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National Health Expenditure Projections, 2014–24: Spending Growth Faster Than Recent Trends

ABSTRACT **Health spending growth in the United States is projected to average 5.8 percent for 2014–24, reflecting the Affordable Care Act's coverage expansions, faster economic growth, and population aging. Recent historically low growth rates in the use of medical goods and services, as well as medical prices, are expected to gradually increase. However, in part because of the impact of continued cost-sharing increases that are anticipated among health plans, the acceleration of these growth rates is expected to be modest. The health share of US gross domestic product is projected to rise from 17.4 percent in 2013 to 19.6 percent in 2024.**

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The outlook on national health spending for the period 2014–24 primarily reflects the effects of the major coverage expansions in the Affordable Care Act (ACA), stronger economic growth relative to the recent past, and the aging of the population. Overall, health spending growth is projected to average 5.8 percent during this period, rising to $5.4 trillion by 2024, while growth in nominal gross domestic product (GDP) is expected to average 4.7 percent. As a result, the health spending share of the economy is projected to rise from 17.4 percent in 2013 to 19.6 percent in 2024.

In the years following the recession and the accompanying modest economic recovery through 2013, growth rates for national health spending remained close to historically low rates near 4 percent. In 2014, however, national health spending is projected to have increased 5.5 percent, the first time growth would exceed 5.0 percent since 2007. This expected acceleration was mostly driven by health insurance coverage expansions under the ACA, as 8.4 million Americans are anticipated to have gained insurance coverage primarily through Medicaid or the new health insurance Marketplaces.

Additionally, partly as a result of expensive new treatments for hepatitis C, prescription drug spending is projected to have risen sharply to 12.6 percent in 2014, reaching its highest rate of growth since 2002. As a result, the projected acceleration in all other health expenditures (excluding prescription drug spending) is more modest than that in overall health spending: 4.8 percent in 2014, compared to 3.7 percent in 2013. In 2015 the health spending growth rate is expected to decelerate slightly to 5.3 percent, as the effects of the coverage expansions moderate and drug spending growth slows.

In the middle of the projection period, health spending growth rates are anticipated to average above 5 percent, as the expansion-related enrollment increases are projected to wane, while other factors become increasingly important as drivers of health spending trends. Health care prices during the period 2016–18 are expected to rebound from recent historically low growth rates, contributing to faster growth in projected health care costs. At the same time, in Medicare, per beneficiary inpatient hospital and physician utilization rates are projected to return to levels that are between the low rates experienced in recent history and the longer-term historical norms relative to recent history, resulting in faster growth in spending per beneficiary.[1]

By the latter stages of the projection period, growth in per enrollee private health insurance

premiums is expected to accelerate, growing more than 5 percent annually, on average, in lagged response to more robust economic growth. Moreover, as the baby-boomer generation continues to age into eligibility for Medicare and as the Medicaid population ages, it is projected that nearly four out of every ten health care dollars will be spent on people enrolled in one or both of these two largely government-funded programs, in which per enrollee costs tend to be higher than average. As a result, national health spending growth rates are projected to be highest (above 6 percent) during the latter years of the projection period, and the share of total health expenses paid for by federal, state, and local governments is projected to increase to almost half. Notably, while these rates of growth represent the highest in the projection period, they are expected to be substantially lower than the average rates that were observed in the three decades prior to the recession.

Model And Assumptions

The national health expenditure projections are developed using actuarial and econometric modeling methods, as well as judgments about future events and trends that influence health spending.[2] The projections are based on economic and demographic assumptions in the 2015 *Medicare Trustees Report*, updated to reflect the latest macroeconomic data.[1,2] The Centers for Medicare and Medicaid Services (CMS) Office of the Actuary Health Reform Model was used to determine the major impacts of the ACA's expansion-related provisions on national health spending and insurance enrollment.[2,3]

The health expenditure projections presented here are consistent with the 2015 *Medicare Trustees Report*, which incorporates recently enacted legislation that affects future Medicare physician fee schedule updates.[1,4]

These projections are inherently subject to substantial uncertainty related not only to the continuing effects of the ACA but also to variable macroeconomic conditions. Indirect effects of the ACA on the market for health care remain highly uncertain, including the behavioral response to reform on the part of consumers, insurers, employers, and providers throughout the projection period. Furthermore, with six years of historically low growth in health spending, questions have persisted about whether or not a more fundamental change is occurring in the health sector, notwithstanding coverage expansions.

The Office of the Actuary's projection approach, particularly as it relates to spending through private insurance, is based on analysis of more than fifty years of National Health Expenditure Accounts data that show a lagged, long-term relationship to economic (income) growth.[2] Recent health spending trends, while low by historical standards, are consistent with expectations inferred from economic trends in the preceding periods that recently peaked in 2002 and reached a trough in 2013. Thus, health spending growth is likely to accelerate in response to improvements in economic conditions that are projected over the coming decade.[5]

Chronological Outlook Of Trends

2014 After averaging 4.0 percent growth annually in the period 2008–13,[6] national health spending is projected to have grown 5.5 percent and to have reached $3.1 trillion in 2014 (Exhibit 1). This is largely due to spending related to the coverage expansions under the ACA, as well as to a substantial increase in prescription drug spending. In 2014, 8.4 million Americans are projected to have gained health insurance coverage primarily through either Medicaid or private plans (which include the health insurance Marketplaces). This led to faster projected growth in spending for these payers and to a projected reduction in the number of uninsured people to 35.7 million (Exhibit 2).

Another factor that contributed to faster projected health spending growth in 2014 is the sharp rise in prescription drug spending growth, which is projected to have accelerated from 2.5 percent in 2013 to 12.6 percent in 2014 (Exhibit 1). This acceleration is mainly due to innovative new specialty drug treatments for hepatitis C (with smaller contributions related to new pharmacological treatments for cancer and multiple sclerosis).[7] In addition, the constraint on price growth from patent expirations diminished somewhat in 2014 (patent expirations reduced drug spending by $19.6 billion in 2013, compared with $11.9 billion in 2014).[7] This allowed for faster overall growth in prescription drug prices, from 2.3 percent in 2013 to 4.1 percent in 2014.

Primarily as a result of the eligibility expansion under the ACA, Medicaid spending is projected to have grown 12.0 percent in 2014, contributing most significantly—compared to spending for other payers—to the projected acceleration in national health spending growth (Exhibit 3). Total Medicaid enrollment is projected to have increased 12.9 percent, to 66.5 million (Exhibit 2). However, since the newly insured are expected to be healthier than the average currently enrolled Medicaid beneficiary, per beneficiary spending growth is projected to have slowed sharply from 3.8 percent in 2013 to −0.8 percent in 2014. Specifically, of the total

EXHIBIT 1

National Health Expenditures (NHE), Amounts And Annual Growth From Previous Year Shown, By Spending Category, Calendar Years 2007–24

Spending category	2007[a]	2012	2013	2014	2015	2018	2024
EXPENDITURE, BILLIONS							
NHE	$2,303.9	$2,817.3	$2,919.1	$3,080.1	$3,243.5	$3,785.5	$5,425.1
Health consumption expenditures	2,158.8	2,653.6	2,754.5	2,915.3	3,075.9	3,593.8	5,154.2
Personal health care	1,921.0	2,379.3	2,468.6	2,596.3	2,728.6	3,184.3	4,550.1
Hospital care	692.5	898.5	936.9	978.3	1,031.1	1,213.6	1,755.1
Professional services	618.6	752.0	777.9	815.1	849.9	978.6	1,373.6
Physician and clinical services	461.8	565.3	586.7	615.0	640.3	735.5	1,034.8
Other professional services	59.5	76.8	80.2	85.5	90.5	108.5	155.4
Dental services	97.3	110.0	111.0	114.5	119.1	134.6	183.4
Other health, residential, and personal care	107.7	140.1	148.2	153.0	159.3	184.8	251.1
Home health care	57.8	77.1	79.8	81.9	86.5	103.6	156.0
Nursing care facilities and continuing care retirement communities	126.4	152.2	155.8	160.2	167.1	195.9	274.4
Retail outlet sales of medical products	318.1	359.4	370.0	407.8	434.7	507.7	739.8
Prescription drugs	236.0	264.4	271.1	305.1	328.4	385.1	564.3
Durable medical equipment	34.3	41.3	43.0	44.2	46.5	53.2	76.9
Other nondurable medical products	47.8	53.7	55.9	58.4	59.8	69.4	98.7
Government administration	29.3	34.2	37.0	39.9	42.5	52.3	82.2
Net cost of health insurance	142.6	165.3	173.6	200.4	222.8	261.0	384.3
Government public health activities	65.9	74.8	75.4	78.7	82.0	96.2	137.7
Investment	145.1	163.7	164.6	164.8	167.6	191.7	270.8
Noncommercial research	42.5	48.0	46.7	45.9	46.7	53.3	72.0
Structures and equipment	102.7	115.7	117.9	118.9	120.9	138.3	198.9
ANNUAL GROWTH							
NHE	7.3%	4.1%	3.6%	5.5%	5.3%	5.3%	6.2%
Health consumption expenditures	7.3	4.2	3.8	5.8	5.5	5.3	6.2
Personal health care	7.2	4.4	3.8	5.2	5.1	5.3	6.1
Hospital care	6.4	5.3	4.3	4.4	5.4	5.6	6.3
Professional services	6.9	4.0	3.4	4.8	4.3	4.8	5.8
Physician and clinical services	6.7	4.1	3.8	4.8	4.1	4.7	5.9
Other professional services	8.1	5.2	4.5	6.6	5.8	6.2	6.2
Dental services	6.9	2.5	0.9	3.2	4.1	4.1	5.3
Other health, residential, and personal care	9.3	5.4	5.8	3.2	4.1	5.1	5.2
Home health care	10.1	5.9	3.4	2.6	5.6	6.2	7.0
Nursing care facilities and continuing care retirement communities	6.8	3.8	2.4	2.8	4.3	5.5	5.8
Retail outlet sales of medical products	9.0	2.5	2.9	10.2	6.6	5.3	6.5
Prescription drugs	11.2	2.3	2.5	12.6	7.6	5.5	6.6
Durable medical equipment	6.1	3.7	4.2	2.9	5.1	4.6	6.3
Other nondurable medical products	4.7	2.4	4.0	4.6	2.3	5.1	6.0
Government administration	8.7	3.1	8.2	8.0	6.4	7.2	7.8
Net cost of health insurance	9.6	3.0	5.0	15.5	11.2	5.4	6.7
Government public health activities	7.6	2.6	0.8	4.3	4.3	5.4	6.2
Investment	6.9	2.4	0.5	0.1	1.7	4.6	5.9
Noncommercial research	7.4	2.5	−2.6	−1.8	1.9	4.5	5.1
Structures and equipment	6.6	2.4	1.9	0.9	1.7	4.6	6.2

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Definitions, sources, and methods for NHE categories can be found at CMS.gov. National Health Expenditure Accounts: methodology paper, 2013: definitions, sources, and methods [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; 2014 [cited 2015 Jul 2]. Available from http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/dsm-13.pdf. Numbers may not sum to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 1990–2007.

Medicaid population, the share of aged and disabled beneficiaries is projected to have declined in 2014 relative to 2013.[8] While aged and disabled enrollees represent the smallest share of enrollment categories in Medicaid, they account for the majority of spending. Absent the impact of the eligibility expansion, enrollment in the program was projected to have grown in 2014 similarly to 2013 (roughly 2 percent for both years), reflecting the effect of projected stable economic growth and lower unemployment rates.[8]

The implementation of the health insurance

EXHIBIT 2

National Health Expenditures (NHE); Health Insurance Enrollment, Aggregate And Per Enrollee Amounts; And Average Annual Growth From Previous Year Shown, By Source of Funds, Selected Calendar Years 2007–24

Source of funds	2007[a]	2012	2013	2014	2015	2018	2024
EXPENDITURE, BILLIONS							
Private health insurance	$777.7	$935.7	$961.7	$1,020.3	$1,085.4	$1,258.3	$1,746.4
Medicare	432.8	566.6	585.7	616.8	646.0	775.3	1,221.3
Medicaid	326.1	423.7	449.4	503.3	544.5	632.1	890.1
ANNUAL GROWTH IN EXPENDITURE							
Private health insurance	7.7%	3.8%	2.8%	6.1%	6.4%	5.1%	5.6%
Medicare	8.4	5.5	3.4	5.3	4.7	6.3	7.9
Medicaid	9.7	5.4	6.1	12.0	8.2	5.1	5.9
PER ENROLLEE EXPENDITURE							
Private health insurance	$ 3,938	$ 4,978	$ 5,080	$ 5,353	$ 5,504	$ 6,209	$ 8,389
Medicare	10,005	11,404	11,422	11,728	11,842	13,048	17,361
Medicaid	7,148	7,347	7,627	7,564	7,727	8,464	11,396
ANNUAL GROWTH IN PER ENROLLEE EXPENDITURE							
Private health insurance	7.1%	4.8%	2.1%	5.4%	2.8%	4.1%	5.1%
Medicare	6.8	2.7	0.2	2.7	1.0	3.3	4.9
Medicaid	5.0	0.5	3.8	–0.8	2.1	3.1	5.1
ENROLLMENT, MILLIONS							
Private health insurance	197.5	188.0	189.3	190.6	197.2	202.6	208.2
Medicare	43.3	49.7	51.3	52.6	54.5	59.4	70.3
Medicaid	45.6	57.7	58.9	66.5	70.5	74.7	78.1
Uninsured	41.1	44.7	44.1	35.7	27.6	25.5	26.4
Population	301.1	313.2	315.3	317.7	320.4	329.2	347.4
Insured share of total population	86.4%	85.7%	86.0%	88.8%	91.4%	92.3%	92.4%
ANNUAL GROWTH IN ENROLLMENT							
Private health insurance	0.5%	–1.0%	0.7%	0.7%	3.5%	0.9%	0.4%
Medicare	1.5	2.8	3.2	2.6	3.7	2.9	2.9
Medicaid	4.5	4.8	2.2	12.9	5.9	2.0	0.7
Uninsured	1.7	1.7	–1.3	–19.1	–22.8	–2.6	0.6
Population	1.0	0.8	0.7	0.7	0.8	0.9	0.9

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** For definitions, sources, and methods for NHE categories, see CMS.gov. National Health Expenditure Accounts: methodology paper, 2013: definitions, sources, and methods (see Exhibit 1 notes). Numbers may not sum to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 1990–2007.

Marketplaces, which provide many Americans with access to new or more generous coverage, contributed substantially to faster projected growth in private health insurance premiums and benefits in 2014. Private health insurance premiums are projected to have risen to $1.0 trillion and to have increased 6.1 percent, up from 2.8 percent growth in 2013 (Exhibit 2). This acceleration in premium growth is due to faster projected growth in premiums per enrollee of 5.4 percent, combined with enrollment growth of 0.7 percent. Growth in private health insurance benefits is also expected to have increased, although not as rapidly as premiums, reaching 5.9 percent (data not shown).

Despite the substantial projected acceleration in the growth of private health insurance spending related to the Marketplace implementation, growth was somewhat moderated by the increased prevalence of employer-sponsored private health insurance plans with high cost-sharing requirements. In recent years employers have increasingly been using these plans to reduce growth in health insurance expenses, and in 2014 roughly one in five employer plans were high-deductible plans.[9,10] Therefore, even among the privately insured, many consumers are still reporting judicious use of medical care because of cost concerns.[11]

Out-of-pocket spending growth is projected to have slowed to just 1.3 percent in 2014 from 3.2 percent in 2013, as a result of the insurance coverage expansions (Exhibit 3). Consequently, the share of national health spending paid for out of pocket is projected to have declined from 11.6 percent in 2013 to 11.2 percent in 2014.

In addition to shifts in the sources of payment related to the expansions of coverage through Medicaid and the health insurance Marketplaces, the financing of health care is projected to have shifted further toward the federal government in 2014. This change reflects both pre-

EXHIBIT 3

National Health Expenditures (NHE), Amounts, Share Of Gross Domestic Product (GDP), And Average Annual Growth From Previous Year Shown, By Source Of Funds, Selected Calendar Years 2007–24

Source of funds	2007[a]	2012	2013	2014	2015	2018	2024
EXPENDITURE, BILLIONS							
NHE	$ 2,303.9	$ 2,817.3	$ 2,919.1	$ 3,080.1	$ 3,243.5	$ 3,785.5	$ 5,425.1
Health consumption expenditures	2,158.8	2,653.6	2,754.5	2,915.3	3,075.9	3,593.8	5,154.2
Out of pocket	293.7	328.8	339.4	343.8	351.0	393.3	543.0
Health insurance	1,611.8	2,029.1	2,102.9	2,249.9	2,390.4	2,802.0	4,053.4
Private health insurance	777.7	935.7	961.7	1,020.3	1,085.4	1,258.3	1,746.4
Medicare	432.8	566.6	585.7	616.8	646.0	775.3	1,221.3
Medicaid	326.1	423.7	449.4	503.3	544.5	632.1	890.1
Federal	185.7	243.7	258.8	306.1	337.3	384.8	525.6
State and local	140.4	180.0	190.6	197.1	207.1	247.4	364.5
Other health insurance programs[b]	75.2	103.1	106.1	109.6	114.6	136.2	195.6
Other third-party payers and programs and public health activity	253.3	295.7	312.2	321.6	334.5	398.6	557.8
Investment	145.1	163.7	164.6	164.8	167.6	191.7	270.8
Population (millions)	301.1	313.2	315.3	317.7	320.4	329.2	347.4
GDP, billions	$14,477.6	$16,163.2	$16,768.1	$17,418.9	$17,976.3	$20,869.1	$27,648.0
NHE per capita	7,652.0	8,995.9	9,257.0	9,694.9	10,124.7	11,498.7	15,618.2
GDP per capita	48,084.1	51,610.3	53,173.8	54,826.8	56,112.7	63,391.7	79,595.4
NHE as percent of GDP	15.9%	17.4%	17.4%	17.7%	18.0%	18.1%	19.6%
ANNUAL GROWTH							
NHE	7.3%	4.1%	3.6%	5.5%	5.3%	5.3%	6.2%
Health consumption expenditures	7.3	4.2	3.8	5.8	5.5	5.3	6.2
Out of pocket	4.8	2.3	3.2	1.3	2.1	3.9	5.5
Health insurance	8.2	4.7	3.6	7.0	6.2	5.4	6.3
Private health insurance	7.7	3.8	2.8	6.1	6.4	5.1	5.6
Medicare	8.4	5.5	3.4	5.3	4.7	6.3	7.9
Medicaid	9.7	5.4	6.1	12.0	8.2	5.1	5.9
Federal	9.7	5.6	6.2	18.3	10.2	4.5	5.3
State and local	9.6	5.1	5.9	3.4	5.1	6.1	6.7
Other health insurance programs[b]	7.8	6.5	2.9	3.3	4.5	5.9	6.2
Other third-party payers and programs and public health activity	6.0	3.1	5.6	3.0	4.0	6.0	5.8
Investment	6.9	2.4	0.5	0.1	1.7	4.6	5.9
Population[c]	1.0	0.8	0.7	0.7	0.8	0.9	0.9
GDP	5.4	2.2	3.7	3.9	3.2	5.1	4.8
NHE per capita	6.2	3.3	2.9	4.7	4.4	4.3	5.2
GDP per capita	4.3	1.4	3.0	3.1	2.3	4.1	3.9

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and Department of Commerce, Bureau of Economic Analysis and Bureau of the Census. **NOTES** For definitions, sources, and methods for NHE categories, see CMS.gov. National Health Expenditure Accounts: methodology paper, 2013: definitions, sources, and methods (see Exhibit 1 notes). Numbers may not sum to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 1990–2007. [b]Includes health-related spending for Children's Health Insurance Program, Titles XIX and XXI; Department of Defense; and Department of Veterans Affairs. [c]Estimates reflect the Bureau of the Census's definition for *resident-based population*, which includes all people who usually reside in the fifty states or the District of Columbia but excludes residents living in Puerto Rico and areas under US sovereignty, and US Armed Forces overseas and US citizens whose usual place of residence is outside of the United States. Estimates also include a small (typically less than 0.2 percent of the population) adjustment to reflect census undercounts. Projected estimates reflect the area population growth assumptions found in the 2015 *Medicare Trustees Report* (see Note 1 in text).

mium and cost-sharing subsidies for coverage in Marketplace plans and a 100 percent initial federal match rate for Medicaid spending incurred by newly eligible enrollees. Health care spending sponsored by the federal government is projected to have risen 10.1 percent in 2014, contributing to an increase in the federal, state, and local governments' collective share of total health spending to 44 percent, up from 43 percent in 2013 (Exhibit 4).

Despite increased coverage and the ensuing growth in the use of health care related to the coverage expansions, the rate of medical price inflation in 2014 remained low (1.4 percent), as was also the case for the two largest categories of health care spending: physician and clinical services (0.5 percent) and hospital services (1.4 percent; data not shown).[12]

EXHIBIT 4

National Health Expenditures (NHE) Amounts, Average Annual Growth From Previous Year Shown, And Percent Distribution, By Type Of Sponsor, Selected Calendar Years 2007–24

Type of sponsor	2007[a]	2012	2013	2014	2015	2018	2024
EXPENDITURE, BILLIONS							
NHE	$2,303.9	$2,817.3	$2,919.1	$3,080.1	$3,243.5	$3,785.5	$5,425.1
Businesses, households, and other private revenues	1,372.5	1,592.7	1,652.8	1,711.1	1,786.3	2,052.8	2,880.1
Private businesses	522.6	587.3	610.9	642.5	673.8	753.0	1,034.0
Households	678.0	801.5	823.8	845.1	882.5	1,029.4	1,465.1
Other private revenues	171.9	203.9	218.1	223.5	230.0	270.4	381.0
Government	931.4	1,224.6	1,266.3	1,369.0	1,457.3	1,732.7	2,545.0
Federal government	530.7	731.5	757.5	833.8	897.6	1,070.5	1,579.1
State and local governments	400.8	493.1	508.8	535.3	559.6	662.2	965.9
ANNUAL GROWTH							
NHE	7.3%	4.1%	3.6%	5.5%	5.3%	5.3%	6.2%
Businesses, households, and other private revenues	6.5	3.0	3.8	3.5	4.4	4.7	5.8
Private businesses	6.8	2.4	4.0	5.2	4.9	3.8	5.4
Households	6.1	3.4	2.8	2.6	4.4	5.3	6.1
Other private revenues	6.8	3.5	7.0	2.5	2.9	5.5	5.9
Government	8.8	5.6	3.4	8.1	6.4	5.9	6.6
Federal government	9.4	6.6	3.5	10.1	7.7	6.0	6.7
State and local governments	8.2	4.2	3.2	5.2	4.5	5.8	6.5
DISTRIBUTION							
NHE	100%	100%	100%	100%	100%	100%	100%
Businesses, households, and other private revenues	60	57	57	56	55	54	53
Private businesses	23	21	21	21	21	20	19
Households	29	28	28	27	27	27	27
Other private revenues	7	7	7	7	7	7	7
Government	40	43	43	44	45	46	47
Federal government	23	26	26	27	28	28	29
State and local governments	17	18	17	17	17	17	18

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** For definitions, sources, and methods for NHE categories, see CMS.gov. National Health Expenditure Accounts: methodology paper, 2013: definitions, sources, and methods (see Exhibit 1 notes). Numbers may not sum to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 1990–2007.

2015 In 2015 national health spending growth is projected to slow to 5.3 percent (Exhibit 1), as two factors that contributed to faster growth in 2014 subside somewhat. First, there is a projected moderation of the effects of the Medicaid coverage expansion after the initial surge in 2014. Second, prescription drug spending growth is projected to decelerate, as lower costs associated with expensive specialty treatments for hepatitis C are negotiated between payers and the drug industry.[13]

Medicaid spending growth is projected to slow to 8.2 percent in 2015, following the program's rapid initial expansion-related enrollment growth (projected enrollment slows to 5.9 percent in 2015 from 12.9 percent in 2014; Exhibit 2). Underlying this trend is an expected slowdown in Medicaid spending growth on physician and clinical services, which is projected to fall from 26.7 percent in 2014 to 6.0 percent in 2015. This reflects the drop in enrollment growth as well as the expiration of the temporary increase in Medicaid payments to primary care providers mandated under the ACA.[14]

Growth rates in private health insurance premiums and benefits, however, are each projected to accelerate slightly, to 6.4 percent (Exhibit 2) and 6.0 percent (data not shown), respectively. Those sustained rates in private health insurance spending of about 6 percent largely reflect the faster growth (relative to 2014) in projected enrollment of 3.5 percent (Exhibit 2), which is mostly due to increased enrollment through the new health insurance Marketplaces. Conversely, growth in premiums per enrollee is projected to slow to 2.8 percent in 2015, in part because of the expectation of somewhat healthier Marketplace enrollees combined with fewer changes in the generosity of benefits offered to the overall privately insured population, relative to 2014.

Medicare spending growth is also projected to

decelerate slightly in 2015, to 4.7 percent from 5.3 percent in 2014 (Exhibit 2). This is mainly due to slower growth in prescription drug expenditures and physician and clinical services spending. Medicare spending growth for prescription drugs is expected to slow from 17.3 percent in 2014 to 9.0 percent in 2015 (data not shown), in part because of increased rebates from pharmaceutical companies for recently available hepatitis C treatments. Furthermore, reductions in physician incentive payments (for various reporting, electronic prescribing, and health information technology initiatives) contribute to slower Medicare spending growth on physician and clinical services of 3.4 percent, down from 4.6 percent in 2014.[1]

Medical price growth in 2015 is projected to remain low, at 1.5 percent, based on the modest expected growth in payments from both private and public payers. The prevalence of high-deductible health plans (which tend to dampen growth in the demand for health care) and the presence of narrow networks in the Marketplace health plans are expected to help prevent sharp increases in health prices.[15] Also contributing to slower-than-average growth in prices are the ongoing productivity-adjustment reductions to Medicare payments and the expiration of temporary payment rate increases to Medicaid primary care providers in many states.

2016–18 National health spending growth is projected to average 5.3 percent in the period 2016–18 (Exhibit 1). This trend is the result of faster projected growth in both Medicare expenditures and medical prices but also of the diminishing impact of the coverage expansions.

Medicare spending growth is projected to average 6.3 percent over this period, compared to 4.7 percent in 2015 (Exhibit 2). Growth in per beneficiary Medicare expenditures is expected to accelerate from 1 percent in 2015 to 3.3 percent over the period 2016–18. This is a result of expectations that growth in the use and intensity of services provided will become closer to longer-term historical norms as aging baby boomers begin to require more care, particularly for hospital services, which have an average growth of 5.6 percent per year over the period, relative to 3.5 percent in 2015 (data not shown).

Medical prices are projected to rise at a faster rate in the period 2016–18, compared to the slow growth in the recent period. By 2016, concurrent with projected increases in economywide prices, the rate of overall medical inflation is anticipated to rise above 2 percent for the first time since 2011 (data not shown). Underlying this trend are expectations of rising costs associated with providing care, such as health care wages.

Medicaid spending is projected to grow 5.1 percent on average in 2016–18, considerably slower than in 2014–15 (Exhibit 2). Underlying this overall deceleration in growth is slower and more gradual average enrollment growth of 2.0 percent, as the major coverage expansion effects moderate. Conversely, growth in spending per enrollee is projected to accelerate—averaging 3.1 percent compared to –0.8 percent and 2.1 percent in 2014 and 2015, respectively—as more expensive dually eligible beneficiaries (those eligible for both Medicare and Medicaid) age into the program during this time.

Although private health insurance enrollment is projected to increase by 5.4 million between 2015 and 2018, the growth rate of per enrollee private health insurance premiums is expected to remain modest, at 4.1 percent (Exhibit 2). This is a result of several factors. First, more employers are expected to provide high-deductible health plans as their only insurance option for their employees.[16] Second, the proliferation of health plans with a narrow network design is expected to increase, potentially limiting both the use and the price of health care goods and services in these plans.[17] Finally, the excise tax on high-cost employer-based insurance plans begins in 2018. This is anticipated to result in some employers reducing the generosity of their plans' benefits, to avoid the tax.

2019–24 Population aging and faster economic growth lead to average projected national health expenditure increases of 6.2 percent per year in 2019–24 (Exhibit 1). Medicare spending is projected to average 7.9 percent over this period (Exhibit 2), as more baby boomers continue to enter the program and as older beneficiaries are projected to use health care at higher rates than younger beneficiaries. Accordingly, per beneficiary Medicare expenditure growth is expected to average 4.9 percent over the period, and average enrollment increases of 2.9 percent are projected (compared to per enrollee and enrollment growth of 2.2 percent and 2.9 percent [data not shown], respectively, in 2008–13). In addition, the aging of the population is also expected to lead to increased Medicaid spending (5.9 percent growth over the period on average), particularly for assistance in paying for nursing home care. Average Medicaid spending per beneficiary during this period is expected to grow more rapidly than in the earlier portions of the projection period, at 5.1 percent.

Expected stronger economic growth in 2017–19 is anticipated to result in a lagged increase in the growth of health expenditures, since increases in the use of health care goods and services typically follow periods of faster growth in disposable personal income. Accordingly, private health insurance premiums are projected

to increase faster in 2019–24 than in 2016–18: 5.6 percent versus 5.1 percent (Exhibit 2). Growth in premiums is still expected to be outpaced by faster overall Medicare spending growth during 2019–24, because of the continued shift of baby boomers out of private health insurance into Medicare. Private health insurance enrollment is thus projected to increase at an average rate of 0.4 percent, or 2.4 percentage points more slowly than Medicare enrollment.

Finally, by the end of the projection period, medical price inflation is expected to reach 3.0 percent, which would be roughly twice as fast as recent price growth (data not shown). Expectations for rising economywide inflation together with higher input costs for providers contribute to this faster projected medical price increase. However, upward pressure is slightly offset by the persisting effects of Medicare payment productivity adjustments and insurance plans with higher cost sharing that are anticipated to lead to greater price transparency and more price sensitivity—which, in turn, is anticipated to temper price growth.[18]

Distributional Changes In Health Spending Between 2013 And 2024

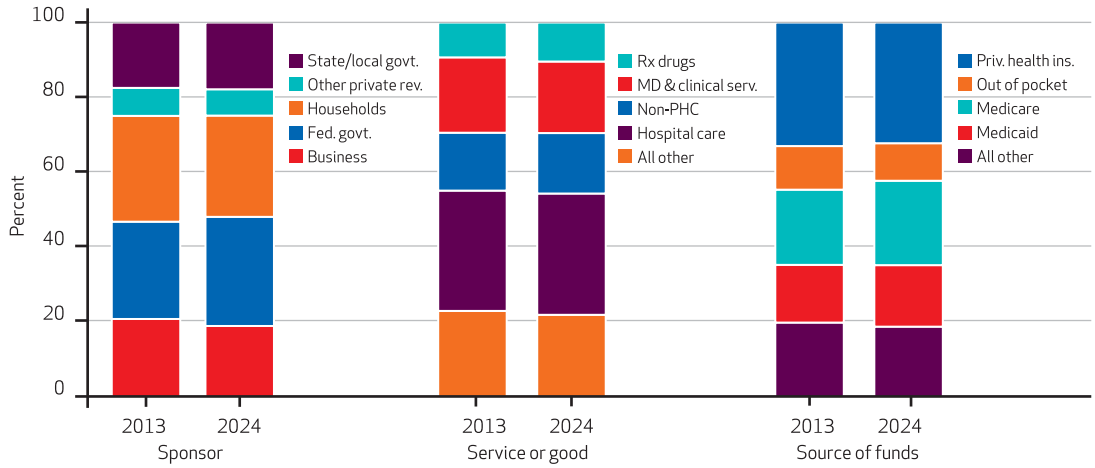
Over the full projection period, there are shifts in the sources of funding for national health expenditures. The share of national health spending paid for by Medicare is projected to rise from 20.1 percent in 2013 to 22.5 percent in 2024 (Exhibit 5). This is due to a projected increase in enrollment of 19.1 million elderly Americans over the period and faster per enrollee spending that results from the aging of previously enrolled beneficiaries. Medicaid spending is also projected to represent a larger share of health expenditures between 2013 and 2024 (15.4 percent in 2013 versus 16.4 percent in 2024), with 19.2 million Americans gaining coverage over the period, largely due to the coverage expansion. During this time, the insured share of the overall US population is anticipated to rise from 86.0 percent to 92.4 percent.

With these changes in health insurance coverage, the share of national health spending paid for out of pocket is expected to decline from 11.6 percent in 2013 to 10.0 percent by 2024. Despite the Marketplace coverage expansion, private health insurance premiums, as a share of total health spending, are projected to decline over the period (from 32.9 percent in 2013 to 32.2 percent in 2024), as many older private health insurance enrollees are projected to shift into Medicare during these years.

Given the coverage shifts described above, by 2024 the share of national health spending financed by federal, state, and local governments is projected to rise to 47 percent from 43 percent in 2013, with total government spending projected to reach $2.5 trillion (Exhibit 4). The increase in governments' share is mostly due to expanded Medicaid eligibility, Marketplace premium and cost-sharing subsidies, and more financing of Medicare from general revenue as a result of a growing gap between dedicated Medi-

EXHIBIT 5

Distribution Of Spending By Sponsor, Service Or Good, And Source Of Funds, Calendar Years 2013 And 2024



SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** For definitions, sources, and methods for national health expenditure categories, see CMS.gov. National Health Expenditure Accounts: methodology paper, 2013: definitions, sources, and methods (see Exhibit 1 notes). Numbers may not sum to totals because of rounding. Percent changes are calculated from unrounded data. Non-PHC is non–personal health care.

care financing and program outlays.[1]

Between 2013 and 2024 the consumption of health care by type of service also shifts (Exhibit 5). During the early part of the projection period, rapid spending growth in prescription drugs related to new specialty drugs, across all sources of payment, leads to a higher share of total health spending by the end of the period (9.3 percent in 2013 versus 10.4 percent in 2024). In contrast, spending for physician and clinical services is projected to grow more slowly in the near-term projection period, particularly among those with private health insurance, which leads to a lower share by the end of the period (20.1 percent in 2013 versus 19.1 percent in 2024). This expectation stems from increasing cost-sharing requirements in private plans that tend to slow growth in the use of benefits.

Major Topics In The Outlook For Medical Services And Goods

HOSPITAL SERVICES

▶ **EFFECT OF COVERAGE EXPANSIONS:** In 2014 total hospital spending is projected to have grown at a rate similar to that in 2013 (4.4 percent and 4.3 percent, respectively; Exhibit 1). However, the ACA coverage expansions are expected to have resulted in substantial shifts in spending among payers, consistent with the overall trend. The coverage expansions are projected to have led to faster spending increases for hospital services paid for by Medicaid (8.9 percent growth in 2014, compared to 4.5 percent growth in 2013) and private health insurance (6.3 percent growth in 2014 versus 4.0 percent growth in 2013; data not shown). With increased health insurance coverage, growth in out-of-pocket spending for hospital services is projected to have declined by 7.2 percent. The increased availability of private health insurance plans with high cost-sharing requirements, however, is expected to have continued to restrain the use of hospital services among enrollees.[9,19]

▶ **HOSPITAL PRICES:** Hospital price growth, as measured by the Producer Price Index, decelerated from 2.2 percent in 2013 to just 1.4 percent in 2014—the slowest rate since 1998.[12] This deceleration was driven primarily by slower growth in payments by private and other non-Medicare and non-Medicaid payers in 2014, compared to the growth in recent history, as well as by continued modest growth in payments from Medicare and Medicaid. By 2022 hospital price growth is expected to reach a peak of 3.1 percent. This is consistent with anticipated increases in input costs for hospital services, which are driven largely by expected growth in compensation.

PHYSICIAN AND CLINICAL SERVICES

▶ **EFFECT OF HIGH-DEDUCTIBLE HEALTH PLANS ON UTILIZATION:** Despite the projected acceleration in overall spending growth for physician and clinical services to 4.8 percent in 2014 (from 3.8 percent in 2013) resulting from the coverage expansions, the proliferation of high-deductible health plans is expected to restrain growth in projected spending for physician and clinical services, in particular in the near term (Exhibit 1).[20] Recent data suggest that the prevalence of these plans and ensuing lower use may be significantly offsetting the effects of the coverage expansion in the Marketplaces on growth in the number of physician office visits made by consumers with private health insurance.[21] Given the prevalence of these plans and employers' expectations to continue or even increase offering them in the near future, growth in visits to physician offices is anticipated to remain modest in the near term of the projection period.[7,9]

▶ **PRICES:** Growth in prices for physician and clinical services is expected to remain near historically low rates through the early part of the projection period and then, when economywide wage and price pressures are projected to increase, to return to rates closer to historical averages. Price growth remained low at 0.5 percent in 2014 (up from 0.0 percent in 2013) and is projected to accelerate slightly to 0.9 percent in 2015 before rising to 2.5 percent by 2024.

Several market dynamics contribute to slower projected near-term price growth. For private health insurers, increases in cost sharing as described above are expected to ease demand pressure on price and cost growth, despite increased enrollment through the coverage expansion. For Medicaid, the ACA-mandated temporary increase in payments to primary care providers is set to expire in 2015, which suggests slower Medicaid payment rate growth in that year. Finally, growth in the Medicare physician payment update is legislated to remain under 1.0 percent per year through 2019.

PRESCRIPTION DRUGS

▶ **EFFECT OF CHANGES IN THE GENERIC DISPENSING RATE:** Recent historically low rates of prescription drug spending growth have been driven by the shift from brand-name medications to less expensive generic drugs. This shift to cheaper medications has offset annual price increases for brand-name drugs. With the generic dispensing rate already at 82 percent in 2014, there is an expectation of only a small increase in this rate over the next ten years. As a result, annual price increases for prescription drugs are expected to average 3.0 percent during the entire projection period and to influence spending growth more than they have in recent history, after patent expirations of several top-selling

brand-name drugs that were replaced in the market by less expensive generic versions.

▶ **PRESCRIPTION DRUG USE AND MIX:** In the recent period of historically low spending growth, there was also a period of relatively slow increases in the number of prescriptions dispensed. Over the next ten years, these increases are projected to rebound somewhat because of expectations of stronger economic growth, modifications in treatment guidelines, and changes in benefit management (for example, increased use of value-based purchasing plans) that stress better drug adherence for people with chronic health conditions to prevent the occurrence of adverse health events.

Prescription drug spending shifted more toward specialty drugs in 2014, with the introduction of new drugs to treat conditions such as hepatitis C and cancer.[7] This trend is expected to continue as research and development is increasingly targeted toward specialty drugs.[7]

Selected Topics In The Outlook For Payers

MEDICARE The recent passage of the Medicare Access and CHIP Reauthorization Act of 2015 affected Medicare payments to physicians and other Medicare payment adjustments.[22] Specifically, the act removed the Sustainable Growth Rate system methodology, which had previously determined payment updates to Medicare fees paid to physicians, and it mandated annual physician payment updates for 2015 and future years that averaged less than 1 percent per year. In 2019 physicians will choose to participate in either an alternative payment model or a merit-based incentive payment system. For 2019 through 2024, this legislation provides $500 million each year as an additional performance adjustment for providers in the merit-based incentive payment system who achieve exceptional performance. Providers receiving a substantial portion of revenue from alternative payment models will receive a lump-sum payment after each year equal to 5 percent of Medicare payments for reimbursed services in that year. The net result of these bonus programs will be faster growth in Medicare physician payments than the payment rates mentioned above would imply.

MEDICAID

▶ **PROJECTED COSTS ASSOCIATED WITH THE EXPANSION POPULATION:** Although those newly enrolled in Medicaid are anticipated to be generally healthier in 2014 than the pool of all Medicaid beneficiaries in 2013, the average benefit costs of newly eligible adult enrollees are projected to have been 19 percent greater than the costs of previously eligible adult enrollees in 2014.[8] This trend is due in large part to coverage of the expansion population through Medicaid managed care plans. The plans had higher average capitation rates for the newly eligible adult enrollees that assumed both pent-up demand and a higher level of acuity or morbidity among newly eligible adults, which suggests more intensive care. However, over the remainder of the projection period, per enrollee costs for newly eligible adults are projected to fall below such costs for other adults, as the effects of pent-up demand and adverse selection from the newly eligible population diminish.

▶ **GROWTH OF MEDICAID MANAGED CARE:** Enrollment in managed care plans within Medicaid increased significantly over the period 2001–13, and, as a result, total Medicaid payments for managed care plans grew more rapidly on average (11.9 percent)[8] than did overall Medicaid expenditures (an average of 6.4 percent; data not shown). Over the projection period, states are generally expected to continue shifting to managed care plans for other types of Medicaid enrollees and the majority of newly eligible adults.

Conclusion

Over the eleven-year projection period (2014–24), health spending growth is expected to increase at an average annual rate of 5.8 percent. By 2024 health spending is projected to account for 19.6 percent of GDP, up from 17.4 percent in 2013.

These trends are in contrast to the experience beginning with the recession and continuing with the modest recovery through 2013, when health spending growth remained at near historically low rates (averaging 4.0 percent during 2008–13), and the health share of GDP was essentially unchanged. However, a closer look at the recent period suggests that some factors in these years (the impacts of slow income growth, loss of insurance coverage, slow economywide and health-specific price growth, and increases in generic drug dispensing) are not likely to persist, whereas others (such as the increased prevalence of insurance plans with greater cost-sharing requirements and various legislative impacts on Medicare payment updates) are likely to have more lasting effects.

In the projection period, a number of factors are expected to contribute to faster spending growth, including coverage expansions from the ACA, faster growth in medical care use as a result of improved economic conditions and population aging, and faster economywide and medical price increases in the face of rising wages.

Ultimately, these longer-lasting factors result in relatively modest projected health spending growth over the next decade, averaging close to 6 percent per year (compared to the average annual growth of about 9 percent over the three decades prior to the recession), even during a period when the uninsured population is expected to decline by almost eighteen million. ■

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4 The physician fee schedule legislated payment rate updates do not include the incentive payments for various health information technology initiatives through 2018 or for alternative payment models for 2019–24. These incentive payments are added elsewhere.

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