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THE BOSTON GLOBE • THURSDAY, NOVEMBER 9, 1995

Congress' plan to curtail Medicaid could swell ranks of uninsured

By Richard A. Knox
GLOBE STAFF

WASHINGTON – The number of people without health coverage could soar over the next seven years to nearly 70 million, one in every four Americans, a bipartisan panel of health policy experts said yesterday. About 40 million lack coverage now.

The projection is based on an analysis of Congress' plans to curtail the federal Medicaid program for the poor and disabled and the continued erosion of workplace-based health insurance. Under bills now before a House-Senate conference committee, Medicare and Medicaid would be cut by $452 billion below current spending rates between now and 2002.

Conservative economists on the panel agreed with the projections, but they disagreed sharply with predictions that needy and uninsured patients would be denied care, saying the system would find ways to adjust for decreased federal funding.

President Clinton has said he will veto the legislation as too drastic, but a substantial cutback in federal health spending is considered inevitable when Congress and White House officials conclude their negotiations.

If anything like the pending legislation is enacted, US hospitals could see their unpaid bills more than double, from $18 billion this year to $43 billion in 2002, according to the new analysis. To remain solvent, the study concluded, hospitals would have to cut their cost growth to levels they have never achieved – less than 2 percent a year.

Urban hospitals especially would be pinched. To avoid a flood of red ink, the analysis found, teaching hospitals would have to slash costs by up to 50 percent below what the Congressional Budget Office estimates they would otherwise spend by 2002.

This would mean denying potentially life-saving care to many uninsured patients, said several members of the National Council on the Economic Impact of Health Care Reform, the privately funded group that commissioned the new analysis.

"People are going to die," said Karen Davis, a member of the council who is executive vice president of the Commonwealth Fund, a New York-based philanthropy.

"What hospitals will do is cut staff," Davis added. "There will be fewer nurses and longer waits." Some patients may die waiting for care, she suggested.

The projections provoked a spirited discussion among council members, who include some conservatives as well as leading liberal health policy authorities.

The analysis was done by Kenneth Thorpe of Tulane University – until recently one of the Clinton administration's main health care numbers crunchers – along with researchers at Brandeis University.

The projections were not questioned by panel conservatives such as Stuart Butler of the Heritage Foundation and Gail Wilensky, former President Bush's health advisor and a consultant to congressional Republicans. However, there were sharp differences over the health care system's ability to adjust to drastic decreases in federal health spending and increased numbers of uninsured Americans.

Wilensky predicted that the effects of Medicaid cuts will be blunted by state initiatives to extend health insurance to some poor and near-poor citizens, combined with state subsidies of "last resort" caregivers – hospitals and other care providers dedicated to care of the poor.

"This doesn't necessarily mean that places of last resort are public hospitals, or even hospitals," Wilensky said. "I hope this won't necessarily mean a return to the old public hospital model."

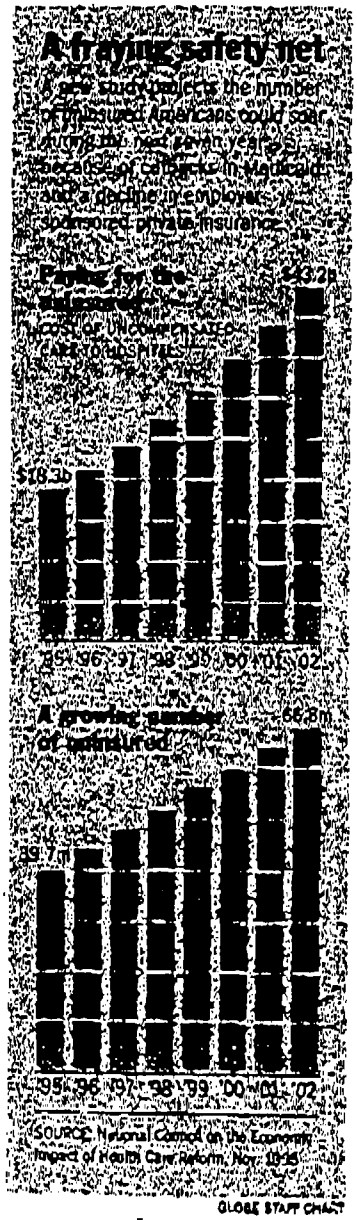
Butler agreed that curtailing federal spending and employer-sponsored insurance will balloon the ranks of the uninsured. "We clearly have an uninsurance problem to address," he said. "That should be the next stage of policy development."

He predicted that federal cutbacks will likely spur "much more aggressive public involvement and perhaps even growth of public hospitals" at the state level.

But this view was contested by other panel members. Dr. James Mongan, executive director of the Truman Medical Center in Kansas City, said he sees no sign that state and local officials will fill the gaps created by federal spending cuts.

"The local boys are aping the guys here in Washington, with very little thought to the consequences," Mongan said. "It's almost politically correct to talk about public hospitals as dinosaurs, not nimble gazelles, and to say maybe we don't need them anymore. I tell you, nobody is talking about what happens to the people who go to them."

James R. Tallon Jr. of the United Hospital Fund of New York agreed. "From a nation so focused just 24 months ago on the issue of universal coverage, we have stopped talking about the large number of people without purchasing power in a purchaser-driven system."


A fraying safety net
A new study projects the number of uninsured Americans could soar during the next seven years because of cutbacks in Medicaid and a decline in employer-sponsored private insurance.
Paying for the uninsured
COST OF UNCOMPENSATED CARE, GOES IN BILLIONS
$18.3b
$43.2b
'95 '96 '97 '98 '99 '00 '01 '02
A growing number of uninsured
39.7m
66.8m
'95 '96 '97 '98 '99 '00 '01 '02
SOURCE: National Council on the Economic Impact of Health Care Reform, Nov. 1995
GLOBE STAFF CHART

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THE COMBINED IMPACT ON HOSPITALS OF REDUCED SPENDING FOR MEDICARE, MEDICAID AND EMPLOYER SPONSORED INSURANCE

By:

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David Shactman
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Alexandra Shields

November 4, 1995

Research for this paper was supported by a grant from the Robert Wood Johnson Foundation to The Council on the Economic Impact of Health Care Reform which is chaired by Stuart Altman and administered at the Institute for Health Policy, The Heller School, Brandeis University.

DRAFT

THE COMBINED IMPACT ON HOSPITALS OF REDUCED SPENDING FOR MEDICARE, MEDICAID AND EMPLOYER SPONSORED INSURANCE

I. OBJECTIVES

Proposed changes in the Medicare and Medicaid programs, along with recent trends in employment based health insurance, will have enormous repercussions on the American health care system. At the time of this publication, there are proposed reductions in the projected growth of Medicare spending of $270 billion and in Medicaid of $182 billion which will take effect in the period 1996 to 2002. During the same time, continued declines in employment based health insurance and increased price competition from managed care organizations will place additional fiscal pressure on health care providers. Although many researchers have examined these changes individually, none have assessed their combined impact on the health care delivery system.

These changes have the potential to rein in the growth of public programs which many feel have been growing at unsustainable levels. They also may encourage consolidation and improved efficiency, which could increase the long term affordability of health care for all Americans. However, the combined magnitude of these changes may be so large as to threaten the financial viability of many providers, particularly those that serve the elderly and the poor, and could seriously reduce access to the populations they serve.

The hospital industry will be particularly affected by these changes. The AHA estimates that $76 billion (28%) of the $270 billion in Medicare reductions would come from hospitals.[1] In addition, with inpatient and outpatient payments to hospitals constituting over 35% of Medicaid spending,[2] these institutions will likely absorb substantial amounts of the reduced Medicaid spending. The combination of potential reductions in Medicaid eligibility and continued declines in employment based insurance will also impact hospitals in the form of increased uncompensated care.

The objective of this study is to estimate the combined effects on the hospital delivery system of reductions in Medicare, Medicaid, and employment based health benefits. We seek to answer the following questions:

1. What is the expected impact on hospital revenues of proposed Medicare and Medicaid reforms and projected declines in employment based insurance?

2. What (reduced) rate of cost growth will hospitals have to achieve in order to maintain fiscal stability in the face of these changes?

We will seek answers to these questions by examining the projected revenues of hospitals by sources of payment (e.g., Medicare, Medicaid, private sector payments, and uncompensated

care). These will be disaggregated by hospital type and cover the years 1995-2002. We will present baseline projections through the year 2002 for each source of payment assuming no system changes, and then project various scenarios for the impact of changes in public and private payments. We will then project various growth rates in total hospital costs and match them with revenues to determine hospital margins under differing assumptions. The results of the study should help policy makers assess how the hospital delivery system may adjust to the combined effects of legislative and market changes now taking place.

II. HISTORICAL PERSPECTIVE

Since the Second World War, the United States has experienced enormous growth in the health care sector. Much of this growth was originally financed by the private sector, spurred by the advent of private health insurance. Private health insurance served as a social protection system, insulating families from suffering the catastrophic financial consequences of an expensive illness. It also insured payment for a growing hospital industry. With few publicly funded federal programs, private sources of payment accounted for more than 75% of national health spending in 1965.[3]

By the 1960s, the expanded use of complex medical procedures and the greater availability of expensive technologies generated an increasingly more expensive healthcare delivery system. It became apparent that many elderly and lower-income citizens could not afford the cost of private health insurance, and that hospitals could not raise sufficient resources to fund the demand for charitable care. In response to this need, the Medicare and Medicaid programs were enacted in 1966 and the source of health spending began to shift to the public sector. By 1991, public dollars accounted for 44% of total health spending.[4]

Coincident with the growth of Medicare and Medicaid, the federal government also expanded its support of bio-medical research and the training of health professionals. The influx of this rapid growth in public funds combined with the continued growth of private insurance fueled a rapid expansion in hospital capacity and in physician services. The hospital sector, whose growth had been encouraged by federal programs since the 1940s, grew to consume 41% of health spending by 1983.[5] National health spending, which was 5% of the GDP in 1960 grew to 10.8% by 1983 and is now in excess of 14%.[6] Public expenditures for health started to become a serious drain on both federal and state budgets.

In response, government policy shifted from expanding capacity to controlling cost. In the 1970s, federal and state governments tried various forms of regulation including Medicare and Medicaid reimbursement reforms, regulation of supply through certificate of need, utilization review, and encouragement of the use of HMOs. Such efforts achieved limited success and, spurred by advancements in medical technology and expansions in eligibility for public programs, health costs continued to grow more quickly than the general economy.

Beginning in the mid 1980s, however, it appeared that spending limits for public programs had finally begun to work. With the introduction of the Medicare Prospective Payment

and the aging of the population, will re-assert themselves and cause hospital costs to return to historical levels. When this happens, they argue, the collective impact of changes discussed herein will push the hospital industry into financial distress. Although they acknowledge that growth in public programs has to be scaled back to more sustainable levels, they contend that the magnitude of changes discussed herein is not necessary and is too large for the hospital sector to absorb.

Given the emergence of competition, the restructuring of hospital markets, and the numerous challenges faced by the hospital industry, there is wide range of opinion concerning the future ability of hospitals to adjust to the changes discussed herein. By projecting the impact on hospital margins of spending reductions in public programs and private insurance, we hope to provide insights to policy makers and industry analysts on these issues.

III. METHODS AND DATA

Overview

In this analysis, we attempt to combine the potential impacts on hospital margins of proposed reforms of Medicare and Medicaid and different possible scenarios regarding the number of uninsured. We examine hospital revenues by source of payment (i.e., Medicare, Medicaid, private insurance, and uncompensated care). We first look at baseline estimates made by the CBO (also using data from ProPAC, AHA, and HCFA) that do not include Medicare or Medicaid reforms. We then project changes in each of these revenue flows according to proposed legislative reforms and different assumptions regarding Medicaid payment/cost ratios, the number of uninsured, and the amount of uncompensated care.

We next examine hospital costs. We first present baseline estimates made by HCFA for total hospital costs from 1995 through 2002. These estimates are comprised of changes in the cost of treating each patient (cost per case), the volume of patients receiving treatment, and differences in case-mix and intensity of service. We then project cost growth at a "best case scenario" in which we assume that costs increase at baseline during 1995 and in the period 1996-2002 they increase by an average rate about 35% below the baseline or 4.4%.[11]

Next, we compare the flows of revenues and costs (using different scenarios) to ascertain the impact on hospital margins. Finally, we calculate the break even rate of cost growth that hospitals will have to achieve under the various scenarios.

Throughout the analysis, we disaggregate our projections by type of hospital (urban vs. rural, and major teaching vs. other teaching vs.non-teaching), so that we can also examine the impact of these changes by hospital type. We start with an estimate of the distribution of revenues and costs by hospital type for 1995 derived largely from the AHA. We include approximately 85% of all expenses and revenues traced to community hospitals. Excluded from the study are Maryland and other hospitals unable to provide full data on both Medicare and total margins. As a result, our base of expenses in 1993 is $222 billion whereas the

AHA reports $266 billion in expenses for all community hospitals. These data were trended to 1995 by ProPAC using an estimated growth in hospital marketbasket. Revenues across hospital types and payers are derived using payment to cost ratios calculated by ProPAC. Costs are distributed across hospital types and payers using data from the AHA provided by ProPAC. We turn first to the revenue projections and begin with Medicare.

Medicare

The current Medicare reform proposal seeks to reduce Medicare spending by $270 billion between 1996 and 2002. In the House bill, these savings include $57 billion of reductions in hospital payments for both inpatient and outpatient services. Under current reimbursement policy, total hospital revenues are expected to rise at approximately 5.4% per year. However, this rate of increase is not uniform across different payers. Spending under the Medicare Prospective Payment System is projected at a 4.3% annual rate (ProPAC). Table 1 compares baseline and reform revenues in 1995 and 2002 (projected revenues are from ProPAC).[12]

Table 1 - Comparison of Baseline and Reform Medicare Revenues ($ billions)

	1995	2002
Baseline Medicare Revenues	80.6	116.3
Reform Medicare Revenues	80.6	101.9

These reductions do not account for the "fail-safe" provision which provides that Medicare payments will be cut back even further to meet the targeted budget ceilings. As shown in table 1, total Medicare spending for hospital services would fall by $14.4 billion or 12.4% from the baseline by the year 2002.

Medicaid

The current Medicaid reform proposals seek to reduce federal Medicaid payments by $182 billion. Under current policy, the CBO estimates that baseline revenues for Medicaid will rise from $89.2 billion in the fiscal year 1995 to $177.8 Billion in fiscal 2002, an average growth rate of 10.4%. Under reform, if states maintain the current level of reimbursement relative to provider costs, revenues for Medicaid will rise from $89.2 billion in fiscal 1995 to $125.8 billion in fiscal 2002, an average annual growth rate of 5% (4.7% between 1996-2002).

However, the assumption that current payment/cost ratios will be maintained may be unrealistic. These ratios were under 80% before disproportionate share payments were raised substantially beginning around 1988. They have risen to 93% today as a result of disproportionate share payments and the Boren amendment.[13] Under Medicaid block grants and repeal of the Boren amendment, it is likely that these ratios will decline at least down to

1988 levels. Hence, we have presented our estimates with both the current Medicaid payment/cost ratios and with a payment/cost ratio of 80%.

We took the year-to-year total Medicaid growth rates from the Congressional proposals and grew Medicaid hospital revenues at this rate of growth, adjusting, as appropriate, for the 80% payment/cost scenario. Table 2 compares the revenue streams under current policy and under reform for both payment/cost scenarios.

Table 2 - Comparison of Baseline and Reform Medicaid Revenues ($ Billions)

	1995	2002
Baseline Medicaid Revenues	29.8	56.5
Reform Medicaid @ current payment/Cost	29.8	41.7
Reform Medicaid @ 80% Payment/Cost	29.8	34.1

Based on these projections, hospital revenues from Medicaid in 2002 would be 26% less than the projected baseline if payment/cost ratios are maintained at current levels, and 40% less if they fall to 80%.

Uncompensated Care

Under current policy, the AHA Annual Survey estimates the amount of hospital uncompensated care at $15.9 billion in 1993 or about 7% of total hospital costs. In our accompanying paper we explain how we derive future estimates of uncompensated care from our projections of the number of uninsured. Under reform, we assume that enrollment in Medicaid is likely to be frozen or possibly even reduced. In such a case, Medicaid enrollment would not be available for those individuals losing private insurance. Hence, as a result of Medicaid reform the amount of uncompensated care would increase. We project uncompensated care under two different scenarios: In Scenario 1, Medicaid enrollment is frozen at current levels and the number of individuals with employment based insurance declines according to CBO estimates. In Scenario 2, Medicaid enrollment is frozen and the trend in ESI continues at the same rate as in 1989-1993.

For the calculations needed in this study we include baseline AHA estimates of revenues from private payers made to hospitals in partial satisfaction of uncompensated care. We trend these amounts to changes in total hospital uncompensated care calculated under our two scenarios. Table 3 presents the baseline and reform estimates of the amount of uncompensated care and corresponding revenues from partial payments by private payers..

Table 3 - Uncompensated Care and Revenues on Account of Uncompensated Care Received From Private Payers ($ Billions)

	1995	2002
Baseline Uncompensated Care	17.7	29.3
Baseline Private Payer Revenues	3.9	6.5
Scenario 1 - Uncompensated Care	18.3	33.4
Scenario 1 - Private Payer Revenues	3.9	7.4
Scenario 2 - Uncompensated Care	18.3	43.2
Scenario 2 - Private Payer Revenues	3.9	8.8

Based on these projections, the amount of uncompensated care increases modestly under the low uninsured scenario, but increases nearly over 47% if ESI continues to decline at recent trend rates. Revenues received by private payers show a corresponding increase, but the ordinal difference is small, rising from $6.5 to $8.8 billion. Our estimates of uncompensated care may be understated by about 5% because we use cost data from PPS hospitals that exclude Maryland and some other hospitals (see endnote for explanation).[14]

Private Insurance

Under current policy, the CBO estimates that the baseline growth in hospital revenues from private payers will increase at an annual rate of 5.6%. This estimate employs the more moderate CBO projections for employment sponsored insurance (ESI). We also project revenues from private insurance under our Scenario 2 in which the trend in ESI continues at the same rate as in 1989-1993. In each case, we take the baseline private health insurance payments and calculate a per capita amount (from the baseline number of privately insured individuals). We then multiply the per capita amount times the number of privately insured under each scenario. Table 4 presents the baseline and reform estimates of hospital revenues from private payers.

Table 4 - Hospital Revenues From Private Payers ($ Billions)
Comparison of CBO Trends and 1989-1993 Trends in Employment Sponsored Insurance

	1995	1996	1997	1998	1999	2000	2001	2002
Baseline Private (same as scenario 1)	111.6	118.9	126.6	134.1	141.1	148.9	156.9	165.0
Scenario 2	111.6	115.7	120.1	124.5	129.1	133.9	138.9	144.1

Based on our assumptions, hospital revenues from private payers in the year 2002 would decline by nearly $21 billion dollars below baseline estimates if the decline in ESI continues along the 1989-1993 trend. These estimates do not assume any further reductions in payment/cost ratios of private payers beyond those in the CBO baseline.

Other

Hospitals receive revenue from a variety of other patient care (state, local, and federal sources) as well as from non-patient care sources. We assume these revenues grow under each scenario at the CBO baseline projection.

Costs

The baseline rate of hospital cost growth is derived from projections provided by the Office of the Actuary, Health Care Financing Association (HCFA). These estimates show total expenses for inpatient and outpatient hospital services including the cost per treating each patient (cost per case), the volume of patients treated, as well as changes in case mix and intensity of services. The HCFA baseline estimates have an average annual growth rate of 7.5%. We rely on the HCFA baseline total costs estimates, to derive our "best case" cost estimate in which we assume that costs increase at baseline during 1995, and in the period 1996-2002 they increase by an average rate of 4.4%. These estimates are performed separately for inpatient and outpatient services, and then are weighted to totals using relative cost shares. In Table 5 we compare the baseline stream and "best case" projections of total hospital costs.

TABLE 5 - Comparison of Baseline and "Best Case" Total Hospital Costs
1995 - 2002 ($ Billions)

	1995	1996	1997	1998	1999	2000	2001	2002
Baseline Total Cost	233.8	250.6	268.9	289.4	311.6	335.3	360.8	387.9
"Best Case" T. Cost	233.8	250.6	260.2	271.0	283.1	295.7	309.7	324.3

IV. RESULTS

We present a summary of our findings in the five tables that follow. All of these projections are for the year 2002.

Table 6 Hospital margins (by hospital type) with costs growth at CBO baseline.

Table 7 Hospital margins (by hospital type) assuming the low uninsured scenario with costs at "best case" (4.4% in 1996-2002). We project two different sets of margins according to our assumptions about

Medicaid payment/cost ratios.

Table 8 Break-even rates of cost growth (by hospital type) assuming the low uninsured scenario. We present two different break-even rates according to our assumptions about Medicaid payment/cost ratios.

Table 9 Same as table 7 assuming the high uninsured scenario

Table 10 Same as table 8 assuming the high uninsured scenario

Table 6, below, projects hospital margins in the year 2002 if hospital costs increase at the HCFA baseline rate. The average of the HCFA baseline rate of hospital cost growth for the years 1995-2002 is 7.5%. Clearly, hospitals cannot operate at the baseline rates of cost growth and maintain their financial viability. This is true across all hospital types.

Table 6 - Hospital Margins in the year 2002
Assuming Baseline Cost Growth

HOSPITAL TYPE	MARGIN
Urban	-16.7%
Rural	-15.0%
Major Teaching	-16.4%
Other Teaching	-16.5%
Non-Teaching	-15.0
Total	-15.8%

Table 7 presents a "best case" scenario for hospitals. We project hospital margins in the year 2002 assuming cost growth at HCFA baseline for 1995 and at 4.4% for 1996-2002 (4.8% overall). Currently, the HCFA baseline hospital cost growth is 7.5%, so hospitals would have to reduce their cost growth by approximately 36% under the baseline amount by the year 2002 to conform to these projections. We assume the more moderate CBO estimates of declines in ESI (the "low uninsured scenario") with Medicaid enrollment frozen. We examine margins with present Medicaid payment/cost ratios and with payment/cost ratios adjusted to 80%. Under these "best case" assumptions, hospitals would maintain margins of 3.1% overall if states continue to reimburse hospitals at the current payment/cost ratio. Margins are clearly higher for rural versus urban hospitals and for non-teaching versus teaching. If states revert to a payment/cost ratio of 80%, overall margins fall to just under 1%. This would have a critical impact on major teaching hospitals as their margins would fall from 2.6% to -3.0%.

Table 7 - Hospital Margins in the year 2002
Low Uninsured Scenario
Cost Growth at "Best Case"

HOSPITAL TYPE	Margin at Block Grant Rate	Margin at 80% Payment/Cost
Urban	2.3%	0%
Rural	3.8%	1.9%
Major Teaching	2.6%	-3.0%
Other Teaching	2.5%	0.8%
Non-Teaching	3.8%	2.7%
Total	3.1%	0.9%

Table 8 has the same assumptions as table 7, but instead of specifying a rate of cost growth, we calculate the break even cost growth for each type of hospital. If states maintain the current Medicaid payment/cost ratios, hospitals overall will break-even at a rate of cost growth of 5.2%. Currently, the overall baseline rate of cost growth is 7.5%, so that by 2002 hospitals would have to reduce their rate of cost growth by over 30%. Given our assumption that reduced revenues from reform or private insurance do not alter the volume of patients treated (some go from Medicaid or private insurance to uncompensated care) this analysis requires that hospitals reduce their cost per adjusted admission by this same 30%.

Table 8 - Hospital Break-Even Growth Rates in the year 2002
Low Uninsured Scenario

HOSPITAL TYPE	Break-Even Rate of Cost Growth at Current Payment/Cost	Break-Even Rate of Cost Growth at 80% Payment/Cost
Urban	5.1%	4.8%
Rural	5.3%	5.0%
Major Teaching	5.2%	4.3%
Other Teaching	5.1%	4.9%
Non-Teaching	5.3%	5.2%
Total	5.2%	4.9%

Table 8 reveals little difference across hospital types. If Medicaid payment/cost ratios were reduced to 80%, the break even level of cost growth decreases by about .2%, except in the case of major teaching hospitals which whose break-even level would decrease by nearly one full percent.

In Table 9, we analyze what happens to hospital margins in the year 2002 if we assume that Employment Sponsored Insurance continues to decline at the same rate as it did from 1989-1993 (the high uninsured scenario). Again, we assume that Medicaid enrollment is frozen and that costs are held to "best case" (4.4% in 1996-2002). Our results indicate that if Medicaid payment/cost ratios are maintained at current levels, margins overall would be -2.9%. All hospitals would experience negative margins under the high uninsured scenario, but rural hospitals and major teaching hospitals would be less impacted by the decline in privately insured payers. If Medicaid payment/cost ratios fall to 80%, margins become quite negative, falling to an overall average of -5.4%. As expected, the impact of lower Medicaid reimbursements has a relatively larger impact on safety net hospitals than the impact of higher uncompensated care caused by declines in ESI, and major teaching hospitals experience the worse margins at -7.2%.

Table 9 - Hospital Margins in the year 2002
High Uninsured Scenario
Cost Growth at "Best Case"

HOSPITAL TYPE	Margin at Block Grant Rate	Margin at 80% Payment/Cost
Urban	-3.7%	-6.3%
Rural	-2.6%	-4.9%
Major Teaching	-1.4%	-7.2%
Other Teaching	-4.3%	-6.3%
Non-Teaching	-2.7%	-4.0%
Total	-2.9%	-5.4%

Lastly, we calculate the break-even rate of cost growth in 2002 under the same assumptions as above (the high uninsured scenario). We find that if states maintain the current Medicaid payment/cost ratio, the overall break-even rate of cost growth is 4.3%. In the year 2002 this would be more than a 40% reduction under the current HCFA estimates of hospital cost growth. Under our assumptions, hospitals would have to reduce their cost per adjusted case by this same amount as previously discussed. The impact across hospitals would not vary widely except for the lesser impact on major teaching hospitals. If states reduce the payment/cost ratio to 80%, the overall break-even level of cost growth falls to 4.0%. This

would require nearly a 47% reduction in the rate of cost growth by the year 2002 compared to CBO baseline cost growth estimates. The break-even rate of cost growth for safety net hospitals would be under 4% and would require nearly a 50% reduction in costs from baseline projections.

Table 10 - Hospital Break-Even Growth Rates in the year 2002
High Uninsured Scenario

HOSPITAL TYPE	Break-Even Rate of Cost Growth at Current Payment/Cost	Break-Even Rate of Cost Growth at 80% Payment/Cost
Urban	4.2%	3.9%
Rural	4.4%	4.1%
Major Teaching	4.6%	3.7%
Other Teaching	4.1%	3.8%
Non-Teaching	4.4%	4.2%
Total	4.3%	4.0%

V. DISCUSSION

Our findings indicate that under all of our scenarios, hospitals will have to reduce their rates of cost growth well below CBO baseline estimates to achieve positive financial margins. We project negative margins of between 15%-17% if costs to continue to rise at the CBO baseline estimates. Clearly, hospitals would not be able to sustain their financial viability at those rates of cost growth.

We find that under the low uninsured scenario, hospitals would have to reduce their rate of cost growth to the 5% area to break even in the year 2002. This represents a 1/3 reduction from the CBO baseline rate of cost growth. Based on HCFA data, we estimate that the baseline projected rate of total hospital cost growth in the year 2002 of 7.5% is comprised of approximately 4.2% in cost per case and approximately 3.3% in increased volume, case mix and intensity of service. In accordance with that estimate, hospitals would have to reduce their growth in cost per case to the 1.7% area in 2002, well below the level of inflation. Although this is a rate of cost growth that hospitals have never achieved, the rate of 1.7% achieved in 1994 was quite close.

Similarly, in the high uninsured scenario, hospitals overall would have to reduce their rate of cost growth to the 4% area to break-even in the year 2002. This represents a 47% reduction

below the CBO estimated growth in hospital costs. Assuming the same breakdown of cost per case and volume stated above, this would require a growth rate in cost per case in the 0.7% area. That would represent a substantial reduction below any rates of growth previously reported.

Can hospitals achieve these reduced rates of cost growth? It is instructive to look at the historical growth rate of hospital costs. From 1990 through 1994 growth rates in total costs ranged from 4.6 to 11.6%. The 1994 rate of 4.6% was the only year hospitals achieved a rate of total cost growth under 7% (HCFA estimates 1995 at 6.9%).[15] In terms of cost per case, the 2.0% rate that hospitals reported in 1994 is the closest to the 1.7% required break-even area under Scenario 1 (the low uninsured scenario). Clearly, even under Scenario 1, hospitals would have to hold their annual increases in cost per case below the level of inflation. Indeed, if inflation rates return to their 1965-1993 average of 5.4%, growth in hospital costs per adjusted case would have to be substantially below the level of inflation.

During 1993 and 1994 hospitals did manage to keep their costs per case under the rate of inflation. In the 4th quarter of 1993 hospital costs per adjusted admission declined below the rate of inflation for the first time, and by the first quarter of 1995 they were 1.7% below inflation. Hence, recent changes in the structure of financing and delivery of care could be indicative of a substantial cost saving potential that we have not experienced in the past. Savings from both consolidation and managed care may present many hospitals with previously unforeseen opportunities to increase efficiency. It is reasonable to speculate that some hospitals, particularly those that provide few services to Medicaid or indigent patients, may be able to overcome these challenges.

To the extent that some hospitals may be able to reduce costs sufficiently to maintain positive margins, the proposed legislation may accomplish some much needed reforms. The growth rate of Medicare and Medicaid, having far exceeded the growth rate of the economy in recent years, could be held to a sustainable level of growth. In so doing, the Medicare trust fund would remain solvent for perhaps another 10 years. Hospitals, which have been able to utilize the availability of public funds to resist necessary consolidation, may now have sufficient market incentive to consolidate to a more efficient and appropriate size relative to demand. These reductions in government programs and in demand for services may make the long term cost of health care more affordable and may enable resources to flow to other important areas of the economy such as education, housing, etc.

However, even given these opportunities to increase efficiency, it is likely that many hospitals will not be able to achieve savings well beyond any historical precedent. In these cases, hospitals will be faced with the following options: Reduce quality and/or access, seek government relief, or be forced to merge or close.

There is ample evidence in the literature of hospitals reducing access and/or quality when faced with stringent regulation, increased competition, or unattractive levels of reimbursement.[16] Although we cannot predict whether such a result may occur in the future,

past evidence would certainly indicate the need for concern. If revenue reductions of this magnitude are enacted, we recommend that quality of care and restrictions in access be closely monitored, particularly at safety-net hospitals which are most at risk for financial difficulties.

Many hospitals that cannot financially cope with these changes are likely to seek rate relief from local, state, and federal government. Given the structure and scope of the reform proposals, it is likely that some budget adjustments will be needed. For example, readjusting allocation among states or changing the budget limits across categories (i.e. hospitals, physicians, home health care, etc.) could solve some of the most pressing problems. They would, of course, meet with stiff political resistance. As an alternative, some additional revenues may be needed if hospitals are unable to adjust to the magnitude of revenue reductions. Given the scope and impact of these reforms, we recommend that procedures to monitor financial impact on hospitals and to recommend possible adjustments should be formulated.

Finally, these changes will encourage mergers, acquisitions and closures in an industry that has been consolidating at an unprecedented pace. Many of these consolidations are likely to generate efficiencies, and should not be impeded. However, there are also potential problems that may arise from consolidation. The hospitals that close will not necessarily be the least efficient, but may be the ones that share the highest burden of providing care for Medicare and Medicaid patients and for the uninsured. Problems of reduced access may occur in places where specific services have been discontinued or where entire hospitals have closed. Such problems can negatively impact the health status of populations in those communities.[17] Additionally, too much consolidation in specific markets may result in an accumulation of market power which could eventually lead to higher prices. We recommend that hospital mergers and consolidations be closely monitored. Previous Council publications[18] have identified the need for increased capabilities in this area.

1. D. Shelton, "Charity's Bottom Line," *AHA News* (10/16/95): 11

2.Prospective Payment Assessment Commission, "Medicare and the American Health Care System: Report to the Congress," (June 1994): 80

3. IBID., 15

4. IBID., 15

5.IBID: 16

6. Employee Benefits Research Institute, "EBRI Databook on Employee Benefits," 3rd Edition (1995): 346

7. Prospective Payment Assessment Commission, Supra #2: 30

8. IBID: 30

9. Prospective Payment Assessment Commission, "Medicare and the American Health System: Report to the Congress," (June 1995): 19

10. American Hospital Association National Hospital Panel Survey

11. This figure represents marketbasket plus increases in adjusted days with other measures of volume such as case mix and intensity of service held constant.

12. ProPAC estimates under the House proposal for hospital non-long term care savings are $11 billion in the year 2002. CBO projects these same savings at $14.7 billion. We used the more conservative ProPAC estimates because their analysis distributed these savings across hospital types.

13. The Boren amendment provides a legal requirement that states reimburse hospitals at a realistic rate relative to costs.

14. Data we use from PPS hospitals slightly understate the financial impact on all hospitals concerning the growth in the number of uninsured. National uncompensated care is $16 Billion in 1993 (6% of $266 Billion) and in our hospitals $14 Billion (6% of $233 Billion). In 1995 this would total nationally nearly $18 Billion (6.1% of $300 Billion in costs). Since we are using a subset, the total is slightly less--around $16 Billion. However, we calculate a per capita using the total number of uninsured. This slightly understates per capita costs. Maryland has only about 0.6 million uninsured on a base of 39.7 million, so we understate uncompensated care across all hospitals by about 5%.

15. Data from HCFA

16.

17. A. Bindman, D. Keane, N. Lurie, "A Public Hospital Closes: Impact on Patient's Access to Care and Health Status, *Journal of the American Medical Association* (June 12, 1990): 2899-2904

18. D. Shactman, S. Altman, "Mergers, Consolidation, and Antitrust: Charting an Appropriate Public Policy" *Health Affairs* (in press).

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NOTES:

ANTICIPATING THE NUMBER OF UNINSURED AMERICANS AND THE DEMAND FOR UNCOMPENSATED CARE:

THE COMBINED IMPACT OF PROPOSED MEDICAID REDUCTIONS AND EROSION OF EMPLOYER-SPONSORED INSURANCE

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DRAFT

Introduction

The rising number of Americans without health insurance has been a public policy issue for some time. This analysis adds to the debate by estimating the combined impact of recent declines in employer-sponsored insurance (ESI) and anticipated cuts in the Medicaid program on the number of uninsured. We also estimate the effect this expected growth in the number of uninsured will have on the demand for uncompensated care.

On a typical day during 1995, over 39.7 million, or about 15 percent of the population, were uninsured. This is up from 13 percent (34.5 million) of the population uninsured in 1990. Not only are more Americans now uninsured, but the length of time without insurance is also increasing. During the late 1980s, an American without insurance was uninsured for 4.2 months (median). Recent data indicate that the median length of time without insurance rose to 7.1 months by 1993 (Bennefield 1993).

The increasing numbers of uninsured raise concerns about the impact on individual health, as well as the strain it will place on the health delivery system by the increased need for uncompensated care. Historically, the cost of this uncompensated care has been borne, in part, by the privately insured in the form of higher prices they paid for their care. In recent years, intensifying pressures from competition and managed care is making it more difficult for providers to shift unreimbursed costs to private payers.

The Medicaid program has been a significant source of coverage for low-income Americans. Yet escalating costs have led Congress to propose reducing the rate of growth of Medicaid spending by $182 billion between 1996 and 2002. This will no doubt impact the number of persons covered under Medicaid, and therefore increase the number of uninsured. The budget limits in these proposals would require at best a substantial restructuring of current programs. Under the House and Senate bills, Medicaid spending would be constrained to about a 4.8 percent annual growth rate in spending. This compares with Congressional Budget Office (CBO) projections of a 10.1 percent annual growth rate, had the program continued on its existing trajectory.

These Medicaid constraints come at a time when the number of Americans receiving health insurance through employer-sponsored insurance (ESI) continues to decline. The most recent data from the March 1994 Current Population Survey (CPS) reports that 56.8% percent of the population now receive health insurance through employer-sponsored programs, compared to 61 percent four years ago (Thorpe 1995). The accelerated decline in ESI is expected to continue, as jobs shift from the manufacturing sector, where workers are more likely to receive health insurance, to the service sector, where health benefits are less prevalent.

In developing our estimates, we first establish a baseline trajectory of the number of uninsured for the years 1996-2002, using the methodology developed by the Congressional Budget Office (CBO). These estimates are then updated using the March 1995 CPS numbers

for the uninsured. We then consider two possible scenarios: First, examine the impact of Medicaid reductions on baseline estimates of the number of uninsured, holding Medicaid enrollment constant.[1] In the second scenario, we project the number of uninsured assuming a faster pace of erosion of ESI consistent with trends over the last four years, in combination with Medicaid reductions (fixed enrollment). Finally, we project the increased demand for uncompensated care and the impact this will have on the hospital sector. We begin with an introductory discussion of what it means to be uninsured. What really is at stake?

I. Why is the Number of Uninsured Important?

The rising number of uninsured is important for two reasons: the adverse impact on individuals, and the burden placed on the health care system in responding to the demand for uncompensated care.

Impact on Individuals' Health.

There has been some debate about the policy relevance of being uninsured when, in fact, many of the uninsured are young and relatively healthy. The rising number of uninsured, some argue, merely reflects individuals who choose to forgo health insurance rather than face eroding wages. It also may reflect the fact that many individuals without any form of third party coverage and with limited incomes have received substantial amounts of free care when in need.

Yet we know that nearly 60 percent of the uninsured are poor or near poor[2], and that these low-income groups are known to have higher risks of disease and mortality (Pappas et al. 1993, Adler et al. 1993). Several studies have also documented that while the uninsured receive substantial amounts of free care, they face delayed access to that care and lower utilization of health care services than those with third party coverage, public or private.[3] A study of five hospitals in Massachusetts, for example, found that poor (income less than $10,000), uninsured patients were twice as likely as insured patients to report delays in care

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[1]Assuming that Medicaid enrollment levels will be frozen is a conservative approach. Between 1992 and 1994, Medicaid enrollment grew an annual average of 6.45 % . The total growth in Medicaid beneficiaries between 1990-94 was 47 percent.(HCFA, Form 2082 data). CBO estimates that Medicaid enrollment will grow from 36.8 million in 1995 to 45.9 million by 2002, representing a growth rate of 3.3 Percent per year (Urban Institute, Impact of Budget Resolution Conference..)

[2]During the period 1990-92, 29.2% of the uninsured (under age 65) were poor, and 29.7% of the uninsured were near poor (100-199% of the federal poverty line). The federal poverty line for a family of three is currently $12,590. (Health Needs and Medicaid Financing: Kaiser, 1995)

[3] For an exhaustive discussion of the literature, see the U.S. Congress, Office of Technology: Does health insurance make a difference? OTA-BP-H-99. Washington: U.S. Government Printing Office, September 1992.

(Weissman et al 1991). Once in the hospital, uninsured patients receive fewer services than privately insured patients (Blendon 1988, Weissman 1989, Hadley 1991, Franks 1993), raising questions about the quality of care received. Uninsured children, too, consistently receive less services than their insured counterparts (Monheit and Cunningham 1992, Newacheck and Halfon 1992, Stoddard et al 1994). Uninsured status is often correlated with other characteristics, such as being poor, black, or without a usual source of care, which place a person at risk for receiving less care than needed (Weissman 1991, Weissman and Epstein 1989, Wenneker and Epstein 1989, Yelin et al 1983). Therefore, it seems clear that uninsured persons are potentially at risk for delays in health care, for receiving less than appropriate health services, and for receiving poorer quality health care than insured persons -- factors leading to poorer health, and diminished functional status and quality of life.

The Uninsured Driving the Growth in the Demand for Uncompensated Care

The number of uninsured is also an important factor for the health care system as a whole. Uncompensated care is generated largely by the uninsured. Totals of uncompensated and unsponsored care provided by hospitals are routinely reported. The CBO traced approximately 77 percent of hospital uncompensated care charges and 89 percent of uncompensated physician charges to the uninsured in 1993[4]. The volume of uncompensated care provided by hospitals has also risen steadily over time. In 1980, uncompensated care costs totaled $3 billion, or 3.9% of hospital costs. By 1993, uncompensated care accounted for $15.9 billion, or 6% of all hospital costs (AHA Annual Survey of Hospitals, 1994).

II. Recent Trends in the Number of Uninsured (1989-1995)

A. Point-in-Time Estimates of the Number of Uninsured

Estimates of the uninsured used in this analysis are based on the March 1995 Current Population Survey (CPS) data. Another common source of data used to generate estimates of the uninsured is the Survey of Income and Program Participation (SIPP).[5] There is potential bias in any survey tool. Hence, a sensitivity analysis was performed comparing point-in-time estimates of the number of uninsured from both survey instruments for the calendar year 1991 (Bennefield 1994).

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[4]CBO Staff memorandum, "Single Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates", April 1993.

[5]The CPS is a point-in-time survey, whereas the SIPP is a multi-panel, longitudinal survey, both of which are conducted by the U.S. Bureau of the Census in the Department of Commerce. Questions concerning health insurance status vary considerably, but as seen here, generate similar estimates (Bennefield 1994).

Table 1. Alternative Estimates of the Number of Uninsured, 1991.

SOURCE OF ESTIMATE	NOT COVERED BY HEALTH INSURANCE
SURVEY OF INCOME AND PROGRAM PARTICIPATION (SIPP)	13.2%
CURRENT POPULATION SURVEY (CPS)	14.1%

SOURCE: BENNEFIELD 1994
NOTE: THE SIPP AND CPS ARE CONDUCTED BY THE U.S. BUREAU OF THE CENSUS.

As seen in Table 1, there were nominal differences in the estimates, with 14.1 percent uninsured according to the CPS and 13.2 percent indicated by the SIPP. Using CPS data, therefore, does not greatly bias our projections of the number of uninsured.

Among the uninsured, children represent a particularly vulnerable group, and one that is growing. During the decade 1977-1987, there was a 40 percent increase in the proportion of children with no health insurance (Cunningham and Monheit 1990). This trend was reversed in the next four years, even though there was a marked reduction in the percentage of children covered by private insurance, from 73.3 percent in 1988 to 69.3 percent in 1992. To make up for this reduced private coverage, nearly 5 million children were added to the Medicaid rolls, representing a 45 percent increase (10.0 million to 14.5 million)[6]. Had Medicaid coverage not expanded, perhaps as many as 3 million of the children that lost private coverage would have been added to the rolls of the uninsured.

In 1992, 8.3 million children (12.4 percent of all non-institutionalized children) were uninsured, with certain groups particularly ar risk, including adolescents, minorities, children living with a single parent and children in poor or near-poor families (Newacheck 1995). The majority of uninsured children were members of two-parent families and were non-Hispanic white. Nearly two-thirds were in families with incomes just above the poverty level and not eligible for Medicaid coverage.

Studies have interpreted the decline in dependent coverage among the ESI population and a concurrent increase in the number of children enrolled in Medicaid differently. Some analysts believe that the decline in ESI dependent coverage was in part generated because of the liberalization of Medicaid eligibility for children. Cutler and Gruber (1995), for example,

[6]This led to the percentage of children with some form of health coverage actually increase slightly in the 1988-1992 period, from 86.9 percent to 87.6 percent.

estimated that as much as 50-75 percent of the increase in Medicaid coverage for women and children between 1987-1992 was accompanied by a reduction in private insurance coverage. An alternative explanation for this reduction in the number of children covered under ESI is offered by one of the authors of this paper. Thorpe (1995) attributes the reduction of ESI primarily to changes in the structure of working families receiving heath insurance through their employer. According to his analysis, there were more children in families where a parent did not have ESI coverage. He supports his thesis by referring to the fact that the number of workers receiving insurance through ESI has remained stable, but the average family size of ESI covered workers has decreased. Given these conflicting studies, it is unclear the extent to which Medicaid expansions "crowded out" private coverage. However, virtually all the analysts agree that there have been declines in ESI dependent coverage, and that Medicaid has become a major source of health coverage for children. Whether this declining trend in private coverage for children will be reversed by a tightening in Medicaid eligibility must await future analyses. In this paper, we adopted a middle ground and kept the number covered at current levels.

B. Longer Spells of Uninsurance for the Newly Uninsured

Not only is the number of individuals uninsured at any point in time increasing, but the length of time individuals remain uninsured is also increasing. As seen in Table 2, approximately 54 percent of the uninsured in 1993 will be uninsured for over two years. Tables 3 and 4 show that the median length of time without insurance (for all persons with observable starts to their uninsured spells) has crept up from 4.2 months in the 1987-89 period up to 7.1 months in the February 1991-93 period. Historically, the trend in length of new uninsured spells was towards shorter spells. This is no longer true. There were 5 percent more long spells (lasting more than 9 months) in 1987 compared to 1984 (62 percent versus 67 percent)[7] (McBride 1994).

The length of time the uninsured remain uninsured is an important policy consideration, since policy interventions would differ depending on whether the target population were chronically uninsured (spells lasting over two years), or persons experiencing short spells without insurance coverage. Conflicting reports exist concerning how many of the uninsured are chronically uninsured and therefore how "big" the problem of the uninsured truly is. McBride and others have attempted to estimate the number of uninsured who are chronically uninsured. Using within sample survival regression models on longitudinal data, they conclude that over half of the uninsured population will remain so for periods lasting more than 25 months, and about 75 percent will be without coverage for more than a year (McBride 1994).[8]

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[7]These estimates include only the first uninsured spell a person endures.

[8]First, a count of all uninsured at a point-in-time, December 1988, was taken. This date was the final month of the survey period. This count then could be traced back through the prior 28 months to see how long individuals had been uninsured thus far. Finally, McBride used a within-sample survival regression model to

Table 2. Length of Uninsured Spell (Point in Time) for Uninsured Population

LENGTH OF SPELL	PERCENTAGE OF UNINSURED	TOTAL UNINSURED (MILLIONS)*
1 TO 4 MONTHS	3.5	1.4
5 TO 8 MONTHS	11.6	3.9
9 TO 12 MONTHS	9.8	3.9
13 TO 16 MONTHS	8.1	3.2
17 TO 24 MONTHS	13.0	5.2
OVER 25 MONTHS	53.9	21.4
TOTAL	99.9**	39.7

SOURCE: AUTHORS' TABULATION USING METHODOLOGY FROM MCBRIDE 1994.
NOTES: *ESTIMATED BY APPLYING "PERCENTAGE OF UNINSURED" TO CENSUS BUREAU ESTIMATE OF UNINSURED PERSONS FROM THE 1993 CPS. ASSUMES CONSTANT PROPORTION OF UNINSURED TO INSURED.
**ERROR DUE TO ROUNDING.

estimate how lone the uninsured in December 1988 would continue to be uninsured after the survey period was complete.

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Table 3. Length of Spell Without Insurance for the Newly Uninsured Population with Observable Starts to Spell, by Employment Status and Income Level, Selected Years (Median Months).

	1987-89	1990-92	1993-93
MEDIAN, ALL SPELLS	4.2	6.0 (0.6)	7.1 (0.2)
EMPLOYMENT STATUS (FOR PERSONS 18 AND OVER)			
FULL TIME	4.0	4.6 (0.9)	5.7 (1.1)
PART TIME	5.5	6.8 (1.6)	7.5 (0.5)
UNEMPLOYED*	6.3	7.8 (0.7)	7.7 (0.5)
NOT IN LABOR FORCE**	5.6	7.2 (0.3)	8.8 (3.2)
RATIO OF INCOME TO POVERTY LEVEL			
UNDER 1.00	4.8	7.2 (0.2)	7.5 (0.3)
1.00 AND OVER	4.0	4.9 (0.7)	6.3 (1.3)
1.00 TO 1.24	7.1	6.8	
1.25 TO 1.49	7.2	7.0	
1.50 TO 1.99	3.9	6.2	
2.00 TO 2.99	3.9	6.2	
3.00 AND OVER	3.7	3.7	

SOURCE: DYNAMICS OF ECONOMIC WELL-BEING: HEALTH INSURANCE (ANALYSIS OF SURVEY OF INCOME AND PROGRAM PARTICIPATION, DEPARTMENT OF COMMERCE)
NOTES: STANDARD ERRORS IN PARENTHESES BESIDE MEDIAN.
*UNEMPLOYED REFERS TO A PERSON WHO HAD NO JOB DURING A GIVEN MONTHS AND SPENT ONE OR MORE WEEKS LOOKING FOR EMPLOYMENT OR WAS ON LAYOFF.
**NOT IN THE LABOR FORCE REFERS TO A PERSON WHICH HELD NO JOB DURING THE MONTH AND SPENT NO TIME LOOKING OR WAS ON LAYOFF.

The distribution of spell length also varies by demographic characteristics. Those most vulnerable to longer periods without insurance are the poor and working poor (those between 100 to ~~150~~ 200 percent of the federal poverty line). ~~As seen in Table 3, it appears~~ that median spell length without insurance ~~has increased markedly for both groups~~. Not surprisingly, comparative spell length also varies inversely with education. Persons (18 and over) with one or more years of college also experience shorter spell lengths than high school graduates with no additional schooling and those with less than four years of high school. As expected, full-time employees have significantly shorter median spell lengths compared to part-time employees, unemployed, and those not in the labor force.

Table 4 captures comparisons across demographic subgroups, showing that certain populations experienced longer median lengths of uninsured spells. In the 1991-93 period, Hispanic persons remained uninsured for a longer time, and more whites experienced longer spells without insurance. Hispanics had significantly different spell lengths at 7.7 months as compared to White persons (not of Hispanic origin) with 6.0 months and Black persons with 7.1 months. This is a shift from the 1990-92 estimate when the Hispanic and Black populations were close in median spell length at 7.2 and 7.3 months, respectively, contrasted to White persons (not of Hispanic origin) at only 4.9 months.

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Table 4. Length of Spell Without Insurance for the Newly Uninsured Population with Observable Starts to Spell, by Race, Education, Sex, and Age, Selected Years (Median Months).

	1987-89	1990-92	1991-93
MEDIAN, ALL SPELLS	4.2	6.0 (0.6)	7.1 (0.2)
RACE			
HISPANIC	4.5	7.2 (0.2)	7.7 (0.3)
WHITE (NOT OF HISPANIC ORIGIN)	4.1	4.9 (0.8)	6.0 (1.0)
BLACK	4.0	7.3 (0.1)	7.1 (0.2)
EDUCATION			
LESS THAN 4 YEARS OF HIGH SCHOOL	7.1	7.6 (0.4)	10.00 (2.1)
HIGH SCHOOL GRADUATE	5.3	7.1 (0.8)	7.2 (0.4)
1 OR MORE YEARS OF COLLEGE	3.8	4.0 (0.1)	5.1 (1.1)
SEX			
FEMALE	4.0	5.5 (0.8)	6.6 (1.4)
MALE	4.7	6.5 (0.9)	7.2 (0.2)
AGE			
UNDER 18 YEARS	4.0	4.8 (1.5)	5.1 (1.0)
18 TO 24 YEARS	4.0	6.4 (1.3)	7.3 (0.4)
25 TO 34 YEARS	5.0	5.4 (1.1)	7.1 (0.4)
35 TO 44 YEARS	4.0	7.4 (0.5)	7.2 (0.5)
45 TO 64 YEARS	7.1	6.4 (1.5)	7.7 (0.5)

SOURCE: DYNAMICS OF ECONOMIC WELL-BEING: HEALTH INSURANCE (ANALYSIS OF SURVEY OF INCOME AND PROGRAM PARTICIPATION, DEPARTMENT OF COMMERCE)
NOTE: STANDARD ERRORS IN PARENTHESES BESIDE MEDIAN.

Reasons for Spells Starting and Ending

One way of better understanding the dynamics of health insurance coverage is to see where individuals losing coverage were previously insured, and what kinds of coverage those previously uninsured finally receive. Table 5 summarizes these trends using the 1987 SIPP data. Among families with incomes greater than 100 percent of the federal poverty line, nearly 32 percent became uninsured because they lost ESI coverage. Another 50 percent lost coverage they had previously had insurance through another family member, approximately 9 percent lost non-group private coverage, and 8 percent lost Medicaid coverage. Not everyone gains the same kind of coverage they lost when they once again gain insurance, though overall it appears they do.

Table 5. Factors Accounting for Start and End of Uninsured Spells for Families with Incomes Greater than 100 percent of the Federal Poverty Line, 1987 (percentage).

Spell Started Due to Loss of		Spell Ended Due to Gain of			
		Employer Coverage	Private Coverage	Others' Coverage	Medicaid
Employer Coverage	31.8	24.8	2.1	4.3	0.7
Private Coverage	9.3	3.3	4.3	1.7	0.1
Others' Coverage	50.7	9.3	2.7	36.4	2.2
Medicaid	8.2	1.0	0.2	3.2	3.9
TOTAL	100.0	38.3	9.2	45.6	6.9

SOURCE: TIMOTHY MCBRIDE 1995.
NOTES: PRIVATE COVERAGE REFERS TO NON-GROUP COVERAGE. OTHERS COVERAGE REFERS TO GROUP OR NON-GROUP COVERAGE THROUGH, FOR EXAMPLE, A SPOUSE'S EMPLOYER.

III. Impact of Proposed Reductions in Medicaid Budget

Summary of Proposed Changes

Both the House and Senate have proposed versions of MediGrant bills aimed at reducing federal spending for Medicaid. These proposals reduce Medicaid spending by $182 billion between 1996-2002. To facilitate efforts to meet the proposed budget targets, states would receive unprecedented flexibility in program design and allocation of funds. The benefit package, eligibility criteria, and rate paid to providers would all be left to state authority in an effort to encourage innovation. Specifically, these MediGrant bills replace individual entitlement and minimum eligibility standards and benefits with block grants to

states. Immunization services for children are the only required benefits, with non-binding language addressing state efforts with regard to children, pregnant women, and the disabled.[9] States have the option of re-establishing individual entitlement to a newly defined set of services for certain groups, or of providing medical assistance to the poor through alternative means, such as grants to health centers, sub-block grants at the county level, or other arrangements.

Table 6 presents CBO baseline expenditure projections from 1996-2002, as well as the budget targets put forth in the House and Senate bills. Projections for enrollment growth are also included. The CBO projects a 3.3 percent annual growth in enrollment, and an annual growth rate in spending of 10.2 percent. In comparison, under either the House or Senate bills, Medicaid spending would be constrained to an annual growth rate of 4.5 and 4.8 percent respectively. This means that states would be facing a 30 percent reduction in federal Medicaid dollars by 2002 as compared to revenues they could expect under current policy. If, however, enrollment increases were to continue at projected levels, the resulting growth in Medicaid spending per beneficiary could be constrained to 1.2 percent per year under the House proposal.

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[9] These proposals allow states unprecedented flexibility in program design and allocation of funds. As Rosenbaum and Darnell (1995) have pointed out, while both bills require state to set aside a certain portion of the MediGrant funds for children, pregnant women and the disabled, the total amount of the set aside equals 41.9 percent of average total state and federal Medicaid spending between fiscal year 1992 and 1994. Over half the block grant amounts can be spent at the total discretion of states. Cost-sharing is also allowed in both bills, except in the case of pregnant women and children under 100 percent of the federal poverty line, and all state restrictions are removed regarding provider payments, disproportionate share payments, federally qualified health centers, and minimum thresholds of eligibility and service provision.

Table 6. Baseline and Proposed Growth in Federal Medicaid Spending (Billions) and Recipients (Millions).

	1996	1997	1998	1999	2000	2001	2002	AVERAGE GROWTH (PERCENTAGE)
SPENDING ($BILLIONS)								
CBO BASELINE	99.2	110	122	134.8	148.1	162.7	177.7	10.2
HOUSE PROPOSAL*	95.7	102.1	106.2	110.5	114.9	119.5	124.3	4.5
SENATE* PROPOSAL	94.1	100.5	104.9	109.5	114.4	119.5	125.7	4.8
ENROLLEE BASELINES (MILLIONS)								
CBO	38.4	40.0	41.2	42.4	43.7	45.0	46.4	3.3
HHS	37.4	39.0	40.5	42.1	43.8	45.6	47.4	4.0

SOURCE: THORPE 1995, CONGRESSIONAL BUDGET OFFICE 1995.
NOTES: CBO REFERS TO THE CONGRESSIONAL BUDGET OFFICE.
HHS REFERS TO THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES.

The proposed formula to allocate federal Medicaid dollars would continue to be based on per capita income, with annual growth rates related to expected state enrollment growth rates. In addition, there would be limits on maximum and minimum spending growth. Higher growth states would receive grants with slightly higher growth rates in the years following the initial block grant, but overall federal spending would be limited to a national growth rate target.

At issue is how states will respond to the slower growth in federal Medicaid payments. State responses will no doubt vary. However, regardless of how states choose to exercise their newfound flexibility, it appears unlikely that states will be able to live within the proposed budget figures without constraining services and eligibility. A recent analysis by Holahan et al. estimates the possible range of savings that might be garnered through aggressive cost-saving strategies, short of cutting eligibility. Table 7 summarizes the menu of policy options designed to reduce the growth of Medicaid spending per beneficiary.

Table 7. Potential Cost Savings from Redesigning Medicaid Programs, by Selected Options

Design Option	Savings as Percentage of Baseline 2002 Spending
Enroll all adults and children in managed care	1.6
Reduce provider payments for acute services by 10 percent	1.8
Eliminate two-thirds of all optional acute care services	5.1
Eliminate 50% of federal disproportionate share payments	3.9
Reduce nursing home payments by 10 percent	2.0
Freeze nursing home beds for two years	0.4
Estate recovery and spousal assets included in nursing home eligibility	0.8
Reduce home health care spending by one-third	1.8
Move ICF-MR patients to lower cost setting	1.0
Total Spending Cuts Per Beneficiary	18.4

Source: Holahan, et al. 1995 NOTE: Estimates do not include interactive effects. *ICF-MR refers to Intermediate Care Facility for the Mentally Retarded.

To the extent that states want to maximize such spending reductions, they could adopt each of the options outlined below. However, even the most optimistic savings projections yield a combined savings of 18.4 percent, well short of the 30 percent reduction in spending per beneficiary needed to stay within budget figures.

In responding to the need to constrain spending further, states may choose to retain current categories of persons eligible for Medicaid but control costs through waiting lists, time limits, or reductions in services available to each beneficiary. Alternatively, states may remove whole groups from Medicaid eligibility (e.g. those over 100% of poverty line, those eligible through "spending down", non-U.S. citizens). Even with more aggressive implementation of capitated managed care, reductions in provider payments, reductions in services provided, and changes in eligibility seem likely. Therefore, given the enrollment dilemma states will face, we believe at a minimum the number of individuals permitted to

receive Medicaid coverage will not grow from today's levels under the new federal spending limits.

Assessing the Impact of Medicaid Budget Limits with Baseline Growth in the Number of Uninsured:
SCENARIO 1

Baseline Methodology. To establish a baseline, we modified estimates from CBO concerning health insurance coverage developed during the last session of Congress for health care reform. This analysis presents estimates of private and public coverage through the year 2005. We have built on this analysis by rebasing their 1995 estimate of the number of uninsured. The most recent data from the March 1995 Current Population Survey (CPS) places that number of uninsured at 39.7 million, slightly less than the earlier estimate of 40.1 million. This includes over 1 million uninsured children between the ages of 10 and 18 living in poverty, currently scheduled to receive Medicaid coverage by the year 2002. Another 8 million or so individuals have Medicaid, but are also covered by Medicare, or in some instances private insurance. Our baseline estimates beyond 1995 used projections of the uninsured as a percent of the population developed from the March 1995 CPS. According to our application of the CBO methodology, the baseline number of uninsured will rise modestly during the next 7 years, from 39.7 million (15.2% of total population) to 43.8 million (15.8%)[10], as seen in Table 8.

We then estimate the number of uninsured, assuming that Medicaid enrollment will be kept at current levels, including groups such as the medically needy and others expected to receive coverage under current law. In this scenario, states would freeze current levels of enrollment, and focus on containing cost growth to the average 4.5 percent per year per beneficiary allowed in the proposed budgets. Using these assumptions, the projected number of uninsured reaches 48.7 million by the year 2002, compared with the 43.8 million in the baseline projections.

The Combined Impact of Medicaid Budget Limits and Accelerated Erosion of ESI:
SCENARIO 2

In our second scenario, we add the effect of the accelerated growth in the decline of ESI seen over the past four years. Between 1989 and 1993, the percent of the population covered by ESI fell from 61 percent to 57 percent. This reduction occurred almost

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[10]These assumptions, however, likely understate the number of newly uninsured. In particular, the CPS undercounts the number of Medicaid enrollees. Program counts place the number of Medicaid enrollees at 33.4 million in fiscal year 1993. The March 1994, however, estimates the number of Medicaid enrollees during the same year at 31.7 million, approximately 5 percent lower than program counts. The disparity in the most recent March 1995 CPS is greater. CPS estimates the number of Medicaid enrollees at 31.6 million, nearly 10 percent lower than program counts. Thus, our estimates for the uninsured are likely quite conservative.

4.6%

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exclusively among dependents of workers, as the number of workers covered by ESI remained stable over the period. Given the well documented shift of jobs from the manufacturing sector of the economy, where workers are more likely to receive health insurance through their employer, to the service sector, where workers are much less likely to receive health coverage through their employer, and given the growth in temporary and part-time work without benefits, it seems reasonable to anticipate that this accelerated decline in ESI coverage will continue.

If the decline in ESI coverage continues on the same trend as 1989-1993, and changes in the Medicaid program prevent expansions in Medicaid eligibility, then those losing ESI have an increased likelihood of becoming uninsured. In Scenario 2, the combined effect of reduced Medicaid revenues and accelerated decline in ESI increases the number of projected uninsured to 66.8 million by 2002.

Table 8. Alternative Scenarios for the Number of Uninsured.

% Population

	1995	1996	1997	1998	1999	2000	2001	2002	
UNINSURED BASELINE	39.7	40.7	41.1	41.7	42.3	42.6	43.2	43.8	15.8%
BASELINE OF THOSE INSURED BY									
ESI	149	149.5	150.1	150.6	151.1	151.5	151.9	152.3	
OTHER	16.5	16.4	16.4	16.4	16.3	16.6	16.5	16.4	
MEDICARE	33.9	34.2	34.7	35.1	35.6	36.0	36.5	37.0	
MEDICAID	23.0	23.7	24.4	25.1	25.8	26.5	27.2	27.9	
TOTAL POPULATION	262.1	264.5	266.7	268.9	271.1	273.2	275.3	277.4	
UNINSURED SCENARIO 1	39.7	41.4	42.4	43.8	45.1	46.1	47.2	48.7	17.6%
UNINSURED SCENARIO 2	39.7	43.7	47.3	51.2	55.2	58.8	62.8	66.8	24.1%

SOURCE: THORPE 1995, CONGRESSIONAL BUDGET OFFICE 1995.
NOTES: BASELINES ARE PROJECTIONS BY THE CONGRESSIONAL BUDGET OFFICE.
ESI REFERS TO EMPLOYER-SPONSORED INSURANCE.

from Urbanstat

IV. Anticipated Demand for Uncompensated Care

Traditionally, care for the uninsured has been provided through a complex web of direct public financing[11] and cost-shifting to patients with public and private health coverage. Although hospitals have been the primary provider of services to the uninsured, physicians, community health centers and other providers also provide a substantial volume of free care. The CBO recently estimated that hospital and physicians provided approximately $20 billion in uncompensated care in 1991. This number reaches approximately $28 billion in 1995. Not all uncompensated care is traced to the uninsured, however. As reported earlier, studies have linked approximately 77 percent of uncompensated hospital care to the uninsured. The remaining amount is traced to individuals who do not pay their deductibles or coinsurance.

The uninsured are reported to account for 89 percent of uncompensated care provided by physicians[12].

In considering the capacity of the health care delivery system to respond to an increased demand for uncompensated care, we focused on hospitals, the largest suppliers of uncompensated care. Table 9 shows the baseline growth in the number of uninsured and the expected baseline rise in hospital uncompensated care.

Baseline Methodology. Our baseline for uncompensated care is derived from the American Hospital Association (AHA) Annual Survey. The AHA survey estimates that community hospitals provided $15.9 billion in uncompensated care costs during 1993. This amounts to approximately 6 percent of all hospital costs. These costs increased to $16.6 billion in 1994 and $17.7 billion in 1995. CBO figures indicate that the uninsured account for 77 percent of uncompensated care charges. Thus, approximately $12.7 billion in uncompensated care is traced to the uninsured. The remaining 23 percent of uncompensated care charges are traced to insured persons that do not or cannot pay their cost sharing amounts.

To calculate the future volume of uninsured uncompensated care, we first estimated the growth in total uncompensated care. We assume such care grows at the rate of growth in hospital costs (although traditionally it has grown faster than overall costs over time). Second, we calculated baseline per capita uninsured uncompensated care by taking 77 percent of this figure and dividing it by the baseline number of uninsured. Third, the per capita was multiplied by the number of uninsured in each scenario. The remaining volume of uncompensated care traced to uninsured patients is estimated to grow at hospital cost growth rate. This assumes the per capita costs of uncompensated care observed today will, despite

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[11]Public hospitals have received direct financing for uncompensated care from state and local tax appropriations. During 1993, these appropriations amounted to $3.1 billion (CBO).

[12] CBO Staff memorandum, "Single Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates", April 1993.

Ken — Announce Corrections on our final numbers

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the likely changes in the composition of the uninsured, remain unchanged. No changes in the Medicare and Medicaid programs are assumed. As Table 9 shows, the baseline projects that growth in uncompensated care will increase at a rate similar to the previous 15 years -- from $16.6 billion in 1995 to $27.4 billion in the year 2002, or at a rate of 6 percent of total hospital expenditures.

Table 9. Baseline and Alternative Projections of the Demand for Uncompensated Care ($billions) and the Number of Uninsured (millions), 1995-2002.

	1995	1996	1997	1998	1999	2000	2001	2002
BASELINE UNINSURED	39.7	40.7	41.1	41.7	42.3	42.6	43.2	43.8
BASELINE UNCOMPENSATED CARE	17.7	19.0	20.3	21.9	23.6	25.4	27.3	29.3
SCENARIO 1 UNINSURED	39.7	41.4	42.5	43.8	45.1	46.1	47.4	48.7
SCENARIO 1 UNCOMPENSATED CARE	18.3	20.0	21.8	23.8	25.9	28.2	30.7	33.4
SCENARIO 2 UNINSURED	39.7	43.7	47.4	51.2	55.2	58.8	62.8	66.8
SCENARIO 2 UNCOMPENSATED CARE	18.3	20.8	23.7	26.9	30.4	34.3	38.5	43.2

not $27.4B

6%

not $29.7B

not $38.4B

SOURCE: DERIVED FROM THE 1993 AMERICAN HOSPITAL ASSOCIATION'S ANNUAL SURVEY OF HOSPITALS AND DATA FROM THE PROSPECTIVE PAYMENT ASSESSMENT COMMISSION.

Under the assumptions of our Scenario 1, in which we use the conservative estimates regarding the erosion of ESI and assume no growth in Medicaid enrollment, the potential demand for uncompensated care grows to $29.7 billion. In our second scenario, which assumes the decline in ESI continues on the same trend as 1989-1993 and again holds Medicaid enrollment constant, the demand for uncompensated care reaches $38.4 billion.[13]

[13]We slightly understate the impact on hospitals of growing levels of uninsured. For example, national uncompensated care was $16 billion in 1993 (6% of $266 billion) and in our hospitals (6% of $233 billion=$14 billion). In 1995 this would total nationally nearly $18 billion (6.4% of $300 billion in costs). Since we are using a subset, the total is slightly less around $16 billion or so. However, we calculate a per capita using total number of uninsured. This slightly understands per capita costs. This is not really a big deal though since Maryland only has about 0.6 million uninsured on a base of 39.7. So we have understated total uncompensated care across all hospitals by about 5%.

It is important to note that the distribution of uncompensated care discussed above will not be uniform across hospitals. Table 10 illustrates the distribution of uncompensated care across hospital types in selected years, as well as the ratio of uncompensated care to total costs in 1993.

Table 10. Distribution of Uncompensated Care Costs Across All Hospitals (Percentage), Selected Years, and Uncompensated Care Costs as Percentage of Total Costs, 1993

Hospital Type	1980	1985	1993	Uncompensated Care as Percentage of Total Costs, 1993
Large Urban	43.1	41.4	59.5	6.4
Other Urban	40.3	43.1	30.3	5.6
Rural	16.5	15.5	10.2	5.1
Major Public Teaching	22.7	13.7	24.8	18.5
Major Non-Public Teaching	9.9	11.5	12.5	5.0
Other Teaching	28.1	30.1	26.4	4.9
Non-Teaching	39.4	44.6	36.1	4.8

Source: Derived from the 1993 American Hospital Association's Annual Survey of Hospitals and data from the Prospective Payment Assessment Commission.

Note that large urban hospitals provide nearly 60 percent of uncompensated care having steadily increased their share from 43 percent in 1980. At the same time, other urban hospitals have declined from 40 percent to 30 percent over the same period. The proportion of uncompensated care provided by major teaching hospitals has also increased from 9.9 percent in 1980 to 12.5 percent in 1993. Major public teaching hospitals together with other teaching facilities provide about a quarter of all uncompensated care. It is also important to note that large urban hospitals have a higher ratio of their total costs consumed by uncompensated care than other hospitals (6.4 percent), with the exception of major public hospitals in which 18.5 percent of costs are attributable to uncompensated care.

The last column of Table 10 indicates the ratio of uncompensated care costs to total cost for each hospital type, showing the financial impact uncompensated care had on these

facilities in 1993. Large urban hospitals provide a large and growing share of uncompensated care (6.4 percent of costs in large urban hospitals, compared to 5.6 percent in other urban and 5.1 percent in rural hospitals). The ratio of uncompensated total costs is also higher in large urban hospitals compared to major private teaching institutions (6.4 percent versus 5 percent).

Table 11 examines the percent of total costs assumed by our baseline and two different uncompensated care cost growth scenarios. Under current policy, we presume that uncompensated care will account for a stable proportion of hospital costs, namely 6 percent. Under scenario 1, where uncompensated rises to $33.4 billion by the year 2002, uncompensated care costs would account for 6.8 percent of hospital costs. Under the second scenario, where uncompensated care rises to $43.2 billion in the year 2002, uncompensated care rises to 8.8 percent of hospital costs.

Table 11. Uncompensated Care as Percent of Hospital Costs

	1995	1996	1997	1998	1999	2000	2001	2002
BASELINE	6	6	6	6	6	6	6	6
Scenario 1	6.2	6.3	6.4	6.5	6.5	6.6	6.7	6.8
Scenario 2	6.2	6.6	7	7.3	7.7	8.1	8.4	8.8

In summary, the number of uninsured will likely increase due to reductions in federal Medicaid funding and may become substantially higher if the recent trends in ESI persist. The amount of uncompensated care will vary directly with the number of uninsured. This will have a large impact on hospitals as revenues from previously insured private payers decline, but most of their demand for services and the cost associated with them will persist. Large urban and teaching hospitals will bear a disproportionate burden of the impact of these changes, and the ability of these institutions to meet the growing demand for uncompensated care seems uncertain at best.

V. Conclusions

The proposed changes in Medicaid could result in increased efficiency in the health care system, and certainly will afford states the opportunity to develop innovative strategies for providing health care. We may see several new types of programs that specialize in providing quality care for low-income persons in a more efficient manner. In addition, state leaders have long cited the burden of federal regulatory requirements as a deterrent for enhanced innovation and collaboration among policy makers and providers at the state level. The have also objected to federal mandates which often come without sufficient federal funding to implement without constituting an additional financial burden to states. The new flexibility allowed under current proposals is welcome news at the state level, although this flexibility comes at a great cost to states in terms of reduced federal revenues.

This reduction in the rate of growth of federal revenues raises several important concerns regarding the financial environment that states and, in turn, hospitals will face in providing care to Medicaid enrollees and the uninsured. The expected rise in the number of uninsured, combined with an even faster trajectory of care demanded by the uninsured raises several potential problems. Without significant expansions of coverage at either the national or state level, hospitals may be forced to restrict care to the uninsured, reduce quality of care, raise more revenues from private payers, or all of the above. The scenarios outlined above indicate that the level of uncompensated care demanded by the uninsured could rise sharply, potentially accounting for nearly 9 percent of hospital costs by the year 2002. Current rates are about 6 percent. The combined impact of reduced revenues, increasing numbers of uninsured, and increased competition may be too much for some hospitals. As recently as November 3rd, The New York Times reported that a Wall Street credit rating firm, Moody's, is anticipating downgrading its ratings of several major hospitals in anticipation of the impact of Medicare and Medicaid cuts. As one Moody executive noted, "Regardless of the measures hospitals take, the cuts will reduce profit margins materially and lead to the closure of weaker performers."

Of particular concern is the continued reduction in private health insurance. Though preliminary data from March 1995 seem to indicate the trends have, for the time being, stabilized, these reductions remain a cause for concern. At the same time, should the Congress and President agree to reduce the growth in Medicaid to the levels currently discussed, and should the declines in ESI coverage continue, the number of uninsured could rise to nearly 67 million. Analyses by the Urban Institute indicate that efforts to reduce spending per Medicaid enrollee would generate at most 60 percent of the reductions needed to meet these new block grant budgets. Although many believe that Medicaid managed care can generate significant long-run savings for these populations, it is unlikely that managed care will generate substantial savings in the near future. It will take time for states to implement more aggressive capitated models. Also, most of the policy options under discussion focus on women and children and do not address the fact the lion's share of Medicaid spending which is for the elderly and disabled. The health care needs of the SSI, blind and disabled populations will make it difficult to realize large savings from managed care for these populations. Even in the most successful programs, managed care has usually resulted in savings of no more than about 5 percent. Hence, the remaining savings would have to come from reducing the number of individuals receiving Medicaid coverage. In this case, state and national policy makers would have to develop auxiliary approaches to providing care for an ever rising tide of uninsured patients.

In conclusion, we anticipate increased numbers of uninsured, increased demand for uncompensated care, and a decreased capacity of the delivery system to meet this need. The majority of the uninsured constitute a vulnerable population with no political voice. While we do not accept the premise that any decrease in funding for the health care of these populations will necessarily decrease the quality and availability of needed services, we are concerned that the magnitude of the reductions could generate serious problems. We therefore strongly recommend that a substantial monitoring effort be developed to track

access to needed medical care, and the quality of care available to our nation's most vulnerable populations.

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