

Who Really Pays for Health Care?

The Myth of "Shared Responsibility"

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WHEN ASKED WHO PAYS FOR HEALTH CARE IN THE United States, the usual answer is "employers, government, and individuals." Most Americans believe that employers pay the bulk of workers' premiums and that governments pay for Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and other programs.

However, this is incorrect. Employers do not bear the cost of employment-based insurance; workers and households pay for health insurance through lower wages and higher prices. Moreover, government has no source of funds other than taxes or borrowing to pay for health care.

Failure to understand that individuals and households actually foot the entire health care bill perpetuates the idea that people can get great health benefits paid for by someone else. It leads to perverse and counterproductive ideas regarding health care reform.

The Myth of Shared Responsibility

Many sources contribute to the misperception that employers and government bear significant shares of health care costs. For example, a report of the Centers for Medicare & Medicaid Services states that "the financial burden of health care costs resides with businesses, households, and governments that pay insurance premiums, out-of-pocket costs, or finance health care through dedicated taxes or general revenues."¹ A New America Foundation report claims, "There is growing bipartisan support for a health system based on shared responsibility—with the individual, employers, and government all doing their fair share."²

The notion of shared responsibility serves many interests. "Responsibility" is a popular catchword for those who believe everyone should pull their own weight, while "sharing" appeals to those who believe everyone should contribute to meeting common social goals. Politicians welcome the opportunity to boast that they are "giving" the people health benefits. Employers and union leaders alike want workers to believe that the employer is "giving" them health insurance. For example, Steve Burd, president and chief executive officer of Safeway, argued that decreasing health care costs is critical to his company's bottom line—as if costs come

out of profits.³ A highly touted alliance between Wal-Mart and the Service Employees International Union for universal coverage pledged that "businesses, governments, and individuals all [must] contribute to managing and financing a new American health care system."⁴

The Massachusetts health care reform plan is constructed around "shared responsibility." The rhetoric of health reform proposals offered by several presidential candidates helps propagate this idea. Hillary Clinton, for instance, claims that her American Health Choices plan "is based on the principle of shared responsibility. This plan ensures that all who benefit from the system contribute to its financing and management."⁵ It then lists how insurance and drug companies, individuals, clinicians, employers, and government must each contribute to the provision of improved health care.

With prominent politicians, business leaders, and experts supporting shared responsibility, it is hardly surprising that most Americans believe that employers really bear most of the cost of health insurance.

The Health Care Cost-Wage Trade-off

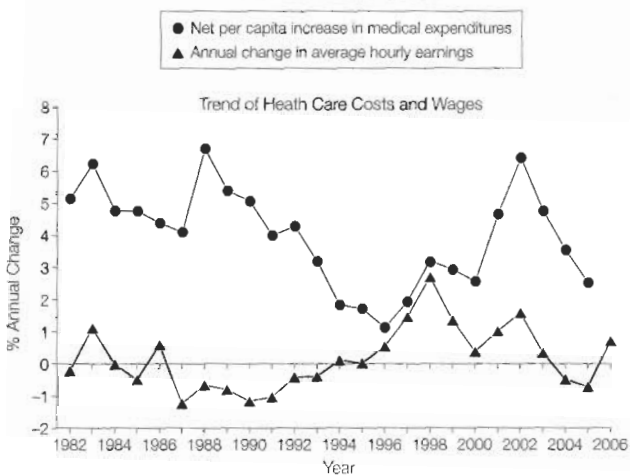
Shared responsibility is a myth. While employers do provide health insurance for the majority of Americans, that does not mean that they are paying the cost. Wages, health insurance, and other fringe benefits are simply components of overall worker compensation. When employers provide health insurance to their workers, they may define the benefits, select the health plan to manage the benefits, and collect the funds to pay the health plan, but they do not bear the ultimate cost. Employers' contribution to the health insurance premium is really workers' compensation in another form.

This is not a point merely of economic theory but of historical fact. Consider changes in health insurance premiums, wages, and corporate profits over the last 30 years. Premiums have increased by about 300% after adjustment for inflation. Corporate profits per employee have flourished, with inflation-adjusted increases of 150% before taxes and 200% after taxes. By contrast, average hourly earnings of workers

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Figure. Changes in Per Capita Health Expenditures and Average Hourly Earnings (Adjusted for Inflation), 1982-2005



Data are from the Council of Economic Advisers⁶ and Catlin et al.⁷

in private nonagricultural industries have been stagnant, actually decreasing by 4% after adjustment for inflation. Rather than coming out of corporate profits, the increasing cost of health care has resulted in relatively flat real wages for 30 years. That is the health care cost–wage trade-off.⁶

Even over shorter periods, workers' average hourly earnings fluctuate with changes in health care expenditures (adjusted for inflation) (FIGURE). During periods when the real annual increases in health care costs are significant, as between 1987 and 1992 and again between 2001 and 2004, inflation-adjusted hourly earnings are flat or even declining in real value. For a variety of reasons, the decline in wages may lag a few years behind health care cost increases. Insurance premiums increase after costs increase. Employers may be in binding multiyear wage contracts that restrict their ability to change wages immediately. Conversely, when increases in health care costs are moderate, as between 1994 and 1999, increases in productivity and other factors translate into higher wages rather than health care premiums.

The health care cost–wage trade-off is confirmed by many economic studies.⁸⁻¹¹ State mandates for inclusion of certain health benefits in insurance packages resulted in essentially all the cost of the added services being borne by workers in terms of lower wages.¹² Similarly, using the Consumer Expenditure Survey, Miller¹³ found that “the amount of earnings a worker must give up for gaining health insurance is roughly equal to the amount an employer must pay for such coverage.” Baicker and Chandra¹⁴ reported that a 10% increase in state health insurance premiums generated a 2.3% decline in wages, “so that [workers] bear the full cost of the premium increase.” Importantly, several studies show that when workers lose employer-provided health insurance, they actually receive pay increases equivalent to the insurance premium.^{8,12}

In a review of studies on the link between higher health care costs and wages, Gruber¹⁵ concluded, “The results [of studies] that attempt to control for worker selection, firm selection, or (ideally) both have produced a fairly uniform result: the costs of health insurance are fully shifted to wages.”

The Cost–Public Service Trade-off

A large portion of health care coverage in the United States is provided by the government. But where does government's money for health care come from? Just as the ultimate cost of employer-provided health insurance falls to workers, the burden of government-provided health coverage falls on the average citizen. When government pays for increases in health care costs, it taxes current citizens, borrows from future taxpayers, or reduces other state services that benefit citizens: the health care cost–public service trade-off.

Health care costs are now the single largest part of state budgets, exceeding education. According to the National Governors Association, in 2006, health care expenditures accounted for an average of 32% of state budgets, while Medicaid alone accounted for 22% of spending.¹⁶ Between 2000 and 2004, health care expenditures increased substantially, more than 34%, with Medicaid and SCHIP increasing more than 44%.⁷ These increases far exceeded the increase in state tax receipts. In response, some states raised taxes, others changed eligibility requirements for Medicaid and other programs, and still others reduced the fees and payments to physicians, hospitals, and other providers of health care services.

However, according to a Rockefeller Institute of Government study of how 10 representative states responded, probably the most common policy change was to cut other state programs, and “the program area that was most affected by state budget difficulties in 2004 was public higher education On average, the sample states projected spending 4.5% less on higher education in FY 2004 than in FY 2003, and raised tuition and fees by almost 14% on average.”¹⁷ In other words, the increasing cost of Medicaid and other government health care programs are a primary reason for the substantial increase in tuition and fees for state colleges and universities. Middle-class families finding it more difficult to pay for their children's college are unwittingly falling victim to increasing state health care costs. Not an easy—but a necessary—connection to make.

Policy Implications

The widespread failure to acknowledge these effects of increasing health care costs on wages and on government services such as education has important policy implications. The myth of shared responsibility perpetuates the belief that workers are getting something while paying little or nothing. This undercuts the public's willingness to tax itself for the benefits it wants.

This myth of shared responsibility makes any reform that removes employers from health care much more difficult to enact. If workers and their families continue to believe that they can get a substantial fringe benefit like health insurance at no cost to themselves, they are less likely to consider alternatives. Unless this myth is dispelled, the centerpiece of reform is likely to be an employer mandate. This is regrettable and perpetuates the widely recognized historical mistake of tying health care coverage to employment. Furthermore, an employer mandate is an economically inefficient mechanism to finance health care. Keeping employers in health care, with their varied interests and competencies, impedes major changes necessary for insurance portability, cost control, efficient insurance exchanges, value-based coverage, delivery system reform, and many other essential reforms.^{18,19} Employers should be removed from health care except for enacting wellness programs that directly help maintain productivity and reduce absenteeism. Politicians' rhetoric about shared responsibility reinforces rather than rejects this misconception and inhibits rather than facilitates true health care reform.

Not only does third-party payment attenuate the incentive to compare costs and value, but the notion that someone else is paying for the insurance further reduces the incentive for cost control. Getting Americans invested in cost control will require that they realize they pay the price, not just for the deductibles and co-payments, but for the full insurance premiums too.

Sustainable increases in wages require less explosive growth in health care costs. Only then will increases in productivity show up in higher wages and lower prices, giving a boost to real incomes. Similarly, the only way for states to provide more support for education, environment, and infrastructure is for health care costs to be restrained. Unless the growth in Medicaid and SCHIP are limited to—or close to—revenue increases, they will continue to siphon money that could be spent elsewhere.

Conclusion

Discussions of health care financing in the United States are distorted by the widely embraced myth of shared responsibility. The common claim that employers, government, and households all pay for health care is false. Employers do not share fiscal responsibility and employers do not pay for health care—they pass it on in the form of lower wages or higher prices. It is essential for Americans to understand that while it looks like they can have a free lunch—having someone else pay for their health insurance—they cannot. The money comes from their own pockets. Understanding this is essential for any sustainable health care reform.

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REFERENCES

- Centers for Medicare & Medicaid Services. Health expenditures by sponsors: business, household and government. <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/bhg08.pdf>. Accessed February 6, 2008.
- Gallagher C, Harbage P. *Growing Support for Shared and Personal Responsibility in Health Care*. Washington, DC: New America Foundation; June 2007. http://www.newamerica.net/publications/policy/growing_support_shared_and_personal_responsibility_health_care. Accessed February 6, 2008.
- Burd S. Meeting the US health care challenge. US Chamber of Commerce CEO Leadership Series: event summary. September 7, 2006. <http://www.uschamber.com/NR/rdonlyres/ekv73cdudc6ygrheayctrps464scv17isnos4gi3zpp4vadvkuz7ycircw3mwy5qvh5nlisfeq3pgt7nns7xrsing/CEOSeriesSafeway.pdf>. Accessed February 6, 2008.
- Kavlianz PB. Wal-Mart, union push universal health care. February 7, 2007. http://money.cnn.com/2007/02/07/news/companies/walmart_healthcare/index.htm. Accessed February 6, 2008.
- Hillary Clinton for President. American Health Choices plan. <http://www.hillaryclinton.com/feature/healthcareplan/americanhealthchoicesplan.pdf>. Accessed February 6, 2008.
- Council of Economic Advisers. *Economic Report of the President*. Washington, DC: US Government Printing Office; February 2007. Appendix B: tables 3, 47, and 90. <http://www.whitehouse.gov/cea/pubs.html>. Accessed February 6, 2008.
- Catlin A, Cowan C, Hartman M, et al. National health spending in 2006: a year of change for prescription drugs. *Health Aff (Millwood)*. 2008;27(1):14-29.
- Eberts R, Stone J. Wages, fringe benefits, and working conditions: an analysis of compensating differentials. *South Econ J*. 1985;52:274-280.
- Sheiner L. *Health Care Costs, Wages, and Aging*. Washington, DC: Federal Reserve Board of Governors; April 1999. <http://www.federalreserve.gov/pubs/feds/1999/199919/199919pap.pdf>. Accessed February 6, 2008.
- Royalby AB. *A Discrete Choice Approach to Estimating Workers' Marginal Valuation of Fringe Benefits*. Indianapolis: Indiana University-Purdue University; June 2003. http://liberalarts.iupui.edu/~anroyalt/wfdisch_j03.pdf. Accessed February 6, 2008.
- Madrian BC. *The US Health Care System and Labor Markets*. Cambridge, MA: National Bureau of Economic Research; January 2006. NBER Working Paper No. 11980. <http://www.nber.org/papers/w11980>. Accessed February 6, 2008.
- Gruber J. The incidence of mandated maternity benefits. *Am Econ Rev*. 1994; 84(3):622-641.
- Miller RD. Estimating the compensating differential for employer-provided health insurance. *Int J Health Care Finance Econ*. 2004;4(1):27-41.
- Baicker K, Chandra A. *The Labor Market Effects of Rising Health Insurance Premiums*. Cambridge, MA: National Bureau of Economic Research; February 2005. NBER Working Paper No. 11160. <http://www.nber.org/papers/w11160>. Accessed February 6, 2008.
- Gruber J. Health insurance and the labor market. In: Culyer AJ, Newhouse JP, eds. *Handbook of Health Economics*. Vol 1. New York, NY: Elsevier Science; 2000.
- The Fiscal Survey of States*. Washington, DC: National Governors Association and National Association of State Budget Officers; June 2007. <http://www.nasbo.org/Publications/PDFs/Fiscal%20Survey%20of%20the%20States%20June%202007.pdf>. Accessed February 6, 2008.
- Fossett JW, Burke CE. *Medicaid and State Budgets in FY 2004: Why Medicaid Is so Hard to Cut*. Albany, NY: Rockefeller Institute of Government; 2004. <http://www.nysl.nysed.gov/scandoclinks/ocm56501455.htm>. Accessed February 6, 2008.
- Blumenthal D. Employer-sponsored health insurance in the United States—origins and implications. *N Engl J Med*. 2006;355(1):82-88.
- Galvin RS, Delbanco S. Between a rock and a hard place: understanding the employer mind-set. *Health Aff (Millwood)*. 2006;25(6):1548-1556.