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Federal Spending on the Health Care Safety Net from 2001 – 2004: Has Spending Kept Pace with the Growth in the Uninsured?

Prepared by

Jack Hadley, Matthew Cravens, Terri Coughlin
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The Urban Institute

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THE HENRY J. KAISER FAMILY FOUNDATION

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

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ACKNOWLEDGEMENTS

The authors thank The Kaiser Family Foundation, which provided support for this study, particularly David Rousseau, Barbara Lyons, and Diane Rowland of the Kaiser Commission on Medicaid and the Uninsured for their continued support and guidance. We also thank Randall Bovbjerg, Sharon Long, Barbara Ormond and Stephen Zuckerman of the Urban Institute for their many helpful comments.

EXECUTIVE SUMMARY

Federal spending is the largest and most important component of funding for the health care safety net, providing an estimated $19.8 billion in funding in 2001. In that year the Federal government provided two-thirds of all government spending on the health care safety net and more than half of all spending from all sources. Yet, in spite of this substantial subsidy, someone uninsured for the entire year still received only about half as much medical care on an annual basis as a privately insured person. A substantial body of research indicates that this deficit in the amount of care received by the uninsured leads to significantly worse health.[1] Since 2001, 4.6 million more Americans have become uninsured, leaving 45.8 million people without insurance coverage in 2004.[2] State and local governments have likely not been able to maintain, let alone increase, their level of support for safety-net funding. This work demonstrates that federal spending on the health care safety net has not kept pace with the growth in the uninsured over the past three years.

Based on information collected from Medicare, Medicaid, and other federal programs that provide funds that support the health care safety net, total federal safety-net spending in grew from $19.8 billion in 2001 to $22.8 billion in 2004 (Table A-1), an increase of 15.4 percent. This overall increase reflects a decline in Medicaid spending through its DSH and UPL programs from $7.6 to $6.7 billion, which was more than offset by increases in Medicare spending from $6.6 billion to $9.2 billion and increases in federal support for discretionary spending programs from $5.6 to $6.9 billion.

Federal support for community health centers, which have been a focal point of the Administration's policy for providing care to the uninsured, increased by more than 50 percent, from $0.43 billion to $0.67 billion. Despite this growth, however, in 2004, federal funding for community health centers still accounted for less than 3 percent of total federal spending on the safety net (Table A-1).

Between 2001 and 2004 the cost of medical care, as measured by the medical care component of the consumer price index, increased by almost 14 percent. Adjusting for inflation and expressing federal spending in constant 2004 dollars reveals that total federal spending on the safety net increased by only 1.3 percent between 2001 and 2004. At the same time, however, the total number of uninsured Americans increased by 11.2% percent, rising from 41.2 million in 2001 to 45.8 million people by 2004. As a result, federal spending per uninsured person actually decreased by 8.9%, from $546 per uninsured person in 2001 to $498 in 2004 (Table A-2 and Figure A-1). These inflation-adjusted figures suggest that overall federal support of the safety net has not kept pace with the increase in the number of uninsured Americans

[1] Institute of Medicine, 2002; Hadley, 2003.
[2] C. Denavas-Walt, B. Proctor and C. Lee, *Income, Poverty, and Health Insurance Coverage in the United States: 2004,* U.S. Census Bureau, Current Population Reports, P60-229, 2005.

Table A-1
Total Federal Spending on The Health Care Safety Net ($billions)

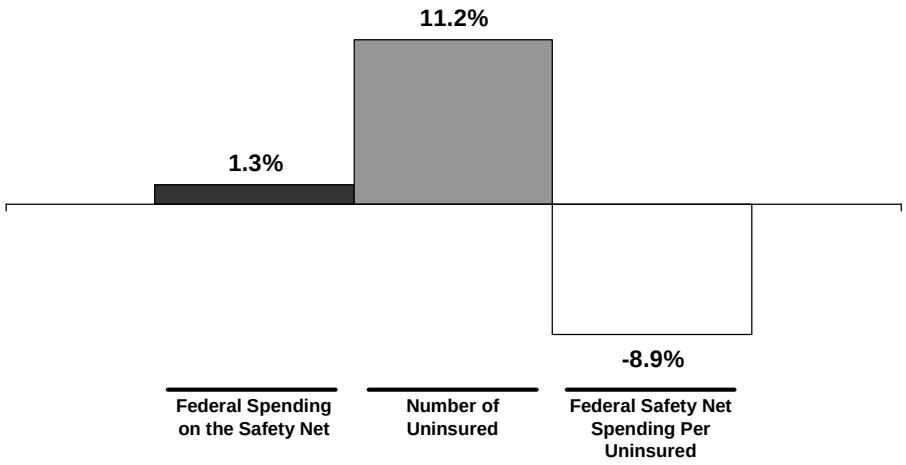
	2001	2002	2003	2004	*% 2004 Total*	*% Change 2001-2004*
Medicare	$ 6.6	$ 7.7	$ 9.0	$ 9.2	*40.4*	*39.4*
Medicare DSH	5.0	6.0	7.2	7.4	*32.5*	*48.0*
Medicare Share of IME	1.6	1.7	1.8	1.8	*7.9*	*12.5*
Medicaid DSH and UPL	$ 7.6	$ 7.2	$ 6.4	$ 6.7	*29.4*	*-11.8*
Direct Care Programs	$ 5.6	$ 5.6	$ 6.5	$ 6.9	*30.1*	*23.7*
VHA	3.23	3.14	3.87	4.18	*18.3*	*29.3*
IHS	1.28	1.29	1.31	1.30	*5.7*	*2.2*
Health Centers	0.43	0.49	0.58	0.67	*2.9*	*56.0*
Ryan White CARE	0.55	0.59	0.65	0.65	*2.8*	*16.3*
MCHB	0.06	0.06	0.06	0.06	*0.3*	*12.5*
NHSC	0.00	0.01	0.01	0.01	*0.0*	*64.5*
Total, All Federal Sources	$ 19.8	$ 20.5	$ 21.9	$ 22.8	*100.0*	*15.4*

Table A-2
Total Inflation-Adjusted Federal Spending on The Health Care Safety Net (billions of 2004 $s), and Number of Uninsured

	2001	2002	2003	2004	*% Change 2001-2004*
Total Federal Spending	$ 22.5	$ 22.3	$ 22.9	$ 22.8	*+1.3%*
Number of Uninsured (000's)	41,207	43,574	44,961	45,820	*+11.2%*
Federal Spending per Uninsured Person	$ 546	$ 512	$ 509	$ 498	*- 8.9%*

Figure A-1

Percent Change in Inflation-Adjusted Total Federal Spending, the Number of Uninsured, and Federal Spending per Uninsured, 2001-2004



It appears unlikely that future federal funding will reverse this trend. More than 70% of federal safety net spending flows through the Medicare and Medicaid programs, both of which are under severe budgetary pressures. In the wake of the 2001 recession, many states faced challenges financing their share of program costs as Medicaid enrollment grew due to increasing poverty and declining availability of affordable private coverage. However, states' ability to continue covering people who lose private insurance coverage is not unlimited. If states retrench the recent growth in Medicaid enrollment, then the increase between 2001 and 2004 in the percentage of people without insurance is likely to be much larger in the future. This will place even greater strain on safety-net providers and on their sources of funding. If safety-net resources continue to shrink while the number of uninsured grows, then the amount of care received by the uninsured, which is already well below the average amount of care received by the insured, will also be jeopardized with potentially significant adverse consequences on the health of the uninsured and the health of our nation.[3]

[3] Institute of Medicine 2002; Hadley 2003.

INTRODUCTION

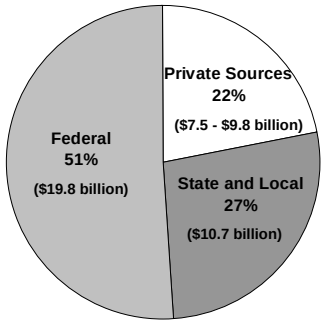
In 2001, America's 41.2 million uninsured received about $35 billion dollars in uncompensated care, defined here as care that was not paid for either by the uninsured themselves or by an identifiable source of insurance.[4] Hospitals provided about two-thirds of this care, clinics, community health centers and other community-based institutional providers delivered about 20%, and office-based physicians the balance.

Uncompensated care represents a substantial proportion of the care received by the uninsured, accounting for over one-third of their total medical care consumption. Yet, in spite of this substantial subsidy, someone uninsured for a full year still received only about half as much medical care on an annual basis as a privately insured person, $1,253 compared to $2,484. A substantial body of other research indicates that this deficit in the amount of care received by the uninsured leads to significantly worse health.[5]

Federal spending is the largest and most important component of funding for the health care safety net, the informal network of hospitals, clinics, community health centers, and other community-based providers that provide most of the uncompensated care received by the uninsured. In 2001, the Federal government spent an estimated $19.8 billion to support the cost of uncompensated care.[6] Federal spending covered just over half of the total cost of uncompensated care; state and local government spending accounted for another 27%, and private sources for the remaining 22% of the total (Figure 1).

Figure 1

Sources of Funding Available for Uncompensated Care to the Uninsured, 2001



Total: $38.0- $40.3 billion

Source: Hadley, J., and J. Holahan. 2003. "How Much Medical Care Do the Uninsured Use, and Who Pays for It?" *Health Affairs—Web Exclusive* (February 12): W3-66 – W3-81.

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Since 2001, the number of uninsured Americans has risen to 45.8 million people in 2004.[7] Although direct data are not available, indications are that state and local governments have probably not been able to maintain, let alone increase their level of support for safety-net funding. The economic recession that began in 2001 coupled with double-digit increases in private insurance premiums have led to a significant drop in the number of

[4] Hadley and Holahan, 2003.
[5] Institute of Medicine 2002; Hadley, 2003.
[6] Hadley and Holahan, 2003.
[7] C. Denavas-Walt, B. Proctor and C. Lee, *Income, Poverty, and Health Insurance Coverage in the United States: 2004,* U.S. Census Bureau, Current Population Reports, P60-229, 2005.

people covered by employer-based private insurance, which fell from 63.6% in 2000 to 59.8% in 2004.[8] Medicaid and SCHIP picked up many, but not all of the people losing or dropping private coverage. As a result, state spending on Medicaid grew by an average of 11.7% per year in 2001 and 2002, while the recession was causing a substantial slowdown in state tax revenue growth, which was only 2% in 2001 and turned negative in 2002 and 2003.[9]

Given the already dominant and probably increasingly important role of federal spending in supporting uncompensated care delivered to the uninsured by safety-net providers, has federal spending on the safety net increased since 2001? Has it kept pace with the increase in the number of uninsured Americans? What are the prospects for federal support over the next few years?

The Administration has made support for the health care safety net a cornerstone of its policy for addressing the problem of health care for the uninsured. In 2002, the Administration announced the Federal Health Center Growth Initiative with the goal of increasing community health center capacity by 60% by 2006.[10] Consistent with this goal, the federal budget for the Bureau of Primary Health Care, which administers the grant program for federally qualified health centers, grew from $1.17 billion in 2001 to a request for $2.04 billion for 2006.[11]

Community health centers, however, represent only a small share, less than 3%, of total federal spending on the safety net. Medicare and Medicaid, which channel more than 70% of federal dollars for the uninsured to health care providers, currently face intense budget pressures as Congress deals with the large federal deficit in the wake of federal tax cuts, sluggish economic growth, and unexpectedly large expenditures for hurricane disaster relief and the wars in Iraq and Afghanistan.

This report updates the earlier analysis of federal spending in 2001 to support the cost of uncompensated care by tracking spending trends between 2001 and 2004.[12] We limit the analysis to federal spending because of its dominant role in funding the health care safety net and because data on state and local spending, which accounted for about one-third of all government spending on uncompensated care in 2001, are not readily available for 2003 and 2004. We examine each of the major components of federal spending on uncompensated care, through the Medicare and Medicaid programs, the Veterans Health Administration, the Indian Health Service, the Ryan White CARE program for people living with HIV and AIDS, and grant programs to

[8] *Ibid.*
[9] Kaiser Commission on Medicaid and the Uninsured. “Immediate State Fiscal Crisis Subsides, but Medicaid Still Faces Long-Term Budgetary Challenges,” News Release, Washington DC: Kaiser Family Foundation, October 19, 2005.
[10] A.S. O'Malley, C.B. Forrest, R.M. Politzer, J.T. Wulu, and L. Shi, "Health Center Trends, 1994-2001: What Do They Portend For The Federal Growth Initiative?" *Health Affairs* 24, no. 2 (2005): 465-472.
[11] Department of Health and Human Services, "FY 2006 President's Budget for HHS" and "FY 2001 Appropriation for HHS," www.hhs.gov/budget/docbudget.htm (30 March 2005).
[12] See Hadley and Holahan, 2003.

support community health centers, maternal and child health clinics, and National Health Service Corps sites in medically underserved communities.

The data for this report come from a variety of government reports on program expenditures, budgets, and appropriations. Unfortunately, spending to support uncompensated care provided to people without any private or public (Medicare or Medicaid) health insurance coverage is seldom identified or explicitly earmarked in government documents. Therefore, the estimates require making several assumptions, documented in the text and tables, about the proportions of people who are uninsured and receive care from providers funded by, or partially funded by, federal programs and about the shares of federal funding that ultimately subsidize the cost of care received by the uninsured.

The first section of the report covers Medicare and Medicaid spending that plausibly subsidizes the cost of uncompensated hospital care for the uninsured, while the second section presents data on federal spending through discretionary programs that provide care to the uninsured. The last section summarizes the trend in total federal spending on the health care safety net from 2001 to 2004, adjusting the spending to reflect increases in medical inflation, and comparing it to changes in the number of uninsured persons during that period.

MEDICARE AND MEDICAID SUPPORT FOR CARE TO THE UNINSURED

The federal government pays for uncompensated care to the uninsured through several provisions in the Medicare and Medicaid programs. Medicare contributes via its disproportionate share (DSH) hospital payments and through payments for graduate medical education. Medicaid makes payments through a DSH program as well, and sometimes through supplemental payments. In this section we present estimates of Medicare and Medicaid expenditures that support the cost of medical care delivered to the uninsured.

Medicare DSH and IME Payments to Hospitals

Under Medicare's Prospective Payment System (PPS) for hospital inpatient care, a disproportionate share hospital (DSH) adjustment is applied to the payment rate for hospitals that treat a large share of poor patients. The DSH adjustment depends on the hospital's disproportionate patient percentage (DPP), which is based on two ratios: the proportion of Medicare inpatient days accounted for by beneficiaries who are eligible for Supplemental Security Income and the proportion of all inpatient days accounted for by

people covered by Medicaid.[13] Hospitals received an estimated $6.0 billion in DSH payments in fiscal 2002, $7.2 billion in fiscal 2003, and $7.4 billion in fiscal 2004.[14]

The purpose of DSH payments has been under debate since the PPS was implemented in 1983. Initially, the Health Care Financing Administration (HCFA, which was renamed the Centers for Medicare and Medicaid Services (CMS) in 2001) did not include a DSH adjustment on the grounds that "the data now available to us do not indicate that Medicare costs are generally affected by disproportionate numbers of low-income patients who are Part A beneficiaries."[15] Nevertheless, Congress required the addition of a DSH adjustment in the Consolidated Omnibus Budget Reconciliation Act of 1985, citing somewhat broader intent: "The disproportionate share adjustment was intended to compensate hospitals for higher costs that may be associated with treating low-income patients because some hospitals that receive disproportionate share adjustments were financially distressed and at risk of closing. The adjustment also helps to maintain access for some Medicaid beneficiaries."[16]

In an early analysis of the relationship between Medicare costs per case and the DPP, the Congressional Budget Office found that the DPP was not significantly associated with higher Medicare costs per case except for a relatively small number of hospitals with extremely high DPPs.[17] Again in the spirit of broader intent, Congress increased both the number of hospitals that qualified for the adjustment and the amount of the payment. In fiscal year 1989 about 1,250 hospitals received about $1.1 billion in DSH payments, while by fiscal year 1997 those numbers had grown to about 1,900 hospitals and $4.5 billion.[18]

The growing magnitude of the DSH adjustment and its dwindling justification on the basis of higher Medicare costs per case reflect the increasing emphasis on the broader purpose of Medicare DSH payments. The Medicare Payment Advisory Committee (MedPAC) asserted that to protect access to care for Medicare beneficiaries, additional (Medicare DSH) funds should be provided to hospitals whose viability might be threatened by providing care to the poor.[19] Presumably, if the poor were adequately

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[13] Prospective Payment Assessment Commission (ProPAC), *Report and Recommendations to the Congress* (Washington: March 1997), p. 31.

[14] Tabulations provided by MedPAC, May 2005. Data on DSH, IME and GME for fiscal years 2002 and 2003 are based on Medicare Cost Report data provided by MedPAC. Fiscal 2004 data are not yet available; thus we use fiscal 2003 data adjusted by the annual update factor (3.4 percent). Actual costs will also reflect changes in volume; thus fiscal 2004 estimates likely underestimate actual spending.

[15] HCFA, "Medicare Program: Prospective Payment for Medicare Inpatient Hospital Services, Final Rule," *Federal Register* 49 no. 1 (January 3, 1984): 276.

[16] Congressional Budget Office (CBO), "Medicare's Disproportionate Share Adjustment for Hospitals" (Washington: May 1990), p. 1.

[17] Ibid., p. 24-25.

[18] ProPAC, Medicare Prospective Payment and the American Health Care System (Washington: June 1989), p. 119-121; ProPAC, Medicare and the American Health Care System (Washington: ProPAC, June 1997), p. 67-70.

[19] Medicare Payment Advisory Committee, *Report to the Congress* (Washington: MedPAC, March 2001), p. 78.

covered, those hospitals would not be under financial pressure and the Medicare DSH payments would be unnecessary.

Medicare payments under the hospital inpatient PPS are also adjusted to recognize the higher patient care costs incurred by hospitals with graduate medical education programs. The Indirect Medical Education (IME) adjustment for each hospital is determined by a measure of its teaching intensity, which is based on the ratio of medical residents to beds. The Prospective Payment Assessment Commission (ProPAC) found in 1997 that the empirical relationship between Medicare cost per case and teaching intensity was about half of the magnitude implied by the payment adjustment at the time and it had been decreasing over the years.[20]

Although the IME adjustment was substantially reduced in the Balanced Budget Act of 1997, it was partially restored in subsequent legislation. In fiscal year 2001 it was still more than one-third higher than would be justified by ProPAC's 1997 analysis. One of the reasons for this is the perception that teaching hospitals perform other social missions – including care for the poor – that should be supported. In fact, almost two-thirds of all teaching hospitals also received Medicare DSH payments in fiscal year 1997, and about two-thirds of all DSH payments went to teaching hospitals.[21] IME payments were $5.2 billion in fiscal 2002, $5.3 billion in fiscal 2003, and $5.5 billion in fiscal 2004.[22] If these payments are indeed one-third greater than justified by teaching hospital's higher costs, the remaining $1.8 billion (fiscal 2004) may be viewed as additional subsidies for teaching hospitals' social missions. Some, if not all, of that amount would probably be eliminated if teaching hospitals were not seen as major safety net providers.

Medicare also paid an estimated $2.4 billion in fiscal year 2004 ($2.3 billion in fiscal 2002 and $2.5 billion in 2003) to reimburse teaching hospitals for the direct cost of their graduate medical education (GME) programs. This payment has been the subject of debate on several grounds, including whether the federal government should subsidize physicians' training costs, and whether the tremendous variation in per-resident payments across hospitals is justified, or in fact related at all to the real cost of training. Again, the major beneficiaries of these payments are hospitals that tend to treat large numbers of poor patients and the roles of many teaching hospitals as safety net providers is used to justify those payments. But because these payments are tied directly to physician training, we do not include them in the tabulation of payments to hospitals that care for the uninsured, nor is it likely that they would be eliminated even if universal coverage were available.

Overall, we estimate that Medicare payments, through the DSH and IME programs, to support hospitals that treat poor and uninsured patients were approximately $9.2 billion in fiscal 2004, compared to $6.6 billion in 2001 (Table 1).

[20] ProPAC, March 1997, p. 28-29
[21] ProPAC, June 1997, p. 67-70.
[22] Tabulations provided by MedPAC, May 2005.

Table 1
Medicare and Medicaid Support for Care to the Uninsured ($billions)

	2001	2002	2003	2004
Medicare Total	$ 6.6	$ 7.7	$ 9.0	$ 9.2
DSH	$ 5.0	$ 6.0	$ 7.2	$ 7.4
Share of IME*	1.6	1.7	1.8	1.8
Medicaid				
DSH and UPL	7.6	7.2	6.4	6.7
Total	$ 14.2	$ 14.9	$ 15.4	$ 15.9

* Assumes that one-third of IME payments support the cost of care for the uninsured

Medicaid DSH and UPL Payments

Medicaid also uses its DSH program to provide a substantial amount of financial support to hospitals that treat a large number of poor patients. Similar to Medicare, Medicaid sponsors a DSH program that states use to make an added payment over and above regular reimbursement to hospitals that care for a disproportionate number of Medicaid or uninsured patients. The Medicaid DSH program, which began in 1981, was expressly designed to provide financial help to safety net hospitals. In fiscal year 2004, Medicaid made an estimated $17 billion in DSH payments to hospitals, more than twice Medicare's DSH payments in that year.[23]

Although the level of Medicaid DSH payments is significant, some states have structured their DSH programs in such a way that only a portion of federal Medicaid DSH spending in fact represents "real" additional gains to hospitals that can be used to help pay for uncompensated care costs.[24] For example, a substantial share of Medicaid DSH payments (about 20 percent in fiscal 2003) is paid to mental hospitals and does not help finance acute care hospitals' costs of caring for the uninsured. Further, some states retain part of federal DSH dollars they receive and use them for other purposes, sometimes health-related and sometimes not.

Additionally, in some cases the state share of DSH payments does not represent new funding to hospitals.[25] Beginning in the mid-1990s, many states started to use intergovernmental transfers to finance their share of DSH payments. Typically, these

[2] Federal share of DSH spending is taken from the Congressional Budget Office, *CBO March 2005 Baseline: Medicaid and the State Children's Insurance Program* (March 2005); state share is based on assumption of an average FMAP of 58.95 percent in fiscal 2004.
[24] Coughlin and Liska, 1997.
[25] Ku and Coughlin 1995; Coughlin et al. 2004

transfers allow a state to receive federal Medicaid DSH funds with the state not incurring any real expense. As a result, under many state DSH programs the only funds potentially available to hospitals to help finance uncompensated care costs are federal DSH dollars. However, not all states use transfers to finance their share of DSH payments. Some pay for their entire share of DSH expenditures, or part of it, with state general funds, like any other Medicaid expense. So, in some DSH programs, state DSH dollars are a very important source of funding for hospitals' uncompensated care costs.

Findings from a 2003 survey of states showed that about 88 percent of federal Medicaid DSH funds paid to state and non-state acute care hospitals may be real gains to the facilities.[26] The survey also revealed that about 25 percent of state DSH payments are funded with state general funds and thus possibly represent real new funding to hospitals. After eliminating payments to mental hospitals and adjusting for state or federal payments that may not be real new funds to hospitals, we estimate Medicaid DSH payments (federal and state) that may be available to acute care hospitals totaled $7.6 billion in fiscal 2002, $7.0 billion in fiscal 2003, and $7.5 billion in fiscal 2004.[27, 28, 29] Although all of this funding does indeed support hospital uncompensated care costs, it should be noted that a portion of it is intended, in part, to offset Medicaid payment rates – set by the states – that do not fully cover the costs incurred by hospitals in caring for Medicaid patients.

Another potential source of Medicaid funding for hospitals' uncompensated care costs is supplemental or upper payment limit (UPL) plans. Under these plans (which are entirely optional under Medicaid and distinct from DSH) states make additional payments to providers (primarily nursing homes but also hospitals) by raising their reimbursement above the established Medicaid payment rate. In fiscal 2004, an estimated $8.8 billion in UPL payments were made.[30] Often structured and financed along the same lines as DSH programs, it is difficult to determine which UPL payments represent real new funds to hospitals. The 2003 survey of state Medicaid supplemental payment programs revealed that about 30 percent of UPL payments were paid to hospitals in 2001. In addition, about 14 percent of potential gains available through

[26] Coughlin et al., 2004.

[27] The dip in DSH spending in 2003 and the jump in 2004 reflects two national policy changes. The drop was caused by reverting to the Balanced Budget Act of 1997 DSH allotments in 2003, whereas the rise in 2004 reflects the 16 percent across the board increase in federal DSH spending provided for in the Medicare Modernization Act of 2003.

[28] These estimates also assume that the design of state DSH programs (e.g., how states financed their program, what share of funds is retained by providers) were similar to that of programs reported in the 2003 survey.

[29] In lieu of using the CBO projected 2004 federal DSH spending, the federal DSH allotment for fiscal 2004 could be used to estimate DSH expenditures. The total 2004 federal DSH allotment was $10.1 billion. However, CBO staff estimate that states will not be able to spend their entire allotments, and that a projection of $8.7 billion is more realistic.

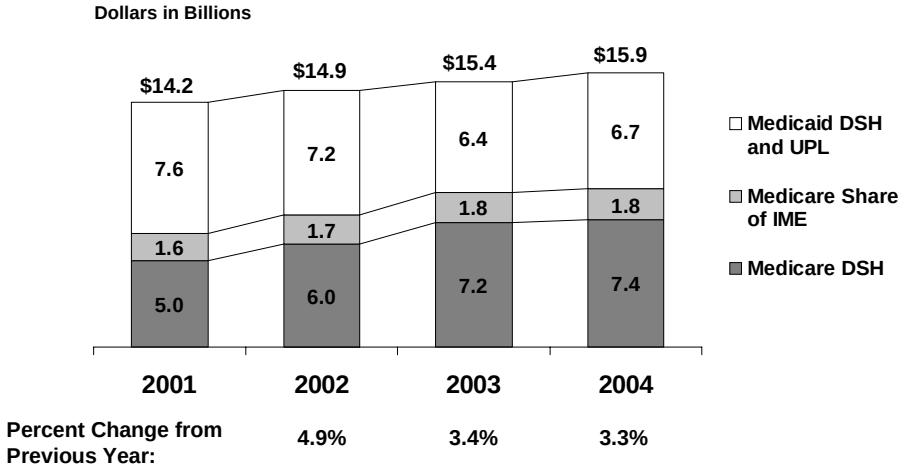
[30] Federal share of UPL spending is taken from the Congressional Budget Office, *CBO March 2005 Baseline: Medicaid and the State Children's Insurance Program* (March 2005); state share is based on assumption of an average FMAP of 58.95 percent in fiscal 2004.

federal UPL payments went to hospitals (state and non-state facilities). The survey also showed that about 23.5 percent of the state share of UPL payments was financed using state general funds. Applying these various percentages to estimated total UPL payments,[31] we calculate that potential funds available to hospitals to cover uncompensated care costs through UPL plans totaled $1.44 billion in fiscal 2002, $1.14 billion in fiscal 2003, and $0.99 billion in fiscal 2004.

Nationally, total spending on Medicaid DSH and UPL payments that arguably went to help finance hospitals' uncompensated care costs is estimated at $9.04 billion in fiscal 2002, $8.14 billion in fiscal 2003, and $8.49 billion in fiscal 2004.[32] Based on the state surveys conducted in 2003, we assume that 79 percent of these funds represent federal spending.[33] As summarized in Table 1, total federal Medicaid spending to support the cost of hospitals' uncompensated care is estimated to decline from $7.6 billion in 2001 to $6.7 billion in 2004. However, the decline in Medicaid spending was offset by greater Medicare spending, so that total federal spending through Medicare DSH and IME plus Medicaid DSH and UPL payments grew from $14.2 billion in 2001 to $15.9 billion in 2004 (Figure 2).

Figure 2

Federal Medicare and Medicaid Support for Uncompensated Care, 2001-2004



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[31] Federal share of UPL spending is taken from the Congressional Budget Office, *CBO March 2005 Baseline: Medicaid and the State Children's Insurance Program* (March 2005); state share is based on assumption of an average FMAP of 57.3 percent in fiscal 2002, 58.4 percent in fiscal 2003 and 58.95 percent in fiscal 2004. The rise in the FMAP reflects the temporary increase in the federal Medicaid match rate provided through the 2003 Jobs Growth Tax Relief Reconciliation Act.

[32] If the federal DSH allotment approach is used (see note 4), total DSH and UPL potentially available to hospitals is estimated at $9.94 billion in fiscal 2004.

[33] Coughlin et al., 2004.

DIRECT CARE PROGRAMS

Veterans Health Administration

The Department of Veterans Affairs (VA) offers a broad range of federal benefits to veterans. In FY 2004 medical care accounted for $28 billion or 43 percent of total VA expenditures, while the remainder paid for pensions, service-connected disability compensation, education, vocational rehabilitation, life insurance and indemnities, and facility construction.[34] VA medical services are administered by the Veterans Health Administration (VHA). Because VHA is a discretionary program, its budget must be approved each year and its spending limited to levels of Congressionally authorized funding (as well as collections from patients and third-party sources). From 2000 to 2004, total VHA funding increased 45 percent, or an average of 10 percent each year.[35] Appropriations increases in 2005 and 2006 are expected to drop moderately.

Although high, the growth in VHA appropriations and spending was outpaced by the growth in demand for VA medical services following eligibility rule changes in 1996 that attracted many new enrollees.[36] The Veterans Millennium Health Care Act of 1999 also expanded services and new enrollment. The freeze on enrollment for Priority 8 veterans (veterans with no service-connected disabilities and incomes above the VA means test level and geographic index) in January 2003 can be seen as a response to VHA budget growth resulting from sharp increases in enrollment.

To estimate the share of VHA spending that funds direct medical care to the uninsured, we apply the proportion of users with no other source of coverage to total appropriations for acute hospital and outpatient care. Acute hospital and outpatient care services comprise nearly three-fourths of each year's total VHA operating expense budget.[37] Long-term rehabilitative, psychiatric, and nursing home care account for the remainder.

Most veterans who use VA services have another source of health care coverage, and most receive the bulk of their care from non-VA sources.[38] To estimate the share of users who are uninsured, we examine annual insurance coverage data from the Current Population Survey (CPS). The VA does not provide information on costs of services specifically used by uninsured veterans. Therefore, this analysis assumes that veterans

[34] Department of Veterans Affairs, "Geographic Distribution of VA Expenditures," 2001-2004, www.va.gov/vetdata/GeographicInformation/index.htm (6 April 2005).

[35] Derived from data on actual annual Department of Veterans Affairs appropriations: Office of Management and Budget (OMB), "Budget of the United States Government, Fiscal Year 2003 [2004] [2005]—Appendix," http://www. whitehouse.gov/omb; Department of Veterans Affairs, "2006 Congressional Submission: Medical Programs," p. 3B-5. All estimates reflect actual appropriations rather than current-year estimated or future-year projected appropriations, both of which may be frequently revised.

[36] See Congressional Budget Office, "The Potential Cost of Meeting Demand for Veterans' Health Care," March 2005, p.5.

[37] Operating expenses exclude capital investments and construction costs. See Table 2 notes for details on the source of acute hospital and outpatient care appropriations.

[38] CBO, 2005.

with only VA coverage use acute hospital and outpatient care services with the same frequency as other VA users. As shown in Table 2, the CPS indicates that from 2001 to 2004, between 19 and 22 percent of persons covered by VA had no other source of coverage.[39]

Periodic surveys of VA users strongly confirm the CPS estimates. The 2001 National Survey of Veterans (NSV) reports 19.1 to 19.8 percent of veterans who used VA health care to be uninsured, and 20.3 to 21.0 percent of veterans who used VA care for

Table 2
Veterans Health Administration Appropriations for Medical Care to the Uninsured ($millions)

	2001	2002	2003	2004
Acute hospital care services	$ 5,257	$ 5,122	$ 5,505	$ 6,632
Outpatient care services	9,970	10,541	11,585	13,872
General operating expenses for acute & outpatient care[a]	487	501	547	656
Total, Acute hospital & outpatient care services	15,714	16,164	17,637	21,159
Percent of VA users with no other coverage[b]	20.6%	19.4%	21.9%	19.8%
Total support for medical care to the uninsured[c]	$ 3,235	$ 3,143	$ 3,870	$ 4,182

Notes:

All amounts exclude capital investments and facility costs.

[a] General operating expenses (GOE) are defined as expenses for administration and oversight of VA benefits. The amount represents $0.032 in GOE for every $1 in expenses (average of 2002, 2003, and 2004 GOE percentages for all VA benefit programs; $.034, $.032, and $.031, respectively). (Source: Dept. of Veterans Affairs, "Geographic Distribution of VA Expenditures," www.va.gov/vetdata/GeographicInformation/index.htm).

[b] Percent of persons reporting full-year VA or military health care coverage who had no other source of coverage that year. "Other sources" include CHAMPUS, CHAMPVA, Medicare, Medicaid, SCHIP, and all private plans. (Source: Current Population Survey, 2001 - 2004 March Supplements.)
Because the CPS asks only about coverage and not service use, the term "users" may more closely resemble "enrollees."
The 2004 percentage is the average of the percentage in the prior four years.

[c] Calculated by multiplying total acute care spending by the percentage of VA users without health insurance.

Source: Annual appropriations to the Department of Veterans Affairs: Office of Management and Budget, "Budget of the United States Government, Fiscal Year 2003 [2004, 2005]—Appendix," http://www.whitehouse.gov/omb; Department of Veterans Affairs, "2006 Congressional Submission: Medical Programs," p. 3B-5. Levels of 2004 acute hospital and outpatient care operating expense appropriations in the OMB budget appendix are not directly comparable to amounts in prior years' budgets, due to a change in the account structure for the medical care business lines. The VA 2006 Congressional Submission is used as the source of 2004 appropriations instead because it provides appropriations by service type under both account structures.

[39] "Other sources" include CHAMPUS/Tricare, CHAMPVA, Medicare, Medicaid, SCHIP, and all private plans. Although VA is the main payer for CHAMPVA, it is a form of insurance rather than direct care; services may be received at non-VA facilities for persons covered by CHAMPVA. As such, budget appropriations for CHAMPVA are excluded in estimating care provided to the uninsured.

emergency room, outpatient care, or overnight hospital stays to lack insurance.[40] In 2003, VHA conducted a survey of enrollees (rather than service users) and found that 22.2 percent were uninsured in the previous year.[41] Both VA surveys closely match the CPS estimates.

Applying the CPS percentage of uninsured users to the amount of spending on acute hospital and outpatient care services produces an estimate of $3.2 billion of care to the uninsured in 2001. Spending on the uninsured grew to $3.9 billion in 2003 and $4.2 billion in 2004 (Table 2). Overall, direct medical care spending on the uninsured represented 12 to 15 percent of the total VA health care budget in the period from 2001 to 2004.

Eligibility for this care source, however, is limited to a specific and finite population: veterans with VA access, or about 5 million of the estimated 25 million U.S. veterans. An additional 1.7 million veterans are estimated to have neither health insurance nor received VA care in 2003.[42] VA frequently notes that its resources are intended only for its "highest priority core veterans"—veterans with service-connected disabilities, those with lower incomes, and veterans with special health care needs.[43]

Indian Health Service

The Indian Health Service (IHS), a discretionary program of the Department of Health and Human Services, operates a comprehensive health service delivery system for approximately 1.6 million of the nation's estimated 2.6 million American Indians and Alaska Natives. Since 1921 the Snyder Act has authorized federal funding "for the relief of distress and conservation of health...[and]...for the employment of...physicians...for Indians tribes throughout the United States."[44] Adhering to the IHS mission of providing tribes maximum participation in delivering services, tribes may either enter the IHS-administered direct health system or assume from IHS the administration and operation of health services in their community. In total, the IHS delivery system is quite extensive: 36 hospitals, 61 health centers, and 49 health stations are operated by the federal system; and 13 hospitals, 158 health centers, 76 health stations, and 170 Alaska village clinics are tribally operated.[45] Additional services are purchased from over 9,000 private providers each year.

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[40] Department of Veterans Affairs, "2001 National Survey of Veterans," March 2003, p. 171, 183. The upper value of the uninsurance range includes the 0.7 percent of users with unknown coverage.

[41] Department of Veterans Affairs, Veterans Health Administration, "Survey of Veteran Enrollees' Health and Reliance Upon VA: 2002 & 1999," December 2003.

[42] S. Woolhandler, et al., "America's Neglected Veterans: 1.7 Million Who Served Have No Health Coverage," *International Journal of Health Services*, 35 no. 2 (2005): 313-323.

[43] Department of Veterans Affairs, "2005 Congressional Submission: Medical Programs," p. 3B-2, 3B-5.

[44] Indian Health Service, HHS, "Indian Health Service Fact Sheet," March 29, 2004, www.ihs.gov/PublicInfo/ PublicAffairs/Welcome_Info/ThisFacts.asp.

[45] Ibid.

Federal appropriations to IHS in FY 2004 totaled $2.9 billion.[46] The share of this IHS funding devoted to care to the uninsured is estimated as the cost of uncompensated acute medical care services. "Acute medical care services" are defined as services at hospitals, health clinics, and contract health services. Approximately two-thirds of IHS appropriations pay for acute medical services.

"Uncompensated care" is defined as those costs not paid for by insurance collections or third party payers. Because program level breakdowns of the IHS budget allocate all insurance collections to the hospitals and clinics budget line,[47] our calculations also consider 100 percent of insurance collections as paying for acute medical care. Employing this set of assumptions and calculations, total IHS funding for care to the uninsured is estimated to range from $1.28 billion in 2001 to $1.31 billion in 2004 (Table 3).

Table 3

Indian Health Service Appropriations for Acute Care to the Uninsured ($millions)

	2001	2002	2003	2004
Acute Care Services:				
Hospitals and health clinics	$1,121	$1,153	$1,212	$1,250
Contract health services	446	461	475	479
Support costs for acute care services*	188	204	206	204
Total Funding, Acute Care	1,755	1,818	1,893	1,933
Insurance Collections:				
Medicaid	321	375	418	446
Medicare	117	109	119	129
Private Insurance	41	44	49	53
Total, Insurance Collections	479	529	586	628
Total Support for Care to the Uninsured**	$1,276	$1,289	$1,307	$1,305

Notes:

* Contract support costs include administration, utilities, training, support staff, and other services. (Source: FY 2003 IHS Budget Justification, p. 23). The percentage of non-support costs devoted to acute care in each year - approximately 76% - is used to estimate support costs for acute care.

** Total funding minus insurance collections

Source: FY 2000 - 2006 IHS Budget Justifications, Program Level Funding Summary Reports, www.ihs.gov/AdminMngrResources/ Budget/index.asp.

[46] The Budget Authority total (equal to the program level total after subtracting third party insurance collections and the separately-budgeted diabetes program appropriation). Funding data are from Indian Health Service, "Justification of Estimates for Appropriations Committees, FY 2003," Program Level Funding Summary Reports, www.ihs.gov/AdminMngrResources/Budget/index.asp.

[47] Indian Health Service, FY 2003 Budget Justification, Breakdown of Program Level, p. 10-11.

The sluggish growth in federal funding for IHS care to the uninsured is largely the result of negligible increases in appropriations for acute care services, and IHS health care more generally. Acute care funding grew by 10.1 percent between 2001 and 2004, while insurance collections increased by more than three times as much, 31.1 percent. The insufficient federal financing of IHS is well documented.[48] For facilities that exhaust funding midway through a year, waiting lists may be required or services may be limited to patients with emergency or priority status.[49]

Community Health Centers

The community health centers program was established in 1965 with the mission of providing affordable and comprehensive primary health care to the medically underserved. Now a central component of the health care safety net, health centers serve a disproportionately low-income and uninsured patient population, adjusting charges in accordance with patients' ability to pay. In 2003, the most recent year for which data are available on federally-supported health centers, over 12 million patients were served at approximately 5,000 urban and rural sites.[50] Around 5 million or 40 percent of those patients were uninsured. The uninsured's share rose 11 percent from the previous year.

Although individual centers may differ in size, management, or patient mix, to qualify for federal funding under section 330 of the Public Health Service Act, 42 USC § 254b, a center must provide a defined set of medical and enabling services. The term "federal funding" here should not be equated with "full federal funding"; grants from federal sources provide only 26 percent of health center revenue on average. Medicaid is the largest source of revenue for health centers, representing 36 percent of total income and 64 percent of patient-related income. In addition to federally-qualified health centers, many "look alike" centers meet federal grant requirements but receive no grant funding. The National Association of Community Health Centers (NACHC) reports that less than one of ten qualified applications for new health center sites were approved for funding in FY 2004 due to availability of funds.[51]

Data used to estimate funding for uninsured patients at health centers are from the Uniform Data System (UDS) supported by the Bureau of Primary Health Care (BPHC), the agency of the Health Resources and Services Administration (HRSA) responsible for administering grants to health centers. UDS data are well-suited for this analysis in that they report charges by patients' insurance type.

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[48] Noren et al., 1998; Schneider, 2005.

[49] See, for example, Guiden and Johnson, "New Challenges for States: Indian Health Care," *State Legislatures*, June 2000, p.1, www.ncsl.org/programs/pubs/600IND.HTM.

[50] Data are from Bureau of Primary Health Care, HRSA, Uniform Data System, National Rollup Reports 2000-2003.

[51] Proser, Shin, Hawkins, "A Nation's Health at Risk III," March 2005, p. 12.

Direct medical care costs, which comprise about 72 percent of total costs, are defined as those for medical staff, labs, x-rays, the UDS "medical/other direct" category, and pharmacy. Dental, mental health, substance abuse, enabling, and other service costs are excluded. Because costs for each insurance group are not broken down by type of service, we assume that self-pay patients use direct care services at the same rate (around 72 percent depending on the year) as insured patients. Total direct care costs increased from $3.23 billion in 2001 to an estimated $4.83 billion in 2004 (Table 4).

Self-pay (uninsured) patients account for roughly 32 percent of total charges at health centers nationwide. Their direct care costs are calculated by multiplying this percentage by the total costs for direct care at health centers. In doing so, we assume that self-pay patients' share of costs is the same as their share of charges. This assumption holds up quite well for the managed care patient groups.[52] The total cost of direct care used

Table 4
Federally Qualified Health Centers: Federal Grants for Uncompensated Care to the Uninsured ($millions)

	2001	2002	2003	Est. 2004[e]
Direct medical costs[a]	$ 2,915	$ 3,405	$ 3,874	$ 4,300
Pharmacy costs	313	370	437	525
Total direct care costs	3,228	3,774	4,312	4,825
Self-pay patients' share of charges	31.9%	31.2%	31.8%	31.8%
Self-pay patients' direct care costs[c]	1,030	1,177	1,371	1,534
Self-pay patients' uncompensated direct care costs[b]	766	873	1,019	1,143
Federal share of non-patient revenues	55.8%	56.2%	57.4%	58.3%
Uncompensated care to uninsured paid by fed. grants[d]	$ 427	$ 491	$ 585	$ 667

Notes:

[a] Includes costs for medical staff, lab and x-ray, other direct medical, and proportionate administrative and facility costs.

[b] Costs minus collections from self-pay patients

[c] Share of charges applied to total direct care costs

[d] Calculated by multiplying uncompensated care costs by federal share of non-patient revenues

[e] 2004 aggregate data becomes available in July, 2005. The 2004 estimates assume a 12% overall growth in direct medical costs (20% growth in pharmacy costs and 11% growth in non-pharmacy direct med. costs), the same growth in self-pay collections (12%), and 1.06% growth in the federal share of non-patient revenue (average of 2000 - 2003 values).

Source: Bureau of Primary Health Care, HRSA, Uniform Data System, National Rollup Report, 2000-2003.

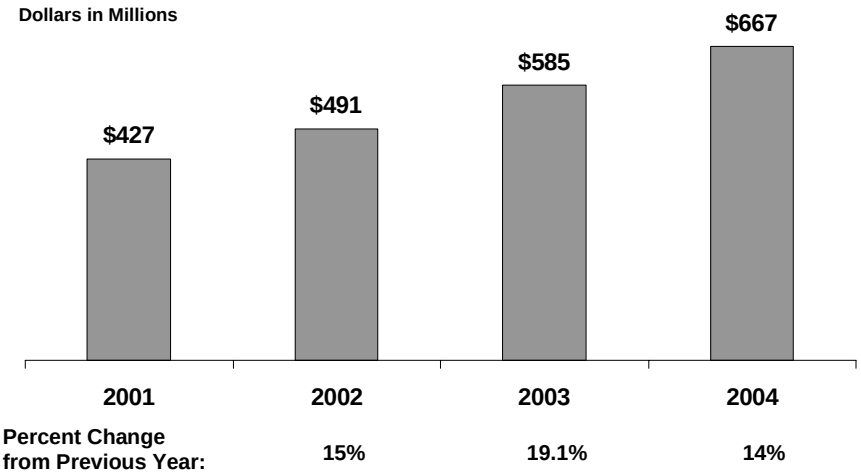
[52] The specific costs incurred by self-pay and non-managed care patients are not reported; however, such data are available for Medicaid, Medicare, other public, and private managed care patients. Cost and charge distributions trended similarly for these patient groups in 2003. The percent of total managed care costs incurred by each group of patients was: Medicaid, 80.9 percent; Medicare, 1.6 percent; other public, 7.0 percent; private, 10.6 percent. The share of managed care charges was: Medicaid, 82.3 percent; Medicare, 1.5 percent; other public, 6.6 percent; private, 9.7 percent. Derived from Tables 9C and 9D of the 2003 Rollup Report.

by self-pay patients is therefore estimated to range from $1.0 billion in 2001 to $1.5 billion in 2004. About one-fourth of these costs are recovered in the form of self-pay patients' out-of-pocket payments (the remaining three-fourths are exempted as sliding discounts or considered bad debt). Subtracting these payments, the total cost of uncompensated direct care to uninsured patients is found to be $0.8 billion in 2001 and $1.1 billion in 2004.

The share paid for by federal sources, mostly BPHC, is estimated to be the same as the federal share of non-patient revenue, or an average of 56.9 percent from 2001 to 2004 (the state and local share is about 30 percent). Therefore, assuming that the sources of non-patient revenue—federal grants, state and local grants, revenue from indigent care programs, etc.—pay for uncompensated care to the uninsured in the same proportion that they contribute to total non-patient revenue,[53] the corresponding amount of federal funding for direct care to the uninsured ranges from $427 million in 2001 to $667 million in 2004 (Figure 3).

Figure 3

Community Health Centers: Federal Grants for Uncompensated Care to the Uninsured, 2001-2004



[53] We recognize that variations in health center spending by patient mix *and* by region, state, and rural vs. urban may exist. However, we find no evidence of patient mix and financing mix interacting in certain regions or areas with enough magnitude to alter the national total of uncompensated care calculated (or at least not enough to justify making separate uncompensated care calculations by region or state to determine the exact magnitude). Markus et al., 2002, using logistic regression analysis of 1998 UDS data, find that health centers serving an extremely high proportion of uninsured patients are significantly more likely to be in the South and West ($p<.01$ and $p<.03$) and be in an urban area ($p<.0001$). However, they also find those health centers to be significantly more likely to have a higher proportion of total revenues from grants than from Medicaid ($p<.0001$). Also see IOM, "A Shared Destiny," 2003, p. 44-46 for a discussion of variations in patient and financing mixes at community health centers by rural and urban differences, especially as it relates to uncompensated care.

Ryan White CARE Act

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, administered by HRSA, is the largest source of federal discretionary funding for care to persons living with HIV and AIDS. With a FY 2004 appropriation of $2.04 billion, CARE provides a range of outpatient and inpatient services, medications, and support services to low income, uninsured, and underinsured persons. Over 500,000 individuals each year are reached by the program. Medicaid and Medicare (entitlement programs) are the largest general sources of spending on care for people with HIV/AIDS in the U.S. Medicaid is estimated to provide $5.4 billion in HIV/AIDS care in FY 2004; Medicare, $2.6 billion.[54]

Most federal CARE Act funding is divided among its four Titles. Title I, receiving about 30 percent of CARE allocations each year, provides emergency assistance to the metropolitan areas most affected by the HIV/AIDS epidemic. Title II receives just over half of CARE allocations, primarily funding the AIDS Drug Assistance Program (ADAP). The remainder of Title II monies go to states to provide medical care and outreach services. Title III offers grants to independent nonprofits and public programs that concentrate mainly on early intervention, and Title IV grants serve women, infants, children, and families affected by HIV/AIDS. The balance is dedicated to Special Projects of National Significance (SPNS), the Dental Reimbursement Program, and HIV/AIDS Education Training Centers. Our estimate of uncompensated care to uninsured patients, however, draws only on Title I and II funding. These Titles fund the bulk of direct medical care delivered via the CARE Act and avoid double-counting of funds: a portion of Title III allocations are directed to BPHC for health centers, and some of Title IV funding is spent on MCHB services.

To estimate the uninsured's uncompensated care, we split federal allocations into three service categories: ADAP; acute care—consisting of ambulatory care, outpatient care, and non-ADAP medications; and health insurance purchasing (HIP). For those without health insurance coverage, Title I and II funding may be used to purchase insurance services or the individual's existing coverage may be extended through COBRA (Consolidated Omnibus Reconciliation Act). HIPs often support insurance coverage while Medicaid or Medicare eligibility is being determined.[55]

All data on federal allocations used to calculate uncompensated care are from the HIV/AIDS Bureau's (HAB) annual Title I and Title II reports of allocations to grantees by service type.[56] The reports present separate nationwide tables of federal allocations for each Title, broken down by specific service type. From 2001 to 2004, ADAP's portion of total allocations has grown an average of 8 percent each year while other portions have

[54] Summers and Kates, "Trends in U.S. Government Funding for HIV/AIDS: Fiscal Years 1981 to 2004," Kaiser Family Foundation, March 2004.

[55] For a full discussion of health insurance purchasing under CARE, see HIV/AIDS Bureau, "Ryan White CARE Act 2001 Data Report," 2001, http://hab.hrsa.gov/reports/saar2001/saar2001report.htm.

[56] HIV/AIDS Bureau, HRSA, Program Allocations by Service Type, Title I: 2000-2004, Title II: 2000-2003, http://hab.hrsa.gov/reports/data2b.htm.

stagnated. In current and inflation-adjusted terms, every category of the Ryan White budget declined in FY 2004 and FY 2005 except ADAP. ADAP's more rapid growth has partly been a response to significant increases in program costs, enrollment, and increasing demand for antiretroviral medications.[57]

Data on the insurance status of individuals served by the broader CARE Act are not systematically collected. However, the National ADAP Monitoring Project consistently reports the percentage of ADAP patients with Medicaid, Medicare, and private insurance coverage annually. We use the remaining share of patients as the share uninsured for ADAP: about 70 to 75 percent.[58]

For acute medical care, we present two estimates of the share of uninsured patients derived from the HAB 2002 Annual Data Report, which provides data on 2,696 providers, or virtually all CARE grantees. The low estimate of 21 percent uninsured represents the percent of duplicated clients receiving CARE services who reported having no medical insurance; the high estimate—51 percent—represents the share with no coverage or unknown coverage.[59] HAB estimates that most clients with unknown coverage in 1999 were uninsured.[60] Finally, among persons with health insurance purchased or continued through CARE, 100 percent of funds are assumed to be devoted to the uninsured (or the would-be uninsured were it not for the HIP-bought coverage).

Applying these percentages to their associated direct care allocations results in a federal contribution of $519 to $591 million in care to the uninsured in 2001 (Table 5). Federal spending was $609 to $685 million in 2003 and in 2004.

Maternal and Child Health Bureau

The Title V Maternal and Child Health Block Grant of the 1935 Social Security Act is the only federal program with the explicit and primary aim of improving the health of all mothers and children in the U.S. It represents the bulk of spending (approximately 80 percent) by the Maternal and Child Health Bureau (MCHB), the HRSA agency administering Title V. With particular emphasis given to low-income, uninsured, and underinsured persons, Title V programs serve over 28 million pregnant women and children, including children with special health care needs, each year.[61] Underserved urban and rural areas are also specifically targeted.

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[57] Many states chose to add some of their Title II base funds to their ADAP in this way. See HAB, "AIDS Drug Assistance Program Funding Overview," July 2004.

[58] National ADAP Monitoring Project, 2000-2005 Annual Reports.

[59] HAB, "Ryan White CARE Act Annual Data Summary," 2002, p. 12.

[60] HAB, "Who the CARE Act Serves: 1999 Annual Program Data," http://hab.hrsa.gov/reports/rp22.htm.

[61] Maternal and Child Health Bureau, Title V Information System (TVIS), "Program Data: Number of Individuals Served by Title V, by Class of Individuals," https://performance.hrsa.gov/mchb/mchreports.

Table 5
Ryan White CARE Act Allocations for Medical Care to the Uninsured ($millions)

Titles I & II Allocations	2001	2002	2003	2004
AIDS Drug Assistance Program (ADAP) allocations[a]	$ 623	$ 680	$ 745	$ 775
Percent of users uninsured[b]	73%	71%	72%	69%
ADAP care to the uninsured	455	483	536	534
Acute medical care allocations[c]	$ 242	$ 242	$ 256	$ 257
Percent of users uninsured[d]	21-51%	21-51%	21-51%	21-51%
Acute medical care to the uninsured	51 - 124	51 - 124	54 - 131	54 - 131
Health insurance purchasing & continuation allocations[e]	$ 13	$ 17	$ 19	$ 19
Percent of users otherwise uninsured	100%	100%	100%	100%
Health insurance for otherwise uninsured	13	17	19	19
Total CARE Act Allocations for Care to Uninsured[f]	$ 519 - 591	$ 550 - 623	$ 608 - 685	$607 - 684

Notes:

[a] Includes a proportionate amount of funding for administration. (Source: HIV/AIDS Bureau, HRSA, Program Allocations by Service Type, Title I: 2000-2004, Title II: 2000-2003, http://hab.hrsa.gov/reports/data2b.htm).

[b] The National ADAP Monitoring Project reports percentages of users with Medicaid, Medicare (since 2000), and private insurance coverage; the remainder are considered uninsured. (Source: National ADAP Monitoring Project, 2000-2005 Annual Reports.)

[c] Sum of all Title I and II allocations to states and eligible metropolitan areas for acute medical care--ambulatory and outpatient care, non-ADAP pharmacy, and a proportionate amount of administration funding. The Title I total includes acute care allocations to the Minority AIDS Initiative; the Title II total includes acute care allocated to the Emerging Communities program. (Source: HIV/AIDS Bureau, HRSA, Program Allocations by Service Type, Title I: 2000-2004, Title II: 2000-2003, http://hab.hrsa.gov/reports/data2b.htm). Title II funding in 2004 is unavailable; 2004 acute medical care and HIC values were imputed using the rate of decline of total Title I & II allocations in the federal budget from 2003 to 2004: -0.6%, or 99.4% of 2003 funding.

[d] The low estimate represents the percent of duplicated clients receiving CARE Act services in 2002 who reported having no medical insurance; the high estimate represents the percent with no coverage or unknown insurance coverage. (Source: HIV/AIDS Bureau, "Ryan White CARE Act Annual Data Summary, 2002," http://hab.hrsa.gov/reports/2002_Data_Summary/page3.htm). HAB estimates that most clients with unknown coverage in 1999 were uninsured. (Source: HIV/AIDS Bureau, "Who the CARE Act Serves: 1999 Annual Program Data," http://hab.hrsa.gov/reports/rp22.htm).

[e] Sum of all Title I and II allocations to states and EMAs for health insurance purchasing & continuation. See (c).

[f] Sum of allocations for ADAP care to unins., acute medical care to unins., health insurance purchasing for unins.

The Title V Maternal and Child Health Block Grant has operated as a federal-state partnership since its original authorization, with states required to spend $3 for every $4 in federal funding provided. Most states contribute significantly more now, and account for roughly three-fourths of all non-patient income.[62] Federal funds make up about 15 percent of the total. These funds are used by state programs to administer a broad range of enabling, population-based, and direct health care services, including prenatal, postnatal, and preventative care, health education, family support, transportation, translation, and immunization. Direct gap-filling health care services, however, are the heart of Title V programs. Such services accounted for nearly 60 percent of total Title V spending in 2003.[63]

Data from the Title V Information System show that the share of Title V patients without health insurance coverage grew from 12.7 percent in 2000 to 14.1 percent in 2003. The uninsurance rate rose for all categories of users except children with special health care needs (CSHCN) and "others."[64] Applying this percentage to total direct health care spending results in $300 to $400 million of direct health care expenditures for the uninsured. The portion of this paid for by federal grants is estimated to be only $54 to $60 million, based on the federal MCHB funding share of all revenues from non-patient sources (Table 6).

Table 6
Maternal and Child Health Bureau Funding for Direct Care to the Uninsured ($millions)

	2000	2001	2002	2003	Est. 2004
Expenditures on direct health care services	$ 2,576	NA	NA	$ 2,787	$ 2,863
Percent of users uninsured	12.7%	NA	NA	14.1%	14.6%
Expenditures on uninsured users[a]	$ 327	NA	NA	$ 393	$ 418
Federal percent of non-patient income	16.4%	16.0%	15.4%	15.3%	15.0%
Total MCHB funding for direct care to uninsured[b]	$ 54	$ 56[c]	$ 58[c]	$ 60	$ 63

[a] Percent of users uninsured applied to direct health care expenditures

[b] Federal percent of non-patient income applied to expenditures on uninsured users

[c] Interpolated from 2000 and 2003 values.

Source: Maternal and Child Health Bureau, HRSA, Title V Information System (TVIS), 2000-2003, https://performance.hrsa.gov/mchb/mchreports.

[62] Analysis of TVIS data. See MCHB table. "States" refers to state and local sources.

[63] Maternal and Child Health Bureau, TVIS, "Federal-State Title V Block Grant Partnership Expenditures by Category of Service," https://performance.hrsa.gov/mchb/mchreports.

[64] The "other" category is the residual after excluding pregnant women, infants, children ages 1 to 22, and CSHCN.

National Health Service Corps

The self-stated mission of the National Health Service Corps (NHSC) is to improve the health of medically underserved persons by recruiting health professionals to serve in communities with the greatest need.[65] NHSC assists physicians and health professionals in training and with the cost of education in return for commitments to serve in areas with a shortage of primary health care access. The bulk of NHSC appropriations—$124 million in FY 2004—fund the scholarships and loan repayment programs for these health professionals,[66] which are not considered direct care and therefore not included in the estimate of care to the uninsured. $45 million is devoted to the facilities at which these clinicians serve.[67]

NHSC is closely aligned with the Bureau of Primary Health Care and its health centers, with half of NHSC clinicians currently serving in community health centers.[68] To avoid double counting uncompensated care to the uninsured in health centers, the NHSC Uniform Data System (UDS) only reports data for NHSC sites that do not receive BPHC grant support.[69]

The algorithm for computing care to the uninsured at NHSC sites is similar to that used with community health centers. Federal sources, however, provide only a minimal share of non-patient income at these sites—between 5 and 10 percent of the total. Federal spending on care to the uninsured is estimated to be only $6 million in 2003 (Table 7). The total drops as low as $3.6 million in 2001.

Table 7
National Health Service Corps: Federal Grants for Uncompensated Care to the Uninsured ($millions)

	2001	2002	2003	Est. 2004
Total expenses at NHSC sites*	$515.2	$552.4	$724.6	$871.9
Self-pay patients' unpaid charges as % of all NHSC charges	14.5%	11.9%	10.5%	9.1%
Self-pay patients' uncompensated expenses	$74.7	$66.0	$75.9	$79.3
Federal share of (non-patient) income	4.9%	9.6%	7.9%	7.5%
Federal spending for care to the uninsured	$3.6	$6.3	$6.0	$5.9

*Only NHSC sites that do not receive BPHC grant support included.

Source: NHSC Uniform Data System, National Rollup Reports, 2000-2003.

[65] National Health Service Corps, "About NHSC," 2003, http://nhsc.bhpr.hrsa.gov/about/.
[66] Office of Management and Budget, "Budget of the United States Government, Fiscal Year 2006—Appendix," http://www.whitehouse.gov/omb.
[67] Ibid.
[68] Department of Health and Human Services, "FY 2006 Budget in Brief: Health Resources and Services Administration," http://www.hhs.gov/budget/06budget/healthres.html.
[69] NHSC Uniform Data System, National Rollup Reports, 2000-2003.

Summary of Direct Care Program Spending

Table 8 summarizes the estimates of total federal support for the cost of care used by uninsured persons receiving care from either federal direct care programs (the VHA and the IHS) or non-federal clinics and health care programs that receive discretionary federal funding. Total federal support grew from $5.6 billion in 2001 to $6.9 billion in 2004. The VHA and the IHS are the two largest sources of care, accounting for almost 80 percent of the federal funds received by the six programs in 2004.

Table 8
Federal Funding for Direct Care Programs and Clinics to Support Care to the Uninsured ($millions)

	2001	2002	2003	2004
1. Veterans Health Administration (VHA)	$ 3,235	$ 3,143	$ 3,870	$ 4,182
2. Indian Health Service (IHS)	1,276	1,289	1,307	1,305
3. Bureau of Primary Health Care (BPHC)	427	491	585	667
4. Ryan White CARE Act	519-591	550-623	608-685	607-684
5. Maternal and Child Health Bureau (MCHB)	56	58	60	*63*
6. National Health Service Corps (NHSC)	4	6	6	*6*
TOTAL*	$ 5,553	$ 5,574	$ 6,475	$ 6,869

* Uses midpoint of the CARE/Ryan White funding estimate

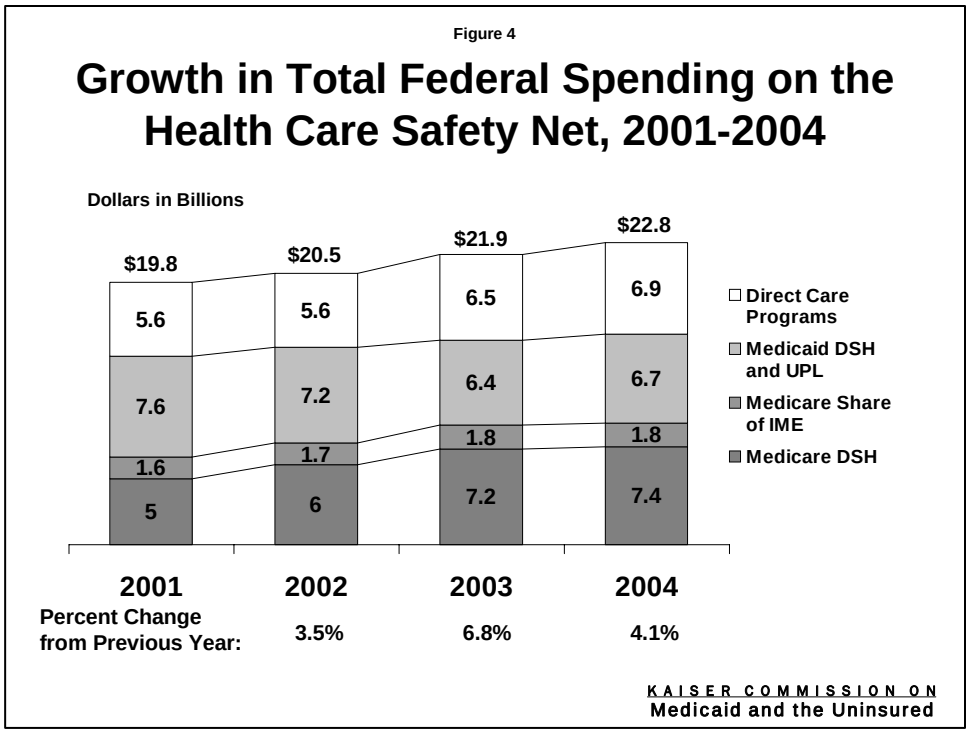
FEDERAL SPENDING ON THE SAFETY NET AND THE NUMBER OF UNINSURED

Combining information from Tables 1 – 8, total federal spending in support of the health care safety net grew from $19.8 billion in 2001 to $22.8 billion in 2004 (Table 9 and Figure 4), an increase of 15.4 percent. This overall increase reflects a decline in Medicaid spending through its DSH and UPL programs from $7.6 to $6.7 billion, which was more than offset by increases in Medicare spending from $6.6 billion to $9.2 billion and increases in federal support for discretionary spending programs from $5.6 to $6.9 billion. Federal support for community health centers, which have been the focal point

Table 9
Total Federal Spending on The Health Care Safety Net ($billions)

	2001	2002	2003	2004	*% 2004 Total*	*% Change 2001-2004*
Medicare	$ 6.6	$ 7.7	$ 9.0	$ 9.2	*40.4*	*39.4*
Medicare DSH	5.0	6.0	7.2	7.4	*32.5*	*48.0*
Medicare Share of IME	1.6	1.7	1.8	1.8	*7.9*	*12.5*
Medicaid DSH and UPL	$ 7.6	$ 7.2	$ 6.4	$ 6.7	*29.4*	*-11.8*
Direct Care Programs	$ 5.6	$ 5.6	$ 6.5	$ 6.9	*30.1*	*23.7*
VHA	3.23	3.14	3.87	4.18	*18.3*	*29.3*
IHS	1.28	1.29	1.31	1.30	*5.7*	*2.2*
Health Centers	0.43	0.49	0.58	0.67	*2.9*	*56.0*
Ryan White CARE	0.55	0.59	0.65	0.65	*2.8*	*16.3*
MCHB	0.06	0.06	0.06	0.06	*0.3*	*12.5*
NHSC	0.00	0.01	0.01	0.01	*0.0*	*64.5*
Total, All Federal Sources	$ 19.8	$ 20.5	$ 21.9	$ 22.8	*100.0*	*15.4*

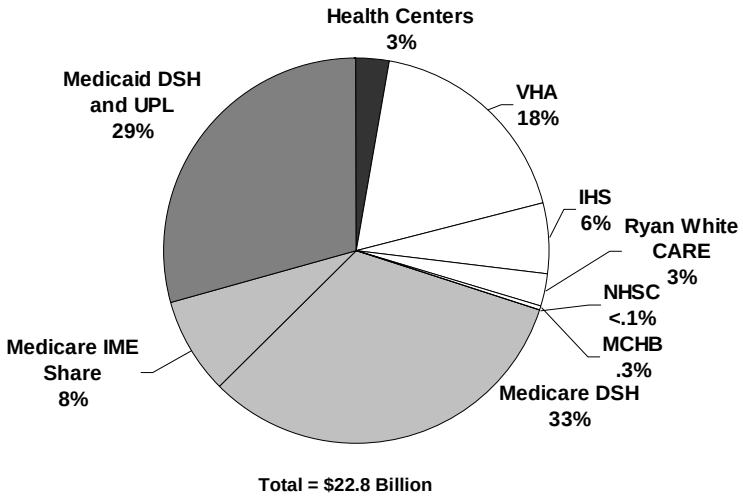
Figure 4



of the Administration's policy for providing care to the uninsured, increased by more than 50 percent, from $0.43 billion to $0.67 billion. However, in 2004, community health centers accounted for less than 3 percent of total federal spending on the safety net (Figure 5).

Figure 5

Total Federal Spending on the Health Care Safety Net by Source, 2004



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The spending figures reported in Tables 1 – 9 are expressed in current dollars. However, the cost of medical care, as measured by the medical care component of the consumer price index, increased by almost 14 percent between 2001 and 2004. Adjusting for inflation and expressing federal spending in constant 2004 dollars shows that total spending increased only by 1.3 percent between 2001 and 2004 (Table 10).

Table 10
Total Inflation-Adjusted Federal Spending on The Health Care Safety Net (billions of 2004 $s), and Number of Uninsured

	2001	2002	2003	2004	*% Change 2001-2004*
Total Federal Spending	$ 22.5	$ 22.3	$ 22.9	$ 22.8	*+1.3%*
Number of Uninsured (000's)	41,207	43,574	44,961	45,820	*+11.2%*
Federal Spending per Uninsured Person	$ 546	$ 512	$ 509	$ 498	*- 8.9%*

To gauge the magnitudes of these changes, the total number of uninsured Americans increased by 11.2% percent between 2001 and 2004, or from 41.2 million to 45.8 million people. As a result, federal spending per uninsured person decreased by 8.9%, from $546 per uninsured person in 2001 to $498 in 2004, a decline of 8.9% (Figures 6 and 7). These figures suggest that overall federal support of the safety net has not kept pace with the increase in the number of uninsured Americans.

Figure 6

Inflation-Adjusted Federal Spending per Uninsured Person vs. the Number of Uninsured, 2001-2004

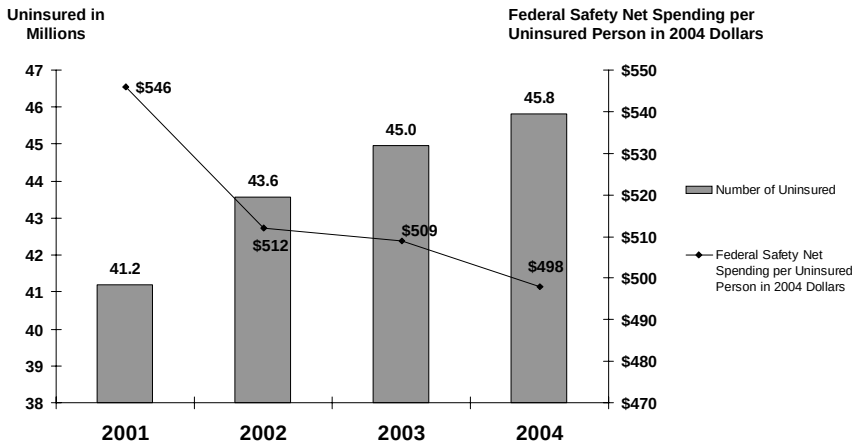

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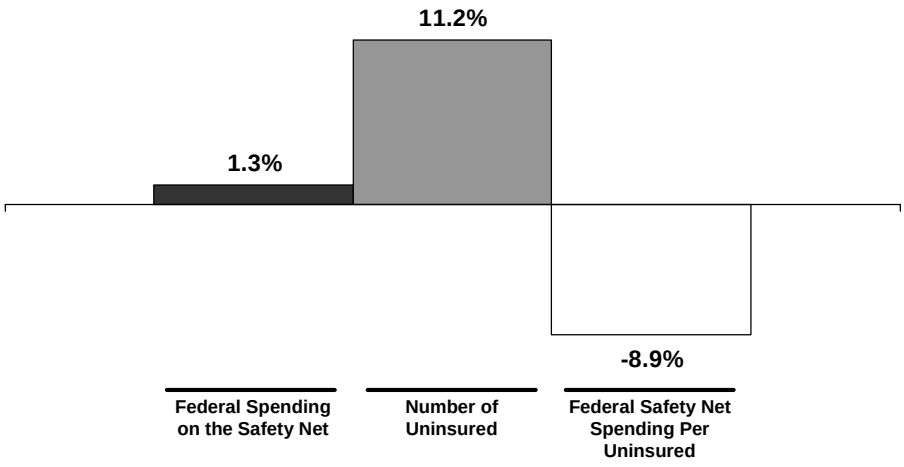
Figure 7

Percent Change in Inflation-Adjusted Total Federal Spending, the Number of Uninsured, and Federal Spending per Uninsured, 2001-2004



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DISCUSSION

The Importance of the Safety Net in Care for the Uninsured

Even with a substantial boost from uncompensated care, the uninsured still receive much less medical care than the insured. In 2004, a person uninsured for the full year received just over $1,600 of care, with more than half of this amount coming from uncompensated care. Nevertheless, this amount represents about 45% less care received than a fully-insured person, who had almost $3,000 in medical care spending.[70]

Some argue that the uninsured are healthier and/or are less likely than the insured to perceive a need for medical care, and if they do get sick, they'll receive the care they need from safety-net providers.[71] However, a substantial body of other research suggests that these arguments are exaggerated. For example, one recent study found that uninsured adults were more likely than insured non-elderly adults to report the recent onset of a new symptom associated with a specific list of 15 potentially serious conditions.[72] Moreover, the uninsured were equally likely to perceive that they needed to obtain medical care, but only half as likely to actually contact a doctor or health care provider.[73] Studies have consistently shown that the uninsured are two-to-three times more likely to have unmet needs for medical care[74] and are less likely to be screened for preventable illnesses.[75] Other research has found that the uninsured are less likely to receive medical care, even when diagnosed with a treatable chronic condition[76] or when admitted to a hospital for a heart attack, a major trauma, or a serious automobile accident.[77] One study found that even uninsured newborns with serious conditions received significantly less care than insured newborns.[78]

Although these findings are both pervasive and compelling, they still leave open the possibility that the insured receive too much care, i.e., that the differences in care received reflect the uninsured receiving the "just right" amount of care while the insured receive a substantial amount of unnecessary care that has no payoff in terms of better health outcomes. If this line of reasoning is correct, then we would expect to find few differences in health outcomes between insured and uninsured people. While not absolutely definitive, the bulk of the research evidence on this question suggests that the uninsured do in fact have poorer health outcomes, both in general and for specific diseases where research has also found that the uninsured are more likely to be diagnosed at a more advanced disease stage and less likely to receive as much

[70] Hadley and Holahan, 2004.
[71] Devon, 2000.
[72] Hadley and Cunningham, 2005.
[73] Hadley and Cunningham, 2005; Baker, Shapiro and Schur, 2000.
[74] Strunk and Cunningham,2004; Hoffman and Schlobohm, 2000.
[75] Nelson et al., 2005; Ayanian et al., 2000; Breen et al., 2000.
[76] Families USA, 2001; Nelson et al., 2005; Obrador et al., 1999.
[77] Doyle, 2005; Sada et al., 1998; Haas and Goldman, 2004.
[78] Braveman et al., 1991.

treatment as the insured.[79] These studies have analyzed outcomes for people with various types of cancers,[80] heart attacks,[81] severe traumas,[82] infant mortality,[83] and general mortality.[84]

Can the Safety Net Keep Pace with the Needs of the Uninsured?

Since 2001, about 4.6 million more Americans have become uninsured. Although direct data are not available, indications are that state and local governments have probably not been able to maintain, let alone increase their level of support for safety-net funding. The economic recession that began in 2001 coupled with double-digit increases in private insurance premiums have led to a significant drop in the number of people covered by employer-based private insurance. Medicaid and SCHIP picked up many, but not all of the people losing or dropping private coverage. As a result, state spending on Medicaid grew by an average of 11.7% per year in 2001 and 2002, while the recession was causing a substantial slowdown in state tax revenue growth, which was only 2% in 2001 and turned negative in 2002 and 2003.[85]

Federal spending constitutes roughly half of the total funds (and two-thirds of all government spending) available to support uncompensated care received by uninsured people.[86] However, federal dollars for the safety net make up very small shares of total federal spending for health care and of the total federal budget. Between 2001 and 2004, federal safety net spending increased by 15.4%, while total federal health care spending increased by 23% and the total federal budget increased by 25.9%. As a result, the federal commitment to the safety net has actually been shrinking, from 4.3% of total federal health spending in 2001 to 3.9% in 2004. Federal spending on the safety net represents just 1% of total federal spending.

Given the importance of federal spending relative to the amount of uncompensated care received by the uninsured, but its relative insignificance to total federal spending, it is important to assess whether the network of federal programs and agencies that support the safety-net is an adequate and reliable source of funding. The trend over the last four years shows that inflation-adjusted federal spending has not kept pace with the growth in the size of the uninsured population. The number of uninsured grew by over 11%, while inflation-adjusted federal spending remained virtually unchanged, increasing by just over 1%. Consequently, federal spending on the safety-net per uninsured person has fallen by almost 9%.

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[79] Hadley, 2003; Institute of Medicine, 2002.
[80] Ayanian et al., 1993; Roetzheim, Pal et al., 2000; Roezheim, Gonzales et al., 2000.
[81] Canto et al., 2000; Young and Cohen, 1991.
[82] Doyle, 2005; Li and Davis, 2001; Hass and Goldman, 1994.
[83] Moss and Carver 1998; Braveman et al. 1989.
[84] Hadley and Waidmann 2005; Sorlie et al. 1994; Franks, Clancy and Gold 1993.
[85] Kaiser Commission on Medicaid and the Uninsured. "Immediate State Fiscal Crisis Subsides, but Medicaid Still Faces Long-Term Budgetary Challenges," News Release, Washington DC: Kaiser Family Foundation, October 19, 2005.
[86] Hadley and Holahan, 2004.

Although this may not seem like a large discrepancy, it is unlikely that future funding will be able to close the gap or make up the difference. More than 70% of the federal money flows through the Medicare and Medicaid programs, both of which are under severe budgetary pressures. Medicare is about to implement a major and costly benefit expansion to help pay for prescription drugs for its beneficiaries. The program is also looking for ways to constrain substantial cost increases that occurred over the last few years and, of course, is bracing for the imminent impact on spending of the baby boom generation's aging into eligibility. Under these circumstances, money to support disproportionate share and indirect medical education payments may be harder and harder to justify.

The Medicaid program faces similar pressures at both the federal and state level. The Congress, with the advice of a Commission established by the Secretary of Health and Human Services, seeks to trim $10 billion from federal Medicaid spending over the next five years. Although not a large share of total Medicaid spending, it comes at a time when pressures on Medicaid's state and federal budgets have been growing because of substantial increases in Medicaid enrollments. Federal disproportionate share payments and increased spending through upper payment limit provisions are also under severe pressure.

In the wake of the 2001 recession, many states faced challenges financing their share of program costs as Medicaid enrollment grew. However, their ability to continue covering people who lose private insurance coverage is not unlimited. Several states, most notably Missouri and Tennessee, are already moving to drop eligibility categories and tighten income limits.[87] If this trend continues, then the modest increase between 2001 and 2004 in the percentage of people without insurance is likely to be a much larger increase in the future. This will place much greater strain on safety-net providers and on their sources of funding.

It is also clear that federal money for care for the uninsured is fragmented and flows through many spigots that are aimed primarily at populations and constituencies other than the uninsured. For example, after Medicare and Medicaid, the Veteran's Health Administration is the next largest single source of providing funding, providing care for uninsured veterans through its network of hospitals and outpatient clinics. However, the VHA required emergency funding in 2005 to cover shortfalls due to increased care demands for service-related injuries. Uninsured veterans who live below means test thresholds without service-related health problems have a relatively low priority for receiving care (priority group 5 out of 8).[88] If the wars in Iraq and Afghanistan result in a growing number of veterans with service-related health care needs, uninsured veterans lower on the priority list will probably find it harder to receive care from the VHA.

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[87] Kaiser Commission on Medicaid and the Uninsured, *Medicaid Budgets, Spending and Policy Initiatives in State Fiscal Years 2005 and 2006,* Pub. #7392; and *In a Time of Growing Need: State Choices Influence Health Coverage and Access for Children and Families,* Pub. #7381, Washington DC, October 2005.

[88] CBO, 2005.

The multiplicity and fragmentation of federal funding sources also results in essentially no coordination across sources and in many cases probably poor targeting of resources. This issue is of greatest concern for Medicare and Medicaid payments, which are tied to indirect indicators of providers' care to uninsured patients. Medicaid DSH and UPL payments are notoriously difficult to track and verify the extent to which they support care received by the uninsured.[89] Care funded through community health centers and the Ryan White CARE Act are more directly targeted to uninsured people, but these two programs, which have been growing relatively rapidly, comprise less than 3% each of total federal spending for the uninsured.

Preliminary Thoughts on Alternative Ways to Re-organize Federal Support

Given the apparent weaknesses in both the amount and structure of federal support for the safety net, it is reasonable to ask if there's a better way. Since addressing this question in detail is beyond the scope of this report, we only outline some possible alternatives that might be a starting point for a more detailed consideration.[90] One option is to consolidate the various sources of federal money for the uninsured into a single program. The advantages of such a program would be greater coordination and targeting of resources based on explicit criteria for evaluating the amount of care various health care providers deliver to the uninsured and variations in need across geographic areas. It would also be easier and more transparent to gauge the federal contribution relative to the number of uninsured in the nation.

Another approach might be to channel federal money through state and/or local agencies that would have primary responsibility for allocating resources to local providers who deliver services to uninsured people. These agencies would be much closer to the point of contact and would presumably be better able to assess needs and delivery models than would a federal agency. Working through designated state and/or local agencies may also provide a more effective mechanism for capturing state and local matching funds and making sure that resources are devoted to caring for the uninsured. As with Medicaid, the state/local match could be inversely related to the number or proportion of uninsured people in the area.

Several existing models around the country could provide blueprints for various ways of structuring such programs. For example, Denver has developed an integrated public sector health care safety net.[91] Other cities, such as Milwaukee, Tampa, and the District of Columbia have implemented coverage-like enrollment programs for the uninsured who receive care from designated providers. Boston has an integrated private safety-net system, organized by the Boston Medical Center, that receives

[89] Coughlin, Bruen and King, 2004.
[90] Bovbjerg and Ullman (2001) offer several options for "re-engineering" local safety nets.
[91] Gabow, 1997, Ormond and Lutzky, 2001.

extensive public funding.[92,93] Local coverage initiative programs,[94] many of which seek ways to extend or integrate private and public insurance options with safety-net providers caring for the uninsured, are another potential source of new approaches.

Developing alternative approaches for delivering federal funds to health care providers who treat the uninsured is obviously a complex task. There are many political and organizational issues that would have to be addressed. For example, existing federal agencies will undoubtedly be resistant to relinquishing any of their current budget allocations. Issues of political capture by dominant local providers and methods of accountability would also need to be addressed. Nevertheless, the combination of growing fiscal pressure on all levels of government and likely continued increases in the number of uninsured make it imperative to explore more effective ways of directing limited federal fiscal resources, which underwrite most of the care received by the uninsured.

CONCLUSION

Federal spending is the largest and most important component of funding for the health care safety net. In 2001, the Federal government provided two-thirds of all government spending on the health care safety net and more than half of all spending from all sources. Since 2001, 4.6 million more Americans have become uninsured, leaving 45.8 million people without insurance coverage in 2004. State and local governments have likely not been able to maintain, let alone increase, their level of support for safety-net funding. This work demonstrates that federal spending on the health care safety net has not kept pace with the rapid growth in the uninsured over the past three years.

Based on information collected from Medicare, Medicaid, and other federal programs that provide funds that support the health care safety net, total federal safety-net spending in grew from $19.8 billion in 2001 to $22.8 billion in 2004, an increase of 15.4 percent. Although federal support for community health centers increased by more than 50 percent, from $0.43 billion in 2001 to $0.67 billion in 2004, federal funding for community health centers still accounted for less than 3 percent of total federal spending on the safety net in 2004.

Between 2001 and 2004 the cost of medical care has risen by almost 14 percent. After adjusting federal spending on the safety net for this increase, real federal funding

[92] For descriptions of the Milwaukee, Tampa and Boston approaches, see Randall R. Bovbjerg, Jill A. Marsteller, and Frank C. Ullman, *Health Care for the Poor and Uninsured after a Public Hospital's Closure or Conversion* (Washington, DC: The Urban Institute/ANF, OC-39) http://www.urban.org/url.cfm?ID=309647.

[93] For a description of the D. C. Alliance, see District of Columbia Primary Care Association, Health Justice Alert: The Alliance on a Fast Track, May 22, 2001 http://www.dcwatch.com/issues/pbc010522.htm.

[94] Ryan, 2005.

available for uncompensated care grew by only 1.3 percent between 2001 and 2004. At the same time, however, the total number of uninsured Americans increased by 11.2% percent, rising from 41.2 million in 2001 to 45.8 million people by 2004. As a result, inflation-adjusted federal spending per uninsured person actually decreased by 8.9%, from $546 per uninsured person in 2001 to $498 in 2004. These figures suggest that overall federal support of the safety net has not kept pace with the increase in the number of uninsured Americans.

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