

INTRODUCTION TO PUBLIC FINANCING IN HEALTH CARE

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"When I use the word, it means just what I choose it to mean, neither more nor less."
– Humpty Dumpty

"If I were made ruler of the world, the first thing I would do would be to fix the meaning of words, because action follows definition."
– attributed to Confucius

Roles of the Public Sector in Health Care

In "Public and Private Roles in Health,"¹ Phillip Musgrove identifies five possible roles for the public sector in health care:

- Informing – examples include anti-smoking campaigns, provider quality reports, and effectiveness research
- Regulating – e.g. licensure, budget reviews, certificate of need
- Mandating – creating an obligation to perform a specific action, such as purchasing insurance
- Financing care – any of a wide variety of ways that care may be paid for, potentially including both the raising of funds and administrative activities associated with making payments
- Providing care – direct provision of care, such as the VA

This report will focus on the financing function, including a discussion of different ways to define public financing. It will also describe, using one definition, the current picture of public financing in Vermont.

Public Financing - Overview

There are at least six different types of spending that may be considered as public financing in Vermont. Some are quite obvious, and are usually what comes to mind when people think about public financing, while others are far more subtle. At a minimum, the definition can be based on how the money is raised, what it buys, who is responsible for how it is spent, and on behalf of whom.

How the Money is Raised

The simplest definition of public funding is any funding that relies on tax revenue. While the vast majority of what is most often thought of as public spending does come from tax revenues, there are several areas where other sources of funds play a significant role.

The best example of this is Medicare. While Part A (primarily hospital inpatient care) is entirely financed by taxes, primarily payroll taxes, both Part B (hospital outpatient, physician) and Part D (prescription drugs) are more like private programs in two ways. First, about one-fourth of their money comes from premiums paid by beneficiaries. Second, enrollment in the program, and therefore premium payment, is voluntary.

¹ "Public and Private Roles in Health: Theory and Financing" Musgrove P; World Bank Discussion Paper 339, 1996

Because of this, we may expand our definition of public dollars to include both tax revenues and non-tax revenues paid to public entities. In the reporting of Medicare and Medicaid revenue and spending below, premiums will be treated as public dollars.

What about tax financing of private health insurance premiums, either in the case of subsidies such as Catamount Health, or for public employees? This spending is not always thought of as public spending, but will be included in this report.

What it Buys - Purchasing Care

The most obvious type of public financing is the use of public funds to pay for care received by a specified population, such as the Medicare or Medicaid programs. Remember, in this report public funds include both tax revenues and premiums paid by individuals to public entities.

While the Medicare and Medicaid programs are the most well-known example of the use of public funds to pay for care, this is also the case for many public employees, when their employers self-insure, rather than buying health insurance. Self-insurance means that the employer assumes the risk that would otherwise be transferred to the insurer, and pays providers directly for services. For example, the State of Vermont self-insures health care costs for its employees and retirees and their families, so when a state employee receives a health service, the state, rather than an insurance company pays for that service (although Cigna, an insurance company, provides administrative services).

Public entities also purchase (or provide) care for other people, such as individuals currently in the military, individuals who have retired from the military, and individuals in custody.

What it Buys - Purchasing Insurance

The second type of public financing is the partial or complete payment of premiums to private insurers. There are a number of examples of this in Vermont, including the premium assistance component of Catamount Health and the employer-sponsored insurance (ESI) programs in both Catamount and VHAP. The original VHAP waiver, under which the Medicaid program paid premiums to private insurers on behalf of many beneficiaries, was also an example of this approach.

Nationally, the most significant example of premium payment with public funds is the Medicare Advantage (MA) program. Under this program, CMS (the Centers for Medicare and Medicaid Services, the federal agency that regulates Medicare) pays premiums to private insurers on behalf of Medicare beneficiaries who chose this coverage option. There are several different types of MA plans, including private fee-for-service and HSA models.

Use of the premium payment model is popular because the risk (uncertainty about actual costs) is transferred from the public entity to the insurer. Further, some believe that the private sector does a better job of managing costs than the public sector, while others believe that this approach costs more than direct payment for care.

What it Buys - Public Health Spending

There are many different activities that are included in public health, including health promotion, protection (such as restaurant licensing), and surveillance. While very important, this type of spending will not be included in this report.

What it Buys - Grants

Governments make many different types of grants to health care providers to support the development and maintenance of an adequate health care system. For example, the Hill-Burton program during the 1950s provided grants to encourage the construction of hospitals. Currently, several federally-qualified health centers (FQHCs) in Vermont receive grant funds. The federal government also provides enormous support for health care research. This type of spending will not be included in this report.

In contrast to these categories, which involve direct payments from public entities, the next two are quite different.

What it Buys - Foregone Tax Revenues

Most people think about public spending as dollars flowing from the government. Another financial aspect of government that can be thought of as spending is the non-collection of taxes, also known as tax expenditures. Is there a significant difference between the government giving me \$100 and the government reducing my tax liability by \$100?

The volume of foregone tax revenues associated with health care is enormous. Two analysts have estimated that the federal government foregoes nearly \$200 billion² per year (2004) as a result of several different exemptions and caps. Two other analysts estimated foregone revenue at \$210 billion for both the federal and state governments in 2002³. For comparison, in 2002 the federal government spent \$187 billion on Medicare.

Between half and three-quarters of foregone revenue results from the exemption of the employer's share of health insurance from taxation as income. Here's how this works. Suppose your marginal tax rate (the rate you pay on the next dollar of income) is 15%. If your employer gives you an additional \$5,000 in wages, even if you use that money to buy health insurance⁴, the federal government would collect \$750 in income taxes. However, if your employer spends the same \$5,000 toward health insurance for you, the government collects nothing. This form of "spending" is a critical incentive for the employer-sponsored health insurance model.

² Shiels J and Haught R; "The Cost of Tax-Exempt Health Benefits in 2004" [Health Affairs](#), web exclusive, February, 2004

³ Selden TM and Sing M; "The Distribution of Public Spending for Health Care in the United States, 2002" [Health Affairs](#), web exclusive, July, 2008

⁴ The exception to this is if your employer has a Section 125, or "cafeteria" plan set up under IRS rules. This plan permits you to tax-shelter your spending on health care, including premiums.

What it Buys - Cross-Subsidies

Perhaps the most contentious area of public financing is cross-subsidy, or cost-shifting. The phenomenon of different purchasers paying different amounts for the same product or service is common across the economy. For example, the amount different passengers pay for their airline tickets on the same flight varies enormously.

This is a major issue in health care. While the exact amounts are often in dispute, there is general agreement that public payers (Medicare and Medicaid) pay substantially less than private payers, and often pay less than the estimated cost to produce the service.

According to an analysis by the Vermont Department of Banking, Insurance, Securities and Health Care Administration, within the \$1.7 billion of revenues received by Vermont hospitals and hospital-based physicians, approximately \$186 million was shifted from public to private payers in Vermont hospitals in 2008 (based on submitted budgets)⁵. Another \$48 million was shifted onto private payers as a result of bad debt and free care.

The simplest way to think about these numbers is that public payers reimbursed hospitals \$186 million less than they would have if all payers paid the same amount for the same service and private payers (primarily health insurers and self-insured employers, but also including those patients who pay their bills directly). How should this amount be incorporated into our estimates of public expenditures?

There is no correct answer to this question. One helpful way to think about it is tied to how you think about who pays for employer-sponsored health insurance. Many economists believe that employer payments for health insurance are not separate from payments for wages and salaries; health insurance payments are just wages, taken in a different form.

If that is the case, households pay for all health care, and discussions about cost shifting are really discussions about how much we pay from the wage pocket and how much we pay from the tax pocket. This balance has enormous implications for individuals, but has a minimal effect on total health care spending.

Since the \$186 million comes from the wage pocket, we can call it private spending. However, it can also be thought of as a hidden tax.

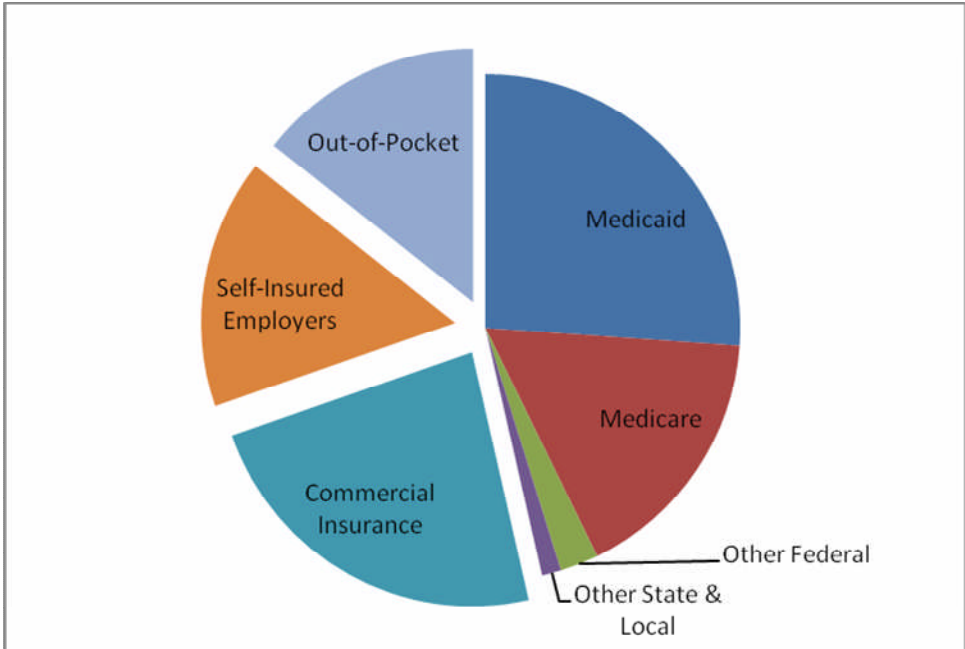
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http://www.bishca.state.vt.us/HcaDiv/Data_Reports/legislative_reports/2008CostShiftAnalysis.pdf

Public Financing – The Current Situation

Unless otherwise indicated, all figures in this section are for 2004. Unfortunately, more timely data are not available from the federal government. According to the annual “Vermont Expenditure Analysis” (EA), published by the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA), just under \$3.3 billion was spent for health care for Vermont residents in 2004. BISHCA projects that spending will increase to \$4.6 billion in 2008 and \$5.3 billion in 2010. Note that these figures include care provided in other states to Vermont residents and excludes care provided in Vermont to residents of other states.

The EA reports spending in two ways: the type of provider who received the payment and the type of entity that made the payment to the provider. The EA classifies payments based on the final transaction, not the source of funds, so payments on behalf of public employees are classified as self-insured or commercial insurance.



Medicaid

Medicaid in Vermont is funded approximately 60 percent by the federal government and about 40 percent by the state (with some local education funding included). State funds came from a wide variety of sources, including the general fund, taxes on health care providers, cigarette and tobacco taxes, the national tobacco settlement, and beneficiary premiums.

Medicaid was responsible for over one-fourth (26%) of all health care payments for Vermont residents in 2004.

Medicare

In 2004, Vermont employers and employees (including the self-employed) paid about \$346 million in payroll taxes to support the Medicare Part A trust fund. Current Medicare beneficiaries paid about \$71 million in Medicare Part B premiums. However, in another example of the complexity of health care financing, a substantial portion of that was actually paid by the federal government and Vermont, because many low-income Medicare beneficiaries are also eligible for full or partial coverage under the Medicaid program.

Medicare made payments of \$545 million on behalf of Vermont residents in 2004, just under 17 percent of total spending.

Other State and Local

The Expenditure Analysis identifies \$120 million (3.6 percent of the total) as other federal, state, and local spending. The largest portion of this, over \$60 million, is the Veterans Administration hospital. Other major components include the Vermont State Hospital and the Department of Health.

Public Expenditures – Estimate 1

If we define public expenditures as the purchase or provision of care by these government programs, public dollars accounted for about **46 percent of all health care spending** on behalf of Vermont residents in 2004.

Health Insurance Coverage – Public Employees

In 2004, an estimated \$300 million was spent on providing health insurance to public employees. This figure includes employees of the federal government working in Vermont, state employees, employees of the Vermont State College system, and school and municipal employees. This figure includes both employer and employee contributions.

Estimate 2

This figure represents about 9.2 percent of all health care spending on behalf of Vermont residents. Adding this to the 46 percent paid directly by federal, state, and local governments results in about **55 percent of all health care spending** being publically financed.

Foregone Tax Revenues

This is the most difficult figure to estimate. All published estimates are national figures. Using Shiels' 2002 figure of \$215 billion for foregone federal and state tax revenue, we can inflate that by 3 percent per year to get to 2004. Vermont's population is about 0.2 percent of the US population. If we take 0.2 percent of the 2004 figure, the federal and state governments would have foregone about \$445 million in Vermont. This is equivalent to 13.6 percent of health care spending on behalf of Vermont residents.

Conclusion

There are several different ways to define public spending. Using the most common definition (government programs such as Medicare and Medicaid, and direct

government provision of services, such as the VA), public spending accounts for about 46 percent of health care spending on behalf of Vermont residents.

If the costs of providing health insurance to public sector employees (including both employer and employee share) are included, public spending in Vermont accounts for about 55 percent of the total.