

“How Much Medical Care Do The Uninsured Use And Who Pays For It?”
Presentation of Findings and Implications
Wednesday, February 12, 2003

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[START TAPE]

JACK HADLEY: Thank you, Robin. Good morning,
everyone.

Before actually getting into the presentation, I'd like to start by thanking and acknowledging a lot of the people who helped us along the way, both with doing the work and putting together the article and the briefing.

And first and foremost, thank you to Diane Rowland for her leadership and guidance in putting this whole effort together and to the Kaiser Family Foundation for its financial support, and also for the collaboration and assistance of several Kaiser staff members. David Rousseau, Katherine Hoffman, Barbara Lyons, Rakesh Thing (Misspelled?).

I'd next like to thank John Eigelhart (Misspelled?) in Health Affairs and the Health Affairs editorial staff, Rob Cunningham, Don Metz, Drew Driesen (Misspelled?), Ron Gardener for working with us on a really very, very tight schedule to get the manuscript group reviewed and published. And without them, we wouldn't be here today.

And finally and especially, I'd like to thank my research assistant at the Urbanist Institute Mark Rockmore (Misspelled?), who's out here somewhere. Mark's the guy who rolls up his sleeves, gets down and dirty with the data, and produces all the numbers that we're going to show you today. So he's the ultimate author of all of this.

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How much medical care did the uninsured use and who pays for it? And we have two questions, two authors. I'll do the first question. And John's going to do the second question.

Before providing answers, however, I want to try to motivate why of these questions are important. They're basically two reasons. One is that the answers have implications, but the debate over expanding health insurance coverage. As proposals for expanding coverage are put forward in the next couple of years and their cause is debated, we believe it'll be very important to be able to distinguish new costs from cost transfers and to identify how much money - government money is already in the system and could potentially be reallocated to help support expanded insurance coverage.

The other reason is actually another question, does uncompensated care make up for the lack of health insurance? If it turns out that the uninsured in fact receive a lot of care from the healthcare safety nets, then maybe there's not so much of a problem here. And that would certainly be worth knowing as well.

Next slide, please? To help you get a better understanding of what this report is about, this hypothetical example illustrates both what a current financing system might look like and the consequences of moving to expanded insurance coverage.

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Let's suppose that column two in this chart, the one that's labeled term financing, represents the current system in which the uninsured do \$50 or receive \$50 worth of medical care to pay for \$20 if it's in cells. \$10 comes from private sources. And the final \$20 is subsidized by indirect government payments. They tax appropriations. So Medicare payments or something of that sort.

And then let's suppose just for example, as illustrated in column 3, that these people have insurance coverage, their total use of care would double to \$100. This coverage was say be subsidized through some sort of an insurance program that was financed by the government. So the government spending would increase to \$85. Private sources would go to \$0. And the uninsured would now spend only \$15 instead of \$20 for the care that they receive.

So what are the new costs and what are the transfer costs? By new costs, we mean the total increase in medical care spending received by the uninsured. And that would be the \$50 that's shown on the bottom row, back in column four.

Now government spending goes up by \$65, but of that \$65, \$15 represents cost transfers as opposed to new costs of the system. So the goal of this project is to triumph in the numbers in column two. So that as the proposals are put forward, that these numbers will provide a benchmark for assessing the classifications of alternative proposal for

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extending insurance coverage.

Now let me give you some definition, trying to keep clear what we're talking about. Uncompensated care, by uncompensated care we mean medical care that the uninsured received, but do not pay for fully themselves. And we use the term really quite broadly. It includes concepts or notions that you've heard in other settings, such as charity care or free care or bad debts of the uninsured, or reduced fee care.

But the basic idea is that full payment is not made by the uninsured themselves for the care that they received.

Now from providers' perspective, the cost of uncompensated care represents the difference between the payment that's received from the uninsured, that's the compensated part, and the cost of the resources used to provide that care.

Now the fact that those costs are not paid by the uninsured doesn't mean that they're not paid at all. Those costs are paid for out of providers' other sources of revenue.

Now for example, government payments, financial surplus, philanthropy. Those were rows two and three in the chart I showed you just a moment ago. Okay?

So in our analysis, we used two independent approaches determining uncompensated care costs. One approach focused on data collected from the uninsured themselves, specifically household survey data from the federal medical expenditure

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panel survey for the years 1996 through 1998.

The other approach looked at data collected from healthcare providers, hospitals, clinics, health centers and physicians. The reason we used two approaches is that neither source is totally comprehensive and unambiguous in identifying either the uninsured, the cost of their care or who pays for it.

Both approaches require making a lot of assumptions. By doing it two ways, we provide, we hope, a basic cross check of the validity of the assumptions that we have to make along the way.

Okay, now let me turn to the first approach next, which is based on the MEPS analysis. And this slide gives you really a very, very cursory summary of the approach here, the methodology that we use. There's more detail available in the Health Affairs web publication. And if you want the gory details, there's a longer version of this paper that I think is available in the back of the room and is also available on the Kaiser Foundation website.

But basically, we did three things, actually four. One of them didn't make it onto the slide. We updated prices to \$2001. Then we tabulated the payments from what MEPS costs, identified sources of payments, other than payments from the uninsured themselves and from identifiable or explicit insurance sources, such as Medicare or Medicaid or private

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The third part of the process was then estimating the value of care from private providers paid by unidentified sources. In the MEPS terminology, it's not a payment unless it's an identified source. But by working with information that they provide on charges for care, we were able to back out on estimates about other sources of financing that aren't measured explicitly by MEPS that we can infer from other information.

And the final step was to calibrate the MEPS to the national health account to adjust for limitations and differences in the MEPS sample sign and the way (INAUDIBLE)
7:39.

The next slide gives you some examples of identified sources of peril if you look at that. One more qualification before turning to the numbers themselves, these are national estimates. Specific patterns, distributions, sources vary from state to state, from community to community, and from institution to institution. So if you're thinking about, you know, your state, or your town, or your hospital, the numbers of the pattern there may be quite different from this. But at a national level, we believe that these numbers accurately reflect the sort of overall pattern of care being delivered.

Okay. So how much is spent? The pie chart on the left from the MEPS data, we estimated that just under \$100 billion,

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\$98.9 billion in total medical care was received by people who were uninsured for at least one month during the year. That is full year insured and part year insured.

The biggest piece of that pie is uncompensated care, which we estimated to be \$34.5 billion or 35 percent of the total value of the care received. The next largest piece is out of pocket payments, payments from the uninsured themselves, which is just over a quarter, \$26.4 billion. And then the two wedges that represent private insurance and public insurance, those were payments made on behalf of the people who have part year coverage in a more uninsured part of the year.

The bar on the right breaks out the sources of uncommon Medicare according to the MEPS approach to defining those sources.

And the next slide, we look at the full year uninsured only. And here, the pie looks quite different, not surprisingly. There's no insurance payments, other than a small piece to work for compensation.

For those who are uninsured for the full year, uncompensated care is just under \$25 billion and represents just over 60 percent of their total care, while out of pocket payments are 35 percent.

So these are the totals. Uncompensated care represents a lot of money, \$35 billion in 2001. Does it make up for the lack of insurance? If you look on the next slide, which is our

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estimates of per capita medical care used by insurance coverage, you see that the full year uninsured spend about or receive about half as much care as the full year privately insured. And those who are uninsured for part of the year, about three-quarters of them, like 25 percent less.

So it would seem that a pretty straightforward answer to our second sub question, does uncompensated care make up for the lack of insurance, at least in terms of medical care used, seems to be no.

Our second approach worked with data from providers. Hospital uncompensated care data came to the American Hospital Association's annual survey based on total unpaid bills reported by hospitals. And for clinics and government programs, we relied on budget reports and agency data reports, going through the process of first trying to identify how much of a budget was devoted to medical care, and then what share of that care was allocated or attributed to people without insurance coverage.

And then for physicians, we relied on physician surveys of times spent providing charity and reduce lead care, and then value that at some estimate of gross revenue per hour.

Going through that process, our second estimate was \$35.8 billion, about a \$1.5 billion more than we had estimated from the MEPS. Roughly two-thirds of that is for hospitals. And the balance is distributed pretty evenly between clinics

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and direct care programs and physicians.

So in some - in answer to the first question, how much medical care do the uninsured receive and how much is uncompensated care, we use very - two very different approaches, but they provide very consistent answers. And our conclusion is that the total amount of uncompensated care in 2001 was probably about \$35 billion.

So for the second question, who pays for it? I'll turn it over to John Holahan.

JOHN HOLAHAN: Okay, thank you, Jack.

So what I'm going to try to address is how much of this \$35 billion is paid for by the government, and where is it hiding? And it turns out it's hiding in a lot of different places. And none of those places directly provide you the information you want on how much of the dollars that are spent really go for the uninsured. We needed to make estimates. I can't go into all the details on the ways we made the estimates are available in the two reports.

This slide provides an overview. And then I'm get into it in a little bit more detail. But if you start at the top and go kind of clockwise, you start with Medicaid dish or supplemental - and supplemental payments are for payment limit programs.

And there, we estimate that the dollars there that go to the uninsured are \$7.6 billion federal, and \$2 billion

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state. Really, there's a lot more money in dish payments than upper payment limit programs than that. But if you net out the part that all of the rest, so you could really isolate the part that goes to the uninsured, we come out with \$7.6 federal and \$2 billion state. And I'll talk a little bit more about that in the next slide.

Federal and Medicare dish and INE, the indirect medical education spending we estimate share of that that goes to the uninsured is \$6.6 billion. And the amount that's there in the name of serving - known for adding dollars to the Medicare payment serving the population.

Going further over, federal and state direct service programs, these are a whole set of programs, community health centers, eternal and child health programs, veterans need health service, and so on, that do a lot of things. And part of what they do is to serve the uninsured. So what we try to do is isolate the share of their spending that goes to an uninsured population.

And spending state and local tax appropriations that go to a hospital, as well as payments for indigent programs, we estimate that to be \$7.4 billion. We're going to turn to the part that goes to hospitals. The largest share of that is Medicaid. And it's both dish and supplemental or upper payment limit programs. The federal share of dish we estimate the \$6.7. The state's share, \$1.7. The totals that are spent on

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dish are \$8.9 federal and \$6.7 state.

What we need to do is to net out the share of the federal dollars and the state dollars that go to mental hospitals, then net out the share of the state dollars that are intergovernmental transfers, that go from the hospital or the counties to the state, then returned back to the hospitals as part of the state's share of that payment.

Clearly, there's no additional state dollars in that transfer, and it's been a big source of the controversy around dish payments. And we've tried to net that out and only count the state general revenue contributions and dish payments.

We're able to do that because of a survey that we've done at the Urban Institute from the Kaiser Clinician on Medicaid and the uninsured that will be released soon. 38 states responded, giving us the kind of data that we needed to separate out the part that's going to hospitals and staying with hospitals, serving the uninsured.

Upper payment limit programs are similar kind of transfer, typically made with the intent of providing more dollars to public hospitals. The four of us that have the same program, a lot of the state money isn't really. It's really used to leverage a lot of federal dollars that sometimes stay for the hospitals and sometimes they don't.

So what we needed to do, again, a lot of these dollars go to nursing homes. We needed to net the share that went to

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nursing homes, net out the state dollars that are intergovernmental transfers, not general revenues and also net out the federal dollars that don't really stay with the hospitals that end up back in the treasury.

Again, relying on the Urban Institute survey, we think we're able to take a good shot at doing that. When we do that, we end up with \$900 million federal, \$300 million state. This is out of a total spending of \$6.6 federal and \$5 billion state.

So we're saying that most of that - of those dollars in those upper payment limit programs really don't stick with the hospital to provide care to the uninsured.

Then we look at Medicare, both dish payments and indirect medical education. Medicaid dish payments were originally intended to compensate hospitals for the additional costs of low income Medicare beneficiaries, CVO has shown, and I think others as well, that additional numbers of low income Medicare payments don't add much to cost per case. Really the justification for this has really become that it's needed to preserve access for Medicare beneficiaries to take to hospitals. So if we didn't have an uninsured population, those dollars wouldn't be needed.

The indirect medical education, again, data - the studies have shown that that adjustment overstates the amount that is needed to compensate hospitals for the cost of teaching

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that the rest goes to serve or to provide support for the broader mission of these hospitals, generally to provide care to the poor to support [unintelligible]

So it's estimated that from the third to a half of those dollars are not related to teaching. We took the mid point and come at it \$1.6 billion for IME and \$5 billion dish payment.

Then we looked at a state and local tax appropriations to hospitals. Most of these dollars go to providers to support uncompensated care. Come out with \$3.1 billion, another \$4.3 for state and local programs for care. Again, you needed to have an uninsured population [unintelligible] programs.

And then we took at stab at the estimates of private dollars that support uncompensated care. Some of this is philanthropy. The problem here is the philanthropy serves a lot of different purposes, only one of which is to serve uncompensated care.

We took - we just laid a rough estimate that 10 to 20 percent of the dollars in philanthropy go to uncompensated care. So that gave us \$800 million, \$1.6 billion. Finally looked at this surplus from privately insured patients. This in 1999 was \$17.4 billion. Most of this, we think, doesn't really go to the poor. There's really a mismatch between surpluses that hospitals have and uncompensated care to hospitals with large surpluses often have.

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Very limited amounts of uncompensated care and vice versa. We made an estimate that it's 10 to 20 percent, giving us \$2.5 million. One of the things that you can see then is that the money that's in the system in the name of supporting the uninsured is greater than the estimate of the cost of uncompensated care that Jack had mentioned earlier. So we're either overstating this or these dollars are poorly targeted. We suspect it's the latter.

But nonetheless, they are - these are our estimates of the dollars that are in the system, that goes towards serving or supporting the hospitals [unintelligible] of company care.

Next, we look at what we're calling the direct service programs, community health centers from the [unintelligible] health line in white, National Health Service Corps, Veterans and New Health Service local health department. We estimate that this is about \$7 billion.

But we did here is to work with expenditure reports and budgets of these various programs, we had to identify the shares as really devoted to medical care. That is taking out the amount that went to Prevention Public Health, long term care, and so forth. So we just had medical care, then estimated the share of those dollars that were either self paid patients or the share of users that were uninsured.

By taking those estimates, then we applied those to the total balance of those in medical care and came out with an

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estimate. We accepted the uninsured people in these programs use it to support a share of these services, the estimate could be low.

So if we put together that \$7 billion with the \$23.5 billion that we got from going to hospitals, you end up with an estimate of \$30.6 billion.

Let me summarize then what both of us have said. Total amount of medical care received by people who are uninsured, any part of the year, amounts to \$98.9 billion, but this includes not only uncompensated care, but also the amount that people are spending out of pocket and for those who are uninsured for part of the year in the public - the amount that's spent by public insurance and private insurance when those people are insured part of the year [unintelligible].

The estimate for the amount spent on those who are uninsured all year long, that is both uncompensated care and the amount that they spend out of pocket, \$40.6 billion. Those are uninsured part of the year, \$58.3.

When we looked at the full year uninsured, we estimated there that they pay the 35 percent of the care that they received. We can't tell how much the part year uninsured are paying while they are uninsured for that part of the year when they are - they lack insurance.

The third point is that even when we count uncompensated care, the full year uninsured spend half as much

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per person as the full year privately insured, \$1253 versus \$2484.

The total amount of uncompensated care, as Jack said, based on our two different estimates were \$34.5 billion or \$35.8 billion. The mid point of that is 2.8 percent of total personal healthcare spending. Now if it comes through government through a variety of sources, the \$30.6 billion, about two-thirds of that is federal and \$19.9 is federal, \$10.7 to date.

And this amounts to about 80, 85 percent of the uncompensated care than the government spending. So it seems like there's a fair amount of money in the system, but when you compare that with the current spending on other healthcare programs, it's relatively small. Medicare in 2001 was \$247 billion. Medicaid was \$226 billion. Tax subsidies were [unintelligible]

Then the implications of this are that there's a lot of money now in the system that's potentially available. But we think it's really most likely truly available only if the insurance [unintelligible] comprehensive. It's hard to make a case when the expansion is incremental because there's going to be a lot of uninsured people in the system and it'll be a strong claim back to people that are now providing care to them, still need them in dollars.

But if an expansion is comprehensive, then these

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dollars are available. And in fact, probably essential because of the large costs of the comprehensive expansion to try to successfully get it already in the system.

So we look and step back and look at this patchwork of dollars that have come in from so many different sources [unintelligible] uninsured. You ask yourself what would be the benefit to provide coverage expansion given that set of facts. The beneficiaries would be uninsured that would use a lot more care than they do now. And they would get that care without the large and complex set of cross subsidies [unintelligible]

[unintelligible] those people hospitals and physicians would benefit and end their dependence on again this imperfectly targeted set of cross subsidies. State and local governments would benefit, particularly or only really if it was federally financed. They would benefit because if they put a lot of money, \$10.7 billion into care, particularly a burden on state and local governments in times like this during the economic downturn.

The final beneficiary would be Medicare and Medicaid payment policies, which now in addition to paying directly for care, in a whole slew of ways add [unintelligible] to support the uninsured [unintelligible] adjustments.

So in addition to expanding coverage and improving the lives of those people [unintelligible] the flow of dollars throughout the system. And with that, thank you.

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MALE SPEAKER: Thank you. Let me start by thanking Diane and the Kaiser Commission on Medicaid and the Uninsured for the support and leadership they've shown on these issues over the past few years.

I'm going to be very brief. And I'm going to just elaborate a bit on the relevance of this paper's findings for the national debate that's going on on the uninsured and what to do about them.

At one level, you could read this paper and say ho hum, so what?

[laughter]

Because after all, we all know that the uninsured utilize a significant quantity of health services, which they don't pay for out of pocket. And that one way or another, the cost of this uncompensated care is covered by other payers and other revenue streams within the system.

In other words, you know, sloshing around somewhere there. But in the - but in thinking about the reform debate and strategies and options that are before us, it matters critically exactly how much uncompensated care there is in the system that's being paid for one way or another, and how that care is distributed across different types of providers and in fact, individual providers, what resource streams there are available to these providers to cover these costs.

Let me illustrate this point by just drawing two

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extreme and unrealistic pictures for you. The first would be a world in which 90 percent of the uncompensated care that is now used by the uninsured is provided by physicians. And physicians compensate for this uncompensated care by raising the prices that they charge to private insurers and to individuals to, you know, meet their income needs.

If the world was like this, there'd be obviously considerable access problems because physicians would try to avoid the uninsured and their uncompensated care burdens.

And the burden of uncompensated care would be probably distributed very unevenly geographically and across individual positions. If a reform occurred in this world that provided insurance to the uninsured, the first thing that would happen is the incomes of those doctors that were providing this uncompensated care would go up. And then over time, probably there'd be negotiations between plans and other insurers that would try and recapture some of that increase in income.

And so there'd be a lot of redistribution that would go on, but none of it would affect the public sector. And in fact, the costs of the subsidized insurance for the uninsured, which would be borne by the government would have no offsets and be relatively expensive.

In the second world, you can imagine that 90 percent of the \$35 billion in uncompensated care that's being provided to the uninsured is being provided by hospitals.

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And hospitals and institutions were getting a significant chunk of money, \$20 billion, \$25 billion, whatever in special payments. Many of them ended to help them bear the burden of providing care to the poor and the uninsured.

In that world, when reform occurred, it would be not unreasonable for the federal government to say all of these other reasons that we have been devoting in a rather haphazard and inefficient way to this purpose should be reprogrammed and distributed through the subsidies that we are providing to those that are currently uninsured.

I think what this paper has done is shown that the world looks more like the second scenario than like the first, although it's still pretty messy. And what it also has underscored is that the amount of uncompensated care that the uninsured use while Jack said is a whole lot of money, in the great scheme of things really is quite a modest amount.

And that suggests that even assuming that there would be large increase in utilization if the uninsured were given insurance, that this is not kind of burden that is unbearable for a modern society like ours, and that we know that there's a significant amount of money in the system if it can be redirected to the purpose for which much of it was intended originally.

The reforms that we're talking about, and if this is a picture of the real world, then as John suggests, has some

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implications for how you go about moving forward. We have been in a continual discussion in this country about whether incrementalism makes more sense than more radical resculpturing of the system. And what I gather from this paper is that the situation is such that incrementalism isn't supported by the evidence in this paper for a simple reason that John raised, one, which is that incrementalism would leave a lot of people uninsured as you went along. And so, it would be hard to capture those resources.

The other is that unless you do a more radical restructuring, you are very unlikely politically to be able to redirect, reprogram these resources and do it in an efficient way.

And so, I think on balance, this is paper which provides, you know, lots of insight that should inform the debate as it unfolds in this country on how doable covering the uninsured is, how to go about doing it, and what kinds of structural reforms in the existing programs would be necessary to bring this about in an efficient way.

[END TAPE]

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