

## UNINSURANCE COSTS THE COUNTRY MORE THAN YOU THINK

**Principle: The health insurance strategy should be affordable and sustainable for society.**

Having a sizeable uninsured population translates into real economic and non-economic costs for our country, including the expenses for services uninsured people use and the costs resulting from poorer health because they often forgo needed services. On the flip side, there are costs for providing universal coverage, including the expense of additional services the previously uninsured will use.

Uninsured people use fewer health services than their insured counterparts, and their health and lifespan are compromised as a result. When they do use services, they are more likely to use costly emergency room services or require hospitalization that could have been avoided if they had received timely primary care.

In addition, uninsurance has costs that extend beyond uninsured people and their families to community health care institutions, providers, and even the insured population. When the uninsured are unable to pay their own medical expenses, those costs are borne by others, particularly taxpayers. The cost of uncompensated care falls more heavily on local communities with larger concentrations of uninsured residents.

### Public dollars pay most of the \$35 billion in uncompensated care.

- \$99 billion was spent on health care services for people uninsured for all or part of 2001 (Hadley and Holahan, 2003.) This includes charity care received, the \$26.4 billion the uninsured paid out of their own pockets, any private or public insurance payments made for services if they were covered for only part of the year, and worker's compensation payments.
- On average, people who are uninsured for a full year pay 35 percent of the overall cost of their medical services.
- The roughly \$35 billion for uncompensated care provided to uninsured individuals is comprised of \$23.6 billion in patients' unpaid hospital bills, \$7.1 billion in public expenditures for government grant and direct service programs (e.g., Veterans Affairs, Indian Health Services, Health Resources and Services Administration programs, local health departments), and \$5.1 billion in free or reduced-cost care provided by office-based physicians and through volunteer service in clinics.
- Approximately \$23.6 billion in tax dollars is used to reimburse hospitals that have a disproportionate share of uninsured patients.

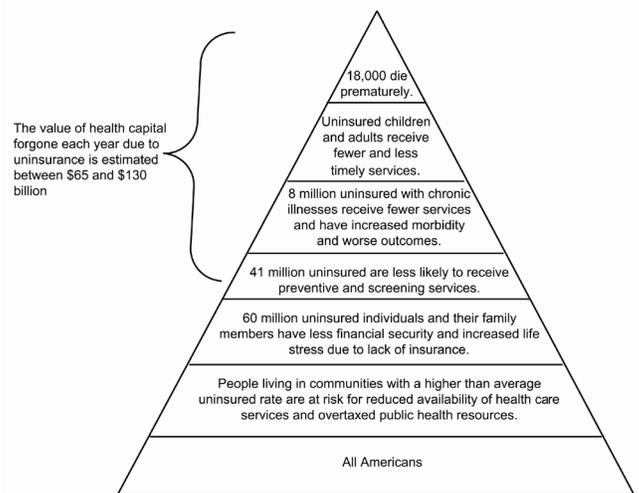
### U.S. health care spending should be more effective.

- The United States spends more per capita than any other nation, 14 percent of gross domestic product in 2002, but our spending has not bought us top health status among nations or reduced the size of the uninsured population. For example, the United States ranks 25th in male life expectancy and 19th in female life expectancy among 29 developed countries.

### The costs of sustaining a large uninsured population are often hidden.

- The health of a nation's populace is part of the nation's

### The Consequences of Uninsurance Add Up



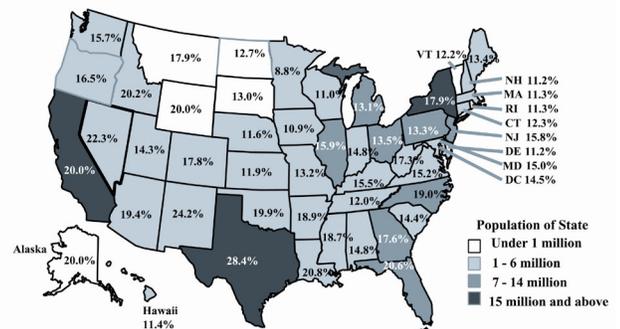
wealth. The poorer health and shorter lifespan of uninsured people can be thought of as “health capital” lost to the nation. The nation loses some \$65 billion to \$130 billion in health capital each year.

- High uninsured rates in a community can put financial pressure on certain services and institutions. Trauma center patients are more likely to be uninsured than all hospital patients. The closure of a regional trauma center or reduction in its scope of services puts the health of everyone in a community — whether insured or uninsured — at risk.
- Clinicians in community health centers located in areas with high rates of uninsurance report difficulties in obtaining specialty referrals for all of their patients, not just those who are uninsured.
- A community’s high rate of uninsurance can adversely affect the overall health status of the community. For example, underimmunization increases the vulnerability of entire communities to outbreaks of measles and influenza. Childhood and adult immunization levels are correlated with having health insurance.

### A federal role is necessary to eliminate uninsurance.

- Where you live matters, whether you are insured or not. Existing local and state financing for the uninsured is spread unevenly, varies by locality, and does not necessarily match local needs.
- Acting alone, states do not have the fiscal resources to fully implement existing public coverage programs despite the use of federal Medicaid waivers to leverage state dollars. Even the states that have led major coverage reforms have not been able to eliminate large and persistent uninsured populations. The uninsurance rate is 11.4 percent in Hawaii; 11.3 percent in Massachusetts; 8.8 percent in Minnesota; 16.5 percent in Oregon; and 12 percent in Tennessee.

**The Likelihood of Being Uninsured Varies By State**



SOURCE: U.S. Census Bureau estimates for 2002, based on March 2003 Current Population Survey. Table HI05, Available at [http://ferret.bls.census.gov/macro/032003/health/h05\\_00.htm](http://ferret.bls.census.gov/macro/032003/health/h05_00.htm).

- The federal Employee Retirement Income Security Act of 1974 (ERISA) currently constrains the ability of states to mandate employment-based coverage, one strategy to expand private coverage within their boundaries.
- State and local governments’ ability to finance health care and coverage extensions is weakest when tax revenues decline during economic downturns, precisely the times when individuals and families need such support.

### Extending coverage to all requires a different national approach.

- All should contribute financially to extending coverage universally through taxes, premiums, and cost sharing, because all will benefit.
- Federal or shared federal-state financing for health insurance programs would distribute the burden of health care more broadly among taxpayers.
- The affordability and sustainability of different universal coverage strategies will largely depend on the nature of cost controls in the system, sources of revenues, the amount of patient cost sharing, and the comprehensiveness of benefit packages.

Drawn from: *A Shared Destiny*, 2003; *Hidden Costs, Value Lost*, 2003; *Insuring America’s Health*, 2004. Institute of Medicine. Washington, DC: National Academies Press.