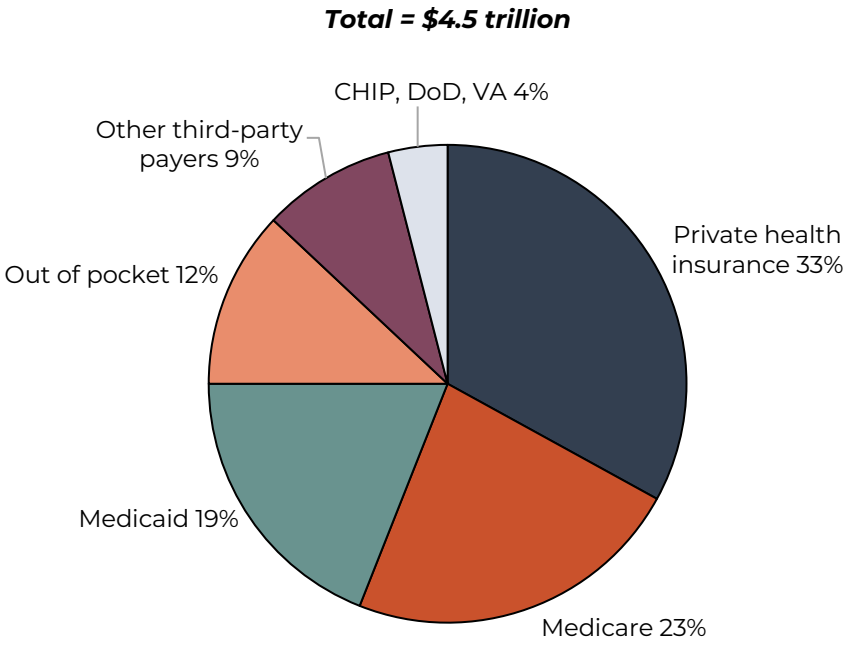
SECTION

1

National health care and Medicare spending

Chart 1-1 Medicare paid for 23 percent of personal health care spending, 2024



Note: CHIP (Children's Health Insurance Program), DoD (Department of Defense), VA (Department of Veterans Affairs). "Personal health care" is a subset of national health expenditures that comprises spending for all medical goods and services provided to patients. "Out-of-pocket" spending includes cost sharing for both privately and publicly insured individuals. Premiums are included in the shares of each program (e.g., Medicare, private health insurance) rather than in the out-of-pocket category. "Other third-party payers" includes worksite health care, other private revenues, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, other federal programs, the Substance Abuse and Mental Health Services Administration, other state and local programs, and school health.

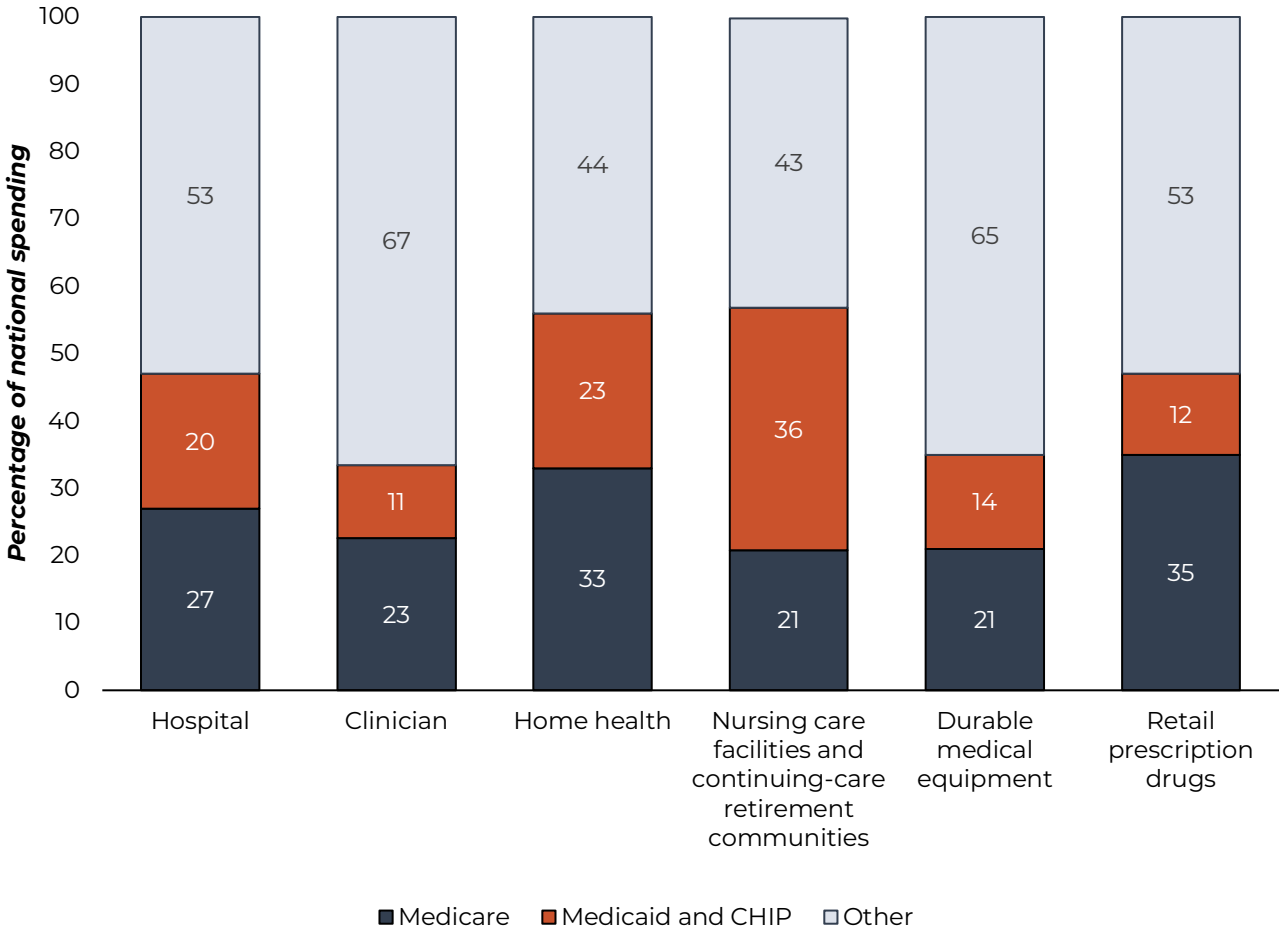
Source: CMS Office of the Actuary, NHE Tables (ZIP), released January 2026, https://www.cms.gov/files/zip/nhe-tables.zip.

> In 2024, $4.5 trillion was spent on personal health care in the U.S.

> Medicare spent $1 trillion on personal health care in 2024, representing 23 percent of national spending on personal health care. Medicare covered 16 percent of people in the U.S. in 2024 (data not shown). (Health care spending per person tends to be higher for Medicare beneficiaries than for younger and healthier people.)

> In this chart, enrollees' premium contributions are included in the spending category of their insurance type.

Chart 1-2 Medicare's share of national spending on personal health care varied by type of service, 2024



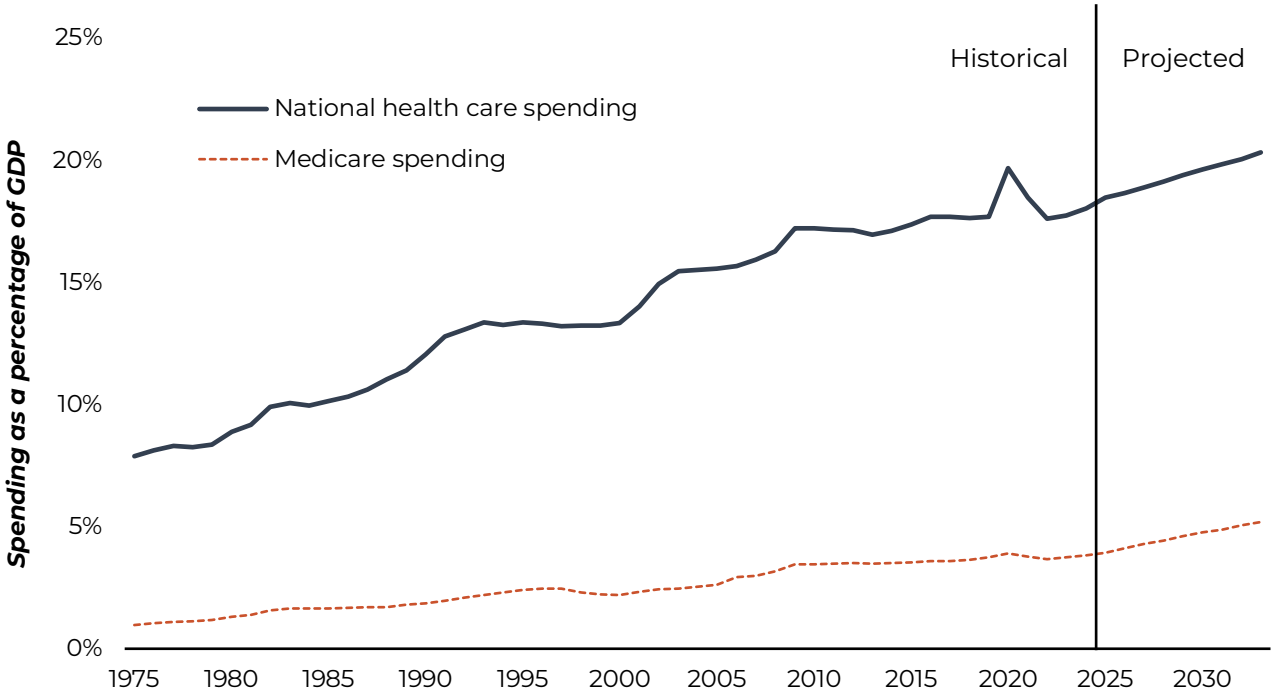
Note: CHIP (Children's Health Insurance Program). "Personal health care" is a subset of national health expenditures that comprises spending for all medical goods and services that are provided for the treatment of an individual. "Other" includes private health insurance, out-of-pocket spending, and other private and public spending. Additional types of health care services not shown here are other professional services; dental services; other health, residential, and personal care; and other nondurable medical products. Percentages may not sum to 100 percent due to rounding.

Source: CMS Office of the Actuary. National health expenditures by type of service and source of funds: Calendar years 1960 to 2024, released January 2026. https://www.cms.gov/files/zip/national-health-expenditures-type-service-source-funds-cy-1960-2024.zip.

> While Medicare's share of total personal health care spending was 23 percent in 2024 (see Chart 1-1), its share of spending by type of service varied, from only 21 percent of spending on durable medical equipment to 35 percent of spending on retail prescription drugs.

> Medicare's share of spending on nursing care facilities and continuing-care retirement communities was smaller than Medicaid's share because Medicare pays only for nursing home services for Medicare beneficiaries who require skilled nursing or rehabilitation services. In contrast, Medicaid pays for custodial care (long-term assistance with activities of daily living) provided in nursing homes for people with limited income and assets.

Chart 1-3 Health care spending has grown as a share of U.S. GDP



Note: GDP (gross domestic product). First projected year in the graph is 2025. Pandemic relief funds are counted as national health care spending rather than Medicare spending since they were meant to offset pandemic-related revenue losses from all payers, not just Medicare.

Source: MedPAC analysis of CMS's national health expenditure data (projected data released in June 2025 and historical data released in January 2026), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html.

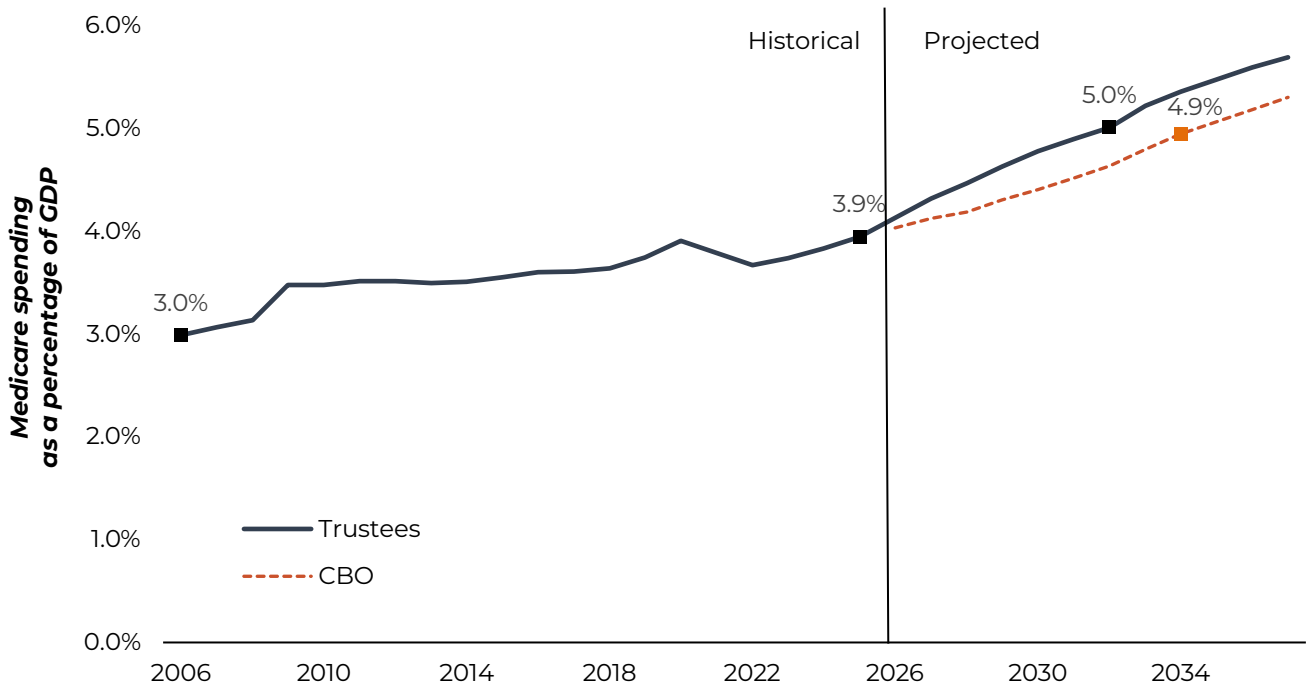
> In 2020, two factors caused total health care spending as a share of GDP to sharply increase (reaching 19.7 percent of the country's GDP, or $4.2 trillion). First, national health care spending increased 10 percent that year due to one-time spending by the federal government on coronavirus pandemic relief funds for health care providers, a relaxation of Medicaid's eligibility rules during the pandemic, and an increase in spending on public health activities (e.g., for vaccine development). Second, the country's GDP shrank by 1 percent that year.

> In 2021 and 2022, spending on health care increased at more typical rates as patients resumed receiving health care. Meanwhile, GDP expanded rapidly in these years. The net effect of these forces was a sharp decline in the share of GDP spent on health care in 2021 and 2022.

> In 2023, both national health care spending and GDP grew by 7 percent, causing no meaningful change in the share of GDP spent on health care that year.

> In 2024, national health care spending grew by 7 percent and GDP grew by 5 percent, causing the share of GDP spent on health care to again increase.

Chart 1-4 Medicare spending constituted 3.9 percent of GDP in 2025



Note: GDP (gross domestic product), CBO (Congressional Budget Office). The CBO line reflects fiscal years, while the Medicare Trustees line reflects calendar years. The first projected year is 2025. Medicare spending includes program spending and spending financed by premiums and other offsetting receipts for beneficiaries in both fee-for-service Medicare and Medicare Advantage but does not include beneficiary cost sharing. The sharp increase in spending in 2020 includes $104 billion in Medicare Accelerated and Advance Payments paid to providers that were then recouped by the Medicare program in subsequent years.

Source: 2025 annual report of the Boards of Trustees of the Medicare trust funds, Figure II.D1; CBO's long-term budget projections released in February 2026.

> Medicare spending is expected to grow more rapidly in the coming years than it has in the past few decades. It took two decades for Medicare spending to increase from 3 percent to 4 percent of GDP, but it is expected to take just one decade to increase from 4 percent to 5 percent of GDP.

> The factors that are estimated to drive Medicare spending in the near term are identified in Chart 1-5.

Chart 1-5 Factors contributing to Medicare's projected spending growth (after subtracting economy-wide inflation), 2025–2034

Medicare part	Average annual percentage change in: Medicare prices for services (minus inflation)	Number of beneficiaries	Beneficiary demographic mix	Other	Medicare's projected spending (minus inflation)
Part A	–0.3%	1.8%	0.4%	1.8%	3.6%
Part B	–1.0	1.9	0.1	4.5	5.5
Part D	–1.3	2.0	–0.2	1.0	1.6
Total	–0.8	1.9	0.2	3.0	4.3

Note: Includes fee-for-service Medicare and Medicare Advantage enrollees. "Medicare prices for services (minus inflation)" reflects Medicare's annual updates to payment rates (not including inflation, as measured by the Consumer Price Index), total-factor productivity reductions, and any other reductions required by law or regulation. "Beneficiary demographic mix" adjusts for age, sex, and time to death. "Other" refers to the residual after the other three factors shown in the table (Medicare prices for services, number of beneficiaries, and beneficiary demographic mix) are removed. "Medicare's projected spending" is the product of the other columns in the table, but components may not produce totals in this column due to rounding. The "Total" row is the sum of the other rows of the table, each weighted by its part's share of total Medicare spending in 2024.

Source: MedPAC analysis of data from Tables II.D1 and V.B2 in the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

> Several factors will contribute to expected increases in Medicare spending over the next decade.

> One driver is general inflation, the projected effect of which is excluded from this table since it is not a factor that health policymakers can easily influence.

> A second driver of Medicare's projected spending growth is increasing enrollment in the program as the baby-boom generation continues to reach Medicare's eligibility age.

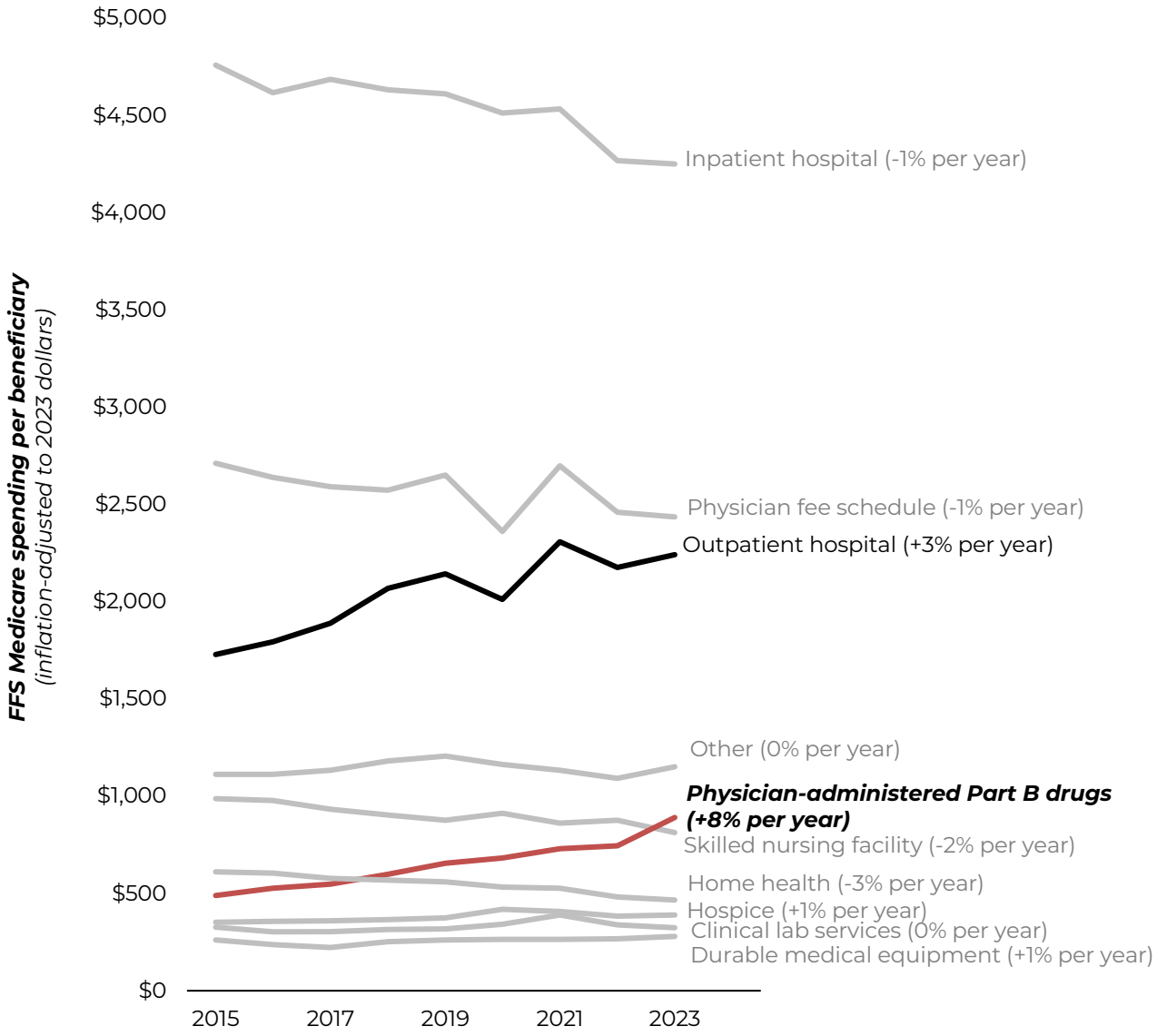
> Medicare's prices are not projected to grow faster than inflation (shown by the fact that the numbers in the first column of the table are negative).

> Changing beneficiary demographics are also not expected to be a driver of Medicare spending growth over the next decade (although demographics will eventually accelerate Medicare spending per beneficiary as enrollees from the baby-boom generation age; beneficiaries generate more spending per year as they age, as shown in Chart 2-2).

> Instead, the table shows that the spending driver that is expected to exert the most influence in the next 10 years is growth in "other" factors—such as growth in the volume and intensity of the services and items that providers deliver, including growth in the average price Medicare pays for Part B drugs (see Chart 1-6).

> In Chart 1-6, we show fee-for-service Medicare spending per beneficiary on different types of services and find that the fastest-growing type of spending is physician-administered drugs covered under Part B, which we discuss in greater detail in Chapter 10.

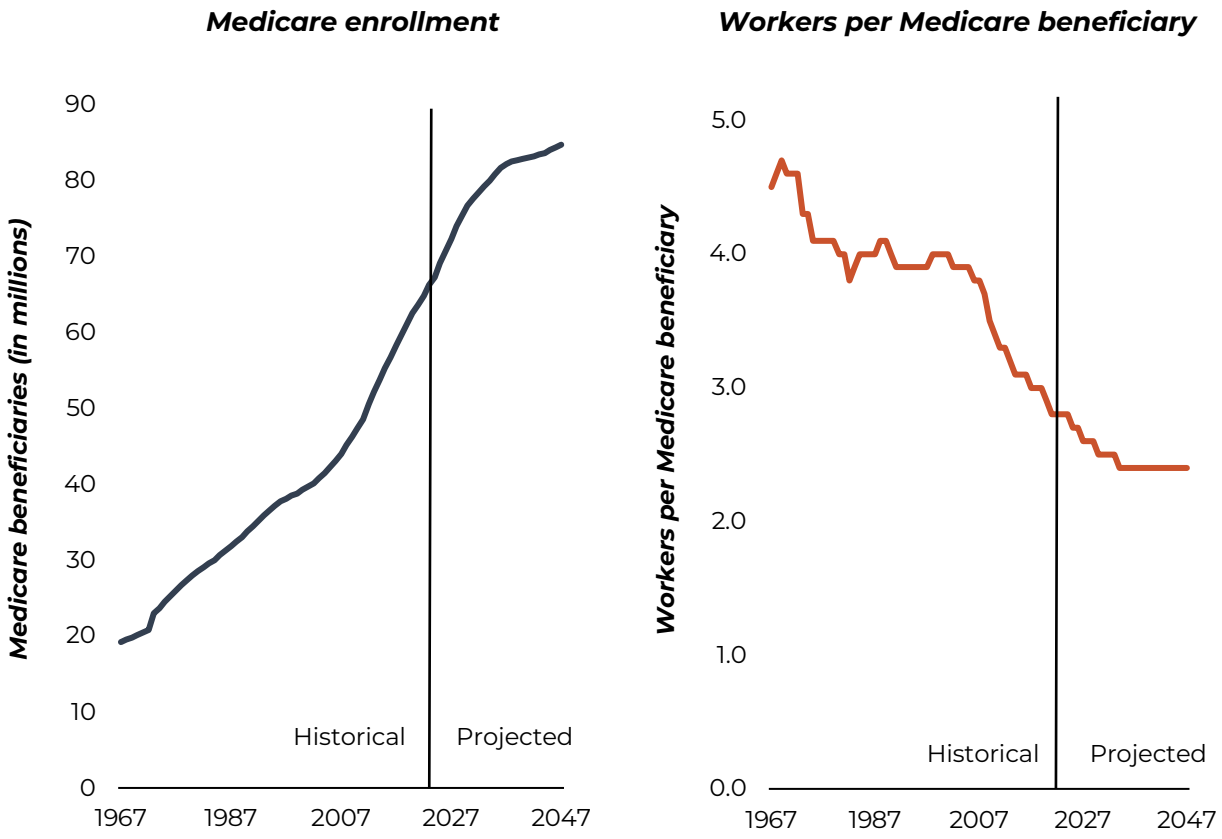
Chart 1-6 The fastest-growing type of FFS Medicare spending is physician-administered drugs covered under Part B



Note: FFS (fee-for-service). Each line in the figure shows annual FFS spending on a type of service or item (inflation adjusted to 2023 dollars using the Congressional Budget Office's annualized Consumer Price Index for All Urban Consumers), divided by the number of eligible FFS Medicare beneficiaries. (For the "inpatient hospital" and "skilled nursing facility" lines, the denominator is FFS beneficiaries enrolled in Part A; for the "physician fee schedule," "durable medical equipment," "clinical lab services," "physician-administered Part B drugs," "outpatient hospital," and "other" lines, the denominator is FFS beneficiaries enrolled in Part B; for the "home health" line, the denominator is all FFS beneficiaries enrolled in Part A and/or Part B; for the "hospice" line, the denominator is all Medicare beneficiaries enrolled in Part A, including both FFS and Medicare Advantage enrollees.) The "physician-administered Part B drugs" line does not include payments for Part B drugs furnished in outpatient hospitals; these payments are instead included in the "outpatient hospital" line. "Other" includes Part B payments to ambulatory surgical centers, ambulance providers and suppliers, federally qualified health centers, rural health clinics, critical access hospitals, and dialysis facilities, for example. Figure shows Medicare program spending, not including spending financed by beneficiary premiums or cost sharing. Percentages in parentheses are compound annual growth rates from 2015 to 2023.

Source: MedPAC analysis of spending amounts and beneficiary enrollment numbers in the 2025 annual report of the Boards of Trustees of the Medicare trust funds (Table IV.A3, Table IV.B6, Table IV.B10, and Table V.B3).

Chart 1-7 The number of workers per Medicare beneficiary has been declining since the program's inception



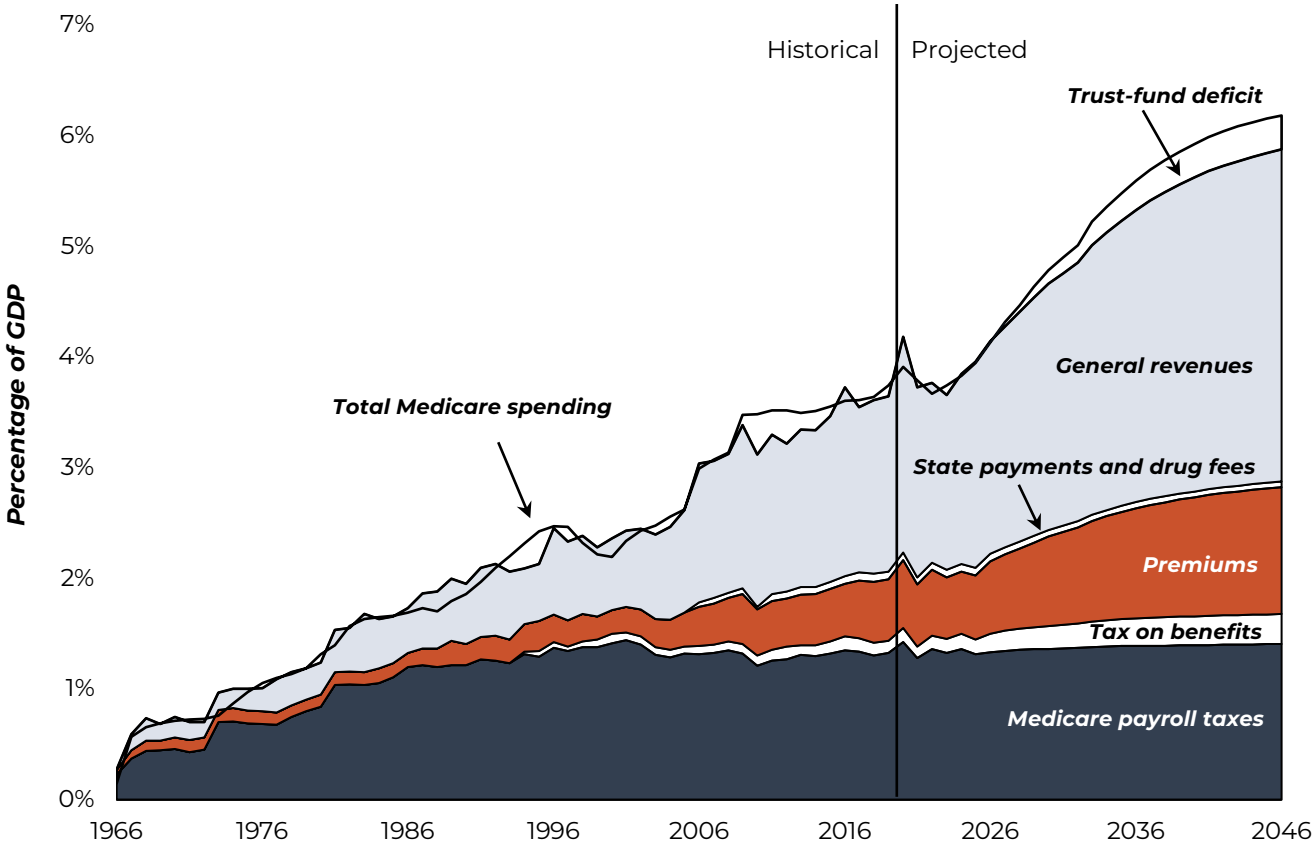
Note: "Medicare beneficiaries" refers to beneficiaries covered by Medicare Part A (including beneficiaries enrolled in Medicare Advantage plans). More beneficiaries have Part A Hospital Insurance than Part B Supplemental Medical Insurance because Part A is usually available to beneficiaries at no cost. First projected year is 2025. Part A services are financed primarily by Medicare payroll taxes (deposited into Medicare's Hospital Insurance Trust Fund) and beneficiary cost sharing.

Source: 2025 annual report of the Boards of Trustees of the Medicare trust funds.

> As the baby-boom generation ages, enrollment in the Medicare program is surging. By 2030, all baby boomers will have reached the age of eligibility for the Medicare program, and 75 million beneficiaries are expected to have Medicare Part A Hospital Insurance—up from 67 million beneficiaries in 2024.

> While Medicare enrollment is rising, the number of workers per beneficiary is rapidly declining. These diverging trends present a financing challenge for Medicare Part A since benefits paid for under this part are primarily financed by workers' Medicare payroll taxes. The number of workers per Medicare beneficiary with Part A Hospital Insurance declined from 4.5 workers per beneficiary in 1967 to 2.8 workers per beneficiary in 2024 and is projected to fall to 2.6 workers per beneficiary by 2029.

Chart 1-8 Medicare's largest funding source has shifted from Medicare payroll taxes to the U.S.'s general revenues



Note: GDP (gross domestic product). First projected year is 2025. Projections are based on the Trustees' intermediate set of assumptions. "Tax on benefits" refers to the portion of income taxes that higher-income individuals pay on Social Security benefits, which is designated for Medicare. "State payments" refers to payments from the states to Medicare, required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, for assuming primary responsibility for prescription drug spending. "Drug fees" refers to the fee imposed by the Affordable Care Act of 2010 (ACA) on manufacturers and importers of brand-name prescription drugs; these fees are deposited in the Part B account of the Supplementary Medical Insurance (SMI) Trust Fund. "Trust-fund deficit" refers to the shortfall when Medicare Part A spending exceeds the amount collected through Medicare payroll taxes and other trust-fund revenue sources. Graph does not include interest earned on trust-fund investments.

Source: 2025 annual report of the Boards of Trustees of the Medicare trust funds.

> Medicare spending accounted for 3.8 percent of GDP in 2024.

> In the early years of the Medicare program, Medicare payroll taxes deposited into the Hospital Insurance Trust Fund (which finances Part A) were the main source of funding for the Medicare program, but beginning in 2009, general tax revenues (which help finance Part B and Part D) became the largest source of Medicare funding. This shift is due, in part, to spending per beneficiary growing more quickly for Part B than Part A (not shown).

> As increasing amounts of general tax revenues have been used to pay for Medicare Part B and Part D, less tax revenue has been available for other priorities such as deficit reduction or investments that could grow the economic output of the country (e.g., federal investments in research and development, education, and transportation).

Chart 1-9 A higher Medicare payroll tax or lower Medicare Part A spending would extend the solvency of Medicare's Hospital Insurance Trust Fund

To extend Hospital Insurance Trust Fund solvency for:	Increase 2.9% Medicare payroll tax to:	or	Decrease Part A spending by:
25 years (2025–2049)	3.47%		12.9%

Note: "Part A spending" includes spending on inpatient hospital, skilled nursing facility, home health agency, and hospice services and includes spending for beneficiaries in fee-for-service Medicare and Medicare Advantage.

Source: MedPAC analysis of Table III.B8 in the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

> Medicare's Hospital Insurance (HI) Trust Fund helps pay for Part A services such as inpatient hospital stays, post-acute care provided by skilled nursing facilities and home health agencies, and hospice services. The trust fund is mainly financed through a dedicated payroll tax (i.e., a tax on wage earnings).

> From Medicare's inception through 2007, trust-fund revenues usually exceeded Part A spending—creating surpluses that increased the trust fund's account balance over time. The trust fund also experienced surpluses in 2016 and 2017, in 2021 through 2023, and is expected to experience surpluses in 2025 through 2027.

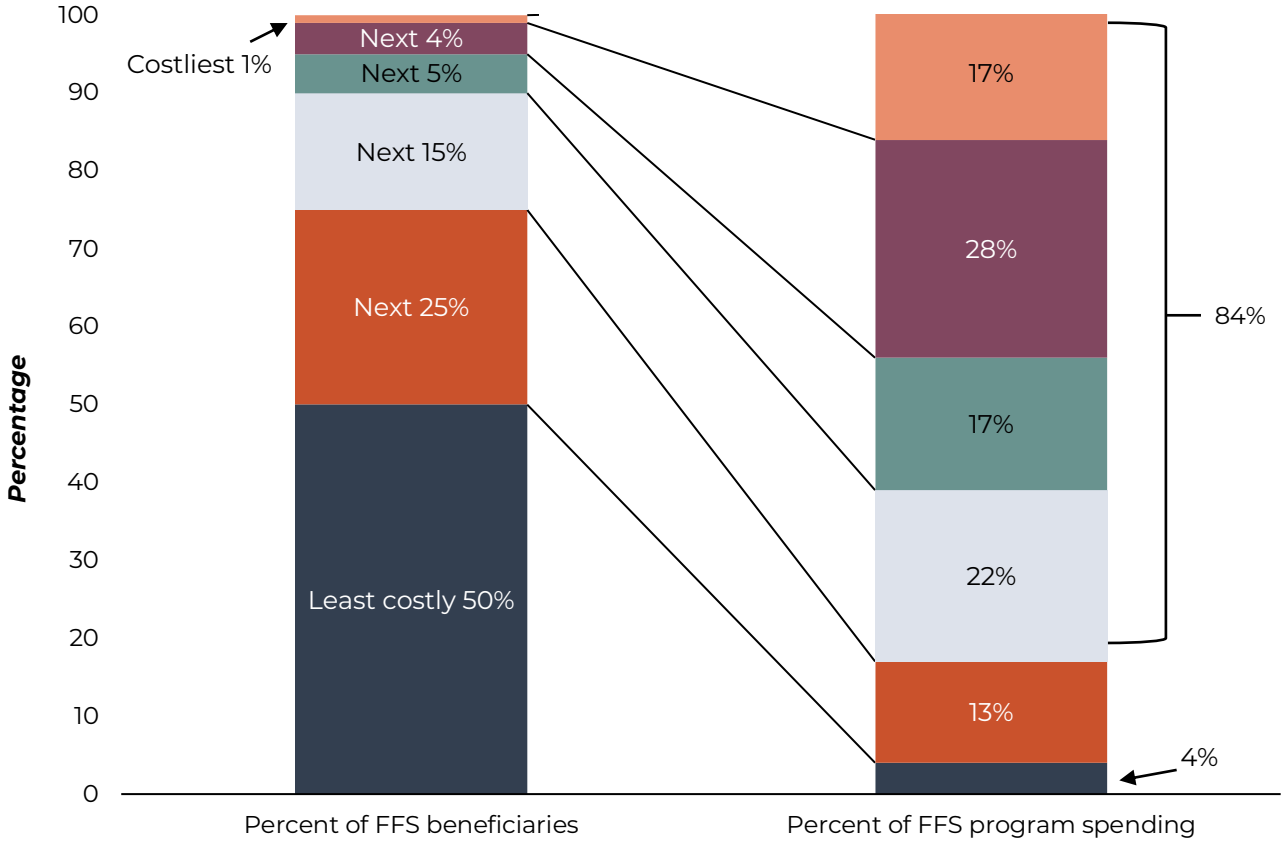
> Revenues from Medicare payroll taxes and other sources were less than Medicare Part A spending in 2008 through 2015, in 2018 through 2020, and in 2024—creating year-end deficits that reduced the trust fund's account balance in those years.

> Medicare's Trustees expect HI Trust Fund deficits from 2028 onward. The Congressional Budget Office (CBO) projects deficits from 2032 onward.

> Medicare's Trustees expect the HI Trust Fund to no longer carry a positive balance starting in 2033—meaning that revenues coming in that year will provide only enough funds to cover 89 percent of Part A spending that year. CBO projects trust-fund insolvency in 2040.

> To extend the solvency of the HI Trust Fund, there are a number of options available to policymakers. Two that are highlighted above are to (1) increase the Medicare payroll tax from its current rate of 2.9 percent to 3.47 percent or (2) reduce Part A spending by 12.9 percent, which is equivalent to a reduction of about $62 billion in 2026, which would then need to be maintained in subsequent years. Either of these approaches would extend the solvency of the trust fund for an additional 25 years. A combination of more moderate spending reductions and revenue increases is another option. Another way to raise revenue for the HI Trust Fund is through the type of broad economic growth experienced in the past few years; this growth has helped extend the projected solvency of the trust fund by a number of years, as more people work (and pay Medicare payroll taxes) and people earn higher-than-expected wages (which results in more wages being taxable).

Chart 1-10 FFS program spending was highly concentrated among a small share of beneficiaries, 2023



Note: FFS (fee-for-service). Analysis excludes beneficiaries with any enrollment in a Medicare Advantage plan or other health plan that covers Part A and Part B services (e.g., Medicare cost plans, Medicare–Medicaid Plans, and Medicare and Medicaid's Program of All-Inclusive Care for the Elderly (PACE)). Component percentages may not sum to 100 due to rounding. The Medicare Current Beneficiary Survey is collected from a sample of Medicare beneficiaries; year-to-year variation in some reported data is expected. Some percentages identified above are different from those mentioned below due to rounding.

Source: MedPAC analysis of CMS's Medicare Current Beneficiary Survey, 2023.

> Medicare FFS spending is concentrated among a small number of beneficiaries. In 2023, the costliest 5 percent of beneficiaries (i.e., the costliest 1 percent and the next-costliest 4 percent at the top of the bar at left) accounted for 45 percent of annual Medicare FFS spending. The costliest 25 percent of beneficiaries accounted for 84 percent of Medicare spending (indicated by the bracket at right).

> The least costly 50 percent of beneficiaries accounted for only 4 percent of FFS spending.

> Costly beneficiaries tend to be those who have multiple chronic conditions, are using inpatient hospital services, are eligible for Medicare due to disability or end-stage renal disease (as opposed to age), are dually eligible for Medicare and Medicaid, and are in the last year of life.