AMERICAN ENTERPRISE INSTITUTE

Statement before the House Committee on the Budget on "Reverse the Curse: Skyrocketing Health Care Costs and America's Fiscal Future"

Health Care Spending and the Long-Run Fiscal Outlook

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Summary

- National health expenditures have risen faster than inflation or economic output for two years in a row, reaching $5.3 trillion in 2024. This creates a particularly notable challenge for federal policymakers due to the federal government's increasing share of spending, which has grown from 32 percent to nearly 50 percent since the late 1980s.

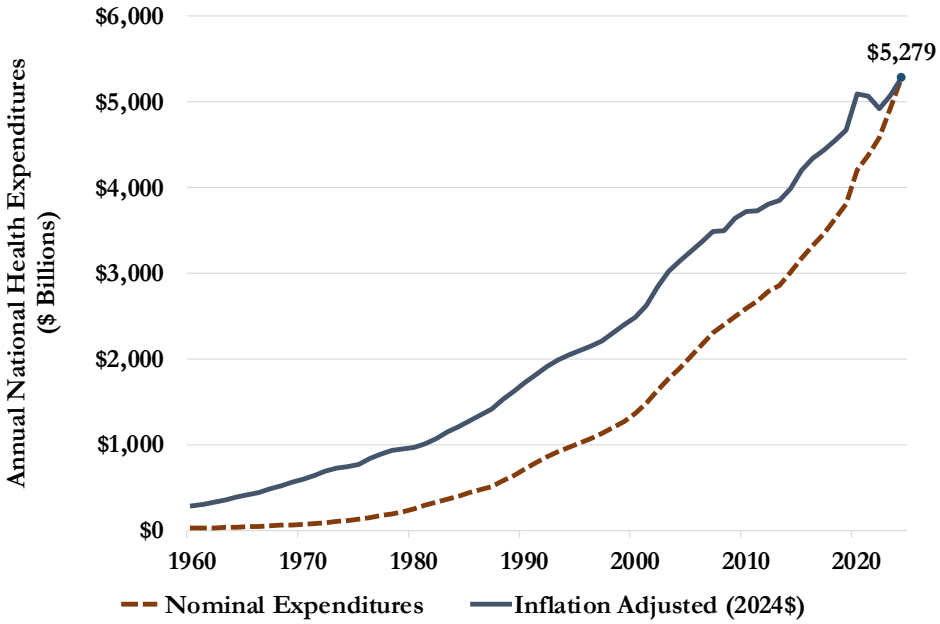
- Costs associated with major health care programs are forecasted to be the biggest contributor to the long run fiscal imbalance outside of interest payments. Given the scale of expenditures, even modest constraints on growth generate significant savings.

- Federal policymakers have a wide variety of reform options to address spending that is not reflective of value. Options include policies that that increase competition, reduce inappropriately high prices in public programs, constrain the use of low-value services in Medicare, reform Medicare Advantage payment rates and oversight, along with many others.

Current and Future U.S. Health Care Spending

Total U.S. health care expenditures increased by 7.2 percent in 2024, reaching nearly $5.3 trillion annually (Figure 1). This followed similarly rapid growth of 7.4 percent in 2023. Both increases exceeded the rates of inflation and economic growth. These represent notably elevated spending growth rates, and some forecasts suggest that health care costs may continue to rise at unsustainable levels in the coming years.[1] Such growth would exacerbate health care's already substantial contribution to the United States' long-run budgetary challenges.

Figure 1: Total National Health Expenditures, 1960-2024



Note: Health spending data are from the National Health Expenditure Accounts produced by the Centers for Medicare & Medicaid Services (CMS). Data for 1960–1999 are taken from CMS historical tables, "National Health Expenditures by Type of Service and Source of Funds." Data for 2000–2024 are taken from CMS National Health Expenditure Fact Sheets. Inflation adjustments use the Consumer Price Index for All Urban Consumers (CPI-U) from the Federal Reserve Economic Data (FRED) database.

High health care costs manifest in many ways—like crowding out spending on other policy priorities, making it harder for firms to increase employee cash wages,[2] raising out-of-pocket costs for consumers, and more—but for this testimony I will primarily focus on its effects on federal spending and the budget outlook.

Rapid cost growth in 2023 and 2024 is particularly notable because costs had recently been increasing modestly by historical standards (Figure 2). From 2009 to 2022, health expenditures grew from 17.2 percent to 17.4 percent of GDP (with a short-term fluctuation due to Covid-19). In other

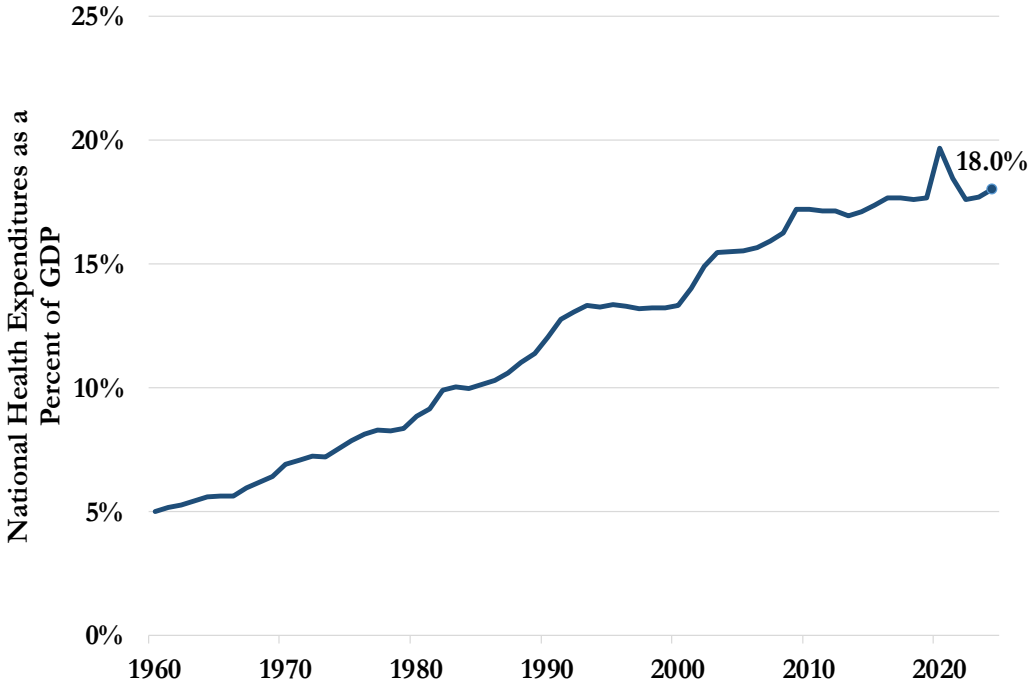
[1] E.g., Keehan, Sean P., et al. "National Health Expenditure Projections, 2024–33: Despite Insurance Coverage Declines, Health To Grow As Share Of GDP: Article features National Health Expenditure Projections, 2024-33." *Health Affairs* (2025): 10-1377. PWC "No let up in sight. Medical cost trend set to grow at 8.5%. Is your playbook ready?" Report. July 16, 2025.

[2] E.g., see Finkelstein, Amy, et al. "The health wedge and labor market inequality." *Brookings Papers on Economic Activity* 2023.1 (2023): 425-503. Arnold D. & Whaley C. (2020). Who Pays for Health Care Costs? *RAND Working Paper.* July 2020.

words, health spending grew only slightly faster overall economic output during that period. (There is no single explanation for this period of slower growth, but evidence suggests several contributing factors including substitution towards lower cost settings or products, modest price growth, expanded scope of practice, and lower administrative cost growth).[3] By comparison, health costs as a share of GDP rapidly grew by four percentage points from just 2000 to 2009 (13.3 percent of GDP to 17.2).

Spending growth in 2023 and 2024 was mostly driven by greater volume and intensity of care (i.e., use of higher cost services or drugs over lower cost options).[4] Price growth was roughly in line with inflation over that period.

Figure 2: National Health Expenditures as a Percent of GDP, 1960-2024



Note: All health spending data are from the National Health Expenditure Accounts produced by the Centers for Medicare & Medicaid Services (CMS). Data for 1960–1999 are taken from CMS historical tables, "National Health Expenditures by Type of Service and Source of Funds." Data for 2000–2024 are taken from CMS National Health Expenditure Fact Sheets. Inflation adjustments use the Consumer Price Index for All Urban Consumers (CPI-U) from the Federal Reserve Economic Data (FRED) database. Nominal GDP data are also from FRED.

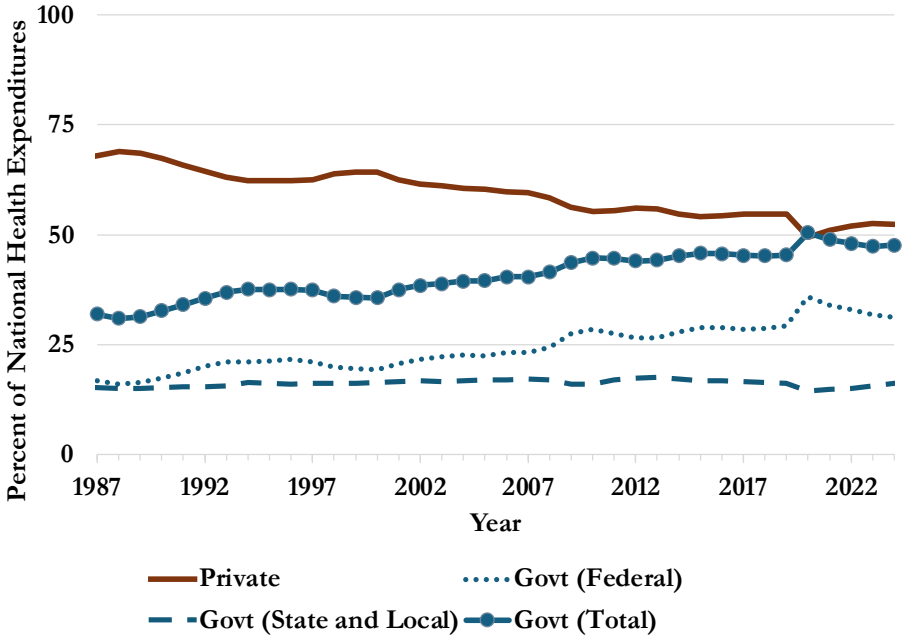
Rising health costs play a particularly notable role in federal policymaking and budgets because the federal government has absorbed an increasing share of spending over time. Since the late 1980s, the share of expenditures paid by private sources (i.e., households and businesses) has fallen from nearly

[3] Glied, Sherry A., and Brendan Lui. "Anatomy Of A Slowdown: Decomposing The Moderation In Health Spending Growth, 2009–19." *Health Affairs* 45.1 (2026): 29-38. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2025.00472

[4] Chernew, M. "Growth In National Health Expenditures: It's Not The Prices, Stupid." *Health Affairs Forefront.* January 15, 2025. https://www.healthaffairs.org/content/forefront/growth-national-health-expenditures-s-not-prices-stupid?utm_medium=social&utm_source=twitter&utm_campaign=forefront

70 percent to 52 percent in 2024 (Figure 3). The increase in the government's share from 32 to 48 percent largely reflects rising federal spending. State and local expenditures have remained around 15 percent of overall outlays (though a constant share still corresponds to rising absolute spending).

Figure 3: Government and Private Spending as a Percent of National Health Expenditures, 1987-2024



Note: Health spending data are from the National Health Expenditure Accounts produced by the Centers for Medicare & Medicaid Services (CMS). See footnotes in NHE Table 5 for components included in private and government. Total expenditures in 2024 were $5,279 billion.

This is likely unsurprising to many observers as notable recent policy reforms have relied heavily on federal spending. For example, Medicaid expansion under the Affordable Care Act (ACA) was almost entirely financed by the federal government[5] and most enrollees on the ACA individual market are from income groups that are heavily subsidized by the federal government.[6] Meanwhile changing population demographics have significantly increased Medicare spending.[7]

Predictably, federal spending on health programs represents a very large portion of overall government expenditures. The $1.9 trillion spent on health programs in fiscal year 2024 was 27 percent of all federal outlays (Figure 4). By comparison, spending on social security and national defense were $1.5 trillion and $0.9 trillion, respectively.

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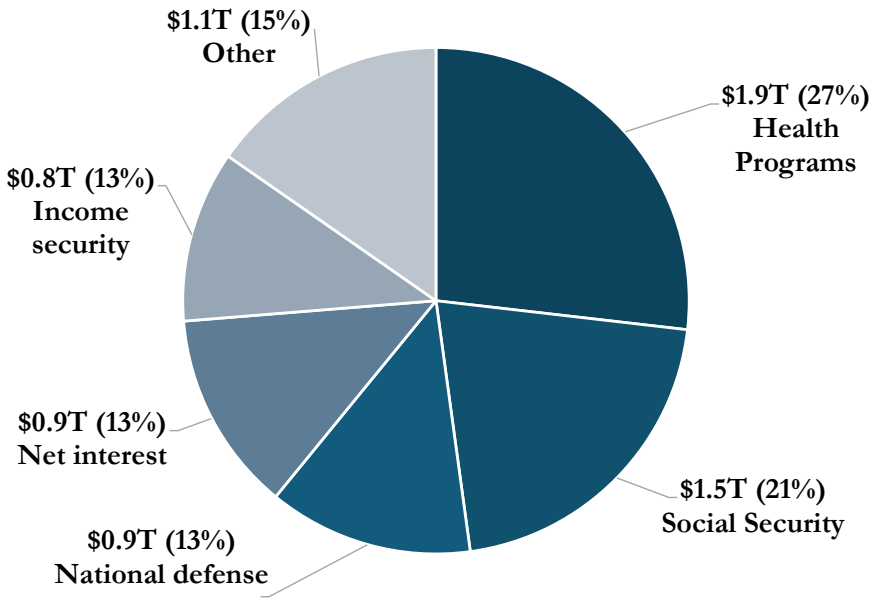
[5] See Mathers, Tolder, Chidambaram, and Cervantes. "5 Key Facts About Medicaid Expansion." Apr 25, 2025. KFF. https://www.kff.org/medicaid/5-key-facts-about-medicaid-expansion/

[6] KFF. "Marketplace Plan Selections by Household Income." https://www.kff.org/affordable-care-act/state-indicator/marketplace-plan-selections-by-household-income

[7] E.g., see MedPAC. "Report to the Congress: Medicare and the Health Care Delivery System." June 2015. Chapter 2. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/chapter-2-the-next-generation-of-medicare-beneficiaries-june-2015-report-.pdf

Figure 4: Net Federal Outlays by Category, FY 2024
(Total Outlays: $6.9 Trillion)



Note: Data from Cubanski, Burns, and Cox. "What Does the Federal Government Spend on Health Care?" February 24, 2025. https://www.kff.org/medicaid/what-does-the-federal-government-spend-on-health-care/

Spending on the largest public programs—Medicare ($838B) and Medicaid ($584B)—account for over half of all total federal support for health programs (Table 1). Spending on ACA subsidies ($111B) and Veterans health ($127B) each account for around 5 percent. In addition, exempting the contributions to employer sponsored health insurance from income taxes costs the federal government nearly $400B per year in foregone revenues. The sheer scale of many of these programs mean that even modest changes to spending trajectories can generate significant savings or budgetary pressure.

Table 1: All Federal Support for Health Programs, 2024

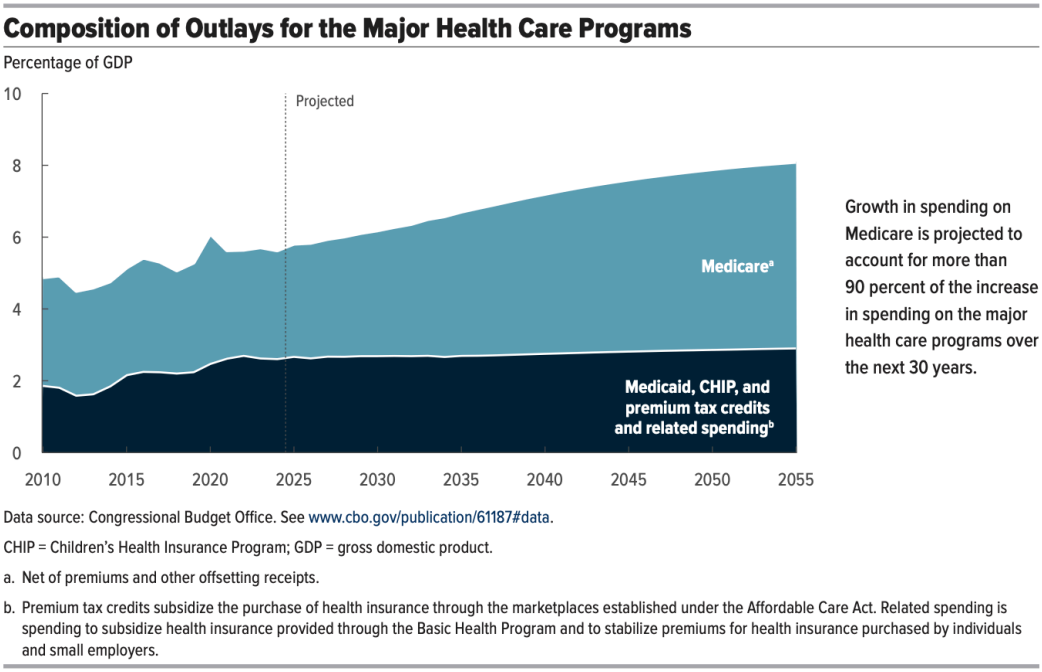
Spending Category	Program	Spending ($Billions)	Percent of Total
Mandatory (70%)	Medicare	838.8	36.3
	Medicaid and CHIP	584.4	25.3
	ACA Marketplace Subsidies	111.2	4.8
	Other Mandatory Spending	81.5	3.5
Tax Subsidies (19%)	Employer Health Insurance	384.0	16.6
	Other Tax Subsidies	65.7	2.9
Discretionary (11%)	Veterans Health	127.6	5.6
	NIH	45.5	2.4
	CDC	8.8	0.4
	Other Discretionary	64.5	2.8

Note: Data from Cubanski, Burns, and Cox. "What Does the Federal Government Spend on Health Care?" February 24, 2025. https://www.kff.org/medicaid/what-does-the-federal-government-spend-on-health-care/

Over the long term, health costs are expected to be an important contributor to the U.S.' worrying fiscal trajectory. From 2024 to 2055, federal outlays are forecasted to rise from 23.4 percent of GDP to 26.6 percent.[8] Most of that expected growth in spending (beyond interest payments) is attributable to growth in major federal health programs, which are expected to grow from 5.6 to 8.1 percent of GDP over that time. Forecasted growth in Medicare spending is the biggest contributor to that projection (Figure 5). Over that time, federal debt held by the public is expected to grow to 156 percent of GDP.

[8] Congressional Budget Office. "The Long-Term Budget Outlook: 2025 to 2055." March 2025. https://www.cbo.gov/publication/61187

Figure 5: CBO Long Term Projection for Federal Health Programs



Note: Figure taken from Congressional Budget Office. "The Long-Term Budget Outlook: 2025 to 2055." March 2025.

Options to Slow Cost Growth

The data show that health spending poses a first-order challenge for federal policymakers, especially if recent cost trends persist. Any serious effort to address long-term spending and revenue imbalances must therefore confront rising health care costs, particularly in the major health programs. This reality does not justify indiscriminate cuts to health care spending, however, as some expenditures generate substantial health and welfare gains. Instead, policymakers should focus on spending least likely to deliver value—most often where markets lack key features such as competition or transparency, or where government program create poor incentives or facilitate wasteful spending. I will highlight just a few.

Reducing consolidation in health care markets

Consolidation represents a consistent challenge in public and private health care markets. As I have previously written, it is a major contributor to spending that is weakly tied to value:[9]

> Consolidation within health care markets is an important contributor to federal health spending. A large amount of empirical research has shown that this consolidation has increased prices paid by commercial insurers.[10] This is true of horizontal consolidation

[9] Ippolito, Benedic. "Examining the Budgetary Effects of Health Care Consolidation." Testimony before the House Budget Committee on Breaking up Health Care Monopolies: Examining the Budgetary Effects of Health Care Consolidation." May 23, 2024.

[10] For reviews of the literature, see Gaynor, Martin. "What to Do about Health-Care Markets? Policies to Make Health-Care Markets Work." *Hamilton Project Policy Proposal* (2020) https://www.hamiltonproject.org/publication/policy-proposal/what-to-do-about-health-care-markets-policies-to-make-health-care-markets-work/; Levinson et al. "Ten

between similar firms (e.g., two hospitals merging) and vertical integration between different types (e.g., a hospital acquiring physicians' practices). Research has found little evidence of commensurate improvements to quality. While empirical studies have focused more on health care providers, horizontal and vertical consolidation in other markets, like Pharmacy Benefit Managers or health insurers, can raise similar concerns.

Importantly, research has also shown that increasing health costs, which raises the cost of employers offering health insurance, leads to lower wages for workers.[11] This effectively means a larger share of total compensation is delivered through a tax-exempt vehicle and is a key reason consolidation lowers federal tax revenues. As noted above, this exemption currently costs over $300 billion per year and is expected to rise to over $600 billion by 2032.[12]

Consolidation can also directly increase spending in public programs. Notably, Medicare typically pays more for the same service if it is delivered in a hospital outpatient department than a physician's office (and to a lesser degree, an ambulatory surgery center). Thus, if hospitals acquire physicians' offices and turn them into HOPDs, Medicare spending increases directly (in addition to beneficiary out-of-pocket spending). By incentivizing consolidation, this also illustrates an example of how public programs can increase commercial health care spending.

There are several opportunities to reduce incentives to consolidate and improve market functioning. Policymakers can continue working to expand Medicare's use of site-neutral payments where appropriate.[13] Doing so would not only lower Medicare spending, but give hospitals less incentive to acquire other entities, like doctor's offices. Congress could also revise the design of the 340B program, which may encourage hospitals to acquire certain physician practices and dispense more expensive drugs.[14] Policymakers may also consider reforms to antitrust enforcement, like lowering reporting requirements for transactions or changing enforcement standards.[15] Federal policymakers can also encourage states adopt several policies that can increase competition, including several supply-side reforms.[16]

Things to Know About Consolidation in Health Care Provider Markets." KFF. April 19, 2024. https://www.kff.org/health-costs/issue-brief/ten-things-to-know-about-consolidation-in-health-care-provider-markets/

[11] E.g., Gruber, J. (1994). The incidence of mandated maternity benefits. *The American Economic Review*, 622-641 https://www.jstor.org/stable/2118071. Arnold, D., & Whaley, C. (2020). Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages. *RAND Corporation*. https://www.rand.org/pubs/working_papers/WRA621-2.html

[12] CBO. (2022). Federal Subsidies for Health Insurance Coverage for People Under 65: 2022 to 2032. https://www.cbo.gov/system/files/2022-06/57962-health-insurance-subsidies.pdf

[13] For a discussion see Ippolito, B. Lowering Health Care Costs Through Transparency and Competition. House Committee on Energy and Commerce Subcommittee on Health. January 31, 2024. https://energycommerce.house.gov/events/health-subcommittee-hearing-health-care-spending-in-the-united-states-unsustainable-for-patients-employers-and-taxpayers

[14] Adler, L., & Ippolito, B. (2023). Procompetitive health care reform options for a divided Congress. *Brookings*. https://www.brookings.edu/articles/procompetitive-health-care-reform-options-for-a-divided-congress/

[15] For a discussion see Ippolito, B. Lowering Health Care Costs Through Transparency and Competition. House Committee on Energy and Commerce Subcommittee on Health. January 31, 2024. https://energycommerce.house.gov/events/health-subcommittee-hearing-health-care-spending-in-the-united-states-unsustainable-for-patients-employers-and-taxpayers

[16] For a discussion, see Ippolito, B. "Policy Options to Address Consolidation in Healthcare Provider Markets." Aspen Institute. https://www.aei.org/wp-content/uploads/2025/02/HMS-HCC-AV-Report-Final_Ippolito.pdf?x97961

Targeting wasteful spending in public programs

There are several examples where spending in public programs is loosely tied to value or beneficiary wellbeing. For instance, evidence suggests that Traditional Medicare (TM) does a poor job of constraining the use of low value services. Large spending variation across the country—which is driven by differences in use of services as opposed to prices—is not systematically tied to variation in enrollee characteristics or outcomes. Indeed, efforts to increase antifraud efforts have been shown to reduce geographic variation in TM.[17] Policymakers should consider further efforts to monitor and deter the use of services that drive spending but not health outcomes in TM (the recently announced "WISeR" model from CMS is consistent with this goal). There are also opportunities to address prices in TM that are likely set inappropriately. For example, evidence suggests TM payments for post-acute care exceed those of private payers and are not tied to improved outcomes.[18]

Analogous opportunities exist in the Medicare Advantage (MA) program. While MA plans can generate certain cost efficiencies, the program does not generate savings for taxpayers.[19] This reflects several policy choices worth reconsidering—like how the federal government sets "benchmark" payments to MA plans and the design of its quality bonus program. The government should also ensure that it polices strategic behavior by firms that may inappropriately inflate costs. For example, it can increase audits on plans, continue efforts to reduce the effects of "coding intensity" on program costs, and adjust payments to reflect advantageous selection into MA plans.

Reduce open-ended subsidies for health care

Finally, federal policymakers should reconsider the use of open-ended subsidies for health care in general (i.e., subsidies which increase indefinitely with the cost of health care). These arrangements are common across the U.S. health care landscape. For example, subsidies on the ACA exchanges are "price-linked" and increase with plan costs. Premiums paid for employer sponsored insurance are exempt from income taxation regardless of how high they climb. The federal government indefinitely pays at least half of all Medicaid spending regardless of how much states expand the program and spending. These designs reduce incentives for purchasers to control health costs and increase long-run federal costs. The federal government can maintain very generous contributions to health expenses while shifting away from these cost-increasing subsidy designs.

Conclusion

Health care costs represent a major challenge for federal policymakers, particularly given unsustainably rapid cost growth over the last two years. With the federal government absorbing an increasing share of total expenses, it must consider ways to moderate cost growth in major federal programs and tax subsidies. Federal policymakers have a wide variety of reform options to address spending that is not reflective of value. Options include policies that that increase competition, reduce prices in some public programs that are inappropriately high, constrain the use of low-value services in Medicare, reform Medicare Advantage payment rates and oversight, along with many others.

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[17] Sood, Neeraj, et al. "Geographic variation in Medicare fee-for-service health care expenditures before and after the passage of the affordable care act." *JAMA Health Forum*. Vol. 2. No. 12. American Medical Association, 2021.

[18] Committee for a Responsible Federal Budget. Can Post-Acute Care Reforms Save the Medicare Trust Fund? MAR 24, 2022. https://www.crfb.org/blogs/can-post-acute-care-reforms-save-medicare-trust-fund

[19] Ippolito B. The Future of Medicare Advantage—Assessing Current Debates and the Likelihood of Near-Term Reforms. *JAMA Health Forum*. 2025;6(8):e253042. doi:10.1001/jamahealthforum.2025.3042