Cost Shifting From the Uninsured: Assessing the Evidence

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One of the most controversial provisions of the recently enacted Patient Protection and Affordable Care Act of 2010 is the mandate on individuals to obtain insurance. A basic premise behind the mandate is that privately insured individuals bear a large financial burden from health care services provided to the uninsured. According to the premise, doctors and hospitals, by charging insured individuals systematically higher prices for health care services, shift the costs of treating the uninsured onto the insured. These higher charges are manifested in higher health insurance premiums. The core of the law's view that the mandate is a necessary and proper exercise of Congress's power under the Commerce Clause of the U.S. Constitution is that it reduces or eliminates this cost shift.

Although federal courts have disagreed about the constitutionality of the mandate and the law as a whole, they have all accepted the premise that cost shifting from the uninsured is an important policy problem:

- Judge Moon, in upholding the constitutionality of the law, wrote that "the costs of providing uncompensated care for the uninsured amounted to $43 billion in 2008 and were passed on to consumers in the form of substantially higher premiums"[1];
- Judge Steeh, in upholding the constitutionality of the law, wrote that "[the uninsured] "plaintiffs are [c]ollectively shifting $43 billion in 2008 onto other market participants"[2];
- Judge Vinson, in holding the law unconstitutional, wrote that "Congress found that the uninsured received approximately $43 billion in uncompensated care in 2008 alone" and that "while $43 billion in

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[1] *Liberty University et al. v. Timothy Geithner, et al*., Case No. 6:10-cv-00015-nkm (W.D. VA), p. 26.

[2] *Thomas More Law Center et al. v. Barack Hussein Obama, et al*., Case No. 10-cv-11156 (E.D. MI), p. 16-7.

uncompensated care from 2008 was only 2% of national health care expenditures for that year, it is clearly a large amount of money"[3];

- Judge Hudson, in holding the mandate unconstitutional, wrote that "the Secretary's argument in defense of the [mandate] and the apparent underlying rationale of Congress are premised on the facially logical assumption that every individual at some point in life will need some form of health care" and that "few persons, absent insurance, can guarantee that they will not shift the cost of that care"[4].

As Judge Vinson explicitly acknowledges, the courts obtained their understanding of the significance of the cost shift from research cited by Congress in the legislative history of the Act. Indeed, in the text of the law itself, Congress highlighted the magnitude of the cost shift and its effect on the national economy:

> "the cost of providing uncompensated care to the uninsured was $43 billion in 2008. To pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average over $1,000 a year. By significantly reducing the number of the uninsured, the [mandate], together with the other provisions of this Act, will lower health insurance premiums."[5]

Congress's assessment of the magnitude of the cost shift -- and, as a result, courts' basis for evaluating the new health care law's constitutionality -- is simply incorrect. It is based on a combination of a correct interpretation of flawed claims by an advocacy group and misinterpretation of a valid peer-reviewed research study. According to the text of the peer-reviewed study, the magnitude of the cost shift is *at most* $14 billion, and probably much less. The study estimates that amount of uncompensated care that could be passed on to the privately-insured is most likely $8 billion -- less than one percent of private insurance premiums. Translated into the burden it imposes on privately-insured individuals, this amounts to an increase in the premiums of typical insurance policy of

[3] *State of Florida, et al. v. U.S. Department of Health and Human Services et al*., Case no. 3:10-cv-91-rv/emt (N.D. FL), p. 45, 50-1.
[4] *Commonwealth of Virginia et al. v. Kathleen Sebelius et al*., Case no. 3:10-cv-188-heh (E.D. VA), p. 6.
[5] Patient Protection and Affordable Care Act, Section 1501(a)(2)(F), 10106(a).

$50 - $80[6] -- not over $1,000 as reported in the Act. Morever, as we point out in the conclusion, this small amount is unlikely to affect interstate commerce.

This paper investigates the empirical evidence on the cost shift to ascertain how this mistake occurred. Section I traces courts' understanding about the cost shift back to its original two sources — a 2005 study by Families USA, a Washington, DC-based advocacy group, and a 2008 peer reviewed study by researchers at the Urban Institute, published in the journal *Health Affairs*. We show how Congress misinterpreted the Urban Institute research to arrive at its $43 billion estimate of uncompensated care. Section II shows how Congress used a study commissioned by Families USA to determine that this cost shift translates into a "hidden tax" of over $1,000 per insured family. We then investigate the validity of the Urban Institute and the Families USA work (we also analyze the findings of a third, more recent, study commissioned by Families USA on the same issue). We compare the calculations in each study to publicly-available government data, step by step. We conclude that, at each step, the estimates from Urban Institute study are valid, and concur with its finding that the amount of cost-shifting from the uninsured is very small. In contrast, we find that the statistics underlying both Families USA papers are at odds with publicly available government sources of data, and these differences are not explained. To summarize, the findings of the Families USA papers -- that there is a substantial cost shift from the uninsured -- are unsubstantiated. Section III concludes with some more general observations about cost shifting from the uninsured and the implications of a correct interpretation of evidence on cost shifting for policy going forward.

I. The Cost of Uncompensated Care for the Uninsured

Researchers have calculated the cost of uncompensated care for the uninsured in three steps. First, they determine the value of care received by the uninsured. Second, they subtract the amount that uninsured people pay out-of-pocket. Third, they subtract the amount of funds providers receive from public programs -- for example, state and local government spending on charity care through community hospitals and health

[6] This figure based on a premium for an employer-sponsored insurance policy of $4,704 in 2008, according the Kaiser Family Foundation Survey of Employer Health Benefits.

clinics, and the Medicaid Disproportionate Share program -- and private charities to compensate them for the costs of this care that the uninsured don't pay themselves.

In December 2008, the Congressional Budget Office (CBO) published a review of the literature on this topic in a report entitled "Key Issues In Analyzing Major Health Insurance Proposals."[7] To determine how much uncompensated care hospitals provide, the CBO turned to a prominent peer-reviewed study by researchers at the Urban Institute, Jack Hadley, John Holahan, Teresa Coughlin, and Dawn Miller, published in the journal *Health Affairs* in 2008.[8] As CBO pointed out, this study estimated that "the *gross costs of uncompensated care* [italics added] would be approximately $43 billion in 2008."

The key term here is the adjective *gross*, by which the CBO means "before subtracting any payments from government or charity to compensate providers for care that the uninsured don't pay themselves." The subsequent use by Congress and the courts of the $43 billion number as an estimate of the *costs of uncompensated care* therefore implicitly assumes that none of these payments should be counted as offsetting the costs of uncompensated care.

There are only two alternative bases for this assumption, neither of which is valid. One is that, as an empirical matter, payments from public programs such as Medicare and Medicaid Disproportionate Share, as well as payments from other state and local programs, serve multiple purposes, so the proportion of them truly devoted to uncompensated care cannot be precisely determined. However, apportioning none of these payments to offsetting the costs of uncompensated care is incorrect.

The second is that, as a conceptual matter, no existing public-program or charity payments should be counted as offsetting the cost of uncompensated care, because such payments are *themselves* a form of cost shifting. According to this reasoning, the payments represent a cost that has been shifted onto taxpayers and donors instead of privately insured persons. But by this measure, the mandate will do nothing to reduce cost shifting; indeed, it will increase it. The reason is that the mandate is, of necessity, accompanied by public subsidies to defray the high cost of the mandated health insurance

[7] Research on the cost of uncompensated care was reviewed in Chapter 5. The Report is available at http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf.
[8] "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," Vol. 27(5): w399-w415.

for low and middle income people. The mandate is inseparable from the subsidies; and the cost of the subsidies alone outweighs the gross cost of care provided to the uninsured without the mandate. According to CBO, the law's required subsidies when the program is fully operational in 2017 will total about $100 billion per year. The 2008 estimate of $43 billion for gross cost of uncompensated care, allowing for health care costs to rise 60 percent faster than the CPI and allowing for a 10 percent increase in the number of uninsured persons, amounts to only $66 billion in 2017.

In either event, the Urban Institute study does not even consider the possibility that no existing payments should be counted as offsetting the costs of uncompensated care; according to the study, the range of estimates of uncompensated care associated with cost shifting is between $8 and $14 billion, or approximately 1.0 to 1.7 percent of private insurance premiums. The upper-bound estimate is not hard to back out; it appears in the plain text of the *Health Affairs* paper.[9] The study's best-guess estimate of cost shifting appears only in a more detailed discussion of the same work that was prepared for the Kaiser Family Foundation.[10]

II. Translating the Cost of Uncompensated Care into a "Hidden Tax" on the Insured

Translating these estimates of the cost of uncompensated care into an amount shifted onto private insurance requires one additional step. Each year since 1999, the Kaiser Family Foundation, in partnership with the Health Research and Educational Trust, conducts a survey designed by the National Opinion Research Center of a random sample of government employers and private firms. The survey collects detailed information on employers' health benefits and the characteristics of workforce and is considered by health policy researchers to be the "gold standard" for this type of information. In 2008, the survey found that the average annual cost of a typical employer-sponsored insurance plan was $4,704. Thus, if cost shifting accounted for 1.0 to 1.7 percent of premiums, it resulted in a hidden tax of approximately $50 to $80.

[9] Ibid., p. w406.
[10] Hadley, Holahan, Coughlin, and Miller, "Covering the Uninsured in 2008: A Detailed Examination of Current Costs and Sources of Payment, and Incremental Costs of Expanding Coverage," Prepared for the Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Foundation, August 2008, p. 52.

The "over $1,000" number cited in the Act therefore could not have come from Urban Institute study. A review of the budget committee report on the reconciliation bill modifying the original version of the Act shows its source. That report cites a 2009 paper by Ben Furnace and Peter Harbage of the Center for American Progress entitled "The Cost Shift from the Uninsured,"[11] which found that the cost shift amounts to $1,100 for the average family insurance policy in 2009. [12] The Furnace and Harbage work, in turn, obtained the percentage increase in premiums due to cost shifting from a 2005 study by Professor Kenneth Thorpe, commissioned by Families USA, entitled "Paying A Premium: The Added Cost of Care for the Uninsured."[13] Furnace and Harbage then proceeded to simply multiply the Families USA estimate -- of 8-9 percent -- by their own estimate of the cost of a family insurance policy in 2009 to arrive at the $1,100 figure.

Which estimate is correct -- the estimate of 1-2 percent from researchers at the Urban Institute (referenced below by the initials of its authors, HHCM), the estimate of 8-9 percent from Families USA (referenced below as FUSA1), or neither? To investigate, we reviewed the academic and policy research about cost shifting from the uninsured. In addition to these two studies, we found a third study, prepared by the actuarial firm Milliman, also commissioned by Families USA, entitled "Hidden Health Tax: Americans Pay a Premium."[14] We refer to this study below as FUSA2.

In the remainder of this section, we highlight the similarities and differences among the these studies; show how the differences translate into the differences in the studies' conclusions; and compare the statistics underlying each study to currently publicly available information to investigate each study's validity.

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[11] H.R. Rep. No. 111-443, pt. II, p. 985 (2010).
[12] See p. 2 of Furnace and Harbage, available at http://www.americanprogressaction.org/issues/2009/03/pdf/cost_shift.pdf.
[13] http://www.familiesusa.org/assets/pdfs/Paying_a_Premium_rev_July_13731e.pdf.
[14] For earlier work, see Jack Hadley and John Holahan, "How Much Medical Care Do the Uninsured Use And Who Pays for It?," *Health Affairs* Web Exclusive (February 2003), w66-w81, and the papers cited by it. This paper finds, as does the later work by Hadley, Holahan, and coauthors discussed below, that cost-shifting from the uninsured is unimportant. We do not review a paper by Jonathan Gruber and David Rodriguez, "How Much Uncompensated Care Do Doctors Provide," *Journal of Health Economics* 26(6): 1151-69 (2007), because that paper focuses on uncompensated care provided by physicians only (not hospitals). That paper finds that cost shifting from the uninsured is actually very small and *negative* -- that is, physicians earn slightly more on uninsured patients, on the whole, than on insured patients. In any event, Gruber and Rodriguez conclude that uncompensated care amounts to *at most* 0.8 percent of physicians' revenues.

The studies all share a common approach to calculating the impact of the cost of uncompensated care for the uninsured on premiums paid by insured individuals.

1. *Determine the base of private health insurance premiums onto which the costs of uncompensated care could be shifted.*

2. *Determine the amount of uncompensated care that is provided exclusive of government programs designed to compensate providers of this care for their services.*

3. *Deduct from the second step the amount paid through government programs to providers for care given to the uninsured.*

4. *Divide the remaining uncompensated care (calculated in the third step) by the total base of insurance premiums (calculated in the first step) to arrive at a final estimate of the impact of uncompensated care on insurance premiums.*

In the analysis that follows, we describe and assess the differences between the three studies, step by step, to show why they arrive at such different conclusions about the uncompensated cost of care for the uninsured.

1. *Determine the base of private health care expenditures onto which the costs of uncompensated care could be shifted.*

The three studies use a common conceptual measure of the base of health insurance premiums onto which uncompensated care costs are shifted. The measure includes health insurance premiums of individuals enrolled in private employer-sponsored insurance plans and in state and local government plans, federal employee health insurance premiums, and premiums of persons enrolled in non-group, or individual, health insurance plans. The base does not include the expenses of health insurance programs financed by the federal government, such as Medicare and Medicaid.

Table 1 reports each study's estimated base of insurance premiums. The estimated bases in the two FUSA studies are similar to one another, but both are significantly lower than HHCM's estimate.

Table 1

	(in billions)		
	FUSA1 (2010)	FUSA2 (2008)	HHCM (2008)
Aggregate Health Insurance Premiums	$496	$557	$830

To obtain an estimate of health insurance premiums of persons enrolled in private and state and local government health insurance plans, FUSA1 and FUSA2 use data from the Medical Expenditure Panel Survey - Insurance Component (MEPS-IC) from 2002 and 2006, respectively. Both studies then inflate the result by an expected growth rate to obtain estimated premiums for employer-sponsored insurance premiums for 2010 and 2008, respectively. Because the MEPS-IC does not include premiums paid for federal government employees or for people with individual insurance coverage, the two studies augment the MEPS-IC total for these sources of insurance spending. The methods differ, but those differences are not empirically important.[15]

The HHCM study, by contrast, uses data on total insurance premiums taken directly from the federal government's National Health Insurance Expenditure Accounts (NHEA) tables. Hence, one possible explanation is that the FUSA studies and the HHMC study use different data sources. If so, which one yields the more accurate measure?

To answer this question, we used the same data source as the FUSA studies, but updated to 2008, to develop an independent estimate. According to the 2008 MEPS-IC data, total spending on health insurance premiums for persons enrolled in employer sponsored insurance plans was $548.3 billion. Total spending on health insurance for individuals employed in the state and local government sector was $142 billion.[16] The total for these two groups alone, $670.3 billion, exceeds the FUSA estimates for the

[15] The contributions of federal employees and persons with non-group coverage represent only a modest portion of total private insurance spending and are, therefore, unlikely to appreciably affect each study's final estimate.

[16] http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_4/2008/tiva1.pdf., tables IV.A.1 and IV.B.1)

entire insured population by large margins — 35 percent and 20 percent for the FUSA1 and FUSA2, respectively.

Why are the FUSA1 and FUSA2 estimates, derived from the 2002 and 2006 MEPS-IC data respectively, so much lower than the estimates from the 2008 MEPS-IC? To answer this question, we independently checked the MEPS-IC data for each of the earlier years. The 2002 MEPS yields an estimate of total non-federal employer-sponsored insurance of $469 billion. This number is only slightly below FUSA1's estimate for 2010 of $496 billion. The 2006 MEPS-IC yields an estimate of $625 billion. This number is nearly $70 billion higher than FUSA2's 2008 estimate of the amount spent by all persons, including federal government employees and persons with individual insurance coverage. It appears that both FUSA studies have made additional adjustments to the data. Unfortunately, neither study provides sufficient information to determine the nature and appropriateness of these adjustments.

Including federal workers and individuals with individual (non-group) plans expands the base of insurance premiums even further. As we noted earlier, the MEPS-IC does not report estimates for federal government employees. Hartmann, *et al.* (2009) estimate that the federal government spent $25.5 billion on private health insurance for its employees in 2007.[17] Combining the two estimates yields a measure of total spending on employer-sponsored insurance in 2008 at approximately $715.8 billion, not counting federal employee contributions.

Neither the MEPS nor other federal health care statistics report data on total U.S. purchases of individual, or non-group, health insurance. However, the U.S. Census Bureau estimates that, in 2008, 16.7 million people were covered by individual insurance, as compared to 163.1 million who were covered by employer-sponsored insurance.[18] Persons insured by non-group plans typically purchase plans that have less extensive coverage and higher copayments than persons who purchase employer sponsored insurance. Accounting for this fact by assuming that the typical premium paid by a person with individual insurance is only two-thirds the cost of the premium of those who

[17] Micah Hartman, *et al*., "National Health Spending in 2007: Slower Drug Spending Contributes to Lowest Rate of Overall Growth Since 1998," *Health Affairs* 28 (2009): 246-61.
[18] http://www.census.gov/hhes/www/hlthins/data/historical/index.html, table HIA-6.

purchase employer-sponsored insurance implies spending on individual insurance of $48.4 billion. (= $715.8 * 0.66* 16.7 / 163.1).

Combining the independent estimates of spending on insurance premiums for each group of employees and individuals yields a total amount of $764.2 billion for 2010. As a separate check, this number can be compared to the total amount spent on health services and supplies reported in the National Health Expenditure Accounts. The latter amount, $783.2 billion in 2008, is quite similar to the former.[19]

Both of these updated estimates are substantially higher than the two FUSA studies' estimates and somewhat below the HHCM estimate reported in Table 1. The fact that both updated estimates are reasonably close to the HHCM estimate leads us to conclude that the latter is the more accurate of the three studies' measures. Why the FUSA estimates are so much lower, we cannot say. Neither FUSA study provides sufficient information to determine why they are below the updated estimate. However, the fact that both updated estimates are similar to one another leads us to conclude that the difference between the FUSA and HHCM estimates is not merely due to the use of different data sources.

The apparent underestimate in FUSA1 and FUSA2 produces a large apparent overstatement in the magnitude of their estimated cost shift. The smaller the base upon which the costs of uncompensated care are shifted, the larger the impact on individuals' insurance premiums. Use of HHCM's more accurate estimate of total spending on private health insurance, all other factors constant, reduces the estimated cost-shift impact on insurance premiums in FUSA1 by 40 percent (from 8.7 percent to 5.2 percent) and in FUSA2 by 33 percent (from 7.7 percent to 5.2 percent).

2. *Determine the amount of uncompensated care exclusive of government uncompensated care programs.*

[19] The current NHEA estimate is slightly smaller than the NHEA estimate reported in HHCM of $829.9 billion, likely due to a downward revision by the CMS Actuary between the publication of HHCM and today.

The next step in the calculation of the cost shift is to determine the cost of care provided to the uninsured exclusive of the amount that government programs provide to compensate health care providers for their services.

All three studies use data from the Medical Expenditure Panel Survey - Household Component (MEPS-HC) to total calculate expenditures on medical care for the uninsured. FUSA1 uses the 2002 MEPS-HC; FUSA2 uses the 2006 MEPS-HC; and HHCM uses the 2002-2004 MEPS-HC. All three studies obtain a basic estimate measure and then update that measure to 2008 or 2010 for the growth in the number of uninsured persons, health care expenditure growth, and an adjustment factor to reflect the fact that MEPS estimates of aggregate health care spending are less than those from the National Health Expenditures Accounts.[20]

FUSA2 and HHCM report separate estimates of the total amount spent on health care for the uninsured and the amount that the uninsured themselves pay for the care they receive. FUSA1 reports only the net amount spent on the uninsured, exclusive of the amount the uninsured pay for their care. In Table 2, we report each study's estimates of these amounts.[21]

Table 2

(in billions)

	FUSA1 (2010)	FUSA2 (2008)	HHCM (2008)
Cost of Care	NA	$116	$83.9
− Out of pocket payments	NA	$42.9	$29.6
= Uncompensated Cost of Care	$60.4	$73.1	$54.3

[20] The increase in the number of uninsured persons is obtained in each study from the Current Population Survey and the growth in health care expenditures is taken from National Health Expenditure Accounts. The adjustment factor is provided by researchers at the U.S. Agency for Health Care Research and Quality and CMS. (see Sing, *et al.* 2006).

[21] The estimate of uncompensated care from HHCM in Table 2 differs from the estimate of uncompensated care from that study discussed in Section I of this paper because the estimate discussed in Section I (and cited by the CBO) excludes care from institutions such as the Veterans Administration that are not likely to have the ability to cost shift. Our analysis in this section includes such care in the gross amount of uncompensated care, but then subtracts spending by such institutions to arrive at an estimate of net uncompensated care.

Table 2 shows that, although the three studies use the same data source and method, they arrive at different results. The differences among estimates of the net cost of uncompensated care (the cost of care for which the uninsured recipient does not pay) are significant. The difference of $20 billion between FUSA2 and HHMC, for example, amounts to nearly three percentage points when applied to an $800 billion base of premiums.

To investigate the accuracy of the FUSA2 and HHCM estimates, we use the 2008 MEPS Web Tool to calculate the total spending on care by the uninsured and the amount the uninsured pay for this care.[22] Turning first to the total amount of care provided to the uninsured, according to the MEPS Web Tool, there were 40.7 million individuals under age 65 who were uninsured for all 12 months of 2008. Also according to summary tables on the MEPS website,[23] 57.4 million people under age 65 were uninsured at a point in time in 2008. The two numbers imply that 16.7 million people were uninsured for part of the year. The Web Tool shows that spending on health care the full-year uninsured totaled $42.3 billion.

Unfortunately, the Web Tool does not provide separate estimates of health care spending on part-year-insured individuals during periods when they were insured and during periods in which they were not. It is highly likely that the rate of spending by part-year-uninsured is higher during the interval in which they have insurance. But if we assume that the rate of health care spending on the part-year uninsured is the same during intervals of time when they are covered and when they are not, and that their rate of spending is the same as those insured for a full year, we can obtain a lower-bound estimate of the amount spent on the uninsured during the intervals when they are not covered by insurance.[24] Adopting these two assumptions, an estimate of the cost of care provided to part-year persons during the time of year in which they are not covered by insurance is $17.4 billion. Combining MEPS-based estimates of the full-year and part-

[22] http://www.meps.ahrq.gov/mepsweb/data_stats/MEPSnetHC.jsp.
[23] http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/hc/hlth_insr/2008/t5_e08.pdf.
[24] This estimate is equivalent to assuming that part-year uninsured people do not time their consumption of health services to coincide with their periods of insurance coverage. This assumption is theoretically implausible and empirically inaccurate. According to HHCM, more than 85 percent of the health services consumed by part-year uninsured people are received during their periods of insurance coverage.

year uninsured yields an initial estimate of the cost of care for the uninsured of $59.7 billion.

However, it is widely recognized among health care researchers in and out of government that the MEPS significantly underestimates the total amount of personal health care services reported in the National Health Expenditure Accounts. Thus, virtually all studies that use MEPS-based personal health care data in the context of national health expenditures, including the three studies analyzed herein, inflate their estimates to correct for this underestimate. An upward adjustment of 25 percent is not unreasonable.[25] Using this adjustment factor raises our estimate of expenditures on care for the uninsured from $59.7 to $74.6 billion. This estimate is smaller than either FUSA2's $116 billion estimate or HHCM's $83.9 billion estimate, but it is closer to the latter.

Of the two estimates, we conclude that HHCM is the more accurate one. We cannot explain why the FUSA2 estimate is so large.

Turning now to the amount the uninsured pay out of pocket for the care they receive, both the FUSA2 and HHCM use the MEPS-HC to calculate the amount paid out-of-pocket by the uninsured for their care. Likewise, both studies use the same factors to update their estimates to 2008 and 2010 values (see footnote 21). FUSA reports an estimate of out-of-pocket spending by the uninsured of $42.9 billion, and HHCM estimates that the amount is $29.6 billion, again a nontrivial difference.

To assess the accuracy of the two estimates, we use the 2008 MEPS-HC. According to the MEPS Web Tool, the amount paid out-of-pocket in 2008 by the full-year-uninsured is $19.5 billion. Using the same approach as was used to calculate total expenditures on the part-year-insured, we estimate that out-of-pocket payments by the part-year uninsured totaled $8 billion. Applying the 25 percent adjustment factor to make the MEPS aggregate conform to the National Health Expenditure Accounts produces an estimate of total out-of-pocket spending by the uninsured of $34 billion.

This estimate of out-of-pocket spending lies between HHCM's lower estimate of $29.6 billion and FUSA2's higher estimate of $42.9 billion. Subtracting the independent estimate out-of-pocket spending from the independent estimate of the cost of care

[25] FUSA1 adjusts its estimates of net expenditures by this amount.

provided to the uninsured yields an estimate of uncompensated care costs of $40.6 billion. This estimate is smaller than the estimates of all three studies reported in Table 2. But it is closest to the HHCM estimate of $54.3 billion, leading us to conclude that it is the most accurate of the three.

How much of a difference do the differences in uncompensated care cost estimates make? Earlier, we showed that using the HHCM estimate of the base of health insurance premiums reduces the impact of uncompensated care on insurance premiums estimated by both FUSA studies to 5.2 percent, all other factors constant. Using the HHCM estimate of uncompensated care costs further reduces the FUSA1 estimate by 13 percent (to 4.5 percent) and the FUSA2 estimate by 44 percent (to 2.9 percent).

3. *Deduct from the second step the amount paid through government programs to providers for care given to the uninsured.*

All levels of government have programs to compensate providers of health care for the cost of care they give to uninsured individuals. Each of the three studies develop estimates of the amount this compensation and subtract it from their estimates of uncompensated care costs to arrive at the total costs of care that can be shifted onto the insured population.

Table 3 reports each study's estimates of this compensation.

Table 3

		(in billions)	
	FUSA1 (2010)	FUSA2 (2008)	HHCM (2008)
Government Compensation	$17.3	$30.4	$42.9

The three studies' methods differ significantly. HHCM identifies four types of sources of public funding available for otherwise uncompensated care for the uninsured: the Medicaid program (primarily through disproportionate-share (DSH) payments); the Medicare program (also primarily through DSH payments); state and local governmental programs; and federal direct-care programs (primarily through the Veterans Administration, Indian Health Service, and Community Health Centers program).

HHCM estimates that spending by these sources totaled $42.9 billion in 2008, of which $30.8 billion was Medicaid DSH, Medicare DSH, and state and local government programs.

FUSA1 makes the more restrictive assumption that only Medicare DSH, Medicaid DSH, and state and local government program spending should be counted as spending to cover the costs of uncompensated care for the uninsured. The paper estimates that public funding through these sources totaled $17.3 billion in 2010.

FUSA1, in effect, assumes that none of the federal direct-care program spending through the Veterans Administration, the Indian Health Services, and Community Health Clinics is for care to the uninsured, despite the fact that these programs were established precisely for this purpose. And the paper offers no explanation for this exclusion.

Regardless of this assumption, however, FUSA1's estimate of Medicare DSH, Medicaid DSH, and state and local government program spending is implausibly low. Its estimate of $17.3 billion is 44 percent less than HHCM. It is also less than the National Health Policy Forum's estimate of spending on Medicaid and Medicare DSH *alone* of $21.1 billion in 2009.[26] For these reasons, we reject FUSA1's estimate as inaccurate.

FUSA2 makes an alternative, also restrictive, set of assumptions about the sources of public funding available for care for the uninsured. That study assumes that no Medicare funds (neither DSH nor other Medicare supplemental payments) are used to finance care for the uninsured. They also assume that no state and local government program spending is used to finance such care. However, it does count Medicaid DSH, Veterans Affairs, Workers Compensation, and certain other private direct spending as used to finance such care. The study claims that spending through these sources was $30.4 billion in 2008.

We believe these assumptions are not realistic. According to HHCM, state and local government program spending is the largest source of public funding for care for the uninsured. In addition, we believe that at least part of Medicare DSH payments are used to finance care for the uninsured; as HHCM point out, although Medicare DSH payments are sometimes justified on the grounds that low-income Medicare beneficiaries

[26] National Health Policy Forum, The Basics: Medicaid Disproportionate Share Hospital (DSH) Payments, June 15, 2009, available at http://www.nhpf.org/library/the-basics/Basics_DSH_06-15-09.pdf.

are more costly to treat, the Medicare Payment Advisory Commission has shown that there is little empirical evidence to support this claim.

Of the three estimates, we therefore conclude that HHCM is the most plausible one.

How much of a difference do the differences in government compensation estimates make? Earlier, we showed that using the HHCM estimate of the base of health insurance premiums and HHCM estimate of the net cost of uncompensated care reduces the impact of care for the uninsured on insurance premiums estimated by FUSA1 and FUSA2 to 4.4 percent and 2.8 percent, respectively holding all other factors constant. Using the more accurate HHCM estimate of the amount of government compensation for uncompensated care costs further reduces the FUSA studies estimates to 1.4 percent.

Summary and Conclusions

Cost shifting from the uninsured has figured prominently in the debate over health reform. Proponents of expanding health insurance coverage frequently highlight cost shifting as an important policy problem to which insurance expansions are the solution. As a result, cost shifting has become one of the key arguments for the use of federal power to impose the mandate that individuals buy insurance in the Patient Protection and Affordable Care Act. If cost shifting from the uninsured imposes a significant burden on everyone else, then mandating that individuals insure is a defensible (though in our judgment, misguided) policy response.

In this paper, we examine the debate over cost shifting and investigate the validity of the underlying evidence. We find that cost shifting from the uninsured is negligible. The sole recent peer-reviewed study on this issue, written by researchers at the Urban Institute and published in *Health Affairs*, found that the burden of uncompensated care on private insurance amounted to at most $14 billion, and most likely $8 billion, in 2008. To put this amount in context, national health expenditures in the United States that year were approximately $2.4 trillion according to the Centers for Medicare and Medicaid Services, of which $830 billion were private insurance premiums. This calibration means that cost shifting from the uninsured was less than one-half of one percent of national health expenditures, and less than one percent of private insurance premiums, or

approximately $50 on a typical insurance policy. This figure implies that the individual mandate will do little to reduce the premiums of the currently insured.

The findings of fact that Congress cited to support its passage of the Act were very different. The legislative history and ultimately the Act itself reported a cost shift of *five to ten times* this amount. But Congress's evaluation of the evidence on this issue was far from rigorous, finding that cost shifting from uncompensated care for the uninsured amounted to $43 billion per year, despite the fact that the text of the study that it cited stated that the cost shift was at most $14 billion, and probably $8 billion. It found that cost shifting increased family insurance premiums by more than $1,000, despite the fact that the statistics underlying this number are inconsistent with the U.S. government's own publicly available data.

The findings of our review are important for the current health care debate. We uncovered only one recent empirical study of the cost shift at the national level that has undergone the normal academic peer review process. Only two other recent studies exist and both of these were funded by the same organization. The quality of the reported evidence aside, the existing body of literature is a very thin foundation upon which to base a public policy of such profound consequences.

We conclude with two observations about cost shifting that have received less attention. First, the negligible amount of cost shifting is unlikely to affect interstate commerce. Cost shifting can only arise when physicians and hospitals have some degree of market power over health insurers, which they use to impose markups to fund the uncompensated cost of care for the uninsured. But because markets for physician and hospital services are local, the impact of cost shifting will be borne where it occurs.

Second, even if there were cost shifting from the uninsured, it is not clear that the Patient Protection and Affordable Care Act will reduce it. According to the Congressional Budget Office, about half of the people who are expected to become newly insured under the Act will be enrolled in Medicaid. But as a review of academic studies by one of us has shown,[27] a long line of research has found that Medicaid payments to doctors and hospitals are so low that the program creates a cost shift of its own.

[27] Daniel P. Kessler, *Cost Shifting in California Hospitals: What is the Effect on Private Payers?*, California Foundation for Commerce and Education (2007).

Table 4: The Cost of Uncompensated Care for the Uninsured

	FUSA1 (2010 $bn)	FUSA2 (2008 $bn)	HHCM (2008 $bn)
Total expenditures on medical care for the uninsured	Not specified	$116.0	$83.9
Less out-of-pocket spending by uninsured	Not specified	$42.9	$29.6
Equals expenditures not paid out-of-pocket	$60.4	$73.1	$54.3
Less payments on behalf of uninsured	$17.3	$30.4	$42.9
Equals uncompensated care	$43.1	$42.7	$11.4
Maximum possible uncompensated care	Not specified	Not specified	$14.1
Private insurance premiums	$496.4	$557.0	$829.9
Ratio of uncompensated care to private insurance premiums	0.087	0.077	0.014
Ratio of maximum possible uncompensated care to private insurance premiums	Not specified	Not specified	0.017