

Section 6

MEDICARE SPENDING

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In FY2004, Medicare benefit payments totaled \$295 billion, Medicare spending accounted for 17 percent of national health expenditures and 12 percent of the federal budget. Medicare is responsible for almost one-fifth of the \$1.4 trillion in national personal health care expenditures, but Medicare's share of spending varies by type of service, reflecting benefits covered and services used by the Medicare population. For example, in 2003, Medicare paid for 30 percent of the nation's total hospital spending and 20 percent of spending on physician services, but less than 2 percent of prescription drug costs.

Currently, inpatient hospital services are the largest category of Medicare benefit payments (39 percent), followed by payments for physicians and suppliers (26 percent). Home health care and skilled nursing facility services account for less than 10 percent of total benefit spending. The composition of Medicare benefit payments will shift with the addition of prescription drug coverage in 2006. By 2010, prescription drugs are projected to account for 20 percent of Medicare benefit payments. The distribution of Medicare payments has shifted over time, reflecting changes in health care delivery and how Medicare pays for services. For example, hospitalizations accounted for 87 percent of program spending in 1966, but 38 percent in 2004, while spending on physician and other outpatient services more than tripled from 12 percent to 37 percent.

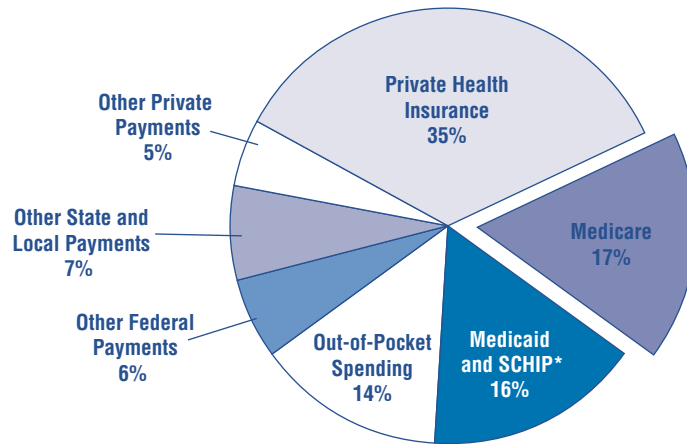
Medicare payments for each beneficiary enrolled in the traditional fee-for-service program averaged \$6,110 in 2002. Per capita payments for the elderly (\$6,002) were nearly \$1,500 higher than they were for the nonelderly disabled (\$4,547). As expected, Medicare per capita spending increases as health status declines. Per capita spending is more than twice the amount for beneficiaries residing in long-term care facilities than for beneficiaries living in the community. Medicare spending is also significantly higher for beneficiaries in their last year of life: \$24,856 for beneficiaries who died in 1999 compared to \$3,669 for those who were alive at the end of that year.¹

Medicare spending is highly concentrated among a minority of beneficiaries. In 2002, 7 percent of beneficiaries incurred expenditures of \$25,000 or more, accounting for just over half of program spending. Twelve percent of beneficiaries accounted for more than two-thirds of program spending. At the lower end, 12 percent of beneficiaries in the fee-for-service program incurred no Medicare expenditures in 2002.

On a per capita basis, Medicare spending has grown at a slightly slower pace, on average, than private health insurance spending for comparable services. Private health insurance spending grew at an average annual rate of 10.1 percent in the period between 1970 and 2003, while Medicare spending grew at an average rate of 9.0 percent. Administrative expenditures currently account for less than 2 percent of Medicare benefit expenditures, significantly lower than the cost of running private health plans.

¹ Calfo, S., et al. "Last Year of Life Study." Office of the Actuary, Centers for Medicare and Medicaid Services.

Figure 6.1
National Health Expenditures in the United States, by Source of Payment, 2003

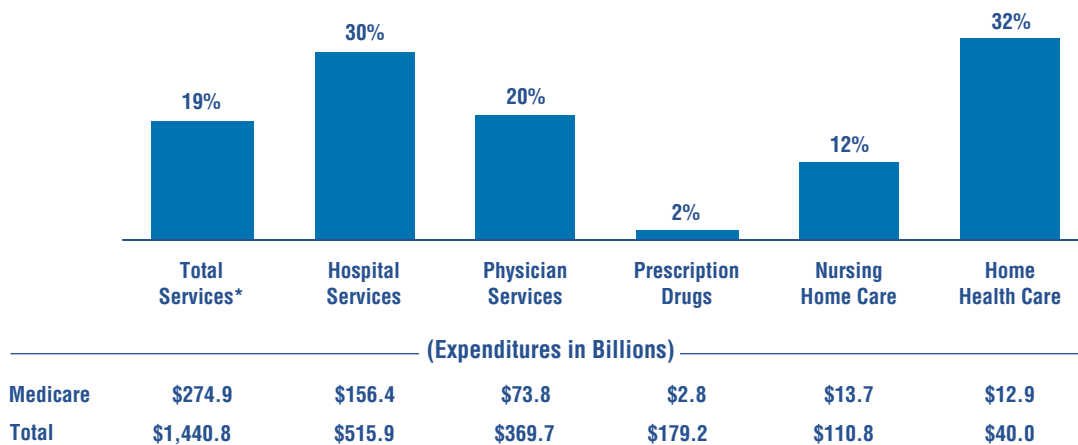


Total = \$1.7 Trillion in National Health Expenditures, 2003

Note: *Medicaid and SCHIP include funds from both federal and state governments. SCHIP is the Title XIX State Children's Health Insurance Expansion.
 SOURCE: C. Smith, et al., "Health Spending Growth Slows in 2003," *Health Affairs*, 24 (January/February 2005) 185-194.

Health care expenditures in the United States totaled \$1.7 trillion in 2003. Medicare represented 17 percent (\$283 billion) of these expenditures, while private health insurance financed 35 percent (\$601 billion), and consumers paid about 14 percent (\$231 billion) out of pocket.

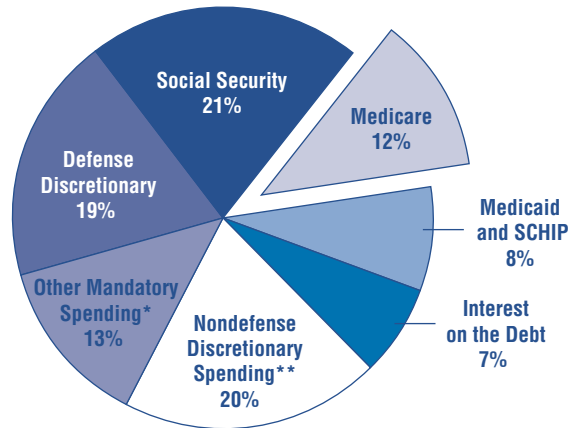
Figure 6.2
Medicare's Share of National Personal Health Expenditures, by Type of Service, 2003



Note: *Also includes dental care, durable medical equipment, other professional services and other personal health care services and products.
 SOURCE: C. Smith, et al., "Health Spending Growth Slows in 2003," *Health Affairs*, 24 (January/February 2005) 185-194.

Medicare is responsible for almost one-fifth of the \$1.4 trillion in personal health care expenditures in the U.S., but Medicare's share varies by type of service, reflecting benefits covered and services used by the Medicare population. For example, in 2003, Medicare paid for 30 percent of all hospital spending and 32 percent of home health care spending but less than 2 percent of prescription drug costs.

Figure 6.3
Medicare Spending as a Share of the Federal Budget, FY2004

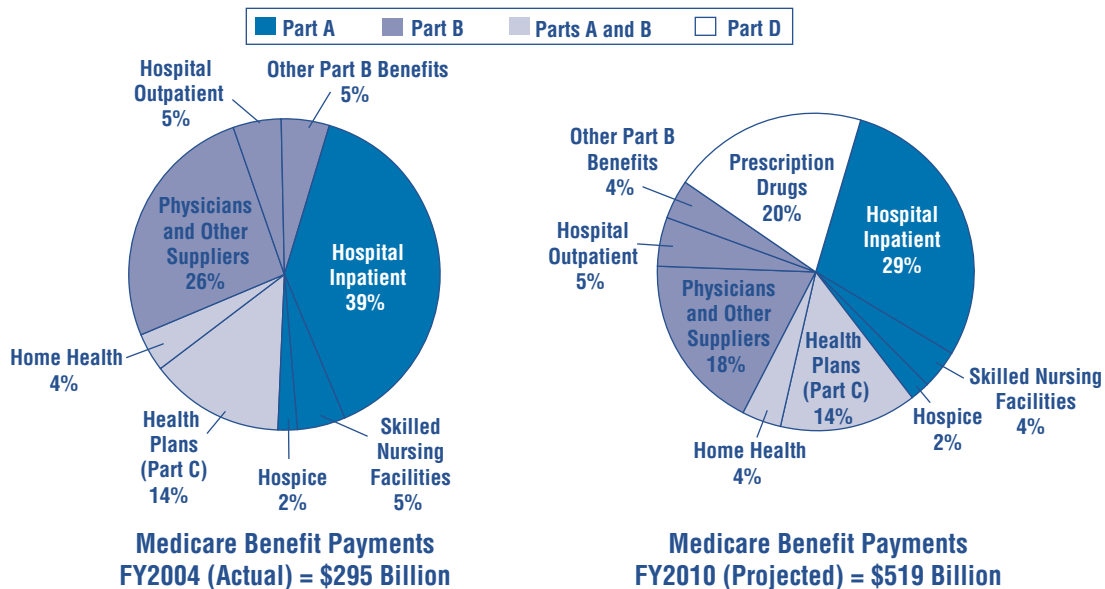


Total = \$2,292 Billion in FY2004 Federal Spending

Note: *Includes other retirement and disability programs, unemployment compensation, and farm price supports; also includes offsetting receipts.
 **Includes funding for homeland security, transportation, education, and public health.
 SOURCE: Office of Management and Budget, Budget of the U.S. Government, FY2006.

Total federal spending in FY2004 was almost \$2.3 trillion. Spending on Medicare was \$265 billion (including offsets), or 12 percent of the total. Spending on Social Security, the single largest program in the federal budget, totaled 21 percent (\$492 billion), while defense spending accounted for 19 percent (\$436 billion).

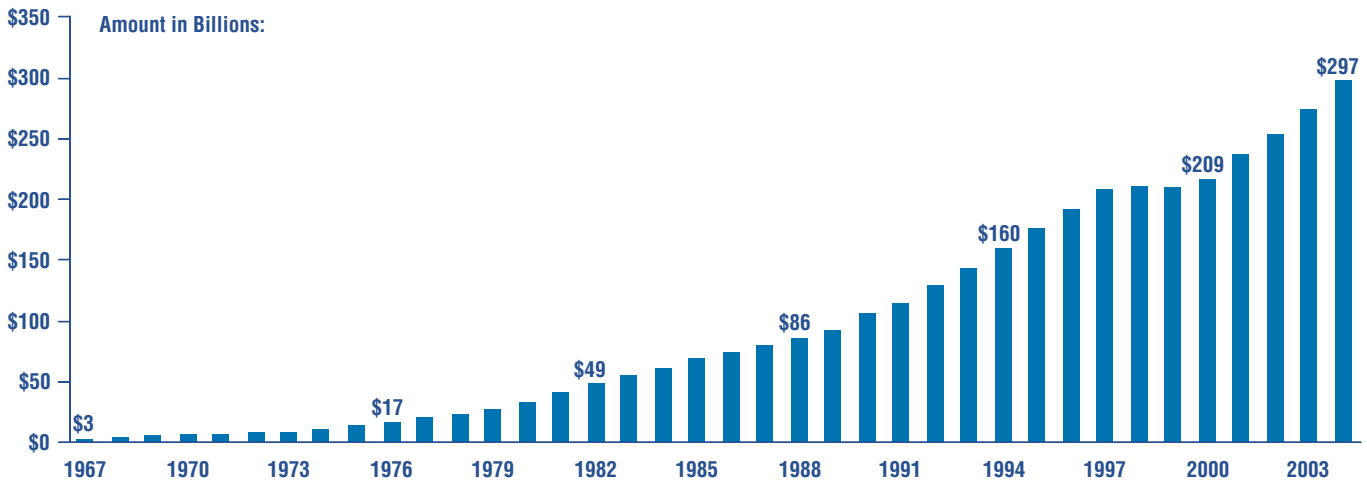
Figure 6.4
Medicare Benefit Payments, by Type of Service, FY2004 (Actual) and FY2010 (Projected)



Note: Figures do not include administrative expenses. Amount for FY2004 excludes Part D low-income subsidy payments.
 SOURCE: Congressional Budget Office, Medicare Fact Sheet, March 2005.

Medicare benefit payments in FY2004 totaled \$295 billion. Currently, the largest category of Medicare benefit payments is inpatient hospital services (39 percent). The composition of Medicare benefit payments will shift with the addition of prescription drug coverage in 2006. In FY2010, prescription drugs are projected to account for 20 percent of Medicare benefit payments.

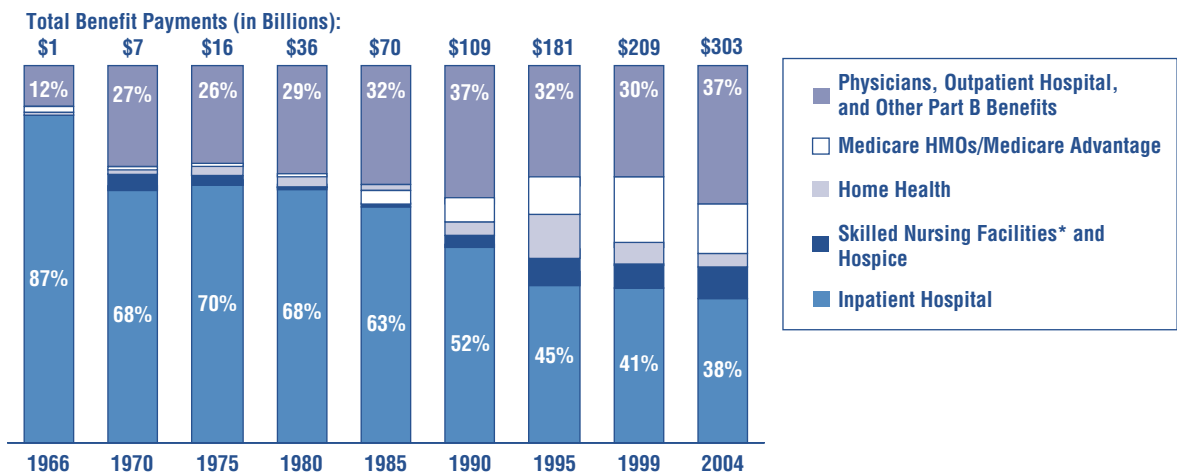
Figure 6.5
Medicare Spending, Fiscal Years 1967–2004



SOURCE: Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2006–2015*, January 2005.

Total Medicare spending was \$297 billion in FY2004. Medicare spending has increased each year since the program began in 1966, with the exception of FY1998-1999, when changes in provider payment policies contributed to a reduction in program spending. Since then, Medicare spending has increased annually.

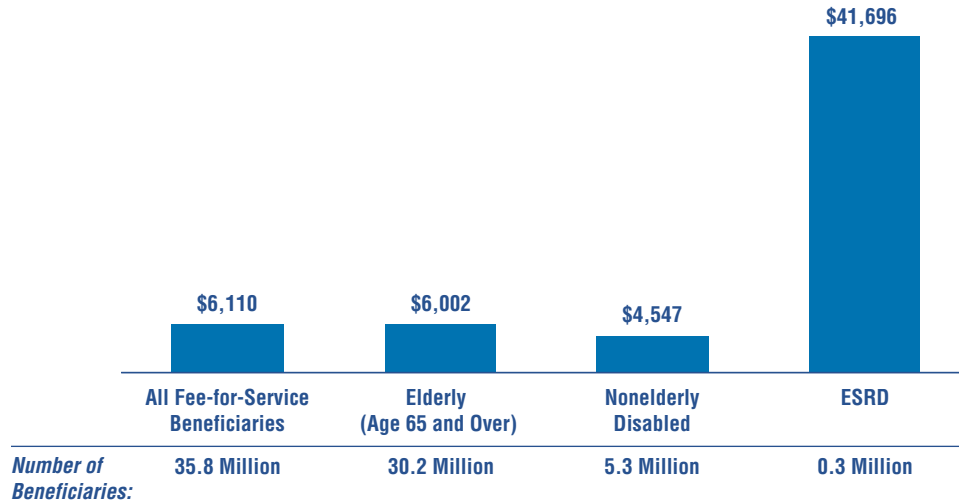
Figure 6.6
Distribution of Medicare Benefit Payments, Calendar Years 1966–2004



Note: *Coverage for skilled nursing facilities was effective January 1, 1967. Total includes expenditures for ESRD beneficiaries, but excludes administrative payments.
 SOURCE: All data are from the Health Care Financing Administration (Office of the Actuary, Medicare and Medicaid Cost Estimates Group), December 2000, except for 2004 data, which are from the 2005 Annual Report of the Medicare Trustees.

The distribution of Medicare benefit payments has shifted over time, reflecting changes in health care delivery and how Medicare pays for services. Hospitalizations constituted 87 percent of program spending in 1966, but only 38 percent in 2004, while spending on physician services and other Part B services more than tripled from 12 percent in 1966 to 37 percent in 2004.

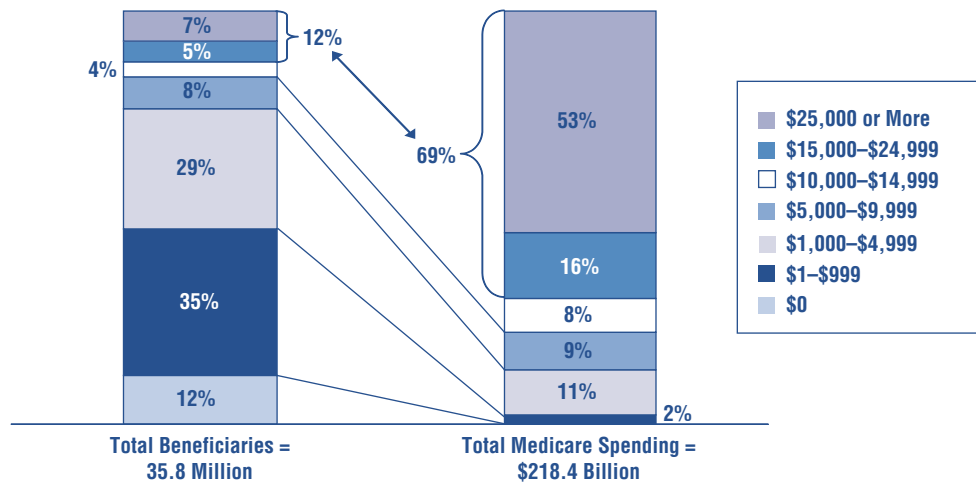
Figure 6.7
Medicare Spending Per Beneficiary, by Eligibility Category, 2002



Note: Excludes beneficiaries enrolled in Medicare HMO plans. ESRD is end-stage renal disease.
 SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

In 2002, Medicare payments for each beneficiary enrolled in the fee-for-service program (excluding those enrolled in Medicare Advantage plans) averaged \$6,110. These payments vary across different types of beneficiaries. Medicare spending on each elderly beneficiary averaged \$6,002, while spending for nonelderly disabled beneficiaries was 25 percent less, averaging \$4,547. Spending is highest for those beneficiaries who are eligible for Medicare because they have end-stage renal disease (ESRD)—\$41,696 on average in 2002.

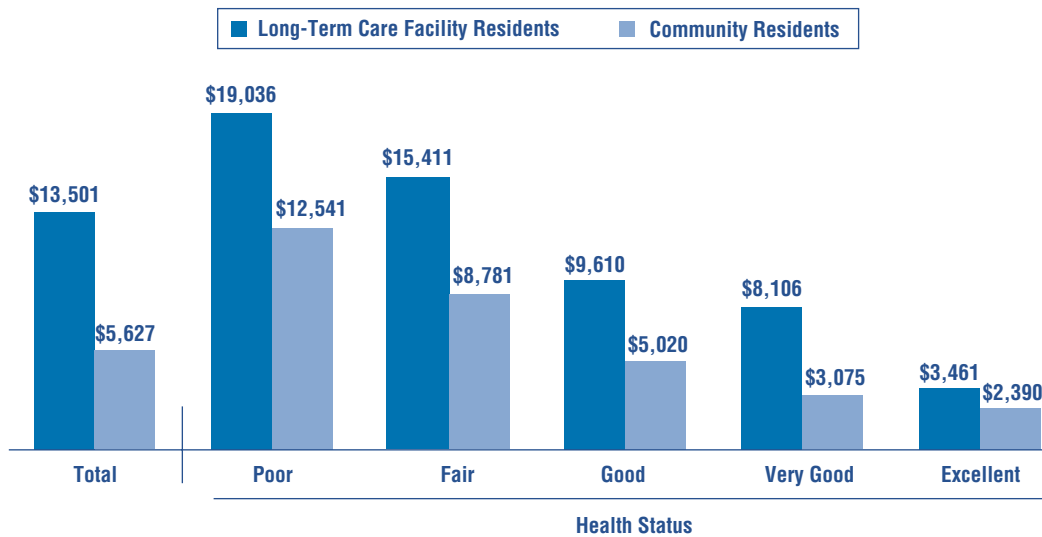
Figure 6.8
Distribution of Fee-for-Service Medicare Beneficiaries and Per Capita Medicare Spending, 2002



Note: Excludes beneficiaries enrolled in Medicare HMO plans.
 SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Medicare spending is concentrated among a relatively small share of beneficiaries. In 2002, 12 percent of fee-for-service beneficiaries (those not enrolled in Medicare Advantage plans) incurred no Medicare spending. More than one-third of beneficiaries (35 percent) incurred less than \$1,000 in Medicare spending per person, accounting for about 2 percent of total Medicare spending. Medicare spending for the 12 percent of beneficiaries who incurred \$15,000 or more in per capita costs accounted for 69 percent of program spending.

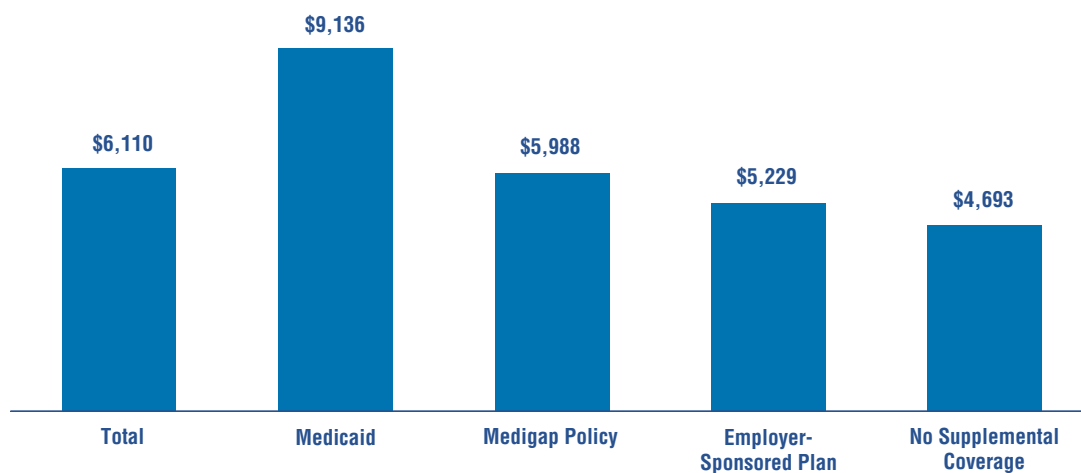
Figure 6.9
Medicare Spending Per Beneficiary, by Health Status and Residence Status, 2002



Note: Excludes beneficiaries enrolled in Medicare HMO plans.
 SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Across all levels of self-reported health status, beneficiaries who reside in long-term care facilities incur higher per capita Medicare expenses than those living in the community. Regardless of residence status, however, Medicare spending increases as health status decreases, with spending for those in poor health more than five times higher than for those who report excellent health.

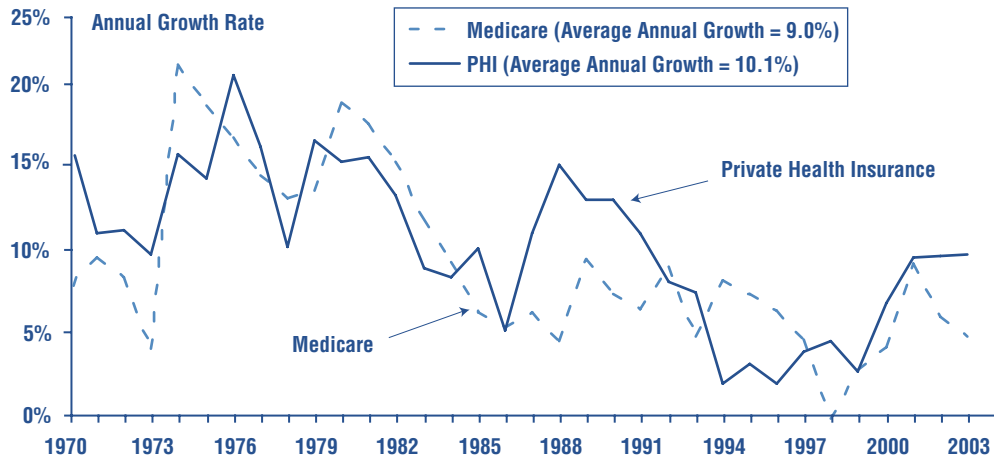
Figure 6.10
Medicare Spending Per Beneficiary, by Primary Source of Supplemental Coverage, 2002



Note: Excludes beneficiaries enrolled in Medicare HMO plans.
 SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Medicare spending per beneficiary varies by source of supplemental insurance coverage, reflecting both differences in health status among those with different types of coverage and the relative generosity of various sources of coverage. In 2002, average Medicare spending for beneficiaries with Medicaid (\$9,136) was higher than for other Medicare beneficiaries, reflecting the greater medical care needs and poorer health status of the dual eligible population.

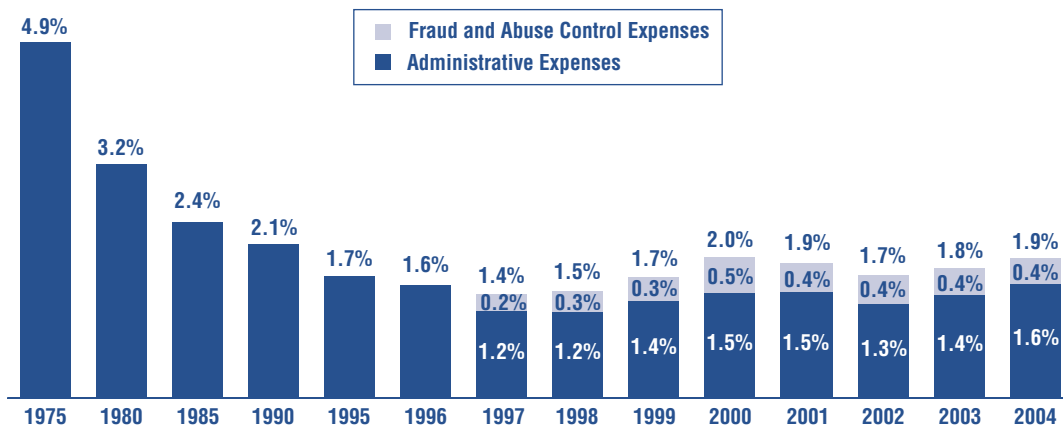
Figure 6.11
Annual Percentage Change in Per Capita Medicare and Private Health Insurance Spending, 1970–2003



Note: Figure shows spending on comparable services covered by Medicare and private health insurance, including hospital services, physician and clinical services, other professional services, and durable medical products. PHI is private health insurance.
 SOURCE: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, 2004.

On a per capita basis, Medicare spending has grown at a slightly slower pace, on average, than private health insurance spending for comparable services. Private health insurance spending grew at an average annual rate of 10.1 percent in the years between 1970 and 2003, while Medicare spending for similar benefits and services grew at an average rate of 9.0 percent.

Figure 6.12
Medicare Administrative Expenditures as a Share of Medicare Benefit Payments, Fiscal Years 1975–2004



Note: Numbers may not sum to total due to rounding.
 SOURCE: 1999–2001 Annual Reports of the Federal Hospital Insurance Trust Fund, 2002–2005 Annual Reports of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

Administrative expenses currently account for less than 2 percent of Medicare benefit payments, which is significantly lower than the cost of running private health plans. Between 1975 and 2004, Medicare's administrative budget declined from 4.9 percent to 1.9 percent of total benefit spending, despite more complicated reimbursement rules and more health care service delivery options available to beneficiaries.