

## **APPENDICES**

### **Caring for the Uninsured in New York**

### **What Does it Cost, Who Pays and What Would Full Coverage Add to Health Care Spending?**

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## Appendix A. Statistical Appendix

### Methodology for Reweighting the Medical Expenditure Panel Survey

The first reweighting stage uses the Current Population Survey (CPS) Northeast sample to estimate a statistical model of the probability of living in New York as a function of socio-demographic variables common to the CPS and the Medical Expenditure Panel Survey (MEPS). The variables include age, race and ethnicity, health insurance status (public, private, or uninsured), gender, education, income, labor force status, marital status, household composition, urban residence, and self-reported health.<sup>1</sup> (Tables A.A.1 and A.A.2 report the parameters of the probit models for adults and children, respectively.) The parameters from this model are then combined with the corresponding variables from the MEPS sample to generate a predicted probability of living in New York for each MEPS respondent. These predicted probabilities are then combined with the actual probability of New York residence observed in the CPS Northeast sample to adjust the MEPS survey person-weight using a formula (described below) developed in the statistical literature.<sup>2</sup> The revised person-weights have the effect of making the MEPS Northeast sample “look like” a sample of New York residents.

#### *Statistical Reweighting Formula*

The following formula describes how the person-weights for the MEPS Northeast regional sample are adjusted to reflect the probability of living in New York. In effect, the MEPS person-weights (NEperwt) for people who have a high predicted probability of living in New York based on their socio-demographic characteristics, as calculated from the probit models reported in tables A.A.1 and A.A.2, are inflated, while the person-weights for people with a low predicted probability of living in New York are deflated.

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<sup>1</sup> The final models also include interactions between the independent variables and (1) race/ethnicity and (2) the MSA (metropolitan statistical area) indicator. Because of differences in survey methodologies and some raw variable definitions between MEPS and CPS (most notably the race variables in the earlier MEPS years vs. the later CPS years), it was important to reliably measure differences in means between the CPS New York population and the MEPS post-reweighting Northeast population for a broad array of characteristics, as a tool for evaluating alternate variable specifications and definitions in the reweighting models.

<sup>2</sup> We follow the reweighting formula described by Barsky et al. (2002), who applied the methodology developed by Rosenbaum and Rubin (1983, 1984).

$NY_{perwt} = NE_{perwt} * [(1 - P_{cps}) / P_{cps}] * [P_{meps} / (1 - P_{meps})]$ , where

$NE_{perwt}$  = the unadjusted person-weight for people in the MEPS Northeast sample,

$P_{cps}$  = the actual probability of living in NY for people in the CPS Northeast sample,

$P_{meps}$  = the predicted probability of living in NY for people in the MEPS Northeast sample.

### *Cell-Based Reweighting*

The second stage of the reweighting methodology employs a cell-based procedure that adjusts for differences in the distributions of key personal characteristics between the reweighted MEPS Northeast and the CPS New York samples. Cases in the MEPS and the CPS New York samples are partitioned into cells delineated by age (adult or child), race and ethnicity (white non-Hispanic, Hispanic, African American, and other races), and type of insurance coverage (private, public, or uninsured). These adjustments assure that the reweighted MEPS Northeast sample matches the size and distribution of the New York population by age, race and ethnicity, and insurance coverage. (See table A.A.3 for details.)

### *Definition of Donated Care*

The expected payment is the ratio of payments to charges for the full-year privately insured (the discount rate), applied to total applicable charges for care received by the uninsured.<sup>3</sup> The private discount rate used is 65.9 percent for adults and 72.3 percent for children. For uninsured people with charges and zero payments, donated care is estimated simply as the amount of charges multiplied by the private discount. Donated care is calculated separately for each uninsured person and is set to zero when negative. This can occur, for example, if the uninsured person pays more out of pocket than would be paid in total for a person with private insurance.

Specifically, donated care is defined according to the following formula:

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<sup>3</sup> Charges for care paid for by public sources, such as the Department of Veterans Affairs and workers compensation, are excluded from these calculations on the assumption that differences between charges and payments received reflect contractual allowances rather than care donated by private providers to uninsured people.

doncare = payments expected if privately insured - actual payments received;  
= [**prv\_discnt** \* **totchgs** \* (**slf+opr+osr**)/**totexp**] - (**slf+opr+osr**), where  
prv\_discnt = total payments / total charges, for the full-year privately insured (excluding people with payments from Medicare, workers' compensation, other state and local, other public, and VA),  
totchgs = total **charges** for care received,  
slf = total out-of-pocket payments,  
opr = total payments from other private sources,  
osr = total payments from other unclassified sources, and  
totexp = total **payments** from all sources.

### **Two-Part Spending Models for Predicting Medical Spending if Fully Insured**

Tables A.A.4 and A.A.5 report the coefficients of the two-part spending models.

**Table A.A.1. Probit Regression Model for New York Residence, Among Adults (19–64) in the Northeast**

	Coefficient
Female	0.011
Race/Ethnicity	
African American	0.508 *
Asian	1.623 *
Amer. Indian	0.061
White Hispanic	0.350 **
Marital status	
Married, not living w/spouse	0.329 ***
Wid., divor., separated	0.099 ***
Never married	-0.071
Household composition	
Number of adults in household	0.077 *
Total number in household	-0.018 *
Veteran living in household	-0.165 *
MSA	0.199 ***
Education	
HS diploma or assoc. deg.	0.290 *
College degree	0.076
Graduate degree	0.226 **
Family income	
100–200% FPL	-0.019
200–400% FPL	-0.044
Greater than 400% FPL	-0.234 *
Labor force status	
Unemployed	-0.034
Not in labor force	0.089 *
Health status	
Very good	0.089 *
Good	0.038 **
Fair or poor	0.066 *
Insurance coverage	
Public	0.098 *
Uninsured	0.049 **
Age group	
19–24	0.114
25–29	0.086
30–34	0.232 *
40–44	0.130 ***
45–49	0.181 **
50–54	0.063
55–59	0.122
60–64	0.136
Constant	-0.993 *

*Source:* Urban Institute analysis of pooled data from the 2001–2003 Current Population Surveys (Northeast sample).

*Note:* Coefficients for the interactions between African American, Hispanic, Asian, MSA, and the remaining independent variables are not shown.

MSA = metropolitan statistical area

FPL = federal poverty level

\*  $p \leq .01$

\*\*  $.01 < p \leq .05$

\*\*\*  $.05 < p \leq .10$

**Table A.A.2. Probit Regression Model for New York Residence, Among Children (0–18) in the Northeast**

	Coefficient
Female	-0.152 *
Race/Ethnicity	
African American	0.033
Asian	1.738 *
Amer. Indian	0.086
White Hispanic	0.006
Parent marital status	
Married, not living w/spouse	0.202
Wid., divor., separated	0.156 **
Never married	0.453 *
Household composition	
Number of adults in household	0.020
Total number in household	0.017 **
Veteran living in household	-0.201 *
MSA	1.115 *
Parent education	
HS diploma or assoc. deg.	0.614 *
College degree	0.253 **
Graduate degree	0.500 *
Family income	
100–200% FPL	0.259 *
200–400% FPL	0.178 **
Greater than 400% FPL	0.060
Parent labor force status	
Unemployed	-0.066 ***
Not in labor force	0.127 *
Health status	
Very good	0.145 *
Good	0.109 *
Fair or poor	0.121 **
Insurance coverage	
Public	0.056
Uninsured	-0.096 **
Age group	
2–4	0.220 ***
5–9	0.294 *
10–12	0.205 ***
13–18	0.266 *
Constant	-1.609 *

*Source:* Urban Institute analysis of pooled data from the 2003–2004 Current Population Surveys (Northeast sample).

*Note:* Coefficients for the interactions between African American, Hispanic, Asian, MSA, and the remaining independent variables are not shown.

FPL = federal poverty level

MSA = metropolitan statistical area

\*  $p \leq .01$

\*\*  $.01 < p \leq .05$

\*\*\*  $.05 < p \leq .10$

**Table A.A.3. Cell-Based Reweighting Adjustment, By Age, Race/Ethnicity, and Insurance Status**

Race/Ethnicity	Insurance	MEPS Northeast <sup>a</sup>			CPS New York <sup>b</sup>			Cell-based weight adjustment <sup>d</sup>
		Unwtd obs.	Wtd %	Annual pop. (sum of wts <sup>c</sup> )	Unwtd obs.	Wtd %	Annual pop. (sum of wts <sup>c</sup> )	
<b>Adults</b>								
White, Non-Hispanic	Private	4,683	30.3	15,511,272	5,512	35.6	5,833,738	0.3761
	Public	455	3.0	1,522,213	394	2.7	445,684	0.2928
	Uninsured	527	3.8	1,921,473	851	6.3	1,037,874	0.5401
African American	Private	744	8.2	4,181,580	1,126	6.6	1,083,373	0.2591
	Public	369	4.7	2,388,277	381	2.4	390,086	0.1633
	Uninsured	207	2.1	1,086,398	465	3.1	508,197	0.4678
Asian & Amer. Indian	Private	398	5.3	2,720,268	569	3.3	537,371	0.1975
	Public	64	0.8	411,971	81	0.5	74,153	0.1800
	Uninsured	85	1.3	679,537	265	1.7	270,821	0.3985
Hispanic	Private	648	5.4	2,763,529	869	4.1	664,069	0.2403
	Public	357	2.4	1,245,854	323	1.5	248,679	0.1996
	Uninsured	379	2.3	1,173,316	608	3.0	497,565	0.4241
<b>Children</b>								
White, Non-Hispanic	Private	1,839	10.4	5,326,327	2,756	12.9	2,120,576	0.3981
	Public	546	3.0	1,534,470	465	2.2	363,305	0.2368
	Uninsured	133	0.6	297,643	223	1.1	172,292	0.5789
African American	Private	354	2.8	1,455,290	504	3.0	485,661	0.3337
	Public	552	4.7	2,428,731	440	2.7	450,025	0.1853
	Uninsured	38	0.3	127,346	136	0.8	134,723	1.0579
Asian & Amer. Indian	Private	176	1.6	792,538	221	1.1	180,128	0.2273
	Public	56	0.6	325,518	73	0.4	69,723	0.2142
	Uninsured	12	0.1	55,175	67	0.3	56,108	1.0169
Hispanic	Private	300	2.1	1,065,904	533	2.2	359,954	0.3377
	Public	635	4.0	2,050,128	502	2.1	342,693	0.1672
	Uninsured	76	0.3	155,120	119	0.5	78,717	0.5075
<b>All Nonelderly</b>		<b>13,633</b>	<b>100.0</b>	<b>51,219,877</b>	<b>17,483</b>	<b>100.0</b>	<b>16,405,514</b>	<b>0.3203</b>

Source: Urban Institute analysis of data reported in Government Accountability Office (2005).

<sup>a</sup> 2001–2003 Medical Expenditure Panel Survey (Northeast sample with 13,633 unweighted observations).

<sup>b</sup> 2003–2004 Current Population Survey (New York sample with 17,483 unweighted observations).

<sup>c</sup> Sum of weights after statistical reweighting.

<sup>d</sup> Ratio of CPS New York weighted population to MEPS Northeast weighted population.

CPS = Current Population Survey

MEPS = Medical Expenditure Panel Survey

**Table A.A.4. Coefficients for Two-Part Expenditure Models, Adults**

	Any expend.	Total expend., if any	Any OOP exp.	Total OOP exp., if any
Percent of year insured	1.361*	0.375*	0.870*	-0.622*
Health status				
Very good	0.256**	0.097	0.300*	0.055
Good	0.153	0.396*	0.189	0.288*
Fair	0.448***	0.494*	0.242	0.105
Poor	0.437	0.812*	0.155	0.186
Mental fair or poor	0.345	0.397*	0.285	0.351*
Deceased or institution	-1.313***	0.730***	-1.429***	-0.131
Limitations				
ADL or IADL	1.789***	0.254	0.446	0.583*
Difficulty lift, step, walk	-0.807	-0.045	-0.567	-0.059
Social or cogn. limitation	-0.072	0.019	-0.123	-0.059
Work, houswk, or schl lim.	0.561	0.438*	0.321	0.280***
Unable work, houswk, schl.	1.367***	0.668*	0.905***	0.386**
Assistive techn. needed	2.417**	0.556*	1.486**	0.052
Medical conditions				
Diabetes	2.740*	0.240**	2.143*	0.379*
Hypertension	1.797*	0.131***	1.585*	0.390*
Asthma	0.735**	0.156	0.990*	0.312*
Back disorder	1.216*	0.181***	0.946*	0.097
Infectious	0.822*	0.015	0.661*	0.034
Endocrine	1.180*	0.209*	1.272*	0.200*
Blood	4.375*	0.396**	2.342**	0.209
Heart	-0.009	0.373**	0.357	-0.021
Bronchitis	0.892*	0.064	0.849*	-0.118
Digestive	2.469*	0.350*	1.778*	0.181**
Genitourinary	2.466*	0.452*	1.552*	0.290*
Skin	2.922*	0.124	2.476*	0.184**
Musculoskel.	1.633*	0.048	1.016*	0.096
Fracture	3.771*	0.477*	1.432*	0.078
Otitis Media	2.253*	-0.067	2.385*	-0.188
Malignant neopl.	0.164	0.608*	0.227	0.281***
MSA	0.173	-0.193**	0.145	0.121
Female	0.889*	0.131**	0.724*	0.171*
Age group				
19–24	0.143	-0.499*	-0.272	-0.833*
25–29	0.159	-0.573*	-0.069	-0.819*
30–34	0.168	-0.186	-0.116	-0.658*
35–39	0.098	-0.341**	-0.221	-0.550*
40–44	0.138	-0.303**	-0.194	-0.420**
45–49	0.108	-0.323**	0.013	-0.507*
50–54	0.292	-0.188	0.045	-0.400*
55–59	0.113	-0.081	0.032	-0.311**

Race/Ethnicity				
African American	-0.904*	-0.132***	-1.047*	-0.555*
Asian	-0.921*	-0.536*	-0.728*	-0.365**
Amer. Indian	-0.930**	-0.366	-1.136*	-0.270
White Hispanic	-0.447*	-0.092	-0.523*	-0.245*
Education				
HS dipl. or assoc. deg.	0.424*	0.119	0.387*	0.186**
College degree	0.761*	0.153	0.704*	0.420*
Graduate degree	0.615**	0.240***	0.730*	0.596*
Family income				
100–200% FPL	0.265***	-0.062	0.398*	-0.010
200–400% FPL	0.363**	-0.159**	0.663*	0.275*
Greater than 400% FPL	0.610*	-0.101	0.717*	0.240**
Marital status				
Married, not living w/ spouse	-0.233	0.100	-0.355	0.241
Wid., divor, separated	0.100	-0.212*	-0.051	0.038
Never married	-0.153	-0.106	-0.190	0.111
Constant	-1.480*	7.739*	-1.360*	6.646*

*Source:* Urban Institute analysis of pooled data from the 2001–2003 Medical Expenditure Panel Surveys (Northeast sample), reweighted to represent New York.

ADL = activity of daily living

FPL = federal poverty level

IADL = instrumental activity of daily living

MSA = metropolitan statistical area

OOP = out of pocket

\*  $p \leq .01$

\*\*  $.01 < p \leq .05$

\*\*\*  $.05 < p \leq .10$

**Table A.A.5. Coefficients for Two-Part Expenditure Models, Children**

	Any expend.	Total expend., if any	Any OOP exp.	Total OOP exp., if any
Percent of year insured	0.812 *	0.248 **	-0.164	-0.732 *
Health Status				
Very good	0.118	0.136	0.150	0.047
Good	0.435 **	0.270 *	0.226 ***	0.037
Fair	0.461	0.972 *	0.748 **	0.486 **
Poor	1.076	0.849 *	1.227 **	0.740 **
Mental fair or poor	-0.120	0.583 *	0.253	0.232
Special educ./therapy	0.903 **	0.627 *	0.071	0.209
Any activity limitation	2.452 *	0.902 *	0.645 **	1.098 *
Deceased or institution.	0.238	0.315	-0.651	-0.117
Newborn	-0.044	0.760 *	-0.749 **	-0.141
Medical conditions				
Asthma	1.056 *	0.632 *	1.014 *	0.496 *
Infectious	1.323 *	0.178 **	0.730 *	0.081
Bronchitis	1.008 **	0.452 *	0.511 **	0.483 *
Digestive	1.207 *	0.557 *	0.719 *	0.294
Skin	4.441 *	0.149	1.697 *	0.034
Musculoskel.	3.378 *	0.476 *	1.156 *	0.555 ***
Fracture	2.023 **	1.026 *	0.995 *	0.447
Genitourinary	1.043 ***	0.514 **	0.417	0.712 *
MSA	-0.779 *	0.006	-0.266	0.142
Female	0.189	-0.074	0.070	0.029
Age group				
0-1	1.036 **	-0.108	0.500 ***	-1.135 *
2-4	0.503 **	-0.489 *	0.204	-1.138 *
5-9	0.463 *	-0.412 *	0.063	-0.730 *
10-12	0.257	-0.311 *	0.012	-0.197
Race/Ethnicity				
African American	-0.772 *	-0.406 *	-1.096 *	-0.682 *
Asian	-0.411	-0.186	-0.262	0.262
Amer. Indian	-0.825	-0.269	-0.296	-0.021
White Hispanic	-0.653 *	-0.177 ***	-0.711 *	-0.382 *
Parents' education				
HS dipl. or assoc. deg.	0.295 ***	0.002	0.403 *	0.039
College degree	0.382	-0.096	0.664 *	0.308
Graduate degree	0.463	0.185	0.284	0.486 **
Parents' marital status				
Married, not living w/ sp.	0.740	0.373	0.689	0.061
Wid., divor., separ	0.197	0.091	-0.046	-0.248 **
Never married	-0.060	0.191 ***	-0.443 *	0.042

Family income				
100–200% FPL	-0.240	-0.012	0.484 *	-0.216
200–400% FPL	-0.230	0.060	0.958 *	0.038
Greater than 400% FPL	1.015 **	0.007	1.008 *	-0.075
Constant	1.055 **	6.795 *	-0.105	6.573 *

*Source:* Urban Institute analysis of pooled data from the 2001–2003 Medical Expenditure Panel Surveys (Northeast sample), reweighted to represent New York.

FPL = federal poverty level

MSA = metropolitan statistical area

OOP = out of pocket

\*  $p \leq .01$

\*\*  $.01 < p \leq .05$

\*\*\*  $.05 < p \leq .10$

## **Appendix B. Evidence on the Validity of the Spending Estimates**

In spite of the comparability of the personal characteristics of the reweighted MEPS Northeast sample and the CPS New York sample (see report, table 5), it is possible that the reweighted MEPS may not fully capture differences in health spending that arise from differences between New York and other states in the Northeast in state policies and institutional settings, rather than from differences in state populations' personal characteristics. The similarity between the MEPS estimate of \$2.68 billion in uncompensated care (see report, figure 1) and the provider-based estimate of \$2.80 billion (see report, table 4) provides some validation of the MEPS estimate, although the provider-based data are not necessarily the gold standard, since they are subject to numerous accounting and allocation assumptions. Therefore, this appendix examines other independent information that can be used to assess the validity of the spending estimates derived from the reweighted MEPS sample of the nonelderly, non-institutionalized civilian population living in the Northeast between 2001 and 2003.

Three areas that we can examine are the levels of medical care prices in New York relative to the Northeast, Medicaid program data on Medicaid spending per non-aged beneficiary, and survey data on health insurance premiums paid by New York employers for private health insurance. Comparing data on medical price levels in New York and the rest of the Northeast will indicate whether New York has substantially different price levels that would cause bias in a sample drawn from the entire Northeast. The Medicaid program data provide a way of comparing New York to Medicaid beneficiaries represented in the MEPS sample. Similarly, premiums for employer-sponsored insurance in New York can be compared to premiums in the other states in the Northeast and to payments made by private insurance plans for people with group insurance coverage in the MEPS data.

In considering these comparisons, it is useful to keep in mind that New York's population comprises about 35 percent of the population of the Northeast census region. Therefore, the MEPS data without the reweighting adjustment implicitly include a large number of New York residents. Overall, we believe that the following comparisons suggest that the MEPS estimates have acceptable validity (i.e., they appear to be within 10 to 20 percent of what the true figures might be).

## **Medical Price Indices**

The Government Accountability Office (GAO) conducted a study of variations in health care prices across metropolitan statistical areas in 2001.<sup>4</sup> The study used medical claims data submitted by federal employees around the country to compute indices of the price of a hospital stay (adjusted for severity of illness and diagnosis), the price of physicians' services, and spending per person. Unfortunately, the GAO price indices are adjusted by the Medicare hospital wage index and the Medicare physician fee Geographic Practice Cost Index, which means that these indices are purged of underlying differences in input costs. In order to reinflate the indices to restore the effects of variations in underlying costs, we obtained data from the Medicare web site on three-year (2003–2005) average hourly wages of hospital workers by metropolitan statistical area (MSA) and used these data to create a new wage index that we multiplied by the deflated GAO price indices. Although this adjustment is crude, it will provide an indication of how medical prices vary in New York relative to the Northeast as a whole. The index of spending per person will reflect differences in utilization that are not affected by input cost variations.

Table A.B.1 shows the GAO indices for New York MSAs and the Northeast MSAs weighted by their populations in the 2000 Census. (The national average for each index is 1.00.) The index of spending per person is nearly identical in the New York and in the Northeast MSAs, which suggests that utilization patterns may not be very different. The price indices suggest that hospital care is less expensive in New York, but the prices of physicians' services are higher. Since the differences are in offsetting directions, and given that we are estimating spending levels that combine hospital and physicians' services, it seems reasonable to conclude that there may be a difference of less than 10 percent between the MEPS spending estimates and the true figures. The primary implication of these comparisons is that New York does not appear to be substantially different from the Northeast as a whole.

## **Medicaid Spending per Beneficiary**

The second source of validating information is the Medicaid Management Information System, which provides detailed data by state on spending by type of service, age, and length of

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<sup>4</sup> Government Accountability Office (2005).

coverage. Limiting the data to acute care services and people covered by Medicaid for the full year, we estimate that in 2003, Medicaid annual spending per beneficiary was \$6,110 for adults and \$2,179 for children. Comparable estimates from the reweighted MEPS sample for people with full-year Medicaid coverage in 2003 are \$6,740 for adults and \$1,726 for children. Thus MEPS may overstate adult spending by about 10 percent and understate children's spending by 25 percent. Given that adults make up 84 percent of the full-year uninsured, the net effect on the MEPS estimate of total spending by the uninsured may be an upward bias of 5 to 6 percent.

### **Private Insurance Premiums for Employer Group Coverage**

The Medical Expenditure Survey–Insurance Component is a large annual survey of employers that collects and publishes information by state on insurance premiums for single and family coverage. Table A.B.2 shows data collected in 2003 on premiums paid by state in the Northeast. In general, the values for New York rank in the middle range compared to other states in the Northeast. Although these comparisons reflect differences in populations as well as differences in state regulations and institutional structures, they suggest that premiums are not uniquely different in New York and that a household sample drawn from the Northeast and reweighted to represent New York's population may be a valid source for making inferences about medical spending in New York.

Finally, to provide a further comparison, we used the reweighted MEPS sample to estimate annual private insurance payments in 2003 for people covered by private employer-sponsored insurance plans. Although data are not available by type of coverage, average private insurance spending per adult was \$2,769, which is 30 percent lower than the full premium for single coverage. The MEPS estimate should be lower than the total premiums paid because it excludes the loading factor that inflates spending up to the premium level by adding in costs associated with administration, marketing, and profit. Depending on firm size, the loading factor can vary from 10 percent to 25 percent. The loading factor may also be higher for single coverage, since there may be a higher risk premium associated with single coverage if individuals with high expected costs are more likely to enroll in coverage.

**Table A.B.1. GAO Price and Spending Indices for New York and Northeast Metropolitan Statistical Areas**

	Spending per person	Hospital price index	Physician price index
New York	0.847	0.853	0.960
Northeast	0.842	0.996	0.850

*Source:* Urban Institute calculations.

**Table A.B.2. Total Premiums (\$) per Enrolled Private-Sector Employee in 2003, by State in the Northeast and Type of Policy**

State	Single coverage	Family coverage	Employee + one
Connecticut	3,676	10,119	7,507
Maine	3,852	10,308	7,031
Massachusetts	3,496	9,867	6,690
New Hampshire	3,563	9,776	7,517
Rhode Island	3,725	9,460	6,798
Vermont	3,596	9,483	7,080
New Jersey	3,814	10,168	7,380
Pennsylvania	3,449	9,133	6,820
<b>New York</b>	<b>3,592</b>	<b>9,439</b>	<b>6,842</b>

*Source:* MEPS-IC, [http://www.meps.ahrq.gov/Data\\_Pub/IC\\_Tables.htm](http://www.meps.ahrq.gov/Data_Pub/IC_Tables.htm).

## Appendix C. The Health Care Reform Act

The Health Care Reform Act (HCRA) is central to New York State’s health care financing, especially for New Yorkers without private insurance coverage.<sup>5</sup> HCRA was initially enacted in 1996, with sunset provisions. Revisions have been enacted about every three years—in 2000, 2002, and 2005. The current law expires in mid-2007.

HCRA-1996 ended the state’s comprehensive system of mandatory hospital rate setting, known as NYPHRM (New York Prospective Hospital Reimbursement Methodology). Private payers and hospitals were freed to negotiate their own rates, although the state continued to set Medicaid rates, which also apply to workers’ compensation and no-fault auto insurance. HCRA also continued three NYPHRM “pools” to fund “public goods” that the newly competitive hospital rates would no longer support.

Spending from the pools covered three types of such public goods:

- uncompensated care (bad debt and charity care, or BDCC),
- graduate medical education (GME), and
- coverage and other initiatives.

On the revenue side, HCRA included

- a 1 percent assessment on inpatient hospital revenues,
- surcharges on hospital rates (about 8 percent for private payers and 6 percent for Medicaid), and
- a new “covered lives” assessment on health insurers and self-insurers.

The hospital assessment also existed under rate setting; in state FY 2005–06, its collections totaled \$223 million. The latter two revenue sources are larger and replaced the rate-setting surcharge previously levied on hospitals but passed through to payers; the new payer surcharges raised \$1,560 million and the covered lives assessment, \$682 million.

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<sup>5</sup> This section relies upon written sources (notably Bovbjerg, Cuellar, and Holahan 2000; Cantor et al. 1998; Division of the Budget 2005, 2006a, b; GNYHA n.d.; HANYS 2006; Holahan et al. 1997; Manatt 2006; Office of the State Comptroller 2003, 2004, 2005; and State of New York 2006), as well as interviews.

Through modifications and re-enactments of HCRA, several key changes have occurred over time.

1. *HCRA has shifted emphasis from supporting safety net services to supporting coverage expansion and Medicaid.* Initially, HCRA, like NYPHRM's rate setting, used the lion's share of pool funding to help offset hospitals' uncompensated care—nearly \$800 million of support in calendar year 1997 (including \$48 million for D&TCs, or freestanding community clinics), about 43 percent of total HCRA funding.<sup>6</sup> From 1997 to 2005, however, there was little growth in BDCC support even in nominal dollars. The pool allowances for GME shrank in nominal dollars because much support was instead channeled through Medicaid payment rates and a Medicaid managed care GME “carve-out,” so as to have local and federal, as well as state, contributions. However, very large growth occurred for supported health coverage programs and other initiatives. The list of HCRA components not related to BDCC or GME grew from about 20 in 1997 to about 70 in 2005. Among the largest such HCRA programs are the following coverage programs:

- Child Health Plus (the state's SCHIP),
- Family Health Plus (Medicaid expansion for parents and childless adults),
- the Healthy New York insurance expansion (low-income workers and employers), and
- the Elderly Pharmaceutical Insurance Coverage (EPIC) program.

Other programs include enhancements to existing Medicaid coverage and shifts of previously General Fund spending into HCRA, various programs of assistance to providers, public health programs, even a medical liability relief subsidy for physicians. Accordingly, the BDCC share of HCRA dropped from 43 percent to 16 percent, whereas the other initiatives rose from 27 percent to 74 percent.<sup>7</sup> A hospital association summary of HCRA spending in 2004 provides a good snapshot of the relative balance of revenues devoted to various HCRA-funded functions.<sup>8</sup>

2. *HCRA has become much larger.* Over 1996–2005, total HCRA pool allotments grew from

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<sup>6</sup> Percentages are calculated from data in Office of the State Comptroller (2003).

<sup>7</sup> Percentages are calculated from data in Office of the State Comptroller (2003) and Manatt (2006).

<sup>8</sup> GNYHA (n.d.)

about \$1.3 billion to \$5.1 billion.<sup>9</sup> Additional revenues to support this growth have come from parts or all of the following sources:

- small increase in surcharge rates,
- a share of higher tobacco taxes,
- a share of tobacco settlement funds,
- temporarily higher federal Medicaid match and UPL allowances, and
- conversion receipts (Blue Cross conversion to for-profit status, then merger with Wellpoint).

The higher surcharges and tobacco taxes are recurring sources of funds, and are sizeable (total surcharge collection in 2005–06, as just noted, was \$1,560 million; tobacco taxes, \$571 million). The other revenues are nonrecurring sources. Conversion receipts realized in 2005–06 were the largest HCRA revenue source, totaling \$2,743 million.<sup>10</sup> Most of the conversion funds, however, have been “banked” in the form of stock holdings, which will be liquidated for cash to spend through 2009.<sup>11</sup>

3. *HCRA has come to act less like a set of interrelated hospital pools* and more like a set of revenues with a more or less matching set of public appropriations. Under NYPHRM’s rate setting, earmarked HCRA revenues came from hospitals and were commingled within dedicated pools, then reallocated back to hospitals, largely without legislative appropriation—all earmarks of pools. Even under NYPHRM, however, some hospital-generated revenues were appropriated for other uses. Under HCRA, hospital assessment revenues have been surpassed by tobacco-related and other revenues, and nonhospital payouts are dominant. Moreover, HCRA sources and uses of funds have recently all been put “on budget,” subject to the same policymaking and budgetary processes and under the same accounting and auditing provisions as General Fund revenues and spending. Finally, HCRA policymaking is closely allied to broader Medicaid policy made at state and federal levels because so much of HCRA is used to leverage Medicaid

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<sup>9</sup> Dollar figures come from Office of the State Comptroller (2003) and Manatt (2006).

<sup>10</sup> Dollar figures come from Division of the Budget (2006a).

<sup>11</sup> The tobacco settlement securitization provided a short-lived infusion of money before this project’s observation year of 2005, but resulted in the loss of an ongoing stream of annual settlement payments. The legislature promised to put into HCRA from General Revenues an amount equal to what would have flowed in through the settlement, had it not be securitized, and has thus far done so. Settlement revenues are expected to recur in about a decade, after the end of the time period whose revenues were securitized.

dollars. These changes make HCRA less of a coherent entity to understand by itself and more part of general New York State health policy.

## Appendix D. Sources of Federal Revenue that Support Uncompensated Care

The following tables provide detail on the federal revenues presented in table 18 in the report.

Sources and derivations for the figures presented appear in detailed notes.

**Table A.D.1. Department of Veterans Affairs Medical Spending on the Uninsured in New York, 2005 (\$, millions)**

Total VA medical expenditures in NY, 2004	1,727.5
Amount for direct medical care (80%, estimated from national VA med. budget <sup>a</sup> )	1,382.0
Amount for uninsured (20.5%, percent of VA users in NY uninsured <sup>b</sup> )	283.3
Adjustment for growth in VA medical services budget, 2004 to 2005	1.071
Estimated total VA spending on medical care for the uninsured, 2005	303.4

a. Estimated from FY 2004 national VA appropriations for medical care:

	Appropriations (\$, millions)	
Acute hospital care services	4,791	
Outpatient care services	11,229	
General operating expenses for acute and outpatient care	513	
Total direct medical care	16,533	80%
Total program budget (medical)	20,560	

General operating expenses are defined as expenses for administration and oversight of VA benefits (calculated here as \$0.032 for every \$1 in total expenses—the average of 2002–2004 percent general operating expenses for all VA benefit programs).

See OMB, Annual Appropriations to the Department of Veterans Affairs, "Budget of the United States Government, Fiscal Year 2004—Appendix."

b. Estimated from pooled 2001–2004 Current Population Survey data: the percent of persons in New York with full-year VA coverage who had no other source of coverage for the year.

**Table A.D.2. Indian Health Service Appropriations for Medical Care to the Uninsured in New York, 2004 (\$, millions)**

	IHS Operating Units in NY			Total NY
	Oneida	Seneca	St. Regis	
IHS appropriations to operating units, FY 2001 <sup>a,b,c</sup>	\$2.6	\$8.9	\$6.8	\$18.4
Exclusion for wrap-around services <sup>d</sup>	\$0.4	\$2.0	\$2.0	\$4.5
IHS appropriations for direct medical services, FY 2001	\$2.2	\$6.9	\$4.8	\$13.9
Adjustment for growth in funding per user and number of users, FY 2001 to 2004 <sup>e</sup>	1.00	1.23	1.13	—
IHS spending on direct medical care to uninsured, FY 2004	\$2.2	\$8.4	\$5.4	\$16.1

a. Based on FY 2001 budget allowances to each operating unit in New York, from the IHS Level-of-Need Funding (LNF) workgroup methodology reports for allocating the Indian Health Care Improvement Fund, available at <http://www.ihs.gov/nonmedicalprograms/Inf/ihcif2002/nashville.pdf>.

b. Collections from insurance and third-party sources are not included in appropriations amounts. Insurance and third-party collections are estimated to pay for approximately 25% of IHS medical expenditures (estimate from the FY 2004 national IHS budget, and LNF workgroup estimate based on the Survey of American Indians and Alaska Natives). The remaining medical expenditures, for users in IHS service areas with only IHS coverage, are funded by IHS appropriations.

c. Includes only funds allocated to specific operating units. Area-wide and IHS-wide funds potentially available to operating units are not included. The LNF workgroup estimates that a combined \$3.3 million in area-wide and IHS-wide appropriations were available to the Oneida, Seneca, and St. Regis Mohawk operating units in FY 2001.

d. Based on LNF methods that define wrap-around services as public health, health education, and prevention services, and a share of mental health and substance abuse services. Costs for facility construction, sanitation facilities, and almost all maintenance are also excluded.

e. Based on funding inflation factors of 1.05, 1.19, and 1.21 for Oneida, Seneca, and St. Regis operating units, respectively, and number of users of 0.96, 1.03, and 0.94. See the FY 2001 and FY 2004 LNF current funding estimates by operating unit.

**Table A.D.3. Maternal and Child Health Block Grant Spending on Care for the Uninsured in New York, 2004 (\$, millions)**

	Children w/special health needs	Others <sup>a</sup>	All users
Total MCH Block Grant expenditures <sup>b</sup>	\$592.0	\$367.8	\$959.8
Total, subtracting infrastructure expenditures	\$547.6	\$340.2	\$887.8
Percent of users uninsured <sup>c</sup>	0.0%	9.3%	0.0%
Est. MCH Block Grant spending on uninsured	\$0.0	\$31.6	\$31.6

*Source:* Maternal and Child Health Bureau, HRSA, Title V Information System (TVIS), FY 2004, <https://performance.hrsa.gov/mchb/mchreports>.

a. Includes pregnant women, infants younger than 1 year, children 1 to 22 years, and all others.

b. Includes federal allocation, New York match and overmatch, and program income. Expenditures on administration are redistributed proportionately.

c. 9.3% for the “others” category is the weighted average of 0.0% (pregnant women), 9.4% (infants younger than 1 year old and children 1 to 22 years old), and 15.1% (all others).

**Table A.D.4. Revenues at Federally Qualified Health Centers in New York, 2005**

	(\$, millions)	%
Grant revenue		
Federal grants		
Migrant Health Center	3.6	1
Community Health Center	78.2	12
Health Care for the Homeless	9.8	2
Public Housing Primary Care	1.3	0
Capital Improvement Program grants	0.6	0
Ryan White Title III HIV Early Intervention	8.3	1
Other federal grants	9.8	2
Non-federal grants		
State government grants and contracts	40.6	6
State/local indigent care programs	9.6	2
Local government grants and contracts	19.1	3
Foundation/private grants and contracts	12.4	2
Total grant revenues	193.2	31
Revenue from service to patients		
Patient self-pay	20.3	3
Third-party payers		
Medicaid	320.6	51
Medicare	29.8	5
Other public	12.6	2
Other (private) third party	42.0	7
Total revenue from services to patients	425.2	67
Other revenue	11.8	2
Grand total revenue	630.2	100
Revenue possibly applied to uninsured <sup>a</sup>	205.0	—
Uninsured patients' charges	126.9	—
Share of charges (uninsured) <sup>b</sup>	—	17.2

Source: Bureau of Primary Health Care, HRSA, Uniform Data System, New York Rollup Report (2005).

a Revenue that is not received via self-payment, or public or private insurance.

b Uninsured patients' charges / all patients' charges = \$126.9m / \$737.7m = 17.2%

**Table A.D.5. Ryan White CARE Act Spending on Medical Care to the Uninsured in New York**

AIDS Drug Resistance Program (ADAP)	
Total ADAP budget, federal and state sources <sup>a</sup>	\$ 228,916,843.0
Percent of ADAP patients uninsured	90%
ADAP spending on uninsured, 2005	\$ 206,025,158.7
Title I	
Federal grants to New York City, Dutchess Co., Nassau/Suffolk Co. (excluding ADAP)	\$129,201,998
Estimated Share for Direct Medical Care <sup>b</sup>	37%
Percent of Title I Patients Uninsured <sup>c</sup>	31%
Title I Spending on Uninsured, 2004	\$ 14,819,469.1
Title II	
Federal Grants to Missouri (excluding ADAP)	\$ 42,847,921.9
Estimated Share for Direct Medical Care <sup>b</sup>	68%
Percent of Title II Patients Uninsured <sup>c</sup>	31%
Title II Spending on Uninsured, 2004	\$ 9,032,341.9
<b>Total, Ryan White Care to Uninsured, 2004/2005</b>	<b>\$ 229,876,969.8</b>

*Sources:* National ADAP Monitoring Project 2005 Annual Report, National Alliance of State and Territorial AIDS Directors, Kaiser Family Foundation, April 2005; HIV/AIDS Bureau, Planned 2004 Program Allocations by Service Type, Titles I & II; Kaiser State Health Facts Online, Ryan White CARE Act Budget, <http://www.statehealthfacts.org>.

a. The ADAP budget is spent almost entirely on medications. However, \$9 million of New York's ADAP funds were used to purchase/maintain health insurance coverage.

b. Based on the share of these funds used for direct medical care in Missouri. Excludes support services, outreach and education, early intervention, and home health. Includes a proportionate amount of administration and planning monies. Also includes spending for health insurance that covers medications.

c. Percent of duplicated clients served by Title I / II providers in 2004 who reported being uninsured (national estimate). (2004 CARE Act Data Report, Section 2, Items 32).

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