

Expanding Access to Health Insurance Coverage Lessens the Burden of Uncompensated Care

BACKGROUND

The latest Census Bureau reports indicate that the number of Americans without health insurance is on the rise, up 2.4 million to 43.6 million in 2002. This increase—the largest in a decade—can be attributed to continued erosion in the number of people covered by employer-sponsored insurance. Responding to both a sluggish economy and double-digit growth in health insurance premiums, employers have increased cost sharing requirements, pared down benefit sets, and, in some cases, dropped coverage altogether. (Commonwealth Fund, 2002; Census Bureau, 2003)

The emergence of national health reform as a major campaign issue for 2004 presidential hopefuls shows that once again, health care is a significant concern for the American public. But policy makers at all levels of government have many reasons to be concerned about the rising number of uninsured. Research confirms that individuals without stable or adequate health insurance are more likely to delay seeking needed care until conditions are advanced, have poorer health outcomes, and are more costly to treat than those with stable coverage. (Institute of Medicine, 2002-2003) In 2000, hospitals alone spent as much as \$21.6 million (American Hospital Association, 2002) on uncompensated care, costs that are ultimately shifted to private sector insurers, public programs, employers, employees, and taxpayers.

State governments have financed the provision of uncompensated care by public hospitals and other providers in a variety of ways, and to a lesser and greater extent. Some states have increased direct payments to safety net hospitals; implemented uncompensated care pools; provided tax subsidies (especially to public and teaching hospitals); and utilized Medicare and Medicaid disproportionate share (DSH) payments. Many states have also used more fundamental strategies of expanding public health insurance programs for the poor and near-poor to both increase access to coverage and reduce uncompensated care burdens.

The link between increased access to insurance and reduced levels of uncompensated care for hospitals seems intuitive, at least on its face. Yet surprisingly few studies in the research literature address this relationship. The following issue brief describes how the State Health Data Assistance Center (SHADAC) tested the hypothesis by assessing the impact that enrollment in the MinnesotaCare program—a state-subsidized insurance program for the working poor—had on levels of uncompensated care provided by Minnesota hospitals over time.

MINNESOTACARE: MINNESOTA'S HEALTH CARE EXPANSION FOR THE WORKING POOR

Enacted in 1992, the MinnesotaCare program was established in response to a growing concern over the number of



uninsured, low-income individuals in the state. When the program began, it covered outpatient services—and shortly thereafter, inpatient services—for families with children whose income was at or below 185 percent of the Federal Poverty Guidelines (FPG). Today, MinnesotaCare covers families with children and pregnant women under 275 percent of FPG, adults without children under 75 percent of FPG, and, with a more limited benefit set, adults without children between 75 and 175 percent of FPG. Except for the lowest income families that pay a fixed nominal yearly enrollment fee, all other program enrollees pay premiums determined on a sliding scale basis, accounting for differences in household size, income, and number of people covered. (MN Dept. of Human Services, 2003)

In its infancy, funding for MinnesotaCare came almost exclusively from a tax placed directly on the gross private patient revenues of hospitals and health care providers referred to as the “provider tax”. Over time, the state also obtained federal matching funds for certain groups of enrollees through its \$1115 Medicaid demonstration waiver (1995), and more recently, through available State Children’s Health Insurance Program (SCHIP) allocations (2001). In state fiscal year 2002, 57 percent of MinnesotaCare funding came from provider tax revenue, and the remainder came from federal financial participation (37 percent), and enrollee premiums and other revenues (6 percent).

ASSESSING THE LINK BETWEEN MINNESOTACARE ENROLLMENT AND UNCOMPENSATED CARE SPENDING

Our analysis tested whether an increase in public program enrollment resulted in reduced hospital uncompensated care costs. Using data from 1992 to 1996, SHADAC used multivariate regression analysis to estimate the effect that enrollment in the MinnesotaCare program had on per capita hospital uncompensated care costs. The early, rapid-growth years of the program were used in our analysis to maximize the likelihood of detecting this kind of relationship, should one exist. The analysis controlled for certain hospital characteristics (such as size,

ownership, admission levels, and out-of-pocket charges), as well as county demographics (such as poverty, unemployment rates, age, race, ethnicity, and enrollment in other public programs). Statistical methods were used to isolate the independent effect MinnesotaCare enrollment had on uncompensated care spending, holding constant other factors believed to influence this spending.

Our research suggests that MinnesotaCare enrollment had a significant effect in reducing uncompensated care costs in the state. Specifically, we found that a one percentage-point *increase* in MinnesotaCare enrollment was correlated with a \$2.19 *decrease* in uncompensated care spending per capita. Figure 1 illustrates this point: as MinnesotaCare enrollment grew between 1992 and 1996, uncompensated care levels declined.

What does this relationship mean for policy makers and others concerned with health care access issues? During the 1992-1996 time period of increases in MinnesotaCare enrollment, this analysis suggests reductions in uncompensated care spending—or, hospital cost savings—of roughly \$58.6 million. As Figure 2 illustrates, with the MinnesotaCare program, hospitals spent \$58.6 million *less* on uncompensated care than they would have without the program. The magnitude of these savings for Minnesota hospitals is considerable, and implies that 60 to 100 percent of the actual spending on hospital services for MinnesotaCare enrollees during this period would have been realized as uncompensated care costs by the state’s hospitals in the absence of the program.

IMPLICATIONS FOR THE POLICY DEBATE AND RESEARCH AGENDA

Originally, some proponents of the financing mechanism contended that the provider tax would “redistribute” health care system dollars toward increased insurance coverage and away from uncompensated care, thus reimbursing providers with increased patient care revenues. Since the program’s inception, however, some provider groups have argued against the tax on the grounds that it unfairly targets a burden that should be spread more broadly across the state’s population. Our findings—namely that



MinnesotaCare enrollment has significantly reduced hospital uncompensated care burdens in the state—provide evidence that the initial policy rationale behind the provider tax was sound.

Beyond Minnesota’s borders, our results suggest that health policy and budget analysts evaluating the costs and benefits of state-level eligibility expansions—either prospectively or retrospectively—should consider the

potential benefits of reduced uncompensated care burdens for hospitals and other providers. Additional research should also evaluate the impact of state access initiatives such as the State Children’s Health Insurance Program (SCHIP) to determine whether the findings in Minnesota can be duplicated in other states. At least in theory, provider savings in uncompensated care costs due to SCHIP enrollment may be passed on to insurers and ultimately, health care consumers.

Figure 1: MinnesotaCare Enrollment and Uncompensated Care Spending

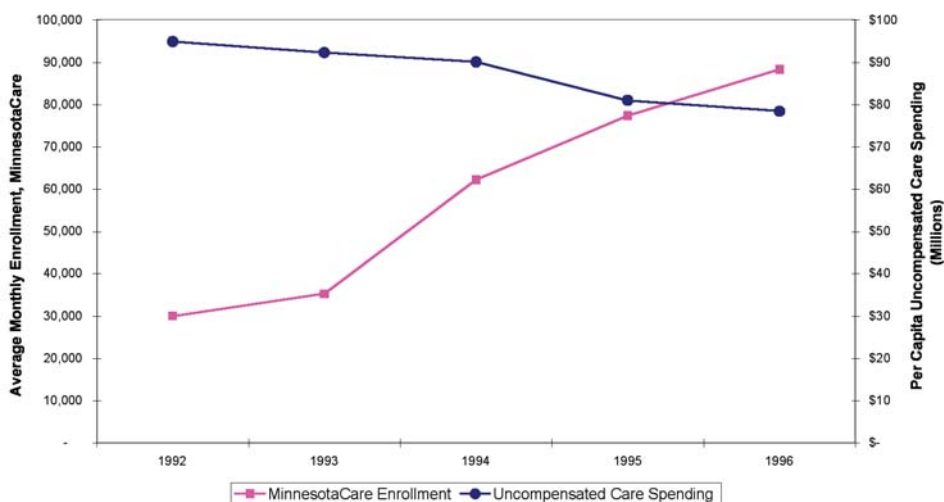
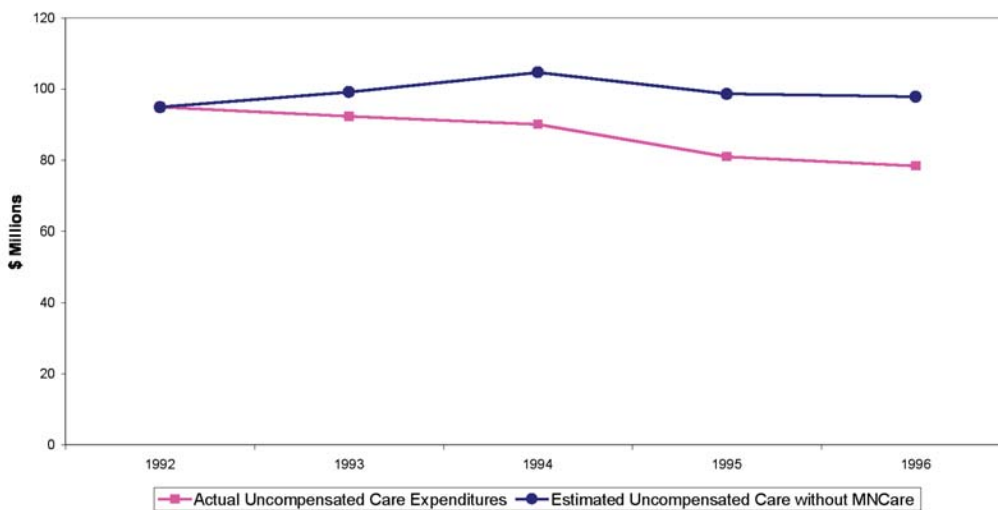


Figure 2: Uncompensated Care Savings Attributed to MinnesotaCare
Cumulative Four-Year Savings = \$58.6 Million





NOTES

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The State Health Access Data Assistance Center at the University of Minnesota promotes the effective use of available data to inform the debate on health coverage and access. A complete account of this study has been published:

Blewett, Lynn A., Gestur Davidson, Margaret E. Brown, and Roland Maude-Griffin. "Hospital Provision of Uncompensated Care and Public Program Enrollment." *Medical Care Research and Review*, December 2003, 60 (4), 509-27.

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