total of 9183 patients seen (archived data from 2013 and 2014 were not available in patients seen format). Understanding whether and where those potential patients may have gone for care and whether there were delays in obtaining care would contribute toward understanding gaps in access to care.

These findings need to be taken in the context of the current state of the ACA. The slight decline in insured STI clinic patients from 2014 to 2019 may represent variation in who completed the survey. Alternatively, with the passage of the Tax Cuts and Jobs Act of 2017,[18] the fine for the individual mandate of the ACA was eliminated at the beginning of 2019. It is possible that a portion of the slight decrease in insured patients in 2019 compared with 2014 is related to the elimination of the fine and lower enrollment in the public option anticipating this change. The Congressional Budget Office estimated that the removal of the fine would increase the number of uninsured Americans by 4 million and 13 million by 2019 and 2027, respectively.[19] In 2021, the COVID-19 relief bill included expansion of the ACA.[20] The American Rescue Plan Act of 2021 addressed this by increasing income eligibility for insurance subsidies to 400% above the poverty level, in addition to increasing the subsidies provided to those who already qualify. This would be expected to result in lowering the cost of insurance to these individuals and therefore increasing access. However, these changes are temporary, lasting for 2 years from January 1, 2021. Continuing to monitor the intersecting trends of health insurance, health care access, and STI safety net care, and subsequent health and population-level impacts, is critical in this dynamic landscape for service planning. COVID-19 has brought the American health care system to the forefront of public attention, with focus on equity and access. After enduring a period where even generally healthy individuals have to be concerned about their health and potentially being hospitalized, more Americans may see the value and need of obtaining health insurance. In addition, with the removal of some aspects of the ACA,[18] ongoing evaluation is necessary to ascertain how this affects enrolled and insured patients, their access to and utilization of care, and health outcomes.

Limitations

We relied on self-reported measures, and although the surveys were given to all patients during survey times and staff reminded patients where they could turn in their surveys at the end of a visit, patients completed surveys voluntarily, and this could introduce selection bias. We did not measure the number of surveys given out, so we cannot estimate a completion rate. There may be unmeasured confounders that could affect our results. The English-only format could have prevented individuals with English as a nonprimary language from filling out the survey in its entirety or accurately. This could particularly be a concern for undocumented immigrants who would have a more difficult time obtaining health insurance and may be more likely to make use of these kinds of safety net services. Going forward, a Spanish language survey will be implemented.

CONCLUSIONS

Chicago public STI clinics saw an increase in patients with insurance and reporting access to care after the ACA implementation. However, a substantial proportion of patients remained without insurance or without access to preventive care. These findings support the role of public STI clinics as safety net providers serving a vulnerable population who might not be able or willing to seek care elsewhere.

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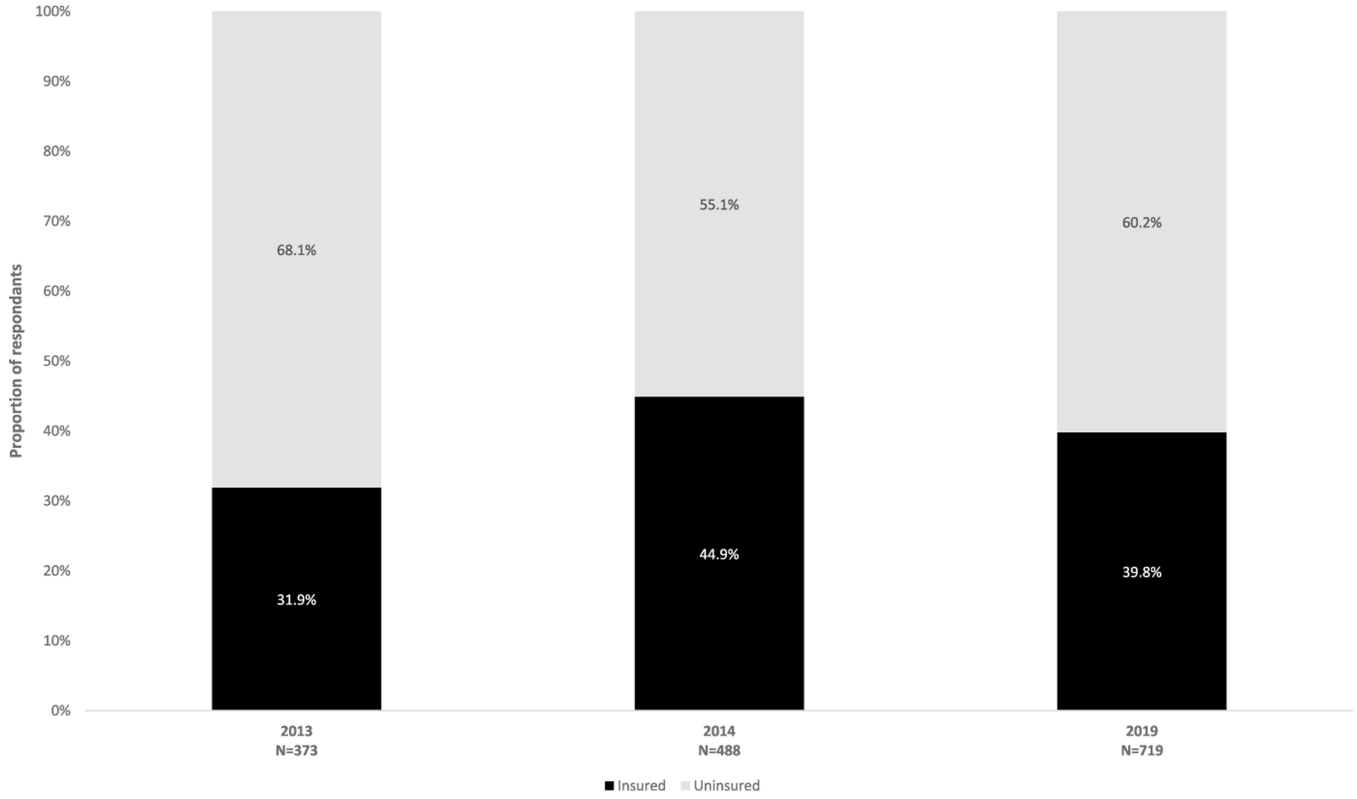

Figure 1.
Survey respondents reporting insurance status by year.

TABLE 1.

Distribution of Survey Respondent Characteristics by Year

	2013, N = 404 (23.6%)	2014, N = 512 (29.9%)	2019, N = 795 (46.5%)	χ^2 *P* Value
Clinic location				0.002
Lakeview	245 (60.6)	307 (60.0)	413 (52.0)	
Austin	159 (39.4)	205 (40.0)	382 (48.1)	
Insurance status				0.001
Has insurance	119 (31.9)	219 (44.9)	286 (39.8)	
No insurance	254 (68.1)	269 (55.1)	433 (60.2)	
Missing	31	24	76	
Employment				0.033
Full time	122 (30.7)	151 (29.7)	310 (39.1)	
Part time	88 (22.1)	114 (22.4)	151 (19.0)	
Unemployed	123 (30.9)	151 (29.7)	213 (26.9)	
Student	44 (11.1)	59 (11.6)	73 (9.2)	
Disabled/other	21 (5.3)	34 (6.7)	46 (5.8)	
Missing	6	3	2	
Race				0.024
White	82 (20.5)	110 (21.8)	127 (16.3)	
Black non-Hispanic	216 (54.0)	245 (48.5)	401 (51.3)	
Hispanic	87 (21.8)	114 (22.6)	206 (26.4)	
Other/mixed	15 (3.8)	36 (7.1)	47 (6.0)	
Missing	4	7	14	
Age group				0.152
13–25	151 (40.0)	196 (40.6)	260 (35.1)	
26–45	187 (49.5)	243 (50.3)	416 (56.1)	
>45	40 (10.6)	44 (9.1)	65 (8.8)	
Missing	26	29	54	
Access to preventative care				<0.001
Have access	141 (36.1)	213 (43.1)	382 (48.0)	
No access	250 (63.9)	281 (56.9)	413 (52.0)	

	2013, N = 404 (23.6%)	2014, N = 512 (29.9%)	2019, N = 795 (46.5%)	χ^2 P Value
Missing	13	18	0	0.239
US or foreign born				
US born	N/A	432 (85.2)	679 (87.5)	
Foreign born	N/A	75 (14.8)	97 (12.5)	
Missing		5	19	
Gender/orientation				<0.001
Female	156 (40.1)	178 (35.7)	290 (38.5)	
Heterosexual male	164 (42.2)	228 (45.7)	385 (51.0)	
Men who have sex with men	69 (17.7)	93 (18.6)	79 (10.5)	
Missing	15	13	41	

TABLE 2.

Distribution of Client Characteristics by Insurance Status and Results of Poisson Regression for Factors Associated With Insurance Status

	Insured Patients, N = 624 (39.5%), n (%)	Uninsured Patients, N = 956 (60.5%), n (%)	χ^2	Crude PRR (95% CI)	aPRR* (95% CI), N = 1414
Year			<0.001		
2013	119 (31.9)	254 (68.1)		Reference	Reference
2014	219 (44.9)	269 (55.1)		1.41 (1.13–1.76)	1.41 (1.11–1.77)
2019	286 (39.8)	433 (60.2)		1.25 (1.01–1.54)	1.24 (0.99–1.55)
Age group, y			<0.001		
13–25	260 (46.3)	301 (53.7)		0.95 (0.73–1.25)	0.83 (0.61–1.11)
26–45	266 (33.7)	524 (66.3)		0.69 (0.53–0.91)	0.65 (0.49–0.87)
>45	67 (48.6)	71 (51.4)		Reference	Reference
Race/ethnicity			<0.001		
White	157 (51.8)	146 (48.2)		Reference	Reference
Black non-Hispanic	295 (37.9)	483 (62.1)		0.73 (0.60–0.89)	0.81 (0.66–1.01)
Hispanic	119 (31.0)	265 (69.0)		0.60 (0.47–0.76)	0.65 (0.51–0.83)
Other/mixed	43 (46.7)	49 (53.3)		0.90 (0.64–1.26)	0.88 (0.62–1.26)
Gender/orientation			<0.001		
Female	256 (44.1)	324 (55.9)		Reference	Reference
Heterosexual male	244 (34.3)	468 (65.7)		0.78 (0.65–0.93)	0.77 (0.64–0.92)
MSM	96 (42.5)	130 (57.5)		0.96 (0.76–1.22)	0.87 (0.68–1.12)
Employment			<0.001		
Full time	260 (47.2)	291 (52.8)		Reference	Reference
Part time	132 (40.62)	193 (59.4)		0.86 (0.70–1.06)	0.81 (0.65–1.01)
Unemployed	114 (25.6)	332 (74.4)		0.54 (0.43–0.68)	0.55 (0.43–0.70)
Student	83 (50.0)	83 (50.0)		1.06 (0.83–1.36)	1.02 (0.78–1.34)
Disabled/other	33 (38.4)	53 (61.6)		0.81 (0.57–1.17)	0.83 (0.56–1.23)
Clinic location			0.382		
Lakeview	367 (40.4)	541 (59.6)		Reference	N/A
Austin	257 (38.2)	415 (61.8)		0.95 (0.81–1.11)	

*Model is simultaneously adjusted for all variables presented.

TABLE 3.

Distribution of Client Characteristics by Access to Preventative Care and Results of Poisson Regression for Factors Associated With Access to Preventative Care

	Access to Preventive Care, N = 736 (43.8%), n (%)	No Access to Preventive Care, N = 944 (56.2%), n (%)	χ^2	Crude PRR (95% CI)	aPRR* (95% CI), N = 1497
Year			<0.001		
2013	141 (36.1)	250 (63.9)		Ref	Ref
2014	213 (43.1)	281 (56.9)		1.20 (1.01–1.41)	1.13 (0.96–1.33)
2019	382 (48.1)	314 (52.0)		1.33 (1.15–1.55)	1.34 (1.15–1.56)
Insured			<0.001		
No	304 (32.4)	633 (67.6)		Ref	Ref
Yes	382 (61.7)	237 (38.3)		1.91 (1.70–2.13)	1.78 (1.59–2.00)
Age group, y			0.158		
13–25	343 (57.7)	251 (42.3)			
26–45	469 (56.3)	364 (43.7)			
>45	72 (49.0)	75 (51.0)			
Race/ethnicity			0.627		
White	174 (55.1)	142 (44.9)			
Black non-Hispanic	478 (56.8)	363 (43.2)			
Hispanic	224 (55.7)	178 (44.3)			
Other/mixed	48 (50.0)	50 (50.0)			
Gender/orientation			<0.001		
Female	283 (45.9)	333 (54.1)		Ref	Ref
Heterosexual male	506 (66.1)	260 (33.9)		0.63 (0.56–0.71)	0.65 (0.57–0.73)
MSM	120 (50.9)	116 (49.1)		0.91 (0.78–1.06)	0.90 (0.78–1.05)
Employment			<0.001		
Full time	297 (51.3)	282 (48.7)		Ref	Ref
Part time	184 (53.0)	163 (47.0)		0.96 (0.84–1.11)	0.94 (0.82–1.09)
Unemployed	308 (64.8)	167 (35.2)		0.72 (0.62–0.84)	0.85 (0.73–0.99)
Student	86 (50.3)	85 (49.7)		1.02 (0.86–1.21)	0.94 (0.80–1.11)
Disabled/other	64 (65.7)	35 (35.3)		0.73 (0.55–0.96)	0.73 (0.54–1.00)
Clinic location			0.696		

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	Access to Preventive Care, N = 736 (43.8%), n (%)	No Access to Preventive Care, N = 944 (56.2%), n (%)	χ^2	Crude PRR (95% CI)	aPRR* (95% CI), N = 1497
Lakeview	531 (55.8)	421 (44.2)			
Austin	413 (56.7)	315 (43.3)			

*Model is simultaneously adjusted for all variables presented.