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Page 4

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NSN 7540-01-317-7368

FORM 101

GENERAL SERVICES ADMINISTRATION

Charts and Figures

The data source for each chart is the 1995 Current Population Survey (CPS) and its March supplement on health insurance.

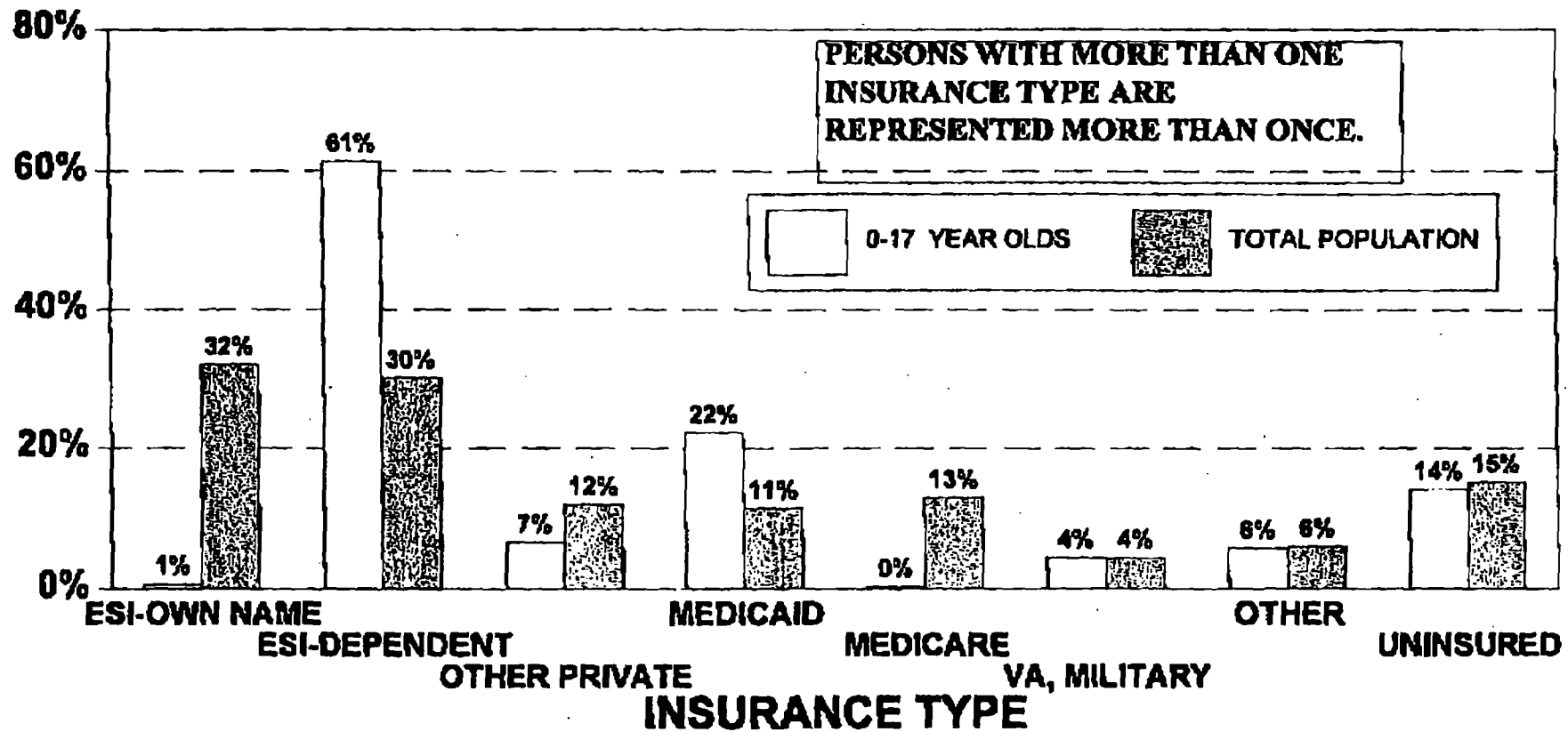
Percent in Health Insurance Class Persons (Millions) by Health Insurance

Each March the Current Population Survey asks each person in the sample what health insurance coverage each person in the household had the previous year. Two charts are included, each contrasting children with the U.S. population as a whole. The first chart indicates the percentage in each group; the second indicates the number of people in millions. Note that persons with more than one insurance type are represented more than once; consequently the percentages add to more than 100%. The third chart, with 0-17 year olds only and indicating the number of children in each category, is included as supplementary information.

- **ESI-Own Name:** Very few children (1%) under 18 years of age have Employer Sponsored Insurance in their own names. For those 18 and older, 32% had ESI in their own names.
- **ESI-Dependent:** 61% of all children, or 43.3 million persons, are covered through Employer Sponsored Insurance as dependents. For those persons over 18, only 30% are covered as dependents.
- **Other Private Insurance:** Only 7% of children, representing 4.6 million people, have "Other Private" insurance coverage (individual policies). Of those over 18, 12% have "Other Private" insurance.
- **Medicaid:** 15.7 million children, representing 22% of all children, are covered by Medicaid. Of those over 18, only 11% are covered by Medicaid.
- **Medicare:** Approximately 0.2% of all children are covered by Medicare (this number rounds to 0% on the graph). For the most part, they are covered under the End Stage Renal Disease provisions.
- **"VA, Military," "Other":** Approximately the same percentages of children and the public as a whole are covered by "VA, Military" (4%) or "Other" (6%) coverage.
- **Uninsured:** Ten million children are uninsured, representing 14% of all children. Virtually the same percentage, 15%, of the public as a whole is uninsured.

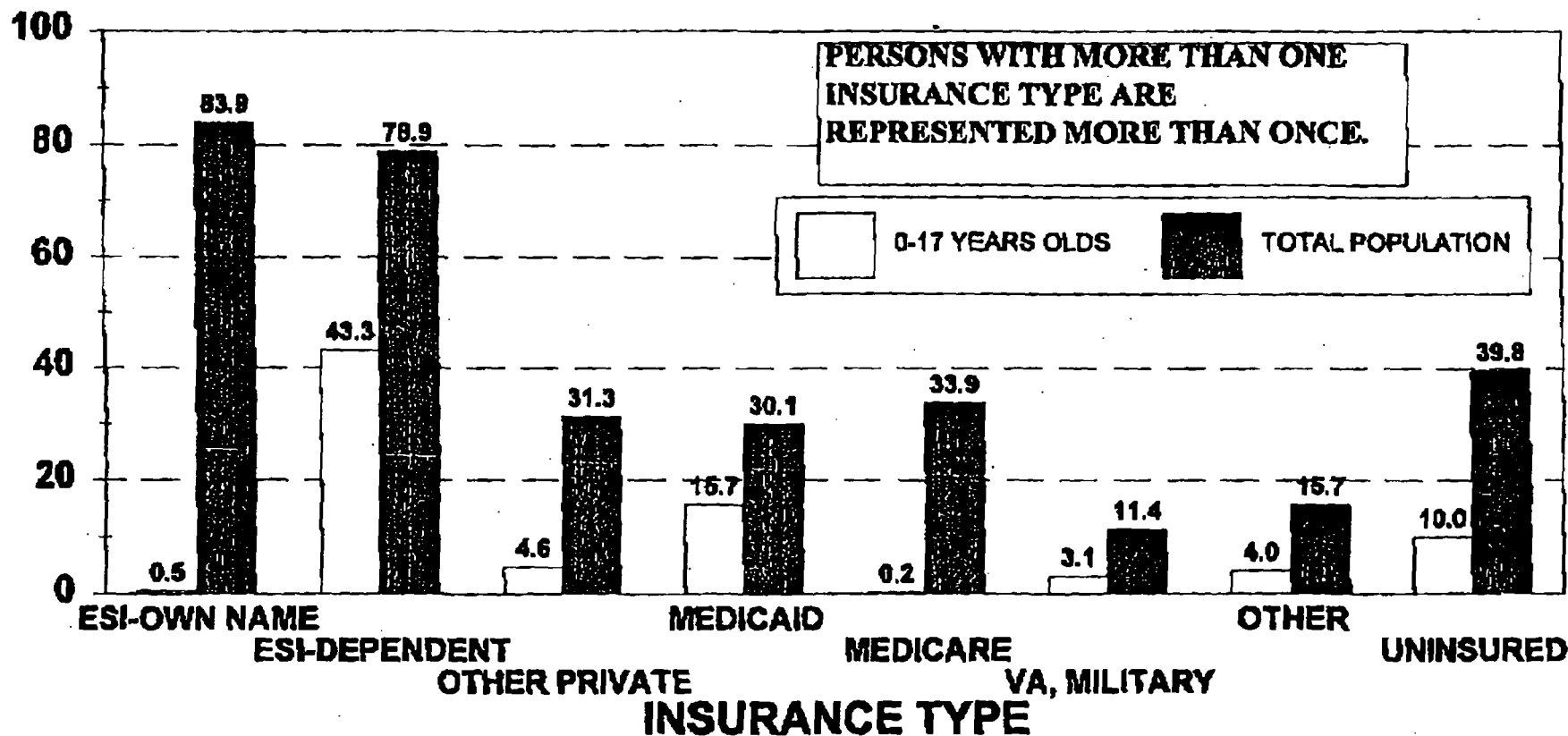
% IN HEALTH INSURANCE CLASS

MARCH 1995 CURRENT POPULATION SURVEY



SOURCE: TABULATIONS BY ASPE OF THE MARCH 1995 CURRENT POPULATION SURVEY.

PERSONS (MILLIONS) BY HEALTH INSURANCE MARCH 1995 CURRENT POPULATION SURVEY



SOURCE: TABULATIONS BY ASPE OF THE MARCH 1995 CURRENT POPULATION SURVEY.

UNITED STATES DEPARTMENT OF COMMERCE NEWS

WASHINGTON, DC 20230

ECONOMICS
AND
STATISTICS
ADMINISTRATION

BUREAU OF THE
CENSUS

EMBARGOED UNTIL: JUNE 24, 1996 (MONDAY)

Public Information Office
301-457-3030
301-457-4067 (TDD)

CB96-102

Robert Bennefield
301-763-8578

NEARLY THREE IN TEN AMERICANS HAVE INTERRUPTION IN HEALTH INSURANCE COVERAGE, CENSUS BUREAU REPORTS

EMBARGOED UNTIL: JUNE 24, 1996 (MONDAY) - Approximately 27 percent of the population (66.6 million people) lacked health insurance for at least one month in a 28-month period starting in early 1992; about 11.9 million people (4.8 percent) were uninsured during that entire period. These findings are contained in a report, Dynamics of Economic Well-Being: Health Insurance, 1992 to 1993, released today by the Commerce Department's Census Bureau. The information was collected in the bureau's Survey of Income and Program Participation (SIPP). The SIPP, which surveys approximately 20,000 households across the country, is designed to collect information on the economic well-being of persons, families and households.

This latest report provides a comprehensive look at those who do and do not have health insurance, the types of insurance coverage used (including employer or union plans, other privately purchased plans, Medicare, medicaid, and military health care), and the characteristics of people who are or are not covered by health insurance. It also provides information on how long people go without health insurance.

According to the report, work experience has a significant effect on health insurance coverage: 87 percent of persons who worked full-time during the survey's time frame were covered continuously by health insurance, compared with 74 percent for part-time workers, and 58 percent for workers with one or more job interruptions.

"Health insurance coverage is commonly associated with other life circumstances, such as employment, retirement, and government program participation. The data indicate there is a strong likelihood some segments of the population will change health insurance status over time," says the report's author Bob Bennefield.

(more)

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EMBARGOED UNTIL: JUNE 24, 1996 (MONDAY)

Some other findings over the 28-month survey period are:

- o Young adults--between 18 and 24 years old--were the most likely age group to lack insurance for at least one month.
- o The percentages of people who spent at least one month without health insurance were: 23 percent for Whites (not of Hispanic origin), 36 percent for African Americans, and 49 percent for persons of Hispanic origin.
- o People who lived in the South and West were more likely to experience one or more months without health insurance coverage than those living in the Northeast or Midwest. The percentages of people with one or more months without health insurance coverage were: 31 percent in both the South and West, 23 percent in the Midwest, and 22 percent in the Northeast.

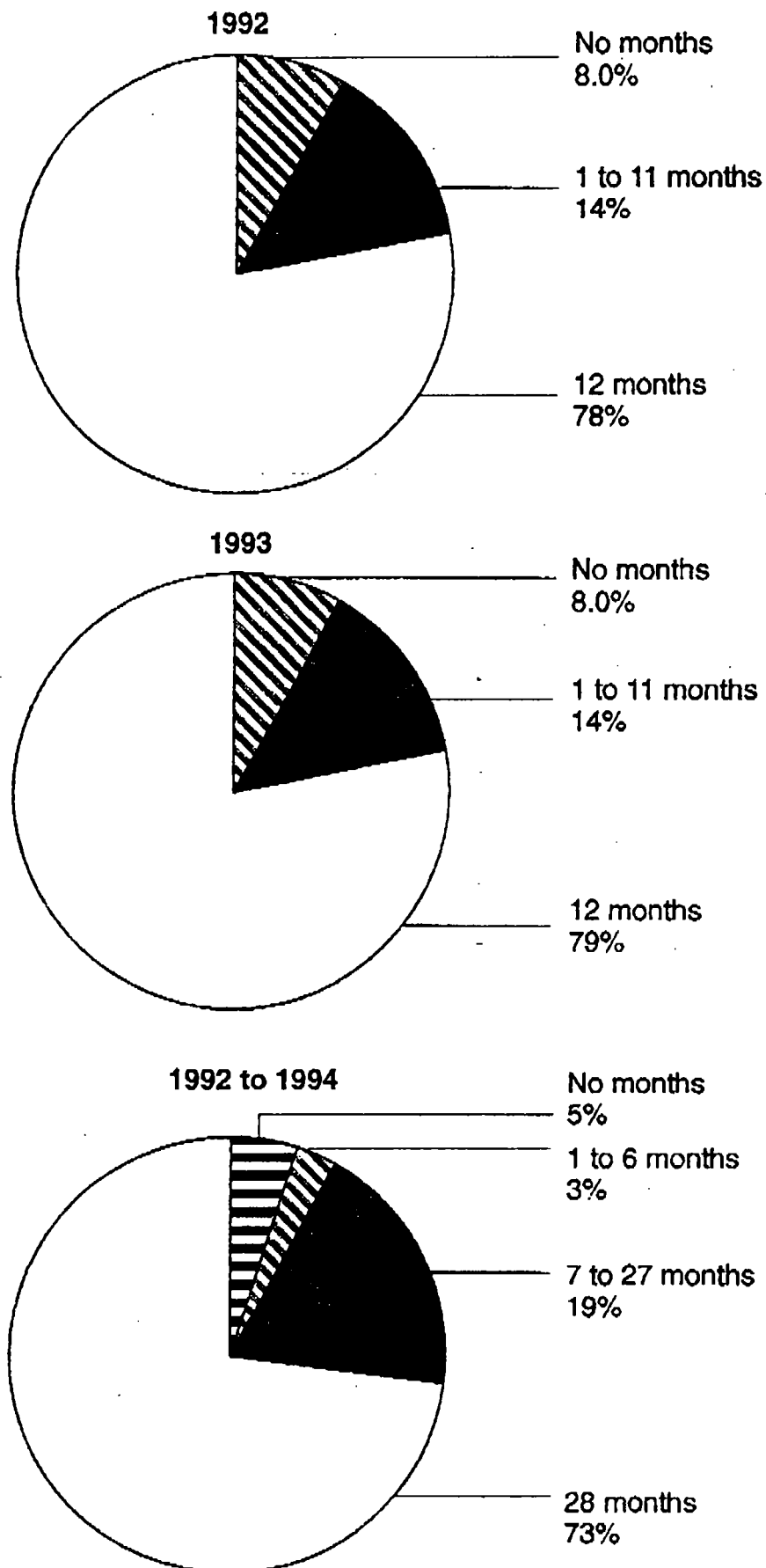
As in all surveys, the data in this report are subject to sampling variability and other sources of error.

The attached chart shows the percent of persons covered by health insurance (1992-1994), by length of coverage.

-X-

Editor's note: media representatives may obtain copies of the report from the Census Bureau's Public Information Office on 301-457-3030; fax: 301-457-3670, or e-mail: pio.@census.gov. Other orders should be directed to the bureau's FastFax: 1-900-555-2FAX (there is a nominal fee); Customer Services Branch on 301-457-4100; or fax: 301-457-3842.

Figure 1.
Percent Covered by Health Insurance: 1992 to 1994



Source: U.S. Bureau of the Census, Survey of Income and Program Participation.

Current Population Reports

Household Economic Studies

Dynamics of Economic Well-Being:
Health Insurance, 1992 to 1993

Who Loses Coverage and for How Long?

By Robert L. Bennefield

CENSUS BUREAU

P70-54
May 1996

Introduction

Many people are concerned about the growing number of Americans who lack health insurance. This report uses data from the Survey of Income and Program Participation (SIPP) to examine this issue. It focuses primarily on the extent to which people are covered by health insurance over a 28-month period beginning in early 1992. The source of this information is the first seven waves of the 1992 panel of the SIPP.

During each SIPP interview, information is collected on health insurance coverage (along with other information on income and labor force and program participation) for each month in the 4-month reference period. It is therefore possible to classify people by the number of months over the 28-month period that the person was covered by one or more types of health insurance. It is also possible to measure the number of months continuously spent without insurance coverage; that is, spells of noncoverage.

Health insurance in this report refers to the following types of coverage: 1) employer- or union-provided insurance, 2) other privately purchased health insurance, 3) medicare, 4) military health care, and 5) medicaid.

Highlights

(The figures in parentheses denote the 90-percent confidence intervals.)

- Estimates for 1993 show that 19.4 (± 1.1) million people were uninsured over that 12-month period. That estimate was not significantly higher than the 1992 estimate of 19.0 (± 1.0) million uninsured people.

- Nearly 4 out of 5 people—78.8 (± 0.6) percent of all people—had continuous health insurance coverage all months of 1993. Thus, 21.2 (± 0.6) percent, or 53.6 (± 1.6) million people, lacked insurance for at least 1 month. This percentage was not significantly different from the 21.6 (± 0.6) percent who experienced a lapse in coverage during calendar year 1992.

- Over a 28-month period during 1992 to 1994, 73.0 (± 0.8) percent of all people had continuous health insurance coverage; therefore, 27.0 (± 0.8) percent, or 66.6 (± 1.7) million people, lacked insurance for at least 1 of those 28 months—4.8 percent (± 0.4) or 11.9 (± 0.8) million were uninsured for the full 28-month period from early 1992 to mid-1994.

- Young adults (those between the ages of 18 and 24 years old) were the most likely of any age group to lack insurance for at least 1 month—over one-half, or 51.5 percent (± 2.5) were not continuously insured during the 28-month period.

- Work experience has a significant effect on health insurance coverage: 86.5 (± 1.1) percent of people who worked full time for the entire period were covered continuously by health insurance, compared with 73.5 (± 4.7) percent for full-period, part-time workers, and 58.1 (± 1.4) percent for workers with one or more job interruptions.

- Those who were poor or near poor were less likely to have continuous health insurance coverage than others: 82.5 (± 0.7) percent of those with an income-to-poverty ratio of 2.0 or greater had continuous coverage, compared with 52.8

(± 1.4) percent of those with an income-to-poverty ratio below 2.0.

- Twenty-seven (± 0.8) percent of all people experienced at least one period of time without health insurance coverage during the 28-month survey period. Of all observed spells without health insurance, half lasted for 5.7 months or longer. This estimate was significantly shorter than the 7.1 months of noncoverage for the 1991-1993 period.

Estimates of Health Insurance Coverage

Health insurance coverage is commonly associated with other life circumstances, such as employment, retirement, and government program participation. As a result, there exists a strong likelihood that, for some segments of the population, health insurance status will change over time. Through the use of longitudinal estimates, it is possible to examine the dynamics of health insurance coverage, and the extent to which people experience a lapse in coverage during a given time period.

The first seven waves of the 1992 SIPP panel file were used to examine the number of months people were covered by health insurance during a 28-month period. Interviews from this panel were conducted between February 1992 and May 1994, allowing examination of health insurance coverage for 2 calendar years, 1992 and 1993. During the 1993 calendar year, 79 percent of all people had health insurance coverage for the entire year; 21 percent, or 54 million people, lacked coverage for at least 1 month. Eight percent, or 19 million people, were never covered in

1993. The 1992 calendar year estimates were similar, showing 78 percent, 22 percent, and 8 percent, respectively.

Between 1992 and early 1994, 73 percent of all people had continuous health insurance coverage over the entire 28-month survey period; 27 percent lacked health insurance for at least 1 month. Eight percent of all people were covered by insurance for 6 months or less (5 percent lacked coverage for the entire period, and another 3 percent were covered for 1 to 6 months) (see figure 1).

Comparisons Over Different Time Periods

The proportion of people with lapses in coverage is greater when measured over a longer time period, as different people may lose coverage in different years. For example, proportions of those with lapses in coverage were similar for calendar years 1992 and 1993; 22 and 21 percent, respectively. However, over the full 28-month period, the proportion of those with a lapse in coverage increased to 27 percent.

Comparisons of estimates over a 28-month period from the 1992 panel with those from the 1991 panel show almost similar patterns of health insurance coverage between the 1991-1993 period and the 1992-1994 period. A slightly lower proportion of people had continuous coverage in the later period—the percent covered for the entire 28-month period dropped from 75 percent in the 1991-1993 period to 73 percent from 1992 to 1994. The remainder of this report will focus only on information collected for the 28 months between February 1992 and May 1994.

Sex, Race, and Hispanic Origin¹

As shown in figure 2, over the 28-month interview period

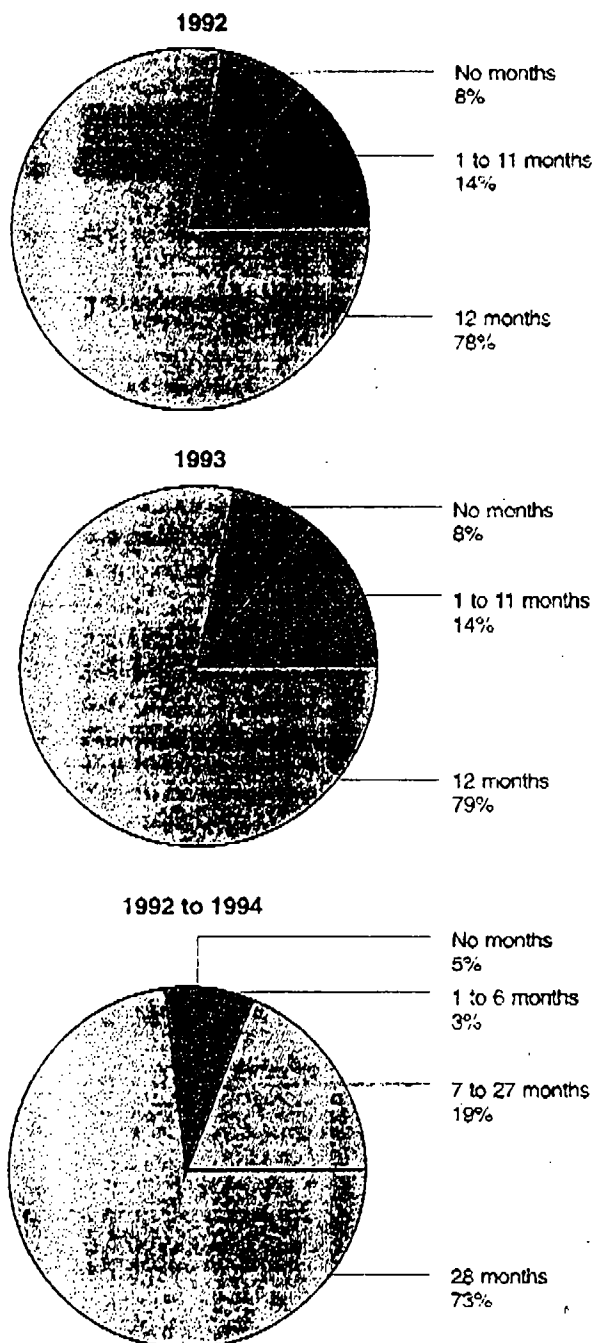
¹ Persons of Hispanic origin may be of any race. The information on the Hispanic population shown in this report was collected in the 50 States and the District of Columbia, and therefore, does not include residents of Puerto Rico.

beginning in February 1992, women were more likely than men to have continuous health insurance coverage—75 percent of women compared with 71 percent of men. This difference is partially attributable to differences in economic status. Women are more likely than men to live in families

with incomes below poverty,² and are more likely to participate in means-tested government

² In 1994 the official poverty rate was 12.6 percent for men and 16.3 percent for women. See Current Population Reports, Series P60-189, "Income, Poverty, and Valuation of Noncash Benefits: 1994."

Figure 1.
Percent Covered by Health Insurance: 1992 to 1994



Source: U.S. Bureau of the Census, Survey of Income and Program Participation.

P70-54

3

assistance programs.³ Thus, women were more likely than men to take part in medicaid.

A second factor contributing to the difference in health insurance coverage between men and women is age. More women than men are 65 years old and over, and virtually everyone in that age group is covered by medicare.

The relationship between race or Hispanic origin and health insurance was a strong one. The percentages of people who spent at least 1 month without health insurance were 23 percent for Whites (not of Hispanic origin), 36 percent for Blacks, and 49 percent for Hispanics.

Age

Young adults (those between the ages of 18 and 24) were the most likely of any age group to spend at least 1 month without health insurance coverage—about one-half (52 percent) lacked insurance for at least 1 month during the 28-month period, while 13 percent were covered for less than 7 months. Moreover, as age increased among adults, continuous health insurance coverage became more common.⁴

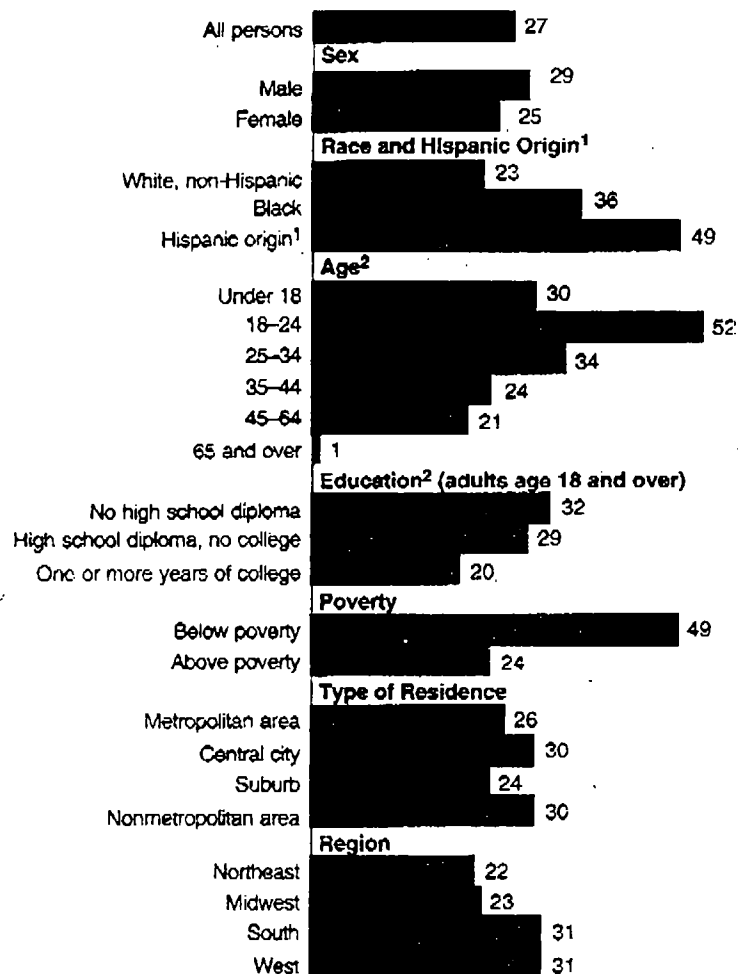
Years of School Completed

People completing at least 1 year of college were less likely to spend at least 1 month without health insurance coverage than those with lower levels of educational attainment. For example, about 20 percent of those (18 years old and over) completing at least 1 year of college were without health insurance coverage for at least 1 month, compared with 29 percent for those who only completed high school and 32 percent for those with less than a high school diploma.

³ For an average month in 1993, 16.0 percent of all women participated in means-tested assistance programs, compared with 11.8 percent of all men. (The source of these estimates is the 1992 SIPP panel file.)

⁴ The difference between the two age groups 35 to 44 and 45 to 64 was not statistically different.

Figure 2.
Percent Without Health Insurance
for at Least 1 Month: 1992 to 1994

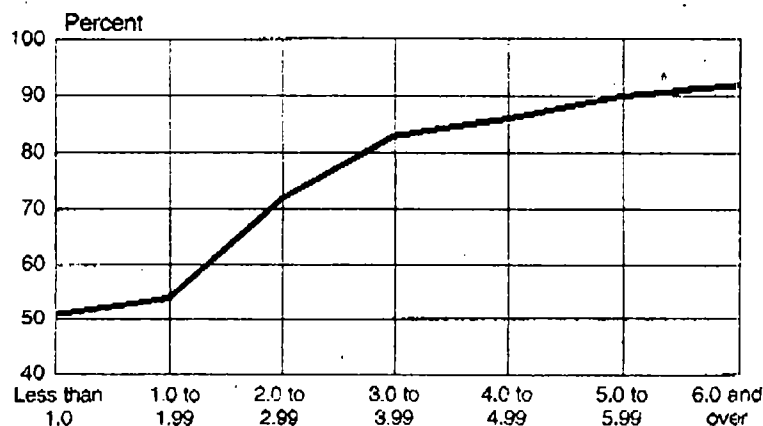


¹ Persons of Hispanic origin may be of any race.

² Age and education refer to February 1992.

Source: U.S. Bureau of the Census, Survey of Income and Program Participation.

Figure 3.
Percent Covered for 28 Months by
Income-to-Poverty Ratios: 1992 to 1994



Source: U.S. Bureau of the Census, Survey of Income and Program Participation.

Type of Residence and Region

People living in suburban areas⁵ were more likely to have continuous health insurance coverage over the 28-month period than people living in central cities or outside of metropolitan areas—76 percent of those in the suburbs compared with 70 percent in other areas.

People residing in the South and West were more likely to experience 1 or more months without health insurance coverage than those living in the Northeast or Midwest—31 percent in both the South and West compared with 23 percent in the Midwest and 22 percent in the Northeast.⁶ Perhaps the higher noncoverage rates in the South and West can be partially attributed to higher concentrations of Blacks in the South and Hispanics in the West. These groups had higher noncoverage rates than Whites who were non-Hispanic.

Income-to-Poverty Ratios

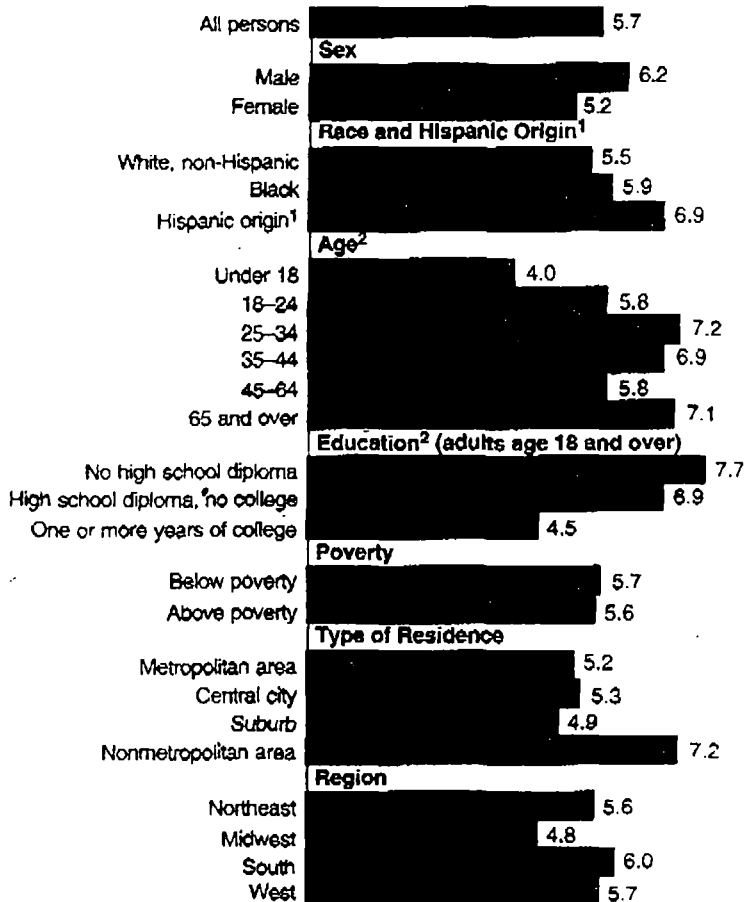
Income-to-poverty ratios represent one way of characterizing individuals by their relative economic status. These ratios are computed by summing the person or family income over the entire 28-month period, and dividing this total by the summed monthly poverty thresholds. Thus, a ratio of under 1.0 indicates that, on average, an individual's family income was less than the sum of that family's poverty threshold. In the 28-month period covered here, 11 percent of all people had an income-to-poverty ratio less than 1.0. About one-half (49 percent) of them lacked continuous health insurance, and 12 percent were not covered at all, compared with 24 and 4 percent, respectively, for all others.

⁵ The term "suburban areas" refers to portions of metropolitan areas outside of central cities.

⁶ There was no significant difference between the noncoverage rate in the Northeast (22 percent) and in the Midwest (23 percent).

Figure 4.
Duration of Spells Without Health Insurance Coverage: 1992 to 1994

Median number of months without health insurance coverage



¹ Persons of Hispanic origin may be of any race.

² Age and education refer to February 1992.

Source: U.S. Bureau of the Census, Survey of Income and Program Participation.

As would be expected, there is a strong correlation between income-to-poverty ratios and the likelihood of continuous health insurance. The percentage of people with health insurance for the entire 28 months rose from 53 percent for those with ratios under 2.0 to 92 percent for those with ratios of 6.0 and over (see figure 3).

Employment Status

The relationship between health insurance coverage and employment is an important one, given that firms provide such a large proportion of total health insurance coverage for employees and their dependents. In order to examine the relationship between health insurance coverage and

employment status, wage and salary workers 18 to 64 years old were separated into three groups:

1. Those who worked full time for the entire period
2. Those who worked for the entire period but not always full time
3. Those with one or more job interruptions.

Eighty-seven percent of all full-time, full-period workers were covered by health insurance for the entire period, but there were significant differences for Whites (non-Hispanic), Blacks, and Hispanics. The continuous coverage rates for these groups were 89, 81, and 69 percent, respectively.

Part-time, full-period workers were more likely than their full-time counterparts to lack continuous health insurance coverage—27 percent, compared with 14 percent.

About 42 percent of workers with one or more job interruptions experienced 1 or more months without health insurance coverage. Men in this category were more likely than women to lack health coverage for at least 1 month (51 to 35 percent).

Younger full-time, full-period workers were less likely than their older counterparts to have been covered by health insurance continuously—38 percent of those age 18 to 24 years old spent 1 or more months without health insurance, compared with 17 percent of those age 25 to 34 and 10 percent of those age 35 to 44.⁷

Spells of Noncoverage

One of the major concerns regarding health insurance is how long Americans go without coverage. Using a technique known as survival analysis, it is possible to estimate the duration of spells without health insurance. A median spell of 5.7 months without health insurance was observed for people who lost their health insurance after the beginning of the 28-month period of the 1992 panel. In other words, of all spells without health insurance (experienced by 27 percent of the

people), half of them lasted for 5.7 months or longer. This estimate is significantly shorter than the 7.1-month median duration of noncoverage for the 1991-1993 period.

Attaining a high level of education appears to shorten the time someone goes without health insurance (see figure 4). The median spell of 7.7 months without health insurance coverage for those without a high school diploma was significantly different from 4.5 months of noncoverage for those with at least 1 year of college.⁸

Among the age groups examined, the median spell of 4.0 months without coverage for children less than 18 years of age was significantly shorter than spells for other age groups, except for those 45-64.

As expected, full-time workers had a significantly shorter median spell without health insurance than those employed part time, those unemployed, or those not in the labor force—5.0 months for full-time workers, compared with 7.2 months, 7.6 months, and 7.1 months, respectively, for the others.⁹

⁸ No statistical difference was observed between other comparisons by educational level.

⁹ Estimates of 7.2 months, 7.6 months, and 7.1 months are not significantly different.

Accuracy Statement

All statistics are subject to sampling error, as well as non-sampling error such as survey design flaws, respondent classification and reporting errors, data processing mistakes, and under-coverage. The Census Bureau has taken steps to minimize errors in the form of quality control and edit procedures to reduce errors made by respondents, coders, and interviewers. Ratio estimation to independent age-race-sex population controls partially corrects for bias attributable to survey under-coverage. However, biases exist in the estimates when missed persons have characteristics different from those of interviewed persons in the same age-race-sex group.

Analytical statements in this report have been tested and meet statistical standards. However, because of methodological differences, use caution when comparing these data with data from other sources. Contact Tracy James, Demographic Statistical Methods Division, at 301-457-4182 or on the Internet at tjames@census.gov for information on (1) the source of the data, (2) the accuracy of the estimates, (3) the use of standard errors, and (4) the computation of standard errors.

Contacts:

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Statistical Methods—
Tracy James
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⁷ The difference between the two age groups 35 to 44 and 45 to 64 was not statistically different.

Current Population Reports

Household Economic Studies

Health Insurance Coverage: 1994

By Robert L. Bennefield

CENSUS BUREAU

P60-190
November 1995

An estimated 39.7 million persons in the United States (15.2 percent) were without health insurance coverage during the entire 1994 calendar year. Among the poor, 11.1 million persons were without coverage. This was 29.1 percent of the poverty population.

This report presents data on the health insurance coverage status of persons in the United States during the 1994 calendar year. The data, which are shown by selected demographic and socioeconomic characteristics, as well as by State, were collected by the March 1995 Supplement to the Current Population Survey (CPS). The CPS is a monthly nationwide survey of about 60,000 households conducted by the Census Bureau.

Employers are the leading providers.

As figure 1 shows, the majority of persons (70.3 percent) were covered by a private insurance plan for some or all of 1994. A private plan is one that was offered through an employer (either one's own or a relative's) or privately purchased. Most private insurance was obtained through a current or former employer or union (group health).

The remaining insured persons had government coverage. This includes Medicaid (12.1 percent), Medicare (12.9 percent, and military health

care (4.3 percent). Many persons carry coverage from more than one type of plan.

The poor are more likely not to have coverage.

Despite the existence of programs such as Medicaid and Medicare, 29.1 percent of the poor (11.1 million) had no health insurance of any kind during 1994. This percentage was about double the rate for all persons. Poor persons comprised 27.8 percent of all uninsured persons.

As figure 1 shows, Medicaid was the most widespread

type of coverage among the poor. About 46.2 percent of poor persons were covered by Medicaid at some time during the year, compared with 12.1 percent of the general population.

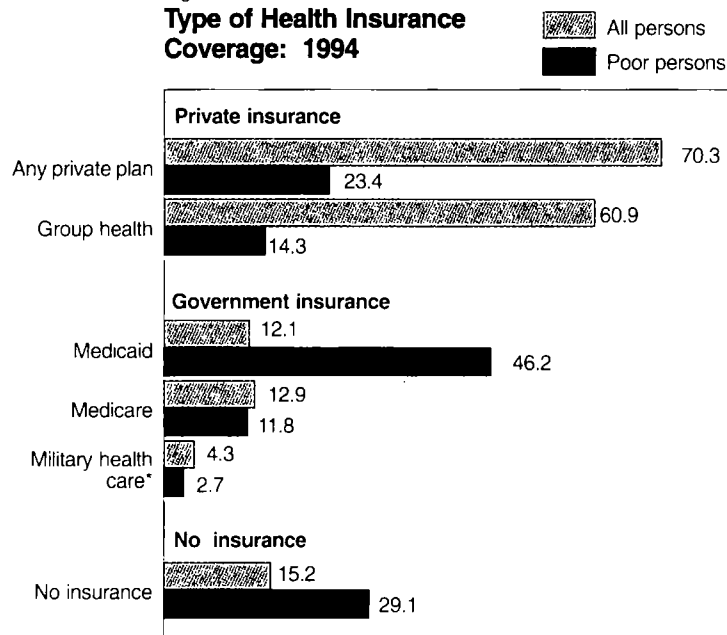
Some are more likely than others to lack coverage.

As figure 2 shows, there were several key factors that influenced the chances of lacking coverage. They included—

- Age – Young adults aged 18 to 24 were more likely than other age groups to lack coverage during all of 1994 (26.7

Figure 1.

Type of Health Insurance Coverage: 1994

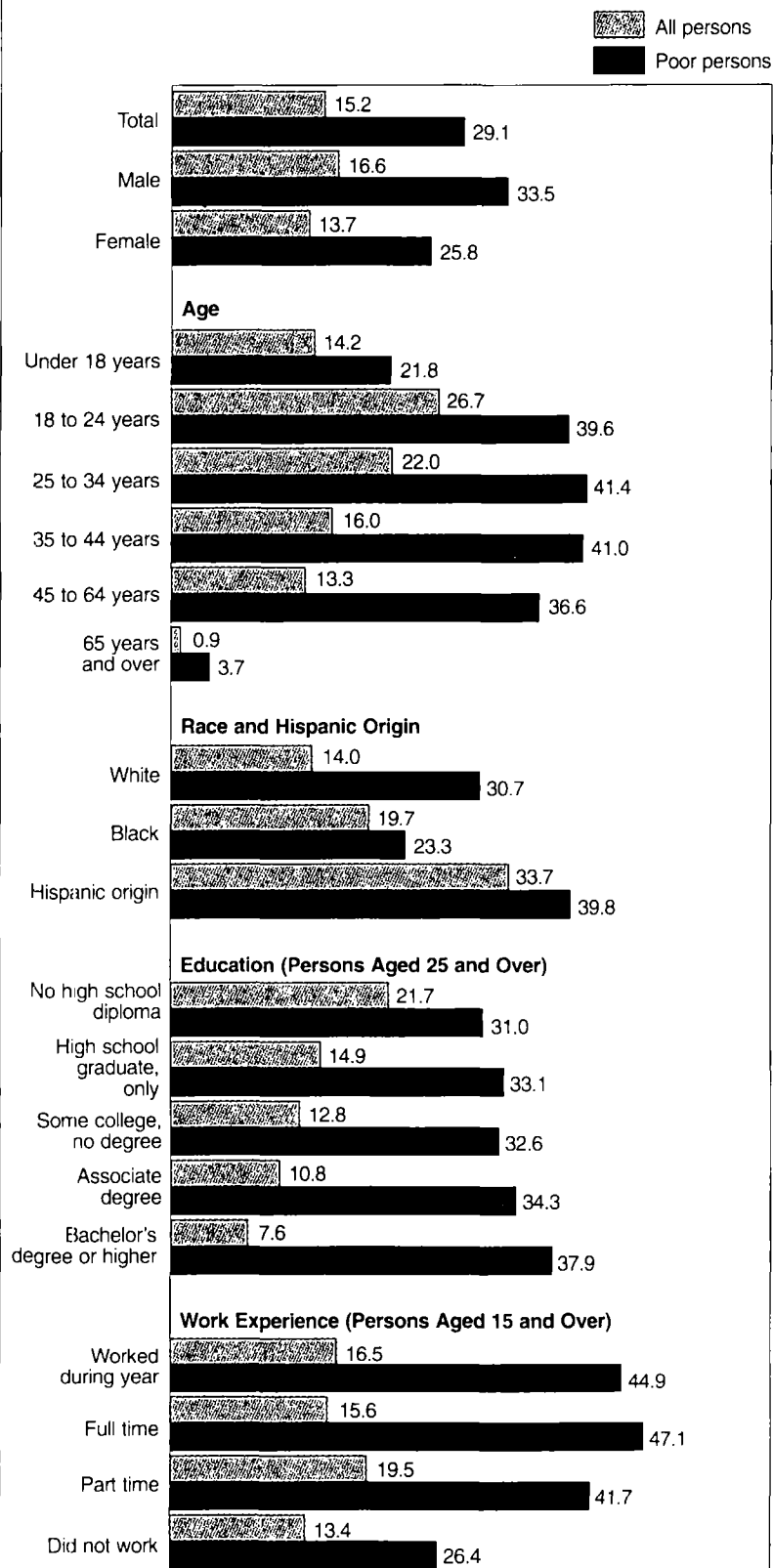


*Military health care includes CHAMPUS (Comprehensive Health and Medical Plan for Uniformed Services), CHAMPVA (Civilian Health and Medical Program of the Department of Veteran's Affairs), Veteran's and military health care.

Note: The percentages by type of coverage are not mutually exclusive; in other words, persons can be covered by more than one type of health insurance during the year.

Figure 2.
Who Lacked Coverage?

Percent of all persons (and poor persons) not covered by health insurance at any time during the year, by selected characteristics: 1994



Note: Persons of Hispanic origin may be of any race.

percent). The elderly were at the other extreme (0.9 percent). Among the poor, adults aged 18 to 64 had much higher noncoverage rates than either children or the elderly.

■ **Race and Hispanic origin** – Among poor and all persons alike, those of Hispanic origin had the highest chance of lacking coverage.

■ **Educational attainment** – Among all adults, the likelihood of being uninsured declined as the level of education rose. Among the poor, however, there were no significant differences across the education groups.

■ **Work experience** – Overall, part-time workers had the highest noncoverage rate (19.5 percent). These workers were adults aged 15 or over who worked less than 35 hours per week in the majority of the weeks they worked in 1994. Thanks to Medicare coverage of the elderly and the Medicaid "safety net," nonworkers had the lowest rate (13.4 percent).

Among the poor, workers had a far higher uninsured rate than nonworkers.

Income and firm size play roles.

Figure 3 shows noncoverage rates by household income. In general, as household income rose, noncoverage rates fell.

Of the 139.1 million workers, 53.3 percent had employer-provided health insurance policies in their own name. The proportion varied by size of employer, with workers employed by small firms (less than 25 people) being less likely to have employer-provided health insurance policies in their own name. (See figure 4.)

States show differences in noncoverage rates.

Percentages of persons without health insurance coverage ranged from 8.4 percent in North Dakota to 24.2 percent in Texas. However, we advise against using these estimates to rank the States. Results from different samples could easily show different estimates and rankings because of small sample sizes. For example, the high noncoverage rate for Texas was not statistically different from that in New Mexico (23.1 percent), while the rates for Vermont, Wisconsin, Hawaii, Minnesota, Iowa, South Dakota, Tennessee, Connecticut, Indiana, and Nebraska were not statistically different from North Dakota.

A Note About the Estimates

The introduction of a computer-assisted CPS questionnaire in 1994 provided the Census Bureau with an opportunity to clarify the questions used to measure the extent to which persons are covered by health insurance. In the past, underreporting of health insurance coverage in the CPS had been a persistent problem, as other surveys (such as the Survey of Income and Program Participation) have shown consistently higher annual coverage rates. The revised questions were successful in that they appear to result in improved reporting of health insurance coverage (and of employer-provided coverage, in particular). This improved reporting, however, makes time series comparisons difficult to interpret. For that reason, this report focuses on comparisons between groups rather than

Figure 3.

As Income Rises, Chances of Having No Insurance Generally Decline

Percent of all persons not covered by health insurance at any time during the year, by household income: 1994

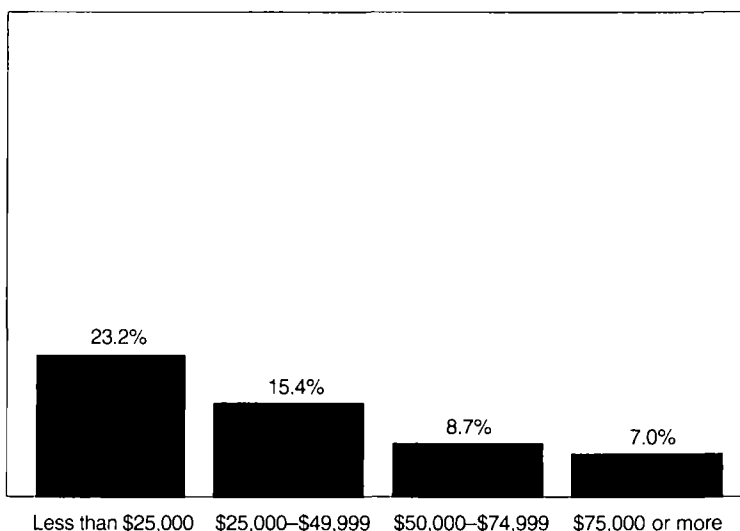
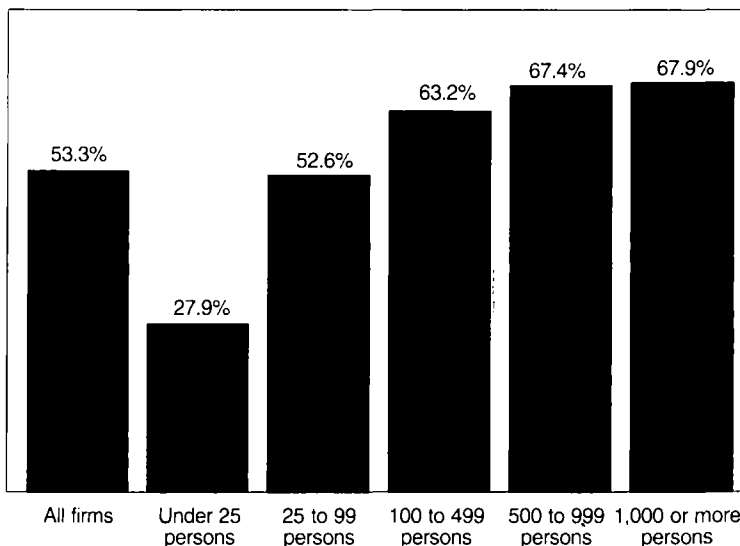


Figure 4.

Workers in Large Firms Are the Most Likely to Have Employer-Provided Insurance

Percent of workers (aged 15 and over) with employer-provided health insurance policies in their own name, by size of firm they worked for: 1994



over time. The Census Bureau is currently working on a document, to be released later this year, that explains the questionnaire changes in detail and their estimated effect on CPS health insurance estimates.

Accuracy of the Estimates

All statistics in the report are subject to sampling variability, as well as survey design flaws, respondent classification errors, and data processing mistakes. The Census Bureau has taken steps to minimize errors, and analytical state-ments have been tested and meet statistical standards. However, because of methodo-logical differences, use caution when comparing these data with data from other sources.

The estimates in this report are based on civilian noninstitu-tional population benchmarks established by the 1990 decen-nial census.

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Figure 4.

Percent of Persons Not Covered by Health Insurance, by State: 1994

State	Percent	Standard error	90-percent confidence interval
Alabama	19.2	1.4	16.9 – 21.5
Alaska	13.3	1.1	11.5 – 15.1
Arizona	20.2	1.4	17.9 – 22.5
Arkansas	17.4	1.4	15.1 – 19.7
California	21.1	0.6	20.1 – 22.1
Colorado	12.4	1.2	10.4 – 14.4
Connecticut	10.4	1.3	8.3 – 12.5
Delaware	13.5	1.4	11.2 – 15.8
District of Columbia	16.4	1.6	13.8 – 19.0
Florida	17.2	0.7	16.0 – 18.4
Georgia	16.2	1.3	14.1 – 18.3
Hawaii	9.2	1.1	7.4 – 11.0
Idaho	14.0	1.1	12.2 – 15.8
Illinois	11.4	0.6	10.4 – 12.4
Indiana	10.5	1.1	8.7 – 12.3
Iowa	9.7	1.1	7.9 – 11.5
Kansas	12.9	1.2	10.9 – 14.9
Kentucky	15.2	1.3	13.1 – 17.3
Louisiana	19.2	1.5	16.7 – 21.7
Maine	13.1	1.3	11.0 – 15.2
Maryland	12.6	1.3	10.5 – 14.7
Massachusetts	12.5	0.7	11.3 – 13.7
Michigan	10.8	0.6	9.8 – 11.8
Minnesota	9.5	1.1	7.7 – 11.3
Mississippi	17.8	1.3	15.7 – 19.9
Missouri	12.2	1.3	10.1 – 14.3
Montana	13.6	1.2	11.6 – 15.6
Nebraska	10.7	1.1	8.9 – 12.5
Nevada	15.7	1.2	13.7 – 17.7
New Hampshire	11.9	1.4	9.6 – 14.2
New Jersey	13.0	0.6	12.0 – 14.0
New Mexico	23.1	1.4	20.8 – 25.4
New York	16.0	0.5	15.2 – 16.8
North Carolina	13.3	0.6	12.3 – 14.3
North Dakota	8.4	1.0	6.8 – 10.0
Ohio	11.0	0.6	10.0 – 12.0
Oklahoma	17.8	1.4	15.5 – 20.1
Oregon	13.1	1.3	11.0 – 15.2
Pennsylvania	10.6	0.6	9.6 – 11.6
Rhode Island	11.5	1.3	9.4 – 13.6
South Carolina	14.2	1.1	12.4 – 16.0
South Dakota	10.0	1.0	8.4 – 11.6
Tennessee	10.2	1.0	8.6 – 11.8
Texas	24.2	0.8	22.9 – 25.5
Utah	11.5	1.1	9.7 – 13.3
Vermont	8.6	1.1	6.8 – 10.4
Virginia	12.0	1.0	10.4 – 13.6
Washington	12.7	1.2	10.7 – 14.7
West Virginia	16.2	1.4	13.9 – 18.5
Wisconsin	8.9	1.0	7.3 – 10.5
Wyoming	15.4	1.5	12.9 – 17.9

Note: The 90-percent confidence interval is the range in which estimates would fall from 90 percent of all possible household samples.

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

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The Council and the authors intend to submit these papers, or revisions thereto, for publication. We request that these papers not be cited or circulated without the permission of the authors.

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I spoke w/ David Shachtman who
said we could cite + quote from
these studies.

-Pauline

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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

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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

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system in 1983 and the physician payment control system in 1989, annual growth in Medicare spending fell from 9.7% from 1980-1983 to 5.0% from 1983-1987.⁷ In comparison to spending growth in the private sector, limits on Medicare spending appeared to be much more effective. At the same time, the Medicaid program, employing tight price regulation impacted hospital margins by low rates of reimbursement. Although volume continued to grow and many services were shifted to less regulated outpatient settings, many hospitals began to experience negative margins from Medicare and Medicaid. In 1992, hospitals lost nearly \$11 billion providing services to Medicare patients, \$3 billion to Medicaid and \$10 billion to uncompensated care.⁸ However, they were able to more than offset these losses by raising prices to the privately insured.

In the 1990s, as hospitals confronted shrinking margins from the public sector, the private sector became a more effective payer in controlling cost. Employing more aggressive use of managed care techniques and tougher bargaining with major health providers, private payers were successful in demanding lower rates of growth in health care prices. This success was greatly facilitated by the growing availability of excess hospital capacity and the increasing numbers of specialists. Hospitals also had to contend with advancements in technology that permitted many procedures to be performed more quickly and in less intensive settings. As a result, hospital occupancy rates fell from 75.9% in 1980 to 61.4% in 1993 and hospital's share of total health expenditures fell below 37%.⁹

Despite all these difficulties, hospitals have been successful in preserving operating margins. They have greatly expanded out-patient services, increased revenues in higher margin areas such as home health care and imaging, cut operating expenses (particularly labor costs), shifted costs to private payers, and consolidated through mergers, acquisitions, and joint ventures. The question that will be confronted in this paper is whether hospitals can absorb the changes now being considered and continue to maintain their financial health.

Some analysts maintain that hospitals can still garner further efficiencies. They argue that there is expensive excess capacity in the system and that the number of hospitals can consolidate by as much as 1/3, greatly reducing fixed expenses. Indeed, many other industries in the United States have downsized over recent years in order to become more efficient and more competitive. These analysts contend that hospitals can re-engineer the structure of hospital care thereby changing the production function and reducing the cost of delivering care. Indeed, evidence in recent years suggests that this is possible. Beginning in the last quarter of 1993, the average cost per hospital admission fell below the rate of inflation for the first time and has remained there since the first quarter of 1994.¹⁰

Other analysts contend that hospitals face increasing fiscal pressures from the problems that we have detailed above. They argue that although some efficiency gains can be garnered through consolidation, the system will be overwhelmed by the magnitude of combined reductions in public spending and private insurance. Furthermore, they maintain that the moderation in cost growth recently achieved by hospitals is a brief departure from a long term trend, and that the chief drivers of medical inflation, increased technological intensity

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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

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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 Hospital 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

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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 Hospital 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 paper¹⁴ 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 employer sponsored insurance (ESI) 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..

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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).¹⁵

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

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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

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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%.

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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%

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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 an overall average of .3%, but by nearly one full percent at major teaching hospitals. Note that the above reductions in the rate of hospital cost growth are required simply to break even. Substantially larger reductions would be necessary to maintain hospital margins at current levels (4.3% in 1993).

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. If states reduce the payment/cost ratio to 80%, the overall break-even level of cost

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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 simply to maintain a zero margin.

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 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 2.0% 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

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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%).¹⁶ 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. These are rates of cost growth that hospitals would have to attain merely to break even. To maintain their current margins (4.3% in 1993), substantially larger reductions in cost would be necessary.

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.



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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.¹⁷ 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 be formulated to monitor the financial impact on hospitals and to recommend adjustments if needed.

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.¹⁸ 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 publications¹⁹ have identified the need for increased capabilities in this area.

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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. K. Thorpe, A. Shields, H. Gold, S. Altman, D. Shactman, "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," Paper Presented to the Council on the Economic Impact of Health System Change, (November 8, 1995)
15. 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.

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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%.

16. Data from HCFA

17. See, for example, J. Mann (1995), J. Dailey (1992), S. Shortell (1988), A. Bindman (1990), D. Dunn (1994), K. Thorpe (1991), M. Fox (1992), D. Shelton (1995)

18. 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

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

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**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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The Council and the authors intend to submit these papers, or revisions thereto, for publication. We request that these papers not be cited or circulated without the permission of the authors.

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I spoke w/ David Shachtman who
said we would cite + quote from
these studies.

-Pauline

INTRODUCTION

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The rising number of Americans without health insurance has been a public policy issue for some time. In this analysis we add to the debate by estimating the combined impact on the number of uninsured of recent declines in employer-sponsored insurance (ESI) and anticipated cuts in the Medicaid program. 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 1994, over 39.7 million, or about 15 percent of the population, were uninsured. This was up from 13 percent (34.5 million) of the population uninsured in 1990. Not only were more Americans uninsured, but the length of time without insurance increased. During the late 1980s, the median time an American was uninsured was 4.2 months. That rose to 7.1 months by 1993 (Bennefield 1993).

The growing numbers of uninsured raises concerns about the impact on individual health, as well as the strain placed on the health delivery system from increased uncompensated care. Historically, the cost of this uncompensated care has been borne, in part, by the privately insured in the form of higher prices. In recent years, intensifying pressures from competition and managed care has made 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 may 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, if the program continues 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, we 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 Health Status of Individuals

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 receive 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 either public or private third party coverage.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 (Weissman et al 1991). Once in the hospital, uninsured patients receive fewer services than privately insured patients (Blendon 1988, Weissman 1989, Hadley 1991, Franks

¹Assuming 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..)

²During 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.

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 places 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, diminished functional status and quality of life.

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 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)

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). 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, we reference a sensitivity analysis comparing point-in-time estimates of the number of uninsured from both survey instruments for the calendar year 1991 (Bennefield 1994).

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

⁵The 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, will not greatly bias our projections of the number of uninsured.

Among the uninsured, children represent a particularly vulnerable group. 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 private insurance declined 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. Particularly at risk were 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 who were not eligible for Medicaid coverage.

Studies have yielded different interpretations of the decline in dependent coverage among the ESI population and concurrent increases in the number of children enrolled in Medicaid. Some analysts believe that the decline in ESI dependent coverage was partly generated by the liberalization of Medicaid eligibility for children. Cutler and Gruber (1995), for example, estimated that as much as 50-75% of the increase in Medicaid coverage for women and children between 1987-1992 was accompanied by a reduction in private insurance coverage.

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

An alternative explanation for this reduction in the number of children covered under ESI was offered by Thorpe (1995). He attributed the reduction of ESI primarily to changes in the structure of working families receiving health insurance through their employers. According to his analysis, there were more children in families where a parent did not have ESI coverage. He supported 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 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.

Longer Spells of Uninsurance for the Newly Uninsured

Not only is the number of individuals uninsured at any point in time increasing, but so is the length of time individuals remain uninsured. 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 to 7.1 months in the February 1991-93 period. The historical trend toward shorter uninsured spells is no longer valid. The proportion of spells lasting more than 9 months increased from 62% to 67% from 1984-1987⁷ (McBride 1994).

The length of time the uninsured remain uninsured is an important consideration, since policy interventions would differ depending on whether or not the target population was chronically uninsured (spells lasting over two years). Conflicting reports exist concerning the proportion of chronically uninsured. McBride estimated this proportion using within sample survival regression models on longitudinal data. He concluded 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

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

⁸First, 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 estimate how long the uninsured in December 1988 would continue to be uninsured after the survey period was complete.

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.

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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 and 150 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, the 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.

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.

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 would 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 would be the only required benefits, with non-binding language addressing state efforts with regard to children, pregnant women, and the disabled.⁹ States would 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 budget targets put forth in the House and Senate bills. Projections for enrollment growth are also included. The CBO projects an annual growth rate in spending of 10.2% which includes a 3.3% annual growth in enrollment. 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 would be constrained to only 1.2 percent per year under the House proposal.

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 the 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 and reductions in services provided, 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

To establish a baseline, we began with CBO estimates of health insurance coverage developed during the last session of Congress. The CBO estimated private and public coverage through the year 2005. We built on this analysis by rebasing their 1995 estimate of the number of uninsured with the most recent data from the March 1995 CPS. This data placed the number of uninsured at 39.7 million, slightly less than the earlier estimate of 40.1 million. This included 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 had Medicaid, but were also covered by Medicare or 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 estimated the number of uninsured, including groups such as the medically needy and others expected to receive coverage under current law, assuming that Medicaid enrollment will be kept at current levels. In this scenario, states would freeze current levels of enrollment, and focus on containing cost growth to the average 4.5% per year per beneficiary allowed in the proposed budgets. Using these assumptions, the projected number of uninsured rises to 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 project the continued rate of decline in ESI as seen over the past four years. Between 1989 and 1993, the percent of the population covered by ESI fell from 61% to 57%. This reduction occurred almost 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

¹⁰These 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.

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 the recent rate of 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 continued declines in ESI increases the number of projected uninsured to 66.8 million by 2002.

Table 8: Alternative Scenarios for the Number of Uninsured.

	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
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
UNINSURED SCENARIO 2	39.7	43.7	47.3	51.2	55.2	58.8	62.8	66.8

750% inc.

SOURCE: THORPE 1995, CONGRESSIONAL BUDGET OFFICE 1995.

NOTES: BASELINES ARE PROJECTIONS BY THE CONGRESSIONAL BUDGET OFFICE.

ESI REFERS TO EMPLOYER-SPONSORED INSURANCE.

IV. ANTICIPATED DEMAND FOR UNCOMPENSATED CARE

Traditionally, care for the uninsured has been provided through a complex web of direct public financing¹¹ and cost-shifting to patients with public and private health coverage. Although hospitals have been the primary source of services for the uninsured, physicians, community health centers and others have also provided a substantial volume of free care. The CBO recently estimated that hospital and physicians provided approximately \$20 billion in uncompensated care in 1991. This will rise to 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.

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 represents approximately 6 percent of all hospital costs. These costs are projected to increase to \$16.6 billion in 1994 and \$17.7 billion in 1995. CBO figures indicate that the uninsured account for 77% of uncompensated care charges. Thus, in 1994, approximately \$12.7 billion in uncompensated care can be traced to the uninsured. The remaining 23% can be traced to insured persons who 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 assumed that the volume of such care grew at the same rate as hospital costs (although traditionally it has grown faster). 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 was estimated to grow at the hospital cost growth rate. This assumed that the per capita costs of uncompensated care observed today will remain unchanged despite the likely changes in the composition of the uninsured. No changes in the Medicare and Medicaid programs were assumed. As presented in Table 9,

¹¹Public 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.

the baseline growth in uncompensated care will increase at a rate similar to the previous 15 years -- from \$17.7 billion in 1995 to \$29.3 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
BASILINE UNINSURED	39.7	40.7	41.1	41.7	42.3	42.6	43.2	43.8
BASILINE 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

SOURCE: AUTHOR'S PROJECTIONS 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 used the more conservative estimates regarding the erosion of ESI and assume no growth in Medicaid enrollment, the potential demand for uncompensated care grows to \$33.4 billion. In our second scenario, in which we assumed the decline in ESI continues on the same trend as 1989-1993 and Medicaid enrollment was again held constant, the demand for uncompensated care reaches \$43.2 billion.¹³

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.

¹³We 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 understates 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%.

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 provided nearly 60% of uncompensated care having steadily increased their share from 43% in 1980. At the same time, the share of other urban hospitals declined from 40% to 30% over the same period. The proportion of uncompensated care provided by major teaching hospitals also increased from 9.9% in 1980 to 12.5% in 1993. Major public teaching hospitals together with other teaching facilities provided about a quarter of all uncompensated care. It is also important to note that large urban hospitals had a higher ratio of their total costs consumed by uncompensated care than other hospitals (6.4%), with the exception of major public hospitals in which 18.5% of costs were 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 provided a large and growing share of uncompensated care (6.4% of costs in large urban hospitals, compared to 5.6% in other urban and 5.1% in rural hospitals). The ratio of uncompensated total costs was also higher in large urban hospitals compared to major private teaching institutions (6.4% versus 5%).

Table 11 presents the percent of total costs consumed by uncompensated care in each of our scenarios. Under current policy, we assumed that uncompensated care would account for a stable proportion of hospital costs, namely 6 percent. Under scenario 1,

uncompensated care rises to \$33.4 billion or 6.8%. Under the second scenario, it increases to \$43.2 billion or 8.8% of total 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.

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. They have also objected to federal mandates which have often come without sufficient federal funding for implementation, 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 to the uninsured. The expected rise in the number of uninsured and in the care they will demand raises several potential problems. Without significant expansions of coverage at either the national or state level, hospitals could 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. Although preliminary data from March 1995 seem to indicate the trends have stabilized for the time being, these reductions remain a cause for concern. 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 that the lion's share of Medicaid spending is for the elderly and disabled. The health care needs of the SSI, blind and disabled may 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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N E W S R E L E A S E

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Embargoed for morning papers, December 6, 1995

**CUTBACKS IN MEDICARE AND MEDICAID FUNDING
UNDER THE BUDGET RECONCILIATION ACT OF 1995
COULD ADD ALMOST 8 MILLION PEOPLE TO THE
ALREADY LARGE RANKS OF THE UNINSURED AND SHIFT
\$85 BILLION IN COSTS TO THE PRIVATE SECTOR,
PREDOMINANTLY TO MIDDLE CLASS FAMILIES**

Washington, D.C. -- The National Leadership Coalition on Health Care today released a study showing that almost 7.8 million people could be added to the already large ranks of the uninsured by 2002 because of the \$434 billion in Medicare and Medicaid spending cutbacks proposed in the Budget Reconciliation Act of 1995. The spending cutbacks are achieved through a combination of reductions in government payments to hospitals and other providers, increased beneficiary cost sharing, reduced coverage, and expanded managed care enrollment. The study was prepared for the Coalition by Lewin-VHI.

The study also shows that under the Act, at least \$84.7 billion in additional health care costs could be shifted to and paid for by the nation's families -- predominantly middle class families -- and employers, as providers shift costs to private payers over the seven years of the cutbacks.

According to the Lewin study, under the provisions of this Act about 7.8 million people could lose insurance coverage in the year 2002 alone. This includes those who could lose coverage due to reductions in enrollment in states that decide to reduce Medicaid eligibility (7.2 million) and workers who could lose employer coverage due to premium increases resulting from the cost shift. Under current policy, Lewin estimates there will be approximately 45.9 million persons uninsured in 2002. Under the Budget Reconciliation Act of 1995, their estimates indicate that the number of uninsured could increase to 53.7 million persons in 2002.

Cost shifting is the process whereby providers recover uncompensated care costs for the uninsured and the payment shortfalls for public program enrollees in the form of higher charges to private payers. The Lewin study points out that most of the cost shift that could occur under this Act, about \$66.9 billion of the \$84.7 billion, would be passed on to workers by employers in the form of foregone wages and in the form of higher cost sharing for health care premiums.

HONORARY CO-CHAIRS

Former President Jimmy Carter
Former President Gerald Ford

CO-CHAIRS

The Honorable Paul G. Rogers, J.D.
The Honorable Robert D. Ray, L.L.B.

PRESIDENT

Henry E. Simmons, M.D., M.P.H.

EXECUTIVE DIRECTOR

Margaret M. Rhoades, Ph.D.

-- more --

The cost shift affects all income levels, but 60 percent of the shift would be concentrated on the broad middle class -- families with annual incomes between \$20,000 and \$75,000. Lower income workers would be disproportionately affected, with those making under \$6.00 an hour losing 10 percent of wage gains under this scenario. Those making over \$25.00 an hour would see only a 1.4 percent cutback.

The bottom line is that it is American families who will pay for the cost shift. Increased cost shifting would mean higher private insurance premiums, with employer health spending increasing by \$69.3 billion over the seven year period. Empirical evidence indicates that employers are likely to pass on much of the increase in costs to employees in the form of reduced wages. The study estimates that the lost wage growth under this scenario could be about \$61 billion, on top of a \$5.9 billion increase in employee contributions to premiums. Thus the total cost shift to workers could be \$66.9 billion, an amount equivalent to almost \$1,000 per covered worker between 1996 and 2002.

This study is meant to raise a warning flag. It is important for the public to understand that the national dialogue on Medicare and Medicaid should include a discussion of the impact of major changes in public programs on the private sector.

The Coalition is a rigorously nonpartisan group. It is the largest and most broadly representative alliance concerned with health care issues. Its 93 members include businesses, labor unions, consumer groups and provider organizations. Its honorary co-chairs are former Presidents Jimmy Carter and Gerald Ford.

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Dec 6 AM papers

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December 1, 1995

Dear Correspondent:

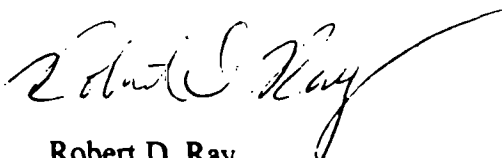
Enclosed is a study conducted by Lewin-VHI for the National Leadership Coalition on Health Care showing that the proposed changes in Medicare and Medicaid under the Budget Reconciliation Act of 1995 could add almost 8 million people to the ranks of the uninsured and shift \$85 million in costs to the private sector.

This study is meant to raise a warning flag. There are large, complex issues involved, and the Coalition believes they should be addressed as a whole. It is clearly beneficial for all Americans -- and certainly for American business -- that the deficit be reduced and the budget be brought into balance.

At the same time, we must be concerned that, as we make major changes in Medicare and Medicaid, we do no harm. Health care is an area where costs are so large -- and growing so rapidly -- that they tempt policy makers to make significant changes and cutbacks. Some may work out well; others may not. The better thought out the changes, the better able we will be to fine-tune the changes in these huge systems as we go.

The Coalition believes that significant increases in the numbers of the uninsured and a large cost shift to the private sector resulting from cutbacks in public programs should be part of the national dialogue on these major program changes. Health care is not a partisan issue; it is an American issue. We urge our political leaders to work together the effect changes with care, remembering always the dictum: Above all, do no harm.

Sincerely,



Robert D. Ray
Co-Chair



Paul G. Rogers
Co-Chair

Enclosures

HONORARY CO-CHAIRS

Former President Jimmy Carter
Former President Gerald Ford

CO-CHAIRS

The Honorable Paul G. Rogers, J.D.
The Honorable Robert D. Ray, L.L.B.

PRESIDENT

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EXECUTIVE DIRECTOR

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paper.

**POTENTIAL COST SHIFTING UNDER
PROPOSED FUNDING REDUCTIONS FOR
MEDICARE AND MEDICAID: THE
BUDGET RECONCILIATION ACT OF
1995**

FINAL REPORT

PREPARED FOR:

**THE NATIONAL LEADERSHIP COALITION ON HEALTH
CARE**

By:

**JOHN F. SHEILS
GARY J. CLAXTON**

LEWIN-VHI, INC.

NOVEMBER 21, 1995

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EXECUTIVE SUMMARY

The Budget Reconciliation Act of 1995 would reduce funding for Medicare and Medicaid by about \$434 billion over the next seven years. These spending reductions would be achieved through expanded enrollment in managed care, increased premiums for Medicare beneficiaries, reduced coverage, and reduced payments to hospitals, nursing homes and other providers. However, some portion of the reductions in provider payments under these programs is likely to be passed on to privately-insured persons in the form of higher charges through cost shifting.

In this study we estimate the potential effects of this cost shifting on private insurance premiums and costs for employers and families. We also estimated the number of persons who would lose coverage under the bill due to reductions in eligibility under the Medicaid program or increases in private plan premiums. In addition, we estimate the increase in charity care expenses due to increases in the uninsured population.

We begin by summarizing the Medicare and Medicaid spending reductions and reviewing the evidence on cost shifting. We also estimate the cost shift under these budget cuts and the impact that this would have on employers and families. In addition, we estimate the change in insurance coverage likely to result from this increase in insurance premiums.

Medicare Spending Reductions

The Reconciliation Act would reduce Medicare program funding by \$270 billion over the next seven years. The act establishes the "MedicarePlus" program which would permit Medicare beneficiaries to enroll in a broader variety of private health plans. The act would also increase beneficiary Part-B premium payments and would improve fraud detection and coordination of benefits for persons with employer-based coverage. The plan also specifies specific cuts in provider payments and creates a "fail-safe" mechanism which would further reduce provider payments if budget spending targets under the bill are exceeded in future years.

The Congressional Budget Office (CBO) estimates that Medicare would save \$57.3 billion due to the Part-B premium increase and another \$9.1 billion through fraud detection and coordination of benefits provisions. Another \$26.7 billion would be saved through increased enrollment in private plans. The reductions in provider payments for services (including "fail-safe" amounts) would be \$105.3 billion for hospitals, \$27.0 billion for long-term care and \$44.5 billion for physicians and other providers.

Medicaid Spending Reductions

The act reduces federal Medicaid funding by about \$163.4 billion over the 1996 through 2002 period. The bill converts the Medicaid program to a block grant program to states. The amount of each state's grant would be based upon spending levels prior to implementing these reforms and would be indexed based upon an overall budget ceiling calibrated to produce \$163.4 billion in federal budget savings over the 1996 through 2002 period. States must match the federal contribution based on state matching rates under the current program in order to receive the maximum federal grant

We assume that states will put into the program only what is required to obtain the maximum federal match under the federal grant program. This implies an additional reduction in state Medicaid spending of \$123.3 billion over the 1996 through 2002 period. We assume that states will reduce provider payment rates so that per-capita growth in costs under the program is reduced from its current growth rate of 7.0 percent to 5.0 percent. If further funding reductions are necessary, they would take the form of reduced eligibility under the program. Under these assumptions, Medicaid enrollment is reduced by 8.5 million persons by 2002.

Evidence on Cost Shifting

Cost shifting is the process whereby providers recover uncompensated care costs and payment shortfalls for public program enrollees through higher charges to private payers. For example, hospital payment rates under public programs are on average about 10 percent below costs. Hospitals also incur about \$12.3 billion in uncompensated care expenses for uninsured and underinsured persons.¹ These shortfalls are recovered at least in part by increasing charges to private payers as much as 30 percent above actual costs for persons covered under private plans.

Some studies suggest that hospitals shift as much as half of these payment shortfalls to private payers while others show less evidence of cost shifting. Our own analyses indicate that in recent years about 40 percent of the increase in hospital payment shortfalls in each year is passed on to consumers in the form of higher mark-ups on care provided to privately-insured persons. In addition, a recent study of physician pricing by Thomas Rice, *et al.* indicates that each one percent reduction in public payer rates is associated with a 0.2 percent increase in physician charges to private payers.² It is clear from these studies, however, that providers are able to shift only a portion of payment shortfalls to private payers in part because selective contracting by health plans has made it more difficult for providers to shift costs.

Based upon a review of the literature, we assumed that 40 percent of the increase in hospital payment shortfalls under these budget cuts would be passed on to private

¹ Estimates reflect the impact of hospital disproportionate share payments under Medicare and Medicaid.

² A summary of these studies is presented in the main body of the paper.

payers in the form of higher charges. However, we assume that the percent of payment shortfalls that are shifted declines in future years to reflect continued growth in selective contracting. We also estimated cost shifting for physician payment shortfalls based upon the Rice analysis.

Under the assumptions used in this analysis, payments to providers would be reduced by about \$218.9 billion over the 1996 through 2002 period. Uncompensated care expenses for those who become uninsured would also increase by about \$65.5 billion over this period. The total increase in provider payment shortfalls would be about \$284.4 billion. We estimate that in response to this, providers would shift about \$84.7 billion (29.7 percent) of the \$284.4 billion in payment shortfalls to private payers (*Figure ES- 1*). About 52.7 percent of the increase in cost shifting would be attributed to the Medicare cuts while 47.3 percent would be attributed to Medicaid cuts.

FIGURE ES- 1
ESTIMATED COST SHIFT UNDER MEDICARE AND MEDICAID BUDGET CUTS

	Hospital Cost Shift ^{a/}	Other Provider Cost Shift ^{b/}	Total Cost Shift
1996	\$1.6	\$0.4	\$ 2.0
1997	3.0	0.9	3.9
1998	6.8	2.4	9.2
1999	10.3	3.5	13.8
2000	11.7	3.9	15.6
2001	14.4	4.4	18.8
2002	16.5	4.9	21.4
Total 1996 - 2002	\$ 64.3	\$ 20.4	\$ 84.7

a/ Includes a percentage of hospital budget cuts under Medicare and Medicaid. The percentage of hospital budget cuts that we assume to be cost shifted is 40 percent in 1994 phasing down to 30 percent by 2002.

b/ Assumes that each 1.0 percent reduction in other provider payments under the bill results in a 0.2 percent increase in private sector rates.

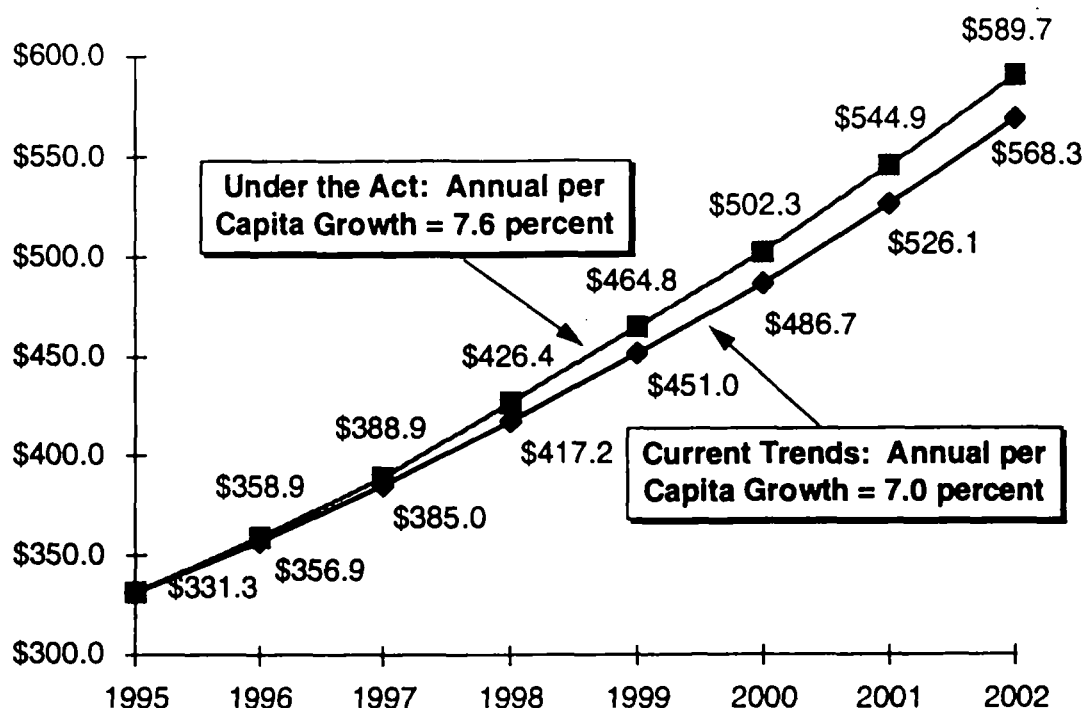
Source: Lewin-VHI estimates.

Cost Shift by Payer

The increase in provider charges to private payers resulting from the cost shift (\$84.7 billion) would be reflected in higher private insurance premiums. Employer health spending would increase by \$69.3 billion over the 1996 through 2002 period, while employee contributions for employer health coverage would increase by \$5.9 billion. Expenditures for individually purchased non-group insurance would increase by \$10.2 billion over this period due to the cost shift. As a result of this cost shift, by 2002, private insurance costs would be about \$21.4 billion (four percent) higher than under current trends (*Figure ES- 2*).

FIGURE ES- 2

CHANGE IN PRIVATE INSURANCE COSTS RESULTING FROM MEDICARE AND
MEDICAID BUDGET CUTS UNDER THE BUDGET RECONCILIATION ACT OF 1995



Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

Impact on Workers and Families

Empirical evidence indicates that employers are likely to pass on much of the increase in employer costs to employees in the form of reduced wages. Based upon a review of the literature, we estimate that about \$61.0 billion of the \$69.3 billion increase in employer costs due to cost shifting would be passed on to workers in the form of lost wage growth. This wage loss is in addition to the \$5.9 billion increase in employee premium contributions resulting from higher private insurance premiums. Overall, the amount of the cost shift passed through to workers would be \$66.9 billion including lost wage growth (\$61.0 billion) and higher employee premium contributions (\$5.9 billion). Lost wages and increased premium contributions – commonly called the pass-through – would equal about \$925 per covered worker over the 1996 through 2002 period (*Figure ES- 3*).

The cost shift would affect costs for both public and private employee health benefits plans. About 18 percent of the cost shift pass-through to workers would fall on government employees (i.e., state, local and federal government employees) while about 82 percent would fall on covered workers in private health plans (*Figure ES- 3*). The amount of the pass-through per worker would tend to be highest among industries with the most comprehensive health plans such as manufacturing and transportation.

FIGURE ES- 3

DISTRIBUTION OF COST SHIFT PASS-THROUGH TO COVERED WORKERS
BY INDUSTRY (1996 THROUGH 2002)

	Pass-through to Covered Workers (billions) ^{a/}	Pass-through per Worker	Percent of Total
Industry			
Construction	\$3.1	\$968	4.6%
Manufacturing	\$15.1	\$936	22.6%
Transportation	\$6.4	\$1,229	9.6%
Wholesale Trade	\$2.8	\$973	4.2%
Retail Trade	\$5.2	\$653	7.8%
Services	\$15.3	\$908	22.9%
Finance	\$4.3	\$914	6.4%
Other	\$2.8	\$973	4.2%
Government ^{b/}	\$11.9	\$950	17.8%
Total	\$66.9	\$925	100.0%

a/ Includes the increase in employee share of premium and the amount of the employer share of the cost increase that is passed on to workers in the form of lost wages.

b/ Includes federal, state and local employees.

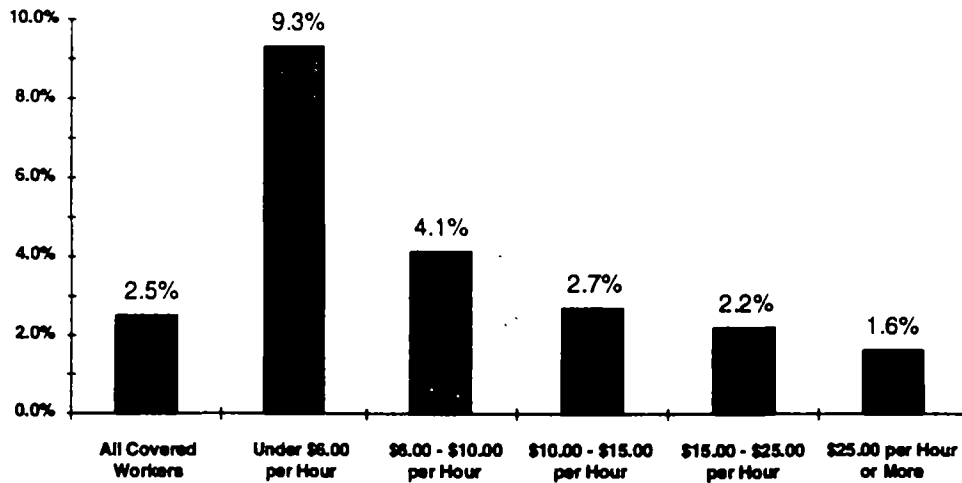
Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

The pass-through of the cost shift will have a disproportionate impact on insured workers in lower wage groups. The lost wage increases resulting from these budget cuts would on average equal about 2.5 percent of the wage increase that workers would have received in the absence of these budget cuts over the 1996 through 2002 period (*Figure ES- 4*). However, the wage growth lost due to cost shifting would vary from about 9.3 percent for covered workers earning \$6.00 or less per hour to only 1.6 percent for persons earning \$25 or more per hour. This reflects the fact that health benefits represent a much greater share of total compensation expenses for lower-wage covered workers than for higher-wage covered workers.

The cost shifting resulting from the proposed Medicare and Medicaid cuts would be distributed across families in all income brackets. Much of the increase in family expenditures would be concentrated among middle and upper income households where private insurance coverage is most prevalent. About 60 percent of the pass-through would fall on families with annual incomes between \$20,000 and \$75,000. About 10 percent would fall on families with incomes below \$20,000 while 30 percent would fall on families with incomes in excess of \$75,000 per year.

FIGURE ES- 4

PERCENT OF WAGE INCREASE FOR COVERED WORKERS OFFSET BY COST SHIFT FROM MEDICARE AND MEDICAID CUTS: 1996 THROUGH 2002^{a/}



a/ This figure shows the cost shift pass-through (i.e., lost wages and increased payroll deductions) as a percentage of the total amount of wage increases that would have occurred over the 1996 through 2002 period for covered workers if the Medicare and Medicaid cuts had not been enacted.

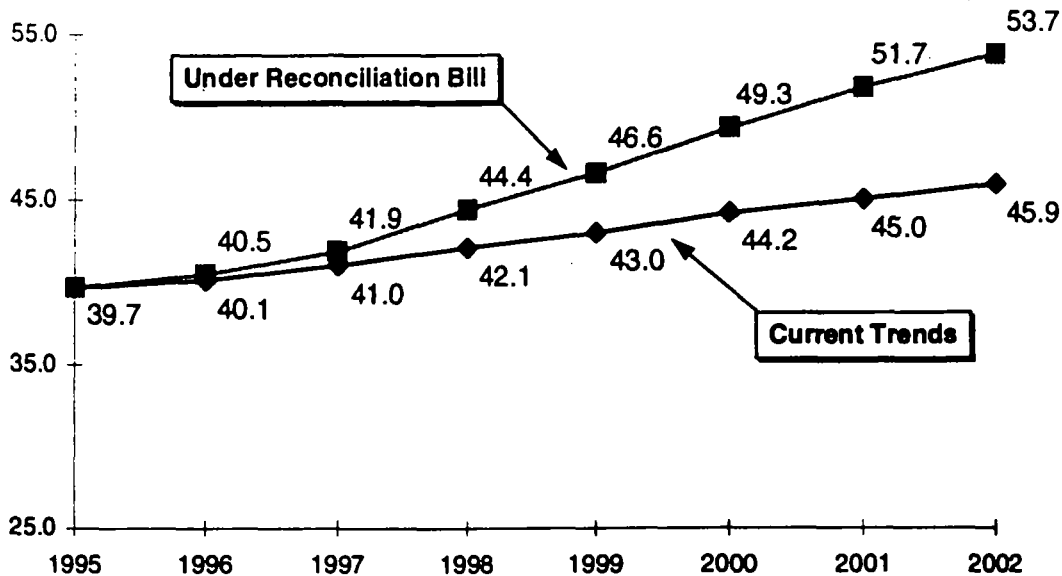
Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

Insurance Coverage

We estimate that the number of uninsured persons in the U.S. under current policy will increase from 39.7 million persons in 1995 to 45.9 million persons by 2002. At the same time, Medicaid coverage is expected to increase from 36.8 million persons in 1995 to 45.9 million in 2002. With the reductions in funding under the reconciliation act, it is unlikely that states will be able to fund this increase in enrollment. In addition, private insurance costs will increase due to increased cost shifting under the act. Thus, the number of uninsured is likely to increase under the act due to reductions in Medicaid eligibility and higher private insurance costs.

Under the reconciliation act, the number of uninsured in 2002 would increase from 45.9 million to 53.7 million (*Figure ES- 5*). This is an increase in the number of uninsured persons of 7.8 million persons in that year. This includes: about 7.2 million persons who lose Medicaid coverage under the bill who have no other coverage; and about 647,000 persons who lose employer coverage due to premium increases resulting from the cost shift.

FIGURE ES- 5
NUMBER OF UNINSURED WITH AND WITHOUT THE RECONCILIATION BILL
(IN MILLIONS)



Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

Summary and Caveats

Ultimately, families will pay for the cost shift. Private insurers pass the burden of higher prices on to their customers in the form of higher premiums. Employers then pass on much of these increased premium costs to workers in the form of reduced wage growth and increased employee contributions. We estimate that the proposed Medicare and Medicaid budget cuts are expected to increase real health expenditures for workers by \$66.9 billion over the 1996 through 2002 period. The cost shift could be substantially different than we have estimated here depending upon the effectiveness of managed care and the way in which providers respond to the budget cuts.

This analysis is limited to the financial effects on employers and employees by industry, firm size and income. It does not describe the effects of increased public-program shortfalls on the availability and quality of care for program beneficiaries and the uninsured. It also does not describe the impact of cost shifting on health care providers beyond the loss of revenues. Moreover, this study examined only the impact of those provisions of recent budgetary legislation affecting Medicare and Medicaid. The study does not examine the impact of various other budgetary changes affecting families such as tax reductions or cutbacks in public assistance benefits.

I. INTRODUCTION

The recent conference agreement on the Budget Reconciliation Act of 1995 would reduce federal funding for Medicare and Medicaid by about \$434 billion over the next seven years. The act includes a combination of expanded enrollment in managed care, increased cost sharing for program beneficiaries, and reduced payments to hospitals, nursing homes and other providers. The act also includes a fail-safe mechanism which would further reduce provider payments automatically if the spending targets in the bill are not met. Some portion of the reductions in provider payments under these programs is likely to be passed on to privately-insured persons in the form of higher charges through cost shifting.

This study analyzes the effects of cost shifting resulting from these budget cuts on private insurance premiums, coverage and costs for employers and families. We begin by reviewing the theory and evidence on cost shifting. We also present information on the amount of these budget cuts that would be implemented through increased enrollment in managed care, provider payment reductions, and increased beneficiary cost sharing. We then present our estimates of the cost shift under these budget cuts and the impact that this would have on employers and families. In addition, we estimate the change in insurance coverage resulting from reduced funding for Medicaid and the increase in private insurance premiums.

This study is an update of a prior Lewin-VHI study in which we estimated potential cost shifting under the 1995 Congressional budget resolutions. This study revises these earlier estimates to reflect the specific provisions included in the Budget Reconciliation bill.

Our analysis is presented in the following sections:

- Medicare and Medicaid Budget Cuts
- Estimated Cost Shift
- Effects of Cost Shifting
- Impact on Insurance Coverage
- Summary and Caveats

II. Medicare and Medicaid Budget Cuts

The Balanced Budget Act would cut Medicare and Medicaid spending about \$434 billion over the 1996 through 2002 period. The bill specifies the cuts that will be made to Medicaid and various components of the Medicare program. In this analysis, we rely upon estimates of the changes in spending resulting from these provisions developed by the Congressional Budget Office (CBO). These estimates were used as the basis for estimating the potential cost shifting. These budget cuts are described below.

A. Medicare Budget Cuts

The act would reduce Medicare program funding by \$270 billion over the next seven years. The bill creates the MedicarePlus program which expands upon the current Medicare HMO risk contract program by permitting beneficiaries to enroll in other types of private health plans such as Preferred Provider Organizations (PPOs) and traditional fee-for-service (FFS) plans. The bill also specifies increases in Part-B premiums for program beneficiaries and requires additional fraud detection and secondary payer recovery initiatives. It also specifies cuts in reimbursement for various categories of providers. In addition, the program establishes a "fail-safe" mechanism which would automatically reduce provider payment levels if the overall spending levels specified in the bill are exceeded.

The CBO indicates that of the \$270 billion in savings, about 10 percent (\$26.9 billion) would occur under the MedicarePlus program (*Figure 1*). These savings would result from reductions in the rate of growth in payments to health plans under the Medicare risk contract program for beneficiaries who enroll. The bill also raises about \$57.3 billion through increased Part-B premiums and would save about \$9.0 billion through improved fraud detection and increased Medicare secondary payer recoveries (i.e., coordination of benefits with private health plans).

The act also specifies \$79.4 billion in reduced payments to hospitals for inpatient and outpatient services. These cuts include reductions in payments for services as well as reductions in medical education payments. The bill also specifies \$27.0 billion in reduced payments for long-term care services including home health and skilled nursing facilities. In addition, the bill specifies \$33.8 billion in reduced payments to physicians and other providers.

FIGURE 1
THE DISTRIBUTION OF MEDICARE PROGRAM SPENDING REDUCTIONS
BY YEAR AND TYPE OF REDUCTION
(IN BILLIONS)

	Total	Hospital Payments ^{a/}	Payments to Physician and Other Providers	Long-Term Care ^{b/}	Increased Part-B Premiums ^{c/}	Medicare Plus Enrollees	Fraud and Other Provisions	Fail-safe	
								Hospital Share	Physician and Other Share
1996	\$6.7	\$3.1	\$0.5	\$0.2	\$3.3	\$0.1	(\$0.5)	\$0.0	\$0.0
1997	\$14.3	\$5.3	\$1.8	\$1.9	\$4.7	\$0.5	\$0.1	\$0.0	\$0.0
1998	\$27.3	\$7.6	\$3.4	\$3.4	\$5.0	\$1.2	\$0.5	\$4.4	\$1.8
1999	\$41.9	\$10.9	\$4.8	\$4.3	\$6.5	\$2.6	\$2.0	\$7.6	\$3.2
2000	\$49.0	\$13.9	\$6.2	\$5.0	\$9.6	\$5.0	\$2.2	\$5.0	\$2.1
2001	\$60.0	\$17.5	\$7.7	\$5.8	\$12.4	\$7.3	\$2.3	\$5.0	\$2.0
2002	\$70.8	\$21.1	\$9.4	\$6.4	\$15.8	\$10.2	\$2.4	\$3.9	\$1.6
TOTAL	\$270.0	\$79.4	\$33.8	\$27.0	\$57.3	\$26.9	\$9.0	\$25.9	\$10.7

a/ Includes reductions in payments to hospitals for inpatient and outpatient services as well as reduction in medical education payments.

b/ Includes reduced reimbursement for skilled nursing facilities and home health care.

c/ Includes the premium increase and the additional premiums collected from high income beneficiaries.

d/ Includes savings resulting from reduced private plan payments for persons enrolling in private plans.

e/ Includes provisions related to fraud detection and increased Medicare secondary payer collections and other miscellaneous provisions.

f/ We assume that the savings resulting from the fail-safe provision will result from additional reductions in provider payments which we assume to be distributed across hospitals and physician services in proportion to the payment reductions specified in the bill for these groups.

Source: Congressional Budget Office (CBO) estimates for the Congressional Budget Reconciliation bill.

The CBO analysis indicates that these program changes will fall short of the \$270 billion in savings called for under the bill by \$36.6 billion. This will trigger additional reductions in provider payment levels under the fail-safe provisions to meet the savings targets. We assume that these fail-safe payment reductions are distributed across hospital and other services in proportion to the payment reductions by category of service specified in the bill. Under this assumption, \$25.9 billion of the \$36.6 billion in reductions under the fail-safe mechanism would be for hospitals while the remaining \$10.7 billion in savings would take the form of reduced payments to physicians and other types of providers.

B. Medicaid Budget Cuts

The act would also reduce federal Medicaid funding by about \$163.4 billion over the 1996 through 2002 period. The bill would convert the Medicaid program to a block grant program to states. In general, the amount of each state's grant would be based upon spending levels prior to implementing these reforms and would be indexed based upon an overall budget ceiling calibrated to produce \$163.4 billion in federal budget savings over the 1996 through 2002 period. States would be allowed to set program eligibility and benefit levels under their state programs and would be given greater flexibility in enrolling beneficiaries in managed care plans. However, the states must match the federal contribution under current Medicaid matching rates to qualify for the federal grant amount.

A key assumption in this analysis is the amount of state funding that would go to the Medicaid program. Under the bill, states are permitted to put more into the Medicaid program than is required to qualify for the maximum amount of the federal grant for that state. States are also permitted to put less into the program than the matching amount required to qualify for the maximum federal grant provided that state funding remains above a minimum threshold amount specified in the bill. However, in these cases, the federal grant amount would be proportionally reduced. In this analysis, we assume that states will put into the Medicaid program only the amount required for the maximum federal grant amount. Under this assumption, the total net reduction in Medicaid spending under the program would be \$286.7 billion (*Figure 2*) which is equal to the reduction in federal payments (\$163.4 billion) plus the associated reduction in state Medicaid payments (\$123.3 billion).

FIGURE 2
CHANGES IN MEDICAID PROGRAM FUNDING AND THE ASSUMED ALLOCATION OF
THESE CUTS ACROSS SERVICES AND ELIGIBILITY
(IN BILLIONS)

	Medicaid Spending Reductions ^{a/}			Assumed Form of Reductions ^{b/}					
	Total	Federal Spending Reduction	Reduced State Match	Provider Payment Reductions ^{c/}			Long-Term Care	Reduced Eligibility	
				Acute Care					
				Total Acute	Hospital	Physician and Other			
1996	\$3.8	\$2.2	\$1.6	1996	\$1.7	\$0.9	\$0.8	\$1.0	\$1.1
1997	\$10.0	\$5.7	\$4.3	1997	\$3.4	\$1.9	\$1.5	\$2.0	\$4.6
1998	\$23.4	\$13.4	\$10.0	1998	\$6.8	\$3.7	\$3.1	\$3.9	\$12.7
1999	\$37.6	\$21.4	\$16.2	1999	\$10.0	\$5.5	\$4.5	\$5.7	\$21.9
2000	\$52.6	\$30.0	\$22.6	2000	\$12.6	\$6.9	\$5.7	\$7.2	\$32.8
2001	\$70.8	\$40.3	\$30.5	2001	\$15.7	\$8.6	\$7.1	\$9.0	\$46.1
2002	\$88.5	\$50.4	\$38.1	2002	\$19.2	\$10.6	\$8.6	\$11.1	\$58.2
TOTAL	\$286.7	\$163.4	\$123.3	TOTAL	\$69.4	\$38.1	\$31.3	\$39.9	\$177.4

a/ In this analysis, we assume that states respond to the reductions in federal payments under the program by reducing the state match to the minimum level required to qualify for the full amount of the federal match.

b/ We assumed that provider payment rates were reduced so that the growth in per-capita costs under the program, currently 7 percent per year, is reduced to 5 percent per year. Budget cuts in excess of the savings resulting from these provider payment reductions are assumed to take the form of enrollment reductions.

c/ Provider payment reductions were allocated in proportion to current spending by type of service.

Source: Lewin-VHI estimates.

It is difficult to estimate the impact of these budget cuts due to the wide latitude that would be permitted states in setting eligibility and coverage levels. For example, some states could respond to funding reductions by cutting back eligibility resulting in a net increase in the number of uninsured. States also may limit covered services or reduce provider payment levels under the program. These changes would increase payment shortfalls for providers either due to increased uncompensated care expenses for the uninsured or through reduced payments for covered services.

In this analysis, we assumed that the growth in per-capita provider payment is reduced from its current rate of 7 percent per year to 5 percent. Budget cuts in excess of the savings resulting from these provider payment reductions are assumed to take the form of reduced enrollment. We estimated the effect of Federal Medicaid savings as follows:

- We calculated a 1995 per-capita spending figure based on CBO baseline federal total spending of \$89.2 billion and enrollment of 36.8 million. To arrive at total Medicaid spending, we divided federal spending by the weighted average federal matching percentage (0.57).
- Federal per-capita spending is estimated to grow at about 7 percent over the period. We assumed that faced with lower federal payments, states would lower payment to providers and reduce services such that the per-capita growth rate was reduced to 5 percent per year. We used the 1995 per-capita

amount and the 5 percent growth rate to calculate per-capita spending amounts for each year 1996 through 2002.

- We next calculated total Medicaid spending under the proposal. To do so, we took the state allotments in the proposal (including the amounts in the supplemental pool and divided the amount for each year by the 1996 weighted average federal matching percentage. This is a conservative assumption because, under the proposal, states are permitted to reduce their matching payment rate.
- To calculate enrollment under the proposal, we divided the total Medicaid spending amount for each year by the per-capita spending amount for the year. The difference between baseline enrollment for each year and the enrollment level calculated for the proposal for the year is the estimated loss of Medicaid coverage under the proposal.
- To calculate the net reduction in payments to providers for those enrolled in Medicaid under the proposal, we subtracted the per-capita spending amount for each year under the proposal from the baseline per-capita spending amount for the year. This difference produces a reduction in the amount per person enrolled. We multiplied this per person reduction amount for each year by the number of enrollees under the proposal for the year to calculate the total reduction in provider payments for enrollees.
- To allocate the total reduction in provider payments between acute care and long-term care providers, we used the baseline ratios of acute care and long-term care to total expenses from the CBO baseline.

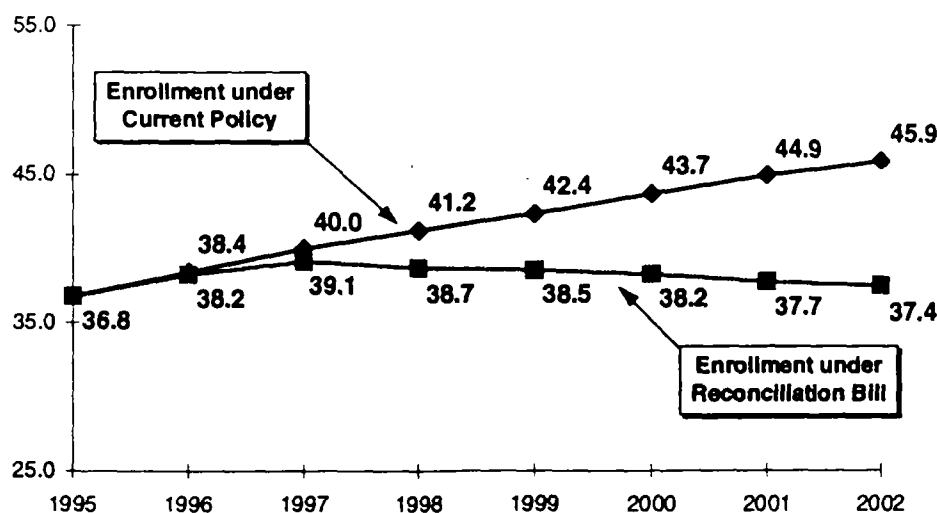
Under these assumptions, about \$109.3 billion of the \$163.4 billion in Medicaid spending reductions would come in the form of reduced provider payments for services while about \$177.4 billion would take the form of reduced enrollment (*Figure 2*). The \$109.3 billion in provider payment reductions are assumed to be distributed across provider groups in proportion to current program spending by type of service. Thus, about 36 percent of program spending cuts (\$39.9 billion) would go to nursing home services. Hospitals would account for about 35 percent of spending cuts (\$38.1 billion), while about 29 percent (\$31.3 billion) would go to physicians and other providers (*Figure 2*).³

There is likely to be a substantial reduction in enrollment in the Medicaid program under the Budget Reconciliation Act. Under current policy, Medicaid enrollment would grow from 36.8 million persons in 1995 to 45.9 million in 2002. Under the Budget Reconciliation Act, states will find it hard to fund this increase in enrollment. Under the assumptions used in this analysis, Medicaid enrollment in 2002 would drop from 45.9 million persons under current policy to 37.4 million persons under the Act (*Figure 3*). This is a reduction in Medicaid enrollment of 8.5 million persons in 2002. We estimate

³ Estimates derived from national health spending estimates provided by the Health Care Financing Administration, Office of the Actuary; data from the Office of National Health Statistics.

that this loss of coverage would result in an increase in uncompensated care costs of \$65.5 billion over the seven-year period for both hospitals and physicians (*Figure 4*).⁴

FIGURE 3
ESTIMATE OF MEDICAID ENROLLMENT WITH AND WITHOUT THE
RECONCILIATION BILL: 1995 - 2002
(IN MILLIONS)



Source: Lewin-VHI estimates.

FIGURE 4
INCREASE IN CHARITY CARE EXPENDITURES DUE TO REDUCTION IN MEDICAID
ELIGIBILITY (IN BILLIONS)

	Resulting Increase in Free Care from Providers		
	Hospital Charity Care	Free From Physician	Total Free Care
1996	\$0.4	\$0.0	\$0.4
1997	\$1.5	\$0.2	\$1.7
1998	\$4.2	\$0.5	\$4.7
1999	\$7.3	\$0.8	\$8.1
2000	\$10.9	\$1.2	\$12.1
2001	\$15.3	\$1.7	\$17.0
2002	\$19.3	\$2.2	\$21.5
TOTAL	\$58.9	\$6.6	\$65.5

a/ Assumes that health spending for those who lose coverage will decline to levels reported by the uninsured. Charity care expense estimates were then developed on the basis of the share of spending associated with charity care for persons who are currently uninsured.

Source: Lewin-VHI estimates.

⁴ In developing these estimates, we assume that total health spending for those who lose coverage (\$177.4) is reduced to levels reported by uninsured persons with similar age, sex, income and health status characteristics. We then estimated free care from hospitals and physicians based upon the percentage of care for uninsured persons provided by these sources as reported in the National Medical Expenditures Survey (NMES).

III. Estimated Cost Shift

Cost shifting is the process whereby providers recover uncompensated care costs and payment shortfalls for public program enrollees in the form of higher charges to private payers. In this section we review the available evidence on cost shifting. We also present the assumptions used in our analysis and estimate the amount of the increase in cost shifting that could result under these budget proposals.

A. Evidence on Cost Shifting

Payment levels under public programs are typically less than payments for comparable services under private insurance plans. In 1993, Medicare hospital payments were equal to about 89 percent of hospital costs for Medicare patients. In addition, payments under the Medicaid program were equal to about 93 percent of costs and hospitals incurred about \$12.3 billion in bad debt and charity care expenses in that year for uninsured and underinsured patients.⁵ In theory, these payment shortfalls are recovered by hospitals in the form of higher charges to private payers. For example, private payer payments were equal to about 129 percent of costs for private sector patients in 1993.⁶

In recent years, some debate has arisen over the existence of the cost shift. While public payers do pay less than average costs, even after adjusting for case mix, this does not necessarily mean that there is cost shifting. In fact, differential pricing across purchasers is often found in many industries. Arguably, the hospitals are engaged in marginal cost pricing and there is no actual cost shift unless services are sold for less than the marginal cost of providing these services. The fact that hospitals have not closed their doors to Medicare patients suggests that the marginal revenues for serving this population exceed their marginal costs. Moreover, with the advent of selective contracting, it has become increasingly difficult for hospitals to shift costs to private payers.⁷

Regardless of whether it is marginal cost pricing or cost shifting, the key question in this analysis is whether prices paid by private payers increase as provider payment shortfalls rise. The literature is mixed on this question. Two studies show that about half of hospital payment shortfalls are passed on to private payers in the form of higher charges.⁸ However, two other studies showed considerably less evidence of hospital cost

⁵ Uncompensated care is estimated on a cost basis.

⁶ "Medicare and the American Health Care System: report to the Congress," Prospective Payment Assessment Commission (ProPAC), June 1995.

⁷ Morrissey, M., *Cost Shifting in Health Care: Separating Evidence from Rhetoric*, American Enterprise Institute, September 1993.

⁸ Dranove, David, "Pricing by Non-Profit Institutions: The Case of Hospital Cost Shifting," *Journal of Health Economics*, Vol. 7, No. 1 (March 1988); and Sloan, Frank and Becker, Edward, "Cross-Subsidies and Payment for Hospital Care," *Journal of Health Politics, Policy and Law*, Vol. 8., No. 4 (Winter 1984).

shifting, although they did not rule out a partial cost shift.⁹ A recent study of physician pricing by Thomas Rice *et al.*, showed that for each one percent reduction in physician payments under public programs, private sector prices increased by 0.2 percent.¹⁰

Data from the Prospective Payment Assessment Commission (ProPAC) also suggest a close relationship between hospital payment shortfalls and prices paid by the private sector. For example, while Medicare and Medicaid payments as a percent of costs declined throughout the 1980's, private payments as a percent of costs rose steadily during this period (*Figure 5*). Historically, the private sector mark-up has increased steadily as public program shortfalls have increased and has been roughly equal to the total payment shortfall for hospitals. After a decade of steady increases, the mark-up on private sector patients actually declined in 1993, apparently due to substantial increases in Medicaid Disproportionate Share Hospital (DSH) payments starting in 1992. Thus, increases and decreases in private payer mark-ups track closely with changes in payment shortfalls from public programs and the uninsured.

For example, data provided by ProPAC indicate that provider payment shortfalls increased by \$1.5 billion in 1991.¹¹ Using these data, we estimated the change in private payer mark-up associated with this change in provider payment shortfalls. These data show that the dollar amount of the change in private payer mark-up in 1991 was \$1.9 billion (*Figure 6*). Of this \$1.9 billion, about \$1.2 billion went to fund increased hospital profits while the remaining \$0.7 billion went to offsetting the increase in the payment shortfall. Thus, of the \$1.5 billion increase in payment shortfalls in 1991, about 47 percent was offset by increased private sector payments. The remainder of the payment shortfall appears to have been absorbed through either increased hospital efficiencies or service reductions. These data also show that in 1992, about 40 percent of the change in payment shortfalls in that year were passed on to private payers (supporting data are included in *Figure 7*).

B. Assumptions

It is clear from these studies that providers are able to shift only a portion of the payment shortfalls to private payers in part due to the increase in selective contracting in recent years. In this analysis, we assume that 40 percent of the increase in hospital payment shortfalls in a year would be passed on to private payers in the form of higher charges. Based upon the Rice analysis, we also assume that each one percent reduction in physician payments under these budget cuts would be associated with a 0.2 percent increase in private sector physician charges. For illustrative purposes, we assume that the proportion of payment shortfalls shifted to private payers would gradually decline by about one-quarter by 2002 due to expanded selective contracting among physicians and hospitals.

⁹ Zuckerman, Stephen, "Commercial Insurers and All-Payer Regulation," *Journal of Health Economics*, Vol. 6, No. 2 (September 1987); and Hadley, Jack and Feder, Judy, "Hospital Cost Shifting and Care for the Uninsured," *Health Affairs*, Vol. 4, no. 3 (Fall 1985).

¹⁰ Rice, Thomas, et al., "Physician Response to Medicare Payment Reductions: Impacts on Public and Private Sectors," Robert Wood Johnson Grant no. 20038, September 1994.

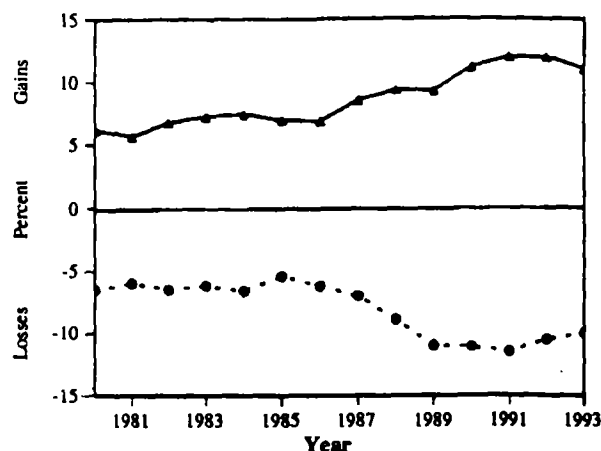
¹¹ "Medicare and the American Health Care System," Prospective Payment Assessment Commission (ProPAC), June 1991 through June 1995.

FIGURE 5
HOSPITAL GAINS AND LOSSES FOR HOSPITALS 1980 - 1993

Year	Hospital Payment to Cost Ratios		
	Medicare	Medicaid	Private
1980	0.96	0.91	1.12
1981	0.97	0.93	1.12
1982	0.96	0.91	1.14
1983	0.97	0.92	1.16
1984	0.98	0.88	1.16
1985	1.01	0.90	1.16
1986	1.01	0.88	1.16
1987	0.98	0.83	1.20
1988	0.94	0.80	1.22
1989	0.91	0.76	1.22
1990	0.89	0.80	1.27
1991	0.88	0.82	1.30
1992	0.89	0.91	1.31
1993	0.89	0.93	1.29

Note: Payments and costs include both inpatient and outpatient services. These ratios cannot be used to compare payment levels, because both the mix of services and the cost per unit of service vary across payers. They do, however, indicate the relative degree to which payments from each payer cover the costs of treating its patients. Due to reporting inconsistencies related to Medicaid disproportionate share payment and provider-specific taxes, there are significant margins of error for the numbers related to all payers in 1992 and 1993.

Source: ProPAC analysis of data from the American Hospital Association Annual Survey of Hospitals



a/ From private payers and operating subsidies above uncompensated care costs.

b/ From Medicare, Medicaid, and other government payers, and uncompensated care.

Note: Gains and losses are the difference between the cost of providing care and the payment received. Operating subsidies from state and local governments are considered payments for uncompensated care, up to the level of each hospital's uncompensated care costs. Excludes non-patient care income. Due to inconsistencies related to Medicaid disproportionate share hospital payments and provider-specific taxes, there are significant margins of error for the numbers related to all payers in 1992 and 1993.

Source: ProPAC analysis of data from the American Hospital Association Annual Survey of Hospitals

FIGURE 6
ESTIMATION OF PERCENT OF PAYMENT SHORTFALLS SHIFTED TO PRIVATE PAYERS

	1990 - 1991 Change	1991 - 1992 Change
Change in Payment Shortfall		
Change in Payment Shortfall (in billions)	\$1.5	\$1.0
Calculation of Private Mark-up Used for Payment Shortfall		
Dollar Change in Private Mark-up (in billions)	\$1.9	\$1.2
Dollar Change in Hospital Margin Financed with Change in Private Mark-up (in billions)	\$1.2	\$0.8
Change in Private Mark-up Shifted to Cover Payment Shortfall (in billions)	\$0.7	\$0.4
Percent Cost Shifted		
Percent of Payment Shortfall Shifted to Private Sector	47%	40%

a/ Includes uncompensated care (on a cost basis) and the total shortfall for public payers including Medicare and Medicaid less state subsidies and net revenues from non-patient income.

b/ Increase in private sector payments in excess of what would have been paid under the prior year's private sector mark-up percentage.

c/ Increase in hospital net revenues in excess of what they would have been under the prior year's hospital total margin (i.e., profits as a percent of revenues).

d/ The difference between the dollar change in the private sector mark-up and the dollar change in the hospital margin is the amount that was used to offset payment shortfalls for other payers.

Source: Lewin-VHI analysis of ProPAC data.

FIGURE 7
HOSPITAL REVENUES AND COSTS BY PAYER SOURCE: 1990 - 1992
(IN BILLIONS)

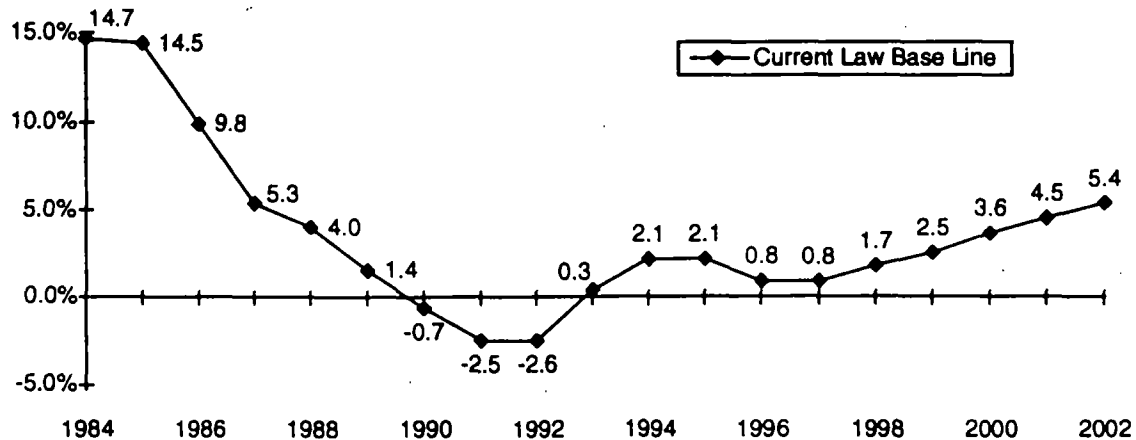
	Revenues			Costs			Net		
	1990	1991	1992	1990	1991	1992	1990	1991	1992
Medicare	\$69.8	\$76.3	\$85.4	\$78.0	\$86.3	\$96.2	-\$8.2	-\$10.0	-\$10.8
Medicaid	18.4	22.7	27.2	23.0	27.8	30.2	-4.6	-5.1	-3.0
Other Government	3.4	3.2	3.6	3.2	3.2	3.7	0.2	0.0	-0.1
Uncompensated	2.5	2.6	2.7	12.1	13.4	14.3	-9.6	-10.8	-11.6
Private	104.1	113.9	122.5	81.6	87.8	93.5	22.5	26.1	29.0
Non-Patient	12.4	13.8	15.0	5.5	6.0	6.6	6.9	7.8	8.4
Other	1.2	2.5	3.6	0.3	0.5	3.6	0.9	2.0	0.0
TOTAL	\$211.8	\$235.0	\$260.0	\$203.7	\$225.0	\$248.1	\$ 8.1	\$ 10.0	\$ 11.9

a/ Includes hospital data excluded from ProPAC analysis.

Source: Data obtained from ProPAC, "Medicare and the American Health Care System," June 1995 (based on AHA data).

In this analysis, the total payment shortfall is defined to be equal to costs minus revenues for the uninsured and revenues for persons in public programs. Non-patient income and payments from state government subsidies are offset against these payment shortfalls. Also, in instances where revenues exceed cost for a particular public program, total payment shortfalls are reduced by the amount of any profits made on care provided to publicly-insured patients. For example, under current trends, hospital margins are projected to increase to positive levels throughout the remainder of the century due to reduced hospital cost growth (*Figure 8*). These positive Medicare margins are assumed to offset payment shortfalls related to Medicaid and uncompensated care

FIGURE 8
PROJECTED MEDICARE PPS INPATIENT OPERATING MARGINS UNDER CURRENT LAW



Source: Lewin-VHI estimates.

C. Cost Shift Estimates

We estimate that the shortfall in payments to hospitals under the reconciliation bill would be \$202.3 billion over the 1996 through 2002 period (*Figure 10*). This includes reduced payments to hospitals for services provided to Medicaid and Medicare enrollees and increased charity care expenses for those who become uninsured. In addition, we estimate that payment shortfalls for physicians would be \$82.4 billion.

Under the assumptions used in this analysis, we estimate a total cost shift of about \$84.7 billion resulting from these budget cuts over the 1996 through 2002 period (*Figure 9*). This includes \$64.3 billion in hospital cost shifting and about \$20.4 billion in cost shifting among other providers. Overall, about 52.7 percent of the cost shift would be attributed to the Medicare cuts while 47.3 percent would be due to the Medicaid cuts.

FIGURE 9
ESTIMATED COST SHIFT UNDER MEDICARE AND MEDICAID BUDGET CUTS
(IN BILLIONS)

	Hospital Cost Shift ^{a/}	Other Provider Cost Shift ^{b/}	Total Cost Shift
1996	\$1.6	\$0.4	\$ 2.0
1997	3.0	0.9	3.9
1998	6.8	2.4	9.2
1999	10.3	3.5	13.8
2000	11.7	3.9	15.6
2001	14.4	4.4	18.8
2002	16.5	4.9	21.4
Total 1996 - 2002	\$ 64.3	\$ 20.4	\$ 84.7

a/ Includes a percentage of hospital budget cuts under Medicare and Medicaid. The percentage of hospital budget cuts that we assume to be cost shifted is 40 percent in 1994 phasing down to 30 percent by 2002.

b/ Assumes that each 1.0 percent reduction in other provider payments under the bill results in a 0.2 percent increase in private sector rates.

Source: Lewin-VHI estimates.

FIGURE 10
SUMMARY OF PAYMENT SHORTFALLS UNDER THE RECONCILIATION BILL:
1996 - 2002 (IN BILLIONS)

	Increase in Payment Shortfalls for Hospitals				Increase in Payment Shortfalls for Physicians			
	Total	Medicare Provider Payment Reductions ^{a/}	Medicaid Provider Payment Reductions ^{b/}	Charity Care for Persons Who Lose Coverage ^{c/}	Total	Medicare Provider Payment Reductions ^{a/}	Medicaid Provider Payment Reductions ^{b/}	Charity Care for Persons Who Lose Coverage ^{c/}
1996	\$4.4	\$3.1	\$0.9	\$0.4	\$1.3	\$0.5	\$0.8	\$0.0
1997	\$8.7	\$5.3	\$1.9	\$1.5	\$3.5	\$1.8	\$1.5	\$0.2
1998	\$19.9	\$12.0	\$3.7	\$4.2	\$8.8	\$5.2	\$3.1	\$0.5
1999	\$31.3	\$18.5	\$5.5	\$7.3	\$13.3	\$8.0	\$4.5	\$0.8
2000	\$36.7	\$18.9	\$6.9	\$10.9	\$15.2	\$8.3	\$5.7	\$1.2
2001	\$46.4	\$22.5	\$8.6	\$15.3	\$18.5	\$9.7	\$7.1	\$1.7
2002	\$54.9	\$25.0	\$10.6	\$19.3	\$21.8	\$11.0	\$8.6	\$2.2
TOTAL	\$202.3	\$105.3	\$33.1	\$58.9	\$82.4	\$44.5	\$31.3	\$6.6

a/ See Figure 1.

b/ See Figure 2.

c/ See Figure 4.

Source: Lewin-VHI estimates.

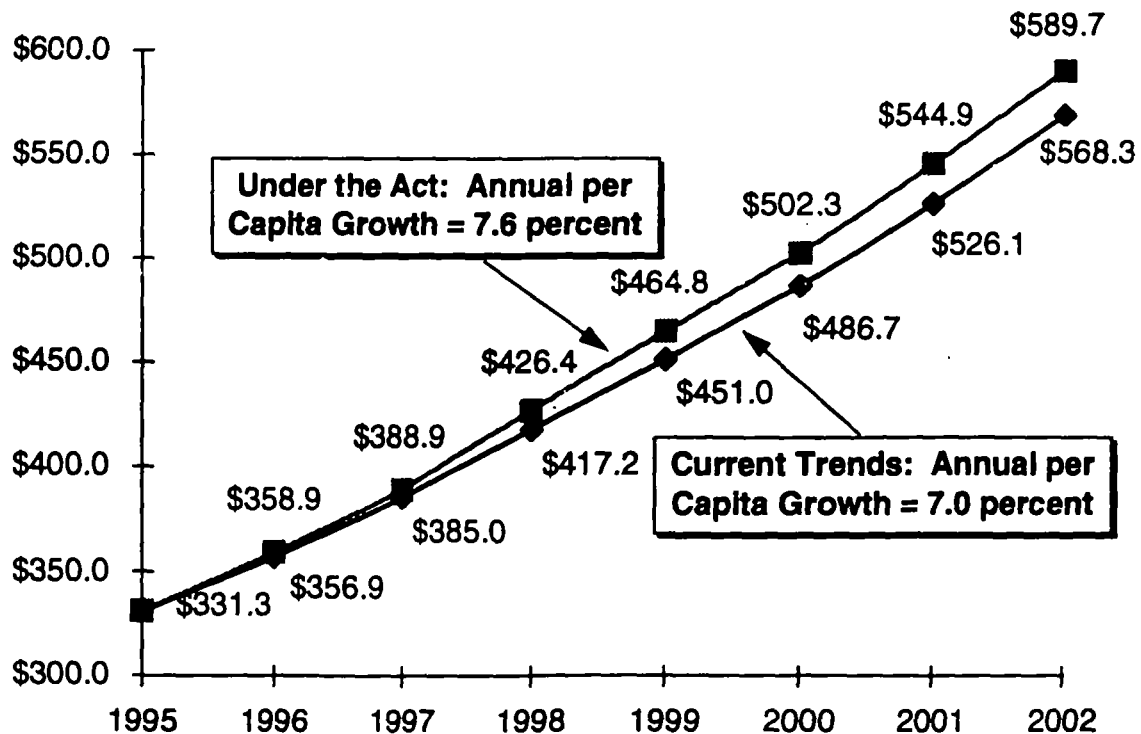
IV. Effects of Cost Shifting

The \$84.7 billion in cost shifting would result in substantial increases in health insurance premiums over the 1996 through 2002 period, affecting all purchasers of private insurance including employers and individuals. The growth in employer costs is also likely to result in slower wage growth for workers in firms with insurance. In addition, some covered individuals and employers would be unable to afford the increase in premiums, resulting in a loss of coverage. These effects are discussed below.

A. Cost Shift by Type of Payer

The increase in provider charges to private payers resulting from the cost shift (\$84.7 billion) would be reflected in higher private insurance premiums. Premiums would increase for both employer health plans and individually purchased non-group insurance. The annual rate of growth in per-capita private insurance costs would increase from 7.0 percent under current trends to 7.6 percent with the Medicare and Medicaid budget cuts. By 2002, private insurance premiums would be about \$21.4 billion (four percent) higher than under current trends due to this cost shift (*Figure 11*).

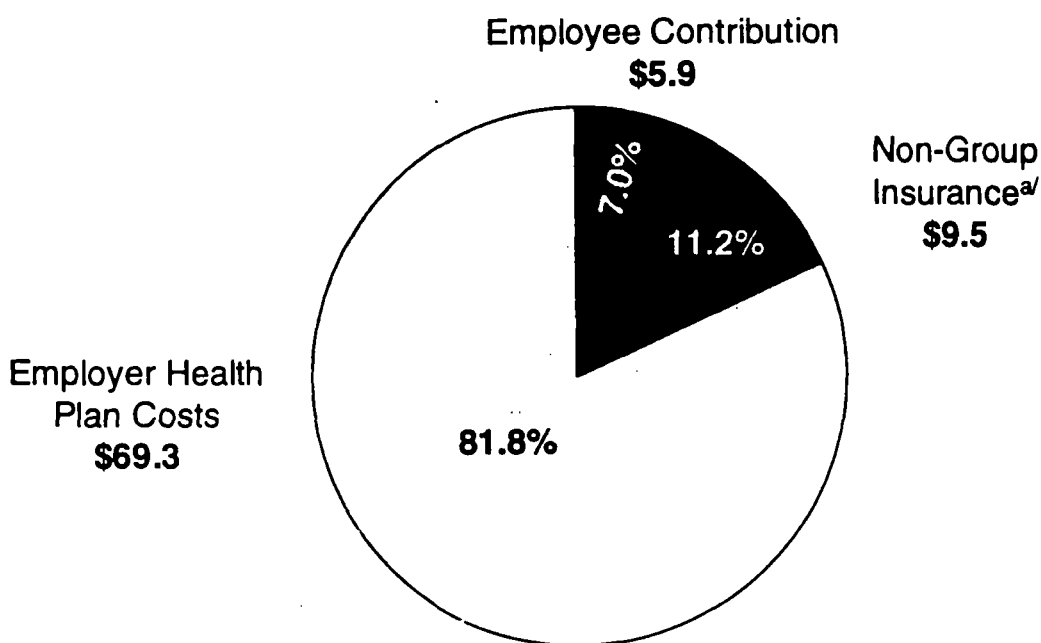
FIGURE 11
PRIVATE INSURANCE COSTS RESULTING FROM MEDICARE AND MEDICAID
BUDGET CUTS IN THE BUDGET RECONCILIATION ACT OF 1995
(IN BILLIONS)



Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

In this analysis, we assumed that this increase in insurance costs would be distributed across employer and individual premiums in proportion to current spending for health insurance. Under these assumptions, employer health spending would increase by \$69.3 billion over the 1996 through 2002 period (*Figure 12*). Employee contributions for employer health coverage also would increase by \$5.9 billion over that period. Family expenditures for non-group insurance would increase by \$9.5 billion due to the cost shift.

FIGURE 12
COST SHIFT TO PRIVATELY INSURED: 1996-2002
(IN BILLIONS)



Total Cost Shift: \$84.7 billion

a/ Includes private Medigap insurance.

Source: Lewin-VHI Estimates using the Health Benefits Simulation Model (HBSM)

The \$69.3 billion increase in employer health care costs resulting from the cost shift represents roughly a 2.7 percent increase in employer costs over this period. The increase in employer health spending would equal about \$950 per worker over the 1996 through 2002 period (*Figure 13*).

FIGURE 13
COST SHIFT TO EMPLOYERS UNDER ILLUSTRATIVE
MEDICARE AND MEDICAID CUTS

	Amount Shifted to Employers (In billions)	Percent Increase In Employer Costs	Cost Increase per Covered Worker
1995	\$0.0	---	---
1996	\$1.6	0.5%	\$22
1997	\$3.2	1.0%	\$44
1998	\$7.5	2.1%	\$104
1999	\$11.3	3.1%	\$157
2000	\$12.8	3.2%	\$175
2001	\$15.4	3.6%	\$210
2002	\$17.5	3.7%	\$238
Total 1996 - 2002	\$69.3	2.7%	\$950

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

B. Impact on Workers by Industry Type and Firm Size

Empirical evidence indicates that employers are likely to pass on much of the increase in employer costs to employees in the form of reduced wages.^{12, 13} Employers are typically limited in what they can charge in the market place, necessitating changes in other compensation costs as employer premiums increase. Based upon a review of the literature, we assume that, on average, 88 percent of the change in employer costs under these reforms would be passed on to workers in the form of lost wage growth.¹⁴

Under these assumptions, about \$61.0 billion of the \$69.3 billion increase in employer costs due to cost shifting would be passed on to workers in the form of lost wage growth. This wage loss is in addition to the \$5.9 billion increase in employee premium contributions resulting from higher private insurance premiums. Overall, the amount of the cost shift passed through to workers would be \$66.9 billion including lost wage growth and higher employee premium contributions (*Figure 14*). Lost wages and

¹² See, for example, Jonathan Gruber and Alan B. Krueger, "The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers Compensation Insurance," in *Tax Policy and the Economy* (1991); Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," *American Economic Review*, (forthcoming); and Lawrence H. Summers, "Some Simple Economics of Mandated Benefits," *American Economic Review* (May 1989).

¹³ See, for example, James Heckman, "What Has Been Learned About Labor Supply in the Past Twenty years?" *American Economic Review*, (May 1993).

¹⁴ This estimate is consistent with estimates presented in the literature. For example, Gruber and Krueger, *op. cit.*, find that about 85 percent of the costs of mandated worker's compensation benefits are shifted to employees in the form of reduced wages, while Gruber, *op. cit.*, found that virtually all of the employer's cost of mandated maternity benefits are shifted to the employee.

increased premium contributions – commonly called the pass-through – would equal about \$925 per covered worker over the 1996 through 2002 period.

FIGURE 14
DISTRIBUTION OF COST SHIFT PASS-THROUGH TO COVERED WORKERS BY
INDUSTRY AND FIRM SIZE (1996 THROUGH 2002) ^{a/}

	Pass-through to Covered Workers (billions)	Pass-through per Covered Worker	Percent of Total
Industry ^{b/}			
Construction	\$3.1	\$968	4.6%
Manufacturing	\$15.1	\$936	22.6%
Transportation	\$6.4	\$1,229	9.6%
Wholesale Trade	\$2.8	\$973	4.2%
Retail Trade	\$5.2	\$653	7.8%
Services	\$15.3	\$908	22.9%
Finance	\$4.3	\$914	6.4%
Other	\$2.8	\$973	4.2%
Government ^{b/}	\$11.9	\$950	17.8%
Firm Size ^{c/}			
Under 10	\$7.0	\$879	10.5%
10 - 24	\$4.4	\$828	6.6%
25 - 99	\$7.2	\$1,014	10.8%
100 - 499	\$7.5	\$853	11.2%
500 - 999	\$2.7	\$826	4.0%
1,000 - 4,999	\$7.1	\$883	10.6%
Over 5,000	\$19.1	\$989	28.6%
Total	\$66.9	\$925	100.0%

a/ Includes the increase in employee share of premium and the amount of the employer share of the cost increase that is passed on to workers in the form of lost wages.

b/ Includes federal, state and local employees.

c/ Includes private firms only.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

The cost shift would affect costs for both public and private employee health benefits plans. About 18 percent of the cost shift pass-through would fall on government employees while about 82 percent would fall on covered workers in private health plans (*Figure 14*). The amount of the pass-through per worker would tend to be highest among industries with relatively generous health benefits plans such as manufacturing and transportation.

In the aggregate, however, much of the cost shift will fall on low coverage industries such as retail trade and services due to the large numbers of persons employed

in these industries. For example, about 23 percent of the pass-through would fall on the services industry due to the large number of persons employed in that industry, even though fewer than half of all workers in this industry have coverage on their job. Thus, even though the cost impact per worker would be greatest in high coverage industries, much of the cost shift will fall on lower coverage industries.

C. Effects By Family Income And Wage Level

As discussed above, employers will pass through to workers about \$66.9 billion of the cost shift resulting under the proposed Medicare and Medicaid cuts. This includes increased employee premium contributions and lost wage growth. About 25 percent of this pass-through will be borne by workers earning less than \$10.00 per hour (\$20,800 per year). The amount of the pass-through to workers over the 1996 through 2002 period would range from \$685 for the lowest-wage workers to \$1,233 for workers making \$25.00 or more per hour (*Figure 15*).

FIGURE 15
DISTRIBUTION OF COST SHIFT PASS-THROUGH PER WORKER
BY FAMILY INCOME AND WAGE LEVEL (1996 THROUGH 2000) ^{a/, b/}

	Pass-through to Covered Workers (billions)	Pass-through per Covered Worker	Percent of Total
Family Income			
Under \$10,000	\$2.2	\$863	3.3%
\$10,000 - \$14,999	\$1.7	\$772	2.5%
\$15,000 - \$19,999	\$3.0	\$962	4.5%
\$20,000 - \$29,999	\$7.6	\$711	11.4%
\$30,000 - \$39,999	\$9.2	\$913	13.8%
\$40,000 - \$49,999	\$8.1	\$881	12.1%
\$50,000 - \$74,999	\$15.0	\$923	22.4%
\$75,000 - \$99,999	\$10.3	\$1,015	15.4%
\$100,000 and over	\$9.8	\$1,084	14.6%
Wage Level			
Under \$4.25 per hour	\$3.4	\$685	5.1%
\$4.25 - \$6.00 per hour	\$2.3	\$726	3.4%
\$6.00 - \$10.00 per hour	\$11.0	\$828	16.4%
\$10.00 - \$15.00 per hour	\$13.9	\$784	20.8%
\$15.00 - \$25.00 per hour	\$21.1	\$1,011	31.5%
\$25.00 or more per hour	\$15.2	\$1,233	22.7%
Total	\$66.9	\$925	100.0%

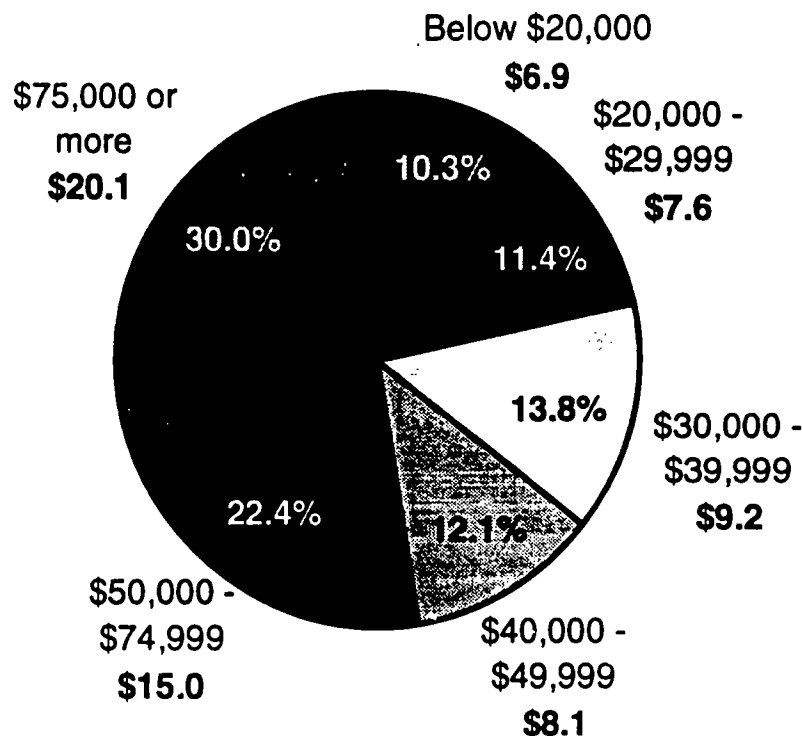
a/ Includes the increase in employee share of premium and the amount of the employer share of the cost increase that is passed on to workers in the form of lost wages.

b/ Family income and wage level are based on 1994 dollars.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

Most of the pass-through resulting from the cost shift would be concentrated among middle-income families. For example, 60 percent of the pass-through to workers would be concentrated among families with incomes between \$20,000 and \$75,000 (*Figure 16*). About 10 percent would fall on families with incomes below \$20,000 while about 30 percent would fall on persons with incomes over \$75,000.

FIGURE 16
DISTRIBUTION OF PASS-THROUGH TO WORKERS
BY FAMILY INCOME: 1996 THROUGH 2000 (IN BILLIONS)^{a/}



Total Pass-through to Workers: \$66.9 billion

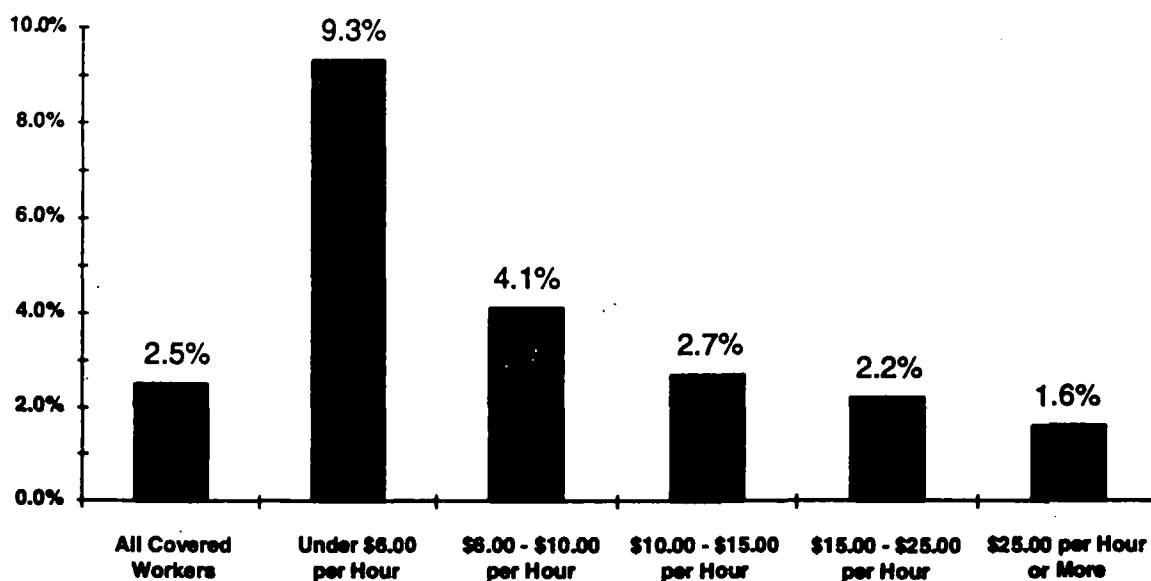
a/ Includes the increase in employee share of premium and the amount of the employer share of the cost increase that is passed on to workers in the form of lost wages.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM)

The wage pass-through resulting from the cost shift will have a disproportionate impact on insured workers in lower wage groups. As discussed above, the cost shift would result in slower wage growth for covered workers as well as increased payroll deductions for the employee's contribution for health insurance. These lost wage increases would on average equal about 2.5 percent of the wage increase that workers would have received over the 1996 through 2002 period in the absence of these Medicare and Medicaid budget cuts (*Figure 17*). However, the wage growth lost due to cost shifting would vary from about 9.3 percent for covered workers earning \$6.00 or less per hour to only 1.6 percent for persons earning \$25 or more per hour. This reflects the fact that health benefits represent a much greater share of total compensation expenses for lower-wage covered workers than for higher-wage covered workers.

FIGURE 17

**PERCENT OF WAGE INCREASE FOR COVERED WORKERS OFFSET BY COST SHIFT
FROM MEDICARE AND MEDICAID CUTS: 1996 THROUGH 2002^{a/}**



a/ This figure shows the cost shift pass-through (i.e., lost wages and increased payroll deductions) as a percentage of the total amount of wage increases that would have occurred over the 1996 through 2002 period for covered workers if the Medicare and Medicaid cuts had not been enacted.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

V. Changes in Insurance Coverage

The Budget Reconciliation Act could result in a substantial reduction in insurance coverage in future years. As discussed above, our estimates assume that a portion of the reductions in Medicaid spending will take the form of reductions in Medicaid eligibility. In addition, the increases in private insurance premiums could result in a loss of private coverage. These potential coverage effects are discussed below.

A. Changes in Employer Coverage

Various studies have shown that employer coverage is sensitive to the price of insurance.¹⁵ Coverage is likely to decline among firms that see an increase in premiums due to this increased cost shifting. The extent to which this loss of coverage would occur depends upon the magnitude of the change in premiums and the price elasticity of employer demand for health insurance. Based upon a review of the literature, we assumed that the price elasticity of employer demand for health insurance is -0.50. That is, for every one percent increase in the premiums, the number of employers purchasing health insurance would decline by 0.50 percent. This elasticity estimate is based upon studies showing how the number of employers purchasing insurance changes at various price levels.¹⁶

We estimate that once these budget cuts are fully implemented in 2002, the number of persons without insurance at any given point in time would increase by about 647,000 persons due to cost shifting. Thus, in 2002 over one-half million people would lose insurance coverage due to the premium increases resulting from increased cost shifting. This includes about 342,000 workers whose employers would discontinue coverage and about 305,000 dependents of these workers. This increase in the average number of uninsured persons will occur gradually as the budget cuts are phased in between 1996 and

¹⁵ C. E. Phelps, *The Demand for Health Insurance: A Theoretical and Empirical Investigation*, Report R-1054-OEO (Santa Monica, CA: The RAND Corporation, 1973); G. S. Goldstein and M. V. Pauly, "Group Health Insurance as a Local Public Good," *The Role of Health Insurance in the Health Services Sector*, ed. R. Rosett (Cambridge MA: National Bureau of Economic Research, 1976), 73-109; G. A. Jensen, *Employer Choice of Health Insurance Benefits* (Doctoral dissertation, University of Minnesota, Minneapolis Minnesota, 1986); A. Leibowitz and M. Chernew, "The Firms' Demand for Health Insurance," *Health Benefits and the Workplace* (Washington: U. S. Department of Labor, 1992), 77 - 84; G. A. Jensen and J. R. Gabel, "State Mandated Benefits and a Firm's Decision to Offer Insurance," *Journal of Regulatory Economics* 4 (1992), 379 -404; and M. A. Morrissey and G. A. Jensen, "State Small Group Insurance Reform," (Paper presented at the University of Illinois conference, "Health Care Reform and the Role of the States," Chicago, IL, 29 April 1994).

¹⁶ Jonathan Gruber and James Poterba, "Tax Subsidies to Employer-Provide Health Insurance," working paper no. 5147, National Bureau of Economic Research, June 1995; K. E. Thorpe, et al., "Reducing the Number of Uninsured by Subsidizing Employment-Based Health Insurance: Results from a Pilot Study," *Journal of the American Medical Association* (19 February 1992), 945 - 948; N. L. Barrand and W. D. Helms, "Testimony before the Subcommittee on Health, Committee on Ways and Means, United States House of Representatives," (Princeton, NJ: The Robert Wood Johnson Foundation, 1991); Helms, et al. "Mending the Flaws in the Small-Group Market;" and McLaughlin and Zellers, "The Shortcomings of Voluntarism in the Small-Group Market."

2002. Many employers also may respond by increasing employee cost sharing in these plans.¹⁷

B. Medicaid Coverage

As discussed above, Medicaid enrollment is assumed to decline due to the reductions in Medicaid funding. Under the assumptions used in this analysis, we estimate that the number of persons covered under Medicaid in 2002 would decline from 45.9 million to 37.4 million. This represents a reduction in Medicaid coverage of 8.5 million persons in that year.

Not all of those who lose Medicaid coverage under the act would become uninsured. For example, many of those who are receiving Medicaid benefits are also covered under Medicare (15 percent). Dual eligible Medicaid beneficiaries who lose their supplemental Medicaid coverage under the act would not be counted as uninsured because they would retain their Medicare coverage. After adjusting for dual eligibility, we estimate that of the 8.5 million persons who lose Medicaid coverage under the act, about 7.2 million would be added to the ranks of the uninsured.¹⁸

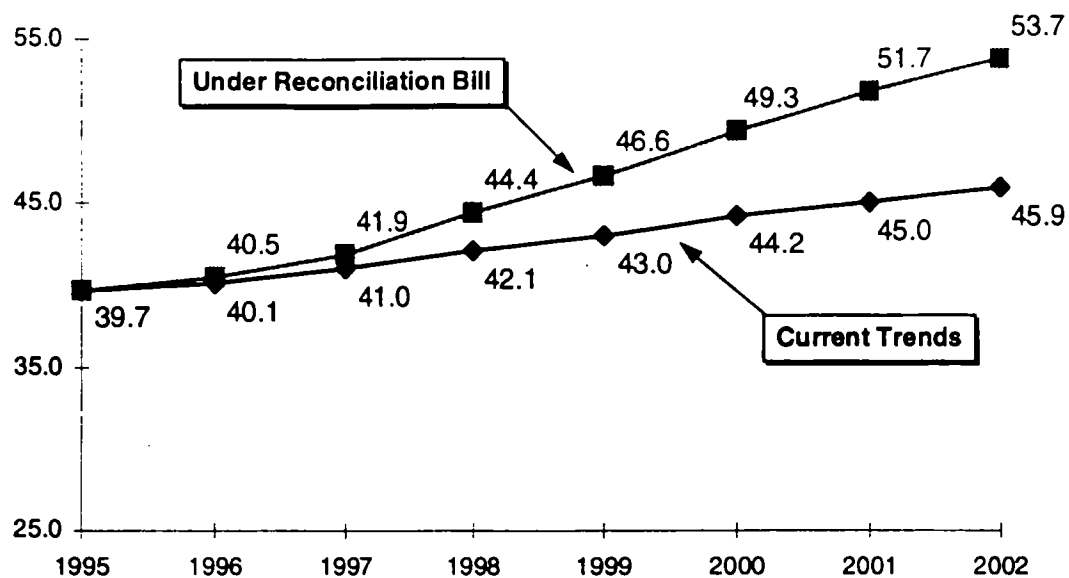
C. Combined Loss of Coverage

Under current policy, we estimate that the number of uninsured persons in the U.S. would increase from 39.7 million in 1995 to 45.9 million by 2002 (*Figure 18*). Under the reconciliation act, the number of uninsured in 2002 would increase from 45.9 million to 53.7 million; an increase of 7.8 million persons. This includes the 7.2 million persons who would lose coverage due to coverage terminations under Medicaid and a reduction in employer coverage of 647,000 persons resulting from the premium increases caused by the cost shift.

¹⁷ The Methodology used to develop these estimates is presented in: John F. Sheils, et al., "The Health Insurance Premium Model (HIPM): Technical Documentation," Lewin-VHI, Report to the Healthcare Leadership Council, March 27, 1995. These estimates are a net figure reflecting the fact that some of the workers who lose employer coverage will purchase individual non-group coverage.

¹⁸ We estimate that 15 percent (1.3 million) of the 8.5 million persons who lose Medicaid coverage under the act would be dually eligible for Medicare.

FIGURE 18
NUMBER OF UNINSURED WITH AND WITHOUT THE RECONCILIATION BILL
(IN MILLIONS)



Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

VI. Summary and Caveats

Our analysis indicates that cost shifting does occur among both hospital and physician services. However, we find that only a portion of increases in payment shortfalls are passed on to private payers in the form of higher prices. The remainder is covered through either increased efficiencies or reductions in services provided. The growing trend toward selective contracting suggests that the provider's ability to shift costs would diminish as selective contracting increases over time.

Ultimately, families will pay for the cost shift. For example, private payers pass the burden of higher prices on to their customers in the form of higher premiums. Employers then pass on the cost of the increased premiums to workers in the form of reduced wage growth and increased employee contributions. We estimate that the proposed Medicare and Medicaid budget cuts are expected to increase real health expenditures for workers by \$72.4 billion over the 1996 through 2002 period. The cost shift could be substantially greater than we have estimated here depending upon the effectiveness of managed care and the way in which providers respond to the budget cuts.

This analysis is limited to the financial effects on employers and employees by industry, firm size and income. It does not describe the effects of increased public-program shortfalls on the availability and quality of care for program beneficiaries and the uninsured. It also does not describe the impact of cost-shifting on health care providers beyond the loss of revenues.