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## A new role for primary care teams in the United States after “Obamacare:” Track and improve health insurance coverage rates

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### Abstract

Maintaining continuous health insurance coverage is important. With recent expansions in access to coverage in the United States after “Obamacare,” primary care teams have a new role in helping to track and improve coverage rates and to provide outreach to patients. We describe efforts to longitudinally track health insurance rates using data from the electronic health record (EHR) of a primary care network and to use these data to support practice-based insurance outreach and assistance. Although we highlight a few examples from one network, we believe there is great potential for doing this type of work in a broad range of family medicine and community health clinics that provide continuity of care. By partnering with researchers through practice-based research networks and other similar collaboratives, primary care practices can greatly expand the use of EHR data and EHR-based tools targeting improvements in health insurance and quality health care.

### Keywords

Insurance, health; Affordable Care Act; electronic health records

### Introduction

The Patient Protection and Affordable Care Act (ACA), also known as “Obamacare,” created an individual mandate to obtain health insurance and increased coverage options for all US citizens and legal residents through expansions in Medicaid (government-sponsored insurance for those with low income) and individual insurance marketplaces [1]. The ACA also promoted continued use of electronic health records (EHRs) and built upon the Health Information Technology for Economic and Clinical Health Act, which included incentive payments to increase the “meaningful use” of EHRs [2, 3]. Health insurance is associated with decreased unmet health care needs and mortality [4, 5]; maintaining coverage is one of

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the “three essential elements” for improving health [6]. For a family medicine clinic or community health center, having higher percentages of continuously insured patients correlates with better quality performance scores [7]. Family medicine and community health clinics are in a unique position to assist their patient populations with maintaining health insurance [8]. Many clinics now have great resources at their fingertips to help with these actions: the EHRs and population data analytics [8–10]. Here we describe current efforts for EHRs data use in US primary care settings to track and improve insurance coverage rates and potential opportunities to improve quality and health outcomes.

## OCHIN

OCHIN (formerly the Oregon Community Health Information Network, now OCHIN as other states joined) is a nonprofit collaborative created in 2001 to develop health information technology tools for community health centers, which serve a large number of uninsured and Medicaid-insured patients [11, 12]. As of April 2016, the OCHIN collaborative was supporting a comprehensive, fully integrated EHRs for 442 clinics in 18 states, with more than 4500 physicians caring for more than 1,400,000 patients. Most patients seen in community health centers within the OCHIN collaborative pay for their visits by Medicaid health insurance (>50%) or are uninsured (>40%). OCHIN partnered with researchers to create a practice-based research network (PBRN) recognized by the US Agency for Healthcare Research and Quality in 2005 [11].

### Tracking health insurance coverage rates

Although there is some variability in how different clinics document and present coverage information, an increasing number of US primary care practices have implemented EHRs [13]. Traditionally, health insurance coverage data from the medical record have been used primarily for billing; however, now that this information is automated in the EHRs, it can also be used to longitudinally assess coverage stability (or instability), and has been shown to correlate well with insurance claims data [14–16]. Longitudinal assessment of EHRs insurance data can help practices understand patients' coverage trends and target interventions to improve coverage stability. For example, the OCHIN PBRN used EHRs health insurance data to discover that a significant portion of its pediatric patients were persistently uninsured. Among children (aged 0–18 years) seen at a network clinic between January 1, 2010 and December 31, 2011 ( $n=185,959$ ), 21% had no insurance at their first visit. Among these uninsured children, 30% were uninsured at all subsequent visits during the study period [16]. For adults seen in the network between January 1, 2012 and December 31, 2013 ( $n=279,654$ ), 41.7% had no insurance at their first visit, and among these uninsured adults, 50% were uninsured at all subsequent visits during the study period [15].

Similar data and longitudinal analyses can be used to track how patients' coverage status and care utilization patterns have changed after the implementation of new insurance policies. For example, OCHIN's PBRN used EHRs data to better understand and compare insurance coverage among a population of patients before and after ACA Medicaid expansions. In the first 6 months after expansions, clinics in states expanding Medicaid experienced a sharp decrease in the percentage of uninsured patient visits and an increase in the percentage of

Medicaid-insured visits, compared with little change in clinics from nonexpansion states (Fig. 1). These analyses also revealed a significant 5% increase in overall visit rates in primary care clinics located in states that expanded Medicaid but no significant change in overall visit rates in clinics located in states that opted not to expand Medicaid [17]. OCHIN also assessed changes in visits and services 12 months after ACA Medicaid expansions, discovering that practices in expansion states saw a 14% increase in the number of new patients and provided 41% more preventive services, whereas practices in nonexpansion states saw no change [18]. By bringing data together from primary care practices across the US, these types of analyses can help to inform practice and policy leaders about future workforce needs and increasing demands for primary care services.

## Improving health insurance coverage rates

PBRNs and similar primary care collaboratives are currently building systems to provide patient-centered, evidence-based heart health care across thousands of primary care practices [19]. Similar mechanisms (e.g., registries, data benchmarking and reports, EHRs-based tools) could be used to improve health insurance rates. For example, after assessing patients' coverage rates across the OCHIN PBRN, we received research funding to evaluate a health information technology intervention to enhance Medicaid enrollment support in primary care settings. The research team engaged patients, families, clinicians, and clinic managers to develop EHRs tools to track insurance coverage dates and clinic workflows to use these tools [20, 21].

The EHRs tools were designed to capture up-to-date health insurance information such as when patients will be due for insurance renewal, where they are in the insurance application process, and what documents are still needed to complete an application. Clinic staff can then use these data to guide patients through the health insurance renewal application process and answer questions about forms and documentation needed. These tools also enable clinic staff to build registries for tracking patients who are currently applying for coverage and assess their progress toward successful application completion and renewal.

Plans include creating patient engagement tools that can facilitate outreach between visits. For example, the health insurance information collected and recorded with the EHR tools can be used to trigger automated phone calls or e-mail or short message service notifications to patients, and prompt clinic staff to make personal phone calls or send personal e-mails or letters to reach out to patients who may need additional health insurance reapplication support [8, 20]. Ideally, this work will build on related research that created effective interactive personal health records [22, 23] by adding information about potential health insurance plans (if a patient is currently uninsured), or a reminder about a patient's upcoming coverage expiration dates (potentially via direct feed from the payer) to the interactive personal health record [20, 24, 25]. With the use of these EHR-based tools, patients are likelier to stay insured. Continuous health insurance is associated with timely access to health care services [26–29], which leads to fewer unmet health care needs, a lower likelihood of delayed receipt of preventive care services [30–32], and reductions in preventable mortality [4, 5].

## Beyond tracking and improving health insurance

As health care delivery moves toward value-based models, more services will be provided outside of traditional face-to-face visits, and the use of data to guide improvements will become increasingly important. Primary care must greatly accelerate our population health analytics and patient engagement capabilities; partnering with researchers in PBRNs will enable primary care to lead the development and evaluation of many new models and tools to facilitate these efforts. In this commentary, we described examples of how the OCHIN PBRN is testing interventions designed to help patients maintain continuous coverage and track insurance status beyond the traditional focus on the day of their scheduled appointment. Although the use of EHRs to track insurance and support patients in obtaining coverage may be most relevant to community health centers in the US, EHRs functionality allows primary care practices to track and improve a variety of clinical metrics as well as issues beyond traditional quality metrics [33]. For example, the length of time a patient waits for an appointment, the volume of telephone calls received by a clinic, and/or the commonest requests by patients over the telephone could also be used to reengineer workflows and develop new tools to meet patients' unmet needs. Some EHR data systems might even be able to detect the length of a patient's past appointments and use this information to create longer appointment times in the future. Thus the information provided here is meant to stimulate additional ideas for how EHRs can be used to improve patient care and how primary care practices can partner with researchers to analyze EHR data and evaluate new EHR-based tools.

## Conclusions

Primary care practices must greatly expand the use of EHR data and EHR-based tools targeting improvements in health insurance coverage and quality health care. We highlighted a few examples from the OCHIN PBRN of tracking and assisting patients with health insurance options to demonstrate the new role US primary care can play in helping patients maintain coverage in the post-Obamacare era. More broadly, there are many new and exciting opportunities for harnessing data sources and building robust analytics infrastructure in family medicine and community health settings that can lead to improved quality of health care.

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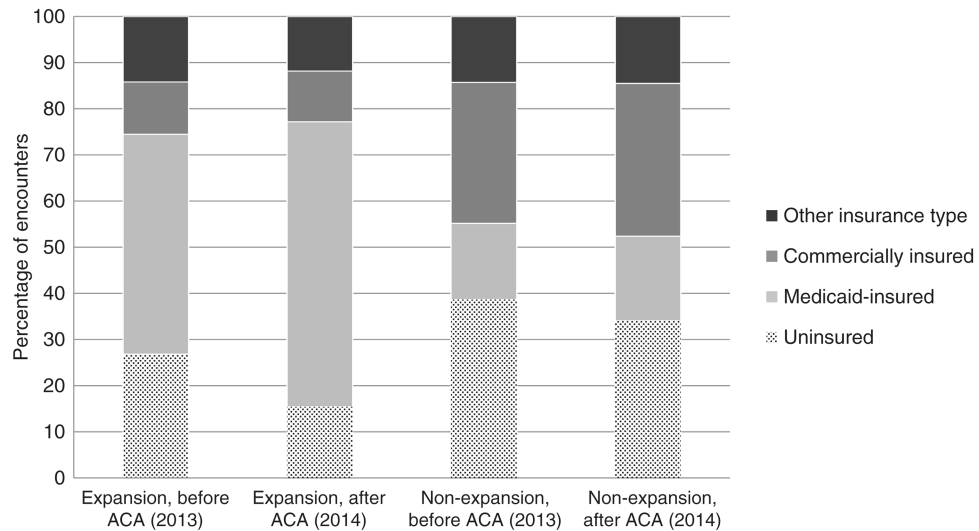
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### Related Information

#### What Are Electronic Health Records (EHRs)?

EHRs are real-time, patient-centered records. EHRs instantly provide information, “whenever and wherever it is required”. EHRs consolidate patient's health records; one of the key features of EHRs is that patient health information can be recorded, managed, and accessed by authorized providers and staff across more than one health care organization. A single EHR can bring together information from current and past doctors, emergency facilities, school and workplace clinics, pharmacies, laboratories, and medical imaging facilities. See: <https://www.healthit.gov/providers-professionals/learn-ehr-basics>.





**Fig 1.**

Payer mix by expansion status across nine states from the OCHIN practice-based research network before and after the Patient Protection and Affordable Care Act (ACA).

Electronic health record data from 137 clinics in five states that expanded Medicaid by January 1, 2014 (California, Minnesota, Ohio, Oregon, Washington) and 19 clinics in four states that did not expand Medicaid by that date (Alaska, Indiana, Montana, North Carolina). In total, 1,276,298 face-to-face primary care visits among 333,655 adult (aged 19–64 years), nonpregnant patients were included.