

EXECUTIVE SUMMARY

Many health reform proposals call for universal coverage. Universal coverage would mean extending coverage to the 37 million people who are currently without health insurance. Measuring both the benefits and the costs of universal coverage requires good estimates of the impact of new insurance coverage on the quantity of health services used by those now uninsured and on the expenditures for that additional use. Using the best available data from three large surveys of the U.S. population, this report develops estimates of the gap in health services utilization between insured and uninsured people that is, the “access gap.” Based on those estimates, the report examines the implications of that gap for national health expenditures and for the adequacy of existing health care resource capacity.

The key findings of this analysis are summarized below:

- In a single year, adults reporting a complete lack of health insurance have 61 percent as many ambulatory health services contacts and 67 percent as many inpatient hospital days as a comparable group with health insurance coverage, (Ambulatory contacts include contacts in person or by telephone with a physician or other medical provider working in a physician’s office, clinic, or hospital emergency room or outpatient department.)
- There is also an access gap for uninsured children, although it is somewhat smaller than that for uninsured adults. Children lacking insurance coverage have 70 percent as many ambulatory contacts and 81 percent as many inpatient hospital days as do otherwise similar children with coverage all year.
- For both adults and children, the gaps for people reporting fair or poor health are greater than those for people reporting excellent or good health.
- Under universal coverage, filling this access gap for all the previously uninsured would lead to an estimated increase in total annual ambulatory contacts of 55 million (3.8 percent), and an estimated increase in total annual inpatient hospital days of 6.1 million (3.6 percent). *In the aggregate*, the health care system has adequate capacity to absorb these increases in utilization.
- The currently uninsured would use a total of \$60.5 billion (in 1993 dollars) of physician and hospital services under universal coverage -- \$40.6 billion that would have been consumed had they continued to be uninsured, plus \$19.9 billion of new resources represented by the access gap. This 19.9 billion, which represents 2.2 percent of total national health expenditures, is a “best estimate.” Tests of the sensitivity of this estimate to use of any one of various alternative sources of data and assumptions suggest that it could range from \$16 billion to \$29 billion, or from 1.8 percent to 3.2 percent of national health spending. From one perspective, spending by the previously uninsured would increase substantially -- by about 50 percent -- once they obtain coverage. On the other hand, this increase represents relatively few resources when compared to the total spent by the U.S. on health care and its administration.

- New insurance premiums for the previously uninsured might total between \$60 billion and \$70 billion. This would pay both for the services currently provided to the uninsured, but financed through taxes, “cost-shifting,” and out-of-pocket payments, and for some of the additional services demanded once they were insured. This is a rough estimate -- its size would depend on the cost-sharing provisions of the reform plan, the services included in its benefit package, the mix of managed care and indemnity plan enrollments, and their administrative costs .
- A number of factors could affect the estimates in this report (see Overview of Methods and Assumptions).

The major contribution of this study is to narrow considerably estimates of the access gap presented in the previous literature. As shown in its review of previous studies, earlier estimates placed use of physician visits by the uninsured at between 46 and 100 percent of use by the insured, and use of inpatient hospital services by the uninsured at between 12 and 81 percent of use by the insured. With a range this large, estimates of the effects of universal coverage were very uncertain. By applying uniform estimation methods to all of the major national surveys from the mid- to late 1980s, the uncertainty of this aspect of health reform estimates is reduced considerably.

In contrast, the estimates of the costs of universal coverage presented here are necessarily less precise than the estimates of the access gap measured in terms of relative use. This is because the available expenditure data are more limited, necessitating numerous assumptions to be made. Moreover, the figures derived in this analysis do not represent predictions of what would happen under any particular health reform proposal that would achieve universal coverage. Any such predictions would have to consider many aspects of the particular reform proposal, which is beyond the scope of this study.

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Overview of Methods and Assumptions

This report provides point estimates of the “access gap” in ambulatory health services contacts and inpatient hospital days per person using the best available data from three recent large national surveys of the U.S. population. The estimates are based on reported health services used by those who are uninsured for a full year and by those who have private employer-sponsored health coverage for a full year; and they are based on people younger than 65 years of age. The report focuses primarily on physician and hospital services both because these services account for most of the spending under private employer-sponsored insurance because most health reform plans would provide the previously uninsured with coverage under this source or its equivalent. The focus is on the nonelderly because they represent 99 percent of the uninsured in the U.S.

The report also estimates the aggregate access gap for the U.S. and it estimates the implications for national health spending of providing universal health insurance coverage. Data on current and projected physician and hospital capacity are used to examine the impact of the added demand for resources that universal coverage would entail; but the interaction between geographic variation in additional demand and available capacity could not be explored with these data. The spending implications are estimated by combining the estimates of additional resource use under universal coverage with the leading source of current information on aggregate physician- and hospital-related health care expenditures. Finally, the report illustrates the projected impact of covering all currently uninsured people on total premium costs,

Methods

The measure of the access gap is based on estimated current use of hospital and physician services by people who were uninsured for a full year and a predicted value of what each person would use if he or she were covered for the year by a plan now typical of those covering people with employer group coverage. Use is predicted from a multivariate model of health services use that includes explanatory variables for health insurance status, demographic and economic characteristics, and health status. Separate models are estimated for adults and children and from each of the three surveys. Annual health care use is estimated for uninsured people and simulated as if they were insured for a full year. The resulting estimates were averaged to produce the measures reported in this summary.

To measure the aggregate volume of increased service use under universal coverage, the predicted access gap was adjusted in two ways. First, people with part year periods of being uninsured had partial access gaps attributed to them, reflecting higher use while insured and lower use while uninsured. Second, the sample was reweighted to reflect the size and age-sex composition of the uninsured population in 1992. The estimates of resource costs are the product of this estimate of increased aggregate demand by the formerly uninsured and the unit costs of each physician and

hospital service calculated from the Health Care Financing Administration's estimates of national health expenditures and U.S. Public Health Service estimates of aggregate use. The unit cost estimates were projected to reflect 1993 dollars based on annual rates of growth in per capita hospital and physician spending.

Assumptions and Limitations

In several ways, these estimates represent a partial analysis of the cost of extending health insurance coverage to the currently uninsured. First, they assume that other aspects of the existing health care financing and delivery system remain unchanged. It is assumed that the policies covering the newly insured under universal coverage would contain the same mix of health maintenance organization and fee-for-service benefits, scope of services, and cost-sharing provisions as those 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 these partial estimates overstate the cost of insuring the uninsured.

The estimates also assume that prices for care do not change in response to either the increased demand for services from implementing universal coverage or the decreased demand for services resulting from cost containment efforts. Finally, only the cost of providing insurance to those who now lack insurance is included; but not the cost of adding benefits for Americans who already have some coverage.

There is some uncertainty surrounding the estimates in this report. First, they rely on assumptions that cannot always be tested with extant data. It is assumed that the currently uninsured, once insured, would use care at the same rate as currently insured persons with similar, and observed, economic and demographic characteristics. This assumption can only be tested through a controlled experiment. The cost estimates rest even more heavily on assumptions than do the estimates of the increased quantity of use because of data limitations. They rely on estimates of the average costs of different services, and assume that this average applies across all individuals and does not vary with quantity. Some of these assumptions were tested where ancillary data exist. The evidence suggests that the estimates are not so sensitive to the assumptions as to negate the qualitative conclusion about the effect of universal access on health care costs.