Chapter 3: Who Pays for Health Services?

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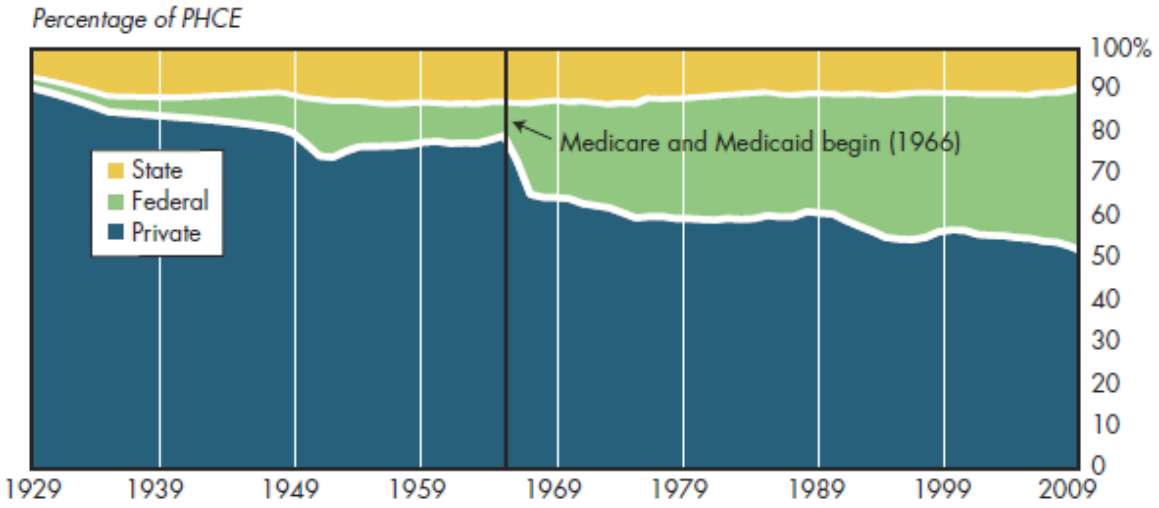
Table of Contents

Chapter 1

3.1 Role of Public Sector in US Health Financing Has Increased[1]

Examining health financing from the standpoint of who literally pays the final bills, a rather steady expansion in the public-sector share of NHE that goes back at least 80 years becomes obvious (figure 3.1a). Starting in the 1960s, when both Medicare and Medicaid first began, the public share of financing increased much more sharply than it had previously.

3.1a Since 1965, the increasing federal share of PHCE has displaced much private and state health spending



Note: In the NHE Accounts framework, federal government health spending includes all of Medicare (including components financed privately, such as Parts B and D premiums), the federal share of Medicaid spending, and other public health-related programs such as DOD and VA health. State/local government health spending includes the non-federal share of Medicaid, workers' compensation, hospital subsidies, and the non-federal share of categorical or block grant programs such as maternal and child health.

From this standpoint of government as payer, Medicare is a federal responsibility because all funds flow through the general treasury before distribution to private administrators who pay claims from providers. This includes all the payroll taxes used to support Part A (inpatient hospital and nursing home services), together with the voluntary premiums for Part B (physician and other outpatient services) and Part D

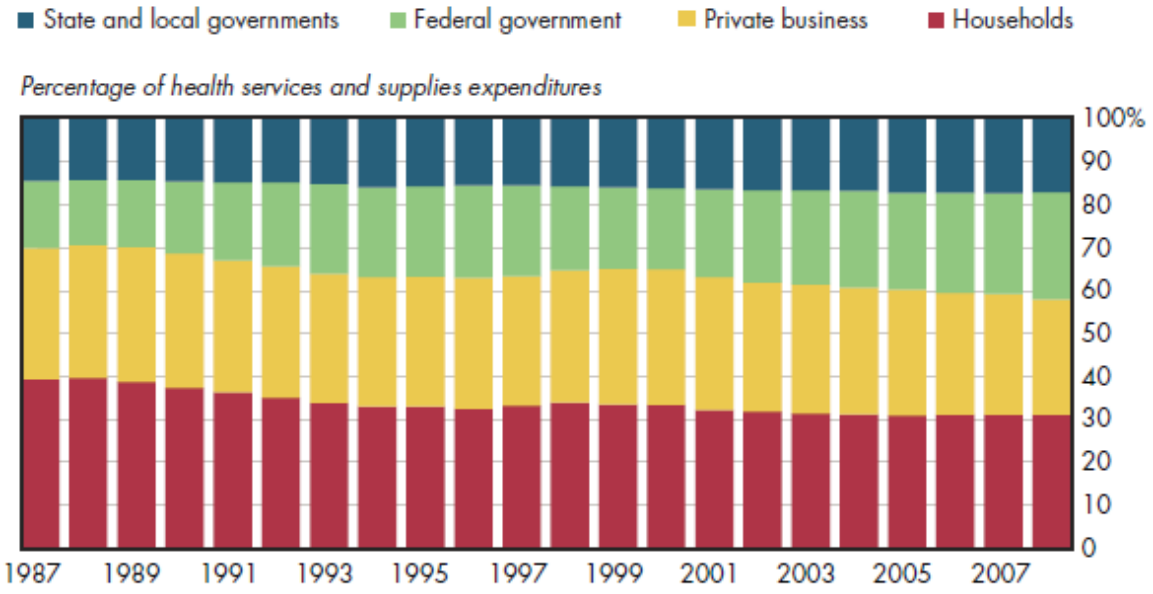
[1]This content is available online at <https://hub.mili.csom.umn.edu/content/m10015/1.2/>.

(prescription drugs). Medicaid—jointly financed by the federal and state governments —nominally increased state and local responsibility for care. In reality, the greatly expanded federal role in health care financing in 1965 displaced much of the traditional state and local government role in paying for care of the poor, disabled, and elderly. Consequently, the state and local share of health spending declined steadily since the 1960s as the federal share expanded. The federal displacement of private insurance and family out-of-pocket payments in this period was even greater.

An alternative way to view health spending is in terms of sources of revenue. Even though households ultimately incur the burden of all health spending, it is possible to differentiate revenues flowing from households, businesses, and various levels of government. In this so-called sponsor view, half of Medicare payroll taxes are assumed to be paid by employers and half paid by employees (households) rather than by the federal government. Conversely, the cost of the Federal Employee Health Benefits Plan (FEHBP) is shifted from private insurers (under the payer view) to the federal government (employer contributions) and households of covered members (premiums paid by federal employees/retirees).

From this sponsor view of health financing, the relative shares of spending paid by business, households, the federal government, and state and local governments have been remarkably stable over the past 20 years (figure 3.1b). Nevertheless, the public role in financing has grown slightly over this period.

3.1b Accounting for each sponsor's share of health revenues results in a much more stable federal share of spending over 20 years



Note: In the framework of "health sponsors," household health spending includes only components that are directly paid, including the employee share of group health insurance premiums, the employee share of Medicare Part A payroll taxes, voluntary premiums paid for Medicare Parts B or D and non-group health insurance, and any out-of-pocket spending not covered by public or private insurance. Business health expenditures include only the private employer share of health insurance premiums for workers and dependents, Medicare Part A and workers' compensation, and industrial in-plant health services.

1.1 Downloads

Download Excel workbooks used to create Figure 3.1a Tables[2] and Figure 3.1b Tables[3] . [Note that you'd have separate links for each set of tables] Figures 3.1a and 3.1b were created from the following tables (the workbook includes all supporting tables used to create this table):

- Fig. 3.1a: Table 3.1.1. U.S. Personal Health Expenditures by Source of Funds: 1929 to 2021
- Fig. 3.1b: Table 3.1.2. Distribution of National Health Expenditures by Sponsor: 1987 to 2011

Download PowerPoint versions of both figures.

- Figure 3.1a Image Slide (as it appears above)[4]
- Figure 3.1a Editable Slide (can be formatted as desired)[5]
- Figure 3.1b Image Slide (as it appears above)[6]
- Figure 3.1b Editable Slide (can be formatted as desired)[7]

1.2 References

A. Author's calculations.
B. Department of Health and Human Services. Centers for Medicare and Medicaid Services.
C. Worthington NL. National Health Expenditures, Calendar Years 1929-73. Research and Statistics Note No 1. Office of Research and Statistics 1975.

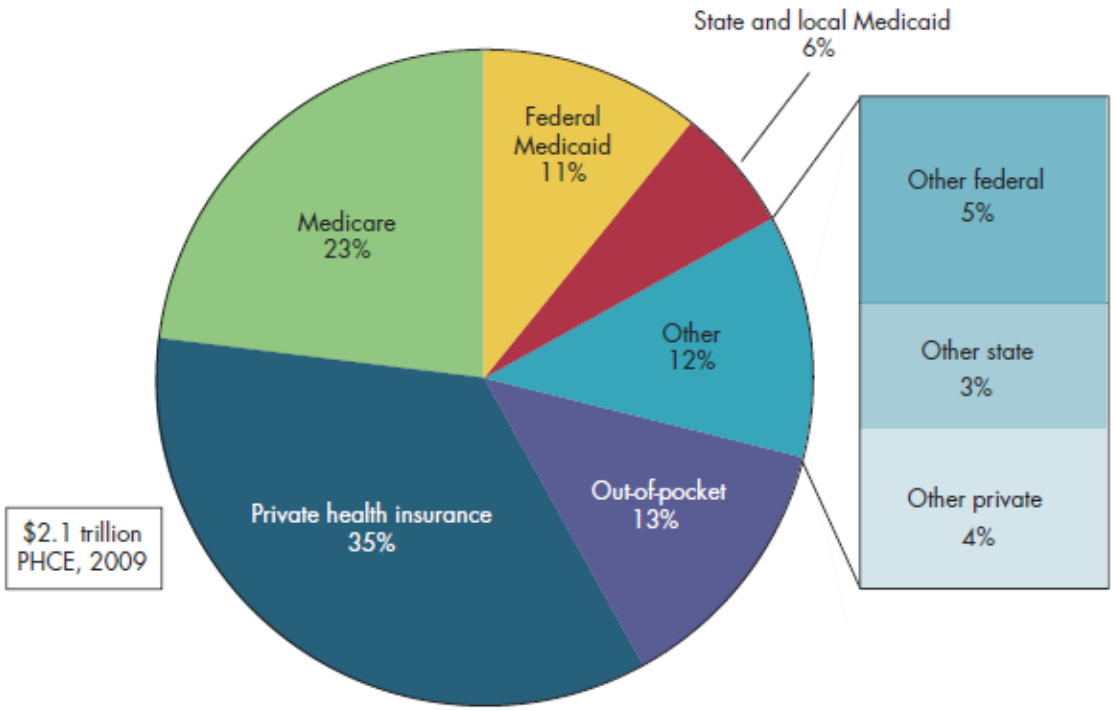
[2]https://hub.mili.csom.umn.edu/content/m10015/latest/3.1aTAB.xls
[3]https://hub.mili.csom.umn.edu/content/m10015/latest/3.1bTAB.xls
[4]https://hub.mili.csom.umn.edu/content/m10015/latest/3.1aIMG.ppt
[5]https://hub.mili.csom.umn.edu/content/m10015/latest/3.1aDATA.ppt
[6]https://hub.mili.csom.umn.edu/content/m10015/latest/3.1bIMG.ppt
[7]https://hub.mili.csom.umn.edu/content/m10015/latest/3.1bDATA.ppt

Chapter 2

3.2 Private Health Insurance Pays Less Than Public[1]

Under the payer view, private health insurance pays for a somewhat smaller share of health spending than do Medicare and Medicaid combined (figure 3.2a). As noted earlier, the Medicare share includes all components paid by Medicare, regardless of source. These include Medicare payroll taxes from all employers (including state and local governments), all premium payments (including premiums paid by state governments under Medicaid for individuals dual-eligible for both programs), and all federal general funds used to finance Parts B, C (managed care plans), and D (prescription drugs).

3.2a Private health insurance pays slightly less for personal health care than do Medicare and Medicaid combined



The federal government also covers approximately two-thirds of Medicaid benefits costs, with state and

[1]This content is available online at <https://hub.mili.csom.umn.edu/content/m10016/1.2/>.

local governments picking up the balance. When all other federal and state programs for direct health services, such as community health centers, local health departments, and maternal and child health are taken into account, government currently finances slightly less than half of all PHCE.

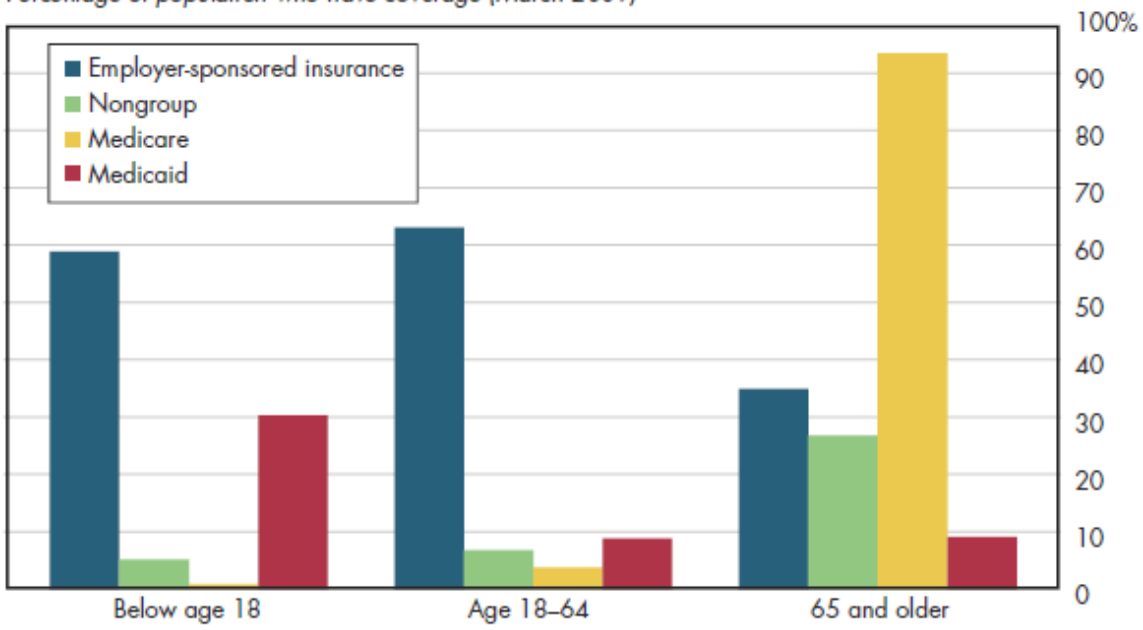
Private health insurance includes all directly purchased health insurance (non-group plans) and all group plans such as employer-sponsored plans, including plans for public employees and self-insured plans typically offered by large employers. In the latter plans, the employer is at risk for most or all of the costs of health services for plan members. However, health claims under such plans usually are processed by private health insurers or third-party administrators.

Out-of-pocket spending (which includes only payments made at the time of service, but not premium payments for either private or public health insurance) accounts for only 14 percent of spending.

Although Medicare covers more than 90 percent of the elderly, public health plans cover fewer than half of children and younger adults (figure 3.2b). Employer-sponsored insurance covers a majority of both groups. Public insurance — notably Medicaid — is more common for children than for younger adults. In the entire population, Medicare and Medicaid constitute less than 30 percent of coverage (this will increase if health reform is implemented). The large mismatch between shares of spending and population illustrate that public plans already cover many of those who are most sick.

3.2b Children and the elderly rely much more on public health insurance than adults younger than age 65 do

Percentage of population who have coverage (March 2009)



Note: Figures add to more than 100% for each age category because of individuals with more than one form of health insurance coverage.

2.1 Downloads

Download Excel workbooks used to create Figure 3.2a Tables[2] and Figure 3.2b Tables[3] . [Note that you'd have separate links for each set of tables] Figures 3.2a and 3.2b were created from the following tables (the

[2]https://hub.mili.csom.umn.edu/content/m10016/latest/3.2aTAB.xls
[3]https://hub.mili.csom.umn.edu/content/m10016/latest/3.2bTAB.xls

workbook includes all supporting tables used to create this table):

- Fig. 3.2a: Table 3.1.1. U.S. Personal Health Expenditures by Source of Funds: 1929 to 2021
- Fig. 3.2b: Table 3.2. Distribution of Health Insurance Coverage by Type and Age, 2011

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- Figure 3.2a Image Slide (as it appears above)[4]
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- Figure 3.2b Image Slide (as it appears above)[6]
- Figure 3.2b Editable Slide (can be formatted as desired)[7]

2.2 References

A. Department of Commerce. Bureau of the Census.
B. Department of Health and Human Services. Centers for Medicare and Medicaid Services.

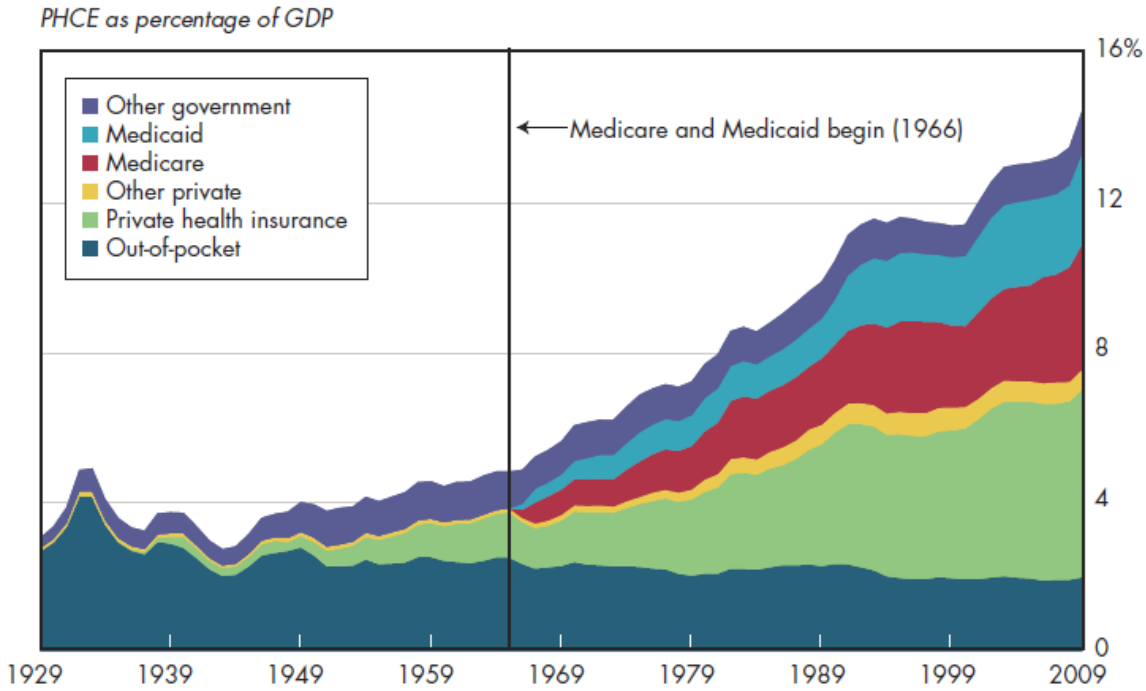
[4]https://hub.mili.csom.umn.edu/content/m10016/latest/3.2aIMG.ppt
[5]https://hub.mili.csom.umn.edu/content/m10016/latest/3.2aDATA.ppt
[6]https://hub.mili.csom.umn.edu/content/m10016/latest/3.2bIMG.ppt
[7]https://hub.mili.csom.umn.edu/content/m10016/latest/3.2bDATA.ppt

Chapter 3

3.3 Health Insurance Financed Growth in Health Spending[1]

Health spending as a percentage of GDP has more than tripled since 1949 (figure 3.3a). The share of GDP paid through out-of-pocket health spending has declined steadily during this same period (except in a handful of years). The growing share of expenditures paid by private insurance and public insurance has bankrolled the entire increase in the health sector share of the economy during this time.

3.3a Since 1949, all the growth in the personal health spending share of GDP has come from increased payments by third parties



There was little private insurance in 1929, but it grew rapidly after World War II. This was fueled by an IRS decision (later codified into law) that employer-provided fringe benefits (including health insurance) would not be taxable. Thus, a dollar of employer-paid health insurance was more valuable to the employee than a dollar of wages from which taxes were deducted. In 1965, Medicare and Medicaid displaced what

[1]This content is available online at <https://hub.mili.csom.umn.edu/content/m10017/1.1/>.

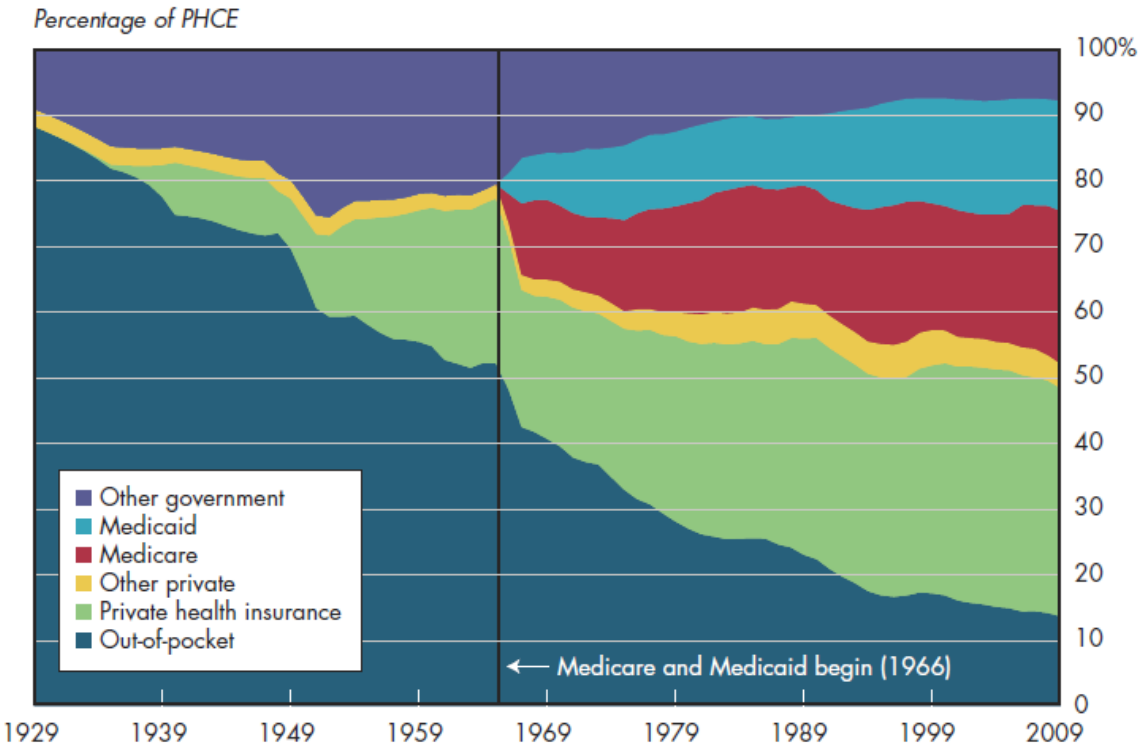
might have been continued growth in private insurance, as shown in figure 3.3a. In fact, for several years in the late 1960s, the private insurance share of GDP declined slightly. Even so, this share more than tripled between 1969 and 2009.

Spending on other government programs also declined slightly with the introduction of public health insurance coverage. This makes sense insofar as Medicaid in particular replaced many state and local programs that had provided direct medical services to indigent individuals. Even so, such other government spending subsequently grew for a period before declining rather steadily until today.

At a more fine-grained level, Medicare grew in size somewhat more rapidly than did Medicaid, while growth in Medicaid slightly outpaced the rate of growth in private insurance.

An alternative view of the same data shows more clearly how public spending grew as a share of personal health spending after World War II, but subsequently was eclipsed in importance by the rapid rise of private health insurance (figure 3.3b). However, this explosion in private health insurance also halted temporarily, starting in 1966 when both Medicaid and Medicare began. Even so, within a few years, although the Medicaid and Medicare shares of spending continued to grow, the role of private health insurance also began to increase.

3.3b Tax-financed health spending expanded more rapidly than private health insurance did after 1965



3.1 Downloads

Download Excel tables used to create both figures: Figures 3.3a/3.3b Tables[2] . Figures 3.3a and 3.3b both were created from the following table (the workbook includes all supporting tables used to create this table):

- Table 3.3. U.S. Personal Health Expenditures by Selected Source of Funds: 1929 to 2021

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- Figure 3.3b Image Slide (as it appears above)[5]
- Figure 3.3b Editable Slide (can be formatted as desired)[6]

3.2 References

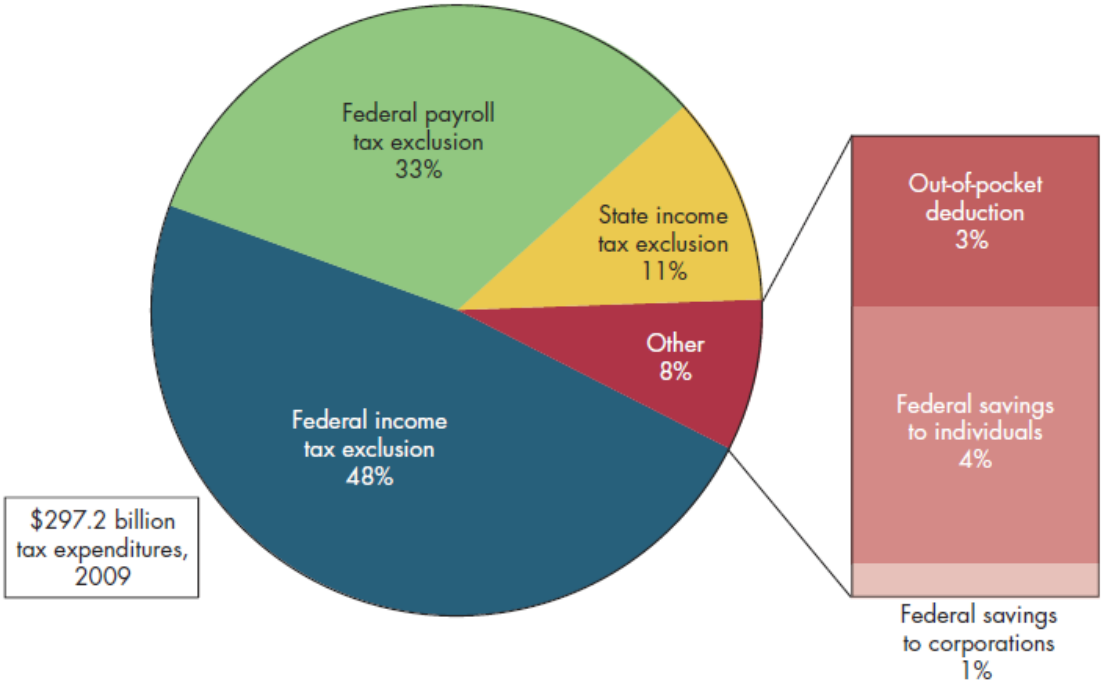
A. Author's calculations.
B. Department of Commerce. Bureau of Economic Analysis.
C. Department of Health and Human Services. Centers for Medicare and Medicaid Services.
D. Worthington NL. National Health Expenditures, Calendar Years 1929-73. Research and Statistics Note No 1. Office of Research and Statistics 1975.

[3]https://hub.mili.csom.umn.edu/content/m10017/latest/3.3aIMG.ppt
[4]https://hub.mili.csom.umn.edu/content/m10017/latest/3.3aDATA.ppt
[5]https://hub.mili.csom.umn.edu/content/m10017/latest/3.3bIMG.ppt
[6]https://hub.mili.csom.umn.edu/content/m10017/latest/3.3bDATA.ppt

Chapter 4

3.4 Federal Tax Subsidies for Health Exceed Federal Spending on Medicaid[1]

3.4a More than 90 percent of tax expenditures used to subsidize health care is from the tax exclusion for employee health benefits



Tax subsidies having to do with health care now amount to approximately $300 billion a year. The federal share of this total is more than the federal government now pays for its share of Medicaid. Thus, ironically, the federal government in 2009 paid more to encourage employer-based health insurance than it spent on public health insurance for those who have low incomes, although this no longer will be true whether or not health reform is implemented.

Tax expenditures represent the lost tax revenue associated with giving more favorable treatment to particular actions or activities. Unlike Medicare and Medicaid, such subsidies do not show up as a line item

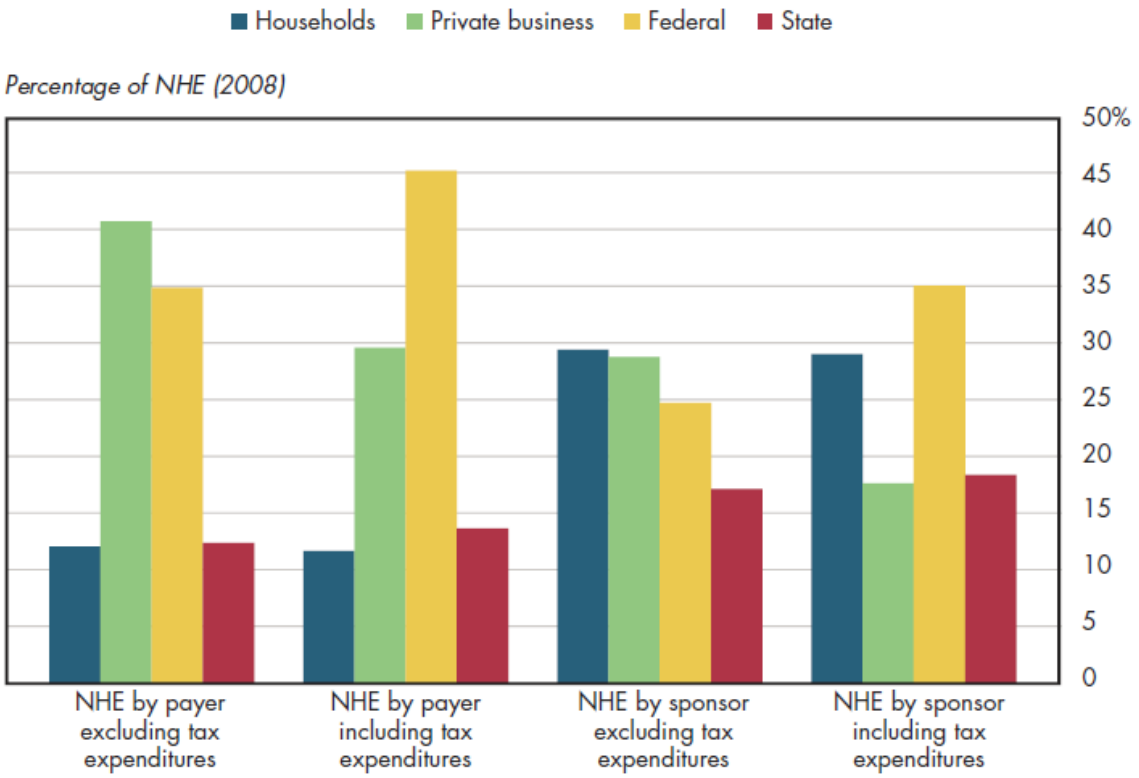
[1]This content is available online at <https://hub.mili.csom.umn.edu/content/m10018/1.1/>.

in the federal budget either as expenditures or as deductions from expected revenue. For this reason, tax expenditures are far less visible to most Americans than are the direct expenditures financed by the national treasury.

Health-related tax expenditures take many forms, but more than 90 percent of costs attributable to them relate to the previously mentioned tax exclusion. This tax exclusion results in income tax losses at the federal and state levels, but also payroll taxes for Medicare and Social Security. By comparison, other tax expenditures (such as the Schedule B deduction for households that have large health expenses relative to income) are minuscule. The large expense threshold currently is 7.5 percent of adjusted gross income (AGI) but will increase to 10 percent in 2013 under the new health reform bill. Other miscellaneous health-related tax benefits received by individuals or corporations account for even smaller amounts of tax expenditures.

The magnitude of tax expenditures changes the picture of who is actually paying for health care. In the traditional payer view of financing, business accounts for more than 40 percent of spending, while the federal government accounts for just over 30 percent. With tax expenditures factored into NHE, the federal government by far becomes the largest payer, accounting for 45 percent of spending (figure 3.4b, left columns). All levels of government account for almost 60 percent of NHE compared with less than half this amount when tax expenditures are ignored. Even under the sponsor view of health spending described previously, government accounts for more than half of all health spending when tax expenditures are made visible.

3.4b Failure to account for health-related tax subsidies substantially understates the government share of NHE



One in seven dollars of personal health care spending now is paid for out-of-pocket compared with seven in eight dollars 80 years ago (figure 3.5a). This by far is the most significant change in health care financing over the past 80 years. Combining all other spending into a single amount, figure 3.5a illustrates quite clearly that the "wedge" of health insurance payments displaced both out-of-pocket and other health spending. This wedge has grown steadily larger each decade.

4.1 Downloads

Download Excel tables used to create Figures 3.4a/3.4b Tables[2] . Figures 3.4a and 3.4b were created from the following table (the workbook includes all supporting tables used to create this table):

- Fig. 3.4a: Table 3.4.1. Distribution of Tax Expenditures Related to Health Care, 2008-2011
- Fig. 3.4b: Table 3.4.2. Distribution of National Health Expenditures by Source of Revenue, 2009

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- Figure 3.4b Editable Slide (can be formatted as desired)[6]

4.2 References

A. Author's calculations.
B. Department of Health and Human Services. Centers for Medicare and Medicaid Services.
C. Office of Management and Budget.
D. Sheils J. The Tax Expenditure for Health: Update for 2007. The Lewin Group. April 29, 2008. http://www.newamerica.net/files/SheilsPPT.pdf (accessed November 13, 2010).

[2]https://hub.mili.csom.umn.edu/content/m10018/latest/3.4TAB.xls
[3]https://hub.mili.csom.umn.edu/content/m10018/latest/3.4aIMG.ppt
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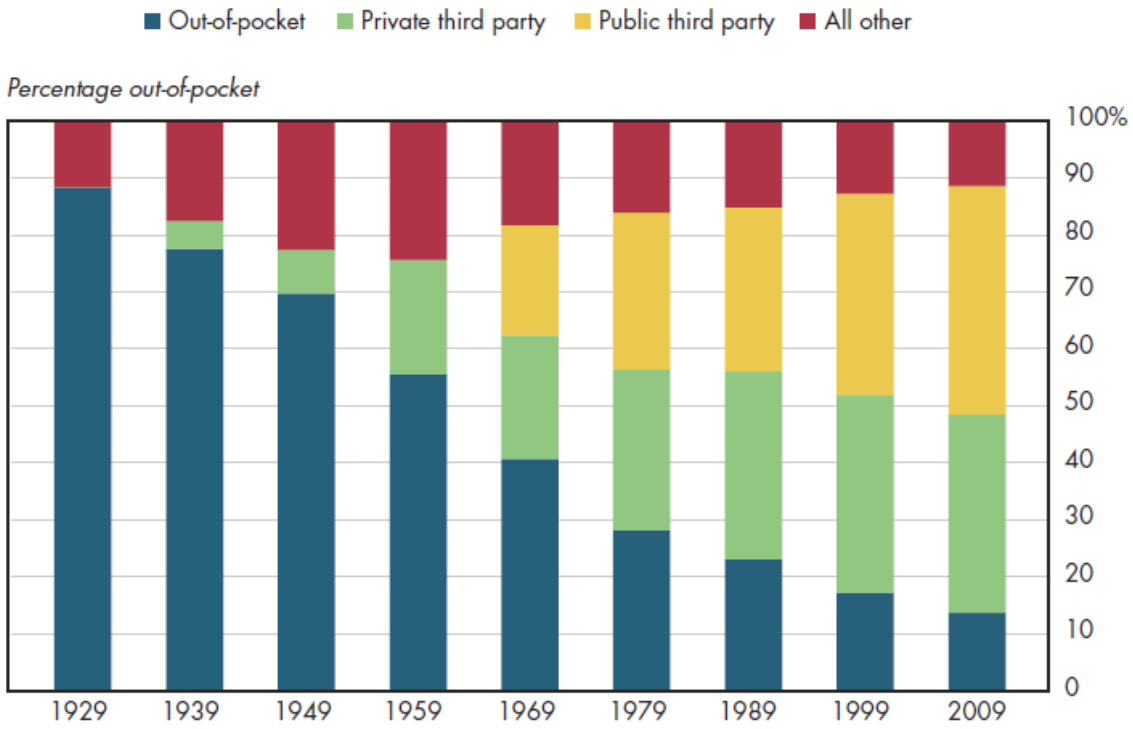
[5]https://hub.mili.csom.umn.edu/content/m10018/latest/3.4bIMG.ppt
[6]https://hub.mili.csom.umn.edu/content/m10018/latest/3.4bDATA.ppt

Chapter 5

3.5 Out-of-Pocket Share of Health Spending Declined[1]

One in seven dollars of personal health care spending now is paid for out-of-pocket compared with seven in eight dollars 80 years ago (figure 3.5a). This by far is the most significant change in health care financing over the past 80 years. Combining all other spending into a single amount, figure 3.5a illustrates quite clearly that the "wedge" of health insurance payments displaced both out-of-pocket and other health spending. This wedge has grown steadily larger each decade.

3.5a One in seven dollars of personal health care spending currently is paid for out-of-pocket compared with seven in eight dollars out-of-pocket 80 years ago



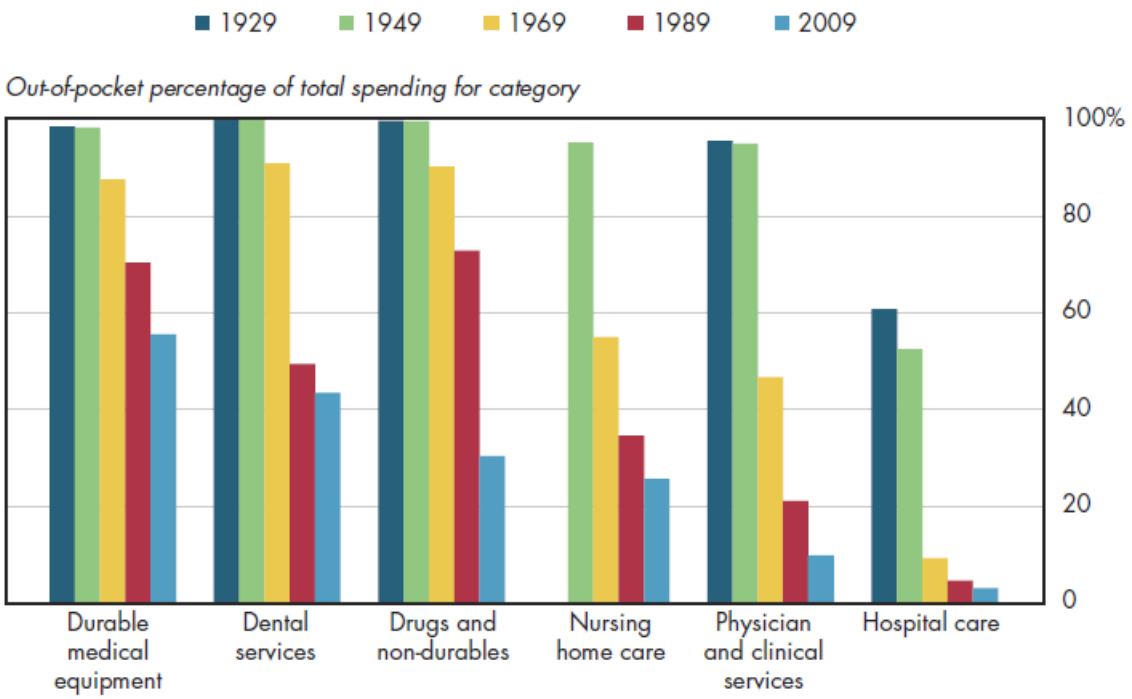
It is also easy to see that although public insurance and private insurance were approximately equal in

[1]This content is available online at <https://hub.mili.csom.umn.edu/content/m10019/1.2/>.

amounts as late as 1979, public insurance today accounts for more than 40 percent of spending while private insurance accounts for less than 35 percent. If the recent health plan is implemented, the projected increase in Medicaid enrollees would exceed 30 percent, in which case this differential would grow faster in future years.

Fig. 3.5b shows how the out-of-pocket share of spending varies by type of service. In 2009, it was highest for durable medical equipment (exceeding 50 percent) and lowest for hospital services (under 5 percent). Even for physician and clinical services, out-of-pocket spending is less than one-tenth of the total. In contrast, more than one-fourth of spending on pharmaceuticals and non-durable medical supplies (e.g., band-aids) and more than one-fifth of nursing home spending is financed out of pocket. Since 1949, the out-of-pocket share of spending has declined much more rapidly for hospital and physician care than for other health services.

3.5b The out-of-pocket share of spending has declined much more rapidly for hospital and physician care than for other health services



The out-of-pocket share of spending might be leveling out. Absent health reform, this share might have begun to increase over time as more employers and individuals switched to high-deductible health plans as a way of lowering premium costs. Health reform is projected to expand coverage to tens of millions of uninsured. Although common sense would require that out-of-pocket expenditures for the newly covered would decline, this is not necessarily the case. On average, per capita out-of-pocket spending for privately insured individuals is approximately 15 percent higher than it is for people who are uninsured all year. Counterbalancing this, however, are provisions in the new law that will set an income-related ceiling on out-of-pocket spending and various expansions in coverage such as prohibiting cost-sharing for preventive services and eliminating lifetime limits on coverage.

5.1 Downloads

Download Excel tables used to create Figures 3.5a/3.5b Tables[2] . Figures 3.5a and 3.5b were created from the following table (the workbook includes all supporting tables used to create this table):

[2]https://hub.mili.csom.umn.edu/content/m10019/latest/3.5TAB.xls

- Fig. 3.5a: Table 3.1.1. U.S. Personal Health Expenditures by Source of Funds: 1929 to 2021
- Fig. 3.5b: Table 3.5. U.S. Out-of-Pocket Expenditures by Type of Expenditure: 1929 to 2021

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- Figure 3.5b Image Slide (as it appears above)[5]
- Figure 3.5b Editable Slide (can be formatted as desired)[6]

5.2 References

A. Author's calculations.
B. Department of Health and Human Services. Centers for Medicare and Medicaid Services.
C. Worthington NL. National Health Expenditures, Calendar Years 1929-73. Research and Statistics Note No 1. Office of Research and Statistics 1975.

[3]https://hub.mili.csom.umn.edu/content/m10019/latest/3.5aIMG.ppt
[4]https://hub.mili.csom.umn.edu/content/m10019/latest/3.5aDATA.ppt
[5]https://hub.mili.csom.umn.edu/content/m10019/latest/3.5bIMG.ppt
[6]https://hub.mili.csom.umn.edu/content/m10019/latest/3.5bDATA.ppt

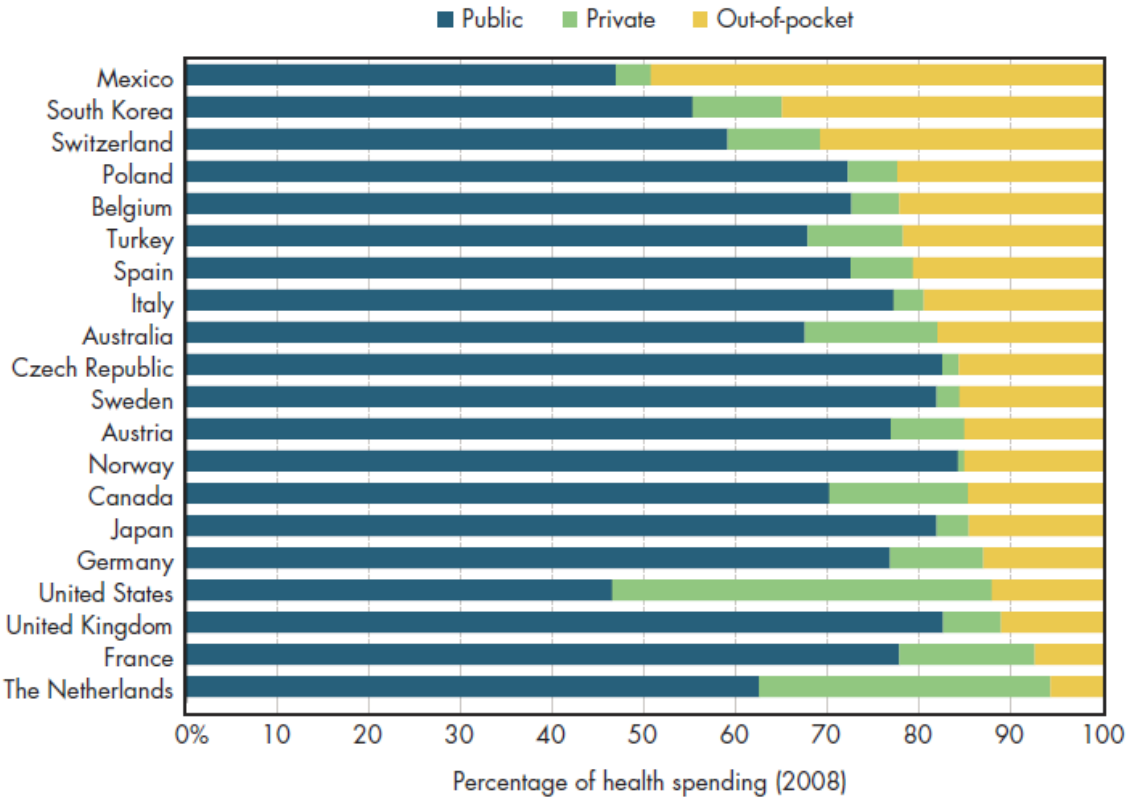
Chapter 6

3.6 US Has among the Lowest Out-of-Pocket Share of Health Spending[1]

Among the 20 largest countries in the OECD, the United States has the fourth lowest share of health spending paid through out-of-pocket payments (figure 3.6a). This might seem surprising because the tax-financed share of spending in the United States is the lowest among these countries. Private health insurance more than makes up for the fact that government is responsible for a smaller fraction of health spending. Compared with its largest OECD competitors, the United States by far relies much more heavily on private health insurance.

[1]This content is available online at <https://hub.mili.csom.umn.edu/content/m10020/1.2/>.

3.6a Among the 20 largest economies in the OECD, the United States has the fourth lowest percentage of health costs paid for out-of-pocket

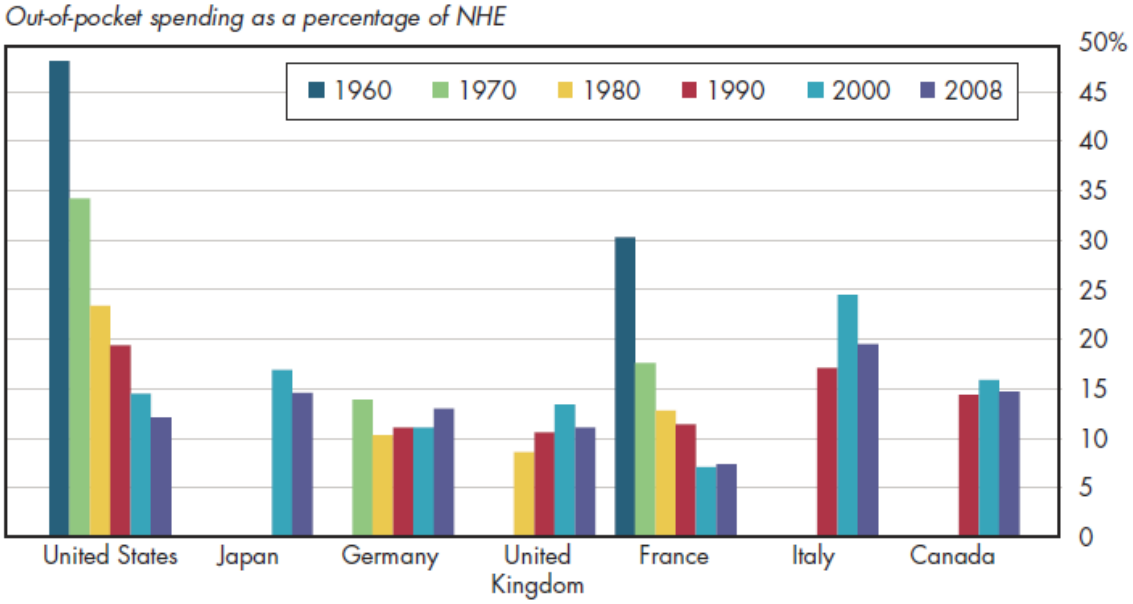


Note: Countries are listed (top to bottom) in order of their out-of-pocket share of total health spending.

Even citizens of countries such as Canada — who pride themselves for having tax-financed universal coverage — pay a higher share of health spending out-of-pocket than do Americans. Switzerland, which relies on an individual mandate analogous to the one recently included in the U.S. health reform plan, has more than 30 percent of its health spending financed through out-of-pocket payments. To be fair, another country with an individual mandate, the Netherlands, is one of only three countries to have a lower out-of-pocket share than does the United States. Even in countries that have universal or near-universal coverage, there is quite a bit of diversity in terms of how much out-of-pocket burden citizens are left to experience.

The current U.S. rank is a sharp change from 1960, when almost half of American health spending was out-of-pocket (figure 3.6b). Unfortunately, there are gaps in the historical data on this measure for the other countries, but at that time, a 20-percentage-point difference existed between France and the United States in terms of the out-of-pocket share of health expenditures. Today that differential is less than five percentage points. Moreover, the U.S. out-of-pocket share now is much more comparable to the other members of the G7, with Japan, Germany, Italy, and Canada all having higher out-of-pocket shares than does the United States.

3.6b The United States in the past relied far more on out-of-pocket spending compared with its competitors, but that is less true currently



6.1 Downloads

Download Excel tables used to create Figures 3.6a/3.6b Tables[2] . Figures 3.6a and 3.6b were created from the following table (the workbook includes all supporting tables used to create this table):

- Fig. 3.6a: Table 3.6.1. Distribution of National Health Expenditures by Source of Revenue, OECD Countries, 2009
- Fig. 3.6b: Table 3.6.2. Out-of-Pocket Share of National Health Expenditures, G7 Countries, Selected Years 1960-2008

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- Figure 3.6b Image Slide (as it appears above)[5]
- Figure 3.6b Editable Slide (can be formatted as desired)[6]

6.2 References

A. Organisation for Economic Co-operation and Development.

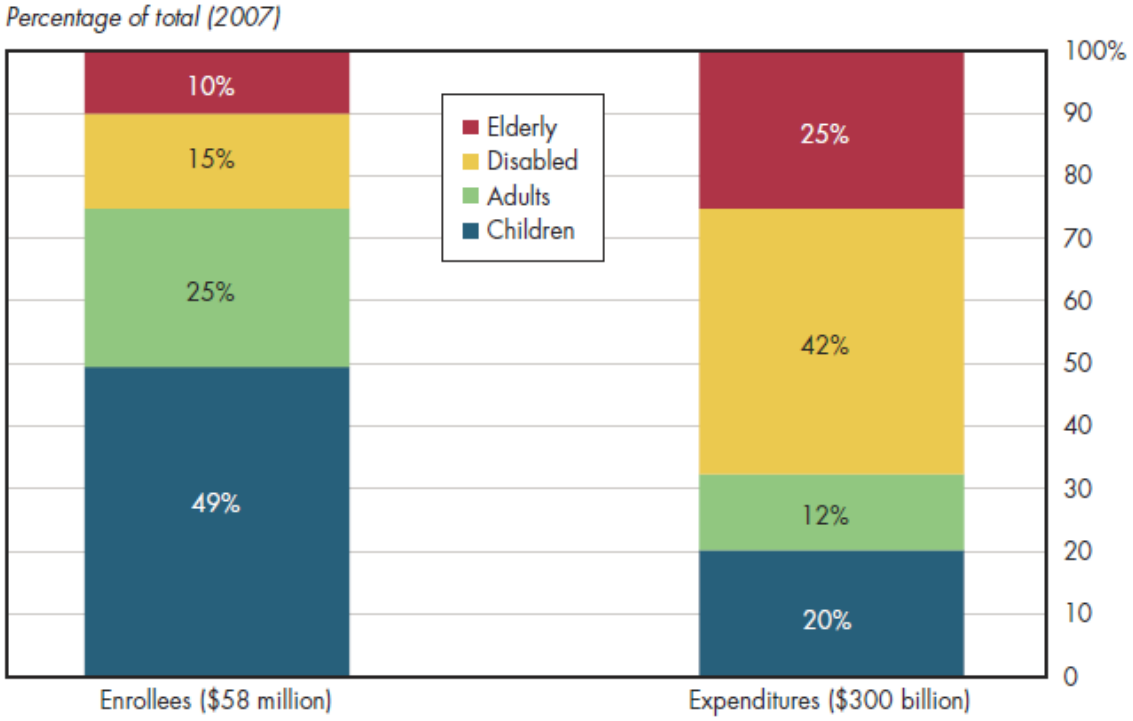
[2]https://hub.mili.csom.umn.edu/content/m10020/latest/3.6TAB.xls
[3]https://hub.mili.csom.umn.edu/content/m10020/latest/3.6aIMG.ppt
[4]https://hub.mili.csom.umn.edu/content/m10020/latest/3.6aDATA.ppt
[5]https://hub.mili.csom.umn.edu/content/m10020/latest/3.6bIMG.ppt
[6]https://hub.mili.csom.umn.edu/content/m10020/latest/3.6bDATA.ppt

Chapter 7

3.7 The Elderly & the Disabled Account for Disproportionately Large Share of Medicaid Spending[1]

The average Medicaid beneficiary is much younger than those who are covered by Medicare. Children account for almost half of Medicaid enrollees, with non-elderly, non-disabled adults (predominantly young parents) accounting for an additional 25 percent (figure 3.7a).

3.7a The elderly and disabled constitute 25 percent of Medicaid enrollees but more than 75 percent of Medicaid spending



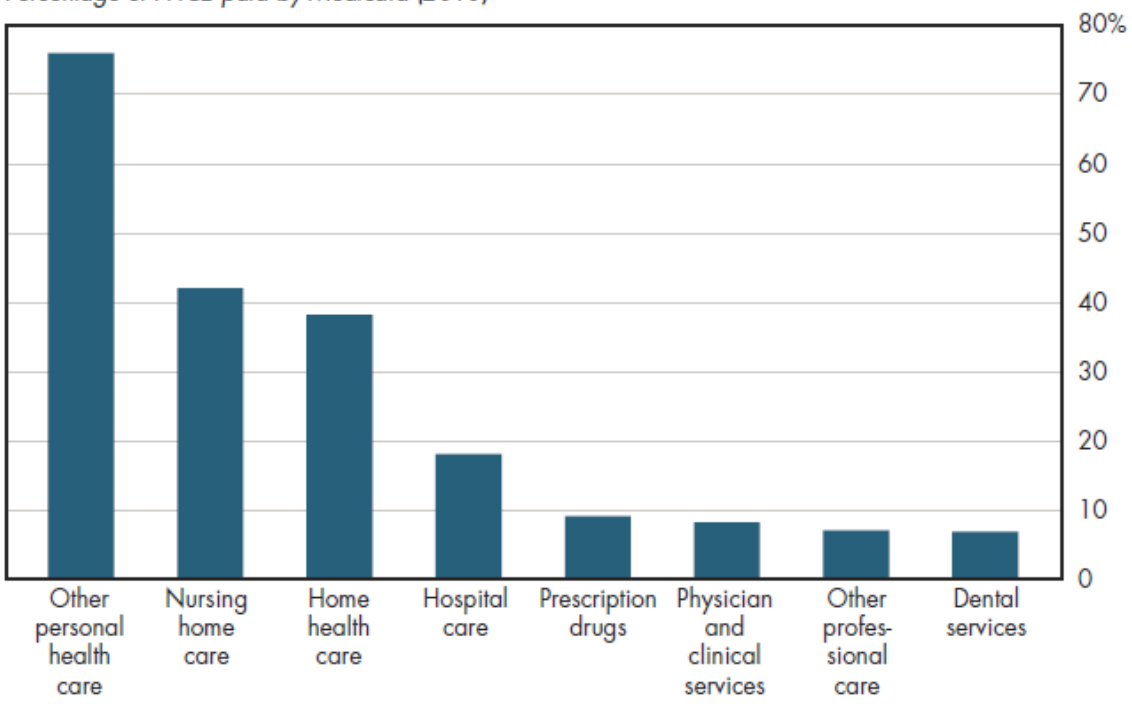
Although the elderly and disabled make up approximately 25 percent of beneficiaries, they account for

[1]This content is available online at <https://hub.mili.csom.umn.edu/content/m10021/1.1/>.

more than 75 percent of all expenditures for medical services. In contrast with Medicare, which was designed to be an acute-care insurance program, Medicaid spending is far more heavily tilted toward long-term care, particularly nursing home care. Approximately 30 percent of Medicaid spending is for long-term care services.

Medicaid accounts for more than 40 percent of all nursing home spending in the United States, and almost 40 percent of home health services (figure 3.7b). Other personal health care includes spending for Medicaid home- and community-based waivers, care provided in residential care facilities, ambulance services, school health, and worksite health care, so it too predominantly consists of long-term care services.

3.7b Medicaid covers approximately 40 percent of the nation's long-term care spending but a much smaller share of acute-care spending



Medicaid enrollees account for fewer than 20 percent of the population, which is similar to the share of hospital spending financed by Medicaid. However, Medicaid covers fewer than 10 percent of all spending on care provided by physicians, dentists, and other health professionals, and prescription drugs.

This largely is a reflection of low Medicaid fees. For example, on average, physician fees under Medicaid are 28 percent lower than Medicare fees, but this varies enormously by state. Some states have physician fees that are 63 percent below Medicare on average, whereas in other states, average Medicaid fees exceed Medicare's by more than 40 percent. In addition, by federal law, state Medicaid programs are given a sizable discount on prescription drug prices in the form of mandatory rebates that must be paid to states by pharmaceutical manufacturers.

Under health reform, this is supposed to change. The new law requires states to raise Medicaid provider payment rates to Medicare levels in 2013 and 2014 for primary care services of pediatricians, internists and general and family practitioners. States subsequently can roll back these fee increases, but this might be politically difficult. Medicare fees for primary care also will be increased 10 percent between 2011 and 2015.

7.1 Downloads

Download Excel tables used to create figure: Figure 3.7b Table[2] . Figure 3.7b was created from the following table (the workbook includes all supporting tables used to create this table):

- Fig. 3.7b: Table 3.7. Medicaid Share of National Health Expenditures, by Component, 1960-2011

There's no table for Fig. 3.7a since source is included directly on the slide.

Download PowerPoint versions of both figures.

- Figure 3.7a Image Slide (as it appears above)[3]
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- Figure 3.7b Image Slide (as it appears above)[5]
- Figure 3.7b Editable Slide (can be formatted as desired)[6]

7.2 References

A. Kaiser Commission on Medicaid and the Uninsured. Medicaid: A Primer. Key Information on Our Nation's Health Coverage Program for Low-Income People. June 2010. http://www.kff.org/medicaid/upload/7334-04.pdf (accessed October 13, 2010).
B. Department of Health and Human Services. Centers for Medicare and Medicaid Services.

[2]https://hub.mili.csom.umn.edu/content/m10021/latest/3.7TAB.xls
[3]https://hub.mili.csom.umn.edu/content/m10021/latest/3.7aIMG.ppt
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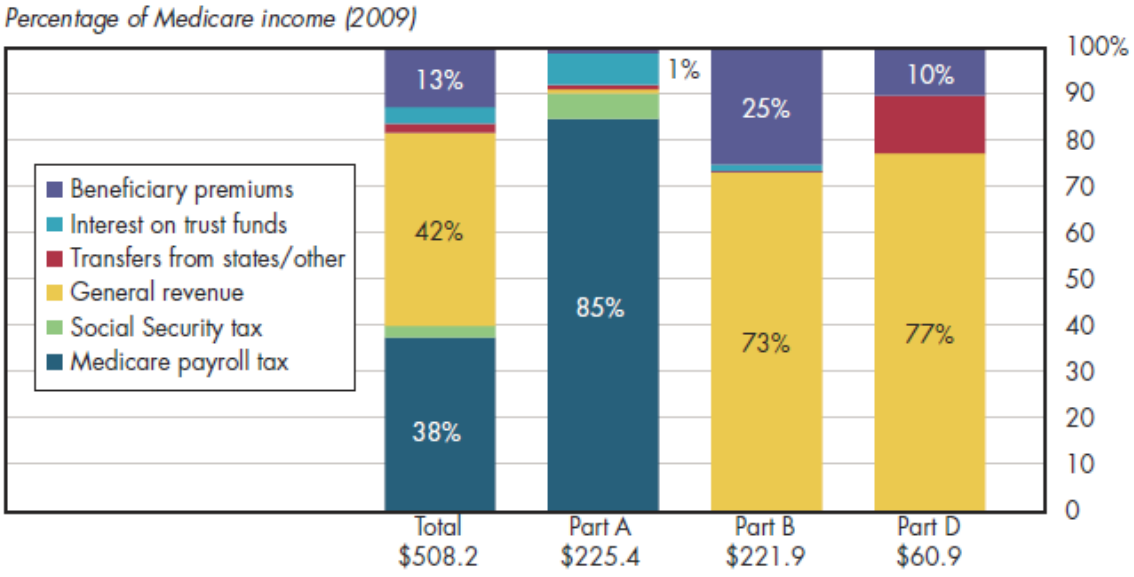
Chapter 8

3.8 Medicare Pays for Less than Half of Health Spending by Beneficiaries[1]

Recall that Medicare is the nation's single largest program financing medical care in the United States, with more than one-half trillion dollars in spending in 2009 (figure 3.8a). Most people think of Medicare as being supported primarily through payroll taxes (1.45 percent each, for employers and employees). Currently, however, a larger share of Medicare is paid with federal general revenues than from payroll contributions. The payroll taxes are used exclusively to finance Medicare Part A, which covers inpatient hospital stays, limited skilled nursing facility care, home health, and hospice.

3.8a Less than 12 percent of Medicare spending is financed through beneficiary premiums, but this varies greatly by component



Note: Part A covers inpatient hospital stays, limited skilled nursing facility care, home health, and hospice. Part B covers physician care, hospital outpatient services, home health care, durable medical equipment, laboratory, ambulance, and related services. Part D covers prescription drugs.

By law, beneficiary premiums cover 25 percent of the costs of Part B, which covers physician care,

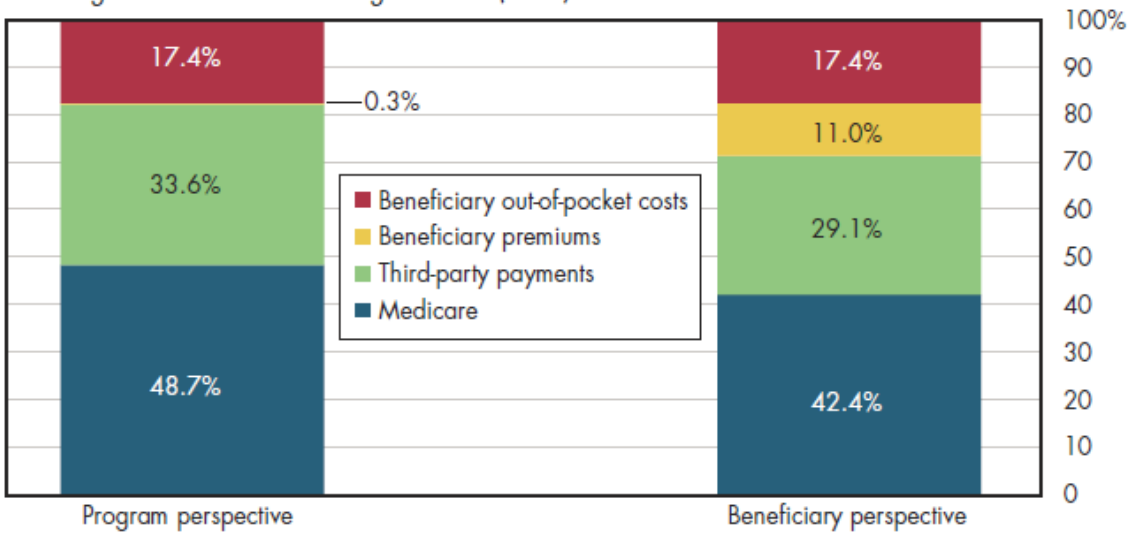
[1]This content is available online at <https://hub.mili.csom.umn.edu/content/m10022/1.1/>.

hospital outpatient services, home health care, durable medical equipment, laboratory, ambulance and related services. The lion's share of remaining expenses is covered from general fund revenue. Part D covers prescription drugs. Beneficiary premiums cover only 10 percent of its costs, with more than 75 percent paid by the federal general fund (the remainder is from state government transfers). Thus, for the Medicare program as a whole, less than one dollar in eight is financed from premium payments made by beneficiaries. The remainder is tax-financed.

Despite its size, Medicare covers less than half of annual medical and long-term care costs for the average beneficiary (figure 3.8b, left bar). However, from a beneficiary perspective, some of those Medicare payments are financed by beneficiary-paid premiums; the same is true for private third-party coverage. Yet even from this perspective, beneficiaries pay only approximately 25 percent of annual costs, including amounts paid out-of-pocket for medical services and the amounts that beneficiaries pay in voluntary premiums for Parts B and D and supplemental insurance ("Medigap" policies and employer-sponsored health plans).

3.8b Medicare pays for less than half of health spending by Medicare beneficiaries; approximately 25 percent is paid for by beneficiaries

Percentage of total medical and long-term costs (2005)



Note: The program perspective counts all Medicare spending under Medicare and all bills paid through public and private third-party payers under third-party payments. Administrative costs related to Medicare and other third-party payers are included as part of beneficiary premiums. The beneficiary perspective includes the full amount of premiums paid to Medicare and third parties under beneficiary premiums and deducts these amounts from Medicare and third party payers. Beneficiary premiums do not appear in the program perspective because they are included as part of third-party and Medicare payments (spending).

The remaining expenses are covered by third-party payers. These expenses include Medicaid coverage for so-called "dual eligibles" (whose spending is more than double that of other beneficiaries), private supplemental Medigap policies (held by 25 percent of enrollees), and group health coverage for retirees (held by almost 30 percent of beneficiaries).

8.1 Downloads

Download Excel tables used to create Figures 3.8a/3.8b Tables[2] . Figures 3.8a and 3.8b were created from the following table (the workbook includes all supporting tables used to create this table):

- Fig. 3.8a: Table 3.8.1. Distribution of Medicare Income by Source of Revenue, 2009

[2]https://hub.mili.csom.umn.edu/content/m10022/latest/3.8TAB.xls

- Fig. 3.8b: Table 3.8.2. Distribution of Medicare Costs per Beneficiary by Source of Revenue, 2005 and 2006

Download PowerPoint versions of both figures.

- Figure 3.8a Image Slide (as it appears above)[3]
- Figure 3.8a Editable Slide (can be formatted as desired)[4]
- Figure 3.8b Image Slide (as it appears above)[5]
- Figure 3.8b Editable Slide (can be formatted as desired)[6]

8.2 References

A. Author's calculations.
B. Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medi- cal Insurance Trust Funds, The. 2010 Annual Report. US Government Printing Office. August 5, 2010.
C. Potetz L and J Cubanski. A Primer on Medicare Financing. July 2009. http://www.kff.org/medicare/upload/7731-02.pdf (accessed August 10, 2010).
D. Seldon TM and M Sing. The Distribution of Public Spending for Health Care in the United States, 2002. Health Affairs Web Exclusive 2008; 27:5w349-w359. http://content.healthaffairs.org/cgi/reprint/27/5/w349 (accessed June 14, 2010).
E. Sherlock DB. Administrative Expenses of Health Plans. Prepared for the Blue Cross Blue Shield Association. http://www.bcbs.com/issues/uninsured/Sherlock- Report-FINAL.pdf (accessed February 2010).

[3]https://hub.mili.csom.umn.edu/content/m10022/latest/3.8aIMG.ppt
[4]https://hub.mili.csom.umn.edu/content/m10022/latest/3.8aDATA.ppt
[5]https://hub.mili.csom.umn.edu/content/m10022/latest/3.8bIMG.ppt
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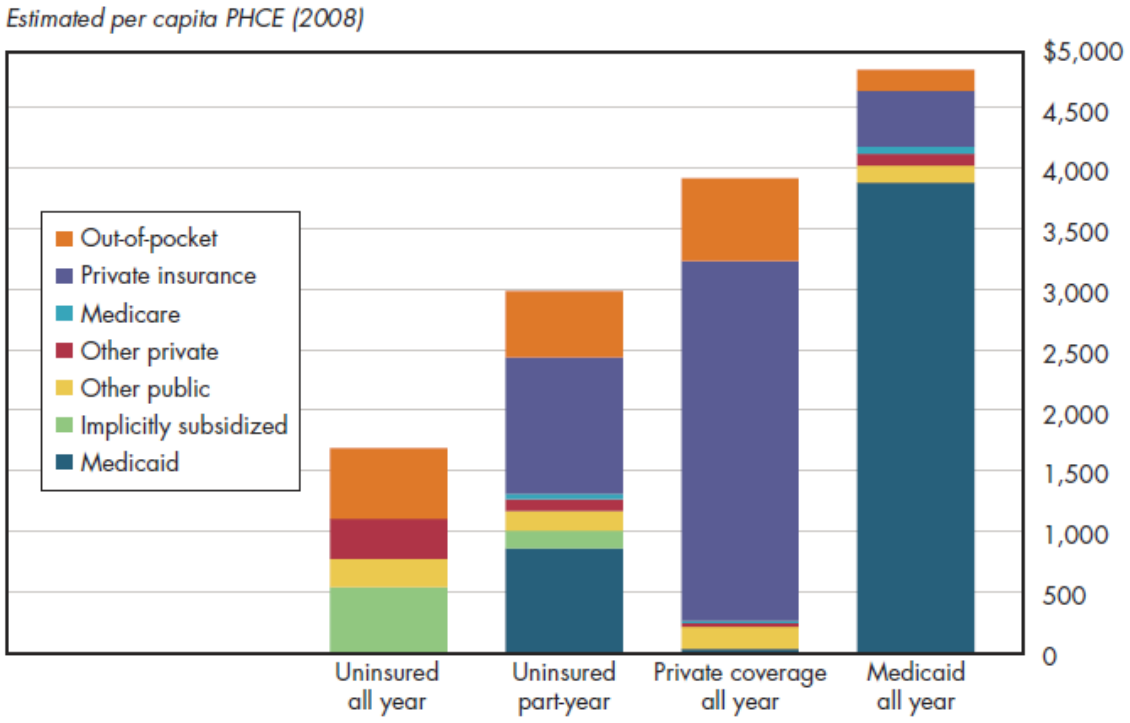
Chapter 9

3.9 The Uninsured Received Much Subsidized Care[1]

In absolute dollars, per capita out-of-pocket health spending is similar among those uninsured all year, those uninsured part-year, and those with year-round private health insurance coverage (figure 3.9a). This might seem counterintuitive, but it reflects the fact that the typical individual with private coverage has a higher income and hence willingness-to-pay for medical goods and services. Among children (where the age distribution is quite similar), total spending is approximately 80 percent higher among those with private coverage compared with individuals uninsured the entire year.

3.9a Out-of-pocket spending is similar among the uninsured and privately insured, but the former receive much more subsidized care

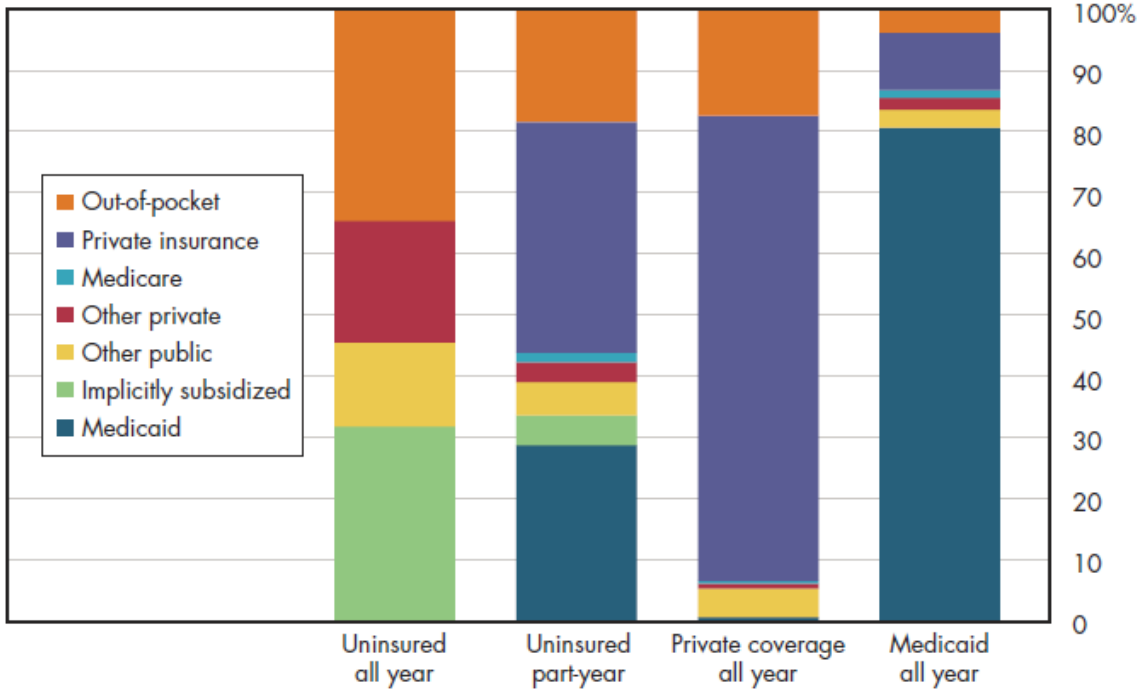


[1]This content is available online at <https://hub.mili.csom.umn.edu/content/m10023/1.1/>.

In figures 3.9a and 3.9b, implicitly subsidized care represents the cost of care indirectly subsidized by hospitals, physicians, and other providers. Other public care includes payments by the Veterans Health Administration (VHA), CHAMPUS-TRICARE (for civilian dependents of military personnel), workers' compensation, and other federal, state, and local public programs that pay directly for care (for example, maternal and child health). Thus, it combines subsidized care to individuals lacking the means to pay, with care to which one might be entitled (for example, work injury). Likewise, other private includes unsubsidized care (for example, payments from accident, automobile, and indemnity policies), and care that likely is subsidized, such as private philanthropy and cash payments by non-family members.

3.9b Almost 65 percent of health expenditures for people uninsured all year is subsidized through taxes or private charity

Estimated per capita PHCE (2008)



The per capita amount of non-Medicaid subsidized care is highest among those uninsured all year, followed by the part-year uninsured and the privately insured. Because the part-year uninsured lack coverage for approximately six months, their annual spending includes some care paid through public and private health plans. If Medicaid is included as a form of subsidized care, those who are uninsured part of a year actually receive more subsidized services than do those without coverage the entire year.

Viewing the same data in terms of shares of spending provides a different result. For the all-year uninsured, at least 30 percent but no more than 65 percent of spending is subsidized (figure 3.9b). In contrast, such sources pay for only approximately 10 to 13 percent of annual spending for the part-year uninsured. However, if Medicaid were counted as subsidized care, this would add almost 30 percentage points to the total for this group.

9.1 Downloads

Download Excel tables used to create both figures: Figures 3.9a/3.9b Tables[2] . Figures 3.9a and 3.9b both were created from the following table (the workbook includes all supporting tables used to create this table):

- Table 3.9. Sources of Payment for Patients, by Insurance Status, 2008

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- Figure 3.9b Image Slide (as it appears above)[5]
- Figure 3.9b Editable Slide (can be formatted as desired)[6]

9.2 References

A. Hadley J, J Holahan, T Coughlin and D 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. Kaiser Commission on Medicaid and the Uninsured. Washington DC. August 2008.

[2]https://hub.mili.csom.umn.edu/content/m10023/latest/3.9TAB.xls
[3]https://hub.mili.csom.umn.edu/content/m10023/latest/3.9aIMG.ppt
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[5]https://hub.mili.csom.umn.edu/content/m10023/latest/3.9bIMG.ppt
[6]https://hub.mili.csom.umn.edu/content/m10023/latest/3.9bDATA.ppt

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