Medical Expenditure Panel Survey

Agency for Healthcare Research and Quality

STATISTICAL BRIEF #465

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Trends in National Health Care Expenses in the U.S. Civilian Noninstitutionalized Population, Percentages by Type of Service and Source of Payment Within Age and Insurance Groups, 1996-2012

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Introduction

This Statistical Brief presents estimates of percentages of health care spending by type of service and distributions by payment sources within age and insurance groups for the U.S. civilian noninstitutionalized population from 1996 to 2012.

Health care expenses, as reported in this Brief, represent payments to hospitals, physicians, and other health care providers based on health care use information collected in the Medical Expenditure Panel Survey (MEPS) Household Component and payment data collected in both the MEPS Household and Medical Provider Components. Expense estimates include amounts paid by individuals, private insurance, Medicare, Medicaid and the Children's Health Insurance Program (CHIP), and other payment sources. All differences between estimates discussed in the text are statistically significant at the 0.05 level.

Findings

In 1996, there was an estimated total of $548.045 million paid for health care received by the U.S. civilian noninstitutionalized population distributed among various health care use service categories including hospital inpatient and outpatient care, emergency room services, office-based medical provider services, dental services, home health care, prescription medicines, and other medical services and equipment. In 2012, total expenses on health care increased to an estimated total of $1.351 trillion. Among the population under age 65, expenses for prescribed medicines comprised about one-tenth of total expenses in 1996 (11.5 percent) and increased to about one-fifth in 2012 (21.9 percent) (figure 1). However, while 36.6 percent of total expenses were attributable to hospital inpatient expenses (including both facility and separately billed physician services) in 1996, this percentage dropped to 28.7 in 2012. The proportion of expenses for ambulatory care provided in office-based settings, hospital outpatient departments, and emergency rooms was similar when comparing the two years (36.9 and 38.5 percent, respectively).

Among the elderly, the proportion of expenses for hospital inpatient services decreased from 43.2 percent in 1996 to 33.8 percent in 2012 (figure 2). Conversely, the proportion spent on prescribed medicines nearly doubled (rising from 12.7 to 21.3 percent) and the proportion spent on ambulatory care increased from 23.4 to 29.8 percent.

Highlights

- Among persons age 65 and older, the proportion of total expenditures spent on prescription medicines and ambulatory care increased while the proportion spent on hospital inpatient care decreased when comparing 1996 with 2012.
- Among the elderly, the proportion of their health care spending paid by Medicare increased while the proportion paid by private insurance/TRICARE decreased when comparing 1996 with 2012.
- Among those under age 65 and those age 65 and older, the proportion of health care spending for prescription medicines nearly doubled when comparing 1996 with 2012.
- When comparing 1996 with 2012, for those under age 65, the proportion of their health care spending on hospital inpatient services decreased while the proportion spent on prescribed medicines increased.

When comparing 1996 with 2012 for those under age 65, the percentage of total health care expenses paid out of pocket decreased (18.9 versus 14.7 percent), and the percentage paid by Medicare (3.6 and 7.8 percent) increased (figure 3). The percentages paid by private insurance/TRICARE® and by Medicaid did not change significantly when comparing the years 1996 and 2012 (57.5 versus 54.8 percent and 10.9 versus 13.4 percent, respectively).

When comparing 1996 with 2012 for the elderly, the percentage paid by Medicare increased from 56.6 to 61.3 percent (figure 4). Conversely, the percentage paid by private insurance/TRICARE decreased (18.8 versus 15.5 percent). The percentage paid by Medicaid was about 4 percent each year (4.0 and 4.1 percent), and the percentage

paid out of pocket was also not significantly different when comparing 1996 and 2012 (15.3 versus 12.8 percent). With the implementation of Medicare Part D in 2006, as expected, the percentage paid by Medicare increased when comparing 2005 (53.4 percent) with 2006 (60.9 percent). Moreover the percentages paid by private insurance/TRICARE (17.6 and 14.2 percent), out of pocket (17.1 and 15.2 percent) and by Medicaid (5.0 and 2.4 percent) decreased. When comparing 2006 with 2012, the percentage paid by Medicare (60.9 and 61.3 percent) and by private insurance/TRICARE , (14.2 and 15.5 percent) remained stable, while the percentage paid out of pocket decreased (15.2 and 12.8 percent) and the percentage paid by Medicaid increased slightly (2.4 and 4.1 percent).

Data Source

The estimates in this Statistical Brief are based upon data from the MEPS Full Year Consolidated Data Files for 1996-2012 (HC-012, HC-020, HC-028, HC-038, HC-050, HC-060, HC-070, HC-079, HC-089, HC-097, HC-105, HC-113, HC-121, HC-129, HC-138, HC-147, and HC-155).

Definitions

Expenditures
Expenditures include total direct payments from all sources to hospitals, physicians, home health providers (agency and paid independent providers), dental providers, other types of health care providers (e.g., physical therapists, chiropractors, optometrists, etc.), and pharmacies for services reported by respondents in the MEPS-HC. Expenditures for hospital-based services include those for both facility and separately billed physician services.

Sources of payment

- Out of pocket: This category includes expenses paid by the user or other family member.
- Private insurance: This category includes payments made by insurance plans covering hospital and medical care (excluding payments from Medicare, Medicaid, and other public sources). Payments from Medigap plans or TRICARE (Armed Forces-related coverage) are included.
- Medicare: Medicare is a federally financed health insurance plan for persons age 65 and older, persons receiving Social Security disability payments, and persons with end-stage renal disease. Medicare Part A, which provides hospital insurance, is automatically given to those who are eligible for Social Security. Medicare Part B provides supplementary medical insurance that pays for medical expenses and can be purchased for a monthly premium. Medicare Part D provides optional coverage for prescribed medicines.
- Medicaid/CHIP: Medicaid and CHIP are means-tested government programs jointly financed by federal and state funds that provide health care to those who are eligible. Medicaid is designed to provide health coverage to families and individuals who are unable to afford necessary medical care while CHIP provides coverage to additional low income children not eligible for Medicaid. Eligibility criteria for both programs vary significantly by state.
- Other sources: This category includes payments from the Department of Veterans Affairs (except TRICARE); other federal sources (Indian Health Service, military treatment facilities, and other care provided by the Federal government); various state and local sources (community and neighborhood clinics, state and local health departments, and state programs other than Medicaid/CHIP); Workers' Compensation; various unclassified sources (e.g., automobile, homeowner's, or other liability insurance, and other miscellaneous or unknown sources); Medicaid/CHIP payments reported for persons who were not reported as enrolled in the Medicaid or CHIP programs at any time during the year; and private insurance payments reported for persons without any reported private health insurance coverage during the year.

Health insurance status
Individuals under age 65 were classified in the following three insurance categories, based on household responses to health insurance status questions:

- Any private health insurance: Individuals who, at any time during the year, had insurance that provides coverage for hospital and physician care (other than Medicare, Medicaid/CHIP, or other public hospital/physician coverage) were classified as having private insurance. Coverage by TRICARE (Armed Forces-related coverage) was also included as private health insurance. Insurance that provides coverage for a single service only, such as dental or vision coverage, was not included.
- Public coverage only: Individuals were considered to have public coverage only if they met both of the following criteria: 1) They were not covered by private insurance at any time during the year, and 2) they were covered by any of the following public programs at any point during the year: Medicare, Medicaid/CHIP, or other public hospital/physician coverage.
- Uninsured: The uninsured were defined as people not covered by private hospital/physician insurance, Medicare, TRICARE, Medicaid/CHIP, or other public hospital/physician programs at any time during the entire year or period of eligibility for the survey.

Individuals age 65 and older were classified into the following three insurance categories:

- Medicare and private insurance: This category includes persons classified as Medicare beneficiaries and covered by Medicare and a supplementary private policy.
- Medicare and other public insurance: This category includes persons classified as Medicare beneficiaries who met both of the following criteria: 1) They were not covered by private insurance at any point during the year, and 2) they were covered by one of the following public programs at any point during the year: Medicaid, other public hospital/physician coverage.
- Medicare only: This category includes persons classified as Medicare beneficiaries but not classified as Medicare and private insurance or as Medicare and other public insurance. This group includes persons who were enrolled in Medicare Advantage (Part C) and persons who had traditional Medicare fee-for-service coverage only.

About MEPS-HC

MEPS-HC is a nationally representative longitudinal survey that collects detailed information on health care utilization and expenditures, health insurance, and health status, as well as a wide variety of social, demographic, and economic characteristics for the U.S. civilian noninstitutionalized population. It is cosponsored by the Agency for Healthcare Research and Quality (AHRQ) and the National Center for Health Statistics.

MEPS expenditure data are derived from both the Medical Provider Component (MPC) and Household Component (HC). MPC data are generally used for hospital-based events (e.g., inpatient stays, emergency room visits, and outpatient department visits), prescribed medicine purchases, and home health agency care. Office-based physician care estimates use a mix of HC and MPC data while estimates for non-physician office visits, dental and vision services, other medical equipment and services, and independent provider home health care services are based on HC-provided data. Details on the estimation process can be found in Machlin, S.R. and Dougherty, D.D. *Overview of Methodology for Imputing Missing Expenditure Data in the Medical Expenditure Panel Survey*. Methodology Report No. 19. March 2007. Agency for Healthcare Research and Quality, Rockville, MD.
http://www.meps.ahrq.gov/mepsweb/data_files/publications/mr19/mr19.pdf

For more information about MEPS, call the MEPS information coordinator at AHRQ (301-427-1406) or visit the MEPS Web site at http://www.meps.ahrq.gov/.

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http://www.meps.ahrq.gov/mepsweb/data_files/publications/st465/stat465.pdf

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AHRQ welcomes questions and comments from readers of this publication who are interested in obtaining more information about access, cost, use, financing, and quality of health care in the United States. We also invite you to tell us how you are using this Statistical Brief and other MEPS data and tools and to share suggestions on how MEPS products might be enhanced to further meet your needs. Please email us at MEPSProjectDirector@ahrq.hhs.gov send a letter to the address below:

Steven B. Cohen, PhD, Director
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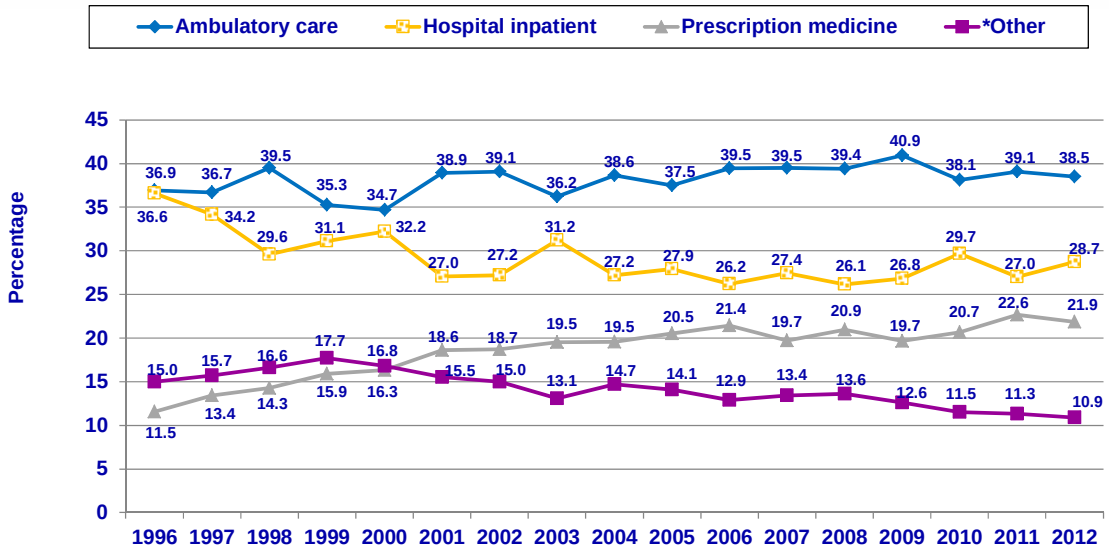
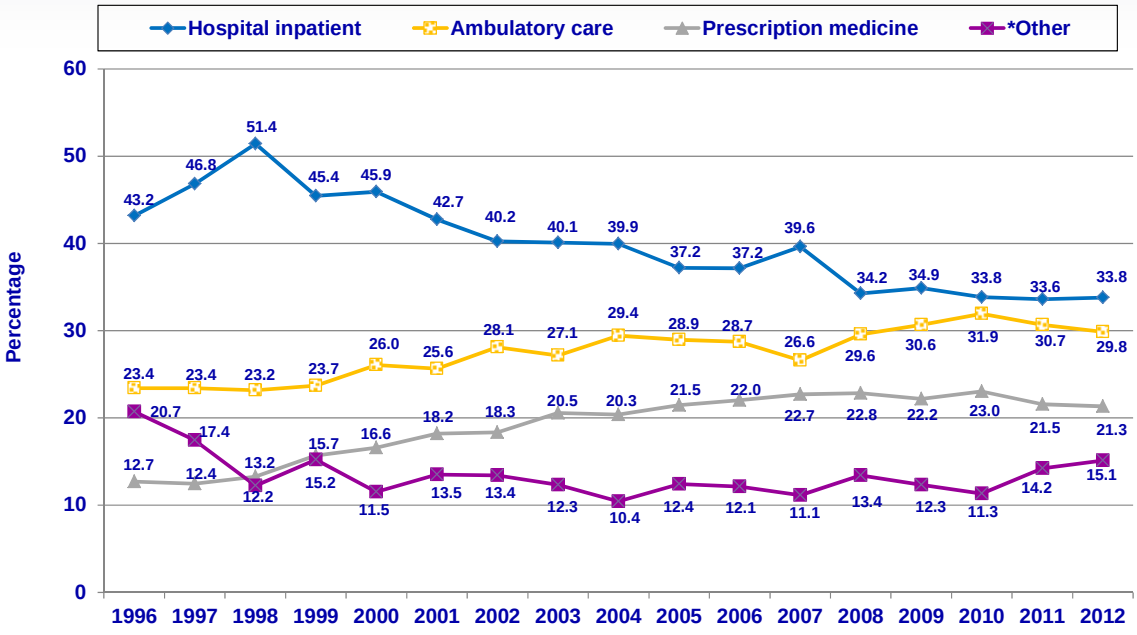
Agency for Healthcare Research and Quality
540 Gaither Road
Rockville, MD 20850

Figure 1. Annual percentage of total health care spending accounted for by specific services, persons under age 65, 1996–2012



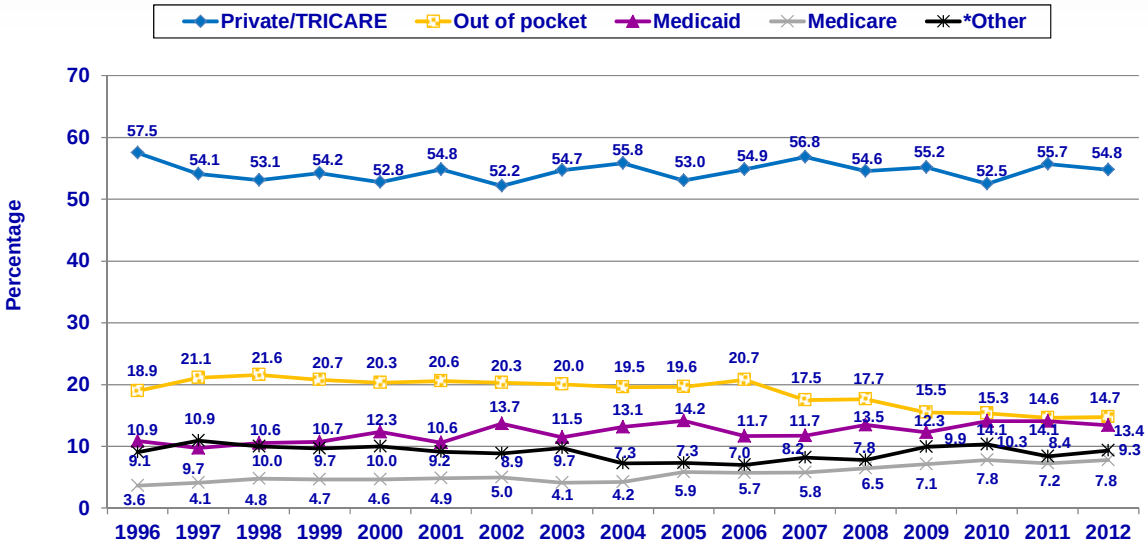
*Other includes dental services, home health care, and other medical services and equipment .
Source: Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey, 1996–2012 Full Year Consolidated Data Files

Figure 2. Annual percentage of total health care spending accounted for by specific services, persons age 65 and older, 1996–2012



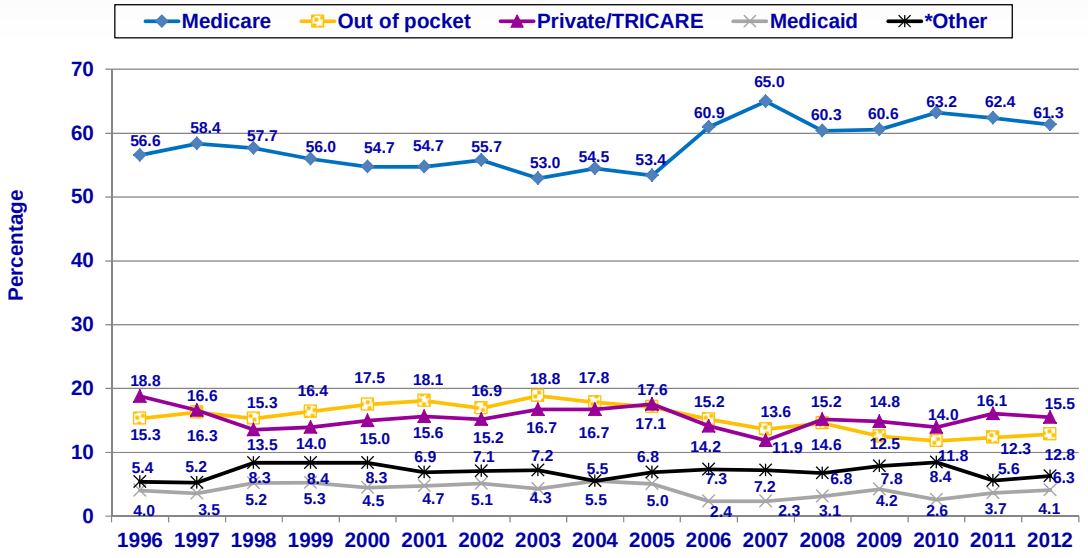
*Other includes dental services, home health care, and other medical services and equipment .
Source: Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey, 1996–2012 Full Year Consolidated Data Files

Figure 3. Annual percentage of total health care spending paid by specific sources, persons under age 65, 1996–2012



*Other includes dental services, home health care, and other medical services and equipment .
Source: Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey, 1996–2012 Full Year Consolidated Data Files

Figure 4. Annual percentage of total health care spending paid by specific sources, persons age 65 and older, 1996–2012



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