GOVERNMENT SPENDING FOR HEALTH ENTITLEMENT PROGRAMS

NIHCM FOUNDATION DATA BRIEF
JUNE 2012

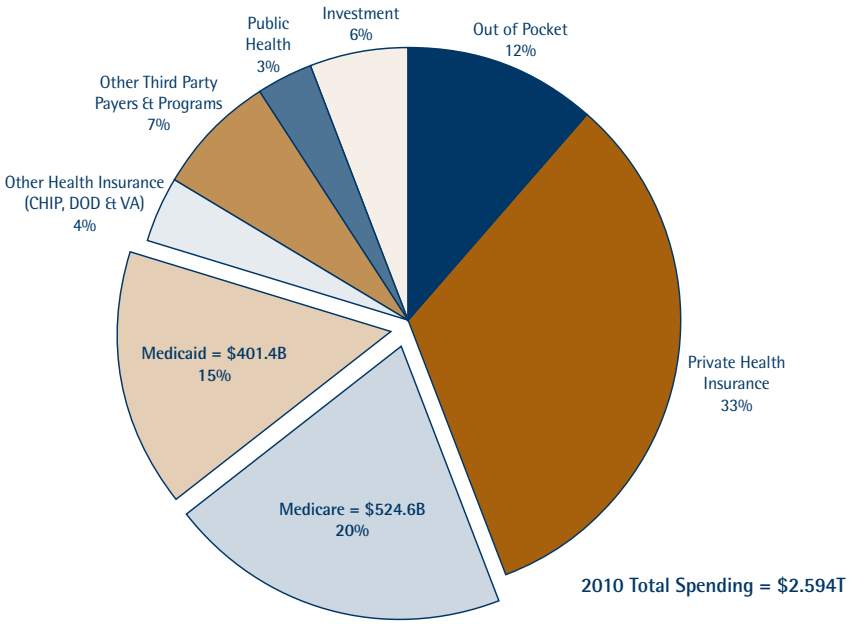
NIHCM FOUNDATION

KEY POINTS FROM THIS BRIEF:

- Spending through the two principal health entitlement programs — Medicare and Medicaid — accounts for well over a third of U.S. health care spending and for one-fifth of all federal spending. On average, states spend almost 25 percent of their budgets on Medicaid.
- Health entitlement spending is projected to grow quickly in the next decade as the baby boom generation ages onto Medicare in very large numbers, costs per enrollee continue to rise, and if more people become eligible for Medicaid as currently expected under national health reform.
- Despite receiving beneficiary contributions through dedicated payroll taxes, increasing premium payments, and beneficiary cost sharing — and despite the existence of the Part A Trust Fund — Medicare is heavily reliant on general revenue financing. Such financing crowds out other uses of general revenue, contributes significantly to annual deficits and cumulating debt, and places upward pressure on taxes.
- The Medicare Trustees have issued a Medicare "fund warning" for each of the past six years, signaling consistent near-term projections that more than 45 percent of the program's annual outlays will be financed from general revenues. Congress has failed to take corrective action in response to these warnings.
- The average person retiring today can expect to receive significantly more in Medicare benefits during retirement than he paid into the program via payroll taxes while working and will pay in annual premiums once retired.
- Based on legislation currently on the books, the Congressional Budget Office projects an improving but still very challenging fiscal outlook for the next decade. More realistic assumptions that result in higher Medicare spending and lower tax revenue yield an even more sobering picture of our future fiscal situation.
- Over the longer term, if federal health entitlement spending grows as it has in the past instead of as projected under current law, our deficits and debt will grow exponentially.

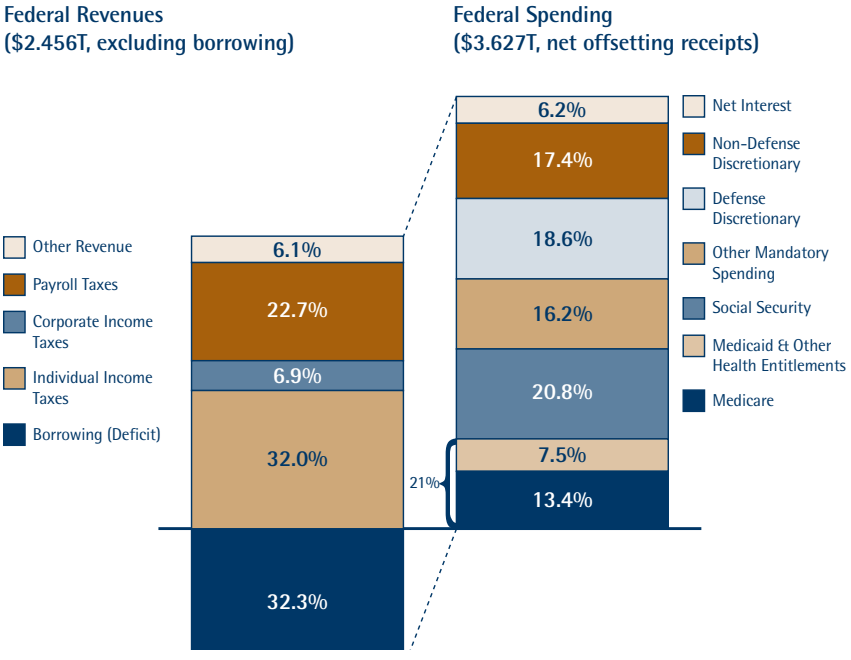
In 2010 spending through Medicare and Medicaid, the principal government health entitlement programs, amounted to $525 and $401 billion, respectively — accounting for a combined total of 35 percent of all health spending in the U.S. (Figure 1). By 2011 Medicare expenditures had risen to $549 billion.[1] Health entitlement program spending also comprises a significant share of the total federal budget. The Congressional Budget Office (CBO) now projects that more than one of every five dollars spent by the federal government in 2012 will go to cover health entitlement expenditures, comparable to total spending on Social Security and outpacing

FIGURE 1. GOVERNMENT HEALTH ENTITLEMENT PROGRAMS AS A PERCENT OF NATIONAL HEALTH SPENDING, 2010



NIHCM Foundation analysis of data from the 2010 National Health Expenditure Accounts.

FIGURE 2. GOVERNMENT HEALTH ENTITLEMENT PROGRAMS AS A PERCENT OF U.S. FEDERAL SPENDING, 2012 (PROJECTED)



NIHCM Foundation analysis of data from CBO's "Updated Budget Projections: Fiscal Years 2012 to 2022," March 2012.

both defense and non-defense discretionary spending (Figure 2).[2] The money to finance all federal spending comes predominantly from individual income and payroll taxes, supplemented by very significant borrowing to cover revenue shortfalls. CBO expects that 32 cents of every federal dollar spent in 2012 will be borrowed. In this brief we take a closer look at spending under the Medicare and Medicaid programs and the implications for the government fiscal situation going forward.

MEDICARE PROGRAM SPENDING

Part A Financing and Spending. Part A of the Medicare program is a mandatory insurance program that covers inpatient hospital stays and post-acute care. Individuals who are over age 64 or long-term disabled qualify for Part A if they or their spouses had at least 40 quarters of Medicare-covered employment. Part A expenditures are handled through the Part A (Hospital Insurance) Trust Fund and are financed primarily by a 2.9 percent payroll tax levied on workers and employers.[i] In 2011 these taxes generated more than 85 percent of the Part A Trust

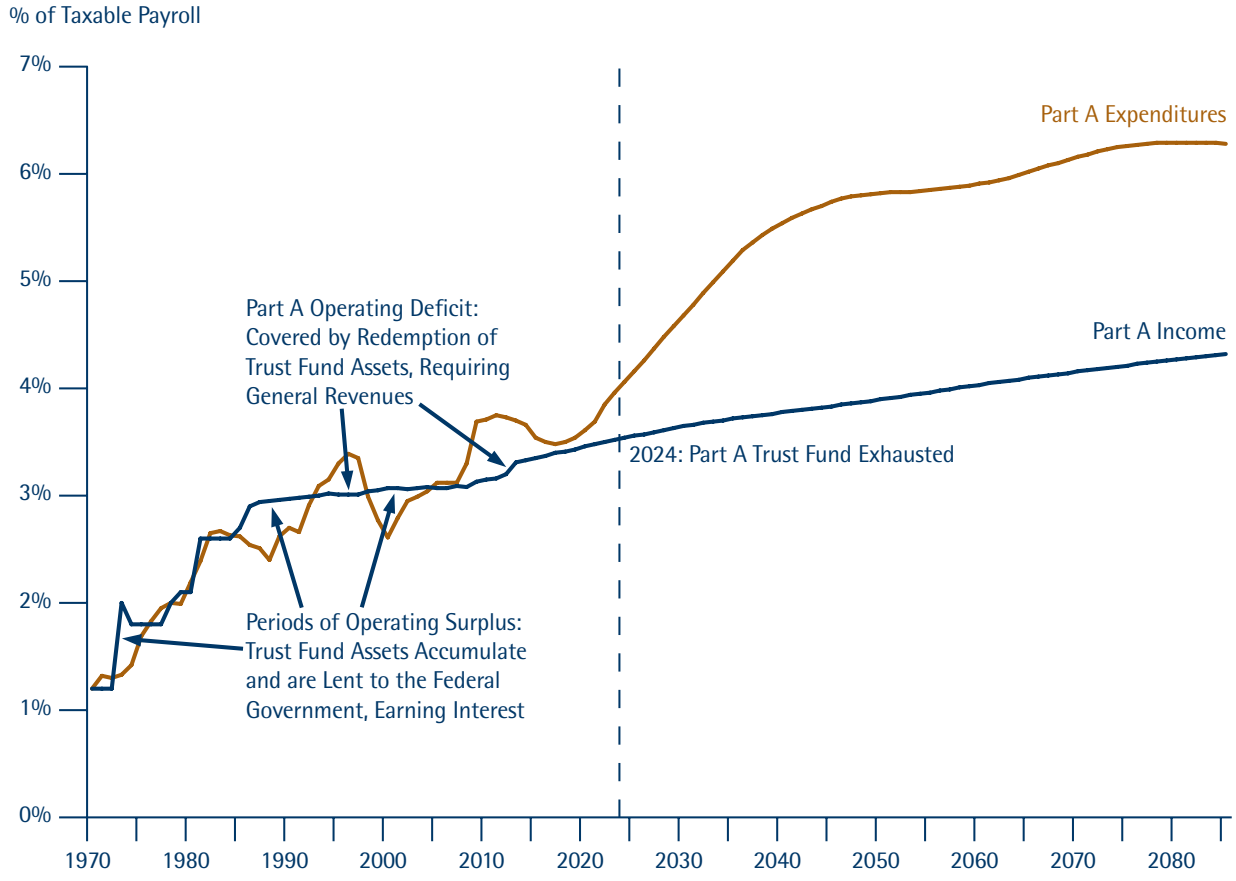
i Other Part A revenue comes from interest earned on Trust Fund reserves and income taxes paid by higher-income beneficiaries on a portion of their Social Security benefits (5 and 7 percent of 2011 revenue, respectively). In addition, a small number of people who do not have the requisite 40 quarters of Medicare-covered employment may gain access to the program by paying a premium for Part A coverage (2 percent of 2011 revenue). When someone who lacks the necessary employment history is eligible for Medicaid, the Part A premium may be paid by his/her state as part of a Medicare buy-in program.

Fund revenue.[3] While workers may believe that their contributions are, in some sense, being held in reserve in the Part A Trust Fund for the time they themselves become eligible for Medicare, in fact the system relies on "pay as you go" financing. That is, the contributions from current workers and employers are used immediately to finance the care for current beneficiaries. Care for future retirees will be financed by contributions from the workers who come behind them.[ii]

In any year when the payroll tax contributions and other smaller sources of revenue exceed the Part A expenses for current beneficiaries, as was the case during several periods in the past few decades (Figure 3), the operating surplus is credited to the Part A Trust Fund. These funds are then, in effect, lent to the federal government by investing in Treasury-backed securities; the Trust Fund earns interest on funds that would otherwise be idle and the federal government is able to finance some of its other current spending needs. However, in years when the payroll tax contributions and other revenue are not sufficient to cover Part A spending for current beneficiaries, the Trust Fund covers the shortfall by redeeming some of its securities. The federal government finances these redemptions from general revenues. As such, Part A represents a claim on general revenues in any year when spending exceeds

ii As more and more members of the baby boom generation retire, the ratio of Medicare beneficiaries to active workers will increase dramatically, placing an added burden on the current and future workers who will be financing Medicare expenditures for the growing beneficiary population.

FIGURE 3. MEDICARE PART A EXPENDITURES AND INCOME OVER TIME



Source: A Summary of the 2012 Annual Reports, Social Security and Medicare Boards of Trustees, www.ssa.gov/OACT/TRSUM

income, even when there is still a surplus credited to the Part A Trust Fund on the government ledgers.

As seen in Figure 3, Part A expenditures have exceeded annual program income since 2008, necessitating redemptions of securities and a corresponding drawdown of the Trust Fund assets. Current projections — driven largely by the massive wave of baby boomer retirements through the mid-2030s and rising per-beneficiary medical costs — are that Part A will continue to operate at a deficit for each year forward. Each annual operating deficit will further deplete the previously accumulated Trust Fund assets. The most recent Medicare Trustees Report[1] predicts that the Trust Fund will be exhausted in 2024 given expected revenue and spending patterns.[iii] If no corrective action is taken to avert this occurrence, it will then be necessary to either reduce Part A outlays overnight to the level that can be financed by current-year receipts (estimated to be 87 percent of scheduled benefits), or enact legislation to permit supplementation of receipts through additional general revenue contributions or other sources of revenue.

Financing and Spending for Parts B and D. Parts B and D of the Medicare program are financed through the Supplemental Medical Insurance (SMI) Trust Fund and cover, respectively, physician and outpatient services and outpatient prescription drugs. Enrollment in Parts B and D is voluntary and requires payment of premiums (either directly from the beneficiary or by a state as part of a Medicare buy-in program).[iv] By statute, aggregate premiums are set so as to cover about 25 percent of Part B and Part D program costs, with higher-income beneficiaries now paying higher premiums. Part B now also derives a small amount of revenue from new fees on manufacturers and importers of brand-name drugs instituted as part of the Affordable Care Act (ACA). Part D receives transfers from states to compensate the federal government for a portion of prescription drug costs for dually eligible beneficiaries, whose drug costs would have fallen entirely to the Medicaid program if not for Medicare Part D (known as "clawback" payments). These latter payments are expected to amount to about 12 percent of Part D costs in 2012.[3]

Program outlays for Parts B and D in excess of the premiums, state transfers and drug fees are financed by automatic transfer of general revenues to the SMI Trust Fund. Thus, by definition, the SMI Trust Fund is always fully financed, although it is requiring larger and larger transfers from general revenues as program expenses mount.

Putting All of the Parts Together. Figure 4 shows these various sources of Medicare program revenue (other than interest earned on the trust fund securities) compared to total Medicare expenditures.[v] It is clear that the specifically-dedicated revenue sources — i.e., the Part A payroll taxes, taxes on Social Security benefits, beneficiary premiums, state transfers for prescription drug coverage for dually eligible beneficiaries, and drug fees from manufacturers and importers of brand name drugs — cover only a fraction of total program expenses. The remaining funds come from general revenue transfers, either as part of the explicit financing structure for Parts B and D or through redemption of Part A Trust Fund securities. As shown in Figure 2, as long as the current levels of taxes and other federal spending persist, a significant portion of these general revenue transfers will have to come from borrowing. After 2024, the Part A Trust Fund will be in a deficit situation, unable to cover current-year Part A expenses with current-year revenue (Figure 3) but holding no more securities to cover the shortfall.

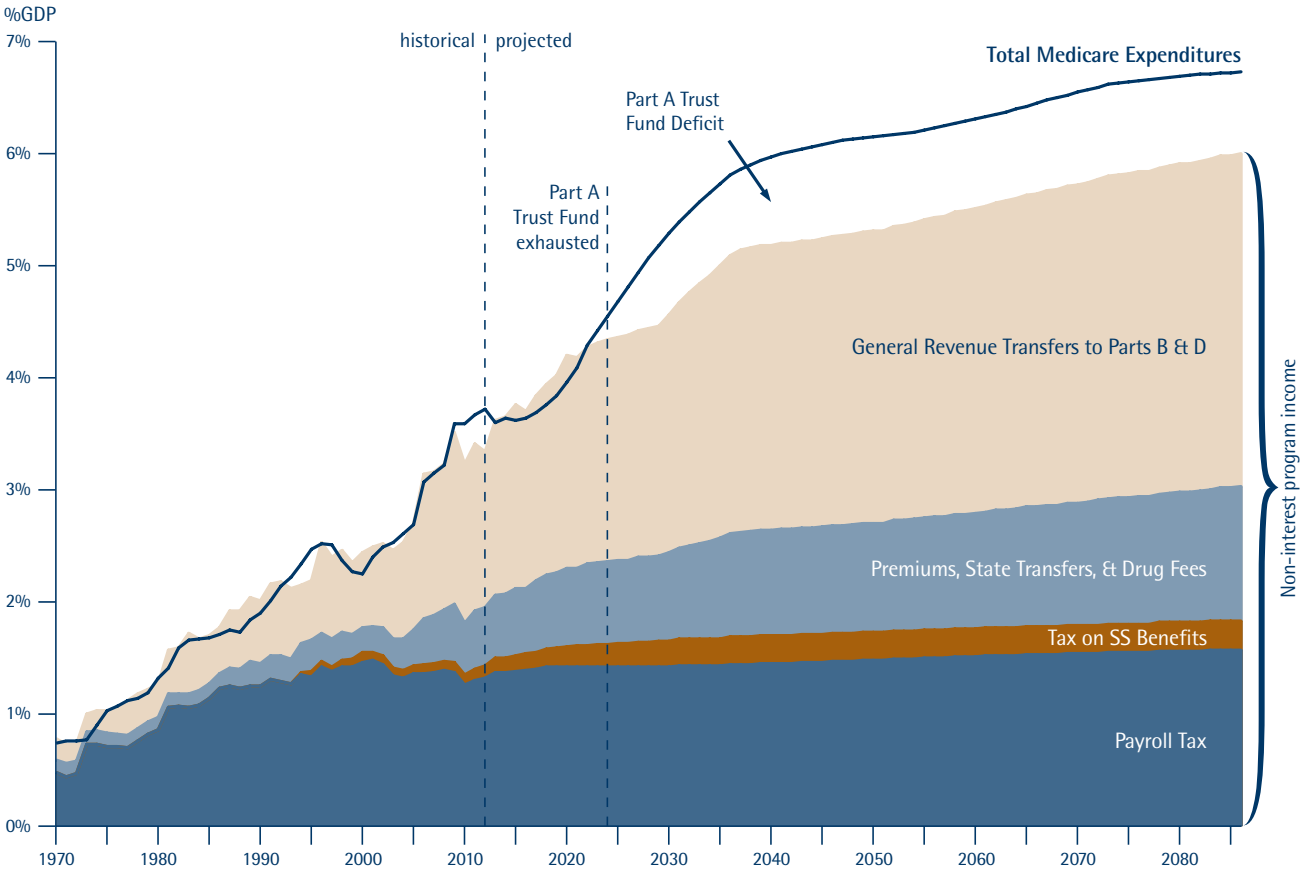
Figure 4 shows clearly the increasing reliance on general revenue financing in future years. Whereas general revenue transfers to the SMI Trust Fund currently comprise about 42 percent of all non-interest program income, this figure will be about 49 percent by the mid-2030s, when the last of the baby boom retirees enter the program. Part A Trust

iii The Trustees' projections reported here are based on the assumption that current laws will be implemented as planned. Most notably, projected Medicare expenditures incorporate the planned reductions in Medicare productivity updates to providers called for in the Affordable Care Act, the cuts in Medicare physician fees required under the Sustainable Growth Rate formula, and the reductions in Medicare provider payment rates required under the sequestration agreement of the Budget Control Act. As discussed in more detail later in this report any deviation from these assumptions will significantly increase Medicare spending and worsen the financial outlook for Medicare and the federal budget. If history is an accurate predictor of future actions by Congress, it is extremely likely that at least some of these scheduled payment reductions will be overturned or relaxed.

iv Beneficiaries may also voluntarily enroll in a private managed care plan under Medicare Part C. Their care is financed through capitated payments drawn from the Part A and SMI Part B Trust Funds.

v Beneficiaries also contribute to the cost of their care through deductibles and coinsurance paid at the time of service. These amounts are not counted as a part of program revenue here because the total program expenditures are net of beneficiary cost sharing.

FIGURE 4. TOTAL MEDICARE EXPENDITURES AND INCOME OVER TIME



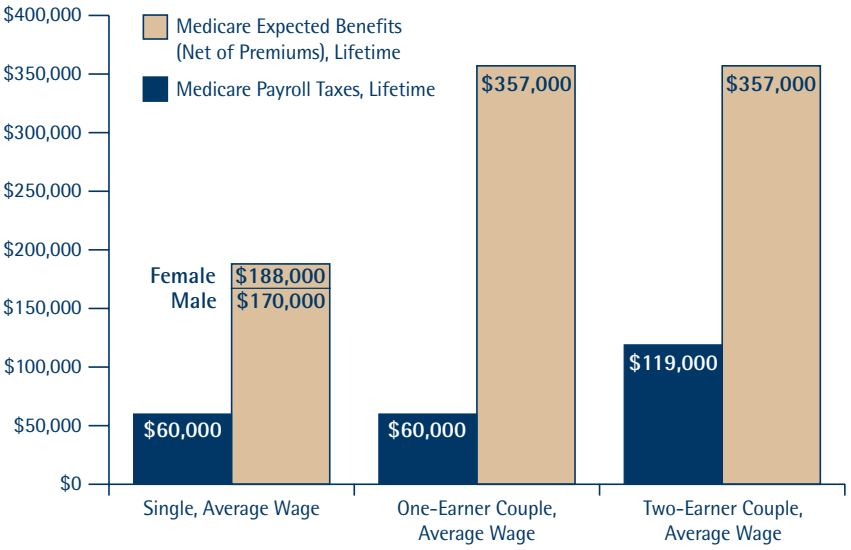
Source: A Summary of the 2012 Annual Reports, Social Security and Medicare Boards of Trustees, www.ssa.gov/OACT/TRSUM

Fund drawdowns prior to 2024 will also require general revenue transfers, and there is the potential for much larger claims on general revenues after that date if new legislation is enacted to permit general revenue financing of Part A deficits after the Trust Fund is exhausted.

Recognizing the vulnerability of the program due to its high reliance on general revenue financing and the important implications for the federal budget of this very large expenditure, the Medicare Trustees are now required to examine annually whether projections for any of the next seven years indicate that more than 45 percent of total program outlays will come from general revenue. The Trustees have made such a determination of "excess general revenue Medicare funding" in each of the past seven years (from 2006 to 2012). Any time this determination is made for two consecutive years, a Medicare "fund warning" is issued, requiring the President to submit proposed legislation to Congress to address the excess general revenue financing. Although warnings have been triggered each year since 2007, Congress has so far failed to take any corrective action in response.[3]

Medicare Financing and Spending from the Beneficiary Perspective. Figure 5 provides another way of looking at the imbalance between dedicated revenue coming into the Medicare program and program outlays, this time from the perspective of individual beneficiaries over their working and retired lifespans.[4] In this analysis a person who had worked a full career at the average wage and retired at age 65 in 2011 would have contributed approximately $60,000 to Medicare through Part A payroll taxes during his or her working years. But this same worker would, on average, expect to receive $170,000 in Medicare benefits during retirement if he is male, and $188,000 if she is female (due to longer

FIGURE 5. MEDICARE EXPENDITURES AND INCOME FROM A BENEFICIARY LIFETIME PERSPECTIVE



Source: Steuerle CE and Rennane S. "Social Security and Medicare Taxes and Benefits Over a Lifetime." Washington, DC: The Urban Institute. June 2011.

life expectancies).[vi] If this worker is married and his/her spouse had not worked, the same $60,000 would have been contributed in payroll taxes by the couple, but expected benefits would double to nearly $360,000 because the non-working spouse would also qualify for Medicare benefits. In a couple where both spouses had worked at the average wage, their combined payroll contributions would have been about $120,000 but their expected lifetime benefits would still be around $360,000. Contributions would be higher than shown in Figure 5 for workers who earned more than the average wage, but even these workers can expect to receive significantly more in benefits from Medicare than they have contributed to the program.

With expected benefits exceeding total program contributions by such significant amounts, it is reasonable to ask whether current and future beneficiaries should cover a larger portion of program expenses explicitly (rather than through general tax contributions). Recent policy changes have increased premiums for Parts B and D for higher income beneficiaries and raised Part A payroll taxes for higher-earning workers. Other pending Medicare reform proposals call for greater contributions from beneficiaries through an across-the-board increase in the Part B premium from 25 to 35 percent of expected spending, further means testing of premiums for higher income beneficiaries, and greater beneficiary cost sharing at the point of service.

Such changes will have to be weighed against the limited ability of many seniors to absorb the increases due to their relatively low incomes and high out-of-pocket spending on medical care. Roughly two-thirds of senior households derive more than half of their income from Social Security, and reliance on this income source increases with age as savings diminish and health expenditures mount.[5] While non-Medicare households spent an average of 5 percent of their budgets on health care in 2010, senior households spent three times that amount (and were working from budgets that were 40 percent lower).[6] In that same year, 35 percent of seniors lived at or below 200 percent of the federal poverty level; this number increases to almost half once medical costs and other factors that reduce disposable income are taken into consideration using the Census Bureau's alternative measure of poverty.[4] Thus, while some portion of retirees is certainly able to bear a larger share of their Medicare costs, higher cost sharing will pose a significant burden for many seniors.

The burden is also potentially great for the current workers who will be future beneficiaries. The latest

vi The lifetime taxes include both the employee and employer contributions and are calculated by adjusting nominal tax amounts for inflation and allowing for a 2 percent rate of return to approximate what the worker could have earned if the tax payments had been invested in a savings account instead of paid to the government. Expected benefits over retirement are for an average beneficiary with the average life expectancy and in average health. The benefit estimate has been reduced by the cost of premiums paid by the beneficiary and is computed as the net present value of funds that the program would need to have on hand upon retirement to cover all future expected benefits, assuming a 2 percent real rate of return on investments. More detail on the methods and assumptions used to make these calculations can be found at http://www.urban.org/retirees/Estimating-Social-Security.cfm.

analyses from the Medicare Trustees project an "actuarial deficit" for the Part A Trust Fund of 1.35 percent of current payroll over the next 75 years using current law assumptions.[1] This means that if the long-run shortfall is to be made up solely by higher contributions from current workers, the Part A payroll tax would have to be increased immediately from the present 2.9 percent to 4.25 percent. More realistic projections that depart from current law assumptions place the actuarial deficit at 2.43 percent of payroll, implying the need for an immediate increase in current workers' Part A taxes to 5.33 percent or nearly double the current rate.

MEDICAID PROGRAM SPENDING

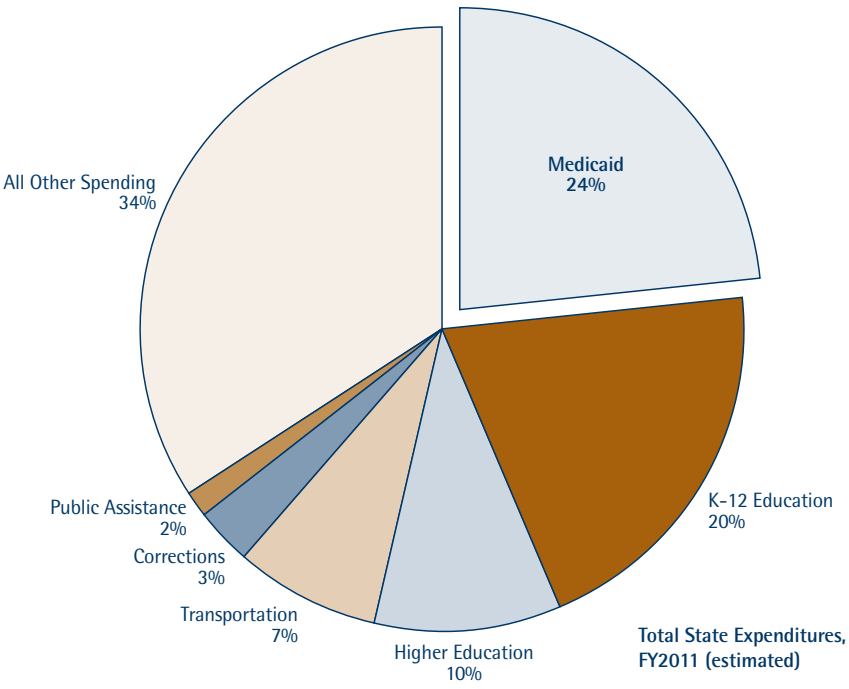
The Medicaid program is financed by a combination of state expenditures from general funds and federal matching funds. At the state level, Medicaid now represents the single largest budget category, accounting for nearly one-quarter of all state spending and eclipsing spending on elementary and secondary education (Figure 6).[7] Since states generally must operate within the constraint of a balanced budget, higher Medicaid spending means that other spending must be curtailed or taxes must rise.

Over the past decade, total Medicaid program spending has more than doubled — rising from $207 billion in 2000 to $429 billion in 2010, with particularly rapid growth during the recent recession due to large numbers of new enrollees (Figure 7). Prior to 2009, states picked up about 44 percent of the total spending, on average, and the federal government contributed about 56 percent through matching funds. Passage of the American Recovery and Reinvestment Act (ARRA) early in 2009 temporarily increased the federal match rates for two years, resulting in average federal contribution levels of about 64 percent. Match rates returned to historical levels in 2011. Even so, rising total program spending will continue to put upward pressure on federal expenditures associated with the Medicaid program, especially once the planned Medicaid expansions of the ACA take effect (see below).

FEDERAL BUDGET IMPLICATIONS GOING FORWARD

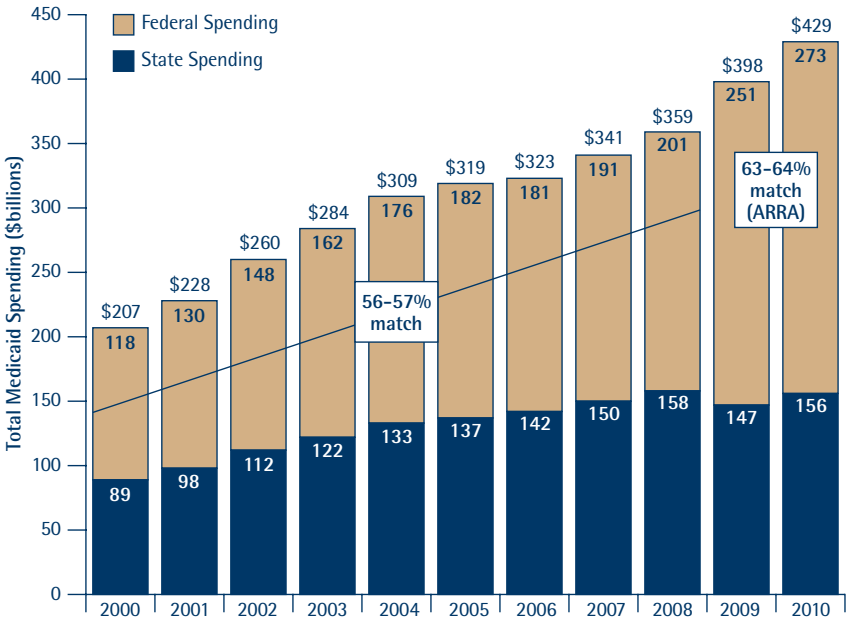
In its March 2012 update on the federal budget outlook, the CBO predicts that mandatory federal spending on all health entitlement programs will more than double in the next decade, rising from 5.1 percent of GDP in 2011 to 6.7 percent of GDP by 2022 (Figure 8).[2] Furthermore, the $1.651 trillion in federal health entitlement spending projected for 2022 will amount to 30 percent of the $5.520 trillion in federal outlays predicted for that year — a significant increase from the 21 percent of federal spending expected for 2012 (see Figure 2).

FIGURE 6. MEDICAID SPENDING AS A PERCENT OF TOTAL STATE SPENDING, 2011



Source: Summary of National Association of State Budget Officers "State Expenditure Report." December 2011.

FIGURE 7. FEDERAL AND STATE MEDICAID SPENDING OVER TIME



NIHCM Foundation depiction of data from National Association of State Budget Officers. "State Expenditure Report." December 2011.

As required with CBO estimates, these "baseline scenario" figures are based on current statute and therefore reflect the up to 2 percent reductions in Medicare benefit spending set to begin in January 2013 under the sequestration process defined in the Budget Control Act, reductions of about 27 percent in Medicare payments for physician services that were anticipated for January 2013 under the Sustainable Growth Rate (SGR) policy (now 31 percent due to a 10-month postponement of scheduled cuts that took effect on March 1, 2012), and full implementation of the ACA including its scheduled reductions in productivity updates for Medicare providers and the Medicaid expansions, insurance exchanges and low-income subsidies.

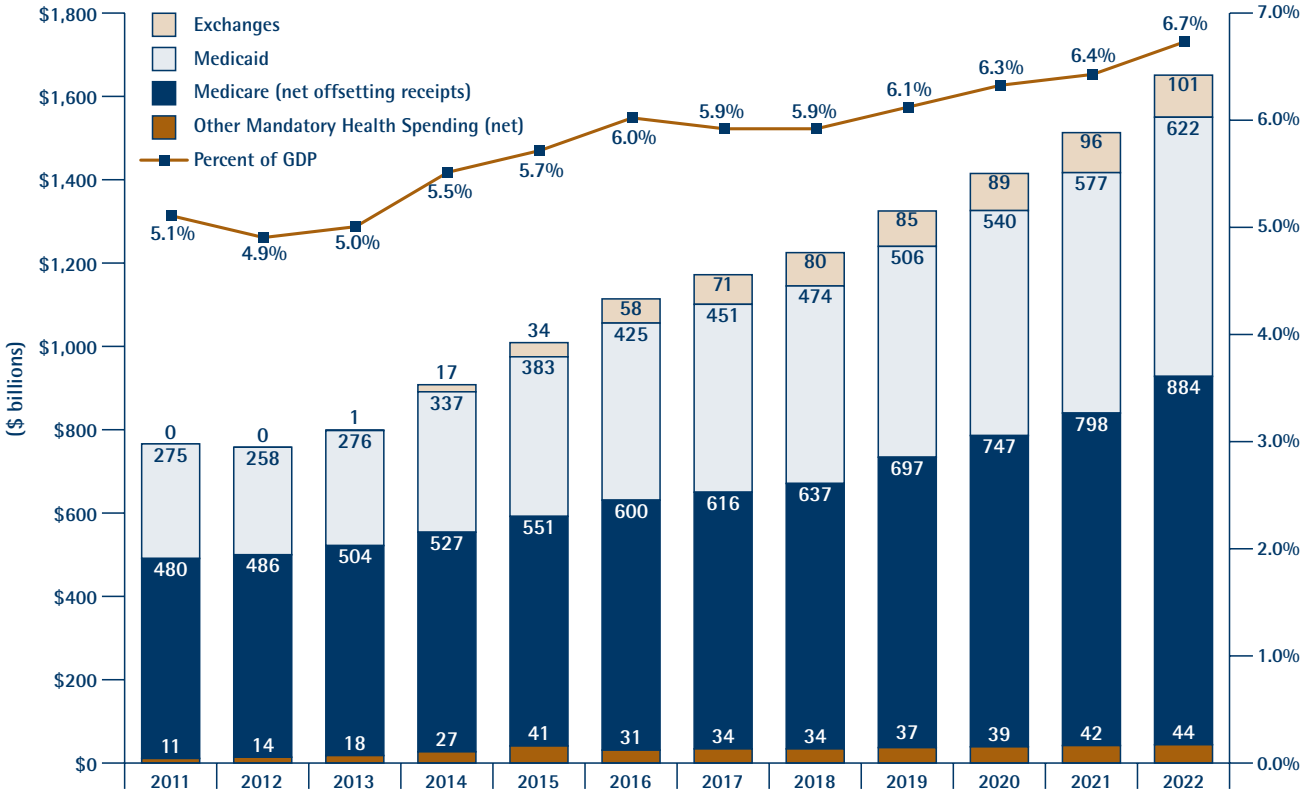
Under these assumptions, Medicare spending is expected to rise by 84 percent in the next decade — from $480 to $884 billion.[vii] This increase will be driven primarily by the retirement of approximately 10,000 baby boomers each day over the period (and beyond) as well as by constrained-but-still-rising spending per beneficiary. federal Medicaid spending is expected to begin to rise rapidly in 2014 as a result of the ACA Medicaid expansions and enhanced federal match rates for certain categories of newly-eligible enrollees, reaching $622 billion in 2022. The new health insurance exchanges and associated subsidies for premiums and cost sharing are also expected to begin in 2014 (with modest expenditures prior to that date for necessary preparations). The exchange-related spending is projected to be a relatively small portion of overall mandatory federal health spending, reaching only about a 6 percent share at its highest level. There is also a small amount of other mandatory spending related to the Children's Health Insurance Program, DOD spending for Medicare-eligible veterans, and other miscellaneous programs; this spending is expected to total $44 billion at its highest level in 2022.

In addition to the current statutes denoted above that affect mandatory health spending, several other statutes affect projections of the revenue that will be flowing into the federal coffers. Specifically, the CBO baseline projections assume that all of the so-called "Bush tax cuts" are allowed to expire as scheduled at the end of 2012, resulting in a dramatic influx of funds starting in 2013, and that the threshold for the alternative minimum tax (AMT) is no longer indexed for inflation (or "patched") for tax years after 2011, forcing a growing proportion of tax payers to pay the higher AMT over time as incomes rise.

In combination, despite the projected growth in mandatory health spending seen in Figure 8, the full set of baseline assumptions yield a somewhat

vii The Medicare spending reported here is net of offsetting receipts, such as premium revenue and transfers from states for drug costs of dually eligible beneficiaries. As such, it will not equal the amounts derived from the National Health Expenditure Accounts that were reported at the outset of this brief since those figures include all spending under the Medicare program regardless of the financing source.

FIGURE 8. PROJECTED MANDATORY FEDERAL HEALTH SPENDING



NIHCM Foundation analysis of data from CBO's "Updated Budget Projections: Fiscal Years 2012 to 2022," March 2012.

improving picture of the federal fiscal situation (Figure 9, top panel). The deficit of $1.171 trillion expected in 2012 is projected to shrink to $303 billion in 2022, a decline from 7.6 percent of GDP to 1.2 percent. At the same time, the debt held by the public to finance our cumulative deficit spending will shrink from 73 to 61 percent of GDP. Although a move in the right direction, this level of debt is still considerably higher than the roughly 40-percent-GDP level at which our economy has operated for the past 50 years.

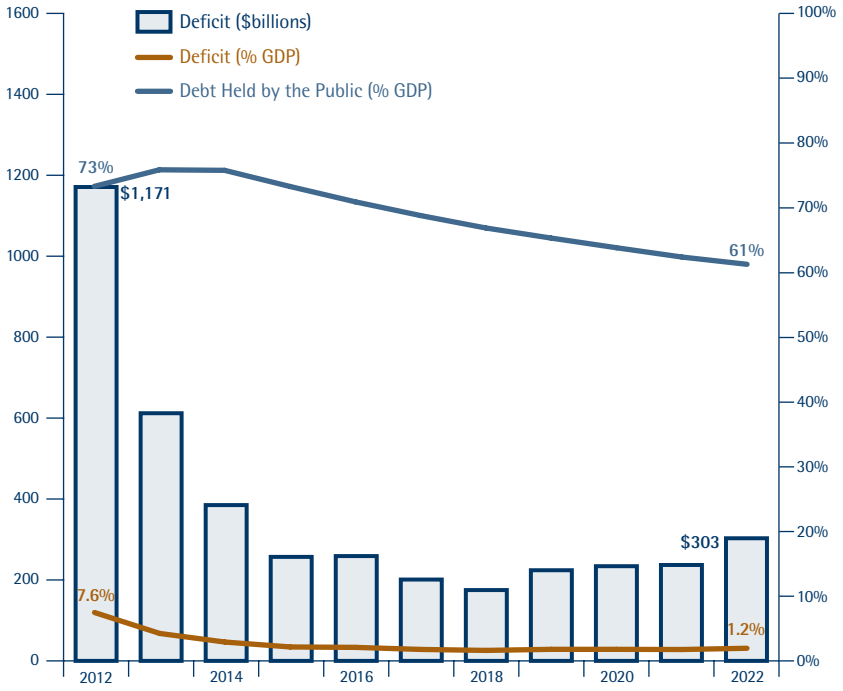
The assumptions underpinning the baseline scenario may be unrealistically rosy, however, on both the revenue and spending sides. In its "alternative fiscal scenario" CBO has assumed that the expiring tax cuts are extended, the AMT threshold is indexed to inflation, the SGR cuts to physician reimbursement levels under Medicare are averted, and the automatic spending cuts required under sequestration (including to non-health programs) are overridden by Congress. These new assumptions lower revenue and increase spending, changing the fiscal outlook considerably (Figure 9, bottom panel). Now the deficit is expected to rise to $1.449 trillion in 2022 instead of falling, accounting for 5.9 percent of GDP and implying a rise in the debt held by the public to 93 percent of GDP.[viii]

The above worsening in our fiscal outlook is driven by modified assumptions that both lower revenues and increase spending across a range of government

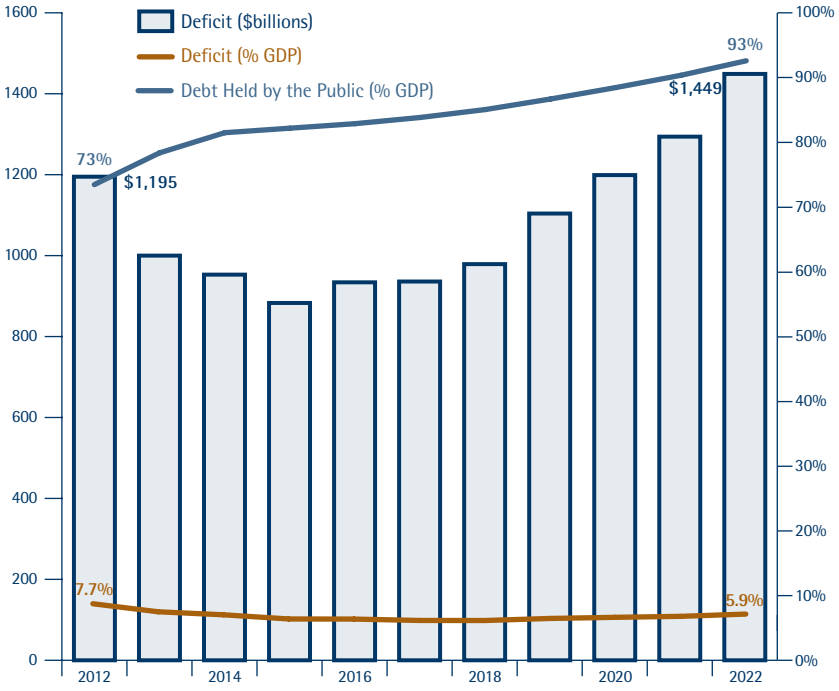
viii Even beyond the possibility that Medicare spending will exceed current law projections if scheduled SGR and sequestration payment cuts are overridden, others have questioned whether the lower updates to Medicare provider payment rates called for in the ACA will be sustainable over the longer run (see, for example, testimony by the Chief Actuary, Richard S. Foster, before the House Committee on the Budget, budget.house.gov/UploadedFiles/fostertestimony1262011.pdf). Any move to reverse or moderate these payment reductions will also push Medicare program spending higher and, all else equal, raise the deficit. CBO accounts for this possibility in its "extended alternative fiscal scenario" projections that look beyond the next decade. See the CBO's "The 2012 Long-Term Budget Outlook," June 2012, for more information.

FIGURE 9. FEDERAL FISCAL OUTLOOK UNDER BASELINE AND ALTERNATIVE FISCAL SCENARIOS

Baseline Scenario



Alternative Fiscal Scenario



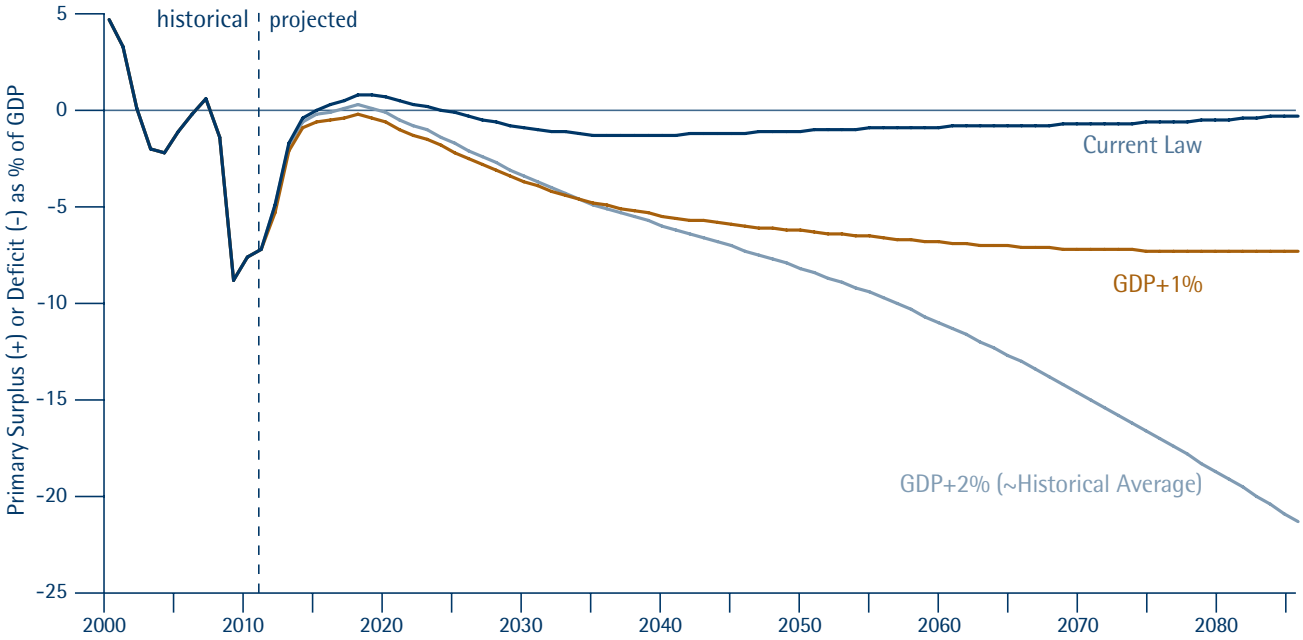
NIHCM Foundation analysis of data from CBO's "Updated Budget Projections: Fiscal Years 2012 to 2022." March 2012.

programs, not only the health programs. But given the outsized importance of spending on health entitlement programs in the federal budget, changes in projections of health spending alone will have dramatic implications for our fiscal situation. The most recent report on the fiscal status of the U.S. government issued by the Secretary of the Treasury illustrates how the deficit outlook is affected by different assumptions about growth in federal health spending.[8] Their analysis revealed that if federal Medicare and Medicaid spending grow as projected under current statute, including full implementation of the ACA, we will realize a very modest primary surplus (i.e., net of interest payments) over the next decade before transitioning to a modest primary deficit over the longer term (Figure 10). If, however, Medicare and Medicaid spending grow one percentage point faster than GDP, no surplus will be realized and the primary deficits will be more pronounced. And if federal health entitlement spending grows, on average, two percentage points faster than GDP – that is, closer to the historical average – deficits will spiral out of control in the very long term.

SUMMARY

High spending for health entitlement programs poses a substantial and increasing burden for government budgets. At the state level, high Medicaid expenditures consume a growing share of state spending, crowd out other types of spending, and put upward pressure on taxes.

FIGURE 10. IMPACT OF DIFFERENT GROWTH RATES IN MEDICARE AND MEDICAID SPENDING



Source: " 2011 Fiscal Report of the U.S. Government." Supplemental Information, Chart 5, http://www.fms.treas.gov/finrep11/supp_info/fr_supplement_info_alternative.html#chart5

The effect is even more profound at the federal level where spending on Medicare, Medicaid, and other entitlement programs is not only consuming a growing share of the federal budget but also contributing to rising deficits and increased debt. Options for achieving more solid financial footing overall include reducing the rate of growth in entitlement spending, imposing additional cost sharing on current and future beneficiaries, cutting back on other categories of spending, and raising taxes (in general and/or specific to Medicare). It seems likely that movement will be required on all fronts, with the exact path forward navigating a delicate balance between many diverse political and fiscal interests.

ENDNOTES

1 Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. "2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund." April 23, 2012. http://www.cms.gov/ReportsTrustFunds/downloads/tr2012.pdf (Accessed April 30, 2012.)

2 Congressional Budget Office. "Updated Budget Projections: Fiscal Years 2012 to 2022." March 13, 2012. http://www.cbo.gov/publication/43119 (Accessed March 13, 2012.)

3 Social Security and Medicare Boards of Trustees. "A Summary of the 2012 Annual Reports." http://www.ssa.gov/oact/TRSUM (Accessed April 30, 2012.)

4 Steuerle CE, Rennane S. "Social Security and Medicare Taxes and Benefits Over a Lifetime." The Urban Institute. June 2011.

5 Komisar H, Cubanski J, Dawson L, Neuman T. "Key Issues in Understanding the Economic and Health Security of Current and Future Generations of Seniors." Kaiser Family Foundation Issue Brief. March 2012. http://www.kff.org/medicare/8289.cfm. (Accessed March 20, 2012.)

6 Cubanski J, Damico A, Levinson Z, Huang J, Neuman T. "Health Care on a Budget. The Financial Burden of Health Spending by Medicare Households." Kaiser Family Foundation Data Spotlight. March 2012. http://www.kff.org/medicare/medicare-spending-briefs.cfm (Accessed March 20, 2012.)

7 National Association of State Budget Officers. "2010 State Expenditure Report." December 2011. http://www.nasbo.org/publications-data/state-expenditure-report (Accessed January 24, 2012.)

8 U.S. Secretary of the Treasury. "2011 Financial Report of the United States Government." December 2011. http://www.fms.treas.gov/finrep11/fr_index_new.html (Accessed January 19, 2012.)

ABOUT NIHCM FOUNDATION

The National Institute for Health Care Management Research and Educational Foundation is a non-profit organization whose mission is to promote improvement in health care access, management and quality.

ABOUT THIS BRIEF

This brief was prepared by Julie A. Schoenman, PhD, (jschoenman@nihcm.org), under the direction of Nancy Chockley, MBA, (nchockley@nihcm.org). We are grateful to Jeff Stensland, PhD, for his thoughtful comments on an earlier draft of this brief.

Part of the Foundation's larger research focus on health care spending, this document is the second in a series of briefs that will present current data and analysis on selected topics relevant to discussions of our nation's high and rising health care spending. The initial brief, "U.S. Health Care Spending: The Big Picture," provided an overview of health care spending in the United States.

All briefs will be available at www.nihcm.org. To request hard copies of any materials, email your request to nihcm@nihcm.org or call 202-296-4426.

NIHCM
FOUNDATION

1225 19th Street NW
Suite 710
Washington, DC 20036

202.296.4426
202.296.4319 (fax)

www.nihcm.org