



Health Care Reform: An Introduction

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August 31, 2009

Congressional Research Service

7-5700

www.crs.gov

R40517

Summary

Health care reform is a major issue in the 111th Congress, driven by growing concern about millions of people without insurance coverage, continual increases in cost and spending, and quality shortcomings. Commonly cited figures indicate that more than 45 million people have no insurance, which can limit their access to care and ability to pay for the care they receive. Costs are rising for nearly everyone, and the country now likely spends over \$2.5 trillion, more than 17% of gross domestic product (GDP), on health care services and products, far more than other industrialized countries. For all this spending, the country scores but average or somewhat worse on many indicators of health care quality, and many may not get appropriate standards of care.

These concerns raise significant challenges. Each is more complex than might first appear, which increases the difficulty of finding solutions. For example, by one statistical measure, far more than 45 million people face the risk of being uninsured for short time periods, yet by another, substantially fewer have no insurance for long periods. Insurance coverage and access to health care are not the same, and it is possible to have one without the other. Having coverage does not ensure that one can pay for care, nor does it always shield one from significant financial loss in the case of serious illness. Similarly, high levels of spending may be partly attributable to the country's wealth, while rising costs, though difficult for many, may primarily mean that less money is available for other things.

Solutions to these concerns may conflict with one another. For example, expanding coverage to most of the uninsured would likely drive up costs (as more people seek care) and expand public budgets (since additional public subsidies would be required). Cutting costs may threaten initiatives to improve quality. Other challenges include addressing the interests of stakeholders that have substantial investments in present arrangements and the unease some people have about moving from an imperfect but known system to something that is potentially better but untried. How much reform might cost and how to pay for it is also an issue.

Health care reform proposals rekindle debate over perennial issues in American health care policy. These include whether insurance should be public or private; whether employment-based insurance should be strengthened, weakened, or left alone; what role states might play; and whether Medicaid should be folded into new insurance arrangements. Whether changes to Medicare should occur at the same time is also being considered. Concerns about coverage, cost and spending, and quality are likely to be addressed within the context of these issues.

The committees of jurisdiction for health care have prepared comprehensive reform proposals. The Senate HELP Committee approved a measure on July 15 (Affordable Health Choices Act), whereas H.R. 3200, a coordinated measure by three House committees (Education and Labor, Ways and Means, and Energy and Commerce), was approved by the first two committees with some variations on July 17 and by Energy and Commerce on July 31. The Senate Finance Committee has no draft available to the public, though it has released policy option documents and many of its debates have been publicized. More than a dozen other comprehensive bills have also been introduced.

This report does not discuss or even try to identify all of the concerns about health care in the United States that are prompting calls for reform. Other concerns may also be important, at least to some, and will likely contribute to the complexity of the reform debate. The report may be updated to include other health care reform issues as the debate in Congress unfolds.

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Introduction

Health care reform is again an issue. For the first time since 1994, when sweeping changes proposed by President Clinton and others failed to be enacted, there is demonstrable interest in reforming health care in the United States. Surveys and studies show persistent problems, political leaders are debating issues and solutions, and interest groups of all persuasions are holding conferences and staking out positions. Some states have enacted their own reforms, and others are considering doing so. President Obama says that it is his top priority, and bills have been prepared, and in some cases approved, by the congressional committees with principal jurisdiction.

Interest in reform is being driven by three predominant concerns. One is coverage. By a commonly cited estimate, more than 45 million people were uninsured at some point in 2007—more than one-seventh of the population. The recession may have increased this number. Without private insurance or coverage under government health programs, people can have difficulty obtaining needed care and problems paying for the care they receive.

A second concern is cost and spending. Health care costs are rising for nearly everyone—employers, workers, retirees, providers, and taxpayers—sometimes in unexpected, erratic jumps. Costs are a particular source of anxiety for families that are planning for retirement or where someone is seriously ill. National health care spending now likely exceeds \$2.5 trillion, more than 17% of the gross domestic product (GDP). Spending has climbed from over 12% of GDP in 1990 and 7% in 1970.

Third, there is concern about quality. Although the United States spends substantially more on health care per person than other industrialized countries, it scores only average or somewhat worse on many quality of care indicators. Medical and medication errors harm many people annually, sometimes resulting in death.

The three concerns raise significant challenges. For one thing, each is more complex than might first appear, which makes it difficult to find solutions, or at least simple or uniform solutions. Second, solutions to the three concerns may conflict with one another. Under many scenarios, for example, providing coverage to the 45 million uninsured would likely drive up costs (as more people seek care) and expand public budgets (since public subsidies would be required to help them get insurance). Attempts to restrict costs may impede efforts to increase quality, since new initiatives often require additional, not fewer, resources. It is possible, however, that cost savings might allow those initiatives to be funded. Other challenges involve significant stakeholder interests that reform might threaten, including those of insurers, hospitals and other health care facilities, and doctors and other providers, many of whom have substantial investments in present arrangements. In 2007, for example, nearly one-third of total health care expenditures occurred in hospitals (see **Table C-1** in **Appendix C**), which cannot be quickly built, easily shut, or transformed simply by their own choice into different kinds of health care providers. In addition, if debates over the Clinton plan are still a guide, some people may be uneasy about moving from an imperfect but known system to something that is potentially better but untried.

This report provides an introduction to health care reform. It focuses on the three predominant concerns just mentioned—coverage, cost and spending, and quality—and some of the legislative issues within which they likely will be debated, including the scope of reform (particularly whether Medicare and Medicaid should be included); the choice between public and private

coverage; whether employment-based insurance should be strengthened, weakened, or left alone; and what role states might play. The report does not attempt to identify, let alone discuss, all the relevant concerns about health care in the United States, even though others may also be important and will likely contribute to the complexity of the reform debate. The report may be updated to include other health care reform issues as the debate in Congress unfolds.

Three Predominant Concerns

The three concerns discussed below—coverage, cost and spending, and quality—loom large in the emerging debate over health care reform. Some Members might not consider every one important, but all have been included in recent congressional debate and proposals.

Other concerns about health care in the United States that are not discussed in this report include the following:

- problems in the private insurance market, particularly for individual and small-group insurance,
- problems with shortages of health care providers,
- problems with public health programs, funding, and administrative oversight,
- problems of economic concentration among insurers and providers,
- problems of equity in access to care and the type of care received, and
- problems of equity in public subsidies.

Coverage

In August 2008, the U.S. Census Bureau estimated that 45.7 million people had no health insurance at a point in time in 2007. The number had declined from 47 million the previous year, largely due to increases in Medicaid and CHIP (the State Children's Health Insurance Program) enrollment.¹ The number may now be going back up due to the recession.

There are both higher and lower numbers that give different perspectives. Families USA, an advocacy group, recently estimated that 86.7 million people—one in three of those under age 65—were uninsured for some or all of the two-year period 2007-2008.² The number indicates that more than 45 million people are likely to be uninsured over a short time period, even if many have coverage at some point. On the other hand, the Agency for Healthcare Research and Quality (AHRQ) has estimated that 26.1 million people were uninsured for the *entire* two-year period 2004-2005, and that 17.4 million were uninsured for the preceding two years as well—four straight years.³

¹ U.S. Census Bureau, Health Insurance Coverage: 2007, <http://www.census.gov/hhes/www/hlthins/hlthin07/hlth07asc.html>.

² Families USA, *Americans at Risk: One in Three Uninsured*, March 2009, <http://www.familiesusa.org/resources/publications/reports/americans-at-risk.html>.

³ Jeffrey A. Rhoades and Steven B. Cohen, *The Long-Term Uninsured in America, 2002-2005: Estimates for the U.S. Population under Age 65*, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey Statistical (continued...)

Coverage is not the same as access, and it is possible to have one without the other. Some uninsured people can get care in community health clinics or from doctors providing pro bono work, even if they have no money. If people need emergency care, hospitals that participate in Medicare are required to stabilize them or provide an appropriate transfer to another facility. On the other hand, having coverage does not guarantee that one can easily find a doctor, as both Medicare and Medicaid participants sometime report. Having coverage also does not ensure that one can pay for care. People with high deductible insurance, perhaps chosen when they were healthy or because premiums were lower, may have to pay several thousand dollars out of pocket before their plan begins reimbursements.⁴ For some people, including those who lose their jobs, paying for health care is a major problem.⁵ Even people with comprehensive plans with low deductibles may have difficulty paying the ongoing costs of chronic conditions or the major costs of serious illnesses.

Being uninsured can cause problems. According to some studies, uninsured people are more likely to postpone or do without care, including screening and preventive tests that health care practitioners commonly use. They are less likely to have regular sources of care and more likely to use emergency rooms.⁶ At the same time, it is sometimes difficult to attribute differences in health status or outcomes to whether one has insurance because other unobservable factors may be important.⁷

The uninsured have diverse characteristics, which suggests they may lack coverage for different reasons. As shown in **Appendix B**, most are employed full time or are family members of those who are, but some are in families where no one is in the labor force. Most are not poor, but many are low income. About one in eight uninsured in 2007 were in household insurance units with incomes over \$50,000.⁸

As Congress considers what to do about the uninsured, a number of issues have arisen, including the following:

- whether it is important for everyone to have coverage,
- whether people should be required to have coverage (an individual mandate),
- what people at various income levels should be required to pay for coverage, and

(...continued)

Brief #183, August 2007, http://www.meps.ahrq.gov/mepsweb/data_files/publications/st183/stat183.pdf.

⁴ The minimum deductible for a family plan that qualifies for a health savings account (HSA) is \$2,300, though insurance reimbursements for preventive care are allowed without any deductible. Families could use funds in their HSAs to pay for some of the deductible, but some accounts may not be large enough. For additional information see CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2009*, by Bob Lyke.

⁵ Peter Cunningham, Carolyn Miller, and Alwyn Cassel, *Living on the Edge: Health Care Expenses Strain Family Budgets*, Center for Studying Health System Change, Research Brief No. 10, December 2008, <http://www.hschange.com/CONTENT/1034/1034.pdf>.

⁶ See Families USA, *op. cit.*, pp. 12-13 and the numerous studies referenced there. Also see Randall R. Bovbjerg and Jack Hadley, *Why Health Insurance is Important*, The Urban Institute, Health Policy Briefs DC-SPG no. 1, November 2007, http://www.urban.org/UploadedPDF/411569_importance_of_insurance.pdf.

⁷ Helen Levy and David Meltzer, "The Impact of Health Insurance on Health," *Annual Review of Public Health*, vol. 29 (2008), pp. 399-409.

⁸ For another recent study, see June E. O'Neill and Dave M. O'Neill, *Who Are the Uninsured? Employment Policies Institute*. June, 2009, http://www.epionline.org/studies/oneill_06-2009.pdf.

- whether coverage provided with public subsidies should meet minimum benefit and cost-sharing standards.

Cost and Spending

According to the U.S. Department of Health and Human Services, spending on health care in the United States increased from 7.2% of GDP in 1970 to 12.3% in 1990 and 16.2% in 2007.⁹ It likely is more than 17% in 2009.¹⁰ Barring changes in law, the Congressional Budget Office (CBO) projected in 2008 that it would rise to 25% of GDP by 2025 and much higher levels beyond.¹¹ CBO has cautioned that “as health care spending consumes a greater and greater share of the nation’s economic output in the future, Americans will be faced with increasingly difficult choices between health care and other priorities.”¹²

The United States spends considerably more on health care than other industrialized countries: on a per capita basis, its spending is more than two times greater than the spending of the median Organization for Economic Cooperation and Development (OECD) country.¹³ It has been argued that some of the higher health care spending has added real value through medical advances.¹⁴ Some of it may be attributable to the higher per capita GDP in the United States, which simply allows Americans to spend more.¹⁵ However, its value has been questioned in light of the mixed performance of the United States on many indicators of health care quality, as described in the next section.

“Cost” and “spending” are often used interchangeably, particularly with the issues discussed in this report. Use of one term instead of the other may reflect differences in context or perspective, not substance, though this is not always the case (for example, prices are usually described as costs, while purchases are usually described as spending). It is apparent that what are called rising costs can cause serious problems for people and entities that cannot easily absorb them. Concern about costs arises from a number of trends. The average annual rate of growth in medical care prices between 1980 and 2007 was 4.7%, in contrast to 2.5% for the entire consumer price index (CPI). Health insurance premiums on average increased by 114% from 1999 to 2007, far more

⁹ Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. National Health Care Expenditures, 2007. Table 1. <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>.

¹⁰ Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. National Health Expenditure Projections 2008 – 2018, Table 1, <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf>.

¹¹ Congressional Budget Office, *Growth in Health Care Costs*, CBO Testimony before the Committee on the Budget United States Senate, January 31, 2008, <http://www.cbo.gov/ftpdocs/89xx/doc8948/01-31-HealthTestimony.pdf>

¹² Congressional Budget Office, *The Long-Term Outlook for Health Care Spending*, November, 2007, <http://www.cbo.gov/ftpdocs/87xx/doc8758/11-13-LT-Health.pdf>.

¹³ Gerald F. Anderson and Bianca K. Frogner, “Health Spending in OECD Countries: Obtaining Value Per Dollar,” *Health Affairs*, vol. 26, no. 6 (2008), pp. 1718-1727. Also see CRS Report RL34175, *U.S. Health Care Spending: Comparison with Other OECD Countries*, by Chris L. Peterson and Rachel Burton.

¹⁴ David M. Cutler, *Your Money or Your Life: Strong Medicine for America’s Health Care System* (Oxford University Press, 2005).

¹⁵ Uwe E. Reinhardt, Peter S. Hussey, and Gerard F. Anderson, “U.S. Health Care Spending in an International Context,” *Health Affairs*, vol. 23, no. 3 (2004), pp. 10-25. Citing their previous work, the authors argue that higher prices for health care in the United States can partly be attributed to the compensation needed to attract talented professionals and the relatively greater power of the supply side versus the demand side in health care markets.

than increases in workers' earnings (27%).¹⁶ The rising cost of health insurance likely is one reason there are increasing numbers of uninsured.

Controlling cost and spending is unlikely to be easy. Many economists argue that the principal factor driving increases in health care spending is technology, both new pharmaceuticals and other products and services and wider use of existing ones.¹⁷ It is not obvious whether some developments can be limited or their application blocked (for example, by limiting diffusion on the basis of clinical evidence) and some would question whether they should. One challenge in controlling costs is that payers may shift burdens to others, sometimes in ways that are not clearly understood or measurable. For example, most economists argue that employer payments for health insurance are actually borne by workers through reduced wages and other forms of compensation. Attempts to limit employer-paid insurance may lead to increases in wages in ways that are difficult to predict.

One particular congressional concern is the cost of federal health insurance programs. In 2007, Medicare and Medicaid, the two largest programs, accounted for about 20% of the federal budget and over 27% of total national health care expenditures (for the latter, see **Table C-2 in Appendix C**). They also constituted about 5% of GDP. If past cost trends continue, it has been estimated the two programs would grow to about 20% of GDP by 2050, approximately the same share of GDP as all federal spending recently.¹⁸ Increases of that magnitude would likely cause serious problems.

As Congress considers what to do about health care costs and spending, a number of issues have arisen, including the following:

- whether markets in health care, if they were less regulated, would result in price reductions and quality improvements that have occurred in other markets,
- whether efforts to reduce costs for some would increase costs for others,
- whether efforts to reduce costs would adversely affect the health of consumers, and
- whether efforts to reduce spending or slow its growth would impede efforts to provide coverage to more people or to improve quality.

Quality

Despite spending more on health care than other industrialized countries, the United States scores only average or somewhat worse on many quality of care indicators. It is near the top for some measures, such as survival rates for breast and colorectal cancer, but near the bottom for others,

¹⁶ Paul B. Ginsburg, *High and Rising Health Care Costs: Demystifying U.S. Health Care Spending*, Robert Wood Johnson Foundation. The Synthesis Project, October 2008, p. 1, <http://www.rwjf.org/files/research/101508.policysynthesis.costdrivers.rpt.pdf>.

¹⁷ Ginsburg, *op. cit.*, p. 1. Technology is often treated as a residual variable in studies of health care costs, so it could be overstated.

¹⁸ Testimony of Peter R. Orszag before the Committee on Budget, United States Senate, January 13, 2009, <http://budget.senate.gov/democratic/testimony/2009/OrszagFINAL011309.pdf>. Due to the recession and federal spending in response to it, some of these percentages may be changing.

such as mortality and hospitalization rates for asthma.¹⁹ A recent Centers for Disease Control and Prevention (CDC) report found that the United States ranked 29th in the world in infant mortality in 2004. The U.S. position in rankings on this measure has been declining.²⁰ Notwithstanding difficulties of cross-national comparisons, these indicators show that Americans do not receive the best value for their health care spending and that there is room for improvement.

Concerns about health care quality in the United States go beyond international comparisons, and they cannot be reduced simply to returns on the dollar. Medical errors appear to be one systemic shortcoming. An influential 1999 Institute of Medicine study found that at least 44,000 people, and perhaps as many as 98,000, die from in-patient hospital care every year. The study found that most medical errors do not result from individual recklessness or actions of a particular group; rather, they are attributable to “faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them.”²¹ A more recent study estimated that if all hospitals performed as well as the best group of hospitals for patient safety, more than 44,000 deaths among Medicare beneficiaries could have been avoided during the years 2002 through 2004.²² Another Institute of Medicine study reported in 2006 that there were more than 400,000 preventable drug-related injuries each year in hospitals alone, and that altogether medication errors harmed at least 1.5 million people.²³

Not adhering to evidence-based practice or clinical practice guidelines is also a problem. One 2003 study found that Americans receive recommended evidence-based care only about 55% of the time. Recommended care was provided more often for conditions such as breast cancer (75.7%) and hypertension (64.7%) than it was for others such as atrial fibrillation (24.7%) or hip fracture (22.8%).²⁴ A later study using the same data found that while differences among sociodemographic subgroups were relatively small, quality problems were profound and systemic.²⁵ Most studies of disparities have found significant differences by sociodemographic subgroups, with whites receiving better care on many core measures than racial and ethnic minorities.²⁶

¹⁹ Anderson and Frogner, op. cit.

²⁰ Marian F. MacDorman and T.J. Mathews, *Recent Trends in Infant Mortality in the United States*, National Center for Health Statistics, Centers for Disease Control and Prevention, October 2008, <http://www.cdc.gov/nchs/data/databriefs/db09.htm>. The report notes that “international comparisons of infant mortality can be affected by differences in reporting of fetal and infant deaths. However, it appears unlikely that differences in reporting are the primary explanation for the United States’ relatively low international ranking.”

²¹ Institute of Medicine, *To Err is Human: Building A Safer Health System*, November 1999.

²² Health Grades, *Third Annual Patient Safety in American Hospitals Study*, April 2006, p. 4, <http://www.healthgrades.com/media/dms/pdf/patientsafetyinamericanhospitalsstudy2006.pdf>.

²³ Institute of Medicine, National Academies, “Medication Errors Injure 1.5 Million People,” press release, July 20, 2006, <http://www8.nationalacademies.org/onpinews/newsitem.aspx?RecordID=11623>.

²⁴ Elizabeth A. McGlynn et al., “The Quality of Health Care Delivered to Adults in the United States,” *The New England Journal of Medicine*, vol. 348, no. 26 (June 26, 2003), pp. 2635-2646. The study was based on a random sample of adults in 12 metropolitan areas in the United States. Over 12,000 adults who received care participated in the survey.

²⁵ Steven M. Asch et al., “Who Is at Greatest Risk for Receiving Poor-Quality Health Care?,” *New England Journal of Medicine*, vol. 354, no. 11 (March 16, 2006), pp. 1147-1156.

²⁶ For example, see Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, *National Healthcare Disparities Report, 2008* (May 2009), <http://www.ahrq.gov/qual/nhdr08/nhdr08.pdf>.

Over the past decade, there have been numerous efforts to improve quality of care in the United States.²⁷ Among other things, there have been attempts to improve and refine the metrics used for measuring quality, to publicly report comparative information, and, in some cases, to use quality standards as one basis for payment policies. Despite observable progress, the most recent National Healthcare Quality Report (2008) indicated that health care quality is suboptimal and continues to improve at a slow pace.²⁸ Among the challenges to making further improvements are disagreements about the utility or appropriateness of some measures (including concerns about how the public might interpret them), the fragmented nature of the American health care system, and barriers to access for some groups that complicate the work of providers.

As Congress considers what to do about health care quality, a number of issues have arisen, including the following:

- whether quality improvements should be pursued for their own sake, regardless of whether they promise to save money,
- whether it is possible to improve the quality of care without reorganizing and restructuring health care delivery systems,
- whether preventive care should have a significant role in improving quality, relative to acute or chronic care services,
- whether the evidence-base is adequate for guiding quality improvement efforts, or whether the way research is organized, financed, and carried out needs to be changed, and
- whether employers and other entities that are not health care providers can play a role in improving health outcomes.

Some Likely Legislative Issues

The reform debate in the 111th Congress has raised some perennial issues about national health care policy. These include deep-seated disagreements about whether insurance should be public or private; whether employment-based insurance should be strengthened, weakened, or left alone; and what role states should play. The scope of reform is itself an issue.

The legislative issues discussed below will affect attempts to deal with the three predominant concerns raised at the beginning of the report. For example, even if there were a consensus that everyone should have coverage—something some Members actually might not consider a priority—that would not resolve questions of whether the coverage should be public or private, whether employer-provided coverage should in some way be favored, or whether states should

²⁷ According to one observer, efforts to improve patient safety stemmed from the Institute of Medicine report cited above (*To Err is Human*) and reflected growing skepticism about the health care system after a decade of managed care. Robert M. Wachter, “The End of the Beginning: Patient Safety Five Years After ‘To Err is Human’,” *Health Affairs Web Exclusive*, November 30, 2004, pp. W4-534-W4-545, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.534v1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=wachter&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT>.

²⁸ Agency for Healthcare Quality and Research, U.S. Department of Health and Human Services, *Key Themes and Highlights From the National Healthcare Quality Report*, 2008. (May, 2009), <http://www.ahrq.gov/qual/nhqr08/nhqr08.pdf>.

have the principal responsibility for enrolling people in plans and subsidizing those who need assistance. Disputes over any of these issues could derail attempts to meet coverage goals.

The discussion below does not cover all issues currently being debated. Other controversies include the following:

- how much health care reform might cost, and how it should be financed,
- whether there should be individual or employer mandates, or possibly both,
- how much individuals and families might be expected to pay for coverage from their own resources, and
- how insurance benefit standards might be set and updated.

The Scope of Reform

The scope of reform is one of the first issues to confront proponents of change. Changing private insurance for people under age 65 through a combination of market restructuring, benefit standards, and financing reforms was the core and most controversial aspect of President Clinton's 1993 proposal, but it was only one part of a comprehensive package. His Health Security Act also would have brought about important changes in Medicare, Medicaid, long-term care, and the tax code, and it included initiatives for administrative simplification, health information privacy and security, health care quality, malpractice reform, prevention and public health, and healthcare workforce expansion.

Perhaps as a consequence of the failure of that legislation, most subsequent health care reform bills have been smaller in scope. Many proposals for insuring people under age 65 have been less sweeping, focusing on creating better options for small businesses, for example, or allowing a Medicare buy-in (i.e., allowing early retirees and others to pay premiums for coverage before age 65.) Other parts of the Clinton proposal that got less attention at the time were addressed in legislation that followed, such as the privacy rules included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191), as were other parts of some Republican proposals of the time, such as the Health Savings Accounts included in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173). Congress proceeded in incremental steps.

Changing the private insurance market for people under age 65 is once again the center of health care reform. Nearly all uninsured people are under that age (see **Table A-1** in **Appendix A**), and many advocates for reform call for giving them access to coverage (and sometimes choice of coverage) that meets specified benefit and cost-sharing standards. If this could be accomplished, many advocates would consider reform initiatives to be successful.

Others argue that reform needs to address additional problems as well. Medicare might be included because older people consume a share of health care disproportionate to the number and Medicare policies and payments significantly affect health care delivery systems. Considering the projected growth in Medicare spending, said to be unsustainable, some argue that it should be reformed sooner rather than later. (H.R. 3200, the House Committees' bill, includes extensive Medicare changes. The Senate HELP Committee measure does not because Medicare is not within its jurisdiction.) Medicaid might also be included because new public subsidies could allow lower-income families to have the same private insurance options as other Americans.

However, Medicaid provides some benefits that historically private coverage has not, so some part of it might have to remain in a system that otherwise has private options. Moreover, some think it preferable to expand Medicaid programs, as discussed in the next section. Arguments are being advanced that improvements in quality, public health, and other matters are needed so that people of all ages, regardless of their insured status, can receive adequate health care.

Public or Private Insurance

Private insurance is the largest source of funding for national health expenditures, providing 34.6% of the total (see **Table C-2** in **Appendix C**). It is somewhat larger than the combined contributions of Medicare and Medicaid (33.9%), the two largest public programs. Private insurance has always been larger than these two programs, though in the past the difference has been greater.

The distinction between public and private insurance sometimes is hard to draw. Medicare has private plan options (Medicare Advantage plans) that now enroll 20% of Medicare beneficiaries, and Medicaid has commercial managed care plans. In both cases, the private plans are publicly financed and closely regulated, but participants often have choices that are characteristic of private coverage. In turn, private insurance is regulated more than other consumer products, including requirements and restrictions on benefits, pricing, and marketing when sold as commercial insurance and tax code and ERISA rules when employers self-insure (for the latter, see “The Role of States,” below). Nonetheless, important differences remain with respect to financing (public programs usually are financed largely with tax dollars, not premiums), eligibility (public programs do not use underwriting), and flexibility (private plans usually can innovate and make other changes quickly). Some people consider these differences important both for health care and for the role of government in general.

Whether public programs should be expanded has become an issue in the current debate. H.R. 3200 would expand Medicaid to all individuals and families with incomes under 133% of the federal poverty level. Proponents of expansion argue that Medicaid would be a simpler way to extend comprehensive coverage to these populations, whereas opponents are concerned about denying them access to private insurance. Even though H.R. 3200 would provide 100% federal financing for the newly added populations, states remain concerned about their ability to finance other parts of the program over the long term.

H.R. 3200 and the Senate HELP Committee legislation would establish health insurance purchasing exchanges like Massachusetts adopted for its comprehensive reform.²⁹ Currently there is contentious debate over whether a public insurance option should be included within their exchanges. Depending on what the public option is—there are a number of possible models—it could provide coverage for people that private insurers normally do not seek, and it could use the government’s purchasing power to control costs. With its potential access to public financing, however, some think that a public plan might compete unfairly against private plans, eventually driving them out of the market.

²⁹ The exchange in Massachusetts is called the Connector. For more information, see its website, <http://www.mahealthconnector.org/portal/site/connector/>.

Employment-Based Insurance

Employment-based insurance is the principal form of coverage for people under age 65. As shown in **Table A-1** in **Appendix A**, more than three-fifths of that population is insured either as a worker or the spouse or dependent of a worker. Employment-based insurance has several strengths, including risk pools that are not formed on the basis of health status, ease of acquisition by workers, and tax subsidies that exceed those for individual market insurance. On the other hand, plans chosen by employers may not meet individual workers' needs, and changing jobs may require obtaining both new insurance and new doctors.

Whether employment-based insurance should be strengthened, weakened, or left alone has arisen in several ways. Some Members have proposed that the tax exclusion for employer-paid coverage be eliminated or capped, both to help finance reform and to discourage what some consider overly generous health benefits. Completely eliminating the exclusion could increase federal receipts by more than \$225 billion a year, more than enough to pay for the reform proposals currently under consideration.³⁰ Because this change might result in tax increases for many households and weaken the attractiveness of employment-based insurance, currently more attention is being given to capping the exclusion. (H.R. 3200, so far the only committee bill to deal with tax issues, would not cap or limit the exclusion.) In assessing the impact of these possible changes, one must take account of how the budget savings they generate are used in a reformed system.³¹

Debate over employment-based insurance is also occurring regarding small employers. Small employers are less likely to offer insurance than large employers: according to one survey, 62% of firms with 3 to 199 workers offered coverage in 2008 whereas 99% of firms with 200 or more workers did. Very small employers (3 to 9 workers) were least likely to offer coverage.³² Both H.R. 3200 and the Senate HELP legislation would allow assistance to small firms to help them offer or maintain coverage. The House bill would establish a 50% tax credit for small businesses that pay at least certain portions of the cost; it would be phased out for firms with 10 to 25 employees or with average wages of \$20,000 to \$40,000 a year. The HELP legislation assumes there would be a tax credit for employers with 50 or fewer employees that pay at least certain amounts. However, both measures would also require employers with more than 25 workers to either offer insurance or pay a penalty. Some argue that the last provision would reduce the number of jobs that all but the smallest employers would create.

³⁰ The Joint Tax Committee estimates that the exclusion reduced individuals' federal income taxes in 2008 by about \$132.7 billion, and individuals' and employers' Social Security and Medicare taxes by about \$93.5 billion. *Background Materials for Senate Committee on Finance Roundtable on Health Care Financing*, (JCX-27-09), May 8, 2009, <http://www.jct.gov/publications.html?func=startdown&id=3557>.

³¹ For additional information on eliminating or capping the exclusion, see CRS Report RL34767, *The Tax Exclusion for Employer-Provided Health Insurance: Policy Issues Regarding the Repeal Debate*, by Bob Lyke, and CRS Report R40673, *Limiting the Exclusion for Employer-Provided Health Insurance: Background and Issues*, by Bob Lyke and Chris L. Peterson.

³² *Employer Health Benefits: 2008 Summary of Findings*. The Kaiser Family Foundation and Health Research and Educational Trust., p. 4, <http://ehbs.kff.org/images/abstract/7791.pdf>.

The Role of States

States have long played a significant role in health care. They are the principal regulators for insurance sold in the private market, particularly the individual and small group markets. While their authority to regulate self-insured employer plans has been preempted by the Employee Retirement Income Security Act (ERISA), they remain largely responsible for regulating business practices associated with the insurance that employers purchase.³³ (Employers that self-insure assume the risk of paying for covered services, though some limit their exposure to large losses through stop-loss insurance. A majority of people covered under employer plans are under self-insured plans.) States are also responsible for licensing of health care providers and investigating certain complaints about them, approval of health care facilities, and much of the law governing contracts, employment, and other matters. As shown in **Table C-2** in **Appendix C**, states and their local subdivisions were also the source of \$281.4 billion in health care expenditures in 2007, over 12% of the total.

An important issue for health care reform is what role states would continue to play. Conceivably one might envision a reformed system that is governed entirely by national policies and national administration, whether part of the federal government or not. However, reform proposals that would do this typically assign some responsibilities to the states or, by their silence, allow much existing state law and regulation to continue. With respect to the health insurance purchasing exchanges, H.R. 3200 would create a national exchange (though states could establish their own instead) whereas the HELP legislation would have only state-based exchanges. Both measures would establish national rules for matters now largely governed by state law, including benefit design, requirements for guaranteed issue and disregard of pre-existing conditions, marketing standards, and pooling mechanisms.

If federal legislation is not enacted, some states will likely attempt to bring about substantial change on their own. Reforms adopted in Massachusetts in 2006 might serve as a model, at least for the possibility of action, as might smaller changes adopted in other states.³⁴ States that act on their own may be able to tailor plans to their particular needs and preferences. However, the problems states face vary greatly, as do their fiscal capacities to pay for reforms. Massachusetts had one of the lowest uninsured rates in the country and one of the highest per capita incomes, though its health care costs are also among the highest. States might be slow to act unless they receive federal assistance. ERISA preemption might block some initiatives. State reforms could leave the country with a patchwork quilt of health care systems, though some might find this better than current arrangements or a national system not to their liking.

The Cost of Reform

The cost of reform and how to pay for it have become important issues in the current debate. Reform is likely to be expensive. The principal proposals under consideration could cost the federal government more than \$1 trillion over the next 10 years, depending on their scope and details. The largest part would be for subsidies to help people under age 65 pay for health

³³ CRS Report RS20315, *ERISA Regulation of Health Plans: Fact Sheet*, by Hinda Chaikind.

³⁴ The Massachusetts plan requires everyone to have insurance, with some exceptions, and established an insurance marketplace called the Connector to help some find coverage. Premium subsidies are available depending on income and family size, and employers that do not offer coverage must pay a penalty.

insurance or be covered by public programs. Not only is reducing the number of uninsured a major goal for many, but individual mandates for coverage (i.e., requirements that one must have coverage) are practical only if people with little money are given assistance. Health care reform may increase costs for others as well, including the states, employers, employees, consumers, health care providers, and taxpayers. If their expenditures do not increase, their income may go down, leaving them in a worse position financially. At the same time, reform would likely have the opposite effect for some of these parties, making them better off.

Under current congressional budget enforcement rules, health care reform legislation must not increase the federal deficit. Projected spending increases and revenue reductions are to be offset by reductions in spending or increases in revenue. Conceptually there are a number of ways this could be accomplished, including increasing general tax rates, reducing various tax subsidies, reducing spending for federal health programs, reducing other federal program spending, and increasing borrowing. Currently, the principal offsets under consideration are Medicare reductions and tax increases. The Medicare changes at issue include reducing the annual updates of Medicare's many fee-for-service payment rates, reducing spending in Medicare Advantage by basing payments on spending in fee-for-service Medicare, and requiring drug manufacturers to provide rebates and discounts in specific circumstances under the Part D prescription drug program. The largest tax increases being considered include limiting the tax rate that high-income taxpayers can use to reduce their tax liability by itemized deductions, an income tax surcharge on high-income taxpayers, and caps or other limits on the exclusion for employer-provided health care. For analyses of some of the proposals, see CRS Report R40648, *Tax Options for Financing Health Care Reform*, by Jane G. Gravelle, and CRS Report R40673, *Limiting the Exclusion for Employer-Provided Health Insurance: Background and Issues*, by Bob Lyke and Chris L. Peterson. Other options were outlined last year by the Congressional Budget Office.³⁵

Congressional Proposals

The committees of jurisdiction for health care have prepared comprehensive reform proposals. The Senate HELP Committee approved a measure on July 15 (Affordable Health Choices Act),³⁶ whereas the Senate Finance Committee has not yet released a proposal, though earlier it provided a range of policy options and many of its debates have been publicized.³⁷ H.R. 3200, a coordinated measure by three House committees (Education and Labor, Ways and Means, and Energy and Commerce), was approved by the first two committees with some variations on July 17 and by Energy and Commerce on July 31.³⁸

³⁵ Congressional Budget Office, *Budget Options Volume 1: Health Care* (December, 2008), <http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf>.

³⁶ For a detailed summary prepared by the HELP Committee, see *In Historic Vote, HELP Committee Approves the Affordable Health Choices Act*, http://help.senate.gov/Maj_press/2009_07_15_b.pdf.

³⁷ The policy options are discussed in three separate documents: (1) *Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs*, <http://finance.senate.gov/sitepages/leg/LEG2009/042809HealthCareDescriptionofPolicyOption.pdf>; (2) *Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans*, <http://finance.senate.gov/sitepages/leg/LEG2009/051109HealthCareDescriptionofPolicyOptions.pdf>; and (3) *Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options*, <http://www.finance.senate.gov/sitepages/leg/LEG2009/051809HealthCareDescriptionofPolicyOptions.pdf>.

³⁸ The bill as introduced and the amendments adopted by the Education and Labor Committee are available through this link: <http://edlabor.house.gov/markups/2009/07/hr-3200-americas-affordable-he.shtml>. The bill as introduced and the (continued...)

Other comprehensive reform bills introduced in the 111th Congress include H.R. 15 (Dingell), H.R. 193 (Stark), H.R. 676 (Conyers), H.R. 1200 (McDermott), H.R. 1321 (Eshoo), H.R. 2399 (Langevin), H.R. 2520 (Ryan of Wisconsin), H.R. 3000 (Lee), S. 391 (Wyden), S. 703 (Sanders), S. 1099 (Coburn), S. 1240 (DeMint), S. 1278 (Rockefeller), and S. 1324 (DeMint). In general, these bills would provide coverage for nearly all people in the United States, sometimes for everyone under new insurance plans and sometimes only for people not covered by Medicare or some other current plans and arrangements. Many would have an individual mandate (i.e., a requirement that everyone have coverage). Some would address quality, administrative simplicity, and other issues as well.

The Administration has not proposed a health reform bill of its own. However, it has been working continually with the House and Senate committees that have prepared (or are still preparing) the legislation mentioned above, and it has been negotiating with some of the principal stakeholders. The FY2010 budget that it released in February included broad principles for reform;³⁹ it also proposed a number of tax changes that would raise \$300 billion over the next 10 years, mostly from limiting the tax rate that high-income taxpayers can use to reduce their tax liability by itemized deductions.⁴⁰ The budget also proposed more than \$280 billion in Medicare savings and \$22 billion in Medicaid savings.⁴¹ On June 13, the President announced more than \$300 billion additional possible savings from Medicare.⁴² Additionally, the Administration transmitted legislation to Congress called the Independent Medicare Advisory Council (IMAC) Act of 2009 on July 17.⁴³ The IMAC would consist of five members who are either physicians or possess specialized expertise in medicine or health care policy. The council's primary function, beginning in fiscal year 2015, would be providing annual recommendations to the President for changing federal payments for various services covered by Medicare. These recommendation packages would have to be created so that implementation would not exceed aggregate Medicare spending over the subsequent 10 year period, compared with expected spending without any changes. Upon the President's approval, recommendations would become active no sooner than 30 days thereafter, unless Congress enacts a joint resolution to disapprove. On July 25, CBO had scored the savings of such proposal to be \$2 billion over the 2016-2019 period.⁴⁴ CBO notes there is a possibility of considerably more savings beyond 2019 contingent on the scope of IMAC recommendations.⁴⁵

(...continued)

amendments adopted by the Ways and Means Committee are available through this link:

<http://waysandmeans.house.gov/MoreInfo.asp?section=52>. The bill as introduced and the amendments adopted by the Energy and Commerce Committee are available through this link:

http://energycommerce.house.gov/index.php?option=com_content&view=article&id=1687&catid=156&Itemid=55

³⁹ Office of Management and Budget, *A New Era of Responsibility: Renewing America's Promise*, February 26, 2009, http://www.whitehouse.gov/omb/assets/fy2010_new_era/A_New_Era_of_Responsibility2.pdf.

⁴⁰ U.S. Department of the Treasury, *General Explanations of the Administration's Fiscal Year 2010 Revenue Proposals* (May 2010), p. 130.

⁴¹ CRS Report R40587, *Medicare: FY2010 Budget Issues*, coordinated by Holly Stockdale.

⁴² See <http://www.whitehouse.gov/MedicareFactSheetFinal/>.

⁴³ See http://www.whitehouse.gov/omb/assets/legislative_letters/Pelosi_071709.pdf.

⁴⁴ See <http://www.cbo.gov/ftpdocs/104xx/doc10480/07-25-IMAC.pdf>; pg. 2.

⁴⁵ See <http://www.cbo.gov/ftpdocs/104xx/doc10480/07-25-IMAC.pdf>; pg. 6.

Appendix A. Overview of Health Insurance Coverage

The following table provides an overview of the sources of health insurance that people have as well as estimates on the number of uninsured. Estimates for 2009 likely have changed somewhat because of additional population growth and the recession.

Table A-1. Health Insurance Coverage, by Type of Insurance and Age, 2007

Age	Population (millions)	Type of Insurance					Uninsured	
		Employment-based	Private Nongroup	Medicare	Medicaid or Other Public	Military or Veterans' Coverage	(percent)	(millions)
Under 19	78.7	60.7%	5.3%	0.7%	27.6%	2.8%	11.3%	8.9
Under 65	262.3	64.4%	6.5%	2.7%	13.8%	3.2%	17.1%	45.0
65+	36.8	35.0%	25.9%	93.2%	8.9%	7.1%	1.9%	0.7
All ages	299.1	60.8%	8.9%	13.8%	13.2%	3.7%	15.3%	45.7

Source: CRS analysis of data from the March 2008 Current Population Survey (CPS). The table is a truncated version of Table I in CRS Report 96-891, *Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 2007*, by Chris L. Peterson and April Grady.

Note: People may have more than one source of coverage; percentages may total to more than 100.

Appendix B. Characteristics of the Uninsured

People under age 65 who were uninsured in 2007 had the following diverse characteristics:⁴⁶

- *Age*: Young adults ages 19 to 24 represented 9.2% of this population but 16.2% of the uninsured,
- *Race and ethnicity*: Hispanics represented 16.6% of this population but 32.4% of the uninsured,
- *Citizenship*: More than one-quarter were not native-born U.S. citizens,
- *Employment*: More than half were full-time, full-year workers or their spouses and children. About a quarter were part-time or partial-year workers or their spouses or children. Less than one-fifth of the uninsured were in households with no attachment to the labor force.
- *Income*: About 57% of household insurance units had incomes below \$25,000, 27% between \$25,000 and \$49,999, 9% between \$50,000 and \$74,999, and 3% between \$75,000 and \$99,999. About 4% had incomes of \$100,000 or more.
- *Poverty status*: Three-quarters had family incomes above poverty thresholds.

Uninsurance rates for people under age 65 vary widely among the states. Based upon Current Population Survey data for 2006 and 2007, states with the highest rates were Texas (27.4%), New Mexico (25.6%), Florida (24.3%), Louisiana (23%), Arizona (21.8%), and California (20.4%). States with the lowest rates were Massachusetts (8.9%), Hawaii (9.2%), Wisconsin (9.6%), and Minnesota (9.9%).⁴⁷

⁴⁶ Estimates are from CRS Report 96-891, *Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 2007*, by Chris L. Peterson and April Grady. The estimates are based on data from the Current Population Survey.

⁴⁷ Robert Wood Johnson Foundation and the State Health Access Data Assistance Center, *At the Brink: Trends in America's Uninsured, A State-by-State Analysis*, March 2009, <http://www.rwjf.org/files/research/20090324ctu.w.pdf>.

Appendix C. Distribution of National Health Care Expenditures

The following table provides an overview of how the nation's \$2.2 trillion in spending for health care was distributed among various services, products, and activities in 2007. The estimates were prepared by the Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services. CMS estimates that aggregate growth between 2007 and 2008 was 6.1%, which would bring total expenditures for the latter year to over \$2.3 trillion.⁴⁸

Table C-1. Distribution of National Health Care Expenditures by Service, Product, and Activity, 2007

Type of Service, Product, or Activity	Expenditures (in billions of dollars)	Percentage of Total Expenditures
HEALTH SERVICES AND SUPPLIES		
Personal health care		
Hospital care	696.5	31.0
Professional services		
Physician and clinical services	478.8	21.4
Other professional services	62.0	2.8
Dental services	95.2	4.2
Other personal health care	66.2	3.0
Nursing home and home health	190.4	8.5
Retail outlet sales of medical products		
Prescription drugs	227.5	10.2
Other medical products	61.8	2.8
Government administration and net cost of private health insurance	155.7	6.9
Government public health activities	64.1	2.9
INVESTMENT (research, structures, and equipment)	143.1	6.4
TOTAL	2,241.2	100.0

Source: Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. National Health Care Expenditures, 2007, Table2, at <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>.

Note: Data might not sum to total due to rounding.

The following table provides an overview of how the nation's \$2.2 trillion in health care spending in 2007 were distributed by source of funds.

⁴⁸ Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. NHE Fact Sheet, http://www.cms.hhs.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.asp.

Table C-2. Distribution of National Health Care Expenditures by Source of Funds, 2007

Source of Funds	Expenditures (in billions of dollars)	Percentage of Total Expenditures
PRIVATE		
Consumer payments		
Out-of-pocket payments	268.6	12.0
Private health insurance	775.0	34.6
Other private funds	162.0	7.2
PUBLIC		
Federal		
Medicare	431.2	19.2
Medicaid	186.1	8.3
Other federal	137.0	6.1
State and local		
Medicaid	143.3	6.4
Other state and local	138.1	6.2
TOTAL	2,241.2	100.0

Source: Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. National Health Care Expenditures, 2007, Table 3, at <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>.

Notes: Data might not sum to total due to rounding.

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