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# National Health Expenditure Projections, 2012–22: Slow Growth Until Coverage Expands And Economy Improves

**ABSTRACT Health spending growth through 2013 is expected to remain slow because of the sluggish economic recovery, continued increases in cost-sharing requirements for the privately insured, and slow growth for public programs. These factors lead to projected growth rates of near 4 percent through 2013. However, improving economic conditions, combined with the coverage expansions in the Affordable Care Act and the aging of the population, drive faster projected growth in health spending in 2014 and beyond. Expected growth for 2014 is 6.1 percent, with an average projected growth of 6.2 percent per year thereafter. Over the 2012–22 period, national health spending is projected to grow at an average annual rate of 5.8 percent. By 2022 health spending financed by federal, state, and local governments is projected to account for 49 percent of national health spending and to reach a total of $2.4 trillion.**

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Annual national health spending growth is projected to remain near 4 percent through 2013, primarily as a result of the recent recession and modest recovery. This projection is consistent with the historical relationship between health spending and economic cycles.

In 2014 the implementation of provisions of the Affordable Care Act related to major coverage expansions is expected to accelerate health spending growth to 6.1 percent. Through the remainder of the projection period discussed in this article, this rate of growth is sustained as a result of improved economic conditions and an aging population's increased demand for health care.

By 2022 the Affordable Care Act is projected to reduce the number of uninsured people by thirty million, add approximately 0.1 percentage point to average annual health spending growth over the full projection period, and increase cumulative health spending by $621 billion.

This article explores the factors influencing overall projected health spending trends through 2022 by major health industry sectors, payers, and sponsors. A summary of the underlying methods is also included. Notably, these estimates incorporate two substantial changes from prior projections. First, the estimates incorporate the June 2012 US Supreme Court ruling that made the Medicaid eligibility expansion under health reform optional for states.[1] Second, unless otherwise stated, the estimates focus on an outlook for spending in which the scheduled Medicare physician payment rate updates under the Sustainable Growth Rate formula do not occur, including a 24.7 percent reduction as of January 1, 2014.

## 2012

In 2012 national health spending is estimated to have reached $2.8 trillion and to have grown 3.9 percent—the same rate observed in 2011

(Exhibits 1 and 2). The low rate of projected growth for national health spending in 2012 reflects the persistent effects of the recession and the modest recovery. This is consistent with historical trends, in which changes to employer benefit design, insurer contracting relationships, and consumer behavior have taken several years to affect the cost and consumption of medical care. After several years of moderate income growth and stagnant insurance coverage, private health insurance spending growth is estimated to have held constant at 3.8 percent in 2011 and 2012 , as consumers remained judicious in their use of health care goods and services. In addition, employers are increasingly relying on health insurance benefits that require higher cost sharing, such as high-deductible health plans.[2,3]

These trends have further influenced consumers' willingness to use health care goods and services. Moreover, tighter budgetary pressures and the expiration of temporary federal matching rate increases have constrained Medicaid spending, which is estimated to have grown 2.2 percent in 2012.[1]

Restrained Medicare spending, combined with stagnant medical prices, also contributed to continued modest spending growth. Estimated Medicare spending growth fell to 4.6 percent in 2012—down from 6.2 percent in 2011, despite faster enrollment growth. This is partly attributable to provisions in the Affordable Care Act that reduced the rate at which payments for certain providers are updated. Additional factors include slower growth in the use of Part A services, particularly skilled nursing facility and home health services. Medical price inflation for total personal health care tapered to 1.5 percent in 2012, down from 2.1 percent in 2011, largely as a result of declines in drug prices after the patents on several popular medications expired.[4]

## 2013

In 2013 the rate of national health spending growth is projected to remain below 4 percent. Consumers are expected to remain sensitive to rising health costs and exhibit caution in their use of health care services as a result of sluggish income growth and the expiration of the payroll tax holiday. Employers are anticipated to increase their focus on controlling costs in preparation for approaching coverage requirements and taxes on high-cost plans under health reform, through higher cost-sharing provisions, tighter management of care in health plans, and narrow network availability.[2,5] In line with this, private health insurance spending is projected to slow to 3.4 percent in 2013.

Medicare spending is an additional factor in the modest projected growth for 2013. The projected Medicare spending growth of 4.2 percent reflects the 2 percent reduction in Medicare payments mandated in the Budget Control Act of 2011, also referred to as sequestration.

## 2014

Growth in national health spending is projected to accelerate to 6.1 percent in 2014, reflecting the expanded insurance coverage that will become available through the Affordable Care Act.[6] Eleven million Americans are projected to gain health insurance coverage in 2014, predominantly through either Medicaid or the Health Insurance Marketplaces,[7] also known as exchanges. The use of goods and services among the newly covered is expected to contribute significantly to spending increases in Medicaid (12.2 percent) and private health insurance (7.7 percent). Accordingly, out-of-pocket spending is projected to decline 1.5 percent in 2014, as a result of both new coverage for those who had previously carried the full burden of health expenses and lower cost sharing for those with improved coverage. Overall, national health spending is projected to grow 1.6 percentage points faster in 2014 than would be expected in the absence of the Affordable Care Act (Exhibits 3 and 4).

Some health care sectors are projected to have more substantial increases in spending growth as a result of the insurance expansions in 2014. The populations gaining coverage are anticipated to be younger and healthier and to require relatively less hospital care than the currently insured population.[8,9] Consequently, they are expected to devote a higher proportion of their health care dollar to prescription drugs and physician and clinical services, compared to the currently insured.

## 2015

In 2015 national health spending growth is projected to remain near 6 percent because of two main factors. First, the major effects of the insurance expansion are projected to continue, with an additional eight million Americans expected to gain coverage during 2015, primarily through Medicaid or the Health Insurance Marketplaces.

Second, the pace of economic recovery is expected to increase in 2014 through 2015, with the projected growth in nominal gross domestic product (GDP), not adjusted for inflation, exceeding 5 percent in 2015 for the first time since 2006. The resulting projected gains in dispos-

**EXHIBIT 1**

**National Health Expenditures (NHE), Aggregate And Per Capita Amounts, And Share Of Gross Domestic Product (GDP), Selected Calendar Years 2009–22**

| Spending category | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2018 | 2022 |
|---|---|---|---|---|---|---|---|---|---|
| NHE, billions | $2,501.2 | $2,600.0 | $2,700.7 | $2,806.6 | $2,914.7 | $3,093.2 | $3,273.4 | $3,889.1 | $5,008.8 |
| Health consumption expenditures | 2,355.1 | 2,450.8 | 2,547.2 | 2,648.4 | 2,753.1 | 2,923.1 | 3,094.4 | 3,674.6 | 4,735.6 |
| Personal health care | 2,111.6 | 2,190.0 | 2,279.3 | 2,365.8 | 2,452.3 | 2,594.0 | 2,743.2 | 3,271.8 | 4,224.3 |
| Hospital care | 777.9 | 815.9 | 850.6 | 892.4 | 929.0 | 973.0 | 1,027.5 | 1,232.3 | 1,581.3 |
| Professional services | 672.5 | 694.2 | 723.1 | 755.4 | 785.0 | 840.7 | 887.2 | 1,045.4 | 1,351.5 |
| Physician and clinical services | 503.2 | 519.1 | 541.4 | 566.5 | 588.8 | 630.7 | 664.9 | 782.8 | 1,012.0 |
| Other professional services | 66.8 | 69.8 | 73.2 | 76.8 | 79.5 | 87.5 | 93.0 | 112.9 | 148.2 |
| Dental services | 102.5 | 105.3 | 108.4 | 112.2 | 116.6 | 122.4 | 129.3 | 149.8 | 191.3 |
| Other health, residential, and personal care[a] | 122.5 | 128.0 | 133.1 | 138.1 | 144.5 | 153.5 | 163.5 | 200.1 | 260.8 |
| Home health care[b] | 67.3 | 71.2 | 74.3 | 77.9 | 81.8 | 86.8 | 92.9 | 115.5 | 157.2 |
| Nursing care facilities and continuing care retirement communities[b,c] | 138.5 | 143.0 | 149.3 | 151.2 | 156.8 | 164.0 | 172.2 | 205.4 | 264.2 |
| Retail outlet sales of medical products | 332.9 | 337.8 | 348.9 | 350.8 | 355.2 | 376.0 | 399.9 | 473.0 | 609.4 |
| Prescription drugs | 254.6 | 255.7 | 263.0 | 260.8 | 262.3 | 275.9 | 294.9 | 350.6 | 455.0 |
| Durable medical equipment | 34.9 | 36.9 | 38.9 | 40.9 | 42.2 | 43.8 | 46.1 | 52.8 | 66.7 |
| Other nondurable medical products | 43.5 | 45.2 | 47.0 | 49.1 | 50.7 | 56.3 | 58.9 | 69.7 | 87.8 |
| Government administration[d] | 30.8 | 31.1 | 32.5 | 34.6 | 37.1 | 41.9 | 44.4 | 54.0 | 70.4 |
| Net cost of health insurance[e] | 137.1 | 150.4 | 156.4 | 166.3 | 180.0 | 199.4 | 215.3 | 243.6 | 313.2 |
| Government public health activities | 75.6 | 79.3 | 79.0 | 81.6 | 83.7 | 87.8 | 91.5 | 105.2 | 127.7 |
| Investment | 146.1 | 149.1 | 153.5 | 158.3 | 161.5 | 170.0 | 179.0 | 214.5 | 273.2 |
| Research[f] | 45.3 | 49.0 | 49.8 | 48.6 | 47.4 | 49.3 | 51.8 | 61.3 | 76.4 |
| Structures and equipment | 100.8 | 100.1 | 103.7 | 109.7 | 114.1 | 120.8 | 127.2 | 153.1 | 196.8 |
| Population (millions) | 306.4 | 308.9 | 311.1 | 313.6 | 316.3 | 319.0 | 321.8 | 330.4 | 341.6 |
| NHE per capita | $8,162.9 | $8,417.2 | $8,680.0 | $8,948.4 | $9,216.3 | $9,697.3 | $10,172.1 | $11,771.2 | $14,663.8 |
| GDP, billions of dollars | $13,973.7 | $14,498.9 | $15,075.7 | $15,678.7 | $16,196.1 | $16,925.0 | $17,805.0 | $20,966.9 | $25,216.9 |
| GDP per capita | $45,604.8 | $46,939.3 | $48,452.4 | $49,988.7 | $51,212.6 | $53,060.6 | $55,328.9 | $63,460.6 | $73,825.2 |
| NHE as percent of GDP | 17.9 | 17.9 | 17.9 | 17.9 | 18.0 | 18.3 | 18.4 | 18.5 | 19.9 |

**SOURCES** 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** Numbers may not add to totals because of rounding. Data from 2012 to 2022 are projections. [a]Includes spending for residential care facilities (North American Industry Classification Codes [NAICS] 623210 and 623220), ambulance providers (NAICS 621910), medical care delivered in nontraditional settings (such as community centers, senior citizens centers, schools, and military field stations), and expenditures for Home and Community Waiver programs under Medicaid. [b]Includes freestanding facilities only. Additional services of this type provided in hospital-based facilities are counted as hospital care. [c]Includes care provided in nursing care facilities (NAICS 6231), continuing care retirement communities (623311), state and local government nursing facilities, and nursing facilities operated by the Department of Veterans Affairs. [d]Includes all administrative costs (federal, state, and local employees' salaries; contracted employees including fiscal intermediaries; rent and building costs; computer systems and programs; other materials and supplies; and other miscellaneous expenses) associated with insuring individuals enrolled in the following public health insurance programs: Medicare, Medicaid, Children's Health Insurance Program, Department of Defense, Department of Veterans Affairs, Indian Health Service, workers' compensation, maternal and child health, vocational rehabilitation, Substance Abuse and Mental Health Services Administration, and other federal programs. [e]Net cost of health insurance is calculated as the difference between calendar year incurred premiums earned and benefits paid for private health insurance. This includes administrative costs and, in some cases, additions to reserves; rate credits and dividends; premium taxes; and plan profits or losses. Also included in this category is the difference between premiums earned and benefits paid for the private health insurance companies that insure the enrollees of the following public programs: Medicare, Medicaid, Children's Health Insurance Program, and workers' compensation (health portion only). [f]Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research expenditures" but are included in the expenditure class in which the product falls.

**EXHIBIT 2**

**National Health Expenditures (NHE), Average Annual Growth From Prior Year Shown, Selected Calendar Years 2000–22**

| Spending category | 2000–09 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2018 | 2022 |
|---|---|---|---|---|---|---|---|---|---|
| NHE, billions | 6.9% | 3.9% | 3.9% | 3.9% | 3.8% | 6.1% | 5.8% | 5.9% | 6.5% |
| Health consumption expenditures | 6.9 | 4.1 | 3.9 | 4.0 | 4.0 | 6.2 | 5.9 | 5.9 | 6.5 |
| Personal health care | 6.8 | 3.7 | 4.1 | 3.8 | 3.7 | 5.8 | 5.8 | 6.0 | 6.6 |
| Hospital care | 7.2 | 4.9 | 4.3 | 4.9 | 4.1 | 4.7 | 5.6 | 6.2 | 6.4 |
| Professional services | 6.2 | 3.2 | 4.2 | 4.5 | 3.9 | 7.1 | 5.5 | 5.6 | 6.6 |
| Physician and clinical services | 6.3 | 3.1 | 4.3 | 4.6 | 3.9 | 7.1 | 5.4 | 5.6 | 6.6 |
| Other professional services | 6.8 | 4.6 | 4.9 | 4.8 | 3.6 | 10.1 | 6.3 | 6.7 | 7.0 |
| Dental services | 5.7 | 2.7 | 3.0 | 3.5 | 3.9 | 5.0 | 5.6 | 5.0 | 6.3 |
| Other health, residential, and personal care[a] | 7.4 | 4.5 | 4.0 | 3.7 | 4.6 | 6.2 | 6.5 | 7.0 | 6.8 |
| Home health care[b] | 8.4 | 5.8 | 4.5 | 4.8 | 5.0 | 6.1 | 7.0 | 7.5 | 8.0 |
| Nursing care facilities and continuing care retirement communities[b,c] | 5.6 | 3.2 | 4.4 | 1.3 | 3.7 | 4.6 | 5.0 | 6.1 | 6.5 |
| Retail outlet sales of medical products | 7.2 | 1.5 | 3.3 | 0.5 | 1.3 | 5.8 | 6.4 | 5.8 | 6.5 |
| Prescription drugs | 8.6 | 0.4 | 2.9 | −0.8 | 0.6 | 5.2 | 6.9 | 5.9 | 6.7 |
| Durable medical equipment | 3.7 | 5.8 | 5.3 | 5.3 | 3.2 | 3.7 | 5.3 | 4.6 | 6.0 |
| Other nondurable medical products | 3.6 | 4.0 | 4.0 | 4.3 | 3.4 | 11.0 | 4.6 | 5.8 | 5.9 |
| Government administration[d] | 6.8 | 0.7 | 4.7 | 6.3 | 7.3 | 13.0 | 6.0 | 6.7 | 6.8 |
| Net cost of health insurance[e] | 8.8 | 9.8 | 4.0 | 6.4 | 8.2 | 10.8 | 8.0 | 4.2 | 6.5 |
| Government public health activities | 6.5 | 4.9 | −0.5 | 3.4 | 2.6 | 4.9 | 4.2 | 4.8 | 5.0 |
| Investment | 5.9 | 2.1 | 2.9 | 3.1 | 2.1 | 5.3 | 5.3 | 6.2 | 6.2 |
| Research[f] | 6.6 | 8.2 | 1.7 | −2.5 | −2.3 | 3.8 | 5.1 | 5.8 | 5.6 |
| Structures and equipment | 5.5 | −0.7 | 3.6 | 5.8 | 4.0 | 5.9 | 5.3 | 6.4 | 6.5 |
| Population | 0.9 | 0.8 | 0.7 | 0.8 | 0.8 | 0.9 | 0.9 | 0.9 | 0.8 |
| NHE per capita | 5.9 | 3.1 | 3.1 | 3.1 | 3.0 | 5.2 | 4.9 | 5.0 | 5.6 |
| GDP | 3.8 | 3.8 | 4.0 | 4.0 | 3.3 | 4.5 | 5.2 | 5.6 | 4.7 |
| GDP per capita | 2.9 | 2.9 | 3.2 | 3.2 | 2.4 | 3.6 | 4.3 | 4.7 | 3.9 |

**SOURCES** 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. **NOTE** 2009 shows average annual growth, 2000–09; data from 2012 to 2022 are projections; percent changes are calculated from unrounded data. [a]Includes spending for residential care facilities (North American Industry Classification Codes [NAICS] 623210 and 623220), ambulance providers (NAICS 621910), medical care delivered in nontraditional settings (such as community centers, senior citizens centers, schools, and military field stations), and expenditures for Home and Community Waiver programs under Medicaid. [b]Includes freestanding facilities only. Additional services of this type provided in hospital-based facilities are counted as hospital care. [c]Includes care provided in nursing care facilities (NAICS 6231), continuing care retirement communities (623311), state and local government nursing facilities, and nursing facilities operated by the Department of Veterans Affairs. [d]Includes all administrative costs (federal, state, and local employees' salaries; contracted employees including fiscal intermediaries; rent and building costs; computer systems and programs; other materials and supplies; and other miscellaneous expenses) associated with insuring individuals enrolled in the following public health insurance programs: Medicare, Medicaid, Children's Health Insurance Program, Department of Defense, Department of Veterans Affairs, Indian Health Service, workers' compensation, maternal and child health, vocational rehabilitation, Substance Abuse and Mental Health Services Administration, and other federal programs. [e]Net cost of health insurance is calculated as the difference between calendar year incurred premiums earned and benefits paid for private health insurance. This includes administrative costs, and in some cases, additions to reserves; rate credits and dividends; premium taxes; and plan profits or losses. Also included in this category is the difference between premiums earned and benefits paid for the private health insurance companies that insure the enrollees of the following public programs: Medicare, Medicaid, Children's Health Insurance Program, and workers' compensation (health portion only). [f]Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research expenditures" but are included in the expenditure class in which the product falls.

able personal income are expected to drive increased use of health care goods and services.

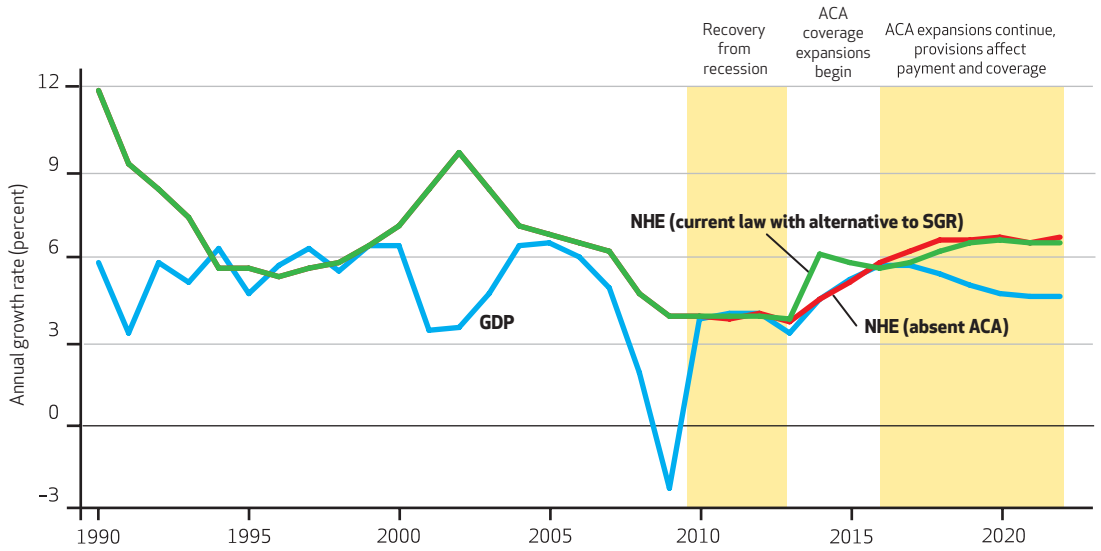
## 2016–22

After 2015 the most significant one-time effects of the coverage expansions are expected to subside. As a result, projected total health spending growth for 2016–18 is largely influenced by an improving economy and the expected ensuing increases in disposable income and consumption of medical care. Health spending growth per capita is projected to average 5.0 percent per year for 2016–18, compared to per capita GDP growth of 4.7 percent. These are marked increases compared to 2012 and 2013, when projected growth in national health spending per capita and in GDP per capita are 3.0 percent and 2.8 percent, respectively.

Finally, for 2019–22 the effects of continued enrollment of baby boomers in Medicare, as well as the ending of the sequester in 2022, lead to a projected growth in average Medicare spending per year of 7.9 percent, compared with 7.3 percent per year for 2016–18. This acceleration in Medicare spending is primarily responsible for slightly faster average growth in total health spending through the end of the projection pe-

**EXHIBIT 3**

**Annual Growth Rates, Gross Domestic Product (GDP) And National Health Expenditures (NHE), Calendar Years 1990–2022**




**SOURCES** Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and Department of Commerce, Bureau of Economic Analysis. **NOTES** Data for 2012–22 are projections. Years 2010–13 are based on modest recovery from the recession and include the impact of some Affordable Care Act (ACA) provisions. Years 2014–15 reflect the beginning of the impact of major ACA coverage expansions. Years 2016–22 reflect the continuation of ACA coverage expansions through 2017 and the effects of other ACA provisions on payment and coverage. Elevated Medicare enrollment growth is due to baby boomers. SGR is Sustainable Growth Rate.

riod (6.5 percent per year) relative to 2016–18 (5.9 percent per year).

Over the whole projection period, 2012–22, national health spending is estimated to grow at an average rate of 5.8 percent per year, which is 1.0 percentage point faster than the average annual economic growth during the period. As a result, the share of GDP devoted to health care is projected to rise from 17.9 percent in 2012 to roughly a fifth of GDP by 2022.

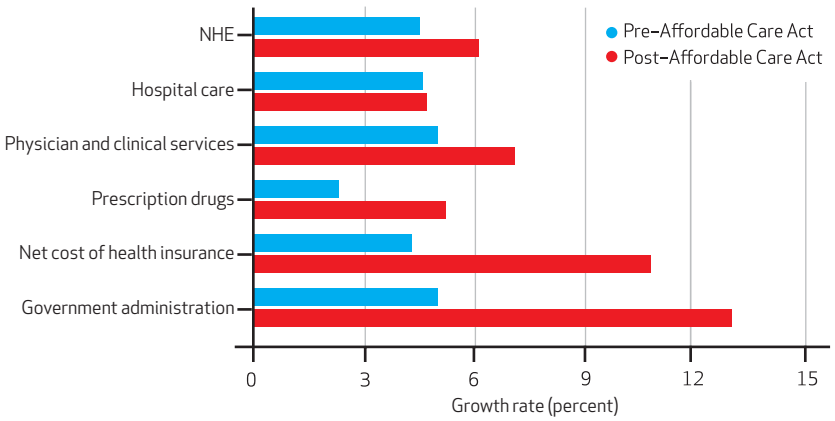
Continued slower health spending growth after the recent economic downturn (discussed above) has raised the question of whether a more fundamental change is occurring in the health sector.[10] However, econometric and actuarial analysis by the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary of the past fifty years of National Health Expenditure Accounts data, which explores the relationship between economic and health spending growth, suggests that health spending growth is likely to accelerate once economic conditions improve significantly.[11] Although projected growth is faster than in the recent past, it is still slower than the growth experienced over the longer term.

## Model And Assumptions

The national health expenditure projections incorporate actuarial and econometric modeling techniques, as well as judgments about future events and trends that influence health spending.[11] The projections use the economic and demographic assumptions from the 2013 *Medicare Trustees Report*, which are updated to reflect the latest macroeconomic data.[11–13] The CMS Office

**EXHIBIT 4**

**2014 Growth Rates By Selected Sector, Before And After The Impact Of The Affordable Care Act**




**SOURCE** Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

of the Actuary used its health reform model and various actuarial cost estimates to determine the full effect of the Affordable Care Act on national health spending and to distribute the impact of reform among categories of goods and services. These projections incorporate the Supreme Court decisions regarding the Affordable Care Act[1] and the recent one-year delay in the implementation of mandated employer insurance coverage for employees.[14]

Consistent with the methodology in the trustees report, the Medicare projections were estimated under two scenarios: current law, in which growth in physician fee schedule rates is based on the Sustainable Growth Rate formula; and an alternative scenario, in which physician fee schedule rates are assumed to grow 0.7 percent annually from 2014 on.[12,15] Because payment rates scheduled under the Sustainable Growth Rate formula have been overridden annually by legislatively set payment rates since 2003, the projections presented in this article reflect Medicare growth rates that are consistent with the alternative scenario in the trustees report.[16] Other than the treatment of the Sustainable Growth Rate formula, all aspects of the projections presented here reflect current law.

In addition, these projections remain subject to substantial uncertainty, given the variable nature of future economic trends and a lack of historical experience with many forthcoming health system reforms. The supply-side effects of the Affordable Care Act, such as changes in providers' behavior in reaction to an influx of newly insured patients, remain highly speculative and are not included in these estimates.[17]

## Outlook For Medical Services And Goods

**HOSPITAL SERVICES** Total hospital spending is estimated to have grown 4.9 percent in 2012, reaching $892.4 billion, compared with 4.3 percent growth in 2011 (Exhibits 1 and 2). This would represent the third consecutive year in which hospital spending growth has been below 5 percent, after averaging 7.2 percent in the period 2000–09. Estimated private health insurance spending growth corresponds with the overall trend, with growth estimated to be less than 6.0 percent for the third consecutive year.

In 2013 total hospital spending growth is expected to slow to 4.1 percent, in part because of reduced Medicare hospital spending growth (3.2 percent) under sequestration. Hospital spending growth is then projected to accelerate to 4.7 percent in 2014 (Exhibit 2). Although the coverage expansions in the Affordable Care Act are expected to result in faster hospital spending growth by themselves, the increases in spending among the newly covered are estimated to be somewhat offset by slower Medicare hospital payment updates, which have been cumulatively affecting spending since 2012. In 2015 the costs associated with the continued effects of the expansion, combined with the effect of faster economic growth on health spending, result in faster projected hospital spending growth (5.6 percent).

In 2016–22 continued population aging and the impacts of improved economic conditions are expected to influence hospital spending, resulting in projected average annual growth of 6.4 percent. For Medicare, enrollment by the baby-boom generation and faster growth in spending per beneficiary are expected to lead to average growth of 7.8 percent per year over this period. Private health insurance spending is projected to grow 5.9 percent per year on average during the period. This faster growth is influenced by an improving economy, which results in income gains and more insurance coverage.

**PHYSICIAN AND CLINICAL SERVICES** Spending on physician and clinical services is estimated to have grown 4.6 percent in 2012 (totaling $566.5 billion), compared to 4.3 percent in 2011 (Exhibits 1 and 2). Although slightly faster, estimated growth for 2012 remains low relative to previous years. Continued slow growth of 3.5 percent is estimated for private health insurance spending, marking the fourth consecutive year in which this rate has been below 4.0 percent. This trend is related in part to consumers' slow return to physician offices after the recession.[4] In addition, 2012 price inflation for these services remained low, at 1.1 percent.[18] Spending growth for overall physician and clinical services is expected to slow to 3.9 percent in 2013. This modest growth is partly due to sequestration and the resulting constraint on Medicare physician spending, which is projected to fall to 3.0 percent in 2013 from 5.8 percent in 2012.

Physician and clinical services spending growth is projected to accelerate to 7.1 percent in 2014 (Exhibit 4). As noted above, people who are expected to gain coverage in 2014 (particularly those who enroll in Medicaid) are generally healthier and require less hospital care than those who currently have insurance. Thus, the newly insured are anticipated to devote a higher proportion of their total health spending to physician and clinical services, compared to people who are already insured.[8,9]

Under current law, projected spending growth for physician and clinical services would still accelerate, but less rapidly, reaching only 4.7 percent. This is lower than the projections presented here because of the estimated 24.7 per-

cent reduction in physician payment rates mandated by Medicare's Sustainable Growth Rate formula.

In 2015–18 average growth in physician and clinical services (5.5 percent) is projected to outpace average spending growth in this category projected for 2012–13 (4.3 percent). This change is attributable to increased demand for these services as a result of continuing coverage expansions and increased income growth arising from the economic recovery.

Toward the end of the projection period, the aging of the baby-boom population is expected to be one factor leading to increasing use of physician and clinical services. Consequently, spending growth is projected to accelerate to an average of 6.6 percent during 2019–22.

**PRESCRIPTION DRUGS** In 2012 prescription drug spending is estimated to have accounted for $260.8 billion in health spending—a decline of 0.8 percent and down from 2.9 percent growth in 2011 (Exhibits 1 and 2). The drop in projected spending was caused by declines in the average price paid for prescriptions (because a number of popular brand-name drugs lost patent protection and there was increased use of generic drugs), increases in cost-sharing requirements, and lower spending on new medicines.[4] These factors were partially offset by more rapid growth in the number of dispensed prescriptions, estimated to have grown 1.3 percent in 2012, compared to 0.6 percent in 2011.[4]

For 2013 prescription drug spending is projected to increase by 0.6 percent, which is still very slow relative to historical trends (Exhibit 2). The combined impact of diminished savings from patent expirations on average prescription drug prices, higher sales of relatively expensive specialty drugs (especially recently approved cancer drugs[19]), and faster growth in the number of dispensed prescriptions is expected to yield a small acceleration in spending growth.

In 2014 prescription drug spending growth is projected to accelerate to 5.2 percent, driven by increases in the use of prescription drugs by people who are newly insured and those who move to more generous insurance plans. Additionally, drug spending growth is expected to rebound from the very low growth anticipated in 2012 and 2013 as the economy improves and the impact of patent expirations continues to diminish.

Through 2022 rising drug prices and expected increases in utilization drive faster overall projected growth in prescription drug spending, compared to the low growth projected for 2012 and 2013. The proportion of generic drugs dispensed is anticipated to level off at roughly 85 percent, pushing average prescription drug prices up. The expected acceleration in growth in disposable income in 2014–16 is expected to influence faster growth in drug utilization and also to enable more consumers to fill prescriptions. Additionally, physicians are expected to prescribe drugs earlier in the treatment process as the population ages, which will increase prescription use. Combined, these factors lead to projected average annual prescription drug spending growth of 6.5 percent for 2015–22.

## Payer Outlook

**MEDICARE** In 2012 Medicare spending growth slowed across most service types. As a result, aggregate Medicare spending growth is estimated to have slowed to 4.6 percent, down from 6.2 percent in 2011, for a total of $579.9 billion (Exhibit 5). In 2013 Medicare spending growth is projected to remain low, at 4.2 percent, mainly because of the sequestration legislation in the Budget Control Act of 2011. The legislation, implemented in April 2013, calls for 2 percent Medicare payment reductions through March 31, 2022.

In 2014 Medicare spending growth is projected to rebound to 5.1 percent (Exhibit 5). In contrast, under the current law with its scheduled 24.7 percent reduction in physician payment rates mandated by the Sustainable Growth Rate formula, Medicare spending is projected to grow just 2.4 percent.

For 2015–22 the average projected Medicare spending growth of 7.4 percent reflects the net effect of opposing factors. Factors encouraging growth in spending include greater numbers of baby boomers becoming eligible for Medicare; more expensive care for Medicare enrollees, as the severity of illness and the intensity of treatment increase with age; faster projected increases in utilization and input prices; and the expiration of the sequestration in 2022. However, certain provisions of the Affordable Care Act serve to constrain spending growth by limiting growth in fee-for-service provider payment updates, mandating lower payments to private plans, and reducing scheduled spending when spending exceeds formula-driven targets.[20]

**MEDICAID** Continuing the slow growth experienced in 2011 (2.5 percent), total Medicaid spending is estimated to have grown 2.2 percent in 2012, reaching a total of $416.8 billion (Exhibit 5). Growth remained slow because of several factors, including the expiration of enhanced federal match rates in 2011 and efforts by states to reduce program costs by shifting enrollees into managed care. In 2013, however, growth in Medicaid spending is projected to rebound to 4.8 percent. This growth in spending is attribut-

**EXHIBIT 5**

**National Health Expenditures (NHE), Amounts And Average Annual Growth From Previous Year Shown, By Source of Funds, Selected Calendar Years 2009–22**

| Source of funds | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2018 | 2022 |
|---|---|---|---|---|---|---|---|---|---|
| NHE ($ in billions) | $2,501.2 | $2,600.0 | $2,700.7 | $2,806.6 | $2,914.7 | $3,093.2 | $3,273.4 | $3,889.1 | $5,008.8 |
| Health consumption expenditures | 2,355.1 | 2,450.8 | 2,547.2 | 2,648.4 | 2,753.1 | 2,923.1 | 3,094.4 | 3,674.6 | 4,735.6 |
| Out of pocket | 293.3 | 299.4 | 307.7 | 320.2 | 329.0 | 324.1 | 333.7 | 371.2 | 458.1 |
| Health insurance | 1,801.1 | 1,879.4 | 1,960.1 | 2,035.2 | 2,117.4 | 2,281.9 | 2,429.0 | 2,909.2 | 3,789.9 |
| Private health insurance | 835.0 | 863.7 | 896.3 | 930.6 | 962.2 | 1,035.9 | 1,099.9 | 1,287.4 | 1,636.5 |
| Medicare | 500.4 | 522.0 | 554.3 | 579.9 | 604.2 | 635.1 | 669.3 | 827.6 | 1,122.9 |
| Medicaid | 375.4 | 397.7 | 407.7 | 416.8 | 436.6 | 490.0 | 530.7 | 647.1 | 839.2 |
| Federal | 248.1 | 267.2 | 248.2 | 232.9 | 249.0 | 291.9 | 320.3 | 390.2 | 499.1 |
| State and local | 127.3 | 130.5 | 159.5 | 183.9 | 187.6 | 198.1 | 210.5 | 256.9 | 340.1 |
| Other health insurance programs[a] | 90.2 | 96.0 | 101.8 | 107.9 | 114.5 | 120.9 | 129.1 | 147.2 | 191.3 |
| Other third-party payers and programs and public health activity[b] | 406.8 | 421.1 | 433.0 | 451.2 | 468.3 | 487.2 | 510.7 | 608.7 | 760.8 |
| Investment | 146.1 | 149.1 | 153.5 | 158.3 | 161.5 | 170.0 | 179.0 | 214.5 | 273.2 |

| Average annual growth from prior year shown | 2000–09 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2018 | 2022 |
|---|---|---|---|---|---|---|---|---|---|
| NHE | 6.9% | 3.9% | 3.9% | 3.9% | 3.8% | 6.1% | 5.8% | 5.9% | 6.5% |
| Health consumption expenditures | 6.9 | 4.1 | 3.9 | 4.0 | 4.0 | 6.2 | 5.9 | 5.9 | 6.5 |
| Out of pocket | 4.2 | 2.1 | 2.8 | 4.1 | 2.7 | −1.5 | 3.0 | 3.6 | 5.4 |
| Health insurance | 7.7 | 4.4 | 4.3 | 3.8 | 4.0 | 7.8 | 6.4 | 6.2 | 6.8 |
| Private health insurance | 6.9 | 3.4 | 3.8 | 3.8 | 3.4 | 7.7 | 6.2 | 5.4 | 6.2 |
| Medicare | 9.3 | 4.3 | 6.2 | 4.6 | 4.2 | 5.1 | 5.4 | 7.3 | 7.9 |
| Medicaid | 7.2 | 5.9 | 2.5 | 2.2 | 4.8 | 12.2 | 8.3 | 6.8 | 6.7 |
| Federal | 8.7 | 7.7 | −7.1 | −6.2 | 6.9 | 17.2 | 9.7 | 6.8 | 6.4 |
| State and local | 4.8 | 2.5 | 22.2 | 15.3 | 2.0 | 5.6 | 6.2 | 6.9 | 7.3 |
| Other health insurance programs[a] | 10.8 | 6.4 | 6.0 | 6.0 | 6.1 | 5.6 | 6.8 | 4.5 | 6.8 |
| Other third-party payers and programs and public health activity[b] | 5.3 | 3.5 | 2.8 | 4.2 | 3.8 | 4.0 | 4.8 | 6.0 | 5.7 |
| Investment | 5.9 | 2.1 | 2.9 | 3.1 | 2.1 | 5.3 | 5.3 | 6.2 | 6.2 |

**SOURCE** Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Numbers may not add to totals because of rounding. Percentage changes are calculated from unrounded data. Data from 2012 to 2022 are projections. [a]Includes Children's Health Insurance Program (Titles XIX and XXI), Department of Defense, and Department of Veterans Affairs. [b]Includes worksite health care, other private revenues, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, other federal programs, Substance Abuse and Mental Health Services Administration, other state and local programs, and school health.

able to increased costs per enrollee, associated with beneficiaries who are relatively more expensive because of their age and disability level, and with increased supplemental payments to providers.

Total Medicaid spending is projected to increase 12.2 percent in 2014, for a total of $490.0 billion. Enrollment is projected to increase by 8.7 million, nearly all as a result of the Affordable Care Act's expansion of coverage. The June 2012 Supreme Court ruling that states would not lose federal funding for their existing Medicaid programs if they did not implement the eligibility expansion under health reform has reduced the projected growth in Medicaid enrollees and associated spending, relative to previous projections.[1,21] Per enrollee Medicaid spending is projected to decline by 2.8 percent in 2014, because most of the enrollees who take advantage of increased coverage options will be nondisabled children and younger and nondisabled adults, who tend to require fewer interventions than older and disabled enrollees.

The coverage expansions in the Affordable Care Act are expected to continue to significantly affect Medicaid enrollment growth trends in 2015 and 2016. Because some states are expected to expand their Medicaid programs after 2014, an additional 8.8 million people are expected to enroll in Medicaid by 2016. Medicaid spending is

expected to grow by 7.9 percent on average in 2015 and 2016. Anticipated Medicaid enrollment growth after 2016 is expected to decelerate significantly and stabilize at closer to historic rates. However, projected Medicaid spending growth is expected to slow less rapidly, to about 6.6 percent. This pattern is primarily influenced by elderly and disabled Medicaid beneficiaries. As the general population ages, these beneficiaries will constitute an increasing proportion of Medicaid enrollees and use relatively more expensive services, such as long-term care.

**PRIVATE HEALTH INSURANCE** Spending for total private health insurance premiums is estimated to have grown by 3.8 percent in 2012—the same rate as in 2011—and to have accounted for $930.6 billion in health spending in 2012 (Exhibit 5). Projected private health insurance enrollment remained unchanged from 2011 (187.3 million enrollees) because of the slow employment recovery. Growth in underlying private health insurance benefits is estimated to have been 3.5 percent (down from 3.8 percent in 2011), for a total of $813.9 billion in 2012. Slow growth in the use of covered health care services is attributed to ongoing increases in plan cost sharing, the decline in prescription drug spending, and continued restraint in the use of physician office visits.[2] Continuing this trend, projected private health insurance spending growth in 2013 slows to 3.4 percent.

In 2014 growth in private health insurance spending is expected to accelerate to 7.7 percent. The higher rate of growth is influenced by an estimated 2.9 million people's obtaining coverage, principally via the Marketplace plans. Improved coverage for those who currently have individually purchased insurance is also expected to influence higher spending growth. On a per enrollee basis, growth in private health insurance premiums is expected to accelerate to 6.0 percent, up from 3.2 percent in 2013.

This acceleration is driven by expected increases in utilization for those covered through the Marketplaces. For these people, the availability of new, or potentially more generous, coverage through the Affordable Care Act's coverage expansion—as well as the presence of premium and cost-sharing subsidies that partially offset the cost of care—is expected to lead to increased spending relative to their current status. These increases are mostly associated with spending on prescription drugs and physician and clinical services.

Private health insurance spending growth is expected to remain somewhat elevated in 2015, at 6.2 percent, primarily as a result of continued enrollment by the newly insured in Marketplace plans. The remainder of the projection period is influenced by faster economic growth, which drives the projected increases in private health insurance enrollment and in the use of services and goods. For 2016–22 the effects of improved economic conditions are expected to result in average private health insurance spending growth of 5.8 percent per year, which exceeds the average growth estimated for 2012 and 2013 (3.6 percent per year).

However, some of the faster projected growth in private health insurance spending is dampened slightly by other factors during the period. For example, some employers of low-wage workers may stop offering health insurance, which could result in many of their employees' gaining coverage through the Marketplaces or becoming uninsured. In addition, the excise tax on high-cost employer-based insurance plans that will take effect in 2018 is expected to slightly inhibit growth in private health insurance premiums.

**OUT-OF-POCKET SPENDING** In 2012 out-of-pocket spending is estimated to have reached $320.2 billion, growing at a rate of 4.1 percent compared to 2.8 percent in 2011 (Exhibit 5).[22] This represents the highest growth rate since the recession began in 2007. However, modest income growth and changes in cost-sharing requirements for the insured (which tend to discourage people from using covered services) have kept estimated spending growth relatively low.[2] For 2013 these factors continue to affect out-of-pocket spending, which is projected to grow at 2.7 percent.

In 2014 out-of-pocket spending is projected to decline by 1.5 percent, largely as a result of expanded insurance coverage through Medicaid and the Marketplaces. In addition, plan cost-sharing provisions will be subsidized for those covered through Marketplace plans if their family income is at or below 250 percent of the federal poverty level.

The continued impact of the insurance expansion is expected to keep out-of-pocket spending growth low in 2015, at 3.0 percent. For the remainder of the projection period, growth in out-of-pocket spending is expected to accelerate, primarily because of the projected faster growth in disposable personal income that is associated with the increased use of health care goods and services. As a result, growth in out-of-pocket expenses is expected to increase to a projection period high of 5.6 percent by 2020. However, by 2022 the share of total health spending attributable to out-of-pocket spending falls to 9.1 percent, down from 11.4 percent in 2012, in part because of expanded coverage under the Affordable Care Act.

## Outlook By Sponsor

For 2012 health care spending sponsored (or financed) by federal, state, and local governments is estimated to have reached $1.3 trillion and to have grown 3.2 percent, down from 4.5 percent in 2011 (Exhibits 6 and 7). Estimated federal spending declined 0.3 percent in 2012, while state and local spending grew 8.8 percent. These diverging public trends are primarily attributable to decreased federal funding of state Medicaid programs.[1] Reflecting growth trends in private health insurance and out-of-pocket spending, outlays by businesses, households, and other private sources are estimated to have risen by 4.5 percent, compared to 3.4 percent in 2011, and to have reached $1.6 trillion in 2012.

For 2013 the divergent spending trends among government sponsors are expected to continue, in part reflecting the stabilizing of Medicaid's Federal Medical Assistance Percentage rates at levels consistent with regular rates, after falling in 2012.[1]

As the major coverage expansions of the Affordable Care Act are implemented in 2014, health care financing is projected to shift further

**EXHIBIT 6**

**National Health Expenditures (NHE) Amounts, By Type Of Sponsor, Selected Calendar Years 2009–22**

| Type of sponsor | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2018 | 2022 |
|---|---|---|---|---|---|---|---|---|---|
| NHE ($ in billions) | $2,501.2 | $2,600.0 | $2,700.7 | $2,806.6 | $2,914.7 | $3,093.2 | $3,273.4 | $3,889.1 | $5,008.8 |
| Business, households, and other private | 1,407.9 | 1,437.5 | 1,485.9 | 1,553.2 | 1,606.8 | 1,648.2 | 1,736.1 | 2,025.0 | 2,560.6 |
| Private business | 533.0 | 534.9 | 557.6 | 577.6 | 596.9 | 623.6 | 659.7 | 752.2 | 950.3 |
| Employer contributions to private health insurance premiums[a] | 415.2 | 416.8 | 435.5 | 452.8 | 470.0 | 492.5 | 522.7 | 590.7 | 753.6 |
| Other[b] | 117.8 | 118.2 | 122.1 | 124.8 | 126.9 | 131.1 | 137.0 | 161.5 | 196.8 |
| Household | 707.2 | 728.7 | 748.8 | 782.7 | 807.6 | 813.3 | 855.0 | 1,006.3 | 1,273.7 |
| Household private health insurance premiums[c] | 258.2 | 267.9 | 272.7 | 286.3 | 296.8 | 292.3 | 308.0 | 368.8 | 468.8 |
| Medicare payroll taxes and premiums[d] | 155.7 | 161.4 | 168.4 | 176.2 | 181.8 | 196.9 | 213.3 | 266.2 | 346.7 |
| Out-of-pocket health spending | 293.3 | 299.4 | 307.7 | 320.2 | 329.0 | 324.1 | 333.7 | 371.2 | 458.1 |
| Other private revenues[e] | 167.7 | 173.9 | 179.5 | 192.8 | 202.3 | 211.3 | 221.4 | 266.5 | 336.6 |
| Government | 1,093.3 | 1,162.4 | 1,214.9 | 1,253.5 | 1,307.9 | 1,445.0 | 1,537.3 | 1,864.1 | 2,448.2 |
| Federal government | 684.2 | 735.2 | 744.6 | 742.1 | 779.2 | 886.8 | 947.0 | 1,162.2 | 1,549.0 |
| Employer contributions to private health insurance premiums | 26.8 | 28.5 | 30.8 | 31.8 | 32.5 | 33.4 | 34.5 | 38.4 | 46.9 |
| Employer payroll taxes paid to Medicare Hospital Insurance trust fund | 3.9 | 4.1 | 4.2 | 4.2 | 4.2 | 4.4 | 4.5 | 5.2 | 6.1 |
| Medicare[f] | 236.6 | 252.0 | 269.2 | 282.5 | 295.7 | 304.1 | 312.3 | 386.5 | 559.7 |
| Medicaid[g] | 255.9 | 276.4 | 257.1 | 240.4 | 256.4 | 299.4 | 328.3 | 399.9 | 512.6 |
| Other programs[h] | 161.1 | 174.2 | 183.4 | 183.3 | 190.4 | 245.5 | 267.4 | 332.1 | 423.7 |
| State and local government | 409.1 | 427.2 | 470.2 | 511.4 | 528.6 | 558.1 | 590.3 | 701.9 | 899.1 |
| Employer contributions to private health insurance premiums[a] | 128.9 | 144.0 | 148.4 | 156.0 | 160.4 | 166.1 | 172.9 | 197.6 | 250.8 |
| Employer payroll taxes paid to Medicare Hospital Insurance trust fund | 11.2 | 11.3 | 11.3 | 11.5 | 11.8 | 12.4 | 13.1 | 15.8 | 19.3 |
| Medicaid | 130.8 | 134.6 | 164.8 | 189.3 | 193.0 | 203.9 | 216.5 | 264.2 | 350.2 |
| Other programs[i] | 138.1 | 137.4 | 145.7 | 154.6 | 163.4 | 175.9 | 187.8 | 224.3 | 278.8 |

**SOURCE** Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTE** Numbers may not add to totals because of rounding. [a]Includes premiums paid on behalf of employees. [b]Includes employer Medicare Hospital Insurance payroll taxes, one-half self-employment payroll taxes, temporary disability insurance, workers' compensation, and worksite health care. [c]Includes household contributions to employer-sponsored health insurance, health insurance purchased through the Health Insurance Marketplaces, and other private health insurance. [d]Includes employee and self-employment payroll taxes and premiums paid to Medicare Hospital Insurance and Supplementary Medical Insurance trust funds. [e]Includes health-related philanthropic support, nonoperating revenue, investment income, and privately funded structures and equipment. [f]Includes trust fund interest income, federal general revenue contributions to Medicare less the net change in the trust fund balance, and payments for the Retiree Drug Subsidy. Excludes Medicare Hospital Insurance trust fund payroll taxes and premiums, Medicare Supplementary Medical Insurance premiums, state phase-down payments, Medicaid buy-ins, and taxation of benefits. [g]Includes Medicaid buy-ins for Medicare premiums for dual eligibles. [h]Includes maternal and child health, Children's Health Insurance Program (Titles XIX and XXI), vocational rehabilitation, Substance Abuse and Mental Health Services Administration, Indian Health Service, workers' compensation, other federal programs, public health activities, Department of Defense, Department of Veterans Affairs, research, structures and equipment, and exchange premium and cost-sharing subsidies. [i]Includes state phase-down payments, maternal and child health, public and general assistance, Children's Health Insurance Program (Titles XIX and XXI), vocational rehabilitation, other state and local programs, public health activities, research, and structures and equipment.

**EXHIBIT 7**

**National Health Expenditures (NHE), Average Annual Growth From Previous Year Shown, By Type Of Sponsor, Selected Calendar Years 2000–22**

| Type of sponsor | 2000–09 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2018 | 2022 |
|---|---|---|---|---|---|---|---|---|---|
| NHE | 6.9% | 3.9% | 3.9% | 3.9% | 3.8% | 6.1% | 5.8% | 5.9% | 6.5% |
| Business, households, and other private | 5.3 | 2.1 | 3.4 | 4.5 | 3.5 | 2.6 | 5.3 | 5.3 | 6.0 |
| Private business | 4.9 | 0.4 | 4.2 | 3.6 | 3.3 | 4.5 | 5.8 | 4.5 | 6.0 |
| Employer contributions to private health insurance premiums[a] | 5.6 | 0.4 | 4.5 | 4.0 | 3.8 | 4.8 | 6.1 | 4.2 | 6.3 |
| Other[b] | 2.9 | 0.3 | 3.3 | 2.2 | 1.7 | 3.3 | 4.5 | 5.6 | 5.1 |
| Household | 5.6 | 3.0 | 2.8 | 4.5 | 3.2 | 0.7 | 5.1 | 5.6 | 6.1 |
| Household private health insurance premiums[c] | 7.6 | 3.8 | 1.8 | 5.0 | 3.7 | −1.5 | 5.4 | 6.2 | 6.2 |
| Medicare payroll taxes and premiums[d] | 5.2 | 3.7 | 4.3 | 4.6 | 3.2 | 8.3 | 8.3 | 7.7 | 6.8 |
| Out-of-pocket health spending | 4.2 | 2.1 | 2.8 | 4.1 | 2.7 | −1.5 | 3.0 | 3.6 | 5.4 |
| Other private revenues[e] | 5.0 | 3.7 | 3.2 | 7.4 | 4.9 | 4.5 | 4.8 | 6.4 | 6.0 |
| Government | 9.3 | 6.3 | 4.5 | 3.2 | 4.3 | 10.5 | 6.4 | 6.6 | 7.1 |
| Federal government | 11.3 | 7.5 | 1.3 | −0.3 | 5.0 | 13.8 | 6.8 | 7.1 | 7.4 |
| Employer contributions to private health insurance premiums | 7.2 | 6.3 | 8.0 | 3.3 | 2.4 | 2.8 | 3.3 | 3.6 | 5.1 |
| Employer payroll taxes paid to Medicare Hospital Insurance trust fund | 4.4 | 6.0 | 0.5 | 0.1 | 0.9 | 3.9 | 4.2 | 4.4 | 4.1 |
| Medicare[f] | 19.1 | 6.5 | 6.8 | 4.9 | 4.7 | 2.9 | 2.7 | 7.4 | 9.7 |
| Medicaid[g] | 8.8 | 8.0 | −7.0 | −6.5 | 6.7 | 16.8 | 9.6 | 6.8 | 6.4 |
| Other programs[h] | 8.7 | 8.2 | 5.3 | −0.1 | 3.9 | 28.9 | 8.9 | 7.5 | 6.3 |
| State and local government | 6.7 | 4.4 | 10.1 | 8.8 | 3.4 | 5.6 | 5.8 | 5.9 | 6.4 |
| Employer contributions to private health insurance premiums[a] | 9.5 | 11.7 | 3.1 | 5.1 | 2.8 | 3.5 | 4.1 | 4.6 | 6.1 |
| Employer payroll taxes paid to Medicare Hospital Insurance trust fund | 4.6 | 0.4 | 0.1 | 1.4 | 3.2 | 4.4 | 5.9 | 6.5 | 5.1 |
| Medicaid | 4.9 | 2.9 | 22.5 | 14.9 | 2.0 | 5.6 | 6.2 | 6.9 | 7.3 |
| Other programs[i] | 6.6 | −0.5 | 6.1 | 6.1 | 5.7 | 7.6 | 6.8 | 6.1 | 5.6 |

**SOURCE** Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Numbers may not add to totals because of rounding. Percentage changes are calculated from unrounded data. [a]Includes premiums paid on behalf of employees. [b]Includes employer Medicare Hospital Insurance payroll taxes, one-half self-employment payroll taxes, temporary disability insurance, workers' compensation, and worksite health care. [c]Includes household contributions to employer-sponsored health insurance, health insurance purchased through the Health Insurance Marketplaces, and other private health insurance. [d]Includes employee and self-employment payroll taxes and premiums paid to Medicare Hospital Insurance and Supplementary Medical Insurance trust funds. [e]Includes health-related philanthropic support, nonoperating revenue, investment income, and privately funded structures and equipment. [f]Includes trust fund interest income, federal general revenue contributions to Medicare less the net change in the trust fund balance, and payments for the Retiree Drug Subsidy. Excludes Medicare Hospital Insurance trust fund payroll taxes and premiums, Medicare Supplementary Medical Insurance premiums, state phase-down payments, Medicaid buy-ins, and taxation of benefits. [g]Includes Medicaid buy-ins for Medicare premiums for dual eligibles. [h]Includes maternal and child health, Children's Health Insurance Program (Titles XIX and XXI), vocational rehabilitation, Substance Abuse and Mental Health Services Administration, Indian Health Service, workers' compensation, other federal programs, public health activities, Department of Defense, Department of Veterans Affairs, research, structures and equipment, and exchange premium and cost-sharing subsidies. [i]Includes state phase-down payments, maternal and child health, public and general assistance, Children's Health Insurance Program (Titles XIX and XXI), vocational rehabilitation, other state and local programs, public health activities, research, and structures and equipment.

toward the federal government. This reflects the enactment of both premium 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.[1] Health care spending sponsored by the federal government is projected to increase 13.8 percent in 2014, contributing to a nearly two-percentage-point rise in the government's share of total health spending, to 47 percent. Expected net lower out-of-pocket spending for those who gain coverage will influence a corresponding household sponsorship decline to 26 percent in 2014, down from 28 percent in 2013.[17]

By 2022 health spending financed by federal, state, and local governments is projected to account for 49 percent of national health spending and to reach a total of $2.4 trillion. Increases in the federal government's share are largely attributable to expanded Medicaid eligibility, premium and cost-sharing subsidies for coverage through Marketplace plans, and growth in Medicare enrollment as baby boomers continue to enter the program.

## Conclusion

National health spending is projected to continue to grow at slow rates through 2013. This trend is influenced by the lingering effects of the economic downturn and sluggish recovery, including limited growth in private health insurance enrollment and continued increases in cost-

sharing provisions in private insurance plans. In addition, constrained federal and state budgets are also expected to contribute to slow growth in national health spending through 2013.

For the period 2014–22, national health spending is projected to rebound to growth rates observed prior to the recession, although growth will still be slower than that experienced over the longer term. This rebound in growth is based on improving economic conditions, coverage expansions in the Affordable Care Act, and the aging of the baby-boom generation. ■

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## NOTES


1 Truffer CJ, Klemm JD, Wolfe CJ, Rennie KE, Shuff JF. 2012 actuarial report on the financial outlook for Medicaid [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; 2013 Mar 1 [cited 2013 Aug 19]. Available from: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2012.pdf

2 Mercer. Employers held health benefit cost growth to 4.1% in 2012, the smallest increase in 15 years [Internet]. New York (NY): Mercer; 2012 Nov 14 [cited 2013 Aug 19]. Available from: http://www.mercer.com/press-releases/1491670

3 Berkrot B. Analysis: ahead of reform, medical care slowdown hits companies. Reuters [serial on the Internet]. 2013 Apr 22 [cited 2013 Jun 19]. Available from: http://www.reuters.com/article/2013/04/22/us-usa-healthcare-slowdown-idUSBRE93L04620130422

4 IMS Institute for Healthcare Informatics. Declining medicine use and costs: for better or worse? Danbury (CT): The Institute; 2013 May.

5 Andrews M. Large companies are increasingly offering workers only high deductible health plans. Kaiser Health News [serial on the Internet]. 2013 Mar 26 [cited 2013 Aug 19]. Available from: http://www.kaiserhealthnews.org/Features/Insuring-Your-Health/2013/032613-Michelle-Andrews-on-high-deductible-plans-and-large-employers.aspx

6 Under the current-law scenario, national health spending growth is projected to be 5.6 percent in 2014. The current-law scenario reflects the impact of an estimated physician payment rate reduction of 24.7 percent, effective January 1, 2014.

7 HealthCare.gov. What is the Health Insurance Marketplace? [Internet]. Washington (DC): Department of Health and Human Services; [cited 2013 Sep 10]. Available from: https://www.healthcare.gov/what-is-the-health-insurance-marketplace/

8 Kaiser Family Foundation. A profile of health insurance exchange enrollees [Internet]. Menlo Park (CA): KFF; 2011 Mar [cited 2013 Aug 19]. Available from: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8147.pdf

9 Freeman JD, Kadiyala S, Bell JF, Martin DP. The causal effect of health insurance on utilization and outcomes in adults: a systematic review of US studies. Med Care. 2008; 46(10):1023–32.

10 Iglehart JK. Are "unsustainable trends" finally coming to a stop? Health Aff (Millwood). 2013; 32(5):830.

11 Centers for Medicare and Medicaid Services. Projections of national health expenditures: methodology and model specification [Internet]. Baltimore (MD): CMS; 2011 Jul 28 [cited 2012 May 17]. Available from: http://www.cms.gov/NationalHealthExpendData/downloads/projections-methodology.pdf

12 Boards of Trustees. 2013 annual report of the boards of trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds [Internet]. Baltimore (MD): CMS; 2013 May 31 [cited 2013 Jun 18]. Available from: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2013.pdf

13 These projections incorporate estimates of GDP as of June 2013 and do not reflect the comprehensive revisions to GDP that were released in July 2013.

14 Carey MA. Employers to get an extra year to implement health law requirement on coverage. Kaiser Health News [serial on the Internet]. 2013 Jul 2 [cited 2013 Aug 19]. Available from: http://www.kaiserhealthnews.org/Stories/2013/July/02/employer-mandate-delayed.aspx

15 The full effects from a 24.7 percent reduction in physician reimbursement are difficult to predict. No secondary effects of the reduction in physician payment rates are modeled in these projections.

16 Centers for Medicare and Medicaid Services. Projected Medicare expenditures under illustrative scenarios with alternative payment updates to Medicare providers. [Internet]. Baltimore (MD): CMS, 2013 May 31. [cited 2013 Jun 18]. Available from http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2013TRAlternativeScenario.pdf

17 Foster RS. Estimated financial effects of the "Patient Protection and Affordable Care Act," as amended [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; 2010 Apr 22 [cited 2013 Jun 24]. Available from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PPACA_2010-04-22.pdf

18 Authors' analysis of Producer Price Index data for North American Industry Classification Codes 6211 and 6215 as of May 2013. See Bureau of Labor Statistics. Producer Price Indexes [Internet]. Washington (DC): BLS; [cited 2013 Jun 19]. Available from: http://www.bls.gov/ppi/

19 Express Scripts. Drug trend report [Internet]. St. Louis (MO): Express Scripts; 2013 Aug [cited 2013 Sep 10]. Available from: http://www.drugtrendreport.com/docs/downloads/Commercial.pdf

20 For more information, see Table V.B2 in the 2013 trustees report (Note 12).

21 Some states may decide not to expand eligibility for Medicaid, and the projections in this article reflect that possibility. This is an issue of particular uncertainty, since a number of states have not declared their intentions at this time.

22 Out-of-pocket spending consists of direct spending by consumers for health care goods and services, including copayments and deductibles. Enrollee premiums for private health insurance and Medicare are not included in out-of-pocket spending.