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National Health Expenditure Projections, 2016–25: Price Increases, Aging Push Sector To 20 Percent Of Economy

ABSTRACT Under current law, national health expenditures are projected to grow at an average annual rate of 5.6 percent for 2016–25 and represent 19.9 percent of gross domestic product by 2025. For 2016, national health expenditure growth is anticipated to have slowed 1.1 percentage points to 4.8 percent, as a result of slower Medicaid and prescription drug spending growth. For the rest of the projection period, faster projected growth in medical prices is partly offset by slower projected growth in the use and intensity of medical goods and services, relative to that observed in 2014–16 associated with the Affordable Care Act coverage expansions. The insured share of the population is projected to increase from 90.9 percent in 2015 to 91.5 percent by 2025.

Over the next decade (2016–25), growth in nominal (not adjusted for inflation) national health expenditures (NHE) is projected to average 5.6 percent, outpacing average growth in gross domestic product (GDP) by 1.2 percentage points. As a result, the health share of the economy is expected to climb from 17.8 percent in 2015 to 19.9 percent in 2025 (Exhibit 1).

The NHE projections are constructed using a current-law framework[1] and thus do not assume potential legislative changes over the projection period, nor do they attempt to speculate on possible deviations from current law. While there is currently significant debate involving potential future health-sector policy changes, the scope, timing, and impact of such possible changes on health spending and health insurance coverage are all uncertain at this time.

In 2014 and 2015, when the largest impacts of the major coverage provisions of the Affordable Care Act (ACA) were observed, health spending growth averaged 5.5 percent.[2] For the period 2016–25, spending is projected to grow similarly (5.6 percent) but to be largely influenced by changes in economic growth and population aging and not as much by changes in insurance coverage. This expectation leads to slower growth in the use and intensity (or complexity) of medical goods and services, relative to the expansion-related growth of 2014–15. However, medical price growth is projected to quicken in the coming decade compared to recent history, as both overall prices and medical-specific price inflation grow faster.

The first two years of the projection period feature the slowest expected rates of growth for the period (4.8 percent in 2016 and 5.4 percent in 2017), as both Medicaid and private health insurance spending growth slow and Medicare spending growth remains low (Exhibit 1). Medicaid spending growth is projected to be low (3.7 percent) for both 2016 and 2017, compared to 11.6 percent growth in 2014 (data not shown) and 9.7 percent growth in 2015 (Exhibit 2), largely due to enrollment growth slowing from an average of 8.4 percent for 2014–15 (data not shown) to less than 2 percent by 2017 (Exhibit 2). Growth in private health insurance spending is expected to also decelerate from its recent peak in 2015 (7.2 percent), but its slow-

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EXHIBIT 1

National health expenditures (NHE), aggregate and per capita amounts, share of gross domestic product (GDP), and average annual growth from previous year shown, by source of funds, selected calendar years 2007–25

Source of funds	2007[a]	2014	2015	2016[b]	2017[b]	2019[b]	2025[b]
EXPENDITURE, BILLIONS							
NHE	$2,295.7	$3,029.3	$3,205.6	$3,358.2	$3,539.3	$3,965.5	$5,548.8
Health consumption expenditures	2,157.3	2,878.4	3,050.8	3,200.1	3,375.4	3,784.9	5,299.9
Out of pocket	289.9	329.7	338.1	350.4	365.8	401.2	542.3
Health insurance	1,609.7	2,228.2	2,384.5	2,508.5	2,652.0	2,990.1	4,234.1
Private health insurance	776.6	1,000.0	1,072.1	1,135.4	1,208.8	1,351.3	1,809.1
Medicare	432.8	618.5	646.2	678.6	718.7	824.9	1,277.8
Medicaid	325.8	497.2	545.1	565.5	586.5	658.1	929.0
Federal	185.5	305.5	344.0	353.3	361.5	404.5	567.6
State and local	140.3	191.7	201.1	212.2	225.0	253.6	361.4
Other health insurance programs[c]	74.6	112.6	121.1	129.0	138.1	155.8	218.1
Other third-party payers and programs and public health activity	257.6	320.5	328.2	341.2	357.6	393.6	523.5
Investment	138.4	150.9	154.7	158.1	163.9	180.6	248.9
Population (millions)	301.0	318.4	320.9	323.8	326.7	332.9	351.2
GDP, billions of dollars	$14,477.6	$17,393.1	$18,036.6	$18,559.7	$19,357.7	$21,270.3	$27,885.1
NHE per capita	7,628.0	9,514.8	9,989.9	10,372.3	10,832.5	11,911.6	15,800.0
GDP per capita	48,106.0	54,631.1	56,209.7	57,323.5	59,247.6	63,891.6	79,402.2
Prices (2009 = 100.0)							
GDP Implicit Price Deflator, chain weighted	0.973	1.088	1.100	1.114	1.137	1.188	1.353
Personal Health Care Price Index	0.949	1.099	1.107	1.121	1.138	1.193	1.398
NHE as percent of GDP	15.9%	17.4%	17.8%	18.1%	18.3%	18.6%	19.9%
ANNUAL GROWTH							
NHE	7.3%	4.0%	5.8%	4.8%	5.4%	5.9%	5.8%
Health consumption expenditures	7.3	4.2	6.0	4.9	5.5	5.9	5.8
Out of pocket	4.7	1.9	2.6	3.6	4.4	4.7	5.2
Health insurance	8.2	4.8	7.0	5.2	5.7	6.2	6.0
Private health insurance	7.7	3.7	7.2	5.9	6.5	5.7	5.0
Medicare	8.4	5.2	4.5	5.0	5.9	7.1	7.6
Medicaid	9.7	6.2	9.7	3.7	3.7	5.9	5.9
Federal	9.7	7.4	12.6	2.7	2.3	5.8	5.8
State and local	9.6	4.6	4.9	5.5	6.0	6.2	6.1
Other health insurance programs[c]	7.8	6.1	7.5	6.5	7.0	6.2	5.8
Other third-party payers and programs and public health activity	6.1	3.2	2.4	4.0	4.8	4.9	4.9
Investment	6.8	1.2	2.6	2.2	3.6	5.0	5.5
Population[d]	1.0	0.8	0.8	0.9	0.9	0.9	0.9
GDP	5.4	2.7	3.7	2.9	4.3	4.8	4.6
NHE per capita	6.2	3.2	5.0	3.8	4.4	4.9	4.8
GDP per capita	4.3	1.8	2.9	2.0	3.4	3.8	3.7
Prices (2009 = 100.0)							
Gross Domestic Product Implicit Price Deflator, chain weighted	2.3	1.6	1.1	1.3	2.0	2.2	2.2
Personal Health Care Price Index	3.3	2.1	0.8	1.3	1.6	2.4	2.7

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and Department of Commerce, Bureau of Economic Analysis and Bureau of the Census. **NOTES** For definitions, sources, and methods for NHE categories, see CMS.gov. National Health Expenditure Accounts methodology paper, 2015: definitions, sources, and methods [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; [cited 2017 Jan 11]. Available from: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/dsm-15.pdf. Numbers may not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 1990–2007. [b]Projected. [c]Includes health-related spending for Children's Health Insurance Program, Titles XIX and XXI; Department of Defense; and Department of Veterans Affairs. [d]Estimates reflect the Bureau of the Census's definition of *resident-based population*, which includes all people who usually reside in the fifty states or the District of Columbia but excludes residents living in Puerto Rico and areas under US sovereignty, and US Armed Forces overseas and US citizens whose usual place of residence is outside of the United States. Estimates also include a small (typically less than 0.2 percent of population) adjustment to reflect census undercounts. Projected estimates reflect the area population growth assumptions found in the 2016 *Medicare Trustees Report* (see Note 5 in text).

down is projected to be not nearly as sharp as Medicaid's (Exhibit 1). Average private health insurance spending growth of 6.2 percent is expected in 2016–17, largely reflecting slowing expected private health insurance enrollment growth (from 2.6 percent in 2015 to less than 1.0 percent in both 2016 and 2017) as expansion-related gains diminish (Exhibit 2). Medicare spending growth is expected to remain low early in the projection period relative to its long-term history, with projected growth staying under 6.0 percent in both 2016 and 2017 and extending a trend that began in 2010 (Exhibit 1).

For 2018 and beyond, both Medicare and Medicaid expenditures are projected to grow faster than in the 2016–17 period, and more rapidly than private health insurance spending, for several reasons. First, growth in the use of Medicare services is expected to increase from its recent historical lows (though still remain below longer-term averages). Second, the Medicaid population mix is projected to trend more toward somewhat older, sicker, and therefore costlier beneficiaries. Third, baby boomers will continue to age into Medicare, with some of them dropping private health insurance as a result. And finally, growth in the demand for health care for those with private coverage is projected to slow as the relative price of health care—the difference between medical prices and economy-wide prices—is expected to begin gradually increasing in 2018 and as income growth slows in the later years of the projection period.

Within personal health care, which reflects the amount spent to treat people with specific medical conditions, the two sectors with the highest projected average spending growth for the entire projection period are home health care (6.7 percent average) and retail prescription drugs (6.3 percent average). Home health care spending growth is expected to be largely driven by growth in Medicare, where spending is projected

EXHIBIT 2

National health expenditures (NHE) and health insurance enrollment, aggregate and per enrollee amounts, and average annual growth from previous year shown, by source of funds, selected calendar years 2007–25

Source of funds	2007[a]	2014	2015	2016[b]	2017[b]	2019[b]	2025[b]
EXPENDITURE, BILLIONS							
Private health insurance	$776.6	$1,000.0	$1,072.1	$1,135.4	$1,208.8	$1,351.3	$1,809.1
Medicare	432.8	618.5	646.2	678.6	718.7	824.9	1,277.8
Medicaid	325.8	497.2	545.1	565.5	586.5	658.1	929.0
ANNUAL GROWTH IN EXPENDITURE							
Private health insurance	7.7%	3.7%	7.2%	5.9%	6.5%	5.7%	5.0%
Medicare	8.4	5.2	4.5	5.0	5.9	7.1	7.6
Medicaid	9.7	6.2	9.7	3.7	3.7	5.9	5.9
PER ENROLLEE EXPENDITURE							
Private health insurance	$ 3,933	$ 5,200	$ 5,433	$ 5,702	$ 6,040	$ 6,679	$ 8,736
Medicare	10,003	11,702	11,904	12,096	12,456	13,497	17,755
Medicaid	7,143	7,585	7,869	7,956	8,103	8,797	11,627
ANNUAL GROWTH IN PER ENROLLEE EXPENDITURE							
Private health insurance	7.1%	4.1%	4.5%	4.9%	5.9%	5.2%	4.6%
Medicare	6.8	2.3	1.7	1.6	3.0	4.1	4.7
Medicaid	5.0	0.9	3.8	1.1	1.8	4.2	4.8
ENROLLMENT (MILLIONS)							
Private health insurance	197.5	192.3	197.3	199.1	200.1	202.3	207.1
Medicare	43.3	52.8	54.3	56.1	57.7	61.1	72.0
Medicaid	45.6	65.5	69.3	71.1	72.4	74.8	79.9
Uninsured	41.1	35.6	29.2	28.0	27.2	26.8	29.8
Population	301.0	318.4	320.9	323.8	326.7	332.9	351.2
Insured share of total population	86.4%	88.8%	90.9%	91.4%	91.7%	91.9%	91.5%
ANNUAL GROWTH IN ENROLLMENT							
Private health insurance	0.5%	–0.4%	2.6%	0.9%	0.5%	0.5%	0.4%
Medicare	1.5	2.9	2.7	3.3	2.8	2.9	2.8
Medicaid	4.5	5.3	5.7	2.6	1.8	1.7	1.1
Uninsured	1.7	–2.0	–17.9	–4.2	–3.0	–0.6	1.8
Population	1.0	0.8	0.8	0.9	0.9	0.9	0.9

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** For definitions, sources, and methods for NHE categories, see CMS.gov. National Health Expenditure Accounts methodology paper, 2015 (see Exhibit 1 Notes). Numbers may not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 1990–2007. [b]Projected.

to average 7.8 percent for 2020–25 as the leading edge of the baby boomers reach their mid-70s and use home health care services more often.[3] Prescription drug spending growth is anticipated to be influenced by higher spending on expensive specialty drugs, with that growth somewhat mitigated by the expectation that the share of prescriptions that are lower-cost generic drugs will continue to increase slowly throughout the projection period.

Following disparate trends in 2014 and 2015, the average growth rates in spending among the major sponsors of health care are projected to be more similar. Private businesses, households, and other private payers are projected to collectively incur average increases of 5.4 percent in the period 2016–25, while combined spending by federal and state and local governments is expected to average 5.9 percent. That 0.5-percentage-point average differential is smaller than the 3.7-percentage-point average differential observed in 2014 and 2015, when the federal government incurred significant cost growth associated with sponsoring the ACA's major coverage expansions. The federal government is expected to continue representing the highest share among all sponsors of care, at 30 percent in 2025. Although states are expected to absorb an increasing share of the responsibility of paying for adults who are newly enrolled in Medicaid, state and local government expenditures as a share of total expenditures are projected to remain unchanged at 17 percent throughout the projection period.

Finally, the insured as a share of the population are projected to increase during the projection period, from 90.9 percent in 2015 to 91.5 percent in 2025 under current law (Exhibit 2). This is mainly a result of continued growth in enrollment in private health insurance—in particular, employer-sponsored health insurance—in the first year of the projection period, as well as enrollment growth in public programs throughout the period.

Model And Assumptions

The annual national health expenditure projections are largely based on current law[1] and the existing regulatory environment.[4] They use the economic and demographic assumptions from the 2016 *Medicare Trustees Report*,[5] which were updated to reflect the latest macroeconomic data, and the latest Medicaid projections from the CMS Office of the Actuary. Finally, these projections are developed using actuarial and econometric modeling methods, as well as judgments about future trends that influence health spending.[6]

Medical price growth is projected to quicken in the coming decade compared to recent history.

These projections remain inherently subject to substantial uncertainty that increases in future years. The uncertainty is related to multiple factors, some of which are in turn related to macroeconomic conditions and others of which are specific to the health care industry. Fluctuations in overall economic growth can affect the job market and growth in economywide price inflation, which will affect health spending growth. Health-specific factors adding to the uncertainty include providers' responses to new payment reforms, trends in population health and medical treatments, and employers' actions and employees' responses to incentives related to employer-provided health insurance benefits. Finally, potential future changes in legislation add to the uncertainty of these projections.

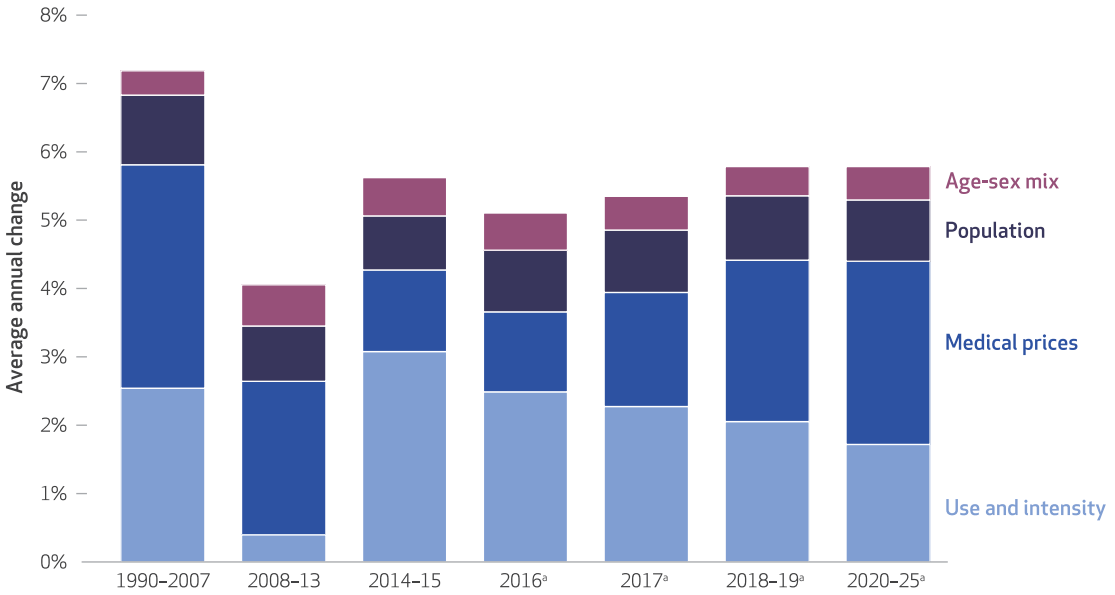
Factors Accounting For Growth

The two primary drivers of growth in personal health care spending during the projection period are medical prices and use and intensity of services; population growth and the population's age-sex mix have smaller impacts (Exhibit 3).

For the most recent two historical years (2014 and 2015), growth rates for both economywide prices (averaging 1.4 percent, as measured by the GDP deflator) and medical prices (1.1 percent, as measured by the personal health care price deflator) have been near historic lows. These trends continued in 2016, when the GDP deflator and the personal health care price index are both projected to have grown at 1.3 percent (Exhibit 1). Medical prices are influenced by both economywide factors and medical-specific price inflation (the latter being the difference between medical and economywide price inflation). For the period 2014–16, medical-specific price inflation averaged –0.2 percent, the lowest rate since 1973. Overall medical price inflation is expected to grow faster in 2017 (1.6 percent) and then average 2.4 percent for 2018–19, driven primarily by anticipated increases in economywide

EXHIBIT 3

Factors accounting for growth in personal health care expenditures, selected calendar years 1990–2025



SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** "Use and intensity" includes quantity and mix of services. As a residual, this factor also includes any errors in measuring prices or total spending. "Medical prices" reflect a chain-weighted index of the price for all personal health care deflators. "Population" is population growth. "Age-sex mix" refers to that mix in the population. [a]Projected.

price inflation. For 2020–25, medical price growth (Personal Health Care Price Index) is expected to accelerate to an average of 2.7 percent as a result of medical-specific price inflation, whose average growth is projected to be about 0.5 percentage point faster than economywide price growth. Medical input prices (including wage growth for health care workers) are expected to rise faster than the price growth for inputs for other sectors of the economy. As a result, growth in medical prices is expected to account for 46 percent of total growth in personal health care spending during the second half of the projection period, up from a share of 25 percent in 2016 (Exhibit 3).

The category of use and intensity of services is projected to have grown 2.4 percent in 2016, slower than the average growth of 3.2 percent for 2014–15 (Exhibit 3), as fewer people gained insurance coverage in 2016 compared to 2014–15. However, this projected rate of use and intensity growth in 2016 remains higher than the growth observed for 2008–13 (which averaged 0.4 percent) as a result of continued strong use of health care goods and services—driven in part by recent gains in disposable personal income (which tends to influence health spending with a lag).[6] Growth in the use and intensity of services is expected to decelerate (averaging 2.1 percent for 2018–19), as employers are expected to continue trying to keep growth in benefit costs low, implementing strategies that include imposing higher cost-sharing requirements and utilization management tools such as prior authorization.[7,8] For the remainder of the projection period (2020–25), use and intensity are projected to grow more slowly, at 1.7 percent per year—because of less demand for care in lagged response to slowing disposable personal income growth and the continuing impact of more people being enrolled in high-deductible health plans and their associated higher cost sharing.[9] As a result, the impact of use and intensity on personal health care spending growth is expected to decrease and account for 30 percent of that growth during the second half of the projection period, down from its share of 47 percent in 2016.

The effects of population growth and the changing age-sex mix are expected to be minor, contributing 0.9 percent and 0.5 percent, respectively, to annual growth for the period 2016–25 (Exhibit 3). As baby boomers age into Medicare, there will be a shift in coverage away from private insurance and into Medicare, with a modest effect on overall growth in health care spending (as estimates of spending for younger [nondisabled] Medicare beneficiaries show that spending is only marginally higher than spending for enrollees in private health insurance who are near the Medicare eligibility age).[10] The share

of the population ages sixty-five and older is projected to increase from 15 percent in 2015 to 18 percent in 2025.

Chronological Outlook Of Yearly Trends

2016 National health spending is projected to have grown 4.8 percent in 2016, compared to 5.8 percent in 2015 (Exhibit 1), and to have reached nearly $3.4 trillion. Even with slower health spending growth, national health expenditures as a share of GDP are projected to have increased to 18.1 percent in 2016, from 17.8 percent in 2015—as nominal GDP grew just 2.9 percent in 2016. Although there were larger decreases in 2014 and 2015, the uninsured population is projected to have fallen by 1.2 million in 2016, to 28.0 million (Exhibit 2), driven mainly by increases in the populations with employer-sponsored insurance and Medicaid.

From the standpoint of payers, the overall slowdown in spending growth primarily reflects a significant deceleration in Medicaid spending growth, from 9.7 percent in 2015 to just 3.7 percent in 2016 (Exhibit 1). This deceleration is driven in part by an expectation of slower enrollment growth, from 5.7 percent in 2015 to 2.6 percent in 2016 (Exhibit 2), as most of the impacts from the ACA's Medicaid expansion were experienced in 2014 and 2015. Also contributing to the slowdown in spending growth was an actual decline in Medicaid's net cost of health insurance (or the difference between premiums received by Medicaid managed care organizations and the benefits paid on behalf of the Medicaid beneficiaries enrolled in them), which is projected to have fallen 5.2 percent in 2016, compared to an increase of 24.9 percent in 2015 (data not shown). This shift in trend is due to the 2016 collection of Medicaid risk mitigation payments made in 2014 and 2015 for newly eligible beneficiaries in managed care plans.[11] Finally, the projected deceleration in Medicaid spending in 2016 was associated with slower Medicaid hospital spending growth—a change from 9.5 percent in 2015, when many states had adopted higher reimbursement rates, to 4.5 percent in 2016.[12]

Private health insurance spending growth is projected to have decelerated to 5.9 percent in 2016, from 7.2 percent in 2015 (Exhibit 2). This pattern of growth reflects a slowdown in enrollment growth that is partially offset by an increase in growth of per enrollee spending. Private health insurance enrollment growth is projected to have slowed to 0.9 percent in 2016 (from 2.6 percent in 2015) as the major impacts of initial enrollment in Marketplace plans waned. However, per enrollee private health insurance spending growth is expected to have accelerated to 4.9 percent in 2016 (from 4.5 percent in 2015), a change related to greater demand for care associated with lagged increases in disposable personal income growth.

Partially offsetting slower growth in Medicaid and private health insurance spending were projected accelerations in Medicare spending growth (reaching 5.0 percent in 2016 from 4.5 percent in 2015) and out-of-pocket spending growth (to 3.6 percent in 2016 from 2.6 percent in 2015) (Exhibit 1). This rise in growth in Medicare spending is largely explained by faster enrollment growth and an expected rebound in the growth in the use of inpatient hospital services, which declined in 2015.[5] The faster expected growth in out-of-pocket spending is primarily attributable to increasing cost sharing and a higher proportion of private health insurance enrollees being in high-deductible health plans.[13]

Among the major goods and services sectors, the category with the largest projected slowdown in 2016 is prescription drug spending, which is projected to have grown 5.0 percent in 2016, down from 9.0 percent in 2015 (Exhibit 4). The main reason for the expectation of decelerating growth is that the use of drugs to treat hepatitis C is expected to have fallen in 2016.[14] In addition, there was an increase between 2015 and 2016 in the dollar value of brand-name drugs whose patents had recently expired—leading to a shift in use from those drugs to less expensive generic drugs in 2016.[15]

One sector that is projected to have experienced faster growth in 2016 than in 2015 (6.6 percent and 6.3 percent, respectively) is physician and clinical services, a change in line with preliminary survey data on health care revenues in this sector.[16] Underlying this increase in growth is a 1.3-percentage-point acceleration in prices for these services in 2016 to 0.2 percent, rebounding from historically slow growth of −1.1 percent in 2015 (which was due primarily to the expiration of the temporary increase in Medicaid payments to primary care providers).[17]

Overall medical price inflation (Personal Health Care Price Index) is projected to have remained low in 2016, growing 1.3 percent—higher than its historically low rate of 0.8 percent in 2015 (Exhibit 1). Hospital price growth is expected to have also remained modest in 2016 at 1.2 percent (data not shown), in part as a result of Medicare's documentation and coding adjustments to its inpatient hospital payment updates and the continuing effects of productivity adjustments to payments for hospitals mandated under the ACA.[5] Although the 2016 growth rate in

EXHIBIT 4

National health expenditures (NHE), amounts and annual growth from previous year shown, by spending category, selected calendar years 2007–25

Spending category	2007[a]	2014	2015	2016[b]	2017[b]	2019[b]	2025[b]
EXPENDITURE, BILLIONS							
NHE	$2,295.7	$3,029.3	$3,205.6	$3,358.2	$3,539.3	$3,965.5	$5,548.8
Health consumption expenditures	2,157.3	2,878.4	3,050.8	3,200.1	3,375.4	3,784.9	5,299.9
Personal health care	1,918.8	2,562.8	2,717.2	2,856.3	3,008.1	3,365.9	4,716.6
Hospital care	692.0	981.0	1,036.1	1,086.8	1,140.8	1,269.1	1,776.0
Professional services	615.6	792.8	840.2	891.0	942.1	1,054.1	1,445.1
Physician and clinical services	458.6	597.1	634.9	677.1	717.0	804.1	1,110.6
Other professional services	60.1	82.8	87.7	92.0	97.1	108.6	149.4
Dental services	97.0	112.8	117.5	121.9	128.0	141.3	185.0
Other health, residential, and personal care	108.3	151.5	163.3	170.0	179.0	201.0	287.5
Long-term care services	182.4	236.2	245.6	256.4	269.4	300.5	430.0
Home health care	57.5	83.6	88.8	94.1	99.9	113.5	170.0
Nursing care facilities and continuing care retirement communities	124.9	152.6	156.8	162.4	169.5	187.0	260.0
Retail outlet sales of medical products	320.5	401.4	432.0	452.1	476.8	541.3	778.1
Prescription drugs	235.6	297.9	324.6	340.7	360.1	412.3	597.1
Durable medical equipment	37.1	46.6	48.5	50.5	53.0	58.7	84.4
Other nondurable medical products	47.8	56.9	59.0	60.9	63.7	70.3	96.7
Government administration	29.1	41.2	42.6	45.0	46.8	55.7	82.9
Net cost of health insurance	143.5	195.3	210.1	216.3	235.1	271.1	384.8
Government public health activities	65.9	79.0	80.9	82.5	85.4	92.2	115.5
Investment	138.4	150.9	154.7	158.1	163.9	180.6	248.9
Noncommercial research	42.6	45.9	46.7	47.9	49.7	54.4	72.2
Structures and equipment	95.8	105.0	108.0	110.2	114.1	126.3	176.7
ANNUAL GROWTH							
NHE	7.3%	4.0%	5.8%	4.8%	5.4%	5.9%	5.8%
Health consumption expenditures	7.3	4.2	6.0	4.9	5.5	5.9	5.8
Personal health care	7.2	4.2	6.0	5.1	5.3	5.8	5.8
Hospital care	6.4	5.1	5.6	4.9	5.0	5.5	5.8
Professional services	6.8	3.7	6.0	6.0	5.7	5.8	5.4
Physician and clinical services	6.7	3.8	6.3	6.6	5.9	5.9	5.5
Other professional services	8.2	4.7	5.9	4.9	5.5	5.8	5.5
Dental services	6.9	2.2	4.2	3.7	5.0	5.1	4.6
Other health, residential, and personal care	9.4	4.9	7.8	4.1	5.3	6.0	6.1
Long-term care services	7.6	3.8	4.0	4.4	5.1	5.6	6.2
Home health care	10.1	5.5	6.3	5.9	6.2	6.6	7.0
Nursing care facilities and continuing care retirement communities	6.8	2.9	2.7	3.5	4.4	5.0	5.6
Retail outlet sales of medical products	9.0	3.3	7.6	4.6	5.5	6.5	6.2
Prescription drugs	11.2	3.4	9.0	5.0	5.7	7.0	6.4
Durable medical equipment	6.5	3.3	3.9	4.2	5.0	5.2	6.2
Other nondurable medical products	4.7	2.5	3.7	3.2	4.6	5.1	5.4
Government administration	8.6	5.1	3.2	5.8	4.0	9.0	6.9
Net cost of health insurance	9.6	4.5	7.6	3.0	8.7	7.4	6.0
Government public health activities	7.5	2.6	2.4	1.9	3.5	3.9	3.8
Investment	6.8	1.2	2.6	2.2	3.6	5.0	5.5
Noncommercial research	7.4	1.1	1.8	2.5	3.8	4.6	4.8
Structures and equipment	6.5	1.3	2.9	2.0	3.6	5.2	5.8

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** For definitions, sources, and methods for NHE categories, see CMS.gov. National Health Expenditure Accounts methodology paper, 2015 (see Exhibit 1 Notes). Numbers may not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 1990–2007. [b]Projected.

prices for physician and clinical services is expected to be faster than the previous year, at just 0.2 percent (data not shown), the growth is still low relative to average growth over the previous decade.

2017 National health spending growth is projected to accelerate to 5.4 percent in 2017, up from 4.8 percent in 2016 (Exhibit 1). Although growth in the GDP is expected to accelerate to 4.3 percent, health spending as a share of the economy is projected to increase again by 0.2 percentage point to 18.3 percent, as growth of health spending exceeds that of the overall economy. The uninsured population is projected to decrease once more, but by just 0.8 million to 27.2 million (Exhibit 2)—partly because of expected small enrollment increases in employer-sponsored insurance and the Children's Health Insurance Program.

From a payer perspective, Medicare spending growth is projected to accelerate to 5.9 percent in 2017, from 5.0 percent in 2016 (Exhibit 1). This trend is due to spending associated with Medicare physician and clinical services (5.3 percent growth in 2017, up from 3.9 percent in 2016) and Medicare hospital services (4.9 percent growth in 2017, up from 4.2 percent in 2016) (data not shown). Higher growth in the use of Medicare hospital services is expected in part as the downward pressure on growth attributable to the readmission penalties and the two-midnight rule that occurred during 2011–15 is not expected to continue.[5]

Private health insurance spending growth is projected to be 6.5 percent in 2017, up somewhat from 5.9 percent in 2016 (Exhibit 2). In anticipation of slower growth in private health insurance enrollment (0.5 percent in 2017, down from 0.9 percent in 2016), private health insurance spending per enrollee is expected to increase at a faster rate of 5.9 percent in 2017 (from 4.9 percent in 2016). One factor contributing to faster growth is a significant acceleration in premium growth for Marketplace plans because of previous underpricing of premiums and the elimination of risk corridor payments.[18] Prescription drug spending growth is also expected to accelerate, reaching 5.7 percent in 2017—up from 5.0 percent in 2016 (Exhibit 4). The increase is primarily due to faster growth in the number of prescriptions dispensed.

In contrast, a slowdown in spending growth for physician care is expected in 2017. Physician and clinical services spending growth is projected to slow 0.7 percentage point, to 5.9 percent in 2017, as the effects of the coverage expansions moderate—particularly for private health insurance and Medicaid.

Medical price growth (Personal Health Care Price Index) is projected to accelerate to 1.6 percent in 2017, up from 1.3 percent in 2016 (Exhibit 1), driven by expectations of an acceleration in economywide price inflation in 2017. However, the acceleration is mitigated by the expectation that patent expirations will moderate the growth in prescription drug prices.

2018–19 National health expenditure growth is projected to accelerate from 5.4 percent in 2017 to an average of 5.9 percent for 2018–19, driven mainly by faster growth in both Medicare and Medicaid. Medicare spending growth is expected to average 7.1 percent for 2018–19 (up from 5.9 percent in 2017), largely related to an expectation that the use and intensity of medical services will increase from historically low rates to rates that are more consistent with Medicare's longer-term historical experience. As a result, Medicare per enrollee average spending growth is projected to accelerate to 4.1 percent for 2018–19, from 3.0 percent in 2017 (Exhibit 2).

Medicaid spending growth is projected to accelerate to an average of 5.9 percent for 2018–19 (from 3.7 percent in 2017) (Exhibit 1), largely because of more rapid projected growth in the use and intensity of care required to meet the needs of Medicaid's increasingly larger proportion of aged and disabled enrollees (who tend to be comparatively more expensive). Medicaid net-cost spending growth is projected to accelerate sharply to 18.8 percent in 2018 (data not shown) after negative growth in 2017, when Medicaid is expected to collect previous risk mitigation payments to Medicaid managed care plans. Overall, projected average Medicaid spending growth per enrollee accelerates to 4.2 percent for 2018–19, from 1.8 percent in 2017 (Exhibit 2).

Growth in private health insurance spending is projected to begin decelerating and average 5.7 percent for 2018–19 (down from 6.5 percent in 2017). The relative price of health care is projected to begin climbing during this period, which is expected to slightly dampen growth in the use and intensity of services demanded by those covered by private health insurance. Additionally, the continued aging of the baby boomers keeps the growth of private health insurance enrollment low, as many boomers reach the age of Medicare entitlement.

Prescription drug spending growth is anticipated to accelerate from 5.7 percent in 2017 to an average of 7.0 percent for 2018–19 (Exhibit 4). This expected higher rate of growth is driven by faster price growth as a result of fewer brand-name drugs losing patent protection. In 2017 a subset of drugs that represents $11.1 billion of brand-name drug spending is expected to lose patent protection and to be mostly replaced by

Health care enrollment and spending trends are projected to revert to being fundamentally driven by changes in economics and demographics.

less expensive generic versions. This compares to $27.7 billion in 2015 and $18.9 billion in 2016.[15] As a result, there is expected to be a significantly smaller amount of brand-name drug purchases shifted to generics in 2018, leading to a faster rate of growth in drug prices.[19]

Growth in prices for hospital services is projected to accelerate during this time period as a result of anticipated increases in input costs, along with stronger projected growth in the use and intensity of hospital services by Medicare beneficiaries. Hospital spending growth for the Medicare program is projected to rise from 4.9 percent in 2017 to an average of 6.4 percent for 2018–19 (data not shown).

2020–25 National health expenditure growth is projected to grow at an average rate of 5.8 percent during the second half of the projection period (2020–25), similar to the average growth rate of 5.9 percent for 2018–19 (Exhibit 1) and still more rapidly than growth in GDP. These trends combine to result in a projected increase in the health share of the economy to 19.9 percent by 2025 (Exhibit 1). The years 2020–25 are the portion of the entire projection period when Medicare spending growth is projected to be at its highest, and spending growth by private health insurers is projected to fall to its lowest rates.

Medicare spending growth is projected to peak in 2020 at 8.0 percent and grow at an average rate of 7.6 percent for 2020–25, up from an average of 7.1 percent for 2018–19 (Exhibit 2). Driving growth in Medicare spending is continued strong enrollment growth from baby boomers (averaging 2.8 percent) and the aging of the existing Medicare population. Both of these effects contribute to increases in growth in the use and intensity of medical services.

Private health insurance spending growth is projected to decelerate to an average of 5.0 percent for 2020–25, from 5.7 percent for 2018–19 (Exhibit 2)—including growth of 4.8 percent in 2020 when the excise tax on high-cost health plans under current law is to be implemented. This slower growth in private health insurance spending is primarily attributable to a lagged response to projected slower growth in disposable personal income near the end of the projection period. Out-of-pocket spending growth is projected to average 5.2 percent for 2020–25, up from 4.7 percent for 2018–19 (Exhibit 1), driven partly by the reduction in the scope of insurance coverage and the accompanying increase in cost sharing associated with employers' being affected by the excise tax.

Average growth in Medicaid spending for 2020–25 (5.9 percent) is expected to be similar to that projected in 2018–19 (Exhibit 1) and about the same as total health spending growth. This rate is the net result of somewhat offsetting trends. First, enrollment growth is expected to average only 1.1 percent for 2020–25, down from an average of 1.7 percent in 2018–19 (Exhibit 2). However, average per enrollee expenditure growth is projected to accelerate 0.6 percentage point between the two time periods, to 4.8 percent—in part because of the aging of the program's population and the expiration of cuts to disproportionate-share hospital payments late in the projection period.

Medical price growth (Personal Health Care Price Index) is projected to accelerate somewhat from a 2.4 percent average for 2018–19 to a 2.7 percent average for 2020–25 (Exhibit 1). Higher input prices associated with the provision of health care (relative to inputs required for other sectors of the economy) are expected to continue to drive growth in medical prices during this phase of the projection period.

Trends By Type of Sponsor

National health expenditures sponsored by federal, state, and local governments are projected to account for 47 percent of total payments by 2025, up from 46 percent in 2015 (Exhibit 5). Driven mainly by continued growth in Medicare enrollment from baby boomers and by ongoing subsidies paid for lower-income Marketplace plan enrollees, spending sponsored by the federal government is projected to reach 30 percent of national health expenditures in 2025, up from 29 percent in 2015 (Exhibit 5). The share of total spending sponsored by state and local governments is projected to remain steady at 17 percent through 2025 (Exhibit 5), with an average annual rate of 5.7 percent growth for the period 2016–

EXHIBIT 5

National health expenditures (NHE) amounts, average annual growth from previous year shown, and percent distribution, by type of sponsor, selected calendar years 2007–25

Type of sponsor	2007[a]	2014	2015	2016[b]	2017[b]	2019[b]	2025[b]
EXPENDITURE, BILLIONS							
NHE	$2,295.7	$3,029.3	$3,205.6	$3,358.2	$3,539.3	$3,965.5	$5,548.8
Businesses, households, and other private revenues	1,369.8	1,662.8	1,739.4	1,827.8	1,942.5	2,173.3	2,942.9
Private businesses	506.5	605.6	637.5	676.3	718.6	803.9	1,059.5
Households	693.2	846.6	886.8	927.9	990.1	1,111.2	1,533.8
Other private revenues	170.1	210.5	215.1	223.6	233.7	258.3	349.6
Governments	925.8	1,366.5	1,466.2	1,530.4	1,596.8	1,792.2	2,605.9
Federal government	528.2	843.1	918.5	959.7	994.7	1,116.9	1,649.6
State and local governments	397.7	523.4	547.7	570.8	602.2	675.3	956.3
ANNUAL GROWTH							
NHE	7.3%	4.0%	5.8%	4.8%	5.4%	5.9%	5.8%
Businesses, household, and other private revenues	6.5	2.8	4.6	5.1	6.3	5.8	5.2
Private businesses	6.9	2.6	5.3	6.1	6.3	5.8	4.7
Households	6.1	2.9	4.7	4.6	6.7	5.9	5.5
Other private revenues	6.8	3.1	2.2	4.0	4.5	5.1	5.2
Governments	8.9	5.7	7.3	4.4	4.3	5.9	6.4
Federal government	9.4	6.9	8.9	4.5	3.6	6.0	6.7
State and local governments	8.2	4.0	4.6	4.2	5.5	5.9	6.0
DISTRIBUTION							
NHE	100%	100%	100%	100%	100%	100%	100%
Businesses, households, and other private revenues	60	55	54	54	55	55	53
Private businesses	22	20	20	20	20	20	19
Households	30	28	28	28	28	28	28
Other private revenues	7	7	7	7	7	7	6
Governments	40	45	46	46	45	45	47
Federal government	23	28	29	29	28	28	30
State and local governments	17	17	17	17	17	17	17

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** For definitions, sources, and methods for NHE categories, see CMS.gov. National Health Expenditure Accounts methodology paper, 2015 (see Exhibit 1 Notes). Numbers may not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 1990–2007. [b]Projected.

25 (data not shown).

National health expenditures collectively sponsored by private businesses, households, and other private revenues are projected to represent 53 percent of total expenses by 2025, down from 54 percent in 2015 (Exhibit 5). As baby boomers reach Medicare eligibility age, many are expected to switch from private coverage, thereby shifting spending to the Medicare program. Although Medicare spending sponsored by private businesses and households is expected to increase 1 percentage point as a share of NHE by 2025, out-of-pocket and private health insurance premium contributions sponsored by these sources are projected to fall by 2 percentage points as a share of NHE over the same period (data not shown).

Conclusion

There is considerable uncertainty regarding how the nation's health care will be delivered and paid for going forward. This analysis finds that under current law and following the recent significant period of transition associated with coverage expansions, health care enrollment and spending trends are projected to revert to being fundamentally driven by changes in economics and demographics. As a result, health care spending is projected to grow 5.6 percent per year, on average, over the period 2016–25 and increase to 19.9 percent of GDP by 2025. Irrespective of any changes in law, it is expected that because of continued cost pressures associated with paying for health care, employers, insurers, and other payers will continue to pursue strategies that seek to effectively manage the use and cost of health care goods and services. ■

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NOTES

1 One exception is that the projections assume that the level of funding for the Children's Health Insurance Program does not expire throughout the projection period.

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