

The Uninsured Versus The Insured: Who Subsidizes Whom?

By John R. Graham

Key Points:

- California Governor Schwarzenegger, Massachusetts Governor Patrick, and other state politicians believe – wrongly – that “covering the uninsured” will eliminate a “hidden tax” that the privately insured pay to subsidize the uninsured.
- The financial crisis of hospital emergency rooms has little to do with the uninsured; rather, there is a far greater “cost shift” from beneficiaries of government health care to the privately insured.
- As a group, the uninsured voluntarily pay about \$60 billion worth of extra federal income taxes – explicit taxes which dwarf the hidden tax of uninsurance.
- Because they use only half the health services, per person, that insured Americans use, the uninsured pay a kind of “hidden subsidy” to the insured, who over-consume health services.
- The hidden tax of overinsurance – which the insured unconsciously levy on each other, is far greater than the relatively insignificant hidden tax of uninsurance.

The political appeal of this is obvious. Employed people who have health insurance are probably not excited about paying higher taxes to provide health care to their uninsured neighbors. If you can convince them that they are already paying for it, proposing mandatory private health insurance is a winner. To back up this notion, Families USA, a self-styled consumer advocacy group, estimates that the uninsured used about \$29 billion worth of health services in 2005 that the privately insured paid for through higher premiums.² This is what Governor Schwarzenegger calls the “hidden tax.” Unfortunately, both the dollar figure and the idea behind it are greatly misguided.

“Cost shifting” is the theory that hospitals do not earn enough revenue from some patients, which results in their increasing charges to those who can and will pay more – the privately insured. Many hospitals struggle with the challenge of unpaid bills, a subject addressed in a previous *Health Policy Prescription*.³ It is extremely unlikely, however, that the uninsured are the primary cause. Rather, the more significant “cost shift” is from the government to private insurers. Table 1 indicates how relatively insignificant the uninsured are to health spending, especially in emergency rooms.

The Uninsured Are Not Driving Up Health-Care Costs

Last year, we noted with concern the rising enthusiasm for mandatory, private health insurance, overseen by state or federal bureaucracies. We proposed that the relative success of the Swiss health-care system was not due to its mandatory nature, but that its method of paying for health care approximates true “insurance” significantly better than America’s does.¹ Our effort has not stemmed the tide.

Today, politicians across the spectrum subscribe to a simple script that portrays the uninsured delaying primary care until their illnesses worsen and they show up at emergency rooms for wildly expensive treatment, after which they fail to pay their bills. From Massachusetts to California, the route to bipartisan, political success in health policy now consists, basically, of ordering the uninsured to become insured.

Table 1: U.S. Health Spending for People Under 65, 2000

	Share of Population with Any Medical Expense	Median Expense Per Person With Expenses	Total Expenses (\$ billions)	Share of Population with Any Emergency Room Expense
Uninsured	57%	\$305	\$28	7%
Privately Insured	86%	\$638	\$320	10%
Taxpayer Insured	83%	\$465	\$76	18%

Source: Agency for Health Research and Quality.⁴

Far fewer uninsured than insured use any health services at all – and those who do incur significantly fewer expenses. Those insured by taxpayers (primarily Medicare and Medicaid beneficiaries) are far more likely to use emergency rooms than the uninsured – and they also represent a far larger population. Hospitals earn significantly less per patient from government programs than from private insurers.⁵

State-level data confirm that chasing the uninsured to beef up hospital revenues is unlikely to succeed. In Massachusetts, only six percent of uncompensated health care went to families with reported incomes greater than 200 percent of the Federal Poverty Line last year, whereas 42 percent of care went to individuals reporting no income.⁶ In California, more than three times as many insured Californians delayed or avoided care such as screening tests, visits to specialists, and urgent care, as uninsured Californians in 2003. Further, 1.8 million insured kids visited ERs, versus only 80,000 uninsured kids.⁷

Any way you look at it, those proposing to rescue hospital finances by “covering the uninsured” are trying to squeeze a lot of blood from a pretty small stone. Nevertheless, uncompensated care for the uninsured obviously costs something.

The Uninsured Subsidize the Insured

The source for table 1 does not fully account for treatment for which there is no payment. A scholarly effort to measure these costs figured them at \$35 billion in 2001 – less than three percent of health spending that year.⁸ As noted above, Families USA’s estimate is slightly lower, which it then allocates to privately insured Americans at a rate of \$922 for a family policy and \$341 for an individual policy – the “hidden tax.” However, this is dwarfed by something both analyses ignore: many uninsured Americans voluntarily pay extra income taxes, because they forgo a non-taxable health benefit.

The Census Bureau reported 46 million uninsured Americans last year, an estimate likely about twice as high as the real figure.⁹ Nevertheless, the Census Bureau reports that many of the uninsured are within taxable income brackets. Indeed, 15 percent earn more than \$75,000 annually. A rough calculation shows that the uninsured likely pay at about \$60 billion extra in federal income taxes alone, by forgoing the tax savings associated with private health insurance – and the figure could easily be much higher.¹⁰

Thus, explicit taxes paid by the uninsured are double the so-called “hidden tax” of uninsurance. If this “hidden tax” were really the biggest element of our health-care “crisis,” then the government could easily eliminate it by simply transferring \$30 billion or so of its windfall tax revenue to the insured, without upsetting the whole health-care system. Note that this analysis has not included the massive taxes paid to support ever-growing government health programs that already exist, for example, \$944 for every American to fund Medicaid and state children’s health insurance programs.¹¹

Overinsurance is a Bigger Problem than Uninsurance

Such a transfer, of course, would do nothing to improve health care because it ignores the perverse incentives caused by traditional health insurance. We should be grateful that the uninsured don’t all pile into it! Indeed, the concentration of health expenses is almost identical in both insured and uninsured populations. About half the people have little or no health expenses, and five percent of the people incur half of the group’s health expenses.¹² Therefore, we should not expect compulsory private health insurance magically to transform the health-care incentives of the uninsured, but simply move them all onto a higher spending baseline. Because the uninsured use much less health services than the insured, they pay the insured a “hidden subsidy” of as much as \$66 billion annually – or \$2,128 per insured family and \$787 per individually insured.¹³

Finally, there is a real hidden tax, but it is levied by the insured on their fellow insured. Because of bad incentives, insured Americans use health services twice as much, per person, as the uninsured.¹⁴ U.S. Senator Tom Coburn of Oklahoma, an obstetrician, agrees with those who estimate that one quarter to one third of health care is wasted because almost nobody has the right incentives to use it wisely. Although we don’t know precisely the hidden tax of overinsurance, it is surely greater than the eight percent of premiums estimated by Families USA.

Politicians don’t talk about this real hidden tax, because asking the 350 million or so insured Americans to take responsibility for the problem is likely a path to electoral defeat. The politician who figures out how to do so will earn our thanks. Until then, we will be deluged with proposals for mandatory health insurance that are unhealthy, unwise, and expensive.

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- ¹ John R. Graham, "Eenie, Meeny, Miney Mandate: Compulsory Private Health Insurance is Not Universal Choice," *Health Policy Prescriptions*, Vol.4, No. 11 (November 2006).
 - ² Families USA, Paying a Premium: *The Added Cost of Care for the Uninsured*, Pub. No. 05-101 (Washington, DC: Families USA, June 2005).
 - ³ John R. Graham, "Health Quality and Price Disclosure by Government: A Transparently Bad Idea," *Health Policy Prescriptions*, Vol.4, No. 4 (April 2006).
 - ⁴ T.M. Ezzati-Rice, et al., *Health Care Expenses in the United States, 2000*, MEPS Research Findings No. 21, AHRQ Pub. No. 04-0022 (Rockville, MD: Agency for Health Research & Quality, 2005).
 - ⁵ See, e.g., Alan Dobson, et al., "The Cost-Shift Payment 'Hydraulic': Foundation, History, and Implications," *Health Affairs*, Vol. 25, No. 1 (January/February 2006), pp. 22-33.
 - ⁶ Massachusetts Division of Health Care Finance and Policy, *Uncompensated Care Pool PFY05 Utilization Report*, (Boston, MA: Massachusetts Division of Health Care Finance and Policy, December 6, 2005).
 - ⁷ Sue Holtby, et al, *Health of California's Adults, Adolescents, and Children: Findings from CHIS 2003 and CHIS 2001* (Los Angeles, CA: UCLA Center for Health Policy Research, May 2006)
 - ⁸ Jack Hadley & John Holahan, "How Much Medical Care to the Uninsured Use, And Who Pays for It?" *Health Affairs*, Vol. 22 (2003), Web Exclusive (published online February 12), pp. W3-66-W3-81.
 - ⁹ Carmen DeNavas-Walt, et al., *Income, Poverty, and Health Insurance in the United States: 2005*, P60-231 (Washington, DC: U.S. Census Bureau, August 2006). Drawbacks to this estimate are discussed at John R. Graham, *California's Uninsured: Crisis, Conundrum, or Chronic Condition?* (San Francisco, CA: Pacific Research Institute, January 2006), and references.
 - ¹⁰ Calculations available from the author by request.
 - ¹¹ John R. Graham, "Taming the Medicaid Monster: The President Pushes Progress but States Shirk Solutions," *Health Policy Prescriptions*, Vol. 4, No. 8 (August 2006).
 - ¹² Mark W. Stanton & Margaret K. Rutherford, *The High Concentration of U.S. Health Care Expenditures*, MEPS Research in Action Issue 19, AHRQ Pub. No. 06-0060 (Rockville, MD: Agency for Health Research & Quality, June 2006).
 - ¹³ This estimate might be too high. Because the uninsured, overall, are poorer than the insured, they are unlikely to increase their use of health resources by quite the same amount as the currently insured have. See Jack Hadley & John Holahan, "Covering the Uninsured: How Much Would it Cost??" *Health Affairs*, Vol. 22 (2003), Web Exclusive (published online June 4), pp. W3-250-W3-265. However, if the government over subsidizes the low-income uninsured to become insured then this could more than likely occur. Calculations available from the author by request.
 - ¹⁴ Jack Hadley & John Holahan, "How Much Medical Care to the Uninsured Use, And Who Pays for It?" *Health Affairs*, Vol. 22 (2003), Web Exclusive (published online February 12), pp. W3-66-W3-81.
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