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POLICY BRIEF

North Dakota State and Tribal Health Policy Forums

North Dakota's Uninsured and Uncompensated Care: Costs and Coverage Options

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North Dakota State and Tribal Health Policy Forums

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North Dakota's Uninsured and Uncompensated Care: Costs and Coverage Options

Imagine if the entire population of Bismarck did not have health insurance. What medical services would they get? How would they get them? Who would pay? The reality is that approximately 52,000 (the population of Bismarck) or 8.2% of state residents are uninsured. To begin addressing questions about the uninsured, the North Dakota Household Survey (NDHS) was conducted by the Center for Rural Health, School of Medicine and Health Sciences at the University of North Dakota in conjunction with the North Dakota Department of Health under a Health Resources and Services Administration, State Planning Grant. Although North Dakota's rates of uninsured are lower than the national average (15.6% in 2003[1]), the NDHS study revealed that several subgroups are experiencing high rates of uninsurance, including North Dakota's children, young employed workers, and Native Americans. The costs associated with these subgroups and all uninsured in terms of uncompensated care, inappropriate use of emergency medical services, and poor health outcomes are cause for concern.

Financial Picture of the Uninsured

Nationally, as well as in North Dakota, the uninsured are predominantly low income workers making less than twice the Federal Poverty Level (200% FPL). Two-hundred percent of poverty for an individual was $18,620 in 2004.[2] The NDHS found that 70% of the uninsured in North Dakota (aged 18 to 64) are living below 200% FPL as compared to 25% of the insured.

Federal poverty guidelines are national financial estimates by the federal government which determine the minimum level of income needed to meet basic survival needs (food, transportation, housing, child care, etc.). In North Dakota, 35% of all state residents lived below 200% FPL in 2001-2002, similar to the national average.[3] A study by the North Dakota State University extension service calculates that an employed single mother with two children needs to earn $2,805 per month after taxes to meet the monthly cost of living.[4]

Table 1. The Estimated Monthly Cost of Living for a Family of Three in North Dakota**

Item	Monthly Cost
Housing (rent, insurance, utilities)*	$705
Phone*	$35
Food	$290
Child care*	$661
Household (personal care, clothing)	$331
Transportation (car payments, gas, repairs, insurance, etc.)	$578
Health care	$205
Total per month	**$2,805**
Total per year	**$33,660**

* Based on local information
** Does not include Medicare taxes or Old Age, Survivors and Disability Insurance (OASDI)

Source: NDSU Extension Service 2002

The Uninsured are Working

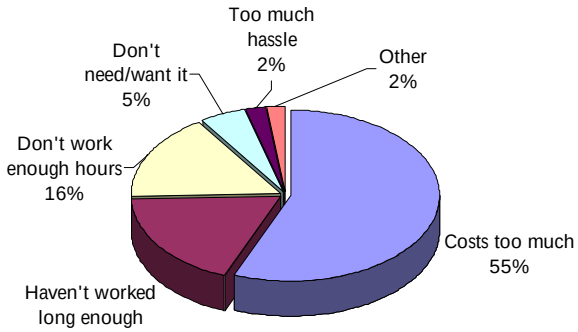
Contrary to the notion that most uninsured are unemployed, the NDHS found that 72% of uninsured adults were employed compared to 82% of insured adults. Fifteen percent of the uninsured employed were working two or more jobs. Further, more than 60% of the uninsured in North Dakota are full-time employees or self-employed full-time. Those self-employed were nearly twice as likely to be uninsured than those employed by someone else.[5]

Employers and Health Insurance

Employer coverage is the main way most Americans get their health insurance. This holds true in North Dakota where approximately 70% of individuals with health insurance are covered through their employers.[5] However, according to the U.S. Census Bureau, the number of people covered by employment-based health insurance fell nationally between 2002 and 2003, from 61.3 percent (175.3 million) to 60.4% (174.0 million). In addition, health insurance premium rates for businesses nationally have increased at a rate of over 11% annually.[6]

Insurance costs have risen enough that some North Dakota businesses anticipate passing on these additional increases in the form of cost shifting to employees.[7] With some costs being passed to employees, health insurance premiums may grow beyond their ability to afford it. The NDHS found that over half of employees eligible for health insurance coverage through their employer who remained uninsured cited cost as the primary reason for not enrolling.

Figure 1. Reasons Why Uninsured Employees Don't Participate in Employer Offered Health Insurance Plans*



n = 4,767

* Does not equal 100% due to rounding

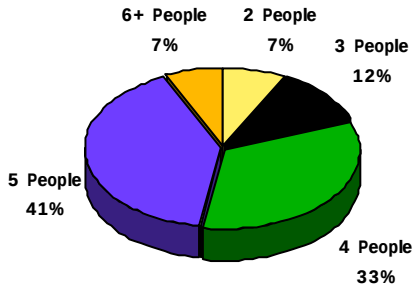
Finally, the size of employer appears to play a role in offering health insurance to employees. In North Dakota, larger firms of 500 or more employees tend to have the highest rate of health insurance coverage. Alternatively, 74% of the working uninsured are employed by firms with less than 10 people.[5]

Uninsured Children and Families in North Dakota

In North Dakota, 11,000 children ages 0-17 are without health insurance, and 70% of them are living at less than 200% FPL. Many of the children in these low income families qualify for state funded programs designed to cover them, but they are not enrolled. It's believed that parents don't apply for a number of reasons, including they: mistakenly believe their children are ineligible, find the enrollment process too burdensome or confusing, feel too embarrassed, or are unaware of the program.[5] The NDHS survey found that of uninsured children, 90% of the parents had not received information about Healthy Steps/Medicaid.

When it comes to families of uninsured children, almost two-thirds of uninsured children live in families with married parents, and 81% of them live in a household of four or more people.[5]

Figure 2. Household Size of Uninsured Children



Geographically, children living in urban areas are nearly twice as likely to be uninsured (34.8%) than those living in small rural areas (18.8%).[5]

Young Adults and Native Americans Lead North Dakota in Rates of Uninsured.

Eighteen to 24 year olds constitute less than 10% of the population in North Dakota, yet represent 16% of the uninsured statewide. National rates of uninsured in this age category are approximately 27%. Some term these youth as the 'young invincibles' who believe insurance is unnecessary.

Far and away, of all race and age groups, Native Americans have the highest percentage of uninsurance in North Dakota at 32%.[5] In fact, 50% of Native American adults between the ages of 35 and 44 are uninsured and their children are four and one-half times more likely to be uninsured than non-Native American children.

Many people mistakenly believe that all Native Americans have ready access to free comprehensive medical care through the Indian Health Service (IHS), an agency within the U.S. Department of Health and Human Services. IHS is responsible for providing federal health services to American Indians and Alaska Natives on reservations. But the inability of IHS to adequately provide direct health care is well-documented as is reflected in a body of research.[9] Therefore, healthcare coverage through IHS is not considered a form of insurance in national data collection efforts by the U.S. Census Bureau[9] and so in keeping with federal guidelines was not considered a form of insurance in the NDHS.

UNCOMPENSATED HEALTH CARE: WHAT ARE THE FINANCIAL IMPACTS?

What Does Uncompensated Care Mean?

The Medicare Advisory Payment Commission defines uncompensated care as "care provided by hospitals or other providers that is not paid for directly by patients or insurers." Uncompensated care encompasses a combination of charity care and bad debts.[11] Charity care is any medical services provided without expectation of payment. Bad debts are those entire or partially unpaid bills for medical services rendered. The difference between bad debt and charity care is that charity care is given with no expectation of payment.

Uncompensated care does not include the contractual allowances of government and private insurers, lack of Medicaid payment for days beyond a length of stay limit, or courtesy discounts for employees, students, members of religious orders, etc.

How is Uncompensated Care Measured?

Hospitals can measure their uncompensated care in a number of ways, including charges (revenue) foregone. But many prefer using uncompensated care costs as a percentage of total expenses. This is a measure of cost which includes the value of efforts to collect unpaid services and other associated expenses. According to the American Hospital Association, in 2000, uncompensated care costs equaled $21.6 billion and 6% of total expenses. North Dakota's percentage of total expenses weighed in at 2.4%, which is below the national average. However this figure is in line with other Midwestern states.

How Do the Uninsured Get Care?

For uninsured requiring certain health services, there is a "safety net." The safety net is comprised of doctors, dentists, nurses, and others who work in non-profit community hospitals, community health centers, public health clinics, and private practices, in both rural and urban areas.[12] These healthcare professionals provide care to people, whether or not they have health insurance or money to pay the deductibles and co-insurance.

Inappropriate Use of Health Services

The uninsured are more likely to access care in inappropriate ways than are the insured.[12] One way this occurs is through use of emergency rooms (ER) as primary care treatment rather than through a primary care physician. In a recent study representing 58,660 visits from seven emergency rooms across the state of North Dakota, nearly 9,500 were categorized non-emergencies (16%). And another 16% were considered emergent but could have been treated earlier via primary care rather than the emergency room.[13] This study revealed that 30 percent (16,718) of all emergency room visits were self-pay, meaning that those who visited the ER paid completely out of their own pocket for a visit.[13]

With the average cost of an emergency room visit in 2003 at $383,[14] these expenses

can add up quickly.

Personal Cost of Illnesses

Research on the uninsured suggests that delays in seeking medical treatment lead to increased costs.[15] Further, research on health outcomes of uninsured indicates: uninsured infants have poorer survival rates than privately insured infants, annual earnings are reduced due to poorer health, and increased vulnerability to serious illnesses.[15,16]

North Dakota Hospitals and Uncompensated Care

The estimated annual dollar amount of uncompensated care in North Dakota during 2000 was $32.5 million. This figure is based on information from the American Hospital Association. In a review done more recently, by the North Dakota Health Care Association Finance Council, North Dakota healthcare facilities provided total bad debts of about $40 million and approximately $12 million in charity care during 2003-2004.

What Revenue Sources Do Hospitals Use to Cover Their Uncompensated Care Costs?

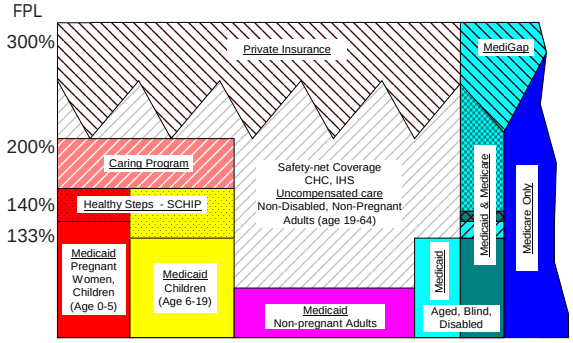
Community hospitals funding sources include payments from Medicaid, Medicare, insurance companies, and patients, as well as direct subsidies from tax monies. Wherever shortfalls occur, healthcare providers use a variety of mechanisms to cover them, these mechanisms include:

1. Shifting charges to private insurers (cost shifting)
2. Using government subsidies
3. Taking advantage of other government payment programs
4. Generating revenue from non-patient sources (fundraising)

WHAT PROGRAMS ARE CURRENTLY OFFERED TO UNINSURED AND LOW INCOME RESIDENTS IN ND?

Privately purchased health insurance, and coverage from employers make up the foundation of insurance coverage throughout the state. To provide care for those lower income families and individuals, public programs are available including Medicaid, Medicare, and Healthy Steps (the State Children's Health Insurance Program - SCHIP). Qualifications for these state-based coverage programs are formulated on a family's annual income earned as a percentage of FPL. The figure below displays the complexity of the health insurance system in North Dakota with the federal poverty levels and age categories graphically depicted.

Figure 3. Patchwork of Healthcare Coverage



Source: John Baird, State Medical Officer 2004

Medicaid is a state-federal partnership with eligibility levels set by the state which covers low-income North Dakota residents. Medicaid also pays healthcare costs for the blind, disabled or elderly over age 65 who earn 100% FPL or less. Medically needy non-pregnant adults up to 50% FPL are eligible for the program (up to 133% for pregnant women and children aged 0-5). **Medicare** is a federal program for the elderly over age 65 and some disabled. MediGap may be privately purchased to pay for some expenses not covered by Medicare. **The Healthy Steps** program is for children 18 years or younger and is extended to Medicaid eligible families earning less than 140% FPL net income. **The Caring Program** while not considered an insurance program, provides funds for some basic health and dental care benefits for uninsured children 141-200% FPL.

In addition to these programs, there are efforts by safety net providers to find and enroll children and eligible adults in avail-

able programs. Part of these efforts, among others, are community health centers, resource coordinators for the Healthy Community Access Program (HCAP), and the Prescription Connection which provides drug assistance for low or fixed income individuals through the North Dakota insurance department.

North Dakota's safety net coverage may be impacted by recent federal and state budgetary changes. For every one dollar the state contributes to Medicaid, the federal government was contributing a Federal Medical Assistance Percentage (FMAP) payment of 71.31 cents. But the future of these payments for North Dakota is challenging. According to David Zentner, Director of Medical Services for the Department of Human Services, FMAP will likely be reduced in the future to 65.16 cents.[17] The North Dakota Department of Human Services estimates that the reduction in payments will require the state to contribute about $34 million more in state dollars for the next biennium to maintain the current state programs.

NEW STRATEGIES, NEW CHALLENGES: WHAT ARE OPTIONS FOR COVERAGE?

Some note that small reforms create a complex maze of programs each with individual eligibility requirements. Nevertheless, it is likely that future health care reforms across the states will be incremental, as opposed to comprehensive and carefully targeted, and many believe that moving forward, the targeting of subsidies through new programs will continue to be related to income.[18]

Vehicles used by states to help expand coverage to families can include: the SCHIP program, the Medicaid program and state only programs (i.e., those funded without federal dollars[19]). Currently, states are considering an array of options. A brief summary of three approaches are highlighted here: 1) authorizing tax-free medical savings accounts in conjunction with high deductible or consumer directed plans, 2) intensifying efforts to identify and enroll eligible but not enrolled individuals, 3) establishing premium assistance or private health insurance buy-in programs (three-share). A comprehensive review of approaches to expanding coverage is covered in the report "State Options for Expanding Health Care Access."[19]

Health Savings Accounts

Health savings accounts (HSAs) are accounts for covered individuals and their families that help finance part of the cost of the deductibles, co-payments and other medical expenses not covered by their health insurance plans. An HSA must be used in conjunction with a high deductible health insurance plan. Funds are deposited into the accounts by an employer for employees and/or by the employees themselves. Unspent HSA funds are allowed to accumulate tax free from year to year. Most states that collect income taxes have enacted legislation to allow for the same type of tax deductibility for HSA plans that is allowed under federal law. One positive aspect to HSAs is that they make premiums more affordable while increasing patient consumer awareness of the actual cost of care. Further, state funds are not required to implement the HSA option. On the other hand, HSAs may benefit younger, healthier workers more than older, sicker workers because HSAs must be part of a high deductible health insurance plan. Older, more ill individuals may be less likely to purchase high deductible plans because of their needs. As well, tax deductibility of HSAs primarily benefit higher income employees who are less likely to be uninsured than those with low incomes.

Intensify Efforts to Identify and Enroll Medicaid and Healthy Steps Eligible Individuals

States are faced with the challenge of how to enroll "hard-to-reach" children. To address this, some states are intensifying outreach efforts and using simplified enroll-

ment procedures to increase the number of children with coverage, including underserved groups. States that want to expand coverage to children have a financial incentive as well, as the federal government pays an enhanced matching for state SCHIP funds. However, conducting outreach programs can be an expensive process, simplifying enrollment forms and procedures may result in more fraud and the possibility exists of crowding-out private coverage plans.

Three-Share Efforts

Three-share efforts are a collaborative between employers, employees, and local healthcare providers that contribute dollars and services to cover the total cost of health care for low-income community residents. The advantage of these programs is that they are budget neutral for the state and can be creatively flexible since they need not comply with federal rules and regulations. On the other hand, success for these types of programs requires substantial political and financial support. As well, they are limited in scope and therefore do not cover large numbers of uninsured nor are health care needs covered outside the geographic area or network of providers of the three-share.

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