Policy Research Perspectives

National Health Expenditures, 2018: Spending Growth Remains Steady Even With Increases in Private Health Insurance and Medicare Spending

By Apoorva Rama, PhD

Introduction

This Policy Research Perspective (PRP) is the latest installment in a series of reports from the American Medical Association (AMA) that examine the U.S. National Health Expenditures (NHE). In December 2019, the Centers for Medicare & Medicaid Services (CMS) released the 2018 NHE data and revised estimates for previous years (Hartman et al., 2020). 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 growth patterns of key spending categories for private health insurance, Medicare, and Medicaid over the 10-year period ending in 2018.

In 2018, NHE increased by 4.6 percent to $3.6 trillion or $11,172 per capita. Although this growth rate is slightly faster than in 2017 (4.2 percent), it is the same as in 2016 (4.6 percent). The slight acceleration in spending can be attributed to spending increases within both private health insurance and Medicare that were driven by the reinstatement of the Affordable Care Act (ACA) health insurance tax (that was previously suspended in 2017). Nevertheless, personal healthcare spending, which includes spending on hospital care, physician services, and prescription drugs, maintained a growth rate of 4.1 percent in both 2017 and 2018. Further, despite the slight acceleration in total spending growth in 2018 compared to 2017, health spending was only 17.7 percent of GDP in 2018 compared to 17.9 percent of GDP in 2017.

What are national health expenditures?

CMS decomposes the NHE in the following three ways:

1. *Type of expenditure*: health care spending is broken down into what was invested (i.e. put towards research, structures and equipment) and what was spent on health consumption expenditures (HCE) (i.e. consumed today). Most of HCE goes towards "personal health care spending," which includes spending on hospital care, physician services, and prescription drugs. The remainder goes towards public health and net costs for insurers (i.e., administration, taxes, fees, and profits of private health insurers). This breakdown answers the question, "where does the money go?"
2. *Source of funds*: health care spending is broken down into what was invested and what was 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:* health care spending is broken down by the financiers (i.e. “sponsors”) of health spending which include households, private businesses, the federal government, state and local governments, and other private revenues. Unlike source of funds, sponsors reflect the original financing source of the spending. For example, private health insurance (PHI) is a source of funds but 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 original financing source for that spending. This breakdown addresses the question, “how is the spending financed?”

For each breakdown of the NHE (by type, source of funds, or sponsor), the sum of the components will be $3.6 trillion.

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

Spending shares

Health care spending can be decomposed by type of expenditure, where the money goes towards either investment or health consumption expenditures (HCE). Exhibit 1 shows that, in 2018, 4.8 percent of total health spending (or $174.4 billion) went towards investment and the remainder went to the HCE category.

Most of the HCE category consists of personal health care spending, which was 84.3 percent of total health spending (or $3,075.5 billion) in 2018. The main categories of personal health care spending are hospital care (32.7 percent of total health spending or $1,191.8 billion), physician services (15.5 percent or $564.4 billion), clinical services (4.4 percent or $161.1 billion), and prescription drugs (9.2 percent or $335.0 billion).[1,2,3] Personal health care spending also includes spending on nursing care facilities (4.6 percent of total health spending or $168.5 billion), home health care (2.8 percent or $102.2 billion), and other personal health care services (15.1 percent or $552.4 billion).[4]

In addition to personal health care spending, HCE also includes spending on government public health activities (2.6 percent of total health spending or $93.5 billion), government administration (1.3 percent of total health spending or $47.5 billion), and the net cost of health insurance (7.1 percent or $258.5 billion). Government administration includes the administrative cost of running government health care programs. The net cost of health insurance, the difference between what insurers incur

[1]Physician services consist of spending made in establishments where physician services are rendered (i.e., Offices of Physicians and Doctors of Osteopathy under the North American Industry Classification System (NAICS)) (Centers for Medicare & Medicaid Services, 2019).
[2]Clinical services include spending made in establishments classified as outpatient care centers under NAICS (Centers for Medicare & Medicaid Services, 2019). 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]In the tables prepared by CMS, physician and clinical services are generally presented as a combined category and, combined they make up the second largest spending category. In this PRP, they are shown separately because of notable differences between the two categories, such as the spending growth rates discussed in Exhibit 2.
[4]Other personal health care services include dental and other professional services, durable medical equipment and other non-durable medical products, as well as other health, residential, and personal care.

in premiums and the amount paid in benefits, goes towards insurers administrative costs, taxes, fees, net profits/losses, etc.

Each of the 2018 spending shares were within a percentage point of those from 2017 (see Rama, 2019 for 2017 values).The stability of the health spending shares between 2017 and 2018 reflects this ongoing pattern over the last few decades (see Kane, 2017 for detailed discussion).[5]

Spending growth

While the previous section focused on the share of spending in 2018 by type of expenditure, this section examines the annual spending growth rates over the 10-year period ending in 2018 by type of expenditure. Exhibit 2 presents this information for personal health care spending and its four main components: hospital care, physician services, clinical services, and prescription drugs. In 2018, there was a deceleration in spending for hospital care (from 4.7 percent in 2017 to 4.5 percent in 2018), physician services (from 4.2 percent in 2017 to 3.6 percent in 2018), and clinical services (6.7 percent in 2017 to 6.0 percent in 2018); this was primarily due to slow growth in the use and intensity of services despite increased price growth for all three categories (Hartman et al., 2020). In contrast, prescription drug spending growth increased (from 1.4 percent in 2017 to 2.5 percent in 2018) as slow price growth for (both generic and brand name) prescription drugs was offset by faster growth in non-price factors (e.g., number of prescriptions dispensed) (Hartman et al., 2020). Overall, total personal health care spending growth remained the same in 2018 and 2017 (at 4.1 percent).

Prior to 2018, each of the four main type of expenditure categories saw a spike in spending growth during ACA implementation (2014 and 2015) and a slowdown in spending growth post-implementation (2016 and 2017). However, the magnitude differed across categories. For example, Exhibit 2 shows a spike in spending growth to 8.2 percent in 2015 for clinical services but only to 5.4 percent for physician services (the lowest of the type of expenditure categories presented). Exhibit 2 also presents the average annual growth rates in spending over the 10-year period ending in 2018. The 10-year average annual growth rate for total personal health care spending was 4.4 percent. The 10-year averages, however, can mask patterns over this period; the average annual growth were similar for physician services (3.6 percent) and prescription drugs (3.4 percent) even though spending during this period was stable for physician services but volatile for prescription drugs (ranging from -0.4 percent in 2010 to 13.3 percent in 2014).

Spending by source of funds: who pays the bill?

Spending shares

Health care spending can be broken down by source of funds (i.e., spending by different health insurance programs, out-of-pocket, and other third-party payers); this distribution is shown in Exhibit 3. In 2018, the largest share of total health spending, 34.1 percent (or $1,243.0 billion), came from PHI; Kane (2017) notes that PHI has had the largest share for the past four decades. Medicare made up 20.6 percent of total health spending ($750.2 billion) and Medicaid made up 16.4 percent ($597.4 billion). Out-of-pocket spending was 10.3 percent of total health spending ($375.6 billion);

[5]Kane (2017) notes that the biggest percentage point change over the past 25 years 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.

this category consists of all payments made directly by all patients regardless of insurance status (i.e., includes pre-deductible spending, copayment and coinsurance payments of insured patients, as well as payments made by uninsured patients). Other health insurance programs accounted for 3.8 percent of total health spending ($138.3 billion) and spending on other third-party payers and programs and public health activity was 10.2 percent ($370.5 billion). These shares are similar to what was observed in 2017 (see Rama, 2019 for 2017 values).[6]

Spending growth

For the four main sources of funds (PHI, Medicare, Medicaid, and out-of-pocket), Exhibit 4 shows spending growth over the 10-year period ending in 2018. Prior to 2013, there was stability in the spending growth of both PHI (remaining under 4 percent, dropping only in 2013 to 1.9 percent) and Medicare (remaining under 5 percent, spiking only in 2009 to 7.9 percent from increases in both spending on services for Medicare fee-for-service and enrollment in Medicare Advantage) (Martin et al., 2011). In contrast, Medicaid spending growth fluctuated, spiking to 8.8 percent in 2009 (from enrollment increases during the Great Recession), before dropping to 2.3 percent in 2011 (Martin et al., 2011). Out-of-pocket spending growth also fluctuated (dropping to -0.5 percent in 2009 before accelerating to 3.4 percent in 2011). For the three payers, spending initially accelerated during the implementation of ACA in 2014 and 2015 (albeit more modestly for Medicare) but later decelerated in 2016 and 2017 (most substantially for Medicaid) as ACA implementation leveled off. In contrast, out-of-pocket spending growth dipped in 2014 (to 1.5 percent) before spiking in 2016 (to 4.5 percent); generally, changes in out-of-pocket spending over this 10-year period reflect plans requiring higher cost-sharing, consumers switching to plans with higher deductibles and/or copayments, or loss of health insurance coverage (Martin et al., 2012 and Hartman et al., 2018).[7]

In the most recent data available, there was an uptick in spending growth for PHI (from 4.9 percent in 2017 to 5.8 percent in 2018), Medicare (from 4.2 percent in 2017 to 6.4 percent in 2018), and Medicaid (from 2.6 percent in 2017 to 3.0 percent in 2018). Different than in most other years with an acceleration in spending growth, the 2018 acceleration was driven by expenditures in the net cost of health insurance (NCHI). NCHI is the expenditure category that includes administrative costs, taxes and fees, net profits or losses, etc. for PHI and private plans administering government health care programs (e.g., Medicare Advantage, stand-alone Medicare Part D plans, Medicaid managed care plans, CHIP managed care plans, etc.). However, federal, state and local government administrative costs, such as government employee salaries and management expenses, fall under the government administration (GA) expenditure category for Medicare, Medicaid and other government health care plans. Because administrative expenses for Medicare and Medicaid appear in both GA and NCHI, Exhibit 5 tracks growth in those two categories combined (GA/NCHI) over the 10 year period ending in 2018.

[6]Other health insurance and third party payers and programs include Children's Health Insurance Program (CHIP), the Department of Defense (DOD) health care program (TRICARE), Department of Veterans Affairs health expenditures, worksite health care (i.e., expenditures for PHC directly provided by employers for their employees), other private revenues, Indian health services, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, other federal programs, substance abuse and mental health services administration, other state and local programs, and school health (Centers for Medicare & Medicaid Services, 2019).

[7]It should be noted that, between 2008 and 2018, out-of-pocket spending growth remained below 5 percent and, in most years, was less than the spending growth of PHI, Medicare, and Medicaid. Further, out-of-pocket spending (as a share of total health spending) has been declining over the past 50 years (data not shown; see Kane, 2017).

Spending growth for GA/NCHI increased from 9.5 percent in 2017 to 15.3 percent in 2018 for PHI, from -2.4 percent in 2017 to 16.0 percent in 2018 for Medicare, and from -1.5 percent in 2017 to 6.8 percent in 2018 for Medicaid (Exhibit 5). The ACA imposed a fixed annual fee on certain for-profit health insurers starting in 2014 (Kirchhoff, 2013), however, the Consolidated Appropriations Act of 2015 set a one-year moratorium in 2017 on this health insurance tax (Keith, 2019).[8] As a result, a projected $13.9 billion was not collected in that year (Carlson et al., 2017). However, the tax was reinstated in 2018 at a higher annual level ($14.3 billion) resulting in high 2018 NCHI expenditures (Carlson et al., 2017 and Hartman et al., 2020) that fed into the growth acceleration seen between 2017 and 2018. The Bureau of Labor Statistics (BLS) reported that the health insurance expenditures component of the consumer price index, which is based on health insurance premiums, had annual growth of 5.4 percent in 2018 up from 0.0 percent in 2017 (Bureau of Labor Statistics 2018, 2019).[9] The underlying reason for this increase is likely the same as that for the NCHI increase in the NHE data. In fact, Altarum (2020) noted that more recent (and preliminary) spending data released by the BLS also suggests that growth rates continue to reflect the periodic suspension of the health insurance tax; in addition to its suspension in 2017, it was also suspended in 2019 but present in 2020 (as well as in 2018). Thus, the uptick in 2018 NCHI spending growth for PHI likely encompasses private plans pricing the health insurance tax into premiums paid by enrollees (consumers). Likewise, Hartman et al. (2020) note that for Medicare, the faster growth was driven in part by private Part C and Part D plans adjusting their premiums to reflect the higher insurance tax.

Exhibit 5 also shows that, over the 10-year period ending in 2018, there were substantial fluctuations in the GA/NCHI spending growth for all three payers. For PHI, NCHI spending growth was -4.0 percent in 2009, reflecting losses from decreased enrollment coupled with high per enrollee spending (Martin et al., 2011). Decreased enrollment will affect premium revenue and high per enrollee benefit spending results in a greater proportion of that revenue going towards personal health care expenditures; thus, the difference between what insurers incur in premiums and the amount paid in benefits (i.e., NCHI) decreases. In 2010, NCHI spending growth increased to 10.3 percent as the economy recovered post-recession. In 2014, PHI NCHI spending growth spiked again due to fees associated with ACA and increases in enrollment which generated other administrative costs (Martin et al., 2016). PHI NCHI spending growth sharply declined to -0.1 percent in 2015, but increased to 4.6 percent in 2016 and to 9.5 percent in 2017 as insurers were better able to price Marketplace plans in line with costs and saw faster growth in investment income in 2017 (Martin et al., 2019).

For Medicare, GA/NCHI spending growth consistently slowed each year between 2009 (14.4 percent) and 2013 (1.7 percent), after which it accelerated and eventually spiked in 2016 (to 12.5 percent); some of the outcomes over this period relate to the patterns in per enrollee benefit

[8]The ACA health insurance tax is a fixed annual fee that is allocated among insurers based on their market share (market share is determined based on an insurer's premium revenue in the prior year) (Keith, 2019). This fee does not apply for government-run insurance programs; other exceptions and conditions are noted in Kirchhoff (2013).
[9]Health insurance expenditures are a component of the medical care index which, in turn, is part of the consumer price index. The medical care index consists of two components: medical care services (i.e., professional services, hospital and related services, and health insurance) and medical care commodities (i.e., medicinal drugs, equipment and supplies). In 2020, health insurance made up 13 percent of the medical care index. See Bureau of Labor Statistics (2020) for details.

spending and enrollment discussed in Rama (2019). In 2017, the Medicare GA/NCHI spending growth rate substantially decreased to -2.4 percent. Regarding Medicare financing, the federal government allocates funds in the prior year for estimated administrative costs; this is later reconciled when the costs have been incurred. There was a decrease in GA expenditures in 2017 due to recoveries from corrections to prior year allocation estimates (Hartman et al., 2020). In 2018, the lack of these recoveries resulted in faster growth in GA spending and the reinstitution of the health care tax (discussed earlier) resulted in faster growth in NCHI spending.

Lastly, for Medicaid, GA/NCHI spending spiked modestly in 2010 (to 11.6 percent) and more substantially in 2014 (to 30.2 percent), the latter due to additional net cost of health insurance expenditures associated with Medicaid managed care plans from expansions in eligibility and enrollment from the ACA (Martin et al., 2016). Although 2011 saw decreases in per enrollee benefit spending (due to healthier/lower-cost enrollees and states taking measures to control expenditure growth), enrollment also decelerated as the economy continued to rebound post-recession (Hartman et al., 2013); on balance, Exhibit 5 shows that Medicaid GA/NCHI spending growth dropped to 4.4 percent in that year. Spending growth also dipped in 2017 to -1.5 percent; this was driven by negative growth in NCHI expenditures as Martin et al. (2019) note that payments were recovered from Medicaid managed care plans.

Spending by sponsor: how is all that financed?

Lastly, health care spending can be broken down by sponsor (i.e., the origin of the funding or the initial financing of the spending). Exhibit 6 presents the shares of spending by sponsor (households, private businesses, the federal government, state and local government, and other private revenues) for the national health expenditures (NHE) in its entirely as well as for two of its components, PHI and Medicare spending.[10]

The rightmost column of Exhibit 6 provides the sponsor breakdown of NHE. In 2018, the largest sponsors were households, who financed 28.4 percent ($1,035.7 billion) of total health spending, followed by the federal government, who financed 28.3 percent ($1,033.8 billion). 2018 marks the first year that both federal government and household financing exceeded 1 trillion dollars. Private businesses sponsored 19.9 percent of total health spending ($726.8 billion), state and local governments financed 16.5 percent ($602.5 billion), and 6.9 percent ($250.7 billion) came from other private revenues. The shares of spending by sponsor have been stable in the short term (e.g., the 2018 shares are within half a percentage point of the 2017 shares). Over the long term, however, the shifts have been significant.[11] The share of spending sponsored by households has decreased substantially (from 38.1 percent in 1987 to 28.4 percent in 2018) while the share sponsored by the

[10]Other private revenues are private sponsors of health care that are not included in private businesses and households (Centers for Medicare & Medicaid Services, 2019). This includes philanthropic support from individuals and organizations, income from operation of businesses in health care institutions (i.e., gift shops, cafeterias, educational programs, and investment income in hospitals, nursing homes, and other such institutions), as well as private investment in research, structures, and equipment.

[11]Rama (2019) contains 2017 values; however, CMS has revised some of the 2017 values during the release of the 2018 data.

federal government has increased (from 16.5 percent in 1987 to 28.3 percent in 2018). Over the last few years the contributions of households and the federal government have been close.[12]

The leftmost column of Exhibit 6 presents the shares of PHI spending by sponsor. PHI spending in 2018 was $1,243.0 billion. Private businesses were the largest sponsors of PHI spending, financing 45.1 percent (or $560.7 billion) through employer contributions to employer sponsored health insurance premiums. Households financed 32.3 percent of PHI spending (or $401.0 billion); this was through employee contributions to employer-sponsored health insurance premiums (22.9 percent of PHI spending or $284.6 billion), household contributions to direct purchase insurance (6.0 percent or $74.1 billion), and the medical portion of property and casualty insurance (3.4 percent or $42.3 billion). State and local governments financed 14.9 percent of PHI spending ($184.8 billion), all of which came from their role as an employer contributing to health insurance premiums. The federal government financed 7.8 percent ($96.5 billion) through employer contributions to health insurance premiums ($38.3 billion of PHI spending or 3.1 percent), other federal health insurance and programs (0.6 percent or $7.1 billion), and marketplace tax credits and subsidies (4.1 percent or $51.1 billion).

The middle column of Exhibit 6 provides the breakdown of Medicare spending by sponsor. Sponsors contribute to the Medicare trust fund, which finances health services for Medicare beneficiaries and consists of two separate funds: the hospital insurance (HI) trust fund and the supplemental medical insurance (SMI) trust fund. The HI trust fund is for Medicare Part A, which helps cover inpatient care in hospitals and skilled nursing facilities for eligible beneficiaries (Centers for Medicare & Medicaid Services, 2019); the main sources of revenue for this fund are payroll taxes and income from taxation on Social Security benefits (Tax Policy Center, 2019).[13] In their role as employers and employees, the four sponsors contributed to Medicare financing with payroll taxes: $169.0 billion (or 22.5 percent of Medicare spending) from households, $113.0 billion (or 15.1 percent) from private businesses, $14.6 billion (or 1.9 percent) from state and local governments, and $4.4 billion (or 0.6 percent) from the federal government. The SMI trust fund is for both Medicare Part B, which helps cover physician services and outpatient care, and Part D, which provides prescription drug coverage (Centers for Medicare & Medicaid Services, 2019). One financing source of the SMI fund is premiums paid by enrollees; e.g., households contributed $90.1 billion to the Medicare SMI (12.0 percent of Medicare spending). The other main financing source of this trust fund is federal general tax revenue (43.8 percent of Medicare spending or $328.5 billion); these are funds that come from the general pool of taxes that were not initially earmarked for Medicare. Overall, the federal government has been the largest sponsor of Medicare since 2005 due to expansionary policies (e.g., Medicare Part D in 2006) that required increasing shares of financing.

[12]Data on sponsors share of health care spending is available from 1987 onwards. In 2015, both households and the federal government sponsored $908.1 billion of health spending. In 2016, the federal government sponsored $951.9 billion and households sponsored $950.5 billion; this is the first and only year the federal government was the largest sponsor of health spending.

[13] According to Tax Policy Center (2019), “interest payments on trust fund balances, premiums from voluntary enrollees ineligible for Medicare coverage based on their earnings records, transfers from the general fund and the Railroad Retirement account, and miscellaneous receipts supply the remainder of revenues.”

Conclusion

Health care spending in the U.S. increased by 4.6 percent in 2018 to $3,649.4 billion or $11,172 per capita. In comparison, spending grew 4.2 percent in 2017 and 4.6 percent in 2016, stabilizing after higher growth rates during the implementation of the Affordable Care Act. Health spending was only 17.7 percent of GDP in 2018 compared to 17.9 percent of GDP in 2017.

In 2018, personal health care spending made up 84.3 percent of total health spending (or $3075.5 billion). The main components of personal health care are spending on hospital care ($1,191.8 billion or 32.7 percent of total health spending), physician services ($564.4 billion or 15.5 percent), clinical services ($161.1 billion or 4.4 percent), and prescription drugs ($335.0 billion or 9.2 percent). These shares have remained stable over the years, usually within a percentage point of the previous year. Nonetheless, there are short-term fluctuations in spending growth; for example, prescription drug spending had a 13.3 percent growth in 2014 before falling below 3 percent from 2016 onwards.

When decomposing total health spending by source of funds, the largest share of spending came from private health insurance (34.1 percent of total health spending or $1,243.0 billion). Medicare spending made up 20.6 percent of total health spending ($750.2 billion), Medicaid spending made up 16.4 percent ($597.4 billion), and out-of-pocket spending made up 10.3 percent ($375.6 billion). Although there are considerable differences across payers in spending growth patterns over the last decade across, spending growth consistently increased in 2018 for PHI (from 4.9 percent in 2017 to 5.8 percent in 2018), Medicare (from 4.2 percent in 2017 to 6.4 percent in 2018), and Medicaid (from 2.6 percent in 2017 to 3.0 percent in 2018). This was due to the reinstatement of the health insurance tax that plans, in part, priced into premiums paid by enrollees.

Finally, breaking down total health spending by sponsors revealed that, in 2018, the largest shares of health spending came from households (28.4 percent or $1035.7 billion) and the federal government (28.3 percent or $1033.8 billion). Private business financed 19.9 percent ($726.8 billion), state and local governments financed 16.5 percent ($602.5 billion), and the remaining 6.9 percent ($250.7 billion) was financed by other private revenues. Although the shares of spending by sponsor have been stable the last few years, there have been significant shifts over the long term (i.e., the share of spending sponsored by households decreased from 38.1 percent in 1987 to 28.4 percent in 2018 while the share sponsored by the federal government increased from 16.5 percent in 1987 to 28.3 percent in 2018).

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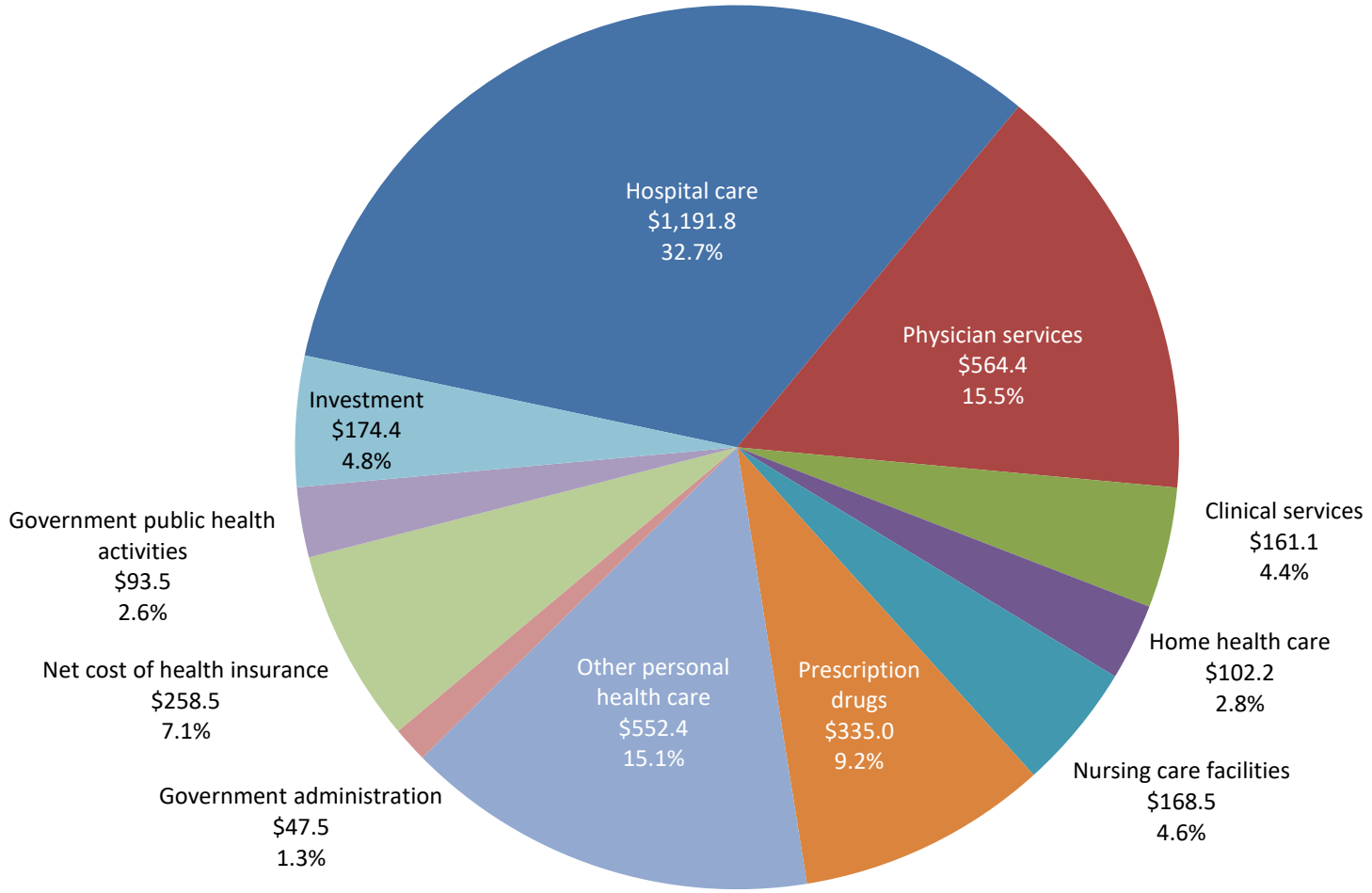
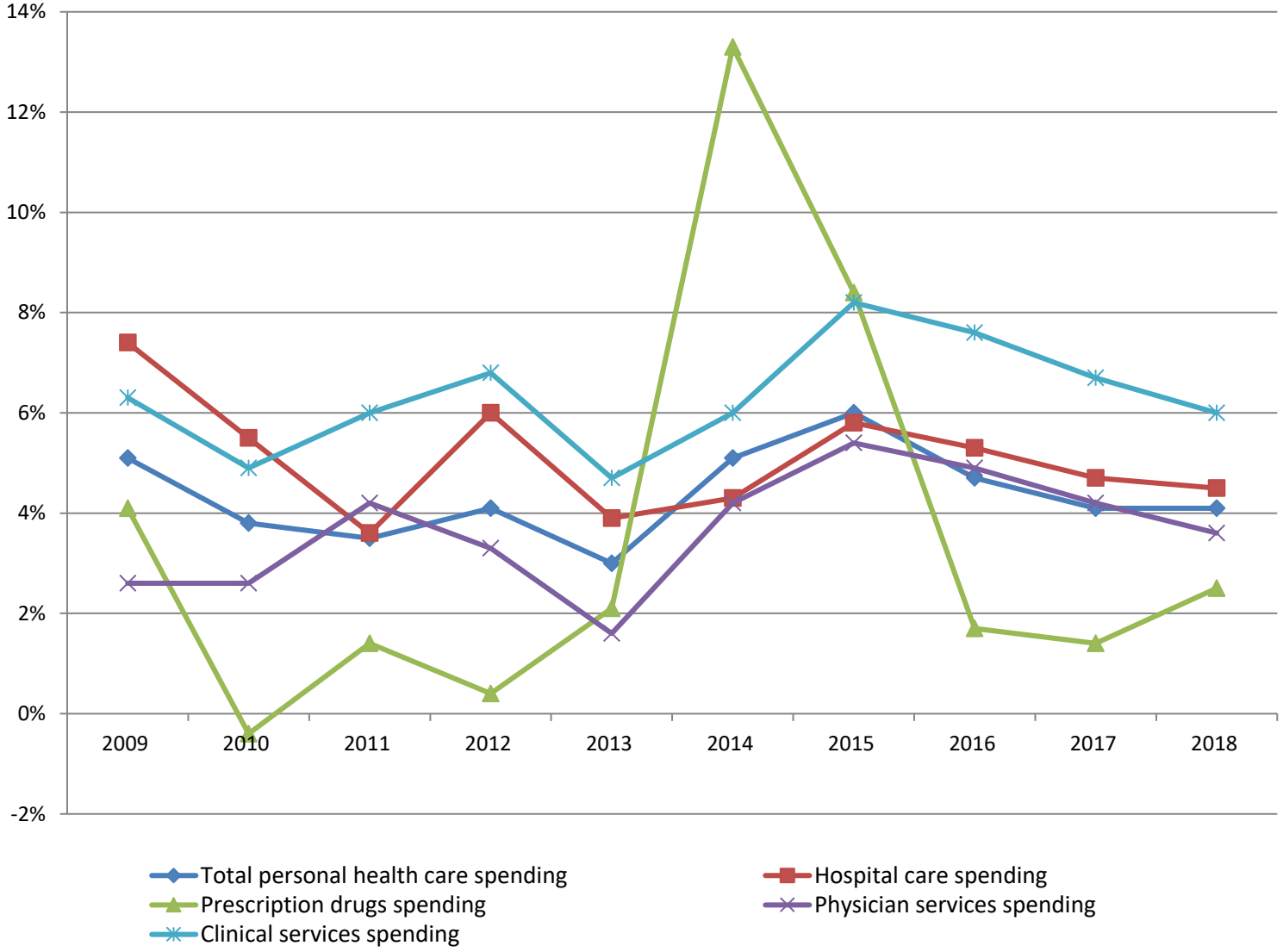
Exhibit 1. The U.S. spent $3,649.4 billion on health care in 2018 where did it go?



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, 2008-2018

Total personal health care: 4.4%

Hospital care: 5.1%

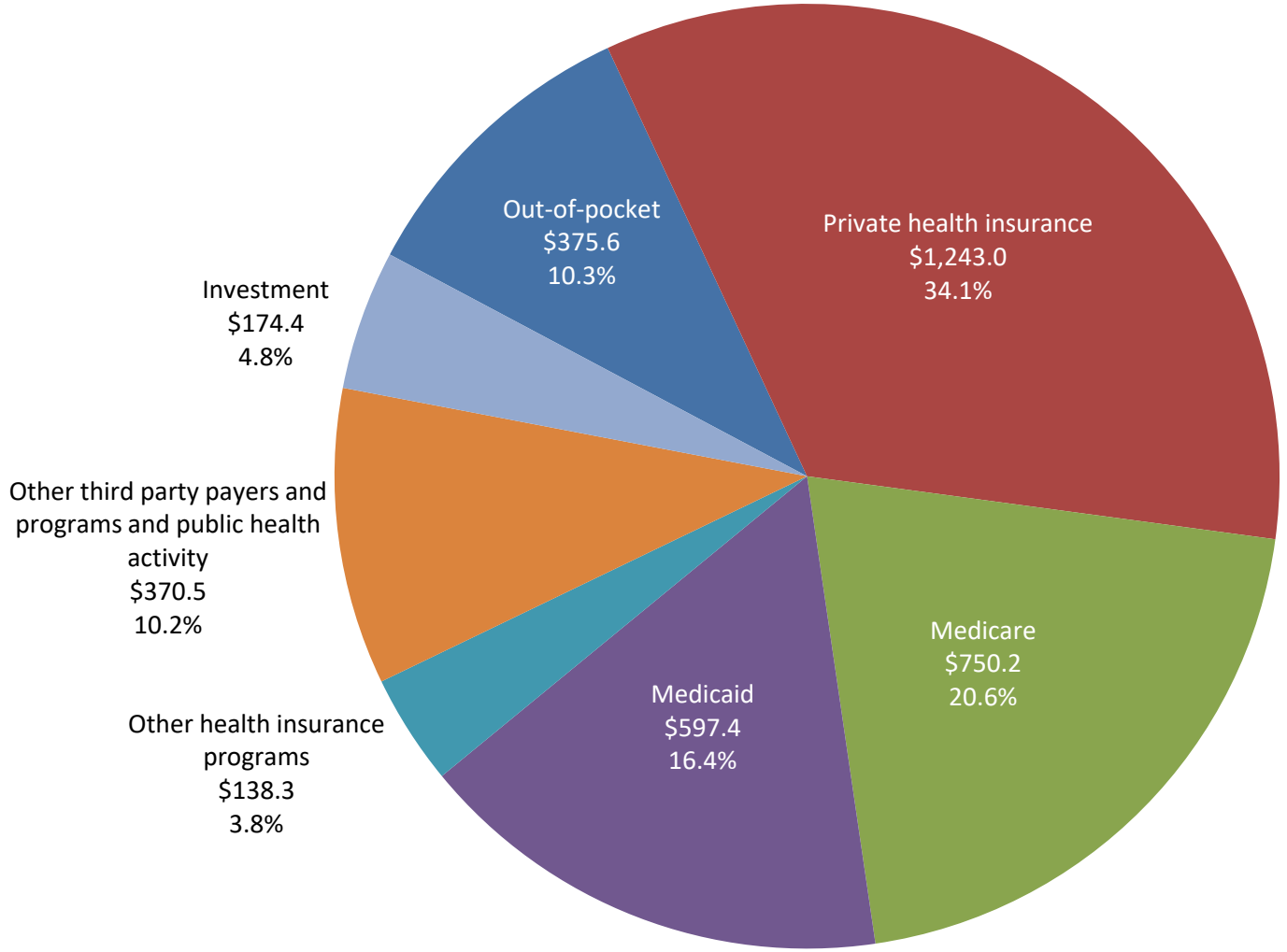
Prescription drugs: 3.4%

Physician services: 3.6%

Clinical services: 6.3%

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].

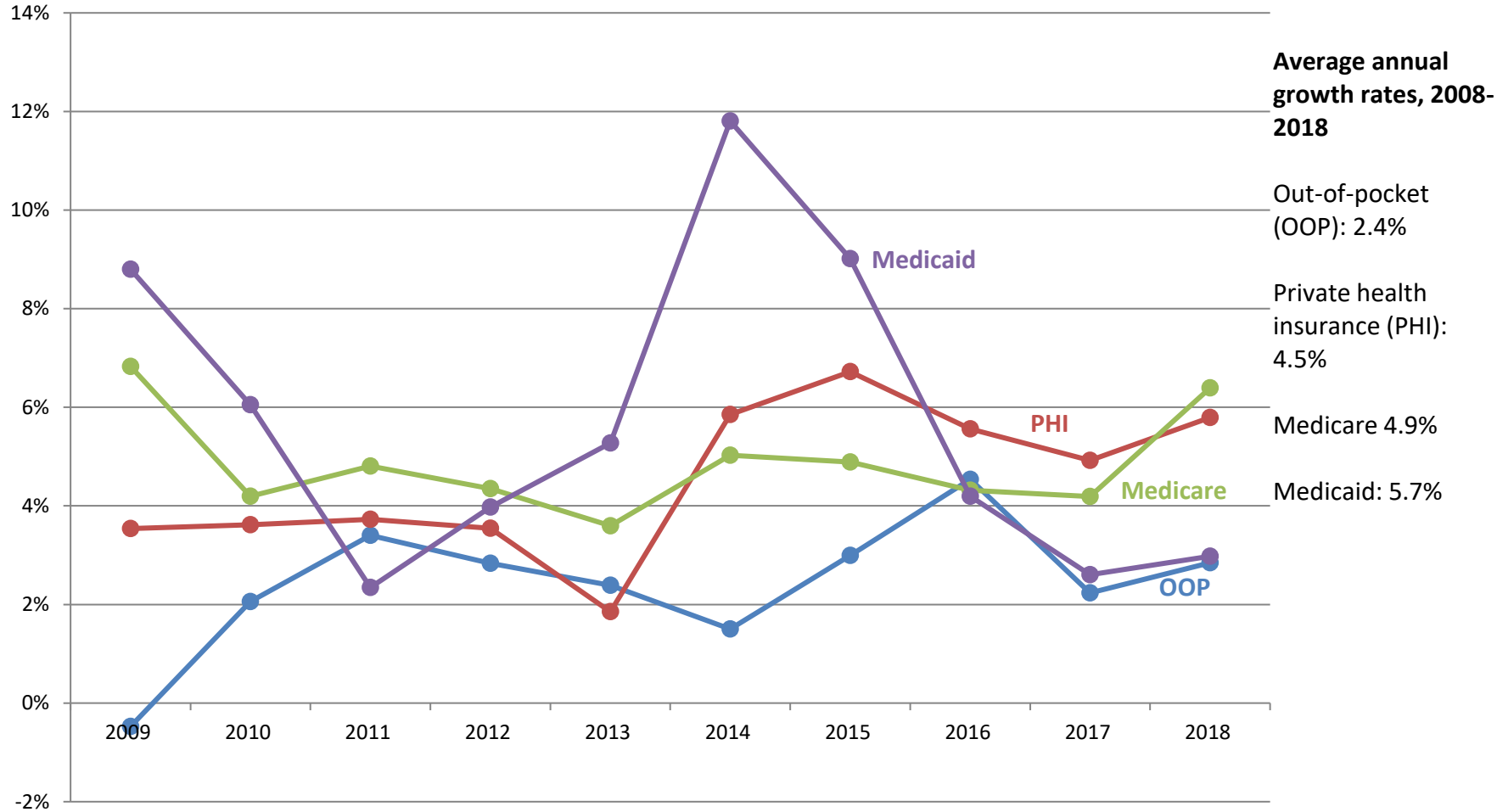
Exhibit 3. 2018 Health care spending by source of funds



Out of a total of $3,649.4 billion

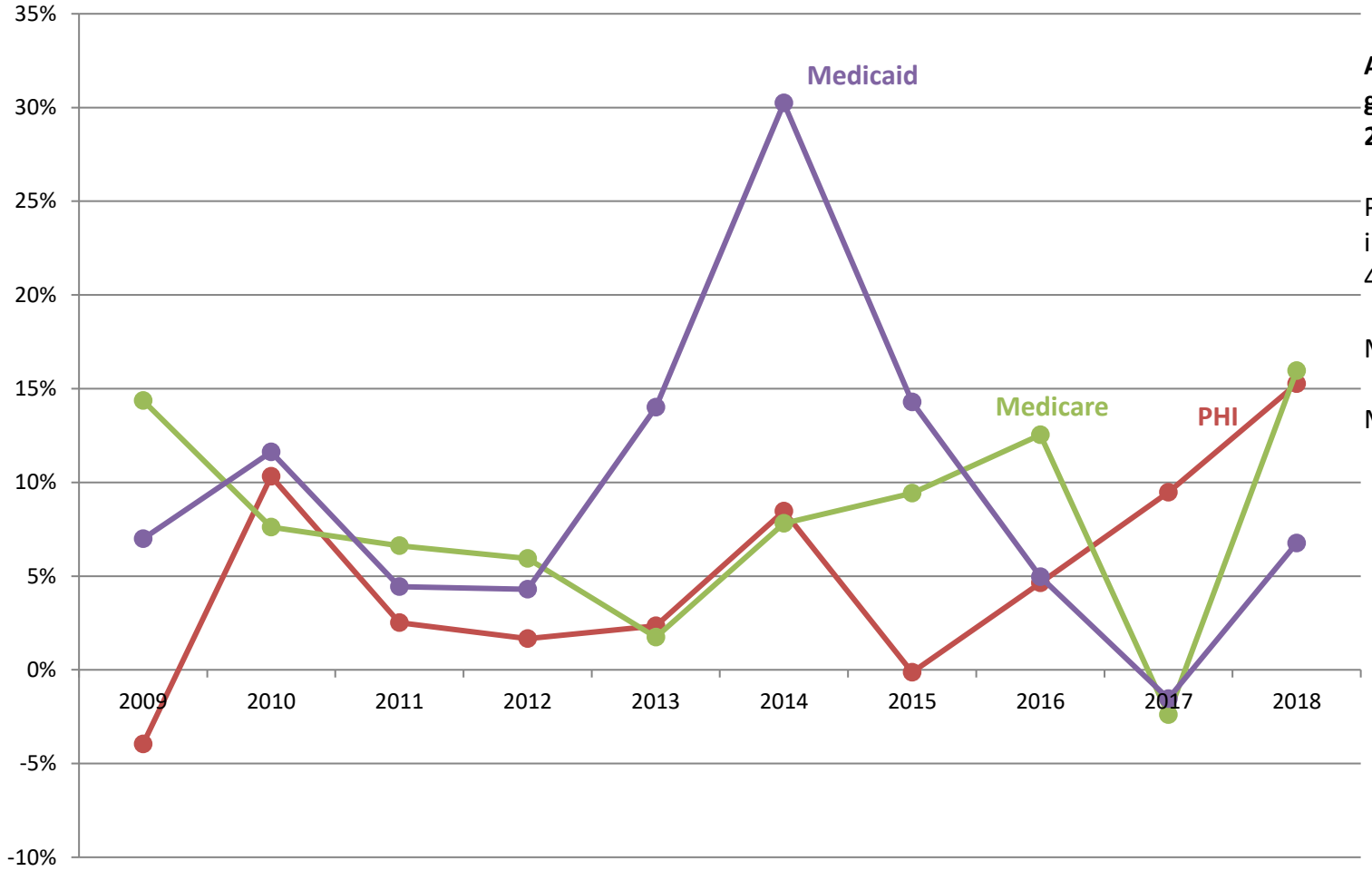
Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html. Table 2 in NHE Tables [ZIP].

Exhibit 4. Spending growth rates by source of funds



Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html. Tables 6, 7, 9, 6 and NHE2018 in NHE Tables [ZIP].

Exhibit 5. Total administration and net cost of health insurance growth rates by source of funds



Average annual growth rates, 2008-2018

Private health insurance (PHI): 4.9%

Medicare 7.8%

Medicaid: 9.3%

Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html. NHE2018 in NHE Tables [ZIP].

Exhibit 6. The Financing of PHI spending, Medicare spending, and NHE in 2018 (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	$560.7	45.1%			$560.7	15.4%
Employer Medicare Hospital Insurance Trust Fund payroll taxes			$113.0	15.1%	$113.0	3.1%
Workers' compensation, temporary disability insurance, worksite healthcare					$53.1	1.5%
Total private business	**$560.7**	**45.1%**	**$113.0**	**15.1%**	**$726.8**	**19.9%**
Household						
Employee contribution to employer-sponsored health insurance premiums	$284.6	22.9%			$284.6	7.8%
Household contribution to direct purchase insurance	$74.1	6.0%			$74.1	2.0%
Medical portion of property and casualty insurance	$42.3	3.4%			$42.3	1.2%
Employee and self-employment payroll taxes and voluntary premiums paid to Medicare Hospital Insurance Trust Fund			$169.0	22.5%	$169.0	4.6%
Premiums paid by individuals to Medicare Supplementary Medical Insurance Trust Fund and the Pre-existing Condition Insurance Plan			$90.1	12.0%	$90.1	2.5%
Out-of-pocket health spending					$375.6	10.3%
Total household	**$401.0**	**32.3%**	**$259.1**	**34.5%**	**$1,035.7**	**28.4%**
Other private revenues					**$250.7**	**6.9%**

Exhibit 6. 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	$38.3	3.1%			$38.3	1.0%
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			$328.5	43.8%	$328.5	9.0%
Federal portion of Medicaid payments					$370.9	10.2%
Federal portion of Medicare buy-in premiums			$11.4	1.5%	$11.4	0.3%
Retiree Drug Subsidy payments to employer-sponsored health insurance plans					$0.8	0.0%
Other federal health insurance and programs	$7.1	0.6%			$228.5	6.3%
Marketplace tax credits and subsidies	$51.1	4.1%			$51.1	1.4%
Total federal government	**$96.5**	**7.8%**	**$344.3**	**45.9%**	**$1,033.8**	**28.3%**
State and local government						
Employer contribution to employer-sponsored health insurance premiums	$184.8	14.9%			$184.8	5.1%
Employer Medicare Hospital Insurance Trust Fund payroll taxes			$14.6	1.9%	$14.6	0.4%
State portion of Medicaid payments					$226.5	6.2%
State portion of Medicare buy-in premiums			$7.7	1.0%	$7.7	0.2%
State phase down payments (Part D)			$11.7	1.6%	$11.7	0.3%
Other programs					$157.2	4.3%
Total state and local government	**$184.8**	**14.9%**	**$34.0**	**4.5%**	**$602.5**	**16.5%**
TOTAL	**$1,243.0**	**100%**	**$750.2**	**100%**	**$3,649.4**	**100%**

Note: total Medicare spending is $750.2; manually summing the components of the Medicare column in Exhibit 6 will result in a slightly higher number due to rounding.

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].