

### Trends in Health Care Costs and Spending

September 2007

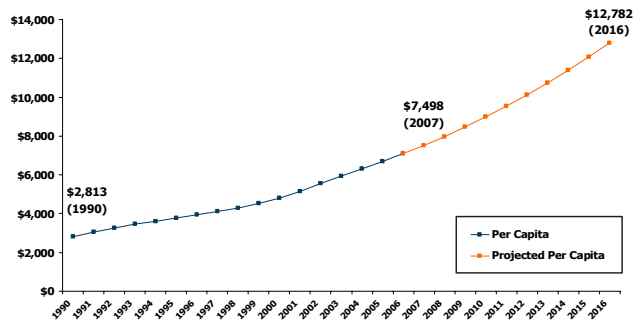
The high and growing cost of health care is a significant issue for businesses, workers, and government. Spending on health care, which is a projected to be 16.2% of the U.S. gross domestic product (GDP) in 2007, has consistently grown faster than the economy overall since the 1960s. This fact sheet presents some of the key statistics about the level and growth of health care costs and spending in the U.S. Links to additional resources are provided at the end of the document.

#### Overall Spending

According to the Centers for Medicare and Medicaid Services (CMS), the U.S. is projected to spend over \$2.2 trillion on health care in 2007, or just under \$7,500 per U.S. resident (Exhibit 1). Health spending in 2007 is projected to account for 16.2% of GDP.<sup>i</sup>

- In 1970, U.S. health care spending was about \$75 billion on health care, or \$356 per resident, and accounted for 7.2% of GDP.
- Health care spending has risen about 2.4 percentage points faster than GDP since 1970.
- CMS projects that by 2016 (nine years from now) health care spending will be over \$4.1 trillion, or \$12,782 per resident, and account for 19.6% of GDP.

**Exhibit 1: National Health Expenditures per Capita, 1990-2016**



Note: Figures from 1990 through 2005 represent historical data; data from 2006-2016 are projected.

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.hhs.gov/NationalHealthExpendData/>. (Historical data from NHE summary including share of GDP, CY 1960-2005, file rhegdp05.zip; Projected data from NHE Projections 2006-2016, Forecast summary and selected tables, file proj2006.pdf).

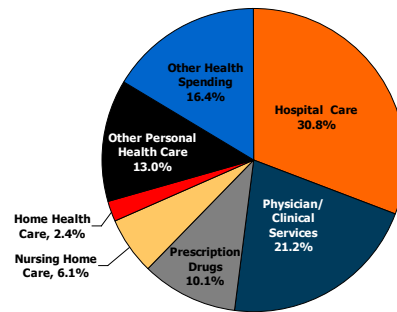
The U.S. devotes considerably more of its economy to health care than other developed countries. (Note that the Organization of for Economic Co-Operation and Development (OECD) uses a somewhat different classification for health care spending than CMS.)<sup>ii</sup>

- U.S. health spending as a share of GDP in 2004 (15.2% in OECD accounting) was considerably higher than all other OECD countries, including Canada (9.2%), France (11.0%), Germany (10.6%), Japan (8.0%),<sup>iii</sup> and the United Kingdom (8.1%). Switzerland was a distant second to the U.S., devoting 11.5% of GDP to health care.

#### Distribution by Service

Just over one-half of national health spending is for hospital, and physician and clinical services (Exhibit 2). Spending on prescription drugs accounts for about 10% of health expenditures.

**Exhibit 2: Distribution of National Health Expenditures, by Type of Service, 2005**



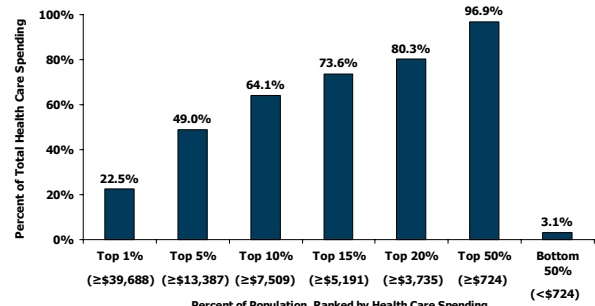
Note: Other Personal Health Care includes, for example, dental and other professional health services, durable medical equipment, etc. Other Health Spending includes, for example, administration and net cost of private health insurance, public health activity, research, and structures and equipment, etc.

Source: Kaiser Family Foundation calculations using NHE data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.hhs.gov/NationalHealthExpendData/>. (see Historical; National Health Expenditures by type of service and source of funds, CY 1960-2005; file rhe2005.zip).

#### Concentration of Health Spending

While discussions about the costs of health care often focus on the average amount spent per person, spending on health services is actually quite skewed.<sup>iv</sup> About ten percent of people account for over 60% of spending on health services; over 20% of health spending is for only 1% of the population. At the other end of the spectrum, the one-half of the population with the lowest health spending accounts for just over 3% of spending (Exhibit 3).

**Exhibit 3: Concentration of Health Care Spending in the U.S. Population, 2004**



Note: Dollar amounts in parentheses are the annual expenses per person in each percentile. Population is the civilian noninstitutionalized population, including those without any health care spending. Health care spending is total payments from all sources (including direct payments from individuals, private insurance, Medicare, Medicaid, and miscellaneous other sources) to hospitals, physicians, other providers (including dental care), and pharmacies; health insurance premiums are not included.

Source: Kaiser Family Foundation calculations using data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), 2004.

## Sources of Health Spending

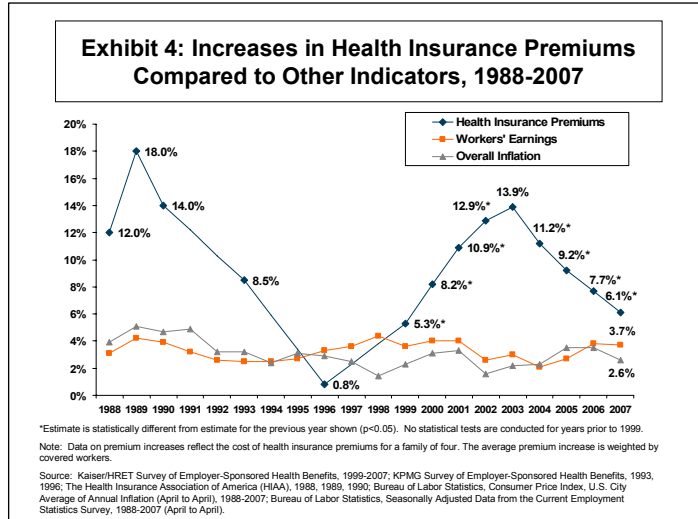
Health spending is fairly evenly split between the private and public sectors, with private health spending accounting for about 55% of total health spending in 2005.

- Spending by private health insurance comprises about 64% of private health expenditures; about 23% of private expenditures is out-of-pocket payments by individuals; the remainder (13%) is expenditures by other private sources (e.g., philanthropy).
- CMS projects that the private share of national health spending will fall to 51% by 2016. The growth in public health spending (to 49%) occurs primarily due to growth in Medicare's share of health spending (to 21% in 2016). One important contributor to the growth in Medicare's share of spending was implementation of the Medicare Prescription Drug benefit, which reduced private out-of-pocket spending and increased public spending for prescription drugs.

## Impact on Businesses and People

The public experiences the cost of health care primarily through the premiums they pay for health insurance and the cost sharing (e.g., deductibles, copayments) that they must pay at the time that they receive care.

- Health insurance premiums have consistently grown faster than inflation or workers earnings in recent years (Exhibit 4). Between 2002 and 2007, the cumulative growth in health insurance premiums was 78%, compared with cumulative inflation of 17% and cumulative wage growth of 19%.<sup>v</sup>



- Although the share of total premiums that workers pay has remained fairly stable (16% for single coverage; 28% for family coverage in 2007) over the recent past, the rapid growth in overall premium levels means that workers are paying much higher amounts than they did a few years ago.
- The amounts people pay out-of-pocket for health care depend on several factors, including the quality of their health insurance (if any) and the type and amount of services that they use. For people with health care expenses, the average share of total health care costs that are paid out-of-pocket was 34% in 2004. Because

many insurance plans have limits on out-of-pocket expenses,<sup>vi</sup> people who have high health total spending have relatively low out-of-pocket shares. For example, the one percent of people with the highest health spending in 2004 (total costs of more than \$39,688) on average paid 6% of their costs out-of-pocket.<sup>vii</sup>

- Almost one-in-five nonelderly individuals were in families where health care spending for premiums and cost sharing exceeded 10% of family income in 2003. This includes a third of individuals in families with incomes below poverty.<sup>viii</sup>

<sup>i</sup> Data from the National Health Expenditure Accounts (NHEA), which are prepared by the Office of the Actuary, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. See <http://www.cms.hhs.gov/NationalHealthExpendData/>. 2007 estimates are projections calculated by CMS, also available at the link above.

<sup>ii</sup> We report OECD data for the United States where the comparison to other countries is of interest. Note that methods of accounting for national health expenditures used by the OECD and CMS are largely but not entirely in accordance. For example, CMS accounting of national health spending includes the value of health-related research whereas OECD-reported data exclude this amount. Further, OECD accounting makes adjustments for the export and import of health services while CMS does not. For more information, see: Eva Orosz, "The OECD System of Health Accounts and the US National Health Accounts: Improving Connections through Shared Experiences," draft paper prepared for the conference "Adapting National Health Expenditure Accounting to a Changing Health Care Environment," Centers for Medicare & Medicaid Services, April 2005. Available online at: <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/confpaperorosz.pdf>.

<sup>iii</sup> Data from Japan for 2003-2004 were undergoing validation and should be considered provisional and subject to revision. See <http://www.ecosante.fr/index2.php?base=OCDE&lang=ENG&langh=ENG&valeur=&source=1>.

<sup>iv</sup> The statistics on concentration of health spending are based on the 2004 Medical Expenditure Panel Survey (MEPS). The MEPS is a national survey of individual members of households and their health care providers that produces nationally representative data on, among other things, health care use and spending. See [http://www.meps.ahrq.gov/mepsweb/survey\\_comp/household.jsp](http://www.meps.ahrq.gov/mepsweb/survey_comp/household.jsp). Estimates of national health spending obtained from the MEPS differ in several ways from the estimates from the NHEA, which is the source of data for most of the estimates in this document. The MEPS provides estimates for the civilian, noninstitutionalized population, which means that health spending by people in the armed forces or who are institutionalized for long periods (e.g., nursing home residents) are not included in MEPS estimates but are included in the NHEA. MEPS and the NHEA also differ in the way that they categorize certain health expenditures (e.g., hospital-based home health services). See Sing, Banthin, Selden, Cowan, and Keegan, "Reconciling Medical Expenditure Estimates from the MEPS and NHEA, 2002" Health Care Financing Review, vol. 28, no. 1, Fall 2006, available at <http://www.cms.hhs.gov/HealthCareFinancingReview/>.

<sup>v</sup> Analysis of data from the Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002-2007; see 2007 Kaiser/HRET Summary of Findings, at <http://www.kff.org/insurance/7673/index.cfm>.

<sup>vi</sup> Seventy-one percent of covered workers with single or family coverage have an out-of-pocket maximum in 2007. However, some workers with no out-of-pocket limit may have low cost sharing. For example, among those with no out-of-pocket limit for single coverage, 88% have a deductible of less than \$500, 16% face coinsurance for hospital admissions, and 22% face coinsurance for an outpatient surgery episode.

<sup>vii</sup> Kaiser Family Foundation calculations of data from 2004 Medical Expenditure Panel Survey. For a more complete discussion of the variation of out-of-pocket costs (using data from the 2003 Medical Expenditure Panel Survey), see "Distribution of Out-of-Pocket Spending for Health Care Services", May 2006, Kaiser Family Foundation, at <http://www.kff.org/insurance/snapshot/chcm050206oth.cfm>.

<sup>viii</sup> Jessica S. Banthin and Didem M. Bernard, "Changes in Financial Burdens for Health Care," Journal of the American Medical Association, vol. 296, no. 22, December 13, 2006, pp. 2712-2719.

Additional copies of this publication (#7692) are available on the Kaiser Family Foundation's website at [www.kff.org](http://www.kff.org).