



# AMA POLICY RESEARCH PERSPECTIVES

---

## National health expenditures, 2024: Second consecutive year of elevated growth driven by increased healthcare utilization

By Allen Hardiman, PhD  
Lead Economist, American Medical Association

July 2026

Executive summary .....	2
Introduction .....	3
Spending by type of expenditure ...	3
Spending by source of funds .....	4
Spending by sponsor .....	7
Conclusion .....	9
References .....	10
Exhibits .....	11

## Executive summary

Using the current U.S. national health expenditures data released by the Centers for Medicare & Medicaid Services in January 2026, this American Medical Association Policy Research Perspective examines 2024 national healthcare spending and how it compares to historical trends.

The United States spent a total of \$5,278.6 billion or \$15,474 per capita on healthcare in 2024. Healthcare spending accounted for 18.0% of gross domestic product (GDP) in 2024, similar to the shares observed over the past decade, except for the brief uptick in 2020 due to the pandemic (19.7% of GDP). Healthcare spending grew by 7.2% in 2024, closely matching the 7.4% growth seen in 2023, and notably outpacing the 2022 and 2021 growth rates of 4.8% and 4.1%, respectively.

Apart from the 10.5% surge in 2020 because of the COVID-19 pandemic, the 2023 and 2024 growth rates are the highest recorded since 2003 (8.6%). Similar to 2023, the acceleration in 2024 stemmed from higher demand for healthcare goods and services. For the second year in a row, the growth in spending (7.2%) outpaced GDP growth (5.3%).

In 2024 personal healthcare spending accounted for 85.4% (\$4,510.2 billion) of total healthcare spending. The four largest components in this category were spending on hospital care (31.0% or \$1,634.7 billion), physician services (15.7% or \$829.0 billion), prescription drugs (8.8% or \$467.0 billion), and clinical services (5.3% or \$280.7 billion). Driven by increased utilization of healthcare goods and services, personal healthcare spending grew by 8.3% in 2024—following a 9.4% surge in 2023, the highest growth rate since 1990.

Among different payers of healthcare (source of funds), private health insurance spending saw the largest growth in 2024 at 8.8%, driven by increased healthcare utilization and considerable rise in Health Insurance Marketplace plan enrollment resulting from enhanced premium tax credits. In contrast, Medicaid spending decelerated considerably in 2024, growing by only 6.6% in 2024 after reaching 9.7% growth in 2022 and 2021, as pandemic-era coverage protections ended and states resumed eligibility redetermination. Although Medicare spending also slowed slightly in 2024 due to the lower benchmark payment rates to Medicare private plans, Medicare fee-for-service spending accelerated notably despite a sixth consecutive year of declining enrollment. Out-of-pocket spending surged in 2021, rising by 10.9%, before decelerating to 5.9% in 2024.

In 2024 the federal government was the largest sponsor of national healthcare spending, financing 31.3% (\$1,652.0 billion). Households financed 27.6% (\$1,458.9 billion), while private businesses and state and local governments sponsored 18.3% (\$967.4 billion) and 16.3% (\$859.7 billion), respectively. The remaining share (6.5% or \$340.5 billion) came from other private sponsors.

---

## Introduction

This American Medical Association Policy Research Perspective examines 2024 national healthcare spending and how it compares to historical trends by using the U.S. national health expenditures (NHE) data released by the Centers for Medicare & Medicaid Services (CMS) in January 2026.

The NHE data provide comprehensive information on the finances of the U.S. healthcare system and serve as the official estimate of total healthcare spending (CMS, 2026). CMS has been collecting data on U.S. healthcare expenditures since 1960. The data are organized into three categories within the NHE. The sum of the components of each category is the same, \$5,278.6 billion in 2024.

- *Type of expenditure:* Where does the money go? In this category, healthcare spending is segmented into what was spent on health consumption expenditures and investment (e.g., research, structures and equipment). Health consumption

expenditures include personal healthcare spending (i.e., spending on hospital care, physician services and prescription drugs), as well as public health, government administration and net costs for insurers (i.e., administration costs, taxes, fees and profits of private health insurers).

- *Source of funds:* Who is the final payer? This category splits healthcare spending into healthcare investment and the amounts paid by each of the payers. The latter includes spending by health insurance programs (private health insurance, Medicare, Medicaid and other), spending by other third-party payers, as well as out-of-pocket spending.
- *Sponsor:* Who is the original source of financing? This category reflects the origin or sponsors of the dollars used by each of the source of funds to pay for healthcare. These sponsors include households, private businesses, other private sponsors, the federal government, and state and local governments.

---

## Spending by type of expenditure

### Spending shares

Personal healthcare spending accounted for 85.4% of healthcare spending in 2024, which corresponded to \$4,510.2 billion. This category includes hospital care (31.0% or \$1,634.7 billion), physician services (15.7% or \$829.0 billion), prescription drugs (8.8% or \$467.0 billion), clinical services (5.3% or \$280.7 billion), nursing care facilities (4.2% or \$219.9 billion), home healthcare (3.2% or \$169.4 billion), and other personal healthcare services (17.2% or \$909.7 billion) ([Exhibit 1](#)).<sup>1</sup> In 2024, personal healthcare spending made up a slightly larger share of healthcare spending compared to 2023 (84.5%), largely resulting from a slightly bigger share of spending on hospital care.

Non-medical insurance expenditures and government administration accounted for 5.8% (\$306.0 billion) and 1.3% (\$66.1 billion) of total healthcare spending, respectively. The former is the difference between what private insurers receive in premiums and the

amount paid in benefits.<sup>2</sup> This includes administrative costs, profits/losses, taxes and fees. This spending category made up a slightly lower share of healthcare spending in 2024 compared to 2023 (6.4%), partly because private insurers paid out more in benefits due to higher-than-expected demand for care (Hartman et al., 2026). Government administration covers the administrative costs associated with running government healthcare programs including but not limited to Medicare, Medicaid and the Children's Health Insurance Program (CHIP). Non-medical insurance expenditures and government administration represent premium dollars that are not spent on healthcare services.

Government public health activities accounted for 3.0% (\$157.6 billion) of total healthcare spending in 2024, continuing the downward trend observed after the pandemic. This category reflects the spending by federal, state and local governments in delivering

---

1. Other personal healthcare services here is the sum of both durable and non-durable medical products, other professional and dental services, and other health, residential, and personal care.  
2. In previous years, non-medical insurance expenditures was labeled "Net cost of health insurance."

## The sharp growth in personal healthcare spending in both 2023 and 2024 was largely attributed to increased demand for healthcare goods and services.

public health services such as vaccination services, disease prevention programs and epidemiological surveillance (CMS, 2026). Lastly, investment accounted for 4.5% (\$238.7 billion) in 2024.

After a notable shift in spending patterns caused by the pandemic, the distribution of healthcare spending in 2024 has returned closer to pre-pandemic trends. From 2019 to 2020, the share of spending on government public health activities doubled from 2.9% to 5.8%, while the share for personal healthcare spending declined from 84.2% to 81.0%. As pandemic-related spending continues to decline, the share of personal healthcare spending in 2024 (85.4%) returned closer to its pre-pandemic share (84.2% in 2019).

### Spending growth

Exhibit 2 shows the annual growth in spending on personal healthcare and its four largest components (hospital care, physician services, clinical services, and prescription drugs) over the 10-year period from 2015 through 2024. Between 2015 and 2024, personal healthcare spending grew by 6.0% per year on average. Among its four components, clinical

services had the largest average annual growth over 10 years (6.8%), followed by physician services (6.3%), hospital care (5.7%) and prescription drugs (4.9%).

Between 2015 and 2019, personal healthcare spending growth was highest in 2015, following the expansion of Medicaid and the launch of the Health Insurance Marketplace (“Marketplace,” hereafter) in 2014 under the Affordable Care Act. For example, spending on clinical services and prescription drugs grew by 8.8% and 7.4% in 2015, respectively. By 2018, spending growth had leveled off and flattened before accelerating again in 2019 due to growth in the utilization of personal healthcare services (Martin et al., 2020).

Total personal healthcare spending growth accelerated to 6.3% in both 2020 and 2021 with the onset of COVID-19 pandemic, before slowing down in 2022 due to slower price increases and lower service utilization.<sup>3</sup> Notably, personal healthcare spending accelerated from 5.1% in 2022 to 9.4% in 2023, marking the highest annual growth rate since 1990. Among the four major components, prescription drugs and hospital care led the 2023 increase, growing by 10.8% and 10.6%, respectively, with physician services and clinical services following with growth rates of 7.5% and 7.0%, respectively. In 2024, personal healthcare spending growth remained high at 8.3%. Spending on physician services and clinical services accelerated to 8.1% and 7.9%, while hospital care and prescription drugs spending decelerated to 8.9% and 7.9%. The sharp growth in personal healthcare spending in both 2023 and 2024 was largely attributed to increased demand for healthcare goods and services.<sup>4</sup>

## Spending by source of funds

### Spending shares

Exhibit 3 shows the spending shares for each source of funds, which represent the final payers for healthcare goods and services. In 2024, health insurance accounted for 73.7%, or \$3,892.9 billion, of healthcare spending. This includes spending by private health insurance (PHI) (31.2% or \$1,644.6

billion), Medicare (21.2% or \$1,118.0 billion), Medicaid (17.7% or \$931.7 billion), and other health insurance programs (3.8% or \$198.6 billion). Since 1980, PHI has consistently been the largest contributor to total healthcare spending. Except for a few years due to the pandemic, this category has accounted for at least 30% of total spending since 1990. Its share declined

3. The growth in 2020 was largely driven by federal spending on public health programs in response to the pandemic, despite a decline in medical care utilization (Hartman et al., 2021). However, healthcare utilization rebounded in 2021 (Rama, 2024).
4. After adjusting for inflation, personal healthcare real spending grew by 5.2% in 2024. Real spending on hospital care, prescription drugs, and physician and clinical services combined rose by 5.4%, 6.4%, and 6.1%, respectively (data are not shown but available upon request).

slightly between 2020 and 2022, when pandemic-related spending increased the share of federal programs, such as Medicaid and government public health activities. Additionally, since its inception in 1965, Medicare has steadily increased its share of total spending, growing from 10.4% in 1970 to 20.5% in 2014, and maintaining around that level since.

Out-of-pocket spending accounted for 10.5% of total healthcare spending (\$556.6 billion) in 2024, similar to the proportion in 2022 and 2023. This category includes payments from both insured patients—such as copayments, coinsurance and deductible costs—and uninsured patients. Since 2000, the share of out-of-pocket spending has gradually decreased, reflecting a steady decline in the share of the population that is uninsured, from 12.1% in 2000 to 8.2% in 2024. In recent years, this trend likely resulted from the ACA and pandemic-relief programs, which contributed to an all-time low uninsured rate of 7.5% in 2023, though the uninsured rate slightly rose in 2024 because the pandemic-era Medicaid continuous enrollment provision of the Families First Coronavirus Response Act (FFCRA) was discontinued.

In 2024, the spending share by other third-party payers and programs and investment were 8.2% (\$432.9 billion) and 4.5% (\$238.7 billion), similar to the proportions seen in 2023.<sup>5</sup>

## Spending growth

This section examines the annual spending, enrollment and spending per-enrollee growth across major source of funds categories from 2015 to 2024. These trends have been significantly influenced by government policies, including the ACA and federal public health programs related to the COVID-19 pandemic, such as the FFCRA. From 2015 to 2024, Medicaid saw the largest average annual growth (6.5%), followed by Medicare (6.1%), PHI (5.9%), and out-of-pocket spending (4.9%). When looking at the overall growth in NHE in 2024, each payer showed deceleration in spending growth from 2023 ([Exhibit 4](#)).

Medicaid spending growth slowed considerably between 2015 and 2019 as the surge in spending

## As states resumed eligibility redetermination after the pandemic-era provision of the FFCRA ended in 2023, Medicaid spending growth decelerated to 7.9% in 2023 and 6.6% in 2024.

and enrollment associated with Medicaid expansion subsided ([Exhibit 4](#) and [Exhibit 5A](#)). During the COVID-19 pandemic, the FFCRA provided extra federal funding to states if they maintained continuous Medicaid coverage, which led to a sharp increase in both Medicaid spending and enrollment. Between 2020 and 2022, Medicaid spending grew by more than 9% each year, peaking at 9.7% in 2021 and 2022. Enrollment also grew considerably, reaching a peak of 11.1% in 2021.

As states resumed eligibility redetermination after the pandemic-era provision of the FFCRA ended in 2023, Medicaid spending growth decelerated to 7.9% in 2023 and 6.6% in 2024. This also led to a noticeable slowdown in Medicaid enrollment, which grew by only 1.3% in 2023 before declining by 8.6% in 2024. As enrollment declined, per-enrollee Medicaid spending rose sharply to 16.6% in 2024—a significant jump compared to the 6.5% rise in 2023 and 2.1% rise in 2022 ([Exhibit 5A](#)). This surge was the result of two primary factors. First, eligibility redetermination shifted the composition of enrollees toward a higher proportion of individuals with greater health needs, as more individuals who were no longer enrolled in the program were lower-cost children and adults. Second, growth in state-directed payments to providers through managed care organizations and increased administrative costs related to Medicaid eligibility redetermination contributed to higher per-enrollee spending (Hartman et al., 2026).<sup>6</sup> Looking ahead, both Medicaid enrollment and spending are expected to decline with the implementation of the One Big Beautiful Bill Act (OBBBA) in 2025.<sup>7</sup>

5. Other third-party payers and programs include worksite healthcare, other private revenues, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, other federal programs, Substance Abuse and Mental Health Services Administration, other state and local programs, and school health.

6. Medicaid government administration spending grew by 19.8% in 2024, compared to 9.2% in 2023 (Hartman et al., 2026).

7. Rao et al. (2026) found that provisions in the OBBBA would reduce state Medicaid budgets by \$664 billion over the 2025–2034 period, and amount to \$714 billion in federal savings. The authors also estimate that there will be 7.6 million fewer Medicaid enrollees in 2034.

There are two main components of PHI: employer-sponsored insurance plans and direct purchase insurance plans.<sup>8</sup> PHI spending growth slowed considerably between 2015 and 2019 and was nearly flat in 2020, rising by only 0.4% resulting from pandemic-related job losses. From 2021 to 2024, PHI spending rebounded with growth rates of 6.7% in 2021 and 7.6% in 2022, and a significant acceleration to 11.2% growth in 2023, which marked the fastest growth rate since 2002. In 2024, PHI spending growth remained robust, rising by 8.8%. This acceleration was driven by two factors. First, there was a sharp increase in enrollment, particularly in direct purchase insurance plans. Enrollment growth rose from 4.1% in 2021 to 12.8% in 2024, resulting from high enrollment growth in Marketplace plans (Exhibit 5A) as enhanced

**Despite the decline in enrollment, FFS spending accelerated in 2024, rising by 6.4% compared to 2.0% in 2023, primarily resulting from higher spending on personal healthcare.**

premium tax-credits lowered the cost for enrollees.<sup>9</sup> The expiration of the Medicaid continuous enrollment in 2023 also played a role, as some individuals who lost Medicaid coverage transitioned to Marketplace plans. Second, demand for medical care grew considerably, with PHI spending on personal healthcare rising by an average of 9.5% per year between 2021 and 2024.<sup>10</sup> This rise in healthcare utilization is also reflected in the upward trend in employer-sponsored and direct Marketplace per-enrollee spending (Exhibit 5B). However, this trend

might not continue and could even reverse because the expanded Marketplace subsidies expired at the end of 2025. The Congressional Budget Office estimates that without a permanent extension of the subsidies, the number of uninsured individuals will rise by 2.2 million in 2026 and 3.7 million in 2027 (Congressional Budget Office, 2024).<sup>11</sup>

After experiencing stable growth between 2015 and 2017, Medicare spending accelerated to 6.6% and 7.1% in 2018 and 2019, respectively (Exhibit 4). This surge in growth was driven by the increased intensity of care needed by the aging Medicare population (Rama, 2024).<sup>12</sup> Medicare spending slowed slightly in 2020 before accelerating significantly to 7.3% growth in 2021. In 2024, Medicare spending grew by 7.8%, a slightly slower growth following the 9.0% increase in 2023. In the longer term, however, Medicare spending is projected to grow rapidly because of strong enrollment growth as the last cohort of baby boomers ages into Medicare through 2029 (Keehan et al., 2025).

Medicare enrollees can choose between enrolling in traditional fee-for-service (FFS) or in Medicare private plans (MPP) (i.e., Medicare part C). Since 2010, there has been a significant shift in Medicare spending from Medicare FFS to MPP, with MPP's share increasing from 25.1% in 2010 to 53.3% of total Medicare spending in 2024. This change reflects strong growth in MPP enrollment and spending, while FFS enrollment and spending—particularly during the pandemic—stagnated or declined. In 2024, enrollment in Medicare FFS declined for the sixth year in a row. Despite the decline in enrollment, FFS spending accelerated in 2024, rising by 6.4% compared to 2.0% in 2023, primarily resulting from higher spending on personal healthcare.<sup>13</sup> In contrast, Medicare private plan spending decelerated in 2024 due to lower benchmark payment rates, which contributed to the slower growth of overall Medicare spending in 2024 (Hartman et al., 2026).

8. Direct purchase insurance plans include Medigap, Marketplace, and plans purchased on the private market that are not associated with an individual's employer or Medigap plan.
9. Between 2021 to 2024, enrollment in direct Marketplace rose by more than 9 million, while enrollment in employer-sponsored insurance increased by 5 million (data are not shown but are available upon request).
10. Data are not shown but are available upon request.
11. Another report by the Urban Institute estimates that without the enhanced Marketplace subsidies, 4.8 million individuals will be uninsured in 2026 (Buettgens et al., 2025).
12. The first wave of baby boomers were born from 1946 to 1954. This suggests that these demographics became Medicare eligible (i.e., age 65) from 2011 to 2019 (Hatley, 2026).
13. Data are not shown but are available upon request.

The deceleration in Medicare private plan spending is expected to continue in 2025 and 2026, driven by slower enrollment growth and market exits in some regions by the two largest Medicare private plan insurers: UnitedHealthcare and Humana (Freed et al., 2025; Ochieng et al., 2025).

Out-of-pocket spending grew steadily from 2015 to 2019 before declining by 1.9% in 2020 because of reduced healthcare utilization ([Exhibit 4](#)). However, in 2021, growth surged to 10.9% as healthcare utilization rebounded. Since then, however, out-of-pocket spending growth has decelerated, reaching 5.9% in 2024.

## Spending by sponsor

### **In 2024, the largest contributor to national healthcare spending was the federal government at 31.3% (\$1,652.0 billion).**

This section examines the sponsors of healthcare spending. Sponsors reflect the origin of the dollars used to make payments for medical goods and services, while source of funds reflects the final payer. For example, employees and employers pay premiums to get PHI coverage. In this case, households and private businesses are the sponsors (origin of the dollars used), whereas PHI is the source of funds (final payer) of the medical goods and services. [Exhibit 6](#) shows the shares of spending by five sponsors: private businesses, households, other private sponsors, the federal government, and state and local governments.<sup>14</sup> In addition, it also shows how each sponsor contributes to different sources of funds: PHI, Medicare, Medicaid.

In 2024, the largest contributor to national healthcare spending was the federal government at 31.3% (\$1,652.0 billion). This was closely followed by households, which accounted for 27.6% (\$1,458.9 billion). Private businesses spent 18.3% (\$967.4 billion), and state and local governments contributed 16.3% (\$859.7 billion). The remaining 6.5% (\$340.5 billion) came from other private sponsors.

Over the past few decades, the distribution of healthcare spending among sponsors has seen significant change. The federal government's share of spending nearly doubled, rising from 16.8% in

1987 (earliest data available) to 31.3% in 2024. In contrast, the household portion of total healthcare spending has decreased substantially, dropping from 36.8% to 27.6%. Similarly, the contribution from private businesses also declined, from 23.2% to 18.3%. During the onset of the COVID-19 pandemic in 2020, the federal government's share rose sharply, increasing from 29.2% to 36.0%, as a result of unprecedented federal spending aimed at managing the crisis. Although this share has decreased as pandemic-related spending has wound down, it remains higher than pre-pandemic levels. The share from households decreased from 28.7% to 26.3% in 2020, and while it has partially recovered, it was still lower than in the pre-pandemic era.

[Exhibit 6](#) also outlines the financing for the \$1,644.6 billion spent on PHI in 2024. The largest sponsor of PHI was private businesses, which accounted for 45.8% (\$753.1 billion) of PHI funding through employer contributions to employer-sponsored health insurance premiums. Household sponsors made up 28.5% (\$468.4 billion) of PHI funding, largely contributed through employee payments to employer-sponsored premiums, with the remaining portion coming from direct purchases of insurance by households. The federal government sponsored a 10.7% share (\$175.9 billion) through its role as an employer and by funding other federal health insurance programs, including pandemic-related spending and Marketplace tax credits and subsidies. The latter began being recorded in 2014 with the introduction of the ACA Marketplace. Finally, state and local governments contributed 15.0% (\$247.3 billion) of PHI funding as employers contributing to employer-sponsored premiums.

14. Other private sponsors include health-related philanthropic support, nonoperating revenue, investment income, privately funded research, and privately funded structures and equipment.

In 2024, total Medicare spending reached \$1,118.0 billion. Medicare is composed of four parts. Medicare Part A covers inpatient care in hospitals and nursing facilities and is funded through payroll taxes and voluntary premium contributions to the Medicare Hospital Insurance (HI) Trust Fund.

Households contributed \$246.4 billion (22.0% of total Medicare spending) through employee and self-employment payroll taxes, as well as voluntary premiums paid to the Medicare HI Trust Fund. Private businesses sponsored \$159.2 billion (14.2%), state and local governments provided \$19.9 billion (1.8%), and the federal government funded \$5.8 billion (0.5%) to Medicare Part A through their role as an employer via payroll taxes.

Outpatient care and medical supplies are covered by Medicare Part B, while prescription drugs are covered by Medicare Part D. Both components are funded through household contributions to the Medicare Supplementary Medical Insurance (SMI) Trust Fund and the Pre-existing Condition Insurance Plan, which accounted for \$132.3 billion or 11.8% of total Medicare spending. The federal government as well as state and local governments paid \$16.1 billion (1.4%) and \$10.7 billion (1.0%) in premiums for Medicare buy-in, respectively. Additionally, state and local governments contributed \$18.0 billion (1.6%) to Medicare Part D through state phase-down payments, which are classified under other programs.

Since payroll taxes and government buy-ins are insufficient to cover the costs of Medicare Parts A, B, and D, 45.6% (\$509.6 billion) of total Medicare spending was funded by federal government funds that were not originally designated for Medicare. Specifically, this funding comes from federal general revenue and Medicare net trust fund expenditures. The introduction of Medicare Part D in 2006 increased the share of these funds to 39.0%, up from being typically under one-third of Medicare spending prior to that. These funds also grew by 9.7% in 2024, following a 15.0% increase in 2023 due to provisions in the 2022 Inflation Reduction Act (IRA) that reduced beneficiary cost sharing and shifted more financial responsibility to the federal government (Hartman et al., 2026).

## Recently, the federal share of Medicaid financing has significantly increased due to two major healthcare reforms: the ACA Medicaid expansion and the FFCRA.

The fourth and last component of Medicare is Medicare Part C (Medicare private plans). Medicare Part C beneficiaries typically receive the standard benefits covered by Parts A, B, and D, along with additional services. As described, funding for Part A benefits comes from the Medicare HI Trust Fund, while funding for Parts B and D is drawn from the Medicare SMI Trust Fund.

Finally, Medicaid spending was \$931.7 billion in 2024. The federal government contributed the largest share, financing 64.0% (\$596.7 billion) of the total, while state and local governments funded the remaining 36.0% (\$335 billion). Unlike Medicare, and despite the federal government providing the majority of the funding, Medicaid is managed by state governments, which control enrollment requirements and benefits.<sup>15</sup> Recently, the federal share of Medicaid financing has significantly increased due to two major healthcare reforms: the ACA Medicaid expansion and the FFCRA. [Exhibit 7](#) illustrates the evolution of this trend.

Under the ACA, states receive a 90.0% federal match for adults covered through Medicaid expansion (Rudowitz et al., 2021). The federal share of Medicaid funding rose from 57.7% in 2013 to 61.4% in 2014, the first year of the ACA expansion, and remained relatively stable through 2019. In 2020, the FFCRA further expanded federal funding incentives because of the COVID-19 pandemic. Combined with additional states adopting Medicaid expansion, the federal government's share of funding rose sharply to 68.5% in 2020, peaking at 70.6% in 2022. However, as these pandemic-era incentives were phased out in the second half of 2023, some of the costs were shifted back to the states. Medicaid financing by federal government declined from 70.6% in 2022 to 64.0% in 2024, which was offset by a 6.6 percentage point rise in states' share of Medicaid spending.

15. This arrangement stems from the 1965 Medicaid legislation, which required the federal government to match state funding for the program.

## Conclusion

In 2024, national healthcare spending recorded its second consecutive year of growth above 7%, rising by 7.2% to reach \$5,278.6 billion or \$15,474 per capita. This rate is similar to the 7.4% increase in 2023, and significantly higher than the 4.8% and 4.1% rise in 2022 and 2021, respectively. Apart from the 10.5% surge in 2020, the increases in 2023 and 2024 represent the fastest growth since 2003 (8.6%). Healthcare spending accounted for 18.0% of gross domestic product (GDP) in 2024, a level comparable to pre-pandemic figures. For the second year in a row, healthcare spending outpaced the growth of GDP (7.2% vs. 5.3%). As in 2023, the significant growth in 2024 was attributed to strong utilization of healthcare goods and services as the share of insured population remained high at 91.8% (Hartman et al., 2026).

Although the future of national healthcare spending remains uncertain, policy changes such as the OBBBA and the expiration of enhanced Marketplace subsidies are likely to impact near-term spending and enrollment trends, especially for payers such as Medicaid and PHI.

The majority of national healthcare spending was attributed to personal healthcare consumption, which accounted for 85.4% in 2024, up from 84.5% in 2023. The four largest components of personal healthcare are hospital care (31.0% of total healthcare spending or \$1,634.7 billion), physician services (15.7% or \$829.0 billion), prescription drugs (8.8% or \$467.0 billion), and clinical services (5.3% or \$280.7 billion). Overall, personal healthcare spending grew by 8.3%, slightly lower than the 9.4% growth in 2023 but significantly higher than the 5.1% growth in 2022. The strong growth in 2024 resulted from sustained robust growth across all four main components of personal healthcare as utilization of healthcare goods and services remained high (Hartman et al., 2026).

PHI was the largest source of funds for national healthcare spending, accounting for 31.2% (or \$1,644.6 billion), followed by Medicare (21.2% or \$1,118.0 billion), Medicaid (17.7% or \$931.7 billion), and out-of-pocket spending (10.5% or \$556.6 billion).

The rise of PHI spending slowed considerably between 2015 and 2020, before experiencing significant rise, particularly in 2023 and 2024, when growth reached 11.2% and 8.8%, respectively. This acceleration was driven by a sharp increase in both demand for medical care and enrollment in Marketplace plans.

Between 2015 and 2019, Medicaid spending and enrollment growth tapered off as the effects of the Medicaid expansion subsided. The enactment of the FFCRA led to a marked increase in Medicaid spending and enrollment between 2020 and 2022, before decelerating in 2023 and 2024 as pandemic-era coverage protections ended and enrollment declined.

After a slowdown in 2020, Medicare spending rebounded in 2023, reflecting continued robust growth in both MPP spending and enrollment, before decelerating slightly in 2024 resulting from lower benchmark payment rates to MPP. Notably, Medicare FFS spending accelerated considerably in 2024 despite a sixth consecutive year of declining enrollment.

**Apart from the 10.5% surge in 2020, the increases in 2023 and 2024 represent the fastest growth since 2003 (8.6%).**

Following a decline in 2020, out-of-pocket spending surged in 2021 as healthcare utilization rebounded. By 2024, however, out-of-pocket spending growth had decelerated to 5.9%.

In 2024, the federal government sponsored 31.3% (\$1,652.0 billion) of national healthcare spending. Households financed 27.6% (\$1,458.9 billion), while private businesses and state and local governments sponsored 18.3% (\$967.4 billion) and 16.3% (\$859.7 billion), respectively. The remaining share (6.5% or \$340.5 billion) came from other private sponsors.

*AMA Economic and Health Policy Research, June 2026*

---

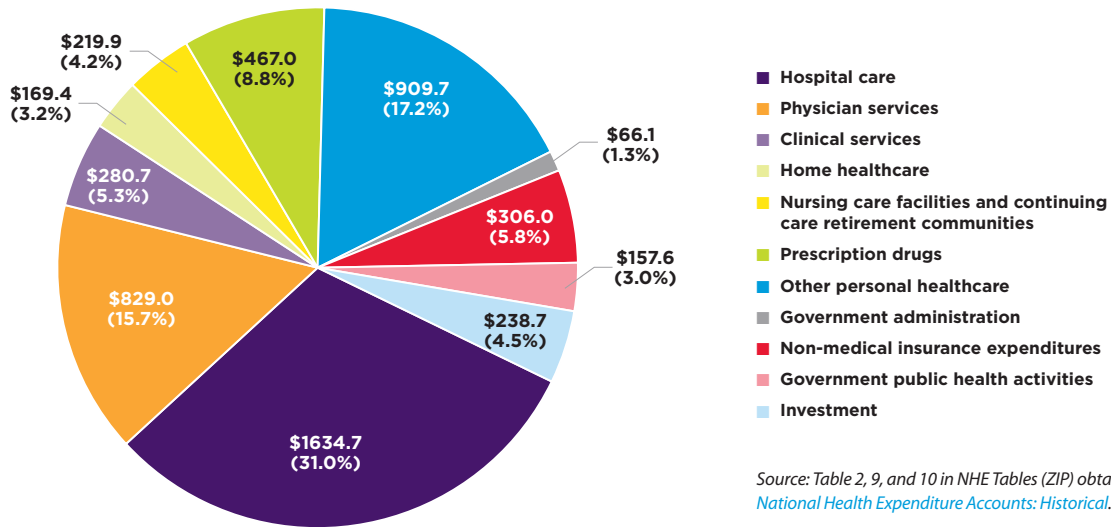
## References

- Buettgens M, Simpson M, Levitis J, Hernandez-Lepe F, Banthin J. [4.8 million people will lose coverage in 2026 if enhanced premium tax credits expire](#). Washington, DC: Urban Institute; 2025. Accessed May 11, 2026.
- Centers for Medicare & Medicaid Services. [National Health Expenditure Accounts: Historical](#). Baltimore, MD: Centers for Medicare & Medicaid Services; 2026. Accessed May 11, 2026.
- Congressional Budget Office. [The effects of not extending the expanded premium tax credits for the number of uninsured people and the growth in premiums](#). Washington, DC: Congressional Budget Office; 2024. Accessed May 11, 2026.
- Freed M, Biniek JF, Damico A, Ochieng N, Neuman T. [Medicare Advantage 2026 spotlight: A first look at plan offerings](#). Washington, DC: Kaiser Family Foundation; 2025. Accessed May 11, 2026.
- Hartman M, Martin AB, Lassman D, Catlin A, National Health Expenditure Accounts Team. [National health care spending increased 7.2 percent in 2024 as utilization remained elevated](#). *Health Affairs*. 2026;45(2),110-120. Accessed May 11, 2026.
- Hartman M, Martin AB, Washington B, Catlin A, National Health Expenditure Accounts Team. [National health care spending in 2020: Growth driven by federal spending in response to the COVID-19 pandemic](#). *Health Affairs*. 2021;41(1),13-25. Accessed May 11, 2026.
- Hatley J. [Early boomers + generation jones: Meet the two boomer subgroups](#). St. Paul, MN: Bridgeworks; 2026. Accessed May 11, 2026.
- Keehan SP, Madison AJ, Poisal JA, Cuckler GA, Smith SD, Sisko AM, Fiore JA, Rennie KE. [National health expenditure projections, 2024–33: Despite insurance coverage declines, health to grow as share of GDP](#). *Health Affairs*. 2025;44(7),776-787. Accessed May 11, 2026.
- Martin AB, Hartman M, Lassman D, Catlin A. [National health care spending in 2019: Steady growth for the fourth consecutive year](#). *Health Affairs*. 2020;40(1),14-24. Accessed May 11, 2026.
- Ochieng N, Freed M, Biniek JF, Damico A, Neuman, T. [Medicare Advantage in 2025: Enrollment update and key trends](#). Washington, DC: Kaiser Family Foundation; 2025. Accessed May 11, 2026.
- Rama A. [National health expenditures, 2022: A return to pre-pandemic growth rates as spending on physician services decelerates](#). Chicago, IL: American Medical Association, Policy Research Perspectives; 2024. Accessed May 11, 2026.
- Rao P, Baker L, Giroso F, Li E, Kerber R, Eibner C. [State-level impacts of key Medicaid provisions in the One Big Beautiful Bill Act](#). Santa Monica, CA: RAND; 2026. Accessed May 11, 2026.
- Rudowitz R, Corallo B, Garfield R. [New incentive for states to adopt the ACA Medicaid expansion: Implications for state spending](#). Washington, DC: Kaiser Family Foundation; 2021. Accessed May 11, 2026.

## Exhibits

### Exhibit 1.

The U.S. spent \$5,278.6 billion on healthcare in 2024: Where did it go?

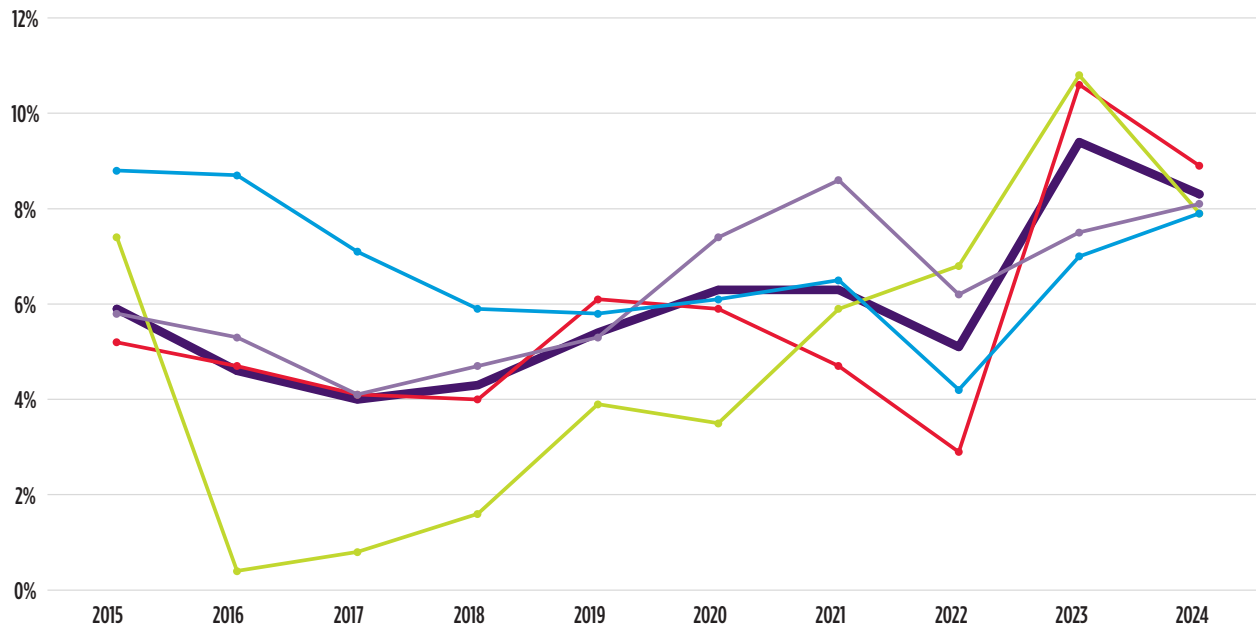
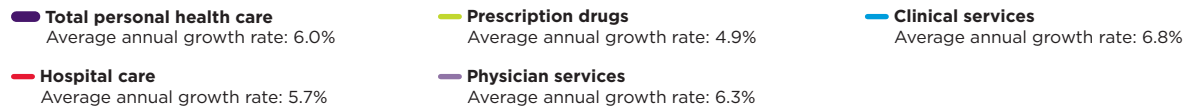


Source: Table 2, 9, and 10 in NHE Tables (ZIP) obtained from *National Health Expenditure Accounts: Historical*.

Note: All categories are shown in billions of dollars.

### Exhibit 2.

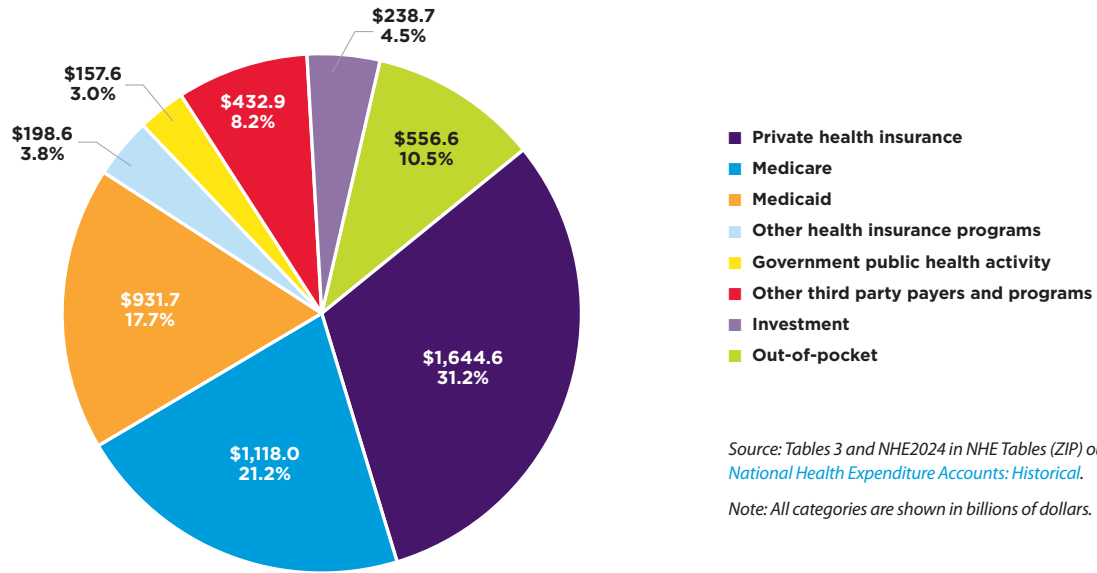
Spending growth rates by type of personal healthcare expenditure (2015–2024)



Source: Tables 2, 6, 7, 9, and 16 in NHE Tables (ZIP) obtained from *National Health Expenditure Accounts: Historical*.

### Exhibit 3.

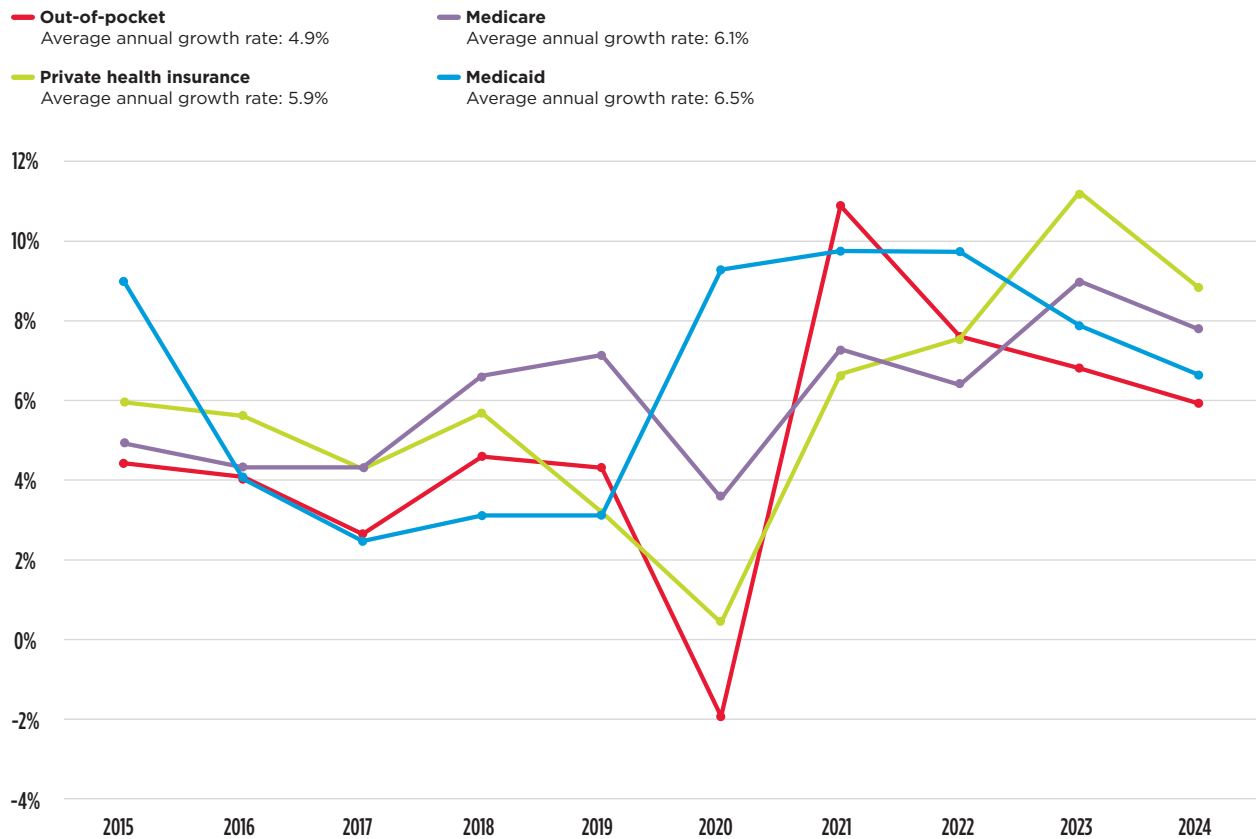
Who pays the bill? 2024 healthcare spending decomposed by source of funds.



Source: Tables 3 and NHE2024 in NHE Tables (ZIP) obtained from [National Health Expenditure Accounts: Historical](#).  
 Note: All categories are shown in billions of dollars.

### Exhibit 4.

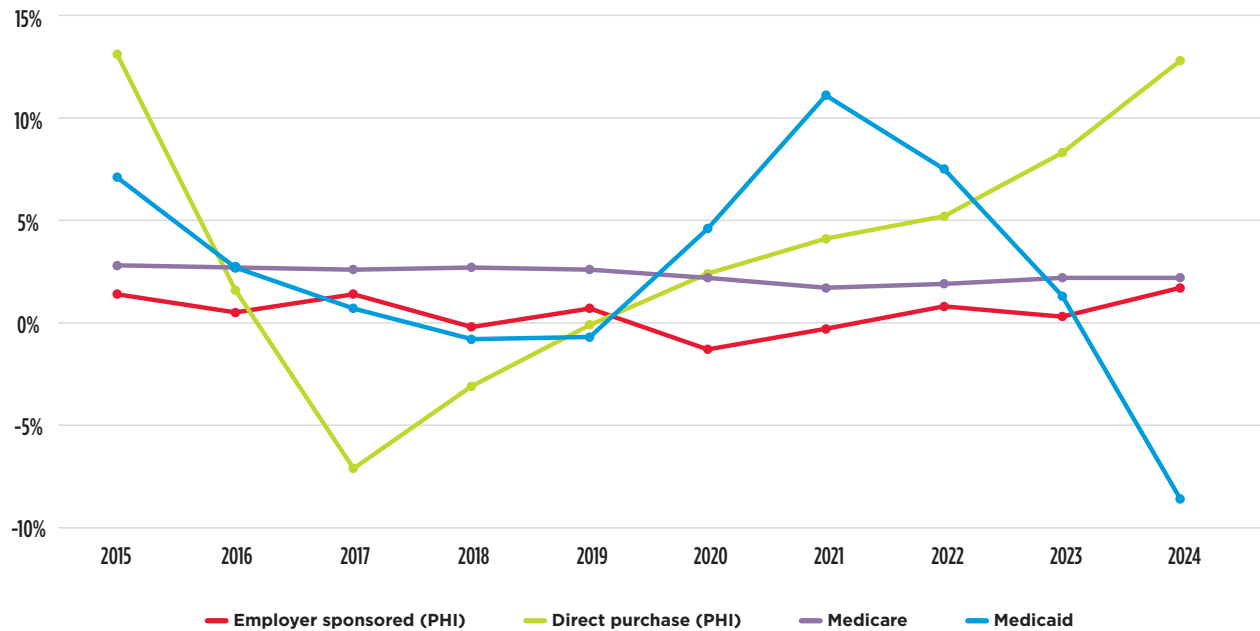
Spending growth rates by source of funds (2015–2024)



Source: Table 3 in NHE Tables (ZIP) obtained from [National Health Expenditure Accounts: Historical](#).

### Exhibit 5a.

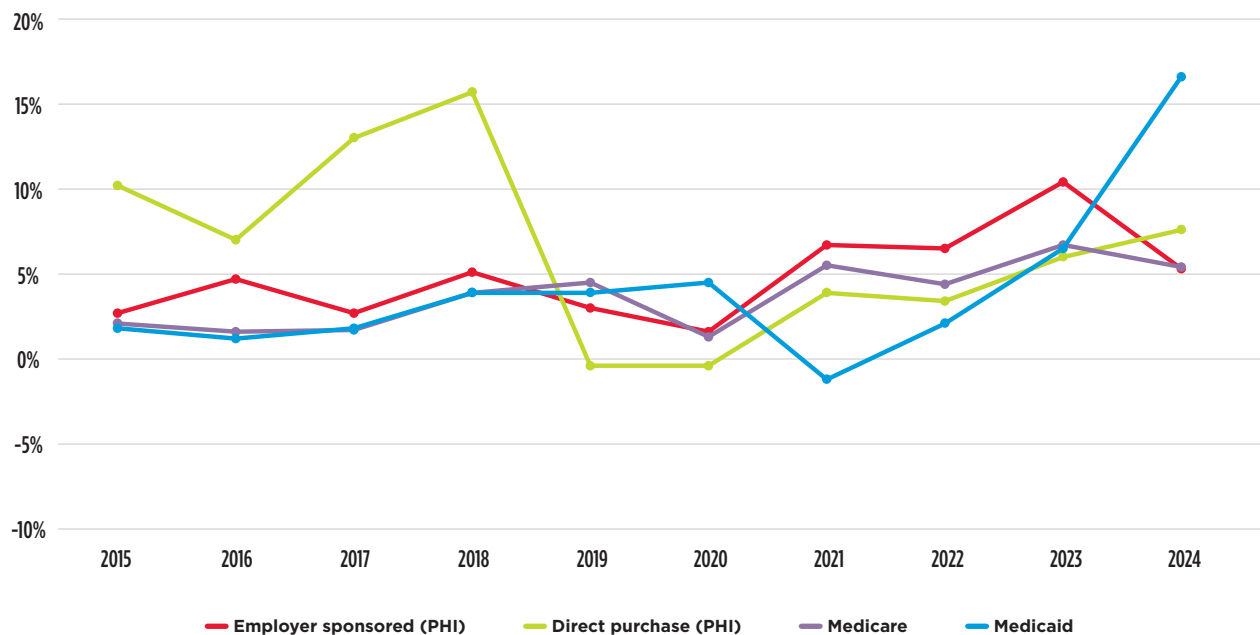
#### Enrollment growth by health insurance program (2015–2024)



Source: Table 21 in NHE Tables (ZIP) obtained from *National Health Expenditure Accounts: Historical*.

### Exhibit 5b.

#### Spending per enrollee growth by health insurance program (2015–2024)



Source: Table 21 in NHE Tables (ZIP) obtained from *National Health Expenditure Accounts: Historical*.

## Exhibit 6.

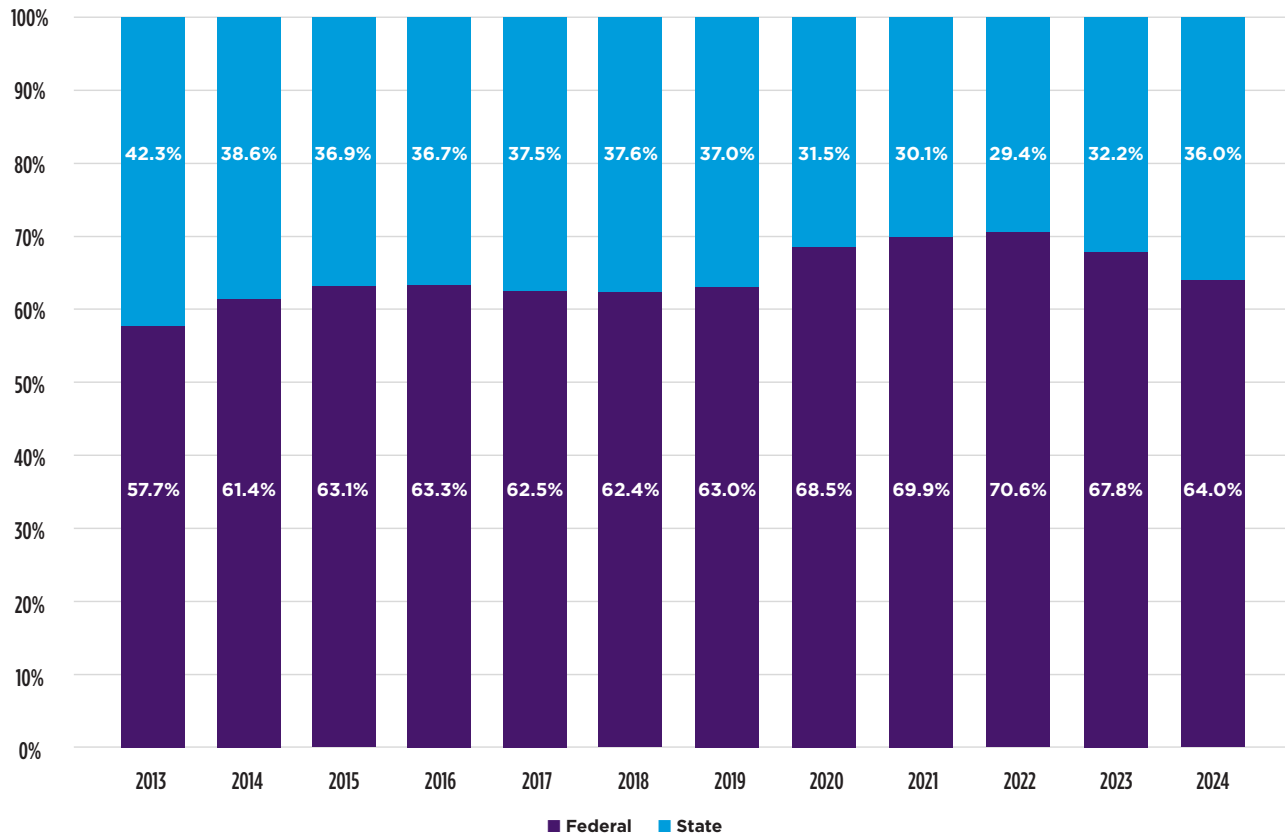
### NHE financing in 2024 (billions of dollars)

SPONSOR	Total		PHI		Medicare		Medicaid	
	Level	Share of total NHE	Level	Share of total PHI	Level	Share of total Medicare	Level	Share of total Medicaid
<b>Private business</b>								
Employer contribution to employer sponsored health insurance premiums	\$753.1	14.3%	\$753.1	45.8%				
Employer Medicare Hospital Insurance Trust Fund payroll taxes	\$159.2	3.0%			\$159.2	14.2%		
Workers' compensation, temporary disability insurance, and worksite healthcare	\$55.1	1.0%						
<b>Total private business</b>	<b>\$967.4</b>	<b>18.3%</b>	<b>\$753.1</b>	<b>45.8%</b>	<b>\$159.2</b>	<b>14.2%</b>	<b>\$0.0</b>	<b>0.0%</b>
<b>Household</b>								
Employee contribution to employer-sponsored health insurance premiums	\$382.1	7.2%	\$382.1	23.2%				
Household contribution to direct purchase insurance	\$86.3	1.6%	\$86.3	5.2%				
Medical portion of property and casualty insurance	\$55.3	1.0%						
Employee and self-employment payroll taxes and voluntary premiums paid to Medicare Hospital Insurance Trust Fund	\$246.4	4.7%			\$246.4	22.0%		
Premiums paid to Medicare Supplementary Medical Insurance Trust Fund and the Pre-existing Condition Insurance Plan	\$132.3	2.5%			\$132.3	11.8%		
Out-of-pocket	\$556.6	10.5%						
<b>Total household</b>	<b>\$1,458.9</b>	<b>27.6%</b>	<b>\$468.4</b>	<b>28.5%</b>	<b>\$378.7</b>	<b>33.9%</b>	<b>\$0.0</b>	<b>0.0%</b>
<b>Other private sponsors</b>	<b>\$340.5</b>	<b>6.5%</b>	<b>\$0.0</b>	<b>0.0%</b>	<b>\$0.0</b>	<b>0.0%</b>	<b>\$0.0</b>	<b>0.0%</b>
<b>Federal government</b>								
Employer contribution to employer-sponsored health insurance premiums	\$46.7	0.9%	\$46.7	2.8%				
Employer Medicare Hospital Insurance Trust Fund payroll taxes	\$5.8	0.1%			\$5.8	0.5%		
Federal general revenue and Medicare Net Trust Fund expenditures	\$509.6	9.7%			\$509.6	45.6%		
Federal portion of Medicaid payments	\$596.7	11.3%					\$596.7	64.0%
Federal portion of Medicare buy-in premiums	\$16.1	0.3%			\$16.1	1.4%		
Retiree Drug Subsidy payments to employer-sponsored health insurance plans	\$0.5	0.0%						
Other federal health insurance and programs	\$360.1	6.8%	\$12.6	0.8%				
Marketplace tax credits and subsidies	\$116.6	2.2%	\$116.6	7.1%				
<b>Total federal government</b>	<b>\$1,652.0</b>	<b>31.3%</b>	<b>\$175.9</b>	<b>10.7%</b>	<b>\$531.5</b>	<b>47.5%</b>	<b>\$596.7</b>	<b>64.0%</b>
<b>State and local government</b>								
Employer contribution to employer-sponsored health insurance premiums	\$246.8	4.7%	\$246.8	15.0%				
Employer Medicare Hospital Insurance Trust Fund payroll taxes	\$19.9	0.4%			\$19.9	1.8%		
State portion of Medicaid payments	\$335.0	6.3%					\$335.0	36.0%
State portion of Medicare buy-in premiums	\$10.7	0.2%			\$10.7	1.0%		
Other programs	\$247.3	4.7%	\$0.5	0.0%	\$18.0	1.6%		
<b>Total state and local government</b>	<b>\$859.7</b>	<b>16.3%</b>	<b>\$247.3</b>	<b>15.0%</b>	<b>\$48.6</b>	<b>4.3%</b>	<b>\$335.0</b>	<b>36.0%</b>
<b>TOTAL</b>	<b>\$5,278.6</b>	<b>100.0%</b>	<b>\$1,644.6</b>	<b>100.0%</b>	<b>\$1,118.0</b>	<b>100.0%</b>	<b>\$931.7</b>	<b>100.0%</b>

Source: Table 5, 5-1, 5-2, 5-3, 5-4, 5-5, 5-6 in NHE Tables (ZIP) obtained from [National Health Expenditure Accounts: Historical](#).

## Exhibit 7.

### Federal and state Medicaid financing shares (2013–2024)



Source: Table 3 in NHE Tables (ZIP) obtained from [National Health Expenditure Accounts: Historical](#).

