SOLVING UNCOMPENSATED HOSPITAL CARE: TARGETING THE INDIGENT AND THE UNINSURED

by Gail R. Wilensky

Prologue: Uncompensated hospital care is a growing problem facing federal and state legislators, hospitals and doctors, and, indeed, all of society. The American Hospital Association’s Annual Survey of Hospitals estimated that $6.2 billion of uncompensated care was provided by community hospitals in 1982. When uncompensated care costs are compared to either total hospital costs or total charges, this figure represents a relatively small proportion of the total—some 6 percent of community hospital payments. However, the uncompensated care burden is not equally distributed among hospitals. Some institutions, particularly publicly sponsored ones, are being forced to bear an increasingly larger share of the burden. In this paper, Gail Wilensky sets out the dimensions of the problem and possible policy options for dealing with it. Wilensky underscores, as the Reagan administration has not, that market-oriented medical care reforms cannot succeed without more explicit policy treatment of the uncompensated care issue. Wilensky is director of Project HOPE’s Center for Health Affairs and vice-president of its domestic division. A nationally recognized health services researcher and policy analyst, Wilensky holds a Ph.D. in economics from the University of Michigan. She was instrumental in the design and management of the National Medical care Expenditures Survey while she worked (1975-1983) at the National Center for Health Services Research.
Uncompensated hospital care is not a new policy issue, but it has received an increasing amount of attention. Factors responsible for this include the recent recession which brought a sharp rise in unemployment, the increased emphasis placed by policymakers on prudent-buyer concepts, the heightened awareness of medical care costs by employers in their role as major purchasers of health care, and the anticipated decline in hospital revenues resulting from Medicare’s prospective payment system. While some may argue that uncompensated hospital care naturally results from increased reliance on market principles—a hallmark of the Reagan administration—there is widespread agreement that these market-oriented reforms cannot succeed without more explicit treatment of the uncompensated care issue. However, designing appropriate public policies requires not only an understanding of why uncompensated care represents a threat to the use of market-oriented reforms, but also of why uncompensated care is generated, how much there is, and who receives it.

Much of the public policy discussion of uncompensated care assumes that it is synonymous with indigent care. This is an unwarranted assumption. Many of the people who generate uncompensated care are not poor. This implies that at least two policy strategies are necessary: one for the poor with little or no insurance coverage, and a second for those who are not poor but who either have little or no insurance coverage, or do not pay their bills.

### How Big Is The Problem?

The amount of dollars spent on uncompensated hospital care is surprisingly small. According to the American Hospital Association’s “Annual Survey of Hospitals,” community hospitals provided $6.2 billion of uncompensated care in 1982. This amount was made up of $4.5 billion of bad debt (costs for patients who were expected to pay but who for some reason did not pay) and $1.7 billion of charity care (cost for patients who were not expected to pay). While there is little question that the amount of uncompensated care provided by community hospitals increased from 1978 to 1982, the size of the increase is less clear. The problem is that the amount of increase is very sensitive to the deflator used in constructing the time series estimate. Using the consumer price index as the deflator, uncompensated care increased from 4.5 billion in 1978 to 6.2 billion in 1982. If the GNP deflator is used, the increase is larger—from 4.2 billion to 6.2 billion—and if hospital prices are used as the deflator,
the increase is smaller—from 5.2 billion to 6.2 billion.\textsuperscript{1}

While the total amount of uncompensated care is not large—6 percent of total community hospital payments and 5 percent of community hospital charges—it is not evenly distributed among hospitals, as shown in Exhibit 1. Both teaching hospitals and government hospital (teaching and nonteaching) provided a substantially greater proportion of uncompensated hospital care. Teaching hospitals, for example, accounted for 27 percent of total hospital charges but 35 percent of the uncompensated care. The disparity between hospital charges and uncompensated care is even more striking for government teaching hospitals, which account for 6 percent of the hospital charges and almost 18 percent of the uncompensated care. Just as the public hospitals and teaching hospitals bear a disproportionately larger share of the uncompensated care, the nonteaching voluntary hospitals and investor-owned hospitals bear a disproportionately small share of the uncompensated care expenses. The discrepancy is substantial for the voluntary nonteaching hospitals, which are respon-

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\caption{Percentage Distribution Of Uncompensated Care And Hospital Charges By Hospital Type, 1982}
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Who Pays For Uncompensated Care?

For the most part, hospitals have financed uncompensated care by shifting costs among private third-party payers. Public hospitals often use appropriated monies to cover the cost of this care. The ultimate payer under cost-shifting is difficult to determine and will vary from hospital to hospital according to both the amount of uncompensated care provided as well as the revenue sources. However, hospitals which attempt to cover their uncompensated care costs by increasing their revenues from their privately insured patients can expect to lose those patients as employers increasingly exercise their roles as prudent buyers and search out the lowest costs of care. Thus, the growing emphasis on price competition will render this option impractical in the future.

Who Generates Uncompensated Care?

Little is known directly about the characteristics of individuals who receive care for which the provider is not compensated. To obtain this information, one would need to sample the hospital discharge records of individuals who had generated bad debt or charity care and then interview these individuals to find out whether they had insurance, whether insurance had been available to those without insurance, the extent of their insurance coverage, and their income and work status. We do, however, have information available about the types of hospitals that experience uncompensated care, such as the urban public teaching hospitals, other teaching hospitals, and, to a lesser extent, the voluntary hospitals and proprietary hospitals. Both the Sloan study and The Urban Institute study have indicated that hospitals with high concentrations of uncompensated care have disproportionate numbers of patients who are uninsured and low income.

As suggested by the patient populations of the hospitals that provide uncompensated care, the individuals most likely to generate uncompensated care are the uninsured and, to a lesser extent, the underinsured. Unlike the data on uncompensated care, much is known about the uninsured population. A limited amount of information is available about the underinsured. Data from the National Medical Care Expenditures Survey indicated that in 1977 approximately 18 million people were uninsured for an entire year and an additional 16 million people were uninsured for a portion of the year. The 1980 National Medical Care Utilization and Expenditures Survey indicated that the number of “always uninsured” was essentially the same in 1980 as it was in 1977. While 1977 and 1980...
data are out of date in some respects, the number of uninsured in 1984 and 1985 is probably about the same as in the late 1970s since the unemployment rate is about the same now as it was then.

There are several characteristics of those who are always uninsured which are worth noting: (1) the age group most likely to be uninsured are the young adults age eighteen to twenty-four; (2) one-third of the uninsured are under age eighteen; (3) one-half of the uninsured are from families with (1977) incomes above $15,000; and (4) over half were employed all or part of the year.

Since virtually none of the aged are uninsured, another way of looking at the always uninsured is to focus on the employed uninsured and their dependents versus the uninsured who are out of the labor force. A recent paper focusing on this issue reveals that the employed uninsured and their dependents account for over 13 million of the uninsured, two-thirds are full-time workers and three-fifths are full-time wage earners; and that nine out of ten of the employed uninsured are unable to obtain insurance through their employers.

An examination shows that the popular image of the uninsured as predominately poor and unemployed or out of the labor force is not accurate. The uninsured are disproportionately poor—nearly one-third are poor or near poor; nonetheless, two-thirds of the uninsured are not poor, and one-half are in families with incomes that are at least twice the poverty level. Similarly, while the uninsured are disproportionately out of the labor force, over three-quarters of the uninsured are employed or are the dependents of employed workers. These workers tend to be lower wage earners with lower levels of education than the labor force as a whole and in almost all cases were not offered insurance by their employers. While young adults are disproportionately represented in the employed uninsured, almost half of this group are over thirty years old. Similarly, compared to the rest of the working population the employed uninsured are more likely to be employed part-time or self-employed, but in absolute terms two-thirds are full-time workers.

In addition to these full-year uninsured, we know that in 1977 there were more than five million individuals who had Medicaid only part of the year and who were otherwise uninsured. Also, there were another ten million who had private insurance part of the year and who were otherwise uninsured. Furthermore, not only are the uninsured a heterogeneous population, but the kinds of care that goes without reimbursement is also varied. As discussed in the Sloan study, not all compensated care can be described as “big ticket” items, for example, the catastrophic care associated with neonatal services, accidents, or burns. Much of the uncompensated care can be attributed to “little ticket” items such as normal delivery, circumcisions, and so forth. Given the large number of young adults among the uninsured, it is not surprising that pregnancy-
related expenses represent an important component of uncompensated care.

To summarize, neither the care nor the people generating the uncompensated hospital care are homogeneous. The care itself is a combination of inpatient catastrophic care, outpatient care, and normal uncomplicated stays. As best we can tell, the people generating uncompensated care are a mix of the poor and the nonpoor uninsured, individuals with inadequate insurance, and individuals who do not pay their deductibles and coinsurance. In view of the diversity of the population at risk for generating uncompensated care, it is unlikely that a single solution will be appropriate.

**What Can And Should Be Done About Uncompensated Hospital Care?**

There are four basic strategies we can consider in dealing with uncompensated care: targeting providers, targeting individuals, providing grants to states, and doing nothing.

**Targeting providers.** The most commonly discussed strategy for attacking uncompensated care is by targeting providers, either by reimbursing them directly through an all-payer system, or indirectly by granting additional revenues to hospitals from a fund of pooled resources. The most direct way to reimburse providers is through an all-payer rate-setting system which includes an allowance for charity and bad debt in each payment made to hospitals. Maryland and New Jersey reimburse providers of uncompensated care through this mechanism.

The all-payer rate-setting system is highly regarded by some policymakers for several reasons: it limits reimbursement to those who would otherwise generate uncompensated care rather than to all those without insurance, it is administratively feasible, all payers of health care contribute a share of the cost, and it does not appear as an additional line item in a governmental budget. Offsetting these advantages are several major disadvantages. The all-payer system pays for care at whatever hospital the individuals use as opposed to directing them to providers who may be the most efficient. More important, many believe that all-payer systems provide little incentive for competitive innovation and that they reinforce existing relationships between payers and hospitals. All-payer systems are also highly regulatory and are therefore not attractive to states with political climates which favor a less imposing government role. Nonetheless, all-payer systems address the problem directly and thus will remain an attractive option in political arenas which make government the primary allocator of resources.

Another way of targeting providers is to grant funds to providers from a common pool of revenues. New York, an all-payer state, has had such a mechanism in place for the last year. Florida, not an all-payer state, has
recently introduced legislation that would provide funds for uncompensated care from a common pool of revenue. Targeting providers through the use of revenue pools could have most of the advantages of the all-payer system with fewer of the disadvantages. Since they need not be tied to all-payer systems, they need not be as highly regulated a system as the all-payer system. In addition, revenue pools could be used to encourage competitive innovation by reimbursing cost-effective providers at a higher rate than less efficient providers. Unfortunately, most systems that target providers have compensated hospitals according to their existing patterns of utilization whether those patterns reinforce efficient delivery of care or not.

Targeting individuals. A second strategy for financing uncompensated hospital care is to target individuals—that is, to make sure that individuals without adequate insurance acquire coverage so that they can pay their bills. There are a variety of options for implementing this strategy: catastrophic illness insurance, state-sponsored insurance for high-risk individuals, insurance for the unemployed or other special populations, and insurance for the indigent.

Several states have adopted catastrophic illness programs, but only Alaska, Maine, and Rhode Island have operational programs. The basic purpose of a catastrophic illness program is to protect individuals and families from being financially ruined by very large medical expenses. Typically, the individual faces a deductible and coinsurance which is based on income, assets, or both. These programs make the state a payer of last resort and serve only a small number of persons who experience catastrophic expenditures. In 1982, for example, the number of people covered by such programs ranged from 160 in Alaska to 1,107 in Maine. To the extent that uncompensated care is associated with the very large hospital bills, catastrophic illness insurance will cover the targeted population. However, because much uncompensated care is not associated with very large bills, this is not a comprehensive solution. It thus becomes more attractive if it is part of a larger package which more accurately covers others who receive uncompensated care.

Risk-sharing pools are used in six states to provide comprehensive insurance to high-risk individuals who would otherwise would have trouble obtaining coverage. The programs are all quite similar in most respects, except that Connecticut has opened its plan to all state residents whereas other states have limited it to high-risk individuals.

As currently established, these programs have involved a tension between the goals of affordable premiums and sufficient total revenues to fund the program. If premiums are kept high in order to keep the program self-funded, then much of the target population may remain uncovered. If premiums are set low, either the state will have to subsidize the program or else there will be substantial pressure on private insurers.
to absorb part of the costs. This, in turn, would require them to cost shift to their other customers and would provide strong incentives for employers to self-insure. In fact, premiums have been set at high rates with little or no subsidy and among the programs now in operation, state risk pools have addressed only a fraction of uncompensated care.

Insurance for special groups of the population other than the indigent, such as the unemployed, may also address part of the uncompensated care issue. This was a particularly popular notion in 1982 and 1983 because of the sharp increase in unemployment and the fact that most private health insurance for the nonaged is employment related. The main difficulty with such programs is that the majority of the uninsured are either themselves employed or dependents of employed individuals. Furthermore, many of the unemployed uninsured have as high or higher incomes than the employed uninsured. While there has been some debate about the increase in the uninsured population during the recent recession, it is clear that the uncompensated care issue will continue to be a major concern, even when unemployment returns to prerecessionary levels as it now has.

A final strategy for targeting individuals is to provide insurance for the indigent by either an expansion of state medically needy programs or a more fundamental change in the Medicaid program. Several states have considered adopting or expanding their medically needy programs. It would also be possible to extend Medicaid to all uncovered poor rather than only the categorically eligible, although that would represent a major new federal program of substantial proportions. Even so, such a program would not address the lack of coverage of the many individuals who are not poor, including those who are low income but not at or below the official poverty line. There is also some concern about the expansion of a program with incentives for beneficiaries to reduce work efforts. This incentive problem relates to the “all or nothing” characteristic of Medicaid coverage—beneficiaries are either fully covered for all Medicaid services in their state or for no services. While the cost of an expanded Medicaid program would be substantial (given the sizable population at risk for coverage), precisely how expensive it would be depends on how successful states are in containing Medicaid costs. There are a variety of cost-containment measures now being tried including case managers, capitation reimbursement, prudent buyers, and lock-in provisions which may allow states to extend coverage at lower levels of costs than was previously possible.

Another way to provide insurance for the indigent would be to give them vouchers for purchasing health insurance. For the lowest income individuals, the voucher value might be set at a level at which a low-cost provider would agree to provide a given set of services. The value of the voucher would be adjusted according to actuarial expectations of the individual. Most voucher systems also allow beneficiaries to supplement
the voucher if they desire higher priced providers. A major attraction of vouchers is that they provide consumers with strong incentives to be cost conscious both in their use of health services and in their choice of providers. It also represents an attractive way to subsidize a low-income individual who needs some assistance without the all or nothing feature of Medicaid. But there are also some major concerns about the use of vouchers, in particular, the problems of adverse and preferred risk selection. Whether vouchers based on actuarial experience can avoid the most serious consequences of preferred risk selection is unclear. There is concern also about the high selling costs and the extensive information which consumers must have about competing insurance plans to make rational choices. Structured vouchers, that is, a limited choice among a prespecified set of plans, have been suggested as a means of eliminating many of these problems, however, structured vouchers also eliminate some consumer choice.

Grants to local governments. Rather than specifying a national program either to target providers or individuals as a way of covering some or all uncompensated care, another possibility is to let each respective state or local government decide the type of program it wants. Assuming that whatever federal responsibility exists is primarily related to the indigent population, a matching or block grant could be provided states with the amount of the grant based primarily on the number of individuals in that state who are below the poverty line. An adjustment might also be made for unusually high levels of unemployment as well. The state, or preferably the local government after receiving a pass-through grant from the state, could then decide whether to reimburse hospitals directly through all-payer rate setting or by lump sums from a pool of revenues, or whether to attempt to provide the uninsured with insurance through a variety of means such as catastrophic illness programs, expanded medically needy programs, or a voucher system. The primary reason to direct grants through the state rather than to local governments is that the levels of responsibility of local governments for the provision of services for the needy varies across the United States. However, as long as states give local jurisdictions the choice as to how the funds are to be distributed, the primary advantages of local decision making would remain.

The major disadvantage of the intergovernmental grant approach is that there would be higher direct costs and higher administrative costs than in a program limited to providers and which therefore only reflected current users. However, the grants approach has several major advantages: it can be used to channel funds to those individuals who are in need, it does not establish a new entitlement program for individuals, it reflects both the needs and desires of local community, and it gives local communities the autonomy to determine their own levels of competition and innovation.
Doing nothing. A final short-run option is to do nothing. This, however, is not a solution in the long run. The competitive pressures resulting from Medicare, Medicaid, and employers adopting prudent-buyer techniques, will focus increased attention on individuals who are without insurance coverage and who generate uncompensated care. Since we as a nation will not allow these individuals to go without the most necessary medical care, some method will be adopted to compensate hospitals providing care for these individuals.

Raising Revenue

Most of the programs discussed will require some increased level of public expenditures on health care. This raises the question of the type of taxes which would be used to support additional expenditures. The most likely options available include general fund financing, a tax on insurance premiums, an excise tax on hospital bills of insured patients, a tax cap on employment-related health insurance, and an excise tax on alcohol and tobacco.

There are a variety of general fund financing mechanisms which could be used to finance a program of uncompensated care, including a consumption tax, a surcharge on the income tax, or a general fund contribution. While some prefer consumption taxes because they provide incentives for savings and others prefer income taxes because they tend to be more progressive, the major problem of general fund financing is our current annual federal deficit of $200 billion. Proposing the use of general funds or specific broad-based taxes for any portion of the program seems unrealistic.

An excise tax on health insurance premiums represents a natural extension of our current mechanism for financing uncompensated care: cost shifting. Cost shifting affects the hospital bills of private patients which in turn raises the premiums for private hospitalization insurance, thus a tax on health insurance premiums would be a formalization of cost shifting. A premium tax would even be mildly progressive since we know that employer contribution shows a positive correlation with family income, and the total premiums rise with income. Furthermore, a tax on insurance premiums could be regarded as recovering some of the subsidy currently provided by the tax exclusion for employment-related insurance. The main problem with the premium tax is that employers who self-insure would be exempt and therefore would not contribute taxes to the fund. This would not only be inequitable, but also would provide a powerful incentive for employers to self-insure and ultimately make the tax unproductive as a revenue raiser. The difficulty with taxing the self-insured is not a technical one—that is, the self-insured could be taxed according to the amounts paid out as an average charge for administration. The
problem is one of a legal nature: the Employee Retirement Income Security Act (ERISA) exempts the self-insured from state regulation such as taxation. A tax on the hospital bills of privately insured patients is an appealing alternative to the premium tax if the legal issues regarding ERISA and the self-insured cannot be resolved. This tax is like a price increase for hospital services which would be spread among all households with private insurance in the form of higher hospitalization insurance premiums. This type of tax, however, has a major psychological problem in that it would be perceived as a tax on the sick even though it would in fact ultimately be paid by those with private hospitalization insurance.

Another financing mechanism frequently discussed for health care is the taxation of employer contribution to employee benefit plans when these contributions exceed a predetermined amount. Economists have been almost uniform in advocating “tax capping” because such a cap not only raises revenue but should also reduce the quantity and cost of health services consumed. Previous attempts by the Reagan administration to introduce tax capping, however, has shown it to be exceedingly unpopular among insurers, employers, and union groups. There is increased interest in capping the amount of employer contribution to all fringe benefits, but revenue from such activity would probably be used to reduce the overall deficit.

Excise taxes on alcohol and tobacco are frequently cited as potential revenue raisers for health care. These taxes are not only good revenue raisers and easy to administer, but they are also regarded as being particularly appropriate to finance health expenditures since the consumers of these products also assume greater than average quantities of medical services. While opponents of these taxes argue that not all consumers of the products are heavy health care users, the primary difficulty of these taxes is that their revenues are already being discussed for purposes of a general deficit reduction as well as the Medicare Trust Fund deficit reduction.

In summary, a general tax such as a consumption tax or an income tax is an attractive revenue source, but in an era of high federal deficit they are politically unrealistic. Excise taxes on alcohol and tobacco are less desirable than general fund taxes and are also being discussed as deficit reduction measures. Should this not be the case, they would be regarded as an attractive mechanism for providing some of the needed revenue. The tax cap, also if not earmarked for other purposes, is a desirable revenue source for funding a risk pool and perhaps a portion of indigent care. An excise tax on premiums is an acceptable approach for financing some or all uncompensated care. A tax on hospital revenue financed by private payers is a less preferred variation on the excise tax on insurance premiums. However, any of the above explicit taxes are preferable to the
current method of financing uncompensated care through cost shifting, which will become untenable in the long run.

### Proposed Policy Directions

While there is not detailed information on who generates uncompensated care, there is suggestive evidence that they are individuals with no insurance or limited insurance. More data are available on the uninsured and these make it clear that many of the individuals without health insurance are not poor. This suggests that direct financing of uncompensated care is more than a problem of financing care for the indigent. Financing care for the indigent, however, is an important component of uncompensated care.

Recognition that uncompensated care reflects a heterogeneous population suggests a two-pronged approach: a program for the indigent and a program for the nonindigent uninsured. Although indigent care can be financed through a variety of policy options, the most promising is the use of grants to state governments with funds passing through to local governments. This would allow communities the ability to assess their own particular circumstances and to decide whether vouchers, direct reimbursement to providers, an expansion of Medicaid or medically needy programs, or some other program would be best for them.

Those individuals who are not poor but are uninsured need to have insurance made available to them at reasonable rates. Risk pools seem to be an attractive way to do this. However, the risk pool should be subsidized by the state or federal government on the grounds that these individuals, unlike the vast majority of nonaged individuals who have employment-related insurance, are not currently receiving any subsidy from the tax exclusion accorded employment-related insurance. Additionally, unless limited subsidization is provided, it is likely that such insurance would be prohibitively expensive. There is a danger, however, that if the subsidy were substantial, employers might encourage their employees to get insurance from the risk pool. Given the substantial advantages associated with the current tax exclusion, this is unlikely to be an issue unless the level for the tax cap was set very low and the subsidy was set very high. These two programs might be financed by a combination of tax capping to support the risk pools and excise taxes on insurance premiums, hospital revenues, or tobacco and alcohol to support additional financing of indigent care.

The two-pronged approach suggested here is not without potential problems. Grants to state governments might not always result in the proper distribution to local government levels, and grants to local governments may be difficult to implement given differing local government structure. Given flexibility, some state and local governments will adopt
more equitable or efficient programs than others, thus leaving some of the indigent better off than others. Furthermore, not all eligibles may take advantage of a risk pool. Some individuals, particularly the young adults, may be willing to engage in “free-rider” behavior, especially if they know that grants are being made to finance uncompensated care.

Finally, some of the care currently being provided is uncompensated care which might not be covered by this type of insurance. Nonetheless, the two-pronged program suggested here is a way of addressing what is currently a major policy issue and it does so in ways that may be politically acceptable because it does not require major restructuring of the entire health care delivery system.

NOTES

7. Farley, “Who Are the Uninsured?”
8. New York’s all-payer system does not include an allowance for charity and bad debt in each payment to hospitals.
10. Sloan et al., “Identifying the Issues.”