

Methodology

The basis for sponsor estimates are the health services and supplies (HSS)¹ totals in the National Health Expenditure Accounts (NHEA). The NHEA structure includes measures of spending for sources that pay for health care services. These sources generally define an entity, usually a third party insurer that is responsible for paying the health care bill. These funding sources are broadly classified into private health insurance, out-of-pocket spending, specific government programs such as Medicare and Medicaid, and other public programs such as DVA (Department of Veterans Affairs), DOD (Department of Defense), and Maternal Child and Health among others. Additionally, a small portion of expenditures is estimated for other private revenues – for example, philanthropic giving, industrial inplant, and revenues received by some health care providers from such non-health activities as the operation of cafeterias, gift shops and educational programs.

Behind each NHEA source-of-funding category is an individual, business, or tax source (either dedicated or general revenue) that is responsible for financing, or sponsoring, those payments. These sponsors – designated as businesses, households, governments and other private funds – provide the financial support from which health care bills are paid. The difference between sources of funds and sponsor can be illustrated using private health insurance as an example. Although private health insurers pay claims on behalf of individuals covered by health insurance policies, premiums are often paid, or sponsored, by a combination of employers (private businesses, Federal

¹ HSS includes expenditures for personal health care, government public health, administrative cost of government programs and the net cost of private health insurance. For more information on definitions in NHE, see http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage

government, and state/local governments), households (as employees or purchased directly by individuals in the form of individually purchased policies), and government (such as the Medicare Retiree Drug Subsidy (RDS) payments to private and state and local employers). So, although private health insurance is considered a private source of funding in the NHEA, in the sponsor analysis it is divided into business, household and government sponsor categories based on who bears the underlying financial responsibility for the health insurance premiums.

Figure 1.

Crosswalk of National Health Expenditure Payers to Business, Household, and Government Sponsors

Sponsor	Business, Household, and Other Private			Government	
	Business	Household	Other Private	Federal	State and Local
Source of Funding					
Health Services and Supplies					
Private Sources of Funds					
Out-of-pocket		X			
Private Health Insurance	X	X		X	X
Other Private Revenues ¹	X		X		
Public Sources of Funds					
Medicare	X	X		X	X
Medicaid ²				X	X
Other Public ³	X			X	X

¹ Other Private Revenues include Industrial Inplant, Philanthropy, and Other Non-Patient revenues.

² Medicaid includes SCHIP expansion (Title XIX).

³ Other Public includes Maternal Child and Health, Vocational Rehabilitation, Substance Abuse and Mental Health Services Administration, Indian Health Services, Department of Defense, Department of Veterans Affairs, SCHIP (Title XXI), Public Health Activities, state/local workers' compensation, Temporary Disability Insurance, and other miscellaneous general hospital and medical programs.

Figure 1 provides an illustrated crosswalk of the transition from the NHEA source-of-funding to sponsor categories. We will now describe the transition in more detail for each NHEA source-of-fund.

Out-of-Pocket:

Out-of-pocket funding is defined as direct spending by consumers for all health care goods and services. This includes the amount paid out-of-pocket for services not covered by insurance and the amount of coinsurance and deductibles required by private health insurance and by public programs such as Medicare and Medicaid (and not paid by some other third party), and includes payments from health and flexible savings accounts. The definition and estimates for out-of-pocket spending is the same as in traditional source of funds estimates and in the sponsor analysis, where it is included with spending by the households. ²

Private Health Insurance:

To produce private health insurance (PHI) estimates that are the financial responsibility of businesses, households and governments, total PHI premiums excluding the Medicare RDS Payments are disaggregated into employer-sponsored and individually purchased PHI premiums. Employer-sponsored health insurance premiums are defined as premiums paid by employers and/or employees through payroll deduction, whether or not the employer actually contributes to the health plan. Union health insurance plans are also considered to be employer-sponsored plans. Employer-sponsored premiums were

² National Health Accounts, Web Methodology, National Health Care Statistics Group.
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estimated separately for private, State/local and Federal employers and each of their employee groups.

The primary data source for estimating private and State/local employer contributions to employer-sponsored health insurance plans is the Medical Expenditure Panel Survey—Insurance Component (MEPS-IC) sponsored by the Agency for Health Care Research and Quality.³ The MEPS-IC contains estimates of PHI expenditures separately for active employees and retirees of private businesses and state/local governments. The employer share of premiums paid by private business and state/local government for active employees and retirees were estimated for 2003 through 2005 using MEPS-IC data. For the period 1987 to 2003 and in 2006, private health insurance premiums paid by employers for active workers were estimated using the annual growth rate from the Employer Cost for Employee Compensation (ECEC) component of the Bureau of Labor Statistics' (BLS) National Compensation Survey.⁴ The U.S. Office of Personnel Management's Office of the Actuary supplied estimates of the premium amounts paid by Federal employers on behalf of their employees and retirees. These sources were used to allocate contributions for employer-sponsored health insurance into business, Federal or State/local governments.

For 2003 through 2005, estimates of private businesses' and state/local government's employer-sponsored PHI premiums paid by active employees, retirees, and former employees who are covered by the Consolidated Omnibus Budget Reconciliation

³ Agency for Healthcare Research and Quality: Data from the Medical Panel Expenditure Survey-Insurance Component, 1996-2005. Rockville MD. November 2007. <http://www.meps.ahrq.gov/mepsweb/>

⁴ U.S. Bureau of Labor Statistics: Data from the Employer Costs for Employee Compensation Survey results for 1987-2007. U.S. Department of Labor. Washington, DC. November 2007. <http://www.bls.gov/ncs/ect/home.htm>

Act (COBRA) were also produced using MEPS-IC data.⁵ To calculate the premiums paid by active employees, retirees and COBRA enrollees from 1987 to 2002, the annual growth rate in household payments for PHI premiums from the BLS's Consumer Expenditure Survey (CE) was applied to the 2003 MEPS-IC estimate.⁶ For 2006, premiums paid by private and state and local employees and retirees were estimated using MEPS-IC data projected using the 2007 Kaiser/HRET Annual Employer Health Benefits Survey combined with the historical relationship between employee/retiree paid and employer-paid share of employer-sponsored health insurance.⁷ The U.S. Office of Personnel Management's Office of the Actuary also supplied data recording payments made by Federal employees and retirees for their health insurance premiums. These estimates, along with other employee contributions to PHI, are considered to be household sector payments. Premiums for individually purchased PHI were estimated using CE data for 1987 to 2004 and growth from the A.M. Best survey for 2005 and 2006.

⁵ In general, COBRA requires certain employers to continue to offer former employees and their dependents health insurance coverage at a cost of 102 percent of the employer premium for a period of 18 months.

⁶ U.S. Bureau of Labor and Statistics: Data from the Consumer Expenditure Integrated Survey results for 1987-2004. U.S. Department of Labor. Washington, DC. November 2007. <http://www.bls.gov/cex/home.htm>

⁷ Kaiser Family Foundation and Health Research and Educational Trust, 2007 Employer Health Benefits Survey. Accessed on the web, November 2007. <http://www.kff.org/insurance/7672/index.cfm>

Other Private Revenues:

Other private revenues consist of philanthropy, industrial inplant, and other private revenues. For the sponsor analysis, industrial inplant is moved to the business category; philanthropy and other private non-patient revenues remain in the other private category.

Medicare:

Estimates for Medicare expenditures are split into sponsor categories of businesses, households and governments. The Medicare program is financed by several different mechanisms. The Hospital Insurance (HI) trust fund is primarily financed through Federal Insurance Contributions Act (FICA) taxes on covered payroll, plus interest, taxation of benefits and other revenues. The Supplementary Medical Insurance (SMI) trust fund (which includes Medicare Part D after 2004) is financed through general revenues, premiums (including buy-ins from Medicaid dually eligible beneficiaries), state phase-down payments, and interest income.

In the sponsor analysis, years where the assets of the Medicare HI trust fund increase allow for immediate reductions in current federal general funding obligations for Medicare, as the surplus is recorded as special interest-bearing treasury obligations that are then intermingled with all other general revenue. We report this surplus as an offset to the difference between program outlays and the dedicated financing sources of Medicare. The dedicated financing sources include HI payroll taxes, the HI share of income taxes on Social Security benefits, beneficiary premiums, and beginning in 2006, Part D state phase-down payments.

The NHE Medicare ‘source of funding’ estimates are distributed to reflect these different financing sources. In the sponsor analysis, the HI payroll taxes paid by employers, along with one-half of the self-employed payroll taxes, were subtracted from NHE Medicare estimates and assigned to the businesses and Federal and state/local governments in which employers or self-employed individuals operate. The employees’ share of HI payroll taxes⁸, together with the other half of the self-employed payroll taxes, HI taxation of benefits, and SMI premiums⁹ were all moved to the household category.

Medicare estimates are further adjusted by the removal of Medicaid buy-ins (payments made by state Medicaid programs for Medicare Part A and Part B premiums for eligible individuals). The buy-in amounts are estimated from Medicaid financial information reports filed by state Medicaid agencies on Form CMS-64 and added to state and local government Medicaid spending. State phase-down payments for Medicare Part D are also reallocated to state and local governments. Additionally, RDS payments are removed from the employer (private and state and local government) share of private health insurance and added to the Federal government Medicare spending category. The remaining Medicare Federal government expenditures are roughly equal to trust fund interest income and Federal general revenue contributions to Medicare and are included in the federal government category.

⁸ Source: SSA Office of the Actuary, private communication. (The Social Security Administration’s Office of the Actuary supplied estimates of tax liability for self-employed workers, employees and their employers).

⁹ Source; CMS, Trustees report. (estimates of the taxation of benefits and SMI premiums are from the Center for Medicare and Medicaid Services’ (CMS) Office of the Actuary).

Medicaid:

The NHE Medicaid estimate of federal and state spending is combined with SCHIP expansion (Title XIX) then moved into the appropriate government category.

Other Public:

Other federal public payers consists of Substance Abuse and Mental Health Services Administration, Indian Health Services, Department of Defense, Department of Veterans Affairs, other miscellaneous general hospital and medical programs, Public Health Activities and the federal share of Maternal Child and Health, Vocational Rehabilitation, SCHIP (Title XXI), state and local workers' compensation, and temporary disability insurance. The state and local government programs include the state share of Maternal and Child Health, SCHIP, general assistance, state and local workers' compensation, and state phase-down payments under Medicare Part D. Temporary disability insurance is reclassified from a state and local government source-of-funding category to the private business sponsor category.¹⁰ Other than this, the other public category is identical under the source of funds and sponsor analysis.

¹⁰ A small expenditure for workers' compensation covering Federal employees is the financial responsibility of the Federal government as an employer. In both the NHE source of funding and sponsor presentation, workers' compensation for Federal employers is in the Federal category.