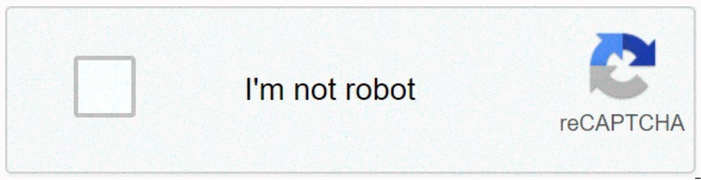

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What does nas stand for in medical terms

ASPE ISSUE BRIEF May 2005 Printer Friendly Version in PDF Format This Issue Brief is available on the Internet at: Contents As the population of the United States ages, it will consume more health care. The elderly suffer from diseases and other medical problems to a greater extent than younger people. And with health care prices continuing to rise much faster than other goods and services, society's cost of use and health care costs are expected to skyrocket in the future. Since public programs fund more elderly health care, over time there will be growing pressure on the federal and state budgets, and long-term strain on public funds will put pressure on tax rates. That, in turn, could cause lawmakers to re-examine insurance commitments they've made through federal and state health care programs. Whatever the outcome of these competitive pressures, steps to moderate the growth of health care prices and increase the efficiency and effectiveness of health care provision are essential to moderate the economic burden that future health care costs are likely to impose. History Perspective National Health Spending 1960 1985 2003 (in the current billions of dollars) Total expenditure 27 427 1,679 Per person 143 1,765 5,670 (in constant billions of dollars 2003 *Total expenditure 166 730 1,679 Per person 891 3,019 5,670 GDP share 5.1% 10.1% 15.3% Source: National Health Spending, Centers for Medicare Services & Medicaid, Actuary Office, National Health Statistics Group; U.S. Department of Commerce, Bureau of Economic Analysis; and the U.S. Bureau of Population Survey * Adjusting for changes in the Consumer Price Index for all urban consumers, all items The Country spends on health care have been on a relentless path or more for a number of decades. In 1960, total medical expenses in the United States reached $27 billion; In 2003, this figure stood at nearly $17 billion up 63 times. By contrast, the U.S. population grew only 51%. Per person (or per person) medical expenses increased from $143 in 1960 to $5,670 in 2003, a 40-fold increase. Overall inflation has pushed prices for goods and services in the economy up five-fold. In contrast, the increase in the price of medical care was recorded 12 times, mainly due to increased hospital fees and doctor's fees. [1] The overall economic aspects of growth were equally impressive, with the proportion of the economy devoted to health care tripled during this period, rising from about 5% of domestic product (GDP) in 1960 to more than 15% in 2003. Inflation and the increase in health care prices from 1960 to 2003 1990-2003 (Percentage price increase) General inflation 515% 41% Overall health care 1.232% 82% Health care services 1.469% 88% Source: Consumer Price Index for urban consumption, loc. cit. Consumption elderly care is greater than the rest of the population. In 1999, health care spending per person for the entire U.S. population, that was $3,834. For a population under the age of 65, that's $2,793. For a population of 65 and older, it is $11,089, or nearly four times as high. Even in an ageing population, the sing-ing is significant. For those aged 65 to 74, it's just $8,167 compared to $20,001 for those 85 and older. Medicare enrollees, 87 percent of them aged 65 and over, made up 14.5 percent of the total population that year, but they accounted for 37 percent of the nation's personal health care spending. [2] For two million recipients residing in full-time nursing homes (three-quarter of them are aged 75 and over), the per person cost $44,520. Among recipients aged 85 and over, 22 percent resided in nursing homes. [3] People aged 85 and over made up 1.6% of the population in 1999, but they accounted for more than 8% of the countries' personal health care spending. Health care expenditure per person per person of the elderly compared to the rest of the population, 1999 Age group spending personal health care per person All ages $3,834 Under 65 2,793 65 or more 11,089 19-44 2,706 2,70645-54 3,713 55-64 5,590 65-74 8,167 75-84 12,244 85 or more 20,001 Source : Age estimates in national health accounts, Exam P. Keehan, Helen C. Lazenby, Mark A. Zezza, and Aaron C. Catlin, Health Care Financing Review, December 2, 2004. Health care spending by Medicare population 65 and older, by spending, 1999 Share health care costs in%: Top 1 percent of Top 5 percent users Top 10 percent users 12.8 percent 35.9 percent 53.8 percent Source: Current Medicare Beneficiary Survey , loc. cit. While average spending by age group illustrates the effects of older age on health care consumption, they do not show a focus of health care use in the elderly population. In any year, the majority of the cost of medical care tends to be in ins provided by a relatively small group of people. In 1999, 1 percent of Medicare enrollees aged 65 and over in 13 percent of that group's health care costs. The top 10 percent with the highest costs in ins ins first ins insy with 54 percent. The significance of that focus is not only that the health care costs of countries will increase as the elderly increase in numbers, those costs will be amplified as those in the population with the highest proportion of health care costs increase as part of the population. Over an eight-year period, 1992 to 2000 alone, the percentage of medicare population including those aged 85 and over increased from 9.7 percent to 10.9 percent. [4] [Go to Contents] The importance of public funding of The Nations Health Care In 2003, public government funding state and state and local governments that combine direct funding close to medical expenses of countries. This includes personal health care, research, construction, materials and other related expenses. They include 44 percent of spending made on personal health care including military care and active veterans. Over the past half century, government agencies have taken on an increasingly larger role in meeting the health care needs of nations. In 1960, they funded 25 percent of the total national health costs. With the advent of Medicare and Medicaid in 1965, the government rate grew rapidly to 38 percent in 1970, and continued to grow there after that, reaching 46 percent in 2003. Public Change (Federal and State) And Private Finance of National Health Spending 1960 1970 1980 1990 2003 (in percent) Public Funds 25 38 43 41 46 Private Funds 75 62 57 59 54 Source: National Health Spending, loc. The largest personal health care funding now comes from private insurance, which provided 36 percent of the funding for those expenses in 2003. Out-of-pay spending accounts for 16%, making it the next largest private source. Medicare and the federal Medicaid portion include the majority of federal government support. States that share Medicaid are the largest component offered by state and local governments. Personal health care financial resources, 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 States and Local 13 3 Source: National Health Costs, loc. cit* Including federal and state funding. Among sources, federal components grew the most in the last four decades, rising from 9 percent of personal health care spending in 1960 to 33 percent in 2003. Although Medicaids emerged in 1966 that significantly increased federal government spending on health care for the poor, the percentage of personal health care spending for the poor funded by state and local governments (including their suitable funds for Medicaid) actually slipped a little over a four-decade period , with their rate decreasing from 13 percent in 1960 to 11 percent in 2002. The federal and state governments fund personal health care spending, 1960 and 2003 1960 2003 Percent funded by: federal government 9 33 State and local governments 13 11 Source: National Health Spending, loc. cit. It is important to note that while private sources still appear to be funding the majority of national health spending 54 percent in 2003 indirect support masks that federal and state and local governments provide through tax incentives for health care. More than $100 billion in so-called tax costs for health care have been in ins ins been ins federal government alone in 2003. Tax expenses income tax is said above because employers and individuals are allowed to exclude from taxable income that portions of their income are used for health insurance premiums and/or related expenses. If the above tax receipts are taken into account, the majority of states with health spending are more than 60 percent either directly funded by federal and state and local governments in 2003 or indirectly supported through tax regulations. With the development of public and private insurance programs over the past four decades, the role of direct payments between individuals and health care providers has changed dramatically. In the 1960s, individuals who paid directly for more than half of all their personal health care needs paid 55 percent of their out-of-pocket medical expenses. In 2003, only 16 percent of personal health care spending was covered out-of-pocket, making third parties the primary means of funding health care in the United States. Although a large number of factors are believed to have contributed to the escalation of medical costs, the expansion of third-party payers (whether government or private) may have reduced incentives for individuals who are conscious of the cost of consuming their health services. [5] [Go to Contents] The importance of government sources in funding health care for personal health care funding for Medicare and NonMedicare populations, 2000 Medicare Non-Medicare Population Percentage 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. * Includes a combination of government and private sources Comparing funding sources for the health care of Medicare and non-Medicare populations reflects the importance of public funding for the elderly. Public funds directly funded less than half of the nation's health costs in 2000, but it was the elderly who received much of this support. About two-thirds of their health care costs are funded by public programs, and more than half come from Medicare. The elderly's re dependence on public health plans has changed dramatically over the past half century, especially since Medicare coverage did not exist before 1966. But even since Medicare was born, public roles have evolved. As described by actuary chief Medicare programs for populations aged 65 and over, Medicare paid for about 42 percent of total personal health care costs in fiscal 1968. By calendar year 1997, the rate had risen to 55 percent, with most of Medicaid balances, private health insurance, and Medicare beneficiary out-of-pay payments increasing in part because of except Part B, which was $50 in 1968 and increased by only three since then, to $100 currently. Because insured costs rise much faster, a larger percentage of the costs covered are in excess of the deductible and are therefore reimbursed by Medicare. In 1968, only 38 percent of beneficiaries had Part B costs exceeding the deductible, but by 1997, this rate had risen to 87 percent of Medicare's growing rate which also reflected the rapid growth in prices, usage, and intensity of covered services such as doctors , skilled nursing and home health care. On the other side, in some years, some costs are not covered as for prescription drugs and long-term nursing home care increases faster than general medical costs, thus adding to the portion funded by non-Medicare sources. Overall, this trend has edewed toward a larger portion of the overall personal health care costs of older Americans who also note the relatively small decline in Medicaid costs as a percentage of the total cost of personal health care for beneficiaries over the age of 65. The proportion of elderly people with incomes below the poverty line (those most likely to qualify for Medicaid) has fallen from about 16 percent in 1966 to 11 percent in 1997 The impact of this trend on Medicaid spending is largely offset, however, by expanding coverage , including the creation of eligible Medicare beneficiaries (QMBs) and low-income Medicare Beneficiaries (SLMBs). (Medicaid pays Medicare premiums on behalf of QMBs and SLMBs and is also the beneficiary's cost-sharing debt to QMBs.) In addition, during this time, Medicaid absorbed a significant portion of the rapidly increasing costs for nursing home care. The percentage of health care costs paid directly by beneficiaries has dropped dramatically since the start of the program, from about 28 percent in 1968 to 20 percent today. This change is primarily due to the increased shares paid for by Medicare and private health insurance[6] Funding for personal health care costs for people 65 and older, 1968 and 1997 Fiscal Year 1968 Fiscal Year 1997 Percent from: Medicare 42% 55% Medicaid 14% 11% Other 11% 3% Out of Pocket 28% 20% Private Health Insurance 5% 11% Source : Medicare spending trends and financial status, 1966-2000, Richard S. Foster, Health Care Financing Review, Fall 2000. In 2003, the Congressional Budget Office reported that the growth in national health spending between 1970 and 2001 exceeded domestic product growth by 2.5 percentage points per year. Medicare, however, grew at a rate greater than 3 percentage points over an equivalent period of time. Medicaid grew at a larger 2.7 percentage point rate. [7] On an annual basis, these differences may seem small, but when complicated in decade, they help explain how Medicares and and The combined rate of personal health care costs has increased from 19 percent in 1970 to 37 percent in 2002. In fact, over a 32-year period, these two large public programs nearly doubled their role in funding the nation's health care costs. [Go to Content] Future perspective The Social Security and Medicare Commissioners project a big increase in the elderly proportion of the population in the coming decades. In cases where people aged 65 and over make up 12 percent of the current total population, they will represent 18 percent by 2025. Moreover, the increase is not only the result of the post-World War II baby boom generation reaching its advanced years. Major improvements in life expectancy and the decline in the birth rate of countries over the past 30 years are forecast to lead to a further increase in the proportion of the elderly in the population after the baby boom. Expected elderly population growth 2005 2025 2045 2065 2080 Age number 37 million 62 million 79 million 89 million 96 million Share total population 12% 18% 21% 22% 23% Source: 2005 Annual Report of the Board of Directors of the Federal Survivor and Survivor Insurance Trust Fund , Washington, D.C., March 23, 2005 For Medicare, these looming demographics mean that a growing number of people will become eligible for coverage each year, and each next group of new enrollees will receive benefits over a long period of their lives. As for Medicaid, they mean a growing number of people will need and become eligible for nursing homes and related institutional care. For both the program and the federal government as a whole, they mean a percentage of the population reduction will be in the main working age band of 20-65, from which the majority of the government tax base comes out. Combining growth from demographic trends is an uncertain but resilient increase in prices and the use of medical care. To what extent they can continue to grow at this level is uncertain. Reduces the birth rate and increases life expectancy, 1965-2080 (real and expected) 1965 2005 2045 2080 Birth per woman in lifetime 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 trust report Loc. Cit. Compare the growth per person of Medicare, Medicaid, and The National Product, 1970-2003 Average annual growth per person in percentage of Medicare Medicaid GDP from 1970 to 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 outlook, CBO, loc. cit. *Between 1975 and 2003. Growth per person was higher in national health costs and Medicare and Medicaid narrowed in the later part of 1970-2003 (Medicaid less Medicare), but it's still growing significantly faster than the overall economy anyway. Recognition Trends, the Medicare trustees in their central long-range forecasts so-called intermediate forecasts have assumed that each cost of enrolling for Medicare will grow at a final rate of 1 percentage point faster than the national product total. [8] This figure is lower than experienced between 1990 and 2003, but still larger than the experience of the economy as a whole. Narrowing the difference between national health spending growth and domestic product growth Accordingly national health spending exceeded GDP growth (as a percentage) from 1960 to 2001 2.5 1970-2001 2.3 1980-2001 1.5 Source: Long-Term Budget Outlook, CBO, 2001 Combining this assumption with their demographic prospects, the Project mandates Medicare that Medicare spending could increase from 2.7 percent of current domestic product to 9.6 percent by 2050 and reach 13.9 percent by 2080. Under a scenario with similar assumptions, the Congressional Budget Office projects that Medicare and Medicaid combined could rise to 11.5 percent of total domestic product by 2050. [9] Spending of that intensity today would represent more than half of the total federal budget. While recognizing the great uncertainty surrounding their forecasts, Medicare commissioners say their forecasts continue to demonstrate the need for timely and effective action to address the Medicares financial challenges both the long-range financial imbalance facing the HI [Hospital Insurance] trust fund and the issue of rapid spending increases. The sooner solutions are enacted, the more flexible and gradual they are[10] What can be said about future private spending is uncertain but equally problematic. Health insurance premiums have risen rapidly. According to one report, in 2002 health insurance premiums increased at a rate eight times faster than general inflation; experienced the largest premium increase in a year in more than a decade. [11] A Kaiser Family Foundation survey found that premiums charged for work-based health insurance increased by 11.2% in 2003, exceeding the previous growth rate. All types of health plans including HMO, PPOs and POSs have demonstrated a two-digit increase in costs. Kaiser reports that premiums paid by employers for employee family insurance rose from an average of $6,438 in 2000 to $9,086 in 2003, and the average amount workers pay for those premiums increased by 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 can be expected to shoulder more medical costs directly by being asked to pay a large portion of the employer's premium or by increasing the cost-sharing requirement. Increase premiums for benefits (i.e. now necessary for services and drug insurance) and for additional Medicare health insurance policies (i.e., Medigap policies) may have the same effect on the elderly. Large premium increases can cause policymakers to impose higher medical deductions or coinsurance and can cause recipients to seek less expensive additional coverage with higher cost-sharing requirements. When such out-of-pay costs will have a limited impact on medical prices is uncertain. Moreover, as they appear, policymakers can step in and require governments to grasp a larger share of the burden. However, tensions between the absorption of out-of-government costs and the government budget will only increase more sharply as costs have been seeped into public programs. The ongoing increase in medical costs has prompted calls for fundamental change of the national health care system. Some advocate greater government intervention to directly or indirectly control prices and use. Others believe that free market competition is greater in ensuring the costs of delivering the most promising routes. Still others believe that medical technology and innovation, greater advocacy of healthy lifestyles, promoting increased case management practice, and making further applications of information technology to disseminate effective medical advances and labyrinths of paperwork for treatment and services will make health care systems less expensive Significant. So far, there seems to be no consensus on what the best solution to raising the price tag for health care can be. Given that uncertainty, it is likely that some combination of different major policy regulations will grow and be implemented as cost pressures, both public and private, exaggerate in the coming years. [Go to Content] Note:[1] Measured by the Urban Consumer Price Index, Bureau of Labor Statistics, U.S. Department of Labor. [2] Trends in MCBS, 1992-2000, Centers for Medicare and Medicaid Services. [3] SeeMedicare Current Beneficiary Survey, Centers for Medicare and Medicaid Services, and Older Americans 2000: Key Indicators of Well-being, Federal Interdisciplinary Forum for Aging-Related Statistics. [4] Trends in MCBS, 1992-2000, loc. cit. [5] Long-term budget outlook, Congressional Budget Office, December 2003. [6] Medicare spending trends and financial and financial status. It should be noted that the law recently increased the

portion B deduction to $110 in 2005, and larger premiums for high-income enrollees will be phased in over a five-year period starting in 2007. [7] Long-term budget outlook, CBO, loc. cit. [8] See the 2004 Annual Report of the Board of Directors of Federal Hospital Insurance and the Federal Supplemental Health Insurance Trust Fund Washington, D.C., March 23, 2004. [10] Long-term budget outlook, loc. cit. [10] The 2004 2004 Reporting by the Board of Directors of Federal Hospital Insurance and the Federal Supplemental Health Insurance Trust Fund, loc. cit. Hospital Insurance (HI) is Part A of Medicare; Additional health insurance (SMI) is made up of traditional B-section and new Part D prescription drug benefits. [11] Health care costs, National Alliance on Health Care, 2004. [12] Cost of health insurance, employer health benefits: 2004 Annual Survey, Kaiser Family Foundation. [13] A study by the Washington Business Group on Health, which represents nearly 200 major employers, found that 80 percent of employers provided health insurance to employees who planned to increase co-payment or cost-sharing in 2003, compared to 65 percent of such responder in 2001. In a recent study, the group found that 57 percent planned to increase cost-sharing for 2004. (Martinez, as medical costs increased, workers had to pay more, the Wall Street Journal reported, June 16, 2003.) A New York Times article reported that After corporate income tax, employee benefits were the second-largest structural cost for U.S. manufacturers, adding 5.8 percent to costs. (Daniel Gross, Whose Problem is Health Care, The New York Times, February 8, 2004.) 2004.)

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