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The Consumer Connection

... linking consumers with health care news and information

Michigan Consumer Health Care Coalition
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The Consumer Connection is a publication of the Michigan Consumer Health Care Coalition with the Michigan League for Human Services

A review of the history of healthcare reform shows that, as a society, we have been grappling with this issue for over a century! In a speech in December **1916**, Yale economist Irving Fisher said: "At present the United States has the unenviable distinction of being the only great industrial nation without compulsory health insurance." That same statement was equally true in December **2009**. In November 2009, Congresswoman Sheila Jackson-Lee, a Texas Democrat, commented that it seems funny to call health-care reform "rushed": "America has been working on providing access to health care for all Americans since the 1930s, the 1940s, the 1950s, the 1960s, 1970s, 1980s, and the 1990s."

Some progress has been made during the intervening decades, but with an estimated 46 million Americans lacking any coverage and millions more being underinsured, significant progress is still needed.

Each of the bills recently passed by the U.S. House and Senate, and waiting to be reconciled, will add coverage for millions of Americans and stop long-standing practices of insurance companies that have been detrimental to those seeking coverage (denials for pre-existing conditions) or seeking care (terminating coverage when a person becomes ill, or setting arbitrary limits on payments). The final process to secure passage of health care reform legislation will have to be modified with the loss of the Democratic super majority in the Senate (with the Massachusetts election results) and no Republican indicating support.

The following excerpt from a Kaiser Family Foundation report provides a brief history on the fits and starts that have been health care reform over the last century. The full report can be accessed at http://healthreform.kff.org/flash/health-reform-new.html and is titled *Timeline: History of Health Reform Efforts in the U.S.*

The History of U.S. Health Reform: A Bird's Eye View

Early 1900s

1912 Teddy Roosevelt and Progressive party endorse social insurance in party platform, including health insurance. National Convention of Insurance Commissioners develops first model state law for regulating health insurance.

1915 American Association for Labor Legislation publishes a draft bill for compulsory health insurance, promotes campaign in several states. A few states show interest but do not enact as U.S. enters World War I. The idea initially was supported by the American Medical Association (AMA) but group withdraws support by 1920.

1921 Congress persuaded to pass the Sheppard-Towner Act to provide matching funds to states for prenatal and child health centers; law expires in 1929 and is not reauthorized.

1927 Committee on the Costs of Medical Care study the economic organization of medical care; economists and major interest groups represented. Recommendations completed by 1932 with the majority supporting medical group practices and voluntary health insurance.

1929 Baylor Hospital introduces a pre-paid insurance plan for a group of school teachers, considered the forerunner of nonprofit Blue Cross plans. Great Depression years begin.

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1930 – 1934

1929-39 Depression spans a decade. President Franklin Delano Roosevelt (FDR) with his New Deal initiatives creates Committee on Economic Security in 1934 to work on issues of social policies to address old age and unemployment issues as well as medical care and insurance. In the end, he did not risk the passage of the Social Security Act to advance national health reform but continued to support the reform throughout his two terms.

1935 – 1939

1935 Social Security Act passed by Congress includes grants for Maternal and Child Health, restoring many Sheppard-Towner Act programs. Committee on Economic Security issues final recommendations, none addressing national health insurance but principles of health reform are outlined. Unpublished report recognizes problem: ''Risks to Economic Security Arising Out of Illness.'' FDR forms Interdepartmental Committee to Coordinate Health and Welfare Activities.

1935-36 National Health Survey conducted by the U.S. Public Health Service to assess health and social and economic factors affecting health, forerunner to today's National Health Interview Survey.

1937 Technical Committee on Medical Care published its report *A National Health Program* in 1938.

1938 National Health Conference convened in Washington, D.C.

1939 Senator Wagner introduces National Health Bill incorporating recommendations from 1938 conference; bill dies in committee. U.S. Department of Health and Human Services created to bring together agencies addressing health, welfare and social insurance. Physicians begin to organize the first Blue Shield plans to cover the costs of physician care.

1940 – 1945

1943 War Labor Board (World War II) rules that wage freeze does not apply to fringe benefits, including health insurance. Senators Wagner and Murray and Representative Dingell introduce proposal to operate a health insurance program as part of social security.

1944 FDR outlines 'economic bill of rights' including right to medical care and opportunity to enjoy good health in his State of the Union address. Social Security Board calls for compulsory national health insurance as part of the Social Security system.

1945 – 1949

1946 President Harry Truman picks up the mantle for a national health program just months after the end of World War II. Congressional opposition used fear of socialism and a desegregated health care system in the south to block all proposals.

Wagner-Murray-Dingell and Taft-Smith-Ball bills to give grants to states for medical care of poor cannot gain traction. Hill-Burton Act (Hospital Survey and Construction Act) is passed to fund construction of hospitals and allows 'separate but equal' facilities while prohibiting discrimination based on race, religion and national origin. Hospitals are charged with providing a 'reasonable volume' of charity care.

1947 Truman again calls for a national health program in a special message to Congress. Wagner-Murray-Dingell bill and Taft bill reintroduced.

1948 National Health Assembly convened in Washington, D.C. by the Federal Security Agency. Final assembly report endorses voluntary health insurance but points to need for universal coverage. AMA launches national campaign opposing national health insurance proposals.

1949 U.S. Supreme Court upholds National Labor Relations Board ruling that employee benefits can be included in collective bargaining.

1950 – 1954

1950 National Conference on Aging convened by the Federal Security Agency.

1951 Joint Commission on the Accreditation of Hospitals formed to improve quality through voluntary accreditation of facilities.

1952 Federal Security Agency proposes law to provide health insurance for Social Security beneficiaries.

1953 Federal Security Agency made a cabinet level agency; renamed Department of Health, Education and Welfare (DHEW).

1954 President Dwight Eisenhower proposes federal ''reinsurance'' fund to help private insurers expand groups covered. Revenue Act of 1954 passed which excludes employers' contributions to employees' health plans from taxable income.

1955 – 1959

1956 ''Medicare'' program enacted for dependents of persons in the armed forces. The Forand bill introduced in the House to provide health insurance for Social Security beneficiaries; reintroduced in 1959.

1957 AFL-CIO comes out in support of government health insurance; the AMA continues its opposition to national health insurance. The first National Health Interview Survey was conducted, an initiative which continues.

1960 – 1964

1960 The Kerr-Mills Act passes providing federal funds to support state medical care programs for the poor and elderly, the precursor to the Medicaid program. The Federal Employee Health Benefit Plan (FEHBP) initiated to provide health care coverage to federal workers.

1961 White House Conference on Aging is held in Washington, D.C. A Presidential Task force recommends health insurance for the elderly under Social Security and President Kennedy sends special message to Congress on health.

Rep. King and Sen. Anderson introduce bill to create a government health insurance program for aged persons. King-Anderson draws support from organized labor but is fiercely opposed by the AMA and commercial health insurance companies.

1962 President Kennedy addresses Medicare in a televised talk at Madison Square Garden.

1963 Kennedy sends special message to Congress on the health care needs of the elderly. King-Anderson bill reintroduced.

1964 President Lyndon Johnson advocates for Medicare in special message to Congress. Civil Rights Act passes.

1965 – 1969

1965 Johnson's Great Society programs for health care signed into law—Medicare for the elderly and the means-tested Medicaid program for the poor, with the country once more pulling back from universal coverage.

Medicare Part A is to pay for hospital care and limited skilled nursing and home health care. An optional Part B is to help pay for physician care. The separate Medicaid program is to assist states with long term care for the poor and distinct categories of people—mainly low income families with children receiving income maintenance payments.

The hospitals and insurance industry were in support of the new bill. No cost controls or physician fee schedules were included in the most significant health care legislation of the century.

1965 Neighborhood health centers, since evolved into Federally Qualified Health Centers (FQHCs), established as part of Johnson's Great Society initiative; part of the Office on Economic Opportunity, the centers provided health and social services in poor and underserved urban and rural areas.

1967 Social Security amendments enacted adding new categories of persons eligible for Medicaid at state option (those not receiving cash support); Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children added as mandatory Medicaid benefit.

1970 – 1974

1971 Wage and price freezes begin, with medical care singled out for specific limits on annual increases in physician services and hospital charges. Medical care limits not lifted until 1974, more than a year after other controls had ended.

1972 Supplemental Security Income (SSI) program instituted to provide cash assistance to the elderly and persons with disabilities. States are required to provide Medicaid coverage to these groups or use their 1972 Medicaid eligibility standards for coverage.

Social Security amendments pass to allow persons under 65 with long term disabilities (after two years of disability's onset) and end stage renal disease (ESRD) to participate in Medicare.

1974 Hawaii adopts Prepaid Health Care Act requiring employers to cover any employee working more than 20 hours a week. (In 1989, Hawaii implemented their state program to cover persons in the gap—those not eligible for Medicaid or employer-based insurance.)

Employee Retirement Security Act (ERISA) passed by Congress exempts employers who "self insure" from state insurance regulations, freeing most employers to operate a health care benefit plan of their own choice and design. Hawaii is given an exception from ERISA requirements.

States are required under federal Health Planning Resources Development Act to develop programs to avoid duplication of services; the law drives wide spread adoption of Certificate of Need programs in states which review and approve building and project expansions.

1975 – 1979

1977 Universal health care efforts stalled due to rapidly rising health care costs. President Jimmy Carter emphasizes cost containment over coverage expansion. Sen. Kennedy continues to push for universal care; Carter opts for incremental changes which would be implemented in 1983.

Health Care Financing Administration (HCFA) established within DHEW. Carter proposes a Medicaid expansion (Children's Health Assessment Program) for poor children under 6; proposal not voted upon by Congress.

National Medical Expenditure Survey (NMCES) of physicians, households, and health insurers, gives first detailed view of individuals' health care costs.

1980 – 1984

1980 DHEW renamed Department of Health and Human Services (DHHS).

1981 Federal budget reconciliation (OBRA 81) requires states to make additional Medicaid payments to hospitals which serve a disproportionate share of Medicaid and uninsured patients and repeals the federal provision which required states to reimburse hospitals at the same rate as Medicare.

States are required to pay nursing homes at ''reasonable and adequate'' rates (the Boren amendment) starting in 1982. Boren amendment requirements extended to hospitals the following year. States can begin to use mandatory enrollment of Medicaid recipients in managed care plans. They are also authorized to cover home and community-based care for persons at risk of being institutionalized.

1982 ''Katie Beckett'' option for disabled children adopted which allows states to expand Medicaid to children with disabilities who need institutional care but could be cared for at home with adequate supports.

1983 Medicare introduces Diagnostic Related Groups (DRGs) as the system for reimbursing hospitals at a fixed rate (prospective payment system) to replace the cost-plus based system in use.

1985 – 1989

1986 Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals participating in Medicare to screen and stabilize all persons who use their emergency rooms regardless of ability to pay. Consolidated Omnibus Budget Reconciliation Act (COBRA) regulations permit employees who lose their jobs to continue in the group's health plan for 18 months. They commonly pay the full cost of coverage plus an administrative fee.

Federal Medicaid changes included in OBRA 86 include options to provide medical coverage only to infants, young children and pregnant women up to 100 percent of the poverty level (this level raised to 185% of poverty for infants and pregnant women the following year); to pay Medicare premiums and cost sharing for qualified Medicare beneficiaries (QMBs) under 100 percent of poverty. This later became a requirement and was expanded.

1987 Census Bureau begins annual estimate of health insurance coverage in the United States with its Current Population Survey finds 31 million uninsured (13% of the population) in 1987. National Medical Expenditure Survey (NMES) is conducted with household information supplemented by surveys of medical and health insurance providers used by respondents.

1988 Medicare Catastrophic Coverage Act (MCCA) expands Medicare coverage to include prescription drugs and a cap on beneficiaries' out-of-pocket expenses. The MCCA is repealed the following year, retracting these major provisions due to the expectation that beneficiary costs would be greater than the benefits. Many elderly resented the idea of financing the new benefits which would add little for those with supplemental coverage. The requirement that states pay Medicare premiums and cost-sharing amounts for certain low-income beneficiaries through Medicaid is maintained. The Family Support Act requires states to extend 12 months of transitional Medicaid coverage to families leaving cash assistance due to earnings from work.

1989 Federal budget reconciliation (OBRA 89) mandates Medicaid coverage for pregnant women and children under age 6, up to 133 percent of the federal poverty level.

1990 – 1994

1990 Federal budget reconciliation (OBRA 90) mandates Medicaid coverage of children age 6-18 up to the poverty level, phased in one year at a time until 2002. National Committee on Quality Assurance (NCQA) forms to accredit managed care health plans.

1993 President Bill Clinton convenes White House Task Force on Health Reform, and appoints First Lady Hillary Clinton as chair. The Health Security Act, President Clinton's proposal, which would provide every American with a ''Health Security Card'' to ensure access to care, is introduced in both houses of Congress in November, but gains little support. Health Insurance Association of America begins airing ''Harry and Louise'' television advertisements portraying a middle-class couple worried about health care under the Clinton health plan.

The Clinton Administration approves Medicaid waivers allowing more statewide demonstrations. Many states use managed care for delivery of services and expand coverage to previously uninsured groups using the savings. The Vaccines for Children program providing federally purchased vaccines to states is established.

Other national health reform proposals are introduced in Congress, but also fail to gain sufficient support for passage. By mid-1994 even a bipartisan bill to expand coverage without comprehensive reform is unable to pass.

1995 – 1999

1995 Mental Health Parity Act passed prohibiting group health plans from having lower annual or lifetime dollar limits for mental health benefits than medical or surgical benefits (excludes treatment of substance abuse and chemical dependency).

Personal Responsibility and Work Opportunity Act delinks Medicaid and cash assistance eligibility and allows states to cover parents and children at current Aid to Families with Dependent Children (AFDC) levels and higher. Except for emergency care, Medicaid coverage of legal immigrants within their first five years in the country is banned.

Health Insurance Portability and Accountability Act (HIPAA) restricts use of pre-existing conditions in health insurance coverage determinations, sets standards for medical records privacy, and establishes tax-favored treatment of long-term care insurance.

Medical Expenditure Panel Survey (MEPS) is conducted; unlike former surveys, it is designed to be ongoing and provide annual updates on health insurance coverage, access to care, use of health services and their costs.

1997 Census Bureau's Current Population Survey estimates 42.4 million (15.7% of the population) are uninsured in the United States.

Balanced Budget Act (BBA) attempts to slow the growth in Medicare spending through provider payment changes. It establishes the Medicare + Choice program, a new Medicare HMO structure, the precursor of Medicare Advantage plans.

The Balanced Budget Act also establishes the State Children's Health Insurance Program (SCHIP) which provides block grants to states for coverage of low-income children ineligible for Medicaid under states' severe low income eligibility ceilings. BBA also allows states to cover employed persons with disabilities with incomes up to 250 percent of poverty, permits mandatory Medicaid enrollment in managed care, and repeals the Boren amendment.

1999 Ticket to Work and Work Incentives Improvement Act allows states to cover working disabled persons with incomes above 250 percent of poverty and imposes income-related premiums for participation.

2000 – 2004

2000 Breast and Cervical Cancer Treatment and Prevention Act passes which allows states to provide Medicaid coverage to uninsured women for treatment of breast or cervical cancer, diagnosed through a CDC screening program, regardless of income or resources.

2002 President George Bush launches Health Center Growth Initiative significantly expanding the number of community health centers serving the medically underserved.

2003 Health Savings Accounts created allowing individuals to set aside pre-tax dollars to pay for current and future medical expenses. The accounts must be used in conjunction with a high deductible health plan.

Medicare Drug, Improvement, and Modernization Act (MMA) passes, creating a voluntary, subsidized prescription drug benefit under Medicare, administered exclusively through private plans, both stand-alone prescription drug plans and Medicare Advantage plans.

Maine passes the Dirigo Health Reform Act, a comprehensive health care reform initiative providing subsidized coverage to individuals and small employers, expanding Medicaid, and creating the Maine Quality Forum.

2005 – 2009

2005 Deficit Reduction Act (DRA) makes significant changes to Medicaid-related premiums and cost sharing, benefits, and asset transfers. Also includes provision requiring Medicaid applicants/beneficiaries to officially document their citizenship.

2006 Medicare Part D Drug benefit is implemented on January 1. Massachusetts passes and implements legislation to provide health care coverage to nearly all state residents. Legislation requires residents to obtain health insurance coverage and calls for shared responsibility among individuals, employers, and the government in financing the expanded coverage. Within two years of implementation the state's uninsured rate is cut in half.

One month after Massachusetts, Vermont passes comprehensive health care reform aiming for near-universal coverage and focusing on improving overall quality of care and the management of chronic conditions through the Blueprint for Health. The Catamount Health Plan for uninsured residents is created.

City of San Francisco creates the Healthy San Francisco program, providing universal access to health services in the city for residents. A controversial provision requiring city employers to spend a minimum amount per hour on healthcare for their employees is challenged in court. In September 2008, the U.S. Ninth Circuit Court of Appeals upholds the employer requirement saying it does not violate the Employee Retirement and Income Security Act of 1974 (ERISA).

2007 Senators Wyden and Bennett introduce the Healthy Americans Act, a proposal requiring individuals to obtain private health insurance coverage through state health insurance purchasing pools. The long-standing favorable tax treatment of employer-sponsored insurance premiums would be eliminated. Legislation gains some bipartisan support.

Census Bureau estimates 45.6 million uninsured (15.3% of the population) in 2007. Periodic changes in survey design make trend analyses complicated, but survey results still most widely used estimate of health insurance coverage.

President Bush announces health reform plan to replace the current tax preference for employer-sponsored insurance with a standard health care deduction. Proposal is not acted upon by Congress.

Congress passes two versions of a bill to reauthorize the State Children's Health Insurance Program with bipartisan support, but President Bush vetoes both bills and Congress cannot override the veto. A temporary extension of the program is passed in December 2007.

California fails in its attempt to pass a health reform plan with an individual mandate and shared responsibility for financing the costs. Compromise legislation cannot get support in both houses of Legislature.

2008 Mental Health Parity Act amended to require full parity. Insurance companies must treat mental health conditions, including substance abuse disorders, on an equal basis with physical conditions when health policies cover both.

Presidential campaign focuses early on national health reform, overshadowed later by housing crisis and economic downturn, yet remains a key pocketbook issue throughout the campaign. Both major party candidates announce comprehensive health reform proposals. Sen. Baucus, Chairman of the Senate Finance Committee, releases White Paper on health reform outlining a national health reform plan based on the Massachusetts model.

2009 President Barack Obama establishes Office of Health Reform to coordinate administrative efforts on national health reform.

The Children's Health Insurance Program (CHIP) is reauthorized, providing states with additional funding, new tools and fiscal incentives to help reach an estimated 4.1 million children through Medicaid and CHIP who otherwise would have been uninsured by 2013.

President Obama's proposed 2010 budget outlines eight principles for health reform and proposes a set aside of $634 billion in a health reform reserve fund.

Congress continues to deliberate national health reform. Both Houses of Congress pass universal health care reform bills: proposals include individual mandates to secure coverage, employer mandate (House) to provide coverage, subsidies for eligible low and modest income individuals and employers to meet the mandates, and the creation of insurance exchanges for choices of coverage. Reconciliation of the differences must occur, followed by a final vote of the House and Senate. To date, only one Republican in the House has voted for the reform legislation.

The American Recovery and Reinvestment Act (ARRA) makes substantial investments to help develop health information technology, to expand the primary care workforce and to conduct research on comparative effectiveness for health care treatment options.

From the consumers' perspective...

The good news is that 2008 health care spending grew by 4.4 percent over total expenditures in 2007. The bad news is that health care spending grew by 4.4 percent in 2008. (For more detail, see separate article in this edition.)

In 2008, the average per person spending on health care in our nation was $7,681, roughly twice as much as most other western countries—places which enjoy universal access to care and better outcomes than we do here in the United States.

Much is being made of the fact that annual inflation in health care spending is moderating.

I would note that every decade or so when we have a national conversation about health care delivery, costs and coverage—usually in the context of legislative "reform" efforts—the cost escalation slows down.

This fact can easily be tracked and strongly suggests that the cost spiral can be controlled. And is, when we're all looking at it.

Hopefully, the Congress is looking at the nation's unsustainable health care costs as its members work toward a health care reform proposal and strengthen the cost control measures baked into the House version.

Otherwise, our hopes for a rational system of care will be dashed once more.

Beverley McDonald
Coalition Chairperson

House Version of Health Care Reform: Timeline of Early Implementation Provisions

The following provisions or timelines may not be in the final version of the legislation. They reflect the U.S. House version which has not been reconciled with the Senate version as of the publication of this communication. They are detailed in this issue to indicate that some consumer-friendly reforms may start earlier than is generally understood.

2010

- Starting in July, insurance coverage will not be allowed to be rescinded when an enrollee gets sick unless there is fraud involved.
- In group plans, starting in January, exclusions for care of pre-existing conditions will only have a 30-day to 3-month look back period. Also starting in January, domestic violence may not be considered a pre-existing condition.
- Lifetime limits will no longer be allowed on payments for enrollee care starting in January.
- Insurers in the small and large group market must spend 85 percent of premium income on health care services starting in January, as will those selling individual policies unless HHS decides the provision would have adverse effects on the market.
- Starting in January, children will be able to stay on their parents' policies until they turn 27.
- Persons using the COBRA extension from a former job will be able to stay on it until they are eligible for other coverage.
- People in ''high risk'' pools cannot be charged higher premiums than healthy enrollees in the general insurance market.
- Provisions protecting young retirees from reduction of benefits unless current employees suffer the same reductions. Assistance will be provided to employers who cover retirees aged 55 to 64.
- The doughnut hole (coverage gap) in Medicare for prescription drugs will begin to close with a 50 percent discount on brand-name drugs; the size of the gap will shrink by $500 and close completely by 2019.
- Pilot programs will begin in the areas of Accountable Care Organizations (ACOs) and ''medical homes'' where groups of providers will be paid jointly to provide and coordinate full care to Medicare beneficiaries.
- In the Medicaid program, cost-sharing for preventive services will be prohibited.
- Gradual increases in reimbursements to providers of primary care services in the Medicaid program will occur until they are in alignment with Medicare payment rates by 2012.
- In the Child Health Insurance Program (CHIP) program, states will have to enroll eligible children for a continuous 12-month period; waiting periods for certain groups of children will be disallowed; maintenance of current state efforts will be required in terms of income eligibility, as they will in the Medicaid program, in (most) states which are using funds from the economic recovery package to shore up these programs.

2011

- Preventive services in Medicare will have no co-payments or deductibles.
- Medicare Advantage plans will be prohibited from charging an enrollee a higher amount for a service than is charged in traditional Medicare.
- Increased share of federal funding available to the states for Medicaid services set to expire at the end of 2010 would be extended to June 2011.
- Starting in 2011, Community Health Centers (CHCs) will receive an additional $12 billion over the next five years.

Adapted from the FamiliesUSA report: ''The House Health Reform Bill: Early Implementation Timeline'' December 2009. For discussion and the full report, see www.familiesusa.org.

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Annual Center for Medicare/Medicaid Services Report Shows 2008 Health Care Costs Increased at Slower Rate

The U.S. Department of Health and Human Services (DHHS) report of January 5, 2010 published in Health Affairs shows the lowest annual increase in health care expenditures in 48 years.

Expenditures increased 4.4 percent in 2008 and accounted for 16.2 percent of the gross domestic product in that year. The 2008 increase differed from the annual growth in 2007 (5%) and the annual average for the previous decade (7%).

The reduced spending on health care services is being laid to the recession: the per capita spending averaged $7,681 per person. In the face of the moderation in the increase in overall health care expenditures, the federal government's spending in 2008 on health care services and supplies accounted for more than one-third of federal receipts (36%), up from 28 percent in 2007. The 2008 share of federal receipts spent on health care was the highest in two decades.

At the state and local level, spending on health care increased 3.4 percent in 2008, accounting for one-quarter of revenues. In the private sector, consumers and employers retrenched. Private business spending on health care for employees remained relatively flat as a share of total compensation at 7.9 percent. Private health insurance premiums and benefits in 2008 grew at their slowest rate since 1967, 3.1 and 3.9 percent respectively.

Due to lost jobs, diminished income, and health insurance loss, many persons turned to Medicaid, the federal-state health care safety net. Federal Medicaid spending in 2008 increased 8.4 percent, the largest increase in 5 years. Medicare spending rose at a similar rate, rising 8.6 percent for total federal spending of $469 billion in 2008.

Spending increases varied among health care providers, with hospital expenditures up 4.5 percent (up 7.7% among Medicare beneficiaries due to increased admissions); nursing homes, 4.6 percent; physician services, 4.7 percent; outpatient clinic services, 6.6 percent. The rise in 2008 home health care expenditures was the largest among providers at 9 percent.

Prescription drugs increased 2.5 percent over outlays in 2007, but well below the average annual increase of 4.1 percent between 1997 and 2007.

Historical data on expenditures by state, provider, types of service, source of payment and age of individuals are available at www.hhs.gov.