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National Health Spending Projections: The Estimated Impact Of Reform Through 2019

ABSTRACT **This paper presents updated national health spending projections for 2009–2019 that take into account recent comprehensive health reform legislation and other relevant changes in law and regulations. Relative to our February 2010 projections under prior law, average annual growth in national health spending over the projection period is estimated to be 0.2 percentage point higher than our previous estimate. The health care share of gross domestic product (GDP) is expected to be 0.3 percentage point higher in 2019. Within these net overall impacts are larger differences for trends in spending and spending growth by payer, attributable to reform's many major changes to health care coverage and financing.**

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This paper presents an update to the 2009–2019 national health spending projections by payer, which were published in February 2010.[1] Our updated projections incorporate the effects of the Patient Protection and Affordable Care Act of 2010 on health spending and coverage, as well as other relevant legislative and regulatory changes.[2] Moreover, our paper includes initial estimates reflecting the impact of the Affordable Care Act on government administrative costs as measured in the National Health Expenditure Accounts.

Overview Of Changes In Projected Spending

Total national health spending is estimated to have grown 5.8 percent in 2009 and to have reached $2.5 trillion (Exhibits 1–4). In 2010, spending is expected to grow by 5.1 percent. These growth rates are 0.1 percentage point and 1.2 percentage points faster, respectively, than previously estimated, because of various changes in law and regulations. For 2011, national health spending is projected to grow more slowly, at 4.2 percent (or 1.0 percentage point slower than our prior projections).

PHYSICIAN PAYMENT This pattern of growth is largely attributable to modifications to the Medicare sustainable growth rate system, which determines Medicare payments for physician services. These modifications removed physician-administered drugs from the formula in November 2009 and postponed a 21.3 percent reduction in Medicare physician payment rates set for January 2010. Instead, small increases in Medicare physician payments were enacted in 2010, and provisions of the law were left intact that will result in a 23 percent reduction in payment rates in December 2010.

PREMIUM SUBSIDIES Changes in law related to Consolidated Omnibus Budget Reconciliation Act (COBRA) premium subsidies (to eligible workers who choose to retain employer coverage following job loss) also are anticipated to have affected national health spending. That is, the extensions in 2009 and 2010 of eligibility for these subsidies, and the length of time that individuals are allowed to receive them, are projected to have led to higher private health insurance enrollment and spending in those years. These subsidies are now scheduled to expire by 2011.

AFFORDABLE CARE ACT Immediate reforms in

EXHIBIT 1

Projected National Health Expenditures (NHE) Under Current Law (September 2010 Projections), Aggregate Amounts By Source Of Funds, Billions Of Dollars, And Health Share Of Gross Domestic Product (GDP), Selected Calendar Years 2009–2019

Source of funds	2009	2010	2011	2012	2013	2014	2019
NHE ($ billions)	2,473.3	2,600.2	2,709.8	2,851.6	3,024.8	3,302.4	4,571.5
Private funds	1,269.9	1,315.8	1,352.1	1,405.7	1,483.5	1,611.0	2,231.6
Consumer payments	1,093.4	1,133.4	1,161.4	1,204.7	1,269.0	1,386.6	1,906.1
Out-of-pocket payments	283.2	288.4	297.5	309.3	325.4	321.8	438.8
Private health insurance	810.2	844.9	863.9	895.4	943.6	1,064.7	1,467.3
Employer-sponsored private health insurance	770.8	802.4	822.2	852.6	899.4	971.7	1,240.7
Exchanges	—[a]	—[a]	—[a]	—[a]	—[a]	84.4	217.3
Other private health insurance	39.4	42.6	41.8	42.8	44.2	8.7	9.2
Other private funds	176.5	182.5	190.7	201.0	214.5	224.5	325.5
Public funds	1,203.4	1,284.4	1,357.7	1,445.9	1,541.2	1,691.4	2,339.9
Federal	918.6	982.9	989.6	1,058.2	1,130.1	1,248.6	1,729.5
Medicare	507.1	534.4	548.9	585.7	619.8	655.8	891.4
Medicaid and CHIP[b]	255.8	285.4	265.2	286.7	310.0	383.5	541.4
Other federal	155.7	163.1	175.4	185.8	200.3	209.3	296.7
State and local	284.8	301.5	368.1	387.8	411.2	442.8	610.4
Medicaid and CHIP[b]	134.2	142.0	200.8	214.8	230.0	250.6	354.8
Other state and local	150.7	159.5	167.4	173.0	181.2	192.2	255.7
Total Medicaid and CHIP[c]	390.0	427.3	466.0	501.5	540.0	634.1	896.2
Health share of GDP (%)	17.3	17.5	17.4	17.2	17.3	17.9	19.6

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. [a]Exchange plans will not be available until 2014. [b]Includes Children's Health Insurance Program (CHIP) (Title XIX and XXI). [c]Subset of public funds; includes both the federal and the state and local portions of Medicaid and CHIP.

EXHIBIT 2

Projected National Health Expenditures (NHE) Under Prior Law (February 2010 Projections), Aggregate Amounts By Source Of Funds, Billions Of Dollars, And Health Share Of Gross Domestic Product (GDP), Selected Calendar Years 2009–2019

Source of funds	2009	2010	2011	2012	2013	2014	2019
NHE ($ billions)	2,472.2	2,569.6	2,702.9	2,850.2	3,024.7	3,225.3	4,482.7
Private funds	1,268.8	1,303.9	1,353.0	1,406.6	1,484.1	1,583.7	2,154.4
Consumer payments	1,092.3	1,121.4	1,162.2	1,205.3	1,269.4	1,353.0	1,826.2
Out-of-pocket payments	283.5	292.1	299.9	311.1	327.3	348.1	465.6
Private health insurance	808.7	829.3	862.3	894.3	942.2	1,004.8	1,360.6
Other private funds	176.5	182.5	190.8	201.2	214.6	230.7	328.2
Public funds	1,203.4	1,265.7	1,349.8	1,443.6	1,540.7	1,641.6	2,328.3
Federal	918.6	965.7	984.8	1,057.3	1,130.6	1,206.9	1,728.5
Medicare	507.1	514.7	544.4	585.7	626.8	672.8	977.8
Medicaid and CHIP[a]	255.8	284.0	262.4	281.4	300.8	318.5	451.5
Other federal	155.7	167.0	178.1	190.2	203.1	215.5	299.1
State and local	284.8	300.0	365.0	386.3	410.0	434.8	599.8
Medicaid and CHIP[a]	134.2	141.7	200.2	214.2	229.6	245.0	350.9
Other state and local	150.7	158.3	164.8	172.2	180.5	189.8	248.9
Total Medicaid and CHIP[b]	390.0	425.7	462.6	495.6	530.3	563.5	802.4
Health share of GDP (%)	17.3	17.3	17.3	17.2	17.3	17.4	19.3

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. [a]Includes Children's Health Insurance Program (CHIP) (Title XIX and XXI). [b]Subset of public funds; includes both the federal and the state and local portions of Medicaid and CHIP.

EXHIBIT 3

Projected National Health Expenditures (NHE) Under Current Law (September 2010 Projections), Average Annual Percentage Growth From Prior Year Shown, By Source Of Funds, Selected Calendar Years 2009–2019

Source of funds	2009[a]	2010	2011	2012	2013	2014	2019	Projection period, 2009–19
NHE	5.8	5.1	4.2	5.2	6.1	9.2	6.7	6.3
Private funds	3.1	3.6	2.8	4.0	5.5	8.6	6.7	5.5
Consumer payments	3.1	3.7	2.5	3.7	5.3	9.3	6.6	5.5
Out-of-pocket payments	1.9	1.9	3.1	4.0	5.2	-1.1	6.4	4.2
Private health insurance	3.5	4.3	2.2	3.6	5.4	12.8	6.6	5.9
Employer-sponsored private health insurance	3.7	4.1	2.5	3.7	5.5	8.0	5.0	4.8
Exchanges	—[b]	—[b]	—[b]	—[b]	—[b]	—[b]	20.8	—[b]
Other private health insurance	-0.5	8.1	-1.9	2.6	3.1	-80.4	1.2	-12.4
Other private funds	3.2	3.4	4.5	5.4	6.7	4.6	7.7	6.0
Public funds	8.7	6.7	5.7	6.5	6.6	9.7	6.7	7.0
Federal	12.4	7.0	0.7	6.9	6.8	10.5	6.7	7.1
Medicare	8.1	5.4	2.7	6.7	5.8	5.8	6.3	6.0
Medicaid and CHIP[c]	22.7	11.6	-7.1	8.1	8.1	23.7	7.1	9.1
Other federal	11.8	4.7	7.6	5.9	7.8	4.5	7.2	7.1
State and local	-1.7	5.8	22.1	5.3	6.0	7.7	6.6	7.0
Medicaid and CHIP[c]	-8.2	5.8	41.4	7.0	7.1	9.0	7.2	8.4
Other state and local	4.9	5.9	4.9	3.3	4.7	6.1	5.9	5.2
Total Medicaid and CHIP[d]	10.0	9.6	9.0	7.6	7.7	17.4	7.2	8.8

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES**: Growth rates are calculated consistent with the National Health Expenditure Accounts methodology. For example, the 2019 growth rate is equal to the level of 2019 expenditures over the level of 2014 expenditures raised to the one-fifth power (the average growth rate over five years); 2019 growth rate is shorthand for 2014–2019 growth rate. [a]2009 growth rate is the one-year growth rate for 2008–2009. [b]Exchange plans will not be available until 2014. [c]Includes Children's Health Insurance Program (CHIP) (Title XIX and XXI). [d]Subset of public funds; includes both the federal and the state and local portions of Medicaid and CHIP.

EXHIBIT 4

Projected National Health Expenditures (NHE) Under Prior Law (February 2010 Projections), Average Annual Percentage Growth From Prior Year Shown, By Source Of Funds, Selected Calendar Years 2009–2019

Source of funds	2009[a]	2010	2011	2012	2013	2014	2019	Projection period, 2009–19
NHE	5.7	3.9	5.2	5.5	6.1	6.6	6.8	6.1
Private funds	3.0	2.8	3.8	4.0	5.5	6.7	6.3	5.2
Consumer payments	3.0	2.7	3.6	3.7	5.3	6.6	6.2	5.1
Out-of-pocket payments	2.1	3.0	2.7	3.7	5.2	6.4	6.0	4.8
Private health insurance	3.3	2.5	4.0	3.7	5.4	6.7	6.3	5.1
Other private funds	3.2	3.4	4.6	5.5	6.7	7.5	7.3	6.1
Public funds	8.7	5.2	6.6	7.0	6.7	6.6	7.2	7.0
Federal	12.4	5.1	2.0	7.4	6.9	6.7	7.4	7.1
Medicare	8.1	1.5	5.8	7.6	7.0	7.3	7.8	6.9
Medicaid and CHIP[b]	22.7	11.0	-7.6	7.3	6.9	5.9	7.2	7.3
Other federal	11.8	7.2	6.6	6.8	6.7	6.1	6.8	7.2
State and local	-1.7	5.3	21.7	5.8	6.1	6.0	6.6	6.8
Medicaid and CHIP[b]	-8.2	5.6	41.3	7.0	7.2	6.7	7.4	8.3
Other state and local	4.9	5.1	4.1	4.5	4.8	5.2	5.6	5.1
Total Medicaid and CHIP[c]	10.0	9.1	8.7	7.1	7.0	6.3	7.3	7.7

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES**: Growth rates are calculated consistent with the National Health Expenditure Accounts methodology. For example, the 2019 growth rate is equal to the level of 2019 expenditures over the level of 2014 expenditures raised to the one-fifth power (the average growth rate over five years); 2019 growth rate is shorthand for 2014–2019 growth rate. [a]2009 growth rate is the one-year growth rate for 2008–2009. [b]Includes Children's Health Insurance Program (CHIP) (Title XIX and XXI). [c]Subset of public funds; includes both the federal and the state and local portions of Medicaid and CHIP.

the Affordable Care Act are also estimated to affect health spending during 2010–13. These include the implementation of the Pre-Existing Condition Insurance Plan, or high-risk insurance pools for those with health conditions that make it difficult to acquire affordable individually purchased coverage. Enrollment in the program is expected to peak at about 375,000 people covered in 2011. Also affecting health spending is the Affordable Care Act provision for coverage of dependents under age twenty-six, which is expected to peak at about 1.5 million people covered in 2013. In total, these provisions are estimated to increase national health spending by $10.2 billion through 2013.

▶ **INSURANCE EXPANSIONS:** The major Affordable Care Act health insurance expansions are set to occur in 2014. They are anticipated to bring about substantial increases in health care coverage. Medicaid coverage will be expanded to all people under age sixty-five in households with incomes up to 138 percent of the federal poverty level. State-level health insurance exchanges will be established to facilitate a new individual and small-group insurance marketplace. Largely as a result of these coverage expansions, growth in national health spending is projected to be 9.2 percent in 2014, versus growth of 6.6 percent in 2014 that was expected prior to the enactment of health reform legislation.

▶ **SPENDING AND ENROLLMENT SHIFTS:** For 2015–19, national health spending is now projected to increase 6.7 percent per year, on average—slightly less than the 6.8 percent average annual growth rate projected in February 2010. However, the year-by-year pattern of growth is anticipated to be different (Exhibit 5). Enrollment shifts associated with the Affordable Care Act coverage expansions are projected to continue, contributing to continuing relatively faster spending growth rates through 2016. Thereafter, spending growth is projected to decelerate more substantially as a result of Affordable Care Act–mandated reductions to Medicare provider payment updates and the excise tax on high-cost insurance plans starting in 2018.

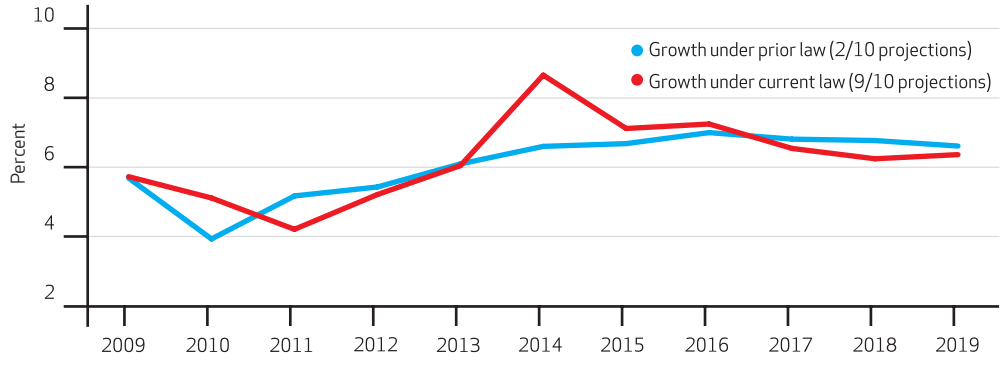
By 2019, the insured share of the population is projected to be 92.7 percent—roughly ten percentage points higher than projected prior to the health reform legislation. The number of uninsured people is estimated to be reduced by 32.5 million, and more than half of the newly insured are expected to gain coverage through Medicaid (Exhibit 6). Enrollment in Medicaid and the Children's Health Insurance Program (CHIP) is projected to reach 82.2 million in 2019—roughly one-third higher than the prior projection.

Enrollment in private health insurance plans through the Affordable Care Act's exchanges is projected to increase from an initial 15.8 million enrollees in 2014 to 30.6 million by 2019 (Exhibit 6). A very slight net decline in employer-sponsored coverage of roughly 100,000 is projected by 2019.[3,4] This decline is expected to occur because the number of people projected to shift from employer-sponsored insurance coverage to Medicaid or exchange coverage is slightly larger than the number that is anticipated to newly take up employer-sponsored coverage as a result of the individual mandate and employer-offer incentives.

▶ **SHARE OF GDP:** Despite the aforementioned changes in the year-to-year patterns of growth, particularly after 2014, spending on health care is projected to grow 0.2 percentage point faster over the entire projection period (2009–19) than estimated in our February 2010 projections.

EXHIBIT 5

Annual Growth Rates In National Health Expenditures (NHE) Under Current Law (September 2010 Projections) Versus Prior Law (February 2010 Projections), Calendar Years 2009–2019



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

EXHIBIT 6

Projected Health Insurance Enrollment Under Current Law (September 2010 Projections) Versus Prior Law (February 2010 Projections), By Source Of Funds, Selected Calendar Years 2009–2019

Source of funds	2009	2010	2011	2013	2014	2018	2019
ENROLLMENT UNDER CURRENT LAW (SEPTEMBER 2010 PROJECTIONS), MILLIONS							
Medicare	45.9	46.8	47.9	50.9	52.4	58.8	60.5
Medicaid/CHIP	51.8	60.4	61.8	63.4	85.2	81.6	82.2
Other public	11.8	12.5	12.8	13.1	13.4	14.8	15.1
Employer-sponsored private health insurance	166.6	162.1	160.8	164.8	168.0	164.2	165.1
Other private health insurance[a]	26.6	27.1	26.3	25.9	14.3	11.9	11.4
Exchanges	—[b]	—[b]	—[b]	—[b]	15.8	30.4	30.6
Uninsured	44.3	49.7	52.0	49.9	25.5	23.9	24.4
Insured share of US population[c] (%)	85.6	84.0	83.4	84.3	92.1	92.8	92.7
ENROLLMENT UNDER PRIOR LAW (FEBRUARY 2010 PROJECTIONS), MILLIONS							
Medicare	45.9	46.8	47.9	50.9	52.4	58.8	60.5
Medicaid/CHIP	51.8	60.4	61.8	63.4	61.9	61.4	61.9
Other public	11.8	12.1	12.4	13.1	13.4	14.8	15.1
Employer-sponsored private health insurance	166.4	160.5	159.5	163.3	165.1	165.3	165.2
Other private health insurance[a]	26.6	27.1	26.9	26.5	26.5	26.7	26.7
Uninsured	44.5	51.7	53.2	50.9	51.1	55.6	56.9
Insured share of US population[c] (%)	85.5	83.3	83.0	84.0	84.1	83.2	83.0

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. Growth rates are calculated consistent with the National Health Expenditure Accounts methodology. [a]In the prior-law baseline, "other private health insurance" includes private Medicare supplemental coverage and individual coverage. In the current-law estimates, "other private health insurance" includes only those with Medicare supplemental coverage. [b]Exchange plans will not be available until 2014. [c]Calculated as a proportion of total US population, including unauthorized immigrants.

After implementation of the Affordable Care Act, the health care share of gross domestic product (GDP) is projected to be 19.6 percent in 2019, or 0.3 percentage point higher than previously projected.

Underlying this increase are a number of larger, albeit mostly offsetting, factors. For example, higher projected spending by a greater number of insured people is somewhat offset by the projected impact of the Medicare savings provisions and relatively lower prices paid to providers for services to newly insured Medicaid beneficiaries.[4]

Model And Assumptions

This update of the national health spending projections relies on a new and additional estimation tool: the Office of the Actuary Health Reform Model. This model was the primary estimation tool used in preparing the Medicare chief actuary's estimates and memoranda describing the estimated impact of health reform proposals on the federal budget, health insurance coverage, and national health expenditures.[5,6]

The model primarily simulates the impact of health reform legislative provisions on households' and employers' decision making in regard to health insurance coverage and spending.[6] The impacts of reform generated by the model, combined with actuarial cost estimates prepared by the Office of the Actuary for Medicare and Medicaid provisions unrelated to the coverage expansions, were used to determine the full impact of reform on national health spending.

The 2009–19 projections published in February 2010 serve as the baseline health spending estimates on which the impact of the Affordable Care Act is modeled.[1,7] Because the purpose of this exercise is to isolate that legislation's impact, no updates have been made to the macroeconomic and demographic assumptions that underlie the baseline projections. However, the projections were updated to reflect current law as of late July 2010, including the extensions of the COBRA premium subsidies, the latest modification to the Medicare sustainable growth rate system, and other changes to the Medicare and Medicaid programs.

The new projections also incorporate the legislation's impact on government administrative costs, which were not included in the Office of the Actuary's prior Affordable Care Act impact analysis. Estimates of administrative costs for Medicare and Medicaid are prepared based on data in the Mid-Session Review of the President's Fiscal Year 2011 Budget.[8] The projections of administrative costs for state exchanges are estimated by the Office of the Actuary, based in part on the Massachusetts experience in funding the Commonwealth Health Insurance Connector Authority's administrative functions.

Consistent with all past iterations of the national health spending projections, these projec-

tions remain subject to substantial uncertainty. Little historical precedent exists for how the health system reforms will operate in practice; how individuals, families, and businesses will respond to the new requirements and financial incentives; or how the effects of coverage changes will affect personal health spending.

Moreover, supply-side impacts, such as behavioral changes on the part of providers in reaction to an influx of new prospective patients as a result of the Affordable Care Act, cannot be estimated with any certainty at this time.[4] In addition, many aspects of the legislation will not be known in detail until they are implemented through the regulatory process. Finally, the trajectory of future economic recovery and growth remains uncertain.

Payer Outlook

PRIVATE HEALTH INSURANCE In 2009 and 2010, private health insurance spending growth is expected to be 3.5 percent and 4.3 percent, respectively (versus the February 2010 baseline projection of 3.3 percent and 2.5 percent; Exhibits 3 and 4). This acceleration in growth from 2009 to 2010 is attributable to changes in the law that extended eligibility for COBRA premium subsidies to May 31, 2010, and increased the duration of eligibility for the subsidies from nine months to fifteen months.[9] These COBRA-related changes are estimated to have resulted in an additional 1.6 million insured people and an additional $15.4 billion in private health insurance spending in 2010 (data not shown).

Private health insurance spending is anticipated to grow just 2.2 percent in 2011, versus the baseline projection of 4.0 percent (Exhibits 3 and 4). Driving this lower rate of expected growth is that under current law, subsidized COBRA coverage will expire for many people. A large proportion of them are projected to remain unemployed in 2011, resulting in declines in private health insurance enrollment and spending. The Affordable Care Act reforms to be implemented in 2010 and 2011, such as dependent coverage up to age twenty-six and the removal of lifetime limits on coverage, are estimated to add about $1.4 billion per year on average from 2010 through 2013 and, therefore, would marginally affect spending growth.[10]

Private health insurance spending growth for 2014 is expected to be 12.8 percent—6.1 percentage points higher than in the prereform baseline projection of February 2010 (Exhibits 3 and 4). During 2014, it is estimated that 15.8 million people will obtain private health insurance coverage through exchange plans (Exhibit 6).

Of those initially covered through exchange plans, it is projected that about three-quarters will have previously had individually purchased insurance. The remainder are primarily the formerly uninsured, as well as some previously covered by employer-sponsored insurance.[11]

We expect that the level of health care spending for the formerly uninsured will nearly double as a result of their gaining coverage through exchange plans.[6] For those who previously held individually purchased coverage, many are projected to be eligible for federal premium subsidies. This factor, together with potentially lower out-of-pocket costs required at the point of service (due to plans' actuarial-value requirements and federal cost-sharing subsidies for many individuals), is expected to lead to slightly higher spending for affected enrollees.

Between 2014 and 2019, private health insurance spending growth is projected to average 6.6 percent per year—0.3 percentage point faster than in our February 2010 projection (Exhibits 3 and 4). This higher growth is largely attributable to two offsetting factors. On one hand, initial exchange enrollment growth is expected to continue through 2015 and 2016. On the other hand, it is expected that many affected employers will lower the value of employer-sponsored plans in 2018 in order to minimize exposure to the Affordable Care Act–mandated excise tax on high-cost insurance plans.[12]

Overall, private health insurance spending is anticipated to account for about 32 percent of national health expenditures in 2019 after the effects of the Affordable Care Act, compared to approximately 30 percent prior to reform (data not shown).

OUT-OF-POCKET SPENDING In 2010, growth in consumers' out-of-pocket spending is expected to be 1.9 percent—1.1 percentage points slower than projected in our February 2010 report (Exhibits 3 and 4). The expectation of slower growth results from a higher estimated number of people, otherwise uninsured, who will retain private health insurance coverage in 2010 through subsidized COBRA coverage. Out-of-pocket spending growth is expected to be 3.1 percent in 2011, versus the prereform projection of 2.7 percent, because the expiration of the COBRA premium subsidies is anticipated to result in higher out-of-pocket spending for those who forgo continued COBRA coverage.

In 2014, the number of uninsured people is expected to fall dramatically, as many are expected to acquire health insurance coverage either through Medicaid or through exchange plans. As a result, out-of-pocket spending is expected to decline by 1.1 percent, compared to the prereform projection of a 6.4 percent increase (Exhibits 3 and 4).

Health care spending for the formerly uninsured is expected to nearly double as a result of their gaining coverage through exchange plans.

Over the remainder of the projection period, out-of-pocket spending growth is expected to vary in reaction to the major Affordable Care Act provisions. We assume that it will take at least three years for the market to fully react to the new coverage options. For 2015 and 2016, as additional people continue to enroll in Medicaid or purchase private coverage through exchanges, we project out-of-pocket spending to grow 1.7 percentage points more slowly than previously projected. By 2018, however, we project out-of-pocket spending growth of 9.6 percent—four percentage points faster than our February 2010 projection. This effect is mainly attributable to the excise tax on high-cost employer-sponsored plans, which is expected to result in greater cost sharing as many affected employers scale back coverage to minimize their tax exposure.[4]

MEDICAID AND CHIP Medicaid and CHIP spending for 2009–13 is anticipated to grow 8.5 percent per year—0.5 percentage point faster than was projected prior to reform (Exhibits 3 and 4). The financial effects of the Affordable Care Act and other recent legislation on Medicaid are estimated to largely offset one another through 2013, minimally affecting net spending and enrollment.[13] The specific Affordable Care Act–mandated provisions that take effect include temporary increases in payment rates for primary care physicians, additional long-term care options, and additional and increased statutory prescription drug rebates.

The Affordable Care Act expands Medicaid eligibility to all people under age sixty-five in households with incomes below 138 percent of the federal poverty level beginning in 2014.[14] Primarily as a result of this expansion in eligibility, Medicaid and CHIP spending is projected to increase 17.4 percent in 2014 to $634.1 billion—11.1 percentage points faster than estimated before reform (Exhibits 1 and 3). Because of the Affordable Care Act, Medicaid and CHIP enrollment is projected to increase by 21.8 million in 2014, to 85.2 million people (Exhibit 6).

In addition to the eligibility expansion mentioned above, the Affordable Care Act provides for facilitated enrollment processes to help the uninsured determine their potential eligibility for Medicaid, as well as other substantial outreach efforts. As a result, the increases in Medicaid enrollment include not only those newly eligible but also those who, although eligible prior to reform, might not have been enrolled.

Most of the expenditures for the newly Medicaid-eligible are to be paid by the federal government, initially through a 100 percent Federal Medical Assistance Percentage that will phase down to 90 percent by 2020. As a result, the federal share of Medicaid spending is estimated to increase from 56.6 percent in 2013, prior to the expansion, to 60.1 percent in 2019 (data not shown).

We anticipate that the expansion of eligibility for Medicaid under the Affordable Care Act will largely reflect a transitional one-time shift in the level of Medicaid enrollment and spending through 2017. We expect that after 2017, enrollment and spending will resume a growth path similar to that projected prior to reform. We also anticipate that CHIP enrollment and spending will fall by 2016, as the additional funding ends. By 2019, Medicaid and CHIP spending is projected to represent 19.6 percent of national health expenditures, up from 17.9 percent from the pre–Affordable Care Act estimates (data not shown).

MEDICARE Medicare spending growth in 2010 and 2011 is now projected to be 5.4 percent and 2.7 percent, respectively—3.9 percentage points faster and 3.1 percentage points slower than we projected in February 2010 (Exhibits 3 and 4). This pattern of growth is largely attributable to legislative and regulatory changes in the sustainable growth rate system of paying physicians.

One of the most significant changes was made in the final physician regulation issued in November 2009, which retrospectively and prospectively removed physician-administered drugs from the definition of *physician services* under the system. This change, which was not in our February baseline, greatly reduced the imbalance between actual and allowed expenditures under the sustainable growth rate system, thereby leading to fewer scheduled reductions in fees for physician services in future years.

In addition, legislative changes to the 2010 Medicare physician fee schedule updates through November 2010 also affected spending growth.[2] In our February 2010 projection, Medicare physician payments were scheduled to de-

cline by 21.3 percent on January 1, 2010. After subsequent legislative changes, Medicare physician payments updates of 0.0 percent were put in place for January–May 2010, and then a 2.2 percent increase was enacted for June–November 2010. In December 2010, however, the average physician payment per service is now scheduled to decrease by 23 percent from the November 2010 level, absent further legislative intervention.[15]

The Medicare provisions in the Affordable Care Act take effect as early as 2010 and are anticipated to result, on net, in much slower Medicare spending growth over the projection period. Specifically, average annual Medicare spending growth is anticipated to be 1.4 percentage points slower for 2012–19 than we projected in February 2010. By 2019, it is projected to grow 7.7 percent—0.9 percentage point more slowly than we projected in February 2010.

Included in these Medicare-related changes under the Affordable Care Act are increases in the value of the Part D prescription drug benefit by gradually phasing out the coverage gap, also known as the doughnut hole. This particular provision is expected to increase spending. However, the law also adjusts annual payment updates for most Medicare services, reducing those updates by growth in economywide multifactor productivity. Furthermore, the law mandates substantial reductions to Medicare managed care plan payments and creates the Independent Payment Advisory Board.[16]

Preliminary Effects On Government Administrative Spending

Many Affordable Care Act provisions will result in new administrative functions at both the federal and state levels. The US Department of Health and Human Services (HHS) and the Department of the Treasury will acquire a number of new or expanded administrative roles. Overall, we project that new HHS functions will add $2.4 billion to federal administrative costs in the National Health Expenditures Accounts over the projection period.[17]

Perhaps the largest new role for state oversight is the creation and operation of the health insurance exchanges. We project that the initial exchange startup costs will be $4.4 billion for 2011–2013, and we assume that these costs will be equal to the estimated cost of the first year of exchange operations (2014). To estimate the cost of exchange operations, we further assume that overall exchange administration as a share of premiums mirrors that of the Massachusetts experience.[18,19]

Many important details of the legislation will evolve through regulatory activity.

Based on these assumptions, we estimate that exchange-related administrative costs would add a cumulative $37.7 billion, or roughly 0.2 percent, to national health spending through 2019. Actual exchange administrative costs could differ greatly from these preliminary estimates, as the collective experience of the states may differ from that of Massachusetts.

Conclusion

In this analysis, we have shown that the net impacts of key Affordable Care Act and other legislative provisions on total national health expenditures are moderate, but the underlying effects on payer spending levels and growth rates are much more pronounced and reflect the Affordable Care Act's many substantive changes to health care coverage and financing. As the provisions are implemented over time, their actual impacts may well differ considerably from these estimates.

Many important details of the legislation will evolve through regulatory activity and become more concrete. Moreover, behavioral responses to reform provisions on the part of health care providers and consumers, employers, and insurers are difficult to anticipate. These will become more apparent only after the bulk of reforms have been implemented in 2014.

When we release our next set of national health spending projections in early 2011, we will shift the analysis an additional year into the future, examine spending by service, and continue the work of estimating the impact of reform on overall national health spending. ■

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NOTES

1 Truffer CJ, Keehan S, Smith S, Cylus J, Sisko A, Poisal JA, et al. Health spending projections through 2019: the recession's impact continues. Health Aff (Millwood). 2010;29(3): 522–9.

2 Relevant changes in law include the Department of Defense Appropriations Act of 2010, the Temporary Extension Act of 2010, the Continuing Extension Act of 2010, and the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010. The Defense Appropriations Act included provisions that prompted an update to our previous 2009 estimates.

3 This anticipated shift reflects our assumption that families will generally make a rational financial decision regarding coverage, based on their income and Medicaid/exchange-subsidy eligibility status. Furthermore, we expect that some employers of mainly low-wage workers will drop coverage to give employees an opportunity to access heavily subsidized and likely richer coverage from the exchanges and that, in return, the employer would pay the less costly legislated penalty amount.

4 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 2010 Jul 2]. Available from: http://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf

5 The Office of the Actuary released memoranda describing estimates of the financial, coverage, and national health spending impacts of HR 3200, HR 3692, HR 3590, and the final Affordable Care Act, as amended, as well as memoranda describing the estimated impact on Medicare of HR 3590 and the final Affordable Care Act, as amended. Links to all of these memos are available at Centers for Medicare and Medicaid Services. Estimated impact of health care reform proposals [Internet]. Baltimore (MD): CMS; 2010 May 4 [cited 2010 Aug 24]. Available for download from: http://www.cms.gov/ActuarialStudies/05_HealthCareReform.asp

6 Centers for Medicare and Medicaid Services. Summary of data, assumptions, and methodology underlying OACT's estimates for national health reform proposals [Internet]. Baltimore (MD): CMS; 2010 Sep 3. Available for download from: http://www.cms.gov/ActuarialStudies/05_HealthCareReform.asp

7 Centers for Medicare and Medicaid Services. Projections of national health expenditures: methodology and model specification [Internet]. Baltimore (MD): CMS; 2010 Feb 4 [cited 2010 Aug 23]. Available from: http://www.cms.gov/NationalHealthExpendData/downloads/projections-methodology.pdf

8 Office of Management and Budget. Mid-session review [Internet]. Washington (DC): OMB; 2010 Jul 23 [cited 2010 Aug 23]. Available from: http://www.whitehouse.gov/omb/budget/MSR/

9 Linehan K. Keeping health insurance after a job loss: COBRA continuation coverage and subsidies [Internet]. Washington (DC): National Health Policy Forum; 2010 Jun 24 [cited 2010 Aug 23]. (Issue brief no. 837). Available from: http://www.nhpf.org/library/issue-briefs/IB837_COBRA_06-24-10.pdf

10 High-risk insurance pools will be jointly run by the federal government and state and local governments; therefore, their impact will be seen in the "other public" category in the National Health Expenditure Accounts, rather than in private health insurance. A minor offset to private health insurance is associated with another immediate reform: the federal reinsurance program in support of employer-sponsored early retiree health benefits. Although the program substitutes federal spending for employer private insurance costs, it has no net impact on total national health spending.

11 By 2019, half of new health insurance exchange enrollees will have had individually purchased insurance prior to enrollment; the remaining new enrollees will be largely the formerly uninsured and some former enrollees in employer-sponsored insurance. This distribution reflects the full transition of employer and individual behavior following the coverage expansions in 2014.

12 Beginning in 2018, the Affordable Care Act will impose a tax on employer-sponsored health plans on the value that exceeds the standard threshold amounts of $10,200 for individual coverage and $27,500 for family coverage (note that some employers will have different thresholds based on the age-gender mix of their workforce, the types of occupations employed, and the existence of qualified retirees). The threshold amounts may be adjusted upward if health care costs rise more rapidly than expected prior to 2018.

13 Freezing the federal poverty level at the 2008 rate to prevent erosion of eligibility was the most notable outcome of the non–Affordable Care Act legislative actions.

14 The Affordable Care Act permits states to expand Medicaid eligibility earlier than 2014 through state plan amendments. However, it is unlikely that many states will greatly expand eligibility before 2014.

15 In practice, it is highly unlikely that Congress will allow this cut to become effective, as other such reductions have been avoided since 2002.

16 The board is required to develop and submit proposals to Congress aimed at extending the solvency of Medicare, slowing Medicare cost growth, and improving the quality of care delivered to Medicare beneficiaries. Its proposals will become law unless overridden by congressional intervention.

17 This estimate is based on the use of $1 billion in authorized implementation funds, plus additional estimated funding that would likely be necessary to continue to fulfill Affordable Care Act–mandated functions. This estimate does not include any other potential federal administrative costs from other Affordable Care Act provisions that were not specified in the legislation.

18 Kingsdale J. Health insurance exchanges—key link in a better-value chain. N Engl J Med. 2010 [published online ahead of print].

19 Kingsdale J. Establishing a health insurance exchange: testimony before Joint Hearing of the Senate and Assembly Health Committees [Internet]. Sacramento (CA): State of California; 2010 May 12 [cited 2010 Jul 22]. Available from: http://senweb03.senate.ca.gov/committee/standing/health/California_Testimony_of_Jon_Kingsdale.pdf