

ACA Implementation—Monitoring and Tracking

The Widespread Slowdown in Health Spending Growth

Implications for Future Spending Projections
and the Cost of the Affordable Care Act

April 2015

John Holahan and Stacey McMorro


Robert Wood Johnson
Foundation


URBAN
INSTITUTE

With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010 (ACA). The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at www.rwjf.org and www.healthpolicycenter.org. The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access and premiums in the states and nationally.

SUMMARY

A recent report from the Congressional Budget Office (CBO) showed another substantial reduction in projected federal spending on the Affordable Care Act (ACA). With these projections now 25 percent lower than CBO's initial ACA estimate for the period 2014-19, there has been renewed attention to the ongoing slowdown in health spending growth. In this paper, we examine the annual health spending projections from the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary from February 2010, just prior to enactment of the ACA, through October 2014. Unlike CBO estimates, which are limited to federal spending, the CMS projections include spending by all public and private payers. We consider how the CMS projections have changed since 2010 and examine the factors that have contributed to these changes, particularly the potential role of the ACA in the altered trajectory of national health spending.

In September 2010, CMS first incorporated the provisions of the ACA into its forecast, and predicted that national health expenditures would increase by \$577 billion over the 2014-2019 period compared to the pre-ACA baseline (Table 1). This included the costs of public and private coverage expansions, less the reductions in Medicare and Medicaid payments. In October 2014, the current forecast suggested that national health expenditures will be \$2.5 trillion less over the 2014-2019 period than under the ACA baseline forecast from September 2010. Over the 2014-2019 period, Medicare spending is now expected to be

lower by \$384 billion, Medicaid by \$927 billion, and private health insurance expenditures by \$688 billion compared to the September 2010 ACA baseline. Clearly, not all of the spending reduction is due to the ACA; much is due to the recent recession and a long period of slow income growth, the growth of high deductible private health plans, cost constraints within state Medicaid programs, and Medicare policies unrelated to the ACA (e.g. sequestration).

But it is also likely that the law contributed; though how much is impossible to estimate. The ACA reduced Medicare payments, established a managed care competition framework in the marketplaces, and imposes an excise tax on high cost health plans beginning in 2018. While the estimated impacts of these provisions on spending were incorporated in the ACA baseline and later forecasts, other effects of the ACA may have contributed to the reduction in projected spending, but have not been attributed as such. These include the impact of Medicare payment adjustments on utilization of a wide variety of services, the spillover effects of Medicare payment policies on private payers, and lower than expected premiums in marketplaces due to strong competition and intense negotiations over provider payment rates. Thus, while the exact impact of the ACA cannot be determined, it is clear that the nation has successfully expanded coverage and is now expected to spend considerably less than anticipated even before the law was enacted.

Table 1. Cumulative Spending Projections for 2014-2019

	Pre-ACA Baseline	ACA Baseline	Current Forecast	Original Estimated Impact of ACA for 2014-2019		Current Forecast (2014-2019) Relative to Pre-ACA Baseline		Current Forecast (2014-2019) Relative to ACA Baseline	
	A	B	C	B-A	% change	C-A	% change	C-B	% change
	(in \$ billions)								
National Health Expenditures	22973	23550	21012	577	2.5%	-1961	-8.5%	-2538	-10.8%
Medicare	4863	4554	4170	-309	-6.4%	-693	-14.3%	-384	-8.4%
Medicaid	4003	4567	3640	564	14.1%	-363	-9.1%	-927	-20.3%
Private Health Insurance	7102	7694	7006	592	8.3%	-96	-1.3%	-688	-8.9%
Out-of-Pocket	2438	2237	2217	-202	-8.3%	-222	-9.1%	-20	-0.9%
Other	4567	4498	3979	-69	-1.5%	-587	-12.9%	-519	-11.5%

Source: CMS Office of the Actuary.

BACKGROUND

The ACA has been criticized for insufficient attention to cost containment, despite Medicare payment reductions, the managed competition framework in the marketplaces, and the excise tax on high-cost plans.¹ The law was originally forecast to add \$577 billion to national health expenditures (NHE) over the 2014–19 period (from \$23.0 trillion to \$23.6 trillion, or 2.5 percent) (table 1). This included the cost of the coverage expansions, less the savings from reductions in Medicare and Medicaid payments.² Since these initial projections were made in 2010, however, national health spending has grown at historically low rates. From 2009 to 2013, national health spending grew at an average annual rate of 3.9 percent.³ Due to the recent slowdown in spending growth, the current projection of NHE for 2014 to 2019 is \$21.0 trillion which is \$2.5 trillion lower than under the original ACA forecast in 2010. Both forecasts include the projected costs of the ACA coverage expansion.

The extended debate about the reasons for the recent slowdown in health spending growth has coalesced around two schools of thought. The first contends that the recession and sluggish economic recovery are the dominant reasons for the slowdown.^{4,5} This view implies that when the economy rebounds, health expenditure growth will return to previous levels. The second view contends that a range of factors, including but not limited to slow economic growth and low inflation, could have contributed to the slowdown.⁶ Factors other than the economy include the movement of more people from private to public insurance with its

lower provider payment rates, increased use of higher deductibles and coinsurance in commercial health care plans, a shift to narrow network options in private insurance, patent expirations and increased generic substitution for prescription drugs, and reductions in Medicare payment rates as well as other Medicare initiatives, including those affecting hospital readmissions. These factors generally reduce the flow of revenues and may have caused the health system to make more permanent structural changes to reduce costs. Under this second view, in the absence of very rapid economic growth or a return to looser payment policies by public and private insurers, spending growth rates are likely to remain lower than in the past.

Despite considerable attention to the recent slowdown in spending growth, there has been little focus on how this slowdown has changed future projections of national health spending and how it relates to the cost of the ACA. Although both the original and current forecasts of health spending under the ACA include estimates of the direct effects of major ACA policies expected to affect health spending, they do not account for any potential spillover effects of ACA policies to other payers (e.g., Medicare payment policies on private payers) or other supply-side responses to the new health care environment. Thus, it is possible that the ACA has played an unmeasured role in the recent spending slowdown and the lower projected future spending.

In this paper, we examine the annual health spending projections from the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary beginning just prior to the ACA's passage and explore how those projections have changed over the past several years. We examine

the legislative, regulatory, and economic factors that have contributed to changes in the projections over time and consider the potential role of the ACA in the changing trajectory of national health spending.

DATA AND METHODS

We use publicly available reports from the CMS Office of the Actuary beginning with the February 2010 NHE projections prior to the passage of the ACA and followed by projections from September 2010, August 2011, July 2012, October 2013, and October 2014.⁷ CMS updates its projections each year with the most recent information on historic health spending, economic conditions, and legislative and regulatory changes. The February 2010 forecast represents the pre-ACA baseline, and the September 2010 projections are the first to include the effects of the ACA (referred to here as the “ACA baseline”). The 2014 forecast (the “current forecast”) includes updated information on actual health spending through 2012 as well as legislative and other changes since the original ACA forecast.

We examine projections through 2019 as this is the last year for which we have a pre-ACA prediction. We focus

on comparing the current projections for the 2014–19 period to those made just before and just after the passage of the ACA. We examine total NHE as well as Medicare, Medicaid, private health insurance, out-of-pocket (OOP) and other spending. Other spending includes other health insurance programs (Children’s Health Insurance Program, US Department of Defense, Veterans Affairs); other third-party payers such as workers’ compensation, maternal and child health, and school health programs; public health activity; and investment (e.g., noncommercial research, the value of new construction and new capital equipment in the medical sector). All Medicare projections include the cuts to physician payments required under the sustainable growth rate formula and will therefore understate spending levels if and when the cuts are reversed as they have been each year since 2003.

RESULTS

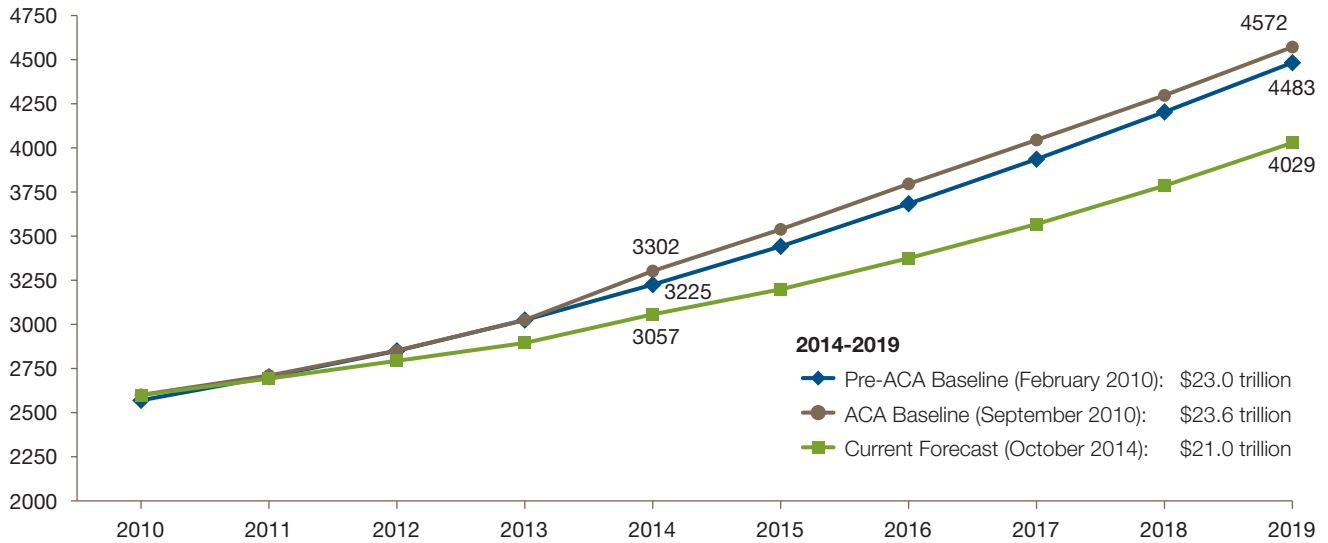
In February 2010, prior to the passage of the ACA, CMS actuaries projected NHE would be \$3.2 trillion in 2014, \$4.5 trillion in 2019, and \$23.0 trillion over the entire 2014–19 period (figure 1). After incorporating estimates of the effects of the ACA, the actuaries increased their projections to \$3.3 trillion in 2014, \$4.6 trillion in 2019, and \$23.6 trillion between 2014 and 2019. Overall, CMS estimated the ACA would increase NHE by \$577 billion—or 2.5 percent—from 2014 to 2019.⁸ New coverage costs in Medicaid and subsidized private insurance plans were offset somewhat by reductions in Medicare payment rates, Medicare and Medicaid disproportionate share hospital payments, and OOP spending. Under the ACA, Medicaid spending was projected to increase by \$564 billion and private health insurance spending by \$592 billion from 2014 to 2019, and Medicare and OOP spending were projected to decrease by \$309 billion and \$202 billion, respectively.

In each subsequent CMS forecast, however, NHE projections were reduced (table 2). In the current forecast, released in October 2014, the spending estimate for 2014 was \$3.1 trillion, the 2019 estimate was \$4.0 trillion, and

the 2014–19 estimate was \$21.0 trillion. For the 2014–19 period, these estimates reflect a decline of \$2.0 trillion compared to the pre-ACA baseline and a decline of \$2.5 trillion compared to the ACA baseline. Medicare spending from 2014 to 2019 is now projected to be \$384 billion less than under the ACA baseline. Similarly, private health insurance and Medicaid spending projections for 2014 to 2019 are lower by \$927 billion and \$688 billion, respectively, than under the ACA baseline (table 1).

Some of these changes can be explained by new legislation and other policy developments (e.g., the Budget Control Act of 2011 and the Supreme Court decision on Medicaid expansion) that have occurred since the ACA baseline forecast in September 2010. But much of the decline in projected spending for the 2014–2019 period seems to be related to the historically low growth in actual health spending that began with the recession in 2008 and has continued to the present. For example, in 2010, health spending growth in 2013 was projected to be a robust 6.1 percent, reflecting the expected economic recovery, but actual health spending growth in 2013 was only 3.6 percent

Figure 1. National Health Expenditure Projections (in \$ billions)



Source: CMS Office of the Actuary. All projections include the cuts to physician reimbursement required by the sustainable growth rate formula.

(table 2). As a result of this slow growth, the NHE estimate for 2014 in the current forecast was \$246 billion less than it had been in the ACA baseline.⁹

Despite NHE growth that has been at or below gross domestic product growth between 2010 and 2013, however, CMS does not continue to project these low growth rates much beyond 2016. Instead, the current forecast assumes that NHE growth will exceed gross domestic product growth by about half a percentage point in 2016 and 2017, by 0.8 of a percentage point in 2018, and by 1.3 percentage points in 2019. By 2019, the growth in national health spending in the current forecast (6.4 percent) is expected to be the same as in the 2010 ACA baseline. Thus, much of the decline in projected spending for the 2014–19 period is due to the lower spending level in 2014 and slower growth from 2014 to 2016, but not to lower growth rates from 2017 to 2019. But the out-year growth rate projections are considerably higher than recent experience and could prove to be too high for reasons we discuss below. If so, NHE spending between 2014 and 2019 will not reach the current projection of \$21.0 trillion.

The economy clearly contributed to the observed slowdown since 2010. Gross domestic product growth from 2010 to 2014 was expected to average 5.6 percent in the ACA baseline but actually fell to 3.8 percent in the current forecast (figure 2). In addition to the economy, other likely contributors to the slowdown in health spending growth include Medicare payment and other quality improvement policies, increased prevalence of higher deductibles and narrow networks in private insurance plans, and continued

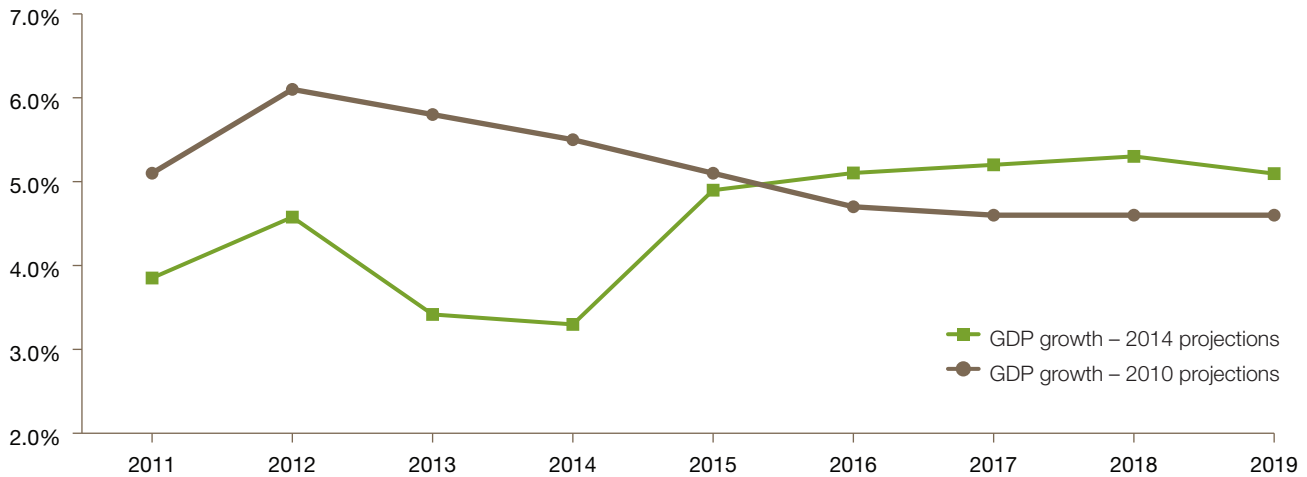
shifts in coverage from employer-sponsored insurance to lower-cost public coverage. The unknown factor, however, is the extent to which the ACA has contributed to the observed slowdown in health spending beyond that incorporated in the ACA baseline.

Both actual and anticipated policy changes under the ACA, including rate reductions and the movement to new payment methods that penalize or shift risk to providers, may have caused private payers to adopt similar policies or have generated cost-cutting responses from providers. If this is true, the observed slowdown in spending growth would not have been as large in the absence of the ACA, and the resulting projections would not have declined so dramatically. To offset the original estimated increase in NHE for the 2014–19 period due to the ACA (\$577 billion), the ACA would have to be responsible for approximately 23 percent of the \$2.5 trillion decline in projected spending from 2014 to 2019, beyond the cost savings explicitly included in the projections. Although we cannot precisely isolate the ACA impact, it is clear that even with a significant expansion of insurance coverage, current NHE projections are \$2.0 trillion less than in the pre-ACA baseline. In the sections that follow we describe some of the observable factors that have contributed to the declining projections since 2010 and consider the extent to which the ACA has also played a role.

Medicare

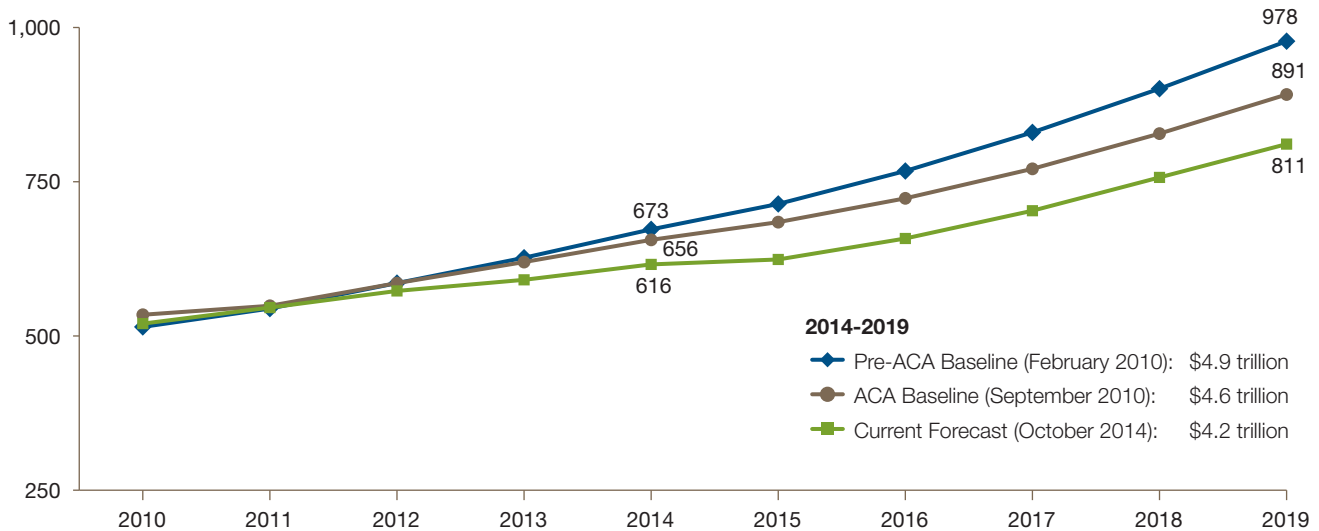
Medicare spending under the ACA was initially forecast to fall by \$309 billion (from \$4.9 trillion to \$4.6 trillion) between 2014 and 2019 compared to the pre-ACA level (figure

Figure 2. Gross Domestic Product (GDP) Annual Growth Rate Projections, 2010-2019



Source: CMS Office of the Actuary. Estimates for 2011-2013 in the 2014 projections are observed GDP growth rates. All others are projections.

Figure 3. Medicare Expenditure Projections (in \$ billions)



Source: CMS Office of the Actuary. All projections include the cuts to physician reimbursement required by the sustainable growth rate formula.

3 and [table 3](#)). This decrease was primarily due to ACA reductions in payments to Medicare Advantage plans and a requirement to reduce the annual payment updates for most institutional providers by the growth in economy-wide multifactor productivity. In the current forecast, Medicare spending is projected to be an additional \$384 billion less between 2014 and 2019 than in the ACA baseline (falling from \$4.6 trillion to \$4.2 trillion).¹⁰ In 2014, Medicare spending is now projected to be \$616 billion, \$40 billion less than in the ACA baseline. This decrease is due to lower than expected growth in Medicare spending from 2010

to 2012 which may reflect unanticipated effects of ACA policies including cuts to Medicare Advantage payments in 2011 and reductions in payments to various providers in 2012. Lower spending in 2014 also reflects the effects of the Budget Control Act of 2011 (i.e., sequestration), which required Medicare payments for all types of services to be reduced by 2 percent beginning in April 2013 ([table 3](#)). The lower rate of spending growth between 2010 and 2014 in the current forecast compared to the ACA baseline is due entirely to lower growth in spending per enrollee. Enrollment growth averages about 3 percent per year in both forecasts,

but growth in spending per enrollee from 2010 to 2014 averaged 2.3 percent in the ACA baseline compared to 1.2 percent in the current forecast (table 4).

Slow growth is expected to continue in 2015 due primarily to the expiration of the Medicare Advantage Quality Bonus Payment Demonstration.¹¹ After 2015, however, CMS assumes that Medicare spending growth for both total spending and spending per enrollee will return to rates similar to those included in the ACA baseline. Thus, the large decline in projected spending from 2014 to 2019 in the current forecast compared to the ACA baseline is primarily a result of slow Medicare spending growth in the early part of the decade and the effects of sequestration. It does not appear that CMS assumes any lasting structural changes have contributed to the recent slowdown in Medicare spending growth, but White and colleagues suggest that unanticipated effects of the ACA have contributed to reduced home health spending, hospital readmissions, and utilization of hospital days, outpatient hospital visits, skilled nursing facility days, and advanced imaging prior to 2014.¹² If these and other effects persist and have not been incorporated in the CMS projections, the estimates of Medicare spending from 2014 to 2019 would be overstated.

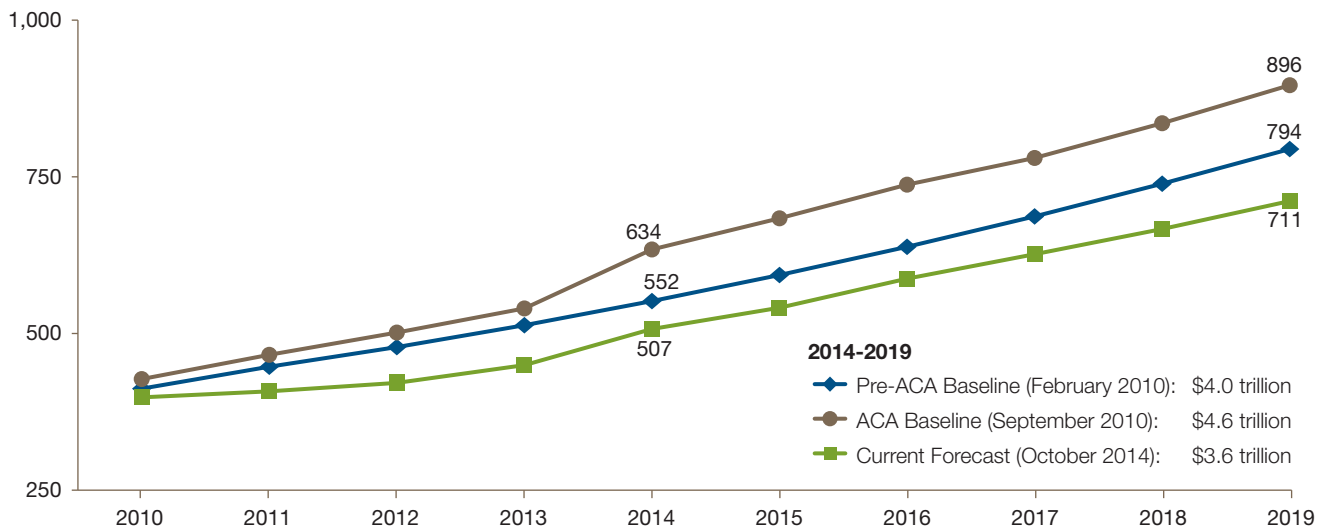
Medicaid

Medicaid spending from 2014 to 2019 under the ACA was originally expected to increase by about \$564 billion (from \$4.0 trillion to \$4.6 trillion) compared to the pre-ACA forecast (figure 4 and table 5). This increase primarily reflects the ACA expansion of Medicaid eligibility to those with

incomes below 138 percent of the federal poverty level. In the current forecast, Medicaid spending is projected to be \$927 billion lower than the original ACA estimate (falling from \$4.6 trillion to \$3.6 trillion). This difference is due in large part to much slower than anticipated spending growth from 2010 to 2012. For example, Medicaid spending grew only 2.4 percent in 2011 compared to the ACA baseline projection of 9.1 percent (table 5). CMS attributes this slow growth to the expiration of enhanced federal match rates in 2011 and state efforts to contain costs.

The Supreme Court decision allowing states to opt out of the ACA Medicaid expansion has also contributed to the drop in projected spending since 2010. The current enrollment estimate for 2014 is about 66 million, compared to approximately 79 million in the ACA baseline, but CMS also assumes continued growth in Medicaid enrollment after 2014 such that for 2019 the current enrollment projection is only 3.3 million less than in the ACA baseline (table 6). This estimate most likely reflects an assumption that many more states will adopt the ACA Medicaid expansion over time. Using the difference in annual enrollment between the current forecast and the ACA baseline and Urban Institute estimates of spending per enrollee for the expansion population, we estimate that the Supreme Court decision reduced projected spending during the 2014–19 period by about \$210 billion (data not shown). Thus, most of the reduction in projected Medicaid spending is not due to lower enrollment, but to lower spending per enrollee. Mainly as a result of the slow growth from 2010 to 2012, spending per enrollee in 2019 is now projected to be \$9,250, compared to \$11,175 in the ACA baseline. But the projected growth in spending per

Figure 4. Medicaid Expenditure Projections (in \$ billions)



Source: CMS Office of the Actuary.

enrollee from 2016 to 2019 is similar to the ACA baseline estimates, which suggests again that CMS does not assume any lasting effects from the slow growth in spending in the early part of the decade.

Private Health Insurance

In the original ACA baseline, private health insurance spending was projected to increase by \$592 billion (from \$7.1 trillion to \$7.7 trillion) for the 2014-2019 period compared to the pre-ACA forecast (figure 5 and [table 7](#)). This increase was due mostly to the ACA expansion of private coverage through federally subsidized exchange plans.¹³ In the most recent forecast, however, private spending is projected to be \$688 billion less than the ACA baseline estimate for the 2014–19 period (falling from \$7.7 trillion to \$7.0 trillion). This difference reflects slower expected spending growth in both the pre- and post-2014 periods ([table 7](#)). In the pre-2014 period, this slower spending growth seems to have been due to slower economic recovery than originally expected and declines in prescription drug spending related to patent expirations and increased generic substitution, as well as a shift toward higher deductibles and cost sharing in private plans. From 2010 to 2014, growth in enrollment and spending per enrollee are both lower in the current forecast than in the ACA baseline ([table 8](#)).

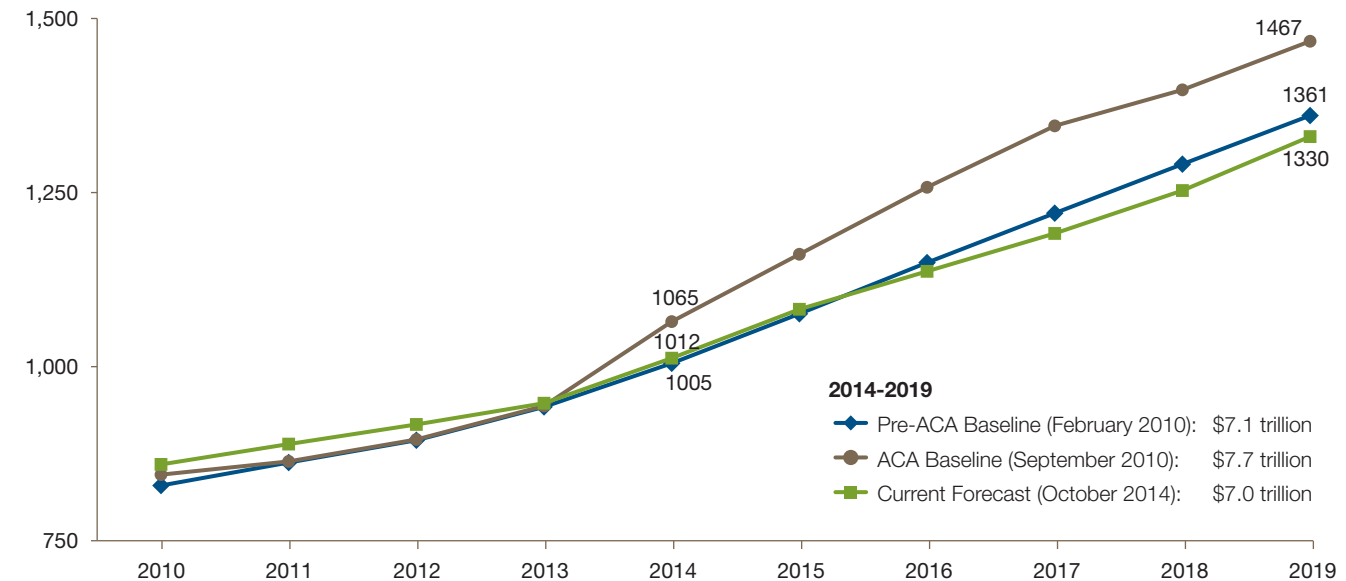
Both total spending and spending per enrollee are currently projected to grow faster beginning in 2014 compared to the pre-2014 period. This faster growth is due to increased enrollment in private health insurance through the exchanges as well as expanded benefits for

those transitioning from the pre-ACA individual market. The continued economic recovery is also expected to spur faster growth in private spending, but this growth is tempered by the excise tax on high-cost plans and an expectation that some employers of low-wage workers will stop offering insurance. Nonetheless, the current projections are considerably lower than those in the ACA baseline. For example, average growth in spending per enrollee from 2014 to 2019 is 4.2 percent in the current forecast compared to 5.7 percent in the ACA baseline. The current estimate includes lower growth rates from 2014 to 2017 compared to the ACA baseline, but higher growth rates in 2018 and 2019 because the expected effect of the excise tax on high cost insurance plans has been reduced. It is not clear whether the forecast has been affected by lower than expected marketplace premiums. Thus, even the current projections may prove too high.

Out-of-Pocket and Other Health Spending

In the ACA baseline, OOP costs during the 2014–19 period were projected to fall by \$202 billion (from \$2.4 trillion to \$2.2 trillion) compared to the pre-ACA forecast (figure 6 and [table 9](#)). This estimated decline was attributed to the coverage expansions under the ACA as well as the provision of additional cost-sharing subsidies to low-income individuals with private coverage through the marketplace. The current forecast predicts that OOP spending from 2014 to 2019 will be \$20 billion lower than the ACA baseline estimate. This change reflects lower growth rates for OOP spending for most of the 2012-17 period ([table 9](#)). The effects of the 2018 excise tax on OOP spending are

Figure 5. Private Health Insurance Expenditure Projections (in \$ billions)



Source: CMS Office of the Actuary.

Figure 6. Out-of-Pocket Expenditure Projections (in \$ billions)

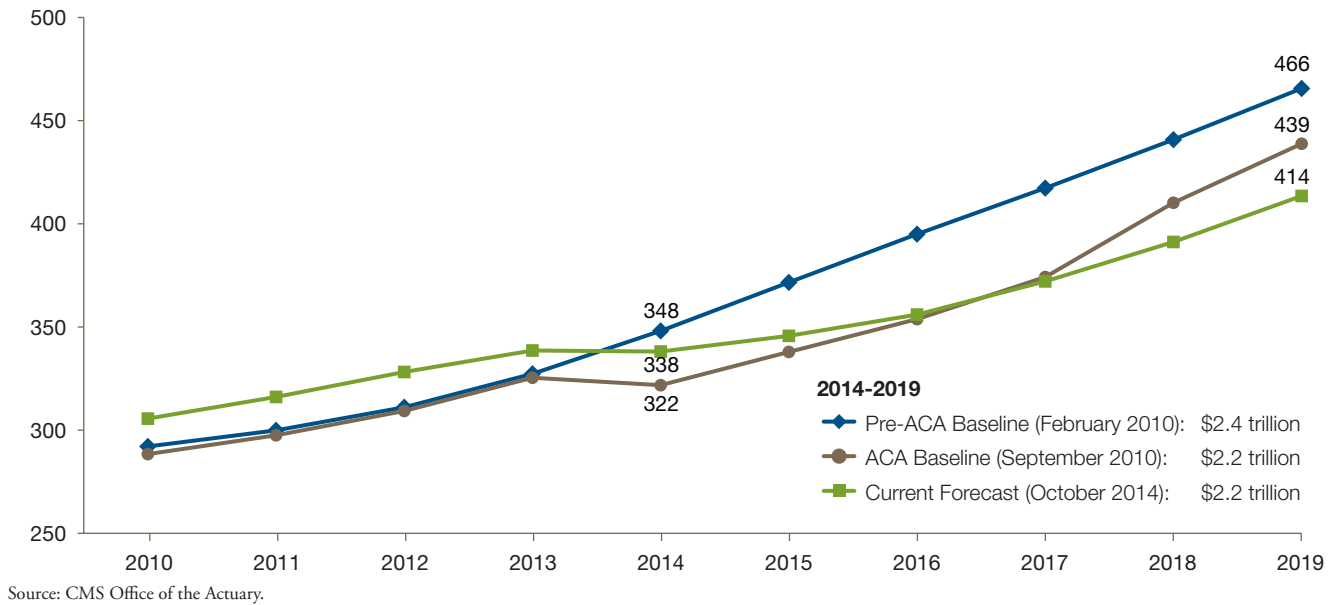
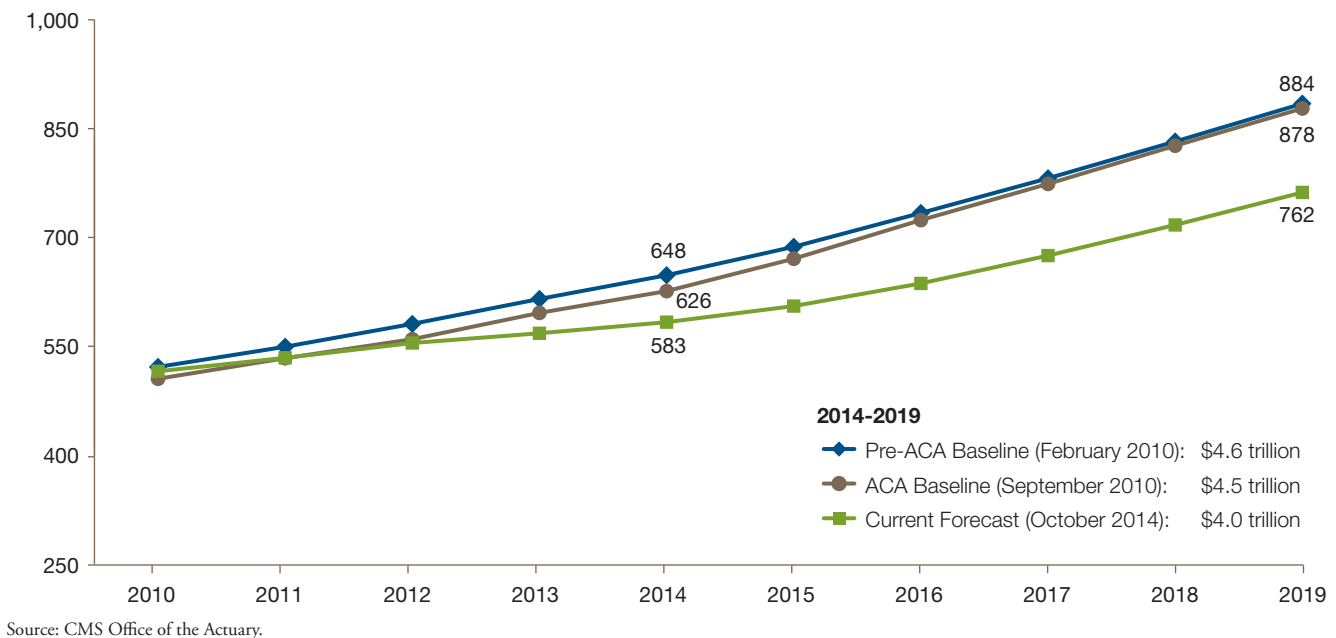


Figure 7. Other Health Expenditure Projections (in \$ billions)



projected to be smaller in the current forecast than in the original ACA baseline. This estimate seems to parallel the projections for private insurance spending, because lower projected private premiums will diminish the effects of the excise tax.

The residual “other” category of NHE consists of spending on a wide range of programs, including the Children’s Health Insurance Program, US Department of Defense and Veterans Affairs health programs, public health

activity, and investments such as new construction and capital equipment in the medical sector. The original ACA forecast predicted a relatively small (\$68 billion) decline from the pre-ACA baseline in other spending during the 2014–19 period; the current forecast projects an additional reduction in other spending of \$519 billion (from \$4.5 trillion to \$4.0 trillion) compared to the ACA baseline, much of which seems to reflect reductions in projected investment spending (figure 7 and table 10).

The slower growth in this category in the current forecast is a significant contributor to the overall decline in the NHE projections for the 2014–19 period. Given the varied components of this spending category, however, it is

difficult to disentangle what might have contributed to the lower projections or whether any of the savings could be attributed to the ACA.

DISCUSSION

The ACA was originally estimated to add \$577 billion to NHE over the 2014–19 period. This included the cost of the coverage expansions (over \$1.1 trillion according to the CMS actuaries) less reductions in Medicare and Medicaid spending. Current projections suggest that NHE will be \$2.5 trillion less than the original ACA estimate for 2014 to 2019. Much of this decrease is due to slower growth in expenditures between 2010 and 2014, but projections for spending growth between 2014 and 2019 are also lower than in the original ACA estimate, particularly for private and OOP spending.

The Congressional Budget Office (CBO) also projects declines in federal expenditures on exchange subsidies, Medicaid and the Children’s Health Insurance Program, and Medicare relative to their original ACA forecast. CBO estimates are limited to the ACA expansion population, both those individuals entering the exchanges or newly enrolled in Medicaid. In 2010, CBO forecast the gross cost of the coverage provisions to be \$921 billion from 2014 to 2019 ([table 11](#)). By March 2015, the forecast had been reduced to \$686 billion, a reduction of 25.5 percent. In its 2010 forecast, CBO projected that exchange subsidies would be \$458 billion over the 2014–19 period. In the most recent forecast, they project \$333 billion, a 27.3 percent reduction. For Medicaid, CBO’s original forecast was \$441 billion in federal expenditures on the ACA expansion population from 2014 to 2019. In 2015, this forecast had been reduced to \$347 billion. Much of this reduction is related to the Supreme Court decision. CBO also projects Medicare spending to be \$443 billion lower during the 2014–19 period than in their original post-ACA forecast.

CMS does not seem to attribute any of the reduction in projected expenditures to the effects of the ACA, though they had incorporated some ACA cost containment provisions into their original projections (e.g., Medicare payment reductions, the excise tax on high-cost plans).¹⁴ But there are several ways in which the ACA could have contributed to the slowdown in spending growth prior to 2014 and thereby to the reduced projections. First, the ACA Medicare payment adjustments that began in 2011 appear to have had a greater impact on utilization than anticipated, with reductions in hospital days, outpatient

hospital visits, skilled nursing facility days, and advanced imaging prior to 2014.¹⁵ Second, lower payment rates in Medicare may have affected payment rates by other payers. Recent research has suggested that payment policy changes by Medicare affect payments by private payers.¹⁶ For example, commercial insurer negotiations over physician payment rates are affected by Medicare rates. Likewise, hospital payment rates by private payers also tend to reflect changes in Medicare payments, and contrary to a theory of cost shifting, private payment rates do not appear to increase in response to cuts in Medicare payments.¹⁷ Third, other Medicare policies under the ACA, including financial penalties for hospital readmissions, may have spilled over to other payers and contributed to slower spending growth. It is unlikely that accountable care organizations, medical homes, and other delivery system reforms have played a significant role in the observed slowdown in spending growth, despite some claims to the contrary.¹⁸ But taken together, the various components of the ACA could have contributed to a cultural shift that has affected provider behavior and, in turn, spending. Finally, the uncertainty associated with the pending implementation of various ACA provisions along with anticipated cost containment efforts by private payers may have caused providers to be more cautious with regard to investments and thereby constrained spending growth.

Components of the ACA not included in the CMS projections could result in even lower future expenditures than in the current forecast. First, premiums in marketplaces are well below expectations (due to strong competition, intense negotiations on provider payment rates, and narrower networks), and these lower premium costs should further mitigate the cost of expanded coverage.¹⁹ Second, if the constraints on Medicare payment rates continue to reduce utilization, the current Medicare projections may be too high. Finally, in markets throughout the country, employers have offered their workers high-deductible and narrow network products that have dampened spending growth, and they are likely to continue shifting their plans in this direction. The net effect is that the \$21.0 trillion estimate of national health spending for the 2014–19 period could be an overestimate.

Of course, other factors suggest the current projections will prove to be an underestimate of future spending. One such factor is the emergence of a new class of specialty pharmaceuticals, such as Sovaldi and Harvoni, which could lead to increased growth in prescription drug spending. Another is a potential backlash, both by consumers and regulatory agencies, against the narrow networks and high deductibles that have helped to hold down spending growth in recent years. Last, many of the factors that have contributed to the decline in spending projections have lowered the level of spending, but history would suggest that sustaining lower growth rates may be more difficult. Thus, if growth rates rebound faster than expected, the current forecast may be optimistic.

To offset the original \$577 billion ACA cost estimate for 2014 to 2019, the ACA would have to be responsible for approximately 23 percent of the \$2.5 trillion decline in projected spending during that period, beyond the ACA cost savings that have already been included in the projections. Although it is impossible to quantify how much the ACA has truly contributed to the reduced spending projections over time, it is clear that NHE levels through 2019 are projected to be substantially lower than the levels forecast just a few years ago and that this decline in projected spending has occurred along with a successful coverage expansion.

ENDNOTES

- Zuckerman S, and Holahan J. *The Affordable Care Act Addresses Health Care Cost Containment*. Washington, DC: Urban Institute, 2012.
- Centers for Medicare and Medicaid Services. *National Health Expenditure Projections 2009–19*, 2010. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/nheprojections2009to2019.pdf>.
- Hartman M, Martin AB, Lassman D, and Catlin A. "National Health Spending in 2013: Growth Slows, Remains in Step with the Overall Economy." *Health Affairs* 34 (1): 150–60, 2014.
- Dranove, D., C. Garthwaite, and C. Ody. "Health Spending Slowdown Is Mostly Due to Economic Factors, not Structural Change in the Health Care Sector." *Health Affairs* 33 (8): 1399–1406, 2014.
- Kaiser Family Foundation. "Assessing the Effects of the Economy on the Recent Slowdown in Health Spending," 2013. <http://kff.org/health-costs/issue-brief/assessing-the-effects-of-the-economy-on-the-recent-slowdown-in-health-spending-2>.
- Chandra A, Holmes J, and Skinner J. *Is This Time Different? The Slowdown in Healthcare Spending*. NBER Working Paper No. 19700. Cambridge, MA: National Bureau of Economic Research, 2013.; Cutler D, and Sahni NR. "If Slow Rate of Health Care Spending Persists, Projections May Be Off by \$770 Billion." *Health Affairs* 32 (5): 841–50, 2013.; Ryu AJ, Gibson TB, McKellar MR, et al. "The Slowdown in Health Care Spending in 2009–11 Reflected Factors Other Than the Weak Economy and Thus May Persist." *Health Affairs* 32 (5): 835–40, 2013.; Holahan J, and McMorrow S. *What Drove the Recent Slowdown in Health Spending Growth and Can It Continue?* Washington, DC: Urban Institute, 2013.; Roehrig C. "What is Behind the Post-Recession Bend in the Health Care Cost Curve?" *Health Affairs Blog*, March 23, 2015. Available at <http://healthaffairs.org/blog/2015/03/23/what-is-behind-the-post-recession-bend-in-the-health-care-cost-curve>.
- Centers for Medicare and Medicaid Services. *National Health Expenditure Data*, 2014. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html>. Truffer CJ, Keehan S, Smith S, et al. "Health Spending Projections Through 2019: The Recession's Impact Continues." *Health Affairs* 29(3): 522–29, 2010.; Sisko AM, Truffer CJ, Keehan SP, et al. "National Health Spending Projections: The Estimated Impact of Reform Through 2019." *Health Affairs* 29(10): 1933–41, 2010.; Keehan SP, Sisko AM, Truffer CJ, et al. "National Health Spending Projections Through 2020: Economic Recovery and Reform Drive Faster Spending Growth." *Health Affairs* 30(8): 1594–1605, 2011.; Keehan SP, Cuckler GA, Sisko AM, et al. "National Health Expenditure Projections: Modest Annual Growth Until Coverage Expands and Economic Growth Accelerates." *Health Affairs* 31(7): 1600–12, 2012.; Cuckler GA, Sisko AM, Keehan SP, et al. "National Health Expenditure Projections, 2012–22: Slow Growth Until Coverage Expands and Economy Improves." *Health Affairs* 32(10): 1820–31, 2013.; Sisko AM, Keehan SP, Cuckler GA, et al. "National Health Expenditure Projections, 2013–23: Faster Growth Expected with Expanded Coverage and Improving Economy." *Health Affairs* 33(10): 1841–50, 2014.
- Although the ACA baseline forecast (September 2010) incorporates a few other policy changes that occurred after the pre-ACA baseline (February 2010), the difference between the two sets of projections is almost entirely due to the ACA.
- The current forecast was released at the end of 2014, but it is based on actual data through 2012. Thus, the 2013 and 2014 estimates are projections.
- Because the ACA baseline forecast included the cuts to physician payments required under the sustainable growth rate (SGR) formula, we use a version of the current forecast that also includes the SGR cuts. If the SGR cuts were not included in the current forecast, Medicare spending for the 2014–19 period would increase by \$57 billion.
- The 2015 estimate also includes the 21.2 percent reduction in physician payments required by the SGR formula.
- White C, Cubanski J, and Neuman T. *How Much of the Medicare Spending Slowdown Can Be Explained? Insights and Analysis from 2014*. Menlo Park, CA: Kaiser Family Foundation, 2014.
- Other ACA provisions including the extension of dependent coverage to young adults, elimination of preexisting condition exclusions, and other private-market reforms contribute a small amount.
- Centers for Medicare and Medicaid Services. "Analysis of Factors Leading to Changes in Projected 2019 National Health Expenditure Estimates: A Comparison of April 2010 and September 2013 Projections," 2013. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ProjectionsRevisionAnalysis.pdf>.
- White, et al. *How Much of the Medicare Spending Slowdown Can Be Explained?*
- Clemens J, and Gottlieb JD. *Bargaining in the Shadow of a Giant: Medicare's Influence on Private Payment Systems*. NBER Working Paper No. 19503. Cambridge, MA: National Bureau of Economic Research, 2013.; White C. "Contrary To Cost-Shift Theory, Lower Medicare Hospital Payment Rates for Inpatient Care Lead to Lower Private Payment Rates." *Health Affairs* 32 (5): 935–43, 2013.; White C, and Wu VY. "How Do Hospitals Cope with Sustained Slow Growth in Medicare Prices?" *Health Services Research* 49 (1): 11–31, 2014.
- White, *Contrary To Cost-Shift Theory, Lower Medicare Hospital Payment Rates for Inpatient Care Lead to Lower Private Payment Rates*.
- Council of Economic Advisers. "Trends in Health Care Cost Growth and the Role of the Affordable Care Act." Washington, DC: Council of Economic Advisers, 2013.
- Holahan J, Blumberg LJ, and Wengle E. *Marketplace Premium Changes throughout the United States, 2014–2015*. Washington, DC: Urban Institute, 2015.

Table 2. National Health Expenditure Projections 2010-2019

	National Health Spending (\$ billions)											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Cumulative Spending 2010-2014 (AAGR)	Cumulative Spending 2014-2019 (AAGR)
A. Pre-ACA Baseline (Feb. 2010)	2570	2703	2850	3025	3225	3442	3684	3936	4204	4483	14373	22973
<i>Growth rate</i>		5.2%	5.4%	6.1%	6.6%	6.7%	7.0%	6.8%	6.8%	6.6%	5.8%	6.8%
B. ACA Baseline (Sept. 2010)	2600	2710	2852	3025	3302	3538	3796	4045	4298	4572	14489	23550
<i>Growth rate</i>		4.2%	5.2%	6.1%	9.2%	7.1%	7.3%	6.6%	6.3%	6.4%	6.2%	6.7%
C. August 2011 Forecast	2584	2708	2824	2980	3227	3418	3632	3850	4080	4347	14324	22553
<i>Growth rate</i>		4.8%	4.3%	5.5%	8.3%	5.9%	6.3%	6.0%	6.0%	6.5%	5.7%	6.1%
D. July 2012 Forecast	2594	2695	2809	2916	3130	3308	3514	3723	3952	4207	14143	21835
<i>Growth rate</i>		3.9%	4.2%	3.8%	7.4%	5.7%	6.3%	5.9%	6.2%	6.5%	4.8%	6.1%
E. October 2013 Forecast	2600	2701	2807	2915	3078	3258	3442	3643	3870	4121	14100	21412
<i>Growth rate</i>		3.9%	3.9%	3.9%	5.6%	5.8%	5.7%	5.8%	6.2%	6.5%	4.3%	6.0%
F. Current Forecast (Oct. 2014)	2599	2693	2793	2895	3057	3199	3375	3568	3785	4029	14037	21012
<i>Growth rate</i>		3.6%	3.7%	3.6%	5.6%	4.6%	5.5%	5.7%	6.1%	6.4%	4.1%	5.7%
GDP in Current Forecast	14958	15534	16245	16800	17354	18204	19133	20128	21195	22275	80891	118289
<i>GDP Growth Rate</i>		3.9%	4.6%	3.4%	3.3%	4.9%	5.1%	5.2%	5.3%	5.1%	3.8%	5.1%

ACA Baseline Relative to Pre-ACA Baseline

Difference (B–A)	31	7	1	0	77	96	112	109	94	89	116	577
Percent change	1.2%	0.3%	0.0%	0.0%	2.4%	2.8%	3.0%	2.8%	2.2%	2.0%	0.8%	2.5%

Current Forecast Relative to Pre-ACA Baseline

Difference (F–A)	29	-10	-57	-130	-169	-243	-309	-368	-418	-454	-336	-1,961
Percent change	1.1%	-0.4%	-2.0%	-4.3%	-5.2%	-7.1%	-8.4%	-9.3%	-9.9%	-10.1%	-2.3%	-8.5%

Current Forecast Relative to ACA Baseline

Difference (F–B)	-1	-17	-58	-130	-246	-340	-421	-477	-512	-543	-452	-2,538
Percent change	0.0%	-0.6%	-2.0%	-4.3%	-7.4%	-9.6%	-11.1%	-11.8%	-11.9%	-11.9%	-3.1%	-10.8%

Source: CMS Office of the Actuary.

Note: AAGR is average annual growth rate. All projections include the cuts to physician reimbursement required by the SGR formula.

Table 3. Medicare Expenditure Projections, 2010-2019

	Medicare Spending (\$ billions)											Cumulative Spending 2010-2014 (AAGR)	Cumulative Spending 2014-2019 (AAGR)
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019			
A. Pre-ACA Baseline (Feb. 2010)	515	544	586	627	673	714	767	830	901	978	2944	4863	
<i>Growth rate</i>		5.8%	7.6%	7.0%	7.3%	6.1%	7.5%	8.2%	8.5%	8.5%	6.9%	7.8%	
B. ACA Baseline (Sept. 2010)	534	549	586	620	656	685	723	771	828	891	2945	4554	
<i>Growth rate</i>		2.7%	6.7%	5.8%	5.8%	4.4%	5.6%	6.6%	7.4%	7.7%	5.3%	6.3%	
C. Current Forecast (Oct. 2014)	520	546	573	591	616	624	658	703	757	811	2846	4170	
<i>Growth rate</i>		5.0%	4.8%	3.3%	4.2%	1.3%	5.4%	6.9%	7.7%	7.1%	4.3%	5.7%	

ACA Baseline Relative to Pre-ACA Baseline

Difference (B–A)	20	5	0	-7	-17	-30	-44	-59	-73	-86	0	-309
Percent change	3.8%	0.8%	0.0%	-1.1%	-2.5%	-4.1%	-5.8%	-7.1%	-8.1%	-8.8%	0.0%	-6.4%

Current Forecast Relative to Pre-ACA Baseline

Difference (C–A)	6	2	-13	-36	-57	-90	-110	-127	-143	-166	-98	-693
Percent change	1.1%	0.3%	-2.3%	-5.7%	-8.5%	-12.6%	-14.3%	-15.3%	-15.9%	-17.0%	-3.3%	-14.3%

Current Forecast Relative to ACA Baseline

Difference (C–B)	-14	-3	-13	-29	-40	-61	-65	-68	-71	-80	-99	-384
Percent change	-2.7%	-0.5%	-2.3%	-4.6%	-6.1%	-8.8%	-9.0%	-8.8%	-8.5%	-9.0%	-3.3%	-8.4%

Source: CMS Office of the Actuary.

Note: AAGR is average annual growth rate. All projections include the cuts to physician reimbursement required by the SGR formula.

Table 4. Medicare Spending, Enrollment and Spending Per Enrollee Projections, 2010-2019

	Medicare Spending and Enrollment											Average Spending/ Enrollment 2010-2014 (AAGR)	Average Spending/ Enrollment 2014-2019 (AAGR)	
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019				
Medicare Spending (\$ billions)														
ACA Baseline	534	549	586	620	656	685	723	771	828	891	589	759		
<i>Growth rate</i>		2.7%	6.7%	5.8%	5.8%	4.4%	5.6%	6.6%	7.4%	7.7%	5.3%	6.3%		
Current Forecast	520	546	573	591	616	624	658	703	757	811	569	695		
<i>Growth rate</i>		5.0%	4.8%	3.3%	4.2%	1.3%	5.4%	6.9%	7.7%	7.1%	4.3%	5.7%		
Medicare Enrollment (millions)														
ACA Baseline	46.8	47.9	49.3	50.9	52.4	53.9	55.4	57.1	58.8	60.5	49	56		
<i>Growth rate</i>		2.4%	2.9%	3.2%	2.9%	2.9%	2.8%	3.1%	3.0%	2.9%	2.9%	2.9%		
Current Forecast	46.6	47.7	49.7	51.0	52.7	54.4	56.0	57.7	59.4	61.1	50	57		
<i>Growth rate</i>		2.4%	4.2%	2.6%	3.3%	3.2%	2.9%	3.0%	2.9%	2.9%	3.1%	3.0%		
Medicare Spending Per Enrollee (\$)														
ACA Baseline	11,419	11,459	11,880	12,177	12,515	12,699	13,052	13,501	14,082	14,734	11,890	13,431		
<i>Growth rate</i>		0.4%	3.7%	2.5%	2.8%	1.5%	2.8%	3.4%	4.3%	4.6%	2.3%	3.3%		
Current Forecast	11,163	11,451	11,519	11,592	11,687	11,471	11,748	12,187	12,751	13,280	11,482	12,187		
<i>Growth rate</i>		2.6%	0.6%	0.6%	0.8%	-1.9%	2.4%	3.7%	4.6%	4.1%	1.2%	2.6%		

Source: CMS Office of the Actuary.

Note: AAGR is average annual growth rate. All projections include the cuts to physician reimbursement required by the SGR formula.

Table 5. Medicaid Expenditure Projections, 2010-2019

	Medicaid Spending (\$ billions)											Cumulative Spending 2010-2014 (AAGR)	Cumulative Spending 2014-2019 (AAGR)
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019			
A. Pre-ACA Baseline (Feb. 2010)	412	447	478	513	552	593	638	687	739	794	2402	4003	
<i>Growth rate</i>		8.5%	7.0%	7.3%	7.5%	7.5%	7.6%	7.6%	7.6%	7.5%	7.6%	7.6%	
B. ACA Baseline (Sept. 2010)	427	466	502	540	634	684	738	780	836	896	2569	4567	
<i>Growth rate</i>		9.1%	7.6%	7.7%	17.4%	7.8%	7.9%	5.8%	7.1%	7.3%	10.4%	7.2%	
C. Current Forecast (Oct. 2014)	398	408	421	450	507	541	588	627	667	711	2184	3640	
<i>Growth rate</i>		2.4%	3.3%	6.7%	12.8%	6.7%	8.6%	6.6%	6.4%	6.7%	6.2%	7.0%	

ACA Baseline Relative to Pre-ACA Baseline

Difference (B–A)	15	19	23	27	82	91	99	93	97	102	167	564
Percent change	3.7%	4.3%	4.9%	5.2%	14.9%	15.3%	15.5%	13.6%	13.1%	12.8%	6.9%	14.1%

Current Forecast Relative to Pre-ACA Baseline

Difference (C–A)	-14	-39	-57	-64	-45	-52	-51	-60	-72	-83	-219	-363
Percent change	-3.4%	-8.8%	-11.9%	-12.4%	-8.1%	-8.8%	-8.0%	-8.8%	-9.8%	-10.4%	-9.1%	-9.1%

Current Forecast Relative to ACA Baseline

Difference (C–B)	-29	-58	-80	-91	-127	-143	-150	-154	-169	-185	-385	-927
Percent change	-6.8%	-12.5%	-16.0%	-16.8%	-20.0%	-20.9%	-20.3%	-19.7%	-20.2%	-20.6%	-15.0%	-20.3%

Source: CMS Office of the Actuary.

Note: AAGR is average annual growth rate.

Table 6. Medicaid Spending, Enrollment and Spending Per Enrollee Projections, 2010-2019

	Medicaid Spending and Enrollment											Average Spending/ Enrollment 2010-2014 (AAGR)	Average Spending/ Enrollment 2014-2019 (AAGR)	
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019				
Medicaid Spending (\$ billions)														
ACA Baseline	427	466	502	540	634	684	738	780	836	896	514	761		
<i>Growth rate</i>		9.1%	7.6%	7.7%	17.4%	7.8%	7.9%	5.8%	7.1%	7.3%	10.4%	7.2%		
Current Forecast	398	408	421	450	507	541	588	627	667	711	437	607		
<i>Growth rate</i>		2.4%	3.3%	6.7%	12.8%	6.7%	8.6%	6.6%	6.4%	6.7%	6.2%	7.0%		
Medicaid Enrollment (millions)														
ACA Baseline	54.9	56.0	56.6	57.2	78.8	78.3	78.1	78.3	79.4	80.2	61	79		
<i>Growth rate</i>		2.0%	1.1%	1.1%	37.8%	-0.6%	-0.3%	0.3%	1.4%	1.0%	9.5%	0.4%		
Current Forecast	53.1	57.1	57.7	58.0	65.9	69.7	74.4	75.5	76.4	76.9	58	73		
<i>Growth rate</i>		7.5%	1.1%	0.5%	13.6%	5.8%	6.7%	1.5%	1.2%	0.7%	5.5%	3.1%		
Medicaid Spending Per Enrollee (\$)														
ACA Baseline	7,783	8,321	8,860	9,441	8,047	8,733	9,443	9,963	10,523	11,175	8,491	9,647		
<i>Growth rate</i>		6.9%	6.5%	6.5%	-14.8%	8.5%	8.1%	5.5%	5.6%	6.2%	0.8%	6.8%		
Current Forecast	7,497	7,140	7,300	7,750	7,697	7,763	7,897	8,298	8,726	9,250	7,477	8,272		
<i>Growth rate</i>		-4.8%	2.2%	6.2%	-0.7%	0.9%	1.7%	5.1%	5.2%	6.0%	0.7%	3.7%		

Source: CMS Office of the Actuary.

Note: AAGR is average annual growth rate.

Table 7. Private Health Insurance Expenditure Projections, 2010-2019

	Private Health Insurance Spending (\$ billions)											Cumulative Spending 2010-2014 (AAGR)	Cumulative Spending 2014-2019 (AAGR)
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019			
A. Pre-ACA Baseline (Feb. 2010)	829	862	894	942	1005	1076	1149	1220	1291	1361	4533	7102	
<i>Growth rate</i>		4.0%	3.7%	5.4%	6.6%	7.1%	6.8%	6.2%	5.8%	5.4%	4.9%	6.3%	
B. ACA Baseline (Sept. 2010)	845	864	895	944	1065	1161	1258	1346	1398	1467	4613	7694	
<i>Growth rate</i>		2.2%	3.6%	5.4%	12.8%	9.1%	8.3%	7.0%	3.8%	5.0%	6.0%	6.6%	
C. Current Forecast (Oct. 2014)	860	889	917	948	1012	1082	1137	1191	1253	1330	4625	7006	
<i>Growth rate</i>		3.4%	3.2%	3.3%	6.8%	6.9%	5.0%	4.8%	5.2%	6.2%	4.2%	5.6%	

ACA Baseline Relative to Pre-ACA Baseline

Difference (B-A)	16	2	1	1	60	86	108	125	107	107	80	592
Percent change	1.9%	0.2%	0.1%	0.1%	6.0%	7.9%	9.4%	10.3%	8.3%	7.8%	1.8%	8.3%

Current Forecast Relative to Pre-ACA Baseline

Difference (C-A)	30	27	23	5	7	7	-13	-29	-38	-30	92	-96
Percent change	3.7%	3.1%	2.5%	0.6%	0.7%	0.6%	-1.1%	-2.4%	-2.9%	-2.2%	2.0%	-1.3%

Current Forecast Relative to ACA Baseline

Difference (C-B)	15	25	22	4	-53	-79	-121	-155	-145	-137	13	-688
Percent change	1.7%	2.9%	2.4%	0.4%	-4.9%	-6.8%	-9.6%	-11.5%	-10.3%	-9.3%	0.3%	-8.9%

Source: CMS Office of the Actuary.

Note: AAGR is average annual growth rate.

Table 8. Private Health Insurance Spending, Enrollment and Spending Per Enrollee Projections, 2010-2019

	Private Health Insurance Spending and Enrollment											Average Spending/ Enrollment 2010-2014 (AAGR)	Average Spending/ Enrollment 2014-2019 (AAGR)	
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019				
Private Health Insurance Spending (\$ billions)														
ACA Baseline	845	864	895	944	1065	1161	1258	1346	1398	1467	923	1282		
<i>Growth rate</i>		2.2%	3.6%	5.4%	12.8%	9.1%	8.3%	7.0%	3.8%	5.0%	6.0%	6.6%		
Current Forecast	860	889	917	948	1,012	1,082	1,137	1,191	1,253	1,330	925	1168		
<i>Growth rate</i>		3.4%	3.2%	3.3%	6.8%	6.9%	5.0%	4.8%	5.2%	6.2%	4.2%	5.6%		
Private Health Insurance Enrollment (millions)														
ACA Baseline	189.2	187.1	188.4	190.7	198.1	200.6	203.7	206.4	206.5	207.1	191	204		
<i>Growth rate</i>		-1.1%	0.7%	1.2%	3.9%	1.3%	1.5%	1.3%	0.0%	0.3%	1.2%	0.9%		
Current Forecast	186.3	187.3	188.0	188.5	190.0	197.0	199.1	200.1	201.7	203.2	188	199		
<i>Growth rate</i>		0.5%	0.4%	0.3%	0.8%	3.7%	1.1%	0.5%	0.8%	0.7%	0.5%	1.4%		
Private Spending Per Enrollee (\$)														
ACA Baseline	4,466	4,617	4,753	4,948	5,375	5,790	6,174	6,520	6,768	7,085	4,832	6,285		
<i>Growth rate</i>		3.4%	2.9%	4.1%	8.6%	7.7%	6.6%	5.6%	3.8%	4.7%	4.7%	5.7%		
Current Forecast	4,614	4,745	4,878	5,027	5,327	5,494	5,710	5,954	6,212	6,547	4,918	5,874		
<i>Growth rate</i>		2.8%	2.8%	3.1%	6.0%	3.1%	3.9%	4.3%	4.3%	5.4%	3.7%	4.2%		

Source: CMS Office of the Actuary.

Note: AAGR is average annual growth rate.

Table 9. Out-of-Pocket Expenditure Projections, 2010-2019

	Out-of-Pocket Spending (\$ billions)											Cumulative Spending 2010-2014 (AAGR)	Cumulative Spending 2014-2019 (AAGR)
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019			
A. Pre-ACA Baseline (Feb. 2010)	292	300	311	327	348	372	395	417	441	466	1579	2438	
<i>Growth rate</i>		2.7%	3.7%	5.2%	6.4%	6.8%	6.3%	5.6%	5.6%	5.6%	4.5%	6.0%	
B. ACA Baseline (Sept. 2010)	288	298	309	325	322	338	354	374	410	439	1542	2237	
<i>Growth rate</i>		3.2%	4.0%	5.2%	-1.1%	5.0%	4.7%	5.8%	9.6%	7.0%	2.8%	6.4%	
C. Current Forecast (Oct. 2014)	306	316	328	339	338	346	356	372	391	414	1627	2217	
<i>Growth rate</i>		3.4%	3.8%	3.2%	-0.1%	2.2%	3.0%	4.5%	5.1%	5.7%	2.6%	4.1%	

ACA Baseline Relative to Pre-ACA Baseline

Difference (B-A)	-4	-2	-2	-2	-26	-34	-41	-43	-31	-27	-36	-202
Percent change	-1.3%	-0.8%	-0.6%	-0.6%	-7.6%	-9.1%	-10.4%	-10.3%	-6.9%	-5.8%	-2.3%	-8.3%

Current Forecast Relative to Pre-ACA Baseline

Difference (C-A)	14	16	17	11	-10	-26	-39	-45	-50	-52	48	-222
Percent change	4.6%	5.4%	5.5%	3.5%	-2.9%	-7.0%	-9.9%	-10.8%	-11.3%	-11.2%	3.0%	-9.1%

Current Forecast Relative to ACA Baseline

Difference (C-B)	17	19	19	13	16	8	2	-2	-19	-25	84	-20
Percent change	6.0%	6.3%	6.1%	4.1%	5.1%	2.3%	0.6%	-0.6%	-4.6%	-5.8%	5.5%	-0.9%

Source: CMS Office of the Actuary.

Note: AAGR is average annual growth rate.

Table 10. Other Health Expenditure Projections, 2010-2019

	Other Health Spending (\$ billions)											Cumulative Spending 2010-2014 (AAGR)	Cumulative Spending 2014-2019 (AAGR)
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019			
A. Pre-ACA Baseline (Feb. 2010)	521.5	549.3	580.8	615.2	647.9	687.1	733.7	781.5	832.2	884.4	2915	4567	
<i>Growth rate</i>		5.3%	5.7%	5.9%	5.3%	6.1%	6.8%	6.5%	6.5%	6.3%	5.6%	6.4%	
B. ACA Baseline (Sept. 2010)	505.2	533.5	559.7	596.0	626.0	670.6	723.9	773.8	826.4	877.8	2820	4499	
<i>Growth rate</i>		5.6%	4.9%	6.5%	5.0%	7.1%	7.9%	6.9%	6.8%	6.2%	5.5%	7.0%	
C. Current Forecast (Oct. 2014)	515.5	534.0	554.5	567.9	583.2	605.4	636.6	675.0	717.2	762.0	2755	3979	
<i>Growth rate</i>		3.6%	3.8%	2.4%	2.7%	3.8%	5.2%	6.0%	6.3%	6.2%	3.1%	5.5%	

ACA Baseline Relative to Pre-ACA Baseline

Difference (B–A)	-16	-16	-21	-19	-22	-17	-10	-8	-6	-7	-94	-68
Percent change	-3.1%	-2.9%	-3.6%	-3.1%	-3.4%	-2.4%	-1.3%	-1.0%	-0.7%	-0.7%	-3.2%	-1.5%

Current Forecast Relative to Pre-ACA Baseline

Difference (C–A)	-6	-15	-26	-47	-65	-82	-97	-107	-115	-122	-160	-587
Percent change	-1.2%	-2.8%	-4.5%	-7.7%	-10.0%	-11.9%	-13.2%	-13.6%	-13.8%	-13.8%	-5.5%	-12.9%

Current Forecast Relative to ACA Baseline

Difference (C–B)	10	1	-5	-28	-43	-65	-87	-99	-109	-116	-65	-519
Percent change	2.0%	0.1%	-0.9%	-4.7%	-6.8%	-9.7%	-12.1%	-12.8%	-13.2%	-13.2%	-2.3%	-11.5%

Source: CMS Office of the Actuary.

Note: AAGR is average annual growth rate.

Table 11: Congressional Budget Office Expenditure Projections, 2010 and 2015

	2010 Report: 2014–2019 (\$ Billions)	2015 Report: 2014–2019 (\$ Billions)	Difference (2010-2015)	
			\$	%
Outlays				
Exchange Subsidies & Related Spending	458	333	-125	-27.3%
Medicaid and CHIP Outlays	441	347	-94	-21.3%
Gross Cost of Coverage Provisions	921	686	-235	-25.5%
Medicare				
Total Mandatory Outlays	4485	4,042	-443	-9.9%
Net Mandatory Outlays	3816	3,378	-438	-11.5%

Sources: Congressional Budget Office, The Budget and Economic Outlook: an Economic Update, August 2010. Congressional Budget Office, Updated Budget Projections: 2015 to 2025.

Notes: CHIP is Children's Health Insurance Program. Estimates are for federal spending and revenues only. Medicaid and CHIP estimates only include ACA expansion population.

Copyright© April 2015. The Urban Institute. Permission is granted for reproduction of this file, with attribution to the Urban Institute.

About the Authors and Acknowledgements

John Holahan is an Institute Fellow and Stacey McMorrow is a senior research associate at the Urban Institute's Health Policy Center. The authors are grateful to Bob Berenson, Linda Blumberg, Kathy Hempstead, Andy Hyman, Don Marron, Bob Reischauer, and Steve Zuckerman for helpful comments and suggestions, and to Megan McGrath and Erik Wengle for outstanding research assistance.

About the Robert Wood Johnson Foundation

For more than 40 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are striving to build a national Culture of Health that will enable all to live longer, healthier lives now and for generations to come. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at [www.rwjf.org/twitter](https://twitter.com/rwjf) or on Facebook at [www.rwjf.org/facebook](https://www.facebook.com/rwjf).

About the Urban Institute

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic and governance problems facing the nation. For more information, visit www.urban.org. Follow the Urban Institute on Twitter [www.urban.org/twitter](https://twitter.com/urbanorg) or Facebook [www.urban.org/facebook](https://www.facebook.com/urbanorg). More information specific to the Urban Institute's Health Policy Center, its staff, and its recent research can be found at www.healthpolicycenter.org.