

Balancing Private and Public Roles in Health Care

Health care is one of the largest and fastest growing sectors of the U.S. economy, employing millions of individuals in hospitals, physician offices, home health agencies, long-term care facilities, insurance, and pharmaceutical and medical device companies. Today, Americans are living longer as a result of public health improvements and advances in medical treatment. While modern health care provides substantial benefits, there are growing concerns about its rising cost. In 2008, the United States is projected to spend approximately \$2.4 trillion, or almost \$8,000 per person, on health care, and forecasts indicate that spending will continue to grow at a rate faster than the gross domestic product (GDP). Recognizing that rising costs pose a threat to Americans' access to health insurance and medical care, the Administration has pursued several initiatives to encourage the efficient provision of health care through private markets and to improve access to affordable health care for individuals in the United States.

This chapter begins with a brief overview of U.S. performance with respect to the population's health status and spending on health care. This is followed by a discussion of key efforts by the Administration to address issues of health care quality, cost, and access. The key points of this chapter are:

- Health care spending is expected to grow rapidly over the next several decades, a trend that is driven by the increased use of high-technology medical procedures, comprehensive health insurance that decreases consumer incentives to shop for cost-effective care, rising rates of chronic disease, and the aging of the population in the United States.
- Markets for health care services can function more efficiently when payers, providers, and consumers have more complete information as well as incentives to use medical care that is clinically effective and of high value.
- Health insurance improves individuals' well-being by providing financial protection against uncertain medical costs and by improving access to care. Market-based approaches and innovative benefit designs can enable people to select coverage that best fits their preferences and to more actively participate in their own health care decision making.
- The Federal Government has an important role in investing in public health infrastructure, particularly with respect to improving the availability of community-based health care for the underserved, preparing for possible public health crises, supporting health-related research and development, and promoting global health improvement.

The Health of the U.S. Population

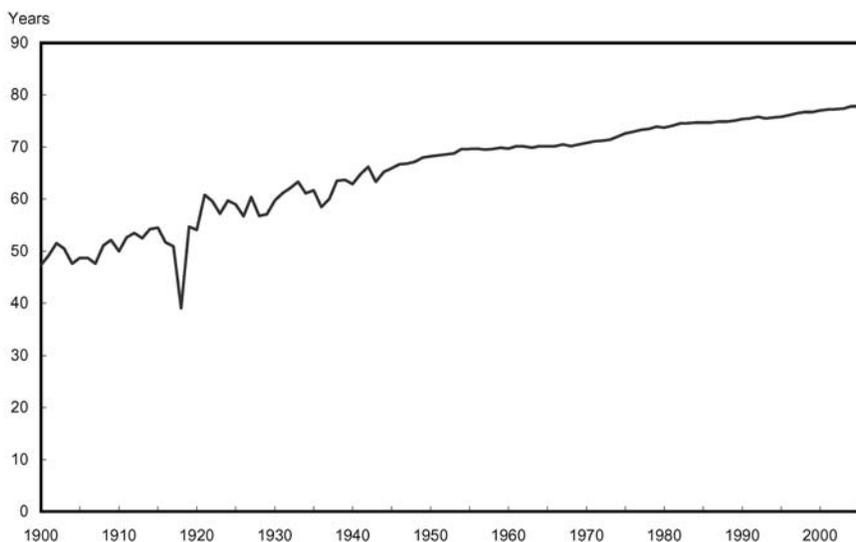
Health can be defined as a state of complete physical, mental, and social well-being. Individuals who are healthy are more productive and happier. Genetic factors; the environment; lifestyle behaviors such as smoking, eating healthy foods, and exercise; and medical care consumption are all factors that have been shown to affect an individual's health.

There are several different ways to measure health outcomes for a population. One consistent and reliable measure is life expectancy, defined as the average number of years of life remaining to a person at a particular age. Chart 7-1 shows how U.S. life expectancy at birth has changed over the past century. In the early part of the 20th century, life expectancy averaged 51 years until an influenza pandemic in 1918 resulted in a significant drop, to 39 years. Following that crisis, there have been steady increases in life expectancy over time. This positive trend can be explained by several factors, most notably, public health improvements such as cleaner water, improved sanitation, and vaccinations, as well as medical innovation.

A second way to measure population health is by examining disease prevalence. Rising rates of age-adjusted chronic diseases, which are conditions

Chart 7-1 **Life Expectancy at Birth**

Life expectancy at birth has increased over time.

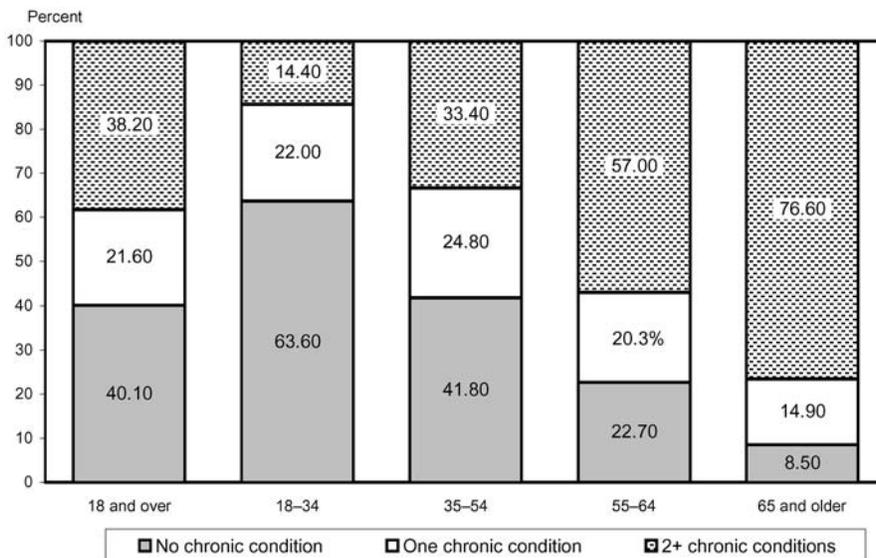


Note: Data from before 1929 are only from states that recorded death statistics.
Source: Centers for Disease Control.

expected to last at least 1 year, are particularly concerning to the medical, public health, and health policy communities. Heart disease and diabetes are two examples of chronic diseases that afflict millions of Americans each year. Heart disease, which affects 7.3 percent of adults 20 years of age and older, has been the leading cause of death for the past 90 years, as well as a major cause of disability. Diabetes affects 7.8 percent of the population, or roughly 23.6 million children and adults, and has numerous costly complications, including kidney damage, eye problems, nerve damage, foot problems, and depression.

In 2005, approximately 60 percent of people 18 years of age and older in the United States had at least one chronic condition, and older adults were considerably more likely to have multiple chronic conditions (Chart 7-2). Managing many chronic diseases can be quite costly. More than 50 percent of total medical care expenditures generated by the adult U.S. population (excluding expenditures for dental care and medical equipment and services) is for the treatment of chronic conditions. However, with medical management and lifestyle changes, people can remain productive and lower their risk of disability from these conditions.

Chart 7-2 Distribution of Adults by Age Group According to Number of Chronic Conditions, 2005
Chronic conditions are more prevalent among older people.



Source: Center for Financing, Access, and Cost Trends, AHRQ, Medical Expenditure Panel Survey, Statistical Brief #203: Health Care Expenses for Adults with Chronic Conditions, 2005.

The good news is that many chronic diseases are preventable. Healthy lifestyle decisions, such as being a nonsmoker, eating nutritious foods, and getting regular physical activity, can significantly lower the likelihood of developing a wide variety of serious medical conditions. In the United States, the rate of smoking has fallen during the past several decades, a trend partially explained by better information about the associated health risks, as well as public policies that deter smoking behavior. However, a major health concern remains in that about 20 percent of adults still report being current smokers. Another major public health concern is the rapid rise in obesity rates among adults and children. Currently, more than 72 million people ages 20 and older are obese, which is defined as having a body mass index (a measure using information on a person's weight and height to indicate body fat) greater than or equal to 30. Obesity is a known risk factor for several costly medical conditions, including heart disease, diabetes, stroke, and some forms of cancer. Continued efforts to promote healthy eating and regular physical activity are critical for reversing this rising trend.

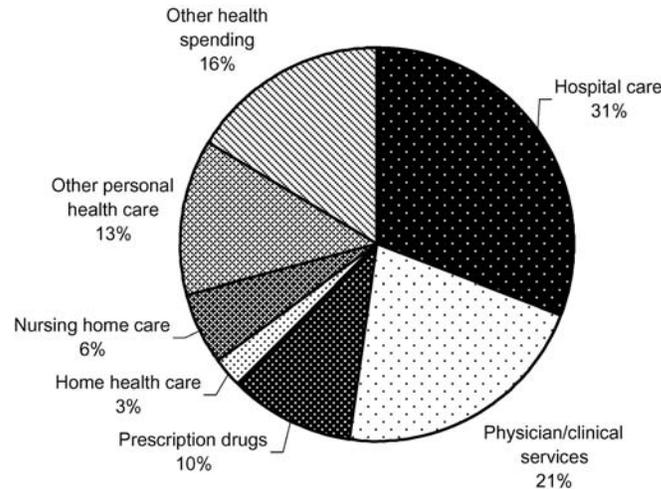
U.S. Health Care Spending

Health-related goods and services include hospital care, physician and clinical services, nursing home care, prescription drugs, and more. Over time, there have been large spending increases across all of these major categories. Chart 7-3 shows the distribution of national health expenditures by type of service in 2006, the most recent year of data available. Hospital care represents the largest segment, at 31 percent of total expenditures, followed by physician and clinical services (21 percent), other types of health spending (which include administration, the net cost of health insurance, public health activity, and research (16 percent)), other personal health care costs such as dental care and medical equipment (13 percent), and prescription drugs (10 percent).

U.S. health care expenditures have grown rapidly during the past several decades. In 2008, the United States is projected to spend approximately \$2.4 trillion, or 16.6 percent of GDP, on health care. Based on actuarial estimates from the Centers for Medicare and Medicaid Services, forecasts indicate that by 2017, the United States will spend approximately \$10,592 per person (in 2008 dollars), which corresponds to 19.5 percent of GDP. Spending a larger share of GDP on health care costs is not necessarily bad; it is to be expected as a nation's wealth rises. In addition to income effects, there are several other factors that drive up the cost of health care in the United States, including population aging, increases in input prices that are greater than inflation, technological advances, and third-party payment.

Chart 7-3 **Distribution of National Health Expenditures by Type of Service, 2006**

Approximately 50% of national health care expenditures are for hospital care and physician services.



Note: "Other personal health care" includes dental and other professional health services and durable and non-durable medical equipment. "Other health spending" includes administration and net cost of private health insurance, public health activity, research, and structures and equipment.

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

Researchers who have investigated the catalysts of health care spending growth suggest that third-party payment and advances in medical technology can account for a significant proportion of the long-term, historical spending trends. Although health insurance provides valuable financial protection, benefit designs that have low out-of-pocket costs at the point of use (such as doctor or hospital visits) greatly inhibit consumers' incentives to search for the lowest-priced providers or to engage providers in discussion about alternative treatment options and their respective costs. Health insurance that has low out-of-pocket cost-sharing can also create distorted incentives regarding the development and diffusion of new medical technologies. Of course, many advances in medicine have been instrumental in helping Americans live longer and healthier lives. For example, providers now have more advanced technologies to diagnose specific problems (such as MRI or CT scanners), treat existing ailments (such as using minimally invasive surgical procedures), and prevent the onset and spread of new diseases or illnesses (such as use of vaccinations or screening procedures). However, when providers and consumers lack strong incentives to control spending, one potential result is that new, more expensive technologies may be prescribed and received, even if they are only slightly more effective than existing therapies. As the amount of financial resources allocated to health care rises, it is important to consider

the role that incentives play in determining the quantity and types of medical care that consumers receive. Additionally, it will be important to continue evaluating the extent to which greater utilization of medical services, including high-technology treatments, translates into better health outcomes.

Improving the Effectiveness and Efficiency of Health Care

The terms “effectiveness” and “efficiency” are frequently used in the context of discussions about improving health system performance. But what do these terms actually mean? *Effective care* includes services that are of proven clinical value. It is medical care for which the benefits to patients far outweigh the risks, such that all patients with specific medical needs should receive it. *Efficient care* includes medical services that maximize quality and health outcomes, given the resources committed, while ensuring that additional investments yield net value over time.

In the United States, there is clear empirical evidence that many patients do not receive the highest quality of care possible. That is, patients do not receive care that fully complies with current clinical guidelines. In one well-respected study, researchers found that only 54 percent of acute care and 56 percent of chronic care provided by physicians conformed to clinical recommendations in the medical literature. Receiving better quality care, particularly for those with chronic conditions, has the potential to reduce the adverse impacts of existing illnesses and prolong life.

There are large differences in the levels of effective care provided in the United States, a result that reflects differences both in provider practice styles and in patient preferences. Researchers associated with the Dartmouth Atlas of Health Care have reported extensive geographic variation in medical care spending and in the use of medical care across a wide range of services such as preventive screenings, diabetes management, joint replacement surgeries, and end-of-life care. Differences across regions of the United States cannot be fully explained by differences in illness rates or well-informed patient preferences. In fact, this research finds that higher rates of utilization reported across the United States do not appear to be correlated with better health outcomes, and that nearly 30 percent of Medicare’s costs could be saved without adverse health consequences if spending in high- and medium-cost areas of the country was reduced to levels in low-cost areas. The Administration has strongly advocated, in its policies, using information and better incentives to improve the effectiveness and the efficiency of health care delivery, including hospital care, physician services, and long-term care.

Health Information Technology

There is optimism among policymakers about the ability of health information technology (IT) to generate significant production efficiencies in the delivery of health care. This is because health IT permits the management of medical information and the secure exchange of information among consumers, providers, and payers. Using IT in health care may help reduce medical errors, provide physicians with information on best practices for diagnosis and treatment, improve care coordination, and reduce duplication of services. The most comprehensive form of health IT is an electronic health record, which is a longitudinal record of patient information that typically includes the patient's demographic characteristics, past medical history, medication use, vital signs, laboratory data, and radiology reports.

One goal of the Administration is for most Americans to have an electronic health record by 2014. While providers have expressed interest in the potential benefits of IT for workflow improvement, adoption has been somewhat slower than anticipated. Results from a survey conducted by the Office of the National Coordinator for Health IT indicate that 14 percent of outpatient doctors currently use an electronic health record, and a study sponsored by the American Hospital Association finds that 68 percent of hospitals have or are in the process of implementing an electronic health record. Key barriers to adoption of health IT include lack of a business case to support adoption; privacy and security concerns; technical issues that make exchanging information difficult; and organizational culture issues, including providers' resistance to changing business processes.

In response to these concerns, the Administration formed the American Health Information Community, a Federal advisory body that includes experts from the public and private sectors, to make recommendations to the Secretary of Health and Human Services about how to accelerate the development and adoption of health IT. Over the past few years, this advisory body has also provided recommendations on how to make records digital and available for providers to share easily, as well as how to assure the privacy and security of those records.

Comparative Effectiveness

For many types of medical conditions, a patient may have a choice between at least two diagnostic methods and/or treatments that have different benefits and risks. Selecting the most appropriate course of care relies on having current information about the effectiveness of each option, given a patient's characteristics. Comparative effectiveness research studies are rigorous evaluations that compare the performance of various diagnostic and treatment options for specific medical conditions and sets of patients. By using

comparative effectiveness research findings, providers can help patients select the most clinically appropriate course of treatment. Advocates of comparative effectiveness research also suggest that widespread use of research findings may help to reduce some of the geographic variation in utilization and spending that exists in the United States.

The number of comparative effectiveness studies has increased in recent decades, and provides the potential to improve the quality of care delivered to patients. A recent Federally-sponsored comparative effectiveness initiative is the Agency for Healthcare Research and Quality's Effective Health Care Program. Created as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, this program funds the creation of new research, synthesizes current research on the benefits and risks of alternative medical interventions, and translates these findings into useful formats that can be easily accessed by health care providers and patients.

Price and Quality Information Transparency

When individuals shop for many goods or services, often they can access information on prices and quality using readily available sources. With this information, they can compare alternatives and then select the one of highest value. Unfortunately, the same information is not readily available for health-related goods and services. Having information on prices and provider quality may be important as people consider which physicians or hospitals to select for care and what impact this might have on their out-of-pocket costs (such as copayments or coinsurance) and their potential health outcomes.

To illustrate, suppose a couple learns that they are expecting their first child and that their physician has admitting privileges at the two hospitals in their community. Wanting to make an informed decision about which hospital they should use for the birth, this couple would benefit from being able to look on their insurer's web site to find information about the price that each hospital charges for different types of deliveries. With this information, they could assess how much it will likely cost them out of pocket for a normal delivery, given their insurance coverage. Additionally, the couple would be able to find information on each hospital's web site about the quality of its maternity services, including the volume of deliveries during the past year, the proportion of deliveries that were performed by Cesarean section, and whether there is a neonatal intensive care unit at the facility.

One challenge in health care is that there are actually two types of prices: list prices and transaction prices. List prices, which are also called charges, are well-documented and are found in all standardized information that hospitals and physicians submit when seeking payment for services. However, list prices are often not relevant because most payers, whether private insurers, Medicare, or Medicaid, pay much less than the list price. The payment

that is actually made by the insurer to the provider is called a *transaction price*. Unfortunately, this information is more difficult to access because it is insurer-specific and providers may be sensitive about having negotiated rates available in the public domain.

In the past 20 years there have been tremendous advances in the development of objective measures of clinical quality for chronic diseases, acute care, preventive care, and long-term care. Improvements in health care quality measurement as well as better information systems are making it easier to evaluate provider performance and generate information that is relevant and timely for providers and individuals. Increasing the transparency of information about health care quality can motivate providers to improve the care that they deliver, and it can help consumers to make more informed decisions regarding their provider choices. A key priority for the Administration has been public reporting of price and quality information. In addition to advocating for greater transparency across the entire health care system, the Federal Government and the Centers for Medicare and Medicaid Services, in particular, have developed Hospital Compare, Nursing Home Compare, and the Medicare Prescription Drug Plan Finder, which are comprehensive, web-based resources providing quality and pricing information.

Pay-for-Performance

Pay-for-performance refers to purchasing practices aimed at improving the value of health care services that are provided to patients, where value depends on both quality and cost. Private insurers, as well as Medicare and Medicaid, are using pay-for-performance programs that provide doctors and hospitals with financial incentives to meet certain performance measures for quality and efficiency or to show quality improvement. Researchers in the private and public sectors are conducting numerous evaluations of pay-for-performance programs to assess whether these programs affect provider behavior and improve the quality of care that patients receive.

One such evaluation includes the Premier Hospital Quality Incentive Demonstration Project, which started in 2003. In this Medicare demonstration, hospitals receive bonus payments based on their performance on five medical conditions, including acute myocardial infarction (heart attack), coronary artery bypass graft, pneumonia, heart failure, and hip/knee replacement. Improvements in quality of care during the first 3 years of the demonstration have saved the lives of an estimated 2,500 acute myocardial infarction patients, based on an analysis of mortality rates at participating hospitals. Additionally, more than 1.1 million patients treated in the five clinical areas at participating hospitals have received approximately 300,000 additional services or recommendations that align with evidence-based clinical quality measures, such as smoking cessation advice, discharge instructions, and pneumococcal vaccination.

Using Market-Based Approaches to Improve Access to Health Insurance

The financial burden of health care costs can be extensive, particularly for those who have a serious health episode, such as cancer or a trauma-related injury. In the United States, about 80 percent of medical care expenditures each year are generated by about 20 percent of the population. Health insurance provides individuals with financial protection against costs associated with medical treatment, giving them access to needed and valuable care that otherwise might not be affordable. This section provides an overview of current health insurance coverage patterns and discusses key Administration initiatives to promote market-based approaches and new types of insurance benefit designs to provide individuals with greater flexibility as they choose coverage that best meets their needs.

Private Health Insurance

The private market for health insurance is really two markets—one for employer groups and another for individuals. Currently, 165 million Americans under 65 years of age obtain their coverage through an employer source, either as a worker or a dependent of a worker, and approximately 17 million non-elderly individuals purchase coverage in the individual market.

In the United States, employer provision of health insurance is voluntary, and while 99 percent of large firms (those with 200 or more workers) offer coverage to their workers as a benefit, a smaller percentage of small firms do. In 2008, 62 percent of small firms (those with 3–199 workers) offered their workers health insurance, down from 68 percent in 2000. Two main factors cause small firms to be less likely to offer health insurance as a fringe benefit relative to large firms. First, small firms may have difficulty pooling risk effectively. Very small groups, in particular, may be less able to absorb the financial shock of a high-cost, low-probability medical problem by one or more of their employees, which may result in higher premiums for a specific amount of coverage, as well as larger rate increases over time. Second, there are human resources costs for firms when they shop for insurance, coordinate enrollment with employees, and integrate employee contributions toward the premium with payroll. If the per-worker administrative costs of insurance are higher for small firms, they may be less likely to offer coverage.

For individuals who are not offered health insurance through an employer, the individual market is an alternative way to acquire coverage. Many who purchase insurance in this market use it as a bridge between jobs that provide employer-sponsored insurance or between employer-sponsored coverage and

Medicare. For others, including the self-employed, coverage purchased in the individual market may need to serve their needs over the long term.

There are several different types of health insurance plans available in the private market, including health maintenance organizations, preferred provider organizations, and point-of-service plans. In addition to traditional managed care plans, a new generation of insurance benefit designs, called *consumer-directed health plans*, is emerging. Consumer-directed health plans typically have three basic features: a high deductible, which is the dollar amount that has to be paid before an insurer covers any medical expenses; an associated account that can be funded with pre-tax dollars and can be used to pay for out-of-pocket medical expenses; and tools to help enrollees make decisions about their medical care treatment options. The two most prevalent forms of consumer-directed health plans are Health Reimbursement Arrangements, which are offered by employers, and Health Savings Accounts, which are offered in both the employer group and individual markets. See Box 7-1 for information about Health Savings Accounts.

Box 7-1: Health Savings Accounts: Innovation in Benefit Design

Health Savings Accounts (HSAs) were signed into law by the President in 2003 as part of the Medicare Prescription Drug, Improvement, and Modernization Act. HSAs are tax-advantaged savings accounts to which individuals can contribute funds that they can then use to pay for qualified medical expenses. HSAs are used in conjunction with High-Deductible Health Plans that meet specific criteria. In particular, these plans must have a minimum deductible of \$1,150 for single coverage and \$2,300 for family coverage in 2009, an annual out-of-pocket limit of no more than \$5,800 for individuals and \$11,600 for families in 2009, and catastrophic coverage in case an individual or family exceeds the out-of-pocket limit as a result of a serious medical episode. Health plans that meet these criteria are referred to as HSA-compatible or HSA-eligible plans.

HSAs are available in both the employer group and individual markets. When offered in an employer setting, both an employer and employee can contribute money to the account, up to specific limits (\$3,000 for individuals and \$5,950 for families in 2009). Also, employees whose health plans meet the deductible and out-of-pocket limit criteria described above can open an HSA on their own if their employer does not open an account for them. Unused balances may be rolled over from year to year and accumulate interest, thus allowing individuals to build up savings that can be used to cover future medical expenses. Additionally, HSAs are portable, which means that individuals are able to

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Box 7-1 — continued

keep any unspent funds in the account when they change employment or exit the labor force.

Enrollment in HSA-compatible health plans has been growing steadily each year. In 2006, over 6.8 million employees and dependents were enrolled in High-Deductible Health Plans, and over 30 percent of these enrollees were in small firms. As of January 2008, approximately 1.5 million consumers had purchased HSA-compatible plans in the individual market. HSAs in combination with a High-Deductible Health Plan are playing an increasingly important role in the individual market, providing an option that is more affordable, on average, than other traditional types of health plans.

HSAs and High-Deductible Health Plans are designed to encourage more consumer control over health care decision making, but concerns have arisen about the impact that these plans may have on policyholders' care-seeking behavior. In particular, some believe that the deductible may lead individuals to forgo or delay getting care such as preventive screenings (for example, mammograms). To mitigate this concern, most insurers now provide some coverage before the insured person meets his or her deductible. Research that analyzes the impact of HSAs and High-Deductible Health Plans on medical care utilization and expenditures is mixed. In coming years, as these plans gain market share, research may help to clarify the full effect of this type of benefit design on care-seeking behavior and costs.

The employer group and individual markets for health insurance have unique advantages and disadvantages. Employer groups are generally able to pool risk, as individuals within an employer group initially come together for a purpose other than buying health insurance and because larger numbers of covered people makes it easier to predict the average expenditure of the group. Effective risk pooling is often more challenging in the individual market, given the potential for adverse selection, whereby individuals who expect high health care costs are more likely to buy coverage, while those who expect to have low costs may be less likely to do so. If insurers are not able to fully identify the risk of individuals seeking coverage and premiums are set according to the average risk in the population, then there will be insufficient funds to cover the claims that are generated. In most States, health insurers use medical underwriting to assess individuals' risk for generating medical expenditures based on their demographics, health status, and past utilization.

Another important distinction between the employer group and individual markets is the tax treatment of premiums. For employer-sponsored insurance, premiums that are paid by employers are exempt from the Federal income

tax, State income taxes in 43 States, and Social Security and Medicare taxes. In addition, many employees can pay their share of the insurance premium with pre-tax dollars if their firm offers a “Section 125” plan. The amount of forgone revenue associated with excluding tax on premiums is often referred to as the “tax subsidy” for employer-sponsored health insurance. The tax exclusion encourages employers to provide a larger share of workers’ total compensation in the form of health insurance benefits, leading employers to offer generous coverage with low levels of coinsurance and deductibles. In turn, these low levels of cost-sharing can encourage moral hazard, whereby individuals use more medical care than they would if they were responsible for the full price of that care.

For self-employed workers and their families, there is a partial tax subsidy of health insurance, which allows them to deduct health insurance for themselves and their families from the Federal income tax (up to the net profit of their business) but not from the self-employment tax (equivalent to the combined tax that they would pay for Social Security and Medicare). For those who neither are self-employed nor have an offer of employer group insurance, medical care expenses, including the premiums for coverage purchased in the individual market, are tax deductible only when these expenses exceed 7.5 percent of adjusted gross income.

As discussed before, not all workers have access to employer-sponsored insurance; those who do may have limited choices, particularly if they are employed at a small firm. While the individual market provides an alternative way to acquire health insurance, for many it is not perceived to be as attractive as employer-sponsored insurance. One way to move toward balancing the attractiveness of the employer group and individual markets is to alter the current tax treatment of premiums. Removing the tax exclusion for employer premiums has the potential to eliminate many of the inefficiencies and equity issues associated with the current system; it would also increase Federal Government income tax revenues by up to \$168 billion in FY 2009.

The President has proposed replacing the current tax exclusion with a flat \$15,000 standard deduction for health insurance for families or \$7,500 for individuals. The amount of the standard deduction would be independent of the actual amount spent on a health insurance policy, which would need to meet a set of minimum requirements for catastrophic coverage. Thus, individuals and families would still be able to take the full amount of the deduction from income and payroll taxes, even if their health insurance premium cost less than that amount. Although individuals with small tax liabilities would not stand to gain as much from a tax deduction as individuals with higher tax liabilities, this approach would make health insurance more affordable, particularly for those who do not have access to employer-sponsored coverage.

Public Insurance

Several programs funded by the Federal Government exist to provide health care to specific populations. These programs include the Federal Employees Health Benefits Program (FEHBP), TRICARE, the Veterans Health Administration (VHA), the Indian Health Service (IHS), Medicaid, the State Children's Health Insurance Program (SCHIP), and Medicare. The FEHBP and TRICARE are health insurance programs for Federal employees and active duty personnel, respectively. The Federal Government also provides medical care to veterans through the Veterans Health Administration. Run by the Department of Veterans Affairs, the VHA provided services to 5.5 million patients in 2007, up from 3.8 million in 2000. The Indian Health Service provides health care to members of Federally-recognized tribes and their descendants. This too is a public health care system in the sense that the Federal Government operates the IHS hospitals and employs the program's health care providers. In 2007, the IHS provided services to 1.5 million American Indians and Alaska Natives.

Established in 1965, Medicaid provides medical assistance for certain children, families, and elderly and disabled individuals with low incomes and low resources. Medicaid is administered by the States and is jointly funded by the Federal Government and States. In 2007, there were approximately 48 million Medicaid enrollees. Another public insurance program is the State Children's Health Insurance Program (SCHIP), which was created in 1997. SCHIP enables States to provide health insurance coverage for low-income children who do not qualify for Medicaid. SCHIP is also administered by the States and jointly funded by the Federal Government and the States. States receive an enhanced Federal matching rate for SCHIP that is higher than their Medicaid matching rate but capped at a fixed level. During fiscal year 2007, more than seven million children were enrolled in SCHIP.

Medicare, also begun in 1965, provides health insurance to nearly all individuals aged 65 and older, as well as some younger individuals with permanent disabilities or those who have been diagnosed with end-stage renal disease. Today, there are approximately 44.6 million Medicare beneficiaries. As discussed in Chapter 6, Medicare consists of four parts: Part A provides coverage for inpatient hospital services, some home health care, and up to 100 days in a skilled nursing facility. Part B provides coverage for outpatient services, including outpatient provider visits and certain preventive screening measures. Part C, also known as Medicare Advantage, provides beneficiaries with the option of enrolling in one of several types of private health plans rather than traditional, fee-for-service Medicare. Finally, Part D provides coverage for outpatient prescription drugs.

Revitalizing and strengthening Medicare Advantage has been a key priority for the Administration. As an alternative to traditional Medicare, beneficiaries may enroll in one of several types of private health plans, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), and private fee-for-service (PFFS) plans. For the past 3 years, 100 percent of Medicare beneficiaries have had at least one Medicare Advantage plan available in their local geographic market, up from 75 percent in 2004. Currently, nearly 10 million people, or over 20 percent of all Medicare beneficiaries, are enrolled in Medicare Advantage plans.

Many beneficiaries are attracted to Medicare Advantage plans because these plans typically cover services that are not covered under traditional Medicare, such as dental care, certain preventive services, and care management for those with chronic conditions. Additionally, Medicare Advantage enrollees may have lower out-of-pocket costs. For 2008, Medicare Advantage plans offered an average of approximately \$1,100 in additional annual value to enrollees in terms of cost savings and added benefits. Of course, it is important to acknowledge that beneficiaries who enroll in Medicare Advantage plans must comply with the particular policies of those plans when using services. In some cases, this may include using only providers in the plan's network.

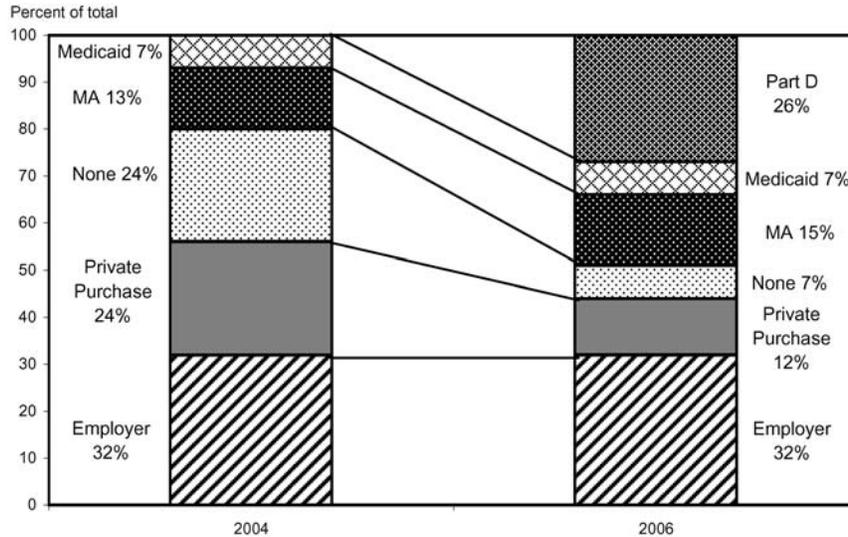
One of the most significant changes in Medicare during this Administration was the creation of Part D, a voluntary program in which beneficiaries are able to purchase prescription drug coverage from private health plans that contract with Medicare. On average, beneficiaries pay 25.5 percent of the cost for standard drug coverage, while the Federal Government subsidizes the remaining 74.5 percent. Each year, beneficiaries can choose a drug benefit plan from a large number of diverse plan offerings. This variety ensures that beneficiaries are able to select the insurance policy that best meets their preferences.

Before Part D was created, beneficiaries could obtain drug coverage by using an employer retiree plan, if they had one; purchasing a private Medigap plan; enrolling in a Medicare managed care plan; or using Medicaid coverage if they were dually eligible. Chart 7-4 illustrates the change in prescription drug coverage among beneficiaries between 2004 and 2006, the year that Part D was fully implemented. In 2004, 24 percent of Medicare beneficiaries lacked prescription drug coverage. By 2006, many of these Medicare beneficiaries obtained prescription drug coverage by choosing a stand-alone drug plan or a Medicare Advantage (MA) plan.

Part D has had important effects on beneficiaries' out-of-pocket spending and their adherence to the medication protocols they have been prescribed. Recent analyses from the Health and Retirement Study data found that the introduction of Part D has been associated with a median decrease of

Chart 7-4 Prescription Drug Coverage for Medicare Beneficiaries in 2004 and 2006

The implementation of Medicare Part D resulted in significant changes for how Medicare beneficiaries obtain coverage for prescription drugs.



Note: Due to rounding, percentages may not add to 100.
Source: The University of Michigan Health and Retirement Study.

\$30 per month in out-of-pocket spending among the newly insured population, compared to median baseline spending of \$100 per month. When prescription drugs are not affordable, individuals may not adhere to their prescribed regimes. They may skip doses, reduce doses, or let prescriptions go unfilled. Recent work finds a small but significant overall decrease in cost-related medication non-adherence following the implementation of Part D. Both the revitalization of Medicare Advantage and the creation of Medicare Part D represent important steps for ensuring that beneficiaries have affordable choices for their health insurance.

The Uninsured

An important issue facing policymakers today is that a large number of individuals lack health insurance in the United States. In addition to providing important financial protection, health insurance can help people obtain timely access to medical care. Research has shown that having health insurance is positively related to having a usual source of medical care, receiving preventive services, and getting recommended tests or prescriptions. Based

on U.S. Census data, the current number of individuals who lacked insurance during the calendar year is estimated to be 45.7 million people, or roughly 15.3 percent of the population. It is important to note that some people in Federal survey-based counts of the uninsured actually may have access to public insurance, but do not wish to report their program enrollment due to the possible stigma, or have not yet enrolled despite their eligibility. Also, others in Federal survey-based counts of the uninsured may have access to private insurance but have chosen not to purchase it.

The uninsured are diverse in terms of their employment and demographic characteristics. Individuals in households that have a full-time, full-year worker make up about 62 percent of the non-elderly uninsured population. Even with strong ties to the labor force, many people may not be offered employer-sponsored coverage. Even if such coverage is available to them, many people may choose not to buy insurance because it is not affordable or they do not place much value on having insurance. Individuals who lack insurance also tend to be younger.

In 2007, roughly 58 percent of the uninsured were under the age of 35. Finally, the uninsured are more likely to be from lower-income households, although a significant proportion of the uninsured population is made up of people in higher-income households. As shown in Table 7-1, among households earning less than \$50,000 per year, more than 20 percent of those households are uninsured. This contrasts with the highest household income category, where only 7.8 percent of individuals lack insurance.

Going forward, it is important that as the Federal Government continues to work on increasing the number of Americans who have health insurance, it uses approaches that effectively target those who are the greatest risk for being uninsured.

TABLE 7-1.—*Uninsurance Rates by Household Income Category*

Household Income	Population	Number of Uninsured	Percentage of Population That is Uninsured
Less than \$25,000.....	55,267,000	13,539,000	24.5%
\$25,000–\$49,999.....	68,915,000	14,515,000	21.1%
\$50,000–\$74,999.....	58,355,000	8,488,000	14.5%
Greater than \$75,000.....	116,568,000	9,115,000	7.8%

Source: Income, Poverty, and Health Insurance Coverage in the United States, 2007, U.S. Census.

Note: Due to rounding, percentages do not add to 100.

Investing in Public Health

The Federal Government plays an important role in identifying and addressing public health issues. This Administration has pursued several public health investment areas, including building a stronger safety net for the medically underserved, preparing for disease outbreaks and bioterrorism threats, supporting health-related research, and taking a leadership role in global health-improvement activities focused on HIV/AIDS and malaria.

Strengthening Community-Based Health Care

The Health Center Program is a Federal grant program that offers funding to local communities for providing family-oriented primary and preventive health care services. Health centers serve as an important safety net for people who need medical care but are underserved, including those without health insurance. Health centers provided care to more than 16 million individuals in 2006, and they are located in all 50 States and the District of Columbia. In 2002, the President made a commitment to create 1,200 new or expanded sites—a goal that was attained in 2007. Additionally, Federal funding for health centers has increased to \$2 billion annually.

Preparing for Public Health Emergencies

The Federal Government plays an important role in ensuring a timely and appropriate response in the event of a public health emergency, such as an influenza pandemic or a bioterrorism threat. These types of situations could potentially lead to high levels of illness, social disruption, and economic loss, and therefore it is important for the Federal Government to invest resources in developing strategies to prepare for them. Working in collaboration with the States, the Federal Government has provided funding, advice, and other assistance to State and local planning efforts.

Supporting Research

Health-related research is multidisciplinary. It includes biomedical and epidemiological work that can reduce a population's mortality and morbidity risks from disease; economic analyses that investigate consumer and provider decision making; and health services research that examines issues such as medical care utilization, quality, and access to services. Americans rate health research as a high national priority. For fiscal year 2009, Federal funding for the National Institutes of Health is \$29.5 billion. These resources will be used predominantly for supporting more than 38,000 research grant awards. It is beneficial to have a balance between investments that support biomedical

research and those that address critical issues pertaining to the delivery and financing of health care, particularly given the substantial amount of resources that are going to be required to meet the medical care needs of the population in future decades.

Promoting Global Health Improvement

Many nations across the world are developing strategies to deal with consequences from the broad transmission of serious diseases, including HIV/AIDS, malaria, and tuberculosis, among others. In less developed parts of the world, people who contract these diseases face a much higher risk of mortality than do people in more developed parts of the world. There is also a significant economic impact from disease. In addition to the direct costs of medical treatment, high rates of serious disease within a population can hinder economic development. For example, HIV/AIDS may lead to large-scale losses in work productivity as the disease progresses and leaves those who are infected and their caregivers unable to work. Studies suggest that the high rate of HIV/AIDS has reduced the average national growth rates in African countries by 2 to 4 percent per year. Over the long term, high levels of disease also may inhibit educational investment, as shorter life expectancy diminishes incentives for human capital investment.

In 2003, the United States took a leadership role in supporting HIV/AIDS treatment, care, and prevention programs around the world, including in 15 countries that together have half of the world's HIV infections: Botswana, Côte d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam, and Zambia. Known as the President's Emergency Plan for AIDS Relief (PEPFAR), this program has supported more than 57 million HIV counseling and testing sessions and has supported care for more than 10.1 million people infected or affected by HIV/AIDS, including more than 4 million orphans and vulnerable children worldwide. Additionally, through September 30, 2008, PEPFAR supported antiretroviral treatment for approximately 2.1 million people and prevention of mother-to-child transmission interventions during more than 16 million pregnancies. In 2008, Congress extended this program for an additional 5 years and significantly increased its authorized funding level.

A second global health initiative pursued by the Administration has been prevention and treatment of malaria. Each year, more than 1 million people die of malaria, most of them young children in Sub-Saharan Africa. It also causes serious morbidity, as those who are infected tend to lose, on average, 6 weeks from school or work due to the illness. Spending related to the disease can account for as much as 40 percent of public health expenditures, as well as high levels of household out-of-pocket expenditures. Beyond imposing high medical costs and lower incomes due to absenteeism, malaria

is likely to impose indirect costs through broader macroeconomic channels, including underdeveloped tourism industries and lower levels of foreign direct investment.

In June 2005, the President's Malaria Initiative was announced. This initiative represents a public-private partnership among the U.S. Government, nongovernmental organizations, corporations, foundations, and faith-based service organizations, with the goal of reducing the mortality rate from malaria in 15 African countries by 50 percent. In 2007, the initiative's second year, 25 million people in Sub-Saharan Africa are estimated to have benefited from the program. More than 6 million long-lasting, insecticide-treated mosquito nets have been purchased, with two-thirds of those nets distributed.

Conclusion

The U.S. health care system is at a critical juncture. While advances in medical technology help millions of Americans lead longer and healthier lives, the rising cost of health care is both threatening the ability of Americans to access care that is affordable and is increasing the strain on Federal and State budgets. There are several opportunities to increase the value of health care and improve health insurance coverage. This Administration has pursued policies to improve the efficiency of health care markets through increased consumer involvement, improved choices, information transparency, and incentives to providers for delivering high-quality, efficient care.

This Administration has also pursued policies to improve the health insurance options of Americans. With the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Medicare was expanded to provide beneficiaries with improved access to affordable prescription drugs. Additionally, this legislation created Health Savings Accounts, which, in combination with High Deductible Health Plans, give individuals the incentive to become more active decision makers regarding their health care and health investments. Finally, this Administration has held to its commitment to make important investments in public health, including the expansion of Health Centers, collaboration with States and local governments to prepare for potential crises or threats, support of health-related research and development, and promotion of global health-improvement initiatives.