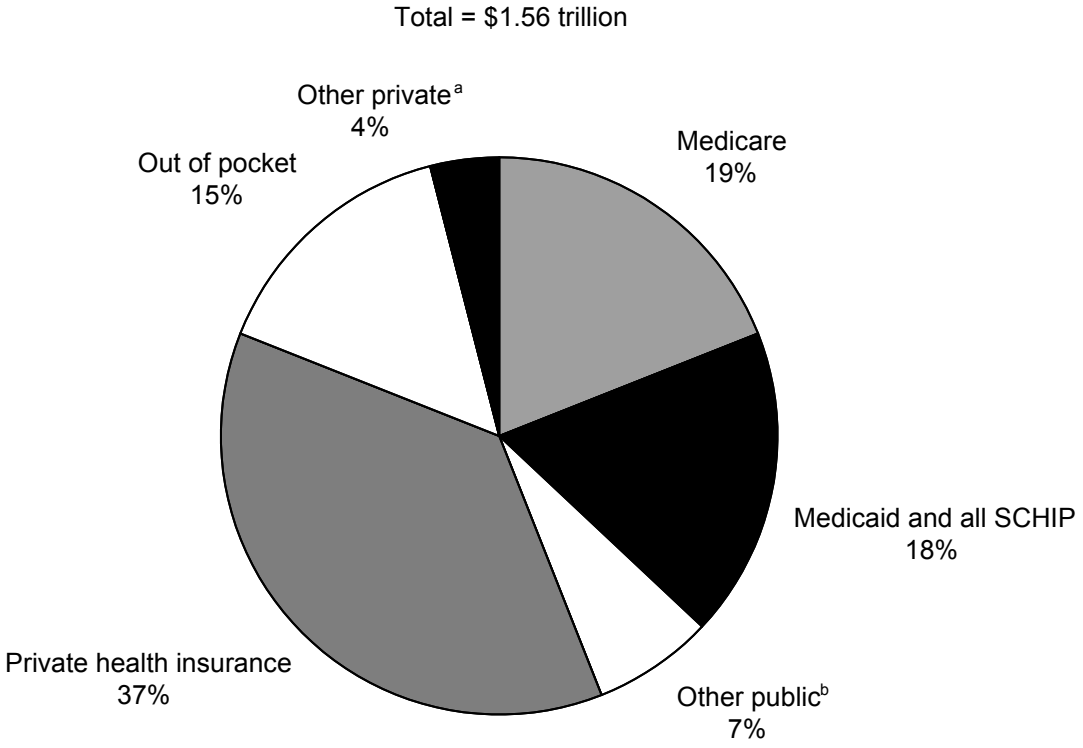
SECTION 1

National health care and Medicare spending

Chart 1-1. Medicare made up about one-fifth of spending on personal health care in 2004



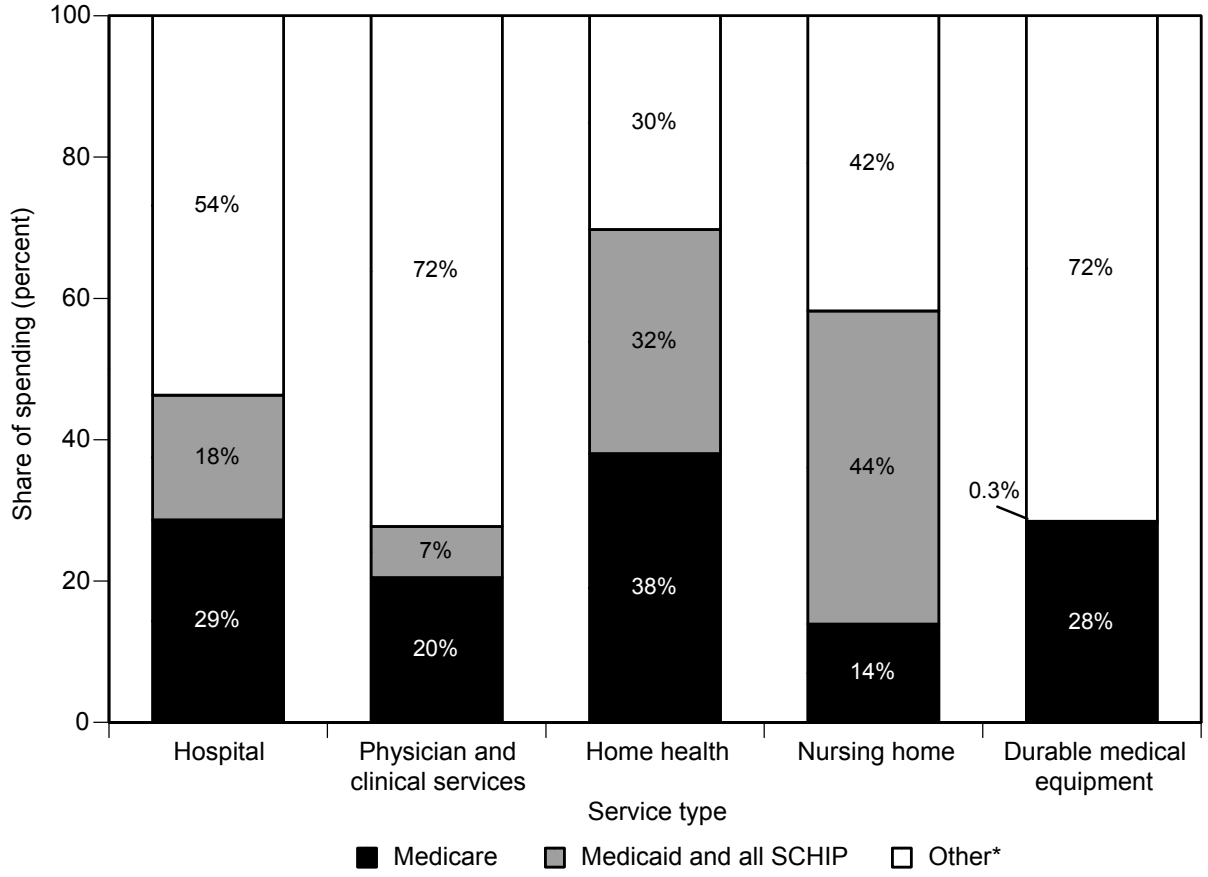
Note: SCHIP (State Children's Health Insurance Program). Out-of-pocket spending includes cost sharing for both privately and publicly insured individuals. Personal health care spending includes spending for clinical and professional services received by patients. It excludes administrative costs and profits. Premiums are included with each program (e.g., Medicare, private insurance), rather than in the out-of-pocket category.
[a] Includes industrial in-plant, privately funded construction, and nonpatient revenues, including philanthropy.
[b] 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, 2006.

- Of the $1.56 trillion spent on personal health care in the United States in 2004, Medicare accounted for about 19 percent, or $300 billion. Spending by all public programs—including Medicare, Medicaid, State Children's Health Insurance Program, and others—accounted for 44 percent of health care spending. Medicare is the largest single purchaser of health care in the United States. Thirty-seven percent of spending was financed through private health insurance payers (employers and plans) and 15 percent was from consumer out-of-pocket spending.

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

Chart 1-2. Medicare's share of total spending varies by type of service, 2004



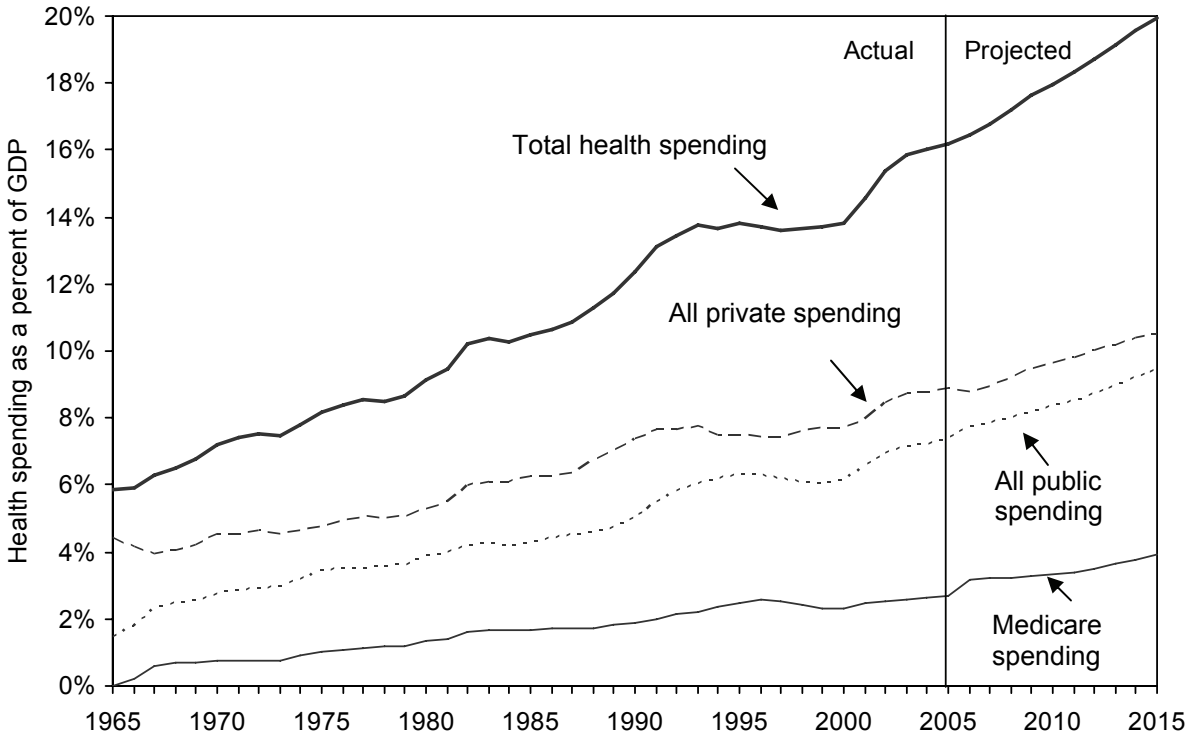
Note: SCHIP (State Children's Health Insurance Program). Personal health spending includes spending for clinical and professional services received by patients. It excludes administrative costs and profits.
Totals may not sum to 100 percent due to rounding.
*Other includes private health insurance, out-of-pocket,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

Source: CMS, Office of the Actuary, National Health Expenditure Accounts, 2006.

- 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 outpatient prescription drugs and long-term care during this time period.

- In 2004, Medicare accounted for 29 percent, 38 percent, and 28 percent of spending on hospital care, home health services, and durable medical equipment, respectively. By comparison, Medicare paid for 14 percent of nursing home care.

Chart 1-3. 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, 2006.

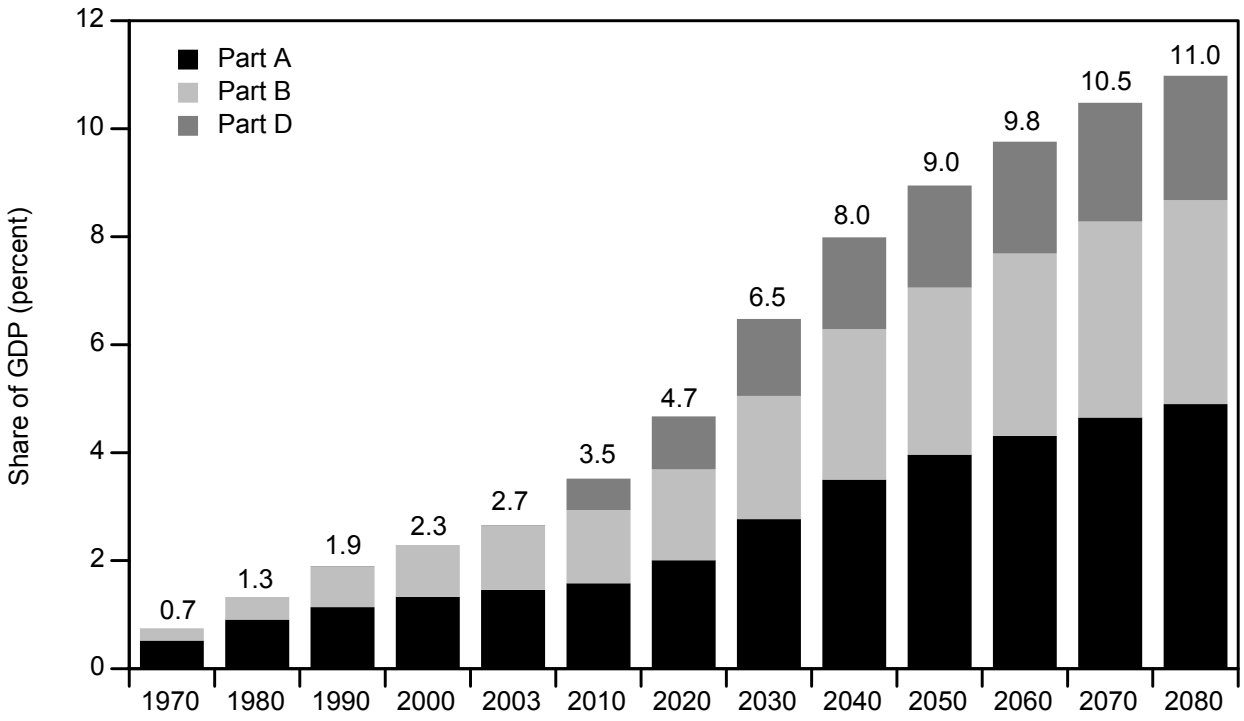
- Total health spending consumes an increasing proportion of national resources, accounting for a double-digit share of gross domestic product (GDP) annually since 1982.

- As a share of GDP, total health spending has increased from about 6 percent in 1965 to more than 16 percent in 2004. It is projected to reach 20 percent of GDP in 2015. 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 larger 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 nearly 4 percent of GDP by 2015.

- In 2004, public spending made up about 45 percent of total health care spending and private spending made up 55 percent. By 2015, those percentages are projected to be 48 percent and 52 percent, respectively.

Chart 1-4. 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.

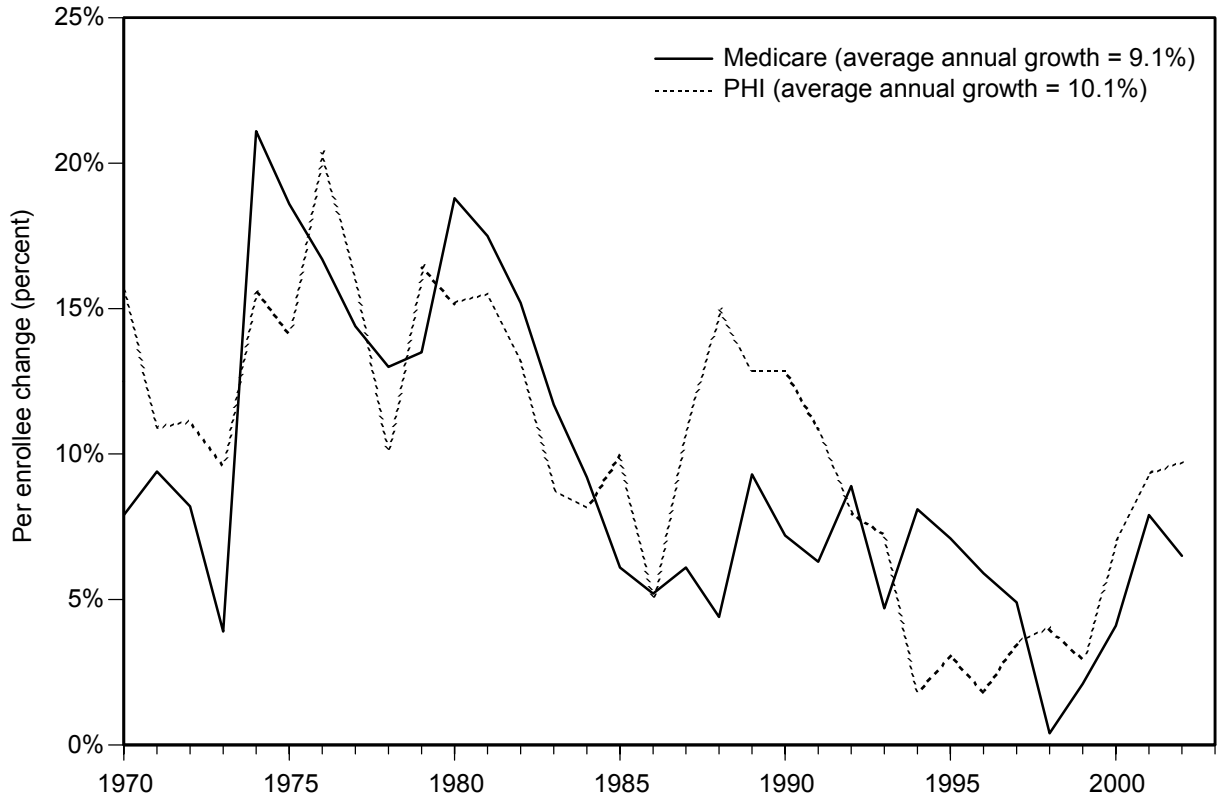
Source: 2006 Annual Report of the Boards of Trustees of the Medicare Trust Funds.

- 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 11 percent of GDP in 2080.

- With a 9.3 percent annual average rate of growth, nominal Medicare spending grew considerably faster over the period from 1980 to 2004 than nominal growth in the economy, which averaged 6.5 percent per year. For the future, Medicare spending is projected to continue growing faster than GDP, but at a rate somewhat closer to GDP growth, averaging 6.2 percent per year between 2004 and 2080 compared with an annual average growth rate of 4.5 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 slower pace.

- 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 interaction between the use of technology and insurance coverage will also contribute to rapid increases in health care spending.

Chart 1-5. 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.

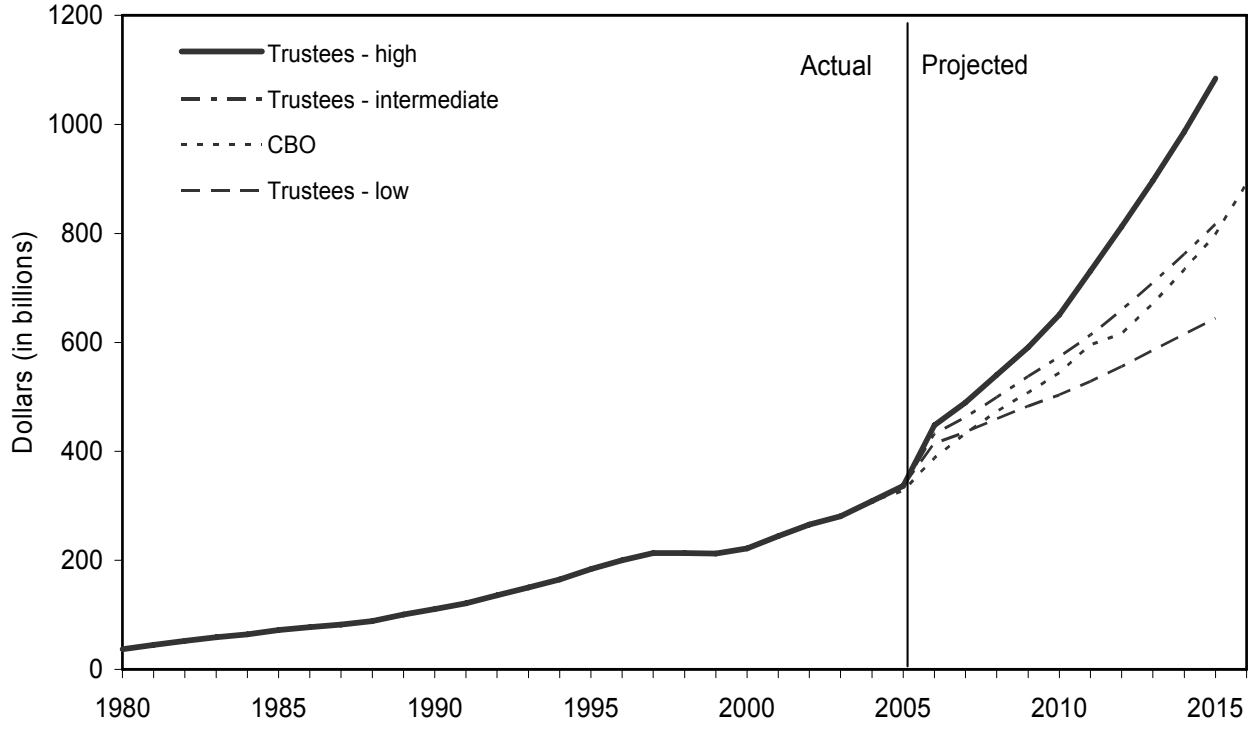
Source: CMS, Office of the Actuary, National Health Statistics Group, 2004.

- 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 about 1 percentage point lower than that for private insurance over the period from 1970 to 2002.

- 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. 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 1-6. Trustees and CBO project Medicare spending to grow at an annual average rate of 7 percent to 8 percent over the next 10 years

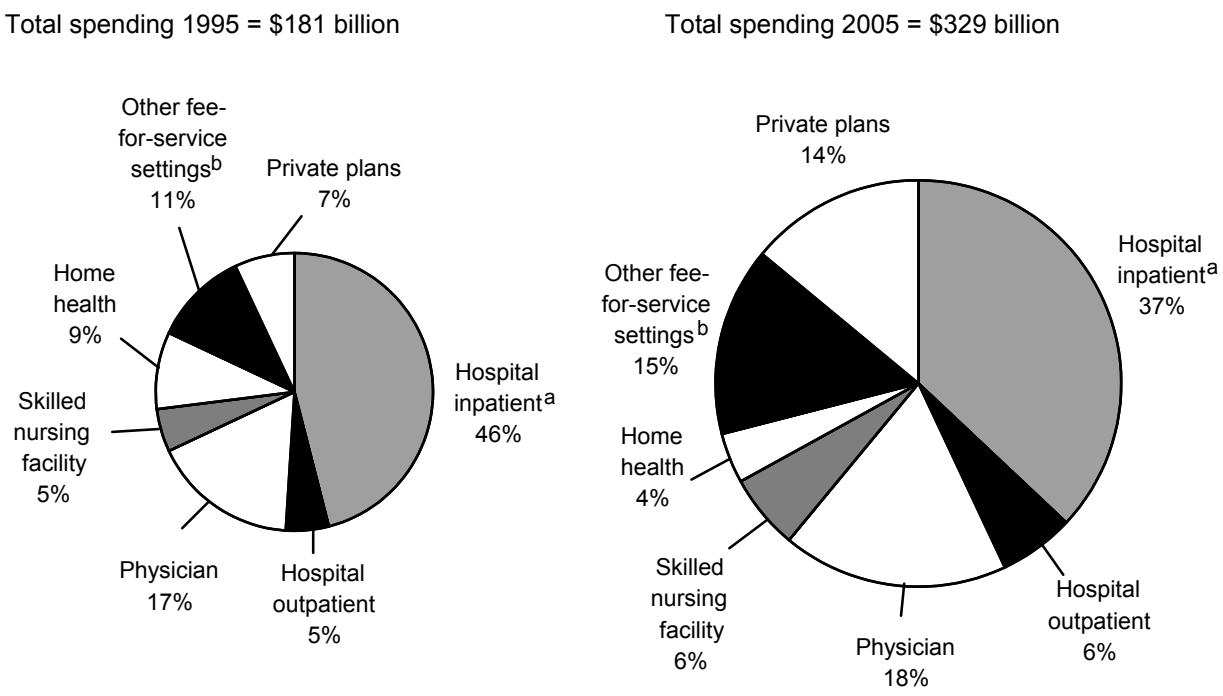


Note: CBO (Congressional Budget Office). All data are nominal, gross program outlays (mandatory plus administrative expenses) by calendar year.

Source: Medicare Trustees Report 2006. CBO March 2006 baseline.

- Medicare spending has grown about ninefold, from $37 billion in 1980 to $336 billion in 2005.
- Medicare spending will increase significantly in 2006 and in subsequent years with introduction of Part D, the new voluntary outpatient prescription drug benefit.
- The Congressional Budget Office projects that mandatory spending for Medicare will grow at an average annual rate of about 8 percent from 2006 to 2015. The Medicare Trustees' intermediate projections for 2006 to 2015 assume about 7 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 1-7. Medicare spending is concentrated in certain services and has shifted over time



Note: 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 hospice, 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.

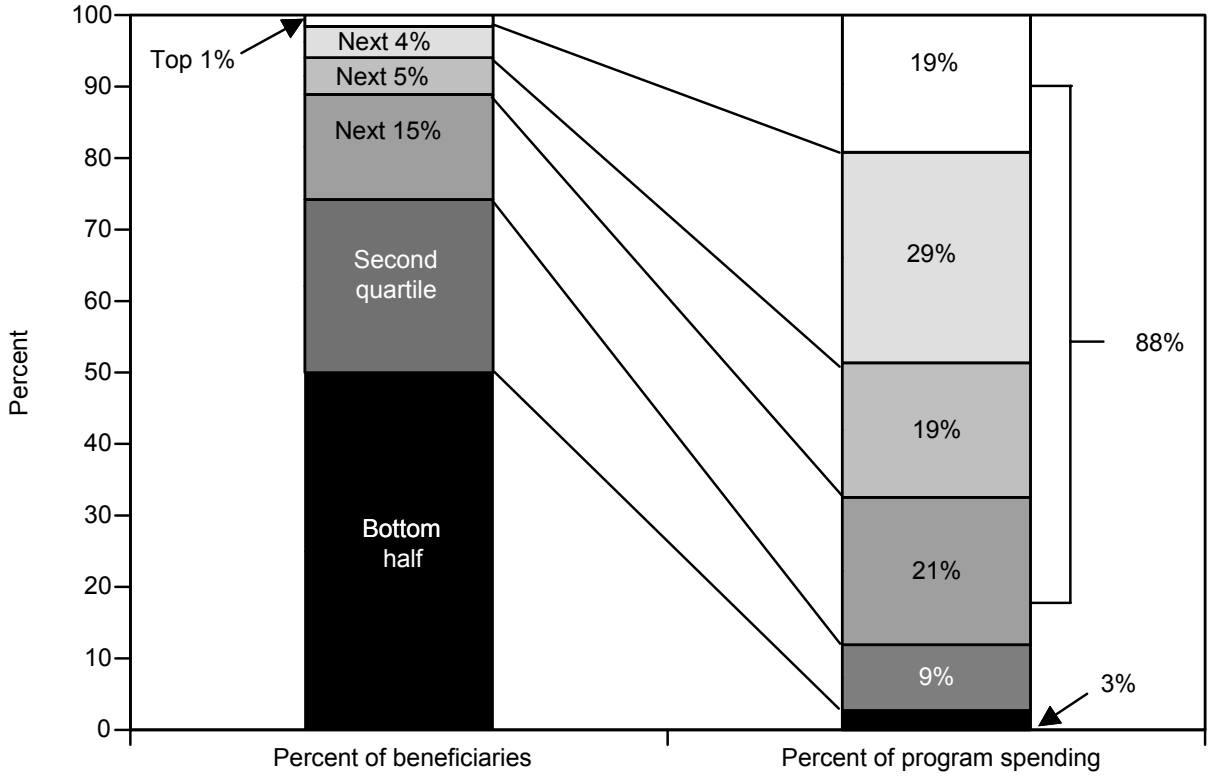
Source: CMS, Office of the Actuary, 2006.

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

- In 2005, Medicare spent about $329 billion, or $8,080 per enrollee. Inpatient hospital services were by far the largest spending category (37 percent), followed by physicians (18 percent), managed care (14 percent), and other fee-for-service settings (15 percent).

- Although inpatient hospital services still made up the largest spending category, spending for those services was a smaller share of total Medicare spending than it was in 1995, falling from 46 percent to 37 percent. Spending on beneficiaries enrolled in private plans has grown rapidly over the past several years, and current enrollment is higher than it was a decade ago.

Chart 1-8. FFS program spending is highly concentrated in a small group of beneficiaries, 2002



Note: FFS (fee-for-service).

Source: Direct Research, LLC, based on a 0.1 percent sample of Medicare fee-for-service enrollees and their claims.

- Medicare fee-for-service (FFS) spending is concentrated among a small number of beneficiaries. In 2002, the costliest 5 percent of beneficiaries accounted for 48 percent of annual Medicare FFS spending and the costliest quartile accounted for 88 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 1-9. Medicare HI trust fund is projected to be insolvent in 2018

Estimate	Year costs exceed income	Year HI trust fund assets exhausted
High	2007	2013
Intermediate	2010	2018
Low	N/A	2041

Note: HI (hospital insurance), N/A (not available). 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.

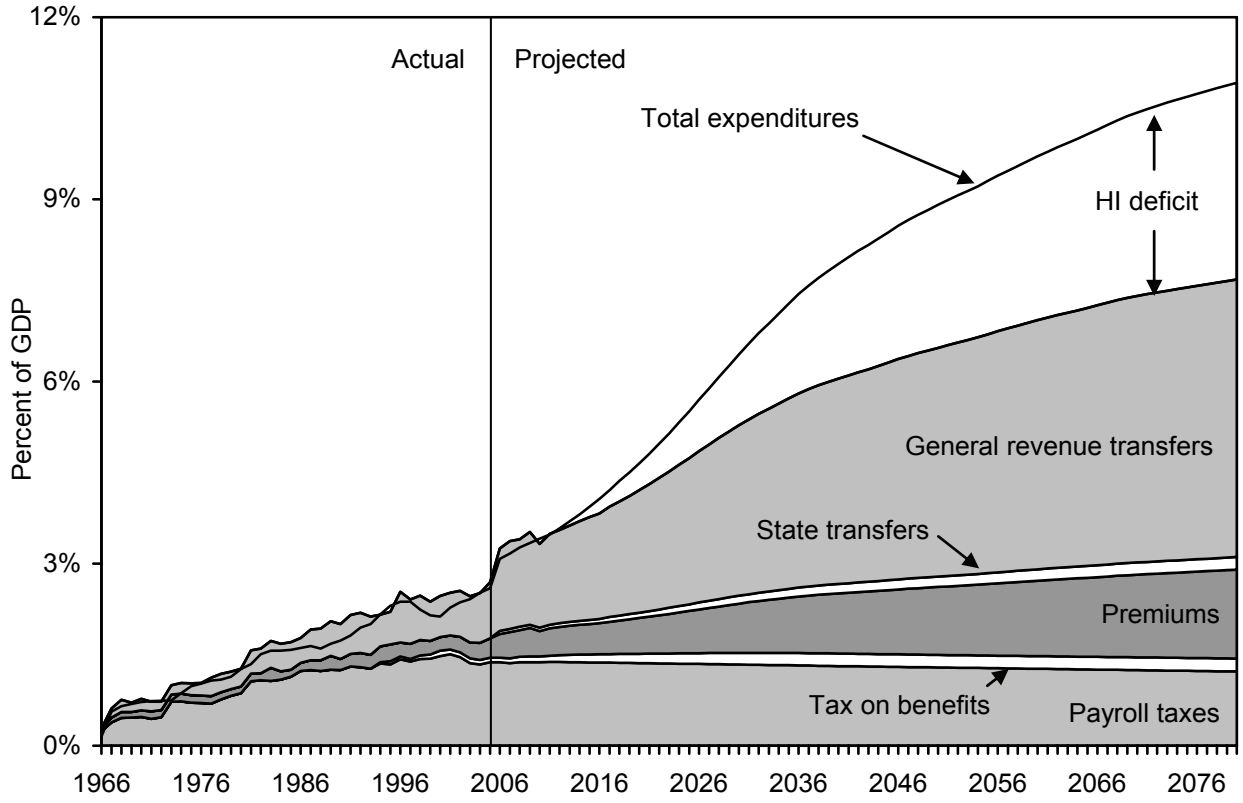
Source: 2006 Annual Report of the Boards of Trustees of the Medicare Trust Funds; CMS, Office of the Actuary.

- 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.)

- Since the SMI trust fund is financed with general revenues and beneficiary premiums, it cannot be exhausted. However, 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.

- Under high cost assumptions, the HI trust fund could be exhausted as early as 2013. Under low cost assumptions, it would remain solvent until 2041.

Chart 1-10. 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.

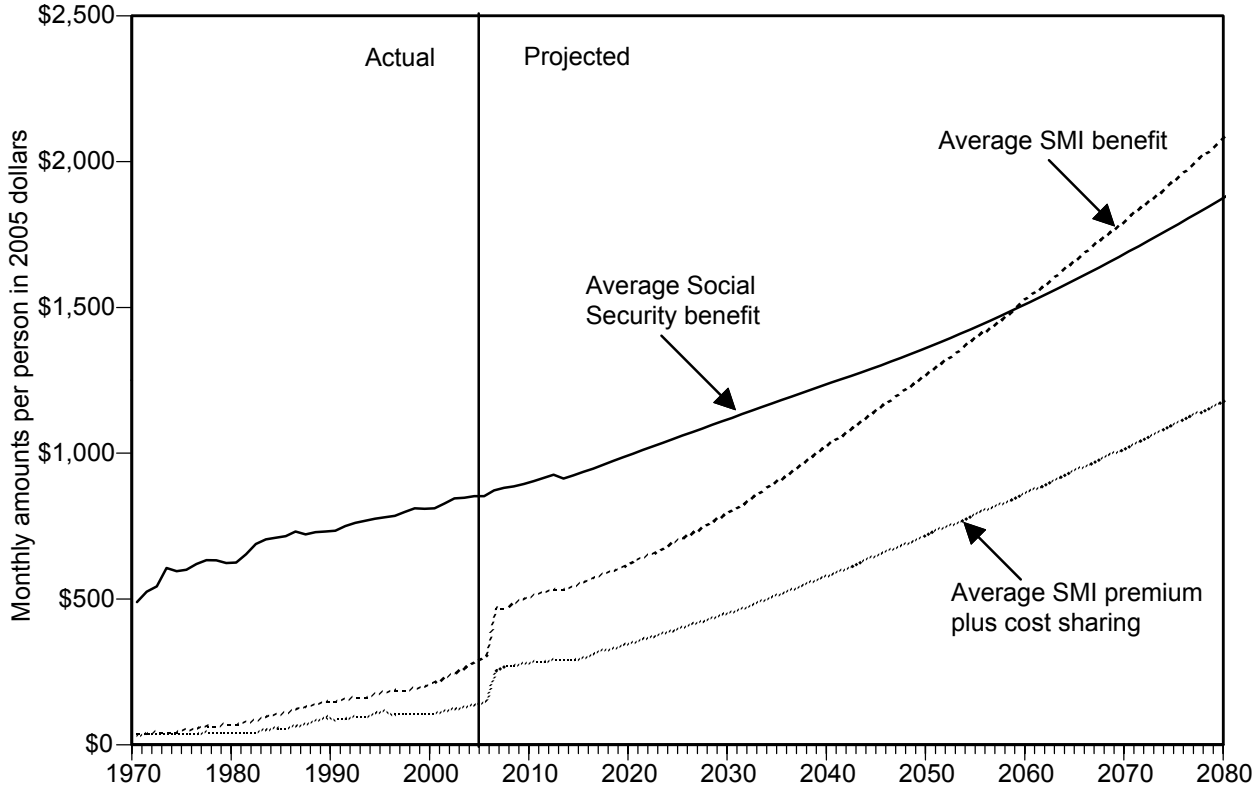
Source: 2006 Annual Report of the Boards of Trustees of the Medicare Trust Funds.

- Under an intermediate set of assumptions, trustees project that Medicare spending will grow rapidly, from about 3 percent of GDP today to 7.5 percent by 2036 and 11 percent by 2080.

- Medicare trustees project that under intermediate assumptions, the HI trust fund will be exhausted in 2018.

- Medicare's problems with long-term financing will become more prominent to policymakers over the next few years 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 2006 report, the Medicare trustees projected that the program would hit this 45 percent trigger in 2012—the last year of the seven-year projection window. If the trustees have a similar finding in their 2007 report, policymakers will be called upon to consider broad changes to Medicare's benefits and financing in the spring of 2008.

Chart 1-11. 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: 2006 Annual Report of the Boards of Trustees of the Medicare Trust Funds.

- Between 1970 and 2005, 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 more than 4 percent annually. 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. Recent Part B premium increases have offset about 30 percent to 40 percent of the dollar increase in the average Social Security benefit. Part D premium increases are not subject to a hold-harmless provision.

- Most beneficiaries who enroll in Medicare's new prescription drug benefit will see lower out-of-pocket (OOP) spending. Beneficiaries' OOP spending on prescription drugs prior to 2006 is not shown in this figure.

- Even with the expansion of Medicare's benefits, including prescription drugs, growth over time in Medicare premiums and cost sharing will continue to outpace growth in Social Security income. Medicare trustees project that between 2006 and 2036, the average Social Security benefit will grow by just over 1 percent annually (after adjusting for inflation), compared with about 2.5 percent annual growth in average SMI premiums plus cost sharing.

Chart 1-12. Medicare FFS providers: Number and spending

Provider	Number of providers 2005	Projected spending FY 2005 (billions)
Inpatient hospitals	6,111[a]	$ 121.6
Hospital outpatient PPS	3,944[b]	19.6
Physicians	618,183	57.3
Skilled nursing facilities	15,625	18.1
Home health agencies	8,082	12.5
Hospices	2,852	8.3
Ambulatory surgical centers	4,506	2.8[c]
Free-standing dialysis facilities	3,898	7.3
Outpatient clinical laboratories	192,533	6.4
Durable medical equipment suppliers	~140,000[d]	7.8

Note: FFS (fee-for-service), FY (fiscal year), PPS (prospective payment system). Data include program spending only and do not include cost sharing or administrative expenses.
[a]Short-stay and nonshort-stay hospitals.
[b]Data are for first quarter of 2006. Analysis does not include alcohol and drug abuse hospitals and critical access hospitals, but does include psychiatric, rehabilitation, and children's hospitals that bill under the outpatient PPS.
[c]Preliminary.
[d]Data are for 2006. Many suppliers do not file a claim every year. For example, in a sample of 2004 claims, about 70,000 suppliers filed claims for reimbursement.

Source: Number of providers comes from a variety of CMS databases, including the Office of Research, Development, and Information 2005 Wallet Card of CMS program data; the Provider of Services file; the Online Survey, Certification, and Reporting system; Standard Analytic files; the Dialysis Facility Compare file; the CMS Clinical Laboratory Improvement Act database; and unpublished CMS data.

- The most numerous Medicare providers are physicians, followed by outpatient laboratories and durable medical equipment suppliers.

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 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/

- The Congressional Budget Office provides projections of Medicare spending.

  http://www.cbo.gov/budget/factsheets/2006b/medicare.pdf

- Chapter 1 of MedPAC's March 2006 Report to the Congress provides an overview of Medicare and U.S. health care spending.

  http://www.medpac.gov/publications/congressional_reports/mar06_ch01.pdf