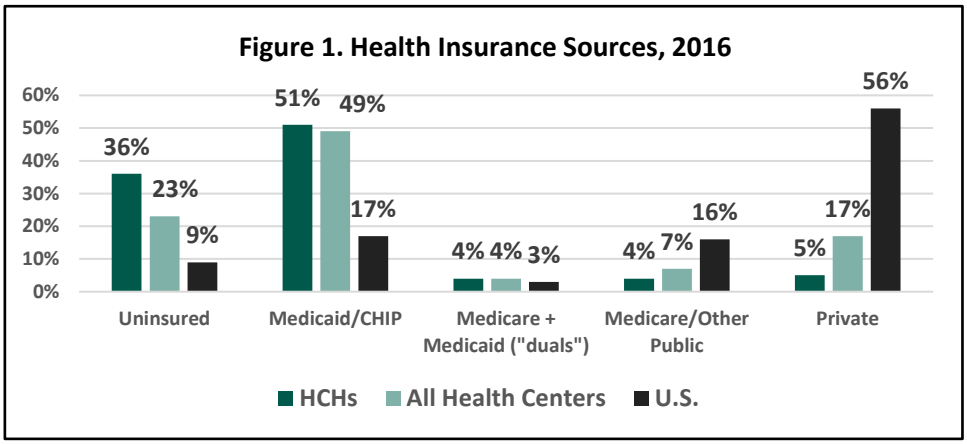
NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Health Insurance Coverage at HCH Programs, 2016

Fact Sheet | May 2018

Improving health outcomes depends on accessing health care services and being able to engage in appropriate treatment. People who are homeless tend to 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. This population also tends to experience greater barriers to accessing care because they tend not to have a stable mailing address, have greater difficulty with transportation, and are focused on meeting basic survival needs such as food, shelter, and safety.

One of the most common barriers to accessing comprehensive care is a lack of health insurance, which helps pay for health care services. Traditionally, people experiencing homelessness have been uninsured at high rates because they cannot afford private insurance and may not qualify 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 their insurance status or ability to pay. But absent insurance, these safety net providers are limited in the ability to refer patients to a broader range of needed care (such as hospitals, addiction and mental health treatment, and specialty care) to address more serious issues. Because care options are more limited when patients lack insurance, it is more difficult to improve health outcomes.



In 2014, changes in federal law gave states the option to expand eligibility for Medicaid to single adults with income at or below 138% of poverty, as well as helped subsidize 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 variability at the state level.

In 2016, there were 295 HCH programs that provided care to 934,174 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), while 5% had a private health insurance plan and 36% were uninsured (see Figure 1). Overall, patients at HCH programs were four times more likely to be uninsured compared to the general public, and show higher rates of being uninsured even compared to patients at other health centers.

Medicaid Expansion States

Not surprisingly, the 32 states (to include DC) that opted to expand Medicaid by 2016 were serving significantly more insured patients than they had prior to expansion, 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 25%. 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 distribution, even in "expansion states:"

- Medicaid: Coverage ranges from 78% to 22%.
- Dually-eligible for Medicare and Medicaid: Coverage ranges from 10% to 0%.
- Medicare and Other Public: Coverage ranges from 10% to 0%.
- Private insurance: Coverage ranges from 43% to 1%.
- Uninsured: Ranges from 63% to 8%.

Medicaid Non-Expansion States

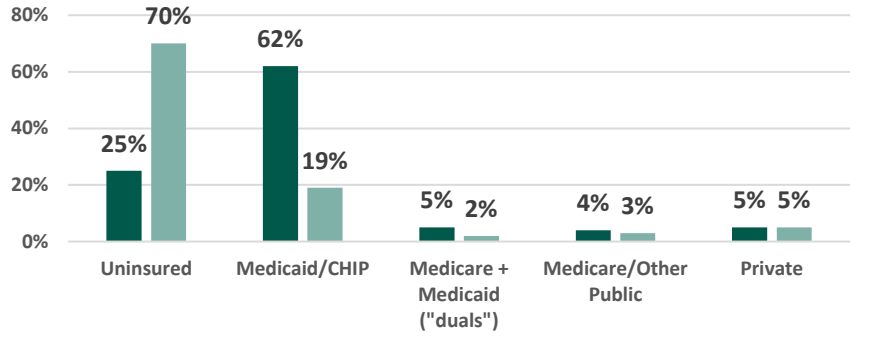
In 2016, HCHs in the 19 states that had not expanded Medicaid had an uninsured rate nearly three times higher than in states that did expand Medicaid. Overall, only 19% of all patients had Medicaid coverage, with only 30% of patients having some type of coverage. Similar to expansion states, those who are dually-eligible for Medicare and Medicaid, those with Medicare only, and those with private insurance all represent small portions of total patients. Within this group of states, there is similar variability in coverage:

- Medicaid: Coverage ranges from 49% to 4%.
- Dually-eligible for Medicare and Medicaid: Coverage ranges from 6% to 0%.
- Medicare and Other Public: Coverage ranges from 11% to 1%.
- Private insurance: Coverage ranges from 14% to 1%.
- Uninsured: Ranges from 89% to 45%.

Discussion

Despite attempts to streamline enrollment, all states and/or programs still vary widely in outreach and enrollment activities, as well as the capacity of other safety net providers in the community to serve vulnerable people. All these factors can influence the distribution of 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 reasons for health coverage variance. For example, Arkansas uses Medicaid funds to purchase private insurance. Wisconsin has Medicaid-eligibility only up to 100% of poverty, but is not formally an expansion state. Montana did not implement its Medicaid expansion until July 1, 2016, which only allowed for a partial year benefit.

Figure 2. Health Insurance Sources at HCH Programs, 2016



Overall, Medicaid is consistently the largest 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 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 in access to care.

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).
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 your advocacy.
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 role of health insurance to provide a foundation of stability that in turn supports employment and self-sufficiency.

Table 1. Health Coverage Distribution of Patients at HCH Projects, 2016
(Ranked by Percentage of Uninsured)

	# Grantees in 2016	Total Number Patients	Medicaid	Medicare + Medicaid ("Duals")	Medicare/ Other Public	Private	Uninsured	% Point Change in Uninsured since 2013
States that Had Expanded as of end-2016								
Total	204	702,204	62%	5%	4%	5%	25%	-26%
WA	7	44,609	78%	3%	7%	5%	8%	-36%
VT	1	1,511	74%	10%	3%	4%	9%	-4%
RI	2	1,289	72%	6%	3%	6%	13%	-64%
MA	7	24,544	64%	9%	9%	4%	15%	-7%
CT	8	10,204	68%	5%	2%	6%	18%	-13%
MN	2	6,810	63%	5%	10%	2%	20%	-5%
MI	14	31,818	62%	4%	4%	9%	20%	-27%
NH	3	5,609	47%	7%	10%	16%	21%	-54%
DC	1	10,443	61%	8%	8%	2%	21%	-2%
IA	4	6,413	64%	5%	2%	7%	22%	-33%
MD	2	10,711	64%	9%	4%	1%	23%	-48%
WV	1	6,567	75%	0%	0%	1%	24%	-75%
KY	6	12,685	54%	4%	8%	10%	24%	-57%
IL	8	17,462	63%	4%	4%	4%	24%	-34%
HI	1	1,504	61%	5%	4%	5%	25%	-1%
NY	21	84,017	62%	4%	4%	5%	25%	-7%
CA	45	243,424	62%	5%	4%	3%	25%	-26%
AZ	3	20,290	56%	4%	5%	8%	26%	-32%
OH	7	22,265	64%	2%	5%	1%	28%	-47%
CO	5	26,606	60%	6%	4%	3%	28%	-41%
AR	1	318	22%	3%	4%	43%	28%	-63%
NJ	7	15,503	56%	3%	4%	8%	29%	-33%
LA*	6	16,725	60%	2%	2%	7%	30%	-10%
OR	12	29,690	56%	5%	4%	4%	31%	-29%
AK	2	1,524	48%	4%	3%	10%	36%	-16%
IN	6	5,898	53%	3%	3%	3%	38%	-38%
PA	6	20,003	50%	3%	5%	3%	39%	-6%
NM	6	13,810	48%	4%	3%	4%	40%	-39%
NV	3	4,067	42%	6%	3%	7%	41%	-33%
DE	2	891	40%	2%	3%	8%	47%	-5%
MT*	4	3,943	41%	3%	3%	2%	52%	-14%
ND	1	1,051	30%	2%	2%	3%	63%	-10%

Table 1 (Continued). Health Coverage Distribution of Patients at HCH Projects, 2016 (Ranked by Percentage of Uninsured)								
	# Grantees in 2016	Total Number Patients	Medicaid	Medicare + Medicaid ("Duals")	Medicare/ Other Public	Private	Uninsured	% Point Change in Uninsured since 2013
States that Had Not Expanded as of end-2016								
Total	86	226,400	19%	2%	3%	5%	70%	-4%
SC	4	9,690	29%	2%	11%	14%	45%	-20%
WI	3	5,953	49%	0%	2%	1%	48%	-24%
ME	2	3,289	30%	6%	1%	5%	58%	-4%
MO	3	9,541	24%	3%	4%	8%	60%	-12%
TN	7	16,174	27%	4%	4%	4%	62%	-21%
NC	10	10,254	21%	5%	3%	8%	63%	-4%
SD	2	2,420	24%	3%	3%	6%	65%	-12%
MS	2	5,547	19%	2%	2%	9%	67%	10%
FL	16	64,622	22%	3%	2%	6%	68%	-6%
KS	3	2,412	22%	1%	5%	3%	69%	-13%
VA	4	7,582	12%	2%	5%	11%	70%	-12%
TX	12	48,787	15%	1%	4%	4%	76%	-10%
OK	2	4,629	16%	2%	2%	4%	76%	-14%
UT	3	6,566	17%	2%	3%	1%	78%	4%
AL	3	5,065	14%	2%	2%	3%	79%	-1%
ID	2	2,724	11%	1%	5%	4%	79%	-7%
NE	1	2,873	10%	2%	2%	5%	81%	-9%
WY	2	1,324	4%	1%	4%	3%	89%	0%
GA	5	16,948	6%	2%	1%	3%	89%	-7%

Data source: HRSA Uniform Data System (UDS) for Calendar Year 2016, Tables 3 and 4.
* Montana expanded Medicaid on January 1, 2016; Louisiana expanded on July 1, 2016.
Note: Puerto Rico has five HCH programs, but as a U.S. territory it receives a Medicaid block grant. These five programs saw 5,570 patients: 48% Medicaid, 2% duals, 1% Medicare/OP, 2% private, 47% uninsured. Since 2013, the percentage of uninsured increased by 15% points.
Other notes: 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; this definition may overlook other types of patient interactions that are not captured in this analysis.

This publication was developed with private funds.