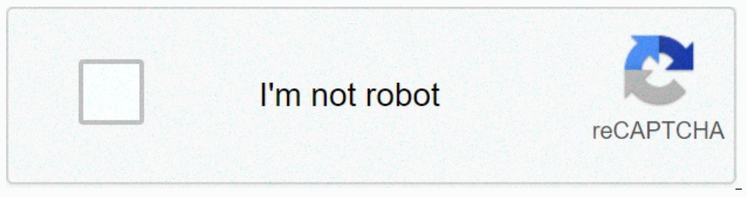

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Diaphoretic definition in medical term

ASPE ISSUE BRIEF May 2005 Printer Friendly Edition in PDF format This short issue is available on the Internet at: Contents As the population of the United States ages, you will consume more healthcare. Older people suffer from diseases and other medical problems to a greater extent than younger people. And with healthcare prices continuing to rise much faster than other goods and services, the use and social costs of healthcare are expected to skyrocket in the future. As public programs fund much of seniors' health care, over time there will be increasing pressure on federal and state budgets, and long-term pressures on public funds will put upward pressure on tax rates. This, in turn, could cause lawmakers to reconsider their coverage commitments through federal and state health care programs. Whatever the outcome of these competitive pressures, steps to curb rising health care prices and increase the efficiency and effectiveness of healthcare provision are essential to curb the financial burden that future health care costs are likely to impose. Historical perspective National health expenditure 1960 1985 2003 (in billions of current dollars) Total expenditure 27 427 1,679 per capita 143 1,765 5,670 (in billions of fixed dollars of 200 3)* Total expenditure 166 730 1,679 Per capita 891 3,019 5,670 Share of GDP 5.1% 10.1% 15.3% Source: National Health Expenditures, Centers for Medicare & Medicare Medicaid Services, Office of the Actuist, National Group on Health Statistics; U.S. Department of Commerce, Office of Economic Analysis; and U.S. Bureau of Inventory * Adjusted for changes to the Consumer Price Index for All-Urban Consumers, all-nation spending data on health care has been on a relentless upward trajectory for several decades. In 1960, total health spending in the U.S. amounted to $27 billion; in 2003, the figure stood at nearly $1.7 trillion a 63-fold increase. By contrast, the U.S. population grew by only 51 percent. Health spending per capita (or per person) increased from $143 in 1960 to $5,670 in 2003 a 40-times increase. General inflation pushed up the prices of goods and services in the economy by 5 times. In contrast, the recorded price increase for medical care was 12 times, mainly due to the increase in hospital fees and doctors' fees. [1] The overall economic dimensions of growth were equally impressive, with the share of the economy devoted to health care during the period, rising from about 5 percent of gross domestic product (GDP) in 1960 to over 15 percent in 2003. Inflation and health care price growth 1960-2003 1990-2003 (Percentage price increase) Inflation generally 515% 41% Medical care overall 1,232% 82% Medical care services 1,469% 88% Source: Consumer Price Index for all-urban consumers, the consumption of health care by the elderly is greater than for the rest of the population. In 1999, per capita health care costs for population as a whole, was $3,834. For the population under 65, it was $2,793. For the population age 65 or older, it was $11,089, or nearly four times as high. Even within the elderly population, the divergence was significant. For those ages 65 to 74, it was only $8,167 compared to $20,001 for those people aged 85 or older. Medicare enrollees, 87 percent of whom were aged 65 and older, made up 14.5 percent of the total population that year, but accounted for 37 percent of nations' personal health care costs. [2] For two million recipients residing in full-time nursing homes (three-quarters of whom were aged 75 and over), the per capita cost was $44,520. Among recipients aged 85 and over, 22 per cent lived in nursing homes. [3] People aged 85 and over made up 1.6 percent of the population in 1999, but accounted for more than 8 percent of nations' personal health care costs. Per capita health care costs by the elderly compared to that of the rest of the population, 1999 Age grouping per capita personal health care expenses all ages $3,834 Under 65 2,793 65 and above 11,089 19-44 2,706 2,706 2,706 19-44 2,706 2,706 2,706 19-44 2.706 19.70645-54 3.713 55-64 5.590 65-74 8.167 75-84 12.244 85 and above 20.001 Source: Age Estimates in National Health Accounts , Sean P. Kehan, Helen K. Lazenby, Mark A. Zezza, and Aaron C. Catlin, Health Care Finance Review, December 2, 2004. Health care costs from Medicare population age 65 or older, from the level of expenditure, 1999 Share of health care costs incurred by: Top 1 percent of users Top 5 percent of users Top 10 percent of users 12.8 percent 35.9% 53.8% Source: Medicare Current Beneficiary Survey, loc. While average spending by age group shows the effects of higher age on health care consumption , do not show the concentration of health care use within the elderly population. In any given year, the bulk of medical care costs tend to be borne by a relatively small group of people. In 1999, 1 percent of Medicare enrollees aged 65 and older made up 13 percent of those health care spending groups. The top 10 percent with the highest spending made 54 percent. The importance of this concentration is not only that the health care costs of nations will increase as the elderly increase in numbers, these costs will be increased as those in the population with the highest frequency of health care costs increase as a percentage of the population. In the period of 8 years alone, from 1992 to 2000, the the Medicare population made up of people aged 85 and over increased from 9.7 percent to 10.9 percent. [4] [Go to content] The importance of public funding of nation health care In 2003, public funding sources Federal and state and local governments that combined directly financed nearly half of the nation's health spending. This includes personal health care, research, construction, supplies and other related costs. They covered 44 per cent of the costs incurred for personal health care, including active military and veterans. Over the last half century, government entities have taken on an increasingly important role in meeting nation health care needs. In 1960, they financed 25 per cent of total national health spending. With the advent of Medicare and Medicaid in 1965, the government share quickly increased to 38 percent in 1970, and continued to grow thereafter, reaching 46 percent in 2003. Change in public (federal and state) and private financing of national health expenditure 1960 1970 1980 1990 2003 (in percentage) Public funds 25 38 43 41 46 Private funds 75 62 57 59 54 Source: National health expenditure, Loc. The largest source of funding for personal health care today comes from private insurance, which provided 36 percent of the funding for these costs in 2003. Out-of-pocket spending accounted for 16 percent, making it the next largest private source. Medicare and the federal share of Medicaid make up the bulk of federal government support. The share of Medicaid states is the largest component supplied by state and local governments. Personal Health Care Funding Sources, 1960 and 2003 1960 2003 Percent Funded by: Private Insurance 21 36 Out of Pocket 55 16 Medicare --- 19 Medicaid * --- 17 Other Private 2 4 Other Federal 9 4 Other State and Local 13 3 Source: National Health Expenditure, loc. cit * Consists of both federal and state funding. Among these sources, the federal component grew more over the past four decades, rising from 9 percent of personal health care costs in 1960 to 33 percent in 2003. Although Medicaid appearance in 1966 significantly increased federal government spending on medical care for the poor, the share of personal health care spending on health care for the poor funded by state and local governments (which includes funds matching them for Medicaid) actually slipped a little over the four-decade period , with their share falling from 13 per cent in 1960 to 11 per cent in 2002. Federal and State Government Financing of Personal Health Care Costs, 1960 and 2003 1960 2003 Percent Funded by: Federal Government 9 33 State and Local Governments 13 11 Source: National Health Expenditures, loc. cit. It is important to note that while private sources still seem to finance the majority of nations' health spending at 54 percent in 2003 the figure covers the indirect support that federal and state and local governments provide through tax health care. More than $100 billion in so-called health care tax spending was made by the federal government in 2003 alone. These tax expenditures represent income taxes that have been avoided because employers and natural persons are allowed to exclude from taxable income the part of their income used for health insurance premiums and/or related expenses. If these avoided tax receipts are taken into account, the majority of nations' health spending of more than 60 percent was either directly by federal and state and local governments in 2003 or indirectly supported through tax provisions. With the development of public programs and private insurance over the last four decades, the role of direct payments between individuals and healthcare providers has changed significantly. In 1960, individuals paid directly for more than half of all their personal health care needs pay 55 percent of their medical expenses out of pocket. In 2003, only 16 percent of personal health care spending was covered out of pocket, making third parties the dominant means of financing health care in the U.S. Although a large number of factors are believed to have contributed to escalating medical costs, the expansion of third-party payers (whether government or private) may have reduced incentives for individuals to be aware of the costs of consuming their medical services. [5] [Go to content] The importance of government sources in funding medical care for aging sources of personal health care funding for Medicare and NonMediccare populations, 2000 Medicare Population Non-Medicare Population Rate Funded by: Medicare 52.3 --- Medicaid 12.2 19.2 Private Insurance 12.2 47.7 Out-of-Pocket 19.4 15.8 Other * 3.9 17.3 Source: Medicare Current Beneficiary Survey, loc. cit. * Consists of a mix of government and private sources Comparisons of funding sources for medicare and non-Medicare medical care reflect how important public funding has become for the elderly. Public funds directly financed less than half of the nations' health spending in 2000, but it was the elderly who received the bulk of this support. About two-thirds of their health care costs were funded by public programs, and more than half came from Medicare. The dependence of the elderly on public health care programs has changed very significantly over the last half century, mainly because Medicare coverage did not exist before 1966. But even after the advent of Medicare, the public role has increased. As described by the Medicare programs lead actuist For the age of 65 or older, Medicare paid for about 42 percent of total personal health care costs in the 1968 fiscal year. By calendar year 1997, this rate had increased to 55 percent, with most of the balance covered by Medicaid, private health insurance, and the beneficiaries' own out-of-pocket Medicare payments increased share is partially attributable to part B deductible, which was $50 in 1968 and has only increased times since then, at $100 today. Because covered costs increased much faster, a larger percentage of covered costs exceed the deduction and are therefore reimbursed by Medicare. In 1968, only 38 percent of beneficiaries had part B costs above the deduction, but by 1997, this rate had increased to an 87 percent increase in Medicare share has also reflected rapid price growth, utilization, and the intensity of those covered covered as a doctor, specialized nursing, and home health care. On the other hand, in a few years, some uncovered costs, such as prescription drugs and long-term nursing home care increased faster than health costs in general, thus adding to the portion funded by non-Medicare sources. Overall, the trend was toward a larger Medicare share of the total personal health care costs of the elderly The chief actuer also noted the relatively small reduction in Medicaid spending as a percentage of total personal health care costs for beneficiaries over 65. The percentage of older people with incomes below the poverty line (who are the most likely to be eligible for Medicaid) fell from about 16 percent in 1966 to 11 percent in 1997 The impact of this trend on Medicaid spending was largely offset, however, from extensions to coverage, including the creation of qualified Medicare beneficiaries (QMB) and specific low-income Medicare Beneficiaries (SLMbs). (Medicaid pays the Medicare premium [s] on behalf of QMB and SLMB, as well as the beneficiary of cost-sharing obligations for QMB.) In addition, during this period, Medicaid absorbed a significant portion of the rapidly increasing costs of care in the nursing home. The percentage of health care service costs paid directly by beneficiaries has fallen significantly since the beginning of the program, from about 28 percent in 1968 to 20 percent today. This change is mainly due to the increase in shares covered by Medicare and private health insurance [6] Sources of funding for personal health care costs for people 65 and older, 1968 and 1997 Fiscal Year 1968 Fiscal Year 1997 Percentage of: Medicare 42% 55% Medicaid 14% 11% Other 11% 3% Out of Pocket 28% 20% Private Health Insurance 5% 11% Source : Trends in Medicare spending and financial situation, 1966-2000, Richard S. Foster, health care finance review, fall 2000. In 2003, the Congressional Budget Office reported that the increase in national health spending over the period 1970-2001 exceeded gross domestic product growth by 2.5 percentage points per year. Medicare, however, grew at a rate that was 3 percentage points higher over a roughly comparable period. Medicaid grew at a rate of 2.7 percentage points higher. [7] On an annual basis, these differences may seem small, but when exacerbated over the decades, they help explain how Medicare and Medicaids combined share of personal health care costs increased from 19 percent in 1970 to 37 percent in 2002. In fact, over a period of 32 years, these two major public almost doubled their role in financing nation health care spending. [Go to contents] Future Perspective Social Security and Medicare project managers a significant increase in the share of the population in the coming decades. Where people aged 65 and over represent 12 per cent of the total population today, they will account for 18 per cent in 2025. In addition, the increase in only the result of the baby boomer generation after the Second World War reaching its advanced years. Significant improvements in longevity and a decrease in the birth rate of nations over the past 30 years are projected to lead to further increases in the proportion of the elderly population after the passing of baby boomers. Projected population growth aged 2005 2025 2045 2065 2080 Age figure 37 million 62 million 79 million 89 million 96 million Share total population 1 2% 18% 21% 22% 23% Source: The 2005 Annual Report of the Board of Directors of the Federal Age and Survivors Insurance and Disability Insurance Trust Funds, Washington, D.C., D.C., March 23, 2005 for Medicare, these emerging demographics mean that an increasing number of people will be eligible for coverage each year , and each successive group of new enrollees will receive benefits for a longer period of their lives. For Medicaid, they mean an increasing number of people will need and become eligible for nursing home and related institutional care. For both programs and for the federal government in general, they mean that a declining percentage of the population will be in the main working age band of 20 to 65, from which much of the government tax base originates. Exacerbating the increase from demographic trends is the uncertain but still resilient price increase and the use of medical care. To what extent they can continue to grow at these rates is uncertain. Fall in birth rates and increase in life expectancy, 1965-2080 (real and projected) 1965 2005 2045 2080 Births per woman in life span of 2.88 2.02 1.95 1.95 Life expectancy at age 65: --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 managers report, loc. cit. Comparison of medicare growth per person , Medicaid, and gross domestic product, 1970-2003 Average annual per person increase in medicare Medicaid GDP rate 1970-2003 6.3 9.4 8.8 * 1980-2003 5.0 7.4 7.1 1990-2003 3.8 5.6 6.0 Long-term budget perspectives, CBO, *For the period 1975-2003. The highest increase per person in national health spending and Medicare and Medicaid declined in the latter part of the period 1970-2003 (Medicaid less than Medicare), but nevertheless still grew significantly faster than the overall economy. Recognizing this trend, Medicare administrators in their central long-term forecast of so-called interim projections have assumed that per enrolled cost for Medicare will increase at a final rate of 1 percentage point faster than gross domestic product. [8] This is lower than in the period 1990-2003, but is still higher than the Generally. Reduction of the difference between the increase in national health expenditure and the increase in gross domestic product an amount by which national health expenditure exceeds GDP growth (in percentage) 1960-2001 2,5 1970-2001 2.3 1980-2001 2.3 1990-2001 Source: The Long-Term Budget, CBO Perspectives, loc. cit. Combining this with their demographic outlook, the Medicare administrators program that medicare spending could increase from 2.7 percent of gross domestic product today to 9.6 percent in 2050 and reach 13.9 percent in 2080. Under a scenario with similar assumptions, the Congressional Budget Office projects that Medicare and Medicaid combined could grow to 11.5 percent of gross domestic product in 2050. [9] Expenditure of this magnitude today would account for more than half of the entire federal budget. Acknowledging the great uncertainty surrounding their forecasts, Medicare administrators say their forecasts continue to demonstrate the need for timely and effective action to address Medicare's financial challenges, both the long-term financial imbalance facing the HI [Hospital Insurance] trust fund and the increased problem of rapid spending growth. The sooner solutions are implemented, the more flexible and gradual they can be[10] What can be said about future private spending is uncertain but equally problematic. Health insurance premiums are rising rapidly. In one report, in 2002 health insurance premiums increased at a rate eight times faster than general inflation; with the largest annual increase in premiums in more than a decade. [11] A survey by the Kaiser Family Foundation found that premiums charged for work-based health insurance increased by 11.2 percent in 2003, exceeding previous growth rates. All types of health plans, including HMO, PPOs and POS, showed double-digit increases in costs. Kaiser reported that premiums paid by employers to cover employee family increased from an average of $6,438 in 2000 to $9,086 in 2003, and that the average amount of workers paid toward these premiums increased nearly 50 percent, from an average of $1,619 in 2000 to $2,412 in 2003. [12] As premiums rise, it is reasonable to assume that employers will try to limit their costs. [13] Workers could be expected to shoulder more of their medical expenses directly either by having to pay a larger share of employer premiums or by having increased cost requirements. Premium increases for Medicare benefits (i.e. now required for non-hospital services and drug coverage) and for health insurance policies that supplement Medicare (i.e., Medigap policies) could have a similar effect on age. Large premium increases can cause policymakers to impose higher medical rebates or coinsurance can cause recipients to seek less expensive supplemental coverage with higher cost requirements. When these out-of-pocket costs will have a restrictive impact on medical prices it is uncertain. Moreover, as they appear, policymakers could step in and demand that governments take on an even greater share of the burden. The tension, however, between further government out-of-pocket cost absorption and government budgets will only increase stronger, as the costs already added to public projects increase. The continued increase in costs have promoted calls for fundamental change in nations' healthcare systems. Some argue for greater government intervention for direct or indirect control of prices and use. Others believe that greater competition in the free market to insure these costs offers the most promising route. Others still believe that medical technology and innovation, greater defence of healthy lifestyles, the promotion of increased case management practices, and the further application of information technology to the dissemination of effective medical developments and the labyrinth of bureaucracy for treatment and services will make the healthcare system significantly less costly. So far, there doesn't seem to be a consensus on what the best solution to raising prices for health care could be. Given this uncertainty, it is likely that a combination of the various major policy prescriptions will evolve and be implemented as cost pressures, both public and private, grow in the coming years. [Go to contents] Endnotes: [1] As measured by the consumer price index for all urban consumers, Bureau of Labor Statistics, U.S. Department of Labor. [2] Trends in MCBS, 1992-2000, Center for Medicare and Medicaid Services. [3] SeeMediccare Current Beneficiary Survey, Center for Medicare and Medicaid Services, and Older Americans 2000: Key Indicators of Well-Being, Federal Intera service Forum on Aging-Related Statistics. [4] Trends in MCBS, 1992-2000, loc. cit. [5]Long-term budget prospects, Congressional Budget Office, December 2003. [6] Trends in Medicare spending and financial situation, loc. cit. It should be noted that recent legislation increased the Part B deductible to $110 in 2005, and higher premiums for high-income enrollees should be phased in over a five-year period beginning in 2007. [7] The Long-Term Budget Outlook, CBO, loc. cit. [8] See the 2004 annual report of the Board of Directors of The Federal Hospital Insurance and Federal Medical Insurance Trust Auxiliary Funds, Washington, D.C., March 23, 2004. [9] The long-term budget outlook, loc. cit. [10]The 2004 annual report of the Board of Directors of the Federal Hospital Insurance and Federal Medical Insurance Trust Auxiliary Funds, loc. cit. Hospital insurance (HI) is part A of Medicare Supplemental Medical Insurance (SMI) consists of traditional Part B and new Part D prescription drug benefit. [11] Health care costs, National Coalition for Health Care, 2004. [12] Cost of health insurance, health benefits Annual survey of 2004, Kaiser Family Foundation. [13] A study by the Washington Business Group on Health, representing nearly 200 major employers, found that 80 percent of employers offering employee health insurance planned to increase co-payments or cost sharing in 2003, compared with 65 percent who responded in this way in 2001. In a more recent study, the team found that 57 percent planned to increase cost-sharing for 2004. (Martinez, as health costs rise, workers have to pay pay Wall Street Journal , June 16, 2003.) A New York Times article reported that After corporate income taxes, employee benefits are the second-largest structural cost for American manufacturers, adding 5.8 percent to the cost. (Daniel Gross, whose problem is health care, The New York Times, February 8, 2004.) 2004.)

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