FACT SHEET

Health Insurance at HCH Programs, 2021

March 2023

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 poor health and earlier mortality. This population also experiences greater barriers to accessing care because they tend not to have a consistent 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. Prior to the Affordable Care Act (ACA), people experiencing homelessness were uninsured at high rates because they were not generally eligible for public programs such as Medicaid or Medicare, and could not afford private insurance. 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 reimbursements from insurance, these safety net providers are more limited in the care they can offer and in their ability to refer patients to a broader range of needed care, such as hospital care, more intensive addiction and mental health treatment, and specialty care.

Medicaid Expansion through the Affordable Care Act

The ACA gave states the option (effective in 2014) to expand Medicaid eligibility to childless adults with income at or below 138% of the federal poverty level (FPL), as well as subsidized private insurance plans for those earning between 100% and 400% FPL. Since then, states that opted to expand Medicaid saw a rapid reduction in the number of HCH patients without insurance, while states that did not expand Medicaid have experienced a more modest decrease. Importantly, nationwide averages mask considerable variation among states (even among those that expanded).

In 2021, there were 299 HCH programs that provided care to 906,259 patients. Just over half were enrolled in Medicaid (54%), while 5% were dually enrolled in both Medicare and Medicaid, an additional 6% were enrolled in Medicare (or another public program), and 5% had a private health insurance plan (see **Figure 1**). Almost one-third (30%) were uninsured. **Overall, patients at HCH programs were over three times more likely to be uninsured compared to the general public** (30% v. 9%), and show higher rates of being uninsured even compared to patients in all health centers (30% v. 20%).

Figure 1. Health Insurance Sources, 2021

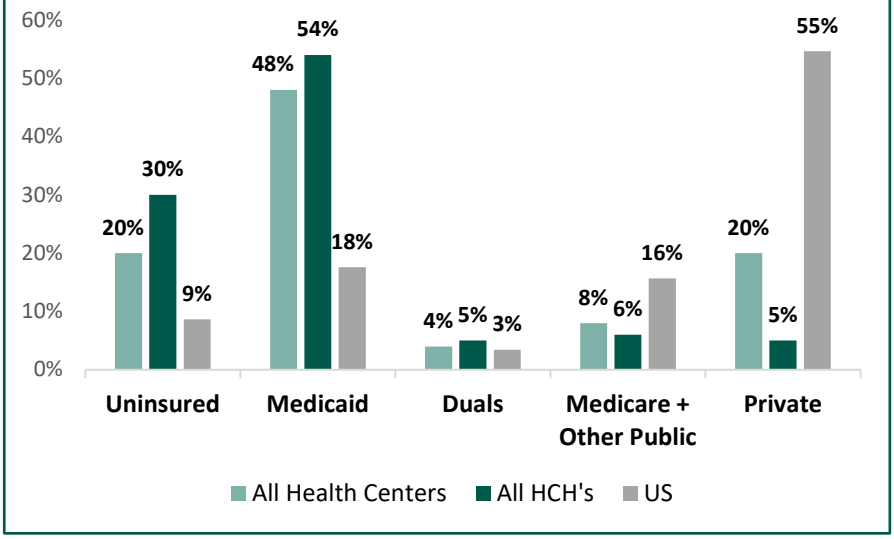
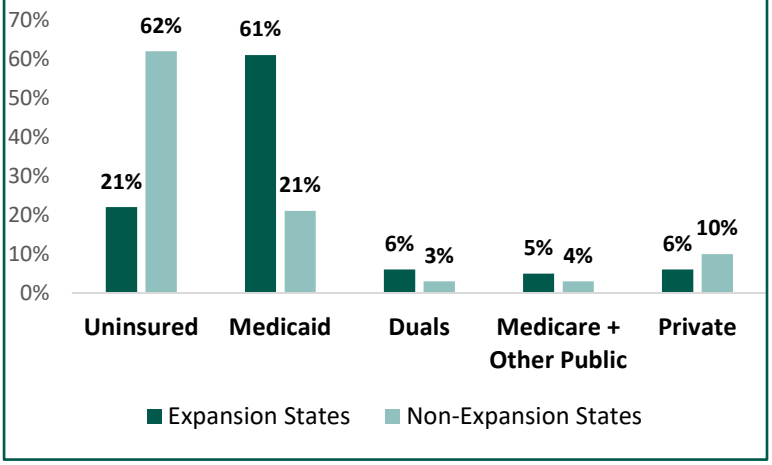


Figure 2 shows the significant disparities in health insurance coverage between HCH programs in states that chose to expand Medicaid coverage, and those in states that continue to refuse to do so—especially in Medicaid and uninsured. The "Medicaid coverage gap" impacts more than 2 million low-income people nationwide—people who remain uninsured but who otherwise would be eligible for Medicaid should their state choose to expand. Figure 2 shows the impact of the Medicaid gap on people who are homeless and only further illustrates the critical importance the ACA provision to expand Medicaid for vulnerable people in need of comprehensive health care.

Figure 2. Insurance Sources at HCH Programs, Expansion v. Non-Expansion States, 2021



States that Expanded Medicaid (Table 1)

Not surprisingly, in the 39 states (to include DC) that opted to expand Medicaid by 2021, HCH programs saw 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 under half that—at 21%. Medicare, those with private insurance, and those with both Medicare and Medicaid ("dual-eligibles" or "duals" 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 **4% to 86%.**
- Medicaid: Coverage ranges from **13% to 78%.**
- Dually-eligible for Medicare and Medicaid: Coverage ranges from 0% to 14%.
- Medicare and Other Public: Coverage ranges from 1% to 19%.
- Private insurance: Coverage ranges from 0% to 18%.

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

In 2021, HCHs in the 12 states that had not expanded Medicaid had an uninsured rate nearly three times as high as states that expanded coverage. Among this group of states, only 21% of HCH patients had Medicaid coverage with nearly two-thirds – 62% – left 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 smaller portions of total patients. Across non-expansion states, there is also wide variation in coverage:

- Uninsured: Ranges from **45% to 75%.**
- Medicaid: Coverage ranges from **10% to 45%.**
- Dually-eligible for Medicare and Medicaid: Coverage ranges from 2% to 5%.
- Medicare and Other Public: Coverage ranges from 2% to 12%.
- Private insurance: Coverage ranges from 4% to 36%.

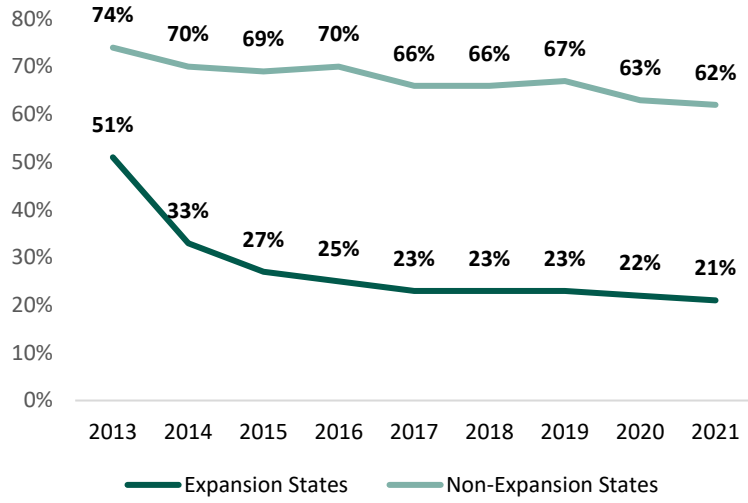
Discussion

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. Rates of uninsured do not mean patients are *uninsurable*—just that they lacked coverage at the last visit from which data was gathered. A "maintenance of effort" provision in the Families First Coronavirus Response Act prohibited states from dis-enrolling people during the pandemic—retroactive to January 1, 2020. Hence, there was a 5% point decrease in uninsured over the past two years among those in expansion states (though only a 2% point decrease in non-expansion states) as the traditional "churn" in Medicaid was eliminated.

States also have unique policy reasons for varying coverage rates. For example, Wisconsin establishes Medicaid eligibility only up to 100% FPL so is not formally an expansion state, and Oklahoma's expansion did not take effect until July 1, 2021. **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 12 states' refusal to expand Medicaid in 2021.

Medicaid is consistently the most common source of insurance for HCH patients, even in states that did not expand Medicaid to single adults. As states continue working to reduce health care disparities and improve health, access to comprehensive health insurance remains a key factor.

Figure 3. Percentage of Uninsured at HCH Programs, 2013-2021



Advocacy Actions

- Call for state lawmakers in the 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).
- Absent state action, advocate for Congress to close the Medicaid coverage gap with a federal program that allows those in non-expansion states to access Medicaid. Even better, push federal lawmakers to establish a single-payer national health plan, which would eliminate the burdensome, fragmented approach to health insurance altogether.
- 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.
- Conduct assertive outreach & enrollment activities to ensure all eligible people are enrolled—especially as Medicaid re-determinations are being conducted for all enrollees post-COVID-19.
- Facilitate health center tours with public officials to illustrate the benefits of Medicaid coverage and the need for low-barrier, streamlined benefits.
- Engage clients and service providers to talk about how health insurance has helped them and incorporate these stories in advocacy activities.
- Demonstrate the benefits of Medicaid coverage for people who are homelessness, as well as larger public health and health care issues, 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 and well-being.
- Fight against attempts to implement work requirements in the Medicaid program, which are expensive to administer, and only serve to cause vulnerable people to lose health insurance. Ironically, denying health coverage only creates additional barriers to obtaining employment because people can't maintain their health.
- Oppose attempts to change Medicaid financing to a block grant or to a per-capita-cap, which only limit the funding available to states to maintain appropriate levels of service.

Table 1. Health Insurance Coverage for Patients at HCH Programs in Medicaid Expansion States, 2021

States that Expanded Medicaid								
	# HCHs in 2021	Total # Patients	Uninsured	Medicaid	Medicare + Medicaid ("Duals")	Medicare/ Other Public	Private	% Point Change in Uninsured since 2013
Total	**223**	**734,154**	**21%**	**61%**	**6%**	**5%**	**6%**	**-34%**
AK	2	1,542	17%	55%	14%	4%	10%	-34%
AR	1	431	31%	48%	2%	1%	18%	-60%
AZ	2	17,099	16%	61%	10%	4%	8%	-43%
CA	44	241,582	21%	66%	6%	3%	3%	-30%
CO	5	19,372	20%	61%	12%	2%	5%	-49%
CT	8	9,068	26%	59%	6%	2%	7%	-5%
DC	1	10,784	17%	56%	0%	19%	8%	-6%
DE	2	686	37%	43%	6%	3%	12%	-15%
HI	1	1,417	4%	78%	8%	3%	7%	-22%
IA	4	6,767	16%	68%	5%	3%	8%	-38%
ID	2	3,328	25%	57%	5%	5%	8%	-61%
IL	8	17,387	20%	66%	4%	5%	5%	-39%
IN	6	5,263	25%	60%	6%	1%	8%	-51%
KY	8	21,290	18%	57%	5%	7%	13%	-63%
LA	6	32,273	10%	70%	2%	6%	13%	-30%
MA	7	22,329	11%	64%	13%	6%	7%	-11%
MD	2	11,519	48%	41%	6%	5%	1%	-23%
ME	2	4,133	34%	49%	5%	1%	10%	-28%
MI	15	24,385	12%	66%	8%	3%	10%	-35%
MN	2	5,635	20%	64%	4%	8%	3%	-4%
MO*	3	7,781	64%	22%	3%	3%	7%	-9%
MT	4	3,266	19%	58%	10%	5%	7%	-47%
ND	1	968	52%	41%	1%	1%	5%	-21%
NE	1	2,291	44%	45%	3%	3%	6%	-46%
NH	3	4,740	14%	58%	5%	6%	17%	-61%
NJ	7	13,594	37%	45%	3%	6%	8%	-25%
NM	6	12,269	19%	61%	6%	5%	9%	-61%
NV	4	4,103	28%	50%	5%	6%	11%	-46%
NY	20	81,129	26%	58%	5%	4%	7%	-6%
OH	8	19,922	27%	59%	4%	5%	5%	-48%
OK**	2	3,121	40%	46%	2%	1%	10%	-49%
OR	12	30,074	17%	68%	7%	4%	4%	-43%
PA	6	15,529	33%	55%	4%	4%	5%	-12%
RI	2	1,454	13%	65%	6%	9%	8%	-64%
UT	3	6,147	28%	57%	6%	4%	5%	-46%
VA	4	7,482	28%	49%	5%	4%	14%	-55%
VT	1	1,555	16%	64%	12%	3%	5%	4%
WA	7	53,491	13%	69%	3%	9%	6%	-32%
WV	1	8,948	86%	13%	0%	1%	0%	-12%

* Missouri Medicaid expansion began when the state started accepting applications in August 2021 and began processing applications in October 2021, with coverage retroactive to July 1, 2021 consistent with a state supreme court order.

** Oklahoma did not open enrollment until July 1, 2021, hence has only a partial year of expansion to record.

Table 2. Health Insurance Coverage for Patients at HCH Programs in Medicaid Non-Expansion States, 2021

States that Did Not Expand Medicaid								
	# HCH Programs in 2021	Total # Patients	Uninsured	Medicaid	Medicare + Medicaid ("Duals")	Medicare/ Other Public	Private	% Point Change in Uninsured since 2013
Total	**71**	**167,737**	**62%**	**21%**	**3%**	**4%**	**10%**	**-17%**
AL	4	5,810	75%	13%	2%	3%	7%	-5%
FL	16	48,350	60%	22%	3%	2%	13%	-14%
GA	5	22,636	64%	24%	2%	3%	7%	-32%
KS	3	3,103	71%	18%	4%	3%	4%	-11%
MS	2	9,355	57%	24%	4%	3%	12%	0%
NC	11	8,129	47%	18%	5%	4%	26%	-20%
SC	4	5,894	59%	20%	4%	4%	12%	-6%
SD	2	1,738	50%	10%	2%	2%	36%	-27%
TN	7	16,887	53%	21%	5%	12%	10%	-30%
TX	12	42,377	71%	18%	2%	5%	4%	-14%
WI	3	2,127	45%	45%	2%	5%	4%	-28%
WY	2	1,331	73%	10%	4%	5%	9%	-16%

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. In 2021, these five programs saw 4,368 patients: 51% Medicaid, 0% duals, 5% Medicare/OP, 7% private, 37% uninsured. Since 2013, the percentage of uninsured increased by 5% points.

Data source: HRSA Uniform Data System (UDS) for Calendar Year 2021, Tables 3 and 4. Some numbers may not add to 100% due to rounding.

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)*
- The Far-Reaching Benefits of the Affordable Care Act's Medicaid Expansion *(Center on Budget and Policy Priorities)*
- The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020 *(Kaiser Family Foundation)*
- The Impact of Medicaid Expansion on States' Budgets *(The Commonwealth Fund)*