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# Healthcare of the Uninsured Population in West Virginia and the United States

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# HEALTHCARE OF THE UNINSURED POPULATION IN WEST VIRGINIA AND THE UNITED STATES

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# HEALTHCARE OF THE UNINSURED POPULATION IN WEST VIRGINIA AND THE UNITED STATES

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## ABSTRACT

**Introduction:** *The uninsured population in the United States has increased dramatically over the past few years. Hospitals and physicians bear the financial burden of the uninsured by compensating for the billions of dollars in bad debt or uncompensated care they incur each year. Emergency rooms and other healthcare facilities are left with billions in uncompensated care due to 47 million uninsured Americans. Uncompensated care in 2006 was \$31.2 billion. Majority of individuals accounting for uncompensated care are those living at or below the federal poverty level and those individuals who can afford health coverage but freely choose to forgo purchasing health insurance. Under the Affordable Care Act of 2010 the number of uninsured Americans will be decrease by 32 million, helping reduce the annual cost of uncompensated care. The purpose of this research was to analyze the effects of the uninsured population on the insured population in terms of quality of, cost, and access to health care.*

**Methodology:** *The methodology for this study was a literature review. Four electronic data bases were used with a total of 31 articles referenced for this research.*

**Results:** *Uncompensated care was shown to increase health insurance premiums of the insured population by \$1,000 annually. Cost-shifting represents around 1.7% of private health insurance costs. An estimated \$14 billion could be funded through cost shifting. Under the Affordable Care Act, the uninsured population is estimated to decrease substantially, thus reducing annual uncompensated care costs.*

**Discussion/Conclusion:** *Effects of the uninsured population on the insured exhibited mixed results. When discussing effects on the insured due to the billions in uncompensated care, health insurance premiums were shown to increase and rises in cost shifting were noted. Reducing the population of uninsured Americans has a direct correlation with reducing uncompensated care costs.*

**Key Words:** *Uninsured population, uncompensated care (UC), access to healthcare, reimbursement*

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## INTRODUCTION

Uninsured patients often leave healthcare facilities with billions in uncompensated care. In 2006, hospitals countrywide delivered more than \$31 billion in uncompensated care, an increase from the previous year's \$28.8 billion (Guggenheim & Verrilli, 2009). When an uninsured individual cannot afford their medical bills the burden falls upon the insured, hospitals, physicians and the federal government. These billions of dollars in unpaid and underpaid healthcare increase health insurance premiums (PBS, 2000). It has been argued uncompensated care is made up by cost shifting. Health care providers have offset the burden of uncompensated care by charging higher prices to privately insured Americans (Hadley, Holahan, Coughlin, & Miller, 2008). A major problem is high populations of uninsured individuals go to emergency rooms for care, where their needs cannot be turned down and they are often charged more for healthcare services (ACEP, 2012). In 2006 the uninsured population gradually increased to above 47 million partially due to decreasing employer sponsored health insurance coverage (U.S. Census Bureau, 2006).

Uninsured population in the United States (U.S) is an expensive barrier. Total uncompensated care includes \$20 billion in care dispersed by community hospitals, \$7 billion in care distributed by community clinics, and an additional \$5 billion in care provided by general practitioners (Galambos, 2005). In addition, the uninsured are more

likely to use emergency care as their primary source of healthcare than those individuals with insurance (Tunzi, 2004).

Definitions of Uncompensated Care (UC) vary greatly from hospital to hospital, and state to state (Coustasse, Lorden, Namarugommula, & Singh, 2009). UC has been defined as the cost of care that is not paid directly by patients or insurers to hospitals and providers (Ashby 2002). The Centers for Medicare and Medicaid Services (CMS) reported in 2005, UC included the cost of care, expressed in undiscounted hospital charges, provided to eligible recipients of state healthcare benefits less any reimbursement for those services by the state, Medicaid, or another payer. However, CMS have also described that UC does not include bad debt or payer discounts (CMS, 2005). The American Hospital Association has defined UC as being an overall measure of hospital care provided for which no payment was received from the patient or insurer, it is the sum of a hospital's "bad debt" and the charity care it provides (AHA, 2010).

Two distinct groups of people account for the majority of UC costs, those living at or below the poverty line and middle to high income individuals who may be able to afford health coverage (Axeen & Carpenter, 2008). In addition, this includes individuals with incomes above the Federal Poverty Level (FPL) which is valued at \$41,000. Understanding the definition of affordability can vary, majority in this category could afford some form of private health insurance. Nonetheless, individuals who could afford health insurance, but choose not to, are known as free riders. When a free rider gets ill, their healthcare bills are absorbed by providers, the government and other patients (Sutherland Institute, 2013). Additionally, 25% of individuals who are eligible for public coverage at little cost do not enroll. In more than 50% of states individuals living at the FPL are not eligible for coverage. While these individuals are not classified as free riders, they still contribute to the hidden tax, which has resulted in higher insurance premiums for the insured population (Axeen & Carpenter, 2008).

It has been projected that uncompensated care in 2008 was \$57.4 billion. The greatest amount of care provided by hospitals totaled at \$35 billion trailed by community providers at \$14.6 billion, and lastly 8 billion was provided by private general practitioners (Hadley et al, 2008). More than one-third of emergency room physicians lose an average of \$138,300 annually due to bad-debt or UC (ACEP, 2012).

Under the Affordable Care Act (ACA) of 2010, when fully implemented in 2020 it will reduce the number of uninsured Americans by over 30 million (U.S. Department of Health and Human Services, 2012). The Affordable Care Act sets up private health insurance exchanges, where uninsured individuals can purchase coverage (McDonough, 2014). Health exchanges have been estimated to cover 24 million Americans. Under this provision up to 2.4 million new adults, 2 million whom are uninsured could gain coverage through their parents' insurance plans (DeParle, 2010). The ACA is the only federal law to ever be approved in the U.S that tries to gain comprehensive health restructuring, meaning enhancement on all three dimensions of access, cost and quality (McDonough, 2014).

The federal government established the Medicaid Disproportionate-Share Hospital (DSH) program in the 1980s to provide financial aid to hospitals who serve a large population of the poor as well as Medicaid patients. DSH payments are intended to assistance in covering the UC costs of hospitals (Dobson, Koenig, El-Gamil, Pick, & Sankaran, 2012). In 2004, Upper Payment Limit (UPL) programs were established by the federal government. These UPL payments have been permitted to exceed the actual cost of medical services delivered to Medicaid beneficiaries, as long as the state does not surpass Medicare UPL (Graves, 2012). An important difference in the two programs is most DSH funds accrue to the providers, whereas, UPL funds go to states, specifically in nursing home UPL programs (Bruen, Coughlin, & King, 2004).

The purpose of this research was to analyze the effects of the uninsured population on the insured population in terms of quality of, cost, and access to health care.

## METHODOLOGY

The primary hypothesis for this study was: decreasing the uninsured population by providing premium subsidies to make private insurance more affordable would decrease health insurance premiums on the insured.

The methodology for this study was a literature review. The Marshall University library on the Huntington campus in Huntington, West Virginia was used for full text articles, utilizing the PubMed, EbscoHost, ProQuest, and MEDLINE databases. Google was used when articles could not be located through the above data bases. Key terms used in the search included 'uninsured population' OR 'uncompensated healthcare', AND 'cost', OR 'quality', OR 'access to healthcare' AND 'financial implications' OR 'reimbursement'. The search was limited to articles published in 2004 through 2014 to order to keep the research current and up to date. Articles were limited to the English language.

Primary and secondary data were included from original articles, research studies and reviews. Relevant articles were selected after review of abstracts was performed. Thirty-one references from 37 total articles were chosen for this research. Abstracts of the sources were reviewed first to determine the relevancy of the data to the study. If academic articles and studies were found to be relevant from the abstract reviews, the data were analyzed and categories were generated based on the findings. This search was completed by LS and MM and validated by AC who acted as a second reader and also double checked if references met the research study inclusion criteria.

The conceptual framework for this research was created by the authors and is illustrated in Figure 1. The researchers argue that UC can increase premiums for insured Americans thus increasing the healthcare expenditures over time. Decreasing the population of uninsured Americans will decrease the amount of money spent on UC thus avoiding the increase in insurance premiums for insured Americans. Without decreasing the population of uninsured Americans, UC will continue to grow affecting the premiums of the large number of insured Americans and leaving billions of dollars unaccounted for (Figure 1).

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Insert Figure 1

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## RESULTS

The study results are displayed in Table 1. A literature review generated the following effects of UC. These results focused on decreasing the uninsured population and analyzing the outcomes of doing so. In addition to the negative effects of UC, the results generated positive information about UC in terms of "negative UC." Findings in the research showed accessibility to health insurance in terms of affordability also added to UC increasing. The results showed UC does affect the insurance premiums of privately insured Americans, by as much as \$1,000 yearly (Table 1).

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Insert Table 1

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Expanding coverage to the uninsured as a solution to dealing with the rising amount of UC and its effects on the healthcare system was mentioned in 2005 by Weissman. Incremental reforms like the formation of Health Savings Accounts (HSA) probably will not have a large effect on uncompensated care. However, a number of objectives may be worth following to help with the problem of UC. Those goals are transparency in pricing, hospital policies and financial records. These three goals could lead to more dependable practices for reporting and giving free care and bad debt (Weissman, 2005), (Table 1).

According to the West Virginia Hospital Association, (2012), UC costs in 2010 in West Virginia were \$724 million, a number that increased 3 million from the previous year. Heyman (2009) reported that these millions of dollars in UC costs raise private health insurance premiums by roughly \$1,000 a year, and reducing the number of uninsured Americans would reduce that expense (Table 1).

The amount associated with cost shifting represents 1.7% of private health insurance costs. This 1.7% is a product of cost shifting (Singer, 2012). It has been suggested that cost shifting as a result of uncompensated care has a substantial impact on private insurance premiums. A projected \$14.1 billion could be financed through cost shifting (Table 1).

Gruber & Rodriguez (2007) completed research on the amount of uncompensated care physicians provide and found that between 45%–59% of medical doctors provide negative uncompensated care; meaning these physicians collected more from uninsured patients than insured patients. As well, 12%–14% of physicians have

found uninsured patients to be more than twice as profitable as their insured patients. This means the net payments from the uninsured have been more than twice the expected payments from insured patients. (Gruber & Rodriguez, 2007) (Table 1).

According to Gruber (2008), procedures that are aimed to reduce the population of uninsured derive in four variations. These four assortments are: policies that increase entitlement to free public insurance; policies that expand access to private mechanisms for acquiring insurance; policies that support the obtaining of private insurance; and policies that mandate insurance coverage (Gruber, 2008).

Thornton & Rice reported in 2008, that by extending insurance, the health outcomes of the uninsured population would show increased improvement. The estimated effect of insurance coverage indicated a 10% increase in the population-insured rate as well as a state reduced mortality by 1.6%-1.9%. Thornton & Rice (2008) determined that extending insurance coverage to the uninsured population in the U.S would save an additional 75,000 lives annually and produce an annual net benefit of over \$400 billion (Thornton & Rice, 2008), (Table 1).

Garrett & Holahan (2010) described the effect on uncompensated care by decreases in the uninsured is slightly offset by increases in costs of healthcare. Without the ACA, the cost of UC would likely increase to amongst \$107 and \$141 billion by 2019, this is dependent on the growth in the economy as well as general health care costs (Table 1).

Stoll & Bailey (2009) determined that in order to make up for uncompensated care; the costs have been shifted to the insured in the form of higher payments for healthcare services. These higher charges are then passed on families as higher insurance premiums by cost shifting. The impact in 2008 of this cost shifting was estimated to be \$1,017 on premiums for individuals and their families (Stoll & Bailey, 2009), (Table 1).

However, Clemans, et al., (2010), reported that UC costs are estimated to decrease under the ACA along with the population of uninsured Americans dropping from 49 million to 15 million. Additionally the total cost of uncompensated care provided to the uninsured in a single year would decrease also from \$61.1 billion to just under \$25.2 billion (Table 1).

## DISCUSSION

The purpose of this research was to explore the financial implications put on the insured population by the uninsured with UC costs. The results of this study suggests mixed outcomes.

The amount of uncompensated care provided is hard to determine due to the differences in the definitions of UC. The definition of UC is inconsistent in many organizations papers and literature reviews. The fluctuating definitions of UC between AHA, CMS, and other healthcare organizations make it challenging to determine the key components of UC. Uncompensated care is often defined as charity care plus bad debt but may include governmental payment deficits (Dobson, Koenig, El-Gamil, Pick, & Sankaran, 2012). Having a universal definition used by all healthcare organizations would make estimated total UC costs more accurate. One argument as to why there is no universal definition for UC is organizations like CMS, do not want to be responsible for specific funds like, bad debt, therefore they do not include it in their definition.

Hadley et al., (2008) found that cost shifting represented 1.7% of the of private health insurance costs. A small percentage of cost shifting compared to what other studies were estimating. This study demonstrated promise; however numbers were said to be inflated to generate specific outcomes. Also the data was used from 2002-2004, more recent could have been used. Hadley et al., (2008) used a lot of estimated numbers as well as assumptions to arrive at their final results. For instance, a survey was used in collection of specific data. This method provides questionable reliability, as the reader cannot be positive the survey was completed by the appropriate person, and/or if the answers were truthful.

Stoll & Bailey, (2009) found the increase in yearly premiums on insured Americans due to hidden tax or UC in 2008 to be \$1,017. However, it could be argued due to the uncertainty of the exact definition of UC used in their study and which key components of UC were measured, the numbers estimated for the hidden tax could vary greatly. Additionally assumptions that cannot be derived from data sources were also used.

However, this study did encounter limitations of its own. Publication bias as well as research bias cannot be ruled out. There was also an abundance of information on UC so valuable information could have been over looked. Other study limitations included no universal definition of UC and restriction of certain databases that could have provided respected information about UC and its effect on the insured population.

Healthcare costs have increased dramatically over the recent years and UC costs are a major factor. It is unlikely without the ACA the federal assistances to states could not support the rising percentage of uncompensated care much longer. The ACA will permit more Americans who are uninsured to get health insurance, ultimately reducing the UC costs burdening the healthcare industry today.

The uninsured population is not the only individuals who endure the consequences when they chose not to purchase health insurance, everyone is affected. As this crisis continues to grow and more people lose their coverage, the amount of uncompensated care can be expected to rise and with it, the hidden health tax. However, the hidden tax has a smaller effect than previously estimated in our hypothesis.

Future research should center on a universal definition of UC to determine more precise findings. Further research should observe data after 2014 when the enactment of the ACA was put forth. This additional research would help decide if the ACA helped or hurt the nation's healthcare problem. Studies after 2014 could demonstrate a lower percentage of Americans without health insurance ultimately lowering the projected cost of UC.

## CONCLUSION

The findings of this study have suggested that UC has the potential to increase insurance premiums of the insured population through cost shifting or the so called hidden tax. However, with the implementation of the ACA by the federal government and other cost saving measures UC showed promise to decrease over the next few years.

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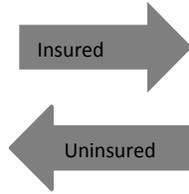
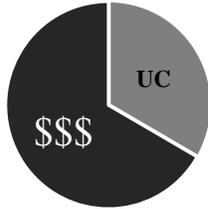
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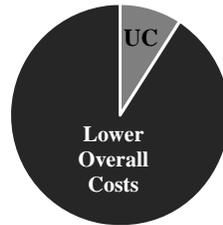
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Overall Patient Costs  
Uninsured



Overall Patient Cost  
Insured



UC = Increased uninsured population  
Increased UC

Decreased uninsured population  
Decreased UC

Uncompensated Care

Figure 1: Conceptual Framework: Healthcare of the Uninsured Population In U.S.

Table 1: Results of Uncompensated Care Affecting the Healthcare of the Insured Population

Author (year)	Type of Study	Key Findings (Keywords)
Heyman (2009)	Qualitative Case Study	UC costs raise private health insurance premiums by \$1,000 a year per family
Gruber & Rodriguez (2008)	Qualitative Literature Review	45%-59% of physicians provide negative UC
Weissman (2005)	Qualitative Literature Review	Three goals in order to lower UC costs are transparency in pricing, financial records, and hospital policies.
Thornton & Rice (2008)	Qualitative Literature Review	A 10% increase in the population-insured rate of a state reduced mortality by 1.69-1.92%
Clemans, et al., (2010)	Qualitative Literature Review	A decrease in the number of uninsured from 49.1 million to 15.1 million under the health care reform bill
Garrett & Holahan (2010)	Qualitative Literature Review	Uncompensated care will increase to between \$107 and \$141 billion in 2019
Singer (2012)	Qualitative Literature Review	The amount associated with cost shifting represents 1.7% of private health insurance costs.
West Virginia Hospital Association (2012)	Quantitative Case Study	UC costs in WV alone in 2010 were \$724 million
The Henry J. Kaiser Family Foundation (2013)	Qualitative Case Study	The majority of the uninsured are in low-income working families. Reflecting the more limited availability of public coverage, adults are more likely to be uninsured than children
Stoll & Bailey (2009)	Qualitative Literature Review	The impact of this hidden health tax in 2008 was estimated to be \$1,017 on annual premiums

UC = uncompensated care