

Public Health in Emergency Medicine



BARRIERS TO HOMELESS PERSONS ACQUIRING HEALTH INSURANCE THROUGH THE AFFORDABLE CARE ACT

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Abstract—Background: Medicaid expansion under the Affordable Care Act (ACA) is intended to provide a framework for increasing health care access for vulnerable populations, including the 1.2 million who experience homelessness each year in the United States. **Objective:** We sought to characterize homeless persons' knowledge of the ACA, identify barriers to their ACA enrollment, and determine access to various forms of communication that could be used to facilitate enrollment. **Methods:** At an urban county Level I trauma center, we interviewed all noncritically ill adults who presented to the emergency department (ED) during daytime hours and were able to provide consent. We assessed access to communication, awareness of the ACA, insurance status, and barriers preventing subjects from enrolling in health insurance and compared homeless persons' responses with concomitantly enrolled housed individuals. **Results:** Of the 650 enrolled subjects, 134 (20.2%) were homeless. Homeless subjects were more likely to have never heard of the ACA (26% vs. 10%). "Not being aware if they qualify for Medicaid" was the most common (70%) and most significant (30%) barrier to enrollment reported by uninsured homeless persons. Of homeless subjects who

were unsure if they qualified for Medicaid, 91% reported an income < 138% of the federal poverty level, likely qualifying them for enrollment. Although 99% of housed subjects reported access to either phone or internet, only 74% of homeless subjects reported access. **Conclusions:** Homeless persons report having less knowledge of the ACA than their housed counterparts, poor understanding of ACA qualification criteria, and limited access to phone and internet. ED-based outreach and education regarding ACA eligibility may increase their enrollment. © 2015 Elsevier Inc.

Keywords—emergency medicine; emergency department; homeless; health insurance; Affordable Care Act; ACA; access to care; uninsured; underinsured; managed care; health systems; health disparities; health policy; Medicare; utilization

INTRODUCTION

Homeless persons are a medically vulnerable population with a high burden of disease and an average life expectancy of only 41 to 47 years compared with the national average of 78 years (1,2). Lack of health insurance in this population leads to their greater use of the emergency department (ED), often as their only health care access point, which in turn can contribute to ED overcrowding and higher overall costs of care (3,4).

Medicaid expansion under the Affordable Care Act (ACA) was enacted at the start of 2014 and is intended

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to provide a framework for increasing health care access for vulnerable populations, including the 1.2 million who experience homelessness each year in the United States (5–7). Opening the door to clinics and other health care access options outside of the ED, the ACA may offload the ED directly (1). It may also indirectly affect homeless persons' presentations to the ED by improving access to primary care and preventive care services (1,3,8).

Any potential benefits of the ACA on improving health care access and outcomes for homeless persons and decreasing use of the ED, however, require that individuals actually enroll in the program and acquire health insurance coverage. Even before the widely publicized ACA, Healthcare for the Homeless reported that 10% to 50% of their homeless clients were eligible for Medicaid but had not enrolled (9). The reasons for homeless persons' nonenrollment have not been clearly delineated—it is possible that many of them simply have not heard of the ACA and opportunities for acquiring health care coverage (8–10).

Marginalization and lack of continuity of care make the homeless population a difficult group to assess from an overall medical needs and public health standpoint (5–8). Serving as their central (and often only) health care access site, the ED is uniquely suited to evaluate their health care knowledge and needs during real-time presentations (3,10). The objectives of this ED cross-sectional study were to characterize homeless persons' knowledge of the ACA, identify barriers to ACA enrollment, and assess their access to various forms of communication that could be used to facilitate their enrollment. We compared these assessments of homeless persons with concomitantly enrolled housed individuals.

METHODS

Study Design, Participants, and Setting

We conducted this cross-sectional survey-based study at an urban county ED, San Francisco General Hospital, during a 10-week period (June to August 2014). During these 10 weeks, all adult patients in treatment areas of the ED between 9 AM and 5 PM Monday through Friday were considered for enrollment. We excluded from the survey patients with any of the following: intoxication, altered mental status, critical injury or critical illness, incarceration, psychiatric holds, under the age of 18 years, inability to understand an English-language survey, and temporary visitation from another country. We obtained institutional review board approval before study initiation and scripted verbal consent from all study subjects.

Survey Instrument

With the help of health literacy experts and after reviewing prior work in this field, we developed a 30-question survey that assessed access to communication, awareness of the ACA, insurance status, and barriers individuals face when considering acquiring health insurance. All answers to survey questions were self-reported, including demographic data and housing status. We defined "homelessness" as lack of stable housing for the previous 2 months, as has been used in previous studies (11). This definition included couch surfing, sleeping at a shelter, sleeping outside, and sleeping in their car, as well as any other form of unstable housing.

The survey instrument included 11 yes/no/not sure questions (e.g., Do you have health insurance?); 3 analog scale questions (On a scale in which 0 = not difficult and 10 = extremely difficult, how difficult was it to obtain health insurance?); 5 other numeric-answer questions (How many days a week do you have access to the internet?); 10 multiple-choice questions (What type of health insurance do you have?); and 2 questions addressing barriers to enrollment in health insurance (multiple choice and free text). See [Appendix A](#) for the full survey instrument.

We pilot-tested the survey on 10 homeless patients to gauge their understanding of the questions and check for survey response consistency by having two different researchers interview each patient with a gap of 2 h between surveys. The κ -statistic of agreement for the five key survey responses was 1.0 (100% agreement). Before the administration of surveys, we gave research personnel a 4-h training session to ensure standard interview technique. Throughout the 10-week study period, we conducted weekly meetings with study personnel and random audits of survey data.

Before the study, we performed a sample size calculation that was driven by the desired width of the 95% confidence intervals (CIs) around the expected point estimate of the proportion of homeless patients who would know about the ACA. We estimated that 30% would know about it and calculated the need to enroll approximately 127 homeless patients to attain the desired 95% CI width of 8% surrounding this point estimate. We managed data using Research Electronic Data Capture (RedCAP), hosted by the University of California, San Francisco (12). We summarized and reported demographic data in aggregate form and calculated frequency percent, means, mean differences with 95% CIs, medians, and interquartile ranges (IQR) using STATA software, version 9.0 (College Station, TX).

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