

CLOSE THE COVERAGE GAP

Close the coverage gap through expanded eligibility/availability of Medicaid and other publicly funded insurance options.



STRATEGY 1

Advocacy and lobbying and other forms of citizen and voter engagement to advance policies that close the coverage gap.

This strategy is designed to increase advocacy and policy efforts at the local and state levels to make Medicaid and other forms of public support available to individuals who are not currently insured (such as VA Health Care; the Children's Health Insurance Program (CHIP), and Medicare). Most pressing is closing the coverage gap for individuals who do not qualify for Medicaid or for federal subsidies to lower the cost of health insurance through the Federally-Facilitated Marketplace.

The Kansas Health Institute reported (February 2014) that approximately 182,000 Kansans fall into this eligibility gap; about 78,000 of them uninsured. Nearly half (47 percent) of Kansans in the gap are also employed. These individuals are between 33 and 100 percent of the Federal Poverty Level (FPL).

In Missouri, more than 260,000 workers with low wages who earn up to 138% of the FPL cannot qualify for Medicaid. Under today's rules in Missouri, childless adults are unable to qualify for basic health care through Medicaid; a single parent of two cannot qualify if she/he makes more than \$3,504 per year – just 18% of FPL.

In both states, adults without children are not eligible for Medicaid except in the case of frail elderly and disabled adults. Individuals between 100- 138% of FPL have two options for health insurance: Medicaid or private health insurance. Federal premium tax credits are available through the health insurance marketplace to consumers who are between 100-400%.

STRATEGIC FOCUS

Invest in direct lobbying and grassroots lobbying, community organizing and actions to raise awareness and educate consumers, and collaborative efforts and coalitions that developed shared strategies to influence policy to expand Medicaid. REACH also will invest in citizen and voter engagement strategies that adopt an integrated voter engagement approach (Refer to Funders' Committee for Civic Participation).¹

¹ Funders' Committee for Civic Participation and Proteus Fund report on the Voter Engagement Evaluation Project. See following reports:

<http://funderscommittee.org/files/files/media/resources/VEEP-FINAL.pdf>

http://funderscommittee.org/files/fccp_integrated_voter_engagement_case_studies_2009_final.pdf

<http://www.washingtonpost.com/blogs/monkey-cage/wp/2014/11/25/engaging-voters-can-kickstart-community-activism/>

TARGET POPULATION

This strategy is designed to impact the most disconnected and marginalized populations in our service area (e.g., rural and urban uninsured, persons living in poverty, migrant workers, homeless individuals and families, and most importantly, individuals who are working but have no access to health insurance). In REACH's service area, 2013 American Community Survey data indicate that 212,503 individuals were uninsured. Of the uninsured, 46% were unemployed, 26% were employed making less than \$25,000 annually, and 21% were employed with income less than 50,000. About 18% were not US citizens. MARC estimates that if Medicaid expansion up to 138% of the FPL were to occur in our service area the uninsured rate would drop at least 3% and as high as 6% in the different REACH counties.

BARRIERS THE STRATEGY ADDRESSES

The primary barrier this strategy addresses is inequitable access to health insurance coverage for people of color and other vulnerable populations such as the unemployed, undocumented, under-educated (i.e., without a high school diploma) and persons living in poverty. In its 2015 report on the health status of Greater Kansas City residents, MARC notes that by the end of 2013 the populations most likely to be uninsured in the Kansas City MSA included non-citizens (54% uninsured), the unemployed (46% uninsured), Latinos (34%), those who are under-educated (33%), living below the Federal Poverty Level (30%), part-time employees (26%), and African-American (20%). White, non-Hispanics in Kansas City were the least likely to be uninsured (9% uninsured).

This barrier is reinforced by resistance from state government leaders to consider Medicaid expansion in Kansas and Missouri. Restrictions on Medicaid eligibility in Kansas and Missouri and the resulting coverage gap that blocks access to subsidies on the health insurance marketplace contribute to a highly disenfranchised segment of the population in the REACH service area. Studies of the uninsured in Kansas and Missouri indicate that the majority of consumers in the coverage gap are living below the federal poverty level and are employed but in jobs that don't provide affordable health coverage. The coverage gap in states not expanding Medicaid disproportionately affects poor, uninsured childless Black adults.¹ Parents' access to health coverage also increases the likelihood that their children will be able to secure stable health care.²

¹ Kansas Health Institute. http://kff.org/disparities-policy/issue-brief/the-impact-of-the-coverage-gap-in-states-not-expanding-medicaid-by-race-and-ethnicity/?utm_campaign=KFF%3A+The+Latest

² L. Ku and M. Broaddus (Oct, 2006). *Coverage of parents helps children, too*. Washington DC: Center for Budget and Policy Priorities.

RATIONALE/SUPPORTING EVIDENCE FOR STRATEGY

The Kaiser Family Foundation reports that “people of color face longstanding and persistent disparities in accessing health coverage that contribute to greater barriers to care and poorer health outcomes.”¹ “Medicaid expansion offers a new pathway to increase health coverage among people of color. Overall, more than four in ten (41%) uninsured adults of color would be eligible for Medicaid (based on income, immigration status, and age) if all states adopted Medicaid expansion, comparable to the share of White uninsured adults who would be eligible. If all states expanded Medicaid, nearly six in ten (57%) uninsured Black adults would be eligible, but only about a third (34%) of uninsured Hispanic adults, reflecting the fact that a greater share would not qualify based on their immigration status.”¹

Medicaid expansion is far from a certainty in Kansas and Missouri given political opposition. REACH's approach is to engage policy advisors on this issue and support the work of advocacy organizations and state and local Medicaid coalitions to build awareness and urgency at the local and state levels, and collaborate with funders, business groups, Medicaid experts and health advocacy consulting firms to better address the issue with lawmakers and government leaders.

REACH will use Community Catalyst's Medicaid Expansion Campaign Planning Guide as a tool to plan with community partners and tailor strategies to the political environment.

¹ Kansas Health Institute. http://kff.org/disparities-policy/issue-brief/the-impact-of-the-coverage-gap-in-states-not-expanding-medicaid-by-race-and-ethnicity/?utm_campaign=KFF%3A+The+Latest

DEFINITIONS

ADVOCACY: Defined as any action that speaks in favor of, recommends, argues for a cause, supports or defends, or pleads on behalf of others.

DIRECT LOBBYING: Defined as communication with a legislator, an employee of a legislator or legislative body, or any covered executive branch or other government employee who may participate in the formulation of legislation.

GRASSROOTS LOBBYING: Enlisting the public to contact legislators about particular policy or legislation. A communication constitutes grassroots lobbying if it refers to specific legislation, reflects a view on that legislation

and encourages the recipient of the communication to take lobbying action, referred to as a call to action.

CITIZEN AND VOTER ENGAGEMENT: Programs and strategies to engage citizens and activate voters around key health and fiscal policy issues central to access to insurance coverage and care.

COVERAGE GAP: Medicaid eligibility for adults in states not expanding their programs is quite limited: The median income limit for parents in 2015 is just 44% of poverty, or an annual income of \$8,840 a year for a family of three, and in nearly all states not expanding, childless adults will remain ineligible. Further, because the ACA envisioned low-income people receiving coverage through Medicaid, it does not provide financial assistance to people below the FPL. As a result, in states that do not expand Medicaid, many adults fall into a “coverage gap” with incomes above their state’s Medicaid eligibility limits but below the lower limit for marketplace premium tax credits.

PUBLICLY FUNDED HEALTH INSURANCE PROGRAMS: Includes Medicare, Medicaid and other medical assistance programs, VA Health Care; the Children’s Health Insurance Program (CHIP); and individual state health plans.

MEDICARE is a federal program that helps pay health care costs for people age 65 older, and for some individuals under age 65 with long-term disabilities.

MEANS-TESTED HEALTH CARE: One method for targeting services and resources to a population of consumers. Means testing is an administrative mechanism for assessing a person’s or a family’s eligibility to receive benefits, based on income or other income-related characteristics of an individual or family.

MEDICAID OR MEDICAL ASSISTANCE is any kind of government-assistance plan for those with low incomes or a disability.

CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP) is a state-level program providing health care to low-income children whose parents do not qualify for Medicaid.

STATE-SPECIFIC PLANS: Some states have their own health insurance programs for low-income, or for high-risk, uninsured individuals. These health plans may be known by different names in different states.

VA HEALTH CARE is a Department of Veterans Affairs program that provides medical assistance to eligible veterans. Those who have ever used or enrolled in VA Health Care are considered covered to have VA coverage.

INDIAN HEALTH SERVICE (IHS) is a health care program through which the Department of Health and Human Services provides medical assistance to eligible American Indians at IHS facilities. In addition, the IHS helps pay the cost of selected services provided at non-IHS facilities.

FEDERAL POVERTY LEVEL (FPL): A measure of income level issued annually by the US Department of Health and

INDICATORS OF EFFECTIVE IMPLEMENTATION

1. Increase number of legislators willing to support Medicaid expansion,
2. Securing hearings in legislative committees,
3. Increase in favorable votes among legislators,
4. Inclusion in the Governor’s budget in either or both states, and
5. Ultimate passage of legislation that effectively closes the coverage gap.

TARGET GOAL

Reduce the percentage of uninsured in the foundation’s service area from 11% in 2014 to less than 5% by 2020.

CLOSE COVERAGE GAP

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STRATEGY 2

Research and analysis to inform policy, and engage voters and policymakers regarding health coverage and population health.

This strategy is designed to produce unbiased, high-quality research and analysis in the public domain to inform health and fiscal policy decisions of lawmakers and policymakers and guide advocates' work in engaging voters in health policy discussions that affect consumers in REACH's service area.

STRATEGIC FOCUS

Engage policy analysts and community research and evaluation organizations to produce nonpartisan research, evaluation and studies that can inform state and local policy discussions and governmental actions. Fact-based policy research is essential for elected and government leaders, advocates and voters concerned with fiscal policy, health and mental health services, and related issues affecting consumers in our service area.

TARGET POPULATION

This strategy is designed to impact residents within the REACH service area who are affected by the health, human service and tax policies and legislation produced in the state capitals. This strategy is designed to 1) Provide a counterpoint to partisan information used to influence voters and legislators; 2) Provide fact-based research and analysis for legislators seeking to make informed policy decisions; 3) Educate voters on issues and how to take action; and 4) Inform advocates' campaign strategies.

BARRIERS THE STRATEGY ADDRESSES

1. Lack of reliable and valid information to inform the work of legislators and advocates.
2. Lack of nonpartisan source material for media outlets.
3. Lack of resources and information that can help to frame arguments in support of or opposition to proposed policy solutions.

RATIONALE/SUPPORTING EVIDENCE FOR STRATEGY

Harvard University professor Jennifer Hochschild writes "A democracy falters when most of its citizens are uninformed or misinformed, when misinformation affects political decisions and actions, or when political actors foment misinformation—the state of affairs the United States faces today. Hochschild and Einstein¹ start with Thomas Jefferson's ideal citizen who uses correct information to make policy or political choices. The authors ask, what are the consequences if citizens are informed but do not act on their knowledge? More seriously, what if they do act, but on incorrect information?" Hochschild and Einstein maintain that citizens' use of incorrect "knowledge" poses a threat to a democratic political system and emphasize the value of a well-informed electorate to a successful democracy.

¹Hochschild JL, Einstein KL. *Do Facts Matter?: Information and Misinformation in American Politics*. Norman, OK: University of Oklahoma Press; 2015.

DEFINITIONS

RESEARCH: In the broadest sense of the word, the definition of research includes any gathering of data, information and facts for the advancement of knowledge; and careful study and investigation for the purpose of discovering and explaining new knowledge.

POLICY: A course or principle of action adopted or proposed by an organization or individual, as in “the government’s controversial economic policies” or “it is not company policy to dispense with our older workers.”

POLICYMAKER: A person responsible for or involved in formulating policies, especially in politics.

ADVOCATE: someone who fights for something or someone, especially someone who fights for the rights of others.

INDICATORS OF EFFECTIVE IMPLEMENTATION

1. Production of the Foundation’s Regional Health Assessment every other year and annual updates to the County Health Profiles.
2. Continued development of an online data warehouse initiated in 2015 in conjunction with the Regional Health Assessment.
3. Development of health-related, state fiscal, tax and budget analyses produced by statewide policy organizations and institutes associated with national nonpartisan think tanks.
4. Continued implementation of the Health Opportunity Mapping for Equity (hot-spotting) initiative to secure additional data regarding ED utilization and super-utilizers to target policy interventions at the local level.
5. Distribution of nonpartisan policy briefs, data summaries and other appropriate research and analyses to inform policymaking, advocacy, and foundation decision making.

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STRATEGY 3

Partnerships to identify, research, test and create new coverage and care opportunities for those who remain uninsured or underinsured.

This strategy is designed to engage and support partnerships with business, government, foundations, insurers, the faith community and other stakeholders that seek to identify or create alternative coverage and access to care opportunities for populations who will likely remain uninsured or underinsured due to their special circumstances (e.g., alternatives to Medicaid expansion, expanded eligibility under existing state programs, health savings account incentives). This includes low-income, hard-to-reach and highly vulnerable populations that remain ineligible for publicly funded health insurance programs due to financial situation or other circumstance.

STRATEGIC FOCUS

Examine community, state-based and systems-level efforts across the US to provide affordable health coverage to aspiring citizens and other highly vulnerable populations through robust partnerships. Priority populations include undocumented immigrants, refugees, children aging out of foster care and homeless persons.

Also considered for support will be safety net health care organizations providing culturally appropriate integrated care (primary care, mental health and oral health care) as part of a recognized patient-centered model of care, and/or provider organizations whose patient population are comprised of a large percentage of uninsured immigrant and other highly vulnerable populations.

TARGET POPULATION

This strategy is designed to impact some of the most disconnected and marginalized populations in our service area; e.g., undocumented immigrants, refugees, homeless individuals and families, and children aging out of foster care. Due to the nature of the circumstances and mobility of these populations, accurate data and benchmarks are difficult to establish. REACH's partner, the Mid-America Regional Council, has estimated the broad outlines of the undocumented, uninsured population in the REACH service area:

The 2013 American Community Survey data indicated that 212,503 individuals were uninsured. Of the uninsured, 46% were unemployed, 26% were employed making less than \$25,000 annually, and 21% were employed with income less than 50,000. About 18% were not US citizens. After open enrollment period 2 (fall 2014-winter 2015), the best estimates of uninsurance rates in the REACH service area suggest that approximately 145,000 individuals remain uninsured (212,500 uninsured in 2013 – 67,215 enrollees in 2014 and 2015 = 145,285). Of these 145,000, MARC estimates that approximately 21,165 are undocumented immigrants.

BARRIERS THE STRATEGY ADDRESSES

The primary barrier this strategy addresses is access to publicly funded programs for highly vulnerable populations due to federal and/or state regulations and restrictions, or as a result of disengagement and disenfranchisement from traditional health and human service systems and organizations. Undocumented and legal immigrants face specific exclusions that prevent them from

accessing benefits available within Medicaid and as part of the Affordable Care Act. Medicaid coverage is very limited among the homeless population because non-disabled, childless adults are not eligible for the program. This barrier is reinforced by resistance on the part of state government leaders to pass expansion of the Medicaid program in Kansas and Missouri. Consumers within these target populations are often distrustful of public systems and are reluctant to apply for assistance. Individuals who are eligible for publicly funded programs face additional problems in completing the Medicaid enrollment process, including language and literacy barriers, inconsistent contact information, inadequate documentation and lack of transportation.

RATIONALE/SUPPORTING EVIDENCE FOR STRATEGY

The Kaiser Family Foundation reports that nearly 40 million immigrants were residing in the US as of 2011, accounting for 13% of the total population.¹ Non-citizens are much more likely to be uninsured and have more limited access to care than citizens. They are less likely to have access to employer-sponsored coverage and are subject to eligibility restrictions for Medicaid and CHIP. Even under the ACA, lawfully-present immigrants are subject to a five-year waiting period for Medicaid. Lawfully-present immigrants are able to purchase coverage on the health insurance marketplace and receive tax credits without a waiting period, including those who are not eligible for Medicaid based on immigration status. However, undocumented immigrants are not eligible to buy health coverage through the marketplace and are not eligible for premium tax credits or other savings on marketplace plans.

Refugees are people who were persecuted in their countries because of their race, religion, nationality, political perspective or membership in a particular social group or political opinion. They are admitted to the US for protection and have a pathway to citizenship. Refugees who are admitted to the US meet the immigration status eligibility requirements for immediate access to Medicaid, the Children's Health Insurance Program (CHIP) and the health coverage options under the Affordable Care Act (ACA). Like other Americans, refugees can apply for health insurance through the health insurance marketplace. Prior to arrival in the US, the majority of refugees spend the greater part of their lives in refugee camps before repatriation or resettlement and have often been exposed to extreme poverty, trauma, violence and war. Limited resources and stress during residence in refugee camps can lead to a variety of acute and chronic diseases which frequently persist upon resettlement. Even after reaching their host country, many refugees do not regularly access health services due to barriers related to language and communication. Furthermore, cultural beliefs and experience with health care in their country of origin can affect refugees' expectations and willingness to access care, contributing to delayed care and affecting short- and long-term health.^{6,7,8}

Homelessness can create health problems and exacerbate existing ones. Conditions among people who are homeless are frequently co-occurring, with a complex mix of severe physical, psychiatric, substance use and social problems. High stress, unhealthy and dangerous environments, and an inability to manage chronic conditions due to lack of preventative care and prescription medications often result in visits to emergency rooms and hospitalization, which can worsen overall health. Therefore, those experiencing homelessness are three to four times more likely to die prematurely than their housed counterparts and experience a reduced life expectancy.^{2,3,4}

Youth ages 16 and older make up approximately 19 percent of all children in foster care. While many youth eventually return to their biological families or find another permanent home through adoption or guardianship, approximately 20,000 foster youth age out of the child welfare system nationally each year. The transition to adulthood is challenging for most adolescents, but for youth in foster care these challenges are compounded by instability. Many youth have spent years in the foster care system and experienced multiple placements and numerous disruptions to their schooling and access to health care. One study found that more than 30 percent of youth in foster care had eight or more placements with foster families or group homes. Sixty-five percent experienced seven or more school changes from elementary through high school. As a result, foster youth are often disconnected from family and social networks and a regular source of medical care. Approximately half of foster youth drop out of high school, limiting their ability to secure employment, obtain employer-sponsored health coverage and achieve self-sufficiency. Many foster youth have experienced trauma and multiple adverse childhood experiences (ACE's) and as a result face significant physical, developmental, behavioral, and mental health challenges.^{3,5}

Providing access to affordable health coverage to aspiring citizens and other highly vulnerable populations like the homeless and children aging out of foster care is an important step in helping individuals more fully integrate into

their communities. It facilitates their ability to obtain needed care, provides financial stability and supports their ability to work and focus on caring for themselves and their families. However, even with increased coverage, there is still a need for safety-net providers equipped to provide high quality and culturally competent care for newly insured immigrants and those who remain uninsured due to homelessness and other life circumstances.

¹Source: <https://kaiserfamilyfoundation.files.wordpress.com/2013/03/8279-02.pdf>

²Source: <http://kff.org/health-reform/report/medicaid-coverage-and-care-for-the-homeless/>

³Source: <http://www.nationalhomeless.org/factsheets/health.html>

⁴Source: http://www.nhchc.org/wp-content/uploads/2011/09/Hln_health_factsheet_Jan10.pdf

⁵Source: <http://www.nga.org/files/live/sites/NGA/files/pdf/0701YOUTH.PDF>

⁶Source: <http://www.cdc.gov/immigrantrefugeehealth/about-refugees.html>

⁷Source: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2778771/>

⁸Source: https://www.acf.hhs.gov/sites/default/files/orr/fact_sheet_refugees_and_the_affordable_care_act_508_8_27_13b_508.pdf

DEFINITIONS

UNDOCUMENTED IMMIGRANT: A foreign national residing in the US without legal immigration status. Includes persons who entered the US without inspection and proper permission from the US government, and those who entered with a legal visa that is no longer valid.

REFUGEE: Someone who, owing to a fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his or her nationality, and is unable to or, owing to such fear, unwilling to avail himself or herself of the protection of that country.

HOMELESS PERSON: An individual who lacks permanent or stable housing. May include an individual whose primary residence is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations; a resident in transitional housing, living on the streets, staying in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or individual who relies on friends and/or extended family members for accommodation.

CHILDREN/YOUTH AGING OUT OF FOSTER CARE: Children who reach adulthood without returning to their birth families or being adopted. Young adults who lack a parent or legal guardian are unable to take advantage of a provision in the ACA that allows 18- to 26-year-olds to remain on their parent's insurance.

INDICATORS OF EFFECTIVE IMPLEMENTATION

1. Identification, research and study of partnerships occurring in other areas of the country that have successfully addressed the unique coverage and access to care barriers of highly vulnerable populations, and which might be replicated in the REACH service area.
2. Expand existing or create new regional coalitions and partnerships comprised of business, government, foundations, insurers, the faith community and other stakeholders committed to identifying alternative coverage and access to care opportunities for highly vulnerable populations such as those who are undocumented immigrants, refugees, those who are homeless, and youth transitioning out of foster care.
3. Increased availability of culturally appropriate, high quality, integrated care within the safety net system.

TARGET GOAL

Reduce the percentage of uninsured in the foundation's service area from 11% in 2014 to less than 5% by 2020.