

State Coverage Initiatives

Can a Sales Tax on Medical Services Help Fund State Coverage Expansions?

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Executive Summary

For states considering health coverage expansions, a health care sales tax (provider tax) is one revenue source that deserves consideration, for many reasons. First, state revenues often decline significantly when states experience an economic downturn, at the very time when demands for state-funded health programs increase. But revenues from provider taxes do not fall when the economy falters, so they are a more stable revenue source. Second, state revenues from most sources do not grow as rapidly as health care costs and the subsequent cost of funding coverage programs, leaving states with a shortfall over time. A tax on providers is a tax on health care costs, so revenues grow as costs increase.

Provider taxes have been criticized as unfair to providers; however, there is little doubt that the taxes are a viable way for a state to recoup uncompensated care costs that are built into the current reimbursement structure, but would no longer be incurred by most providers if nearly everyone had coverage. Further, because consumers' demand for health services is generally not very sensitive to price changes (especially when the cost is covered by insurance), providers would pass on most of the cost of a tax rather than bearing the burden themselves.

Introduction

For many years, people concerned about the uninsured have looked to the federal government for a solution. But in recent years, as the number of uninsured has grown and it has become increasingly evident that comprehensive federal action is unlikely, several states, perhaps most notably Massachusetts, have taken major steps to expand health coverage. These initiatives have prompted a number of other states to consider policies to achieve something close to universal coverage.

The most formidable barrier, as usual, is money. Virtually any approach that would significantly expand coverage will require states to generate substantial new funding, either to support subsidies for the purchase of private insurance for those who otherwise could not afford it or to cover the state's share of public program expansions. Medicaid and State Children's Health Insurance Program (SCHIP) expansions are especially attractive as elements of the policy mix because the federal government

pays a minimum of 50 percent of the bill. But even expanding these federally supported programs requires an increased financial commitment from states. Most funding options require either raising existing taxes or levying new ones. For obvious reasons, all are likely to meet with resistance.

Some tax options available to states have the advantages of being broad-based; that is, many people pay the tax and thus contribute to financing the programs for which the revenue is used. Such broad sharing of the burden seems to be a fair way to fund "redistribution" programs like subsidized coverage expansion. Another advantage of broad-based taxes is that small increases in tax rates can generate substantial revenue. Examples include personal income and retail sales taxes. Some broad-based taxes are seen as being more equitable than others because they are based on ability to pay—the most obvious example being personal income taxes. But raising broad-based taxes is politically very difficult because such taxes impose new burdens on nearly everyone, and rate increases are highly visible. Thus it seems likely that states, in deciding how to finance coverage expansion, will consider a variety of possibilities and may need to use several revenue sources.

This paper discusses one specific approach to paying part of the cost of coverage expansion—namely, imposing what amounts to a sales tax on some or all medical services. In essence, a small percentage of the amount providers are paid for direct patient services would be sent to state government. When Governor Arnold Schwarzenegger proposed a system for achieving near-universal health coverage in California, he included a provider tax (initially proposed for hospitals and physicians) to help fund the increased state expenditures that would have been required. Other states have had provider taxes in place for some time.¹ For example, 43 states have some kind of provider tax, and 30 states taxed more than one category of providers.² Many of these taxes were put in place as a way of leveraging federal matching funds for the purpose of raising provider reimbursement rates, especially for hospitals. The purpose for which provider taxes are addressed in this paper is to fund coverage expansion, including

subsidies to make private insurance more affordable for people who are not eligible for public programs but who still need assistance.

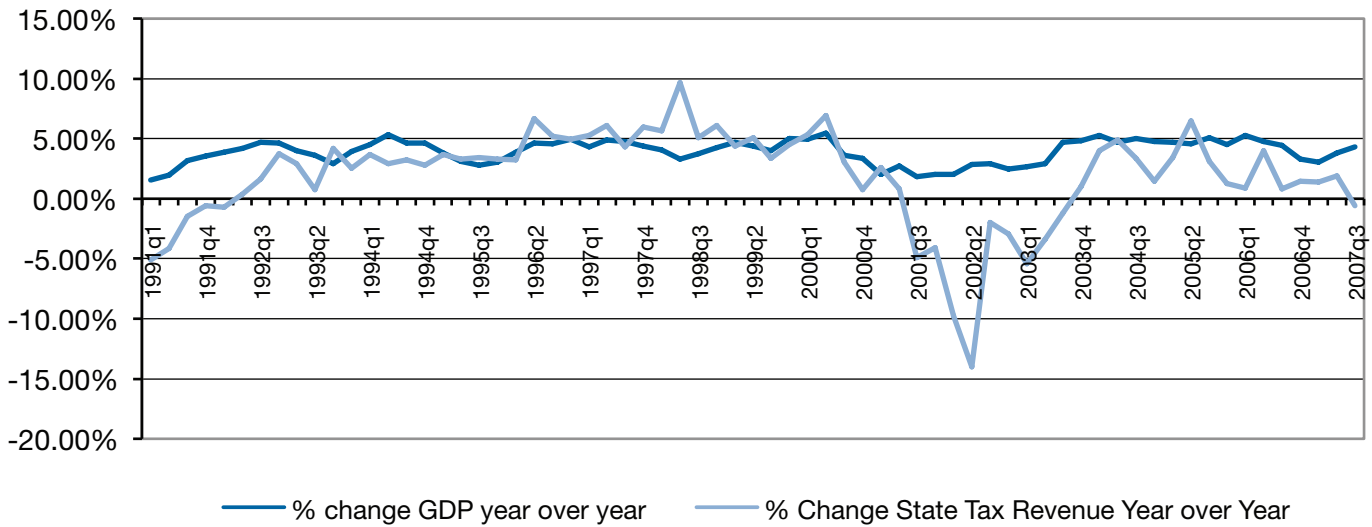
States face two difficult problems in funding coverage expansion. First, during an economic downturn, state revenues often decline greatly while the demands for state-funded health programs increase. Second, over time, state revenues are not likely to grow as rapidly as health care costs and the cost of funding coverage programs. Because provider taxes can help to address these problems, especially when the expectation is that the reforms will achieve nearly universal health insurance coverage, they deserve consideration as a source for funding coverage expansion.

A More Stable Source of Revenue

States are subject to large revenue losses during troughs in the state's economic cycle, a problem that poses a major barrier to states' aspirations to move toward universal coverage. The nature of most taxes—for example, personal and corporate income taxes and retail sales taxes—is that their revenue yield is closely tied to the level of state economic activity. As consumer income and spending decline, business receipts and spending fall. So do tax revenues. In fact, state tax revenues often decline at a more rapid rate than the state economy as a whole. Figure 1 compares year-over-year changes by quarter in gross domestic product (GDP) with adjusted state tax revenues³ from the first quarter of 1991 through the third quarter of 2007. The fluctuations in state tax revenue are significantly more extreme than in the national GDP, which is the measure of total economic growth for the nation.⁴ The degree of revenue volatility varies widely from state to state, depending in part on the nature of the state's economy and on which kinds of taxes they rely most heavily. So the variations shown in Figure 1, which aggregates all states, understate the volatility and the extent of the problem for many states. Similarly, individual states often suffer recessions that are deeper and longer than those of the national economy as a whole.

The problem is made worse for states because, during dips in the economic cycle, demands for public services, particularly health services, rise as more people need

Figure 1. Year-Over-Year Percent Change in GDP and State Tax Revenue by Quarter Adjusted for Inflation and for Legislative Changes in Taxes



Source for GDP data: Bureau of Economic Analysis, Bureau of Economic Analysis, U.S. Department of Commerce, <http://www.bea.gov/national/nipaweb/IndexG.htm#G>. Source for state revenue data: Rockefeller Institute, <http://www.rockinst.org/WorkArea/showcontent.aspx?id=13500>.

the assistance of state-subsidized insurance and safety-net programs. Figure 2 shows that state-only spending for Medicaid rises rapidly during periods of national economic recession, as in 2001 and 2002. An Urban Institute study that estimated the effects of recession on the demand for Medicaid services found that a 1 percent increase in unemployment produces Medicaid enrollment increases of about 4.1 percent for adults, 4.5 percent for children, and 1.7 percent for the blind and disabled.⁵

If states move toward universal coverage by providing increased assistance to lower income people, health spending will be an even bigger share of the total state budget than it is now, and the problems for state budgets will be even worse during dips in the business cycle. Most states have constitutional prohibitions against running deficits,⁶ so when they experience an economic downturn and consequent declining tax revenues, they are forced either to cut back on spending or raise tax rates, which is particularly difficult in tough economic times. States suffering an economic downturn often would be forced to cut back on their now-expanded health coverage program to bring spending in line with revenues. The recent last-minute failure of a promising major health reform in California appears to have been due in large part to a revised budget projection that showed that the state was facing a large deficit.

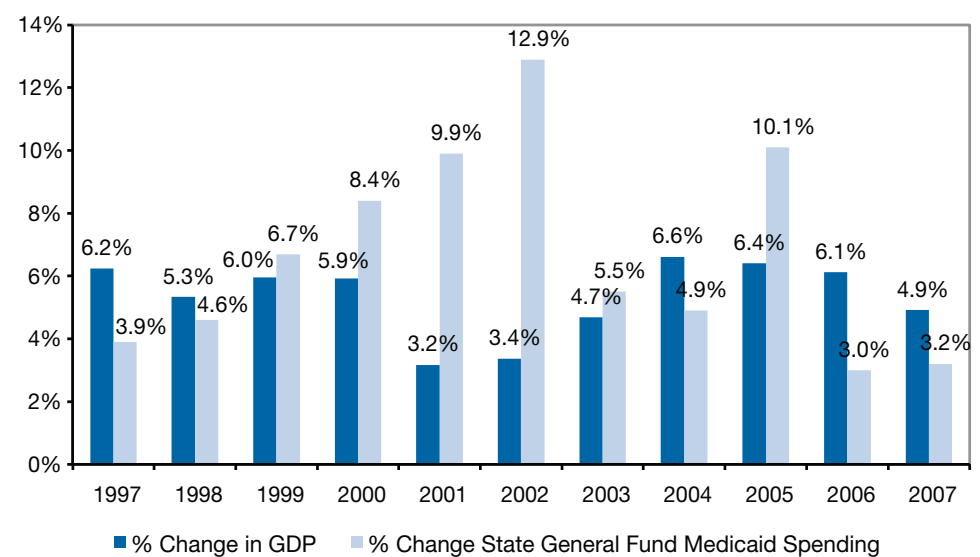
A sales tax on provider services has a major advantage over most other state funding sources: The revenue flow is largely recession-proof. People’s needs for medical services do not decline during recessions; they still go to doctors and hospitals for care. Thus the revenue from the sales tax on provider services is unlikely to fall appreciably, if at all, when the economy is in recession. As Figure 3 shows, during the entire period from 2000 through 2006, the growth rate for physician and hospital spending essentially equaled, exceeded, or substantially exceeded the GDP

growth rate,⁷ and during the recession that began in 2001 and lasted into 2003, both hospital and physician spending grew rapidly. In short, a sales tax on provider services could be expected to be a more reliable source of revenue over the business cycle than most other forms of taxation, reducing the need to curtail spending.

A Growing Source of Revenue

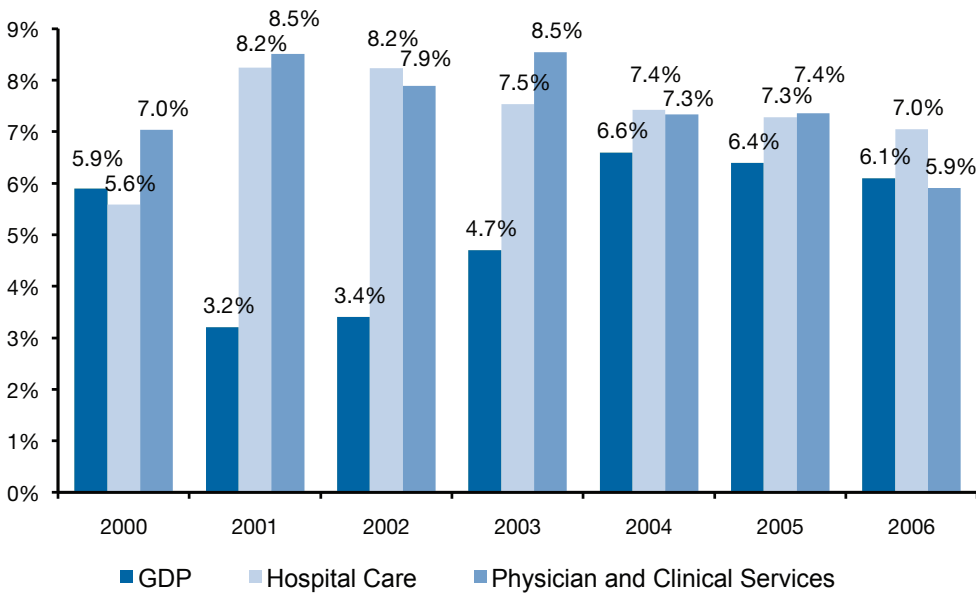
With few exceptions, medical care costs have outpaced the growth of the economy as a whole over a long period of time,

Figure 2. Percent Change in GDP and State Medicaid Spending



Source: KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates and FY 2007 and FY 2008, based on KCMU survey of Medicaid officials in 50 states and the District of Columbia conducted by Health Management Associates, October 2007.

Figure 3. Percent Change in GDP and Spending for Hospital and Physician Services, 2000-2006



Source: Centers for Medicare and Medicaid Services, Department of Health and Human Services, National Health Expenditure Accounts, http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage.

as Figure 4 shows, and they are certainly likely to do so in the future. This means that even if states did not have to worry about revenue shortfalls during periods of economic recession, over time they would likely find that the revenue that supports a comprehensive coverage expansion program would not keep pace with the need to fund that program. Over the long run, payroll taxes and other business taxes, sales taxes, and income taxes all tend to grow at a rate roughly approximating the growth of the state economy, but usually not faster. A provider sales tax, in contrast, is very likely to grow at approximately the same (high) pace as overall medical care costs, since provider costs make up the majority of health care costs.⁸ A provider tax is essentially a tax *on* the cost of health care; therefore, a tax on provider services helps increase the probability that revenue will be sufficient over time.

A Broader Revenue Base than Other “Health” Taxes

In seeking revenue to fund policies to improve coverage, such as high-risk pools, state policymakers often have levied taxes on insurers, typically with some kind of premium tax. This alternative to a provider tax might raise less vehement political opposition. Most economists would agree that all or at least most of the cost of provider taxes gets passed on to people who buy health insurance. Depending on partic-

ular circumstances, a provider tax may also be passed on to the users of medical services through the price they pay for those services. What, then, is the advantage of a provider tax over a premium tax? The burden of the provider tax is borne by everyone who uses medical services, including those covered by self-insured plans. But a premium tax can be levied only on *insurance* premiums; self-insured people do not share in the burden. The federal Employee Retirement Income Security Act (ERISA) has the effect of prohibiting states from regulating (and thus taxing) employer benefit plans, including fully insured and self-insured plans. This means that when states do levy premium taxes, only insured plans pay the tax; self-insured plans are exempt. Most large employers are self-insured, so a large portion of the population bears no burden. The advantage of a provider tax is that the burden is borne across a much broader base of the population than a premium tax. Provider taxes have been determined to be generally permissible under ERISA.

Is a Provider Sales Tax Fair?

Some would argue that it is not fair to tax provider services—that doing so puts the burden on providers when it should be more broadly shared. However, if one looks past the rhetoric, that proposition may not hold up.

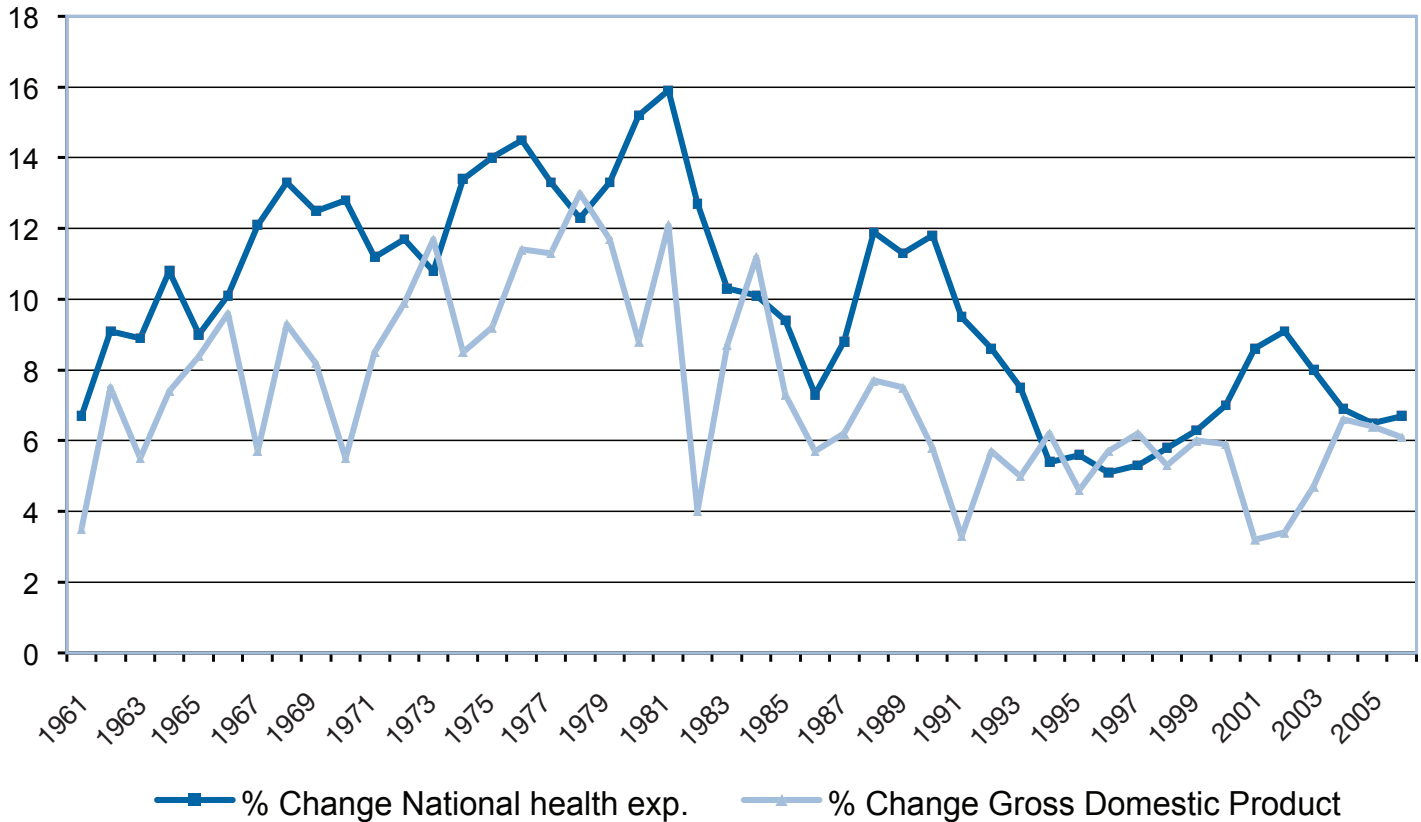
Compensating for Uncompensated Care Payments

Currently, payments to providers include an amount to cover what would otherwise be uncompensated care—that is, the costs that providers incur because some patients without adequate financial resources or any insurance receive free care or pay an amount that is less than the cost of providing the care. In these cases, most if not all of the uncompensated care costs get shifted to others through the insurance system or offset by direct government payment programs, such as the Disproportionate Share Hospital (DSH) program. If providers were not able to shift these costs to payers, they could not remain economically viable because they could not cover their costs. The fact that providers are generally not forced to close—though there are exceptions⁹—shows that most are covering these costs over the long run. Of course, this does not mean that they are necessarily receiving the income they expect or think they deserve, but most receive enough income from all sources combined to keep them from switching to a different kind of economic activity.¹⁰

Under a universal coverage or near-universal coverage system, most, if not virtually all, uncompensated care would be eliminated. Today, providers are being paid for uncompensated care through the cost shift and some direct government payments programs like DSH. If uncompensated care costs are no longer incurred because of universal coverage, providers in the aggregate would enjoy a windfall gain, provided that reimbursement rates remain unchanged. A provider tax is a way of “capturing” this provider savings, as it reduces or eliminates the windfall gain. Assuming the provider tax collects an amount equal to the previous cost of uncompensated care, in the aggregate, net provider income stays the same.

Of course, the indigent care burden is by no means spread evenly; many providers are not providing uncompensated care, or at least not a proportionate share. The amount of uncompensated care differs among types of providers and within any provider category among providers who serve different types of patients. Generally speaking, uncompensated care costs are likely to be a higher proportion of total expenses for hospitals than for physicians and other professional providers.¹¹

Figure 4. Percent Change in GDP and National Health Spending



Source: Centers for Medicare and Medicaid Services, Department of Health and Human Services, National Health Expenditure Accounts, www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage.

Even though the argument is not universally valid, it could be argued that at least some providers who were not serving their share of uninsured patients were previously enjoying “undeserved” windfall gains, being reimbursed at rates that included an amount for uncompensated care even though they were not incurring their fair share of the costs of providing such care.¹² (See below for further discussion of distributional effects.) Of course, no effort to recapture the savings that some providers would realize when cost-shifting is largely eliminated could be completely fair to all of the providers affected. Like the present system of cost shifting or any kind of tax, such a policy change would produce some winners and some losers.

Who Bears the Tax Burden?

Assume for the moment that there is no current payment for uncompensated care and thus no savings to be captured through a provider tax when universal coverage is achieved. Would a tax on providers then be inappropriate? Would it be an unfair burden on providers?

Business people, including providers, often object to taxes levied on any aspect of business activity. They say the tax, such as a payroll tax, will hurt their sales and net revenues because they cannot pass on all the costs to their customers in the form of higher prices. Thus they will experience a decrease in income. There is some economic validity to this argument. Even when all businesses have to pay a comparable tax, if businesses try to pass on all the tax in higher prices, the usual result will be that the higher price will deter some customers from buying the product or service, and revenues will fall. (For example, if a payroll tax on restaurants that raises labor costs causes restaurant owners to raise meal prices, some people will eat at home or select less expensive items on the menu.) Profits for the taxed businesses might decline and production levels might fall slightly. However, a sales tax on provider services is unlikely to have this effect because providers would probably be able to pass on most, if not all, of any net cost increase.

Passing on the Cost to Consumers

The provider sales tax scenario is generally analogous to a sales tax on groceries: Almost everyone recognizes that most of the burden of that tax is borne by the consumers who buy the groceries, even though it is the grocer that sends the money to the state treasury. A one-time, relatively small increase in the price of medical services—for example, 3 or 4 percent—is not likely to deter people from getting needed care. When people need medical care, they are not likely to be very sensitive to small price increases, especially given the long history of large annual price increases.¹³ (Unlike the restaurant customers who can substitute home-cooked meals for restaurant fare, ill patients cannot perform their own surgery or get an MRI at home.)

An extensive review of the literature that studied how sensitive people are to changes in the price of medical services concluded that they are, in fact, not very sensitive. The authors of the review found that “although the range of price elasticity estimates is relatively wide, it tends to

center on -0.17 , meaning that a 1 percent increase in the price of health care will lead to a 0.17 percent reduction in health care expenditures.¹⁴ However, it is important to note that these findings reflect consumer reactions when they are paying for the services out of their own pockets. Thus a sales tax of 4 percent on provider services might cause something like a 0.5 percent to 1 percent drop in demand for the taxed medical services, assuming the consumer is paying all of the increase out of pocket. In other words, *providers could raise their prices by enough to cover the new tax without losing much business or net revenue, even when patients are paying out of pocket.* But when insurance pays for most of the cost of services, as is the case for insured consumers once they have met their deductible, the consumers' price sensitivity will obviously be much less, so that providers will experience almost no loss in business or after-tax revenue.

Passing on the Cost to Insurers

The question, then, is whether insurance would cover the increase in price that providers would try to pass on to insurers as a result of the new tax. If the tax on providers is greater than the savings they realize by not having to provide "uncompensated" care, it is likely that most insurers (with the important exception of Medicare) would pay the net difference in costs. The state Medicaid program would need to increase payments rates to providers to offset the net tax increase. Of course, the state would then be using some of the funds collected from the provider tax to compensate Medicaid providers for their cost increase, but the state would still generate net revenue from this transaction because of the federal matching funds. (The Centers for Medicare and Medicaid Services [CMS] limits the extent to which states can levy provider taxes and then use the funds to increase provider reimbursement. See box.) With respect to the private market, just as private insurers and self-insured employers have paid for uncompensated care through the cost shift, they could generally be expected to pay for the increased net costs due to the tax, since the tax would apply to all providers and would be a legitimate cost of doing business.¹⁵ Over the long run, if they did not cover this legitimate cost, a substantial number of providers would be forced out of business, which would not be in the interest of these payers and the people they insure. (This is not to say that insurers would not try to persuade providers to be more efficient.)

Of course, insurers would then pass on these costs to those who have coverage. There would almost surely be no significant decline in the amount of medical services consumed and very little real reduction in net revenue realized by providers as a whole.

If the cost is passed back to the people who have coverage, the tax could be seen as perpetuating the cost shift. But if coverage is virtually universal, with subsidies to make coverage affordable for everyone, the costs are shifted back to everyone, and the burden is thus broadly shared. All households would be bearing the burden of the tax, approximately in proportion to the cost of their coverage.¹⁶ But if the reform makes coverage affordable for everyone, this result could be considered reasonably equitable. It is still regressive, because the tax burden is a higher proportion of income for lower-income people than for higher-income people. But that tends to be true of most state taxes, other than income taxes.

Distributional Considerations

There is an important caveat to this analysis: Even if the provider sales tax would not produce a net increase in costs for providers in the aggregate, the tax could produce an undesirable redistribution of costs among providers. For example, providers, both hospitals and physicians, that have a disproportionate number of Medicare patients could be at a disadvantage by a tax on all patient revenues. Under present reimbursement rules, Medicare will not

pay more just because the providers in one state have to pay a tax on Medicare patient revenue. Even if private insurers pay for a cost increase attributable to the tax—as they likely would—they are not likely to provide higher reimbursement rates to those providers with a disproportionate share of Medicare patients. So such providers could suffer financially. One possible solution is to apply the tax to a revenue base that helps to avoid such unfair redistributive effects, for example, excluding Medicare revenue. (This is the approach used in Minnesota, and it was part of the agreement worked out in California for the proposed reform.) Although redistributive effects should be assessed before imposing any provider tax, it is important to realize that any kind of tax increase will have redistributive effects that have a greater impact on some providers than on others.

A "Sick Tax"?

Some people criticize provider taxes as being a "sick tax" because a disproportionate share of the burden would be borne by those who use the health care system. The argument is that if doctors and hospitals pass on a portion of the costs of the tax to patients, then the people who are lucky enough to be healthy and thus use few medical services will not pay their fair share. The validity of this argument depends on the extent to which people are paying provider bills out of their own pockets rather than through insurance.

Limits on Provider Taxes from the Medicaid Program

States that levy provider taxes and then use the revenue to increase provider Medicaid reimbursement can receive federal matching funds (known as "FFP") on those Medicaid provider payments only if the provider tax mechanism is structured in a way that does not "hold [the payer of the tax] harmless." CMS regulations require that the tax be bonafide; i.e., it cannot ensure a financial return to a provider "taxpayer" that is equal or substantially equal to the cost of the tax. Under CMS regulations governing "permissible health-related taxes," a threshold test for "hold harmless" is articulated, as follows: "When the tax or taxes are applied at a rate that produces revenues in excess of 6 percent [now 5.5 percent] of the revenue received by the taxpayer, HCFA [now CMS] will consider a hold harmless provision to exist if 75 percent or more of the taxpayers in the [health-related] class receive 75 percent or more of their total tax costs back in enhanced Medicaid payments or other State payments." Thus, provider taxes levied at a rate below the threshold and structured without a "hold harmless" promise to the taxpayer would generate state revenue that could fund Medicaid program expenses without adverse effects on federal funding.

According to a study of national health expenditures for 2003, for every \$5 of health spending, people pay about \$1 out of pocket—approximately 20 percent. As one would expect, people who have the highest spending in a year pay the most: The 1 percent of the population who had the highest medical bills—which are many times higher than the average—paid an average of \$4,331 out of pocket, which was 7 percent of their total bill; in contrast, the 20 percent with the lowest spending paid on average only \$281, which was 37 percent of their bill. Of course, the out-of-pocket expenditures were smaller for people with insurance. The top 1 percent of the non-elderly, privately insured population paid out-of-pocket costs equal to \$2,487, which is 57 percent of the amount paid by the comparable group for the whole population. Out-of-pocket spending for people with insurance varies for different kinds of services. The average shares of out-of-pocket spending for the non-elderly with insurance were 4 percent for hospital care, 13 percent for outpatient care, and 28 percent for office-based care.¹⁷

What are the implications of these data for the argument that a provider tax is a “sick tax”? The data show that many people pay out of pocket, and a provider tax that is passed on would therefore affect their costs. But if the tax is a small percentage, say 2 percent to 4 percent, the burden would be small. Moreover, out-of-pocket payments are highest for those without insurance, and the point of collecting provider taxes would be to fund coverage expansion, so that fewer people would be uninsured and thus fewer would incur high out-of-pocket expenses.

Conclusion

Achieving near-universal coverage in most states will require coming up with new revenue, which almost certainly means a tax increase or imposing some kind of new tax. No tax increase will easily pass through the political process, and a provider tax is no exception. Every tax raises issues related to fairness and redistribution of burdens, but as this analysis shows, a tax on provider sales has some economic advantages that make it worthy of consideration as one source of revenue for major coverage expansion.

Limits on Provider Taxes from the Medicaid Program

In 1992, Minnesota began to put in place a comprehensive provider tax to fund coverage for the uninsured, specifically to provide funding for the MinnesotaCare program. Initially the tax—which applies to gross receipts from services provided directly to patients—applied to hospitals, but it was subsequently extended to many other providers, including prescription drug distributors. Pharmacies, nursing homes, home health agencies and other similar providers are not subject to the tax. In addition, revenues from services provided to Medicare patients and revenues from other federal programs (Federal Employees Health Benefit Program, Veterans Administration, etc.) are excluded. Those subject to the tax include about 8,000 practitioners and 192 hospitals. Most providers pay a tax equal to 2 percent of gross receipts, although the rate has been lower at some times. In 2007, revenue from that tax amounted to more than \$397 million.

The state tax research office takes the position that the tax is passed on to those who use health services, but at least some provider groups argue that they bear the burden. The original law included a provision to require insurers to allow the tax to be passed to them, but state officials argue that it is essentially impossible to determine whether this has happened. Once the program has been in effect for a number of years, there is no way to measure whether payments from insurers actually include a specific element to cover the providers' tax costs. State officials acknowledge that the tax has a more regressive incidence than would an income tax, but they also note that the tax receipts tend to keep up with the rising costs of providing medical coverage. In fact, at times the fund has run a surplus, which legislators often wish to tap to fund programs other than MinnesotaCare.

In addition, a study of the impact of the Minnesota provider tax on hospitals found that their costs were basically offset by reduced uncompensated care costs that were a result of rising coverage rates due to expanded public coverage. When provider taxes are implemented for hospitals they can be offset by savings in uncompensated care.¹⁸

About the Author

Elliot K. Wicks, Ph.D., is an economist and policy researcher with more than 30 years experience analyzing health policy issues. He is Senior Economist with Health Management Associates, a Michigan-based consulting firm.

Dr. Wicks specializes in analysis of policy reforms to help bring affordable health coverage to more Americans, especially workers in small firms. He has extensive knowledge of the small-group and individual insurance markets and of arrangements to make coverage more affordable for small employers through pooled purchasing of health coverage. Dr. Wicks is the author of numerous articles and monographs on these subjects and others related to health care financing and cost containment.

He has worked for health care consulting firms, policy research institutes, a trade association, and state government, and he was formerly a faculty member at Michigan State University and the University of Portland. He has a Ph.D. in Economics and Social Policy from Syracuse University and an M.A. in Economics from Northwestern University.

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Endnotes

- 1 Many provider taxes were initiated in the mid-1980s as a way for states to increase federal contributions to the state Medicaid programs under regulations related to the Disproportionate Share Hospital program. In effect, provider taxes counted as state contributions and were matched by federal funds, even when the contributions were then returned to providers.
- 2 Smith, V. et al. "As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2007 and 2008," Kaiser Family Foundation Commission on Medicaid and the Uninsured, October 2007. The Medicaid budget study shows 20 states taxing hospitals, 15 states taxing managed care organizations, 28 states and the District of Columbia taxing Intermediate Care Facilities/Mental Retardation-DD, 33 states/District taxing nursing homes, four taxing pharmacies, and two taxing residential care and day rehabilitation providers. (www.ncsl.org/programs/health/HealthTaxes.htm#2).
- 3 The adjustments remove changes due to inflation and changes in state tax laws.
- 4 Although the general pattern is that state revenues move in the same direction as and by more than GDP, this is not always true. The discrepancies may be due in part to lags between revenues and business cycles.
- 5 Holahan, J. and B. Garrett, "Rising Unemployment and Medicaid," Urban Institute, October 16, 2001.
- 6 The exceptions are Vermont and Wyoming. John W. Ellwood and Mary Sprague, "Options for Reforming the California State Budget Process," <http://igs.berkeley.edu/library/htConstReform2003-ELLWOODtext.pdf>.
- 7 In the mid- to late-1990s this pattern did not hold as precisely. In some of those years, the GDP growth rate exceeded the growth rate of health expenditures, especially hospital services. This is often attributed to the market penetration of managed care plans that were fairly aggressive in trying to hold down costs. The subsequent "backlash" against managed care cost-containment efforts is often given as the explanation for the more rapid subsequent growth of health expenditures, which was more typical of years prior to the mid-1990s.
- 8 2006 National Health Expenditures data show that expenditures for hospital services and physician professional services alone account for 56 percent of total national health services and supplies.
- 9 Some hospitals, other facilities, and health professionals struggle financially and may go out of business, but in all markets, some participants fail—either because they are inefficient, their costs are too high relative to competitors, or there just is not enough demand to support their cost structure. The reimbursement system for health care providers should not be expected to guarantee that all providers get enough revenue to stay in business. If the level of reimbursement is so low that many reasonably efficient providers are not able to survive, then payment is inadequate.
- 10 From an economic standpoint, the test of whether any profession is receiving "enough" compensation is whether the number of qualified people willing to take up that occupation is sufficient to meet the need for services the profession provides.
- 11 A recent study by Jonathan Gruber and David Rodriguez concludes that the amount of uncompensated care provided by physicians is much less than generally thought. Their study notes that uncompensated care has often been calculated by looking at the difference between what uninsured patients are charged and what they pay. But Gruber and Rodriguez argue this is an invalid measure because most insured patients pay far less than this amount due to the heavily discounted rates negotiated by insurers. If uncompensated care is calculated as the difference between what insured patients pay and what uninsured patients actually pay, there is almost no uncompensated care, because the uninsured patients who pay their bills are charged much more than insured patients for the same service. At most, according to the study, physician uncompensated care amounts to 0.8 percent of physician revenues. See Jonathan Gruber and David Rodriguez, "How Much Uncompensated Care Do Doctors Provide?" NBER Working Paper No. 13585, November 2007, JEL No. I1.
- 12 I am indebted to Rick Curtis of the Institute for Health Policy Solutions for having brought this point to my attention.
- 13 From 1996 to 2006, national health expenditures grew at an annual average rate of 6.3 percent.
- 14 *The Elasticity of Demand for Health Care: A Review of the Literature and Its Application to the Military Health System*, RAND Health, National Defense Research Institute, www.rand.org/pubs/monograph_reports/2005/MR1355.pdf.
- 15 One might ask why, since the provider tax gets shifted back to insurers and then back to employers and employees, the tax should not be levied on insurers directly? The answer is that such a tax would not generate revenue from medical expenditures incurred by people covered by self-insured employers, who account for a large share of total medical expenditures.
- 16 This assumes, as economists generally conclude, that employers shift the cost of employer-paid premiums back to employees in the form of lower wages.
- 17 Kaiser Family Foundation, "Distribution of Out-of-Pocket Spending for Health Care Services," May 2006, www.kff.org/insurance/snapshot/chcm0502060th.cfm#5.
- 18 State Health Access Data Assistance Center "Expanding Access to Health Insurance Coverage Lessens the Burden of Uncompensated Care," December 2003, www.shadac.umn.edu/img/assets/18528/issuebrief8.pdf.