

Health Care Reform: Priorities for Addressing Homelessness

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Homelessness is hazardous to your health: Individuals experiencing homelessness face complex health problems, are generally sicker and die earlier than their housed counterparts, and have minimal financial resources. They are among the most frequent and expensive users of emergency room and inpatient hospital care and are much more likely than those in the general population to be uninsured. It is imperative that health reform address the complex needs and life circumstances of people experiencing homelessness. Failing to do so will continue the current cycle of high-cost hospitalizations, unemployment, disability, and homelessness.

National principles of reform: President Obama outlined eight principles for comprehensive health care reform. As Congress continues to draft and refine reform legislation, four of these principles are particularly relevant for the prevention and amelioration of homelessness:

1. Ensuring affordable coverage for everyone,
2. Ending barriers to those with pre-existing conditions,
3. Protecting families from bankruptcy, and
4. Investing in prevention and wellness.

National Council Priorities: Embracing the spirit of these principles, the National Health Care for the Homeless Council offers the following six priorities. The National Council continues to support the concept of comprehensive system-wide reform expressed through H.R. 676, *The Expanded and Improved Medicare for All Act*. Since the current debate is far more incremental in nature, this analysis focuses primarily upon leading proposals under serious consideration by Congress. The following reform priorities and analysis reflect the priorities of the National Council and the provisions contained in the House Leadership bill, the *Affordable Health Care for America Act* (H.R. 3962) and the Senate Leadership bill, the *Patient Protection and Affordable Care Act* (H.R. 3590).

1. Expand Medicaid

National Council Priority: Health Care for the Homeless projects served nearly 1 million patients in 2008. At least 70% of these individuals are uninsured, and only 22% receive Medicaid. Expanding the current Medicaid system to include all low-income adults at or below 200% of the federal poverty level (thereby removing categorical eligibility requirements) would ensure that vulnerable adults receive the comprehensive services necessary to prevent and end homelessness. Such a measure also would streamline the Medicaid program, remove difficult-to-navigate eligibility categories, and reduce state-by-state variances in coverage.

Provisions of the current legislation: The House bill establishes eligibility for Medicaid at 150% of FPL (~\$16,000 for an individual), and the Senate Leadership bill establishes eligibility at 133% of FPL (~\$14,400 for an individual). Both bills create uniform income thresholds and remove unwieldy categorical requirements. The Congressional Budget Office (CBO) estimates that roughly 15 million additional individuals will qualify for Medicaid when eligibility is set at 150%. Such an expansion would provide coverage for the majority of those experiencing homelessness and could prevent homelessness for the lowest-income Americans. It is imperative that Medicaid expansion occur as soon as possible, and not be delayed. The House and Senate proposals would not allow for expansion until 2013 and 2014, respectively, which is far too late for the millions in need of insurance now.

These changes extend only to those who can prove U.S. citizenship or are legal immigrants in the country for at least five years. Hence, two groups will continue to have problems accessing health care coverage: those who are U.S. citizens but lack proper documentation (often people who are homeless), and those who are not legally present in the country (or have not been legally present long enough). None of the proposals change the documentation requirements needed to prove citizenship, which are often difficult for homeless individuals to afford and navigate.

The proposed expansion would be partially federally funded under the House and Senate proposals for newly eligible enrollees. States are required to maintain current eligibility levels (to prevent current recipients from losing benefits). In the House proposal, starting in 2014, some children covered under the Children's Health Insurance Program (CHIP) will be transitioned to Medicaid. The expansion eliminates current eligibility disparities among states; this will be more equitable and more efficient. Currently, only six states cover childless adults (and 18 others have limited Medicaid programs for childless adults). Under current laws, states expend tremendous resources to determine whether an individual meets criteria that match up with allowable categories. The CBO estimates that the House bill will increase state spending on net by about \$34 billion over the next 10 years, if Medicaid is expanded to 150% of FPL with federal financing.

2. End the 2-Year waiting Period between Disability and Receiving Medicare

National Council Priority: Federal law requires that people with disabilities must first receive SSDI for 2 years before becoming eligible to receive Medicare. Nearly 2 million people with established disabilities fall into this waiting period. While originally intended to keep costs down and encourage continued private insurance coverage, nearly 39% of those waiting for Medicare are uninsured at some point during that waiting period, and 24% have no health insurance for the entire time. Because the average time to establish SSDI can take a year or more, individuals with disabilities often wait three or more years before being able to qualify for health care. Ending the two-year waiting period would be a solid step toward ensuring appropriate health services are available to people with proven disabilities.

Provisions of the current legislation: Neither of the current health reform proposals contain a provision to end this waiting period; however, the policy options originally drafted by the Senate Finance committee phased out or reduced the two-year waiting period (it is not included in its current version). In order to ensure individuals with proven disabilities are not left without insurance, this provision should be returned to the active proposals.

3. Ensure Health Care is Affordable for All

National Council Priority: Poor health, lack of access to health services, and escalating medical costs are primary causes of homelessness. In 2007, 62% of all personal bankruptcies were due to medical debt, a two-fold increase over 2001 rates.¹ In order to prevent the downward spiral of illness, loss of employment and subsequent loss of housing, it is critical to ensure that health care is affordable for everyone.

Provisions of the current legislation: For those who do not qualify for the expanded Medicaid, the House and Senate bills includes premium credits and cost-sharing assistance on a sliding scale for households up to 400% of FPL (~\$43,000 for an individual) to offset the purchase of insurance. Fines would be assessed on those without insurance under both proposals.

4. Fund Medical Respite and Supportive Services within Housing Programs

National Council Priority: Both medical respite and supportive housing programs have been proven to reduce high end health care and other service utilization, show better personal outcomes, and fill a gap in needed community services. However, there are no reliable funding sources through Medicaid or other programs to fund case management, which is critical to ensuring successful follow-up for individuals. The National Council strongly advocates for creating these funding mechanisms so that programs are sustainable and able to be more widely implemented, and so that clients are able to receive more comprehensive services.

Provisions of the current legislation: The House and the Senate proposals add a reimbursement structure for incentives for case management, care coordination, and discharge activities and programs to prevent hospital readmission. These activities are central to both medical respite and supportive housing programs.

5. Support the Health Center Program

National Council Priority: Last year, Congress unanimously passed the Health Care Safety Net Act of 2008, which reauthorized the Community Health Center (CHC) program (Section 330 of the Public Health Service Act, including the HCH program) for five years. The HCH Program currently supports over 200 HCH projects throughout the U.S., serving nearly 1 million individuals in 2008—a sizable number but far below the 3.5 million Americans who annually experience homelessness, as reported by the Urban Institute. In FY 2009, Congress appropriated \$2.2 billion for CHCs, including \$191 million (8.7%) for the HCH program. We urge Congress and the Administration to strengthen and expand community health centers and appropriate sufficient funds to meet the growing need. Additional funds for all Health Center programs would enable Health Centers to provide primary care and related services to a growing number of uninsured people, including those who are experiencing, at risk of, or in transition from homelessness. Additional funds for the Health Care for the Homeless program would assist grantees to care for more people experiencing homelessness, maintain financial viability, expand addiction and mental health services, and develop medical respite care arrangements.

Provisions of the current legislation: The House bill authorizes dedicated appropriations to a new Public Health Investment Fund, which would disperse the funds for community health centers, workforce development,

¹ Himmelstein, D., Thorne, D., Warren, E., and Woolhandler, S. (2009). Medical Bankruptcy in the United States, 2007: Results of a National Study. *American Journal of Medicine* 122 (8), 741-746.

and service delivery. The bill authorizes \$34 billion in appropriations for this Fund over the next 5 years. While this amount would still need to be approved through annual Congressional appropriations, it is helpful to have a guaranteed funding source. The Senate bill quadruples funding levels to \$8.3 billion for Federally Qualified Health Centers (FQHCs) between FY 2010 and FY 2015, and increases flexibility about the location of such entities.

6. Increase Network of Health Care Providers

National Council Priority: In order to meet the health needs of individuals experiencing homelessness (and those of the general public), it is imperative there be an adequate health care workforce trained and available to provide quality services.

Provisions of the current legislation: Both the House and Senate bills allocate significant investments over the next 10 years to the National Health Service Corps Program and related funds toward scholarship and loan repayment programs, primary care education and training programs, recruitment and retention programs, and nursing workforce development. The Senate proposal includes Medicare bonus payments for primary care doctors, increases graduate medical education training, and provides demonstration grants for education, training and certification programs.

The House legislation also increases Medicaid payments to primary care physicians and practitioners for primary care services to 100% of Medicare rate levels by 2012 through 2014 (federally financed), 90% thereafter. This in turn expands the base of service providers and access to care because patients will be better able to find a provider willing to see them. Currently, Medicaid reimbursement for primary care providers is 66% that of Medicare, which discourages providers from seeing Medicaid patients.

H.R. 676: The National Council's Preferred Health Care Reform Mechanism

H.R. 676, the *Expanded and Improved Medicare for All Act*, establishes a single payer system for health care. Single payer is a streamlined financing mechanism where one entity administers the health care funding and payments, but not the services. It expands the cost-effective and administratively efficient Medicare program to cover everyone in the United States. Health care services and delivery (such as hospitals and doctors) remain private and patients are guaranteed choice of care from providers. A single payer plan would address all the principles set out by the President as well as those priorities held by the National HCH Council.

Conclusion

As the health care debate continues, details of the current legislative proposals will certainly change. Substantial, comprehensive reform to the existing health care system is required in order to ensure that all people have access to health insurance. Incremental changes will not yield healthier Americans, nor will they control the costs that are bankrupting individuals as well as the system itself.