An Overview of the U.S. Health Care System Chart Book

Centers for Medicare and Medicaid Services

And

Office of the Assistant Secretary for Planning and Evaluation

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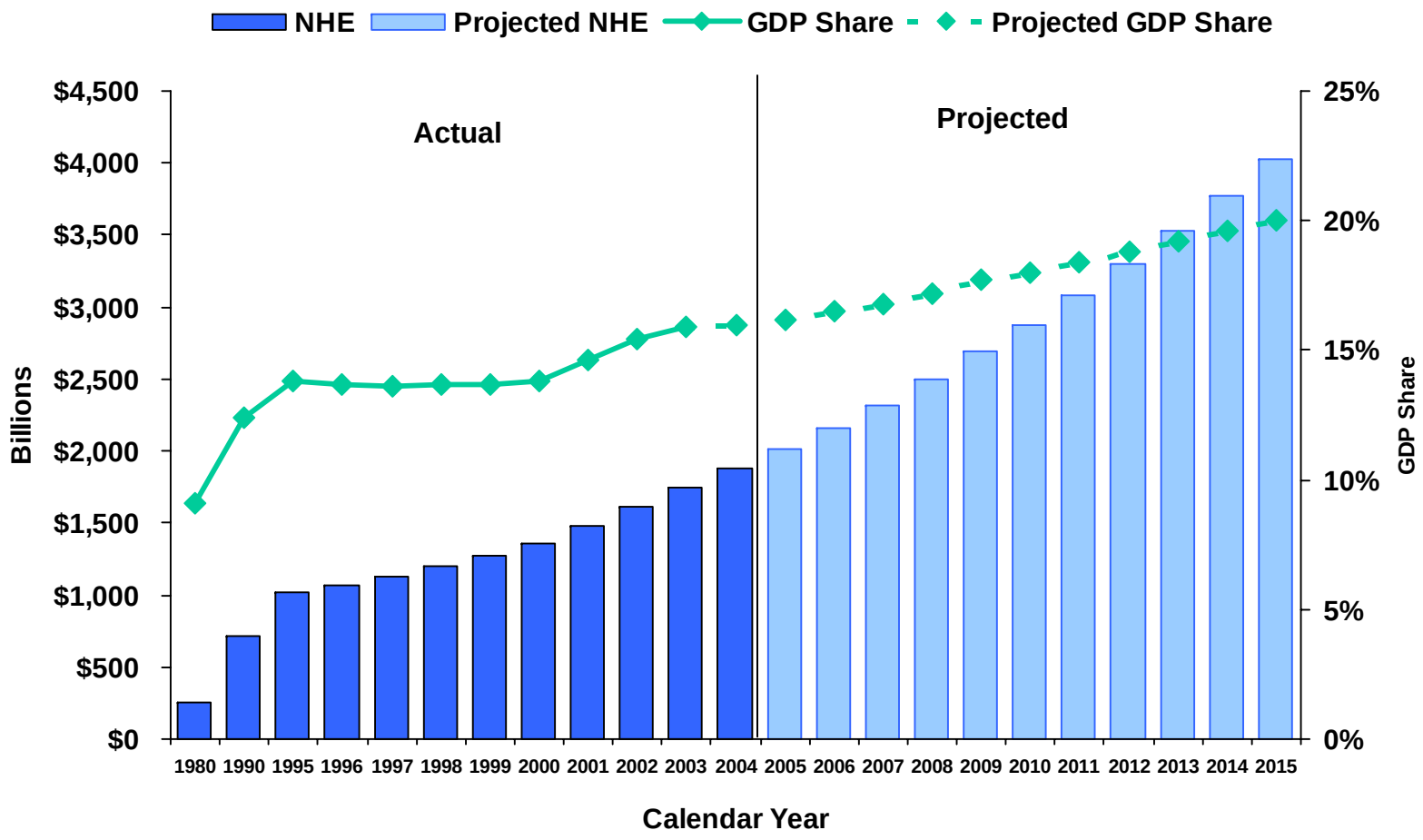
Section 1

Overview of the U.S. Health Care System

Table 1.1
National Health Expenditures and Their Share of Gross Domestic Product (GDP), 1980-2015

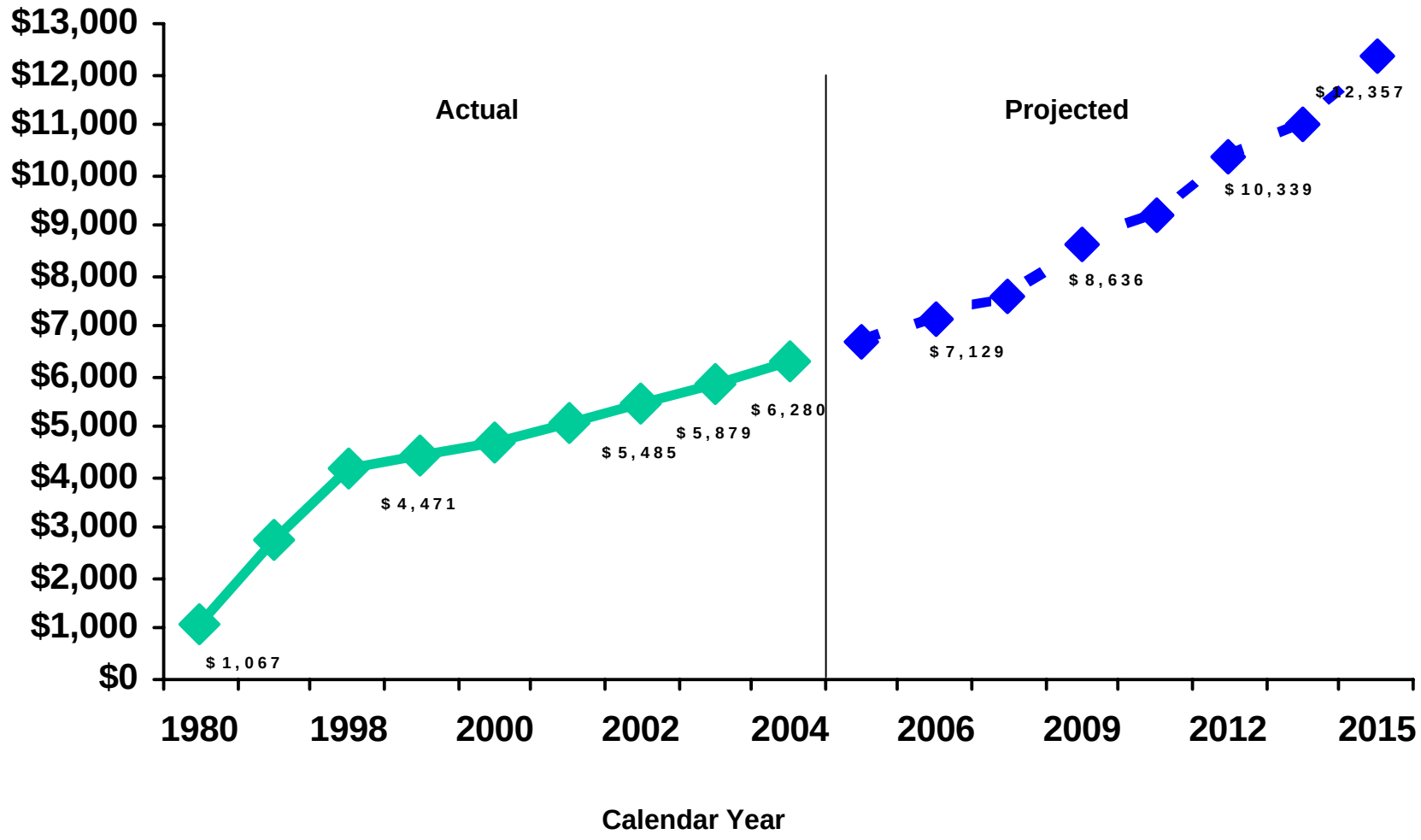
National health spending is projected to continue to increase as a share of GDP over the next decade.



Source: CMS, Office of the Actuary, National Health Statistics Group.

Table 1.2
National Health Expenditures Per Capita, 1980-2015

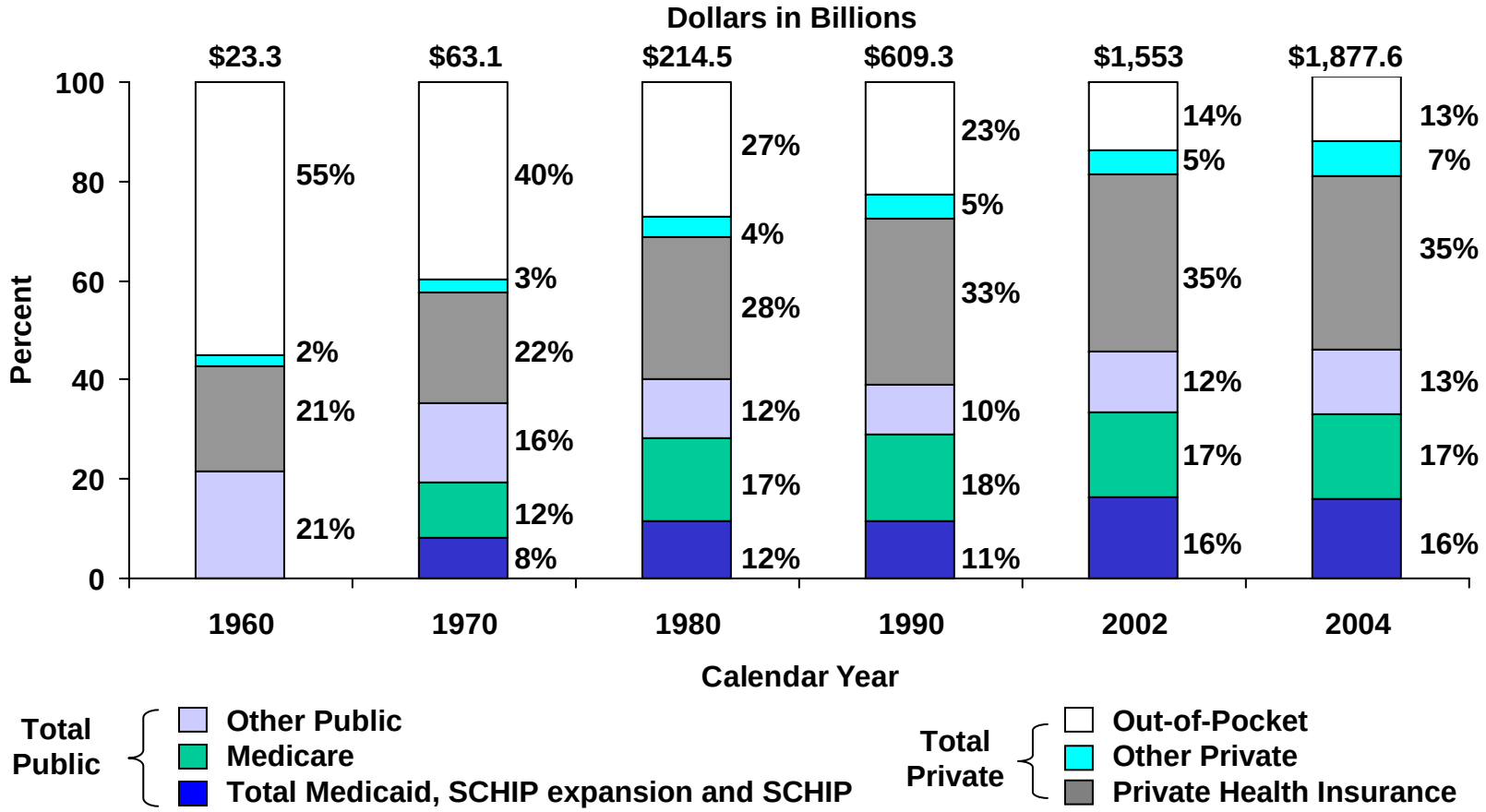
National health spending per capita is projected to increase rapidly over the next decade.



Source: CMS, Office of the Actuary, National Health Statistics Group.

Table 1.3
Personal Health Care Expenditures by Source of Funds: Selected Years 1960-2004

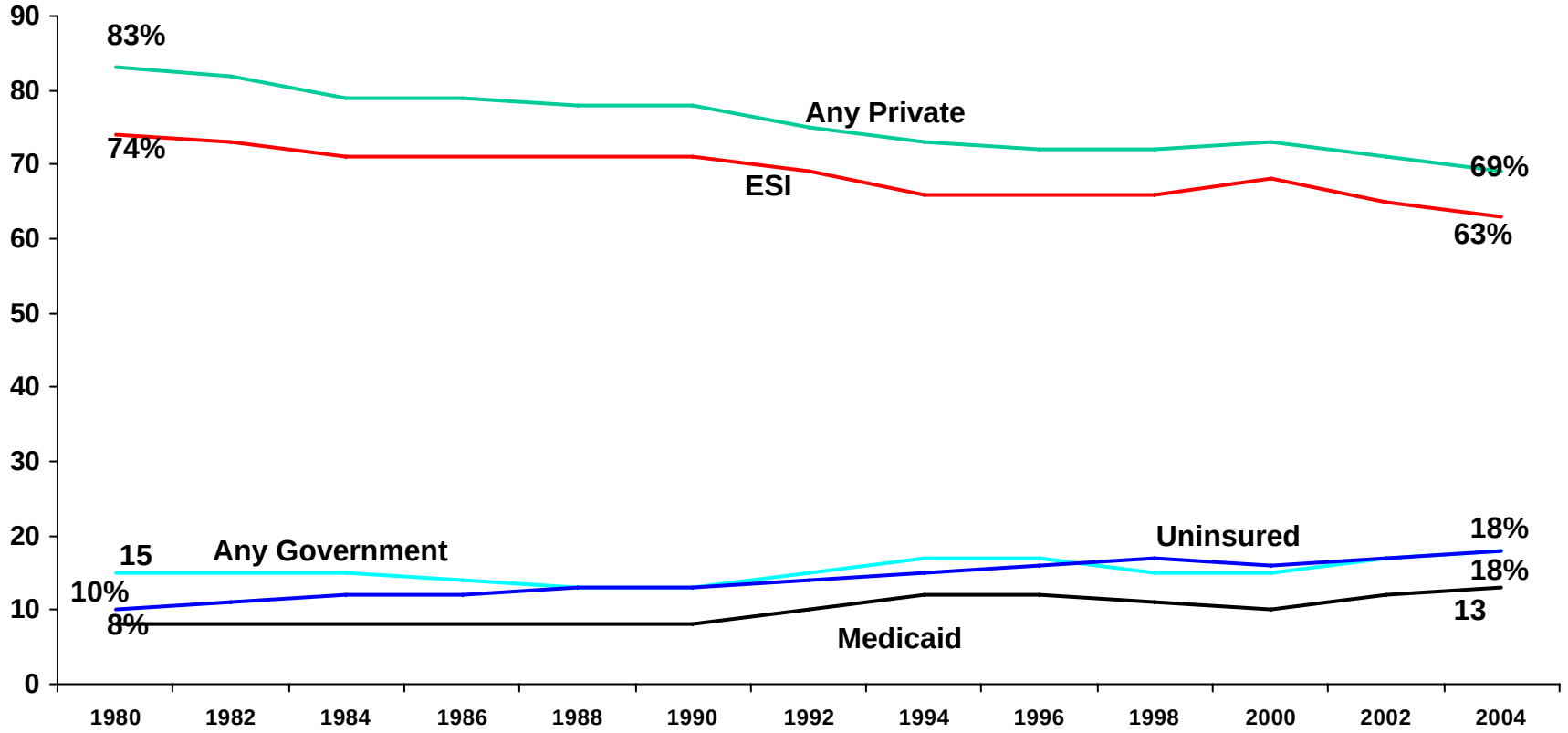
Over the last several decades, both the public and private sector share of health spending has increased, while the share from out-of-pocket spending has declined.



Source: CMS, Office of the Actuary, National Health Statistics Group.

Table 1.4
Health Insurance Coverage for the Under 65 Population, 1980-2004

Over the last two decades, private coverage has declined, public coverage (mostly Medicaid) has increased a small amount, and the uninsured have grown.

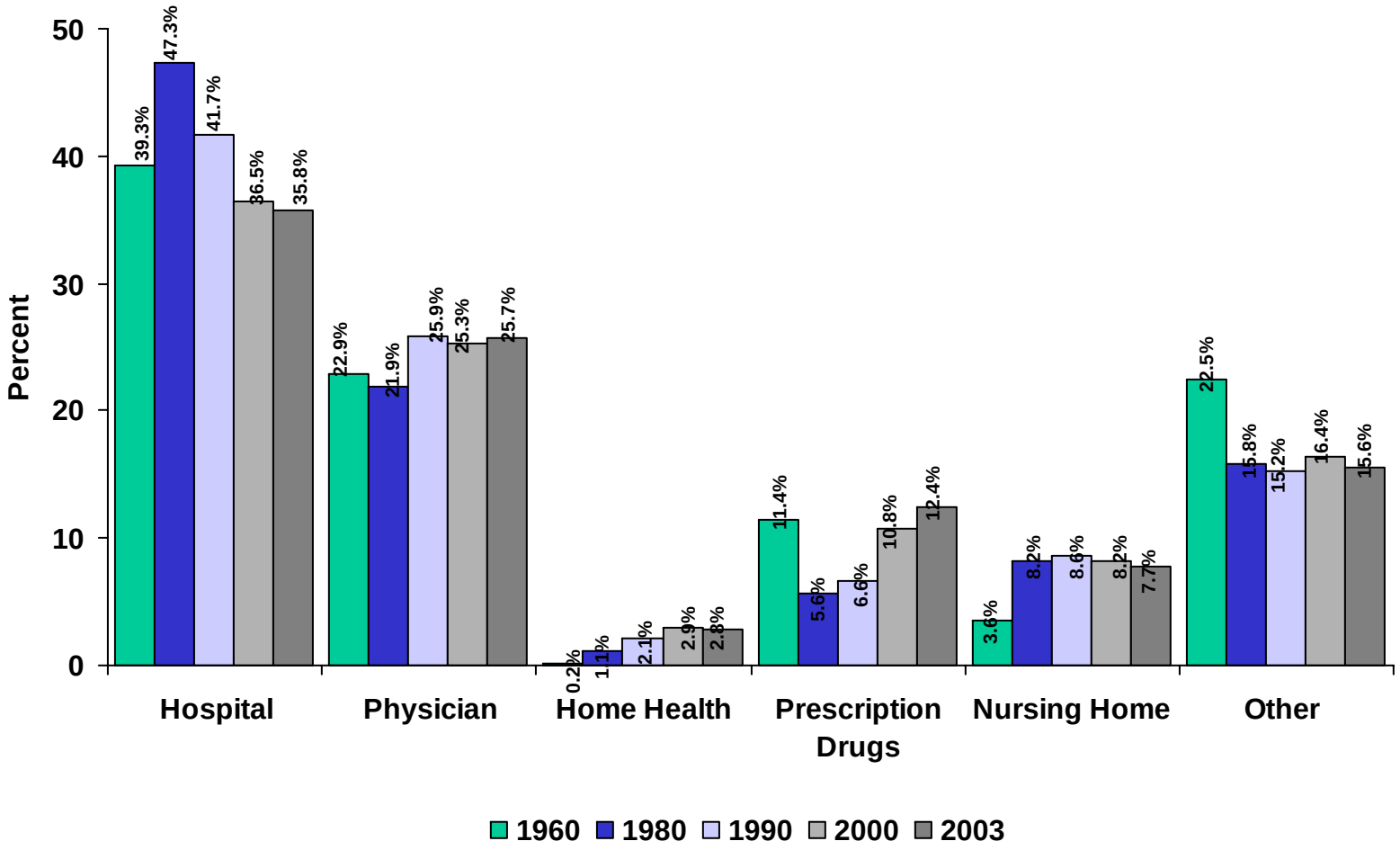


Notes: ESI - Employer Sponsored Insurance. Any Private includes ESI and individually purchased insurance. Any government includes Medicare for the disabled population.

Source: Tabulations of the March Current Population Survey files by Actuarial Research Corporation, incorporating their historical adjustments.

Table 1.5
Personal Health Care Expenditures by Type of Service, 1960-2003

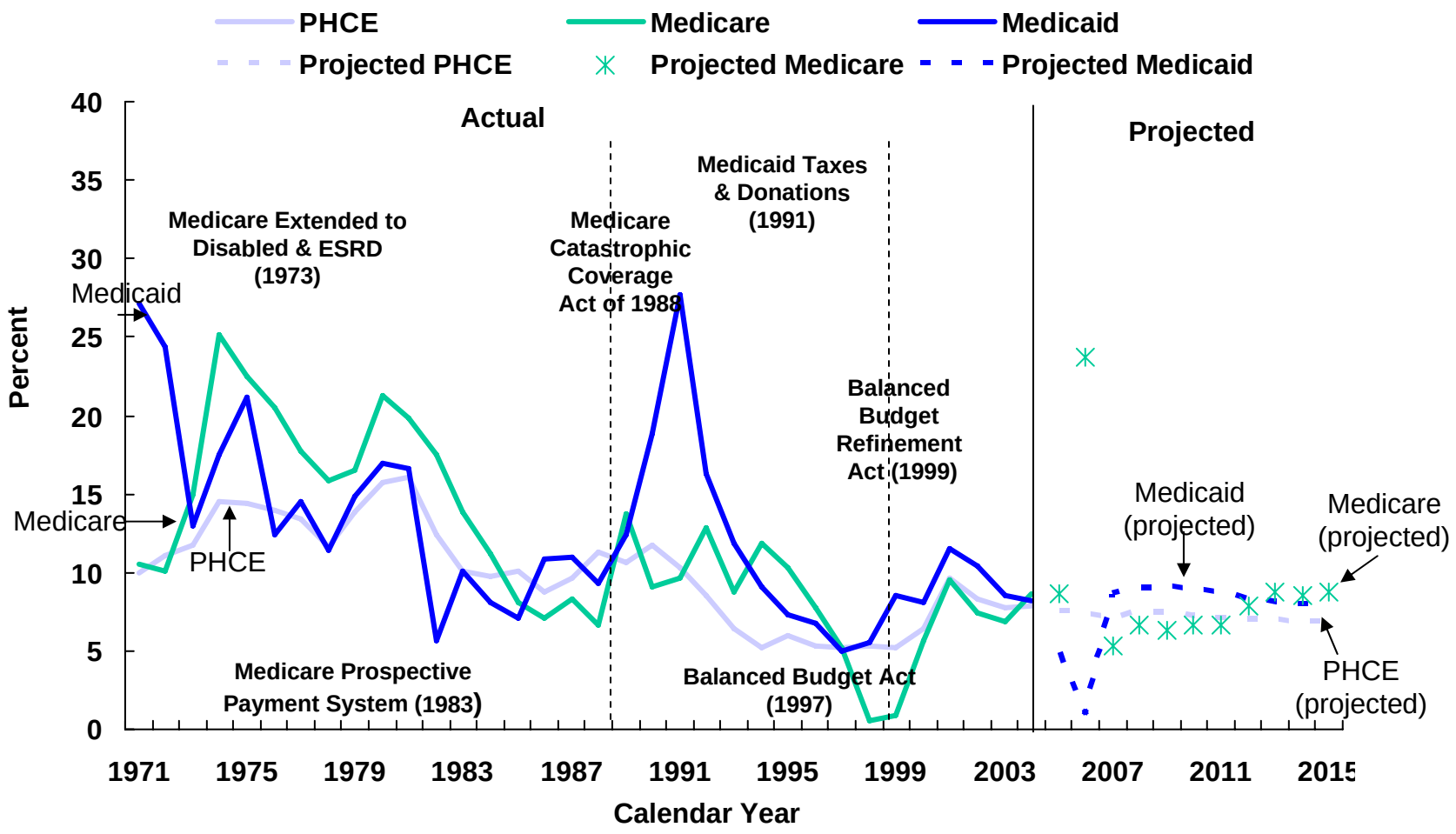
The share of health spending on prescription drugs has grown since 1980. Physician share has stayed about the same while the hospital share grew and then declined.



Source: CMS, Office of the Actuary, National Health Statistics Group.

Table 1.6
Annual Percent Change in Personal Health Care Expenditures for Medicare, Medicaid and Total: 1971-2015

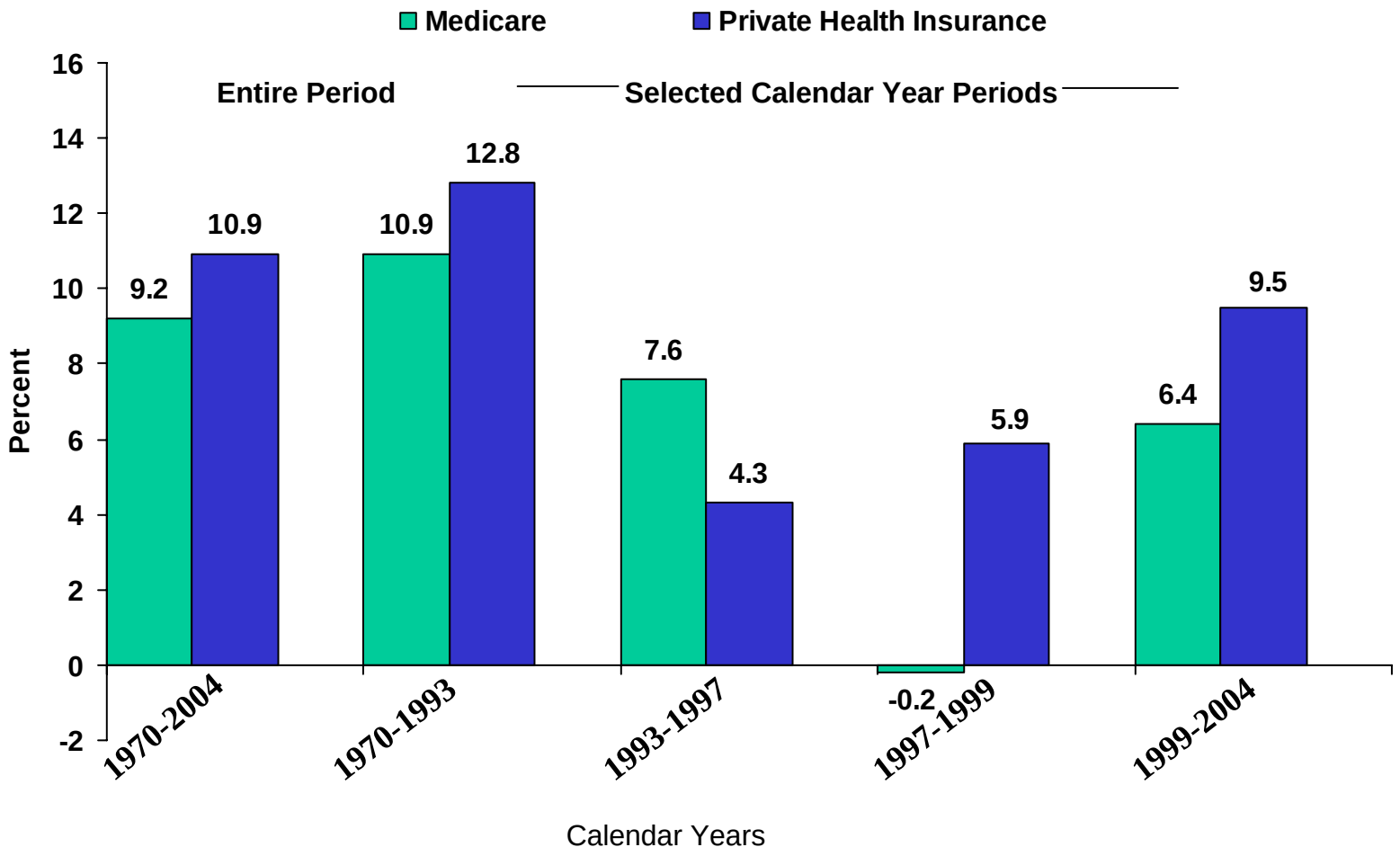
While the actual percent changes vary, overall spending for Medicare and Medicaid tend to rise and fall together.



Source: CMS, Office of the Actuary, National Health Statistics Group.

Table 1.7
Average Annual Growth in Medicare and Private Health Insurance Benefits Per Enrollee : Selected Periods

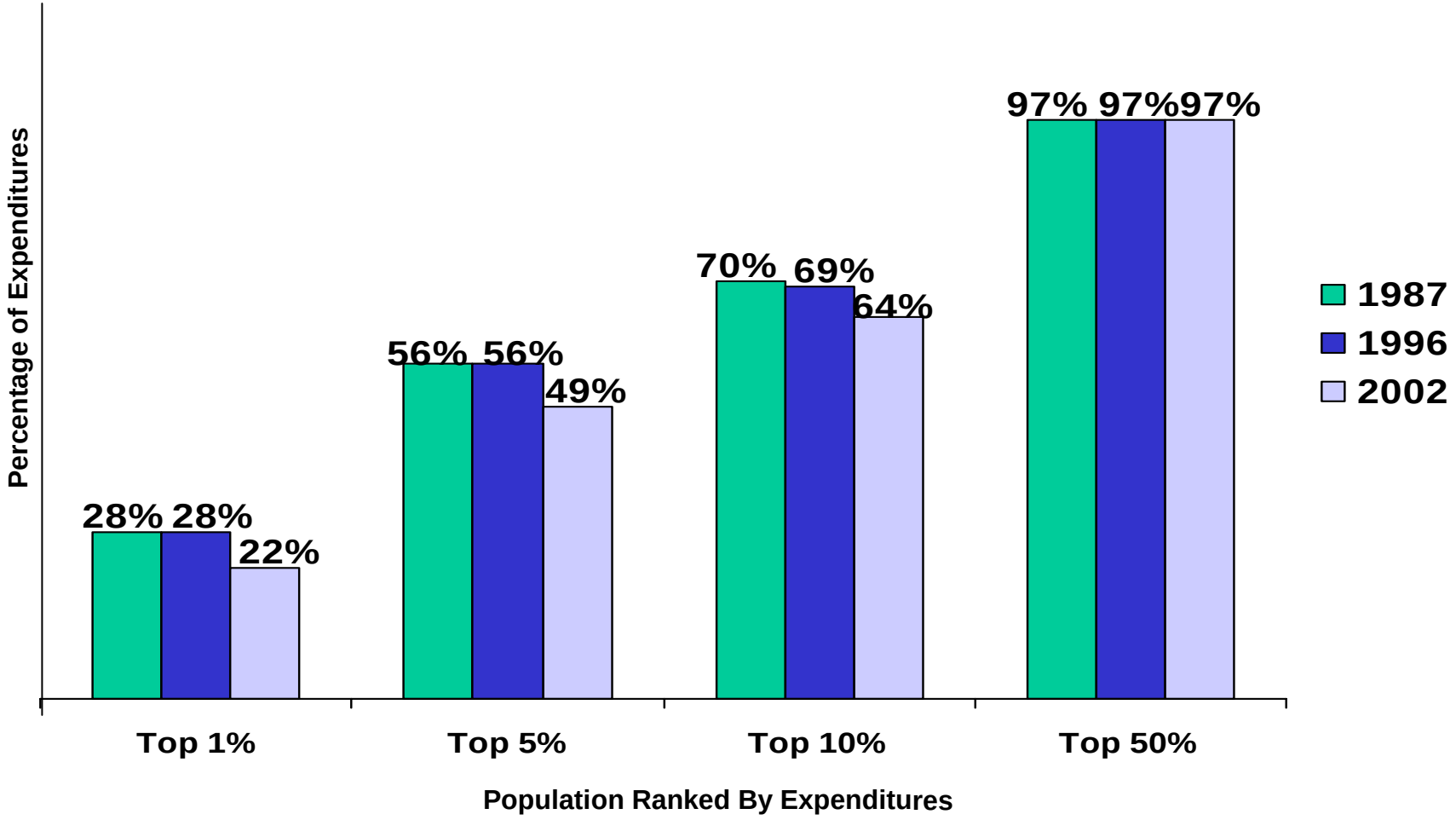
Except for 1993-1997, Medicare has grown slightly more slowly than private health insurance.



Source: CMS, Office of the Actuary, National Health Statistics Group.

Table 1.8
Concentration of Health Spending, 1987-2002

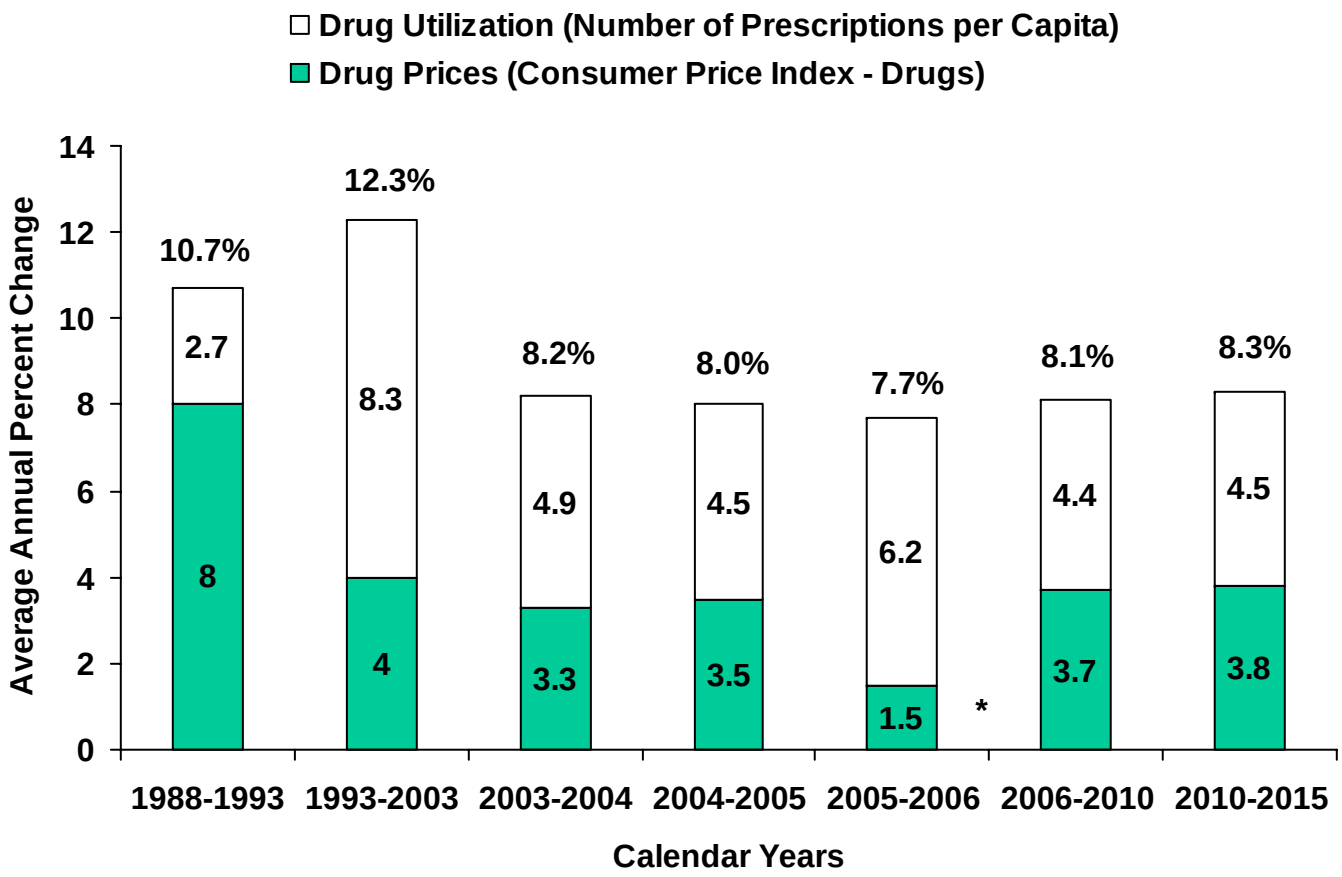
Health spending remains highly concentrated on a small percentage of people. The top 1% of people account about a quarter of all health spending,



Source: Yu, William W. & Trena M.Ezzati-Rice, Medical Expenditure Panel Survey Statistical Brief #81, AHRQ, May 2005.

Table 1.9
Factors Accounting for Growth in Prescription Drug Spending per Capita, 1980-2011

Drug Prices and Utilization significantly affect prescription drug spending per capita.

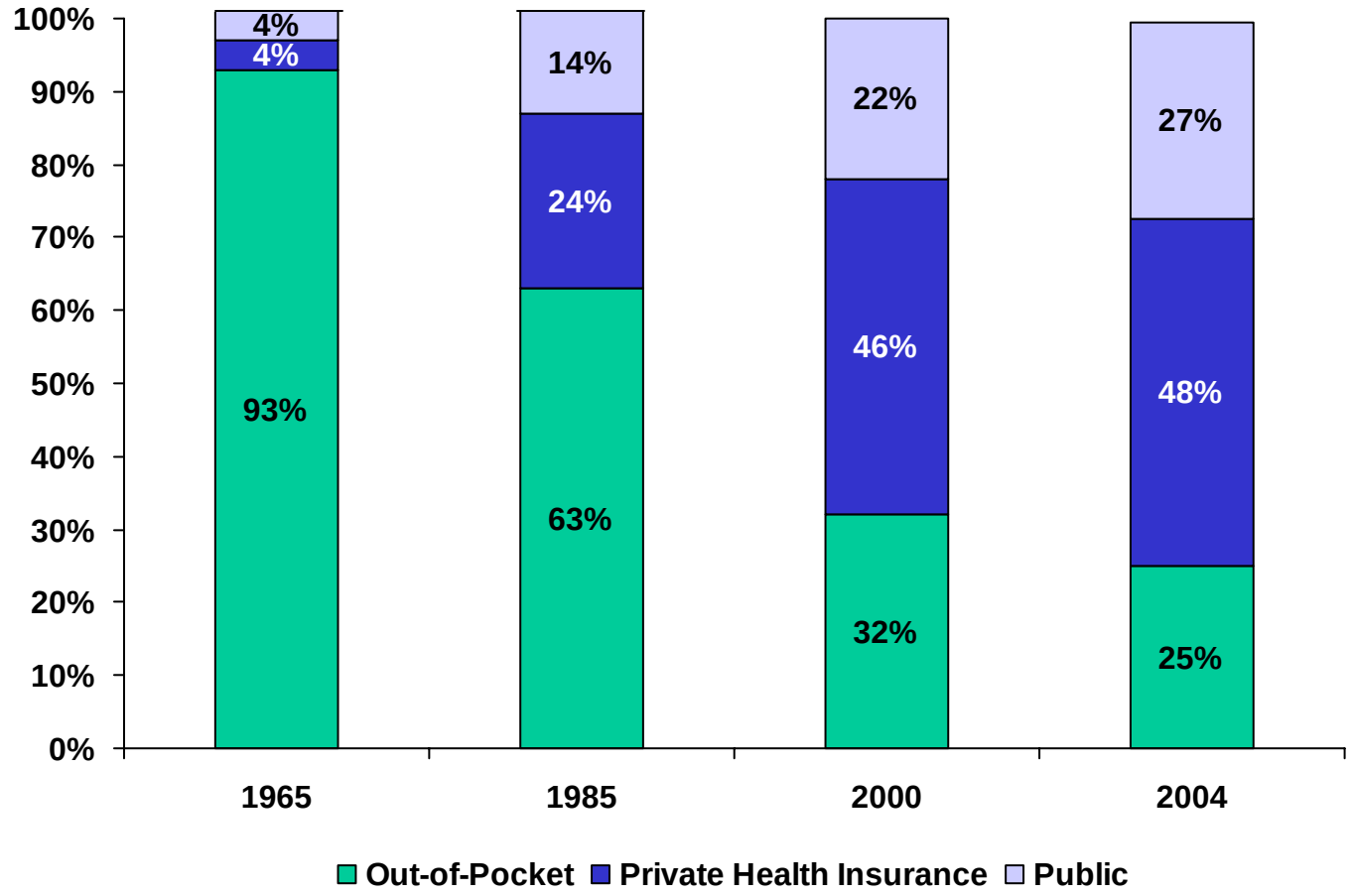


Note: Utilization also includes the effects of intensity and population growth. Per capita drug spending in 1990 was $252

* Without the effect of Part D, overall growth would be 8.1% (price: 3.8%, Utilization 4.3%)
Source: CMS, Office of the Actuary, Health Affairs Web Exclusive, Exhibit 6, pp. W70

Table 1.10
Prescription Drugs Expenditures by Source of Funds, 1965-2004

The share of drug spending covered by public and private sources has grown significantly.

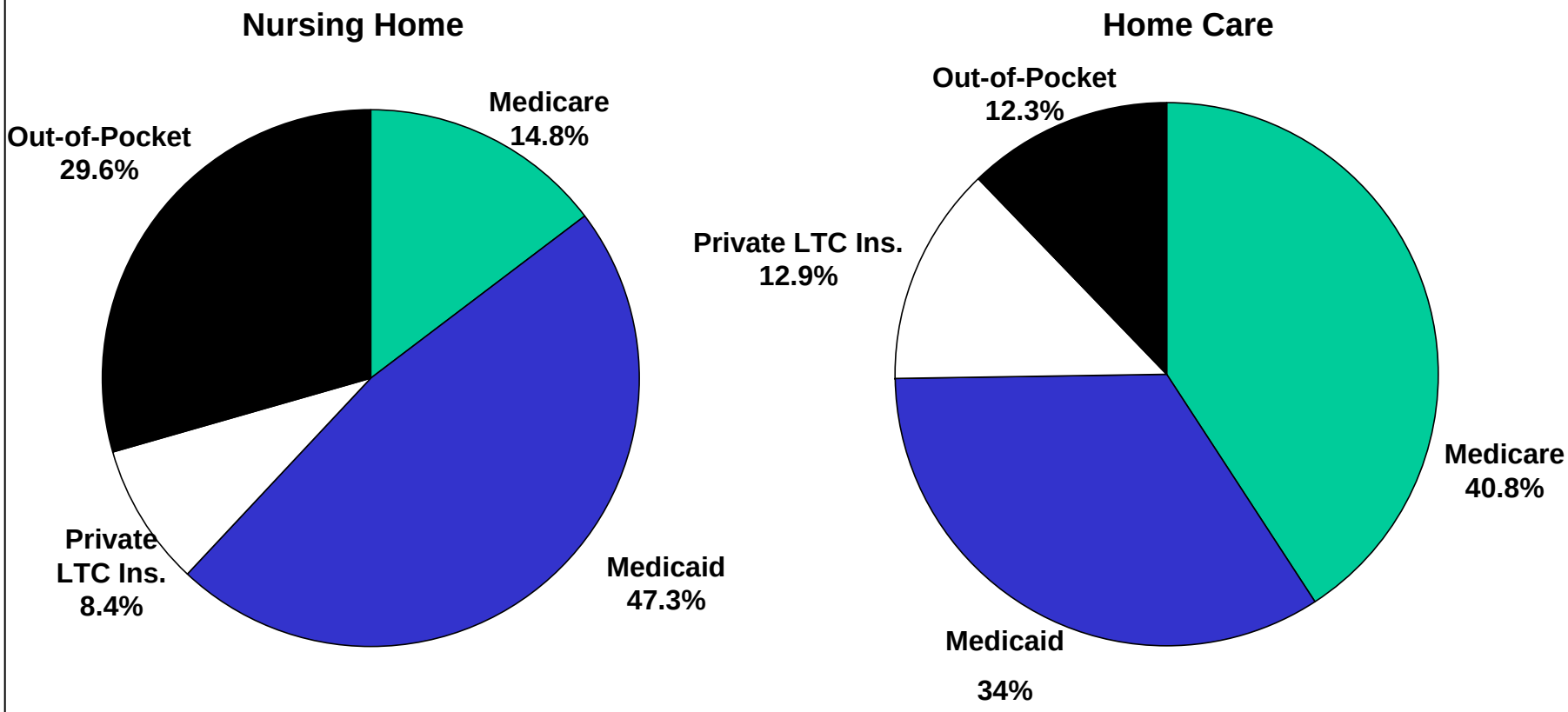


Note: Percentages may not sum to 100 due to rounding. Drug spending grew from $3.7 billion in 1965 to $188.5 billion in 2004

Source: CMS, Office of the Actuary, National Health Statistics Group.

Table 1.11
Sources of Payment for Nursing Home and Home Health Care, 2004

Most such care is paid for by Medicare and Medicaid.

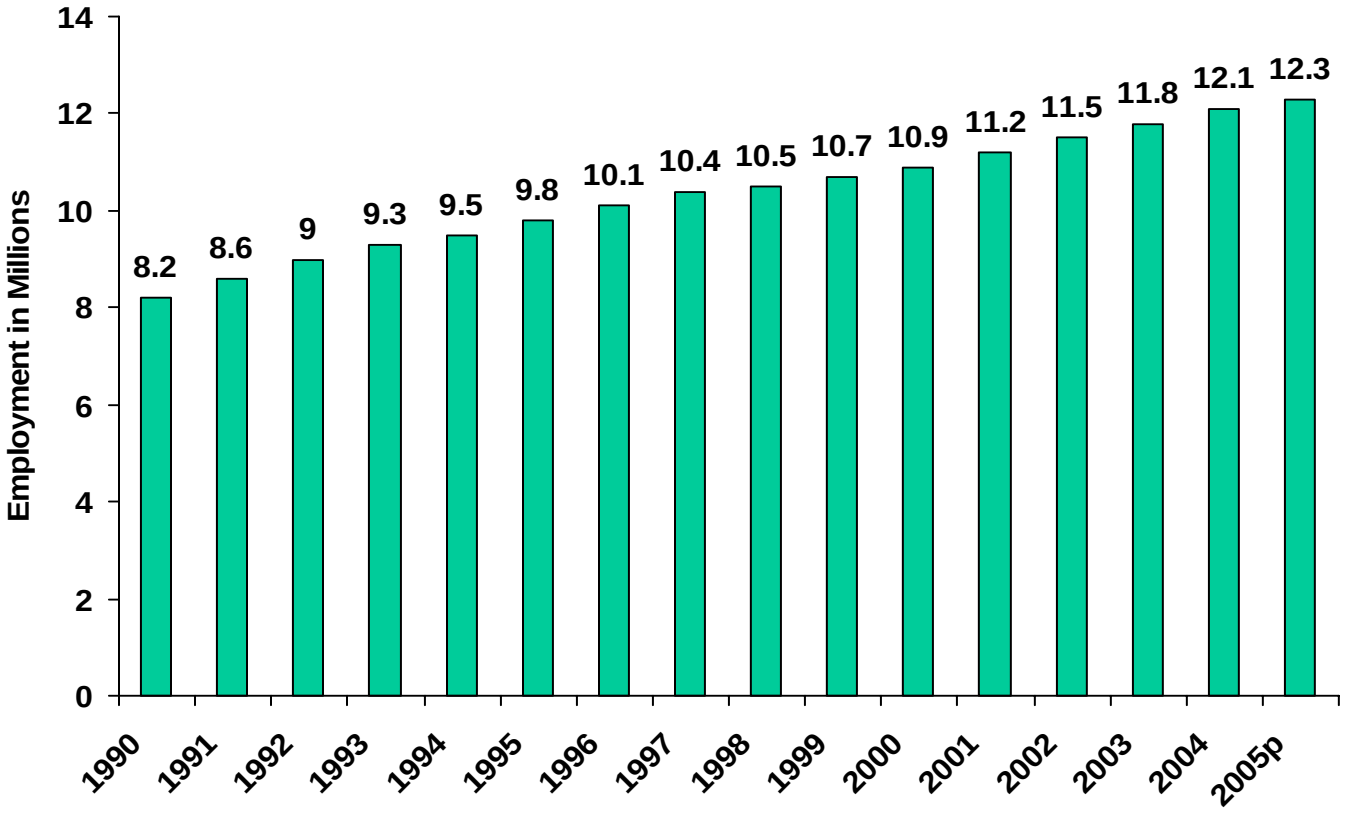


Total nursing home and home health care spending in 2004 is $148 Billion

Source: CMS, Office of the Actuary, National Health Statistics Group.

Table 1.12
Number of People Employed in Health Care, 1990-2005

Number of people employed in health is growing.

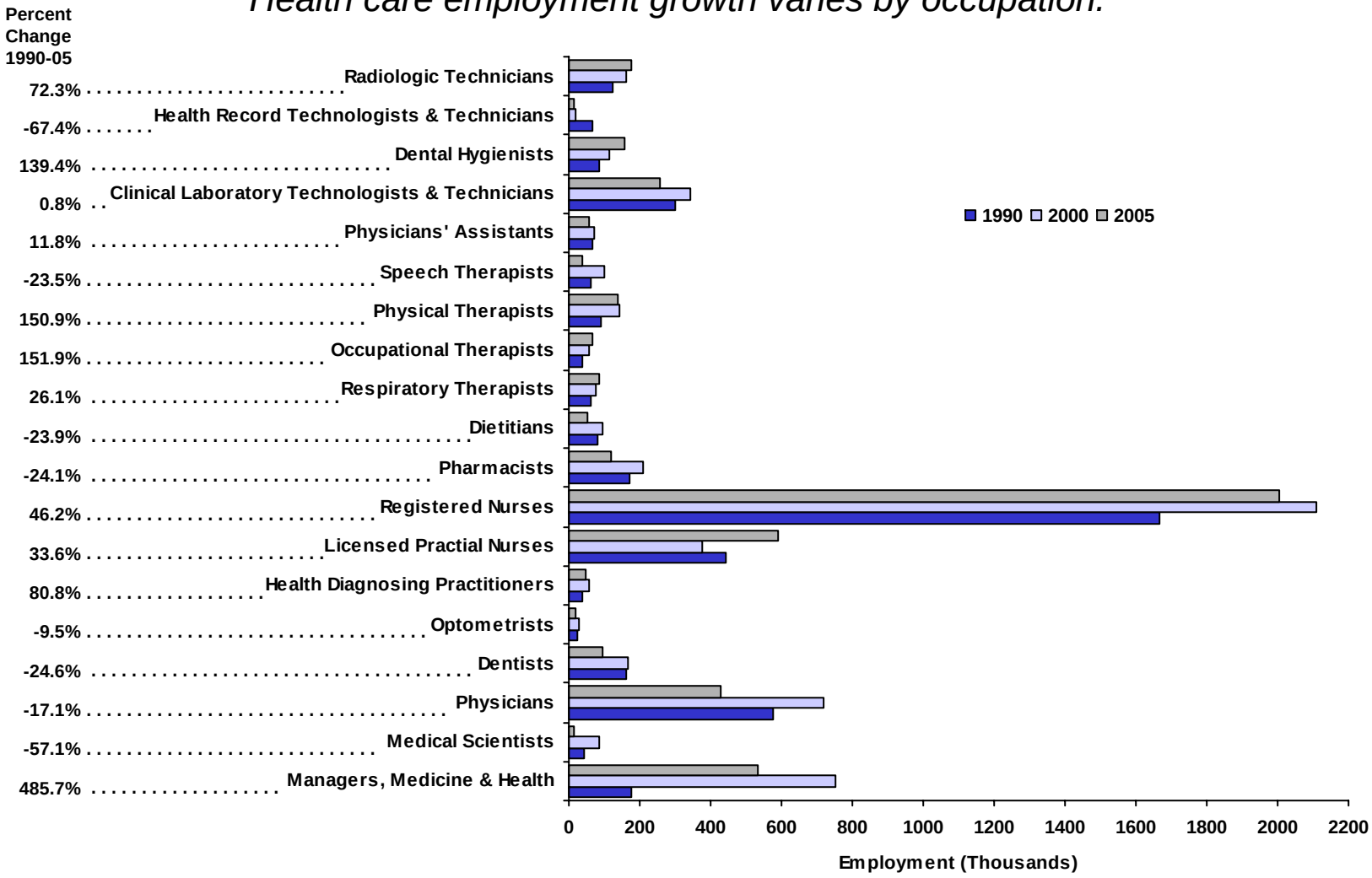


Health Services Employment as a % of Non-Farm Private Sector Employment	
7.5%	1990
8.0%	1991
8.2%	1992
8.3%	1993
8.3%	1994
8.4%	1995
8.4%	1996
8.4%	1997
8.4%	1998
8.3%	1999
8.2%	2000
8.5%	2001
8.8%	2002
9.1%	2003
9.2%	2004
9.2%	2005

Note: Not seasonally adjusted. Health Care Employment includes those who work in ambulatory health care services, hospitals, and nursing and residential care facilities.
Source: Kaiser Family Foundation, *Trends and Indicators in the Changing Health Care Marketplace, 2006 Chartbook*.

Table 1.13
Health Care Employment by Occupation, 1983-2005

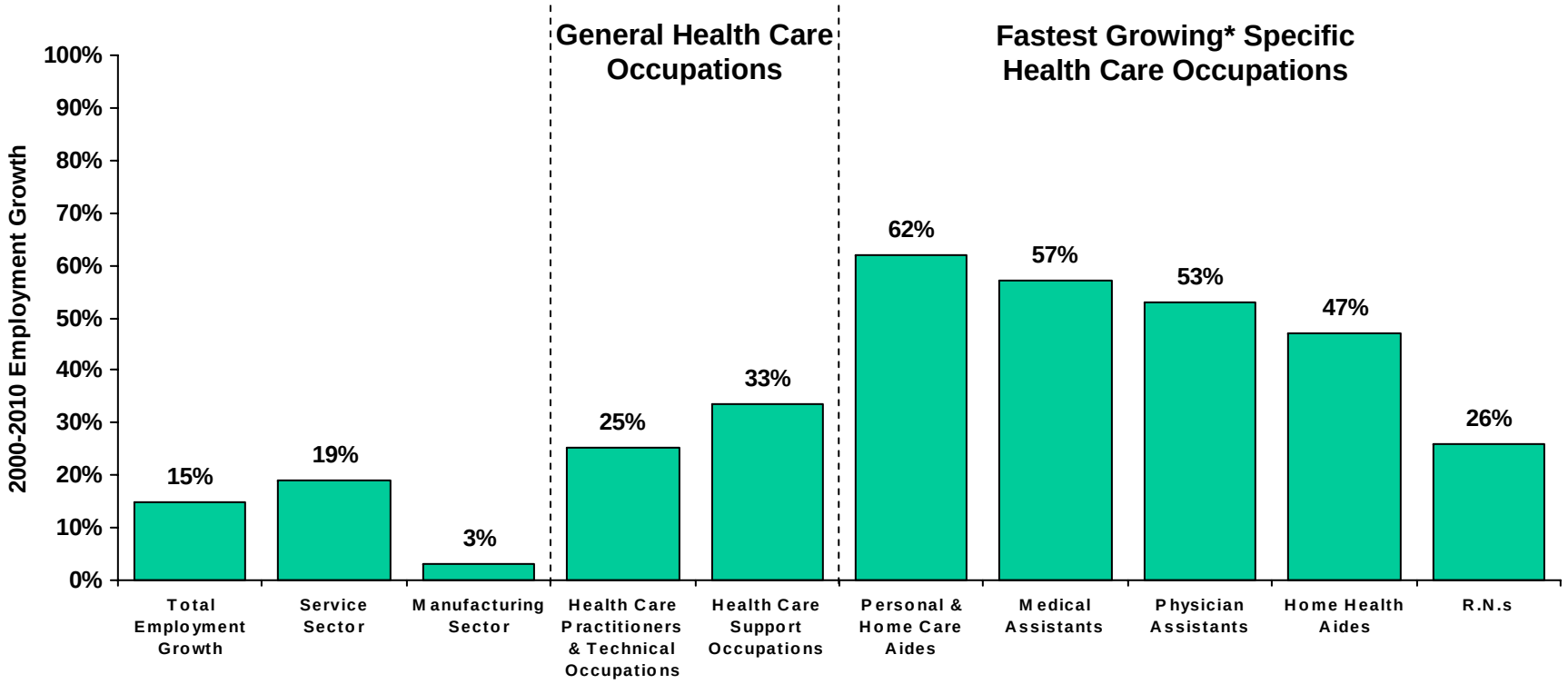
Health care employment growth varies by occupation.



Source: Dept. of Labor, Bureau of Labor Statistics. Occupational Employment Statistics.

Table 1.14
Health Care Employment Growth Projections, 2000-2010

Over the next decade, health care employment is expected to grow at a rapid rate.

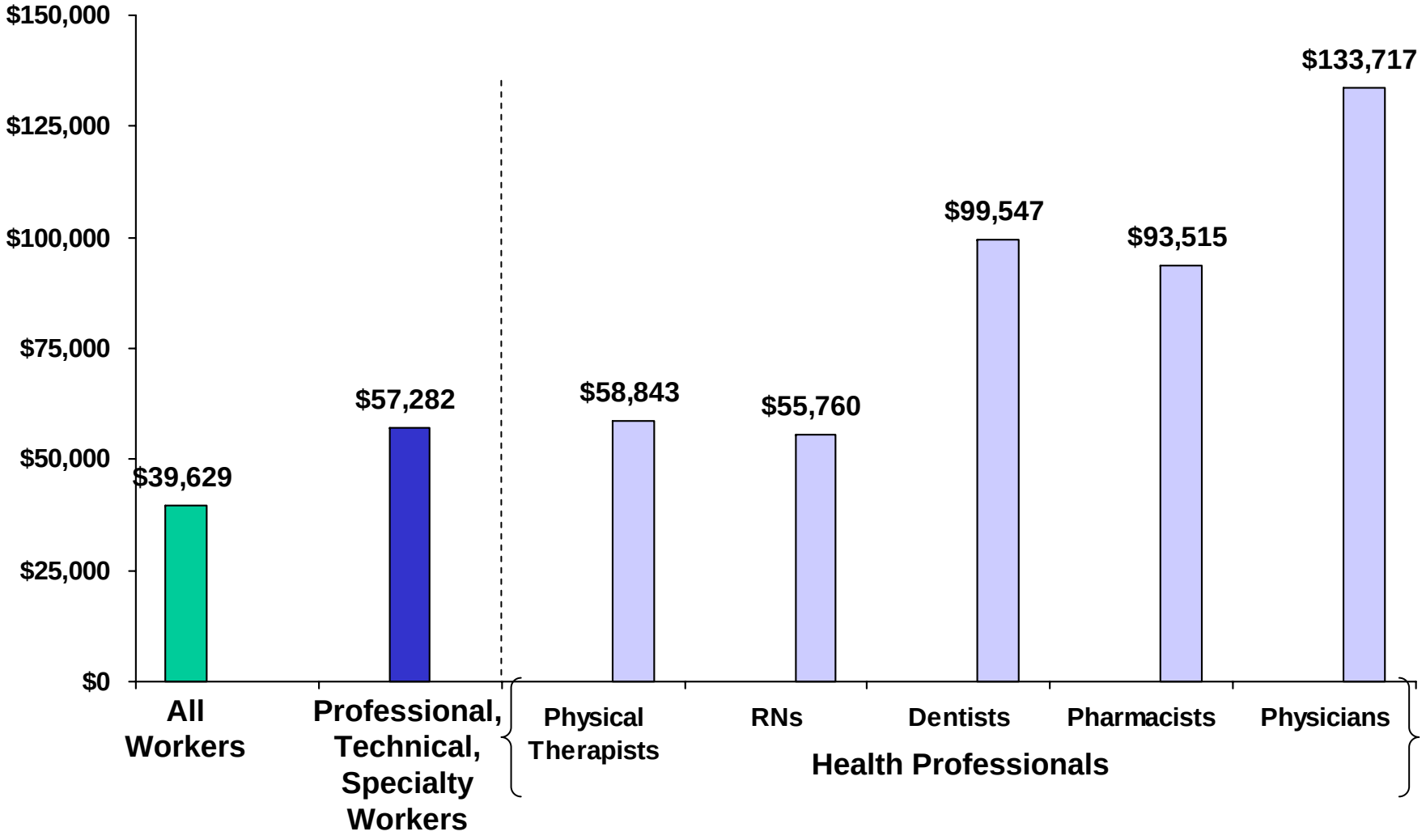


*Note: Five of the nation's top 10 fastest growing occupations are in health care.

Source: Dept. of Labor, Bureau of Labor Statistics. Monthly Labor Review. November 2001.

Table 1.15
Average Annual Salaries for Selected Groups of Workers, 2005

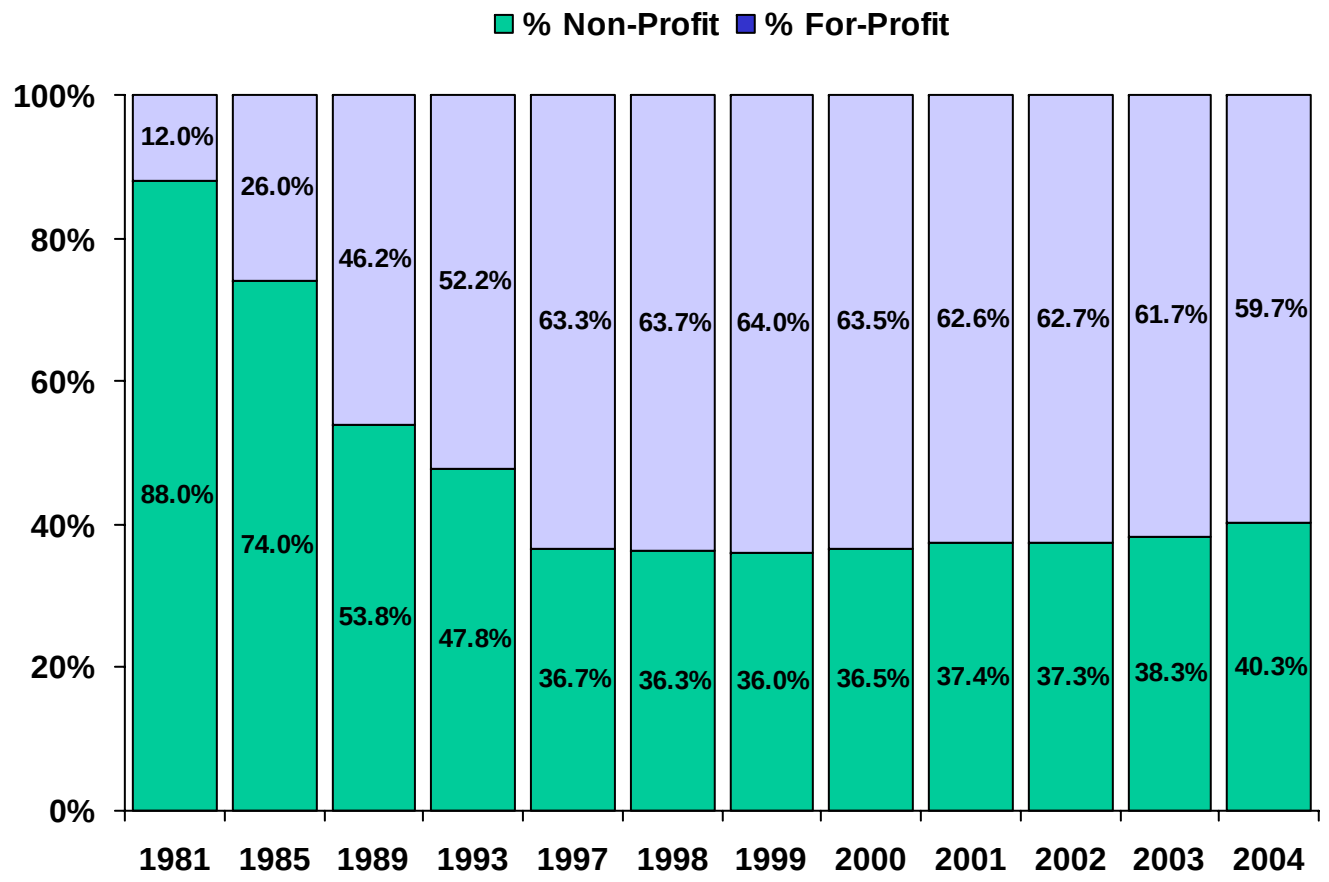
Health professionals earn higher than average incomes.



Source: National Compensation Survey: Occupational Wages in the US, June 2005 . US Department of Labor, July 2006.

Table 1.16
HMO Enrollment by Ownership Status, 1981-2004

The proportion of HMO enrollees in not-for-profit plans stabilized in 1997.



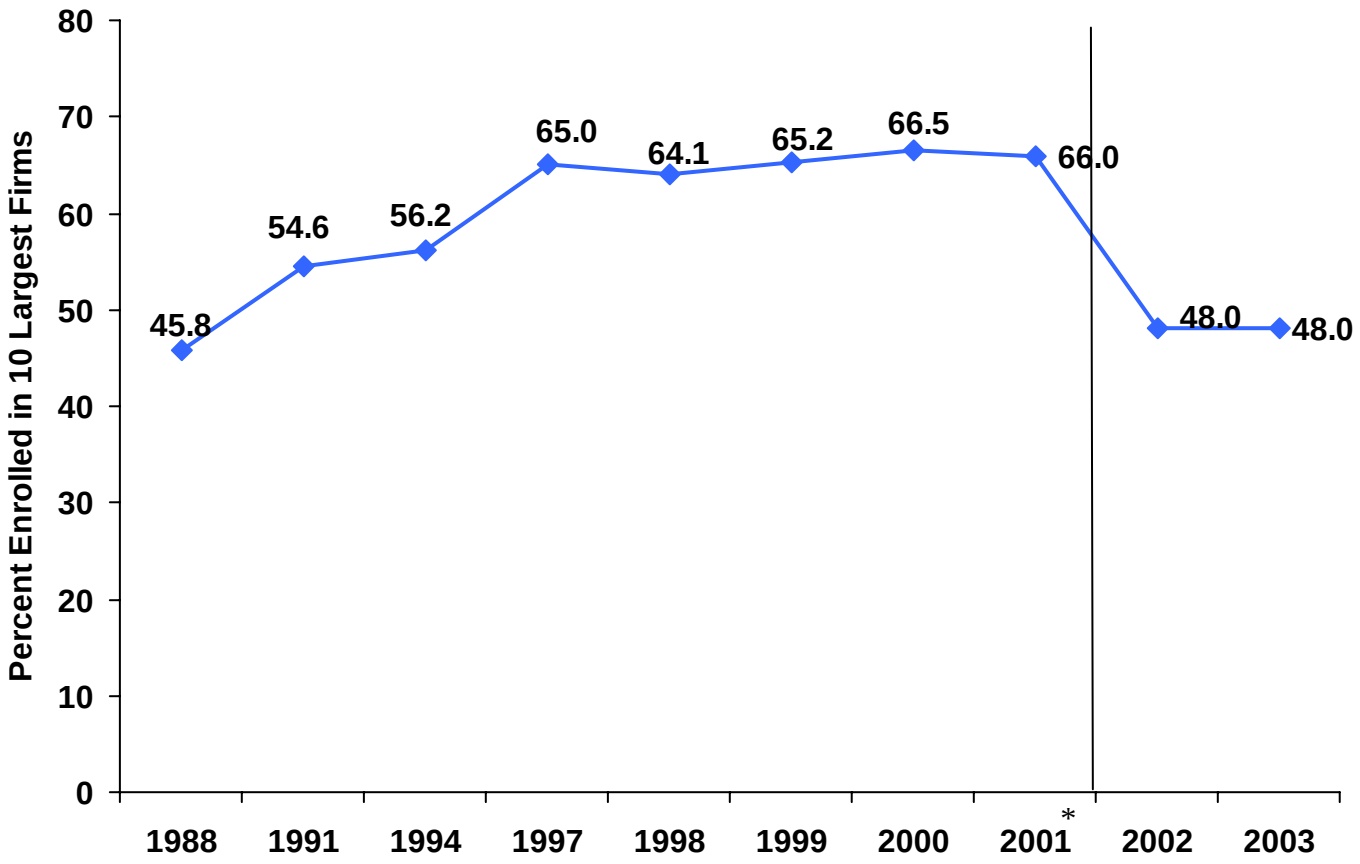
Total HMO enrollment in 2004 = 66.1 Million

Note: HMO enrollment includes enrollees in both traditional HMOs and point-of-service (POS) plans through: group/commercial plans, Medicare, Medicaid, the Federal Employees Health Benefits Program, direct pay plans, supplemental Medicare plans, and unidentified HMO products.

Source: Kaiser Family Foundation. Trends & Indicators in the Changing Health Care Marketplace, 2006 Chartbook.

Table 1.17
Concentration of Managed Care Enrollment, 1988-2003

Half of managed care enrollees are enrolled in the nation's 10 largest managed care firms.

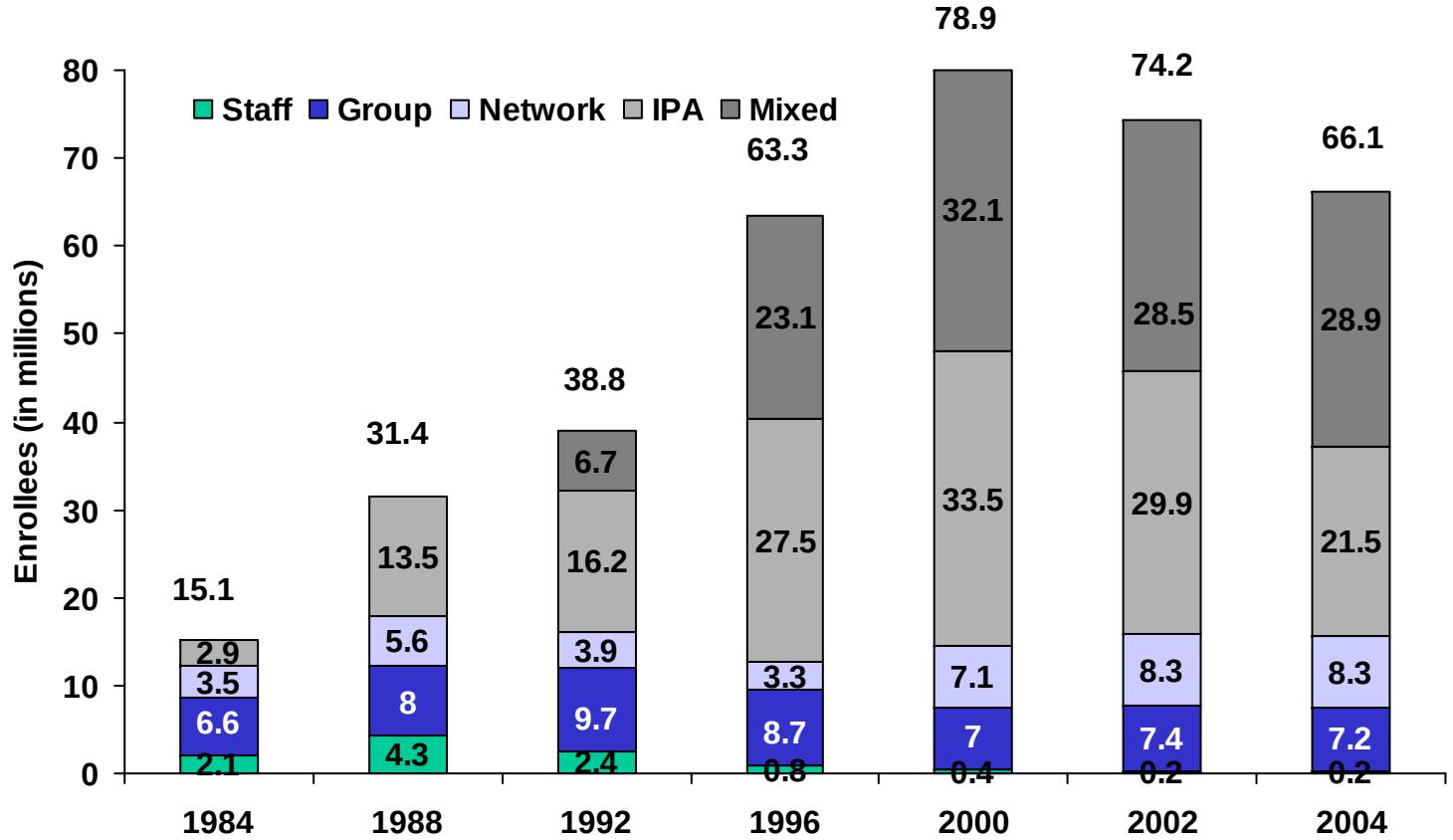


*Note: The decrease in concentration does not represent a decline, but rather a change in the methodology.
Note: The largest national managed care firms include Kaiser Foundation Health Plans, UnitedHealth Group, WellPoint Health Networks, Aetna, and Health HMO enrollment includes enrollees in both traditional HMOs and point of service plans.

Source: Kaiser Family Foundation. Trends & Indicators in the Changing Health Care Marketplace, 2005 – Chartbook.

Table 1.18
Managed Care Enrollment by Type of Plan, 1984-2004

Mixed model HMO plans grew rapidly before 2000 and declined less rapidly after 2000.



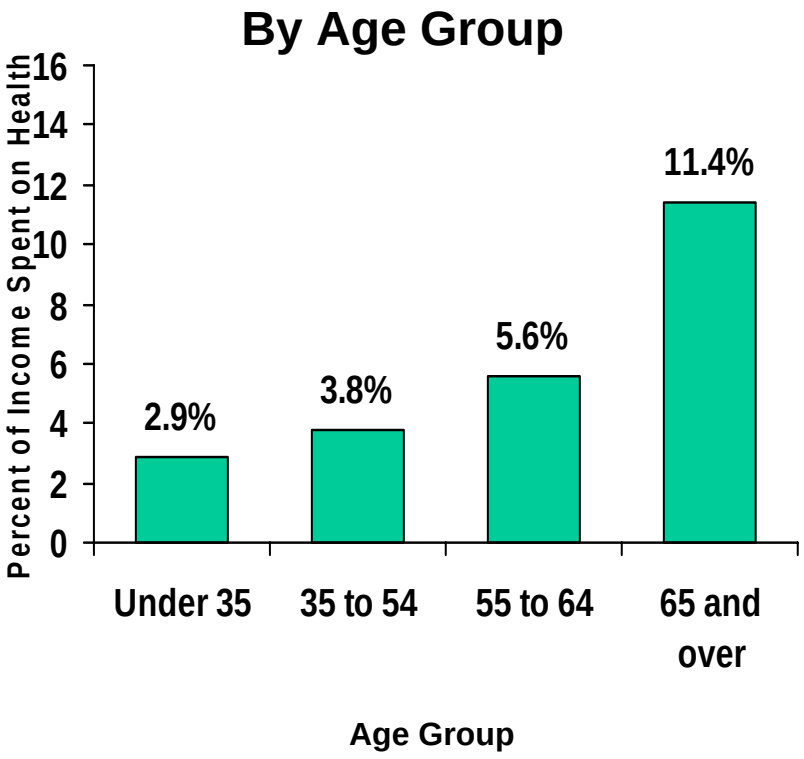
	1984	1988	1992	1996	2000	2002	2004
Mixed	NA	NA	17.3%	36.4%	40.0%	38.4%	43.7%
IPA	19.5%	43.0%	41.7%	43.4%	41.9%	40.2%	32.6%
Network	23.3%	18.0%	10.0%	5.3%	8.9%	11.2%	12.5%
Group	43.6%	25.4%	24.8%	13.7%	8.8%	9.9%	11%
Staff	13.6%	13.6%	6.2%	1.2%	0.4%	0.2%	0.3%

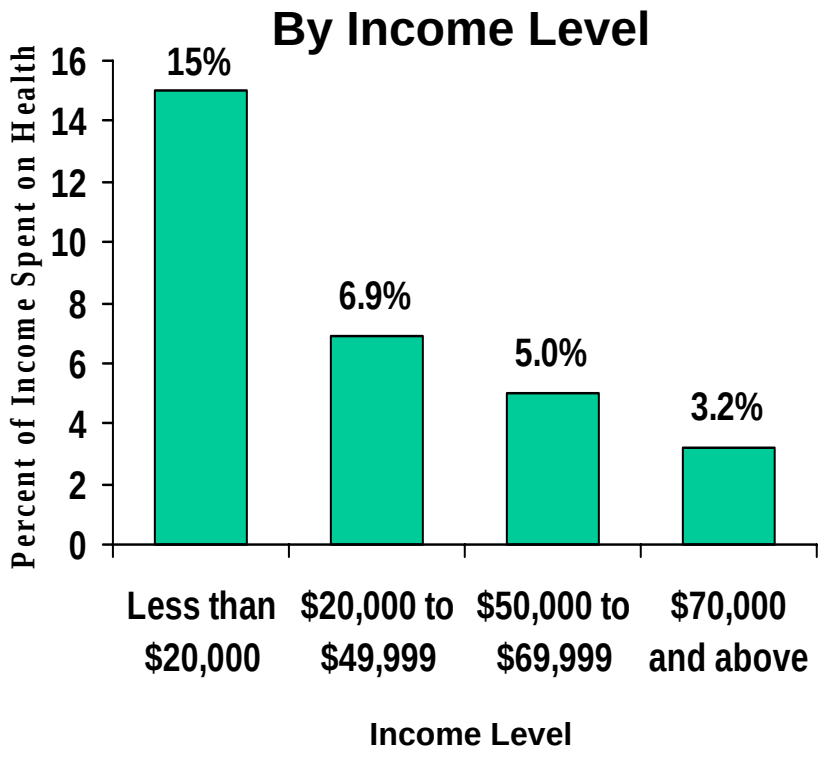
Note: Plans analyzed are comprehensive HMO plans. Traditional HMOs and point of service plans are included, managed care carveouts for selected services such as behavioral health are not included. Enrollment includes group and commercial plans, Medicare, Medicaid, Federal Employee group health program, and others.

Source: Kaiser Family Foundation, Trends & Indicators in the Changing Health Care Marketplace, 2006 Chartbook.

Table 1.19
Health Care as a Percent of Income by Age, 2004

Those over 65 and those with incomes under $20,000 spend a higher percentage of their income on health than other groups.

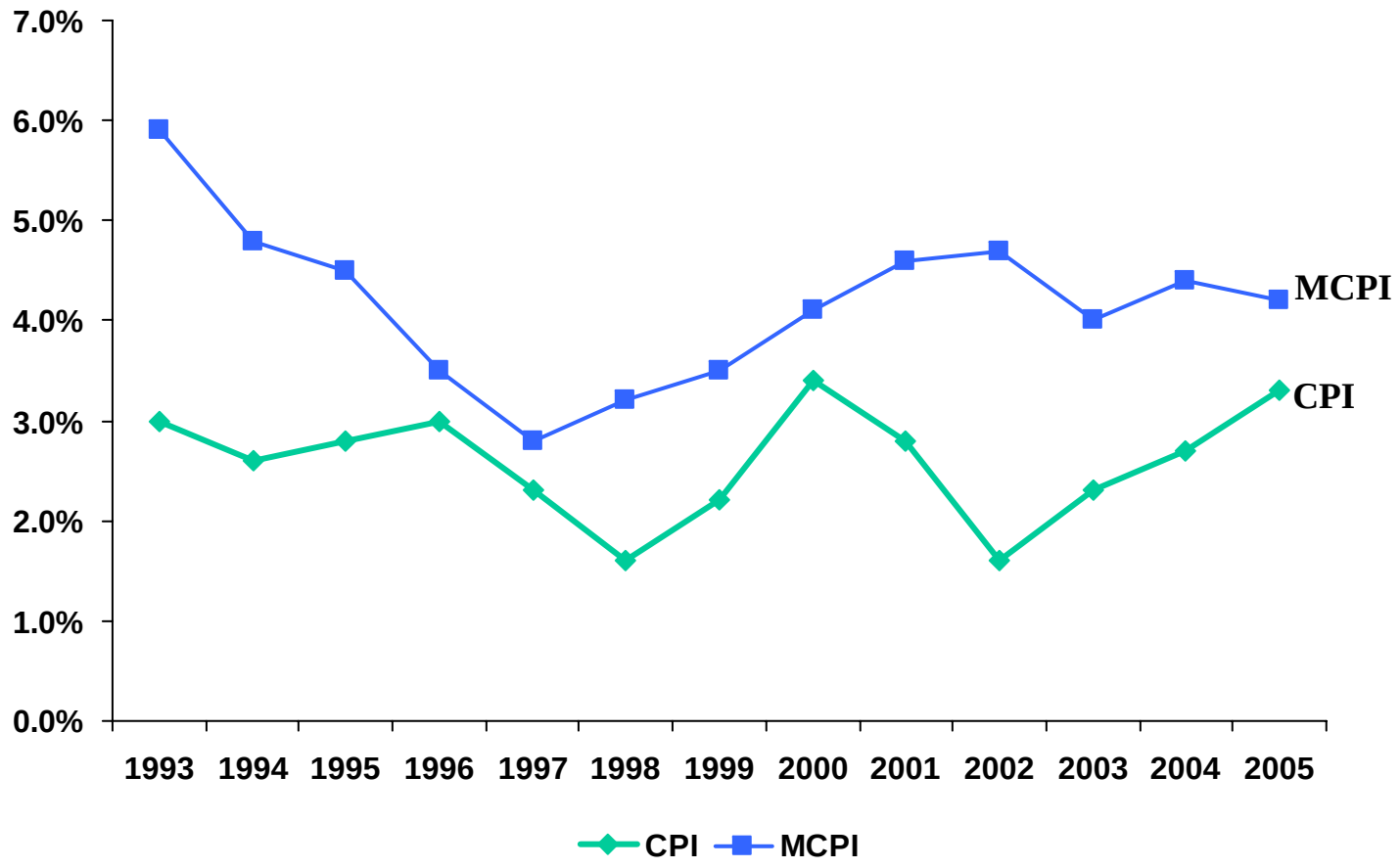




Source: Dept. of Labor, Bureau of Labor Statistics, Consumer Expenditure Survey.

Table 1.20
Annual Growth Rates in the Overall Consumer Price Index (CPI) and Medical-Specific Consumer Price Index (MCPI), 1993-2005

Medical prices have risen faster than overall consumer prices.



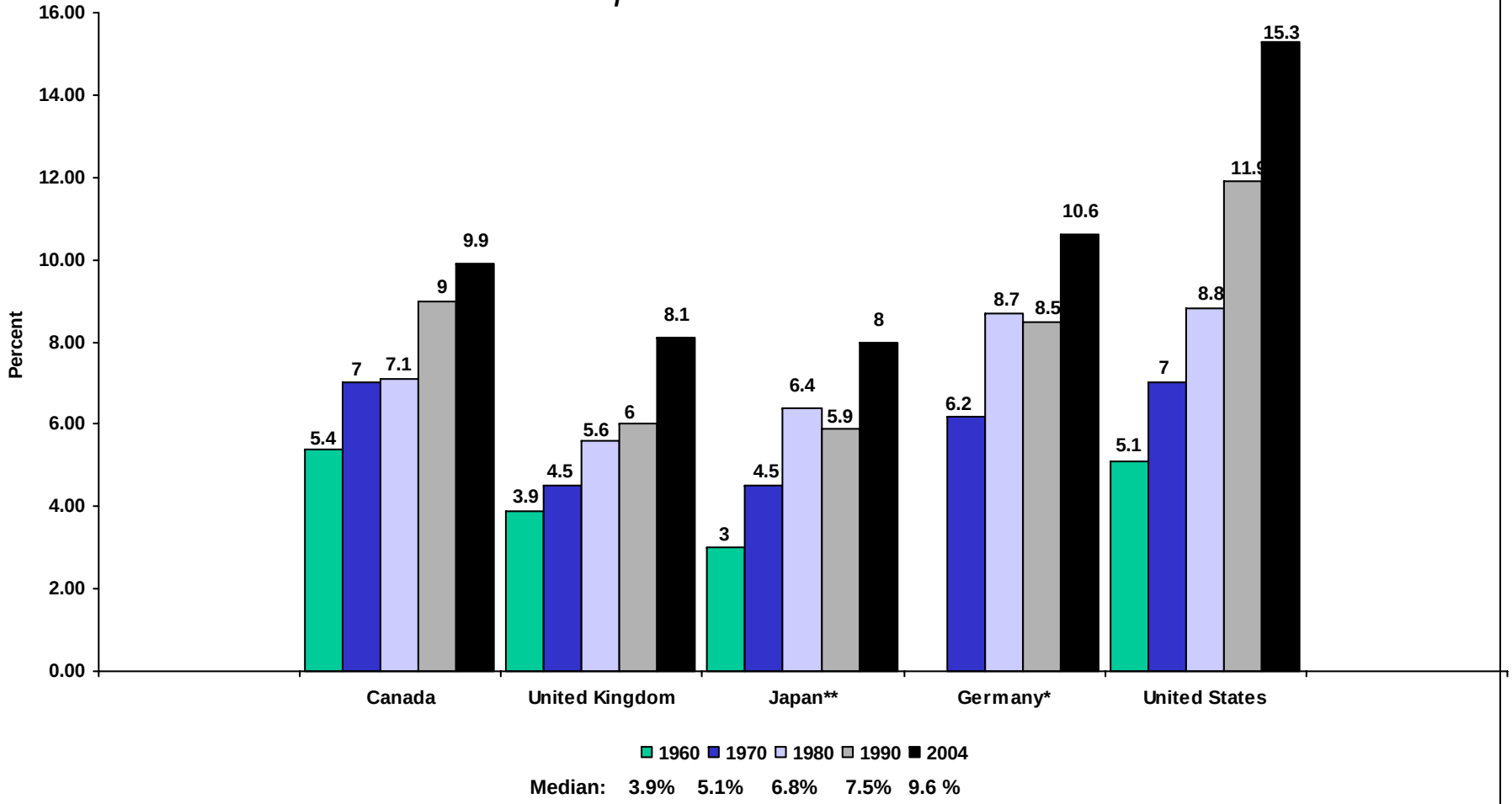
Source: Dept. of Labor, the Bureau of Labor Statistics.

Section 2

International Comparisons

Table 2.1
Percent of GDP Spent on Health Care by OECD Country, 1960-2004

The U.S. has had a higher share of GDP spent on health than the OECD median for the past four decades.

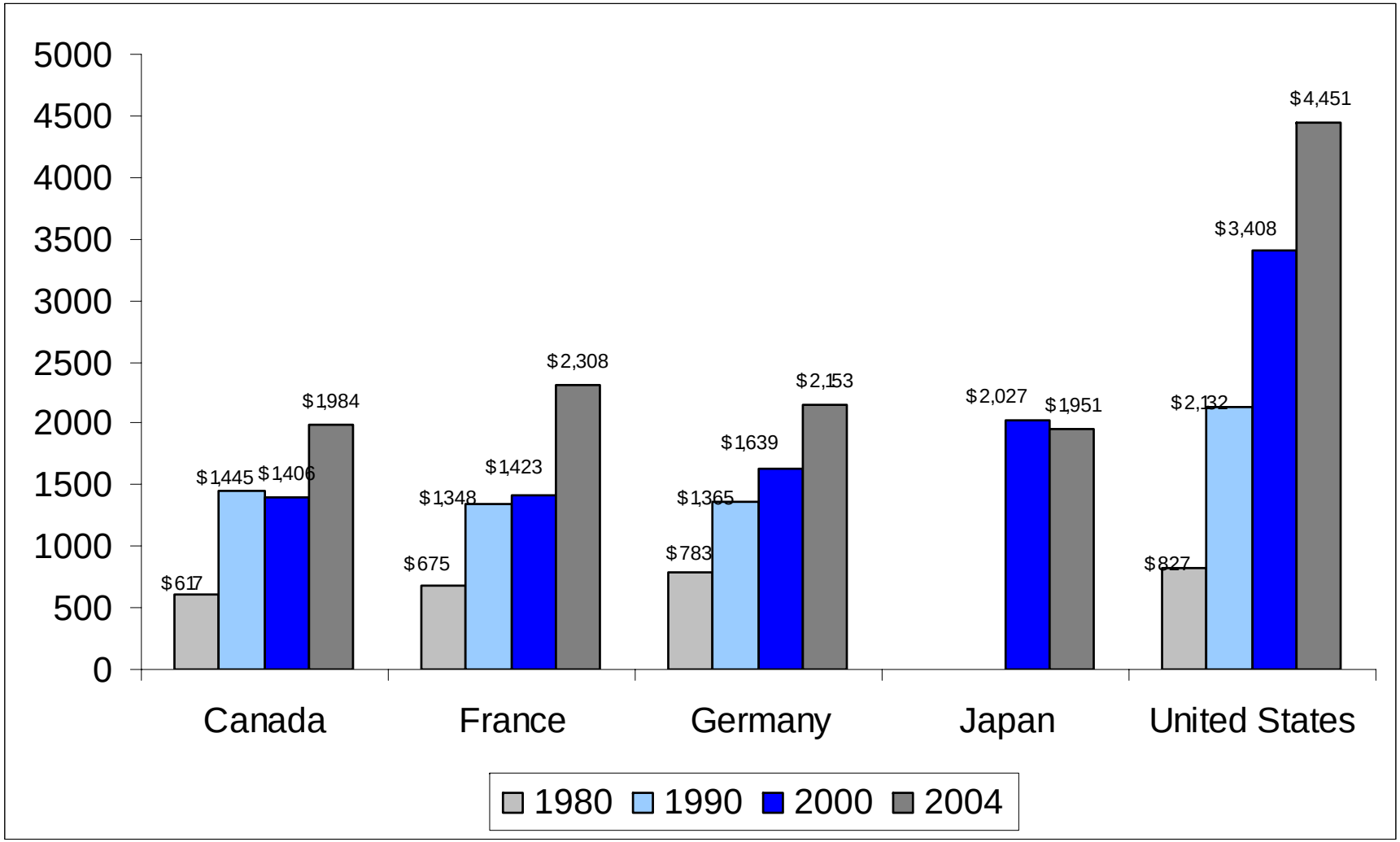


*For 1960, no data was available.
**2003 data was used because 2004 were not available.
Note: The data is arrayed by spending growth from 1990 to 2004. The medians include all OECD countries.

Source: OECD Health Data 2006.

Table 2.2
Per Capita Spending on Medical Services by OECD Country, 1980-2004

US spending is growing rapidly compared with other OECD countries.

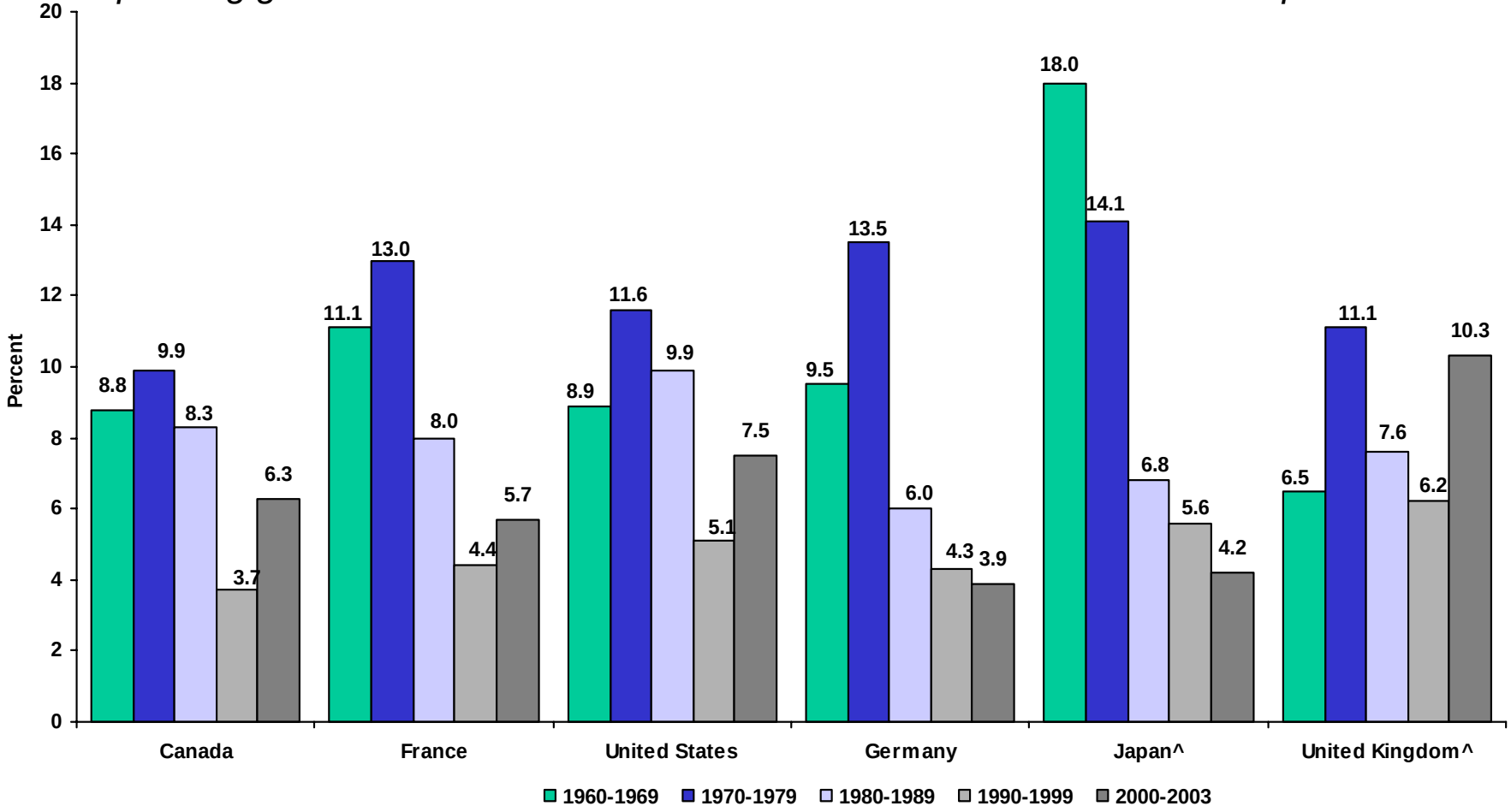


* 2003 Data Used for Germany and Japan

Source: OECD Health Data, 2006

Table 2.3
Average Annual Growth in Per Capita Spending by Decade by OECD Country, 1960-2003

Health spending growth over the last decade is lower in OECD countries than in prior decades.



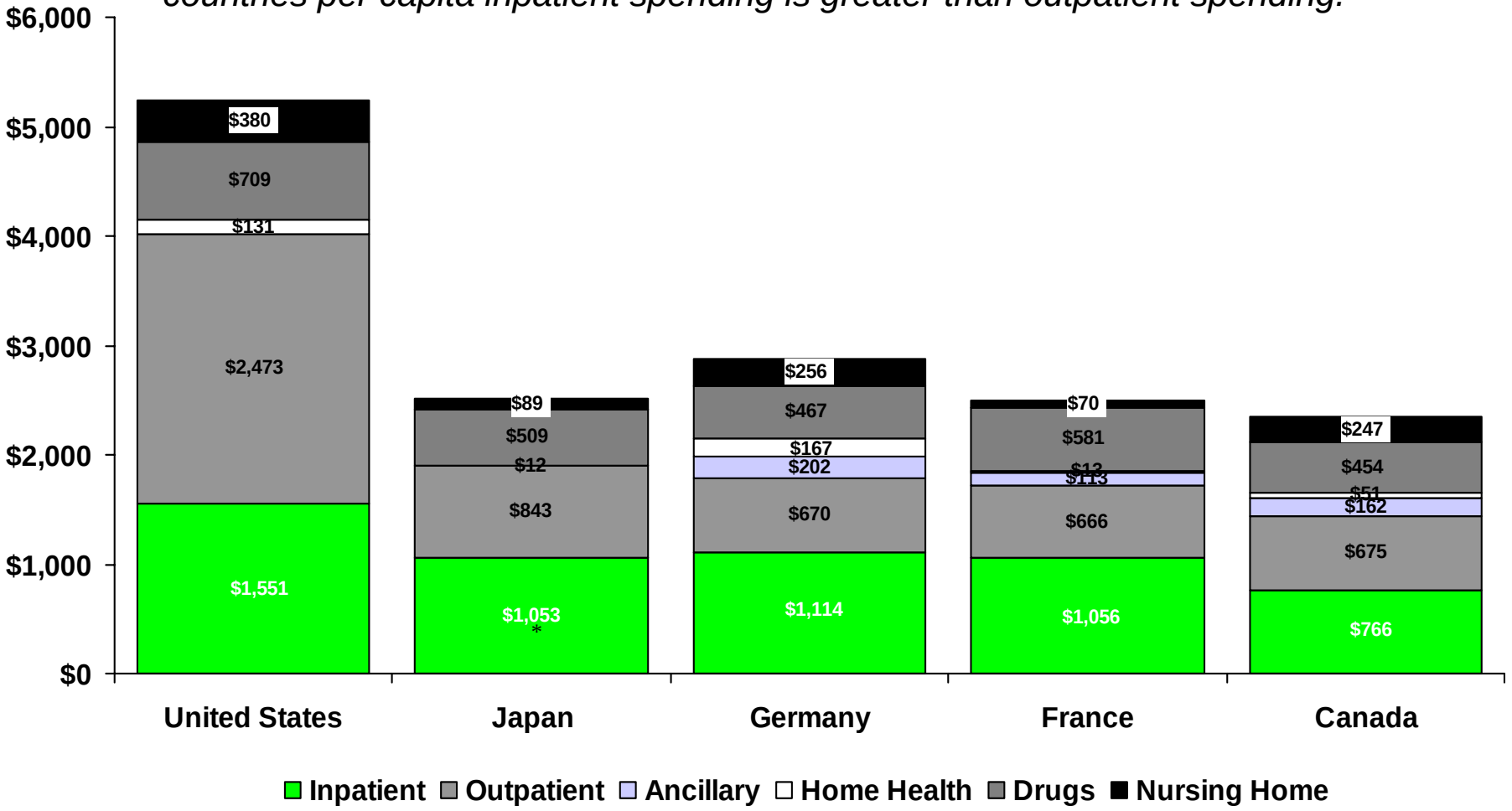
^ Average annual change calculated from 2000-2002

Note: Each bar represents the average annual nominal growth over the decade. The data is arrayed by spending growth from 1990 to 1999. The medians include all OECD countries.

Source: OECD Health Data 2005.

Table 2.4
Per Capita Health Spending by Type of Service by OECD Country, 2003

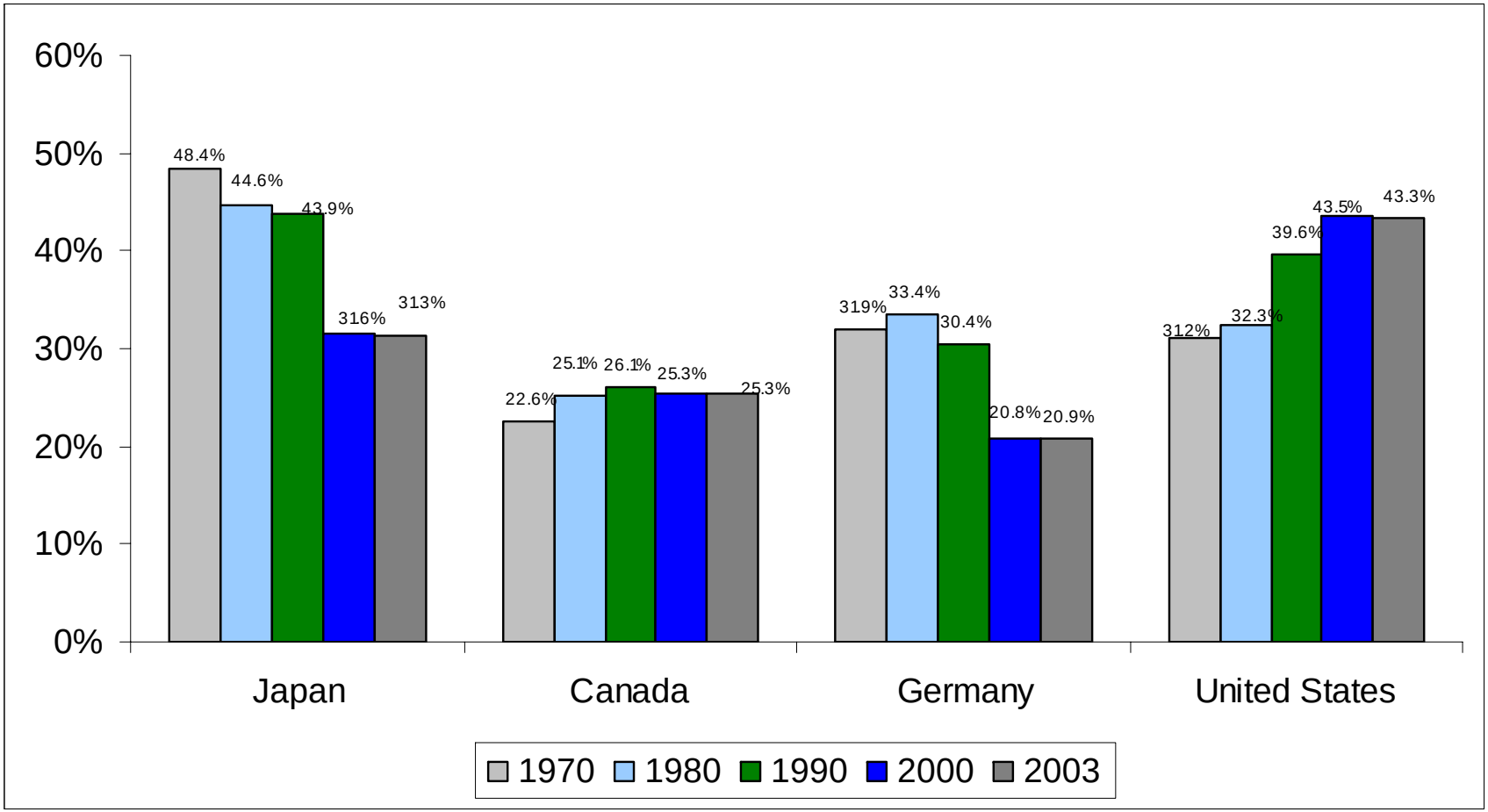
Per capita outpatient spending in the US is almost double inpatient spending. In other OECD countries per capita inpatient spending is greater than outpatient spending.



Source: OECD Health Data 2006.

Table 2.5
Share of Total Health Spending on Out-Patient Care by OECD Country, 1970-2003

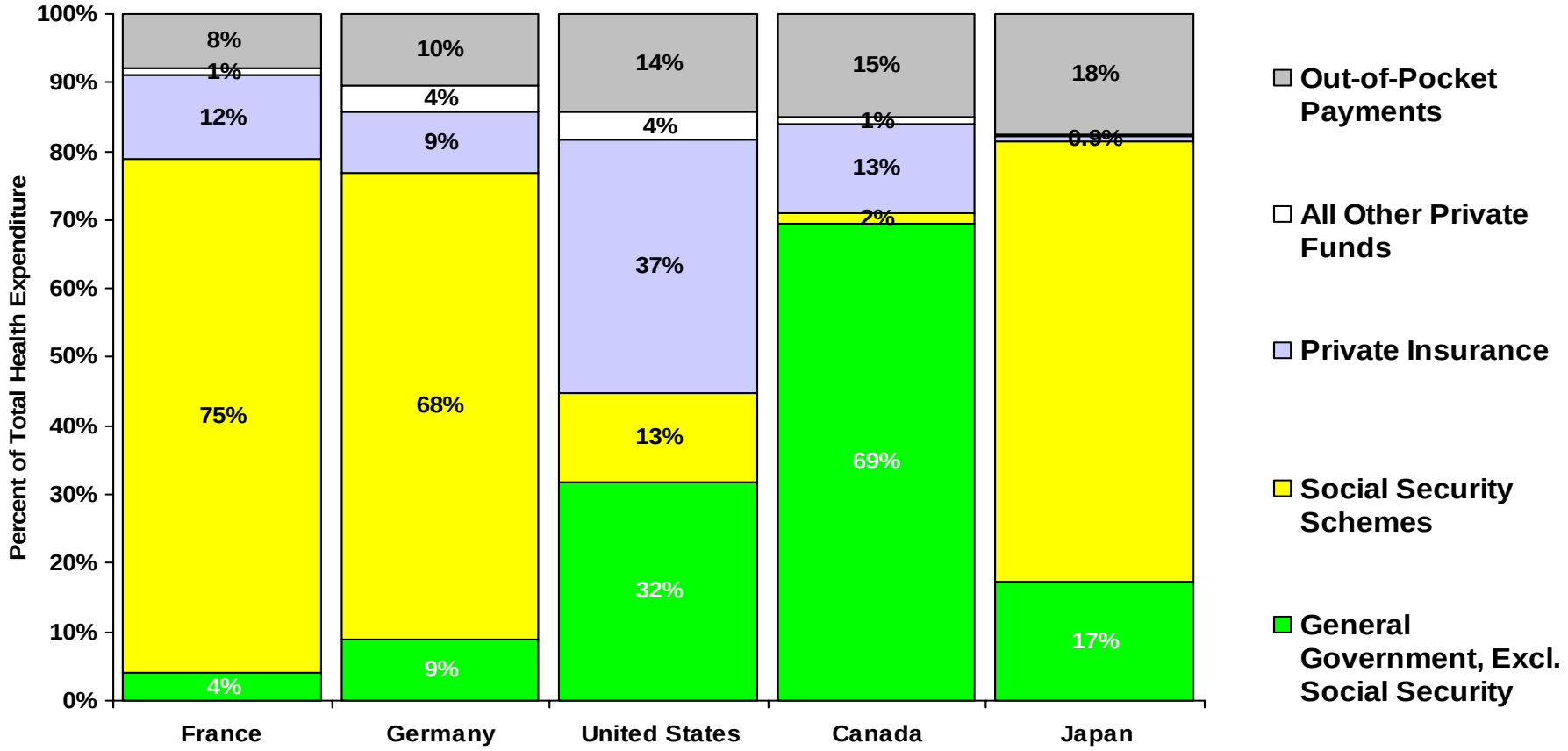
In 2003, the U.S. spent the highest percent of total healthcare spending on out-patient care; In 1970 Japan spent an even higher percent of total health care spending on outpatient care



Source: OECD Health Data 2006

Table 2.6
National Health Spending by Source of Funds by OECD Country, 2003

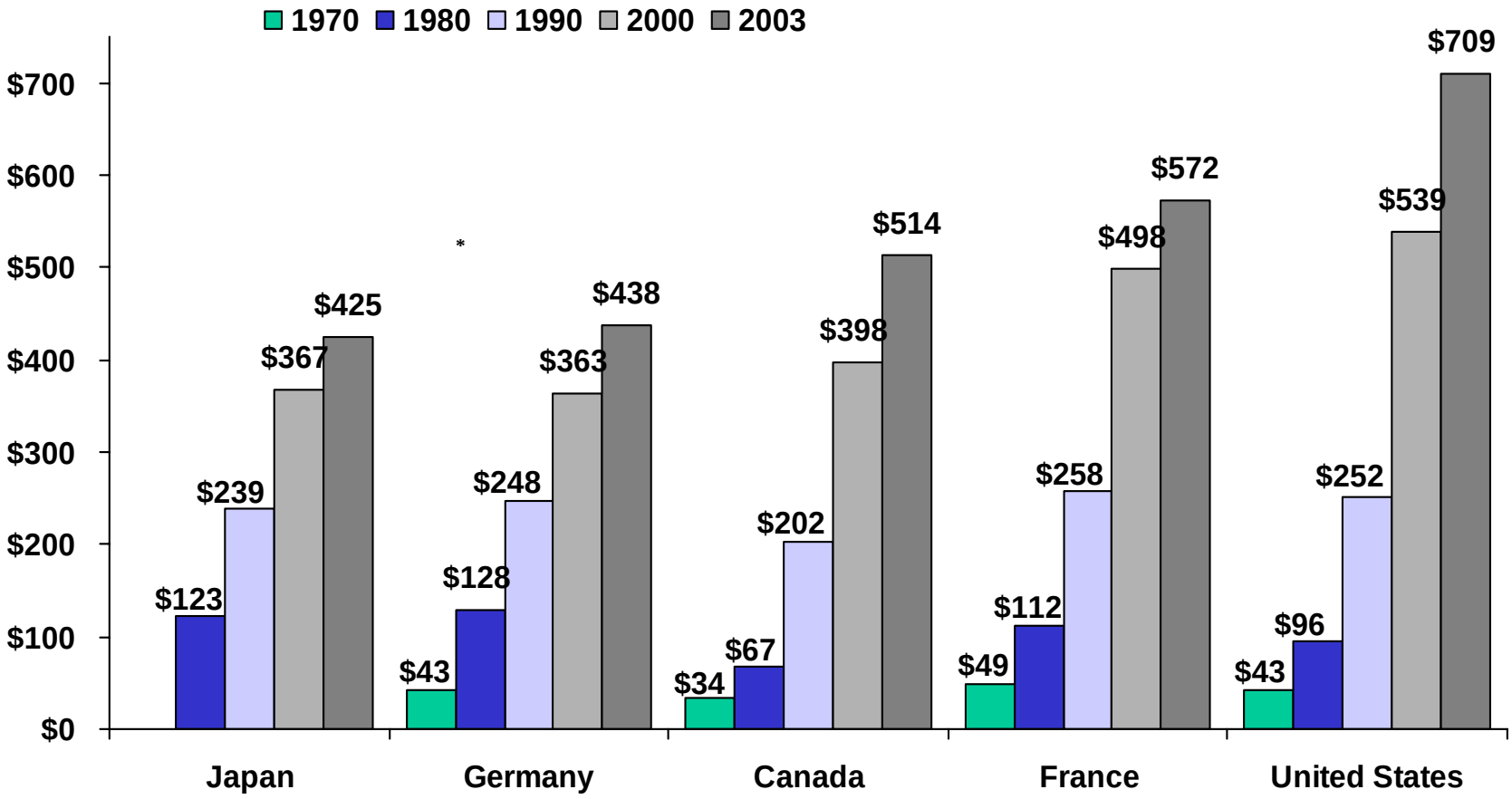
Source of funding varies significantly by country. For instance, out-of-pocket spending ranges from 8% to 18% of health spending, with the U.S. at about the median.



Source: OECD Health Data 2006

Table 2.7
Per Capita Spending on Pharmaceuticals and Other Non-Durables by OECD Country, 1970-2003

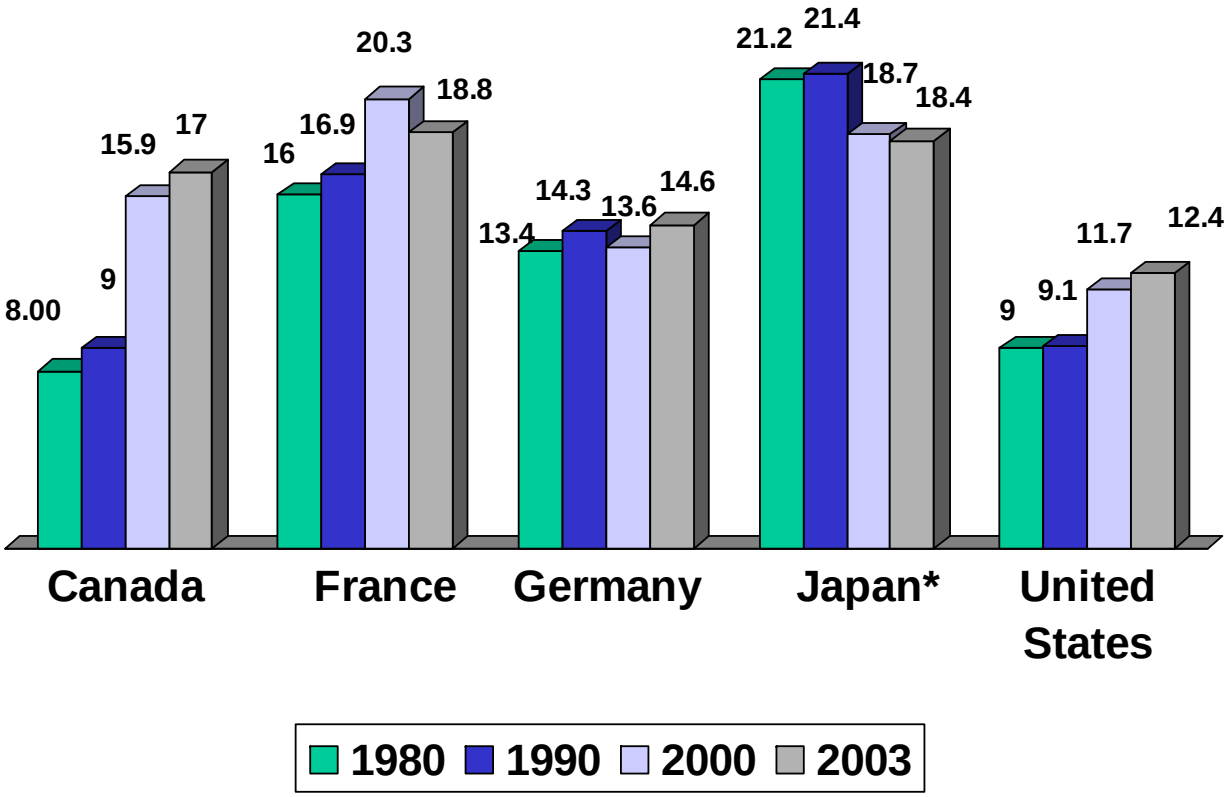
Variation across countries is increasing. Recent growth in North America is most rapid.



Expenditures in U.S. dollars using purchasing power parity rates.
Note: Data is arrayed by spending levels for 2003. Japan not available for 1970.
Source: OECD Health Data 2006.

Table 2.8
Drug Spending as a Percentage of Total Health Spending by OECD Country, 1980-2003

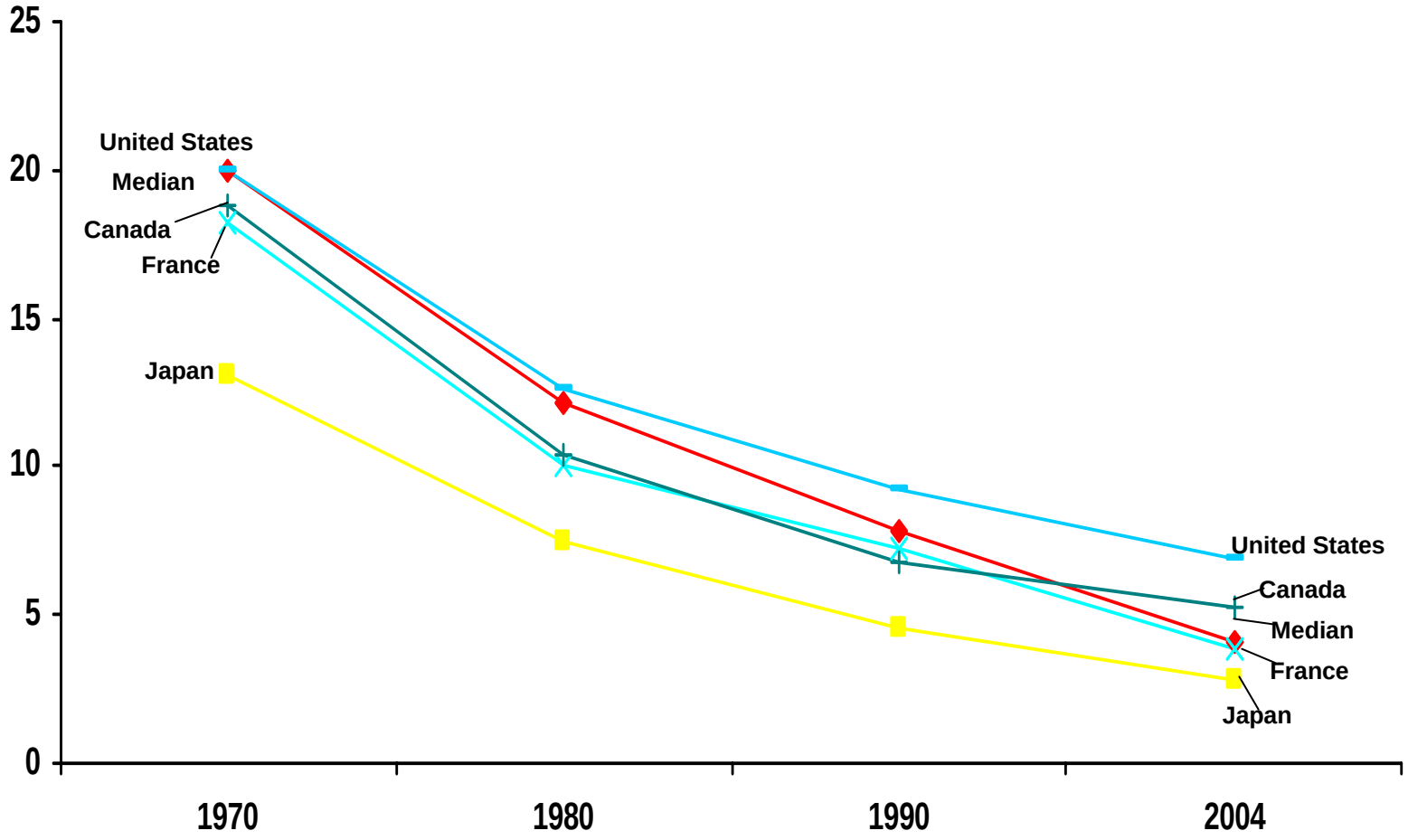
Although, recent drug spending in the United States on this measure has grown, it is still low compared to other OECD countries



***2003 data for Japan is not available; 2002 was used**
Source: OECD Health data, 2006.

Table 2.9
Infant Mortality Rates per 1,000 Live Births by OECD Country, 1970-2004

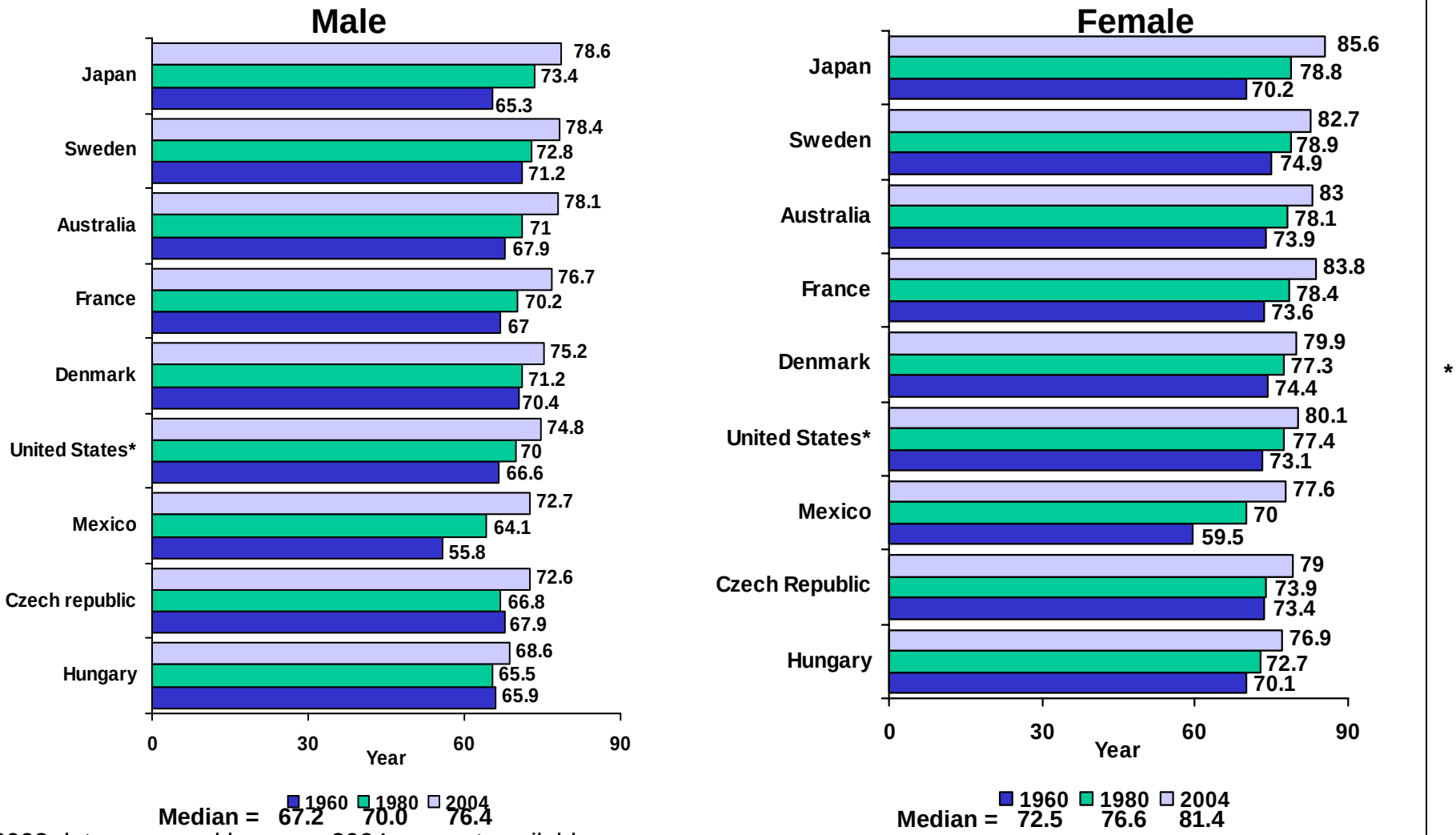
OECD country infant mortality rates have declined since 1970.



Note: The median includes all OECD countries. The decrease from 1960-2004 is in percentage points.
2003 data used for Canada and the United States as the latest available.
Source: OECD Health Data 2006.

Table 2.10
Male and Female Life Expectancy at Birth by OECD Country, 1960-2004

Japan has the highest life expectancy at birth for both males and females.



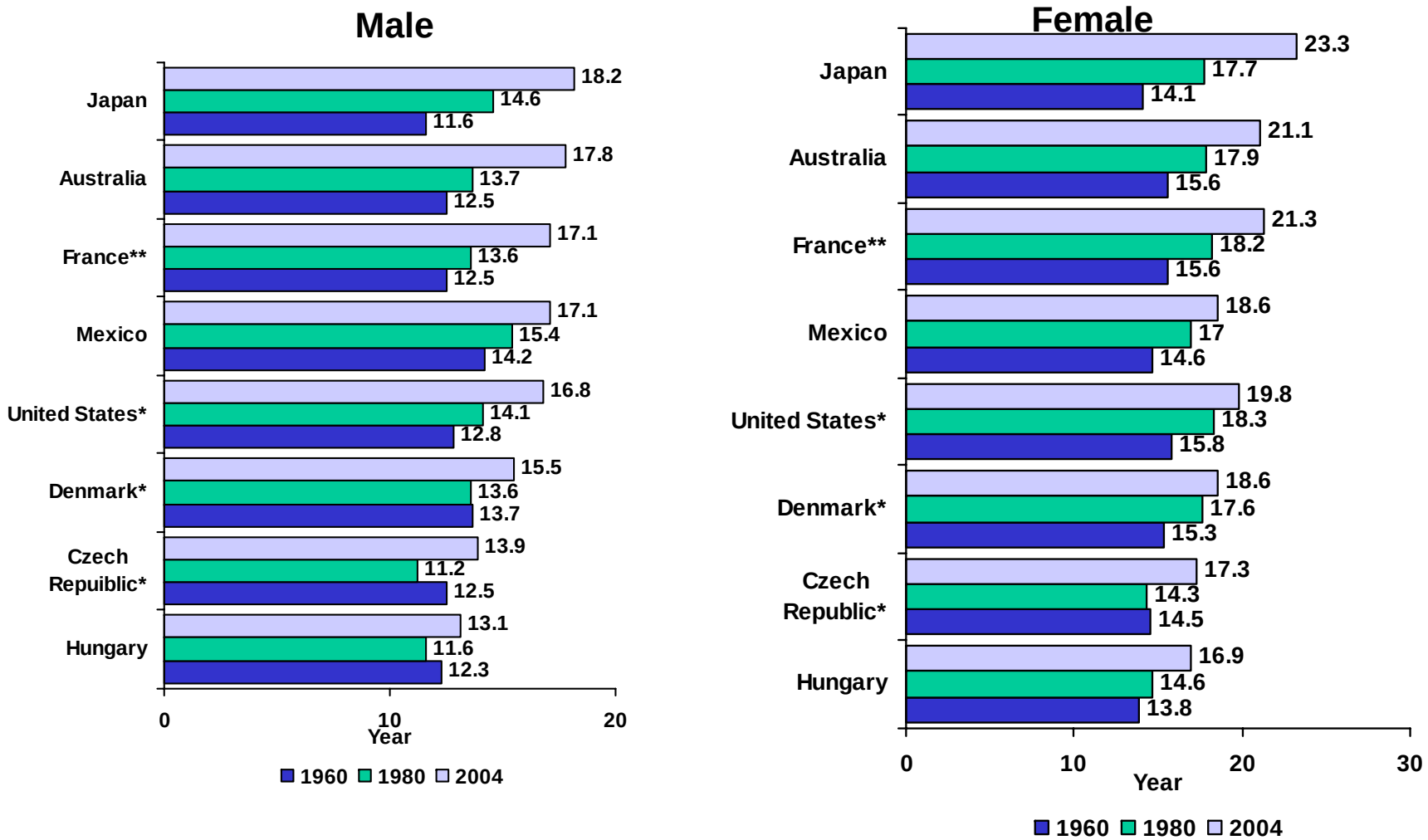
*2003 data was used because 2004 was not available.

Note: Data are arrayed by male life expectancy; countries are kept together. The medians include all OECD countries.

Source: OECD Health Data 2006

Table 2.11
Male and Female Life Expectancy at Age 65 by OECD Country, 1960-2004

Japan has the highest male and female life expectancy

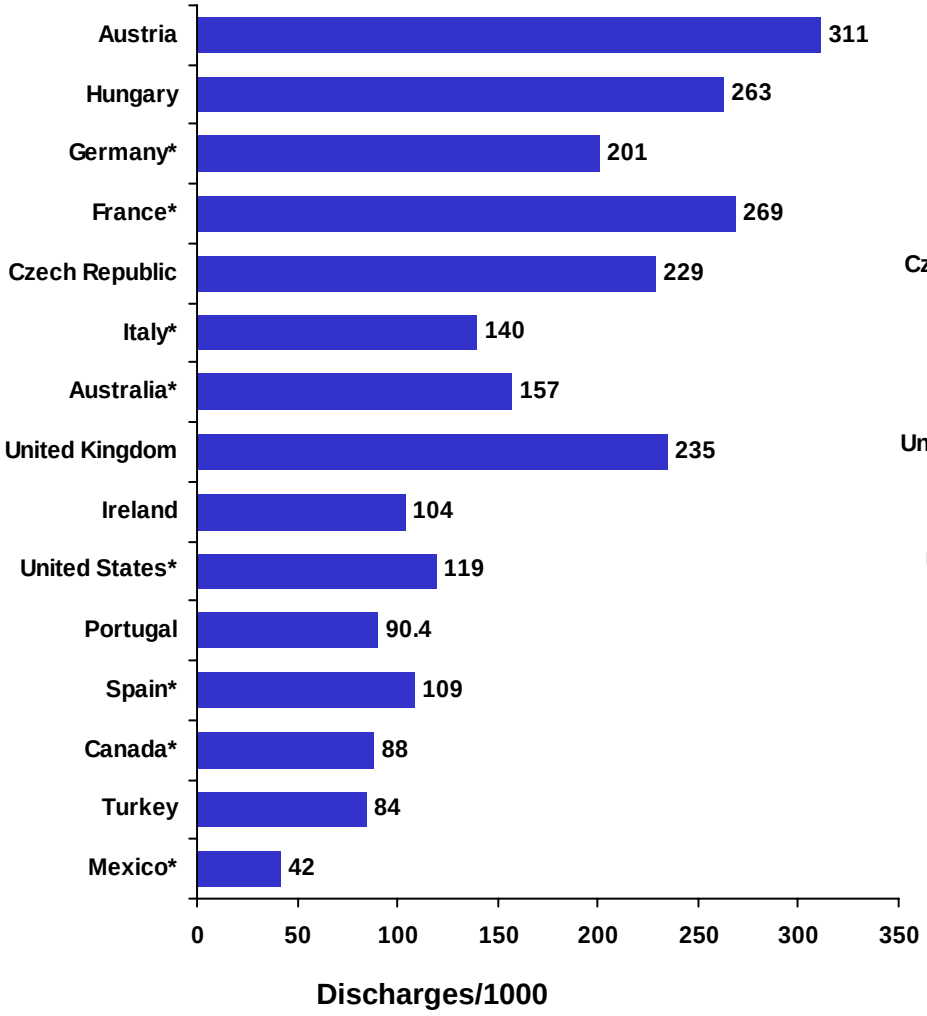


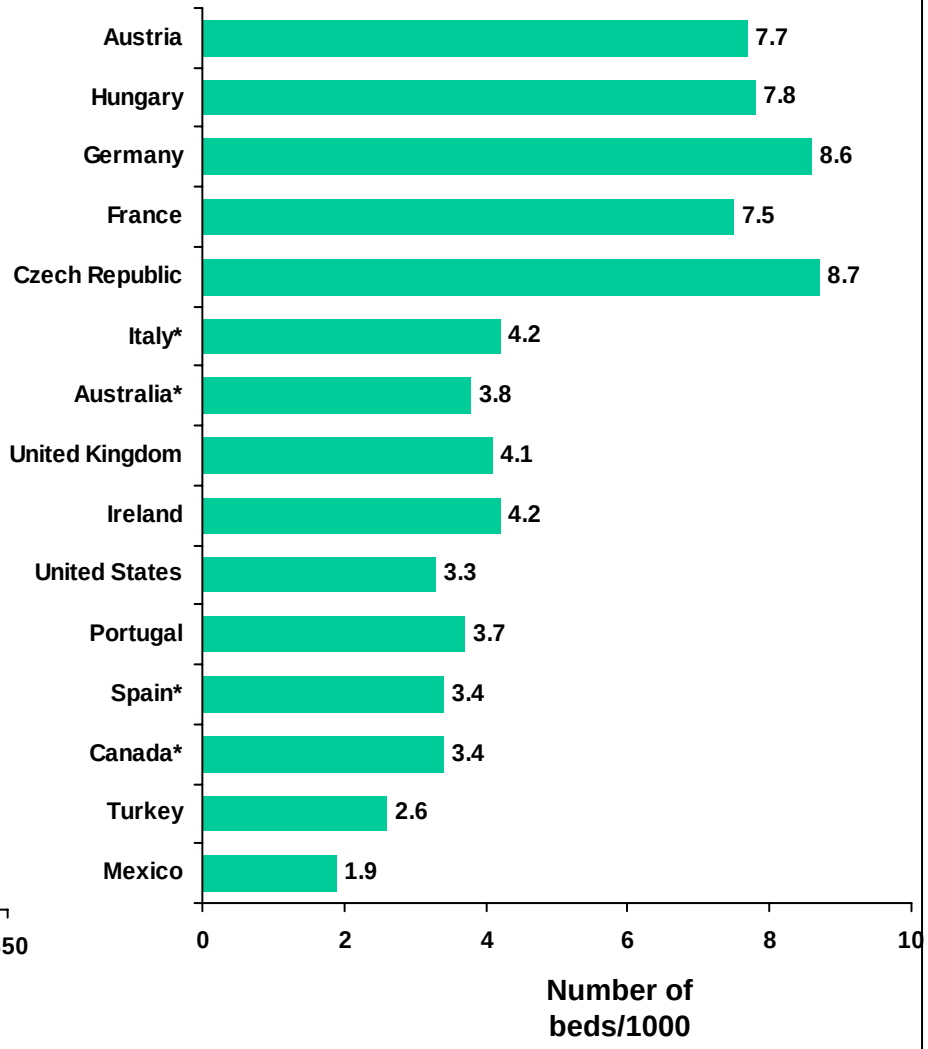
Note: Data are arrayed by male life expectancy; countries are kept together * 2003 data **Data are 2001 for females and 2002 for males.

Source: OECD Health Data 2006.

Table 2.12
Number of In-Patient Discharges and Total Beds per 1,000 Persons by OECD Country, 2004

Discharge rates generally track bed supply.



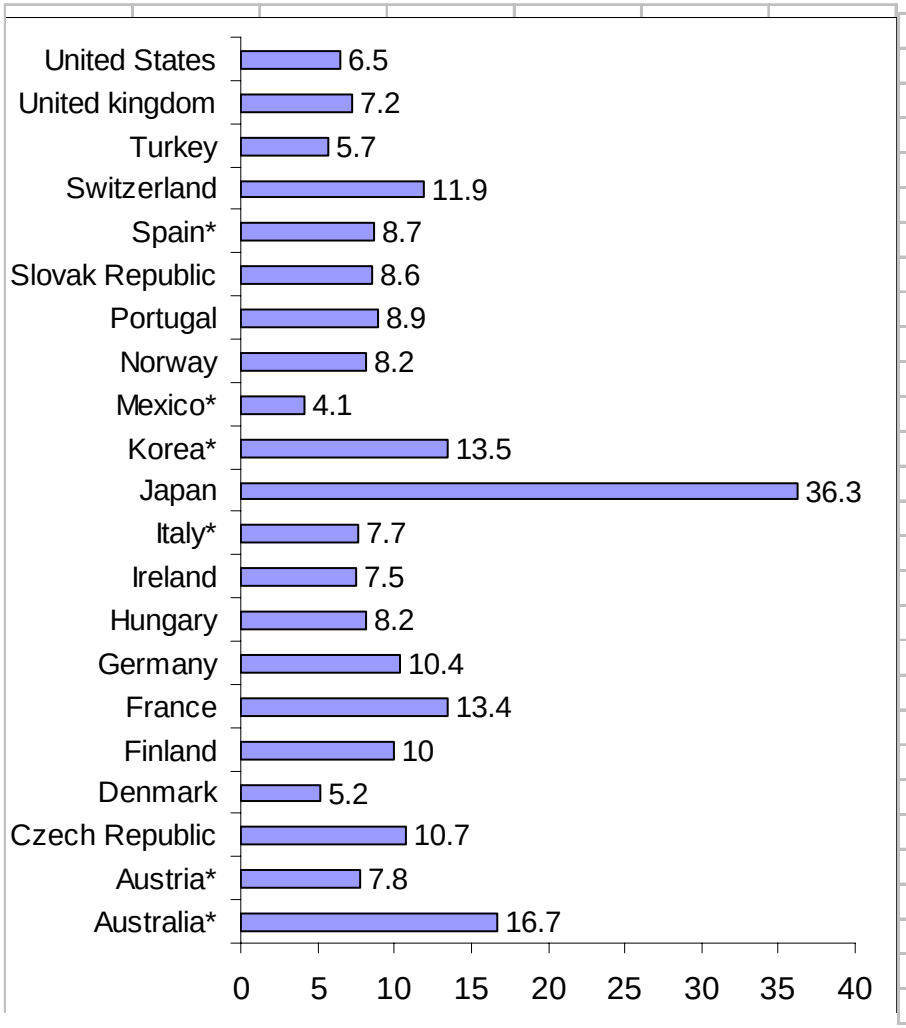


Source: OECD Health Data 2006 * 2004 data not available, used 2003.

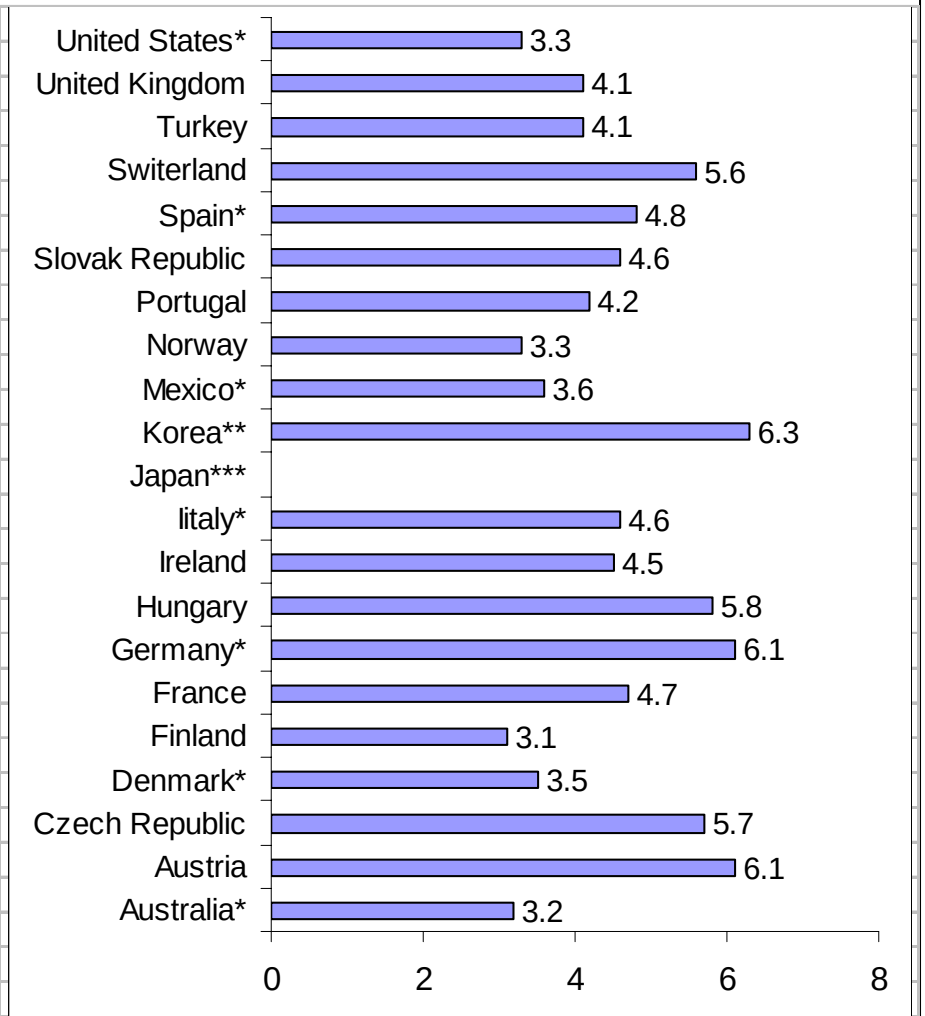
Table 2.13
Average Length of Hospital Stay For Selected OECD Countries, 2004

The length of stay for specific procedures varies differently from total length of stay

Average Length of Stay- In-Patient Acute



Average Length of Stay- Appendicitis*



*2003 Data.; **2002 data ***no data available Countries are listed alphabetically. Data Expressed in Days

Source: OECD Health Data 2006.

Table 2.14
Medical Technology and Use of High-Technology Medical Procedures by OECD Country, 2004

Different countries spend health dollars in different ways: Japan has the highest rate of diagnostic high-tech procedures, the U.S. has the highest rate of heart procedures.

	MRIs per Million People	CT Scanners per Million People	Coronary Bypass Procedures per 100,000 People	Coronary Angioplasty Procedures per 100,000 People	Patients Undergoing Dialysis per 100,000 People	Bone Marrow Transplants per 100,000 People
Australia	3.7	20.8*****	77.9*	153.0*	39.5	5.6*
Austria	14.9	28.5	54.6*	174.8****	43.7	4.6
Canada	4.9	10.3	97.6*	167.4***	56.4	3.9***
Denmark	10.2	14.5	60.0*	156.9*	45.1	0.7*****
France	3.2	7.5	40.8***	155.9****	26.2*****	6.9
Germany	6.6	15.4	86.5	301.6	73.9	4.8
Greece	2.3**	17.1**	59.6*****	122.9**	75.4	1.9
Hungary	2.6	6.8	135.5	235.8	49.6	2.8
Italy	10.2	20.6	46.5*	92.4*	34.4*****	7.1*
Japan	35.3**	92.6**	_	_	194.3	0.9
Mexico	1.7	3.1	2.3	1.5	37.2	0.1
Netherlands	3.9*****	9*****	58.2	92.6*	28.2*****	3.6
Poland	1*	6.3*	8*****	19*****	……	2.1*
Spain	7.7	13.3	29.9*	58.5*	49.3	4.6
Sweden	7.9*****	14.2*****	75.1*	144.0*	25.5*****	2.0***
Switzerland	14.3	17.9	32.6	85.6	26.5*****	1.7
United Kingdom	5.0	7.0	55.5	113.4	41.6	4.2
United States	…..	…..	160.7*	426.4*	159.5*	5.1*
Median	6.0*	14.0*	60.0*	158.5*	45.1*	2.9*

*2003 data,**2002 data, ***2001 data, ****2000 data, *****earlier data. Medians reflect all OECD countries

Source: OCED Health Data 2006

Table 2.15
Selected Indicators of Morbidity by OECD Country, Selected Years

Risky behaviors vary significantly by country: the U.S. has higher rates of obesity and HIV; Western Europe has higher rates of smoking and in some countries, surgery.

	2002 Incidence of Cancer (All Types of Malignant Neoplasms) per 100,000	2004 Incidence of AIDS in Population, per 1,000,000	2004 Total Surgeries on an In-patient Basis, per 1,000	2004 Percentage of Population That is Obese (BMI >30)	2004 Percentage of Population That are Daily Smokers	2004 Percentage of Total Live Births That are Low-birthweight Births
Australia	312.0	12.0	50.2*	21.7*****	17.7	6.3*
Austria	275.5	8.2	133.6*	9.1*****	36.3*****	6.8
Canada	299.9	9.4	44.8*	122.4	15.0	5.8*
Denmark	281.4	9.9	97.4	9.5****	26.0	5.3
France	289.5	23.4*	_	9.5	23.0	6.8
Germany	283.3	6.0*	79.4	12.9*	24.3*	6.9
Greece	203.0	6.8	_	21.9*	38.6	8.6
Hungary	318.8	2.3	228.6	18.8*	30.1*	8.3
Italy	276.5	29.2	52.7*	8.0*	24.2*	6.7*
Japan	214.5	3.0	_	3.2*	29.4	9.4
Mexico	147.3	45.3*	31.3	24.2****	26.4**	9.1
Netherlands	283.0	12.1	39.8	10.9	30.0	5.4**
Poland	256.1	4.9	_	_	27.6****	5.1
Spain	243.4	43.0	51.9*	13.1*	28.1*	7.1
Sweden	264.7	7.5	54.6**	9.8	16.2	4.2
Switzerland	284.6	4.8	103.9	7.7**	26.8**	6.5
United Kingdom	273.6	14.1	63.3	23.0*	25.0	7.6*
United States	357.7	149.0	89.9	30.6**	17.0	8.1
Median	266.2	9.9	52.7*	12.9*	26.5	5.1

*2003, **2002, ***2001, ****2000, *1999 or earlier
Median includes all OECD countries.
Source: OECD Health Data 2006.

Table 2.16
Selected Indicators of Mortality by OECD Country, 2004

Causes of mortality differ: the U.S. and Mexico have high homicide rates, Japan and Europe have high suicide rates.

	Cancer Mortality Rates, per 100,000	Suicide Rates for Total Population, per 100,000	Homicide Rates for Total Population, per 100,000	Homicide Rates for Males, per 100,000	HIV Mortality Rates for Total Population Due to HIV Infection, per 100,000
Australia	161.0	11.1**	1.4**	1.9***	0.5**
Austria	161.4	14.5	0.7	0.7	0.5
Canada	173.2**	10.6**	1.5**	2.0**	1.0**
Denmark	212.5****	11.3***	.8***	1.1***	0.5***
France	172.7**	15.1***	0.8**	.9**	1.4**
Germany	161.2	10.3	0.6	0.7	0.5
Greece	152.4*	2.9*	1.0*	1.5*	0.2*
Hungary	244.8*	22.6*	1.8*	2.2*	0.1*
Italy	167.3**	5.6**	0.9**	1.3**	0.0**
Japan	146.5**	20.3*	0.15*	0.6*	0.4*
Mexico	114.2****	_	20.1****	37.8****	_
Netherlands	182.2	7.9	1.1	1.6	0.4
Poland	202*	13.6*	1.4	2.0*	0.3*
Spain	158.*	6.7*	0.9*	1.4*	3.2*
Sweden	148.8**	11.4**	1.1**	1.1**	0.3**
Switzerland	144.1**	15.3**	0.9**	0.8**	1.1**
United Kingdom	181.8**	6.3**	1.2**	1.2**	0.3**
United States	166.3**	10.2**	6.2**	9.7**	4.2**
Median	166.0**	11.5**	1.2**	1.5**	0.35**

Median includes all OECD countries. *2003 data;**2002data;***2001data,****earlier data
Source: OECD Health Data 2006.

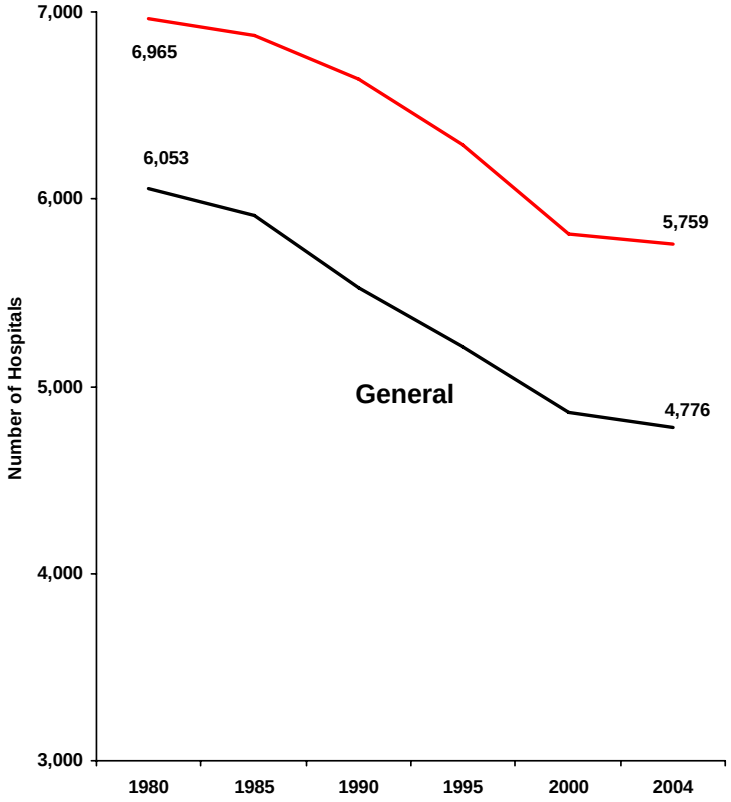
Section 3

Providers

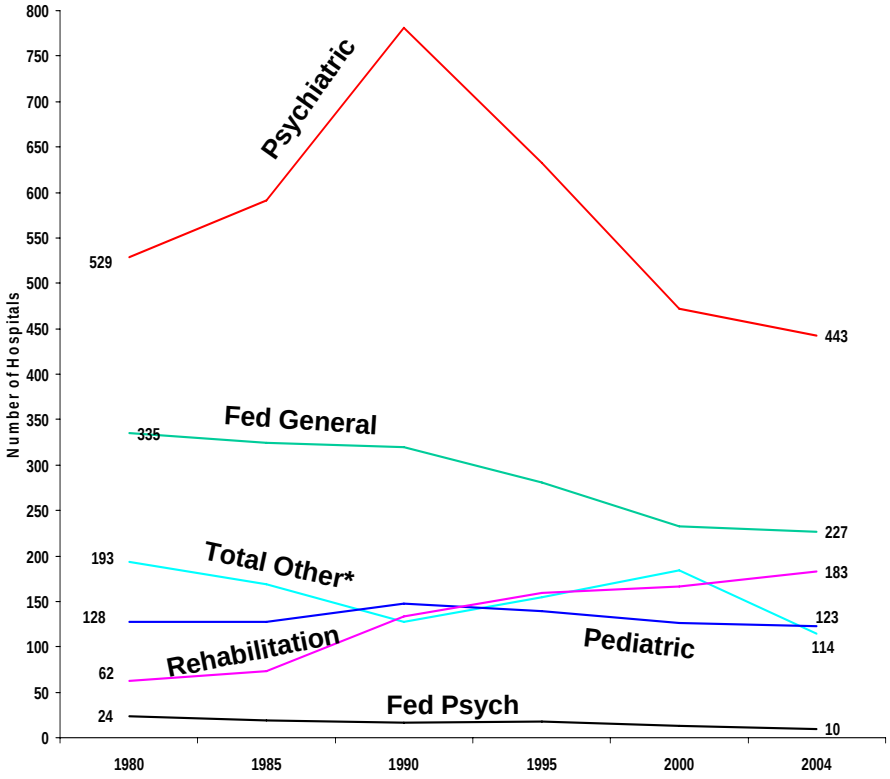
Table 3.1
Number of Hospitals by Type, 1980-2004

The number of hospitals has declined with the exception of rehabilitation hospitals.

All Hospitals



Specialty Hospitals

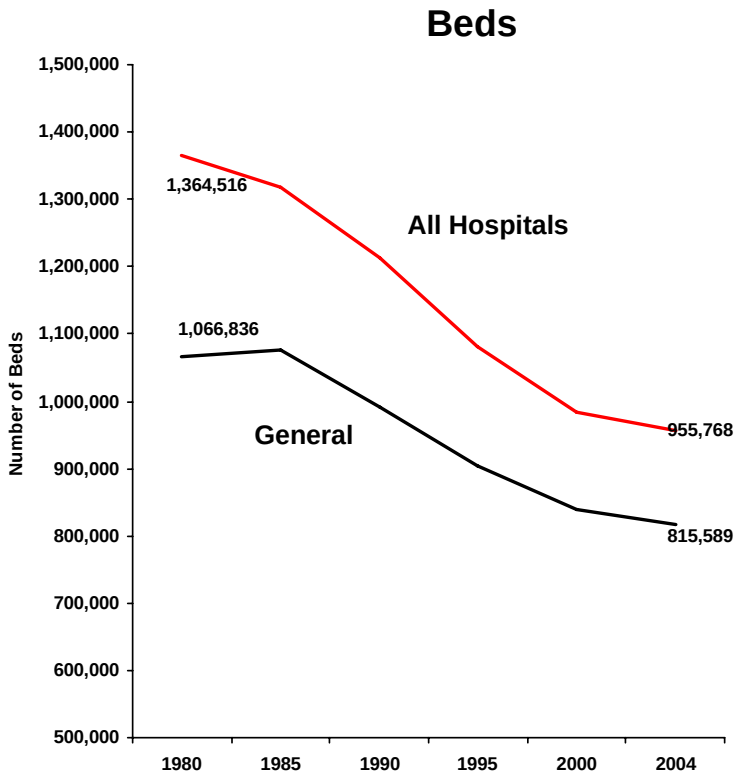


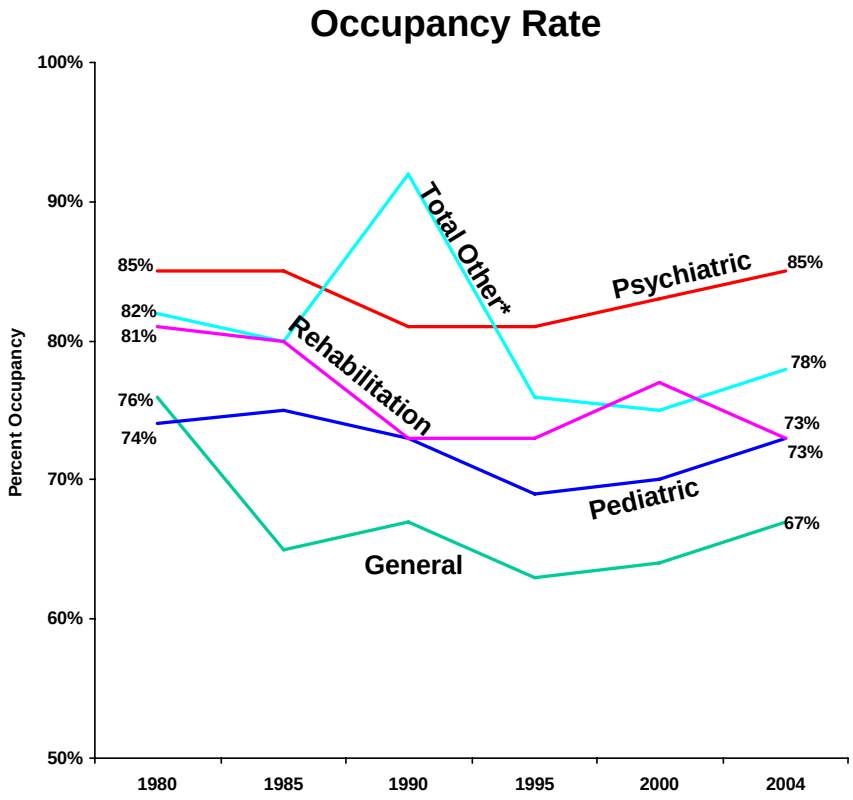
*Includes specialty hospitals such as TB, Ob-Gyn; eye, ear, nose and throat; orthopedic and chronic disease.

Source: American Hospital Association, personal communication, 2006.

Table 3.2
Number of Hospital Beds and Occupancy Rates by Hospital Type, 1980-2004

The decline in the percentage of general hospital beds is greater than the percentage decline in occupancy rates in general hospitals.



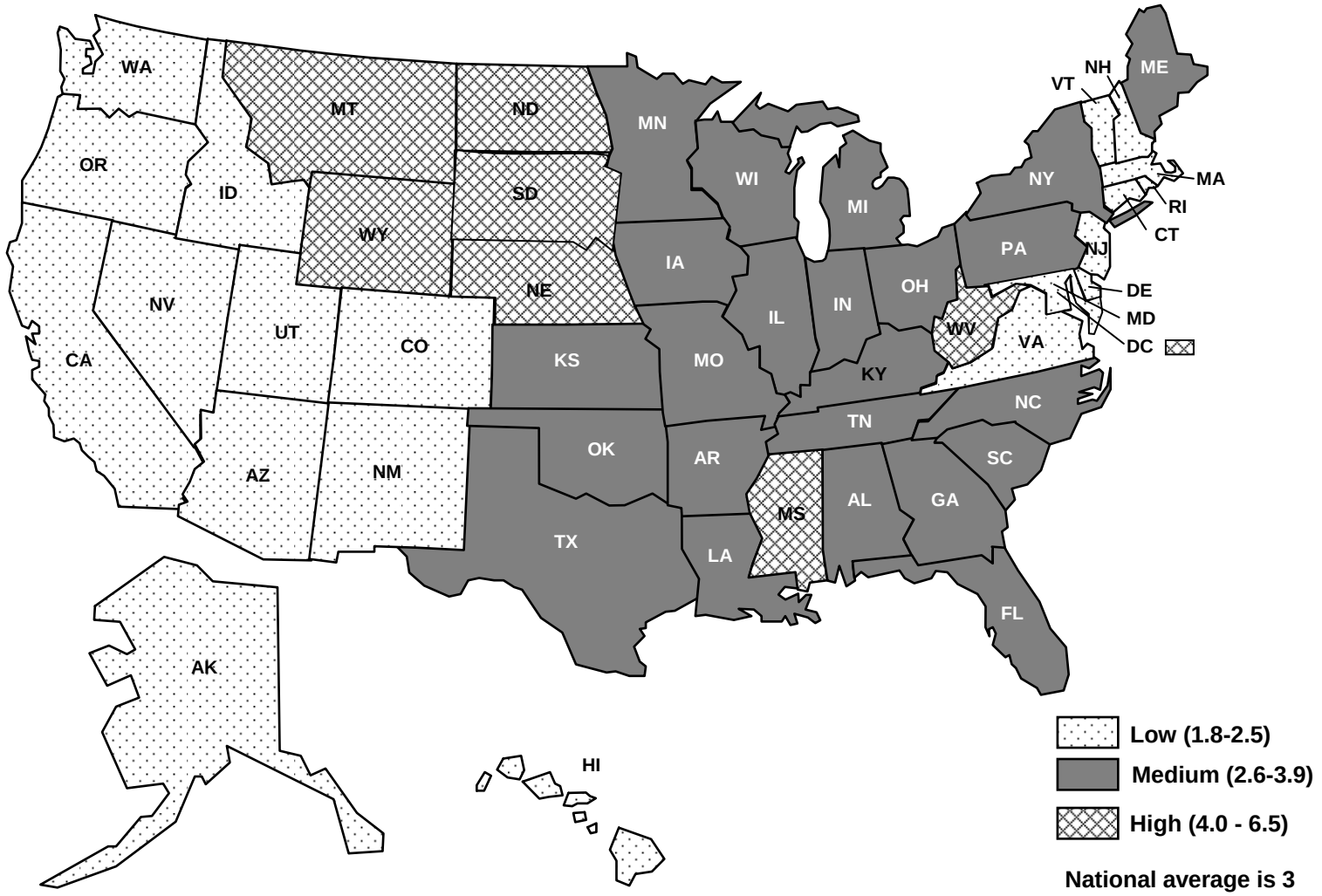


*Includes specialty hospitals such as TB, Ob-Gyn; eye, ear, nose and throat; orthopedic and chronic disease.

Source: American Hospital Association, personal communication, 2006.

Table 3.3
Number of Hospital Beds per 1,000 Persons by State, 2004

The number of hospital beds varies by state, with the lowest concentration in the Western U.S.

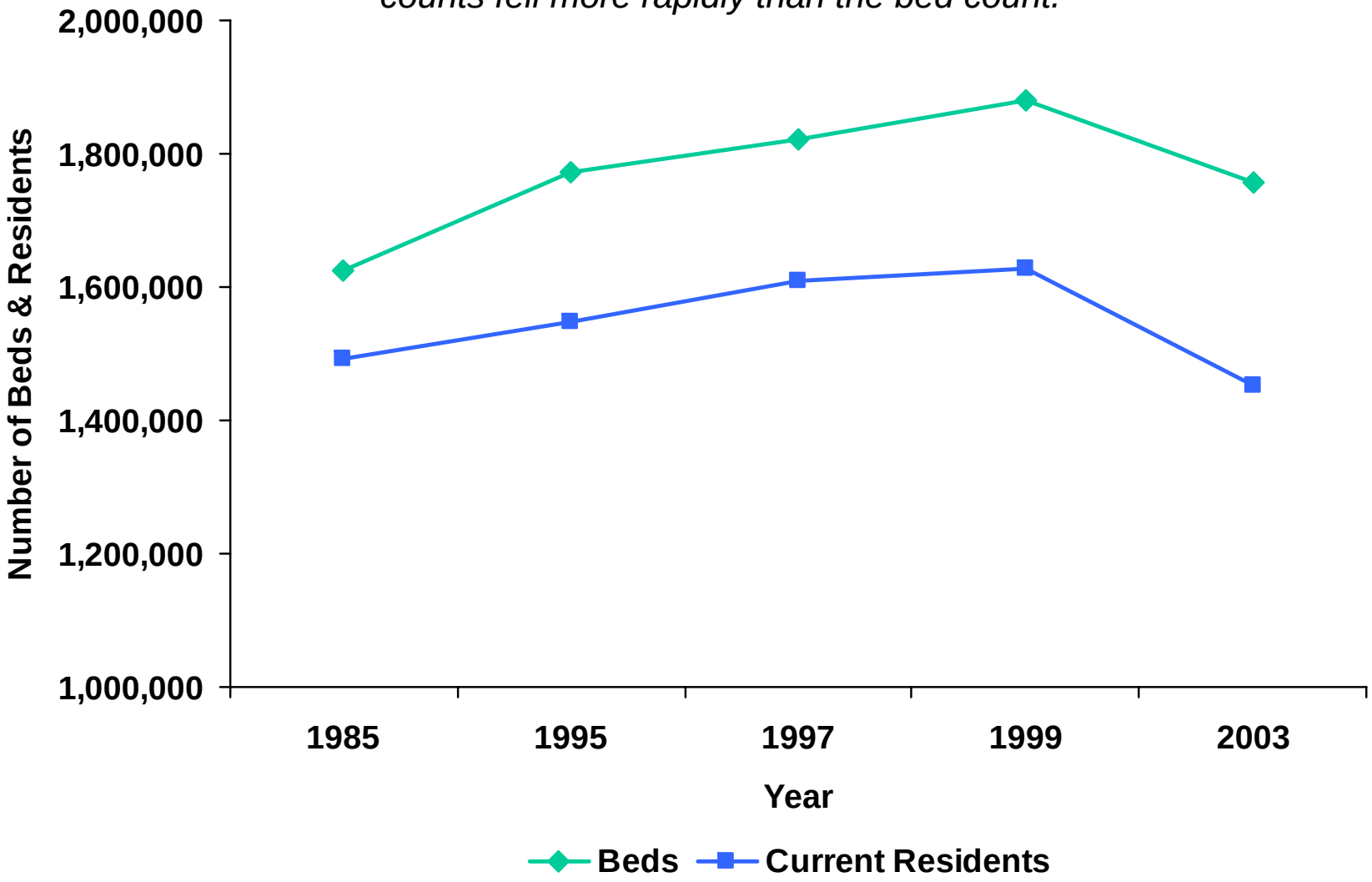


Note: Per 1,000 population.

Source: 2004 AHA Annual Survey. Kaiser Family Foundation State Health Facts Online.

Table 3.4
Number of Nursing Home Beds and Total Residents, 1985-2003

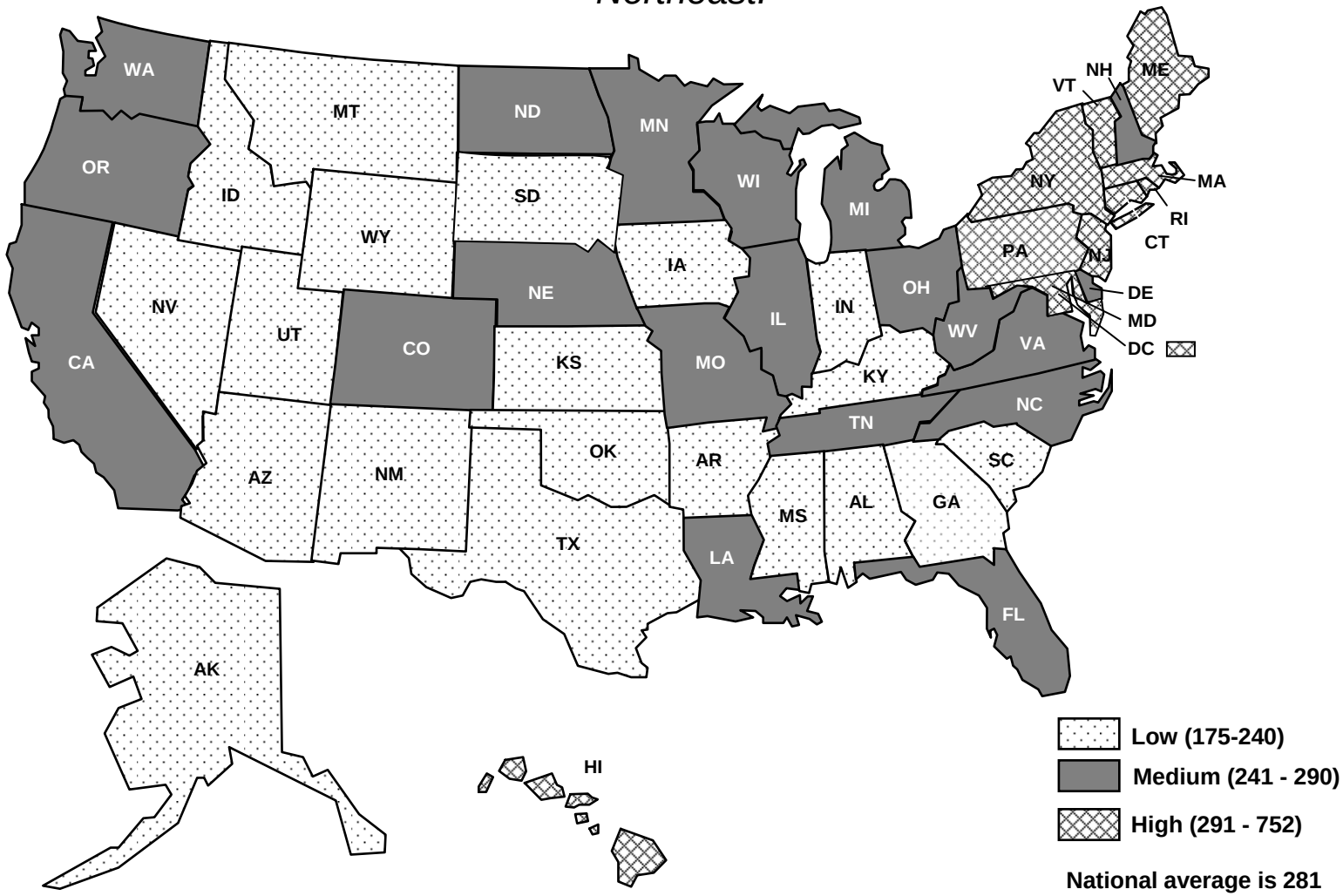
From 1985 to 1999 beds grew slightly more rapidly than residents, after 1999, resident counts fell more rapidly than the bed count.



Source: Health, United States, 2005, National Center for Health Statistics.

Table 3.5
Number of Physicians per 100,000 Persons by State, 2004

Availability of Physicians varies substantially by state, with the highest concentration in the Northeast.

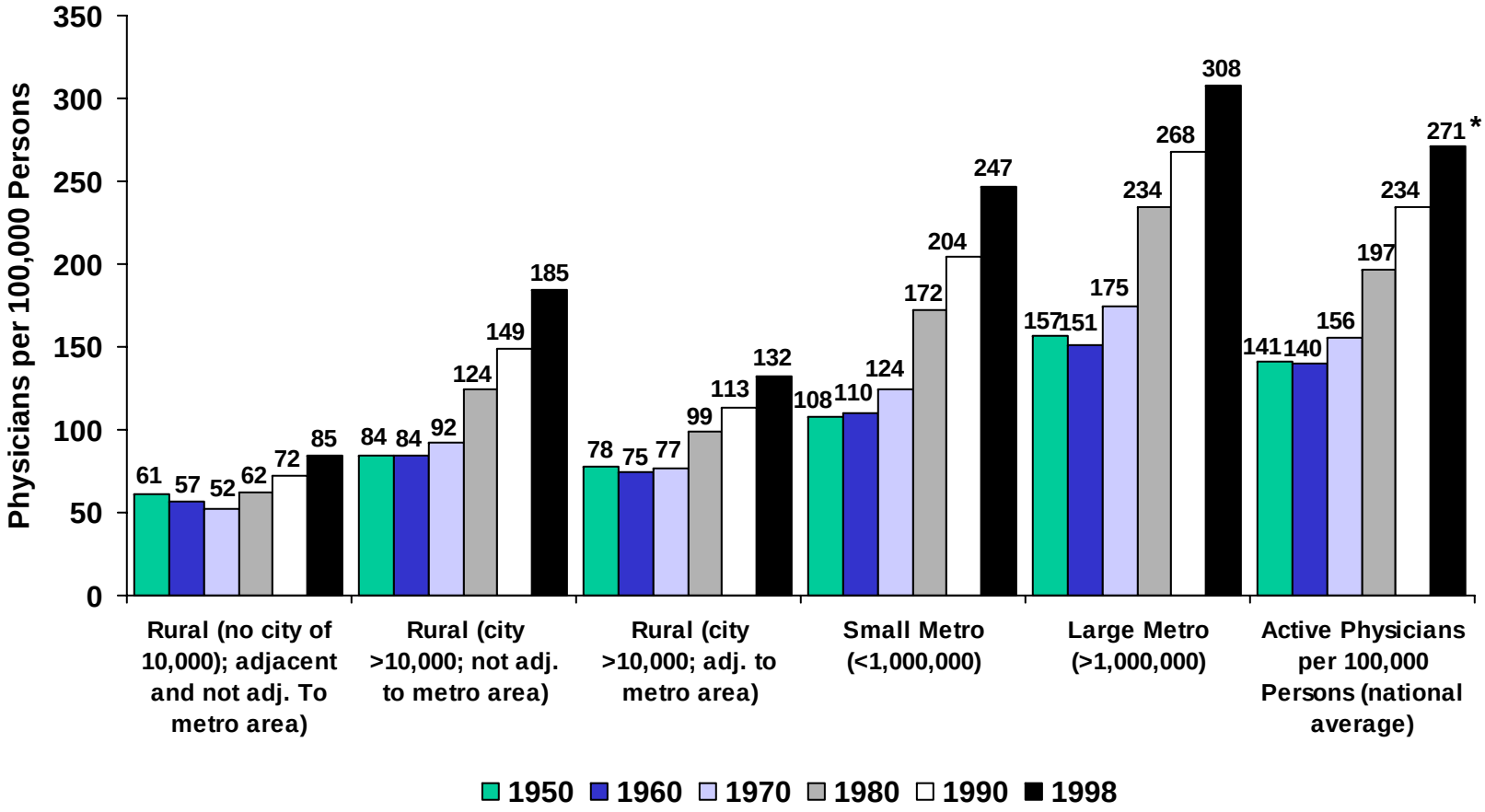


Note: Includes non-federal physicians only.

Source: Physician Characteristics and Distribution in the U.S. 2004. American Medical Association. Kaiser Family Foundation State Health Facts Online.

Table 3.6
Distribution of Active Physicians, 1950-1998

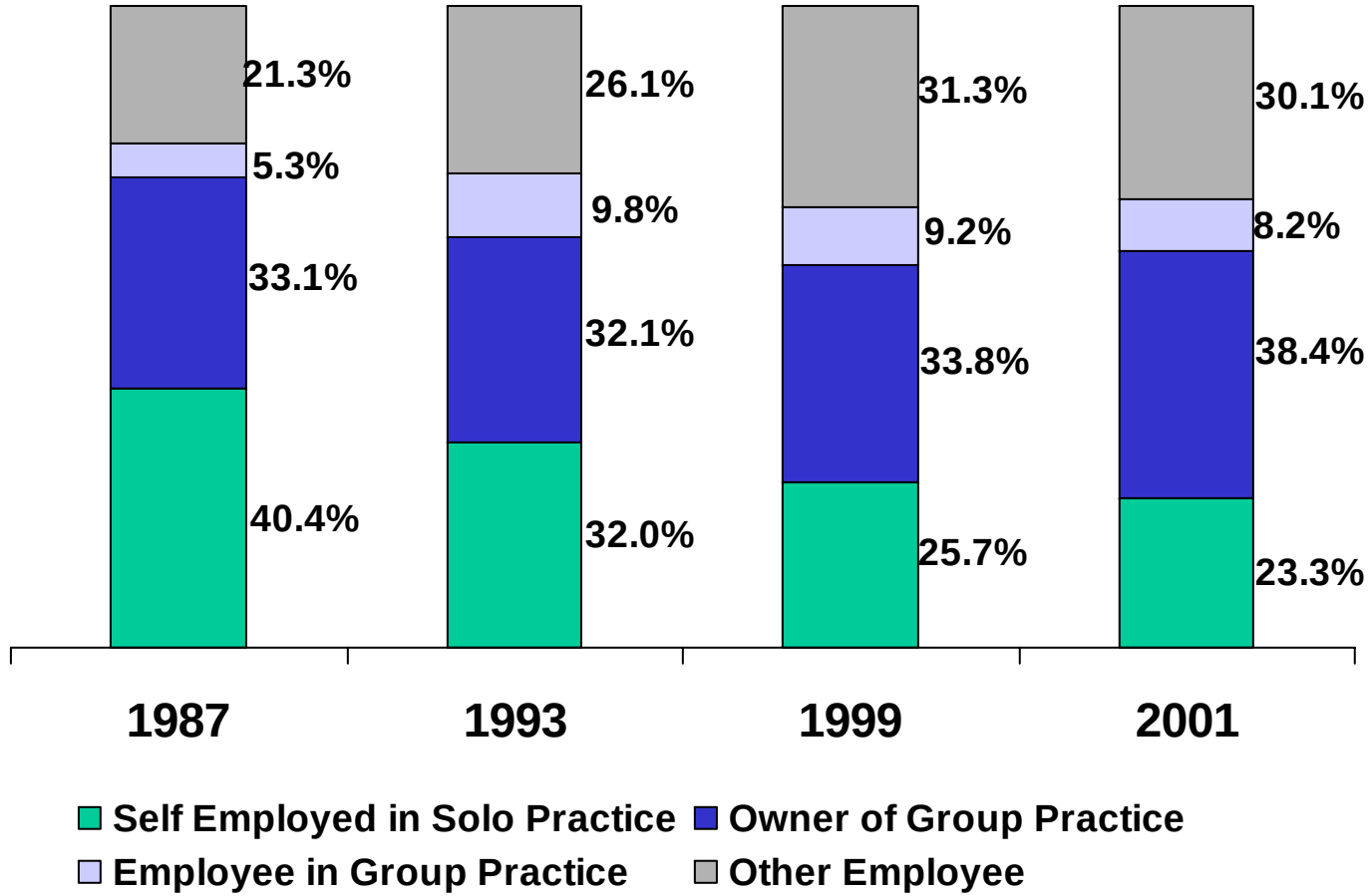
Since 1950, urban areas have seen much more rapid growth in physicians than rural areas.



*Projection for 2000.
Note: Includes all active physicians.
Source: AMA data from the Bureau of Health Professions and Health, United States, 1993.

Table 3.7
Percentage of Physicians in Differing Practice Arrangements, 1987-2001

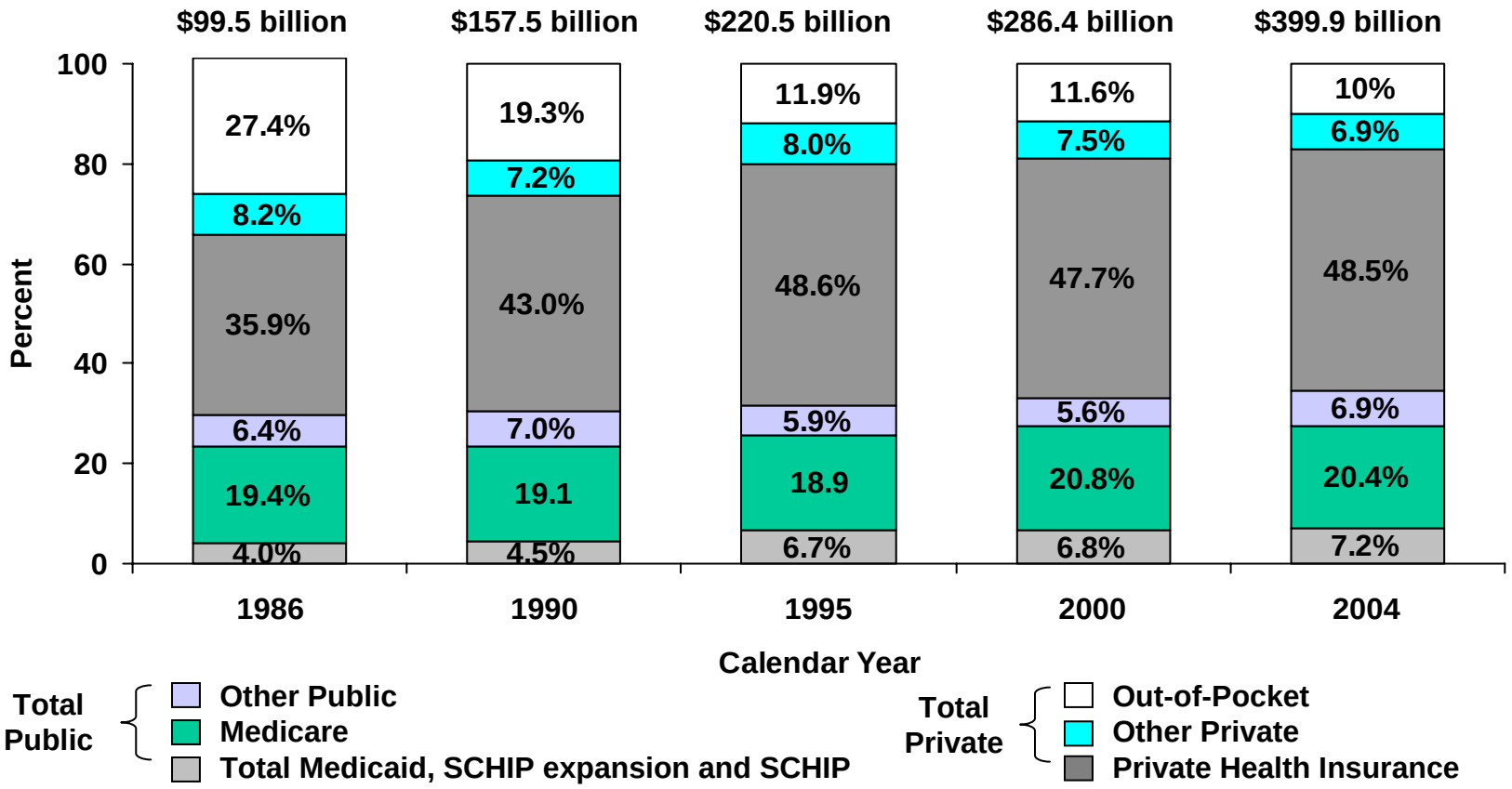
Declines in solo practice physicians are offset by increases in salaried physicians and group practices.



Source: AMA Socioeconomic Monitoring System and 2001 Patient Care Physician Surveys, American Medical Association

Table 3.8
Physician Revenue by Payer, 1986-2004

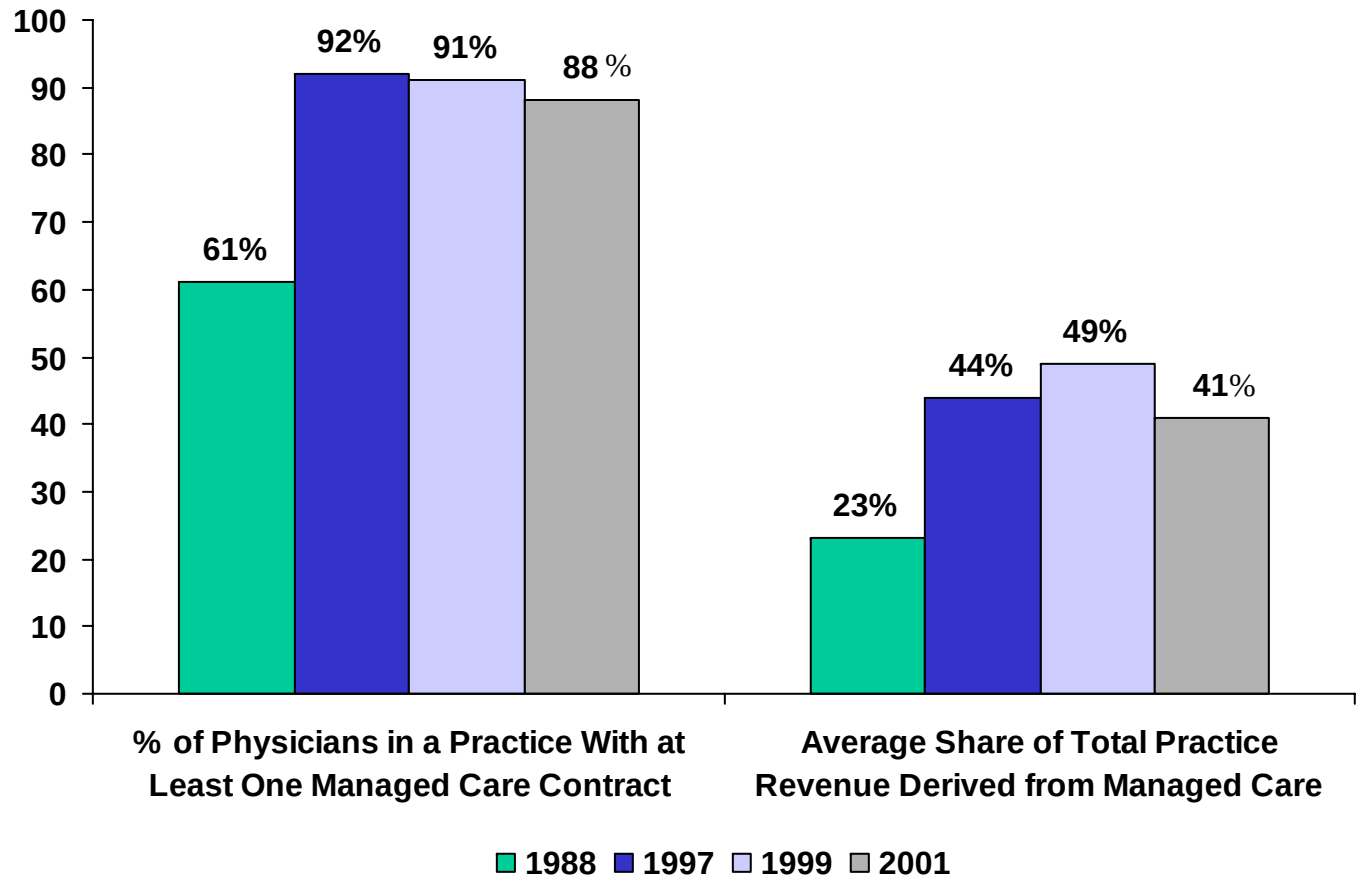
The share of physician and clinical services revenue paid by patients out-of-pocket has declined substantially since 1986. Private health insurance continues as the largest source of physician and clinical services revenue.



Source: CMS, Office of the Actuary, National Health Statistics Group.

Table 3.9
Physician Participation in Managed Care, 1988-2001

Most physician practices have managed care contracts and receive a significant share of revenue from them.

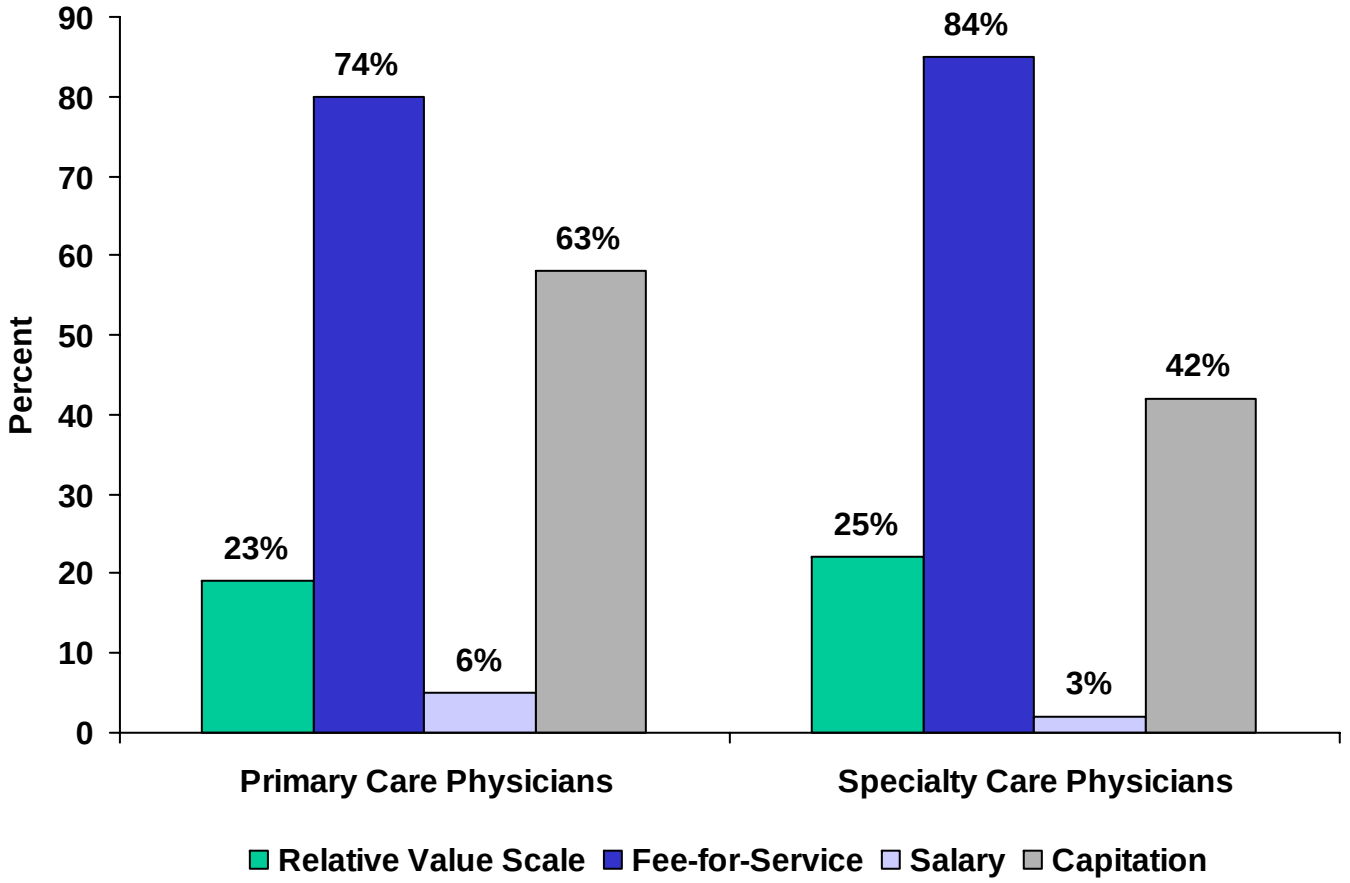


Note: Managed care contracts include HMOs, IPA, and PPOs. Data from the American Medical Association.

Source: Trends and Indicators in the Changing Health Care Marketplace, 2005, Kaiser Family Foundation.

Table 3.10
Physician Managed Care Payment Arrangements, 2001

Fee-for-Service is the predominant payment arrangement for physicians.

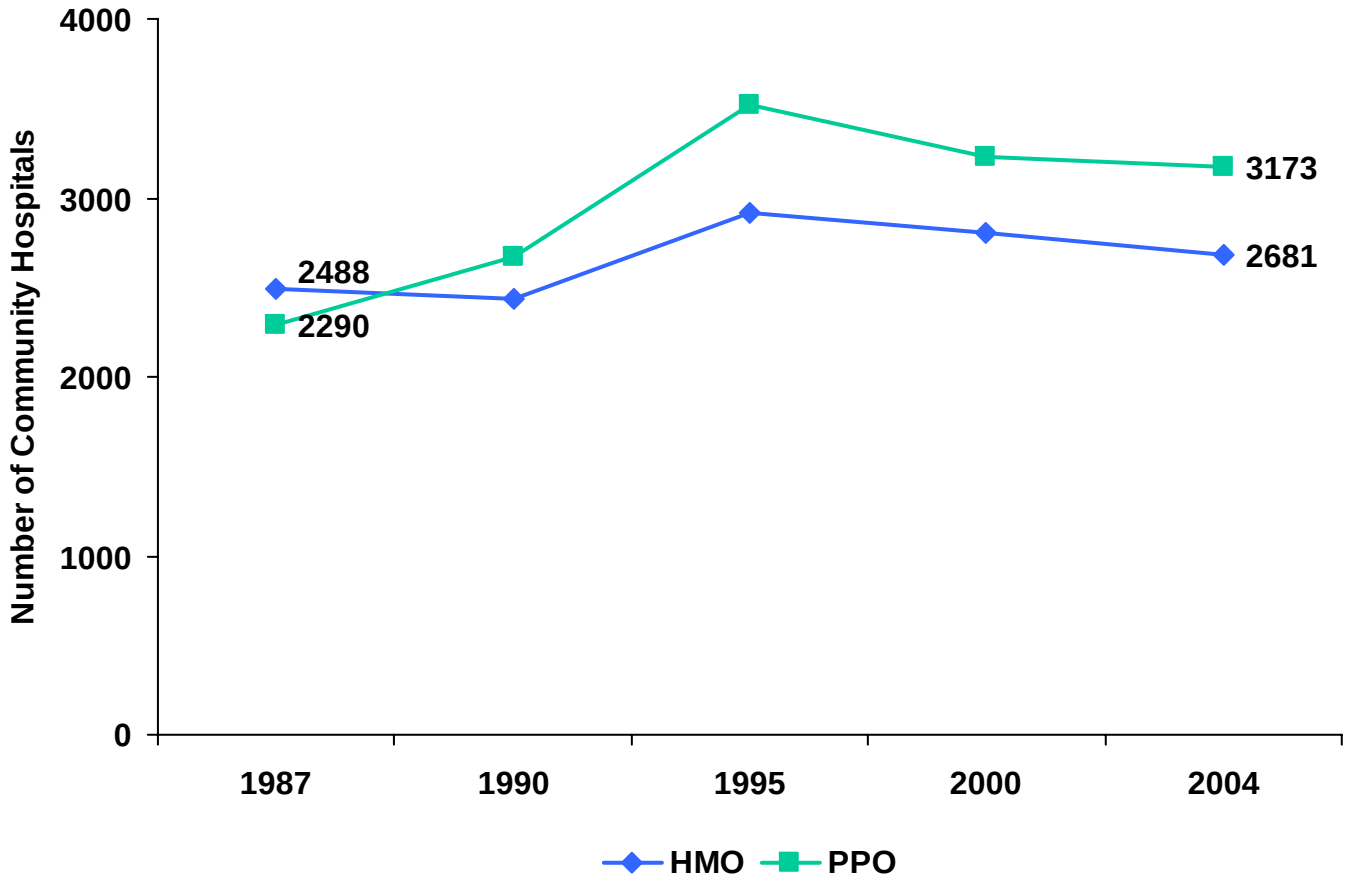


Note: Physicians may receive payment in multiple ways, so the payment methods do not add to 100%.

Source: Trends and Indicators in the Changing Health Care Marketplace, 2005, Kaiser Family Foundation.

Table 3.11
Hospital Participation in HMOs and PPOs, 1987-2004

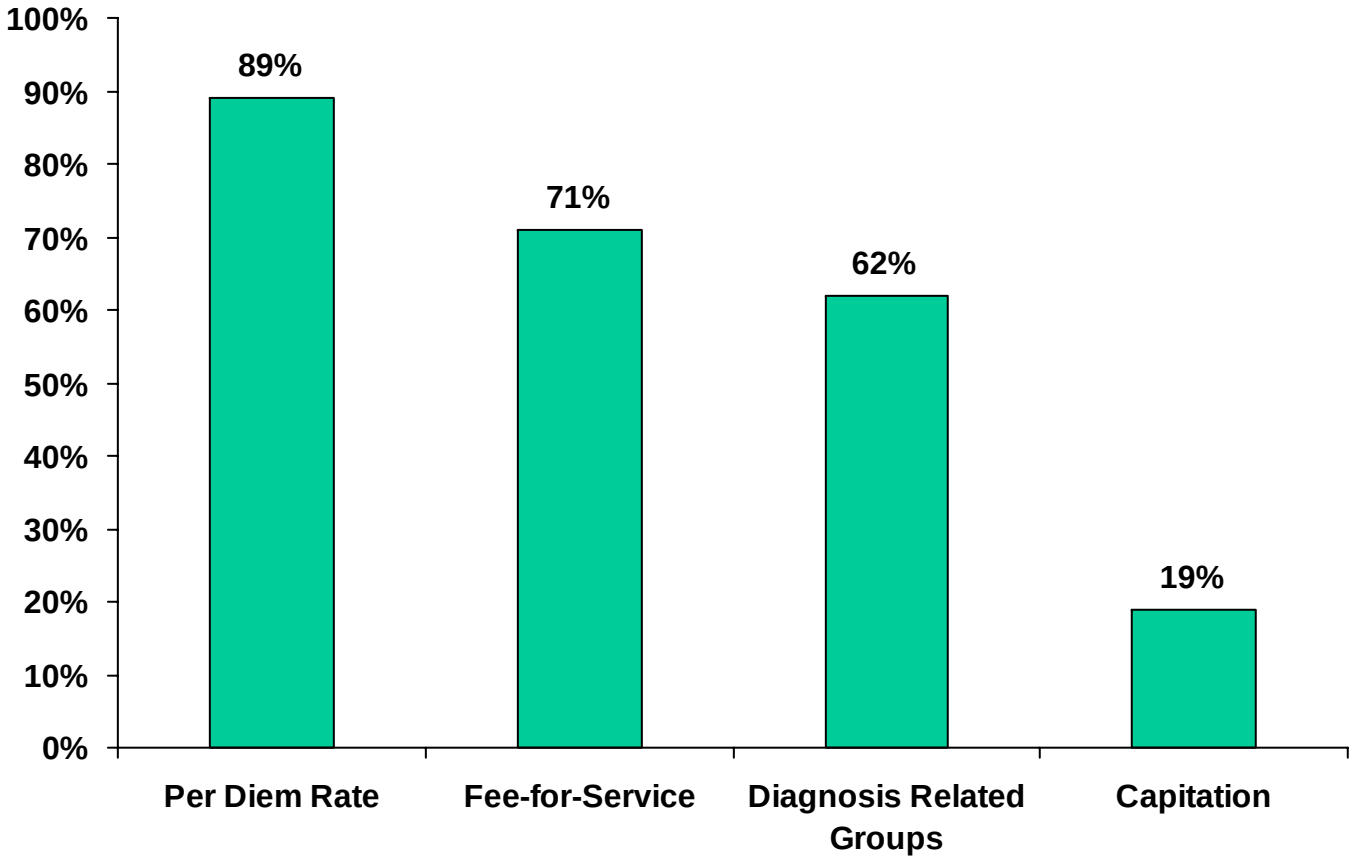
A steady rise in the number of hospitals participating in both Health Maintenance and Preferred Provider Organizations has leveled off in recent years.



Source: American Hospital Association, personal communication.

Table 3.12
Hospital Managed Care Payment Arrangements, 2001

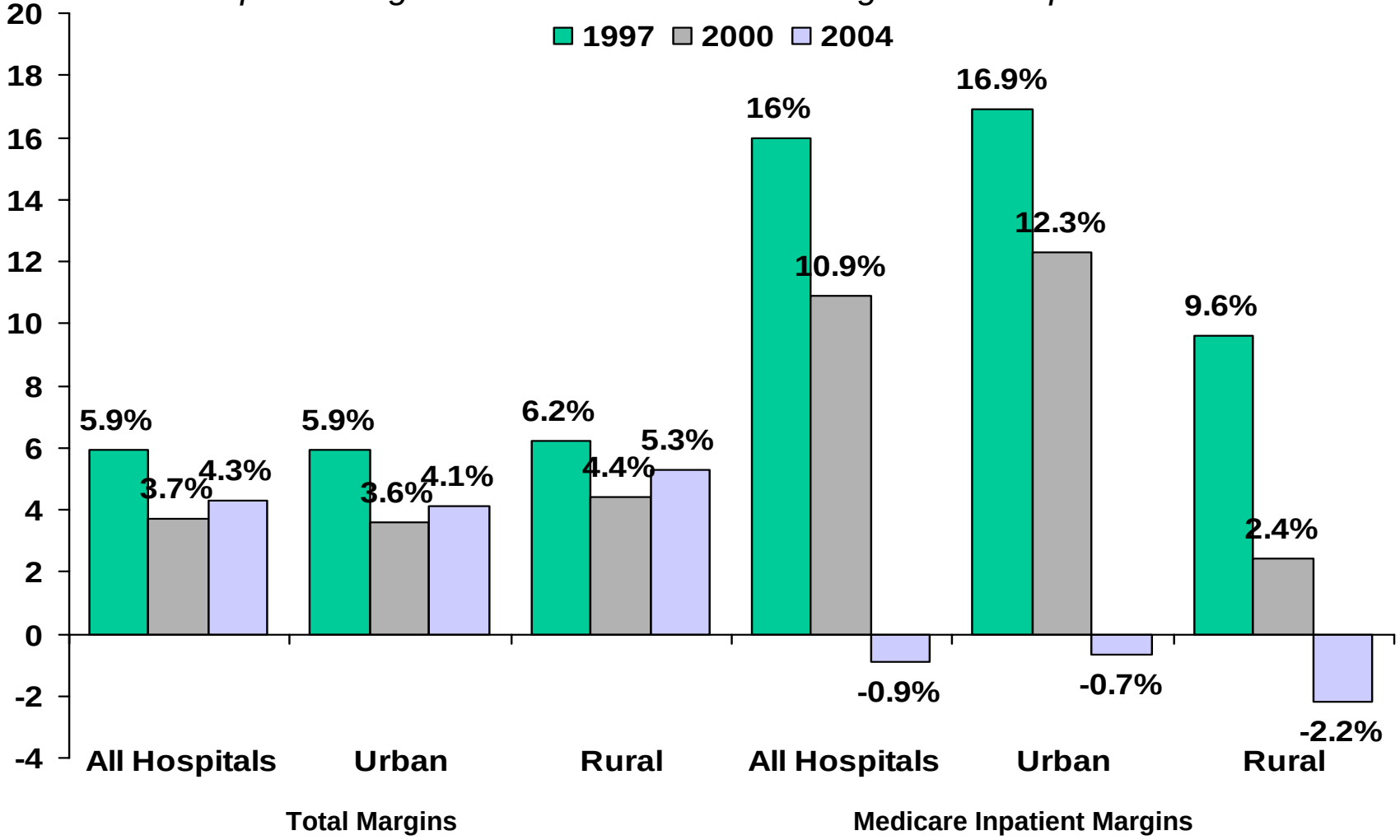
Most hospitals receive per diem and fee-for-service payments, a much smaller number also receive capitated payments.



Source: Trends and Indicators in the Changing Health Care Marketplace, 2005, Kaiser Family Foundation.

Table 3.13
Hospital Profit Margins for All Payers and Medicare, 1997-2004

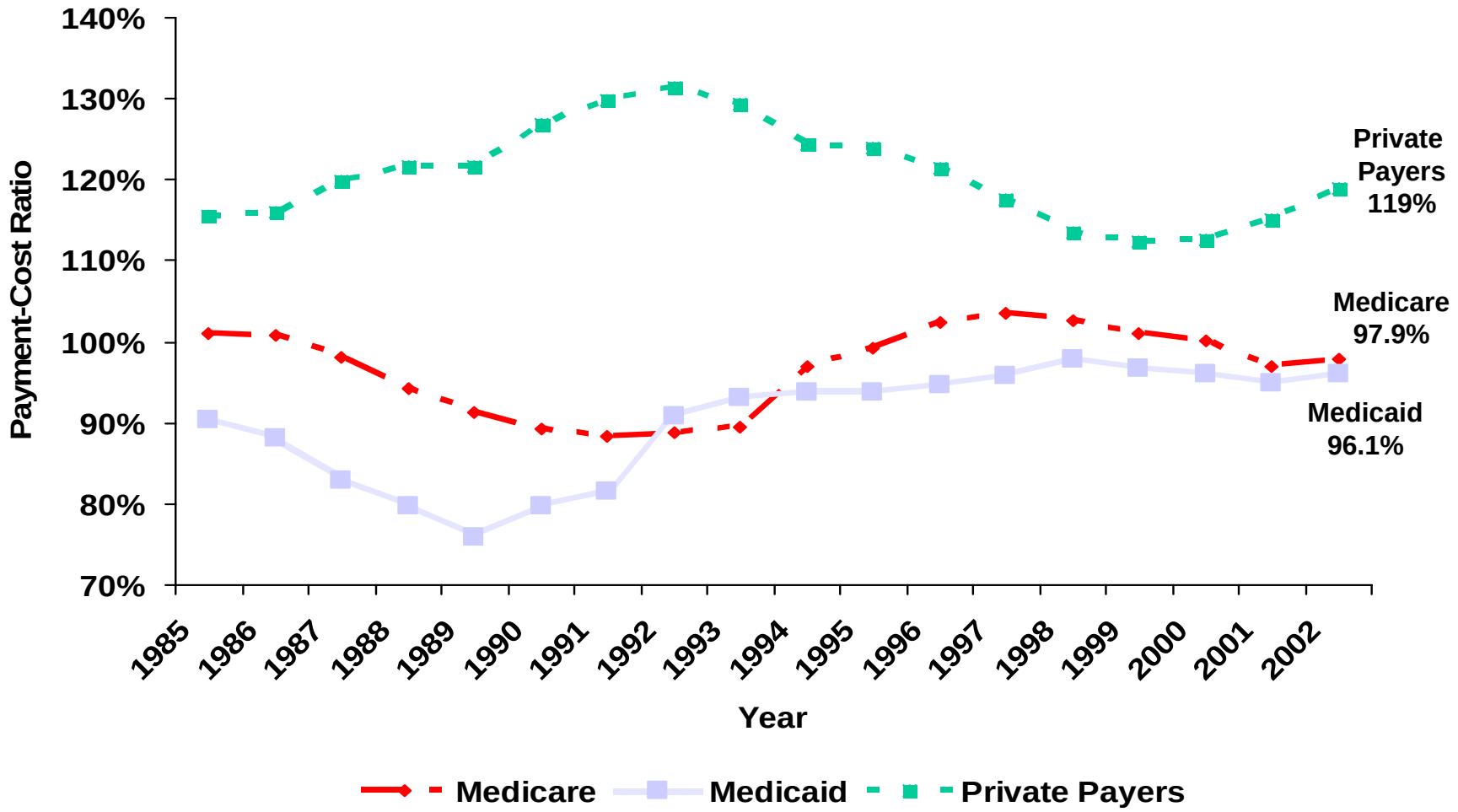
For both rural and urban hospitals, overall and Medicare inpatient hospital profit margins have declined. Total margins remain positive.



Source: CMS, Office of the Actuary. Medicare cost report data.

Table 3.14
Hospital Payment to Cost Ratios for Medicare, Medicaid, and Private Payers, 1985-2002

Private Payers continue to pay a larger share of hospital costs than Medicare and Medicaid but less so than in the late eighties and early nineties..

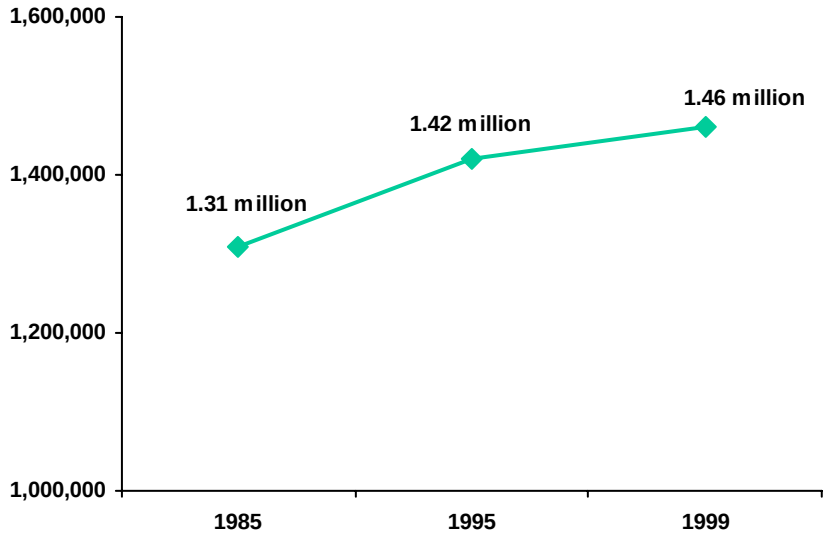


Source: American Hospital Association Annual Survey. Chapter 4. Trends in Hospital Financing

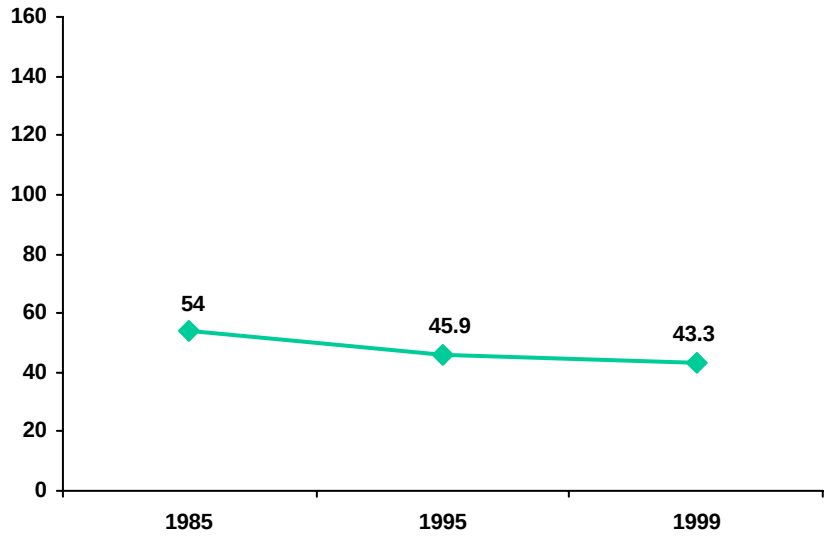
Table 3.15
Change in Nursing Home Institutionalization Rate for the Elderly, 1985-1999

While the absolute number of elderly in nursing homes continues to rise, the number of residents per 1,000 elderly has declined.

Total Number of Elderly in Nursing Homes



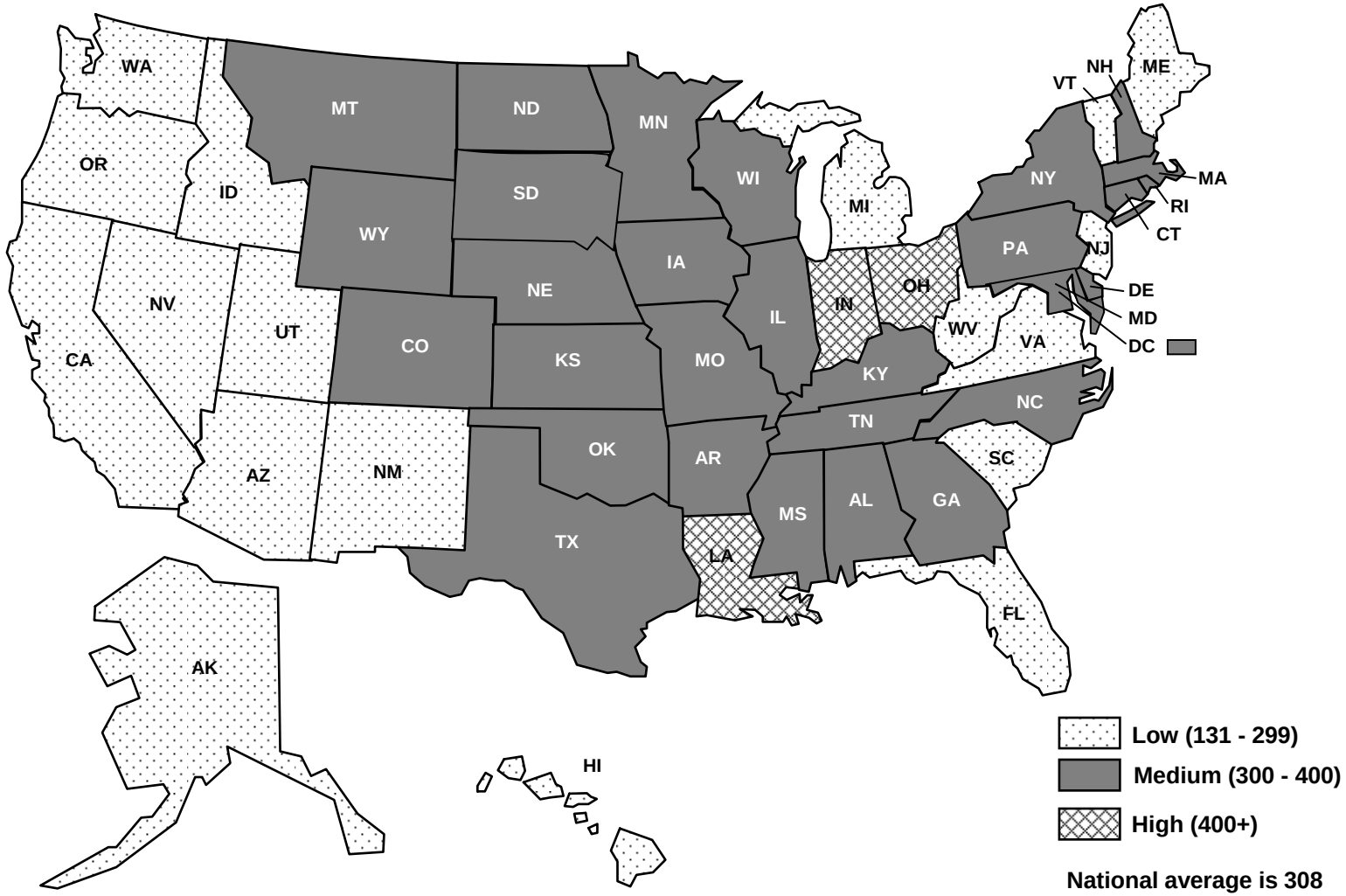
Rate of Elderly in Nursing Homes per 1,000 Elderly



Source: Health, United States, 2005, National Center for Health Statistics.

Table 3.16
Nursing Home Resident Rate by State, 2003

The Western U.S. houses the smallest share of nursing home residents.

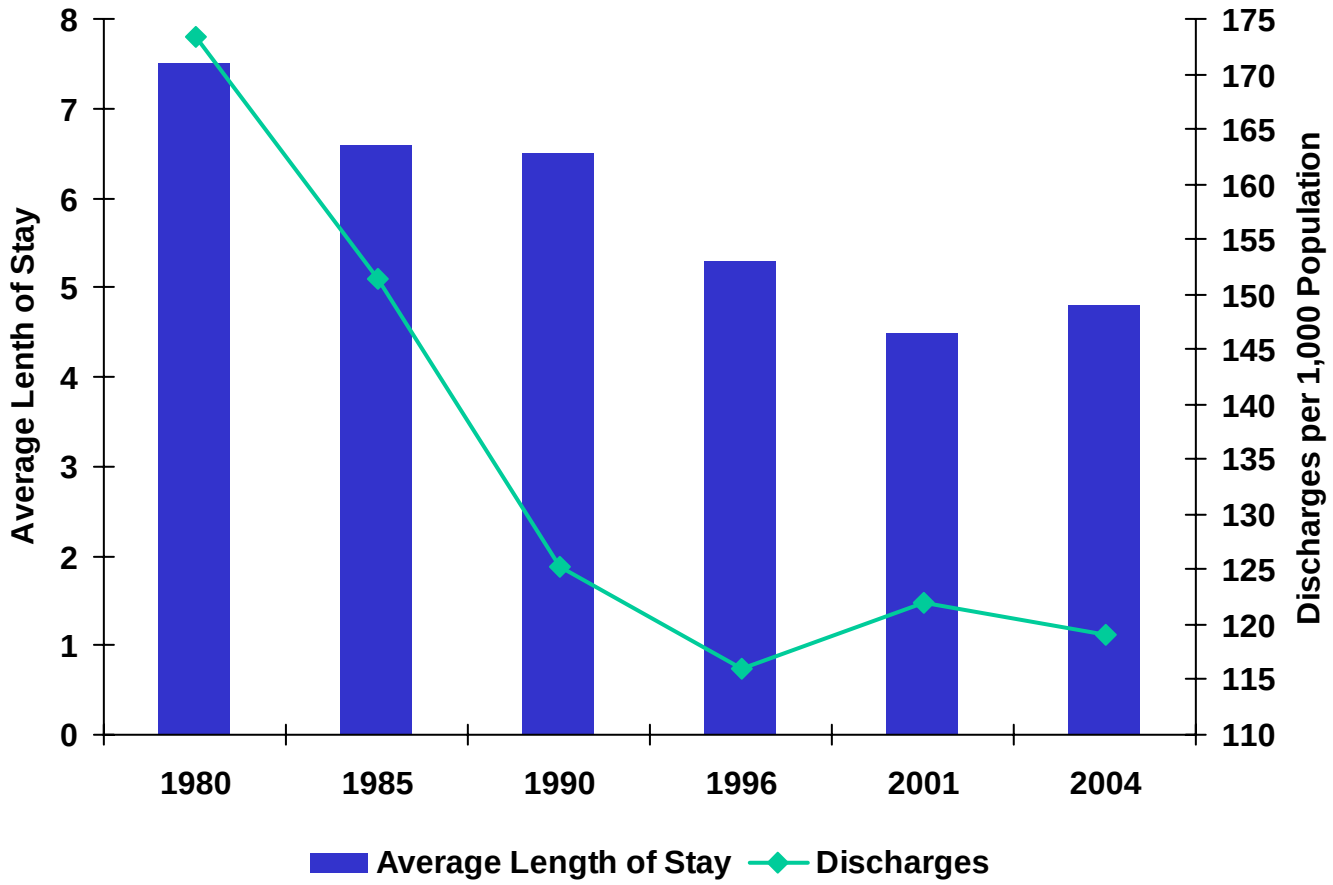


Note: Number of nursing homes residents (all ages) per 1,000 resident population 85 years of age and over.

Source: Health, United States, 2005. Table 116.

Table 3.17
Number of Hospital Discharges and Average Length of Stay, 1980-2004

Hospital discharges and length of stay have generally declined over the last two decades.

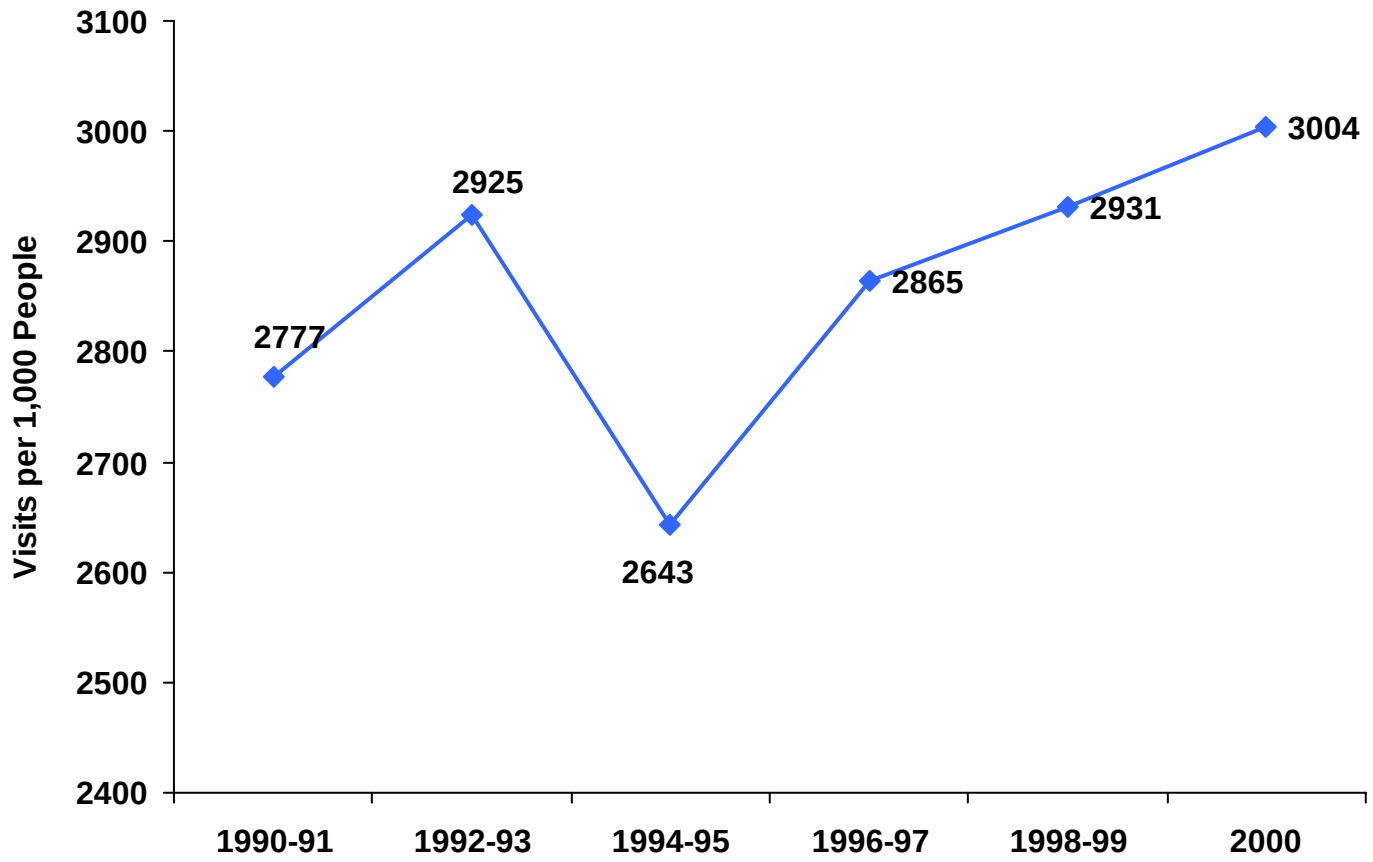


Note: Non-Federal short-stay hospitals.

Source: Center for Disease Control and Prevention, National Center for Health Statistics.

Table 3.18
Number of Physician Visits per 1,000 Persons, 1990-2000

While there was a drop in the overall number of physician visits during the early nineties, by 1996-97, visits steadily increased.



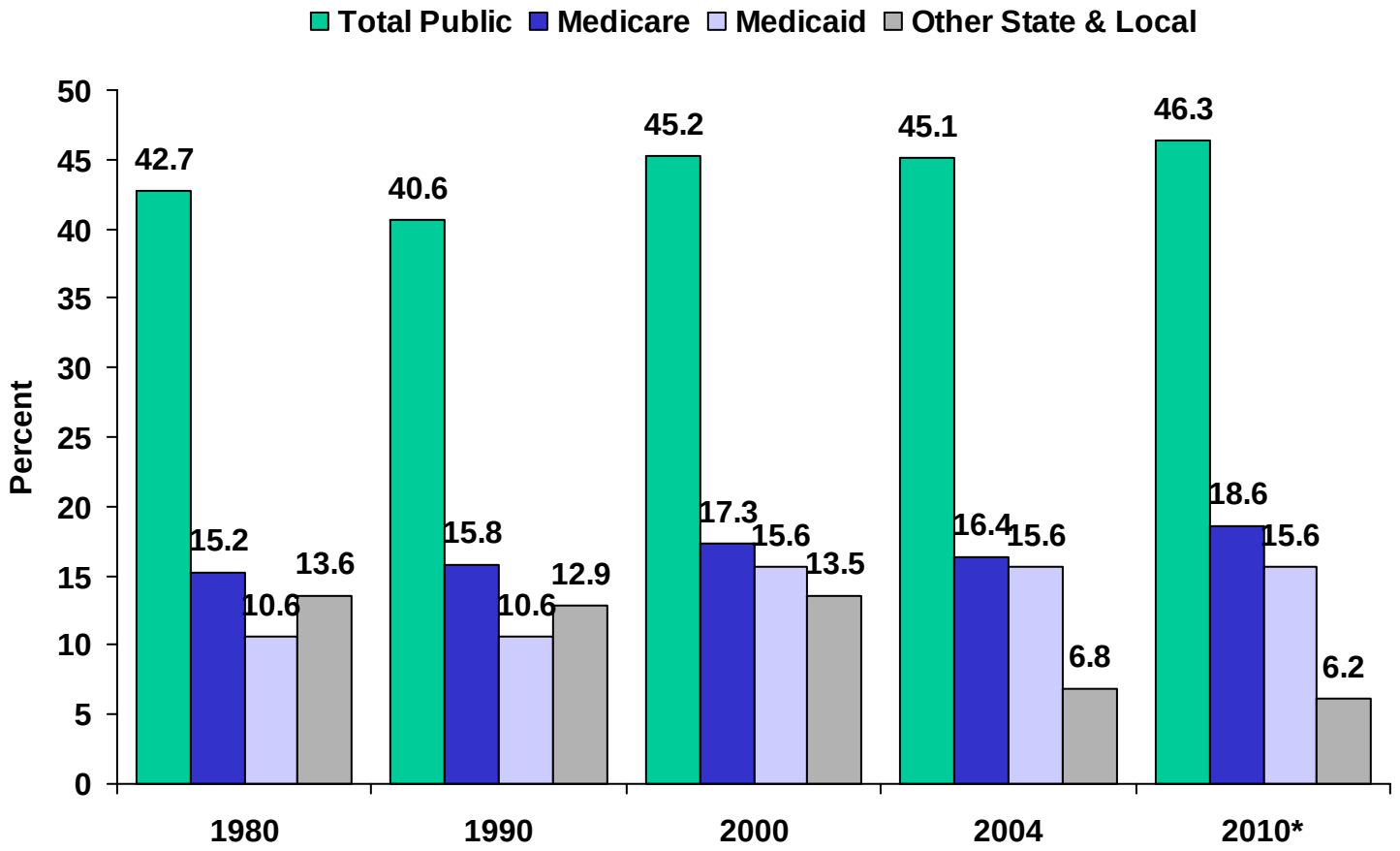
Source: Center for Disease Control and Prevention, National Center for Health Statistics.

Section 4

Public Programs

Table 4.1
Public Payers' Share of National Health Spending, 1980-2010

The share of national spending by public payers has increased slightly over the last two decades, driven by faster growth in Medicare and Medicaid spending.

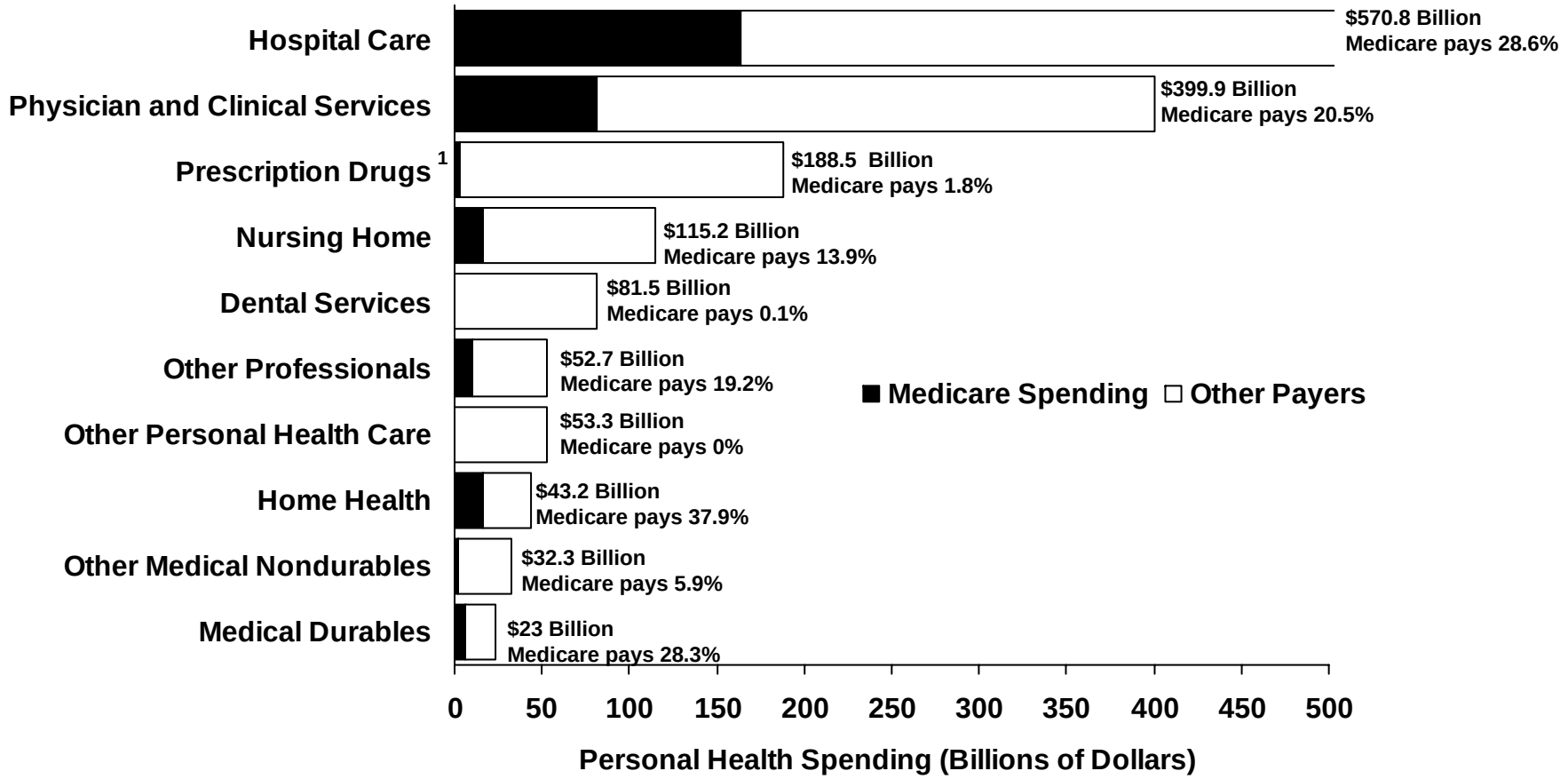


Note: Total public includes Medicare, Medicaid, other federal (not shown) and state and local spending.
*2010 is a projection.

Source: CMS, Office of the Actuary, National Health Statistics Group.

Table 4.2
Personal Health Care Expenditures by Type of Service and Percent Medicare Paid, 2004

Total personal health care spending in 2004 was $1.56 trillion; Medicare accounted for over 19%.

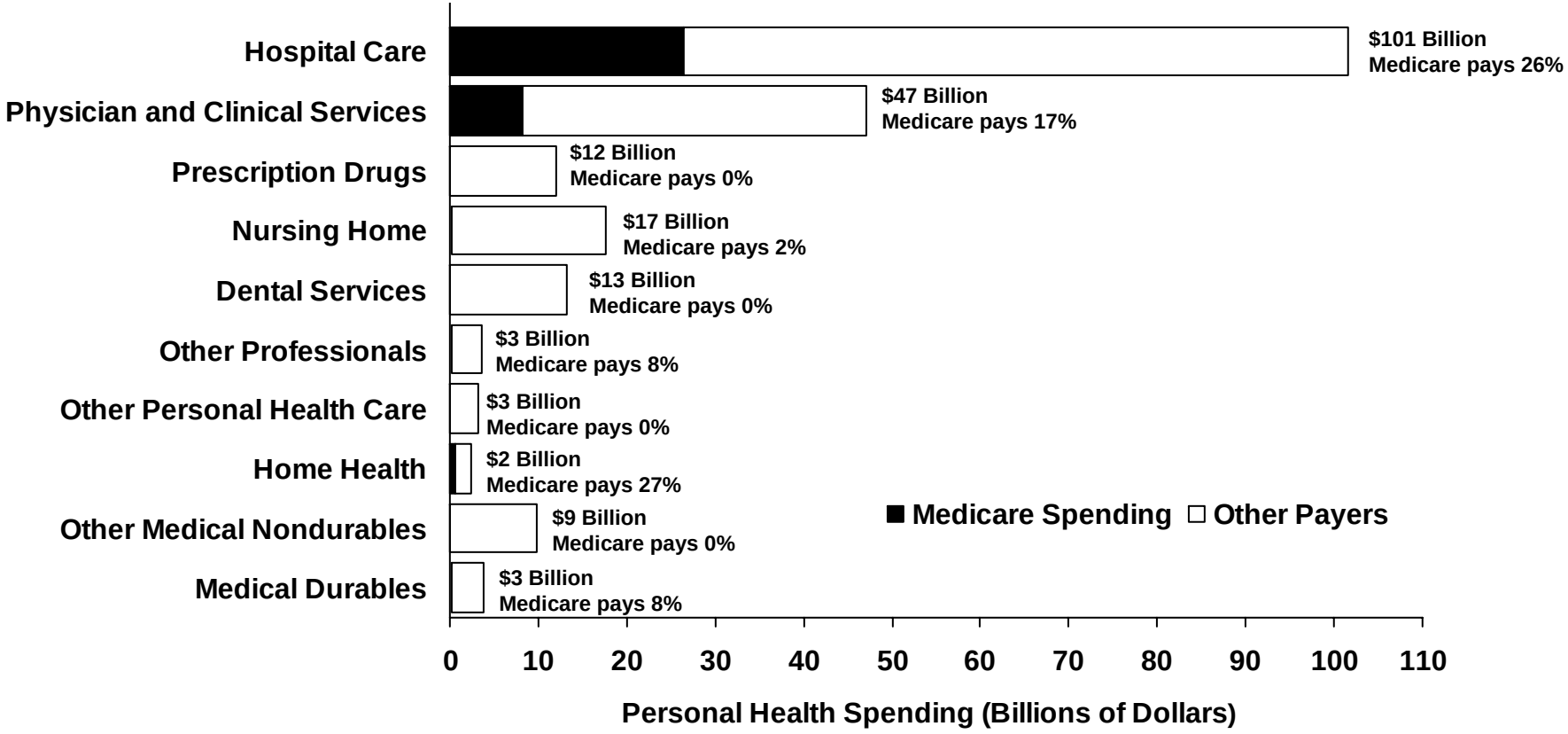


[1] Medicare payments are mostly from managed care plans, since fee-for-service Medicare did not generally cover outpatient prescription drugs in 2004.

Source: CMS, Office of the Actuary, National Health Statistics Group.

Table 4.3
Personal Health Care Expenditures by Type of Service and Percent Medicare Paid, 1980

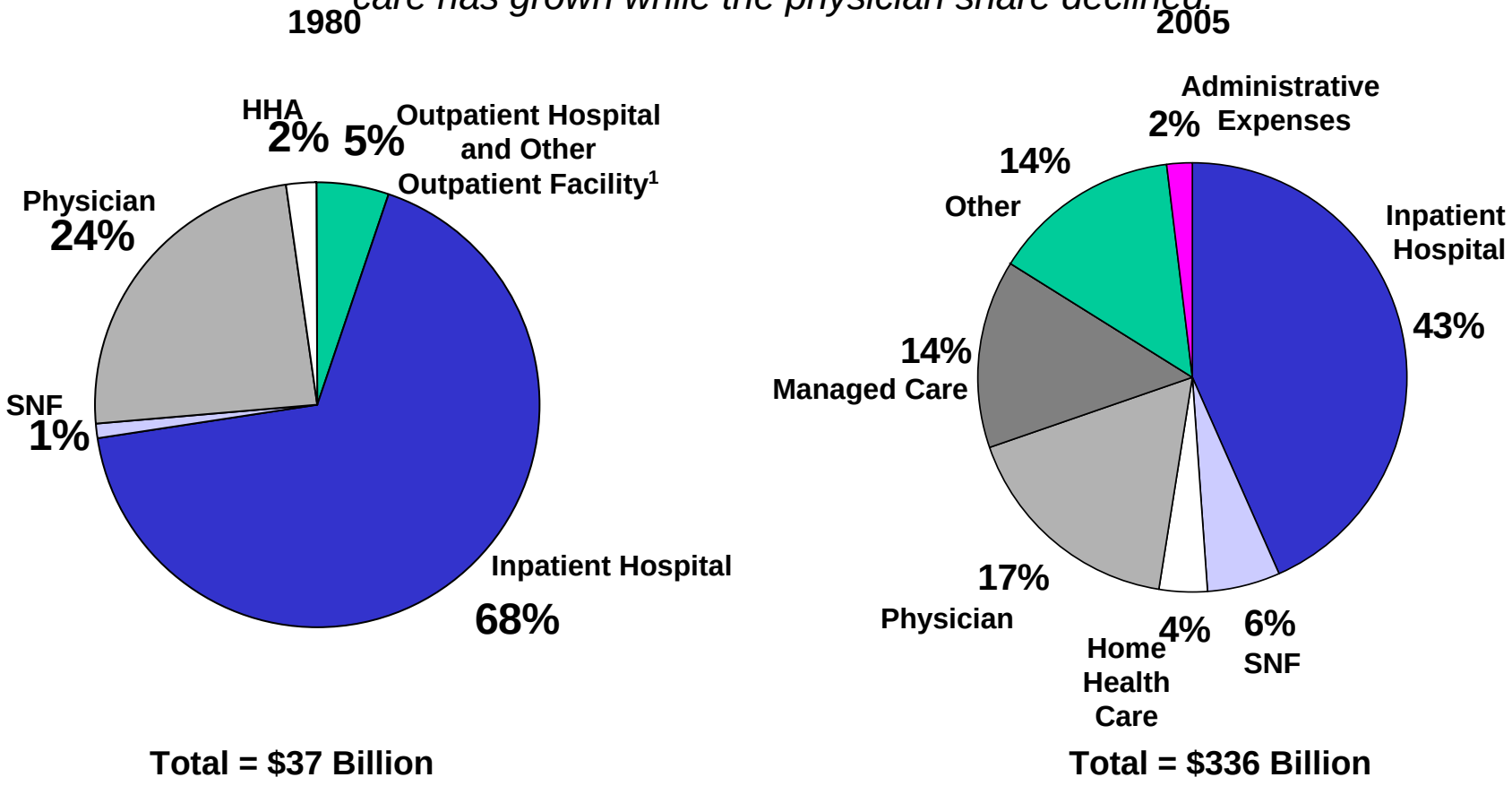
Total personal health spending in 1980 was $214.6 billion; Medicare accounted for 17%



Source: CMS, Office of the Actuary, National Health Statistics Group.

Table 4.4
Where the Medicare Dollar Went: 1980 and 2005

Medicare spending has moved from inpatient hospital services to all other settings. Managed care has grown while the physician share declined.

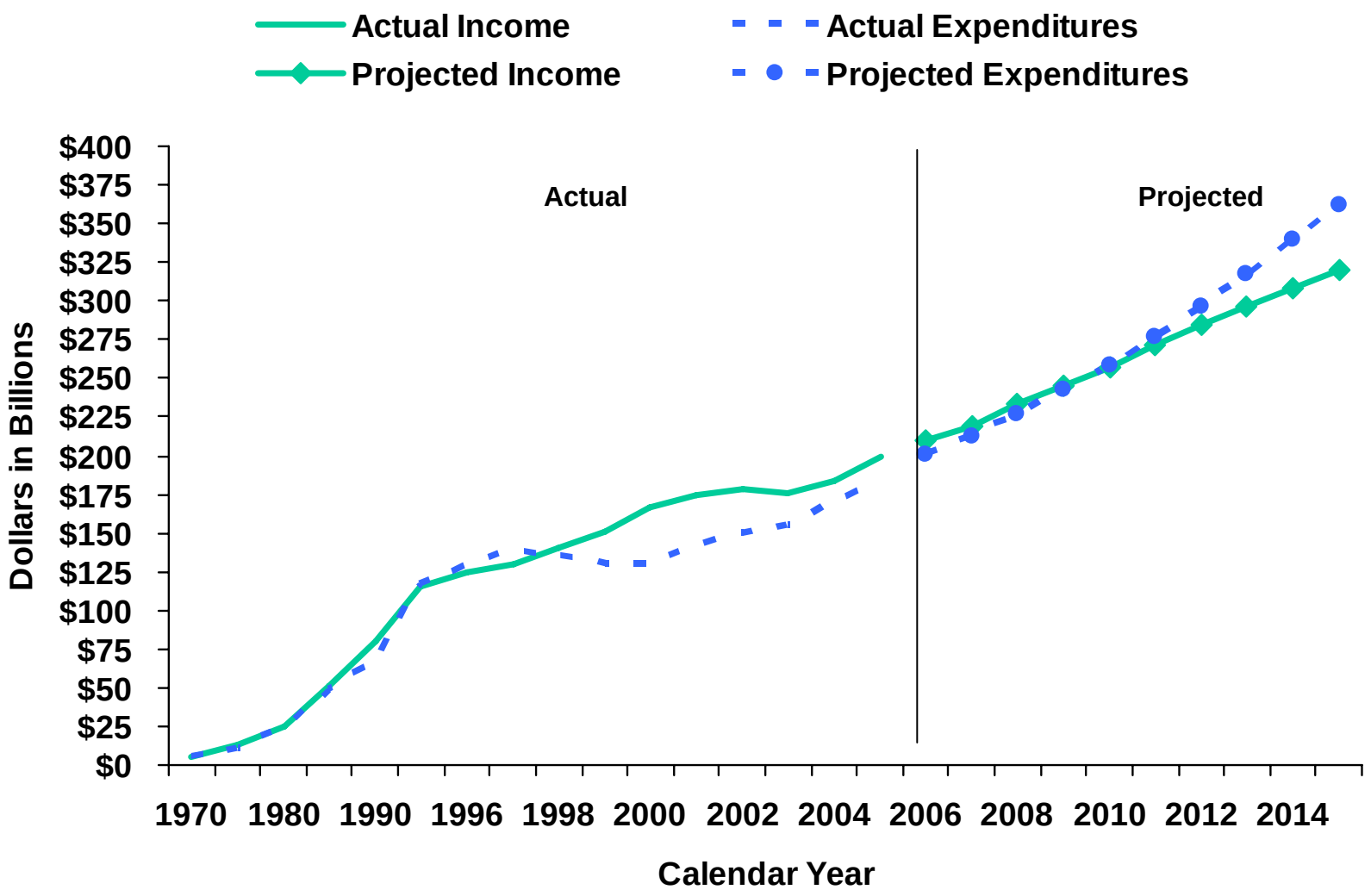


[1] Other services include other professional services and ambulance services.
Note: Data do not sum due to rounding. Spending includes benefit dollars only.

Source: CMS, Office of the Actuary, Trustees Report 2006

Table 4.5
Medicare Trustee's Report: Part A Income and Expenses, 1970-2015

Projected Expenditures First Exceed Projected Income in 2011



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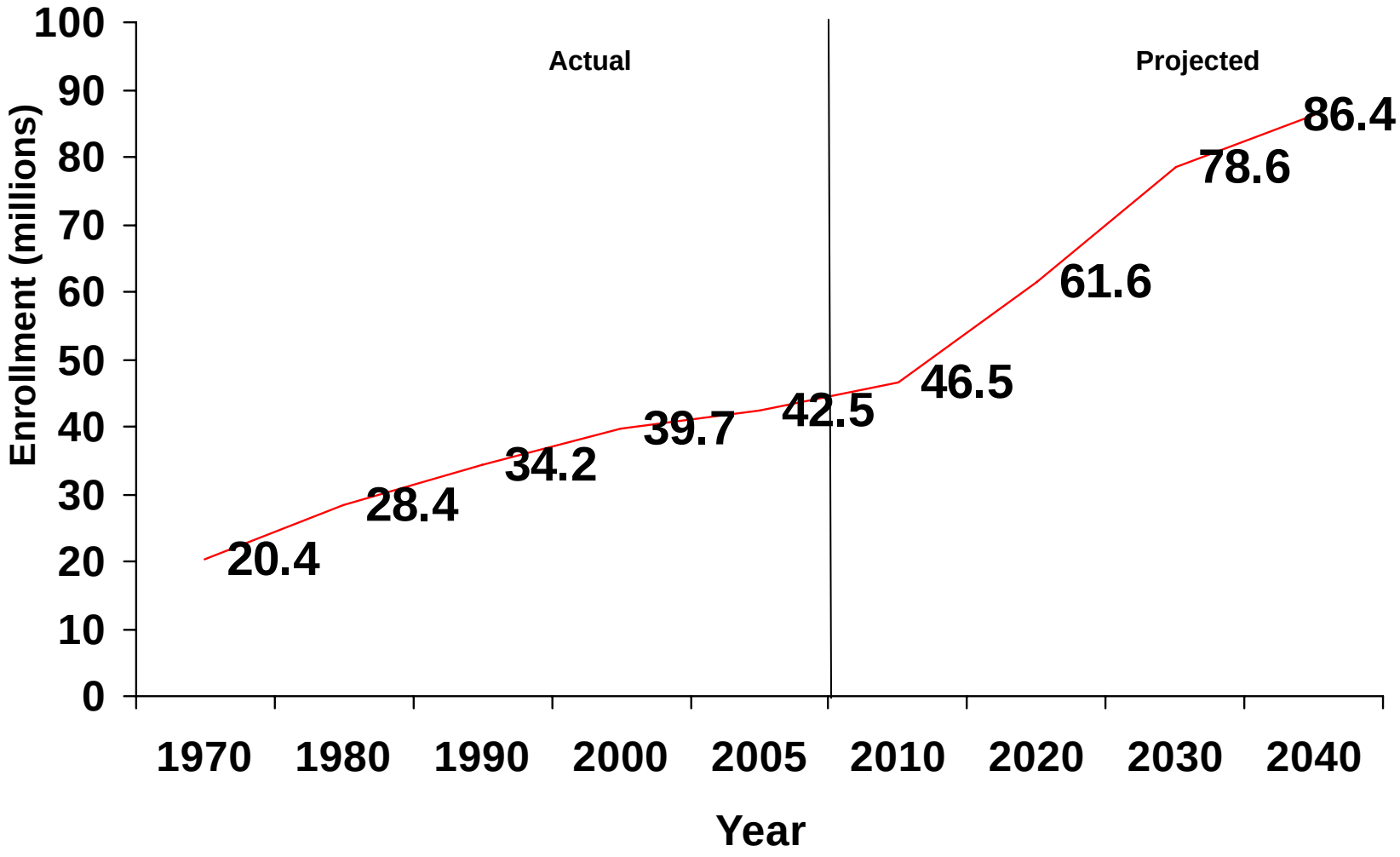
Source: CMS, Office of the Actuary.Trustees Report, 2006.

Table 4.6
Number of Medicare Beneficiaries, 1970-2040

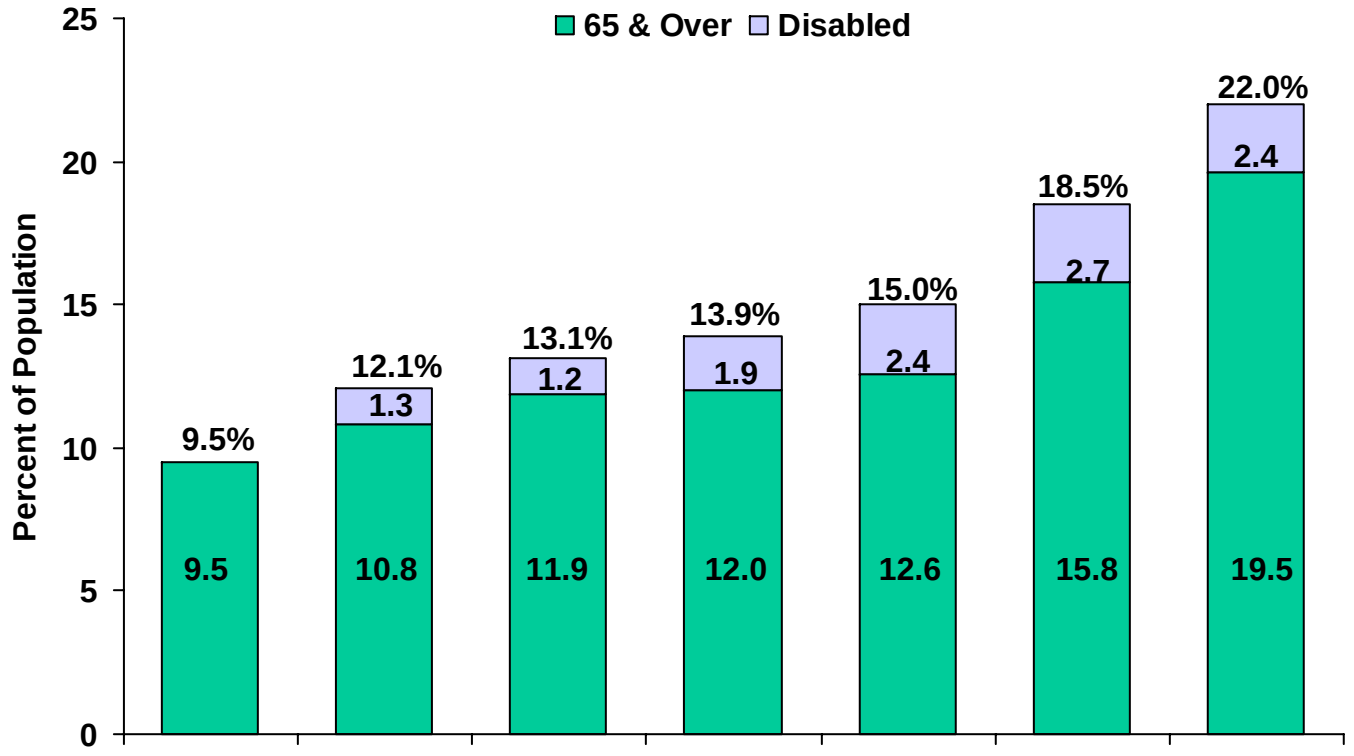
Enrollment in the Medicare Program is projected to nearly double in the next 30 years.



Source: Medicare Trustees Report 2006

Table 4.7
Medicare Beneficiaries as a Share of the U.S. Population, 1970-2030

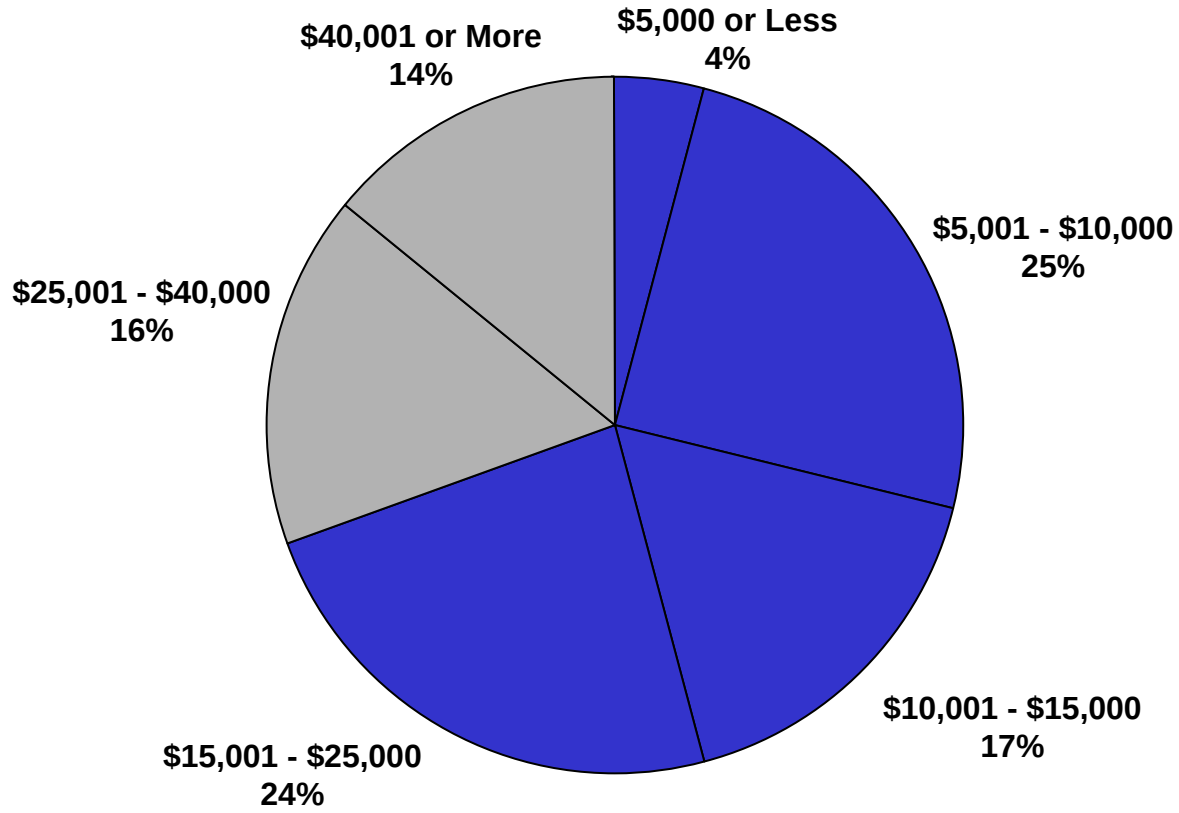
The U.S. population will age rapidly through 2030, when 22 percent of the population will be eligible for Medicare.



Source: Social Security Administration, Office of the Actuary.

Table 4.8
Medicare Spending for Fee-for-Service Beneficiaries by Income, 2003

About seventy percent of Medicare expenditures are on behalf of individuals with annual incomes of $25,000 or less.

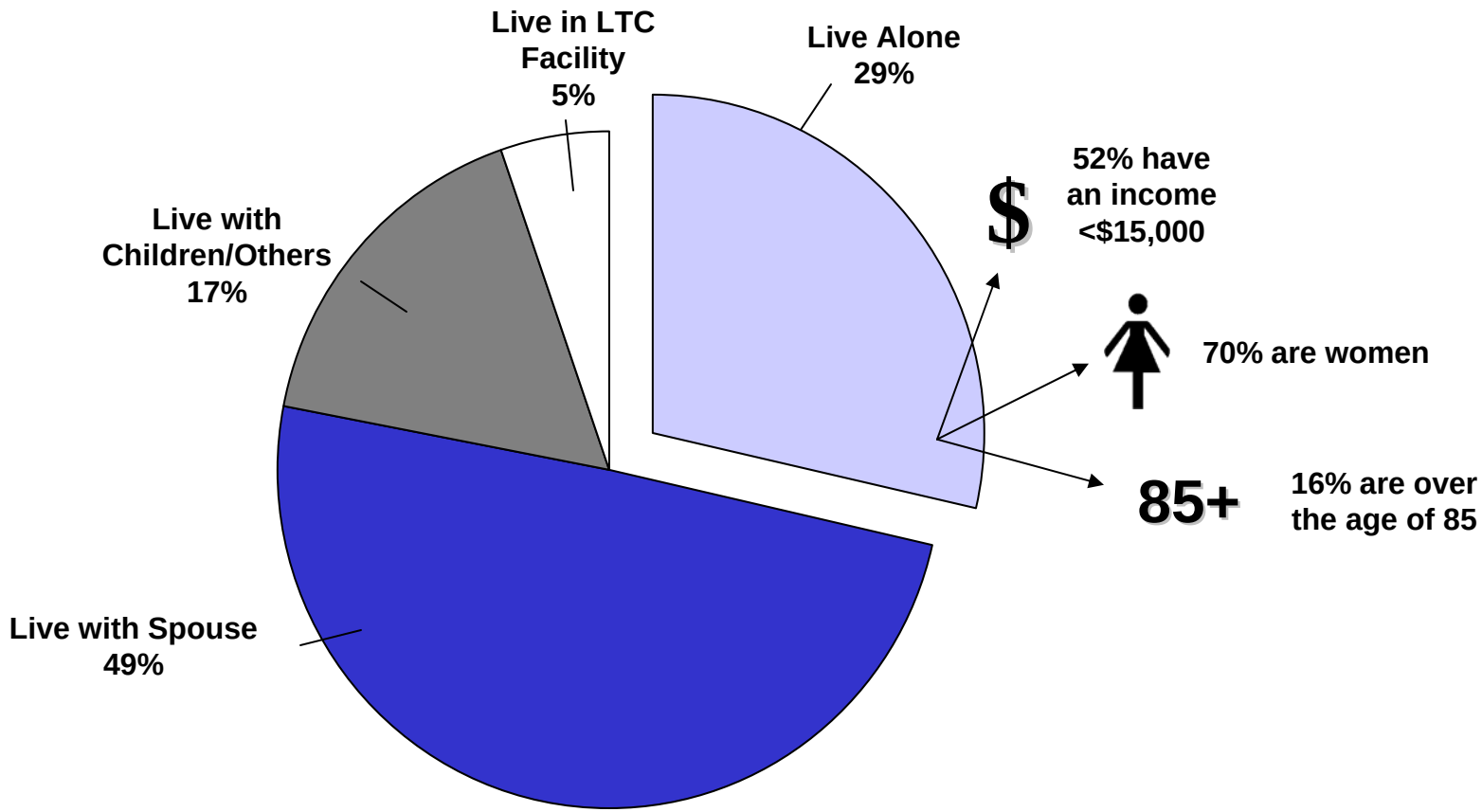


Note: Data may not sum due to rounding.

Source: CMS, Office of Research, Development, and Information: Data From the Medicare Current Beneficiary Survey (MCBS) 2003 Access to Care File.

Table 4.9
Living Arrangements of Medicare Beneficiaries, 2003

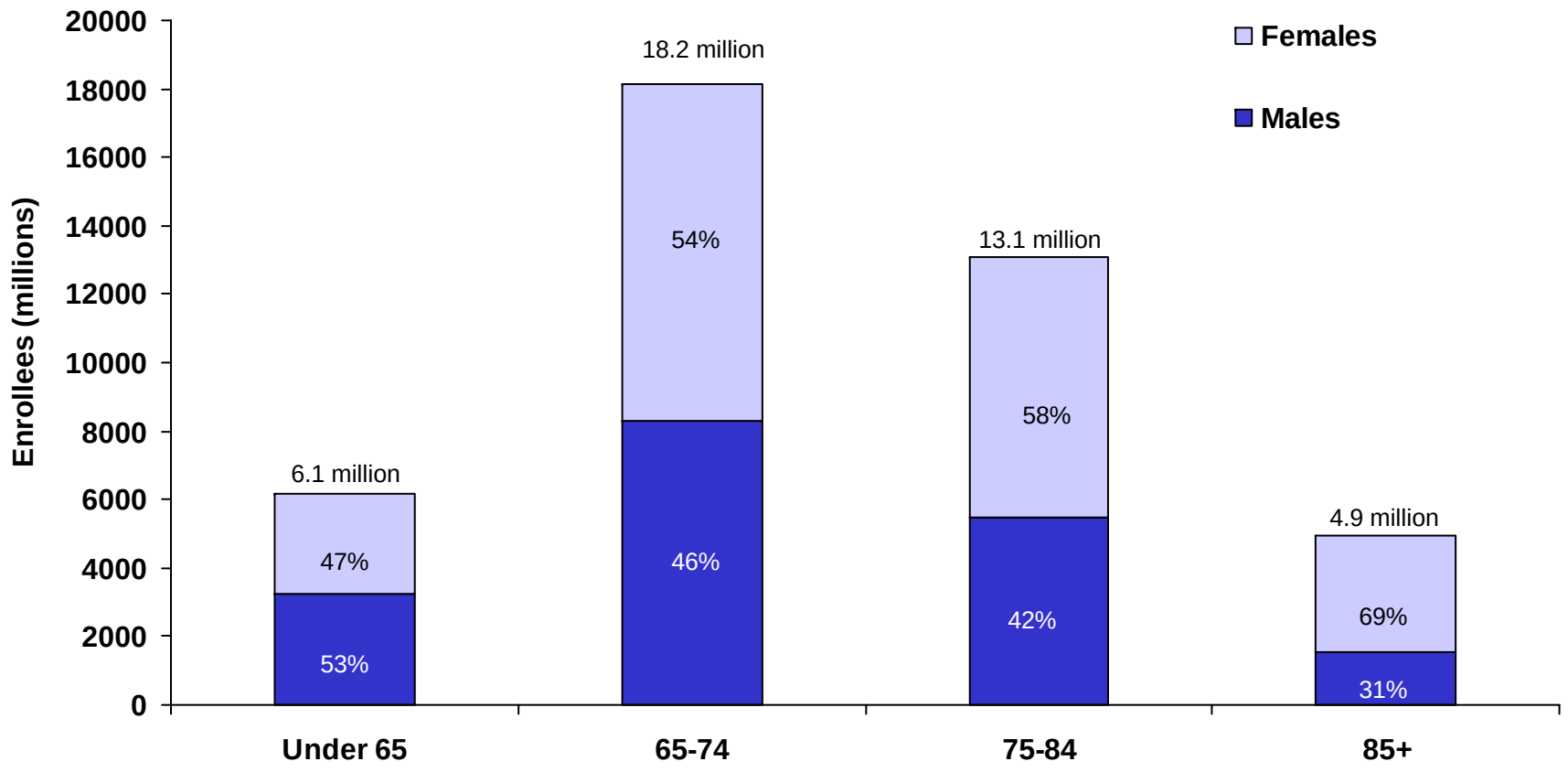
Among the nearly 30 percent of beneficiaries living alone, a large proportion are women and have low incomes.



Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2003 Access to Care File.

Table 4.10
Age and Gender of the Medicare Population, 2003

The proportion of women increases among those 85 and older.

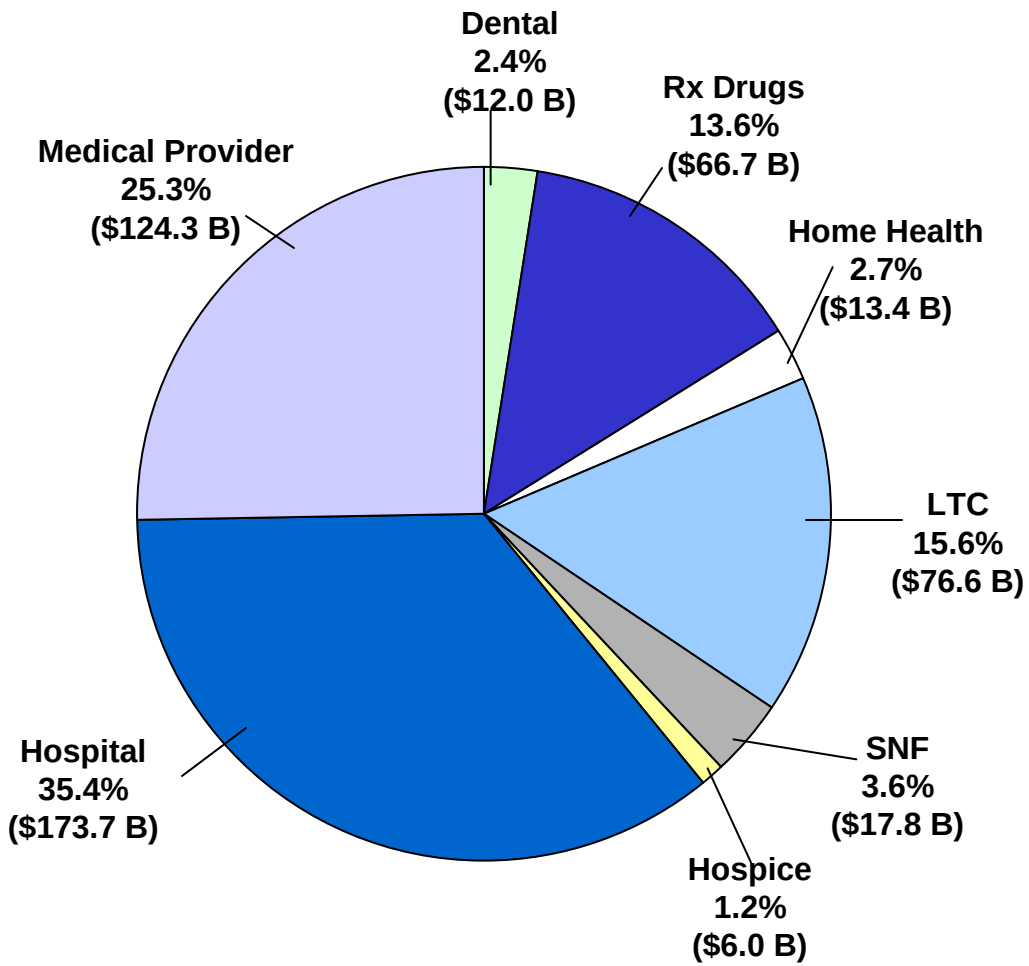


Note: Fifty-three percent (23.7 million) of all Medicare beneficiaries are female; 44% (18.6 million) are males. Data reflect Medicare beneficiaries ever enrolled in the program during the year.

Source: CMS, Office of Research, Development, and Information: data from the Medicare Current Beneficiary Survey (MCBS) 2003 Access to Care File.

Table 4.11
Total Health Care Expenditures for Medicare Beneficiaries, 2003

Total Health Care Expenditures = $491 Billion

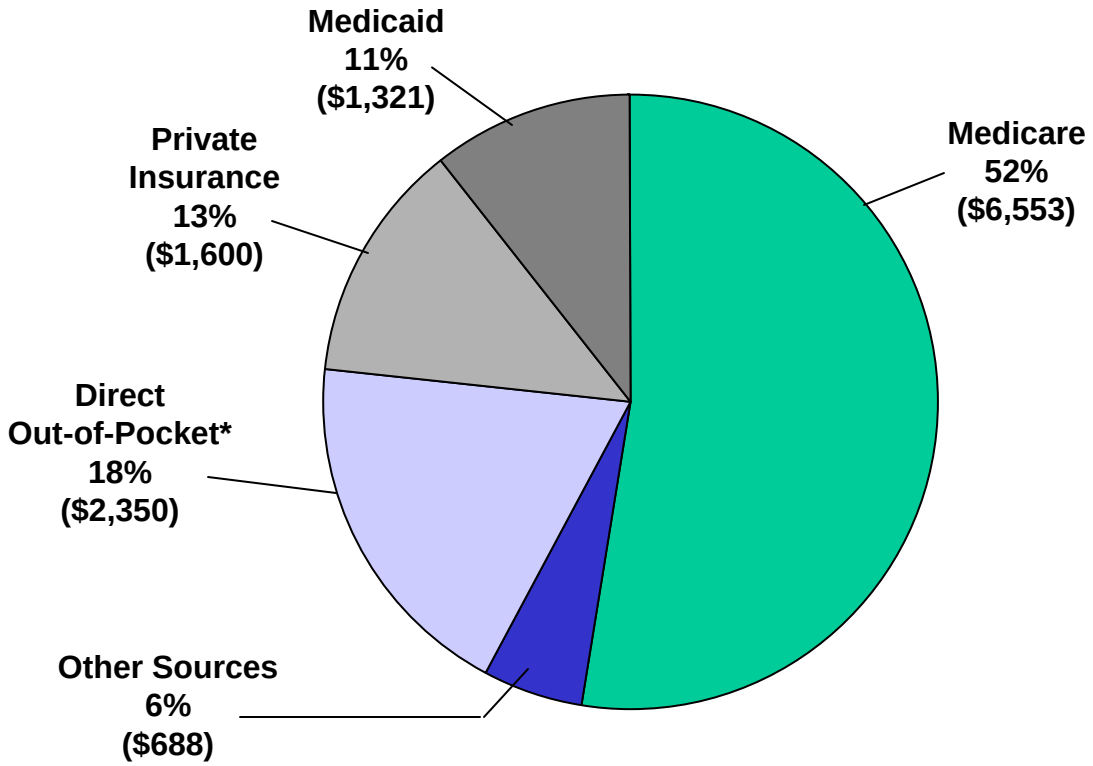


Note: Premium payments are excluded. LTC is long-term care. SNF is skilled nursing facility.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2003 Cost and Use File.

Table 4.12
Sources of Payment for Medicare Beneficiaries' Medical Services, 2003

Medicare pays a little more than half of the total cost of beneficiaries' medical care.



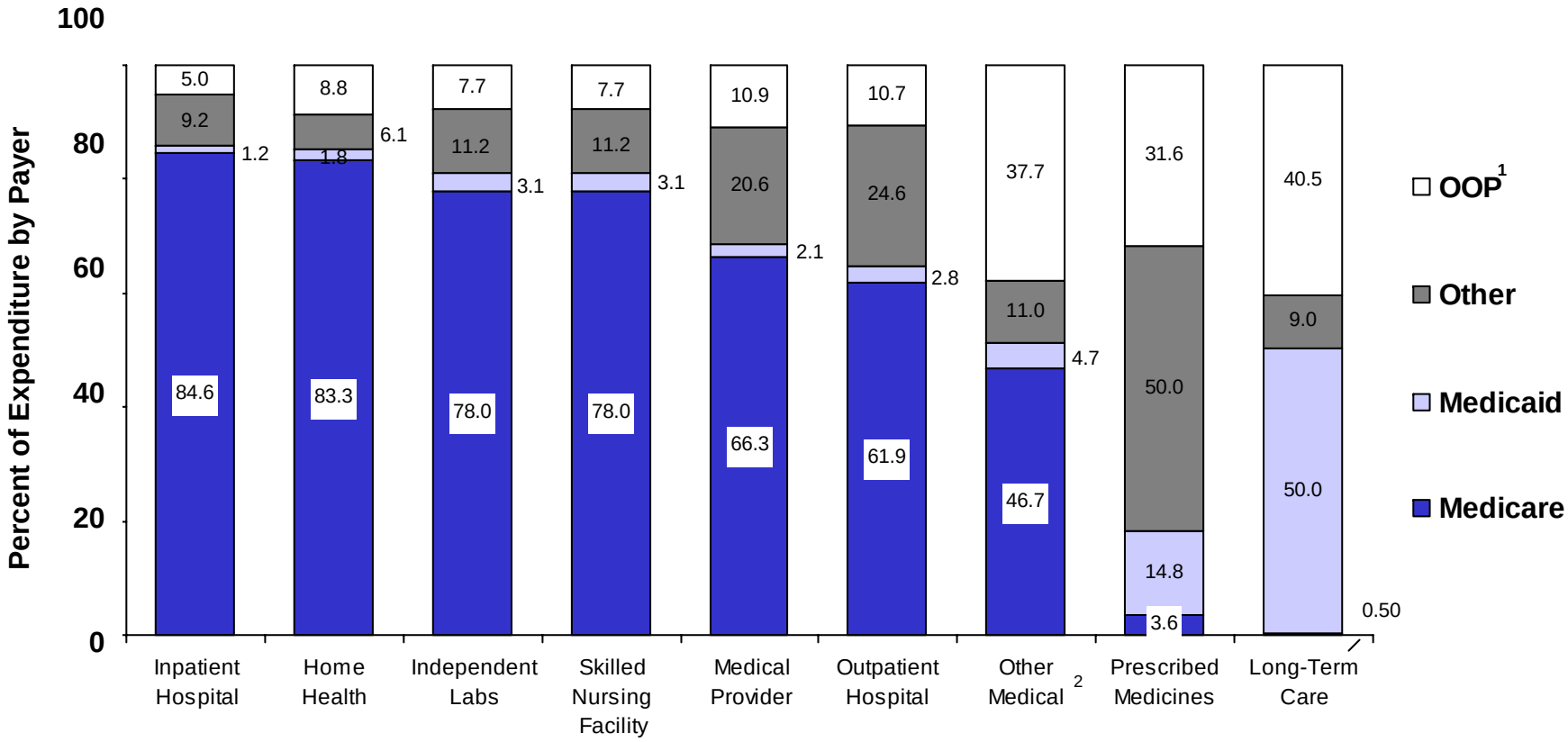
Overall Medical Expenses per Medicare Beneficiary = $12,512

*Beneficiary out-of-pocket spending does not include their payments for Medicare Part B premiums, private insurance premiums, or HMO premiums.
Note: Data are for all beneficiaries, both fee-for-service and Medicare+Choice enrollees.

Source: CMS, Office of Research, Development, and Information: Data From the Medicare Current Beneficiary Survey (MCBS) 2003 Cost and Use File.

Table 4.13
Sources of Payment for Medicare Beneficiaries by Type of Service, 2003

Medicare pays a large proportion of the total expenses of services it covers.

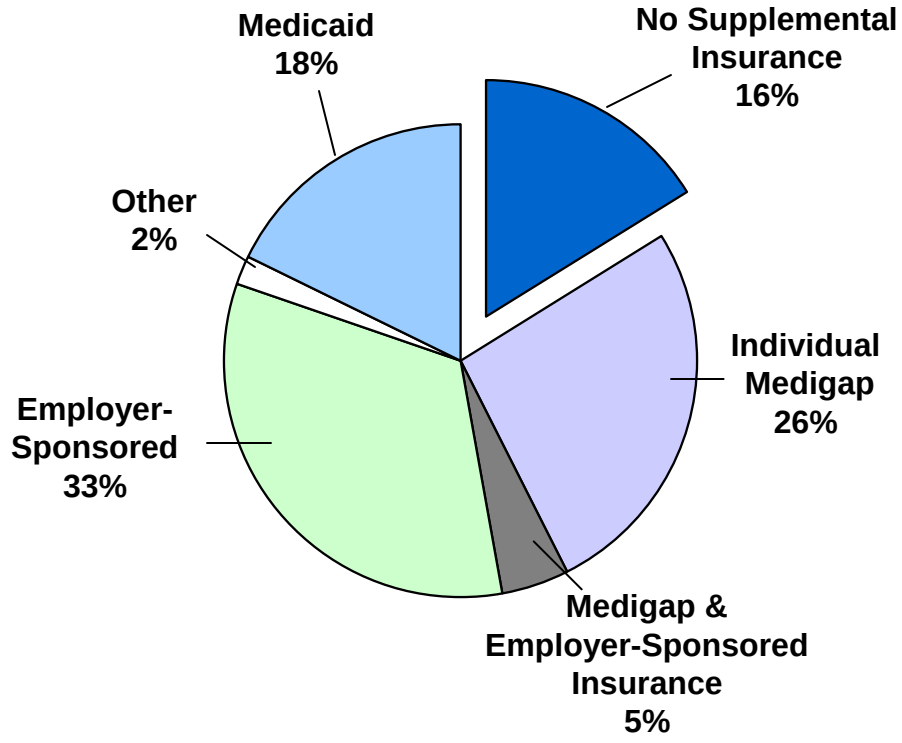


[1] OOP is out-of-pocket.
[2] Other Medical includes things such as hospice and durable medical equipment.

Note: Medicare did not generally cover outpatient prescription drugs in 2003.
Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS), 2003 Cost and Use File.

Table 4.14
Types of Supplemental Health Insurance held by Fee-for-Service Medicare Beneficiaries, 2003

Most beneficiaries using fee-for-service Medicare have private, supplemental health plans.

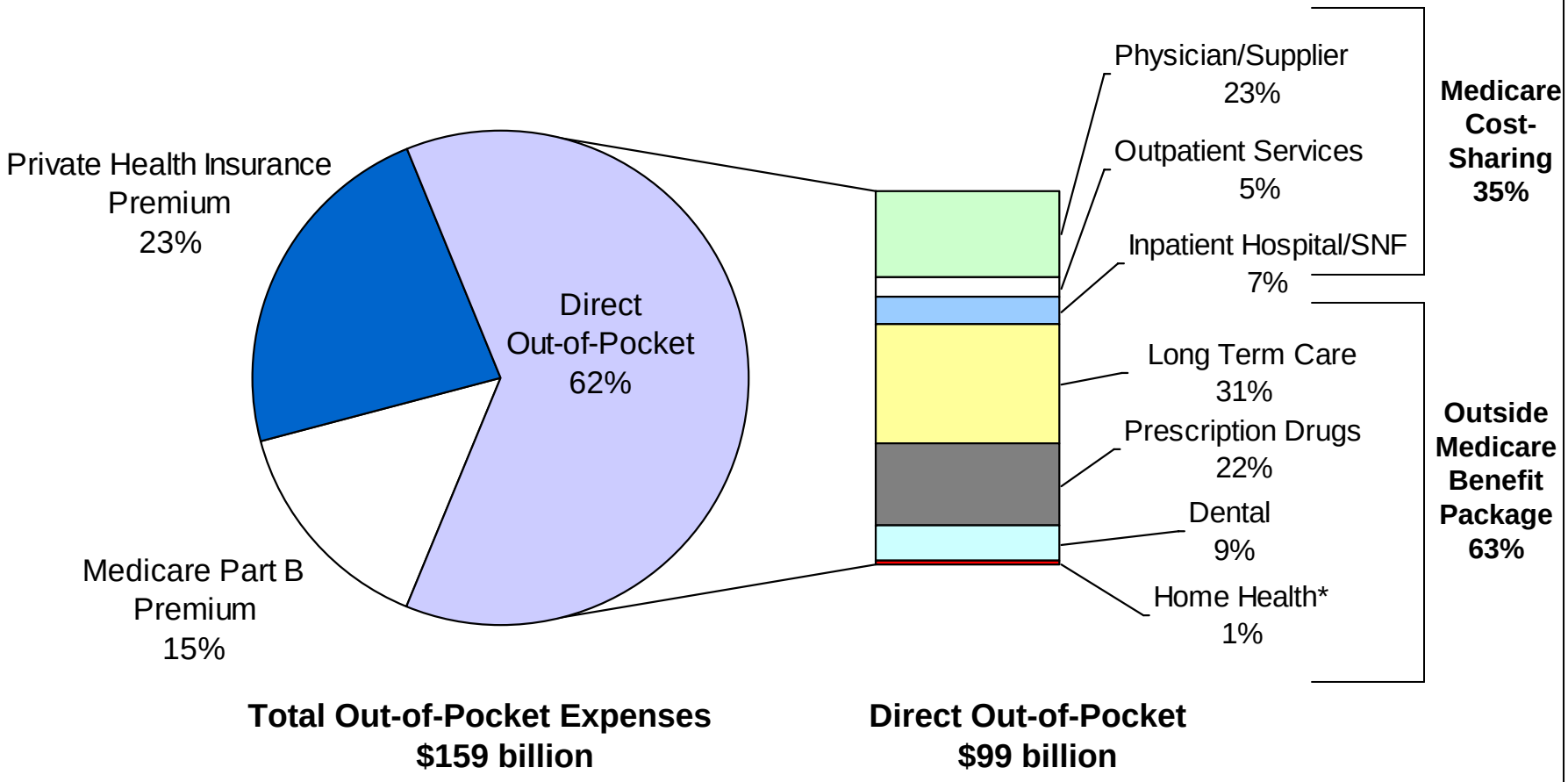


Note: Medicaid (shown above) includes both Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs).

Source: CMS, Office of Research, Development, and Information: Data From the Medicare Current Beneficiary Survey (MCBS) 2003 Access to Care File.

Table 4.15
Medicare Beneficiary Out-of-Pocket Spending, 2003

The majority of beneficiary out-of-pocket spending is for Medicare cost-sharing and payment for non-covered services.



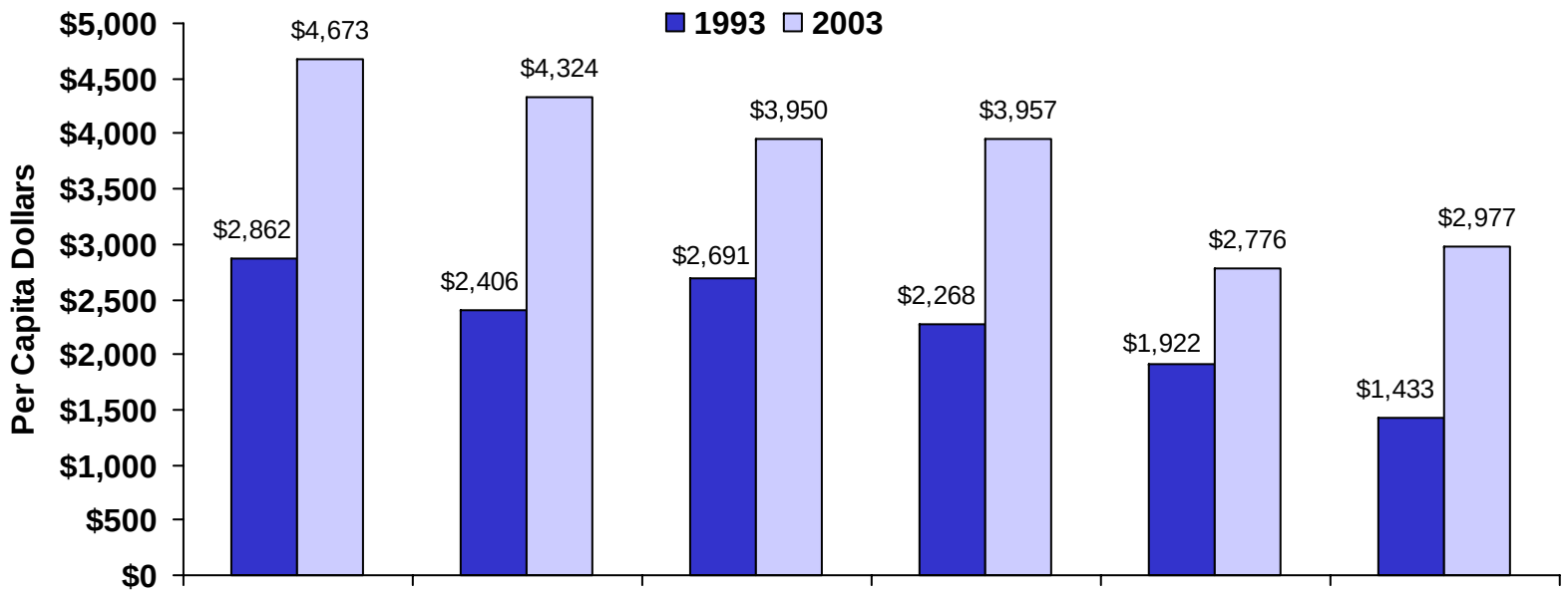
*These are for home health services not covered by Medicare.

Note: 1) Data are for all beneficiaries, both fee-for-service and Medicare+Choice enrollees. 2) Total per capita direct out-of-pocket spending is $3,765

Source: CMS Office of Research, Development and Information, Medicare Current Beneficiary Survey (MCBS) 2003 Cost and Use file

Table 4.16
Per Capita Out-of-Pocket Expenses for Medicare Beneficiaries by Type of Insurance Coverage, 1993 and 2003

Beneficiaries without supplemental insurance and those with Medigap coverage have higher out-of-pocket spending than other groups.



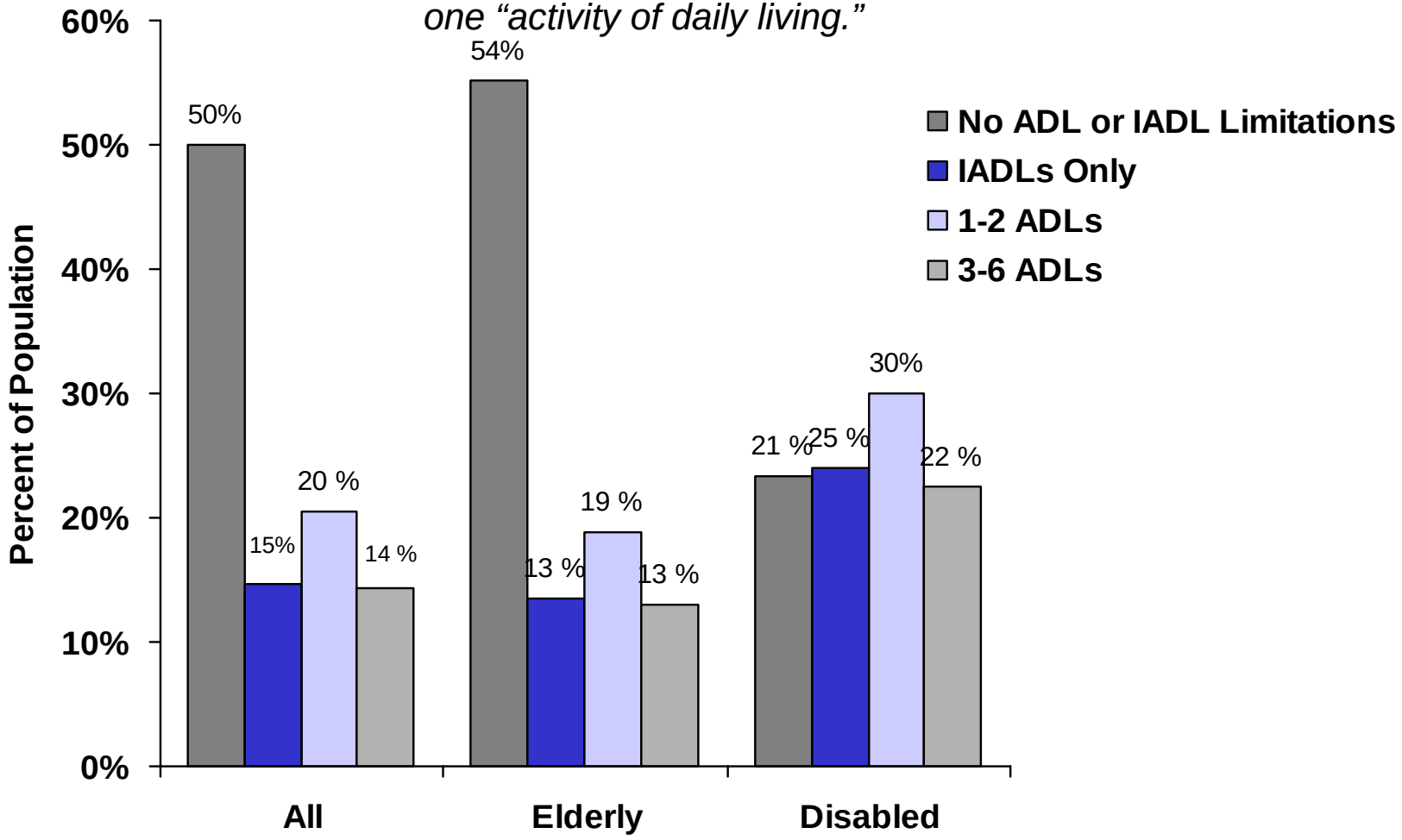
	Medicare FFS Only	Medigap	Other	Employer Sponsored Plan	Medicaid	Medicare Risk HMO
Percent Change, 1993 to 2003	63.3%	79.7%	46.8%	74.5%	44.4%	107.7%

Note: Premium payments are included.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS), 1993 and 2003 Cost and Use Files.

Table 4.17
Distribution of Medicare Enrollees by Functional Status, 2003

More than one-third of the Medicare population needs assistance with at least one "activity of daily living."

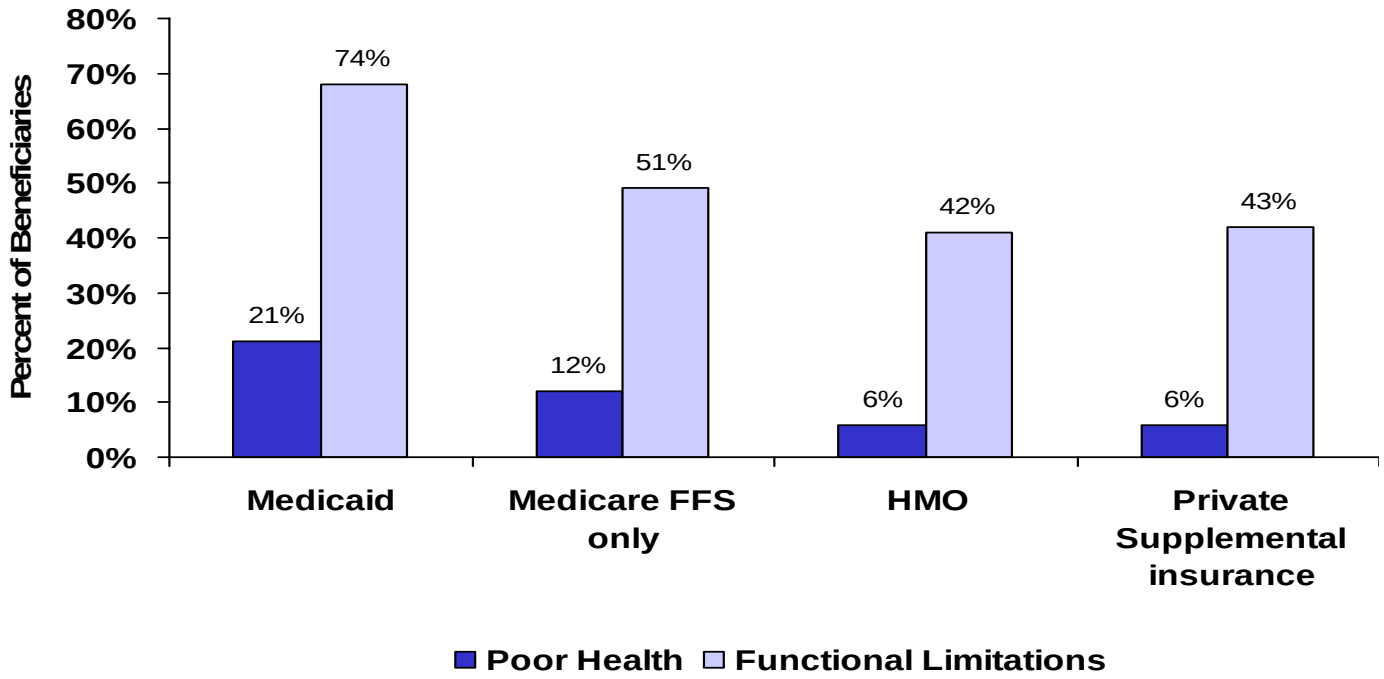


Note: ADLs are activities of daily living (e.g., eating, bathing); IADLs are instrumental activities of daily living (e.g., shopping, use of phone, cleaning).

Source: CMS, Office of Research, Development, and Information: Data from Medicare Current Beneficiary Survey (MCBS) 2003 Cost and Use File.

Table 4.18
Beneficiaries with Poor Health and Functional Limitations by Insurance Status, 2003

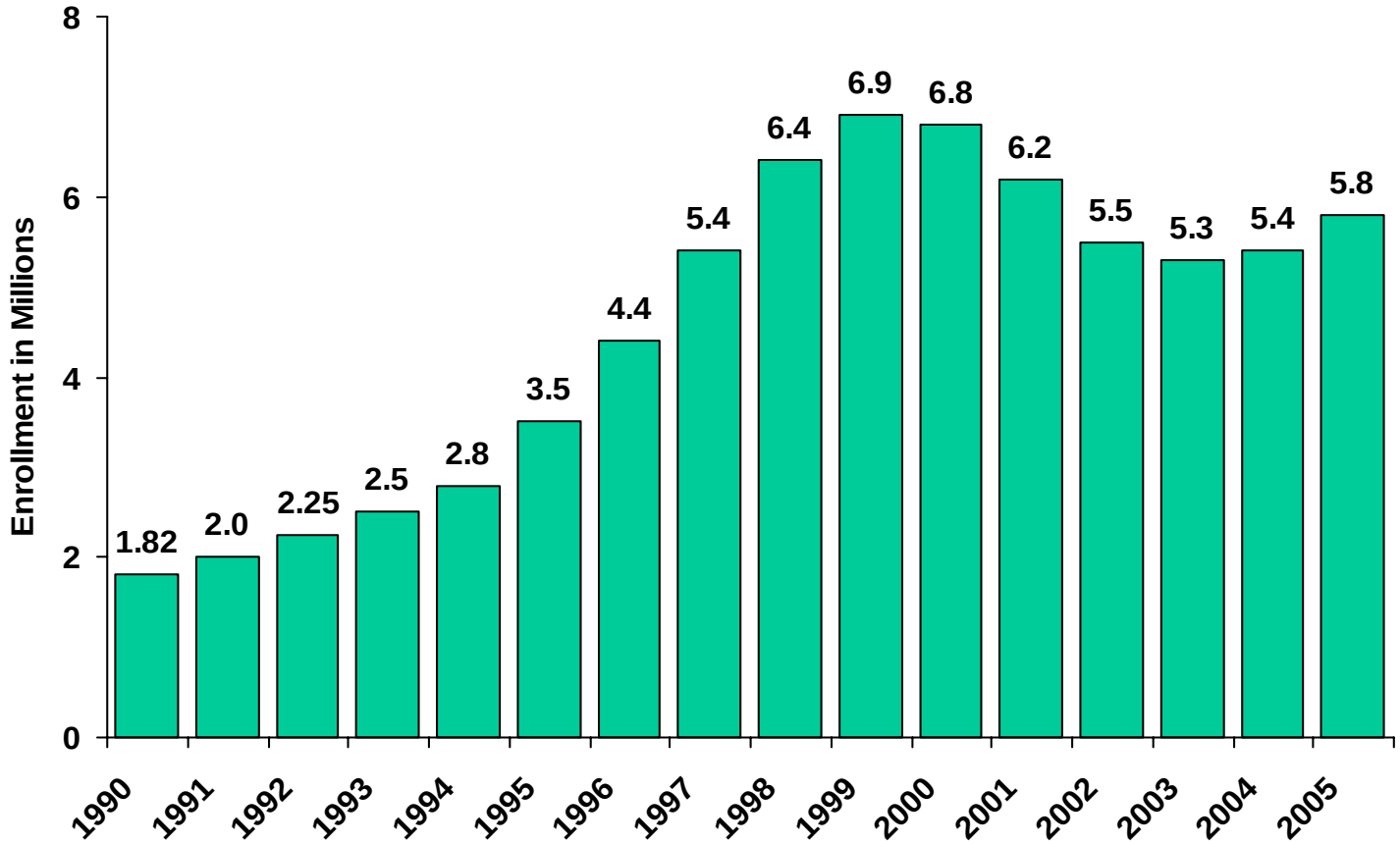
Medicare beneficiaries in poor health or with functional limitations are more likely to receive Medicaid or to have no supplemental insurance.



Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2003 Access to Care File.

Table 4.19
Medicare Managed Care Enrollment, 1990-2005

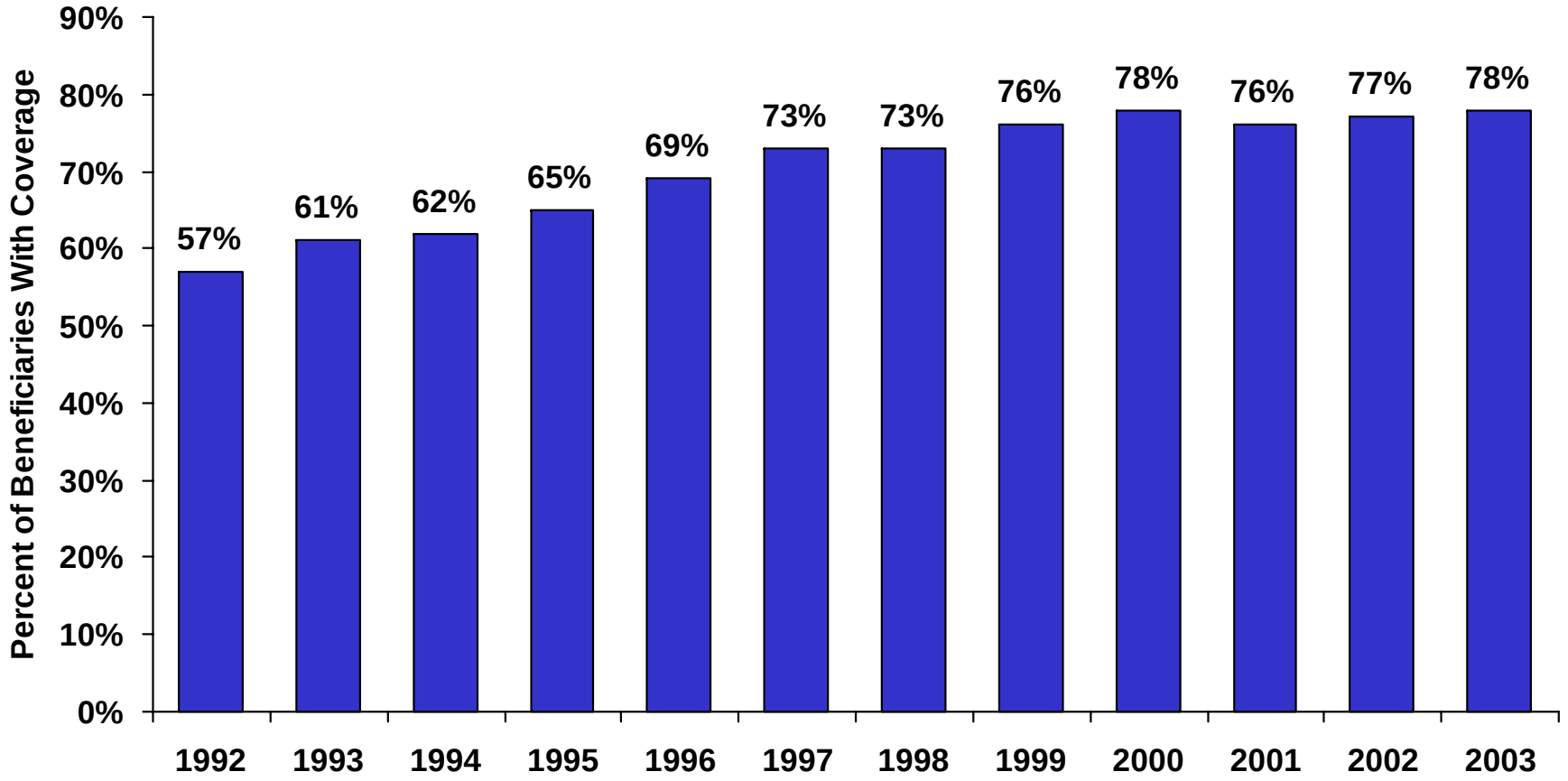
Managed care enrollment grew through 2000, then declined, and is now on the upswing.



Source: CMS, Office of the Actuary.

Table 4.20
Percent of Medicare Beneficiaries with Prescription Drug Coverage, 1992-2003

About three-quarters of Medicare beneficiaries had prescription drug coverage at some point in 2003.

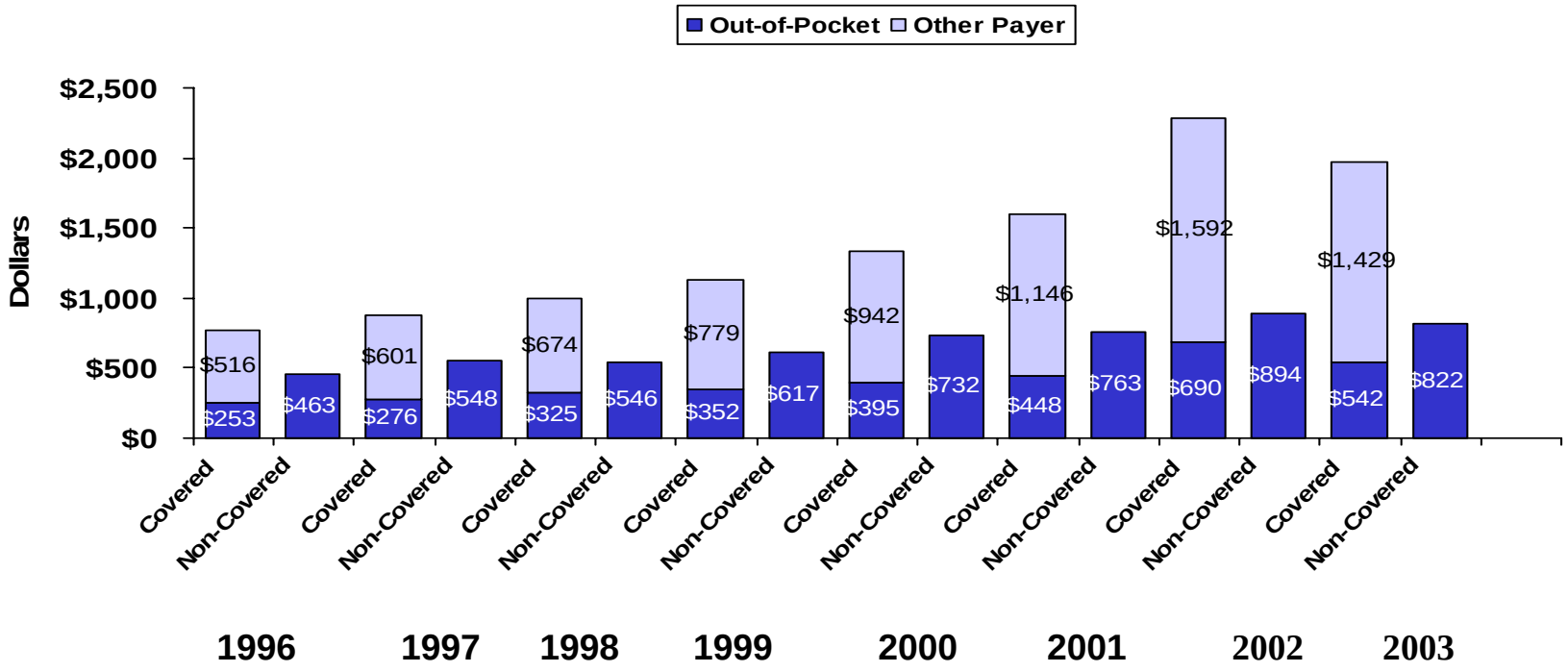


Note: This includes beneficiaries who had some type of drug coverage at any point during the year. Does not include beneficiaries in facility care.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 1992-2003 Cost and Use Files.

Table 4.21
Total Spending for Prescription Drugs for All Medicare Beneficiaries, 1996-2003

Total spending for drugs was higher for beneficiaries with drug coverage than without; however, non-covered beneficiaries pay substantially more out-of-pocket costs.

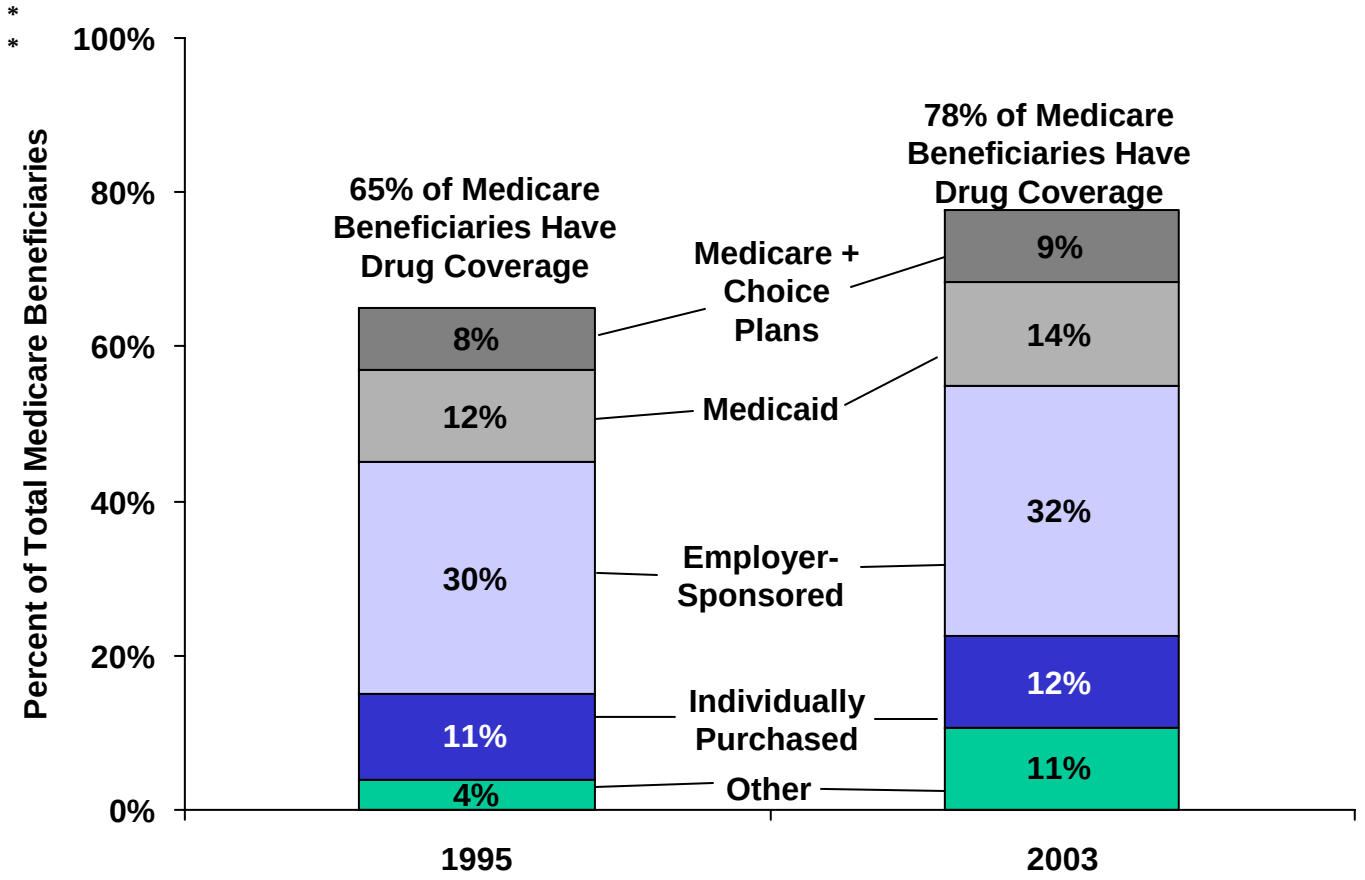


Note: Does not include beneficiaries in facility care. Does not adjust for underreporting of prescription drugs.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 1996-2003 Cost and Use Files.

Table 4.22
Medicare Beneficiaries With Drug Coverage by Primary Source of Supplemental Coverage, 1995 and 2003

Employer-sponsored retiree coverage is the largest source of coverage for drug spending.

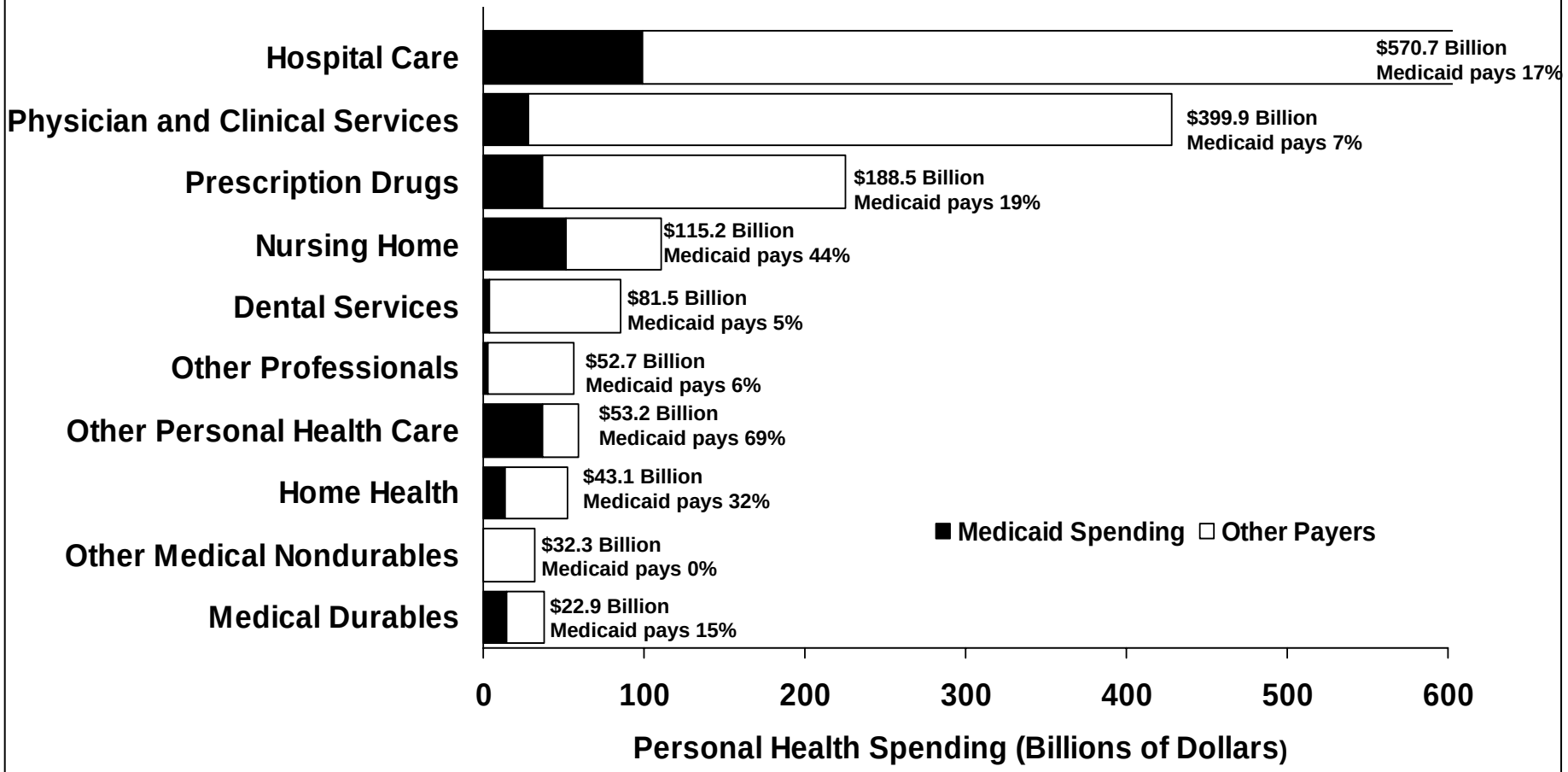


Note: Data are based on the non-institutionalized beneficiaries.
Percentages shown in bars are Medicare beneficiaries with drug coverage as a percent of total Medicare beneficiaries. Beneficiaries do not necessarily get drug coverage from their primary sources of supplemental insurance.

Source: CMS/Office of Research, Development and Information. Data are from the Medicare Current Beneficiary Survey.

Table 4.23
Personal Health Expenditures by Type of Service and Percent Medicaid Paid, 2004

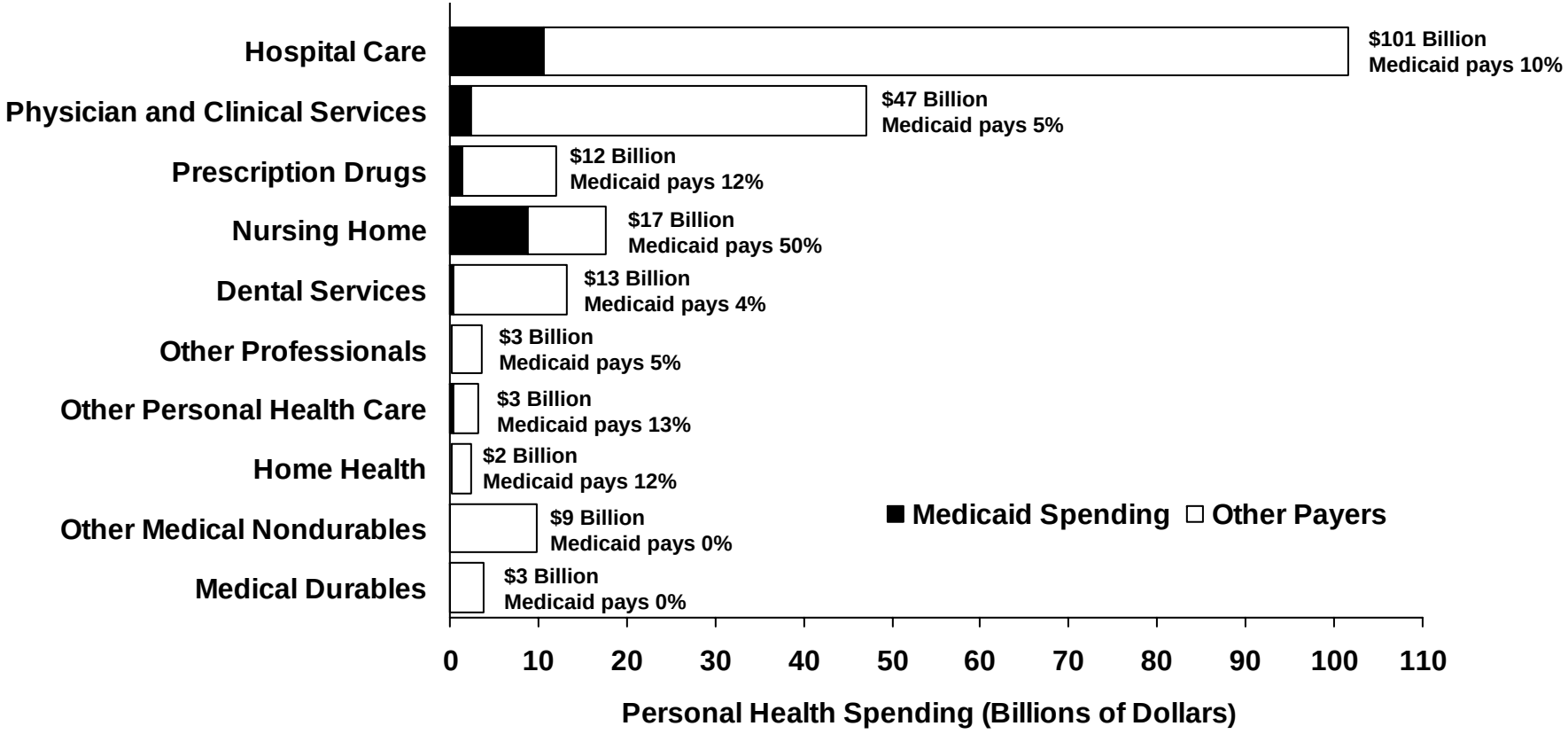
Total personal health spending in 2004 was $1,560,241,000,000; Medicaid accounted for 17%



Source: CMS, Office of the Actuary, National Health Statistics Group.

Table 4.24
Personal Health Expenditures by Type of Service and Percent Medicaid Paid, 1980

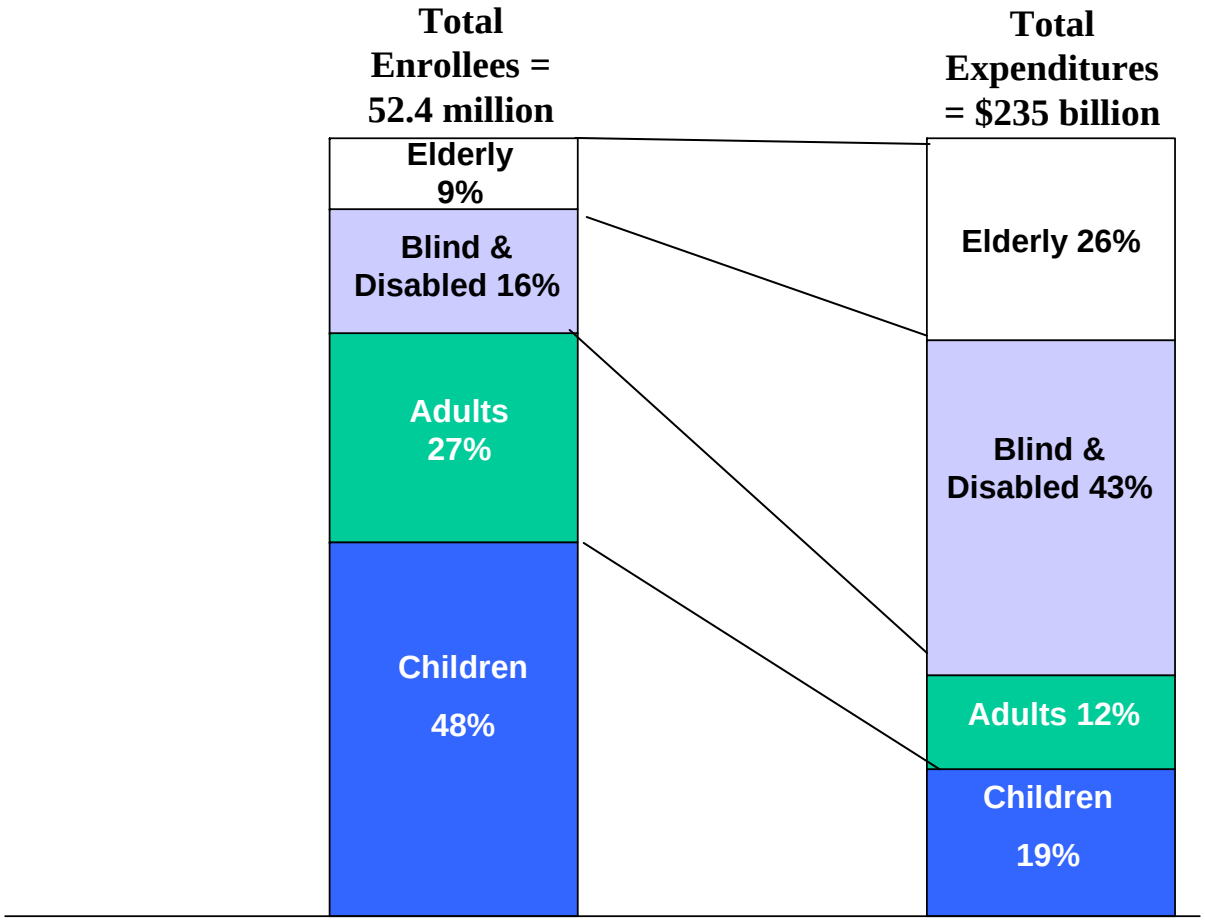
Total personal health spending in 1980 was $214.6 billion; Medicaid accounted for 12%.



Source: CMS, Office of the Actuary, National Health Statistics Group.

Table 4.25
Medicaid Enrollment by Eligibility Group, 2003

Payments for the elderly, blind and disabled account for 69 percent of total payments.

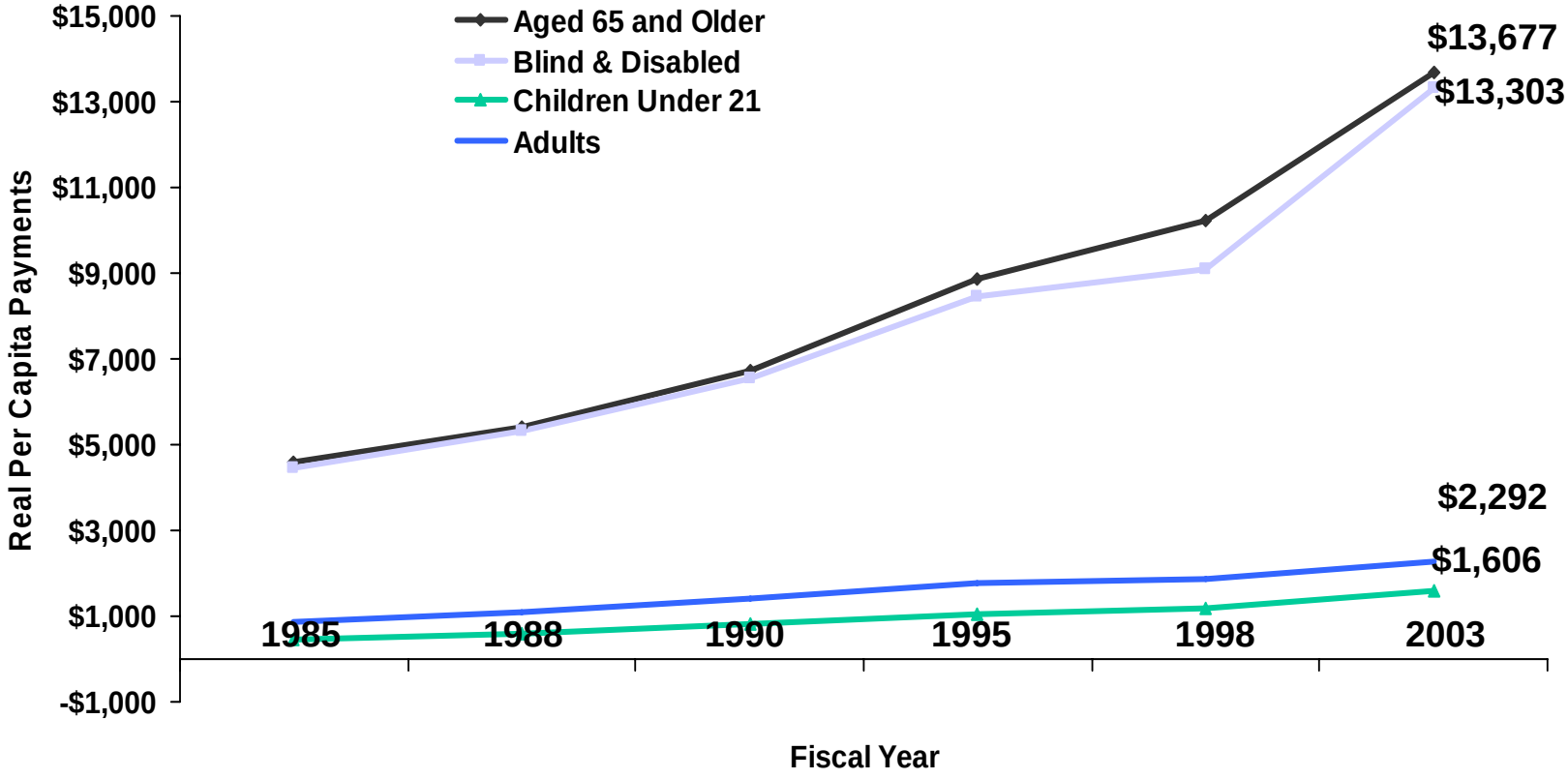


Note: Expenditure distribution based on Congressional Budget Office data that includes only federal spending on services and excludes DSH payments, supplemental provider payments, vaccines for children, administration, and the temporary Federal Medicaid Assistance Percentage Increase..

Source: Kaiser Family Foundation, Trends and Indicators in the Changing Health Care Marketplace Chartbook 2004.

Table 4.26
Average Medicaid Payments per Person Served by Eligibility Group, 1985-2003

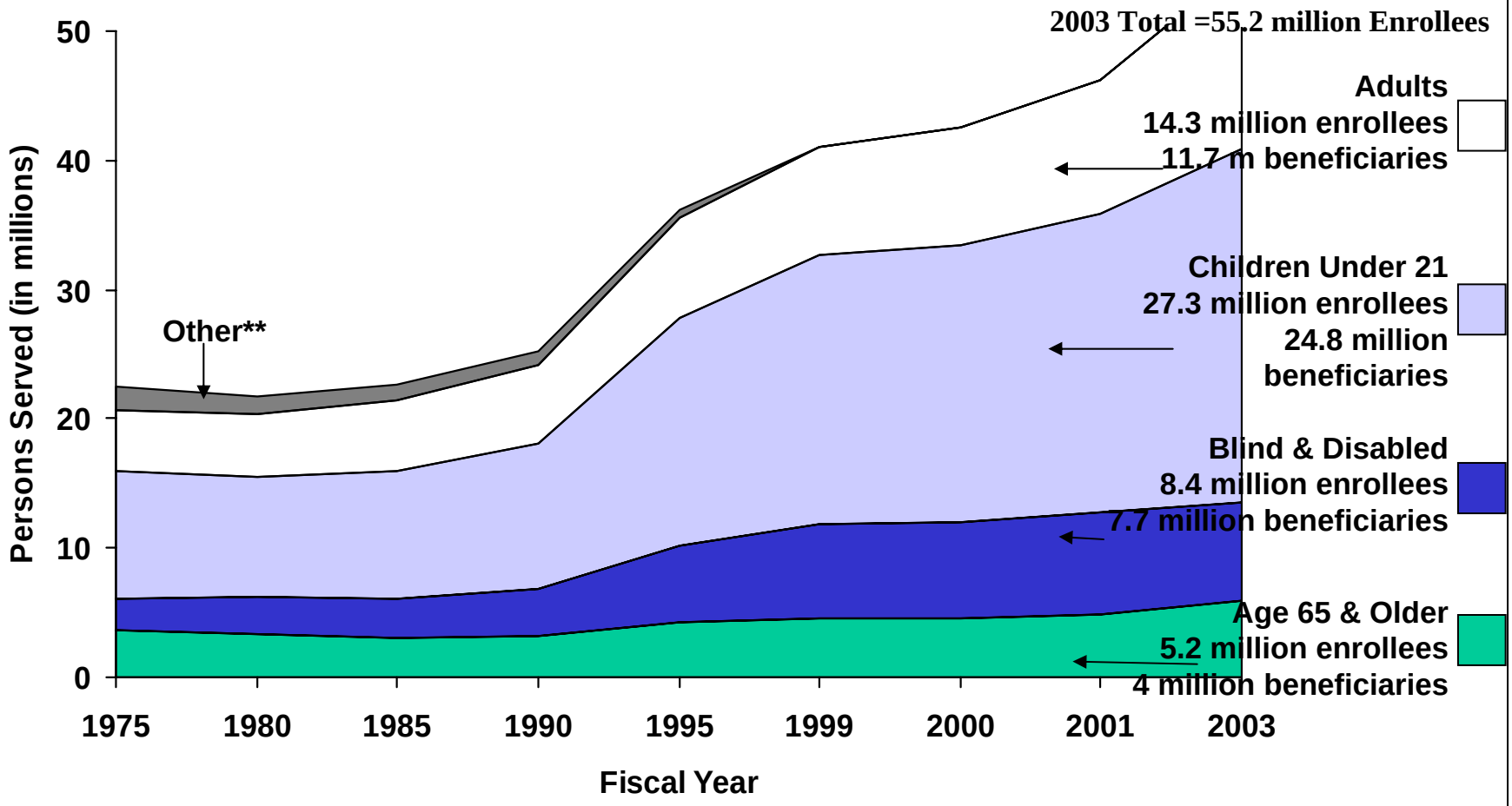
Per capita payments for the elderly, blind and individuals with disabilities continue to be significantly higher than payments for other groups.



Source: CMS, CMSO, HCFA-2802 reports; Medicaid Statistical Information System.

Table 4.27
Medicaid Enrollees and Beneficiaries by Eligibility Group, 1975-2003

Children historically represent the largest group of Medicaid enrollees.



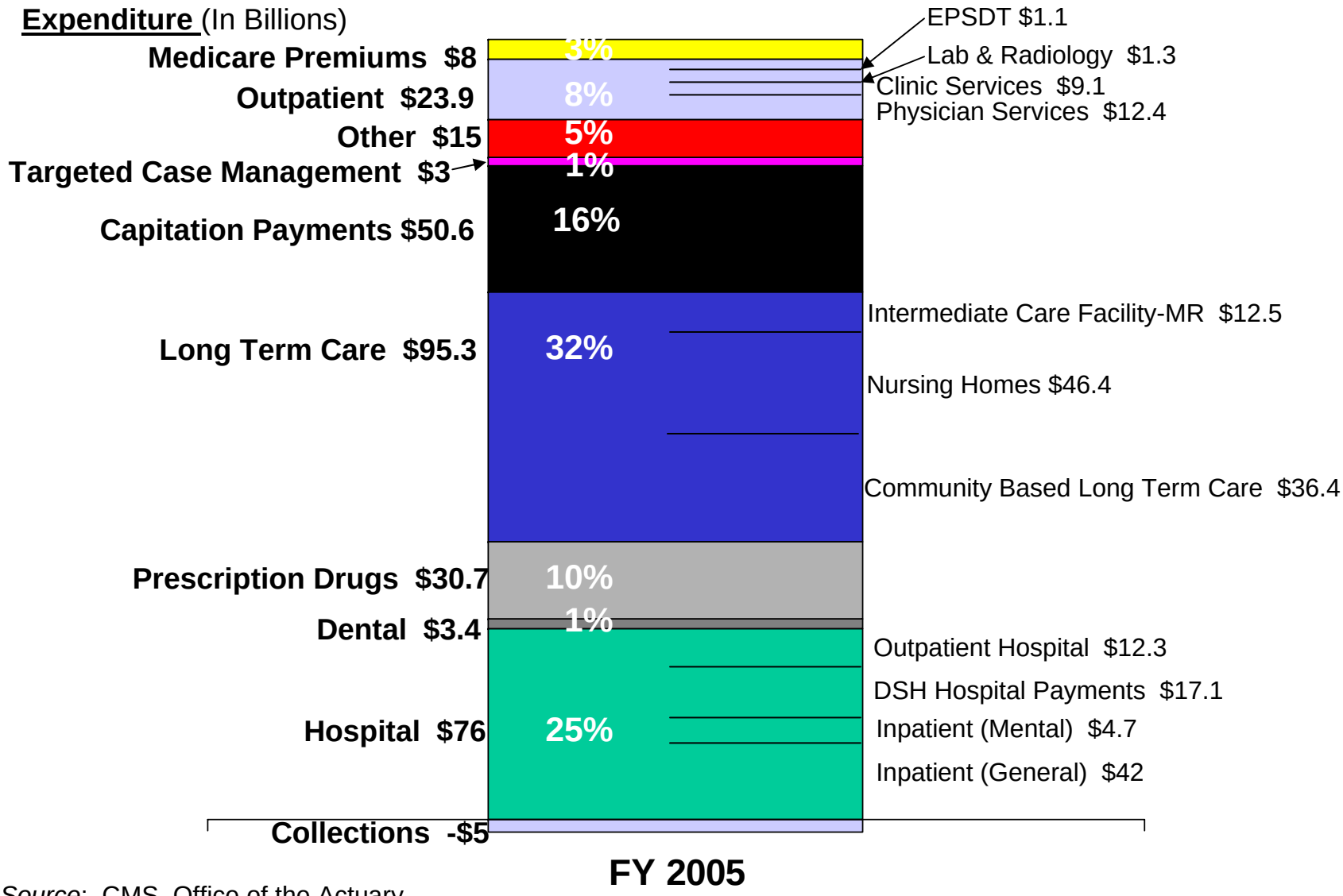
Medicaid "enrollees" are those who are enrolled in Medicaid at any time during the fiscal period. "Beneficiaries" are those for whom services have been reimbursed during the fiscal period.

*Note: (1) In 1998, a large increase occurred in the number of persons served which is mainly the result of a new reporting methodology of classifying payments to managed care organizations; FY 1998 was the first year capitation payments were counted as a service for purposes of the HCFA 2082 reporting, and thus all managed care enrollees were counted as individuals receiving services; this new methodology probably has the greatest effect on the reported number of children; (2) the term "adults" as used above refers to non-elderly, non-disabled adults; (3) disabled children are included in the blind & disabled category shown above. **The Other category was dropped in 1999.

Source: CMS, CMSO, Medicaid Statistical Information System.

Table 4.28
Total Medicaid Expenditures by Type of Service, FY 2005

Total Medicaid Expenditures in FY 2005 were $300.7 billion

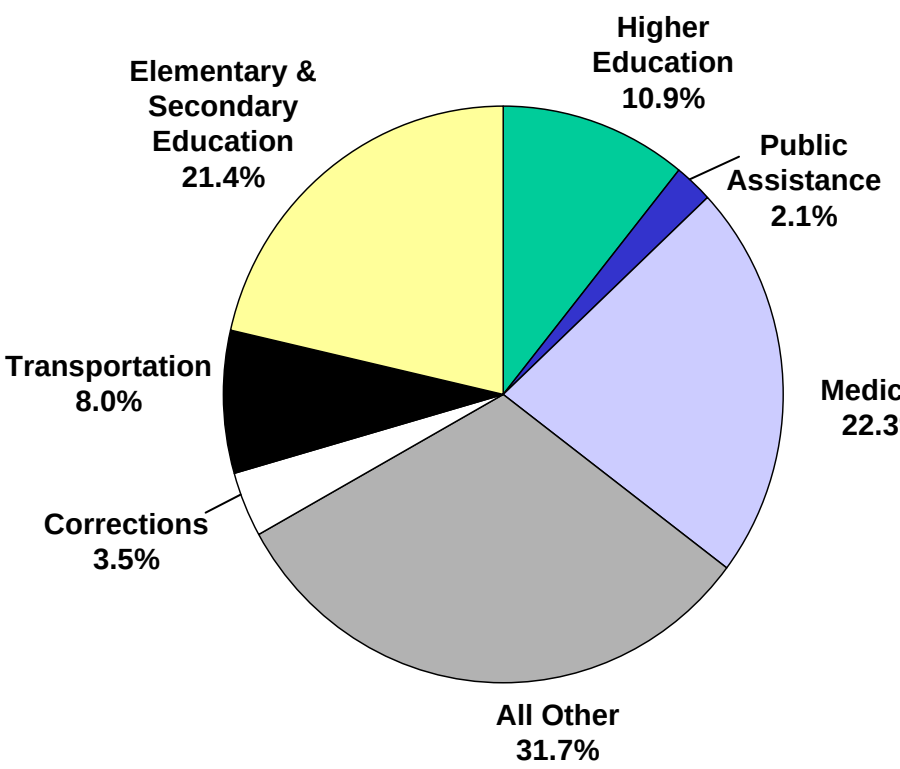


Source: CMS, Office of the Actuary.

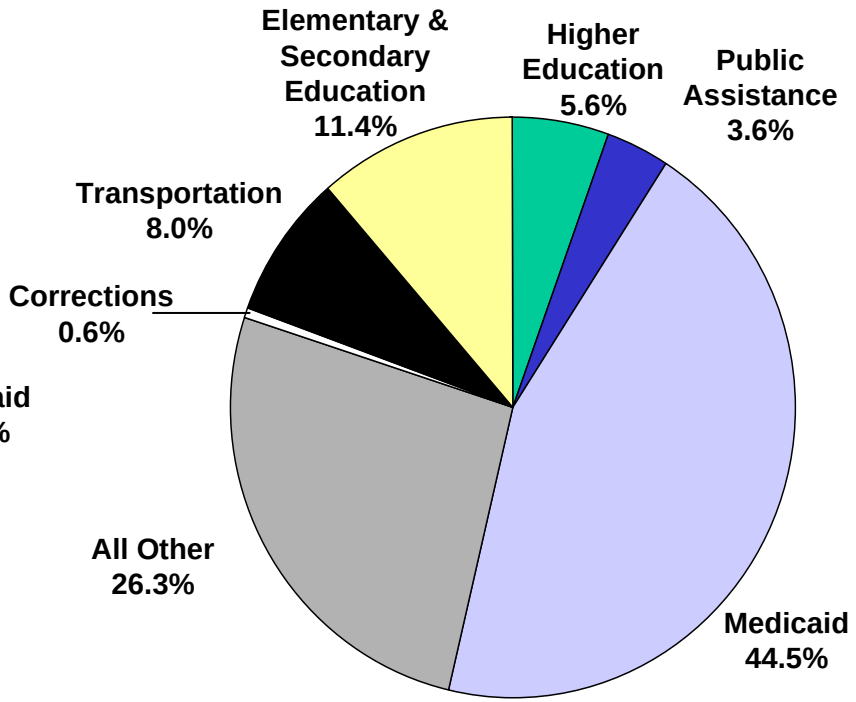
Table 4.29
Total State Spending and Federal Funds Provided to States, 2004

Over twenty-two percent of state total spending and over forty-four percent of federal funds provided to states were spent on Medicaid.

Total State Spending



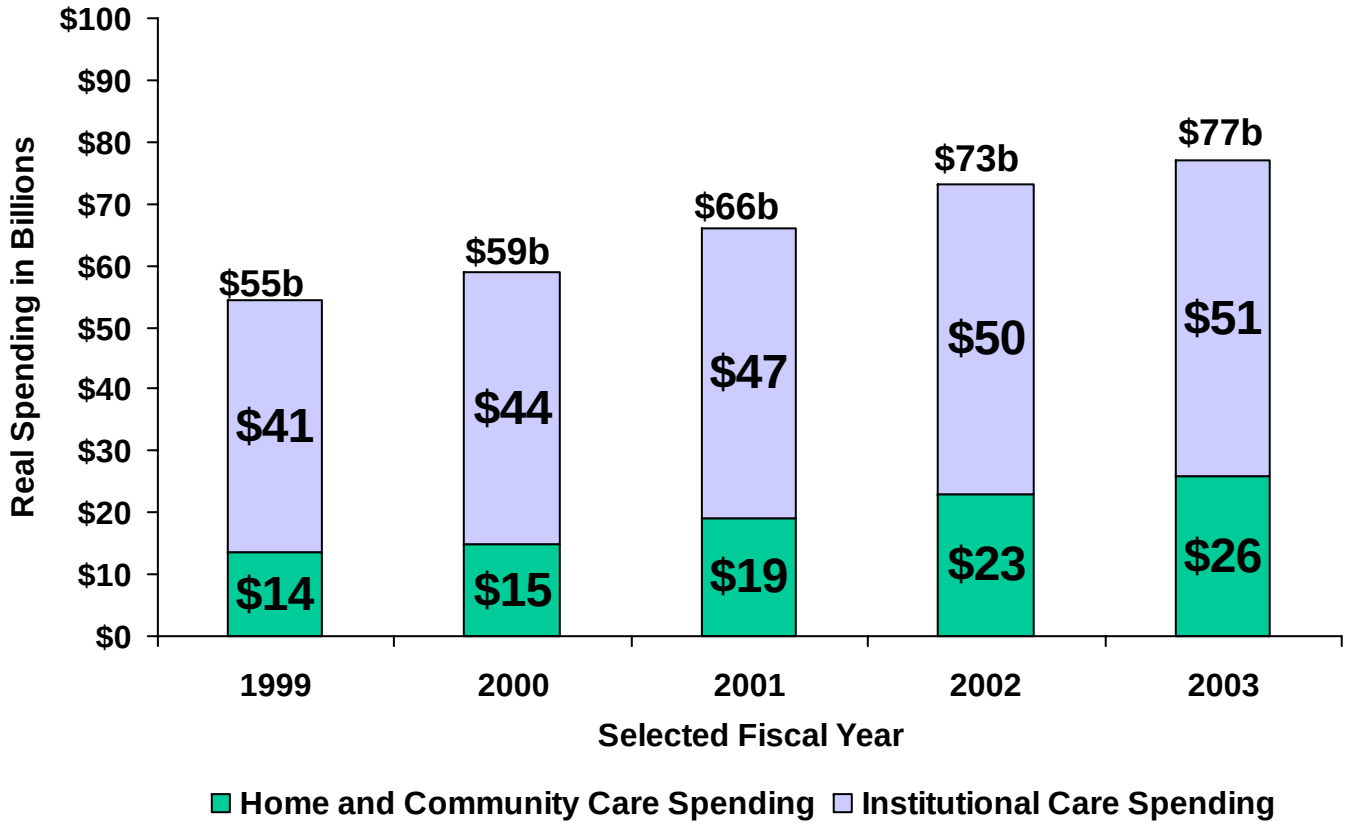
Federal Funds Provided to States



Source: National Association of State Budget Officers, *2004 State Expenditure Report.*

Table 4.30
Medicaid Spending for Long-Term Care, 1999-2003

Home and community-based services are a growing share of Medicaid's long term care spending.

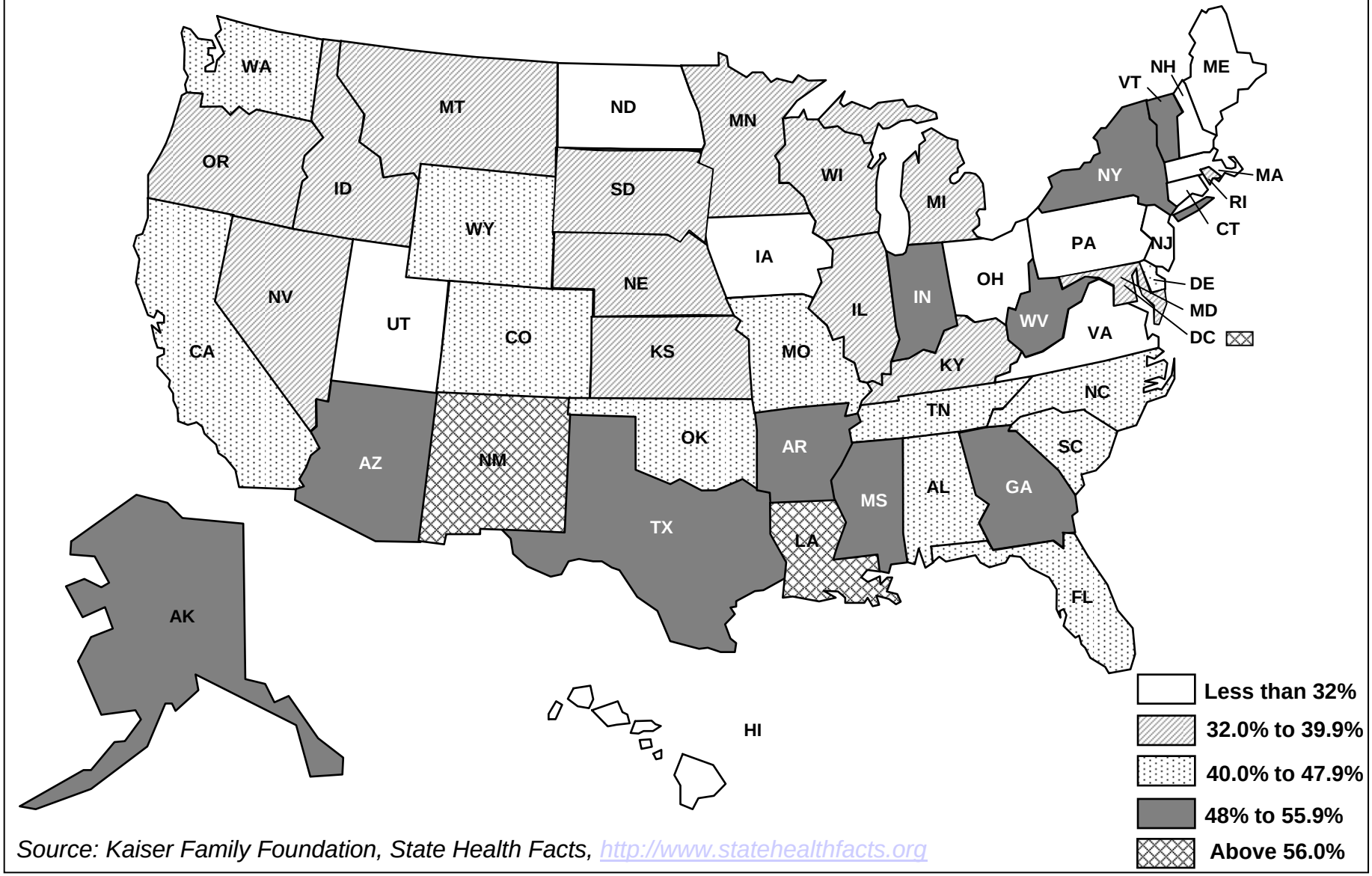


Notes: The share of Medicaid spending on long term care devoted to home and community based settings increased from 25% of the total in FY1999, 26% in FY2000, 29% in FY2001, 32% in FY2002, to 34% of the total in FY2003. Institutional spending includes SNF's, ICF's, ICF-MR, and Psychiatric Hospitals.

Sources: CMS, Center for Medicaid and State Operations, MSIS data.

Table 4.31
Births Financed by Medicaid as a Percent of Total Births by State, 2005

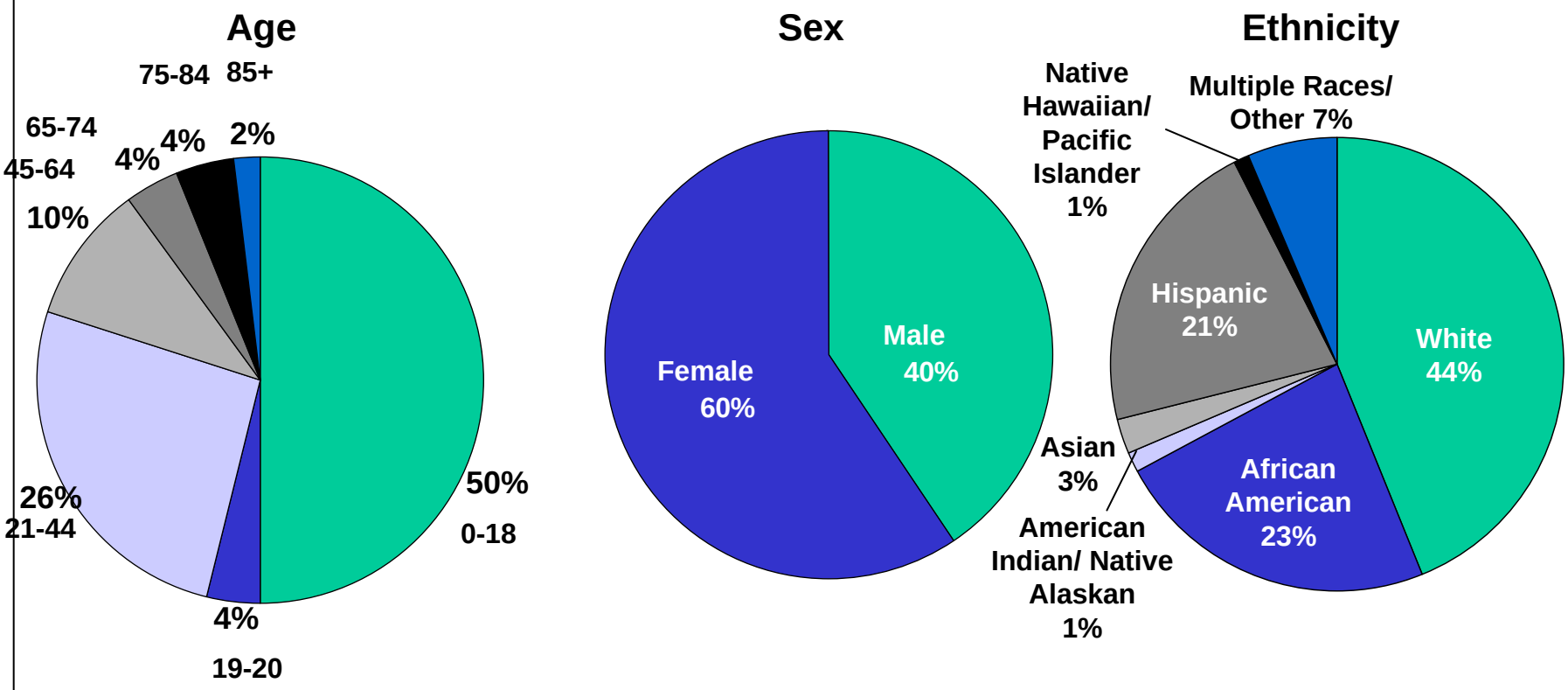
Medicaid pays for about 41% of the nation's births.



Source: Kaiser Family Foundation, State Health Facts, http://www.statehealthfacts.org

Table 4.32
Medicaid Enrollment by Age, Sex, and Ethnicity, 2003

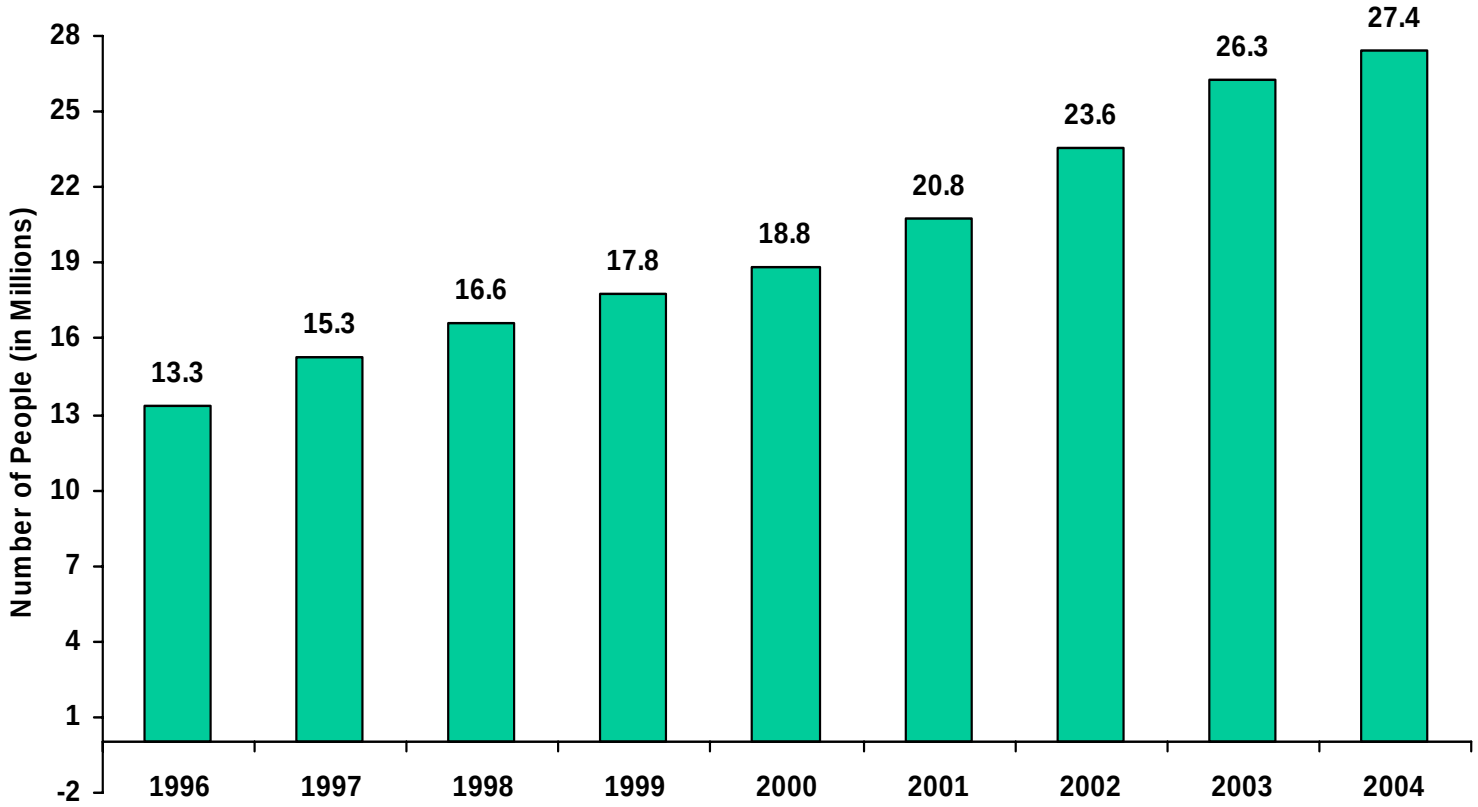
There were 55.2 million Medicaid enrollees in 2003.



Source: MSIS State Summary for 2003.

Table 4.33
Medicaid Managed Care Enrollment, 1996-2004

Medicaid managed care enrollment grew rapidly over the last decade.



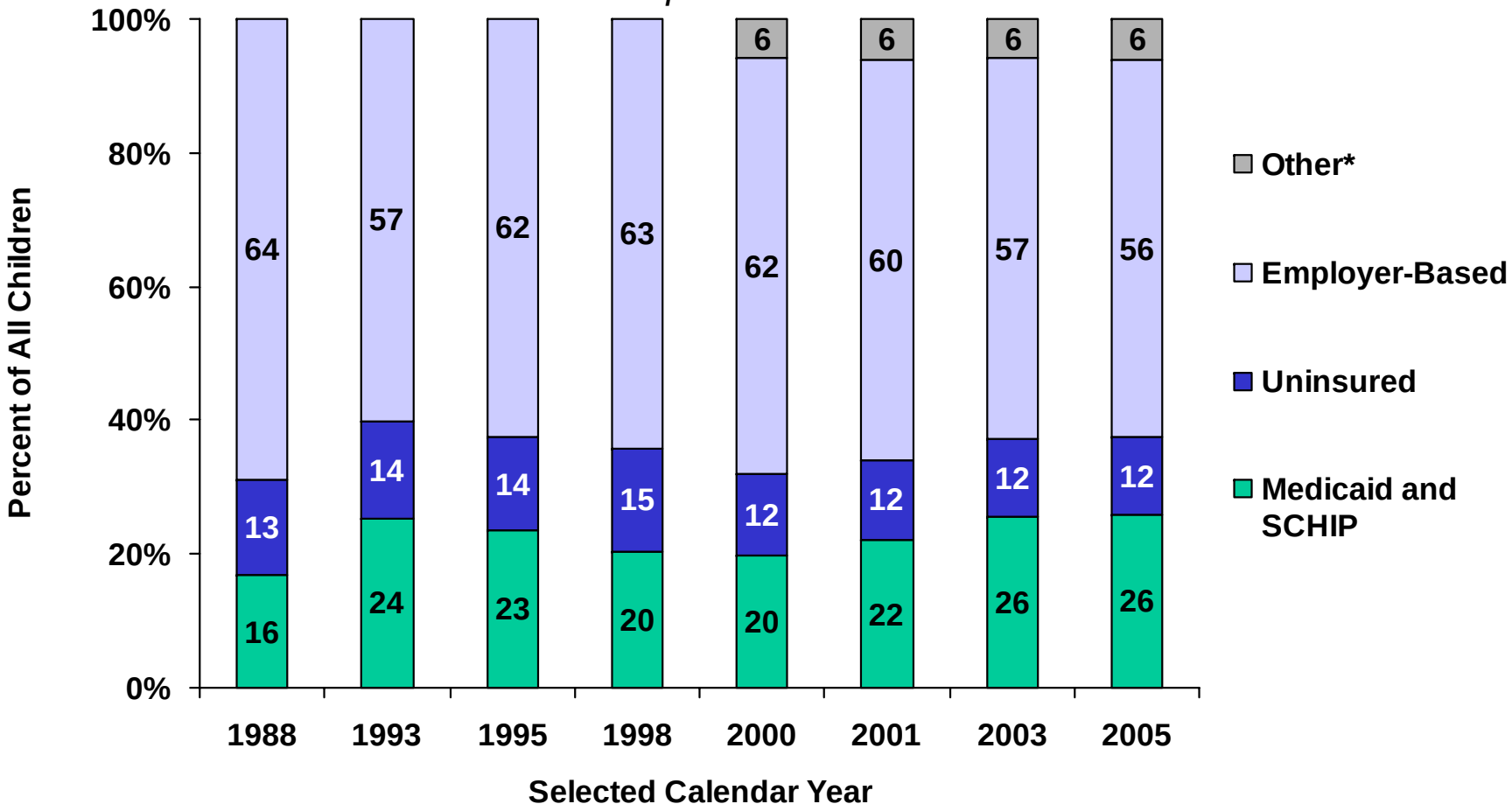
% Enrolled in Managed Care	1996	1997	1998	1999	2000	2001	2002	2003	2004
	40%	48%	54%	56%	56%	57%	57%	60%	61%

Note: The unduplicated managed care enrollment figures include enrollees receiving comprehensive benefits and limited benefits. This table also provides unduplicated national figures for the Total Medicaid population and Other population. The statistics also include individuals enrolled in State health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards.

Source: CMS, Center for Medicaid and State Operations: National Summary of Medicaid Managed Care Programs and Enrollment June 30, 2001. CMS, Medicaid Managed Care Enrollment Data, 2002-2004.

Table 4.34
Health Insurance Coverage of Children, 1988-2005

The percentage of children without health insurance has declined since SCHIP was Implemented in 1998.



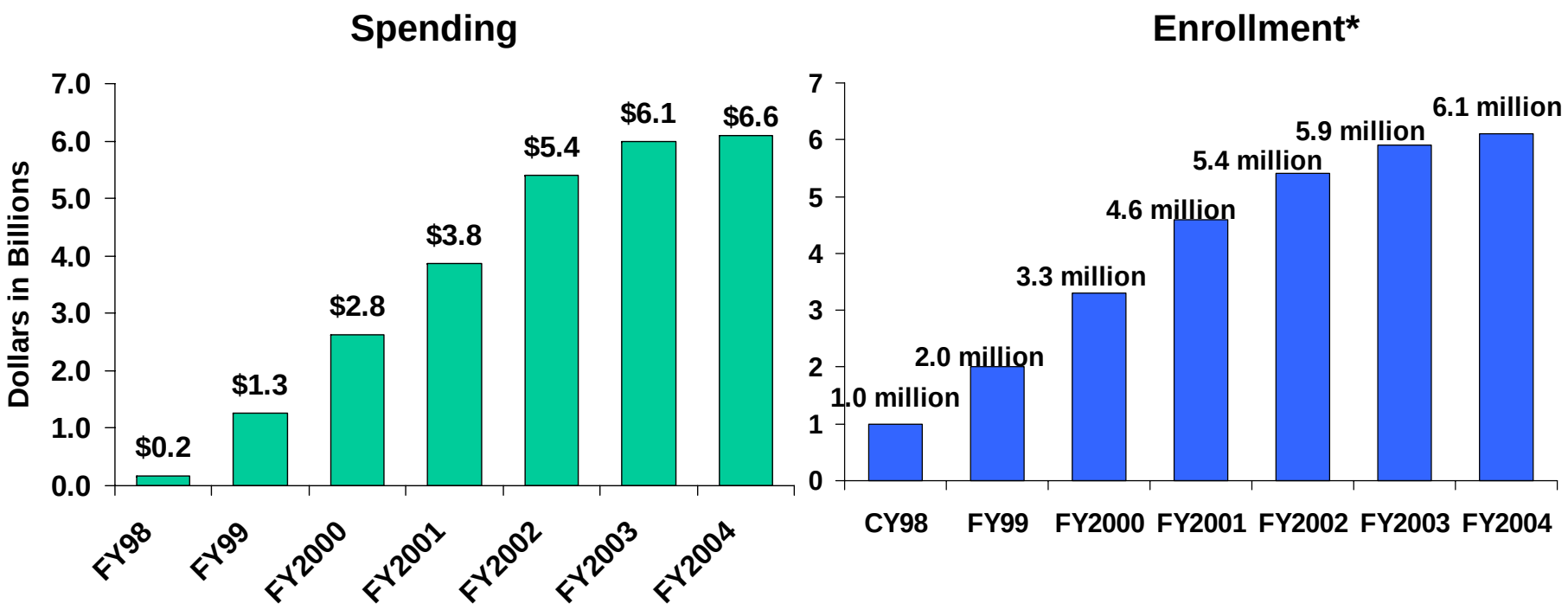
*Other includes private non-group and other public insurance. A change in the census questionnaire allowed this category to be separately identified starting in 2000. see also Table 6.6

Notes: About 23% of children below poverty (or 4.1 million kids) had no health insurance in 2004.

Source: Tabulations of the March Current Population Survey files by Actuarial Research Corporation, incorporating their historical adjustments.

Table 4.35
State Children's Health Insurance Program
Spending and Enrollment, 1998-2004

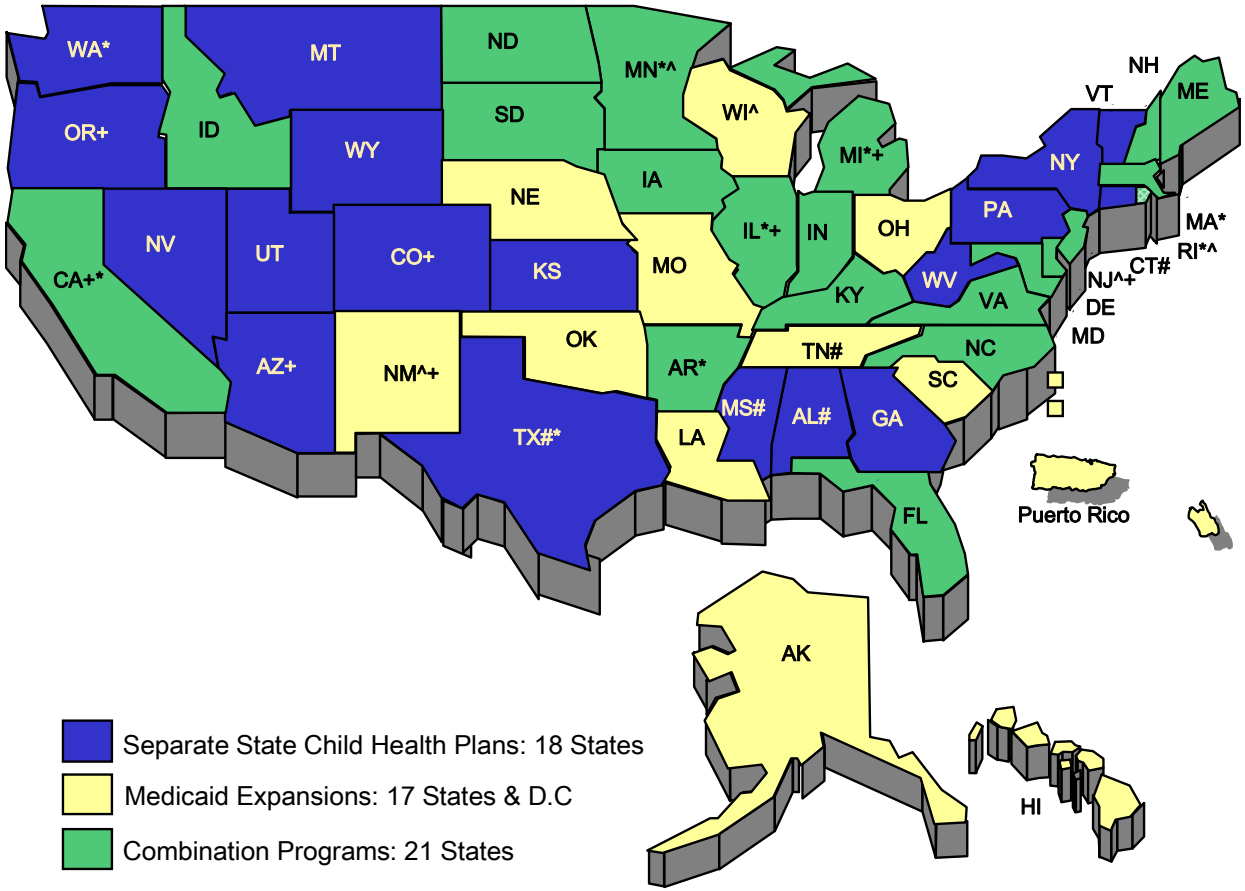
The SCHIP program covers a growing number of uninsured low-income children.



*Note: Ever enrolled in SCHIP during the year, not a point in time estimate.

Source: Center for Medicaid and State Operations

Table 4.36
State Children's Health Insurance Program Plan Type by State, 2006



Key

* **Approved Unborn State Plan Amendments: 9** (AR, CA, IL, MA, MI, MN, RI, TX, WA)

^ **Approved SCHIP 1115 Demonstrations: 6** (AK, MN, NM, NJ, RI, WI)

\+ **Approved HIFA Demonstrations: 13** (AZ, AR, CA, CO, ID, IL, MI, NJ, NV, NM, OR, UT, VA)

\# **State** no longer has a Medicaid expansion program as of September 30, 2002, due to the aging out of the children phased into the Medicaid program under OBRA'90.

Summary Information (in order of submission/approval):

Number of Approved Separate State Child Health Plans: 18 (CO, PA, OR, NV, UT, MT, GA, AZ, KS, VT, WA, WY, WV, AL, MS, TX, CT, NY)

Number of Approved Medicaid Expansions: 17 (SC, OH, MO, OK, WI, PR, DC, NE, NM, VI, LA, AK, HI, GU, AS, CNMI, TN)

Number of Approved Combination Plans: 21 (FL, MA, NJ, ME, NH, KY, MI, IA, NC, ND, IN, IL, MD, SD, VA, CA, RI, MN, DE, AR, ID)

Total Number of Amendments Approved: 272

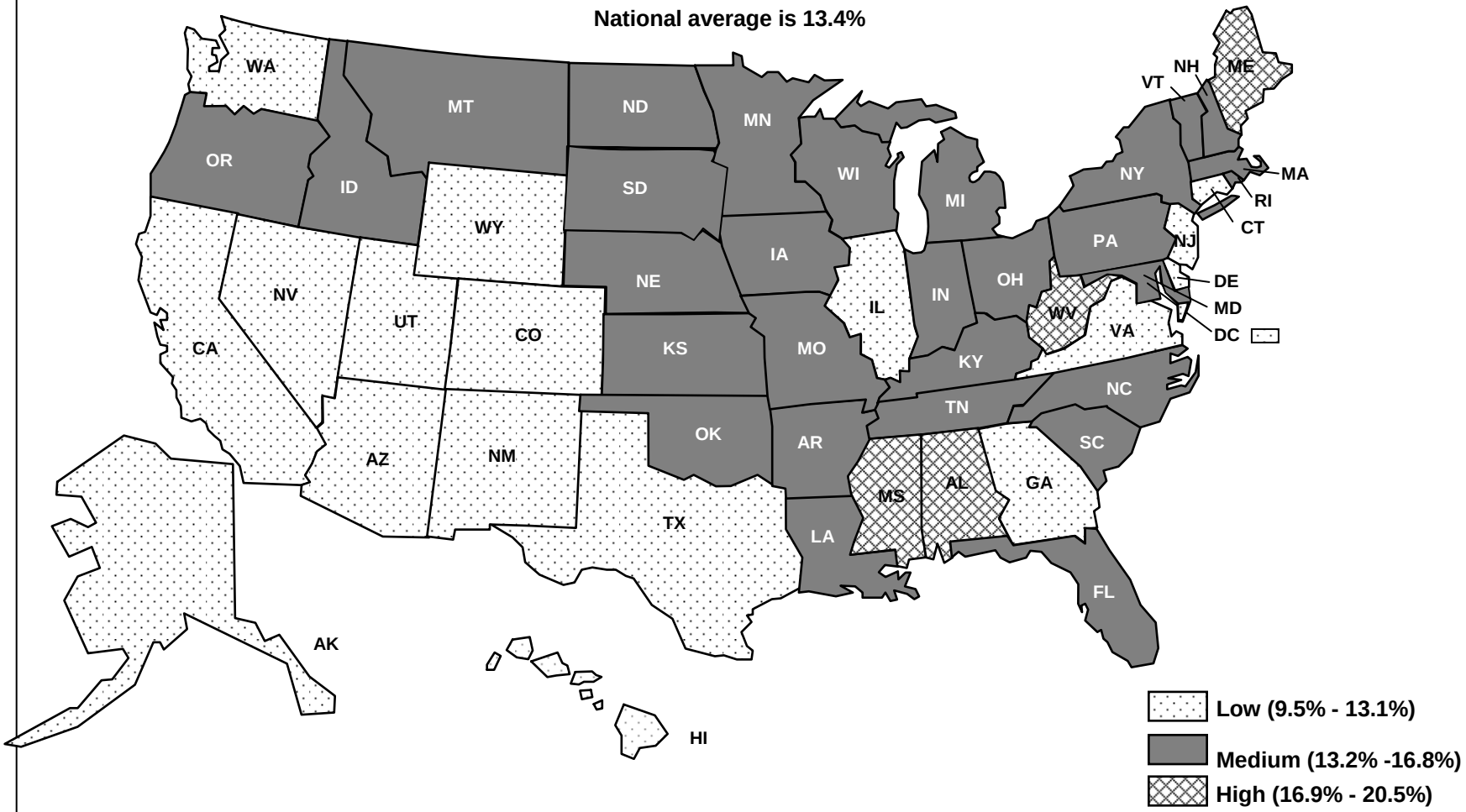
Number of Amendments Under Review: 13 (TN,VA-6th amend, IL-6th amend, IL-7th amend, CA-11th amend, WI-4th amend.)WV-6th-amend; FL-17th amend; PA-7th amend.; DE-3rd amend, WA-8th amend.

Source: CMS Center for Medicaid andState Operations.

Table 4.37

State Health Spending as a Percent of Gross State Product 2004

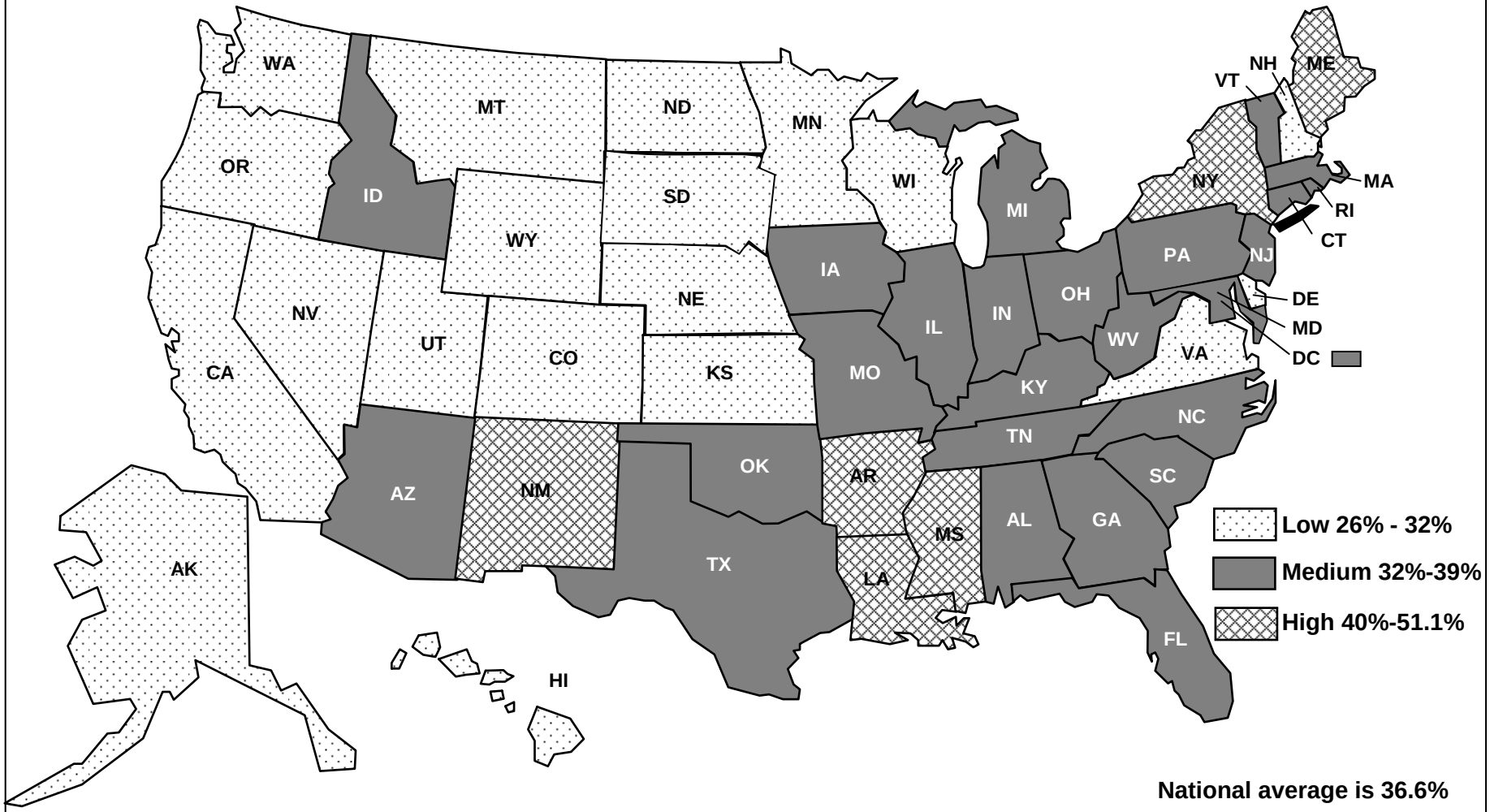
Proportion of state output devoted to personal healthcare varies by state.



Note: Data are for personal health care by state of provider.
Source: CMS, Office of the Actuary, National Health Statistics Group.

Table 4.38
Share of State Health Spending Financed by Both Medicare and Medicaid, 2004

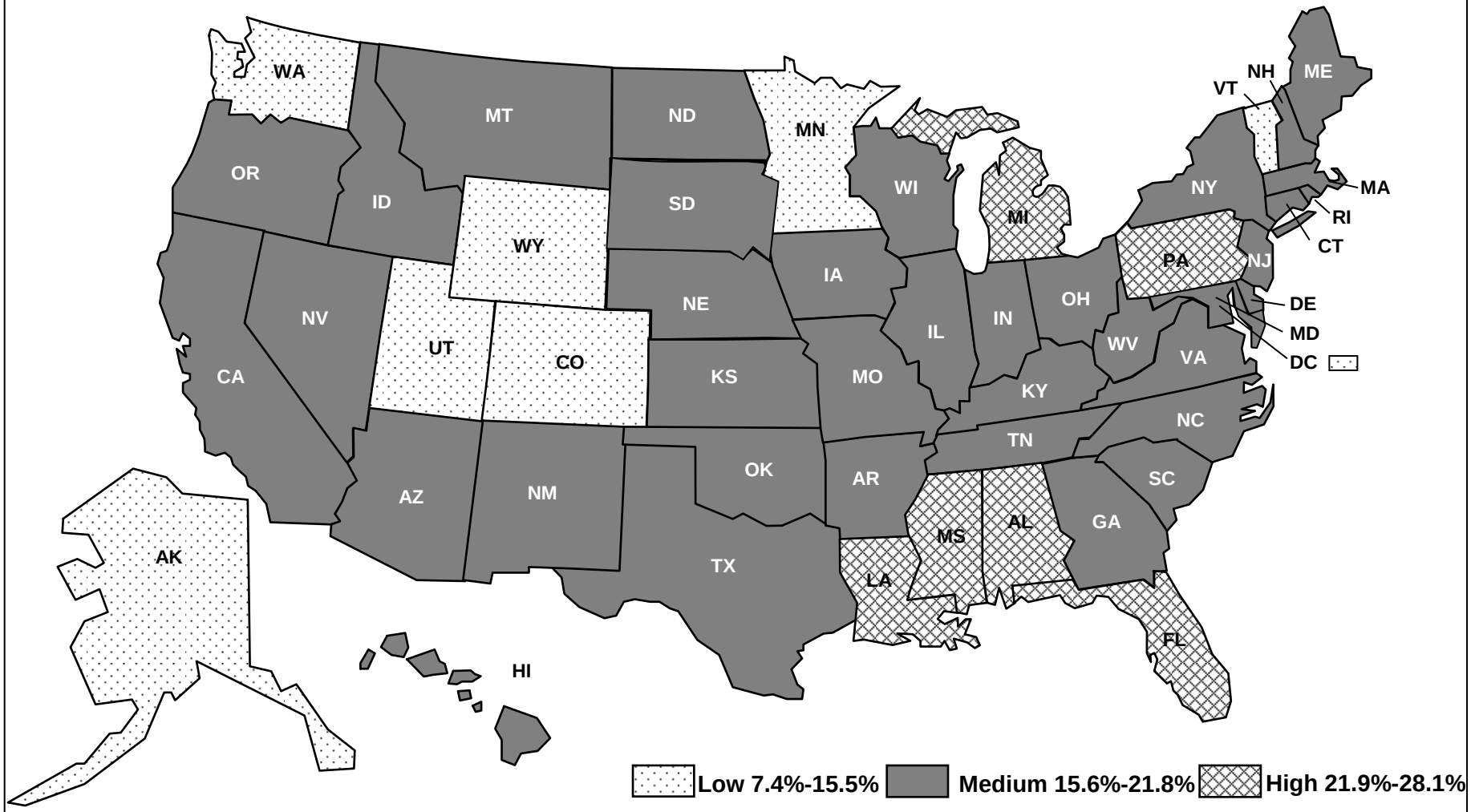
Medicare and Medicaid finance varying proportions of State health spending.



Source: CMS, Office of the Actuary, National Health Statistics Group.

Table 4.39
Share of State Health Spending Financed by Medicare, 2004

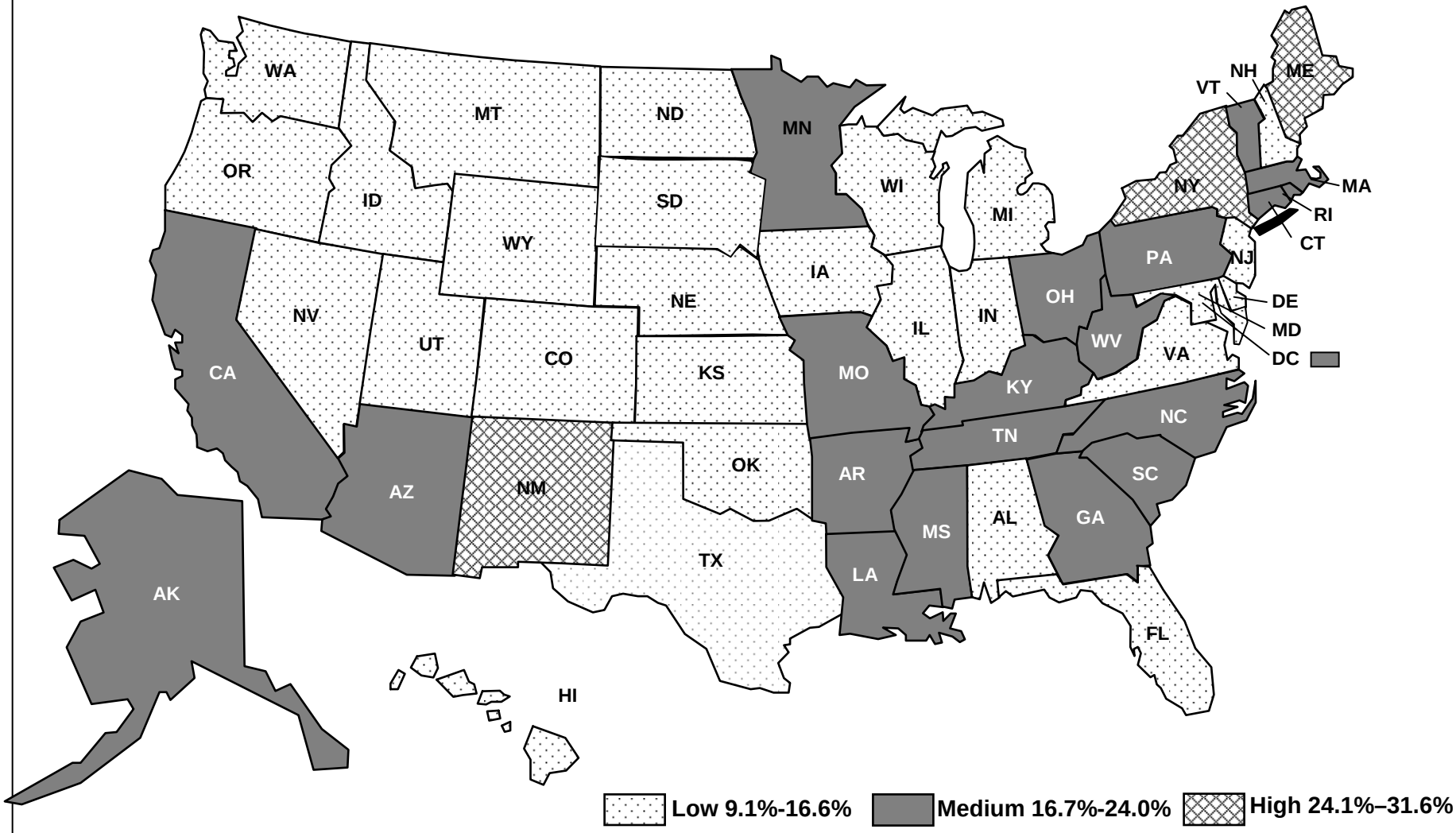
Medicare finances a varying share of State health spending.



Source: CMS, Office of the Actuary, National Health Statistics Group.

Table 4.40
Share of State Health Spending Financed by Medicaid, 2004

Medicaid finances a varying share of State health spending.



Source: CMS, Office of the Actuary, National Health Statistics Group.

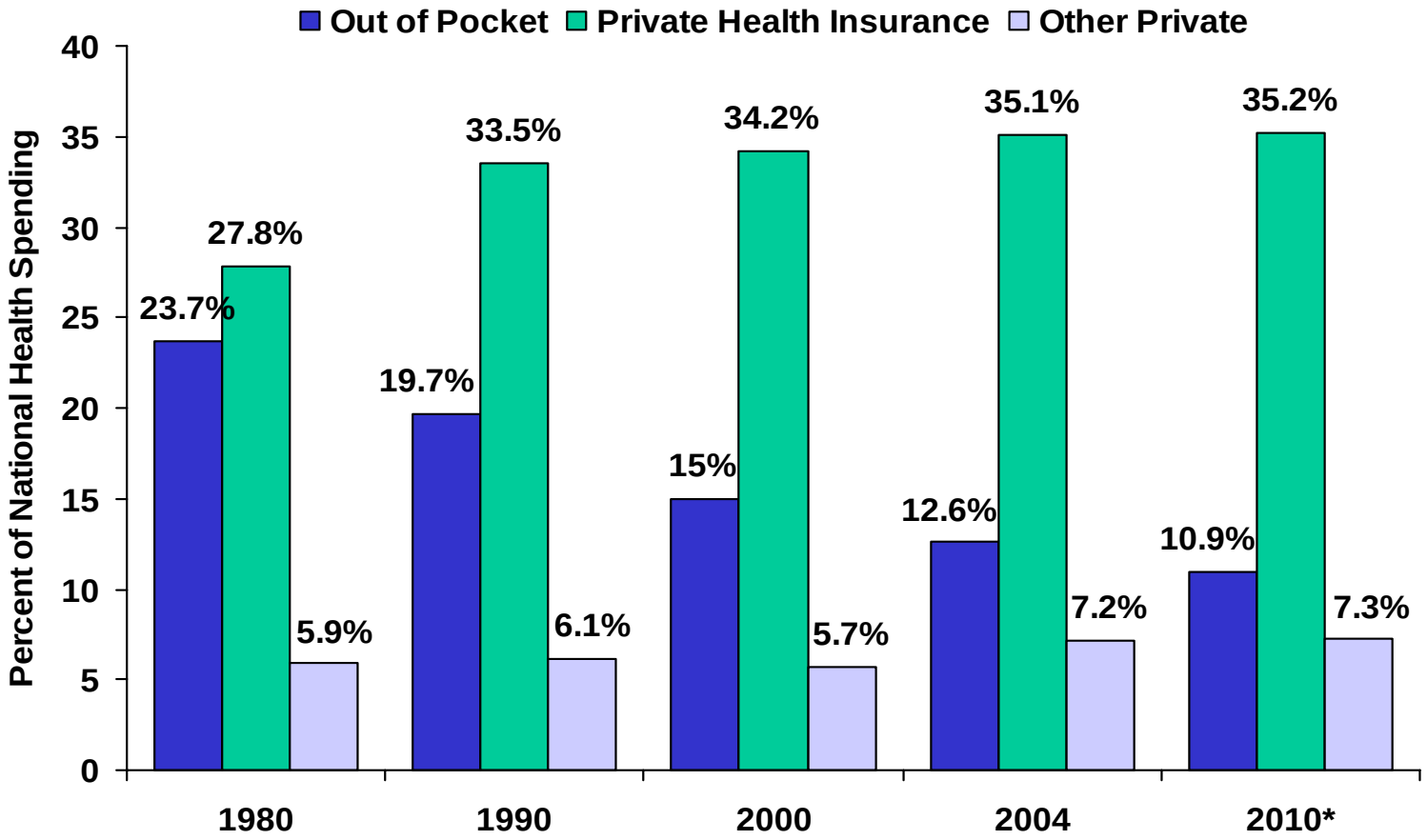
National average is 17.4%

Section 5

Private Health Insurance

Table 5.1
National Health Spending From Out-of-Pocket and Private Health Insurance, 1980-2010

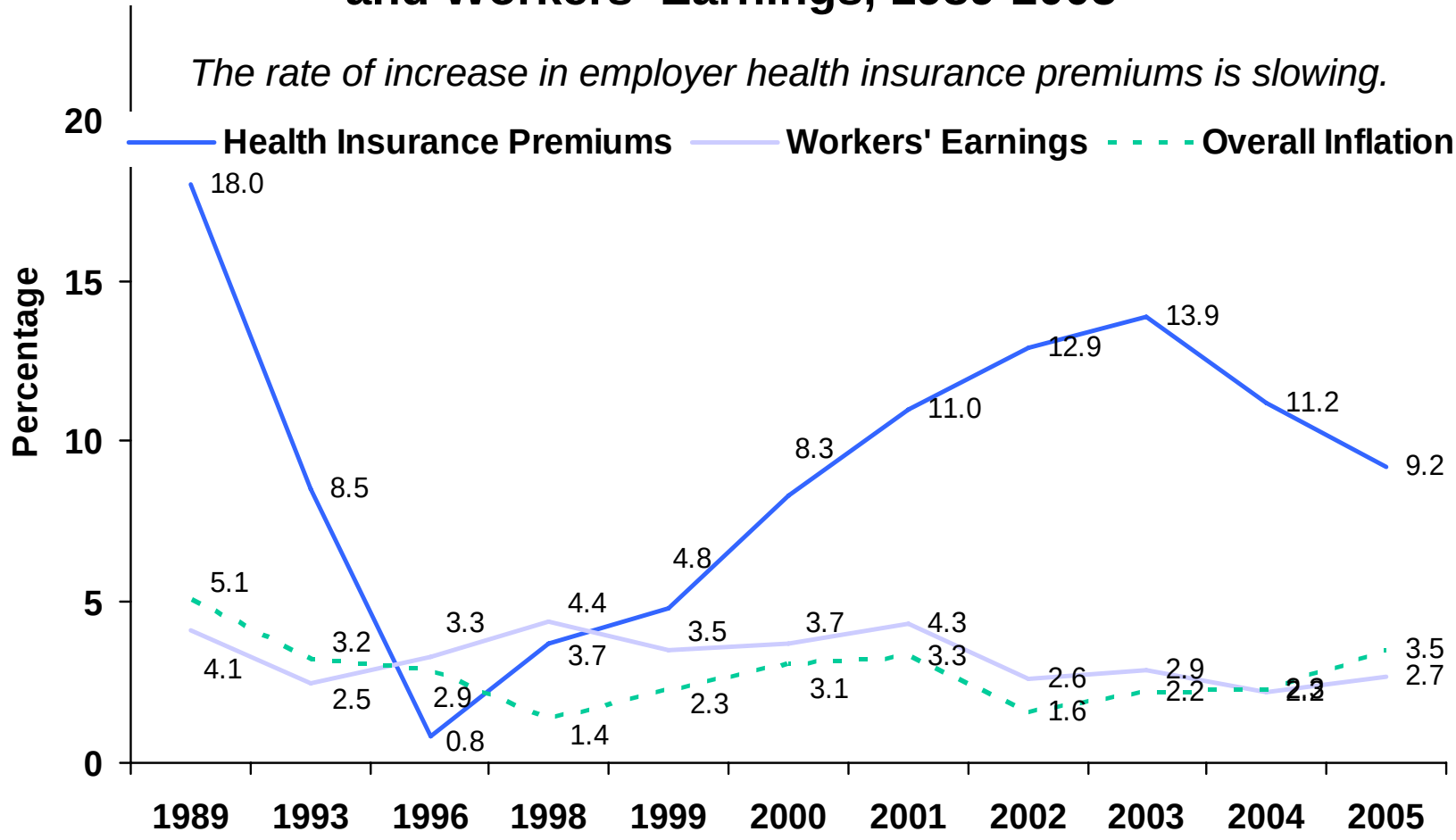
Over the last 25 years, the share of national health spending from out-of-pocket sources has declined, while that from private health insurance has increased.



*Projected

Note: The remainder of national health spending is from public sources. This chart is a subset off Table 1.3
Source: CMS, Office of the Actuary, National Health Statistics Group.

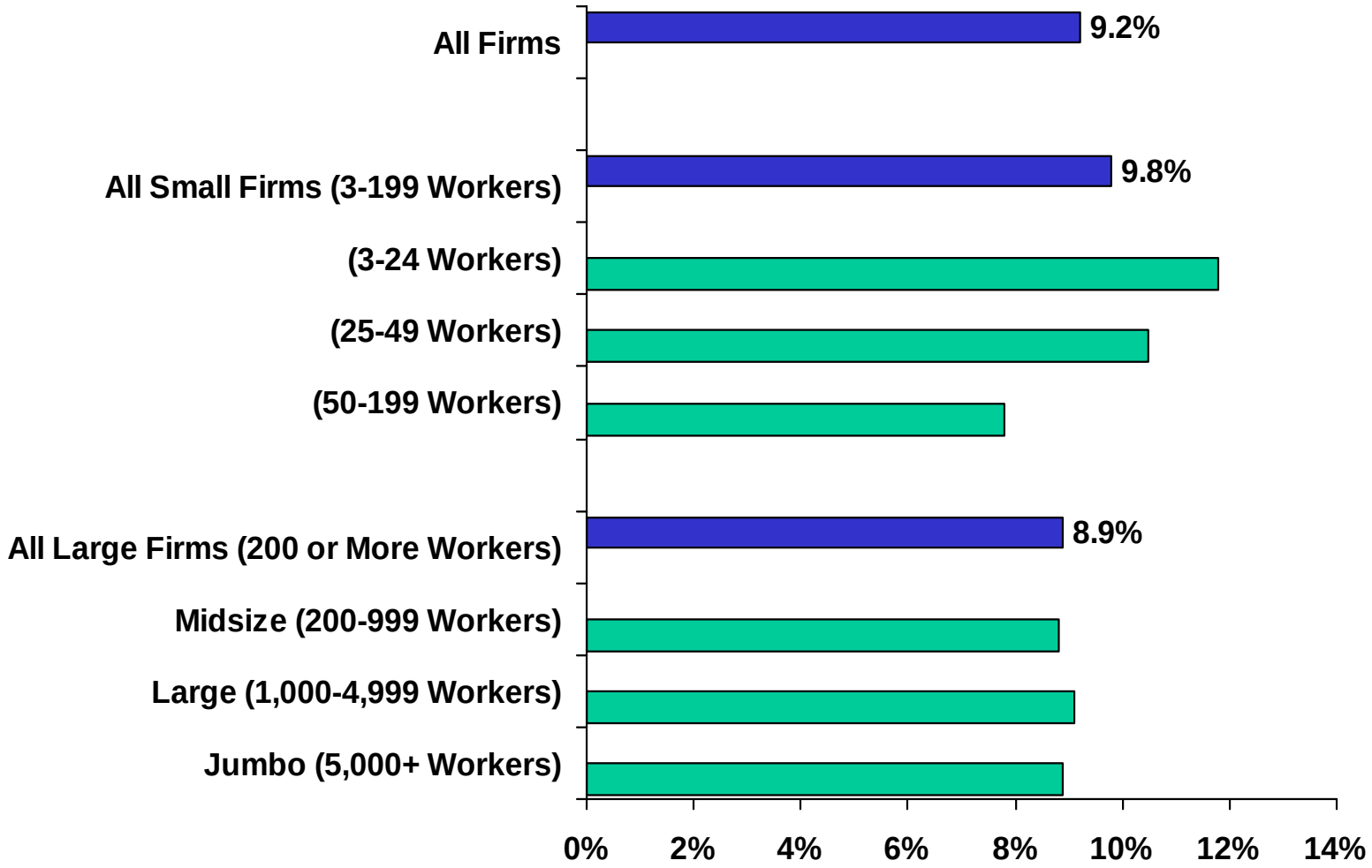
Table 5.2
Changes in Employer Health Insurance Premiums, Overall Inflation, and Workers' Earnings, 1989-2005



Source: Health Insurance Premiums from personal communication of data from KFF/HRET Employer Health Benefits Surveys from 1999, 2000, 2001, 2005: KPMG Survey of Employer-Sponsored Health Benefits: 1993, 1996; HIAA Employer-Sponsored Health Insurance Survey; 1989. Workers' Earnings from Bureau of Labor Statistics Current Employment Statistics Survey (April-April), 1988-2001. Overall Inflation from Bureau of Labor Statistics, CPI estimates (April-April), 1988-2001, at www.bls.gov. Trends and Indicators in the Changing Health Care Marketplace, 2002 – Chartbook.

Table 5.3
Annual Change in Health Insurance Premiums by Firm Size, 2005

Small firms face higher premium growth than larger firms.

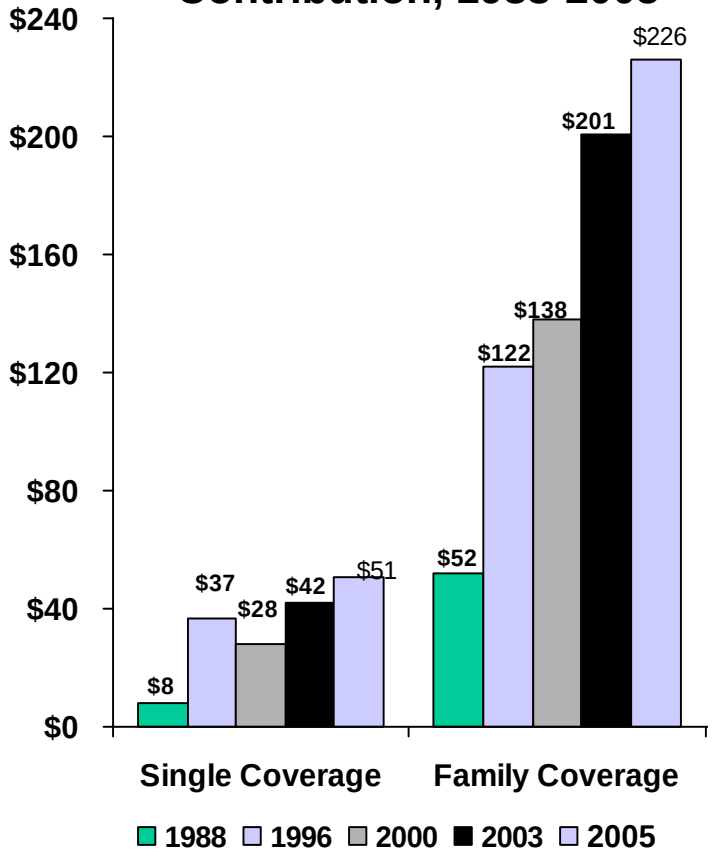


Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2005.

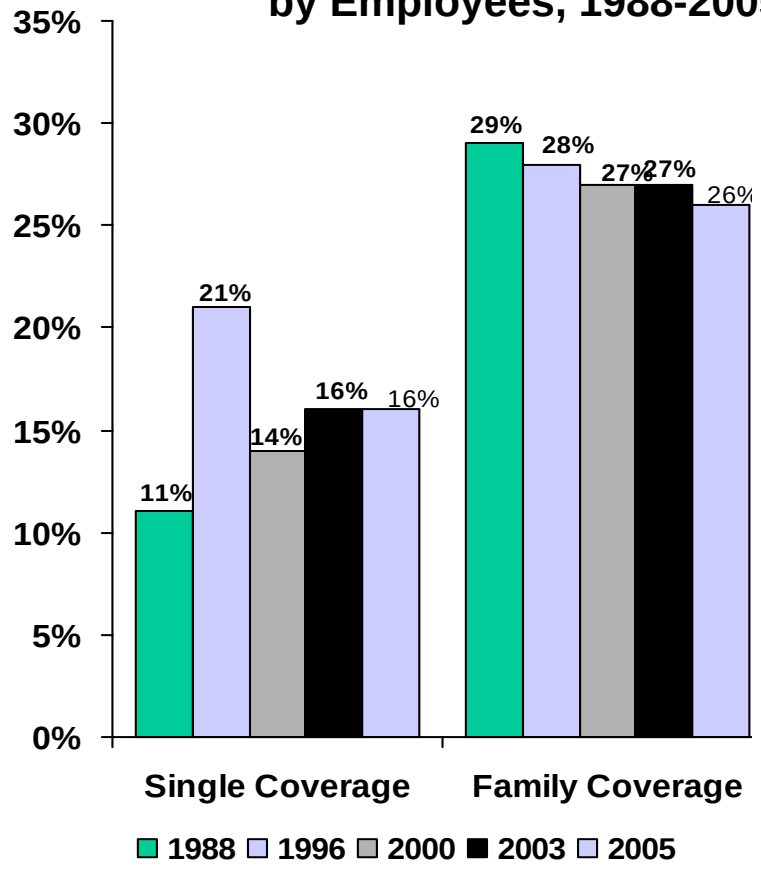
Table 5.4
Employee Contributions to Health Insurance Premiums, 1988-2005

Employees are paying a higher dollar value, but smaller share of their health insurance premiums.

Average Monthly Employee Contribution, 1988-2005



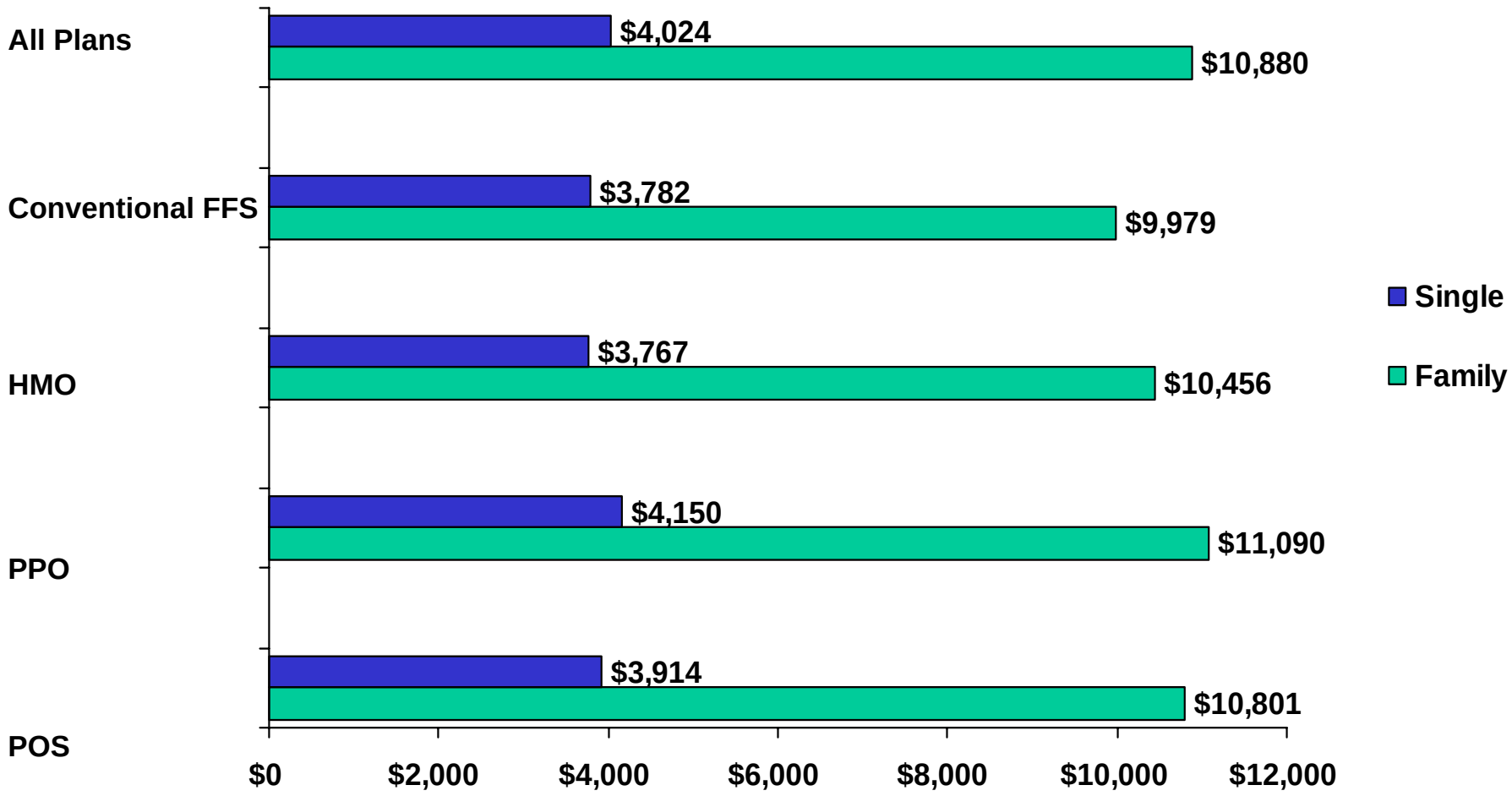
Percentage of Premium Paid by Employees, 1988-2005



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2000, 2001, 2003, 2005; KPMG Survey of Employer-Sponsored Health Benefits: 1988, 1993, 1996.

Table 5.5
Average Annual Premium Costs by Plan Type, 2005

Average premiums vary by plan type.

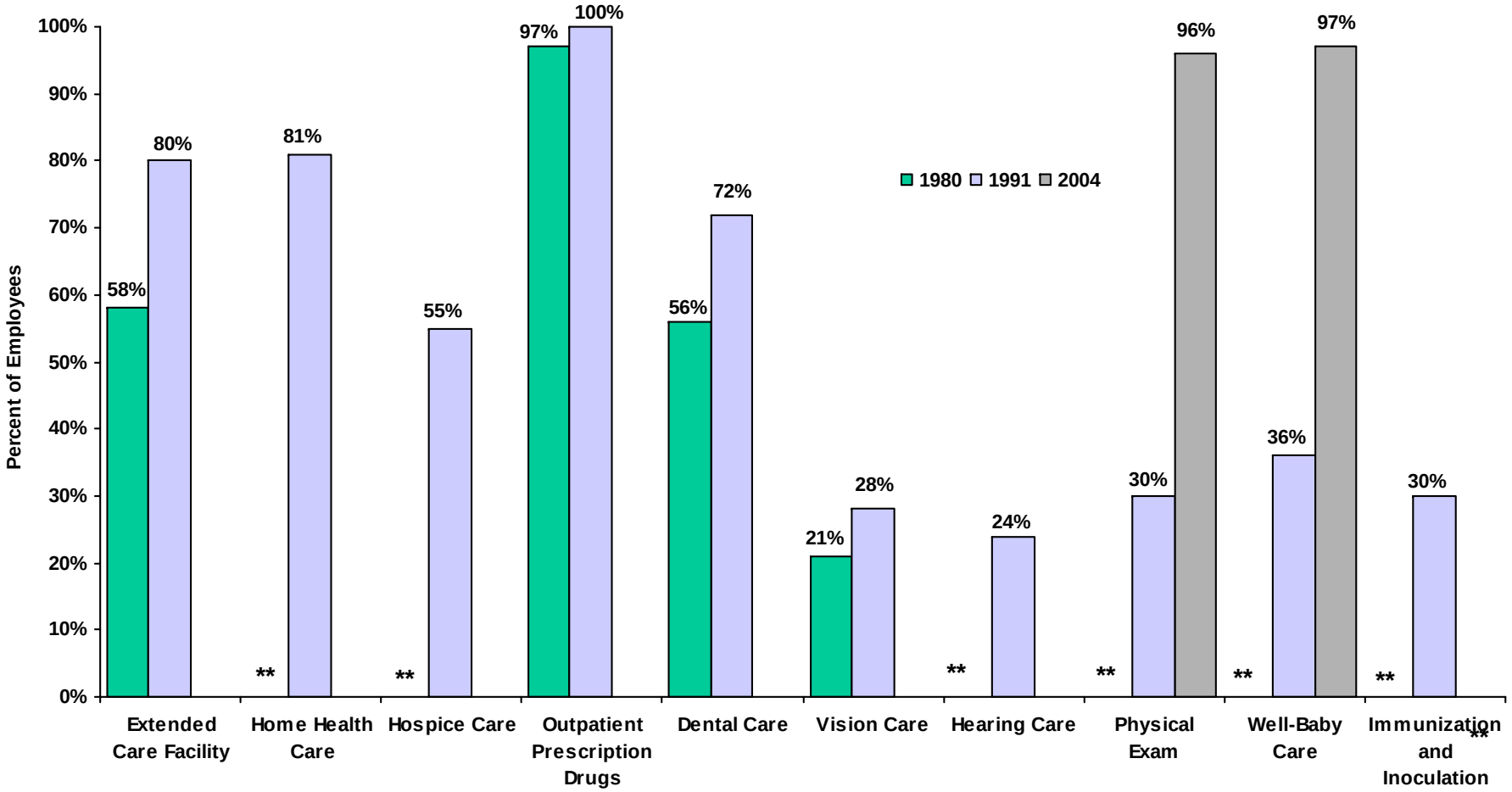


Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2005.

Table 5.6

Changes in Employee Benefit Packages, 1980-2004

Employees were offered more generous benefit packages in recent years.



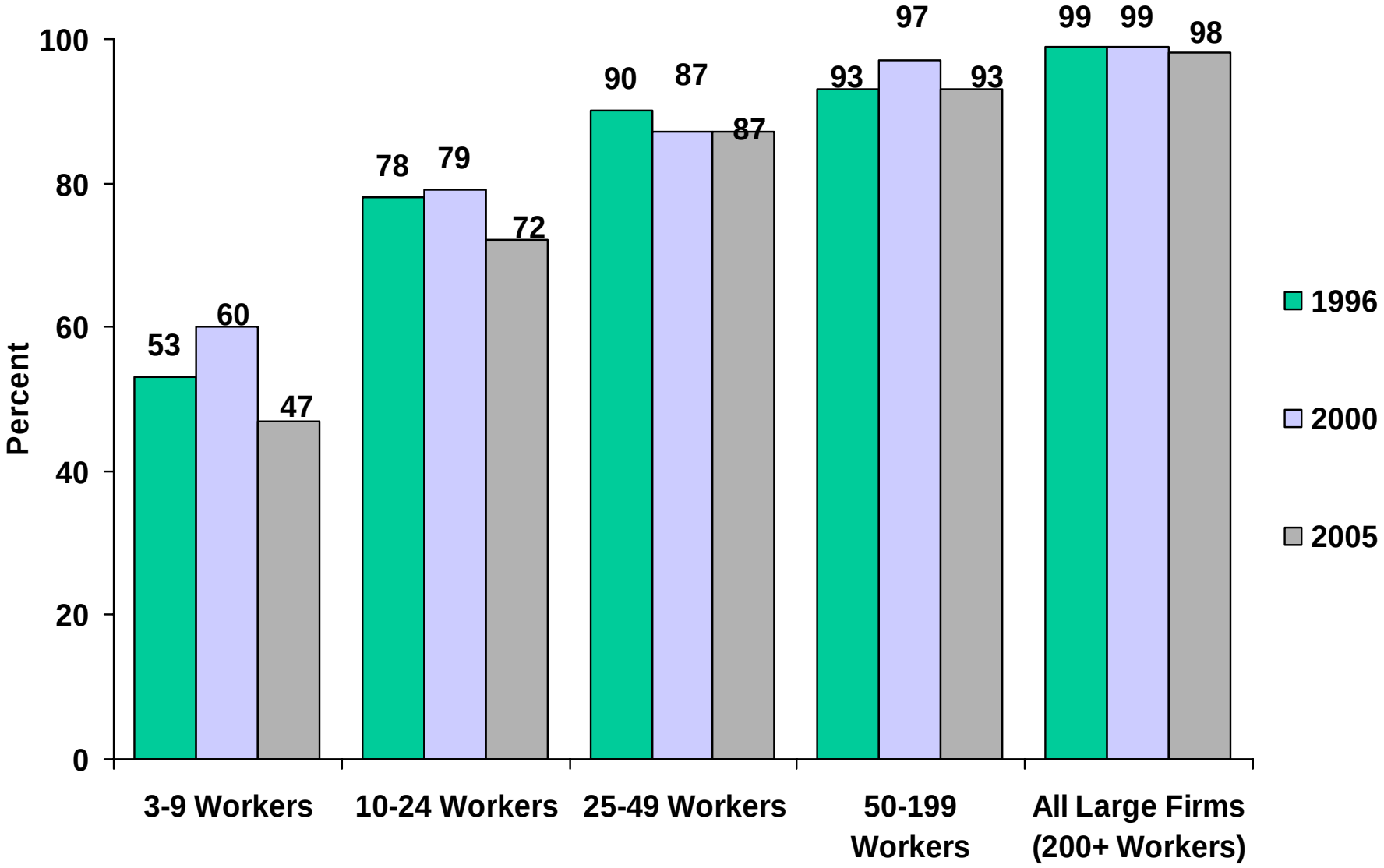
Note: Coverage for selected services offered by medium and large establishments, displayed by % of employees that have each benefit available to them.

**Not available. 2004 data available only for physical exams and well baby exams.

Sources: Dept. of Labor, Bureau of Labor Statistics. Report by Sophie Korczyk, "Trends in Employer-Provided Health Care Coverage: 1980-1997, Final Report March, 2000. 2004 data from Employer Health Benefits 2004 Annual Survey, Kaiser Family Foundation.

Table 5.7
Firms Offering Health Insurance Coverage by Firm Size, 1996-2005

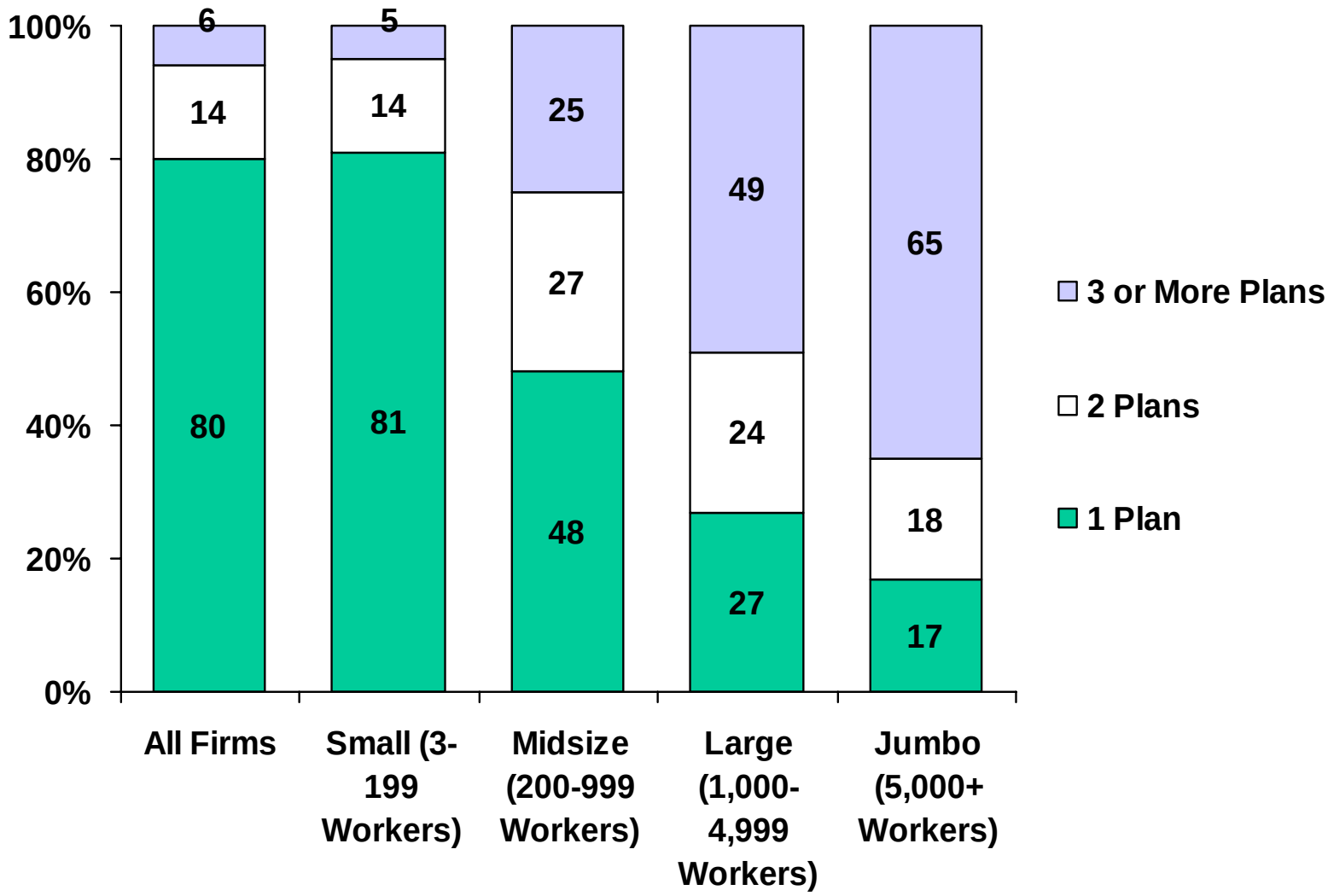
Larger firms are more likely to offer health insurance than smaller firms.



Source: Employer Health Benefits, 2005 Annual Survey, The Kaiser Family Foundation, and Health Research and Educational Trust.

Table 5.8
Number of Health Plans Offered by Firm Size, 2005

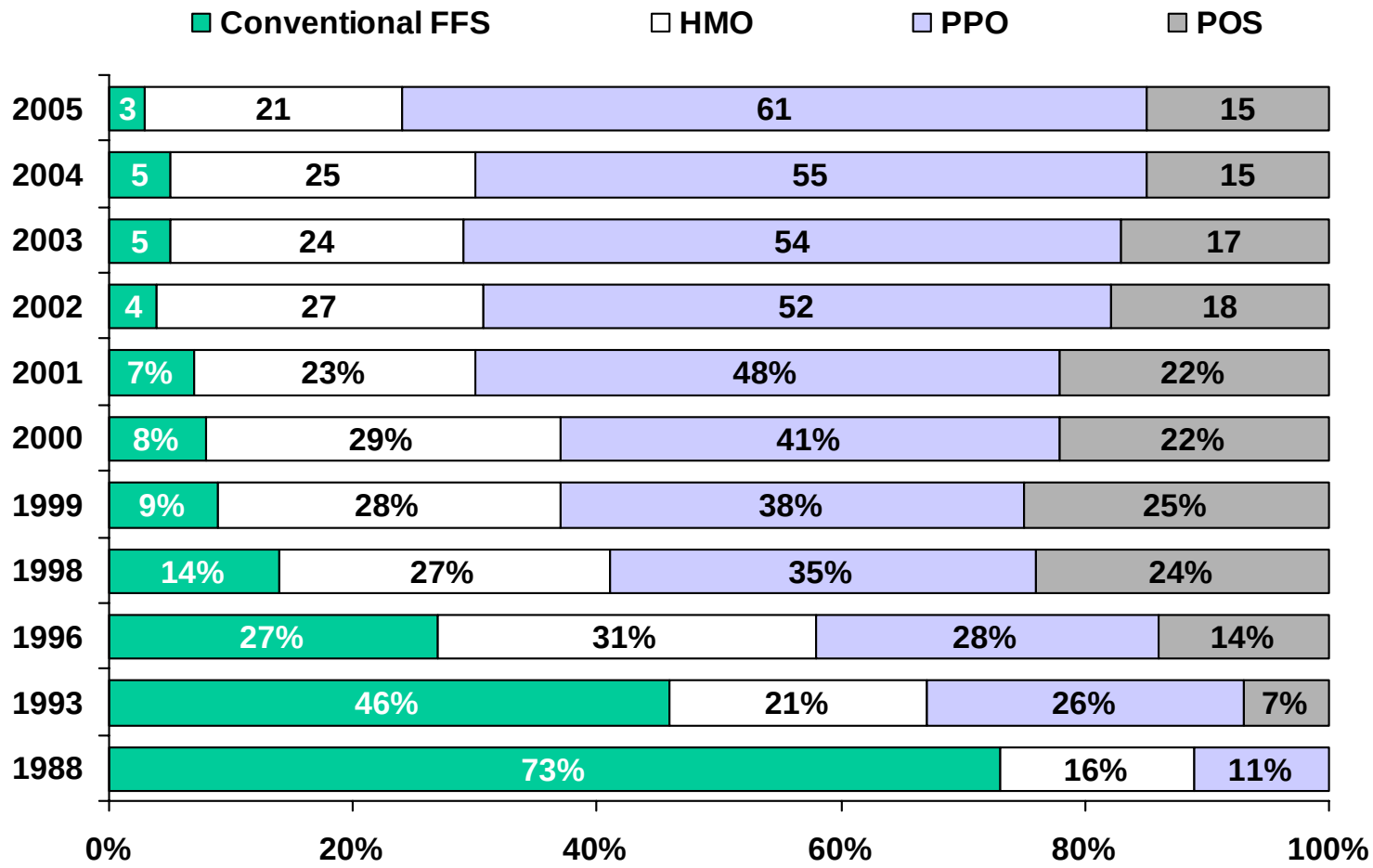
Large firms are more likely to offer employees a choice of plans.



Source: Employer Health Benefits, 2005 Annual Survey, The Kaiser Family Foundation, and Health Research and Educational Trust.

Table 5.9
Private Health Insurance Enrollment by Plan Type, 1988-2005

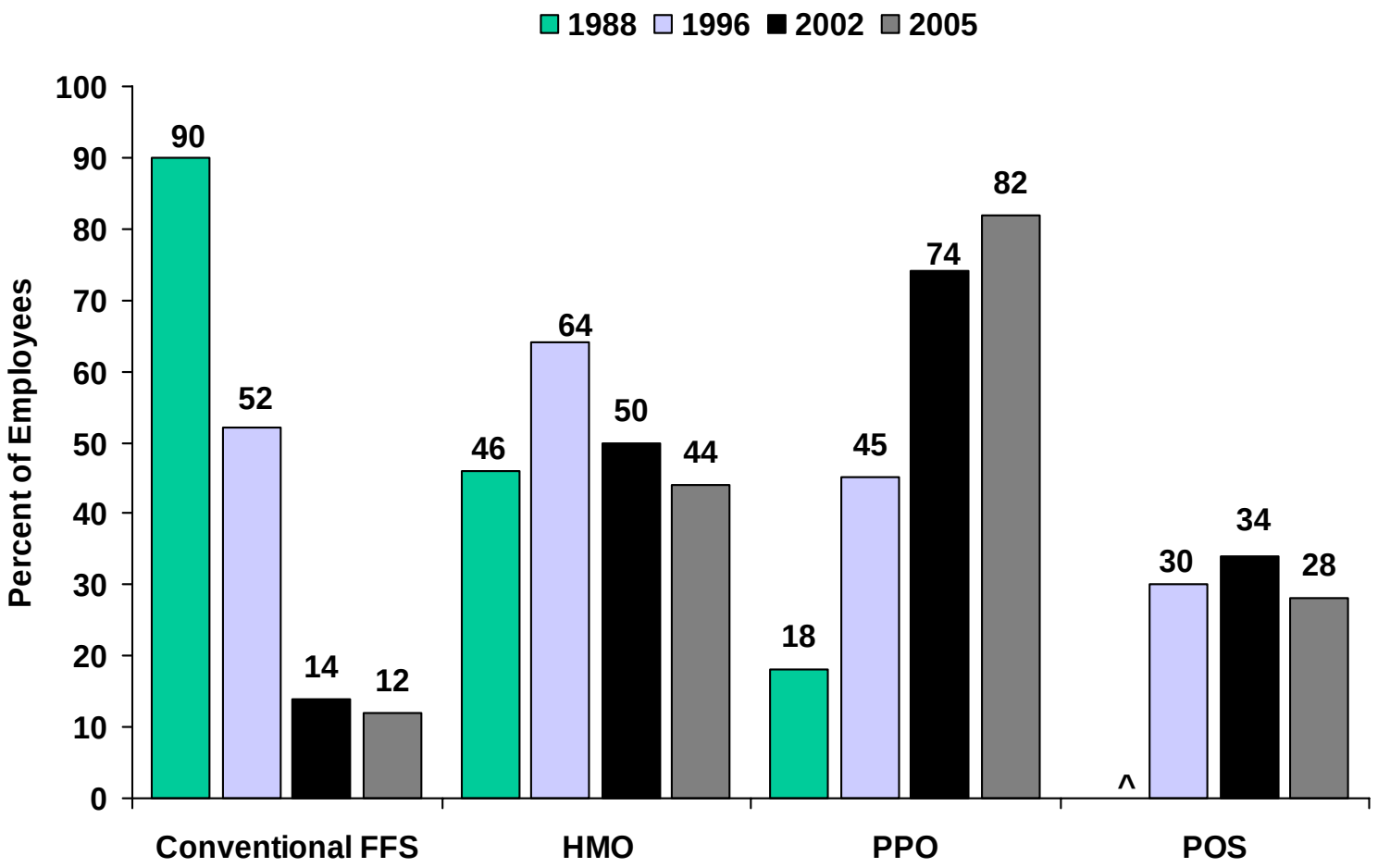
Since 1988, Conventional Fee-for-Service plans have almost disappeared, while PPOs have grown significantly.



Source: Employer Health Benefits, 2001-2005 Annual Survey, The Kaiser Family Foundation and Health Research and Educational Trust. Trends and Indicators in the Changing Health Care Marketplace, 2002 – Chartbook.

Table 5.10
Employees With a Choice of Health Plans, 1988-2005

In recent years, fewer employees have a choice of conventional FFS plans. A growing share have a choice of PPOs and POS plans.

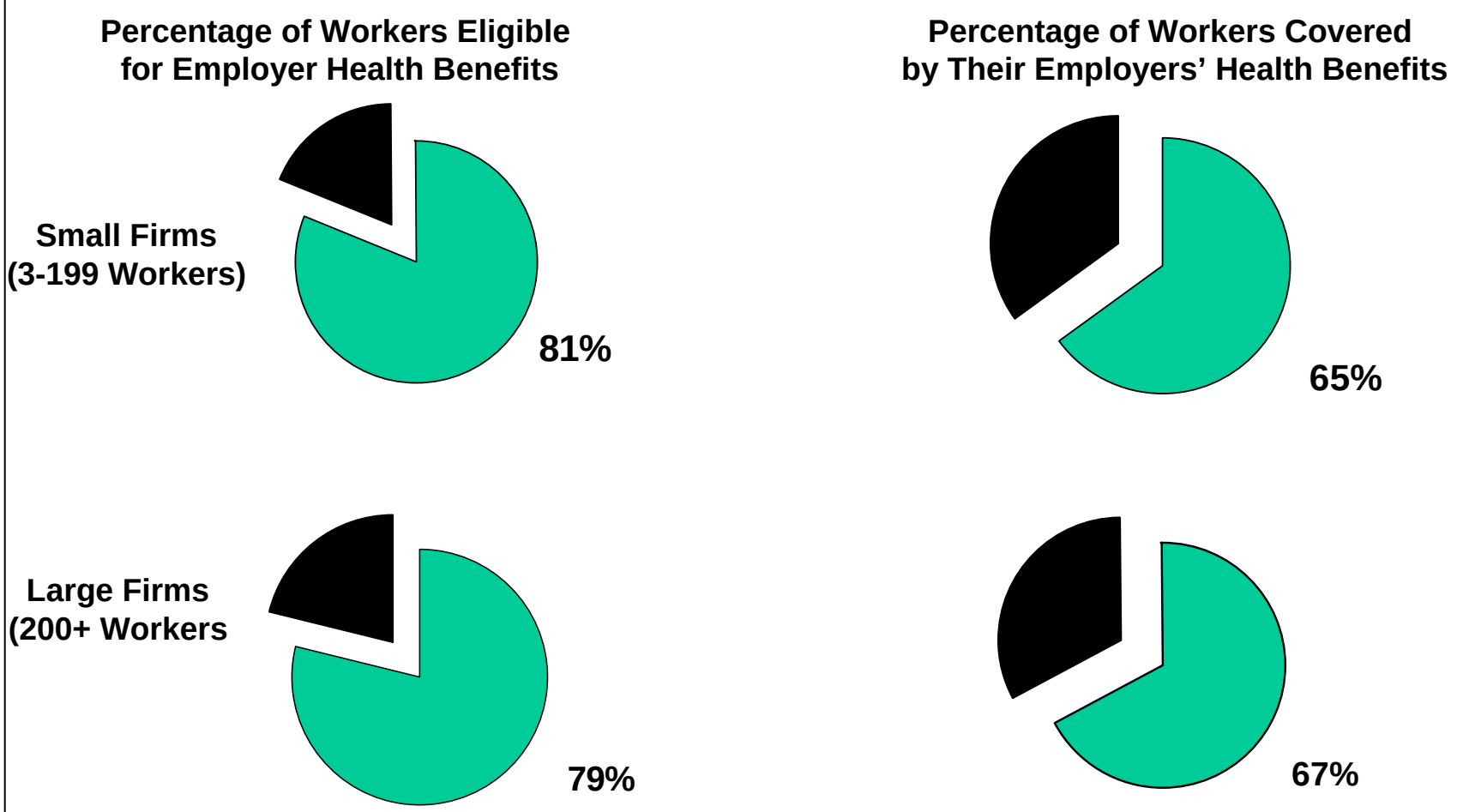


^ Information was not obtained for POS plans in 1988.

Source: KFF/HRET Survey of Employer-Sponsored Health Benefits, 2000-2005; KPMG Survey of Employer-Sponsored Health Benefits: 1988, 1993, 1996.

Table 5.11
Covered Employees in Firms That Offer Health Benefits, 2005

Not all eligible employees enroll in an employer's health plan.



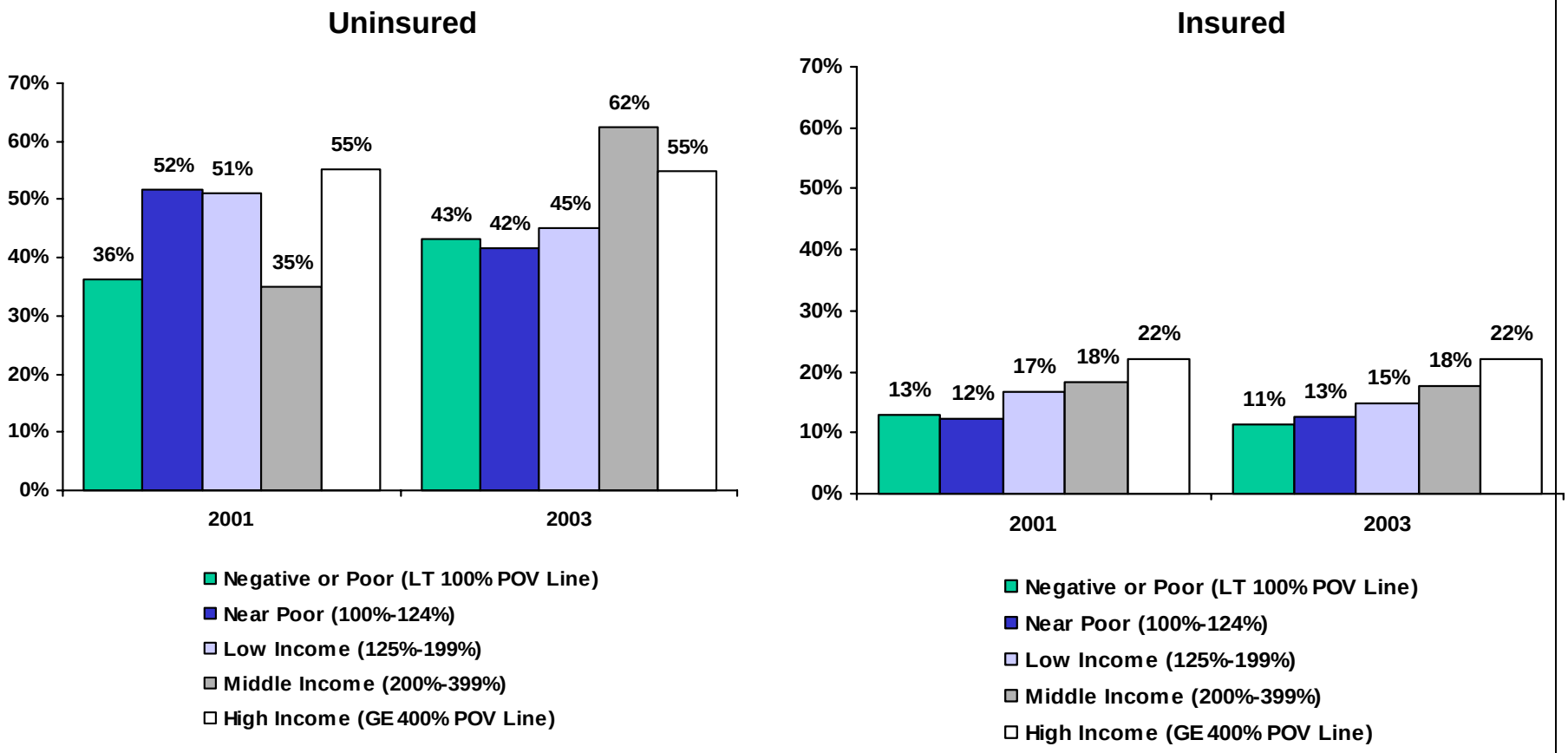
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2005.

Section 6

The Uninsured

Table 6.1
Out-of-Pocket Spending by the Under 65 Population by Insurance Status by Income, 2001 and 2003

The percent of health spending from out-of-pocket sources by the uninsured is significantly higher than for those with insurance.

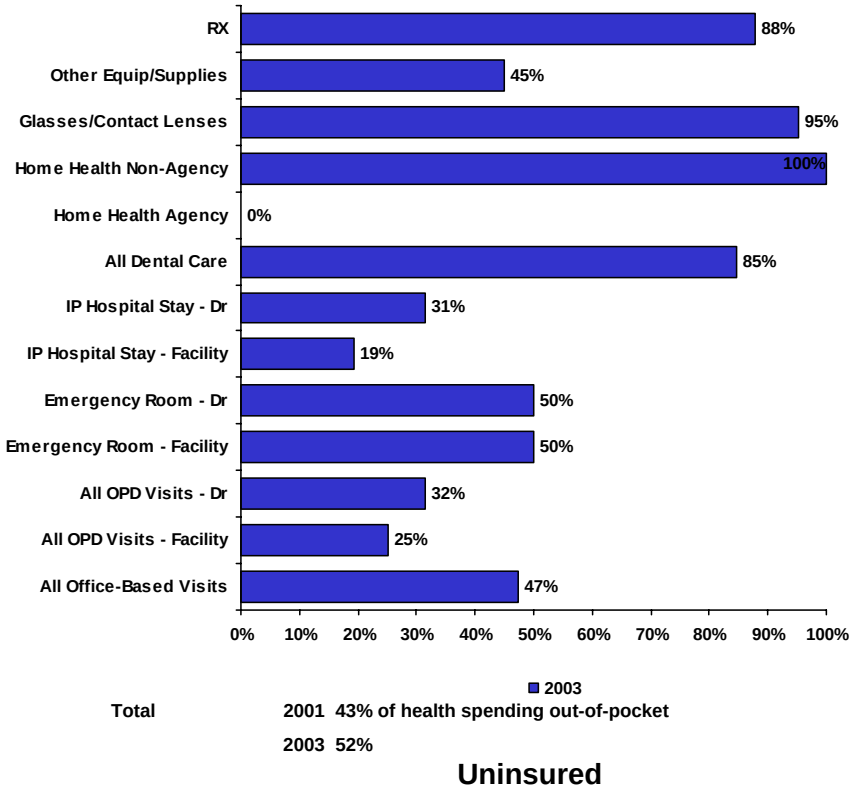


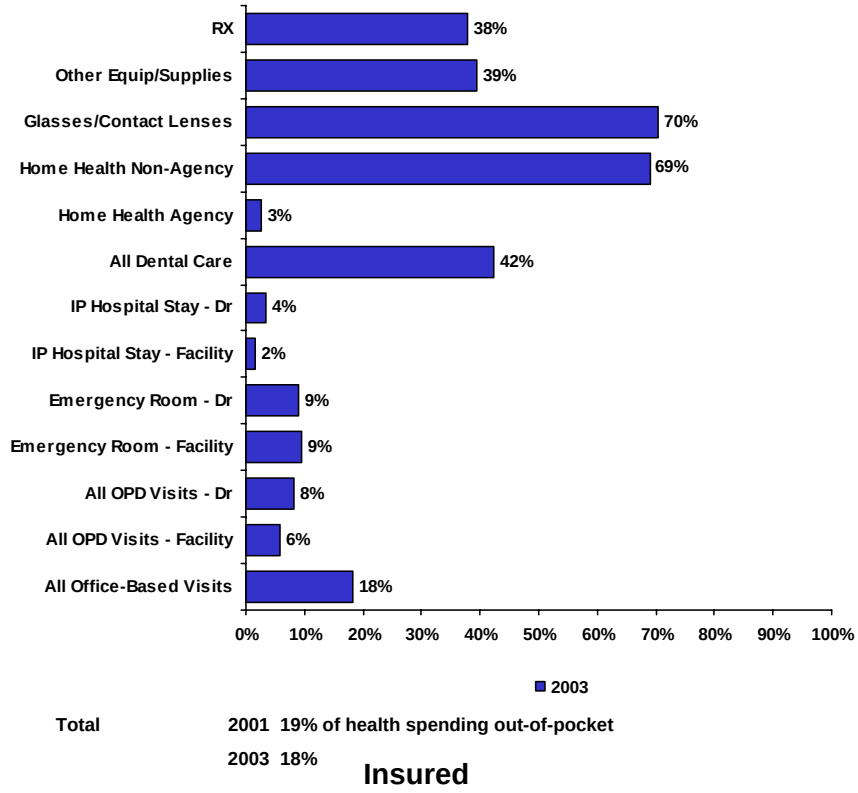
Note: Insured includes all types of insurance coverage.

Source: Actuarial Research Corporation tabulations of Medical Expenditure Panel Survey.

Table 6.2
Out-of-Pocket Spending by the Under 65 Population by Insurance Status by Type of Service, 2001 and 2003

In 2003, the insured paid about 18% of their health expenses out-of-pocket, compared to about 52% for the uninsured.



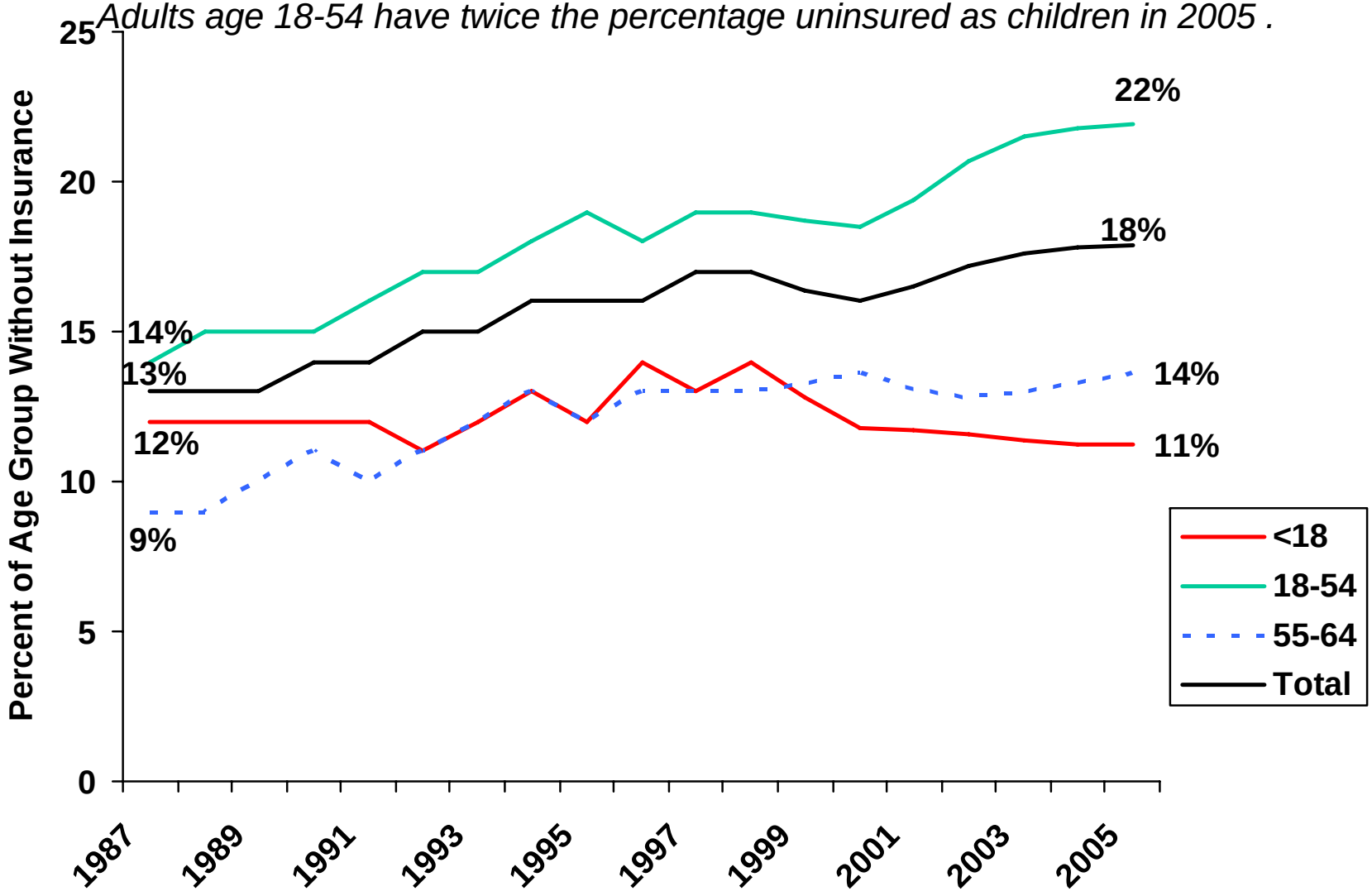


Note: Insured includes all types of insurance coverage. Uninsured individuals may have some of their care financed in part by charity or providers as uncompensated care.

Source: Actuarial Research Corporation tabulations of Medical Expenditure Panel Survey.

Table 6.3
The Percent Uninsured Within Age Categories, 1987-2005

Adults age 18-54 have twice the percentage uninsured as children in 2005 .

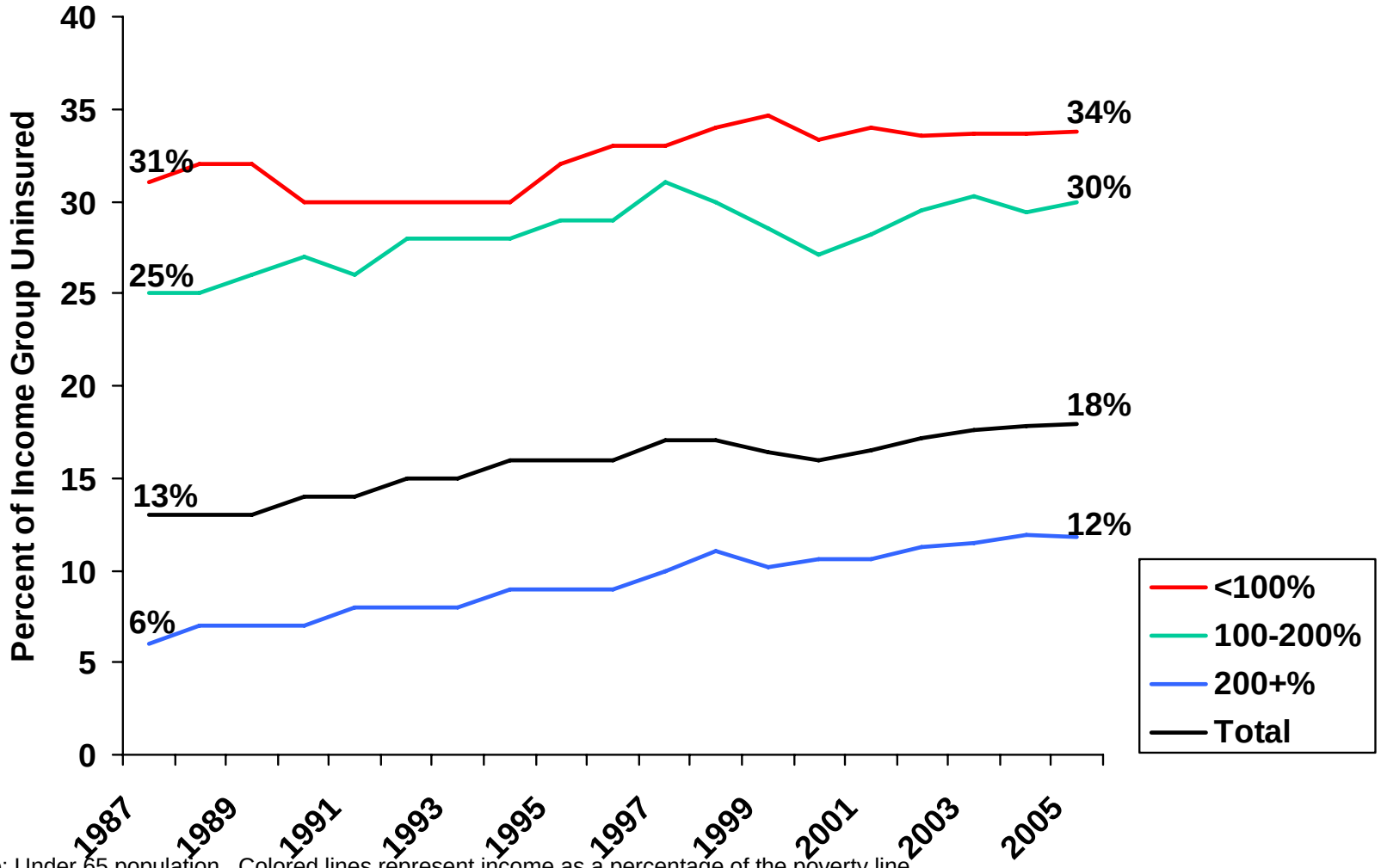


Note: Under 65 population.

Source: Tabulations of the March Current Population Survey files by Actuarial Research Corporation, incorporating their historical adjustments.

Table 6.4
Percent Uninsured Within Income Category, 1987-2005

Lower-income groups are more likely to be uninsured than higher-income groups.

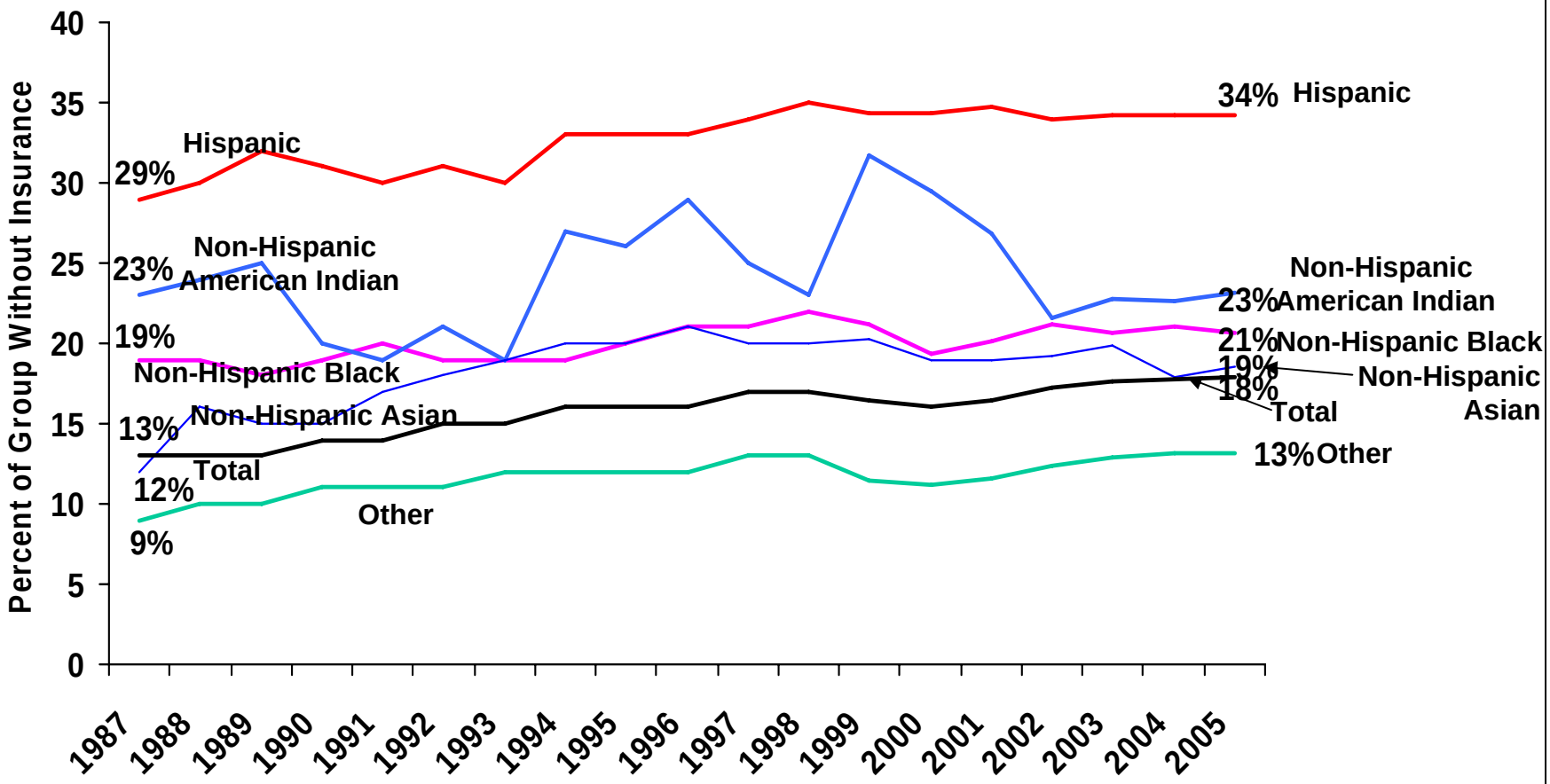


Note: Under 65 population. Colored lines represent income as a percentage of the poverty line.

Source: Tabulations of the March Current Population Survey files by Actuarial Research Corporation, incorporating their historical adjustments.

Table 6.5
Percent Uninsured by Ethnicity, 1987-2005

About half of the uninsured are white, and the other half are racial or ethnic minorities.

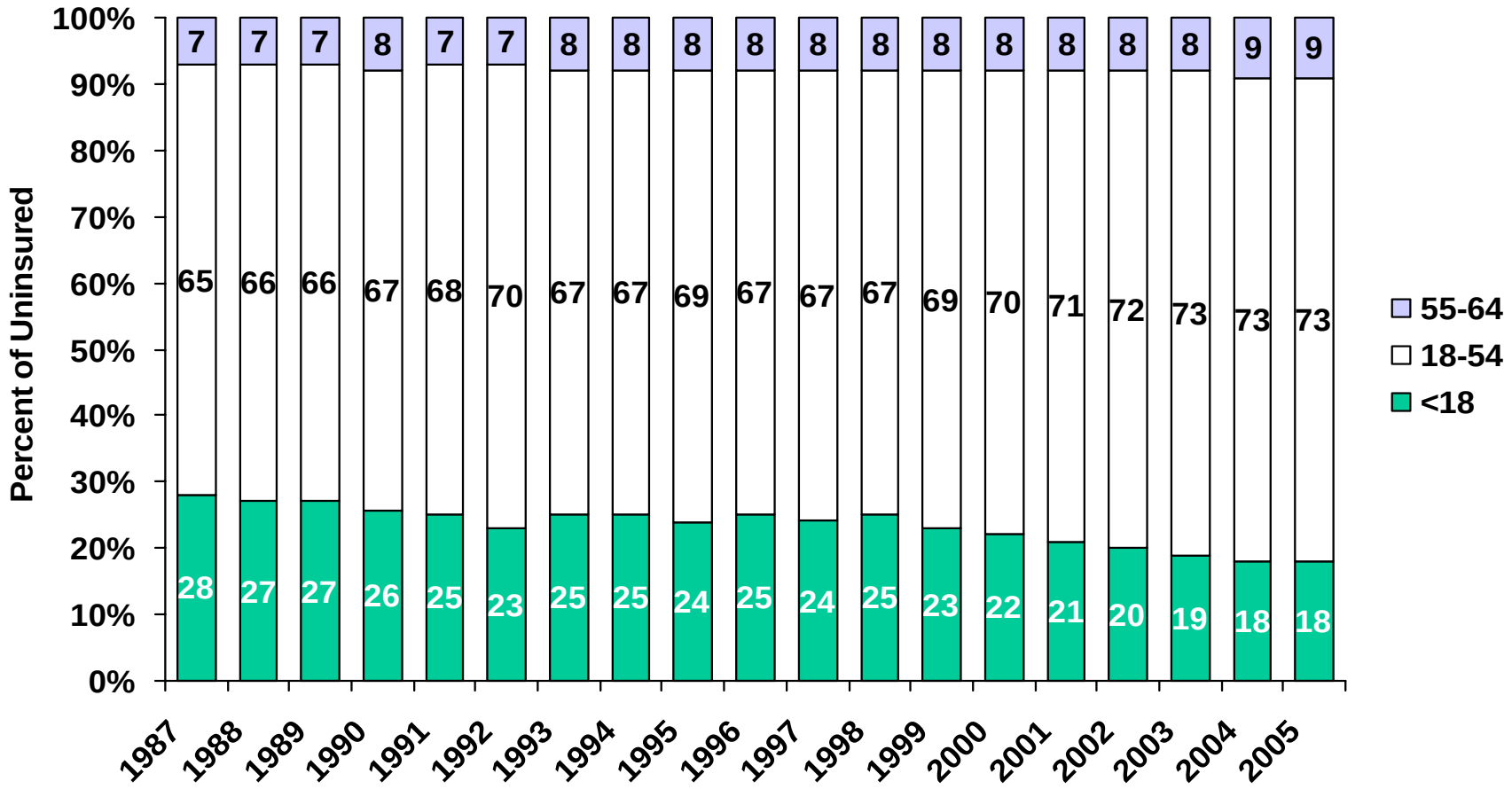


Note: Under 65 population.

Source: Tabulations of the March Current Population Survey files by Actuarial Research Corporation, incorporating their historical adjustments.

Table 6.6
The Uninsured by Age, 1987-2005

A growing majority of the uninsured are adults 18-54.

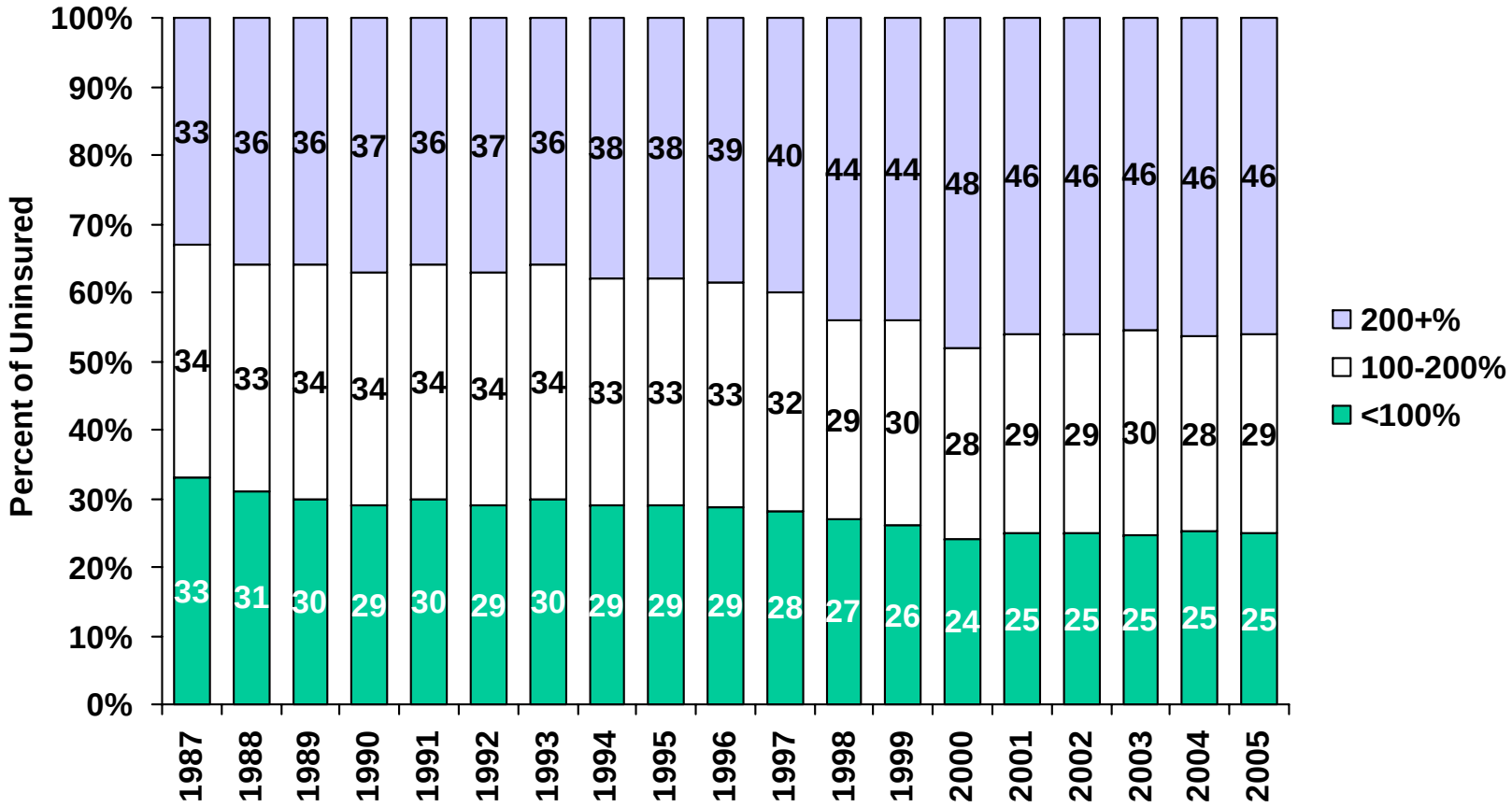


Note: Under 65 population. See also table 4.34

Source: Tabulations of the March Current Population Survey files by Actuarial Research Corporation, incorporating their historical adjustments.

Table 6.7
The Uninsured by Income, 1987-2005

The share of the uninsured with incomes above 200% of poverty is growing.

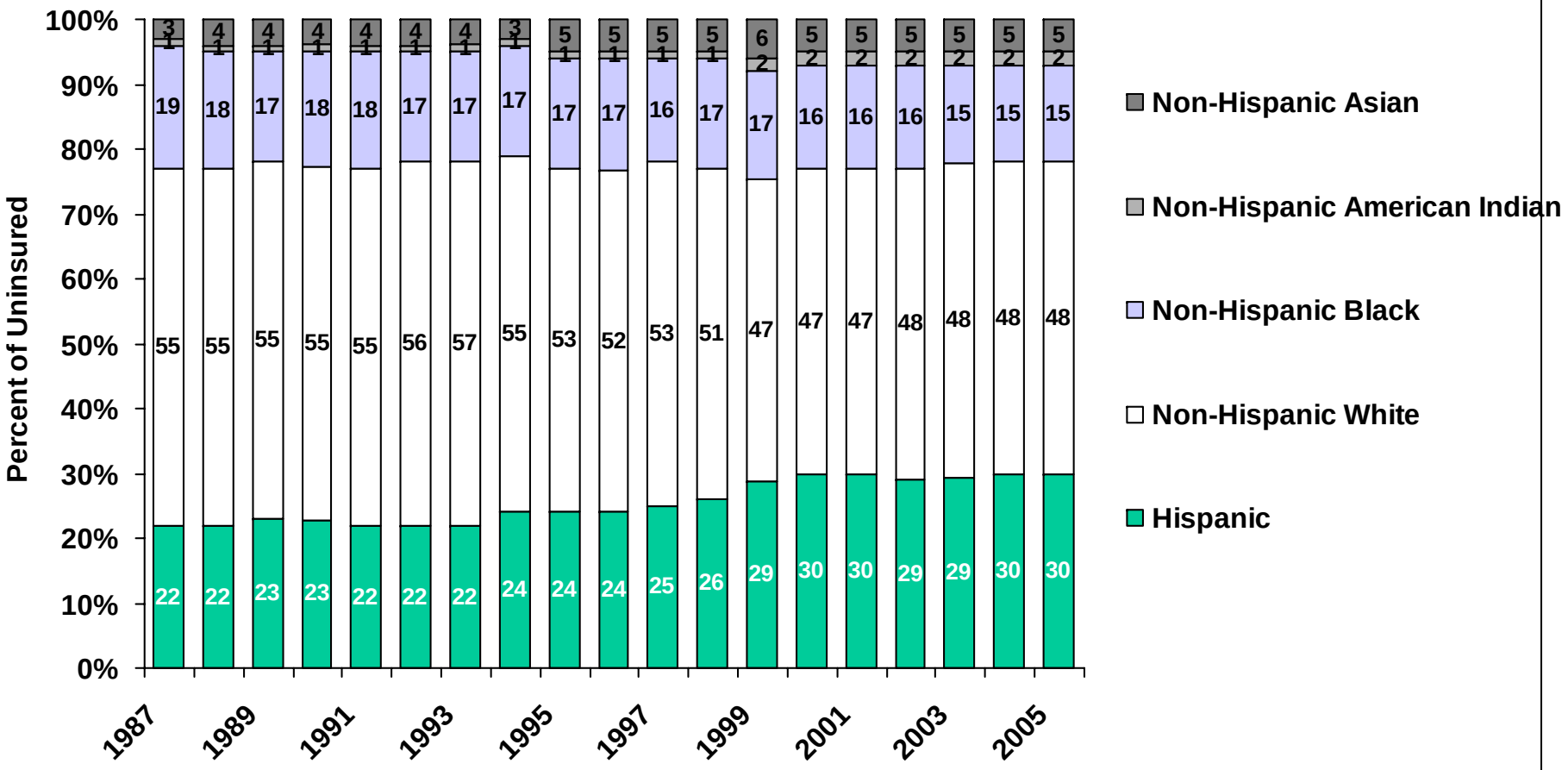


Note: Under 65 population.

Source: Tabulations of the March Current Population Survey files by Actuarial Research Corporation, incorporating their historical adjustments.

Table 6.8
The Uninsured by Ethnicity, 1987-2005

About half of the uninsured are white, nearly one-third are Hispanic.

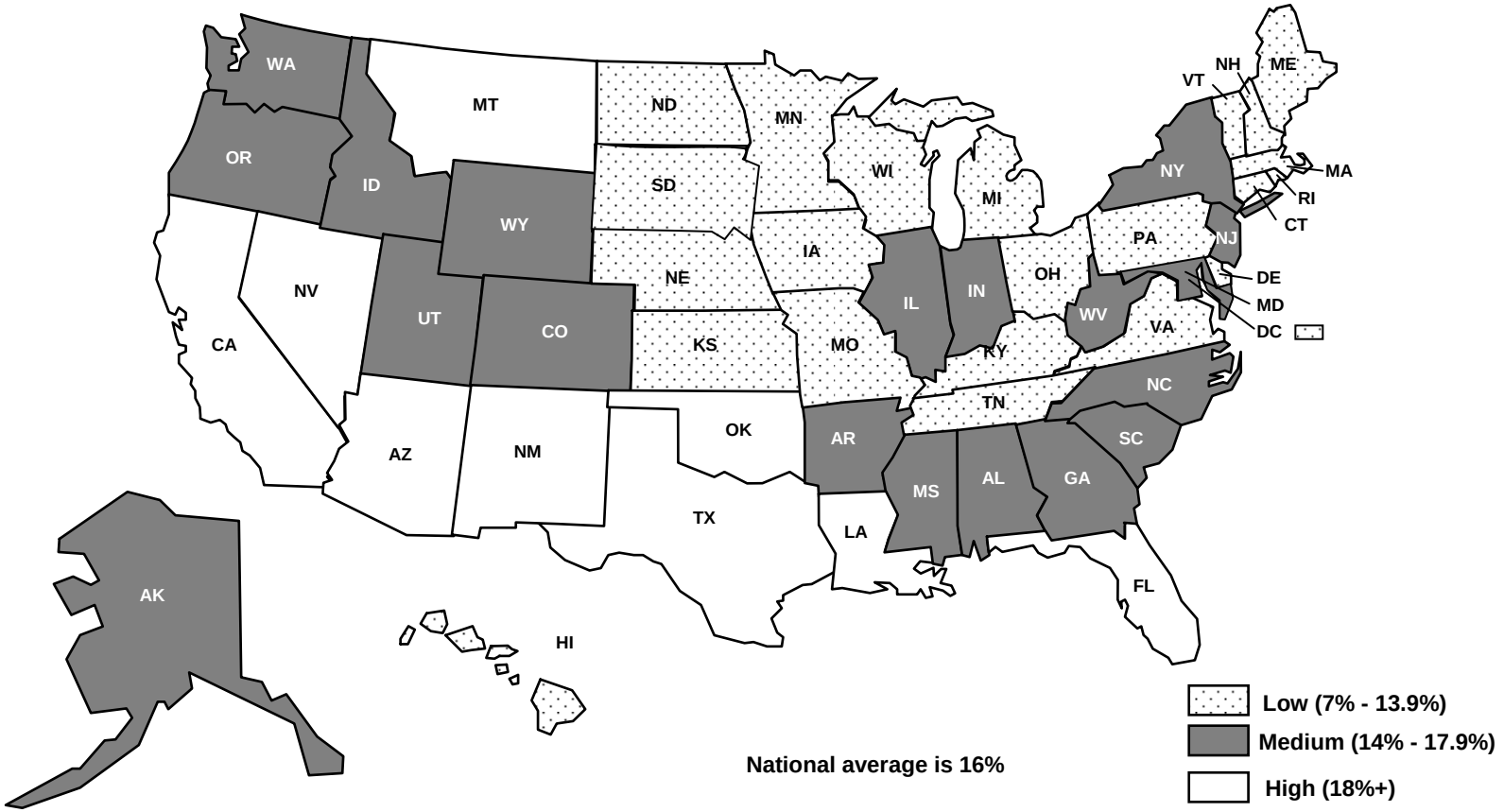


Note: Under 65 population.

Source: Tabulations of the March Current Population Survey files by Actuarial Research Corporation, incorporating their historical adjustments.

Table 6.9
The Uninsured by State, 2005

The South and West have higher rates of uninsured than the Mid-west and East.

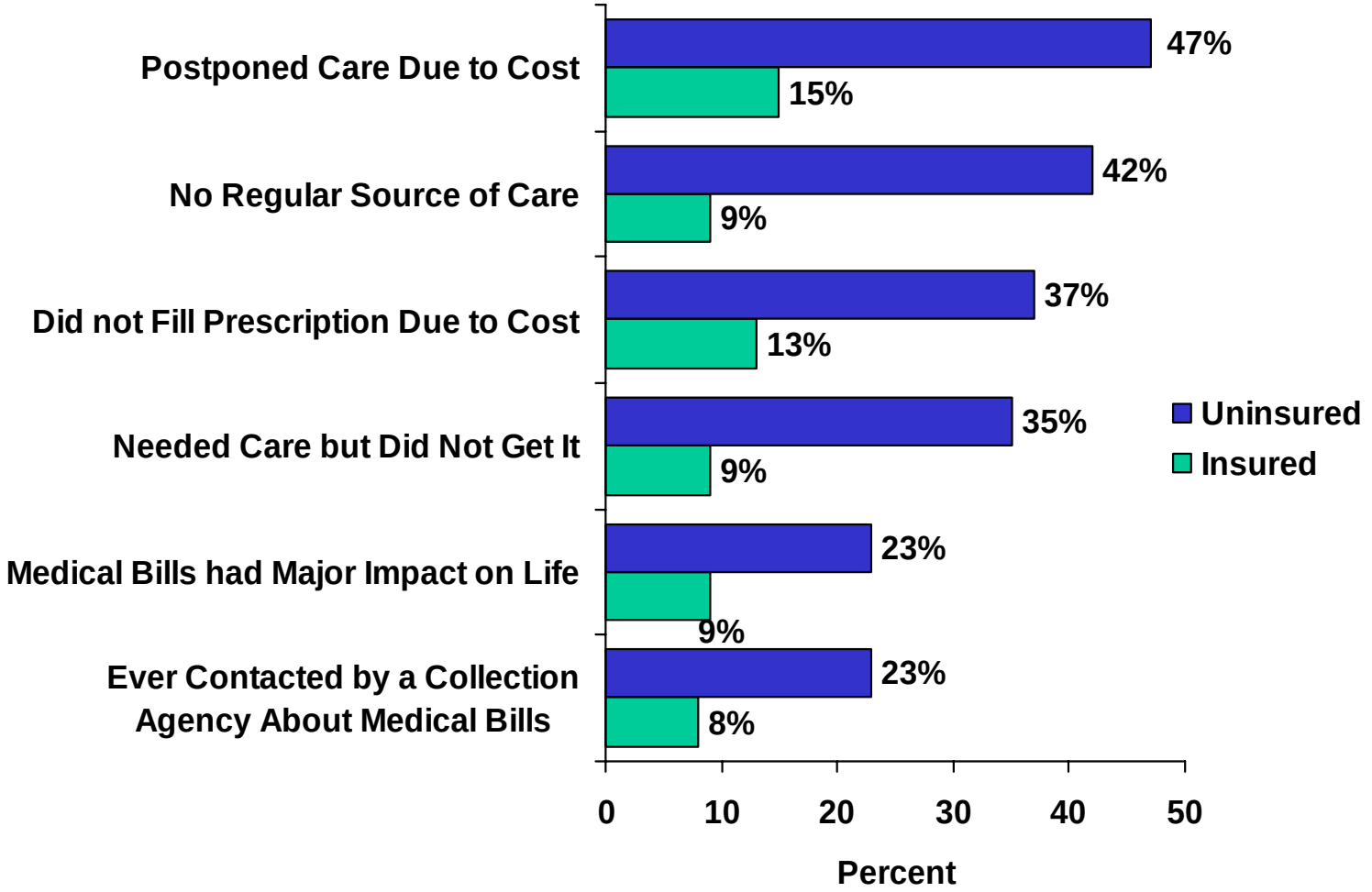


*Other includes private non-group and other public insurance (mostly Medicare and military-related). Medicaid includes CHIP.

Source: Census Bureau, March Current Population Survey.

Table 6.10
Impact on Non-Elderly Adults of Being Uninsured, 2006

The uninsured face financial and other barriers to health care.



Note: Among adults under age 65.

Source: Kaiser Foundation, The Uninsured: A Primer, Jan. 2006.