POLICY brief

Estimating the Cost of Caring for California's Uninsured

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California faces a serious challenge in providing care for the 6.3 million uninsured individuals living in the state.[1] Many Californians are unable to pay for all their health care needs, and are forced to go without or delay care for themselves and their children. The uninsured pay for a large portion of their health care costs out-of-pocket, and also access needed services by relying on subsidies and free care. The cost of providing uncompensated health care to the uninsured is a large burden for public and private providers and organizations.

This policy brief documents the relative disparities in spending for direct personal health care services[2] between California's uninsured and insured population (ages 0-64) and provides an estimate of the direct costs that would be incurred if the uninsured were provided with health insurance, while controlling for demographic differences and health status. Hospitals and safety-net clinics in California already spend over $3 billion caring for the uninsured,[3] but the expenses discussed in this brief are direct personal health care expenditures paid by individuals and other third-parties for their care.

Average Direct Spending for Health Care: Insured versus Uninsured

Exhibit 1 shows that adults (ages 18-64) who are insured for the entire year will have the highest average per capita direct expenditures, either out-of-pocket or made on their behalf by a third party in 2004 – an estimated $2,793. For this group, the

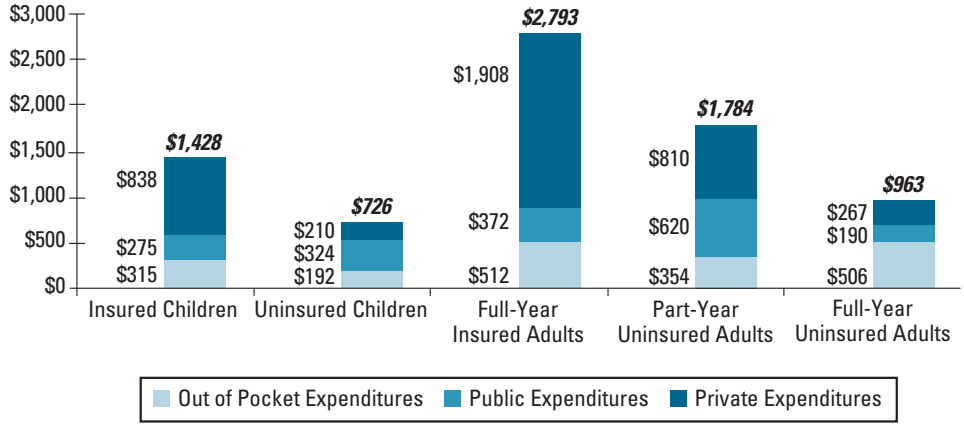


Exhibit 1. Estimated Per Capita Direct Health Care Expenditures by Payer Source and Insurance Status, Ages 0-64, California, 2004
Source: 2001 California Health Interview Survey and 1998-2000 Medical Expenditure Panel Survey Household Component

Note: Totals are in italics and may not sum due to rounding

1 Brown ER, and Lavarreda SA, *Over Half of California's 6.3 Million Uninsured Lack Health Insurance Coverage for More Than a Year.* Los Angeles: UCLA Center for Health Policy Research, 2003.

2 Direct personal healthcare expenditure estimates are based on multivariate analyses using the 1998-2000 Medical Expenditure Panel Surveys (see Data and Methods for more detail). These expenditures are direct payments to providers on the behalf of a user from any source. Funds for safety net providers, Disproportionate Share Hospital (DSH) payments, and other programs that do not directly reimburse providers are not included in this analysis.

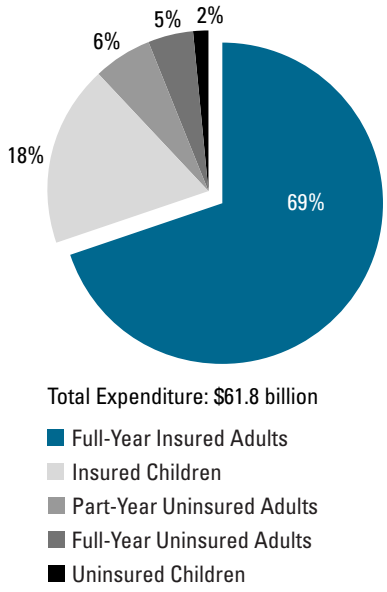
3 *On the Brink: How the Crisis in California's Public Hospitals Threatens Access to Care for Millions.* Oakland: California Association of Public Hospitals (CAPH), 2003, and the Health Resources and Services Administration (HRSA) Uniform Data System, 2002 California Rollup. Using Office of Statewide Health Planning and Development (OSHPD) Annual Hospital Financial Data, the CAPH found that $2.9 billion was spent in California on providing hospital care to the uninsured in 2002. In addition, the HRSA Uniform Data System shows that 75 federally-funded health centers in California received over $300 million in grants and funding from the Bureau of Primary Health Care (BPHC), state and local governments, and private foundations to further their mission to care for the uninsured.

majority of expenditures – $1,908 per capita (68%) – are paid from private sources (mostly private insurance), while about $512 per capita (18%) comes from out-of-pocket expenditures. This stands in sharp contrast to full-year uninsured adults, who spend $506 on average and a larger share (53%) for their care in out-of-pocket expenditures.

The same disparity in total and out-of-pocket spending is observed among children. Children with insurance all year have higher average health care expenditures relative to children who are uninsured all or part of the year – $1,428 versus $726 – but a lower share of out-of-pocket expenditures – 22% versus 26%.

The cost of care for the uninsured is also paid through a variety of public and private sources, such as workers' compensation or programs like the Sacramento County Medically Indigent Services Program (MISP) and publicly funded direct service programs for HIV/AIDS or cancer patients. Private firms may make donations that are linked to direct health care or provide insurance coverage for specific diseases. These insurance products are not considered true sources of comprehensive insurance.

Exhibit 2: Proportion of Total Direct Expenditures by Insurance Status, Ages 0-64, California, 2004
Source: 2001 California Health Interview Survey and 1998-2000 Medical Expenditure Panel Survey Household Component



Note: Percentages are rounded to total 100%

Total Direct Spending for Health Care: Insured versus Uninsured

To understand the impact of the uninsured on the state's health care system, we estimated total direct health care expenditures for the insured versus uninsured Californians in 2004.

As shown in Exhibit 2, total direct expenditures for personal health care services among those aged 0-64 in California are estimated to be $61.8 billion. This amount excludes public and private expenditures that are not directly linked (by reimbursement) to a patient's care. Services that are funded by grants and other indirect sources of money are not included.

The majority of personal health care expenditures in the state will come from full-year insured adults, with $43.1 billion (69%) spent from private or public insurance, out-of-pocket costs, and other sources. Insured children account for 18% of expenditures, or almost $11.3 billion. In comparison, spending by uninsured children and adults constitutes a combined 12% of expenditures, a total of $7.4 billion.

Can We Cover the Uninsured?

Although uninsured adults and children in California account for only $7.4 billion in direct health care expenditures, spending among the uninsured is clearly lower due to the lack of insurance. We assumed that provision of health

Exhibit 3: Estimated Additional Direct Expenditures for Covering the Uninsured, Ages 0-64, California, 2004
Source: 2001 California Health Interview Survey and 1998-2000 Medical Expenditure Panel Survey Household Component

	EXPENDITURES PER CAPITA	POPULATION	TOTAL EXPENDITURES (IN BILLIONS)
UNINSURED CHILDREN			
CURRENT DIRECT SPENDING	$726	1,308,845	$0.950
PROJECTED DIRECT SPENDING IF INSURED	$1,397	1,308,845	$1.829
		INCREASE	$0.878
PART-YEAR UNINSURED ADULTS			
CURRENT DIRECT SPENDING	$1,784	2,051,260	$3.659
PROJECTED DIRECT SPENDING IF INSURED	$2,538	2,051,260	$5.206
		INCREASE	$1.547
FULL-YEAR UNINSURED ADULTS			
CURRENT DIRECT SPENDING	$963	2,931,491	$2.823
PROJECTED DIRECT SPENDING IF INSURED	$2,668	2,931,491	$7.821
		INCREASE	$4.998
TOTAL ADDITIONAL DIRECT EXPENDITURES			**$7.423**

insurance would increase direct expenditures among the uninsured to levels comparable to the insured, adjusting for differences in the use, health status, and demographic characteristics of the uninsured population.

Exhibit 3 shows the estimated increase in direct health care spending by the uninsured if they were to have insurance. We estimate statewide expenditures would increase by another $7.4 billion. The uninsured would spend about $14.8 billion in total on direct health care if fully insured, compared to the $7.4 billion they already spend out-of-pocket or that is paid on their behalf from other public and private sources.

This $7.4 billion increase in expenditures represents a 12% increase in total direct personal health care expenditures in the state. The additional expense would be about $1,180 per uninsured person in the state. This estimate does not consider the savings that may occur due to reduced morbidity and mortality because of improved health status, better access to care, increased use of preventive services, or reduced spending from safety net providers and revenue sources that are not linked to directly subsidized patient care.

Findings and Implications

Covering the uninsured is a significant step in improving the health status and quality of life for all Californians by guaranteeing that no Californian will face access barriers as a result of losing their health insurance. The projections in this policy brief show that an expansion of health insurance would increase direct expenditures. However, it would also provide much needed care to the 6.3 million people who lack health insurance, as well as provide equal access to health care in the state. Clearly, substantial spending on behalf of the uninsured already occurs in the form of direct subsidies to facilities, such as the disproportionate share-payment programs of Medicare and Medi-Cal, privately-subsidized health care clinics, and federally-funded health centers and clinics. Hospitals, physicians, and other providers also provide direct services to the uninsured in the form of uncompensated care.

Shifting resources could enhance the ability of the state to insure the uninsured, improving access to care and the health of Californians. We are working to estimate these indirect sources of expenditures on behalf of the uninsured, and to develop options on how all these direct and indirect sources of expenditures might be combined to provide affordable insurance for California's uninsured population.

In light of our estimates, the costs of an insurance expansion may be more affordable if the state can find mechanisms for redirecting current sources of public and private expenditures on behalf of the uninsured.

Data Sources and Methods

This policy brief is based on findings from the 2001 California Health Interview Survey (CHIS 2001) and the 1998-2000 Medical Expenditure Panel Surveys (MEPS). CHIS 2001, the largest health survey conducted in any state, covers a broad range of public health concerns including health status and condition, health-related behaviors, health insurance coverage, and access to health care services. CHIS 2001 completed interviews with 55,428 adults, 5,801 adolescents ages 12-17, and 12,592 parents of young children ages 0-11. The data were weighted based on the 2000 Census. The interviews were conducted between November 2000 and September 2001.

This analysis also used 1998-2000 data from the Medical Expenditure Panel Survey (MEPS). MEPS data are collected by the Agency for Health Care Research and Quality (AHRQ) and include information on the direct expenditures by individuals for personal health care services. For information on MEPS, please visit www.meps.ahrq.gov.

We used MEPS to develop predictions for five population groups: (1) children insured all year; (2) children uninsured part or all of the year; (3) adults insured the entire year; (4) adults uninsured part of the year; and (5) adults uninsured all year. CHIS demographic and health status data from 2001 were then applied to the MEPS models to estimate the level of expenditures for each of these groups.

Within each group, we developed total direct expenditure estimates for individuals with and without inpatient stays, then aggregated total expenditures within each of the five groups and adjusted to 2004 dollars. Total direct expenditures were calculated by multiplying the number of Californians in each of the five categories from CHIS 2001 by the average direct expenditure per person obtained from applying CHIS 2001 population characteristics to the MEPS expenditure models. To estimate the share of total direct expenditures from public, private, and out-of-pocket sources, we applied proportions from the MEPS data for the western region of the U.S. to our average per capita direct expenditures. Finally, we obtained estimates of the cost of insuring California's uninsured population by substituting the demographics and usage patterns of the uninsured population into the models for insured adults and children. This assumes that the uninsured will have the same use and expenditure pattern as the insured, controlling for differences in their demographic characteristics, including health status.

The California Health Interview Survey (CHIS) is a collaboration of the UCLA Center for Health Policy Research, the California Department of Health Services, and the Public Health Institute. Funding for CHIS 2001 was provided by the California Department of Health Services, The California Endowment, the National Cancer Institute, the California Children and Families Commission, the Centers for Disease Control and Prevention (CDC), and the Indian Health Service. For more information on CHIS, visit www.chis.ucla.edu.

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