Display and Categorization of Source of Funds Estimates in the National Health Expenditure Accounts: Incorporating the MMA

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[This paper was prepared in April 2005 and thus does not reflect changes made to the National Health Expenditure Accounts since that time. Such changes include methodological, conceptual, and data revisions that accompanied the comprehensive benchmark of National Health Expenditures that were released in January 2006. For more information on these changes, please see http://www.cms.hhs.gov/NationalHealthExpendData/downloads/benchmark.pdf]

Introduction

On December 8, 2003, President George W. Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. The MMA contains several provisions that impact the National Health Expenditure Accounts (NHEA). This paper presents a summary of the current NHEA source of funds classifications followed by recommendations for the classification of new flows of funds that result from provisions of the MMA.

The current form of NHEA was initially published in 1964.[1] The accounts are best described as a series of accounting matrices that measure the amount spent on health care in the United States, enumerated by the type of health care purchased and by the source of funds used to make these purchases. Importantly, the accounting matrices reflect total spending on health care so that the estimates are mutually exclusive and exhaustive, particularly ensuring there is no double counting of overlapping programs. The NHEA contain measures of spending on particular health care services and products (hospital care, physicians' services, drugs) delineated by the source of funding of these expenditures. Expenditures for each type of health care service or product (see Exhibit A) are denominated as either private sources of funds or public sources of funds, and these designations are further subdivided into the particular public program (Medicare, Medicaid) or private source (private health insurance, out-of-pocket spending). In addition, the NHEA measure spending on public health activities, on the net cost of private health insurance and administration of public programs, and on the investment in medical structures (see Exhibit B).

The MMA provides for a number of new Medicare benefits, most notably prescription drug coverage. The MMA also creates new benefits for preventative care and establishes subsidies for companies that maintain retiree health insurance plans with drug coverage that is actuarially equivalent to the new Medicare drug benefit. Many of the new benefits in the MMA are easily categorized in the existing NHEA source of funds structure.

[1] Reed, L.S and Rice, D.P.: "National Health Expenditures: Objects of Expenditures and Source of Funds", *Social Security Bulletin*, 27(8):11-21, August 1964. For more discussion on the history of health accounting in the United States, see "Origins and Elaborations of the National Health Accounts 1926-2006." by Bruce M. Fetter, *Health Care Financing Review* , Fall 2006, Volume 28(1), pages 53-67. http://www.cms.hhs.gov/HealthCareFinancingReview/09_2006%20Edition.asp#TopOfPage

However, the following four specific provisions give rise to questions on how the new flows of funding should be categorized as to the source of these funds since they involve overlaps among different payers:

- The Medicare Part D benefit, or prescription drug coverage for Medicare beneficiaries.
- The "maintenance of effort" payments from States to Medicare for dual eligibles.
- The transitional benefits for years 2004 and 2005–drug discount cards and subsidies for low-income seniors.
- The employer subsidies for continuing to fund retiree health insurance plans with drug benefits that are actuarially equivalent to the Part D benefit.

Classification of Sources of Funds in the NHEA

When the NHEA were initially conceived, the concept of the "source of funds" was fairly straightforward. The "source of funds" and the health care provider engaged in what was essentially a single transaction. Most payments for health care were paid directly out-of-pocket (OOP), with only limited private and public third-party health insurance payments available. The concept of 'source of funds' was developed when these third parties tended to pay the health care provider directly in a single transaction.

Over time, the U.S. health care system became increasingly complex. At various points during the last three decades, entities that financed health insurance experienced rapidly increasing cost growth. Businesses explored self-insurance as a way to curb cost growth by avoiding premium taxes and higher administrative costs. Sometimes they paid claims directly, and at other times they used a third-party administrator—often an insurer—to pay claims. Medicare, along with other public and private programs that had been paying HMOs to deliver services to beneficiaries for several decades, embraced managed care plans as a way to efficiently deliver benefits to its covered populations.

As these new arrangements between public and private insurers developed, decisions had to be made about how to classify "overlapping" sources of funds in the NHEA. The delivery and payment of Medicare HMO services were considered to be Medicare program payments, even though the final exchange of funds, between the bill payer and the health care provider, was between a private insurer—the HMO—and the health care provider. Medicare HMO enrollees were classified as such by virtue of their Medicare eligibility.

In another example of this complexity, Medicaid paid Medicare Part B premiums for dually eligible recipients who otherwise could not afford these premiums. These Part B premium payments entitled enrollees to specific benefits under Medicare. In an accounting framework, health care expenditures can be counted once and only once. In the NHEA, Medicare Part B premiums paid by Medicaid were subtracted from the Medicaid category (lowering total Medicaid expenditures) and counted as part of Medicare expenditures. This decision was in part driven by data availability. OACT's National Health Statistics Group had access to data on Medicare payments to various types of providers, but it would have been impossible to trace the specific amounts paid to these providers on behalf of beneficiaries for whom Medicaid had paid the part B premium—or possible only by expending an extraordinary amount of effort and making some rough assumptions.

Complications increased as State Medicaid programs obtained waivers and began paying workers' premiums for employer-sponsored health insurance. In addition, the Department of Defense embarked upon a new program (TriCare) that used private insurers to administer insurance for military personnel and their eligible family members. These program changes added a financial intermediary into the transaction that the National Health Expenditure Accounts needed to address. Currently these intermediaries are considered to be "transfer agents" between the programs (purchaser) and the providers.

Current Classification of Sources of Funds

In the NHEA, the principle guideline is to classify third-party sources of funding on the basis of who ***purchases*** the health care. The ***purchaser*** is the entity that sets the coverage and benefits structure and bears the burden of payment. If an entity that is a bill payer merely acts as a transfer agent, or financial intermediary, between the purchaser and the provider, we do not classify that entity as the "source of funds". Rather the ***purchaser*** of the health care, the entity that determines the benefits and bears the financial burden of payment, is determined to be the "source of funds". In certain cases, NHEA source of funds classifications recognize that more than one purchaser exists in any given "transaction". These ***co-purchasers*** are differentiated as separate "sources of funds". For example, in a transaction in which an enrollee of a private health insurance policy purchases prescription drugs under that policy, the cost of the prescription at the point of the transaction is attributed to both the private health insurance plan (private health insurance source of funds) and to the beneficiary in the form of a co-payment (OOP source of funds).

The following examples illustrate how we have applied this general principle in classifying "source of funds" on a purchaser basis. See Exhibit C for a more comprehensive treatment of the different types of health care transactions.

Example 1. Many public insurance programs (Medicare, Medicaid, Department of Defense, and Department of Veterans Affairs) make payments to private insurers, such as managed care plans, for care provided to specific populations. Currently, the NHEA classify these expenditures as public sources of funds. In most cases, these managed care plans function as intermediate purchasers of health care for these public programs, which serve a specifically defined population and are not available to the general public. Since the managed care plans in this instance act more like agents for the public programs than like separate entities, these payments are classified with the public program that sets the coverage and benefit structure and bears the payment burden.

Example 2. Workers' compensation is more complex. We currently count it as a public State program, since in most cases States mandate coverage and regulate the plans. Variations in the financing mechanisms make it difficult to classify workers' compensation programs consistent with the purchaser principle. That is, States set the coverage and benefit structure, but the program is financed by employers through a combination of private workers' compensation insurance plans, self-insurance, and state funds. The treatment of workers' compensation programs will continue to be evaluated in the future.

Example 3. Medigap policies are currently treated as private health insurance. The insurance industry sets the types and payments of the Medigap policies, albeit under the guidance of the public sector (in this case Medicare). This treatment is consistent with classifying sources of funds according to the purchaser.

Example 4. The classification of OOP expenditures as co-payments is also consistent with the purchaser guidelines. In this case the individual becomes a co-purchaser of the health care benefit. While the individual has little control over the benefit and payment

structure, he or she does bear the financial burden of payment and directly influence utilization by choosing whether or not to purchase the health care service or product.

International Classifications–a Comparison

Several international bodies have developed economic accounting systems that include elements of national health expenditure accounting. Among these are the *System of National Accounts* (SNA), developed by the United Nations; *A System of Health Accounts* (SHA), developed by the Organization for Economic Cooperation and Development (OECD); and the *Guide to producing national health accounts with special applications for low-income and middle-income countries*, developed by a coalition of groups including the World Health Organization (WHO), the World Bank, the United States Agency for International Development (USAID), and other partners. Each of these manuals strives to codify health accounting rules and principles–methodological guidelines–that delineate how to identify and measure health care expenditures. The implicit goal in establishing these accounting rules and principles is to facilitate accurate, meaningful international comparisons of health care systems and health care expenditures.

In its health account manual *A System of Health Accounts* (SHA), the OECD offers some guidance on the determination of source of funds in national health accounting schemes:

> National systems of flows of financing in health care tend to be fairly complex and the level of standardization across countries of even the basic categories of public and private funding is in general low. As with other aspects of health care (activities, providers), similar designations of "social insurance", "mutualités", "friendly societies", etc. often describe different institutional arrangements and financing regulations. In addition, country specific forms of intergovernmental transfers as well as transfers in the private sector between public and private funds increase the complexity of reporting on sources of funding in international comparisons. [67]

The classification of payers in the OECD SHA manual is as follows:

> …health care is financed by social insurance (social security and private social insurance), by tax financed direct government provision of health care services, and various private arrangements (private insurance…; non-profit charities). [69]

The following are the International Classification for Health Accounts (ICHA) classification for sources of funding (as shown in the OECD SHA manual) and reflect policy areas of importance in providing health insurance/services to different groups of individuals:

General Government
- General government excluding social security funds
- Social Security funds

Private Sector
- Private social insurance
- Private insurance (other than social insurance)
- Private household
- Non-profit institutions serving households (other than social insurance)
- Corporations (other than health insurance)

Rest of World (68)

Although OECD does offer two perspectives on health care financing ("third-party payment arrangements plus direct payments by households" and "ultimate burden of financing borne by sources of funding"), it provides little direct guidance regarding complex issues of financing flows that exist in the US health care system, both within the general government and between the general government and private sector.

Impact of Policy on Classifying Sources of Funds

The *Guide to producing national health accounts with special applications for low-income and middle-income countries* produced by WHO, the World Bank and USAID in 2003, provides a practical approach and guidance on this issue of defining payer, and states that a classifying scheme for expenditures should include the following:

- It should represent an important, policy relevant dimension, and should partition the dimension in policy relevant ways.
- It should partition the dimension in a mutually exclusive and exhaustive way, so that each transaction of interest can be placed in one—and only one—category.
- It should respect and reflect, to the extent possible, existing international standards and conventions.
- It should be feasible to implement using the data available. (5)

Using the criteria described above; the source of funds classifications of the new flows of funds resulting from the four MMA provisions in question should provide information that is policy relevant. Additionally, the source of funds classifications should conform as closely as possible to the health accounting rules and principles and methodological guidelines included in internationally recognized health accounting systems. The NHEA funding flows are generally consistent with international standards. The classifications are primarily based upon the purchaser, which for the most part is the entity that determines the coverage and benefit structure and payments.

Recommendations

Because the policy implications of source of funds classification decisions are so important, and because it is necessary to adhere to international standards whenever possible, a team from NHSG developed the following recommendations, which take into account the data available in the context of policy needs.

Medicare Part D: The recommendation is that this category should be treated as Medicare expenditures, since as the purchaser it sets the coverage, benefit, and payment structures for the outpatient prescription drug benefit. This drug benefit coverage can be provided either through a private Prescription Drug Plan (PDP) that offers drug-only coverage or through Medicare Advantage plans that offers both prescription drug and health care coverage. These entities act as an agent of Medicare and provide insurance services that are an extension of the Medicare program.

States' "Maintenance of Effort" Payments: The recommendation is that State governments' "maintenance of effort" payments should be treated as Medicare expenditures. That is, we should not count the "maintenance of effort" payments as Medicaid vendor payments. Medicare is the purchaser and determines the coverage and benefits. States are in effect paying back Medicare for some of the

costs of prescription drug purchases made by individuals dually eligible for Medicaid and Medicare. States' "maintenance of effort" payments are transfers of State funds to Medicare drug program and should be treated as such when we disaggregate bill payers in the NHEA. To treat the States "maintenance of effort" payments as Medicaid vendor payments would in effect double-count these payments. Policy makers interested in these payments could be presented with the data as a side bar or complementary table.

Transitional programs:
Purchase of the discount card: The recommendation is that these payments be included in the net cost of private health insurance for the two years that the program was in place prior to the start of the Medicare Part D program. The $30 that is paid by each Medicare beneficiary who wishes to participate in the drug card program is not directly allocated to the purchase of specific drugs but rather supports an administrative function.

Low-income subsidies: The recommendation is that the subsidies provided to low-income beneficiaries for the purchase of prescription drugs be classified as Medicare expenditures. Medicare is the final payer and determines the coverage, benefit, and payment structure. These subsidies are intended to ease beneficiary burden when purchasing drugs. For the purpose of determining the classification of the flow of funds, the nature of the mechanism for transferring these funds to the provider is immaterial, since that mechanism would, in any case, be acting as an agent of Medicare.

Employer Subsidies: The recommendation is that the premium subsidies be subtracted from Medicare program expenditures. The amount of the subsidies would implicitly be included with estimates of private health insurance premiums, whether these premiums are payments to health insurance companies or premium-equivalent estimates for self-funded plans.

Employers set up retiree health care plans and offer benefits through private health insurance companies. The public sector (i.e., Medicare) provides guidance and sets the minimal standard of coverage (in this case, the actuarial equivalent to the prescription drug coverage under Medicare), but the employers have considerable amount of flexibility regarding the structure of the plan. Moreover, from a data perspective, some of this Medicare premium subsidies amount will appear as private health insurance (PHI) benefits, and there may be no clear-cut way to appropriately remove these expenditures without making some very significant assumptions. Since the PHI premium amount subsidized by the government is not linked to a specific payment of a benefit in a given year, a subsidies payment cannot be attributed to the benefit.

From a policy viewpoint including these subsidies with the Medicare program would be of value; however, these subsidies cannot be included in both the Medicare and private health insurance estimates and a determination has to be made as to where these amounts would be most appropriately classified. In this case, including the subsidies with the private health insurance estimates would satisfy the criteria of classifying based on the purchaser concept. The employer subsidies will likely be presented as a sidebar to the NHE estimates so policy makers can more accurately understand its magnitude and significance.

Conclusion

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 includes several provisions that impact the NHEA. This paper describes both the NHEA structure and the classification of purchases of health care services and products into sources of the funds. Decisions regarding this system of classification must be informed by not only international standards on national health accounting, which requires that there be no double counting of payments and transfers, but also by the information needs of policy makers.

Any program that attempts to categorize complex systems of payments needs guidelines to provide a consistent method of classification. At this time, there is not a prioritized list of rules to apply when a new program that contains significant transfers among sources is initiated as is the case with the MMA. Every effort has been made to be consistent within the principle guideline of classifying source of funds based on the purchaser of the health care. The next step is to set up a series of guidelines and/or rules that could be applied to any new program (and existing programs) to ensure new concepts are measured consistently within established health accounting standards**.** In addition, it is imperative that policy makers and users of the NHEA need to provide direction regarding what types of supplemental and complementary tables would be most useful to them in their work.

Exhibit A: Selected Services by Source of Funds, 2003

Source of Funds	Hospital Care	Physician and Clinical Services	Prescription Drugs
Levels in billions of dollars			
Personal Health Care Expenditures	$515.9	$369.7	$179.2
Out-of-Pocket Payments	16.3	37.6	53.2
Third-Party Payments	499.6	332.1	126.1
Private Health Insurance	177.4	183.6	82.9
Other Private	21.3	25.5	--
Public	300.8	123.0	43.2
Federal	242.1	101.3	25.2
Medicare	156.4	73.8	2.8
Medicaid	52.6	15.8	19.9
Other	33.0	11.7	2.5
State and Local	58.7	21.7	18.0
Medicaid	34.4	10.4	13.7
Other	24.3	11.4	4.2

Source: National Health Statistics Group, OACT, CMS

Exhibit B: National Health Expenditures by Source of Funds.

	2003	2002	2001
Levels in Millions of dollars			
National Health Expenditures	$1,678,868	$1,558,992	$1,426,394
Private Funds	913,200	841,026	771,763
Consumer Payments	831,077	763,664	698,633
Out-of-pocket Payments	230,483	214,200	201,986
Private Health Insurance	600,594	549,465	496,647
Other Private Funds	82,123	77,362	73,130
Industrial Inplant	4,906	4,653	4,443
Privately funded construction	16,914	16,049	13,952
Other Private Revenues			
Including Philanthropy	60,303	56,660	54,735
Public Funds	765,668	717,966	654,631
Federal Funds	541,656	508,551	463,791
Medicare	283,104	267,746	248,817
Workers' Compensation	797	756	714
Public Assistance	162,131	151,324	133,887
Medicaid (Title XIX)	157,510	147,397	130,914
Medicaid SCHIP Expansion (Title XIX)	1,193	996	883
SCHIP (Title XXI)	3,428	2,930	2,089
Non-XIX Federal	0	0	0
Department of Defense	17,223	17,612	15,219
Maternal/Child Health	625	626	610
Veterans' Administration	24,549	22,248	21,488
Vocational Rehabilitation	682	662	624
General Hospital/Medical			
General Hospital /Medical NEC	5,833	5,617	5,097
Substance Abuse and Mental Health Services Administration	3,084	2,947	2,771
Indian Health Services	2,020	1,932	1,903
Public Health Activity	7,432	6,354	5,427
Research	33,320	29,891	26,532
Construction	856	837	702
State and Local Funds	224,011	209,415	190,840
Temporary Disability	49	49	49
Workers' Compensation	33,179	30,267	27,024
Public Assistance	116,888	108,603	97,668
Medicaid (Title XIX)	109,463	101,953	91,520
Medicaid SCHIP Expansion (Title XIX)	462	400	355
SCHIP (Title XXI)	1,505	1,284	931
Non-XIX State/Local	0	0	0
General Assistance	5,459	4,966	4,863
Maternal/Child Health	2,039	2,076	2,111
Vocational Rehabilitation	214	205	204
State and Local Hospital and School Health	15,490	14,669	14,032
Public Health Activity	46,319	44,802	41,963
Research	4,308	4,013	3,722
Construction	5,525	4,731	4,067

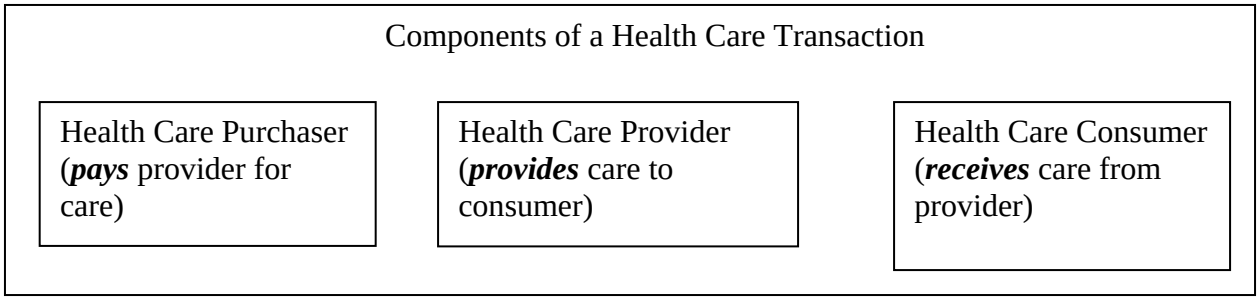
Source: National Health Statistics Group, OACT, CMS

Exhibit C: Types of Health Care Transactions

Each health care transaction involves three distinct entities:

- A health care provider
- A health care consumer (patient)
- A health care purchaser (source of funds)

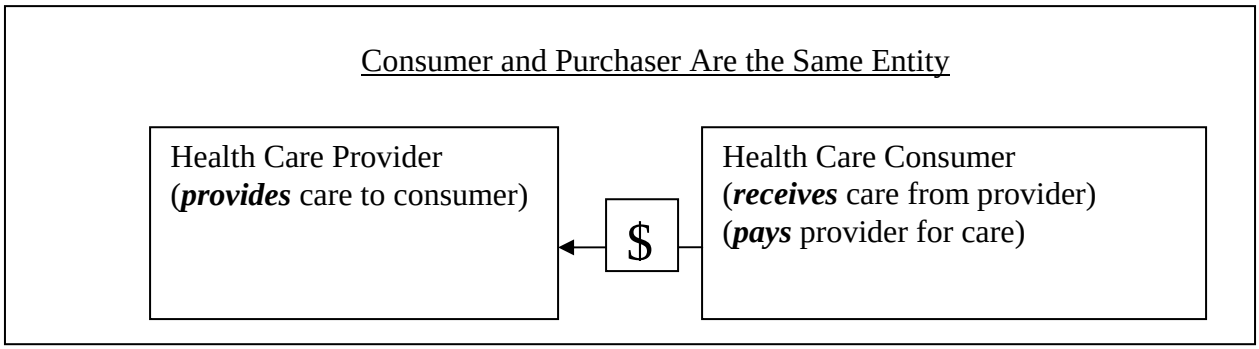
The consumer and the purchaser are sometimes the same entity.
The provider and the purchaser are sometimes the same entity.



Transactions in which the consumer and purchaser are the same entity:

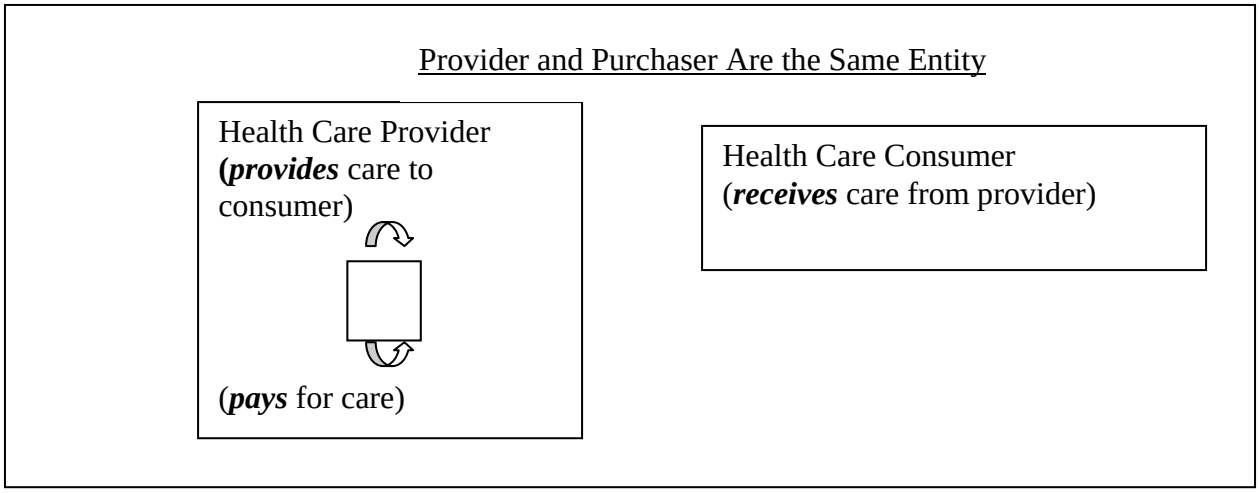
- The most straightforward transaction occurs when an individual purchases an episode of care with his/her own funds. In this case, the purchaser is the same as the consumer (patient).

- In the NHEA, this transaction would be recorded by the type of provider (service) and by the source of funds – out-of-pocket (private).



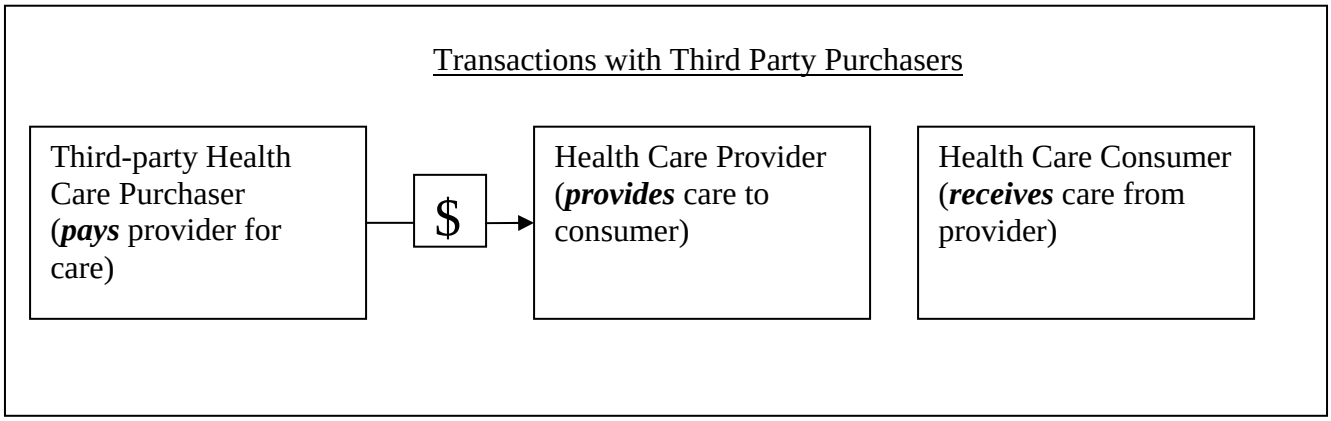
Transactions in which provider and purchaser are the same entity:

- This type of transaction occurs when an individual receives care in a facility owned by the purchaser, for example, a hospital operated by the Department of Veterans Affairs (DVA).
- In the NHEA, this transaction would be recorded by the type of provider (service = hospital) and by the source of funds – DVA (public source of funds).



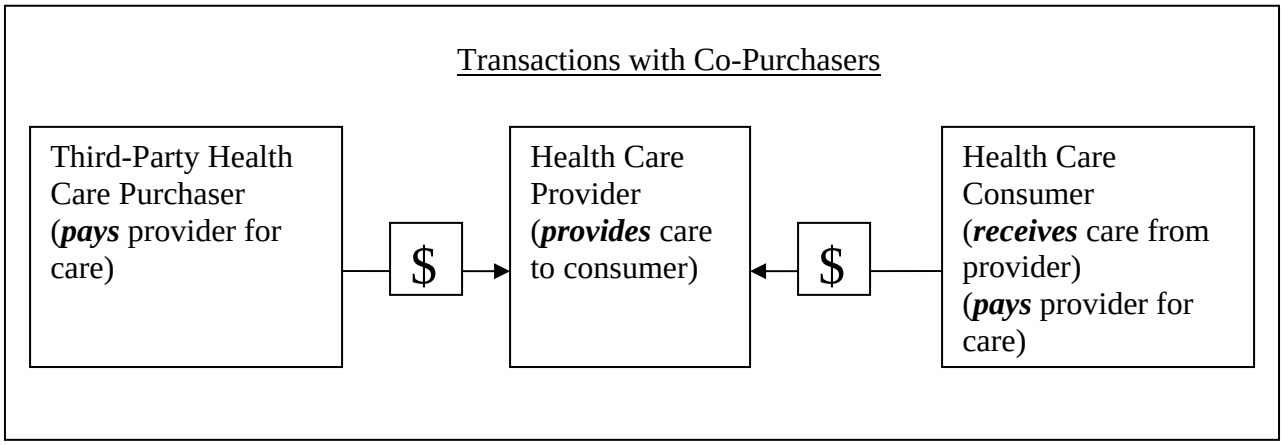
Transactions with third - party purchasers:

- The transaction occurs when a consumer receives health care purchased by a third-party – for example, when an individual receives care at a community hospital, and a private health insurance policy pays the hospital for that care. Here the purchaser is the third-party, and the provider is the hospital.
- In the NHEA, this transaction would be recorded by the type of provider (service) and by the source of funds of the third-party – either private for private health insurance or public for government purchasers.



Transactions with co-purchasers:

- The transaction occurs when a consumer receives health care purchased by a third-party, but also contributes his/her own funds through a co-payment or deductible payment – for example, an individual receives health care at a community hospital, and a private health insurance policy pays the hospital for that care along with the consumer, who makes a co-payment. Here the co-purchasers are the third-party and the consumer (patient). The provider is the hospital.
- In the NHEA, this type of transaction would be recorded by the type of provider (service) and by the source of funds of the co-purchasers – the third party (either private for private health insurance or public for government purchasers) and private out-of-pocket for the consumer.



Transactions with financial intermediaries:

The transaction occurs when a consumer receives health care purchased by a third-party. The purchaser is the third-party; however, other entities act as financial intermediaries. The financial intermediaries transfer funds from the purchaser to the provider or to another financial intermediary – for example, a Medicare beneficiary may enroll in a managed care plan. In this case, the purchaser is Medicare, the provider is the service provider (physician, hospital), and the private health insurance company that pays the HMO is the financial intermediary.