ISSUE BRIEF

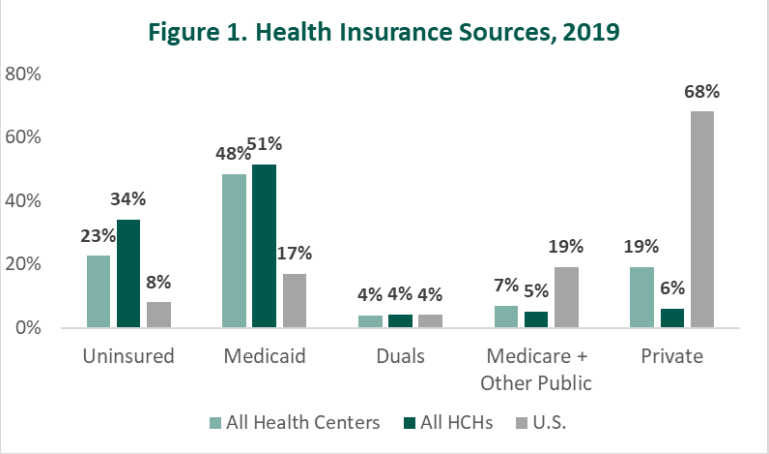
NATIONAL HEALTH CARE for the HOMELESS COUNCIL

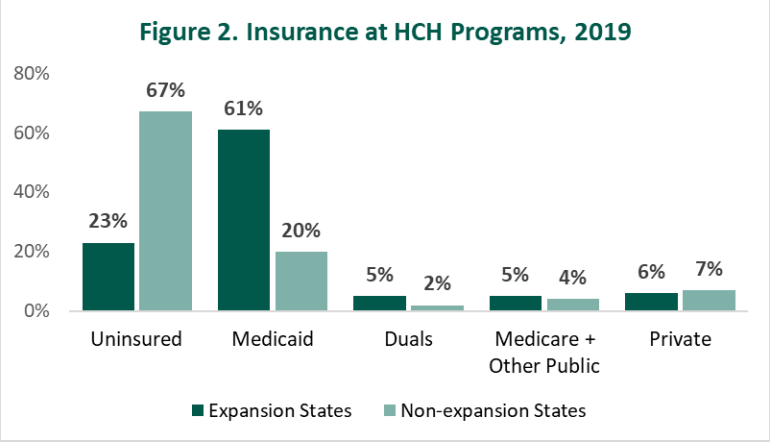
Health Insurance at HCH Programs, 2019

April 2021

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 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 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.





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, although nationwide averages mask considerable variation among states.

In 2019, there were 300 HCH programs that provided care to 1,051,869 patients. Just over half were enrolled in Medicaid (51%), while 4% were dually enrolled in both Medicare and Medicaid, an additional 5% 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 four times more likely to be uninsured compared to the general public (34% v. 8%), 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 among HCH programs—especially in Medicaid and uninsured—largely based on state decisions to expand Medicaid.

States that Expanded Medicaid (table 1)

Not surprisingly, in the 34 states (to include DC) that opted to expand Medicaid in 2019, there were significantly more insured patients, primarily through Medicaid (61%). 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 variation among states, even when they have expanded Medicaid:

- Uninsured: Ranges from **12% to 56%.**
- Medicaid: Coverage ranges from **29% to 70%.**
- Dually-eligible for Medicare and Medicaid: Coverage ranges from 1% to 13%.
- Medicare and Other Public: Coverage ranges from 0% to 9%.
- Private insurance: Coverage ranges from 1% to 19%.

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

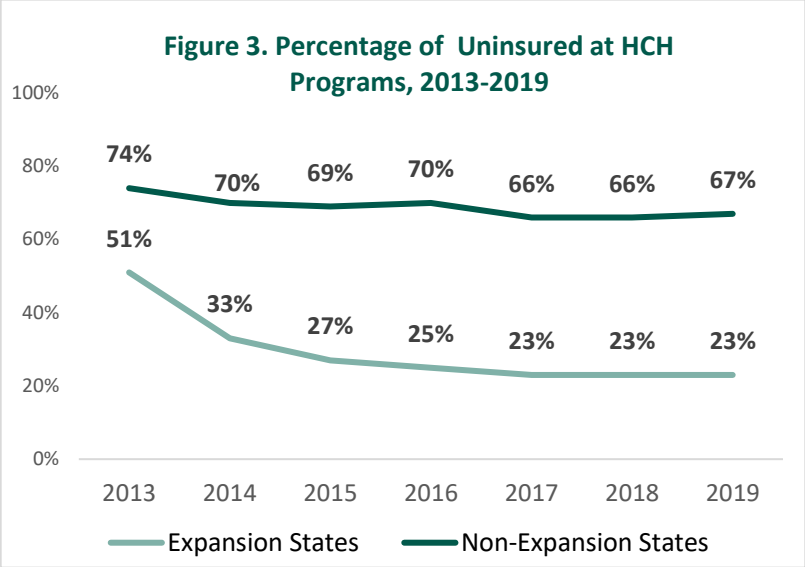
In 2019, HCHs in the 17 states that had not expanded Medicaid had an uninsured rate nearly three times higher than in states that did expand Medicaid. Among this group of states, only 20% of all HCH patients had Medicaid coverage, with only one-third (33%) of patients having any type of coverage—leaving 67% uninsured. 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 non-expansion states, there is also wide variation in coverage:

- Uninsured: Ranges from **49% to 82%.**
- Medicaid: Coverage ranges from **5% to 42%.**
- Dually-eligible for Medicare and Medicaid: Coverage ranges from 1% to 5%.
- Medicare and Other Public: Coverage ranges from 2% to 12%.
- Private insurance: Coverage ranges from 2% to 11%

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, Maine did not expand Medicaid until July of 2018; and Wisconsin establishes Medicaid eligibility only up to 100% of poverty, so is not formally an expansion state. Between June 2018 and April 2019, Arkansas implemented work requirements in their Medicaid program, causing many people to lose coverage. 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 17 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 85% of HCH patients have income below 100% of poverty, it is not surprising that the greatest gains in insurance were in states that expanded 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. Call for state lawmakers in the 17 states yet to expand Medicaid to take advantage of the robust federal incentives to expand the program included in the American Rescue Plan Act* with no barriers to enrollment or coverage limitations (such as work requirements, service reductions, copays, or premiums).

2. Advocate for state lawmakers to authorize presumptive eligibility for hospitals and/or health centers so that people who are likely eligible for Medicaid may obtain coverage more quickly.

3. Conduct assertive outreach & enrollment activities to ensure all those eligible are enrolled.

4. 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.

5. Engage clients and service providers to talk about how health insurance has helped them and incorporate these stories in advocacy activities.

6. Demonstrate the benefits of Medicaid coverage for people who are homelessness, as well as larger public health and health care issues, such as equitable COVID-19 response, 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, 2019

States that Expanded Medicaid								
	# HCH Programs in 2019	Total # Patients	Uninsured	Medicaid	Medicare + Medicaid ("Duals")	Medicare/ Other Public	Private	% Point Reduction in Uninsured since 2013
Total	**213**	**796,852**	**23%**	**61%**	**5%**	**5%**	**6%**	**28%**
AK	2	1,058	24%	56%	5%	6%	10%	-27%
AR	1	673	27%	62%	2%	2%	6%	-64%
AZ	2	23,771	14%	60%	6%	6%	15%	-45%
CA	45	263,118	21%	66%	6%	4%	3%	-30%
CO	5	22,659	21%	66%	7%	3%	3%	-48%
CT	8	10,159	24%	63%	7%	1%	5%	-7%
DC	1	10,741	21%	58%	10%	5%	6%	-2%
DE	2	774	34%	44%	5%	4%	13%	-18%
HI	1	1,587	21%	63%	4%	3%	9%	-5%
IA	4	7,673	21%	62%	4%	3%	10%	-34%
IL	8	19,970	27%	60%	5%	4%	4%	-32%
IN	6	7,350	39%	50%	4%	2%	5%	-37%
KY	8	16,081	27%	48%	4%	8%	13%	-54%
LA	6	23,631	21%	66%	2%	5%	5%	-19%
MA	7	25,620	17%	59%	13%	5%	6%	-5%
MD	2	10,714	38%	48%	9%	4%	1%	-26%
ME	2	4,536	45%	40%	5%	1%	9%	-17%
MI	15	38,089	18%	59%	5%	5%	13%	-29%
MN	2	6,291	22%	62%	4%	9%	3%	-3%
MT	4	3,700	21%	66%	6%	5%	3%	-44%
ND	1	1,203	56%	37%	2%	3%	2%	-17%
NH	3	5,421	19%	53%	6%	8%	14%	-56%
NJ	7	19,601	36%	41%	2%	4%	16%	-26%
NM	6	16,744	33%	51%	5%	4%	8%	-47%
NV	4	7,383	30%	46%	4%	9%	10%	-44%
NY	20	84,580	25%	61%	4%	4%	6%	-8%
OH	8	23,281	26%	62%	4%	5%	3%	-49%
OR	12	32,176	25%	60%	7%	4%	4%	-34%
PA	6	21,073	31%	57%	1%	6%	4%	-14%
RI	2	1,944	12%	66%	5%	9%	8%	-65%
VA	4	9,354	44%	29%	3%	4%	19%	-38%
VT	1	1,623	14%	65%	11%	3%	7%	1%
WA	7	66,076	14%	70%	3%	7%	6%	-31%
WV	1	8,198	55%	44%	1%	0%	1%	-43%

Table 2. Health Insurance Coverage for Patients at HCH Programs in Medicaid Non-Expansion States, 2019

States that Did Not Expand Medicaid								
	# HCH Programs in 2019	Total # Patients	Uninsured	Medicaid	Medicare + Medicaid ("Duals")	Medicare/ Other Public	Private	% Point Reduction in Uninsured since 2013
Total	**82**	**251,120**	**67%**	**20%**	**2%**	**4%**	**7%**	**7%**
AL	4	7,428	81%	10%	2%	3%	4%	1%
FL	16	67,444	65%	21%	2%	2%	10%	-9%
GA	5	23,062	80%	10%	2%	2%	6%	-16%
ID	2	5,070	71%	12%	2%	4%	11%	-15%
KS	3	3,094	70%	19%	3%	2%	5%	-12%
MO	3	9,963	70%	19%	3%	3%	6%	-3%
MS	2	11,803	66%	20%	2%	2%	10%	9%
NC	11	10,925	60%	21%	5%	4%	10%	-8%
NE	1	3,896	81%	11%	1%	2%	4%	-9%
OK	2	4,652	75%	18%	2%	2%	3%	-9%
SC	4	12,070	63%	19%	3%	8%	7%	-2%
SD	2	1,869	66%	17%	2%	5%	10%	-12%
TN	7	19,336	58%	21%	3%	12%	5%	-25%
TX	12	57,578	68%	19%	2%	6%	5%	-18%
UT	3	7,101	49%	42%	4%	4%	2%	-25%
WI	3	4,128	62%	31%	2%	3%	3%	-11%
WY	2	1,701	82%	5%	3%	6%	4%	-7%

NOTES:
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 3,897 patients: 49% Medicaid, 0% duals, 2% Medicare/OP, 7% private, 41% uninsured. Since 2013, the percentage of uninsured increased by 9% points.
Data source: HRSA Uniform Data System (UDS) for Calendar Year 2019, Tables 3 and 4.
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

- Five Ways Medicaid Expansion Is Helping Homeless Populations *(Health Affairs)*
- 50 Reasons Medicaid Expansion is Good for Your State *(National Health Law Program)*
- Medicaid Provisions in the American Rescue Plan Act *(Kaiser Family Foundation)*