FACT SHEET

Health Insurance at HCH Programs, 2022

February 2024

Improving health depends on accessing health care services and engaging in appropriate treatment. People experiencing homelessness have higher rates of chronic medical 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 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. 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 other specialty care.

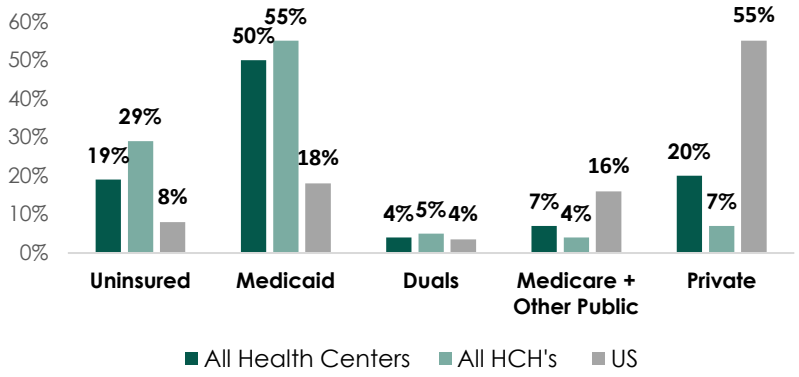
Because this data is from CY2022, it does not reflect the significant losses of Medicaid coverage currently underway as part of "unwinding" the Medicaid continuous enrollment provision from the COVID-19 pandemic. To date, 17 million people have been disenrolled from Medicaid, with 70% of these occurring for procedural reasons not related to eligibility (such as not returning paperwork sent to a prior address, which will be especially common among those with residential instability).

Medicaid Expansion through the Affordable Care Act

Effective in 2014, the ACA gave states the option 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.

In 2022, there were 299 HCH programs that provided care to 940,499 patients. **Figure 1** shows that just over half were enrolled in Medicaid (55%), while 5% were dually enrolled in both Medicare

Figure 1: Health Insurance Sources at HCH Programs, 2022



and Medicaid, an additional 4% were enrolled in Medicare (or another public program), and 7% had a private health insurance plan. Nearly 3 in 10 people (29%) were uninsured. **Overall, patients at HCH programs were over three times more likely to be uninsured compared to the general public** (29% v. 8%), and show higher rates of being uninsured even compared to patients in all health centers (29% v. 19%).

Figure 2 shows the significant disparities between health insurance coverage at HCH programs in states that chose to expand Medicaid coverage, and those in states that continue to refuse to do so. Expansion states see 62% of their patients covered by Medicaid with 22% uninsured—while those in non-expansion states see nearly the exact inverse—60% of patients uninsured with only 24% enrolled in Medicaid.

Figure 2: Insurance Sources at HCH Programs, Expansion v. Non-Expansion States, 2022

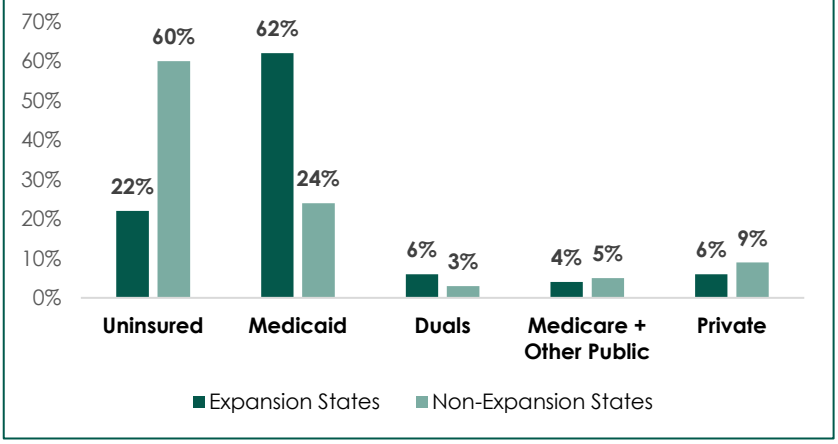
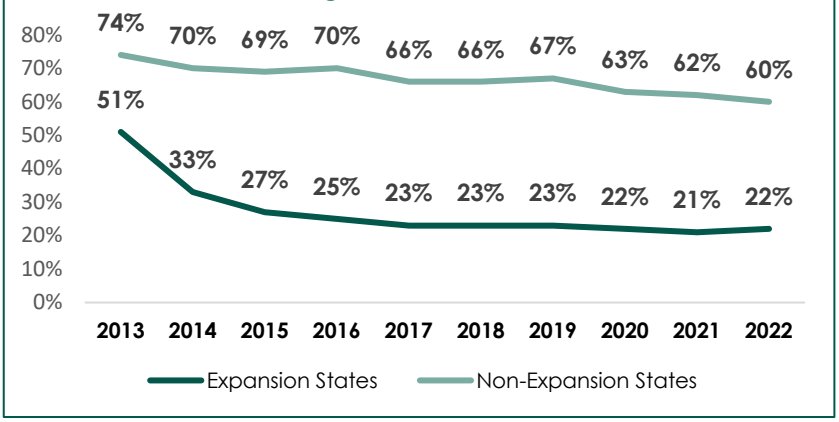


Figure 3 shows the reduction in uninsured since the ACA's Medicaid expansion for single adults went into effect in 2014. States that opted to expand Medicaid saw a rapid reduction in the number of HCH patients without insurance, while states that did not expand Medicaid have experienced a more modest decrease. Importantly, nationwide averages mask considerable variation among states (even among those that expanded).

Figure 3: Percentage of Uninsured at HCH Programs, 2013-2022



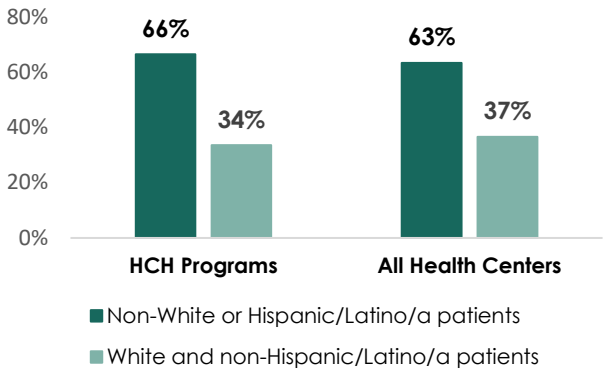
Implications for Geographic and Racial Equity

Figures 2 and 3 illustrate the "Medicaid coverage gap"—people who remain uninsured but who otherwise would be eligible for Medicaid should their state choose to expand—and its impact on people who are homeless. These state-level decisions directly contribute to coverage disparities based on geography, and make it harder for vulnerable people to access comprehensive health care.

Increasing access to Medicaid is also a race equity issue. Black, Indigenous, and other People of Color are disproportionately impacted by poverty and homelessness, and more likely to be uninsured. **Figure 4** shows that nearly two-thirds of all health center patients—**66% of patients at HCH programs—are non-White or Hispanic**. (Note: data analysis did not show significant differences in patient race/ethnicity between expansion and non-expansion states.)

Expanding Medicaid coverage will disproportionately impact BIPOC groups and help close geographic disparities in coverage and health outcomes.

Figure 4. Race/Ethnicity of HCH and Health Center Patients, 2022



States that Expanded Medicaid (Table 1)

Not surprisingly, in the 39 states (to include DC) that expanded Medicaid in 2022, 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 22%. 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% in HI to 71% in WV.**
- Medicaid: Coverage ranges from **28% in WV to 76% in OK.**
- Dually-eligible for Medicare and Medicaid: Coverage ranges from 0% in WV to 14%.
- Medicare and Other Public: Coverage ranges from 1% to 14 in AK%.
- Private insurance: Coverage ranges from 0% in WV to 22% in AR.

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

In 2022, HCHs in the 12 states that continued to opt out of expanding Medicaid had an uninsured rate nearly three times as high as states that expanded coverage. Among this group of states, only 24% of HCH patients had Medicaid coverage with 60% 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 **19% in WI to 68% in TX and WY.**
- Medicaid: Coverage ranges from **13% in WY to 65% in WI.**
- Dually-eligible for Medicare and Medicaid: Coverage ranges from 2% in FL and TX to 9% in WI.
- Medicare and Other Public: Coverage ranges from 2% in FL and SD to 11% in TN.
- Private insurance: Coverage ranges from 3% in WI to 26% in SD.

Discussion

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

As mentioned at the outset, states were still following a COVID-19 "maintenance of effort" provision in 2022, which prohibited states from dis-enrolling people from Medicaid during the COVID-19 pandemic. Hence, this time period should reflect a continuity of coverage that does not normally exist, as the traditional "churn" in Medicaid was eliminated. (The "unwinding" of this policy started in April 2023, and an early study shows that in the first 6 months of unwinding, disenrollments disproportionately impacted American Indian and Alaska Native, Black or African American, and Hispanic/Latino groups, as well as those with HIV/AIDS, mental health needs, or substance use conditions—characteristics that exist at higher rates for people experiencing homelessness.)

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, while other states that expanded did so only reluctantly and fail to support the program's success.

Strong advocacy is needed to protect, expand, and strengthen Medicaid as a vital safety net program. The HCH Community should be actively engaged with their state and local policymakers to ensure they understand the program's positive impact on patients and program operations.

Advocacy Actions

1. **Expand Medicaid in all states:** 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). Expand eligibility to additional populations, such as postpartum or undocumented people. Expand services through 1115 waivers for tenancy supports, medical respite care, and other health-related social needs.
2. **Advance a national solution:** 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.
3. **Ensure enrollment:** 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. Identify geographic, racial/ethnic, or other disparities in disproportionately impacted populations and tailor enrollment strategies accordingly. Publicly report enrollment data, stratified by race/ethnicity.
4. **Engage policymakers:** Facilitate health center tours with public officials to illustrate the benefits of Medicaid coverage and the need for low-barrier, streamlined benefits.
5. **Expand presumptive and continuous eligibility:** 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. Reduce churn by extending continuous eligibility—moving to 12-month time periods (or longer).

6. **Share personal narratives:** Engage clients and service providers to talk about how health insurance has helped them and incorporate these stories in advocacy activities.

7. **Illustrate the advantages:** Demonstrate the benefits of Medicaid coverage for people who are homelessness, as well as larger public health and health care issues, 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.

8. **Fight policies that weaken Medicaid:** Oppose 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. Resist 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, 2022

States that Expanded Medicaid								
	# HCHs in 2022	Total # Patients	Uninsured	Medicaid	Medicare + Medicaid ("Duals")	Medicare/ Other Public	Private	% Point Change in Uninsured since 2013*
Total	**223**	**763,232**	**22%**	**62%**	**6%**	**4%**	**6%**	**-29%**
AK	2	1,850	14%	46%	14%	6%	20%	-37%
AR	1	487	29%	48%	2%	0%	22%	-62%
AZ	2	20,228	11%	66%	7%	5%	11%	-47%
CA	44	242,402	19%	68%	6%	3%	3%	-32%
CO	5	18,770	26%	59%	12%	2%	2%	-43%
CT	8	9,886	24%	60%	6%	2%	9%	-7%
DC	1	10,578	19%	58%	11%	9%	3%	-4%
DE	2	541	26%	46%	5%	1%	22%	-26%
HI	1	1,402	4%	74%	9%	3%	10%	-23%
IA	4	7,137	19%	66%	5%	3%	8%	-36%
ID	2	3,050	31%	53%	6%	5%	6%	-55%
IL	8	17,649	19%	67%	2%	6%	5%	-39%
IN	6	5,819	24%	61%	6%	2%	8%	-52%
KY	8	23,159	19%	56%	4%	6%	16%	-62%
LA	6	32,312	14%	67%	2%	5%	12%	-26%
MA	7	23,914	12%	62%	13%	6%	7%	-10%
MD	2	11,954	56%	33%	4%	6%	1%	-15%
ME	2	5,016	38%	47%	4%	1%	10%	-23%
MI	15	24,608	12%	64%	9%	3%	11%	-35%
MN	2	6,612	22%	63%	6%	6%	3%	-3%
MO	3	8,066	45%	40%	4%	4%	7%	-27%
MT	4	3,441	18%	60%	10%	5%	7%	-47%
ND	1	1,150	32%	57%	4%	2%	4%	-40%
NE	1	2,232	34%	52%	4%	3%	7%	-56%
NH	3	4,621	14%	56%	6%	8%	16%	-61%
NJ	7	13,844	38%	42%	3%	6%	11%	-24%

States that Expanded Medicaid								
	# HCHs in 2022	Total # Patients	Uninsured	Medicaid	Medicare + Medicaid ("Duals")	Medicare/ Other Public	Private	% Point Change in Uninsured since 2013*
NM	6	14,403	29%	54%	4%	4%	9%	-50%
NV	4	4,099	28%	49%	4%	7%	12%	-46%
NY	20	84,192	31%	54%	5%	3%	7%	-2%
OH	8	20,557	31%	56%	6%	4%	3%	-44%
OK	2	3,725	14%	76%	2%	1%	7%	-76%
OR	12	30,139	17%	66%	8%	4%	5%	-42%
PA	6	15,501	31%	57%	3%	3%	4%	-13%
RI	2	1,409	12%	63%	6%	8%	11%	-65%
UT	3	6,986	28%	57%	7%	4%	5%	-46%
VA	4	6,523	24%	53%	6%	4%	13%	-58%
VT	1	1,575	19%	62%	11%	4%	5%	6%
WA	7	64,047	13%	70%	3%	8%	6%	-32%
WV	1	9,348	71%	28%	0%	0%	0%	-27%

* Not all states expanded Medicaid on January 1, 2014 so the comparison to 2013 data is only a general benchmark of progress.

Table 2. Health Insurance Coverage for Patients at HCH Programs in Medicaid Non-Expansion States, 2022

States that Did Not Expand Medicaid								
	# HCH Programs in 2022	Total # Patients	Uninsured	Medicaid	Medicare + Medicaid ("Duals")	Medicare/ Other Public	Private	% Point Change in Uninsured since 2013
Total	**71**	**172,308**	60%	24%	3%	5%	9%	-14%
AL	4	6,078	66%	15%	4%	3%	11%	-14%
FL	16	50,157	58%	29%	2%	2%	8%	-16%
GA	5	22,485	62%	25%	3%	3%	8%	-34%
KS	3	2,951	67%	19%	5%	3%	6%	-15%
MS	2	9,269	53%	25%	4%	3%	15%	-4%
NC	11	7,565	47%	22%	5%	3%	23%	-20%
SC	4	6,442	67%	16%	4%	4%	9%	2%
SD	2	1,938	54%	15%	3%	2%	26%	-24%
TN	7	16,603	52%	23%	5%	11%	10%	-31%
TX	12	45,569	68%	19%	2%	7%	5%	-18%
WI	3	1,931	19%	65%	9%	3%	3%	-53%
WY	2	1,320	68%	13%	4%	5%	11%	-21%

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 2022, these five programs saw 4,959 patients: 57% Medicaid, 2% duals, 8% Medicare/OP, 6% private, 26% uninsured. Since 2013, the percentage of uninsured decreased by 6% points.

Data source: HRSA Uniform Data System (UDS) for Calendar Year 2022, Tables 3 and 4. Some totals may not add to 100% due to rounding.

Use of UDS Data: Rates of uninsured do not always mean patients are *uninsurable*—just that they lacked coverage at the last visit from which data was gathered. All HCH programs differ in the level of internal resources for outreach and enrollment, as well as the demographics of patients seen. Likewise, all communities are different in terms of the type and/or capacity of other health care providers in the area who provide care people experiencing homelessness. 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

- Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021 (Kaiser Family Foundation)
- Impact of the Medicaid Coverage Gap: Comparing States That Have and Have Not Expanded Eligibility (Commonwealth Fund)
- Five Ways Medicaid Expansion Could Benefit The Economy And Main Street (Forbes)
- Medicaid and Racial Health Equity (Kaiser Family Foundation)
- Closing Medicaid Coverage Gap Would Help Diverse Group and Narrow Racial Disparities (Center on Budget and Policy Priorities)