Policy Research Perspectives

National Health Expenditures, 2016: Annual Spending Growth on the Downswing

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Introduction

This Policy Research Perspective (PRP) provides a detailed examination of U.S. National Health Expenditures (NHE) through 2016. The Centers for Medicare and Medicaid Services (CMS) released the 2016 data in December 2017 (Hartman et al., 2017). As with every annual release of historical data, estimates for previous years were also revised. 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 the allocation of spending (i.e. hospital care, physician services, and prescription drugs) for private health insurance, Medicare, and Medicaid and discusses the surprising differences across payers.

Health spending in the U.S. increased by 4.3 percent in 2016 to $3.3 trillion or $10,348 per capita. This growth rate is lower than what was observed in 2015 (5.8 percent) and 2014 (5.1 percent) and closer to the growth rates over the 5-year period ending in 2013 which averaged 3.8 percent per year. Notably, the deceleration in spending occurred almost across the board for many types of health care services and in many programs. This can be attributed to the leveling off of spending growth in 2016 after relatively high growth rates during the implementation of the Affordable Care Act in 2014 and 2015. Although 2016 saw a decrease in the growth rate for health spending, because it still increased 1.5 percentage points faster than GDP, health spending as a share of GDP increased from 17.7 percent in 2015 to 17.9 percent in 2016.

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 services, procedures, and products such as hospital stays, physician provided services, and prescription drugs. The remainder goes towards administration, public

[1] For each breakdown of the NHE (by type, source of funds, or sponsor), the sum of the components will be $3.3 trillion.

health, and profits of private health insurers. This breakdown answers the question, "where does the money go?"

2. *Source of funds*: For health consumption expenditures, CMS identifies spending under different health insurance programs (private health insurance, Medicare, Medicaid, and other), out-of-pocket spending, and spending by other third party payers that are not considered to be a form of health insurance (i.e. workers compensation). This breakdown address the question, "who pays the bill?" for health consumption expenditures.
3. *Sponsor:* CMS identifies the financiers (i.e. "sponsors") of health spending. Financing is different from source of funds as it reflects the origin of the spending. For example, one source of funds is private health insurance (PHI) spending. Health spending for patients covered by PHI comes from the premium revenue of insurers, which, in turn, is funded by employees and employers. Thus, households and private businesses would be sponsors since they are the ultimate financing source for that spending. Other sponsors include the federal and state and local governments. This breakdown addresses the question, "how is all that financed?"

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

Spending shares

Exhibit 1 shows the distribution of health care spending in 2016 by type of expenditure. As mentioned in the previous section, health spending can go towards investment or HCE. Investment accounted for $157.4 billion (or 4.7 percent of total health spending), while the remainder went towards the broad HCE category. CMS divides HCE into spending on personal health care, government public health activities, government administration, and the net cost of health insurance.

Personal health care spending was $2,834.0 billion in 2016; this made up the bulk of the HCE category and was 84.9 percent of total health spending. The main categories of personal health care spending include spending on hospital care ($1,082.5 billion or 32.4 percent of total health spending), physician services ($521.7 billion or 15.6 percent), clinical services ($143.2 billion or 4.3 percent), and prescription drugs ($328.6 billion or 9.8 percent).[2] Also included in personal health care spending are spending on nursing care facilities ($162.7 billion or 4.9 percent of total health spending), home health care ($92.4 billion or 2.8 percent), and other services ($503.1 billion or 15.1 percent).

The rest of the HCE category consists of spending on government public health activities ($82.2 billion or 2.5 percent of total health spending) and government administration ($43.8 billion or 1.3 percent). It also includes the net cost of health insurance; this 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 2016, the net cost of health insurance was $219.8 billion or 6.6 percent of total health spending.

The shares shown in Exhibit 1 are similar to what was observed in 2015 and have remained relatively stable over the past 25 years. Kane (2017) notes that the biggest percentage point change

[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.

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

Although the shares of health care spending have remained relatively stable over the past quarter-century, the annual growth rates for many of the categories often fluctuate over the short term. Exhibit 2 compares the annual growth rates over the 10-year period ending in 2016 for personal health care spending and its three largest components: hospital care, physician and clinical services, and prescription drugs. As in Exhibit 1, physician and clinical services are shown separately (they are generally shown as a combined category in tables prepared by CMS). Spending in 2016 decelerated in all of these categories except for clinical services (Exhibit 2).

There are a variety of reasons for fluctuations in growth rates. Health spending is determined not only by the prices paid for health care used ("price factors") but also by how much and what types of health care are used ("non-price factors"). Thus, changes in health spending growth can be attributed to changes in the underlying growth in these factors. As Kane (2017) and Hartman et al. (2017) both mention, ACA implementation – a non-price factor – increased utilization from expansions in health insurance coverage in 2014 and 2015. This is the primary reason for the relatively high spending growth rates in hospital care (in 2015), physician services, and clinical services during that period.

In 2016, spending on hospital care decelerated to a 4.7 percent growth rate (compared to 5.7 percent in 2015), primarily due to spending leveling off after an initial spike in 2015 spending from increased utilization during ACA implementation. Spending on physician services also decelerated to a 4.6 percent growth rate in 2016 (compared to 5.4 percent in 2015) for the same reason. On the other hand, clinical spending slightly accelerated (from 8.1 percent growth in 2015 to 8.2 percent in 2016). This is in part because of particularly strong growth in spending for freestanding ambulatory surgical and emergency centers (Hartman et al., 2017). Prescription drug spending decelerated to a 1.3 percent growth rate in 2016 (compared to 8.9 percent in 2015). This can be attributed to both price factors and non-price factors, including a decrease in the number of new medicines approved, slower spending growth for brand-name drugs, and a decline in spending for generic drugs (from slower growth in prices) (Hartman et al., 2017).

Finally, Exhibit 2 also includes the average annual growth rates in spending. Over the 10-year period ending in 2016, average annual spending growth rates ranged from 3.8 percent for physician services to 6.5 percent for clinical services. Although prescription drug spending had an average annual growth rate of 3.9 percent, almost as low as that for physician spending, growth in prescription drug spending was clearly the most erratic of the large spending categories; while it fell to near 0 percent in 2010 and 2012, it also spiked to 12.4 percent in 2014. Due to this variability, the average annual spending growth rates for prescription drugs over the 10-year periods ending in 2014 and 2015 were much higher—4.5 percent and 4.7 percent—than for the period ending in 2016—just a year or two makes a difference. In contrast, the average annual spending growth rates for physician services over the 10-year periods ending in 2014 and 2015 were similar to the 3.8 percent for the period ending in 2016. Moreover, physician spending had the lowest average annual

growth rate among the large expenditure categories in those earlier 10-year periods as well. This illustrates that physician spending growth has remained relatively low and stable.

Spending by source of funds: who pays the bill?

Spending shares

Exhibit 3 identifies the breakdown of health care spending by source of funds. As has been the case since 1977[3], PHI had the largest share of total health spending at 33.7 percent (or $1,123.4 billion). Medicare spending, at $672.1 billion, accounted for 20.1 percent of total health spending and Medicaid spending, at $565.5 billion, made up 16.9 percent. Out-of-pocket spending, which includes all payments made directly by patients regardless of patient insurer type or whether the patient is uninsured, was $352.5 billion or 10.6 percent of total health spending. Finally, spending on other health insurance programs was 3.8 percent of total health spending ($125.8 billion) and spending on other third party payers and programs and public health activity was 10.2 percent ($340.5 billion). These shares are within one percentage point of what was observed in 2015 (see Kane, 2017).

Spending growth

The growth rates in PHI, Medicare, Medicaid and out-of-pocket spending over the 10-year period ending in 2016 are shown in Exhibit 4. These reflect a number of underlying factors including changes in policy, which we focus on here. Generally, we see acceleration in spending during years of implementing expansionary policy changes.

Spending growth for PHI increased from 2.0 percent in 2013 to rates of 5.7 percent and 6.9 percent in 2014 and 2015 during the implementation of the ACA. In 2016, PHI spending grew by 5.1 percent. This deceleration was partly driven by changes in enrollment patterns, as enrollment grew by less than 0.1 percent in 2016 compared to 2.7 percent and 1.8 percent in 2014 and 2015.

Medicare spending growth rates were the highest in the early years of the 2007 to 2016 period, just after the implementation of Medicare Part D in 2006. Medicare growth has stayed below 5 percent since 2010. Medicare spending grew more slowly in 2016 than in 2015 (3.6 percent compared to 4.8 percent) due to lower *per enrollee* growth rates for both the traditional FFS program and Medicare Advantage (Hartman et al., 2017).

Over the 2007 to 2016 period, Medicaid spending growth rates have been the most erratic compared to those of other payers. Medicaid spending growth spiked first in 2009 (to 8.8 percent) as a result of increased enrollment from the recession, and then fell to just over 2 percent growth in 2011 as the economy recovered. Growth spiked again in 2014 and 2015 (to 11.5 percent and 9.5 percent) during the implementation of ACA. In contrast, Medicaid spending grew by only 3.9 percent in 2016, due to both slower growth in enrollment (the leveling off of ACA implementation) as well as slower growth in spending per enrollee (due to states' efforts to control costs and a decrease in per enrollee costs for newly eligible adults) (Hartman et al., 2017).

[3] Kane, 2017 finds that during the 1965 to 2015 period, out-of-pocket spending had the highest share of total health spending prior to 1977.

Lastly, although out-of-pocket spending as a share of total health spending has been on a continuous decline over the past 50 years (data not shown; see Kane, 2017), there have been fluctuations in the annual growth rate of out-of-pocket spending in recent years. For example, 2009 saw negative growth in out-of-pocket spending, with acceleration in spending in 2011 and again in 2015 and 2016.

Where does the money go (revisited)?

Earlier, we examined where our health care dollars were spent in 2016—hospital care, physician services, prescription drugs, etc. (Exhibit 1). Exhibit 5 shows this same breakdown, but specifically for PHI and the Medicare and Medicaid programs (the three main sources of funds). Interestingly, the allocation of our health care dollars is quite different for Medicaid compared to Medicare and PHI, which have similar break downs in spending. In this section, we explore this variation and examine potential underlying factors such as fundamental differences in program coverage and cost sharing, as well as differences in the needs and behaviors of the populations covered by each program.

The distribution of Medicaid spending stands out as different from the other two. In particular, 17.4 percent of 2016 Medicaid spending went towards "other health, residential, and personal care" compared to only 0.7 percent of Medicare spending and 1.2 percent of PHI spending. This category includes spending for Medicaid home and community based waivers and care provided in residential care facilities (CMS, 2017). The high percentage for Medicaid spending is due to the fact that long-term services and support is primarily covered by Medicaid and not by Medicare (CMS, 2016) or PHI. Without separate private insurance for long term care, expenses may not be affordable for even middle-class Americans, who often spend down or transfer their assets in order to qualify for Medicaid coverage (Gorman and Ostrov, 2016). [4]

Further, the ratio of physician to hospital spending is much lower for Medicaid compared to that of other payers. In Medicaid, for every dollar spent on hospital care only 21 cents was spent on physician services, compared to more than 50 cents in the other two programs.[5] The magnitude of this difference is surprising. While we were not able to piece the full difference out into its underlying components, there are a number of probable contributing factors including differences in access to care and behaviors of the covered populations. Although Medicaid payment rates vary from state to state, on average Medicaid pays only 63 percent of employer-sponsored health insurance and 75 percent of Medicare rates for primary care checkups, and 52 percent of employer-sponsored health insurance and 60 percent of Medicare rates for specialist visits (Biener and Selden, 2017).[6] These payment differences drive spending differences. In addition, although more than 80 percent of physicians treated Medicaid patients in 2016 (Gillis, 20127) research has linked these payment differences to lower physician participation in Medicaid (relative to Medicare and PHI) and reduced

[4]According to the U.S. Department of Health and Human Services, on average, an American turning 65 will incur $138,000 in future long-term services and support costs (Favreault and Dey, 2016).

[5] The percentage of Medicaid spending spent on physician services (7.1 percent) is also lower than the corresponding percentages of PHI and Medicare spending (approximately 21 percent). As discussed, that is partly due to the high percentage of Medicaid spending for "other health, residential, and personal care." Thus, a more fair comparison across programs is of the ratio of physician spending to hospital spending.

[6] Biener and Seldon, 2017 present the estimated average standardized total payments for office-based physician visits. Using this information, we calculate Medicaid payments as a percentage of ESI and Medicare payments.

access to care for Medicaid beneficiaries (Rosenbaum, 2014). Further, comorbidities are particularly common among low-income adults (Akinyemiju et al., 2016). KFF (2012b) found that the majority of Medicaid beneficiaries with either diabetes, cardiovascular disease, respiratory disease, or mental disease had at least one of the other conditions, which they describe as evidence of the complex health care needs of a population that is also costly to treat. This may also drive the high ratio of hospital to physician spending in the Medicaid program.

Similarly, the ratio of prescription drug to hospital spending was also lower in Medicaid than in Medicare and PHI. Under Medicaid's "best price" policy, drug manufacturers must offer the best price with a mandatory rebate of 23.1 percent off the list price to state Medicaid programs (Baghdadi, 2017). This may drive a wedge between Medicaid prescription drug spending and prescription drug spending in Medicare and PHI. Further, even the low co-pay (typically under $5) (KFF, 2012a; Medicaid, 2017; Gifford, et al., 2017) might render prescription drugs out of reach for some low-income individuals. Finally, other contributing factors include the fact that most states have quantity and/or service day limits on prescription drugs (KFF, 2012a; Gifford, et al., 2017), and that the limited access to physician services (discussed above) may subsequently result in reduced access to prescription drugs.

Despite the differences in the populations covered by Medicare and PHI, the spending distributions are similar. In both programs, almost 40 percent of 2016 spending went towards hospital care, just over 20 percent towards physician services, and around 13 percent towards prescription drugs.

Spending by sponsor how is all that financed?

While source of funds allocates health spending to different health insurance programs and related entities, this section focuses on spending by sponsor—how spending is financed. The initial financiers of health care spending are households, private businesses, and (federal, state, and local) government. The right most column of Exhibit 6 provides the breakdown of total 2016 health spending by sponsor. The left most and middle columns include the breakdown of PHI and Medicare spending.

In 2016, 19.9 percent of total health spending ($664.6 billion) was financed by private business. Households accounted for 28.1 percent of total health spending ($938.8 billion) while the federal government accounted for 28.3 percent ($944.1 billion). Finally, 16.9 percent of total health spending ($564.5 billion) was financed by state and local governments.

Private business was the largest sponsor of PHI spending, financing 44.9 percent of PHI spending in 2016 in the form of employer contributions to the health insurance premiums of enrolled employees. Households financed 32.0 percent of PHI spending through employee contributions to employer-sponsored health insurance premiums (23.5 percent), household contributions to direct purchase insurance (5.2 percent) and the medical portion of property and casualty insurance (3.3 percent). The federal government financed 6.6 percent of PHI spending. This includes employer contributions to the health insurance premiums of federal employees (3.2 percent) as well as marketplace tax credits and subsidies (3.0 percent). Finally, state and local governments financed 16.6 percent of PHI spending through their role as an employer (again through contributions to the health insurance premiums, in this case for the premiums of state and local government employees).

For Medicare spending in 2016, only 15.6 percent was sponsored by private businesses in the form of employer Medicare hospital insurance trust fund payroll taxes. Households financed 33.8 percent of Medicare spending. This includes employee and self-employment payroll taxes and voluntary premiums paid to the Medicare hospital insurance trust fund (23.4 percent) as well as premiums paid by individuals to the Medicare supplementary medical insurance trust fund and pre-existing condition insurance plan (10.4 percent).

The federal government was the largest sponsor of Medicare spending, and financed 46.1 percent of total Medicare spending in 2016. This is predominantly due to spending in the subcategory "federal general revenue and Medicare net trust fund expenditures," which is the largest single source of Medicare financing. This subcategory includes general federal reserves from U.S. taxpayers (funds appropriated by Congress from the trust fund to finance Medicare). More plainly, this is the portion of Medicare spending that is not "self-financed" by beneficiaries in the form of payroll taxes and premiums directly for Medicare (PGPF, 2017).

In 2000, this subcategory made up only 22.0 percent of Medicare spending. Over the next 10 years, its share increased steadily until it reached 47.5 percent in 2010. Growth in this subcategory is particularly evident in years when overall Medicare spending growth is higher (i.e. during the implementation of Medicare Part D in 2006, Medicare spending increased by 18.8 percent and federal general revenues and Medicare net trust fund expenditures increased by 30.9 percent) or growth in funds from other areas of financing are lower (i.e. during the recession in 2009, the growth rates of Medicare premiums and payroll taxes from households and private businesses were relatively low). Since 2010, however, the share of Medicare spending from federal general revenue and Medicare net trust fund expenditures has gradually and steadily decreased to 44.0 percent ($295.5 billion) in 2016. Further, the spending growth rate of this subcategory in 2016 was 0.5 percent, the lowest it has been since 2000.

Finally, state and local governments financed 4.5 percent of Medicare spending through a number of 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 4.3 percent in 2016 to a level of $3,337.2 billion or $10,348 per capita. In comparison, spending grew 5.8 percent in 2015 and 5.1 percent in 2014; this faster growth was driven by the initial implementation of the Affordable Care Act. Spending as a share of GDP also increased from 17.7 percent in 2015 to 17.9 percent in 2016.

Spending on personal health care ($2,834.0 billion) made up 84.9 percent of total health spending. This includes spending on hospital care ($1,082.5 billion or 32.4 percent of total health spending), physician services ($521.7 billion or 15.6 percent), clinical services ($143.2 billion or 4.3 percent) and prescription drugs ($328.6 billion or 9.8 percent). Although these shares have remained relatively stable over the past quarter-century, short term fluctuations in the annual growth rates for personal health care spending are not unusual. In particular, spending growth in prescription drugs hit a low of 0.1 percent in 2010 and a high of 12.4 percent in 2014 before decreasing to a rate of 1.3 percent in 2016. Physician spending growth, on the other hand, has remained relatively stable over

the past decade, and had the lowest average annual growth rate (3.8 percent) compared to hospital care, clinical services, and prescription drugs.

Considering spending by source of funds, private health insurance had the largest share at 33.7 percent ($1,123.4 billion) of total health spending followed by Medicare at 20.1 percent ($672.1 billion) and Medicaid at 16.9 percent ($565.5 billion). An analysis of how private health insurance, Medicare and Medicaid dollars were spent (i.e. hospital care, physician services, and prescription drugs) revealed similar spending patterns in private health insurance and Medicare. Compared to those two programs, however, Medicaid had a much higher percentage of spending for “other health, residential, and personal care” (which includes long term care) and lower percentages of spending for physician services and prescription drugs. However, the break down in Medicaid spending differed compared to the other two programs. In Medicaid, for every dollar spent on hospital care only 21 cents was spent on physician services compared to more than 50 cents in the other two programs.

With regard to financing, the federal government financed the largest share of health spending at 28.3 percent ($944.1 billion), followed by households at 28.1 percent ($938.8 billion), private business at 19.9 percent ($664.6 billion) and state and local governments at 16.9 percent ($564.5 billion).

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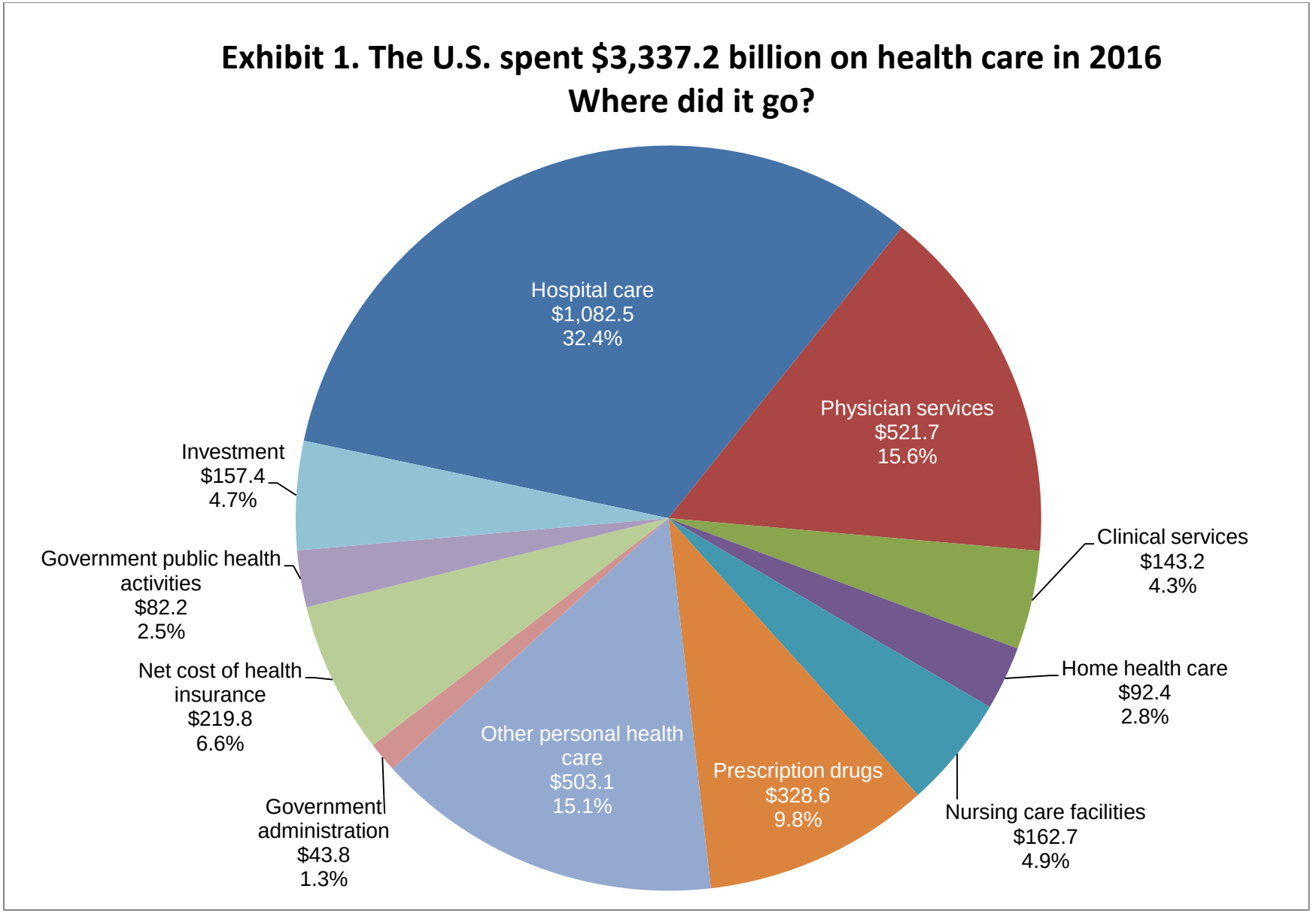
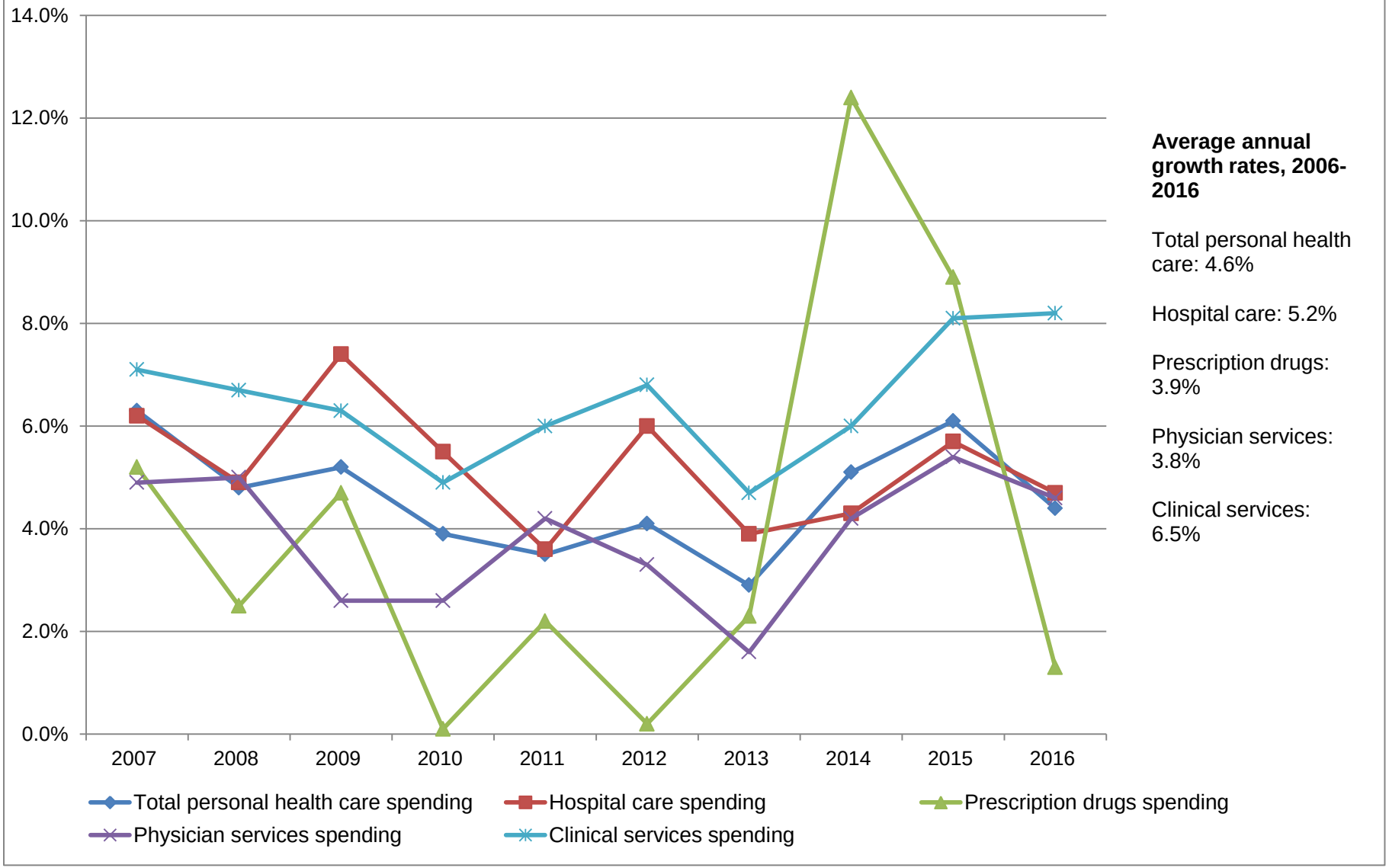


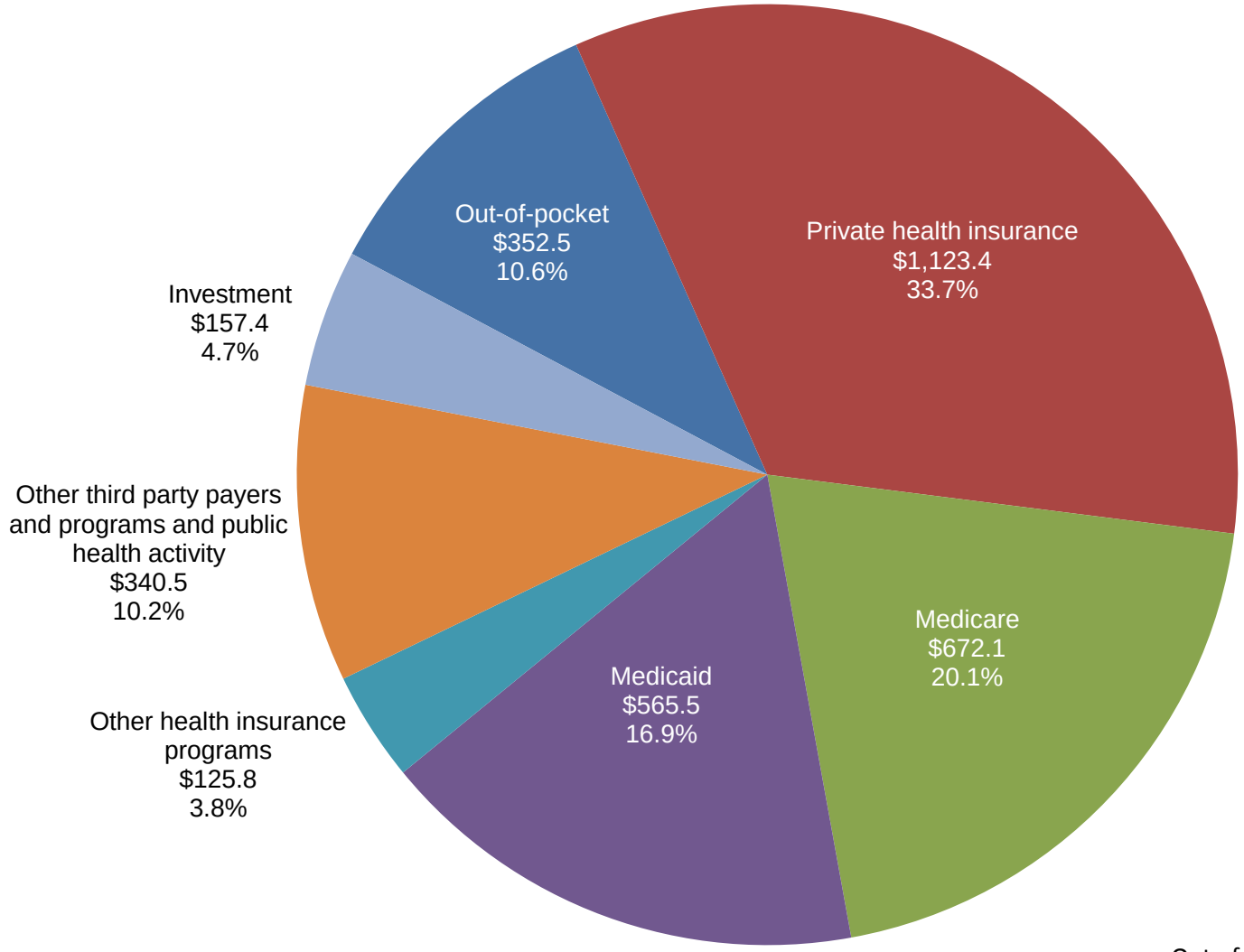
Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-andReports/NationalHealthExpendData/NationalHealthAccountsHistorical.html. Tables 6, 7, 9, 10, and 16 in NHE Tables [ZIP].

Exhibit 2. Spending growth rates by type of expenditure



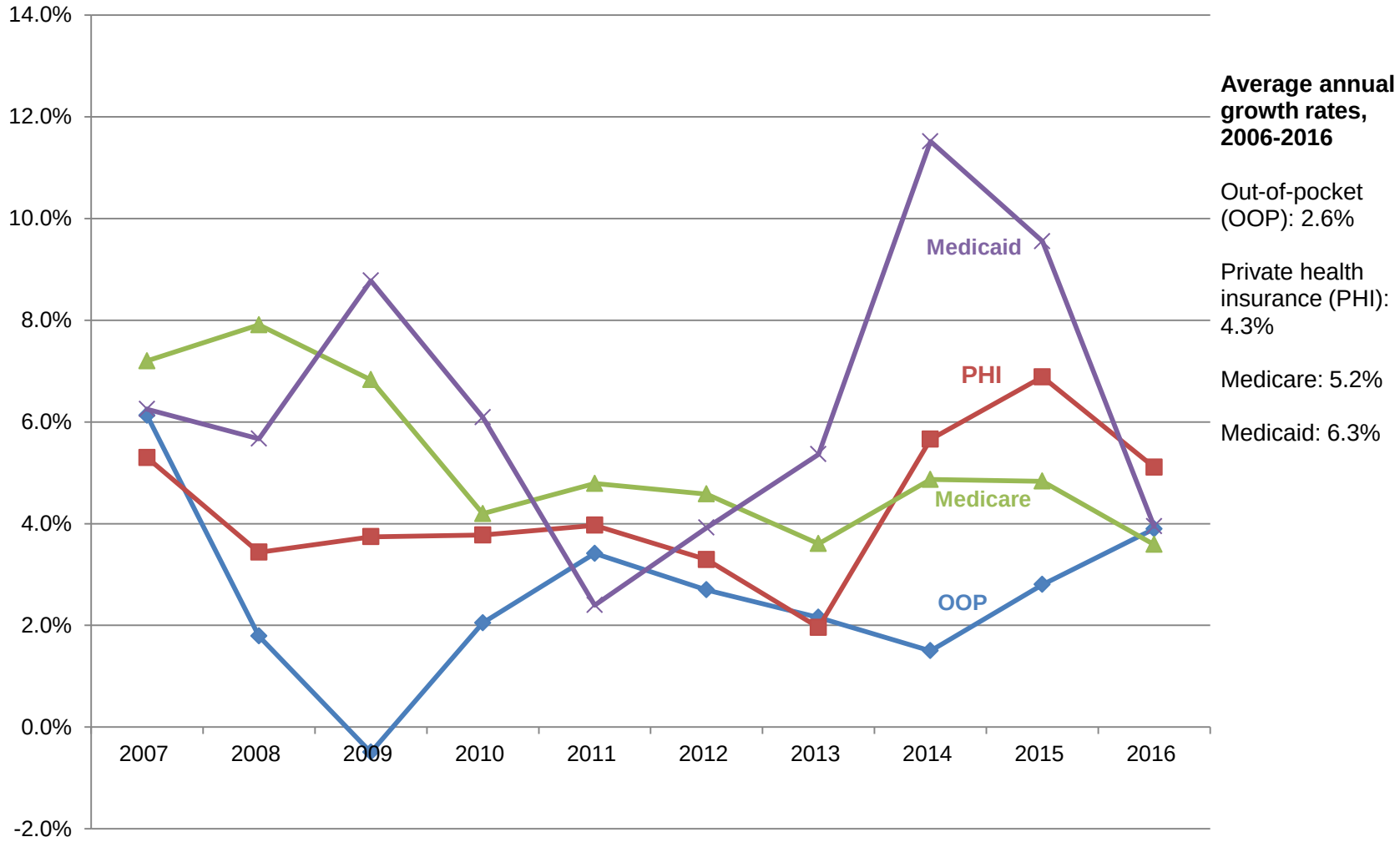
Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-andReports/NationalHealthExpendData/NationalHealthAccountsHistorical.html. Tables 6, 7, 9, 10, and 16 in NHE Tables [ZIP].

Exhibit 3. 2016 Health care spending by source of funds



Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-andReports/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-andReports/NationalHealthExpendData/NationalHealthAccountsHistorical.html. NHE2016.xls in National Health Expenditures by type of service and source of funds [ZIP].

Exhibit 5. Where did the money go? A breakdown of PHI, Medicare and Medicaid spending by type of expenditure in 2016

Type of expenditure	Source of funds: Private health insurance	Medicare	Medicaid
Hospital care	38.0%	39.8%	33.6%
Physician services	21.3%	20.7%	7.1%
Clinical services	4.2%	1.6%	5.8%
Home health care	0.9%	5.6%	6.0%
Nursing care facilities and continuing care retirement communities	1.3%	5.6%	8.8%
Prescription drugs	12.7%	14.2%	5.9%
Other health, residential, and personal care	1.2%	0.7%	17.4%
Government administration and net cost of health insurance	11.5%	7.0%	10.7%
Other	8.8%	4.9%	4.8%
Total	100%	100%	100%

Note: Other includes other professional services, dental services, durable medical equipment, and other non-durable medical products.
Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-andReports/NationalHealthExpendData/NationalHealthAccountsHistorical.html. Table 4 in NHE Tables [ZIP].

Exhibit 6. The financing of PHI spending, Medicare spending, and NHE in 2016 (billions of dollars)

	Private health insurance spending		Medicare spending		NHE	
SPONSOR	**Level**	**Percentage**	**Level**	**Percentage**	**Level**	**Percentage**
Private business						
Employer contribution to employer sponsored health insurance premiums	$504.3	44.9%			$504.3	15.1%
Employer Medicare hospital insurance trust fund payroll taxes			$104.6	15.6%	$104.6	3.1%
Workers' compensation, temporary disability insurance, worksite health care					$55.7	1.7%
Total private business	**$504.3**	**44.9%**	**$104.6**	**15.6%**	**$664.6**	**19.9%**
Household						
Employee contribution to employer-sponsored health insurance premiums	$264.2	23.5%			$264.2	7.9%
Household contribution to direct purchase insurance	$58.3	5.2%			$58.3	1.7%
Medical portion of property and casualty insurance	$36.6	3.3%			$36.6	1.1%
Employee and self-employment payroll taxes and voluntary premiums paid to Medicare hospital insurance trust fund			$157.0	23.4%	$157.0	4.7%
Premiums paid by individuals to Medicare supplementary medical insurance trust fund and the pre-existing condition insurance plan			$70.2	10.4%	$70.2	2.1%
Out-of-pocket health spending					$352.5	10.6%
Total household	**$359.1**	**32.0%**	**$227.1**	**33.8%**	**$938.8**	**28.1%**
Other private					**$225.2**	**6.7%**

Exhibit 6. continued

SPONSOR	Private health insurance spending Level	Private health insurance spending Percentage	Medicare spending Level	Medicare spending Percentage	NHE Level	NHE Percentage
Federal government						
Employer contribution to employer-sponsored health insurance premiums	$36.2	3.2%			$36.2	1.1%
Employer Medicare hospital insurance trust fund payroll taxes			$4.3	0.6%	$4.3	0.1%
Federal general revenue and Medicare net trust fund expenditures			$295.5	44.0%	$295.5	8.9%
Federal portion of Medicaid payments					$358.1	10.7%
Federal portion of Medicare buy-in premiums			$9.9	1.5%	$9.9	0.3%
Retiree drug subsidy payments to employer-sponsored health insurance plans					$1.1	0.0%
Other federal health insurance and programs	$4.3	0.4%			$205.9	6.2%
Marketplace tax credits and subsidies	$33.2	3.0%			$33.2	1.0%
Total federal government	**$73.6**	**6.6%**	**$309.7**	**46.1%**	**$944.1**	**28.3%**
State and local government						
Employer contribution to employer-sponsored health insurance premiums	$186.4	16.6%			$186.4	5.6%
Employer Medicare hospital insurance trust fund payroll taxes			$13.8	2.0%	$13.8	0.4%
State portion of Medicaid payments					$207.5	6.2%
State portion of Medicare buy-in premiums			$6.8	1.0%	$6.8	0.2%
State phase down payments (Part D)			$10.0	1.5%	$10.0	0.3%
Other programs					$140.1	4.2%
Total state and local government	**$186.4**	**16.6%**	**$30.6**	**4.6%**	**$564.5**	**16.9%**
TOTAL	**$1,123.4**	**100%**	**$672.1**	**100%**	**$3,337.2**	**100%**

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