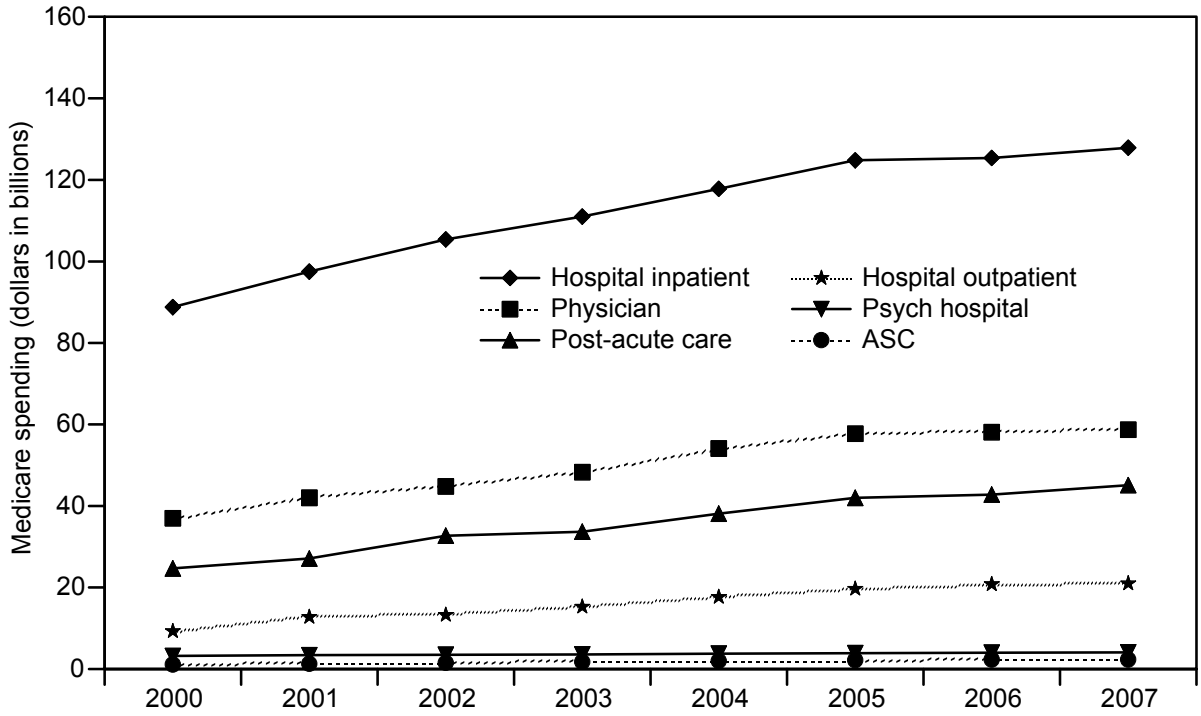
SECTION 1

National health care and Medicare spending

Chart 1-1. Aggregate Medicare spending among FFS beneficiaries, by sector, 2000–2007

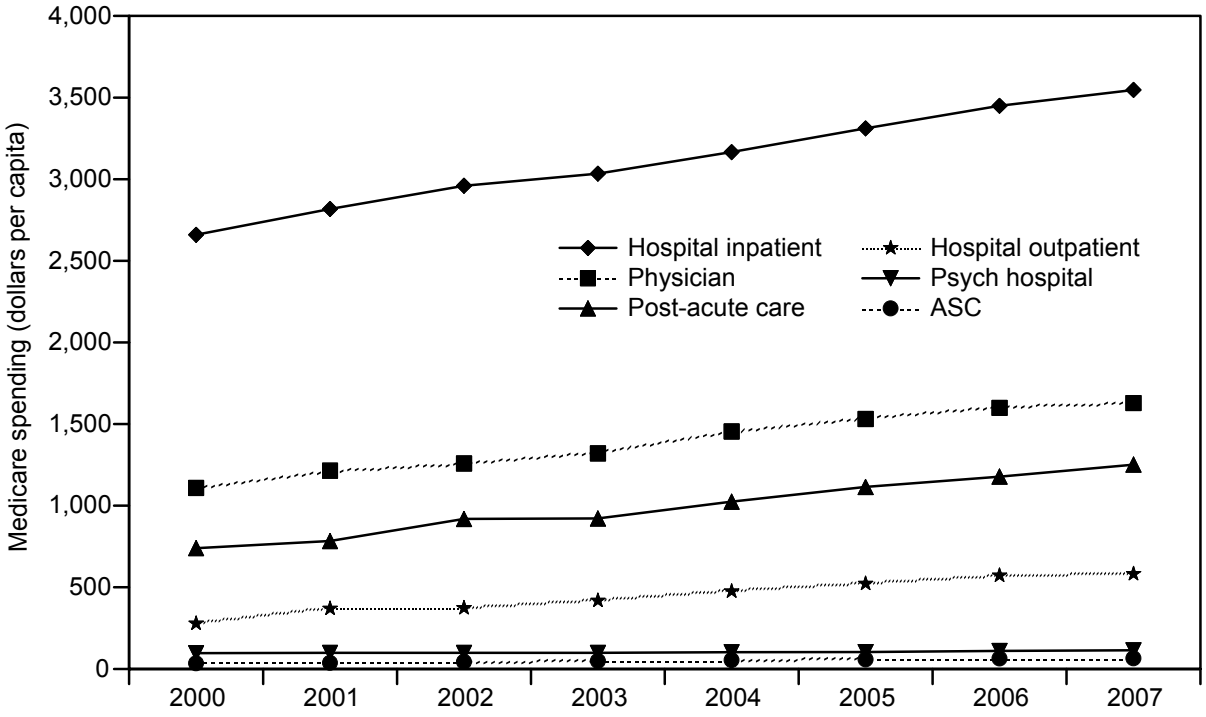


Note: FFS (fee-for-service), ASC (ambulatory surgical center). Dollars are Medicare spending only and do not include beneficiary cost sharing. The growth in spending was slowed in 2006 and 2007 by large increases in the number of Medicare Advantage enrollees, who are not included in these aggregate totals.

Source: Office of the Actuary at CMS and the 2008 annual report of the Boards of Trustees of the Medicare Trust Funds.

- Medicare spending among fee-for-service (FFS) beneficiaries grew strongly in most sectors from 2000 through 2005. The rate of growth slowed in 2006 and 2007, largely because enrollment in FFS Medicare declined because many beneficiaries changed their enrollment to a Medicare Advantage plan. However, spending per beneficiary remained strong in most sectors through 2006 and 2007 (see Chart 1-2).

Chart 1-2. Per capita Medicare spending among FFS beneficiaries, by sector, 2000–2007

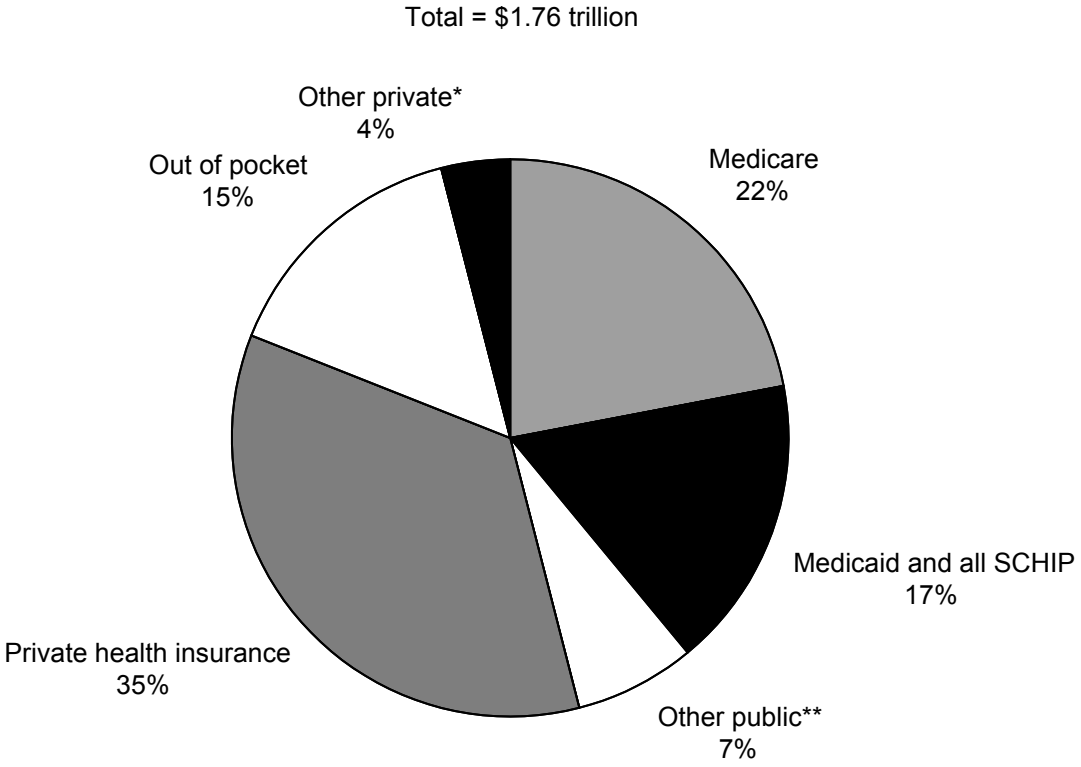


Note: FFS (fee-for-service), ASC (ambulatory surgical center). Dollars are Medicare spending only and do not include beneficiary cost sharing.

Source: Office of the Actuary at CMS and the 2008 annual report of the Boards of Trustees of the Medicare Trust Funds.

- Medicare spending per beneficiary in fee-for-service (FFS) Medicare increased steadily in most sectors from 2000 through 2007. This contrasts with a slowing in aggregate spending in FFS Medicare in 2006 and 2007 caused by a decline in the number of FFS beneficiaries.

Chart 1-3. Medicare made up over one-fifth of spending on personal health care in 2006



Note: SCHIP (State Children's Health Insurance Program). Out-of-pocket spending includes cost sharing for both privately and publicly insured individuals. Personal health care spending includes spending for clinical and professional services received by patients. It excludes administrative costs and profits. Premiums are included with each program (e.g., Medicare, private insurance), rather than in the out-of-pocket category.
*Includes industrial in-plant, privately funded construction, and nonpatient revenues, including philanthropy.
**Includes programs such as workers' compensation, public health activity, Department of Defense, Department of Veterans Affairs, Indian Health Service, state and local government hospital subsidies, and school health.

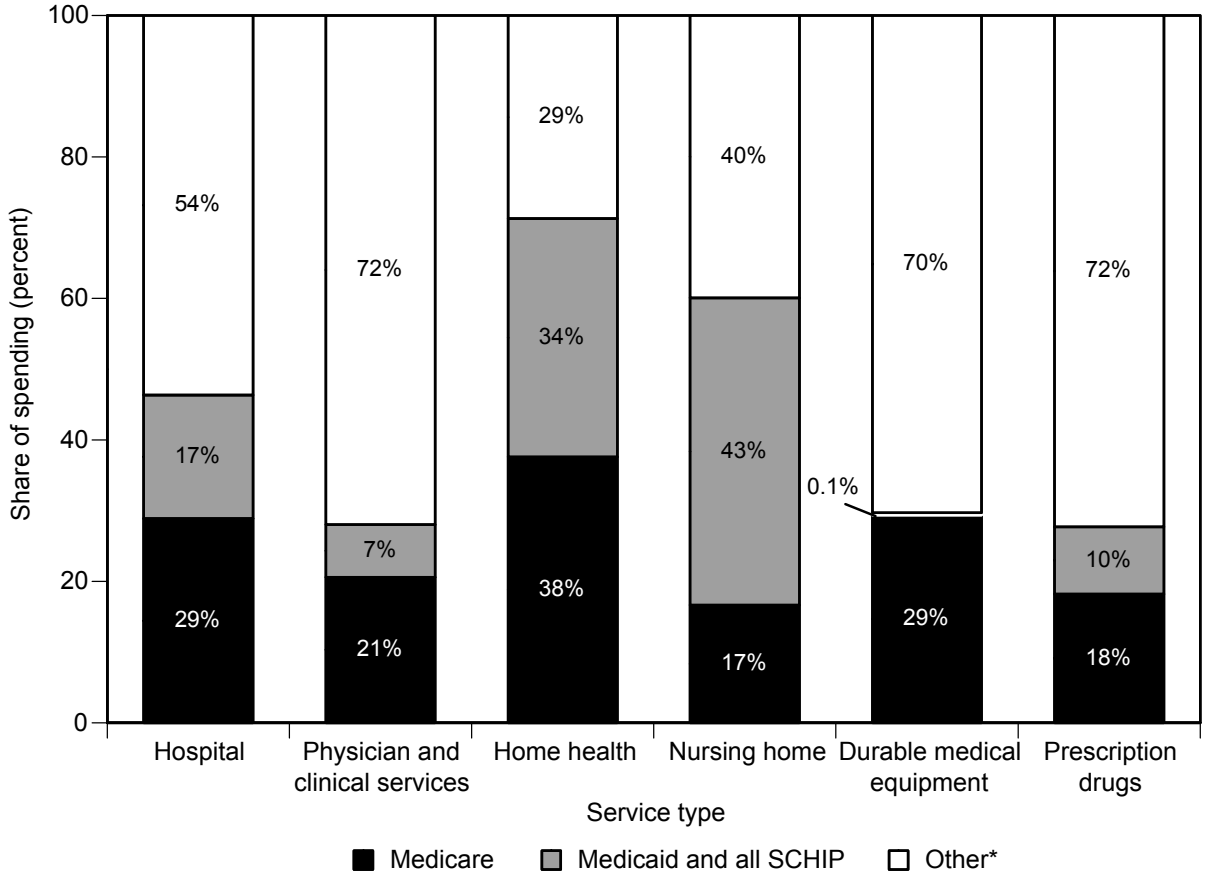
Source: CMS, Office of the Actuary, National Health Expenditure Accounts, 2008.

- Of the $1.76 trillion spent on personal health care in the United States in 2006, Medicare accounted for 22 percent, or $381 billion. Spending by all public programs—including Medicare, Medicaid, SCHIP, and other programs—accounted for 46 percent of health care spending. Medicare is the largest single purchaser of health care in the United States. Thirty-five percent of spending was financed through private health insurance payers and 15 percent was from consumer out-of-pocket spending.

- Medicare and private health insurance spending includes premium contributions from enrollees.

- 2006 is the first year that spending for Medicare's voluntary outpatient prescription drug benefit (Part D) is included in the national health accounts.

Chart 1-4. Medicare's share of total spending varies by type of service, 2006



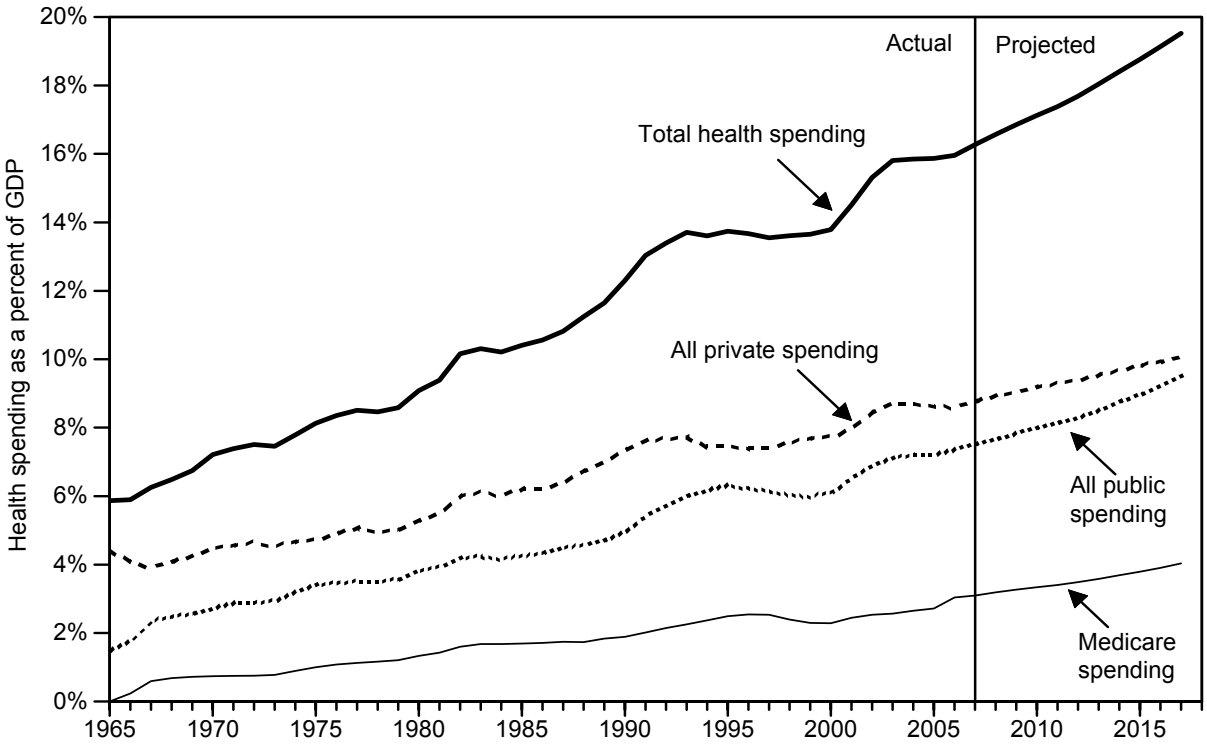
Note: SCHIP (State Children's Health Insurance Program). Personal health spending includes spending for clinical and professional services received by patients. It excludes administrative costs and profits. Totals may not sum to 100 percent due to rounding.
*Other includes private health insurance, out-of-pocket spending, and other private and public spending.

Source: CMS, Office of the Actuary, National Health Expenditure Accounts, 2008.

- The level and distribution of spending differ between Medicare and other payers, largely because Medicare covers an older, sicker population and did not cover services such as long-term care.

- In 2006, Medicare accounted for 29 percent, 21 percent, 38 percent, 17 percent, 29 percent, and 18 percent, of spending on hospital care, physician and clinical services, home health services, nursing home care, durable medical equipment, and prescription drugs, respectively.

Chart 1-5. Health care spending has grown more rapidly than GDP, with public financing making up nearly half of all funding

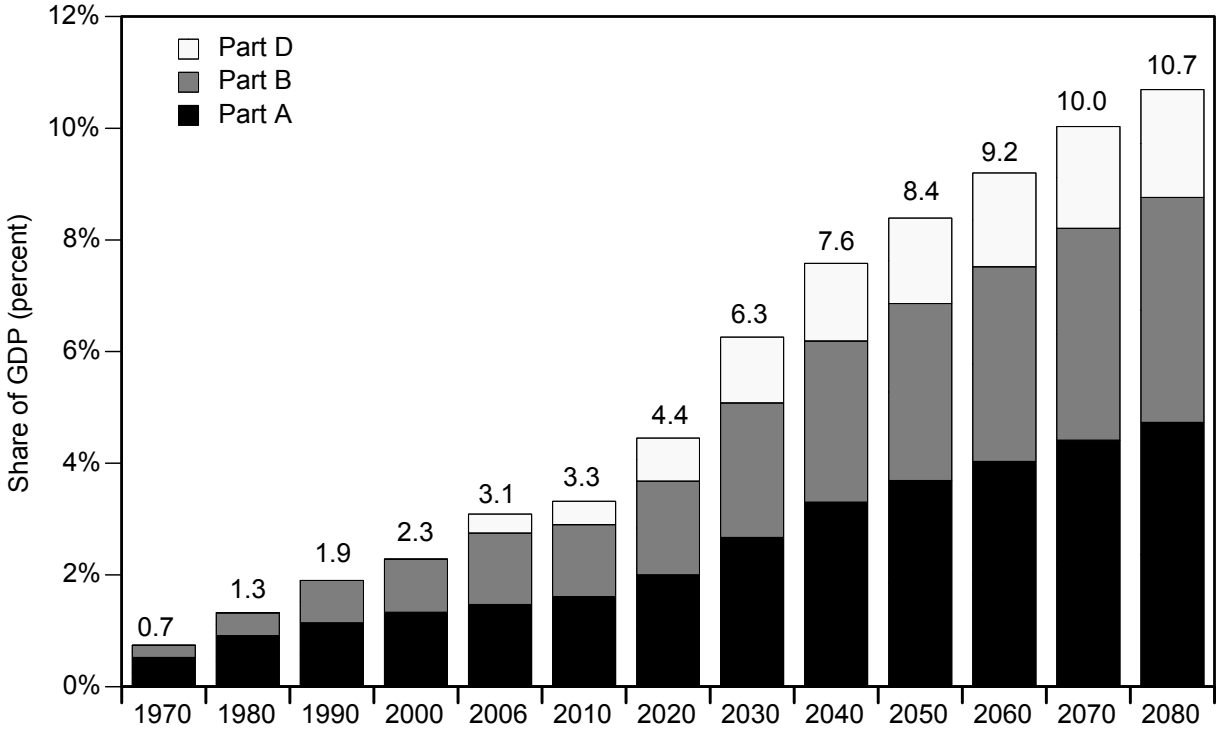


Note: GDP (gross domestic product). Total health spending is the sum of all private and public spending. Medicare spending is one component of all public spending.

Source: CMS, Office of the Actuary, National Health Expenditure Accounts, 2008.

- Total health spending consumes an increasing proportion of national resources, accounting for a double-digit share of gross domestic product (GDP) annually since 1982.
- As a share of GDP, total health spending has increased from about 6 percent in 1965 to about 16 percent in 2006. It is projected to reach nearly 20 percent of GDP in 2017. Health spending's share of GDP was stable throughout much of the 1990s due to slower spending growth associated with greater use of managed care techniques and higher enrollment in managed plans as well as a strong economy.
- Medicare spending has also grown as a share of the economy from less than 1 percent when it was started in 1965 to about 3 percent today. Projections suggest that Medicare spending will make up over 4 percent of GDP by 2017.
- In 2006, all public spending made up about 46 percent of total health care spending and private spending made up 54 percent. By 2017, those percentages are projected to be 49 percent and 51 percent, respectively.

Chart 1-6. Trustees project Medicare spending to increase as a share of GDP



Note: GDP (gross domestic product). These projections are based on the trustees' intermediate set of assumptions.

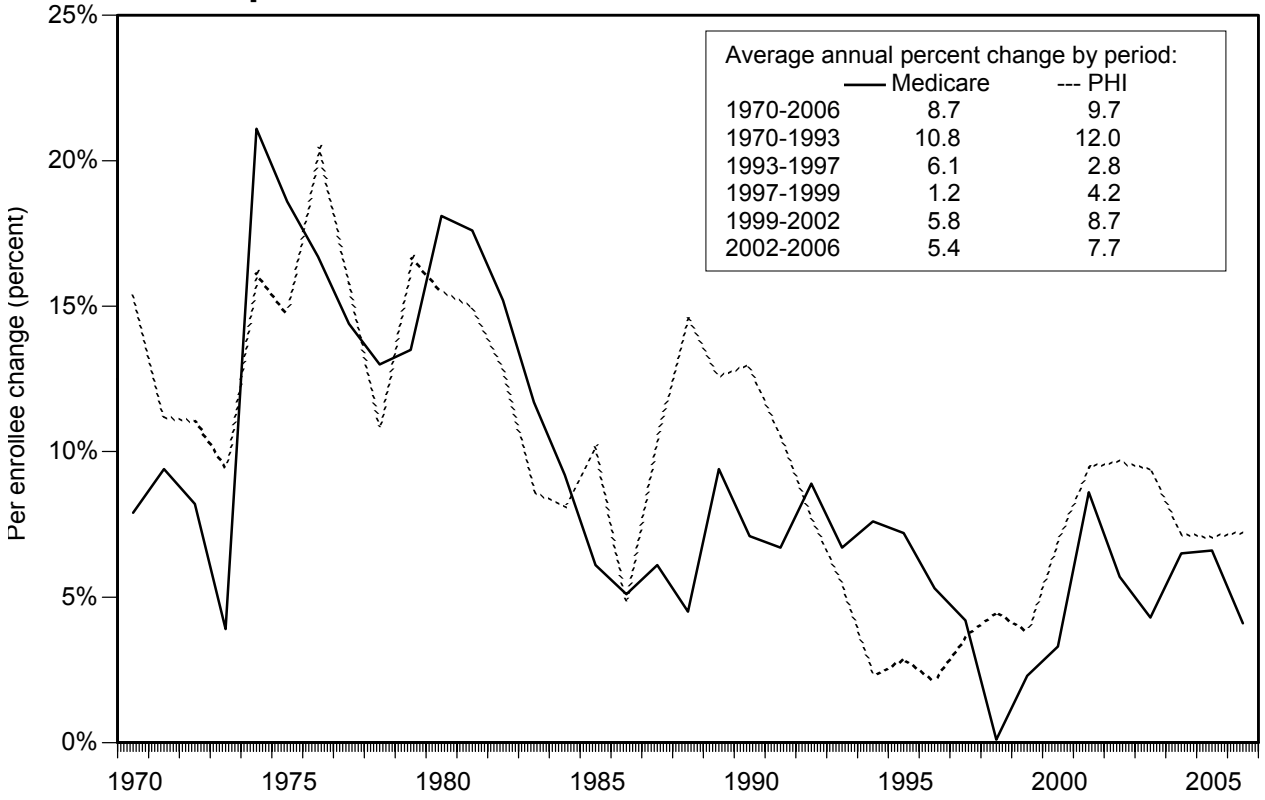
Source: 2008 annual report of the Boards of Trustees of the Medicare Trust Funds.

- Over time, Medicare spending has accounted for an increasing share of gross domestic product (GDP). From less than 1 percent in 1970, it is projected to reach nearly 11 percent of GDP in 2080.

- With a 9.7 percent annual average rate of growth, nominal Medicare spending grew considerably faster over the period from 1980 to 2006 than nominal growth in the economy, which averaged 6.2 percent per year. Future Medicare spending is projected to continue growing faster than GDP, but at a rate somewhat closer to GDP growth: averaging 6.4 percent per year between 2006 and 2080 compared with an annual average growth rate of 4.6 percent for the economy as a whole. In other words, Medicare spending is projected to continue rising as a share of GDP, but at a slightly slower pace. Still, Medicare's growth rate is nearly 2 percentage points higher than GDP growth.

- During the 1990s, Medicare's share of the economy grew more slowly than it did in other periods. This was due to payment reductions enacted in 1997 combined with faster economic growth. Beginning in 2010, the aging of the baby boom generation, an expected increase in life expectancy, and the Medicare drug benefit are all likely to increase the proportion of economic resources devoted to Medicare. Additional factors such as innovation in medical technology and the widespread use of insurance (which shields individuals from facing the full price of services) will also contribute to rapid increases in health care spending.

Chart 1-7. Changes in spending per enrollee, Medicare and private health insurance



Note: PHI (private health insurance). Chart compares services covered by Medicare and PHI, including hospital services, physician and clinical services, and durable medical products.

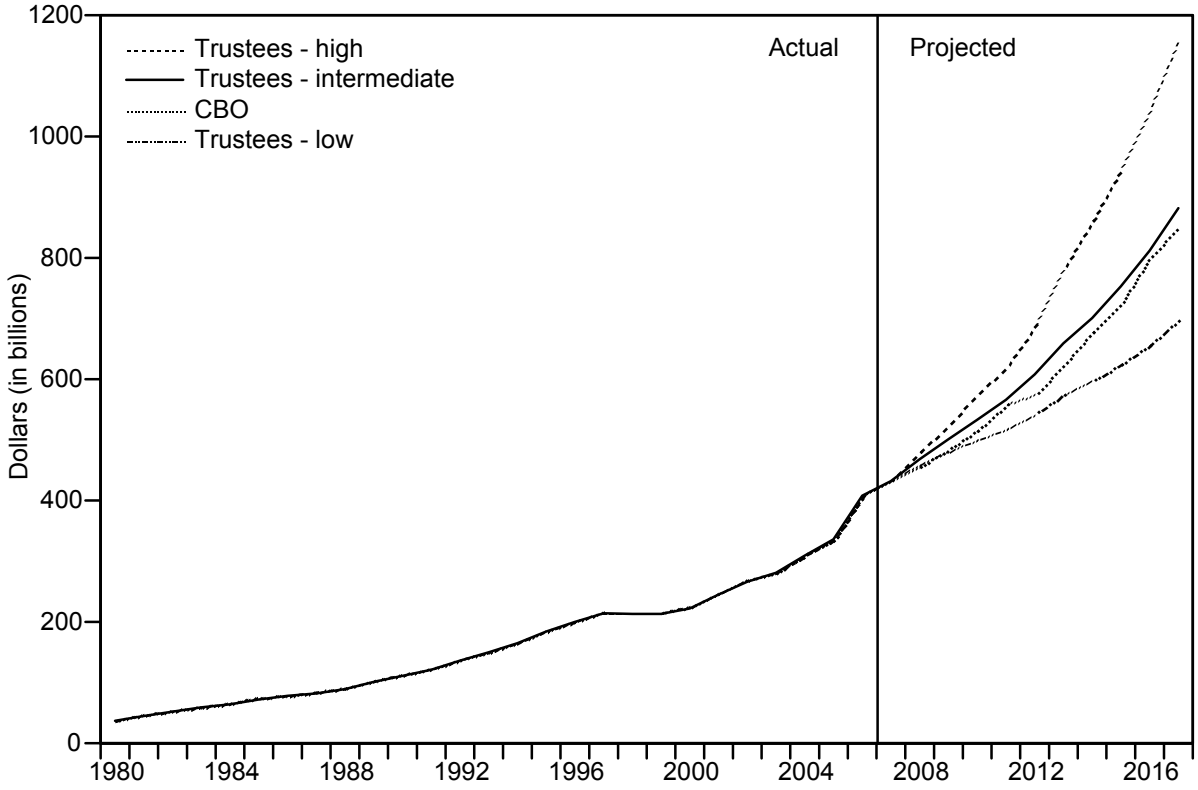
Source: CMS, Office of the Actuary, National Health Statistics Group, 2008.

- Although rates of growth in per capita spending for Medicare and private insurance often differ from year to year, over the long term they have been quite similar. When comparing spending for benefits that private insurance and Medicare have had in common—notably, excluding prescription drugs—Medicare's per enrollee spending has grown at a rate that is 1 percentage point lower than that for private insurance over the 1970 to 2006 period.

- This comparison is sensitive to the endpoints of time one uses for calculating average growth rates. Also, private insurers and Medicare do not buy the same mix of services, and Medicare covers an older population that tends to be more costly. In addition, the data do not allow analysis of the extent to which these spending trends were affected by changes in the generosity of covered benefits and, in turn, changes in enrollees' out-of-pocket spending.

- Differences appear to be more pronounced since 1985, when Medicare began introducing the prospective payment system for hospital inpatient services. Some analysts believe that since the mid-1980s, Medicare has had greater success at containing cost growth than private payers by using its larger purchasing power. Others maintain that relative to the 1970s, benefits offered by private insurers have expanded and cost-sharing requirements declined. In addition, enrollment in managed care plans grew during the 1990s. These factors make the comparison problematic, since Medicare's benefits changed little over the same period.

Chart 1-8. Trustees and CBO project Medicare spending to grow at an annual average rate of 7 percent over the next 10 years

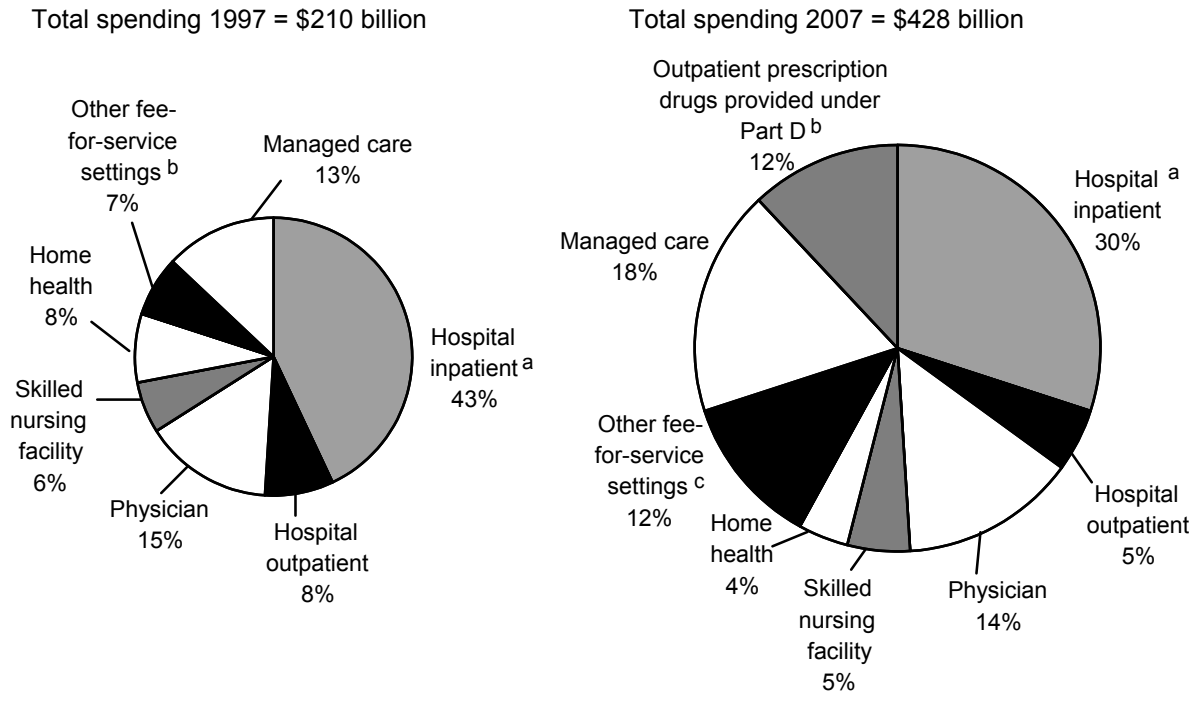


Note: CBO (Congressional Budget Office). All data are nominal, gross program outlays (mandatory plus administrative expenses) by calendar year.

Source: 2008 annual report of the Boards of Trustees of the Medicare Trust Funds. CBO March 2008 baseline.

- Medicare spending has grown nearly 12-fold, from $37 billion in 1980 to $432 billion in 2007.
- Medicare spending increased significantly after 2006 with the introduction of Part D, Medicare's voluntary outpatient prescription drug benefit.
- The Congressional Budget Office projects that mandatory spending for Medicare will grow at an average annual rate of 7 percent between 2007 and 2017. The Medicare trustees' intermediate projections for 2007 to 2017 assume about 7.4 percent average annual growth. Forecasts of future Medicare spending are inherently uncertain, and differences can stem from different assumptions about the economy (which affect provider payment annual updates) and about growth in the volume and intensity of services delivered to Medicare beneficiaries, among other factors.

Chart 1-9. Medicare spending is concentrated in certain services and has shifted over time



Note: Medicare's outpatient drug benefit began in 2006, and thus the distribution of spending for 2007 differs significantly from earlier years. Spending amounts are gross outlays, meaning that they include spending financed by beneficiary premiums but do not include spending by beneficiaries (or spending on their behalf) for cost-sharing requirements of Medicare-covered services. Values are reported on a calendar year, incurred basis and do not include spending on program administration. Totals may not sum to 100 percent due to rounding.
[a] Includes all hospitals—those paid under the prospective payment system (PPS) and PPS-exempt hospitals.
[b] Includes stand-alone prescription drug plans and Medicare Advantage prescription drug plans.
[c] Includes hospice, nonhospital outpatient laboratory, durable medical equipment, physician-administered drugs, ambulance services, ambulatory surgical centers, dialysis, rural health clinics, federally qualified health centers, and outpatient rehabilitation facilities.

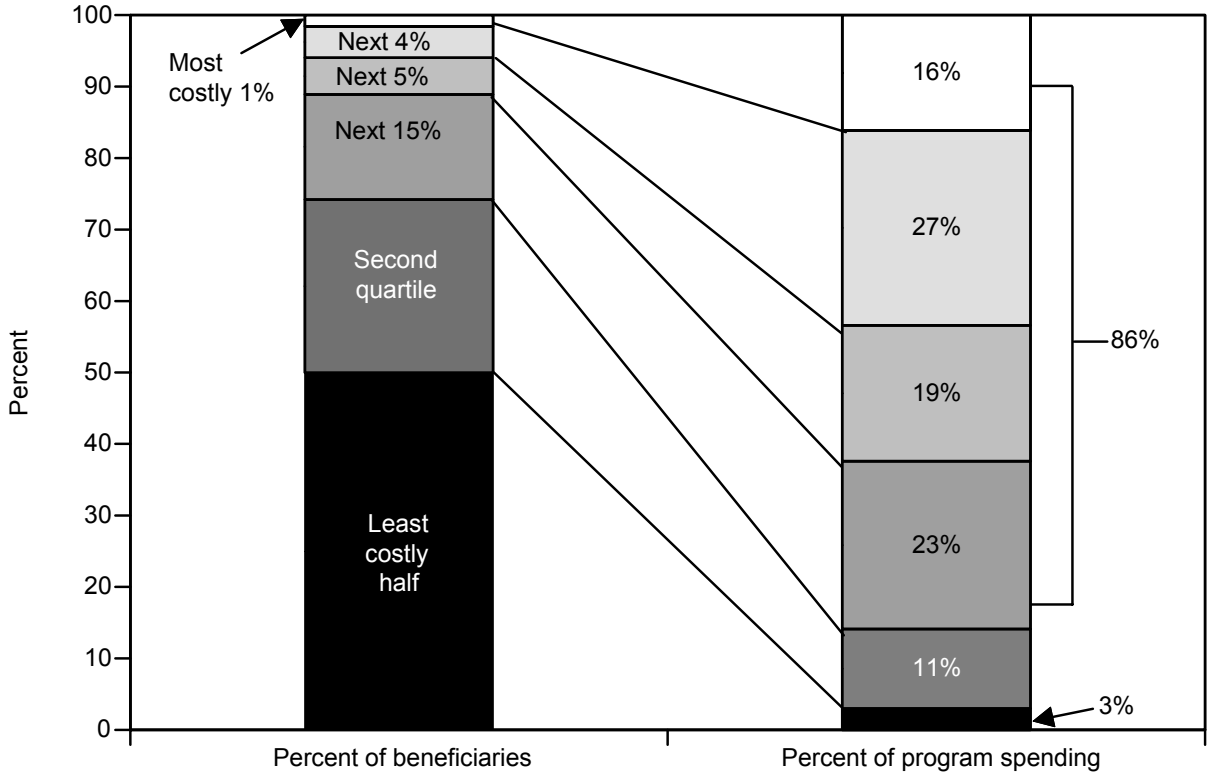
Source: CMS, Office of the Actuary, 2008.

- Medicare spending is concentrated on certain services, and the distribution among services and settings can vary substantially over time.

- In 2007, Medicare program spending was $428 billion, or nearly $10,500 per enrollee. Inpatient hospital services were by far the largest spending category (30 percent), followed by managed care (18 percent), physicians (14 percent), outpatient prescription drugs provided under Part D (12 percent), and other fee-for-service settings (12 percent).

- Although inpatient hospital services still made up the largest spending category, spending for those services was a smaller share of total Medicare spending in 2007 than it was in 1997, falling from 43 percent to 30 percent. Two reasons account for this decline: 1) a shift toward providing more care in outpatient settings, and 2) the introduction of Part D beginning in 2006. (Medicare did not pay for outpatient prescription drugs in 1997.) Spending on beneficiaries enrolled in managed care plans has grown from 13 percent to 18 percent over the same period. The number of beneficiaries enrolled in managed care plans has grown rapidly over the past several years, and current enrollment is higher than it was a decade ago.

Chart 1-10. FFS program spending is highly concentrated in a small group of beneficiaries, 2005



Note: FFS (fee-for-service). Excludes beneficiaries with any group health enrollment during the year. Numbers do not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use files.

- Medicare fee-for-service (FFS) spending is concentrated among a small number of beneficiaries. In 2005, the costliest 5 percent of beneficiaries accounted for 44 percent of annual Medicare FFS spending and the costliest quartile accounted for 86 percent. By contrast, the least costly half of beneficiaries accounted for only 3 percent of FFS spending.

- Costly beneficiaries tend to include those who have multiple chronic conditions, those using inpatient hospital care, and those who are in the last year of life.

Chart 1-11. Medicare HI trust fund is projected to be insolvent in 2019

Estimate	Year costs exceed income	Year HI trust fund assets exhausted
High	2008	2015
Intermediate	2010	2019
Low	2020	2040

Note: HI (Hospital Insurance). Income includes taxes (payroll and Social Security benefits taxes, railroad retirement tax transfer), income from the fraud and abuse program, and interest from trust fund assets.

Source: 2008 annual report of the Boards of Trustees of the Medicare Trust Funds; CMS, Office of the Actuary.

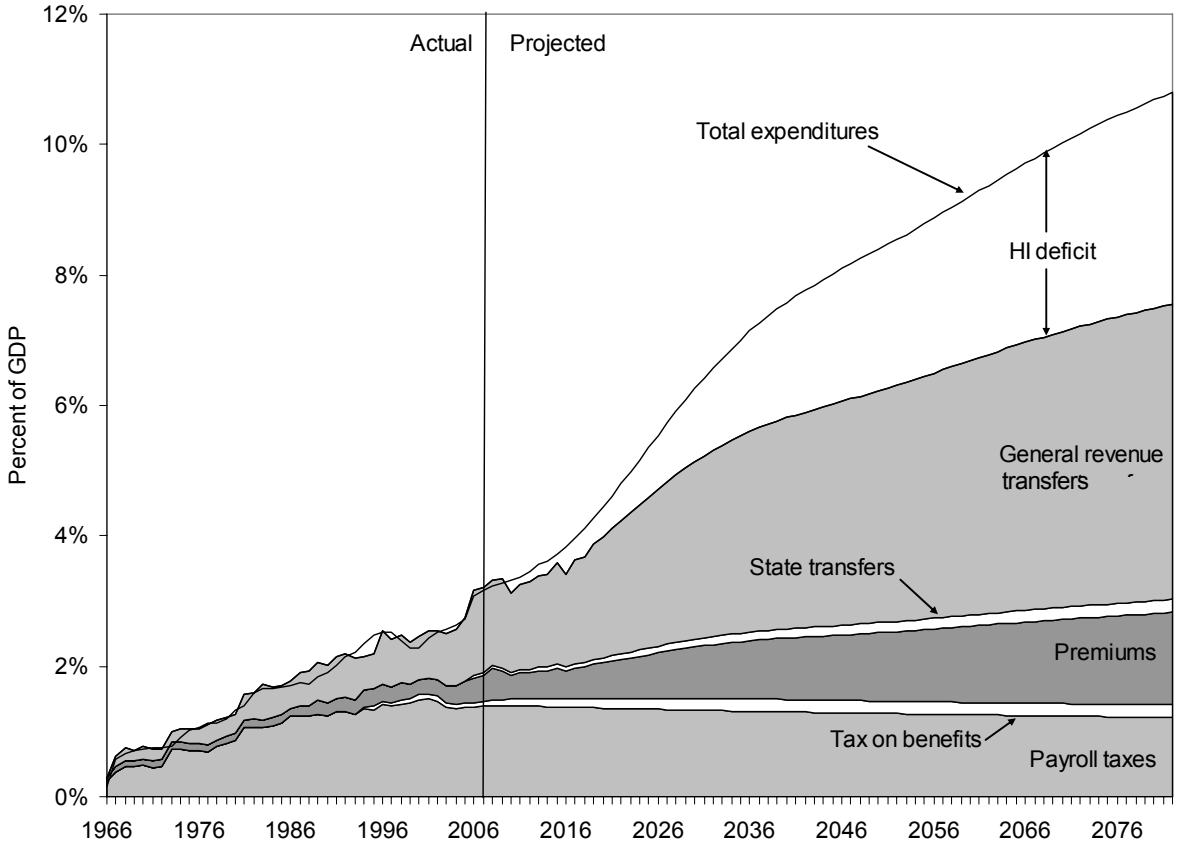
- The Medicare program is financed through two trust funds: one for Hospital Insurance (HI), which covers services provided by hospitals and other providers such as skilled nursing facilities, and one for Supplementary Medical Insurance (SMI) services, such as physician visits and Medicare's new prescription drug benefit. Dedicated payroll taxes on current workers largely finance HI spending and are held in the HI trust fund. The HI trust fund can be exhausted if spending exceeds payroll tax revenues and fund reserves. General revenues finance roughly 75 percent of SMI services, and beneficiary premiums finance about 25 percent. (General revenues are federal tax dollars that are not dedicated to a particular use but are made up of income and other taxes on individuals and corporations.)

- The SMI trust fund is financed with general revenues and beneficiary premiums. Some analysts believe that the levels of premiums and general revenues required to finance projected spending for SMI services would impose a significant burden on Medicare beneficiaries and on growth in the U.S. economy.

- Medicare trustees project that under intermediate assumptions, HI cost will exceed income (including interest income) by 2010 and the HI trust fund will be exhausted in 2019.

- Under high cost assumptions, the HI trust fund could be exhausted as early as 2015. Under low cost assumptions, it would remain solvent until 2040.

Chart 1-12. Medicare faces serious challenges with long-term financing



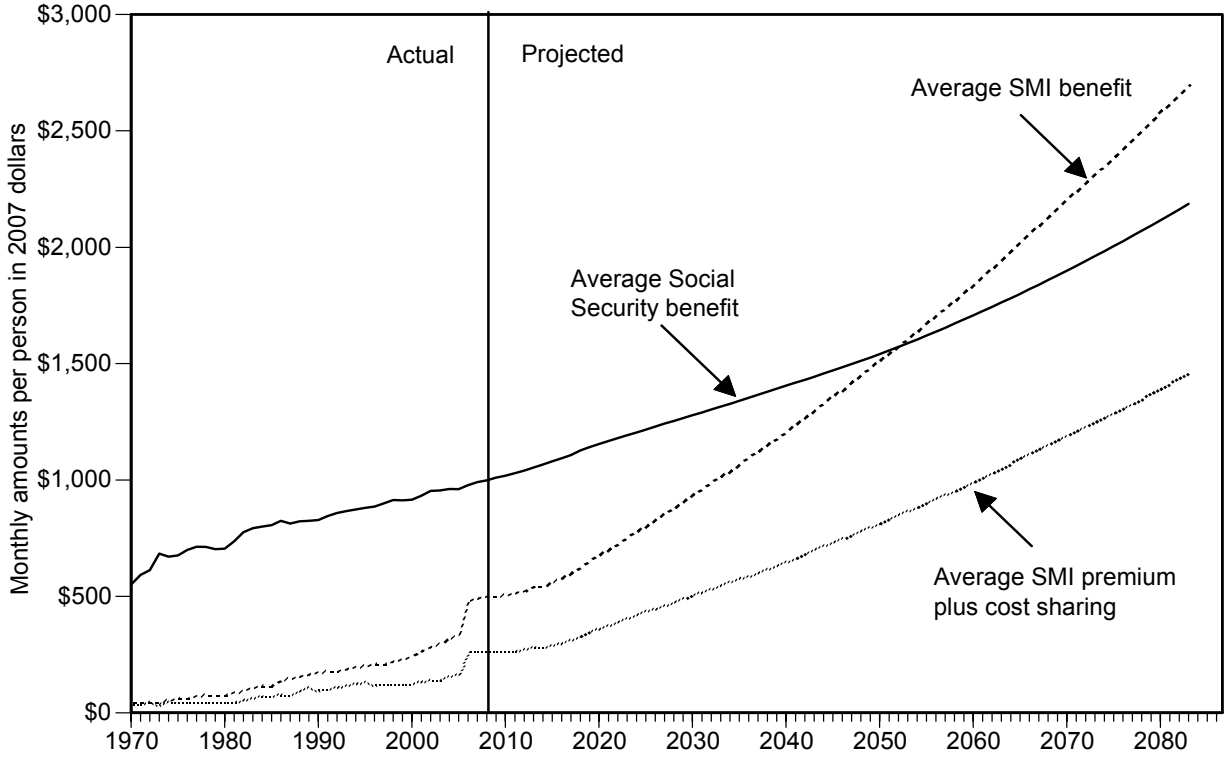
Note: GDP (gross domestic product), HI (Hospital Insurance). These projections are based on the trustees' intermediate set of assumptions. Tax on benefits refers to a portion of income taxes that higher income individuals pay on Social Security benefits that is designated for Medicare. State transfers (often called the Part D "clawback") refer to payments called for within the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 from the states to Medicare for assuming primary responsibility for prescription drug spending.

Source: 2008 annual report of the Boards of Trustees of the Medicare Trust Funds.

- Under an intermediate set of assumptions, the trustees project that Medicare spending will grow rapidly, from about 3 percent of gross domestic product today to 7.1 percent by 2036 and to nearly 11 percent by 2080.

- Medicare's problems with long-term financing may become more visible to policymakers because of a warning system set up in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Each year, the trustees are required to project the share of Medicare outlays that is financed with general revenues in the current and six succeeding fiscal years. If two consecutive annual reports project that general revenue will fund 45 percent or more of Medicare outlays in any given year, then the President must propose and the Congress must consider legislation to bring Medicare's spending below this threshold. In their 2008 report, the Medicare trustees projected that the program would hit this 45 percent trigger in 2014, the last year of the seven-year projection window. This is the third consecutive report with such a finding. As was the case for 2008, the administration must propose and policymakers must consider broad changes to Medicare's benefits and financing in the spring of 2009.

Chart 1-13. Average monthly SMI benefits, premiums, and cost sharing are projected to grow faster than the average monthly Social Security benefit



Note: SMI (Supplementary Medical Insurance). Average SMI benefit and average SMI premium plus cost-sharing values are for a beneficiary enrolled in Part B and (after 2006) Part D. Beneficiary spending on outpatient prescription drugs prior to 2006 is not shown.

Source: 2008 annual report of the Boards of Trustees of the Medicare Trust Funds.

- Between 1970 and 2007, the average monthly Social Security benefit (adjusted for inflation) increased by an annual average rate of 1.6 percent. Over the same period, average Supplementary Medical Insurance (SMI) premiums plus cost sharing and average SMI benefits grew by annual averages of 5.5 percent and 6.7 percent, respectively. Under current hold-harmless policies, Medicare Part B premiums cannot increase by a larger dollar amount than the cost-of-living increase in a beneficiary's Social Security benefit. From 2003 to 2006, Part B premium increases offset 20 percent to 40 percent of the dollar increase in the average Social Security benefit. For 2007 and 2008, the increase in the Part B premium offsets 13 percent and 8 percent of the Social Security benefit increase, respectively. Part D premium increases are not subject to a hold-harmless provision.
- Most beneficiaries who enroll in Medicare's new prescription drug benefit see lower out-of-pocket (OOP) spending. CMS's Office of the Actuary estimates that in 2006, with Part D coverage, about 10 percent of elderly Medicare beneficiaries' total spending for prescription drugs would come from direct out-of-pocket spending, compared with roughly 31 percent in the absence of Part D coverage. Beneficiaries' OOP spending on prescription drugs prior to 2006 is not shown in this figure.
- Growth over time in Medicare premiums and cost sharing will continue to outpace growth in Social Security income. Medicare trustees project that between 2007 and 2037 the average Social Security benefit will grow by just over 1 percent annually (after adjusting for inflation), compared with about 3 percent annual growth in average SMI premiums plus cost sharing.

Chart 1-14. Medicare FFS providers: Number and spending

Provider type	Number of providers, 2007	CY 2007 program spending (billions)
Inpatient hospitals	6,176[a]	$129.6
Hospital outpatient PPS	3,884[b]	20.7
Physicians, limited license practitioners, and nonphysician practitioners	1,075,571	58.6
Skilled nursing facilities	15,060	22.3
Home health agencies	9,227	15.5
Hospices	3,071	10.0
Ambulatory surgical centers	4,707[c]	2.3
End-stage renal disease facilities	4,798	8.4[c]
Clinical laboratories	199,817	6.8[d]
Durable medical equipment suppliers	~116,000	8.2

Note: FFS (fee-for-service), CY (calendar year), PPS (prospective payment system). Data include program spending only and do not include cost sharing or administrative expenses.

[a]Short-stay and non-short-stay hospitals.
[b]Analysis does not include alcohol and drug abuse and critical access hospitals but does include psychiatric, rehabilitation, and children's hospitals that bill under the outpatient PPS.
[c]Numbers are for 2006.
[d]Includes carrier and intermediary lab spending.

Source: U.S. Department of Health and Human Services, 2007 CMS Statistics. CMS's Provider of Service file. Spending from Office of the Actuary.

- The most numerous Medicare providers are physicians, limited license practitioners, and nonphysician practitioners. Among the more than one million of these practitioners, physicians numbered 660,819. Clinical laboratories and durable medical equipment suppliers are the next most numerous categories of Medicare providers.

- Among the more than 6,000 hospitals, 3,375 operate under the inpatient prospective payment system, 1,283 are critical access hospitals, 480 are psychiatric hospitals, 391 are long-term care hospitals, and 217 are inpatient rehabilitation facilities.

Web links. National health care and Medicare spending

- The Trustees' Report provides information on the financial operations and actuarial status of the Medicare program.

  http://www.cms.hhs.gov/ReportsTrustFunds/

- The National Health Expenditure Accounts developed by the Office of the Actuary at CMS provide information about spending for health care in the United States.

  http://cms.hhs.gov/NationalHealthExpendData/

- The CMS chart series provides information on the U.S. health care system and Medicare program spending.

  http://www.cms.gov/TheChartSeries/

- CMS statistics provides information about Medicare beneficiaries, providers, utilization, and spending.

  http://www.cms.hhs.gov/CapMarketUpdates/02_CMSstatistics.asp

- The Congressional Budget Office provides projections of Medicare spending.

  http://www.cbo.gov/budget/factsheets/2008b/medicare.pdf

- MedPAC's March 2008 Report to the Congress provides an overview of Medicare and U.S. health care spending in Chapter 1, Context for Medicare Payment Policy.

  http://www.medpac.gov/chapters/Mar08_Ch01.pdf