



THE KAISER COMMISSION ON
Medicaid and the Uninsured

**THE COST OF NOT COVERING
THE UNINSURED**
PROJECT HIGHLIGHTS

AN ONGOING INITIATIVE OF
THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED

JUNE 2003

THE COST OF NOT COVERING THE UNINSURED PROJECT

Much of the ongoing debate over ensuring health coverage for the over 40 million Americans who have no health insurance today revolves around the questions of how much it will cost and who ought to pay. The debate periodically stalls, perhaps in part, because the full benefits of universal coverage – particularly the economic benefits – to both the individual and the nation as a whole, have not yet been fully measured and discussed.

The Kaiser Family Foundation initiated The Cost of Not Covering the Uninsured project to explore what is known and what should be known about the costs society incurs when so many have no health insurance coverage. Under this initiative, we convened an expert advisory group that worked with staff of the Kaiser Commission on Medicaid and the Uninsured to plan and oversee new analyses and reports that would further the understanding of this critical issue.

This brief summarizes the initiative's first three analyses and reports, conducted by Jack Hadley, Ph.D. and John Holahan, Ph.D. of the Urban Institute. The project's advisory group was chaired by Robert Reischauer, President of the Urban Institute, and consisted of Sheila Burke, Arnold Epstein, Judy Feder, Uwe Reinhardt, Dorothy Rice, Earl Steinberg, Jim Tallon, and Marta Tienda.

The Kaiser Commission on Medicaid and the Uninsured is the Henry J. Kaiser Family Foundation's largest operating program and serves as the organizing vehicle for the Foundation's work on health care for low-income people. The Commission functions as a policy institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform. The Commission, begun in 1991, strives to bring increased public awareness and expanded analytic effort to the policy debate over health coverage and access, with a special focus on Medicaid and the uninsured. The Commission is based at the Foundation's Washington, DC office. The Foundation is an independent national health care philanthropy headquartered in Menlo Park, California, and is not associated with Kaiser Permanente or Kaiser Industries.

Key Findings

- The uninsured receive less preventive care, are diagnosed at more advanced disease stages, and once diagnosed, tend to receive less therapeutic care and have higher mortality rates.
- A conservative estimate based on the full range of studies is that a reduction in mortality of 5-15% could be expected if the uninsured were to gain continuous health coverage.
- Better health would improve annual earnings by about 10-30 percent and would increase educational attainment.
- On average, the uninsured receive about half as much care as people who are insured all year. In 2001, persons uninsured for the full year used \$1,253 per year in medical care compared to \$2,484 for persons with private coverage for the full year.
- Total uncompensated care provided in 2001 was estimated to be \$35 billion dollars. The primary source of funding for uncompensated care is government, which spent an estimated \$30.6 billion for care of the uninsured, two thirds of which is federal.
- If insurance coverage were comparable to an “average” public health plan, estimated per person spending by people uninsured for any part of the year would rise by a little over 50%, increasing from \$1,383 to \$2,121. Under an “average” private health plan, spending would rise to \$2,676.
- Expanding coverage to the entire uninsured population would increase spending by \$34 billion under a public coverage standard and \$69 billion under a private coverage standard. Including the \$99 billion in medical care already used by the uninsured, the total cost of medical care used by the previously uninsured under universal coverage would range from \$133 billion to \$168 billion.
- The overall impact of universal coverage on total health care costs would be an increase 3-6% in total health care spending in the U.S., less than the annual inflation in health care spending (8.7% in 2001) in the current health care system.

Sicker and Poorer: The Consequences of Being Uninsured

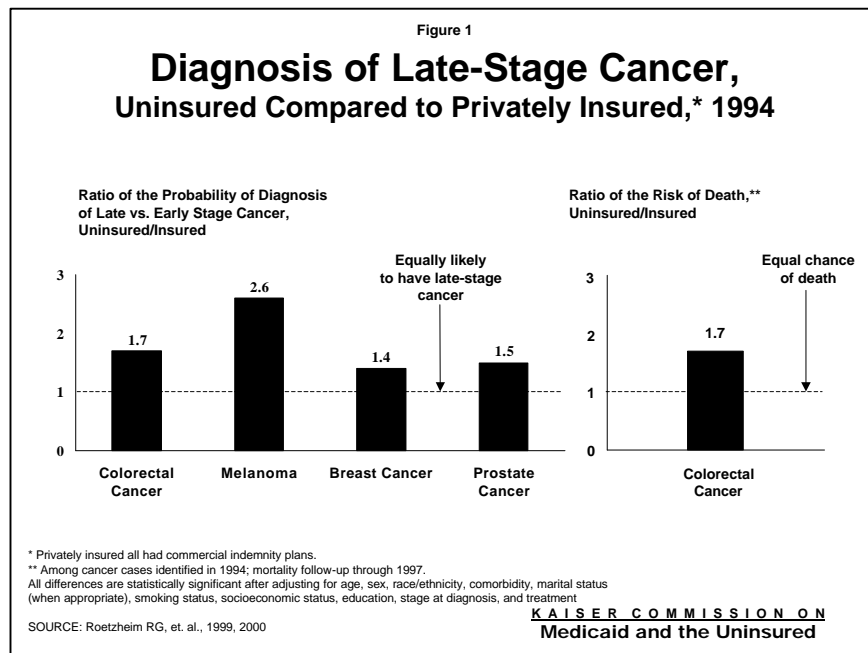
Hadley, Jack. *Medical Care Research and Review*, Vol. 60, No. 2 (Supplement), June 2003

In order to measure the economic benefits of health insurance we first need to establish whether having coverage can actually improve health – a question that has been studied extensively over the past 25 years. Research showing that having health insurance positively affects the *use* of health services is clear and widely accepted. Therefore, this review of the literature specifically addresses the relationship between health insurance and health outcomes, as well as the link between health and educational attainment and economic opportunity.

The report concludes that a compelling case has been made that having health insurance does lead to improved health and longer lives by means of better access to medical care and that the available research begins to provide a reasonable basis for future economic analyses of the benefits of health insurance to the nation as a whole.

The central findings are:

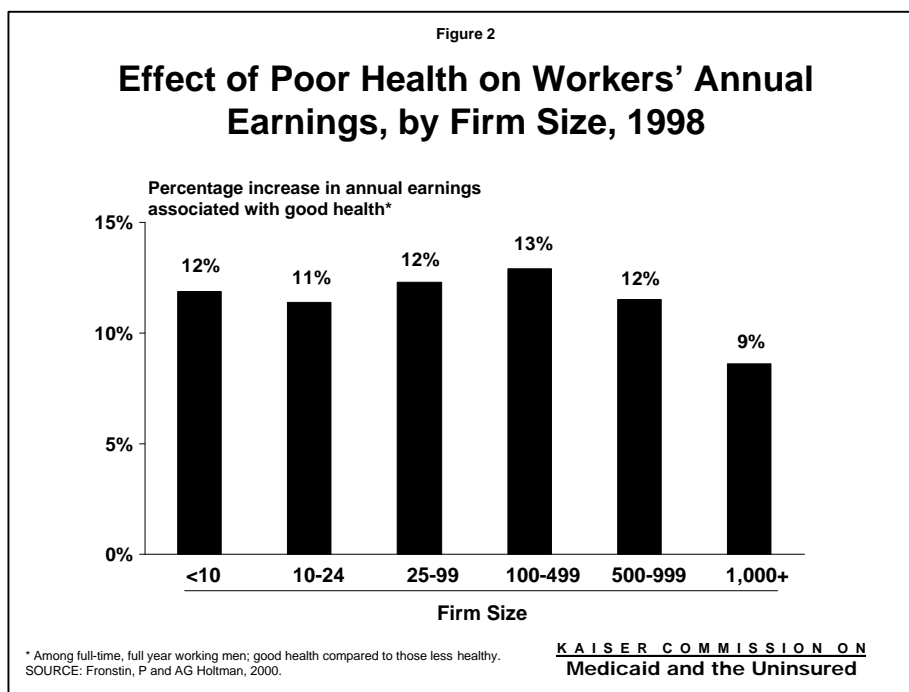
The uninsured receive less preventive care, are diagnosed at more advanced disease stages, and once diagnosed, tend to receive less therapeutic care and have higher mortality rates. For example, chances of surviving cancer are greatly reduced when the disease is diagnosed late in its progression and consequently the uninsured have higher cancer mortality rates (1.2 to 2.1 times greater) across different types of cancer (Figure 1). Uninsured persons with heart disease are less likely to



undergo diagnostic and revascularization procedures, less likely to be admitted to hospitals with cardiac services, more likely to delay care for chest pain, and have a 25 percent higher in-hospital mortality rate.

A conservative estimate based on the full range of studies is that a reduction in mortality of 5-15% could be expected if the uninsured were to gain continuous health coverage. A number of longitudinal studies have found that those who are uninsured at the outset of the study have higher mortality rates over time. For example, uninsured newborns' chances of dying are about 1.5 times higher than insured newborns. Another study found that the share of uninsured compared to those with insurance who had died over the 17-year study period was nearly twice as high (18.4% vs. 9.6%).

Better health would improve annual earnings by about 10-30 percent and would increase educational attainment. Poor health among adults leads to lower labor force participation, lower work effort if in the labor force, and lower earnings (Figure 2). Children in poor health have poorer school attendance, with both lower school achievement and cognitive development.



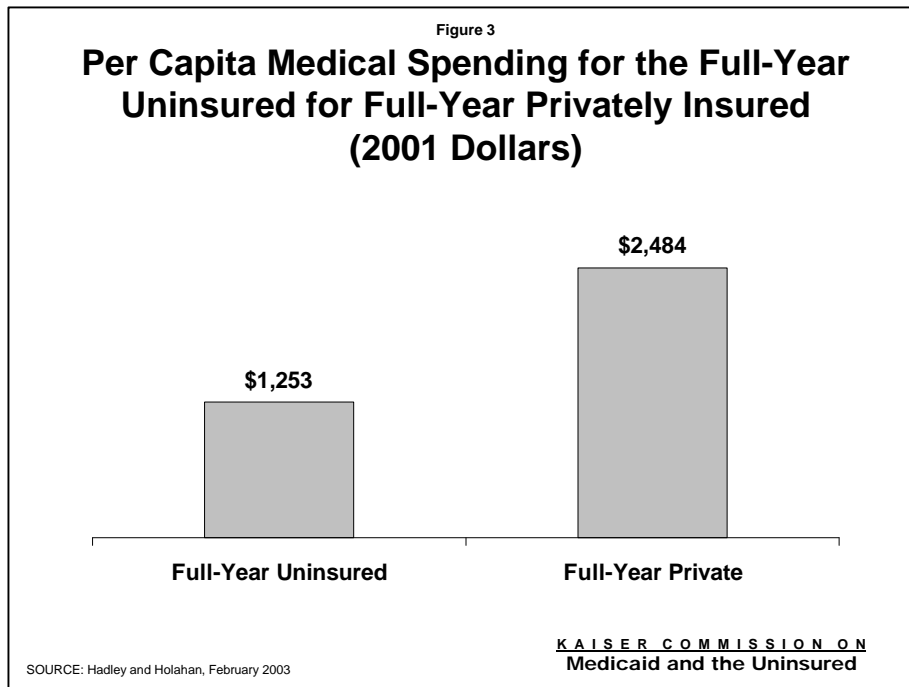
Who Pays and How Much?

The Cost of Caring for the Uninsured

Hadley, Jack and John Holahan. *Health Affairs*, (Web Exclusive), February 12, 2003

By estimating how much medical care the uninsured use and who pays for it, this analysis determines the resources that are already in the medical care system and potentially available to help pay for expanded insurance coverage. Knowing the existing funding sources already paying for care could help policymakers identify where some of the money for new coverage might be obtained.

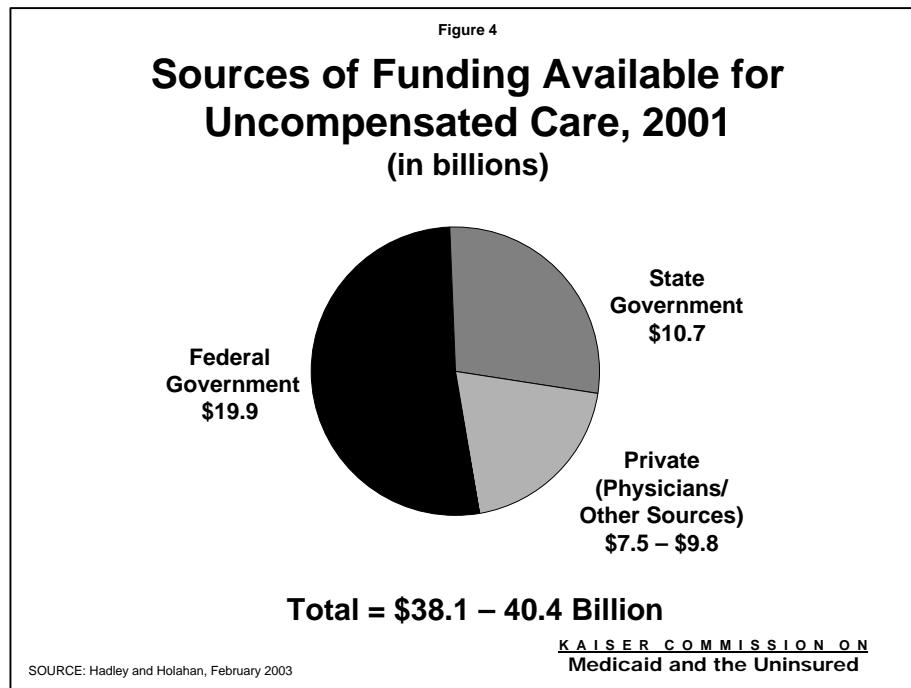
On average, the uninsured receive about half as much care as people who are insured all year. In 2001, persons uninsured for the full year used \$1,253 per year in medical care compared to \$2,484 for persons with private coverage for the full year (Figure 3).



Total medical care expenditures among the uninsured in 2001 (including those without coverage for all or part of the year) were almost \$100 billion. About a quarter of those costs were paid directly by the uninsured out-of-pocket. Private and public insurance for those who were uninsured only part of the year paid almost 40% of this amount, which left 35% of the total costs uncompensated.

Uncompensated care in 2001 was estimated to be \$35 billion dollars. Two independent methods of determining the amount of uncompensated care in 2001 yielded very similar estimates. Uncompensated care refers to care that is not paid for either out of pocket or by a private or public insurance source.

The primary source of funding for uncompensated care is government, which spent an estimated \$30.6 billion for care of the uninsured (accounting for 75-80% of all uncompensated care funding (Figure 4)). Although this is a substantial public expenditure, it represents less than 6% of total government spending for personal health care in 2001. In contrast, others have estimated that government subsidies through the tax code for the purchase of private insurance cost the government \$138 billion in 2001.



About two-thirds of the \$30.6 billion of government spending on uncompensated care, roughly \$20 billion, comes from the federal government. Medicare and Medicaid payments for disproportionate share hospital payments, indirect medical education dollars, and supplemental payments to providers constitute a large share of this amount. These estimates suggest that because a substantial part of the financing of care received by the uninsured is already in the public sector, then some share of these funds is potentially available to transfer to new government efforts to expand health coverage.

Almost \$24 billion – the majority of government funds – go to uncompensated care provided by hospitals. While it may be impossible to redirect all the existing government funds for uncompensated care, much of the spending to hospitals could potentially be reallocated as hospitals would be the primary beneficiary of expanding coverage to the uninsured since they provide two-thirds of uncompensated care.

Covering the Uninsured: How Much Would It Cost?

Hadley, Jack and John Holahan. *Health Affairs*, (Web Exclusive), June 4, 2003

Having health insurance increases medical care use, and so a critical question in the ongoing national debate over whether and how to extend insurance to people who are uninsured is – how much more will it cost, over and above what is currently being spent on the cost of their medical care?

This analysis estimates the cost of increased medical care use by the uninsured if all were to gain coverage comparable to:

- lower to middle-income people covered by the “average” private insurance policy, *or*
- people covered by the “average” public insurance policy (primarily low-income people covered by Medicaid and S-CHIP).

If insurance coverage were comparable to an average public health plan, estimated per person spending by the uninsured would rise by a little over 50%, increasing from \$1,383 to \$2,121. In contrast, expansion through an average private health plan would almost double per person spending, which would rise to \$2,676 (Figure 5).

Figure 5

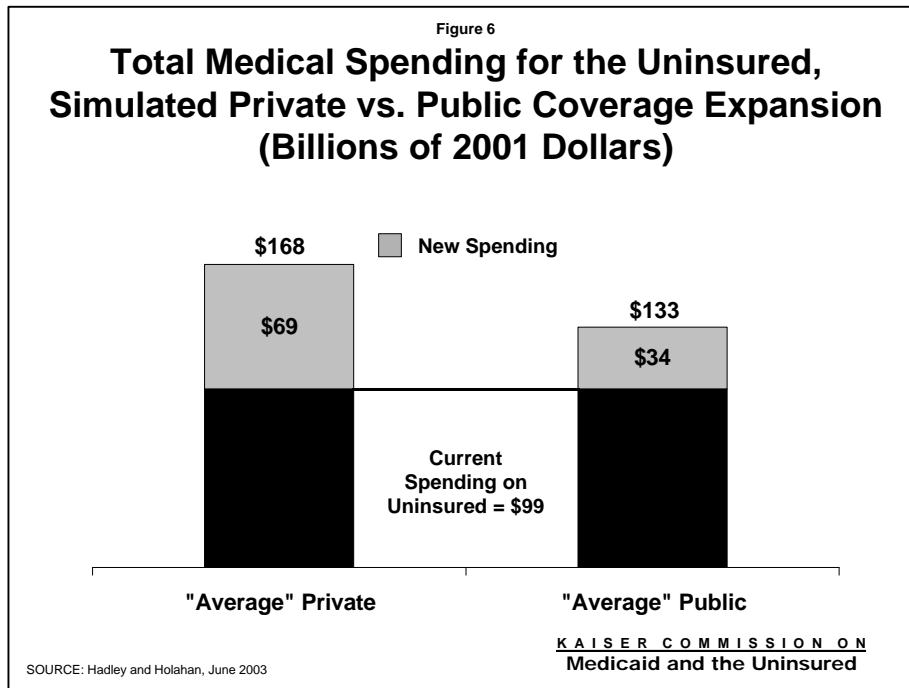
**Simulated Spending per Capita
(2001 Dollars)**

	Baseline (actual)	“Average” Private	“Average” Public
All Uninsured	\$1,383	\$2,676	\$2,121
Full-Year Uninsured	\$989	\$2,650	\$2,068
Part-Year Uninsured	\$1,813	\$2,705	\$2,178

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SOURCE: Hadley and Holahan, June 2003

Total spending for those who would gain coverage under a universal expansion would increase from current spending of almost \$100 billion (which includes all uncompensated care and out-of-pocket payments by the uninsured) to \$168 billion if coverage were similar to the average private insurance policy for lower/middle-income Americans. If the expanded coverage were similar to the average public insurance plan, the estimated total spending would be less – \$133 billion (Figure 6).



Most of the difference in the additional costs of covering the uninsured through a private vs. a public plan are due to differences in current payment rates. Total charges (what a provider bills) and use of services (hospital days, office visits) differ little depending on whether the uninsured gain public vs. private coverage. It is the low provider payment rates under public programs such as Medicaid that reduce public costs. However, if public coverage were used to cover more of the uninsured, political pressure to increase Medicaid provider payments could reduce the differential.

The overall impact of universal coverage on total health care costs would be an increase of \$35-\$70 billion, representing roughly 3-6% of total health care spending in this country. It would increase health spending's share of GDP by less than one percentage point, from 14.1% of GDP to 14.5-14.9%

A benefit of a comprehensive rather than incremental approach to covering all of the uninsured is that some of the public money already being used to pay for care received by the uninsured (about \$30 billion annually) could be reallocated towards the cost of insurance. However providers caring for the uninsured now may be reluctant to relinquish their existing subsidies unless assured that all people will have health insurance.

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The three reports have been published as journal articles and are also available through the Kaiser Family Foundation website at www.kff.org:

“Sicker and Poorer – The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income.” By Jack Hadley. *Medical Care Research and Review*, Vol. 60, No. 2, Supplement. June 2003. Available at: <http://www.kff.org/content/2003/4115/>

“How Much Medical Care Do the Uninsured Use, and Who Pays for It?” By Jack Hadley and John Holahan. *Health Affairs* (Web Exclusive). February 12, 2003. Available at: <http://www.healthaffairs.org/WebExclusives/2202Hadley.pdf>

“Covering the Uninsured: How Much Would It Cost?” By Jack Hadley and John Holahan. *Health Affairs* (Web Exclusive). June 4, 2003. Available at: http://www.healthaffairs.org/WebExclusives/Hadley_Web_Excl_060403.htm



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