Reaching Vulnerable Populations through Health Reform

The Affordable Care Act (ACA) has the potential to dramatically improve rates of health insurance coverage for low-income Americans, including many vulnerable populations. In states that are opting to expand Medicaid, people with incomes up to 138 percent of poverty ($16,105 for a single adult in 2014) may enroll with little or no cost sharing. Individuals and families with household incomes between 100 and 400 percent of poverty ($11,670 to $46,680 for a single adult in 2014) are eligible for subsidies to purchase affordable coverage.[1]

Although the federal government and a number of states have launched marketing efforts to educate Americans about coverage options under the ACA, vulnerable populations with traditionally poor access to health care may have missed the March 2014 enrollment deadline. Those that missed the deadline may apply for Medicaid or the Children's Health Insurance Program at any time, or for marketplace coverage outside of an open enrollment period if they experience a qualifying life event (e.g., getting married, having a baby, or leaving prison). This fact sheet highlights particularly vulnerable populations that could benefit from insurance coverage, but may have trouble getting access. It suggests opportunities to connect these individuals to coverage with an eye toward the next open enrollment period.

Racial and Ethnic Minority Populations

Uninsurance rates among minorities are higher than rates among the non-Hispanic white population. A large proportion of uninsured minorities are eligible for Marketplace tax credits and Medicaid or CHIP in states that expand Medicaid, but awareness of sources of coverage is low, especially among Hispanics.[2,3] Improving awareness and securing health coverage is particularly important for individuals in minority groups who experience disproportionate rates of illness, premature death, and disability compared to the general population.[4] Organizations working with uninsured racial and ethnic minorities (e.g., charity care organizations) could facilitate connections to health insurance by steering individuals toward coverage that fits their health needs and by building health literacy.[5] One such organization, HealthCare Access Maryland, found success during the last open enrollment period partnering with 17 regional organizations[6] to ensure that navigator staff conducted tailored outreach to specific populations in a culturally sensitive manner.

Uninsurance by Race, 2012

Race	Rate (percent)	Number (millions)
Non-Hispanic White	11	21.6
Black	19	7.6
Asian	15	2.5
Hispanic	29	15.5

Source: U.S. Census Bureau (2013). "Income, Poverty, and Health Insurance Coverage in the United States: 2012." Available at http://www.census.gov/prod/2013pubs/p60-245.pdf

Homeless Individuals

Depending on a state's decision to expand Medicaid, virtually all of the estimated 610,000 individuals nationally who are homeless[7] could be eligible for Medicaid. Outreach to this population is difficult, and complicated by high rates of mental illness (30%) and co-occurring substance use problems (50%).[8] Therefore, enrollment outreach will likely be more successful when paired with treatment or social service activities. Mobile technology to perform on-the-spot enrollment may also benefit this population, as has been shown by outreach workers with the Chicago Coalition for the Homeless.[9] Once connected to coverage, this population could benefit from the ACA's health homes provision (Section 2703), which provides funding for Medicaid to integrate physical and behavioral health. Medicaid programs that link care management with supportive housing can help reduce the use of crisis and inpatient services and improve outcomes for chronically homeless individuals.[10]

The Jail-Involved Population

Approximately 10 million individuals are released from jails across the country each year, a population that is disproportionately young, male, minority, and poor, with low levels of education.[11] Mental illness and

substance use disorders are prominent health conditions for this population—63 percent of men and 75 percent of women entering jails exhibit symptoms of a mental health disorder.[12] Alcohol plays a role in more than 50 percent of incarcerations and illicit drugs in more than 75 percent.[13] The overwhelming majority of individuals released from jails have no health insurance, but an estimated 25 to 30 percent of those released may be eligible in states that expand Medicaid.[14] Connecting this population to coverage and needed mental and physical health services could improve health and reduce recidivism. States may choose to expand outreach and enrollment activities to jails and other criminal justice institutions, such as courts and booking centers, and take advantage of enhanced funding to upgrade eligibility and enrollment systems to facilitate these efforts.[15] In Connecticut, discharge planners work with all jail and prison inmates and parolees to help individuals fill out a shortened form of Medicaid application. The state Medicaid agency can also access daily electronic feeds from the Department of Corrections to allow the state to quickly "switch on" benefits upon an inmate's release.

Veterans

There are roughly 1.3 million uninsured veterans in the United States under age 65, of which approximately 40 percent have incomes that could qualify them for Medicaid under the ACA's expanded coverage.[16] Low-income veterans who are eligible for Medicaid may also be eligible for free or low-cost health care from the Department of Veterans Affairs (VA). In general, family members of veterans are not covered by the VA, but may seek coverage through Medicaid or the marketplace. Because of multiple sources of coverage available to veterans and the differences in coverage options for veterans and their families, education and guidance when choosing coverage is critical. Navigators and consumer assistance programs could be educated on the health concerns of veterans and their families and where services are available, to match individuals to the most appropriate source of coverage. Enhanced data matches between coverage programs (e.g., the Department of Defense, the VA, state Medicaid, and marketplaces) could also facilitate appropriate enrollment.

As states learn which segments of the previously uninsured population have signed up for coverage in the first open enrollment period, engaging consumer assistance programs, Medicaid and commercial health plans, and other coverage systems to identify gaps and share best practices will help maximize outreach to the remaining "left behind" populations in the months and years ahead.

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