HEALTH POLICY 101

Health Care Costs and Affordability

May 2024

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

KFF

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

Introduction

I have long planned to create an online resource or mini “textbook” for faculty and students interested in health policy. One of the stumbling blocks is that there is no agreed upon definition of “h alth policy.”

We took a stab at it of sorts at KFF in our headquarters when we created a physical timeline—as shown in the photo above—of the central events in the history of our field on a all in our headquarters in San Francisco. But, of course, you can’t all visit our offices to see our health policy history wall—and many of you may have quibbles if you did.

For us at KFF, our definition efle ts our views and what we do: Health policy centers around, well policy—what the government does, and public programs like Medicare, Medicaid, and the ACA, and heavily emphasizes financing and overage.

We also focus relentlessly on people, not health professionals and health care institutions (I have never been fond of the word “provider”). Others have a more expansive definition and th t’s fine. Wh t I ultimately settled on doing is far simpler: Organizing the basic materials we have on the issues we work on, recognizing that they do not represent every topic of interest to the faculty and students we hope to assist.

The result is the following chapters. We will add chapters over time as we develop them. Our organization changes to play our role as an independent source of analysis, polling, and journalism on national health issues, and as that happens, we will add more content on subjects not covered in this fi st installment. We will also add chapters as we get feedback from you. And we will update the “101” at least annually as data and circumstances change.

Let me know if this is helpful and how it can be improved. You can reach me at daltman101@kff.org.

Dr. Drew Altman
CEO, KFF

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Introduction

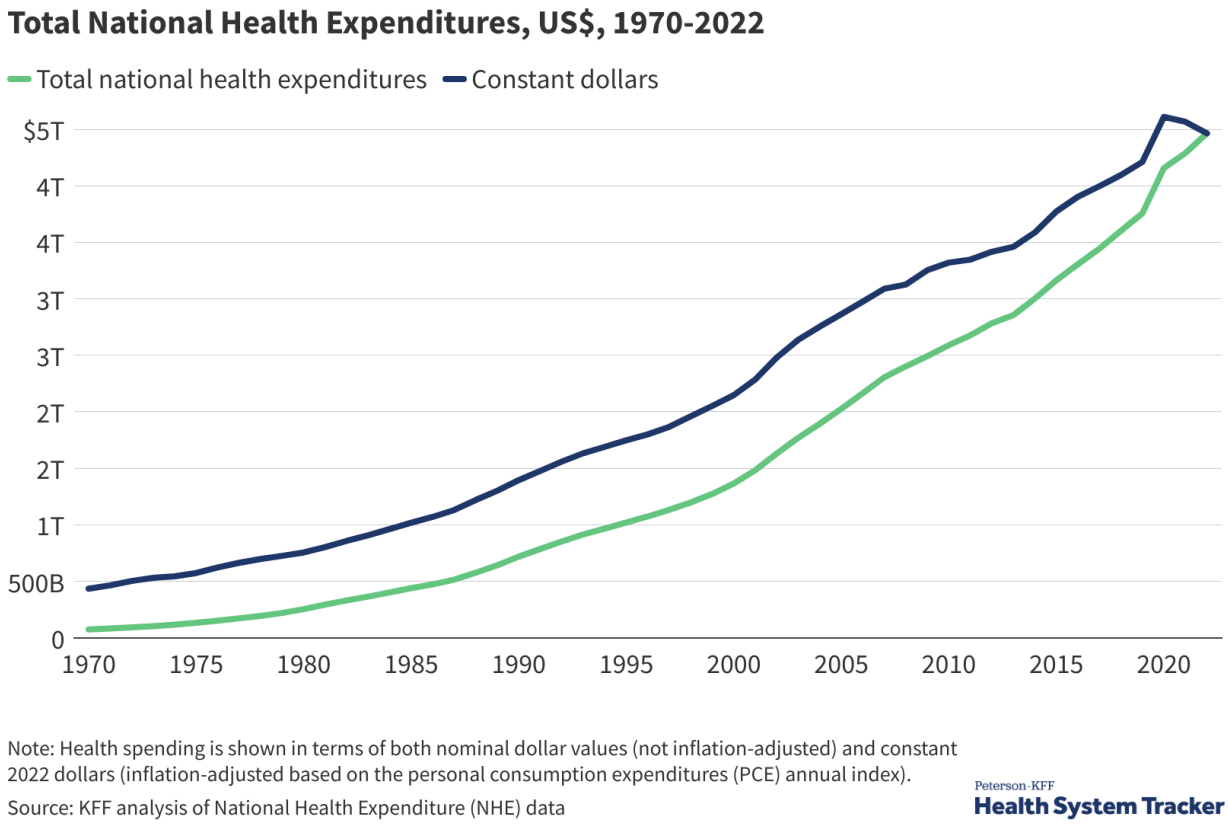
Health care costs in the United States have generally grown faster than inflation. The U.S. far exceeds other large and wealthy nations in per capita health spending, and health care represents a much larger share of the economy in the U.S. than in peer nations. Elevated health care expenditure in the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

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

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

Total Health Spending Reached $4.5 Trillion in 2022

Figure 1



Note: Health spending is shown in terms of both nominal dollar values (not inflation-adjusted) and constant 2022 dollars (inflation-adjusted based on the personal consumption expenditures (PCE) annual index).

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

Peterson-KFF Health System Tracker

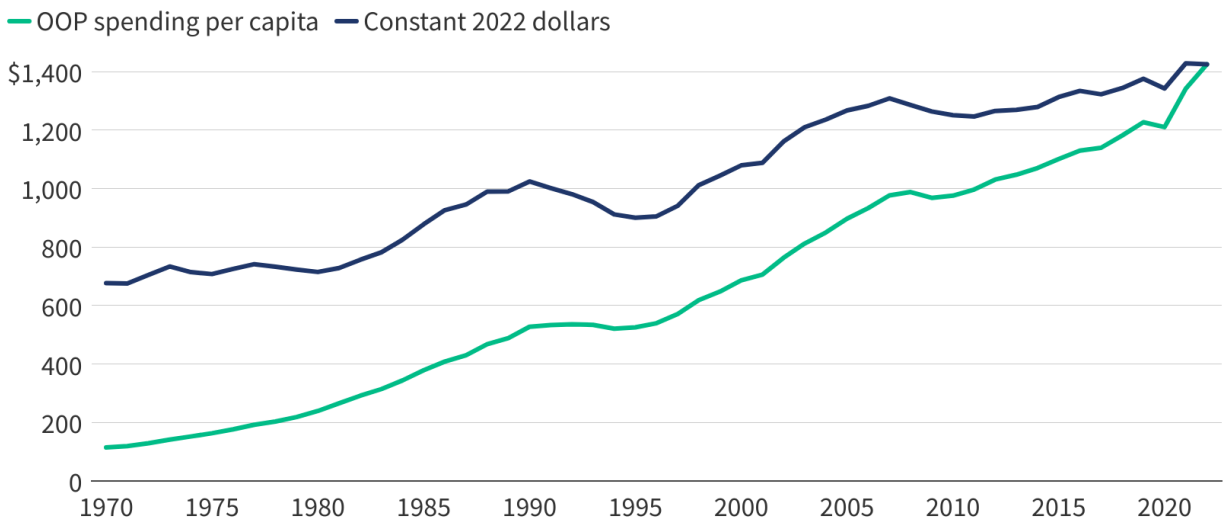
Health spending in the U.S. has risen sharply over the last several decades. The official data on national health expenditures from the Centers for Medicare and Medicaid Services (CMS) show health spending totaled $74.1 billion in 1970. By 2000, health expenditures had reached about $1.4 trillion; in 2022, the amount spent on health tripled to $4.5 trillion. In the first year of the COVID-19 pandemic, health spending accelerated by 10.6% in 2020, even as the use of health care dropped, driven largely by public health spending and financial relief provided to health care providers. Health spending grew modestly from 2021 to 2022, by 4.1%, slightly faster than the 3.2% increase from 2020 to 2021.

In Figure 1, spending is shown in terms of both nominal dollar values (not inflation-adjusted) and constant 2022 dollars (inflation-adjusted based on the personal consumption expenditures, or PCE, index). Inflation in the rest of the economy increased faster than in the health sector in 2022.

Currently, health care represents about 17% of the U.S. economy (measured as a share of gross domestic product, or GDP). In other words, almost 1 out of every 5 dollars spent in the U.S. goes toward health care. Back in 1960, health spending represented just 5% of GDP, meaning 1 in every 20 dollars in the U.S. economy was spent on health care.

Figure 2

Per Capita Out-of-Pocket Expenditures, 1970-2022



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

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

Peterson-KFF Health System Tracker

Out-of-pocket costs have also risen over time. Out-of-pocket costs represent the amount of money spent by individuals on health care that is not paid for by a health insurance plan or public program like Medicare or Medicaid. This can include cost-sharing (i.e. copays, deductibles, coinsurance), as well as health spending by uninsured people or spending by insured people for care that is not covered at all by health insurance. Out-of-pocket spending does *not* include the amount spent on a person's monthly health insurance premium.

Out-of-pocket spending per person was $115 in 1970 (or, adjusted for inflation, $677). By 2022, out-of-pocket spending had reached $1,425 per person. Despite this rise in out-of-pocket spending, health insurance now covers a larger share of total health spending (72%) than it did in 1970 (42%), in part because more people have gained coverage, especially public coverage, but also because health insurance spending per enrollee has grown.

What Factors Contribute to U.S. Health Care Spending?

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

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

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

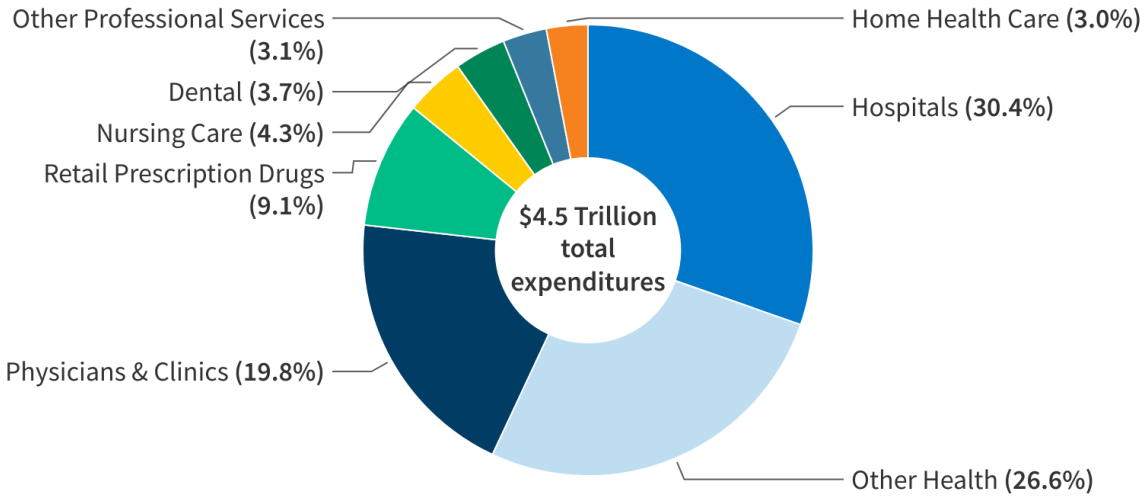
There are other factors, largely outside the control of the health system, that also are likely at play, such as socioeconomic conditions (like income inequality and other social determinants of health), and differences in so-called lifestyle factors (like diet, drug use, or physical activity) that could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

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

Hospital and Physician Services Represent Half of Total Health Spending

Figure 3

Relative Contributions to Total National Health Expenditures, by Service Type, 2022



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

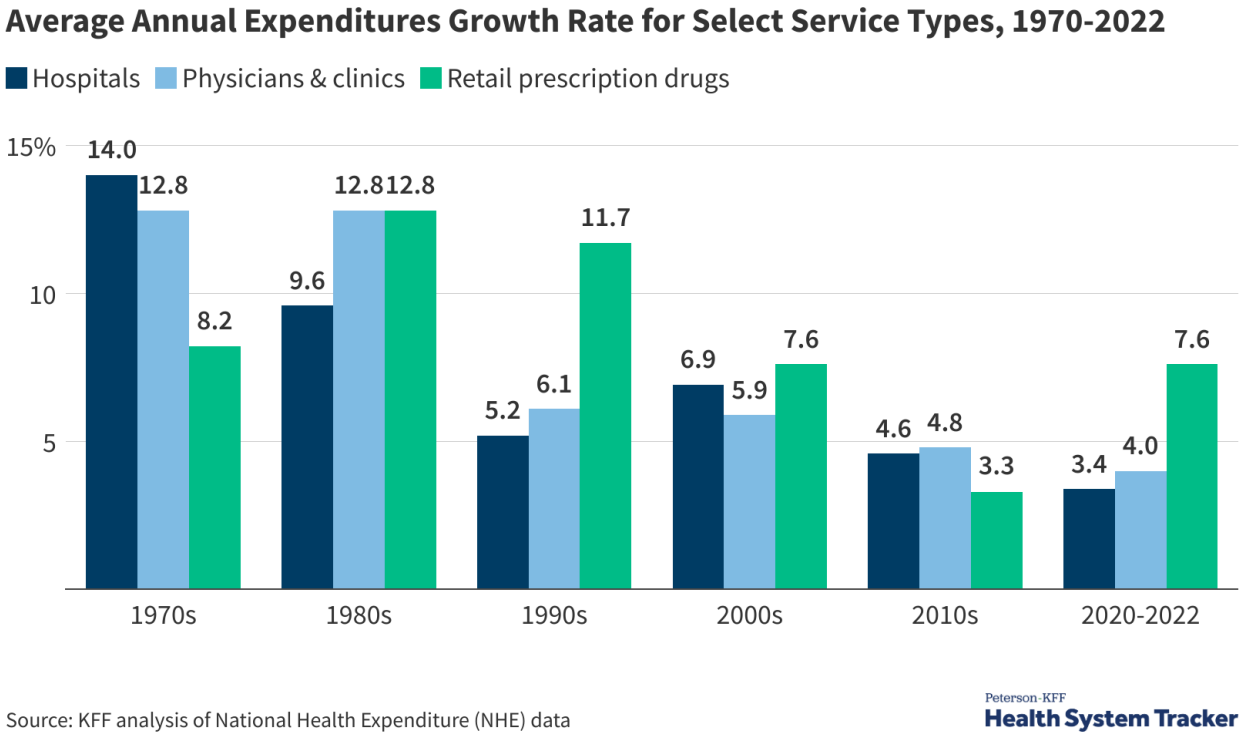
Source: KFF analysis of National Health Expenditure (NHE) data

Peterson-KFF Health System Tracker

Most health spending in the U.S. and peer countries is on hospital and physician care, followed by prescription drugs. In the U.S., hospital spending represented nearly a third (30.4%) of overall health spending in 2022, and physicians/clinics represented 19.8% of total spending. In comparison to other large and wealthy countries, the U.S.'s higher spending on inpatient and outpatient care explains the vast majority of higher spending on health care overall.

Spending Has Grown for Hospitals, Physicians, and Drugs

Figure 4



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

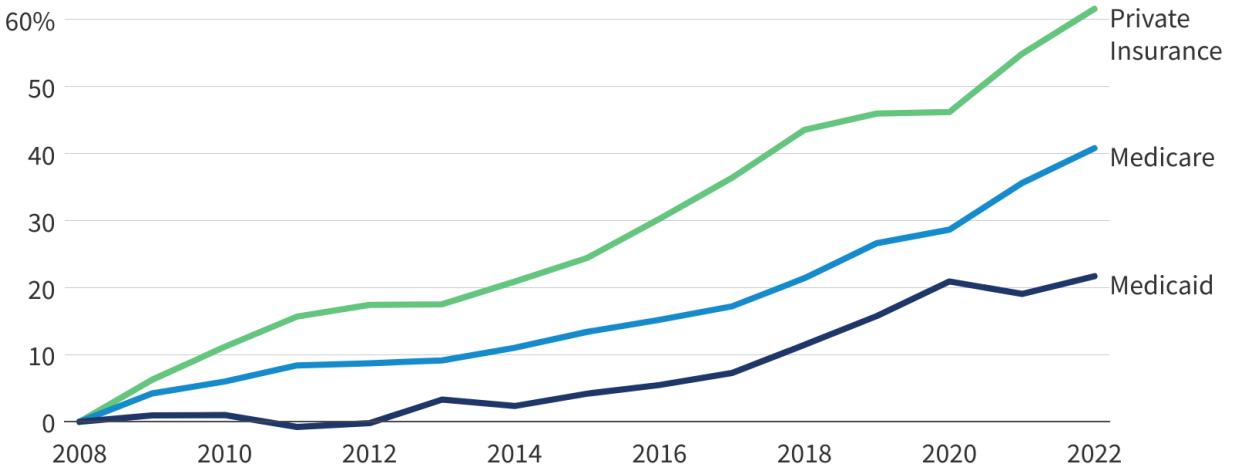
Peterson-KFF Health System Tracker

During the 1970s, growth in hospital expenditures outpaced other services, while prescriptions and physicians/clinics saw faster spending growth during the 1980s and 1990s. From 2020 to 2022, retail prescription drugs experienced the fastest growth in spending at 7.6%, following 3.3% average annual growth from 2010 to 2020. Average spending growth for hospitals and physicians/clinics between 2020 and 2022 was 3.4% and 4.0%, respectively.

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

Figure 5

Cumulative Growth in Per Enrolled Person Spending by Private Insurance, Medicare, and Medicaid, 2008-2022



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

Peterson-KFF Health System Tracker

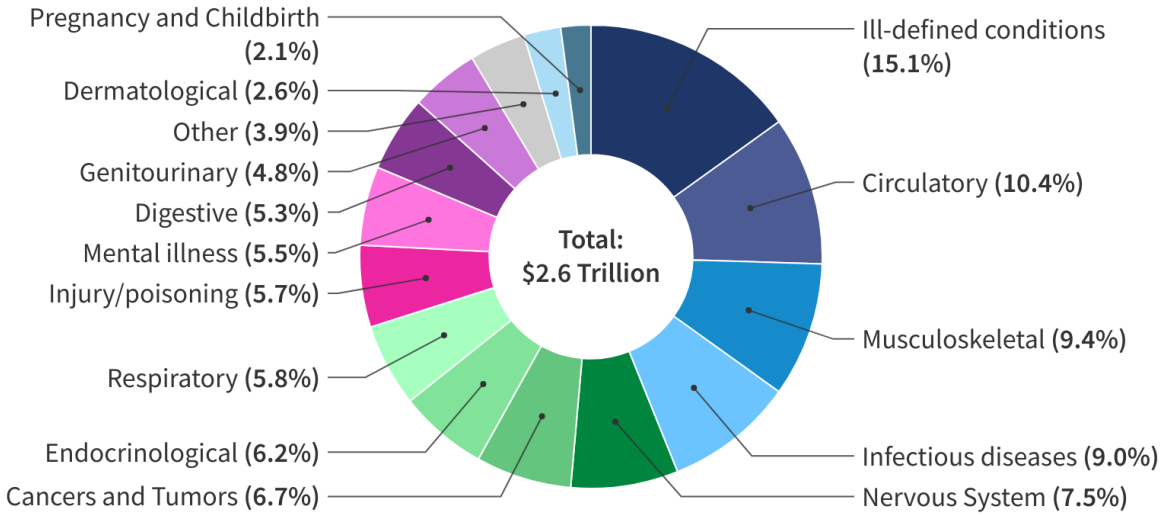
Per-enrollee spending by private insurance grew by 61.6% from 2008 to 2022 – much faster than both Medicare and Medicaid spending growth per enrollee (40.8% and 21.7%, respectively). Generally speaking, private insurance pays higher prices for health care than Medicare and Medicaid.

Per-enrollee spending for Medicaid rose by 2.2% in 2022 from the previous year and also continued to increase in private insurance and Medicare (4.3% and 3.8% respectively). Medicare and private insurance per enrollee spending continued to grow faster in 2021 and 2022 after slower growth in 2020. Medicaid per-enrollee spending previously declined in 2021 as total enrollment grew, particularly among children and non-elderly adults, who generally have lower per-enrollee spending.

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

Figure 6

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



Note: "Other" includes residual codes, blood/blood-forming organs, perinatal, and congenital anomalies.
Source: KFF analysis of BEA Health Care Satellite Account (Blended Account)

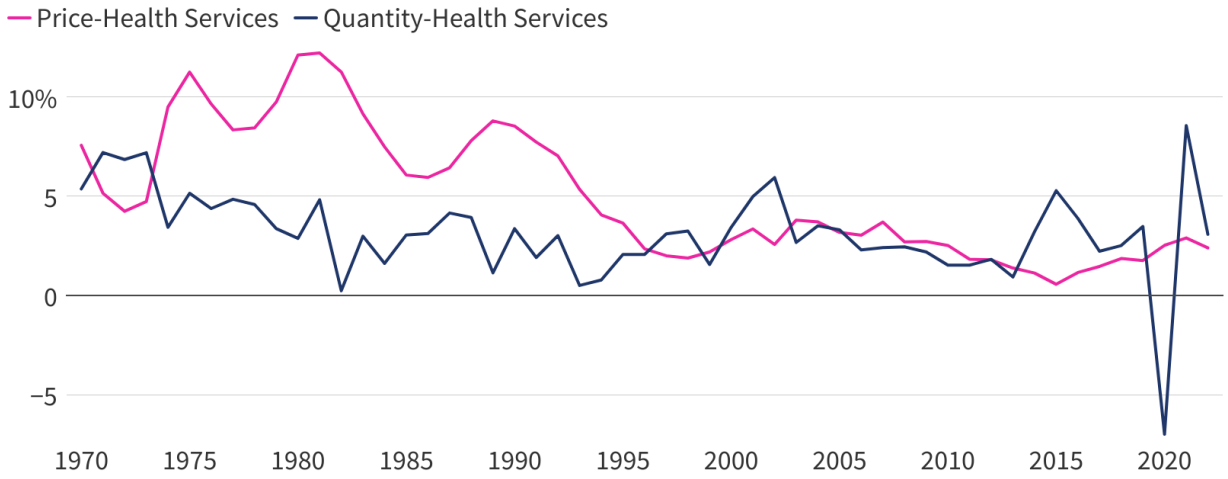
Peterson-KFF Health System Tracker

An alternative way to examine the components of health spending is to use the Bureau of Economic Analysis (BEA)'s Health Care Satellite Account, which estimates spending and price growth by disease category (e.g. cancer, infectious disease). This approach differs from the official categorization of health spending by service type (e.g. provider services). Essentially, the new satellite account redefines the "commodity" in health care as the treatment for specific diseases rather than a hospital stay or a physician visit. BEA researchers found that the largest categories of medical services spending include the treatment of circulatory diseases (10.4% of health spending in 2021), musculoskeletal conditions (9.4%) and infectious diseases (9.0%). Another large share of health spending (15.1%) is for "ill-defined conditions," which can include routine check-ups and follow-up care that is not easily designated for a particular illness.

Health Spending is a Function of Prices and Use

Figure 7

Annual Percent Change in Price and Quantity Personal Consumption Expenditure Indexes of Health Services, 1980-2022



Note: Price and quantity indices are for health services consumption. Annual data are not seasonally adjusted. Index numbers 2017=100

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

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

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

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

More recently, the COVID-19 pandemic has led to fluctuations in health care use. Early in the pandemic, many health services, such as elective surgeries, were postponed or canceled and many people elected not to get care to avoid infections at health care sites. In 2021, health services use increased by 8.6%. This increase in health

care use in 2021 followed a sharp decrease in health utilization in 2020. Health care prices increased moderately in 2021 by 2.9%. A rebound in utilization and labor pressures are expected to put upward pressure on prices in recent years.

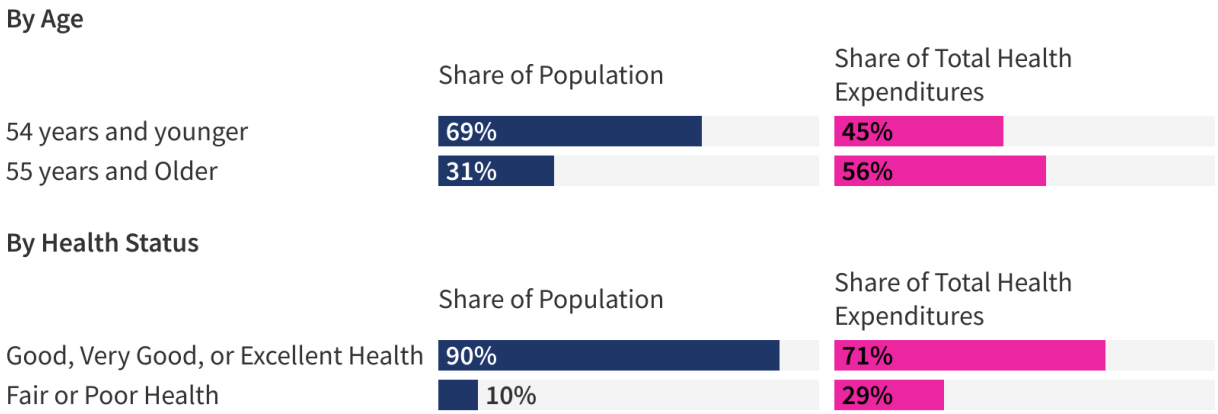
How Does Health Care Spending Vary Across the Population?

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

Older People and People with Significant Health Needs Account for Most Health Expenditures

Figure 8

Share of Total Population and Total Health Spending, by Age Group and Health Status, 2021



Source: KFF analysis of 2021 Medical Expenditure Panel Survey data

Peterson-KFF Health System Tracker

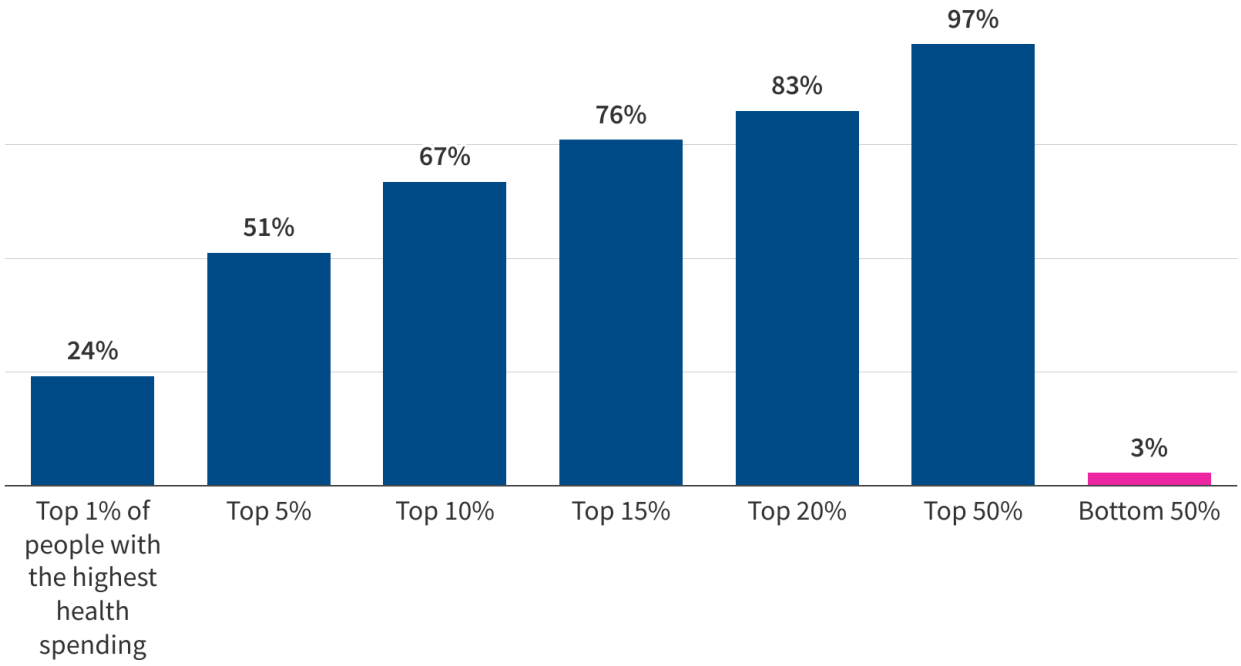
While there are people with high spending at all ages, in 2021, people 55 and over accounted for 56% of total health spending despite making up only 31% of the population. In contrast, people under age 35 comprised 44% of the population but were responsible for only 21% of spending.

People with significant health needs account for a large portion of total health spending. People reporting fair or poor health status account for 10% of the population and 29% of the total health spending.

A Small Share of the Population Incurs Most of Health Spending

Figure 9

Share of Total and Out-of-Pocket Health Spending, by Percentile, 2021



Source: KFF analysis of 2021 Medical Expenditure Panel Survey data

Peterson-KFF Health System Tracker

In 2021, the 5% of people with the highest health spending accounted for just over half of total health spending and had an average of around $71,100 in health expenditures annually; people with health spending in the top 1% had average spending of over $160,000 per year. At the other end of the spectrum, the 50% of the population with total health spending below or equal to the 50th percentile accounted for only 3% of all health spending; the average spending for this group was $385. Roughly 14% of the population had $0 in health expenditures in 2021.

Out-of-pocket spending on health services is concentrated similarly to overall health spending. In Figure 9, out-of-pocket spending includes direct payments to providers and cost-sharing but does not include monthly premium payments or contributions towards health coverage. Out-of-pocket health spending is similarly concentrated among high-health-need individuals. This small portion of the population accounts for a substantial share of total out-of-pocket health spending in a year.

In 2021, people in the top 1% of out-of-pocket spending paid an average of about $24,490 out-of-pocket for health services per year, and people in the top 10% spent an average of around $6,190 out-of-pocket per year. People who are in the bottom 50% of out-of-pocket spending spent an average of $24 out-of-pocket.

How Do High Health Costs Affect Affordability of Care?

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

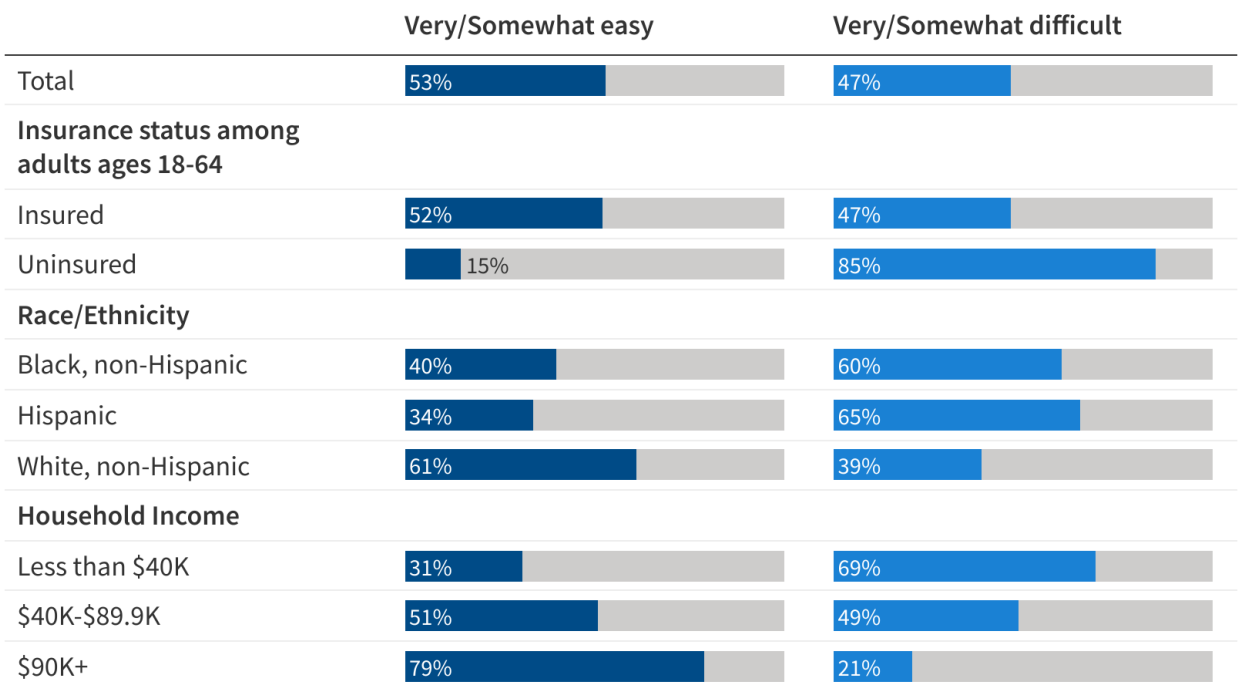
When health care is unaffordable, it can lead to cost-related access barriers for individuals, like forgoing or delaying needed medical care. For those who do receive care, this care can lead to medical debt and other forms of financial instability. Some people experience both affordability challenges,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

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

Figure 10

Half of Adults Say it is Difficult to Afford Health Care Costs, Including Large Shares of the Uninsured, Black and Hispanic Adults, and Those with Lower Incomes

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



Note: See topline for full question wording.
Source: KFF Health Care Debt Survey (Feb. 25-Mar. 20, 2022)

KFF

About half of U.S. adults say it is difficult to afford health care costs (Figure 10), and one in four say they or a family member in their household had problems paying for health care in the past 12 months (Figure 11). People with lower incomes, people in fair or poor health, and the uninsured are particularly likely to report problems affording health care in the past year.

Among those under age 65, uninsured adults are more likely to say affording health care costs is difficult (85%) compared to those with health insurance coverage (47%).

Those who have health insurance coverage are not immune to the burden of health care costs. About 4 in 10 insured adults worry about affording their monthly health insurance premium, and 48% worry about affording their deductible before health insurance kicks in. Large shares of adults with employer-sponsored insurance

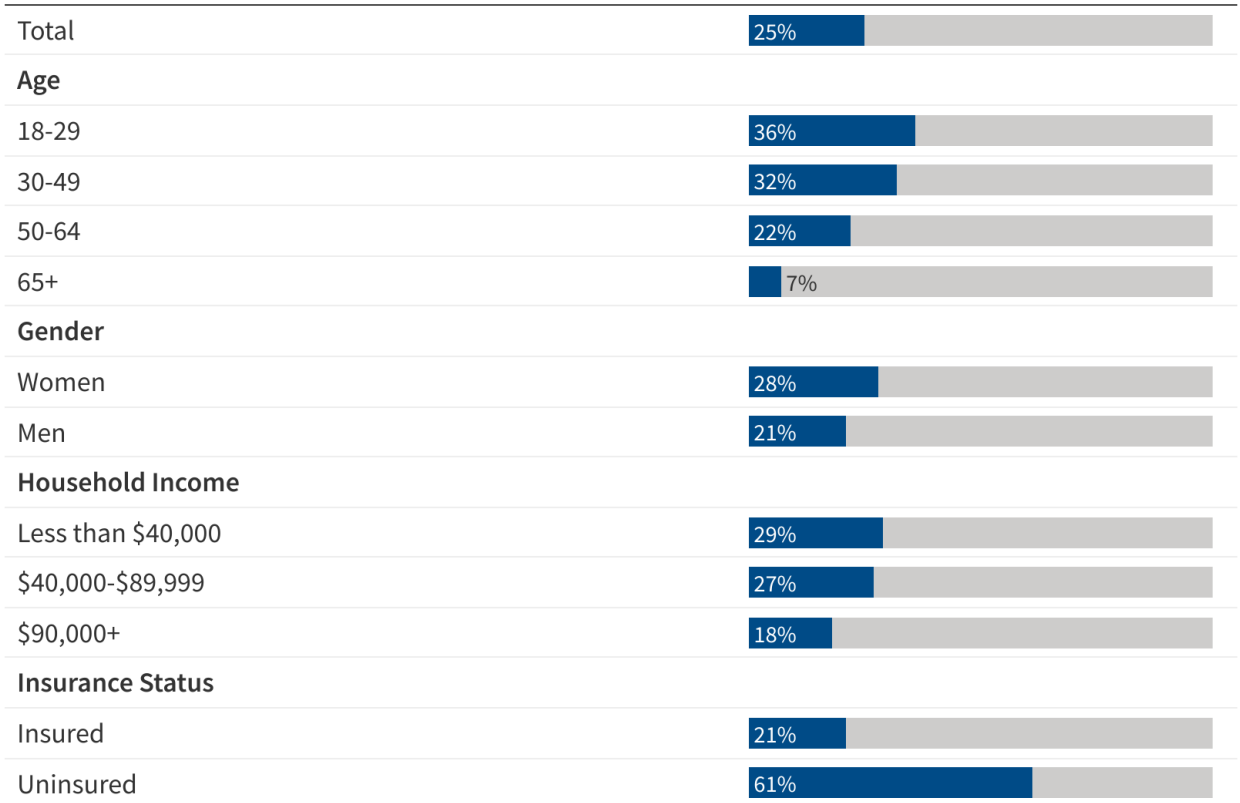
(ESI), and those with Marketplace coverage, rate their insurance as “fair” or “poor” when it comes to their monthly premium and out-of-pocket costs to see a doctor.

1 in 4 Adults Report Putting Off Health Care Because of Cost

Figure 11

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

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



Note: See topline for full question wording.
Source: KFF Survey on Racism, Discrimination, and Health (June 6-August 14, 2023)

KFF

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

One-quarter of adults say that in the past 12 months, they have skipped or postponed getting health care they needed because of the cost, according to KFF polling. Women are more likely than men to say they have skipped or postponed getting care (28% vs. 21%). People aged 65 and older, most of whom are eligible for health care coverage through Medicare, are much less likely than younger age groups to say they have not gotten health care they needed because of cost. Six in 10 uninsured adults (61%) say they have skipped or postponed care for cost reasons. Additionally, insured people are not immune from cost-related barriers to accessing care, as 1 in 5 adults with insurance (21%) still report not getting health care they needed due to cost.

What Impact Do Health Care Costs Have on Financial Vulnerability?

Despite the vast majority of the United States population having health insurance, medical debt is common. Different ways of measuring medical debt result in different estimates of prevalence, but regardless of the method, there is consensus that medical debt is a persistent and pervasive problem in the United States, including for people with insurance.

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

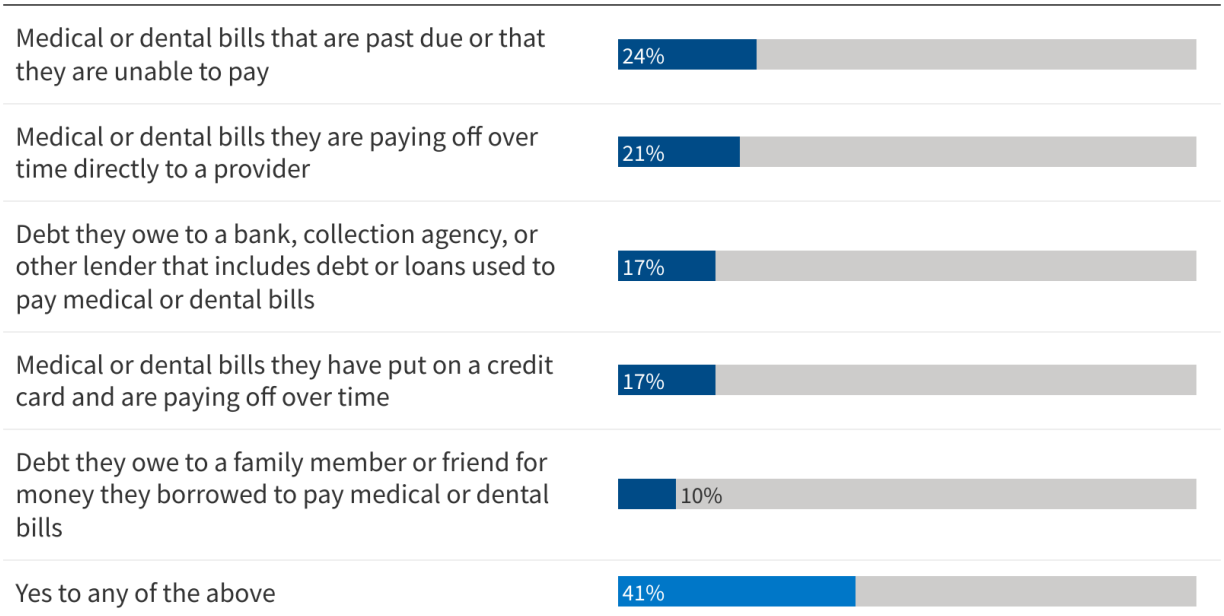
Another way to measure medical debt is with surveys, which can allow respondents to describe their debt in more detail, with nuance. Questions about medical debt and other financial matters can be difficult to compare across surveys. For example, it is not always clear whether respondents are answering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

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

Figure 12

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

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



Note: See topline for full question wording.
Source: KFF Health Care Debt Survey (Feb. 25-Mar. 20, 2022)

KFF

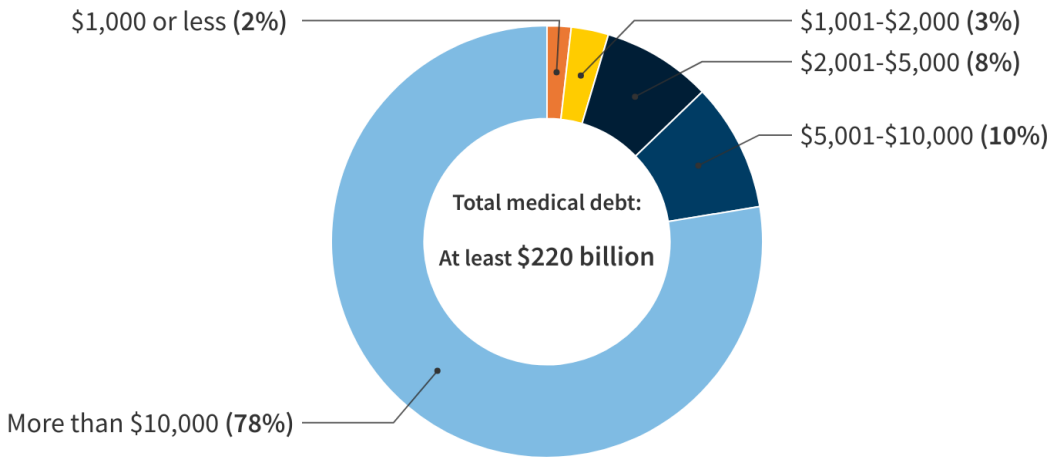
The U.S. Survey of Income and Program Participation (SIPP) asks whether money was owed for a medical bill and not paid in full during the past year for each person in the sample household. SIPP results, therefore, can be looked at on the individual level or for an overall household. This survey shows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

Regardless of the survey used to examine medical debt, some common themes emerge when looking at differences across demographic groups. People who are Black, uninsured, lower-income, and in worse health are more likely to have medical debt. In particular, people with disabilities are much more likely to have significant medical debt, which, in addition to the burden of medical costs, could also reflect inadequate supplemental income for people who are unable to work due to disability or illness.

Nationally, Medical Debt Totals at Least $220 Billion

Figure 13

Share of Aggregate Total Medical Debt in the U.S., by the Amount of Debt Individuals Owe, 2021



Note: To reduce the influence of the highest debt holders on the total, KFF used a conservative method to calculate medical debt for respondents with extremely high debt amounts. This approach removes the highest debt values from the calculation. This analysis is limited to those owing over $250 in medical debt.

Source: KFF analysis of the Survey of Income and Program Participation (SIPP)

Peterson-KFF Health System Tracker

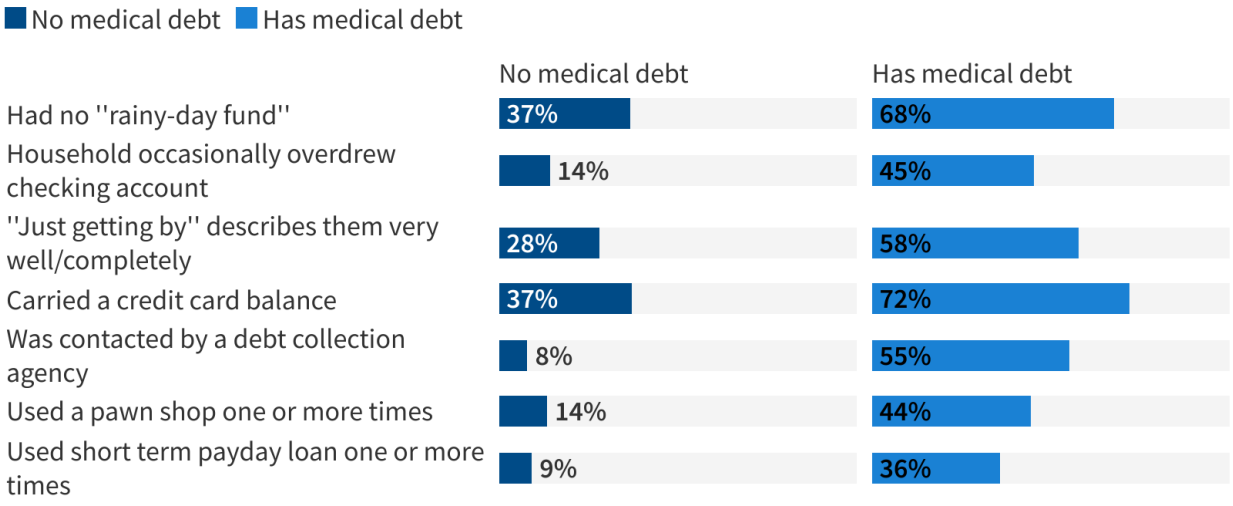
The Consumer Financial Protection Bureau (CFPB) estimates that $88 billion in medical debt is reflected on Americans' credit reports. However, credit reports may not capture all forms of medical debt. For example, medical debt disguised as credit card debt or money owed to family or friends may not be captured. Surveys may capture medical debt that is not visible on credit reports or is otherwise disguised as another form of debt. The 2021 Survey of Income and Program Participation suggests that total medical debt owed was at least $220 billion at the end of 2021.

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

Figure 14

Medical Debt is Associated with Other Forms of Financial Vulnerability

Share of adults who reported the following financial conditions, 2021



Note: *All differences between "No medical debt" and "Has medical debt" significant at p < .05.
Source: KFF Analysis of 2021 NFCS

Peterson-KFF Health System Tracker

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

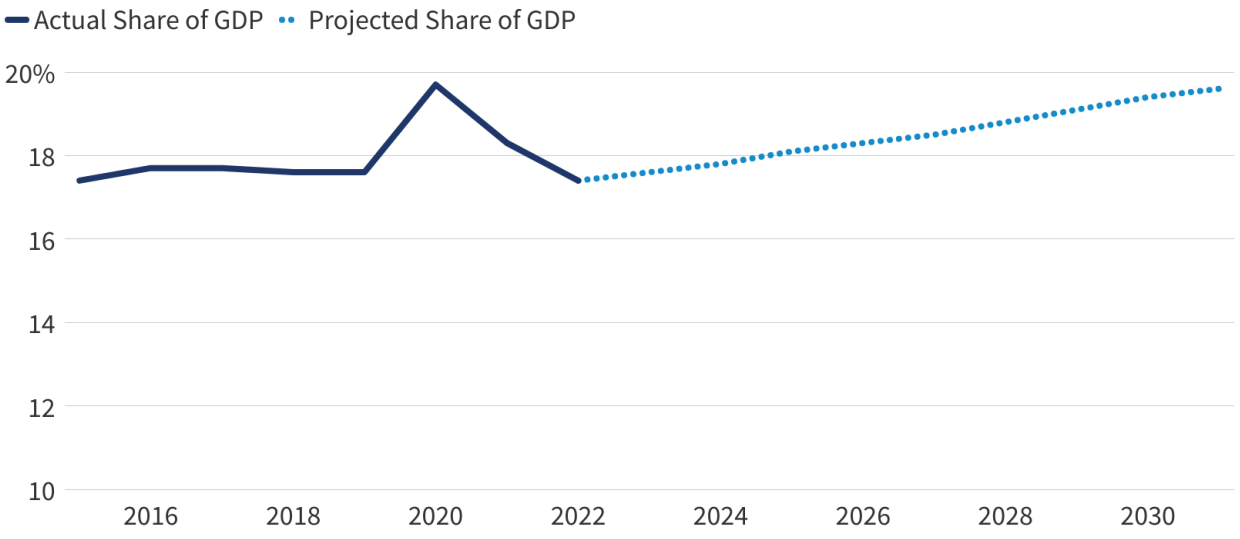
People with medical debt are much more likely to have other forms of financial distress than those without medical debt. Indicators of financial vulnerability—such as spending more money than one's income, having no "rainy day" fund, or agreeing with the statement "I am just getting by financially"—are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

How Much is Health Care Spending Expected to Grow?

Each year, actuaries from the Centers for Medicare and Medicaid Services (CMS) project future spending on health. With utilization continuing to return to pre-pandemic levels and price inflation in the health sector, per-person health spending is projected to rebound to an annual rate of 4.8% per capita on average from 2022 to 2031, which is slightly above pre-pandemic growth rates (average of 3.9% from 2014 to 2019).

Figure 15

Health Spending as a Percent of Gross Domestic Product (GDP), Actual (2015 - 2022) and Projected (2023 - 2031)



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

Peterson-KFF Health System Tracker

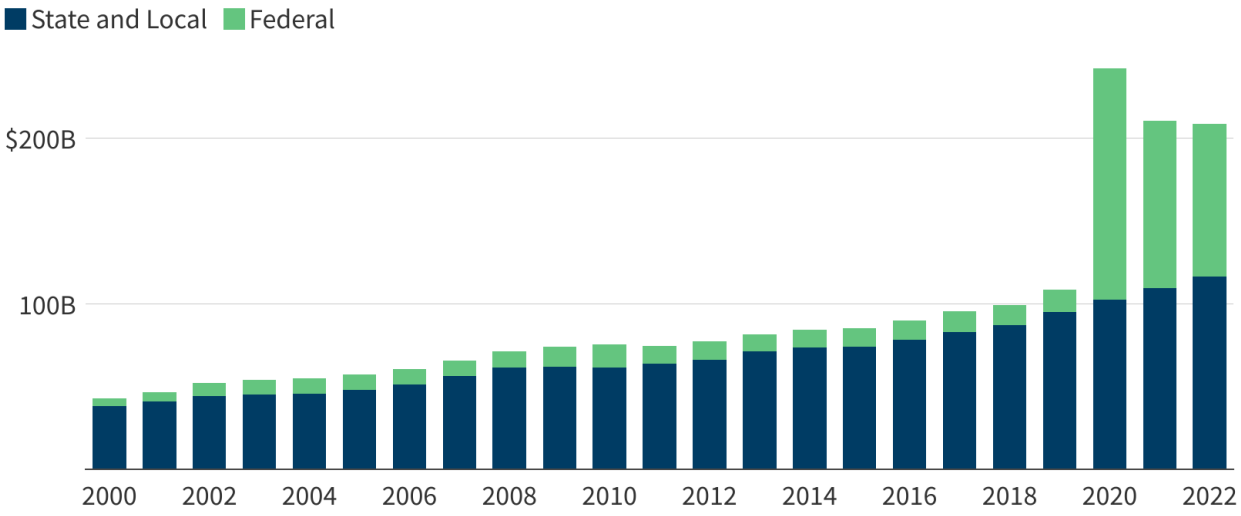
An aging population, labor pressure driving higher prices, and new high-cost prescription drugs coming to market are expected to contribute to a growth in health spending. Health spending was 17.4% of the U.S. economy in 2022 and is expected to reach 19.6% by the end of the decade.

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

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

Figure 16

Federal and State/Local Expenditures on Public Health, US$ Billions, 1970-2022



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

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

Peterson-KFF Health System Tracker

Total national health spending includes spending on direct patient care, as well as spending on public health or prevention. After a sharp increase in 2020 driven by the federal response to the COVID-19 pandemic, spending on public health has fallen. Federal public health spending decreased by 27% from $139.3 billion in 2020 to $101.1 billion in 2021. In 2022, federal public health spending also decreased slightly (dropping $9 billion or 9%). Meanwhile, state and local public health spending grew by 6.3%, in line with previous years. Total public health spending is expected to continue to decline over the next couple of years.

Future Outlook

Key policy issues will shape future health spending and affordability:

- **Evolution of State Cost Controls:** States implementing measures to control health cost growth, including those potentially supported by the Biden Administration's new AHEAD model, may prompt further experimentation. However, states can only regulate a subset of private health insurance plans.

- **Price Transparency Requirements:** Federal price transparency requirements aim to illuminate prices paid to hospitals and providers. However, there are challenges with the quality of the data and the Congressional Budget Office expects minimal impact on health care prices.
- **Prescription Drug Pricing:** The Inflation Reduction Act of 2022, targeting Medicare drug spending through government negotiation of drug prices, is expected to reduce Medicare costs, but potential effects on the private market remain uncertain. While CBO expects minimal effects on the availability of new treatments, there is considerable uncertainty surrounding those estimates.
- **Expansion of Virtual Care:** The COVID-19-induced rise in telehealth, with expanded reimbursement and access, has uncertain impacts on care coordination, quality, health outcomes, and costs.
- **Market Dynamics and Anticompetitive Practices:** Consolidation among providers, insurers, and drug manufacturers has elevated health care prices, leading to regulatory actions against anticompetitive practices, aiming to protect consumers from rising costs.
- **Provider Payment Reforms:** Bipartisan efforts in site-neutral payment reform, addressing concerns about higher payments in outpatient settings, have led to Medicare implementing site-neutral payments in some settings and additional legislative proposals. However, challenges in provider charging practices and facility fees persist.
- **Value-Based Payment Models:** The proliferation of value-based payments aims to transfer some of the cost risks from payers to providers, but concerns remain about the effectiveness of these approaches, limited quality improvement, administrative burdens, and reduced physician participation incentives.
- **Changes in Coverage:** Despite reduced uninsured rates through continuous Medicaid enrollment and expanded Affordable Care Act Marketplace subsidies during the pandemic, affordability challenges persist among the insured. Renewed disenrollments from Medicaid and the expiration of Marketplace subsidies after 2025 may increase uninsured rates and affordability issues.
- **Addressing Medical Debt:** Ongoing efforts to address medical debt involve planned credit reporting agency requirements and regulatory actions. However, the root causes of high health costs and underinsurance remain untouched by most efforts to mitigate the negative effects of medical debt.

Resources

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

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

Citation:

Amin, Krutika, Cox, Cynthia, Ortaliza, Jared & Wager, Emma, Health Care Costs and Affordability. In Altman, Drew (Editor), Health Policy 101, (KFF, May 28, 2024) https://www.kff.org/health-policy-101-health-care-costs-and-affordability/ (date accessed).

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