OHIO COMMON GROUND RESEARCH CENTER

White Paper

White Paper No. 018 · Tracking ID: RL-2026-028 · Version: 1.0

Who Pays for American Healthcare?

Generational Patterns in Health Care Financing, Coverage, and Government Programs

A review of selected financing trends across the Silent Generation, Baby Boomers, Generation X, Millennials, and Generation Z, drawing on CMS National Health Expenditure Accounts, U.S. Census Bureau coverage estimates, and Bureau of Labor Statistics Consumer Expenditure Survey data

Status current through August 2026 (most recent published federal data: calendar year 2024)

Prepared by the Ohio Common Ground Research Center

Published August 19, 2026

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Suggested Citation

Ohio Common Ground Research Center. Who Pays for American Healthcare? Generational Patterns in Health Care Financing, Coverage, and Government Programs. White Paper No. 018, Tracking ID RL-2026-028, Version 1.0. Dublin, Ohio: Ohio Common Ground, August 19, 2026.

Publication Record

Series: OCG White Paper

Catalog No.: White Paper No. 018

Tracking ID: RL-2026-028

Version: 1.0

Publication date: August 19, 2026

Prepared by: Ohio Common Ground Research Center

Review: Internal editorial review and external peer review; all resulting factual corrections were independently verified by OCG against the primary sources cited in this report before adoption.

Update cadence: Reviewed and reissued periodically as new federal data are released. Not on a fixed calendar interval.

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Executive Summary

This report describes how Americans finance health care, with particular attention to differences across five generational cohorts — the Silent Generation, Baby Boomers, Generation X, Millennials, and Generation Z — and to how those patterns have shifted over time. It draws on the Centers for Medicare & Medicaid Services (CMS) National Health Expenditure (NHE) Accounts, U.S. Census Bureau health insurance coverage estimates, and Bureau of Labor Statistics (BLS) Consumer Expenditure Survey (CE) data reported by generation of the reference person, together with primary program documentation for Medicare, Medicaid, the Children's Health Insurance Program (CHIP), TRICARE, Department of Veterans Affairs (VA) health care, and Affordable Care Act (ACA) Marketplace premium tax credits.

In 2024, national health expenditures reached **$5.3 trillion** ($15,474 per person), or 18.0% of GDP. Private health insurance accounted for 31% of spending, Medicare 21%, Medicaid 18%, and out-of-pocket payments 11%, with the remainder split among other public and third-party programs. By sponsor — the entity that ultimately finances the spending, as distinct from the insurer or program that pays the bill — the federal government accounted for 31%, households 28%, private businesses 18%, state and local governments 16%, and other private revenues 6%.

Payment sources vary sharply by age and, because generational cohorts occupy different points in the life cycle at any given moment, by generation as well. In 2024, adults 65 and older — the Silent Generation and most Baby Boomers, who by 2026 are aged 62–80 and therefore mostly already Medicare-eligible — had near-universal health insurance coverage, with Medicare as the dominant coverage source. Working-age adults, predominantly Millennials and Generation X, relied primarily on employer-sponsored insurance. Children and young adults, mostly Generation Z, drew on a mix of parental employer coverage, Medicaid, and CHIP. BLS Consumer Expenditure Survey data show average annual household health care spending rising steadily with the age of the generational cohort: $2,297 for Generation Z households, $5,092 for Millennial households, $6,531 for Generation X households, $7,496 for Baby Boomer households, and $8,001 for households headed by someone born in 1945 or earlier, in 2024.

This report distinguishes two different kinds of generational difference that are often conflated in public discussion. A lifecycle effect is a difference driven by age itself — for example, that people who are currently older spend more on health care because older age brings higher utilization, not because of when they were born. A cohort effect is a difference tied to the particular historical and policy conditions a generation encountered — for example, that a generation which entered the workforce after the Affordable Care Act's 2014 coverage expansions encountered a different insurance landscape at age 25 than a generation that turned 25 before 1965. Cross-sectional statistics comparing generations today capture both effects at once; this report flags where that ambiguity applies and, in Section 6, presents an initial historical comparison at matched ages that holds age approximately constant — though, as Section 6 explains, this does not by itself isolate a pure cohort effect from other changes that occurred over the same calendar time. Fully separating the two would require individual-level longitudinal or historical microdata this report has not assembled; that remains a priority for future research (Section 14).

Section 6 goes further than a purely cross-sectional snapshot: it uses BLS age-band data published continuously since 1984 to compare repeated cross-sections of households at matched ages rather than at generations' current, different ages. That comparison finds that real (inflation-adjusted) household health care spending at a given age has been higher for each successive generation observed — for example, households aged 35–44 spent an estimated $3,307 in 2024 dollars when Baby Boomers occupied that age band (1995) versus $4,027 when Generation X did (2012), a 22% real increase at the same age. Because age is held approximately constant, age alone cannot explain this difference. However, the comparison cannot distinguish a true birth-cohort effect from other changes that occurred over the same calendar span and affected everyone at that age — medical technology,

insurance design, health care prices, and the broader economy among them — so this report describes the finding as a historical pattern at matched ages, not as proof of a "genuine cohort effect" in the technical sense.

Government programs finance a growing share of the total. Medicare and Medicaid alone accounted for 39% of national health spending in 2024, and the federal government's sponsor share is projected by CMS to rise from 31% in 2024 to 33% by 2034, driven substantially by the continued aging of the Baby Boom generation into Medicare eligibility. A significant near-term development is documented in Section 9: enhanced ACA Marketplace premium tax credits, in place since 2021, expired at the end of 2025, and CMS and Kaiser Family Foundation (KFF) tracking indicates a sharp decline in Marketplace enrollment and a rise in average premium payments and deductibles for 2026 — a change concentrated among working-age adults, the cohort most reliant on Marketplace coverage.

This report is descriptive. It does not evaluate whether current financing arrangements are adequate, fair, or sustainable, and it does not recommend policy changes. It documents what the data show about who pays, through what mechanism, and how that has changed — as a foundation for readers, policymakers, and OCG's separate organizing and advocacy work to draw their own conclusions.

1. Introduction and Scope

This white paper examines how Americans finance health care, with particular attention to differences across generational cohorts and to how financing patterns have changed over time. It covers the major sources of funds — private health insurance (employer-sponsored and individually purchased), Medicare, Medicaid, out-of-pocket payment, and other public and third-party programs — and the major federal programs that finance care, including Medicare, Medicaid, CHIP, TRICARE, VA health care, and ACA Marketplace premium tax credits.

Official federal statistics on health spending and insurance coverage are compiled primarily by age group rather than by named generation. This report maps standard federal age bands onto fixed birth-year generational cohorts (defined in Section 2) wherever an official source publishes data specifically by generation — as BLS does in its Consumer Expenditure Survey — and otherwise presents the underlying age-group data directly, with the corresponding generational cohorts identified for context. Where this report characterizes a data point as generational rather than merely age-based, that data point comes from a source that itself tabulates by generation of reference person or equivalent; **this report does not independently reallocate age-banded totals into generational totals.**

A central methodological distinction runs through this report: the difference between a lifecycle effect (a pattern driven by age itself, which every generation will eventually experience) and a cohort effect (a pattern tied to the specific historical and policy circumstances a generation encountered). Cross-sectional data — a snapshot of all generations today — cannot, by itself, separate these two effects. Section 6 presents an initial historical comparison at matched ages using repeated cross-sections, which holds age constant but cannot on its own isolate a cohort effect from other changes over calendar time; Section 12 discusses this distinction and its limits in more detail.

This report is descriptive, consistent with OCG Research Center editorial standards. It does not rate, endorse, or oppose any policy, program, or official, and it does not offer policy recommendations. It also does not attempt a comprehensive census of every mechanism by which any individual American pays for health care — for example, medical debt, crowdfunding, direct primary care membership fees, and health care sharing ministries are outside the scope of the primary federal data sources this report relies on, and are addressed in part in Section 11 and noted as a priority for further research in Section 14.

2. Definitions and Cohort Framework

2.1 Generational Cohorts

This report uses the following fixed birth-year cohort definitions, consistent with the U.S. Bureau of Labor Statistics' Consumer Expenditure Survey generational tables and with common federal and demographic usage:

Cohort	Birth Years	Approx. Age in 2026	BLS CE Series (2024)
Silent Generation and earlier	1945 or earlier	81 and older	CXUHEALTHLB1609M
Baby Boomers	1946–1964	62–80	CXUHEALTHLB1604M
Generation X	1965–1980	46–61	CXUHEALTHLB1603M
Millennials	1981–1996	30–45	CXUHEALTHLB1608M
Generation Z	1997–2012 (2024 data covers the adult/near-adult portion of this cohort as reference persons)	14–29	CXUHEALTHLB1607M

Table 1. Generational cohort definitions used in this report, with corresponding BLS Consumer Expenditure Survey "generation of reference person" series identifiers for 2024 healthcare expenditure data. Source: U.S. Bureau of Labor Statistics, Consumer Expenditure Surveys, retrieved via FRED, Federal Reserve Bank of St. Louis.

Generation Alpha (born 2013 or later) is not treated as a separate analytical cohort in this report. Where this report's sources include children of Generation Alpha, they generally appear within the "0–18" or "under 19" age bands used by CMS and the Census Bureau, alongside the youngest members of Generation Z.

2.2 Key Terms

- **Source of funds.** In CMS National Health Expenditure Accounts terminology, the entity that pays the health care provider or supplier — for example, a private insurer, Medicare, Medicaid, or the patient directly (out-of-pocket). This is the answer to "who writes the check to the doctor or hospital?"
- **Sponsor.** The entity that ultimately finances the spending, as distinct from the entity that pays the provider. For example, an employer-sponsored insurance claim is paid by a private insurer (source of funds) but financed jointly by the household (through premium contributions and forgone wages) and the private business (through its premium contribution) — the sponsors. CMS publishes both breakdowns separately; this report presents both. This accounting classification is distinct from the separate economic question of incidence — economists generally treat employer health-benefit costs as part of total compensation, meaning some or much of the employer's nominal contribution may, over time, be borne by employees through lower cash wages than they would otherwise receive. CMS's sponsor accounting does not resolve that incidence question, and this report does not attempt to.
- **Lifecycle effect.** A pattern in health care financing or spending driven by age itself, which every generation experiences in turn as it ages — for example, rising per-person spending after age 65 regardless of birth year.
- **Cohort effect.** A pattern tied to the specific historical, economic, or policy conditions a generation encountered at a given life stage — for example, a generation that turned 26 after the ACA's 2010 dependent-coverage provision took effect had a different option set than one that turned 26 before it.
- **Age-period-cohort problem.** A well-known identification problem in social statistics: any observed difference between generations at a given age reflects some combination of age itself, the specific calendar

period observed (which brings its own prices, technology, and policy environment), and the birth cohort's distinct characteristics — and these three components cannot be fully separated using aggregate, repeated cross-sectional data of the kind this report relies on in Section 6. Individual-level longitudinal data, tracking the same people over time, is generally required to separate the three more rigorously.

- **Same age, different generation.** An analytical approach that compares different generations' financing patterns at the same point in the life cycle (for example, Baby Boomers at age 35 versus Millennials at age 35) rather than comparing all generations at their current, different ages. Section 6 applies an initial version of this approach using repeated cross-sections of BLS age-band data — a historical matched-age comparison that holds age approximately constant but, per the age-period-cohort problem above, cannot fully isolate a cohort effect from period effects. A more complete version using individual-level longitudinal or historical microdata remains a priority for future research (Section 14).
- **Personal health care (PHC) spending.** The CMS NHE subcategory measuring spending on medical goods and services delivered to individuals; it excludes government public health activity, program administration, the net cost of health insurance, and investment in structures, equipment, and research, and is the basis for CMS's spending-by-age tables in Section 7.

3. The National Financing Landscape

3.1 Total Spending, 2024

According to CMS National Health Expenditure Accounts, U.S. health care spending reached $5.3 trillion in 2024 ($15,474 per person), growing 7.2% from 2023 and accounting for 18.0% of GDP, up from 17.7% in 2023. Spending growth outpaced GDP growth (5.3%) for the second consecutive year — the strongest two-year stretch of spending growth since 1991–92. CMS attributes the growth substantially to increased utilization and intensity of care rather than to price growth alone.

3.2 Who Pays: Sources of Funds

CMS reports the following distribution of 2024 national health expenditures by source of funds:

Source of Funds	2024 Level	Share of NHE	Growth vs. 2023
Private health insurance	$1,644.6 billion	31%	+8.8%
Medicare	$1,118.0 billion	21%	+7.8%
Medicaid (federal + state/local)	$931.7 billion	18%	+6.6%
Out-of-pocket	$556.6 billion	11%	+5.9%
Other third-party payers and programs	—	8%	—
VA, DoD (TRICARE), and CHIP	≈ $199 billion (component estimate)	4%	—
Government public health activities	—	3%	—
Investment (structures, equipment, research)	—	5%	—

Table 2. National health expenditures by source of funds, 2024, using CMS's full "Nation's Health Dollar: Where It Came From" breakdown rather than the abbreviated five-category summary. "Other third-party payers and programs" includes worksite health care, other private revenues, the Indian Health Service, workers' compensation medical benefits, general assistance, maternal and child health, vocational rehabilitation, and other federal, state, and local programs; it is reported by CMS as a distinct 8% category, separate from the 4% VA/DoD/CHIP category, government public health activities (3%), and investment (5%). The VA/DoD/CHIP dollar estimate is this report's own calculation (VA $117.6 billion + DoD/TRICARE $50.0 billion + CHIP $31.0 billion ≈ $198.6 billion, consistent with CMS's reported 4% share of $5.3 trillion), not a CMS-published dollar total for this exact grouping. Figures do not sum to precisely 100% due to CMS rounding conventions. Sources: CMS Office of the Actuary, NHE Fact Sheet, Historical NHE 2024; CMS, "The Nation's Health Dollar (2024): Where It Came From"; Bryan and Rosso, "In Focus: U.S. Health Care Coverage and Spending," Congressional Research Service, CRS IF10830 (VA/DoD/CHIP component amounts).

Medicare and Medicaid together financed 39% of national health spending in 2024. Including CHIP, VA, TRICARE, and the other public programs captured above, the combined direct public-program share is higher still. The categories in CMS's abbreviated "health dollar" presentation do not cleanly map onto a single public-program total, and this report accordingly reports the components separately rather than constructing a derived aggregate that mixes program and sponsor concepts. Section 8.5 discusses an alternative, sponsor-based government total. Section 8 describes each major public program individually.

3.3 Who Ultimately Finances Care: Sponsors

CMS separately reports spending by sponsor — the entity that ultimately finances the spending, which for private health insurance differs from the insurer that pays the claim. In 2024:

Sponsor	2024 Share	Approx. 2024 Spending
Federal government	31%	$1.7 trillion
Households	28%	$1.5 trillion
Private business	18%	≈ $954 billion (calculated)
State and local government	16%	≈ $848 billion (calculated)
Other private revenues	6%	≈ $318 billion (calculated)

Table 3. National health expenditures by sponsor, 2024. The federal ($1.7 trillion) and household ($1.5 trillion) figures are reported directly by CMS as cited in Health Affairs; the private business, state/local, and other private revenue dollar figures are not separately published by CMS in these terms and are instead calculated by applying the reported percentage share to total 2024 NHE of $5.3 trillion, marked accordingly. Source: CMS Office of the Actuary, as reported in Martin et al., "National Health Care Spending Increased 7.2 Percent In 2024," Health Affairs (2025); NHE Fact Sheet, Historical NHE 2024.

The federal government is the single largest sponsor of U.S. health spending, a position it has held for the recent past. Its share includes the federal portion of Medicaid, federal Medicare spending, and the federal government's contribution to health coverage for its own employees. CMS projects the federal sponsor share will rise from 31% in 2024 to 33% by 2034, driven in substantial part by continued Baby Boomer aging into Medicare eligibility and by projected Medicaid spending growth.

3.4 The Long-Term Shift Since 1960

Before the creation of Medicare and Medicaid in 1965, a large share of health care for the elderly and for prescription drugs nationally was paid directly out of pocket, and hospital insurance coverage was far less prevalent than today. The introduction of the two major public programs, combined with the postwar expansion of employer-sponsored private insurance, sharply reduced the out-of-pocket share of national health spending and increased the role of third-party payment. Health System Tracker analysis of CMS data shows private insurance's share of national health spending rising from 20.4% in 1970 to 31.2% today, while per-capita total health spending rose from $353 in 1970 to $15,474 in 2024 in nominal dollars.

Out-of-pocket spending, which historically bore most of the risk of catastrophic medical cost for the elderly, fell from a majority of health spending before 1965 to 11% of national health expenditures in 2024, and is projected by CMS to continue declining as a share (to roughly 9% by 2033) even as the dollar amount continues to rise. This decline in the out-of-pocket share and corresponding rise in third-party (private insurance and public program) payment is among the largest structural changes in American health care financing of the postwar era, and it is the backdrop against which every generational cohort in this report has experienced the health care system differently depending on when it was born.

4. Coverage by Age and Generational Cohort, 2024

The Census Bureau's Current Population Survey Annual Social and Economic Supplement (CPS ASEC) estimates that 92.0% of the U.S. population had health insurance for some or all of 2024, with private coverage (66.1%) more prevalent than public coverage (35.5%) nationally, though the two are not mutually exclusive; many people, particularly Medicare beneficiaries with supplemental private coverage, have both. The Health Affairs NHE reconciliation separately reports the insured share, on a related but not identical concept, at 91.8% in 2024, down from a peak of 92.5% in 2023. The American Community Survey (ACS), a larger but methodologically distinct survey with a different reference period and questionnaire design, put the uninsured rate at 8.2% in 2024, up from 7.9% in 2023 — the first year-over-year increase in the ACS series since the ACA's major coverage expansions took effect. This report treats CPS ASEC as its primary series for the age-specific breakdowns below and notes ACS or NHIS figures separately where they are used, rather than blending the two into a single range.

Children and Adolescents (predominantly Generation Alpha and the Youngest Generation Z)

Children under 19 had a private coverage rate of 63.0% and an uninsured rate of roughly 5–6% in 2024 (estimates vary modestly by survey; CPS ASEC and NHIS both place child uninsurance in this range, while ACS estimates ran somewhat higher). Medicaid and CHIP are the dominant public coverage sources for children in lower-income households; parental employer-sponsored insurance covers most privately insured children. Since ACA implementation, young adults may also remain on a parent's plan through age 25 — a provision that, during this report's 2024–2026 period, is most directly relevant to Generation Z (aged roughly 14–29 in 2026) as it ages through young adulthood, rather than to Millennials, who by 2026 are aged roughly 30–45 and past the dependent-coverage age threshold.

Working-Age Adults (Millennials and Generation X)

Adults aged 19–64 had a private coverage rate of 74.0% and a public coverage rate of 17.9% in 2024 (CPS ASEC), with an uninsured rate of 11.0%–11.6% depending on survey. Employment-based coverage is the largest coverage subtype within this age group. The uninsured rate is not uniform within this band: adults aged 19–25 had the highest uninsured rate of any age group measured (14.3% in 2024), while adults 45–64 had the lowest working-age uninsured rate (8.8%). This report's Generation Z cohort spans the 19–25 highest-uninsured-rate range as it enters adulthood, while older Generation X and the oldest Millennials fall within the lower-uninsured 45–64 range.

Adults 65 and Older (Silent Generation and Most Baby Boomers)

Adults 65 and older had a private coverage rate of 44.3% (primarily Medicare Advantage, Medigap, and retiree supplemental coverage layered atop Medicare) and combined with Medicare, near-universal health insurance coverage overall — the Census Bureau describes 65-and-older coverage as “near universal” — with Medicare as the dominant coverage source. Medicare enrollment reached 66.6 million beneficiaries nationally in 2024 and continues to grow as the remainder of the Baby Boom generation ages into eligibility. Because Baby Boomers are born 1946–1964, most of the generation — not merely its oldest members — is already 65 or older by 2026 (Boomers are aged 62–80 in 2026); the youngest Boomers, born 1964, turn 65 in 2029, at which point the entire generation will have aged into Medicare eligibility.

Age Group (2024)	Private Coverage	Uninsured	Predominant Cohort(s)
Under 19	63.0%	~5–6%	Generation Alpha / youngest Generation Z
19–25	—	14.3% (highest of any age band)	Generation Z

Age Group (2024)	Private Coverage	Uninsured	Predominant Cohort(s)
19–64 (all)	74.0%	11.0–11.6%	Millennials / Generation X
45–64	—	8.8% (lowest working-age rate)	Generation X / older Millennials
65 and older	44.3% (supplemental, atop Medicare)	~1.0% (near-universal via Medicare)	Silent Generation / Baby Boomers

Table 4. Health insurance coverage rates by age group, 2024. Uninsured-rate estimates differ modestly across the Census Bureau's CPS ASEC, ACS, and the CDC's National Health Interview Survey due to differing survey methodologies and reference periods; this report presents the CPS ASEC figures as the primary series, with ranges noted where surveys diverge. Sources: U.S. Census Bureau, Health Insurance Coverage in the United States: 2024 (CPS ASEC); U.S. Census Bureau, American Community Survey Briefs, 2024; CDC/NCHS, National Health Interview Survey Early Release, 2024.

5. Household Health Care Spending by Generation

The BLS Consumer Expenditure Survey (CE) publishes average annual household health care expenditures directly by "generation of reference person," making it the most direct generational (rather than age-banded) data source available for this report. The reference person is the household member identified first when a survey respondent is asked to name the person who owns or rents the home; a household's generational classification follows that person's birth year, not every member's.

In 2024, average annual household health care spending rose steadily by generation, from youngest to oldest:

Generation	2024 Avg. Annual Household Health Care Spending	Change from 2020
Generation Z (b. 1997+)	$2,297	+101.7% (from $1,139)
Millennials (b. 1981–1996)	$5,092	+42.6% (from $3,570)
Generation X (b. 1965–1980)	$6,531	+25.2% (from $5,217)
Baby Boomers (b. 1946–1964)	$7,496	+21.2% (from $6,187)
Silent Generation and earlier (b. 1945 or earlier)	$8,001	+20.6% (from $6,634)

Table 5. Average annual household health care expenditures by generation of reference person, 2024, with percentage change since 2020. "Health care" in the BLS CE definition includes health insurance premiums, medical services, prescription drugs, and medical supplies paid by the consumer unit; it does not include the employer-paid share of employer-sponsored premiums. Source: U.S. Bureau of Labor Statistics, Consumer Expenditure Surveys, "Expenditures: Healthcare by Generation" series (CXUHEALTHLB1607M, CXUHEALTHLB1608M, CXUHEALTHLB1603M, CXUHEALTHLB1604M, CXUHEALTHLB1609M), retrieved via FRED, Federal Reserve Bank of St. Louis.

Read this table carefully: these figures are household/consumer-unit expenditures, not the total amount of health care spending attributable to each generation. They exclude employer-paid premiums, the taxes that finance public programs, and health expenditures paid on a household's behalf by government or other third parties. A generation with a low figure in this table is not necessarily receiving less total health care resource support than one with a high figure — see the discussion following this table and Section 11.

Two patterns are notable in this table. First, the level of spending rises consistently with generational age, consistent with the well-documented lifecycle pattern of rising health care utilization with age (see Section 7) and is examined directly at matched ages in Section 6. Second, the rate of increase since 2020 is far steeper for the youngest generations than the oldest: Generation Z household health care spending more than doubled over four years, while spending for the oldest cohort rose about one-fifth. Because Generation Z households were also aging into higher-spending life stages over this same period — the same lifecycle effect that produces the cross-generational pattern in the first place — this report does not attribute the growth rate itself to a cohort-specific cause without further analysis; separating how much of Generation Z's 2020–2024 increase reflects aging within the cohort versus a genuinely different cost trajectory for this generation at a given age is a same-age, different-generation question examined directly in Section 6.

It is also useful to note what this BLS measure excludes. Because it captures only the consumer unit's own payments — premiums the household pays directly, deductibles, copayments, and out-of-pocket medical costs — it does not include the employer's share of employer-sponsored insurance premiums (material for Millennial and Generation X households, where employer-sponsored coverage predominates) or the government's share of Medicare and Medicaid financing (material for Silent Generation and Baby Boomer households). Table 5 therefore understates the total resources devoted to each generation's health care by a different amount for each cohort and should be read as a measure of direct household cash outlay rather than of total health care resources consumed or received.

6. Same Age, Different Generation: A Historical Matched-Age Comparison

Section 5 compared generations at their current, different ages in 2024 — a cross-sectional view that mixes lifecycle effects with cohort effects, as discussed in Section 2. This section instead compares generations at matched ages, using BLS Consumer Expenditure Survey data published by age of reference person continuously since 1984. Because these age-band series extend back four decades, they show what households headed by, for example, a 35-to-44-year-old actually spent on health care when that age band was mostly occupied by Baby Boomers, then by Generation X, and now by Millennials.

This comparison uses repeated cross-sections rather than individual-level longitudinal data: it does not follow the same people over time. Each figure below is BLS's observation of everyone whose reference person fell in a given age band in a given year, associated with a generation because that generation's median member was at the midpoint of the band that year — an assignment this report makes, not a BLS generational tabulation.

6.1 Method

For each of three ten-year age bands (25–34, 35–44, and 45–54), the representative year for a generation is its median birth year plus the age-band midpoint, rounded to the nearest whole year (25–34 → midpoint age 30; 35–44 → 40; 45–54 → 50). Median birth years used: Baby Boomers 1955, Generation X 1972, Millennials 1988. Where the resulting year has not yet occurred, this report substitutes the most recent available year and labels the observation partial. Nominal dollar figures are converted to 2024 dollars using the CPI-U annual average for each representative year.

General CPI-U, rather than a medical-specific price index, is used because this comparison asks how much of a household's overall purchasing power went to health care at a given age, not whether the price of an identical bundle of medical services changed; medical care prices have historically moved differently from prices generally, so a comparison using a medical price deflator would answer a different question.

A generation is included in a given age band only once its median member has reached that band's midpoint. Generation Z's median member (born approximately 2005) will not reach the midpoint of the 25–34 band until the mid-2030s, so Generation Z is not included in Table 6; only a small, non-representative share of Generation Z had entered the 25–34 age range at all as of the most recent available data, which would not support a meaningful matched-age observation for that generation using this method.

6.2 Results

Generation	Representative Year	Nominal Spending	2024 Dollars (Inflation-Adjusted)
Baby Boomers	1985	$763	$2,225
Generation X	2002	$1,417	$2,471
Millennials	2018	$3,072	$3,837

Table 6. Household health care spending at ages 25–34, in the year each generation's median member reached the midpoint of that age band, in nominal and 2024 dollars. Source: U.S. Bureau of Labor Statistics, Consumer Expenditure Surveys, "Expenditures: Healthcare by Age: from Age 25 to 34" (CXUHEALTHLB0403M), retrieved via FRED; CPI-U annual averages calculated from U.S. Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers (CPIAUCNS), retrieved via FRED.

At ages 25–34

In real (2024-dollar) terms, households aged 25–34 spent about $2,225 on health care when Baby Boomers reached the midpoint of that age band (1985), $2,471 when Generation X did (2002), and $3,837 when Millennials did (2018) — roughly 72% higher for Millennials than for Baby Boomers at the same age.

Generation	Representative Year	Nominal Spending	2024 Dollars (Inflation-Adjusted)
Baby Boomers	1995	$1,607	$3,307
Generation X	2012	$2,948	$4,027
Millennials (partial; most recent available year, not yet at band midpoint)	2024	$5,949	$5,949

Table 7. Household health care spending at ages 35–44, in the year each generation's median member reached the midpoint of that age band, in nominal and 2024 dollars. Source: as Table 6, using series CXUHEALTHLB0404M. The median Millennial (born 1988) reaches the midpoint of this band in 2028; since that year has not occurred, this report substitutes 2024, the most recent available year, as a partial, early observation.

At ages 35–44

In real terms, households aged 35–44 spent about $3,307 when Baby Boomers reached the midpoint of that band (1995) and $4,027 when Generation X did (2012) — a 22% real increase. The 2024 figure for Millennials ($5,949) is included as an early, partial data point rather than a matched-age observation, since most Millennials will not reach the midpoint of this band until the late 2020s; it is well above the Generation X figure, consistent with the upward trend across the two completed observations.

Generation	Representative Year	Nominal Spending	2024 Dollars (Inflation-Adjusted)
Baby Boomers	2005	$2,672	$4,292
Generation X	2022	$6,082	$6,514

Table 8. Household health care spending at ages 45–54, in the year each generation's median member reached the midpoint of that age band, in nominal and 2024 dollars. Source: as Table 6, using series CXUHEALTHLB0405M. Millennials have not reached this age band (the oldest Millennials, born 1981, turn 45 in 2026) and are omitted rather than estimated.

At ages 45–54

In real terms, households aged 45–54 spent about $4,292 when Baby Boomers reached the midpoint of that band (2005) and $6,514 when Generation X did (2022) — a 52% real increase.

6.3 What This Comparison Shows and Does Not Show

Across all three age bands with more than one completed generational observation, real household health care spending at a given age has been higher for each successive generation: Baby Boomers to Generation X at ages 25–34, 35–44, and 45–54, and the partial Millennial data available at 25–34 and 35–44. Because age is held approximately constant across each comparison, age alone cannot explain these differences.

What this comparison cannot do is attribute the difference specifically to birth cohort. This is the age-period-cohort problem described in Section 2: the observed difference between, say, Generation X at 45–54 in 2022 and Baby Boomers at 45–54 in 2005 reflects some combination of genuine cohort effects, period effects that would have influenced any generation occupying that age band in that particular calendar year — medical technology, insurance design, drug prices, the broader economy — and compositional or measurement differences in what the BLS survey captured each year. Repeated cross-sectional data of the kind used here cannot fully separate these components; that would generally require individual-level longitudinal data tracking the same people over time. This report accordingly describes its Section 6 finding as a historical pattern at matched ages — later generations, at comparable points in the life cycle, report higher real household health spending than earlier generations did — rather than as proof of a cohort effect in the strict technical sense.

This pattern is consistent with the well-documented rise in national per-capita health spending and employer premium growth (Section 11), which would raise the age-band figures for later generations regardless of any cohort-specific characteristic. The comparison does not extend past the 45–54 band for Generation X: the median Generation Xer (born 1972) reaches the midpoint of the 55–64 band around 2032, a year not yet reached, though individual Generation X members are already within that band's lower end today. A future revision can extend this analysis as more years of data become available, and Section 14 identifies individual-level microdata analysis as the next step toward a fuller age-period-cohort decomposition.

7. Personal Health Care Spending by Age

CMS separately publishes personal health care (PHC) spending broken out by five-year and broader age bands; the most recent full breakdown covers calendar year 2020 (CMS has not yet published an equivalent full age/payer breakdown for a more recent year):

Age Group	Share of Population	Share of PHC Spending	Per-Person Spending
0–18 (children)	23%	10%	$4,217
19–64 (working-age)	60%	53%	$9,154
65 and older	17%	37%	$22,356

Table 9. Personal health care spending by age group, 2020 (most recent full CMS age/payer breakdown available). Source: CMS Office of the Actuary, National Health Expenditure Accounts, Age and Gender Highlights, 2020.

Per-person spending for the 65-and-older population was roughly 2.4 times that of working-age adults and 5.3 times that of children in 2020 — the clearest illustration in this report's data of the lifecycle effect described in Section 2. Because the Silent Generation and older Baby Boomers occupy the 65-and-older band almost entirely, and because Generation Alpha and Generation Z occupy the under-19 band while Generation Z and Millennials occupy the younger portion of the working-age band, this age gradient substantially explains the cross-generational spending gradient shown in Table 5 in Section 5 — without this report needing to conclude that any generation's underlying health needs, as opposed to its current age, differ from any other's.

CMS's age-banded data also show that spending for people 55 and older accounts for a share of total national health spending disproportionate to their population share, a pattern consistent across the age-banded series CMS has published historically (1999, 2010, and 2020 estimates all show a similar structure, with the specific per-capita dollar figures rising over time).

8. Government Health Care Programs

Public programs are central to how Americans — especially older and lower-income Americans — pay for care. The major programs are described below, organized by the generational cohorts most affected by each, though most programs serve people across multiple generations.

8.1 Medicare

Medicare is the federal health insurance program primarily for people age 65 and older and for certain younger people with long-term disabilities or end-stage renal disease. It is the dominant coverage source for the Silent Generation and is becoming increasingly dominant for Baby Boomers as they age into eligibility. It consists of:

- **Part A (Hospital Insurance) —** financed primarily by dedicated payroll taxes; covers inpatient hospital care, limited skilled nursing facility care, home health, and hospice.
- **Part B (Medical Insurance) —** financed by general federal revenues and beneficiary premiums; covers physician services, outpatient care, and preventive services.
- **Part C (Medicare Advantage) —** private plans, paid by CMS on a capitated basis, that deliver Medicare benefits and often additional coverage. As of February 2026, more than 35 million people — 55% of Medicare beneficiaries with both Part A and Part B (the population eligible to enroll in MA) — were enrolled in Medicare Advantage plans, though year-over-year enrollment growth has slowed (3% in 2026, down from 4% in 2025 and an average of 9% annually from 2007–2024).
- **Part D (Prescription Drug Coverage) —** private plans, subsidized by federal payments, covering outpatient prescription drugs. Inflation Reduction Act provisions eliminated the coverage gap and capped Part D beneficiary out-of-pocket drug spending at $2,000 annually beginning in 2025; the cap is indexed annually and rose to $2,100 for 2026. Medicare drug-price negotiation for select high-cost drugs began affecting prices in 2026.

Medicare financing draws on multiple sponsor sources simultaneously: dedicated payroll taxes (primarily for Part A), beneficiary premiums, general federal revenues (primarily for Part B and the federal subsidy portion of Part D), and taxation of Social Security benefits for higher-income beneficiaries. A given Medicare-financed medical bill is therefore rarely traceable to a single funding source in the way a simple “government pays” description might suggest — a point developed further in Section 8.5.

8.2 Medicaid and CHIP

Medicaid is a joint federal-state program financing care for low-income individuals, including many children, pregnant women, people with disabilities, and low-income seniors (who may be dually eligible for Medicare and Medicaid). It is financed through a federal-state matching formula (the Federal Medical Assistance Percentage, or FMAP) that varies by state, with the ACA's Medicaid expansion financed at a substantially higher federal match rate (90%) in states that adopted it. Finalized CMS data show Medicaid enrollment declining from a peak of 92.2 million in 2023 to 84.3 million in 2024 (an 8.6% decline, or 7.9 million fewer enrollees) as states completed post-pandemic eligibility redeterminations, even as per-enrollee Medicaid spending rose sharply (16.6% in 2024, up from 6.5% growth in the prior year).

The Children's Health Insurance Program (CHIP), enacted in 1997, extends coverage to children in families with incomes modestly above Medicaid eligibility thresholds but below what most families can afford in the private market; it is jointly financed by federal and state governments, generally at a higher federal match rate than standard Medicaid. Medicaid and CHIP together are the dominant public coverage sources for children, a cohort composed of Generation Z's youngest members and Generation Alpha.

8.3 TRICARE, VA Health Care, and Indian Health Service

TRICARE, administered by the Department of Defense, provides health coverage to active-duty service members, military retirees, and their dependents, financed through federal appropriations. The Department of Veterans Affairs separately operates a direct health care delivery system for eligible veterans, financed through federal appropriations to the VA rather than through an insurance-claims model. The Indian Health Service (IHS), part of the Department of Health and Human Services, provides and finances health care for eligible American Indian and Alaska Native people through federal appropriations. Nationally, an estimated 9 million people (2.8% of the U.S. population) had TRICARE and 7 million (2.2%) had VA health care in 2023. CMS's National Health Expenditure Accounts group VA, DoD/TRICARE, and CHIP spending together at approximately 4% of total NHE in 2024; a Congressional Research Service compilation of the underlying appropriations puts VA health spending at roughly $117.6 billion, DoD/TRICARE at roughly $50.0 billion, and CHIP at roughly $31.0 billion (≈ $198.6 billion combined, consistent with CMS's reported share — see Table 2, Section 3.2).

No primary source consulted for this report breaks out TRICARE, VA, or IHS coverage by generational cohort specifically, since eligibility is tied to military service history or tribal enrollment rather than age or birth year. Census Bureau coverage estimates do, however, report VA and CHAMPVA coverage (combined with TRICARE in some tables) by broad age band, which offers an approximate proxy: among veterans aged 25–64 nationally, Census-based analysis for 2019–2021 found 44.6% had VA health care either alone or combined with other coverage, with 16.6% holding TRICARE and 5.3% uninsured. Roughly half of all veterans nationally are 65 or older and covered primarily through Medicare, with VA or TRICARE as supplemental coverage; the other half are working-age veterans spread across Generation X, Millennial, and Generation Z cohorts, among whom employer-sponsored insurance remains the single most common coverage type even though VA and TRICARE are also widely used. This age-band data is the closest available proxy for a generational breakdown and is offered as such rather than as a true generation-specific tabulation.

8.4 ACA Marketplace Coverage and Premium Tax Credits

The Affordable Care Act (ACA), enacted in 2010, established health insurance Marketplaces (exchanges) where individuals without employer coverage can purchase private insurance, with income-based premium tax credits (PTCs) reducing the net premium for eligible enrollees on a sliding scale. The American Rescue Plan Act (2021) temporarily enhanced these credits — increasing subsidy amounts and, for the first time, extending eligibility above the ACA's original 400% of the federal poverty level income cap — and the Inflation Reduction Act (2022) extended the enhancement through the end of 2025. These enhancements are widely credited with driving ACA Marketplace enrollment to record highs — 21.1 million people enrolled through Marketplace direct-purchase plans in 2024, according to CMS's national health expenditure accounting, up from 16.2 million in 2023 and 9.8 million in 2019 — and with contributing to historically low national uninsured rates in 2023–2024.

The enhanced premium tax credits expired on January 1, 2026, without congressional extension. Marketplace coverage is used disproportionately by working-age adults without access to employer-sponsored insurance — a population concentrated among Millennials, Generation X, and the oldest Generation Z adults, since Marketplace enrollees are, by definition, under 65 and therefore not yet Medicare-eligible. Section 9 documents the observed effects of this expiration through mid-2026 in detail, as they represent the most significant 2025–2026 development bearing on how working-age generations finance individual-market health coverage.

8.5 Government Pays — But Government Is Also Financed

Sections 3.2 and 3.3 and the program descriptions above describe Medicare, Medicaid, CHIP, VA, TRICARE, and ACA subsidies as government-financed, using CMS's own source-of-funds and sponsor accounting. That accounting identifies the immediate financing sector correctly, but it stops at the point money enters a public program; it does not trace how the government itself raises the money it spends on health care. A reader could

reasonably come away from the sponsor breakdown in Table 3 thinking of "government" and "households" as two separate, independent payers. As an accounting matter, government health spending is itself financed through taxes imposed on households and businesses and through borrowing that creates future financing obligations, via several channels this report has not attempted to model or size:

- Dedicated Medicare payroll taxes (currently 2.9% of covered wages, split between employee and employer, financing Part A) are paid by working-age households throughout their careers, well before most of them draw Medicare benefits.
- Federal income taxes finance the general-revenue portion of Medicare Part B and Part D, ACA premium tax credits, and the federal share of Medicaid.
- State and local taxes finance the state share of Medicaid and CHIP under each program's federal matching formula.
- Social Security benefits are themselves subject to federal income tax for higher-income beneficiaries, a mechanism that indirectly returns some Social Security income to the federal government, part of which finances Medicare.
- Federal borrowing (deficit financing) covers part of federal health spending in any given year, deferring the tax cost to future taxpayers rather than eliminating it.
- The federal tax exclusion for employer-sponsored insurance — employees do not pay income or payroll tax on the value of employer health benefits — is a large federal tax expenditure subsidizing employer-sponsored coverage. A tax expenditure is not the same thing as an NHE government expenditure: it does not appear as "government spending" in the NHE sponsor tables, since CMS's accounting classifies the underlying premium as privately sponsored, even though the tax treatment itself is a public policy choice with a real fiscal cost.

This report does not attempt a full tax-incidence model of American health care financing — that would require assumptions about who ultimately bears payroll taxes, corporate taxes, and deficit financing that go beyond what CMS's descriptive accounting provides. The point of this subsection is narrower: CMS's sponsor accounting identifies the immediate financing sector, not the ultimate economic incidence of the taxes, wages, or borrowing that finance government health programs. Readers should not treat "government pays" as meaning government is a source of resources independent of the households and businesses that finance it through taxation or borrowing. CMS's own sponsor categories, read together, describe federal and state/local government as financing 47% of national health spending in 2024 (31% federal plus 16% state/local) — a figure meaningfully different from, and not to be confused with, the source-of-funds shares for specific public programs like Medicare and Medicaid discussed in Section 3.2.

9. Recent Developments, 2025–2026

Several developments since 2025 bear directly on how different generational cohorts finance health care and are documented here because they postdate the annual federal data series discussed in Sections 3–6.

Expiration of enhanced ACA premium tax credits

As described in Section 8.4, enhanced ACA Marketplace premium tax credits expired at the end of 2025. Federal data released in late June 2026 show observed effectuated (premium-paid) Marketplace enrollment falling 13%, from a 2025 high of roughly 22.1–22.3 million people to 19.2 million people in February 2026 — a decline KFF characterizes as the first drop in ACA Marketplace enrollment since the first Trump administration. KFF's earlier-year projections had anticipated further attrition to an average of roughly 16.5–17.5 million effectuated enrollees by the end of 2026 as the year progresses; this report leads with the observed February 2026 figure as the more current data point and presents the fuller-year projection as a projection, not an observed outcome.

On premiums, this report distinguishes two different figures that are easy to conflate. KFF's widely cited 114% estimate is a counterfactual projection of how much more a subsidized enrollee's net premium payment would rise, on average, if that enrollee kept the exact same plan without the enhanced credits — from $888 in 2025 to $1,904 in 2026. The actual, observed change in what 2026 Marketplace consumers paid, across all enrollees and reflecting plan-switching and the disproportionate exit of higher-cost enrollees from the market, was smaller: average net monthly premiums rose from $113 to $178, a 58% increase, according to CMS data summarized by AJMC. Both figures are accurate descriptions of different things — the projected same-plan increase for people who stayed in place, and the observed average across a market that also lost enrollees and shifted plan mix — and this report reports both rather than treating either alone as "the" premium change. A separate KFF/Peterson-KFF Health System Tracker analysis found average Marketplace deductibles rising from $2,759 in 2025 to $3,786 in 2026 (+37%), driven substantially by enrollees shifting toward lower-premium, higher-deductible bronze plans to manage the higher net premium cost.

Medicare Advantage enrollment growth continues, at a slower pace

Medicare Advantage enrollment reached more than 35 million beneficiaries by February 2026, continuing two decades of growth, though KFF's analysis of 2026 CMS data found the growth rate slowing to 3%, down from 4% in 2025 and well below the 9% average annual growth rate from 2007–2024. Growth in 2026 was concentrated in special-needs plans (which serve beneficiaries with specific chronic conditions or dual Medicare-Medicaid eligibility), while individual Medicare Advantage plan growth was modest and employer-group Medicare Advantage enrollment declined slightly.

Continued Medicaid enrollment decline following pandemic-era unwinding

Medicaid enrollment continued to decline in 2024 and into 2025 as states completed post-pandemic eligibility redeterminations that had been paused during the COVID-19 public health emergency, even as per-enrollee Medicaid spending rose sharply. This report's sources do not provide a generational breakdown of who left Medicaid coverage during this period; it is noted here as a documented recent trend rather than characterized by cohort.

10. A Half-Century of Structural Change, 1965–2026

The following timeline identifies major federal actions that changed how Americans finance health care, selected for their direct bearing on the financing mechanisms discussed in this report. Each generation in this report's cohort framework encountered a different configuration of these mechanisms at each stage of its own life course — the central premise underlying this report's distinction between lifecycle and cohort effects (Section 2).

- 1965 — Medicare and Medicaid enacted, establishing the first major federal health financing programs for the elderly and for low-income Americans, respectively.
- 1970s–1980s — Employer-sponsored health insurance and managed care expand substantially as the dominant private financing mechanism for working-age Americans.
- 1986 — COBRA enacted, requiring many employers to offer continued (though unsubsidized) group health coverage to employees who lose or leave a job.
- 1997 — CHIP enacted, extending public coverage to children in families with incomes above Medicaid eligibility but below typical private-market affordability.
- 2003 / 2006 — Medicare Modernization Act enacted (2003), creating Medicare Part D prescription drug coverage (effective 2006) and strengthening financial incentives for Medicare Advantage plan participation.
- 2010 / 2014 — Affordable Care Act enacted (2010); major coverage provisions — Marketplace exchanges, premium tax credits, Medicaid expansion, and the dependent-coverage-to-age-26 provision — take effect (2014, with dependent coverage effective 2010).
- 2020–2023 — COVID-19 pandemic-era Medicaid continuous enrollment protections and extraordinary federal public health spending, followed by the post-emergency “unwinding” and resumption of Medicaid eligibility redeterminations.
- 2021–2022 — American Rescue Plan Act enhances ACA premium tax credits (2021); Inflation Reduction Act extends the enhancement through 2025 and phases in Medicare Part D out-of-pocket caps and drug-price negotiation authority (2022).
- 2025–2026 — Enhanced ACA premium tax credits expire (January 1, 2026); Medicare Part D's annual out-of-pocket cap takes effect at $2,000 (2025), indexed to $2,100 (2026); Medicare drug-price negotiation begins affecting select drugs (2026); post-pandemic Medicaid eligibility redeterminations continue.

A Baby Boomer born in 1950 turned 26 in 1976, well before COBRA, CHIP, or the ACA existed, and turned 65 in 2015, after Medicare Part D and ACA implementation. A Millennial born in 1990 turned 26 in 2016, after the ACA's dependent-coverage and Marketplace provisions were fully in effect and will not turn 65 until 2055. Each generation in this report's framework has therefore encountered a materially different sequence of financing mechanisms at each life stage — the empirical basis for treating cohort effects as distinct from lifecycle effects rather than assuming today's older generations simply “had it easier” or “had it harder” than younger ones at a comparable age.

11. Household Financial Exposure: Employer Premiums and Medical Debt

This section addresses two components of household health care financing not captured in the BLS Consumer Expenditure Survey figures used elsewhere in this report: the employer's share of employer-sponsored insurance premiums, which BLS household spending data excludes because it is not paid directly by the household, and medical debt, which is a stock (accumulated unpaid balance) rather than a flow (annual spending) and therefore does not appear in either the BLS or CMS series used in Sections 3–6.

11.1 Employer and Worker Premium Contributions Over Time

The KFF Employer Health Benefits Survey has tracked employer-sponsored insurance premiums and the worker/employer split of those premiums annually since 1999. Three data points from this series illustrate the trend across the period spanned by this report's generational cohorts:

Year	Average Family Premium	Average Worker Contribution (Family)	Worker Share
1999	$5,791	$1,254	≈ 22%
2010	$13,770	~$3,997 (30% share applied to total)	30%
2025	$26,993	$6,850	26%

Table 10. Average annual employer-sponsored family health insurance premiums and worker contribution share, selected years. The 2010 and 2025 figures are from the KFF/HRET Employer Health Benefits Survey series. The 1999 worker-contribution figure is drawn from a different federal survey, the Agency for Healthcare Research and Quality's 1999 Medical Expenditure Panel Survey — Insurance Component (MEPS-IC), which reports average employee contributions per enrolled employee for family coverage directly rather than requiring derivation from aggregate totals. Because MEPS-IC and the KFF/HRET series use different samples and definitions, the 1999 figure is not perfectly continuous with the 2010 and 2025 figures and should be read as indicating the general order of magnitude for that year. Sources: AHRQ, 1999 MEPS-IC, Table V.D.2(c), Average Total Employee Contribution for Family Coverage, United States (1999); Kaiser Family Foundation (KFF)/Health Research & Educational Trust, Employer Health Benefits Survey, 2010 and 2025 annual reports.

The worker's share of the family premium was roughly 22% in 1999, rose to 30% in 2010, and settled back to 26% in 2025, while the dollar amount workers contribute has risen substantially over the period — from roughly $1,250 in 1999 to $6,850 in 2025, well above general inflation over the same span. Because employer-sponsored insurance is the dominant coverage source for working-age adults (Section 4), this trend is directly relevant to how Generation X and Millennials have financed care over their careers, even though it does not appear in the household-only spending figures in Sections 5 and 6: a Millennial household's BLS-reported health care spending reflects only its own premium contribution, not the substantially larger employer contribution paid on the household's behalf, which has also grown over this period.

11.2 Medical Debt by Age

KFF's analysis of the Census Bureau's Survey of Income and Program Participation (SIPP) provides the most direct available breakdown of medical debt by age:

Age Group	Share Reporting Significant Medical Debt	Predominant Cohort
35–49	11%	Millennials / Generation X
50–64	12% (highest of any age group)	Generation X / Baby Boomers
65–79	6%	Baby Boomers / Silent Generation

Table 11. Share of adults reporting significant medical debt (generally defined as over $250 in unpaid medical bills), by age group. Source: KFF, "1 in 10 Adults Owe Medical Debt, With Millions Owing More Than $10,000," 2025, analysis of U.S. Census Bureau Survey of Income and Program Participation (SIPP) data.

Medical debt is highest among adults aged 50–64 and lowest among adults 65 and older, a pattern KFF attributes to Medicare eligibility beginning at 65, which reduces (though does not eliminate) the risk of high out-of-pocket medical costs. This pattern is consistent with the years immediately before Medicare eligibility being a period of comparatively high household financial exposure to health care costs, spanning the late-career years of Generation X and the pre-Medicare years of Baby Boomers, more than it is a distinctly generational pattern; KFF's data are cross-sectional (a single point in time across ages) rather than longitudinal, so whether the 50–64 age band will carry the same elevated medical-debt risk for Millennials once that generation reaches those ages remains to be seen.

12. Interpretive Considerations

- **Cross-sectional data cannot, by itself, separate cohort effects from lifecycle effects, and repeated cross-sections (Section 6) only partly close that gap.** Every table in this report showing spending or coverage "by generation" in a single year (2024, in most cases) reflects each generation's current age as well as any generation-specific circumstance. Section 6 goes further by comparing generations at matched ages using BLS age-band data — an initial, aggregate historical comparison — but as explained there, this method cannot fully separate a true cohort effect from period effects that influenced everyone alive during a given calendar year, or from compositional differences in who the BLS survey captured in each year. A more complete separation would require individual-level longitudinal or historical microdata this report has not assembled (Section 14). This report accordingly presents its Section 6 findings as a historical pattern at matched ages, not as a settled account of a generational cohort effect in the strict sense.
- **The age gradient in spending is well established; its precise magnitude by data source varies.** BLS Consumer Expenditure Survey data (Table 5), CMS personal health care spending data (Table 9), and Census coverage data (Table 4) all show the same directional pattern — rising public-program reliance and rising spending with age — using different methodologies, populations, and spending definitions. This report treats the consistent direction of the pattern across independent sources as more reliable than any single source's precise magnitude and has flagged where a figure (such as the 2020 CMS age-banded breakdown in Table 9) is not the most recent year available.
- **Medicare's financing mechanism is not a single, uniform "government pays" transfer, and "government" itself is financed by households and businesses.** As described in Section 8.1, Medicare draws simultaneously on payroll taxes, beneficiary premiums, general federal revenues, and taxation of Social Security benefits. Treating Medicare-financed care as a single undifferentiated "government benefit" obscures that current beneficiaries, including many in the Silent Generation and Baby Boomer cohorts, have also paid into the system's payroll-tax financing over their own working lives, and that working-age cohorts today are simultaneously financing current beneficiaries' Part A benefits through their own payroll taxes. More broadly, as Section 8.5 discusses, CMS's sponsor accounting identifies the immediate financing sector for health spending but not the ultimate economic incidence of the taxes, forgone wages, and borrowing that finance government health programs; this report does not treat "government" and "households" as fully independent payers.
- **This report's cohort comparisons are not lifetime net-contribution or net-benefit calculations.** A full accounting of whether any generation is a net contributor to or net beneficiary of American health care financing over its full lifetime — weighing lifetime taxes paid against lifetime benefits received — is a substantially more demanding analytical undertaking than this report attempts, requiring actuarial-style lifetime projections this report's primary sources do not provide. This report describes financing patterns at points in time; it does not calculate or claim any generation's net lifetime position.

13. Limitations and What This Report Does Not Claim

- **Not a comprehensive census of every financing mechanism.** This report covers the major sources identified in CMS, Census, and BLS federal statistics. It does not cover medical debt, health care crowdfunding, direct primary care membership fees, health care sharing ministries, or employer self-insurance plan design in detail; these are addressed in part in Section 11 and remain a priority for further research in Section 14.
- **Cross-sectional, not longitudinal, for most comparisons.** As discussed in Section 12, most of this report's generational comparisons reflect a single point in time (generally 2024) and cannot, without further same-age, different-generation analysis, separate how much of any cross-generational difference is attributable to current age versus to the generation's distinct historical experience.
- **Descriptive, not evaluative.** This report does not rate, grade, or conclude whether current financing arrangements are adequate, equitable, or sustainable for any generation, and does not offer or imply policy recommendations. It documents what the data show, not what OCG believes should be done about it.
- **Data vintages differ by source.** NHE totals, Census coverage estimates, and BLS CE generational data are all current through calendar year 2024, the most recent year for which each series has been fully published; CMS's full age-banded personal health care spending breakdown (Table 9) is current only through 2020, the most recent year for which CMS has published that specific breakdown. This report flags each figure's vintage individually rather than presenting all data as equally current.
- **Government program totals are not summed into a single headline figure.** Consistent with OCG Research Center editorial standards, this report does not add Medicare, Medicaid, CHIP, VA, TRICARE, and ACA subsidy spending together into a single "total government health spending" figure, because the underlying CMS categories use different accounting conventions (source of funds versus sponsor) that would double-count or omit components if combined without a documented, source-consistent methodology. Section 3.2 presents each source-of-funds component separately for this reason.
- **TRICARE, VA, and IHS are approximated by age band, not broken out by generation.** No primary source consulted for this report tabulates TRICARE, VA health care, or Indian Health Service spending or enrollment by generational cohort. Section 8.3 reports the closest available proxy — Census Bureau coverage estimates by broad age band for veterans — but this remains an approximation rather than a true generation-specific tabulation, and IHS in particular is not broken out by age or generation in any source this report consulted.

14. Future Research

- Extend the same-age, different-generation comparison begun in Section 6 (Section 2 defines the method) to additional age bands (55–64, 65 and older) as Generation X and Millennials age into them, and to Medical Expenditure Panel Survey (MEPS) or Census microdata for a fuller matched-age comparison than the BLS age-band series alone can provide.
- Obtain or construct a current (post-2020) CMS-equivalent personal health care spending breakdown by five-year age band, to update Table 9 with more recent data than the 2020 estimates currently available.
- Incorporate Federal Reserve Survey of Consumer Finances (SCF) data on medical debt balances specifically by generation rather than by age alone, to extend the age-based medical-debt findings in Section 11.2 into a true generational comparison.
- Analyze KFF Employer Health Benefits Survey longitudinal data on employer versus employee premium contribution shares over time, to assess whether the employer-employee split within employer-sponsored insurance (a major but incompletely disaggregated component of Table 5's household spending figures) has shifted across generations at comparable career stages.
- Track effectuated ACA Marketplace enrollment and premium-payment data through the remainder of 2026 as final-year figures are published, to confirm or revise the preliminary 2026 estimates cited in Section 9.
- Examine state-level variation in Medicaid expansion status and its effect on generational coverage patterns, particularly for Millennials and Generation X in non-expansion states.
- Assess CHIP, TRICARE, VA, and Indian Health Service enrollment and spending by generational cohort if and when a primary federal source publishes that breakdown, to close the gap identified in Section 13.

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Conclusion

This report describes how Americans finance health care across five generational cohorts and how those patterns have shifted since the mid-1960s. It finds that payment sources vary substantially by age — employer-sponsored private insurance dominant for working-age adults, near-universal health insurance coverage with Medicare as the dominant source for adults 65 and older, and a mix of parental coverage and public programs for children and young adults. Public financing plays a substantially larger role in U.S. health care than it did before Medicare and Medicaid were enacted in 1965, and CMS projects the federal sponsor share will continue to increase, from 31% in 2024 to 33% by 2034, as the Baby Boom generation continues aging into Medicare eligibility — though, as Section 8.5 discusses, that federal share is itself financed substantially by the same households and businesses that appear as separate sponsors in CMS's accounting.

This report has taken particular care to distinguish patterns driven by a generation's current age (lifecycle effects) from patterns tied to the specific historical and policy circumstances a generation encountered (cohort effects) and has flagged throughout where its data cannot fully separate the two. Section 6 carries out an initial historical comparison at matched ages for three age bands, using repeated cross-sections of BLS data — a meaningful step beyond a purely cross-sectional snapshot, but, as that section explains, not a full age-period-cohort decomposition. Completing that fuller analysis with individual-level longitudinal or historical microdata remains a priority for future research (Section 14).

This report does not evaluate whether current financing arrangements are adequate, equitable, or sustainable for any generation, and it does not offer policy recommendations. Future editions may incorporate additional data sources identified in Section 14, extend the historical and cross-generational analysis, or update figures as more recent federal data are published.

Revision History

This is a living document, reviewed and reissued periodically as new federal data are released. Each revision is logged below, and superseded versions are preserved in the OCG Research Library.

Version 1.0 — August 19, 2026 — Initial publication.

Appendix A. Generational Cohort Reference Table

Cohort	Birth Years	2024 Household Health Care Spending	2026 Age Range
Silent Generation and earlier	1945 or earlier	$8,001	81 and older
Baby Boomers	1946–1964	$7,496	62–80
Generation X	1965–1980	$6,531	46–61
Millennials	1981–1996	$5,092	30–45
Generation Z	1997–2012	$2,297	14–29
Generation Alpha (not separately analyzed in this report)	2013 or later	n/a	0–13

Source: U.S. Bureau of Labor Statistics, Consumer Expenditure Surveys, generation-of-reference-person tables, 2024, retrieved via FRED.

Appendix B. Government Health Care Program Glossary

- **Medicare Part A (Hospital Insurance) —** Covers inpatient hospital, limited skilled nursing facility, home health, and hospice care; financed primarily by payroll taxes.
- **Medicare Part B (Medical Insurance) —** Covers physician services, outpatient care, and preventive services; financed by general revenues and beneficiary premiums.
- **Medicare Part C (Medicare Advantage) —** Private plans delivering Medicare benefits, paid by CMS on a capitated basis; over half of eligible beneficiaries are enrolled as of 2026.
- **Medicare Part D —** Outpatient prescription drug coverage through private plans, subsidized by federal payments; includes an annual beneficiary out-of-pocket cap, $2,000 in 2025 and $2,100 in 2026 under indexing required by the Inflation Reduction Act.
- **Medicaid —** Joint federal-state program for low-income individuals, financed through federal-state matching (FMAP), with a higher federal match for ACA expansion populations in states that adopted expansion.
- **CHIP (Children's Health Insurance Program) —** Joint federal-state program covering children in families with incomes above Medicaid thresholds but below typical private-market affordability; enacted 1997.
- **TRICARE —** Department of Defense health coverage for active-duty service members, military retirees, and dependents.
- **VA Health Care —** Direct health care delivery system operated by the Department of Veterans Affairs for eligible veterans, financed through federal appropriations.
- **Indian Health Service (IHS) —** Federal agency within HHS providing and financing health care for eligible American Indian and Alaska Native people.
- **ACA Marketplace Premium Tax Credits —** Income-based subsidies reducing net premiums for individual-market coverage purchased through ACA exchanges; enhanced 2021–2025, with the enhancement expiring January 1, 2026.