Title
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The high rate of Californians without health insurance places a great demand on the federal, state and county programs that provide services and subsidies to care for the uninsured. Analysis of the most recent California Health Interview Survey data shows that 6.6 million Californians were uninsured at some time in 2003, an increase from 6.3 million in 2001.[1] The increasing number of uninsured residents in California is placing greater fiscal pressure on federal, state and local governments. Based on our analysis, however, the additional cost of insuring all of California's uninsured population may be as low as $842 million, which represents an increase of about 6% in current total spending for the uninsured, and an increase of less than 1% of overall health care spending in the state.

Currently, the uninsured receive care through two different funding sources. Many uninsured patients pay directly for services out-of-pocket, or their care is paid directly by public and private sources, such as county indigent care programs. The other category of funding is indirect, and is provided through subsidies to health care facilities. These safety-net providers receive public subsidies, such as Disproportionate Share Hospital (DSH) payments or grants, to compensate for care delivered to the uninsured.

One alternative to the current system of providing direct services and indirect funding subsidies to providers and facilities that care for the uninsured would be to subsidize insurance premiums on behalf of the uninsured. This program could be implemented through health care reform that would expand Medi-Cal and Healthy Families, or by allowing the uninsured to buy-in to private insurance programs usually reserved for employees. Many policy and administrative issues would need to be addressed before developing an effective program for subsidizing health insurance for the uninsured. This policy brief, based on data from the 2001 California Health Interview Survey (CHIS 2001) and federal surveys, addresses perhaps the most fundamental question in developing such a program, namely: How much would it cost to insure all uninsured Californians?

We estimate that current direct spending by and for California's uninsured is $9.8 billion in 2005. Indirect subsidies from federal, state and county sources account for another $3.6 billion in expenditures, for a combined total of $13.4 billion. We also estimate that the uninsured would spend approximately $14.3 billion if fully insured. Therefore, the gap between current and projected spending is approximately $842 million, or $143 additional dollars for each uninsured individual in California. We conclude that this is a modest increase in expenditures that would greatly benefit the state and counties by enabling all Californians to obtain the health care they need.

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The California Endowment

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Exhibit 1 **Regional Direct, Indirect and Projected Health Care Spending on Behalf of the Uninsured, Ages 0 to 64, California, 2005***

Regional County Group**	Number Uninsured in Each County (2001)	Current Indirect Subsidies (millions)	Current Total Direct Spending (millions)	Total Current Spending for Uninsured (millions)	Projected Total Spending if Insured (millions)	Total Projected Spending Less Total Current Spending (milllions)***	Percent Difference Between Current Spending***
Formulas	**A**	**B**	**C**	**D = B + C**	**E**	**F = E - D**	**G**
Alameda	177,000	$160	$237	$397	$369	-$27	-6.9%
Butte	35,000	$16	$60	$77	$76	-$1	-1.1%
Contra Costa	92,000	$55	$158	$214	$212	-$1	-0.7%
El Dorado	28,000	$11	$42	$53	$55	$2	3.7%
Fresno	159,000	$85	$247	$332	$355	$24	7.2%
Humboldt	21,000	$13	$32	$48	$34	-$13	-27.9%
Del Norte	4,000	$3					
Imperial	29,000	$18	$60	$78	$99	$21	26.8%
Kern	141,000	$97	$183	$281	$249	-$32	-11.4%
Kings	21,000	$9	$38	$47	$55	$9	18.6%
Los Angeles	2,176,000	$1,313	$3,242	$4,555	$5,028	$473	10.4%
Madera	26,000	$15	$38	$53	$63	$10	19.3%
Marin	24,000	$11	$51	$62	$65	$3	4.6%
Mendocino	17,000	$12	$40	$57	$55	-$3	-4.4%
Lake	12,000	$5					
Merced	44,000	$30	$55	$85	$65	-$20	-23.7%
Monterey	97,000	$43	$205	$253	$282	$29	11.7%
San Benito		$5					
Napa	19,000	$8	$31	$39	$44	$5	12.9%
Nevada	14,000	$9	$28	$39	$37	-$2	-6.0%
Plumas	3,000	$2					
Sierra	1,000	$0.3					
Orange	559,000	$245	$1,008	$1,253	$1,416	$164	13.1%
Placer	21,000	$12	$31	$44	$39	-$4	-10.0%
Riverside	319,000	$186	$517	$704	$814	$111	15.7%
Sacramento	171,000	$77	$284	$361	$346	-$15	-4.0%
San Bernadino	335,000	$213	$540	$754	$916	$163	21.6%
San Diego	510,000	$257	$821	$1,078	$1,044	-$33	-3.1%
San Francisco	137,000	$101	$175	$276	$219	-$57	-20.6%
San Joaquin	97,000	$61	$205	$266	$287	$21	7.9%
San Luis Obispo	39,000	$24	$65	$89	$97	$8	9.4%
San Mateo	73,000	$44	$96	$140	$128	-$12	-8.7%
Santa Barbara	86,000	$32	$113	$145	$146	$2	1.0%
Santa Clara	210,000	$149	$247	$396	$320	-$76	-19.1%
Santa Cruz	46,000	$21	$88	$109	$105	-$4	-3.9%
Shasta	28,000	$18	$40	$59	$54	-$4	-7.6%
Siskiyou	10,000	$3	$24	$33	$39	$6	18.7%
Lassen	3,000	$5					
Modoc	1,000	$1					
Trinity	3,000	$1					
Solano	37,000	$15	$54	$68	$79	$10	15.1%
Sonoma	68,000	$32	$88	$120	$119	-$0.4	-0.3%
Stanislaus	72,000	$37	$124	$161	$172	$11	6.8%
Sutter	12,000	$10	$50	$66	$76	$9	13.8%
Yuba	11,000	$6					

Exhibit 1 (continued) **Regional Direct, Indirect and Projected Health Care Spending on Behalf of the Uninsured, Ages 0 to 64, California, 2005***

Regional County Group**	Number Uninsured in Each County (2001)	Current Indirect Subsidies (millions)	Current Total Direct Spending (millions)	Total Current Spending for Uninsured (millions)	Projected Total Spending if Insured (millions)	Total Projected Spending Less Total Current Spending (milllions)***	Percent Difference Between Current Spending***
Formulas	**A**	**B**	**C**	**D = B + C**	**E**	**F = E - D**	**G**
Tehama	9,000	$6					
Glenn	8,000	$3	$26	$36	$39	$3	8.7%
Colusa	3,000	$2					
Tuolumne	10,000	$5					
Calaveras	5,000	$4					
Amador	4,000	$3					
Inyo	3,000	$2	$67	$83	$70	-$13	-15.2%
Mariposa	2,000	$2					
Mono	1,000	$1					
Alpine	1,000	$0.1					
Tulare	94,000	$41	$185	$226	$227	$1	0.5%
Ventura	140,000	$62	$200	$262	$317	$54	20.7%
Yolo	24,000	$10	$29	$39	$61	$22	56.2%
Total	**6,292,000**	**$3,609**	**$9,823**	**$13,433**	**$14,275**	**$842**	**6.3%**

Source: 2001 California Health Interview Survey and the 1998-2000 Medical Expenditure Panel Survey.

* Dollar amounts were inflated to 2005 dollars based on inflation factors from K Levit, C Smith, C Cowan, A Sensening, A Catlin. Health Spending Rebound Continues in 2002. *Health Affairs*, January/February 2004.

** The regional county group totals represent aggregated data for all counties in the group, which are represented by shading.

*** A positive value in the columns for total and percent difference indicates the additional money necessary to provide insurance to all of the uninsured in the county. The methodology for these estimates can be found at *www.healthpolicy.ucla.edu/cost_methods_2005.html*.

(continued from page 1)

Our findings also suggest that the greatest challenge facing policymakers is not finding substantial new sources of revenue to cover the uninsured, but in combining the diverse funding streams for the uninsured into a single program. It is worth noting that even if all Californians have health care coverage, safety-net clinics and public agencies may need to provide additional services to low-income and other underserved persons to enable them to get the care they need. For example, Federally Qualified Health Centers (FQHC) and other safety-net clinics provide enabling services, such as transportation, extended hours, language translation and parenting classes. These additional services targeted to low-income or medically-needy individuals are likely to be worthwhile additional expenditures.

County Estimates of the Cost of Insuring the Uninsured

Exhibit 1 shows the breakdown of current spending for the uninsured from direct and indirect sources, and the projected spending by the uninsured if fully insured, for the 58 counties and 41 regional county groups in California. As shown in this Exhibit, several large counties (Los Angeles, Orange, Riverside and San Bernardino) account for most of the gap between current and projected spending to insure the uninsured. For example, Los Angeles County—which accounts for 35% of the state's uninsured population and has one of the highest percentages in the state—would need an additional $473 million to insure the uninsured. This amount represents a 10.4% increase in total expenditures for the uninsured in Los Angeles County, and

accounts for more than half of the additional projected spending statewide to insure the uninsured.

Sixteen of the 41 regional county groups in Exhibit 1 would experience a reduction in spending by insuring the uninsured. Spending in these counties to insure the uninsured may continue to be greater than we estimate, if safety-net clinics and public agencies are to provide the additional services needed to overcome barriers to health care.

Policy Implications

If all uninsured Californians were provided with health insurance, their utilization of health care services and thus, direct health care expenditures would increase because of the reduction or elimination of current financial barriers to obtaining care faced by the uninsured.

Conversely, the indirect subsidies provided to safety-net facilities to care for the uninsured could be reduced, except for additional services to facilitate access to care. If currently uninsured persons have adequate health care coverage, grants and subsidies to safety-net providers could be largely replaced by insurance revenue. This would enable these providers to have a stable source of income and alleviate the need to provide large amounts of uncompensated care.

Given the patchwork nature of funding health care services in California (and the nation), one viable alternative would be to consolidate all of the varied sources of revenue so that appropriate health care could be provided to every Californian. Having a regular source of care and insurance coverage would enable most Californians to seek care when needed, obtain preventive care, obtain referrals to specialists, and receive early interventions for chronic and developing diseases in order to avoid emergency room visits that overburden hospitals and clinics.

Specific proposals for health care reform have been introduced in the state legislature, including SB 840 (formerly SB 921), which would create a single-payer system and cover all Californians. Other proposals, such as Senate Bill 437 (Escutia) and Assembly Bill 772 (Chan), which would cover most children in the state, would cover only a portion of the uninsured. Although our analysis does not propose a specific policy to insure all Californians, it does measure how much the costs would increase due to the increased utilization associated with being insured vs. uninsured. Our findings indicate that covering all of the uninsured would result in increased direct spending of about $4.5 billion. This estimate is somewhat less than the costs associated with increased utilization estimated in the financial analysis of SB 921 by the Lewin Group.[2] Of course, if other measures were taken to achieve savings and efficiencies, the net cost of insuring the uninsured could be substantially lower than our estimate. For example, The Lewin Group's analysis of SB 921 indicated that the net economic effect of that single-payer system would be a net savings of as much as $8 billion in the first year of implementation.

By not specifying a particular policy that would solve the uninsured problem, there are numerous political, administrative and economic issues that we have not addressed. For example, we have not estimated the costs of expanding Medi-Cal to all of the uninsured, or how a single-payer system would fare in California's current health care market. Our estimates compare spending among the uninsured with the average spending by all insured Californians, which includes both those with public and private insurance.

The costs of specific proposals for insuring the uninsured would need to account for the specific components of how insurance would be offered to the uninsured, for example,

through public or private insurance. Nevertheless, our estimates provide valuable information indicating that the current expenditures from all sources for the uninsured in California, if combined into a single program and supplemented with modest additional expenditures, could provide sufficient funding to provide health insurance for all of California's uninsured population.

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. For more information on CHIS, visit *www.chis.ucla.edu*.

This analysis also used 1998-2000 data from the 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.*

To estimate expenditures by the insured and uninsured in California, we developed a microsimulation model based on MEPS by substituting demographic information from California's population in CHIS (including age, employment status, income and health status) into expenditure models developed using MEPS. Additional information on our methodology, the 95% confidence levels for the expenditure estimates and our approach for determining indirect subsidies at the county-level in California can be found at the Center's web site, *www.healthpolicy.ucla.edu/cost_methods_2005.html*.

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Notes

1 ER Brown and SA Lavarreda. *Job-based Coverage Drops for Adults and Children but Public Programs Boost Children's Coverage*. Los Angeles: UCLA Center for Health Policy Research. February 2005.

2 JF Sheils, RA Haught, *The Health Care for All Californians Act: Cost and Economic Impacts Analysis*, The Lewin Group, 2005.

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