

CHAPTER

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**Context for Medicare  
payment policy**

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# Context for Medicare payment policy

## Chapter summary

Medicare and other purchasers of health care in our nation face enormous challenges for the future. As growing health care costs challenge individuals and private and public payers, quality frequently falls short of patients' needs. The Commission has recommended a number of measures to increase the value of care, such as pay for performance, measuring resource use, and comparative effectiveness. The increasing spending and variation in use and quality of care in the current system suggest that opportunities exist for reducing waste and improving quality for beneficiaries, but realizing them requires addressing the myriad factors that drive the current health care system.

Another difficult challenge relates to financing. As is true for other purchasers of health care, Medicare's spending has been growing much faster than the economy. Our substantial national income, the availability of newer medical technologies, and health insurance are thought to account for much of this long-term growth, and some of those forces will likely push future spending higher. Medicare will have the additional challenge of higher enrollment associated with retiring

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baby boomers, which will affect program spending as well as the demand for federal resources for other programs that benefit the elderly, such as Social Security and Medicaid.

Because of these forces, the Medicare trustees and others warn of a serious mismatch between the benefits and payments the program currently provides and the financial resources available for the future. If Medicare benefits and payment systems remain as they are today, the trustees note that over time the program will require major new sources of financing. Projected levels of spending could also impose a significant financial liability on Medicare beneficiaries, who must pay premiums and cost sharing.

The program's shaky financial outlook is a strong impetus for change. As is true for other purchasers of health care services in the United States, Medicare's spending is growing much faster than the U.S. economy. In addition, CMS began Medicare's new outpatient prescription drug program, Part D, in 2006. This program added an important benefit to Medicare but greatly expanded the program's need for resources. Finally, the leading edge of the baby boomers will become Medicare beneficiaries after 2010, which will also accelerate Medicare spending. These factors will lead Medicare to require an unprecedented share of our gross domestic product.

Moreover, because of the retirement of the baby boom generation, other federal programs such as Social Security and long-term care services financed through Medicaid will require greater resources at the same time that Medicare spending expands. Some analysts point out that growth in our nation's economy has historically been large enough to finance expansion of both health and nonhealth spending (Chernew et al. 2003). Other analysts disagree, saying long-term economic growth alone will not be sufficient to bring the country's fiscal position into balance (Bernanke 2007). According to this point of view, fiscal stability will likely require a sizable slowdown in the growth rate of spending on health care and may also require a substantial increase in taxes as a share of our nation's economy (CBO 2005).

Addressing a challenge of this magnitude will require an extended effort, and analysts have urged policymakers to take immediate action to address Medicare's finances. They argue that major changes to these programs should be phased in to allow beneficiaries, providers, and taxpayers time to adapt to major alterations. However, Medicare's financial challenge is already growing more acute. For example, in 2004, expenditures for the Hospital Insurance trust fund, which funds inpatient stays and other post-acute care, began to exceed its annual income from taxes. Since 2004, Part A has remained solvent due to existing trust fund balances and interest income. As cost inflation continues to outstrip revenue and the retirement of the baby boom generation begins, the time for phasing in major changes is growing shorter.

Examining Medicare in a broader context is useful for understanding the choices facing policymakers. This chapter begins with a review of Medicare eligibility and financing and then discusses the factors that are increasing spending for Medicare and the health care system. ■



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## Introduction

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Medicare fills a critical role in our society—ensuring that the elderly and disabled have access to medically necessary care. Along with other payers in our health care system, the program has helped to finance important strides in medical technology. For the sake of its beneficiaries, we must preserve those aspects of the Medicare program. However, Medicare is not unique in struggling to control costs and improve quality. While Medicare is unique in its financing and eligibility relative to other health care programs, many of the factors that increase spending for other health care payers also increase Medicare spending (Aaron 2007).

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## Eligibility and financing for Medicare

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Medicare shifted much of the financial liability for health care spending from the elderly to taxpayers through a hybrid system with three major parts—A, B, and D—that had different eligibility requirements and different financing mechanisms.<sup>1</sup>

Part A, the Hospital Insurance (HI) program, covers stays in hospitals and skilled nursing facilities, hospice care, and some home health care. The Congress designed Part A as a compulsory social insurance program tied to employment in work covered by Social Security, currently financed through a dedicated 2.9 percent payroll tax. Part A essentially finances health care expenses through payroll taxes on current workers, with the promise of future benefits to those workers.

The Congress also established Part B, Supplementary Medical Insurance (SMI), covering services such as physician visits and outpatient hospital care. Part B is voluntary and available to anyone aged 65 or older. Beneficiary premiums finance about 25 percent of Part B program spending, and general revenues finance the remainder, which currently requires about 10 percent of all personal and corporate income tax revenue. Beneficiaries also pay cost-sharing requirements for a portion of their services, described in the following section.

In 2006, the Medicare prescription drug benefit, known as Part D, began operation. Like Part B, the drug benefit is voluntary and funded through a mixture of beneficiary premiums and a general fund contribution. Premiums cover about 11 percent of Part D costs, and the general

fund pays for about 78 percent of spending. States make payments to offset some of the costs of their Medicaid-eligible beneficiaries who receive Part D benefits.

Beneficiaries may opt to receive their benefits through private plans that have contracted with Medicare under Part C, also known as Medicare Advantage. Payments to these plans are funded through the HI and SMI trust funds. Beneficiaries must be eligible for both Part A and Part B to enroll in Medicare Advantage.

Most beneficiaries become eligible for Medicare when they turn 65, but there are two major exceptions. Individuals who qualify for disability payments from the Social Security disability program are eligible for Medicare after they complete a 24-month waiting period. Individuals with end-stage renal disease are eligible regardless of age.

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## Benefit design and cost sharing

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Medicare places some financial responsibility for health spending on beneficiaries through cost-sharing requirements at the point where they receive medical services. Medicare's original benefit package left certain services uncovered; for example, until 2006 Medicare did not cover outpatient prescription drugs. These factors have led most Medicare beneficiaries to obtain supplemental coverage, primarily through individual medigap policies or employer-based retiree coverage. Medicaid provides supplemental coverage for lower income Medicare beneficiaries.

The proportion of spending for Medicare-covered services paid through cost sharing has remained fairly stable. Part A cost-sharing requirements generally increased at the same rate as payment updates for Part A services. Cost sharing for many Part B services is proportional to allowed charges (typically 20 percent coinsurance).<sup>2</sup> Before 2005, lawmakers rarely increased Part B's annual deductible. However, in 2005 they raised it to \$110, and it now increases at the same rate as growth in Part B spending per person (in 2008, the deductible is \$135).

Most Medicare beneficiaries have supplemental coverage to fill in some or all of Medicare's gaps in cost sharing and coverage. In 2004, about 91 percent of Medicare beneficiaries obtained supplemental coverage through former employers (33 percent), medigap policies (26 percent), Medicare Advantage plans (13 percent),

Medicaid (17 percent), or other programs (2 percent) (MedPAC 2007). Supplemental coverage often allows enrollees better predictability of their out-of-pocket spending. In return for paying an annual premium, beneficiaries receive supplemental coverage, such as medigap policies, that reduces their cost sharing to zero or nearly zero from the time they begin using health services each year.

Some protection against high out-of-pocket spending is desirable, but such coverage may reduce beneficiaries' sensitivity to costs. Individuals with supplemental coverage tend to use services more than those with similar health status and no supplemental coverage. One estimate based on data from the mid-1990s suggests that Medicare spending ranges from 17 percent higher for those with employer coverage to 28 percent higher for those with medigap policies (Christensen and Shinogle 1997). Other analysts believe that when supplemental coverage encourages beneficiaries to adhere to medical therapies that prevent hospitalizations or the use of other services, higher levels of Medicare spending may be more modest than this (Chandra et al. 2007). However, while many supplemental plans cover all or nearly all of Medicare's cost-sharing requirements, they do not cover medical services that have better evidence of preventing hospitalizations any more selectively than they cover services that tend to be used inappropriately. Another line of research suggests that the responsiveness of beneficiaries to cost sharing is varied, and the effects of supplemental coverage are more modest for individuals in poorer health (Remler and Atherly 2003).

Policymakers created the Medicaid program at the same time as Medicare to address the health care needs of low-income individuals. The federal government, along with the states, assumes nearly all the cost of health care for beneficiaries who meet means and asset tests, and the federal share is financed with general revenues (like Part B). The presence of Medicare and Medicaid creates certain challenges for serving individuals eligible for both programs (called dual eligibles). Federal and state policy goals for the programs sometimes conflict, and current policies toward dual eligibles create incentives to shift costs between payers, often hinder efforts to improve quality and coordinate care, and may reduce access to care (MedPAC 2004a). Medicaid has become the primary public payer for long-term care, with many beneficiaries gaining eligibility and qualifying for benefits through medical indigence (Moore and Smith 2005). The

intersection of the two programs' payment policies has created particular problems related to shifting costs among payers for beneficiaries' post-acute and long-term care needs.

There are myriad federal programs, some funded through Medicaid, to help low-income beneficiaries with their Medicare costs, such as the low-income drug subsidy (LIS) and the Medicare Savings Programs. These programs help beneficiaries pay their premiums and, in some cases, their copays and deductibles. Eligibility for these programs is based on income and assets. Despite the protection these programs offer, only a fraction of eligible beneficiaries enroll in them. For example, despite considerable publicity, participation for LIS remains limited. As of January 2007, about 9.5 million beneficiaries were receiving the drug subsidy. Of these, about 7 million were deemed automatically eligible because they were dual eligibles (Kaiser Family Foundation 2007). Another 2.3 million, or 17 percent of the eligible population, applied for LIS and were found eligible by the Social Security Administration. Of those beneficiaries not automatically enrolled in LIS, the National Council on Aging estimates that between 35 percent and 42 percent of those eligible have enrolled. A number of concerns, including complex program requirements, lack of awareness of the program, and the challenges of communicating with hard-to-reach populations, have been faulted as hindering enrollment (see Chapter 5 for discussion of Medicare programs for low-income enrollees).

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## Today's concerns about Medicare

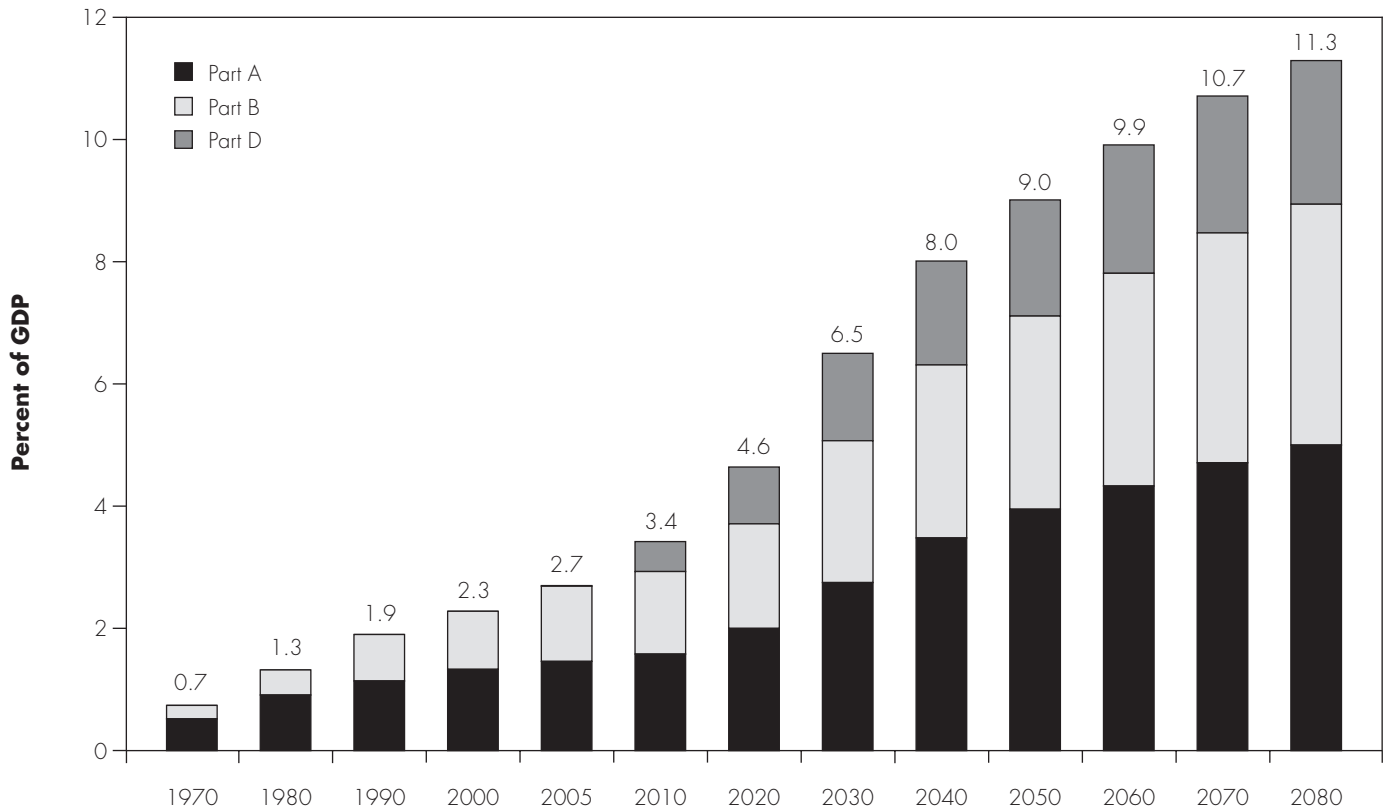
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As is true for other purchasers of health care, Medicare's spending is growing much faster than the economy (Figure 1-1). Projections of continued rapid growth in spending in the health care system combined with the retirement of the baby boom population foreshadow accelerated growth in Medicare outlays in 2010 and beyond. At the same time, the Medicare program spends widely different amounts per beneficiary across geographic regions, much of which can be attributed to differences in practice patterns rather than to differences in underlying health status. There are also wide geographic disparities in the quality of care beneficiaries receive, with no relationship or a negative relationship between quality of care and spending (Fisher et al. 2003).



**FIGURE  
1-1**

**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: 2007 annual report of the Boards of Trustees of the Medicare trust funds.

**Projections of Medicare's long-term financing needs**

In their most recent report, the Medicare trustees project that the assets of the HI trust fund will be exhausted in 2019. Income from payroll taxes collected in that year would cover 79 percent of projected benefit expenditures. In the future, the share of benefit expenditures covered by payroll tax collections would fall as health care cost inflation exceeds growth in payroll; by 2080, payroll tax collections at current levels would cover only 29 percent of projected Part A expenditures. Medicare will have no authority to pay the remainder of Part A benefits due. The SMI trust fund is financed automatically with general revenues and beneficiary premiums, but the trustees point out that SMI financing would have to increase sharply to match the expected growth in spending. Such rapid growth

would have repercussions on beneficiaries as well as on the availability of funds for other federal priorities.

The status of Medicare trust funds does not give a complete picture. If Medicare benefits and payment systems remain as they are today, the trustees note that over time the program will require major new sources of financing for Part A and will automatically require increasing shares of general tax revenues for Part B and Part D (see text box, pp. 10–11). The trustees project that dedicated payroll taxes will make up a smaller share of Medicare's total revenue and that a large deficit between spending for Part A (HI) and revenue from dedicated payroll taxes will develop (Figure 1-2, p. 12).

To finance the projected deficit through 2080, the trustees estimate that Medicare's payroll tax would need to increase immediately from 2.9 percent to 6.44 percent of

## Projecting Medicare growth

In making long-term projections of Medicare's costs, a critical assumption is the growth rate in program spending per person, exclusive of impacts due to the changing age and gender mix of the population. Growth rates vary depending on the time period for which one calculates them. Nevertheless, on average, real rates of increase in our nation's health expenditures have risen faster than real growth in the economy over the past six decades (2004 Technical Review Panel on the Medicare Trustees Report).

Before their 2001 report, the Medicare trustees assumed that long-range spending would grow at about the same rate as gross domestic product (GDP) per person, in recognition of the practical inability of growth in health spending to exceed economic growth indefinitely. This assumption was adopted in the mid-1980s (when 75-year projections were first included in the annual trustees report) as a way to highlight the long-term impact of demographic changes on Medicare costs, and the assumption was found to be "not unreasonable" by the independent 1992 Medicare Technical Review Panel. In recognition of the continuing significant growth differential, however, the Medicare trustees asked the 2000 Medicare Technical Review Panel to consider this assumption. The 2000 panel recommended that the trustees assume that long-range Medicare program spending per person would grow at a rate of GDP plus 1 percentage point, excluding effects resulting from the population's age and gender mix (which they model separately). The panel arrived at this unanimous recommendation after consideration of several different approaches and based the assumption principally on the expected ongoing effects of new medical technology. Their recommendation was adopted by the Medicare Boards of Trustees in 2000 and again in 2001 and was first implemented with the 2001 annual report. The

2004 Medicare Technical Review Panel concurred with its continued use. Both expert panels also recommended further research into the relationship between the health sector and the overall economy and how this relationship would change in the future.

For their 2006 report, the Medicare trustees refined their assumptions based on an economic model developed by the Office of the Actuary at the Centers for Medicare & Medicaid Services. This model incorporates the expected future societal trade-off between health care and nonhealth consumption, as the cost of health care continues to require a growing share of national income. It also reflects the potential for new medical technology to reduce costs versus continuing (on average) to increase costs. The new approach was reviewed and approved by an independent panel of health economists and actuaries and was adopted as a minor refinement of the "GDP + 1 percent" assumption. (Because the model parameters could not be uniquely estimated based on past data, they were selected to be consistent with calculations of 75-year Hospital Insurance actuarial balances under an assumption of growth rates of GDP plus 1 percentage point.) The key impact of the new forecasting model is a more gradual transition from current rates of growth to an assumption that Medicare growth rates ultimately will equal GDP growth. For example, the model projects that per capita growth rates in Medicare spending for 2030 will be 1.4 percentage points above GDP growth, declining gradually to GDP plus 0.8 percent in 2050 and to about GDP plus 0.2 percent in 2080 (Boards of Trustees 2007). The Medicare Trustees anticipate that cost growth will be slowed, even in the absence of legislative changes, by factors such as private and public health plans' limits on payment for new technology, individuals' ability to afford health

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earned income, or HI spending would need to decrease immediately by 51 percent. Delays in addressing the HI deficit would eventually require even larger increases in the tax rate or even more dramatic cuts in spending. The premiums and general revenues required to finance projected spending for SMI services could impose a

significant financial liability on Medicare beneficiaries and on resources for other priorities. If income taxes remain at the historical average share of the economy, the Medicare trustees estimate that the SMI program's share of personal and corporate income tax revenue would rise from 11.4 percent today to 25 percent by 2030. For beneficiaries,

## Projecting Medicare growth (cont.)

insurance premiums or cost-sharing payments, and a greater focus by payers, physicians, and other providers on more efficient, outcome-oriented practice standards.

The Congressional Budget Office (CBO) has developed an alternative projection of long-term spending that has a higher assumption about the long-term rate of excess growth (CBO 2007). CBO's projection includes all health care spending, both public and private sector, and it uses the same approach for modeling excess growth in these sectors. Between 2008 and 2017, the projection follows the spending for Medicare and Medicaid that CBO uses for its budget baseline. After 2018, CBO's projection assumes the rate of excess growth will gradually slow to prevent a decline in real per capita spending for non-health care goods and services. In effect, the projection assumes that consumers will allow excess growth to continue at the historical rate as long as it does not reduce income by so much that they have to reduce the consumption of non-health care goods in real terms.

CBO's projections assume that the private sector will begin to act to curb excess growth as it threatens to shrink per capita non-health care spending. The projection does not assume implementation of any particular set of reforms to slow growth, but the assumption is that payers, providers, and consumers will begin to behave in a more cost-sensitive manner in the face of higher costs. For example, plans may raise cost sharing or limit the services they cover. Some of these changes may spur health care providers to change their practice patterns. The net effect of these changes would be to slow health care spending so it does not reduce the inflation-adjusted level of spending for non-health care goods. Under this assumption, per capita excess growth for the private sector and federal programs besides Medicare and Medicaid would decline from 2 percent in 2018 to 0.1 percent in 2082.

The projection assumes that a "spillover effect" from the slowdown in private sector excess growth, increases in beneficiary cost sharing, and regulatory action by Medicare will curb costs in the future, but that excess growth will fall at a slower rate compared with that for private payers. Specifically, for Medicare the decreases in excess growth will be equal to a quarter of the size of the decrease for non-Medicare and non-Medicaid health care spending. CBO assumes a smaller decline for Medicare because the private sector should have more flexibility to implement major changes, and CBO did not assume that legislative changes that reduce Medicare spending would occur.<sup>4</sup> Consequently, the rate of excess spending will not fall by the same amount as the rest of health care spending. Over the period from 2018 to 2082, CBO assumes excess growth will decline from 2.4 in 2018 to 1.1 in 2082. CBO's projections, by assuming that consumers will not allow real non-health care spending to decline, reflect one estimate of a spending slowdown. However, even with this slower rate, CBO finds that Medicare spending as a percentage of GDP could grow from 3 percent in 2018 to almost 17 percent in 2082.

Compared with the trustees' methodology, CBO's methodology produces a higher rate of excess growth for Medicare in the long run, with an average of 1.7 percent for 2018 to 2082. The differences between the two projections materialize gradually, and the two projections have nearly identical spending projections through 2037. Over 75 years, however, the CBO projection is higher. In 2082, Medicare spending as a percentage of GDP equals about 11 percent under the trustees' projection, while in CBO's projection it will be about 17 percent. ■

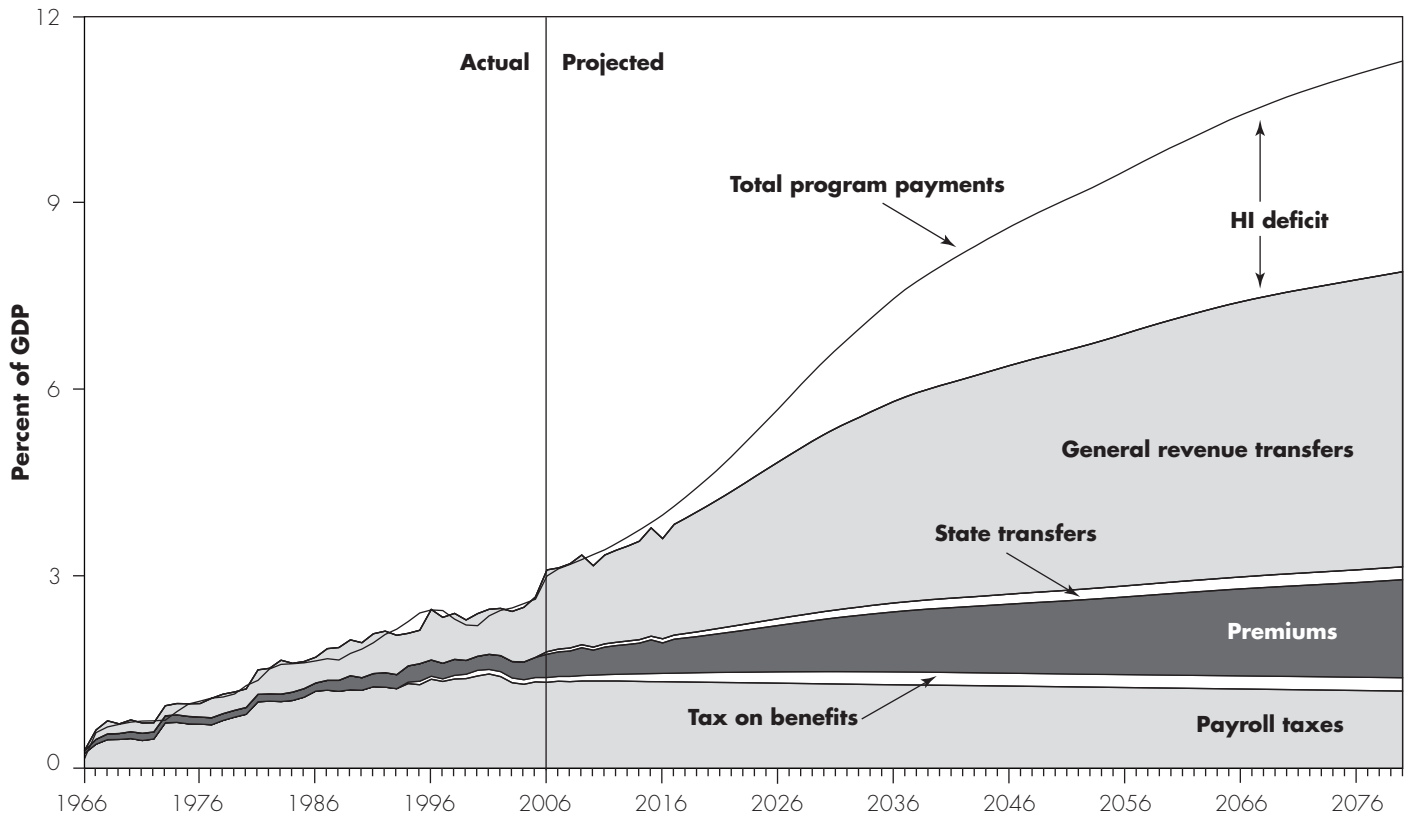
even though Part D now covers a portion of their spending on prescription drugs, growth in Medicare premiums and cost sharing for SMI services will require more of their incomes, which could lead to financial hardship for some; in 2004, roughly half of all Medicare beneficiaries had family incomes of less than 200 percent of the federal poverty level (MedPAC 2007).<sup>3</sup>

### The 45 percent trigger

Medicare's problems with long-term financing will become more visible to policymakers over the next few years because of a warning system established in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) known as the 45 percent trigger. Lawmakers included this provision to

**FIGURE  
1-2**

**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 designated for Medicare that higher income individuals pay on their Social Security benefits. State transfers (often called the Part D "clawback") were called for in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and refer to payments from the states to Medicare for assuming primary responsibility for prescription drug spending.

Source: 2007 annual report of the Boards of Trustees of the Medicare trust funds.

spark debate on balancing national priorities between Medicare and other uses for general revenue financing.

Each year, the Medicare trustees are required to project the share of Medicare outlays that are financed with general revenues in the current and six succeeding fiscal years. Under the warning system, if two consecutive annual reports project that general revenue will fund 45 percent or more of Medicare outlays in any year of the seven-year projection window, then the President must propose and the Congress must consider legislation to bring Medicare's spending below this threshold. However, the provision does not require the Congress to pass legislation. 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 window (Boards of Trustees 2006). The trustees released a similar finding for their 2007 report, so policymakers will need to consider changes to Medicare's benefits, payments, and financing by the spring of 2008.

The trigger has been criticized as an arbitrary mechanism that limits options for responding to Medicare's financial problems (Moon 2005). For example, it is not clear why limiting Medicare's general fund contribution to 45 percent is appropriate. However, the trigger raises an issue that policymakers must confront: How much of the federal government's general fund should be devoted to Medicare? General fund financing has always been a part of Medicare, but the level required in future years will

grow substantially. In addition to balancing Medicare's funding needs with other federal priorities, policymakers will need to assess the burden of Medicare's funding on taxpayers and beneficiaries. Measures of solvency should not dictate the choices of policymakers, but the underlying questions they raise about Medicare's sustainability cannot be avoided.

### **Increasing financial liability for beneficiaries**

Rapid growth in Medicare spending has implications for beneficiaries as well as taxpayers, since both groups finance the program. Although the premiums Medicare beneficiaries pay (primarily for Part B and Part D) are projected to make up a steady 12 percent to 13 percent of total program revenue, the dollar amounts of those premiums will require growing shares of beneficiaries' incomes. Part B premiums for 2008 are \$96.40 per month (or almost \$1,157 for the year), a \$2.90 per month increase (3.1 percent) over the 2007 amount. This is a much smaller increase than expected—the lowest since 2000. The small increase is attributable to the discovery of an accounting error that misallocated Part A benefits to Part B and to lower-than-anticipated growth in Part B spending. In addition to projected increases in Part B spending, the need to ensure an adequate financial reserve to cover unanticipated increases in expenditures accounted for a portion of the increase. The additional financial reserve should serve as a cushion if policymakers act to override the planned decrease in physician payments; similar decreases have been reversed in each of the last five years. The MMA also created a Part B income-related premium; CMS estimates that about 5 percent of Part B enrollees will pay higher premiums based on income (CMS 2006).<sup>5</sup> The highest income beneficiaries will pay premiums of about \$238 in 2007, more than double the standard premium.

Between 2000 and 2007, Medicare beneficiaries faced average annual increases in the Part B premium of nearly 11 percent. Meanwhile, monthly Social Security benefits, which averaged around \$900 per month in 2005, grew by about 3 percent annually over the same period.<sup>6</sup> Under hold-harmless policies, Medicare Part B premiums cannot increase by a larger dollar amount than the cost-of-living increase in an individual's Social Security benefit. The dollar amount of recent increases in Part B premiums has absorbed 20 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.

Medicare has provided important financial protection to beneficiaries, but they still need to cover some of the costs through cost sharing. In 2002, about half of beneficiaries had incomes of about \$20,000 or less (MedPAC 2007). Eighteen percent had incomes less than the poverty level (defined then as \$9,060 for people living alone and \$11,430 for married couples), and 49 percent had incomes at 200 percent of the poverty level or below (MedPAC 2007). In 2005, Social Security payments were 50 percent or more of annual income for about 65 percent of elderly recipients (SSA 2007).

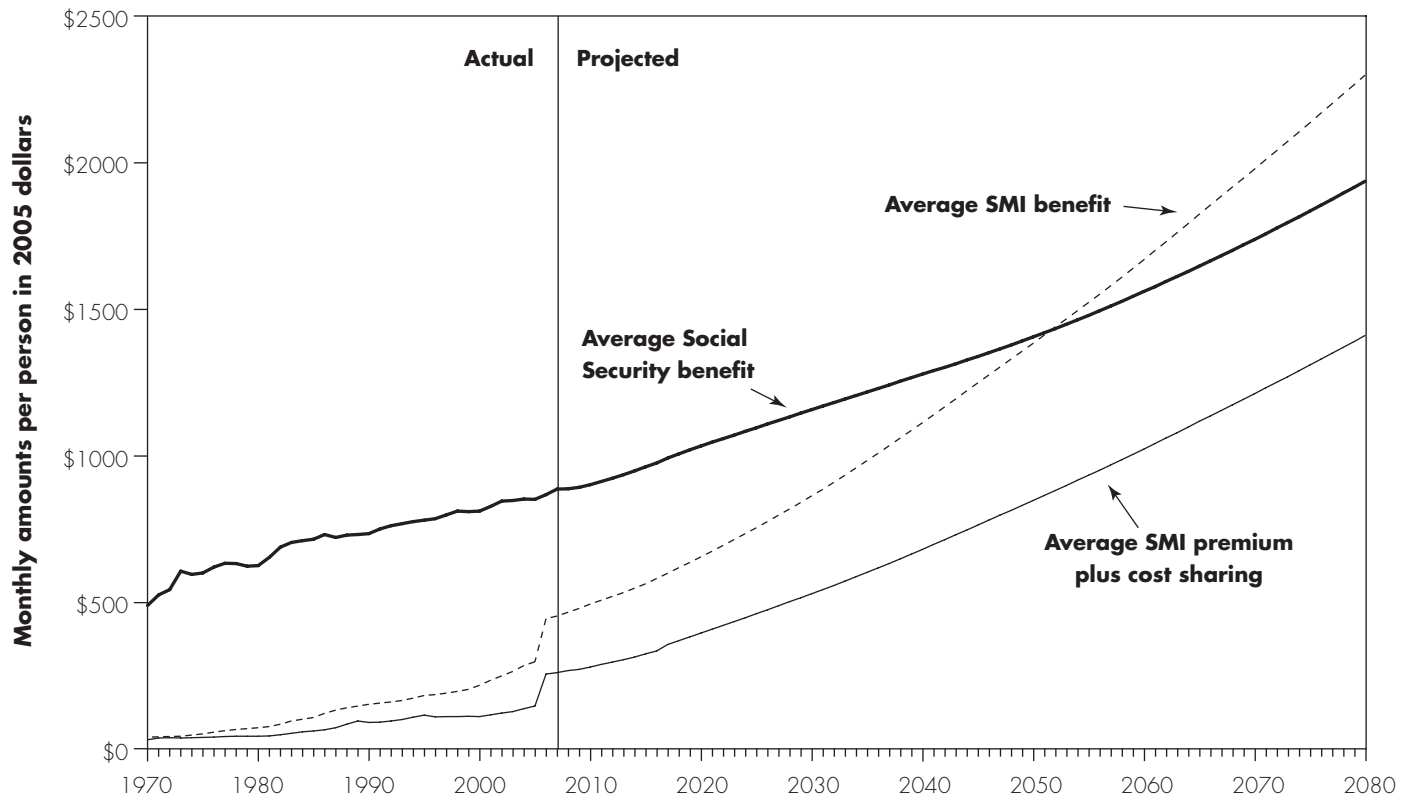
Early analysis of Part D suggests that more beneficiaries have prescription drug coverage but that drug costs remain a problem for some enrollees. The number of seniors without prescription drug coverage has dropped from 33 percent to 10 percent (Neumann et al. 2007). However, enrollees in stand-alone Part D plans may face higher costs than those in employer-sponsored plans or seniors with access to the drug benefit available from the Department of Veterans Affairs. Only 8.1 percent of enrollees in employer drug benefits reported not filling a prescription because of cost, while 15.6 percent of enrollees in Part D plans reported not filling a prescription for the same reason. The differences, however, may not be surprising because the standard Part D benefit includes a coverage gap that significantly increases beneficiary liability.<sup>7</sup> This coverage gap was included to lower the cost of the Part D benefit for the federal government, and consequently the design of the Part D benefit is less generous than a typical employer-sponsored plan (Moon 2006). Beneficiaries enrolled in the Part D LIS are not subject to the coverage gap and report lower rates of skipping prescriptions and lower out-of-pocket spending (see Chapter 4 for a discussion of the Medicare prescription drug benefit).

Even with the expansion of Medicare's benefits to include prescription drugs, growth in Medicare premiums and cost sharing will continue to absorb an increasing share of Social Security income. With the introduction of Part D, the average cost of SMI premiums and cost sharing for Part B and Part D absorbs about 30 percent of Social Security benefits.<sup>8</sup> However, this amount is likely to be less than what beneficiaries spent on premiums and cost sharing for Part B and prescription drugs before 2006. On balance, even though most beneficiaries get relief from out-of-pocket spending because of Part D, growth in health care spending eventually will outpace growth in Social Security benefits (Figure 1-3, p. 14). At the same time, Medicare's lack of a catastrophic cap on cost sharing



**FIGURE 1-3**

**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: 2007 annual report of the Boards of Trustees of the Medicare trust funds.

under Part A and Part B means that some beneficiaries could face extremely high out-of-pocket expenses.

Projections such as these highlight the importance of finding ways to slow growth in Medicare spending (Figure 1-4). If policymakers do not act quickly, Medicare's need for financing will place an increasing liability on beneficiaries through their premiums and cost sharing, crowd out resources for other federal priorities, and potentially affect the federal budget deficit, the level of federal taxation and debt, and economic growth.

### The broader U.S. health care system

Medicare is a very large program with projected expenditures of \$431 billion in 2007 (HHS 2007). Even

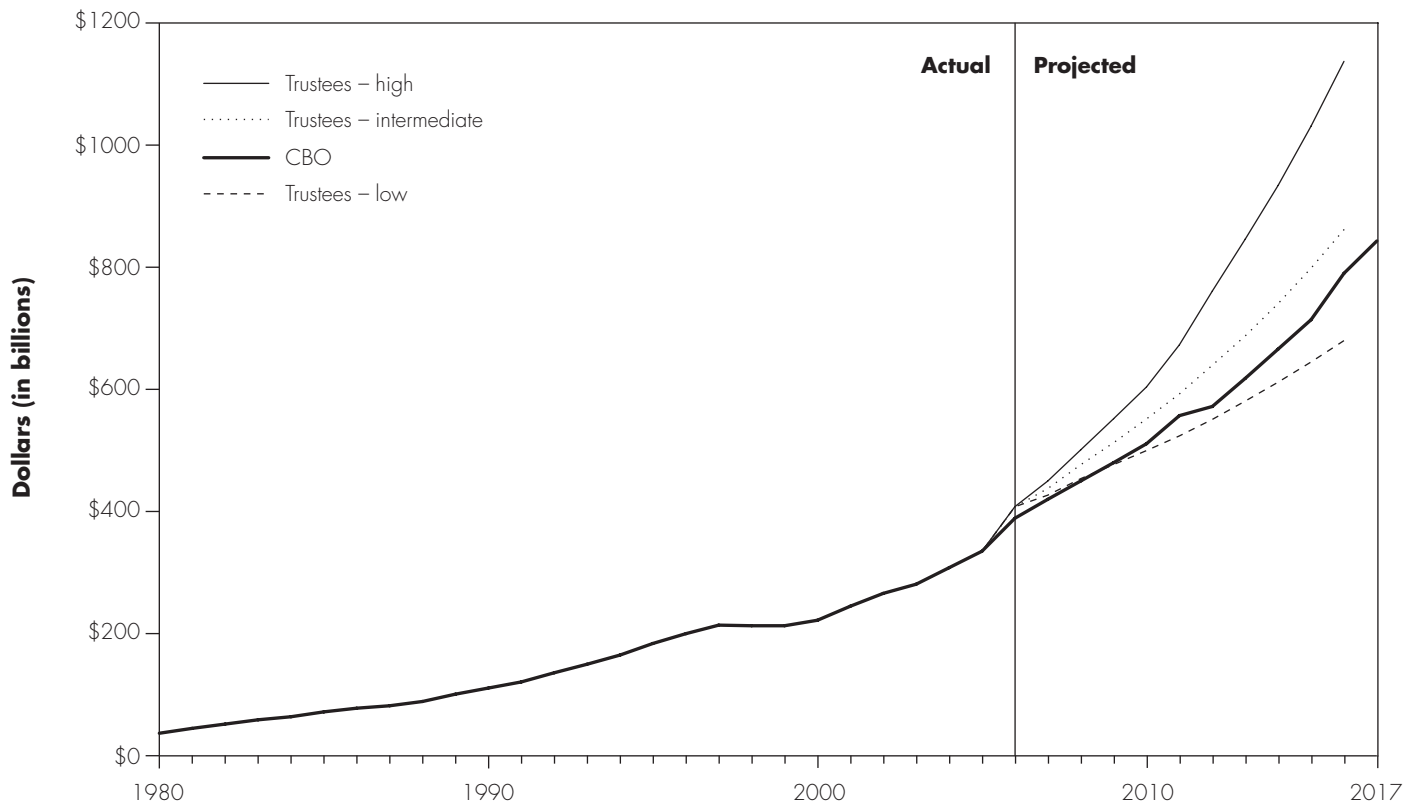
so, it is just one part of an expansive and growing U.S. health care system. That system includes a broad array of private and public purchasers, insurers, providers, manufacturers, and suppliers. Combined expenditures on health care services in the United States totaled nearly \$2.1 trillion in 2005, or 16 percent of our economy (Catlin et al. 2007) (Figure 1-5, p. 16).

### Private versus public financing in the U.S. health care system

Currently, public financing—federal, state, and local programs—makes up about 45 percent of all U.S. health care spending, with private sources providing the rest. The public share will rise by a few percentage points to nearly 50 percent by 2016 (Poisal et al. 2007). In 2004, employers were the largest source of health insurance,

**FIGURE  
1-4**

**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: 2007 annual report of the Boards of Trustees of the Medicare trust funds. CBO March 2007 baseline.

covering about 60 percent of individuals residing in the United States (Fronstin and Collins 2005).

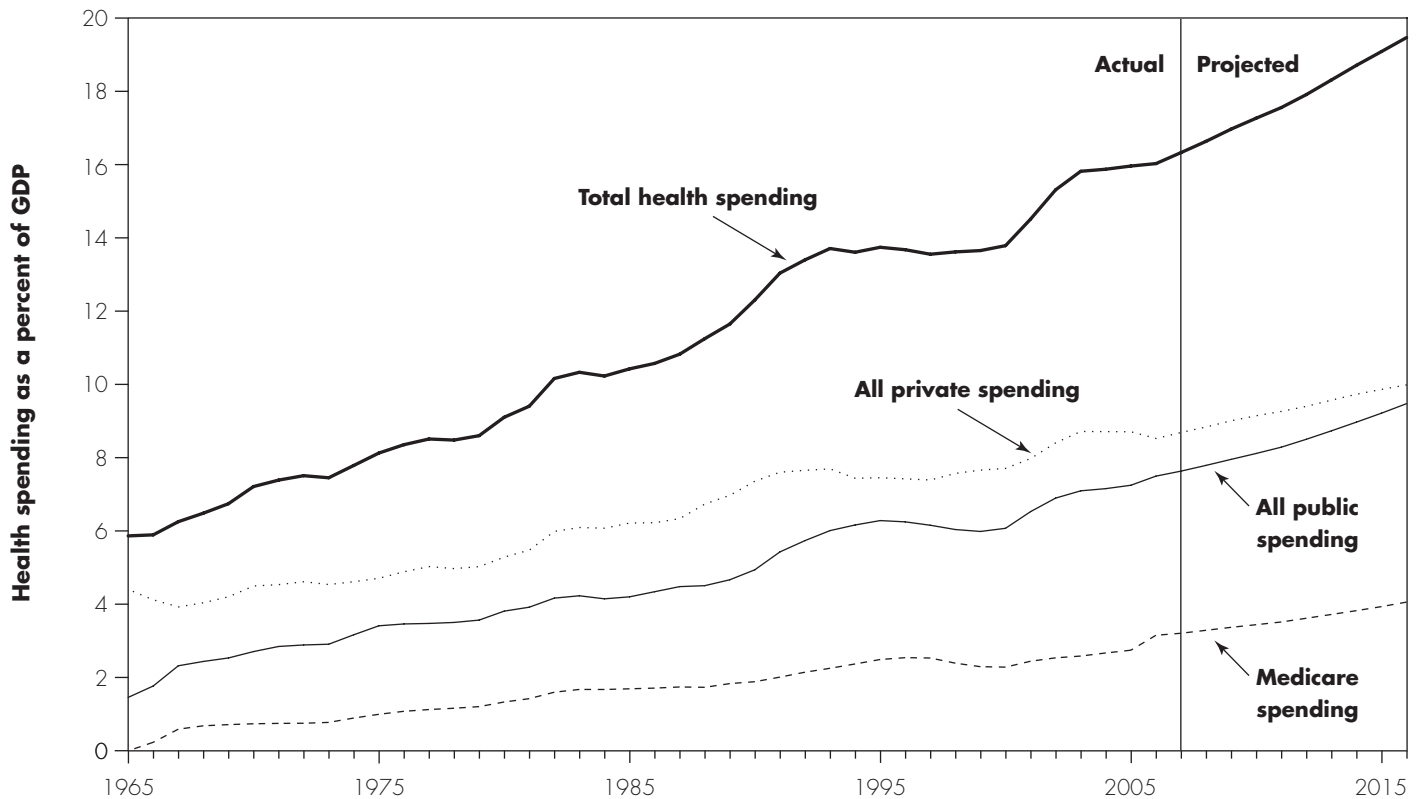
The United States uses private health insurance extensively because of the country's tax policies and economic history. During the World War II era, larger U.S. companies began offering health insurance to provide higher compensation to a relatively scarce labor force while avoiding wage and price controls. The federal government did not consider such fringe benefits subject to wage controls, and health insurance contributions paid by employers were not considered taxable income (Helms 2005). At the time, the health insurance industry was in its infancy. Since then, the use of employer-sponsored health insurance and the broader market for private insurance have grown substantially. For 2004, the exemption of employer-paid

health insurance from payroll and individual income taxes reduced federal revenues by about \$160 billion—about 6.6 percent of federal revenues (OMB 2007).

Some analysts believe that, if one considered the value of tax subsidies for employer-paid health insurance, the public share of health care spending would be closer to 60 percent (Woolhandler and Himmelstein 2002). A counterargument is that a wide variety of tax policies affect decisions about the mix of goods and services the country produces and consumes, yet generally we do not include the value of those tax subsidies in any of our national accounts.<sup>9</sup> The exemption of employer-paid health insurance from payroll and individual income taxes is one reason our nation uses private health insurance so extensively.

**FIGURE  
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, 2007.

### Higher spending in the United States

Health care spending in the United States is far higher than in other countries—about \$6,400 per person in 2005, or more than twice the median of member countries of the Organisation for Economic Co-operation and Development (OECD) (OECD 2007).<sup>10</sup> Though all industrialized nations have seen cost growth in excess of gross domestic product (GDP), there is some evidence that health care spending has grown faster in the United States than in other countries. One recent analysis suggests that this higher growth rate remains even after adjusting for changes in demographics and differences in the rate of growth in the economies of industrialized nations (White 2007). The increase in health care costs exceeded the annual growth in GDP by 2 percent for the United States in the period from 1970 to 2002, while excess growth

was only 1.1 percent for the other OECD nations. Several factors, such as differences in the availability of insurance and the structure of health financing, may account for these differences. However, the finding of excess growth may be sensitive to the way it is measured. As many countries continue to experience significant growth, it is not clear that this differential in growth rates will continue.

Another study found that the United States has higher spending even after adjusting for differences in wealth and disease prevalence (McKinsey Global Institute 2007). The analysis estimated how much the United States would have spent based on per capita income.<sup>11</sup> It found that the United States spent \$477 billion more, or \$1,645 per capita, even after accounting for the United States' higher per capita income. The increased incidence in disease accounted for only \$25 billion of the difference.



The remainder was attributable to higher utilization, higher input costs for labor and capital, and administrative and operational costs. The analysis suggests that the inefficiencies that increase costs are spread throughout the system, and any reform will require multiple strategies.

Other estimates have suggested that the rates of diagnosis and treatment (“rate of treated disease”) are much higher for many common conditions in the United States (Thorpe et al. 2007). For example, the rate of chronic lung disease among individuals age 50 or older in the United States is almost double that among the same age group in certain European countries. Among those with this diagnosis, almost twice as many individuals in the United States reported receiving medication associated with this condition compared with people in Europe. Thorpe concluded that if the United States had the same rate of treated disease for the studied conditions as the selected European countries, aggregate expenditures on health care in the United States would have been 13 percent to 19 percent lower in 2003. Thorpe did not examine how health outcomes varied for the selected conditions, but other analysts have found that the quality of care in the U.S. health care system often lags behind Europe (Davis and Schoen 2007).

Because the organizational structure of financing health care is more fragmented in the United States, providers may use their market power to negotiate more favorable payments and higher incomes than providers in other countries (Bodenheimer 2005). By being more monopsonistic or exerting regulatory power to a greater degree, other governments may lower or restrain growth in payment rates for providers and prices for other services. The tactics of those governments include using a single-purchaser approach, allowing multiple purchasers to bargain collectively, and using global budgets (Reinhardt et al. 2004).

The health care systems of other countries may not be clearly preferable to ours. A recent survey of patients in the United States and six other countries found that patient satisfaction and access to care varied, and no country clearly outperformed the others (Schoen et al. 2007). For example, the wait time for elective surgery was shortest in Germany and longest in the United Kingdom. However, more patients in Germany reported forgoing doctor visits for financial reasons. The United States ranked second after Germany in short wait times, but the share of patients opting to forgo care was nearly double that in Germany. Each health care system reflects the social, economic, and political circumstances of its country, and as a result

each system has a mixture of strengths and weaknesses. Comparison with other countries may provide useful information for benchmarking performance, but it is not clear that any one country’s system is preferable.

Some analysts believe the high levels of spending in U.S. health care are largely attributable to paying higher prices for the same services than other countries do, including higher administrative costs. Data from the mid-1990s suggest that U.S. physicians had considerably higher incomes than physicians in other OECD countries (Reinhardt et al. 2002). However, the United States has a wider distribution of compensation for all workers. For skilled health professionals, labor costs are higher because they would otherwise enter other fields that offer high compensation. The organizational structure of providers and the regulation of health services in other countries also affect salaries. Countries with public systems that provide care directly often contract with general practitioners at salaries negotiated centrally with physicians’ associations. Other countries make risk-adjusted, capitated payments to general practitioners for each patient they add to their list, thereby putting insurance risk on those physicians for the volume of care they provide. A few countries mix salary with capitated payments (Docteur and Oxley 2003).

### **Is higher spending worth it?**

Advances in medical technology have led, on average, to improvements in our health and gains in life expectancy. Recently, Cutler and colleagues concluded that, on average across all ages, increases in medical spending between 1960 and 2000 (attributed largely to advances in medical care) provided reasonably good value, with an average cost per life-year gained of \$19,900 (Cutler et al. 2006).

However, when focused on real spending adjusted for inflation and life expectancy for individuals age 65 or older, the same research found that the incremental cost of an additional year of life rose from \$46,800 in the 1970s to \$145,000 in the 1990s. These estimates suggest that the value of health care spending for the elderly has been decreasing, and the authors suggest that their estimates for the 1990s would fail many cost-benefit criteria.

More recent research suggests that survival gains have stagnated since 1996 for patients with acute myocardial infarction (AMI) (Skinner et al. 2006). Skinner and colleagues found that the survival rate for AMI has not improved since 1996, even though spending for patients with this condition has increased. These trends suggest that higher spending is not yielding better outcomes. These

authors also compared regional differences in spending for AMI and found that areas with higher spending did not have better health outcomes.

Research on the wide geographic variation in health care spending suggests that we waste resources (Fuchs 2005). Some payment systems contribute to the problem of wasteful spending by rewarding inefficient or low-quality care as much as—if not more than—high-quality care delivered by efficient providers. Given questions about Medicare’s sustainability, the Commission has called for distinguishing between high-quality care and care of more questionable value (MedPAC 2004b).

Despite spending more than other countries, the U.S. health care system does not consistently deliver higher quality care (Schoen et al. 2006). For example, the United States has a higher death rate for diseases that are amenable to medical care than the three leading industrialized nations. The United States also had a higher rate of medical errors than other industrialized countries. This disparity between spending and quality raises questions about the value for patients and health care payers of the higher level of spending in the United States.

### **Rapid growth in health care spending among all payers**

For each of the past several decades, the United States has spent an expanding share of its resources on health care. In 1960, for example, national health expenditures made up about 5 percent of the GDP by 2005. That share grew to 16 percent, and CMS projects that it will make up 19.6 percent by 2016 (Figure 1-5, p. 16) (Poissal et al. 2007). All payers in the U.S. health care system—public (including Medicare and Medicaid) and private—are facing similar upward pressures on spending.

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 (Pauly 2003). When comparing spending for benefits that private insurance and Medicare have in common—notably excluding prescription drugs—Medicare’s per enrollee spending grew at a rate about 1 percentage point lower than that for private insurance from 1970 to 2002. However, the comparison is sensitive to the endpoints of time one uses for calculating average growth rates (Figure 1-6). Differences have been more pronounced since 1985, when Medicare began introducing the prospective payment system for hospital inpatient services (Levit et al. 2004). Some analysts believe that, since the mid-1980s,

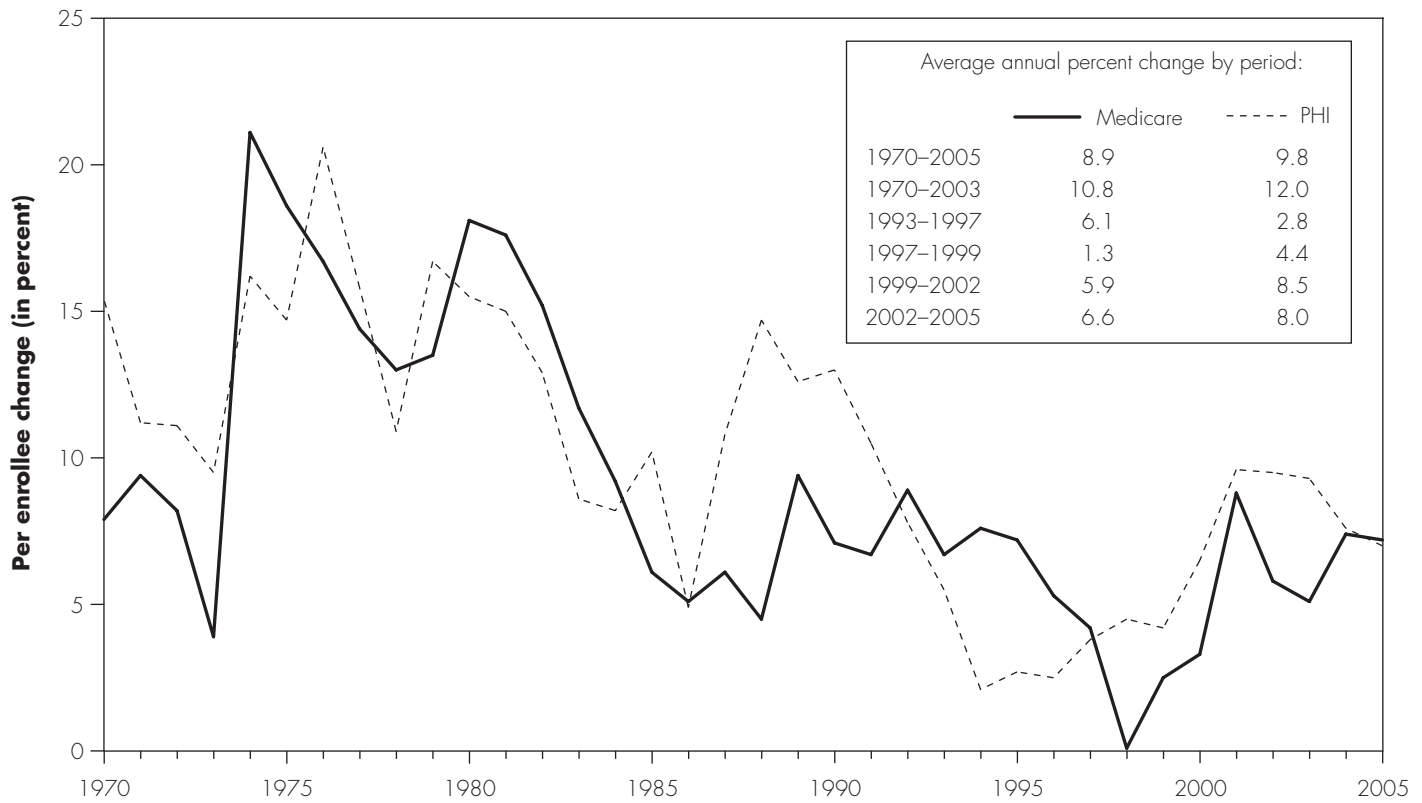
Medicare—with its larger purchasing power—has had greater success than private payers at containing cost growth (Boccuti and Moon 2003). Others maintain that benefits offered by private insurers have expanded as cost-sharing requirements declined over the entire period and enrollment in managed care plans grew during the 1990s. The comparison is thus problematic, since Medicare’s benefits changed little over the same period (Antos and King 2003).

Although often disputed by economists, many analysts contend that certain health care sectors are able to shift costs by charging some payers higher prices to compensate for changes in the administered prices of other payers. Many hospital and other health industry executives are convinced that limits on Medicare and Medicaid payment rates lead to higher prices for private payers (Ginsburg 2003). Cost shifting could occur only when providers have sufficient market power to raise their prices. If such a phenomenon occurs, it underscores the need for public and private payers to collaborate with one another on payment policy, since both sets of payers face similar upward pressures on spending in the long term.

### **Drivers of growth in health spending**

One main driver of growth in spending is growth in income. Some analysts believe that, as our country’s standard of living grows, we should expect to spend more on health care (Hall and Jones 2007). As individuals become better off and their consumption increases, the incremental value of buying more commodities (e.g., another television or more clothing) falls. By contrast, the marginal value to them of an extended life span does not diminish as quickly. Similarly, the marginal value of procedures that are not life saving but that may improve the quality of life (e.g., joint replacements or cosmetic surgery) may increase relative to other goods. Hall and Jones suggested that, because of our underlying preferences, it is reasonable to expect health care spending to reach 30 percent of GDP by the middle of this century.

Many analysts point to the rates of development and diffusion of new technologies as another major driver of growth in health care spending (Fuchs 2005, Newhouse 1992). Many technologies reduce the invasiveness, serious side effects, discomfort, or recovery time associated with the therapies they replace, thereby lowering nonmonetary obstacles to beneficiaries as they decide whether to seek treatment. When procedures, drugs, or devices become available, a base of evidence may not exist to help providers decide how newer therapies compare with older

**FIGURE  
1-6****Changes in spending per enrollee for Medicare and private health insurance**

Note: PHI (private health insurance). This figure 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, 2007.

ones. When providers recommend newer therapies that are covered by Medicare or other insurance, patients do not face the full cost of their care and may not be concerned about the comparative value of those therapies. Although some medical technologies lead to savings by reducing lengths of hospital stays or avoiding hospitalizations, most technologies tend to expand the demand for health care and increase spending. In some cases, providers may use new technologies inappropriately or more broadly than intended.

This uncertainty about the efficacy of new technology is compounded under fee-for-service payment systems. Because these payment systems tie reimbursement to the volume of services provided, new technologies can create opportunities for providers to increase their volume and revenues. Many of the additional services may be beneficial, but fee-for-service payment encourages

providers to pursue the technologies that result in higher volume and payment regardless of value. This can bolster the “arms race” mentality that providers must pursue the latest technologies to remain financially successful relative to their peers (Berenson et al. 2006). Under alternative systems, such as capitation or value-based approaches that tie payments to a measure of a procedure’s clinical efficacy, the rewards for additional volume are diminished. Providers under these systems would have less financial incentive to pursue the volume opportunities associated with new technology.

Research highlights the important role of health insurance in fueling growth in spending. Finkelstein found that Medicare had a much more pronounced effect on hospital spending than estimates of insurance effects on an individual’s behavior would suggest (Finkelstein 2007). According to Finkelstein, the broad increase in

demand for hospital services that occurred after the start of Medicare led to greater incentives for hospitals to enter markets, purchase new equipment and facilities, and adopt new practice styles. Extrapolating from her Medicare findings, she suggested that about half of the increase in per capita health spending between 1950 and 1990 could be attributable to the spread of health insurance. Other analysts have noted that small changes in assumptions behind Finkelstein's extrapolation to all health care spending would lead to much smaller effects (Ellis 2006).

Our nation's underlying health status and changes in clinical treatment thresholds also affect spending. Recent work by Thorpe and Howard suggests that, between 1987 and 2002, nearly all the growth in health care spending for Medicare beneficiaries can be attributed to patients being treated for five or more conditions (Thorpe and Howard 2006). In 2002, about 50 percent of all Medicare beneficiaries were being treated for five or more conditions, compared with about 31 percent of beneficiaries in 1987. At the same time, a larger proportion of patients being treated for five or more conditions reported that they were in excellent or good health—60 percent in 2002 compared with 33 percent in 1987. The authors concluded that medical professionals are treating healthier patients, treatments are improving health outcomes, or both are occurring.

Thorpe and Howard also suggest that the rising prevalence of obesity plays a part in the increased number of beneficiaries with multiple comorbidities. Obesity in the elderly is associated with increased risk of diabetes mellitus, cardiovascular disease, hypertension, stroke, lipid abnormalities, osteoarthritis, and some cancers. The prevalence of obesity doubled among Medicare beneficiaries between 1987 and 2002 (reaching 23 percent), and obese individuals accounted for 25 percent of spending in 2002. While the share of spending for the obese is approximately proportional to their share of the population, 90 percent of the spending for the obese in 2002 was attributable to the 14 percent of beneficiaries with five or more comorbidities. To the extent that obesity has contributed to an increase in the number of beneficiaries with multiple comorbidities, the rise in obesity has increased Medicare spending. Higher weight, however, does not necessarily result in higher Medicare costs. Medicare beneficiaries who are classified as overweight but not obese have lower spending than obese individuals and have longer life expectancy relative to those in other weight classifications.

Medicare spending is concentrated among relatively few beneficiaries, but some evidence suggests that the concentration has fallen. For example, the most costly 1 percent of beneficiaries accounted for 15.5 percent of Medicare expenditures in 2004. However, recent analysis of long-term per beneficiary spending trends has found that the concentration of spending for Medicare beneficiaries has fallen (Riley 2007). In 1975, the top 5 percent of beneficiaries accounted for 54 percent of spending, while in 2002 they accounted for 43 percent of spending. The trend suggests higher treatment intensities for a broader range of patients. The balance of spending among services has also changed over time for all beneficiaries, not just the most costly. For example, in 1975 hospital services accounted for about 69 percent of the annual expenditures for a beneficiary. In 2004, hospital expenditures fell to 43 percent of annual spending, while the share for physician and outpatient services increased. Despite these changes, significant concentration does remain, and hospital services are still the largest single category of expenditures. However, the rise in spending for less costly beneficiaries and the growth in nonhospital spending suggest that improving the efficiency of health care delivery will require interventions that consider multiple categories of services and consider the changing concentration of beneficiary spending.

Recent years have also seen the consolidation of health care providers and health plans. These consolidations may result in new efficiencies that lower costs, but they can also lead to lower quality and higher prices (Vogt and Town 2006). The concern is that the primary motivation for much of this consolidation is to capture more market share and to leverage this market share for more favorable payments. Similarly, insurers seek market share to push providers for lower rates. This consolidation has resulted in some markets being served by a few dominant plans and providers, and depending on the characteristics of the local market it can sometimes result in cooperation to achieve system improvements (Ginsburg and Lesser 2006). In markets where collaboration takes place, consolidation may unify local delivery systems around common goals such as improving quality. However, markets with few plans and providers may lack sufficient competition to spur needed improvements in efficiency and innovation. Some analysts have found that providers do not compete on price and efficiency in many markets; instead, they compete to increase their market share of the most profitable business lines (Berenson et al. 2006). This can lead to an increase in the supply and volume of medical



services, but this type of competition does not necessarily address quality or efficiency concerns.

### **Consequences of rapid growth in health spending**

Rapid growth in health spending has wide-ranging effects. The U.S. health care sector has produced many medical innovations that lengthen or improve the quality of life. At the same time, some employers argue that the rising cost of health care premiums affects their ability to compete in the world marketplace. However, most economists contend that growth in health premiums paid by employers has no long-term effect on the competitive position of firms (Fuchs 2005). Instead, a firm's costs for health premiums substitute for cash compensation that it would otherwise pay to workers, in the same way that retirement and other benefits substitute for higher wages. Long-term contracts with workers may prevent some firms from keeping their full compensation package in line with their productivity. As would be the case with any other cost, rapid growth in health premiums can make apparent firms' need for greater productivity. To achieve productivity gains quickly, firms sometimes take disruptive steps and redistribute income and health coverage for workers and retirees.

Other distributional issues arise from rapid growth in spending on health care. In response to rapid increases in premiums, many employers have raised cost-sharing requirements for their employees, asked them to pay a larger share of premiums, or—particularly for smaller firms—reduced the availability of coverage. The percentage of nonelderly individuals with employer-based health insurance fell from 67 percent in 2000 to 62 percent in 2005, which analysts attribute to the rising cost of providing health benefits (Fronstin 2006). Since required premium contributions by enrollees have risen faster than income, some workers choose to forgo coverage (Ginsburg 2004). During 2006, nearly 47 million people, or 15.8 percent of the U.S. population, were uninsured at some point in time (DeNavas-Walt et al. 2007).

Increases in the numbers of people without private health insurance raise demand for public coverage. In addition, those who cannot secure coverage may receive uncompensated care, and providers may seek higher payments for insured patients to cover losses. The costs of caring for the uninsured do not fall equally on all providers, since the uninsured often postpone care until their condition becomes more serious. In turn, providers that bear more of those costs sometimes seek public

subsidies or limits on the competition they face. Rising costs put upward pressure on the financing needs of public and private health care programs for the beneficiaries who already have coverage. Some analysts believe that higher health care costs may also lead to greater fragmentation of risk pools in the health care market, as healthier people search for insurance alternatives that are less costly (Glied 2003).

New insurance products have emerged in response to rapid growth in spending on health care. Employers are beginning to offer health plans that combine a health reimbursement or savings account with a high-deductible insurance policy. Although more employers are beginning to offer these products to their workers, thus far enrollment is low.<sup>12</sup> Enrollees in these newer products generally accept higher cost sharing at the point of service. The intent is to make them more cost conscious when they seek care. In return, they pay lower premiums (Tollen et al. 2004). The law allows employers to make nontaxable contributions to certain health savings accounts (HSAs), and contributions by individual account holders are tax deductible. Current Medicare beneficiaries cannot establish HSAs, but as individuals enroll in Medicare, they may use tax-free distributions from existing HSAs to pay for Medicare premiums or the retiree share of premiums for employment-based retiree health insurance. Medicare beneficiaries may use a similar type of product if they choose: medical savings accounts, a type of high-deductible plan that is combined with a savings account offered by several private organizations within Medicare Advantage.

A recent review of the literature on high-deductible plans suggested that the current evidence on the effectiveness of such plans is mixed (Beeuwkes Buntin et al. 2006). Individuals who selected such plans were often more wealthy and healthier than beneficiaries who opted for other products in the selected studies (GAO 2006, Fronstin and Collins 2005). Enrollees generally had lower costs and lower cost growth, but Beeuwkes Buntin cautioned that further study of this issue with more robust methods is necessary. The results for the effect of such plans on quality of care were mixed. Some studies have found that beneficiaries receive more of certain preventive procedures and are better about following medication regimes (Downey 2004, Humana 2005). Other studies have found that the cost consciousness that plans emphasize led enrollees to forgo care for less serious conditions and skip some medical visits (Agrawal et al. 2005, Davis et al. 2005). It may be too early

to draw conclusions about the prospects for these plans. Beeuwkes Buntin and colleagues noted that the current literature reflects that the experience of “early adopters” is limited to a few case studies and needs more rigorous analysis of the population differences.

Addressing the quality and efficiency challenges will require a robust long-term effort, and reaching agreement

on reform will likely prove challenging. Adding to the challenge, social, economic, and technological changes will continue to alter the health care system. Long-term success will require continuous intervention that adapts to future changes in the financing and delivery of care. However, even small improvements in productivity could yield significant gains for payers. ■

## Endnotes

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- 1 As Robert Myers, the Social Security Administration's Chief Actuary in 1965, put it, designing a two-part program resulted from a "legislative process [that] was a matter of political compromise and was not by any means dictated by actuarial principles" (Myers 2000).
- 2 Aside from the direct method of increasing the payroll tax rate, a number of changes over the years have increased revenue to the HI trust fund. Certain employment groups were not included in the Social Security system and were added, expanding the payroll tax base. For example, self-employed physicians were not covered under Social Security until 1965. State and local government employees and federal civil servants were also excluded from the set of workers covered under Social Security (and therefore were not paying HI payroll taxes) until the 1980s. While the Social Security portion of the payroll tax has an upper limit of yearly earnings that are taxable (\$97,500 for 2007, having gradually increased from the 1966 level of \$6,600), the upper limit on HI contributions was removed in 1994 so that all earnings are subject to the HI tax. The age of Medicare entitlement for the nondisabled remains 65, but raising the "normal retirement" for Social Security—the age at which beneficiaries can receive unreduced retirement benefits—also increases the pool of workers contributing to the HI trust fund to the extent that individuals 62 or older continue to work. Provisions that make Medicare the secondary payer in relation to other insurers have also reduced expenditures for Medicare. An additional source of funds for Medicare is the income tax on Social Security benefits that is designated for the HI trust fund.
- 3 In 2004, 200 percent of the federal poverty level equals about \$18,000 for individuals and \$22,000 for married couples.
- 4 One exception is funding for the HI trust fund. CBO assumed that Medicare would continue to pay all benefits due for Part A, even after the trust fund becomes insolvent in 2019.
- 5 Individuals with modified adjusted gross incomes (MAGIs) of \$82,000 or more and married couples with MAGIs of \$164,000 or more will receive less than the 75 percent subsidy that all other Part B enrollees receive. CMS is phasing in higher premiums over a three-year period. By the end of that time, higher income individuals will pay monthly premiums equal to 35 percent, 50 percent, 65 percent, or 80 percent of Medicare's average Part B costs for aged beneficiaries, depending on their income. All other individuals pay premiums equal to 25 percent of average costs for aged beneficiaries. Whether higher premiums will affect beneficiaries' willingness to remain enrolled in Part B remains to be seen.
- 6 Social Security recipients received a 3.3 percent increase for 2007.
- 7 The standard Part D benefit for 2007 includes a \$265 deductible and 25 percent coinsurance up to \$2,400 in total drug costs, followed by the coverage gap where enrollees pay 100 percent of drug costs until they have \$5,451 in total drug costs (\$3,850 from their own pocket). Beyond this level, Medicare pays 95 percent of drug costs and the enrollee pays 5 percent. Many Part D plans offer benefits that vary from the standard benefit, but all Part D plans must be actuarially equivalent to the standard benefit, and most plans include a coverage gap (Kaiser Family Foundation 2007).
- 8 Medical insurance premiums and cost sharing will make up a lower percentage—just under 20 percent—for those beneficiaries who do not enroll in Part D.
- 9 For example, when calculating how much we spend on children, we would not include the value of personal exemptions from individual income tax for dependent minors.
- 10 Dollar amounts are adjusted for purchasing power parity—differences in the cost of living across countries—by comparing prices for a fixed basket of goods. OECD's adjustment is a broad-based basket, not one specific to health costs.
- 11 The model uses data from OECD countries to estimate the predicted relationship between per capita income and per capita health care consumption. The authors then compare the estimated health care spending for the United States based on the model with actual health care spending and arrive at a variance of \$477 billion between actual and predicted spending.
- 12 In 2005, about 10 percent of privately insured, nonelderly adults were enrolled in high-deductible health plans (Fronstin and Collins 2005). Nevertheless, such plans have attracted considerable attention. Supporters believe that higher cost sharing will lead members to lower their use of unnecessary services, thereby slowing growth in health spending. Other analysts expect that this new type of product will encourage risk segmentation, since healthier enrollees might find lower premiums attractive while sicker individuals would likely stay with more comprehensive coverage. A recent review of the literature on these products suggests that, at this early stage, the evidence is not sufficient to draw firm conclusions. Nevertheless, early studies show modest favorable selection into consumer-directed health plans, some evidence that such plans may help lower costs and cost increases, and mixed effects on quality with evidence of both appropriate and inappropriate changes in use of services (Beeuwkes Buntin et al. 2006).

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