

HEALTH POLICY 101

Health Care Costs and Affordability

October 2025

This publication is available at kff.org/health-policy-101

KFF

This is one chapter of KFF's Health Policy 101, a resource for students and educators of health policy. View its other chapters at the links below or at: kff.org/health-policy-101

[Medicare 101](#)

[Medicaid 101](#)

[The Affordable Care Act 101](#)

[Employer-Sponsored Health Insurance 101](#)

[The Uninsured Population and Health Coverage](#)

[Health Care Costs and Affordability](#)

[The Regulation of Private Health Insurance](#)

[Health Policy Issues in Women's Health](#)

[Race, Inequality, and Health](#)

[LGBTQ+ Health Policy](#)

[U.S. Public Health 101](#)

[International Comparison of Health Systems](#)

[The U.S. Government and Global Health](#)

[The Role of Public Opinion Polls in Health Policy](#)

[Congress, the Executive Branch, and Health Policy](#)

[The Politics of Health Care and Elections](#)

Table of Contents

Introduction	1
How Has U.S. Health Spending Changed Over Time?	1
What Factors Contribute to U.S. Health Spending?.....	4
How Does Health Spending Vary Across the Population?	10
How Do High Health Costs Affect Affordability of Care?	12
What Impact Do Health Care Costs Have on Financial Vulnerability?.....	15
Medical Debt is Associated with Financial Vulnerability Across a Range of Indicators	18
How Much is Health Spending Expected to Grow?	18
Future Outlook.....	20
Resources	22

Introduction

Health care costs in the United States generally grow faster than [inflation](#). The U.S. far exceeds other large and wealthy nations in per capita health [spending](#), and health care represents a much larger share of the economy in the U.S. than in peer nations. Despite substantial spending, the U.S. health system grapples with disparities and gaps in coverage. Elevated health care expenditure in the U.S. does not consistently translate into superior health outcomes. Rising health care costs instead contribute to Americans facing difficulties affording medical care and drugs, even among those with insurance.

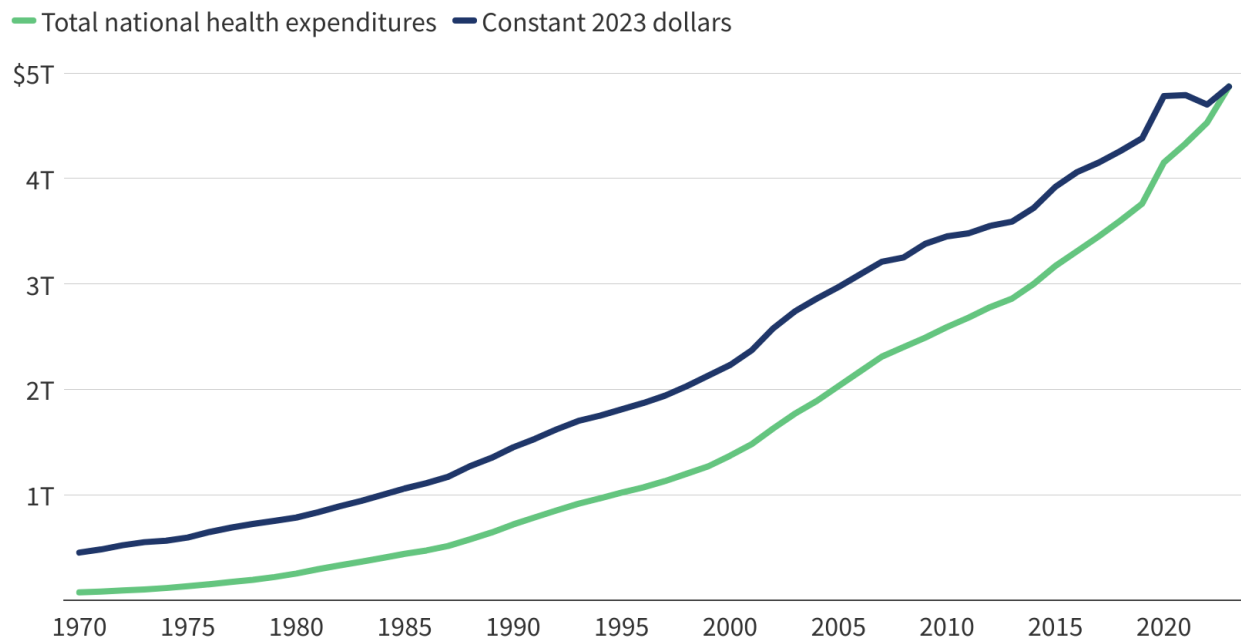
How Has U.S. Health Spending Changed Over Time?

Many people are familiar with the high and rising cost of health care in the United States from seeing how much they spend on their own health insurance premiums and out-of-pocket costs. In addition to these very visible health costs, there are also [tax dollars](#) that go to fund public programs and the amounts [employers](#) spend toward their employees' health insurance premiums. Total national health expenditures include spending by both public programs and private health plans, as well as out-of-pocket health spending. Total health expenditures represent the amount spent on health care (such as doctor visits, hospital stays, and prescription drugs) and related activities (such as insurer overhead and profits, health research and infrastructure, and public health).

Total Health Spending Reached \$4.9 Trillion in 2022

Figure 1

Total National Health Expenditures, US dollars, 1970-2023



Note: Health spending is shown in terms of both nominal dollar values (not inflation-adjusted) and constant 2023 dollars (inflation-adjusted based on the personal consumption expenditures (PCE) annual index).

Source: KFF analysis of National Health Expenditure (NHE) data

Peterson-KFF
Health System Tracker

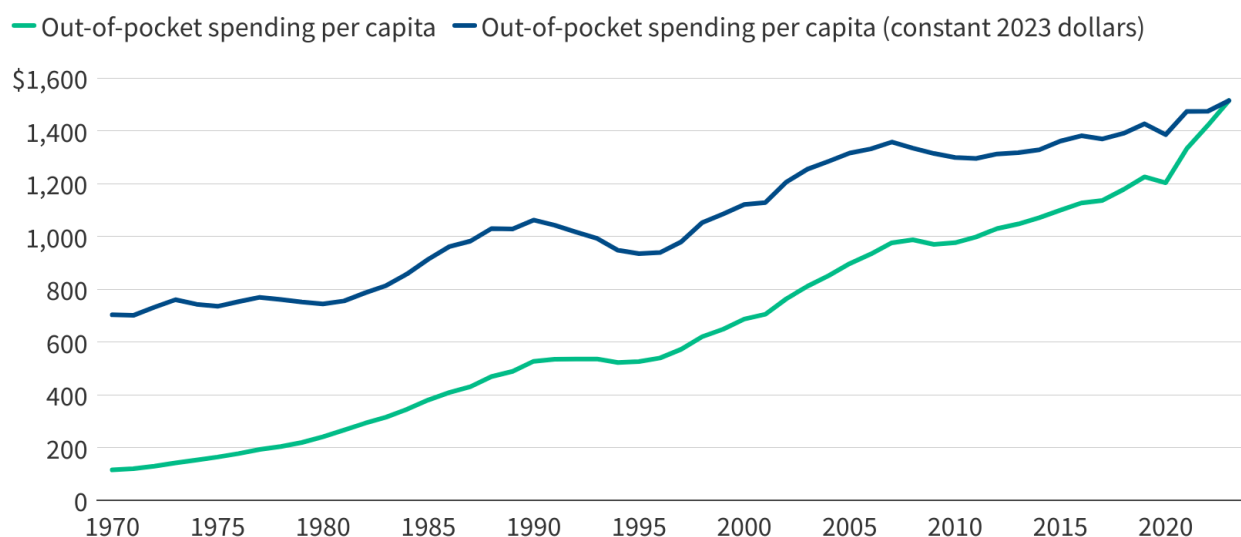
Health spending in the U.S. has risen sharply over the last several decades. The official data on [national health expenditures](#) from the Centers for Medicare and Medicaid Services (CMS) show health spending totaled \$74.1 billion in 1970. By 2000, health expenditures had reached about \$1.4 trillion, and in 2023 the amount spent on health had more than tripled to \$4.9 trillion. In the first year of the COVID-19 pandemic, health spending accelerated by 10.4% from 2019 to 2020, even as the use of health care dropped, driven largely by public health spending and financial relief provided to health care providers. Most recently, health spending grew 7.5% from 2022 to 2023, faster than the previous year's 4.6% increase from 2021 to 2022. Health spending is expected to continue to grow at a similar pace for the foreseeable future.

In the chart above, spending is shown in terms of both nominal dollar values (not inflation-adjusted) and constant 2023 dollars (inflation-adjusted based on the personal consumption expenditures, or PCE, index). [Inflation](#) in the health sector increased slightly faster than across the general economy in 2023.

Currently, health care represents about 18% of the U.S. economy (measured as a share of gross domestic product, or GDP). In other words, almost 1 out of every 5 dollars spent in the U.S. goes toward health care. Back in 1960, health spending represented just 5% of GDP, meaning 1 in every 20 dollars in the U.S. economy was spent on health care.

Figure 2

Per Capita Out-of-Pocket Expenditures, 1970-2023



Note: A constant dollar is an inflation adjusted value used to compare dollar values from one period to another.

Source: KFF analysis of National Health Expenditure (NHE) data

Peterson-KFF
Health System Tracker

Out-of-pocket costs have also risen over time. Out-of-pocket costs represent the amount of money spent by individuals on health care that is not paid for by a health insurance plan or public program like Medicare or Medicaid. This includes cost-sharing, the most common forms of which are deductibles (an amount that must be paid before most services are covered by the plan), copayments (fixed dollar amounts), and coinsurance (a percentage of the charge for services). (i.e., copays, deductibles, coinsurance), as well as health spending by uninsured people or spending by insured people for care that is not covered at all by health insurance. Out-of-pocket spending does *not* include the amount spent on a person's monthly health insurance premium.

Out-of-pocket spending per person was \$115 in 1970 (or, adjusted for inflation, \$703). By 2023, out-of-pocket spending had reached \$1,514 per person. Despite this rise in out-of-pocket spending, health insurance now covers a [larger share](#) of total health spending (73%) than it did in 1970 (27%), in part because more people have gained coverage, especially public coverage, but also because health insurance spending per enrollee has grown.

What Factors Contribute to U.S. Health Spending?

Over the last several decades, health spending has been driven higher by a number of factors, including but not limited to an aging population, rising rates of chronic conditions, advancements in medicine and new technologies, higher prices, and expansions of health insurance coverage. While there are always differences across countries, many of these factors driving health costs upward in the U.S. are also driving health costs growth in peer nations. For example, while the U.S. population is indeed aging and that is driving health costs up, many large and wealthy nations have even more rapidly [aging populations](#).

Other factors may explain the United States' relatively high health spending compared to its peers. The U.S. health system is fragmented, with many private and public payers, and with regulation of these payers split between states and the federal government. However, these features are not entirely unique to the U.S., either. Indeed, some other countries with much lower health spending have multiple private payers or differences in public programs across states or provinces. The U.S. is also [not alone](#) in having a mainly fee-for-service payment system.

The U.S. health insurance system is largely voluntary, whereas [peer countries' health systems](#) are almost entirely compulsory. Additionally, the U.S. federal and state governments have generally done less to directly regulate or negotiate prices paid for medical services or prescription drugs than have governments of similarly large and wealthy nations. The U.S. often pays higher [prices](#) for the same brand-name [prescription drugs](#), [hospital procedures](#), and [physician care](#) than similarly large and wealthy countries do.

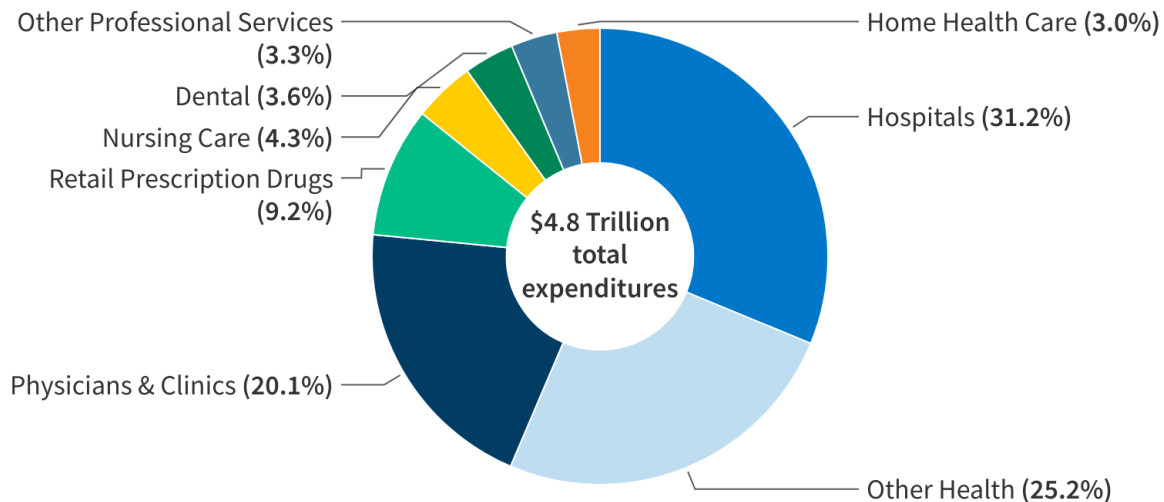
There are other factors, largely outside the control of the health system that are also likely at play, such as [socioeconomic conditions](#) (like [income inequality](#) and other [social determinants of health](#)), and differences in so-called lifestyle factors (like diet, drug use, or physical activity) that could contribute both to higher spending and worse outcomes.

Breaking total national health spending into its components can reveal the major drivers of health costs and where cost containment efforts could be most effective. The charts below show various ways of examining the key contributors to health spending. For example, the [National Health Expenditure Accounts](#) show trends in how health spending varies by type of service (e.g., hospital care vs. retail prescription drugs) or by source of funds (e.g., private health plans vs. public programs). An alternative and relatively new approach to understanding health spending is to break out total health spending into the share that goes to treat certain diseases (e.g., heart disease, cancer). Finally, health spending can also be better understood by looking at trends in prices (e.g., the dollar amount for a hospital stay) and utilization (e.g., the number of hospital stays).

Hospital and Physician Services Represent Half of Total Health Spending

Figure 3

Relative Contributions to Total National Health Expenditures, by Service Type, 2023



Note: "Other Health" includes spending on durable equipment and non-durable products, other health, residential, and personal care, government public health activities, administration and net cost of health insurance, and investments. "Other Professional Services" includes services provided by chiropractors, optometrists, physical, occupational, and speech therapists, podiatrists, and private-duty nurses. Nursing care includes nursing care facilities and continuing care retirement communities.

Source: KFF analysis of National Health Expenditure (NHE) data

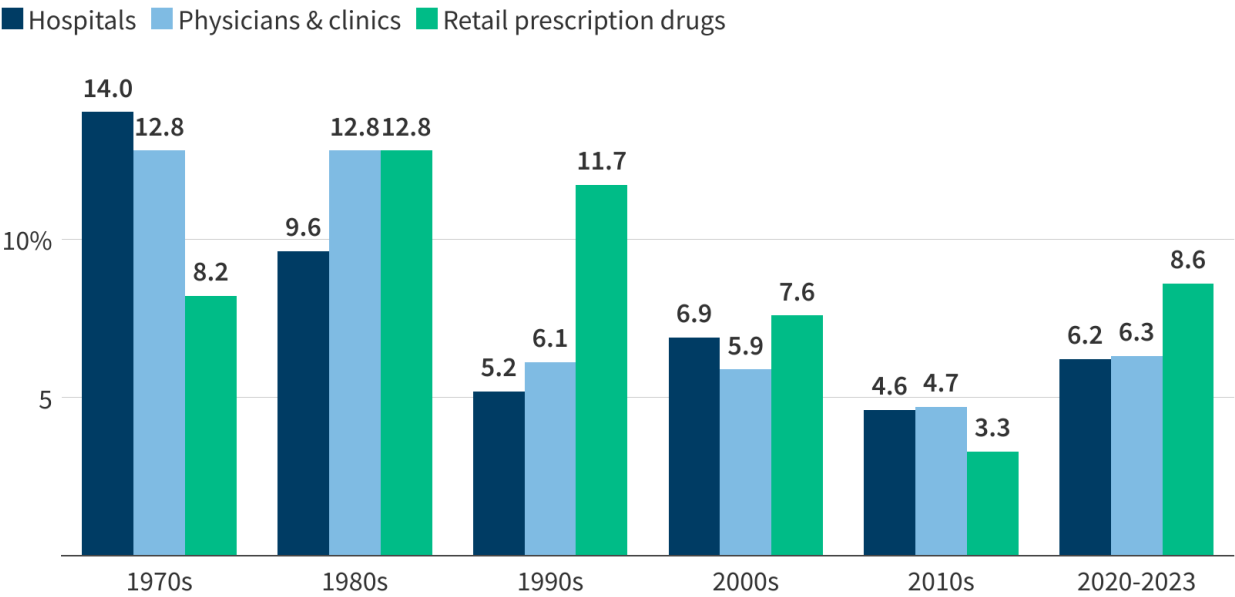
Peterson-KFF
Health System Tracker

Most health spending in the U.S. and in peer countries is on hospital and physician care, followed by prescription drugs. In the U.S., hospital spending represented close to a third (31.2%) of overall health spending in 2023, and physicians/clinics represented 20.1% of total spending. In comparison to other large and wealthy countries, the U.S.'s higher spending on inpatient and outpatient care [explains](#) the vast majority of higher spending on health care overall.

Spending Has Grown for Hospitals, Physicians, and Drugs

Figure 4

Average Annual Expenditures Growth Rate for Select Service Types, 1970-2023



Source: KFF analysis of National Health Expenditure (NHE) data

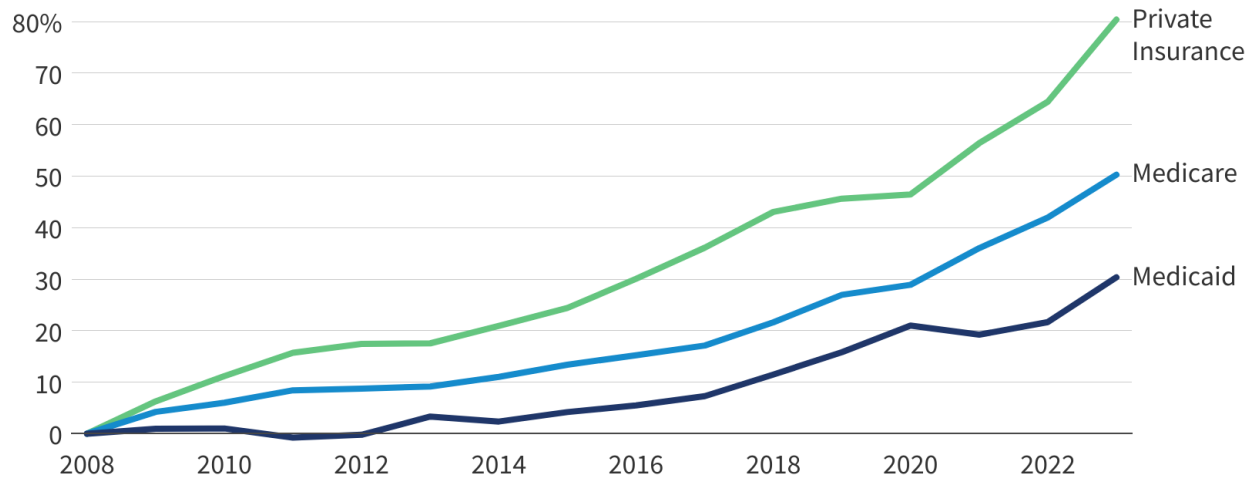
Peterson-KFF
Health System Tracker

During the 1970s, growth in hospital expenditures outpaced other services, while prescriptions and physician and clinic services saw faster spending growth during the 1980s and 1990s. From 2020 to 2023, retail prescription drugs experienced the fastest growth in spending at 8.6%, following 3.3% average annual growth from 2010 to 2020. Average spending growth for hospitals and physicians/clinics between 2020 and 2022 was 6.2% and 6.3%, respectively.

On a Per-Enrollee Basis, Private Insurance Spending Has Typically Grown Much Faster Than Medicare and Medicaid Spending

Figure 5

Cumulative Growth in Per-Enrollee Spending by Private Insurance, Medicare, and Medicaid, 2008-2023



Source: KFF analysis of National Health Expenditure (NHE) data

Peterson-KFF
Health System Tracker

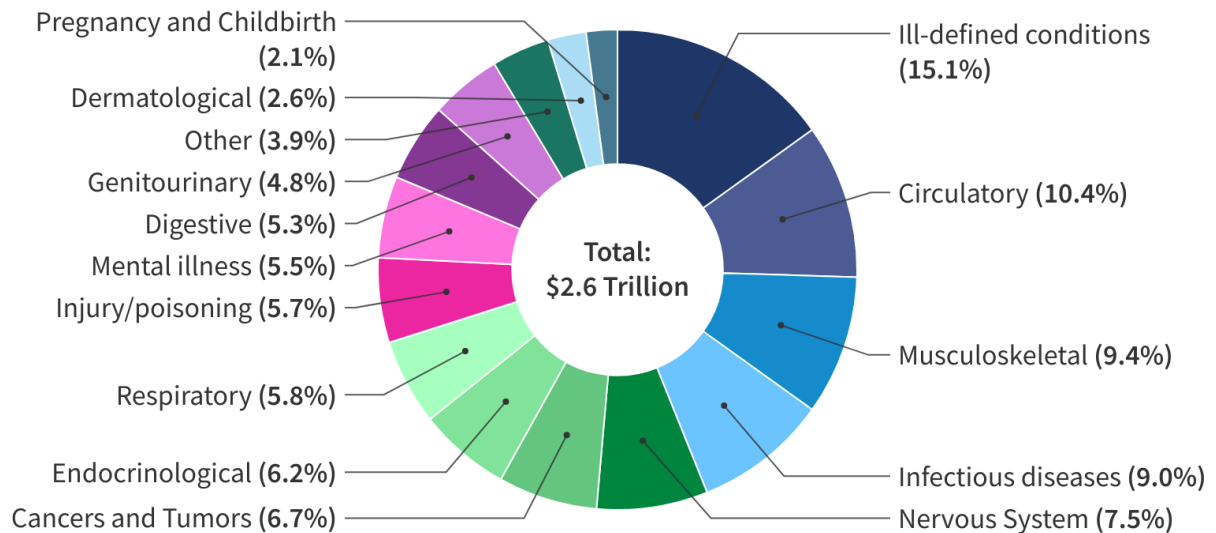
Per enrollee spending by private insurance grew by 80.4% from 2008 to 2023 – much faster than both Medicare and Medicaid spending growth per enrollee (50.3% and 30.3%, respectively). Private insurance often pays higher prices for health care compared to prices paid by Medicare and Medicaid.

Per enrollee spending by Medicaid rose by 7.9% in 2023 from the previous year, and also continued to increase in private insurance and Medicare (5.9% and 7.1% respectively). Medicare and private insurance per-enrollee spending continued to grow faster between 2021 and 2023 after slower growth in 2020. Medicaid per-enrollee spending had previously declined in 2021 as total enrollment grew, particularly among children and non-elderly adults, who generally have lower per-enrollee spending.

A Substantial Share of Health Spending Goes Toward the Treatment of Circulatory and Musculoskeletal Conditions

Figure 6

Distribution of Total Medical Services Expenditures, by Medical Condition, 2021



Note: "Other" includes residual codes, blood/blood-forming organs, perinatal, and congenital anomalies.

Source: KFF analysis of BEA Health Care Satellite Account (Blended Account)

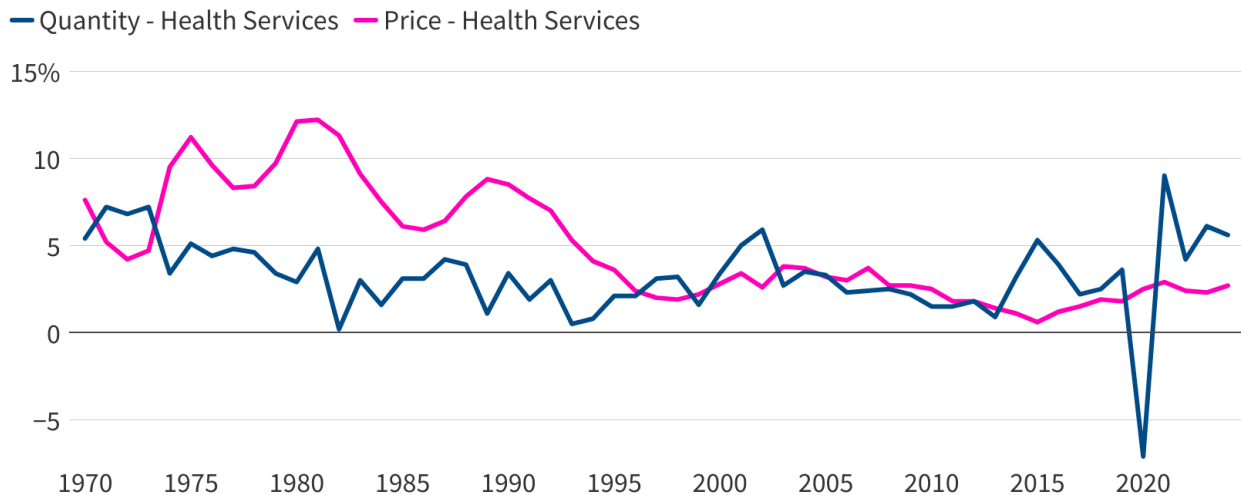
Peterson-KFF
Health System Tracker

An alternative way of examining the components of health spending is to use the Bureau of Economic Analysis (BEA)'s [Health Care Satellite Account](#), which estimates spending and price growth by disease category (e.g., cancer, infectious disease). This approach differs from the official categorization of health spending by service type (e.g., provider services). Essentially, the new satellite account redefines the "commodity" in healthcare as the treatment for specific diseases, rather than a hospital stay or a physician visit. BEA researchers found that the largest categories of medical services spending include the treatment of circulatory diseases (10.4% of health spending in 2021), musculoskeletal conditions (9.4%) and infectious diseases (9%). Another large share of health spending (15.1%) is for "ill-defined conditions," which can include routine check-ups and follow-up care that is not easily designated for a particular illness.

Health Spending is a Function of Prices and Use

Figure 7

Annual Percent Change in Price and Quantity Personal Consumption Expenditure Indexes of Health Services, 1970-2024



Note: Price and quantity indices are for health services consumption. Index numbers 2017=100

Source: KFF analysis of Bureau of Economic Analysis (BEA) data

Peterson-KFF
Health System Tracker

Health services spending is generally a function of prices (e.g., the dollar amount charged for a hospital stay) and utilization (e.g., the number of hospital stays).

People and health plans in the U.S. often pay higher prices for the same prescription drugs or hospital procedures than people in other large and wealthy nations do. In terms of utilization, there is not much evidence that people in the U.S. use more health care. In fact, Americans generally have shorter average [hospital stays](#) and fewer [physician visits](#) per capita. Therefore, a large part of the [difference](#) in health spending between the U.S. and its peers can be explained by higher prices, more so than higher utilization.

Over time, within the U.S., prices and utilization have driven health cost growth to varying degrees. In the 1980s and early 1990s, growth in health care prices far exceeded growth in use. Faster growth in health prices in the U.S. during this time drove the [divergence](#) in per capita health spending between the U.S. and other large, wealthy OECD countries. While health care prices have grown more moderately in recent decades, prices in the U.S. for health services continue to exceed what other countries pay.

More recently, the COVID-19 pandemic led to fluctuations in [health care use](#). Early in the pandemic, many health services, such as elective surgeries, were postponed or cancelled and many elected to not get care to avoid infections at health care sites. In 2021, health services use [increased by 9%](#) from the previous year, but

subsequent years showed slightly lower growth rates (2024 health services use increased 5.6% from 2023). This increase in health care use in 2021 followed a sharp decrease in health utilization in 2020. Health care prices increased moderately – between 2 and 3% - between 2020 and 2024, but [changing market conditions](#) since the pandemic and [policies](#) enacted in 2025 are likely to increase health costs at an increasing rate.

How Does Health Spending Vary Across the Population?

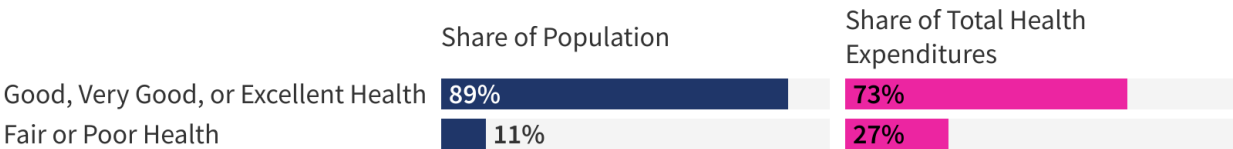
A small portion of the population accounts for a large share of health spending in a given year. Although we tend to focus on averages, a small number of people spend around the average since individual health needs vary over the life course. Some portions of the population (older adults and those with serious or chronic illnesses) require more and higher-cost health services than those who are younger, healthier, or otherwise in need of fewer or less costly services.

Older people and people with significant health needs account for most health expenditures

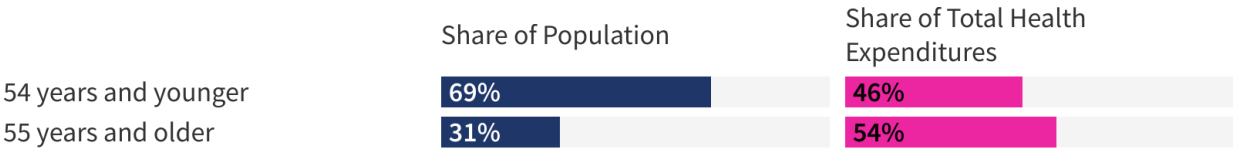
Figure 8

Share of Total Population and Total Health Spending, by Age Group and Health Status, 2022

By Health Status



By Age



Source: KFF analysis of 2022 Medical Expenditure Panel Survey data

Peterson-KFF
Health System Tracker

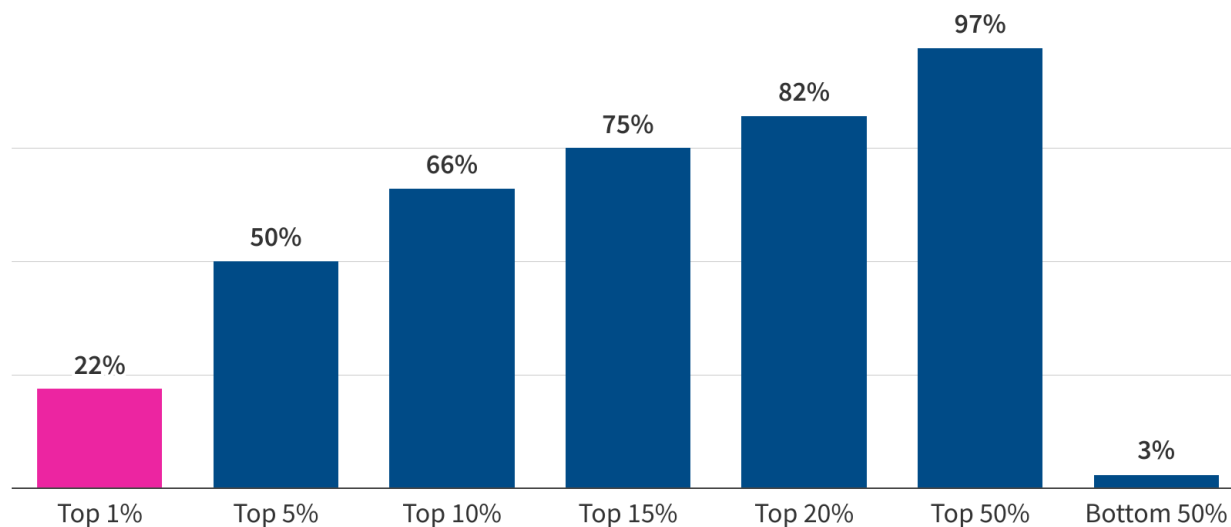
While there are people with high spending at all ages, overall, people 55 and over accounted for 54% of total health spending in 2022, despite making up only 31% of the population. In contrast, people under age 35 made up 44% of the population but were responsible for only [23% of spending](#).

People with significant health needs account for a large portion of total health spending. People reporting fair or poor health status account for 11% of the population and 27% of the total health spending.

A Small Share of the Population Incurs Most Health Spending

Figure 9

Share of Total and Out-of-Pocket Health Spending, by Percentile, 2022



Source: KFF analysis of 2022 Medical Expenditure Panel Survey data

Peterson-KFF
Health System Tracker

In 2022, the top 5% of people with the highest health spending accounted for half of total health spending and had an average of \$67,300 in health expenditures annually; people with health spending in the top 1% have average spending of over \$147,000 per year. At the other end of the spectrum, the 50% of the population with total health spending below or equal to the 50th percentile accounted for only 3% of all health spending; the average spending for this group was \$374.

Out-of-pocket spending on health services is concentrated similarly to overall health spending. In this chart, out-of-pocket spending includes direct payments to providers and cost-sharing, including deductibles, copays, and coinsurance, but does not include monthly premium payments or contributions towards health coverage. Out-of-pocket health spending is similarly concentrated among high-health-need individuals. A small portion of the population accounts for a substantial share of total out-of-pocket health spending in a year.

In 2022, people in the top 1% of out-of-pocket spending paid about \$23,700 out-of-pocket for health services on average per year, and people in the top 10% spent an average of \$6,126 out-of-pocket per year. People who are in the bottom 50% of out-of-pocket spending spent an average of \$24 out of pocket.

How Do High Health Costs Affect Affordability of Care?

In addition to being expensive for the nation as a whole, health care is often also expensive for individuals. High health costs can particularly pose a hardship for people who are in worse health and those with lower incomes. However, challenges affording health care are not limited to certain groups; these challenges are pervasive across the U.S. Even people with private health insurance through their employers are often exposed to high and rising [deductibles](#), and therefore also face [affordability challenges](#). A [substantial share](#) of the population does not have [enough savings](#) or other liquid assets to afford a high deductible or out-of-pocket maximum common in private health plans.

When health care is unaffordable, it can lead to cost-related access barriers, like forgoing or delaying needed medical care. For those who still receive unaffordable health care, this care can lead to medical debt and other forms of financial instability. Some people experience both types of affordability challenges, missing some needed care while also incurring medical debt for other care.

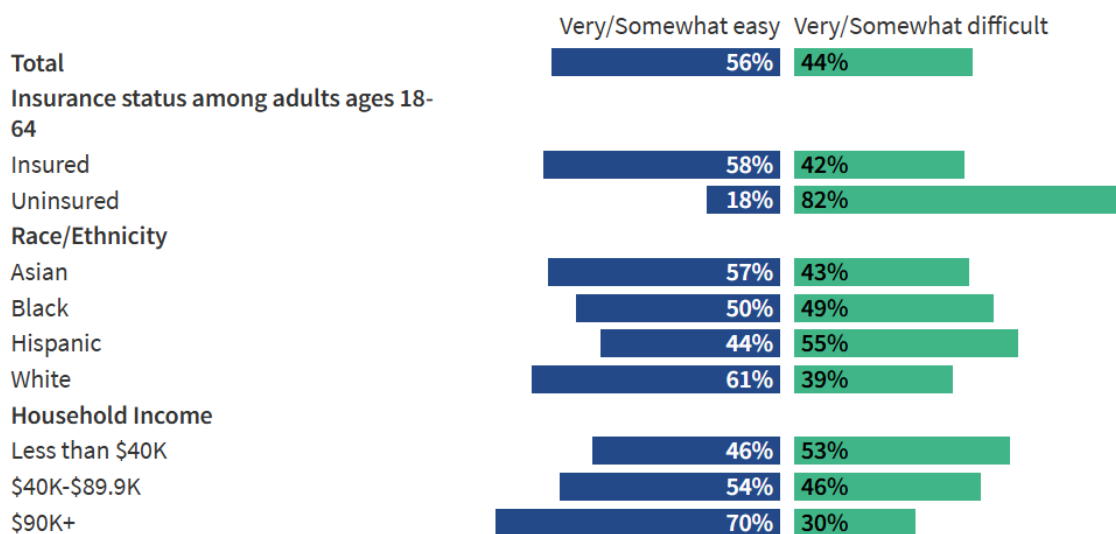
Half of Adults Say it is Difficult to Afford Health Care Costs

Figure 10

Nearly Half of Adults Say It Is Difficult To Afford Health Care Costs, Including Large Shares of the Uninsured, Black and Hispanic Adults, and Those With Lower Incomes

In general, how easy or difficult is it for you to afford your health care costs?

■ Very/Somewhat easy ■ Very/Somewhat difficult



Note: See topline for full question wording.

Source: KFF Health Tracking Poll (May 5-26, 2025) • [Get the data](#) • [Download PNG](#)

KFF

Almost half of U.S. adults say it is [difficult to afford](#) health care costs, and one in four say they or a family member in their household had problems paying for health care in the past 12 months. Younger adults, those with lower incomes, adults in fair or poor health, and the uninsured are particularly likely to report problems affording health care in the past year.

Among those under age 65, uninsured adults are more likely to say affording health care costs is difficult (82%) compared to those with health insurance coverage (44%).

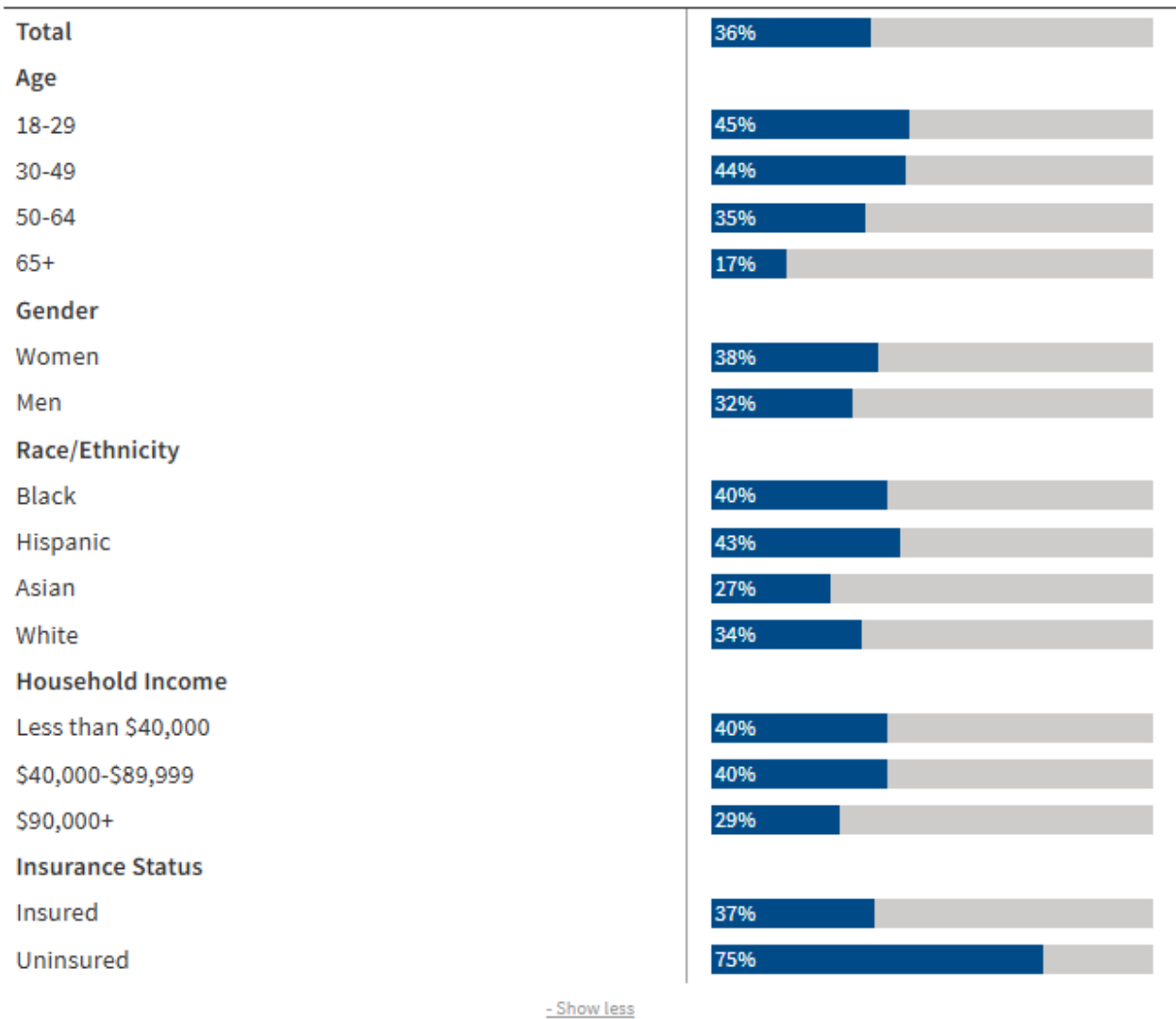
Those who are covered by health insurance are not immune to the burden of health care costs. About 4 in 10 insured adults worry about affording their monthly health insurance premium, and [62% worry](#) about affording their deductible before health insurance kicks in. Indeed, large shares of adults with employer-sponsored insurance (ESI) and those with Marketplace coverage rate their insurance as “fair” or “poor” when it comes to their monthly premium and out-of-pocket costs to see a doctor.

1 in 3 Adults Report Putting Off Health Care Because of Cost

Figure 11

Three in Four Uninsured Adults Say They Have Skipped or Postponed Getting Health Care They Needed in the Past 12 Months Due to Cost

Percent who say, in the past 12 months, they have skipped or postponed getting health care they needed because of the cost:



Note: See topline for full question wording.

Source: KFF Health Tracking Poll (May 5-26, 2025) • [Get the data](#) • [Download PNG](#)



Cost-related [barriers](#) to accessing health care are more common for some demographic groups than others. For example, people who are Hispanic, lower-income, in worse health, and/or uninsured tend to have higher rates of self-reported cost-related access barriers.

One-quarter of adults say that in the past 12 months they have skipped or postponed getting health care they needed because of the cost, according to KFF polling. Women are more likely than men to say they have skipped or postponed getting health care they needed because of the cost (38% vs. 32%). Adults ages 65 and older, most of whom are eligible for health care coverage through Medicare, are much less likely than younger age groups to say they have not gotten health care they needed because of cost. Three in four uninsured adults (75%) say they have skipped or postponed getting health care they needed due to cost. Insured people are not immune from cost-related barriers to accessing care and more than one in three adults with insurance (37%) report not getting health care they needed due to cost.

What Impact Do Health Care Costs Have on Financial Vulnerability?

Despite the vast majority of the United States population having health insurance, [medical debt](#) is not uncommon. Different ways of measuring medical debt result in different estimates of prevalence, but regardless of the method, there is consensus that medical debt is a persistent and pervasive problem in the United States, including for people with insurance.

One way to examine medical debt is through credit reporting, but medical debt is often disguised as other forms of debt when people pay for medical bills on their credit cards or choose to pay off their medical bills while falling behind on other payments.

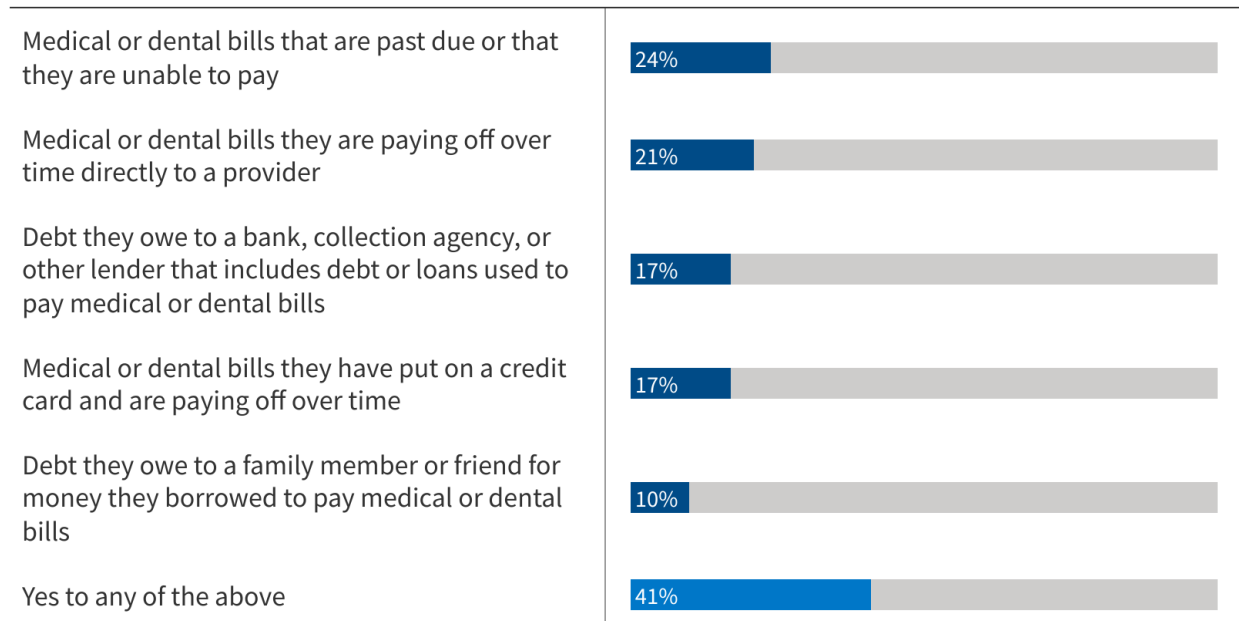
Another way to measure medical debt is with surveys, which can allow respondents to describe their debt with more detail or nuance. Questions about medical debt and other financial matters can be difficult to compare across surveys. For example, it is not always clear whether respondents are answering about their personal experiences or about their broader family or household. Surveys may also differ in the way they define medical debt or describe what forms of debt to include.

The [KFF Health Care Debt Survey](#) asked respondents to think about money that they currently owe for their own health or dental care or someone else's, such as a family member or dependent. The KFF Health Care Debt Survey finds that 41% of adults currently have some form of debt caused by their own or a family member's medical or dental bills.

Figure 12

Four In Ten Adults Currently Have Debt Due to Medical or Dental Bills

Percent who say they have each of the following types of debt due to medical or dental bills for themselves or for someone else's care, such as a child, spouse or parent:



Note: See topline for full question wording.

Source: KFF Health Care Debt Survey (Feb. 25-Mar. 20, 2022)

KFF

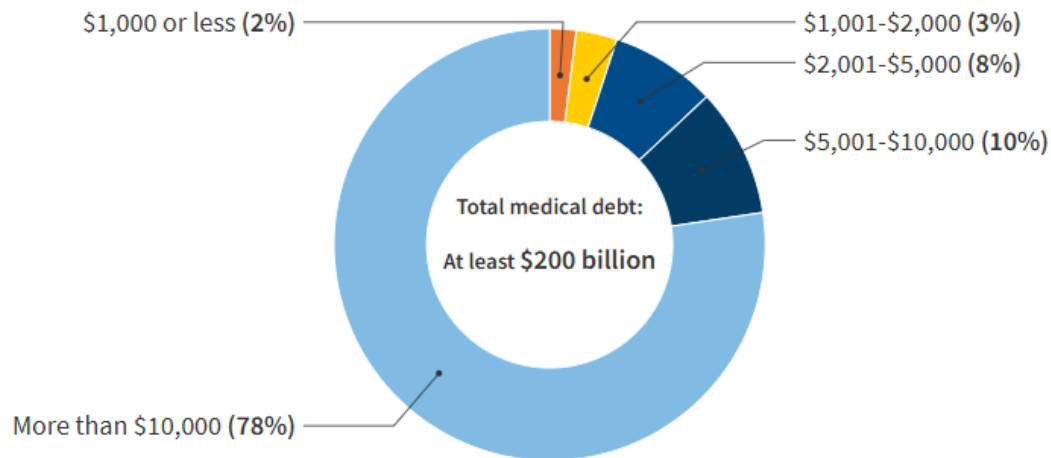
The [U.S. Survey of Income and Program Participation \(SIPP\)](#) asks whether money was owed for a medical bill and not paid in full during the past year for each person in the sample household. SIPP results, therefore, can be looked at on the individual level or for an overall household. This survey shows that about [1 in 12 adults have medical debt](#) they owe for themselves or their family's medical care in the past year.

Regardless of the survey used to examine medical debt, common themes emerge when looking at differences across demographic groups: adults who are Black, uninsured, lower-income, and in worse health are more likely to have medical debt. People with incomes under \$40,000 are significantly more likely than people with higher incomes to [go into debt](#) to cover an unexpected medical bill, and people with disabilities are also much [more likely to have significant medical debt](#), which, in addition to the burden of medical costs, could also reflect inadequate supplemental income for people who are unable to work due to disability or illness.

Nationally, Medical Debt Totals at Least \$200 Billion

Figure 13

Share of Aggregate Total Medical Debt in the U.S., by the Amount of Debt Individuals Owe, 2023



Note: To reduce the influence of the highest debt holders on the total, KFF used a conservative method to calculate medical debt for respondents with extremely high debt amounts. This approach removes the highest debt values from the calculation. Numbers do not sum to 100 due to rounding. This analysis is limited to those owing over \$250 in medical debt.

Source: KFF analysis of the Survey of Income and Program Participation (SIPP) • [Get the data](#) • [Download PNG](#) Peterson KFF **Health System Tracker**

The Consumer Financial Protection Bureau (CFPB) estimates that \$88 billion in medical debt is reflected on Americans' [credit reports](#). However, credit reports may not capture all forms of medical debt. For example, medical debt disguised as credit card debt or money owed to family or friends may not be captured. Surveys may capture medical debt that is not visible on credit reports or is otherwise disguised as another form of debt. The 2023 Survey of Income and Program Participation suggests that total medical debt owed was at least \$200 billion at the end of 2023.

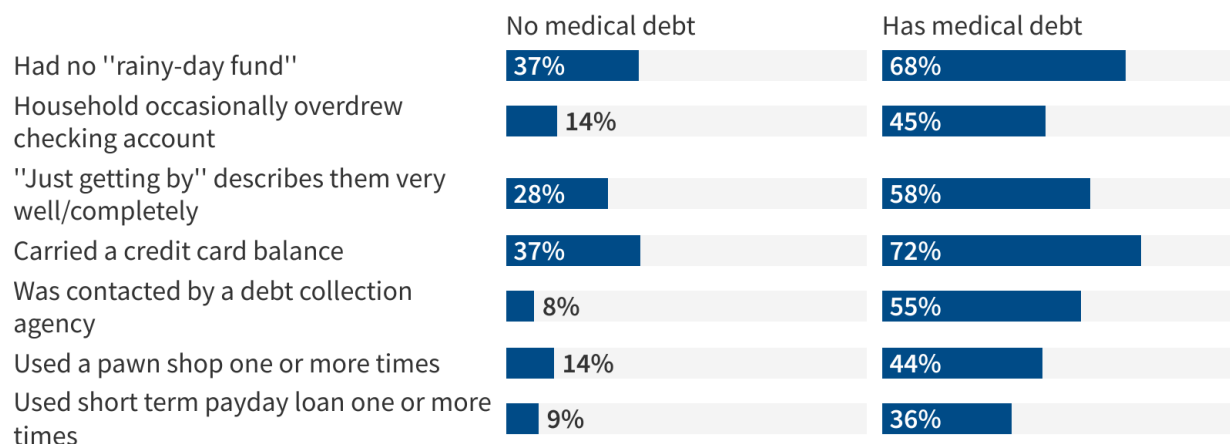
Medical Debt is Associated with Financial Vulnerability Across a Range of Indicators

Figure 14

Medical Debt is Associated with Other Forms of Financial Vulnerability

Share of adults who reported the following financial conditions, 2021

■ No medical debt ■ Has medical debt



Note: *All differences between "No medical debt" and "Has medical debt" significant at $p < .05$.

Source: KFF Analysis of 2021 NFCS

Peterson-KFF
Health System Tracker

The [National Financial Capability Survey](#) (NFCS) is a triennial survey sponsored by the FINRA Foundation that provides information on the financial security, experiences, and vulnerabilities of people and households.

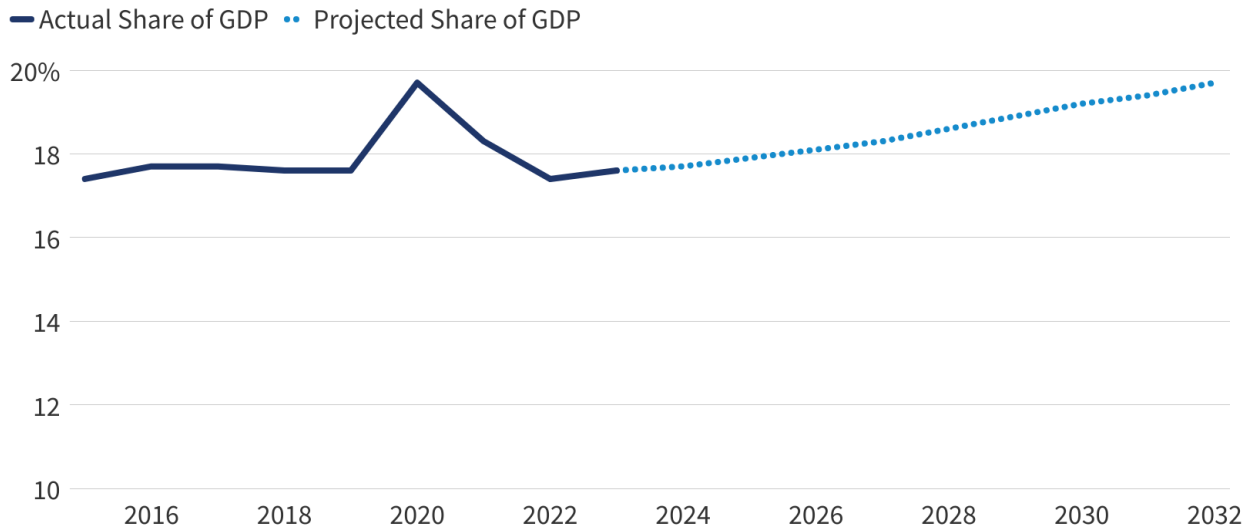
People with medical debt are [much more likely](#) to have other forms of financial distress than those without medical debt. Indicators of financial vulnerability — such as spending more money than one's income, having no "rainy day" fund, or agreeing with the statement "I am just getting by financially" — are more common among adults with medical debt than those without. Additionally, people with medical debt are more likely to overdraw their checking account, have a credit card balance that exposes them to interest payments, take a cash advance on their credit card, or have been contacted by debt collectors. Adults with medical debt are much more likely to use payday loans or other costly loans than those without medical debt.

How Much is Health Spending Expected to Grow?

Each year, actuaries from the Centers for Medicare and Medicaid Services (CMS) project future spending on health. With health care utilization [returning](#) to pre-pandemic levels and [price inflation](#) in the health sector continuing to outpace general economic inflation, per-person health spending increased 7% in 2023. Annual per capita health spending is projected to grow at an annual rate of 5% per capita on average from 2023 to 2032.

Figure 15

Health Spending as a Percent of Gross Domestic Product (GDP), Actual (2015 - 2023) and Projected (2024 - 2032)



Source: KFF analysis of National Health Expenditure (NHE) data

Peterson-KFF
Health System Tracker

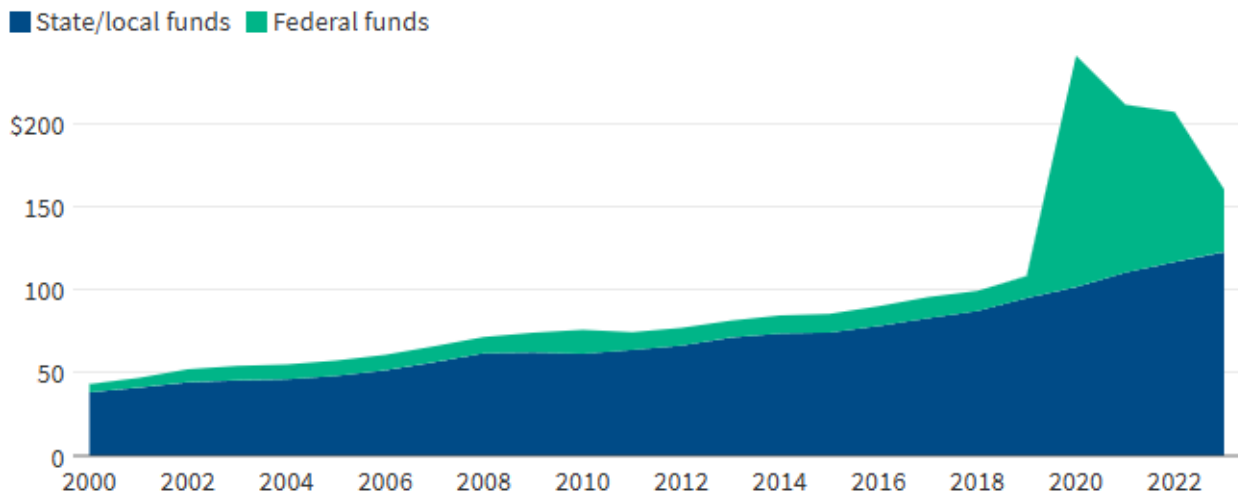
An aging population, labor pressure driving higher prices, and new high-cost prescription drugs coming to market are expected to contribute to a growth in health spending. Health spending was 17.6% of the U.S. economy in 2023 and is expected to reach 19.7% by 2032.

The pandemic has had direct and indirect effects on the health system that can make projections difficult. COVID-19 has led to new costs for vaccination, testing, and treatment and has also caused other shifts in health utilization and spending. Some people avoided medical settings out of concern of contracting COVID and thus missed or delayed routine care or cancer screenings earlier in the pandemic, for example, which could lead to pent-up demand, worsening health conditions, or more complex disease management going forward. Increased use of telemedicine could also shift spending patterns in the future. Further, the recent broad-based inflation trends in the economy and health sector employment trends also add to the uncertainty of these projections.

Federal Government Infusion of Public Health Funding Has Subsided Since Early in the COVID-19 Pandemic

Figure 16

Federal and State/Local Expenditures on Public Health, US\$ Billions, 1970-2023



Note: Government public health activity includes organizing and delivering publicly provided health services such as epidemiological surveillance, inoculations, immunization/vaccination services, disease prevention programs, the operation of public health laboratories, and other such functions.

Source: KFF analysis of National Health Expenditure (NHE) data • [Get the data](#) • [Download PNG](#)

PewResearch Center
KFF
Health System Tracker

Total national health spending includes spending on direct patient care, as well as spending on public health or prevention. After a sharp increase in federal funding in 2020 driven by the national response to the COVID-19 pandemic, spending on public health has fallen, decreasing by over 58% between 2022 and 2023. Meanwhile, state and local public health spending grew 5%, in line with previous years. Overall public health spending is expected to continue to decline over the next couple of years.

Future Outlook

Signed in July 2025, the [tax and budget reconciliation law](#) (formerly known as the “One Big Beautiful Bill Act”) includes provisions for addressing federal spending on Medicaid and Affordable Care Act exchanges. The Congressional Budget Office (CBO) expects the law to [decrease spending](#) on Medicaid and the Affordable Care Act (ACA) Marketplaces by over \$1 trillion and lead to 10 million more uninsured people through 2034.

Additional policy issues that will shape future health spending and affordability include:

- **Evolution of State Cost Controls:** States implementing [measures](#) to control health cost growth, including those potentially supported by the Biden Administration's new [AHEAD model](#), may prompt further experimentation; however, states can only regulate a [subset](#) of private health insurance plans.
- **Price Transparency Requirements:** Federal [price transparency](#) requirements aim to illuminate prices paid to hospitals and providers. There [remain challenges](#) with the quality of the data, though CMS continues to request suggestions for improved guidelines. As for a budgetary impact, CBO predicted minimal impact on health sector prices.
- **Prescription Drug Pricing:** The Trump administration's 2025 [executive order](#) called on pharmaceutical manufacturers to match most-favored-nation prices (MFN, the lowest price offered in other developed nations). The effects of this order on prescription drug prices in the U.S. remain uncertain. Additionally, the [Inflation Reduction Act of 2022](#), targeting Medicare drug spending through government negotiation of drug prices, is expected to reduce Medicare costs, but potential far-reaching effects are still unclear. While CBO expects minimal effects on the availability of new treatments, there is considerable uncertainty surrounding those estimates.
- **Expansion of Virtual Care:** The COVID-19-induced rise in [telehealth](#), with expanded [reimbursement](#) and access, has uncertain impacts on care coordination, quality, health outcomes, and costs.
- **Market Dynamics and Anticompetitive Practices:** [Consolidation](#) among providers, insurers, and drug manufacturers has elevated health care prices, leading to regulatory [actions](#) against anticompetitive practices, aiming to protect consumers from rising costs.
- **Provider Payment Reforms:** Bipartisan efforts in site-neutral payment reform, addressing concerns about higher payments in outpatient settings, have led to [Medicare](#) implementing site-neutral payments in some settings and additional [legislative](#) proposals. However, challenges in provider charging practices and facility fees persist.
- **Value-Based Payment Models:** The proliferation of [value-based care](#) aims to transfer some of the cost risks from payers to providers, but [concerns](#) remain about the [effectiveness of these approaches](#), limited quality improvement, administrative burdens, and reduced physician participation incentives.
- **Changes in Coverage:** Despite reduced uninsured rates through continuous [Medicaid](#) enrollment and [expanded](#) Affordable Care Act Marketplace subsidies during the pandemic, affordability challenges persist among the insured. Renewed [disenrollments](#) from Medicaid and the [expiration](#) of Marketplace subsidies after 2025 may increase uninsured rates and affordability issues.

- **Addressing Medical Debt:** Ongoing efforts to address [medical debt](#) involve buying medical debt for forgiveness and regulatory actions. However, the root causes of high health costs and underinsurance remain untouched by most efforts to mitigate the negative effects of medical debt.

Resources

- [National Health Spending Explorer - Peterson-KFF Health System Tracker](#)
- [How has U.S. spending on healthcare changed over time? - Peterson-KFF Health System Tracker](#)
- [How much is health spending expected to grow? - Peterson-KFF Health System Tracker](#)
- [What are the recent and forecasted trends in prescription drug spending? - Peterson-KFF Health System Tracker](#)
- [How does medical inflation compare to inflation in the rest of the economy? - Peterson-KFF Health System Tracker](#)
- [How many people have enough money to afford private insurance cost sharing? - Peterson-KFF Health System Tracker](#)
- [Americans' Challenges with Health Care Costs | KFF](#)
- [How does cost affect access to healthcare? - Peterson-KFF Health System Tracker](#)
- [The burden of medical debt in the United States - Peterson-KFF Health System Tracker](#)
- [Health Care Debt In The U.S.: The Broad Consequences Of Medical And Dental Bills | KFF](#)

This chapter was prepared by Krutika Amin, Emma Wager, Lynne Cotter and Cynthia Cox and draws on existing KFF products.

Citation

Amin, K., Wager, E., Cotter, L. & Cox, C., Health Care Costs and Affordability. In Altman, Drew (Editor), Health Policy 101, (KFF, October 2025) <https://www.kff.org/health-policy-101-health-care-costs-and-affordability/> (date accessed).



The independent source for health
policy research, polling, and news.

Headquarters

185 Berry Street, Suite 2000
San Francisco, CA 94107
650.854.9400

**Washington Office &
Barbara Jordan Conference Center**

1330 G Street NW
Washington, DC 20005
202.347.5270

This publication is available at kff.org/health-policy-101