Chapter 5: Government Health Expenditures, Taxes, and Deficits

By:
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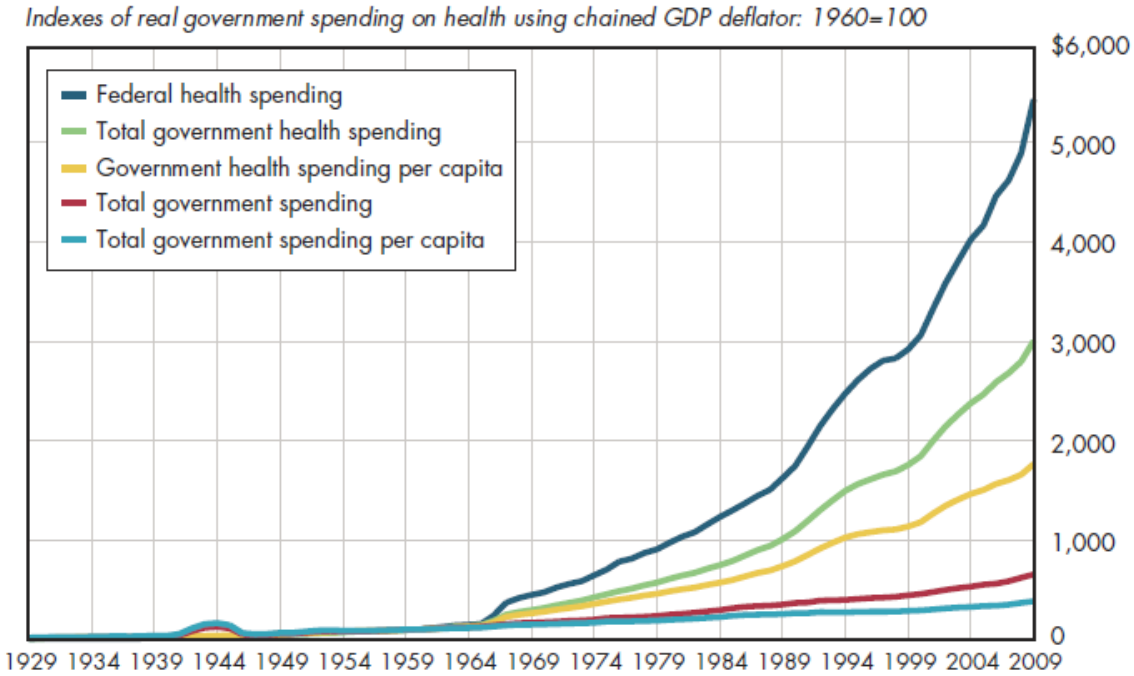
Chapter 1

5.1 Government Expenditures for Health, 1929-2009[1]

The rise in government-funded health care has been extraordinary by any measure. In terms of constant purchasing power for everyday goods, tax-financed health care has increased 30-fold just since 1960 (figure 5.1a). This includes all federal, state, and local government spending for health care, such as public health, direct delivery of health services, public health insurance, and investments in medical R&D and facilities construction. However, real federal spending on health care grew far faster than tax-paid health care overall. This reflects a substantial shift in the relative roles of federal government vis-à-vis state and local governments in financing (and regulating) health care.

5.1a Real government spending on health has increased 30-fold in the past 50 years; the increase is 17-fold in per capita terms



In per capita terms, the overall increase was 17-fold. This does not mean that real health output funded

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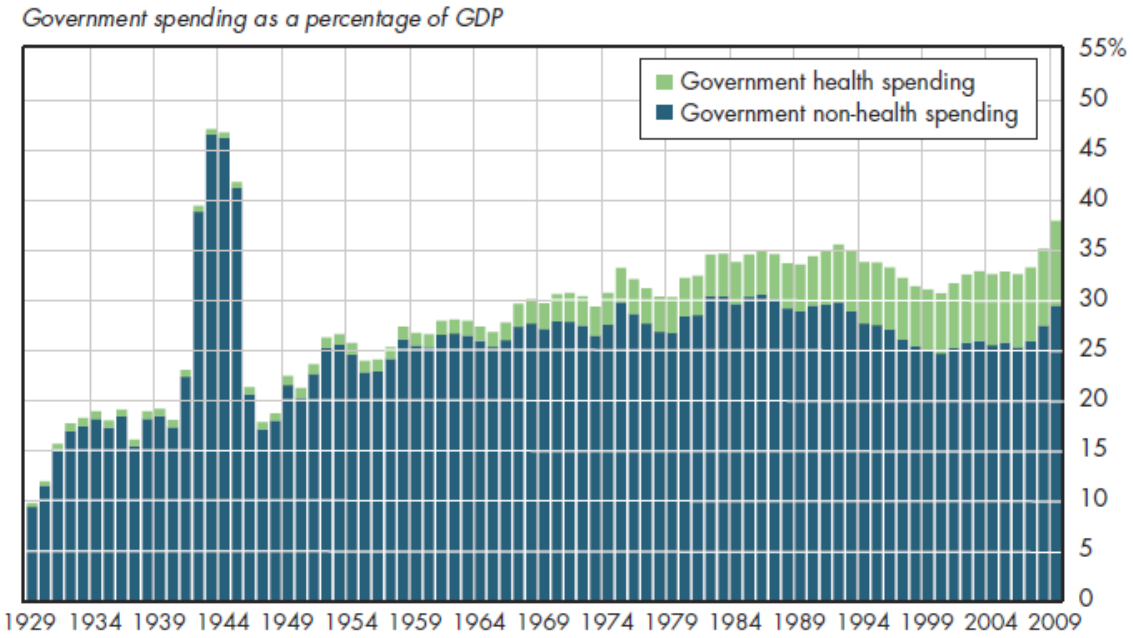
by taxpayers rose 17-fold in 50 years. The inflation adjustment used for all series in figure 5.1a is based on the GDP price deflator rather than a medical price deflator. Thus, the increase represents how much more real output in the general economy was foregone to bankroll the tax-financed share of U.S. health spending. This rapid increase in government health spending was approximately five times as large as the increase in overall government spending during the same time.

Recall from chapter 1 that real GDP also grew enormously during this period. As a share of GDP, publicly-financed health spending in 2007 (the most recent "normal" year) was five times as large as it was in 1965 (figure 5.1b). In contrast, the share of the economy attributable to government spending on all other activities unrelated to health was almost identical in these two years. In summary, the entire amount of the increase in the size of government between those years was accounted for by rising public expenditures on health care.

5.1b Between 1966 and 2007, all of the increase in the size of government was attributable to growth in tax-financed health care



Note: Data include debt service, but the entire amount appears under non-health spending. If allocated by shares of spending, this would increase government health spending and reduce non-health spending.

Except for a brief downward turn during the latter half of the 1990s, the tax-financed health share of the economy has risen without exception each year since 1929.

1.1 Downloads

Download Excel tables used to create Figures 5.1a/5.1b Tables[2] . Figures 5.1a and 5.1b were created from the following table (the workbook includes all supporting tables used to create this table):

- Fig. 5.1a: Table 5.1.1. Total and Health-Related Government Expenditures Based on Chained 2009 Dollars: 1929-2021
- Fig. 5.1b: Table 5.1.2. Total Government Expenditures on Health Care as a Percent of GDP: 1929-2021

Download PowerPoint versions of both figures.

[2]https://hub.mili.csom.umn.edu/content/m10028/latest/5.1TAB.xls

- Figure 5.1a Image Slide (as it appears above)[3]
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- Figure 5.1b Image Slide (as it appears above)[5]
- Figure 5.1b Editable Slide (can be formatted as desired)[6]

1.2 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.

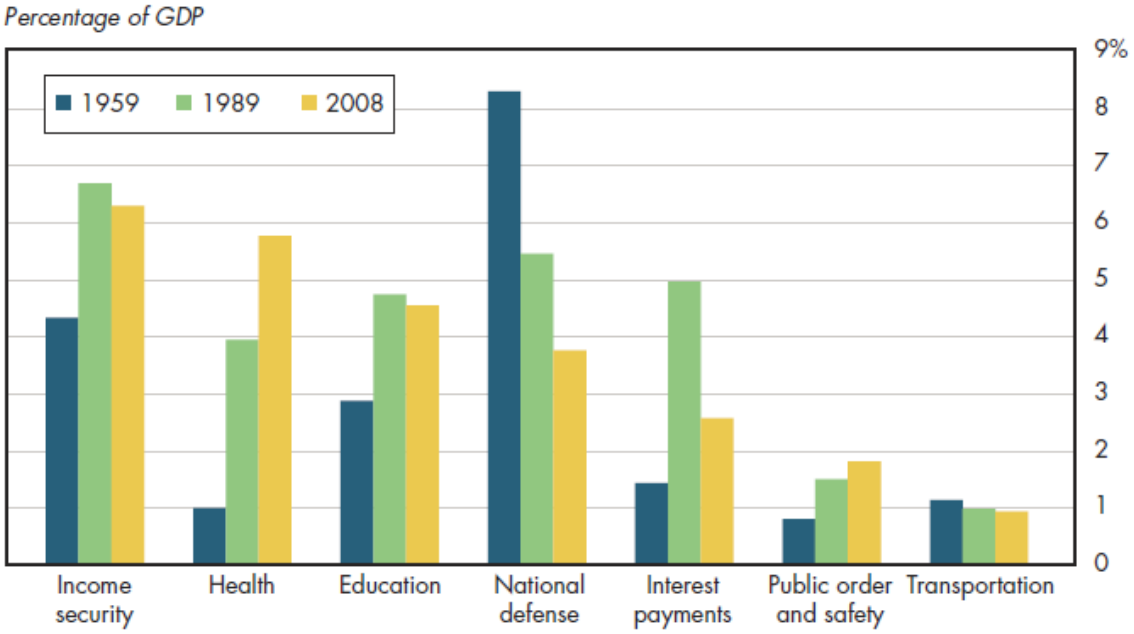
[3]https://hub.mili.csom.umn.edu/content/m10028/latest/5.1aIMG.ppt
[4]https://hub.mili.csom.umn.edu/content/m10028/latest/5.1aDATA.ppt
[5]https://hub.mili.csom.umn.edu/content/m10028/latest/5.1bIMG.ppt
[6]https://hub.mili.csom.umn.edu/content/m10028/latest/5.1bDATA.ppt

Chapter 2

5.2 Health Component Grew the Fastest in Government Spending[1]

Tax-financed health expenditures over the past 50 years have grown faster than any other major functional area of government spending, including defense, income sup- port, and education. Since 1959, the increase in government health spending as a percentage of GDP more than exceeded the decline in defense spending's share of the economy through 2008 (figure 5.2a).

5.2a Government health spending has been the fastest growing major component of government budgets for the past 50 years



Note: This chart shows the seven largest functional areas of federal, state, and local budgets in 2008, displayed (left to right) by percent of GDP in 2008.

Along with defense, transportation funding declined as a share of GDP relative to 1959 levels. In the aftermath of the Great Society initiatives in the 1960s, it should not be too surprising that both income

[1]This content is available online at <https://hub.mili.csom.umn.edu/content/m10029/1.1/>.
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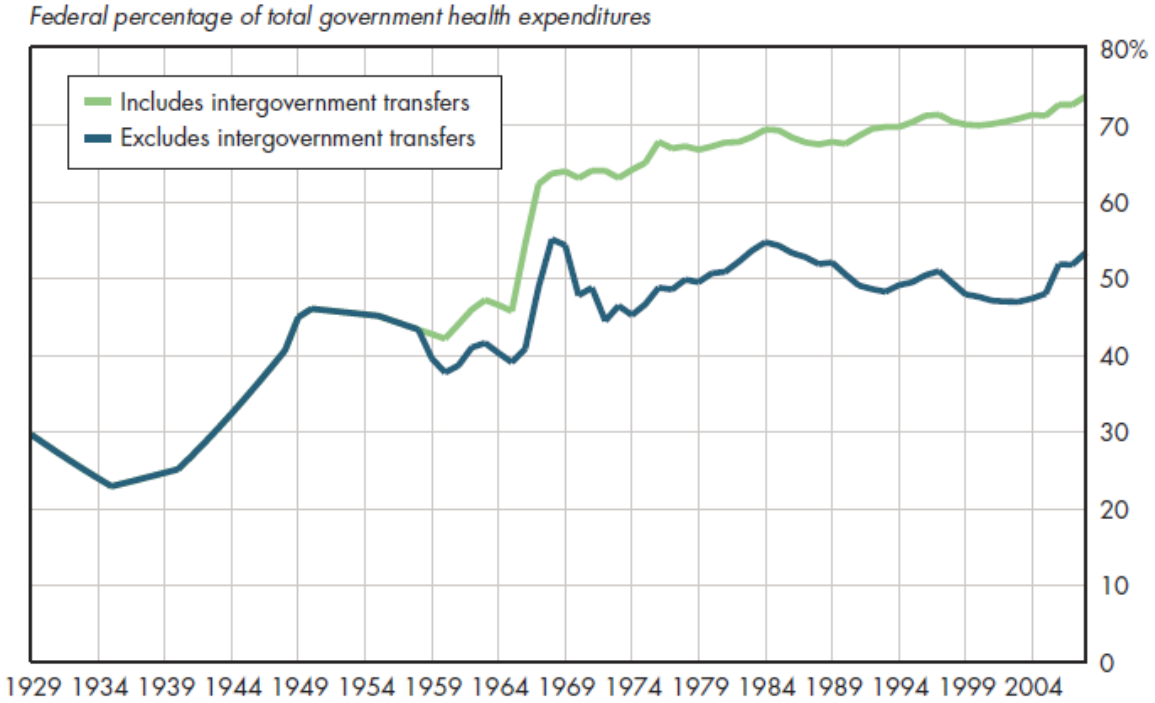
support and education grew as a percent of GDP between 1959 and 1989, but both also subsequently had declined by 2008. Even interest payments on the national debt followed a similar path (although this will change considerably in the decades going forward).

Of the seven largest functional areas of federal, state, and local budgets, the only one (other than health care) that grew in the 30 years from 1959 to 1989 and the almost-30 years from 1989 to 2008 was spending for public order and safety. However, the increase in GDP share attributable to government-paid health care during this period was almost five times as large as the increase for public order and safety.

This highlights the reason why health care has become such an intense focus of attention at all levels of government in recent years. In almost every state, health care has become either the largest or the fastest-growing component of public spending, making it increasingly difficult to finance other priorities such as education or criminal justice.

The federal share of government-paid health spending has generally risen during this period, as has the role played by intergovernmental transfers (IGTs) of funds from the federal government to state and local governments (figure 5.2b). These include federal matching funds provided under Medicaid (ranging from a minimum of 50 percent in the wealthiest states such as New York and Massachusetts to more than 80 percent in Mississippi), federal categorical grants for health care, and federal block grants for health care, such as maternal and child health services. If IGTs are counted on the federal side of the ledger, the federal share of health spending is now approaching 75 percent.

5.2b Taking into account federal transfers to states for health, the federal share of government health spending exceeds 70 percent



2.1 Downloads

Download Excel workbooks used to create Figure 5.2a Table[2] and Figure 5.2b Table[3] . [Note that you'd have separate links for each set of tables] Figures 5.2a and 5.2b were created from the following tables (the workbook includes all supporting tables used to create these tables):

- Fig. 5.2a: Table 5.2.1. Government Current Expenditures as a Percentage of GDP, 1959-2010
- Fig. 5.2b: Table 5.2.2. Federal Health Expenditures as a Percentage of Total Federal, State and Local Health Expenditures, 1929-2021

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- Figure 5.2b Editable Slide (can be formatted as desired)[7]

2.2 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.

[2]https://hub.mili.csom.umn.edu/content/m10029/latest/5.2aTAB.xls
[3]https://hub.mili.csom.umn.edu/content/m10029/latest/5.2bTAB.xls
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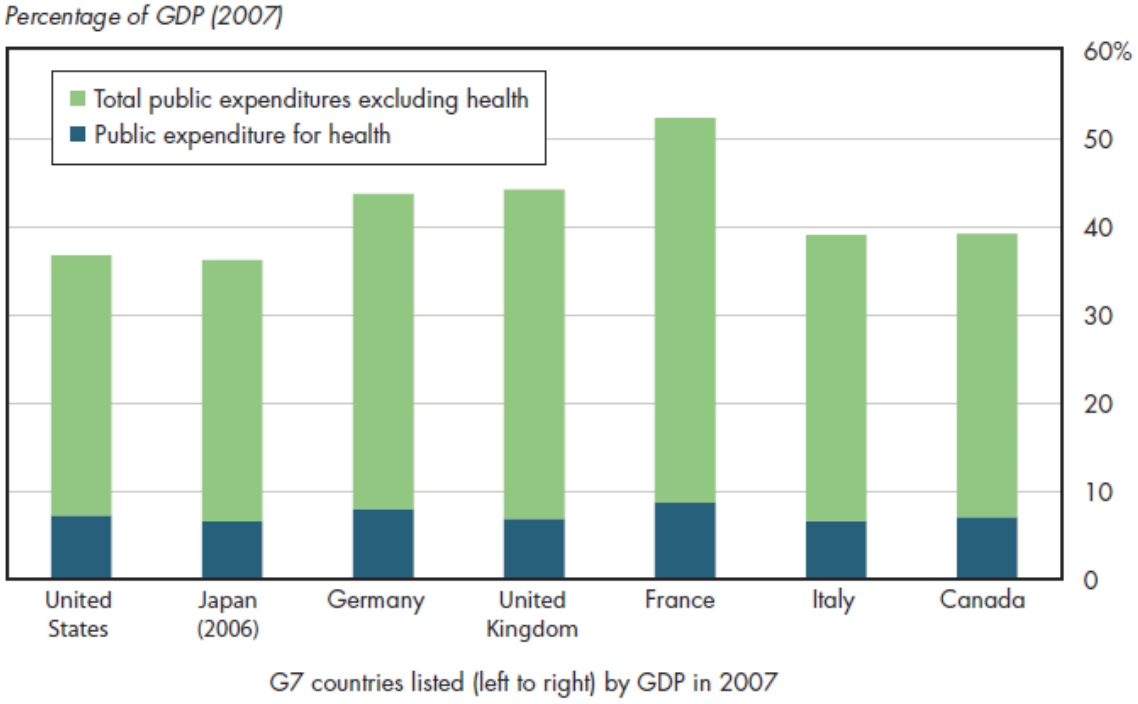
[5]https://hub.mili.csom.umn.edu/content/m10029/latest/5.2aDATA.ppt
[6]https://hub.mili.csom.umn.edu/content/m10029/latest/5.2bIMG.ppt
[7]https://hub.mili.csom.umn.edu/content/m10029/latest/5.2bDATA.ppt

Chapter 3

5.3 US Health Share of Government Spending among G7 Counties[1]

The government share of GDP is lower in the United States than in any other country in the G7 except Japan (figure 5.3a). However, the share of GDP attributable to tax-financed health care is higher in the United States than in all other G7 nations except Germany and France. Currently, the difference is not large but is likely to grow because of the new U.S. health reform law. Even for Germany and France, the lion's share of the large difference in government spending relative to GDP relative to the United States is accounted for by factors unrelated to public spending on health care.

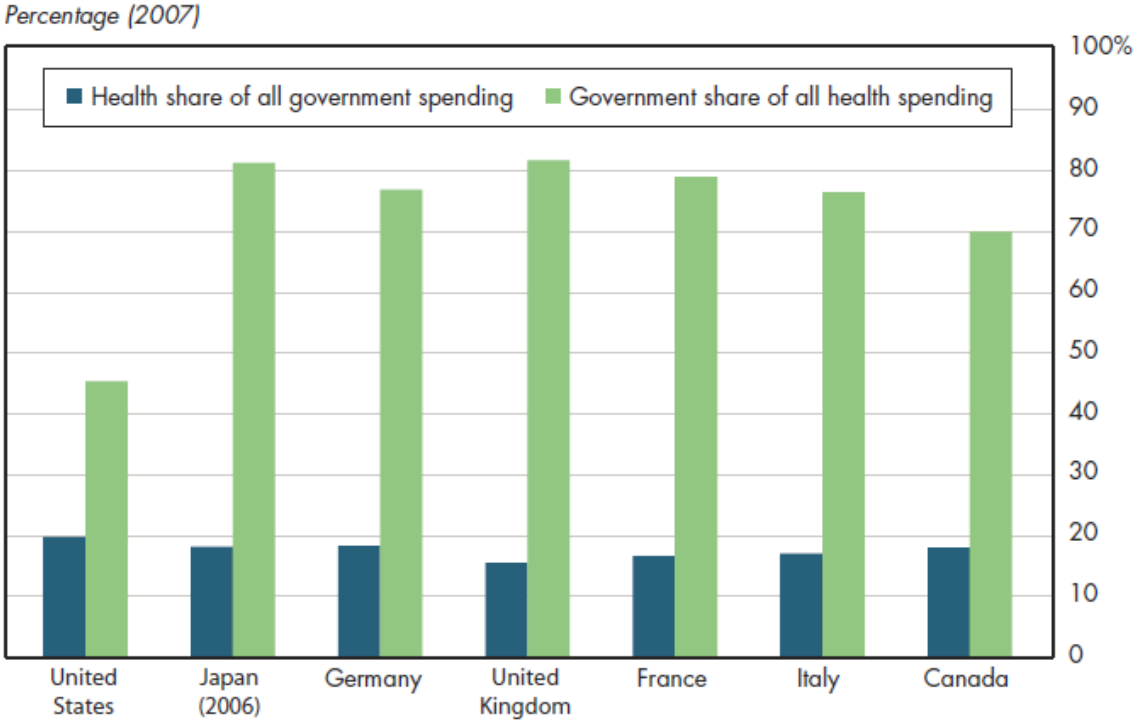
5.3a The U.S. share of GDP devoted to tax-financed health spending is comparable to that of its G7 competitors.



[1]This content is available online at <https://hub.mili.csom.umn.edu/content/m10030/1.1/>.

Figure 5.3b compares in a different way the public role in health spending between countries. The United States outpaces all of its G7 competitors in terms of the fraction of total government spending that is devoted to health care (this would be true even if the pool of major competitors is extended to include China and Russia). Again, this relatively small difference is likely to increase if the health reform law is implemented over several years.

5.3b In the G7, the United States has the highest share of government spending devoted to health but the lowest public share of total health spending



Despite this, the overall fraction of total health spending that is financed by government is far lower in the United States — by 25 to 35 percentage points — than in any of the other G7 nations. Recall from figure 3.6a that except for a handful of countries, private health insurance in the United States more than fills this "gap" in spending, resulting in out-of-pocket spending as a lower share of U.S. health spending than in almost any other OECD country. Thus, the main difference between the United States and its competitors is not in terms of the fraction of spending that is financed through third parties, but simply the extent to which the United States relies on public insurance rather than private insurance.

3.1 Downloads

Download Excel tables used to create both figures: Figures 5.3a/5.3b Tables[2] . Figures 5.3a and 5.3b both were created from the following table (the workbook includes all supporting tables used to create this table):

- Table 5.3. Total General Government Expenditures and Public Expenditures on Health as a Percent of GDP for Selected Industrialized Countries, 2007

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- Figure 5.3b Editable Slide (can be formatted as desired)[6]

3.2 References

A. Author's calculations.
B. Organisation for Economic Co-operation and Development.

[4]https://hub.mili.csom.umn.edu/content/m10030/latest/5.3aDATA.ppt
[5]https://hub.mili.csom.umn.edu/content/m10030/latest/5.3bIMG.ppt
[6]https://hub.mili.csom.umn.edu/content/m10030/latest/5.3bDATA.ppt

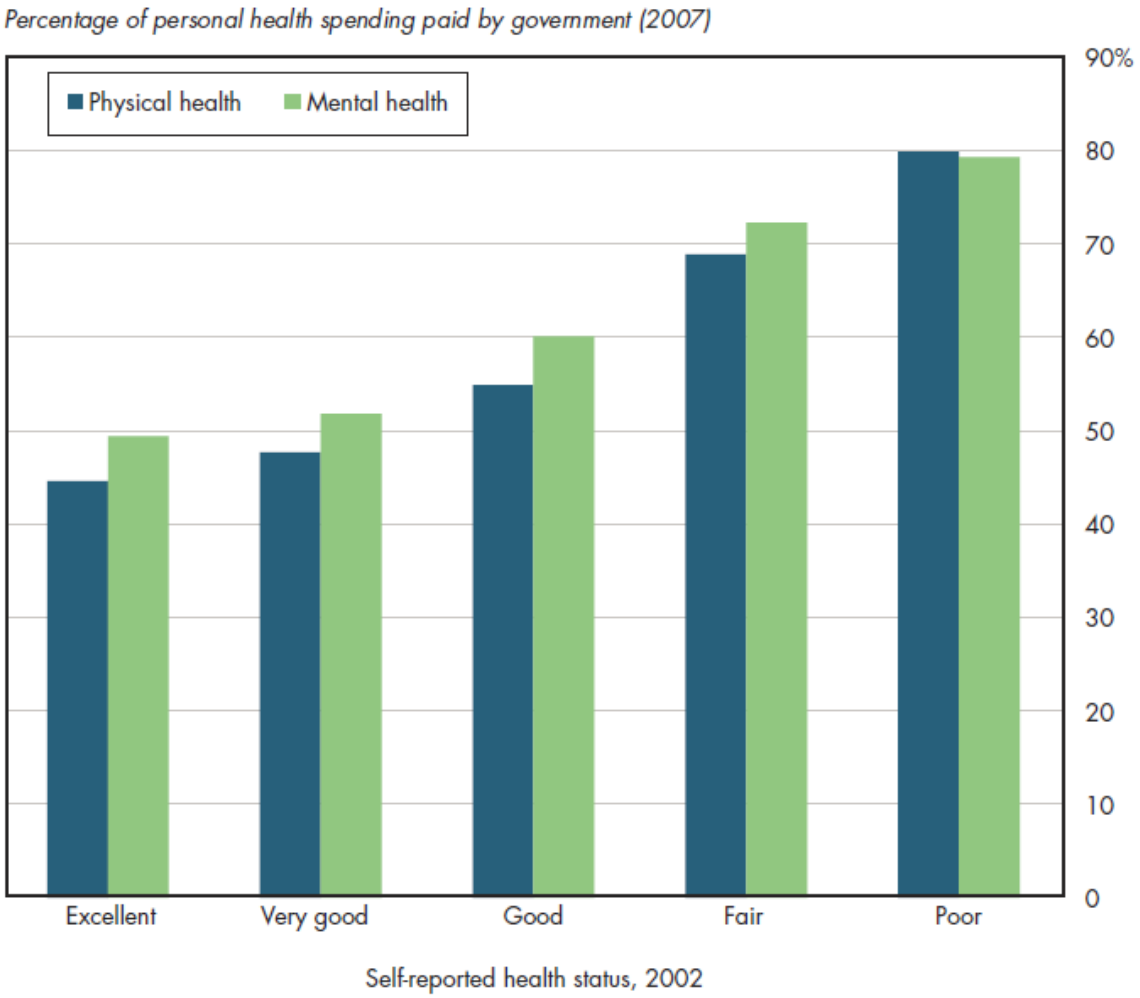
Chapter 4

5.4 Public Sector Pays 80% Health Costs for People of Poor Health[1]

Approximately 80 percent of health spending by people who have the worst health is tax-financed. This is true whether health status is measured in terms of physical health or mental health. The numbers shown in figure 5.4 are based on self-reported health status, in which individuals categorize their health as Excellent, Very Good, Good, Fair, or Poor. Self-reported health status has been shown to be a good proxy for mental and physical health, using "objective" measures such as the ability to perform activities of daily living (eating, bathing, and so forth).

[1]This content is available online at <https://hub.mili.csom.umn.edu/content/m10031/1.3/>.

5.4 The share of health spending covered by government increases as physical or mental health status declines



As shown in figure 5.4, the share of health spending paid by the government rises steadily as health status worsens. This suggests at least some degree of "target efficiency" in terms of focusing public spending on those most in need of medical care. Yet even among those in excellent health, more than 40 percent of health spending is publicly financed. This happens for two reasons. First, Medicare provides near- universal coverage for the elderly, some of whom report excellent health. Although Medicare covers less than half the health spending for a typical person age 65 or older, an important reason for this low percentage is that Medicare was not designed to cover long-term nursing care costs. Among the elderly who have excellent health, nursing home expenses would be minimal; hence, Medicare would finance a higher share of their total annual spending. The second important contributor to this result is that the public spending amounts include tax expenditures such as the subsidy for employer-based health benefits. Given the large fraction of the population who have employer-provided health insurance, this particular subsidy is largely independent of health status. It should not be surprising that many in excellent health benefit from it.

Those who live in families below the poverty level tend to have worse health than those with higher incomes. Nevertheless, many such individuals are in excellent health. However, to the degree that the tax exclusion subsidizes both a higher dollar amount and share of health spending for those who have high incomes and who are in excellent health, the targeting efficiency of taxpayer-financed health spending might

be questioned.

4.1 Downloads

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- Figure 5.4 Image Slide (as it appears above)[2]
- Figure 5.4 Editable Slide (can be formatted as desired)[3]

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4.2 References

A. 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).

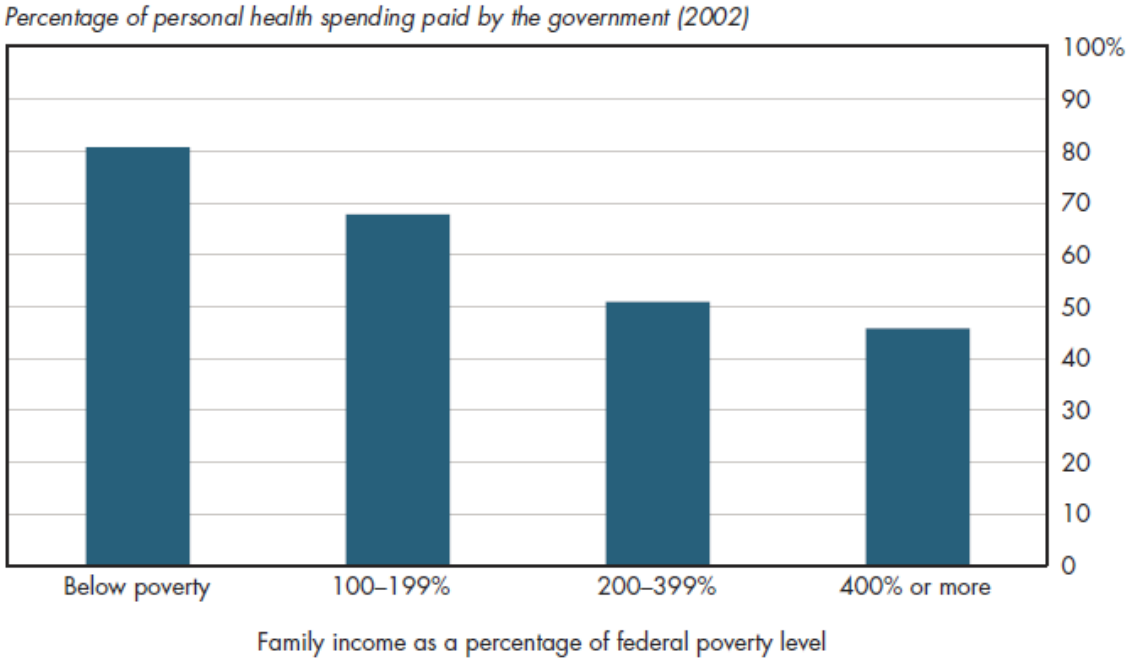
[2]https://hub.mili.csom.umn.edu/content/m10031/latest/5.4IMG.ppt
[3]https://hub.mili.csom.umn.edu/content/m10031/latest/5.4DATA.ppt

Chapter 5

5.5 Taxpayers Finance Almost Half of Health Spending for the Highest-Income Families[1]

Although more than 80 percent of health spending among those with incomes below poverty is tax-financed, so too is almost half of the spending for families with incomes at four or more times the poverty level (figure 5.5a). As with health status, there is some evidence of target efficiency in terms of greater reliance on public financing for health expenses as family income declines.

5.5a Although the public share of health expenses increases as income declines, almost half of spending for families above 400 percent of poverty is tax-financed



Despite major expansions of Medicaid in recent decades, fewer than half of those with incomes below poverty are enrolled in Medicaid or the State Children's Health Insurance Program (SCHIP). Medicaid covers

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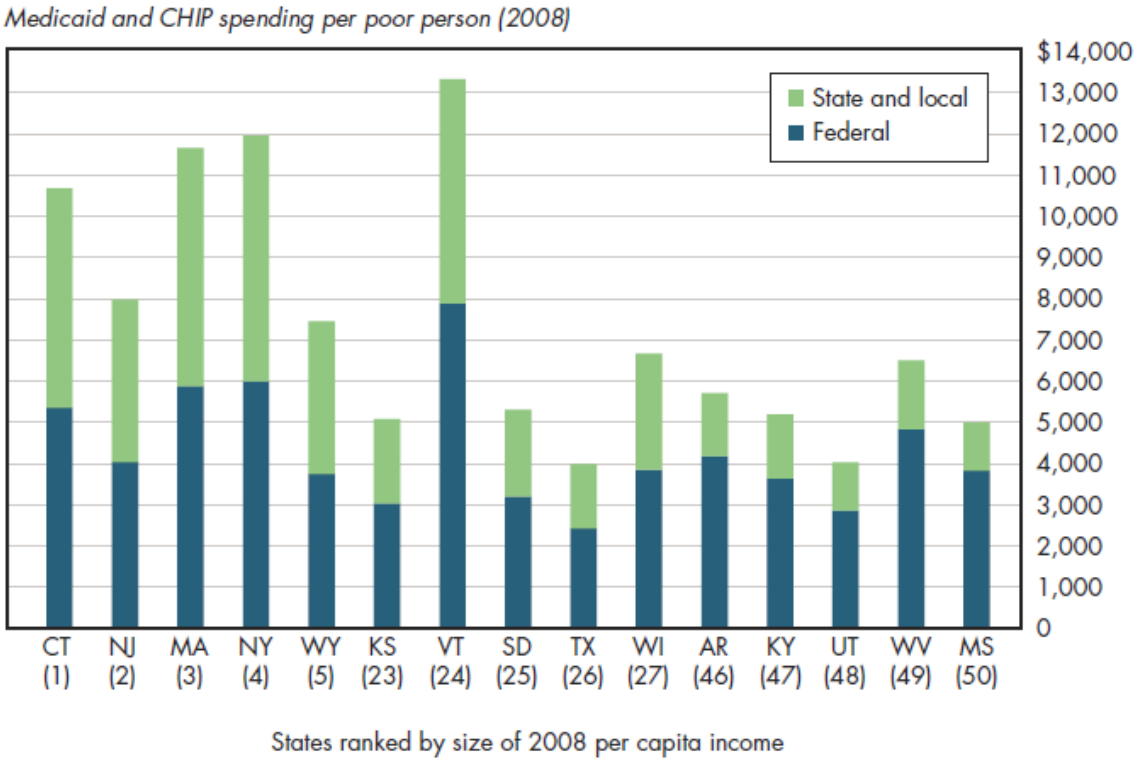
much more than half of health spending for the poor. Many states have "spend-down" programs that permit those with high medical expenses to deduct those from family income for purposes of determining Medicaid eligibility. Consequently, Medicaid covers nearly two-thirds of nursing home patients. Almost 10 percent of the poor are covered by Medicare, which further boosts the share of spending covered by taxpayers. Finally, it was shown previously that a high fraction of health spending among those uninsured all year is uncompensated care—much of which is indirectly paid through taxpayers.

As for the tax exclusion, in a technical sense, individuals at the highest income level pay for themselves. That is, assuming that every dollar of tax expenditures must be offset by a dollar of tax revenue obtained elsewhere, the gross amount of taxes paid by the highest income households to make up this revenue difference will exceed the value of the tax benefit provided by the exclusion. However, especially in the light of the deadweight losses imposed by various forms of taxation, it would be far more efficient to simply let such households pay for their own health benefits directly rather than subsidize these through the tax system. The Office of Management and Budget (OMB) estimates the amount to be at least 25 cents per dollar of taxes collected, but it could be anywhere from 30 cents to more than one dollar, according to other estimates.

The formula used to determine the federal funding share of Medicaid and the Children's Health Insurance Program (CHIP) takes into account per capita income. Even so, there are wide state-level disparities in Medicaid/CHIP funding per poor person, partly due to higher federal spending per poor person in some of the wealthiest states (figure 5.5b).

5.5b Federal Medicaid and CHIP spending per poor person varies widely by state; the amount does not decline as state income rises



5.1 Downloads

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- Fig. 5.5b: Table 5.5.2. Medicaid and CHIP Expenditures per Poor Person, 2008 and 2012

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- Figure 5.5b Image Slide (as it appears above)[5]
- Figure 5.5b Editable Slide (can be formatted as desired)[6]

5.2 References

A. 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).
B. Kaiser Family Foundation, The. statehealthfacts.org.

[2]https://hub.mili.csom.umn.edu/content/m10032/latest/5.5TAB.xls
[3]https://hub.mili.csom.umn.edu/content/m10032/latest/5.5aIMG.ppt
[4]https://hub.mili.csom.umn.edu/content/m10032/latest/5.5aDATA.ppt
[5]https://hub.mili.csom.umn.edu/content/m10032/latest/5.5bIMG.ppt
[6]https://hub.mili.csom.umn.edu/content/m10032/latest/5.5bDATA.ppt

Chapter 6

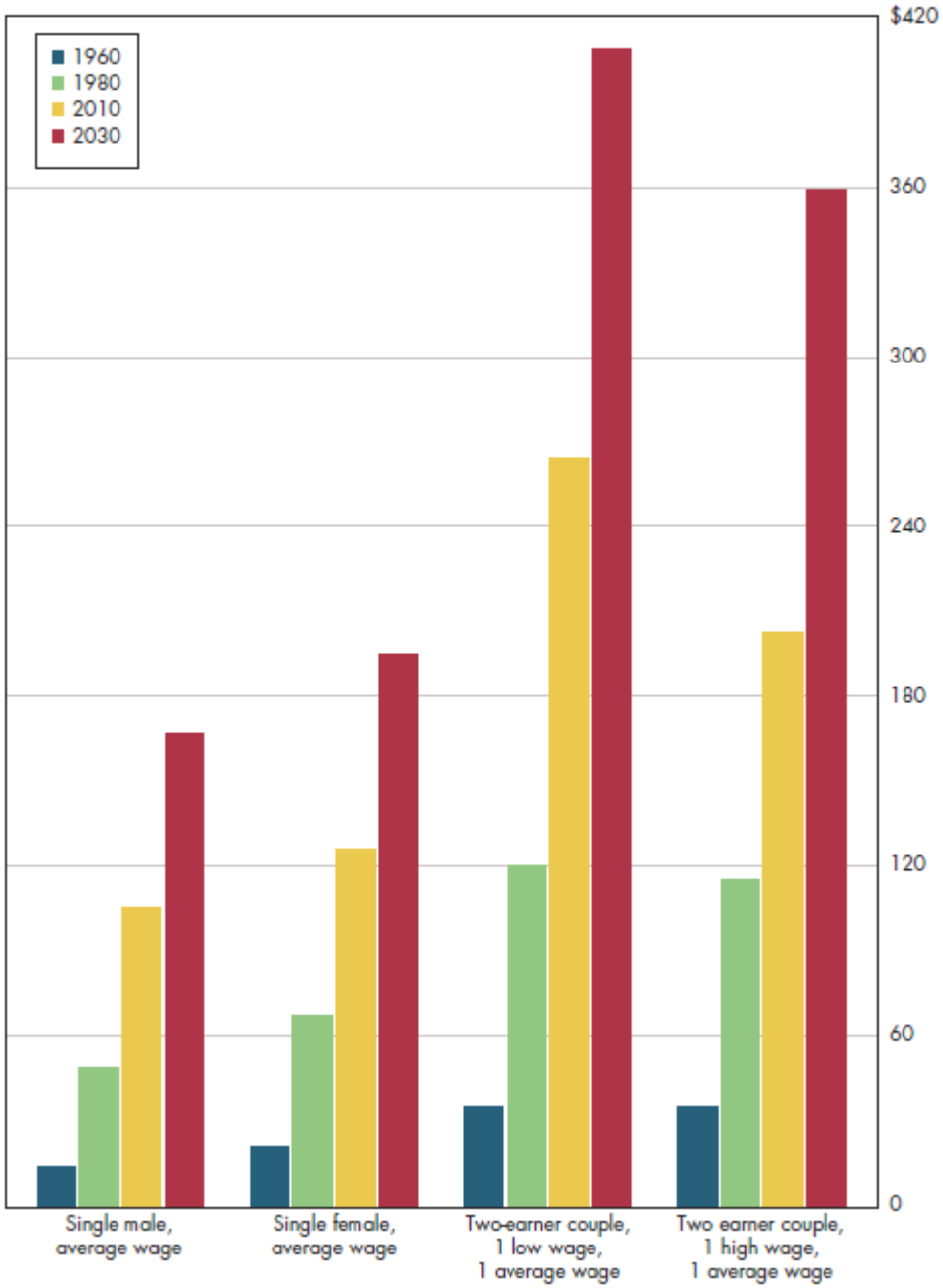
5.6 Medicare Beneficiaries Receive More Than They Pay[1]

Most Medicare beneficiaries—even those who have high incomes—do not pay for themselves. The difference between the dollar value of lifetime benefits paid and the dollar amount of lifetime payroll taxes is generally measured in tens of thousands of dollars per Medicare beneficiary, as shown in figure 5.6. These calculations use inflation-adjusted dollars and a reasonable discount rate to equalize future dollars with today's dollars.

[1]This content is available online at <https://hub.mili.csom.umn.edu/content/m10033/1.2/>.

5.6 Lifetime Medicare benefits grew fastest for low-income workers; even for high-income workers, net lifetime benefits exceed $30,000

Net lifetime Medicare benefits (own benefits minus own taxes paid), 2010 dollars in thousands



For most income groups, the net lifetime benefits of Medicare have increased over time. This reflects that growth in per capita medical spending has outpaced the rate of increases in wages and salaries over time. It also is a function of increases in life expectancy, which have had a far larger impact on lifetime medical expenses financed by Medicare than on the amount of lifetime payroll taxes paid into Medicare. In figure 5.6, low-income individuals are represented by those whose average lifetime earnings are $5,000 annually, while high-income individuals are assumed to have average annual lifetime earnings of $140,000; these individuals

comprise a small fraction of Medicare beneficiaries.

For this highest-income group, net lifetime benefits no longer kept increasing for those who became eligible for Medicare in 1995. This reflects the elimination of the cap on earnings to which the 2.9 percent Medicare payroll tax originally applied. Clearly, for those who have extremely high incomes, for example, averaging $300,000 per year, lifetime Medicare benefits might well be negative, but this situation affects a minuscule fraction of current eligible individuals. This number surely would grow under the new taxes included under health reform. These are restricted to high-income households and include increasing the payroll tax deduction by 0.9 percentage points and imposing, for the first time, a 3.8 percent tax on investment income.

Regardless of whether their net Medicare benefits are positive or negative, it would be far more efficient, as noted for the tax exclusion, for high-income individuals to finance their own Medicare benefits directly than to provide benefits because they already had paid for them through various taxes.

6.1 Downloads

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6.2 References

A. Steuerle CE and S Rennane. Social Security and Medicare Taxes and Benefits Over a Lifetime. Urban Institute. January 2011. http://www.taxpolicycenter.org/UploadedPDF/social-security-medicare-benefits-over-lifetime.pdf (accessed June 10, 2011).

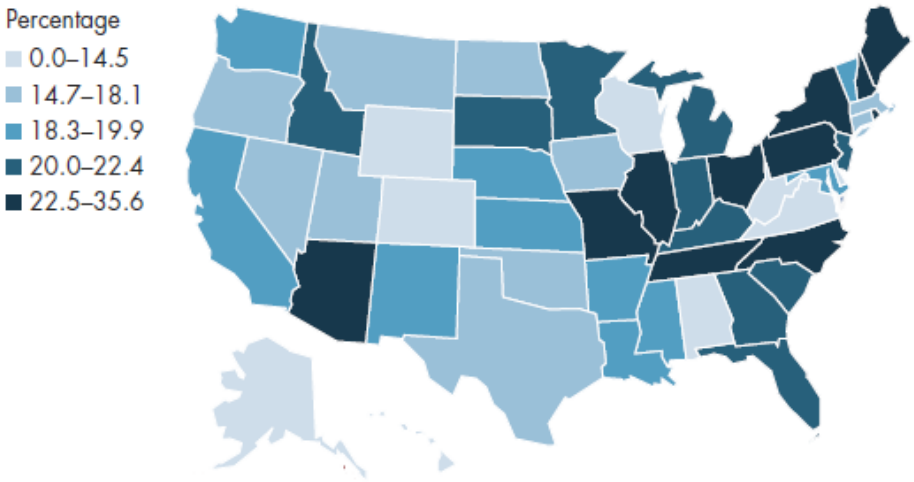
[2]https://hub.mili.csom.umn.edu/content/m10033/latest/5.6IMG.ppt
[3]https://hub.mili.csom.umn.edu/content/m10033/latest/5.6DATA.ppt

Chapter 7

5.7 Medicaid Share of State Health Spending across States[1]

Medicaid spending now is the largest single component of state government expenditures. With the exception of Arizona, states that have the largest Medicaid programs relative to all other spending are concentrated in the eastern half of the United States, predominantly in the northeastern region (figure 5.7a).

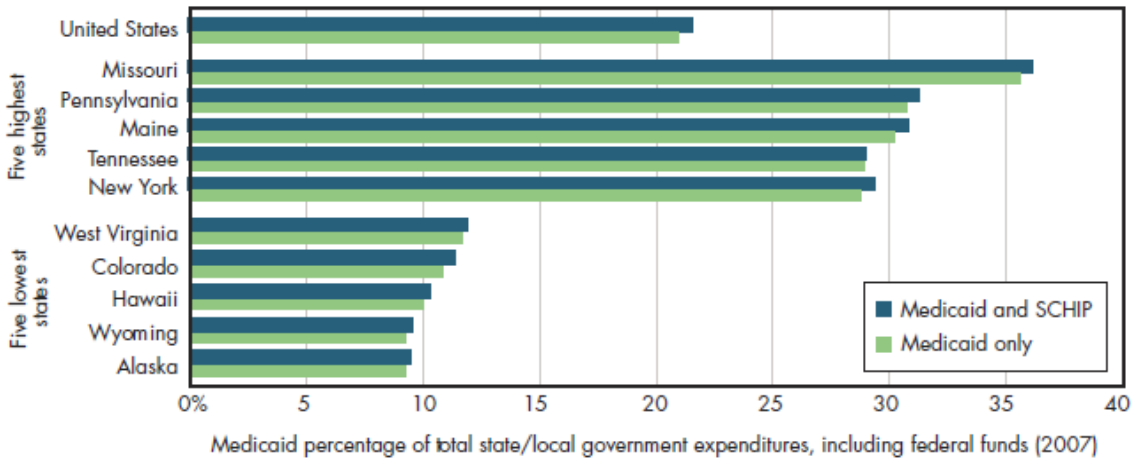
5.7a FY2007 Medicaid expenditures as a percentage of total state government expenditures are highest in the Northeast



These numbers are for 2007 because it might be more representative of relative differences across states than data from more recent years. The federal government now finances almost 60 percent of Medicaid and SCHIP costs. The federal share of overall spending for these programs ranges from a high of 76.3 percent in Mississippi to 50 percent in 12 states whose high per capita income precludes their qualifying for a higher federal matching rate. The numbers on the map are derived by counting all Medicaid/SCHIP spending (including federal funds), and dividing this amount by the total amount of consolidated state expenditures (which also include federal funds). Using this measure, the Medicaid share of total spending averages approximately 21 percent nationally but varies by a factor of three across states (figure 5.7b). In the five states that have the largest shares, Medicaid spending represents approximately 30 cents of every dollar spent. Conversely, in states with the lowest shares, Medicaid spending is only approximately 10 cents on the dollar.

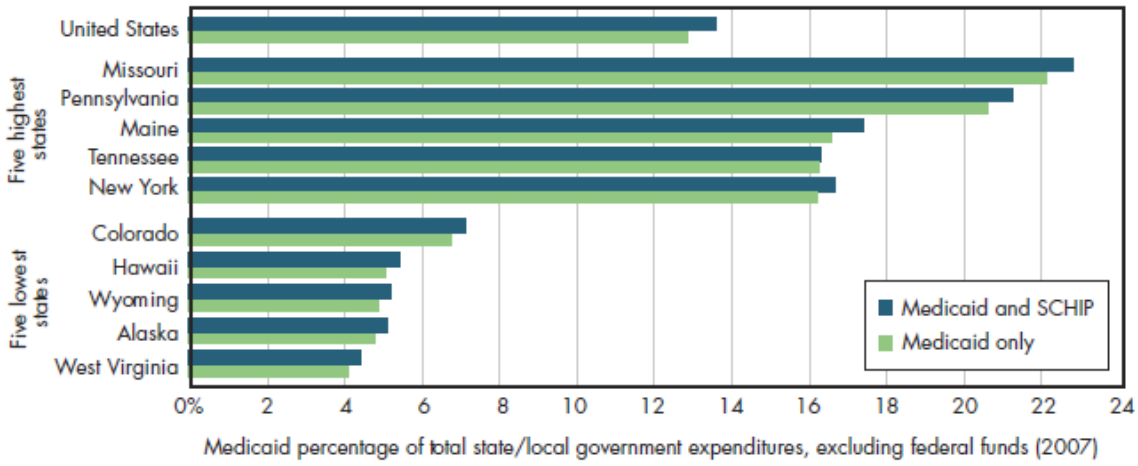
[1]This content is available online at <https://hub.mili.csom.umn.edu/content/m10034/1.3/>.

5.7b The Medicaid share of state spending varies by a factor of three across states



When federal Medicaid spending is excluded, a somewhat different view emerges. The national Medicaid share of state spending is approximately 13 percent, but by this metric, there is a four-fold difference across the states (figure 5.7c). However, although the rankings change a bit, the states included in the top and bottom five are identical to the states facing the highest and lowest burdens when federal funds are included.

5.7c If federal funds are excluded, the Medicaid share of state expenditures is much smaller, but this share varies by a factor of four



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- Figure 5.7b Editable Slide (can be formatted as desired)[5]

[2]https://hub.mili.csom.umn.edu/content/m10034/latest/5.7aIMG.ppt
[3]https://hub.mili.csom.umn.edu/content/m10034/latest/5.7aDATA.ppt
[4]https://hub.mili.csom.umn.edu/content/m10034/latest/5.7bIMG.ppt
[5]https://hub.mili.csom.umn.edu/content/m10034/latest/5.7bDATA.ppt

- Figure 5.7c Image Slide (as it appears above)[6]
- Figure 5.7c Editable Slide (can be formatted as desired)[7]

There's no table for figures since source is included directly on the slides.

7.2 References

A. National Association of State Budget Officers. State Expenditure Report Fiscal Year 2008. http://www.nasbo.org/Publications/StateExpenditureReport/tabid/79/Default.aspx (accessed June 15, 2010).

[6]https://hub.mili.csom.umn.edu/content/m10034/latest/5.7cIMG.ppt
[7]https://hub.mili.csom.umn.edu/content/m10034/latest/5.7cDATA.ppt

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