## Estimating the Impact of Public Program Eligibility Changes on Uncompensated Care

Julie Sonier
Director, Health Economics Program
Minnesota Department of Health

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## Background

- Over the past few years, various states including Minnesota considered and implemented cuts in public health insurance to reduce expenditures in a time of budget deficits.
- In 2003, Minnesota was one of a handful of states that attempted to quantify the impact of those changes on the uninsured, uncompensated care, and health care providers.

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## Study Objective

- To estimate the future impact of proposed changes in public program eligibility on:
  - The number of uninsured Minnesotans
  - The level and distribution of uncompensated care at hospitals and clinics in Minnesota

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## Uncompensated Care Defined

- Uncompensated care is medical care the uninsured receive but do not pay for.
- This care includes:
  - Charity care: care provided to the uninsured for which the provider did not expect payment.
  - Bad debt: Care provided to the uninsured for which the provider anticipated, but did not receive, payment.

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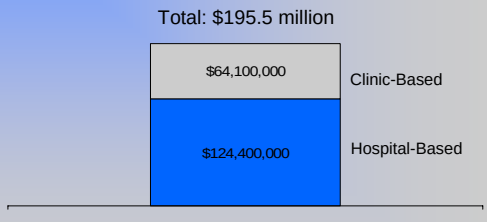
## Uncompensated Care Costs in Minnesota, 2003




Source: Minnesota Department of Health, Health Economics Program.

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## Largest Uncompensated Care providers, by hospital, 2003

| Hospital | Share of statewide UC |
|---|---|
| Hennepin County Medical Center | 17.0% |
| Regions Hospital | 7.2% |
| St. Mary's, Rochester | 6.5% |
| Abbott Northwestern | 4.7% |
| St. Mary's, Duluth | 3.7% |
| United | 3.6% |
| Rochester Methodist | 3.2% |
| Fairview University Medical Center | 2.9% |
| Mercy Hospital | 2.7% |
| North Memorial | 2.6% |

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## Minnesota's issues: uncompensated care

- Minnesota's levels of uncompensated care are below those nationally (1.6% vs. 5.5% of operating expenses), but
- The burden of uncompensated care is distributed unevenly
  - HCMC, Regions, St. Mary's
  - Certain regional hubs in Greater MN
  - Community Clinics

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## Methodology/Analysis

- Goal of analysis: To estimate the amount of additional uncompensated care that would occur at Minnesota's hospitals and clinics from changes in public program insurance and the resulting uninsured:
  - Analysis does not estimate other impacts of the loss of health insurance coverage, such as health status or productivity effects.
- Starting point: Figures on average monthly enrollment reductions and forecasted expenditures associated with reductions.

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## Methodology (I)

- Use estimates of enrollment declines by budget item to determine the number of people who would no longer be covered.
- Adjust for insurance take-up: Some of the people no longer covered by public programs are estimated to purchase private coverage or take-up employer coverage:
- Resulting figure is the estimated number of uninsured, above current levels, that would likely result from public program changes.

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## Methodology (II)

- Given the estimated number of additional uninsured, estimate what spending on behalf of these individuals would have been had they remained enrolled in public programs.
- This figure is then adjusted to account for differences in expenditures between the uninsured and the insured.

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## Methodology (III)

- Adjustments to uninsured expenditures:
  - Uninsured spend half of what the insured spend on health care. (MEPS, Hadley & Holahan 2003, Long & Marquis 1994).
  - Adjustment to reflect that public program enrollees are sicker in general than the uninsured (2001 MN Health Access Survey, Holahan 2001).

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## Methodology (IV)

- Resulting figure is the estimated use of services by the additional uninsured ("uninsured costs").
- Uninsured costs can be "paid" for in two ways:
  - Out of pocket payments by the uninsured
  - Uncompensated care
- Research shows that the uninsured pay a portion of their care costs regardless of their income (MEPS, Hadley & Holahan 2003).

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## Methodology (V)

- The resulting uncompensated care figure is divided between hospital and clinic based uncompensated care.
- Uncompensated care is allocated 34% to clinics and 66% to hospitals based on geography, public program revenue distribution, and distribution of uncompensated care.

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## Results: Estimated Impact on Uninsured

- Uninsured increase by the following relative to current levels:
  - 2003 Baseline: 272,000, 5.4%
  - 2004: 12,990, 5.7%
  - 2005: 24,805, 5.9%
  - 2006: 30,027, 6.0%
  - 2007: 34,099, 6.0%

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## Results: Estimated Impact on Uncompensated Care Levels

- Uncompensated Care at hospitals and clinics is estimated to increase by the following amounts (in millions):

| | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|
| Total | $48.2 | $84.3 | $100.6 | $116.6 |
| Hospital | 38.2 | 66.0 | 77.3 | 88.7 |
| Clinic | 10.1 | 18.3 | 23.2 | 27.9 |

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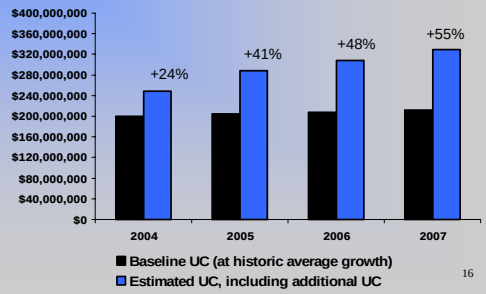
## How Do These Estimated Increases in Uncompensated Care Compare to Current Levels?

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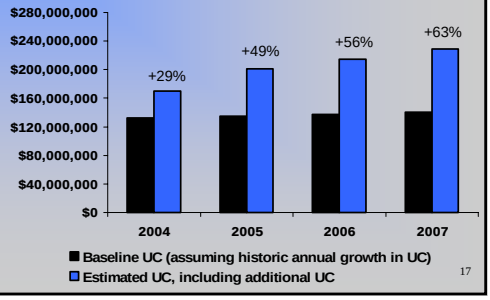
## How Do These Estimated Increases in Uncompensated Care at Hospitals Compare to Current Levels?

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## Some Hospital-specific estimates

- Uncompensated Care is estimated to increase by the following amounts at these select hospitals (in millions):

| | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|
| HCMC | $7.6 | $12.7 | $14.2 | $15.8 |
| Regions | 3.9 | 6.4 | 7.1 | 7.9 |
| FUMC | 3.0 | 5.1 | 6.0 | 6.8 |
| North Memorial | 1.7 | 2.8 | 3.1 | 3.4 |
| Abbott NW | 1.3 | 2.2 | 2.6 | 2.9 |
| St. Mary's (Duluth) | 1.2 | 2.2 | 2.6 | 3.0 |
| St. Luke's (Duluth) | 0.8 | 1.4 | 1.8 | 2.0 |
| St. Mary's (Roch.) | 2.3 | 3.8 | 4.4 | 4.9 |
| St. Cloud Hosp. | 1.2 | 2.2 | 2.8 | 3.4 |
| North Country | 0.4 | 0.8 | 1.0 | 1.2 |

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## Impact of Changes on Uninsured and Uncompensated Care

- Compared to the Governor's original budget proposal:
  - Uninsured estimated to increase from 5.4% to 6.0% in 2007, instead of 6.6%.
  - Overall UC estimated to increase by $117 million in 2007, instead of $172 million.
  - Hospital UC estimated to increase by $89 million in 2007, instead of $134 million.
- In late 2004, hospitals reported that their UC levels were up 23% to 32%:
  - Similar to estimated increase of 29% for 2004.

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