U.S. Health Reform—Monitoring and Impact

The Evidence on Recent Health Care Spending Growth and the Impact of the Affordable Care Act

May 2017

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Robert Wood Johnson Foundation

Support for this research was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

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 health reform. 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**.

INTRODUCTION

Conventional wisdom holds that health care cost growth is high and the Affordable Care Act (ACA) has done little to address the problem.[1–6] However, overall increases in national health expenditures (NHE) since the law passed have been lower than anticipated, premiums and premium growth in the ACA's health insurance marketplaces are high in some states but quite low in others, and growth in Medicare and Medicaid spending per enrollee has been very modest. NHE are still high, now at 18.3 percent of gross domestic product, or GDP[7] (well above health expenditures of other industrialized nations),[8] and remain an ongoing problem for federal and state budgets as well as family budgets. In this brief, we attempt to address several misconceptions about recent spending increases;[9–12] these misconceptions are centered in three areas:

- the recent and projected growth in NHE
- the levels and recent growth of ACA marketplace premiums
- the recent and projected spending growth in the Medicaid program.

NATIONAL HEALTH EXPENDITURES ARE GROWING MORE SLOWLY NOW THAN IN PAST DECADES

National health expenditures grew at historically low rates in recent years (3.6 percent per year on average in between 2009 and 2013),[7] and projections for future growth rates are significantly below those experienced over recent decades. Average annual growth rates between 1970 and 2010 were equal to growth in GDP plus 2.5 percent.[13] Current estimates from the Centers for Medicare & Medicaid Services (CMS) indicate that the average annual growth in NHE between 2010 and 2020 will be GDP growth plus 0.8 percent; for 2020 to 2025, CMS projects the increase in NHE to be GDP growth plus 1.2 percent. The slow growth in recent years was at least partly related to the recession and slow economic recovery,[14,15] but other factors, including changes associated with the ACA, seem to have contributed as well; evidence indicates and analysts predict that these and other factors are likely to cause these slower growth rates to persist into the future.

CMS routinely revises its spending forecasts as new data become available. The most recent forecast, released in February 2017, includes actual spending estimates for 2010 to 2015, and projections for 2016 to 2025.[7] Table 1 compares the current (2017) estimates of actual spending growth to the forecast for 2010 to 2015 spending that was made shortly after the ACA passed in 2010.[10] The most recent estimates suggest NHE grew 4.3 percent annually from 2010 to 2015 compared with the original forecast of 6.5 percent. Current estimates

Table 1: Changes in National Health Expenditure Estimates for 2010 to 2015

	Cumulative spending, 2010–2015 ($ trillions)		Average annual growth rate, 2010–2015	
	2010 CMS estimates (projected)	2017 CMS estimates (actual)	2010 CMS estimates (projected)	2017 CMS estimates (actual)
National health expenditures	18.1	17.2	6.5%	4.3%
Medicare	3.7	3.5	5.8%	4.5%
Medicaid	3.3	2.7	9.9%	6.5%
Private insurance	5.8	5.7	6.6%	4.4%
Out-of-pocket spending	1.9	1.9	3.2%	2.5%
Other spending	3.5	3.4	5.8%	3.1%

Source: Urban Institute analysis of Centers for Medicare & Medicaid Services national health expenditure projections, 2010 and 2017.

Notes: CMS = Centers for Medicare & Medicaid Services. The 2010 estimates for Medicare and national health expenditures include an adjustment assuming that cuts to physician payments (required under the sustainable growth rate system in 2010) were replaced with rate freezes or small increases. The 2017 forecast reflects the permanent fix under the Medicare Access and CHIP Reauthorization Act of 2015.

of growth in each component of NHE spending for the 2010 to 2015 period are lower than the original forecast, from 5.8 percent to 4.5 percent for Medicare, from 9.9 percent to 6.5 percent for Medicaid, and from 6.6 percent to 4.4 percent for private insurance. "Other" health spending, which includes spending on the Children's Health Insurance Program, the US Department of Defense and Veterans Affairs health programs, public health activity, and investments, including new construction and capital equipment, was originally projected to increase 5.8 percent; the spending for that category actually grew 3.1 percent.

Actual NHE growth from 2010 to 2015 was lower than projected in 2010 for several reasons. Those reasons include the 2007 to 2009 economic recession and slow recovery, unexpectedly low inflation, increased employer offerings of high-deductible insurance plans (higher cost-sharing requirements lead to lower use of care), cost-containment efforts within state Medicaid programs, and Medicare policies unrelated to the ACA, including cuts as a result of sequestration. But the ACA, too, probably contributed to low NHE growth in several ways.[10]

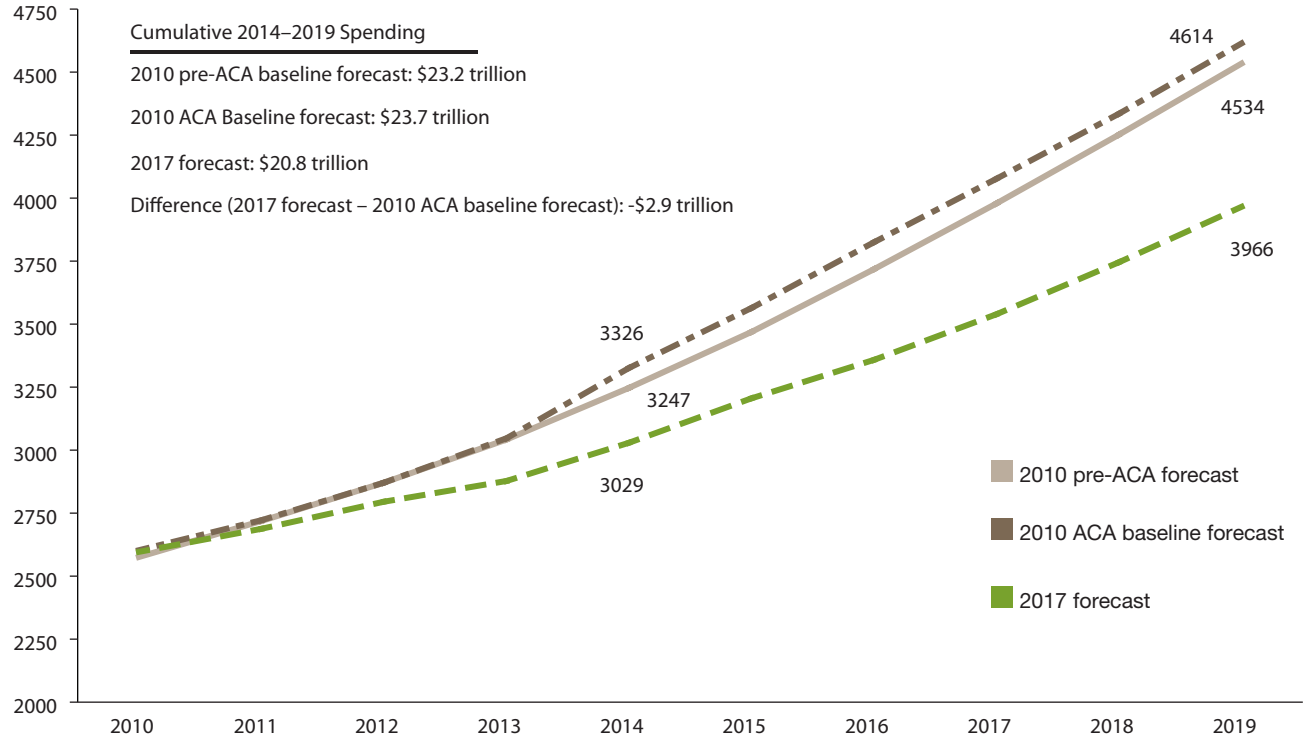
Many of the cost-containment provisions of the ACA were reflected in the 2010 forecast, including the Medicare payment reductions to hospitals and other providers; the reduction in Medicare Advantage payments; and the managed competition structure in marketplaces that limited subsidies to the second-lowest-cost silver plan, in turn forcing insurers to price aggressively. Thus, any contribution of the ACA to reductions in projected spending not already in the baseline would have come from larger-than-anticipated effects of these provisions or from other factors.

Many ACA-related factors that were not included in the original projections may have helped slow spending growth. First, starting in 2011, adjustments to ACA Medicare payments seem to have played a role in reducing the number of Medicare hospital days, outpatient visits, skilled nursing facility days, and advanced imaging procedures between 2010 and 2014.[16] Second, lower Medicare payment rates may have had spillover effects on other payers; commercial insurers often use Medicare as a benchmark for their negotiations with hospitals and physicians.[17–19] Finally, Medicare policies such as financial penalties for hospital readmissions may have changed provider practice patterns for patients of other payers as well.

The lower-than-expected spending from 2010 to 2015 has also contributed to lower projected spending through 2019. We compare the estimates for the 2014 to 2019 period (the current forecast), which reflect actual data for 2014 and 2016 and projections for 2016 to 2019, to the projections made for the same period in 2010. We find that the most recent 2017 CMS forecast estimated that national health expenditures for 2014 to 2019 would total $20.8 trillion;[7] this is $2.9 trillion, or 12 percent, below the CMS forecast of $23.7 trillion for the same period made in late 2010, shortly after the ACA was passed (Figure 1).[10]

The 2017 forecast also estimated lower spending for Medicare, Medicaid and private insurance, compared with the 2010 forecast of spending after enactment of the ACA (data not shown). Medicare expenditures for 2014 to 2019 were projected to be $4.3 trillion in the 2017 forecast, down from $4.7 trillion in the original 2010 ACA baseline forecast. In the 2017 projections, Medicaid spending for 2014 to 2019 was

Figure 1. National Health Expenditure Projections ($ Billions)



Note: ACA = the Affordable Care Act.

Source: Authors' analysis of Centers for Medicare and Medicaid Services national health expenditure projections. The 2010 estimates include an adjustment assuming that cuts to physician payments (required under the sustainable growth rate system in 2010) were replaced with rate freezes or small increases. The 2017 forecast reflects the permanent fix under the Medicare Access and CHIP Reauthorization Act of 2015.

projected to be $3.5 trillion, compared with $4.6 trillion in the ACA baseline forecast. Some, but not all, of this decline stemmed from the Supreme Court decision that made Medicaid expansion a state option.[20] Private health insurance expenditures for the 2014 to 2019 period were projected to be $7.7 trillion in the ACA baseline forecast but fell to $7.0 trillion in the updated 2017 forecast.

Current CMS estimates of NHE for 2014 to 2019 (Table 2) show an average annual increase of 5.5 percent (2014 and 2015 estimates reflect actual data; 2016 to 2019 are projections). The population is projected to grow 0.9 percent per year, so NHE per capita is projected to increase 4.6 percent per year. In aggregate Medicare, Medicaid and private insurance are all projected to grow faster than NHE, with out-of-pocket and other spending growing more slowly (data not shown). Both public programs are projected to have significant enrollment growth. Medicare enrollment is increasing 3.0 percent per year, largely because the population has aged. Medicaid enrollment is expected to increase by 2.7 percent, largely because of the ACA Medicaid eligibility expansion but also because of declining incomes, increases in disabilities and an aging population. Annual spending per enrollee however is expected to grow quite slowly in comparison with NHE at 2.9 percent for Medicare and 3.0 percent for Medicaid. Spending by those with private insurance is projected to increase 6.2 percent overall and 4.8 percent on a per insured basis, the latter considerably faster than the public programs.

The ACA, particularly Medicare payment policies and the managed-competition structure of the marketplaces, likely contributed to the slowdown in spending growth, and these provisions probably will continue to place pressure on providers. Though average marketplace premium increases were higher in 2017 than in 2015 and 2016, marketplace competition in large urban markets has generally been intense, leading to narrower networks of providers who are willing to accept lower payment rates in private insurance plans.[11] It is not necessary to attribute any cost savings to ACA innovations such as accountable care organizations, medical homes, or other delivery system reforms. The Medicare payment reductions, slow income growth, increased cost-sharing in private plans, and pressure to establish narrow networks in the private nongroup market have together reduced the flow of revenues to providers. This in turn may have caused providers to make substantial structural changes to adapt to the new environment. To the

Table 2: Current Estimates of National Health Spending and Enrollment for 2014–2019, by Major Insurance Type

	Spending ($ billions)			Enrollment (millions)			Spending per enrollee ($)		
	2014	2019	Average annual growth rate	2014	2019	Average annual growth rate	2014	2019	Average annual growth rate
Medicare	619	825	5.9%	53	61	3.0%	11,714	13,501	2.9%
Medicaid	497	658	5.8%	66	75	2.7%	7,591	8,798	3.0%
Private insurance	1,000	1,351	6.2%	191	204	1.4%	5,247	6,621	4.8%
National health expenditures	3,029	3,966	5.5%	318	333	0.9%	9,515	11,912	4.6%

Source: Urban Institute analysis of Centers for Medicare & Medicaid Services national health expenditure projections, 2017. Estimates are based on observed data for 2014 and 2015 and projections for 2016 to 2019. For national health expenditures, the enrollment estimate reflects the whole U.S population.

extent that such structural changes are maintained, they could contribute to slower spending growth in the future.

This is not to suggest that all spending problems are solved. The state of the overall economy will also continue to affect health spending growth. If the economic recovery strengthens, employers and other payers may be more willing to accommodate higher rate increases for providers and reduced cost-sharing in both private and public plans; both could generate faster spending growth. Furthermore, consumers may begin to push back against the higher deductibles and narrow networks that have helped to hold down costs, echoing the backlash against managed care in the 1990s. Continued provider consolidation also could lead to higher levels of spending because large health systems have greater negotiating leverage over insurers.

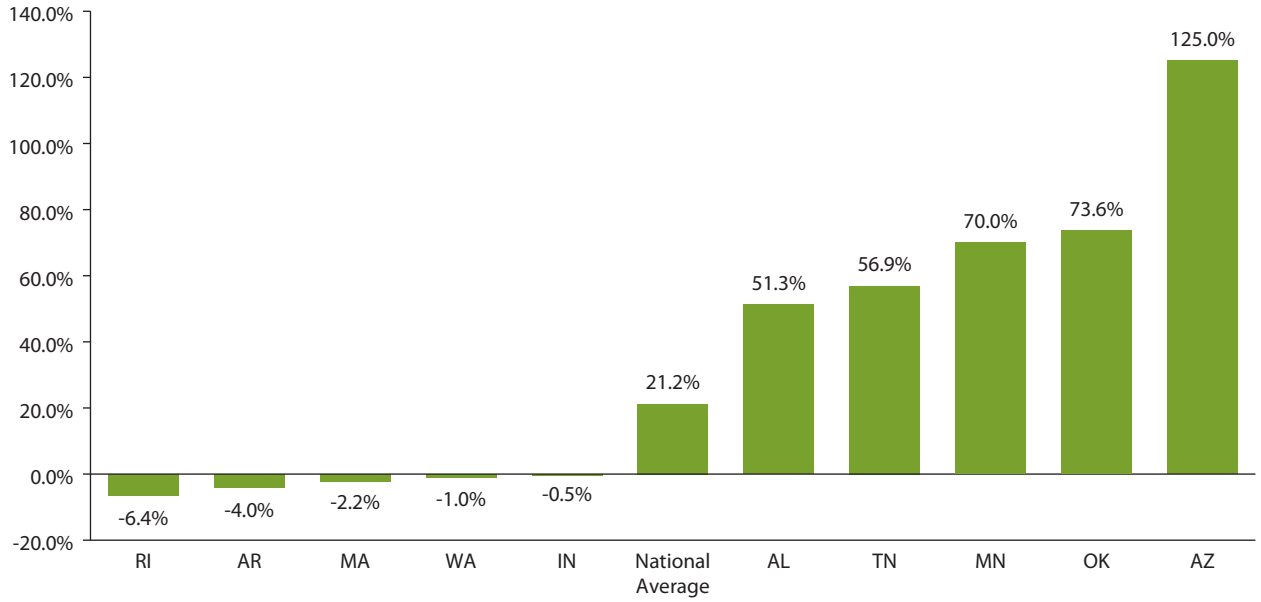
PREMIUMS IN THE NONGROUP INSURANCE MARKET ARE HIGH IN SOME AREAS, BUT THE PROBLEM IS FAR FROM UNIVERSAL

The marketplace premium increases for 2017 are not indicators of unstable nongroup markets. Though some markets did experience premium increases of 25 percent or more, and Arizona's benchmark premiums increased more than 100 percent, the broader national evidence shows that premium growth has varied and has remained low in many states and substate regions, particularly in more populated areas. In addition, the high percentage premium increases were in large part attributable to catch-up from premiums that were set too low in earlier years, either because such prices were an effort to gain initial market share or because insurers lacked sufficient knowledge about the enrollee population. Some evidence suggests that insurers felt encouraged by 2017 premium growth and anticipated reaching target profitability soon under current law. An analysis by Standard & Poor's concluded that nongroup markets were becoming more stable rather than less, and that nongroup insurer profits would grow.[21] A recent analysis by the Congressional Budget Office (CBO) also indicated that ACA nongroup markets were expected to be stable into the future under the prior administration's policies.[22] However, insurer or provider concentration in some areas is cause for concern about premium prices as are uncertainties created by the current policy environment.

Geographic Variation in Marketplace Premiums and Premium Growth

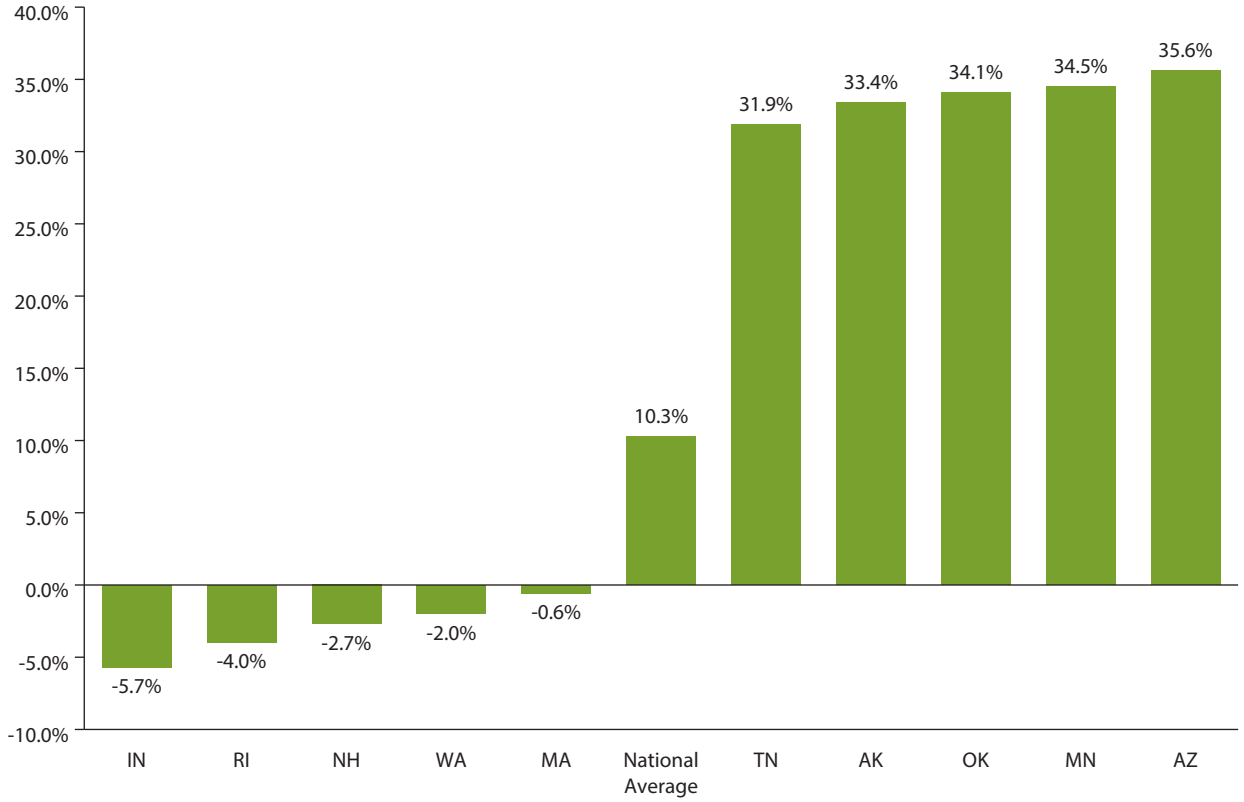
In a recent paper, we showed that 14 states saw reductions or single-digit percentage increases in their states' average lowest-cost silver premiums for 2017.[11] About 40 percent of the nonelderly population lives in these states. At the same time, about 40 percent of the population lives in areas where premiums increased 20 percent or more in 2017. Figure 2 shows the average change in lowest-cost silver premiums

Figure 2. Statewide Average Change in Lowest-Cost Silver Premiums, 2016–2017



Source: Holahan J, Wengle E, Blumberg LJ, Solleveld P. *What Explains the 21 Percent Increase in 2017 Marketplace Premiums, and Why Do Increases Vary Across the Country?* Washington: Urban Institute; 2017. http://www.urban.org/sites/default/files/publication/87021/2001052-what-explains-the-21-percent-increase-in-2017-marketplace-premiums-and-why-do-increases-vary-across-the-country_1.pdf. Published January 2017.

Figure 3. Statewide Average Annual Change in Lowest-Cost Silver Premiums, 2014–2017



Source: Holahan J, Wengle E, Blumberg LJ, Solleveld P. *What Explains the 21 Percent Increase in 2017 Marketplace Premiums, and Why Do Increases Vary Across the Country?* Washington: Urban Institute; 2017. http://www.urban.org/sites/default/files/publication/87021/2001052-what-explains-the-21-percent-increase-in-2017-marketplace-premiums-and-why-do-increases-vary-across-the-country_1.pdf. Published January 2017.

for states with the lowest and highest premium increases from 2016 to 2017; Figure 3 provides the same data for 2014 through 2017. The reasons behind these increases are different and complicated but important to understand.

Areas with low premium increases typically have many competing insurers as well as competition from national or local Medicaid plans, Blue Cross Blue Shield health maintenance organization plans, or provider-sponsored insurers.[11] In a more recent paper, we showed that markets with 6 or more insurers had median monthly benchmark plan premiums of $270 in 2017 versus $451 in markets with only one insurer. Growth rates averaged 5.0 percent in the former and 29.8 percent in the latter.[23]

High Premiums Caused by Catch-Up From Underpricing and Provider or Insurer Concentration

Our analysis showed that markets with the largest premium increases in 2017 tended to have low premiums in 2016 and vice versa; this strongly suggests that insurers raised premiums to correct for previous pricing mistakes.[11] Lack of insurer competition was also a problem in many geographic areas before the ACA and persists in some areas, particularly those where Medicaid managed care insurers have not entered the marketplaces and where provider-sponsored insurers have not developed.

Provider concentration can also lead to higher premiums. Markets with few providers or dominant provider systems tend to have high premiums because even strong insurers do not have leverage to negotiate over payment rates when the hospital system or physician specialty practice is the only game in town. In many rural areas, providers have substantial leverage in negotiating with insurers. These market concentration problems will persist under the ACA or under repeal.

The Extremely Large Premium Increases in Arizona Are an Outlier

Anecdotal evidence suggests that a combination of early underpricing by marketplace insurers and rampant sales of non-ACA-compliant insurance policies contributed to Arizona's extremely large percentage premium increases. Early underpricing by some insurers drove other competitors out of the market, and the remaining insurers experienced losses from underpricing, leading to more exits. Sales of noncompliant policies, such as those offering less than a year of coverage, are permitted in the state and are exempt from ACA rules that spread health care risk broadly across the population enrolled in ACA-compliant nongroup coverage (rules such as modified community rating, guaranteed issue, and essential health benefits). These policies appear to be drawing better health care risks out of the statewide insurance pool and driving up the average health care costs of those remaining in the pool. As we have written elsewhere,[24] the problems caused by noncompliant policies can be addressed effectively through state or federal regulation.

In Most States, Average Nongroup Marketplace Premiums Are Lower Than or Close to Employer Premiums

Despite persistent problems in some geographic areas, premiums in the nongroup market are often below or close to those in the employer-sponsored insurance market after controlling for enrollee age and actuarial value differences. We cannot control directly for benefit differences, but because most states set their essential health benefits benchmark to the benefits offered in their state's small-group insurance plan with the greatest number of enrollees,[25] we assume they are comparable. Table 3 compares statewide average second-lowest-cost silver premiums and statewide average employer-sponsored insurance premiums. Because the two lowest-cost silver options have the highest enrollment,[26] the second-lowest-cost premium is a reasonable proxy for the average silver premium (plan enrollment data are generally not available to compute actual weighted averages). Using a methodology consistent with our earlier estimates,[26,27] 20 states have average 2017 nongroup marketplace premiums that are below their average employer-sponsored insurance premiums; 11 states have average marketplace premiums that exceed employer-sponsored insurance premiums by less than 10 percent. The remaining 20 states have average 2017 marketplace premiums that are more than 10 percent above the state average employer premium. With few exceptions, the states with substantially higher average marketplace premiums are located in the South and West, which see much less competition in the nongroup insurance markets. These states account for only 21.5 percent of marketplace enrollees;

Table 3: Percentage Difference Between Nongroup and Employer-Sponsored Insurance Premiums

Nongroup Less than ESI		Nongroup Greater than ESI by 10 Percent or Less		Nongroup Greater than ESI by More Than 10 Percent	
Percentage of US total ACA nongroup enrollment		Percentage of US total ACA nongroup enrollment		Percentage of US total ACA nongroup enrollment	
47.6%		30.9%		21.5%	
California	-2%	Arkansas	3%	Alabama	42%
District of Columbia	-19%	Colorado	2%	Alaska	106%
Indiana	-19%	Florida	0%	Arizona	66%
Kentucky	-22%	Georgia	2%	Connecticut	17%
Maryland	-14%	Hawaii	9%	Delaware	17%
Massachusetts	-40%	Idaho	5%	Kansas	13%
Michigan	-20%	Illinois	3%	Louisiana	22%
Nevada	-6%	Iowa	4%	Maine	10%
New Hampshire	-29%	Mississippi	7%	Minnesota	37%
New Jersey	-15%	Pennsylvania	2%	Missouri	12%
New Mexico	-23%	Wisconsin	4%	Montana	32%
New York	-9%			Nebraska	43%
North Dakota	-2%			North Carolina	63%
Ohio	-23%			Oklahoma	56%
Oregon	-4%			South Carolina	15%
Rhode Island	-30%			South Dakota	37%
Texas	-15%			Tennessee	54%
Utah	-8%			Vermont	15%
Virginia	-7%			West Virginia	32%
Washington	-29%			Wyoming	36%

Notes: ACA = the Affordable Care Act; ESI = employer-sponsored insurance.

Source: Urban Institute calculations based upon analysis of 2017 marketplace nongroup premiums and 2015 employer-sponsored insurance premiums aged to 2017. Marketplace premiums are adjusted to account for age differences between employer coverage and nongroup coverage enrollees as well as actuarial value differences. Employer premium data comes from the 2015 Medical Expenditure Panel Survey – Insurance Component.

the states with nongroup premiums below employer-sponsored insurance premiums account for 47.6 percent of marketplace enrollees, and those with comparable premiums account for 30.9 percent of marketplace enrollees

Strategies for Addressing High Premiums in Some Geographic Areas

These markets could be improved in several ways. First, increased enrollment, which tends to draw in healthier individuals, can improve risk pools, lower costs and reduce year-to-year premium variability. The federal government could encourage enrollment by providing targeted outreach and enrollment assistance, increasing premium and cost-sharing subsidies, making subsidized family coverage of workers available in marketplaces, eliminating the loophole for short-term policies, and allowing states the flexibility to expand Medicaid coverage to 100 percent of the federal poverty level instead of 138 percent. Second, either the federal government or state governments could spur marketplace competition by establishing maximum provider payment rates for all nongroup ACA-compliant insurance plans, as is done for the Medicare Advantage program. These maximum rates could be set to some multiple of traditional Medicare payment rates (e.g., 115 percent) and would apply for both in-network and out-of-network providers; insurers could negotiate lower rates if they were able. This policy would encourage insurers to enter new markets because they would know they could set premiums based on reasonable, known rates. The approach would also break the monopoly pricing power of dominant providers. Finally, subsidizing extremely high-cost medical cases for nongroup enrollees through a permanent reinsurance program would lower premiums and year-to-year variability in markets where enrollees have higher-than-average costs.[24,28]

MEDICAID ENROLLMENT HAS INCREASED SIGNIFICANTLY, BUT LEVELS AND GROWTH IN SPENDING PER ENROLLEE ARE LOW

Recent growth in Medicaid spending—both pre- and post-ACA—has been driven largely by enrollment growth. Increases in spending per enrollee have been low compared with other programs and private insurance. Between 2007 and 2013, Medicaid spending growth averaged 5.7 percent per year; enrollment increased 3.9 percent annually and spending per enrollee increased 1.7 percent annually after adjusting for the changing age and disability composition of enrollees (Table 4).[29] As of August 2016, aggregate Medicaid spending growth between 2014 and 2019 was projected to be 5.8 percent; enrollment was projected to increase 2.7 percent per year and spending per enrollee 3.0 percent.[30] In addition, levels of health care spending per Medicaid enrollee are low compared with other public and private sources of insurance. Understanding the level and sources of growth in Medicaid spending overall and per enrollee is critical to assessing whether spending under the program should be a concern. For example, policies such as block grants or per capita caps are predicated on the perception that Medicaid spending is too high and needs to be contained.

Sources of Increased Medicaid Enrollment

Enrollment in Medicaid, which covered an estimated 76 million low-income Americans in 2015,[31] has increased over the past decade for several reasons beyond underlying population growth; the expansion of eligibility under the ACA is only one of these reasons. First, the number of elderly retiring baby boomers has been increasing for years; this has increased the size of the aged component of Medicaid. Second, the disabled population has grown faster than the general population because disability rates increase with age, in turn increasing the size of the disabled component of Medicaid. Third, enrollment growth has increased because the number of people with low incomes (and who are thus eligible for Medicaid) has increased over the past decade.

Medicaid enrollment historically has increased more rapidly during economic recessions as unemployment causes the loss of employer-sponsored insurance and depresses family incomes. The Great Recession from 2007 to 2009 was no exception, and relatively high postrecession unemployment rates extended the effect.[32] More recently, the ACA permitted states to expand Medicaid eligibility up to 138 percent of the federal poverty level, leading to substantial increases in enrollment in 2014 and later in 31 states that opted to expand eligibility.[31] All of these demographic and economic developments, combined with the Medicaid expansion, have contributed to enrollment-driven spending increases in Medicaid. Some trends, including the demographic changes, will continue to drive such spending increases into the future.

Medicaid Spending per Enrollee

The Kaiser Family Foundation study showed that the 1.7 percent average annual increase in spending per enrollee (Table 4) between 2007 and 2013 matched per capita growth in GDP and was lower than the average annual increases in both national health expenditures per capita (3.1 percent) and the consumer price index (2.1 percent). The projections for 2014 to 2019 (Table 4) show a similar picture (2014 and 2015 estimates reflect actual data; 2016 to 2019 are projections). Medicaid spending per enrollee is expected to average 3.0 percent per year, lower than the increase in NHE per capita (4.6 percent) and GDP per capita (3.2 percent), though greater than the consumer price index (1.8 percent).

Table 4: Growth in Average Annual Medicaid Spending on Medical Services Versus Growth in Various Benchmarks, 2007–2013 and 2014–2019 (Percentage)

	Medicaid spending	Medicaid enrollment	Medicaid spending per enrollee	NHE per capita	GDP per capita	CPI
2007–2013	5.7%	3.9%	1.7%	3.1%	1.7%	2.1%
2014–2019	5.8%	2.7%	3.0%	4.6%	3.2%	1.8%

Note: CPI = consumer price index; GDP = gross domestic product; NHE = national health expenditures.

Source: Medicaid estimates are from Urban Institute analysis of data from the Medicaid Statistical Information System, Medicaid Financial Management Reports (CMS Form 64), and Kaiser Commission and Health Management Associates data. NHE and private health insurance data are from the Centers for Medicare & Medicaid Services Office of the Actuary, National Health Statistics Group. CPI data are from the Bureau of Labor Statistics, Consumer Price Index Detail Report Tables. GDP data are from the Bureau of Economic Analysis.

Older studies confirm that Medicaid spending growth has been relatively low. For example, a 2015 CBO report showed that Medicaid spending was driven primarily by enrollment and that between 1990 and 2013, per capita Medicaid spending growth was only 0.3 percent higher than per capita GDP growth.[33] In contrast, overall national health expenditure growth exceeded overall growth of the economy by 1.1 percentage points over the same period. A 2016 Congressional Budget Office report that included 2014 data showed that Medicaid spending in excess of economic growth from 1990 to 2014 was still lower than growth in both overall national health expenditures and Medicare spending in excess of economic growth.[34] Consistent with these results, a study by Iglehart and Sommers covering 1966 to 2014 showed that inflation-adjusted per capita Medicaid spending was relatively flat and that virtually all the spending growth was caused by increased enrollment.[35] The reasons for low Medicaid spending growth on a per enrollee basis include low provider payment rates, extensive use of managed care, aggressive control over prescription drug pricing and utilization, and initiatives to slow the growth of nursing home care.[36,37]

Estimates by the Medicaid and CHIP Payment and Access Commission indicate that the annual growth rate in Medicaid spending per enrollee will remain lower than or comparable to that for private insurance and Medicare in the future (Table 5).

Although CMS's projected 3.6 percent annual growth in Medicaid spending per enrollee between 2014 and 2023 is higher than the historical growth rate, it is lower than the projected per-enrollee spending growth rate in Medicare (4.2 percent) and private insurance (ranging from 4.0 percent to 6.0 percent), and it is lower than the consumer price index for medical care (4.0 percent) and GDP (4.0 percent) over that period.

Levels of Medicaid Spending per Enrollee

Beyond lower growth in spending per Medicaid enrollee, the level of spending per enrollee is also lower for Medicaid than for private insurance after controlling for health status and other characteristics. A recent study using data from 2003 to 2009 concluded that the average low-income adult would have 25 percent higher health care costs on private insurance than on Medicaid;[38] a study using data from 1996 to 1999 found that the average adult's costs would be 18 percent higher on private insurance.[39] The Congressional Budget Office concluded that costs for an adult population would be 50 percent higher if they were enrolled in marketplace plans than if they were enrolled in Medicaid.[40] This finding led to ACA legislation extending Medicaid coverage to those with incomes up to 138 percent of the federal poverty level rather than 100 percent.

Table 5: Average Annual Growth in Medicaid Spending per Enrollee Compared with Various Benchmarks, 1987–2023

	1987–1991	1991–1999	1999–2005	2005–2006[a]	2006–2013	2013–2014	2014–2023[b]
Average annual growth in spending per enrollee by coverage type							
Medicaid	9.2%	5.9%	2.8%	-0.3%	1.9%	-2.0%	3.6%[3]
Medicare	7.8%	5.9%	6.6%	16.5%	2.6%	2.4%	4.2%
Private	14.2%	5.3%	8.8%	4.8%	4.4%	3.2%	4.0–6.0%[c, d]
Average annual growth in prices and economic output							
CPI-U	4.6%	2.6%	2.7%	3.2%	2.1%	1.6%	2.0%
CPI-U medical care	8.0%	4.4%	4.3%	4.0%	3.4%	2.4%	4.0%
GDP	6.1%	5.8%	5.2%	5.8%	2.7%	4.1%	4.0%

Notes: CPI-U = consumer price index for all urban consumers; GDP = gross domestic product. Growth rates reflect calendar years except the rates for Medicaid and private insurance for 2014–2023, which reflect fiscal years. Time periods displayed through 2014 were selected by grouping years with roughly similar Medicaid growth rates. Growth rates are not controlled for changes in enrollee mix or benefit design.

a Reflects implementation of Medicare Part D, which created a new drug benefit for Medicare enrollees and shifted drug costs for dually eligible beneficiaries from Medicaid to Medicare.

b Data are projected.

c Projected growth is for fiscal years 2014–2023.

d Private health insurance spending per enrollee is projected to grow an average of 4.3 percent per year from fiscal years 2014 to 2018 (CBO 2015). Private health insurance spending per enrollee is projected to increase an average of 5.3 percent per year from fiscal years 2016 to 2025 (CBO 2016c). The Congressional Budget Office projects premiums for private plans will increase an average of about 4 percent per year from fiscal year 2014 through fiscal year 2018 and increase 5 percent to 6 percent per year from fiscal year 2019 to fiscal year 2025 (CBO 2016d).

Source: Report to Congress on Medicaid and CHIP Washington: MACPAC; 2016. https://www.macpac.gov/wp-content/uploads/2016/06/June-2016-Report-to-Congress-on-Medicaid-and-CHIP.pdf Published in June 2016.

CONCLUSION

In this brief, we reviewed the evidence on health care spending in recent years, including when the ACA was implemented. First, national health expenditures grew at historically low rates from 2009 to 2013, and projections for future growth are significantly below historic rates as well. Together, the managed competition structure of the marketplaces, aggressive cost containment policies in both Medicare and Medicaid, higher cost sharing, and more-limited private insurance networks have worked to contain spending growth. The projected increases in NHE still exceed increases in GDP but by a smaller margin than in decades past. The ACA has expanded coverage to over 20 million Americans as NHE projections continued to fall relative to the original post-ACA forecast. It is impossible to say how much the ACA itself contributed to the reduced projections over time, but the evidence suggests some effect. Furthermore, additional cost containment measures can certainly be adopted within the ACA structure.

The recent large increases in marketplace premiums in some areas have mostly been a catch-up response to premiums originally set too low or a reflection of near-monopoly conditions in insurer or provider markets. The fact that many states saw small increases or even decreases in premiums indicates that the large premium increases some states have experienced are not inherent to the ACA. When age and cost-sharing differences are accounted for, marketplace premiums tend to be similar to employer-sponsored insurance premiums except in states with few insurers or with provider concentration. The lack of competition in these areas is an ongoing problem that would exist without the ACA, but it can be addressed with policy strategies similar to those used in the Medicare Advantage program. An array of strategies to increase marketplace enrollment could improve the average health of those insured in the nongroup market, bringing premiums down.

Medicaid spending growth has been driven largely by enrollment, and much of that enrollment reflects demographic and economic change. Per-enrollee spending has been low for Medicaid compared with other payers, GDP, and the consumer price index. States have pursued aggressive policies on payment rates, managed care, prescription drug pricing and utilization, and alternatives to nursing homes to restrain cost growth.

We conclude that the ACA has expanded coverage without causing a permanent spike in health spending growth. There has not yet been major delivery system restructuring but rather significant control over payment rates in both Medicare and Medicaid, high deductibles and limited networks in private insurance, and serious competition in many marketplaces. Sustaining these efforts in both the private and public sectors will take concerted effort by all. Although health expenditures are growing more slowly than in the past, they are still growing faster than the economy. This means pressure will continue on federal and state budgets and require either program cuts or new revenues. Moreover, most families will see health care costs increasing faster than wages and salaries.

ENDNOTES

1. Kliff S, Oh S. America's health care prices are out of control. These 11 charts prove it. *Vox*. July 19, 2016. http://www.vox.com/a/health-prices.
2. El Sanadi N. Why are healthcare costs out of control? *Becker's Hospital Review*. November 18, 2015. http://www.beckershospitalreview.com/finance/why-are-healthcare-costs-out-of-control.html.
3. Bloomberg View editors. Out of pocket, out of control. *Bloomberg View*. February 16, 2015. https://www.bloomberg.com/view/articles/2015-02-16/after-obamacare-health-care-reform-needs-to-curb-costs.
4. Sisson P. Why our health care costs so much—and why fixes aren't likely. *San Diego Union-Tribune*. March 18, 2017. http://www.sandiegouniontribune.com/news/health/sd-me-healthcare-costs-20170318-story.html.
5. Zuckerman S, Holahan J. *Despite Criticism, the Affordable Care Act Does Much to Contain Health Care Costs*. Washington: Urban Institute; 2012. http://www.urban.org/sites/default/files/publication/25856/412665-Despite-Criticism-The-Affordable-Care-Act-Does-Much-to-Contain-Health-Care-Costs.PDF. Published October 2012.
6. Josten RB. Letter from the U.S. Chamber of Commerce to the U.S. House of Representatives opposing the Senate-passed version of H.R. 3590, the "Patient Protection and Affordable Care Act." https://www.uschamber.com/sites/default/files/legacy/issues/health/files/100312hr3590patientprotectionaffordablecarehouse.pdf. Published March 12, 2010.
7. National Health Expenditure Data – Projected, 2016-2025. Centers for Medicare & Medicaid Services website. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html. Updated March 21, 2017.
8. Per Capita Healthcare Costs—International Comparison. Peter G. Peterson Foundation. http://www.pgpf.org/chart-archive/0006_health-care-oecd. Published October 17, 2016. Accessed May 5, 2017.
9. Clemans-Cope L, Holahan J, Garfield R. *Medicaid Spending Growth Compared to Other Payers: A Look at the Evidence*. Washington: Kaiser Family Foundation; 2016. http://www.urban.org/sites/default/files/publication/80161/2000769-medicaid-spending-growth-compared-to-other-payers-a-look-at-the-evidence.pdf. Published April 2016.
10. McMorrow S, Holahan J. *The Widespread Slowdown in Health Spending Growth: Implications for Future Spending Projections and the Cost of the Affordable Care Act: An Update*. Washington: Urban Institute; 2016. http://www.urban.org/sites/default/files/publication/81636/2000824-the-widespread-slowdown-in-health-spending-growth-implications-for-future-spending-projections-and-the-cost-of-the-affordable-care-act.pdf. Published June 2016.
11. Holahan J, Wengle E, Blumberg LJ, Solleveld P. *What Explains the 21 Percent Increase in 2017 Marketplace Premiums, and Why Do Increases Vary Across the Country?* Washington: Urban Institute; 2017. http://www.urban.org/sites/default/files/publication/87021/2001052-what-explains-the-21-percent-increase-in-2017-marketplace-premiums-and-why-do-increases-vary-across-the-country_1.pdf. Published January 2017.

12. Blumberg LJ, Holahan J, Wengle E. *Are Nongroup Marketplace Premiums Really High? Not in Comparison with Employer Insurance*. Washington: Urban Institute; 2016. http://www.urban.org/sites/default/files/publication/84256/2000931-Are-Nongroup-Marketplace-Premiums-Really-High-Not-in-Comparison-with-Employer-Insurance.pdf. Published September 19, 2016.
13. National Health Expenditure Data – Historical, 1960-2015. Centers for Medicare & Medicaid Services website. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html. Updated December 6, 2016.
14. Dranove D, Garthwaite C, Ody C. Health spending slowdown is mostly due to economic factors, not structural change in the health care sector. *Health Aff*. 2014;33(8):1399–1406. doi:10.1377/hlthaff.2013.1416. Published August 2014.
15. Kaiser Family Foundation. *Assessing the Effects of the Economy on the Recent Slowdown in Health Spending*. Menlo Park, CA: Kaiser Family Foundation; 2013. http://kff.org/health-costs/issue-brief/assessing-the-effects-of-the-economy-on-the-recent-slowdown-in-health-spending-2/. Published April 22, 2013.
16. White C, Cubanski J, Neuman T. *How Much of the Medicare Spending Slowdown Can Be Explained? Insights and Analysis from 2014*. Menlo Park, CA: Kaiser Family Foundation; 2014. http://files.kff.org/attachment/issue-brief-how-much-of-the-medicare-spending-slowdown-can-be-explained-insights-and-analysis-from-2014. Published December 2014.
17. Clemens J, Gottlieb JD. *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. http://www.nber.org/papers/w19503.pdf. Published October 2013. Updated January 27, 2015.
18. White C. Contrary to cost-shift theory, lower Medicare hospital payment rates for inpatient care lead to lower private payment rates. *Health Aff*. 2013;32(5):935–943. doi:10.1377/hlthaff.2012.0332. Published May 2013.
19. White C, Wu VY. How do hospitals cope with sustained slow growth in Medicare prices? *Health Serv Res*. 2014;49(1):11–31. doi:10.1111/1475-6773.12101. Published October 1, 2013.
20. *National Federation of Independent Business v. Sebelius*. 567 U.S. 519 (2012).
21. Standard & Poor's. *The U.S. ACA Individual Market Showed Progress in 2016, But Still Needs Time to Mature*. New York: Standard & Poor's; 2017. https://www.globalcreditportal.com/ratingsdirect/renderArticle.do?articleId=1828594&SctArtId=421970&from=CM&nsl_code=LIME&sourceObjectId=10047007&sourceRevId=5&fee_ind=N&exp_date=20270408-00:16:31. Published April 7, 2017.
22. Congressional Budget Office. *Cost Estimate: American Health Care Act*. Washington: Congressional Budget Office; 2017. https://www.cbo.gov/publication/52486. Published March 13, 2017.
23. Holahan J, Blumberg L and Wengle E. *Characteristics of Marketplaces with One or Two Insurers*. Washington: Urban Institute; May 10, 2017.
24. Blumberg LJ, Holahan J. *High Premiums in Nongroup Insurance Markets: Identifying Causes and Possible Remedies*. Washington: Urban Institute; 2017. http://www.urban.org/sites/default/files/publication/86816/2001044-high-premiums-in-nongroup-insurance-markets-identifying-causes-and-possible-remedies_4.pdf. Published January 4, 2017.
25. Corlette S, Lucia KW and Levin M. *Implementing the Affordable Care Act: Choosing an Essential Health Benefits Benchmark Plan*. Publication 1677. Washington: The Commonwealth Fund; 2013.
26. Blumberg LJ, Holahan J, Wengle E. *Are Nongroup Marketplace Premiums Really High? Not in Comparison with Employer Insurance*. Washington: Urban Institute; 2016. http://www.urban.org/sites/default/files/publication/84256/2000931-Are-Nongroup-Marketplace-Premiums-Really-High-Not-in-Comparison-with-Employer-Insurance.pdf. Published September 19, 2016.
27. Authors built upon the previous paper's methodology by applying a 3.8 percent growth rate to 2016 MEPS IC ESI average premiums.
28. Holahan J, Blumberg LJ. *Instead of ACA Repeal and Replace, Fix It*. Washington: Urban Institute; 2017. http://www.urban.org/sites/default/files/publication/87076/2001054-repeal-and-replace-aca-fix-it_2.pdf. Published January 16, 2017.
29. Garfield R, Rudowitz R, Young K, et al. *Trends in Medicaid Spending Leading Up to ACA Implementation*. Washington: Kaiser Family Foundation; 2015. http://files.kff.org/attachment/issue-brief-trends-in-medicaid-spending-leading-up-to-aca-implementation. Published February 12, 2015.
30. Keehan SP, Poisal JA, Cuckler GA, et al. National health expenditure projections, 2015–25: economy, prices, and aging expected to shape spending and enrollment. *Health Aff*. doi:10.1377/hlthaff.2016.0459. Published July 2016.
31. Centers for Medicare & Medicaid Services Office of the Actuary. *2016 Actuarial Report on the Financial Outlook for Medicaid*. Washington: US Department of Health and Human Services; 2016. https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/medicaid-actuarial-report-2016.pdf.
32. Centers for Medicare & Medicaid Services Office of the Actuary. *2013 Actuarial Report on the Financial Outlook for Medicaid*. Washington: US Department of Health and Human Services; 2014. https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/medicaid-actuarial-report-2013.pdf.
33. Congressional Budget Office. *The 2015 Long-Term Budget Outlook*. Washington: Congressional Budget Office; 2015. https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50250-LongTermBudgetOutlook-3.pdf. Published June 16, 2015.
34. Congressional Budget Office. *The 2016 Long-Term Budget Outlook*. Washington: Congressional Budget Office; 2016. https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51580-ltbo-2.pdf. Published July 12, 2016.
35. Iglehart JK, Sommers BD. Medicaid at 50—from welfare program to nation's largest health insurer. *N Engl J Med*. 2015;372:2152–2159. doi:10.1056/NEJMhpr1500791. Published May 28, 2015.
36. Clemans-Cope L and Holahan J. *Medicaid Spending Growth Compared to Other Payers: A Look at the Evidence*. Menlo Park, CA: Kaiser Family Foundation; 2016.
37. Medicaid and CHIP Payment and Access Commission (MACPAC). Chapter 1: Trends in Medicaid Spending. In: MACPAC. *June 2016 Report to Congress on Medicaid and CHIP*. Washington: MACPAC; 2016: 12.
38. Coughlin TA, Long SK, Clemans-Cope L, Resnick D. *What Difference Does Medicaid Make? Assessing Cost Effectiveness, Access, and Financial Protection Under Medicaid for Low-Income Adults*. Washington: Kaiser Family Foundation; 2013. https://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf. Published May 2013.
39. Hadley J, Holahan J. Is health care spending higher under Medicaid or private insurance? *Inquiry*. 2003;40(4):323–342. doi:10.5034/inquiryjrnl_40.4.323.
40. Congressional Budget Office. *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision*. Washington: Congressional Budget Office; 2012. https://www.cbo.gov/publication/43472. Published July 2012.

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