

# Inpatient Hospital Utilization among the Uninsured Near Elderly: Data and Policy Implications for West Virginia

*Donna L. Spencer, Sally K. Richardson, and  
Melissa Kolb McCormick*

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**Objective.** To inform state policy discussions about the insurance coverage of the near elderly in West Virginia (WV) and the impact of the uninsured near elderly on hospitals in the state.

**Data Sources.** 2003 West Virginia Uniform Bill (UB) hospital discharge data. The data represent all adult inpatient discharges in the state during the year.

**Study Design.** We compare the near elderly with other adults and examine differences by insurance status. Key variables include volume of discharges, health insurance coverage, patient characteristics, and charges incurred.

**Findings.** The near elderly constitute the largest group of nonelderly adult inpatient hospital discharges. They are more likely than younger adults to be admitted for emergency conditions; have comorbidities and complications; have longer hospital stays; and incur higher charges on average. Although the near elderly are least likely to be uninsured, they represent the second largest group of uninsured discharges and incur the most in uninsured charges.

**Conclusions.** The specific needs of the near elderly warrant consideration in WV's (and other states') ongoing development and evaluation of policies aimed at reducing uncompensated care costs, including programs to expand access to health insurance and primary and mental health care among the uninsured.

**Key Words.** Near elderly, insurance coverage, hospital costs, uncompensated care, state health policy

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This paper examines the health insurance status and inpatient hospital utilization of the near elderly within the state of West Virginia (WV). The near elderly (defined here as 50–64 year olds) have been identified by health policy researchers and practitioners within the United States as an uninsured subgroup in need of special attention (Cunningham 1998; GAO 1998; Sloan and Conover 1998; Powell-Griner, Bolen, and Bland 1999; Brennan 2000; Budetti

et al. 2000; Monheit, Vistnes, and Eisenberg 2001; Ziller and Coburn 2003; Holahan 2004; McWilliams et al. 2004; Weller, Wenger, and Gould 2004; Hadley and Waidmann 2006). While the majority of elderly persons (65 years of age and older) are at least partially covered by Medicare, roughly 18 percent of the nonelderly population remains uninsured (Kaiser Family Foundation 2005). The near elderly present a coverage problem *not* because of their risk of uninsurance; in fact, they have been shown to have higher rates of insurance and health care access than other nonelderly adults (Cunningham 1998; GAO 1998; Brennan 2000; Monheit, Vistnes, and Eisenberg 2001; Holahan 2004). Instead, the near elderly are a growing concern because of the distinguishing circumstances that make adequate, affordable insurance less accessible to them and that make lack of coverage particularly risky for them—namely lower labor force participation (e.g., early retirement, job loss), poorer health status and higher medical expenditures, and lower family incomes overall (Cunningham 1998; GAO 1998; Powell-Griner, Bolen, and Bland 1999; Budetti et al. 2000). Concerns about the near elderly are magnified by the demographic fact that they represent one of the fastest growing segments of the U.S. population.

Recent Current Population Survey data (Table 1) suggest that the near elderly in WV may warrant particular attention. The near elderly's share of the overall population is larger in WV relative to the rest of the United States, and growth in WV's near elderly population has been more rapid over the last decade. Further, compared with other near elderly within the country, WV's near elderly are at greater risk of being uninsured,<sup>1</sup> and their vulnerabilities to uninsurance are more pronounced: fewer near elderly in WV are connected to the labor force, more are poor, and their health status is worse overall. In addition to these demographic patterns, recent economic changes in WV have raised flags about insurance coverage for the near elderly and other nonelderly adults in the state. Of particular concern has been the significant number of manufacturing plant closings, which have forced many employees out of a job or to retire early.<sup>2</sup>

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Address correspondence to Donna L. Spencer, M.A., Senior Research Fellow, University of Minnesota School of Public Health, State Health Access Data Assistance Center, 2221 University Avenue, Suite 345, Minneapolis, MN 55414-3164. Sally K. Richardson, Executive Director/Associate Vice President, and Melissa Kolb McCormick, M.A., Research Associate, are with the West Virginia University Institute for Health Policy Research, Robert C. Byrd Health Sciences Center, Charleston, WV.

Table 1: Key Demographic Characteristics of the United States and West Virginia (WV) Near Elderly (50–64 Years) Populations, 2003

Characteristic	U.S. <sup>†</sup> (n = 30,889)		WV (n = 511)	
	%	SE (%)	%	SE (%)
Population size				
% of total population aged 50–64***	14.7	0.1	18.0	0.7
% growth in population aged 50–64, 1994–2003***	13.6	0.1	17.5	1.2
Uninsurance rate*	13.7	0.2	17.0	1.7
Employment				
Employed, full-time (35+ hours/week)***	53.5	0.3	39.3	2.2
Employed, part-time (<35 hours/week)*	9.0	0.2	6.7	1.1
Self-employed <sup>‡</sup> ***	11.1	0.2	6.5	1.1
Unemployed**	2.8	0.1	1.4	0.5
Retired**	12.6	0.2	18.2	1.7
Other not in labor force <sup>‡</sup> *	7.2	0.1	10.8	1.4
Living in poverty (<100% federal poverty level)***	8.3	0.2	17.2	1.7
Health status				
Excellent/very good***	52.9	0.3	36.6	2.1
Good	28.3	0.3	30.7	2.0
Fair/poor***	18.8	0.2	32.7	2.1

*Source:* Current Population Survey, 2004. The 1995 Current Population Survey data, used to calculate change in the near elderly population, included 19,560 U.S. and 265 WV near elderly. All rates are based on weighted data. The complex survey design is corrected for using *StataSE* version 9.1 software.

Differences between WV and the rest of the United States significant at the

\* $p \leq .05$ , \*\* $p \leq .01$ , or \*\*\* $p \leq .001$  levels.

<sup>†</sup>U.S. data exclude WV.

<sup>‡</sup>Includes homemakers, full-time students, and those not working due to disability.

Many other published studies on the near elderly's access to health insurance and health care have relied on household survey data and have generated information about the unique characteristics and risks of this subgroup at a national level. A recent report on WV (Spencer and Blewett 2005) compared the state's near elderly and younger adults, and key differences observed resembled national findings. While relative to other nonelderly adults, the near elderly in WV do not have a higher rate of uninsurance, they rely slightly less on employer-based insurance, and compared with most younger adults, they rely slightly more on public and self-purchased forms of insurance. On the other hand, the near elderly as a whole in WV have greater health care access and utilization compared with younger

adults. However, there are important differences according to insurance status, with the uninsured near elderly in WV reporting poorer access and lower utilization rates.

Our study extends prior research on the near elderly by putting to use data that have been underutilized in recent published studies. We analyze hospital discharge data to inform policy discussions about not just the status and vulnerabilities of the near elderly in WV but the potential impact of their lack of insurance on the state's health care system. Hospitals are a significant provider of medical care for the uninsured and underinsured. In fact, it has been estimated that as much as 63 percent of all uncompensated care costs (i.e., both charity care and bad debt) in the United States are borne by hospitals (Hadley and Holahan 2003). In WV, hospitals alone incur over \$360 million per year in uncompensated care (WV Hospital Association 2004). The financial burden associated with uncompensated care and hospitals' ongoing ability to provide such care are significant policy concerns. We conclude with a summary of our findings and a discussion of the current policy environment in WV.

## METHODS

Our analyses are based on WV Uniform Bill (UB) hospital discharge data (WV Health Care Authority 2001). The data include all adults patients discharged during 2003 (a total of 273,668 discharges) by general acute care, psychiatric, and medical rehabilitation hospitals in the state. Approximately 98 percent of the records are inpatient discharges (96.1 percent of which are for acute care/critical access with the remaining 3.9 percent for psychiatric, rehabilitation and long term acute care); fewer than 2 percent are skilled nursing facility (SNF) unit discharges; and fewer than 1 percent are SNF swing bed discharges. Elderly patients comprise over 85 percent of the SNF unit and swing bed discharges. Given the elderly's disproportionate share of these discharges and the different nature of these stays, we excluded the SNF-related discharges and limited our analyses to inpatient hospital discharges only. The resulting number of discharges for our analysis is 267,637. For each discharge, the UB data provide information on the patient (e.g., age, payer status, medical condition) and his/her hospitalization (e.g., type of admission, length of stay, charges).

We present four types of data. We first assess the volume of discharges by age group. Secondly, we analyze primary payer types to examine

variations in the age composition of insured and uninsured discharges. Third, we review the hospital charges incurred by adults discharged during the year. Finally, we examine patient and discharge characteristics (e.g., condition type and severity) related to costs. In presenting these data, we compare the near elderly to other adults and examine differences by insurance status. All results are based on descriptive analyses (e.g., proportions, medians). Because the data represent a census of inpatient hospital discharges, no statistical testing was performed.

While the UB data do not allow for uncompensated care costs to be examined explicitly (the data report patient charges and not costs ultimately incurred by a payer), the data do identify charity care discharges (care provided by hospitals with no expectation of payment) and self-pay discharges (care paid out-of-pocket by the patient). We refer to these two types of discharges as “uninsured.” Our analyses likely fail to capture all un- or underinsured patients. For example, even discharges with an insurance payer may eventually result in out-of-pocket expenses for a patient and bad debt costs for hospitals. Such cases cannot be determined within the UB data.

## FINDINGS

### *Discharge Volume*

The number of adult inpatient discharges in WV during 2003 amounted to 267,637. While the elderly comprise the largest percentage of these discharges (46.1 percent), near elderly patients make up the second largest group (21.8 percent) and the largest nonelderly group (40.5 percent). Among all adults, patients aged 25–34 and 35–44 years contribute approximately 10 percent and those aged 18–24 and 45–49 years contribute just over 6.0 percent.

### *Payer Types*

Table 2 presents the age breakdown for adult discharges under each of eight primary payer categories: Medicare, Medicaid, other public insurance, Public Employees Insurance Agency (PEIA, the largest single employment-based insurer in the state), private insurance, other insurance, self-pay, and charity care. “Other public” includes federal programs other than Medicare (e.g., Veterans Administration and CHAMPUS), WV Workers’ Compensation, other WV government programs, as well as other states’ government programs. Private insurance includes commercial insurance, nonprofit insurance,

Table 2: Adult Hospital Discharges in West Virginia (WV), by Primary Payer Type\* and Age Group (%)

Age Group	Uninsured								
	Medicare (N = 138,827)	Medicaid (N = 33,465)	PEIA (N = 9,645)	Other Public (N = 12,080)	Private (N = 58,350)	Other (N = 2,566)	Total (N = 12,704)	Self-Pay (N = 11,085)	Charity Care (N = 1,619)
18-24 years	0.2	24.8	4.3	13.3	8.0	10.1	14.1	14.6	11.1
25-34 years	1.0	20.1	13.7	14.6	18.4	20.5	22.8	22.6	24.2
35-44 years	2.5	17.8	14.7	15.2	17.0	18.6	25.6	25.3	27.5
45-49 years	2.2	9.1	13.3	8.6	11.3	12.0	12.0	11.9	13.0
50-64 years	12.2	26.5	48.1	25.9	36.1	30.8	23.5	23.7	21.7
65+ years	81.9	1.7	6.0	22.4	9.2	8.0	2.0	1.9	2.5

Source: 2003 West Virginia UB hospital discharge data. Includes all acute care/critical access, long term acute care, rehabilitation, and psychiatric inpatient hospital discharges. Excludes skilled nursing facility unit and swing bed discharges.

\*Medicaid includes WV Medicaid. Other public includes Workers' Compensation, other federal government, other WV government, and other states' government. Private includes commercial, nonprofit, and employer/union insurance. Other includes unclassified and unknown.

and employer/union coverage. "Other insurance" refers to discharges for which the payer is unknown or unclassified. Charity care represents care donated by hospitals with no expectation of payment, and self-pay is care paid out-of-pocket by the patient.

Overall, we find that the near elderly represent the largest share of all insured discharges (except Medicare). This is especially true for PEIA (48.1 percent), private insurance (36.1 percent), and "other" insurance sources (30.8 percent) but is also the case for Medicaid (26.5 percent) and other public insurance (25.9 percent). Furthermore, the near elderly are among the largest groups of self-pay and charity care patients, comprising over a fifth of both types of discharges. The near elderly represent the second largest group of uninsured discharges overall despite the fact that they are least likely among all nonelderly patients to be uninsured (5.1 percent versus as much as 12 percent for 25–24 and 35–44 year olds, data not shown).

### *Hospital Charges*

Our analyses of hospital charges are based on total charges, including both ancillary and room charges. While charges represent the pricing associated with a patient's care, they are not necessarily equivalent to costs ultimately incurred by a payer. In fact, charges likely exceed actual costs because charges do not factor in the discounts received by some private payers (Finkler 1982).

Total charges for all inpatient discharges amount to approximately \$3,370 million. Table 3 presents the breakdown of charges by age (see first column). As is the case with the volume of discharges, the elderly's share of total charges is the largest (51.3 percent). In fact, charges for all elderly discharges (\$1,727.7 million) exceed those of all younger adults combined, including the near elderly. The near elderly, however, contribute the second largest proportion (24.5 percent, or \$825 million) and have the largest non-elderly share (50.2 percent) of charges. The higher charges among near elderly and elderly patients are a function of not only age differences in the volume of discharges but also in median charge amounts, which range from \$4,573 for the youngest group to \$8,765 for the elderly. The median charge for the near elderly is noteworthy, as it is nearly identical to that of the elderly.

Table 3 also summarizes charges for uninsured patients, by age. A total of \$133.9 million is attributable to adult self-pay and charity care patients in WV during 2003. Given the availability of Medicare, the elderly represent a very small share (2 percent) of uninsured charges. All other age groups

Table 3: Hospital Charges\* for All and Uninsured Adult Patients in West Virginia (WV), by Age Group

<i>Age Group</i>	<i>Uninsured Discharges</i>			
	<i>All Discharges (N= 267,637)</i>	<i>Self-Pay (N= 11,085)</i>	<i>Charity Care (N= 1,619)</i>	<i>Total (Self-Pay and Charity Care) (N= 12,704)</i>
<i>Overall</i>				
Total charges (millions)	\$3,369.9	\$112.5	\$21.4	\$133.9
Median charge amount	\$7,683.0	\$6,541.6	\$8,550.0	\$6,654.4
18–24 years				
Charges (millions)	\$122.7	\$13.8	\$1.9	\$15.7
Median charge amount	\$4,573.3	\$5,142.3	\$6,579.5	\$5,250.9
% of total charges	3.6	12.3	8.7	11.7
25–34 years				
Charges (millions)	\$201.0	\$20.8	\$4.7	\$25.5
Median charge amount	\$5,184.2	\$5,649.0	\$6,901.7	\$5,754.3
% of total charges	6.0	18.5	22.0	19.0
35–44 years				
Charges (millions)	\$286.6	\$27.7	\$5.7	\$33.4
Median charge amount	\$6,881.8	\$6,661.8	\$9,059.4	\$6,771.2
% of total charges	8.5	24.6	26.6	25.0
45–49 years				
Charges (millions)	\$207.4	\$14.0	\$3.3	\$17.4
Median charge amount	\$7,736.4	\$7,244.3	\$12,223.3	\$7,481.2
% of total charges	6.2	12.5	15.6	13.0
50–64 years				
Charges (millions)	\$824.6	\$34.1	\$5.4	\$39.5
Median charge amount	\$8,726.0	\$8,059.5	\$11,378.2	\$8,185.0
% of total charges	24.5	30.3	25.4	29.5
65+ years				
Charges (millions)	\$1,727.7	\$2.1	\$0.4	\$2.5
Median charge amount	\$8,765.2	\$5,141.9	\$800.0	\$4,330.2
% of total charges	51.3	1.9	1.8	1.9

*Source:* 2003 West Virginia UB hospital discharge data. Includes all acute care/critical access, long term acute care, rehabilitation, and psychiatric inpatient hospital discharges. Excludes skilled nursing facility unit and swing bed discharges.

\*Based on total charges (including both ancillary and room charges).

compensate with disproportionately higher contributions to self-pay and charity care charges. Overall, the near elderly make up 30 percent of all uninsured charges and incurred almost \$40 million in self-pay and charity care charges, the highest amount for any adult age group.



As with charges for all discharges overall, the median charge for uninsured discharges is higher for each older age group, but this pattern is only observed through the near elderly. The median uninsured charge across all age groups is \$6,654, and ranges from under \$5,300 for the youngest adults to over \$8,100 for the near elderly. Across all nonelderly age groups, the median charge for charity care discharges is consistently higher than that of self-pay discharges. The difference between the two uninsured categories is particularly noticeable among 45–49 year olds and the near elderly, for whom charity care charges are 69 and 41 percent higher, respectively, over self-pay charges.

### *Patient Characteristics Related to Costs*

To further assess differences in hospital charges by age and insurance status, we analyzed several patient and discharge characteristics: type of admission, length of stay, diagnosis, and condition severity. Table 4 presents the median charge amount for each characteristic and the distribution of characteristics by age group. There are important cost and age differences across these characteristics.

Regarding type of admission, the overall median charge is highest among elective discharges (\$8,595) and lowest among urgent charges (\$6,903), with emergency admissions falling in between at \$7,714. While the most expensive (elective) admissions are most common among younger patients, the rate of emergency admissions is noticeably higher for each older age group, with a significant proportion (just over half) of all patients aged 45 and older falling into this group. Further, urgent admissions, overall the least expensive admission type, are least likely among older patients.

Longer stays may also help to explain the near elderly's higher costs on average. As expected, the median charge is lowest for stays of one to two days (\$4,673) and significantly higher (\$16,118) for the longest stays, lasting six or more days. Whereas more than half of all discharges for patients aged 18–24 and 25–34 years fall in the shortest category and less than 15 percent in the longest, just over a third of near elderly stays are short and more than a quarter are 6 or more days in duration. Overall, visits lasting three to five days incur a charge of \$7,270, and the rate of these does not vary dramatically by age.

Type and severity of diagnosis also vary by age group and result in different charge levels overall. Table 4 presents the top five major diagnostic categories (MDCs) in volume for each age group. (For three groups, six MDCs

Table 4: Age Group and Total Charge\* Differences in Discharge Characteristics among Adult Patients in West Virginia (WV)

Characteristic	Median Charge Amount	Distribution by Age Group (%)					
		18-24 years	25-34 years	35-44 years	45-49 years	50-64 years	65+ years
Type of hospital admission							
Emergency	(N = 267,637) \$7,714	(N = 17,331) 28.7	(N = 25,300) 33.6	(N = 26,267) 49.0	(N = 16,858) 51.3	(N = 58,464) 52.0	(N = 123,417) 55.5
Urgent	\$6,903	37.2	32.0	24.8	23.5	23.2	21.7
Elective	\$8,595	33.4	33.9	25.9	25.0	24.7	22.5
Length of stay (in days)							
1-2	(N = 267,637) \$4,673	(N = 17,331) 56.0	(N = 25,300) 53.8	(N = 26,267) 46.3	(N = 16,858) 43.2	(N = 58,464) 36.4	(N = 123,417) 25.5
3-5	\$7,270	33.7	33.5	33.5	34.0	35.4	36.3
6+	\$16,118	10.3	12.7	20.2	22.8	28.2	38.3
Top five major diagnostic categories (MDCs)							
Pregnancy	(N = 267,604) \$4,206	(N = 17,331) 59.9	(N = 25,300) 43.5	(N = 26,266) —	(N = 16,858) —	(N = 58,462) —	(N = 123,387) —
Mental	\$6,346	8.3	8.7	10.7	8.2	—	—
Digestive	\$7,697	4.8	6.6	10.1	10.8	10.0	10.1
Respiratory	\$7,984	2.9	4.4	8.5	10.6	15.7	18.9
Female reproduction	\$8,174	—	4.7	8.8	7.3	—	—
Nervous	\$8,531	2.8	—	—	—	6.5	8.1
Circulatory	\$8,804	—	4.7	15.5	23.9	30.3	28.8
Musculoskeletal	\$13,856	2.8	—	—	7.3	8.1	9.5
Presence of comorbidities and complications (CC) among Top 20 diagnosis-related groups (DRGs) <sup>†</sup>							
Without CC	(N = 113,038) \$6,199	(N = 2,359) 71.1	(N = 5,596) 68.9	(N = 10,637) 64.4	(N = 7,503) 59.6	(N = 25,738) 46.8	(N = 61,205) 31.2
With CC	\$7,480	26.1	27.9	32.1	35.7	44.5	53.9
With major CC	\$12,063	2.8	3.2	3.5	4.8	8.8	14.9

Source: 2003 West Virginia UB hospital discharge data. Includes all acute care/critical care, long term acute care, rehabilitation, and psychiatric inpatient hospital discharges. Excludes skilled nursing facility unit and swing bed discharges.

\*Based on total charges (including both ancillary and room charges).

<sup>†</sup>Based on discharges with one of the 20 most common DRGs (not including delivery or cesarean section DRGs) across all age groups.

are shown because of a tie in proportion.) The least expensive among these MDCs, pregnancy (median = \$4,206), makes up a significant proportion of discharges for the youngest adults (59.9 and 43.5 percent for 18–24 and 25–34-year-olds, respectively). In contrast, respiratory, nervous, circulatory, and musculoskeletal conditions—all involving higher charges on average (ranging from \$7,984 to \$13,856)—are more common among near elderly and elderly patients. In fact just under a third of these older patients had a circulatory condition, which is the second most expensive among these MDCs.

Using All-Payer Severity-Adjusted Diagnosis-Related Groups (APSDRGs), we also assessed severity for the most common DRGs. We identified the top 20 DRGs (in volume, not including pregnancy-related discharges) across all age groups and categorized each discharge within this subset as having comorbidities and complications (CC), as having major CC, or as not having CC. Table 4 summarizes the presence of CC (and the charge amounts) across all age groups. As expected, the median charge amount varies by CC status and is particularly high (\$12,063) among those with major CC. The presence of CC is consistently higher for each older age group, with over half of the near elderly discharges involving CC, major or otherwise. In contrast, the share of top 20 discharges without any CC decreases noticeably from 71.1 percent for the youngest adults to 31.2 percent for the elderly. Fewer than half of the near elderly discharges involve no CC.

Finally, we explored the higher charges among charity care discharges (data not shown). Contrary to expectation, we found that charity care discharges are *less* likely to be emergency and elective admissions (overall, the more expensive admission types) and are less likely to involve major CC. However, charity care patients have significantly longer stays and are disproportionately diagnosed with a mental disease/disorder or substance abuse-related condition. While higher charges and longer stays are not associated with these two MDCs in general, charity care patients with these MDCs require longer stays and incur higher charges. These patterns are not only observed for the near elderly but charity care discharges in general. These findings likely speak to a number of factors including fewer mental health benefits offered by private insurance; strained mental health safety net funding and limited mental health services especially in rural areas of the state; the prevalence of mental and medical comorbidities; and inadequate personal and community supports for individuals with serious mental illness, thus impacting discharge transitions and rehospitalizations (Shi and Singh 2004; WV Department of Health and Human Resources 2005; WV Bureau of Behavioral Health and Health Facilities, Office of Behavioral Services 2007).

## SUMMARY AND CONCLUSIONS

The near elderly are a unique subgroup of the uninsured, and their risks are especially evident in WV. Our study builds on other studies of the uninsured near elderly through its examination of hospital discharge data and its consideration of the potential impact of the uninsured near elderly on hospital providers in the state. The near elderly make up the second largest adult group and the largest nonelderly group of all inpatient hospital discharges (in terms of discharge volume and total charges) in the state. They are more likely to be admitted for emergency conditions, have comorbidities and complications, have longer hospital stays, and incur higher charges. Although near elderly patients are most likely among all nonelderly patients to have insurance as their primary payer, based on their large numbers alone, they represent the second largest group of uninsured—that is, self-pay and charity care—discharges. Taking also into consideration their higher charges on average, the near elderly in WV incurred a total of approximately \$40 million in self-pay and charity care charges in 2003, the largest amount in uninsured charges for all age groups.

The uninsured in general pose significant costs to the health care system with hospitals providing the majority of care to the uninsured (Hadley and Holahan 2003). In WV, inpatient hospital charges for the uninsured near elderly are significant. Many of these charges may go without payment, leaving WV hospitals with uncovered care. Through payment rate increases, uncompensated care costs in part are passed on by hospitals to insurers and insured patients (WV Hospital Association 2004), thereby increasing costs for all.

States have relied on a variety of funding mechanisms to help offset the costs of uncompensated care provided by hospitals. These include Medicaid and Medicare Disproportionate Share Hospital (DSH) funds, increased hospital payments from state funds, and uncompensated care pools (Blewett et al. 2003; Silow-Carroll and Alteras 2004). The largest public mechanism for hospital uncompensated care reimbursement is the Medicaid DSH program. In 2005, WV's Medicaid DSH payments totaled \$82 million (Kaiser Commission on Medicaid and the Uninsured 2006). Although the federal government has established parameters for the calculation of DSH payments, states have flexibility in determining the level and distribution of payments to hospitals. In comparison with the United States overall, WV spends less of its total Medicaid spending on DSH (3.7 versus 5.6 percent) but allocates more of its DSH funds to mental health hospitals (22.1 versus 17.0 percent) (Coughlin, Bruen, and King 2003).

Policies to expand insurance coverage and access to care among the uninsured also are important strategies for controlling levels of uncovered hospital care (Blewett et al. 2003; Silow-Carroll and Alteras 2004). In fact, other research evidence suggests that state efforts to broaden public coverage can reduce uncompensated care costs (Blewett et al. 2003). Policy focusing on the uninsured near elderly is limited at both the national and state levels. During national reform discussions in the 1990s, proposals for expanding Medicare to adults approaching the normal retirement age were considered. However, these did not come to fruition in the context of the new Medicare prescription drug benefit.

At a state level in general, most health policy has not been directed to the near elderly per se but has addressed more generally the concerns of employment transitions, pre-existing conditions and health status, and coverage affordability. Insurance reforms have been a dominant type of expansion initiative. Many states, including WV, also have established high-risk pools to assist those with health conditions in purchasing affordable coverage.

Most recently, through their U.S. Health Resources and Services Administration (HRSA) State Planning Grant (SPG) funding, WV has collected a substantial amount of data on the state's uninsured population. Working from this information, the WV Health Care Authority (the lead SPG agency) and WV University Institute for Health Policy Research (a partnering organization), along with a stakeholders' Affordable Insurance Workgroup, put forth several policy recommendations in 2005 to expand affordable health care to the uninsured and to help contain costs in the state's health care system. The vulnerabilities of the state's near elderly population were studied by the group and considered in the development of their recommendations.

Two of the group's policy options were enacted into legislation in 2006. Importantly, both emphasize preventive and primary care coverage (in some cases including mental health services) and are therefore intended to help reduce the demand for expensive emergency and inpatient hospital care among the near elderly and others in the state. The first is the introduction of individual limited health benefits plans, which will provide affordable basic or limited-benefit insurance products, sold in the commercial marketplace, for low-income adults. The second is a pilot program called the Preventive Care Clinic-Based Plan. Building on the community health centers that comprise the state's medical safety net, the goal of the program is to expand community-based preventive and primary care services and to establish a "medical home" for the uninsured. Funds for evaluating the program,

including the effectiveness of the program for the uninsured near elderly, are currently being sought.

Access to health insurance and primary health care including mental health services is relevant for reducing emergency and inpatient hospital care costs. Some states are directly making the link between coverage/access and uncompensated care costs by redirecting DSH and other uncompensated care funds away from hospitals and toward improving primary care access for the uninsured (Silow-Carroll and Alteras 2004). While WV has not pursued this approach to date, the state could examine the limitations and advantages of existing state models and consider options for leveraging DSH funds for expanding insurance coverage and primary and mental health care access within the state.

Given the role that the near elderly play in hospital care provided to the uninsured, they warrant attention in WV's ongoing development and assessment of policies aimed at controlling uncompensated care costs, including programs to expand access to health insurance and primary medical and mental health care among the uninsured. Regardless of whether current policies or those under consideration are designed to target the near elderly exclusively, WV (and other states) should evaluate whether their initiatives adequately reach and tend to the specific health care needs of the uninsured near elderly. This is especially the case in the absence of any federal program to address this subgroup of the uninsured population.

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*Disclaimers:* The conclusions and opinions expressed in this paper are those of the authors. No endorsement by the U.S. HRSA or the West Virginia Health Care Authority is intended or should be inferred.

## NOTES

1. See the on-line appendix for near elderly uninsurance rates for all 50 states and the District of Columbia.
2. An estimate of 58 industry closings (9,300 employee separations) occurred between 2001 and the first half of 2005 (WV University Institute for Health Policy Research 2005).

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## SUPPLEMENTARY MATERIAL

The following supplementary material for this article is available:

Appendix A. Uninsurance Rates for Near Elderly (50–64 Years), West Virginia versus Other U.S. States, 2003.

This material is available as part of the online article from: <http://www.blackwell-synergy.com/doi/abs/10.1111/j.1475-6773.2007.00765.x> (this link will take you to the article abstract).

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