Policy Research Perspectives

National Health Expenditures, 2022: A Return to Pre-Pandemic Growth Rates As Spending on Physician Services Decelerates

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Introduction

This Policy Research Perspective (PRP) from the American Medical Association (AMA) examines the breakdown of health care spending in 2022 and related historical trends using the U.S. National Health Expenditures (NHE) data released by The Centers for Medicare & Medicaid Services (CMS) in December 2023.

In 2022, NHE spending was $4.5 trillion or $13,493 per capita. This health spending was 17.3 percent of GDP in 2022, similar to pre-pandemic shares (17.5 percent in 2019) after an uptick in 2020 (19.5 percent) and 2021 (18.2 percent). Spending growth was 4.1 percent in 2022, up from 3.2 percent in 2021. Nonetheless, this growth is less than that of 2020 (10.6 percent) and is comparable to pre-pandemic rates (4.3 percent in 2019). Although federal government expenditures to manage the COVID-19 pandemic led to substantial increases in total health spending in 2020, these expenditures significantly declined in 2021 while utilization of medical goods and services rebounded. By 2022, top-level patterns in health spending more closely reached that of the pre-pandemic period. This report examines the various components of healthcare spending in 2022, comparing patterns from before and after the pandemic as well as across different spending categories.

What are national health expenditures?

The NHE exhaustively encompasses the finances of the U.S. health care system and are the official estimates of total health care spending (Centers for Medicare & Medicaid Services, 2023). CMS releases historical health spending data (as early as 1960), utilizing common definitions and methods that allow for comparisons over time and across categorization schemes (i.e., methods through which the data can be decomposed). The following are the three categorization schemes of the NHE (the sum of the components for each categorization scheme will be $4.5 trillion).

1. *Type of expenditure*: Where does the money go? In this categorization scheme, health care spending is divided into what was invested (e.g., research, structures and equipment) and what was spent on health consumption expenditures. Health consumption expenditures includes personal health care 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).
2. *Source of funds*: Who is the final payer? Health care spending is divided into what was invested and what was spent under different payers. The latter includes spending by health insurance

programs (private health insurance, Medicare, Medicaid, and other) as well as out-of-pocket spending and spending by other third-party payers (e.g., workers compensation and other federal programs).

3. *Sponsor:* Who is the original source of financing? Health care spending is divided by the financiers (i.e. "sponsors") of health spending. This includes households, private businesses, other private revenues, the federal government, and state and local governments.

Spending by type of expenditure: where does the money go?

Spending shares

In 2022, 83.0 percent of health spending was from personal health expenditures ($3,704.8 billion). This includes spending on hospital care (30.4 percent of total health spending or $1,355.0 billion), physician services (14.5 percent or $647.7 billion), prescription drugs (9.1 percent or $405.9 billion), clinical services (5.3 percent or $237.2 billion), nursing care facilities (4.3 percent or $191.3 billion), home health care (3.0 percent or $132.9 billion), and other personal health care services (16.5 percent or $734.9 billion).[1] Although CMS generally presents physician and clinical services as a combined category, they are examined separately in this report because of notable differences between the two categories in spending levels and growth rates.

Net cost of health insurance was 6.3 percent of total health spending ($279.4 billion) and government administration was 1.2 percent ($54.2 billion). Together, these two categories reflect premium dollars (or revenue) that are not spent on benefits. Government administration includes the administrative cost of running government health care programs while net cost of health insurance is the difference between what private insurers incur in premiums and the amount paid in benefits (i.e., administrative costs, taxes, fees, and net profits/losses).

Government public health activities was 4.7 percent of total health spending ($208.4 billion), which reflects spending by federal, state, and local governments related to public health concerns and providing public health services (Centers for Medicare & Medicaid Services, 2023). Finally, 4.9 percent ($217.8 billion) went towards investment.

Prior to the pandemic, the shares of spending for each category rarely fluctuated (i.e., they were within half a percentage point of the previous year). However, the pandemic led to an increase in the share of spending for government public health activities (from 2.9 percent in 2019 to 5.8 percent in 2020) to manage the pandemic and a commensurate decrease in the personal health care share (from 84.4 percent in 2019 to 81.2 percent in 2020). Although not quite at the pre-pandemic percentages, the 2022 spending shares have begun to shift towards pre-pandemic share levels.

Spending growth

The annual growth in spending on personal health care and its three largest components (hospital, physician, and prescription drug spending) over the 10-year period ending in 2022 is presented in

[1]In this report, other personal health care services not only include the other health, residential, and personal care category designated by CMS but also dental and other professional services, durable medical equipment, and other non-durable medical products.

Exhibit 2. Personal health care, which made up 83.0 percent of health spending, had an average annual growth rate of 4.7 percent over this period. The two largest subcomponents of personal health care, hospital care and physician services, had lower average annual growth rates of 4.4 percent and 4.2 percent, respectively, while prescription drugs had an average annual growth rate of 4.7 percent.[2]

As Exhibit 2 suggests, there is important year-to-year variation underlying the average annual rates that differ across categories. Trends prior to 2019 were heavily influenced by the implementation of the Affordable Care Act (ACA). During this period, spending growth across all the categories spiked, although some categories had more substantial growth rates than others; prescription drugs peaked to 12.1 percent growth in 2014 whereas physician services and hospital care growth rates peaked in 2015 to 5.8 percent and 5.2 percent, respectively. By 2018, spending growth had leveled off and began approaching pre-ACA rates. There was some acceleration in 2019 due to growth in the use and intensity of personal health care services (Martin et al., 2021).

Spending growth after 2019 was greatly affected by the COVID-19 pandemic. Personal health expenditures accelerated from 5.1 percent growth in 2019 to 6.4 percent growth in 2020. Although growth in 2019 for hospital care (6.3 percent) and physician services (3.9 percent) was driven by use and intensity of services (Martin et al., 2021), utilization of medical goods and services declined in 2020. In that year, spending growth for hospital care (6.2 percent) and physician services (7.0 percent) was instead driven by federal government spending on pandemic-relief programs.[3] In 2021, utilization of medical goods and services rebounded, but this increase was more than offset by the significant decline in pandemic-relief spending, resulting in deceleration in personal health care spending (5.5 percent growth in 2021) and in its subcomponents physician services (4.8 percent) and hospital care (4.5 percent). In 2022, physician services spending continued to decelerate to only 2.6 percent growth due to both slower growth in prices and utilization of services (Hartman et al., 2024). Hospital spending also decelerated (2.2 percent growth) due to slower growth in prices compared to 2020 and 2021 (but still higher than pre-pandemic price growth) and declines in hospital days and discharges (Hartman et al., 2024). Unlike physician services and hospital care, prescription drug spending remained stable during the pandemic (4.0 percent growth in 2019 and 4.4 percent in 2020) and accelerated after the pandemic (6.8 percent growth in 2021 and 8.4 percent growth in 2022). Hartman et al. (2024) note that, in 2022, this was driven by increased utilization of retail prescription drugs as well as acceleration in prescription drug prices.

Also included in Exhibit 2 are the trends in the net cost of health insurance (NCHI) category. Private insurer revenue comes from premiums paid by enrollees; their costs come from paying out benefits for enrollees. NCHI is what remains, i.e., spending out of premiums that does not go to medical care. This not only includes net profits/losses, but also administrative costs, taxes, and fees for private health insurance and private plans administering government health care programs (e.g., Medicare Part C, stand-alone Medicare Part D plans, Medicaid managed care plans, CHIP managed care plans, etc.). Over this 10-year period, many of the trends seen in NCHI were shaped by both insurer profitability and policies from the ACA, notably the health insurance tax (ACA tax, hereafter) and

[2] Other components of personal health expenditures also had high average annual growth rates over the 10 year period ending in 2022, including clinical services (6.3 percent) and home health care (5.5 percent).
[3] Federal government spending on pandemic-relief for physician services include the Provider Relief Fund and the Paycheck Protection Program. See Rama (2022) for details.

medical loss ratio (MLR) provision. The ACA tax is a fixed annual fee on the health insurance industry, where each private insurer pays a portion based on their market share. The ACA tax went into effect in 2014, however subsequent bills were passed such that it was suspended in 2017 and 2019, and then repealed in 2021. The ACA MLR provision requires insurers to spend at least 80 percent (85 percent for large group insurers) of their premium income on health care claims and/or quality improvement (Ortaliza et al., 2023a).

NCHI grew 12.2 percent in 2014, in part due to the introduction of the ACA tax ($8 billion for 2014) (Kaiser Family Foundation, 2013) and additional administrative costs from increases in enrollment (Martin et al., 2016). NCHI growth dropped in 2015 (5.6 percent) and 2016 (5.5 percent). Although the ACA tax was suspended in 2017 (i.e., the $13.9 billion fee was not collected from the health insurance industry), the growth rate remained stable at 5.2 percent. Insurers were better able to price Marketplace plans in line with costs and thus saw faster growth in profit (i.e., Martin et al., 2019 note that investment income had faster growth and Ortaliza et al., 2013b show an increase in gross margin per enrollee). In 2018, NCHI spiked again with 11.8 percent growth as the ACA tax was reinstated at $14.3 billion (Kaiser Family Foundation, 2013). Regardless, insurer profitability may have increased (i.e., Ortaliza et al., 2013b show the gross margin per enrollee increased in 2018 for private insurers in both the individual and group market) since private plans started pricing the ACA tax into premiums.[4] In 2019, NCHI decreased by 5.4 percent due to the ACA tax suspension before growing 26.2 percent in 2020. The spike in 2020 was impacted significantly by the pandemic-related drop in utilization of medical goods and services and, to a much lesser extent, the ACA tax. Private health insurers were required to adhere to the ACA MLR provision and were partly able to manage this by waving cost-sharing requirements related to COVID-19 services and increasing coverage of telehealth. Nonetheless, Ortaliza et al. (2023b) show the gross margins per enrollee increased in 2020 for all private insurance markets, suggesting many insurers remained profitable. In 2021, NCHI decreased by 13.3 percent as the ACA tax was repealed and utilization of medical goods and services rebounded. However, in 2022, evidence suggests increased profitability for private insurers as NCHI accelerated to a growth rate of 8.5 percent. Hartman et al. (2024) note increased gains in net profits for insurers and Ortalzia et al. (2023a) show the average percentage of premium income insurers spent on claims declined in 2022.[5]

Spending by source of funds: who is the final payer?

Spending shares

Health care spending can also be broken down by the source of funds, i.e., the final payer of the medical goods and services utilized. In 2022, 71.9 percent of health spending (or $3,211.5 billion) was from health insurance. This includes spending by private health insurance (PHI) (28.9 percent of total health spending or $1,289.8 billion), Medicare (21.2 percent or $944.3 billion), Medicaid (18.0 percent or $805.7 billion), and other health insurance programs (3.8 percent or $171.6 billion). PHI has consistently been the largest share of total health spending in the source of funds breakdown, making up at least 30 percent of health spending since 1960 and only dropping below that in 2020

[4] Hartman et al. (2020) note that private Part C and Part D plans adjusted their premiums to reflect the higher ACA tax; this was likely the case for private health insurance plans as well.
[5] Ortalzia et al. (2023a) show that the average simple loss ratio declined from 90 percent in 2021 to 88 percent in 2022 for large group markets, from 88 percent to 86 percent in individual markets, and 84 percent to 83 percent in small group markets.

as pandemic-related spending drove up the share levels of other federal programs and government public health activities.

Out-of-pocket spending was 10.6 percent of total health spending ($471.4 billion). This category not only includes payments made by uninsured patients, but also pre-deductible spending, copayments, and coinsurance payments made by insured patients. Spending by other third-party payers and programs was 7.6 percent ($338.4 billion) and other federal programs was 0.4 percent ($17.2 billion).[6] Other federal programs includes spending by the federal government on pandemic-relief programs. As a result, in 2020, it was 4.7 percent of total health spending before declining in 2022 back to pre-pandemic levels (0.4 percent in 2019).

As noted earlier, government public health activities made up 4.7 percent of total health spending ($208.4 billion) and investment was 4.9 percent ($217.8 billion).

Spending growth

This section examines the year-to-year spending growth in the major source of funds categories for the 10-year period ending in 2022 (Exhibit 4). As was the case with the type of expenditures breakout, the trends during this period were influenced by government policies (i.e., shut-down of services during the pandemic as well as expansion of insurance and benefits from ACA and Families First Coronavirus Response Act) as well as the economy (i.e., recession).

PHI spending grew only 0.1 percent in 2013 but spending growth spiked during ACA implementation, reaching a peak of 5.8 percent in 2015. The growth rate remained high and similar from 2014 through 2018, only dropping significantly in 2019 (to 2.4 percent growth). During the pandemic, in 2020, PHI spending declined by 0.8 percent as enrollment declined by 1.0 percent (from pandemic-related shifts in employment) and per-enrollee spending decelerated to a 0.2 percent growth rate (from decreased utilization of medical goods and services). By 2021, there was a significant acceleration in PHI spending (6.3 percent growth) that was driven by PHI spending per enrollee (5.9 percent growth) from increased utilization of medical goods and services after the 2020 shut-down. In 2022, PHI spending growth was 5.9 percent as enrollment increased (by 1.5 percent) from both employer-sponsored insurance and Marketplace plan enrollment accelerating, the latter influenced by increased premium subsidies per the American Rescue Plan Act (Hartman et al., 2024). Spending per enrollee decelerated (4.3 percent growth in 2022) since PHI had slower growth in personal health care expenditures (including physician services and hospital care) although there was an acceleration in net cost of private health insurance in 2022 (discussed earlier).

Medicare spending growth increased from 3.6 percent in 2013 to 4.8 percent in 2014, before stabilizing (just over 4 percent) for the next three years as both enrollment and per-enrollee spending growth were generally stable. In 2018, Medicare spending accelerated (6.3 percent growth) as per-enrollee spending accelerated while enrollment growth remained stable. The growing effect of the baby boom on Medicare becomes evident in the later part of this 10-year period, as the aging Medicare population requires increased intensity of care (the first wave of boomers) and an

[6] In the NHE tables, other third party payers and programs includes other federal programs. For this report, other federal programs was made a separate category.

increasing number of people became eligible for Medicare (the second wave of boomers).[7] Medicare-eligible enrollees can choose to be in traditional fee-for-service (FFS) or in Medicare private plans (MPP) (i.e., Medicare Part C, which is predominantly made up of Medicare Advantage wherein patients choose a private health plan). In 2013, roughly 72 percent of Medicare spending was from FFS while only 28 percent was from MPP. By 2022, only 50 percent of Medicare spending was from FFS and an equal share was from MPP (Hartman et al., 2024). This 22 percentage point increase in the MPP share of Medicare spending over 10 years reflect significant growth in both MPP enrollment and per-enrollee spending while FFS enrollment and per-enrollee spending generally stagnated.

To illustrate this, Exhibit 5 shows the spending, enrollment, and per-enrollee spending growth of both Medicare FFS and MPP. After decelerating in 2016, MPP spending began to accelerate again, peaking at growth rates of 15.2 percent in 2019 and 15.6 percent in 2020. During this period, enrollment growth was generally stable and high (just below 10 percent). Per-enrollee spending accelerated (peaking at 7.0 percent in 2019), before decelerating in 2020 (5.6 percent growth due to decreased utilization of medical goods and services from the shut-down) and in 2021 (1.3 percent growth). MPP spending growth has consistently been significantly higher than that of FFS, as is the case with enrollment and per-enrollee spending in recent years.

FFS spending growth patterns, also presented in Exhibit 5, were closely tied to per-enrollee spending growth. FFS spending growth was stable prior to the pandemic (around 2 percent), but this spending declined by 4.0 percent in 2020 from pandemic-driven declines in both enrollment and per-enrollee spending. In 2021, FFS spending grew 3.8 percent despite continued declines in enrollment as per-enrollee spending increased by 7.9 percent from pent-up demand for medical goods and services. However, in 2022, FFS spending decreased by 1.9 percent as enrollment continued to decrease (by 3.0 percent) and per-enrollee spending decelerated (1.1 percent growth). This differs from MPP, where enrollment grew 8.5 percent and per-enrollee spending accelerated (6.1 percent growth) in 2022. In general, recent patterns show declines or deceleration in FFS spending but positive growth or acceleration in MPP. As a result, only 45.8 percent of Medicare beneficiaries are MPP enrollees but they account for half of total Medicare spending; i.e., not only has MPP enrollment increased, but the share of the Medicare spending pie that MPP enrollees consume is disproportionately more than that of FFS enrollees.

Returning to Exhibit 4, the growth in MPP discussed in Exhibit 5 resulted in overall Medicare spending growth reaching 6.3 percent in 2018 and 7.0 percent in 2019. Although the shut-down during the pandemic led to a 3.7 percent growth rate in 2020, Medicare spending growth bounced back to 7.2 percent in 2021 and was 5.9 percent in 2022. Hartman et al. (2024) note that there was slower growth in Medicare personal health care spending, including physician services which was impacted by both the rebound in utilization in 2021 as well as the elimination of the 2021 temporary physician fee schedule update factor of 3.75 percent.

Exhibit 4 also shows the growth rates for Medicaid. Medicaid spending growth is strongly tied to Medicaid enrollment growth, which noticeably spikes during years of expansionary policy (i.e. ACA in

[7] The first wave of boomers were born from 1946-1954 and became Medicare eligible (i.e., age 65) from 2011-2019 while the second wave of boomers were born 1955-1964 and became (or will become) Medicare age from 2020-2029 (Werde, 2024).

2014 and 2015, as well as Families First Coronavirus Response Act in 2020) or during recession (i.e. COVID-19 pandemic). Prior to the pandemic, Medicaid spending growth reached a high of 12.0 percent in 2014 before significantly declining to 3.1 percent in 2019. The ACA led to increased enrollment in Medicaid, resulting in high Medicaid growth even though per-enrollee spending declined 0.9 percent in 2014 (Martin et al., 2016 note that new Medicaid enrollees tended to be lower cost). During the pandemic (2020), Medicaid spending accelerated to 9.3 percent growth because of the recession and incentives to retain enrollees in the Families First Coronavirus Response Act (Hartman et al., 2024). As enrollment continued to grow, spending growth in Medicaid remained high and stable, at 9.4 percent in 2021 and 9.6 percent in 2022. In 2021, this was due to a continued acceleration in Medicaid enrollment offsetting decreases in per-enrollee spending that resulted from less costly patients enrolling into the program. Different, in 2022, per-enrollee spending accelerated, driven by increases in Medicaid home and community-based waivers and care provided in residential facilities (Hartman et al., 2024). This falls into the other, health, residential, and personal care expenditures subcategory which makes up a substantial share of Medicaid spending (18.5 percent in 2022) because Medicare and PHI do not cover long-term services and support. Individuals that want to be eligible for such long-term care services (under Medicaid) must “spend down” their income and assets (American Council on Aging, 2024). Thus, the aging population not only impacts Medicare spending but may also influence Medicaid spending through this venue.

Finally, out-of-pocket spending is generally impacted by government policies (e.g., ACA) and changes in insurer plan coverage or cost-sharing requirements. Compared to health insurance, out-of-pocket spending growth remained low prior to the pandemic (reaching a pre-pandemic trough of 1.5 percent in 2017). However, in 2020, out-of-pocket spending declined by 1.0 percent when the shut-down significantly decreased utilization of medical goods and services. The rebound in utilization led to an 11.0 percent growth rate in 2021. In 2022, spending decelerated (6.6 percent growth) due to lower growth in spending for dental services, durable medical goods, and physician services – which had previously accelerated in 2021 from pent-up demand (Hartman et al., 2024).

Spending by sponsor: who is the original source of financing?

While the previous section focused on source of funds, this section examines how health care is sponsored. The distinction between the two categorization schemes is that source of funds reflects the final payer, whereas sponsors reflect the origin of the dollars used to make those payments. For example, employees and employers pay premiums which private health insurers spend for covered patients. Thus, households and private businesses would be sponsors (original financing source) whereas private health insurance would be the source of funds (final payer) of the medical goods and services. Exhibit 6 presents the shares of health care spending by the five sponsor types (private businesses, households, other private revenues, the federal government, and state and local governments) and then this sponsor data is further broken out by source funds (i.e., showing the original financing for PHI, Medicare, and Medicaid).

For total health spending, the largest financer was the federal government (33.2 percent or $1,483.5 billion), followed by households (27.6 percent or $1,231.6 billion), private businesses (17.6 percent or $787.3 billion), state and local governments (15.1 percent or $673.1 billion), and other private revenues (6.5 percent or $289.1 billion). While the shares for the type of expenditure and source of funds historically had consistency from year-to-year prior to the pandemic, there were more

differences for the sponsor shares. Notably, the share of spending sponsored by the federal government increased from 16.8 percent in 1987 (earliest data available) to 29.4 percent in 2019 while that of households decreased from 36.8 percent in 1987 to 28.3 percent in 2019. Households were generally the largest financiers until they were surpassed by the federal government in 2015 but, even then, the two sponsors remained within a percentage point of each other until the pandemic. In 2020, the share of financing from the federal government increased by 7 percentage points (to 36.6 percent of total health spending) while the share for households (26.0 percent of total health spending in 2020) and other categories declined (data not shown). This was driven by the unprecedented increase in federal government spending to manage the pandemic, which is incorporated in the other federal health insurance and programs subcategory. Prior to the pandemic, this subcategory was less than 7 percent of total health spending but increased to 13.8 percent in 2020 (data not shown). Although it has declined since, it was still 8.4 percent of total health spending 2022 (see Exhibit 6). This, along with increases in the federal portion of Medicaid payment (discussed later), has resulted in the 2022 share financed by the federal government to remain higher (at least 4 percentage points) than its pre-pandemic shares.

The financing of the $1,289.8 billion spent in 2022 for PHI is in the second column of Exhibit 6. PHI was largely sponsored by private businesses, as 45.9 percent ($591.8 billion) came from employer contributions to employer sponsored health insurance premiums. Households sponsored 29.3 percent of private health insurance spending ($378.2 billion) through employee contributions to employer-sponsored health insurance premiums and, to a lesser extent, household contributions to direct purchase insurance. State and local governments sponsored 15.1 percent ($194.4 billion) through their role as employers (contributing to employer-sponsored health insurance premiums). Finally, the federal government sponsored 9.7 percent ($125.4 billion), also through its role as an employer (3.2 percent) as well as through other federal health insurance and programs (0.8 percent) and marketplace tax credits and subsidies (5.7 percent). While most components of private health insurance financing have generally been consistent over the last ten years, the marketplace tax credits were introduced in 2014 (ACA) and, at the time, made up only 1.9 percent of private health insurance spending.

Medicare spending was $944.3 billion in 2022. There are four parts to Medicare. First, Medicare Part A covers inpatient care in hospitals and skilled nursing facilities. By contributing to the hospital insurance (HI) trust fund in their role as employers via payroll taxes, private businesses financed $142.9 billion (15.1 percent of total Medicare spending), state and local governments financed $17.3 billion (1.8 percent), and the federal government financed $5.1 billion (0.5 percent) that went towards Medicare Part A. Households contributed $216.7 billion (or 22.9 percent of total Medicare spending) through employee and self-employment payroll taxes and voluntary premiums paid to the HI trust fund.

Medicare Part B covers outpatient care (including physician services) and durable medical supplies while Medicare Part D covers prescription drugs. Both components receive financing from households through premiums paid by individuals to the Medicare Supplementary Medical Insurance (SMI) Trust Fund and the pre-existing condition insurance plan ($122.4 billion or 13.0 percent of total Medicare spending). State and local governments contribute $13.7 billion (or 1.4 percent) to Medicare Part D through state phase down payments (classified under other programs). Finally, the federal portion of Medicare buy-ins was $17.4 billion (1.8 percent) and the state and local

government portions of Medicare buy-ins was $8.8 billion (0.9 percent) – this contributes to both the HI (Medicare Part A) and SMI (Medicare Part B and D) trust funds.

Financing through payroll taxes and government buy-ins to cover the costs of Medicare Part A, B, and D is not sufficient. As such, the bulk of total Medicare spending ($400.1 billion in 2022) comes from federal general revenue and Medicare net trust fund expenditures – this includes funding from federal government funds that were not initially appropriated for Medicare. Federal general funds not initially appropriated to Medicare has historically remained below a third of Medicare spending, but with the implementation of Medicare Part D in 2006, it increased to 39.0 percent and made the federal government the largest sponsor of Medicare (data not shown). It continues to be a large component of Medicare financing, making up 42.4 percent of Medicare spending in 2022.

The fourth part of Medicare, Medicare Part C (i.e., Medicare private plans, described in the previous section), intersects with the other three components as Medicare private plan enrollees typically receive the standard package of benefits (i.e., services covered by Part A, Part B, and Part D) as well as additional services. Thus, even for Medicare private plans, funds for Part A benefits are drawn from the HI trust fund and funds for Part B and Part D benefits are drawn from the SMI trust fund (see Cubanski and Neuman, 2023)

Finally, Medicaid spending was $805.7 billion, of which 29.3 percent (or $236.1 billion) was financed by state and local governments and 70.7 percent (or $569.7 billion) was financed by the federal government. Unlike Medicare, which is managed by the federal government, Medicaid is managed by state governments. Although the federal government sets a standard for Medicaid programs, participating states have control over enrollment requirements and benefits. Furthermore, although state governments contribute to financing their Medicaid program, the bulk of financing ultimately comes from the federal government. This was initially because, with the passage of the Medicaid legislation in 1965, the federal government was required to match funds for states with the program. Over the years, the share of financing from the federal government has significantly increased, most recently during the pandemic due to the federal medical assistance percentage under the Families First Coronavirus Response Act and state expansions of Medicaid coverage (Hartman et al., 2022 and Hartman et al., 2024). The federal portion of Medicaid payments grew by only 4.1 percent in 2019, compared to 18.8 percent in 2020, 11.6 percent in 2021, and 10.8 percent in 2022 (data not shown). As such, the vast majority of Medicaid financing continues to come from the federal government.

Conclusion

U.S. health care spending increased in 2022 by 4.1 percent to $4,464.6 billion or $13,493 per capita. This is comparable to pre-pandemic spending growth (4.3 percent in 2019 and 4.6 percent in 2018) after an acceleration in spending in 2020 (10.6 percent growth) and subsequent deceleration in 2021 (3.2 percent growth). Health spending was 17.3 percent of GDP in 2022, down from both 2021 (18.2 percent) and 2020 (19.5 percent) but, again, similar to pre-pandemic shares (17.5 percent in 2019 and 17.4 percent in 2018). These patterns were driven by increased spending to manage the pandemic in 2020 and the rebound in utilization of medical goods and services in 2021. The big picture measures for 2022 suggest that U.S. health spending is back to similar growth rates as before the pandemic.

Eighty-three percent of health spending was from personal health expenditures ($3,704.8 billion). The main components of this spending are hospital care (30.4 percent of total health spending or $1,355.0 billion), physician services (14.5 percent or $647.7 billion), and prescription drugs (9.1 percent or $405.9 billion). Personal health care spending growth was 4.0 percent in 2022, as the 8.4 percent growth for prescription drugs outpaced the 2.6 percent and 2.2 percent growth for physician services and hospital care, respectively. Prescription drug spending has accelerated since 2016 and, in 2022, this was driven by both an acceleration in prescription drug prices and increased utilization of retail prescription drugs (Hartman et al., 2024). The low spending growth for physician services and hospital care was driven by slow growth in both prices and utilization of medical goods and services (Hartman et al., 2024).

Considering health spending by source of funds, the largest share came from private health insurance (28.9 percent of total health spending $1,289.8 billion) followed by Medicare (21.2 percent or $944.3 billion) and Medicaid (18.0 percent or $805.7 billion). During the 10-year period ending in 2022, fluctuations in spending growth were strongly tied to ACA implementation and the COVID-19 pandemic. Private health insurance spending decreased by 0.8 percent in 2020 before growing 6.3 percent in 2021 and 5.9 percent in 2022 from increased utilization of medical goods and services. Medicare spending growth decelerated (to 3.7 percent growth) in 2020 before rebounding to 7.2 percent growth in 2021 and 5.9 percent growth in 2022. This was driven by patterns in Medicare private plans, which grew significantly faster than Medicare fee-for-service (15.1 percent compared to -1.9 percent in 2022). Medicaid spending accelerated during the pandemic (9.3 percent growth in 2020) and this growth remained high and stable for both 2021 (9.4 percent) and 2022 (9.6 percent). Out-of-pocket spending declined by 1.0 percent in 2020 but has since increased by 11.0 percent in 2021 and 6.6 percent in 2022.

Finally, decomposing health spending by sponsors, the largest sponsor of health spending was the federal government, financing 33.2 percent of health care spending in 2022, or $1,483.5 billion. Households financed 27.6 percent ($1,231.6 billion), private businesses financed 17.6 percent ($787.3 billion), and state and local governments financed 15.1 percent ($673.1 billion). The share of spending sponsored by the federal government has steadily increased from 16.8 percent in 1987 (earliest data available) to 29.4 percent in 2019, before substantially increasing to 36.6 percent in 2020 and remaining at a share level that is higher than before the pandemic.

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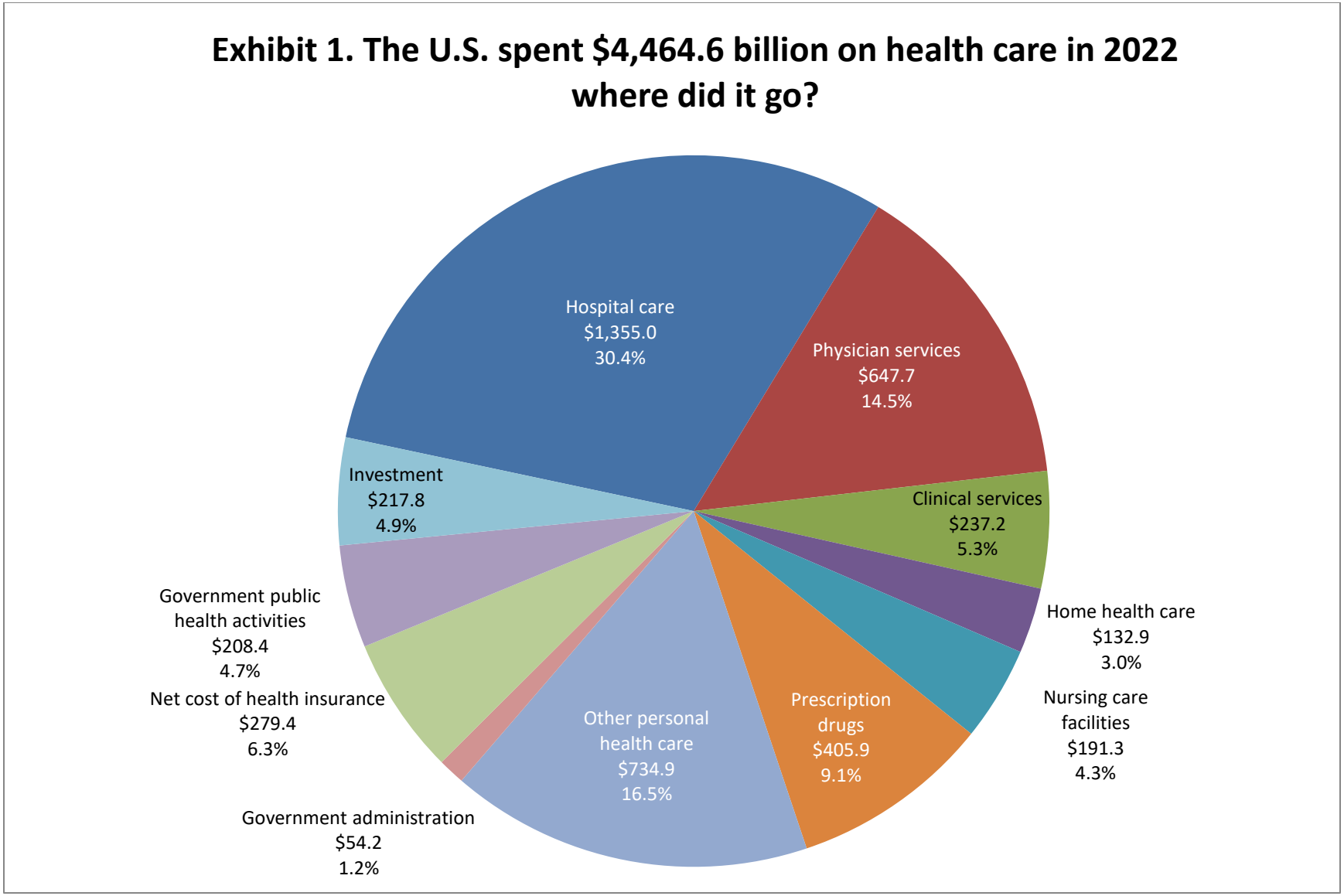
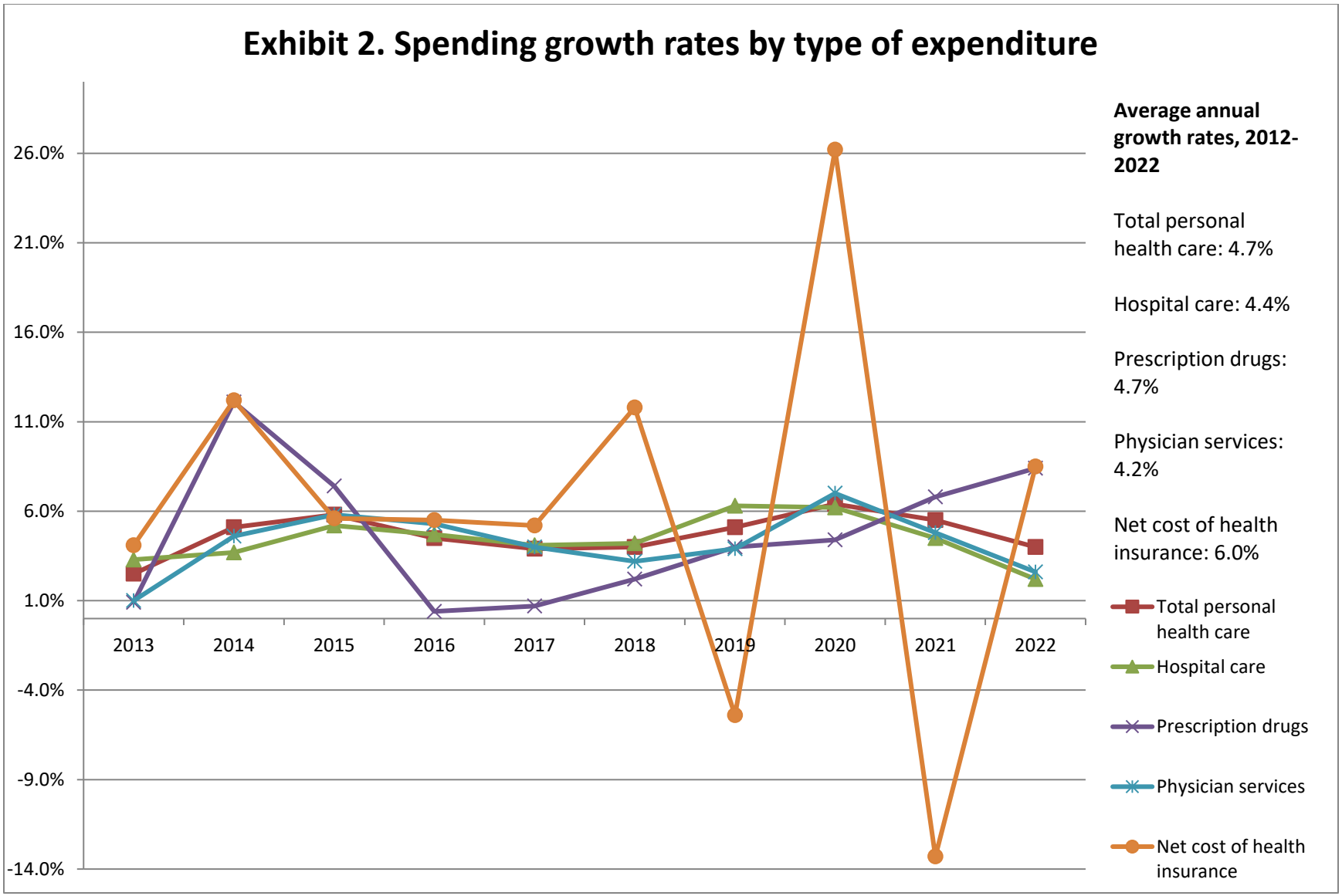


Source: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical. Table 2, 9, and 10 in NHE Tables [ZIP].



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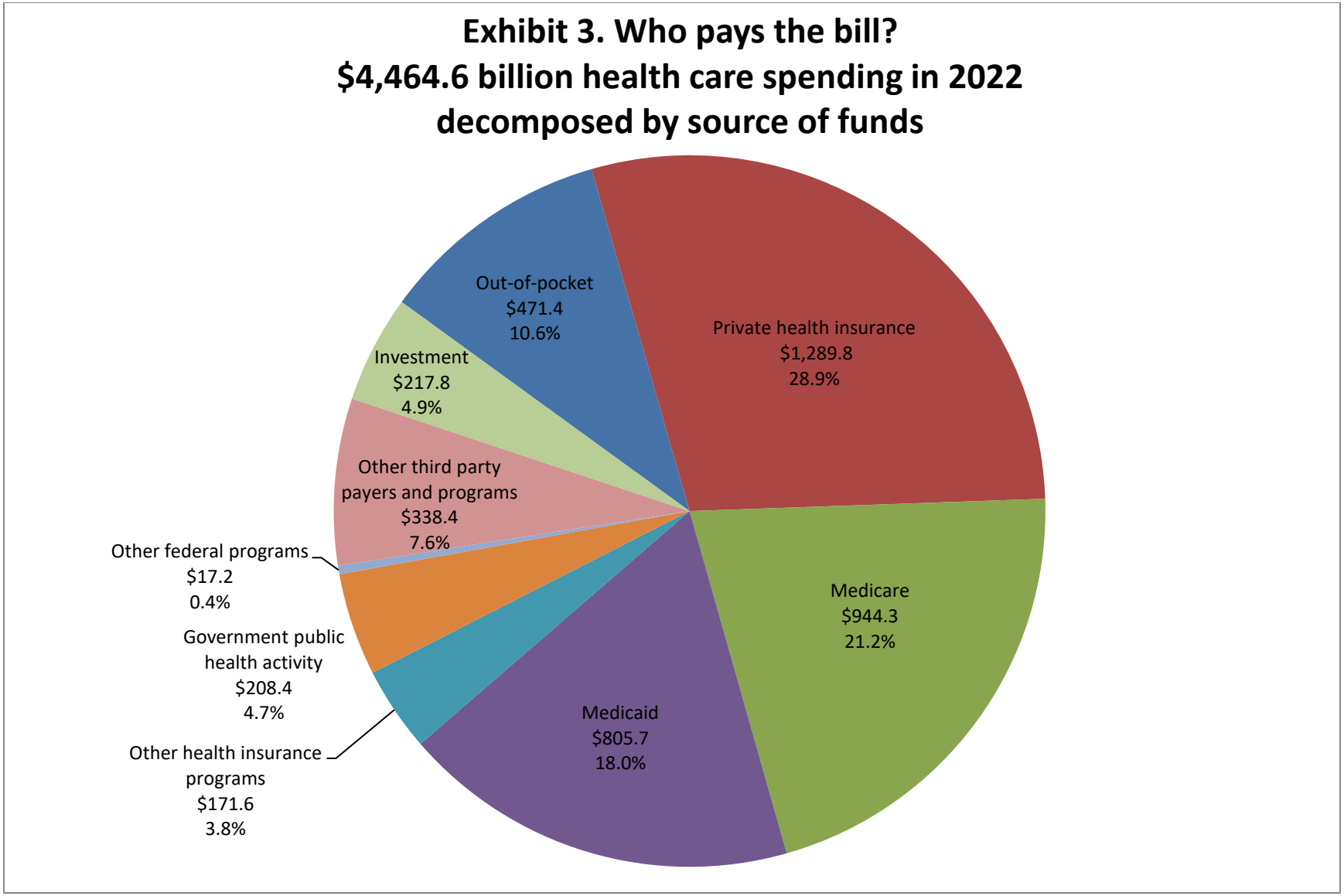

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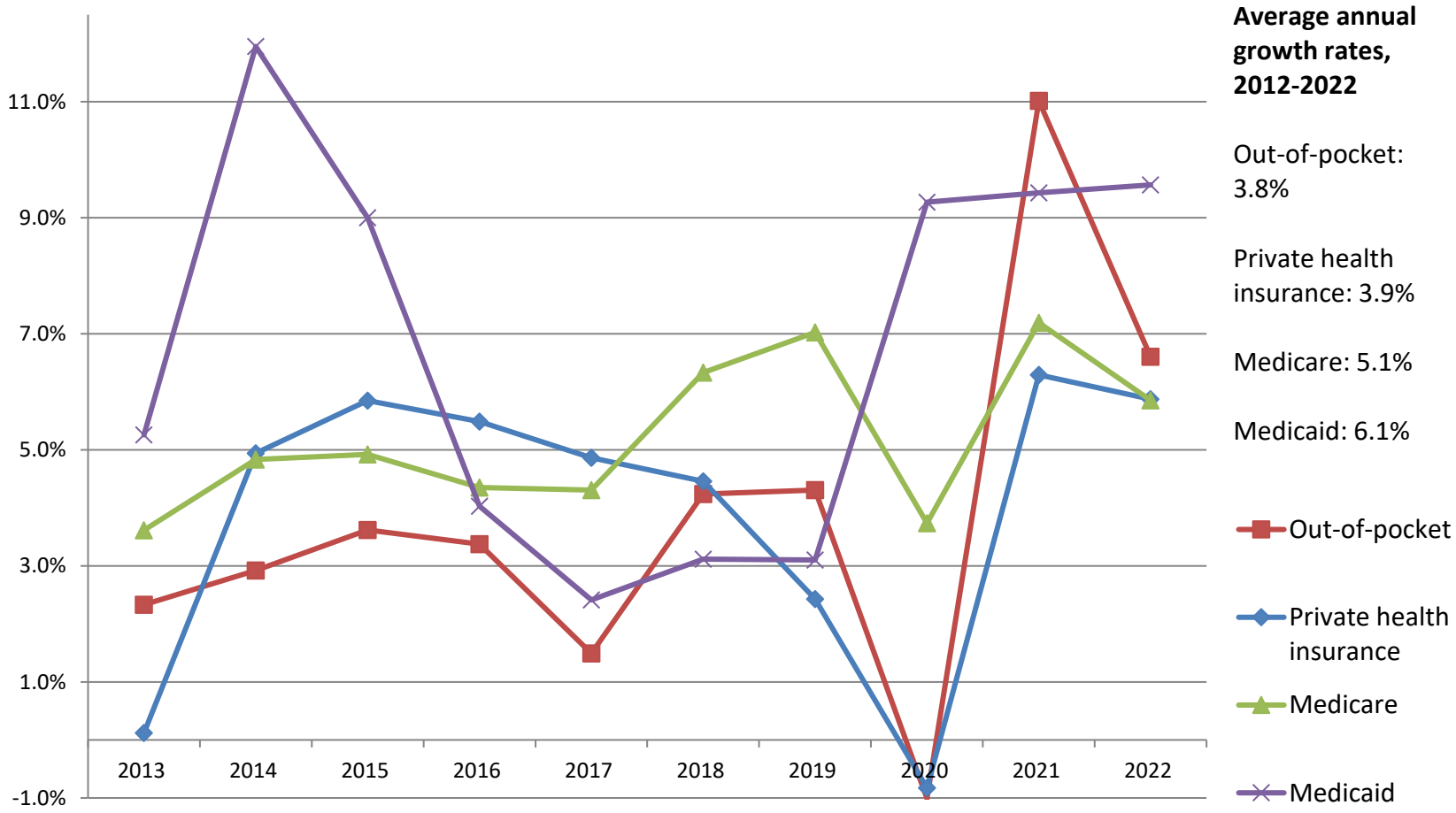
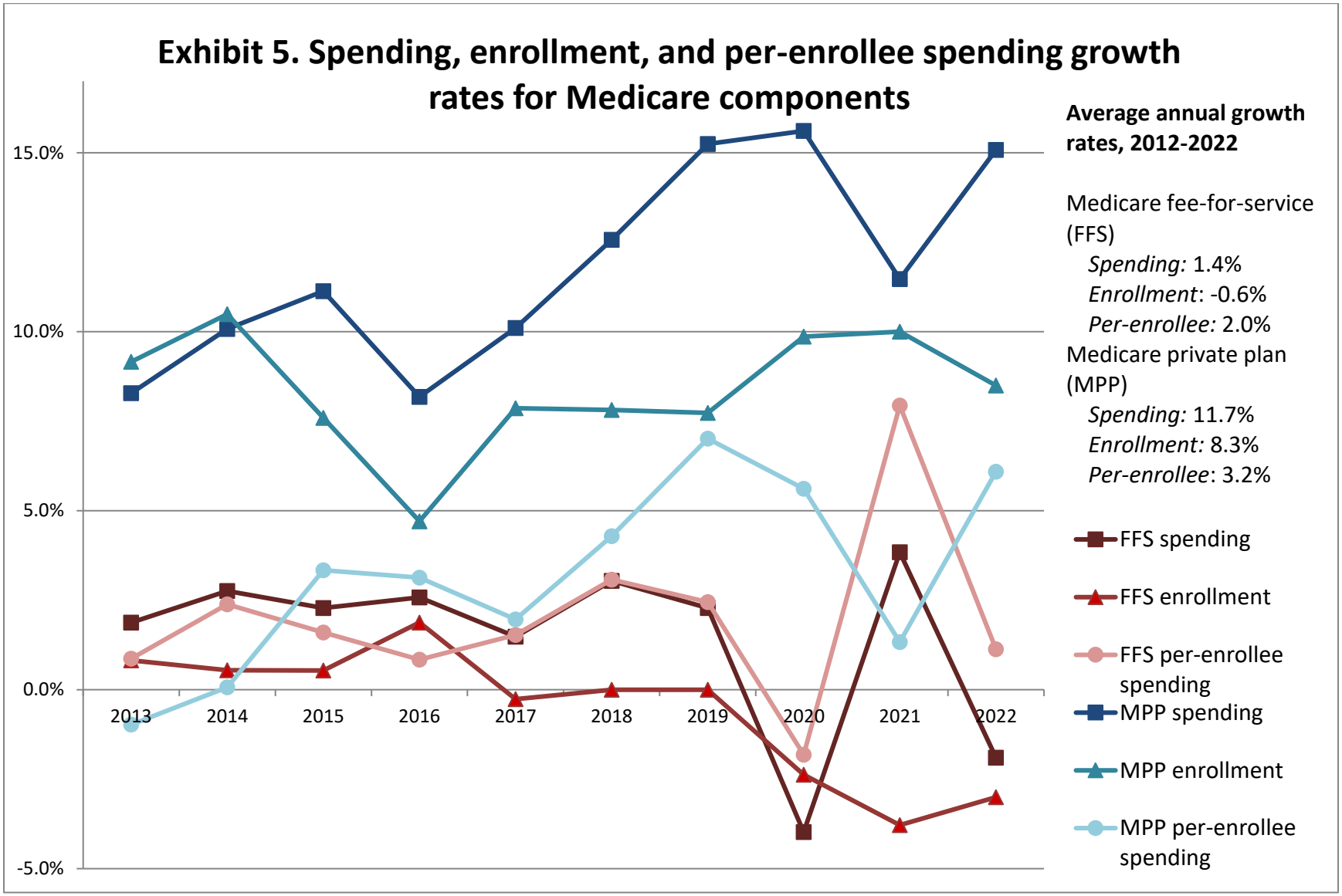
Exhibit 4. Spending growth rates by source of funds



Source: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical. Table 3 in NHE Tables [ZIP].

Exhibit 5. Spending, enrollment, and per-enrollee spending growth rates for Medicare components



Source: Data was obtained through direct correspondence with CMS NHE Health Expenditures Team and Hartman et al. (2024). Analysis of data is printed with permission.

Exhibit 6. NHE Financing in 2022 (billions of dollars)

	Total		PHI		Medicare		Medicaid	
SPONSOR	**Level**	**Share of total NHE**	**Level**	**Share of total PHI**	**Level**	**Share of total Medicare**	**Level**	**Share of total Medicaid**
Private business								
Employer contribution to employer sponsored health insurance premiums	$591.8	13.3%	$591.8	45.9%				
Employer Medicare Hospital Insurance Trust Fund payroll taxes	$142.9	3.2%			$142.9	15.1%		
Workers' compensation and temporary disability insurance	$43.9	1.0%						
Worksite health care	$8.7	0.2%						
Total private business	**$787.3**	**17.6%**	**$591.8**	**45.9%**	**$142.9**	**15.1%**	**$0.0**	**0.0%**
Household								
Employee contribution to employer-sponsored health insurance premiums	$308.3	6.9%	$308.3	23.9%				
Household contribution to direct purchase insurance	$69.9	1.6%	$69.9	5.4%				
Medical portion of property and casualty insurance	$42.9	1.0%						
Employee and self-employment payroll taxes and voluntary premiums paid to Medicare Hospital Insurance Trust Fund	$216.7	4.9%			$216.7	22.9%		
Premiums paid by individuals to Medicare Supplementary Medical Insurance Trust Fund and the Pre-existing Condition Insurance Plan	$122.4	2.7%			$122.4	13.0%		
Out-of-pocket health spending	$471.4	10.6%						
Total household	**$1,231.6**	**27.6%**	**$378.2**	**29.3%**	**$339.1**	**35.9%**	**$0.0**	**0.0%**
Other private revenues	**$289.1**	**6.5%**	**$0.0**	**0.0%**	**$0.0**	**0.0%**	**$0.0**	**0.0%**

Source: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical. Table 5, 5-1, 5-2, 5-3, 5-4, 5-5, 5-6 in NHE Tables [ZIP].

Exhibit 6. continued

	Total		PHI		Medicare		Medicaid	
SPONSOR	**Level**	**Share of total NHE**	**Level**	**Share of total PHI**	**Level**	**Share of total Medicare**	**Level**	**Share of total Medicaid**
Federal government								
Employer contribution to employer-sponsored health insurance premiums	$41.5	0.9%	$41.5	3.2%				
Employer Medicare Hospital Insurance Trust Fund payroll taxes	$5.1	0.1%			$5.1	0.5%		
Federal general revenue and Medicare Net Trust Fund expenditures	$400.1	9.0%			$400.1	42.4%		
Federal portion of Medicaid payments	$569.7	12.8%					$569.7	70.7%
Federal portion of Medicare buy-in premiums	$17.4	0.4%			$17.4	1.8%		
Retiree Drug Subsidy payments to employer-sponsored health insurance plans	$0.6	0.0%						
Other federal health insurance and programs	$375.1	8.4%	$9.8	0.8%				
Marketplace tax credits and subsidies	$74.1	1.7%	$74.1	5.7%				
Total federal government	**$1,483.5**	**33.2%**	**$125.4**	**9.7%**	**$422.6**	**44.8%**	**$569.7**	**70.7%**
State and local government								
Employer contribution to employer-sponsored health insurance premiums	$194.4	4.4%	$194.4	15.1%				
Employer Medicare Hospital Insurance Trust Fund payroll taxes	$17.3	0.4%			$17.3	1.8%		
State portion of Medicaid payments	$236.1	5.3%					$236.1	29.3%
State portion of Medicare buy-in premiums	$8.8	0.2%			$8.8	0.9%		
Other programs	$216.6	4.9%			$13.7	1.4%		
Total state and local government	**$673.1**	**15.1%**	**$194.4**	**15.1%**	**$39.7**	**4.2%**	**$236.1**	**29.3%**
TOTAL	**$4,464.6**	**100%**	**$1,289.8**	**100%**	**$944.3**	**100%**	**$805.7**	**100%**

Source: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical. Table 5, 5-1, 5-2, 5-3, 5-4, 5-5, 5-6 in NHE Tables [ZIP].