

UNIVERSAL HEALTH INSURANCE AND UNINSURED PEOPLE: EFFECTS ON USE AND COST

CHAPTER 1. INTRODUCTION

Numerous health care reform proposals are before the Congress, calling for dramatic changes in the current system that, if passed, would represent possibly the most significant social policy reform since the passage of the Social Security Act. On many points the various proposals differ, But there is general agreement on some principles among many of the various plans. For example, many of them call for guaranteed insurance coverage for all Americans,

Long-standing advocates of universal coverage point to the lower use of health services by the uninsured than by the insured as evidence of poor access to health care services for the uninsured. If the insured use the appropriate quantity of services, then one implication of the lower use by the uninsured is said to be a reduction in health status and productivity, The larger the gap in use, the greater the expected benefits of universal access in improved health for the uninsured and in increased output.

Universal coverage may also benefit those who currently finance health care. One component of current health care costs, particularly of inpatient and outpatient hospital costs, is uncompensated care for the uninsured. These costs are thought to be “shifted” to other payers -- including private insurers, whose costs are passed on to business in higher premiums, and taxpayers supporting local public hospitals. National health reform is intended to finance the care of the uninsured in some other way. Therefore, one benefit of reform may be relief to those now paying the “cost-shift.” The larger the gap in use between the uninsured and the insured, however, the less the extent of current cross subsidies, and hence the smaller the benefit to those paying the cost-shift.

Universal coverage is likely to increase the use of health care services by the previously uninsured, thus drawing additional resources into the provision of health services, The additional resource cost of universal access will be greater the larger the current access gap and hence the greater the expected increased demand resulting from the extension of insurance benefits to the uninsured.

Thus, measuring both the benefits and social costs of reform requires precise estimates of the access gap. Here represent estimates of the gap and its implications for the cost of national health reform based on the best available data. Our estimates, in several ways, represent a *partial* analysis of the costs of extending health insurance coverage to the currently uninsured.

First, the estimates assume that other aspects of the existing health care financing and delivery system remain unchanged. That is, universal coverage is assumed to induce the

currently uninsured to consume health services at the rate that the insured currently consume, assuming that the policies covering the newly insured would contain the same mix of HMO and fee-for-service benefits, scope of services, and cost-sharing provisions as held by the currently insured. However, health reform has a second objective -- to reduce the growth in health care spending and the use of inappropriate services by promoting managed care, prudent purchasing, and competition among providers and insurers. If these efforts lower the insured norms for use and spending, then our partial estimates overstate the cost of insuring the uninsured.

Another dimension on which our estimates are limited is the types of services considered. Available utilization data cover inpatient hospital care and ambulatory care at all sites, mostly by physicians. Our estimates of the access gap are limited to these services. By assuming that the access gap for inpatient physician services (for example, surgery) is the same as that for ambulatory care, our cost estimates apply to all hospital and physician services. These services represent a very large proportion of the spending under health insurance plans for the nonelderly population. Depending on the covered benefits of any particular reform plan, however, our estimates may understate the incremental cost. We illustrate the magnitude of this omission by estimating the total cost required to add prescription drugs to the services we consider.

Our estimates also assume that prices for care do not change in response to either the increased demand for services from universal coverage or the decreased demand for services from efforts to contain costs and reduce inappropriate service use. Because we estimate only a small induced demand from universal coverage, this assumption does not appear to be a very strong one.

Finally, universal coverage is intended to extend insurance protection to the 37 million Americans who now lack coverage, but it is also intended to improve protection for many Americans who have insurance coverage but are underinsured, either because the scope or generosity of their benefits is inadequate or because coverage for certain pre-existing health problems is excluded from coverage. Our estimates do not include the costs of eliminating undercoverage.

There is some uncertainty surrounding the point estimates that we report. First, the estimates of increased use are based on surveys, and such estimates can differ from the true population values because of sampling error. Second, our estimates rely on assumptions that cannot always be tested with extant data. We assume that the currently uninsured, once insured, would use care at the same rate as currently insured individuals with similar economic and demographic characteristics. This is an assumption that is made in any observational study of behavioral response, and can only be tested through a controlled experiment.

Our estimates of cost rest even more heavily on assumptions than do the estimates of the increased quantity of use because there is limited information about health care expenditures in the aggregate and even more limited information about how spending varies among different groups of individuals and with the quantity of service consumed. As a result, we have had to rely on estimates of average costs of different services and

assume that the average applies across all individuals and does not vary with quantity. Where even limited ancillary information exists to test this assumption, we have reported estimates of the sensitivity of our point estimates to the assumption. Despite some uncertainty about the actual magnitude of the cost of universal coverage, informed debate requires the best estimate that can be obtained. We have sought to provide this. Moreover, the evidence that we have found suggests that our estimates are not so sensitive to the assumptions as to negate the qualitative conclusion about the effect of universal access on health care costs.

The next chapter is intended for the reader who is interested in a brief summary of our key findings, but not in the methodological detail about how they were obtained. It presents estimates of the differences in rates of ambulatory care use and inpatient hospital care use by insured and uninsured individuals and the implication of those differences for the cost of national reform. Chapters 3 and 4 provide the technical detail of our estimation. Chapter 3 presents the methods for estimating relative use by the insured and uninsured, Chapter 4 describes how these relative use estimates are converted into estimates of aggregate costs.