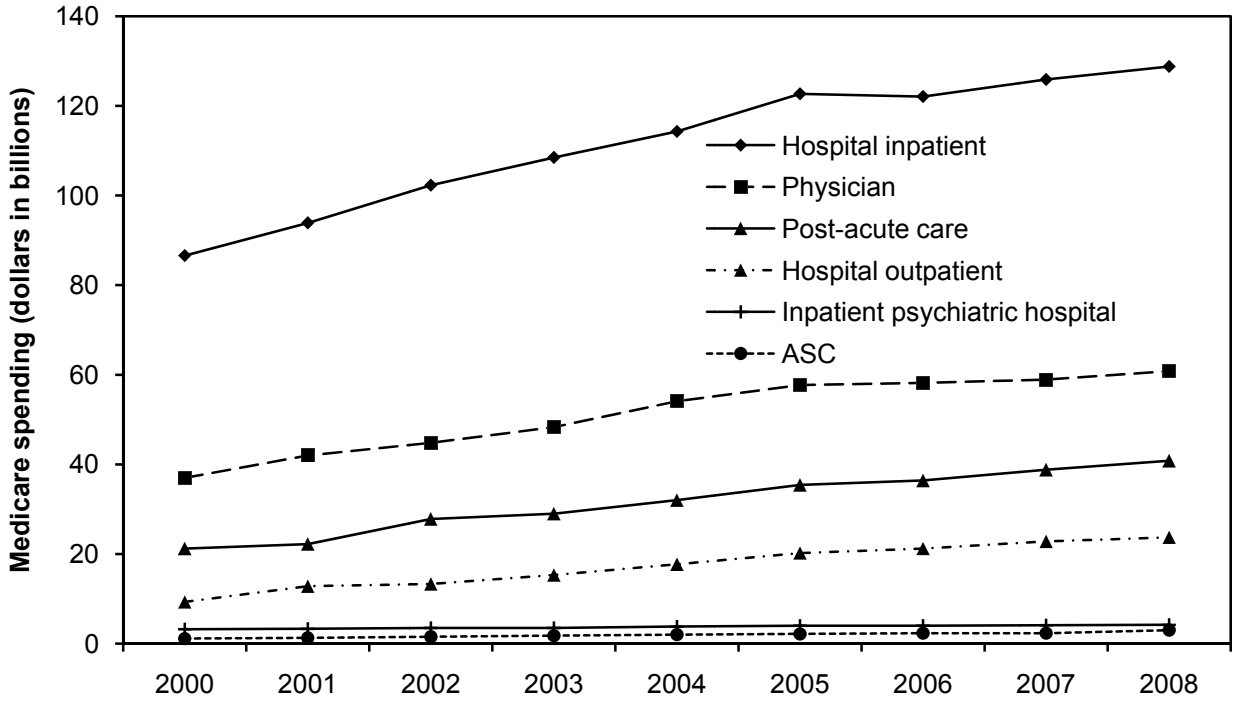
SECTION 1

National health care and Medicare spending

Chart 1-1. Aggregate Medicare spending among FFS beneficiaries, by sector, 2000–2008

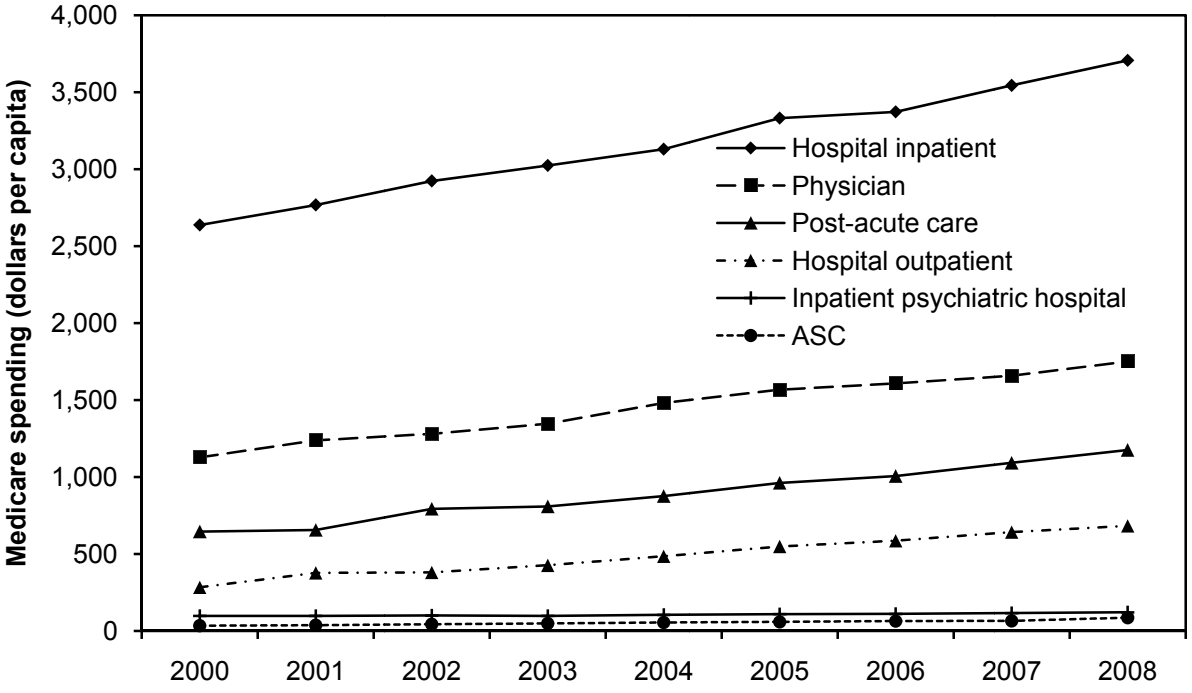


Note: FFS (fee-for-service), ASC (ambulatory surgical center). Dollars are Medicare spending only and do not include beneficiary cost sharing. The growth in spending was slowed between 2006 and 2008 by large increases in the number of Medicare Advantage enrollees, whose spending is not included in these aggregate totals.

Source: CMS, Office of the Actuary and the 2009 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 through 2008, reflecting a decline in FFS enrollment as many beneficiaries changed their enrollment to a Medicare Advantage plan. However, spending per beneficiary remained strong in most sectors from 2006 to 2008 (see Chart 1-2).

Chart 1-2. Per capita Medicare spending among FFS beneficiaries, by sector, 2000–2008

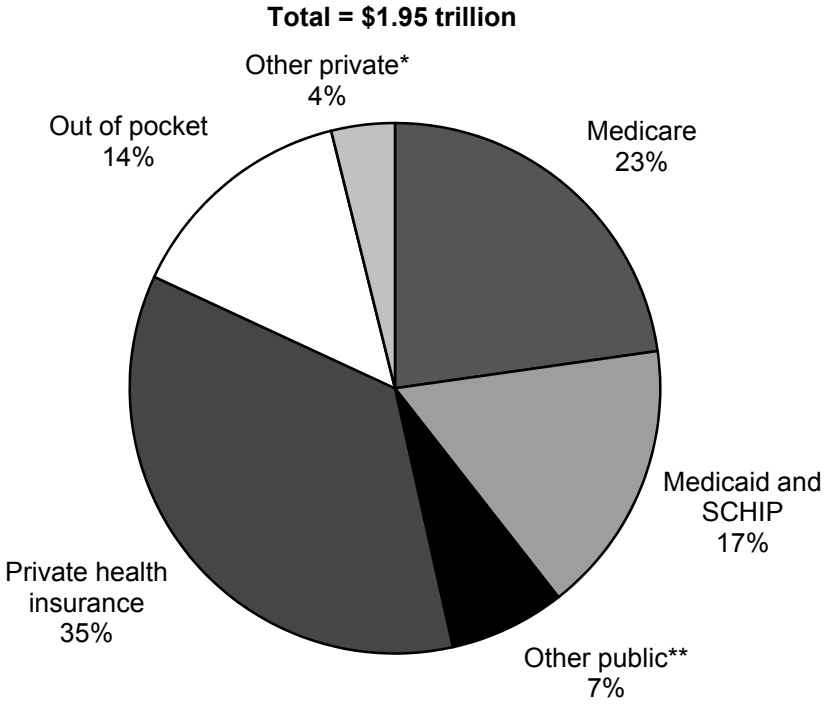


Note: FFS (fee-for-service), ASC (ambulatory surgical center). Dollars are Medicare spending only and do not include beneficiary cost sharing.

Source: CMS, Office of the Actuary and the 2009 annual report of the Boards of Trustees of the Medicare Trust Funds.

- Medicare spending per beneficiary in FFS Medicare increased steadily in most sectors from 2000 through 2008. This trend contrasts with a slowing in aggregate spending in FFS Medicare from 2006 to 2008 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 2008



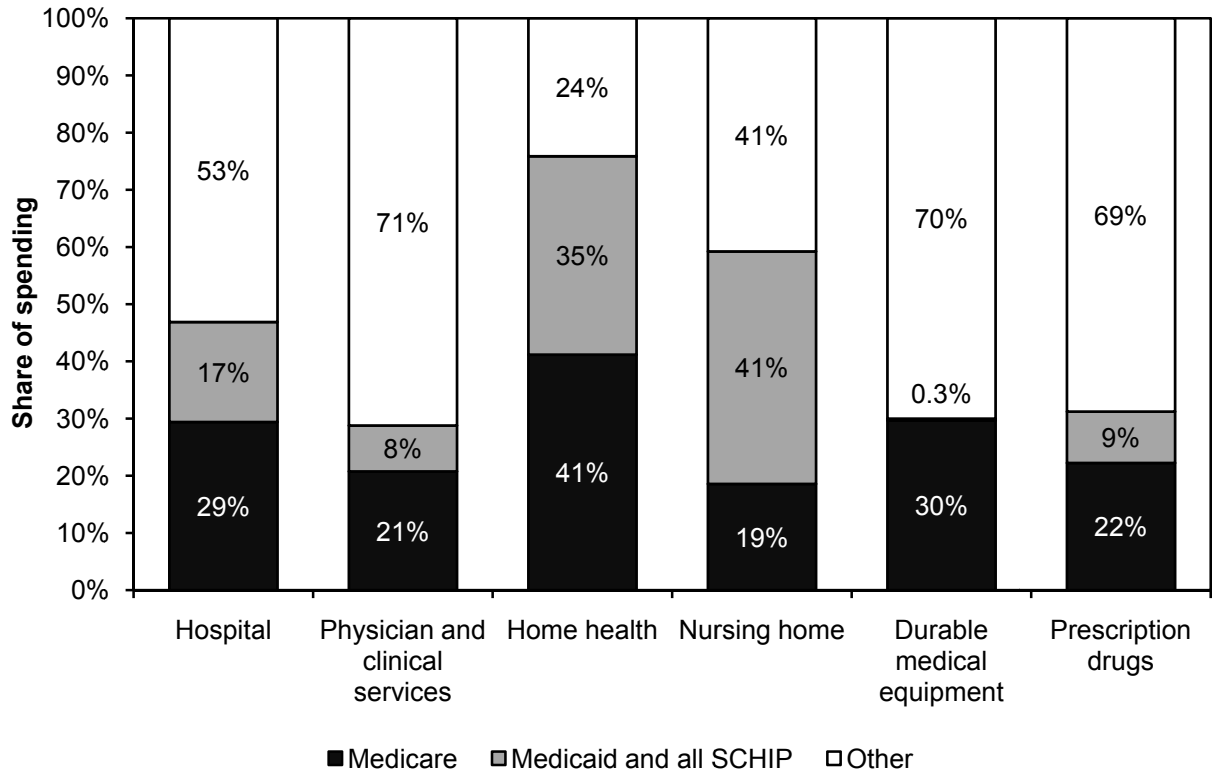
Note: SCHIP (State Children's Health Insurance Program). Out-of-pocket spending includes cost sharing for both privately and publicly insured individuals. Personal health care spending includes spending for clinical and professional services received by patients. It excludes administrative costs and 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, 2010.

- Of the $1.95 trillion spent on personal health care in the United States in 2008, Medicare accounted for 23 percent, or $444 billion (as noted above, this amount includes direct patient care spending and excludes certain administrative and business costs). Spending by all public programs—including Medicare, Medicaid, State Children's Health Insurance Program, and other programs—accounted for 47 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 14 percent was from consumer out-of-pocket spending.

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

Chart 1-4. Medicare's share of total spending varies by type of service, 2008

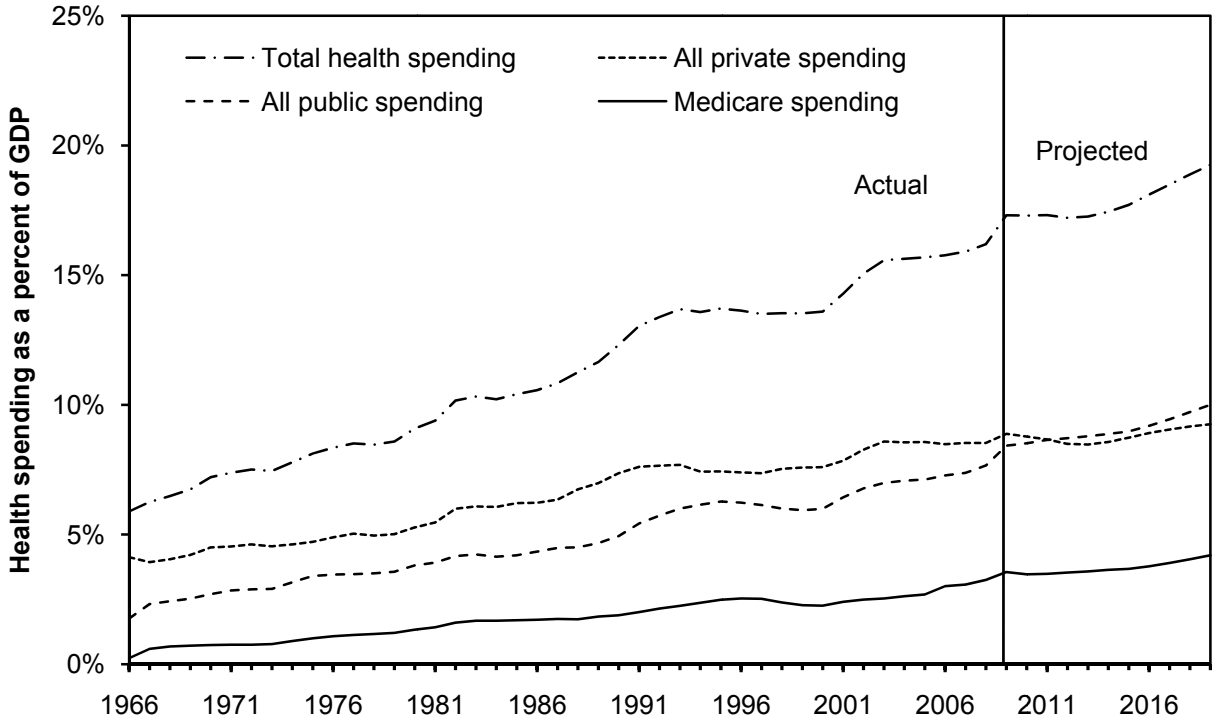


Note: SCHIP (State Children's Health Insurance Program). Personal health spending includes spending for clinical and professional services received by patients. It excludes administrative costs and profits. Totals may not sum to 100 percent due to rounding. Other includes private health insurance, out-of-pocket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

Source: CMS, Office of the Actuary, National Health Expenditure Accounts, 2010.

- The level and distribution of spending differ between Medicare and other payers, largely because Medicare covers an older, sicker population and does not cover services such as long-term care.
- In 2008, Medicare accounted for 29 percent of spending on hospital care, 21 percent of physician and clinical services, 41 percent of home health services, 19 percent of nursing home care, 30 percent of durable medical equipment, and 22 percent of prescription drugs.

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

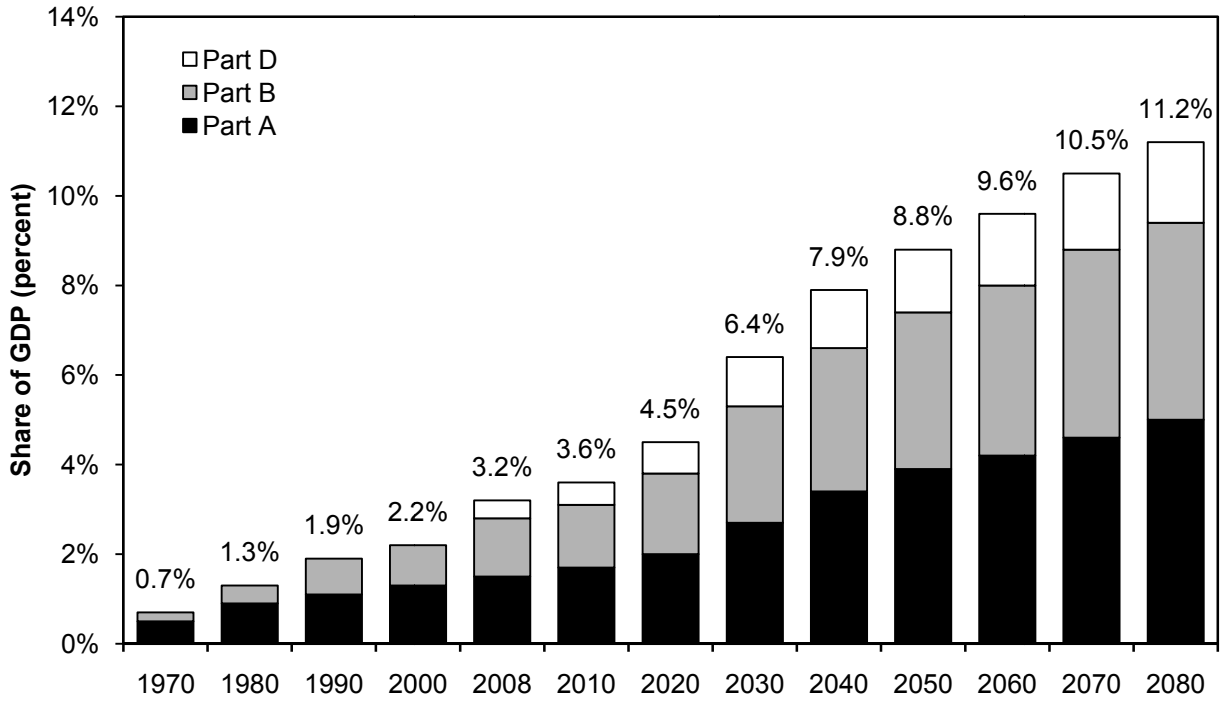


Note: GDP (gross domestic product). Total health spending is the sum of all private and public spending. Medicare spending is one component of all public spending.

Source: CMS, Office of the Actuary, National Health Expenditure Accounts, 2010.

- 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 2008. It is projected to reach almost 20 percent of GDP in 2019. 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 4 percent of GDP by 2019.
- In 2008, all public spending made up about 47 percent of total health care spending and private spending made up 53 percent. By 2019, those percentages are projected to be 52 percent and 48 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.

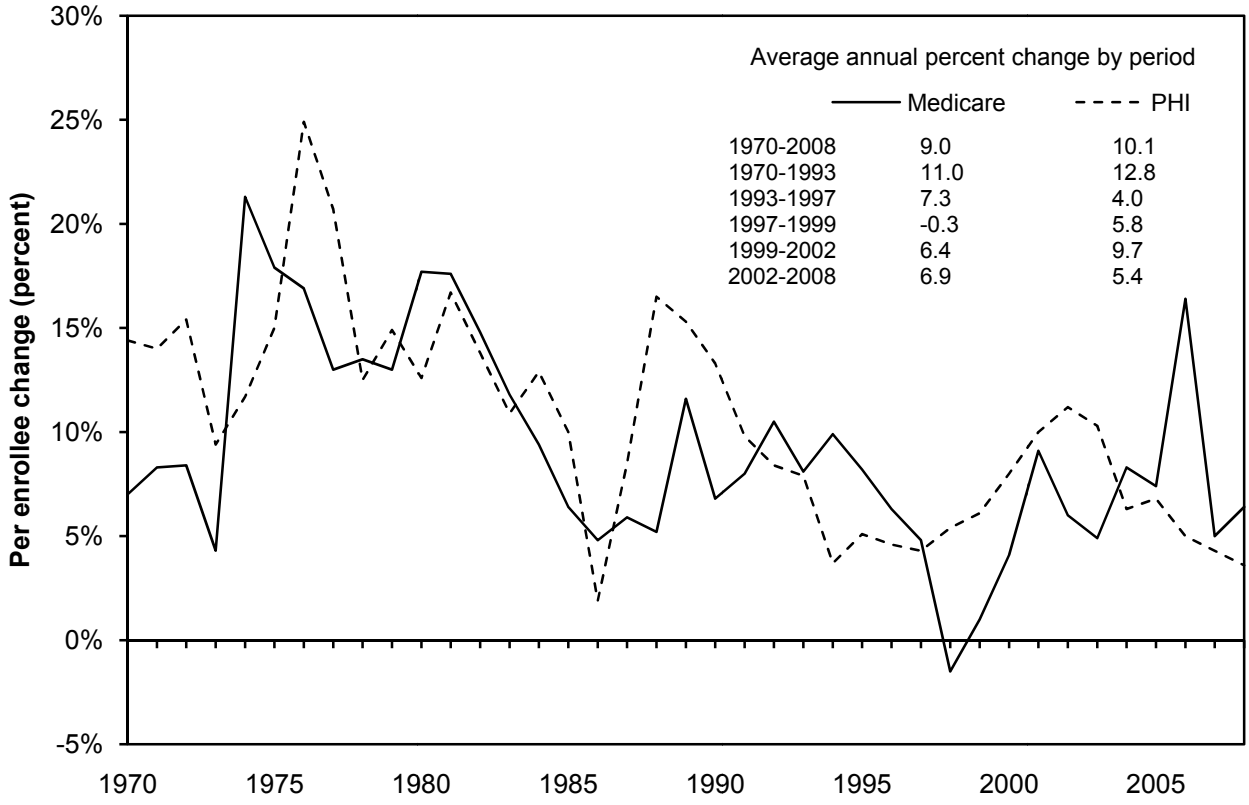
Source: 2009 annual report of the Boards of Trustees of the Medicare Trust Funds.

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

- With a 9.6 percent annual average rate of growth, nominal Medicare spending grew considerably faster over the period from 1980 to 2007 than nominal growth in the economy, which averaged 6.1 percent per year. Future Medicare spending is projected to continue growing faster than GDP, averaging 6.4 percent per year between 2007 and 2080 compared with an annual average growth rate of 4.4 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.

- During the 1990s, Medicare's share of the economy grew more slowly than it did in other periods. This factor 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



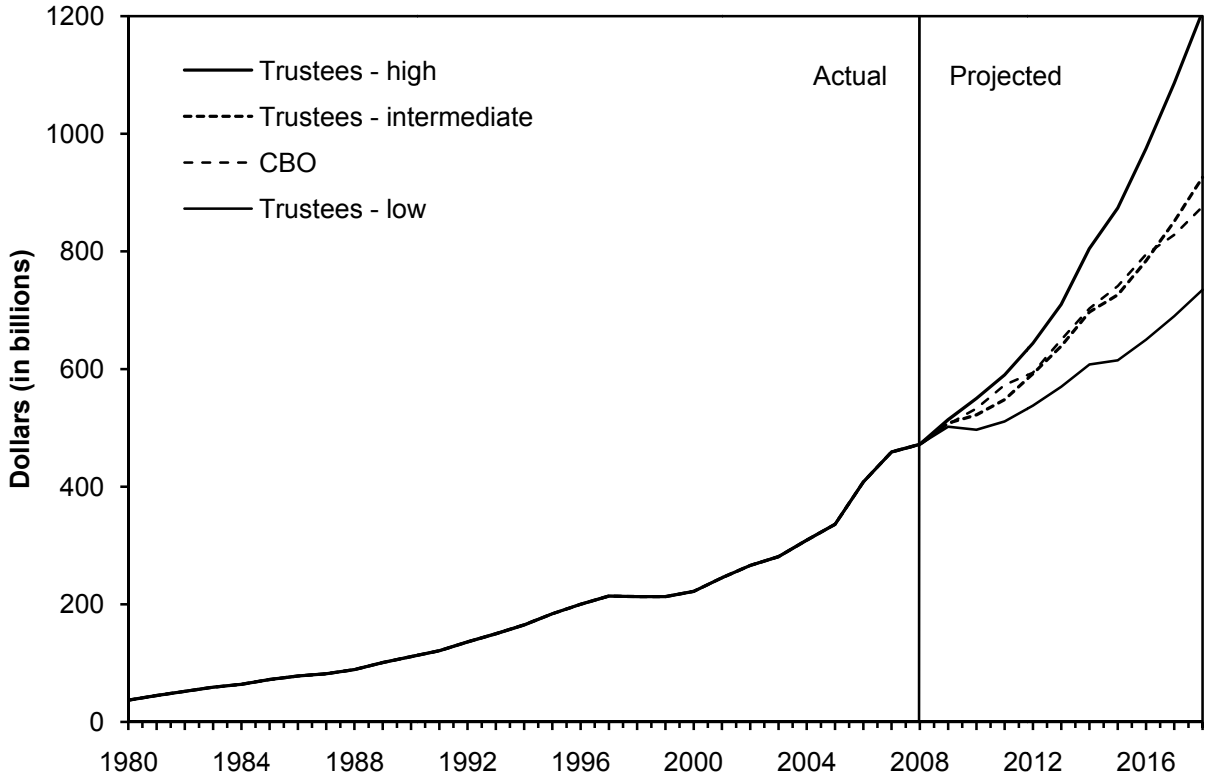
Note: PHI (private health insurance). In most years in this period Medicare and PHI do not cover the same services. Medicare expenditures include both fee-for-service and private plans.

Source: CMS, Office of the Actuary, National Health Statistics Group, 2010.

- 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. However, this comparison is sensitive to the end points 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 since the 1970s, benefits offered by private insurers have expanded and cost-sharing requirements declined. These factors make the comparison problematic, as 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

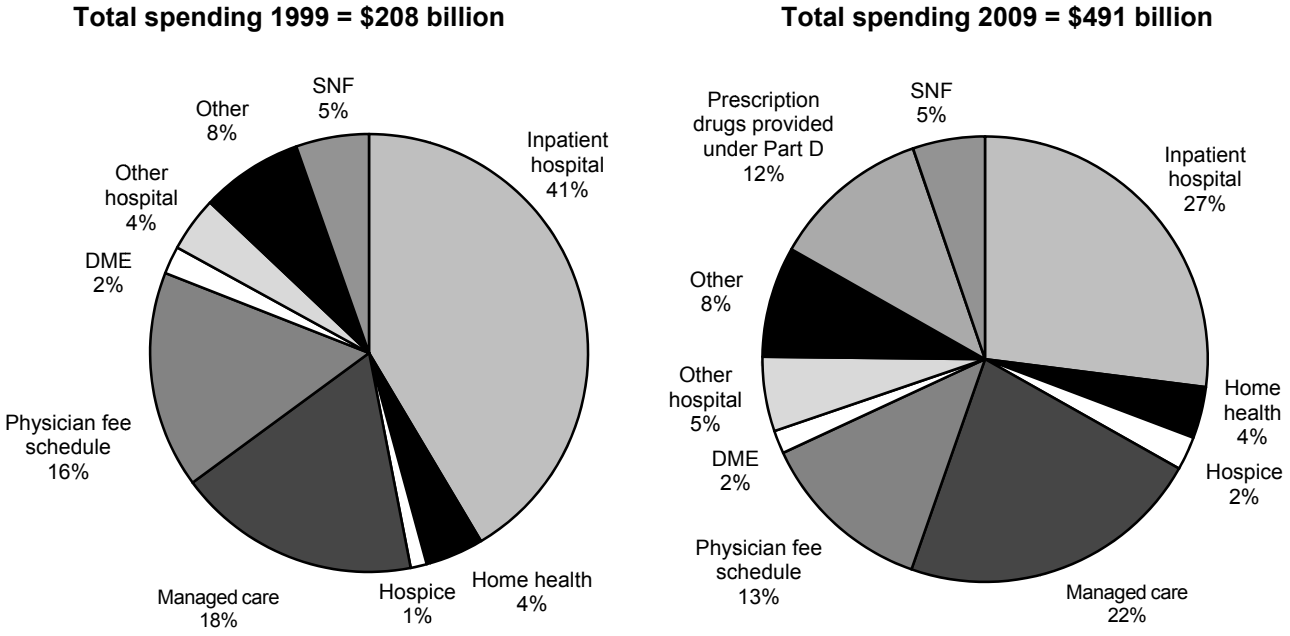


Note: CBO (Congressional Budget Office). All data are nominal, gross program outlays (mandatory plus administrative expenses) by calendar year.

Source: 2009 annual report of the Boards of Trustees of the Medicare Trust Funds. CBO March 2009 baseline.

- Medicare spending has grown nearly 13-fold, from $37 billion in 1980 to $468 billion in 2008 (see Chart 1-3; these data include benefit payments and administrative expenses).
- Medicare spending increased significantly after 2006 with the introduction of Part D, Medicare's voluntary outpatient prescription drug benefit.
- The CBO projects that mandatory spending for Medicare will grow at an average annual rate of 6.4 percent between 2008 and 2018. The Medicare trustees' intermediate projections for 2008 to 2018 assume about 7.1 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

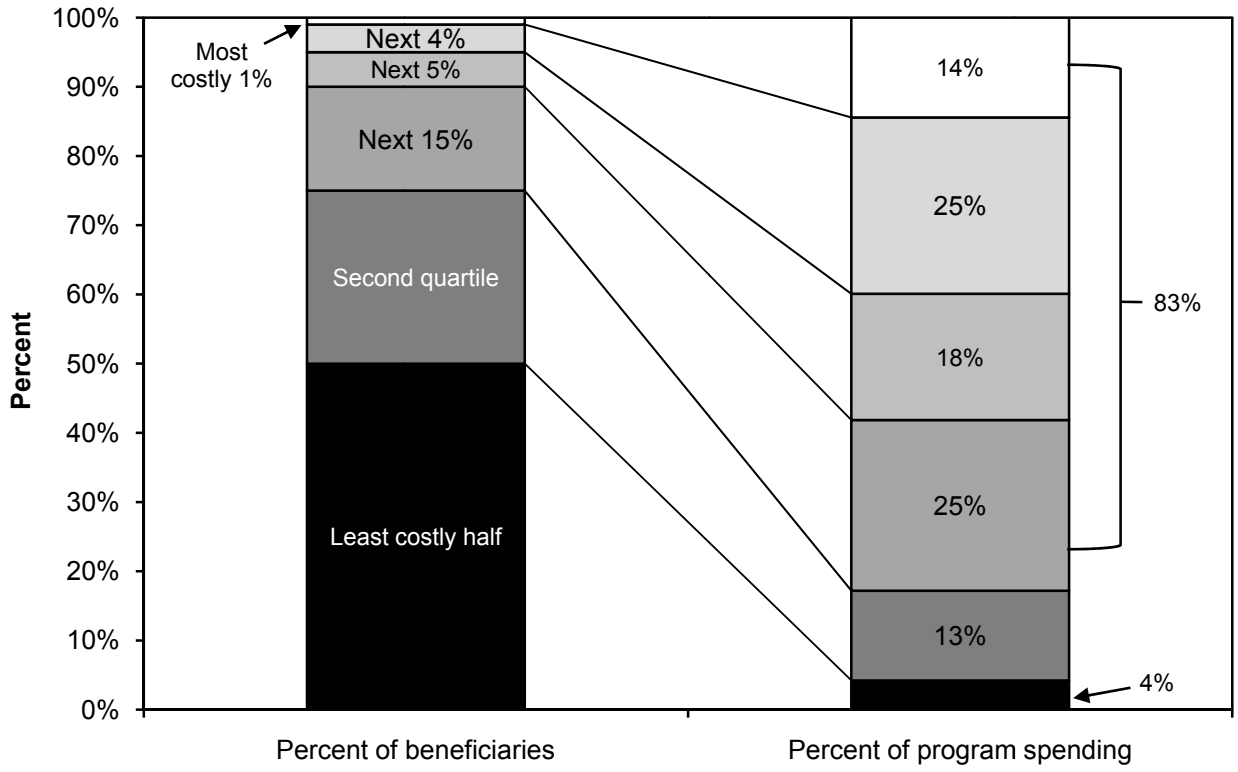


Note: SNF (skilled nursing facility), DME (durable medical equipment). Medicare's outpatient drug benefit began in 2006, and thus the distribution of spending for 2009 differs significantly from earlier years. Spending amounts are gross outlays, meaning that they include spending financed by beneficiary 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. The other category includes carrier lab, other carrier, intermediary lab, and other intermediary. Totals may not sum to 100 percent due to rounding.

Source: CMS, Office of the Actuary, 2009; 2011 President's Budget.

- The distribution of Medicare spending among services has changed substantially over time.
- In 2009, Medicare spent about $491 billion for benefit expenses. Inpatient hospital services were by far the largest spending category (27 percent), followed by managed care (22 percent), physicians (13 percent), outpatient prescription drugs provided under Part D (12 percent), and other fee-for-service settings (8 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 2009 than it was in 1999, falling from 41 percent to 27 percent. Spending on beneficiaries enrolled in managed care plans has grown from 18 percent to 22 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, 2006



Note: FFS (fee-for-service). Excludes beneficiaries with any group health enrollment during the year. Numbers may not sum to 100 percent due to rounding. Spending data reflect revised 2006 Medicare Current Beneficiary Survey Cost and Use file from CMS. As such, spending figures may differ from those in the MedPAC 2009 data book.

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

- Medicare FFS spending is concentrated among a small number of beneficiaries. In 2006, the costliest 5 percent of beneficiaries accounted for 39 percent of annual Medicare FFS spending and the costliest quartile accounted for 83 percent. By contrast, the least costly half of beneficiaries accounted for only 4 percent of FFS spending.

- Costly beneficiaries tend to include those who have multiple chronic conditions, those using inpatient hospital services, those who are dually eligible for Medicare and Medicaid, and those who are in the last year of life.

Chart 1-11. Medicare HI trust fund is projected to be insolvent in 2017

Estimate	Year costs exceed income	Year HI trust fund assets exhausted
High	2008	2014
Intermediate	2008	2017
Low	2018	2028

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.

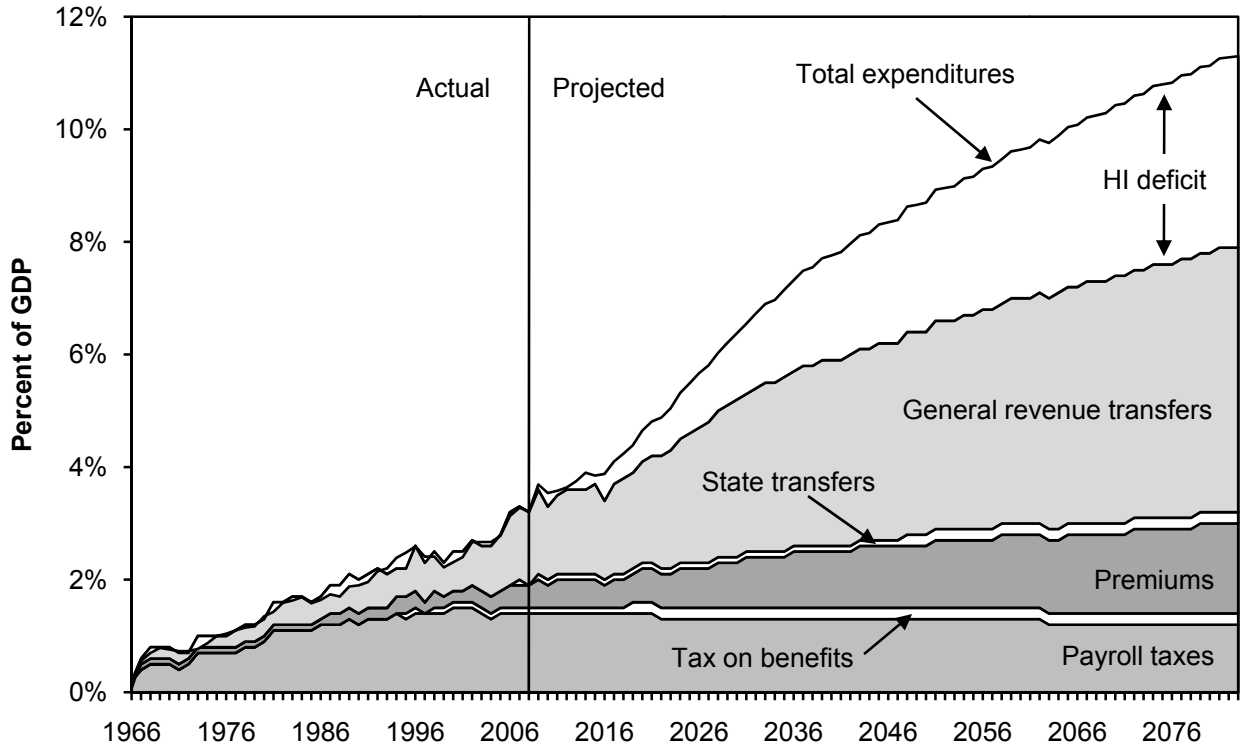
Source: 2009 annual report of the Boards of Trustees of the Medicare Trust Funds; CMS, Office of the Actuary.

- 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.

- In 2009 Medicare trustees reported that HI's expenses exceeded its income in 2008, and under the intermediate assumptions the HI trust fund will be exhausted in 2017. Under high cost assumptions, the HI trust fund could be exhausted as early as 2014. Under low cost assumptions, it would remain solvent until 2028.

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

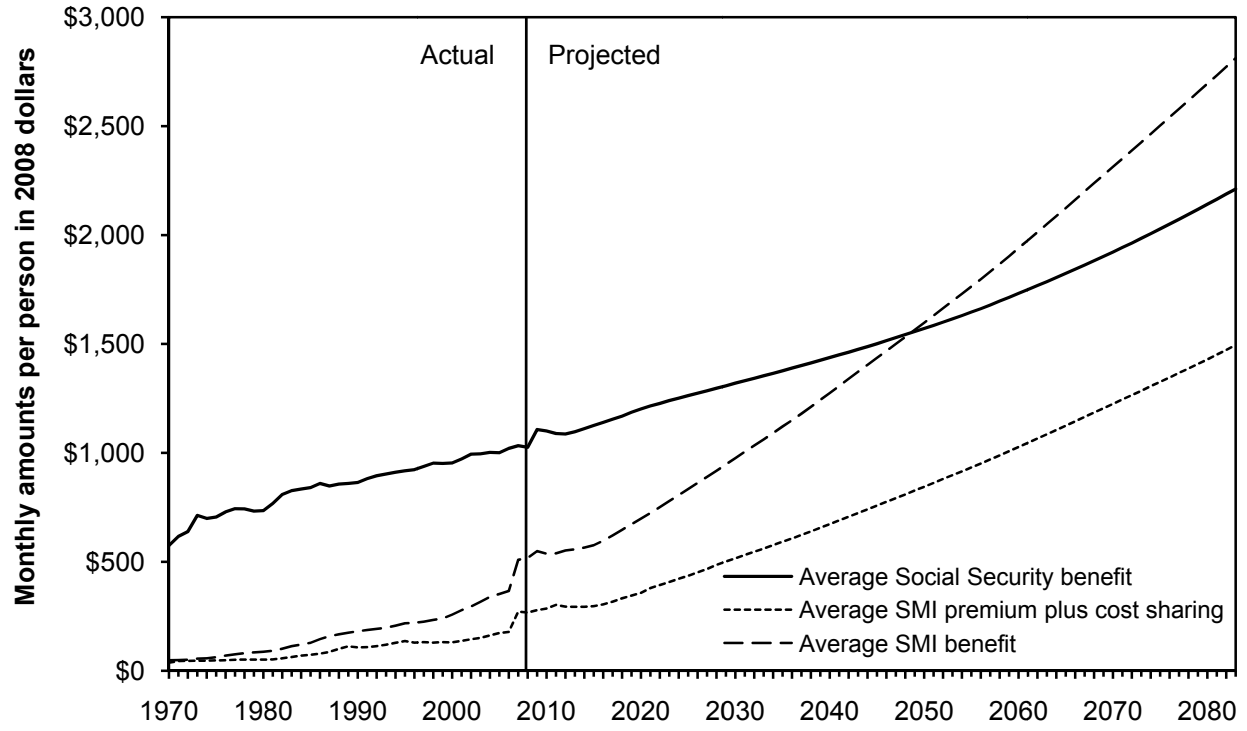


Note: GDP (gross domestic product), HI (Hospital Insurance). These projections are based on the trustees' intermediate set of assumptions. Tax on benefits refers to a portion of income taxes that higher income individuals pay on Social Security benefits that is designated for Medicare. State transfers (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: 2009 annual report of the Boards of Trustees of the Medicare Trust Funds.

- Under an intermediate set of assumptions, trustees project that Medicare spending will grow rapidly, from about 3 percent of GDP today to 8 percent by 2040 and to about 11 percent by 2080.

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 before 2006 is not included.

Source: 2009 annual report of the Boards of Trustees of the Medicare Trust Funds.

- Between 1970 and 2008, the average monthly Social Security benefit (adjusted for inflation) increased by an annual average rate of 1.6 percent. Over the same period, average SMI premiums plus cost sharing and average SMI benefits grew by annual averages of 5.4 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. In the 2003–2007 periods, 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.
- Growth over time in Medicare premiums and cost sharing will continue to outpace growth in Social Security income. Medicare trustees project that between 2008 and 2040 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.
- Most Medicare beneficiaries pay their Part B premium by having it withheld from their monthly Social Security benefit. In 2010, Social Security benefits are not expected to increase, and as a result about 75 percent of Medicare beneficiaries will be protected by the hold-harmless provision. This situation means that these beneficiaries will pay the same Medicare Part B premium as they did in 2009, even though Part B costs increased.
- Three categories make up the 25 percent of Medicare beneficiaries who will not be protected under the hold-harmless provision. They include: new enrollees in Medicare who did not pay a premium in 2009, high-income enrollees who pay the income-related Part B premium, and Medicare beneficiaries who are also eligible for Medicaid. (For this last group, Medicaid pays for their Part B premiums.) These three groups will pay Part B premiums high enough to offset the costs of providing the hold-harmless protection to the other 75 percent of beneficiaries.

Chart 1-14. Medicare benefits and cost sharing per enrollee in 2008

	Average benefit (in dollars)	Average cost sharing amount (in dollars)
Part A	$5,179	$442
Part B	4,322	1,214
Part D	1,517	602
Total	11,018	2,264

Note: Average benefit spending for Part D includes both Part D enrollees and beneficiaries with drug coverage through former employers who receive Medicare's Retiree Drug Subsidy. Part D average cost sharing does not include beneficiaries with drug coverage through former employers who receive Medicare's Retiree Drug Subsidy.

Source: CMS, Office of the Actuary.

- In calendar year 2008, the Medicare program spent an average of $11,018 on Part A, Part B, and Part D benefits per enrollee. Part A benefits made up 47 percent of the total, followed by 39 percent for Part B benefits and 14 percent for Part D.
- In the same year, beneficiaries owed an average of $2,264 in Medicare cost sharing. Fifty-four percent was made up of coinsurance for Part B services and 20 percent was made up of Part A cost sharing, followed by 26 percent for Part D cost sharing.
- Most Medicare beneficiaries have supplemental coverage through former employers, medigap policies, Medicaid, or other sources that fill in much of Medicare's cost-sharing requirements.

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.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://www.cms.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.gov/DataCompendium/

- MedPAC's March 2010 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/Mar10_Ch01.pdf