



Health Policy Brief

August 20, 2009

Key Issues in Health Reform:

- The federal government's role in financing and delivering health care
- Lowering the rate of growth of Medicare spending
- Advance care planning for serious illness

New Debates

Proposed health reform legislation would make sweeping changes in the way health care is financed, organized, and delivered in the United States. As this brief is published, there is significant focus on three key areas in particular: the role of the federal government; the potential impact of reform on lowering the growth rate of Medicare spending; and provisions in a bill approved by three committees of the U.S. House of Representatives that would pay physicians and other qualified health care practitioners to counsel Medicare beneficiaries on advance care planning, as well as to collect information on quality measures for end-of-life care.

This policy brief offers basic facts about the status quo and about how major pieces of reform legislation might affect the picture. As of the publication date of this brief, there are two principal legislative drafts in near-final form: the so-called House Tri-Committee bill, the America's Affordable Health Choices Act of 2009 (HR 3200); and the Senate Health, Education, Labor, and Pensions

(HELP) Committee bill, the Affordable Health Choices Act. The Senate Finance Committee is still negotiating its bill, which is expected to be the main Senate reform legislative vehicle but is not likely to be unveiled before mid-September.

The Role of the Federal Government

What's true now: As in all industrialized nations, the U.S. national government plays a large role in financing, organizing, overseeing, and, in some instances, even delivering health care. In many instances the government's role is focused on getting care to people who wouldn't otherwise have it — the poor, the disabled, and the elderly, many of whom could not afford insurance or might be turned away by insurance companies when they try to buy it. But the government's role in health and health care also reaches far beyond this — into the realm of fostering new discoveries, regulating private-market activities, and much more.

One way to examine government's role is to look at what is the share of total national health spending carried out by various governments —

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state, federal, and local. In 2008, national health spending was estimated to reach \$2.4 trillion. The total public share of this amount — again, state, federal, and local — was estimated at \$1.108 trillion, or about 46 percent of all national health spending. The federal share alone, through Medicare, Medicaid, and other programs and entities, was \$810.6 billion, or 33.7 percent of total national health spending. If tax subsidies that encourage provision of health coverage and health care are added in, the total public share comes close to three-fifths of all U.S. health spending.

The United States has several publicly financed health insurance programs. In these programs, the government does not deliver health care directly; rather, it serves as a financial conduit, collecting money from taxpayers and funneling it through the federal government to pay mostly private-sector health care providers for delivering health care. In terms of federal expenditures, Medicare is the largest of these programs; it currently covers about 45 million people in total — approximately 38 million who are age 65 and older and about 7 million who are disabled. The program is funded by the federal government and individual contributions from beneficiaries for premiums, copayments (fixed-dollar payments for services), and coinsurance (a percentage of what providers charge). Almost 61 million low-income beneficiaries are enrolled in Medicaid, which is paid for by a combination of federal and state funds.

Share of GDP: Another way to look at the impact of government spending on the two largest health programs is to compare it to the size of the nation's overall output of goods and services: the gross domestic product, or GDP. Through this lens, federal spending currently devoted to Medicare and Medicaid is equal to about 4 percent of GDP and is projected to rise to nearly 6 percent by 2019 and 12 percent by 2050. Most of that increase will result from growth in per person costs of providing health care, rather than from the aging of the population or other factors.

In addition to Medicare and Medicaid, there is also the Children's Health Insurance Program (CHIP), which began in 1997 and is paid for jointly by the federal and state governments. The program covers roughly 7 million children whose families generally have low to middle incomes, but not so low that the children qualify for Medicaid.

The federal government is also an employer, so it pays for a large share of the health coverage

of nearly 9 million federal workers and their dependents, through the Federal Employees Health Benefits (FEHB) program. And the government funds and provides health care directly to many others who work or have worked for the federal government as well. Defense Department programs for active-duty and retired military personnel and their families deliver care directly in facilities owned by the government, using health care providers who work for the government. Approximately 7.8 million veterans, out of a total U.S. veteran population of 25 million, receive care directly from the Veterans Health Administration, a division of the Department of Veterans Affairs (VA). This care is also delivered in government-owned facilities, by providers employed by the government. The Indian Health Service, which is part of the Department of Health and Human Services (HHS), runs a health care system that provides care directly to approximately 1.9 million American Indians and Alaska Natives in 35 states.

In addition, the federal government plays a broad role in many other aspects of health, health care, and health benefits. Through the National Institutes of Health, the nation's — and the world's — largest biomedical research institute, the U.S. government pumps nearly \$30 billion a year into discovering and advancing science, leading to new forms of prevention, treatment, and cures. The U.S. Centers for Disease Control and Prevention works to protect public health and safety through disease prevention and control — especially for infectious diseases, but also in areas like safety on the job. The U.S. Food and Drug Administration regulates and supervises the safety of foods, dietary supplements, drugs, vaccines, biological medical products, blood products, and medical devices — in effect, about a quarter of the nation's overall economic output.

In the area of health care, federal laws govern oversight of the Medicare and Medicaid programs and, by extension, the health care providers who are paid under the programs. The Federal Trade Commission and the Justice Department have jurisdiction over antitrust and other competitive issues affecting health care providers. Under various laws and regulations, the U.S. Labor Department oversees many aspects of employer-provided health insurance benefits. And that is just the federal role; under the U.S. Constitution, responsibilities not directly delegated to the federal government were reserved to the states. This means

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that states take the lead in many aspects of health system oversight, such as licensing physicians and health care facilities.

States also are responsible for regulating health insurance companies. Through authority delegated by the federal government, state regulators assure that companies do not engage in price fixing, and they protect consumers from misleading marketing, privacy violations, and other concerns.

Finally, both federal and state governments provide several important tax subsidies for health care. The largest and most important is the so-called tax exclusion of employment-based health coverage (see Health Policy Brief, [“Tax Debate,”](#) July 9, 2009).

What could change under health reform: None of the major health reform bills making their way through Congress includes proposals to establish a federal health care delivery system like the VA or those found in other countries — such as the National Health Services in the United Kingdom. Nor is there any prospect of passing a so-called single-payer plan that would in effect extend Medicare or create a new government-financed program to cover the entire U.S. population.

Instead, one of the most controversial changes in the legislation would create a “public” or government-run health insurance plan that would compete with private insurance in the new insurance marketplace. The public plan proposed in HR 3200 (the America’s Affordable Health Choices Act), the bill approved by three committees of the House of Representatives, is designed to finance itself through premiums, rather than taxpayer funding. There is extensive debate over this proposal, as discussed in Health Policy Brief, [“A Public Health Insurance Plan,”](#) June 19, 2009.

In addition to the public plan, there are proposals to expand Medicaid coverage, offer new options for families whose children are eligible for CHIP, and change how federal and state governments would share the costs. Low-income people who still earn too much money to qualify for government health insurance would be eligible for subsidies to help them purchase coverage. (See Health Policy Brief, [“Coverage for Low-Income People,”](#) July 24, 2009.)

The House and Senate bills would also create an array of new responsibilities for the federal government. These would include helping to develop a national insurance marketplace known as

a health exchange or gateway, or set parameters for states to create and operate them; determining what “essential” health insurance benefits would have to be offered by health plans participating in exchanges; and regulating health insurance at the national level, in conjunction with the states. And depending on how any final health reform measure is crafted, the federal government may impose new requirements: on employers to contribute to coverage or pay fees to subsidize coverage for the uninsured, and on individuals to have qualified coverage or pay a penalty through taxes.

The legislation may also give the states new responsibilities. As part of their role monitoring consumer protection, state regulators may also provide oversight to ensure that insurance companies do not discriminate against sick, elderly, or disabled patients.

Taken together, health reform proposals appear to drive in the direction of an expanded federal role, including into some new key areas, such as insurance regulation at the national level. What’s more, under many health reform options under consideration, total federal spending on health care would undoubtedly increase. However, it also appears to be the case that without certain cost-saving mechanisms proposed in versions of health reform legislation, projected spending growth under existing programs would be even larger. And a total “government takeover” of health insurance or health care, as some critics warn, is not envisioned in the two main House and Senate bills now under consideration.

Lowering Growth of Medicare Spending

What’s true now: Medicare spending in 2008 is estimated by actuaries for the Centers for Medicare and Medicaid Services to total \$466 billion. By 2019, under current projections, overall spending will more than double, to \$931.9 billion. Even as millions more people grow older and become eligible for the program, most of the increase in expenditures will be driven by the rapid rate of growth in per capita costs of providing health care, rather than expanded enrollment or other factors.

What could change under health reform: Legislation approved by three House committees (HR 3200) would trim \$563 billion from the projected growth of Medicare over the course of a decade. These savings translate into “cuts” only

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in the sense that they would reduce projected Medicare spending growth; they do not represent cuts in actual dollar terms, since all components of Medicare spending would still increase substantially. For example, without the Medicare savings proposed in health reform, Medicare outlays would total about \$6 trillion during the decade from 2010 to 2019, and spending in the tenth year would be \$797 billion, assuming that large scheduled cuts in physician payments took effect. However, with the proposed Medicare savings from health reform counted in — and with a payment increase for doctors under HR 3200 factored in, rather than a payment cut — Medicare would still spend about \$5.8 trillion over the decade. Medicare spending in the tenth year would be an estimated \$750 billion.

One of the largest areas of projected savings in Medicare, about \$156 billion, would come from the government’s payments to insurance companies offering private Medicare coverage known as Medicare Advantage plans. In 2009 these private plans will receive an average of 14 percent more than it would cost if their beneficiaries stayed in traditional Medicare. (See Health Policy Brief, [“Medicare Advantage Plans,”](#) April 29, 2009.) Other Medicare savings would be achieved by reducing payment increases for services other than physician services, reducing preventable hospital readmissions, and “bundling” payments for specific medical conditions or procedures, instead of paying each provider separately.

A significant exception to the projected Medicare savings is what Medicare pays physicians. Under the House bill, HR 3200, Medicare physician fees would actually rise \$245 billion over ten years, rather than falling as they would in current law. It is not clear as yet whether this provision will be incorporated into reform legislation emanating from the Senate.

The House bill and the bill reported out of the Senate HELP Committee would also attempt to reduce the rate of growth of Medicare spending by empowering the secretary of HHS to conduct pilot or demonstration projects designed to achieve greater value in health care. These projects, for example, could test new payment and delivery systems, including “bundled” payments; so-called accountable care organizations; and bo-

nuses or incentive pay for Medicare providers who achieve certain goals.

In addition to congressional efforts to lower the rate of growth of Medicare spending, a number of health care organizations and industry groups have pledged their own separate cost-cutting steps. Hospitals, health insurance companies, and medical equipment suppliers, among others, offered pledges to the Obama administration that they would work to lower the overall rate of national health spending growth by 1.5 percentage points per year over a 10-year period, for a \$2 trillion savings. In particular, the American Hospital Association, the nation’s largest hospital group, agreed to pursue \$155 billion in Medicare savings over 10 years; it pledged to undertake a number of initiatives to reduce the rate of costly hospital-acquired infections, to make potentially cost-saving investments in health information technology, and to better coordinate care of the chronically ill. Pharmaceutical companies have promised to make brand-name drugs available at a 50 percent discount to Medicare beneficiaries with drug spending levels that place them in the “coverage gap,” or so-called doughnut hole. These agreements, however, are not enforceable and, for the most part, are not counted by the Congressional Budget Office as “scorable” savings that could be used to offset other new spending under health reform legislation.

Beneficiary impact? Concerns have been raised that proposed Medicare cost savings — again, reductions in the rate of the program’s growth — would inevitably result in cuts in coverage for beneficiaries. In fact, it is likely that the decreased payments to Medicare Advantage plans will prompt at least some plans to scale back on the extra benefits they made available that are not normally paid for by Medicare — for example, coverage of eyeglasses prescriptions. And a lower growth rate in Medicare spending will inevitably mean that some providers or institutions will be paid less than projected. This raises the question of whether some beneficiaries may begin to experience access problems, depending on how the institutions or providers they use respond to lower-than-expected payment rates. Some institutions and providers may become more efficient and may be able to cope with lower payments without beneficiaries’ experiencing deleterious

effects. But there is no guarantee that all institutions will do so and that no beneficiaries will ever face access problems.

However, if some measures to rein in Medicare spending growth result in more efficient or higher-quality care — for example, if fewer people are harmed by preventable hospital-acquired infections — Medicare would save money and patients would be healthier. And some reductions in coverage or payments might not necessarily be harmful. Researchers at the Dartmouth Institute for Health Policy and Clinical Practice have found that patients who get more medical tests and treatments do not always receive better care or the care they need. It is well established that U.S. health care is riddled with unnecessary, ineffective, and even harmful treatments.

At this point in time, it is too early to conclude that changes instituted by legislation still being drafted will automatically harm beneficiaries — or even lead to sharply reduced growth in the value of future Medicare benefits.

Advance Care Planning

What's true now: There is considerable evidence that by many standards, Americans are unprepared for serious illness and the eventuality of death. Fewer than a third of Americans have advance directives — legal documents such as the living will, durable power of attorney, and health care proxy — that declare their treatment preferences should they become incapacitated. Even though a federal law requires hospitals to inform patients that they have a right to state their preferences in an advance directive, few do so. Some researchers have found that in the majority of instances, patients and doctors do not have honest conversations about patients' conditions, and therefore patients may not be aware of the need for, or desirability of, advance directives. As a result, there is a significant gap between what people say they would prefer to happen in their last days or months of life, and what actually happens when they become seriously or terminally ill. In a survey of 2,515 Medicare patients with a mean age of 76, published in the journal *Medical Care* in May 2007, 86 percent preferred to spend their last days at home rather than in a hospital or nursing home. In fact, however, 80 percent of

Americans die in institutions, mainly in hospitals or nursing homes.

When patients have not expressed their wishes regarding end-of-life care, health care providers typically provide full treatment, except in rare instances where there is broad agreement among providers and family members that additional medical care would be futile. For the past two decades, about 25 percent of Medicare's budget has been spent on the 5 percent of beneficiaries who die in a given year. On average, about \$40,000 is spent on each Medicare beneficiary in the last year of life.

What could change under health reform:

Section 1233 of the House "tri-committee" bill, HR 3200, contains a provision that would allow Medicare to pay for a voluntary "advance care planning consultation" to take place every five years between a given Medicare beneficiary and his or her physician, nurse practitioner, or physician assistant. The voluntary consultation would thus become a new Medicare-covered benefit, created by Congress the same way most other Medicare services are established: in a law.

The language of the bill says that the consultation will include a discussion of "key questions and considerations, important steps, and suggested people to talk to" and an explanation of "advance directives, including living wills and durable powers of attorney, and their uses." The health care provider must also explain "the continuum of end-of-life services and supports available, including palliative care and hospice, and benefits for such services" that Medicare covers. It does not say that patients must choose a certain option or limit their care in any way. If Medicare beneficiaries decide to prepare "an order regarding life sustaining treatment," the provision says they can request full treatment or certain kinds of treatment.

Section 1233 of the House bill also contains a provision designed to improve the quality of care delivered to Americans at the end of life, by incorporating new quality measures on "end of life care and advance care planning" into reporting requirements for hospitals and physicians in 2011 and beyond. Specifically, the provision would require these measures to be "adopted or endorsed by a consensus-based organization, if appropri-

ate”; the HHS secretary would then be required to publish these proposed quality measures in the *Federal Register*.

Another section of HR 3200, section 138, requires that group health insurance plans participating in newly created purchasing exchanges also must provide information about end-of-life planning. It does not require beneficiaries to participate in such planning, however, and prohibits the insurer from promoting “suicide, assisted suicide or the active hastening of death.”

The Senate HELP Committee’s Affordable Health Choices Act takes up the issue of advance care planning in a dramatically different context. The bill would create a new, voluntary benefit to help individuals pay for long-term services and supports if they became disabled. Individuals would become eligible for the benefits by contributing through payment of a new tax. One benefit available through this program would be that individuals could obtain legal assistance with advance care planning. This could include assistance in formulating their own living will, obtaining a durable power of attorney, and getting help

with “decision-making concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives or other written instructions . . . in the case that an injury or illness causes the individual to be unable to make health care decisions.”

A separate provision of the Senate HELP Committee bill would bar any government entity or health care provider that receives federal taxpayer money or any health insurance plan created under the legislation from engaging in assisted suicide, euthanasia, or mercy killing.

As this brief was published, the Senate Finance Committee was still working on its health reform legislation. In early August 2009, Iowa Sen. Charles Grassley, the committee’s senior Republican, said that the bill’s negotiators had rejected end-of-life planning provisions. In a written statement, Grassley said that putting such provisions in a health care reform bill that aims to control costs, while also creating a government-run health plan, would lead to limiting or rationing health care services.

Resources

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