

# HEALTH CARE COSTS A PRIMER

MARCH 2009

KEY INFORMATION ON  
HEALTH CARE COSTS  
AND THEIR IMPACT

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### Key Facts

- In 2007, the U.S. spent \$2.2 trillion on health care, an average of \$7,421 per person.
- The share of economic activity (gross domestic product, or GDP) devoted to health care has increased from 7.2 percent in 1970 to 16.2 percent in 2007.
- Health care costs have grown on average 2.4 percentage points faster than the GDP since 1970.
- Almost half of health care spending is used to treat just 5 percent of the population.
- Although only 10 percent of total health expenditures, spending on prescription drugs has received considerable attention because of its rapid growth (89 percent from 2000 to 2007).
- About 30 percent of the poor spent more than 10 percent of their income on health in 2004; for the total population with private nongroup insurance, the share of the poor spending more than 10 percent of income increased by more than one-third, from 39 percent in 2001 to 53 percent in 2004.
- Many policy experts believe new technologies and the spread of existing ones account for a large portion of medical spending and its growth.

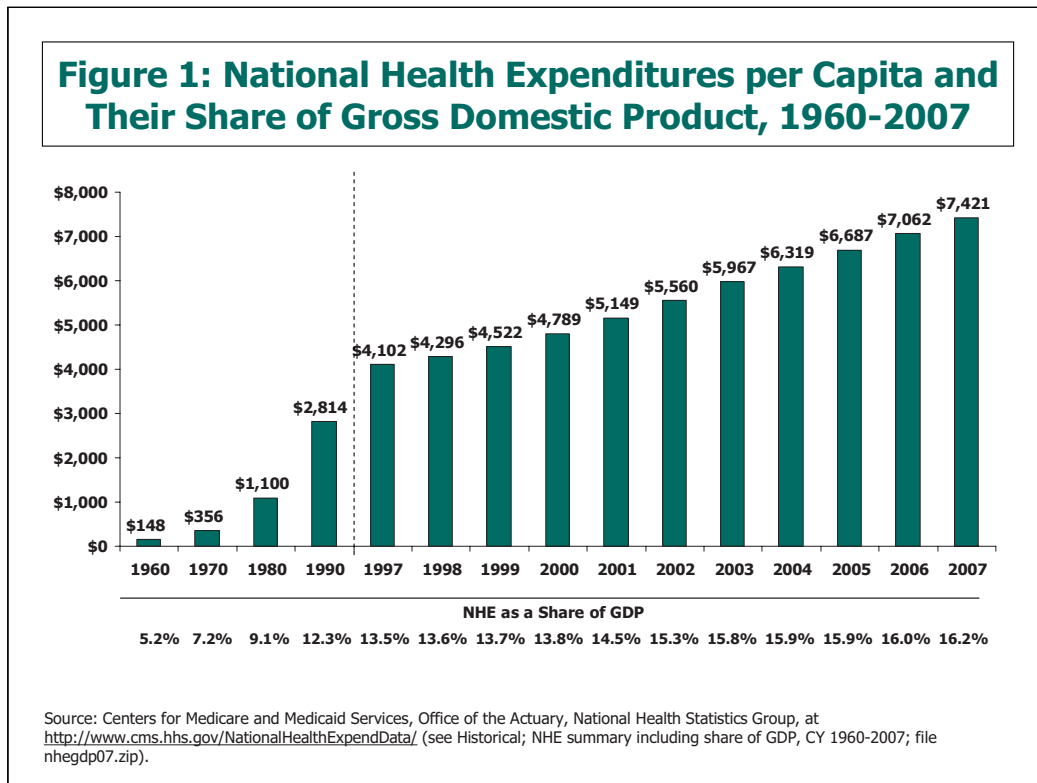
### Introduction

Health care accounts for a remarkably large slice of the U.S. economic pie. Each year health-related spending grows, often outpacing spending on other goods and services, meaning that the size of that slice increases. These cost increases have a significant effect on households, businesses, and government programs. Among other things, rising health care costs make health insurance less affordable for individuals, families, and businesses, contributing to the over 45 million Americans who are uninsured and to the costly problem of extending coverage to them; put pressure on businesses that offer insurance coverage to their employees; can be a major financial burden to families, even those that have insurance; can result in individuals not receiving the health care services they need; and take an increasing share of taxpayer dollars for government programs such as Medicare and Medicaid.

This paper gives a brief glimpse of available data on health care costs, and summarizes the impact of spending growth on various parts of society. The National Health Expenditure Accounts (NHEA), the source for several of the analyses below, present the costs of care by type of health service or product (such as hospital care, physician services, or prescription drugs) and also show spending by payer (such as private insurance, Medicare, Medicaid, or out-of-pocket by the individual patient). Results from both the Kaiser Family Foundation/Health Research and Educational Trust Employer Health Benefits Survey and the Medical Expenditures Panel Survey are also shown to help explain how health costs are distributed among families. Finally, we conclude by discussing some commonly-held explanations for why health care costs have grown over time and how they can be addressed.

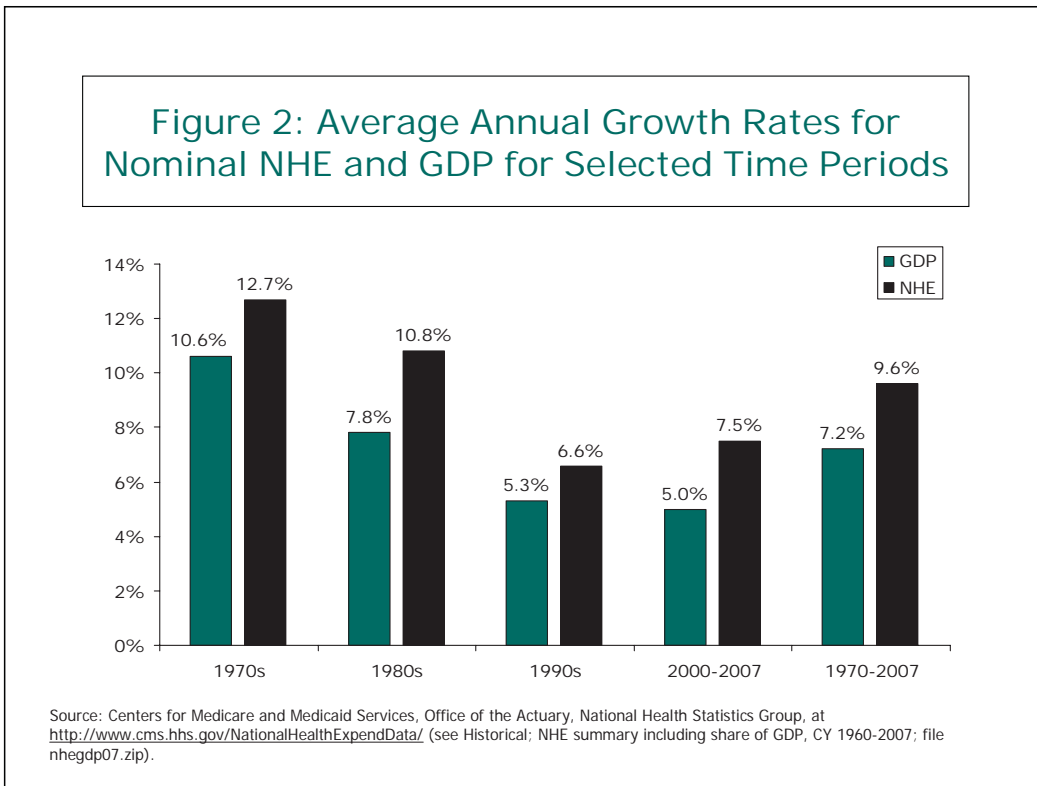
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e s ends a out er erson on eat care eac year i teen percent o t e econo y is de oted to eat care The United States spent \$2.2 trillion on health care in 2007. Spread over the population, this amounts to about \$7,421 per person (Figure 1). This \$2.2 trillion represents 16.2 percent of the nation s total economic activity, referred to as the gross domestic product or GDP. hile these figures are themselves staggering, of principal concern is their rapid growth over time.



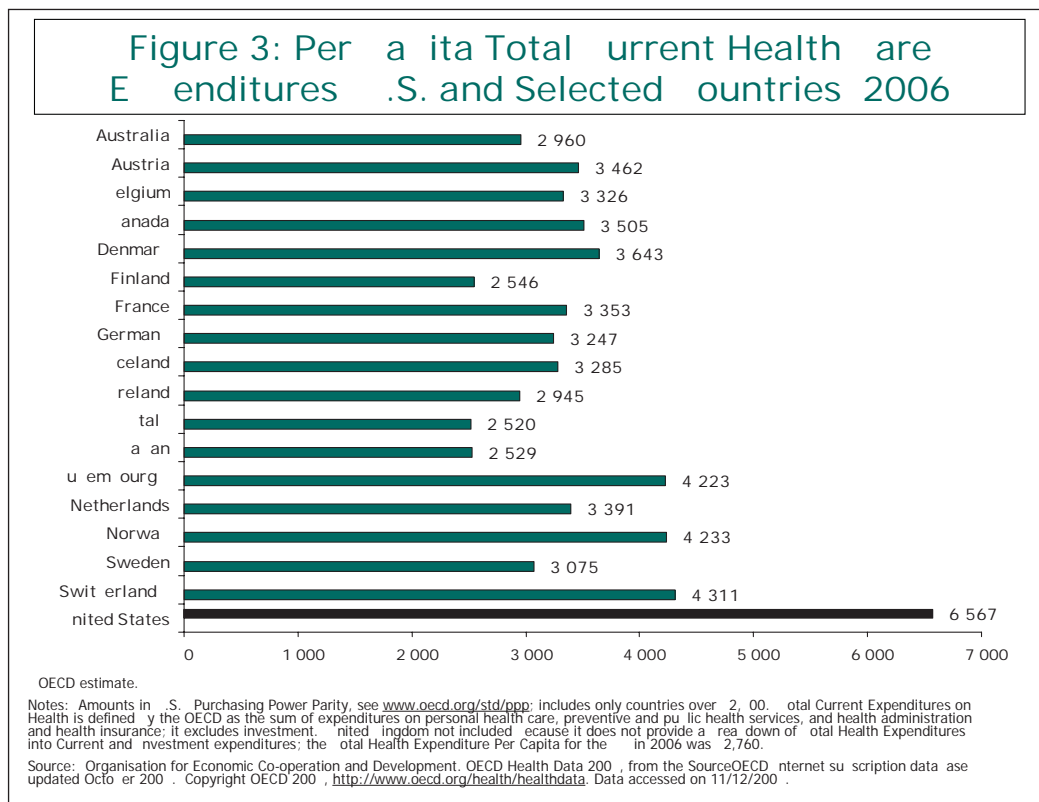
eat care s endin is consu in an increasin s are o econo ic acti ty o er ti e Health care grows faster than many other sectors of the economy and thus its share of economic activity has increased over time. For example, whereas the education, transportation, and agriculture industries may, on average and over time, grow at rates close to the economy as a whole, health care does not. In 1970, total health care spending was about \$75 billion, or only \$356 per person. In less than 40 years these costs have grown to \$2.2 trillion, or \$7,421 per person. As a result, the share of economic activity devoted to health care has grown from 7.2 percent in 1970 to 16.2 percent in 2007. By the year 2018, the centers for Medicare and Medicaid Services ( MS) projects that health spending will be one-fifth of GDP (20.3 percent).<sup>1</sup>

health care spending has exceeded economic growth in every recent decade over the last four decades, the average growth in health spending has exceeded the growth of the economy as a whole by between 1.3 and 3.0 percentage points (Figure 2). Since 1970, health care spending has grown at an average annual rate of 9.6 percent or 2.4 percentage points faster than nominal GDP. The persistence of this trend suggests systematic differences between health care and other economic sectors where growth rates are typically more in line with the overall economy. In large part because of the current recession, MS projects that NHE growth is expected to significantly outpace GDP growth in 2008 and 2009. For 2009, MS projects health spending to increase 5.5 percent while GDP is expected to decrease 0.2 percent (the first decrease in GDP since 1949), resulting in the largest one-year increase in the health share of GDP in history (from 16.6 percent in 2008 to 17.6 percent in 2009).<sup>2</sup>



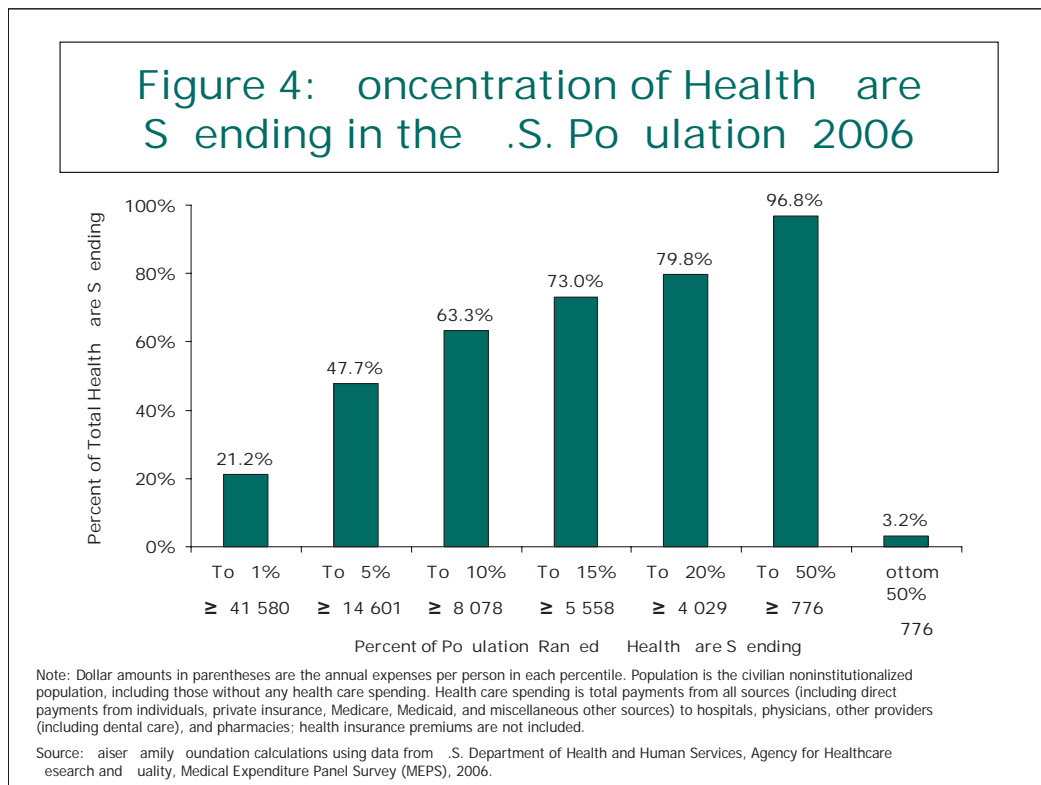
OECD countries are the other countries

Figure 3 shows per capita health expenditures in 2006 U.S. dollars for Organisation for Economic Co-operation and Development (OECD) countries with above-average per capita national income. According to OECD data, health spending in the United States was \$6,567 in 2006.<sup>3</sup> This amount was 52 percent higher than in the next highest spending country, and about 90 percent higher than in many other countries that we would consider global competitors. As a share of GDP, health care spending in the United States also exceeds that of any of its European counterparts by at least four percentage points.<sup>4</sup> Despite this relatively high level of spending, the United States does not appear to achieve substantially better health benchmarks compared to other developed countries.<sup>5</sup>



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s a s are o eo e accounts or a si ni cant s are o e enses in any year In 2006, almost half of all health care spending was used to treat just 5 percent of the population, which included individuals with health expenses at or above \$14,601 (Figure 4).<sup>6</sup> Under a uarter of health spending (21.2 percent) went towards the treatment of the 1 percent of the population who had total health expenses above \$41,580 in 2006. Because the onset of disease is unpredictable and can re ure intensive technology and time to treat, the distribution of health spending is highly concentrated.



Health care spending varies by age and sex. Adults aged 65 and older have the highest health care spending, averaging \$8,776 per person in 2006. Average spending increased with age, although children and young adults (those aged 24 and younger) spent roughly the same amount per person in 2006 (Figure 5). Women are reported to have higher average spending than men (\$3,886 vs. \$3,002, respectively).

Figure 5: Distribution of Average Spending Per Person 2006

	Average Spending Per Person
<i>Age (in years)</i>	
	1,000
-17	1,267
18-24	1,100
25-34	2,000
35-44	3,600
45-64	7,776
<i>Sex</i>	
Male	3,002
Female	3,886

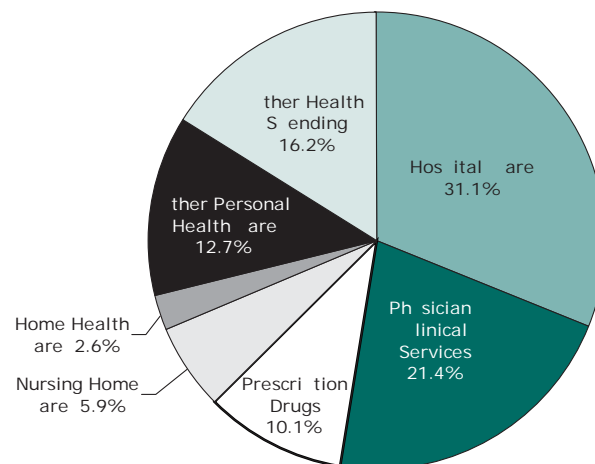
Notes: Excludes individuals without any spending in 2006.

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), 2006.

## Cost of Health Care Expenditures by For and by Source

Most health care spending is for care provided by hospitals and physicians. Health care spending encompasses a wide variety of health-related goods and services, from hospital and prescription drug spending to dental services and medical equipment purchases. Figure 6 illustrates spending on health by type of expense in 2007. Spending on hospital care and physician services makes up just over one-half of health care expenditures (53 percent). While spending on prescription drugs accounts for only about 10 percent of total health expenditures, its rapid growth has received considerable public attention (an 89 percent increase since 2000, compared to 67 percent for hospitals and 66 percent for physician/clinical services not shown).

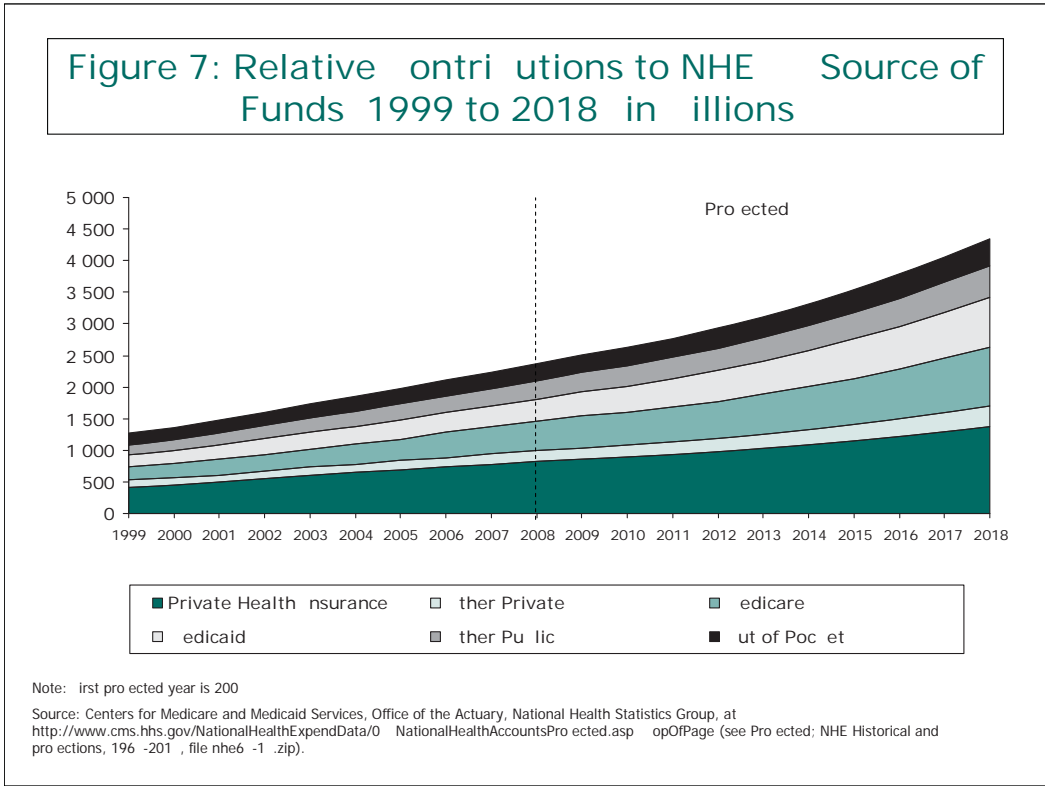
Figure 6: Distribution of National Health Expenditures by Type of Service 2007



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.

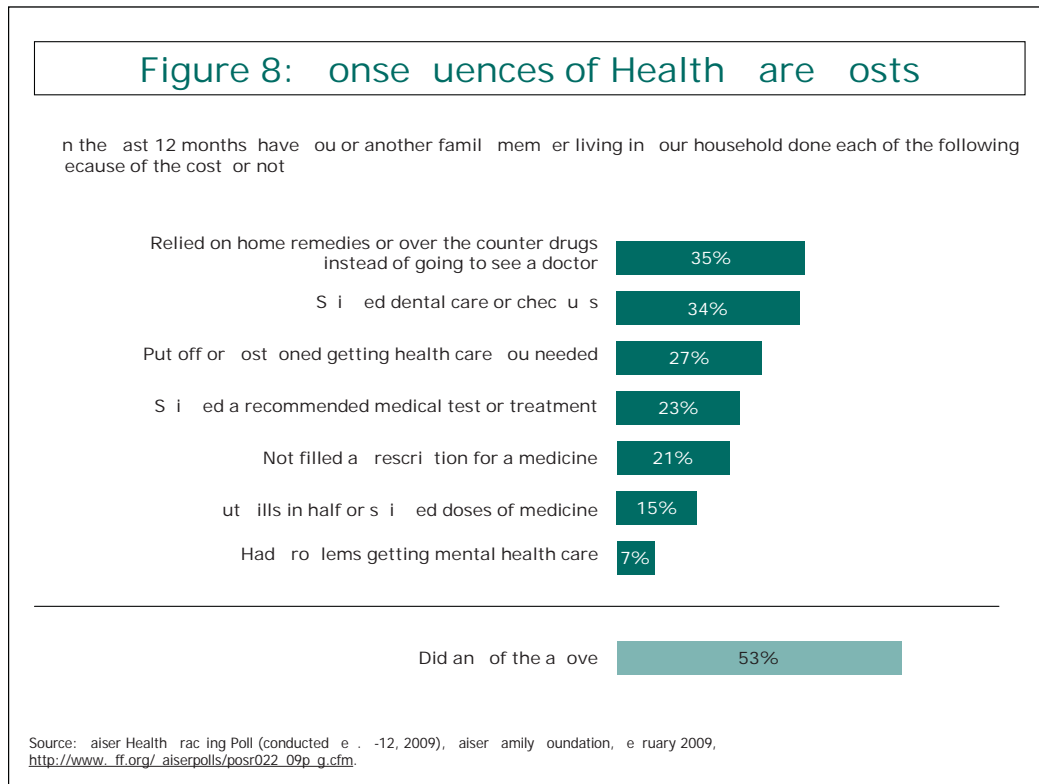
Source: Kaiser Family Foundation calculations using NHE data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.hhs.gov/NationalHealthExpendData/> (see Historical; National Health Expenditures by type of service and source of funds, CY 1960-2007; file nhe2007.zip).

Private health insurance or public programs pay for 35 percent of total health spending when health goods and services are used, someone pays for them either directly or indirectly. Private health insurance is the largest source of health spending, accounting for 35 percent of health spending in 2007. Public programs, including Medicare, Medicaid, and the State Children's Health Insurance Program, etc., pay for 46 percent of health spending. Figure 7 shows actual and projected cost increases by source of payment, including private, public, and out-of-pocket (individual) payments. As this figure shows, health cost growth is an issue for both private and public third-party payers. The share paid by public funds is projected to increase to 51 percent in 2018, with the private share falling to 49 percent.



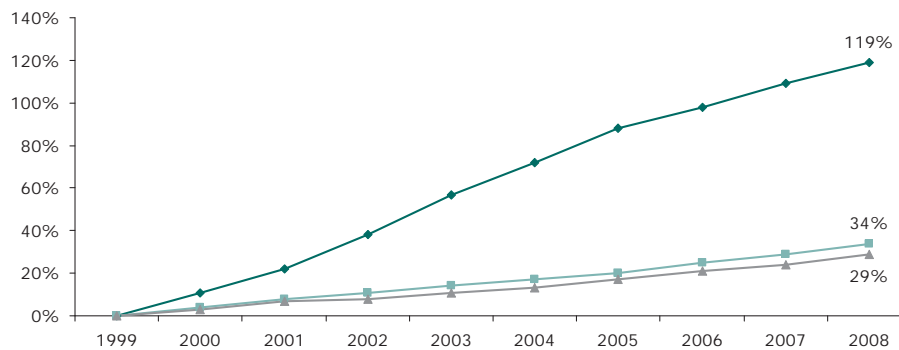
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is in eat care costs result in a i ies cuttin ac on care and acin serious inancia ro e s A recent Kaiser Health Tracking Poll found that more than half (53 percent) of Americans say their family cut back on medical care in the past 12 months because of cost concerns by, for example, relying on home remedies and over-the-counter drugs rather than visiting a doctor (35 percent), skipping dental care (34 percent), and postponing getting health care they needed (27 percent) (Figure 8). ne in five (19 percent) said they experienced serious financial problems due to family medical bills, with 13 percent using up all or most of their savings, 12 percent saying they have been contacted by a collection agency, and 7 percent reporting being unable to pay for basic necessities like food, heat, or housing. Beyond actual financial hardship due to medical care, nearly half of Americans (45 percent) report that they are very worried about having to pay more for their health care or health insurance, the highest proportion measured in Kaiser polls since late 2006.<sup>7</sup>



Health insurance premium increases consistently outpace inflation and the growth in workers' earnings. The growth in health insurance premiums is a straightforward way to measure changes in the cost of private health insurance. As health care costs increase, it becomes increasingly difficult for families and businesses to purchase coverage because the price of coverage (the premium) typically increases. Employers, as purchasers of insurance, may also decide to increase the amount covered workers must pay to visit the doctor or go to the hospital (the cost sharing), which can put pressure on family budgets when family members become ill. Figure 9 compares the annual increase in employer premiums to both worker earnings growth and overall inflation. Premium growth has outpaced the growth in workers' earnings almost every year. Whereas premium increases have been between 5 and 14 percent per year since 2000, inflation and changes in workers' earnings are typically in the 2 to 4 percent range. This usually means that workers have to spend more of their income each year on health care to maintain coverage. Again, these effects may either be direct through increased worker contributions for premiums or reduced health benefits or indirect such as when employers reduce wages or limit wage increases to offset increases in premiums.

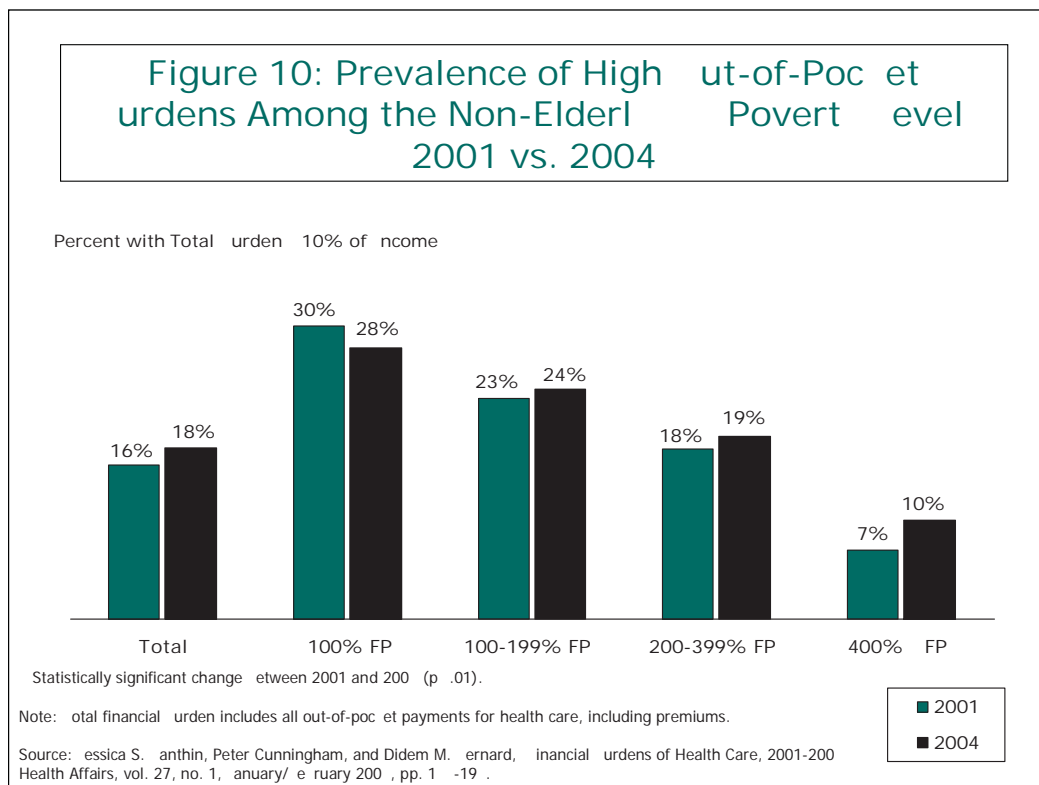
Figure 9: Cumulative changes in Health Insurance Premiums, Inflation and Workers' Earnings 1999-2008



Note: Due to a change in methods, the cumulative changes in the average family premium are somewhat different from those reported in previous versions of the Kaiser/H E Survey of Employer-Sponsored Health Benefits. See the Survey Design and Methods Section for more information, available at <http://www.kff.org/insurance/7790/index.cfm>.

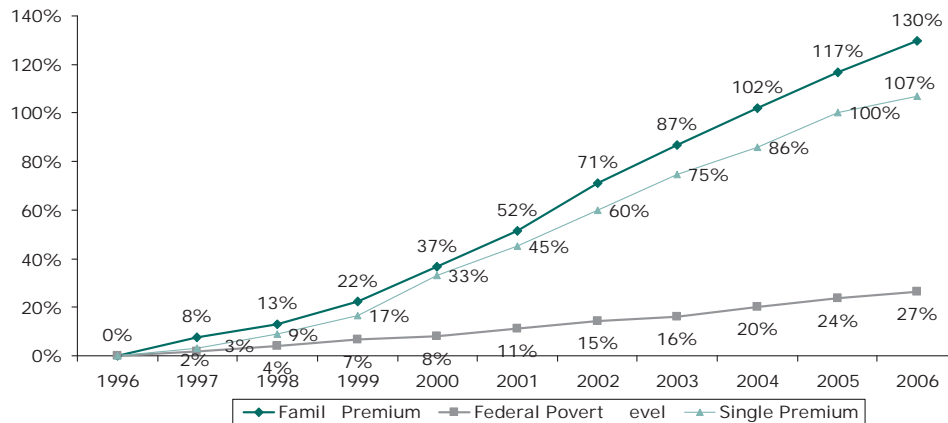
Source: Kaiser/H E Survey of Employer-Sponsored Health Benefits, 1999-2008; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2008; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2008 (April to April).

**Families are paying more out of pocket for health care** Another useful way of gauging the burden of rising health costs on households is to look at payments for health insurance premiums and cost sharing for health usage, as a percentage of family income.<sup>8</sup> Figure 10 shows that the percentage of non-elderly individuals whose family out-of-pocket expenses for health care exceeded 10 percent of income increased from 16 percent in 2001 to 18 percent in 2004. Not surprisingly, the increase in the burden of premiums and out-of-pocket costs for care was even larger for those below the federal poverty level (FPL) (30 percent in 2001 and 28 percent in 2004).



Eligibility standards for public programs such as Medicaid and CHIP do not increase as the cost of health care rises. Public programs provide health insurance coverage to people who are considered too poor to afford the full cost of coverage on their own. Medicaid also covers many children and individuals with disabilities who may not be able to afford or find private coverage to meet their needs. Eligibility for these programs is generally restricted to people in families with incomes at or below specific poverty levels (although it varies by state, in January 2009 the median income at which children qualify for Medicaid or CHIP is 200 percent of poverty; Medicaid coverage for parents is much lower than for children, with the median income eligibility for working parents at 68 percent of poverty and for jobless parents at 41 percent of poverty).<sup>9</sup> The cost of health insurance, however, has risen substantially faster than the increase in the federal poverty level over time (Figure 11). For people whose income just exceeds the eligibility standards for public coverage, the share of family income required to pay for private health insurance increases substantially (see example at <http://www.kff.org/insurance/snapshot/chcm021507oth.cfm>).

Figure 11: Cumulative Change in Single and Family Health Insurance Premiums and Federal Poverty Level 1996-2006



Source: Premium data from Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 1996-2006, at <http://www.meps.ahr.gov/mepsweb/>. Federal Poverty Level based on HHS Federal Poverty Guidelines (1996 through 2006) at <http://aspe.hhs.gov/poverty/figures-fed-reg.shtml>; rate of growth based on change for one person (change for a four-person family would be 28% rather than 27% over the period).

## Why health care costs rise faster than the economy

As shown in Figure 1, the portion of the economy devoted to health care has risen steadily for at least 40 years, rising from just over 5 percent of GDP in 1960 to 16 percent of GDP in 2007. MS estimates that one-fifth of GDP will be devoted to health care by the year 2018. So why does spending on health care grow so much faster than overall economic growth?<sup>10</sup>

**Healthier countries can afford to spend more on health care technologies** Studies looking at the United States and other economies have found a strong correlation between wealth and health care spending—as nations become wealthier, they chose to spend more of their wealth on health care.<sup>11</sup> Nations can spend more because the health care community continues to learn more every day about human health and health care conditions and, with that knowledge, is constantly expanding the inventory of health care products, techniques, and services that are available to address those conditions. Health care experts point to the development and diffusion of medical technology as primary factors in explaining the persistent difference between health spending and overall economic growth, with some arguing that new medical technology may account for about one-half or more of real long-term spending growth.<sup>12</sup>

**Demographic trends in order and disease prevalence as contributors** Other factors also influence spending growth. The U.S. population is aging, and because older people have more health problems and use more health care than younger people, population aging will have a small but persistent impact on cost growth in the years to come.<sup>13</sup> Increases in disease prevalence, particularly chronic diseases such as diabetes, asthma, and heart disease, coupled with the growing ability of the health system to treat the chronically ill, contribute to the high and growing levels of health spending. Rising obesity levels are another factor which may be influencing cost growth, but other trends, such as lower levels of smoking and alcohol consumption, may have a moderating effect.<sup>14</sup>

**Insurance coverage has increased** Government subsidies for health coverage also affect cost levels and potentially cost growth. Tax subsidies for health insurance and public coverage for certain groups (poor, disabled, and elderly) reduce the cost of health care to individuals, encouraging them to use more of it. Some argue that the high prevalence of health insurance encourages health technology development because those developing new technologies know that insurance will bear a substantial share of any new costs.<sup>15</sup>

**Americans pay a larger share of health care costs than they used to** Another factor that may help explain rising health spending is the falling share of health care expenditures that Americans pay out-of-pocket.<sup>16</sup> Between 1970 and 2007, the share of personal health expenditures paid directly out-of-pocket by consumers fell from 40 percent to 14 percent. Although consumers faced rising health insurance premiums over the period which affected their budgets, lower cost sharing at the point of service likely encouraged consumers to use more health care, leading to expenditure growth.

**Inefficiencies in medical care delivery and financing** Wide variation in the use and cost of services across providers and in different geographic areas has called into question the appropriateness and value of the care received. The role of provider payment has also been cited as contributing to increased costs by, for example, encouraging the use of specialists or profitable equipment. The lack of integrated, efficient systems to electronically store and transmit health data is said to contribute to higher costs and limit the data available to study treatment effectiveness.<sup>17</sup>

## at an e one o d d r e s s i n g c o s t s

Finding a way to address high costs and cost growth without unreasonably reducing access to new and needed services is a significant challenge. The information presented above shows that the United States faces two issues with health care costs (1) the amount the U.S. spends per person on health care is high, particularly when compared with the amounts peer nations pay for care; and (2) health care expenditures grow rapidly relative to the economy overall, and have consistently done so for decades. Policymakers considering policy interventions related to costs need to distinguish between factors that affect how much health care costs at a point in time and factors that affect long-term cost growth.

**o e a r o a c e s o r d e a i n i t e a t c a r e c o s t s m a y r e d u c e t h e e e o s e n d i n g b u t n o t t h e r a t e o f r o t** Many of the policies under discussion in health policy circles to address costs — such as increasing the use of electronic medical records and other information technology, promoting evidence-based medicine, provider payment reform such as pay-for-performance, changing the tax treatment of health benefits, consumer-directed health care, disease prevention and chronic disease management, or eliminating fraud and waste — are aimed at improving the efficiency with which care is delivered. Successfully implementing these policies, which is not an easy task, would likely reduce the amount that we pay on average for care, but they are not likely to be longer-run solutions for addressing the rate of cost growth.

For example, medical errors and other quality lapses very likely increase the amount that we pay for health care, but to influence long-term cost growth, the prevalence or severity of errors and poor quality would need to be an increasing share of expenditures each year, which is probably not likely. Policies that reduce medical errors may well reduce the amount that we pay for care (and are important even if they do not). But assuming that errors can be reduced to more optimal levels, costs would likely continue to grow, albeit from a lower level, at previously observed rates. Other interventions intended to make the health system more efficient, such as reducing the disparities in health care practices across regions and providers or increasing the use of electronic medical records, are likely to have similar effects. These are important initiatives that could make the health care system cheaper (compared to what we would spend without them) and better. By themselves, however, these types of initiatives are unlikely to address the long-term pattern that we have observed of health care's growth as a share of economy.

**o i c i e s f o c u s i n g o n n e w a n d e m e r g i n g t e c h n o l o g i e s m a y b e s u c c e s s f u l i n r e d u c i n g t h e r a t e o f r o t b u t c a n b e d i f f i c u l t t o i m p l e m e n t** Over the long run, bringing health spending growth closer to the rate of overall economic growth would likely require finding ways to slow the development and diffusion of new health care technologies and practices. Developing ways to explicitly assess and weigh the benefits and costs of new technologies is one promising approach, although such evaluations present serious challenges.<sup>18</sup> The sheer volume and pace of medical advances would make it difficult to assess important changes before they are incorporated into medical practice; focusing on the most expensive new treatment options might be more practical and could have a meaningful impact on cost growth.<sup>19</sup>

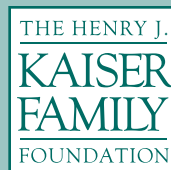
Health technology assessment may also involve difficult decisions about whether a medical benefit is worth the cost and whether it should be covered by a public or private insurance program. For example, the National Institute for Health and Clinical Excellence (NICE), the U.K. authority charged with approving medical treatments, received widespread criticism when it excluded beta interferon to treat multiple sclerosis from the list of publicly-covered treatments.<sup>20</sup> Other ways of potentially reducing the development and diffusion of new health care technologies, such as much higher cost sharing that could reduce the ability of many to afford expensive treatments (which in turn would dissuade their development), are no less controversial. Recent legislation provided federal funding for the development and dissemination of comparative effectiveness research, specifying that the funding be used to evaluate and compare the clinical outcomes, effectiveness, risk, and benefits (but not the costs) of various technologies and treatments, and not be used to mandate coverage, reimbursement, or other policies for public or private payers.<sup>21</sup>

## Conclusion

Policymakers face significant challenges, short and longer term, as they think about how the nation will pay for the growing cost of health care. Recent discussions about health care reform include proposals for health care cost containment. But there are many facets to health care reform including expanding coverage for the uninsured, reducing health care costs for individuals and employers, controlling entitlement spending for government programs such as Medicare and Medicaid, and reforming the health care delivery system, to name a few. Successfully improving the efficiency and quality with which care is delivered is an enormous challenge, one that will require substantial investment in research, new information systems, performance incentives, and education, with the hope of transforming how health care is delivered by thousands and thousands of providers dispersed across our largely disaggregated health care system. Coming to terms with the potential of medical technology and its long-run influence on costs is a different type of challenge, but one that is also important. The advances in health care that have occurred over the past half-century have increased how long we live and have reduced the burden of disease for countless people. Developing the philosophical, ethical, and political framework necessary to balance the benefits of future advances with our ability to pay for them is one of the next great challenges for health policy.

## ndnotes

- <sup>1</sup> U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, National Health Expenditure Projections 2008-2018, February 24, 2009, [http://www.cms.hhs.gov/NationalHealthExpendData/03\\_NationalHealthAccountsProjected.asp](http://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp) Top Page.
- <sup>2</sup> Ibid., <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf>.
- <sup>3</sup> The report on E D data for the United States where the comparison to other countries is of interest. Note that accounting for national health expenditures used by the E D and MS are largely but not entirely in accordance. For example, MS accounting of national health spending includes the value of health-related research whereas E D-reported data exclude this amount. Further, E D accounting makes adjustments for the export and import of health services while MS does not. For more information, see Eva Rosz, The E D System of Health Accounts and the US National Health Account 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, <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/confpaperrosz.pdf>.
- <sup>4</sup> E D Health Data 2008, December 2008 version, online subscription, accessed 2/11/09.
- <sup>5</sup> Gerard F. Anderson and Bianca K. Frogner, Health Spending in E D Countries Obtaining Blue per Dollar, *Health Affairs*, vol.27, no. 6, Nov/Dec 2008, pp. 1718-1727; The Commonwealth Fund, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008*, July 2008, <http://www.commonwealthfund.org/content/Publications/Fund-Reports/2008/why-Not-the-Best-Results-from-the-National-Scorecard-on-U-S-Health-System-Performance-2008.aspx>; Cathy Schoen et al., In Chronic Condition Experiences of Patients with Complex Health Care Needs, In Eight Countries, 2008, *Health Affairs*, Web Exclusive, Nov. 13, 2008, w1-w16; McKinsey Global Institute, Accounting for the Cost of Health Care in the United States, January 2007, [http://www.mckinsey.com/mgi/rp/healthcare/accounting\\_cost\\_healthcare.asp](http://www.mckinsey.com/mgi/rp/healthcare/accounting_cost_healthcare.asp); RS Report for Congress, U.S. Health Care Spending Comparison with Other E D Countries, September 17, 2007, [http://assets.opencrs.com/rpts/R\\_34175\\_20070917.pdf](http://assets.opencrs.com/rpts/R_34175_20070917.pdf).
- <sup>6</sup> The source for this information is the Medical Expenditure Panel Survey (MEPS), conducted by the Agency for Health Care Research and Quality, U.S. Department of Health and Human Services. The survey collects information on the U.S. civilian, noninstitutionalized population. Spending for people in the military or in longer-stay institutions, such as nursing homes, is not included in the totals or the spending distributions calculated from the survey. This means that some of the spending that is measured by the National Health Expenditures Accounts, which is the data source for the national total and per capita spending discussed above, is not accounted for in the tables based on MEPS.
- <sup>7</sup> Kaiser Family Foundation, Kaiser Health Tracking Poll, February 2009, <http://www.kff.org/kaiserpolls/posr022509pkg.cfm>.
- <sup>8</sup> Jessica S. Banthin, Peter Cunningham, and Didem M. Bernard, Financial Burden of Health Care, *Health Affairs*, vol. 27, no. 1, January/February 2008, pp. 188-195.
- <sup>9</sup> Kaiser Commission on Medicaid and the Uninsured, *Challenges of Providing Health Coverage for Children and Parents in a Recession: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2009*, January 2009, p.7, <http://www.kff.org/medicaid/upload/7855.pdf>. The Federal Poverty Line for a family of three in 2009 is \$18,310 per year.
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