

The Cost of Uncompensated Care with and without Health Reform

Timely Analysis of Immediate Health Policy Issues

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Summary

Both the Senate and House health reform proposals will dramatically reduce the number of uninsured as well as the amount spent on uncompensated care. If health reform is not enacted, the number of uninsured will increase significantly, as will uncompensated care burdens. We estimate that the cost of uncompensated care will fall from \$62.1 billion in 2009 to \$46.6 billion in 2019 under the Senate bill, and to \$36.5 billion in 2019 with the House bill. The impact on uncompensated care of the large reductions in the uninsured is somewhat offset by

increases in health care costs. Without reform, the cost of uncompensated care will increase to between \$107 and \$141 billion in 2019, depending on growth in the economy and health care costs. We estimate that from 2014 to 2019, uncompensated care costs would be \$330 billion with the Senate bill and about \$240 billion under the House bill. In contrast, the cost of uncompensated care over the same period without reform would be between \$560 and \$700 billion. The budget implications for state and local governments are substantial.

Introduction

An issue that has received little attention in the health reform debate is the impact of reform on the amount of uncompensated care, that is, the cost of services provided to the uninsured that the uninsured do not pay for themselves. The Congressional Budget Office has estimated that the number of uninsured would fall to 23 million in 2019 under the Senate bill¹ and to 18 million in 2019 under the House bill.² (As of this writing, the Congressional Budget Office has not released estimates of President Obama's revised plan, but the results should be within the same range.) Because the number of uninsured will drop considerably with reform, the cost of uncompensated care will decline. Without reform, we estimate that the number of uninsured would increase from 49.1 million in 2009 to between 57 and 65 million in 2019.³ Because the number of uninsured will increase dramatically without reform, the amount of uncompensated

care will increase as well. In this brief, we provide estimates of the cost of uncompensated care over the next decade with and without health reform.

As coverage expands, the need for uncompensated care will be reduced and resources used to pay for it can be used for other purposes. In this brief, we describe how uncompensated care is currently financed and where savings could result. We show that spending on uncompensated care will fall with reform because the reduction in the number of uninsured more than offsets the rise in health care costs. We then show that the number of uninsured and the cost of uncompensated care would grow considerably higher without health reform. We conclude that state and local governments will bear much of the higher costs without reform, because current federal contributions to financing health care will not be likely to expand appreciably because of budget pressures.

How Is Uncompensated Care Paid for Today?

Uncompensated care is financed through various sources. Hadley et al. documented these sources and estimated the cost of uncompensated care to be \$57.4 billion in 2008 (table 1).⁴ Public funds financed as much as \$42.9 billion—about 75 percent of total uncompensated care costs.

Hadley et al. estimated that \$7.2 billion of uncompensated care (12.5 percent) was paid by Medicare's disproportionate share hospital payments and indirect medical education payments.⁵ Medicaid also had a sizeable disproportionate share hospital payment program as well as supplemental provider payment programs that contributed to support for uncompensated care. These funding streams also offset Medicaid underpayments. The authors estimated that after accounting for underpayments, Medicaid spending on uncompensated care through these

**Table 1. Sources of Funding of Uncompensated Care Spending
(in Billions of 2008 Dollars)**

Medicare	\$7.2	(12.5%)
Medicaid	\$10.9	(19.0%)
State and local	\$10.6	(18.5%)
Direct care programs	\$14.6	(24.4%)
Physicians	\$7.8	(13.6%)
Private	\$6.3	(11.0%)
Total	\$57.4	(100.0%)

Source: Hadley, Jack, John Holahan, Teresa Coughlin, and Dawn Miller. 2008. "Covering The Uninsured in 2008: Current Costs, Sources Of Payment, And Incremental Costs." *Health Affairs* Web Exclusive w399-415.

Notes: Medicare payments include a share of disproportionate share hospital payments and indirect medical education payments that are directed to care for uninsured populations. Medicaid payments include disproportionate share hospital payments and supplemental payments that, net of offsetting Medicaid underpayments, are directed to facilitate covering the uninsured. State and local include tax appropriations to hospitals and public assistance programs. Direct care programs include the share of Veterans Administration, Indian Health Service, community health centers, and other program spending that support the uninsured. Physicians include in-kind contributions of doctors. Private included primarily amounts that are reimbursed from financial surpluses on private patients.

programs accounted for \$10.9 billion or 19.0 percent of total uncompensated care costs.

Hadley et al. also estimated that another \$10.6 billion (18.5 percent) came from tax appropriations by state and local governments for hospitals and state public assistance programs.⁶ Various community providers, including the Veterans Health Administration (VHA), maternal and child health programs, and

community health centers, contributed another \$14.6 billion (24.4 percent). Physicians accounted for \$7.8 billion (13.6 percent) in in-kind contributions or lost revenue. At least another \$6.3 billion (11.0 percent) was shifted onto private insurers. The amount of cost shifting to private payers was limited because a large share of the community health centers and public hospitals that provide care to the uninsured had relatively small shares of private

payers, and thus, there were not many private payers on which these costs could be shifted.⁷ This does not imply that hospitals with considerable market clout could not increase charges to private payers, but rather that this was not a dominant source of financing for uncompensated care.

If health reform is enacted, many of these funds could be reallocated. Medicare and Medicaid payments that directly or indirectly support the uninsured could be reduced. State and local tax appropriations that support uncompensated care could be lowered. Funds that support the Veterans Administration (VA) and various other community health programs could be reallocated for other purposes. Physician's incomes would be higher. There would be less need to shift the cost of uncompensated care to private payers.

Uncompensated Care with Health Reform

Under health reform, the number of uninsured is projected to fall substantially (table 2). To estimate the impact of health reform on uncompensated care, we use the estimates of the cost per uninsured

Table 2. Estimated Changes in Spending on Uncompensated Care under Comprehensive Health Reform

	Number of uninsured (millions)	Cost per uninsured person ^a	Spending on uncompensated care (billions)
Senate			
2009	49.1 ^a	\$1,264	\$62.1
2014	34.0 ^c	\$1,588	\$54.0
2019	23.0 ^c	\$2,026	\$46.6
House			
2009	49.1 ^a	\$1,264	\$62.1
2014	23.0 ^d	\$1,588	\$36.5
2019	18.0 ^d	\$2,026	\$36.5

^a Holahan, John, Bowen Garrett, Irene Headen, and Aaron Lucas. 2009. "Health Reform: The Cost of Failure." Washington, DC: The Urban Institute.

^b Clemens-Cope, Lisa, Bowen Garrett, and Matthew Buettgens. 2010. "Health Care Spending Under Reform: Less Uncompensated Care and Lower Costs to Small Employers." Washington, DC: Urban Institute; Holahan, John, Bowen Garrett, Irene Headen, and Aaron Lucas. 2009. "Health Reform: The Cost of Failure." Washington, DC: Urban Institute.

^c The Congressional Budget Office, The Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment, Letter to Senator Harry Reid, December 19, 2009.

^d The Congressional Budget Office, H.R. 3962, Affordable Health Care For America Act, Letter to Senator Harry Reid, November 20, 2009.

Table 3. Increase in the Number of Uninsured with No Health Reform under Alternative Assumptions, 2009–2019

	2009		2014		2019	
	N (millions)	Percent of nonelderly	N (millions)	Percent of nonelderly	N (millions)	Percent of nonelderly
Worst case	49.1	18.4%	57.7	20.9%	65.7	23.2%
Intermediate case	49.1	18.4%	56.2	20.4%	62.2	21.9%
Best case	49.1	18.4%	53.1	19.3%	57.0	20.1%

Source: Holahan, John, Bowen Garrett, Irene Headen, and Aaron Lucas. 2009. "Health Reform: The Cost of Failure." Washington, DC: The Urban Institute.

Table 4. Increase in Uncompensated Care Costs with No Health Reform under Alternative Assumptions, 2009–2019

	2009 (billions)	2014 (billions)	% Change 2009–2014	2019 (billions)	% Change 2014–2019	% Change 2009–2019
Worst case	\$62.1	\$92.3	48.7%	\$141.4	53.2%	127.8%
Intermediate case	\$62.1	\$87.0	40.1%	\$123.1	41.5%	98.3%
Best case	\$62.1	\$81.0	30.4%	\$106.6	31.6%	71.7%

Source: Holahan, John, Bowen Garrett, Irene Headen, and Aaron Lucas. 2009. "Health Reform: The Cost of Failure." Washington, DC: The Urban Institute.

person from Clemans-Cope et al.⁸ and then project increases in these costs using inflation factors from the Center for Medicare and Medicaid Services (CMS) actuaries.⁹ We find that the cost of uncompensated care under reform in the Senate bill would fall from \$62.1 billion in 2009 to \$54.0 billion in 2014 and \$46.6 billion in 2019 (table 2). Under the House bill, uncompensated care costs for the uninsured would be \$36.5 billion in 2014 and remain at \$36.5 billion in 2019. The changes reflect two offsetting forces: the decline in the number of uninsured and the increase in health care costs. In inflation adjusted terms, the reductions in uncompensated care burdens are substantial.

These estimates assume no changes in the risk profile of the uninsured; in other words, the uninsured will have the same average health status in 2019 after reform as they did in 2009 before reform. In reality, the remaining uninsured could be healthier because those with health problems would be more likely to seek coverage after reform. On the other hand, many of those who remain uninsured would be older people with incomes too high to be eligible for subsidies. They could face high premiums relative to

incomes in the exchange because of age rating, with the result that the uninsured could be more expensive on average.¹⁰ In the first case, our estimates of uncompensated care spending would be overstated and in the second, understated.

Uncompensated Care without Health Reform

In earlier work, we used the Health Insurance Policy Simulation Model (HIPSM) to estimate changes in the uninsured and uncompensated care if reform were not enacted.¹¹ Without health reform, health care costs and health insurance premiums will grow faster than incomes. This trend will affect employer offers and individuals' ability to afford coverage. More people will become eligible for Medicaid, but many would also become uninsured. How many more will be uninsured depends on changes in the economy, health care costs, and insurance premiums. We made alternative assumptions about changes in key variables, creating worst, intermediate, and best cases. In the worst case, the economy does not return to full employment by 2014, incomes grow relatively slowly, and health care costs

as well as health insurance premiums grow faster than inflation. In the best case, the economy returns to full employment by 2014, income growth is faster, and health costs and premium growth increase more slowly. The intermediate case uses assumptions between the worst and best cases.

Table 3 shows that in the worst case, the number of uninsured increases from 49.1 million in 2009 to 57.7 million in 2014 and 65.7 million in 2019. In the best case, the number of uninsured increases to 53.1 million in 2014 and 57.0 million in 2019. Table 4 shows a 2009 estimate of uncompensated care at \$62.1 billion in 2009. In the worst case, the cost of uncompensated care increases to \$92.3 billion in 2014 and \$141.4 billion in 2019. In the best case, the cost of uncompensated care increases to \$81.0 billion in 2014 and \$106.6 billion in 2019.

These results mean that over the six-year period (2014–2019) if nothing is done, the cost of uncompensated care will be about \$700 billion in the worst case, \$630 billion in the intermediate case, and \$560 billion in the best case. The amount of uncompensated care if health reform is enacted will be substantially lower than in the absence

of reform. We estimate that under the Senate bill, uncompensated health care will total about \$330 billion over the 2014–2019 period (52 percent of the intermediate case without reform), and about \$240 billion under the House bill (38 percent of the intermediate case without reform).

Discussion

As we discussed above, health reform would mean that many sources of funding for uncompensated care could be reallocated for other purposes. Reform proposals already envision some reductions in Medicare and Medicaid disproportionate share hospital payments, but these are far

less than our projected reduction in uncompensated care.

It is unlikely that, absent reform, the federal contributions to states and localities that support uncompensated care will cover the same share of uncompensated care costs in the future as they do today. A large share of funding for uncompensated care comes from Medicare and Medicaid, which will be under severe budget pressures in coming years. The growth in the components of these programs funding uncompensated care is likely to be small. Similarly, proposed caps on discretionary spending in the federal budget could affect budgets for other federal programs, including the VA, Indian Health Service, maternal and

child health programs, and community health centers. This means that, at the margin, state and local governments are likely to bear a large share of the cost of uncompensated care. Without health reform, the number of uninsured and the amount of uncompensated care will grow substantially. This will translate into increased pressure on state and local government to finance the growing cost of the uninsured, although the ability of many state and local governments to generate new funding sources for this purpose is unclear. We also expect that, absent reform, hospitals and clinics will face increasing financial stress and, as a result, may not be able to provide the same amount of uncompensated care to the uninsured that they do today.

Notes

1 Congressional Budget Office, The Patient Protection and Affordable Care Act, Incorporating the Managers' Amendment, December 19, 2009, http://www.cbo.gov/ftpdocs/108xx/doc10868/12-19-Reid_Letter_Managers_Correction_Noted.pdf.

2 The Congressional Budget Office, H.R. 3962: Affordable Health Care for America Act, November 20, 2009.

3 Holahan, John, Bowen Garrett, Irene Headen, and Aaron Lucas. 2009. "Health Reform: The Cost of Failure." Washington DC: The Urban Institute. <http://www.urban.org/url.cfm?ID=411887>.

4 Hadley, Jack, John Holahan, Teresa Coughlin, and Dawn Miller. 2008. "Covering The Uninsured in 2008: Current Costs, Sources Of Payment, And Incremental Costs." *Health Affairs* web exclusive w399-415.

5 Ibid.

6 Ibid.

7 Hadley, Jack, John Holahan, Teresa Coughlin, and Dawn Miller. 2008(2). "Covering The Uninsured in 2008: A Detailed Examination of Current Costs and Sources of Payment, and Incremental Costs of Expanding Coverage." Kaiser Commission on Medicaid and the Uninsured. <http://www.kff.org/uninsured/upload/7809.pdf>.

8 Clemens-Cope, Lisa, Bowen Garrett, and Matthew Buettgens. 2010. "Health Care Spending Under Reform: Less Uncompensated Care and Lower Costs to Small Employers." Washington DC: The Urban Institute. <http://www.urban.org/url.cfm?ID=412016>.

9 Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Expenditure Projections 2008–2010, Forecast Summary and

Selected Tables, http://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp.

10 Blumberg, Linda J., Matthew Buettgens, and Bowen Garrett. 2009. "Age Rating Under Comprehensive Health Care Reform: Implication for Coverage, Costs, and Household Financial Burdens." Washington DC: The Urban Institute. <http://www.urban.org/url.cfm?ID=411970>.

11 The HIPSM model is a health microsimulation model that reflects the best evidence on employer and individual behavior, that is, the employers' decisions to offer coverage and individuals' decisions to accept employer offers, buy health insurance in the individual market, or take up public coverage, if eligible. More detailed explanation of the model is available in Holahan et al. (2009).

About the Authors and Acknowledgements

John Holahan is the director and Bowen Garrett is a senior research associate in the Urban Institute Health Policy Center. The authors are grateful to Linda Blumberg, Genevieve Kenney and Steven Zuckerman for their comments and suggestions, and to all those who helped in the development of the Health Insurance Policy Simulation Model which made this brief possible.

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