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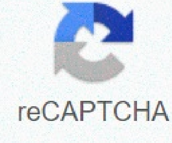

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Aspe issue, a brief May 2005 printer-friendly version in PDF format. As the population of the United States ages, it consumes more health care. Older people suffer from diseases and other medical problems at a greater level than young people, and with healthcare prices still rising faster than other goods and services. As public programs finance the majority of elderly health care over time, there will be increased pressure on the federal and state budgets, and long-term strains on public funds will put pressure on tax rates. On the other hand, it could allow legislators to re-examine the coverage commitments they have made through federal and state health care programs. Whatever the outcome of the competing pressures, the steps to assess health care price growth and increase efficiency and effectiveness of healthcare deliveries are essential to scrutinize the economic burden that future health care costs are likely to impose. Total spending 166 730 1,679 per capita 891 3,019 5,670 GDP 5.1% 10.1% 15.3% Source: National Health Care, Medicare and Medicare Centers, Actuary Office, National Health Statistics Group, U.S. Department of Commerce, Bureau of Economic Analysis and U.S. Census Bureau * Adjusted for changes in the consumer price index for all urban consumers, all items the country spends on medical care have been on the upward path steadily for decades. In 2003, the figure was nearly $1.7 trillion, up 63 times, in contrast to the U.S. population growing only 51 percent, up from $1 per person. In 2003, a 40-fold increase in general inflation pushed prices of goods and services into the economy five-fold. The overall economic outlook for growth is equally impressive, with the share of the economy devoted to healthcare increasing from about 5 percent of gross domestic product (GDP) in 1960 to more than 15 percent in 1960. 2003[1] Inflation and increase in healthcare prices 1960-2003 1990-2003 (price increases) General inflation 515% 41% overall medical care 1,232% 82% medical services 1,469% 88% Source: All Consumer Consumer Price Index, Loc. Health care consumption by the elderly is larger than the rest of the population. The overall population is at $3,834 for a population under the age of 65, it is $2,793 for a population 65 and older, it is $11,089, or nearly four times as high. Even in an ageing population, differences are important. For those aged 65 to 74, there was only $8,167, compared with $20,001 for those aged 85 and over; 87 percent of Medicare enrollees aged 65 and over comprised 14.5 percent of the total population that year, but they accounted for 37 percent of the nation's personal health care costs. For two million recipients living in a full-time nursing home (three-quarters of those aged 75 and over), the cost per capita is $44,520 among recipients aged 85 and over, 22 per cent living in nursing homes. Individuals aged 85 and over comprised 1.6 percent of the population in 1999, but they accounted for more than 8 percent of the nation's personal health care spending. Health care spending per capita by the elderly compared to the rest of the population, 1999 Age grouping per Capita personal health care spend ages $3,834 under 65 2,793 65 and older 11,089 19-44 2,70 6 45-54 3,713 55-64 5,590 65-74 8,167 75-84 12,244 85 and older than 2001 Source: Age estimate in National Health Account Sean P. Kihan, Helen C. Lazenby, Mark A. Zezza and Aaron C. Catlin review health care funding December 2, 2004. 5 percent of users, up to 10 percent of users, 12.8 percent, 35.9% 53.8%Source: Current Medicare Beneficiary Survey, loc. While the average cost by age group shows the impact of higher age on health care consumption, they do not show the concentration of health care use within the aging population. In any year, many medical care costs tend to be incurred by a relatively small group of people. In 1999, 1 percent of Medicare enrollees aged 65 and over incurred 13 percent of the group's health care costs, the top 10 percent with the highest cost incurred at 54 percent. The importance of that concentration is not only that the national health care costs will increase as the number of older people increases, those costs are expanded as the population has increased as the highest incidence of health care costs increases as a share of the population. This covers personal health care, construction research, consumables and other related costs. They cover 44 percent of the spending made for personal health care, including care. Enthusiastic soldiers and veterans Over the past half-century, government agencies have increasingly assumed a role to meet the nation's health care needs. By 1960, they funded 25 percent of overall national health costs, with the advent of Medicare and Medicare in 1965, the government's share rose sharply to 38 percent in 1970, and continued to rise after that to 46 percent in 2003, replacing the federal and state governments and private funding of national health costs. 1960 1970 1980 1990 2003 (percent) public funds 25 38 43 41 46 private funds 75 62 57 59 54 Source: National Health Expenditure, cit. The largest personal health care funding source currently comes from private insurance, which refurbished 36 percent of the funding for those costs in 2003, spending 16 percent off-pocket, making it the next biggest private source. Medicare and the federal share of Medicaid comprise a lot of federal support. The state's share of Medicaid is the largest component furnished by state and local governments. Sources of funding of personal health care, 1960 and 2003 1960 2003 percent funded by: Private Insurance 21 36 out of pocket 55 16 Medicare --- 19 Medicaid * --- 17 other private sectors 2 4 other Federal 9 4 states and 13 localities: National health costs, loc* Among those sources, the federal component grew the most over the last four decades, rising from 9 percent of personal health care spending in 1960 to 33 percent in 2003, although Medicaids formed in 1966 significantly raised federal spending on medical care for the poor, the share of personal health care spending on medical care for the poor financed by the state and local (which included their matching funds for Medicaid) actually slipped slightly over the last four decades, Their share dropped from 13 percent in 1960 to 11 percent in 2002. It's important to note that while private sources still seem to be financing most of the nation's health costs at 54 percent in 2003, the figure conceals indirect support that federal and state and local governments provide through tax settings for health care, more than $100 billion in so-called tax expenditures for health care incurred by the federal government alone in 2003. If the alleged tax receipts are taken into account, most of the country's health spending is more than 60 percent directly. By federal and state and local governments in 2003 or indirectly funded through tax provisions. With the growth of public programs and private insurance over the last four decades, the role of direct payments between individuals and healthcare providers has changed dramatically. In 2003, only 16 percent of personal health care spending was covered out of pocket, making third parties a dominant method of medical financing in the United States. Although many factors are thought to contribute to increasing medical costs, the expansion of third-party payers (whether government or private) may have less incentive for individuals to charge about consuming their medical services. The importance of the government's source of medical funding for personal health care funding for the Medicare and NonMedicare populations, 2000 Medicare populations, non-Medicare percentage funded by: Medicare 52.3 --- Medicaid 12.2 19.2 Private Insurance 12.2 47.7 out of pocket 19.4 15.8 others * 3.9 17.3 Source: Medicare Medicare The current survey, loc. cit. * consists of a mix of comparing government and private funding sources for medical care of the Medicare population and non-Medicare. This reflects how important public funding has become for the elderly. Public funds were directly funded for less than half of the country's health costs in 2000, but as well as the elderly received a lot of support. About two-thirds of their health care costs are funded by public programs, and more than half come from Medicare. Age dependency on public health care programs has changed dramatically over the last half century, especially since Medicare coverage did not exist before 1966, but even since the advent of Medicare, the public role has grown, as described by the Medicare chief actuary program for populations aged 65 or over, In the 1997 calendar year, this percentage increased to 55 percent, with the majority of the balance covered by Medicaid, private health insurance and out-of-pocket payments of Medicare beneficiaries as part of the deductible, which stood at $50 in 1968 and increased only three times since it was currently $100. In 1968, only 38 percent of beneficiaries had b-section costs beyond deductibles, but in 1997 this proportion increased to 87 percent. In contrast, in some years, some un coverage costs for prescription and long-term nursing home care increased more rapidly than general health costs, thereby increasing the portion supported by non-Medicare sources. Acting chief also identified The relatively small reduction in Medicaid costs as a percentage of total personal health care costs for beneficiaries over the age of 65, the proportion of seniors with incomes below the poverty threshold (those who are likely to be eligible for Medicaid) fell from about 16 percent in 1966 to 11 percent in 1997. In addition, during this time, Medicaid absorbs a significant portion of the rapidly rising costs for nursing home care. The proportion of the cost of providing health care services paid directly by beneficiaries has fallen significantly since the start of the program, from about 28 percent in 1968 to 20 percent today. The change is due to increased share, covered by Medicare and private health insurance. [6] The source of funding for personal health care costs for individuals 65 or more 1968 and 1997 fiscal year 1968, fiscal year 1968% from: Medicare 42% 55% Medicaid 14% Other 11% Other 11% 3% out of pocket 28% 20% Private health insurance 5% 11% Source: Medicare and financial status trends, 1966-2000, Richard S. Foster, In 2003, the Congressional Budget Office reported that the growth of national health spending during the 1970s to 2001 exceeded gross domestic product growth by 2.5 percentage points per year. However, Medicare grew at a rate of 3 percentage points over comparable periods. Medicaid grows at a rate of 2.7 percentage points more. A view on the future Social Security and Medicare care programs has increased dramatically in the age share of the population in recent decades. In cases where people aged 65 and over account for 12 percent of the current overall population, they will represent 18 percent in 2025. Solely the effect of creating a baby boom after World War II reached the advanced years. Significant improvements in longevity and a decline in the national birth rate over the past 30 years are expected to lead to a further increase in the age proportion of the population after the passing of baby boomers. It is expected to increase the ageing population 2005 2025 2045 2065 2080 number age 37 million 62 million 79 million 89 million shares 96 million shares Population 12% 18% 21% 22% 23% Source:2005 Annual Report of the Board of Directors of the Federation of Elderly and Survivors Insurance and Disability Trust Funds, Washington, D.C., March 23, 2005 For Medicare, these escalating demographic groups mean more people will be eligible for coverage each year, and each new enrollee will receive benefits for a longer period of their lives. As for Medicaid, they mean more people are required to have and are eligible for nursing homes and related institutional care. For both the program and the federal government in general, they mean a declining proportion of the population will be in the core working age band of 20 to 65, where the government's tax base is largely emanating from the growing mix of demographic trends, namely uncertainty, but still flexibility in prices and the use of medical care. To the extent that they can continue to grow at these rates is uncertain. Decreased birth rate and increased life expectancy, 1965-2080 (actual and predicted) 1965 2005 2045 2080 Born to a woman in her life 2.88 2.02 1.95 1.95 Life expectancy at age 65 years: --The average age of death for men 78.5 82.0 84.4 86.1 -Average age of death for women 83.0 84.7 87.0 88.7 Source: 2005 Social Security Administrator Report, <a0> </a0 cit of comparing Medicare growth and gross domestic product 1970-2003 average annual growth in Medicare Medicaid GDP percentage 1970-2003 6.3 9.4 8.8 * 1980-2546 5.0 7.4 7.0. 1 1990-2003 3.8 5.6 6.0 CBO long-term budget trends *For the period 1975-2003, growth of higher national health costs and Medicare and Medicaid narrowed in the latter part of the 1970-2003 period (less than Medicare). Acknowledging this trend, Medicare administrators in their so-called mid-term forecasts have assumed that further enrollment costs for Medicare will grow at an optimal rate 1 percentage point faster than gross domestic product. This is lower than experienced during the 1990-2003 period, but still more than experienced by the economy in general. The narrowing difference between the growth of national health expenditures and the growth of gross domestic product, where national health expenditure exceeds GDP growth (percent) 1960-2001 2.5 1970-2001 2.3 1980-2001 2.3 1990-2001 1.5 long-term source:CBO loc, cit. With their demographic view, the Medicare trustees program on Medicare costs could rise from 2.7 percent of gross domestic product today to 9.6 percent in 2050 and up to 13.9 percent in 2080 under similar assumptions, the Congressional Budget Office program that Medicare and Medicaid combined could rise to 11.5 percent of gross domestic product in 2050. While recognizing the great uncertainty surrounding their forecasts, Medicare administrators say their forecasts continue to demonstrate the need to act seamlessly and effectively to address medicare's financial problems, both the long-term financial imbalances facing HI [hospital insurance]. Trust funds and higher problems of rapid growth of costs. [10] The sooner the solution is enforced, the more flexible and gradually it becomes. Health insurance premiums rose sharply, with one report, in 2002, health insurance premiums rising at a rate eight times faster than conventional inflation; experiencing the biggest one-year premium increase in more than a decade. A survey by the Kaiser Family Foundation found that premiums charged for work-based health insurance rose 11.2 percent in 2003, higher than the previous growth rate. All types of health plans, including HMOs, PPOs and POSs, represent a double-digit cost increase. Kaiser reported that premiums paid by employers for employee family coverage rose from an average of $6,438 in 2000 to $9,086 in 2003, and the average number of workers paid to those premiums rose by nearly 50 percent from an average of $1,619 in 2000 to $2,412 in 2003. Workers may be expected to shoulder more of their medical bills directly either by having to pay a greater share of the employer's wages or by having to demand increased cost sharing. Premium hikes for Medicare benefits (i.e. now required for non-hospital services and drug coverage) and for Medicare-supplemented health insurance policies (such as Medigap policies) are likely to have a similar effect to seniors. A large premium increase could lead policymakers to impose higher medical or coin deductibles and could lead recipients to seek more expensive coverage with higher cost-sharing requirements. When such out-of-pocket costs are affected, medical price inhibition is uncertain. What's more, when they emerge, policymakers can step in and want the government to assume an even greater burden. However, the tension between the government's additional absorption of out-of-pocket costs and the government's budget is growing stronger as the costs included in public programs increase. Continued increase in The bill has promoted calls for fundamental changes to the nation's health care system. Some advocate more government intervention to control prices and take advantage directly or indirectly. Others believe that more free market competition to insure those costs is the most likely route. Others believe that medical technology and innovation, supporting a more healthy lifestyle, promoting increased case management approaches and making it more commonly used to disseminate effective medical advances and document labyrinths for treatment and services will make the healthcare system much less costly. Given the uncertainty, it is likely that the combination of various major policy prescriptions will evolve and be used as cost pressures, both public and private, extended in recent years. Trends in MCBS, 1992-2000, Medicare and Medicare Centers. See the current Medicare beneficiary survey, Centers for Medicare and Medicaid Centers, and Americans older than 2000: Key indicators of well-being, an inter-federal forum on age-related statistics. Trends in MCBS, 1992-2000, loc. cit. [5]Long-term budget trends, congressional budget office, December 2003. It should be stated that the latest law lifted section B deductibles to $110 in 2005, and a bigger premium for high-income enrollees will end in the five years that began in 2007. See the 2004 Annual Report of the Federal Hospital Insurance Oversight Committee and the Federal Supplemental Health Insurance Trust Fund, Washington, D.C., 23 June 2015. [10]Annual Report 2004 of the Federal Hospital Insurance Foundation Board and the Federal Supplemental Health Insurance Trust Fund, loc. cit. Hospital Insurance (HI) As part of Medicare; Health Care Costs, The National Federation on Health Care, 2004. Health insurance costs, employer health benefits: A 2004 survey, the Kaiser Family Foundation. A study by the Washington Business Group on Health, representing nearly 200 major employers, found that 80 percent of employers who offered employee health insurance planned to increase co-payments or cost sharing in 2003, compared with 65 percent who responded in that way in 2001. The New York Times article reported that after corporate income tax, employee benefits were the second-largest structural cost for American manufacturers, adding 5.8 percent to costs (Daniel Gross, whose problem is Health Care, New York Times, February 8, 2004.) 2004.)

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