

Improving health depends on accessing health care services and engaging in appropriate treatment. People experiencing homelessness have higher rates of chronic conditions, acute illnesses, and behavioral health issues compared to their housed counterparts, which contributes to earlier mortality and higher rates of disability and poor health. This population also tends to experience greater barriers to accessing care because they tend not to have a stable mailing address, often lack transportation, face stigma and discrimination when accessing care, and must prioritize meeting basic survival needs such as finding food, shelter, and safety on a daily basis. Poor health is a leading cause of homelessness, and the experience of homelessness creates new health problems while worsening current ones. Combined, these factors make it hard to regain housing stability.

One of the most common barriers to accessing health care is a lack of health insurance, which pays for services. Traditionally, people experiencing homelessness have been uninsured at high rates because they cannot afford private insurance and were often not eligible for public programs such as Medicaid or Medicare. Health Care for the Homeless (HCH) programs, as part of the larger HRSA-funded health center program, are dedicated to providing comprehensive primary care, behavioral health, and support services to people who are homeless regardless of their insurance status or ability to pay. But absent insurance, these safety net providers are much more limited in their ability to refer patients to a broader range of needed care, such as hospitals, addiction and mental health treatment, and specialty care. Because care options are more limited when patients are uninsured, it is more difficult to improve health outcomes.

Medicaid Expansion

In 2014, changes in federal law gave states the option to expand Medicaid eligibility to single adults with income at or below 138% of poverty, as well as subsidized private insurance plans for those earning between 100% and 400% of poverty. Since then, the proportion of HCH patients without insurance has declined, but these nationwide averages mask considerable variation among states.

In 2017, there were 299 HCH programs that provided care to 1,008,648 patients. Just over half were enrolled in Medicaid (51%), while 4% were dually enrolled in both Medicare and Medicaid, an additional 4% were enrolled in Medicare (or another public program), and 6% had a private health insurance plan. One-third (34%) were uninsured (see Figure 1). Overall, patients at HCH programs were nearly four times more likely to be uninsured compared to the general public (34% v. 9%), and show higher rates of being uninsured even compared to patients at health centers without an HCH program (34% v. 23%). Figure 2 shows the disparities in coverage—especially in Medicaid and uninsured—largely based on state decisions to expand Medicaid to low-income, single adults.

Figure 1. Health Insurance Sources, 2017

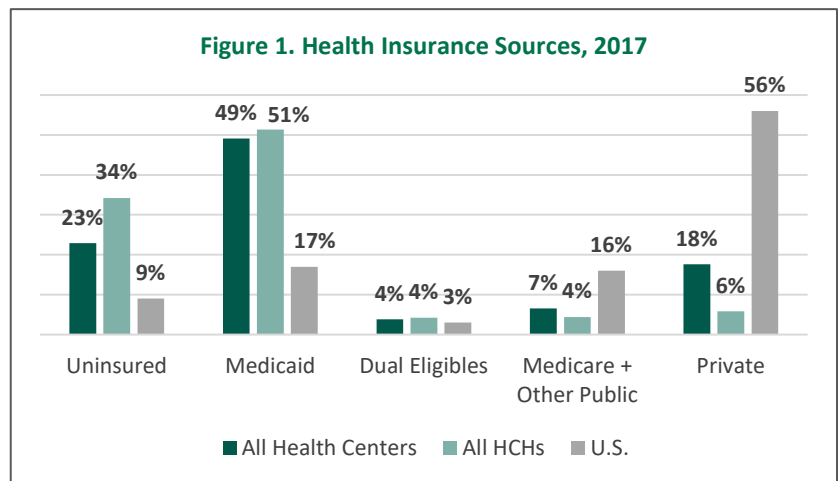
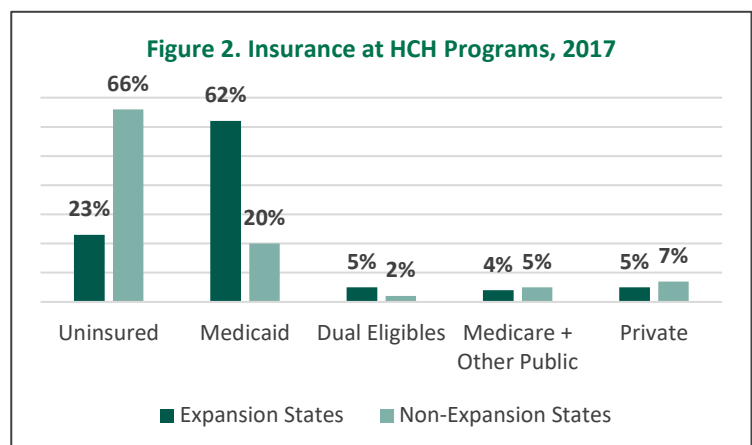


Figure 2. Insurance at HCH Programs, 2017



States that Expanded Medicaid (Table 1)

Not surprisingly, the 32 states (to include DC) that opted to expand Medicaid by 2017 were serving significantly more insured patients, primarily through Medicaid (62%). Prior to the expansion, HCHs in expansion states had an uninsured rate of 51%; now, the rate is half that—at 23%. Medicare, those with private insurance, and those with both Medicare and Medicaid (“dual-eligibles,” who are often disabled) are a smaller proportion of total coverage. However, there is a wide range of health coverage rates, even in “Medicaid expansion states:”

- Medicaid: Coverage ranges from 80% to 27%.
- Dually-eligible for Medicare and Medicaid: Coverage ranges from 11% to 0%.
- Medicare and Other Public: Coverage ranges from 13% to 0%.
- Private insurance: Coverage ranges from 45% to 0%.
- Uninsured: Ranges from 58% to 9%.

States that Have Not (Yet) Expanded Medicaid (Table 2)

In 2017, HCHs in the 19 states that had not expanded Medicaid had an uninsured rate nearly three times higher than in states that did expand Medicaid. Among this group of states, only 20% of all HCH patients had Medicaid coverage, with only 34% of patients having any type of coverage. Similar to expansion states, those who are dually-eligible for Medicare and Medicaid, those with Medicare only, and those with private insurance all represent small portions of total patients. Across these states, there is also wide variation in coverage:

- Medicaid: Coverage ranges from 60% to 4%.
- Dually-eligible for Medicare and Medicaid: Coverage ranges from 5% to 1%.
- Medicare and Other Public: Coverage ranges from 12% to 1%.
- Private insurance: Coverage ranges from 29% to 1%.
- Uninsured: Ranges from 87% to 36%.

Discussion

All states and/or local communities vary widely in outreach and enrollment activities, eligibility for coverage, and the capacity of other safety net providers to serve vulnerable people. Any of these factors can influence whether patients have health coverage. It is important to note that rates of uninsured do not mean patients are uninsurable—just that they lacked coverage at the last visit from which data was gathered. States also have unique policy reasons for varying coverage rates. For example, Arkansas uses Medicaid funds to purchase private insurance; and Wisconsin has Medicaid eligibility only up to 100% of poverty, so is not formally an expansion state. States adding work requirements and other barriers to their programs will see coverage rates decline in response. Figure 3 shows the reduction in uninsured since 2013 for both expansion and non-expansion states—illustrating the ongoing disparity in health coverage driven largely by 19 states’ refusal to expand Medicaid.

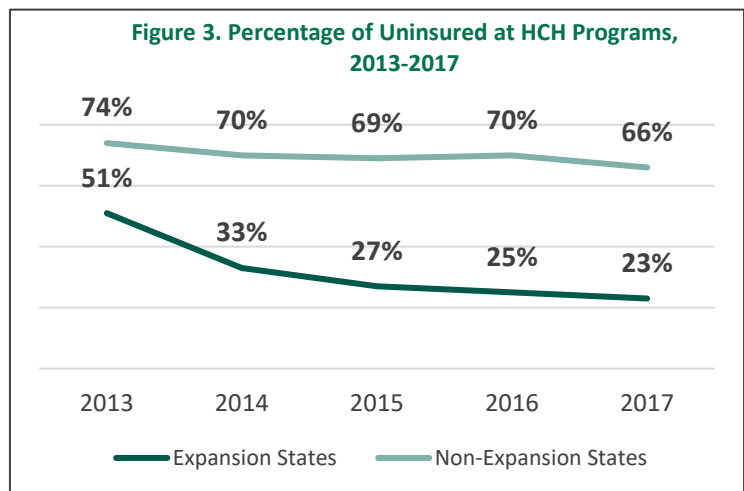


Figure 3 shows the reduction in uninsured since 2013 for both expansion and non-expansion states—illustrating the ongoing disparity in health coverage driven largely by 19 states’ refusal to expand Medicaid.

Overall, Medicaid is consistently the most common source of insurance for HCH patients, even in states that did not expand Medicaid to single adults. Given that 69% of HCH patients have income below 100% of poverty, it is not surprising that the greatest gains in insurance were in states that did expand Medicaid. [Note: states such as MA, DC, HI, NY, MN, and VT had a generous Medicaid benefit for single adults already in place by 2014, hence realizing a more modest increase compared to 2013.] As states continue working to reduce health care disparities and improve health, access to comprehensive health insurance remains a key factor.

Advocacy Actions

1. Push for state lawmakers to expand Medicaid in all states with no barriers to enrollment or coverage limitations (such as work requirements, service reductions, copays, or premiums).
2. Conduct assertive outreach & enrollment activities to ensure all those eligible are enrolled.
3. Facilitate tours and meetings with public officials at health centers and other service sites to illustrate the benefits of coverage and the need for low-barrier, streamlined benefits.
4. Engage clients and service providers to talk about how health insurance has helped them and incorporate these stories in advocacy activities.
5. Demonstrate the connection between health insurance and larger public health and health care issues, such as the opioid crisis, mental health and substance use disorders, and chronic disease management. Also emphasize the importance of health insurance in providing a foundation of stability that in turn supports health, employment, and self-sufficiency.

Table 1. Health Insurance Coverage for Patients at HCH Programs in Medicaid Expansion States, 2017

States that Expanded Medicaid (ranked by percentage of uninsured)								
	# Programs in 2017	Total Number Patients	Medicaid	Medicare + Medicaid ("Duals")	Medicare/ Other Public	Private	Uninsured	% Point Reduction in Uninsured since 2013
Total	207	749,557	62%	5%	4%	5%	23%	28%
RI	2	1,583	72%	4%	5%	10%	9%	68%
WA	7	51,700	75%	3%	6%	5%	11%	34%
VT	1	1,674	70%	11%	1%	5%	13%	0%
MA	7	25,692	64%	10%	6%	4%	15%	7%
MI	14	42,565	59%	4%	6%	14%	18%	29%
WV	1	7,287	80%	1%	0%	1%	18%	80%
LA	6	18,860	73%	2%	2%	5%	19%	21%
AZ	3	21,843	60%	5%	6%	11%	19%	40%
CT	8	11,117	67%	7%	2%	5%	19%	12%
NH	3	5,763	52%	7%	9%	13%	19%	56%
MN	2	6,741	62%	5%	11%	2%	20%	5%
AR	1	380	28%	3%	3%	45%	20%	71%
AK	2	758	66%	6%	2%	6%	21%	30%
IA	4	7,331	63%	5%	2%	7%	22%	33%
DC	1	10,786	59%	3%	13%	3%	22%	1%
CA	45	246,765	65%	6%	3%	3%	23%	28%
KY	7	13,507	52%	4%	7%	12%	24%	57%
HI	1	1,370	62%	0%	9%	4%	25%	1%
OH	8	24,018	64%	3%	4%	3%	26%	49%
NY	21	88,490	58%	4%	4%	7%	27%	6%
MT	4	3,720	59%	7%	3%	4%	27%	38%
CO	5	26,729	61%	5%	4%	3%	27%	42%
OR	12	31,019	56%	5%	5%	6%	28%	31%
IL	8	17,169	56%	4%	3%	8%	29%	30%
MD	2	10,859	58%	9%	3%	0%	29%	42%
NJ	7	19,147	52%	2%	7%	9%	30%	32%
DE	2	755	47%	4%	2%	14%	34%	18%
NM	6	16,533	53%	4%	4%	6%	34%	46%
IN	6	6,169	54%	2%	2%	6%	36%	40%
PA	6	21,502	51%	4%	4%	3%	37%	8%
NV	4	6,469	27%	3%	7%	24%	39%	35%
ND	1	1,256	34%	2%	4%	2%	58%	15%

Table 2. Health Insurance Coverage for Patients at HCH Programs in Medicaid Non-Expansion States, 2017

States that Did Not Expand Medicaid (ranked by percentage of uninsured)								
	# Programs in 2017	Total Number Patients	Medicaid	Medicare + Medicaid ("Duals")	Medicare/ Other Public	Private	Uninsured	% Point Reduction in Uninsured since 2013
Total	87	254,233	20%	2%	5%	7%	66%	8%
WI	3	6,187	60%	1%	1%	1%	36%	37%
OK	2	4,514	17%	1%	3%	29%	49%	41%
SC	4	10,378	32%	2%	7%	8%	50%	15%
TN	7	17,766	25%	4%	12%	5%	54%	29%
ME	2	4,053	28%	5%	1%	6%	60%	2%
VA	4	8,462	14%	3%	5%	16%	61%	21%
NC	10	11,187	20%	5%	4%	9%	63%	5%
MS	2	10,450	21%	2%	2%	9%	66%	↑ 9%
KS	3	2,457	23%	4%	3%	3%	66%	16%
FL	16	70,198	21%	2%	3%	8%	67%	7%
MO	3	8,939	21%	3%	3%	6%	67%	6%
TX	12	56,865	18%	2%	8%	5%	68%	18%
ID	2	3,140	14%	1%	6%	7%	72%	14%
SD	2	2,144	15%	5%	1%	8%	72%	6%
UT	3	7,023	16%	2%	2%	1%	78%	↑ 4%
NE	1	2,828	11%	1%	2%	5%	81%	9%
AL	4	7,133	10%	2%	2%	4%	82%	↑ 2%
GA	5	19,211	10%	2%	1%	4%	83%	13%
WY	2	1,298	4%	1%	3%	3%	87%	2%

NOTES:

Data source: HRSA Uniform Data System (UDS) for Calendar Year 2017, Tables 3 and 4.

Puerto Rico: there are five HCH programs in PR, but as a U.S. territory, it receives a Medicaid block grant, and is not included in the above analysis. These five programs saw 4,858 patients: 51% Medicaid, 0% duals, 8% Medicare/OP, 3% private, 38% uninsured. Since 2013, the percentage of uninsured increased by 6% points.

Use of UDS Data: All HCH programs differ in the level of internal resources for outreach and enrollment, as well as the demographics of patients seen. All communities are different in terms of the type and/or capacity of other health care providers in the area to see newly insurance (or remaining uninsured) patients. Finally, the data that informed this analysis defines a visit as “documented, face-to-face contact between a patient and a licensed or credentialed provider who exercises independent professional judgment in providing services.” This definition may overlook other types of patient interactions that are not captured in this analysis.

More Resources

- [Medicaid & Work Requirements: Likely Impact on the HCH Community](#) | National HCH Council
- [50 Reasons Medicaid Expansion is Good for Your State](#) | National Health Law Program
- [The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review](#) | Kaiser Family Foundation

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