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"Cost-Shifting Onto Employer-Based Health Insurance: Uncompensated Care and Free-Riding Spouses"

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Chairman Andrews and Representative Kline, as well as all the Subcommittee Members, thank you for inviting me here today to address important issues related to employer-based health insurance.

Employers in the United States face significant constraints on profitability due to rising health insurance costs. Many of these costs are well known:

- National health expenditures reached a record high last year: $2.4 trillion, about $7,900 per person.[1]
- A quarter of our nation's health spending is supported by businesses. The largest share of that spending – 77 percent – is employer contributions to health insurance plans for their employees. In 2007, businesses spent a total of $518 billion dollars on health services: $398 billion in employer contributions to private health insurance premiums, $82 billion in contributions to the Medicare Hospital Insurance Trust Fund, and $38 billion to workers' compensation,

temporary disability, and worksite health services. Health spending by private businesses grew 3.9 percent in 2006 and accelerated 5.6 percent in 2007.[2]

- Employer-sponsored health insurance (or ESI) covers 160 million individuals, about 62 percent of the non-elderly population. Overall, 63 percent of American businesses offer health insurance to their workers.[3]
- In 2008, the average employer-based health insurance premium for family coverage was $12,608, a rise of 5 percent from the previous year. Of that, employers paid $9,325 (74 percent) and workers paid $3,354 (26 percent). In contrast, the average cost for a single worker's health insurance was roughly half: $4,704. Of that, employers paid $3,983 (85 percent) and workers paid $721 (15 percent).[4]
- Since 1999, average family coverage premiums have risen 119 percent.[5] Premiums for employer-sponsored health insurance in the United States have been rising four times faster on average than workers' earnings since 2000,[6] and health insurance costs are on track to overtake profits in this decade.[7]

However, certain costs associated with employer-based health insurance are less apparent in the frequent tallies of spending. Today I will focus on two: First, the costs associated with uncompensated care that are shifted onto America's employers. And, second, the costs employers bear for providing coverage to workers they do not employ, the spouses (and, increasingly, domestic partners) of their employees.

SHIFTING COSTS OF UNCOMPENSATED CARE TO THE PRIVATE SECTOR

In 2008, uncompensated care for America's 47 million uninsured ran to an estimated $57.4 billion. Overall, uncompensated care has been roughly 6 percent of hospital costs for many years, despite a steady increase in the percentage of people uninsured.[8]

When they can, hospitals (and physicians) shift rising uncompensated costs from the uninsured as well as the underinsured to private payers. Providers also subsidize below-cost reimbursements from Medicare, Medicaid, and CHIP through cost-shifting. The extent of this cost-shifting is uncertain, in part because some economists do not define charging private payers higher rates as "cost shifting." Differential pricing is instead seen as a rational market response to the ability and willingness of some payers to pay more than others, analogous to the airline and hotel industries.[9] In my view, however, regardless of what we call it, it is clear that private payers pay more and that these higher payments are used by providers to defray the costs of care for other patients.

Several potentially countervailing factors affect cost-shifting to private payers, such as:

- **Patient mix**: Uninsured and underinsured patients, along with Medicaid and CHIP beneficiaries, are disproportionately cared for in safety net facilities, which do not serve large numbers of privately insured patients, limiting private payer cross-subsidization. Of course, because these costs are supported by tax dollars, including corporate taxes, employers are bearing some of the burden, along with individual taxpayers. Estimates of the costs of uncompensated care vary,

depending on what is counted, as do assessments of who pays. The Institute of Medicine puts public support from federal, state, and local governments at 75-85 percent of the total value of all uncompensated care estimated to be provided to uninsured people each year.[10] An analysis I conducted of the costs of care for uninsured patients alone puts governments' contributions for this population at 33 percent, with the remainder covered by patients with private insurance.[11] Medicare patients, in contrast, are largely cared for in private hospitals, which can shift costs to privately insured patients. Medicare's recent decision to no longer reimburse hospitals for eight "never events," which several private insurance plans followed, may result in additional cost-shifting, as institutions seek to recover the costs of these rare but costly events, including wrong-site surgery, mismatched blood transfusions, and major medication errors.

- **Hospital type**: There is evidence that for-profit hospitals provide less uncompensated care but also cost-shift more than nonprofit institutions do. On the other hand, however, research by former CMS director Mark McClellan indicates that areas with for-profits have lower labor and capital costs, and, overall, about 2.4 percent lower levels of hospital expenditures per patient as do areas without for-profit hospitals. The net effect of lower costs overall on any cost-shifting has not been determined.[12]
- **The level of uninsurance in the community**: There are significant differences in community-level uninsurance rates across the nation, as well as

within states and even counties. For example, in 2007, uninsurance rates ranged from 6 percent in Massachusetts to almost 28 percent in Texas. Within Los Angeles county, uninsurance rates for people under age 65 ranged from 6 percent to 45 percent in 2005. In addition to cost-shifting, research suggests that when community-level rates of uninsurance are relatively high, insured adults have difficulty obtaining needed health care and to be less satisfied with the care they receive.[13] Clearly, job loss is associated with health insurance loss. The current economic downturn has already resulted in larger numbers of uninsured individuals as well as increases in the numbers of Medicaid and CHIP beneficiaries, which may, in turn, result in additional cost shifting to private payers.

- **Hospital negotiating power:** Some hospitals, particularly large urban teaching hospitals, have sufficient market power to negotiate higher payment rates from employers and private insurers. So do some large physician groups. But research has not been definitive on the frequency and amount of shifting.

In sum, the costs of health care for uninsured, underinsured, and publicly insured individuals are, to an unknown extent, supported by higher payments from privately insured individuals and employers. In its most recent report to Congress, the Medicare Payment Advisory Commission, MedPAC, reported that average Medicare margins are projected to fall to -6.9 percent this year, a shortfall made up for by what MedPAC characterized as "unusually high hospital margins on private-payer patients."[14] Rising

premiums, along with higher co-pays and deductibles, result, in part, from this cross-subsidization. Because the majority of uncompensated care is paid for by governments through tax revenues, uncompensated care thus amounts to a double levy: once in the form of taxes and twice in the form costs hidden in escalating payments for employer-sponsored health insurance.

SHIFTING THE COSTS OF SPOUSES TO COVERED WORKERS' EMPLOYERS

There is a second significant cost to employers in providing health insurance, even more opaque than the costs of uncompensated care: The cost of providing health insurance to spouses and domestic partners.

Nationwide, 51 percent of people under age 65 with private health insurance are covered through their own employer; another 10 percent directly purchase private health insurance. The remaining 39 percent of individuals with private health insurance receive coverage through their spouse or partner.[15] It is this last category of worker I will address.

In 2006, there were 31 million families (62 million adults) in which both adults were employed all or part of the year. An analysis I conducted with colleagues at Emory University showed that more than half of dual-income families (55 percent) received health insurance through one but not the other employer; a quarter of families elect

separate coverage under both employers.[16] Nationally, the cost of workers receiving health insurance through their spouses amounted to $46 billion in 2006.

Employer contributions to health insurance premiums average 77 percent, as I noted earlier. However, there are notable locality differences in average contributions. For example, in the District of Columbia, the typical employer contribution to employee-plus-one coverage is 81 percent, or about $6,265 per employee. In Louisiana, the average is just 68 percent for the same coverage.[17]

Employers who do not offer insurance – 37 percent in 2008 – have been called "free riders," because at least some of their workers receive coverage via a spouse's employer. There are significant differences in insurance offerings by firm size: Just under half (49%) of firms with 3 to 9 workers offer coverage, compared to 78 percent of firms with 10 to 24 workers, 90 percent of firms with 25 to 49 workers, and over 95 percent of firms with 50 or more workers.[18] Thus, larger firms are subsidizing health insurance in smaller firms. It is important to note that many smaller employers say they would like to offer health insurance, but cannot afford to do so. Because smaller employers have fewer employees to spread risk among, insurers consider their risk profile less predictable and more vulnerable to high-cost claims.[19] As a result, premiums are considerably higher, often beyond the reach of employer and employee alike.

There are also disparities across business sectors. Industries that benefit the most from being free-riders include retail, agricultural, fishing, and forestry. Among U.S. dual-income families who receive ESI coverage and work in the retail or other services industry, 45 percent of workers receive insurance through their spouses' employers. In agriculture, fishing, and forestry, the percentage is slightly less at 42 percent. These aggregate figures mask noteworthy differences, however. Among the 73 percent of people working in the retail or other services industry covered under one policy, 45 percent are free-riders and 28 percent are the actual policyholders; and, among the 74 percent of persons working in the agriculture, fishing, and forestry industry who are covered under one policy, 42 percent are free-riders and 32 percent are the actual policyholders. Populations of free-riders in other industries in the U.S. range from 21 to 34 percent. Free-riders are least prevalent in the mining and manufacturing industries, comprising only 21 percent of these industries' insured workers.

There are two ways to examine the costs of free-riders. The first is in terms of incremental cost savings to the free-riding employer – that is, how much the free-riding employer would have contributed to its employee's health insurance had that employee not been covered by her or his spouse. For each employee covered by a spouse's policy, the free-riding U.S. employer would have spent $2,886 in 2006 had that business provided health insurance to its own worker. Another way to examine the cost of free-riders is to calculate the cost to the employers who cover the working spouse of an employee. In 2006, the incremental cost to employers covering a worker from a free-

riding firm was $2,713 per employee. Either way the costs are totaled, they are substantial: $46 billion versus $49 billion, respectively.

CONCLUSIONS

The rise in the number of dual-income families combined with a decline in the share of employers offering insurance is placing continued financial pressure on those employers that continue to offer insurance. The "doubling up" of both workers on a single policy results in added costs to those employers covering both workers. These issues raise important questions regarding equity in the distribution of spending among businesses in the United States.

Additional equity concerns are raised by cost-shifting from uninsured, underinsured, and publicly insured individuals to privately insured individuals and employers. This care is largely funded by governments through tax receipts from corporate and individual taxes. Rising premiums affect both employer and employee; in addition, employees face higher out of pocket costs in the form of increasing co-pays and deductibles. Uncompensated care thus amounts to a double levy: once in the form of taxes and twice in the form of costs hidden in escalating payments for employer-sponsored health insurance.

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