The Distribution of Public Spending for Health Care in the United States in 2010

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Public spending on health care can take many forms, including: Medicaid, Medicare and other forms of public insurance; public tax subsidies for private insurance; other provider payments; and spending on public health. In this paper we use data from the Medical Expenditure Panel Survey to examine the amount and "benefit incidence" of public spending by program category across socioeconomic groups defined by age, poverty level, and more.

Prior research using the 2002 MEPS found that public health care spending on behalf of the civilian, non-institutionalized population was $752.9 billion in 2002, representing 56.1 percent of total (public and private) spending. Whereas means-tested benefits, such as Medicaid coverage, are heavily tilted toward lower-income groups, the overall incidence of public spending is substantially less progressive.

Since 2002, there have been several notable changes in public spending. Medicare Part D prescription drug coverage was implemented in 2006, and as a result Medicare prescription drug spending increased from $3.9 billion in 2005 to $45.9 billion in 2007. In addition, increases in (subsidy-eligible) private insurance premiums out-paced inflation. Between 2002 and 2010, the average premium for single coverage rose from $3,189 to $4,940, and the average premium for family coverage rose from $8,469 to $13,871. In addition, numerous states expanded (means-tested) eligibility for public coverage, especially for parents and childless adults. For all of these reasons and more, we believe it is useful to conduct an updated benefit incidence analysis.

In our paper we apply the 2002 methodology (Selden and Sing, Health Affairs, 2008) to more recent data from the Medical Expenditure Panel Survey (MEPS), a household survey sponsored by the Agency for Healthcare Research and Quality (AHRQ). MEPS provides household-level data on medical spending for a range of public programs and a wide array of socio-economic characteristics and is therefore an ideal starting point for analyzing the distribution of public spending. However, no single data source provides all of the necessary components for a comprehensive analysis of the distribution of public spending. To account for public outlays that are missing or underreported in MEPS, we align and supplement MEPS with national benchmarks from the National Health Expenditure Accounts (NHEA) as well as tax simulations from the National Bureau of Economic Research's TAXSIM model and employer-sponsored premium estimates from the MEPS Insurance Component survey of establishments. We focus on 2010 the most recent year for which MEPS is available. The paper is based on a reconciliation of medical expenditures from the MEPS and NHEA for 2007 (Bernard, Cowan, Selden , Cai, Catlin and Heffler, 2012) the most recent year for which Economic Census data supports a detailed alignment between MEPS and the National Health Expenditure Accounts.

Following the previous study, we examine the distribution of public spending by age, sex, race/ethnicity, health status, poverty level and insurance coverage. Furthermore, we extend the literature by examine the distribution of public spending by wealth and medical conditions. Our study can help policymakers prioritize among different sectors of health care by identifying subpopulations that benefit the most from public spending prior to the full implementation of the Affordable Care Act in 2014.