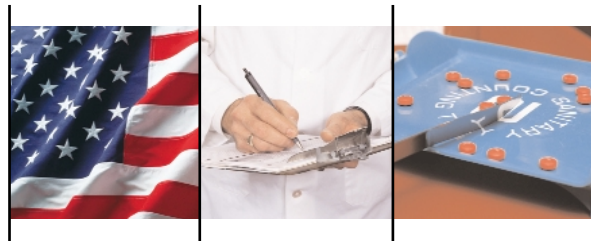


# Issue Brief

Findings from HSC



## MANAGED CARE COST PRESSURES THREATEN ACCESS FOR THE UNINSURED

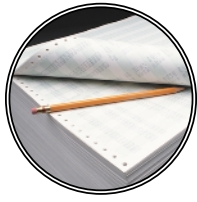
*People without health insurance have historically received medical care from the safety net, which among many kinds of providers includes physicians who voluntarily provide uncompensated care. With 43 million Americans uninsured today—a group that has grown by 1 million a year for the last decade—the health care safety net is increasingly critical as a way for the medically indigent to get services. However, there are signs that the safety net is weakening because of certain changes in the health care system. This Issue Brief discusses Center for Studying Health System Change (HSC) findings from its Community Tracking Study indicating that higher managed care penetration is associated with both physicians providing less charity care and less access to care for the uninsured.*

### Access Suffers in High Managed Care Markets

**C**hanges in the health care system are putting a strain on safety net providers, including free-care clinics, public and teaching hospitals, some not-for-profit hospitals and others that voluntarily provide uncompensated care. Specifically, there is growing concern among policy makers and advocates for the poor that the financial and competitive pressures associated with the rise of managed care—including Medicaid managed care—are limiting providers' ability to offer uncompensated care to the needy.

Few studies examine how managed care affects physicians' provision of charity care and access to care of uninsured persons. An analysis of HSC's Physician and Household Surveys provides new insights into these issues and offers the following four key findings:

- Physicians who derive most of their practice revenue from managed care provide 40 percent less charity care than those who receive relatively little revenue from managed care plans.
- Physicians who practice in areas with high managed care penetration provide less charity care than physicians in other areas, regardless of their own level of involvement with managed care.
- Low-income uninsured persons report lower access to care in areas with high Medicaid managed care penetration.
- Differences in access between insured and uninsured persons—the so-called access gap—are even greater in areas with higher Medicaid managed care penetration.



## Data Sources

This Issue Brief is based on data from the Community Tracking Study Household and Physician Surveys. The Household Survey is a nationally representative telephone survey of the civilian, noninstitutionalized population as well as of 60 randomly selected communities. Data were supplemented by in-person interviews of households without telephones to ensure proper representation. The survey contains observations on nearly 33,000 families and 60,000 individuals.

The Physician Survey is a nationally representative telephone survey of non-federal, patient care physicians (excluding certain specialties—e.g., radiology, anesthesiology, pathology) and is conducted in the same 60 communities included in the Household Survey. Primary care physicians were oversampled. The survey contains observations on over 12,000 physicians.

Interviews for both surveys took place between July 1996 and August 1997. Both surveys achieved a response of 65 percent. Information about the specific samples used in the analyses can be found in the related journal articles cited on page 6 of this Issue Brief.

## Pressures on the Safety Net

One way providers have long subsidized the care they provide to the medically indigent is by shifting the costs of this care onto other public and private payers. However, with managed care increasing its share in both public and private insurance, health plans have pushed down provider payment rates, making cross-subsidization of indigent care more difficult. In addition, many traditional safety net providers—such as public hospitals and community health centers—face increasing competition for Medicaid managed care patients, a source of revenue that is important for their very survival and their ability to subsidize care for the uninsured.

Other pressures on the safety net, taken collectively, could further decrease access to care for uninsured persons:

- Many safety net providers are facing increased demands for uncompensated care because of the growing numbers of uninsured Americans.
- Direct public subsidies for indigent care have been reduced in many areas, due to cuts in state uncompensated care pools and reductions in Medicaid disproportionate share hospital payments resulting from the Balanced Budget Agreement of 1997.

## Physicians as Providers of Charity Care

Physicians are a significant part of the safety net, and HSC's survey found that 77 percent of doctors provided at least some charity care, averaging 10.3 hours a month. The survey defined charity care as charging either no fee or a reduced one because of the financial need of the patient; care for patients expected to pay but who did not was not counted.

Researchers then examined the relationship between the level of charity care physicians provided against the amount of revenue their practice derived from all types of managed care plans and the overall level of managed care penetration in the community where they practice. Managed care penetration in the community is defined here as the percent of physician revenue derived from managed care, averaged across all physicians in the community. Researchers also controlled for specialty as well as other physician practice and market characteristics that might be related to the amount of charity care that physicians provide.

Researchers found that the number of hours spent on charity care varied significantly based on physicians' involvement with managed care. More managed care

**Figure 1**  
Hours Physicians Spent Providing Charity Care during the Previous Month

PERCENT OF PHYSICIAN'S PRACTICE REVENUE DERIVED FROM MANAGED CARE	MANAGED CARE PENETRATION AT THE COMMUNITY LEVEL		
	LOW	AVERAGE	HIGH
0	11.2 hours	10.0 hours	8.5 hours
1-20	9.4	8.4	7.2
21-40	8.6	7.7	6.6
41-60	8.3	7.4	6.3
61-84	8.5	7.5	6.5
85+	5.8	5.2	4.4

Note: Estimates are computed from multivariate analyses that include other characteristics of physicians, physician practice and the market.

HSC Community Tracking Study, Physician Survey, 1996-1997

meant fewer hours treating the indigent for free or a reduced fee.

Specifically:

- Physicians who derive 85 percent or more of their total practice income from managed care provided about half as much charity care as those with no managed care business, and about 40 percent less than those who

derive 1-20 percent of revenue from managed care (see Figures 1 and 2).

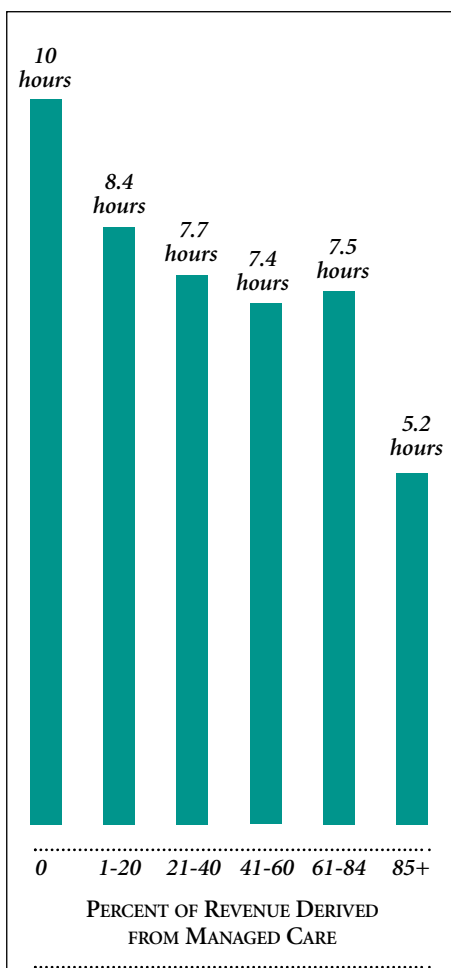
- The degree of managed care in the community is also an important factor. Researchers found that physicians who practiced in areas of highest penetration provided about 25 percent less charity care than those in areas of lowest managed care penetration.
- Practice arrangements, size and ownership made a difference in how much charity care physicians provided. Physicians in medium to large groups were one-third less likely to offer charity care than those in solo or two-person practices, while physicians in staff- and group-model health maintenance organizations (HMOs) were only one-third as likely to provide charity care as those in solo or two-person practices. Physicians in larger practices provided less charity care than those in smaller practices, and physicians who are full or part owners of their practices were almost twice as likely to provide charity care than those who did not own any part of their practice.

This may be due to larger practices setting up unintentional or intentional barriers to their physicians giving charity care because of competing organizational goals or other reasons. In addition, physicians in large groups and those who do not have an ownership stake in their practices may have less control over their ability to see needy low-income patients without insurance. Because charity care provision is more strongly associated with small or solo-practice physicians, the growing number of physicians affiliated with larger and more formal groups who may also not have an ownership stake in their practice raises the concern about further erosion of charity care.

HSC's findings also showed that physicians tend to provide more charity care in areas with relatively fewer public hospitals or hospital emergency rooms. This suggests that physicians pick up some of the excess demand for indigent care where there are fewer community-based resources. On the other hand, physicians tend to provide more charity care in areas with relatively large numbers of teaching hospitals. It could be that teaching hospitals and their staff play an important role by encouraging a community-wide commitment to charity care.

**Figure 2**

**Average Hours Physicians Spent Providing Charity Care during the Previous Month**



Note: Estimates are computed from multivariate analyses that include other characteristics of physicians, physician practice and the market.

HSC Community Tracking Study, Physician Survey, 1996-1997

**Impact on Access for the Uninsured**

HSC researchers examined how low-income uninsured people's access to health care services relates to the level of managed care penetration in the community as well as Medicaid managed care penetration in the state. This latter measure is important given how dependent many safety net providers are on Medicaid revenue. The Medicaid managed care penetration measure reflects the percentage of Medicaid enrollees in capitated managed care plans in the state; community-level data were not available.

To determine whether a low-income person had access to care, researchers used three standard measures of access: (1) whether a person had an ambulatory care visit in the past year; (2) whether that person had a usual source of care; and (3) whether that individual was able to obtain needed medical services during the previous year. The study controlled for individual demographic characteristics, including health and socioeconomic status, and community and health system characteristics.

In general, the low-income uninsured had more difficulty getting access to care in communities with high Medicaid managed care penetration (see Figures 3A and B):

- Only about half of all low-income uninsured persons had an ambulatory care visit in the past year in high Medicaid managed care states, while more than 60 percent of the uninsured had such visits in low Medicaid managed care areas.
- Uninsured persons were about 75 percent more likely to lack a usual source of care in states with high Medicaid managed care penetration than uninsured persons in low Medicaid managed care states.

The gap between insured and uninsured persons as it relates to access to care is larger in areas with high Medicaid managed care (see Figure 4). Specifically, uninsured persons are about 2.5 times more likely than insured persons to lack a usual source of care in states with low Medicaid managed care penetration, but more than four times more likely in high Medicaid managed care states. This gap is larger, in part, because for low-income people with health insurance, there are virtually no differences on these two measures by the level of Medicaid managed care in the community.

On another measure, unmet medical needs, low-income persons as a group—the insured and uninsured—were more likely to report difficulty in states with high Medicaid managed care penetration. The difference for the uninsured population on this measure was not statistically significant, perhaps due to a smaller sample size.

When researchers examined the relationship between overall managed care penetration and access for the uninsured, little independent effect was found. This suggests that Medicaid managed care is the dominant factor in explaining lower access to care for the uninsured in high managed care markets.

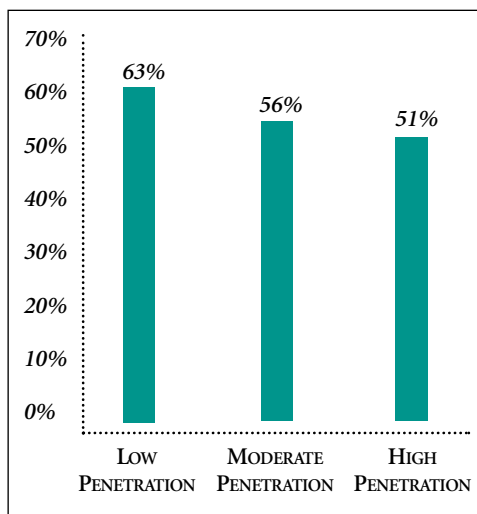
In addition to Medicaid managed care penetration, the rate of uninsurance in the community proved to be an important factor associated with access. In communities with the highest levels of uninsurance, the uninsured had the most difficulty getting access to care, perhaps due

**Figure 3**

**Access to Care for Uninsured Low-Income Persons by Level of Medicaid Managed Care in the Area**

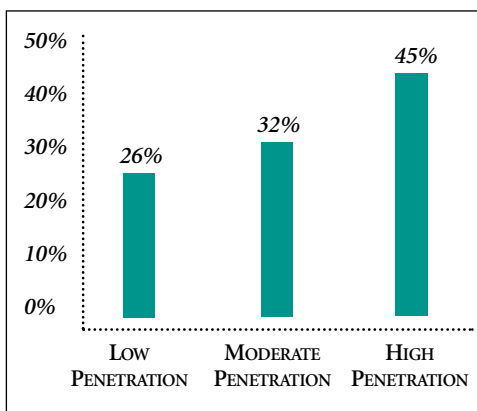
**3A**

**Percent with an Ambulatory Care Visit**



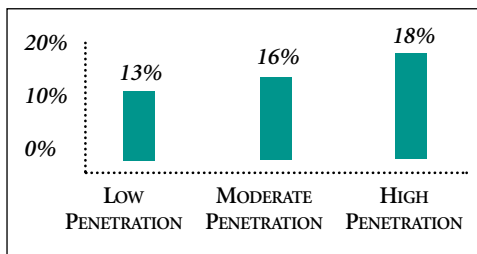
**3B**

**Percent with No Usual Source of Care**



**3C**

**Percent with Unmet Medical Needs**



HSC Community Tracking Study, Household Survey, 1996-1997



**The hours spent on charity care varied significantly based on physicians' involvement with managed care. More managed care meant fewer hours treating the indigent.**



**The low-income  
uninsured had  
more difficulty  
getting access  
to care in  
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penetration.**

**Figure 4**  
**Access to Care for Low-Income Persons by Level of Medicaid Managed Care in the Area**

MEDICAID MANAGED CARE PENETRATION	PERCENT WITH AN AMBULATORY CARE VISIT		PERCENT WITH NO USUAL SOURCE OF CARE		PERCENT WITH UNMET MEDICAL NEEDS	
	UNINSURED	INSURED	UNINSURED	INSURED	UNINSURED	INSURED
<i>Less than 10%</i>	63%	82%	26%	11%	13%	6%
<i>10-39%</i>	56*	83	32*	9*	16	7
<i>40% and higher</i>	51*	83	45*	10	18	8*

\* Within insurance groups, difference with estimate for sites with lowest managed care penetration/uninsurance rate is statistically significant at the p<0.05 level.

Note: Estimates control for sociodemographic and health characteristics of individuals, health system and other market characteristics.

HSC Community Tracking Study, Household Survey, 1996-1997

to higher community demand for indigent care. Specifically, in these communities, uninsured persons were less likely to have had an ambulatory care visit in the past year, more likely to lack a usual source of care and more likely to have unmet medical needs than uninsured persons in areas with low rates of uninsurance (see Figure 5).

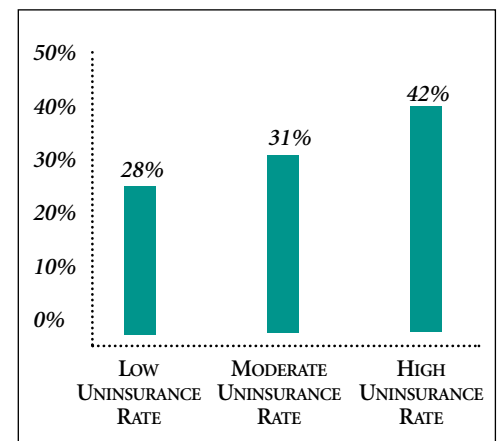
**Implications for the Uninsured**

HSC’s findings related to managed care raise concerns about the continued viability of the safety net, where most uninsured people receive care in the United States. While many people credit managed care with containing runaway health care costs, one apparent consequence of managed care’s drive toward greater cost efficiency is a loss of more generous payments that providers use to cross-subsidize care for the medically indigent. This appears to be an unintended consequence of managed care’s more aggressive cost control objectives. Any type of cost control that limits provider revenue could potentially produce the same result.

There are two caveats: HSC researchers did not directly measure the causal mechanisms—financial and competitive pressures—attributed to these results.

And because the analysis was based on comparisons across communities at one point in time, rather than longitudinally, HSC cannot conclude with certainty that an increase in managed care over time is eroding charity care and access to care of the uninsured. However, HSC researchers have previously found that access to care

**Figure 5**  
**Percent of Uninsured Low-Income Persons with No Usual Source of Care by the Uninsurance Rate in the Community**



Note: Estimates control for sociodemographic and health characteristics of individuals, health system and other market characteristics.

HSC Community Tracking Study, Household Survey, 1996-1997

for the uninsured is eroding, specifically the proportion of uninsured individuals who do not have a usual source of care.

Some health policy analysts believe that cost savings from managed care will actually reduce the number of uninsured persons, either by making private insurance more affordable to employers and families or by states explicitly using cost savings from their Medicaid managed care programs to fund increased eligibility for current programs or to support additional ones for the poor. While HSC researchers did not test this hypothesis directly, the descriptive findings question such assertions. Specifically, HSC's results show that the uninsurance rate (and therefore the demand for indigent care) is at least as high in areas with high managed care penetration as it is in areas with low managed care penetration, suggesting that lower access for uninsured persons is not offset by fewer numbers of uninsured.

### Policy Implications

The U.S. health system has long provided care for the indigent, in part through private cross-subsidization that is unique in the industrialized world. Historically, hospitals and physicians have charged insured patients rates high enough to leave them with the ability to provide free or less expensive care to low-income patients without insurance. When these rates are squeezed, whether through Medicare and Medicaid reimbursement policies or competitive purchasing by managed care plans, these important cross-subsidies are threatened.

Policies that respond to these threats and enable providers to continue serving the uninsured fall into three general categories. First, steps can be taken to expand insurance coverage, thus reducing the need for cross-subsidization. These can be incremental

expansions, such as the federal Children's Health Insurance Program (CHIP), or universal expansion policies. Second, steps can be taken to lessen the degree of downward pressure on payment rates. Finally, steps can be taken to provide explicit subsidies to those providers that provide uncompensated care. This can be done either with public funds or through a pool of funds obtained from all payers.

Policies in each of these categories have been pursued to some extent in the past. However, given the well-documented problems of access to care for the uninsured, it is possible that more fundamental changes need to be made in providing care for the medically indigent.

### JOURNAL ARTICLES

This Issue Brief is adapted from "Managed Care and Physicians' Provision of Charity Care," by Peter J. Cunningham, Joy M. Grossman, Robert F. St. Peter and Cara S. Lesser, which appeared in the *Journal of the American Medical Association*, Vol. 281, No. 12 (March 24-31, 1999) and "Pressures on the Safety Net: Differences in Access to Care for Uninsured Persons by the Level of Managed Care Penetration and Uninsurance Rate in a Community," by Peter J. Cunningham, which appeared in *Health Services Research*, Vol. 34, No. 1, Part 2, Supplemental Edition (April 1999).

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