Policy Research Perspectives

National Health Expenditures, 2017: The slowdown in spending growth continues

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Introduction

This Policy Research Perspective (PRP) provides a detailed examination of U.S. National Health Expenditures (NHE) through 2017. In December 2018, the Centers for Medicare and Medicaid Services (CMS) released the 2017 health spending data and revised estimates for previous years (Martin et al., 2019). This PRP examines the breakdown of health care spending and changes in its various subcomponents. Different from previous years' PRPs on this topic, this report also examines insurance enrollment and per-enrollee spending, discussing differences across payers.

NHE increased by 3.9 percent in 2017 to $3.5 trillion or $10,739 per capita. This growth rate is lower than what was observed in 2016 (4.8 percent) and 2015 (5.8 percent). After a period of relatively fast growth in 2014 and 2015 during the implementation of the Affordable Care Act (ACA), 2017 was characterized by slower growth that continued from 2016. In fact, growth in 2017 was similar to the 3.7 percent average annual rate of the 5-year period ending in 2013. These growth rates are the lowest since the early 1960s when health spending was first tracked in its current format. The slower growth in 2017 was influenced by both the use and intensity of goods and services (hospital care, physician services, and retail prescription drugs) and was evident in each major source of insurance. Health spending remained at 17.9 percent of GDP in 2017 (only slightly below its 18.0 percent of GDP in 2016) because it increased 0.3 percentage points *slower* than GDP.

What are national health expenditures?

CMS decomposes NHE in the following three ways:[1]

1. *Type of expenditure*: CMS identifies health care spending that was invested (i.e. saved and put towards research, structures and equipment) and spent on health consumption expenditures (HCE) (i.e. consumed today). The bulk of HCE goes towards "personal health care spending," which includes spending on hospital care, physician provided services, and prescription drugs. The remainder goes towards administration, public health, and profits of private health insurers. This breakdown answers the question, "where does the money go?"

[1] For each breakdown of the NHE (by type, source of funds, or sponsor), the sum of the components will be $3.5 trillion.

2. *Source of funds*: CMS identifies health spending that was invested and spent under different health insurance programs (private health insurance, Medicare, Medicaid, and other), out-of-pocket, and by other (non-insurance) third-party payers (i.e. workers compensation). This breakdown addresses the question, "who pays the bill?" for health consumption expenditures.
3. *Sponsor:* CMS identifies the financiers (i.e. "sponsors") of health spending which include households, private businesses, and the federal and state and local governments. Financing differs from source of funds as it reflects the origin of the spending. For example, one source of funds is private health insurance (PHI) spending. Spending by insurers for patients covered by PHI comes from insurer premium revenue, which, in turn, is funded by employees and employers. Thus, households and private businesses would be the sponsors of PHI spending since they are the ultimate financing source for that spending. This breakdown addresses the question, "how is all that financed?"

Breakdown by type of expenditure: where does the money go?

Spending shares

Exhibit 1 decomposes health care spending in 2017 by type of expenditure. In this breakdown, health spending can go towards investment or HCE. Investment accounted for $167.6 billion (or 4.8 percent of total health spending). The remainder went to the HCE category, which CMS divides into spending on personal health care, government public health activities, government administration, and the net cost of health insurance.

The bulk of the HCE category is made up of personal health care spending, which was $2,961 billion or 84.9 percent of total health spending in 2017. The four main categories of personal health care spending are hospital care ($1,142.6 billion or 32.7 percent of total health spending), physician services ($544.2 billion or 15.6 percent), clinical services ($150.1 billion or 4.3 percent), and prescription drugs ($333.4 billion or 9.5 percent).[2,3] Also included in personal health care spending are spending on nursing care facilities ($166.3 billion or 4.8 percent of total health spending), home health care ($97.0 billion or 2.8 percent), and other services ($527.3 billion or 15.1 percent).

The remainder of HCE includes spending on government public health activities ($88.9 billion or 2.5 percent of total health spending) and government administration ($45.0 billion or 1.3 percent). It also includes the net cost of health insurance which is the difference between incurred premiums for insurance and the amount paid for benefits (i.e. what insurance companies have left over after benefits are paid). In 2017, the net cost of health insurance was $229.5 billion or 6.6 percent of total health spending.

For all the HCE categories, the shares of total spending in 2017 are all within half a percentage point of the shares in 2016 (see Rama, 2018 for 2016 values). This suggests that 2016 spending growth among categories was similar. In fact, the shares in Exhibit 1 have remained stable over the past 25

[2] Clinical spending includes spending made in establishments classified as outpatient care centers under the North American Industry Classification System (NAICS). Outpatient care centers include family planning, outpatient mental health and substance abuse, HMO medical, kidney dialysis, freestanding ambulatory surgical and emergency, and other not already categorized outpatient care centers.
[3] Although physician and clinical services are generally shown as a combined category in the tables prepared by CMS, they are shown separately in this PRP as there are differences between the two categories, such as the spending growth rates.

years. Kane (2017) notes that the biggest percentage point change over this period was for prescription drugs, which accounted for 5.6 percent of total health spending in 1990 but has remained at or above 9 percent since 2001.

Spending growth

Exhibit 2 compares the annual growth rates over the 10-year period ending in 2017 for personal health care spending and its four main components: hospital care, physician services, clinical services, and prescription drugs. Spending in 2017 decelerated in all four categories. Health spending is determined both by prices paid for health care used ("price factors") and how much or what types of health care are used ("non-price factors"). Similar to 2016, the lower growth rate in health spending in 2017 follows the spike in spending growth during ACA implementation (a non-price factor) which increased utilization from health insurance expansion in 2014 and 2015.

Hospital care spending in 2017 decelerated to a 4.6 percent growth rate (compared to 5.6 percent in 2016); this reflects slower growth in outpatient visits and stabilized growth in inpatient days despite a slight increase in price growth for hospital care services. Spending on physician services decelerated (from 5.0 percent growth in 2016 to 3.9 percent in 2017) as did clinical spending (from 7.9 percent growth in 2016 to 5.0 percent in 2017); this is a result of slower growth in non-price factors since price growth remained stable (0.4 percent growth in 2017 compared to 0.2 percent growth in 2016). Prescription drug spending decelerated to a 0.4 percent growth rate in 2017 compared to previous years (2.3 percent in 2016 and 8.9 percent in 2015). This was influenced by slow growth in non-price factors (i.e. quantity dispensed, shift to low cost generics, etc.) and, to a lesser extent, prices (i.e. decrease in generic drug prices, lower price increases in brand-name drugs, etc.) (Martin et al., 2019).

Exhibit 2 also includes the average annual growth rates in spending over the 10-year period ending in 2017. Over this period, the annual growth rates of total personal health care, hospital care, physician services, and clinical services spending have generally moved in line with each other (i.e. increasing or decreasing at the same time, albeit at varying rates). However, prescription drug growth fluctuated greatly, spiking to 12.4 percent in 2014 and 8.9 percent in 2015, while reaching lows in 2010 (0.1 percent), 2012 (0.2 percent), and 2017 (0.4 percent). The fact that both physician services and prescription drugs have a similar average annual growth rate over the 10-year period ending in 2017 (3.8 percent and 3.5 percent, respectively) masks the extreme fluctuations in prescription drug spending growth contrasted with the stability of physician services spending growth.

The top-level takeaways from Exhibit 2 and the discussion around Exhibit 1 might appear at odds with one another and deserve further explanation. While the discussion for Exhibit 1 noted that the shares of spending by type of expenditure have remained stable, Exhibit 2 highlighted that the annual spending growth by type of expenditure can sometimes fluctuate. There are two reasons for this. First, the type-of-expenditure categories that have had high spending growth or large fluctuations in their spending growth account for a relatively small share of total health spending. For example, in Exhibit 2 we see that clinical services had the highest average annual growth rate at 6.2 percent for the 10-year period ending in 2017. However, because clinical services accounted for only 3.6 percent of total health spending at the start of this period, its relatively high average growth rate

did not result in a noteworthy increase in its share. In contrast, the type-of-expenditure categories that are a large share of total health spending have relatively low or stable growth rates. This is particularly evident with physician services, which is the second largest type-of-expenditure category.

Spending by source of funds: who pays the bill?

Spending shares

Exhibit 3 shows the distribution of health care spending by source of funds. PHI had the largest share of total health spending at 33.9 percent ($1,183.9 billion), as has been the case for the past four decades (Kane, 2017). Medicare spending accounted for 20.2 percent of total health spending ($705.9 billion) and Medicaid spending made up 16.7 percent ($581.9 billion). Out-of-pocket spending, which includes all payments made directly by all patients regardless of insurance status, was 10.5 percent of total health spending ($365.5 billion). Spending on other health insurance programs was 3.8 percent of total health spending ($132.6 billion) and spending on other third-party payers and programs and public health activity was 10.2 percent ($354.8 billion). These shares are within half a percentage point of what was observed in 2016 (see Rama, 2018).

Spending growth

The total spending growth in PHI, Medicare, and Medicaid over the 10-year period ending in 2017 are shown in Exhibits 4 through 6. Here, total spending is decomposed into per-enrollee spending and enrollment.[4] The total spending growth for each payer is roughly equal to the sum of per-enrollee spending growth and enrollment growth. To help understand the trends seen in total spending growth, Exhibits 4 through 6 also include the enrollment and per-enrollee spending growth rates. As they will show, fluctuations in Medicare spending growth over the last decade were strongly tied to per-enrollee spending rates while fluctuations in Medicaid spending growth were more dependent on enrollment growth rates. PHI maintained a relatively stable spending growth rate due to both enrollment and per-enrollee spending fluctuating widely in opposite directions.

Exhibit 4 shows the growth rates for PHI. Between 2008 and 2011, spending growth for PHI remained stable at just below 4.0 percent. However, this stability masks fluctuations in enrollment growth that were offset by fluctuations in per-enrollee spending growth in the opposite direction. During this period, enrollment growth was negative, reaching a low of -3.1 percent in 2009; this was partly due to lost jobs during the recession (Hartman et al., 2010). In contrast, per-enrollee spending growth remained positive, peaking at 7.1 percent in 2009 when per-enrollee spending on prescription drugs and hospital services also peaked and spending per enrollee on benefits grew faster than premiums. The years 2010 and 2011 saw reduced growth in per-enrollee spending due to increases in cost sharing, a shift by consumers to lower-cost (less generous) plans, and slower growth in use of services (i.e. elective hospital procedures, prescriptions dispensed, and physician office visits). In those years, spending per enrollee on benefits grew slower than premiums (Martin et al., 2012).

[4] Per-enrollee spending reflects the amount spent per enrollee on personal health spending (benefits) and used for administration or retained as profit (net cost). It is the same as the premium paid per enrollee.

After PHI spending growth dropped to 2.0 percent in 2013, it spiked in 2014 and 2016 due to modest spending increases in employer-sponsored insurance (which accounts for roughly 90 percent of PHI spending) and drastic changes with direct purchase insurance during ACA implementation. Increases in the growth rates of both direct purchase enrollment (from Marketplace plans) and per-enrollee spending (from mandated changes to benefit designs and newly insured patients being sicker, using more services, and having higher costs) resulted in a total spending growth of 43.0 percent for direct purchase insurance in 2014 (data not shown) (Hartman et al., 2015 and Martin et al., 2016). By 2017 (post-ACA implementation), the PHI spending growth rate dropped to 4.2 percent; this is closing in on the below 4.0 percent rates from the 2008 to 2013 (pre-ACA implementation) period.

In Exhibit 5, Medicare spending growth rates are shown to be the highest in the early years of the 2008 to 2017 period, following the implementation of Medicare Part D in 2006. During this time, enrollment growth remained stable and the decreases in per-enrollee spending growth were directly reflected in total spending growth. The year 2012 saw a spike in enrollment growth (due to the oldest members of the baby-boom becoming eligible to enroll in Medicare), but a drop in per-enrollee spending (due in part to a decline in skilled nursing facility spending) (Martin et al., 2014) (The Boards of Trustees, 2018). Nonetheless, since 2010, Medicare spending growth has generally stayed below 5 percent with enrollment growth consistently remaining above per-enrollee spending growth. CMS projections (Cuckler et al., 2018) suggest that the baby boom won't have a substantial impact on Medicare spending until 2019. Between then and 2025, Medicare spending growth is projected to average around 8 percent per year as baby boomers shift into Medicare and the aging of the Medicare population results in increased intensity of care.

Exhibit 6 shows the growth rates for Medicaid. During the 10-year period ending in 2017, Medicaid spending growth rates fluctuated more than those for Medicare and PHI. Medicaid spending growth is strongly tied to Medicaid enrollment growth, which noticeably spikes during years of expansionary policy (i.e. ACA implementation in 2014 and 2015) or during recession (i.e. the Great Recession in 2009) and drops when the economy begins to recover from recession (i.e. 2010 and 2011). Although per-enrollee spending growth is not as strongly tied to total spending growth, there are interesting fluctuations in per-enrollee spending growth to note. From 2008 to 2011, per-enrollee spending growth decreased as generally healthier, lower-cost children and adults enrolled in Medicaid and cost-reduction measures were implemented by states (i.e. reductions in provider reimbursement and benefits, restrictions in eligibility, and increased cost sharing) (Hartman et al., 2013). Per-enrollee spending peaked in 2013 due to growth in provider reimbursement rates and expansion of select states' benefits (Hartman et al., 2015) before dropping in 2014 as new Medicaid enrollees during ACA expansion tended to be lower-cost (Martin et al., 2016). It spiked again in 2015 as states increased reimbursement rates (Martin et al., 2017). At the end of this period, Medicaid spending growth dropped to 4.2 percent in 2016 and to 2.9 percent in 2017. The lower growth in 2016 and 2017 is attributed to slower growth in both enrollment and spending per enrollee.

Spending by sponsor: how is all that financed?

Exhibit 7 shows the allocation of spending by sponsor; this reflects the origin of the funding or the entity that initially financed the spending. The right most column of Exhibit 7 provides the breakdown of NHE by the four sponsors of funding: households, private businesses, the federal government,

and state and local governments. In 2017, 19.9 percent ($696.5 billion) of total health spending was financed by private businesses, 28.0 percent ($978.6 billion) by households, and 6.8 percent ($239.0 billion) by other private revenues. The remaining was financed by government: 28.1 percent ($982.4 billion) by the federal government and 17.1 percent ($595.5 billion) by state and local governments.

The leftmost and middle columns of Exhibit 7 have the spending breakdown of PHI and Medicare by sponsor. PHI spending was to $1,183.9 billion in 2017. Through employer contributions to employer sponsored health insurance premiums, private businesses financed 45.3 percent ($536.3 billion) of PHI spending - the largest contribution among sponsors. Households were the second largest sponsor of PHI spending, financing 31.5 percent ($372.4 billion) of PHI spending through employee contributions to employer-sponsored health insurance premiums (23.5 percent), household contributions to direct purchase insurance (4.6 percent) and the medical portion of property and casualty insurance (3.4 percent). The government had the smallest contribution to PHI spending with state and local governments financing 16.2 percent ($192.3 billion) and federal government financing 7.0 percent ($83.0 billion) of PHI spending through contributions to health insurance premiums in their roles as employers and, in the case of the federal government, marketplace tax credits and subsidies as well.

Medicare spending was to $705.9 billion in 2017. As has been the case since 2005, the federal government was the largest sponsor of Medicare spending in 2017. The federal government financed 46.0 percent ($324.7 billion) of Medicare spending, mainly through federal general revenue and Medicare net trust fund expenditures. This comes from funds appropriated by Congress to finance Medicare, reflecting Medicare spending that is not “self-financed” by households via payroll taxes and beneficiary premiums. Through those two avenues, households financed 34.1 percent ($240.1 billion) of Medicare spending in 2017. Prior to 2005, households were the largest sponsor of Medicare spending but this has changed through a series of expansionary policies that have required increasing shares of federal government financing. Fifteen percent ($107.5 billion) of Medicare spending was sponsored by private businesses in the form of Medicare hospital insurance trust fund payroll taxes and 4.7 percent ($32.9 billion) by state and local governments through various channels, the largest of which was the payroll taxes for state and local government employees.

Conclusion

Health care spending in the U.S. increased by 3.9 percent in 2017 to a level of $3,492.1 billion or $10,739 per capita. In comparison, spending grew 5.8 percent in 2015 due to the ongoing implementation of the Affordable Care Act. The growth slowdown in 2016 to 4.8 percent continued in 2017. Spending as a share of GDP remained stable at 17.9 percent in 2017 compared to 18.0 percent in 2016.

Spending on personal health care ($2,961.0 billion) made up 84.9 percent of total health spending. This includes spending on hospital care ($1,142.6 billion or 32.7 percent of total health spending), physician services ($544.2 billion or 15.6 percent), clinical services ($150.1 billion or 4.3 percent), and prescription drugs ($333.4 billion or 9.5 percent). These shares have remained relatively stable over the past quarter-century, although certain categories of spending fluctuate in the short-term. For

example, while physician spending growth has remained stable, prescription drug growth has fluctuated by hitting a high of 12.4 percent in 2014 before eventually dropping to 0.4 percent in 2017.

Considering spending by source of funds, private health insurance had the largest share at 33.9 percent of total health spending ($1,183.9 billion) followed by Medicare at 20.2 percent ($705.9 billion) and Medicaid at 16.7 percent ($581.9 billion). During the 10-year period ending in 2017, fluctuations in Medicare spending growth were strongly tied to Medicare per-enrollee spending rates while fluctuations in Medicaid spending growth were more dependent on Medicaid enrollment rates. PHI maintained a relatively stable spending growth rate due to both enrollment and per-enrollee spending growth fluctuating heavily in opposite directions.

With regards to financing, the federal government financed the largest share of health spending at 28.1 percent ($982.4 billion), closely followed by households at 28.0 percent ($978.6 billion). Private business financed 19.9 percent ($696.5 billion) and state and local governments financed 17.1 percent ($595.5 billion).

References

CMS. National Health Expenditure Data: Historical. Centers for Medicare and Medicaid Services. 2018. Available from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html

Cohen, R.A., Zammitti E.P. High-deductible health plan enrollment among adults aged 18–64 with employment-based insurance coverage. National Center for Health Statistics Data Brief, no 317. August 2018. Available from: https://www.cdc.gov/nchs/products/databriefs/db317.htm

Cuckler, G., Sisko, A., Poisal, J., Keehan, S., Smith, S., Madison, A., Wolfe, C., Hardesty, J. National Health Expenditure Projections, 2017–26: Despite Uncertainty, Fundamentals Primarily Drive Spending Growth. February, 2018. Available from: https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.1655

Hartman, M., Martin, A., Nuccio, O., Catlin, A., and The National Health Expenditure Accounts Team. Health Spending Growth At a Historic Low In 2008. January, 2010. Available from: https://www.healthaffairs.org/doi/10.1377/hlthaff.2009.0839

Hartman, M., Martin, A., Benson, J., Catlin, A., and The National Health Expenditure Accounts Team. National Health Spending In 2011: Overall Growth Remains Low, But Some Payers And Services Show Signs Of Acceleration. January, 2013. Available from: https://www.healthaffairs.org/doi/10.1377/hlthaff.2012.1206

Hartman, M., Martin, A., Lassman, D., Catlin, A., and The National Health Expenditure Accounts Team. National Health Spending In 2013: Growth Slows, Remains In Step With The Overall Economy. January, 2015. Available from: https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1107

Kane, C. Policy Research Perspectives: National Health Expenditures, 2015: Annual Spending Growth at its Highest Rate Since 2007. American Medical Association. March, 2017. Available from: https://www.ama-assn.org/system/files/media-browser/prp-annual-spending-2017.pdf

Martin, A., Lassman, D., Whittle, L., Catlin, A., and The National Health Expenditure Accounts Team. Recession Contributes to Slowest Annual Rate of Increase in Health Spending In Five Decades. January, 2011. Available from: https://www.healthaffairs.org/doi/10.1377/hlthaff.2010.1032

Martin, A., Lassman, D., Washington, B., Catlin, A., and The National Health Expenditure Accounts Team. Growth in US Health Spending Remained Slow in 2010; Health Share of Gross Domestic Product Was Unchanged From 2009. January, 2012. Available from: https://www.healthaffairs.org/doi/10.1377/hlthaff.2011.1135

Martin, A., Lassman, D., Whittle, L., Catlin, A., and The National Health Expenditure Accounts Team. National Health Spending In 2012: Rate Of Health Spending Growth Remained Low For The Fourth Consecutive Year. January, 2014. Available from: https://www.healthaffairs.org/doi/10.1377/hlthaff.2013.1254

Martin, A., Lassman, D., Benson, J., Catlin, A., and The National Health Expenditure Accounts Team. National Health Spending In 2014: Faster Growth Driven By Coverage Expansion And Prescription Drug Spending. January, 2016. Available from: https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1194

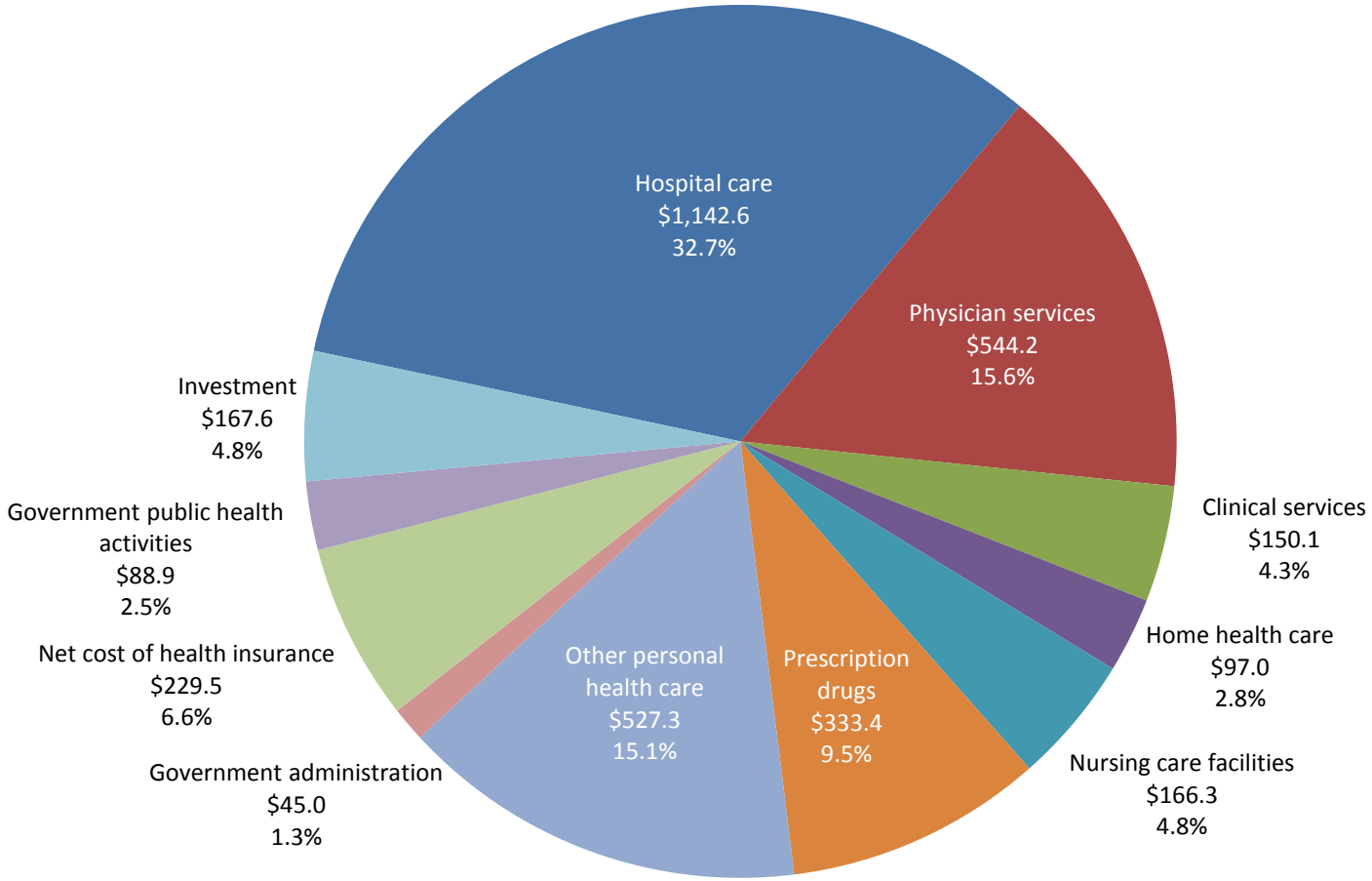
Martin, A., Lassman, D., Washington, B., Catlin, A., and The National Health Expenditure Accounts Team. National Health Spending: Faster Growth In 2015 As Coverage Expands And Utilization Increases. January, 2017. Available from: https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1330

Martin, A., Hartman, M., Washington, B., Catlin, A., and The National Health Expenditure Accounts Team. National Health Care Spending In 2017: Growth Slows To Post–Great Recession Rates; Share Of GDP Stabilizes. January, 2019. Available from: https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05085

Rama, A. Policy Research Perspectives: National Health Expenditures, 2016: Annual Spending Growth on the Downswing. American Medical Association. May, 2018. Available from: https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/member/health-policy/prp-annual-spending-2016.pdf

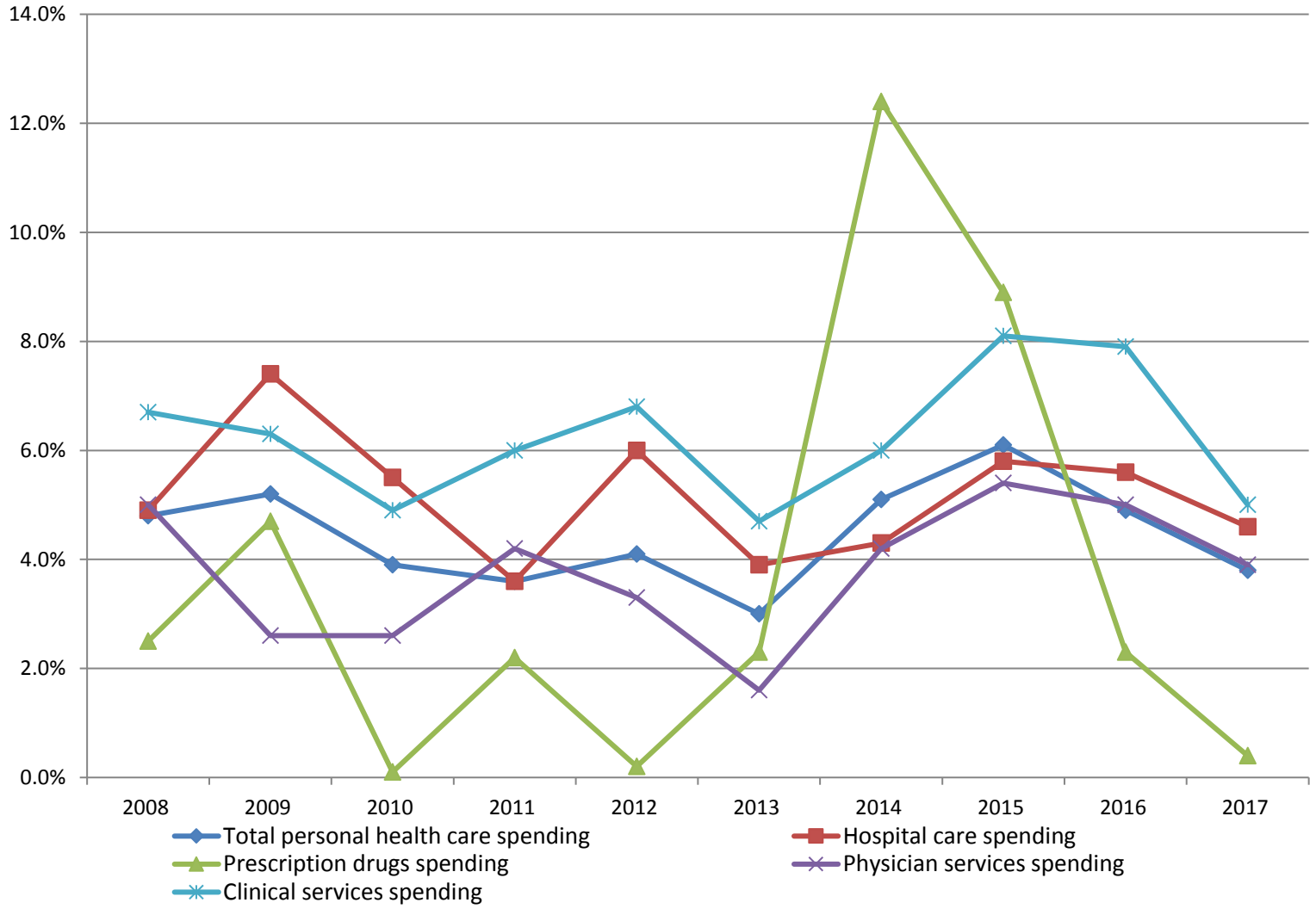
The Boards of Trustees. 2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds [Internet]. Baltimore (MD): CMS. June, 2018. Available from:http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf

Exhibit 1. The U.S. spent $3,492.1 billion on health care in 2017 where did it go?



Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html. Tables 6, 7, 9, 10, and 16 in NHE Tables [ZIP].

Exhibit 2. Spending growth rates by type of expenditure



Average annual growth rates, 2007-2017

Total personal health care: 4.4%

Hospital care: 5.1%

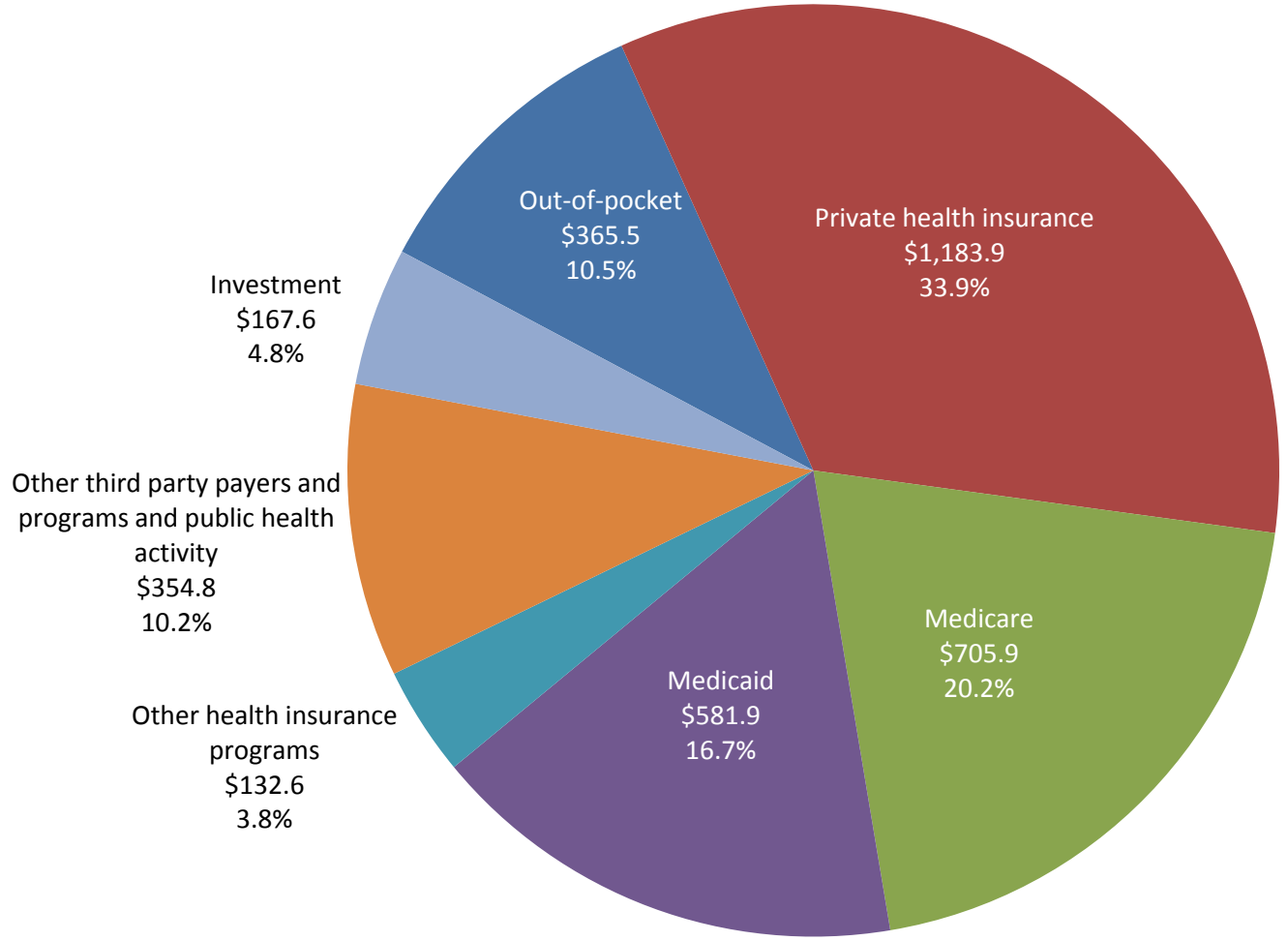
Prescription drugs: 3.5%

Physician services: 3.8%

Clinical services: 6.2%

Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html. Tables 6, 7, 9, 10, and 16 in NHE Tables [ZIP].

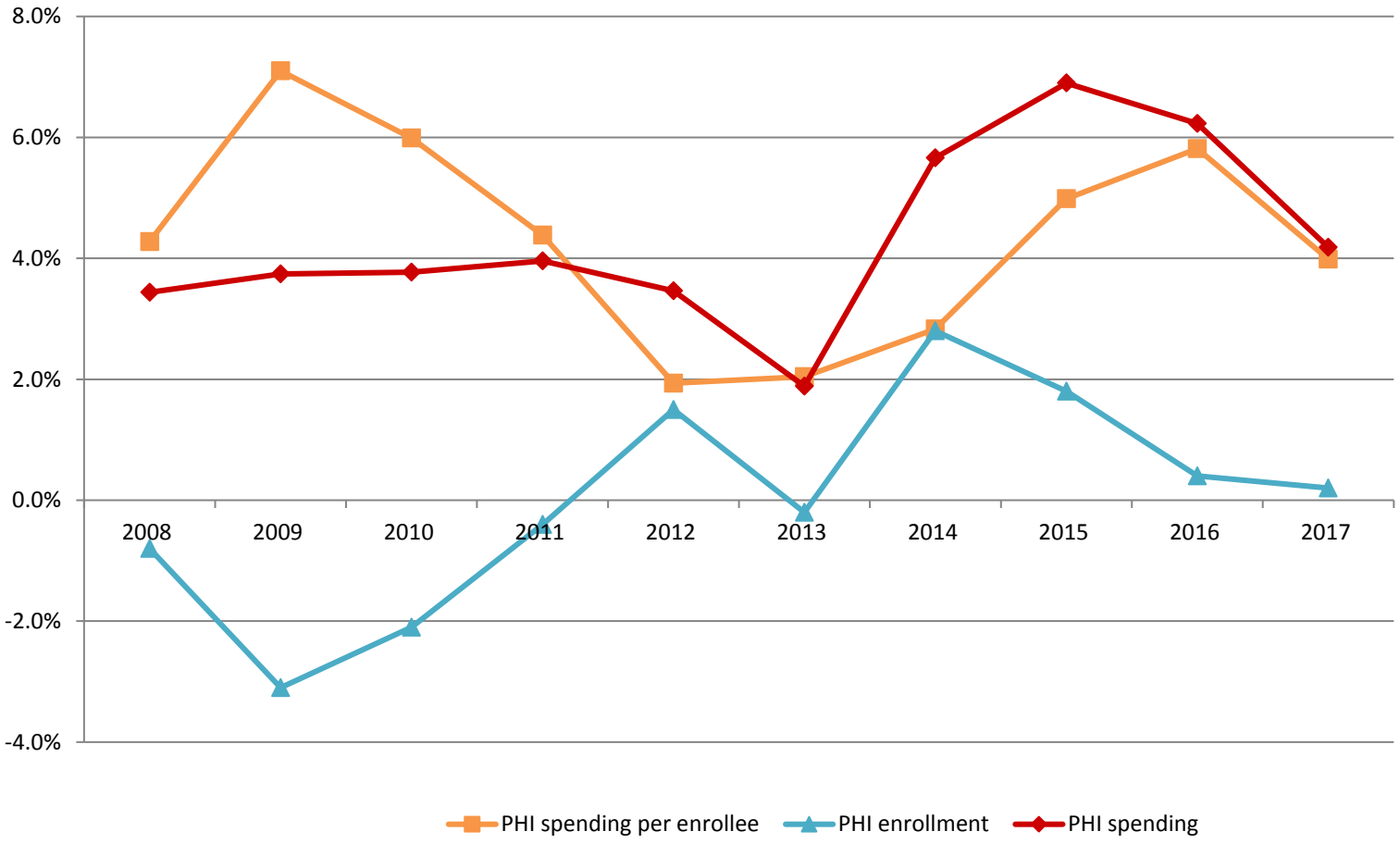
Exhibit 3. 2017 Health care spending by source of funds



Out of a total of $3,492.1 billion

Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html. Table 2 in NHE Tables [ZIP].

Exhibit 4. Private health insurance spending and enrollment growth rates



Average annual growth rates of private health insurance, 2007-2017

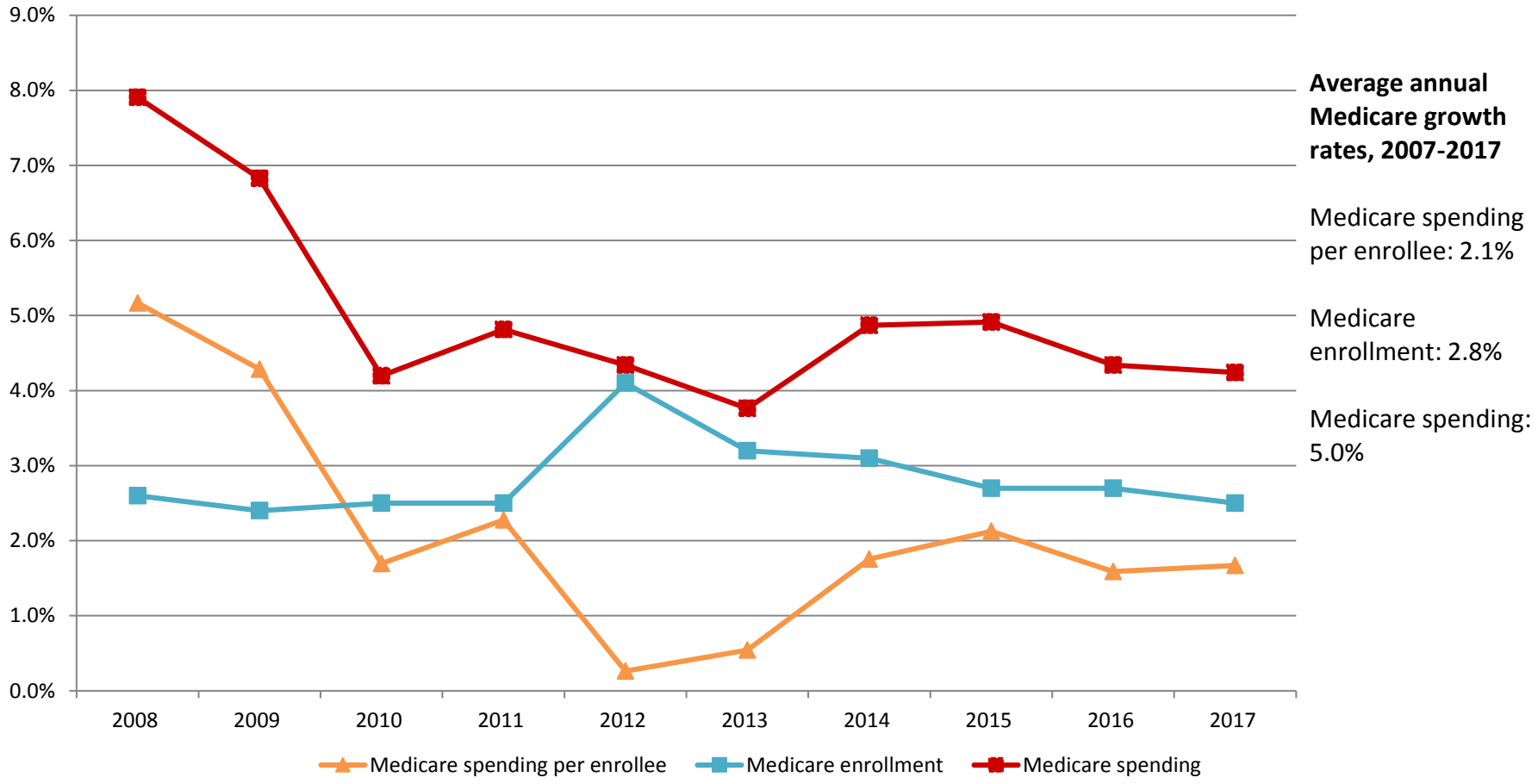
PHI spending per enrollee: 4.3%

PHI enrollment: 0.0%

PHI spending: 4.3%

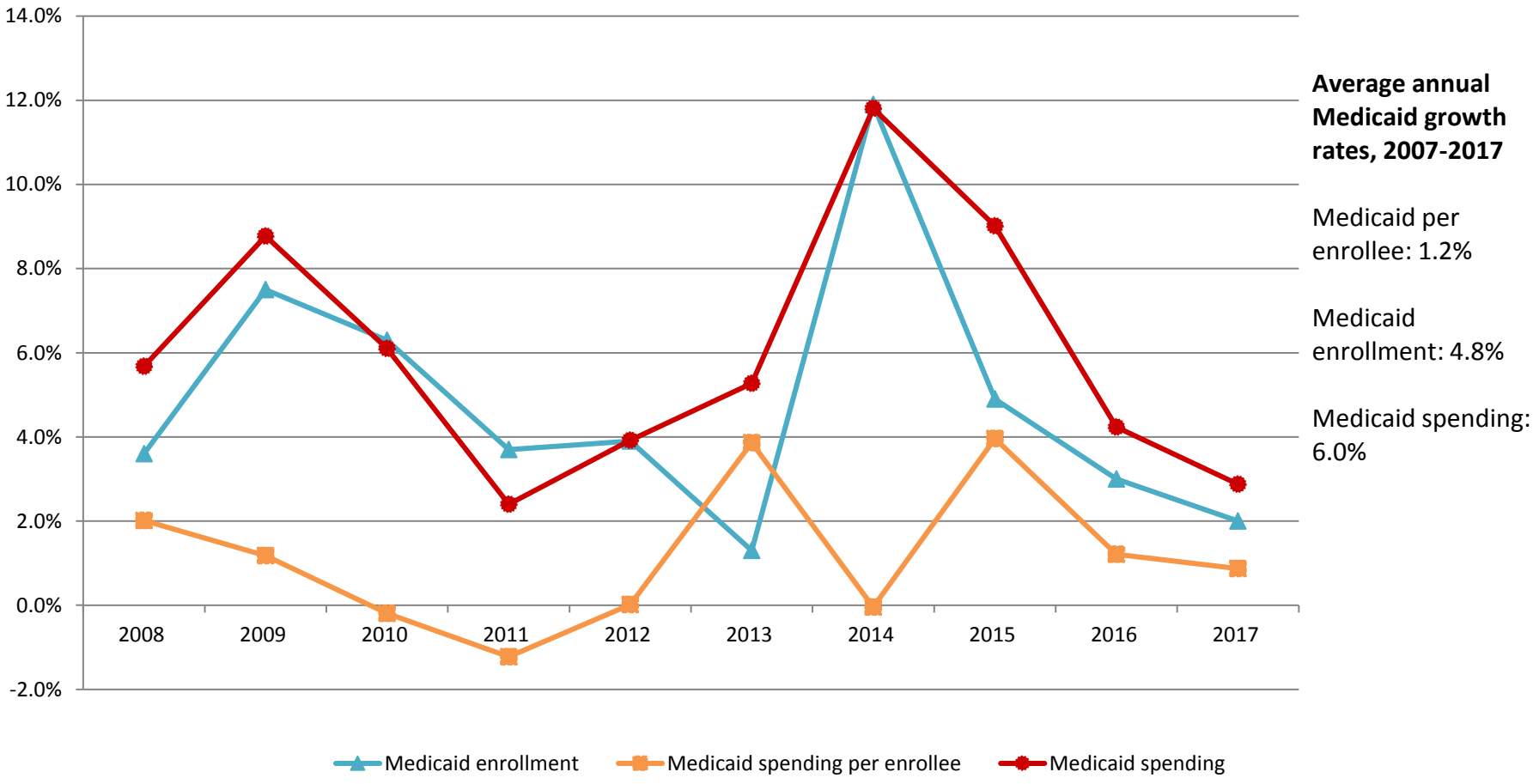
Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html. Table NHE2017 and Table 22 in NHE Tables [ZIP].

Exhibit 5. Medicare spending and enrollment growth rates



Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html. Table 21 in NHE Tables [ZIP].

Exhibit 6. Medicaid spending and enrollment growth rates



Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html. Table 21 in NHE Tables [ZIP].

Exhibit 7. The Financing of PHI spending, Medicare spending, and NHE in 2017 (billions of dollars)

	PHI spending		Medicare spending		NHE	
SPONSOR	**Level**	**Percentage**	**Level**	**Percentage**	**Level**	**Percentage**
Private business						
Employer contribution to employer sponsored health insurance premiums	$536.3	45.3%			$536.3	15.4%
Employer Medicare Hospital Insurance Trust Fund payroll taxes			$107.5	15.2%	$107.5	3.1%
Workers' compensation, temporary disability insurance, worksite healthcare					$52.7	1.5%
Total private business	**$536.3**	**45.3%**	**$107.5**	**15.2%**	**$696.5**	**19.9%**
Household						
Employee contribution to employer-sponsored health insurance premiums	$278.0	23.5%			$278.0	8.0%
Household contribution to direct purchase insurance	$54.7	4.6%			$54.7	1.6%
Medical portion of property and casualty insurance	$39.7	3.4%			$39.7	1.1%
Employee and self-employment payroll taxes and voluntary premiums paid to Medicare Hospital Insurance Trust Fund			$162.2	23.0%	$162.2	4.6%
Premiums paid by individuals to Medicare Supplementary Medical Insurance Trust Fund and the Pre-existing Condition Insurance Plan			$78.6	11.1%	$78.6	2.3%
Out-of-pocket health spending					$365.5	10.5%
Total household	**$372.4**	**31.5%**	**$240.8**	**34.1%**	**$978.6**	**28.0%**
Other private revenues					**$239.0**	**6.8%**

Exhibit 7. continued

SPONSOR	PHI spending Level	PHI spending Percentage	Medicare spending Level	Medicare spending Percentage	NHE Level	NHE Percentage
Federal government						
Employer contribution to employer-sponsored health insurance premiums	$37.5	3.2%			$37.5	1.1%
Employer Medicare Hospital Insurance Trust Fund payroll taxes			$4.4	0.6%	$4.4	0.1%
Federal general revenue and Medicare Net Trust Fund expenditures			$309.3	43.8%	$309.3	8.9%
Federal portion of Medicaid payments					$361.2	10.3%
Federal portion of Medicare buy-in premiums			$11.0	1.6%	$11.0	0.3%
Retiree Drug Subsidy payments to employer-sponsored health insurance plans					$0.9	0.0%
Other federal health insurance and programs	$5.1	0.4%			$217.7	6.2%
Marketplace tax credits and subsidies	$40.5	3.4%			$40.5	1.2%
Total federal government	**$83.0**	**7.0%**	**$324.7**	**46.0%**	**$982.4**	**28.1%**
State and local government						
Employer contribution to employer-sponsored health insurance premiums	$192.3	16.2%			$192.3	5.5%
Employer Medicare Hospital Insurance Trust Fund payroll taxes			$14.0	2.0%	$14.0	0.4%
State portion of Medicaid payments					$220.6	6.3%
State portion of Medicare buy-in premiums			$7.5	1.1%	$7.5	0.2%
State phase down payments (Part D)			$11.4	1.6%	$11.4	0.3%
Other programs					$149.7	4.3%
Total state and local government	**$192.3**	**16.2%**	**$32.9**	**4.7%**	**$595.5**	**17.1%**
TOTAL	**$1,183.9**	**100%**	**$705.9**	**100%**	**$3,492.1**	**100%**

Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html. Tables 5, 5-1,5-2,5-3,5-4,5-5, and 5-6 in NHE Tables [ZIP].